

Keynote Address:
Speakers: Matthew Swindells

Matthew: Thank you all for being here, it is a very wide-angle audience for about this, trying to maintain eye contact with audience, over on this side it is hard. So yes, I am, what I would like to do to talk for a while about firstly where are we now and what are the immediate priorities we need to deal with? I want to talk about STP's and the accountable care system and how they are playing into the overall strategy. Then information and technology and our wider strategy and how it comes together and then maybe land on the challenge.

The first thing I want to do is to say thank you to the NHS staff in the audience. There is no yes, the NHS is working under a lot of pressure, no question having to work in order to provide the best possible care for our patients. The on-going commit. The number of people who routinely go beyond the call of duty to provide the care people need in hospitals and in community and primary care and is always awe inspiring so thank you.

Because despite the pressure we operate under, despite the challenges of, there is not enough money to go around, the NHS continues to deliver whilst we want to improve and need to improve our A&E performance, I have come back from 3 years working in the States, if you go to a big General Hospital, into the A&E department in one of the major American cities, you will take longer to get admitted than you do in a hospital in England today.

If you are not fortunate enough to have expensive health insurance, around the world, you cannot go from referral to treatment in 18 weeks, not just the States and so on. So, we are still delivering under the pressure, world class performance, not all the time, not every time but overwhelmingly the NHS delivers first class performance.

The chart behind me, just a few weeks ago, American think tank said that looking across 11 health systems in affluent countries the UK system was, was the best and so, we should be proud of that and we should be fighting to make sure that remains true and I would go further to say, we continue to be probably the most efficient health system in the world.

The latest OECD data looking at the amount spent per head of population for health care showed that for instance if we were to be spending the same amount per head as the French, the NHS would be spending another £15 billion a year. So, we do a hell of a lot in

an extremely efficient way and we should be extremely proud of that.

But we can't rest on our laurels; there is a hell of a lot still to do. In July, we had between ourselves and social care managed to reduce the number of delayed transfers of care across the NHS this year by 570.

Between the two parties, We had got bed occupancy to just over 91% against the NHS target of getting bed occupancy down to 92% in order to create a flow through hospital but the A&E wait time was still flat lining at 90% seen and treated within 4 hours.

We had the conditions in July to get back to 95% and we didn't and we cannot afford to settle for good enough. We need to be better than that. We need to get back to excellent. We need to make sure that we are driving innovation and we are driving at the same time as we are driving basic good practice. We have to get a grip. We have to take the opportunity to make that shift now before we get into the winter because when the pressure of the winter comes, if we haven't done the work now, we won't be able to maintain the sort of quality of services that we want across the winter.

We still have something like 30% of patients in hospital who are stranded in hospital. They need some care but they don't need to be in hospital. We are holding them in frequently elderly care wards, against their will. We are denying people a freedom. All of these patients are waiting for a social care package or expensive continuing care, proportion of patients waiting for that, but a vast majority of them are waiting for us to get our act together.

The vast majority of people, people's mums and dads on a hospital ward deprived of their freedom, unable to live the last years of their life with the best opportunity they can. We should be focused on that not because of A&E target not because of bed occupancy number, but if we want to give people best chance on their life. Holding people on an elderly care bed ward is not your best chance in life.

So, when we look across our A&E departments, we have done a study across a number of high performance forming A&E departments, about 50% of patients could be treated elsewhere, could have gone to the pharmacist, or primary care. While we are investing now in primary care streaming in A&E and while we are investing in treatment centres and extending the access to primary care, we need to shift the patients, we need to get them to a more appropriate location.

I would like us to be committed to patients who don't need to be committed to hospital, a 100% of them should be treated in 4 hours. If you look across the walk-in centres many of them are at 99.5%. When we suck patients into hospitals where more complex patients

needing focused time, they end up waiting for things that can be done quickly. We need to grip the transformation that is required and if as the royal college of GP's say, 27% of the patients who go to GP's, don't need to go.

We get the story of why we have to have a system shift. Why if we want patients who are in A&E treated in primary care, we need to create the space in primary care by creating the space elsewhere. It is like the 9 box slide things where you have one empty space and trying to make a picture of the Eiffel Tower, you have to move all of the pieces, if you focus on a silo we won't get the shift we need. The opportunities are out there and the opportunities for us to think as a system, to make the changes necessary.

When you look at the work that right care and GIRFT have done, estimating £2.4 billion of savings. Saying 3.4 billion saved between now and 20, 21 by the adoption of best practice. This is not about depriving people of the things they need. This is about giving them the things they need in the right kind of way. If we don't make the decisions or chances we end up having another conversation we have talked about the difficult conversations that we have to have in order to deliver the NHS that the public need and to be able to keep a sustainable service and I would say to you that we need to consider what we mean by a difficult conversation, if we it is, the difficult practice needs to change and the waiting times are going out and you can't have IVF anymore.

