An NHS for patients: Making clinical commissioning work

Clinical commissioning and the patient
Clinical commissioning and risk
Clinical commissioning and integration

With Rt Hon Andrew Lansley CBE MP, Andrew Gwynne MP,
Dr Charles Alessi, Viggo Birch, John Chapman, Dr Zack Cooper,
Dr Sundiatu Dixon-Fyle, Mike Farrar CBE, Michael Izza, Simon Moody,
Dr Niti Pall, Sumita Shah, Matthew Swindells and Andy Ward

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No.2 Royal Mint Court
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Wednesday 26 October 2011
Reform is an independent, non-party think tank whose mission is to set out a better way to deliver public services and economic prosperity.

We believe that by reforming the public sector, increasing investment and extending choice, high quality services can be made available for everyone.

Our vision is of a Britain with 21st Century healthcare, high standards in schools, a modern and efficient transport system, safe streets, and a free, dynamic and competitive economy.
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## Programme

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| 09.20 – 10.10 | Clinical commissioning and the patient                                           | **The Government has set out a vision of a patient-centred health service, where the guiding principle is “no decision about me without me”. Clinical leadership will serve to build on the relationship between clinicians and patients, bringing commissioning closer to the public. In the new NHS clinicians will have a key role in coordinating care and delivering better disease management programmes. This session will explore how clinical commissioners will champion choice and patient-centred care.**  
Andrew Gwynne MP, Shadow Health Minister  
Dr Niti Pall, Chair, Pathfinder Healthcare Developments  
John Chapman, Partner, Bevan Brittan LLP  
Dr Sundiata Dixon-Fyle, Healthcare Expert, McKinsey & Company |
| 10.10 – 11.00 | Clinical commissioning and risk                                                   | Clinical commissioning aims to make healthcare more patient-centred, clinically led and localised. However there is tension between smaller consortia, that are more responsive and more able to deploy local knowledge, and larger federations that can minimise risk. Reducing risk also demands greater financial management. This session will explore how Clinical Commissioning Groups are being established and the potential for clinicians to deliver better commissioning.  
Mike Farrar CBE, Chief Executive, NHS Confederation  
Andy Ward, Managing Principal, GE Healthcare Performance Solutions  
Simon Moody, Consulting Actuary, Milliman  
Sumita Shah, Manager, Practice Risk and Public Sector Audit, ICAEW |
| 11.00 – 11.30 | Keynote speech                                                                   | **Rt Hon Andrew Lansley CBE MP will deliver a keynote speech on the progress of NHS reforms. It will be followed by Q&A from the audience, chaired by Nick Seddon, Deputy Director, Reform.** |
| 11.30 – 12.00 | Coffee                                                                           |                                                                                                                                                  |
| 12.00 – 12.50 | Clinical commissioning and integration                                           | Integrated care will be essential for improving the quality of care, particularly for long term conditions. Clinical Commissioning Groups and clinical senates will enable more integrated care pathways and greater cooperation between primary and secondary care. This session will explore the opportunities and challenges in improving integration in the health service.  
Dr Charles Alessi, Chair Elect, National Association of Primary Care, and Executive Member, Kingston Clinical Commissioning Group Pathfinder  
Viggo Birch, Vice President Europe, Novo Nordisk  
Matthew Swindells, Senior Vice President, Global Consulting, Cerner  
Dr Zack Cooper, ESRC Fellow, Centre for Economic Performance, LSE |
| 12.50 – 13.00 | Close                                                                            | Nick Seddon, Deputy Director, Reform                                                                                                                  |
|             |                                                                                  | Michael Izza, Chief Executive, ICAEW                                                                                                                  |
| 13.00       | Lunch                                                                            |                                                                                                                                                  |
When the talking is over, the action can begin. The Government’s reforms have faced an uphill struggle since June 2010 and the launch of the White Paper. With the consultation phase, the NHS Future Forum and now further amendments likely to be put forward by the House of Lords, the eventual reforms will look very different to the original proposals. However the core idea of clinically led local commissioning remains intact.

Whatever the merits of the proposals, the time for debating the principles of the reforms has passed; the challenge is now to make clinical commissioning work.

Implementing the Health and Social Care Bill could prove more demanding than getting the Bill through Parliament. For a start the deadlines are tight. In 18 months from now, on April 1 2013, SHAs and PCTs will be abolished and the NHS Commissioning Board will take on its full functions. A full system of Clinical Commissioning Groups will be established, with the Commissioning Board authorising groups to assume their responsibilities when they have met set conditions.

The good news is that real progress is being made. As of July 2011 257 Clinical Commissioning Groups have been formed covering 97 per cent of the population. Some entrepreneurial and innovative clinical commissioners and GP leaders have emerged. The Commissioning Board has been established in Shadow form, SHA and PCT clusters are being set up, local authority Wellbeing Boards and HealthWatch are coming together. However the pillars of the new system and nascent commissioners still have a long way to go.

NHS leaders and policy makers now need to focus on getting the most from the Government’s reforms. The Commissioning Board will need to allow more flexibility for commissioning groups to capture the potential of clinical leadership and local innovation. As well as retaining the best management and leadership skills, the NHS needs to improve commissioning and the financial skills of clinicians. Commissioners will need to be bold in fostering greater competition between providers and making healthcare responsive to patients. New entrants will be needed to develop working partnerships between primary, secondary and social care. All the time clinical commissioners will need to help deliver the £20 billion Nicholson challenge and maintain and improve the quality of care.

Clinical commissioners will face many hurdles but now is the time to learn from the best. There is valuable commissioning expertise in the system and outside that cannot be lost. Some pathfinder groups are already showing what clinical commissioning can achieve. This event will showcase, celebrate and help spread best practice at a time when the NHS needs a step change in the pace of change.

When the Health Bill is passed into law it will mark the “end of the beginning” for the NHS this Parliament. The challenge is clear: making clinical commissioning work and delivering value for money in ways that lead to better healthcare.
The conference

On 26 October 2011, Reform brought together 150 delegates, from policy, business and the NHS, to listen to and debate presentations on clinical commissioning.

The speakers were:

- Rt Hon Andrew Lansley CBE MP, Secretary of State for Health
- Andrew Gwyne MP, Shadow Health Minister
- Dr Charles Alessi, Chair Elect, National Association of Primary Care
- Viggo Birch, Vice President Europe, Novo Nordisk
- John Chapman, Partner, Bevan Brittan LLP
- Dr Zack Cooper, ESRC Fellow, Centre for Economic Performance, London School of Economics
- Dr Sundiatu Dixon-Fyle, Healthcare Expert, McKinsey & Company
- Mike Farrar CBE, Chief Executive, NHS Confederation
- Michael Izza, Chief Executive, ICAEW
- Simon Moody, Consulting Actuary, Health Practice, Milliman
- Dr Niti Pall, Chair, Pathfinder Healthcare Developments
- Sumita Shah, Manager, Practice Risk and Public Sector Audit, ICAEW
- Matthew Swindells, Senior Vice President, Cerner
- Andy Ward, Managing Principal, GE Healthcare Performance Solutions

This conference provided the chance to receive questions from a range of delegates. A booklet containing short think pieces was published with the summit. Presentations and questions and answers during the day were recorded. This report contains a copy of the agenda of the event, the booklet that accompanied it and the transcript of the discussions.

The conference, and particularly the Secretary of State’s speech, received extensive media coverage. Andrew Lansley’s announcement of 700 more inspections of care homes and hospitals by the Care Quality Commission, and the criteria for failing hospitals to receive additional Government support, were trailed in both the Financial Times and Today. His speech was also covered widely in the national press, including The Daily Telegraph, The Guardian, The Independent, The Daily Mail, The Sun and Channel 4 News.

Clinical commissioning and the patient

Speaking on the first panel, Andrew Gwynne MP, Shadow Health Minister, accepted that an organisation created in the 1940s is not necessarily suitable for 2011 and acknowledged the value of local, clinically led commissioning, but questioned the pace and scale of the Government’s reforms. With the financial pressures facing the NHS, the reorganisation of commissioning structures will make it harder for the service to meet higher patient expectations and risk undoing the progress that has been made in the past decade. With the Bill nearing its final stages the challenge has now passed from the policy makers to the “policy implementers” to make the reforms work in the interest of patients.

John Chapman from Bevan Brittan put clinical commissioning in a legal context, and highlighted three legal obligations facing Clinical Commissioning Groups: the need to involve public and patients in the planning of services, a duty to promote equality, and a pledge in the NHS Constitution for commissioners to provide the public with information about future changes. Dr Sundiatu Dixon-Fyle from McKinsey & Company argued that there is great potential to make the NHS patient-centred and discussed three opportunities for commissioners to put patients in the driving seat: empowering patients with information, commissioning patient-centred care and implementing effective behaviour-change programmes to strengthen prevention and chronic disease management. The final speaker on the first session, Dr Niti Pall, reflected on her experiences in developing patient centred care in Birmingham and working with other partners in the health economy to redesign end-of-life care.

Clinical commissioning and risk

Mike Farrar, the Chief Executive of the NHS Confederation, led the second panel session and described the different kinds of risks, or “four kinds of pain”, the NHS is facing. In particular he highlighted the risks of incentives in the system not being aligned with the need to control demand and the need to be honest with the public about the scale of financial challenge. He also stressed the need for Clinical Commissioning Groups to have the freedom to innovate and do things in different ways as well as an effective failure regime for the new commissioners.

Andy Ward from GE urged the NHS not to discount and lose the experience, talent and skills that exists in the system. Simon Moody from the actuarial firm Milliman welcomed making commissioners more financially accountable and discussed how to make risk pooling arrangements work to improve efficiency and outcomes for patients. Finally, Sumita Shaw from the ICAEW stressed the need to embed the skills and culture of financial management in the new commissioning groups, and in particular the need for better guidelines from the Department of Health.
In his keynote speech, Rt Hon Andrew Lansley CBE MP, Secretary of State for Health, set out proposals to “root out poor performance”. While he argued that at its best the NHS outperforms every health system in the world, he recognised that at times there is a “conspiracy of silence about poor performance” and a system has developed where “failure was rewarded”. For hospitals with problems with debt and PFI payments he announced additional support for recapitalisation, provided the hospitals are facing exceptional problems, improving productivity and delivering quality care to patients. In addition, he threatened to remove and replace management teams that fail to deliver. To address poor quality care, the Secretary of State, announced a further 700 Care Quality Commission inspections on hospitals and other providers. Patients also have a right to have information on the quality of NHS care, while commissioners and clinical leaders need to be empowered to deliver improvements in care.

Speaking on the final session of the day, Dr Charles Alessi, Chair Elect of the National Association of Primary Care, made the case for integrated care that would increase value for the patient, reduce duplication and waste, and improve the patient interface. He also described how he saw the reforms opening the way for population health, with local authorities and primary and secondary care providers managing the health needs of a population under a finite budget. Dr Zack Cooper from the London School of Economics, claimed that productive integration cannot be achieved without competition and financial incentives. Productive integration will be driven by patient needs, information on outcomes and rationalising services to deliver best quality.

Matthew Swindells from Cerner suggested that the only way the NHS will deliver £20 billion of productivity savings will be to change the relationship between organisations and consumers, how organisations are run and the use of information to transform practice. In particular he cited the need for co-production of healthcare with patients, using data to inform quality standards and redesigning and coordinating services through better use of technology and information. The last speaker on the panel, Viggo Birch from Novo Nordisk, discussed chronic conditions such as diabetes and the need for integrated care, which entails moving the focus away from acute providers to patient centred services. Key will be managing the parts of the system rather than changing the elements in the system.
By January 2012, Clinical Commissioning Groups need development plans in place. In many ways, it’s a blank sheet of paper. Clinical Commissioning Group management budgets will be tiny compared to PCTs – and we need to think way outside the box and do things radically differently.

In Healthworks Clinical Commissioning Group, we have used the last six months to learn by doing commissioning in end of life care. Healthworks covers two PCT clusters and two local authorities. We could have wasted hours in meetings, working out the theory on how we would collaborate. Instead, we have just got down to it and used end of life care – a key challenge across many Clinical Commissioning Groups – to engage. By its very nature, end of life care embraces most of our stakeholders – so this work has provided a unique opportunity to engage and think through how we will manage the business of commissioning differently.

Using a lean “task and finish” approach, we have developed a strategy through a series of co-design events where local people and front line clinicians came together in a safe space to determine how we want end of life care.

Supported by a dedicated commissioning programme manager who has driven the programme and liaised with our supportive PCT cluster to collate the necessary public health and commissioning data, we have quickly identified both the strengths and the weaknesses in the system. We have also tested out a genuinely patient centred approach that ticks all the involvement boxes – and we know we can replicate this model and apply it to other commissioning challenges.

To achieve early authorisation, we need to prove competence. The benefit of having delivered a piece of real life commissioning is that we are credible when we talk about the experience, and we have a compelling case study that foretells the future. As we want to continue working together in the cohesive cluster that we have become, this is vital. Our current boundaries might have worked against us. We were already gathering 360 degree feedback to help us to learn what works and audit the time it has taken to deliver the strategy, so the added bonus is that when authorisation mirrors this, we can already guess what people will say – and it’s a really great story.

Moving forward, and having learnt so much, it is hard to imagine how we could be where we are today without “learning by doing” commissioning. Build a real life commissioning programme into the development plans for 2012 and we will be absolutely sure that our Clinical Commissioning Group form fits its new function.

**Dr Niti Pall, Chair, Pathfinder Healthcare Developments**
The commissioning consortia will also have a duty to comply with, and indeed to promote, the NHS Constitution which reflects these rights and also commits the NHS to providing patients and the public with the information needed to influence and scrutinise the planning and delivery of NHS services.

A further element of challenge for commissioners is the duty to comply with the Equalities Act under which they have to take into account, in making decisions, the impact of their decisions and the way in which they provide or commission services on individuals with protected characteristics which include age, race, sex, religion or belief, or disability. This creates a significant tension between decisions which the clinicians may seek to promote on the basis of clinical evidence and the potential for challenge around failure to adequately involve or consult the public or to take account of the impact under the equalities legislation.

Clinical Commissioning Groups will need to ensure that they have effective engagement mechanisms with the public that enable them to manage these risks effectively so as to avoid the danger of legal stalemate arising where decisions cannot be taken because there is no adequate assessment or involvement of the impact on the public. Commissioning in the NHS may be clinically led but it is not being handed over entirely to the clinicians and they will need to ensure that they meet the legal requirements for commissioning a public service.

John Chapman, Partner, Bevan Brittan LLP

Ben Richardson and Dr Sundiatu Dixon-Fyle

Shifting the mindset

The promise of clinical commissioning is to align accountability for financing and quality in the GP as the navigator of the patient through the system. Patients are becoming increasingly mobilised in healthcare, as in other industries such as banking. Clinical commissioners can help transition patients from passive recipients to co-creators of their healthcare, through “patient-centred clinical commissioning”. And this goes beyond conventional patient and public engagement.

There are clear benefits in terms of improved quality, satisfaction, and cost. For example, patients can be incentivised to undergo screening or stop smoking in pregnancy. Patients with chronic conditions who are given their test results and helped with formulating questions before doctor visits adhere better to care plans. Informing patients about the risk/benefit of discretionary procedures reduces unnecessary spend. Helping patients navigate local services helps them utilise healthcare more judiciously. And allowing patients to give feedback to providers helps hold them to account.

We suggest three key elements of this approach.

Firstly, empower patients with better information and access to local services: new information portals go beyond service directories to provide quality information, allow patient feedback, and enable patient-provider and patient-peer interactions using email and social media.

Secondly, support providers to transform the way they engage patients. Examples include care plans, establishing mechanisms to track adherence, programmes to educate patients and their carers and give them more control through shared decision-making.

Thirdly, develop effective behaviour change programmes to help patients better manage their chronic conditions. Typically this includes several steps. Segmenting patients and mapping patient journeys to pinpoint moments at which interventions have greatest impact. Using outreach to engage “influencers” – family members, community groups, local pharmacies. A whole host of exciting new approaches can be deployed such as group and multidisciplinary consultations, better coordination with community-based and social care, telehealth, and use of behaviour change techniques such as motivational interviewing.

Making these changes requires a mindset shift away from traditional views of patients, towards models which make best use of behavioural psychology, incentives, targeted intervention design and new technologies.

Ben Richardson, Principal, and Dr Sundiatu Dixon-Fyle, Healthcare Expert, McKinsey & Company

An NHS for patients: Making clinical commissioning work
Clinical commissioning and risk

Mike Farrar CBE
Massive opportunities and significant risks

The root and branch reform programme that has been set out for the health service in England creates both massive opportunities and significant risks for the NHS.

Placing clinicians at the heart of the new commissioning system creates the opportunity for a new and more mature dialogue between patients, the public and professionals about the future for healthcare, and about what the NHS can and should deliver in a context of economic, technological and demographic change.

But it does so at a time when commissioners face a period of major structural change and are tackling the most difficult financial challenge in the history of the NHS. There are substantial risks to both quality and safety and to financial stability in this context, and the new Clinical Commissioning Groups must be enabled and supported to manage them.

While factors such as the size of the commissioning groups will impact on their ability to do this, history suggests that their structure and configuration will be less important than the context and environment in which they are required to operate and the policies governing how they function and how their performance will be measured.

Certain conditions need to be met if Clinical Commissioning Groups are to be given the best possible chance of success.

In particular, Clinical Commissioning Groups must have sufficient resources available to them to do the job they have been asked to do, and the ability to influence and control the nature of the help and support they receive.

They must have freedom to act, and strong political and managerial support for taking difficult decisions about local services where they are clinically defensible and can be justified in the context of their specific circumstances and priorities.

Clinical Commissioning Groups face the toughest set of challenges in the NHS’s history, and cannot be expected to solve them overnight. If they are to rise to this challenge and have the best chance of success, the questions asked of them in the early stages of development must be relevant, focused on achievable goals and sensitive to local conditions. The greatest risk to the new system is that of framing these questions incorrectly and, as a result, setting our new commissioners up to fail.

Mike Farrar CBE, Chief Executive, NHS Confederation

Andy Ward
Dear NHS

Dear NHS, remember what you know ...

However a health system is administered, overarching directional themes of improving access, providing safe, quality care and achieving affordability are essential – there’s no choice given continued increasing demand and costs. The NHS has invested huge effort and money developing capabilities and structures taking us in these directions with varying degrees of success, especially over the last ten years. The current reform is a little different in that the economic environment and mood to invest scarce resources in change are negative.

The NHS already knows what it needs to do to reform itself – it’s out there in its corporate memory. The trick is going to be finding and directing the capabilities to great effect in the emergent organisational landscape. Anyone setting up a new organisation would be remiss not seeking out premium talent, depth of experience and “battle scars”, mainly residing within people “at risk” of redundancy.

