Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: Thursday, 11 June 2015

Committee:
Health and Wellbeing Board

Date: **Friday, 19 June 2015**
Time: **9.30 am**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Corporate Head of Legal and Democratic Services (Monitoring Officer)

Members of Health and Wellbeing Board

Karen Calder (Chairman)
Ann Hartley
Lee Chapman
Professor Rod Thomson
Stephen Chandler
Karen Bradshaw
Dr Caron Morton (Vice Chairman)
Dr Helen Herritty
Dr Bill Gowans
Paul Tulley
Jane Randall-Smith
Rachel Wintle

Your Committee Officer is:

Karen Nixon Committee Officer
Tel: 01743 252724
Email: karen.nixon@shropshire.gov.uk

AGENDA

1 Apologies for Absence and Substitutions

To receive apologies for absence and any substitutions that have been notified.

2 Disclosable Pecuniary Interests

Members are reminded that they must not participate in the discussion or voting on any matter in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

3 Minutes (Pages 1 - 8)

To approve as a correct record the Minutes of the previous meeting held on 8 May 2015, which are attached.

Contact Karen Nixon Tel 01743 252724.

4 Public Question Time (Pages 9 - 20)

To receive any questions, statements or petitions from the public, notice of which has been given in accordance with Procedure Rule 14.

5 Better Care Fund Update June 2015 - For Decision (Pages 21 - 40)

A report is attached.

Contact Stephen Chandler, Director of Adult Services Tel 01743 253704 or Dr Julie Davies, Director of Strategy and Service Re-Design 01743 277500.

6 Quality Premium Indicators 2015/16 - For Decision (Pages 41 - 48)

A report is attached.

Contact Sam Tilley, Head of Planning and Partnership, Tel 01743 277500.

7 Primary Care Co-commissioning Update - For Discussion

A report will be made.

Contact Dr Caron Morton, Accountable Officer, Shropshire CCG, Tel 01743 277500.

8 Community Hub Development - For Discussion (Pages 49 - 54)

A report is attached.

Contact George Candler, Director of Commissioning, Tel 01743 255003.

9 Health and Wellbeing Board Strategy Framework - For Information

A verbal update will be made.

Contact Stephen Chandler Director of Adult Services, Tel 01743 253704 or Bill Gowans, Vice-Chair Shropshire CCG Board, Tel 01743 277500.

10 Map of Maps Update - For Information

A verbal update will be made.

Contact Bharti Patel Smith, Director of Governance and Involvement, CCG, Tel 01743 277500.

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Committee and Date

Health and Wellbeing Board

19 June 2015

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING
HELD ON 8 MAY 2015
9.30 - 11.30 AM

Responsible Officer: Karen Nixon
Email: karen.nixon@shropshire.gov.uk Tel: 01743 252724

Present
Councillor (Chairman)
Councillors Lee Chapman, Professor Rod Thomson, Stephen Chandler, Karen Bradshaw, Dr Helen Herritty, Dr Bill Gowans, Rachel Wintle (substitute for Jackie Jeffrey) and Tim Barker (substitute for Ann Hartley)

Others in attendance;
Kerrie Allward, George Candler, Gerald Dakin, Lynne Deavin, Sue Ibbotson, Adrian Osborne (SATH),

1 **Disclosable Pecuniary Interests**

Members were reminded that they must not participate in the discussion or voting on any matter in which they had a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

2 **Apologies for Absence and Substitutions**

Apologies for absence were received from Karen Calder, Caron Morton, Paul Tulley and Jackie Jeffrey.

Cllr Tim Barker substituted for Ann Hartley and Rachel Wintle substituted for Jackie Jeffrey, VCSA.

In the absence of the Chair and Vice-Chair, Cllr Lee Chapman was appointed as Chairman for the meeting.

3 **Minutes**

RESOLVED: That the Minutes of the meeting held on 27th March 2015 be approved as a correct record and signed by the Chairman.

4 Public Question Time

Members of the Board received a written copy of the responses to the four questions posed by Mr David Sandbach under Public Question Time (copy attached to the signed minutes) and the Board thanked Mr Sandbach for his questions.

The Board agreed that the topic of health hubs was an important issue for the prevention element of the health agenda and enabling the community to manage conditions. The Board discussed the potential of redesigning library services and the opportunity that this created for community-based prevention initiatives. It was emphasised that the plans for Future Fit included a community hub element as an integral part of addressing the wider determinants of health and that community resources needed to be citizen led.

It was emphasised that a unified Health and Wellbeing Strategy was required to address community-based challenges in Shropshire. Ongoing conversations would include discussion about Health and Library Services working together and include health in hub development discussions.

5 Better Care Fund - Update and Performance

The Director of Adult Services presented the programme update for the Better Care Fund (copy attached to the signed minutes). Members of the Board were asked to note the content of the report and the provision of a draft ‘Conflict of Interest’ policy. Board Members were asked to provide comment on the draft policy to Kerrie Allward and Stephen Chandler.
The Board agreed that the report and draft policy were an excellent start and thanked the Director of Adult Services and the team for their work.

RESOLVED:

That the content of the report be noted by the Board and that comments or amendments to the draft ‘Conflict of Interest’ policy be provided.

6 Mental Health Crisis Care Concordat (MHCCC) Update Report

Louise Jones, Commissioning Lead Mental Health and LD, Shropshire CCG, presented a report into the Mental Health Crisis Care Concordant (copy attached to the signed minutes). It was illustrated that the Crisis Care Concordant set out how organisations would work together and better in order to improve outcomes for those with Mental Health issues. The four key areas of access to support before crisis point, urgent and emergency access to crisis care, the right quality of treatment and care when in crisis and recovery and staying well, and preventing future crisis were emphasised. Key actions included the piloting of a Mental Health Crisis Helpline, improving access for young people and developing improved coordination of crisis responses across agencies. It was noted that the new Mental Health Crisis Helpline went live in April 2015.

The Board discussed the content of the report and highlighted the importance of prevention in developing emotional resilience amongst individuals and the community, particularly amongst young people and families. The importance of parity of esteem between mental health and physical health was stressed. Building community capacity was discussed as having a key role in prevention and ensuring mental health and wellbeing.

It was raised that the voluntary and community sector could have been better consulted on the development of the Crisis Care Concordat. With a key role in providing mental health services, the voluntary and community sector alongside Healthwatch wished to have had more opportunity to have been involved in the development of the Crisis Care Concordat and development of the action plan.

It was queried if a member of the Mental Health Trust had been invited to attend the Health and Wellbeing Board meetings. It was stated that the Chair had been trying to establish a working relationship with non-executive leads at all Trusts and would be following up that opportunity. It was also detailed that the Mental Health Trust had not signed up to the VCSA Compact but that the newly developed Health and Wellbeing Communication and Engagement Strategy would require this action.

The issue of the de-commissioning of Rapid Assessment Interface and Discharge (RAID) within Telford & Wrekin was raised as an issue of potential health inequality for Shropshire residents living close to the Telford area. Healthwatch stated that they were already working to investigate this issue and would return to the Board with information and an update in the near future.

The Board requested more information about measures of success for the action plan. It was agreed that the action plan and development work would return to the Board at a future meeting to provide an update on the impact of the Helpline and other measures. Louise Jones agreed to share the Helpline telephone number with all Board Members in order to increase promotion of the service.

The Board thanked Louise Jones for the report.

RESOLVED:

a. That the Board noted the report and developing action plan.
b. That attendance of the Mental Health Trust at future Health and Wellbeing Boards be followed up.
c. That Healthwatch return to the Health and Wellbeing Board with a report on the impact of de-commissioning of RAID services in Telford & Wrekin.
d. That Louise Jones return to the Health and Wellbeing Board with an update report in the future.
e. That Louise Jones would circulate the Helpline telephone number to all Members of the Board following the meeting.

7 Care Act Update

The Director of Adult Services explained that the statutory changes around the Care Act had strengthened the rights of carers. It was explained that the Care Act has two phases of implementation and that the next phase would affect people

currently funding their own care when a cap on care costs takes effect from April 2016. Preparation to implement the changes were currently underway. It was stated that Shropshire Council was acting as a national leader in the transformation of Adult Services.

It was discussed that there was a risk in seeing the Care Act as something separate and distinct from the rest of the work across the health and wellbeing economy. The Health and Wellbeing Board needed to be aware of the changes through the Care Act and how Shropshire Council would develop services. The Board was asked to consider the report and progress made to date (copy attached to the signed minutes).

The Board congratulated the Director of Adult Services on the work thusfar to transform Adult Services. The Board discussed the importance of taking an asset-based approach to health and wellbeing and seeing the Care Act as an integral part of what we did and taking its vision as a steer for behaviour. It was agreed that this will be important for the Health and Wellbeing Strategy.

RESOLVED: That the recommendations be agreed.

8 **Shropshire Pharmaceutical Needs Assessment**

The Director of Public Health presented the final report (copy attached to the signed minutes) of the Shropshire Pharmaceutical Needs Assessment (PNA). The Board had previously considered an earlier draft of the report. The Director of Public Health explained that the consultation period for the draft document had now ended and that received feedback had been included in this updated version. It was explained that the PNA is a new responsibility for the Health and Wellbeing Board, but that the commissioning of pharmacy services remains the responsibility of NHS England who will utilise the report’s information and recommendations.

The Director of Public Health thanked the Local Pharmaceutical Committee for its support in collating the returns from pharmacies. It was stated that the creation of the PNA involved a significant exercise in collaboration, alongside the work of Shropshire Public Health, noting the involvement of Tracy Savage from the CCG.

It was emphasised that pharmacies had a key role in health promotion and prevention in diverting individuals from using emergency services when other services may be more suitable. The Board discussed how pharmacies should be fully networked into the health and care system, but it was understood that this was a challenge and required the leadership of the Health and Wellbeing Board in bringing together agendas.

There was discussion about completing a ‘lessons learnt’ exercise around the process of creating the PNA. It was suggested that it would be helpful if all parties who were involved could note their commitment to undertaking this exercise and report back to the Board in the future.

RESOLVED:

a. That the recommendations, as tabled in the report, be agreed.
b. That a 'lessons learnt' exercise around the process of creating the PNA to be completed by those parties involved in the formation of the document.

9 **Healthy Child Programme**

Lindsay MacHardy, Associate Director of Public Health Performance, presented a report (copy attached to the signed minutes) on the Healthy Child Programme. It was explained that recent changes included Public Health taking responsibility for the commissioning of the School Nursing service as of April 2015, and that from October 2015, it would also take commissioning responsibility for Health Visiting services. The report also detailed work underway to bring together services such as School Nurses, Health Visitors, the Family Nurse Partnership and Children's Centres in order to reduce duplication and to find any opportunities for improved provision. It was emphasised that the team were looking to streamline and integrate services where possible.

It was highlighted that many programmes were showing positive improvement on health and wellbeing including reduced numbers of women smoking during pregnancy, the beginning of a change in trends of child obesity and successful programmes such as TaMHS and Early Help.

It was stated that locality reports were key for developing services for children and young people and that it would be useful for the developing JSNA to include these in order to ensure that young people get the best start in life. Accident prevention across the lifecourse was also highlighted as a key area for development by the Board and it was requested that the Board make a focus upon this topic.

It was also suggested that there was a key role for partners including the Voluntary and Community Sector, providers such as Shropshire Community Health NHS Trust, the CCG and others to work together to contribute towards improvements.
The Board discussed the role of creating a new forum for these discussions, but it was suggested that there were existing forums through the Children's Trust or Family Solutions that might be able to adopt these roles and investigate the suggestions posed in the report.

The Board thanked Lindsay MacHardy for the report.

RESOLVED:

a) That the Board welcomed the report and discussed key 'areas' for ensuring children and young people received the best start in life.

b) That further investigation of existing forums to assess the recommendations and priorities proposed in the report be made.

