A partnership between NHS England (London region), NHS Trust Development Authority, London Clinical Commissioning Council, London Councils, and Monitor

London Health and Care Leaders Forum

First meeting 14 October 2013: Questions and Answers on system barriers

Q1: How can we encourage Foundation Trusts to release resources so we can start investing properly in community and primary care rather than having all the money locked up in those great institutions called hospitals?

Andrea Sucliffe:
Firstly, actually its not just all about money, it is about the way people work together and I think that's the key thing around the key five areas that we identified in the research that Social Care for Excellence published last year. When you look at some of the things that Mark was saying about the focus on the transactional needing to move to the focus on the transformational, again I think that gives us some insight into how we could potentially release resources - not fighting over who is paying for what but actually collaboratively working together to say if we truly want to be person centred and coordinated, what is the best way for us to bring that together?

It is a collective responsibility across commissioners as well as providers and working not just in our silos of health and social care but across the whole system so we need to be focussing on that perspective and trying to galvanise all of us to achieve the vision that I know that you share.

Mark Britnell:

1. I was a Chief Executive of a Foundation Trust 10 years ago, and in our perspective, we wanted to create a number of joint venture companies with Birmingham City Council and Birmingham Primary Care Trust and we wanted to create joint ventures for both healthcare and social care and many of the outpatient services. We were stopped by the PCT and SHA on the basis that we'd become too powerful not that we'd actually mapped out the care pathways that suited the needs of the people in Birmingham.

2. What I'll be saying tomorrow to the Foundation Trust network is that as an early demonstration of faith in a system which is of course as they would see it becoming very hot at the front and back door i.e. discharges and admissions - but their £3-4 billion worth of cumulative/accumulated surpluses need to now be invested for population health. I believe that some of them are already willing to do that and I believe it's a down payment of good faith before its taken away from them if they don't show leadership responsibility in the community.

3. I genuinely think that will happen and I hope that we aren't too far away from it - is that just to tell you one story from Japan which as you know is the oldest population on the planet. They've been looking at this issue for a long time, their economy has flat-lined over 20 years and they have the oldest people in the world. I recently went to do some work with a Japanese security company that started with home alarm devices, and now what they do is own health systems.
   Going back to one of the things about hospitals without boundaries or fortifica tions, I think at some stage Foundation Trusts need to be thinking about their responsibilities to residential and age care in a profoundly different way. I would hope that's not a bigger fortification or circle of wagons but it would involve other people taking responsibility as well.

Tim Kelsey:

1. There is a funding flow issue and if commissioners and providers can't resolve this in a way that somebody recently described as productive tension, the setting outcomes for patients that will force the development of pathway based treatments than the system clearly is never going to work so its as much as a responsibility for commissioners as well as providers. **[Nigel:** Valid point but have we not got a fundamental problem that CCGs can't commission primary care? I think you're right but how do they do that?] **Tim:** When I say we, I mean NHS England - the way the system is currently loaded (not that anyone probably wants it that way) is that we probably hold in our hands because of our direct commissioning of primary and specialised services, the conversation that will set the tone for the rest of the system. So if we can't get that conversation right particularly in specialised services (and these aren't that specialised, its £28 billion of public expenditure) and if we can't have productive but occasionally some what tense conversations with some providers that deliver outcomes for patients which are in patients' interests in which we are clearly advocating for patients, the system will I'm sure carry on as it has done before but I think there is a specific emphasis on the commissioning of specialised services and NHS England's own tactics as a national commissioner.

2. Also, unlikely to happen unless we activate people so we need to create pressure from the demands side as well so if Sam's kids (referring to the video/presentation) realised that that was possible, how can we give them a means by how they can actively campaign that Sam gets that kind of treatment? So, putting pressure through various Health and Wellbeing Boards, through contacts of local commissioners, through the accountability of the commissioning system as a whole is really important and my biggest worries right now is that we don't have a system that's accountable enough to ordinary people to make those cases. So certainly there's a collective issue which again needs to be something that people think about locally where we actively go out and promote awareness amongst local communities of what good likes like so they can literally start campaigning for it.

3. Competition. If we don't get the funding flows right and eventually don't stand up as a commission and do the right thing for patients and we don't activate the patient voice adequately enough - the third thing that is going to get us is the fact that we are still disarrayed over what we think of competition. Integration depends on us taking a benevolent view of how systems can get

together not necessarily always having to go through a procurement process. There's a tension I think between Integration and Competition. As a community, we all need to start quickly resolving. [**Nigel:** Any thoughts on how?] **Tim:** I think we and society sometime ago decided that we were going to have a monopoly of universal healthcare and we probably just have to accept that that isn't necessarily completely compliant with European legislation.

