Better Care Fund Meeting
Wednesday 5th February 2014 - Blackpool Stadium, CCG Boardroom

In attendance:

Blackpool Council
Neil Jack, Chief Executive
Delyth Curtis, Assistant Chief Executive
Dr Arif Rajpura, Director of Public Health
Steve Thompson, Assistant Chief Executive – Treasurer Services
Lynn Donkin, Public Health Specialist
Judith Mills, Public Health Specialist
Liz Petch, Public Health Specialist
Nicola Stubbins, Head of Adult Safeguarding and Wellbeing
Mark Golden, Finance Manager
Hilary Shaw, Head of Business Support and Resources
Val Raynor, Head of Commissioning
Scott Butterfield, Corporate Development Manager
Traci Lloyd-Moore, Health and Wellbeing Project Officer

Blackpool CCG
Dr Amanda Doyle, Chief Clinical Officer
David Bonson, Chief Operating Officer
Gary Raphael, Chief Finance Officer
Howard Naylor, Head of Organisation Development and Corporate Business
Steven Gornall, Assistant Director of Primary Care Development
Helen Lammond-Smith, Head of Commissioning

NHS England
Jane Higgs, Director of Operations and Delivery

Voluntary and Community Sector
Richard Emmess, Chief Executive Blackpool Wyre and Fylde CVS

Blackpool Teaching Hospitals NHS Foundation Trust
Wendy Swift, Deputy Chief Executive, Director of Strategy
Feroz Patel, Assistant Director of Finance
Liz Holt Director of Community Health Services
Pauline Tschobotko, Nurse Manager
Vicki Ellarby, Director of Business Development

Better Care Fund Update – David Bonson			
Overview	**Considerations**	**Issues**	**Actions and Timescales**
David presented an update explaining that the first draft of the template needs to be submitted by 14th Feb with a final submission by 4th April (The first iteration signalling intent and direction of travel). **See presentation** David outlined some of the key conditions of the Fund which includes protection of social care services, 7 day working and a pre-requisite to use the NHS Number. **Pay for performance** There would be a payment for performance element based on key performance metrics to include reablement, reduced admissions and other local metrics which we will be held to account for. David explained that the target can be a process – e.g. use of NHS number **Completing the template** David advised that this would need to be taken up outside of the meeting – but the key aim of the draft is to signal where we are going **The Vision and Aims** The vision is a variation of the health and wellbeing vision set out in the JHWS and has been agreed by the Board. Aims to achieve this vision were agreed at the	**The Model** Will move us towards a local way of working based around GP Practises. This will involve development of a neighbourhood model comprised of multi-disciplinary/agency teams focusing on health prevention and wider issues with clear navigation/pathways through the system. Acute would feature at the top end as a specialist service with community services attached to GPs and patients supported to maintain health by access to local care **Public Consultation on BCF - Feedback from Shaping the Future Event 31st Jan.** Overall it was deemed to be a positive first step. No one disagreed with the proposal and understood why the changes were required. The concept of the vision/core of the model was well received by the public but people want clarity about • how this will happen • what improvements will happen as result	**NHS Number** • Working with CSU on technical issues of using the number **Implications on Acute Sector** • Achieve reduction in NEL activity and length of stay which will mean fewer beds • Less money going into acute system • Must achieve this by migrating the risk	David clarified next steps and key dates: • First draft BCF template to be submitted by – 14th Feb • Full Submission – 4th April • Continued Engagement – Public, Health Scrutiny • Ongoing discussion with the Trust on risks Healthwatch to provide hard data on public consultation event to support the submission – Nicola to request this David to circulate template to relevant partners including the Trust for their input so that the template is ready for submission on 14th Feb

meeting on 10th December (see attached) **Pooled budgets** Work is underway to align budgets **Internal and External Support** In moving forward additional support would be provided by Andy Roach – Director of Integration and Transformation, Blackpool CCG Blackpool has been selected by NHS England to work with Oliver Wyman (National consultants on models of care and risk stratification) to support us in our thinking in shaping the model http://www.oliverwyman.com/index.html			

Community Mapping – Dr Arif Rajpura			
Overview	**Considerations**	**Issues**	**Actions and Timescales**
Community Mapping Arif led a presentation outlining his vision for the future health and wellbeing in Blackpool and the key issues facing health and social care highlighting the importance of social support – **see presentation** **Update on mapping** Large maps illustrating different Model/Hub options were presented using social groups (segmentation) mapped to postcode level. GP practises were coded by level of disadvantaged against national deciles. Cleveleys identified as the least deprived area 3 patterns have emerged from the mapping exercise • North (of railway line) (characterised by older population) • Central (characterised by single, transient, poor quality housing) • South (of Yeadon Way) Option 1 – 5 areas by grouping practices into North and South with Central split into 3 Option 2 – 4 areas by grouping practices into North and South with Central split into 2	**The future system** There is a need to re-engineer the system and move social issues away from the health service which needs to remain clinically focussed The greatest barrier is the entrenched disease model of care. There was consensus that that the new model would lead to healthier communities which are more resilient, but presently the system reacts to demand It was queried what the lead in time is to make healthier communities. Arif stared that if we get the model right model this could occur within in less than a generation **Volunteering** We need to industrialise volunteering. This is a low cost option to providing services and can be moved forward through the Fairness Commission. There is a need to tap into unused talents to solve social problems –e.g. hospital members, hospital to home schemes **Key considerations** • Evidence suggests that a modest rise in non-professional care reduced demand for health and social care services • The Third/Voluntary Sector have a key role to play as well as families, Church and Faith Groups	**Care Co-ordination** The Care navigator role is not just about signposting but actively managing service users through the pathway and providing follow up. With intensive teams set up to look after the highest users within a neighbourhood. **Community Health workers** Linking to care co-ordination the scope of the CHW role needs to be taken forward as evidence shows the positive impact of CHWs on improving health outcomes **Community Orientated Primary Care (COPC)** The group agreed that at the front end COPC would work but we need to have both approaches i.e. achieve technological efficiencies and improve health to reduce costs **Primary Care** • Self-directed care - needs to be more widely promoted in Blackpool and a whole infrastructure required • Role of HCAs and	Arif to explore possibility of a site visit to Bromley by Bow Principles of COPC to be incorporated into the design and development of the model To engage GPs in development of the model – as their agreement is key. Meeting with GP's to take place on 12 Feb to talk through model options.

