Herefordshire Council

AGENDA

Cabinet

Date:	**Thursday 15 September 2016**
Time:	**2.00 pm**
Place:	**Council Chamber, The Shire Hall, St Peter's Square, Hereford, HR1 2HX**

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

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Agenda for the meeting of Cabinet

Membership

Chairman	**Councillor AW Johnson**
Vice-Chairman	**Councillor PM Morgan**
	Councillor H Bramer
	Councillor DG Harlow
	Councillor JG Lester
	Councillor PD Price
	Councillor P Rone

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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HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Cabinet held at Council Chamber, The Shire Hall, St Peter's Square, Hereford, HR1 2HX on Thursday 28 July 2016 at 2.00 pm

Present: **Councillor AW Johnson (Chairman)**
Councillor PM Morgan (Vice-Chairman)

Councillors H Bramer, DG Harlow, JG Lester and PD Price

Cabinet support members in attendance	Councillors JA Hyde, NE Shaw, EJ Swinglehurst and BA Durkin
Group leaders in attendance	Councillors JM Bartlett, TM James, RI Matthews and AJW Powers
Scrutiny chairmen in attendance	Councillors WLS Bowen
Other councillors in attendance:	Councillors J Stone
Officers in attendance:	Alistair Neill, Annie Brookes, Richard Ball, Gill Cox, Richard Gabb,Josie Rushgrove, Martin Samuels and Adam Scott

17. APOLOGIES FOR ABSENCE

Apologies were received from Councillor P Rone.

18. DECLARATIONS OF INTEREST

None.

19. MINUTES

RESOLVED: That the Minutes of the meeting held on 21 July 2016 be approved as a correct record and signed by the Chairman.

20. ONE HEREFORDSHIRE AND THE HEREFORDSHIRE AND WORCESTERSHIRE SUSTAINABILITY AND TRANSFORMATION PLAN

Cabinet received an updated report on the One Herefordshire programme and the Herefordshire and Worcestershire sustainability and transformation plan (STP) submission. The following areas were highlighted:

- The One Herefordshire programme provided a framework for whole system leadership and collaboration which would enable system wide strategic direction and delivery mechanism to deliver the Health and Wellbeing Strategy and the Children and Young People's Plan. It would enable the council to engage with wider public sector partners in a co-ordinated manner to increase efficiency and value for money.

- Exploring joint commissioning arrangements with the CCG represented an opportunity to improve the efficiency and impact of the council's commissioning function alongside that of the NHS, to provider better value for money.

- The STP process was intended to provide the central vehicle through which local government and the NHS can work together in order to achieve the 'triple aim' of improving the health and wellbeing of the local population, improving the quality and safety of care delivery and securing ongoing financial sustainability. It was expected that the STP process would be merged with the requirement for all areas in the country to produce a plan for the full integration of health and social care by 2020.

In reply to questions from a Group Leader, the director of adult's wellbeing said:

- That the recommendation before cabinet was for the chief executive to lead the initiative because it had implications not only for adults, but also for children's wellbeing.

- That the intention was to put pressure on the NHS to recognise the value of the triple aim philosophy of improving local health and wellbeing; the quality and safety of care delivery and securing ongoing financial sustainability. Local government was the greater contributor in this area than the NHS, as it was responsible for areas such as housing and green spaces.

- That the phased three year process would allow for a gradual implementation and help ensure that there was a change in attitudes presently embedded in the cultures of the organisations involved.

Resolved:

That:

(a) the strategic direction of the One Herefordshire programme and of the Herefordshire and Worcestershire STP both be supported;

(b) the chief executive be tasked with exploring joint commissioning arrangements with Herefordshire Clinical Commissioning Group (CCG), as outlined at paragraphs 14-18 and bringing back proposals for decision;

(c) the chief executive be authorised to enter into such non legally binding agreements on behalf of the council as may be appropriate to support the development of the One Herefordshire partnership, including potentially forming a shadow strategic alliance between the council, Herefordshire CCG, Wye Valley NHS Trust, 2gether NHS Foundation Trust and Taurus Healthcare, with links to the voluntary and community sector (VCS), and to provide updates on progress as part of future corporate performance reports.

21. WEST MIDLANDS COMBINED AUTHORITY

A report to approve Herefordshire Council's application to become a non-constituent member of the West Midlands Combined Authority (WMCA) was received.

The leader said that the intention would be to sign up as a non-constituent member, and receive an updated report from the chief executive in the New Year which would lay out the council's experience to date of being a member of the WMCA. This would provide a basis for a decision for a way forward.

In the ensuing discussion the following points were made:

- That, as a non-constituent member Herefordshire would retain all its current powers and responsibilities but would gain a voice in the development of policies and projects affecting the economy of the West Midlands region.

- That non-constituent members were not affected by the existence of a mayor, but that a future report would address this issue as it affected constituent members.

Resolved:

That:

a) Herefordshire Council applies to become a non-constituent member of the West Midlands Combined Authority (WMCA) at an annual cost of £25k;

b) the leader of the council, or his nominated substitute, be authorised to represent the council at the WMCA board, and exercise the council's vote as a non-constituent member; and;

c) the general overview and scrutiny committee be invited to consider building into their future work programme an appraisal of further devolution options (to include the potential for the council to become a constituent member of WMCA) and report the outcome of their review to inform any future decision of Cabinet.

22. UNACCOMPANIED ASYLUM SEEKING CHILDREN TRANSFER SCHEME

Cabinet received a report to approve joining the National Unaccompanied Asylum Seeking Children (UASC) Transfer Scheme and accept the statutory responsibility for a number equivalent of up to 0.07% of the child population within the county.

The head of looked after children highlighted the following areas:

- The UASC scheme was a fair, equitable and transparent system for caring for children across the UK; the scheme was voluntary and locally led.

- The transfer scheme offered the council an opportunity to demonstrate compassion for young people who had experienced conflict and trauma both within their home countries and during their journey to the UK.

- Of those seeking asylum, 62% were aged 16 or 17 and a minority were female. Almost all children aged under 16 were fostered with half of those aged 16 to 17 being placed in foster care and half being placed in semi-supported accommodation. UASC's who were given leave to remain within the UK were entitled to the same care and support as any other care leavers.

In the ensuing discussion the following points were made:

- That there were a variety of levels of language skills amongst the UASC's. Those who were already here were doing well, but interpreters were provided for formal meetings involving their legal status in this country.

- That the council would make use of regional expertise from Solihull Council in dealing with UASC's.

- That all 16 and 17 year olds in care would be entitled to the same care leaver support that other looked after children were, but that they would have to seek leave to remain in the country once they turned 18.

Resolved:

That:

(a) the principle that the council would offer sufficient placements so that the number of UASC accommodated in its looked after system was equivalent to 0.07% of our child population be accepted; and

(b) the director for children's wellbeing be requested to, working with partner councils as appropriate, continue to make the case to government for sufficient funding to adequately resource these additional pressures and provide a further report on the outcome of those negotiations.

23. UNDERSTANDING HEREFORDSHIRE: INCLUDING THE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2016

Cabinet received the annual update of Understanding Herefordshire including the JSNA.

The cabinet member reported that the document was the responsibility of the Health and Wellbeing Board, and that the board had agreed a robust management arrangement in order to ensure that the intelligence was used to the fullest extent.

In reply to a member, the director of adult's wellbeing said that the statement in the presentation that migration was the sole driver of population referred to population growth, rather than any change in the population structure.

He went on to say that the statement that Bromyard had fallen into the bottom deprivation quartile represented a reflection that other areas were becoming less deprived more quickly rather than an absolute decline for Bromyard.

Resolved:

That:

(a) the 2016 Understanding Herefordshire JSNA 2016 summary report be noted;

(b) having regard to the key issues identified for Herefordshire, and any specific priorities cabinet wish to highlight, the directors for adults and wellbeing, children's wellbeing and economy, communities and corporate be requested to ensure that, as they review current policies and strategies and develop new policies and strategies, ensure that these have full regard to identifying the most effective ways to assist in addressing the challenges identified within Understanding Herefordshire; and;

(c) the evidence base provided by Understanding Herefordshire continue to be used to inform future decision-making.

24. RESTATED 2015/16 CAPITAL OUTTURN PER SCHEME

A report to inform cabinet of the revised presentation of the capital outturn figures for 2015/16 following the identification of errors in one table within the report to cabinet on 16 June was noted.

The head of corporate finance reported that the 2015/16 capital outturn reported to cabinet on 16 June had contained correct data relating to capital spend in 2015/16 but that the second table in appendix B to the report showing spend per capital scheme contained twenty three inaccuracies. This error had not affected the total capital spend reported, the funding of that investment or the 2016/17 capital budgets presented on 21 June. This error did not impact on the treasury management outturn approved by Council on 15 July, and no decisions had been founded on the inaccurate data in the table.

The error arose from moving source data into the 2015/16 outturn compared to 2015/16 budget table included in appendix B, rather than from any inaccuracy in the source data itself. The table was intended to provide greater clarity on where capital investment in 2015/16 was allocated by capital scheme. Action had been taken to strengthen the quality assurance of data tables produced for reports to minimise the potential for such human error in the future.

Resolved: That the revised table (at paragraph 7) summarising capital spend against budget in 2015/16 be noted.

The meeting ended at 3.35 pm **CHAIRMAN**

Herefordshire Council

Meeting:	**Cabinet**
Meeting date:	**15 September 2016**
Title of report:	**Recommissioning short breaks for disabled children**
Report by:	**Cabinet member for young people and children's wellbeing**

Classification

Open

Key decision

This is a key decision because it is likely to result in the council incurring expenditure which is, or the making of savings which are, significant having regard to the council's budget for the service or function to which the decision relates and because it is likely to be significant in terms of its effect on communities living or working in an area comprising one or more wards in the county.

Notice has been served in accordance with Part 3, Section 9 (Publicity in Connection with Key Decisions) of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012

Wards affected

Countywide

Purpose

To brief Cabinet on the duties to provide short breaks for disabled children and their carers, and the level of need for such services in Herefordshire.

To recommend the continuation of council funding up to £450,000 per year for 2017-2020 to procure services for Herefordshire's short breaks offer for disabled children.

Recommendation(s)

THAT:

(a) the commissioning plan and intentions at paragraphs 20-23 and Appendix B are agreed;

(b) funding up to £450,000 per year is allocated to Herefordshire's short breaks for disabled children programme for the three years 2017/18 to 2019//20

(c) procurement of the provision of short breaks services for three years from

April 2017 be undertaken to the indicative timetable at paragraph 21; and

(d) authority be delegated to the director for children's wellbeing, following consultation with the director of resources and cabinet member for young people and children's wellbeing, and subject to confirmation of funding from the clinical commissioning group (CCG) to finalise procurement documentation and award service contracts within the financial envelope as set out in this report

Alternative options

1 Reduced funding could be allocated to Herefordshire's short breaks offer. The existing short breaks offer has been through a period of significant change since the last commissioning exercise in 2013/2014. While the cost of some services has decreased, it is anticipated that demand for targeted and specialist short breaks could increase over the 2017-2020 period. There is a risk that reduced funding would not be sufficient to meet statutory responsibilities.

2 Existing contracts could be renewed. The maximum renewal options have already been applied to existing contracts, further renewal would require an exemption from council procurement rules. Renewing the existing contract for residential short breaks, as it is, would create overcapacity. New providers have expressed interest in entering the local short breaks market, which could offer more choice for families following a competitive procurement process. Different types of contract arrangement may also increase choice, control and flexibility for families, which could involving moving away from traditional block contracts towards dynamic purchasing systems or framework agreements.

Reasons for recommendations

3 The contracts awarded to external providers as a result of the previous commissioning cycle will end on 31 March 2017.

4 Allocation of funding for 2017-2020 will provide the families of disabled children and the providers of short breaks services some stability over the period and enable development and shift to a more child and family centred approach within existing resources.

5 Access to a range of short breaks opportunities, arising from the commissioning exercise, will assist the council to continue to carry out its statutory duty to provide appropriate short breaks to meet the needs of disabled children and their carers.

6 The re-commissioning exercise provides an opportunity to review local need, look at good practice from elsewhere, and seek the views of children and families in order to reshape and further improve the Herefordshire short breaks offer.

Key considerations

7 As set out in national legislation, children and young people in Herefordshire may be eligible for funded short breaks if they have a condition diagnosed by a doctor or consultant and substantial, long lasting, permanent, physical and/or learning disability or a life limiting, life threatening condition. Not all children and families will need the same type or level of short break; some will need more than others because of the nature or severity of the child's disability.

8 Herefordshire's Children and Young People's (CYP) Plan 2015/2018 has been agreed by the CCG and Herefordshire Council as well as other partners. It contains the collective goal to enable all children and young people in Herefordshire to have the best start in life, grow up healthy, happy and safe within supportive family environments. Specifically for disabled children, the vision is that they will be healthy, safe and achieving well and will go on to lead happy and fulfilled lives with choice and control.

9 Short breaks for disabled children are part of Herefordshire's local offer for children, young people with special educational needs and disabilities and their families. The overall strategic direction continues to be to facilitate families to make arrangements for themselves and their children, and take-up of community based activities and services where appropriate to a child's needs. This is often what is most appropriate to meet need and what many families want. The approach also achieves efficiencies and reduces reliance on high-cost specialist services. Two of the CYP Partnership's aims are to:

- enhance local support for families, including family based respite services by retaining budgets and reinvesting resources
- develop personal budgets and personal health budgets to enable families to exercise more choice and control over their lives within the budgets available

10 In 2015, the council's HOSC (health and social care overview scrutiny committee) task and finish group looked at short breaks provision in the county. Actions that arose included continuing to work with a range of potential short breaks providers to widen the offer in Herefordshire, recommissioning a range of short breaks by March 2017, and consulting with parents and carers and children on the recommissioning of short breaks provision.

11 The council is the lead commissioning body for short breaks services in Herefordshire. The previous commissioning exercise took place in 2013/2014. On 21 November 2013, cabinet took the decision to commit funding of up to £1.3m as the council element of a pooled budget with the CCG totalling up to £3.3m for the period 2014/2017 to support services within the local short breaks offer. During the period, the council's funding commitment has increased in 2016/17, while the CCG contribution has decreased. The CCG funding decrease was a planned approach in recognition that responsibility for arranging and enabling shortbreaks rests with the Council and the changing model of short breaks provision. The CCG continues to be supportive by retaining investment.

12 Because of a historic restricted choice in the local short breaks offer, combined with relaxed referral and assessment practices, a culture developed over a long period that led to a reliance on a single high-cost residential short breaks setting commissioned and delivered by health. Over the last 3-years, that culture has changed significantly. Where appropriate, children and families now receive a comprehensive assessments of their needs in order to identify the most appropriate way to provide their support.

13 There are three tiers of service that can offer a short break, described below:

14 **Tier 1 - Universal:** mainstream community services that are accessible without an assessment such as youth clubs, uniformed groups (i.e. cubs, brownies), leisure centres, nurseries, childminders and activity-based groups

15 **Tier 2 - Targeted:** daytime activities designed specifically for disabled children that can be accessed without a social care assessment. Services are available through a mix of commissioned and non-commissioned providers.

16 **Tier 3 - Specialist:** Specialist short break services can be provided to meet a specific need following a social care assessment of the child's and carer's needs. Depending on the outcome of the assessment, needs can be met through a range of services, including:

- direct payments that families can use to employ a personal assistant or fund other non-commissioned activities
- specialist daytime buddying
- family-based overnight short breaks
- residential-based overnight short breaks

17 Appendix A provides further detail of the Tier 2 and Tier 3 commissioned short breaks commissioned for 2016-2017 and the expected levels of demand for 2017-2020.

18 One of the strategic national and local aims is to increase levels of choice and control for disabled children and their families across a range of support including short breaks services. Since 2013, increasing numbers of families have chosen to access a short break via a direct payment in lieu of a commissioned service, a trend that is expected to continue for 2017-2020. With short break services mainly based on block contracts so far, there has not been an opportunity to establish a formal relationship between the short breaks and direct payments budgets to accommodate those families choosing to opt for direct payments instead of a commissioned service.

19 Subject to the outcomes of funding decisions and consultation activity, it is intended that the recommissioning exercise should seek to achieve increased choice, control and flexibility within Herefordshire's short breaks offer. This could be achieved by:

i. market development, particularly supporting the universal and community sector, to offer and promote more inclusive opportunities. There are good examples from other areas of provider networks being developed across the universal, targeted and specialist sectors. Such work can be associated with provision of good quality information about available services to inform choice

ii. considering alternative contracting and purchasing arrangements for each level of service within the short breaks offer. Block contract arrangements may continue to be appropriate for some services. However, moving towards dynamic purchasing systems or framework agreements could mean that more service providers could be approved as part of the short breaks offer. Increasing the flexibility of resources can also facilitate choice for families, either by choosing between a range of commissioned services or choosing a direct payment in lieu of a commissioned service

iii. improving the value for money of overnight residential-based services for the small number of children that need them. Assuming that there is not a significant increase in demand for overnight residential short breaks and sufficient capacity is commissioned nearer to the market rate from a range of providers, it may be possible to invest additional resources in activities supporting services in other levels of the short breaks programme. The 2016/2017 cost per residential bed night is £630, which is mainly based on a large block contract. Whereas, the market rate for overnight residential-based short breaks is around £300-£400 per night depending on the complexity of need of individual children

20 Appendix B contains the commissioning intentions proposed to meet local need and

comply with statutory duties. This commissioning plan has been, and continues to be informed by, the voices of children and families alongside an ongoing equality impact assessment and strategic analysis of local need.

21 Subject to the outcomes of consultation and governance decisions, the council will initiate a procurement exercise in September 2016. The intention will be to award contracts before the end of the calendar year to allow for a mobilisation period before services commence from 1 April 2017. The procurement will involve the following lots:

Lot	Description	Funding options
1	Market Development	Block or in-house
2	Tier 2 Targeted open-access activities	Dynamic purchasing system or framework agreement
3	Tier 3 Specialist daytime activities	Dynamic purchasing system, framework agreement or in-house
4	Tier 3 Specialist residential overnight breaks	Framework agreement

22 Paragraph 42 sets out the expected budget allocations that support these commissioning intentions. This is subject to confirmation of budgets by the council and CCG. Where contracts are awarded to external providers, it is anticipated that this will be for a three year period, with an option to renew for up to a further two years, subject to appropriate governance decisions during the period.

23 The commissioning plan set out above has been informed by ongoing analysis of population-level needs and by the voices of families of disabled children. Further formal consultation around the commissioning intentions will be completed over the summer 2016 to inform the final specification of services and award of contracts for April 2017. Families and children will be represented in the evaluation of bids and awarding of contracts.

Community impact

24 The commissioning intentions contained in this report enable the council and the clinical commissioning group to support disabled children and their families through local provision whilst also continuing to develop a breadth of short breaks provision. ONS (office of national statistics) population forecasts show that there could be small increases in the number of children that might require a commissioned short break. Children included in SEN (special educational needs) bands D&E may benefit from a targeted daytime activity. Those known to the councils CWD (children with disabilities) team may require specialist daytime or overnight short breaks. In some cases, some children may fall into both of these groups:

	Apr-17	Apr-18	Apr-19
General 0-18 population increase	0.27%	0.27%	0.69%
SEN Tariffs D&E	174	175	176
CWD team short breaks caseload	127	128	129

25 In forecasting the demand, described below, for the next three years:

- feedback from families has informed service planning
- overall population increases have been considered
- comparisons have been made with Herefordshire's statistical neighbours
- needs-led SEN data has been considered for targeted daytime activities
- the anticipated needs of children already known to the CWD team have been included for targeted and specialist services

26 **Tier 2 Targeted daytime activities:** As these services are available without the need for a professional assessment, there is limited data available to forecast future need. However, the current play sessions contract has been fully utilised each year by around 70 children. There have been some significant variations in individual take-up, ranging from less than ten to over 100 hours per child, the reasons for which are not clear. In recent childcare sufficiency and short breaks surveys, families have said that more opportunities are needed particularly during the school holidays and weekend. It is reasonable to expect that access to such services can prevent needs escalating and placing pressure on more specialist services. SEN data also suggests that up to 175 children could benefit from a targeted activity and that elgibility criteria should be reviewed to ensure resources are targeted effectively.

27 **Tier 3 Specialist daytime activities:** Between 6,000 and 7,000 hours are expected to be needed each year for 35 to 45 children. Families have valued the current specialist buddying service model but would like more socialisation opportunities for their children with friends and peers. In its review of the short breaks offer in December 2015, the health and social care overview scrutiny committee task and finish group recommended that consideration should be given to in-house delivery of specialist daytime short breaks (currently 1:1 buddying). The planned consultation will consider this proposal to help inform an options appraisal.

28 **Tier 3 Specialist family-based overnight short breaks:** The council is establishing the specialist family-based overnight short breaks service in 2016, delivered by its in-house fostering service. Carer recruitment is progressing well and the first short breaks placements have begun. Between fifteen and twenty children are anticipated to require a family-based overnight break each year. Around 450 nights are expected to be required in 2016/2017, rising to 600 by 2019/2020. As this is a new approach in Herefordshire, it is not proposed that the service is included in the procurement exercise for 2017-2020.

29 **Specialist residential-based overnight short breaks:** around 550 bed nights are expected to be needed for 12 children in 2017-2018, decreasing to around 10 per year by 2020. Children can have a combination of health, physical and behavioural needs. In most cases, the primary need for an overnight break is expected to arise from a child's health or physical needs. For a small number of children, severe challenging behaviour will be the primary reason for needing a residential short break.

Equality duty

30 As the provision of short breaks and overnight respite services continue to be developed throughout 2017-2020, the council will pay due regard to our public sector equality duty under Section 149, General Duty whereby:

"A public authority must, in the exercise of its functions, have due regard to the need

to:

- eliminate discrimination, harassment, victimisation and any other conduct ... prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

31 Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

a. remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
b. take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
c. encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low. "Protected characteristic" includes disability and all the children and young people accessing short breaks are likely to fall within this definition.

32 This is relevant to all public services and a key component of enabling families to lead fulfilled lives is unimpeded access to services and opportunities that those without disabilities are able to do. Part of the approach recommended to cabinet is to work with univiersal settings for children, adults and families in Herefordshire to ensure this equality duty is being fully carried out.

33 An equality impact assessment has been prepared with regard to Herefordshire's short breaks offer, and will continue to be reviewed over the 2017-2020 period. This has highlighted the following potential inequalities.

34 Varying knowledge of, or access to, useful information about short breaks and activities may mean that some families are not taking up the opportunities available to them. Work being done to establish a voluntary disabled children's register will go some way to improving the council's ability to communicate directly with families that might be interested in short breaks for disabled children. Ongoing work to improve the availability of information provided at www.herefordshire.gov.uk/shortbreaks and via WISH, as well as the ongoing consultation exercise are also all helping to promote the local short breaks offer.

35 Where people are able to identify activities that could meet their needs, inequalities of cost or transport issues can be a barrier for some families.

36 Ongoing consultation and engagement work has identified an anecdotal perception of a level of inequality among some families and professionals that 'those that shout loudest get the most'. An initial review of available data also suggests that Tier 2 targeted daytime activities could be targeted more effectively to meet need. To inform the future eligibility criteria for these services, the short breaks consultation is asking for preferences for whether targeted short breaks should be available on a first-come first serviced basis, or more related to levels of need such a special educational needs.

37 At the point of the previous recommissioning exercise in 2013, 38 children had accessed overnight residential short breaks over a nine-month period. By the end of 2016, it is expected that the number of children using residential short breaks will

have reduced to less than twenty. Furthermore, most children that historically accessed such services did so without a comprehensive social care assessment. This led to many of them being offered up to, and in some cases over, 75 nights care per year, at which point looked after children regulation would apply. Research of Herefordshire's statistical neighbours showed that most children in other areas were receiving 13-36 nights per year, where as in Herefordshire most were receiving over 75 nights per year.

38 Improving assessment of need and allocation of services means that both the number of children receiving residential short breaks, and the number of nights they receive has reduced, enabling investment alternative appropriate support packages. By working closely with individual families to explore the different ways their child's needs could be met, some have chosen to move to the council's new family-based overnight short breaks services, and other have chosen to take-up direct payments or daytime short break services. One of the intentions of this recommissioning exercise is to continue to redistribute resources throughout the tiers of the short breaks offer.

39 Given the relatively small number of children that require a specialist overnight short break, and the wide range of needs that they have, there have previously been concerns that there could be inequalities in the availability of overnight services to meet assessed need. To address these, the council:

- is establishing a new family-based overnight short breaks service, a model that has been seen to work well in other parts of the country for several years. By the end of 2016, it is expected that this new service will be providing short break placements to 6 children. As the service becomes further established from 2017, it is expected that 14-15 children will be supported with up to 600 nights each year
- has been working to develop the local market in preparation for the planned recommissioning exercise for 2017-2020. Of the 500-550 nights expected to be required each year, almost 250 are already being delivered by a new provider from 2016. Other potential organisations have expressed interest in becoming approved providers for the short breaks offer from 2017
- continues to work with individual families to identify and agree alternative ways to meet their needs when either family-based or residential short breaks may not be appropriate or locally available. For example, this could involve significant direct payment packages that allow services to be delivered within the home.

Financial implications

40 For recommissioning planning purposes it has been assumed that the 2017-2020 annual budget levels will remain similar to previous years (below), subject to governance within the Council's and CCGs medium and long term financial strategy:

Income	**Source**
£453,000	Herefordshire Council
£427,000	CCG via Better Care Fund

41 It is expected that efficiencies will continue to be achieved as a result of

- improved child assessment practices that ensure that the most appropriate service is provided to meet individual needs
- considering options for framework agreements or dynamic purchasing systems, in favour of block contracts, to ensure that only services used are funded
- purchasing overnight short breaks at the market rate

42 The following table sets-out the indicative annual budgets as at 1 August 2016, This indicative plan is subject to further consultation and governance decisions over the summer of 2016.

2017-2020 Short breaks offer	Indicative spend p.a.
Brokerage	£25,000
Market Development	£35,000
Targeted daytime activities	£100,000
Specialist daytime activities	£163,000
Specialist family-based overnight breaks	£154,000
Specialist residential overnight breaks	£400,000
TOTAL	**£877,000**

Legal implications

43 The Council has a statutory duty set out in the Children Act 1989, paragraph 6 of Schedule 2, to provide services designed to minimise the effect of their disabilities on disabled children within Herefordshire and to give such children the opportunity to lead lives that are as normal as possible. There is also a duty to assist the individuals who provide care for disabled children to continue to do so or to do so more effectively by giving them breaks from caring.

44 The duty to provide short breaks for disabled children and their carers is further detailed within the Breaks for Carers of Disabled Children Regulations 2011 in that a Local Authority must provide, so far as is reasonably practicable, a range of services which is sufficient to assist carers to continue to provide care or to do so more effectively.

45 In particular, the local authority must provide, as appropriate, a range of day-time care in the homes of disabled children or elsewhere; overnight care in the homes of disabled children or elsewhere; educational or leisure activities for disabled children outside their homes; and services available to assist carers in the evenings, at weekends and during the school holidays.

46 The proposals set out in this report are designed to meet these duties in light of identified need. A failure to provide such services would be unlawful and a breach of statutory duty.

47 The recommendations put forward within this report have been informed by public consultation which accords with the Council's general duty to act fairly in the exercise of its functions.

48 The Council is required to comply with its' Contract Procedure Rules (CPRs), and where relevant the Public Contract Regulations 2015, when letting contract opportunities.

Risk management

49 If the council or CCG reduces its financial contribution it will pose a risk to the delivery of services. Further risk to partner reputations could arise from community, political or legal challenge to any funding reductions.

50 Risk will be managed and controlled through the governance structure, which includes the council's corporate governance arrangements, the better care fund partnership group, the joint commissioning board and the health and wellbeing board.

51 If service contracts cannot be awarded following a procurement exercise, either as a result of insufficient or unacceptable bids from providers, there is a risk that there will be service gaps from April 2017. Options for managing the risk include renewing existing contracts with incumbent providers for a period or interim delivery of services in-house. Should there be a gap in service, the children with disabilities team will continue to work closely with families to identify different ways of meeting individual needs.

52 If future purchasing arrangements are not based on traditional block contract arrangements, increasing numbers of families may choose alternative services to meet their needs. This could put the long-term sustainability of some current services at risk unless they are able to attract families with a quality offer or attract additional income from other sources.

Consultees

53 In May 2016, Herefordshire Council set out to survey 100 families that had used short breaks services for disabled children about their experiences and outcomes, and the preferences for the future. The survey, which was conducted by telephone, achieved a good response rate with 55 families of 60 children providing their views:

- Two thirds of families gave their current short breaks a good satisfaction rating
- Short breaks are achieving good outcomes for most children and families
- Children take part in interesting activities and become more independent or confident
- Getting to know other families can help, but it is not the main aim of a short break
- Most families feel that their child had fun with carers who understood their needs
- Families want more and cheaper breaks, offering socialisation consistency and choice
- Most children prefer to do things with their friends or in organised groups
- Many families would prefer to choose from a selection of approved providers
- Most families want to be kept informed about short breaks in Herefordshire

54 Early in 2016, the council conducted a supplementary childcare sufficiency survey regarding the childcare needs of disabled children. Over 400 paper questionnaires

were issued, with 61 responses being received, some of which also related to short breaks provision. Childcare for disabled children aged 8–11 years with complex needs, was difficult to source in Herefordshire and trained staff in complex needs/extreme behaviour was very limited. The most sought after childcare was specialist holiday play schemes and after school clubs.

55 The commissioning intentions set out by this report form part of further consultation activity over the summer 2016, which will inform the procurement process and contract award decisions. A summary of the consultation feedback will be published in the autumn of 2016. The council has written directly to 800 families concerning the recommissioning exercise and consultation work, which has also been promoted indirectly through schools and special schools, provider organisations and parent carer networks. Families and children can engage in several different ways:

- Talk to us at one of the parent/carer drop-in sessions
- Complete the online survey
- Request a paper copy of the survey by calling Carol Williams on 01432 261584
- Email ideas, questions or suggestions to shortbreaks@herefordshire.gov.uk
- Children can talk to our participation officer at one of the scheduled events (advance registration is required), or contact us to see if we can arrange an alternative by calling Carol Williams on 01432 261584

Appendices

Appendix A: Short breaks for disabled children 2017-2020 needs analysis

Appendix B: Short breaks for disabled children Commissioning Intentions 2017-2020

Background papers

- None identified.

Short breaks for disabled children 2017-2020 needs analysis

Herefordshire Council has a duty to ensure there is a sufficient range of short break services available to meet the assessed needs of disabled children and their carers in the county. We do this through the *'short breaks offer'.* The council's short breaks statement provides further information about the current offer and eligibility criteria.

There are three tiers of service that can offer a short break:

Tier 1 Universal: These are everyday community services that are accessible without an assessment such as youth clubs, after school activities, uniformed groups (i.e. Cubs, Brownies), leisure centres, nurseries, childminders and activity-based groups. These are not paid for by the council but form part of valuable experiences for children and young people

Tier 2 Targeted: Specific daytime activities for disabled children that families can self-refer to. Some of these services will be paid for by the council

Tier 3 Specialist: Short break daytime or overnight services or direct payments that are designed to meet a specific need following a social care assessment of an individual child and their carers

2016-2017 commissioned short breaks

At each of the levels described above, there will be some services provided or funded by organisations other than the council. Information about these non-commissioned services is available at www.herefordshire.gov.uk/shortbreaks.

The council currently commissions services at the targeted and specialist levels in order to meet the assessed needs of disabled children and families known to the council's children with disabilities team:

	Service description	2016-2017 capacity	Cost	Average unit cost
Tier 2 Targeted	Saturday play sessions (4.5 hours)	18 sessions 234 places	£55,000	£107 per place
	Easter & Summer play sessions (4.5 hours)	20 sessions 280 places		
Tier 3 Specialist	Daytime buddying	74 children 7304 hours	£168,000	£23 per hour
	Overnight family-based	14 children 1200 nights	£180,000	£150 per night
	Overnight residential spot-purchase	6 children 243 nights	£75,000	£308 per night

	Overnight residential block-purchase	15 children 920 nights	£567,000	£616 per night

Voices of families of disabled children

The council continues to listen to the families of disabled children in order to further develop and improve the short breaks offer in Herefordshire. There have been several recent focussed engagement activities, which are summarised below.

Further consultation activities are taking place over the summer of 2016 so that the voices of disabled children and their families can further inform the recommissioning of short breaks for 2017-2020. This includes writing directly to 800 families to invite them to attend one of a series of drop-in sessions and/or complete an online consultation survey, details of which can be found at www.herefordshire.gov.uk/shortbreaks.

Some of the key themes around short breaks that families say are important for them and their disabled children are:

In May 2016, Herefordshire Council surveyed 55 families that had used short breaks services for disabled children about their experiences and outcomes, and the preferences for the future. A summary of responses is available online, the main messages were:

- short breaks are achieving good outcomes for most children and families
- children take part in interesting activities and become more independent or confident
- getting to know other families can help, but it isn't the main aim of a short break
- most families feel that their child have fun with carers who understood their needs
- families want more and cheaper breaks, offering socialisation, consistency and choice
- organising and spending direct payments needs to be made easier
- most children prefer to do things with their friends or in organised groups

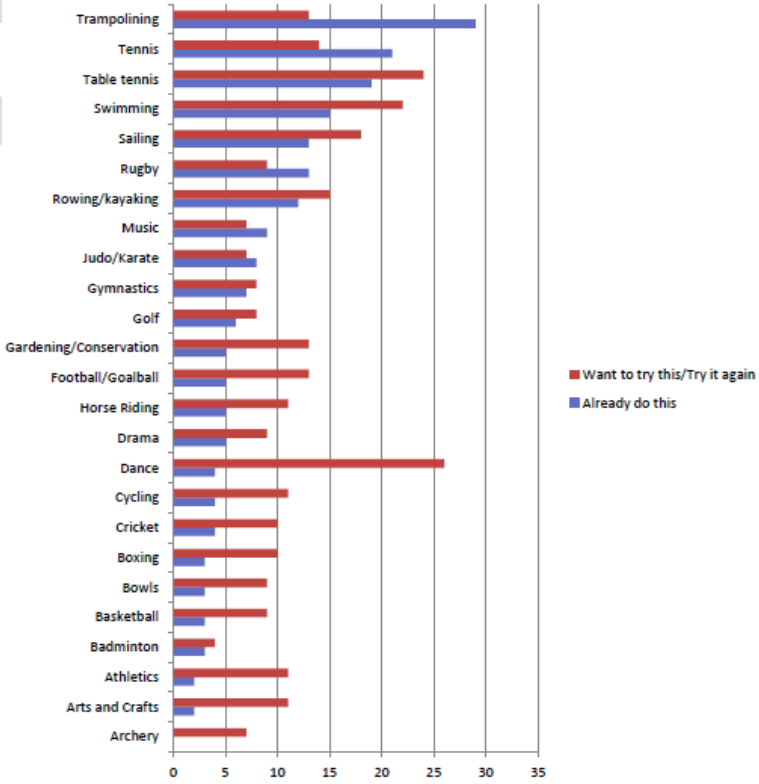
- many families would prefer to choose from a selection of approved providers
- most families want to be kept informed about short breaks in Herefordshire
- better communication is needed about the range of available short breaks
- value for money is an important factor
- stability and long term planning are important

A survey for the council's children with disabilities childcare sufficiency report received 61 responses in early 2016.

- most respondents found childcare through family and friends, childminder/nursery, buddying or were having respite services for very complex needs
- the most sought after childcare was specialist holiday play schemes and after school clubs
- childcare for disabled children aged 8–11 years with complex needs, was difficult to source in Herefordshire
- trained staff in complex needs/extreme behaviour was very limited
- limited capacity to provide 1:1 and 1:2 support.
- where respondents had trouble finding childcare, the reasons given were; difficulty in finding trained staff, special school does not have after school club, child could not manage in a busy childcare environment (autism) need 1:1 care

In 2015, Herefordshire Carers Support conducted a survey of parent carer views. The types of activities disabled children were interested in is illustrated by the chart below. In relation to short breaks and activities for their disabled children, parents wanted:

- more inclusive activities where children with disabilities could socialise and make friends with other children and develop social and independent living skills
- trained volunteers, mentors, buddies or personal assistants who are flexible with their hours to support access to activities
- outward bound course etc.
- adapted activities in safe environments with 1:1 and sometimes 2:1 support due to complex needs
- support for siblings
- affordable access to childcare after school and during the holidays to overcome some barriers to parent employment



2017-2020 demand

Forecasting future demand is often informed by trend information over several preceding years. However, data around short breaks in recent years relates to historical practice and service models that did not support the overall strategic direction to facilitate take-up of community based activities and services where appropriate to a child's needs. In forecasting the demand for the next three years:

- feedback from families has informed service planning
- overall population increases have been considered
- comparisons have been made with Herefordshire's statistical neighbours
- needs-led SEN data has been considered for targeted daytime activities, rather than data from the usage of the current contracted service alone
- the anticipated needs of children already known to the councils children with disabilities teams, together with an estimation of potential new cases based on statistical neighbour indicators, has informed planning for specialist daytime and overnight short breaks

No data has been made available to indicate any future trends in the size and shape of the overall population of disabled children in Herefordshire. The ONS (office of national statistics) has produced forecasts for the general population in Herefordshire. If the ONS growth rates for 0-18 year olds are applied to relevant local data from the SEN and children with disabilities team, the potential growth in the targeted and specialist populations is small:

	Apr-17	Apr-18	Apr-19
General 0-18 population increase	0.27%	0.27%	0.69%
SEN Tariffs D&E	174	175	176
CWD team short breaks caseload	127	128	129

2017-2020 Targeted daytime activities

These services include activities designed specifically for disabled children, such as holiday clubs. As these services are currently available without a professional assessment, there is limited data available to forecast future need. However, the current play sessions contract has been fully utilised each year by around 70 children.

