The View from the Frontline: The staff and patients delivering new care models

Stage: Innovate Stage

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Speakers:

- Louise Watson – Programme Director, New Care Models, NHS England (Chair)
- Sir Sam Everington OBE, Chair, NHS Tower Hamlets CCG
- Jason Morris - Clinical Team Leader, London Ambulance Service
- Paul Maubach - Programme Director, Dudley Multispecialty Community Provider

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Louise:

Morning everyone. How are you? Good, excellent thank you, we have got a really lovely session for you today, I am pleased to be talking to you about the work of the new care models programme over the last two and a-years, I will check one this one is right. There are a couple of things I wanted to say, these are quotes from people who have worked in the service and also patients who have been affected by the new care models programme.

The first is from Ronnie, 81 and he is a patient within Dudley MCP, so Paul might recognise this. Fundamental to the New Care Models programme is how we deal with patients, how we support patients and how patients are the centre of the care that we deliver. But not only that, what we are also working with is ensuring that the staff environment and how staff are working together is a motivating and encouraging environment for them. So, Dr Andrew Weatherburn from Fylde Coast, great to hear the impact we are having.

These are two quotes from a myriad of conversations we have had with people over the last 2 and a half years about the how they felt about developing the new care models. This isn't and I stress this, a national initiative in the way we traditionally understand it. This is about supporting local communities and local health services in developing a really positive model of care for their patients.

Why are we set up in this is very quick sort of context stuff? We were set up as a consequence of the Five Year Forward View and a real need to ensure sustainability within the health service and we were addressing the 3 fundamental gaps which were talked about within that document. The health and wellbeing gap, the care and quality gap and also the funding gap. Then what was different about the programme when I think probably still remains fairly unique can't be fairly unique, but unique is that clinical engagement was first and foremost at the centre of how we wanted to deliver the programme.

To ensure that clinicians and patients as well were the people who designed and developed the care models. That it was locally owned so the local system was, the people within that system were the people who were developing the care model. From a national perspective, my team were the people who were supporting in the development and there to support when questions were asked or when support was needed in terms of different policies and procedures or in essence directives from a national perspective.

This is the map, this is where all the 50 vanguard sites are across the country. We are showing a difference. We have to be cautious about this. But from a national perspective always like statistics and we also know that through any UK model programme or any national programme we need to make sure there is a robust evaluation. So, what we are seeing and this is tracked by three quarters now that in terms of the new care models programme and the population health aspects of the programme we are seeing that per capita, we are tracking at below the rest of England in terms of the emergency admissions. So, we have seen that now for the last three quarters and we will continue tracking that until the end of the programme. But from our perspective it is, we are cautiously optimistic around the impact that we are seeing.

But enough from me. In terms of what you will hear today, what we wanted you to hear about is the perspective locally, what you will hear are perspectives from clinicians and patients from front line service providers. Also from our national adviser and hopefully what you will go away with is some tantalising examples of the things you can be doing in your communities.

Sam:
New models of care, why is it so important. In Tower Hamlets where I am a GP the life expectancy between rich and poor is 11 years, you can expect in Tower Hamlets to reach the age of 75 at the age of 55 in terms of your profile. We were reminded clearly yesterday that the rest of Europe is living longer and we are stalling. It is about dealing with the financial challenge, it is the about the Five Year Forward Plan shifting care generally into the community. It is about holistic care for patients, so a patient is not defined by their disease but by themselves as a person

Finally, it is about social prescribing. 70% of health care is around social prescribing. We only probably deliver about 30% in the NHS. The good news with the new models of care, all of them are involved in it. Now a thousand network across the country and 20% of GP's define themselves as a social prescribers.

In fact I would suggest to you as a result in 5 years' time, it will be as normal when you go to your GP to get a prescription from naproxen as it will be to get a social prescription.

The new models of care is about the change in the NHS, in separate ways, traditionally it is seen as top down, it uses this mechanism most commonly.

New models of care is about the other two areas you get changes in society. It is about innovation and it is about cooperation. So, what does this mean for patients? It means a fundamental shift in when you look at them not defining what the matter is with them, but what matters to them. Of course, that is where social prescribing comes to the fore. It makes me think also of something I read the other day about actually what prevents cancer and doesn't it question actually so much the typical things we do in the NHS. It is happiness; actually, we know cell regeneration is better if you are happy; not stressed. It is about activity; ten years loss of life comes from inactivity. It is about gardening, Mediterranean diet, minimising your alcohol and about not smoking, if you do all of those things, you can expect many more years of life far more than you would get from the NHS.

