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

Date: Friday, 14 March 2014
My Ref:
Your Ref:

Committee:
Health and Wellbeing Board

Date: **Friday, 21 March 2014**
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
Graham Urwin
Jackie Jeffrey

Your Committee Officer is:

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

AGENDA

1 Apologies for Absence and Substitutes

To receive apologies for absence and any substitutions that may be notified.

2 Minutes (Pages 1 - 12)

To confirm the Minutes of the Health and Wellbeing Board meeting held on 24 January 2014 and the Minutes of the Special Health and Wellbeing Board meeting held on 12 February 2014, attached.

3 Public Question Time

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

4 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.

5 Health & Wellbeing Strategic Review - EVIDENCE/ENGAGEMENT (Pages 13 - 20)

To receive a report from Karen Calder and All Board Members.

Contact: Karen Calder.

6 NHS England - Local Primary Care - QUALITY & PERFORMANCE (Pages 21 - 26)

To receive a presentation from NHS England via Graham Urwin.

Contact Graham Urwin 03007900 233 ext 3495.

7 Terms of Reference Health & Wellbeing Board - FOR DECISION (Pages 27 - 32)

To receive a report from the Director of Public Health.

Contact: Penny Bason (01743) 252767

8 Better Care Fund - FOR DECISION

To receive a report from Shropshire Clinical Commissioning Group

Contact: Dr Julie Davies (01743) 252295

9 Quality Premium - FOR DECISION (Pages 33 - 42)

To receive a report from Shropshire Clinical Commissioning Group

Contact: Dr Julie Davies (01743) 252295

10 Future Fit - FOR INFORMATION

To receive a report from the Shropshire Clinical Commissioning Group

Contact: Caron Morton, Accountable Officer (01743) 277595

11 Immunisation Update - FOR INFORMATION

To receive a report from NHS England

Contact: Graham Urwin 0300 7900 233 ext 3495

12 Date of Next Meeting

There will be a Special meeting of the Health and Wellbeing Board at 10.30 am on Friday 28th March in the Oswestry Room at the Shirehall, Shrewsbury. This will be followed by the already diaried meeting, scheduled for 9.30 am on Friday 25th April 2014 in the Shrewsbury Room, at Shirehall, Abbey Foregate, Shrewsbury.

Shropshire Council

Committee and Date	Item
Health & Wellbeing Board 21 March 2014 9.30 am	**2b** Public

MINUTES OF THE SPECIAL HEALTH AND WELLBEING BOARD MEETING HELD ON WEDNESDAY 12 FEBRUARY 2014 AT 3.30PM IN THE LUDLOW ROOM, AT SHIREHALL, SHREWSBURY

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

PRESENT

Members:

Karen Bradshaw	Director of Children's Services
Karen Calder	Portfolio Holder for Health (Chairman)
Stephen Chandler	Director of Adult Services;
Lee Chapman	Portfolio Holder for Adult Services
Carole Hall	substitute for Jane Randall-Smith, Healthwatch Shropshire
Ann Hartley	Portfolio Holder for Children's Services
Helen Herritty	Shropshire CCG
Jane Randall-Smith	Chairman, Shropshire Healthwatch
Prof. Rod Thomson	Director of Public Health
Paul Tulley	Shropshire CCG
Dr Caron Morton	Accountable Officer, Shropshire CCG (Vice-Chairman)
Jackie Jeffrey	Chairman VCSA
Ros Francke	substitute for Graham Urwin, NHS England

Officers and others in attendance:

Penny Bason	Health & Wellbeing Co-ordinator
Dr Julie Davies	Director of Strategy and Service Redesign
Ruth Houghton	Head of Social Care, Efficiency and Improvement
Madge Shineton	Shropshire Councillor
Sam Tilley	Shropshire CCG
Tina Wigfall	Shropshire CCG

59. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

59.1 Apologies for absence were received from Mr Gerald Dakin, Chairman of Health Scrutiny; Mr Graham Urwin, Director Shropshire and Staffordshire Area Team, NHS England and Dr Bill Gowans, Vice-Chairman Shropshire CCG.

59.2 Substitutions notified were as follows: Carole Hall substituted for Jane Randall-Smith (Shropshire Healthwatch) and Ros Francke substituted for Graham Urwin (NHS England).

60. DISCLOSABLE PECUNIARY INTERESTS

60.1 There were none.

61. THE BETTER CARE FUND

61.1 The Board received copies of the two parts of the Better Care Fund Planning Template – copy attached to signed Minutes – which was introduced and amplified by the Director of Adult Services. It was noted that this had to be submitted in draft format by Friday 14 February, with the final submission being due on 4 April 2014.

61.2 It was anticipated that formal feedback from NHS England Area Team would be gathered over the next two or three weeks. In commenting on the Shropshire template, Ros Francke offered to highlight some assurance issues which were welcomed by members. In doing so, she stated that she felt Shropshire was underselling itself and needed to expand more in two particular areas; firstly on the involvement of patients and carers and secondly on provider engagement.

61.3 It was noted that provider engagement work was planned around patient/service user involvement by the CCG. It was agreed that this would also be good evidence to include in the Shropshire response; showing what had contributed to where we are now.

61.4 It was explained that the assurance process needed to understand what we had done and that a clear expression of what was intended to be undertaken in the future too.

61.5 Given the time constraints it was agreed that the draft needed to include a covering document which referenced work undertaken to date and provided links to more detail, bearing in mind triangulation and satisfaction that all groups had had representation.

61.6 At page 9, under Governance, it was agreed to include an explanation in here that workshops had been held and to expand on the matters discussed. It was also highlighted that this was 'work in progress'. Furthermore it was agreed that an item on the Better Care Fund should be put onto the next Health and Wellbeing Board agenda in March.

61.7 The Risk Matrix was discussed in detail at page 13 and the following main issues were highlighted:

- Cross Border/Commissioning Boundaries.
- The Clinical Services Review was not seen as a high risk to the Better Care Fund.
- It was agreed that the risk for 'Financial Implications of Rurality…' needed to be re-described as not having appropriate links between the Better Care Fund and Future Fit.
- The fifth risk down, Workforce needed rephrasing ('older workforce' to be changed)
- Recruitment and retention of staff was to be included.
- Implications of the Care Bill to be expanded.

61.8 It was agreed that electronic signatures would be used to sign off the document once amended up and ready to be submitted in draft format.

61.9 **RESOLVED**: That officers be authorised to amend and update the draft Better Care Fund Planning Template as per discussions above.

62. QUALITY PREMIUM

62.1 A verbal update on the progress of Quality Premium Measure Arrangements for Clinical Commissioning Groups in 2014/15 was given by Dr Julie Davies, Director of Strategy & Service Redesign, Shropshire CCG.

62.2 The quality premium paid to CCGs in 2015/16 – to reflect the quality of health services commissioned by them in 2014/15 – will be based on six measures that cover a combination of national and local priorities. It was noted that the CCG and the Health and Wellbeing Board need to agree on certain elements of the quality premium measures.

62.2 To this end, it was noted that a draft report would be submitted to the Green Paper meeting of the Health and Wellbeing Board on 21 February 2014 (programme planning) and then a further report would be made to the CCG Board. A formal paper would then go to the next formal Health and Wellbeing Board meeting in March for final sign off.

62.3 **RESOLVED:** That the update be noted.

63. DATE OF NEXT MEETING

63.1 **RESOLVED:** That the next meeting of the Health and Wellbeing Board be held at 9.30am on Friday 21 March 2014 in the Shrewsbury Room at Shirehall, Shrewsbury, SY2 6ND.

Chairman : ……..

Date : ……..

The meeting finished at 16.25pm

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Committee and Date	Item
Health & Wellbeing Board 21 March 2014 9.30 am	**2a** Public

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 24 JANUARY 2014 AT 9.30 AM IN THE SHREWSBURY ROOM, SHIREHALL

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

PRESENT

Members:

Karen Calder	Portfolio Holder for Health (Chairman)
Lee Chapman	Portfolio Holder for Adult Services
Carole Hall	substitute for Jane Randall-Smith, Healthwatch Shropshire
Prof. Rod Thomson	Director of Public Health
Dr Caron Morton	Accountable Officer, Shropshire CCG (Vice-Chairman)
Dr Bill Gowans	Vice-Chairman Shropshire CCG
Jackie Jeffrey	Chairman VCSA
Ros Francke	substitute for Graham Urwin, NHS England

Officers and others in attendance:

Penny Bason	Health & Wellbeing Co-ordinator
Andy Begley	Head of Adult Social Care Operations
Lorraine Currie	MCA/DoLS Manager
Gerald Dakin	Health Scrutiny Chair
Dr Julie Davies	Director of Strategy and Service Redesign
Paul Haycox	Shropshire CCG
Ruth Houghton	Head of Social Care, Efficiency and Improvement
Kal Parkash	Diversity Officer
Emma Sandbach	Public Health Specialist, Shropshire Public Health
Madge Shineton	Shropshire Councillor
Sam Tilley	Shropshire CCG

47. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

47.1 Apologies for absence were received from Joyce Barrow, Young People's Scrutiny Committee Chair; Karen Bradshaw, Director of Children's Services; Stephen Chandler, Director of Adult Services; Ann Hartley, Portfolio Holder for Children's Services; Helen Herritty, Shropshire CCG; Jane Randall-Smith, Chairman, Shropshire Healthwatch; Paul Tulley, Shropshire CCG; Graham Urwin, Director Shropshire and Staffordshire Area Team, NHS England

47.2 Substitutions notified were as follows: Carole Hall substituted for Jane Randall-Smith (Shropshire Healthwatch) and Ros Francke substituted for Graham Urwin (NHS England).