Making the most of organisations, systems and processes – I recently heard some PCT CEOs lamenting the passing of World Class Commissioning. They definitely didn’t want it back, but they didn’t want to lose the ordered, benchmarked organisational and developmental rigour to address the challenges of running a health system. It nurtured a huge cohort of skills, ready to be deployed.

Drawing on the massive pool of leadership across the clinical and managerial spectrum – having skills is one element, but being able to apply these in the new world will make them relevant. Some great development programmes created a tranche of leaders across the health system and the opportunity to get return on these past investments is an opportunity too good to miss.

Adopting the innovation that is out there, not reinventing it – emergent Clinical Commissioning Groups, whether large or small, can access huge pools of innovation. A big role for the outgoing SHAs, PCTs, other forms such as the Institute and HIECS, and then the Commissioning Board, is to signpost these innovations to make the market an even playing field. The UK is repeatedly slammed for uptake of innovation, and health particularly so. The clever use of IT, proactive, early use of diagnostics, technology enabled self-care – all investments in disruptive innovations that can support the affordable, risk managed healthcare system transformation needed.

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So, NHS, don’t you dare forget what you have learned and what you know on this journey. That journey has been expensive and painful, but the pain of having to rediscover is higher. Applied experience and capability are key elements of risk management, and even the smallest players can acquire expertise that’s out there to match the agility of their size with the scale of task they have taken on.

Andy Ward, Managing Principal, GE Healthcare Performance Solutions

Simon Moody
Insuring the risk

It is widely understood that stricter financial accountability of commissioners is needed to save money without compromising quality of care. Real financial accountability means that commissioners must understand how to manage their financial risk. They will need to examine the potential for variations in spend relative to their budget allocation and develop strategies which manage financial risk.

The optimum size of Clinical Commissioning Groups has been the subject of considerable discussion, but has mainly centred on the minimum size necessary to efficiently manage the fixed administrative costs of commissioning. Less consideration has been given to the minimum size necessary to successfully manage the financial risks of actual healthcare delivery costs.

There will always be variability in healthcare expenditures, caused by unexpected variation in both utilisation and average costs. Smaller organisations are at particular risk. They have greater underlying risk volatility i.e. their smaller budget allocation is especially sensitive to random variations, such as one unexpectedly expensive patient. The modelling underlying their budget allocation is also likely to be less accurate than that of larger groups, since it is based on fewer, more variable data.

Commissioners may therefore need to start thinking about insurance-style solutions such as risk pooling, or maybe even “insuring” the risk of over spend with external reinsurers.

Informal risk pooling already exists within the NHS. For example if a Primary Care Trust exceeds its budget, surpluses are transferred from elsewhere to supplement the deficit. But there’s a sense in which that doesn’t seem equitable, since efficient organisations that generate budget surpluses see their resulting gain distributed to those who are less efficient.

Ultimately this means limited incentive to improve the efficiency of care provided. At the same time it is important to recognise that not all overspends are due to inefficiency.

For risk sharing to be equitable, accurate calculations of the risk that a particular organisation brings to the pool are necessary. These calculations should reflect the underlying financial risk volatility of the commissioning group and the steps which it puts in place to mitigate that risk. Actuaries can play a role here. Actuaries are experts in both quantifying risk and identifying insurance-style financial risk management solutions.

We live in times when budgets are tight. Commissioners will have to manage those budgets much more carefully while still delivering quality healthcare to their patients.

Simon Moody, Consulting Actuary, Milliman

Michael Izza
Integrating financial management

Ensuring sustainable and sound public finances is a global challenge. The fiscal realities we now operate within require all policymakers to adapt and reform their approach to public services.

As a leader in the accountancy and finance profession ICAEW understands the role of financial management in fostering transparency, accountability and good governance. We recognise this private sector ethos can help to support the effective delivery of public services whilst ensuring “value for money” for taxpayers.

Health, more specifically, represents a serious pressure point to UK public finances. According to the Office for Budget Responsibility’s first annual Fiscal Sustainability Report, the impacts of an ageing population on health spending requires immediate action, and like any good finance model, planning for identified risks in the short term helps support financial stability in the long term.

The introduction of the Health and Social Care Bill represents a transformation in the way the NHS provides services. The creation of Clinical Commissioning Groups aims to ensure health practitioners are in the driving seat of managing local clinical practice and in the quality, planning and spending of local health resources.

As Chartered Accountants we understand that the success of this policy will rely on the integration of financial management within clinical commissioning.
With patients at the centre of the clinical commissioning process, and their wellbeing and money at stake, the Government’s listening exercise on NHS modernisation has allowed for a wider debate on how Clinical Commissioning Groups will embed financial management within their planning process.

The Bill now recognises the role of governing bodies in relation to Clinical Commissioning Groups. This amendment now accepts the value of standard corporate governance models currently within both the private and public sector, through the creation of governing boards and audit committees.

At the same time additional questions remain. Take the example of financial skills. Clinical Commissioning Groups will be required to have an Accountable Officer. The Accountable Officers’ responsibilities will be primarily focused on keeping to budget while providing and improving the quality of care. The Accountable Officer is also not required to be a financially qualified person or a GP. Who then will be best qualified and have the right competencies and skills to provide both this financial leadership and health service leadership? And how do we ensure we are supporting the right people for these critical roles?

The environment under which policymakers now operate requires them to think about how services can be financially sustainable and deliverable. This is an even greater policy challenge when it comes to health. The conference today provides an important moment to assess the bigger picture. Not only is the public purse at risk, but so are the costs of getting it wrong when the lives and wellbeing of patients are at risk as well.

Michael Izza, Chief Executive, ICEAW
Healthcare is changing all over the developed world from a service that manages episodes of ill health to a service that is concerned with improving the citizen’s health. Financial imperatives make this change all the more urgent as the increasing burden of ill health in an aging population is making the service we provide in healthcare unsustainable.

Parts of the difficulties we face are the fragmentation of services for patients between health (as well as social care) providers for patients and their families as well as the disconnection between clinical behaviour and their fiscal consequences. It is obvious that by integrating services and functions we can not only lessen duplication and over-engineering, but also offer the patient a less fragmented journey through the system.

We all live in a state funded system for the delivery of healthcare which is the NHS. As practitioners working within this universal system we must acknowledge that we have fiscal responsibilities around the part we play for the populations we serve and that our responsibility is around the prioritising of care within that budgetary constraint.

Wellbeing and commissioning is about more than healthcare. It is about the health of the patient and the citizen. It thus includes much more than the medical and health interventions and thus the role of the local authorities is going to be a key determinant of success.

For integrated care to have real meaning it needs to serve a purpose and that must be more than simply increasing efficiencies. The unifying purpose of integrated care is population health. This gives a purpose that all participants can sign up to around a defined population. The purpose is to give the most personalised and efficient delivery of care within an agreed financial envelope which goes beyond the management of ill health.

Population health is our future. If we accept that we are all tied into a system with finite resources and we all acknowledge that we all have to live within these confines then we will be in a better place to discharge our responsibilities to our populations.

Dr Charles Alessi, Chair Elect, National Association of Primary Care, and Executive Member, Kingston Clinical Commissioning Group Pathfinder

Viggo Birch, Vice President Europe, Novo Nordisk

Integration of care in England has the potential to revolutionise the health of the nation. It could change the lives of patients for the better – not to mention the benefits for clinicians and payers. We have all seen sports teams with some of the best players in the world fail because they don’t play together. The same could be said of the way different elements of the health service approach the treatment of long term conditions. At the moment, such patients often fall between the cracks of a fragmented healthcare system. This contributes to 40 per cent of type 2 diabetes patients being in poor glucose control. Diabetes patients in poor control are at the risk of kidney failure, heart disease, glaucoma, having a limb amputated and have an increased chance of hypoglycaemic attacks. This has a significant and unsustainable human, social and economic impact.

I would like to think that we have learned enough now to say that for the treatment of many patients the distinction between “primary” and “secondary” care should be yesterday’s news. We have tried it before and we can do better. A functional integrated system does not have to be expensive. Changing processes and incentive schemes can go a long way to achieve it. A clinical commissioning system that incentivises commissioners to focus on what I call “petty cash management” is not good for anybody – especially the patient. A central issue will be improving the utilisation of hospitals and reducing their number if needs be. This would save money, improve care and free the NHS to promote and support innovation.

Long term conditions need long term perspectives, and it is essential that high quality care is retained in the new NHS environment. If this is sacrificed to short term efficiency savings the long term burden for both patients and the NHS will be unsustainable, and we cannot let it happen.
Managing risk and integrating care

Matthew Swindells

Cerner believes that the NHS is too important to stay the same; it needs to evolve if it is to survive, and indeed, thrive. The reforms contained within the Health and Social Care Bill, currently making their way through the House of Lords, may be some of the most controversial within the history of the NHS but the NHS cannot afford to sit back and wait for the debate to play out. It must seize the opportunity to deliver a health system in which clinicians are given controls of care delivery but choice is firmly in the hands of patients.

One of the keys to making NHS reforms a success is the quality of the clinical commissioning and the management of the risk by both commissioners and providers. Great commissioning will move beyond managing activity and budgets to focus on risk stratification, pro-active health interventions, quality and the application of best practice evidence. This will require high-quality information and data in real time. The National Programme for Information Technology (NPfIT) can offer parts of the structure required for this, the Spine, a piece of genuine technical innovation, has delivered: a single NHS number; 30,000 hospital appointments made with Choose and Book every day; GP records transferred seamlessly between practices; and NHS mail has made secure clinical communication possible. However, whilst Millennium has been delivered to a wide range of trusts in London and the South and created the platform for digitised hospitals, this is the exception rather than the rule in acute hospitals. If hospitals are to deliver a step change in quality and productivity and commissioners are to improve population health within constrained finances, the NPfIT vision of digital clinical pathways must be delivered in other ways.

Cerner is leading efforts to embed clinical leadership in health IT development; the recently launched Chief Clinical Information Officer (CCIO) campaign, backed by the BCS, NHS Confederation and a number of Royal Colleges, seeks to make clinical involvement in IT a reality in providers of all sizes. If this campaign is successful, not only can the relationship between clinicians and IT be re-forged and redefined, but the Government’s vision of an local NHS-led programme for IT will face a bright future. However, more importantly, it is likely to be one of the most significant factors in delivering the access to high-quality information and data required by clinical commissioners so that risk can be managed and the reform so desperately needed to safeguard the NHS can be achieved.

Matthew Swindells, Senior Vice President, Global Consulting, Cerner

outside the NPfIT. We are successfully deploying localised systems to providers through involving the invaluable input of trust staff and patients so that systems are adapted and evolve to match the needs of individual providers – it’s a far cry from the old approach of fitting clinicians around the needs of an IT programme!

An NHS for patients: Making clinical commissioning work

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The untold story of NHS IT is that suppliers, like Cerner, are already working alongside a number of local NHS trusts

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Full transcript

Welcome and introduction

Nick Seddon: Good morning ladies and gentlemen. Welcome to this conference, “An NHS for patients: Making clinical commissioning work”. My name is Nick Seddon and I’m the Deputy Director of Reform. For those of you who don’t know Reform it’s a non-party think tank that was set up in 2002 with the aim of finding a better way to deliver public services and economic prosperity. Events like this feed very much into our research and are a powerful vehicle for generating and also for disseminating ideas. So thank you all so much for being here. The quality of the people that attend raises the quality of the debate, and therefore I’m immensely thankful. We’ve got a great group of speakers. We’ve got a great audience, and looking around the floor there are many people who are coming as attendees who we would choose to put on the podium. So that’s fantastic.

So I’m just going to say a few very quick words about the context, about the programme, and then a very quick bit of housekeeping. So when – if – the Health and Social Care Bill becomes law it’s going to mark the end of the beginning. There has been a lot of talk. There will be a lot more talk. It’s certainly going to look very different from July’s White Paper. But one thing will remain largely in place, at least thematically, and that is the idea of clinical commissioning in some form or other. The question now is about execution. It’s the time to deliver. And the challenges for this are immense. As you all know the Bill could still be slowed by the political process. The budgets are exceptionally tight with the ubiquitous “Nicholson Challenge”. The timelines are tight. Even if the Bill went through now there would be 18 months until the Clinical Commissioning Groups (CCGs) are supposed to be fully authorised. So the timelines are really tough.

The good news is that progress is being made. In July, 257 Clinical Commissioning Groups covered 97 per cent of the population. Some of those clinical commissioners are doing some fantastically exciting work, grouping together very intelligently, understanding the financial risk, questions of integration and so on. And what we wanted to do – in fact when we thought of this conference about nine months ago when they were still GP consortia – is to try to bring together a group of people that can share best practice and expertise both within and outside the healthcare system. So that we can start talking about how to actually harness the knowledge and make this work, because it goes without saying it’s a very large amount of taxpayers’ money.

So let me take you through the programme. The first panel session as you will see is looking at the idea of clinical commissioning and the patient. The White Paper said “no decision about me without me”. So how will clinical commissioning turn that into a reality? The second panel session then addresses clinical commissioning and risk, and particularly I think obviously financial risk because risk management and financial management are so closely connected, and we all know that there is a tension between the kind of small GP consortium idea and the much bigger organisation – federated, understanding finance, perhaps risk-sharing much more effectively. So how does that balance work?

Then I’m delighted that the Secretary of State, Andrew Lansley, is going to give the keynote. I believe that was trailed this morning on the Today programme. So we will be hanging onto his every word. Then the third and final session will look very specifically at the integration of care and try to get to grips with what that means and how it comes into place under the clinical commissioning world. Clearly to some people integration is a sort of group hug, and to others it is something much more stringently organisationally integrated. What we’re looking at today is how to get more joined-up care pathways to deliver high value to patients. Our goal is to deliver the best care that is possible to the patient because the patient deserves nothing less.

I’m very proud indeed of the speakers that we have today, and I’m also immensely grateful to our sponsors. We’re recording this conference, so that means it is definitely not Chatham House. We will publish a transcript and we will circulate that transcript more widely, and indeed you will all get a copy of the transcript for your own record of what was said. And it is because we have such generous sponsors that Reform – a little organisation based in Westminster in a pokey little office – is able to put together a really smart event like this and produce it properly for a big attendance.

I suppose the point really is we have intellectual capital as well as financial capital in terms of our support from our sponsors. So John Chapman from Bevan Brittan will talk on the patient panel. Andy Ward from GE and Simon Moody from Milliman and Sumita Shah from the ICAEW will speak about risk. Viggo Birch from Novo Nordisk and Matthew Swindells from Cerner will speak about integration. We’ve always wanted to bring together the insights from business because we feel that their knowledge is absolutely central and too often left out of the Whitehall policymaking world. And I do believe that these organisations have a great deal to bring to the table. And my profound thanks to the ICAEW who are looking after us with such fantastic hospitality today, and I’m going to ask Michael Izza who is the Chief Executive of the ICAEW to say a word or two before we go into the first session.

The only other thing that I’m going to say is I’m going to rule timekeeping with an iron rod to make sure firstly that the Secretary of State gets to come on...
time and leave on time, and secondly that at the end of the day you can all leave on time, because I know you’ve all got very busy diaries. So thank you all. I’m looking forward to what I’m sure will be a fascinating day. Michael.

Michael Izza: Well Nick, thank you very much. Good morning ladies and gentlemen. I guess some of you are sitting in the audience wondering why is the ICAEW, the Institute of Chartered Accountants, interested in clinical commissioning. Well there are several reasons for that. First of all we have an increasing number of our members who work in the public sector. As governments, as a result of the fiscal crisis, have taken more and more assets on to their balance sheet it’s become increasingly important for them to have higher standards of financial management and fiscal probity. And as a result of that the best qualified financial professionals are now increasingly looking for a career in the public sector.

Secondly we have nearly a thousand members who work in our Health Special Interest Group, for whom today’s topic is very pertinent and relevant to their day-to-day role. We also have a public interest remit which is enshrined in our Royal Charter. And as this is a key policy area of concern for many citizens, it becomes a key area of concern for us. Now as an organisation we campaign for financial transparency, accountability, and good governance, both in the private and the public sector. And in recent years we have been very vociferous advocates for the publication of Whole of Government Accounts, for example, and indeed actively supported and were instrumental in the launch of the creation of the Office for Budget Responsibility.

Now from that perspective I would like to make a couple of observations on the topic today. First of all in terms of the health sector in general, the UK’s spending on healthcare and the value for money derived from it compares pretty well with other countries. For example, we spend just over half of what the US spends as a percentage of GDP, and yet we have a slightly better life expectancy. Now although we heard during the last election that the political narrative was to protect the NHS budget, what has happened is that the fiscal reality is becoming very different. The Audit Commission has said that the NHS should reduce its costs by cutting down on ineffective procedures, thereby saving £500 million a year. But at the same time the NHS in England has been tasked to make up to £20 billion in cumulative efficiency savings by 2015.

That puts the fiscal pressures into context, but this has also been exacerbated by a lack of growth. And that has led to a decision to cut costs across the public sector, and the NHS is now not excluded from that. Now the UK is generally considered to have been leading the way in terms of tackling the deficit in comparison with, say, North America – particularly the US – and other European countries. But we do this at a time when this is compounded by the fact that we’re living longer – we have an ageing population that costs more in healthcare – and that’s a challenge that faces not just us but many parts of the more mature world. So a key challenge therefore is how will the NHS be able to balance its cost cutting over the next few years while trying to maintain and improve its services. And importantly, how does clinical commissioning fit into this process?

Following the Government’s listening exercise some financial and management structures are now being proposed for Clinical Commissioning Groups, and my colleague Sumita Shah will talk about those later. But there are still a whole host of questions that need to be answered. So as the Bill goes through its parliamentary stages, I would just like to flag up a few key areas that we might want to look at. And they come very broadly under the headings of governance, risk management, and ethics.

On the governance side, how will the relationship between NHS commissioning boards and CCGs play out? Will NHS Commissioning Boards be commissioning but also authorising, regulating, and inspecting? Now the private sector has the scars of evolving its corporate governance, and I think the public sector and CCGs can learn from their mistakes. What we do need to know and what we need to ensure is that on all these key areas – commissioning, authorising, regulation, and inspecting – we have a clear segregation of duties. There should not be any confusion about that.

What we do need to know and what we need to ensure is that on all these key areas – commissioning, authorising, regulation, and inspecting – we have a clear segregation of duties. There should not be any confusion about that.

Secondly, risk management. If there is a possibility that a CCG will go bust, are there going to be mechanisms in place to either stop that happening or to be able to continue to deliver the patient care for that particular area covered? What are those rescue mechanisms? Because the time to actually think this through and make the planning is now, not when it happens.