I invite you as a Norwegian myself, to go Norway or go and look at it on-line because it is the happiest country in the world. You have to ask yourself why?

What does it mean to staff? It means about leadership; leadership for everyone. It means about quality improvements; it means diversification and relationships, most of all I would say it means break the rules for the benefit of patients. If you are not breaking the rules you are probably not doing the right thing in the NHS.

So, to summarise the new models of care is about shifting knowledge to patients. Patients are the centre. It is about what matters to patients not what the matter is to them. It is about leadership for the many; not the few.

Typically, in the NHS, leadership is seen as just the people at the top. It is about the person as a person; not them as a disease. It is about community; it is about working in partnership. Above all it is about don't waste a crisis but most of all it is about focusing on the health and the wellbeing of our population.

Louise: Thank you, we will move on to the rest of the Panel.

Jason:

I am a paramedic, been on the front line for the last 18 years and I think what has changed about this programme is, the first time in my career I have actually felt that the ambulance service has actually been accepted as part of one of the partners and starting to work together and I think we started to do it but not very effectively. I think what actually brings to mind is, what do we know about each other's roles, we have got community services involved. We have got care homes etc. and we have got the hospital. I think there is a partner called Maria, done 25 years and said Jason, I didn't know that the ambulance service did this, just take patients to hospital. No, we have a massive amount of data, we can make a difference.

What has really made a difference for me in this programme from the front line is actually people listening to us. People say we want to stop people from going to hospital. Well, everyone involves the community services but no one involves the ambulance service. We never talk together and we never used to get together. We used to have meetings, turn up and sit in meetings, yes, that is fine and walk out. Whereas now the partnership is much stronger. What happens is we share information. We breaking the rules as Sam says. We are sharing information about patients to make a difference so we actually reducing you know; we have got a care home who is on the list, who is done 15 admissions to hospital.

Instead of going and beating them with a stick and putting things in places, so was it sepsis to cause him to go in or falls? Sepsis at home, I went in and talked to him for half an hour, turned out to be a 4-hour chat with the nurses. The nursing staff I never understood. So, 18 years I have always gone and looked at the nursing home and said it is their fault, always their fault and nothing to do with them. We always blame them yet actually it is let's work together and understand each other's roles. If there is one thing I would ask you the take away, go away and do you actually understand what your community services is. Do you know what your care homes do and do you know what each of your partners do?

I think through joining together. We call it the fab four, extended you know, local authorities now inviting us to meetings, they are asking us, got practice nurses ringing us up? Do you know Joe Blogs, this person etc.?

We can make a difference together and I think what this programme has shown, collaborative working and Sam says breaking the rule, don't go with the norm, actually break the rules and actually share information and you will find that it will reap benefits and you will stop people going in, stop looking at data, stop looking at what people are doing and why and actually understand; it is the same with all patients once you understand why they are calling, a lot of it is actually just supporting the staff within inside the homes I think from a front line, from an ambulance point of view, because that is who I am.

My crews saying, why we going to this home? This home doesn't understand, we can make a difference now, sit up and joined intelligence groups and starting to work together as a partnership. I think we all like using the word and integration but, I would challenge you, I don't believe all systems are integrated we used the word too freely and I would actually say, you know, learn about your partners and you will reap the benefits and that is what I have taken from being involved in the Sutton vanguard has just been amazing.

It is just you know, what we have managed to do to take the learning through to other areas which is actually even better. So, I work in the southwest of London and now starting to actually take the learning from there and spreading it and it is refreshing actually listening to people and people saying, saying I never knew you did this and I never knew community services, I had a peg fed patient ringing, I never knew a pharmacist could solve that problem, we go to a nurse. That person no longer calls us.

It is the key to everything. We forget that. That's my key thing, which I've learned, really learning what "partnership" actually means.

Louise: I'm going to move on to Paul.

Paul:

I lead the development of the Dudley MCP. One of the slides that Louise put up there was the three gaps of health and wellbeing, equality and funding. For me they are all one and the same because the funding gap, in particular, which is one that is always something that we're being challenged over and are challenged over, for me the currency for funding is really the money.

