

CANNOCK CHASE COUNCIL
MINUTES OF THE MEETING OF THE
HEALTH AND WELLBEING POLICY DEVELOPMENT COMMITTEE
TUESDAY 11 MARCH, 2014 AT 4.00 P.M.
IN THE CIVIC CENTRE, BEECROFT ROAD, CANNOCK

PART 1

PRESENT:
Councillors

Freeman, Miss. M. (Chairman)

Davis, Mrs. M.A.	Jones, R.
Gamble, B.	Rowley, J.
Allt, Mrs. A	

Also present: Justine Palin, Cannock Chase Clinical Commissioning Group (CCG).

29. Apologies

Apologies for absence were received from Councillors Mrs. A.F Bernard, and A. Pearson.

30. Declarations of Interests of Members in Contracts and Other Matters and Restriction on Voting by Members

No declarations of interests in addition to those already confirmed by Members in the Register of Members Interests were made.

31. Minutes

Members made a further request for information with regard to statistics in respect of new mums' breastfeeding and what the statistics showed. The Head of Environmental Health would make a request for this information.

Members were keen to know when the Dementia Friendly Communities would be taking place and what the timetable was for making a decision on this. The Head of Environmental Health would pursue this.

RESOLVED:

That the Minutes of the meeting held on 17 December 2013 be approved as a correct record.

32. Macmillan End of Life Care Project

A presentation was received from Justine Palin, Cannock Chase CCG.

Both the background to the project and the partnership working with the NHS and Macmillan was explained. Justine Palin reported that she was attending on behalf of Cannock Chase CCG and provided Members with information on her role which covered the four CCG areas.

She reported that the four CCG areas covered a mix of urban and rural areas with a varying demographic, with a population which covered over 850,000 people. She explained that the patient could alter this figure depending on where they decided to go for treatment. This could have an impact for the transition to end of life care.

She reported that the areas which were covered were:

- Programme Vision
- Fragmented Care
- Local experiences
- Growth in demand
- High quality care for all
- How will it be done
- CCG Areas
- Lack of co-ordination
- Existing Insight; Looking forward
- Current Commissioning of services
- Transforming cancer and of life care
- Scope, pace and innovation

The reasoning behind the project was essentially to radically transform the way that cancer and end of life care (which includes all inoperable diseases) was commissioned in future, and would involve changing peoples behaviour towards the two areas.

She explained that the original programme considered the last twelve months of end of life care which could impact on people who were long term ill, meaning they could be missed in the transition to end of care life. Palliative care needed to be incorporated into the end of life care and patients needed prevention screening for cancer together with a quick diagnosis.

She reported that cancer care, for example, with breast cancer could be very fragmented. There was a need for an integrated and seamless transition between the different providers for health services that the patient required.

There was extensive work carried out with providers, cancer patients and carers through large scale consultations to understand what the real issues were. An overriding factor that emerged was that cancer patients felt lost in the system and were left to manage on their own, and only when they reached crisis point would they attend A&E for treatment.

From the consultations it had emerged that the end of life care for cancer patients was a much better experience than for the frail and elderly.

She reported that there were good pockets of care in the surrounding areas but there needed to be a joined up approach with health providers and the voluntary sector.

It was reported that a patient could be placed on the end of life twelve care register only if they consented to it. However, in Staffordshire County this showed only 0.2% of patients on this register and there was a further 75% of the public that was unaccounted for. The register was predominantly used for cancer patients.

Discussions were being held with a view to nurses adding patients to the register given that they were in contact with the patients on a daily basis, particularly if they were in nursing homes. This would be flagged as an issue and required investigation.

Members were concerned how this work would link in with the data sharing from the GP's and how this would improve the co-ordinated approach. The Officer explained that this was all part of the transition process and data sharing was very much at the heart of it to enable the end of life people greater choice.

It was reported that across the four CCG's 50 per cent of patients passed away in hospital. She explained that through commissioning people should have the option to decide where they want to live the rest of their lives. The North of the County was a good co-ordinating centre for patients on the end of life register, however, the South was not as co-ordinated.

The results of the local consultation mirrored similar results from the national survey, and Macmillan nurses tended to have positive stories from cancer patients and hospices. This was in line with the national cancer survey.

Members queried why the north of the county was better co-ordinated and whether this would impact on future funding from the South. It was explained that there would be no impact on funding.

It was reported that in the future people would expect more tailored services and personalisation. The NHS needed to be better at responding to what people wanted/needed and to manage the funding better by investing in the care. Lay people have been involved proactively in this process to assist with behavioural and culture change.

Members raised concern about the responses from some of the surveys and the way patients had been left to find out about their care options themselves. The Officer explained that these were true quotes and what was needed was someone available 24 hours to act as a support, to discuss the options, the benefits they may be entitled to, what would the repercussions be on their job, and what the impact on the family could be. This type of support should be offered immediately to stop the feeling of isolation.

There would be a growth in demand for cancer care over the next 10 years as more cancer patients were surviving and living longer.