10 Health and Wellbeing Programme Update

This report was presented by the Chief Officer of Healthwatch Shropshire (copy attached to the signed minutes). The Board had already read an earlier draft of the strategy and action plan and it was explained that changes had been made as the result of a consultation and feedback received. It was made clear that the action plan was a draft document to be shaped by the operational group who were to be elected to continue the communication and engagement work on behalf of the Health and Wellbeing Board.

It was explained that a patient experience group was to be restarted with the intention that as well as having membership from the health sector and voluntary and community sector, it would also include representation from Shropshire Council.

The Board commended the Task & Finish Group on the work that had been completed on behalf of the Health and Wellbeing Board. It was stated that the composition of the operational group to continue the communication and engagement work should include representation across all partners involved in health, social care and wellbeing. The operational group would require a clear understanding of its intention and it was stressed that keeping the message as simple wherever possible was preferable. The process of delivering messages and seeking responses around health and wellbeing must not add a level of bureaucracy and instead must free people to deliver help and guidance.

The Board discussed the importance of how messages around health and wellbeing were everyone's responsibility and that communities must be empowered to be able to take responsibility for their health.

RESOLVED:

a. That the Board approved the final draft of the Strategy

b. That membership of the future Communication and Engagement Operational Group should come from all partners across the health and wellbeing economy and therefore all partners would be invited to participate on the Operational Group

c. That the Communication and Engagement Task & Finish Group should invite all partners to nominate membership of the Operational Group. The Operational Group would continue the work around communications and engagement on behalf of the Health and Wellbeing Board and would continue to formulate the action plan.

11 Public Health Annual Report

The Director of Public Health presented the Annual Report (copy attached to the signed minutes). The report would be published as widely as possible via digital format. The report outlined the achievements and challenges for the Public Health team and the Director of Public Health's message focused on reducing physical

inactivity and maximising volunteering opportunities for Shropshire residents, particularly those that involved physical activity.

During the Health and Wellbeing Board's Year of Physical Activity, it was stated that the Public Health team was focusing upon reducing physical inactivity and highlighting the physical health benefits such as reducing heart disease and stroke, as well as the mental health benefits. The work would also highlight the engagement activities underway.

Miranda Ashwell, Programme Lead for Physical Activity, would return to the Health and Wellbeing Board to update on how the Board could assist in promoting the message around physical activity and how it could influence partner organisations. The Director of Public Health stated that he would be looking to the Board and other partners for 'champions' to promote the message of physical activity.

The Voluntary and Community Sector reminded Board Members of the VCSA's Annual Assembly on the 20th May and reminded members that they would be encouraged to take part in the 'midday mile' walk taking place around Shrewsbury Town Football Club. The Board were also reminded of the Shrewsbury and Telford Hospital NHS Trust's 'Social Network' event taking place on Saturday 6th June where individuals were encouraged to run, walk or cycle a distance of 18 miles to raise money for the Lingen Davies Cancer Fund.

The Board also discussed the recent Health and Wellbeing Launch Event for the 'Year of Physical Activity' and congratulated the team on the good session.

The Board discussed how it was important to ensure that volunteering roles did not become akin to an unpaid job and that members were mindful that not too much was asked of volunteers.

RESOLVED:

a. That the report be noted and that the key focus for reducing physical inactivity was ensuring that employers were supported to enable their employees to be more physically active in the workplace in order that physical activity became a normal part of daily life.

b. That Board members be asked for their individual activity commitment as Champions.

Signed ………………………………………………… (Chairman)

Date:

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Health and Wellbeing Board, 19th June 2015
Public Questions – DAVID BEECHEY

I understand that there is a proposal for the introduction of local JSNAs and while this appears to be a good idea I would like to know how it would work in practice. In particular I would like to ask the following questions:-

1. **How is it intended to define 'local'? It has been suggested that some commissioning should be devolved to existing Local Joint Committees but these now only meet twice a year with limited admin support and no funding so how would this work?**

Answer:

The intention is to develop **Locality JSNAs or Locality Evidence Bases** using the 18 Place Plan area geographies. The Shropshire Place Plans include a wealth of rich information that inform us about local areas. The 18 Place Plans identify the infrastructure and investment needs within each community; and are aimed at ensuring that Shropshire Council and our partners understand the local priorities within each community and that resources can therefore be targeted appropriately. By drawing together the Place Plans, health and wellbeing data collected by public services (including hospital, economic, environmental information), quantitative and qualitative information gathered through partner organisations including Healthwatch and VCS organisations, and through our own surveys and engagement processes, we can begin to build a rich picture of each area to support the targeting of resources and to support the development of communities.

We are in the process of working out how we develop the Locality Evidence Bases and our level of ambition and ability to combine our resources needs to agreed and established. To inform this, scoping work will be carried out to establish the data that is currently contained within the Place Plans and the JSNA and the additional intelligence that is held by the council and our partners. It is envisioned that we can create a draft resource that can be consulted on internally and externally.

LJCs are an important part of Shropshire Council's locality commissioning approach and we envisage the Locality Evidence Bases as an important development to support LJCs decision making processes.

LJCS are meeting regularly with the majority of them using delegated funding to commission youth activity this year. Whilst LJCs may not have the grant making budget that they originally had, the council's vision for LJCs is to support the creation and maintenance of Resilient Communities through opportunities for locality commissioning.

2. **To what extent will parish and town councils be involved in the development of local JSNAs? These councils vary considerably in their size and capacity but they differ from VCS organizations in that they are statutory bodies that have tax raising powers which are (so far) unrestricted. If they are to be involved are there any plans, in conjunction with SALC, to provide training and capacity building and, possibly, to encourage clustering of councils to increase their effectiveness?**

Through combining information from across services and organisations based on the Place Plan area geography and by working with the Place Plans, we envisage town and parish councils to be at the heart of this developing evidence base. As described in the question we need to continue to work closely with Town and Parish Councils and SALC to understand local need. Capacity building is something that the HWBB is keen to support throughout our communities and there is an opportunity through the council's Transformation Challenge Award project to deliver a programme of capacity building training and support to town and parish councils and the VCS.

3. **Local neighbourhood plans are intended to identify priorities within local communities for the size and location of housing and other forms of development (including medical facilities) within their areas while place plans should identify priorities for expenditure of community infrastructure levies (CILs) arising from local housing developments. To what extent would these plans contribute to local JSNAs?**

As described above, Place Plans are a key component of the developing Locality Evidence Base/ JSNA. The intention is to draw together evidence from across Shropshire Council and all partners, including engagement and consultation information to inform decision making at a local level. Infrastructure planning, including housing and the environment, is a key element of this.

Health and Wellbeing Board, 19th June 2015

Public Questions – DAPHNE LEWIS, on behalf of the Patient & Public Engagement Committee (committee to the Board, Shropshire Clinical Commissioning Group).

QUESTION:

Have the HWBB, Public Health and the Local Authority considered whether the accessibility of Public Toilets in Shropshire, particularly in Shrewsbury, could lead to an increase in medical and psychological complications – with their attendant cost implications - amongst the population?

A number of Public Conveniences have closed in recent years, meaning there can be considerable distances between facilities (bearing in mind a few hundred yards can be a very long way to the aged or disabled). Existing facilities are not always easy to find, particularly for people with sight impairment.

There are huge numbers of patients in Shropshire whose quality of life is literally dependent upon speedy access to a safe and private facility. This need is likely to increase as our population ages, in particular with conditions such as prostate cancer, diabetes and IBS. The anxiety caused by people afraid to venture into town for fear of embarrassment will undoubtedly lead to other medical conditions both physical and mental.

Presumably the town has reduced the number of public conveniences on the basis of cost, but is this effective long term? Or would it be possible for the Local Health Economy to pioneer a scheme (Comfort Scheme?) where businesses are prepared to offer a toilet for public use. If they were to display a sticker on the door possibly bearing an NHS logo, that would imply the toilet is for use of patients, and would deter inappropriate use.

I raise this question based on personal experience of two family members who are afraid to leave the house for fear of being 'caught short'. This means there is very limited exercise in their lives, and very little enjoyment of shops and social interaction.

Daphne Lewis 09/04/15

Answer:

Thank you for your question regarding public conveniences. The Board understands that for many people concern of this nature are very important to their wellbeing. According to the NHS Choices website, urinary incontinence and IBS affects millions of people in the UK, with a number of causes (as you suggest in your question).

The Board would foremost encourage anyone with concerns of this nature to be in contact with their GP or health professional to discuss medical advice, if not already done so. There are a number of medical interventions plus practical advice that a GP can provide in order to

support people who have concerns. Some may be shy about discussing with GP, however it is an important issue that should not be dismissed.

The HWBB would like to encourage our older and/or vulnerable citizens, or those with a medical condition, to feel confident to access town centres. There are a number of possibilities for consideration:

Encouraging people to contact their GP, pharmacy or nurse for helpful advice;

- Investigate linking with other schemes such as Safe Places (described below) and Dementia Friends;
- Use our networks including town and parish councils and the Business Board to promote awareness of the public facilities and perhaps businesses that are happy for their facilities to be used.

An example of partnership working in Shropshire for vulnerable people is the **Safe Places** initiative:

> *'Safe Places' is a short term safe place for vulnerable people who feel threatened.*
>
> *How does it work?*
>
> *•Shops businesses and public buildings sign up to the project.*
>
> *•Staff are briefed in what to do if someone needs help.*
>
> *•The premises that sign up are provided with a sticker symbol that goes in a visible place in the window.*
>
> *•The scheme is supported by West Mercia Police. Local Police Community Support Officers are aware of where local Safe Places are.*
>
> *•People using the 'Safe Places' Project are given a card by the organisations involved which has the same Safe Places symbol as the window sticker. They add details of people to contact if help is needed. Cards can also be obtained from hatecrime@shropshire-disability.net or ann.shaw@westmercia.pnn.police.uk*
>
> *•If the person feels threatened or has a crime committed against them while they are out in the community they can come into any 'Safe Places' premises to ask for support.*

Town and Parish Councils are key stakeholders in any discussion regarding town centre facilities. Discussions regarding facilities may be included in community development discussions.

Health and Wellbeing Board, 19th June 2015

Public Questions – DAVID SANDBACH

Providing Clarity on the use of the term Community Hub developments -

We have used the descriptions of visions for Community Hubs from Shropshire Council's paper to this Health & Well-Being Board meeting and the Future Fit Clinical Design Workstream Final Report to initially assess their commonalities, opportunities and differences.

The assessment has shown that the overarching statement made within the Future Fit document – 'the Community Hub will be the place I go when I have a question or a problem' is shared by Shropshire Council in its aspirations. Other commonalities include an aspiration to create a gateway to a hub of services, a focus on prevention – supporting people away from crisis, a desire to utilise the resources and assets within communities to promote good health and well-being, and a recognised importance of effective signposting and referring activity as well as a sense that even if you're not quite sure what the problem is, someone at the Hub will want to try and help you.

Both visions describe the opportunity to bring health and social care services closer together, and both models rely on maximising opportunities within communities to create Hubs - we will all have to use existing resources to do this and to shape our services to best meet the needs of our communities.

The primary difference between the two models is that the one described within Future Fit is fundamentally focussed on health and tackling issues with our health system and Shropshire Council aspires to delivering a range of face to face services with an early help/preventative focus – libraries, customer service points, information, advice and advocacy – along with effective signposting to other activity. The two models have come from different organisations as a solution to tackling challenging issues within their areas of responsibility and it is only natural that these are focussed in this way. This difference will give clarity to future discussions on developing the two models and could actually be helpful in ensuring that they complement each other.

It will be clear from the documentation that this concept is still in development and the point raised in the question is key in this development. Essentially if we get this right individuals should not need to know the difference between these elements, they should know where they can go to access help and the schemes should work together to provide this.