I can say that because I'm an accountant. The currency is our people. Because the NHS is a people business. There's two groups of people involved in that.There's our staff and then there's our public. So, when we're thinking about how do we deliver sustainable care, as you heard Sam talk about, the culture we're trying to develop is how public and staff work together. The way we have been going about developing the MCP has all been about how do we maximise the potential of the individual, how do we maximise the potential of our staff and, more importantly, how do we maximise the potential of the two together? So, when you are looking at those three issues, if you take our staff to start off with, you can't do this work unless you have a really good OD programme.

You have to have a way of constantly engaging, empowering, working and engaging with your staff. In Dudley, we had peer to peer reviews between people in our practices. It started a decade ago. We have a facilitation of teams across organisations, we have a partnership board of all the organisations in the system working together. The importance of that is it builds trust and it building a culture of empowerment for our staff. You can't do this work and make changes happen unless you have an effect I didn't have, comprehensive OD programme.

When it comes to the public, we completed quite an interesting piece of analysis, which, again, Sam I'm going to say a lot of things that Sam said he said about 17% of care not being delivered by the health service. We costed up the care by carers in the voluntary sector, trying to put a price to it. If you had to pay for it, it would cost more than the entire budget of social care in Dudley put together. If you add to that the fact that most of us, 99% of the time, manage our own health and wellbeing, then that isn't Health and Social Care, it is people in their own communities and own social networks. So, for an MCP or any health and social care system to be sustainable, you have to engage and invest in that relationship with people and their social networks. What we have been able to demonstrate is by doing that, particularly one of the things that we did in Dudley was investing in workers between Primary Care and the voluntary sector.

We have been able to reduce social isolation and, as a result of that, reduce utilisation of health services by as much as 30%. So, investing and understanding our relationship with the public is extremely important. That goes into deciding what it is we're trying to achieve. So, in Dudley we have done a huge amount of work, constant public and patient engagement around what outcomes are we trying to achieve and getting them involved in defining the outcomes for the system.

Thirdly, the issue then is about not just staff and the public but how we enable them to work more effectively together. We've looked at three main themes in this in Dudley. The first theme is around access to services. People want effective access and timely access. A couple of years ago we did a review of access to long term conditions and we found one patient who attended our local hospital more than once every single week. It cost them in time nearly three weeks of their waking hours in the year going backwards and forwards travelling to the hospital and probably over 300 pounds in parking charges.

It may not have been a funding issue for the health service, but it was a funding issue for the person. So, when we're thinking about how we provide services, we're thinking about how do we maximise the potential for the public to engage with us and therefore looking at more online services, consultations over the phone, more services in community rather than hospital. But the biggest agenda in terms of that is the one third of our population who are living with at least one long term condition.

We in Dudley have long term assessment conditions where an individual can have all conditions assessed in one go and have a health check covering everything. More importantly, as part of that, they get to record and talk to their commission about what their objectives for the year are. We found the most empowering part of the work we do has been the opportunity that the individuals have to state what their objectives are. They feel more engaged and more empowered and more earn subsidised to manage their condition because there is a two-way dialogue about their condition. Thirdly, one of the things we developed in Dudley, which is common to many MCPs is multi-disciplinary team working. Creating teams without walls, where all frontline staff with work effectively together to collaborate with each other. Particularly for those patients with the most complex conditions.

By organising that around the patient and by organising our staff so they can work together, our staff are more empowered and earn subsidised. And our patients feel they are properly supported. As a consequence of that, their utilisation of healthcare has gone down. In summary, everything that we're trying to do in developing the MCP is all about the culture of the organisation. It all about maximising that potential of the public of our staff and of them working together. Really it is all about an empowerment culture. As Sam was saying earlier, it is about building that from the bottom up, rather than the top down. If we can achieve that we have a chance of having a sustainable health and social care system.

Louise:

You heard about people who are working actually in the service. What we wanted to leave you with are some reflections of someone who has been and still is receiving care within the service, and that's Ian.

Ian:

My name is Ian, I'm a patient. I started my patient journey at Hospital where after multiple tests I was diagnosed with thyroid cancer. That was in 2014. I couldn't be treated locally, because the cancer was at stage 4. I was referred to hospital B.

In late November, I had a six-hour operation to remove my thyroid and a bunch of lymph nodes. I was referred on to hospital C, C for the Christie, luckily for me. I had six weeks of daily radiotherapy in January/February 2015.I then had radioactive iodine therapy in May where they give you a couple of tablets of the stuff that fell out of the sky in Chernobyl.

