Leading system change – What does it take to be a good accountable care system?

Future NHS Stage

Tuesday 11 September 2017

14.00-15.00

Speakers:

- Dr Amanda Doyle - GP, Chief Clinical Officer, Blackpool CCG and Co-Chair of NHS Clinical Commissioners
- Cathy Winfield - Chief Officer, Berkshire West CCGs
- Jon Rouse - Chief Officer, Greater Manchester Health and Social Care Partnership
- Matthew Swindells - National Director: Operations and Information, NHS England

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Amanda:

Thank you.

Quite often at this sort of thing people want to know a lot of detail about governance, about the system, about the organisations. I don't want to talk about any of that, I just want to say that the changes around how we make decisions and how we work together across organisations are really only there to put us in the best possible position to succeed at what we're trying to do.

There is sort of a temptation to spend a lot of your time and effort on that stuff because in many ways it is relatively easier. But what we actually have to do is just as difficult, whether you're an accountable care system or a whole collection of separate organisations. One thing that is really important, as you

develop as a system, is that you clearly establish what you are trying to do and what your common purpose is.
So, we've put some time into being really clear that our common purpose about improving the health of our population and improving clinical outcomes for our population, and doing it within the resources available, is our single aim and objective for our whole system, moving further away from our individual organisations and what our responsibility is to deliver for that organisation. The proof of the pudding is in the eating. What are our patients seeing that is different?

They are certainly seeing more services out of hospital. They are seeing less reliance on hospital services and therefore much more opportunity to get the care they want in their own homes in primary care, in the community and closer to home.

So, we've moved on from being a vanguard to developing our extensive care service which is about really intensive management at home and in the community of our very highest users. Fifty per cent of our resource was spent on 3% of our patients two years ago on the far coast. We've made moves to intensively manage that 3% of the population in a different way, reducing reliance on hospital and freeing up resource to devote to the next cohort of the population.

That next cohort is seeing enhanced primary care. We have moved with all of our general practices into neighbourhoods, the famous 50,000 population. Each of those neighbourhoods has a fully integrated out-of-hospital team which includes community nursing and mental health, and therapists and social care, working with practices with registered lists and actually putting a significant amount of resource into patients with complex problems but perhaps not the highest users. We've invested in primary care but a lot of the investment in primary care has gone into services that support primary care to

deliver, so we've gone live with seven-day access for our population to routine pre-bookable primary care.
We have integrated it with our urgent care primary service in our walk-in centres and urgent treatment centres. We have our GP out-of-hours services co-ordinating care plans and responding to paramedics who are in patients' homes.

We have been able, through becoming an accountable care system, to bring our system together to deliver in the way most likely to achieve our objective. In doing that, we are throwing out some of the perverse incentives in the system. So, getting rid of some of that transactional relationship and actually devoting our energies into cost effective pathways of care and actual delivery of care in a different way. It's not easy. Probably our biggest challenge is workforce. As I said at the beginning, this is putting us in the best position we can be in to succeed

Gavin:
Amanda, can I pick up one point there? There are so many organisations and as a GP you've seen them as well. People are resistant, even outside of the health service. Is that a problem? Does it involve any structural changes that people are resistant to? Or can people within the profession immediately see the benefits they can pass on in patient care?

Amanda:
It is different with different people. Clinicians generally immediately see the benefit and want to move very, very quickly, almost more quickly than we can keep up with. There is a lot of nervousness, particularly around the boards and governing bodies of statutory organisations who are genuinely concerned about the accountabilities they have for statutory organisations and the ask that we're putting out there for them to not forget about that but not make that their primary concern.

So they want to know “have I got air cover if I'm acting for the good of the population as a whole, rather than what I'm actually responsible for, which is the health of an organisation?” We have put a lot of work into trying to provide reassurance to help people think through those things.
There are people who don't want to change and that's the same with any change. It takes time.

Gavin:
Cathy Winfield is Chief Officer of the Berkshire West Clinical Commissioning Group, an ex-nurse. Can you give us our perspective?

