South Tyneside
Clinical Commissioning Group

Local Engagement Board

Thursday 10 December 2015 1.00 – 3.30pm

Jarrow CA, Cambrian Street, Jarrow, NE32 3QN

AGENDA

From 12.30	Light lunch and Registration
1.00 to 1.05	Welcome and Opening Remarks *(Dr Matthew Walmsley, Chair STCCG)*
1.05 to 1.10	Feedback from September LEB
1.10 to 1.20	Planning for 2016/2017 – introduction and format of the afternoon
1.20 to 1.40	Round table session 1
1.40 to 2.00	Round table session 2
2.00 to 2.10	Comfort break
2.10 to 2.30	Round table session 3
2.30 to 2.50	Round table session 4
2.55 to 3.00	Highlights, general questions and closing comments *(Dr Walmsley)*
3.00 to 3.30	Meet the presenters

Date of next meeting:

Thursday 10 March 2016 1-3.00pm (lunch from 12.30pm), Living Waters, St Jude's Terrace, Laygate

If you would like to attend please contact Jenna Easton on 0191 2831903, or email jenna.easton@nhs.net.

Feedback from the Primary Care Discussion at September LEB

We asked you about:

- How practices communicated with you
- Evening and weekend GP services
- Meeting your urgent care needs

Thank you very much for all your suggestions

Our member practices are currently in discussions about the future development of GP services in the borough, and they are very interested in your views which will be taken into consideration.

South Tyneside
Clinical Commissioning Group

South Tyneside Local Engagement Board – Thursday 10 December 2015

Jarrow CA, 1-3.30pm

Feedback from the September 2015 LEB was followed by a presentation on planning for 2016/17 and then round table discussions.

Round table discussions

Cancer discussions

Q People living in South Tyneside with cancer tend to present to the NHS later than in other parts of the country. Why might that be and what can we do about that (as presenting early means a high chance of survival)?

People felt that there is a failure to take up screening and wondered if people were embarrassed to do so. People discussed issues when accessing the GP:

- GPs only have ten minutes to talk about one thing; there is no time to talk about other symptoms which may be relevant to a cancer diagnosis
- People expect GPs to know everything medical but GPs aren't specialists
- Does the GP have to consider costs if sending people for screening/ diagnostics
- Two week wait for GP appointment; it's a long time to worry if have a possible cancer symptom
- The most important symptoms are often the last thing a patient mentions when leaving a GP appointment

Attitude and culture were also seen as issues:

- 'Got to die of something' attitude
- People not bothered until affected by symptoms
- Tend to think we are 'quite hard up here' and we ignore our symptoms
- Culture is 'get on with life'
- Fear
- Young people can tend to ignore symptoms more
- 'No point in seeing a GP, I'll be better by the time I get an appointment'

People felt awareness and publicity about cancer were key:

- Patients are not aware of symptoms; lack of publicity and not getting through to people
- How do we approach people directly at the average age that cancer strikes? People should stand in the supermarket and target people
- Lots to be learnt from sales people. NHS should profile people and actively sell the issue to people

- People need to know what is causing symptoms
- Some people do not take notice of information and campaigns
- If celebrities do the adverts people take more notice, especially men; celebrities endorsing having tests done
- Have local people to signpost people in the pubs
- TV screens in GP practices are good; lots don't work at present
- Tell people that if they think they have cancer symptoms to request an urgent GP appointment

Q If you have any worries about cancer who would you ask?

Some people would go to the GP first but it was suggested that some people may feel they are wasting the GP's time. It was felt that if you have a good relationship with a specific GP this is good. Some people would go to the practice nurse. One person has a poor experience of their GP and would want to self-refer and bypass the GP.

A number of people would go to a pharmacist first, take their advice and if the problem wasn't solved they would go to GP. Some people were not aware that most pharmacists have consulting rooms. Some people would talk to a relative or close friend about health concerns and a number of people were wary of using the internet.

Q People would go for cancer screening appointments more readily if . . .

- There were less myths about screening
- They could get over their embarrassment
- If they weren't frightened of pain
- Public transport was better; travel is a barrier if the screening is far away, for example travelling to Gateshead for breast screening
- They were offered a variety of times.

Q The best thing that the CCG could do to reduce cancer in South Tyneside would be . . .

- Reduce the fear
- Keep campaigns going
- Include women over 75 in screening
- Use graphic pictures, of lungs for example
- Keep plugging away at lifestyle issues
- Get children to challenge their parents on lifestyle issues – eating too much chocolate for example
- Identify best practice and see if we can apply it
- Stop using deprivation as an excuse
- Encourage early presentation at the GP

<u>End of Life Care discussions</u>

Q If it was for my family the most important thing for their end of life care would be…

Those patients are free of pain and have dignity, comfort and company. The patient's choice about where they are cared for and die; surrounded by people they want there. Patients need to be taken through options for their care including honesty and support needs to be in place to support the individual's choice. There needs to be consideration for those individuals who don't have family/support networks and we need to ensure consistency of experience; there's too much variance in care delivery at end of life. There needs to be provision of support carers/family.

Q More people in South Tyneside die at hospital than in their own home. This is not the case in other parts of the country. Why do you think that might be?

There aren't options in place regarding choice and the 'System' doesn't provide the options; no choice is given, hospital is the default position. One reason is the high levels of deprivation in South Tyneside so people don't have the money or resources to care for family at home. There is also a lack of available relatives to take care of the patients; there are a lot of people living on their own and a lot of isolation. There is no community spirit and some people don't want to 'put on' their family.

Q If it was for me the place I would want my end of life care would be…

At home – it is more comfortable and safe.

Q The best thing that the CCG could do to improve end of life care would be…

- Clearer communication around DNARs
- Increased support for carers enabling them to continue caring
- Highlight the fact that specialist services can support non cancer diagnosis
- Ensure honest communication with patients/families at the end of life
- Ensure provision of care service in the community - ensuring consistent standards
- Ensure a holistic approach
- Ensure communication across all professionals involved to reduce families having to repeat their 'stories'
- Increased provision of information

<u>Respiratory discussions</u>

Q What support would be beneficial if you were diagnosed with a Lung Disease? For example one to one with GP/Practice Nurse, group session with other newly diagnosed patients in your locality or at South Tyneside hospital?

- To have a "buddy" who has the same condition/disease; this person would be an expert patient who can provide information and support shortly after diagnosis. Good for motivation purposes
- Active care planning with a clear pathway for patients to follow, knowledge of things you should do
- Structured advice and support which could be given by the person's GP or the lung foundation; could also be an expert providing one to one support

- Patient to be able to meet other people so they don't feel socially isolated, possibly in an informal atmosphere which is engaging and doesn't feel prescribed
- Complete support system for people to help make the right lifestyle choices

Q How can patients with lung disease be better supported to help them maintain their health and independence. For example referral for exercise at their local sports centre, advice re exercise that the patient can do themselves, referral to specialist exercise programme? Would community support groups in the patient's locality help them to support each other? Would GP/Community Nurse/Respiratory Specialist Nurse/Expert Patient be helpful to support these groups?

- Active care passports – to help with self-care and self-management and referral to support services in a timely way
- Support attached to a GP with contact details for patients to access if certain symptoms should occur
- Informing and educating the patient: techniques that can help their condition; how to use the equipment properly; exercise information; general information such as temperatures to be kept at home to how to get the humidity right, keeping control of dust etc
- What happens at diagnosis is important; patients should be aware of things that should be done to help themselves
- There should be a prescribed exercise out of hospital for a number of sessions
- NHS health checks more publicised
- Look at environmental factors and car usage and whether air pollution is a causation factor in COPD
- Pre identification; how can you test your lungs to see if they are ok? Understand how spirometry testing is commissioned.
- Compare STCCG to other CCGs and local authorities and copy those that are doing well
- To be informed of the dangers of continuing to smoke and raising the tax on smoking

Q How can patients with end stage respiratory disease be better supported in the community? For example regular contact with GP/Community Nurse/Respiratory Specialist Nurse/Expert Patient.