Access to the current service is by registration with the provider and determined on a mainly 'first come, first-served' basis. Each year, around 70 children access play session places, which are part funded by the council in Herefordshire. There have been some variations in individual take up, ranging from less than 10 to over 100 hours per child per year.

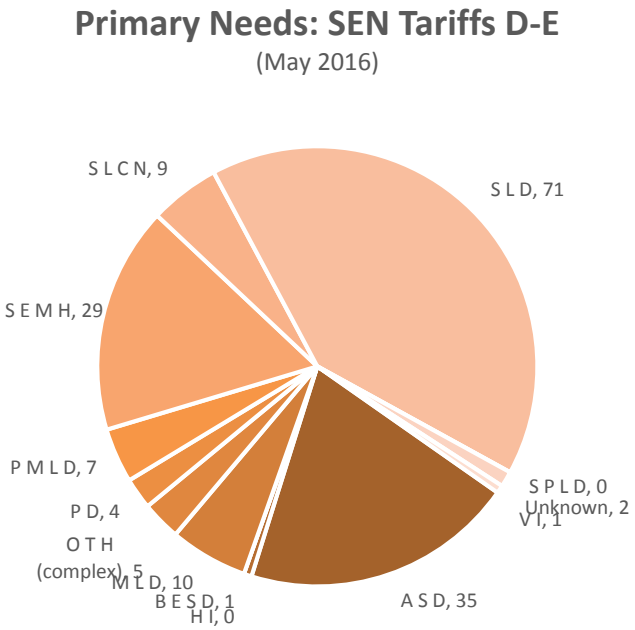
While the service is highly valued by the families that use it, there has been feedback about limited availability/high demand for some sessions and a desire for a wider range of activities to be available. Some families have also reported that the location of sessions presents travel challenges and the family fees can be unaffordable, despite the service being heavily subsidised by the council and other funding streams.

Listening to families, there is clearly a level of unmet demand and a desire for more choice. Other statistical neighbour areas, such as Shropshire, and Wiltshire, operate schemes that could help to address these issues in Herefordshire. Although there are variations in each scheme, they share a methodology for targeting short breaks resources based on a child's level of special educational need (SEN).

In Herefordshire, children with special educational needs are supported through a banded system, which could also be used to improve the targeting of short break services that do not require a social care assessment. The SEN system consists of bands A to F. Children in bands D and E are most likely to have needs of a level that they or their families could benefit from a targeted daytime short break. In May 2016 the primary needs of children in each band were as follows:

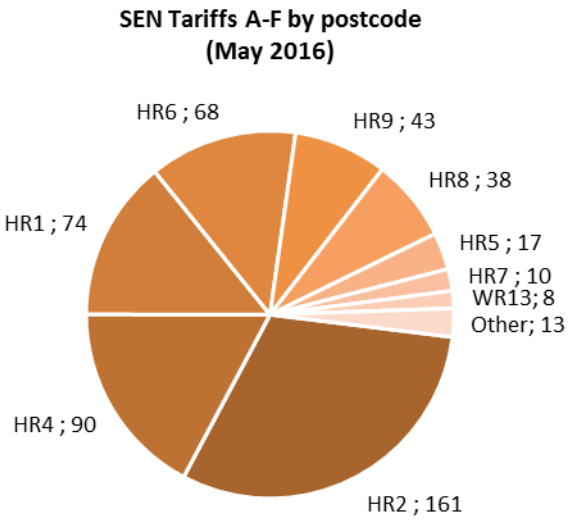
	SEN Band					
	A	**B**	**C**	**D**	**E**	**F**
Autistic spectrum disorder	8	6	38	14	21	1
Behaviour, Emotional and Social Difficulties	0	0	0	1	0	0
Hearing impairment	0	0	7	0	0	0
Moderate learning difficulty	11	5	32	6	4	0
Other difficulty / disorder	2	2	6	5	0	0
Physical disability	7	2	11	2	2	1
Profound and Multiple Learning Difficulties	0	0	3	1	6	6
Social, emotional and mental health	16	7	58	27	2	0
Speech, language and communication needs	31	11	23	8	1	1
Severe learning difficulty	2	1	24	32	39	9
Specific learning difficulty	1	1	1	0	0	0
Unknown	0	5	7	2	0	1
Visual impairment	1	0	2	1	0	0
	79	**40**	**212**	**99**	**75**	**19**
					174	

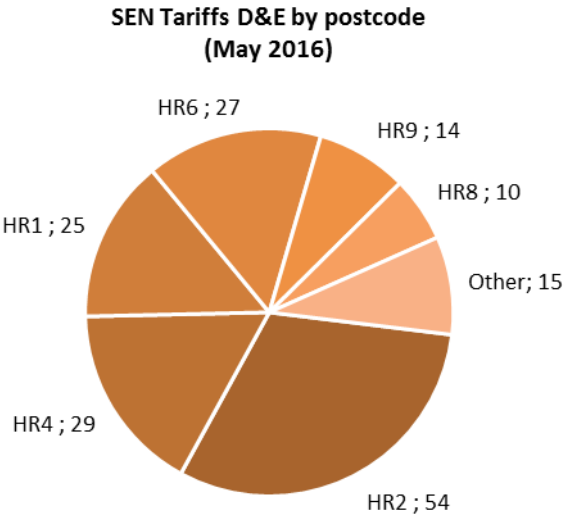
The short breaks needs of band A-C children can usually be met through mainstream community-based activities. Families can still request a social care assessment if they feel there are additional needs that cannot be met by such activities.



Bands D&E children are likely to have additional needs that may benefit from targeted short break activities designed for disabled children. It is likely that many of these children are accessing activities in their local communities without needing to also access a commissioned service. Some families may also wish to request an assessment for further specialist short break services through social care

Band F children will have complex needs that are already subject to an assessment, which would address their needs for specialist daytime or overnight short break services as part of a wider package of support.



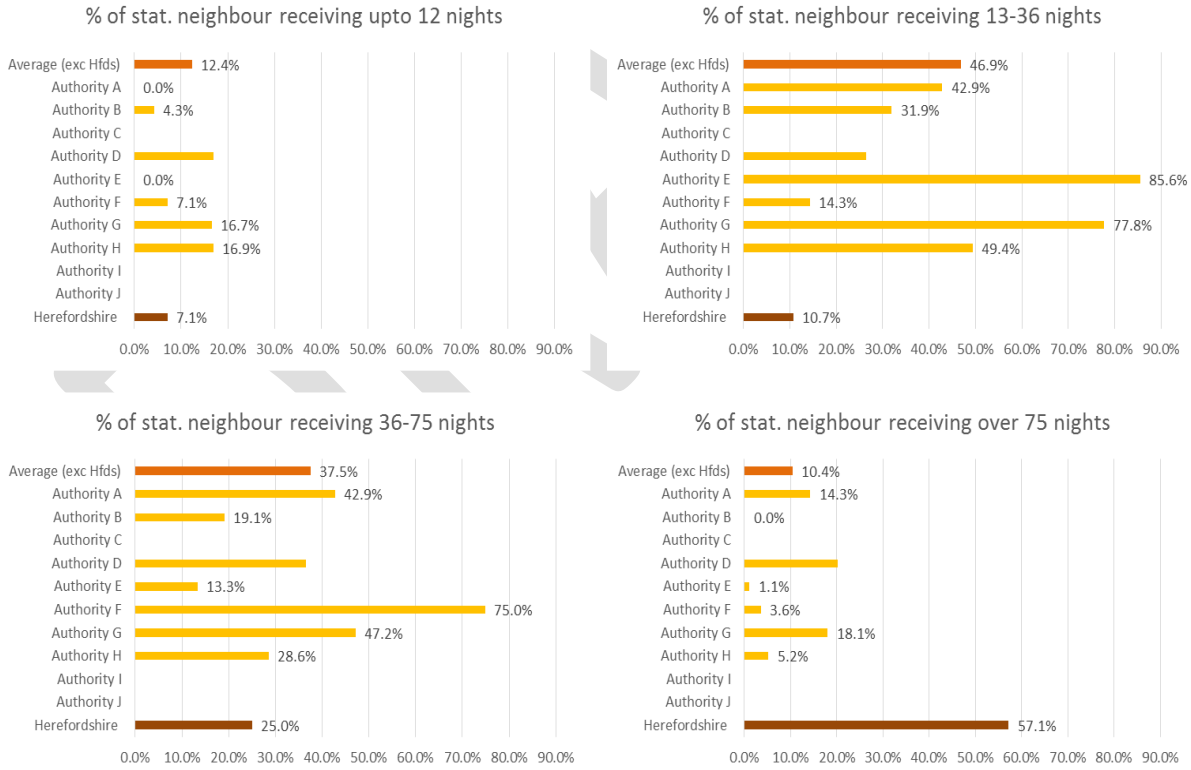


2017-2020 Specialist short breaks

Some children may have a higher level of need that can't be met by universal or targeted services alone. This is why the Local Authority may need to undertake a social care assessment with a child / young person and their family to ensure the right amount of support is provided at the right time. Specialist short break services can be provided to meet a specific need following a social care assessment of the child's and carer's needs. In order to determine the individual needs and identify the most appropriate solutions, the Council's children with disabilities team will work with families to complete their needs assessment. Depending on the outcome of the assessment, the social worker will discuss the different ways in which needs could be met, which could involve needs:

- direct payments that families can use to employ a personal assistant
- buddying delivered by commissioned service providers on a 1:1 or small group basis
- family-based overnight short breaks delivered by the council's in-house fostering service
- residential-based overnight short breaks delivered by commissioned service providers

Until recently, Herefordshire's overnight short breaks offer has been based on a historic model that relied on a single residential setting. For several years, children accessed the service without a comprehensive assessment of their needs. This led to a situation where most children using the service accessed it for 75 or more nights per year, which should have triggered LAC (looked after child) arrangements. Compared to statistical neighbours in early 2016, where most children accessed 13-36 nights per year, Herefordshire was shown to be atypical, as illustrated below.



Since 2015-2016, children using overnight short break services have undergone comprehensive social care assessments and appropriate reviews. Following assessment of the children that were using the service, they are now being supported by a range of services that meet their needs, including direct payments, daytime short breaks, family based short breaks or alternative residential short breaks.

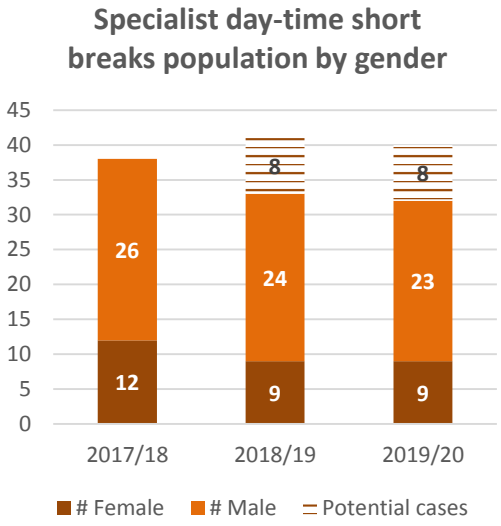
Specialist daytime short breaks

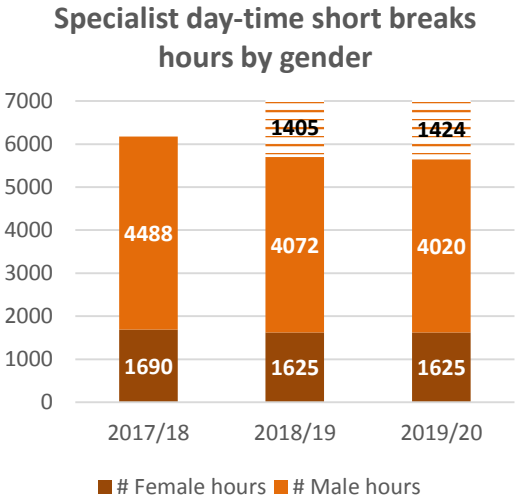
Children may be assessed as requiring a specialist daytime short break when either universal or targeted activities are unable to meet their needs. Specialist daytime services can include child-specific support in order to access universal or targeted activities, or intensive support designed around the child or family because longer or more frequent breaks are required.

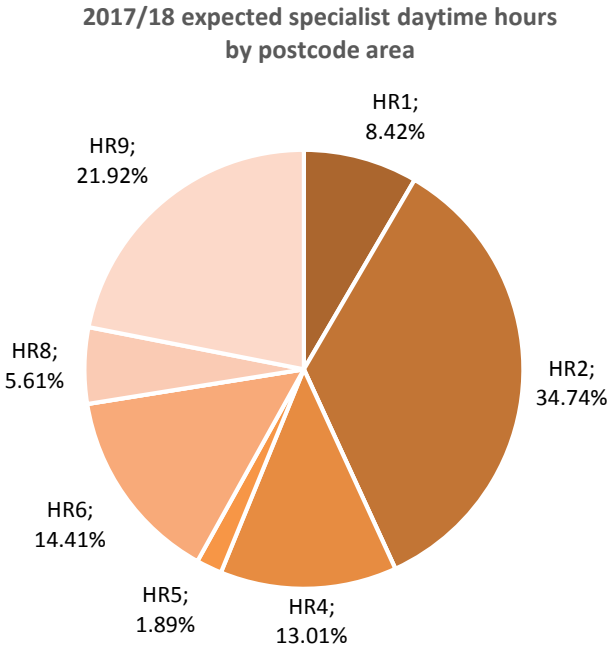
Approximately 40 children per year will need specialist daytime short breaks. Most of these are currently supported by a buddy, but a few are supported by domiciliary care services in the home. Other daytime activities may also be suitable. Families would like to see more socialisation or friendship group based activities, for example.

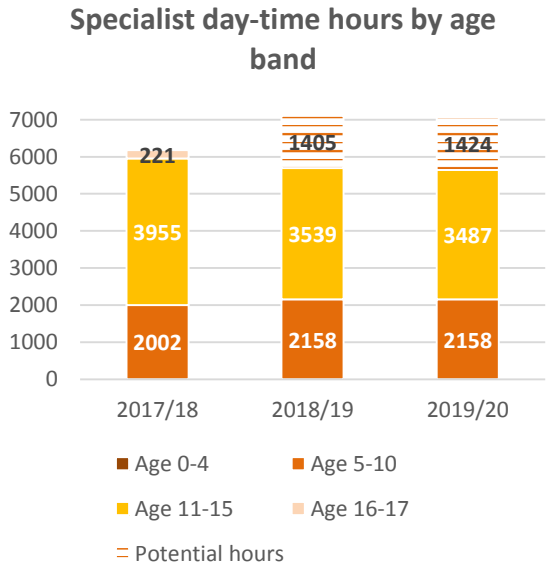
Around 7,000 hours per year are expected to be needed, mostly for males. Total hours expected includes 10%-15% delivered as two staff to one child.

Young people aged 11-15 are expected to need approximately half of the total estimated hours.









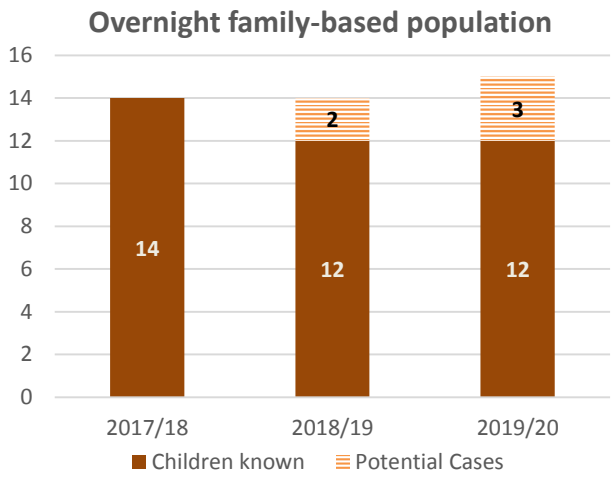
Family-based overnight short breaks

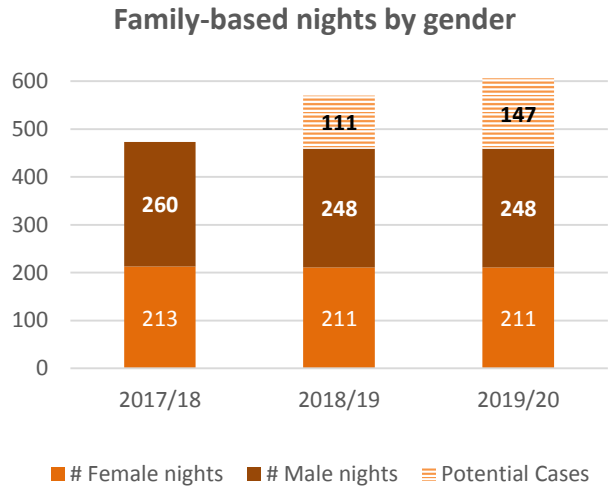
In 2016, Herefordshire is establishing a new family-based overnight short breaks service, a model that has been seen to work well in other parts of the country for several years.

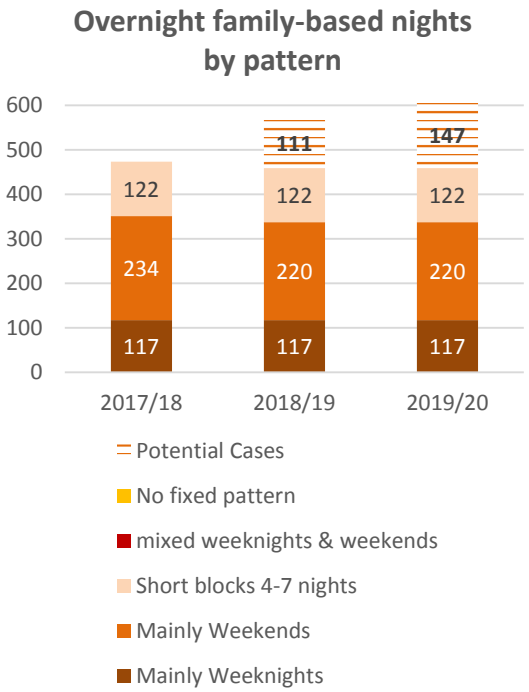
By the end of 2016, it is expected that this new service will be providing short break placements to 6 children. As the service becomes further established from 2017, it is expected that 14-15 children will be supported with up to 600 nights each year. Slightly more nights are expected to be needed for males than females.

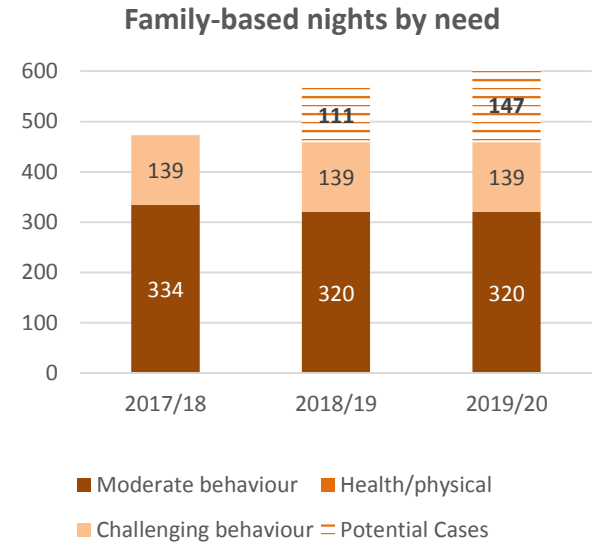
The primary need for children requiring a family-based short break is moderate or challenging behaviour. Some children will also have associated health or physical needs.

Around a half of nights are expected to be required at weekend, and a quarter are expected to be needed for either weekends or as short blocks.







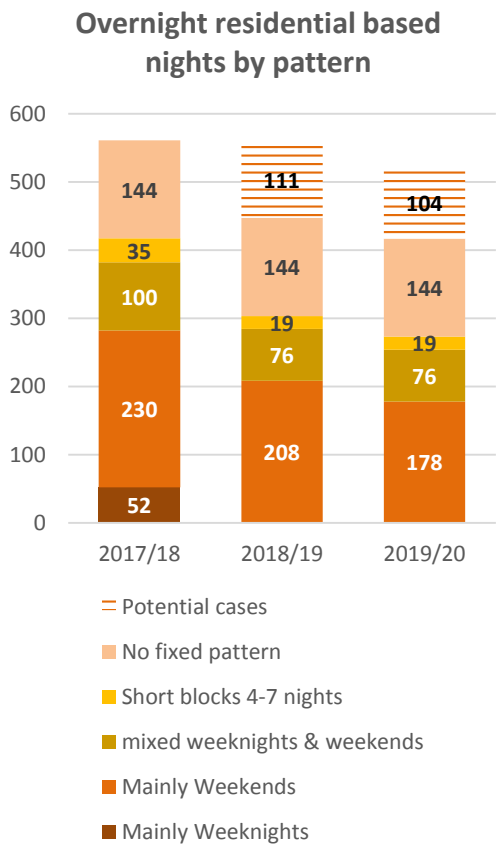


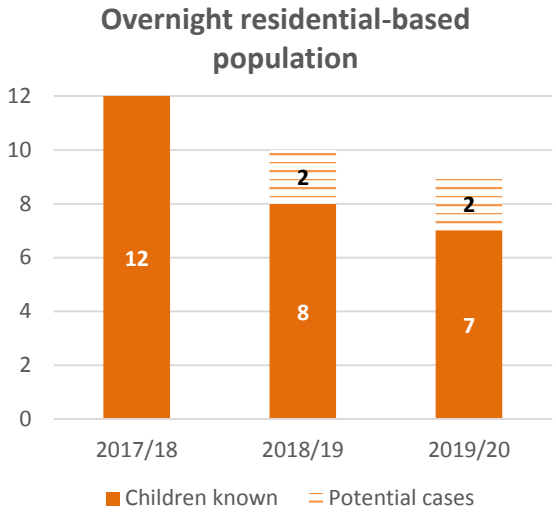
Residential overnight short breaks

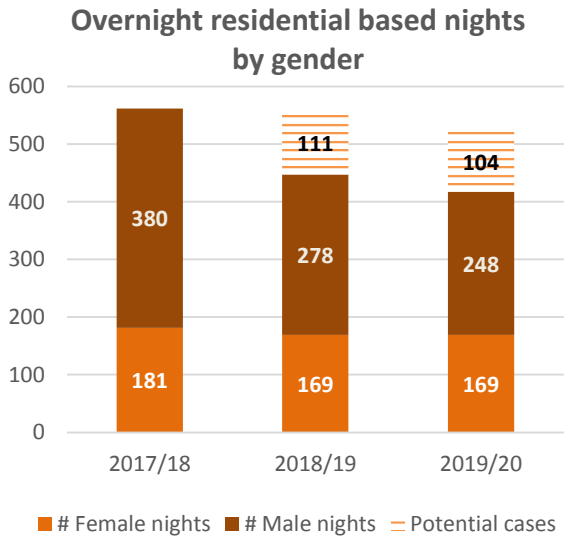
The number of children using residential short break services has decreased in recent years as a result of thorough individual needs assessment and an improving range of available short breaks.

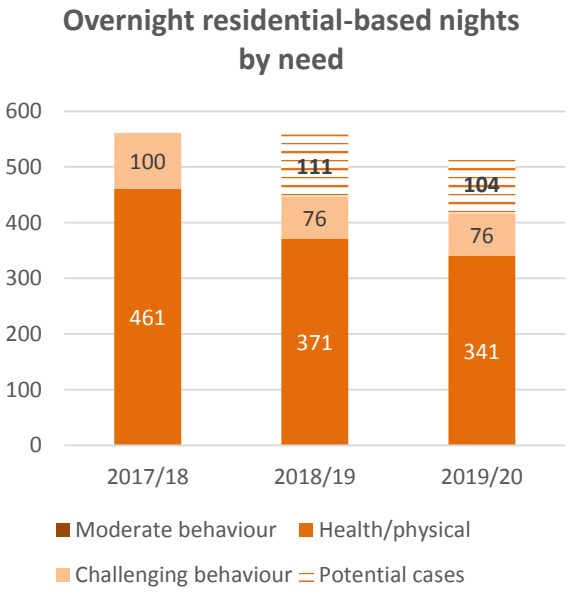
By 2020, it is expected that the number of children requiring such breaks will stabilise at around ten children needing 500-550 nights per year. In 2017-2018, at least 250 of these nights are likely to be a continuation of existing placements.

Around two-thirds of nights will be needed for males. The primary need for children requiring residential nights is expected to arise from their physical or health needs. Challenging behaviour will be the primary need for up to a quarter of children. The majority of children are likely to have a combination of health, physical and behavioural needs. Most nights are expected to be needed at weekends, with scope for some mid-week and blocks of nights.









Appendix B

Short breaks for disabled children
Commissioning Intentions 2017-2020

Commissioning intention	Notes
Market Development	Families, professionals and partners all report that availability, and information about, short break across the tiers continues to require improvement. Ongoing consultation is asking what practical measures could have a beneficial impact. The intention is to make new investment in supporting organisations and providers to either improve their understanding of disability issues, offering training or equipment, or coordinating and promoting information about services.
Targeted daytime activities	Families continue to report that more choice and availability of targeted daytime activities specifically for disabled children is needed. Analysis of relevant SEN (special educational needs) data suggests that significantly more children may need such support than are currently able to be provided for. The current contract supports around 70 children per year, whereas the application of SEN bandings indicates that up to 175 children may benefit from access to a targeted activity. Assuming that efficiencies can be achieved in the cost of specialist services, the intention would be to make additional investment in targeted daytime activities. Subject to consultation, the intention would also be to review existing service eligibility criteria to ensure that resources are being targeted effectively. This may mean that around 20 current users would not be eligible to access a place funded by the council, however the provider may still be able to offer a place from within its other resources.
Specialist daytime activities	Approximately 40 children per year will need specialist daytime short breaks. Around 7,000 hours per year are expected to be needed, mostly for males. The intention is to develop the tested buddying model to offer more socialisation or friendship-group based activities, where appropriate, rather than the current, more rigid, 1:1 Support model. At the recommendation of HOSC, there is also an intention to consider the capabilities and costs for specialist daytime activities to be delivered in-house by the council as an alternative or complimentary option.
Specialist family-based overnight breaks	It is not intended to include family-based short breaks in the recommissioning exercise as the new service is being established in 2016. Carer recruitment is progressing and by the end of 2016, it is expected that this new service will be providing short break placements to 6 children. This will increase up to 15 children supported with up to 600 nights per year in subsequent years. If needed, additional short breaks can also be sought from independent fostering agencies through existing contract

	arrangements is establishing a new family-based overnight short breaks service.
Specialist residential overnight breaks	Specialist breaks may be offered following a social care assessment. Forecasts have been informed by current known need of individual children and statistical neighbour comparisons. Analysis has shown that Herefordshire's provision of overnight breaks has been atypical, with a much higher proportion of children receiving 75 or more nights per year. Improving assessment practice and availability of a range of overnight services is expected to continue the delivery of efficiencies from historic levels. By 2020, it is expected that around ten children will require such breaks per year, equating to 500-550 nights annually. The intention will be to move to a more flexible purchasing system, such as a framework agreement, rather than the historic block contract arrangements and to secure placements at nightly costs closer to the market rate of £300-400 per night. It is expected that this approach will deliver efficiencies that can be reinvested in improving the short breaks offer across all tiers.

Herefordshire Council

Meeting:	**Cabinet**
Meeting date:	**15 September 2016**
Title of report:	**Healthy child programme 0-19 years**
Report by:	**Cabinet member health and wellbeing**

Classification

Open

Key decision

This is a key decision because it is likely to result in the council incurring expenditure which is, or the making of savings which are, significant having regard to the council's budget for the service or function to which the decision relates and because it is likely to be significant in terms of its effect on communities living or working in an area comprising one or more wards in the county.

Notice has been served in accordance with Part 3, Section 9 (Publicity in Connection with Key Decisions) of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012

Wards affected

Countywide.

Purpose

To seek agreement to extend the current health visiting and school nursing contract whilst further work is undertaken to explore options to secure a more integrated service model and approach to meeting the needs of children and young people from the ages of 0-19.

Recommendation(s)

THAT:

a) **agreement is given to extend the existing health visiting and school nursing (public health nursing) contracts for a period of up to one year from 1 April 2017 at an annual cost of £2.6m (service detailed in appendix 1);**

b) **an option appraisal be undertaken to inform a further decision about the provision of an integrated children's service by the end of March 2017; and**

c) **by virtue of this decision report an exemption to paragraph 4.6.13.2 of the council's contract procedure rules shall be granted to enable the extensions for the reasons as set out in paragraph 4 below and referred to throughout this document.**

Alternative options

1. Go to open procurement now for an integrated school nursing and health visiting service to deliver the universal healthy child programme 0-19 years for a preferred contract term of up to five years with effect from 1 April 2017. This would require investment of up to £13.1m (£2.6m each year). This is not recommended as it would not enable the council time to consider the integration referred to in paragraph 4. In addition, given the uncertainty of the current financial situation for local government and in particular potential changes to the national funding formula for public health, this is considered high risk. A shorter term contract, running for a maximum of two years, is likely to reduce the number of bidders significantly as it would represent too great an uncertainty for any new provider. In addition, there are a number of large scale health visiting and children's centre procurements running at the current time in other local council areas, seeking bidders from what is a limited provider market. Taken together, these factors mean there is no certainty that a costly procurement exercise at this time would engender any viable bids. There is also a national review examining the cost benefits of the current mandatory requirements of the healthy child programme, which may lead to changes in what is required.

2. Continue with the statutory provision of health visiting and school nursing services under the existing contract with some disinvestment in the non-statutory elements of the current provision. This is not recommended as the current contract expires on 31 March 2017 and the council would fail to meet its statutory obligations. In addition, this is likely to significantly undermine health outcomes in children, young people and families, require significant change management and NHS redundancies and represent a false economy relating to increased demand on other services.

3. Transfer the full health visiting and school nursing service or only the workforce resource to the council. This is not recommended as there is insufficient time to undertake the due diligence in relation to this transfer or to establish the necessary clinical governance and safeguarding arrangements to affect such a change by 1 April 2017. The council would need to market test the insourcing of a workforce only approach to ensure there is a sufficient market in place to deliver the infrastructure arrangements.

Reasons for recommendations

4. By extending the current contract for a further fixed period, the council will be able to continue to effect quality improvements within the finances known to be available. This will also give the council time to develop the options to secure a more integrated approach across early years services by encompassing children's centre services. This would be in line with recent recommendations from the overview and scrutiny task and finish group and the direction set out and approved in the children and young people's plan.

Key considerations

5. The council has identified as a strategic priority, in the children and young people's plan, the need to strengthen the approach to improving outcomes in the early years, in child and parental mental health and in improving overall health and wellbeing. There has been pleasing progress over the past three years in terms of a rise in the number of children who are immunised, of smoking cessation and of ensuring that children have a good level of development by the time they start school. However, inequalities still remain and for some children the gap between their health and development and that of their peers is widening. Dental health in the early years remains a significant concern.

6. The current health visiting and school nursing service is commissioned by the council from Wye Valley NHS Trust. The service makes a significant contribution to improving children's outcomes in the priority areas in the children and young people's plan. The service is a universal service, provided to all children in Herefordshire. There are currently 40.9 full time equivalent (FTE) health visitors with caseloads of approximately 240 children per nurse. There are nine FTE school nurses to cover all schools in Herefordshire, including special schools, equating to in the region of 3,000 children per nurse. All the staff are qualified nurses and have additional skills and specialisms.

7. As well as playing a significant role in improving health and wellbeing outcomes, including those set out in the national healthy child programme, such as the child measurement programme to detect and prevent emerging obesity issues, the services work in close partnership with GPs, schools, social care and the voluntary sector as part of the early help workforce and child protection arrangements in Herefordshire.

8. Although the service has been improving, further improvements remain to be made. These include access to technology, better access and application of data to target resources and continued progress to improve the uptake of the mandated child health reviews to a minimum of 95% coverage as set out in table 1 below:

Table 1		
Health visitor mandated indicators	**Herefordshire performance 2015/16**	**Local comparison to national performance***
Number of new mothers who receive a first face to face antenatal contact with a health visitor (28 weeks or above) – proxy target based on 2015/16 birth data	914* (51%)	No data
Percentage of births that receive a face to face new birth visit within 14 days by a health visitor	87%	Herefordshire Similar
Percentage of children who received a 6-8 week review by the time they were 8 weeks old	100%	Better
Percentage of children who received a 12 month review	92%	Better
Percentage of children who received a 2 – 2.5 year review	89%	Better

*Source: National return HSCIC 2015/16 *based on Q3 data from 149 councils. Q4 data due for release end of July 16*

9. The current contracts with Wye Valley NHS Trust were extended in March 2016 and are due to end on 31 March 2017. Whilst the original intention was to go to open procurement for a new contract, for the reasons set out in the alternative options above, further consideration of the following elements has resulted in a revised understanding of the situation:

    - better alignment with the emerging early years and early help plans;
    - consideration of the pending national reviews relating to the healthy child programme and mandated reviews;
    - the One Herefordshire transformation programme and Sustainability Transformation Plan (STP) programme; and
    - understanding the potential market.

    These considerations have influenced the recommended next steps which are to extend the current contract for a year in order for the council to undertake an options appraisal to secure the best way of achieving a more coherent and integrated model. This could include open procurement or insourcing to the council or a combination of both.

10. Further analysis of the need in Herefordshire, and consideration of national evidence of effective service delivery models, has enabled a clearer picture to be developed of the key elements of the future service required locally. Therefore the main features of an alternative model would be:

- a service which integrates health visiting and school nursing services with other services, including children's centres and other early help services;
- an infant and maternal mental health service for 0-2 year olds working in partnership with the third sector;
- a young parents service;
- peer parenting and community support programmes;
- a fit family healthy weight programme.

Community impact

11. The health and wellbeing strategy, the children and young people's plan and the council's corporate priorities are very clear that it is families who bring up children best. These plans also prioritise the focus on addressing health, education and care inequalities for some children. These services play a specific role in that ambition and evidence shows that health visitors and school nurses are generally well regarded by families, GPs, mental health services, schools and early years providers.

12. In particular they :

- promote and provide early help for families, developing the "Think Family" approach and culture across Herefordshire;
- improve the emotional and mental health and wellbeing of children, young people, and their parents and carers; and
- meet the needs of children and young people requiring safeguarding.

Further detail is available in appendix 1.

13. In Herefordshire, however, we know that some rural families have difficulties accessing services when they need them. There has also been a reduction in some early help services over the past few years and there is limited access to mental health support. A re-designed service, which is better integrated with others, will enable the council to re-shape the use of resources and achieve better value for money.

14. A new service model would be particularly focussed on improving:

- children's readiness for school including language development and early identification of communication problems;
- healthy social and physical development including health protection;
- readiness to learn and ability to build positive relationships;
- reducing inequalities and improving educational attainment;
- emotional development, resilience and mental wellbeing.

Equality duty

15. The Equality Duty 2010 has three aims (general duty):

- Eliminate discrimination, harassment, victimisation and any other conduct prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected

characteristic and persons who do not share it.

- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

16. The Public Sector Equality Duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations, and demonstrate that we are paying "due regard" in our decision making in the design of policies and in the delivery of services.

17. The development of the new model will be subject to a full equality impact assessment.

Financial implications

18. The Department of Health has announced that the public health grant will be subject to reductions year on year during the remainder of the medium term financial strategy period, amounting to some 10% of the total. Given that rural councils are also comparatively underfunded in their general funding; the public health budget will need to be reduced proportionately. To mitigate these challenges, the health visiting and school nursing services need to be cost efficient. The healthy child programme is currently commissioned in a fragmented way at a total cost of approximately £2.9m per annum.

19. Nationally, the 'invest to save' cost benefit of an effective health visiting and school nursing approach is between £1.37- £9.20 for every pound invested. In the light of the funding environment and the medium term financial strategy, there is a need to reduce service cost, increase impact in improving health outcomes and secure a greater impact in areas where the gap between good and poor outcomes are the widest.

20. The cost of extending the contract for one year is £2.6m. The development of an integrated model and exploration of other providers, including potentially the council, will enable the council to ensure maximum financial efficiency, reduce oncosts, appropriate financial flexibility to meet changing budget levels and maximise the use of resources with children and families.