Cathy:
Yes, I thought it might be helpful to pick a different example of where working as an ACS has been a practical solution to a problem that we faced. In our system, we seemed to be doing pretty well, our performance was pretty good, we were managing the money but it is just not good enough. We're not going to be able to manage the demand we face within the resource we have got going forwards

So there was an imperative for us to think differently and do something differently so we have begun thinking about an accountable care system for the last two years and we agreed formally to work like that in June last year.
One of the examples in our patch, just thinking about the previous session, was that we were a significant outlier for musculoskeletal activity - so lots of hips and knees going on, lots of money being spent.
Quite short wait times, so the system running quite hot and quite a big supply side with a range of providers. But our PROMs measure is poor - so high spend but not necessarily great outcomes. And a real question mark for us about whether we were spending our money in the best place for our population.

We started to do something different and engaged directly with patients and

worked with the third sector, with Arthritis UK. We gave patients the opportunity to spend time thinking about their choices and what alternatives there might be to surgery. We were absolutely astonished at the results of that and after a relatively short intervention, one hour, 80% of our patients decided that they would manage their condition in a different way.
We thought, well, that might be a flash in the pan and they will all rock along in six months' time but we actually sustained that over a 24-month period. So, it has not been a short-lived feature.

While it is absolutely right to put all of the effort into improving efficiency on the supply side, on the provider side, it is equally important to go back to basics and engage the patient and fundamentally ask the question of: "are we doing the right thing?" Given that we also have quite a lot of private activity in Berkshire, an affluent and leafy area, of course we don't count that in our data so there must have been virtually nobody with their own hip or knee in Berkshire. So we did have to think about it fundamentally differently.

So, we started saying to our provider colleagues, "we want you to join in with this and if you get referrals through and there's no evidence that a patient's been through shared decision making and had that opportunity, we'd like you to send the referrals back.

In fact, we're going to contractually ask you to do that so we don't get anybody listed for surgery that hasn't had that opportunity." And that was really when the ACS way of thinking came in because our colleagues in the acute sector were saying, "We don't want to do that. We are going to hack off the GPs and if we bounce back a referral they may send it to another provider that they think will be more helpful and co-operative. Therefore we'll lose income and our organisation will lose out to our competitors."
So that whole thinking about what's right for our population, what's the right level of intervention for this population and how do we all collectively take responsibility for that, is really important. The trust clinicians felt under

pressure, on the elective side, to drive activity to cross subsidise those parts of the system that need support inside the hospital. If we take all of that away and move to a cost recovery model and say what does our population actually need and then we'll pay what it costs, you take away some of those incentives and people stop talking about price and income and start talking about cost and optimal care pathways.

So, some of that ACS thinking has really helped us and now we're going through a process of structure collaboration with all of those providers and the voluntary sector and patients and all of our community providers together, co-producing the right pathway for MSK in our patch. We're hoping, as a result, we will get better outcomes and better value for the Berkshire West pound.

Gavin:
Can I ask you, right at the very start of our conversation there, what you talked about in terms of patients and changing behaviour and changing lifestyle? Every patient and condition is different but is there one thing that tips the balance for many patients? Why do they do this?

Cathy:
Some of the things we have done for the patients, the emphasis on access and short wait times, I think sometimes some patients have felt propelled along and don't really like to say it. They find themselves, "I have a twinge in my knee in week one and I'm in a gown in pre-op a few weeks later." There is not often time in a primary care consultation, so creating a space for that is really important. We've had some really good help from our patients in things like our NHS 111 redesign, our headache pathway, our chronic fatigue redesign. It's been fantastic. We have to unpack our own assumptions about what patients want, and sometimes where policy drives us, and go back to basics.

Gavin:

So is it actually time rather than money? Time spent explaining and if you explain you may save time and money later because you're not doing quite what you were doing before?

Cathy:

Yes.

Gavin:

That is extraordinary. You're clearly quite surprised by this. Were you?

Cathy:

Yes.

Gavin:

Maybe we will pick up on that in a moment. Jon Rouse is Chief Executive Officer of the Greater Manchester Health and Social Care Partnership

Jon:

Thanks very much. We are also an accountable care system and have this added ingredient of devolution which means that everything we do in terms of decision-making is linked and rooted in local democracy in terms of the way we make and take decisions. It is a partnership between the NHS, local government, the combined authority and increasingly, the Mayor of Greater Manchester as well.

