

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

29. Apologies

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

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 requested again the information of the statistics and percentages regarding breastfeeding and what the percentages meant in real figures. The Head of Environmental Health agreed to source this information.

With reference to the Dementia Friendly Communities Members queried when this would be happening and what the timetable regarding making this decision was. The Head of Environmental Health agreed to pursue this.

RESOLVED:

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

32. Macmillan End of Life Care Project

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

The background to the project was explained and the partnership working with the

NHS and Macmillan. Although Justine Palin was attending on behalf of Cannock Chase CCG she explained that her role covered the four CCG areas.

The four CCG areas cover a mix of urban and rural areas with a varying demographic. The population covers over 850,000 people. However, the patient's flows can alter this depending on where they decide to go for treatment as they can go out of the area if they wish. This can have wider implications for the transition to end of life care.

The areas 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) is commissioned in future. This would involve changing peoples behaviour towards these two areas.

The original programme only looked at the last twelve months of end of life care which mean that people who were long term ill could be missed in the transition to end of care life. Palliative care needed to be incorporated into the end of life care. Patients needed prevention screening for cancer and a faster diagnosis.

It was explained that the cancer care using the example of breast cancer can be very fragmented. There needs to be an integrated and seamless transition between the different providers for the health services that the patient requires.

There has been extensive work with providers, cancer patients and carers through large scale consultations to find out what the real issues are. An overriding factor that emerged was that cancer patients felt lost in the system and were left to manage on their own and when they reached crisis point they would go to 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.

There are good pockets of care in the surrounding areas but there needs to be a joined up approach with health providers and the voluntary sector.

At the moment it is the GP who with the consent of the patient can put the patient on the end of life twelve care register. However with in Staffordshire County this only shows 0.2% of patients on this register. There are a further 75% of the public

that is unaccounted for. The register is mainly used for cancer patients.

A discussion was being had regarding nurses being able to put patients on the register as they were in contact with the patients on a daily basis if they were in nursing homes. This has been flagged as an issue and needed to be investigated.

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.

Across the four CCG's 50% of patients die in hospital. Through commissioning people should have the option to decide where they want to die i.e. in their own homes. The North of the County has a good co-ordinating centre for the patients on the end of life register, however, the South is not as co-ordinated.

The results of the local consultation mirror similar results from the national survey. Macmillan nurses tend to have positive stories from cancer patients and hospices. This is 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. The officer responded that there would be no impact on funding.

The officer explained that looking forward to the future that people want more tailored services and personalisation. As the NHS it needs to be better at responding to what people want/need and to manage the funding better by investing in the care that the patients need/want.

Lay people have been involved proactively in this process to assist with behavioural and culture change.

The members were concerned 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 will be a growth in demand for cancer care over the next 10 years as there are more cancer patients surviving and living longer.

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

It is important to change the way the commissioners contract out for care. They

need to check the quality of care and it should be collaborative commissioning between health and social care.

The aim is 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 carers needs.

Funding for end of life care has to be applied for and it is distributed differently across the four CCGs. There needs to be follow up on the Think Local Act Personal Agenda.

The reasoning behind the ten year plan is to give sufficient time for the processes to bed in and allow for change in the way that commissioning of services is 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 has been chosen as one of the 14 National Pioneers for an integrated approach to health care. There is no funding for this but there is additional five years worth of support from NHS England and other national bodies.

It is imperative that the public are involved in the new programmes and give their views and opinions as the only way to improve the service is to listen to the service users.

On the board there are three salaried non executive members and lay people who have been tasked with the question – how do we improved the integrated service and the quality of care for end of life patients.

There is also a non executive partnership group – Healthwatch and the CCGs and on these groups there are lay people. There are 39 champions across Stoke and the County. These champions will check, test and report back on the programme and their finding will assist with how services are commissioned.

Members welcomed the information but were disheartened to hear that this was what was happening as they already thought that this had happened. Following on from a previous Health Scrutiny meeting regarding end of life these issues had been raised there.

The reason for Macmillan being involved was that this was flagship programme for them and have agreed to invest £4millionn 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 will be done. There was a national drive to get voluntary organisations involved.

The 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) which would appoint 2 people 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.

Co-ordinating all the pathways will take a number of years. Previously when contracts have been awarded they have only been for one or two years this is something that needs to change. Discussions are taking place regarding extending the length of contracts to 10 year contracts. 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 have been carried out the results have shown that the money could have been spent more wisely through an integrated approach.

The PPM needs to be promoted and viewed as a consortium and not a monopoly.

The members were in agreement that the one and two year contracts were too restrictive but thought needs to be given to the 10 year contracts where towards the end of it the contract is of less value.

It is important to keep pace with innovation and therefore ensure that contracts are fit for purpose.

It is essential to have engagement from all relevant people, patients, carers, Gps, healthcare etc...

With regard to the procurement process there needs to be competitive dialogue. There will be pre-qualifying questionnaires and if the service is eligible it will be taken forward, then another qualifying stage and then take a selected few forward. Both commissioners, providers and the public will be involved in this dialogue. Training will be given as well as support.

Members queried again whether they thought the GPs were on board with this approach.

The Officer answered that it was a moving feast for the GPs as they 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 this work.

A possibility would be to appoint a Clinical Director to go and work with GPs and cover the three areas:

- Community
- Procurement stage
- Education and training.

It is more of a cultural change that the GPs need to appreciate and understand.

Members felt 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 Office agreed that there had not been the uptake from the GPs including no questions asked by them of the board. There is a big difference between the CCG in the North compared to the South. In the North the Head of the CCG is a GP and this seems to have helped.

Members were critical of the CCG as 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 come to the Community Forums but has only come once. Members felt very strongly as they were accountable to the residents but if they do not receive the relevant information then they cannot share it with their constituents.

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

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

RESOLVED

Members agreed with the presentation that integrating services needed to be done but more consultation and discussion was needed. They asked for a non executive to come to a future meeting and explain what their role was.

33. Date of Next Meeting

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

The meeting closed at 5.50pm

CHAIRMAN