Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 3 APRIL 2014 at 9.30am

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council
Karen Chouhan	–	Chair, Healthwatch Leicester
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group
Dr Simon Freeman	–	Managing Director, Leicester City Clinical Commissioning Group
Chief Superintendent Rob Nixon	-	Leicester City Basic Command Unit Commander, Leicestershire Police
Councillor Rita Patel	–	Assistant City Mayor, Adult Social Care
Tracie Rees	–	Director of Care Services and Commissioning, Adult Social Care, Leicester City Council
Councillor Manjula Sood	–	Assistant City Mayor (Community Involvement), Leicester City Council
Trish Thompson	–	Director of Operations and Delivery, Leicestershire and Lincolnshire Area, NHS England
Deb Watson	–	Strategic Director Adult Social Care and Health, Leicester City Council

Invited attendees

Councillor Michael Cooke	-	Chair Leicester City Council Health and Wellbeing Scrutiny Commission
Sarah Prema	-	Chief Strategy and Planning Officer, Leicester City Clinical Commissioning Group
Geoff Rowbotham	-	Programme Director, Leicester, Leicestershire and Rutland, Better Care Together Programme

In attendance

Graham Carey	–	Democratic Services, Leicester City Council
Sue Cavill	–	Head of Customer Communications and Engagement - Greater East Midlands Commissioning Support Unit

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59. APOLOGIES FOR ABSENCE

Apologies for absence were received from Elaine McHale, Interim Strategic Director, Children's Services, Leicester City Council and David Sharp, Director,

Leicestershire and Lincolnshire Area, NHS England.

60. WELCOME AND INTRODUCTIONS

Councillor Palmer welcomed everyone to the meeting. He welcomed Karen Chouhan, Chair of Healthwatch Leicester, to her first meeting of the Board in place of Philip Parkinson following her appointment as the Chair of Healthwatch Leicester. A welcome was also extended to Trish Thompson, Director of Operations and Delivery, Leicestershire and Lincolnshire Area, NHS England who was attending as a substitute for David Sharp.

61. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business to be discussed at the meeting.

Councillor Sood declared an Other Disclosable Interest arising from being a patron of CLASP and having family members who received social care services.

In accordance with the Council's Code of Conduct, these interests were not considered so significant that they would prejudice Councillor Sood's judgment of the public interest and she was not, therefore, required to withdraw during any discussion involving those items on the agenda.

62. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

that the minutes of the previous meeting of the Board held on 30 January 2014 be confirmed as a correct record.

63. BETTER CARE FUND

The Strategic Director Adult Social Care and Health and the Managing Director, Leicester City Clinical Commissioning Group submitted a report including a final draft of the Better Care Fund Plan.

Dr Freeman stated that the previous draft plan presented to the Board on 30 January 2014 had been submitted to NHS England and the Local Government Association (LGA). The draft plan had been refined following comments received from both NHS England and the LGA, who had no material concerns. In addition, a number of events had been held with voluntary and community sector groups and stakeholders which had also influenced amendments and the content of the plan.

Initial feedback had been received assessing the plan as having a medium risk and medium deliverability. Specific comments had also been made on aligning

the plan to the wider Leicester, Leicestershire and Rutland 5 Year Strategic Plan.

For ease of reference the changes to the first draft were highlighted in yellow and the final draft would be submitted to NHS England and the LGA on 4 April 2014.

It was noted that a number of outstanding contractual issues influencing whether the plan was affordable had been discussed the previous day between the Clinical Commissioning Group and University Hospitals of Leicester NHS Trust and a formal response to the agreements made was awaited. It was felt that the plan would most probably be affordable subject to a contract being signed with UHL.

Following the Chair's question it was reported that a Better Care Fund Implementation Group had been formed and would be led by the Lay Chair of the Leicester City Clinical Commissioning Group. The Group, which included representatives from the CCG, the Council and providers, would oversee the delivery of the plan and develop key performance indicators to monitor the progress of the plan. The plan represented the bulk of the Quality Innovation, Productivity and Prevention Plan (QIPP) savings plan in 2014/15 and would be reflected in the underlying contracts with the health providers.

It was also confirmed that the Group would report to the Joint Integrated Commissioning Board, and there was a commitment to include Healthwatch in appropriate ways in the process. Discussions were taking place to determine the appropriate level for this representation to take place.