48. MINUTES

48.1 Arising thereon; the Chair asked for a timeline at Minute 35.7. It was agreed that this work would be ready to report back to the H&WB in March 2014. Subject to the foregoing it was duly

48.2 **RESOLVED:** That the Minutes of the Health and Wellbeing Board meeting held on the 22 November 2013, be approved and signed by the Chairman as a correct record.

49. PUBLIC QUESTION TIME

49.1 There were no public questions.

50. DISCLOSABLE PECUNIARY INTERESTS

50.1 There were none.

51. WINTERBOURNE VIEW

51.1 The Board received and welcomed a progress report on joint work on the Winterbourne View Review and Concordat – copy attached to signed Minutes – by Shropshire Council and the Shropshire CCG. Overall good steady progress was being made

51.2 The Chairman asked about how and on what basis the independent review of Learning Disability residential services would be undertaken by Healthwatch. It was agreed that conversations would be had by officers after the meeting to agree a way forward.

51.3 The Accountable Officer for Shropshire CCG welcomed the report and highlighted that it would be useful if a mapping exercise could be undertaken showing where Adults with Learning Disabilities were placed throughout Shropshire, enabling GP's to link in to this information aswell.

51.4 **RESOLVED**:

a) That the progress made to date on compliance with the Winterbourne View Concordat recommendations be noted.

b) That the feedback received from the LGA and NHS England on the stock take submitted by Shropshire be noted.

c) That a wider learning Disability Report be submitted to the Health and Wellbeing Board on an annual basis on the three work streams governed by the Learning Disability Programme Board as set out in the summary in the report.

d) That Healthwatch Shropshire be requested to discuss with Adult Social Care the possibility of providing an independent view of Learning Disability residential services in Shropshire.

e) That it be noted that pooled funding arrangements would be addressed in part as Better Care Funding came on stream.

52. DEPRIVATION OF LIBERTY SAFEGUARDS

52.1 A report on Deprivation of Liberty Safeguards, introduced in April 2009 as an amendment to the Mental Capacity Act 2005, was received by Members. The safeguards provided protection for vulnerable people against arbitrary detention. They apply to people 18 and over who lack mental capacity to consent to be accommodated in hospitals or care homes and apply only where the person has a mental disorder and where care or treatment cannot be provided in a less restrictive way.

52.2 The report covered information about levels of DoLS activity in 2012/13 for hospitals and care homes in Shropshire and a comparison with the West Midlands. Areas of regional and national engagement were also highlighted.

52.3 It was noted that training and promotion courses were provided across the health and social care workforce and that demand was growing. A specific request was made for more information about training provided to the primary care sector in Shropshire, including the percentage of staff trained.

52.3 Joint working arrangements had been confirmed between Shropshire Council and Shropshire Clinical Commissioning Group from 2013 onwards which was welcomed. However concern was expressed that the joint arrangement did not include Telford and Wrekin Clinical Commissioning Group or T&W local authority due to a distribution problem with funding. Ros Francke, NHS England representative, undertook to look into this after the meeting.

52.4 Case studies provided at Appendix 2 were welcomed as a good tool with which to put the contents of this report into context.

52.5 **RESOLVED:**

a) That the Health and Wellbeing Board receive quarterly statistics in relation to DoLS applications and analyse them relative to the other West Midlands authorities.

b) That the Health and Wellbeing Board receive reports from the MCA/DoLS Operational Group which meets quarterly.

c) That the Health and Wellbeing Board receive a report following Shropshire's participation in the West Midlands regional peer audit.

d) That training information be provided for primary care showing the percentage of staff trained and that this be regularly updated.

e) That Ros Franke (NHS England) be requested to remedy any funding distribution problems connected to Telford and Wrekin Clinical Commissioning Group and the local authority.

f) That staff be commended for their excellent work.

53. JSNA - HEALTH INEQUALITIES

53.1 The Director of Public Health introduced and amplified a report – copy attached to signed Minutes – which highlighted the story of Shropshire with regard to health inequalities; demonstrated the health inequalities in Shropshire and where they existed, what was currently being done to reduce these inequalities, what other partnership groups were doing to reduce inequalities: and to highlight what more we

could do as a Health and Wellbeing Board to make Shropshire a leader in reducing health inequalities.

53.2 Following much discussion about how everyone needed to work together in partnership and engage more it was agreed that a tangible priority was required; something everyone could champion to change in Shropshire, such as earnings ratios for staff for example.

53.3 The Director of Public Health suggested that in making links with the business sector it would be hoped that they could work together to positively influence how things were done in their organisation, make Shropshire a better place to invest in and make employment more accessible. It was highlighted that the voluntary and community sector could contribute in kind too, if not financially.

53.4 It was agreed that Appendix C needed to be more robust, especially the third bullet point down. In the last bullet point, it was agreed that reference needed to be made to the way we commission outcomes, principles and structures. It was requested that social mobility also be included. Subject to the foregoing, it was agreed that an updated charter be submitted back to the 21 March meeting for approval.

53.5 **RESOLVED:**

a) That the Health and Wellbeing Board continue to support the increase of investment in prevention programmes across organisations and partnerships in order to reduce health inequalities and that progress on this be reported back to the Health and Wellbeing Board in 6 months time (July 2014).

b) That the Health and Wellbeing Board enhance joint working with the Business Board, the Local Enterprise Partnership and the Local Nature Partnership to address Inequalities and that the Director of Public Health formally links in to the Business Board.

c) That the Health and Wellbeing Board provide a collective response to the Marches LEP European Structural and Investment Funds Strategy.

d) That the Health and Wellbeing Board support the voluntary and community sector by endorsing the Compact (draft copy at Appendix B) and encourage relevant statutory partners and provider organisations to sign up to the Compact;

e) That the Health and Wellbeing Board discuss the draft Equalities Charter (with any proposed amendments) and endorse its ratification across the Health Economy (Appendix C) – once this has been updated to be more robust and reported back to the 21 March meeting.

f) That the Health and Wellbeing Board note and support the development of a Social Value Framework for Shropshire (described in section 5.24 of the report).

54. THE LEP EUROPEAN STRUCTURAL & INVESTMENT FUND STRATEGY

54.1 The Health and Wellbeing Co-ordinator introduced and amplified a report – copy attached to signed Minutes – on a consultation by the Marches Local Enterprise Partnership (LEP) about their Structural Investment Funds Strategy 2014 -2020: Five Strategic Priorities.

54.2 At Response 3 of the questionnaire, the first bullet point was amended to read 'Reducing inequalities and ensuring fair wages'.

54.3 At Response 6 of the questionnaire Ruth Houghton requested that targeted groups, include adults with mental health and learning difficulties

54.4 It was requested that 'normalisation', which does not have a financial cost, also be included in this document.

54.5 **RESOLVED:**

That subject to the foregoing, the Board approved the draft response, for submission immediately following the Health and Wellbeing Board meeting on the 24th of January 2014.

55. CHILDREN AND YOUNG PEOPLE & FAMILIES PLAN REFRESH

55.1 A report by the Director of Children's Services – copy attached to signed minutes – was received by Members.

55.2 **RESOLVED:**

a) That the Health and Wellbeing Board support the development of a refreshed Children Young People and Families Plan, noting that the Trust delivers the priority of Improving the emotional wellbeing and mental health of children and young people, by focussing on prevention and early support for the Health and Wellbeing Board;

b) That the Health and Wellbeing Board note the strong links between the Board and the Children's Trust with regard to health inequalities and reducing child poverty.

56. BETTER CARE FUND AND S.256 AGREEMENT

56.1 The Committee received the report of the Shropshire Clinical Commissioning Group (CCG) – copy attached to the signed Minutes – on the current joint strategic position across Shropshire CCG and Shropshire Council in relation to the implementation of the Better Care Fund (formerly the Integrated Transformation Fund), the performance monitoring requirements, the financial implications and key areas of work associated with it.