So, we are doing all of the things that Amanda is doing. We're not doing some of them as well as Amanda is doing but we are of a very similar menu. And it sounds like we can learn a lot on elective care from Cathy and her team.

I thought I would take a different lens again and talk about some of the key

enablers of successful transformation of health and care. And they are finance, workforce, digital and estates, just to give us a different perspective. So, if we start with finance.

We have created, in our sub-governance, a single finance committee, a finance executive group that has directors of finance from CCGs, from trusts and from local government treasurers who collectively take ownership, along with NHSI, for the financial performance of our whole system. That means they are tracking and monitoring how we're doing against plan, there are conversations around control totals - are they fair and are we going to meet them and so on.

By having that collective ownership, that sort of one-for-all, all-for-one mentality, last year we were able to deliver a £235 million surplus across commissioners and providers within our NHS. Now, things will get tougher this year, and probably tougher again next year, but I'm absolutely convinced that that collaborative model of the whole system owning each individual organisation's performance and without taking away accountability providing a support and assurance framework around that was a big assist.

Our second one is workforce. Here we have a looser structure, we have a developed a workforce collaborative that has again the people you would expect in terms of commissioners and providers, but also four universities. It also has Health Education England and Skills for Care as well. They have developed a single workforce strategy for Greater Manchester, with three big priorities.

The first is Grow Your Own. This is about developing our own workforce really from school onwards, pulling through more apprentices and developing new pathways into the NHS and social care. The second is a more flexible workforce, making it easier for people to move within the system, including between health and care and also particularly in integrated care services to take on new jobs, like care coordinator or care navigator, regardless of the originating professional background. Then the third is a single approach, a

coherent approach to hard to fill positions. Just to give you an example of that, we will see this year an increase of 11.5% in the number of nurses starting courses in Greater Manchester, compared to a 6% reduction nationally. That is because we have made it attractive for nurses to come and study and work here and we see it as one piece across Greater Manchester, with all the trusts and universities offering that course, working together. Very quickly on digital, very similar, single digital strategy, digital collaborative, with all the key players working together: single Chief Digital Officer and then working with each of the localities and organisations in terms of their contribution to that plan.

And on estates, a single estates plan with a prioritised pipeline of capital projects, identified a financial strategy to fit with those projects, a heavy emphasis on improving utilisation of space, linked to our acute services strategy, and then a grown up dialogue with Government and the national bodies in terms of our need for public services capital for some, but not all, of the execution of that plan.

So, I use those as examples to show it is about frontline, of course it is. It's about integrated models of care, it's about all of the things that Amanda and Cathy described. But it's also about what's going on behind the scenes and making sure all of the key enablers are supporting your frontline strategy.

Gavin:

Just on that point, Amanda raised a very interesting question. People have got a statutory duty, it's their job, it's their box to tick, and then you are asking them to do something wider, for the greater good. Sometimes, some people will find it difficult to get their head around that.

Jon:

Yes but the way you can construct a different paradigm around that is to say that, by doing that thing for the greater good you are going to find it easier to

fulfil your accountabilities within your own organisation because we are going to bring support to you to enable you to do so.

Gavin:
Matthew Swindells is NHS England's National Director of Operations and Information. How do you see it Matthew?

Matthew:
What you've heard here are three systems that are doing real change and are making a reality of what we were hoping for when we started down the STP and ACS journey, which was to create an environment for what's been described to me by one of the think tanks as the NHS' first ever bottom-up reorganisation - create the space to make a system that works for you, putting patients at the centre, building it around place and local communities and expecting institutions to work in partnership rather than around institutions' own vested interest.

What we are trying to do is create a permissive regime where we can devolve regional and national resources, we can say reinvent the payment model if you need to reinvent the payment model locally. We can say, you need to make your system balance and be of a high quality and having one brilliant organisation and another failing organisation is not a great system.
And it was really driven by the sort of conversation I had just over a year ago with one of the London teaching hospital chief executives. I was discussing with him why he had such a high proportion of his population attending A&E and he said, "well what you need to understand, Matthew, is that my chairman would not allow me to turn away those patients because that is how I make the profit on which I run my hospital." So, I said to him, obviously, if he needed help handling his chairman I was prepared to have that conversation for him.

