Appendix 6a

Strategic Commissioning Group
Notes and Actions
18 June 2014, 1:30-3:30pm
Pitchview Room, Stadium

Present	David Bonson, Chief Operating Officer, Blackpool CCG (Chair) Dr Amanda Doyle, Chief Clinical Officer, Blackpool CCG Steve Thompson, Assistant Chief Executive – Treasurer Services, Blackpool Council Dr Mark Johnston, Associate Director Acute Commissioning and Service Redesign Blackpool CCG Helen Lammond-Smith, Head of Commissioning, Blackpool CCG Gary Raphael, Chief Finance Officer, Blackpool CCG Andy Roach, Director of Integration and Transformation, Blackpool CCG Dr Arif Rajpura, Director of Public Health, Blackpool Council Liz Petch, Public Health Specialist, Blackpool Council Judith Mills, Public Health Specialist, Blackpool Council Wendy Swift, Director of Strategy/Deputy Chief Executive, Blackpool Teaching Hospitals NHS Foundation Trust Jane Higgs, Director of Operations and Delivery NHS England (Lancashire)
Also present	Jeannie Harrop, Senior Commissioning Manager, Blackpool CCG Traci Lloyd-Moore, Health and Wellbeing Project Officer, Blackpool Council
Apologies	Delyth Curtis, Assistant Chief Executive/Director - Adult Services, Blackpool Council Lynn Donkin, Public Health Specialist, Blackpool Council Jane Cass, Head of Public Health, NHS England (Lancashire) Sue Harrison, Director of Children's Services, Blackpool Council

1.	**Apologies** Apologies were noted.
2.	**Welcome and Introductions.** David welcomed everyone to the meeting.
3.	**Notes and actions from previous meeting.** Notes from the previous meeting were agreed. **Actions from previous meeting:** Police representation on the Better Care Fund Programme Board

	Helen reported that a meeting with Stuart Noble has been arranged. David asked for an update at the next meeting. <u>Better Start and Complex Needs/Fulfilling Lives – programme mapping</u> Andy, Helen and Judith will meet to map out activity against the Better Start and Complex Needs Fulfilling Lives programmes. There was consensus that the programmes need to form part of the CCG strategic plan and that commissioning plans needed to be tightened up now that Blackpool had been successful in these bids. In terms of governance and accountability arrangements there was agreement that the Better Start Executive should feed into the Health and Wellbeing Board and that the revised Children's Trust should be a delivery mechanism for the Board. David advised that clear governance arrangements would be required across all programmes. The group concluded that the Health and Wellbeing Board should act as the overarching body to ensure the programmes are implemented effectively. David asked for a progress report on mapping to be brought to the next meeting. <u>Fylde Coast 5 Year Strategic Plan</u> David explained that the item was on today's agenda and that Dr Mark Johnston was in attendance to present the plan that will be taken to the Health and Wellbeing Board in July. <u>Data Access</u> Liz reported that the process was now in place and testing underway via requests to Helen Lammond-Smith and confirmed that it is currently working well. <u>HWB Project Officer Post</u> David advised to keep this on the agenda for the next meeting to discuss with Delyth Curtis. In a change to the scheduled agenda, David asked that Blackpool CCG Strategic Plan be taken as the first item.
4.	**Blackpool CCG Strategic plan 2014-19.** Dr Mark Johnston introduced the plan and noted that the final submission was required on 20th June. He outlined the planning timeline and the current position of the plan which involved, peer review, modelling and sense checking. Mark explained that this is the overarching plan for delivering and commissioning healthcare services in Blackpool and is supported by a series of smaller plans including a two year operational plan, financial plan and Better Care Fund planning. He added that the three cross cutting themes (CVD, Respiratory Disease and Mental Health) link in well with the priorities of the Health and Wellbeing Board and Public Health recognising that social isolation impacts across these areas and as a result there would be a greater focus on upstream interventions. He presented the new model of care which would focus on:

	• Self-care • Groups of GP practises • Neighbourhoods wrapped around GP practises • Community based services • Hospital care Mark explained that the neighbourhood model had been informed by mosaic profiles, practice locations and existing services and six neighbourhoods would be developed – covering the far north, north, central west and east, south central and south. Mark added that the plan describes the system we want to create and the benefits and impact of these (both financial and satisfaction). Arif commented that neighbourhoods should be based around communities, not just services and to think about natural communities. Amanda agreed, noting that subdividing is hard to do but recognised that pockets of neighbourhoods should be developed on a community level and would naturally overlay with local groups. Amanda explained that community elements would be taken into account and outlined in the plan. Amanda also emphasised the importance of GP engagement with patients and residents find out what they need in terms of services and that it was likely to happen organically. Mark explained that whilst the plan is high level it is not prescriptive and we need to think of mechanisms to capture local activity and to be mindful that neighbourhoods will engage with multiple communities. The group agreed that it would need to consider how communities and VCFS map into the neighbourhoods. Amanda requested that the presentation to the Board should draw out the key changes and highlight: • Primary Care commissioning • The vision for hospital services ,making it explicit that this is for sign up • Community engagement – making the link with the third sector
5.	**HIV Update** Judith provided an overview of the current HIV screening pilot in the AMU. She gave context by explaining that the pilot had been established in response to a letter from NICE to high prevalence areas asking them to do more screening to improve outcomes. The pilot had now been revisited after limited success. Judith explained that the introduction of the Healthcare Assistant champion - to encourage staff to improve screening for patients had resulted in an increase in uptake. Judith explained that whilst the pilot is working, if rolled out further, clarity is needed on which organisations are