56.2 Progress to date was good bearing in mind its rapid introduction and that final guidance was published in December 2013. It was noted that it was hoped to be more transformational and inspirational and the Task and Finish Group requested that the Fund be carried out in two phases

56.3 There was some concern about bringing providers into this, but initial discussions with providers had been positive a workshop scheduled for the following week would help in moving this element forward.

56.4 It was requested that Reablement be included in the Forward Plan.

56.5 **RESOLVED:**

Part One – Better Care Fund

a) That the Fund be used to support the overarching themes of – Prevention, Living Independently for Longer, Long Term Conditions and Managing and Supporting people in Crisis.

b) That the Better Care Fund supports the key priorities set out in the JSNA and Health and Wellbeing Strategy.

c) That the implementation of the Fund be carried out in two phases for 2014/5 and 2015/16 as set out in the report.

d) That the Task and Finish Group will continue to meet to further develop the next stage of the plans required to implement the Fund and the required submission to NHS England.

e) That the Task and Finish group will continue to develop the local financial plans required for implementation in 2015/16 which will be presented to the Health and Wellbeing Board in September 2014.

f) That the final selection of the local performance indicator be delegated to the Task and Finish Group.

g) That the Task and Finish Group develop a Better Care Fund risk register, of which the first draft will be presented to the Health and Wellbeing Board in March 2014.

h) That the Task and Finish group will develop more detailed recommendations regarding the governance arrangements for the Better Care Fund which will be presented to the Health and Wellbeing Board in March 2014.

Part Two – S256 Agreement

a) That the activity to date against each of the expenditure allocations be noted.

b) That annual performance activity against the suite of Local Authority performance indicators (both national and local indicators) be reported to the board in the Summer of each year once validated by the information centre.

c) That the Health and Wellbeing Board prioritises areas for in depth review as part of the forward plan to include preventive services and locality commissioning.

57. MATERNITY SERVICES REVIEW

57.1 The Accountable Officer, Shropshire CCG introduced this item – copy of report attached to signed minutes - and explained the background to this Review. Healthwatch queried the engagement element of the Review and the implementation of recommendations.

57.2 A brief discussion ensued and the Accountable Officer clarified that it was proposed to re-establish a new Maternity Liaison Committee, which would involve stakeholders and users. It was agreed that a progress report on actions would be made to the Board in 6 months time.

57.3 Looking ahead it was considered important to connect this report to the Clinical Services Review, which was another important piece of work.

57.4 **RESOLVED:**

a) That the report be received and that a progress report on its implementation be made back to the board in 6 months time (July 2014)

b) That the recommendations to Shropshire CCG Governing Body Board which were presented to the Board on 11 December 2013 and approved, be noted.

58. DATE OF NEXT MEETING

58.1 **RESOLVED:** That the next meeting of the Health and Wellbeing Board be held at 9.30am on Friday 21 March 2014 in the Shrewsbury Room at Shirehall, Shrewsbury, SY2 6ND.

Chairman : …….

Date : …….

The meeting finished at 11.30 am

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Health and Wellbeing Board Strategic Review 2013/14

Responsible Officer Rod Thomson
Email: Rod.thomson@shropshire.gov.uk Tel: Fax:

1. Summary

1.1 On 1st of April 2013 (after 18 months operation in shadow form), the Health and Wellbeing Board began its statutory duties. During 2013 a number of new members joined the Board including the Portfolio Holder for Health (following election), Karen Calder, Portfolio Holder for Adult Services, Lee Chapman, the Chief Officer of Healthwatch Shropshire, Jane Randall-Smith, and the Chair of the Voluntary and Community Sector Assembly, Jackie Jeffery.

1.2 During 2013/14 the Health and Wellbeing Board planned decision making around the five outcomes of the Health and Wellbeing Strategy and each Board meeting focussed on one of the outcomes or priorities. This process was undertaken to ensure that the Board had a good understanding of the issues relating to the five outcomes (the JSNA and engagement results) and to ensure that the Board had effective mechanisms for delivery against these outcomes. The Board always ensured that there was flexibility with each agenda to add emergent or statutory items for decision.

1.3 The delivery mechanisms for the Health and Wellbeing Strategy include:

Outcome	Delivery Group	Lead
Health Inequalities	Health and Wellbeing Executive	Rod Thomson
Healthy Lifestyles – priority healthy weight	Public Health	Kevin Lewis / Rod Thomson
Mental Health 1) Children and Young People's Mental Health and Emotional Wellbeing	1) Children's Trust	Karen Bradshaw/ Jo Robins (Public Health)
Mental Health 2) Dementia	2) Proposed - County wide dementia steering group	Sal Riding (CCG)
Independent for Longer	1) Assistive Technology Steering Group 2) Isolation and loneliness Task and Finish Group	Julie Davies TBC
Accessible, good quality and 'seamless' services / service integration	Health and Wellbeing Executive/ Better Care Fund Access to Information Task and Finish Group	Stephen Chandler/ Julie Davies Rod Thomson

1.4 During the year some new and key statutory responsibilities have been placed on the Health and Wellbeing Board; the primary new duty is the Better Care Fund (discussed in the body of the report). The Health and Wellbeing Board also must endorse the CCG's 5 Year Business Plan, and as the local health and social care economy embark on large programmes of transformation, the Board must understand these developments and aid transition. Combined these pieces of work will form a large portion of the focus of the Health and Wellbeing Board over 2014/15.

1.5 The Terms of Reference for the Health and Wellbeing Board have been revised to ensure appropriate governance for the Better Care Fund (for agreement on 21st March HWBB).

1.6 During the year 2013/14 there has been extensive consultation and engagement with the stakeholders discussing a wide range of issues pertaining to the local health economy. Some of these include HWBB focus group sessions, the Call to Action, the Rural Health Survey, the School Nurse Review, the Members of Youth Parliament and a continual dialogue with the Health and Wellbeing Stakeholder Alliance.

1.7 Also during the year, Overview and Scrutiny, Healthwatch Shropshire, and the Health and Wellbeing Board have made efforts to understand each other's roles post implementation of the Health and Social Care 2012. Two stakeholder events have given rise to an action plan and a Memorandum of Understanding between the HWBB, OSC and Healthwatch Shropshire.

1.8 The Health and Wellbeing Board has used 2013 to further develop positive partnership relationships and cooperation across Health and Social Care, and good progress has been made to deliver on its statutory functions. During 2014/15 the HWBB will move to create a robust governance and performance monitoring structure across Board functions to ensure the delivery of the HWB Strategy.

1.9 It has always been anticipated and communicated that Health and Wellbeing Boards would evolve over time, and as new statutory duties for the Board have come into effect during 2013/14, this report is asking the Board to confirm some of the processes it will go through to make the necessary evolution.

2. Recommendations

2.1 That the Board agree and confirm that during 2014/15 the Board's development will include:

- Through partnership working and collaboration of all Board members, the further development of the Boards governance and delivery mechanisms for the HWB Strategy and statutory functions, including reviewing and updating the Terms of Reference of all groups as appropriate;
- Through partnership working and collaboration of all Board members, the further development of the collective understanding of the HWBB role in Quality and Performance of Health and Social Care in Shropshire and its role in supporting the Communication and Engagement around key transformation programmes;
- The development of an induction pack for new members of the Health and Wellbeing Board to ensure that newly elected members from both Shropshire Council, the CCG and the VCSA have a smooth induction into the Board in the future;
- The progression of the Board's engagement and consultation processes to include streamlining information collected across the Health and Social Care economy for input into the JSNA and decision making processes.

REPORT

3. Risk Assessment and Opportunities Appraisal

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

As part of the ongoing development of the Board it will create an appropriate Risk Matrix linked

4. Financial Implications

There are no financial implications associated with this report.