Our communities are likely to already contain the assets and resources that are required to start creating Community Hubs and opportunities to do this should be harnessed and not lost. Evidence and intelligence should be used to inform the development of Community Hubs, e.g. the data that is being collected to support the thinking on how Resilient Communities can be created and maintained. As both Community Hub models are in the early stages of development, there is an excellent opportunity for joint working to deliver them within localities using existing assets and resources and shaping the services whose delivery will benefit residents in a myriad of ways.

The Health & well-Being Board may wish to recommend that further joint work between Shropshire Council, Shropshire CCG and communities is undertaken to fully understand the opportunities that exist to create Hubs as described and to pull in elements of the Resilient Communities activity – e.g. creating an evidence base for locality working, the Community Connector role – to create the best possible solutions for residents.

Please see Appendix A below for extracts of hub development documentation.

Q 1.

Community Hubs and Community Connectors Our Resilient Communities approach will be built around the development of "Community Hubs" which will act as "gateways" to a diverse range of local activities.

People involved in the Future Fit program have signalled the eventual introduction of "Health Hubs". Will Community Hubs and Community Connectors be the same as Health Hubs?

In principle Community Hubs development (both Council and CCG) is likely to be something to be considered on a locality by locality basis depending on local opportunities. As discussed above, the use of Community Hub currently has different emphasis for the Local Authority and the CCG. For Shropshire Council Community Hubs will be places that support early conversations with local residents that give them the best possible chance of accessing the support that they need within their communities – this support will no doubt, often be within the services and activity that make up a Health Hub. Each community is different and the assets available within it to create and deliver our visions of Community Hubs, Health Hubs and Community Connectors will vary. Working together to find those opportunities and make something out of them is the challenge we should rise to.

Community Connectors will connect people to the activity of the organisations present in their location and often these organisations and the services they deliver will be based in a hub environment. The Community Connectors role is different to that of service delivery through hubs and whichever organisation was delivering the role would be expected to knowledgeable about what is delivered or organised locally regardless of sector or theme.

Q 2.

Who will pay for the Health Hubs?

As outline above Health Hubs is not a specific term used in the documentation. However, as the approach to Hubs is developed as set out in the response above the funding of this activity will be determined. As always the most efficient way of using resources will be paramount

Q 3.

I am getting older and worry about being confused when it comes to people trying to help me. So how will I know the difference between a community hub, a community connector and a health hub?

We jointly have to be clear at a strategic level about what each of things are for and what we expect them to achieve, making reference to how each complements the other. We then have to translate this through to localities to enable delivery on the ground. It's patently obvious that each 'resource' has to have a relationship with the other within each locality, that is meaningful and productive for the people using them, and it would be useful if each 'resource' was clearly and consistently identifiable to help people understand what they are and what their purpose is.

The most important thing is that the people looking for help in their communities find it as quickly and easily as possible. This is equally dependent on effective communication between locality based 'resources' such as hubs and community connectors to ensure quick and easy signposting and referring take place, as it is on the right help being available.

The activity of the Community Connector in making and encouraging 'warm referrals' and linking people up to the good things that are in their communities, is really important is supporting this effective communication, which can be difficult to achieve.

Here are some of the key principles of the Community Connector role -

- Community Connectors will connect people to the activity of the organisations present in their location, e.g. all the voluntary and community groups, commissioned services, Shropshire Council, the town/parish council, health services, the police, fire and rescue service. The creation of a Local Community Directory will be key to this.

- Community Connectors should be supported to think of the best solutions for the people they are working with and not only what the organisation they are linked to can offer.

- There is a need for a change to the current culture in which services are delivered, if Community Connectors are going to achieve their full potential and community resilience accessed for the benefit of the people using those services.

- Community Connectors should not be located in or linked to solely one place in a locality, but have the ability to operate in all the suitable places where people go to do things, complementing any existing signposting or referral activity.

Appendix A

Extract from Shropshire Council's Community Hubs paper to the H&WBB May 2015

Our Resilient Communities approach will be built around the development of "Community Hubs" which will act as "gateways" to a diverse range of local activities. The effectiveness of community hubs in reaching the people who will benefit from them, will be maximised through the development of Community Connector roles. Residents coming into the hubs will get the right information and support at the right time – the right things often being something that family, friends and the community can offer and the right time being as early as possible. We know that we have to end a culture of people only being signposted into social care or health care provision that they then cannot access until they reach a certain eligibility level or have experienced a crisis.

Our approach is designed for everyone within their local community. We want to increase the demand on universal early advice, information and guidance provision and by having a very different conversation about what a person needs, how their need can be met and reducing demand on expensive specialised services at a later date.

Through the development of Community Hubs, Shropshire Council wants to work with partners to re-design existing face to face customer focused services and to use the transformation of our Libraries and Customer Service Points as a catalyst for change. While we recognise the importance of technological solutions in enabling remote access to services, we also know that face to face contact is vital to potentially vulnerable residents in order to give them the best chance of finding support within their community and reducing the need for expensive "professionally led" interventions. By having a very different conversation as early as possible about what a person needs and how their need can be met, we will reduce demand on expensive specialised services at a later date.

We will harness the existing energy and commitment of a range of partners, and develop community hubs as the natural home for cross-sector working and for the redesign of services around people. We will do this by:

- Creating vibrant inclusive sustainable places run by the community for the community
- Coordinating and building volunteer activity and supporting the growth of community led initiatives
- Transforming the way that information, advice and guidance, prevention and early help services are delivered by Shropshire health and social care partners.

What will the future look like?

The development of community hubs within the context of a resilient community approach will be part of the catalyst for changing how we:

- Maximise the opportunities for health care and social care integration in communities
- Integrate Adult Social Care (ASC) and Children & Young People's Services (CYPS) early help provision in communities and adopt a family approach
- Enable primary health and Community & Care Co-ordinators to effectively link into the wider community resources that will ensure that the most frail and vulnerable patients are supported
- Use and invest in the resources available in our communities to signpost/connect people to activities that they will enjoy and benefit from, e.g. through the community co-ordinator and community connector roles
- Make referrals into services and move people between services and community resources, i.e. stepping people up and down between different levels of support
- Utilise all the resources available in a community to address loneliness and to promote good health and well-being
- Build 'teams around the community' that will emphasise prevention and early help and will reduce the overall demand on the public sector.

Community Hubs, the spaces at the centre of this approach, aim to meet the needs of the people that they serve and to host a range of transformed services including libraries, Customer Service Points, information, advice and guidance, early help for adults and children, community health, community mental health, voluntary groups who are delivering

commissioned services and community groups providing local activity. All of this provision will adopt the ambition to involve all the local resources in helping people to find solutions to their particular issues.

We will know that we will have got this right when:

- Everyone agrees that living at home is normal and people live independently at home for longer
- People feel connected to their communities, know where they can go to get advice and can help others to get the advice that they need
- People are more active as they feel safe, welcome and that someone is looking out for them when they go out
- All the activity in and around the hub is intelligently designed and delivered, joined up and has a local flavour

Extracts from Clinical Design Workstream Final Report

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5.2.3. Empowered communities

The development of community hubs will provide a focus for community mobilisation. They will be experienced as a 'cared for', non-institutional environment, welcoming to everyone, whether there by appointment or 'walk in'. It will provide consistent services and activities which not only promote patient and community empowerment, but also enhance the quality and sustainability of local NHS acute, planned and long term condition services. The community hub will 'be the place I go when I have a question or a problem'.

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7.5 Community Hubs

Community hubs should have a number of characteristics and co-locations which would strengthen their connection with the local community and individual patients. This would not only provide a number of valuable community orientated services, but also improve the quality and sustainability of any co-located NHS acute, planned and LTC services. Community hubs would become 'the place I go when I have a question or problem'.

These characteristics should include:

- A 'cared for', non-institutional environment which was welcoming to everyone, whether there by appointment or 'walk in'.
- A strengthening of 'community spirit' which values the hub as an integral part of the local community (and which mitigates the risk of this being lost through a more strategic design and use of beds)
- Consistent services, many open 24/7, which are sustainable through achieving a 'critical mass'

- Local people involved in the design and running of the services which are built around an ‘asset based’ model of what already works well.
- A co-location of services carefully designed to improve the overall quality of acre in a cost efficient way
- A potential for tailoring services in different areas of the county according to demographic need
- An emphasis on prevention, self-management and patient empowerment
- More help for carers to help them cope, rather than purely the provision of respite
- A more timely access to expert opinion, responding earlier to need even if it is undifferentiated and of low acuity
- A way of doing things that reduces social isolation and enhances inter-generational mixing (e.g. co-locating Sure Start children’s services in an environment catering largely for the elderly).
- Enabling community services to be more effective and better integrated with services which require beds
- A range of community services which ‘waters down’ the tendency to base planning only on ‘beds’

Because of these characteristics, citizens and patients will want to come to a community hub for a variety of reasons:

- Prevention
- Addressing the wider determinants of health. The more the better!
- To experience a ‘cared for’ environment which tackles social isolation, and promotes making every contact count
- With an undifferentiated need
- ‘dis-ease’, anxieties, wants, crisis, etc
- Providing excellent navigation and signposting for medical, social and mental health needs
- Including the ability to check on appointments anywhere in the system
- Because ‘I’m anxious’
- Handled through contact with voluntary sector and only escalated to a health professional if required
- For LTC education to improve self-management in groups to provide economy of scale and a social environment
- For non-urgent, holistic, integrated assessments, including social, medical and mental health, possibly performed by a single generically skilled professional
- Community and care co-ordinator functions and skills might be well placed here
- To access an expert opinion which may not be directly available 24/7 but which can be signposted to or accessed remotely via ‘telehealth’

Extract from first Community Hospitals Cross Cutting Themes meeting – May 2014

The community hub functions would provide a more holistic environment in which (next to which / co-located with?) acute, planned and LTC care can be delivered. This would include:

Diagnostics

- Observation (6-12 hrs with clear escalation protocols)
- Pharmacy with ‘named responsible pharmacists’ for people with LTCs and networked urgent care functions)
- Place of safety
- Early follow up after discharge from hospital
- Planned care remote consultations
- DAART facilities – ‘comprehensive geriatric assessment’ as part of UCC service and as a referral destination following assessment elsewhere
- Beds for re-ablement. Although reablement at home would be the default, there are patients with a slower trajectory of recovery, who cannot yet transfer safely, whose comorbidity persists or whose level of confusion means they don’t stay in bed who will require bed based care for a short period. The potential for networked care utilising
- private sector (care home) beds and minimising beds at community hospitals was discussed (to be continued at next meeting).
- Co-location of teams including community nursing, social care and community mental health teams who work in different care settings and follow the patient in their journey.
- A ‘skills lab’ providing generic health care training to everyone who wants it, including HCA’s, carers, volunteers, care home staff etc. This has the potential for income generation and achieving academic standing to enhance quality, sustainability, recruitment and retention.

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Agenda item 5

Shropshire Clinical Commissioning Group

Health and Wellbeing Board
19 June 2015

BETTER CARE FUND UPDATE JUNE 2015

Responsible Officer Stephen Chandler
Email: stephen.chandler@shropshire.gov.uk

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1. Summary

The Better Care Fund was officially launched in April 2015 as a mechanism for developing and improving commissioning between health and social care. The Health and Wellbeing Board will be familiar with the Better Care Fund Plan developed with Health & Wellbeing stakeholder involvement to take forward our local vision for the Fund and approved in the autumn of 2014. As part of developing joint working a Conflict of Interest policy was presented to the Board in May for comments and amendments. No further amendments have been requested in relation to this policy it is therefore presented to the Board today for approval. (See appendix A for the Shropshire HWB Conflict of Interest Policy)

In addition a performance report is presented to the Health & Wellbeing Board for information. This performance report sets out performance against the BCF suite of metrics as at 5 June 2015. Further work is planned to refine and develop this performance report and regular updates will be brought to the Board. (See appendix B for the BCF performance report).