Something similar to Macmillan nurses for support, reassurance and continuity of care. End stage needs to be in the home and services should come to them.

<u>Cardio Vascular Disease discussions</u>

Q How can we promote NHS health checks better so that we can identify patients with increased risk of illness caused by blocked arteries (vascular disease)?

Majority of people on each table were unaware of NHS health checks. Suggestions included:

- Proactive marketing potentially on the back of buses and use of mass marketing via social media but libraries and waiting rooms in surgeries are not good as there are too many posters
- Practices could have a theme for a month on different health topics
- Targeted posters and stop sugar coating the message
- Advertise where people are at risk – shopping centres, pub, and clubs - similar to the way blood drives are done.
- Make care and hospital sites smoke free and remove smoking shelters
- Difficult to get a repeat test, for example if you have embarked on a health improvement regime it is difficult to get a second test to know if you are doing the right thing
- Could testing be centralised
- Need to myth bust about health checks.
- Better training for the staff interpreting the results.
- Think about the location of fast food takeaways and schools
- Value in using patient stories to sell the message, but they needed to have a good cross section, not just the shocking story, that would help people identify with the person.

Q What steps need to be made to help people understand their risk of developing vascular disease?

There was discussion about educating individuals and what the government should do centrally, for example sugar taxes. It was recommended that education should start early in schools as we need to make younger people aware of the problems your body will have if you don't look after it. It was suggested that patient stories could be used to explain what can happen, not the extremes but with real people. Another suggestion was use of health message in the local paper, with different themes. It was also suggested to link with community assets work, letting people know what is available to them in the area, which is everything from health walks to bike rides to social groups. We should work with employers to encourage exercise before shifts

Q How can patients with vascular disease be better supported and encouraged to self-care and manage their illness?

- Give the right information to people so that they can understand their condition and what to do if something goes wrong
- Maybe some training similar to the DESMOND training for newly diagnosed diabetics
- There needs to be a tool kit of options developed for professionals

Q How can patients with end-stage vascular disease be better managed in the community and supported to reduce the need for hospitalisation?

The group felt people don’t know what their options/choices are so suggestions were:

- Use of patient champions
- Integrated community teams to support these types of patients
- Marie Curie involvement, they are not just for cancer patients

- End of life care – make sure there is parity on what is offered compared to what is offered to cancer patients

General Questions and Comments

C CAST have befrienders but they are under financial pressure and if they leave they aren't replaced. Age UK set up a befriending service 18 months ago but there is a one year wait for the service. There is also Happy at Home but there is a two year waiting list for this service. If we are trying to keep people out of hospital the befriending service makes a hug difference.

Q There is a lot of emphasis on what individuals are doing to damage their health but nothing about what the government are doing?
A The devolution agenda would give us the power to act locally, so we could have more impact.

Q Does the CCG have a role with the Health and Wellbeing Board and partners regarding lobbying about, for example, roads and schools?
A We do and we are involved in this.

C Getting people out of hospital into the correct environment where they are happy, comfortable and supported is a weak point. Currently they have to wait for various assessments of their needs.
A We are working very closely with the council and other partners and there are a variety of measures in place. A further discussion took place regarding this area outside of the meeting.

Closing Comments

The chair thanked the audience for attending and their contribution to the round table discussions.

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Planning update

December 2015

Previous planning process

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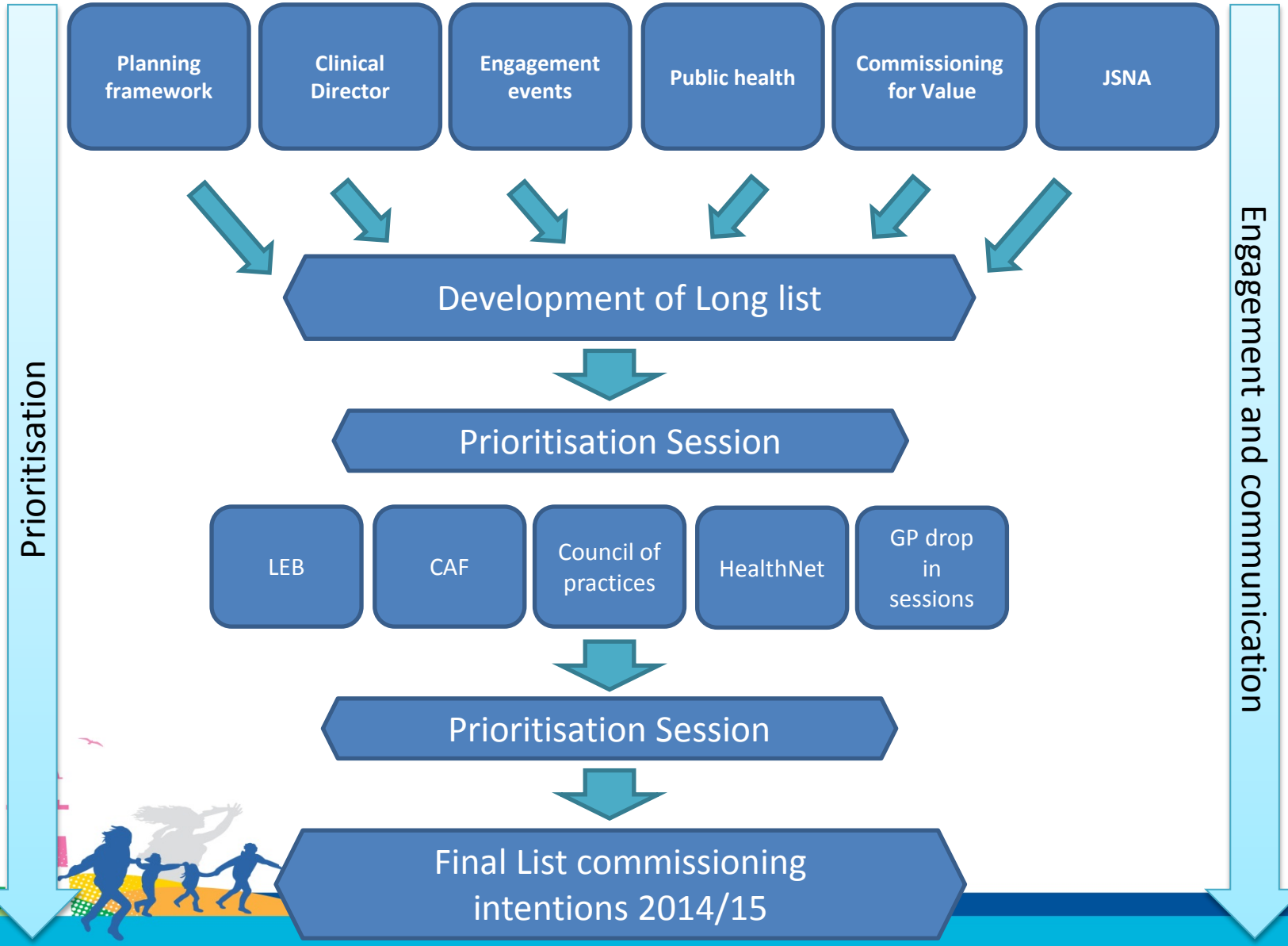

Programmes of Work

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- Planned care
- Cancer
- Prescribing
- Urgent care
- Long term conditions
- End of life
- Mental health
- Children