Q2: Tim, if you are going to use NHS numbers, please can we remind patients what they are - and let everybody on a mass campaign have their NHS number or a card and use it to enable them to access the services in an appropriate way?

Tim Kelsey:
I met a 90 year old lady the other day who really remembers her NI number because it was the same number that was used during the war for rationing. There is a whole generation of people who are very familiar with these somewhat complex 6 or 7 digit numbers. So when people say we can't put out NHS numbers as the elderly won't like it, the elderly are very literate indeed. The other number which isn't quite so accurate which we use as an identifier, so we actually do have some very big plans to not only create public awareness of the NHS number but over the next few months as we head up to people this offer that they can access their GP records and so on from March 2015. But more broadly than that we're also very concerned to make sure the public are fully aware of their rights not to do that if they don't want to so there is an engagement exercise which we are about to start.

Mark Britnell:
We are not particularly good at is that if you say so that 30 years ago I believe it to be true but actually really focusing on homes being the organising principle of healthcare for the 21st century and also supporting carers. If you think about the numbers - 1.4 million people work in the NHS, 1.6million people work in social care, we have 3 million volunteers and 6 million carers and as I know from my own personal experience from my mother who is in and out of hospital with a stroke, my step-fathers just gone off his legs because he's simply exhausted from looking after my mother. I have seen the cost and the chaos that's caused through not looking after carers as well so they would be my 3 priorities over the next 5-7 years. And what's behind that is we should integrate but we shouldn't spend a lot of time arguing about integration, which is not I think a strategic priority and therefore I think some hospitals have to sort themselves out and basically commissioning for primary care should be done at the local possible level subject to a plan being agreed of course with NHS England and Tim Kelsey.

Andrea Sutcliffe:
1. We need to be concentrating as a leadership community on the horizontal - I think that we to be honest we reflect society's obsession with hospitals and I do have to say that David being at the Care Quality Commission (CQC) played an absolute blinder at the point that the Chief Inspector of Hospitals

was announced and saying actually if we are going to do that, we are going to have one for Adult Social Care and one for Primary Care as well. Obviously, I am very very grateful now because I got the job but I do think that that approach saying that yes hospitals are important but these other things are really important too. They are going to be sat their at the Board and bringing that perspective to the work that we do at the CQC - that's what needs to be replicated elsewhere in the system.

2. About GPs and CCGs having the ability and the power to do some of this, to be honest, very many don't necessarily have all the information at their disposal and the understanding of what is possible. So I think actually, there is A Call to Action if you like to colleagues in the social care and local authority world to actually share that information, to be proactive and actually suggesting what the solutions are and for national organisations like SCIE, to make that information available so that CCGs and GPs can be confident about what's possible as well.

Q3: Foundation Trusts and Health and Wellbeing Boards

I do feel slightly invisible a lot of the time these days because my Trust provides community facing integrated services across a health, social care and mental health spectrum so we provide everything from palliative care, dentistry, mental health, immunisation, health visiting and so on and so forth.

We employ 4000 staff, the public invests £460 million every year in the work we do yet the CQC has no inspector of community health services. I'm told that the CQC Inspector of Hospitals was shocked to find that he was also inspecting mental health and community facing health services so he will get a deputy to help him do that.

Apart from the obvious huge chip on my shoulder, but it's a more important point which is where of course we spend our lives working with GPs, local authorities, the third sector and we have worked for years on delivering home facing care, we have developed care coordination and I am not saying we are perfect or we have all the answers not at all but we are a Foundation Trust, we are not a hospital and we do have 1000 inpatient beds of one flavour or another across a wide geography but I suppose it's a plea to remember that these are important services and our commitment to partnership working built up over years probably founded on mistakes as well as what we've done well means we have an expertise and a valuable contribution to make that simply time and time again gets no mention and seems to not exist so I want to say that.

I also want to say Andrea if I might, what a very refreshing message from the CQC in terms of working in collaboration. I have two last points and it's a question. Mark, I really liked your point about transformation and not transaction but with one year contracts, its ridiculous, its a nonsense that we'll invest our surpluses as FTs when we know we're investing in something over 3-7 years because we know we can really shape transformation and innovation so I agree.

Lastly, Health and Wellbeing Boards, we sit on many. Some are great and really doing this joint job but all too many absolutely aren't and I think we ought to stop talking about them as the transformation vehicle. I really got that off my chest - thank you!