And finally let me just pose a question about ethics. How will GP commissioners handle the multiple conflicts of interest that they will be faced with as both patient advocates and business holders? This is a concern that I know is already felt deeply by many health representative bodies, but I just ask you...
to consider how the headline will play when we start to hear about GPs paying themselves £1 million from the public sector, because we have some very commercial GPs out there.

All of these changes are going to be complex, and there is a great deal of scope to get things wrong. As Nick mentioned in his introduction we can get the strategy right, but actually the most difficult part is execution. And it’s the executional risk that I think is of primary concern to us.

But there are some really good things happening. My research team has reviewed some of the interesting tools that are now available to help GPs commission cost-effective care. And I would cite in particular tools that have been developed by the South East Public Health Observatory and QIPP’s Health Investment Packs. They allow you to compare what works and what results people are getting in different areas. The will to get it right is clearly there, and I’m sure that we all hope that GPs will get clinical commissioning right, essentially evolving the work that they already do and improving long term health outcomes for the benefit of all of us.

So what can ICAEW bring to the table in this discussion? Well we hope that our members will be able to facilitate discussions like the one that we’re having today and support the Department of Health as it develops these changes and, indeed, help and support parliamentarians as the Bill goes through its legislative procedure. And for CCGs and the new support organisations, we hope that we will be able to provide the financial management to provide a better health service for our population.

I hope you all enjoy the conference, and could I now ask the first panel to come up to the table at the front. Thank you.

[applause]
The NHS is undergoing massive change. I don't need to lecture you on that. And there has always been a need for change in the NHS. An organisation established for the late 1940s isn't necessarily suitable for 2011.

And so in many respects you've got to kind of second-guess what the policymakers may come up with in the House of Lords and when the Bill comes back to the House of Commons.

But I think particularly on commissioning there is a consensus across the party divides that there is a greater role for GPs as commissioners of local services. And I think that is absolutely crucial. Now of course it's quite difficult in some ways because the Bill hasn't gone through all its parliamentary procedures, and there may well be further changes to the Bill before it becomes an Act of Parliament.

And so that's enough from me. How we'll run this is I'll ask each of the speakers for five minutes, and then we'll have time for Q&A. So Andrew, over to you.

Andrew Gwynne: OK. Thank you very much, and it's my great pleasure to be here. I mean they say that some people have greatness thrust upon them and then others get to be the Shadow Health Minister. So I'm really pleased to be here, and I know that Liz Kendall was hoping to be here and is very sorry that she has been called away to something else.

The NHS is undergoing massive change. I don't need to lecture you on that. And there has always been a need for change in the NHS. An organisation established for the late 1940s isn't necessarily suitable for 2011. But I think the important thing – and certainly for me as a Shadow Health Minister – is that the underlying principles of a National Health Service, free at the point of delivery, should remain solid. And that is, I think, a view that transcends party politics.

Now certainly before the election all parties said that the NHS needed a period of stability after a period that, I have to admit, under the Labour Government had quite a lot of organisational change in structures. And so there were commitments to no top-down reorganisations. Of course we now know that that wasn't to be the case, and there is the Health and Social Care Bill. And of course there are some very real differences between the parties on the contents of the Health and Social Care Bill which is currently before the House of Lords.

And I suppose the challenge for many of you in the room, you'll be tasked in making the changes work, and particularly in the interests of the patient. And I think that is absolutely crucial. Now of course it's quite difficult in some ways because the Bill hasn't gone through all its parliamentary procedures, and there may well be further changes to the Bill before it becomes an Act of Parliament.

But I think particularly on commissioning there is a consensus across the party divides that there is a greater role for GPs as commissioners of local services. And so we're already starting to see that with longer waiting times for treatment and for tests. So there was a real challenge there that people's expectations have been raised, that people expect the NHS to carry on delivering and delivering for them a more personalised service at a time when you're all focused on reorganisation and when budgets are incredibly tight.

So the feeling, certainly from my constituents – and it's a feeling shared across the country – is that there is a risk that the NHS starts to go into reverse and some of the very real achievements that have been made in recent years start to be undone. And we're already starting to see that with longer waiting times for treatment and for tests. So there was a real challenge there that people's expectations have been raised, that people expect the NHS to carry on delivering and delivering for them a more personalised service at a time when you're all focused on reorganisation and when budgets are incredibly tight.
An NHS for patients: Making clinical commissioning work

And in terms of the Government’s commissioning model in the Health and Social Care Bill, of course by abolishing the Primary Care Trusts and giving the job that one single body is currently doing to five different ones, we fear would create a more complex structure. So I think those wider concerns about the clinical commissioning groups will undoubtedly have an impact on patient care because it’s taken years for Primary Care Trusts to understand the ethics of priority setting and also to get good financial management in place. And of course there is a worry that some of those benefits will start to be undone. Of course over time there will be some combined commissioning groups, and they will share their expertise and clinical evidence. And I think that is right and necessary.

And I think where best practice already exists that really does need to be shared and needs to be shared quite quickly so that those groups can really start to take that experience further. And of course the funding pressures on CCGs will also make the need for more collaboration I think quite urgent. But of course the Primary Care Trusts will be replaced by three times as many CCGs and there is a danger that instead of collaboration between several Primary Care Trusts we have at present we could have dozens of CCGs that will need to combine to achieve the same results. So you could end up with an incredibly complex structure in order to get the same results.

There is a danger that instead of collaboration between several Primary Care Trusts as we have at present we could have dozens of CCGs that will need to combine to achieve the same results. So you could end up with an incredibly complex structure in order to get the same results.

I think also we need to ensure that the Clinical Commissioning Groups are responsible for the entire population within their boundaries and not just the people who are on their practice lists, and that is a concern that we have had as the Bill has gone through Parliament. And also the relationship between the Clinical Commissioning Groups and the local authorities is going to be absolutely crucial because one of, I think, the real benefits of the Primary Care Trust model has been the partnership working between a variety of agencies but including the local authorities.

And of course with the shifting of the public health side of things solely to the local authorities there is a real risk and a real danger that local authority budgets are tight and that public health itself doesn’t become as much of a priority as it really ought to be. And then you have that mismatch between the aims and ambitions of the CCG and the aims and ambitions of the local authority and the expectations of the wider public and the wider health needs for that particular community.

So I think we need to ensure that that partnership is working and that that collaboration continues and that there is some real joint working with local authorities on the public health side of things as well. The real danger is that we go back into the silo mentality of the past that that is the local authority’s responsibility and therefore we’ll leave them to it, and this is our responsibility – because actually you will know that a lot of the real benefits of tackling health needs across the whole of the health economy requires the acute sector, the Primary Care Trust and the local authority sector to work together with other agencies as well.

And I think finally we need to ensure that we don’t lose the benefits that we’ve seen. Budgets are incredibly tight as we say, and there is a risk that the financial situation could start to unpick some of the real benefits. And that’s why I think joint working is absolutely crucial too, so that you can start to share some of the cost burdens with partner agencies too. I could go on and in a lot more detail, but I’ve been allotted five minutes and I realise that you want to stick to that.

So I think the real challenge is that – and the real challenge will soon move from us the policymakers to you the policy implementers – to make sure that the system, however it ends up, works in the best interests of patients, and I think ultimately upholds the integrity of our NHS. The Bill, I think, is far from perfect. But I think that involving GPs more in the day-to-day running of the NHS is potentially a good thing, but we’ve got to get it right. And we’ve got to make sure that for patients they see a seamless transition from the current situation to the new situation and that they don’t see what we fear: that reversal of some of the benefits and some of the very real advances we’ve seen in the health sector in recent years. So thank you very much.

[applause]

John Chapman: Good morning everyone. As the lawyer on the panel I thought I would talk about the legal context of involving patients in clinical decision making and in particular look at how you can avoid the risk of best plans being laid awry by challenges from patients.

Clinical Commissioning Groups are going to be looking to create effective services delivering quality and improving outcomes. But also they’re going to be looking for efficiency and cost effectiveness in tight financial challenges. Patients, on the other side, are going to be looking at local services, issues such as accessibility, personal outcomes, and quite frequently you’ll find there will be a resistance to change, as of course we’ve seen in acute hospital reconfigurations. One of the big attractions of clinical commissioning is that GPs are close to the patient and through their practice access the views of patients. But that is probably not enough, and attention comes – and
Clinical Commissioning Groups have got to involve patients and the public in the planning of services, the development and consideration of changes in services, which impact on either the way they’re delivered or the range of services available, and then decisions in operation.

Groups to get patients heavily involved. And that may mean consulting on appropriate issues where patients and the public expect to be consulted.

The equalities duty has a requirement that they advance equality of opportunity between people with protected characteristics and those without those characteristics. That means age, disability, pregnancy, maternity, gender reassignment, race, religion, belief and sexual orientation. And in working in advancing equality they have to look at removing or minimising disadvantages to groups that are protected, taking steps to meet differing needs of people with protected characteristics, and encouraging their participation in public life and in engagement.

These rights are reflected again in the NHS constitution, and there is a pledge in the NHS Constitution to provide information to patients and the public, which they need to influence and to scrutinise the planning and delivery of health services. So these are strong obligations, and failure to comply with these may not only delay changes being put through clinical commissioning but potentially scupper them completely. So basically Clinical Commissioning Groups are going to need to build in strong mechanisms into their decision making processes to take into account the patient voice and to promote equalities.

In particular they’re going to have to have mechanisms to involve, inform, and engage users, to consult with them in appropriate circumstances, and importantly to take into account their views. In relation to discrimination they’re going to need to analyse and assess the protected characteristics in particular services, engage with those people, set objectives and then provide information about what they’ve done. And key to all of this is going to be evidence. They will need some very clear audit trails about how patients are involved in order to successfully defend and eliminate challenges to clinical commissioning decisions.

Thank you everyone.

[applause]

Sundiatu Dixon-Fyle: One of the fascinating things about the NHS is its remarkable potential to be patient-centred. There are already great examples of patient-centred commissioning and provision of care dotted all around the country. So the challenge is really how do you mainstream and how do you scale up some of these examples of best practice and build on the opportunity which clinical leadership – increased clinical leadership – that commissioning now offers.

The evidence suggests that the benefits are significant. Improved outcomes, for example through improved adherence and by delivering care closer to home. Improved population health through more effective prevention and through more effective chronic disease management. Reduced costs and increased satisfaction of patients, but also carers and staff. So this is really about transforming the relationship between patients and the health system, and putting patients much more in the driver’s seat, co-creating health with health professionals.

So we believe the clinical commissioners have the opportunity to do three things much more consistently and on a larger scale. Firstly, empower patients with information. Secondly, commission patient-centred care from providers. And thirdly, commission effective behaviour-change programmes to strengthen prevention and chronic disease management. So to illustrate what this could look like from the point of view of a fictitious patient I’m going to talk about Melanie, a 48 year-old smoker and a busy mother of two who suffers from type 2 diabetes and has just been diagnosed with a risk of heart failure.
An NHS for patients: Making clinical commissioning work

So as I said, the first opportunity is to empower patients with the right information through the right channels and at the right time. So Melanie needs to find a GP practice which scores highly on managing diabetes. So she searches online. She registers online, and books her first appointment online. She would like some diabetes education classes which she also does online – signs up for self-care and cooking classes. And now she manages her condition better. She’s able to track her progress on markers such as HbA1c by accessing her medical record. And she can prepare questions to ask and discuss with her GP and her team by email, or she can discuss them on the phone or at her next appointment. She can share tips online with other diabetics that she has met, again through a social network, and decide to join a local support group. And if she’s not very computer savvy she can get all of this information through a relative, such as her children, or from a local health coach in her community. So the effect of empowering patients with information is better use of care and more satisfied patients.

The second opportunity I would like to talk about is requiring providers to deliver patient-centred care and incentivising them appropriately to do so through commissioning contracts. Continuing with Melanie, who now has a hospital episode for heart failure, when in hospital nurses do brief interventions to help her start on a journey to quit smoking. Before she is discharged Melanie and her cardiologist jointly develop her post-discharge care plan and tailor it so that she is more likely to adhere to it. Back home Melanie monitors her blood pressure and her weight using devices which can communicate with a call centre, and receives regular calls from a care manager. So the effect of this is better primary and secondary prevention, better adherence and lower hospital admission rates.

The third opportunity is commissioning high impact prevention disease management and self-care programs which integrate the latest approaches and thinking in behaviour change and the use of technology. So finally Melanie requires assistance to quit smoking and to manage her risk factors for heart disease. So what services could clinical commissioners put in place to support her? They could commission research to understand what motivational segment she fits into using the latest thinking from behavioural psychology, behavioural economics and social marketing. She could be offered tailored interventions which she is most likely to effectively respond to.

Some of these could include new forms of patient-directed incentives such as deposit contracts. Melanie could set herself a target to walk five thousand steps every day and join a commitment contract scheme in which she puts down money against meeting this goal, which is tracked using a pedometer, and if she meets her goal she can dispose of the money as she sees fit, and if she loses, the money goes to somebody she would rather it didn’t go to. She can track her daily performance using the pedometer, load the information to a website where she can see how she is doing, and she can also compare her performance with that of other friends who may have also joined the scheme.

Likewise for patients who use the technology or who have family members who do there are now mobile phone apps which can help heart failure patients take their medications and which can trigger calls from their carers when, for example, their weight has increased. So the benefits for this, again increased compliance, more effective prevention and ultimately more satisfied patients and reduced costs for the healthcare system.

So these are just a few examples of some of the things that the clinical commissioners can put in place to empower patients with better information, to commission patient-centred care from their providers and incentivise them to do so, and to commission effective behaviour change programs enabled by the latest thinking and by technology. As I mentioned, a lot of this is already ongoing in the NHS and elsewhere. And the challenge is really about how you mainstream and scale this. Finding ways to do this is what I would look forward to addressing in the upcoming discussion. Thank you.

[applause]

Thomas Cawston: Thank you. I’m very pleased to introduce Dr Niti Pall to the panel. Dr Pall, as I said earlier, is a GP from Birmingham. She is a Vice Chair of Healthworks Pathfinder Consortium, and also the Chair of Pathfinder Healthcare Developments.

Niti Pall: Hi, sorry I’m late and disturbed everybody. But a little bit of an excuse: half an hour late on Virgin trains and I’ve just returned from India so I have quite a different perspective on what the patient means in healthcare. So I’m going to talk to you a little bit – everybody has said everything I was going to say about the policy challenges. What are the challenges within this policy? And what can we be doing, and what are we doing?

So we’re a consortium that’s being now asked to merge with other consortia in the area. And there are some of you in the room who know what’s going on in Birmingham. Well I’m in Sandwell. So here’s a policy puzzle for you. “No decision about me without me.”
Did anybody hear that before? I think I did, about ten times before. And now we’ve got something else happening with that. Authorisation, we’ll need to demonstrate this. So either this can be a tick box exercise – and some of you may have said this. It could be a tick box exercise and I think a lot of us will get through it. We can tick our little boxes. We have our Patient Participation Groups. We have clinical senates or patient senates. It will tick the box. Will everybody know – will anybody know – whether we are engaging our patients in proper clinical commissioning? So it can be different, and I know it can because we made it different in our area. This is about embedding a culture change. It’s what the previous speaker said about Melanie, but this is about whole commissioning process. Patients have said to me – we have 45 community volunteers who work alongside of Pathfinder – and they have said don’t step me up to do cardiac pathways one day. Then don’t step me down to do something else, and then don’t call me in to do a better commissioning for you. I really don’t want that. People have got fed up with hearing that, and they won’t engage. So this is about a real mind shift.

I’m going to just tell you a little bit about what we’ve done with this. We’ve used an approach called experience based learning, and experienced based commissioning. We work with Oxford University and Westminster University and an independent associate to make this happen, and we chose end-of-life care because it was one of our QIPP priorities. It’s also something that can go horribly wrong, and we found that nearly 79 per cent of our patients still die – with palliative care diagnoses – in hospital. Total waste of everybody’s time, and the patient doesn’t want it. So why does this continue happening? I’ve been a GP in this area now 22 years, and we’ve been talking about this for 22 years. So why have things not changed? And what’s happened now is we’re taking this to the way we do things around here. So we’ve started getting to is this is the way we do things around here. So we’ve started taking this now to care homes because what we found was that people with end-of-life care and we’re taking this now to care homes.

So what we did is we co-designed the process with our local people, all our providers, and our front line professionals. And it felt different. And I’m going to give you a few quotes from what patients actually said about this. So over 70 individuals and organisations inputted into this. We had a whole bunch of stuff flying to us from the PCT and the others saying you’re going to be up against competition law, you’re going to be up against a whole bunch of other stuff. And actually, you know what? The patients don’t care and I don’t care, as a front line professional. It doesn’t matter. You’ve got to get it right. So over 30 people and organisations at the end of this process have pledged their time and support to implement the strategy, not just to talk about the pathway or to say what the strategy ought to look like. And most of this time is for free. And I call these our community assets, and we need to bank them. We need to build them right now.

So how did we get there? I think we just got there by doing it – just by learning and getting on with it. I’m really fed up at the moment because all the debates we’ve been having in our local area – and I don’t know if there are many people in this room who will echo the same – it’s about who is going into which cluster with whom. We’re halfway through a contracting round. We’re already spending our money halfway through the year. Millions of pounds have already been spent, and here we are talking about what shape we’re going to be. It really is most frustrating, and the patients don’t give a monkey’s. They don’t give absolutely a monkey’s about what shape, size, and form we’re in.

So what did we do? We got everybody into a room together. We used patients’ stories. We actually used audiovisual aids, and we started to embed this. And what’s happened now is we’re taking this to our board the day after tomorrow. I have the strategy in front of me if anybody wants to come up to me in our board the day after tomorrow. I have the strategy and to see them listening. I really appreciate that. And I think where we’re getting to is this is the way we do things around here. This isn’t about the process, about what shape we are and what form we’re going to be. This is about the way we do things around here. So we’ve started with end-of-life care and we’re taking this now to care homes because what we found was that people from care homes were ending up in hospital and dying there.

I’m going to read you a few quotes from people as they came along. “So I think that’s what the difference was, because we were concentrating for the first time on the patients and talking about their stories, then wretched care pathways. And it sounded and felt different, which was very telling for me.” And this theme was repeated. “I loved it. It’s been very interactive. I hope this process and what has been said today will make a difference. It’s great to see GPs here and to see them listening. I really appreciate that.” This is from the CEO of Crossroads, a carer support charity. Another one: “I think it’s a really good thing that people are listening. ELC for me is good. It runs nicely with what we’re doing. When we listen to patients of course they want good clinical care. But it’s

"Nearly 79 per cent of our patients still die – with palliative care diagnoses – in hospital. Total waste of everybody’s time, and the patient doesn’t want it. Why does this continue happening? I’ve been a GP in this area now 22 years, and we’ve been talking about this for 22 years. So why have things not changed?"