1 Delivery plan
8 workstreams
52 initiatives (& growing!)

Approach for 2015/16

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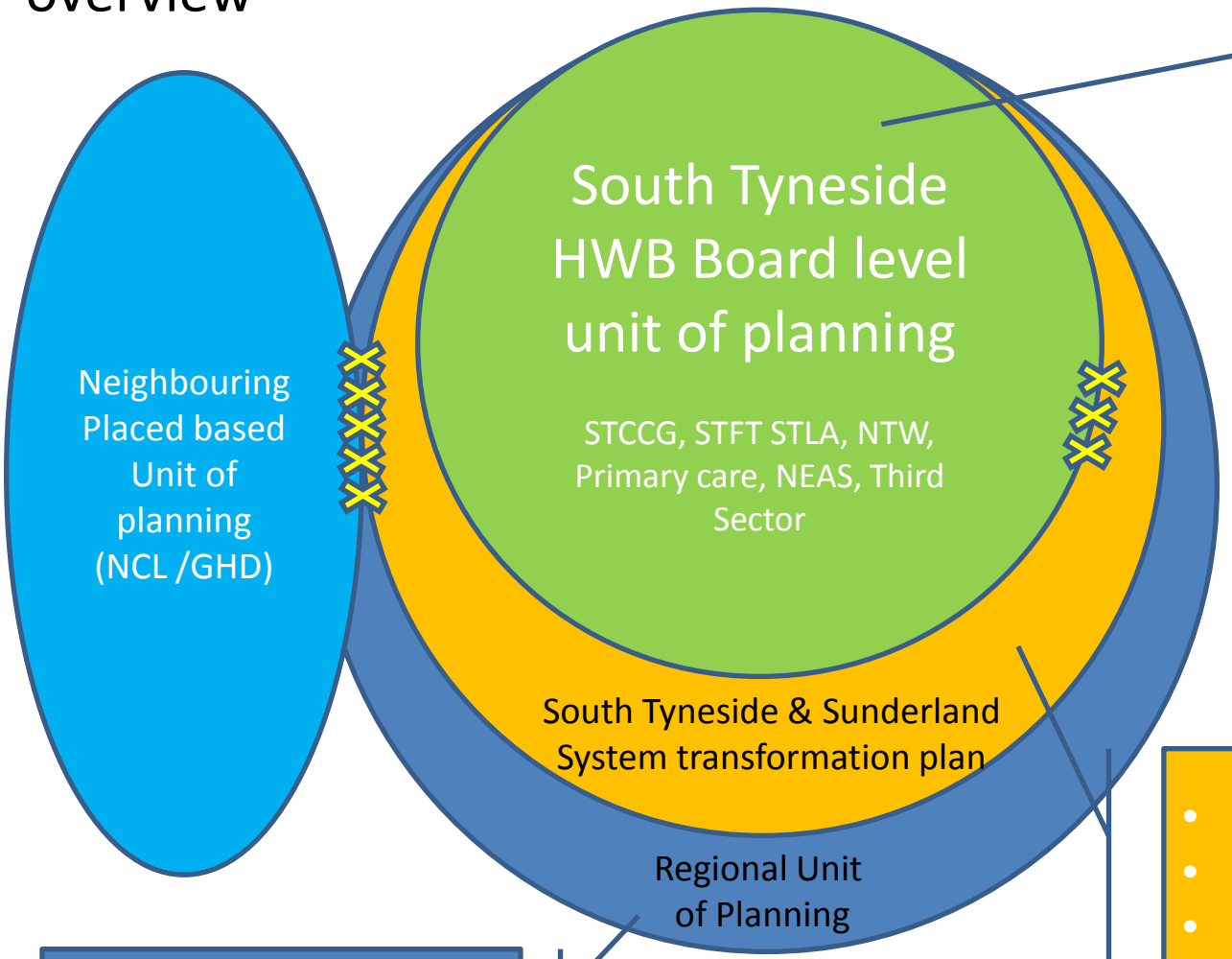
80%	Cancer	• **Premature mortality** is extremely high • Below average performance in **new cancer cases diagnosed** • Below regional average for **1 year survival rate** • **Cancer programme Board in place**
	CVD	• Below average in **19 of 21 CVD** related prevalence indicators • Emergency diagnosis per 100,000 for; **stroke, Hypertension and IHD** are high • Emergency LOS shows high for: **Stroke, Atrial Fibrillation & Hypertension** • **Programme Board to be developed**
	Resp	• **COPD is a huge outlier, highest in the region** • **LoS: 9 out of 11 indicators are extremely high in relation to the average, most notably in COPD** • **Programme Board Established**
20%:		• National/mandatory **must dos** • Urgent Care Hub • Procurements • Cross cutting work; **End of Life**

South Tyneside CCG - Units of planning overview



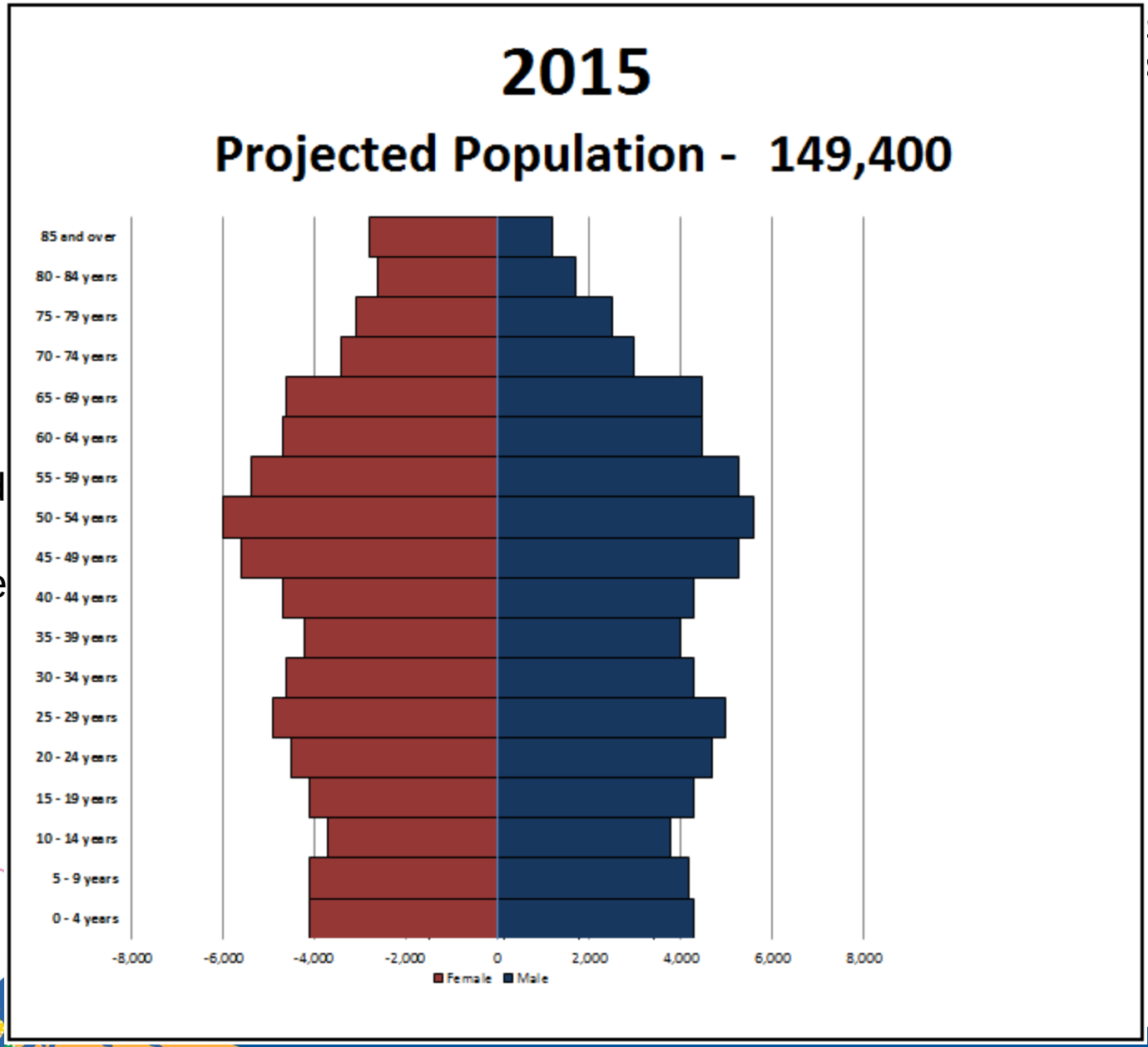
- CCG planning return
- Activity modelling
- Performance trajectories
- SRG planning
- Local digital Road map
- BCF planning
- Integration board
- Primary care strategy
- Pathways / Right care