We are having the wrong difficult conversation. We need to face the service and say, even as the most efficient in the world and even as a high performing service we need to get better and drive changes and we need to challenge the status quo and we need to remove unwarranted variation, in order to do for the public that we serve, the things that they have a right to. It is going to take really good, really brave leadership to make that historic shift. Part of doing that is why we created the STP's and the accountable care systems because we have changed what the question means to be a really good Chief Executive in the NHS. Only a few years ago the measurement of being a really good Chief Executive was the institution. Now the measure is the success of your system.

The rules and the challenges that we now face are too complex to be dealt with in silos we have to work in partnerships and we have to be able to do as Andrew Morris says, by working with community and primary care services he has managed to create an emptier department at Frimley Park and a bigger hospitals. How great is your A&E department -- the challenge is are the right people in hospital receiving hospital care and with STP's, we are trying to bring together systems we are trying to give permission to make the right decisions. I don't want to hear any more excuses like, payment by result makes it impossible for us to

do the right thing.

The Chief Executive at the London teaching hospital last year who told me his Chairman wouldn't allow them to put stream into the A&E department because it was on the primary care patients they made their profit. That is a dinosaur; we have to move beyond that.

The question isn't the profitability of an institution; it is the sustainability of a system and the quality of care that we are delivering. So, we are trying to give the freedoms, the permission to say, if I can make my health system balance, let's not get obsessed by individual departments and individual organisations. Let's come together and redesign the system to deliver high quality care for everybody let's focus on the people who need it most. Let's deliver excellent care in the right location and out of the removal of error, the removal of unwarranted variation will come the savings we need.

We have to do that now because next year is going to be harder. The financial challenge this year is going to be greater next year. That is why we put in place 2 year contracting round at this time last year, this year we have the luxury of not running another contracting round; not waiting for a new set of prices to be published; not waiting for a new set of targets and standards not waiting for the sequin rules to appear, getting on with the plans in place.

I know year 2 plans written in pencil rather than ink at this time last year, we need to focus on, what will our system look like in 18 months' time? Am I taking the decisions now, that will take 12 months to have the benefits, when I go to next winter, I have done the things for next winter and for this winter. That is what the NHS asked us for, they said lift the burden of the contracting round of sending forms up to the centre and let us get on with delivering stuff with a longer time horizon. We need to get on with it. It isn't a pass not to have to worry about next year, this is a continuous set of changes. If our assumptions were wrong, we have to bring them back in line.

There isn't going to be another roll of the dice to say, you know what? We might get lucky and we might get more money next year because we know what the allocations are and now we need to deliver the changes.

We know we can do it because we are already delivering the best value highest quality health service in the world, the question is, do we want to participate in losing that and drive on from there.

I see as I have walked around here, the amount of innovation that is going on. Both in terms of service delivery but also in terms of technology. I saw my M health showing their app for supporting COPD done the proper evaluation and published the evidence to show that using

their system you can people can manage their own COPD and other conditions better.

I saw the work that the organisation in Cheshire and Wirral, to improve the pathway management for people needing continual health care, making sure that data flows across the system, we standardise data capture once, we take the bureaucracy out of the system and focus on the right answer for individuals.

I talked to primary care suppliers much maligned over the years about playing within their walled gardens talking about interoperability, population health the need to share data across boundaries and the need to create picture of the health needs of a patient, whether it is in a primary care surgery or somewhere else.

That is to me is symbolic of the sea change we are seeing everywhere. I have spent most of the last year talking to the 44 STP's, I think I have met them twice and many more. We have some brilliant STP's at the leading edge of change and some struggling to build the partnerships, nowhere hasn't moved forward or have a better sense of partnership now than it had a year ago if we can now build that into the use of technology; the use of IT to accelerate what we are doing, we can make a big change.

That is why this is, we called the IT strategy, it is IT strategy on the page, focus firstly on patients, empowering patients to self-care, empowering carers to look after them and opening up an ecosystem of development whilst we centrally will offer everybody access to their day at the, people can start to create the solutions that work for individuals to innovate around pathways using technologies. The work we have done is beginning to bear fruit. We're out in the first acute hospitals, the first mental health trusts.

We're about to launch GDEs into the ambulance service, and this afternoon the Secretary of State will talk about the next group of fast followers, how we are extending the GDE programme to get first class providers and away from being trapped in a paper based nightmare. We are focusing appeared we tried to learn this from the States, where they invested a lot in Hospital IT, how do we target real change? How do we focus our IT on focusing on the real challenges that the NHS is trying to? How do we create better ling age into social care? How do we create a hub, building on the best of what is happening, in order to be able to create one view of the patient?