5. Background

5.1 Health and Wellbeing Board Decisions

5.1.1 During 2013/14 a number of key decisions have been made by the Health and Wellbeing Board. These include:

- Approved the Shropshire Adult Autism Strategy
- Required that the work streams reporting to the Health and Wellbeing Board (Steering Groups) incorporate actions that will mitigate against isolation and loneliness;
    - To develop a local measure for isolation and loneliness;
    - To require isolation and loneliness to be considered as part of all relevant commissioning and contracting processes within Shropshire Council and the CCG
- Resolved to established a task and finish group around isolation and loneliness;
    - To identify where existing community networks exist,
    - To explore how to make these more accessible and well communicated to individuals,
    - To identify gaps,
    - This group should address the stigma of loneliness by raising awareness of the issue; consider how to address the needs of carers in a meaningful way
    - To consider addressing Isolation and Loneliness through all the priorities of the Health and Wellbeing Strategy
- Established a Task and Finish Group be set up to oversee the development of the joint plan for the introduction of the Integration Transformation Fund (ITF), now **BETTER CARE FUND**. Subsequent decisions:
    - § Approval of the first draft of the Better Care Fund (discussed in section 5.3)
    - § Final Draft to be approved and submitted by 4th April 2014
- Nominated Prof Rod Thomson as Champion of the Access to Services T& F group who will ensure appropriate linkages with the 'map of maps' and Building Healthy Partnerships project
- Agreed the section 256 agreement and monitoring arrangements
- Agreed and endorsed 2014 as the Year of Dementia Training and Awareness Raising for Shropshire.
    - Endorsed the development of a Dementia Stakeholder Reference Group
- Determined that the HWBB will decide and communicate its role with regard to Organ Donation in 2014/15
- Endorsed the development of a Medical Health Scholarship Scheme in Shropshire
- Endorsed the development of as Assistive Technology Memorandum of Understanding to be adopted by Health and Social Care Partners
- Responded to the Local Enterprise Partnership's draft European Structural & Investment Fund Strategy
- Determined the Board's involvement in the Deprivation of Liberty (DoL) and determined to receive quarterly performance updates from the DoLs team
- On Health Inequalities the Board resolved that:
    - The Health and Wellbeing Board continue to support the increase of investment in prevention programmes across organisations and partnerships in order to reduce health inequalities and that progress on this be reported back to the Health and Wellbeing Board
    - The Health and Wellbeing Board enhance joint working with the Business Board, the Local Enterprise Partnership and the Local Nature Partnership to address Inequalities and that the Director of Public Health formally links in to the Business Board.
    - The Health and Wellbeing Board provide a collective response to the Marches LEP European Structural and Investment Funds Strategy.
    - The Health and Wellbeing Board support the voluntary and community sector by endorsing the Compact and encourage relevant statutory partners and provider organisations to sign up to the Compact;
    - The Health and Wellbeing Board discuss endorse and sign the Equalities Charter

- The Health and Wellbeing Board note and support the development of a Social Value Framework for Shropshire

5.2 Health and Wellbeing Board Consultation and Engagement

5.2.1 A key function of the Health and Wellbeing Boards is to ensure that we work with our communities to design health and wellbeing services in Shropshire. More than this, working with the public will enable everyone to understand their roles and responsibilities in keeping our population healthy; it will encourage the public to better understand how they can take charge of their own health and how they can support each other in their own homes and communities.

5.2.2 Patient and public engagement: a practical guide for health and wellbeing boards (2012), developed by the National Learning Set, highlighted three key points for Health and Wellbeing Boards:

- Patient and public engagement (PPE) should take place from the start of the life of health and wellbeing boards and be woven into the DNA of boards throughout their work.
- There will be different types and levels of appropriate engagement depending on the situation, from involvement of individual members of the public in shared decision-making about their own health and care, to local community engagement in co-production of services.
- PPE is the business of every board member. All members must be assured that appropriate PPE, shown to make a difference, is taking place in relation to the work of the board.

5.2.3 Shropshire's Health and Wellbeing Strategy is based on the Joint Strategic Needs Assessment and on a series of consultation events with patients and the public during 2011 and 2012.

5.2.4 Following the official launch of the Health and Wellbeing Board in April 2013 it was felt that it would be useful to test the HWB Strategy by asking the public to get together in focus groups to discuss the key health and wellbeing issues for them and their communities.
The groups were asked to discuss priorities for improved health & wellbeing in their community. Many of the priorities discussed during the focus group sessions fit within the Health and Wellbeing Strategy five outcomes as highlighted below:

Health Inequalities

- Clear pathways for diagnosis for everyone
- Person centred services
- Training to support young people and to support carers
- Respite care – short breaks for cares
- Autism diagnosis and pathway
- Child poverty/ serious disadvantage in some communities
- Better help and preparation for children with disabilities to transition to adulthood

Healthy Lifestyles

- Education around diet, exercise, obesity, smoking
- Inclusive activity, not just sport
- Creating opportunities for GPs to link people into healthy lifestyles, activities, sport

Mental Health

- Better links with GPs/ more access to counselling services through GPs
- Access to activities and education about how physical exercise and activities promote better mental health
- Access to information about mental health services
- Promotion of community and social interaction to support mental health
- Focus on mental wellness for all, not just the old and the young

Independent for Longer

- Make better links around how isolation impacts on mental health
- Support community based social activities and places to meet
- Promoting physical activity for older people and all age groups
- Education about how assistive technology can support not isolate

Access to Services

- More access to counselling via GP surgeries
- Access to screening services (prostate in particular)
- Access to information about mental health services
- Access to services for 16-18 year olds in a way that would improve access to preventative health services
- Sharing of patient records so that patients don't have to tell their story over and over
- Joint planning of services with the patients/ public
- Person centred service provision
- Local access to diagnostic services
- Longer opening hours for mental health services and groups
- Better use of community hospitals
- Better communication of where/ how to access services
- Community beds and staff

5.2.5 Some gaps that were emphasised by stakeholders that may fit within one of the HWB outcomes above, but there may not have previously been a clear or a clearly communicated pathway for addressing the gap. These include:

- Children's Autism strategy – However, as part of their Children and Young People's Plan refresh 2014 the Children's Trust will conduct a **Children and Young People's Autism Needs Assessment for Shropshire.**
- Better help and preparation for children with disabilities to transition to adulthood – However, work is being undertaken through the Children's Trust and the **Special Educational Needs and Disability reform programme (SEND)** to ensure that transition arrangements for SEN children are improved.
- Carer support is often highlighted as an issue, however as there are a number of Carer support services and support mechanisms (including support through the voluntary and community sector) throughout Shropshire, the Board may wish to endorse better communication of the support available. Also the Better Care Fund (detailed below) includes good consideration of Carers.

5.2.6 Other consultation and engagement through the year included:

- CCG - the Call to Action (Autumn 2013)
- Stakeholder Alliance (on going)
- MYP engagement (2013)
- Dementia Workshop (October 2013)
- Assistive Technology Workshop (September 2013)
- School Nurse Review (Summer 2013)
- Rural Health Survey (Summer 2013)
- Building Health Partnerships (2013)
- Making it Real (on going)
- Children's Trust Area Forums (September 2013)
- Healthwatch Planning Event (November 2013)

5.2.7 The engagement has delivered some clear and consistent messages. Access to a wide range of services and access to services through GPs and primary care is consistently communicated as a priority. As well mental health and how good mental health underpins all health concerns remains a key message. The wider determinants of health including finance, housing, and rural isolation are all key concerns. Community capacity building and the willingness and interest of communities to be part of developing healthy communities are also important messages that

have been communicated consistently. Summaries of all consultations can be found on the Shropshire Together website, click here.

5.3 Better Care Fund

5.3.1 The Better Care Fund (BCF) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas.

5.3.2 In Shropshire the BCF development supports the key priorities as set out in the JSNA and the Health and Wellbeing Strategy. The BCF development also recognises the current health and social care context in Shropshire relating to a review and transformation of services and the Future Fit Programme.

5.3.3 The draft submission of the BCF was approved in February, and the final submission is due on the 4th of April. The Health and Wellbeing Board have agreed the following key themes for the BCF in Shropshire:

Prevention:
- Carers Support and Liaison
- Think Local Act Personal and citizen engagement
- Access to employment and leisure activities for people with Learning Disabilities
- Locality Commissioning
- Improved care service monitoring (safeguarding)
- Falls prevention

Living Independently for Longer:
- Maximising Independence – Hospital discharge/ admission avoidance
- Handyman Scheme
- Telecare
- Support for Adults with learning Disabilities
- Supported Living for people with learning Disabilities/ Mental Health
- PATH House supported living
- Jointly funded staff to support learning disabilities services
- Community and Care Co-ordinators
- Continuing Care respite
- Crossroads care attendants scheme
- Children and families – short breaks/ Summer play schemes/ Hope House
- Mental Health Carers Network and Carers Support
- End of Life Care – Hospice at Home service
- Carers Link Workers
- Primary Care carers support worker
- Substance Misuse carers support
- Age UK
- Compassionate Communities

Long term Conditions (including Dementia):
- Enhancing preventions services (LTC)
- Services for people with Dementia
- Supported Housing (The Willows, Oak Paddock, 64 Abbey Foregate)

Managing Patients in Crisis:
- Crisis Resolution
- Integrated health and social care pathway
- Mental health and Learning Disabilities Respite
- Escalation beds
- Independent Living Partnership
- PATH House

Supporting People After Crisis:

- Increased social work capacity
- Rehabilitation beds
- START (Short Term Assessment and Reablement Team)
- Home from Hospital
- Stroke Association
- Social work input to support early discharge
- Step down START beds
- Headway (Acquired Brain Injury Support)
- Integrated Care Service

5.4 The Future Fit

5.4.1 During the autumn the CCG ran a major discussion with the public and clinicians as part of the Call to Action led by NHS England.