- Transformational work
- Acute configuration
- Stroke pathway work
- Develop place-based plans demonstrating how local services will evolve and become sustainable over five-years in order to close all three gaps (quality of care, preventative health and finance) for their populations between now and 2020.

- UEC Vanguard
- LD transformation
- Specialised commissioning

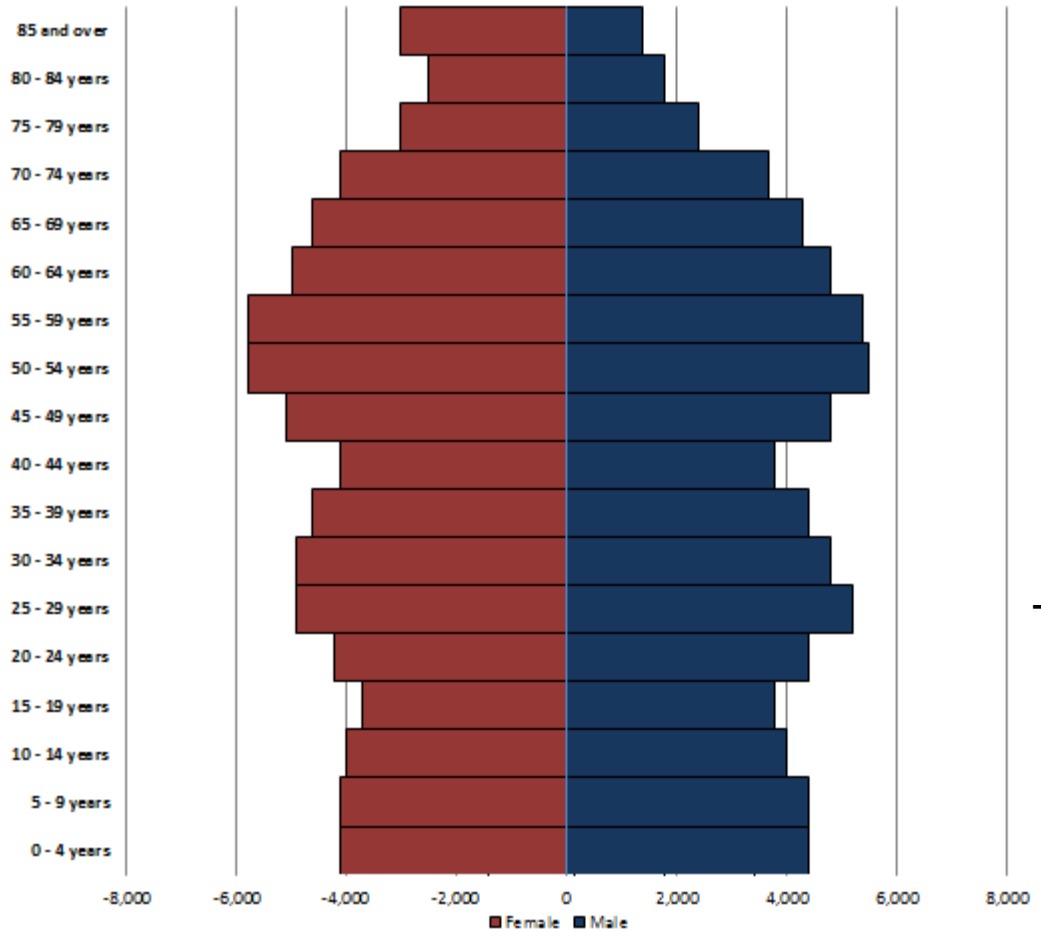
1 in 5
Aged over 65+

People aged 85+ have **tripled** since 1981



2018

Projected Population - 150,600



An extra

1,400

Over 65s

An extra

300

Over 85s

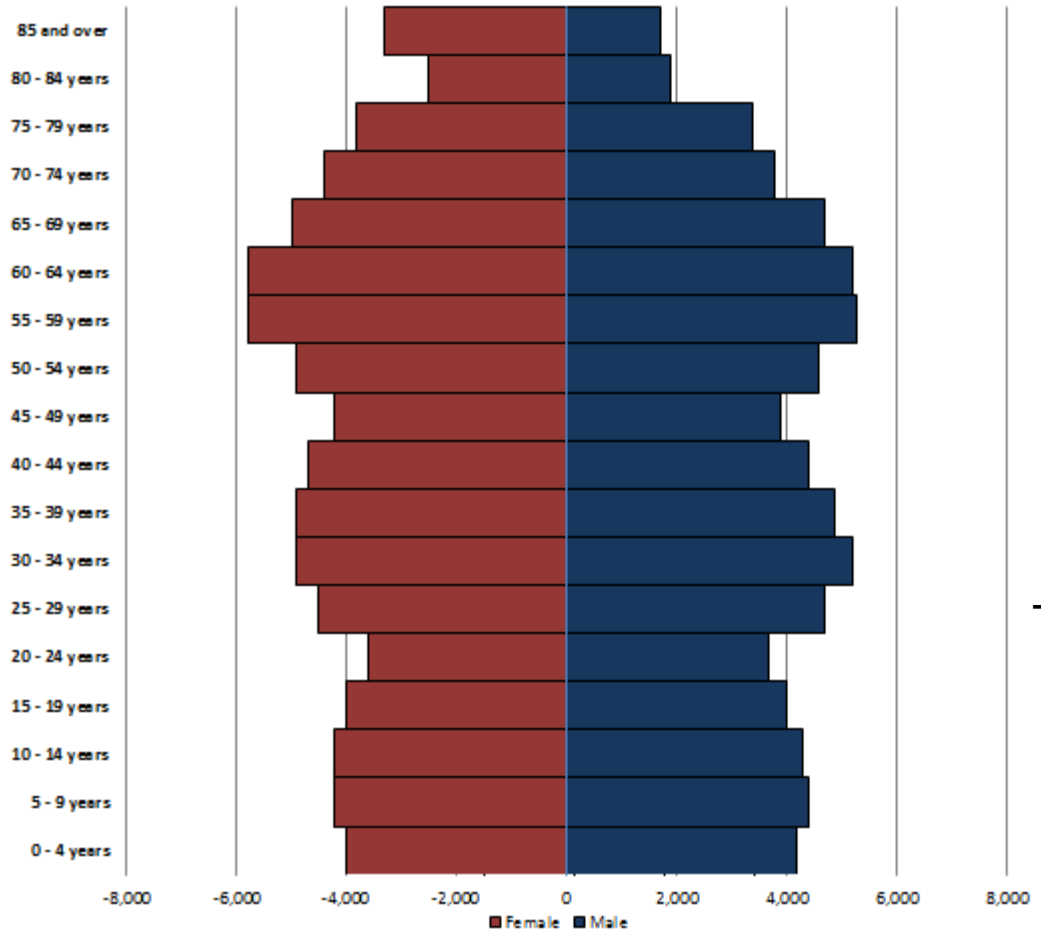
This would fill the beds on

9

wards

2024

Projected Population - 153,000



An extra

5,300

Over 65s

An extra

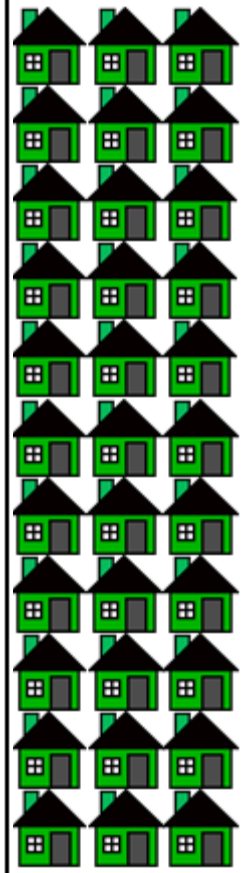
1,100

Over 85s

This would fill the beds on

33

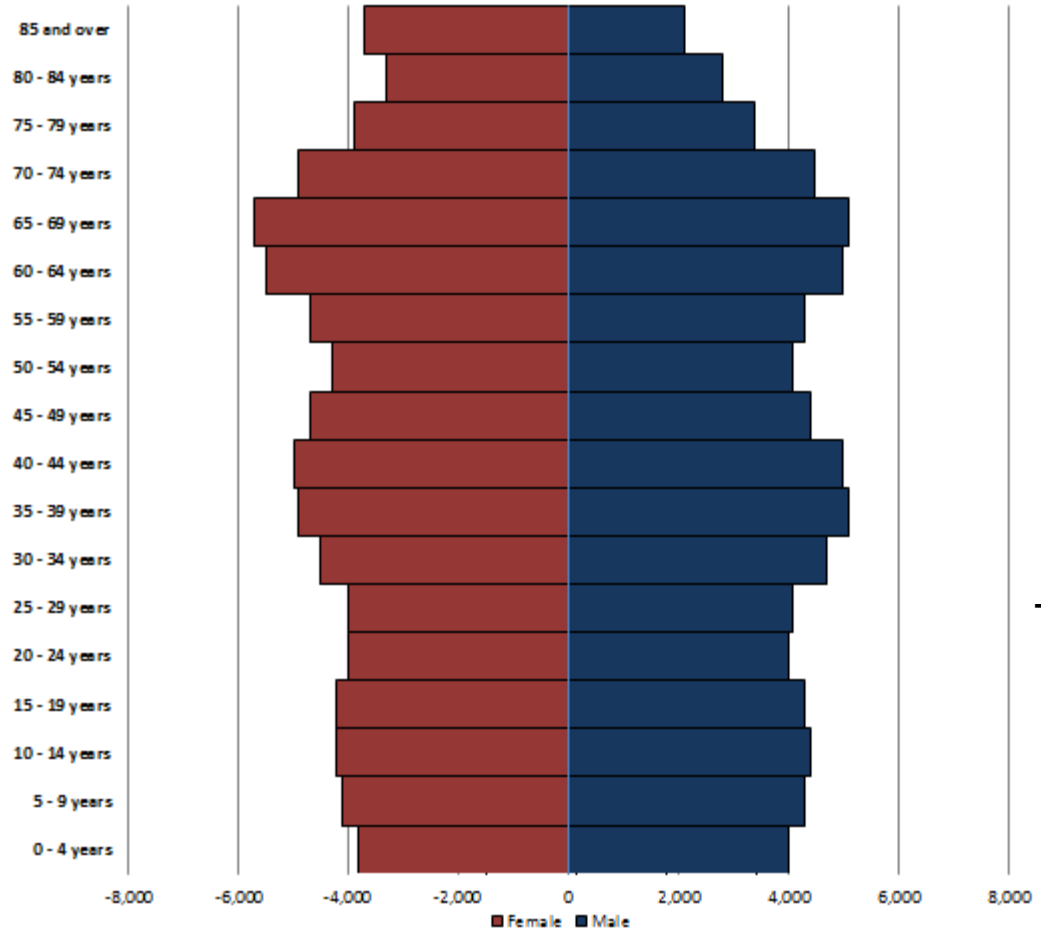
wards



2030