More seriously, that kind of perverse incentive does run across the NHS - of people being urged to do one thing and then being financially rewarded to do something else - and part of what we are trying to do here is create an environment which says no, get your heads together and work out how we make the system work as a whole. There is a fixed amount of money, there is a population that needs care and how do you make that work? And some of the examples we have been hearing are where systems are coming together and really starting to make that happen and I think just listening to Cathy's story, Jack Wennberg, the inventor of the Population Health Atlas in the States would probably be delighted to know that the study he did, - probably 25 years ago, on if you consult patients over their need for urological surgery and give them the information they need, a very high proportion choose not to have that surgery - Cathy has reinvented that study with orthopaedics and we've finally got a system that may be able to make best practice adoptable across the NHS.

Gavin:

I can see from the packed hall there are a lot of questions. We have at least two people with microphones, one each side. So who would like to kick us off with some questions, points or some ideas? I think we are in the ideas business. Yes, there is a gentleman in the middle there.

Question: David Smith, I am chairman of East Sussex Healthcare Trust. We are running, in a shadow form, an ACS. I was interested to hear all three aspects but one of the big challenges we have is in primary care and the shortage of GPs, particularly in some areas where we facing a 30% shortage of GPs. My question, I guess, is have any of you done any work on reimagining primary care so we can cope with the accountable system, with the shortage of GPs as it is at the moment?

Gavin:

I think we have all have thoughts on that. Amanda, go ahead.

Amanda:

One of my jobs, I am a partner in a GP practice and what you are describing is reflected everywhere.

There are all sorts of things and schemes and programmes going on to increase the number of GPs but I fundamentally believe that we won't succeed in increasing retention and recruitment until we make it a job that people want to do, and that is doable. So a lot of what we are doing is around supporting primary care so that GPs do the stuff that GPs are good at and are best at and that we have other staff and other avenues available for the things that other people do just as well or better. So we have pharmacists in every practice doing, not only medicines, management stuff, but chronic disease management. We have a fairly well-developed out of hospital integrated urgent care system whereby we have acute primary care on offer, where people can access through prescribing nurse practitioners, and we are training large numbers of prescribing nurse practitioners and paramedics who have a lot of acute experience and can train and adapt really quickly to an acute primary care environment.

We are supporting primary care by investing in community services. There has been a huge decrease in the number of district nurses available and therapists available, but those people off-load huge amounts of work that people are attending GPs with for lack of anywhere else to go.

It's difficult, it's difficult everywhere. It's particularly difficult in coastal places, and you will be aware of that, but we have to do something about the job. It's no good just importing more and more GPs and watching the ones we have got walk away. It's about letting primary care transform itself into something we can sustain and deliver.

Matthew:

I did a session with all of the Chief Executives and accountable officers for the Kent, Surrey and Sussex area only about two months ago and as part of my presentation I put up a slide showing the density of GPs across the patch

because you have across those counties some very well-GP'd areas and some of great GP shortage.
Two things surprised me. One was that the accountable officers didn't know what it was like in the patch next to them and every hospital Chief Executive was surprised to discover there are areas of shortage of GPs. So, part of what we are trying to do here is create a communication across the system whereby the solutions we find reflect the reality of what can be delivered. I think there is no question that we need to drive through with an attempt to recruit more GPs but I'd also say that Amanda's point is absolutely right. I think it was an RCGP study that said that 27% of people who turn up in a GP practice don't need to see a GP, but 25% of people who turn in up in an A&E really should have seen a GP. If we don't work as a system then the whole thing is blocked and you can't make the cascade.

So, what are the services that we at the NHS are offering to people who are coming to see a GP and never needed to see one? They need help and support, otherwise they wouldn't be coming to see a GP but we could do it more efficiently than saying, "join the wait to get to see your local GP."

Gavin:
Cathy, similar problem?

Cathy:
Very similar actually. Even the GPs we train we don't necessarily get to keep in Berkshire because it's an expensive place to live. We face exactly the same challenges. Matthew is right to talk about the channel shift,I often say to GPs when they are sitting in surgery, it's like trying to run outpatients and A&E side by side.