	responsible for commissioning and screening (case-finding) as this was complex. Amanda and Arif confirmed that public health were responsible for screening in primary care and CCG screening in hospitals In order to build on the initial pilot, Judith asked the group to consider whether to continue: • Screening in the AMU or roll out to other hospital departments • The Healthcare Assistant champion role Judith added that NICE guidance advises that everyone should be screened, which included screening in A&E. Jane Higgs queried the impact of the pilot and whether it had proved cost-effective Steve queried the cost of screening given the low number of cases identified Amanda asked whether there was a demographic in primary care rather than AMU to ensure that further screening was more effective. Judith responded that there had been moderate success in identifying patients with HIV and of the three cases identified; two were high risk. Judith explained that the cost of treatment is high but if found later on treatment becomes more complex and therefore more expensive. Judith added that screening already takes place in high risk venues. And that the cost is £8 per test. The group consensus was that they were happy with the principle of rolling out the scheme but felt that continuing to screen in AMU maybe at too late a stage as patients would already be showing signs. The group agreed at this stage: • To continue screening in AMU • To look at other options for the general population to include NHS Healthchecks • To consider including the champion role in contracts to encourage screening **Action:** Judith and Helen to review costs and to take forward discussions with Fylde and Wyre on the approach
6.	**Fylde coast strategic end of life group** Jeannie Harrop provided an overview of the group which is comprised of a number of project groups including a strategic and operational group. Jeannie reported on revisions to the Liverpool Care Pathway (LCP) which was to be phased out by 7th July. Arif queried whether the pathway itself had changed Jeannie explained that local schemes would replace the LCP with new forms and

	algorithms to be rolled out and in preparation for these changes the Acute Trust is currently delivering transforming end of life training for key workers. Jeannie added that for people who want to die in their own homes the new scheme would seek to address gaps at evening and weekends. In terms of strategy Jeannie added that whilst the end of life strategic plan co-ordinates with the CCG plan the link with public health was missing and she would be keen to develop the relevant links. Arif explained that he receives real time death rates from registrars and and is alerted to deaths in care homes which means it is easy to triangulate information - which is useful for investigations. Jeannie explained that she receives data on deaths in care homes but these have a 2 year data lag. Jeannie and Arif agreed that data needed to be better co-ordinated. **Action:** Jeannie to meet with Arif and Liz to look at co-ordination of data **Action:** Traci to add EOL to the Health and Wellbeing Boards forward plan and liaise with Jeannie on timing
7.	**Better Care Fund Update** Andy Roach explained that we are currently awaiting further national guidance but that Blackpool's plan was progressing and workstreams were now in place and had each developed a project plan. He reported that a development day had been arranged for workstreams on 10th July and Jane Bentley would take up her post as Programme Manager in mid-July.
8.	**Health and Wellbeing Board Development Session** Wendy commented that in terms of the four drivers identified at the session, the Board would need to make clear what their role is and what this means. Liz added that the priority areas identified at the VCFS JSNA event matched the key drivers with the exception of employment. In moving forward, it was agreed: • The key drivers would have an impact on life expectancy and chronic conditions • To remove frail elderly and young people from social isolation as this will cover all ages • To make clear the Board's role in relation to housing is about improving health outcomes via selective licensing (i.e. improving HMO stock) • Incorporate the views from the VCFS JSNA Event into the improvement plan • To bring the improvement plan back to the next meeting for fuller discussion • To present the outcome of the VSCF JSNA event to the Health and Wellbeing Board and Fairness Commission

	Action: Traci to make amendments to the improvement plan based on initial comments and include on the agenda for the next meeting **Action:** Traci to include VCFS JSNA event on the Board's forward plan and liaise with Liz on timing.
9.	**SCG Terms of Reference** David asked that the terms of reference be circulated electronically to the group for comments/suggested amendments **Action:** Traci to circulate terms of reference to the group for comments
10.	**Health and Wellbeing Board – July and September agenda items** David noted the Board items for July and asked that the proposed items for September be brought to the next meeting **Action:** Traci to include items for September Board on the next agenda
11.	**Agenda Items for next meeting** Not discussed
12.	**AOB** None
13.	**Dates of Future Meetings** All meetings will run 1:30-3:30pm in the Anteroom unless otherwise indicated as follows: • Weds 6 Aug • Thurs 25 Sept (Boardroom) • Thurs 6 Nov 14 • Thurs 11 Dec 14 • Thurs 15 Jan 15 • Thurs 19 Feb 15 • Thurs 19 Mar 15