Legal implications

21. In the exercise of this council's general public health function under section 2B of the National Health Service Act 2006, which is to improve health of people in its area, the council must secure (in accordance with regulation 2103/351) the provision of a universal health visitor review to be offered to pregnant woman and children aged under five years in our area.

22. Under the Health and Social Care Act 2012, local authorities are responsible for commissioning public health services for children and for improving the health of their local population.

23. This extension in these circumstances (i.e. where the extension is not expressly mentioned in the current contract) is to be regarded (for procurement purposes) as if it were a new contract.

24. Under clause 4.6.13.2 of the Council's Contract Procedure Rules, a new contract over £50,000 (which includes an extension in these circumstances) requires a tender.

25. However, this requirement may be waived under clause 4.6.18.1 in 'exceptional circumstances'. The current extension is comfortably above the £50,000 threshold,

and would ordinarily require a tender unless there are exceptional circumstances to justify a waiver.

26. The circumstances described in this paper (e.g. the need for the council to do the various tasks described in this paper) appear to be exceptional circumstances justifying a waiver of the requirement to conduct a tender.

27. Given the value of the extension (i.e. over a £589,148 threshold), the council must also comply with EU Treaty principles. One Treaty principle that is relevant here is that the council must treat all suppliers equally. There is a theoretical argument that by awarding this extension to a particular provider, the council has not treated all suppliers equally (i.e. Wye Valley NHS Trust has been given some kind of preferential treatment).

28. In practice, given the circumstances (i.e. the relatively short nature of the extension, the very small size of the potential supplier market, and the work the council is undertaking to prepare for a larger procurement), the risk of a challenge to the council for breaching this Treaty principle is regarded as very small.

Risk management

29. Key risks are outlined in the table below:

Risk	Mitigating actions
Extension of the existing contract will be contrary to procurement rules and may be subject to challenge. The council require a robust transformation plan.	• The council agrees to a system wide transformation plan which seeks to integrate services in line with the children and young people's plan 2015-18 and reduce the impact of cost efficiencies as a consequence of the cuts to the public health grant. • Any new arrangement shall enable open procurement of any appropriate services.
The reduction in the public health grant and the consequent 10% savings required from services generate three main risks: 1. That ongoing improvement in health and reductions in health inequalities might be jeopardised due to the loss of health visitor posts (approximately 4 FTE posts). This would expand the caseloads and potentially reduce quality of care to clients. 2. That any reduced investment in prevention might lead to a rise in demand for health, social care and other public services. 3. That a reduction in income might destabilise the existing	1. The council intends to mitigate this through service integration, re-design and re-commissioning, focusing on greatest need, and by strengthening universal prevention and early help. This includes providing information and advice, improving access to technology, encouraging and enabling communities, and effective, skilled early assessment and risk management. 2. This would be mitigated by introducing the 10% reduction to these services in 2017/18 to give partners the opportunity to consider alternative sources of funding and to allow time for service re-design and re-commissioning. 3. This would be mitigated by deferring

provider.	the saving until 2017/18 to give the opportunity to consider alternative sources of income and to allow time for service re-design and re-commissioning. The service would be commissioned to allow for the full impact of the public health grant cuts over the next four years.
To ensure the service complies with the Care Quality Commission (CQC) regulations and standards.	• To communicate any commissioning intentions and outcomes to the CQC to ensure proactive engagement and advice.
Any further reductions required to the council contracts shall require year on year cost efficiencies.	• Flexibility in the contract to enable amendments to the contract value. • Commissioners to ensure that efficiencies are communicated in the contract. • Commissioners to assure quality and workforce competencies. • Commissioners continue to work with providers and partners to deliver more effective and efficient ways of working. • Ensure that the effective use of technology is a key contractual component.
During the development of the new model and options appraisal, the workforce becomes anxious and this adversely impacts on the quality of service delivery.	• Appropriate sharing of information, engagement of staff in the re-design and continuation of the transformation meetings. • Providers fully engaged in any children's service developments and strategic planning. • Regular communication and updates. • Commissioners to performance manage and quality assure service.
New opportunities and/or challenges, and national public sector directives arise during the development of the service specification which adversely impact on the timelines for change.	• Robust project management and agreed strategy. • Ensure engagement of partners in the specification development and future direction of the services. • Communicate plans and progress. • Risk management.
If there are further reductions or a de-commission of the healthy child programme this will adversely impact on reducing inequalities and meeting the Ofsted requirements for children with special needs in relation to the educational health plan and the delivery of public health outcomes.	• To mitigate this, the council needs to be able to articulate roles and responsibilities and have assurance that the public health contribution to the outcomes for the most vulnerable children is evidenced.

Consultees

No consultees.

Appendices

Appendix 1: Integrated healthy child programme 0-19 years

Background papers

None identified.

Integrated Healthy Child Programme 0-19 years: Overview of Health Visiting and School Nursing Service Specification (public health nursing).

1. Improving Outcomes

Herefordshire Council is seeking to better integrate school nursing and health visiting services with early years and early help service plans. The council intends to develop an options appraisal by December 2016 which takes account of the scrutiny committee findings and the children and young people's priorities and plan.
The health and wellbeing strategy (2015) and joint strategic needs assessment refresh (2016) sets out the importance of the universal healthy child programme (HCP) pregnancy (0) to 19 years and the significant contribution of the public health workforce, particularly in relation to reducing health and social inequalities.

The intention to integrate these services shall enable economies, cost efficiencies and better joint working across the wider children's workforce. The model has been informed by national and regional best practice and evidence (i.e. through the call to action and research).Through local engagement with mothers and young people (see section 8). Further local engagement and consultation shall be included in the plan.

The proposed model meets the recommendations of the All Party Parliamentary Group (2016) which are:

- A good local primary prevention approach with good universal services.
- Central role of children' centres (to be determined).
- Universal early identification of need for extra support.
- Good antenatal services.
- Good specialised perinatal mental health services (not currently available locally).
- Universal assessment and support for good attunement between parent and baby.
- Prevention of child maltreatment.

The integrated services will build on the existing services to provide the following outcomes:

1.1 To deliver the 'six high impacts changes' for the 0-5 year old children and their families:

- Transition to parenthood and the early weeks.

- Maternal mental health (perinatal depression).

- Breastfeeding (initiation and duration).

- Healthy weight, healthy nutrition and physical activity;
  a) HV to monitor and record growth in line with HCP assessments and give appropriate health promotional guidance and referral with parental consent.

- Managing minor illness and reducing hospital attendance and admission;
  a) deliver interventions in line with Royal Society for the Prevention of Accidents (RoSPA) and/or latest best practice;

b) to target interventions based on the latest Hospital episode data: HVs service to prioritise the following areas of prevention: reductions in head injury; falls; burns (including injuries from hot liquids whilst breast feeding) and poisoning.

- Health, wellbeing and development of the child age 2 – 2.5 year old integrated review and support to be 'ready for school' (ref: *Department for Education (2014) Early years foundation stage profile attainment by pupil characteristics, England 2014).*

1.2 To deliver the 'six high impacts changes' for the 5-19 year old young person and their family:

- building resilience and improving emotional health and wellbeing as highlighted in Future in Mind, working closely with schools, parents and local services;
- keeping safe, managing risk and reducing harm – including child sexual abuse and exploitation (CSE);
- healthy lifestyles – including reducing childhood obesity and increasing physical activity;
- maximising achievement and learning – helping children to realise their potential and reducing inequalities;
- supporting additional health needs* – supporting children with special educational needs and disability (SEND) in line with the SEND reforms;
- transition and preparing for adulthood – aligning with the NHS Five Year Forward View (self-care and prevention agenda).

**public health nurses provide a public health and 'non clinical' service to children with special needs. The clinical service is commissioned by HCCG and is not part of this contract.*

1.3 To deliver the agreed public health outcomes:

Table 1: Public health domain framework

Domain 1	Improving the wider determinants of health	1.01 Children in poverty 1.02 School readiness 1.03 Pupil absence 1.04 First time entrants to the youth justice system 1.05 NEETs 1.10 Road casualties 1.11 Domestic Abuse 1.10 Killed and seriously injured causalities on England's road 1.13 Re-offending levels 1.15 Homelessness 1.16 Utilisation of outdoor space for exercise/health reasons
Domain 2	Health improvement	2.01 Low birth weight 2.02 Breastfeeding 2.03 Smoking at delivery 2.04 Under 18 conceptions 2.06 excess weight 4-5 & 10-11 year 2.07 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0 -14 and 15 - 24 years

		2.08 Emotional wellbeing of looked after children 2.09 Smoking at 15 years old (WAY survey) 2.10 Self harm 2.11 Diet 2.18 Alcohol related admissions 2.21 Antenatal and Neonatal screening 2.23 Self reporting well-being
Domain 3	Health protection	3.02 Chlamydia detection 3.03 Population vaccination coverage 3.05 TB
Domain 4	Health care, public health and preventing premature mortality	4.01 Infant mortality 4.02 Decaying teeth 4.3 Mortality rate from causes considered preventable 4.5 Under 75 mortality rate from cancer 4.6 Under 75 mortality rate from liver disease 4.7 Under 75 mortality rate from respiratory diseases 4.10 Suicide rate

Source PHE 2015

1.4 The services need to work closely with children centre services and midwifery to improve breast feeding rates where these are poorer than the national average. The funding for breast feeding was previously transferred to children centres and better integration shall enable better coordination and delivery of the UNICEF baby friendly standards which are currently only at level 1. The required level is level 3.

1.5 Herefordshire has a teenage conception rate of 26.0 per 1,000 girls aged 15-17 years in 2011 or 86 conceptions. It ranks fourth (in terms of performance) out of 15 comparator local authorities within the same national deprivation decile. This rate is not significantly different from the national rate of 30.7 per 1,000 girls. The new service will improve the outcomes identified above for young parents, where there is currently no intensive service offering.

1.5.1 Evidence shows that young parents are more likely to experience multiple risk factors, including increased prevalence of mental illness, poor attachment, joblessness and disadvantage. Teenage pregnancy, like child poverty, tends to follow inter-generational cycles. As Ermisch et al (2003) found, children disadvantaged by deprivation and poverty are at an increased risk of teenage pregnancy, especially those living in workless households, aged 11-15 years and who leave school at 16 with few or no qualifications.

Targeted support for young parents may be more likely to deliver the following outcomes depending on the severity of disadvantage and the wider determinants (Social Research Centre 2014):

- Reduced need for social care.
- Improved emotional and social wellbeing through strong parent child attachment, and positive parenting and family relationships
- Smoking reduced and not using cannabis.
- Living in rented accommodation.
- Eating more healthy meals.
- Fewer childhood accidents.
- Better language and communication development.
- Improved self-management of respiratory conditions .i.e. asthma.

- Appropriate use of primary, acute and urgent care services.
- Aspires to entire education in future years.
- Using contraceptives and improved relationships with family.

1.5.2 Health visitors are skilled at providing intensive support for vulnerable groups including young parents in the absence of a Family Nurse Partnership (FNP) model. The integrated service shall offer an intensive service for all adolescent parents, from booking to two years.

The service shall offer:

- consistency of carer and lead professional;
- involve parents in the co design and ongoing service improvement;
- improve access to education and employment;
- improve secure attachment and perinatal mental health;
- deliver the 6 high impact changes and include improved dental health and breast feeding;
- deliver outcomes in line with the Herefordshire family first outcomes framework where the family are identified as eligible for phase 2 of the *Troubled Families* programme.
- Develop and implement an accredited programme NVQ 1 as a minimum offer for the parents aged 15 years and over. This shall be in partnership with the council and education providers.

2. New opportunities through an integrated healthy child programme 0-19 years:

The following are areas are improvements to the current services: Funding for these schemes are reinvestments from the existing PH grant.

2.1 Integrating peer education (PE) into the HCP 0-19 programme in five secondary schools each year to focus on healthy lifestyles and improving awareness of child sexual exploitation. In addition, improving access to primary care through the introduction of You're Welcome standards in partnership with primary care.

2.2 Proposed fit families healthy weight programme (learning from Shropshire Council) to offer vulnerable young people who meet the required criteria, access to health advice and lifestyle coaching.

2.3 Recognition of the absence of current service provision for perinatal mental health which includes access to psychotherapy to improve poor attachment and infant mental health. A proposed new service offer in partnership with the third sector.

2.4 Improved alignment and integrated pathways in relation to early help and early years services i.e. registration with early years services; increasing access to the 2 year early education offer; improved access to language development and parenting programmes;

2.5 Recognition of the relative poor dental health of 5 year olds (currently 41%* dental caries which is worse than the national and regional averages). Proposal to better coordinate the dental health promotion offer; working closely with early years' providers and provision of dental packs at health assessments. **Data based on PHE 2014 dental health survey.*

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2.6 Improved co-ordination and offer of pregnancy and post-natal parenting programmes in the most deprived area.

2.7 Named nurses for each school and improved access through new technologies.

2.8 Increase delivery of integrated two year assessment.

2.9 Continued improved performance in mandated assessments and ability to respond to new system developments.

2.10 Better able to measure client impact and deliver primary source data.

2.11 An integrated service model would include the following new features (not exhaustive):

- Key links to children centre services to include registration of all children and sharing agreed information and 2 year ASQ with parental consent.
- Targeted support for disadvantaged 2 year olds to encourage access to education.
- Coordinated community offer based on needs assessment to fully engage children centre advisory boards, schools and emerging community hubs.
- Full need assessment of each school and agreed action plan.
- Lead the UNICEF baby friendly initiative to level 3 working in partnership with midwives and local service coordinators.
- Annual needs assessment to inform JSNA.
- Improved social value offer to include peer led and volunteer programmes and apprenticeships i.e. ready steady mums (RSM) and adolescent peer support.
- Integrated care pathways which improve the client experience and reduce duplication.
- Improved focus on language development in partnership with local service coordinators.
- Improved links and joint working with the third sector to evaluate a care plan approach.
- Continued safe and effective management of cases where these do not meet the threshold of significant harm in partnership with other agencies and communities.
- Champions and specialist health visitors and school nurses who shall lead the way to reduce inequalities and ensure best practice with the following vulnerable groups: (in no particular order)

    - Gypsy Roma Traveller population
    - Supporting teenagers parents during pregnancy and up to 2 years old
    - Parents with mental health, learning and physical difficulties
    - Military families
    - Asylum seekers and migrant families
    - Families in poverty.

3. Service improvements and cost efficiencies as a result of integration are intended to be:

- Shared professional leadership and operational management.
- Deliver the community offer in line with locality plans and to advance social capital initiatives such as peer parenting and so on.
- Specialist practice in key areas of need and inequality: obesity; drugs and alcohol; smoking c; domestic violence, Roma, Gypsy Traveller and non-English speaking communities.
- Shared IT systems and improved technologies to advance mobile working, client management and outcome reporting.
- Improved transition planning, joint planning and delivery of services with schools and communities.
- Seamless care pathways to ensure effective transitions between early years and schools.
- Improved client experience due to less duplication and sharing of information.

4. Current provision

Health visitors and school nurses deliver regular drop in's and clinics, in addition to the reviews set out in table 1 below. Clinics are usually delivered in children centres or health centres. Valuable access to children centres or similar facility will encourage market development and enable more effective mobilisation.

Table 1 details the current provision including the mandated 0-5 year's healthy child programme. This provision shall continue as follows:

Table 1: High level summary of key public health interventions:

Review	Description	Delivered by	Commissioned by
Antenatal Review Mandated	A full health and social care assessment of needs, risks and choices by 12 weeks of pregnancy Identifying and sharing information about women. This booking assessment is generally undertaken in children centres.	Midwives or maternity healthcare professionals	NHS clinical commissioners (CCG)
	Antenatal screening for fetal conditions	Midwives or maternity healthcare professionals Screening services	NHS England
Antenatal health promoting visits	Includes preparation for parenthood Health and social assessment Healthy Start	Health Visitors (HV)	Herefordshire Council (HC)

Appendix 1; Healthy Child Programme 0-19 years

Review	Description	Delivered by	Commissioned by
By 72 hours	Physical examination – heart, hips, eyes, testes (boys), general examination and matters of concern	Midwives or maternity healthcare professionals	CCG
At 5 – 8 days (ideally 5 days)	Bloodspot screening	Midwives or maternity healthcare professionals Screening services	NHS England
New Baby Review Mandated	Face-to-face review by 14 days with mother and father to include: Infant feeding; promoting sensitive parenting; promoting development; assessing maternal mental Health; sudden infant death; Keeping safe. If parents wish or there are professional concerns: An assessment of baby's growth. On-going review and monitoring of the baby's health. Safeguarding	HV	Herefordshire Council
6 – 8 Week Assessment Mandated	Includes: On-going support with breastfeeding involving both parents. Assessing maternal mental health	HV	Herefordshire Council
	Health review and comprehensive physical examination of the baby with emphasis on eyes, heart and hips (and testes for boys)	GPs (physical examination of the baby)	NHS England
3-4 month review	Targeted based upon need	HV	Herefordshire Council
By 1 Year Mandated	Includes: - Assessment of the baby's physical, emotional and social needs in the context of their family, including predictive risk factors - Supporting parenting, provide parents with information about attachment and the type of developmental issues that they may now encounter - Monitoring growth - Health promotion, raise awareness of dental health and prevention, healthy eating, injury and accident prevention relating to mobility, safety in cars and skin cancer prevention	HV	Herefordshire Council

Appendix 1; Healthy Child Programme 0-19 years

Review	Description	Delivered by	Commissioned by
By 2 – 2½ Years Mandated	Includes: - Review with parents the child's social, emotional, behavioural and language development - Respond to any parental concerns about physical health, growth, development, hearing and vision Offer parents guidance on behaviour management and opportunity to share concerns. Offer parent information on what to do if worried about their child. Promote language development. Encourage and support to take up early years education. Give health information and guidance. Review immunisation status. Offer advice on nutrition and physical activity for the family. Raise awareness of dental care, accident prevention, sleep management, toilet training and sources of parenting advice and family information. This review should be integrated with the Early Years Foundation Stage two year old summary as appropriate to the needs of the children and families.	HV	Herefordshire Council
3-5 years	Targeted reviews and support based upon need.	HV	Herefordshire Council
3-5 years	Vision screening – outreach in schools (TBC)	Acute services	CCG
4-5 years	Transition to school. Inform the EHC- Education, Health Care plan where no clinical intervention. School entry HCP review to inform needs assessments and school plan. On ward referral as appropriate. Statutory National Child Measurement Programme	HV and School Nurse	Herefordshire Council
5- 14 years	Immunisations and health protection https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/500213/9406_PHE_2016_Routine_Childhood_Immunisation_Schedule_A4_04.pdf	GP NHS England	NHS England
10-11 years	Statutory National Child Measurement Programme https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/487707/NCMPguidance201516FINAL.PDF	School Nurse	Herefordshire Council

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Review	Description	Delivered by	Commissioned by
All school age	Regular school drop in service and access to the school nurse. Targeted support to meet identified needs.	School Nurse	Herefordshire Council

The service specification is currently being developed and sets out a description of public health's children and young people's health and wellbeing programme and provider expectations. It takes into account key national, local evidence and drivers to ensure the public health elements of the Healthy Child Programme 0-19 years (DH 2009) is offered to all children and young people with targeted and additional support provided where needed (including safeguarding).

5. Key areas for improvement in Herefordshire include (PHE 2015)

Herefordshire has lower than expected outcomes for some children and young people; particularly relating to dental health, school readiness (EYFS), breastfeeding, and obesity.The following are high level improvements included in the new specification and based on need:

- Achieving the best possible overall physical and mental health and well-being of children and families- applying evidence based health assessments and approaches. Sign posting to NHS and other key agencies where additional need i.e. special needs children and development delay; maternal and child mental health.

- Improving immunisation rates among children 0-5 years. Currently not all children are fully immunised which is a health protection risk. This varies across Herefordshire. HVs are targeting gaps and leading children centre interventions. They need to be better linked to early years' providers which a new contract shall deliver.

- Strategies to reduce tooth decay (worse than regional and England average) - all HVs shall be linked to early years providers with immediate effect and, prospectively to all schools. HVs are responsible for offering all parents dental packs and education during health assessments.

- Improving local breastfeeding initiation (current 75.5%) and prevalence at 6-8 weeks (continuation) rates (48%) which is slightly higher than England average. HVs and Midwives shall lead the UNICEF baby friendly standards aligned to the children centre services, as the funding to deliver breast feeding peer support is currently in the children centre budget. This arrangement shall be reviewed alongside the early year's project.

- Focus on reducing inequalities especially for the most vulnerable and non-English speaking children (see JSNA 2016). HVs will assess all children, refer to specialist services; signpost and deliver family focused and community interventions with partners where appropriate. HVs routinely screen for communication, behavioural and development delay and offer targeted support.

- Improved smoking cessation rates during pregnancy (14%) and early childhood (worse than England and regional averages). Partnerships with maternity services to develop integrated pathways which access help 2 Quit services early.

- 25% of maternities are obese (WVT 2016), HVs are key to leading the development of HCP pathways with Midwives. This work is being developed.

- 16-18 year olds NEET (worse than England and regional averages). Implementing intensive teenage parenting based on evidenced approaches and improved PH nursing services with proposed youth work competencies, is intended to impact on outcomes for the most vulnerable.

- Hospital admission due to alcohol (worse than England and regional averages although numbers low (n20). A review of team competencies required to deliver interventions in partnership with Police and Substance Misuse services for example are required. Peer education approaches are being proposed with Police, youth engagement and safeguarding specialists.

- 21.6 % of reception children are obese, HV and SNs are developing plans with schools and leisure services to improve health education and develop integrated pathways. This is in its infancy and there appears to be a lack of healthy weight approaches and services for children and young people. There is evidence that schools have a key role supported by public health nurses, children centre and leisure services for example. The links with mental health and obesity; and obesity and dental health are evident. Herefordshire requires a remobilisation of HVing and SNing to lead integrated pathways.

- Improvement parent and child attachment and reduce incidence of 'disorganised attachment', the latter may result in escalation of cases into social care. Midwives and Health Visitors are key to informing risk and signposting to psycho therapeutic support through an evidenced based programme such as Parent and Infant partnership programme (PIP);

- Ensuring all children are ready for school is a key priority; this includes the requirement for children to be able to communicate; have started to read and write (within developmental limits), and be continent (clean and dry). HVs working with partners shall ensure that children are ready to learn (where appropriate) prior to school admission.

- Safeguarding children and reducing harm. SN and HV services are vital to increasing an awareness and early identification of CSE and FGM.

6. Heathy child programme 0-19 years key priorities:

6.1 Reducing Obesity

The National Child Measurement Programme (NCMP) measures the height and weight of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obesity levels in children within primary schools. This data can be used at a national level to support local public health initiatives and inform the local planning and delivery of services for children. Participation rates in Herefordshire were 96% in Reception and 90% in Year 6. Participation rates nationally

were 96% and 94% respectively.

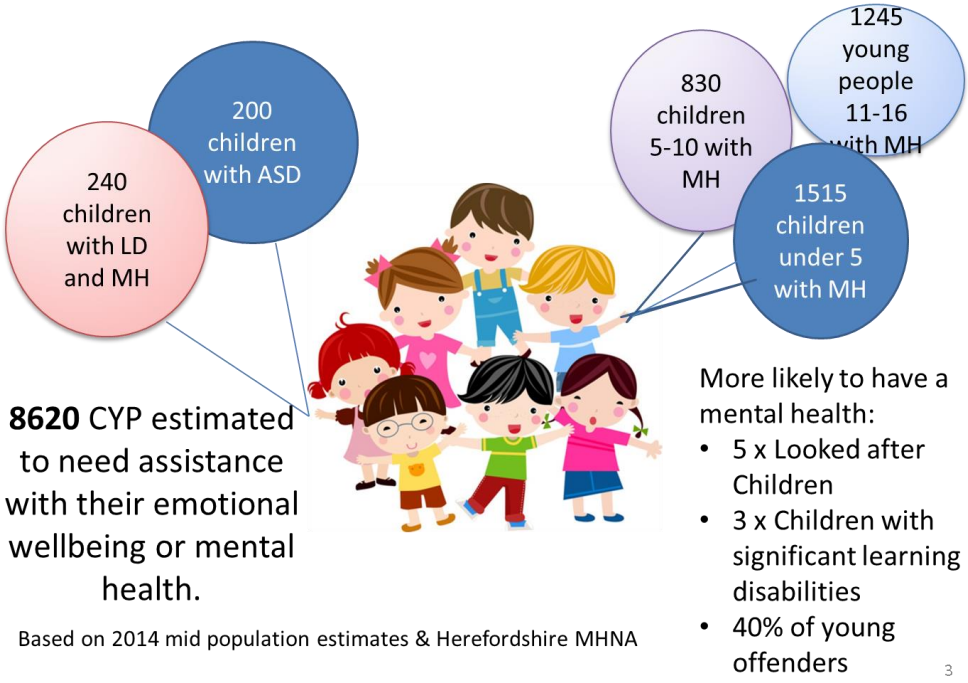
In Herefordshire 21.6% of reception children were deemed to be overweight or obese and 32.1% of year 6 pupils the same. Both figures represent a rise on 2013-14 when comparable figures showed 19.3% of Reception and 31.1% of Year 6 pupils were overweight or obese. Meanwhile, the percentage of pupils nationally deemed to be overweight or obese has fallen both for reception (22.5% in 2013-14 to 21.9% in 2014-15) and Year 6 (33.5% in 2013-14 to 33.2% in 2014-15).As a result Herefordshire's ranking, in terms of the lowest percentage of overweight or obese pupils, has fallen from 13 to 63 for pupils in Reception and 41 to 51 for those in Year 6.

The health visitor school nurse services contribute to the broader agenda of health and wellbeing which includes the impact on health and social services of overweight or obesity such as diabetes and cardiac disease.

6.2 Improving mental and emotional wellbeing

In Herefordshire, an estimated 8,620 children and young people require support with their mental health or emotional resilience.

Figure 2: Mental Health Prevalence



The Herefordshire mental health needs assessment (March 2015) recommended the need to:

- Enhance tiers 1 and 2 support for children and young people
- Improve the availability and quality of information available on mental health and well-being to young people, parents and carers
- Improve professionals' knowledge and awareness of the signs and symptoms of mental health, tiers of need, thresholds and referral routes

- Improve collaboration between service providers in the identification and response to emotional health, well-being and mental health need
- Development of comprehensive referral care pathway using a 'stepped' model.

School Nurses and Health Visitors in partnership with others shall contribute to the assessment recommendations and make a significant contribution to prevention and early identification by providing:

- Timely information, advice and support to promote the well-being of children and young people and support for parents, carers and practitioners.
- Recovery and avoidance of crisis. There is evidence-based practice to inform this area.
- Raise awareness of mental health and emotional well-being in children and young people and contribute to addressing the stigma associated with it. More young people able to talk about mental health and reduce the isolation felt by children and young people seeking help with their mental health.

7. High Level 0-19 year's outcomes

Age	High Level Outcome	High Level Specification Description	Lead Professional/access point
0-5	Starting well (H&WB Strategy and CYP Plan)	Full delivery of the HCP. Antenatal and Perinatal programmes. Dental health promotion in preschool settings and HCP assessments. 5 mandated universal offer Improving breast feeding rates. Healthy weight and nutrition. Speech and Language programmes. Improving immunisation rates. Early identification and brief interventions re child emotional and mental health.	Health Visiting *Partners inc:* *Primary care* *CCG Maternity* *Children Centres* *Early Years services* *Schools*
0-5 Families	Confident and competent parenting	Improved choice and confidence during pregnancy and birth (working with MWs and HVs). Maternal mental health: Prevention; early identification and intervention. Early help and parenting interventions. Improved access to early years education offer. Improved attachment and reduced social isolation. Smoking cessation and healthy lifestyle programmes.	HV *Partners inc:* *Primary care* *CCG Maternity* *Children Centres* *Early Years services* *Psychotherapy*

Appendix 1; Healthy Child Programme 0-19 years

Age	High Level Outcome	High Level Specification Description	Lead Professional/access point
		Contribute to neighbour and community plans in a meaningful way.	
5-19	Healthy and happy young people who have aspirations for their future	Improve on line resources Improving emotional wellbeing and building resilience and preventing risky behaviours. Positive transitions to adulthood. Reducing school absence and exclusions. Improving health outcomes in areas of deprivation. Improving dental health. Reducing hospital admissions due to unintentional or deliberate injuries. Contribute to neighbour and community plans in a meaningful way.	School Nursing Decipher ASSIST *Partners inc:* *Primary Care* *CCG CAMHS* *Education* *PCC* *Community Safety* *Schools*
5-19	Young people are supported to develop the confidence to protect their health	Increasing physical activity and healthy eating behaviours inc. NCMP. Improving sexual health and relationship education. De-stigmatising asking for advice. Increasing population vaccination cover, particularly for vulnerable children. Reducing smoking; alcohol and drug use. Promote positive self-image.	School Nursing Decipher ASSIST *(as above)*
5-19	Provide targeted support for vulnerable groups	Support young people with long term conditions, chronic disease and disability to maintain their independence and good health. Improve health literacy.	School Nursing *Partners inc.* *CCG- clinical nursing* *Education*
All	Social Capital: Identify and harness community assets and encourage co production activities	All community elements of the Public Health programmes. Connecting to existing and emerging community programmes. Stimulate social networks through public health programmes. Building strengths within communities. Peer led parenting	HV/SN ASSIST *All Partners.* *Community* *Wellbeing*

Andrea Westlake June 2016 v0.5

8. Engagement

8.1 High level summary School feedback (AW 2016)

The team had the opportunity to visit a number of schools. The school nursing service needs to encourage full participation of the school and share best practice approaches. Delivery of emotional wellbeing is a significant concern to schools who suggest that they would appreciate a better understanding and access to services. School nurses are valued and staff appreciate regular drop in's. A key area of concern was access to sexual health advice. We have opportunities to work with other partners to agree a strategy i.e. Taurus has been approached to explore joint initiatives to develop peer education. Schools would value SNs having better access to technology to enable teachers and students to refer via text and web mail.

The National Institute for Health and Clinical Excellence (NICE) guidelines for social and emotional well-being in secondary education (NICE, 2009) recommend that secondary schools 'adopt an organisation-wide approach to promoting the social and emotional well-being of young people' (p.7). Langford et al. (2014) state, 'Investment in these formative years can prevent suffering, reduce inequity, create healthy and productive adults, and deliver social and economic dividends to nations. Schools are an obvious place to facilitate this investment' (p.34).

8.2 Young people and parent's feedback (sources: PHAST 2014; Health Watch 2015; Public Health 2016)

- Access to the school nurse through the VLE and mobile texting
- Help to sign post and to understand mental health issues
- Regular drop ins
- School nurses were valued as a trusted source of confidential, expert advice on health matters, "*Making sure that the school nurse is consistent and can be able to support students on a regular basis so that when students get the courage to make contact the nurse is there otherwise they might not try again*." (Secondary school pupil).
- Parents saw a key role for school nurses in prevention and health promotion for their children, "*They should be teaching on health relating issues in schools and community centres such as drug misuse, stopping smoking, dealing with stress, parenting skills*." (Parent) and "*More support in sexual health is needed*
- Young people wanted better access to transport to improve their independence and access to services. Reduced transport charges for students would be welcomed.
- Making GP practices welcoming and confidential as some young people perceived that living in a rural area "*everyone knows everyone's business"*
- Improved transition pathways from education.

Future in mind. Promoting, protecting and improving our children and young people's mental health and wellbeing (DH 2015) describes school nursing as non-stigmatising and that HVs and SNs have a key role to play in offering universal assessment of need. Young people reported that access to GPs and explaining issues was challenging in Herefordshire. The You're Welcome standards have yet to be implemented.

Andrea Westlake June 2016 v0.5

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Herefordshire Council

Decision maker:	**Cabinet**
Decision date:	15 September 2016
Title of report:	**Agreement of section 75 (S75) arrangements between the council and Herefordshire clinical commissioning group (CCG)**
Report by:	**Cabinet member health and wellbeing**

Classification

Open

Key decision

This is a key decision because it is likely to be significant in terms of its effect on communities living or working in an area comprising one or more wards in the county.

Notice has been served in accordance with Part 3, Section 9 (Publicity in Connection with Key Decisions) of the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012

Wards affected

Countywide

Purpose

To agree variations to the Better Care Fund section 75 agreement (the BCF s75) effective from 1 October 2016.

Recommendation(s)

THAT:

(a) the variations to the BCF s75 set out at appendix one, be agreed effective from 1 October 2016; and

(b) authority is delegated to the director for adults and wellbeing to complete the varied section 75 agreement following legal review of the document.

Alternative options

1 To extend the original s75 agreement to run alongside the BCF s75. This is not recommended due to the duplication of contractual arrangements and inefficiencies in monitoring and delivering the two s75 agreements in parallel. The principle of developing a single s75 agreement was approved by cabinet on 17 March 2016.

2 Both of the s75 agreements to be terminated and services to be commissioned individually by partners. This is not recommended due to the benefits gained through joint commissioning. It is also a national requirement of the Better Care Fund that a minimum level of resources be held between the council and the CCG under a S75 agreement.

3 For the extension period to be removed from the varied BCF s75. If this extension option is not included, the BCF s75 will automatically end on 31 March 2018. It is recommended that the option to extend is included in the BCF s75 to enable it to be extended should both parties agree this is appropriate. Current national guidance suggests that the BCF will continue, at least in some form, beyond March 2018.

Reasons for recommendations

4 A partnership arrangement under section 75 of the NHS Act 2006 enables partners to commission integrated health and social care services to better meet the needs of service users than if the partners were operating independently. The 'original' section 75 arrangement, which was entered into by the council and the CCG in 2013 for a period of three years, will end on 30 September 2016. The principle of developing and implementing a single legally binding agreement has already been agreed by cabinet and the recommendations implement that decision.

5 Variations to the BCF s75 will provide a single arrangement for the remaining 18 month period of the BCF s75 (from 1 October 2016 to 31 March 2018). The variation will also include an option for the BCF s75 to be extended for a further 18 months after 31 March 2018, up to 30 September 2019; any exercise of that option would be subject to a further decision.

6 It is a national requirement of the BCF to have a s75 agreement to manage the pooled budget arrangements. By consolidating the historical s75 arrangement with the better care fund arrangements, a single agreement on health and social care covering both adults and children will be in place. The implementation of a single arrangement will enable partners to achieve efficiencies, reduce duplication and will also facilitate the further development of joint commissioning between the council and the CCG.

Key considerations

7 Section 75 agreements provide a contractual framework for the use of pooled funds between the council and the CCG to enable services to be delivered and commissioned co-dependently, the BCF s75 is documented in appendix two.

8 On 17 March 2016 cabinet approved the principle of developing a single section 75 agreement between the council and the CCG replacing the current two agreements.

9 It is proposed that to achieve a single agreement the existing BCF is varied to incorporate all other pooled resource activity.

10 The services included within the BCF s75 agreement are set out in the table below:

Scheme name	Financial contribution (full year equivalent 2016/17)				2016/17 in S75 1/10/16 to 31/3/17			
	Council £'000	CCG (PASC) £'000	CCG £'000	Total spend £'000	Council £'000	CCG (PASC) £'000	CCG £'000	Total spend £'000
Reablement		420		**420**	-	210	-	**210**
Falls prevention service			123	**123**	-	-	62	**62**
Virtual wards / hospital at home			768	**768**	-	-	384	**384**
Risk stratification			768	**768**	-	-	384	**384**
Carers support		460	50	**510**	-	230	25	**255**
DTOC support		23	32	**55**	-	11	16	**27**
Integrated community care			3,806	**3,806**	-	-	1,903	**1,903**
Rapid response		550		**550**	-	275	-	**275**
Rapid access to assessment and care		494	240	**734**	-	247	120	**367**
Community equipment store / Home improvement		272		**272**	-	136	-	**136**
Kington court (intermediate care provision)		366	534	**900**	-	183	267	**450**
Children's short breaks *1			427	**427**	-	-	214	**214**
Care Act implementation *2		460		**460**	-	230	-	**230**
Support for social care staff		832		**832**	-	416	-	**416**
Demand management		793		**793**	-	397	-	**397**
LD health (2g)		331		**331**	-	165	-	**165**
Sub Total Minimum Revenue Fund	**-**	**5,001**	**6,748**	**11,749**	**-**	**2,500**	**3,375**	**5,875**
Care home market management	19,468		9,272	**28,740**	9,734	-	4,636	**14,370**
Sub Total BCF Revenue Pools	**19,468**	**5,001**	**16,020**	**40,489**	**9,734**	**2,500**	**8,011**	**20,245**
Disabled Facilities Grant (Capital)	1,558			**1,558**	779	-	-	**779**
Total Better Care Fund	**21,026**	**5,001**	**16,020**	**42,047**	**10,513**	**2,500**	**8,011**	**21,024**
Children's commissioning unit (new from 1/10/16)	40		40	**80**	20	-	20	**40**
Children's short breaks *1	453			**453**	226	-	-	**226**
Children's complex needs solutions	2,995		499	**3,494**	1,498	-	249	**1,747**
Safeguarding boards *2	**138**		80	**218**	69	-	40	**109**
Sub Total Pool 3 Childrens Services	**3,626**	**-**	**619**	**4,245**	**1,813**	**-**	**309**	**2,122**
Annual cost for schemes	**24,652**	**5,001**	**16,639**	**46,292**	**12,326**	**2,500**	**8,320**	**23,146**

*1 Part of Childrens short breaks and respite funding (Ledbury Road within BCF minimum fund)

*2 Funding for Adults Safeguarding board £103k within Care Act as new burden for councils

11 The new agreement will not take effect until 1 October 2016, however the schemes will be operational under the existing arrangements, therefore full year equivalent figures are shown. The full value for each scheme over the life of the agreement will be subject to CCG and council budget setting for 2017/18 (see finance section below). The council and CCG have been working together to develop a single s75 agreement. This consolidation of pooled resource activity into a single agreement will allow monitoring and reporting to be streamlined and will ensure that duplication is minimised. It will also enable partners to further improve the quality and efficiency of services and continue to make more effective use of resources.