Simon talked in his speech about the innovation hubs. What we want to create are clinical hubs, with anonymised information. Collect the data once and use it multiple times. So, we can move away from management meetings that spend more time talking about what needs to be done and less time talking about whose spreadsheet is accurate. Can we move away

from the time that we waste squabbling over coding and have one source of truth we are all debating for the good of the patient.

Can we leverage that to make the NHS a hub of research and development, genomics and development medicine to take things forward. I think we are making great strides there. People have been doing a fantastic job. But the challenge for managers now is how do you build technology into your business strategy in? I'm not expecting people to learn this off by heart. But the yellow parts are technologies intervention in a modern emergency care pathway from patients being able to access the information to self-care so they don't need to access a clinician at all. They can access over 111, where a clinician on the phone can access your medical record with your permission. Can directly book you to see a GP or can directly book you into an urgent treatment centre, but can also write you are prescription. The number of appointments that follow a 111 call because somebody now needs to go to their GP in order to get a prescription filled, we can strip that out by using technology.

We can prescribe to patients the information that they need. So, we now need every board to put IT at the top of their agenda, to be thinking cyber security, to be thinking service redesign, to be thinking data quality, data capture, to be thinking how do I use the new technologies to drive the changes I'm making rather than IT being in a corner.

The challenge is making the case for how we can use technology to transform care. The challenge to every organisation and every vendor is to be open, is to not be protective about your data. The data belongs to the patient and if the patient wants you to share what you've got with another clinician who is treating them, I don't want to see vendors locking the data down and treating it as some kind of market opportunity. That's not the NHS that we are.

The NHS we are is around the health of populations. It is important because working together is working. We know here are some of our best examples. But right across the country, these are examples from accountable care. For all patients referred to a shared decision supporting process prior to having joint surgery, 80% of them choose not to have surgery. Flip the other way around, 80% of patients are currently having a knife taken to them by a person wearing a mask because they didn't understand what's about to happen to them.

There ought to be a law against that sort of thing. We need to be able to leverage the best of what's going on. You don't have to be one of these elite health systems. You can deal with tough problems. I was on the Isle of Wight where the work they are doing with police to keep mental health patients out of police cells is spectacular. If you talk to Surrey and

Sussex hospital about the work they are doing around creating homes that are healthy. We all have an opportunity to do a transformation, we all have an opportunity to make people's lives better.

I would end by saying do we believe we can do it? I believe we can do it

I think the technology is becoming real rather than a press release. I think we have a sense of focus and a sense of partnership re-emerging in the NHS which plays to our core values. That we have a sense of focus on the patient which is making a huge difference and I'm seeing that across the country. Really hard problems being solved in our most challenged health systems by people coming together across their institutions. I think we have the best leader and the most committed staff in the world.

That's why we have the NHS we have. To quote Simon from this morning, on the eve of the NHS's 70th anniversary, the future is in your hands.

Thank you very much.

JENNY: Does anybody have any questions for Matthew?

Question: That was the first time I heard anybody note that current IT vendors are locking data down. How can we empower staff to not buy IT that doesn't work? That's my first question.

Question: Winter is coming and you talked about getting on with transformational change. Not a huge amount of time to do that. What are the kinds of things that a Trust should be focused on in the short term before winter in terms of making those transformations that need to be made.

Matthew: To pick up on the IT, I don't think any of our staff go out deliberately to buy IT that doesn't work. I think the challenge, which I believe the industry is now picking up, is that we need to create a view that is wider than individual institutions. I think there are two parts to that.

One is that data needs to be opened up and in our GDE programmes and as we go back out to procurement to refresh the GP systems of choice, we will be making open data, interoperability, secure access to patient information necessary for all of them. As we put the hubs into place, we're going to be clear about which vendors are sharing and which vendors aren't. Because with the adoption of international standards, we are expecting to be able to both get away from half-baked systems that do half a job and into solving real complex problems, but also creating the space within that for small vendors to be able to

innovate.

I have just come here from meeting with the US Department of Health. An interesting opportunity to meet with President Trump's appointed IT advisers. It turns out they are not mad, they know a lot about this stuff and they also are interested in data sharing, how do we create an international market that allows the best vendors to be able to innovate on the edge. So, I think we need to be really grippy about this. We need to not take any shit. In terms of into winter, I think people know what they need to do.

We need to drive the emergency care strategy into place.

We need to get 111, that is dealing and solving people's problems.

We need to get our urgent treatment centres open and operating and providing a standardised service and for patients to know about it.