5.4.2 There were some clear messages that had strong agreement between public and clinicians. For example:

•An acceptance that some changes are needed to improve health outcomes, experience and safety for patients

•A clear expectation that any changes should be led by clinicians with full involvement of patients and communities

5.4.3 Whilst these messages came about as part of a bigger debate across the NHS in England, there was also clear recognition that it must include Welsh communities who rely on Shropshire's hospitals for their acute care.

5.4.4 So, there is now a compelling case to review the way hospital services are provided for future generations to benefit. Patients are calling for more accessible and connected care which is closer to home and responds to the needs of the local population. Clinicians are calling for safe care that brings together specialist expertise in the best way to offer patients the best outcomes and a great experience.

5.4.5 This is why the Shropshire and Teford and Wrekin CCGs are launching the NHS Future Fit programme. This will bring together patients, NHS leaders and local authority partners to analyse in detail how services are currently used and compare that with the best clinical practice across the UK and beyond. By using the outcomes from this we will develop options for how services can be improved in order to deliver excellence for the future.

5.5.6 The NHS Future Fit programme will focus on the hospital services provided by Shrewsbury & Telford Hospital NHS Trust and Shropshire Community Health NHS Trust. There are other providers of services to the Clinical Commissioning Groups who will be involved in the review and design of services, bringing their expertise and allowing us to collectively shape hospital based acute and community care. However the full services of these organisations' will not be part of the review for the Future Fit programme.

5.5 Health and Wellbeing Forward Planning

5.5.1 Terms of Reference of the Health and Wellbeing Board require the Board to refresh its terms of reference, strategy and action planning annually and as such the Board is being asked to consider this paper and the recommendations.

5.5.2 In light of the new statutory requirements for the Board (the Better Care Fund) and the large scale planned transformation programmes, the Health and Wellbeing Board must not lose sight of the priorities of our population highlighted in the JSNA and through consultation and engagement. The Board must make certain that these priorities are captured in the framework of our health and social care plans and transformation.

5.5.2 The Board must work to support the delivery of integration and quality and develop our processes for holding one another to account for delivery of an integrated health and social care service in Shropshire. To do this the Board will develop its governance structure and performance monitoring. It will also be important for the Board to understand and develop its role in communication of both the Board's work programmes and how it can support the Health and Social Care economy.

5.5.3 The Board will be required to hear the evidence of the JSNA that incorporates engagement and consultation results, it will also routinely monitor quality and performance and it will ensure that it is discharging its statutory duty to oversee health and social care developments and integration.

6. Additional Information

None.

7. Conclusions

None.

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) Karen Calder
Local Member
Appendices

General Medical Services
Shropshire County Area

Staffordshire & Shropshire Area Team March 2014

THE NHS CONSTITUTION
the NHS belongs to us all

Summary- No Change

- Number of GP practices = 44
- Number of WTE GPs = 160

- GP to patient patio (Shropshire) = 1,948
- GP to patient ratio (Area Team) = 2,101
- GP to patient ratio (England) = 1,900

<u>Contract type</u>

GMS = 34

PMS = 9

APMS = 1

Shropshire Practices- Contractual Actions

- No Contractual actions/notices to GPs in 2013/14, generally well performing
- NHS England Primary Care Assurance Tool, no practices were classed as outliers (5 or more negative indicators)
- QoF scores are generally better than the NHS England and AT average. Average score 974 (1000 max)

Shropshire Positive Updates

- Willow street merged with Cae Glas practice in Oswestry to form the new Cambria practice on 1st April 2013 in the new primary care centre. GP, community and therapy services including minor injury unit and x-ray on this site!

- Work on a new surgery for Cleobury Mortimer due to be completed at the end on May 2014. Large Practice with over 7000 patients will have wrap around community services

- Bishops Castle long standing partnership dispute now resolved, sustained work from the Area Team to enable resolution

AT Plans for the next year

- Primary Care Joint Commissioning Board- with AT, CCG and LA – 5 key programmes
- **Programme 1-** Unwarranted Clinical Variation. Systematically identify and address the systemic and clinical causes of variation and significantly improve the poorest practices.
- **Programme 2-** Improved Access We will explore innovative approaches to improving access to general practice services. We will look to support the changes to the urgent care system to make 7/7 working a reality across the whole system
- **Programme 3- Workforce** We will build on existing good work and look to address the workforce problems facing general practice in Shropshire and Staffordshire (300k Identified)
- **Programme 4- "At Scale Work stream"** Where appropriate we will to explore the shift to working at greater scale through networks, federalisation or mergers.
- **Programme 5 – Pharmacy, Optometry and Dentistry.** We will look to these professions play a greater role in treating minor ailments; empowering patients with long term health conditions to manage their own health more effectively; improving the efficiency across the whole system

APMS Review

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Health and Wellbeing Board
21 March 2014

Terms of Reference Health and Wellbeing Board

Responsible Officer Rod Thomson
Email: Rod.thomson@shropshire.gov.uk Tel: Fax:

1. Summary

1.1 With the introduction of the Better Care Fund and the large scale transformation programmes being undertaken throughout the health and social care economy in Shropshire, the governance arrangements of both the Better Care Fund and the Health and Wellbeing Board must be developed and reviewed.

1.2 The Better Care Fund guidance requires the governance arrangements for the fund to be developed prior to the submission of the final delivery plan and as such the Terms of Reference of the Health and Wellbeing Board must reflect the Better Care Fund accordingly.

1.3 More work will be required to adjust and develop the governance arrangements of the Health and Wellbeing Board and to ensure appropriate membership on the Board and the Delivery groups of the Board (including task and finish groups and subgroups).

1.4 Timescales have not allowed this review and exploration to take place as yet and therefore the attached document accurately reflects the new governance arrangements of the Better Care Fund, but work will be undertaken over the coming months in order to accurately reflect the governance arrangements of the Board as a whole.

2. Recommendation

2.1 That the Health & Wellbeing board accept **Appendix A** as the revised interim Terms of Reference.

REPORT

3. Risk Assessment and Opportunities Appraisal

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

3.1 The 'work of the Health and Wellbeing Board centres around **reducing inequalities**.

4. Financial Implications

4.1 There are no financial implications associated with this report.

5. Background

For background and guidance of the Better Care Fund, please use this link.

For a summary of the Health and Wellbeing activity and planned progress, please see the HWBB Strategic Review paper (21st March 2014 HWB Board).

6. Additional Information

None at this time.

7. Conclusions

None.

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) Karen Calder
Local Member
Appendices

HEALTH & WELLBEING BOARD
REVISED TERMS OF REFERENCE – APRIL 2013

1. Purpose

The purpose of the Shropshire Health & Wellbeing Board is to lead on improving the strategic co-ordination of commissioning across NHS, social care and related children's and public health services. Its focus will be on achieving the best possible health outcomes for all residents.

2. Health and Wellbeing Board Vision

Everyone living in Shropshire is able to flourish by leading healthy lives, reaching their full potential and making a positive contribution to their communities

3. Role

3.1. The Health & Wellbeing Board will develop, implement and annually refresh the Health & Wellbeing Strategy and Action Plan. It will do this through the help of the Health and Wellbeing Executive and by convening any necessary task and finish groups;

3.2. The Health & Wellbeing Board will have oversight and accountability for the administration and implementation of the Better Care Fund. This will include budgetary responsibility, approval of joint plans and finance and performance monitoring. Day to day accountability will be devolved to the Health and Wellbeing Executive who will be responsible for regular reporting to the Board.

3.3. The Health & Wellbeing Board will drive a genuine collaborative approach to commissioning of improved health and care services which improve the health and wellbeing of local people.

3.4. The Health & Wellbeing Board will develop a shared understanding of the needs of the local community through the development of an agreed Joint Strategic Needs Assessment.

3.5. The Health & Wellbeing Board will work with Healthwatch in Shropshire ensuring that appropriate engagement and involvement within existing patient and service user involvement groups takes place.

3.6. The Health & Wellbeing Board will consider and take advantage of opportunities to more closely integrate health services and social care services in provision and procurement.

3.7. The Health & Wellbeing Board will keep under review, the financial and organisational implications of joint and integrated working across health and social care services, ensuring that performance and quality standards for health and social care services to children, families and adults are met and represent value for money across the whole system.