We need to think about how we can stream that work and make the job more tolerable and doable but also help in getting patients seen in the right place. We have just launched our new 111 integrated urgent care service last

Monday and we are hoping we will start to see some of the benefits in hours in general practice and eventually that to be the mechanism for access to in-hours general practice.

Gavin:

John, you mentioned raising your own and all sorts of things. Doing it with GPs is obviously slightly tricky isn't it?

Jon:

Yes but we are going to try, with increasing numbers. Just to add to what everyone else has said, rather than repeating, one other ingredient we have put in place is a GP excellence programme across Greater Manchester which is an expert hub which we have created in partnership with the RCGP and working with the individual local medical committees as well. That is based on a model of peer support and review. So it's not just a resilience programme, although we will pick up practices that are struggling. We start from the premise that everyone has something to learn and contribute and run it as a network.

Question: Have you considered doing conversation clinics at GP surgeries and using members of the public? A conversation clinic would be where a health champion type person, a conversation champion, might meet someone next door in a cafe and people get referred to the conversation clinic and all the other lonely people are just wanting to talk to somebody accepting and normal to tell them about their gas bills and, I am sure it would free up loads of GP time.

Gavin:

Okay, thank you

Amanda:

We don't call it that, but we do have various aspects of that. We have done a

lot of work in our central Blackpool most deprived area around community orientated primary care, which has involved quite in-depth conversations with the community about what would benefit them, what would meet some of those needs which aren't medical but where people don't know where else to go.

We have the Citizens Advice working, offering support, we have care coordinators and wellbeing support workers in our integrated neighbourhood teams. We are trying to pick up that very specific need, which actually people don't know where to go to meet it and so they end up in general practice.

Gavin:
Two people who want to come in here. Let's start with the gentleman over there. Maybe give the microphone to the two people there.

Question:
Thank you, I am Robin Wigs from Liverpool Heart and Chest Hospital. I would like to ask the panel what an accountable care system is accountable for and to whom is it accountable? And is that different in a devolved system like Manchester compared to leafy Berkshire?

Jon:
Yes, it is different. There is a higher level of delegation in the devolved system than there is in the accountable care systems at the moment. Overall within Greater Manchester, we have responsibility for over £6 billion of resource each year. That is split between my team and I have certain delegated responsibilities from NHS England and some from Public Health England as well. Then also obviously the Clinical Commissioning Groups, local government, the NHS Trust and then we have a single governance structure which goes up to a strategic partnership board which is chaired politically by the leader of Wigan Council on behalf of all the leaders and that is where we get ultimately our business done, plus through the sub

governance.

What would be different? We have responsibility for about half of specialised commissioning, budgets and modalities and we have also got all of our transformation funding for four years rolled up and delegated for us to decide how that is allocated, albeit we have to meet the Five Year Forward View objectives. So that is £450 million over four years. You add it all up and it comes to just over £6 billion a year.

Gavin:

Anyone else on that? Cathy? How accountable and to whom?

Cathy:

We're in the middle of signing our memorandum of understanding with NHS England. So, the organisations that are part of the ACS are signing up to be accountable to NHS England and NHSI for the CCG allocation, plus transformation money and to deliver requirements of the Five Year Forward View. There is a formal line of accountability. There is a formal assurance process that goes alongside that. That's how that accountability will work. There are some things very similar to Jon, we have our delegated responsibility for primary care and so on. For us, we're too small to take the responsibility for specialist commissioning. We would do that at an STP level because we sit within a larger STP. It is horses for courses. But the principles are the same for everybody.

Matthew:

At the heart of that question is that this is not a strategy change. We have not changed the law, we haven't created a new legal entity. So, you could consider that to be a problem or you could consider it to be an opportunity. The NHS does, as Gavin said earlier, re-organisations all of the time. This actually, to work, requires people's hearts and minds to come with it because you can only run an accountable care system if the organisations within it choose to share some of their authority with the system as a whole and NHS

England and NHS Improvement choose to share their authority down into it. It probably takes a bit longer to learn something like this than just passing an act. But the chances of getting by are higher in this way and the possibility that we might actually create the behaviours, as well as the structures, and save time is what I'm clinging on to to allow me to sleep at night. If everybody goes back into their cells and declares them as defencing their organisations, this does not work.