2. Recommendations

- The Health & Wellbeing Board note the content of the report and that no requests for amendments have been received since the last Board meeting
- The Health and Wellbeing Board approve the HWB conflict of interest policy
- The health & Wellbeing Board to note the content of the performance report

REPORT

3. Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

The BCF plan contains a comprehensive account of the work to be undertaken and risks are monitored via the BCF sub groups

4. **Financial Implications**
   A comprehensive financial plan has been developed alongside the BCF narrative approved by the Health & Wellbeing Board. The budget continues to be managed within agreed parameters

5. **Background**
   Further to the report presented at the May Health & Wellbeing Board the attached Conflict of Interest Policy sets out the governance arrangements associated with the administration of the Better Care Fund plan and associated finances

   The attached performance report sets out an update performance position following on from the report presented at May's meeting

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) **Cllr Karen Calder**
Local Member **Covers all constituencies**
Appendices Appendix A – Partnership Agreemnet Appendix B – BCF Performance

Document Title	Shropshire Health & Wellbeing Board Conflicts of Interest policy
Version	V2 Draft
Document Owner	Kerrie Allward, Better Care Fund Manager
Date of Approval	
Approval Committee	
Date policy is due for review	October 2015
Summary	This policy sets out how NHS Shropshire Clinical Commissioning Group (SCCG) and Shropshire Council (SC) will manage conflicts of interest arising from the operation of the Health and Wellbeing Board (HWBB) and the Better Care Fund (BCF). The Target audience is members of the Health and Wellbeing Board and its sub-committees, SCCG and SC employees involved in commissioning, contracting, procurement processes and decision making in relation to the Better Care Fund

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Health & Wellbeing Board Conflicts of Interest Policy v1 Draft

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1. Purpose and scope

1.1. This policy sets out how NHS Shropshire Clinical Commissioning Group (SCCG) and Shropshire Council (SC) will manage conflicts of interest arising from the operation of the Health and Wellbeing Board (HWBB) and the Better Care Fund (BCF).

1.2. This policy, which incorporates the NHS England guidance published in December 2014, applies to members of the Health and Wellbeing Board and its sub-committees, SCCG and SC employees involved in commissioning, contracting, procurement processes and decision making in relation to the Better Care Fund (for the purposes of this document they will be known as relevant individuals).

1.3. The aim of this policy is to protect both organisations/the Health and Wellbeing Board and the individuals involved from any appearance of impropriety and demonstrate transparency to the public and other interested parties.

1.4. It is the responsibility, of all relevant individuals to familiarise themselves with this policy and comply with its provisions.

1.5. Relevant individuals should also refer to their respective codes of conduct and in particular the HWBB Code of Conduct.

2. Introduction

2.1. Managing conflicts of interest is essential for protecting the integrity of SCCG and SC

2.2. Conflicts of interest are inevitable in many aspects of public life. However, by recognising where and how they arise and dealing with them appropriately, the HWBB and its members, will be able to ensure proper governance, robust decision making, and appropriate decisions about the use of public money.

2.3. Where an individual, i.e. an employee, Board member, or a member of a committee or a sub-committee of the Board has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this policy.

3. Statutory requirements

3.1. As required by section 14O (conflicts of interest) of the National Health Service Act 2006, as inserted by section 25 of the 2012 Act, the HWBB "will make arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the group will be taken and seen to be taken without any possibility of the influence of external or private interest."

3.1.1. Maintain an appropriate registers of interests, which will be published to our website and made available on request;

3.1.2. Ensure individuals declare any conflict or potential conflict in relation to a decision to be made by the Board, and record them in the register as soon as they are declared, and within 28 days;

3.1.3. Have arrangements, as set out in this policy, for managing conflicts of interest and potential conflicts of interest in such a way as to ensure that they do not, and do not appear to, affect the integrity of the Board's decision-making processes.

3.1.4. Have regard to guidance published in relation to conflicts of interest.

3.1.5. Will not award a contract for the provision of services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract

3.1.6. Will keep, and publish, a record of how it managed any such conflict in relation to contracts it enters into.

4.0 Standards of business conduct

4.1. The employees, members, committee and sub-committee members of the Board (and its committees) should act in good faith and in the interests of the Board and should follow the *Seven Principles of Public Life*, set out by the Committee on Standards in Public Life (the Nolan Principles):

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honest
- Leadership

4.2. Individuals contracted to work on behalf of the Board, or otherwise providing services or facilities to the Board, will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract.

5.0 Conflict of interest: definition

5.1 A conflict of interest occurs where an individual's ability to exercise judgement or act in one role is, or could be, impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise. A *potential* for competing interests and/or a *perception* of impaired judgement or undue influence can also be a conflict of interest.

5.2. Conflicts can arise from an indirect financial interest (e.g. payment to a spouse) or a non-financial interest (e.g. kudos or reputation). Conflicts of loyalty may arise (e.g. in respect of an organisation of which the individual is a member or has an affiliation). Conflicts can arise from personal or professional relationships with others, e.g. where the role or interest of a family member, friend or acquaintance may influence an individual's judgement or actions or could be perceived to do so.

5.3. For individuals involved in commissioning, a conflict of interest may, therefore, arise when their own judgment as a commissioner could be, or be perceived to be, influenced and impaired by their own concerns and obligations as a provider, as a member of a particular peer, professional or special interest Board, or as a friend or family member.

5.5 A conflict of interest will include:

5.5.1. **A direct pecuniary interest:** where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);

5.5.2. **An indirect pecuniary interest:** for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;

5.5.3**. A non-pecuniary interest:** where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract);

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5.5.4. **A non-pecuniary personal benefit:** where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house);

5.5.5. **A close relationship with an individual or organisation with an interest:** Where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.

5.6. Below are some examples of what might constitute a conflict of interest within these categories:

5.6.1. **Direct pecuniary interest:** The individual is a GP with a Special Interest or has a partner working in a Care Home with whom the BCF might contract for beds.

5.6.2. **Indirect pecuniary interest:** Substantial shareholder in a company that might bid for a BCF contract.

5.6.3. **Non-pecuniary interest:** Trustee of a charity that might provide services for the BCF.

5.6.4. **A non-pecuniary personal benefit:** Living next door to a busy care home that might lose a contract with the BCF thus resulting in less traffic.

5.6.5. **A close relationship with an individual or organisation with an interest:** A friend runs a company that seeks a contract with the BCF.

5.7. Members' declarations should include the following:

5.7.1. Directorships, including non-executive directorships, held in private companies or PLCs;

5.7.2. Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the HWBB;

5.7.3. Shareholdings (more than 5%) of companies in the field of health and social care;

5.7.4. A position of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care;

5.7.5. Any connection with a voluntary or other organisation contracting for NHS services;

5.7.5. Research funding/grants that may be received by the individual or any organisation in which they have an interest or role;

5.7.6. Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the HWBB.

5.8 It is important that individuals remember that:

5.8.1. A *perception* of wrongdoing, impaired judgement or undue influence can be as detrimental as them actually occurring;

5.8.2. If in doubt, it is better to assume a conflict of interest and manage it appropriately, than to ignore it;

5.8.3. For a conflict to exist, financial gain is not necessary.

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6.0 Principles for managing conflicts of interest

6.1 Conflicts of interest will be managed by the HWBB, in line with the following underpinning principles, which will be applied at all stages of the commissioning process.

6.1.1 **Doing business properly appropriately.** The HWBB will endeavour to ensure needs assessments, consultation mechanisms, commissioning strategies and procurement procedures are right from the outset, making conflicts of interest much easier to identify, avoid or deal with, because the rationale for all decision-making will be transparent and clear and should withstand scrutiny.

6.1.2 **Being proactive not reactive.** The HWBB will seek to identify and minimise the risk of conflicts of interest at the earliest possible stage and ensure appropriate action is taken. This will include considering potential conflicts of interest when individuals come into a decision-making role, and by ensuring individuals understand their obligations to declare conflicts of interest. Rules should assume people will volunteer information about conflicts and will exclude themselves from decision making where they exist, but there should also be prompts and checks to reinforce this. Please see sections 8 and 9 for more information.

6.1.3 **Assuming that individuals will seek to act ethically and professionally, but may not always be sensitive to all conflicts of interest.** There will be prompts and checks in place to reinforce the procedures outlined in this policy, recognising that while most individuals involved in commissioning will seek to do the right thing for the right reasons, they may not always do it in the right way because of a lack of awareness of the roles and procedures, insufficient information about a particular situation, or lack of insight into the nature of a conflict.

6.1.4. **Being balanced and proportionate.** HWBB policy and guidance is to be clear and robust but not overly prescriptive or restrictive. Rules should protect and empower people by ensuring decision-making is efficient, transparent and fair, not constrain people by making it overly complex or slow.

6.1.5 **Openness.** The HWBB will ensure early engagement with the public in relation to proposed commissioning plans.

6.1.6. **Responsiveness and best practice.** The HWBB will ensure that commissioning intentions are based on local health and social care needs and reflect evidence of best practice.

6.1.7. **Securing expert advice.** The HWBB will ensure that plans take into account advice from appropriate health and social care professionals, and will draw on commissioning support where appropriate.

6.1.8. **Engaging with providers.** The HWBB will ensure early engagement with both incumbent and potential new providers over potential changes to the services commissioned for the local population.

6.1.9. The HWBB will **create clear and transparent commissioning specifications** that reflect the depth of engagement and set out the basis on which any contract is awarded.

6.1.10. The HWBB will **follow proper procurement processes and legal arrangements**, including even-handed approaches to providers.

6.1.11. The HWBB will **ensure sound record-keeping, including an up to date register of interests**.

6.1.12. The HWBB will have a **clear, recognised and easily enacted system for dispute resolution**.

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7.0 Maintaining a register of interests and register of procurement decisions

7.1 The HWBB will maintain a register of the interests of the members of the Board and the members of its committees or sub-committees and individuals engaged in commissioning activity on behalf of the Board.

7.2 When entering an interest on the register of interests, the HWBB will ensure that it includes sufficient information about the nature of the interest and the details of those holding the interest.

7.3. The register will be made available for inspection at the following locations:

7.3.1. The register will be published on the Council's 'Shropshire Together' website: http://www.shropshiretogether.org.uk/

7.3.2 The register(s) will also be available on request for inspection at the Council headquarters (address below) and upon application in writing to the following addresses:

7.3.3. By post: Shropshire Council, Shirehall, Abbey Forgate, Shrewsbury SY2 6ND

7.4. The full register of interests will be reviewed and updated regularly (at least every six months) and reviewed at least annually by the Health Overview and Scrutiny Committee.

7.5. The HWBB will maintain a register of procurement decisions taken, including:

7.5.1. The details of the decision;

7.5.2. Who was involved in making the decision (i.e. committee members and others with decision-making responsibility);

7.5.3. A summary of any conflicts of interest in relation to the decision and how this was managed by the HWBB.

7.5.4. The register of procurement decisions will be updated whenever a procurement decision is made.

8.0 Declaring and registering interests

8.1. The HWBB needs to be aware of all situations where an individual has private interests which have the potential to result in a conflict of interest. All individuals identified in paragraph 1.2 must act in such a way as to avoid being placed in a position that creates a potential conflict between their private interests. All individuals must declare relevant and material interests to the HWBB.

8.2. Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the Board, in writing to the HWBB, using a standard declaration form as soon as they are aware of it and in any event no later than 28 days after becoming aware. (Notes on how to complete the form, and how it should be submitted are included on the form.)

8.3. Where an individual is unable to provide a declaration in writing, for example if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter.