So here’s a policy puzzle for you. “No decision about me without me.” Did anybody hear that before? I think I did, about ten times before.
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But how are you going to fight off the Queen Elizabeth and the Sandwell and Dudley hospitals who all want more money from your commissioning group and where admission rates have been rising quite a bit?

The little things that make the difference, and maybe the little things that aren’t available through the NHS.” This is a charity CEO again saying this. “Charities like us are around and can help.”

So everybody said to us it was the little things that made the difference, that made it real for them, that made commissioning real for them and the provision real for them. So our challenge I think is going to be – and I would really like to open a discussion on this – how are we going to embed this as the way we do things around here?

[applause]

Thomas Cawston: Many thanks. So four excellent presentations. And I’ll take Niti’s lead and say the challenge is, how do we embed this, how do we build up best practice. There is about 15 minutes or so left for Q&A so I’ll take groups of three. So please do raise your arm, please do wait for the mic, and please do tell us who you are. So does anyone want to kick us off? One here.

Malcolm Durham: Malcolm Durham. I’m a relative newcomer to the health sector, working in financial management, but I was inspired by what you say, Niti. And trying to see how this could develop, it seems to me that what is missing in the NHS since it started is an idea that the patient has freedom that the customer can do what it wants, because it seems to start from the basis that if the state gives, then the state dictates. And I don’t think anybody in Britain has a problem with individual delivery of service outcomes. What we have a problem with is the stupid little things that stop somebody being well looked after. So I’ll put it back to the politicians, the policymakers. How little policy can you make in order to give people the freedom to let common sense prevail within the governance structure and the economic purse that is given to the NHS?

Thomas Cawston: Thank you. Over there as well.

Nick Bosanquet: Nick Bosanquet, Professor of Health Policy at Imperial College. Many congratulations to Niti for what you’re doing in Sandwell following on what we did in Birmingham in the 90s. That’s wonderful to hear about it. But how are you going to fight off the Queen Elizabeth and the Sandwell and Dudley hospitals who all want more money from your commissioning group and where admission rates have been rising quite a bit? I mean the hospitals there have some achievements. I mean the one-year survival rates in the West Midlands for cancer are much better than in some other areas. But how are you going to stop them taking more and more of your money? As the NHS Information Centre recently showed, spending on secondary care has risen 9 per cent in the last year while spending on primary care has only risen 2 per cent.

Thomas Cawston: Thank you. Do you want to come back on that straight away, Niti?

Niti Pali: OK. Just quickly there is one point. It’s the little things, and we just have to be brave and we have to act. We can’t let this paralyse us. And at the moment we’re in paralysis mode. That’s how it feels. So we were just brave and said we’re doing it. Don’t care what you’re saying. We’re just going to go ahead and do this. And about the hospital, actually they’ve helped co-produce this. And they signed up and they put their names on it. This was the chief executives of the hospitals. I think if you keep the providers out of this play you’re making a very, very big mistake. And I think we’ve really got to get our act together on integrated care if we really believe in it. If we don’t believe in this, it’s not going to happen.

Thomas Cawston: Thank you. Andrew, do you have any comments on those few points?

Andrew Gwynne: I think in relation to Malcolm’s question it’s absolutely crucial that we do develop our policy along the notion that the patient has freedom. And actually this is a challenge not just for the National Health Service but right across the public sector where the public’s expectations of public services are far beyond the ability of many of those public services to deliver and there is a real challenge there. I think as far as my constituents are concerned, they just want quality care when they need it and quite frankly don’t care how they receive that, so long as they receive it.

And I remember many years ago now, when I first became a Member of Parliament, the local Primary Care Trust management changed and brought in a very different ethos, such that basically if the local hospital couldn’t deliver it, we would bring someone else in to deliver these health outcomes for the local community. And they did. And there was a huge uproar within the health sector because of course the local health economy was a nice cosy little arrangement at that time where you supported the local hospital. But actually it really drove a challenge to the local hospital to up its game as well. And as far as my constituents were concerned they got treated a lot quicker, and in most cases they got better treatment through other providers that were brought in to meet that challenge.

So I think that one of the benefits has to be giving the powers to innovate so that you can say: if you’re not going to deliver the kind of service we want for our area, we are going to look at developing something better and involving others who might...
come in. But as far as the patient is concerned, they want to have that freedom, they want to have that quality care, and quite frankly they deserve it. And so yes, that is a challenge right across the public sector that people’s expectations are here. Sometimes the public sector’s ability to deliver is down here, and the only way that you raise that is by setting those very challenges. And that has been done within the existing structures where Primary Care Trusts have innovated.

Thomas Cawston: Andrew, thank you. John, please, yes.

John Chapman: I just wanted to add that a key part of this is going to be actually innovation in procurement and actually creating care pathways and integrated care pathways that build choice in. And that’s not something that’s happened a lot so far. There are models beginning to develop along those lines. And the other area I think is interesting is actually in the development of tariff, because tariff can be a constraint on choice if it’s defined in the wrong way. Equally the existence of a tariff can actually give people choice, because if you have a currency, then people can choose with the tariff. So how the tariff develops under the new regime is going to be very key I think also in allowing choice in the future.

Thomas Cawston: Great. There are a few more hands in the air. I’ll take one final group of questions. So the lady at the back there, the lady there and the gentleman in the front as well.

Elaine Bennett: Elaine Bennett, Finnamore. I was very interested in the panel’s comments. I was involved in a piece of work last year in London, and I think the NHS is getting more and more insight into how to engage with the different groups and how to really effect change through more effective interventions, learning from within this country and internationally. I think we’ve spoken about some of the one-on-one important patient focused commissioning decisions that need to be made. But I think a real challenge is for the new CCG commissioners to have the courage to really change some of the commissioning decisions that are being made, and to move away from mass marketing campaigns to much more focused and targeted interventions. So I would be interested in the panel’s views on how we are going to upscale the CCGs and give them the space to make some of the tough commissioning decisions needed to progress this agenda.

Thomas Cawston: Thank you. And the lady on the third row.

Miranda Dodwell: Miranda Dodwell. I’m a patient representative. I was very pleased that John talked about the CCGs’ obligation to involve and consult with service users. But I wanted particularly to say that are already lots of initiatives to improve patient experience and improve patient centred care. The NHS productive series – a productive ward for example – their work on experience based design, involving patients in how services are designed, and the new shortly to be published NICE quality standard on patient experience. And I really wanted to know how these sorts of things can be embedded in policy.

Thomas Cawston: Thank you. And the gentleman on the front row here as well.

Faisal Shaikh: Hi, my name is Dr Faisal Shaikh, I’m a consultant psychiatrist and clinical director in Dudley and Walsall Mental Health NHS Trust. I actually wanted the panel’s views about the idea of – in terms of effectively implementing patient-centred care and integration – the idea of mirroring the GP-led commissioning with consultant-led providing on the provider side. Obviously this being the idea of extending it beyond the clinical leadership into more priority setting, financial management, given the tight financial climate and so on. A lot has been talked about GP-led commissioning and obviously there has been this idea – linking the idea that GPs are closer to the patients’ narratives and practitioner based and so on. A similar sort of thing applies on the provider side – the consultant body or the hospital consultants. So my idea was extending the corporate involvement, including consultants and so on.

Thomas Cawston: Thank you. One last question from the gentleman on the second row from the back.

Andy McKeon: Thanks, it’s Andy McKeon from the Audit Commission. I was thinking that there’s lots of talk about patient experience, but actually as far as I’m aware the NHS has no systematic way of tracking patient experience other than annual satisfaction surveys. And actually experience is different from satisfaction because you actually want to know did the service actually work rather than were you overall satisfied. Nor does it have any way of tracking experience across boundaries between health and social care or
between different institutions, which is where many of the problems of patient experience arise. So I wonder if the panel would advocate that actually commissioners should begin a systematic way of tracking patient experience in a way that would be informative and a way in which they could act on providers.

**Thomas Cawston:** Thank you. I’ll start with Sundiatu. The challenge of how to upscale has come back to us. So what are your thoughts on how you upscale best practice?

**Sundiatu Dixon-Fyle:** OK. So I think there are literally three elements to this. The first of all is recognising what best practice looks like. And there is a real opportunity for CCGs to become informed as to what “good” looks like in terms of some of these behaviour change programmes.

The second is making the decision as to where and how to best access the capability, and clearly there is capability which resided in previous organisations and in a variety of NHS and non-NHS organisations. And it will then be up to CCGs to make the decision as to what is the best source, whether it is worth investing and building this capability in house, or whether it’s worth partnering with other organisations including the third sector or patient organisations to develop insight and to deliver some of these interventions.

I think the third thing is really that organisations need to develop the courage, in a sense, to implement some of these innovations. Not all of them have as robust an evidence base as, for example, some drugs, but there still is enough evidence out there to be able to build coherent programmes. And so there is a large element of taking the initiative and wanting to take the risk to experiment with some of these approaches.

**Thomas Cawston:** Thank you. I wonder if John, you want to come in on anything you heard.

**John Chapman:** I just had a couple of points to make. One was sort of echoing what you said really, is the paper coming out – or that seems to have come out in draft form; everyone seems to have seen it – on commissioning support. And I think one of the big things for Clinical Commissioning Groups will be to decide what they should do and what others should do, enable them to focus on the key issues themselves. And I think there has been a lot more debate on that going forwards over the next few months about where the right place it to put different bits of commissioning support in the system.

The other thing on patient experience, I think what we haven’t mentioned is the Health and Wellbeing Boards and local HealthWatch, which is another resource to bring in monitoring the patient response and which is actually really delivering what patients need. And I think those will be very useful vehicles for looking at areas such as patient experience and patient feedback.

**Niti Pall:** May I quickly come back to you on the question of patient experience? I’ve lived with this for 20-odd years, OK? I work in an inner city Sandwell practice. I have 33 different languages spoken in my practice. I look after the drug addicts and homeless. We have five different areas to run out of. It’s a difficult place to be. It’s not an easy place to be. But actually if we get paralysed by inventing new things, I think what is going to happen at the moment, which is really worrying me in terms of delivering something that the patient is held at the heart of, is the layers we seem to be putting into the system.

So yes, there is HealthWatch. And yes, there are Health and Wellbeing Boards. And they have a role to play as long as it doesn’t paralyse us to do the doing, to actually get on and do some of the things that our local people are asking for. And the problem is that we wait too long for that to happen. And before we know it, contracting rounds are done, the year has gone by, and nothing has happened. And that has been my experience over the years of clinical commissioning through fundholding down to today. So I think we mustn’t let this paralyse us.

**Thomas Cawston:** Thank you. Andrew, finally, what are your key thoughts on what we’ve heard today. What are the lessons you’re taking away from today and going forward?

**Andrew Gwynne:** Well I really think the challenge ahead is to make this work and to make this work in the interest of the patient. And that’s easier said than done because there are some incredible challenges ahead. There is massive organisational upheaval. There is huge pressure on adult social care budgets. There is huge pressure more generally on local government budgets as they take on a greater role in respect of public health. So there are massive challenges there in the local government sector to get their health responsibilities right. And then obviously there is the shift away from Primary Care Trusts towards the new models. So we need to make sure that there is, as far as possible for the patient, a seamless transition so that the benefits that we’ve seen aren’t lost. And that’s a real challenge – not for us as the policymakers now, but for the policy implementers.

**Thomas Cawston:** Andrew, thank you. We’re right on time so I’ll draw to a close there. I’ll just invite you to say thank you ever so much to our panel.

[applause]

**Thomas Cawston:** And I’ll ask Patrick to come forward with the next session.
Session 2: Clinical commissioning and risk

Patrick Nolan: Hello. I’ll start with my opening remarks as we’re getting set up here. I think this next session follows on very nicely from the last one. Points that Andrew Gwynne made right in his closing remarks that we need to make this work in the interests of the patient are particularly relevant, but also the points that Niti Pall made around the risks of adding any extra layers into the system. So there are real challenges, I think, to how we deal with risk in the new commissioning environment. So I think this is an incredibly important discussion, and we’ve got an incredibly good panel to be discussing this.

And we’re going to start with Mike Farrar who is the Chief Executive of the NHS Confederation. He’s been in that role since 2011 and before that was the Chief Executive of North West England SHA. And to me, quite importantly, he’s also a Board Member of Sport England and he had aspirations to be a professional footballer and cricketer. And he played semi-professionally for Rochdale Football Club. So that’s quite good.

[laughter]

Patrick Nolan: And then we’ll go to Andy Ward who is a Managing Principle of GE Healthcare Performance Solutions which is the performance improvement advisory and technology business of GE Healthcare. And Andy has also been in that role since March 2011. And prior to this he worked in a consulting role to a range of government healthcare providers and commissioning organisations across the NHS and even further afield in Dubai and Australia, but I don’t know if you ever managed to get any work in New Zealand.

Andy Ward: I visited briefly.

Patrick Nolan: You visited. Well that’s close enough for me, so there you go. And then we have Simon Moody who is a consulting actuary from Milliman. Simon has over 20 years’ experience in the UK health insurance industry and also a significant experience of international health insurance markets. And his main interests are the use of data analysis and modelling to assist health needs of populations, which I just think is an incredibly important topic going forward because in this environment where resources are going to be tight we really are going to have to think quite carefully about where we direct resources and how we intervene into populations.

And then finally we’re going to hear from Sumita Shah who is the Manager of Practice Risk and Public Sector Audit at ICAEW. Sumita is responsible for public sector audit and insurance issues, and is the Technical Editor of the monthly newsletter Audit & Beyond. So we’ve got a very good panel there who I think are going to provide with an incredibly interesting discussion. I will just say I’m going to be quite strict on the time of the panellists, so if you hear the dreaded tinkling of the glass that means your five minutes is up. So if I could then just pass over to Mike. Thank you.

Mike Farrar: It always sounds good, doesn’t it, telling them about being a semi-professional footballer. And then you have to spoil it by saying that I played for Rochdale when we were bottom of the fourth division in 1982. So yes, it’s all fur coat and no knickers, I promise you.

[laughter]

Mike Farrar: Right. What’s interesting in talking about risk in clinical commissioning is I suspect that given the sophistication of the audience you could all effectively right now predict the kind of things that we’re all going to talk about. So – and if we were going to do our flipcharts and our stickies we would probably organise them around contextual risk, operating conditions for new commissioners, and some of the ways in which we frame the questions of them and the expectations. So we broadly know what we’re going to talk about.

But I thought I would try something different with you today in a way to try and think about the fact that the way in which we understand risk at the moment needs to be differentiated. And it needs to be differentiated because the responses and the way in which we manage and handle the risks in the system at this point in its design and delivery are going to be critical. And the analogy really goes back to my sporting days because sadly I have a bad back. And in having a bad back I’ve had a numerous amount of sort of physiotherapy and all the rest of it. And one of the physiotherapists who was very helpful to me described the fact that there are four types of pain.

And the four types of pain are old pain, which effectively is the sort of feeling you get from the original problem. There is then warning pain, and warning pain is when you are trying to attempt something but you get a warning because there are things happening that might exacerbate the old pain. Then there is good pain, and good pain is about where you are trying to effectively exercise and sort of work through to try and prevent that, so the kind of stress of the muscles trying to support the vertebrae in my
back when I’m trying to exercise. And then there is new pain, and new pain is very dangerous because you get the new pain because that is something completely different that’s happening as a consequence of all the things that are happening and you need to watch out for that because that could be different.

So if I just give you a chance to relate that across to risk, and I’ll try and sort of bring the issues into those four areas. So the first is old risk. And the importance of old risk is that if we set up a new system, understanding some of the problems of the past and we don’t deal with them, we’re going to be in significant difficulty. And I’ve got kind of four that are worth just mentioning by way of illustration.

The first is incentives. Commissioning at the moment doesn’t struggle just because commissioners are poor. Partly it struggles because the context and the incentives in the system do not align to support the management of demand and movement away from provision. Most of our provision is incentivised, and it was done deliberately at the beginning of 2000 to try to deal with the backlog of waiting. Most of our secondary care provision is incentivised to do more activity, not to do less. And it’s easier to generate income to deal with financial problems than to take out cost.

The second is if we don’t go into the new world with a more honest debate with the public about the scale of the financial challenge, we will have no mandate to make the tough decisions. And clinicians in commissioning will be set up to fail. We have to do that. And so what we really want from the public is that the politicians to give us our honest debate, to lead that discussion so we have a mandate for planned change to avoid unplanned cuts. And that’s really critical because this is about redirecting existing spend from fixed costs in terms of beds and variable costs in terms of people, by taking out beds and posts to try and deal with our problems differently.

PFI and our asset management is another good example of an old pain, an old risk. You know, we do have rather unusual business models, district general hospitals – an agglomerated mass of entities which when you try and take patient choice and patient value out and you try and strip that away, you come up with a thing about well we have this big fixed cost, the management of the asset causes problems. And there are obviously big legacy issues going forward in things like PFI and list costs that have to be dealt with.

And lastly the issue on patient safety. Patient safety has nothing to do with reform. But if we want an honest debate with the public to support tough commissioning decisions, you have got to provide the basics right: microcultures in hospitals, in care homes, in primary care that provide absolutely the basics right. And we should be unrelenting and unforgiving of poor quality basics.

Second area: the warning pain, the warning risk. Well what are the warning risks that say some things that we’re doing will exacerbate those old problems? The first one I would give you to illustrate, management costs and management resources.

A £110 billion industry needs to spend proper money organising care if you’re going to get optimal clinical delivery. I was delighted in the summer when McKinsey backed up a point that I was wanting to talk about which was the amount that this country spends on organising care. It is very low before the cuts. It will be excessively and dangerously low afterwards. That would exacerbate – that is a warning risk around do we provide sufficient resource for new commissioners to do the jobs they’re being asked.

The other is CCGs. CCGs need freedom to act. The warning risk there is that the culture that we’ve had for performance management previously, if we apply it to CCGs will not work. We need a different performance management regime to support Clinical Commissioning Groups.

And the last warning risk is payment by results. Payment by results was deliberately designed to get the results that we got over the last decade. It’s not right for the future. It needs to change. It needs to be sorted. Otherwise trying to apply that solution to the problems we face will point us in the wrong direction and create perverse incentives.