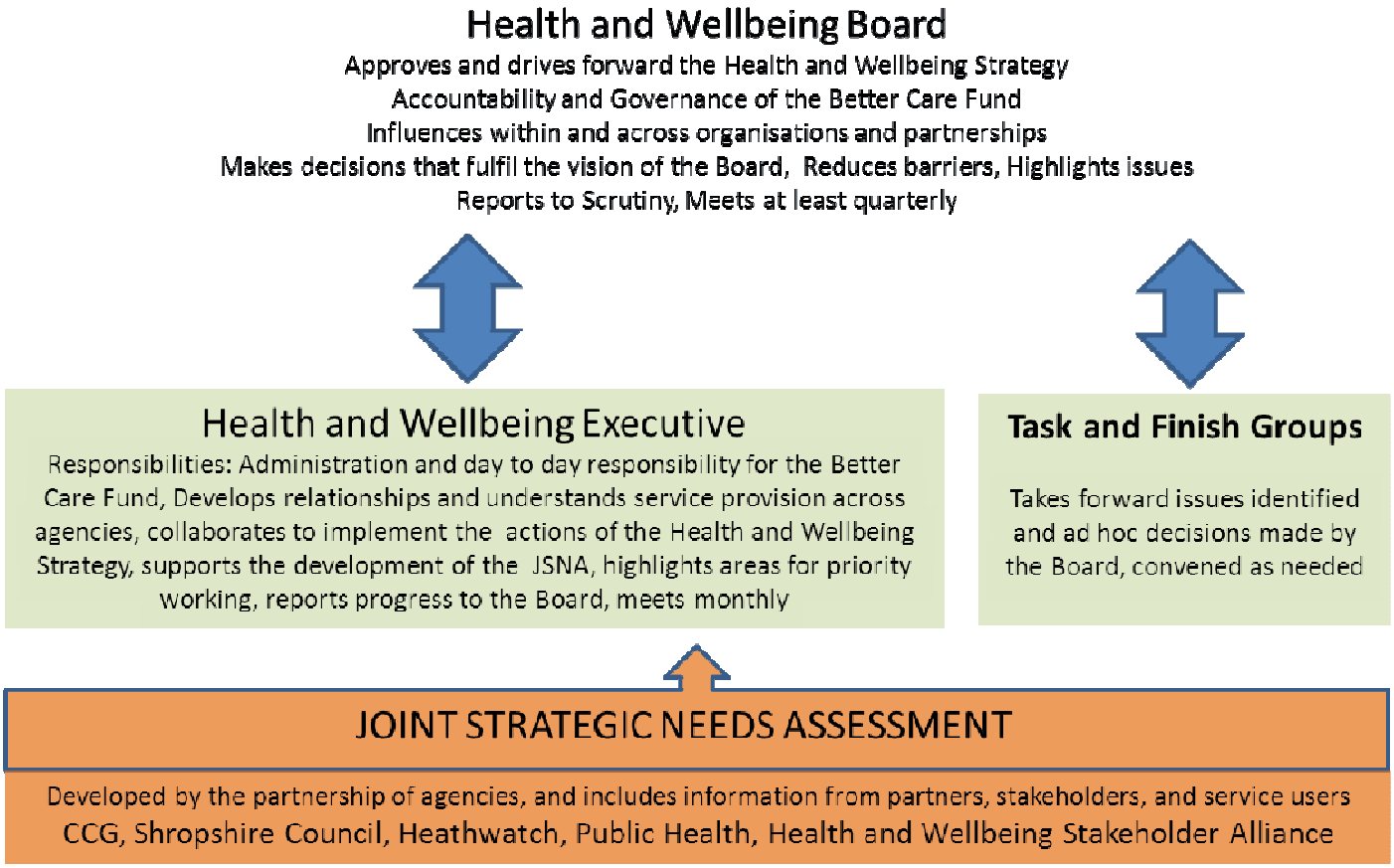
3.8. The Health & Wellbeing Board will consider options and opportunities for the joint commissioning of health and social care services for children, families and adults in Shropshire to meet identified needs (based on the findings of the joint strategic needs assessment) and to

consider any relevant plans and strategies regarding joint commissioning of health and social care services for children and adults.

3.9. To engage and influence the wider partnership to help take forward priorities and to highlight and collaborate on cross cutting issues; this will ensure that the role of government in creating a positive landscape for service delivery in Shropshire is realised

3.10. The Health & Wellbeing Board will review the operation of the Children's Trust and the Safeguarding Board for Children and Adults.

3.11. The Health & Wellbeing Board will act as a key forum for local democratic and public accountability of the NHS, social care for adults and children and other commissioned services that the Shadow Health and Wellbeing Board agrees are directly related to health and wellbeing in Shropshire.



4. Principles

To drive a genuine collaborative approach to the commissioning of services which improve the health and wellbeing of local people, the board will abide by the following principals:-

- The Health & Wellbeing Board will work primarily to improve the health and wellbeing of the citizens of Shropshire.

- The Health & Wellbeing Board will work collaboratively and consensually.

- The Health & Wellbeing Board will add value over and above our current arrangements to really tackle key priorities and delivery outcomes for our communities.

- Members of the Health & Wellbeing Board will have genuine levels of trust and an open and honest willingness to work collaboratively.

- The Health & Wellbeing Board will communicate, listen and engage with the communities they serve, actively seeking ways to enable stakeholders to influence the work of the Health & Wellbeing Board.
- Decisions will be based on evidence and data sharing will be the norm.
- Will develop creative and constructive challenge to ensure that the Board is always working to maximise its potential as partners
- Will be pro-active by developing collaborative working to deliver the HWB strategy, whilst maintaining appropriate flexibility to respond to issues as they arise.
- Responsibility and accountability - to our members, our staff and our public.
- The role and functioning of the Health & Wellbeing Board is evolving and will be subject to regular review.

5. Membership

The membership reflects the core membership as outlined in the "Liberating the NHS: Legislative Framework".

- Cabinet Member – Portfolio Holder Health
- Cabinet Member – Portfolio Holder Adult Social Care
- Cabinet Member – Portfolio Holder Children's Services
- Clinical Commissioning Group – Lay Chair
- Clinical Commissioning Group - Accountable Officer
- Director of Children's Services
- Director of Adult Services
- Clinical Commissioning Group – Vice Chair
- Clinical Commissioning Group – Chief Operations Officer
- Director of Public Health
- Representative from Healthwatch
- Voluntary and Community Sector Assembly – Representing the Voice
- Representative from NHS Commissioning Board

6. Meeting Arrangements

Notice of Meetings – meetings of the Board will be arranged by Shropshire Council, who will also provide the clerking and recording of the meeting.

Quorum – Quorum for all meetings of the Health and Wellbeing Board is 5 with at least one representative from Shropshire Council and one from the CCG and one other.

Substitutes – nominating groups may appoint a substitute member for each position. Notification of the named substitute member must be made in writing or by e-mail to the clerk, who will arrange for electronic copies of papers to be sent. Substitute members will have full voting rights.

Meeting Frequency – The Board will meet at least quarterly.

Status – Meetings of the Board will be open to the press and public and the agenda reports and minutes will be available on the Council's website at least five working days in advance of each meeting. There will be an opportunity for members of the public to ask questions, however this must be done in writing at least 2 full working days in advance. A response to the question will be tabled and a brief opportunity will be provided to the member of the public to ask a follow-up question. Guidance for this process is available on the Shropshire Council website.

Confidential Items – Members of the public and press may only be excluded either in accordance with the Access to Information Rules as set out in Part 4 of Shropshire Council's Constitution or Rule 26 (Disturbance by the Public).

7. Election, Roles and Responsibilities of the Chair and Vice Chair

Election - The Chair of the HWBB is elected from the Councillor Board Members and the Vice Chair is elected from the CCG Board Members

Responsibilities – Represent views of the Board as required; allow views to be heard fairly and cultivate an atmosphere of true collaboration.

Decision making – it is expected that decisions will be reached by consensus; however, if a vote is required it will be determined by a simple majority of members present and voting. If there are equal members for or against, the Chair will have a casting vote

8. Member Responsibilities

Represent views of the Board as required; adhere to the principles of the Board and behave in a manner conducive to partnership working and collaboration

9. Review Process

The Terms of Reference will be review annually to ensure that the Board is fit for purpose and able to respond to the changes in the way we work.

Shropshire Council | NHS Shropshire Clinical Commissioning Group | Shropshire together

Health and Wellbeing Board
21 March 2014

Quality Premium

Responsible Officer Julie Davies
Email: Julie.Davies@shropshireccg.nhs.uk Tel: Fax:

1. Summary

1.1 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 reducing inequalities.