RESOLVED:

1) that Better Care Plan be approved for submission to NHS England and the Local Government Association on 4 April;

2) that the Chair of the Board (Deputy City Mayor), Dr Simon Freeman (Managing Director, Leicester City Clinical Commissioning Group) and Andy Keeling (Chief Operating Officer, Leicester City Council) be given delegated authority to make any necessary subsequent amendments and approve the plan for final submission.

3) that the Joint Integrated Commissioning Board submit progress reports on the implementation of the Better Care Fund Plan to the Health and Wellbeing Board at regular intervals.

64. JOINT HEALTH AND WELLBEING STRATEGY

The Chair of the Integrated Commissioning Board submitted a report providing an update on the implementation of the Joint Health and Wellbeing Strategy.

This was the second bi-annual progress report to the Board and it aimed to provide an assurance that actions identified in the strategy were either being delivered and/or were flagged up as potential risks to delivery. In addition the report also aimed to report on the performance indicators used to monitor the progress of the strategy. The report monitored the strategy at a high level and was underpinned by separate monitoring and reporting through governance arrangements of partner organisations.

It was noted that there were no areas of the strategy where serious concerns were expressed or where action had not taken place. There were 6 areas where progress was slower than expected but it was considered that progress could be recovered. There were 10 areas where good progress was being made, particularly in relation to the initiatives relating to teenage pregnancy, alcohol, NHS checks, dementia, carers and mental health. Substantial improvements had been made in relation to initiatives for sustaining breastfeeding, bowel cancer screening uptake, reducing the number of persons aged 65+ years being admitted permanently to residential or nursing care and the success of reablement (older people supported to live at home following discharged from hospital).

Three indicators had worsened either since the strategy was published or since the last report. These were smoking cessation which was showing lower achievements of people quitting than in previous years, which was thought to be largely attributable to people using e-cigarettes and reflected a nationwide trend. There was also a slight deterioration in the number of women smoking in pregnancy, but there were relatively small numbers involved which exaggerated the fluctuations in percentage changes in this indicator. This was not felt to be a specific cause of concern or trend but there were actions being taken to strengthen performance. The third area related to indicators in relation to carers number of actions had been taken to improve the experience of carers and how they felt they were supported.

In response to a question about outcomes, it was noted that the agreed indicators contained in Appendix 2 of the report were broadly used as a monitoring process to indicate whether the contents of the strategy were delivering the changes that were being sought. Specific outcomes beneath these indicators would be monitored by the various stakeholders involved in implementing the various actions. In addition, the CCG Operational Plan had a range of outcomes, including one relating to potential years of life lost to healthcare amenable conditions, and as part of this the CGG had to commit to series of reduction trajectories relating to these areas.

It was also noted that in relation to young carers, work was in progress to enhance the current joint carer strategies between Adult Social Care, Children's Services and the CCG.

Following questions about whether there was a further breakdown of figures for ethnicity etc in relation to the indicators for health checks concerning heart disease, high blood pressure, cholesterol and diabetes as well as mental health; it was noted that the CCG had information which indicated that there

was a consistent level of take up for health checks from all groups in differing parts of the City. It was also noted that the health economy was currently struggling with regard to mental health bed capacity and that the three CCGs have recently begun a review of pathways for mental health across the City and the County to improve care and outcomes for patients and in particular review capacity, and this review will report later in the year.

The Chair commented that the report indicated that the direction of travel was making progress but it did not fully recognise that there was a lot of work going on to improve and secure improvements in relation to mental health outcomes. A number of mental health summits had been held in the City and the Council's Health and Wellbeing Scrutiny Commission were currently undertaking a review of mental health services for young black British men.

RESOLVED:

1) that the progress on the delivery of the Joint Health and Wellbeing Strategy be noted.

2) that the Board noted with concern that 20% of the indicators had slipped from the baseline but also noted that remedial actions were being taken to address these.

3) that future reports include both percentage changes and actual numbers involved in the performance indicators.

65. LEICESTER CITY CLINICAL COMMISSIONING GROUP - 2 YEAR PLAN

The Managing Director, Leicester City Clinical Commissioning Group (CCG) gave an introduction to the presentation providing an overview of Leicester City Clinical Commissioning Group's 2 Year Operational Plan which had to be submitted to NHS England on 4 April 2014. The whole of the health economy in Leicester and the County were required to submit a 5 Year Strategic Plan setting out the medium term direction of travel for health care and support provided across Leicester, Leicestershire and Rutland by the three CCGs, the three local authorities with responsibility for health and the two main health NHS Trust providers.