12 The council and CCG have a longstanding joint approach to the provision of short breaks to support families with children with disabilities. The joint approach maximises the use of resources whilst enabling a single, coherent programme of development and provision. The provision covers a range of accessible opportunities in universal services through to some highly specialised services which do include overnight respite. The approach also includes the use of direct payments. It is underpinned by the s75 agreement with contributions from both parties as recognised in the financial table. One benefit from combining the two s75 agreements will be that this will bring together the different funding sources for children's respite care and for the safeguarding boards, which are currently split between the agreements.

13 Short breaks provision will be recommissioned for April 2017 and will be dependent upon the continued joint contributions from the council and CCG. The financial contributions will be finalised as part of the development of the BCF s75 delivery plan for April 2017 onwards and will need to give a clear ongoing commitment over a number of years. This will enable the council and CCG to provide preventative services, reducing the pressure on high cost interventions and enable Herefordshire to continue to revise the short breaks offer to meet the needs of children and families whilst also meeting the financial challenges for both organisations.

14 The governance and monitoring processes are currently under review and will be subject to a further decision. NHS England require that quarterly performance returns are approved by the health and wellbeing board; the council's elements of the BCF s75 are also included within the corporate performance reports to cabinet.

15 The varied BCF s75 is subject to approval by the CCG governing body on 6 September 2016.

Community impact

16 The Understanding Herefordshire report and different local needs assessments have provided the evidence base which has informed the development of this single BCF s75.

17 The BCF s75 supports the delivery of the council's corporate plan 2016 – 2020 aim to enable residents to live safe, healthy and independent lives and to secure better services, quality of life and value for money.

18 In addition the BCF s75 supports the health and wellbeing strategy aim that 'Herefordshire residents are resilient, lead fulfilling lives, are emotionally and physically healthy and feel safe and secure'.

Equality duty

19 The council is committed to equality and diversity using the public sector equality duty (Equality Act 2010) to eliminate unlawful discrimination, advance equality of opportunity and foster good relations.

20 It is not envisaged that the recommendations in this report will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

21 Equality Impact Assessments (EIA) will be undertaken on the individual schemes which will consider the Equality Act 2010 and will review all of the nine protected characteristics in the event of any changes.

Financial implications

22 The initial full year equivalent value of the agreement reflects the funding agreed for the 2016/17 BCF plan and the continuation of the existing funding arrangements and funding levels for children with complex needs, as shown in the table below, further details on the finance contributions are within appendix four:

	LA £'000	CCG £'000	Total £'000
BCF within S75			
Minimum Revenue Fund - Protection of ASC *1		5,001	5,001
Minimum Revenue Fund - CCG schemes		6,748	6,748
Additional Pool Contributions	19,468	9,272	28,740
Total BCF Revenue Fund	**19,468**	**21,021**	**40,489**
BCF Capital	1,558		1,558
Total BCF in Section 75	**21,026**	**21,021**	**42,047**
Other Existing S75 Services			
Children with complex Needs *2	2,995	499	3,494
Children's short breaks (LA contribution)	453		453
Safeguarding Boards*3	138	80	218
New - Children's Commissioning Unit*4	40	40	80
Sub Total Other Services	**3,626**	**619**	**4,245**
Total Section 75	**24,652**	**21,640**	**46,292**

*1 includes protection of adult social care and care act funding.

*2 Children with complex needs funded through both Dedicated Schools Grant and core budget in LA

*3 £103k of funding for safeguarding boards within care act funding in BCF (note 1 above). Additional funding for the safeguarding boards from other partners is not included but provides an additional £63k pf funding per annum.

*4 Estimated cost of new integrated childrens commissioning unit. Value TBC

23 The new agreement will be in place for the final six months of 2016/17 and the whole of 2017/18. At this stage, the total value of the agreement can be estimated but not confirmed, as expenditure for 2017/18 will be dependent upon the allocation of the BCF funding by NHS England, the agreement of partners on the values of the additional pool contributions, the centrally awarded disabled facilities grant and the outcomes of budget setting by both partners for 2017/18. Furthermore the partners may jointly wish to include additional services within the pooled arrangements as part of the move towards the integration of health and social care. An indicative estimate of the total value of the agreement over the eighteen month period is shown in the table below:

Period October 2016 to March 2018	**LA £'000**	**CCG £'000**	**Total £'000**
BCF within s75			
Minimum revenue fund	29,202	31,532	60,734
BCF capital *5	2,337		2,337
Total BCF revenue fund	**31,539**	**31,532**	**63,071**
Other schemes	5,439	929	6,368
Total section 75	**36,978**	**32,461**	**69,439**

*5 The comprehensive spending review highlighted a significant increase in funding for disabled facilities grants, but no indication of the settlement for 2017/18 is available, therefore no uplift assumed.

24 The BCF funding includes £4.5m for the protection of adult social care and £0.5m for implementing the additional requirements introduced through the Care Act. These are in line with the 2015/16 financial plan and as reflected within the 2016/17 plan for the

adults and wellbeing directorate.

25 The council is required to include the capital funding received for the Disabled Facilities Grant (DFG) within the minimum BCF. This is £1.5m for 2016/17, which is an increase of £0.6m compared to 2015/16.

26 It is proposed that the new section 75 agreement continues with the additional pool for residential and nursing placements. Further, it has been agreed that this includes a new risk share arrangement on a restricted client cohort, replacing the previous much broader risk share arrangement. An arrangement has been agreed with Herefordshire CCG which caps the council's risk share on pool 2 at 13% of the current cost of this cohort of 27 individuals. Consequently this limits the financial risk to the council at £180k per annum, on a non recurrent basis, please see appendix three for the detailed risk share agreement.

27 The current risk share arrangement for the children with complex needs will continue unchanged, on the basis of budget contributions.

28 All other risks will be borne by the respective partners.

Legal implications

29 Section 75 of the National Health Service Act 2006 contains powers enabling NHS bodies (as defined in section 275 and 276 of the NHS Act 2006) to exercise certain local council functions and for local councils to exercise various NHS functions. The parties entered into the BCF S75 in exercise of those powers under and pursuant of the NHS Regulations 2000.

30 Clause 32 of the BCF S75 provides that variations to the BCF S75 will be valid if they have been agreed in accordance with the governance process of each partner's constitution and are then recorded in writing and signed for and on behalf of each of the partners. Schedule 9 of the BCF S75 provides the template to be used to vary this agreement, having followed any required governance process of each partner's constitution.

Risk management

31 If the CCG does not agree to vary the BCF S75 it may pose a risk to the council and to the delivery of services. Council officers have worked closely with CCG colleagues in developing this proposed agreement and continue to work in close partnership to minimise risk.

32 Risk will be managed and controlled through the governance structure, which includes the better care fund partnership group, the joint commissioning board and the health and wellbeing board.

33 A risk share arrangement has been agreed with Herefordshire CCG which is set out in paragraph 26 above.

Consultees

34 The council has worked closely with colleagues from the CCG to finalise better care fund plans for 2016/17, which have been approved at both a regional and national level. The development of a single s75 agreement has formed part of these discussions. In addition, a small working group involving both parties has been

established.

Appendices

Appendix 1 – Summary of variations to be effected.

Appendix 2 – Section 75 agreement

Appendix 3 – Risk share arrangement (Schedule 4)

Appendix 4 – Schedule 1 and 2 of section 75 agreement

Appendix 5 – BCF plan 2016/17

Background papers

None identified

NHS Herefordshire Clinical Commissioning Group

Herefordshire Council

VARIATION AGREEMENT
Intention to Vary / Confirmation of Variation*

Contract/Variation Reference:

Proposed by:	The County of Herefordshire District Council
Date of Proposal: 15 September 2016	**Date of Variation Agreement**: 1 October 2016

1. The Parties have agreed the Variation summarised below:

Describe Variation in Words

(1) To incorporate the delivery of certain services currently provided for and covered by the section 75 agreement made between the Council and the CCG during 2013 (the original s.75 agreement) which services need to continue to be provided/delivered after the original s.75 agreement expires on 30 September 2016; and
(2) To include specific provisions relating to safeguarding; and
(3) To incorporate uplifts to, adjustments and restatement of budgets as set out in the table below – Total BCF Budget.

Total BCF Budget*[1]			
Financial Impact of Variation	**Herefordshire Council £'000**	**Herefordshire CCG £'000**	**Fund Total £000**
Pre variation budget total per S75	**23,085**	**24,505**	**47,590**
Details of variation:			
Uplift for 2016/17 / PASC adjustment	277	32	**309**
Adjustment to final pool 2 budget 15/16	(3,366)	(4,103)	**(7,469)**
Restatement Pool 2 budgets 16/17	1,030	587	**1,617**
Adjustment to 18 month term of agreement	10,513	10,511	**21,024**
Inclusion of new services (from original S75)	5,439	929	**6,368**
Revised Budget Contribution (18mth value)	**36,978**	**32,461**	**69,439**

*[1] see appendix for revenue / capital breakdown

2. The Proposer requires the proposed Variation to take effect on 1 October 2016.
3. The Proposer requires the Recipient to respond to this Variation Proposal in writing within 10 Operational Days, setting out whether:
   - it accepts the proposed Variation; and/or
   - it has any concerns with the contents of this Variation Proposal,

   and any other comments it may have in relation to the proposed Variation.
4. The Variation is reflected in the revised and attached Framework Partnership agreement relating to the commissioning of health and social care services in connection with the Better Care Fund and the Parties agree that the Contract is varied accordingly.
5. The Variation takes effect on 1 October 2016.

NHS Herefordshire Clinical Commissioning Group

Herefordshire Council

IN WITNESS OF WHICH the Parties named below have signed this Variation Agreement on the date(s) shown below

Signed by	[INSERT AUTHORISED SIGNATORY'S NAME]
for and on behalf of Herefordshire Council*	
Signature	
Title	
Date	

Signed by	[INSERT AUTHORISED SIGNATORY'S NAME]
for and on behalf of Herefordshire Clinical Commissioning Group*	
Signature	
Title	
Date	

*Delete as required

*If the Contract being varied is in the form of the NHS Standard Contract 2014/15 (and all Commissioners have agreed, via their Collaborative Commissioning Agreement or otherwise, that the Co-ordinating Commissioner may sign the Variation Agreement on their behalf), only the Co-ordinating Commissioner need sign. In all other circumstances, all Commissioners must sign the Variation Agreement. Delete/complete as appropriate.

Capitalised words and phrases in this Variation Agreement have the meanings given to them in the Contract referred to above.

NHS Herefordshire Clinical Commissioning Group

Herefordshire Council

Appendix 1

Section 75 Variation Template Financial Impact

Revenue Budget			
Financial Impact of Variation	**Herefordshire Council £'000**	**Herefordshire CCG £'000**	**Fund Total £000**
Pre variation budget total per S75	21,729	24,505	**46,234**
Details of variation:			**0**
Uplift for 2016/17 / PASC adj	75	32	**107**
Adjustment to final pool 2 budget 15/16	(3,366)	(4,103)	**(7,469)**
Restatement Pool 2 budgets 16/17	1,030	587	**1,617**
Adj original to 18 month term of agreement	9,734	10,511	**20,245**
Inclusion of new services (from original S75)	5,439	929	**6,368**
Revised Budget Contribution	**34,641**	**32,461**	**67,102**

Capital Budget			
Financial Impact of Variation	**Herefordshire Council £'000**	**Herefordshire CCG £'000**	**Fund Total £000**
Pre variation budget total per S75	1,356	0	**1,356**
Details of variation:			**0**
Uplift for 2016/17 / PASC adj	202		**202**
Adjustment to final pool 2 budget 15/16			**0**
Restatement Pool 2 budgets 16/17			**0**
Adjustment to 18 month term of agreement	779		**779**
Inclusion of new services (from original S75)			**0**
Revised Budget Contribution	**2,337**	**0**	**2,337**

Total BCF Budget			
Financial Impact of Variation	**Herefordshire Council £'000**	**Herefordshire CCG £'000**	**Fund Total £000**
Pre variation budget total per S75	23,085	24,505	**47,590**
Details of variation:	0	0	**0**
Uplift for 2016/17 / PASC adj	277	32	**309**
Adjustment to final pool 2 budget 15/16	(3,366)	(4,103)	**(7,469)**
Restatement Pool 2 budgets 16/17	1,030	587	**1,617**
Adjustment to 18 month term of agreement	10,513	10,511	**21,024**
Inclusion of new services (from original S75)	5,439	929	**6,368**
Revised Budget Contribution	**36,978**	**32,461**	**69,439**

Dated **2016**

THE COUNTY OF HEREFORDSHIRE DISTRICT COUNCIL

and

NHS HEREFORDSHIRE CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES IN CONNECTION WITH THE BETTER CARE FUND

Contents

THIS AGREEMENT is made on **day of** **2016**

PARTIES

(1) **COUNTY OF HEREFORDSHIRE DISTRICT COUNCIL of Plough Lane, Hereford, HR4 0LE** (the **"Council"**)

(2) **NHS HEREFORDSHIRE CLINICAL COMMISSIONING GROUP of Plough Lane, Hereford, HR4 0LE** (the "**CCG"**)

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the county of Herefordshire.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the county of Herefordshire.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose. The Partners have chosen to extend the use of pooled funds to include funding streams beyond the minimum fund required by the Better Care Fund

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also the means through which the Partners will pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services.

(G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

(I) Partners have agreed to vary the Agreement with effect from 1 October 2016 and the provisions of this Agreement shall replace and supersede the provisions of the agreement entered into by the Council and the CCG on xxxxx in relation to the Better Care Fund.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2006 Act means the National Health Service Act 2006.

2014 Act means the Care Act 2014

Affected Partner means, in the context of Clause 26, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund (BCF) means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

BCF Partnership Group: means the Steering Group for the operational delivery of the BCF Plan. Members of the group take responsibility for delivery of the Individual Schemes and Services.

Better Care Fund Plan means the plan attached at Schedule 7 setting out the Partner's plan for the use of the Better Care Fund.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Chief Financial Officer means the Chief Financial Officer of the CCG

Commencement Date means 00:01 hrs on 1 April 2015

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund or Non Pooled/Aligned Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict; (b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies; (g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund and for each Non Pooled/Aligned Fund the Partner that will host the Non Pooled /Aligned Fund

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other is exercise of both the NHS Functions and Council Functions through integrated structures.

Joint (Aligned) / Co-Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) / co-commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Joint Commissioning Board means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 6.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and

the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Local Authority means The County of Herefordshire District Council also referred to as “the Council”

Local Objectives means the local objectives to be met in Herefordshire as are more particularly set out in the Better Care Fund Plan

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as defined in the 2016/17 Department of Health Better Care Fund policy framework, which are relevant to BCF schemes only, or subsequent publications.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Scheme Specification

Non Pooled/Aligned Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 10.6.

Overspend means any expenditure from a Pooled Fund or Non Pooled/Aligned Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.2.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer (Local Government Act 1972) for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 8.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Performance Payment Arrangement means any arrangement agreed with a Provider and one of more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Section 151 Officer means the Chief Financial Officer of the Council

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individuals for whom the Partners have a responsibility to commission the Services and/or who are eligible to receive the Services.

SOSH means the Secretary of State for Health.

Third Party Costs means all such third party costs (including legal and other professional fees) as agreed by the Joint Commissioning Board on an individual scheme basis.

Underspend means any expenditure from a Pooled Fund or Non Pooled/Aligned Fund in a Financial Year which is below the Financial Contributions for that Financial Year.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971. For the avoidance of doubt additional non-working days for Council employees (contractual unpaid leave to which they are entitled) will be treated as bank holidays for the purposes of social care support and cover and as such, shall not constitute "Working Days".

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or

"includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until 31st March 2018 unless terminated earlier in accordance with Clause 24.

2.3 The Agreement may be extended for a period of eighteen (18) months from 1 April 2018 to 30 September 2019.

2.4 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any Council function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

3.4 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanisms through which the Partners have agreed that they may implement the Better Care Fund Plan. These are:

4.1.1 The establishment of one or more Pooled Funds;

4.1.2 Lead Commissioning Arrangements;

4.1.3 Joint (Aligned) /Co-Commissioning; and

4.1.4 Integrated Commissioning.

As more particularly described in the Scheme Specifications in relation to Individual Schemes (the "Flexibilities")

4.2 At the Commencement Date, there are no Health Related Functions to be delegated by the Council for the CCG to exercise. In the event that, during the term of this Agreement, the Partners identify the need for the Council to delegate Health Related Functions to the CCG, and the CCG agrees to exercise those, to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions, this delegation shall be preceded by:

- The identification of the Functions to be delegated;
- The undertaking of any necessary consultation;
- The seeking of legal advice;
- The Council constitution and schemes of delegation being updated to reflect the changes required; and
- A deed of variation being signed by the Partners to effect a variation of this Agreement.

4.3 The CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification. The Partners shall agree arrangements designed to achieve delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 This Agreement shall include such functions as shall be agreed from time to time by the Partners, having followed the governance processes required by each of their constitutions and in response to any recommendations made by the Joint Commissioning Board.

5.2 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be completed in the form set out in Part 2 of Schedule 1 and agreed between the Partners. The initial Scheme Specifications, as at the Commencement Date, are set out in Part 3 of Schedule 1.

5.3 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.4 The introduction of any Individual Scheme will be subject to business case approval by the Partners, following the governance processes required by each Partner's Constitution, on the recommendation of the Joint Commissioning Board.

6 COMMISSIONING ARRANGEMENTS

Integrated/Joint Aligned/Co-

Commissioning

6.1 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, both Partners shall work in cooperation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.2 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

6.3 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partner's Financial Contribution in respect of that Individual Scheme in each Financial Year.

6.4 The Partners shall comply with the arrangements in respect of the Joint (Aligned) / Co-commissioning as set out in the relevant Scheme Specification.

6.5 Each Partner shall keep the other Partners and the Joint Commissioning Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled/Aligned Fund.

6.6 The Joint Commissioning Board will report back to the Health and Wellbeing Board as required by its Terms of Reference.

Appointment of a Lead Commissioner

6.7 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

6.7.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

6.7.2 ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.7.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.7.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

6.7.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

6.7.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.7.7 undertake performance management and contract monitoring including any enforcement action required of all Service Contracts;

6.7.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

6.7.9 keep the other Partner and the Joint Commissioning Board regularly informed in writing of the effectiveness of the arrangements including the Better Care Fund and as soon as practicable after becoming aware of any projected Overspend or Underspend in a Pooled Fund or Non Pooled/Aligned Fund.

6.8 Detailed commissioning obligations where Lead Commissioning Arrangements apply are set out in

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Schedule 4.

7 ESTABLISHMENT OF A POOLED FUND

7.1 At the Commencement Date and in exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain the Pooled Funds that are described in Part 1 of Schedule 1 and to utilise those Pooled Funds in connection with the Individual Schemes in the manner set out in Part 1 of Schedule 1 and in the Scheme Specifications. For the avoidance of doubt, the Partners may agree variations to the Pooled Funds and may add additional Pooled Funds during the term of this Agreement which will be recorded using the variation template (Schedule 9). Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement and Regulation 7 of the Regulations.

7.2 It is agreed that the monies held in a Pooled Fund may only be expended on the following "Permitted Expenditure":

7.2.1 the Contract Price;

7.2.2 the Permitted Budget where the Council is to be the Provider;

7.2.3 Performance Payments;

7.2.4 Third Party Costs ; and

7.2.5 Approved Expenditure.

7.3 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner and for the avoidance of doubt there is no obligation on either Partner to agree to any such expenditure not constituting Permitted Expenditure. Management overheads, accommodation costs and other administrative support costs shall not constitute Approved Expenditure unless otherwise agreed by the Partners in writing.

7.4 Monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.

7.5 At the Commencement Date, the Partners have agreed to appoint the Council as Host Partner for the Pooled Funds. The Host Partner shall be the Partner responsible for:

7.5.1 Reporting on / holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.5.2 providing the overall financial analysis including supporting administrative systems for the Pooled Fund;

7.5.3 appointing the Pooled Fund Manager; and

7.5.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement as detailed in Clause 8

7.6 The minimum fund capital expenditure for the BCF which is constituted by the Disabled Facilities Grant and Social Care Capital Grant will be included within the Scheme Specifications in so far as it is required to be allocated to a Pooled Fund, but will be devolved to the Council for administration. The Council will report to the Joint Commissioning Board, details of capital expenditure made from the Pooled Fund, including in respect of the Social Care Capital Grant and Disabled Facilities Grant.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund; and

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager shall have the following duties and responsibilities: 12

8.2.1 To develop and implement an overarching Commissioning Project Plan for the BCF, to maximize Joint (Aligned)/Co commissioning and Integrated Commissioning opportunities allied to the Pooled Fund working in conjunction with the lead officers of each Partner organisation.

8.2.2 To lead on the delivery of the joint procurement and management of the Residential and Nursing Care Home Market to ensure effectiveness and efficiency of such procurements across health and social care.

8.2.3 To support the development of Joint (Aligned) Co-commissioning/Integrated Commissioning strategies for Learning Disability and Mental Health.

8.2.4 To embed the governance structure set out in Schedule 2 of this Agreement within both organisations and to develop and deliver a work plan for the BCF for 2015/16.

8.2.5 Oversee the performance management arrangements for the BCF.

8.2.6 To oversee the day to day operation and management of the Pooled Funds established pursuant to this Agreement, ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification.

8.2.7 Reporting and ensuring action is taken to manage any projected Underspends or Overspends in accordance with this Agreement.

8.2.8 Preparing and submitting to the Joint Commissioning Board monthly summary reports, full Quarterly reports and an annual return regarding the income and expenditure from the Pooled Funds in accordance with the Partners instructions. Such reports to include any other information as may be required by the Partners and the Joint Commissioning Board to monitor the effectiveness of the delivery of the Services and the operation of the Pooled Funds and to enable the Partners to complete their own financial accounts and returns. For the avoidance of doubt, the Partners will supply all necessary information to the Pooled Fund Manager to enable the reports to be prepared.

8.2.9 To liaise with the Commissioning Lead for each Individual Scheme to ensure that Quarterly reports are submitted to the Health and Wellbeing Board.

8.3 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall have regard to the recommendations of the Joint Commissioning Board and shall be accountable to the Partners.

8.4 The Pooled Fund(s) will be managed and operated in accordance with the Finance Protocol set out in Part 1 of Schedule 1 and in accordance with the Management Arrangements set out in Schedule 10.

8.5 The Joint Commissioning Board may agree to the viring of financial contributions between Pooled Funds and Individual Schemes (subject to presentation and approval of a business case by the Partners), in so far as it is permitted to do so and not restricted by any ring fencing or specific conditions which apply to Financial Contributions under consideration for virement. For the avoidance of doubt any proposed virements must be compliant with the virement rules of the Partner organisations.

9 NON POOLED/ALIGNED FUNDS

9.1 Any Financial Contributions agreed to be held within a Non Pooled/Aligned Fund will be notionally held in a fund established for the purpose of commissioning that Service as set out in the relevant Scheme Specification. For the avoidance of doubt, a Non Pooled/Aligned Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.

9.2 When introducing a Non Pooled/Aligned Fund in respect of an Individual Scheme, the Partners shall agree:

9.2.1 which Partner if any shall host the Non-Pooled Fund; and

9.2.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.

9.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

9.4 Both Partners shall ensure that in the event that any Services are commissioned using a Non Pooled /Aligned Fund these Non Pooled/Aligned Funds will be commissioned solely in accordance with the relevant Scheme Specification and following joint written agreement of both Partners and agreed through the Joint Commissioning Board.

9.5 Where there are Joint (Aligned) Co-Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:

9.5.1 the NHS Functions funded from a Non-Pooled Fund are carried out within the CCG Financial Contribution to the Non- Pooled Fund for the relevant Service in each Financial Year; and

9.5.2 the Health Related Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the CCG and the Council to any Pooled Fund or Non-Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out Part 1 of Schedule 1 and in the relevant Scheme Specification.

10.2 In subsequent Financial Years, the BCF Partnership Group shall commence discussions in September of each Financial Year in order to make recommendations which will be presented to the Partnership Board to enable it to agree the Financial Contributions to be made by each Partner to Individual Schemes in the following Financial Year. The Partners shall endeavour to reach agreement on such Financial Contributions via the Partnership Board by no later than 31st October in the relevant Financial Year in order to enable the Partners to include and reflect their financial commitments, budget adjustments and delivery plans for the Better Care Fund in their annual budget setting process for the following Financial Year.

10.3 The Financial Contributions from the Partners required for each Individual Scheme in each Financial Year will be assumed to be based upon the expenditure incurred by them in relation to those Individual Schemes during the previous Financial Year.

10.4 In the event that the Joint Commissioning Board is unable to agree the contributions to the Individual Schemes and the Pooled Funds in any Financial Year, the matter will be escalated to the Authorised Officers for resolution as between the Partners. If the Partners are unable to agree the Financial Contributions, the dispute resolution procedures in Clause 25 shall be applied.

10.5 The creation of the Better Care Fund Pooled Fund does not remove the statutory duties of the Council's Section 151 Officer and the CCG's Chief Financial Officer to retain accountability and responsibility for their organisation's use of financial resources, including those Financial Contributions made to the Pooled Fund. Apart from Pooled Funds where agreed, health and social care funding will be held by the relevant Partner organisation and may be managed in an aligned way between the Partners in order to facilitate joint approaches by them.

10.6 Financial Contributions will be paid as set out in each Scheme Specification.

10.7 With the exception of Clause 13, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Joint Commissioning Board minutes and recorded in the budget statement as a separate item.

10.8 Each Partner shall bear its own costs of the establishment of the Partnership Arrangements under this Agreement.

11 NON FINANCIAL CONTRIBUTIONS

11.1 Unless otherwise detailed in a Scheme Specification non-financial contributions which include, but are not necessarily limited to, staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform a Partner's obligations pursuant to this Agreement (including, but not limited to, the management of Service contracts and the hosting of a Pooled Fund) will be funded by and remain in the ownership of the contributing Partner.

12 RISK SHARE ARRANGEMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The Partners have agreed risk share arrangements as set out in Schedule 3 (Memorandum of Understanding Risk Share) which provides for financial, operational, reputational and quality risks arising in connection with the commissioning of Services from the Pooled Funds and the financial risk to the Pooled Funds arising from the payment for performance element of the Better Care Fund.

Overspends in Pooled Fund

12.2 Subject to Clause 12.4, the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Joint Commissioning Board in accordance with Clause 12.4.

12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Joint Commissioning Board, the Section 151 Officer and Chief Financial Officer, are informed as soon as reasonably possible and the provisions of Part 1 of Schedule 1 "Financial Protocol" and Schedule 3 shall apply.

Overspends in Non Pooled/Aligned Funds

12.5 Where in Joint (aligned) / Co-commissioning Arrangements either Partner forecasts an overspend in relation to a Partner's Financial Contribution to a Non-Pooled/Aligned Fund that Partner shall as soon as reasonably practicable inform the other Partner and the Joint Commissioning Board. The Lead Officers, named in Part 1 of Schedule 1 shall also have responsibility for ensuring that any such predicted Overspends are notified to the Accountable Officer of the CCG and the Section 151 Officer for the Council as soon as they are identified in order that each Partner's governing bodies are informed of the position.

12.6 Where there is a Lead Commissioning Arrangement the Lead Commissioner is responsible for the management of the Non-Pooled / Aligned Fund. If the Lead Commissioner forecasts an Overspend in relation to a Non-Pooled / Aligned Fund, they shall as soon as reasonably practicable inform the other Partner and the Joint Commissioning Board.

Underspend

12.7 In the event that expenditure from any Pooled Fund or Non Pooled/Aligned Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree, by means of proposals approved by the Joint Commissioning Board, how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners and the terms of the Performance Payment Arrangement.

13 CAPITAL EXPENDITURE

13.1 Neither Pooled Funds nor Non Pooled/Aligned Funds shall normally be applied towards any one-off

expenditure on goods and/or services, which will provide continuing benefit to a Partner and which would historically have been funded from the capital budgets of one of the Partners. If a need for additional capital expenditure is identified this must be agreed by the Partners as being a capital cost in accordance with the generally accepted accounting principles of the Partners, and be subject to the same business case justification as for revenue proposals in accordance with the governance procedures set out in this Agreement.

14 VAT

14.1 The Partners shall agree the treatment of the Pooled Fund for VAT purposes and the Host Partner shall ensure the treatment is in accordance with any relevant guidance from HM Customs and Excise.

14.2 The Partners shall agree that subject to clause 14.1:

i) In considering the VAT regime to be applied to the Pooled Fund they will seek to maximise the recovery of tax incurred; and

ii) They will jointly endeavour to minimise the complexity of VAT and other taxation.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner(s) shall arrange for the audit of the accounts of the relevant Pooled Fund(s) and shall require the Audit Commission to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998 (as amended by forthcoming legislation including the Audit and Accountability Act 2014).

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or a Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner or anyone within its control or acting on its behalf contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Joint Commissioning Board.

16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

16.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Each Partner shall:

16.4.1 ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement; and

16.4.2 where it is the commissioner of Services, use its reasonable endeavours to ensure that Service Contracts contain:

(a) appropriate insurance obligations which as a minimum require the relevant Service provider to obtain and maintain in force, for an appropriate period, policies of insurance which reflect the Service provider's risks under the Services Contract; and

(b) indemnities from the Service provider which provide appropriate protection for both the Partner commissioning the Services Contract, and the other Partner and also for Service Users.

16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

17.5 The Partners will make arrangements to ensure that all Service Users are safeguarded and their welfare is promoted. The Partners will lead and support the organisation and development of the Herefordshire Safeguarding Children Board and the Herefordshire Safeguarding Adults Board. They will ensure services commissioned have clear safeguarding policies with policies/procedures agreed by the Herefordshire Safeguarding Children Board and the Herefordshire Safeguarding Adults Board.

17.6 Partners will ensure services commissioned adhere to safeguarding policies, and procedures which will be made clear in all contracts and framework agreements. These will be monitored and action will be taken where breaches occur.

17.7 The Partners will also be able to demonstrate that they have:

17.7.1 Clear priorities for early intervention, safeguarding and promoting the welfare of children, young people and vulnerable adults in their strategic plans.

17.7.2 A clear commitment by senior managers to the importance of early intervention, safeguarding and promoting children, young peoples and vulnerable adult's welfare and the need to work across organisations to be effective in safeguarding the public.

17.7.3 That the responsibilities to safeguarding and promoting the welfare of children, young people and adults are integral to each member of staff's work and are integrated into corporate plans.

17.7.4 A culture of listening to and engaging dialogue with children, young peoples and vulnerable adults seeking their views in ways appropriate to their age and competency and taking account of these in individual decisions and the establishment or development and improvement of services

17.7.5 Clear plans (whether corporate or for individual Service Users) which demonstrate that personalised care is central to all clinical or social interventions

17.7.6 Clear lines of accountability and governance across the organisation for the provision of services which take account of early intervention, safeguarding and promoting children, young peoples and vulnerable adult's welfare

17.7.7 Arrangements to work effectively across organisations including clear policies and protocols regarding sharing information to enable staff to safeguarding and promoting the welfare of children, young people and vulnerable adults

17.7.8 Clear policies to safeguard and promote the welfare of children, young people and vulnerable adults including effective complaints policies, whistle blowing policies and procedures for dealing with allegations against a member of staff or volunteers which members of staff/volunteers are made aware of.

17.7.9 There are clear care pathways and care plans for times of transitions for children/young people and adults who receive treatment both within and outside Herefordshire.

17.7.10 Arrangements to ensure all staff receive the appropriate training (and refresher training) to equip them to carry out their responsibilities with regard to safeguarding effectively.

17.7.11 That there is an effective complaints process in place and available to all staff and Service Users.

17.7.12 There is a process for recording incidents, concerns and referrals in relation to children, young people and vulnerable adults and the actions that result from these

18 CONFLICTS OF INTEREST

18.1 The Partners shall comply with the agreed policies for their respective organisations for identifying and managing conflicts of interest as set out in Schedule 7 through the Joint Commissioning Board. Any such conflicts of interest identified will be recorded and referenced in any decision report, and registered within the Partner organisations in accordance with each Partner's governance regulations.

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the Partners is vested in the Health and Wellbeing Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

19.2 Governance and oversight in relation to the subject matter of this Agreement will be undertaken by the Joint Commissioning Board which is based on a joint working group structure. Each member of the Joint Commissioning Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Joint Commissioning Board to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.

19.3 This Agreement requires Partners to comply with best practice principles in relation to, including but not limited to, decision making, information access, data protection, accountability, transparency and openness.

19.4 The terms of reference of the Joint Commissioning Board shall be as set out in Schedule 6.

19.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability

and probity required by each Partner's own statutory duties and organisation are complied with.

19.6 The Joint Commissioning Board following consultation with the Health and Wellbeing Board (where required) shall be responsible for the overall approval of the Individual Schemes, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund and approval of new Individual Schemes.

19.7 Each Scheme Specification shall confirm the governance arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to the Joint Commissioning Board and Health and Wellbeing Board.

20 REVIEW

20.1 Where the Joint Commissioning Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund and Non Pooled/Aligned Fund and the provision of the Services within three (3) Months of the end of each Financial Year.

20.2 Subject to any variations to this process required by the Joint Commissioning Board, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

20.3 The Partners shall within 20 Working Days of the Annual Review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Joint Commissioning Board.

20.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

21.1 Partners agree that they shall apply their own complaints procedures to the matters which are the subject of this Agreement, however they agree that they shall assist one another where required in the management of such complaints including those arising from the provision of the Services.

21.2 Complaints will be handled as follows:

21.2.1 where a complaint wholly relates to one or more of the Council's Health Related Functions it shall be dealt with in accordance with the statutory complaints procedure of the Council;

21.2.2 where a complaint wholly relates to one or more of the CCG's NHS Functions, it shall be dealt with in accordance with the statutory complaints procedure of the CCG;

21.2.3 in the event that one Partner receives a complaint about a Service provided by the other Partner through an Individual Scheme included within this Agreement it will raise this with the other Partner for resolution through the other Partner's complaints procedure until such time as a joint complaints system has been put in place.

21.2.4 where a complaint relates partly to one or more of the Council's Health Related Functions and partly to one or more of the CCG's NHS Functions then a joint response will be made to the complaint by the Council and the CCG, in line with local joint protocol to be jointly developed by the Partners during the first year of this Agreement; and

21.2.5 where a complaint cannot be handled in any way described above or relates to the operation of the arrangements made pursuant to this Agreement or the content of this Agreement, and then the Joint Commissioning Board will set up a complaints subgroup to examine the complaint and recommend remedies to the Partners.

21.2.6 complaints received by the Partners in connection with this Agreement and the Services shall be reported to the Joint Commissioning Board.

21.3 The Partners shall each, and shall use their reasonable endeavours to ensure any Provider shall, fully

comply with any investigation undertaken by any properly appointed Ombudsman ("the Ombudsman"), including providing access to Information and making staff available for interview.

22 HEALTHWATCH

22.1 The Partners shall co-operate with each other to enable each Partner to comply with its duties under Part 14 of the Local Government and Public Involvement in Health Act 2007 as amended ("2007 Act"). Such co-operation shall include, but shall not be limited to the following:

i. allowing Healthwatch organisations to view and observe the carrying-on of activities on premises within the relevant Partners' control from which the Services are provided;

ii. assisting one another with responding to requests for information made by Healthwatch organisations and making requested information available;

iii. promoting and facilitating the involvement of Service Users, carers and members of the public in decision-making concerning the Partnership Arrangements as may be required by Healthwatch organisations; and .

iv. ensuring that contracts for Services require the relevant Service Provider to co-operate with Health Watch organisations as required.

23 SCRUTINY

23.1 The Partners shall co-operate fully with the Health and Social Care Overview and Scrutiny Committee and shall comply with any reasonable requests for information and reports which are requested by the Committee in fulfilment of their role.