Gavin:
I was going to say that we're all in this together but that has gone out of fashion that phrase! I will scrub that from the record. Gentleman there.

Question: My name is Tim Benson. How will you measure success in terms of benefits to patients on a day-to-day basis?

Cathy:
We have various outcome metrics. We want to focus on clinical outcomes and patient experience metrics. Part of our work around co-design and some of the things I was talking about around the MSK is talking to patients about what is important to them. That can be a surprising experience and would help us drive our impact and outstanding measures, really. We want them to be part of that as well.

Gavin:
Amanda, what difference do the patients see or feel? Or do they not generally notice?

Amanda:
What we're trying to do was the same as we were trying to do in separate organisations. We've got some very long-term objectives that are largely public health, health improvement related around life expectancy and around, you know, chronic disease management and around outcomes. But in the

short-term, you know, however unfashionable performance targets are, they are there for a reason so we are measuring ourselves on delivering A&E performance on referral to treatment times, on cancer pathway times, on transforming mental health services for patients.
Some see them as political or arbitrary measures but these are real patient experience measured related directly to outcomes, so it's really important that we don't get so caught up in designing a new system that we forget that if you've got a cancer it's really important that you are diagnosed and treated very rapidly and appropriately and that if you go to A&E in an emergency you are seen and sorted and treated in a timely manner. So, we are holding ourselves to account for the key performance measures in the same way we were before. We're just doing it as a system, rather than doing it by individual organisations.

Matthew:
Tim has been inventing metrics for measuring patient experience since I was still in shorts! I think that the answer you are getting at is right. We are trying to measure patient experience and we have a lot of metrics in play. I would also say that as we develop our public consumer engagement with the NHS the opportunity to have a much more granular feedback on what the consumer considers they've just received from the NHS, as opposed to the measures we put in place, is a step forward that we should be moving towards and it's one of the reasons we have to get the interaction between people and the NHS using technology to a level where we can understand it at a much more granular level than we can at the moment through our surveys.

Question: Richard Kemp from the Local Government Association. I heard a very interesting description from our last speaker that STPs were a bottom-up process.
I must tell you that's not something that we recognise. Chief executives of trusts getting together to provide a report which largely deals with NHS

institutions doesn't seem to me to relate to a bottom-up approach where we would go from neighbourhood to community, to area, to district, to council and then the councils coming together through an aggregation of their joint strategic needs processes to actually find new ways, with many partners well outside the health service. If we all lived in a decent house and had nice parks and places like that, we wouldn't have to call on the health service. So, I think if you think STPs were bottom-up, with the exception of Manchester where the STP was a three-year process which built on so much good practice, then I think you're badly wrong.

Gavin:

Jon that was an interesting thing to pick up on what Andy Burnham was saying this morning. The opportunities and people will look to Manchester, Greater Manchester as the leader in this.

Jon:

And in some ways, we are in that leadership cadre with the other accountable care services. To some extent we're different and we are defiantly different.

By which I mean, we do see this as a joint partnership between local government, local democracy and the NHS.
We're still fully part of the NHS but we believe that we are building a bridge between the two which we believe should have been there from 1948 onwards and wasn't built into the system and that is what we're trying to do. It is a paradigm shift. We're unashamed about saying that. Because of that, we are focused on things like school readiness and reducing homelessness and improving access to employment and, you know, working with Chris Boardman, our new walking and cycling commissioner, to change the way we move around this city. We're as passionate about that as we are about A&E targets, because we care about those as well. In terms of measures, you have to find a balance between the short-term, which is really important, and the medium-term, which you have to start to bleed together some wider public

service ethos and objectives.

Gavin:

Anybody else?

Cathy:

I would absolutely agree with the point about local government. I think there is a bit of a risk that the STPs and the ACSs sound like the NHS going off on a frolic on its own. What is happening in the areas where we're working the exemplars there is a long history of that integration and joint working. In my patch, we have the Berkshire West ten, which is our CCGs, our NHS providers and local government working together as a cohort and that's been going on for two years before we started to think is about accountable care system

And what we are doing now is bringing those programmes together in a coherent way, for all of the reasons that Jon has described, really. I would completely endorse what you're saying, it's essential.