After that I have some cancer on my lungs. They are what the expert call stable. I'm monitored every six months.

I stressed the hospital A, B, C bit particularly. Because in NHS jargon you call that fragmented services. In my life, I have been through a full set of the most stressful situations. I have been through relocation, bereavement, divorce, redundancy, even the cancer itself.

Fragmented services beat the lot. It is, without doubt, the worst period of my life. I was told I had advanced cancer, I was sent away with the book and I read the book and realised I had stage 4. When you flick the page, there isn't a stage 5. That's dead.

So that's quite stressful. But between hospitals A and B, for the next 14 days I just ceased to exist. I was lost in transit. I left A, I hadn't arrived at B, if you are a patient, you don't exist. You can't get in touch with them. No one answered phones, no one returned calls, answer phone messages ignored, no one could tell me what happened next or even what next might be or when it might be. I was convinced in my own mind this was because I had gone too far and no one wanted to break the news to me.

My stress levels were through the roof. The system wasn't there for me. It was unnecessary, it didn't need to happen; it took a bit of thought, a bit of planning, someone giving me a card with a contact name on, a MacMillan number. So, if you hear "fractured services", get behind the jargon and look from the eyes of a patient. Look for the cracks that people are going to fall through. There are going to be cracks.

I love that quote from the NHS Five Year Forward View, think like a patient, act like a taxpayer. That sums it up beautifully. I wouldn't want you to think I'm kicking the NHS. I'm here because I love it. Most of my treatment was brilliant. It probably saved my life. But I love it because I believe in free public healthcare to the highest standard. If I can help with that, I will.

As I started to get better I realised I wanted to put something back in. I wasn't sure how or what I would do that until I heard a talk from a lady from the Manchester user involvement team.

In my professional career, I have been a finance director I'm an accountant too -- too many accountants on the panel and a chief executive.

Since 2002 I have worked for not for profit organisations. An environmental charity, a couple of health-related organisations, a couple of social housing providers, etcetera. As a result of that I have seen a lot of different structures of governance. In the not for profit world there tends to be separation between those who do things and those two decide things, who are trustees or governor. In structures that were described there seemed to be opportunities for me to use my experiences. All credit to Manchester for the way it embraced coproduction.

Since I got involved I have done loads of things. One that suits my background the best is a vanguard project looking at better and more innovative ways for counsel services. It is a massive project. You can track a golden thread on it. This makes it sound like the speakers have had conversations and have talked about the themes they want to bring out. But we haven't. We haven't met each other before today. But the golden thread that I've picked up is the Five Year Forward View identifies these three gaps you heard about, of which funding is one. It talks about the cost of cancer support provision treatment increasing by 9% a year and the incidence of cancer by 2%. Plainly that's unsustainable.

The national cancer strategy sets out six strategic priorities in response, of which the sixth is the transformation of commissioning, provision and accountability. The national cancer vanguard is the main delivery vehicle for this and it talks about changing the architecture, strength NHS England the streamline commissioning, then the programme scope of the Greater Manchester council vanguard takes this further and puts detail on that concept. If there's all that strategy and support, why do you need a patient on a commissioning project steering group?

Well the first point I would make is you can only think like a patient if you know what a patient thinks. A big part of my job is to feed in those thoughts and opinions. I don't operate alone. There's a big network supporting me with a user involvement team and a huge group of people affected by cancer. Secondly it is about challenge and the challenge is likely to be in the following areas.

Is it true to the golden thread, is it innovative and sustainable? Is accountable? Accountable is a great word for patients, lack of accountability is one of the things that allows this fragmentation to occur. Accountability is the thing that avoids protectionism, people wanting to protect their own patch at the expense of patients. The third and last thing, is does the payment system incentivise the right behaviours, for the patient, speed of diagnosis and treatments, the outcomes, cancer survivable and the quality.

That is also been mentioned in Greater Manchester, is the treatment going to be the same if you live in the most deprived post code as it is if you live in an affluent rural area. If we can have a system that meets those challenges then it is a privilege to have been involved. It has been a privilege to speak today, thank you for listening.

Louise:

Thank you Ian. What we hope we have given you today is example, sound bites of the work of the New Care Models programme. But within the last two and a half years and to continue over the next 6 months as well. What we are doing are creating fundamental models of care which are much, much broader than the sound bites that you have heard today.