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Pharmacists and Community Nurses also have a key role and must be engage
Promotion of self-care is key
Arif posed 6 questions for consideration – see presentation

Community Orientated Primary Care (COPC)
Is about working with communities to identify problems and solutions, agreeing and implementing interventions and evaluating their impact. The process needs time and engagement; the will and commitment of professionals and partners. The obvious benefits of COPC are that it mobilises community resources wider than primary care. Arif referred to the example in Bromley by Bow.

Nicola Stubbins added that we are doing much of this already but struggle with co-ordination. Judith Mills noted that the Wellness Service provides some of this support and care co-ordinators forms part of the Big Lottery Fulfilling lives – Complex Needs Bid
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receptionists - supporting and promoting self-care in localities, but recognised not qualified to make diagnoses

Increase in community based urgent care
Develop use of e-consultations
Improve access to diagnostics

Localities

What is cost-effective and affordable?
What can we get practices to deliver?
Localities may be different for certain services?
Some services will be coordinated by practices and some services will be part of a wider locality

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Tier Zero – Community and Voluntary Sector Capacity Building – Richard Emmess			
Overview	**Considerations**	**Issues**	**Actions and Timescales**
Richard gave presentation on capabilities and capacity of CVS – **see presentation** • Outlined definitions of CVS groups • Infrastructure based on NCVO structure across three thematic areas (Lifestyles, Heath and Social Care, Society and Environment) covering Fylde Coast Area and Blackpool 305 health and social care organisations in total a working at Tier Zero Level Richard highlighted the number of volunteers working across Wyre Together calculated as 22,000 hours per week with a monetary value of over £7 million per year	**Groups working in Blackpool** • Micro-organisations (unconstituted, some are health based and self funded and unlikely to seek commissioned work)] • Medium sized – part time funded posts – UR Potential, CVS, well networked locally and can seek commissioned work • Large – Branches of national charities – Age UK, Oxfam – focus on fundraising, well connected into local groups with local delivery reliant on community organisations Richard gave an overview of activity at Tier Zero **South Beach Community Champions** • Public Health funded, set up by 2 business groups • Suicide and Social Isolation are key issues in the area • Local groups – trained up volunteers using Time to Change • Friendship groups have been established - referrals into Transience Groups, Health Trainers and It's a Goal. • Moving to becoming self-sustaining **Revoelution** • £1mill Big Lottery Fund project in the Central Drive area • Community-led project focussed on • Economy, health (Drugs and Alcohol)	**Making the connections** In term of BCF there is a need for a detailed map to work out how to incorporate these groups **Community Networks** Community networks are being developed and need to link into BCF **Co-ordination** There is a substantial amount of 'Asset Based Community Development' work underway at Tier Zero which requires co-ordination and needs to be linked into the social support infrastructure as outlined in Arif's presentation with the intention that this is included in the model design	Richard to circulate Wyre Audit report (volunteers)

	• Activities for young people • Environmental improvements to Central Drive • Greenspaces (supported by Groundwork) The local Residents Association are also involved in Revoelution supporting initiatives around welfare, mental health and debt management		

Discussion and actions			
Overview	**Considerations**	**Issues**	**Actions and Timescales**
Delyth gave an update on progress against the actions and outcomes from the meeting on 10th December • Mapping of areas – undertaken • Social isolation work – started • Public consultation – started • Health and Wellbeing Board sign off – agreed • Delegated Authority – agreed • Use of NHS Number – in progress • Review of what is working/not working – in progress • Modelling – not yet started • Workstreams - not yet started	• Operational, Financial and Section 75 Legal Framework • Further reviews on governance and buy-in • Workforce changes and HR Considerations • Shared records/shared IT **Governance** • It was agreed that Strategic Commissioning Group would act as the Programme Board **Development of workstreams** • The group agreed to adopt the same process used in the transfer of Public Health to the Council. Suggested workstreams - Operational and Design - HR - Estates - Finance - Risk Governance - ICT/Shared information - Communications/Engagement	**Governance** • Clarity is needed about the how the model would work locally – line management responsibility • Clarity is needed about what the model offers/delivers in terms of services • Clarity is also needed about governance in agreeing/development of the model and overseeing spend – reporting lines	A follow up meeting to be organised for Thursday 3rd April following similar format. Traci to circulate 'hold-the-date' email to all attendees. The Operational and Design Team agreed as the first group to be established to include • Delyth Curtis • Arif Rajpura • Les Marshall • Val Rayner • Andy Roach • Mark Johnston • Helen Lammond-Smith • Steve Gornall • Wendy Swift • Pauline Tschobotko • Liz Holt • Healthwatch representative The Operational and Design team to meet no later than **21st February** for an initial meeting to: • Re-confirm the strategic vision and aims – how do we see the future service delivery? What will

			services look like 2014-2019? What are the new service models and different ways of working? • What is a workable locality model? • What are the workstreams /working groups needed? Who should be on these? What are the governance arrangements for these? • What's the immediate delivery plan 2014-2015-2016?