8.5 Where individuals are unsure whether a situation gives potential for a conflict of interest, they should seek advice from the Chair of the Health & Wellbeing Board, who will obtain appropriate advice to inform a decision. If in doubt, the individual concerned should assume that a potential conflict of interest exists.

8.6 Any declaration of interest will be included in the HWBB register of interests.

8.7 Declarations of interest will be made and regularly confirmed or updated in the following circumstances:

8.7.1 **On appointment:** Applicants for any directly related appointment to the CCG or SC will be asked to declare any relevant interests. When an appointment is made, a formal declaration of interests will again be made and recorded.

8.7.2. **Quarterly:** All registered interests will be confirmed at least quarterly.

8.7.3. **At meetings:** All attendees will be asked to declare any interest that they have in any agenda item before it is discussed or as soon as it becomes apparent. Even if an interest is declared in the Register of Interests, it should be declared in meetings where matters relating to that interest are discussed. Declarations of interest will be recorded in minutes of meetings.

8.7.4. **On changing role or responsibility:** Where an individual changes role or responsibility with the CCG or SC, any change to the individual's interests will be declared.

8.7.5. **On any other change of circumstances:** Wherever an individual's circumstances change in a way that affects the individual's interests (e.g. where an individual takes on a new role outside the CCG or SC or sets up a new business or relationship), a further declaration should be made to reflect the change in circumstances. This could involve a conflict of interest ceasing or a new one materialising.

9.0 Managing conflicts of interest: general

9.1. Individual members of the Board, committees or sub-committees, and employees will comply with the arrangements determined by this policy for managing conflicts or potential conflicts of interest.

9.2. For every interest declared, either in writing or by oral declaration, arrangements will be put in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the decision making process. The arrangements will depend on the nature and extent of the conflict of interests, but may include:

9.2.1. If the conflict of interests is so material that it would be inappropriate for the individual to partake in discussions around the decision-making process, as well as the decision itself, then the individual concerned will be excluded from relevant meetings, or relevant parts of those meetings.

9.2.2. Where the conflict of interests makes it inappropriate for the individual concerned to participate in the decision-making, however it is deemed appropriate for the individual to partake in the discussion, then the individual will be able to attend the meeting, having declared their interest, and join in the discussion, but will not have a vote in relation to the decision.

9.3. The relevant individual arrangements for managing the conflict of interests, or potential conflicts of interests, will be discussed with the individual and followed up in writing as soon as possible after the declaration has been made. The arrangements will confirm the following:

9.3.1. When an individual should withdraw from a specified activity, on a temporary or permanent basis;

9.3.2. Any other specified actions or constraints.

9.4. Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity that is, or may be, connected with the declared interest, they have received

confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the HWBB.

9.5. Managing conflicts of interest: Meetings

9.6. Where an individual member, employee or person providing services to the Board is aware of an interest which:

9.6.1. Has not been declared, either in the register or orally, they will declare this at the start of the meeting;

9.6.2. Has previously been declared, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the Chair of the meeting, together with details of arrangements which have been confirmed for the management of the conflict of interests or potential conflict of interests.

9.7. The Chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

9.8. Where the Chair of any meeting of the Board, including committees, sub-committees, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the Deputy Chair will act as Chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the conflict of interests or potential conflicts of interests in relation to the Chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the Deputy Chair may require the Chair to withdraw from the meeting or part of it. Where there is no Deputy Chair, the members of the meeting will select one.

9.9. Any declarations of interests, and arrangements agreed in any meeting of the HWBB, committees or sub-committees, will be recorded in the minutes and published in the register of interests.

9.10. Where more than 50% of the members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interests or potential conflicts of interests, the Chair (or deputy) will determine whether or not the discussion can proceed.

9.11. In making this decision the Chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the Boards terms of reference. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the Chair of the meeting shall consult on the action to be taken. This may include:

9.11.1. Requiring another of the Board's committees or sub-committees, which can be quorate to progress the item of business; or if this is not possible,

9.11.2. Inviting on a temporary basis one or more of the following to make up the quorum so that the Board can progress the item of business:

9.11.2.1. An appropriate individual from one or more of the statutory members of the HWBB
9.11.2.2. A statutory member of a Health and Wellbeing Board in another locality

9.12. These arrangements must be recorded in the minutes.

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9.13. Managing conflicts of interest: Other transactions

9.14. In any transaction undertaken in support of the HWBB exercise of its commissioning functions (including conversations between two or more individuals, e-mails, correspondence and other communications), individuals must ensure, where they are aware of an interest, that they conform to the arrangements confirmed for the management of that interest. Where an individual has not had confirmation of arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in the course of that transaction, and declare that interest as soon as possible thereafter. The individual must also inform their line manager (in the case of employees) of the transaction.

9.15. The HWBB will take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared.

10.0 Managing conflicts of interest: contractors and people who provide services to the Board

10.1. Anyone seeking information in relation to procurement, or participating in procurement, or otherwise engaging with the HWBB in relation to the potential provision of services or facilities to the Board, will be required to make a declaration of any relevant conflict / potential conflict of interest.

10.2. Anyone contracted to provide services or facilities directly to the HWBB will be subject to the same provisions of this policy in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

10.3. The HWBB will manage conflicts and potential conflicts of interest when awarding a contract by prohibiting the award of a contract where the integrity of the award has been, or appears to have been, affected by a conflict.

10.4 The HWBB will keep appropriate records of how conflicts in individual cases have been managed.

11.0 Mitigating conflicts of interest

11.1. Where a conflict of interest exists, there are various ways in which the conflict may be managed, depending on its impact. The level of mitigating action will be determined by the Chair of the HWBB in consultation with the Chair of the Health Overview Scrutiny Committee, and in the case of an employee by the line manager.

11.2. This decision will be recorded either in the relevant minutes or in the register of interests and these documents will be shared with the individual making the declaration.

12.4 Where mitigation arises the Chair of the HWBB would be expected to conduct informal discussions with the individual concerned to ensure they fully understand the action requested of them, and they have an opportunity to seek clarity or raise concerns.

12.0 Transparency in designing and procuring services

12.1. The Board recognises the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The Board will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers.

12.2. The HWBB will ensure adherence to good practice in relation to procurement, will not engage in anti-competitive behaviour that is against the interest of patients, and will protect the right of patients to make choices about their health and social care. Good practice includes acting transparently, proportionately and

without discrimination and treating all providers and potential providers equally, in particular from not treating one provider more favourably than another on the basis of ownership.

12.3. The HWBB will publish a Strategy which will detail the Commissioning Intentions of the Board, and will:

12.3.1. Be compliant with The NHS (Procurement, Patient Choice and Competition) Regulations 2013, ensuring that service redesign and procurement processes are in line with the three main principles of procurement law, namely equal treatment, non-discriminatory and transparency. This includes ensuring the same information is given to all.

12.3.2. Ensure that potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services;

12.3.3. Ensure that service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way.

13.0 Responsibilities

13.1. The HWBB has overall responsibility for managing conflicts of interest and has delegated this responsibility to the Health and Wellbeing Coordinator, who will be responsible for:

13.1.1. Creating and maintaining the Register of Interest;

13.1.2. Ensuring that for every interest declared either in writing or by oral declaration, arrangements are in place to manage any conflict or potential conflict of interest to ensure the integrity of the HWBB's decision making process;

13.1.3. Recording in writing the means whereby such conflicts of interest will be managed within a week of its notification;

13.1.4. Communicating these means to the individual concerned on behalf of the chair of the relevant committee.

13.1.5. Ensuring that these means are available for inspection in the Register of Interests.

13.2. Oversight of the management of conflicts of interest will be provided by the Health Overview and Scrutiny Committee.

14.0 Breaches of the policy

14.1. If an individual fails to declare an interest or the full details of the interest, this may result in disciplinary action resulting in the individual being dismissed or removed from their role on the HWBB.

14.2. Any unwitting failure to declare a relevant and material interest or position of influence, and/or to record a relevant or material interest or position of influence that has been declared, will not necessarily render void any decision made by the HWBB or its properly constituted committees or sub-committees, although the HWBB will reserve the right to declare such a contract void.

15.0 Equality and Diversity Statement

15.1. At all times all those individuals who must comply with this policy will be treated equally and without discrimination, regardless of age, disability, gender reassignment, marriage or civil partnership, maternity or pregnancy, race, religion or belief, sex and sexual orientation.

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16.0 Monitoring compliance and effectiveness of the policy

16.1. The policy will be reviewed annually by the Health Overview and Scrutiny Committee. HWBB members will be reminded of the policy and register of interests at least quarterly.
16.2. Any new members of the HWBB or sub-committees will be made aware of this policy and the register by the Chair and copies/links made available for viewing.

17.0 References

1. Managing conflicts of interest: Statutory Guidance for clinical commissioning groups CCGs, NHS England, March December 2014
   http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf 3
   http://www.england.nhs.uk/wp-content/uploads/2013/03/manage-con-int.pdf
2. National Health Service Act 2012 http://www.legislation.gov.uk/ukpga/2012/7/enacted
3. National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013
   http://www.legislation.gov.uk/uksi/2013/500/pdfs/uksi_20130500_en.pdf
4. Committee on Standards in Public Life
   http://www.public-standards.gov.uk/
5. Substantive guidance on the Procurement, Patient Choice and Competition Regulations, Monitor
   https://www.gov.uk/government/publications/procurement-patient-choice-and-competition-regulations-guidance

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Shropshire Council

NHS Shropshire Clinical Commissioning Group

Shropshire together

Better Care Fund Performance Report - June 2015

BCF 1 - Non Elective Admissions:

		Jan - Mar 2015			Apr - Jun 2015			Jul - Sep 2015			Oct - Dec 2015		
2015/16		Actual	7199	G	Actual			Actual			Actual		
		Plan:	7250		Plan:	7174		Plan:	6551		Plan:	6654	
		Annual Plan 27,629								Cumulative to Date		7199	

BCF 2 - Residential Admissions

	Q4 2014/5	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	548.8												

Status			Forecast	

BCF 3 - Reablement: Data to be reported from Feb.

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15							R	A	A	A	A	A	
2015/16													

BCF 4 - Delayed transfers of care: delayed days

	Q4 2014/5	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	R	R											

Status	R		Forecast	R

BCF 5 - Patient / Service User Experience Metric. The next survey will be run Feb to June 2015.

	13/14 Baseline	14/15 Plan	15/16 Plan
Plan		**50%**	**70%**
Result	50.0%		
Num	146		
Denom	292		

BCF 6 - Local Metric

Local people admitted (unplanned) to Redwoods Hospital with a diagnosis of dementia as a proportion of those with a dementia diagnosis

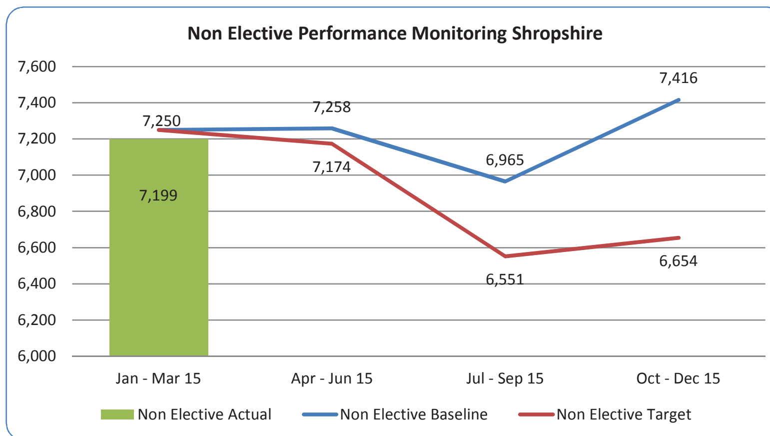
	13/14 Baseline	14/15 Plan	15/16 Plan
Plan		**1.4%**	**1.2%**
Result	1.6%	1.4%	1.2%
Num	41	40	38
Denom	2624	2936	3258

Summary:

BCF 1 - Non Elective Admissions

Emergency Admissions to hospital

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	
Historic & Projected	6,824	6,668	7,408	7,250	7,258	6,965	7,416	7,430	7,509	7,588	7,667	
Target								7,250	7,174	6,551	6,654	
Actual					7,227	6,973	7,446	7,199	0	0	0	



Rationale:

Performance Comments: Performance is better than the Q4 plan.
Queries: Revised baseline activity is still awaited for all contributing CCG's along with all P4P plans.
Cumulative performance plan is to achieve a reduction in Non Elective Admissions by **1260** during 2015.