So, our ambition and what we will be looking to achieve by the end of the third year is to have across the country, 50 sites who are at the point of not exactly what we are not calling it maturity, because they won't be.

They will be at the start of the journey of maturity, into developing the model of care that we have been talking about. So, the multi-specialty community provider for instance, the enhanced health in care homes, the primary and acute care systems. We will have examples of how to operate that system in sites across this country.

In addition to that, we have and we have developed with the support of the vanguards, frameworks, support tools, job descriptions, patient group directions. A significant amount of information for the NHS to use and to utilise for their own purposes so that that can help you on your journey, what we have done this over the last two and a half years is absolutely recognise, a degree of honesty about this, where things haven't worked. So, we have celebrated the fact that some of the things haven't been right. Where they haven't been right we have documented it, and said why it hasn't been right. Then what has happened as a consequence of that.

So, there is then a significant amount of iterations which have been documented to demonstrate this didn't work and this is what we did about it. This didn't work again, so this is what we have done about it. What we tried to do within that is show the learning process as well, so other people don't need to go through that in the same way. You have got some starting points.

What we also recognise is that your starting point will be different and you will want to adapt these tools, mechanisms, frameworks for your own purposes and also fundamental to all of this and a lesson I have picked up from all of the speakers is, this is about localism. That the engagement locally with the staff on the ground and with the patients is fundamental to this and the shared vision and leadership. No matter how much information you can access on this website, that doesn't matter. You can pull that down and it will be useful to you. But it will only be useful to you if you have got the engagement and you have got the leadership locally that you can use and adapt it.

So that is my key message to you. I would really encourage you to access the website; speak to the team at the team are available, the vanguards are available. Part of their commitment is that they will talk to the rest of the NHS about their experiences, so absolutely use that and access it.The access it in the context of what your local and shared vision is because only in that way, will it be useful.

So, I am going to stop there, I think we have got opportunity for questions If you have got questions, we have probably got about 10 minutes, got a number of questions.

Question: Jeannette, Chairman of a charity that tries to keep people involved in the community and stop them becoming isolated. We are multifaceted, have Community Transport, we are a UK on-line centre and we run social groups for people with dementia or people who are just lonely.

My plea to the National Health Service is that it is not so much your money that we want; I mean a little bit to run administrator would be wonderful. But what we need is someone who is making the referrals to us. For instance, 18 months ago we were asked by the local authority who were using the CCG money to set up a group for people who have had life limiting diagnose sis. There were 6 charities in our area, commissioned, given £7,000 to run that scheme. Not one of those groups in 18 months has had one referral. So, the money is coming through; there is no referrals, we could within 6 months set up groups self-funding and wouldn't need further funds if we had those referrals. So that is what I would plea to your various CCG's, please use the third sector that is out there; they know about us when we have worked with them it has been successful but I understand that they are very rushed and I don't blame them but I just wish we could have this little change so that the wellbeing side of health and wellbeing was more addressed.

Louise:

That is a good point, I think two members of the Panel who wanted to respond to that, Sam then Paul?

Sam:

This might help you put pressure on the CCG, as chair, I put a pound per patient, that is a quarter of a million pounds into ensuring that social prescribing is available in every practice. That means that the doctor has a referral form which they can fill in seconds. They can tick a box about what the concern of the patient is, it might be around finance, lonely, stress, might be repeat attenders, goes social prescribing team, spend an hour with a patient over a cup of coffee, access 1500 organisations in Tower Hamlets that systematises, that automatically gets the referral to the voluntary sector that has something on offer. It means you don't have to market your wares, I don't have to remember 1500 voluntary sector organisations, it is a pound per patient, speak to your CCG.

Louise: Let Paul come in, then Jeannette we will ask you to respond.

Paul:

It pays for itself, in Dudley we have done something similar. We as a CCG have invested in just 5 people who are linked to our local CBS. The GP's can refer any of their patients to those people. They will assess them and then link them up to the voluntary sector, as I gave that statistic earlier, we can evidence that the investment saves money. By having the link workers into the voluntary sector, we have reduced peoples use by primary care by as much as 30%. We can give you the evidence that you can take to your CCG to prove that it, that they can save money by investing in the voluntary sector in that way.