Projected Population - 154,900

1 in 4
Aged over 65+



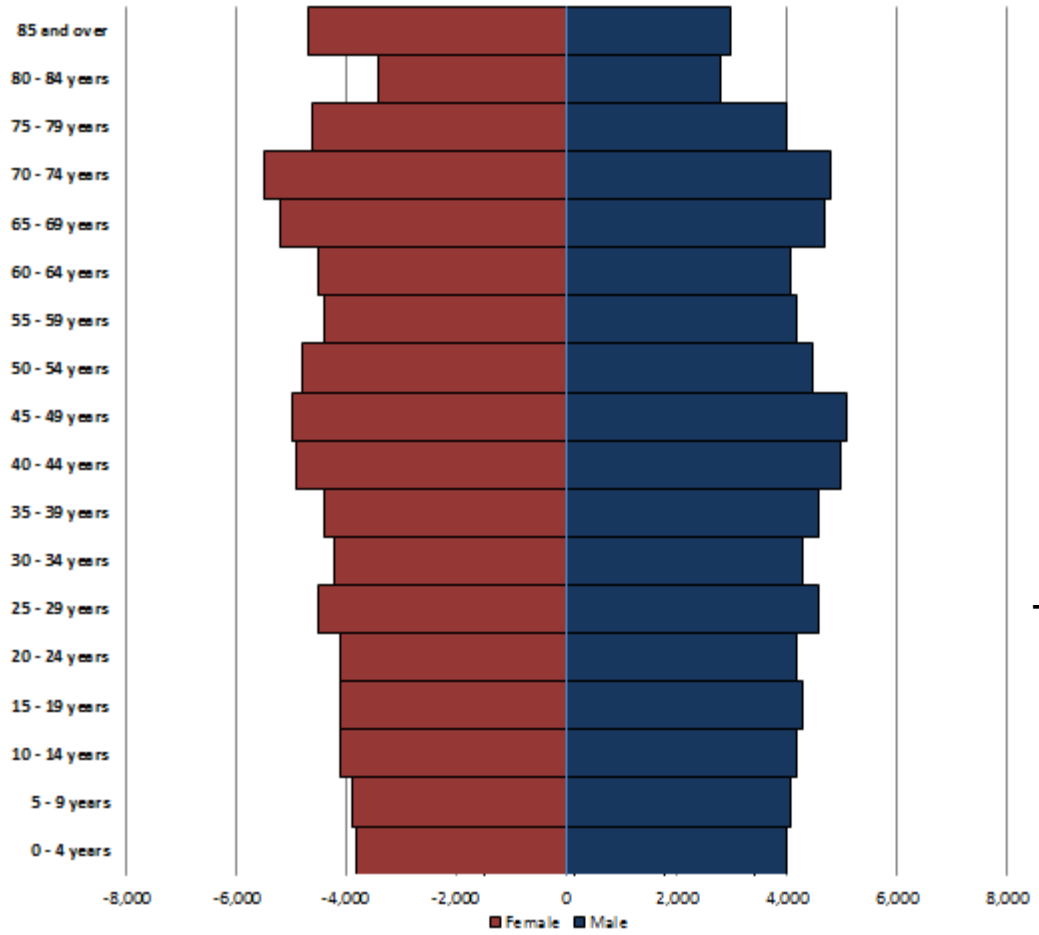
An extra
10,100
Over 65s

An extra
1,800
Over 85s

This would fill the beds on
55
wards

2036

Projected Population - 156,400



An extra

13,400

Over 65s

An extra

3,700

Over 85s

This would fill the beds on

112

wards

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Population needs (over 65s)

2015

- 2,097 with dementia
- 3,639 people with diabetes
- 7,687 people who are obese
- 7,708 with a Limiting Long Term Illness

2025

- 470 more with dementia
- 744 more diabetics
- 1,441 more obese
- 3,597 more with a Limiting Long Term Illness

Cost of care

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Spending and costs

The costs of health and care services are not widely known. Some costs can be avoided or reduced through cost-effective public health interventions.