23.2 The Partners acknowledge that the Partnership Arrangements and Services shall be monitored and reviewed by the Health and Wellbeing Board, as well as any properly authorised regulator.

23.3 The Partners will make senior officers available to attend each other's committees and boards with responsibility for the development of policy and the scrutiny of commissioning decisions taken in relation to the Services.

23.4 The Partners will also supply monitoring information for consideration by such committees and boards, and will also comply with any other reasonable request for information from those committees and boards.

23.5 The Partners shall maintain and comply with their own separate whistleblowing policies in regard to this Agreement.

24 TERMINATION & DEFAULT

24.1 This Agreement may be terminated by any Partner giving not less than six 6 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes

24.2 Each individual scheme may be terminated in accordance with the terms set out in the relevant scheme specification provided that the Partners ensure that the Better Care Fund requirements continue to be met..

24.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partner may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partner may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be dealt with in accordance with Clause 25.

24.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses 16.1.

24.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their reasonable endeavors to minimise disruption to the health and social care which is provided to the Service Users.

24.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:

24.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

24.6.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

24.6.3 the Lead Commissioner shall make reasonable endeavors to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment;

24.6.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

24.6.5 the Joint Commissioning Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

24.6.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

24.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 24.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

25 DISPUTE RESOLUTION

25.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

25.2 The Authorised Officers of both Partners shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 25.1, at a meeting convened for the purpose of resolving the dispute.

25.3 If the dispute remains after the meeting detailed in Clause 25.2 has taken place, the Partners' respective Chief Executives /Chief Accountable Officers or their nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

25.4 If the dispute remains after the meeting detailed in Clause 25.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation,

either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

25.5 Nothing in the procedure set out in this Clause 25 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

26 FORCE MAJEURE

26.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

26.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

26.3 As soon as practicable, following notification as detailed in Clause 26.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 26.4, facilitate the continued performance of the Agreement.

26.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

27 CONFIDENTIALITY

27.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 27, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

27.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

27.1.2 the provisions of this Clause 27 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

27.2 Nothing in this Clause 27 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

27.3 Each Partner:

27.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

27.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 2

27.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 27;

27.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

28 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

28.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

28.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 27 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

29 OMBUDSMEN

29.1 The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

30 INFORMATION SHARING (DATA PROTECTION ACT)

30.1 The Partners will follow the Information Governance Protocol set out in schedule 8, and in so doing will ensure that the operation of this Agreement complies with Law, in particular the 1998 Act.

31 NOTICES

31.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 31.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

31.1.1 personally delivered, at the time of delivery;

31.1.2 sent by facsimile, at the time of transmission;

31.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

31.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

31.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

31.3 The address for service of notices as referred to in Clause 31.1 shall be as follows unless otherwise notified to the other Partner in writing:

31.3.1 if to the Council, addressed to the Director for Adults and Wellbeing

Tel: 01432 260339

Email: martin.samuels@herefordshire.gov.uk

and

31.3.2 if to the CCG, addressed to The Chief Accountable Officer;

Tel: 01432 383308

Email: simon.hairsnape@herefordshireccg.nhs.uk

32 VARIATION

32.1 No variations to this Agreement will be valid unless they have been agreed in accordance with the governance process of each Partners' constitution and are then recorded in writing and signed for and on behalf of each of the Partners. A variation template is set out in Schedule 9, and having followed any required governance process of each Partner's Constitution.

33 CHANGE IN LAW

33.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

33.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavors to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

33.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 25 (Dispute Resolution) shall apply.

34 WAIVER

34.1 No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

35 SEVERANCE

35.1 If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

36 ASSIGNMENT AND SUB CONTRACTING

36.1 The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

37 EXCLUSION OF PARTNERSHIP AND AGENCY

37.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

37.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

37.2.1 act as an agent of the other;

37.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

37.2.3 bind the other in any way.

38 THIRD PARTY RIGHTS

38.1 Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

39 ENTIRE AGREEMENT

39.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

39.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

40 COUNTERPARTS

40.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

41 GOVERNING LAW AND JURISDICTION

41.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

41.2 Subject to Clause 25 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

42 PUBLICITY

42.1 The Partners shall consult one another before making any press announcements concerning the Services or the discharge of either Partner's functions under this Agreement.

43 FAIR DEALINGS

43.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that if in the course of the performance of this Agreement, unfairness to either of them does or may result then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

44 INTERNAL APPROVALS

44.1 This Agreement will be ratified on behalf of the CCG by the CCG's Governing Body and on behalf of the Council by Cabinet in accordance with the constitution, standing orders and schemes of delegation in the Partner organisations.

45 RISK AND BENEFIT SHARE ARRANGEMENTS

45.1 The risk share arrangements are detailed in the memorandum of understanding / risk share agreement (Schedule 4)

46 REGULATORY REQUIREMENTS

46.1 In the event that there are regulatory requirements in relation to any Individual Scheme these will be noted within the Scheme Specification.

47 INFORMATION SHARING AND COMMUNICATION

47.1 The information sharing protocol is documented under Schedule 9.

48 DURATION AND EXIT STRATEGY

48.1 The duration and exit strategy in relation to any Individual Scheme will be noted within the Scheme Specification

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE CORPORATE SEAL of **THE COUNTY OF HEREFORDSHIRE DISTRICT COUNCIL** was here unto affixed in the presence of:)
)

PRINT NAME:
JOB TITLE:
DATE:

Signed for on behalf of **HEREFORDSHIRE CLINICAL COMMISSIONING GROUP**

PRINT NAME:
JOB TITLE:
DATE:

SCHEDULES

MEMORANDUM OF UNDERSTANDING

BETTER CARE FUND

RISK SHARE AGREEMENT 2016/17

1. AGREEMENT

Between Herefordshire Clinical Commissioning Group and Herefordshire Council, this agreement is dated 31/08/2016.

Signed on behalf of Herefordshire Clinical Commissioning Group

.....

NAME: ...Simon Hairsnape

POSITION: Chief Accountable Officer

DATE:.....1/9/16.....

Signed on behalf of Herefordshire Council

.....Martin Samuels.....

NAME : Martin Samuels

POSITION: Director Adults and Wellbeing

DATE:.....31 AUG 2016.....

BCF Risk Share Arrangements in Herefordshire 2016/17

Agreed Principles

Overarching Principles

1. **Targeted Actions and Behaviour Change**
    - Any risk/reward share arrangements must be supported by a targeted programme of actions that change behaviour and improve the effectiveness and efficiency in deployment of resources.
2. **Measureable and Evidence Based**
    - Changes in behaviour and agreed actions must be measurable and evidence based.
3. **Baseline Metrics and Regular Reviews**
    - Baseline metrics to measure impact must be jointly agreed beforehand and regularly reviewed and where necessary updated throughout the period of the agreement.
4. **Limit to Financial Risk / Ownership of Financial Costs**
    - No risk / reward share can have an open ended financial risk / reward to either partner.
    - The risk share agreement is intended to support joint working on specified areas to improve care and reduce overall system costs. It will do this by sharing the impact (both positive and negative) of in-year changes in how care is provided and commissioned. It is not intended for the risk share arrangement for 2016/17 to create a long term subsidisation by either partner in statutory funding responsibilities.
    - For the longer term, financial costs should be borne by the partner who has the statutory responsibility for those costs. That is to say health costs and impacts on the system should be borne by the CCG and social care costs and impacts on the system should be borne by the council.
    - For specific clients with both health and social care needs, where a joint approach is agreed, the appropriate ratio and lead commissioner arrangements will be jointly agreed and documented.
    - Any increase in cost to the other partner as a result of changed behaviour relating to pool 2 , this means outside of normal day to day processes*[1] (these processes will be defined) will be managed through application of the risk sharing agreement. The partners have agreed that it is their intention to identify any likely groups of patients to which the latter arrangement would apply and agree a framework to ensure that the specific patients can be clearly identified (e.g. noting through the assessment process when the deterioration in condition actually occurred).

- When agreeing the financial implications of a risk share scheme both financial costs and potential financial benefits/rewards should be considered.

[1] day to day processes are defined as undertaking 3 month reviews for new clients, and annual reviews for all clients.

5. Joint Agreement

- The partners recognise and support the requirement that plans for spending the resources in the BCF should be jointly agreed by the H&WB Board and signed off by the Local Authority and the CCG governance systems. The BCF risk share agreement will also be signed off by the Local Authority and CCG governance systems.

6. Regular and Effective Monitoring

- Both partners will ensure that clear and regular monitoring is in place to ensure that the BCF partnership is able to demonstrate how the joint fund is supporting the delivery of care in Herefordshire within the agreed strategic objectives.
- Each partner will identify a lead review officer to report on progress and performance each month.
- Progress will be monitored by BCPG, with regular jointly produced financial updates provided by the partners.
- Issues / success / lack of progress will be reported by BCPG to JCB for escalation and action to resolve where necessary.

Financial Risk Share Arrangements for 2016/17

Pool 1 (Minimum Fund)

Agreement

It has been agreed by the partners that there will be no financial risk share arrangement in relation to pool 1.

Herefordshire council have agreed to fund the therapeutic and medical inputs for the redesigned RAAC scheme to the values agreed in the scheme for 2016/17 only.

The partners will agree how the RAAC scheme will be redesigned and the effective start date of the new scheme by 30th September date.

Measurement and Monitoring

The partners will monitor the delivery of the scheme through performance metrics which will be jointly agreed by the partners.

Monthly update reports will be provided to the BCPG, for consolidation into the JCB monitoring report

Pool 2 (Additional Fund)

1. Definition of the Risk Share Cohort (Risk Share 1) –"catch up cohort"

The partners have agreed that the risk share agreement will be restricted to a defined and agreed cohort of clients. This client cohort will be defined as follows:

1. Includes those clients who are not funded at the usual price*[2] and who have not been reviewed in the twelve month period since 1st April 2015
2. The list of clients identified in 1 above will be jointly assessed by the council and CCG to agree which clients are likely to result in a behaviour change*[3] due to the length of time since the last review or for other reasons relating to a change in the approach being taken by the commissioner.
3. The defined client list excludes any clients identified by the CCG as being part of separate arrangements with 2g for risk share. (The client list for 2g as provided by Jade Brooks and matched to the BCF client list).
4. The defined list will exclude non-reviewed clients who, the partners jointly agree, are unlikely to have incurred a substantive change in health and care needs in the intervening period. These clients will be classified as business as usual and excluded from the specific risk share arrangement.
5. The eligible clients list, as defined above, will include the totality of eligible clients, this is a total of 27 clients and is within appendix one of this document.
6. The expectation will be that the clients will be reviewed within the next six months and the monitoring of the reviews will be through the Better Care Fund Partnership Group, with further reporting to the Joint Commissioning Board.

*[2] *in this context the usual price is defined as any local authority client funded at either the old, or new usual price for older peoples residential and nursing care (£570, £523, (old / new nursing rates),£468, £457*

(old/new residential & dementia rates) per week), and clients who receive FNC/FCO only support from the CCG

**[3] in this context the term behaviour change means that the partners agree that due to the length of time since the last review a stepped change in level of needs is likely to be identified upon review which may result in a change of statutory partner responsibility for the individual client*

2. Financial Risk Share Arrangement

a. Value of the Risk Share Pool

The current annual cost of the defined client cohort is £1,384.7k. Costs within the risk share pool are split as follows:

Table 1

	No Clients	Annual Cost	Cost Ratio
Herefordshire Council	22	1,036.6	75%
Herefordshire CCG	5	348.4	25%
Total	**27**	**1,384.7**	**100%**

b. Calculation of the Value of the Cap

The cap will be set at an agreed percentage of the pool value. If partners subsequently agree a change in the value of the risk share pool the cash value of the cap will be varied in line with the agreed percentage.

Table 2

Cap %	Cap Value £'000
10%	135k*[1]
12%	166k*[2]
13%	**180k*[4]**
14%	200k*[3]

*[1] council position
*[2] MS proposal to SH
*[3] CCG counter proposal
*[4] Agreed percentage

The cap has been jointly agreed at 13% of the pool value.

The total cost of any clients that transfer responsibility will be split **75:25** up to a maximum of £180,000 for each partner in 2016/17 (as specified in table 1 above) based on the agreed client cohort. Any costs over and above £180,000 for each partner will be met by the partner to whom statutory responsibility transfers.

The risk or benefit of clients whose package change but whose statutory responsibility does not change will not be factored into the risk sharing arrangement.

Packages of care which move from sole partner to joint funded will be excluded from the risk share arrangement, unless there is an agreed change of statutory responsibility.

The financial risk will be applied to the overall net cost or gain from those clients who change statutory responsibility. (See worked example 4 below)

3. Savings Targets

It is recognised that both partners have in year savings targets of £500k each. These savings are deliverable across the totality of both the in county placements included in pool 2 and out of county placements.

All savings achieved by the partners will be retained by the beneficiary partner, in so far as they are not associated with the specific clients subject to the risk share arrangements.

4. Measurement and Monitoring of Risk Share

The baseline will be the agreed cohort at the uplifted 2016/17 budget value by client.

For the agreed cohort, regular (monthly) reports to the Better Care Partnership Group (BCPG) will

- Identify the number of clients reviewed in the month, and cumulative year to date.
- Summarise the number of packages which have switched statutory responsible partner as a result of the review
- Include a summary of the number of packages which have increased / decreased / had no change in value
- Summarise the in year financial impact and full year equivalent cost impact.
- Include a cumulative summary of the risk share impact for both partners.

The BCPG will on a monthly basis provide a summary update to JCB on the risk share arrangement.

BCPG will receive and review on a monthly basis reports on the performance on the totality of pool 2 in addition to the specific risk share arrangements.

5. Joint Agreement

This agreement is only valid if this memorandum of understanding is signed by both partners.

6. Review of the scope and success of the agreement

The partners will formally review the agreement at 3 monthly intervals (September will be the first review point) and consider whether the scope of the agreement should be extended to include additional specific cohorts of individuals.

Additions to the scope of the agreement will only be considered where there is a clearly worked up proposal, including full identification of the resources required to deliver the proposal, and where the proposal has been developed jointly.

The partners will formally review the Risk Sharing agreement in January 2017.

The risk share will require formal re-ratification by both partners if to continue on the same basis in 2017/18.

7. Risk Share 2 – In Year Changes in Commissioning Behaviour - Potential Arrangement

The partners have agreed in section 6 above to regular formal reviews to determine whether any in year changes in commissioning behaviour beyond the "catch up cohort" covered by the risk share arrangement, for example a substantive change in review processes or frequency, are likely to give rise to substantive financial risks / benefits between the partners.

In the event a substantive risk being identified by either partner, the partners will work together to provide an informed estimate of the financial scope, and derive and equitable approach to managing the risk for the remainder of the financial year.

Worked Examples

1. HC transfer £100k of client costs to CCG, and no clients transfer from the CCG to council,
    a. HC would pay 75k to CCG under risk share cap (£100k cost transfer x75% being council contribution to pool), net benefit to LA **£25k**
    b. Net cost to CCG **£25k**
2. HC transfer £240k of client costs to CCG, no clients transfer from CCG, agreed cap at £180k.
    a. Cost £240k x75% = 180k, cap limit is reached.
    b. Net saving to council £240k less £180k **£60k**
    a. Net cost to CCG £240k less risk share contribution £180k at max cap value of £180k **=£60k**
3. HC transfer value £400k and no clients transfer from the CCG to council (and cap £180k)
    a. Cost x75% = £300k, above cap threshold therefore cap applies.
    b. Net Saving to council £400k less cap £180k = **£220k**
    c. Net cost to CCG £400k less risk share contribution at max cap value of £180k **=£220k**
4. HC transfer value £400k to CCG, CCG transfer value to council £100k (and cap £180k)
    a. Net Transfer cost £400-£100k = £300k
    b. Net Cost benefit to council £300k before cap. £300k x75% = £225k, above cap therefore cap paid in full to CCG
    c. Net Saving to council £300k less cap £180k = **£120k**
    d. Net cost to CCG £300k less risk share contribution at max cap value of £180k **=£120k**

SCHEDULE 1

PART 1 – FINANCIAL CONTRIBUTIONS

Establishment of Pooled Funds and Financial Protocol

Details of the provisional Pooled Funds to be established and the Financial Contributions to be made during the first Financial Year of the term of the Agreement are set out below:

Financial Year 2016/2017

This agreement includes three funds, one for the minimum Better Care Fund (BCF), as prescribed by NHS England, the second for the additional BCF pooled fund created by the partners, and the third fund relates to children's services for which pooled fund arrangements were in existence prior to the creation of the BCF

Pool 1 has two components

The funding for the protection of social care (Council is Lead Commissioner), and Care Act implementation

The community health and social care redesign (CCG is Lead Commissioner)

Pool 2 – is a Pooled Fund to fund expenditure on residential placements including continuing health care placements (CHC) and funded (free) nursing care (FNC). At the Commencement Date, the Services are commissioned by the Partners separately..

Pool 3 – covers children with complex needs, safeguarding boards and short breaks for children with disabilities

Agreement of Financial Contributions

The agreement commences on 1 October 2016 and continues for a period of 18 months. The financial contributions have been agreed (draft figures) for the part Financial Year 2016/17, full year equivalent figures are also shown for comparative purposes as summarised in the table below.

Scheme name	Financial contribution (full year equivalent 2016/17)				2016/17 in S75 1/10/16 to 31/3/17			
	Council £'000	CCG (PASC) £'000	CCG £'000	Total spend £'000	Council £'000	CCG (PASC) £'000	CCG £'000	Total spend £'000
Reablement		420		**420**	-	210	-	210
Falls prevention service			123	**123**	-	-	62	62
Virtual wards / hospital at home			768	**768**	-	-	384	384
Risk stratification			768	**768**	-	-	384	384
Carers support		460	50	**510**	-	230	25	255
DTOC support		23	32	**55**	-	12	16	28
Integrated community care			3,806	**3,806**	-	-	1,903	1,903
Rapid response		550		**550**	-	275	-	275
Rapid access to assessment and care		494	240	**734**	-	247	120	367
Community equipment store / Home improvement		272		**272**	-	136	-	136
Kington court (intermediate care provision)		366	534	**900**	-	183	267	450
Children's short breaks *1			427	**427**	-	-	214	214
Care Act implementation *2		460		**460**	-	230	-	230
Support for social care staff		832		**832**	-	416	-	416
Demand management		793		**793**	-	397	-	397
LD health (2g)		331		**331**	-	166	-	166
Sub Total Minimum Revenue Fund	**-**	**5,001**	**6,748**	**11,749**	**-**	**2,501**	**3,374**	**5,875**
Care home market management	19,468		9,272	**28,740**	9,734	-	4,636	14,370
Sub Total BCF Revenue Pools	**19,468**	**5,001**	**16,020**	**40,489**	**9,734**	**2,501**	**8,010**	**20,245**
Disabled Facilities Grant (Capital)	1,558			**1,558**	779	-	-	779
Total Better Care Fund	**21,026**	**5,001**	**16,020**	**42,047**	**10,513**	**2,501**	**8,010**	**21,024**
Children's commissioning unit (new from 1/10/16)	40		40	**80**	20	-	20	40
Children's short breaks *1	453			**453**	227	-	-	227
Children's complex needs solutions	2,995		499	**3,494**	1,498	-	250	1,747
Safeguarding boards *2	**138**		80	**218**	69	-	40	109
Sub Total Pool 3 Childrens Services	**3,626**	**-**	**619**	**4,245**	**1,813**	**-**	**310**	**2,123**
Annual cost for schemes	**24,652**	**5,001**	**16,639**	**46,292**	**12,326**	**2,501**	**8,320**	**23,146**

PASC = Protection of Adult Social Care Funding

*1 Funding for Adults Safeguarding board £103k within Care Act as new burden for councils

*2 Part of Childrens short breaks and respite funding (Ledbury Road within BCF minimum fund

PART 2 FINANCIAL GOVERNANCE

FINANCIAL GOVERNANCE ARRANGEMENTS

The following financial governance arrangements have been agreed by the Partners in respect of the Pooled Funds and shall be reviewed and updated by them as required prior to the commencement of each Financial Year during the term of this Agreement.

HOSTING OF THE POOLED FUNDS

The Council will act as Host Partner for the pooled funds and shall have overarching responsibility for financial reporting and financial governance in respect of those Pooled Funds.

Changes to levels of Financial Contributions / budgets

Financial Contributions to Pooled Funds in Financial Years subsequent to Financial Year 2016/2017 will be determined by the Partners in accordance with the Agreement.

Payment of Financial Contributions

At the beginning of each month the Council will present an invoice to the CCG for one twelfth of the Financial Contribution due from the CCG to Pooled Fund in respect of pool 1a (Individual Scheme 1 (Protection of Social Care and the Care Act), plus one twelfth of the contribution in respect of children's respite services (Ledbury Road)

At the beginning of each quarter the council will present an invoice to the CCG for one quarter of the financial contribution due to the Pooled Fund in respect of children with complex needs.

A single annual invoice will be raised by the Council and presented to the CCG in respect of the contributions to the Carer's Hub and the Children's Safeguarding board

In order to ensure that the CCG complies with national requirements in respect of the carry forward of Financial Year end cash balances, any payments due to the CCG in respect of expenditure from the Pooled Fund during the last month of the Financial Year (March) will be reviewed by the Partners and agreed to be rescheduled for payment to the CCG where indicated by evidence of projected cash balances.

All invoices delivered pursuant to this Agreement are to be settled within 5 working days of being issued. In the event that an invoice is disputed and remains unresolved after 60 days of it being disputed, the matter shall be raised for resolution at the next Quarterly finance review undertaken by the Partners.

The Partners agree that they shall review and revise the invoicing and payment arrangements set out in this Agreement in line with any guidance issued by NHS England from time to time.

Eligibility Criteria

Individual Scheme Specifications contain the eligibility criteria for Service Users that relate to each Individual Scheme.

Where Service Users may be charged for Services, financial assessments will be undertaken by the Council's welfare and financial assessments team to ensure that income is collected where appropriate and in accordance with local/national charging policies and guidance.

Access to the Pooled Funds

The Financial Contributions to minimum fund – Pooled Fund 1a (Protection of Social Care) will be accessible by the Council as Lead Commissioner.

Financial Contributions to minimum fund - Pooled Fund 1b (Community Health & Social Care Services Redesign) will be accessible by the CCG as Lead Commissioner.

Access to Pooled Fund 2's Financial Contributions will depend on the Commissioning Arrangements implemented by the Partners but expenditure shall in any event be limited by Service User eligibility for the Services.

Access to the pool for Children with Complex Needs will be through the joint panel process.

The Joint Commissioning Board shall be entitled to direct how Financial Contributions to Pooled Funds should be spent, operating in accordance with its terms of reference.

Pooled Fund Manager - BCF

It has been jointly agreed that a Commissioning and Pooled Fund Manager who is an employee of the Council will be appointed by the Council from the Commencement Date, to oversee Pooled Funds 1 and 2 and the delivery of Individual Schemes funded from those Pooled Funds pursuant to this Agreement. The scope and extent of the authority of the Pooled Fund Manager will be determined by the Joint Commissioning Board and shall otherwise be as is set out in this Agreement.

AUDIT ARRANGEMENTS

Audit requirements

The Host Partner has responsibility for the audit of the relevant Pooled Fund.

Appointment of Internal Auditor

The internal auditor for Pooled Funds 1a, 2 and 3 will be the Council auditor South West Partnership. The internal auditor for Pooled Fund 1b is Baker Tilly

Liaison / Management of Auditors

Will be undertaken by the Council Business Partner and the management accountant for Adults and Wellbeing

External Audit

The audit regime of the organisation who is acting as Host Partner will apply to the relevant Pooled Fund.

The Council's and CCG's external auditors are Grant Thornton.

External audit fees which are incurred specifically to meet national audit requirements for the Better Care Fund, insofar as they are specifically identifiable, will be borne in equal proportion by the Council and CCG.

FINANCIAL MANAGEMENT

Financial Systems

For Individual Schemes funded from the Financial Contributions made to Pooled Fund 1, Lead Commissioning Arrangements will be utilised as set out above.

For Pooled Fund 2 any changes to the long term systems and commissioning arrangements will be jointly confirmed following the completion of a mobilisation project. Current arrangements will continue in the interim period, whereby the Council records transactions for residential care within the Council system and the CCG records the transactions for Funded Nursing Care and Continuing Health Care with the CCG financial system.

Monitoring Arrangements

Monitoring of financial performance of the Pooled Funds will be through the Better Care Partnership Group and Joint Commissioning Board as outlined in Clause 19, and Schedule 5 of this Agreement.

Monitoring Reports

Monitoring reports will be produced by the Host Partner in the format specified in Schedule 5.

The CCG will be required to submit timely reports on expenditure and Individual Scheme performance under the management of the CCG to the Council where the Council is acting as Host Partner in order to enable the Council to prepare full reports for the Joint Commissioning Board.

Reports will be prepared monthly for review by the BCF Partnership Group and for summary review by the Joint Commissioning Board, or where variation in performance requires, more frequently.

Annual Accounts

The respective Partners will report the expenditure incurred by them in connection with this Agreement in their annual accounts in accordance with all applicable Laws and relevant guidance.

Managing Overspends

No Individual Scheme is expected to Overspend in terms of the Financial Contributions made to it but in the event that an Overspend is predicted to arise the commissioning Partner should take whatever mitigating action is practicable to minimise the impact of such Overspend on the Financial Contributions to the BCF

Overspends in relation to pool 2 shall be managed in accordance with Part 2 of Schedule 3

The risk share agreement at Schedule 4 specifies that for Financial Contributions to Pooled Fund 1a the Council and for Financial Contributions made to Pooled Fund 1b, the CCG, respectively will carry the risk in the event that Overspends arise.

Overspends in relation to the Children with Complex Needs pool will be borne by the partners in ratio to budget contributions

Delegated Authority

The terms of the schemes of delegation of each Partner under which the members of the Joint Commissioning Board and Lead Officers receive delegated authority from the Partners are as recorded in Clause 46.6.4 for the Council and Clause 46.6.5 for the CCG.

The Council constitution and financial procedures do not permit its Partnership Board representatives or the Pooled Fund Manager to Overspend on its behalf without authorisation. The Joint Commissioning Board has a monitoring and oversight role to ensure compliance but shall be required to obtain prior authorisation from the Council to approve any Overspends.

The Council Scheme of Delegation delegates to the Director of Adults and Wellbeing authority for:

(a) Joint working with the CCG and other commissioners;

(b) Specific/joint service re-design and improvement

The CCG scheme of delegation delegates to the Governing Body through the Accountable Officer authority for:

(a) Joint working with the Council and other commissioners;

(b) Specific/joint service re-design and improvement

Budget Virements – In Year

For Pooled Fund 1, the Host Partner will, following receipt of consent from the Joint Commissioning Board, be permitted to vire funds within the Financial Contributions made to the sub pools 1a and 1b so that Underspends in one sub pool of the Pooled Fund can be utilised to mitigate overspends elsewhere within the Pooled Fund.

Budget virements between Pooled Funds and Individual Schemes will be subject to presentation of a business case and approval by the Joint Commissioning Board. The impact of agreed virements will be reported through the agreed monitoring arrangements.

Treatment of Budget Underspends – Year End

It is recognised that underspends may arise for a variety of reasons including:

- lower than predicted demand for Services

- greater effectiveness than planned for savings schemes within the Services
- Service redesign efficiencies

In the event that any or all of the Pooled Funds are expected to deliver an underspend which has not been allocated to support other Individual Schemes the following options will be considered by the Joint Commissioning Board and the approach agreed prior to Financial Year end closedown procedures being completed:

(a) Underspends in Pooled Funds 1a / 1b may be retained by Host Partner, or

(b) Underspends in Pooled Funds 1a /1b may be shared between Partners in a ratio to be agreed at the relevant time, or

(c) Underspends which are unspent Financial Contributions may be carried forward to fund the delivery of Individual Schemes in future Financial Years.

Creation of Reserves

In the event that a carry forward of underspends is agreed by the Joint Commissioning Board, all Financial Contributions will need to be remitted to the Council before the Financial Year end to enable the relevant reserve to be created.

The creation of reserves will require the agreement of both Partners and shall be subject to approval through the relevant organisation's governance processes. The creation of reserves may be either for a specific purpose (business case required) or for a general/ contingency reserve.

Reserves created pursuant to this Agreement, will be held and managed by the Council as both Host Partner and the only Partner with the necessary financial governance mandate to do so.

Subject to paragraph 46.9.5, the release/use of reserves will require a business case and the agreement of the Joint Commissioning Board.

Reserves agreed to be created for specific purposes will not require additional Joint Commissioning Board approval for release, provided the reserve is authorised for release within 12 months of it having been created. Specific reserves to be retained for more than 12 months will require review and re-validation by the Joint Commissioning Board as part of Financial Year end sign off procedures.

Treatment of Inflation

In so far as any of the Pooled Fund expenditure relates to staff costs it will be the responsibility of the employing organisation to make provision for pay inflation.

For Pooled Fund 1, the determination and application of non pay inflation will remain with the relevant Host Partner.

Pool 2 includes expenditure commitments from both Partners with the same Service providers. The Council will assess the requirement to award an inflation uplift and present the recommendation for joint agreement by both Partners. In the event that an inflation award is agreed it will be funded by both Partners in relation to budget contributions to Pooled Fund 2.

Reserve/Contingency Fund

Financial Contributions for Financial Year 1 (2016/17) of this Agreement do not make provision for the formation of a reserve/contingency fund.

As part of the development of enhanced risk sharing arrangements in Financial Year 2 of the term of this Agreement and beyond, consideration will be given by the Partners to the creation of a reserve/contingency fund within the Pooled Funds.

In the event that a general contingency reserve is created as outlined in paragraph 46.9 of this Schedule, this reserve may be utilised to provide non-recurrent funding to Individual Schemes with the approval of the Joint Commissioning Board.

Year End Accounting Principles

Accounts for the Pooled Funds will be produced under accruals accounting methodology

The Partners will confirm year end reporting timetables and requirements to the Pooled Fund Manager in a timely manner to ensure all necessary information can be exchanged to meet accounting deadlines.

Capital Investment

In so far as there are any assets which are utilised by the Partners to support the delivery of the BCF, the Partners do not intend to pool those existing capital assets. Each Partner will retain ownership of its existing assets.

Assets created from the capital elements of the BCF, namely the Disabled Facilities Grant and Social Care capital will be recorded as assets in the balance sheet of the Council. This is a continuation of current practice.

Use of the Social Care (community capacity) grant requires submission and approval of a business case within the Council.

In the event that future developments BCF require a capital investment a business case will be required for consideration for funding from the social care capital fund.

Management Costs and Overheads

The Partners have jointly agreed that management costs and overheads will not be charged to the Pooled Fund but carried by the relevant Host Partner.

The Partners will discuss appropriate and sufficient arrangements to support delivery of their shared objectives pursuant to this Agreement. This may include joint funding of pooled/joint posts including a Pooled Fund Manager, and/or the creation of a joint team. The BCF Partnership Group will develop any proposals for this which shall be subject to approval by the Joint Commissioning Board

VAT

The Council's VAT regime will apply for Individual Schemes funded from Pooled Fund 1a, Pooled Fund 2, and pooled fund 3. The CCG's VAT regime will apply for the Individual Schemes funded from Pooled Fund 1b.

GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

Section 75 agreement – appendix 4 – schedule 1

The governance arrangements for the Partnership, including the terms of reference for the Joint Commissioning Board are included in Schedule 6 of this Agreement.

ASSURANCE AND MONITORING

Details of assurance and monitoring arrangements including performance measures are included within Scheme Specifications.

SCHEDULE 2

NON FINANCIAL RESOURCES

49.1.1 Council contribution

	Details	Charging arrangements	Comments
Premises		To be provided free of charge to BCF by each Partner	
Assets and equipment			
Contracts			
Central support services			

49.1.2 CCG Contribution

	Details	Charging arrangements	Comments
Premises		To be provided free of charge to BCF by each Partner	
Assets and equipment			
Contracts			
Central support services			

50 STAFF

50.1 The Council and the CCG will provide staff to work on the Individual Schemes and in connection with the management of the Pooled Funds as required.

50.2 All staff will remain as employees of their current Partner organisation. As working arrangements develop through, staff roles will be aligned as they are required to work jointly on Individual Schemes and in terms of ensuring monitoring and reporting on future developments. This may include secondment arrangements for a small number of staff.

50.3 Consideration will be given as agreed by both partners to any required transfer of staff between Partner organisations. This will include consideration of TUPE, pension arrangements and pay awards.

50.4 Council staff to be made available to the arrangements

50.4.1 The roles listed below are the lead professionals who will be made available to assist with delivery of the BCF Plan but this will form part of their existing roles. Additional members of the wider teams will be engaged as service delivery and developments require.

Roles
Assistant Directors AWB and CWB
Business Partner
Finance Manager AWB
Commissioning Lead - BCF
Performance Manager
Commissioning Officers

50.5 CCG staff to be made available to the arrangements

50.5.1 The roles listed below are the lead professionals who will be made available to assist with delivery of the BCF Plan but this will form part of their existing roles. Additional members of the wider teams will be engaged as service delivery and developments require.

Roles
Operations Director
Chief Financial Officer
Finance Planning Manager
Head of Commercial Development
Management Accountant
Performance
Programme Managers

Herefordshire Better Care Fund Plan

2016-17

Submission Four

27 June 2016

TABLE OF CONTENTS

1. INTRODUCTION

The Better Care Fund (BCF) programme aims to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. A key principle of the BCF is to use a pooled budget approach in order for health and social care to work more closely together. The need for integrated care to improve people's experience of health and social care, the outcomes achieved and the efficient use of resources has never been greater.

Within Herefordshire a Redesign Management Group has been established to lead and implement a transformational change across all services and to develop a 'One Herefordshire' alliance. The One Herefordshire Plan has been developed through an alliance of all the Herefordshire health partners[1] and the council working in partnership to address the fundamental issues facing the county. It provides the fundamental context and approach that underpins this BCF plan.

Within the overall One Herefordshire approach, the BCF plays a key enabling role in delivering our system wide vision by creating a substantial pooled budget between the council and CCG for the delivery of community based services, residential and nursing provisions and the protection of adult social care that are strongly focused on shared aspirations. This will provide a robust platform for developing more integrated approaches to service delivery and integrated commissioning and governance.

The Herefordshire BCF plan 2016/17 demonstrates the progress made on the 2015/16 intentions, details key milestones for 2016/17 and describes the future vision for the county. This plan is a key component of, and wholly consistent with, the system wide transformation of Herefordshire's health and social care economy. In addition the BCF also supports the delivery of the Sustainability and Transformation Plan (STP) common objective: *Collaboration and joint working on a scale not achieved before to deliver transformational change that closes the triple aim gap and supports a financially sustainable health and social care economy.*

[1] The partners are: Herefordshire Council, Herefordshire CCG, Wye Valley NHS Trust, 2gether NHS Foundation Trust and Taurus Healthcare

2. LOCAL VISION FOR HEALTH AND SOCIAL CARE SERVICES

"The vision for the local health and care system in Herefordshire is one where strong communities encourage individual citizens to live healthy lives and offer support when this is required for them to maintain their independence, with sustainable, aligned health and care services for local people".