Gavin:

Thank you, lady at the front.

Question: My name is Marsha. I've got both physical and mental health conditions. About 15 physical conditions and I take about 30 tablets a day. I've started thinking about how I can control my own stuff because every single tablet I take is more toxin in my body. You were talking about musculoskeletal, I have fibromyalgia which is very debilitating.

I'm using this table to take some pain away from me. But I was watching something over the weekend and it was about juicing diet and they went on a programme for, like, a month and it was amazing.

It is in Portugal and it is £800 a week, but say, for instance, the CCGs paid for me to go there for a month, there was people that their diabetes was

reversed, they don't have fibromyalgia and everything like that, so is this accountable care thing about looking a bit outside the box? Because imagine how much – I won't have a carer in any more, I would be away from that - does my medication cost a week, my patient transport to my hospital appointments and everything like that?

So, really, the CCGs need to sort of not think... they used to group by everything, so it's my hope that you sort of... I know that the population plan... I do stuff with Greater Manchester and I'm really proud of the stuff we do and how far it's coming.

But I hope that you start seeing us as people and not just as money and we will save long-term.

Amanda:
You're absolutely right. Unless we reduce demand on the system by helping and enabling people to take a role in, and care of, their own conditions - so give people the tools they need to manage their own long-term conditions, whether that's education and information, whether that's the technology, whether that's access to personalised budgets so that their care plan for patients with complex conditions can be tailored - we are never going to reduce our dependence on relatively expensive in-hospital care.

So a lot of what moving towards a whole system approach enables us to do is look at individual patients or individual conditions and look at the best way to enable patients or groups of patients to take responsibility and become involved in managing their own care, looking after themselves and calling on us when they need it.

Now, we haven't gone anywhere near packages in Portugal. But certainly, that enablement of managing long-term conditions, as you describe, has huge benefits for a system. This focus on the whole system and the whole system

resource will enable us to do that

Gavin:

One final slightly wider point on that - what we've been discussing throughout the day is innovation and joined up thinking within the NHS, and also local government and others, but in the end the buck stops with government, doesn't it? You can take a lead in many of these things.

I'm not talking about any particular government, but it's up to government to suggest that actually whether children are ready for school age five, as Andy Burnham suggested. I think he said almost a third of five-year-olds were not ready. That has all sorts of issues attached to it, as do many of the things we've been discussing today.

Matthew:

The role of government is to say what shape of NHS they want and how much they're prepared to spend on it, and to set the core framework, what we call the mandate. To an extent, you can have an NHS for any amount of money a government chooses to spend on it. There are just things you don't get if you decide to spend less money and things you do get if you decide to spend more.

Within democratic boundaries, I think it's the role of the people in this room, the role of us, to deliver the best population health that we possibly can and that undoubtedly involves been innovative about delivering care but also making sure that a patient gets the opportunity to have a proper conversation with a GP about what the pros and cons of the medicines they're on versus not taking those medicines are because that's a complex discussion which shouldn't be taken on the basis of a Channel 4 documentary or whatever, but should be taken on the basis of an adult-to-adult conversation between the person who is taking the medication and the person writing that prescription to get to the right answer for that individual, which may be different for you to

somebody else with exactly the same conditions.

Gavin:
A few more minutes left. Some other thoughts? We had had a couple of thoughts sent in on Glisser. Anybody else with burning thoughts? Yes, gentleman here.

Question: Hi, I just wanted to, I was wondering, I think that all of you would agree that self-care is an absolutely essential part of what needs to happen and it's not just about reducing demand, it's just a better way of doing things. You want people to feel they have more control over their lives but, certainly from my perspective, having worked in the self-care field for a long time in the third sector, most of the obstacles are not to do with the people, they are to do with the professionals working with people and the perverse incentives within the system that make that so.
So what I want to know from the panel is how are you going to manage that transformation, and it would be an utter transformation, towards a proper self-care model, changing the way the workforce works?

Gavin:
Good question. Jon?