The King's Fund
Local Government Association

Key Financials

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- No growth means loss of £4.5m per year
- Impact of loss of tariff efficiency, estimate £1.7m
- Impact of new tariff rules, information from some CCGs is increase in A&E and maternity costs – impact not yet quantified

Opportunities

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- To revisit and review planning process.
- To understand where and why we are different.
- To focus resource in the areas of highest need for our population
- To understand what others are doing.
- To increasingly become an innovative, effective and efficient

Diagnostics

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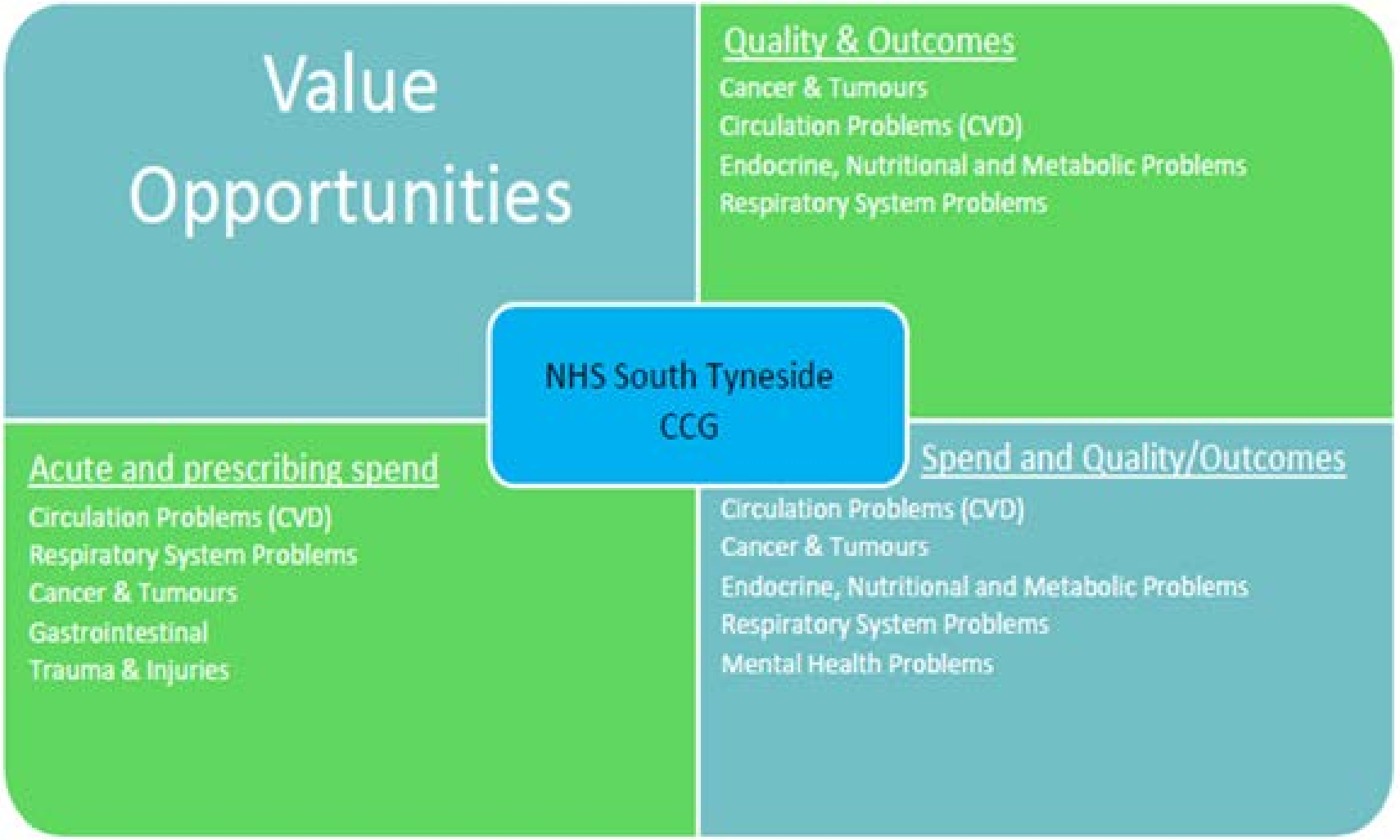

What causes shorter life in the NE?