Jeannette:

In about 6 years one of the first organisations that did run a social prescriptions scheme with one of our local health centres. Only one of the doctors out of the 8 there used it. But we sort of got it down to the point where in order to reduce doctor time and input, we gave some small cards which just said, please show this to the receptionist, they wrote the permission in a book they can contact them with names and telephone numbers. Then we did the interviewing, we had a comprehensive list of everything that was going on in the area and the town, referred people both to our own activities if they needed the transport or to anything else be it an art class or social group. It worked very well. We had excellent qualitative monitoring. Never found time to do anything at the surgery.

Louise:
Thank you I wanted to ensure that we had opportunity to speaking to others, thank you for sharing that experience Jeannette.

Martin:
It is all very well for Sir Sam to sit there and break the rules, I don't think many of his colleagues are keen on doing that, which rules they ought to be breaking and what they do when wrath descends?

Louise:
I think that is a fair challenge, I am sure Sir Sam will respond to that, he might need a few minutes to think about it first.

Anyone else? I will start because I think that is, when we talk about breaking the rules, it is very much about challenging the status quo. What we talked about here was a consistent vision, a consistent leadership, what we have found in the two and a half years that people who have been inspired by the vision, inspired to do things differently, so within that it is people who would not normally put themselves forward to do leadership activities or to challenge.

So, with increased challenge around what the rules say, what we have found that the rules are flexed. So that is what I would say in terms of actually what we have seen over the last 2 years it is people more prepared to challenge and therefore the rules are not necessarily as fixed and finite adds you would expect. So, with that I will move over to Jason sorry?

Jason:

We broke the rules in Sutton, we talked together, set up groups etc... It is actually just blossomed and we have actually made difference from breaking the rules and those breaking those rules initially, we have actually leaps and bounds and now breaking the rules everywhere. It is people hide behind things like ID etc., when we have broken them down, there is common ground. We have to put the patient at the centre and -- we managed to do in a lot of our things, stop hiding behind things, it is the patient that needs to be centre and we say we can't do things but we have managed to do it. We have got social care, set up a committee, the ambulance and community services are working with the social care etc. and things that we had never done before.

So, I am going on a morning visits to nursing homes etc. to put an ambulance so working together. We need to stop hiding behind rules and that is what we do. We need to put the patient and that is what it is down to.

Louise: Thank you, Sam ready to respond?

Sam:

Thank you for that challenge Martin, if you come to Bromley, the reception is open and you can hear the conversations, people can go behind the desk and use the photocopier and get a cup of coffee, you probably guess that is against the rules of confidentiality, but what you get in terms of human interaction and conversations and relationships far outweighs that.

The second example is the focus on choose and book.

We are breaking the rules on that because we think it doesn't work. One example of that. We think it should be choose and consult.

Let me give you one example of what we have developed. If you have a kidney problem, come to my surgery, I can send an e-note to the consultant renal physician; they can look at it remotely in my notes with all the blood test results and typically get back to me within 2 weeks with no need for the patient to go to the hospital. That is breaking the rules. Now I can give you a 101 examples but lots of them and trust me, if you are not breaking the rules. Don't forget breaking the rules in the interest of the patient; that is the test you always have apply and I will leave you with a final thought on it is that also means don't ever ask permission for anything, seek forgiveness afterwards!

Louise: Another question from this lady here.

Question: The question I'm going to ask is in terms of my patient and public involvement. I'm from Leicester. One of the key things that really concerns me is actually the lack of listening to the patient voice. I'm talking about examples in secondary care where a patient is discharged into the community and there's no joined-up work. Primary care are not speaking to secondary care and the services are non-existent in some cases and the patient often has to go into A&E and the whole process starts again. How do we make that work? What examples of good practice do you have to make that better and work?

Louise: I look to the panel.

Paul:

It is about building the services between clinicians and services. One of the things we have been doing in Dudley is trying to connect up teams and staff who should be working more effectively together. We have a common interest in working with patients on the same issue.

For example, bringing a clinician to work with the GP or bringing the psychiatrist to work alongside the GP and do joint planning for patients with severe, enduring a mental illness. What we're doing with the culture we're trying to create is to bring clinicians together so they can, first of all, work more effectively together and on the back of that work more effectively with the patient.

Question: The voice of the carer is ignored. As a patient or carer, you know how that patient is feeling and that is often ignored. There needs to be a change in culture. I don't know how that can materialise.