1.2 NHS England has sought to design the quality premium to ensure that it:

- rewards CCGs for improved outcomes from the services they commission against the main objectives of the NHS Outcomes Framework and the CCG Outcomes Indicator Set, i.e. reducing premature mortality, enhancing quality of life for people with long-term conditions, helping recovery after acute illness or injury, improving patient experience, and ensuring patient safety;
- sets broad overarching objectives as far as possible, leaving CCGs to determine with health and wellbeing partners what specific local priorities they will need to pursue to achieve improvements in these areas;
- promotes reductions in health inequalities and recognises the different starting points of CCGs: all of the measures except avoidable emergency admissions include the ability for CCGs and local partners to set either partially or fully the level of improvement to be achieved,
- further promotes local priority-setting by highlighting the importance of local approaches reflecting joint health and wellbeing strategies;
- underlines the importance of maintaining patients' rights and pledges under the NHS Constitution.

1.3 The CCG is required identify 5 local and national measures that will reflect improvement in quality (discussed below) and to work with Health and Wellbeing Boards in each area identify a further local measure that should be based on local priorities identified in joint health and wellbeing strategies (15 per cent of quality premium).

2. Recommendations

The Health & Wellbeing board is asked to support the following recommendations:

i) Measure 1 Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people **- that the minimum further reduction of 3.2% is set for this target.**

ii) Measure 4. Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in their local health economy in 2014/15 and showing improvement in a selected indicator from Domain 4 of the CCG Outcomes Indicator Set **- that the indicator chosen is the one for acute inpatient and A&E and that the percentage improvement in 2014/15 should be 5% to take the target average score for positive responses from 75% in 13/14 to 80% in 2014/15.**

iii) Measure 5 Improved reporting of medication-related safety incidents - **that the local providers chosen are Shrewsbury & Telford Hospitals Trust, Robert Jones and Agnes Hunt Orthopaedic Hospital and Shropshire Community Trust. The increase in reported incidents related to medication is to be set at 10% for all providers.**

iv) Measure 6 The local measure agreed by each CCG with their local Health and Wellbeing Board and with NHS England is - **People with COPD and Medical Research Council Dyspnoea Scale >= 3 referred to a pulmonary rehabilitation programme. The target is a 20% increase in the number of this type of patient who is referred in year for a programme over and above the baseline measured for 2013/14.**

v) Quarterly progress against all these measures will be taken formally to the Health & Well Being Executive with an exception report sent to the Health & Well-being Board for information.

REPORT

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

3.1 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 **reducing inequalities**.

3.2 Risk - A CCG will not receive a quality premium if it:

a) is not considered to have operated in a manner that is consistent with Managing Public Money1 during 2014/15; or

b) incurs an unplanned deficit during 2014/15, or requires unplanned financial support to avoid being in this position; or

c) incurs a qualified audit report in respect of 2014/15.

4. Financial Implications

4.1 The maximum quality premium payment for a CCG will be expressed as £5 per head of population, calculated using the same methodology as for CCG running costs. (This is in addition to a CCG's main financial allocation for 2014/15 and in addition to its running costs allowance.)

5. Background

5.1 NHS England has published a number of documents to support planning for 2014/15 and beyond. These are

- "Everyone Counts: Planning for patients 2014/15 to 2018/19;
- The CCG outcomes indicator set 2014/15: At a glance & technical guidance
- Quality Premium: 2014/15 guidance for CCGs

5.2 The quality premium that could be paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – will be based on six 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 and including addressing locally agreed priorities for reducing premature mortality** (15 per cent of quality premium);

2. **Improving access to psychological therapies (IAPT)** (15 per cent of quality premium);

3. **Reducing avoidable emergency admissions** (25 per cent of quality premium);

4. **Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator** (15 per cent of quality premium);

5. **Improving the reporting of medication-related safety incidents in a locally selected measure** (15 per cent of quality premium);

6. **A further local measure that should be based on local priorities identified in joint health and wellbeing strategies** (15 per cent of quality premium).

5.3 All of the measures except avoidable emergency admissions include the ability for CCGs and local partners to set either partially or fully, the level of improvement to be achieved. These, together with the additional local measure, should be agreed by individual CCGs with their Health and Wellbeing Board and with the relevant NHS England area team.

5.4 The maximum quality premium payment for a CCG will be expressed as £5 per head of population, calculated using the same methodology as for CCG running costs.

5.5 **N.B.** There is no requirement to agree the target improvement for IAPT as the CCG is not achieving 13% or greater by 31st March 2014 and therefore the target required in 2014/15 is set nationally at 15% by 31st March 2015.

5.6 A discussion paper was brought to the green paper meeting in February (Appendix A) outlining the detail behind these individual measures to inform the board and for the board to discuss options for the local measure. This paper is the result of those discussions and makes the following recommendations to the board.

5.7 Recommendations - explained

5.7.1 Measure 1. Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people

Latest data shows that Shropshire is within the best quartile for this measure and therefore it is recommended ***that the minimum further reduction of 3.2% is set for this target.*** This would mean an actual target of 1897.96 (2012 baseline of 1960.7) It should be noted however that as this measure is based on death registrations and is to be achieved between the calendar years 2013 and 2014 the work of the CCG combined with colleagues in the local authority may have minimal impact on the achievement of this target in the short- medium term.

5.7.2 Measure 4. Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in their local health economy in 2014/15 and showing improvement in a selected indicator from Domain 4 of the CCG Outcomes Indicator Set

The CCG recommends ***that the indicator chosen is the one for acute inpatient and A&E and that the percentage improvement in 2014/15 should be 5% to take the target average score for positive responses from 75% in 13/14 to 80% in 2014/15.*** This is based on the work already undertaken by the CCG with Shrewsbury & Telford Hospitals Trust to improve responses linked to A&E which was a particular area of poor performance in 2013/14. The CCG has plans in place with all its providers to both address issues that were identified in this year's friends & family test and to further roll out the test in 2014/15.

5.7.3 Measure 5. Improved reporting of medication-related safety incidents

NHS England patient safety and nursing teams have committed to developing a Safety Thermometer for medications in order to measure improvement locally and also to meet the requirements of the NHS Outcomes Framework which requires the NHS to focus on a small number of key outcomes that must be measured across the country. One such improvement area indicator will cover 'incidence of medication errors causing serious harm'. The H&WB board agreed in February that the national medication safety thermometer should be used as the basis for this measure to avoid duplication and make the best use of resources available.

The CCG recommends that the local providers chosen for this measure ***are Shrewsbury & Telford Hospitals Trust, Robert Jones and Agnes Hunt Orthopaedic Hospital and Shropshire Community Trust. The increase in reported incidents related to medication is to be set at 10% for all providers.*** This is included in the quality schedules in the contracts for 2014/15 subject to final agreement. The specific areas chosen within the medication safety thermometer for increased reporting are those based on the drugs ,which if doses are missed, may cause the most harm.

5.7.4 Measure 6. Further local measure agreed by each CCG with their local Health and Wellbeing Board and with NHS England

The following measure is recommended to the H&WB Board following the discussion of the short list presented in February.

People with COPD and Medical Research Council Dyspnoea Scale >= 3 referred to a pulmonary rehabilitation programme. The target is a 20% increase in the number of this type of patient who is referred in year for a programme over and above the baseline measured for 2013/14.

This is a key component of high quality care for people with COPD and is in line with our priorities relating to improving care for people with long term conditions, specifically COPD which is a CCG priority for 2014/15. There is an issue with selecting this measure as the national technical guidance says the in-year data won't be available until June 2015. However we believe we can measure this locally via our GP practices and the Community Trust who provide the rehab programme. We are currently working with the

CCG Practice Support Team to establish the baseline for 2013/14 via our GP practices whilst obtaining this year's referral data for pulmonary rehabilitation programmes into the local community trust and will be aiming for a 20% improvement on that baseline during 2014/15.

Quarterly progress against all these measures will be taken to the Health & Well Being Executive with an exception report sent to the Health & Well-being Board for information.

6. Additional Information

7. Conclusions

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) Karen Calder
Local Member
Appendices

Quality Premium Measure Arrangements for Clinical Commissioning Groups in 2014/15

Background

NHS England has published a number of documents to support planning for 2014/15 and beyond. These are

- "Everyone Counts: Planning for patients 2014/15 to 2018/19;
- The CCG outcomes indicator set 2014/15: At a glance & technical guidance
- Quality Premium: 2014/15 guidance for CCGs

The quality premium paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – will be based on six measures that cover a combination of national and local priorities. These are:

7. **Reducing potential years of lives lost through causes considered amenable to healthcare and including addressing locally agreed priorities for reducing premature mortality** (15 per cent of quality premium);
8. **Improving access to psychological therapies (IAPT)** (15 per cent of quality premium);
9. **Reducing avoidable emergency admissions** (25 per cent of quality premium);
10. **Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator** (15 per cent of quality premium);
11. **Improving the reporting of medication-related safety incidents in a locally selected measure** (15 per cent of quality premium);
12. **A further local measure that should be based on local priorities identified in joint health and wellbeing strategies** (15 per cent of quality premium).