Now on to the good news, the good risk. What is the good risk? What is the good pain? What is the great stuff that’s happening? Well, engaging clinicians in this, Clinical Commissioning Groups I think are going to be fabulous. They can do lots of things in very different ways. But they will need support but this is great to unlock the power and latent potential of clinicians to deal with some of these problems. The new public health opportunities – another great new risk around for us. You know, local authorities taking a bigger set of responsibility. The opportunities of new technologies – and in fact the silver lining of the recession – to start pulling through new technologies. Telehealth, new medical devices, new pharmaceutical introductions – all of that can really bring new risk, new things that we should be embracing.

And finally I was last night with a group of new leaders, young emerging clinicians and managers in Reading who were forming themselves into a different group with energy, with passion, not browbeaten, not being rewarded for doing the same things, really great opportunities to put risk to promote some of those people sooner into jobs.
to get some real leapfrog opportunities to sort of bring those through.

And then last, the new risk. What is the new risk? Well, there are things about this new system that really do create some new risk. The alignment of some of those new national bodies, how are they going to operate? The prevention of failure regime, which is going to require a regulator to defend telling commissioners to spend more than they naturally formulate allocated resources on particular services in one part of the country to sustain a service, but not necessarily in other parts of the country? That’s going to be a great new interesting dimension, not to mention the perverse incentives of putting the cost on prevention of failure down into the system and probably dealing with absolute failure with a central pot. You can see the perverse incentives there. And finally the complexity of the system that we’re going to go into, that really is new risk.

So the reason I mention those four areas is because I think they all need different responses. Some encouraged, some recognising, some tackling head-on. But if we just talk about risk in the way that we might do predictably, I don’t think that gets us to where we need to be. And my very, very last point is this: who suffers the consequence of failure to manage and handle this risk?

The truth is that most managers have opportunities. A lot in 2013 can take redundancies, walk off, be very, very happy. Clinicians can go back and they can go back into practice if commissioning doesn’t work for them. The people who suffer the consequences are our patients and the public. So when we talk in management terms about these challenges and we convert them to opportunities, the point about risk is these aren’t challenges nor opportunities. These are obligations. We absolutely have to get this right. Thank you.

[applause]

Andy Ward: So I guess I wouldn’t be the first speaker to stand up here and say the NHS is facing the greatest challenge in a generation. I think just about everyone has alluded to it in just about every conversation that you hear at similar events to this. But let’s just think about that for a moment. This time we’re reforming the NHS in one of the toughest set of economic conditions that we’ve seen in living memory and probably for many of us in career history as well. Last time round there were seemingly endless pots of money and investments in process improvement, in people development and in technology solutions and safeguards. And I think it’s probably fair to say that we didn’t really get the benefit back from all of those. Some were seen to conclusion, but some of them were stopped halfway through. And it was really expensive.

So this time round we’re trying to deliver QIPP savings – big changes in the NHS with top to bottom reform. But we’re trying to do this at the same time as delivering a great service. And if that wasn’t challenging enough, we’ve put a group of people in charge to drive this bus who haven’t been allowed to drive the bus previously. Oh, and by the way, haven’t we just told a load of the people that we’ve invested in in the past and the organisation forms we’ve invested in in the past that we don’t want them anymore? So that’s pretty risky.

We’ve talked about risk. We’re here to talk about risk. But we’ve got a million clever minds out there in the NHS so we must be able to make something of the situation, those past investments. So I’m sure my colleagues – as Mike already has done and the others will do – will talk about many different forms of risk. But a good way to mitigate risk is to apply the experience – the experience that exists in the system. So how can we really make something of this body of knowledge and wisdom that sits within the NHS and apply it to the future, the evolving NHS as it comes out?

And this is something we can do, but the NHS leaders have really got to be quite bold. They’ve got to be bold enough, yet humble enough as well, to see where those gems of wisdom are, where the gems of knowledge are, and make sure that we’re also smart enough to discard the parts that didn’t work. There is a whole host of three-letter acronyms that we can throw at this. TCS, SHA, PCT, PBR, even CFH – a lot of taxpayers’ money went into those to develop people, to find pockets of knowledge which we should seek out and reuse. I guess one of the most obvious legacies that came out of those past investments over ten years are some of the processes and the organisations and capabilities. So if we can get the best part of those and apply them in this new world, we’re managing a number of our risks.

I’ll give you an example of musculoskeletal services in Oldham. There is a group of clinicians there – forward-thinking clinicians who have taken the best parts of the processes, the people, and have banded those together with some new glue and come up with some radically disruptive models of care. These are being provided at a fraction of the cost of the service that was being delivered before, with remarkably better outcomes. We’re also seeing, as we scale up to the integrated care organisations, that those organisations which are using ideas like population modelling, business intelligence, and also looking at the way that they link into their host organisations, are using this information to prove and de-risk what they do before they go to the large scale.

The ones who will get there quickest and the safest will be the ones who can pluck the best knowledge, intelligence and experience out of the NHS and apply it there, which then gets us to the people, particularly the clinical and managerial leaders. Leadership development isn’t a new thing. Even though there is a thousand people right now in the NHS who are on the Top Leaders programme, I think that’s about 0.1 per cent of the whole of the NHS employee set. That pales into insignificance when you look at the amount of leadership development that has been carried out in the last ten years across all
levels. It’s often quoted that the NHS needs more leadership, not more leaders. And there is a untapped talent out there that I think that new forms of organisations can look at and can draw upon, and draw them into their organisation before they leave the organisation.

Many of the CCGs out there could well be looking at many of the skill sets that were developed around World Class Commissioning, if we remember that. And they may want to seek out those skills and use those as a way of seeing where the people who got the best from those programmes could be redeployed in the new. Does that mean that we want World Class Commissioning back? I’m sure we could do a quick show of hands in the room. And I’m sure most places would say no. But I think there are some great relevant skills there. Seek this out. It’s pre-trained. It’s pre-bruised. It will know what you need to do, and it will spot many of the risks before they happen in the system as it’s evolving.

And finally I’ll mention values. Values are something that sit right of the heart of just about everybody you speak to in the NHS, whether they express them explicitly or implicitly in the way that they work, be they clinicians or managers. Yet most NHS organisations I work with, if they have performance management systems that are applied properly, do not look at how they are integrated with their values.

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within the resources available to them. The detail is still unclear, but what does seem to be clear in particular is that there is going to be greater, tougher level of financial accountability for CCGs going forward.

There’s also been a lot of discussion, including in the White Paper, about the use of risk pooling, and particularly perhaps the National Commissioning Board (NCB) facilitating this, perhaps as an insurer of last resort. But whether risk pooling amongst the CCGs or a blanket cover provided by the NCB is in place, for it to be equitable and for there to be incentive for CCGs to improve clinical commissioning efficiency, and with it improve outcomes for the patients, there are two principles of insurance that actually must be also in place.

The first one is that the pool participants should not be able to immorally select or cheat the system as part of the risk-pooling mechanism. And I think this is what the Department of Health tend to call the service risk. So this is around poor prescribing, referral practice etc. It’s important to get the incentives right therefore in terms of that side of things. There may also be the need for the pools to instigate rules that participants should follow – sort of like insurance terms and conditions, perhaps including risk sharing within the pool itself. But you don’t want to remove all the downside risk so that ultimately you actually negate the effect of what you’re trying to do here, such that you actually remove all the risk from CCGs and they end up overspending going forward.

One of the things here as well is that a pool is unlikely to be for profit, and hopefully all the participants have the same objectives in terms of improving the quality of care for their patients within the budgets that they have available to them. And so therefore we would hope that all the participants would actually be playing to the same set of rules and happy with that.

The second thing is that the pool participants should pay a premium to the pool that actually adequately and appropriately reflects the risk that they’re bringing to it. So this is not just about random fluctuation or volatility in utilisation costs – and that will depend on the size of the risk that the participant brings to the pool – but it’s also about the processes, the protocols they put in place to manage the risk – things like following evidence based care guidelines, for example.

It’s also about the expected adequacy of the delegated budget. That’s going to be very risky in the first few years because you’re going to have new populations that the budget needs to be spread across. And how do you know that your delegated budget is adequate in the first place? Of course it should also reflect any anticipated commissioning spend that will actually be ring fenced or provided at a more regional level, say, so maybe things like mental health. But what the pool covers and how risk transfer is structured will depend on the objectives and as well the attitude to risk of the participants and CCGs themselves, and there are actually many options which you can take from the insurance industry in terms of designing that.

But if there is going to be tougher financial accountability then I think that CCGs are going to have to understand their underlying risk first. How likely is it that you’re going to exceed your budgets, and what are the reasons why that might take place? And also what are the steps you can put in place to actually mitigate that risk, to reduce it, to control it? And also of course how can you maybe share that risk with others if you really want to? And a lot of that depends, again, on your risk aversion. All of this is to try and avoid having to shut the stable door, really, after the horse has bolted, and the potential loss of the public faith when they start to see or if they start to see providers of essential services failing financially. Thank you.

[applause]

Sumita Shah: Pretty much a lot of what I wanted to say has been covered by my colleagues. That’s the detriment of being number nine on the two panels. But I’m really fascinated by all the discussions that are taking place. And when my colleagues asked me to speak today I was trying to think of what would be a statement that the ICAEW could make at this debate. We are, after all, accountants. I think the statement that I would like to make is that the cost of getting this wrong could be very, very high, not just for taxpayers but for our own public health and wellbeing. And I’m thinking now, listening to some of the discussions earlier, if I fall ill or when I get old, what sort of care am I going to get myself and how am I going to be treated.

That really just takes me back to what are the important aspects. We’ve already talked about some of the wider things going on in the public sector, never mind just the health service. There is the bigger challenge. The health service is going to have to make £20 billion in efficiency savings by 2015, and secondly this massive reform that you’re having to go through. So individually each change is a big ask of health professionals. But together the challenges create a number of risks that we’ve already alluded to today.
I’m going to just talk about another aspect – the financial aspect. There is a wider aspiration by Treasury around the Finance Transformation Programme to strengthen financial disciplines across Government and to manage taxpayers’ money wisely. That’s your money. That’s my money. So the idea of managing public money well is perhaps even more important with these two big challenges that you’ve got. And you could even say that the task is urgent. In the health service you could even say it could be a matter of life and death.

We’re not going to profess that we know very much about healthcare. We’re not. We’re a bunch of accountants. But as accountants we do look at and recognise the importance of financial activities in any organisation, and we look at the key functions within each organisation. We look at accountability, we look at governance, and we look at the risks within organisations. So reflecting on these Clinical Commissioning Groups we’re glad to see first of all in the Bill the structure around governance boards. We’re glad to see that the concept of accountable offices has come into play.

But we think there are still a number of risks that need to be mitigated, for example this huge change abolishing PCTs and moving towards these commissioning groups. While at the same time you’ve been asked to cut costs and generate savings, part of the savings will be to reduce staff. So one of the biggest risks to the NHS will be to manage its workforce, but there is so much uncertainty still around the future of the workforce. But the success of the groups will depend on the retention of key staff and key skills in key positions.

While at the same time you’ve been asked to cut costs and generate savings, part of the savings will be to reduce staff. So one of the biggest risks to the NHS will be to manage its workforce, but there is so much uncertainty still around the future of the workforce. But the success of the groups will depend on the retention of key staff and key skills in key positions.

And we would talk about finance managers. Recent issues in the press around PFI highlight the need to have strong finance skills, strong financial capabilities in the NHS and in the wider public sector. And after all, isn’t finance one of the key concepts in all of this decision making? So a question for health professionals in the audience and in the wider field: how is the NHS managing its human resources? Is it retaining the skilled finance managers in the NHS to help with the extent of the cuts that you’re going to have to make? And are finance managers in place to help manage this transition to CCGs?

In the new proposals the budgets will be allocated to the commissioning groups, and these will be real budgets. It won’t be notional budgets like in the past. So practices are going to need to start looking hard at the efficiencies and the expenditure, and they will be held to account for their spend. So another question: are practice managers up to the job of financial management? Do they understand the role that they’re taking on? We’re aware that a number of the good CCGs, where they’ve already started to merge, to consolidate, are starting to put these practices into place. But there is a large number of CCGs, covering large areas of the UK, that are struggling.

This takes me on to the next risk as we see it: the lack of real practical guidance. We’ve seen the report on developing commissioning support, and we’re pleased to see that the Department of Health is producing some guidance. GPs badly need it. But we understand this guidance is still in draft, and therefore it might not reflect the current position. This is a good thing because we hope there is still opportunity for further changes as we think this guidance could really go further.

For example, in this guidance it states – and I’m quoting this – “Introduction of CCGs is intended to put clinical added value right at the heart of decision making.” It talks about which services ought to be commissioned in order to meet population health needs. It talks about a framework to support CCGs to ensure that they have all the right information and expertise to help them make the best decisions and deliver better outcomes for patients as well as monitoring the delivery and impact.

This is great. We don’t disagree with these messages. But surely underpinning all of this should be the money aspects. So we think this document misses the other big challenge in the NHS and in the health reforms: the objective to make the most efficient use of our money. So our view is that this other objective needs to be integrated into the guidance. After all is it possible to do everything that the NHS needs to do without having a handle on its finances and managing them more efficiently?

The document goes on to discuss a number of risks, and it talks about managing risk and discusses how it intends to guard against these risks. But really the commissioning groups need to understand more about these risks so they can better understand the risks that they’re taking on and how then they will mitigate them.

The guidance then goes on to talk about four specific functions that are critical to the future smooth running of commissioning. And earlier we talked about tougher financial accountability. So we would actually go as far as to say that there is a fifth function that is critical to these commissioning groups: that of financial management. The institute’s view is that strong financial management is going to be a key element not only to the need to make and achieve this £20 billion in savings, but even more to the process of moving over from PCTs to these new commissioning groups.

At this critical time for the government and for the NHS it’s even more important that the financial
management as a concept is embedded within the wider NHS and certainly in the transfer from trust to the commissioning groups. The quality of care will depend on the quality of the decision making. And our view is that the quality of decision making has to also involve finance elements. So in order to manage money wisely and to help commissioning groups improve the quality of care for reform, financial management needs to be a key and strong part of this bigger reform, not just a back office function.

So this conference actually provides a forum for health professionals to think about these big issues. And there are a number of risks. We see the current risks as retention of big staff, making sure you have the right skills in place, and embedding financial management within the wider NHS and certainly within the commissioning groups. Of course as time goes by there will be other risks that crop up and will need to be mitigated. But if you don’t have some of these key things in place then I think I’ll take you back to my very first point. The cost of getting it wrong could be very high, but we would say it’s not too late to take the steps to get it right now. Thank you.

[applause]

**Patrick Nolan:** Well thank you to the four panellists and for four fascinating presentations. Mike started us off by talking about the four types of pain really as sort of a metaphor for the four types of risk: old pain, warning pain, good pain, and new pain. And Andy talked about where the gems of wisdom are and the importance of not losing those and the importance of people. And Simon then talked about risk pooling and what a pool should cover and how risk transfer should be structured, which is an incredibly important discussion. Those issues were also picked up by Sumita, who said that we have to think about how the NHS manages its money because there is a big financial risk here. If we don’t get the finances right then actually it is also going to be a real cost to the health of the population as well. So four very good presentations. So what I’ll do is I’ll take a clutch of questions, if I may, and then we’ll go from there. So I’ll start there and there and Malcolm to start with.

Great. Thank you.

**Andrew McConaghi:** Andrew McConaghie from *Pharmafocus*. Does the panel think that the Government is setting up a deliberate survival of the fittest situation among CCGs where some of them are going to go to the wall and that’s a good competitive situation, or is it purely that there are more details to come? And particularly do we need to be quite explicit about failure regimes I guess is hidden in there as well. Then Peter raised a question about individual GPs potentially doing quite well out of this, and so are the accountability arrangements sufficient. And then Malcolm had sort of a similar point around governance structures. How the new CCGs could be structured so that they capture the past experience of what has gone before? And how can they get hold now of the innovation that is happening within the system? Because it seems to me that the system of budget holding and going according to budgets works against innovation and particularly when they’re held as an annual process. And how can we radicalise the use of budgets to get the innovation that we require whilst not incurring unnecessary risk?

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But in order to turn that into cashable benefit they’ve then got to confederate because they have to reconfigure acute care to take out the capacity that they generate. And of course the truth is that CCGs are being asked to do exactly both of those, there is sufficient accountability and transparency in place under the new arrangements to reassure the public that the money intended for patient care is being well spent.

**Malcolm Durham:** It seems to me that there is very little that is risky for the population as a whole, but what we’re talking about here is the risk of individual organisations. And the danger is by creating new organisations, as Andy said, we lose what’s gone before. So my question is about governance structures. How the new CCGs could be structured so that they capture the past experience of what has gone before? And how can they get hold now of the innovation that is happening within the system? Because it seems to me that the system of budget holding and going according to budgets works against innovation and particularly when they’re held as an annual process. And how can we radicalise the use of budgets to get the innovation that we require whilst not incurring unnecessary risk?

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**Mike Farrar:** OK. I mean the interesting thing about all those three questions is they all have a kind of inherent paradox in them which I think is the name of the game at the moment when you’re trying to create effectively a new system in a complicated set of reforms. Survival of the fittest – I actually think that the intention is to try to allow CCGs to form thinking about their own sort of route and place. And of course the truth is that CCGs are being asked to do exactly both of those,

**Patrick Nolan:** And Malcolm.
An NHS for patients: Making clinical commissioning work

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to actually look from an individual patient perspective at redesigning pathways. But in order to turn that into cashable benefit they've then got to confederate because they have to reconfigure acute care to take out the capacity that they generate. Otherwise it will be exactly what PCTs found, they do a lot of care pathway redesign, and it just gets replaced with other stuff. So I don't think it's a deliberate attempt to go to one side. I think it's trying to get that balance right and that is difficult.

And equally with GPs earning money. If we said we're only really interested in outcomes, would it matter where the resources were going if we were getting the right outcomes and value for taxpayers? But at the same time we know that you're trying to balance that with the accountability bit. I do worry, for example, about the fact that primary care spending is likely to be steered from a national quango, you know, at the point where you really want it to be connected. It maybe not in total quantum, but in shape you need to be – that needs to be really driven locally. And it seems to me the earning potential, we do need to make sure you don't get conflicts of interest and impropriety, but actually if people are doing really great primary care development, which is effectively improving the lives for patients and getting better outcomes, we need to reward that properly in the system.

And then the last point on the connection of the population – just to throw one in, really – which is how do governance structures operate in that environment. We have a phenomenal opportunity with CCGs to connect to local populations. To me the radical transformation for all health systems worldwide is to connect with people to think about their own health and use of resources. Now you can do that really well. We tried a bit with Foundation Trusts. About 80 pass the Monitor test. 70-odd of them, can you behave like a private sector organisation? Four or five, can you connect to local people without having governors and members? What have we done about the latter? Almost nothing. I'm a member of three Foundation Trusts. I don't know why because they never talk to me. How do they engage me in their business? I've got no idea – and I won't mention which ones for obvious reasons.