Q4: Public Health and Prevention

I just love this debate. I think its exciting, it's interesting and absolutely to see health and social care going towards integration is brilliant. But, I feel I am looking at two-legged stool. So if we don't get beyond this debate and include Public Health and Prevention, we are going to miss the point. So, if we are talking about transformation - what about getting to patients when they are still people and not patients - you know if we are going to solve diabetes, isn't it something to do with the obesity epidemic in our children?

And, if we can prevent three cases of HIV, we prevent 1 million in annual lifetime expenditure to the NHS and it's not coming across in the presentations. And I know why - because we are still chasing the expenditure and the huge problem on that and not the underlying problems so I guess for me it's where is the third leg of the stool please?

Finally for Tim, I would love to get my hands on GP data. Unfortunately, every DPH (we all signal each other around the room); we are cut off from it. We cannot do the work we did last year. We've been divorced from access from looking at the data. Our role is to advise the CQC on commissioning of acute health services. Our role is to look at the lifetime of our population, advise our local authorities where to put their money and work across councils and we are absolutely being stopped from doing it.

Q5: Cross party policitical agreement

Question is around how do we get cross party political agreement to some of the changes that need to be made because we've already all talked about transformation and everyone working together particularly across London - how do we get the politicians behind us in order to make some of the significant changes that need to happen?

So, on a small scale in Bexley, we are looking at outcome based commissioning but actually we're not really supportive of the systems we've got in place so how do we look at things like PBR and do things differently to allow us to make that transformational change?

Q6: Paying attention to both our staff and the confidence of the public we serve

I want to just pick up a slightly different theme about leadership and as a leadership community. In the presentations, Mark made really quite an inspirational point about the quality of the NHS internationally on effectiveness, efficiency etc. but a lot of the other language has been quite negative.

Of course, we need to set out the challenges that face us as a system but we have two huge groups that we need to worry about in terms if you like in the presentation of the what the NHS does. One is our 1.3 million staff - they need to feel motivated and valued as well as criticised and pointed at. And of course the public themselves need to have confidence in the service that they are receiving nationally.

Sometimes, I think we talk too much and are too critical without balancing that with some of the excellent and more good things that happen. Andrea did mention in

passing some of the brilliant things that are done. But I think we should talk in the language which is building on the strengths that we have and we shouldn't forget the important lessons around how easy it is to destroy a brand with one simple remark. The NHS is a hugely important brand in which people have confidence and we are custodians of that. So sometimes in our leadership discussions, I think we need to pay careful attention to that both for the motivation of our staff and the confidence of the public we serve.

Response to Q3-6

Andrea Sutcliffe:

1. One of the things that Mike Richards is very clear about is that we do need to be working with people like yourselves to make sure that we are doing that properly.

2. The second thing about prevention. Actually Adult Social Care is part of prevention as well and that's definitely in my mind in terms of the role that adult social care can have in supporting people to live independently in the communities and working with the private and voluntary sector around that. The example in Sam's story about working with our local befriending scheme to support an elderly gentleman who is lonely. We know the evidence tells us very clearly that loneliness and isolation is a problem in elderly people and it can lead to depression and it obviously leads to people needing the support of the health services. Actually, if we are proactively thinking about things like that then we can be building prevention into what we are doing from an adult social care perspective as well as from a public health perspective.

3. Finally, in terms of the leadership point about motivating and valuing our staff and building confidence in services, I think if you worry about that from a health service perspective just try and be a carer at the sharp end in some domiciliary services for example rushing from pillar to post and getting your services criticised at every opportunity. So, it's not just from a heath service perspective, it's across the health and care system. I completely agree with you that there is great stuff going on and I did mention it in the presentation that I made and we do need to be positive about that.

   But again it is I think as I said in response to Michelle's point, we are a reflecting society here and I had a conversation last week with the chief executive of the Carers' Trust, who had a fantastic story actually. Something had happened and she was really supportive about it. Something that she and her organisation had been working on about support for young carers and getting an amendment in to the children and families bill. They had been successful in that, the government had accepted it, everybody was being very positive about it - it was a good news story. She spent half an hour on the phone to various journalists trying to sell that story in - they didn't want to know. So, we are battling here I think we do have good news stories to tell but it's the bad news stories that make the headlines and sell the newspapers. But actually at a local level, people can do an awful lot of that. When I was running the Appointments Commission, I used to say to non executive directors that journalists could be very lazy and actually they really like the press releases that gave them the stories. They might not reproduce them all of the time but they will definitely reproduce them some of the time. So you get your good news stories out.