We need to make sure that we have primary care cover across the winter period and that people know where to access it.

There was a bit last year where we had a lot of primary care open and people assumed it wasn't and went to A&Es anyway.

We need to make sure that when people are giving up time to offer patient services, people know how to get to them.

We need to get the streaming into A&E, so A&E doctors are treating patients who need to be in A&E and we have a primary care service alongside it.

We need to get discharge strategy into place and we need to drive this you hospitals really good practice.

We need to make sure that A&E problems are not the problem of the A&E department, they are the problem of the whole of the hospital; that we are viewing the flow of patients through, the right patients being at the right time is at the core business of the hospital.

I think the strategy is out there. I think people understand it. I think we need to make sure that we don't hit the targets and miss the point. We don't open urgent treatment centres that more people don't use. That we don't create streaming services that people don't use. We actually need to move the flow of patients.

Question: About the innovation in primary care services, how do you get the message out

to patients in the community about all the services that are available?

Matthew: There are two elements to that. We need to use the mechanisms that are there to tell people. I would like to be able to wander into November into any town in England and see on the side of the buses clarity about where you go on Boxing Day if you need primary care.

I would like it to be on local radio, in the newspapers, pushed out through Facebook. I would like us to be marketing the services that are on offer because we need to understand different people need to access information in different ways. I think in terms of access to the technology, we need to make it much easier for people to access their record, book appointments, communicate with their GP online.

When I came about 18 months ago we were trumpeting that. 97% of people could access their GP record and in little subtext it said "2% do." I'm not interested in the 97% who can, I'm interested in how many people are actually using it. We need to focus on are we affecting the experience of people in their lives, not on have we ticked the box that we made something available.

I think that's a big change we have seen with the strategy which had all the right stuff in it, but the question is are we doing anything in terms of the way the NHS works and the experience for patients rather than just the that's an IT thing just as much as its "these services are available to you" sort of thing. Are the patients accessing it, are we reaching the people we need to talk to, not have we fulfilled some pledge somewhere.

Question: I just wondered, given that the workforce accounts so much of the NHS spend, do you think we're doing enough about the workforce in keeping good people, a lot of the reasons that good trusts will be struggling is vacancy rates, as much as anything else.

Matthew: I think there's two aspects to it. One is retention, motivation, optimism, the things that leadership needs to deliver to the service. We drive the NHS very hard. We need to remember to say, "thank you." We need to celebrate what we are doing well as well as when things go wrong. We need an environment where people are proud and optimistic about working in the NHS.

Because however hard we work on recruitment if people are leaves us faster than that, then the bath will end up empty. There is a huge focus we need to make on, on retention, on being creative about flexible working; about giving people the opportunity to work in the right

way.

Then I think we need to be thinking about the vacancies we have. Firstly, we need to ensure that across the everywhere across the country we have really good bank systems so that we are not dependent on the high rates that we pay for agency workers coming in, much of which is not going into the pocket of the worker but going into the pockets of the agencies. We need to have bank statements; we need to think bigger than by institution by institution.

We have occasions where we say, this A&E is bordering on dangerous because of staffing, and down the road. We need to think about our work force at a system level as well. Then we need to drive the recruitment and we need to get people into training, into work force, back into the work force and creating that environment.

Given that what we pay people is outside our direct control, what is in our control is the experience of working for us and I, people wanting to be in the NHS and feeling valued and wanting to stay. I think we can all do something about that.

Question: Matthew Hi, Nick Price I wanted to take you back to the winter planning stuff and you said 30% of people in hospital that didn't need to be there, then the difficulty of New Zealand with flu and things like that.

I was just thinking you know, we don't have a fantastically high uptake rate for flu vaccinations for staff or the public. What are the things that you think people can do to prevent people turning up unnecessarily with avoidable illnesses like the flu jab, like helping people on cold days put bins out so they don't fall. That must be as important as winter planning than any of the stuff focused on flow.

Matthew: The flow is getting ahead of the curve, it encourages the public health message, making sure all of the staff are vaccinated. We did well, why don't we get them all vaccinated?

Getting the message out to the public and making it easily accessible for people who are difficulty getting out of their own homes, can get to boots but not their GP. We need to be creative but we must not let winter take us by surprise, it comes at the same time every year.

How are we preparing for the capacity we will need for winter, if we get hit by flu, we will be need more capacity than last year, if more people in beds, having their liberty deprives losing their health in hospital and if they hang on long enough they will get a hospital acquired infection. Those is, ... hospitals, community services, primary care, requires them to work together to solve that. I would like us to be focusing not just on the detox target, but how do

I release the beds -- we will get a lot closer than if we ignore the problem.