An important area of work would be around prevention, screening and diagnosis. However, the funding for this was block funded in the past when it went out to commissioning with cancer being put in with acute diseases. This would make it difficult to assess the expenditure purely on cancer.

It was important to change the way the commissioners contract out for care. They were required to check the quality of care and it should be collaborative commissioning between health and social care.

The aim was to have one point of contact which would integrate all the services similar to a one stop shop. The one point of contact would enable the customer care operative to have all the information relevant to patient to enable a quick and effortless assessment of the patients, the family and the carer's needs.

It was reported that funding for end of life care would need to be applied for and it was distributed differently across the four CCGs. A follow up on the Think Local Act Personal Agenda was also required.

The reasoning behind the ten year plan was to give sufficient time for the processes to bed in and allow for change in the way that commissioning of services was done especially over the next two years. During the first two years collection of all relevant data should be undertaken to develop an integrated system which ultimately should improve the patient experience.

Cannock Chase CCG was chosen as one of the 14 National Pioneers for an integrated approach to health care. There was no funding for this but there was an additional five years worth of support from NHS England and other national bodies.

It was imperative that the public would be involved in the new programmes and give their views and opinions. The only way to improve the service was to listen to the service users.

She explained that the Board consisted of three salaried non executive members and members of the public. They were tasked with improving the integrated service and the quality of care for end of life patients.

There was also a non executive partnership group – Healthwatch and the CCGs which also included members of the public. There were 39 champions across Stoke and the County and these champions would check, test and report back on the programme and their findings would assist with how services would be commissioned.

Members welcomed the information but were under the impression that this had already taken place. This was based on a previous Health Scrutiny Committee meeting concerning end of life and issues which had been raised

there.

She stated that Macmillan's involvement was that of a flagship programme and they agreed to invest £4million in services over the next 5 years across Stoke on Trent and the County. There would be funding for the first two years for change in the way commissioning would be done and included a national drive to get voluntary organisations involved. Outcomes that are required are an integrated specification for services in order to try to increase exceptional end of life care.

Through changing the commissioning service and using the Prime Provider Model (PPM), 2 people would be appointed and include one specifically for cancer treatment and the other specifically for end of life care. The PPM would manage and co-ordinate the commissioning and would enable one organisation to be held to account. They would be the supply chain and management of all providers.

She reported that co-ordinating all the pathways would take a number of years, and previously when contracts had been awarded they would have been only for one or two years, however this was something which required change. Discussions were being held regarding the extension of the length of contracts with an increase to 10 years. This would allow the service providers to develop, be innovative and change where necessary.

During 2012 there was approximately £30million spent on cancer across the 4 CCGs. From surveys that were carried out the results had shown that the money could have been spent differently through an integrated approach.

She reported that the PPM required promoted and viewed as a consortium and not a monopoly.

Members agreed that the one and two year contracts were too restrictive, however some thought was required concerning the 10 year contracts where towards the end, the contract was of less value.

It was important to keep pace with innovation and therefore ensure that contracts were fit for purpose, and essential to have engagement from all relevant people including patients, carers, GPs and healthcare.

It was reported that the procurement process would require competitive dialogue and there would be pre-qualifying questionnaires. If the service was eligible, it would be taken forward to another qualifying stage and then a selected few would be taken forward. Commissioners, providers and the public would be involved in this dialogue and training would be given as well as support.

Members were concerned as to whether they thought the GPs were on board with this approach.

The Officer responded and reported that GPs would be 'wearing two hats', one

as a provider and one as a commissioner. The GPs could form their own consortium and bid to be part of the work.

It was possible that a Clinical Director could be appointed to work with GPs and cover the three areas of community, procurement stage and education and training. It was more of a cultural change that the GPs were required to appreciate and understand.

Members were of the opinion that GPs were not receptive to the CCG or end of life care and that they had shown in the past a resistance to change.

The Officer agreed that there had not been the uptake from the GPs including a lack of questions directed to the board. There was a big difference between the CCG in the North compared to the South, whereas In the North, the Head of the CCG was a GP.

Members raised concern that the CCG meetings were not publicised, there was poor communication, the meetings were held in public but were not public, and that the CCG gave a commitment to attend the Community Forums but attended only once. Members appeared strongly about this as they were accountable to the residents, however due to the lack of information sharing there was nothing that could be shared with their constituents.

The Officer appeared very keen to work with the Council and agreed to provide a report back to the CCG on their concerns.

The Members reiterated that the CCG was there to be challenged. With regard to the Commissioning Partnership there were other organisations who were represented and included Fire, Police and voluntary organisations. However, the CCG had not been represented at the last three meetings.

Members agreed with the presentation that integrating services needed to be carried out but more consultation and discussion was needed.

RESOLVED

That a request be made for a non executive member to attend a future meeting of the Health and Wellbeing Policy Development Committee to explain their role.

33. Date of Next Meeting

The date of the next meeting was scheduled for 4 August 2014.

CHAIRMAN

(The meeting concluded at 5.50 p.m.).