Jon:
So the first thing I would say is that it may not be right to start with the NHS. I think the voluntary and community sector have a massive role to play in this space, in facilitating cultural change within the statutory bodies and also facilitating a different dialogue between the individual service user, carers and the system. And just to give you one example of how we are doing that, we are backing a programme called Focus Care, which is run by a third sector organisation called the Shared Health Foundation. And that's embedding workers in GPs in our most deprived areas and we have 22 of these workers at the moment who can be drawn from a whole number of professional

backgrounds.

They're picked on a value-based recruitment process because we recognise that they know how to have a different conversation and how to enable and facilitate people to help themselves and give them access to the types of resources that they need. And by embedding them within primary care, we can then train and develop professionals to understand how that conversation looks and feels different and how it gets different outcomes.

Matthew:
I think it's a very important point. There is a study done a number of years ago putting a value on the self-care and supporting care, the free care, given within the economy and the value was about £120 billion. So, the value of the unpaid care service is about the same size as the NHS.

If you think the amount of time we spend trying to make the NHS more efficient, use technology, use different ways of working and then compare that to the almost no time at all we spend in terms of making the care environment more effective, I think we are missing a big trick. So when you listen to us talking about new models of care and the technology strategy we talk about self-care, carers, engaging the public, engaging the patient and engaging the person in their own wellness as key parts of that strategy because I don't think we end up with an affordable health service in 10, 20 years' time if we don't manage to make the sort of transformation you are talking about and I don't think we know how to do it.

Gavin:
One of the things I wanted to pick up on, and it links to that, is a lot of what you have all been talking about is effectively soft skills – about how to get people excited about it, how to get people to co-operate, how to get patients more time to explain things. These are people with expertise and really hard skills, is that a slightly difficult change to make, to say you just actually have to

communicate better, in some ways?

Matthew:

I think it's a really hard change. I think we have spent the best 10 or 15 years setting the NHS up to compete with itself, to operate on a trading basis and we are basically saying that, under the conditions that we are operating at the moment, the solutions we want are too complex for that model to operate.

Therefore, the things that made you the best possible chief executive in the country two years ago, it's not the same exam paper anymore and you need to learn a new set of skills with things we are expecting from our clinicians in terms of engaging a wider community. The challenge from local government, which I don't wholly accept but I accept parts of it, is that we as the NHS have a box around it, local government has a box around us, and if we don't work out how to make that a permeable membrane then a lot of things that need to happen won't happen and we need to go on the journey together.

Gavin:

You were talking about soft skills, with colleagues and others, to try to do things better.

Amanda:

That is right. The trick is to keep people well, and we are not going to do that as an NHS that devotes its time and energies to treating illness. The gentleman who talked about local government involvement, we absolutely cannot deliver this agenda without local government involvement, if we don't focus on prevention and on reducing the ill-health burden on the self-care agenda, on social care and supporting carers and home care services and looking at the nursing care market and all of those things. If we just focus on clinical treatment of ill people we are not going to deliver within the resources we have got and some of the stuff that you are talking about doesn't need doctors, it doesn't need highly skilled nurse practitioners, it needs people who

have time: wellbeing support workers who have time to sit and explain to people, sometimes for the fifth or sixth or tenth time, what each tablet is for, how to make sure they don't run out, have they had a flu jab, do they know what their treatment plan is for something they might have been referred to hospital before. All of those things take time and doesn't need me or other GPs to do it. It needs people at home with our patients and our community, putting the time in to enable them to look after themselves better.

Gavin:

I want to give the final word, because we are out of time, to Cathy. Just in terms of your experience of it, ACS has been quite surprising has it and exciting potential?

Cathy:

I think it's given those clinicians that intuitively want to work this way with their patients the platform to do that. The other example I would give is the work we have done on diabetes, where we have completely transformed the model. People were trotting up to outpatients all the time, all of our diabetic population. Very few go near the hospital now. That is a community-based model, we have worked with primary care, with nurse specialists, with consultants to support the team to do that, but also with Diabetes UK. And our patients have become completely empowered in their own condition, they access their own care plans, they know their results and what they mean and they are empowered to be in control of their own condition and that is the change we need.

Gavin:

And happy?

Cathy:

Yes, absolutely.

Gavin:

Cathy, Amanda, Jon, Matthew, thank you all very much.