One Herefordshire, January 2016 (B.1.i)

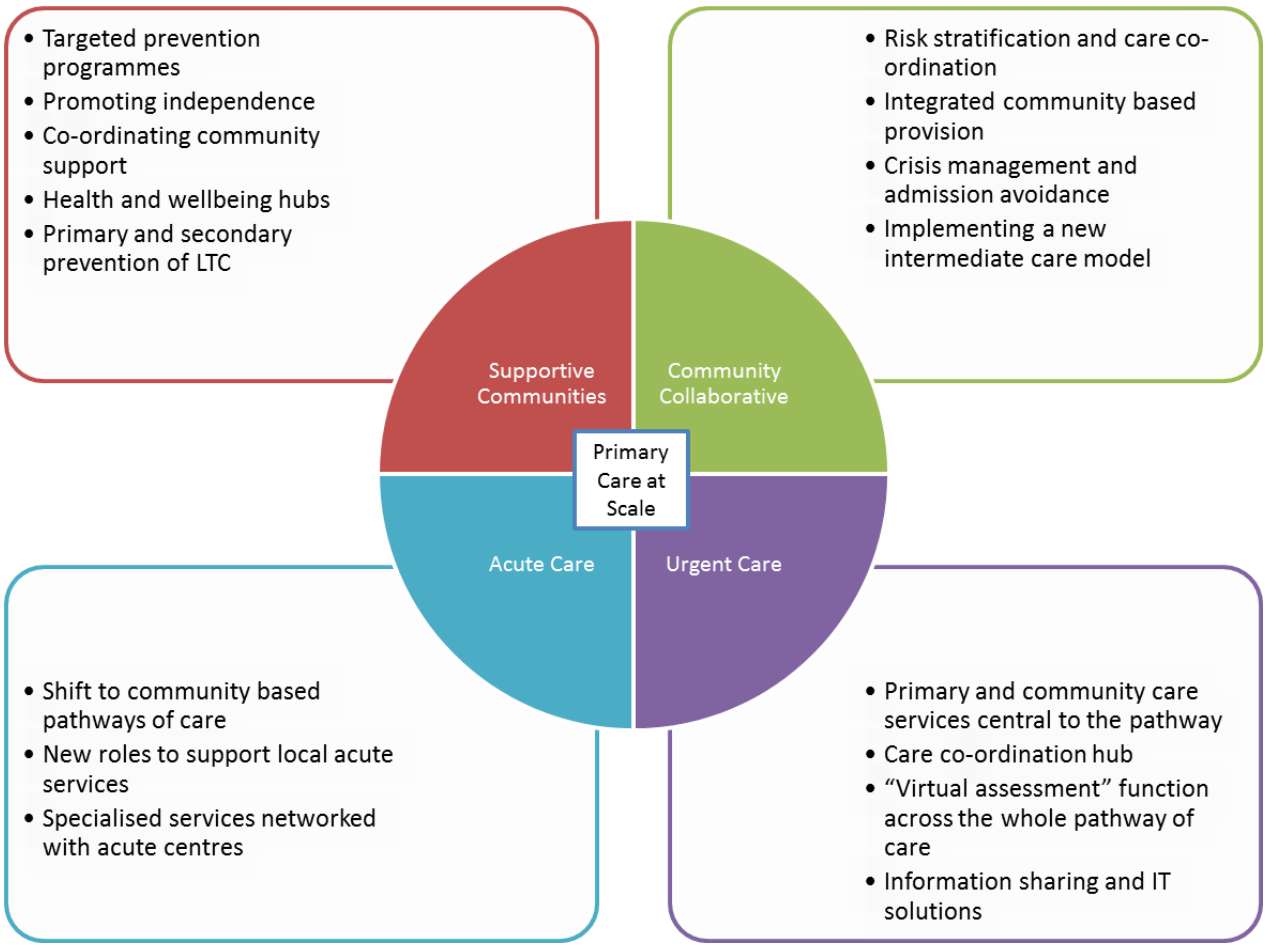
Our shared intent is to redesign services in order to deliver person-centred care, working together to support people to improve their wellbeing, maintain their independence and live longer in good health. By working in partnership across organisational boundaries we will increase support for self-care, maximise the provision of care in community settings, and reduce demand for specialist care in acute hospital settings or in residential and nursing homes.

This plan is based on securing a change in the relationship between the citizen and public services, such that individuals and their communities take on the prime responsibility for maintaining their own wellbeing and independence. The intention is to enable the public to avoid the crises that would otherwise push them into reliance on statutory care services. Under this new approach, the statutory sector will play a vital role as a catalyst for the development and maintenance of the necessary community capacity, supporting a lead taken by our vibrant local voluntary sector partners. Our services will be designed through a philosophy of supporting self-care, cohesive delivery in the community wherever practical, and reduced reliance on specialist care, whether provided in hospital or in residential and nursing homes.

Recent analysis of current spending shows that 48% of budgeted spending is on acute services, with a further 13% on residential, nursing and continuing care. Herefordshire's new model of care will deliver a significant shift in this position, as:

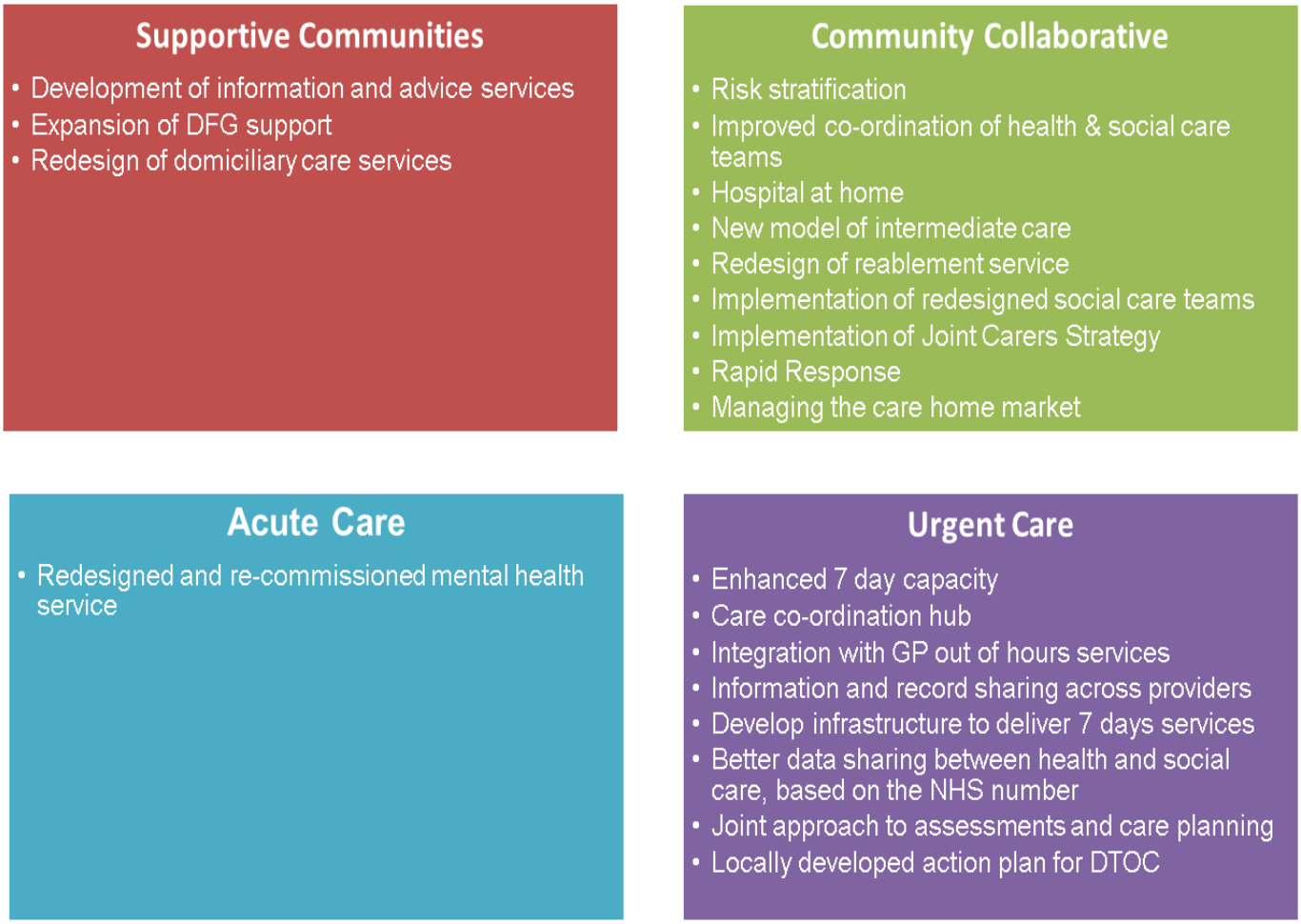
- Investment in preventative services and self-care will have a medium to long-term benefit in avoiding the need for acute and institutional care services – albeit we are prudent on the scale of financial benefits that can be realised within the five-year timeframe of the STP
- Investment in primary care at scale and community services will have a short- and medium-term impact in redirecting work from acute settings and providing financial benefits.

The diagram below sets out the key deliverable workstreams of the One Herefordshire transformation programme and lists some of the key features of the projects that they are delivering. The BCF plan is a key enabler supporting many areas of that programme.



The arrangement not only includes the commissioners and main providers of care but also closer collaborative working with other key agencies that have an impact on the wider determinants of health and wellbeing within the county. This approach is fully consistent with the Government's vision for full health and social care integration by 2020.

In line with both with the NHS England 'Five Year Forward View' and the existing One Herefordshire programme, we expect to test new models of care delivery, drawing on concepts such as community development and empowerment, integrated primary, community, mental health and acute provision, clinically networked services, and technology-driven delivery solutions. The BCF plan underpins this wider One Herefordshire plan in a number of ways and clearly links into the work-streams of the transformation programme as shown below ***(B.1.ii)***:



The vision for future service delivery in Herefordshire embraces national thinking on new models of care, and embodies a number of themes, including a commitment to:

- Empower communities to behave differently and reduce demand for services
- Support enhanced provision of primary, community care and mental health care at scale
- Utilise technological innovations to deliver improved care
- Deliver preventative and tailored care to support people keeping well, at home
- Develop proposals for primary care at scale that underpin the delivery of the above
- Support local delivery of acute hospital services
- Consolidate clinical networks across care settings to ensure optimum sharing of expertise to deliver high quality, safe and cost effective services

The Future Vision

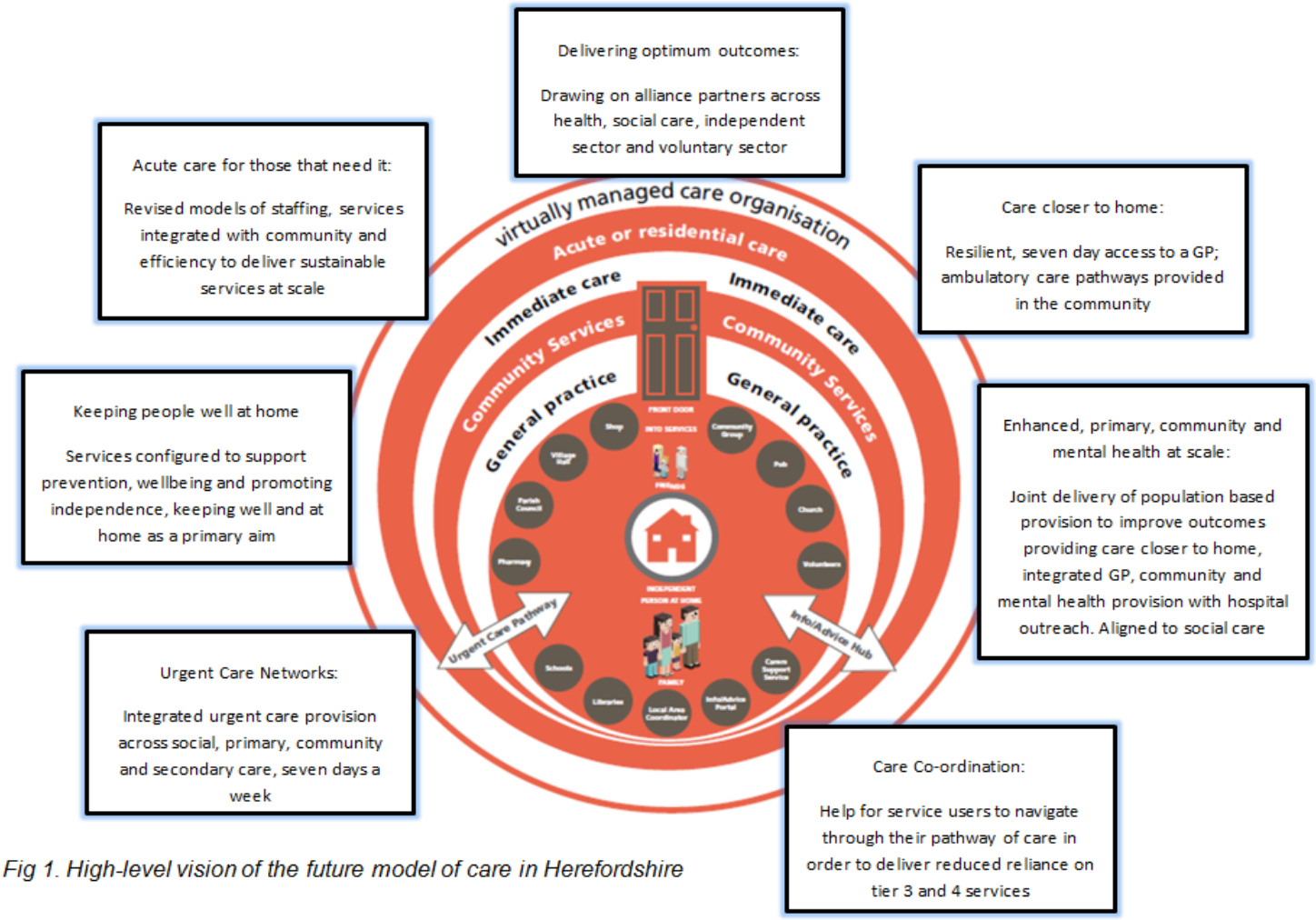


Fig 1. High-level vision of the future model of care in Herefordshire

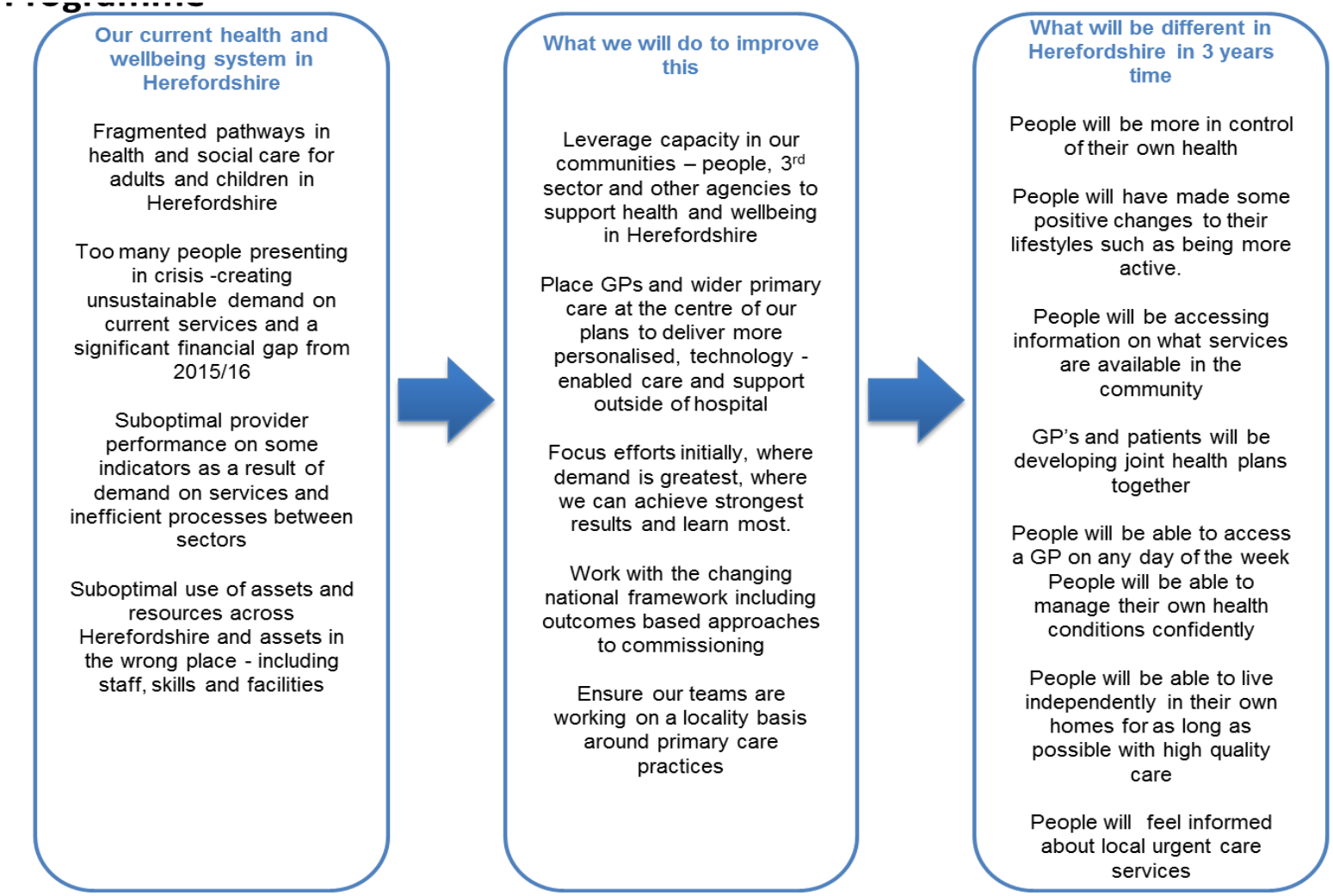
At a strategic level the BCF intends to support the One Herefordshire alliance in achieving the following **aims *(B.2.iii)***:

- to improve the health and wellbeing of everyone in Herefordshire by enabling people to take greater control over their own health and the health of their families and helping people to remain independent within their own homes and communities
- to reduce inequalities in health (both physical and mental) across and within communities in Herefordshire, resulting in additional years of life for citizens with treatable mental and physical health conditions
- to improve the quality and safety of health and care services, thereby improving their positive contribution to improved wellbeing and enhancing the experience of service users
- to achieve greater efficiency, making better use of resources
- to take out avoidable cost thereby reducing financial pressures and ensuring a better alignment between funding and cost

- to ensure that we have sufficient workforce is that is appropriately trained to provide the services our population require in the future.

3. EVIDENCE BASE FOR CHANGE

The vision for Herefordshire is illustrated below. This provides a **clear comparison between current state and planned state post-plan delivery and is described in terms of changes to patient and service user experience and outcomes *(B.1.iii)***:



Further details in relation to the changes and developments to be delivered through the BCF plan 2016/17 are contained within the Integrated Action Plan (section 4) and within section 3.2 – The Challenges in Herefordshire.

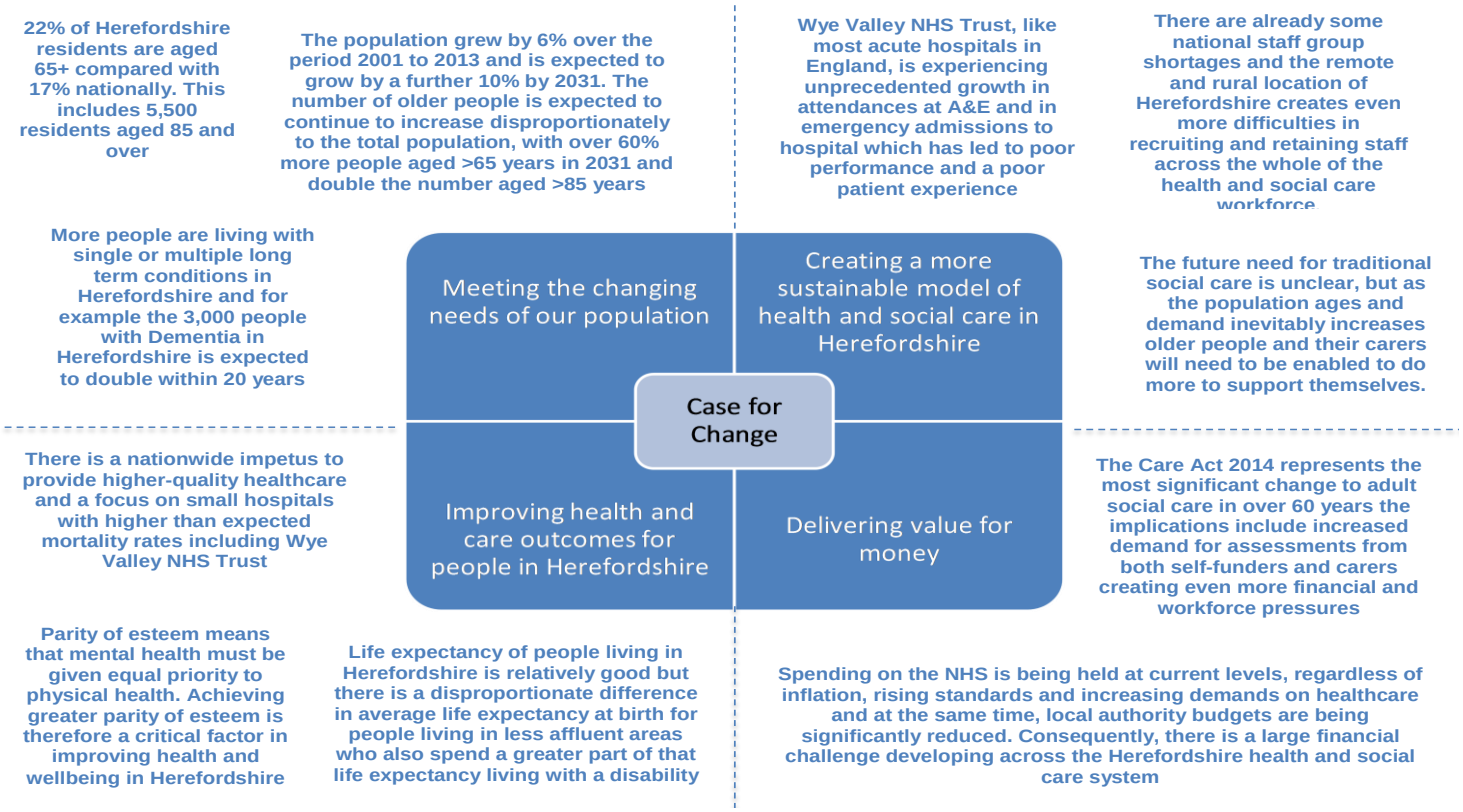
3.1 SUPPORTING THE CASE FOR CHANGE

There are a number of local challenges in Herefordshire that we must address if we are to ensure sustainable services:

- **Our population is small and its rural nature means that it is widely dispersed** – the population in 2013 was 186,100 and has grown by six percent since 2001 through migration only. Almost all of Herefordshire's land area falls in the 25% most deprived in England in relation to geographical barriers to services. Transport is severely limited, with limited railway and road networks. There are few public transport routes that are commercially viable, which further restricts mobility. Access to health services in rural areas is limited with 21% of rural households having to travel 2.5 miles or more to visit their GP or other health services.
- **Herefordshire has a much older population than nationally and this will grow** - 23% of Herefordshire residents are aged 65+ compared with 17% nationally. This includes 5,500 residents aged 85 and over. The number of older people is expected to continue to increase disproportionately to the total population, with over 60% more people aged 65+ in 2031 and double the number aged 85 and over.
- **People living longer will experience more health and wellbeing issues** - more people are living with single or multiple long term conditions in Herefordshire, for example, the number of people with Dementia in the county is expected to double within 20 years, from 3,000 to 6,000. Linked to this, Wye Valley NHS Trust, like most acute hospitals in England, has experienced significant growth in attendances at A&E and in emergency admissions to hospital and this has had an impact on performance and patient experience.
- **All of our provider and commissioner organisations are facing challenges to their finances, service delivery and sustainability** - this was dramatically highlighted in the recent report produced by Ernst and Young (partly funded by NHS England). This showed that even with significant changes in behaviour, and unprecedented efficiency savings, our local economy would still be facing a gap of £30m-£38m by the end of the decade.

- **Our services lack the scale and efficiency to meet the needs of the future** - As one of the smallest Trusts in England; WVT faces significant diseconomies of scale when providing a range of general hospital services for such a small population. The diseconomies of scale cannot solely be resolved by reducing the range of services through providing them at another hospital, as the distances are such that a range of services have to be available within the county, not least to serve the population of Powys. In contrast, some services that are provided at scale, such as mental health, are more resilient as a result.
- **National issues with recruitment and retention are felt more acutely in Herefordshire** - there are already some national staff group shortages and the remote and rural location of Herefordshire creates even more difficulties in recruiting and retaining staff across the whole of the health and social care workforce.
- **We have significant infrastructure challenges** - many of our buildings are outdated and our services have outgrown them. At the same time, changes in the model of delivery mean we have a number of sites that could be rationalised without impacting the quality of care. However improvements in the physical infrastructure would need to be made. There is a need to review the health and social care estate to assess the possibility of greater efficiencies. Our IT infrastructure is also limited but there are many opportunities; the secondary care services have extremely low digital maturity and are largely paper-based but our primary care services are extremely well integrated across one system.

The illustration below details Herefordshire's case for change:



Data driven explanation of issues that the BCF plan is addressing (B.2.i)

In developing this BCF plan, insights from the Herefordshire Joint Strategic Needs Assessment (JSNA) have been used to understand the current and future population trends as well as the real and predicted changes in use of unplanned care and those being supported through primary care and social care services. The following **data supports the case for change and illustrates a clear and quantified understanding of the precise issues that the BCF will be used to address in Herefordshire (B.2.i),** ***(B.2.iv)***.

Herefordshire's population grew by 6% over the period 2001 to 2013, largely as a result of inward migration and is expected to grow to approximately 205,300 by 2031. However the number of older people is expected to continue to increase disproportionately to the total population, with over 60% more people aged >65 years in 2031 and double the number aged >85 years. Although the life expectancy of people living in Herefordshire is relatively good, there is a disproportionate difference in health outcomes for people in less affluent areas who generally have a shorter average life expectancy at birth, (6.2 years for males and 5.9 years for females) and spend a greater part of that life expectancy with a disability compared with residents in less deprived areas.

Primary care

Whilst overall primary care is of a high quality there is some variation in performance and in Herefordshire in 2011-13, across the GP-registered population, there were 567 premature deaths amounting to 12,695 potential 'years of life lost' from conditions that are usually treatable.

Similarly, over the past 5 years, the number of unplanned hospital admissions in Herefordshire from chronic conditions that should normally be managed in a primary or community care setting (often referred to as 'ambulatory care sensitive conditions') has been increasing.

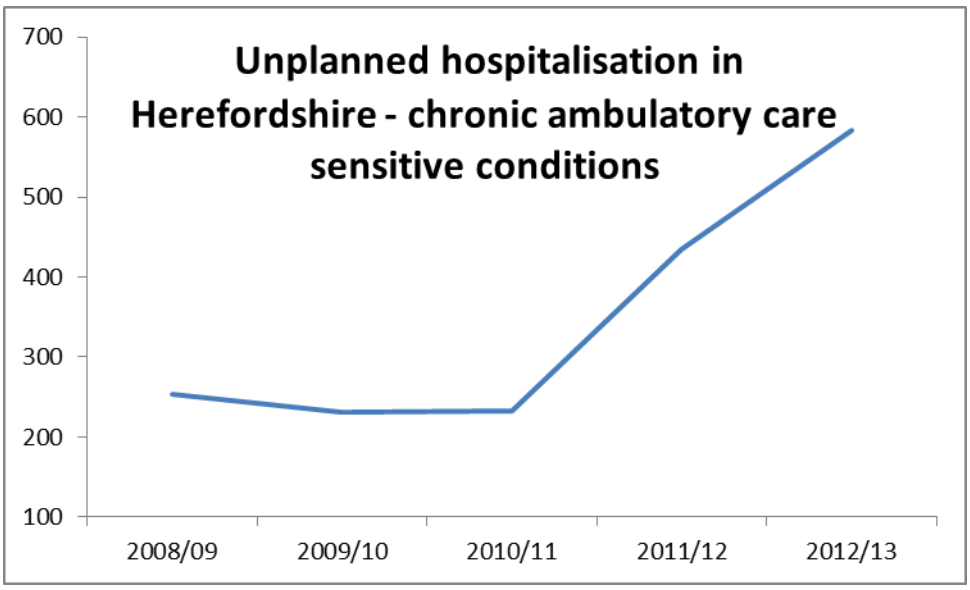


Figure: Unplanned hospitalisation for chronic ambulatory care –sensitive conditions (Indirectly age/sex standardised rate per 100,000 population) Source: The Health and Social Care Information Centre (http://www.hscic.gov.uk/)

Community-based services

Community-based services involve a range of service types and providers, including social care, district nursing, health visiting and community mental health care. Providers have reported that services have struggled in recent years to cope with an increase in workload and referrals**,** and the trend is set to continue due to the increase in our elderly population.

This extra burden has adversely affected their ability to respond as swiftly and effectively as we would like, and to be more effective, they need to be better integrated with primary care and with hospital – based specialised care in Herefordshire. In the 2011/12 National GP Survey, 55% of respondents in Herefordshire said that they had a long standing health condition and although 70% of people said that they felt they had sufficient support from relevant services and organisations to manage their

condition, more often than not this care and support is not well joined-up and may result in duplication of effort without improvement in the outcomes of care.

Adult Social Care

Adult social care and support in Herefordshire is provided by Herefordshire Council working with private care homes, home care agencies and other organisations to deliver services on its behalf. In 2013-14 the local authority funded adult social care for 4,200 people aged 18 and over. Seventy two per cent received this care mainly because of a physical disability, frailty or sensory impairment. Nearly three quarters of adult social care clients are aged 65 and over. Social care providers have struggled in recent years because of severe downward pressure on fee rates due to cuts in social care budgets and because they are finding it increasingly difficult to compete with other employers in attracting workers into a career in social care.

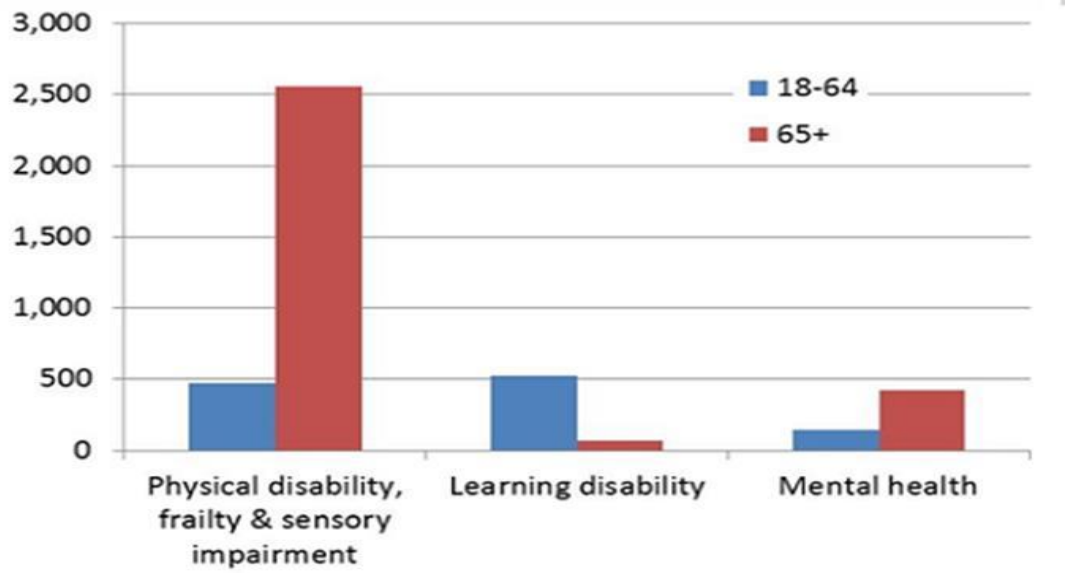


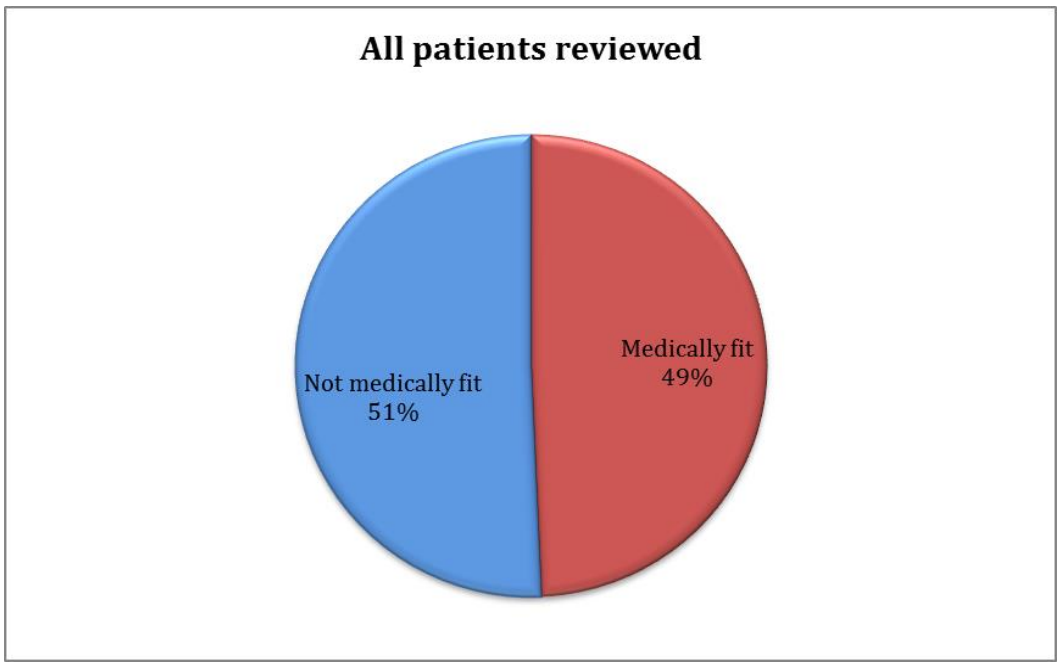
Figure: Adult social care clients (persons) in Herefordshire 2013/14

Source Understanding Herefordshire 2014, Herefordshire County Council

Herefordshire supports a smaller proportion of older people in social care than the national average, due in part to residents being on average healthier and more able to self-fund than elsewhere. The future need for social care is unclear, but as the population ages and demand inevitably increases (for example, an estimated 3.000 people with dementia could almost double in 20 years) older people and their carers will need to be enabled to do more to support themselves.

In addition to the data taken from the JSNA, a recent Length of Stay review, conducted during January 2016, has provided a clear evidence base for the development of Herefordshire's DTOC plan. This review was carried out using a tried and tested methodology developed by the Emergency Care Intensive Support Team ECIST which has been used in many acute and community hospitals across England. Four multi-disciplinary teams were formed and visited a number of community hospitals and wards, where a total of 144 patients were reviewed.

Of the 144 patients reviewed 49% (71) were found to be medically fit for discharge from their current bed but waiting for some form of onward care, intervention or equipment. The average LOS of those found to be medically fit is 23 days and on the day of the review the 71 patients had occupied 1669 bed days.



Data analysis of the review concludes the following:

- There are a high proportion of patients across the hospital wards reviewed who are medically fit for discharge but waiting for intervention.
- The majority of patients are waiting for some form of external assessment/input to allow them to move on.
- Patients are deteriorating whilst waiting for discharge and alternating between being fit and unfit.
- Length of stay for patients who are medically fit is high at 23 days.

Section 75 agreement – appendix 5

3.2 THE CHALLENGES IN HEREFORDSHIRE

The table below summarises the key challenges facing Herefordshire (source One Herefordshire Plan) and identifies the activities of the BCF plan which will support their resolution. This clearly identifies **the precise aspects of the change that the local area is intending to deliver using the BCF *(B.1.iv).*** This table details the changes which will be delivered through the BCF plan, within consideration to impact and provides clear links to its contribution to the delivery of the One Herefordshire Plan ***(B.1.iii)(B2.i)***

The Problem	What we will do to address this	BCF Contribution / Alignment to One Herefordshire Plan
Lack of capacity across statutory services against a backdrop of increasing demand	Leverage capacity in the community, including the public, third sector and other agencies to promote independence	Development of community links model (April 16) to develop local solutions and support.
Abundance of voluntary assets, poorly co-ordinated and poorly understood	Co-ordinated voluntary support, linked to health and wellbeing hubs and care co-ordination service	Development of information and advice services, community and web based (Feb 16), Further enhancements / developments of web system in 2016/17
Disparate community services, little co-ordination	Community and mental health locality teams, integrated with primary care and social care Development and implementation of joint service specification for community health, mental health and social care services	Social care teams redesigned, locality and complex teams to promote closer working with community health and mental health Single model agreed through One Herefordshire programme.

The Problem	What we will do to address this	BCF Contribution / Alignment to One Herefordshire Plan
Fragmented urgent care pathways in health and social care	Development and implementation of joint service models and specifications. Care co-ordination centre acts as a hub, allowing healthcare professionals to navigate care pathways Review of RAAC (Rapid Access to Assessment and Care) provision to align with community services redesign. Increased focus on Delayed Transfers of Care from community settings to support improved pathways for individuals to the most effective setting to meet their needs.	Joint Service Specification for community health, mental health and social care services agreed as part of One Herefordshire Community Collaborative project. Implemented in health contracts from 1st April 2016.
Too many people presenting in crisis creating unsustainable demand	Focus on prevention, case finding and proactive case management of high risk clients – optimal management of long term conditions, frailty and the implementation of an agreed urgent care strategy	Expansion of DFG Redesign housing support Intermediate care redesign to support step up provision Role out of Risk Stratification and “Virtual Ward” model across the county.
Bed occupancy of acute and some community hospital beds routinely 98%	Reduce to best practice occupancy levels of 92% through reducing demand and increasing capacity	Redesign domiciliary care model (2016-2017), rapid response service. Step up / step down beds

The Problem	What we will do to address this	BCF Contribution / Alignment to One Herefordshire Plan
	ECIP review commissioned in early 2016 and demonstrates that around 50% of current occupancy of acute and community beds assessed as “medically fit”. Alternative models of provision, assessment and transfer required to support improved flow.	Intermediate care redesign Providing an option for self-funders Joint Service Specification for community health, mental health and social care services
Lack of information sharing between providers means that service users receive inefficient sub-optimal care	Protocols for sharing information agreed and IT systems linked	Social care system upgrade, potential for web based data sharing? IM&T Programme Board in place and working collectively on Digital Roadmap, linking in with STP, to support long term improvement across all systems.
Services commissioned in silos and not aligned	Community commissioning would be aligned between HCCG and HC, and through the STP, wider opportunities are being explored for commissioning to be aligned at a strategic level, where this is appropriate and able to deliver demonstrable benefits, with Worcestershire and other neighbouring areas.	BCF key enabler to support the development of integrated commissioning. Joint Service Specification for community health, mental health and social care services.