Definition: Sum of Non Elective FFCE's for the Contributing CCG's as per the BCF Template. Source: Unify2.

RAG Rating - until confirmation is received the RAG rating is; Red = non elective admissions is over target - Green = non elective admissions is under target

Definition:

BCF 2 - Residential admissions

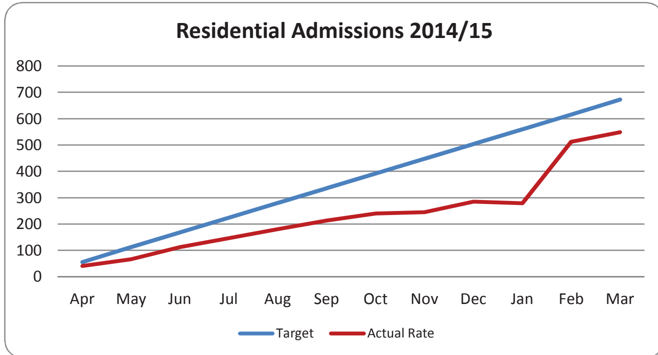
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 older population

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	52	104	156	208	260	312	364	416	468	520	572	623.7
Annual Rate	0	0	0	0	0	0	0	0	0	0	0	0
Number	0	0	0	0	0	0	0	0	0	0	0	0
Population	72635	72635	72635	72635	72635	72635	72635	72635	72635	72635	72635	72635

Status	

Forecast	

Data in accordance with new paperwork in line with the SALT Return is not available, at this stage.



Rationale: Avoiding permanent admissions into care homes is a good measure of delaying dependency. Our focus, therefore, is to keep admissions as low as possible, particularly inappropriate admissions.

Performance Comments: Performance for 2014/15 is better than target (which is now in accordance with the new SALT return) shows that we are performing well, keeping admissions low, and within target.

Definition:
Numerator: Number of older people aged 65+, admitted into permanent residential/nursing care, duting the year. Source: SALT Return.
Denominator: Total number of older people, aged 65+, in Shropshire. Source: ONS Mid Year Estimate.

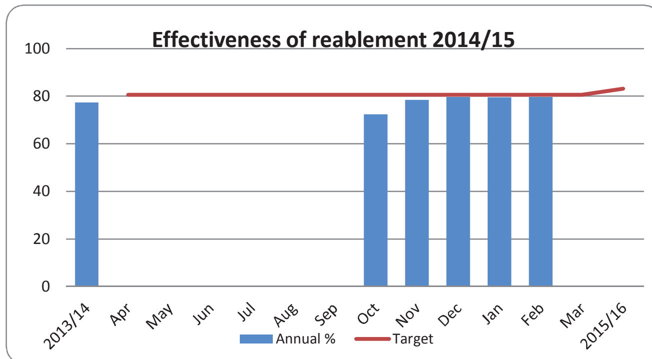
BCF 3 - Reablement

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement /

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	80.6	80.6	80.6	80.6	80.6	80.6	80.6	80.6	80.6	80.6	80.6	80.6
Annual %	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	72.4	78.5	79.7	79.5	79.7	#DIV/0!
Number	0	0	0	0	0	0	76	164	243	346	444	0
Population	0	0	0	0	0	0	105	209	305	435	557	0

Status	A

Forecast	A



Note: Data is **cumulative.**

Definition: Proportion of older people discharged from hospital into reablement services, who are still at home 91 days' later.
Numerator: Number of older people (65+), within the denominator, who are still at home 91 days' after their discharge.
Denominator: Total number of older people (65+) discharged from hospital into reablement services.

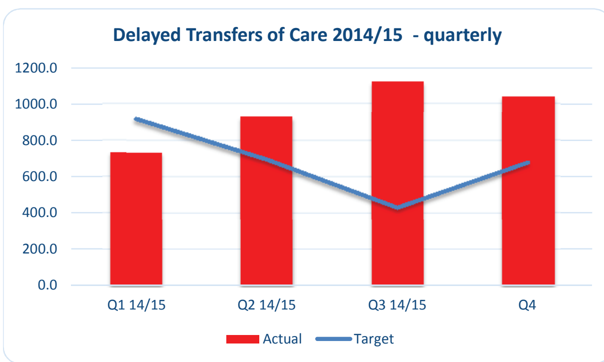
We are continuing to improve both the volume and effectiveness of our reablement service. Performance shown, is cumulative, since October, and we are close to (slightly below) target, as at end February. Performance in February is better than target. Continuation of this level of performance would change the year end forecast to green.

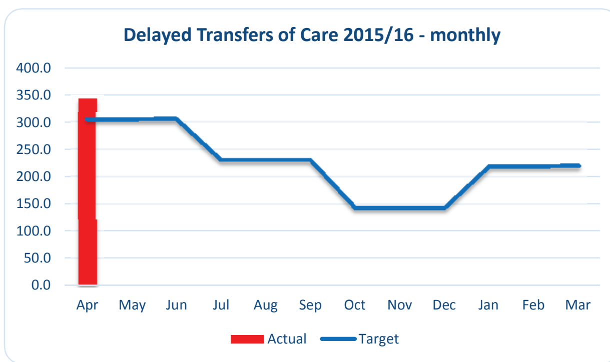
BCF 4 - Delayed transfers of care

Delayed transfers of care **(delayed days)** from hospital per 100,000 population (aged 18+). Reported one month in arrears.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	306	306	307	232	232	232	144	144	144	220	220	221
Monthly Rate	343.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Number	864	0	0	0	0	0	0	0	0	0	0	0
Population	251893	251893	251893	251893	251893	251893	251893	251893	251893	253354	253354	253354

	Q1	Q2	Q3	Q4
Target 15/16	919.4	696.7	432.7	661.9
Quarterly Rate	0.0	0.0	0.0	0.0
Number	0	0	0	0
Population	251893	251893	251893	253354





Rationale: This measures the effectiveness of joint working arrangements at the interface between Health and Social Care Services. Aim to keep delays to a minimum.

Performance Comments: Performance for the first reporting month of the year is worse than target.

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Agenda item 6

Shropshire Clinical Commissioning Group

Health and Wellbeing Board
19 June 2015

QUALITY PREMIUM INDICATORS 2015/16

Responsible Officer
Samantha Tilley, Head of Planning & Partnerships Shropshire CCG
Email: Samantha.tilley@shropshireccg.nhs.uk

1. Summary

The ‘quality premium’ is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reductions in inequalities in access and in health outcomes. Guidance relating to the Quality Premium Indicators for 2015/16 was received by Shropshire CCG on 31 March 2015.

The quality premium, paid to CCGs in 2016/17, reflects the quality of the health services commissioned by them in 2015/16 and will be based on measures that cover a combination of national and local priorities

The guidance stipulates that CCGs and Health & Wellbeing Boards should work together to agree two locally determined indicators that align with Health & Wellbeing priorities.

In addition to these local measures, the CCG Board has considered national measures. Their selections are also presented to the Health & Wellbeing Board for agreement.

2. Recommendations

National measures:

Urgent and Emergency care measures

The CCG has opted for both measures Ai and B, allocating 20% and 10% of the quality premium payment to each measure respectively.

Measure Ai - Avoidable Emergency Admissions Composite measure - a reduction, or a zero per cent change, in the annualised trended change in the Indirectly Standardised Rate of emergency admissions for these conditions over the 4 years 2012/13 to 2015/16. The CCG achieved an 11.5% reduction against this measure in 2014/15 putting it is a very strong position to achieve this quality premium measure.

Measure B – DTOC performance has been worse in 2014/15 than in the previous year. This allows a reasonable margin for improving performance in 2015/16 and achieving the measure

Following consideration the CCG felt it most appropriate to split the quality premium payment across two measures, but to weight the proportion towards the strongest indicator.

Mental Health measures

The CCG has opted for Measure A, allocating 30% of the quality premium payment to this measure.

Measure A – Reduction in the number of patients attending an A&E department for a mental health-related need who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.

Local measures
The following indicators are recommended to the Health & Wellbeing Board for approval on the basis of their alignment to the Health & Wellbeing and Better Care Fund priorities, the ability to make progress in year and the data available:

- People with diabetes diagnosed less than 1 year referred to structured education

Performance against this indicator allows room for improvement within 2015/16. Currently patients can be referred into the structured education programme by a GP, diabetic specialist or by self referral. The SCHT diabetic referral team currently record referrals and attendances and if this indicator is chosen this information can be shared on a monthly basis. This indicator also builds on the processes used for the COPD indicator chosen for 2014/15 so we would be embedding knowledge and understanding for our patient groups but also embracing a culture of referral to education for our patients from our practices. In addition, in year there are already plans to look at the way education is delivered for Diabetes and therefore this also aligns with our commissioning intentions and the national focus on Diabetes.

- Hip Fracture: Multifactorial risk assessment of future falls

This work aligns to the work already in train for the prevention strand of the Better Care Fund. Our current performance allows room for improvement and a significant number of CCG's are achieving 100%. There are proposals being considered for the further development of our falls provision which would support this indicator. However, some focused work with key provider staff to ensure the universal use of multifactorial assessment could increase our performance in this area without further investment.

REPORT

Context

The 'quality premium' is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reductions in inequalities in access and in health outcomes. Guidance relating to the Quality Premium Indicators for 2015/16 was received by Shropshire CCG on 31 March 2015.

The quality premium, paid to CCGs in 2016/17, reflects the quality of the health services commissioned by them in 2015/16 and will be based on the following measures that cover a combination of national and local priorities. These are:

1) **Reducing potential years of lives lost through causes considered amenable to healthcare** (10 per cent of quality premium);

2) **Urgent and emergency care**-a menu of measures worth 30 per cent of the quality premium. CCGs can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

3) **Mental health**- a menu of measures worth 30 per cent of the quality premium. CCGs can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

4) **Improving antibiotic prescribing in primary and secondary care** (10 per cent of quality premium);

5) **Two local measures** which should be based on local priorities such as those identified in joint

health and wellbeing strategies (20 per cent of quality premium -10 per cent for each measure).

The guidance stipulates that CCGs and Health & Wellbeing Boards should work together to agree the two locally determined indicators that align with Health & Wellbeing priorities. Following lengthy consideration of the local measures recommended in this paper including input from the CCG Board and the Health & Wellbeing Delivery group, this report sets out two recommended indicators from a range of options

In addition to these local measures, the CCG Board has considered measures in categories 1-4 and their selections are also be presented to the Health & Wellbeing Board for agreement. Further details of these are set out below.

The health & Wellbeing Board should note that Quality premium measures 1 and 4 (Reducing potential years of life lost and antibiotic prescribing) are fixed requirements and as such the CCG Board has to accept these measures.

Quality premium measures are usually taken from the overall prescribed CCG Outcome Indicator Set (CCG Outcome Indicator Set 2014/15: technical guidance) However, CCG's can choose to develop their own local measure linked to referral or demand management subject to approval from NHS England. It is not proposed on this occasion that a locally developed measure outside the indicator set be adopted.