Sara Prema, Chief Strategy and Planning Officer, Leicester City CCG, gave the presentation, a copy of which is attached as an appendix to these minutes. In addition to the points illustrated in the presentation, the following comments were made:-

a) Whilst everyone over 75 years old would have an accountable GP and a care plan, not everyone would need a detailed care plan, as this would be dependent upon their health condition.

b) The Urgent Care Working Group were taking action to deliver improvements in urgent care and to deliver the NHS responsibility to provide access to A&E and this would be discussed further at the

later meeting of the Board.

Following questions on the presentation it was noted that:-

a) Transforming primary care services would require a new model of GP service delivery. The old model for basic patient care had worked well but there would not be any improvements in service delivery without a new service model. Discussions on a new model were at an early stage and other models that had worked well elsewhere in the country were being appraised. The new models would need to provide for more team working and integrated coverage based upon federation or locality working, particularly in view of the large number of single doctor practices in the City.

b) GPs recognised that the existing model was not sufficiently robust to meet the challenges on meeting the transformation of primary care services, through the Better Care Fund, and a major challenge was getting sufficient resources in the community to ensure that it was possible to move from one model to another. There were challenges to recruit more GPs to work in City practices, develop a trained workforce that was fit for purpose, develop effective team working and ensure there was good communication with all sectors of the heath economy and social care, if the desire to keep people out of hospitals was to be delivered.

c) There was more to be done on 'patient education' within the context of communications as part of the strategic objectives to make patient aware of different referral pathways. Specific work was taking place with local authorities around the lifestyle hub as part of this. More communications work was needed reducing the need for hospital care and retaining patients within the primary care and community care sector for longer to reduce hospital admissions. A strong communications plan would be would be essential for this to be achieved. It would also be essential to get the communications right to explain other changes and to get commitment from both clinicians and the public to the changes otherwise any system that was established in the future would be liable to be undermined by patients not following the appropriate pathway.

d) In response to a question about CCG surpluses, it was clarified that there were NHS planning requirements for CCGs to plan for a budget surplus and as these were required to be recreated each year, the surplus did not effectively exist and was not available to the CCG to spend.

e) The CCG had an obligation to work with its member practice GPs to improve quality and outcomes for patients. Within the operating plan there were a number of requirements including that by March 2015 all GP practices in the City would have to offer online facilities to

make an appointment and to request a repeat prescription.

f) A learning and development event (Projected Learning Time or PLT) was held each month attended by all 63 practices and an invitation was extended to the members of the Board to attend, observe and see for themselves the progress being made.

g) NHS England worked with CCGs to improve and offer better access to patients and there was also a joint responsibility with the CGGs to improve quality in patient care.

A representative of the Older People's Forum stated that older people had two areas of concern. The first was that a number of elderly people did not have access to the internet to make appointments and to ask for repeat prescriptions and the second was that older people preferred to see the same doctor each time for their treatment. It was requested that this be borne in mind in future planning. In response Karen Chouhan stated that Healthwatch had made primary care and access to it a priority and they would be discussing this with the CCG. It was also stated that the introduction of a named doctor for patients over 75 years old would ensure that the same person could be contacted for patient care issues.

It was noted that whilst the comments of the Older People's Forum representative were accepted, it must be remembered that most GP practices in the City were working hard under difficult circumstances and were experiencing difficulties in recruiting staff in some parts of the City. Public expectations were increasing and it must be recognised that operational difficulties existed.

Following a question from a member of the public in relation to people over 75 years old being susceptible to fragility fractures, it was stated that this would be considered when each person's care plan was prepared and reviewed.

RESOLVED:

1) that the presentation be received and noted; and

2) that further update reports be submitted to the Board during the life of the Plan.

3) That members of the Board be invited to the next PLT meeting.

66. LEICESTER, LEICESTERSHIRE AND RUTLAND 5 YEAR STRATEGY (BETTER CARE TOGETHER)

The recently appointed Programme Director for Leicester, Leicestershire and Rutland Five Year Strategy submitted a report on the 5 Year Strategic Plan required to be submitted to NHS England.

The Leicester, Leicestershire and Rutland (LLR) Better Care Together Board held a Health and Social Care partner summit in January 2014 at which a shared vision for all partners was agreed together with the key actions required to support its successful delivery.

Five priority clinical work streams based on local needs assessments had been agreed for immediate review. These were cancer, cardiovascular disease, respiratory disease, dementia and mental health and substance abuse.