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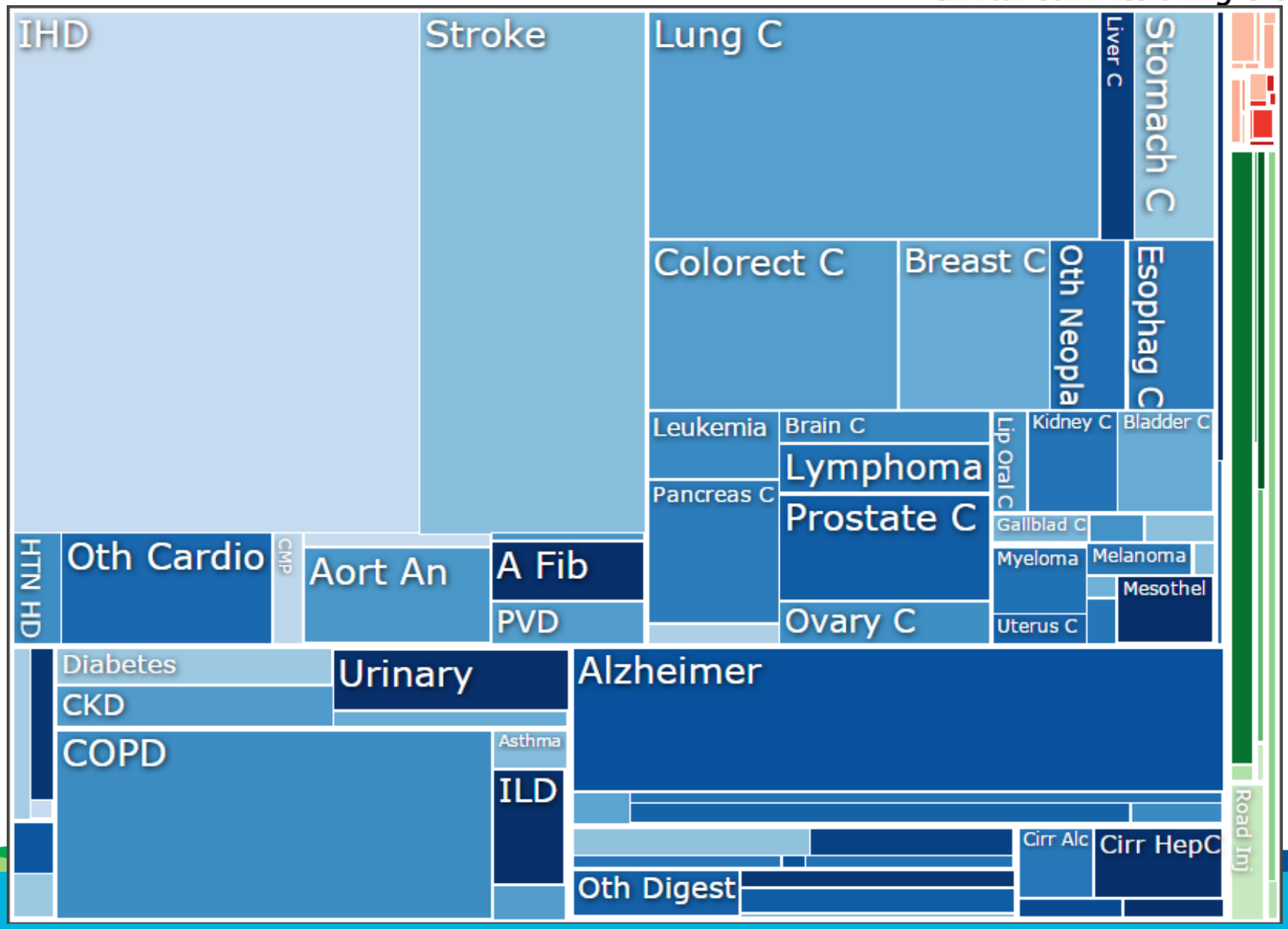
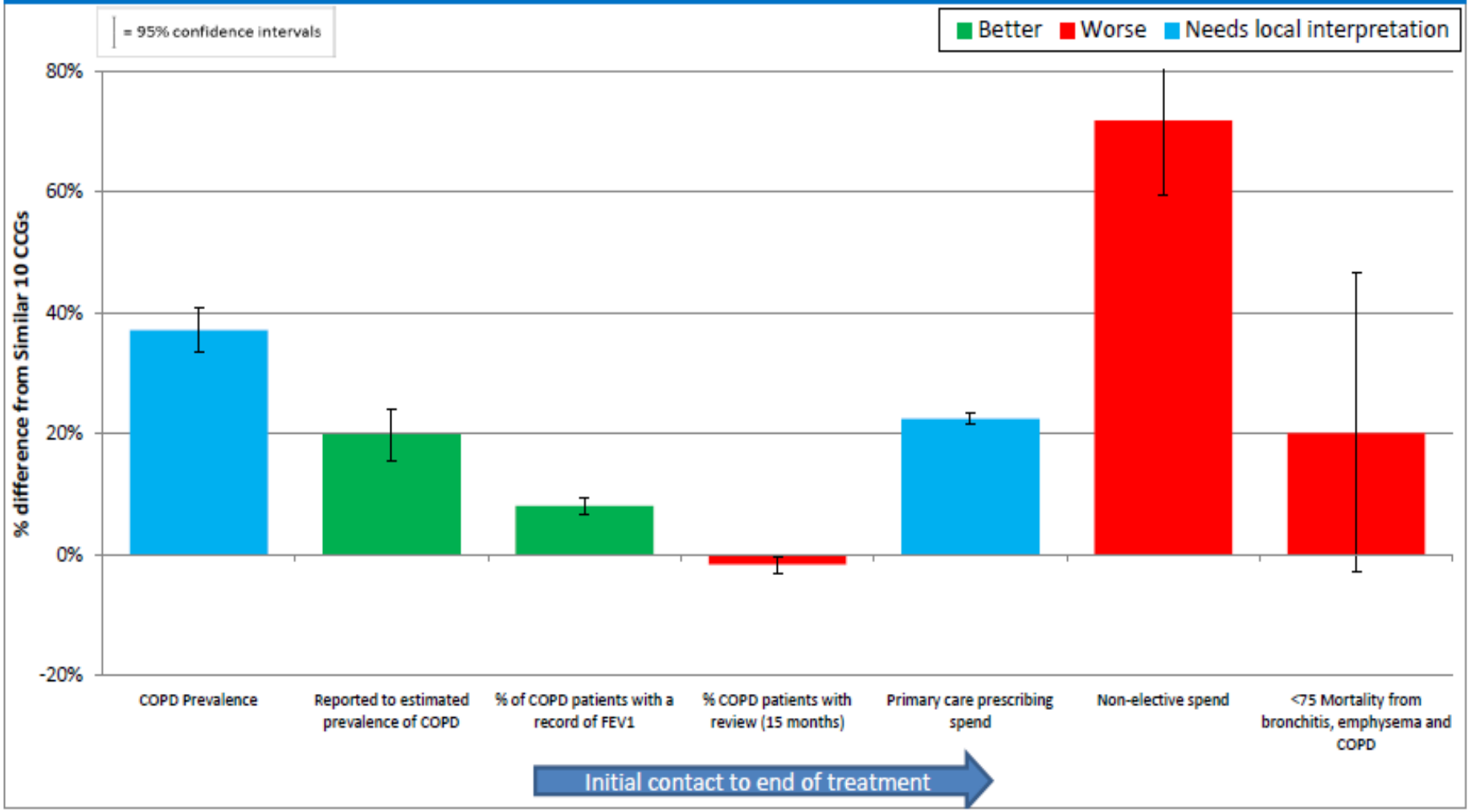