The Measures for consideration

Urgent and emergency care
The following menu of measures is worth 30 per cent of the quality premium. CCGs can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

<u>A) Avoidable Emergency Admissions Composite measure</u>

ii) a reduction, or a zero per cent change, in the annualised trended change in the Indirectly Standardised Rate of emergency admissions for these conditions over the 4 years 2012/13 to 2015/16 ; or

ii) the Indirectly Standardised Rate of admissions in 2015/16 at less than 1,000 per 100,000 population.

<u>B) Delayed Transfers of Care (DTOC) which are an NHS responsibility</u>

<u>C) Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.</u>

Mental Health
The following menu of measures is worth 30 per cent of the quality premium. CCGs can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

A) <u>Reduction in the number of patients attending an A&E department for a mental health-related needs who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.</u>

B) <u>Reduction in the number of people with severe mental illness who are currently smokers</u>

C) <u>Increase in the proportion of adults in contact with secondary mental health services who are in paid employment.</u>

D) <u>Improvement in the health related quality of life for people with a long term mental health condition</u>

The following indicators were selected by the CCG Board:

Urgent and Emergency care measures

It is recommended that for this measure the CCG opts for both measures Ai and B, allocating 20% and 10% of the quality premium payment to each measure respectively.

Measure Ai - Avoidable Emergency Admissions Composite measure - a reduction, or a zero per cent change, in the annualised trended change in the Indirectly Standardised Rate of emergency admissions for these conditions over the 4 years 2012/13 to 2015/16. The CCG achieved an 11.5% reduction against this measure in 2014/15 putting it is a very strong position to achieve this quality premium measure.

Measure B – DTOC performance has been worse in 2014/15 than in the previous year. This allows a reasonable margin for improving performance in 2015/16 and achieving the measure

Following consideration the CCG felt it most appropriate to split the quality premium payment across two measures, but to weight the proportion towards the strongest indicator.

Mental Health measures

It is recommended that for this measure the CCG opts for Measure A, allocating 30% of the quality premium payment to this measure.

Measure A – Reduction in the number of patients attending an A&E department for a mental health-related need who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.

The CCG is already achieving both elements of this measure. However, it should be noted that as waiting times in A&E improve performance in relation to those patients with mental health issues will need to improve proportionality.

After consideration the CCG agreed that this was the only measure in the mental health section that should be considered due to lack of robust data or implementation issues relating to the other measures and therefore the full 30% payment has been allocated in this case.

The Local Measures for consideration

The guidance stipulates that CCGs and Health & Wellbeing Boards should work together to agree the two locally determined indicators that align with Health & Wellbeing priorities, these priorities are set out below.

Shropshire's Health & Wellbeing priorities as set out in the Health & Wellbeing Strategy are:
Priority 1 – Health Inequalities are reduced
Priority 2 - People are empowered to make better lifestyle and health choices for their own and their family's health and wellbeing
Priority 3 – Better emotional and mental health and wellbeing for all
Priority 4 - Older people and those with long term conditions will remain independent for longer
Outcome 5 - Health, social care and wellbeing services are accessible, good quality and 'seamless'

A review of the entire CCG Outcomes Indicator Set was carried out and those indicators which align with the Health and Wellbeing Strategy priority areas and work streams under the Better Care Fund were identified. Items where data was not available were removed from the list. The following indicators were considered in more detail:

- Hip Fracture: Incidence – the rate of people admitted with a primary diagnosis of hip fracture per 100,000 of population
- People with diabetes who have received the nine care processes
- People with diabetes diagnosed less than 1 year referred to structured education
- Hip Fracture: multifactorial risk assessment of future falls risk
- Alcohol admissions (primary diagnosis)
- Alcohol readmissions (primary diagnosis)
- Improving experience of healthcare for people with mental illness

Details of the latest available Shropshire CCG performance is set out below. The data is taken from the Health & Social Care information Centre.

Hip Fracture: Incidence – the rate of people admitted with a primary diagnosis of hip fracture per 100,000 of population
Hip fracture is the most common reason for admission to an orthopaedic trauma ward and the incidence is projected to rise.

In 2013/14 of 88,451 patients admitted to an orthopaedic trauma ward 219 were for hip fractures. This gives a standardized rate of 249.6 admissions per 100,000 of population. The standardized England average is 439.1. Shropshire is therefore performing considerably better than the England average

People with diabetes who have received the nine care processes
This indicator measures the percentage of patients with both type 1 and type 2 diabetes who have received the basic health checks for:

- Weight and BMI management
- Blood pressure
- Smoking status
- Blood tests
- Urinary albumin test
- Serum creatinine test
- Cholesterol levels
- Eye check
- Foot check

Since the indicator was published the eye check has been removed from the process so the measures include *eight* care processes

The following table sets out the Shropshire and England average positions. This data is taken from the National Diabetes Audit (NDA) by which performance would be monitored:

	2010/11	2011/12	2012/13
Shropshire CCG	52.0%	51.0%	54.4%
England & Wales	60.6%	60.5%	59.9%

Shropshire's performance has seen an overall improvement it is still below the England/ Wales average.

Although we know that some of our practices are underperforming against some of the NDA measures and steps are being taken to improve these the NDA use data that is 18 months old and it is therefore likely that any data used for performance against the quality premium indicator cannot not be influenced and will not be affected by improvements we make in 2015/16.

Smoking is one of our lowest scoring areas in relation to the 8 care processes. However, there is currently a discrepancy between the data codes used by the NDA and the practices in recording and reporting on this activity. Whilst discussions are taking place in relation to this we cannot be confident that this matter will be resolved in the timescale required to support choosing this quality premium indicator.

People with diabetes diagnosed less than 1 year referred to structured education
The most recent data is for 2011/12 and shows that of the 490 individuals diagnosed in that period, 9.8% were referred on to a structured education programme. Shropshire sits at 98th position out of 203 CCGs placing it at the top of the third quartile

Performance against this indicator allows room for improvement within 2015/16. Currently patients can be referred into the structured education programme by a GP, diabetic specialist or by self referral. The SCHT diabetic referral team currently record referrals and attendances and if this indicator is chosen this information can be shared on a monthly basis. This indicator also builds on the processes used for the COPD indicator chosen for 2014/15 so we would be embedding knowledge and understanding for our patient groups but also embracing a culture of referral to education for our patients from our practices. In addition, in year there are already plans to look at the way education is delivered for Diabetes and therefore this also aligns with our commissioning intentions and the national focus on Diabetes.

Hip Fracture: multifactorial risk assessment of future falls risk
For the 2013 calendar year 88.3% of patients with a hip fracture received a multifactorial assessment of future falls risk. Shropshire was 169th of 233 CCGs putting it in the bottom quartile for this indicator. 68 of the 233 CCGs were achieving 100%

This work aligns to the work already in train for the prevention strand of the Better Care Fund. Our current performance allows room for improvement and a significant number of CCG's are achieving 100%. There are proposals being considered for the further development of our falls provision which would support this indicator. However, some focused work with key provider staff to ensure the universal use of multifactorial assessment could increase our performance in this area without further investment.

Alcohol admissions
Data for this indicator is based on our Acute provider. Data for 2013/14 shows that of 299,002 patients 163 were admitted with a primary diagnosis of alcohol. The standardized rate per 100,000 of population is 52.8. This puts Shropshire in the top 20 performers against this indicator

Alcohol readmissions
Data for this indicator is based on our Acute provider. Date for this indicator is compiled on a rolling basis from April 2011 to March 2014 and gives us a standardized rate of 104.7 readmissions with a primary diagnosis of alcohol per 100,000 of population. This places Shropshire 72 out of 210 CCGs and puts us in the third quartile.

Improving experience of healthcare for people with mental illness
This indicator is based on SSSFT as the provider and is taken from the weighted average of 4 survey questions with scores out of 100.
For 2013 the England average performance was 85.8 with Shropshire's performance sitting above this at 86.4.

Recommendations
Having reviewed the indicators set out above, the available data and performance it is proposed that the following indicators be recommended to the Health & Wellbeing Board for approval on the basis of their alignment to the Health & Wellbeing and Better Care Fund priorities, the ability to make progress in year and the data available:

- People with diabetes diagnosed less than 1 year referred to structured education

Performance against this indicator allows room for improvement within 2015/16. Currently patients can be referred into the structured education programme by a GP, diabetic specialist or by self referral. The SCHT diabetic referral team currently record referrals and attendances and if this indicator is chosen this information can be shared on a monthly basis. This indicator also builds on the processes used for the COPD indicator chosen for 2014/15 so we would be embedding knowledge and understanding for our patient groups but also embracing a culture of referral to education for our patients from our practices. In addition, in year there are already plans to look at the way education is delivered for Diabetes and therefore this also aligns with our commissioning intentions and the national focus on Diabetes.

- Hip Fracture: Multifactorial risk assessment of future falls

This work aligns to the work already in train for the prevention strand of the Better Care Fund. Our current performance allows room for improvement and a significant number of CCG's are achieving 100%. There are proposals being considered for the further development of our falls provision which would support this indicator. However, some focused work with key provider staff to ensure the universal use of multifactorial assessment could increase our performance in this area without further investment.

3. Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

Those for a who have considered the Quality premium Indicators have done so on the basis of choosing those indicators which pose the least risk to the CCG and are the most likely to achieve

4. Financial Implications

There are no financial implications per se. Quality premium measures are paid in arrears and as such are not built into any financial planning assumptions until such time as they are realised

5. Background

Please see above report

6. Additional Information

7. Conclusions

Please see above report

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Cllr Karen Calder
Local Member **Applies to all constituencies**
Appendices -

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Agenda item 8

Health and Wellbeing Board
19th June 2015

COMMUNITY HUB DEVELOPMENT

Responsible Officer: George Candler – Director of Commissioning
Email: george.candler@shropshire.gov.uk Tel: 01743 255003 Fax:

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1. Summary

Shropshire Council and its partners see the development of Community Hubs as a significant opportunity to deliver integrated information, advice and guidance, prevention and early help services based on better outcomes for local residents. Shropshire Council's Business Plan and Financial Strategy 2014-17, Shropshire's Better Care Fund Plan, Shropshire Health & Wellbeing Strategy 2012, Children & Young People's Strategy 2012, Shropshire Council's CYPS Early Help services and ASC new operating model all contain references to, or are designed around the development of Community Hubs and Resilient Communities.

Investment from the DCLG's Transformation Challenge Award is supporting the redesign of existing face to face customer focused services, including libraries and Customer Service Points, to provide places that residents can easily get information and advice that both helps them and enables them to help others within their community. The development of Community Hubs is also a key tenet of the Resilient Communities scheme within the Better Care Fund Strategic Theme of Supporting People to Live Independently for Longer.

Investment in the development of Community Hubs will enable the building of 'teams around the community' that will emphasise prevention and early help and will reduce the overall demand on the public sector.

2. Recommendations

It is recommended that:

a. Members of the Health and Wellbeing Board comment on the progress to date and highlight further areas of opportunity

b. Request a further update on progress and how this links into the wider resilient communities agenda in 12 months time

REPORT

3. Risk Assessment and Opportunities Appraisal

The development of Community Hubs within the context of a Resilient Communities approach is purposely inclusive and community based. Indeed part of their success will come from their shaping and "ownership" at a local level.

Resilient Communities is a key theme within the Shropshire Better Care Fund and it is recognised that it is a foundation building block and enabler for all the other themes and ultimately for headline measures of success including reducing hospital admissions.

Within the context of the Better Care Fund and Transformation Challenge Award (TCA) funded Community Hub project a number of high level risks to the roll out of a Resilient Communities approach have been identified:

<table>
<tr><th>Risk</th><th>Mitigating action</th></tr>
<tr><td>Absence of clear unifying project vision and aims</td><td rowspan="6">Strong governance has been created to support and measure the success of the Better Care Fund themes of which Resilient Communities is one. Within this the Resilient Communities approach is being co-created and managed by a “Supporting People to Live Independently” group with representation drawn from Shropshire Council, the CCG and voluntary sector.