The Leicester, Leicestershire and Rutland health economy had been identified as one of the 11 distressed health economies that would be offered support from April 2104 by NHS England, the Trust Development Authority and Monitor to develop the 5 Year Strategic Plan. Ernst and Young had been commissioned nationally to help with producing the 5 Year Plan in the 11 distressed health economies by the end of June. The framework document for the 5 Year Plan would be submitted on the following day and would form the basis for developing the details of the 5 Year Plan with Ernst and Young.

The Programme Director had met approximately 60 partners in health and social care including Healthwatch and the voluntary sector to review the current position in relation the governance of the programme. It is being proposed that the programme will be streamlined to become more effective and focused. The Programme Board would also be extended to include the 3 Chairs of the LLR Health and Wellbeing Boards and the 3 Chairs of the LLR Healthwatches to make the Board more balanced. Reference groups have also been introduced to provide a reference point for the Board as the strategy develops and is implemented. The Public and Patient reference group would be co-ordinated by the 3 Healthwatch Chairs. The other two reference groups would be drawn from clinical and political representatives. The Political Group would help the Board to understand how to take the recommendations forward through the various political structures within Leicester, Leicestershire and Rutland.

The five clinical work streams were being developed and work was being prioritised along 3 key criteria areas of quality (improve outcomes and patient experience), scaleability (opportunity to scale up to have the maximum impact in the quickest time) and achievability.

The four key next steps were:-

a) A LLR Health and Social Care Partnership Group had been established to develop the 5 Year Strategy with the external consultants.

b) A cross partnership programme governance structure was being put in place to ensure an effective and timely approval and implementation of the Plan and to demonstrate that there is a clear governance structure.

c) Developing an Integrated Health and Social Care Communication & Engagement Programme. A further summit was planned for the 6

May 2014.

d) Philip Parkinson had agreed to be the Interim Chair of LLR Board over the next few months and to lead on recruiting the substantive Chair of the Board.

The Chair expressed concern at the appointment of external consultants for the 11 areas chosen for additional support and the cost to the health economy for this and questioned the value that it would add to the process. What assurance could be given that they would be working to a local health agenda and not a national government agenda and how would the structure execute decisions within the existing democratic structures it the health system?

In response the Programme Director stated that there were insufficient resources within the organisation involved in place at the moment to provide the work by the timescales required without any detrimental effect on the day to day work and service provision. The Programme Director and the Chief Executive of University Hospitals of Leicester NHS Trust had met with the consultants yesterday and there was a clear understanding about the different relationships and how they would work and all parties were committed to undertaking a piece of work that was owned and developed by the Board. As part of the process the Board had to demonstrate clear evidence and give an assurance that there was the ability, commitment and structure in place to deliver the Plan and the consultants would be a valuable means of giving that assurance to a number of other bodies, including the Health and Wellbeing Board.

The Director of Operations and Delivery, Leicestershire and Lincolnshire Area, NHS England, stated that the engagement of external consultants was to strengthen the decision making and governance areas around the Better Care Together Programme, particularly as sufficient progress had not been made to date. Also, given the current financial situation of the local health economy and the provider issues in relation to their deficit and the very difficult current commissioning round, the appointment of consultants was necessary to take the process forward and the governance arrangements were particularly strengthened by having that external support.

Following a further question from the Chair, it was stated that external consultants had been commissioned nationally and not left to local to commissioning arrangements by NHS England, the Trust Development Agency and Monitor because they wished to have oversight of the process and to co-ordinate the external support to ensure that resources were targeted to where they were required. It was also unlikely, that given the current £40m deficit in the local health economy, such decisions would be taken locally and not nationally.

After further questions from members of the Board it was stated that:-

a) The Better Care Together Board would sign off the 5 Year Plan initially and then each constituent body would be required to fulfil its

objectives in the Plan by submitting their own 5 Year Strategies.

b) Each Health and Wellbeing Board would be expected to receive the Plan as well.

c) There was no formal report expected from the external consultants, the only report from the process with the consultants would be the 5 Year Plan to be presented to the Better Care Together Board and others.

d) That in relation to keeping the vision clear and simple to understand, it was accepted that the strategic vision needed to be seen with the objectives behind it for it to become clearer as they were more action orientated. This point would be taken back to the Better Care Together Board for further consideration.

e) The feedback from the previous engagement and consultation events had been taken on board and any draft reports and information to be discussed at the 6 May event would be circulated in advance so these could be considered by participants beforehand.

f) Councillor Palmer would be representing the Board on the Political Reference Group and work would start soon on developing the terms of reference for the group.