Louise:
One of the things we're doing as part of the programme, and it was set up at the very start, we talked about one of the key principles, which is patient involvement, so all the sites have to demonstrate how they are involving patients in that. Again, it is something that we can share across. There's a lot of information about how each of the sites has involved patients as part of the development of their care model. But not only that, as part of the evaluation that has been running for the last 2.5 years there's a patient evaluation stream. That looks as how the patient has been involved, but then the difference it has made to the patient as well. So, if you are interested, and we can talk to you and share with you the mechanisms and the tools used to track that, but also how that patient we are involving patients as well. Was there anything you want to respond to quickly?

Sam:
Addressing your issue of connecting primary and secondary care. In our healthcare system now wick go straight through to a consultant on their mobile phone. We're hoping to make that reciprocal, the other way around. Any of my patients with complex decease, terminal care, they get my mobile phone number and my email address. Doctors now, in all our surgeries across the east end of London can look at the system and results.

If you came today and had a CT scan requested by a hospital doctor, normally three weeks if you have a follow up. Actually, I can give you the result then and there. Final I'd say that’s great, the connection between primary and secondary care, but the next stage is a three-way partnership with patients. So, it should be the normal.

So, you get an outpatient letter, but one of our consultants now is writing the letter not back to the GP but to the patient and copying it to the GP. It will become normal that when a referral is done by a doctor, a GP, actually it will be copied in to you as a patient and into the hospital doctor.

Louise: We have been given license for one more. Can we speak at the end, is that okay? We'll just take this gentleman here. Is this a quick one? A short one? Okay, we'll make sure we can come to you as well.

Question: I'm a doctor from Somerset. It is a question for Ian on a topic. He mentioned the user involvement team, was there anything they have done to help him get involved in this and perhaps be here today?

Ian:
Yeah, one of the projects in Manchester on the Manchester Council Vanguard Projects is about this information and sharing and transparency. It is only in its infancy, that one. But the concept is that it could be something like a trip adviser for patients, so you get to put comments on line and these are publicly available. So, if you are going somewhere, if you have a problem, then you can check out what people say. It's a fabulous concept. I think patients are very, very much in favour of that one. You know, it puts a different kind of pressure on the system to perform.

Question: A fantastic presentation. Just that 47 years ago I trained in the NHS and still practice three days a week within children's services. 15 years ago, went into long term condition management, and have lived in Dudley and nationally, so everything is close to my heart.

The thing in your programme was about workforce. What we haven't mentioned at all is the fact that, actually, everybody is moving into the local authority, local district budget within the communities at the moment. And within west Yorkshire where I am, our contract has been taken over by the local council. The cuts and the culture and the workforce and misunderstanding around what the workforce are deriving is having a direct impact on the public. It is not just patients. We talk about NHS and patients, we haven't talked about the local authority. I know Manchester is devolved and it's a big joined up thing. But I can tell you from a frontline worker's perspective, we have a critical issue about the capacity, the understanding about what that relationship because, Sam, you talked about it is patient and public. You talked about patient and public. It is our front-line workers and they are on their knees because one of the issues is they're moving into the local authorities and the local authority culture is completely different. I know this is an expo NHS, but place make a comment on that.

Louise:

Do you want me to start with that or would you like to go there? I'll start there. In terms of the work that we've done, the majority of the sites are integrated in terms of working with the local authorities, and Dudley is an example of that, actually. So, where there's a shared vision and this is why we come back to the point around some of the sites, it has taken them 18 months to two years to get to a place where they have a common understanding of what they want to deliver. In essence, it went from complete conflict to resolution. So, it was the conflict curve. It has got to a point where they are able to understand each other and collaborate. We have seen it working well. I recognise your point across some others of the country, but I can give you some hope in terms of in places where I have witnessed a collaborative working culture we have seen what the care provision needs to look like.

Paul:

It is a challenge. It is different from the culture of the voluntary sector, yet all of these have to work together if we are going to make this effective. That's why I think the OD agenda with staff is so critical. For us in Dudley it is noting the agenda across all the agencies and it is a partnership agenda across all the agencies and it is not easy, but you have to keep working at it and you have to build trust. That's the only way you can work through it.

Louise:

Thank you very much, everyone, for bearing with us in terms of time. Can you show your appreciation for the panel who have been with us today and for their honesty? Thank you very much.

Jenny:

Thank you to Louise for chairing the session. I wanted to let you all know you should stick around because you can watch Simon Steven's keynote speech from here. You can spread out, fight the crowds at the other stage. You can watch it here. You're more than welcome.