Workforce Challenges

In Herefordshire we have specific challenges around recruitment and retention of staff and the system change we are planning to implement will need to take account of these. Any system change requires the full engagement and support from the workforce and effective service delivery across a system will only be possible when the clinicians and practitioners are fully engaged in the process.

Herefordshire's model proposes system change that moves from the acute to the community, to a team working approach across disciplines based around the GP practice to one that promotes self-help and enables people to manager their own conditions through peer support groups.

To achieve this will require significant cultural, relational and behavioural change; not just changes in organisational structures or processes but in the ways in which staff work alongside patients and residents. We have already started to identify some merging good practice and a genuine willingness to change. We propose to progress this by identifying our current workforce capacity, **assessing future capacity and workforce requirements across the system** and creating some early implementer change projects ***(C.1.iv)***.

Risk Stratification

Identifying those most at risk within our communities and supporting them to self-care and reduce their reliance on care services is key. As detailed within the BCF plan 2015/16, within Herefordshire 5.5% of adult population is deemed to be at risk of sudden deterioration and hospital admission. This figure was derived from work by the former PCT in collaboration with the BUPA risk stratification tool. Herefordshire CCG is currently working through IG compliance issues and is implementing the Aristotle risk stratification tool across the county. Currently each GP practice determines a patient's risk of hospital admission via clinical search of the primary care patient data base. Currently each GP practice in Herefordshire has identified 2% of their patients who are most vulnerable to sudden deterioration and hospital admission and are ensuring personalised care plans are developed with a named accountable GP for each patient. Within the adult patient population of Hereford City the risk stratification (virtual ward) pilot supported the most vulnerable 3% of the practice population with development of a jointly produced personalised care plan. The intention with implementation of the HiHub risk stratification tool is to increase identification over the coming months. The roll out of risk stratification across Herefordshire, supported by the extension of the Virtual Ward and Hospital at Home programme is well advanced and the project aims to achieve significant reductions in

emergency admissions and improvements in the safety and quality of care for some of the most vulnerable individuals being managed in community settings. ***(B.2.ii)***

The risk stratification tool is in place within Herefordshire and is used to inform monthly multi-disciplinary meetings, where a range of organisations are present including GPs, mental health, adult social care, occupational therapy, physio therapy, ambulance service and integrated care practioners. However, due to the often limited implementation of the tool and its sparse data set, it is often supplemented by patient information provided by professionals at a locality level. In order to encourage GP participation in risk stratification case management, Herefordshire CCG are currently implementing a local incentive scheme with each GP practice in the county. Practices are to be incentivised for identifying, through the use of an approved computerised risk stratification tool nominated by the CCG, patients who will benefit from proactive case management. Once the consistency and quality of the information collated by the risk stratification tool is improved Herefordshire will then by in a stronger position to use this data more effectively to improve quality and reduce costs based upon a segmented risk stratification approach **(B.2.ii).**The following high level timescales apply to the implementation of risk stratification in Herefordshire:

Action	Deadline
GP Local Incentive Scheme agreed with Practices	April 2016
Display of patient facing advice and posters including individual patient opt out opportunities	April-July 2016
Data sharing agreements with Practices	April – May 2016
Full testing of the GP extract in first GP Practice	May 2016
Risk Strat tool with Secondary Care data accessible in all GP Practices	June 2016
Monthly GP MDT meetings inc use of risk stratification to case find patients – incremental approach	May –October 2016
Additional 5 GP Practices agreement to GP data extraction	June-July 2016
Remaining GP Practices agreement to GP data extraction	July – September 2016
Monitoring report of risk stratification usage to inform case finding	end Q3 2016

4. INTEGRATED ACTION PLAN

The following section details the strategic objectives of the principal schemes in the BCF plan, provides an update on the changes delivered during 2015/16, and gives a high level perspective on the additional developments planned for 2016/17 and longer term aims for delivery by 2020. ***(B.1.iii)***

SCHEME: MINIMUM PROTECTION OF ADULT SOCIAL CARE	
Strategic objective of the scheme	To maintain the existing levels of NHS (section 256) investment in social care in order to enable the local authority to support services which meet the wider strategic objectives of the BCF.
Planned Change 2015/16	Investment in a community based model of care across a range of services which addresses one or more of the following key criteria: • Prevention • Managing demand • Early intervention / Rapid Response • Intermediate care • Managing long term conditions
Change Delivered 2015/16	The Protection of social care funding was invested in the following areas: • Urgent care and rapid response • Community equipment • Reablement • Intermediate care • Carers, including reprocured carer's services • Mental/LD health • Demand management Key outcomes achieved: ✓ The reprocurement of carer's services ✓ The implementation of an information advice and guidance service (to divert demand). ✓ Improvements in community equipment service delivering savings for both council and CCG ✓ Implementation of rapid access to discharge bed provider framework ✓ Realignment of the care management teams with additional focus on hospital discharge and the advice and referral team
Planned Developments 2016/17	This funding will enable the ongoing delivery of services. The investment will support the delivery of the strategic aims and objectives outlined within this plan.

SCHEME: MINIMUM PROTECTION OF ADULT SOCIAL CARE	
	Specific developments within these service areas for 2016/17 include: • Implementation of redesigned social care teams into locality / complex care teams • Review and redesign of reablement services to align with the wider development of community health, mental health and social care services. • Redesign of the RAAC provision to enable a community based support service offering both "step up" and "step down" provision • Implementation of the Joint Carers Strategy • Reduced delays in transfer of care from community settings to the most appropriate setting to support individual needs
Further Developments to 2020	• Further development of aligned working arrangements • Implementation of an outcomes focused home care provision • Further development of preventative services

SCHEME: CARE ACT IMPLEMENTATION	
Strategic objective of the scheme	To ensure that all duties under The Care Act 2014 are met.
Planned Change 2015/16	For the BCF to be utilised to meet the requirements of the new duties, including: • Setting national eligibility criteria • Implementing statutory safeguarding adults boards • New duties for self-funders • Duties for self-funders • Provision of advocacy • Provision of information and advice
Change Delivered 2015/16	• New information and advice website launched • City centre IAS service open • Pop up hubs will be implemented across the county
Planned Developments 2016/17	• Enhance content of IAS • Re-procure advocacy service • Initial local area development of community links model
Further Developments to 2020	• Rollout community links model countywide • Develop / expand preventative / self help services • Preparation for delivery of phase 2 of Care Act – details TBC

SCHEME: COMMUNITY HEALTH AND SOCIAL CARE SERVICES REDESIGN	
Strategic objective of the scheme	To deliver the right Community Health and Social Care services in the most appropriate way by reviewing the current menu and method or models of provision and implementing the changes required to achieve the transformation aims and objectives.
Planned Change 2015/16	• Improved patient care, safety and experience • Improved Urgent Care • System benefit • Improved systems efficiency, cost effectiveness • Improved outcomes A short description of the existing initiatives and service areas within this scheme is set out in the appendices.
Change Delivered 2015/16	• Roll out of Virtual Ward and Hospital at Home provision across the county • Implementation of a highly effective falls rapid response service • Review of the short break provision for children and families • Re-procured the carers information and advice centre • Rapid response service was enhanced to provide additional support for community and hospital discharge
Planned Developments 2016/17	• Full implementation of the joint service model for community health, mental health and social care services • County wide roll out of the Virtual Ward and risk stratification model, identifying and supporting more individuals in community settings. • Reduction in delayed transfer of care from community settings through an increased focus and development of risk sharing arrangements across health and social care to support and incentivise improvement • Continuation of the short break provision for children and families • Rapid response service will continue at an enhanced level • Intermediate care strategy to be implemented with a focus on step up/step down provisions • Commencement of engagement on redesign of the community hospital

SCHEME: CARE ACT IMPLEMENTATION	
	and intermediate bedded provision
Further Developments to 2020	• Review of all carer services • Full implementation of intermediate care provision • Step change from community hospital and intermediate care bedded provision and focus on community provision • Improved pathways and alignment across acute, community, mental health and social care provision reducing complexity and improving efficiency and effectiveness of care

SCHEME: DISABLED FACILITIES GRANT	
Strategic objective of the scheme	The purpose of the disabled facilities grant is the delivery of essential structural changes to enable people to remain in their own homes and avoid the need for admission to residential care
Planned Change 2015/16	• Using the CSR assumptions approximately 10% of adaptations result in avoiding the need for admission to a care home. • The average cost of an adaptation in Herefordshire is £4.8k. The grant for 2015/16 is £0.866m which enables circa 180 adaptations per annum, resulting in a possible 18 avoided care home admissions
Change Delivered 2015/16	✓ Currently forecasting to spend full grant allocation in line with plans
Planned Developments 2016/17	Grant increases to £1.558m enabling an additional 144 adaptations to be undertaken, circa 325 in total, subject to OT capacity. This gives the potential to avoid circa 32 admissions based on CSR assumptions. • Establish a working group to review the DFG scheme • Continue to work with Housing colleagues to ensure a joined up approach to improving outcomes across health, social care and housing.
Further Developments to 2020	Extrapolating DFG funding forward to 2020 would result in circa 400 adaptions per annum, 40 care home admissions avoided.

SCHEME: SOCIAL CARE CAPITAL	
Strategic objective of the scheme	To enhance community capacity, support system changes required to meet the information technology changes required arising from the Care Act and BCF national condition relating to the NHS identifier
Planned Change 2015/16	• Complete systems updates for use of NHS identifier • Complete system upgrades for Care Act compliance • Upgrade social care system for enhanced capabilities / better integrated working
Change Delivered 2015/16	✓ NHS identifier embedded in social care systems – used for additional pool reporting ✓ Upgrades complete ✓ Mosaic upgrade phase 1 go live April 16
Planned Developments 2016/17	No funding for social care capital after 1 April 2016. Scheme ceases to exist
Further Developments to 2020	Not Applicable

SCHEME: CARE HOME MARKET MANAGEMENT	
Strategic objective of the scheme	To deliver more effective market management across Herefordshire to enable the more cost effective purchasing of Residential and Nursing placements through both the council and Continuing Health Care (CHC).
Planned Change 2015/16	Savings released through this scheme to be utilised to provide additional funding for the protection of social care above the minimum funding level. Scheme expected to deliver: • Better care outcomes for people • Better functioning system • Better value for money • Financial savings
Change Delivered 2015/16	✓ Unified contract currently in negotiation and under development. Liaising closely with providers with regards to contractual proposals and implementation milestones. ✓ Care home market strategy developed encompassing both council and CCG information

SCHEME: CARE HOME MARKET MANAGEMENT	
Planned Developments 2016/17	• Agree and implement unified contract in relation to residential, nursing and CHC placements.
Further Developments to 2020	Alignment of internal processes including payment processes. Development of market capacity aligned to health and social care needs. Outcomes based commissioning to be developed and to consider incentivized support for addressing DTOC issues in the county.

5. NATIONAL AND LOCAL METRICS 2016/17

The following section provides an overview of 2015/16 performance and an update in relation to the following national and local metrics:

- Non-elective admissions
- Permanent Admissions to Residential and Nursing Homes (Age 65+)
- Older people at home 91 days after Reablement
- Delayed Transfers of Care
- Reduction in Fall Related Admissions
- Patient experience

Metric: Non-elective admissions *(E.1.i, E.1.ii. E.1.iii)*

2015/16 target	14,786
2015/16 performance and update	**Description**: Total non-elective admissions to hospital (general & acute), all ages, per 100,000 A number of schemes have been set up during 2015/16, including via the SRG programme, to address the increased demand. These include rapid assessments, fallers first response, virtual wards and hospital at home.

Plan					Actual			
Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	**Q4 14/15**	**Q1 15/16**	**Q2 15/16**	**Q3 15/16**
4,311	4,182	4,178	4,462	4,527	**4,108**	**4,072**	**4,204**	**4,473**

Achieved: 16,857

2016/17 target	Partners have developed a range of schemes that will impact on NEA in 2016/17. This work has built on success of schemes in 2015/16 and subsequent evaluation. This modelling has also been undertaken to assess the impact of the

	CCGs QIPP schemes and is linked to the Contract Negotiations. For example this includes: • The plan is based on the QIPP planning submission which includes all expected NEA reductions therefore no additional quarterly reductions are expected within the BCF plan; please note this is a change from the first submission. • This assumption will be tested before the next submission. • Impact of Virtual wards schemes during 15/16, subsequent analysis and modelled as lead to projected impact of county-wide roll-out for 16/17 • Continued impact of Falls scheme during 16/17 on NEA, building on successful roll-out in 15/16, • Continued use of RAAC beds, as an alternative to hospital admissions • Development of Care co-ordination Hub, and proactive signposting and management in community settings • Projected impact of Hospice at home and anticipatory care planning developments in 16/17 based on pilots and experiences elsewhere • CHC – management of market to ensure improved care planning and avoidable admissions; and development of personal budgets, to improve self-care and self-management, and to enable choice to minimise avoidable admissions • Enhanced Re-ablement schemes to reduce readmissions

Metric: Permanent Admissions to Residential and Nursing Homes (Age 65+) *(E.2.i, E.2.ii, E.2.iii)*	
2015/16 target	680.4
2015/16 performance and update	**Description:** Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population. Permanent admissions to residential and nursing care experienced a 16% surge in admissions during 2014/15 which provided a higher baseline figure for 2015/16. During the past year there has been a steady state of admissions and this is expected to continue in 2016/17. The implementation of a culture change through the care management team

is in development to review the cases being referred into residential and nursing homes with a view to source alternative provisions of care.

Permanent Admissions to Residential and Nursing Care													
65+ Rate (YTD)		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	2013/14	53.9	120.0	171.5	232.7	296.4	338.1	436.1	477.7	512.0	558.5	595.3	607.5
	2014/15	71.6	149.9	219.3	290.9	313.3	349.1	398.4	434.2	478.9	530.4	584.1	655.3
	2015/16	**50.9**	**101.9**	**132.0**	**180.6**	**196.8**	**238.5**	**266.3**	**296.4**	**324.1**	**345.0**		

2016/17 target

	Actual 14/15	Planned 15/16	Forecast 15/16	**Planned 16/17**
Annual rate	653.2	680.4	484.4	**487.0**
Numerator	283	302	215	**221**
Denominator	43,326	44,387	44,387	**45,382**

Metric: Older people at home 91 days after Reablement *(E.3.i, E.3.ii, E.3.iii)*	
2015/16 target	85.0
2015/16 performance	**Description**: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

and update

The community reablement provision has experienced a consistent performance for the last two reporting quarters. The target of 85% has been revisited with a view to reduce this to 80% which is consistent across the country. The reablement provision in Herefordshire is a small, targeted provision therefore a slight change in the reporting would show a large outturn in the performance of the service.

Location of clients at 91 days following completion of Reablement Intervention												
Percentage at home 91 days (YTD)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	50.0%	86.0%	86.5%	82.5%	78.5%	78.6%	78.9%	79.1%	79.0%	77.9%		

2016/17 target

	Actual 14/15	Planned 15/16	Forecast 15/16	**Planned 16/17**
Annual %	73.3%	85.0%	79.0%	**80.0%**
Numerator	55	544	79	**80**
Denominator	75	640	100	**100**

Metric: Delayed Transfers of Care (E.4.i, E.4.ii, E.4,iii)	
2015/16 target	516.3
2015/16 performance	**Description**: Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+) A number of schemes have been delivered during 2015/16 which are being worked through to help address the

and update

pressures of delayed transfers of care, including earlier identification of potential discharges, additional RAAC capacity and brokerage and additional support to self-funders and care homes. To date, the number of delayed cases continues to rise with forecast to continue. Quarterly figures are therefore likely to be further above the target. Data is taken as a snapshot at month end and therefore can appear volatile.

Delayed Transfers of Care (delayed days) from hospital per 100,000 population								
	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4
Target Rate	539	527	477	527	448	461	474	516
Actual Rate	539	712	559	602	614	611	750	693

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2016/17 target

	2016/17			
	Q1	**Q2**	**Q3**	**Q4**
Quarterly rate	609	606	744	513
Numerator	932	928	1139	790
Denominator	153,009	153,009	153,009	153,968

Metric: Reduction in Fall Related Admissions

<table>
<tr><td>2015/16 target</td><td></td></tr>
<tr><td>2015/16 performance and update</td><td>The Falls Responder Service provides a 24/7 mobile response to adults who have fallen in their home environment and are uninjured. The team are trained to safely move an individual who articulates that they are uninjured, provide a welfare check, provide signposting to sources of support, notify the GP and refer (with consent) to the Falls Prevention Team for follow up clinical assessment and intervention. A follow up telephone call is made to each individual 24 hrs after the responder visit to clarify impact post fall.

Since the introduction of the Falls responder service monthly analysis of WMAS conveyances to Hereford County Hospital which are coded as 'Fall' (as a percentage of all WMAS conveyances) are measured as a 12 month rolling average, this indicates a reducing trend for falls conveyances. The falls responder data also indicates that the number of WVT admissions per month with a falls diagnosis measured as a 12 month rolling average indicates an overall decline in the number of admissions. Monthly data analysis indicates that the responder service is delivering the projected system benefits alongside positive patient feedback.</td></tr>
<tr><td>2016/17 target</td><td><table><tr><th></th><th>Planned 15/16</th><th>Planned 16/17</th></tr><tr><td>Metric Value</td><td>16.0</td><td>0.0</td></tr><tr><td>Numerator</td><td>732.0</td><td>0.0</td></tr><tr><td>Denominator</td><td>4561.0</td><td>0.0</td></tr></table>
The metric for 15/16 was to reduce admissions which is forecast to achieve. The identified metric for 16/17 for the falls responders service will be expected to reduce the ambulance conveyance and A&E attendances.</td></tr>
</table>

Metric: Patient experience	
2015/16 target	User experience (ASCOF) 83.0

<table>
<tr><td>2015/16 performance and update</td><td>The performance of this metric is based upon survey outputs, taken from an annual data collection. Surveys were distributed during January 2016 to approximately 880 service users. To date (17 March 2016) around half of these have been returned. Strata response rates will be calculated at the end of the survey period in order to establish confidence level.

Returns are currently being manually uploaded in order to collate results.</td></tr>
<tr><td>2016/17 target</td><td>The target has been set on the basis of continuous improvement, and in line with our previous years performance of 67% and trends of comparators.

Improvements in this measure will not be specific to BCF initiatives as the survey is based on a random sample of service users. Evidencing the cause-effect of any one initiative in an overall population satisfaction measure will be difficult. However any improvements made in the result will indicate general improvements made within the system.

Please be aware that we are proposing a change to the measure for this year and as such comparison with last year’s performance is not possible.

<table>
<tr><th></th><th>Planned 15/16</th><th>Planned 16/17</th></tr>
<tr><td>Metric Value</td><td>83.0</td><td>70.0</td></tr>
<tr><td>Numerator</td><td>265.0</td><td>182.0</td></tr>
<tr><td>Denominator</td><td>320.0</td><td>260.0</td></tr>
</table>

Used ASCOF 4b measure in 15/16 which references feeling safe. Changed to ASCOF 3a for 16/17 customer satisfaction as this is a more meaningful measure.</td></tr>
</table>

6. MEETING THE NATIONAL CONDITIONS 2016/17

The following section details how the Herefordshire BCF plan meets the following national conditions:

- Jointly Agreed BCF Plan
- Maintain provision of social care services in 2016/17
- Supporting progress on meeting the 2020 standards for seven day services
- Better data sharing between health and social care, based on the NHS number
- A joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care, there will be an accountable professional
- Agreement on the consequential impact on the providers that are predicted to be substantially affected by the plans
- Agreement that a proportion of the allocation is invested in NHS commissioned out-of-hospital services
- Agreement on a local action plan to reduce delayed transfers of care

6.1 JOINTLY AGREED BCF PLAN

Herefordshire's BCF Plan for 2016/17 was signed off by The Health and Wellbeing Board (HWB) on 21st April 2016. This final submission (27th June 2016) has been approved on behalf of the council by the Director for Adults and Wellbeing, the Director of Operations for the CCG and the chair of the HWB prior to submission. ***(C.1.i)***

In agreeing the plan, the CCG and council commissioners have engaged with health and social care providers in both the acute and private sectors. This has been done to ensure that they understand the implications of the proposals contained within this BCF plan insofar as they relate specifically to services they provide to the BCF partners and **to achieve the best outcomes for local people *(C.1.ii)*. There is joint agreement across commissioners and providers as to how the BCF in Herefordshire will contribute to a longer strategic plan**. The CCG and council, as commissioners, and Wye Valley NHS Trust and 2gether NHS Foundation Trust, as providers, are all fully engaged in the alliance to deliver the One Herefordshire Plan and all are sighted on the role of the BCF within the wider transformation programme.

The Disabled Facilities Grant (DFG) has again been allocated through the BCF fund and therefore ***local housing authority representatives have been involved in developing and agreeing the***

plan (C.1.vi). Herefordshire is a unitary authority which does not devolve DFG to a second tier authority. The management of the DFG sits within the local authority housing team in the adults and wellbeing directorate of the council, and is overseen by the head of prevention. ***This assists in ensuring that a joint up approach to improving outcomes across health, social care and housing are achieved.*** Many DFG referrals are received via social care staff and assessment of eligibility for DFG is consistent with delivering wider health and social care benefits, and keeping people safe in their own homes.

6.2 MAINTAIN PROVISION OF SOCIAL CARE SERVICES IN 2016/17

Adult social care services in Herefordshire will continue to be supported within the BCF plan 2016/17 in a manner consistent with 2015/16 ***(C.2.v)***. Broadly, funding is assigned to the same service areas although some areas have seen increases (due to in year pressures such as DOLS) or decreases following successful recommissioning of external services (e.g. carers) which have delivered the same level of service, or improved service outcomes for less. Funding is reallocated to make best use of the available funds to services which are aligned to supporting health outcomes.

Protection of adult social care (PASC) has not been protected in real terms as the overall increase in the BCF minimum fund allocation for Herefordshire has been capped at £55k or £0.5%. A real terms uplift of 1.9% would equate to £86k on the 2015/16 figure of £4,520k, more than the total uplift for the fund. We have therefore determined that the most pragmatic solution is to pro rate the uplift in line with the 2015/16 allocations across social care and community health schemes. This means that funding for PASC has increased by £21k only, £65k less than a real terms uplift. ***(C.2.vi)***

As stated above, due to the adjustments to the NHS funding formula Herefordshire CCG has not received the full inflationary uplift as it is deemed under the new formula to be funded above the target. To have awarded a full inflationary increase to the PASC funds would have created an additional pressure on the already financially challenged CCG. The partners have therefore agreed that applying the minimal uplift awarded for the CCG minimum BCF allocation prorata to the 2015/16 allocations was the most appropriate action.

The LGA Care Act indicative funding allocation model would assign funding of £506k for Care Act implementation in Herefordshire, an increase of £48k, whereas the current assumption is an uplift of only £2k.

Overall social care is therefore underfunded by £111k for 2016/17. **In setting the level of protection for social care the local area has ensured that any change does not destabilise the local social and health care system as a whole *(C.2.vii)*.** As the funding for PASC shows a marginal uplift compared to 2015/16 this has reduced the risk of destabilisation of social care services, but will slow down the pace of change.

The Joint Spending Plan section of this document (section 7) provides **a comparison to the approach and figures set out in the 2015/16 plan *(C.2.viii)***. Herefordshire is not planning any significant changes from the schemes included in 2015/16. It should be noted that the approved BCF plan for 2015/16 included indicative figures for the additional pooled resource. When partners finalised the figures these were adjusted down to the level shown in the table in section 7 below and have been used for in year reporting. A high level comparison to the original BCF will show an overall reduction year on year of circa 12% but in reality funding is above the amended 2015/16 budget.

Funding is reallocated to make best use of the available protection of adult social care (PASC) funds to services which are aligned to supporting health outcomes. In agreeing the PASC funding for 2015/16 significant discussions between council and CCG over a considerable period were necessary to agree the allocation of the PASC funds to ensure that the CCG was satisfied that the services invested in were providing health benefits. The overall approach for allocating PASC is consistent with 2015/16 and therefore meets the requirements of the 2012 DH guidance ***(C.2.viiii)***.

6.3 SUPPORTING PROGRESS ON MEETING THE 2020 STANDARDS FOR SEVEN-DAY SERVICES

This approach will prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week **(C.3.ii)** and improve discharge planning.

Plans are in place to provide 7 days services (throughout the week, including weekends) across community, primary, mental health are social care **(C.3.i)** and the approach will support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care **(C.3.iii).**

The One Herefordshire Programme, via its Urgent Care and Community Collaborative workstreams, and the schemes within the BCF, have a central focus on ensuring coherence across primary, community and secondary care, seven days a week. This will be achieved through:

- Professional Facing Care Co-ordination Hub which delivers multi-disciplinary clinical input to support decision making and co-ordinating and simplifying:
- Access to most appropriate care that can prevent emergency admissions e.g. diagnostics, community services, social care
- emergency admissions and discharges
- access to specialist opinion and advice (through regional procurement)
- Integration with GP out of hours services to achieve better of continuity care for users, patients carers.
- Improved access to records, including information and record sharing across providers, enabling front line staff to access records to improve the continuity of care and work toward an integrated approach to access of records to effective care across Herefordshire
- Developing IT interoperability enabling direct booking of appointments across service providers first phase NHS 111 direct booking of extended hours primary care appointments
- Building on learning from the Prime Ministers Access Fund (2015) pilot, which makes available primary care extended hours 6-8pm Monday to Friday in three locations across the county and 10am to 2pm on Saturday and Sundays in Ross on Wye and Leominster and 8am to 8pm in Hereford. Core to the success of this work has been full access to patient's primary care record with consent sought at time of clinical consultation.
- To work with primary care at scale to further develop locality based 7 day access to primary care, the PMAG extended hours approach will be marinated in 16/17, primary care at scale evolving model April 2017.
- Wye Valley NHS Trust and 2gether Foundation Trust are working to develop integrated multidisciplinary place based care formulated around GP practice population; a newly appointed joint director of community services is taking this forward in 16/17, with the evolving model being in place by April 2017. This work will improve continuity of information, care co-ordination, transition planning, discharge planning and hospital avoidance, and community based care as an alternative to hospital based care
- As part of the Community Collaborative work focus on virtual community team model drawing together community functions delivered through a multi-disciplinary team identifying the vulnerable

through a risk stratification approach and taking a case management approach to establish individual care plans and person centred –outcomes – with focus on education, self-management and reducing hospital admissions, attendances and outpatient appointments. Aligned to this is a quality initiative across both 2g, WVT and West Midlands designed to reduce frequent attendees across several pathways.

- The principle of seven day working is embedded within One Herefordshire and our service redesign plans. **(C3.iv)**
- Our Delayed Transfer of Care action plan (see attachment) describes in more detail several areas of focus that is aimed to support the timely discharge of patients
- Primary care and community services central to the urgent care pathway – with increased capacity and capability over 7 days at locality level
- Potential realignment of resources within Minor Injuries Units and the Walk-In Centre, to simplify access routes for the public, reduce service duplication, and realign workforce and skill sets to primary care and A and E. The Walk-In Centre and Minor Injury Units are to remain open with no immediate changes while proposals for urgent care and for seven-day GP services are being developed, but we are reviewing these services to determine whether care is being provided in the best place at the best time for patients. The outcome of the review is not yet known and no decisions have been made. We will be undertaking a comprehensive and robust consultation with the residents of Herefordshire as part of our work.
- An Integrated NHS111/GP Out of Hours service is currently being commissioned across the West Midlands, on behalf of 16 CCGs which includes Herefordshire. Each CCG in the West Midlands has an opportunity to influence how the NHS 111 service works in their area and we will be ensuring that NHS 111 will be integrated with Herefordshire's urgent care services. Local schedules attached the NHS 111 and Out of hours to ensure appropriate local delivery.
- A public facing "virtual assessment" function across the whole pathway of care, to move towards "talk before you walk", across primary care, NHS 111, WMAS and the "front door" of A and E. Consistently assessing and directing people to the most appropriate service, with redirection to primary care whenever appropriate.
- The brokerage function within the Adults Wellbeing directorate for the local authority provides 7 days a week support to enable hospital discharges

- Enhanced capacity has been provided to hospital social care management function 7 days a week
- The approach to delivering seven day services will be underpinned by the integrated urgent care pathway and health hubs.
- Plans for 2016/17 are in place for the developments outlined above as part of the One Herefordshire plan but are subject to further development and refinement.
- Hospice at home to support quality and effective EoLc 24/7 hospice at home service was commissioned and started in February 2016 to enable people to die in their preferred place of care outside of hospital.

6.4 BETTER DATA SHARING BETWEEN HEALTH AND SOCIAL CARE, BASED ON THE NHS NUMBER

One of the major cross-cutting themes within the One Herefordshire transformation programme is the need to share information about patients and service users. It is clear that our patients and service users expect that when they interact with a public-sector body regarding their wellbeing, that the care should be “joined-up”. Technology is a vital component in enabling that care.

By April 2016, every local area is now required to deliver, co-ordinated by the CCG,

- A Footprint detailing the partners and the governance arrangements to drive the local health and care system to become paper-free at the point of care.
- A baselined and benchmarked process towards becoming paper-free at the point of care using a new Digital Maturity Self-Assessment Tool.
- A digital roadmap outlining the steps (operational and strategic) to be taken towards being paper-free at the point of care.

The major recommendation from the workstream to date is that Herefordshire should implement a shared care record, with data being supplied from providers once appropriate systems are in place. This would provide a platform that improves the quality of care, the information available to professionals and clinicians and should, with appropriate business change, reduce time in hospital, support living at home longer, improve outcomes for patients and reduce costs.

As yet, the financial evidence about the level of saving that might be achieved is not extensive. There is more evidence of improved outcomes for service users and patients. Additionally, there are a set of

smaller activities that would support working within the county. These “quick wins” leverage existing investments and would improve efficiency. This set of activities should be progressed to be in place by Mid-2016.

A service re-design management sub-group has been established called the Transformation Through Technology Group (TTTG), to support the delivery of the Digital Road map in Herefordshire. Initial membership of the group includes representation from the CCG, local authority and key providers including WVT, 2G, St Michaels Hospice and Taurus Healthcare. The digital roadmap is the key deliverable for the TTTG to ensure that Herefordshire have interoperability of systems by 2020 at patient points of care across both health and social care. The digital footprint was agreed as ‘Herefordshire’ and submitted to NHS England in October 2015. The TTTG have submitted their Digital maturity Index returns on schedule in January as required by NHS England.

Within Herefordshire, **the right cultures, behaviours and leadership are demonstrated locally by all partners, fostering a culture of secure, lawful and appropriate sharing of data to support better care. *(C.4.i)*.** The **NHS number is being used as the consistent identifier for health and care services *(C.4.ii)***. For example, the NHS identifier is being used for reconciliation and reporting purposes within the Care Home Market Management BCF pool and is available for reporting within social care systems. All systems being developed or investigated have an API interface ***(C.4.iii)*.**

The cultures, behaviours and local leadership are demonstrated through the collaborative approach taken within the four key workstreams of the One Herefordshire transformation programme in which all partners actively participate to develop local solutions.

It is recognised that there is a requirement for **appropriate Information Governance controls to be in place for information sharing in line with the revised Caldicott principles and guidance** (available by the IGA). To date, the council has achieved 74% of the current IG toolkit submission and is at least level 2 in all areas ***(C.4.iv)***. A Herefordshire memorandum of understanding on information sharing is in place and local data sharing agreements amongst partners are in the process of being developed. All staff receive mandatory training in information governance and specific multi-agency face-to-face training is in the planning stages for roll-out in the coming months.

Local people of Herefordshire have clarity about how data about them is used, who may have access and how they can exercise their legal rights (in line with the recommendations from the National Data Guardian review. A general privacy notice for Adult Social Care is in place and further privacy notices and consent forms are being reviewed and added as part of the work on

implementing privacy notices. Consent forms were also reviewed as part of the work for the changes brought about by the recent Care Act ***(C.4.v)***.

These changes highlighted will be an enabler for integration of services in the future and will provide the foundation of successful partnerships. All stakeholders are committed to the delivery of better data sharing to improve and enhance the journey through health and social care. ***(C.4.vi)***

6.5 A JOINT APPROACH TO ASSESSMENTS AND CARE PLANNING

The proportion of our local population which has been identified (using our virtual wards scheme) and through the risk stratification tool is 2% **(C.5.i).** The electronic risk stratification tool draws together primary and secondary care data to identify those individuals likely to experience significant deterioration and hospital admission. These vulnerable individuals are offered targeted support, an individual care plan and proactive case management from a member of the multi-disciplinary community team.

Herefordshire Council and CCG have developed and implemented an aligned assessment for continuing healthcare (CHC) and have also fully implemented the joint support planning process, with an accountable professional assigned to each case.

There is a joint approach to dementia care and living well with dementia in Herefordshire – with a clear shared vision across our system to increase the availability of early diagnosis of dementia, and to support people with dementia, their carers and families to live well with dementia. The model of dementia care is based on a primary facing pre and post diagnosis support. This includes efficient access to assessment (within 4 weeks); a partnership between mental health services and voluntary sector to offer tailored person-centred care that recognizes the different stages of the illness, e.g. carers support, information and advice, maximizing independence, advance care planning; and care coordination. Health and social care are working together to ensure that multi-agency and multi-disciplinary input is coordinated and provided for people with dementia within the community. The coordination extends to ensuring support is provided during times of ill health, e.g. hospital stays, and in different settings, e.g. Care Homes **(C.5.ii)**

We currently have an Integrated Urgent Care Pathway project in place, which is a joint project between the Local Authority and Wye Valley NHS Trust to further develop an integrated Urgent Care Pathway, utilising the existing community health and locality social care teams to maximise

opportunities to avoid admissions into the acute hospital, support earlier discharge and facilitate discharge to assess where there is further recovery or rehabilitation required to enable longer term planning to take place. This project develops the footprint for multidisciplinary working building on, lead professional (Key Worker), Trusted Referrer and Trusted Assessor roles across multiple Health and Social Care teams.

The strategic objective is to enable individuals to remain as independent and healthy as possible in their usual place of residence, to minimise admissions and subsequent spend within the acute hospital environment thereby facilitating investment in community health and social care services to meet our shared objectives of safely and effective care which maintains independence within the community for vulnerable adults.

The pathway prompts rapid responses to urgent care requirements, establishing the principles of right care, in the right place and at the right time, maintaining the person's independence within their usual community setting by deploying the optimal skill mix to ensure the response provided is appropriate and proportionate to the assessed needs. As a health and care system we are working towards the default position where individuals are supported to remain at, or return to their home.

The delivery plan detailed below provides key milestones for Herefordshire's joint approach to assessments and care planning **(C.5.iii-iv).**

Delivery	**By when?**	**By who?**
Commitment and scoping of a plan to develop joint or aligned assessments, with the aim to shift to prevention and reduce the number of high cost service users/patients.	Q1 2016/17	CCG and LA
Agree proposal for a functional delivery model for health and social care.	Q1 2016/17	CCG and LA
Full governance agreement to the functional model to include the JCB, System Redesign group, One Herefordshire working groups – • Urgent Care • Community Collaborative • Supportive Communities	Q1 2016/17	CCG and LA

Delivery	By when?	By who?
Share the proposal and develop further with key providers. To include: • WVT • 2gether Foundation Trust • Shaw Healthcare • Blanchworth • Key LA providers.	Q1 2016/17	CCG and LA
Develop further joint working across agencies and community (provider input required). To include the following: ➢ Risk stratification ➢ Virtual wards/hospital at home ➢ Rapid response ➢ Voluntary sector ➢ Mental Health	Q1 and ongoing	CCG and LA
Risk stratification tool to be developed through the community teams to identify people 'at risk' of entering the system.	Q1 2016/17	Community collaborative
Establish joint approach to care planning in line with the delivery model (self-assessment and appropriate professional assessments) and agree milestone plan.	Q1 2016/17	CCG and LA
Identify and establish key processes in relation to key priority populations (e.g. frail/elderly)	Q2 2016/17	CCG and LA
Providers and commissioners to agree pathway and process implementation	Q2 2016/17	CCG and LA
Identification of potential Trusted Assessors, to achieve focus on functions not roles and to enable workforce efficiencies across providers.	Q2-3 2016/17	CCG and LA
Plan for rollout of training programme for Trusted Assessors	Q4 2016/17	CCG and LA

Section 75 agreement – appendix 5

Delivery	By when?	By who?
Care Home Inreach Team to review care home residents to identify those without a diagnosis of dementia but who might have dementia, assess them and request that their usual GP adds them to the dementia QOF register if dementia is diagnosed.	Q4 2016/17	CCG
Community dementia team to make effective links with community hospitals to develop process for identification of patients requiring dementia assessment	Q1 2016/17	CCG
Targeted case finding for key groups with GP surgeries and Mental Health Liaison Service, e.g. frail elderly people, older carers, people with LTCs, patients in care homes, and people with learning disabilities.	Q4 2016/17	CCG
Multi-agency dementia training to aid joint working	Q1 2016/17	CCG

Through implementing the above delivery plan health and social care teams will use a joint process to achieve effective joint working which benefits patients/service users through promoting independence, preventing hospital admission reducing people entering into the care system and ensuring people are in the right part of the system as quickly as possible.