The Chair stated that he had already suggested that the Political Reference Group should also include the 3 chairs of the health scrutiny committees/commissions for each authority as this would strengthen the political input by including both executive and scrutiny members. He hoped that this would be accepted by the Better Together Care Board.

It was noted that the programme was essentially designed to provide good care and at an early stage so that fewer things could go wrong and there would be less people in hospital when they didn't need to be, which was good for both individuals and the future sustainability of the health economy. However, this was dependent upon the right plans being developed and being able to be implemented at pace. The governance arrangements were also important to reinforce the local ownership and control of the programme and it was encouraging that these had been strengthened in recent weeks. The Programme Director was also thanked for the progress made since his appointment.

Following a question from a member of the public the Programme Director indicated that the base evidence used to reengineer the local health economy through this process would be shared with the public.

RESOLVED:-

that the progress made in the last 12 weeks be4 noted together with the proposed key steps to be taken during the period in April-

June.

67. NHS ENGLAND DRAFT OPERATIONAL PLAN 2014/15 AND EMERGING STRATEGY UPDATE

Trish Thompson, Director of Operations and Delivery, Leicestershire and Lincolnshire Area Team, NHS England, presented a report on the Draft Operational Plan 2014/15 and Emerging Strategy update.

The draft plan had been prepared by taking account of the health needs of the population from resources made available and by canvassing Directors of Public Health to identify key strategic issues. The draft plan was being shared with all Health and Wellbeing Boards and public health colleagues with a view to receiving comments during April so that the final plans would take account of commissioning appropriate services to meet the needs of the population.

The Strategic Director for Adult Social Care and Health referred to the floor targets in the Commissioning Intentions for NHS England nationally and to the undertaking made by the Area Director at the last meeting that where the targets in Leicester were higher than the floor targets, there would be no reduction in these targets as Leicester wished to see a process of continual improvement particularly in relation to immunisation and cancer screening. The Strategic Director also made the following comments:-

a) The performance data in the plans related to Leicester, Leicestershire, Rutland and Lincolnshire and these average figures did not present a true picture for Leicester as it tended to perform less well than Leicestershire, Rutland and Lincolnshire. Specific performance data for Leicester would be preferable.

b) Equally, the overall targets for Leicestershire, Rutland and Lincolnshire could also be made specific to Leicester.

c) It was unlikely that the 75% target for seasonal flu immunisations for the over 65 year olds would be achieved in 2014/15, and it was suggested that, as public health and social care staff with voluntary sector partners had already taken part in work relating to this, they could work with NHS England to strengthen the outputs required.

d) The 5 year strategic and 2 year operational plans currently being prepared relied heavily on a robust primary care sector and it was difficult to see what means of funding for primary care was in these draft plans.

e) It was welcomed that the importance of oral health in the City was recognised given the last dental survey which had led to the City putting in place a local strategy to improve the situation. The support from NHS England in this strategy was also welcomed. Increasing the overall provision of dental services would also be welcomed to improve dental care in the City.

In response, the Director of Operations and Delivery stated that:-

a) The comments relating to providing more focused performance data and overall target aims were noted and it should be possible to provide more Leicester focused information and targets.

b) In relation to the funding issues it would be possible to provide a further briefing specifically relating to Leicester.

Members of the Board referred to recent communications and a meeting the previous day relating to the loss of practice differential rates for GPs funding. A number of points raised included:-

a) It was not totally clear where this left GP practices in the City and anything that reduced access to GPs was of concern.

b) The CCG would need to work closely with GPs to improve the understanding and uncertainty caused by the recent communications from NHS England.

c) It was understood that the proposal would also mean NHS England moving funds from the target part of the budget to the basic global sum part of the budget as a result of removing the differential payments which were designed to allow GP practices in the City to complete equally.

d) It was understood that the removal of these payments amounted to a continued recurrent loss of £2 million in the Leicester, Leicestershire and Rutland budgets. This was likely to reduce access to primary care at a time when increased access was required.

e) The proportion of NHS budget spent on primary care had decreased in the last decade from approximately 11% to 7-8% and if more primary care was required under the Better Care Together Strategy then this trend needed to be reversed.

f) Different areas had different needs and Cities with large areas of deprivation would now be expected to provide services for the same costs as areas with higher levels of affluence.