COPD pathway

NHS South Tyneside CCG



NICE guidance:
http://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease

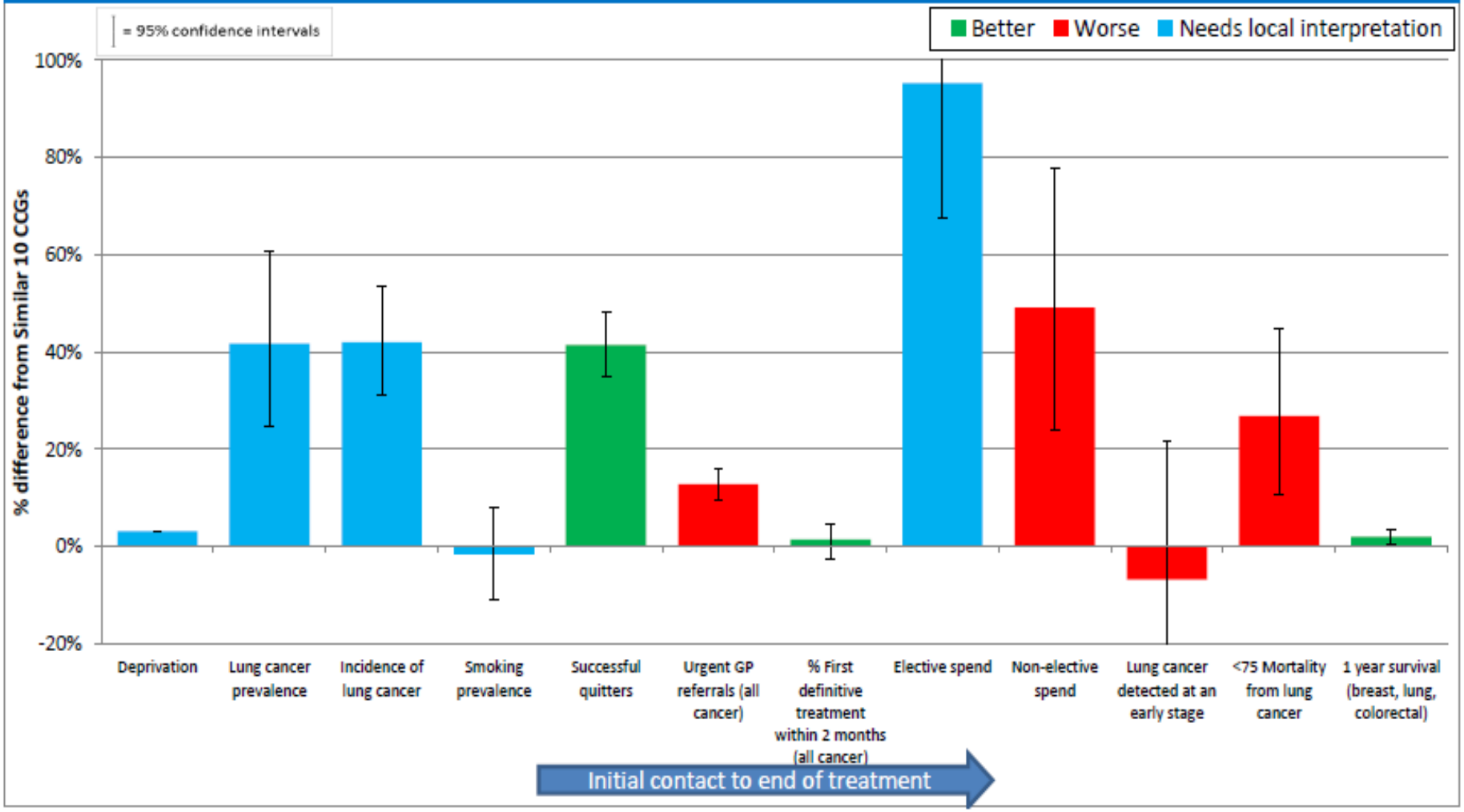
Public Health England

RightCare

NHS England

Lung cancer pathway

NHS South Tyneside CCG



NICE guidance:
http://pathways.nice.org.uk/pathways/lung-cancer

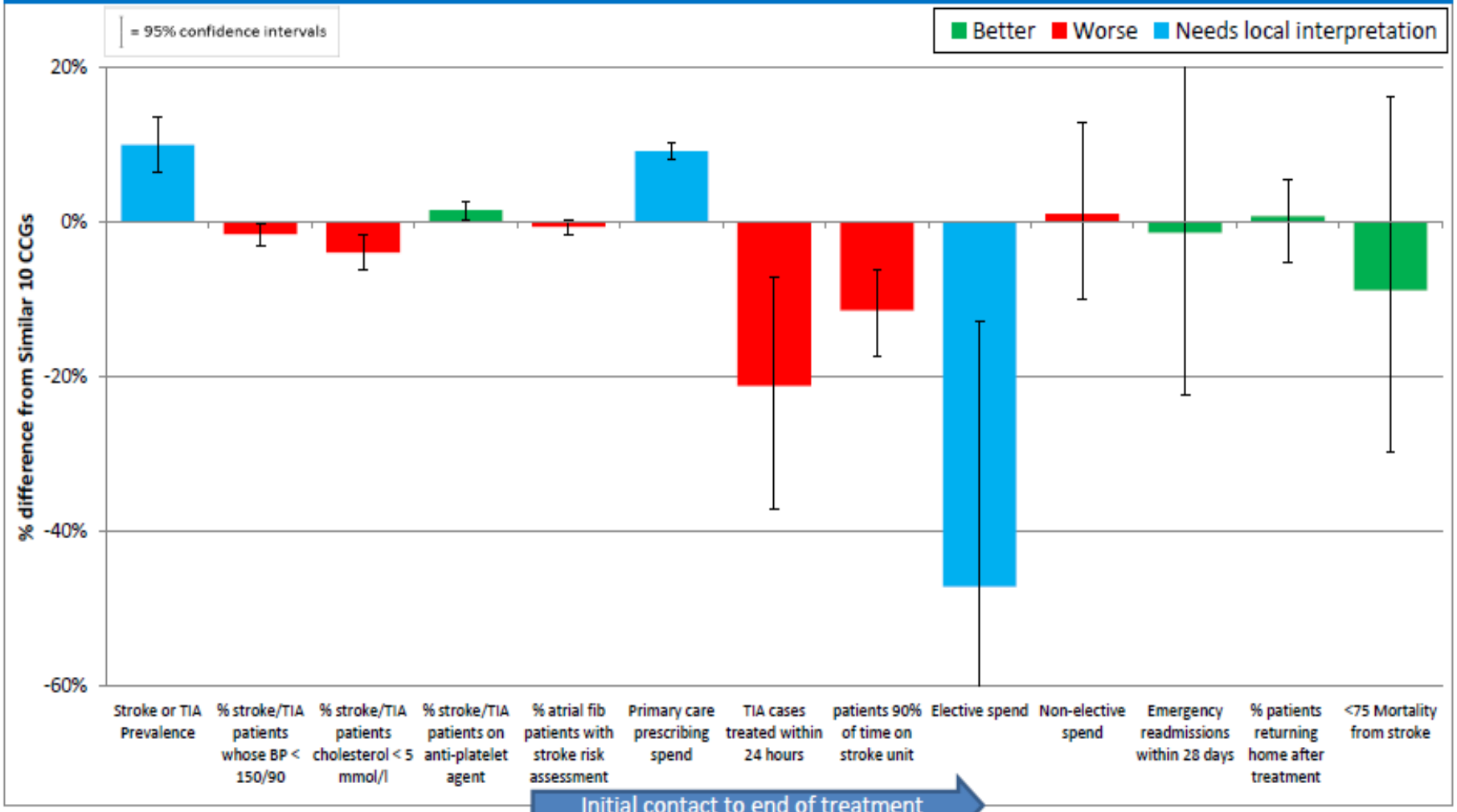
Public Health England

RightCare

NHS England

Stroke pathway

NHS South Tyneside CCG



NICE guidance:
http://pathways.nice.org.uk/pathways/stroke

Public Health England

RightCare

NHS England

Areas of opportunity

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Cancer	Respiratory	CVD
1. **Premature mortality** is extremely high – poorest of all CCGs 2. Below regional average for **1 year survival rate** 3. Below average performance in **new cancer cases diagnosed** at stage 1 or 2 4. **Bowel screening** extremely poor performing – worst of all CCGs 5. **Elective spend** per admission higher than average 6. **Elective LOS** higher than average	1. **COPD** is a huge outlier, highest in the region 2. **Smoking prevalence** is high comparatively 3. **Respiratory drug spend** by GP pharmacists is the highest spend 4. **LoS**: 9 out of 11 indicators are extremely high in relation to the average, most notably in **COPD**	1. Below average in 19 of 21 **CVD related prevalence** indicators 2. **Atrial Fibrillation** in females is high 3. **Health checks** offered to eligible patients is 6% below average 4. **Emergency diagnosis** per 100,000 for **Hypertension and IHD** are high 5. **Emergency diagnosis** per 100,000 for **Stroke** patients is well below average 6. **Emergency LOS** shows high for: Stroke, Atrial Fibrillation & Hypertension

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Timescale

Month	Task
November	Update to Exec Committee Draft activity trajectories agreed (may be several submissions during Jan and Feb)
December	Final Planning guidance released National tariff published including tariff inflation and efficiency Development of 2015/16 CQUIN/national CQUIN issued Standard 15/16 contract released **LEB- 10th** **Council of Practices- 17th**
November/January	Update to GB Endorsement via GB National contract issued
January	Sign off via Exec Committee **Education Forum- 21st**
February	Publish Commissioning intentions Submission of full commissioner plans **OSC 16th** **Education Forum- 25th**
March	Assurance of plans Completion of contract sign off (post mediation) Plans approved by Governing Body 2016/17 CQUIN sign off Update as necessary to Integration Board Checkpoint for progress with trajectories
April	Submission of full final plans

Help!

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- 4 round table discussions
  - Table 1) Cancer
  - Table 2) End of Live
  - Table 3) CVD
  - Table 4) COPD