6.6 AGREEMENT ON THE CONSEQUENTIAL IMPACT OF THE CHANGES ON THE PROVIDERS

Herefordshire have reviewed this section following the submission two assurance process and believe the narrative below meets the KLOE requirements. Please note the assurance process was rag rated fully met by one reviewer and not met by the other.

Providers are fully briefed on the projects included within the BCF that impact on them. We are working with our providers to support delivery of the key elements of the One Herefordshire projects and where appropriate, changes are reflected in our contractual relationship with providers.

Key providers are full members of the One Herefordshire programme of work, to which the BCF plans are integral. This ensures that providers are engaged with, and co-produce, transformation and service redesign plans at an early stage (though if re-procurement of a service is required,

appropriate conflicts of interest safeguards are in place). **Implications for local providers are set out clearly within this process and allow recognition of service change consequences *(C.1.v)***.

BCF is an enabler in Herefordshire for the delivery of our system wide plans. For example, the CCG and Herefordshire Council have developed a joint specification for community services which is being included in contractual relationships with key providers. This includes KPIs relating to increasing the amount of care that is provided in a community and primary care setting as opposed to acute setting; improving outcomes for patients receiving care in community settings.

All key service changes are subject to quality and equality impact assessment to ensure any adverse consequences are identified and mitigated against if appropriate. Significant service changes will be subject to wider consultation and engagement of stakeholders, users and patients.

The impact of local plans has been agreed with relevant health and social care providers *(C.6.i)*. The CCG's contract with its main acute provider (WVT) includes QIPPs and contractual changes that reflect the implementation and extension of schemes that are supported through the BCF – e.g. extension of the Virtual Wards across the whole county. Activity and performance trajectories are modelled, alongside financial impact and these are taken into account through contract negotiations. A clear provider engagement plan will be developed within the BCF 2016/17.

The largest pool within the BCF plan for Herefordshire is for the joint contracting and commissioning of residential and nursing placements. The unified contract has been developed during the last year and the consequential impact on the implementation and delivery of the contract has been monitored and reported on a regular basis. A large engagement process has been undertake with the market of the contract principles and changes which has been considered throughout the process.

There is ongoing public, patient and service user engagement in the planning process by partners, through our usual activities. A significant engagement programme was undertaken in summer 2015 to support the development of the Health and Wellbeing Strategy which underpins the transformation programme and informed the setting of our local objectives. CCG and council provide regular updates to governing body, Cabinet and members as part of the routine governance and assurance processes. ***(C.6.ii)***

These align to provider plans and the longer term vision for sustainable services *(C.6.iii)* through the One Herefordshire Plan

The **importance of mental health as well as physical health** was demonstrated as it was the number one priority arising from the consultation on the health and wellbeing strategy. A joint work programme on the redesign of mental health services is currently underway. ***(C.6.iv)***

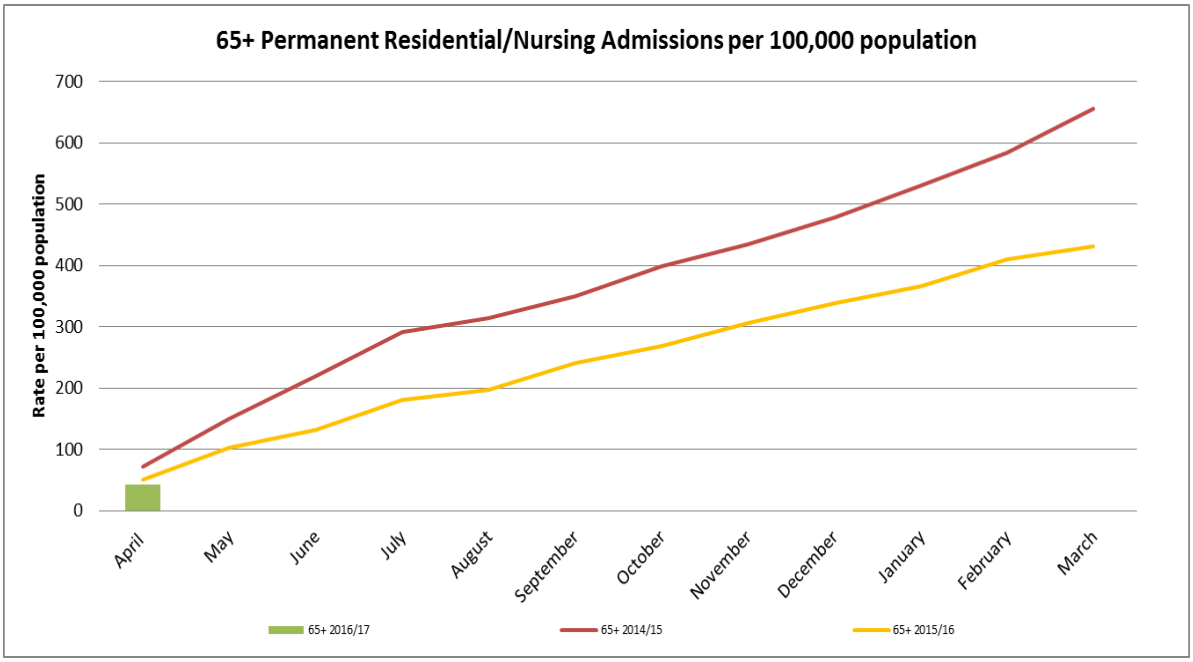
A demonstration of clear alignment between the overarching BCF plan, CCG Operating Plans, and the provider plans is shown in the One Herefordshire Plan. ***(C.6.v)***

6.7 AGREEMENT THAT A PROPORTION OF THE ALLOCATION IS INVESTED IN NHS COMMISSIONED OUT-OF-HOSPITAL SERVICES

Within Herefordshire there is agreement that NHS commissioned out-of-hospital services and services that were previously paid for from funding made available as a result of achieving their non-elective admission, continue in a manner consistent with those agreed in 2015/16 ***(C.7.vi).*** The community health scheme meets the requirement for allocation of at least £3,339k to be invested in NHS commissioned out of hospital services. The funding has been allocated in full and not retained as part of a local risk sharing agreement. This funding is allocated to district nursing and other community based nursing ***(C.7.i)***. The specific detail is clearly set out within the summary and expenditure plan tabs on the BCF planning return template ***(C.7.ii).***

In developing and forming an agreement in relation to the allocation invested in NHS commissioning out-of-hospital services a range of data analysis has been completed which considered the long term trend in admissions and the success of the schemes implemented to date. The information provided below is a sample of the data monitoring and analysis which is completed on a regular basis by Herefordshire's Joint Commissioning Board **(C.7.iv)**.

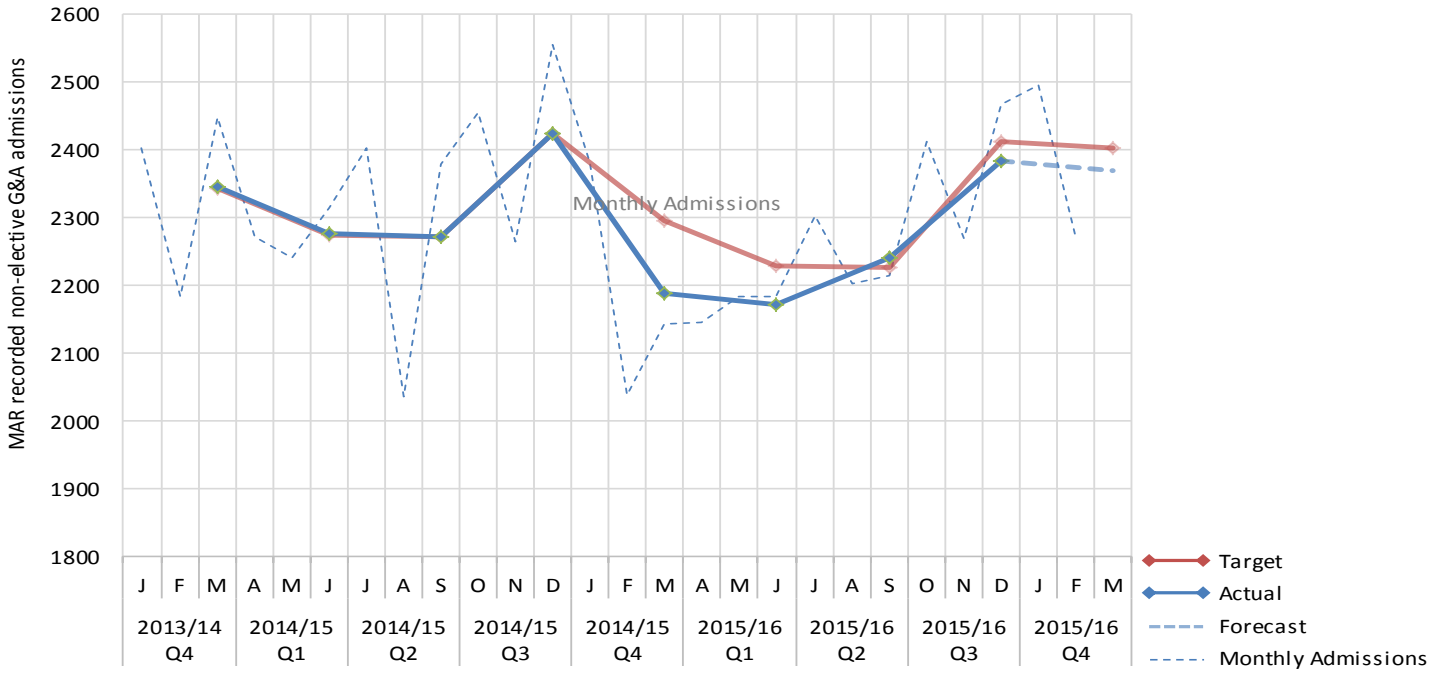
Admissions to Residential & Nursing Homes (Age 65+)



2015/16 data, whilst still in draft, presents a significant improvement in the previous year's results. This is in part due to the more rigorous process of the quality assurance panel, challenging the appropriateness of all residential placements. The target for 2016/17 admissions is to maintain at those levels recorded in 2015/16, therefore the target this year is 2015/16 actual line.

Non-elective Admissions

A number of schemes have been set up via the BCF programme, to address the demand in non-elective admissions with a view to reduce these further. These include rapid assessments, falls first response, virtual wards, and hospital at home.

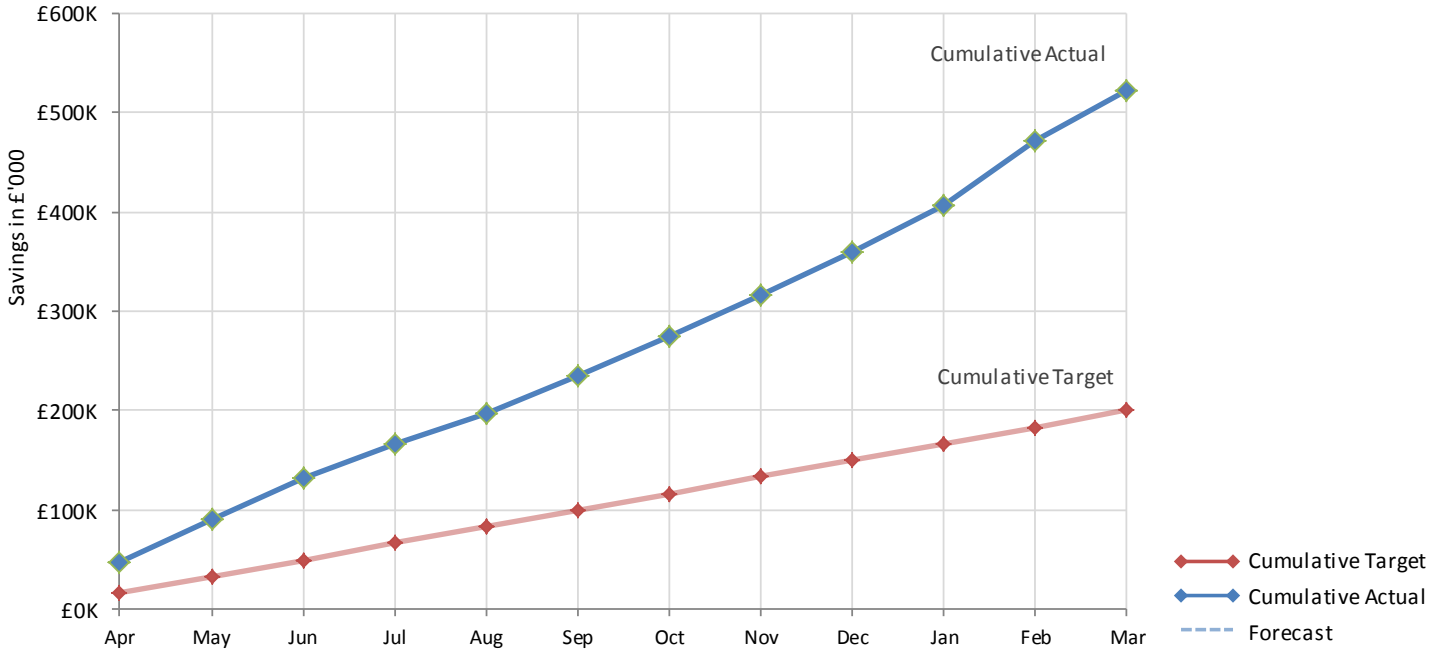


Intermediate Care Scheme Redesign

A number of schemes are being worked through to help address the pressures of non-elective admissions, including earlier identification of potential discharges, increased capacity in brokerage and additional support to self-funders and care homes. During 2015/16 a Rapid Access to Assessment and Care scheme was delivered, however the effectiveness of the scheme is currently being discussed and partners are working together to carry out a complete review and redesign of the intermediate care pathway and offer in Herefordshire **(B.2.iv)(C.7.iv).**

The review will be supported by analysis undertaken of the non-elective admissions and modelling this for the future demand of unplanned activity. The schemes such as the falls response service has been an effective provision in supporting unplanned activity and is identified as a scheme that will continue **(C.7.iii).**

Falls Response Service



Falls represent a large proportion of ambulance conveyances to wye Valley Trust and the falls related admissions are high. The graph above illustrates the falls response measure, which is in line with the HCCG QUIPP scheme. This is in relation to the impact of service changes in reducing falls related costs. The falls first responder's scheme continues to help address the gaps in the falls pathways in Herefordshire, caring for those fallers who have not received serious injury. Due to the continuing success of this service it has been agreed to continue to invest in this service, in order to assist in reducing the number of non-elective admissions reported. **(C.7.iv)**.

6.8 AGREEMENT ON A LOCAL ACTION PLAN TO REDUCE DELAYED TRANSFERS OF CARE (DTOC)

A local area action plan for DTOC has been developed and is attached to this document, which demonstrates clear lines of responsibility, accountabilities and measures of assurance and monitoring ***(C.8.i), (C.8.vii)***. The aim of this plan *is to reduce delayed transfers of care ensuring that people are discharged in a timely manner to the most appropriate setting to meet their needs.*

A number of objectives are identified in our DTOC plan which include:

- to ensure that our local DTOC improvement plan is based on national guidance and best practice ***(C.8.viii)***
- to ensure that the DTOC improvement plan is implemented within the framework of the overall System Resilience Group plan for improving patient flow and performance, with all partners engaged in and accountable for implementation **(C.8.iii)**
- to ensure a whole pathway approach, with an emphasis on prevention and admission avoidance as well as on discharge planning.
- to monitor and assure progress against key milestones and performance through the JCB and Systems Resilience Group
- to provide a framework for shared outcomes through risk pooling.

Our DTOC plan will be a key component of monitoring and reporting in both the System Resilience Group and the Joint Commissioning Board. As such it sits within the overall context of the System Resilience Group plan for improving patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community (e.g. reducing avoidable admissions, effective in-hospital management and timely and safe discharge). The plan was discussed within the February SRG and will be presented formally at a future meeting. ***(C.8.iii***) The adoption of a risk share agreement for DTOC has been considered and is further discussed within section 8 of this plan – financial risk sharing and contingency ***(C.8.v).***

In delivering and further developing the DTOC plan, we will continue to engage with the relevant acute and community trusts ***(C.8.vi).*** We have a process of continuous engagement with our local independent and voluntary sector providers on a range of topics. A key element of the DTOC plan is the use of intermediate care and step up / step down beds as the redesign of these services is a key focus of the 2016/17 BCF the engagement with providers through our current processes will form an integral part of this. ***(C.8.ix)***

The local area, including the local acute and community Trust, has developed a detailed action plan for reducing delayed transfers of care. Unify data indicates that Herefordshire, and the local acute provider is not a significant outlier in terms of acute delayed transfers, and the action plan focusses upon non-acute delayed discharges. A significant amount of work is being undertaken, following on from schemes begun in 2015/16, the plans are laid out in detail in the DTOC Action Plan. The local area target is based on the action plan delivering reductions in DTOC by the end of 2016/17, such

that there is a 7.5% reduction in DTOC per 100,000 population in Herefordshire compared to the out-turn performance for 2015/16 **(C.8.ii.)**

Reducing delayed transfers of care is an important enabler in HCCG's operational plan. Reduction in DTOCs is important to the Acute and Urgent care work streams of the CCG's operational plan, and reducing DTOCs per 100,000 population is a key target in the Urgent Care work stream. The plan reflects the importance of BCF as an enabler in the wider transformation of health and social care in Herefordshire. The importance of reducing DTOC through working with the local acute and community provider Trust is reflected in the detailed DTOC action plan. Work with the local provider reflects ECIP analysis and recommendations and also the provider is working with peer organisations to improve discharge performance. This work will promote adoption of best practice and effective interventions, as well as improving data quality **(C.8.iv).**

The local DTOC stretch targets have been established and developed and are detailed within section 5 of this document. **(C.8.ii.)**

7. JOINT SPENDING PLAN

Funding contributions for 2016-17 *(A.3.iii)*

Herefordshire's minimum fund contributions and indicative additional contributions from each partner are summarised below. This table also **sets out any changes from funding levels in 2015/16 *(A.3.iv).*** The final budget contributions for the additional pool are based on the cost of care for current clients as at end March 2016.

Overview of Contributions 2016/17 versus 2015/16

£'000	Ref No.	Source	Funding by LA	Funding by CCG	Total 2016/17	Total 2015/16*[1]	Incr *[2] (Decr)
Protection ASC	1	Minimum		4,541	4,541	4,520	21
Care Act	2	Minimum		460	460	458	2
Community Health & Social Care	3	Minimum		6,748	6,748	6,716	32
Sub Total Minimum Fund		Minimum		**11,749**	**11,749**	**11,694**	**55**
DFG (15/16 figs incl. SC capital)	4/5	Min Fund	1,558		1,558	1,356*[2]	202
Care Home Market Mgmt	6	Additional	19,468	9,272	28,740	27,048	1,692
Total Indicative BCF			**21,026**	**21,021-**	**42,047**	**40,098**	**1,949**

*[1] The figure reported for BCF budget for 2015/16 is lower than the budget included in the approved plan. This is because at the time of submission the exact criteria for the additional pool contributions had not been finalised, and final contributions were confirmed at a lower level as out of county placements were excluded from the final pool. Overall funding for 2016/17 is now confirmed and agreed by the partners.

*[2] in 2015/16 social care capital contribution £490k, DFG £866k

*[3] increase in minimum BCF provisionally allocated pro rata

The minimum fund includes the former carer's breaks and reablement funding at the same level as 2015/16 in line with the original BCF allocations and assumptions. (***A1.i, A1.ii, A1.iii, A1.iv, A1.v***)

Allocation of the funding for the protection of adult social care has been rebalanced in some areas to reflect financial efficiencies achieved in year through recommissioned services (carer's support) which do not result in reduced service provision & to enable the resources to be allocated to meet other service pressures such as DOL's demand. Funding also reflects the redesign of social care teams to provide better support to crisis response, facilitating hospital discharge and closer working with health teams.

The Herefordshire BCF plan maintains the schemes identified in the 2015/16 BCF submission and therefore an assessment of the impact of these changes on these services is minimal, however the impact of the key schemes is summarized below **(A.3.v).**

The funding for the protection of social care includes increased support to deliver DOLS in response to the increased demand seen as a result of legal rulings.

The funding currently identified for RAAC within the protection of social care will be reallocated. Partners are currently discussing the form that this new service will take. One option under consideration is an alternative service in the community to support hospital discharges, potentially through an expanded / enhanced rapid response service. This has the potential to support discharge for approximately double the number of patients as the existing scheme on a full year equivalent basis.

The increased funding for DFG in 2016/17 provides the potential to deliver additional adaptions, potentially up to 100 more in year (subject to local capacity). Based on central government estimates this may lead to the delay of residential admissions of up to 30 people (10% per CSR projections).

The investment in the falls response service has proved very successful delivering more than double the target savings in 2015/16. This scheme is jointly funded by the CCG, council and the provider.

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In relation to pool 2 the partners are looking to reduce the risks by engaging providers to actively risk share and improve provision across the entire pathway. This is work in progress and may result in a reduction in the pool 2 budget in year as these arrangements and confirmed.

The risk stratification and hospital at home services has proved to be highly successful and is being rolled out county wide and will impact further in 2016/17.

The scheme summary is included within tab 4 HWB expenditure plan of the reporting template but is shown below for completeness.

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Scheme Summary (Ref Tab 4)

Scheme Name	Ref No	Scheme Type	Area of Spend	Comm.	Provider	Source of Funding	Expenditure		
							2016/17 (£'000)	Budget 15/16 (£'000)	Outturn 15/16 (£'000)
Intermediate Care - reablement (Kington court)	3	Reablement services	Comm Health	CCG	NHS Community	CCG Min.	534	484	484
Integrated Community Care (community health svcs)	3	Integrated care teams	Comm Health	CCG	NHS Community	CCG Min.	3,806	3879	3879
Early Interv'n & rapid response / intermed. care -Hospital at Home	3	Pers. support/care @ home	Comm Health	CCG	NHS Community	CCG Min.	768	800	800
Early Interv'n & rapid response - Risk Stratification	3	Pers. support/care @ home	Comm Health	CCG	NHS Community	CCG Min.	768	800	800
Early interv'n & rapid response -Falls Response service	3	Pers. support/care @ home	Comm Health	CCG	NHS Community	CCG Min.	123	123	123
Intermediate Care - Step up / Step down community bed	3	Intermediate care services	Comm Health	CCG	Charity/Vol. Sec.	CCG Min.	240	153	153
Prevention - Short breaks / respite care for children and families	1	Ledbury Road (carers)	Comm Health	LA	NHS Acute	CCG Min.	427	427	427
Carers Support	1	Carers	Comm Health	LA	Charity/Vol. Sec.	CCG Min.	50	50	50
Support to ECIP/DTOC	1	Joint Commissioner	Comm Health	CCG		CCG Min.	32	0	0
Reablement	1	Reablement services	Social Care	LA	Charity/Vol. Sec.	CCG Min.	420	420	420
Carers Support	1	Support for carers	Social Care	LA	Private Sector	CCG Min.	460	843	718
Community Equipment / HIA	1	Pers. support/care @ home	Social Care	LA	Private Sector	CCG Min.	272	266	266
Rapid Response / OT	1	Pers. support/care @ home	Social Care	LA	Local Authority	CCG Min.	670	595	648
Kington Court	1	Intermediate care services	Social Care	LA	Private Sector	CCG Min.	366	366	366
RAAC	1	Intermediate care services	Social Care	LA	Private Sector	CCG Min.	494	494	352
Integrated Crisis and urgent care	1	Integrated care teams	Social Care	LA	Local Authority	CCG Min.	712	641	713
LD Health	1	Other	Social Care	LA	NHS MH Provider	CCG Min.	331	331	331
Other Social Care Demand	1	Other	Social Care	LA	Local Authority	CCG Min.	793	564	706
Support to ECIP/DTOC	1	Other	Other	LA	Local Authority	CCG Min.	23		
Care Act	2	Support for carers	Social Care	LA	Charity/Vol. Sec.	CCG Min.	460	458	458
Disabled Facilities Grant	4	Pers. support/care @ home	Other	LA	Private Sector	LA Min	1,558	866	866
Care Home Market Management CCG contribution	6	Other	Contin. Care	CCG	Private Sector	CCG Add'l	9,272	8685	9888
Care Home Market Management LA contribution	6	Other	Social Care	LA	Private Sector	LA Add'l	19,468	18363	18418
Social Care Capital	5	Other	Other	LA	Private Sector	LA Min	-	490	490
Total BCF							**42,047**	**40,098**	**41,356**

*Reference numbers to cross reference scheme details to high level summary table above

The total allocated to carers support across the CCG and council is £937k, including £477k former carers grant (***C.2.iv, A.1.iv***).

8. FINANCIAL RISK SHARING AND CONTINGENCY

A **fully populated and comprehensive risk log** is located within the appendices of this plan ***(B.3.V)***. This has been developed in partnership with all key stakeholders and provides a description of how risks will be managed operationally.

The following KLOEs have been addressed within this submission of the narrative plan:

(B.5.i), (B.5.ii), (B.5.iii), (B.5.iv), (C.7.iii), (C.7.v)

The BCF plan for 2015/16 contained a risk share arrangement for pool 2 for the first year of operation. The risk share arrangement recognised that a revised arrangement would need to be negotiated for future years. The Joint Commissioning Board were to use the first year of the BCF to monitor and evaluate both performance and risks arising in year to inform the development of more sophisticated risk share arrangements for future years.

The BCF fund is fully allocated to existing schemes within Herefordshire, and no funds have been retained for contingency or payment for performance purposes.

Herefordshire took up the offer of regional support to develop a local approach to risk share arrangements for 2016/17. The support was used to consider the options for risk share arrangements in relation to non-elective admissions, DTOC and the additional aligned fund contained within the BCF plan for 2016/17. The support facilitated a workshop between both partners and to inform the discussions with best practice of risk sharing arrangements and the development and implementation of these in other areas.

Partners have worked together to consider the use of a local risk sharing agreement with respect to a number of key areas, including DTOC. Following clear consideration partners have concluded that a risk share, in relation to DTOC, NEA and schemes contained within pool 1 of this plan would not be of benefit to either party at this time. In regards to pool 1, as previously mentioned, partners are currently working together to review and redesign the Intermediate Care Scheme (previously delivered through the RAAC framework). This redesigned service offer will provide a therapeutic reablement provision within clients homes following discharge from hospital, as well as utilising existing block contracts to deliver bed-based intermediate care options in the county and will focused on unplanned activity and supporting DTOC ***(C.8.v)***.

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The principles of a risk and benefit sharing arrangement has been agreed for Herefordshire which is based on behavioural change and service innovation within the system aligned to the funding contained within pool 2.

The risk share arrangement for pool 2 is currently being finalised with the detailed funding split to be agreed. It will be based on a cap for risk and benefits to both partners and will be consistence with guidance.

The delivery of service innovation with the implementation of the unified contract for the residential and nursing commissioning of placements and assertive reviews for continuing healthcare provision are key deliverables for this risk and benefit share arrangement.

The following scoping of the risk sharing arrangement for pool 2 has been undertaken.

The partners are finalising that the risk share agreement will be restricted to a defined and agreed cohort of clients. This client cohort will be defined as follows:

1. Includes those clients who are not funded at the usual price*2 and who have not been reviewed in the twelve month period since 1st April 2015

2. The list of clients identified in 1 above will be jointly assessed by the council and CCG to agree which clients are likely to result in a behaviour change*3 due to the length of time since the last review or for other reasons relating to a change in the approach being taken by the commissioner.

3. The defined client list excludes any clients identified by the CCG as being part of separate arrangements with 2g for risk share.

4. The defined list will exclude non-reviewed clients who, the partners jointly agree, are unlikely to have incurred a substantive change in health and care needs in the intervening period. These clients will be classified as business as usual and excluded from the specific risk share arrangement.

5. The eligible clients list, as defined above, will include the totality of eligible clients, this is a total of 27 clients and is within appendix one of this document.

6. The expectation will be that the clients will be reviewed within the next six months and the monitoring of the reviews will be through the Better Care Fund Partnership Group, with further reporting to the Joint Commissioning Board.

*2 in this context the usual price is defined as any local authority client funded at either the old, or new usual price for older peoples residential and nursing care (£570, £523, (old / new nursing

rates),£468, £457 (old/new residential & dementia rates) per week), and clients who receive FNC/FCO only support from the CCG

*3 in this context the term behaviour change means that the partners agree that due to the length of time since the last review a stepped change in level of needs is likely to be identified upon review which may result in a change of statutory partner responsibility for the individual client.

The cohort of clients that has been scoped for the risk share agreement is quantified in the table below:

Clients not reviewed since 1/4/15	**Number**	**CCG £k**	**LA £k**	**Total £k**
CHC	4	314		314
Joint Funded	1	34	-	34
LA non usual price clients	22	6	1,031	1,037
TOTAL	**27**	**354**	**1,031**	**1,385**
Proportion		26%	74%	

The non-financial risks associated with not meeting the BCF targets are:

- The BCF targets contribute to both partner organisation strategic objectives and this will have a negative impact on delivery of these.
- Further pressures and destabilisation will be placed on a fragile health and social care system
- The people of Herefordshire outcomes will not be improved
- Limiting our ability to meet the changing needs in the population

The principles and risk share arrangement and will be subject to the section 75 agreement. The delivery of the risk share will be monitored on a monthly basis within the BCFPG and will routinely reported to the JCB. The financial risk will be applied to the overall net cost or gain from those clients who change statutory responsibility with the balance being agreed on an annual basis.

9. DELIVERING THE PLAN

The delivery plan below details **key milestones associated with the delivery of the plan of action in 2016/17** ***(B.3.iv)*** Please see the attached risk log for further information regarding managing risk in relation to the following delivery plan.

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Delivery	By when?	Accountable partner*
HWB sign off BCF plan 2016/17 (12th April 2016)	Q1 2016/17	Both
BCF plans 2016/17, including pooled fund arrangements commence	Q1 2016/17	Both
Agree approach to Risk share arrangements	Q1 2016/17	Both
Single S75 to be developed and agreed	Q2 2016/17	Both
Approval of unified contract	Q1 2016/17	Both
Implementation of unified contract	Q2 2016/17	Both
Implementation of redesigned social care teams into locality / complex care teams	Q4 2015/16	LA
Monitor effectiveness of redesigned social care teams via BCPG	Q2 2016/17	Both
WISH (Wellbeing Information & Signposting for Herefordshire) service launched	Q1 2016/17	LA
Enhance content of IAS	Q2 2016/17	LA
Review and reconfigure RAAC framework arrangement	Q1 2016/17	Both
Implementation of Herefordshire Carers Strategy	Q2 2016/17	Both
Develop a provider engagement plan	Q1 2016/17	Both
Care Co-ordination Centre mobilised	Q1 2016/17	Both
Submit System Transformation Plan	Q1 2016/17	Both
Agreed county-wide Estates Strategy that supports consolidation & transformation	Q3 2016/17	Both
Devolution of acute specialities to community settings	Q3 2016/17	CCG
Increased primary care capacity through development of primary care at scale	Q3 2016/17	CCG
New community Health and Wellbeing Hubs opened in x localities	TBC	CCG
Single physical and mental health community teams in place	Q1 2016/17	CCG
Re-procure advocacy service	Q1 2016/17	LA
Initial local area development of community links model	Q1 2016/17	Both
Establish working group to review DFG scheme	Q1 2016/17	Both
Procurement exercise following redesign of domiciliary care	Q2 2016/17	LA
Intermediate care redesign	Q2 2016/17	Both

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Delivery	By when?	Accountable partner*
Primary care and community services - Increase capacity and capability over 7 days at locality level	National announcement awaited	CCG
Integrate NHS 111 with Herefordshire's urgent care services	Mobilisation of new contract Q4 2016/17	CCG
Complete consultation exercise regarding Minor Injuries Units and Walk-In Centre	Q1 2016/17	CCG
New model of care for community hospitals	Q1 2017/18	CCG
Integrated single gateway for urgent care	Q1 2017/18	CCG
Single health and social care record	Q1 2018/19	Both

* Accountable partners are identified as Herefordshire Council (LA), Herefordshire CCG (CCG) or both.

10. GOVERNANCE AND ACCOUNTABILITIES

The Herefordshire Health and Wellbeing Board is responsible for agreeing the BCF plans and for overseeing delivery through quarterly reports from the Joint Commissioning Board.

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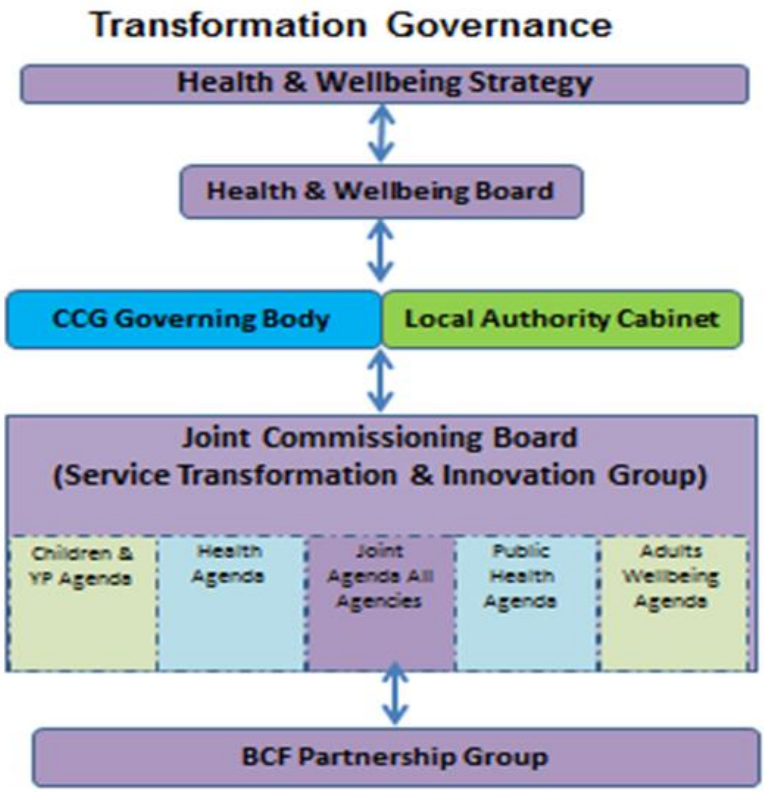

The BCF Partnership Group includes representation from provider organisations and is responsible for overseeing implementation of the action plan and for the continuing review and development of the fund.

Oversight and responsibility for the BCF is embedded within the Senior Leadership Team of both Adults and Wellbeing within the council and the Clinical Commissioning Group ***(B.3.i)***. In both cases this is in the form of a senior leader who is able to maintain the profile of this agenda and ensure linkages to wider health and social care matters as well as connection to the corporate council agendas in the case of Adults and Wellbeing

A dedicated multi-agency group (the Better Care Fund Partnership Group) is supporting focus and progression of the Better Care Fund and acts as the key problem solving vehicle and is accountable to the Joint Commissioning Board. The JCB will receive a monthly highlight report from this group with key decisions and issues being escalated to the board for resolution as appropriate

An integrated performance report has been developed and is shared with the Joint Commissioning Board on a monthly basis. Such **arrangements are in place to support joint working** ***(B.3.iii)*** and to enable a move to increasing alignment of our commissioning arrangements, including development of joint strategies and commissioning arrangements, in particular in relation to adult community health

and social care services including personal budgets, support to carers, care home market management, mental health and learning disabilities. The next stages of completion of our BCF section 75 agreement will include confirmation of the future ways of working to support delivery of our shared objectives ***(B.3.ii)***.

The proposed governance structure for the wider transformation programme can be located within the One Herefordshire report, in the appendices of this document.

11. INTEGRATION PLAN

Herefordshire has developed the One Herefordshire plan which is an alliance of all the health and social care organisations working together to address the fundamental issues facing our community.

The BCF plan is a key component and integral part of this overarching plan for Herefordshire.

Herefordshire has also agreed its STP footprint and governance arrangements as part of its relationship with Worcestershire, details of which can be found in the appendices. The One Herefordshire plan, which the BCF plan supports, is the central contribution on behalf of the county to the wider STP plan.

12. APPENDICES – SUPPORTING INFORMATION

One Herefordshire Plan As per submission two	**STP - Governance** As per submission two
2016/17 DTOC plan As per submission three	**JSNA – Evidence Base** As per submission two
Risk Register As per submission two	**Original BCF Plan** As per submission two