All of the measures except avoidable emergency admissions include the ability for CCGs and local partners to set either partially or fully, the level of improvement to be achieved. These, together with the additional local measure, should be agreed by individual CCGs with their Health and Wellbeing Board and with the relevant NHS England area team.

A CCG will not receive a quality premium if it:

a) is not considered to have operated in a manner that is consistent with Managing Public Money during 2014/15; or
b) incurs an unplanned deficit during 2014/15, or requires unplanned financial support to avoid being in this position; or
c) incurs a qualified audit report in respect of 2014/15.

NHS England also reserves the right not to make any payment where there is a serious quality failure during 2014/15 i.e. where it is identified through the CCG assurance process that:

a) a local provider has been subject to enforcement action by the Care Quality Commission; or
b) a local provider has been flagged as a quality compliance risk by Monitor and/or have requirements in place around breaches of provider licence conditions; or
c) a local provider has been subject to enforcement action by the NHS Trust Development Authority based on a quality risk and

i) it has been identified through NHS England's assessment of the CCG, in respect of the quality and governance elements of the assurance framework, that the CCG is not considered to be making an appropriate, proportionate response with its partners to resolve the above quality failure; and

ii) this continues to be the position for the CCG at the 2014/15 end of year assessment.

The total quality premium payment for a CCG will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to (a) maximum 18-week waits from referral to treatment, (b) maximum four-hour waits in A&E departments,(c) maximum 14-day wait from a urgent GP referral for suspected cancer, and (d) maximum 8-minute responses for Category A red 1 ambulance calls.

The maximum quality premium payment for a CCG will be expressed as £5 per head of population, calculated using the same methodology as for CCG running costs. (This is in addition to a CCG's main financial allocation for 2014/15 and in addition to its running costs allowance.)

Areas where the CCG need H&WB Board agreement

The following elements of the quality premium measures require agreement by the local Health & Well Being Board:-

1. Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people

Agree with Health and Wellbeing Board partners and with the relevant NHS England area team the percentage reduction in the potential years of life lost (adjusted for sex and age) from amenable mortality for the CCG population to be achieved between the 2013 and 2014 calendar year. This should be no less than 3.2% and based on the Directly Standardised Rate

4. Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in their local health economy in 2014/15 and showing improvement in a selected indicator from Domain 4 of the CCG Outcomes Indicator Set

To earn this portion of the quality premium the CCG must have agreed plans with providers to address specific issues identified from the 2013/14 FFT and deliver those plans. The number of negative responses received via the FFT for local providers must reduce between Q1 and Q4 of 2014/15. The CCG must also have assurance that providers are taking appropriate action in response to their FFT feedback and ensure providers are rolling out FFT by the end of 2014/15. The CCG Director of Nursing, Quality, Patient Safety and Experience has confirmed that these plans and processes of assurance are in place for next year.

In addition there is an improved average score achieved between 2013/14 and 2014/15 for one of the patient improvement indicators set out in the CCG Outcomes Indicator Set with the specific indicator agreed by the CCG with the Health and Wellbeing Board, the NHS England area team and the relevant local providers. CCGs should be assured that NHS providers have plans in place to reduce the proportion of people reporting a poor experience of care in line with the locally set level of ambition.

5. Improved reporting of medication-related safety incidents

A CCG will earn this portion of the quality premium if:

• it agrees a specified increased level of reporting of medication errors from specified local providers for the period between Q4, 2013/14 and Q4, 2014/15; and

• these providers achieve the specified increase.

The local measure may include improved levels of reporting from primary care.

The measure should be agreed by the CCG with its local Health and Wellbeing Board and the NHS England area team.

Where the same provider is a local provider (see below), for more than one CCG, those CCGs may wish to jointly agree an increased level of reporting with that provider.

6. Further local measure agreed by each CCG with their local Health and Wellbeing Board and with NHS England

This should reflect priorities within the local Joint Health and Wellbeing Strategy, especially where the outcomes are poor compared to others and where improvement in these areas will contribute to reducing health inequalities. The local measure should be based on an indicator from the 2014/15 CCG Outcomes Indicator Set issued by NHS England, unless the CCG, the relevant Health and Wellbeing Board and the NHS England area team mutually agree that no indicators on this list are appropriate for measuring improvement in the identified local priorities. The 2014/15 CCG Outcomes Indicator Set is attached as Appendix A
The local measure should not duplicate the other quality premium measures described above, including individual components of composite measures, nor should it duplicate the NHS Constitution measures set out below. It should reflect services that CCGs are responsible for commissioning or that they commission jointly with other organisations. It may, if a CCG and its Health and Wellbeing Board so wish, include aggregate or composite indicators.
N.B. There is no requirement to agree the target improvement for IAPT as the CCG is not achieving 13% or greater by 31st March 2014 and therefore the target required in 2014/15 is set nationally at 15% by 31st March 2015.
Recommendations
Measure 1. Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people
Latest data shows that Shropshire is within the best quartile for this measure and therefore it is recommended ***that the minimum further reduction of 3.2% is set for this target.*** This would mean an actual target of 1897.96 (2012 baseline of 1960.7) It should be noted however that as this measure is based on death registrations and is to be achieved between the calendar years 2013 and 2014 there is virtually nothing the CCG can still do to directly impact on the achievement of this target.
Measure 4. Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in their local health economy in 2014/15 and showing improvement in a selected indicator from Domain 4 of the CCG Outcomes Indicator Set
The CCG recommends ***that the indicator chosen is the one for acute inpatient and A&E and that the percentage improvement in 2014/15 should be 5% to take the target average score for positive responses from 75% in 13/14 to 80% in 2014/15.*** This is based on the work already undertaken by the CCG with SaTH to improve responses linked to A&E.

Measure 5. Improved reporting of medication-related safety incidents

The CCG recommends ***that the local providers chosen are SaTH & RJAH and we await the national guidance for the Medication Safety Thermometer and link our local improvement to that identified within the national target***. If the H&WB Board are in agreement with this approach, the detail of this will be included in the final paper coming to the Board in March for formal approval.
Measure 6. Further local measure agreed by each CCG with their local Health and Wellbeing Board and with NHS England

The following three measures are recommended to the H&WB Board as a short list for the local measure:-

a) People with COPD and Medical Research Council Dyspnoea Scale >= 3 referred to a pulmonary rehabilitation programme.

This is a key component of high quality care for people with COPD and is in line with our priorities relating to improving care for people with long term conditions, specifically COPD which is a CCG priority for 2014/15. There is an issue with selecting this measure as the national technical guidance says the in-year data won't be available until June 2015 but we are currently exploring with the CSU whether we can measure this locally via our GP practices and the Community Trust

who provide the rehab programme. If the monitoring can be arranged this would be our preferred option.

b) Care Coordination

The Community and Care Coordinator Project in Shropshire is a key strand of our long term conditions strategy and our Frail and Complex work. It is also intended to be part of our Better Care Fund work. This would be a local measure not identified within the national outcomes framework that could either record:-

i) The increase in the number of patients who had their care coordinated vs the number measured in 12/13 or

ii) The increase in the referrals to the voluntary sector from the care coordinators

Either of these measures is a step towards monitoring the expected reduction in the dependency on statutory bodies for the care required by the elderly to maintain their independence. This could be the basis for a crucial indicator for the future assessment of the impact of the Better Care Fund. If the H&WB Board consider this to be of sufficient importance the CCG will work with its CSU to confirm the actual position for 12/13 as the baseline and support the collection of the data in 14/15 to demonstrate the level of improvement. If the H&WB Board are in agreement with this approach and we secure the support of the NHS England local area team, the detail of this measure will be included in the final paper coming to the Board in March for formal approval.

c) Estimated diagnosis rate for people with dementia.

Dementia is a key priority for Shropshire and is highlighted in both the local JSNA and our H&WB priorities. The latest information available for this metric show that in 2012/13, the estimated diagnosis rate was 43.3%. There is a national target to deliver 67% by the end of March 2015. This equates to an increase of 1,259 diagnoses between April 2013 and end of March 2015.This is a significant increase on currently levels of performance (total of 2197 diagnoses at the end of March 2013) and the CCG believes this is too high risk for inclusion as a quality premium measure. The CCG will continue to work with its health and wellbeing partners to get as close to this target as possible during 2014/15.

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