The truth is there is an opportunity to engage differently with patients and people and the public, and we should use this opportunity to create really interesting governance systems that do connect to people and don't pretend to connect to people.

Patrick Nolan: Andy.

Andy Ward: So I guess picking up on the first point about whether this is a deliberate mechanism for survival of the fittest, I think there is that whole kind of market tension in here which is that I would quite like this to be a mechanism to ensure that only the fittest survive. And then how can we make sure that the whole of the population is served by those that are fit enough, because we wouldn't want any parts of the community or any parts of the national populace currently served by the NHS not served by anybody.

And then we get back to the pithy debate about failure mechanisms. So what's a failure mechanism for a CCG that isn't fit enough? One would hope that there are going to be controls in place to spot that and to make sure that those which are fit enough are out there and are picking it up. But I think that also picks up on a point that was kind of inferred from what all of us were saying, that this is a huge task. We can all find pockets of innovation in the NHS and areas where there is integration of healthcare, early adopters of innovation. But to do that scaleably, repeatedly and quickly over the whole nation is going to be tremendously risky, and I think that's where this reform has got a risk of the centre almost saying "give it here" and then we get exactly to the top-down reform that we were hoping not to have.

I guess then picking up on the middle point that was made around the GP that earns £1 million a year, I can see the headline already. There may be one or two but I can’t imagine there will be that many. There is huge scope in there for moral hazard. I think this is where both the national controls and the regulators – the economic regulators around the system – act to make sure that moral hazard just can’t come in. And I think this is where the role of both regulators and auditors can make sure that those early indicators are picked up.

Patrick Nolan: Simon.

Simon Moody: Yes, I mean speaking from a financial perspective about survival of the fittest, those who are perhaps more astute, and understand their financial risk a little better of course are going to be the fittest and those who will survive.

A lot of talk has also been about the size of CCGs and the fact that in theory there is this perception that the smallest ones, whilst they can be nimble and they know the needs of their population in terms of the clinical side of things, well surely they can’t survive financially in terms of risk. I don’t necessarily agree with that. I mean it is about understanding your underlying risk, understanding the risk of the population that you’re serving, and if you put the right process in place or put the right risk management or risk transfer processes in place then you can survive even being quite a small CCG.

I think the other thing in there is that at the moment there doesn’t seem to be an awful lot of detail around how the rewards and incentive structure or even penalty structure will work for those that fail and I suspect that’s because it’s just
A lot of talk has also been about the size of CCGs and the fact that in theory there is this perception that the smallest ones, whilst they can be nimble and they know the needs of their population in terms of the clinical side of things, well surely they can’t survive financially in terms of risk.

Patrick Nolan: Thank you. We’ve literally got four minutes left so what I want to do is exercise the Chair’s prerogative and ask a question of the panel. And I’ll get you each to give me a quick 30-second reply. And I actually want to pick up on a question that you asked. We need to push back on areas that will work and areas that could be improved. So if you had 30 seconds to highlight a number of areas that you think could be improved, what would they be? And if we could have quite quick answers too please.

Sumita Shah: OK, just taking the first question about survival of the fittest and whether we think CCGs are being set up for a fall, I genuinely don’t think that’s where this policy objective is going. I think this fits into a wider agenda, the agenda around localism and giving power to the people. So I think there is that sort of wider agenda that we need to think about.

But I think the comment that was made when this question was asked is, I think, that there is a lot more detail that needs to be thought through. In the experience that we’ve been having talking to the Department of Health and other Government bodies in this area, they haven’t necessarily thought through all the implications. And I think some of the things that have been talked about today, these sort of conferences, pushing back on some of the detail to the Department of Health would really help. So I think they’re in listening mode at the moment and we should really just take this opportunity to push back on areas that we think will work and how things could be improved.

On the question around accountability and transparency, we agreed there might be some conflicts now turned completely on its head because of obviously what has happened with the financial crisis more than anything. And I don’t think that’s going to serve the public health sector particularly well if that same thing applied here in terms of putting too much regulation in place.

But something which Sumita mentioned, which I think is quite interesting, is whether CCGs or maybe groups of CCGs need to think about having someone equivalent of a chief risk officer that is actually now an important or probably one of the most important parts of a financial services company under the new solvency laws. So there are a lot of similarities and things I think you can learn from other industries that have been through this and had the pain to avoid you going through it yourselves.

Sumita Shah: I think I would say financial management needs to be embedded into this process for moving PCTs from PCTs to commissioning groups, for GPs. On the one hand you’re in a CCG group and you’ve got to make a decision. But what about the private sector side where you’re trying to get the money and fund patients through the private health side? Those are real risks. We’re glad to see – I mentioned earlier – governing bodies have been put into place and audit committees have been put into place. But all of these arrangements haven’t actually been thought through. The detail of the accountability arrangements still haven’t been thought through.

And finally just touching on the point about budget holders and how to radically use budgets in CCGs, I think I will go back to one of the points I made around the wider finance transformation programme, the Treasury’s aspirations to embed finance management across the department rather than just within different functions. When I talk to Government departments they tell me: oh, well we have a finance department that does X, Y, Z but really finance needs to be embedded across the department. So within Clinical Commissioning Groups finance needs to be involved in all of the decision making because if you don’t know what your budget is, you don’t know how much you’ve got left, six months into the financial year you don’t know how much you’ve got left – how will you make a decision about which bit of care, which care package to buy in for your patient? So I would say that financial management needs to be embedded right across the organisation, not stuck into one department.

Sumita Shah: I think I would say financial management needs to be embedded into this process for moving PCTs from PCTs to commissioning groups,
but also across the wider NHS. And there needs to be some more guidance given at a practical level.

**Patrick Nolan:** Simon.

**Simon Moody:** Actually you've stolen my thought as well. Yes, I think as well as that, there are other things not just understanding your risk but also how you go about controlling it or mitigating it. And a lot of that is actually in just good quality commissioning in terms of making sure that you're following evidence-based guidelines and things like that, because ultimately if that's what you're doing, you're going to reduce some of the risk, and ultimately you're going to be in better control of your budgets. I mean there are a number of things as well that we could discuss about as well on the financial side.

**Andy Ward:** Yes, I guess, as like all things for the NHS as it changes, the trick will be spotting what does need to change and what doesn't. But if we're going to go after areas that we need to make sure we keep hold of, like I said in the talk, I think we need to spot our talent, we need to see where that experience sits because it's through that knowledge management we'll manage risk. I think the other areas that we need to be brutal about is not only to say what we are going to do but what we're not going to do, and make sure that we remove many of the barriers to change which will mean the NHS is not as agile as it could be.

**Patrick Nolan:** Mike.

**Mike Farrar:** I think if you'll allow me, my point is a cultural one which can improve our system, which is really about understanding the nature of power. And that is to understand that the system will work if it recognises that power is not a finite commodity, but actually if you empower other organisations in the system, you create more power, you empower others, you become more powerful to deal with the challenges that we face. Too many bits of our system fail because people think that if they give away power or empower commissioner to provider, provider to commissioner, hospital doctors to primary care, social care to healthcare – if we recognise that power is not a finite commodity, then actually we can make all the system work really well.

**Patrick Nolan:** Well thank you. Well I don't have anything to add. I thought they were four excellent points. So can you all join me in thanking the panel? So thank you very much.

[applause]

**Patrick Nolan:** It's now my pleasure to pass over to Nick and the Secretary of State for Health, Andrew Lansley. Thank you.
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where interestingly 95 per cent of staff at that hospital say they would be happy to have a member of their family, a member of their community treated at that hospital – all examples embodying everything that’s brilliant about the National Health Service.

And I think where the NHS is great we should be enthusiastic in our celebration of its achievements. And let me be clear, I really do recognise that because every day, all over the country, NHS staff are caring exceptionally well for sick and vulnerable patients.

Look at our results for cardiac surgery, or our mental health services – acknowledged by the World Health Organisation to be among the best in Europe – the system of general practice, as I mentioned, or, as an example of recent progress, strides – dramatic strides – forward in preventing venous thromboembolism.

Yet I want the NHS to lead the world in everything it does, not just some of what it does. And so, without taking anything away from the standards so often achieved, I want to focus on when things go wrong, because unless we face up to the challenges, unless we take action when patients are let down, we will never be able to achieve the consistent high quality we seek.

Yes, we have hospitals that are respected across the world for what they do. But those are others that simply aren’t good enough. And crucially, as we have discovered through the CQC’s latest dignity and nutrition inspection reports, we have hospitals with very high reputations where particular services or even particular wards in that hospital fail to deliver good care. At times, however, it can seem as though there is a conspiracy of silence about poor performance, that doctors and nurses who were not up to the job go unchallenged by their colleagues, that institutions that deliver poor quality care, that kept patients waiting for treatment months on end, or who themselves ran up massive debts, were excused or bailed out by the government. We allowed a system to develop where, sometimes – actually quite often – failure was rewarded.

Last year, I ordered a programme of work to turn around hospitals that had struggled for years under Labour, but whose problems Labour chose to ignore. In addition to the Labour bailouts, which rapidly snowballed into huge debts, some trusts are also dealing with the consequences of badly-negotiated PFI deals and years of revolving-door management. The recent National Audit Office report shows that of all NHS trusts yet to reach Foundation Trust status, 80 per cent face financial issues, 65 per cent face quality and performance issues, 39 per cent face governance and leadership issues.

Labour turned a blind eye to these problems for a decade. In some cases, they exacerbated them through bungs and bailouts that papered over the cracks of poor performance, doing nothing to tackle the root causes of the problems they were facing. Well, no more. No more sticking plaster solutions. No more back room deals. We need to be honest about the problems – burdensome debt, onerous PFI payments – and transparent about how we go about fixing them.

First and foremost it is for organisations, working with others locally, to put their own houses in order to show how they can achieve the quality and sustainability of services consistent with foundation status. But where the underlying issue is not of their making, where they face difficulties through no fault of their own, we will help them. We will provide ongoing support to the small number of hospitals struggling with PFI deals to ensure that local services are protected, and one-off transparent loans to help recapitalise hospital trusts and enable them to sustain high standards of care and service.

But these hospitals will only be able to access this once they have met four key tests. The problems they face must be exceptional and beyond those faced by other organisations. They must show that the problems are historic and that they have a clear plan to manage their resources in the future. They must show that they are delivering high levels of annual productivity savings. And they must deliver clinically viable, high-quality services, including delivering waiting times and other performance measures.

These are tough tests, but they are fair – fair to the hospitals that are facing up to these problems, and fair to the rest of the NHS. These hospitals owe it to their local communities to take the tough decisions necessary to improve the quality of care. Hospitals that are financially out of control cannot properly serve the needs of their patients. And Clinical Commissioning Groups, as they take up their responsibilities, have to be focused on using their resources to deliver the best possible care for the patients whom they serve, not – as in the past – seeing themselves as having constantly to use a significant part of those resources to manage a system that is failing to manage itself successfully.

There is no point us arriving 20 years after the first proposal that there should be a purchaser-provider split and arriving at a place where the purchasers of care find themselves constantly mired in trying to deal with provider issues. We have to deal on the provider side in ensuring that commissioning groups have access to a range of viable, sustainable high quality provision in the NHS because actually that is in the NHS’s interest for that to happen.

And that is why we’ve established a transparent and open process to help them to do this. NHS trusts have set out and signed up to plans to make themselves clinically and financially sustainable.

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And that is why we’ve established a transparent and open process to help them to do this. NHS trusts have set out and signed up to plans to make themselves clinically and financially sustainable.
It is now up to them to deliver. It’s not an easy job. I have the greatest respect for the management teams who not only recognise that they have to face up to difficult decisions about how local health services can meet changing health needs, but are doing this in partnership with local people.

Take an example: Winchester and Eastleigh NHS Trust, who know they provide good care now but that they simply cannot sustain it on their own into the future. So they are partnering with Basingstoke and North Hampshire Foundation Trust because they know that in doing so they will be better able to develop services that can best meet the needs of local people.

Sometimes the root of a problem lies in the wider health community, and that is why we are making the whole system more transparent and accountable. But sometimes the problem rests with a hospital’s management team, unable or unwilling to take the difficult decisions needed to turn things around. I’m afraid for them I have a warning. You have signed agreements telling us and your local communities by when you will be clinically and financially sustainable. It’s why I corresponded directly with the chairs of all of those trusts in the autumn of last year. If your hospitals are not there by the time you say, you’re not getting there at all. The Secretary of State has the power to remove and replace management teams that fail to deliver, and I will not hesitate to use that power if needed. I can’t pretend this is going to be easy. But trusts owe it to their own communities and their own patients to do it.

And neither will we turn a blind eye to poor quality care. Many hospitals offer care that the most successful health systems in the world would be proud of. But there are others whose past problems became by-words for failure – obviously at Stafford General Hospital or at Maidstone and Tunbridge Wells hospitals. Extreme cases? Perhaps. We were told by Labour ministers each time that there weren’t any others. Perhaps not exactly the same, but we saw from the report that the Care Quality Commission (CQC) conducted into the care of older people, poor care is more common in our hospitals than many would like us to believe or, in some cases, admit.

Of the 100 unannounced nurse-led inspections, half of the hospitals visited gave cause for concern 20 – one in five – were not delivering care that met the essential standards the law and indeed their registration process said the public had a right to expect. And I have to say, separate from that, I was also pretty alarmed to see in 14 hospital trusts on the last year’s NHS staff survey, fewer than half of the staff of those hospital trusts said that they would be happy to see a friend or relative treated there – in their own hospital. Remember Robert Jones and Agnes Hunt, top of that list, and actually many of the specialist hospital trusts are - 95 per cent. These are 14 hospital trusts where that figure is below 50 per cent.

And there are people in this audience from outside the healthcare sector who will no doubt be able to transfer that thought to the questions that are asked about what people working in other services believe about their own organisation. I think if you were in an organisation where fewer than half of your staff thought that the service you provide would not be good enough for your family or friends, you would want to do something about it.

There are trusts in that 14 – trusts like East Lancashire Hospitals Trust, Scarborough and North East Yorkshire Healthcare Trust – who have got a long way to go. They provide good care in many instances, but we need to help them to arrive at a place where that kind of response simply does not happen in future.

Now I’m often told that satisfaction with the NHS is high and that therefore nothing must change. I’m also told by other people that there are serious examples of poor care, that that is somehow typical, and that everything must change. The truth is neither of those is right. We have to modernise. We have to improve. We have to raise quality for all. And especially, we have to shine a light on poor performance and then know that it will change, not because everything is wrong but because we want everything to be right.

It is not about being anything other than committed to the NHS. It is about being uncompromising in our commitment to securing the best for patients. That means both celebrating the NHS’s achievements and being prepared to shine a spotlight on poor performance, because poor performance is not simply a statistic or a line in a graph.
which shows that 70 per cent say they are satisfied with the NHS, I have to say that is great, but we want it to be higher. We cannot say that 70 per cent is enough. What about the remaining 30 per cent? Can we be content that they are not satisfied? Can we disregard the experience of an unhappy minority? The public perception survey gives us an indication of how well the NHS is doing, but it doesn’t tell the whole story, and it can’t be used to hide the pockets of poor performance that we see.

Just as the CQC’s report showed how different wards in the same hospital could have very different standards of care, the majority of customers in an external organisation might say they are satisfied with their bank or telecoms company. Of course, the difference is that if a bank lets a customer down, most customers have a choice. They can take their business elsewhere. An older person who is rushed to an emergency department does not have that choice. If we ignore poor care, we undermine the efforts of the many great NHS staff who do a fabulous job, even in circumstances that are often very difficult. And if we ignore poor care, we damage – sometimes irrecoverably – public confidence in the National Health Service.

When problems finally burst out into the open they are usually so serious that the public asks – rightly – why such poor care has been tolerated for so long. And too often we deny the experience of patients and their family members who have been at the sharp end of poor treatment. That is why earlier this year I asked the CQC to perform 100 inspections – unannounced inspections – in hospitals, focusing on dignity and nutrition. And it is why the CQC is going to go on now to perform an additional 700 inspections in hospitals, in learning disability services, and in care homes to identify and drive out poor care, especially amongst older people. These inspections won’t just focus on clinical care, but dignity, privacy and nutrition. Where they identify poor care they will take tough action, including ordering the closure of services if standards are simply unacceptable.

I want change in the NHS because I believe it can and should offer excellent care to every patient, no matter where they live, how old they are, or how sick they are. It means doing everything possible to root out poor quality care. A modernised NHS means greater transparency where great care and poor care will be visible in equal degree.

There was some effort by the last administration to encourage openness. Star ratings were an instrument introduced a decade ago to help the NHS focus on the quality of what it did. More recently, quality accounts allowed trusts themselves to give a more sophisticated account of the standard of care they deliver, and they include perspectives of patients to tell it like it really is. But of course star ratings gave you one rating for the whole of the hospital trust. It didn’t tell you about poor care on particular wards. Quality accounts, when they were first introduced, were effectively an opportunity for

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Bill strengthens the position of the NHS constitution so anyone who commissions health services will have to make sure that its principles and values are reflected in the services they commission for patients.

A modernised NHS is one that prizes clinical leadership, giving clinicians the autonomy they need to deliver better services for the patients. It also means addressing poor care. It is clinical leadership in hospitals, in Foundation Trusts, of medical directors, nurse leaders – frankly nurse and clinical leaders at every level in those organisations – but also clinical leadership in commissioning.

Clinical leaders and Clinical Commissioning Groups who know their patients, who know the services that they are accessing, who accept a personal as well as a collective responsibility for the health of the patients they look after and the population they look after. That clinical leadership is the only way we will address poor performance.

Actually, more importantly, it is the only way in which we will drive great performance.

Of course it must be the people who work with patients on the front line every day who know whether patients are being fed properly, whether they are getting pain relief, who have the power to change these things. Clinical leadership, clinical commissioning, and the relationship between the commissioners and the clinical providers of care are absolutely central to making those improvements. So it’s up to those clinical leaders to take whatever action is necessary to make sure that all patients are being treated with dignity and respect.

We will do everything in our power to make sure that every NHS organisation offers the best possible quality of care and is financially sustainable to continue doing so. We are going to give, whether it’s through quality provision, through transparency and data, whether it’s clear quality standards, the Clinical Commissioning Groups the tools to do the job.

They’re not just on their own. We are going to make sure they are in a culture and an environment that supports high quality care that shines a light on poor performance. Transparency, so patients and the public know how well the NHS performs. A stronger voice for patients. Support for whistleblowers where needed. Stronger leadership everywhere. A real focus on treating patients well and less focus on bureaucracy.