In response the Director of Operations and Delivery stated that:-

a) All GP practices received letters on 1 April 2014 informing them of the proposed changes and the reasons for the changes in order to realign funding in primary care so that is was equitable and consistent for all practices.

b) The previous minimum income guarantee payments dated back to

2004 and it was viewed that, as some practices received more in payments per patient for providing the same care, this was not considered fair and equitable.

c) The National Guarantee Payments would be phased out and the standard payment was being increased from £66 to £73 in November 2014. Some practices in Leicester received up to £74 under the previous guarantee payment scheme.

d) The changes would enable services to be commissioned in line with national standards.

A member of the public stated that it seemed as though the situation was leading to less funding for primary care cloaked in equality balance etc. They commented that if care was being moved into primary care, more money was needed to pay for it.

A member of the public referred to the comprehensive review of all specialised services outlined in the report which was intended to ensure that care was centred around centres of excellence and asked if the data for making any subsequent changes in the service provision could be made available for public scrutiny. The Director of Operations and Delivery stated that it was expected that any evidence submitted as part of the review would be made available.

RESOLVED:

1) That the contents of the draft plans be noted.

2) That the comments made above be noted by NHS England and that any further comments be fed back through the Strategic Director of Adult Social Care and Public Health.

3) That a further presentation be made at the next/future Board meeting to provide more clarity and a specific overview of the funding proposals for Leicester.

68. QUALITY PREMIUM REQUIREMENT - INCREASED REPORTING OF MEDICATION INCIDENTS

Dawn Leese, Director of Nursing and Quality, Leicester City CCG submitted a report on the Quality Premium Requirement – Increased Reporting of Medication Incidents. Sarah Prema, Chief Strategy and Planning Officer, gave a short presentation on the report These premiums were being paid to CCGs as an incentive to increase outputs and reduce inequalities. The payments were £5 per head and payments earned in 2014/15 could be spent on healthcare in 2015/16 if targets and conditions were met. Equally the payments could be reduced if conditions were not met.

There were 6 measures, 5 of which were prescribed and one chosen locally. These were:-

- Reducing potential years of life lost from causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality (seasonal flu, falls and pneumonia etc). The target was a 3.2% reduction in the first year increasing to 7.4% in 2018/19. It was not considered that 3.2% would be achieved in the first year so a target of a 1.5% reduction per year had been agreed.

- Improving Access to Psychological Therapies – 17% of the population to enter treatment by the end of 2014/15 and 20% by the end of 2015/16.

- Reducing avoidable emergency admissions – either a reduction of the 2013/14 outturn or less than 1,000 admissions per 100,000 population.

- Addressing issues identified in the 2013/14 Friends and Family Test (FFT) supporting the roll out of the FFT in 2014/15 and showing improvement in locally selected measures. (Move from 162.6 to 159.4 in 2014/15 of proportion of people reporting poor patient experience of inpatient care).

- Improving the reporting of medication related safety incidents based on a locally selected measure. Increase reporting incidents by 15%.

- Increase referral to weight management services following a NHS Health Check (Local Measure). Increase referrals to 619 in 2014/15 (5% increase)

Each of the six targets accounted for 15% of the total payment, except the target to reduce emergency admissions which accounted for 25% of the total payment.

Details for the local indicator were set out in full in the report.

RESOLVED:

1) That the quality improvement requirement for the CCG in 2014/15 be noted.

2) That the target increases and approach be approved.

69. PEER CHALLENGE REVIEW FEEDBACK

The Chair provided an update on the initial feedback received on the Peer Challenge Review. The Chair thanked everyone for their participation in the review and stated that the initial feedback had been positive, indicating the Board had a clear sense of direction and good levels of understanding of the issues before it. The Chair was having a discussion by phone with the review lead the following day and would circulate the formal letter/report of the review.

A Board development day focusing on the report would be held later in the month.

70. ANNOUNCEMENTS

There were no announcements from Members of the Board.

71. QUESTIONS FROM MEMBERS OF THE PUBLIC

No further questions were received from members of the public attending the meeting.

72. DATES OF FUTURE MEETINGS

The Board noted that future meeting would be held on the following dates:-

Thursday 3 July 2014
Thursday 9 October 2014

Meetings of the Board would be held in the Council Chamber, 1st Floor Town Hall, at 10.00am unless stated otherwise on the agenda for the meeting.

The Chair stated that meetings of the Board may become more frequent as a result of the LGA Peer Challenge Review. Details of any additional meetings would be notified in due course.

73. CLOSE OF MEETING

The Chair declared the meeting closed at 11.25 am.