Tim Kelsey:

1. Very tricky question on staff and public confidence. One of the things I am responsible for is communications and marketing for NHS England, it is a real issue. I won't go into details but I take a lot of heart for the fact that the mainstream media has no longer the influence it had even till three years ago. What matters much more than that is the conversation the whole community is having on social media where I can tell you people are very much more objective on their views of the health service and it's not all good news but there is an awful lot of awareness of the pressures we are under. I think if we just can be just more transparent of our challenges as the Call for Action asks us to be then I think we will find a public which is very supportive of wanting us to make difficult decisions collaboratively with them.

2. My next point about investing over the longer term, it is quite obvious that if we don't break frankly the political cycle of 3-5 year planning in the health service, we won't be able to make this journey from transaction to transformation that Mark highlighted. We can use different words for that but in essence what that means is, people who are planning for local health and care services are able to have the air cover to have difficult conversations and not worry about the political cycle and that's fundamentally what The Call to Action is about. And if NHS England achieve one single thing, is to provide that air cover for the conversations you all need to have about planning beyond the political cycle that all being a serious success because so far the NHS hasn't been able to have those conversations so we recognise that is part of our role and hope we can achieve it for you.

Mark Britnell:

1. First of all, having been an Executive Director of Central Middlesex hospital, I remember the great work that your fore fathers and sisters did in North West London. To answer your question, which part of flat real terms growth don't people get for the next five years - therefore you have to I think reduce the transaction costs of basically better defining the problem which is basically characterised the way that most parties have negotiated over the last 21 years. Other countries are now taking a more enlightened approach over 3-5 years. I believe it is possible with sufficient will in the NHS. It will require the agreement of Her Majesty's Treasury. However, that takes me on to the second point - in terms of what can we do for politicians. I genuinely believe in the run up to the election, the people that will save the NHS will be people sitting in this room and the people working for it, not the politicians. And I think the analogy or metaphor I would like to use is that in the next year or 16-18 months, you will have to understand as you always do how you float political ships but actually this piece of work now that NHS England has started is about building service submarines over a 5 year period. Given that we all know what sort of knock about is coming, I actually believe of course keep your eye on the ship, it can get you sacked but I think building this service submarine over a 5 year period, I would say is one of the most important gifts NHS England can give to an incoming administration after the summer of 2015. And, it's at that point then I think that people will really understand what they have to do. I would be having those conversations as an independent Board with all political parties as soon as possible because you can make sure of two things - nobody will want to talk about it before the election and everyone will want to talk about it after the election. [**Nigel:** I do think that sometimes, the politicians need to believe that actually the problem is the

arguments that we are using are just not that good. And we somehow expect the politicians to be brave in a way that we don't expect anyone else to be on the basis of arguments which don't appear to them to very convincing.] **Mark:** I think that's certainly the case and I would hope that as we move into the second part of the Call to Action - I thought that the Call to Action is a very worthy description of the problems that we face and this is the issue that we are in danger of better defining the problem, not being more expansive or imaginative about the solution so I think as far as answering your question, that's where I would concentrate in terms of the next five years.

2. The last point I would like to respond to and I think Tim's made the point about public health and commissioning. When I go around the world, we talk about how staff are engaged or otherwise in the NHS and if you don't mind can we play a quick game, I call it primary research. When I go around the world and I say to organisations that employ thousands of people, whether its 7,000 in some cases, in the case of Apollo its 75,000-100,000 people and the question I ask is how many of your staff have had a meaningful appraisal where there has been training and support and material consequences as a result of that appraisal? Please be honest. All those in the room that believe that 80% or more of their staff have had a meaningful appraisal where their training needs have been discussed, their performance has been agreed and then they have adopted new skills and techniques to improve care and also money - hands up? Ok lets say 50% (hands raised), ok lets say 20% (hands raised).

   I think a bit like when we wrote the NHS plan in 2000, within 2 years there will be a big discussion about a run on staff and their shortages. It will appear as it is now in social care; it will appear very strongly in primary care for reasons which you know about. I genuinely believe it is possible to get 15% more quality and efficiency by caring and supporting for our staff, directing them, empowering them and yes holding them to account in a fundamentally different way from the passive relationships that have existed for decades and decades because we are simply afraid to have conversations which result in consequences for performance. This will be in my opinion, one of the most central things that we need to address in the next seven years in the National Health Service. If we do it properly, I have seen it work in other parts of the world - we can give confidence to people, we respect their contribution and indeed I think make people more productive. Imagine a world where 1.3/1.6 million people were trained in the latest 6 sigma and lean techniques and their pay progression depended on acquiring that scale and the knowledge and skills framework and then applying it to improve quality and cost efficiency. Imagine the social movement for change that would exist in the NHS.

End