But where things are clearly going wrong and patients are being repeatedly put at risk, we will not stand by. We won’t wait on a repeat of a scandal like Staffordshire General. Under the 2009 Health Act there is an unsustainable providers’ regime, but it has not been used once. I will not flinch from using it if NHS trusts are clearly failing patients or failing financially.

So, my message today is this. Wherever there are pockets of poor performance, we will root it out. Where there are institutions that are letting patients down or are financially unsustainable, we will expose them. But where hospitals are doing the right thing but struggling with debts that are no fault of their own, where they have good plans in place, where they are facing up to the tough decisions they need to make, where the local health system has done everything in its power to help, in those cases we will help them.

And most of all, where there is excellence we will reward it and celebrate it. As I said right at the beginning, there is much excellent care in the NHS. We have an enormous number of truly dedicated and inspiring staff. They deserve – they have our recognition and admiration. Their ambition – and mine – is for the NHS to be excellent in every aspect and for patients and the public to be confident that they will get the best possible care for the best possible outcome. Thank you very much.

[applause]

Nick Seddon: Secretary of State, thank you so much for those words. The patient deserves nothing less than the best care that is possible, an emphasis on quality and rooting out poor performance, the institution of a failure regime, particularly with attention to finance, an emphasis on information that drives choice and transparency, and clinical leadership. There is a lot to get our teeth into. I will take questions in clutches if that’s all right. And so as Hamlet said, “come give us a taste of your quality.”

Ed Davie: Hi, Ed Davie from Pulse magazine. Earlier Mike Farrar said he was worried about the fact that a national quango will have so much control over primary care spend, and that same national quango will be able to remove principle officers from CCGs and to change the boundaries of CCGs without consultation. Are you worried yourself that you’re creating too much of a centralised quango in the National Commissioning Board?

Nick Seddon: Great, thank you. And then Stephen.

Stephen Hughes: Hi. Steve Hughes from Bevan Brittan. Secretary of State, two linked questions. The first is in giving away transparent loans are we merely going to perpetuate unaffordable debt for organisations that are already struggling? And are we going to end up with a genuine failure regime, and without one are we ever going to be able to make the radical changes that are needed?
Nick Seddon: Great. Thank you. And then Malcolm.

Malcolm Durham: Malcolm Durham. You talked about excellent quality of supply from the existing NHS service. Could you address one of the issues there regarding the supply of private sector companies and organisations? In my own experience there is an organisation of midwives who are being prevented from providing excellent services through the NHS due to the, can I say, incorrect application of the supplier status of such organisations being kept out of it. And just separately, you talk about whistle blowing and care and allowing people to raise concerns. Within the private sector mentoring is becoming a growing way of helping people to deal with not just problems but also to develop themselves to provide a better service, and I wonder if that is something you might consider in the longer term.

Nick Seddon: Brilliant. Thank you. Let’s take those. So the power of the independent commissioning board, the perpetuation of debt leading to the failure of a genuine failure regime, new entrants, and mentoring.

Andrew Lansley: Right, I’ll try and be quick. First, Ed, the National Health Service Commissioning Board – yes, it has a responsibility to deliver the direct commissioning of primary medical services, dentistry, ophthalmic services and pharmacy. I think because we are looking for consistency in that and through the contracting process for the professions, I think that is a real plus. But it doesn’t do it in isolation. It does it, for example, when you look at pharmaceutical needs assessments or indeed the joint strategic needs assessment conducted through the Health and Wellbeing Boards, that is one of the starting points – an essential starting point – for the view that the NHS Commissioning Board needs to take about its commissioning of services if there is a need for additional services in any particular area.

I think there is something slightly, I have to say, ironic in being accused of creating a centralised system in the NHS Commissioning Board.

I think there is something slightly, I have to say, ironic in being accused of creating a centralised system in the NHS Commissioning Board. The fact of the matter is compared to Primary Care Trusts, albeit that we are strengthening, as it were, the end bit in National Health Service in the NHS Commissioning Board, by creating statutory bodies in themselves in Clinical Commissioning Groups, clinically led, there is a major transformation in the shift of control in the National Health Service closer to patients and in the hands of clinicians. And all the things you described – basically insofar as Clinical Commissioning Groups meet clear, transparent standards for authorisation, then they are in a place where they are able to enjoy that freedom themselves to respond to the needs of their community and liaise with their community.

Second thing is, Steve, in relation to failure regime, well of course again it’s slightly ironic. I live in the world where I served on the standing committee of the Health Act that introduced Foundation Trusts, and we were told there was going to be a transparent failure regime set out in regulations, and it never happened. In the Bill I served on the standing committee of the Health Act that introduced Foundation Trusts, and we were told there was going to be a transparent failure regime set out in regulations, and it never happened.

at least with the Clinical Commissioning Groups – whose job is to be clear about what services are required for patients. And the failure regime has to deliver continuity of services for those patients, whether it’s Foundation Trusts, NHS trusts (while they exist) or independent sector providers.

And actually the essence of a failure regime is that there must be something which impacts on Foundation Trusts which is, because of their public service character and public sector character, different from the insolvency processes that would apply to an independent sector provider. Nonetheless, this enables us to be clear both that Foundation Trusts will not be protected against the consequences of their own failure – as indeed shareholders and owners of independent sectors are not protected against the consequences of their own failure – but in both cases patients are protected.

And I think that’s where we are, and we go through that process in the Lords of trying to get it absolutely right, but like many other things we’re having to do, there were things not done before the election which we’re having to face up to. And we are taking the brickbats for facing up to them. But that’s what we’re here to do, to make things better in the future by instituting what I regard as a long term structure that will be sustainable for the service.

The third point about supplier status - I said we would move from the concept of any willing provider to any qualified provider, but there has to be a process by which not only are providers meeting the essential standards, they are also compliant with NHS needs in terms of a qualification process. We’ll set out more about that. But of course as Clinical Commissioning Groups themselves look for something which helps them to drive quality, actually I think they will increasingly want to move away from a system which is based on single tender processes and competitive tendering which tends to focus then on price, not just quality. It tends in fact sometimes to elevate price above quality – and try to get to a place whereby the
extension of tariff, we get to increasing opportunities for any qualified provider.

I mean I find some of the sort of trade union and organisations’ antipathy to any qualified provider completely perverse because it is by its very nature shifting the NHS from competition on price through tendering to competition on quality based on patient and commissioning choice. GPs and their patients are able to exercise a choice between a range of providers based on quality because they’ve got an established tariff. It seems to me on the face of it a no-brainer. You want to have that kind of competition to drive that quality. You don’t want to have a structure which is constantly compromising on quality because of the nature of the competition that’s applied.

Nick Seddon: Fantastic.

Andrew Lansley: Also you did say about mentoring. I mean from my point of view I can understand and I’ve seen it in some – in truth, I’m hoping to move to a place where that kind of adoption of best practice is something which is part of the culture of management inside health and social care organisations. It doesn’t have to be prescribed by the Secretary of State, but I completely understand what you say.

Nick Seddon: Right, thank you. I’m allowed three more questions so I’m going to go this side of the room because their hands went up first. It’s Nick and then Norman and the gentleman on the front row here.

Nick Bosanquet: Nick Bosanquet from Imperial College. Wouldn’t it be possible to redesignate the funding help for hospitals as a fund for service redesign which would be allocated in relation to jointly agreed strategies with the commissioners? Because certainly service redesign is the absolute challenge over the next few years, not least in the South East where there is a fairly general problem with about 50 per cent of hospitals having financial problems.

Nick Seddon: Thanks, Nick. And Lord Warner?

Norman Warner: Norman Warner, one of those weak, underperforming former health ministers who only got public satisfaction up to 75 per cent.

“...I was actually taken on the point of clinical leadership made by yourself and was wondering if in mirroring your reforms about GP-led and clinical commissioning groups, would you mirror medical leadership on the provider side by having something along the lines of consultant-led providing?”

Faisal Shaikh: My name is Dr Faisal Shaikh. I’m a consultant psychiatrist and clinical director in Dudley and Walsall. I was actually taken on the point of clinical leadership made by myself and was wondering if in mirroring your reforms about GP-led and clinical commissioning groups, would you mirror medical leadership on the provider side by having something along the lines of consultant-led providing with the premise that medical leadership research has shown that medical engagement has led to driving up quality and improving performance and patient safety. And I understand there is an elaborate medical management structure in most organisations, but there is the lack of authority over corporate structures such as priority setting, financial management. There is mere influencing of medical managers in these areas, and perhaps position medical leaders close to the senior management chief executives, would that be something that would mirror GP-led commissioning and thereby drive quality and improve performance?

Nick Seddon: Fantastic. Thank you. So there are two questions really about redesign. One, could the bailout actually be a fund for redesign? Norman’s point reminds me of the Groucho Marx principle: “I have my principles. If you don’t like them, I have others.”

[laughter]
Nick Seddon: How are you going to prevent the Groucho Marx principle coming into play in redesign? And then a question about clinical leadership and consultant-led providing.

Andrew Lansley: Right, Nick, I mean we have a fund for service redesign. It’s part of the current process of – I think this year, as last year, there was a significant proportion of total resources allocated to the NHS which was specifically intended to be held for non-recurrent investment in service redesign. So under the quality, innovation, prevention, and productivity programme – the QIPP programme – that is happening.

What I’m talking about, and maybe I didn’t really answer this point from Steve as well, what we’re talking about is recapitalising NHS trusts to a place where they can become Foundation Trusts, as long as they meet the tests that I mentioned. That isn’t a transfer of spending power from anybody else and it doesn’t give them any additional spending power. What it does is recapitalises them as trusts. So to that extent it isn’t their ability then to go and spend it because we’re not intending it to be any kind of a bailout, which is what we’ve had in the past. They’ve been given money, in effect, simply to cover annual debts. More will become obvious as time goes on, but I would urge you to avoid thinking that this is somehow spending power being transferred into them or away from anybody else.

Norman, of course you are to be exempted from any strictures on past governments.

[laughter]

Andrew Lansley: I actually think it’s interesting because this afternoon I have to rush back because Andy Burnham has got an Opposition day debate and one of the thing he’s saying is that when I said at the last election where there would be a moratorium on, for example, forced closure of A&E and maternity hospitals, he’s complaining because the moratorium has not turned out to be something that stops it happening forever, because of course a moratorium is precisely what it says. It is a pause. We’re fond of pauses. They can do you a lot of good.

[laughter]

Andrew Lansley: And what it has meant in a lot of places is the opportunity to apply critical tests. They’re about consistency with patient choice, consistency with the public’s view as expressed through local authorities, democratic institutions, consistency with clinical evidence about quality and safety, and consistency with the prospective decisions of commissioners, particularly of course we were talking about the future commissioning groups as they were establishing themselves.

My experience is that the application of those four tests has made in many cases a considerable difference. It hasn’t completely eliminated controversy and political difficulty. But I could take you to places – and I probably won’t list them because everybody will instantly head off and try and work up trouble – but there have been a lot of places where what was prior to the election, to my personal knowledge clearly a failure for the public, GPs, clinical opinion and local authorities to have been brought together in order to agree that this was the right thing to do. And I can think of half a dozen places since the election where now such reconfigurations are proceeding, and they are proceeding effectively with public and clinical support.

And when you look at future reconfigurations, we don’t really need to have a moratorium because they should only get to a place where they’re about to happen where they meet those four tests. And it will be very difficult for politicians – local or national – to say well you shouldn’t be doing this thing in circumstances where those four tests have properly been met because by definition it’s clinically good for patients. It’s what their clinicians are supporting. It’s what the local authority supports, and it’s what the public themselves want in terms of choice.

And when you look at future reconfigurations, we don’t really need to have a moratorium because they should only get to a place where they’re about to happen where they meet those four tests. And it will be very difficult for politicians – local or national – to say well you shouldn’t be doing this thing in circumstances where those four tests have properly been met because by definition it’s clinically good for patients. It’s what their clinicians are supporting. It’s what the local authority supports, and it’s what the public themselves want in terms of choice.

The third question, it’s a very good question. When I sat round the table in Dudley with the clinical commissioners, they, like everyone else that I was talking to, illustrated what they were doing by reference to the way in which they were thinking about referral pathways in their area. And mental health services – as in so many other places – is one of the places where they are putting their effort into the redesign of clinical pathways. And they are doing it with their specialist colleagues from a range of healthcare providers. And that’s vital they do that.

I think from my point of view, I’m not proposing to tell hospitals how they should manage themselves. I’m trying to get out of trying to do that business if I possibly can. I’m trying to arrive at a place where
And the understanding is that integrated care will be essential to improving quality and driving down cost, and I think there is an enormous amount of evidence from international studies to say that this is the case, that the challenge really is doing the right things and doing the right things in the right ways and doing the right things in the right places.
Pathfinder. Charles is sure well known to all of you. He’s been very prominent in the health debates in the last 18 months and also well before that. He advises trusts including Kingston and Lewisham. He’s led the pathfinder. He’s been one of the key champions of the new world. So I am delighted that Charles is speaking and I’m sure will have very clear picture for us.

Next in line is Zack Cooper, an academic at the LSE in the Centre for Economic Performance. Those of you that keep in touch with debates about choice and competition will be aware of the fact that Zack is one the pre-eminent analysts of competition in hospital and insurance markets much loved by the BMA and BMJ, who write him thank you cards regularly.

[laughter]

Nick Seddon: Zack has written speeches for policymakers and politicians and endless pieces for newspapers – a very familiar face both here and – his accent will inform you – on the other side of the pond.

Then Matthew Swindells. I was looking through Matthew’s biography yesterday when I was preparing and realised that he has a terrifyingly impressive set of achievements, ranging from running a large acute hospital and turning it around to being a policy adviser for the Secretary of the State, and then on the NHS Management Board as the NHS’s first Chief Information Officer, then at Tribal. He is a visiting Professor of Management at the University of Surrey, Chair of the Charitable Trustees at Imperial College, HRC, HSC and the Chair of British Computer Society – or the health division anyway.

And then the final speaker is Viggo Birch form Novo Nordisk. And Viggo has been with Novo for 23 years. He’s worked all over the world on certainly two major continents – Europe and Latin America. Spends a lot of time in Spain and Portugal so he has a very good understanding of the contextual debates here on integration and a very specific interest from pharmaceutical perspective on how integration could drive improvement in the uptake and use of medicine, which I think is very important and interesting. Viggo also has a list of achievements: Chairmanships, Trusteeships and Board Memberships that again makes me wince, but we are delighted to have Viggo here as well.

So the order of play, as per the previous sessions, is that each will speak for five minutes and then I will chair a Q&A with the single responsibility to make sure that I finish at 13:00 so that we can all go and enjoy lunch and carry on the conversations.

Charles Alessi: Thank you. I think I will start by reflecting for a second about some things I heard earlier this morning about clinical commissioning. Is clinical commissioning really new? And yes, of course, we do need a failure regime, but is failure something which is likely to be new within the NHS? And I think on both those counts I have somewhat different take. One on failure. I may be one of the few people to know this, but I have been associated with an NHS that has had PCTs fail for the last I don’t know how many years on occasions. So failure exists within the NHS of the moment anyway. We have good ways of managing that because what tends to happen is a process is set up whereby Primary Care Trusts around the Primary Care Trust that has had a problem come together to support it through a transition – and similarly with trusts.

And also is clinical commissioning new? Well aspects of it are perhaps less new. Every time a clinician gives a patient a prescription or a referral, in essence that clinician writes a cheque. So the process of clinical commissioning I think has been in existence for a long time. And it would be helpful if we thought of the changes that are taking place perhaps as not completely new and different, because there are a lot things have been happening for a long time. This is just a somewhat different take on them.

But coming back to the subject I’m supposed to be talking about and that’s integration – I think integration is an extremely good concept. And if we think in terms of why, I think there are many reasons we can come up with. It clearly reduces duplication. It clearly increases value – not financial value but value in terms of the quality of service that’s been provided – because once one has well stitched in service, one reduces the problems with the interface. And if we look at where most of the complaints around the NHS take place, it is around that interface because we’re all very good in our own organisations at ensuring we have some really good walls around it. And we toss the patient over those walls, often in the vain hope that there will be somebody at the other end who will pick that patient up. Sadly sometimes there’s nobody on the other end and the patient crashes to the ground.

And if we look at where most of the complaints around the NHS take place, it is around that interface because we’re all very good in our own organisations at ensuring we have some really good walls around it. And we toss the patient over those walls, often in the vain hope that there will be somebody at the other end who will pick that patient up. Sadly sometimes there’s nobody on the other end and the patient crashes to the ground. So I really think the interface issues will be dealt with better once we have integrated care.

But does integration in itself actually answer all the problems we have? I don’t believe that it does because it only has coherence if it’s in the context of population health. And population health is really what for me these reforms and the clinical commissioning aspects of these reforms are about.
An NHS for patients: Making clinical commissioning work

It’s moving down the pathway of integration of health and social care. It is tying in fiscal responsibility with clinical behaviour, and it is getting people to understand that the treatment of an individual is in the context of a population. And by a population one also means an unregistered population within the geographic area that one is dealing with, because unless we have some solutions to that population, clearly the whole concept lacks coherence.

So going back to population health, it’s very interesting the way that we have somehow ignored the fact that we do have responsibility around managing the health of populations as well as individuals. And I am really not quite sure why we’ve done that over the years, because we have a real opportunity now around thinking in terms of local authorities perhaps at least as much as thinking about clusters and new organisations that are set up as part of the National Commissioning Board. And if we look at the last couple of years, we look at what’s happened in places like London where the treatment of stroke has been transformed. And I would advise any of you who is thinking of having stroke to come to London to have your stroke because it is by far the best place to have a stroke in terms of the outcomes.

[laughter]

Charles Alessi: But that’s only as regards health. And if we think in terms of what happens once one is discharged from a hospital after one has had the stroke, the care is as disjointed and in many cases as dysfunctional as it always has been. And I think there is a real opportunity here for us to start thinking in terms of co-commissioning with our local authorities around the whole of the pathway because I think this can bring real advantages.

So coming back to local authorities, there are immense advantages to us thinking in terms of them as being strategic allies. Health and Wellbeing Boards are organisations. They are organisations which will ensure that GPs do not earn £1 million because if there is a change to healthcare and to a pathway which is commissioned by a Clinical Commissioning Group, it will have to pass an acid test. And that test is: will this change actually benefit a population, or will it merely be a translocation of services into a community? And I think it’s clear that if we do not get the added advantage around a change, perhaps there’s a question as to why one needs to make that change in the first place.