Investment in the redesign of the Council’s libraries and customer service points is being overseen by a Programme Board including representation from Shropshire Association of Local Councils (SALC) and the VCSA.

A detailed project plan linked to the development of scheme metrics and the delivery of the Transformation Challenge Award funded project has been developed
Working with SALC and the VCSA to support the development of “community capacity” to respond to new opportunities</td></tr>
<tr><td>Absence of detailed project plan (and related governance structures) identifying clear milestones and roles & responsibilities</td></tr>
<tr><td>Poor local and stakeholder engagement in the co-design and implementation of approaches</td></tr>
<tr><td>Approach inadequately resourced with insufficient senior management and leader’s “buy in”</td></tr>
<tr><td>Lack of clarity and consistency on the metrics and poor evaluation and measurement resulting in a weak evidence base</td></tr>
<tr><td>Absence of the “culture change” required to underpin the new way of working</td></tr>
</table>

4. Financial Implications

The development of Community Hubs is not intended to be resource hungry; it is the culture change at a local level that is more important. Notwithstanding it is recognised that local support may be required to redesign spaces and to develop new activities. The main challenge and opportunity is to realign existing resources and commissioning intentions to support the development of Resilient Communities rather than to find new monies.

To help create the conditions for change Shropshire Council, in partnership with the VCSA and SALC, has been awarded funding through the DCLG’s Transformation Challenge Award programme to develop Community Hubs. The funding will support the re-design of existing face to face customer focused services, notably libraries and Customer Service Points, to provide places that residents can easily get information and advice that both helps them and enables them to help others within their community.

At a time when libraries are threatened with closure nationally, TCA investment will strengthen these valuable community assets and provide better services. Our libraries are a trusted resource that can be maximised to achieve many important outcomes and they will often be at the core of the Community Hubs that we want to build.

In addition to the TCA funding, through the Better Care Fund, “reward” funding may be made available to invest in successful schemes, but this will depend on schemes meeting BCF targets. This may be difficult to directly evidence for Resilient Communities, although local “proxy measures” are being developed. These hubs would need to demonstrate that the effect of the total of their activity is greater than the sum of the individual parts, effectively provide very early help and preventative advice and activity and actively support people to live independent lives. To be sustainable they will have to host services and activities from a range of sectors and that reflect the needs and aspirations of the communities they serve. We

should be explicit that the role of hubs is to support people to stay away from expensive targeted services as far as possible through maximising the benefits of the support that is available from within the community and that this is one of our approaches to managing the future challenge of increasing demand on services in a time of reducing budgets.

5. REPORT

What is the problem that we are trying to solve through the adoption of a "Resilient Communities" approach?

At a strategic level, a range of documents (Shropshire's Better Care Fund Plan, Shropshire Health & Wellbeing Strategy 2012, Children & Young People's Strategy 2012, Shropshire Council's Business Plan and Financial Strategy 2014-17, Early Help Services Strategy and the new Adults Social Care operating model) all contain references to, or are designed around the development of resilient communities and community hubs.

At the centre of the development of Resilient Communities is a shared vision by Shropshire Council, the CCG and partners to:

- Increase the availability (and demand for) of universal early advice, information and guidance provision.
- Have a very different conversation about what a person needs and how their needs can be met within their local community.
- Reduce demand on expensive specialised services.
- Build on the existing resilience in Shropshire's communities so that people are able to help themselves and others to be happy, healthy and independent.

We know that we have to make these changes now because Shropshire's future demographic and the needs it is likely to create will overwhelm public services at the same time as they face unprecedented on-going financial challenges.

To understand what is meant by community hubs it is necessary first to understand the key elements within a Resilient Communities approach:

1. Local partnership working and governance - to support a collective action based approach to meeting local aspirations that transcends individual organisation priorities.
2. Evidence and intelligence - that supports good decisions and the careful targeting of limited resources.
3. Community based activities - that are accessible and support people to achieve their aspirations and positive outcomes.
4. First line of support – that broker and facilitate support from community organisations to individuals.
5. Support and social networks - that encourages self-help between individuals and supports communities' ability to respond to challenges.

What do we mean by a Community Hub?

The real opportunity for a "step change" in the Resilient Communities approach described above is "investment" in the first line of support and in supporting people to have the confidence to get involved in activities and services already available within their community. Work is already underway to develop this approach, for example:

- Community & Care Coordinators linked to local GP surgeries
- Adult Social Care First Point of Contact and Let's Talk Local sessions
- Community Advice & Advocacy Network
- Testing the Community Connector role in areas where new Community Hubs are being created
- The redesign of Customer Service Points within communities

Alongside initiatives such as the above, Community Hubs will provide a focal point to foster greater local community activity and to bring residents, smaller organisations and the local business community together to improve the quality of life in their areas.

We think that community hubs will be “neutral” venues often best managed by community based organisations and will be at the centre of a diverse range of local activities. Community Hubs will be buildings that are accessible to all groups in the area. They will be multi-purpose Centres providing a range of high quality and cost effective services to the local community, with the potential to develop new services in response to changing community needs. A Community Hub will have strong working relationships with other local community services - for example, tenants’ rooms, Children's Centres, nurseries, extended schools and faith groups.

But more importantly Community Hubs will be a base for outreach and signposting people to other local services. Ultimately it is not the place that is important but what goes on within it and from it. The effectiveness of community hubs in reaching the people who will benefit from them, will be maximised through the development of the community co-ordinator / community connector / community mentor role. Residents coming into the hubs will get the right thing at the right time – the right things often being something that family, friends and community can offer and the right time being as early as possible.

What work is happening now and who is involved?

The development of Community Hubs within the context of a Resilient Communities approach is not intended to be exclusive to any organisation and the terms are used by different organisations – Registered Social Landlords, West Mercia Police, the CCG, town and parish councils, social enterprises - in slightly different ways. These organisations see the development of community hubs as a significant opportunity to deliver integrated information, advice and guidance, prevention and early help services based on better outcomes for local residents. A few examples, illustrating the range of existing activity, are provided below:

- Craven Arms Community Centre – managed by the South Shropshire Furniture Scheme
- Barnabas Community Centre – managed by the Church
- Oswestry Community Hub – managed by Shropshire Council
- Enterprise House – managed by Enterprise South West
- Whitchurch Foyer - a partnership of Bromford Support, Stonham and Mercian
- Ludlow Foyer- managed by the Shropshire Housing Groups- with services provided by the Sustain Group.
- Mayfair Community Centre - managed by the Strettons Mayfair Trust, a charitable set up in 1996, to provide a variety of healthy living services.

The Better Care Fund, the Transformation Challenge Award funding, and above all the imperative to transform the way that social care and health services are delivered provide the opportunity to develop and put into practice the development of a Resilient Community approach. Specifically the role of the Community Connector and Community Hubs will be developed alongside the community based activities that will support people to find their support of choice within their local community. In the first instance we want to support the roll out of the approach and gather evidence of its success in a minimum of six locations within 2015/16.

Our approach to developing Resilient Communities is based on a collective understanding that people are our most important resource and that working together is the best way to address the challenge of supporting potentially vulnerable residents. This can be best summarised as:

- Independence and living at home is normal - investing in the things that increase people’s independence
- Starting well – providing an emphasis on providing the right support to people at the right time within their communities
- Asset based community development - recognising the existing capacity of the community and that it is underpinned by strong local networks, relationships and a commitment to a common cause
- A locality based approach - enabling local flexibility of approach within a set of overarching principles

There is a considerable amount of development that has already taken place and a significant amount of resources already in place. However, we have identified that to increase community resilience further we need to focus on developments in the following areas:

- Develop a Community Hub / Gateway approach to support the development of community places where people can access information and support
- Develop the role of the Community Connector to support the provision of information, advice and guidance and to "mediate" between people with low level needs and existing assets within the community
- Continue to develop and support the role of the Community & Care Co-ordinator and Team around the Practice
- Continue to develop and invest in pathways from FPOC and COMPASS to community support and help
- Support communities to develop a "Compassionate Communities" and "Dementia Friendly Communities" approach within which communities take "ownership" of approaches to supporting people
- On-going support for the Voluntary and Community sector and Town and Parish Councils to develop their capacity and ability to respond to the needs of communities and individuals by Building Health Partnerships and strong local "governance"
- Continue to develop and support a range of "local" schemes such as People2People, "Ageing Well" prototypes etc. which in turn will support and underpin the Community Resilience approach, further examples of which are set out later in this section.

Community Hubs and Community Connectors

Our Resilient Communities approach will be built around the development of "Community Hubs" which will act as "gateways" to a diverse range of local activities. The effectiveness of community hubs in reaching the people who will benefit from them, will be maximised through the development of Community Connector roles. Residents coming into the hubs will get the right information and support at the right time – the right things often being something that family, friends and the community can offer and the right time being as early as possible. We know that we have to end a culture of people only being signposted into social care or health care provision that they then cannot access until they reach a certain eligibility level or have experienced a crisis.

Our approach is designed for everyone within their local community. We want to increase the demand on universal early advice, information and guidance provision and by having a very different conversation about what a person needs, how their need can be met and reducing demand on expensive specialised services at a later date.

Through the development of Community Hubs, Shropshire Council wants to work with partners to re-design existing face to face customer focused services and to use the transformation of our Libraries and Customer Service Points as a catalyst for change. While we recognise the importance of technological solutions in enabling remote access to services, we also know that face to face contact is vital to potentially vulnerable residents in order to give them the best chance of finding support within their community and reducing the need for expensive "professionally led" interventions. By having a very different conversation as early as possible about what a person needs and how their need can be met, we will reduce demand on expensive specialised services at a later date.

We will harness the existing energy and commitment of a range of partners, and develop community hubs as the natural home for cross-sector working and for the redesign of services around people. We will do this by:
Creating vibrant inclusive sustainable places run by the community for the community –
Coordinating and building volunteer activity and supporting the growth of community led initiatives
Transforming the way that information, advice and guidance, prevention and early help services are delivered by Shropshire health and social care partners.

What will the future look like?

The development of community hubs within the context of a resilient community approach will be part of the catalyst for changing how we:

- Maximise the opportunities for health care and social care integration in communities
- Integrate Adult Social Care (ASC) and Children & Young People's Services (CYPS) early help provision in communities and adopt a family approach
- Enable primary health and Community & Care Co-ordinators to effectively link into the wider community resources that will ensure that the most frail and vulnerable patients are supported
- Use and invest in the resources available in our communities to signpost/connect people to activities that they will enjoy and benefit from, e.g. through the community co-ordinator and community connector roles
- Make referrals into services and move people between services and community resources, i.e. stepping people up and down between different levels of support
- Utilise all the resources available in a community to address loneliness and to promote good health and well-being
- Build 'teams around the community' that will emphasise prevention and early help and will reduce the overall demand on the public sector.

Community Hubs, the spaces at the centre of this approach, aim to meet the needs of the people that they serve and to host a range of transformed services including libraries, Customer Service Points, information, advice and guidance, early help for adults and children, community health, community mental health, voluntary groups who are delivering commissioned services and community groups providing local activity. All of this provision will adopt the ambition to involve all the local resources in helping people to find solutions to their particular issues.

We will know that we will have got this right when:

- Everyone agrees that living at home is normal and people live independently at home for longer
- People feel connected to their communities, know where they can go to get advice and can help others to get the advice that they need
- People are more active as they feel safe, welcome and that someone is looking out for them when they go out
- All the activity in and around the hub is intelligently designed and delivered, joined up and has a local flavour

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Shropshire Council's Business Plan and Financial Strategy 2014-17, Shropshire's Better Care Fund Plan, Shropshire Health & Wellbeing Strategy Children & Young People's Strategy
Cabinet Member (Portfolio Holder) Cllr Tim Barker
Local Member All local members
Appendices -