There’s also another advantage with Health and Wellbeing Boards. We can think in terms of ways in which it can assist us with selecting the any qualified providers. And there is a pathway we can follow end to end, starting with pharmaceutical needs assessment, joint strategic needs assessments, identifying either inequalities in the way that the service is provided within an area or differences in terms of either quality or even cost, i.e. too much cost for poor quality compared to our peers. And that will lead us to think that we should be using the any qualified provider route to ensure that we plug that gap. And by using the any qualified provider, I might add, it’s really important that we include our local acute trusts as a part of that process because that’s not necessarily close to them. That’s self-evident, but I think a lot of people forget that.

So for integrated care to work we really need to be thinking in terms of secondary care, actually understanding that they inhabit the same geography we inhabit in primary care, and they also have a fiscal responsibility.

So I’ve run out of time. I’ll leave you with one final thought as to why so many clinicians seem to be against the reforms, and I think it’s around the way the question has been asked. If you had to ask me whether I wished to practise my pure craft without having any fiscal responsibility whatsoever – if I have a choice – I probably would say, like most of my peers, I’ll just practise my craft and you can deal with the fiscal responsibility yourself. But if you had to ask a clinician: you live with in a state-funded system where there are finite resources determined by the state as to be used for health. Do you wish to have an influence on how those are spent? I think the answer you get may be somewhat different.

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[applause]

Zack Cooper: Thank you. So I’m an American economist working in Britain and talking about introducing competition into the NHS. I get it. I’m sort of literally and figuratively playing an away game. I get asked a lot to talk about this relationship between

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I think too often what we see in the NHS is a system that’s designed for the convenience of those working in it, not for those getting care. If I’m a patient, I don’t care about primary care versus secondary care. I don’t care about primary medicine versus surgery. I care about healthcare.

What integration looks like. What does integration actually mean? And then talk a little bit about how we get there. How do we move from the service we’ve got now to one that is more highly integrated?

I think this integration debate came up because it was viewed as the antidote to competition. Folks didn’t like competition. They were very sceptical of it. Integration was viewed as the opposite. And I think we’ve got to stamp out that view. Integration cannot be for getting rid of financial incentives within the NHS. It cannot be for rolling the NHS back to some 1985 service without incentives for quality or productivity, where providers are allowed to silo amongst themselves and not be accountable to the system. That’s not productive integration.

You know, and I think here it’s worth thinking about what productive integration looks like and differentiating that with unproductive integration. Now look, I’ll be the first to admit that we need integration – lots of it. But the question is: what does that mean? Unproductive integration to me is essentially a merger between primary care and secondary care where providers do the same thing but in a less competitive environment with fewer incentives for quality. That’s unproductive. Fewer incentives, less control over the system – and I don’t think that’s going to lead to better outcomes. Unproductive integrations are horizontal mergers between hospitals and organisations. They come together and again do the same processes they were doing before in bigger units.

Now I think we can contrast that with productive integration. And I think too often what we see in the NHS is a system that’s designed for the convenience of those working in it, not for those getting care. If I’m a patient, I don’t care about primary care versus secondary care. I don’t care about internal medicine versus surgery. I care about healthcare. And so I think productive integration looks at what the patient sees and designs a service around them. So services that are built around conditions, built around diseases – breast cancer clinics, hip replacement clinics, diabetes clinics where all the providers who you would need for that service are integrated into one unit. That for me is productive integration. It’s the head and neck cancer clinic at the Cleveland Clinic where you’ve got surgeons, you’ve got general medicine doctors, you’ve got rehabilitation specialists, you’ve got audiologists all coming together to provide excellent care for those conditions. It’s driven by the demand side, not by the supply side.

And so I want to think about what are the essentially three steps we’ve got to take – three quick steps. The first is, I think, this idea of patient-led integration shouldn’t be driven by the supply side. It should be driven by what the patient wants. Second: information, information, information. Measure outcomes – patient reported outcomes, patient experience, how well they do. Let that be the arbiter of what integration looks like. And the third is I think going to be the most controversial. Send patients further for care. We can’t do the same thing in every region of the country. It’s bizarre that we think every area needs to do everything and do it well. Be comfortable sending patients further. Show them what good outcomes look like. And let them travel 30 miles, 60 miles to get that excellent care. That’s going to provide the competitive pressure to get the good local service. It’s not choice or a good local service. It’s choice gets you the good local service. So now I will hand over to Matthew.

**Nick Seddon:** Thank you, Zack, very much indeed.

[applause]

**Matthew Swindells:** Well thank you. I would like to talk about the clinical part of clinical commissioning because I think we’ve probably established that driving 20 per cent productivity out of the 3 per cent that the NHS spend on management costs isn’t probably going to add up. So we’re going to have focus on what the NHS spends the rest of its money on, which is the delivery of the care to patients.

If you look at industries around the world and how they have fundamentally transformed the productivity of the way they work, they only do two things. One of them is that they shift their workforce to somewhere with lower labour costs. That’s not a...
brilliant strategy if you are trying to deliver an inner city GP practice. The other thing that they do is fundamentally redesign the relationship between their organisation and their consumers, the way they run their organisation, and the way in which they use information and technology in order to transform practice. And that is the only option that is available to the NHS.

So the question here is can clinical commissioning be used to drive that transformation of the relationship between the patient and the NHS, the way the NHS operates, the way the NHS uses technology and information in order to create a cheaper, better NHS that can face up to the scale of the challenges that we face. And we know from the stories of variations in care, and the fact that you can almost never correlate the variations in quality of care with the cost of that care, that the opportunities are out there. I would like to pick out what I think we know works which is that evidence based care works, and when the evidence supports integrated care then we do the right integration of care. And when the evidence doesn’t support integrated care, it supports competition, we do competition around care, but picking the right integration. We know that that works.

The first element of that is patient engagement. In my organisation Cerner, pretty well all the staff carries one of these. It’s a wireless pedometer. It’s a Fitbit. It links to my electronic patient record, and when I was given one I was told that a healthy person should do 10,000 steps a day. And when I plugged it in I discovered I was doing about 8,000 steps a day. Now as a Manager I know that you deliver what you measure. I now do 10,000 steps a day by making small changes in my behaviour.

The role of communities, of employers, and of other organisations beyond the NHS being enabled to drive the health of population is a key element of the redesign of the NHS’s relationship with its consumer, in order to create a healthier population. And when we think of 900,000 people in this country who are receiving services from anticoagulation clinics, either going in once a month into their GP or going into hospital to have their medications adjusted, the published evidence shows 80 per cent of those patients could be testing their own bloods, adjusting their own medications, and not using the NHS on such regular basis. That’s better for the patient in terms of outcomes and results in a lower cost for the NHS. We need to change that relationship.

The second thing that I would like to pick on is how we think about end to end care. There are technologies out there – like MCAP, like InterQual – which allow you to use clinical evidence in order to assess the appropriate level of care that a patient needs. Every time you test a hospital in this country you find 30 to 40 per cent of the patients in that hospital don’t need to be in a hospital. It’s not that they don’t need care. It’s that they don’t need to receive that care in hospital. And yet we don’t use it all the time, we don’t use it in a rigorous way, and we don’t redesign our services around the outcome of evidence based management, which means that we run around saying what services are we going to stop rather than what services are we going to redesign.

So the use of technologies like that and the use of technologies which will allow you to link up care – one of the failures of the national program has been to silo healthcare again. We need to bring back in the technologies that will link up hospitals, community services, primary care and the role of the patient themselves and what they can access at home, in order to allow us to design care pathways where the technology supports care being delivered in the right place. If you know something in a hospital laboratory and a district nurse goes into someone’s home, the evidence can be brought together to produce the prompt to lead the care because the third thing that we know is that evidence based care is cheaper and better.

There is a mountain of evidence that shows that if you do the right thing, you make fewer errors, and patients get better more quickly. A great study of 60,000 patients in America with the simple problem of pneumonia in hospital: half of them were receiving evidence based best practice, half of them weren’t. The half that were had a third shorter length of stay, a third lower cost and a third lower mortality rate. It is cheaper and better to do the right thing.

Why don’t we do the right thing all of the time. Well NICE has shown that the half-life for half the doctors to adopt a new piece of evidence is 17 years. So anything that is invented now, half of doctors will be doing by the time I retire. So if you’re working in the field of research around elderly care, now would be a good time to publish.

[laughter]

Matthew Swindells: Why? Is this because doctors are difficult? Of course doctors are difficult, but is this the reason? No. The reason is this – there was a piece published a couple of years ago saying that at the point at which you became a consultant – you come
out of medical school and you become a consultant and you know everything that there is to know about medicine – if from that day onward you read and remembered two journal articles every night for a year, at the end of the year you would be only 1,225 years behind on your reading.

We have a healthcare system that is based around memory based healthcare, and it is insane. You cannot do it in a modern environment. We have to do what works, and we know that what works is providing evidence based decision support into the clinical pathway. Giving doctors the internet which allows them to look up the guidelines has 0 per cent impact on their behaviour. Giving them evidence based pathways into their clinical practice has a 75 per cent impact. So we know better care works. We know that it is cheaper and has better outcomes. We know how to drive it into place. We know that is the only place this solution sits. The question is can we drive it into place. And I would say clinical commissioners need to rage against memory based machinery for production of concrete – dosing and the ingredients of that. And I couldn’t help, seeing Mr Lansley this morning being very passionate and very proud about the NHS – “the best in the world”. And I’m sure it is. I’ve heard many Health Ministers from around the world saying the same.

[Viggo Birch: About their systems of course. Our company, we are specialised in diabetes. And in diabetes I can just tell you here in the UK almost 40 per cent of all people with diabetes are in so-called bad control. They are in potential danger of developing long term complications. And those are the ones that are driving the cost. Diabetes costs the healthcare system 10 per cent of the budget – £10 billion every year. And I can assure you it’s not because of the medicine or drugs we give because they are only accounting for 5 or 6 per cent of the diabetes budget. But it is the lack of care that is not good enough. And it’s not good enough anywhere in the world. So I won’t say that you go to Denmark and you’ll see there it’s only 10 per cent in bad control. No, no. It is basically the same percentage all over the world.

And it’s because the systems – all the healthcare systems – are based on acute care. And we need to integrate the services. And integrated services – or I could say shared services – mean really that we need to share, to eliminate the barriers and, as Zack said, see it from the patient’s point of view. The patient doesn’t care what primary and secondary care is. The only thing that counts is that they have access to all the services. There are examples from Diabetes UK where people with diabetes have been reliant on 14 different NHS services. Imagine those spread out all over the place with variation in quality.}

management consultant for a company that produced machinery for production of concrete – dosing equipment. They were actually the world leader at that time. This is many years ago. I was very impressed at that time when I went into the workshop and saw a sign on the wall stating that good concrete consists of water, pebbles, sand, stone and cement. And then there was another sign saying bad concrete consists of exactly the same elements.

And that has followed me throughout life because this is actually a key picture of how to deal with chronic diseases. The elements are the same but what really makes the difference is how you manage the everything and the ingredients of that. And I couldn’t help, seeing Mr Lansley this morning being very passionate and very proud about the NHS – “the best in the world”. And I’m sure it is. I’ve heard many Health Ministers from around the world saying the same.

[laughter]
Nick Seddon: I’m taking the executive decision to slightly reduce the final 10 minutes that we’ve got for the closing remarks because they’re often a bit too boring anyway, and therefore give us another 20 minutes or so now for a proper discussion, partly because I’ve had to shut everybody off before they would have liked to have finished and partly because I think there is so much interesting stuff that’s been thrown up about – well, I’m not even going to try and summarise, but things that have interested me: silos versus organisational integration, good quality costs less, the importance of fiscal responsibility among clinicians, the relationship between productive and unproductive integration. Information has come through very, very strongly, I think, in a number of comments, and the importance of measurement and evidence based care, the over dependency on acute care being inappropriate for chronic diseases. And I love the good concrete and bad concrete analysis. So lots to get our teeth into. I’ve seen three hands go straight up. One straight at the back, and then one is Niti, and then one is here, Mike.

Michiel Verkoulen: My name is Michiel Verkoulen from the Co-operation and Competition Panel. There is a lot of talk about competition being in conflict with the idea of integration, and I wonder if there are actual examples of that being the case because I find it very hard to think of those examples. So perhaps the panel can help me.

Nick Seddon: Thank you. Mike, I think you were next.

Mike Sadler: Chief Operating Officer from Serco Health. Slightly unfortunate in some ways that on a session on integration we didn’t have any local authority representative present. So perhaps I could ask the panel to act as proxy. Given that there are some new powers going over to local authorities around some ring fenced funding, the leadership of the Health and Wellbeing Board, the transfer of the public health funding, how do you think local authorities should best use those new powers for the benefits of patients and clients?

Nick Seddon: Great, thank you. And then Niti.

Niti Pall: Just very interestingly, on the comments that Zack made. Could I just ask the panel to perhaps think of primary care as productive integration, because that’s what we do in primary care? We integrate complex patients’ pathways and we coordinate care. And may I just put it to you to perhaps consider that extending that piece is what I would call integrated care in communities, because that’s the challenge we’re facing. And then on the other hand, having just returned from India operationalising a primary healthcare business where it doesn’t exist in India, having met the likes of Devi Shetty in Narayana Hrudayalaya and Aravind Eye Hospitals, the concept of integration looks extremely different because there are no concretised systems there. So I think it is about creating some of that energy within our systems here, and I would like the panel to consider that – particularly the one about primary care bringing productive integration.

Nick Seddon: Brilliant. Thank you. Charles, would you like to just come back straight on this question of productive integration?

Charles Alessi: Well, I mean what could I do other than agree for two reasons. One, I value my life and to disagree with Niti is dangerous.

[laughter]

Charles Alessi: But two, I actually also agree. I think that is the model. And taking communities and the population with you is the model, and your patients with you, as you quite rightly say. I’m also really struck by the Indian connection because clearly what they’re managing to do in India certainly in terms of cataracts is something that shames us all in terms of what they’ve managed to achieve: extraordinary quality for unbelievably low price.

Zack Cooper: I take your point. I think what I would like to do is stop using the word integration – I mean just like I would like to stop saying choice competition – because I think integration means very, very different things in different services. The integration that we would need in cardiothoracic care or cataract care is going to be very, very different integration than you’re talking about in primary care.

I think there is an extent to which the NHS is talking about integration where it’s actually trying to find a way to deal with the perverse incentives of the payment structure.

The integration that needs to happen for the diabetic patient, clearly primary care has a role. Now for the person with a hip replacement it’s probably a
little different. So I think it’s massaging in that nuance when we talk about integration.

**Nick Seddon:** Just to come back on Michiel’s question about competition and integration and whether or not they’re in conflict, is there any evidence about that? Do you know?

**Zack Cooper:** Not that I’ve seen. I mean I think the only thing you can look at is in times in the US where they’ve seen pretty heavy increases in competition up until about 1980, 1990. And what you see is actually competition between integrated units. So you see organisations like MD Anderson actually going out and trying to integrate with organisations outside of their region so they expand market share and get them. It’s a hub and spoke model where they operate – it’s kind of like the Catholic Church. They’ve got the church in your neighbourhood, they get you hooked, and then they bring you to the Vatican if you need surgery.

[laughter]

**Zack Cooper:** That’s the one I wish I hadn’t said in a room on the record.

[laughter]

**Nick Seddon:** Yes, where was the internal edit faculty when you needed it.

**Zack Cooper:** Not there.

**Nick Seddon:** Matthew.

**Matthew Swindells:** I think there is an extent to which the NHS is talking about integration where it’s actually trying to find a way to deal with the perverse incentives of the payment structure. So we talk about integrating organisations because where you see perverse competition or unenforced competition is competition around the budget in a patch where a hospital doesn’t want to let go of patients who could be treated elsewhere, because it’s their income stream. And Mike Farrar talked about this, and I think we could make a lot of this problem about forcing structural integration versus organisations just doing the right thing around the

patient if we designed the financially flows appropriately. I was talking to a colleague from GE during the coffee break. Cerner and GE compete the hell out of each other in some markets and partner in other markets, and actually compete and partner in the same markets depending on what they think the customer wants. So all over industry that idea of both competing and partnering works absolutely fine. And in the NHS we have this perception you have to be one or the other.

**Nick Seddon:** And is that just contractual? I mean the balance between competition and collaboration for want of using those terrible buzzwords, is that just about whether or not you use contracts, or is there something more to it than that?

**Matthew Swindells:** I think it’s around the alignment of incentives, and I think it plays a bit to Mike’s question about local authorities as well in that there is almost reverse competition at the moment between the NHS and local authorities trying to dump patients on each other because they’re different budget pots. And if you want to address that then we have to create an integration that actually runs across the pathway of the care for a patient rather than along the structural boundaries of the institutions.

**Nick Seddon:** Viggo.

**Viggo Birch:** If I can just add, I don’t think you can say that primary care is the integration. I think we should forget about the physical locality of it and we should look at the patient pathway. One of the issues when you talk about complicated chronic diseases is that the know-how is not necessarily there to the extent it should be. And that is where you need a dialogue with the specialist and with the consultants. And I don’t think you can do without it, but you can probably do 80 per cent of the work in primary care, but you need to get the consultants into the community, or you can go into the hospital. It doesn’t really matter. One of the barriers there – and this is contrary to what Mr Lansley said – is that the Foundation Trusts in my book are one of the biggest barriers against integrating care because they are building a bomb shelter around an artificial service. And then you will never break out of it. And you need to break down the pyramid, you need to break down the hospitals, and you need to put it all on the middle of the table and then you start from there.

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coordination of care, and that’s what I meant by primary care being integration.

**Nick Seddon:** OK, we’ve got – thank you – lots of strands of thought running. I’m going to go back to Andy and then to Norman for two further questions or comments.

**Andy McKeon:** Thanks. Andy McKeon again. The theme of this conference is obviously that clinical commissioning is the way forward, but I just wanted to just challenge that for a moment and I’ll say three points. So Charles, you talk about commissioning across Clinical Commissioning Groups and local authorities and social care as the way forward, but I don’t know how that’s going to work when lots of people in social care will have personal budgets – 300,000 now, target for everybody to have a personal budget. So I don’t know how commissioning is going to be integrated.

Matthew, I thought you gave some fantastic examples of integration and how that could be achieved in improvement in cost and quality, but actually most of them didn’t seem to have much to do with commissioners to me. There was one that might about providing appropriate care in appropriate places where you could see people shifting money, but actually the providers could do that.

And lastly on Viggo, on the 14 services that diabetic patients have to go to, I mean the fact is there will soon be four commissioners for those 14 services spread across Clinical Commissioning Groups, the National Commissioning Board and Public Health England and local authorities for some public health prevention services, all of which means to say to me that integration of a service with those four commissioners is going to be very difficult.

**Nick Seddon:** Thank you very much.

**Norman Warner:** Norman Warner. Very simple question for the four members of the panel. You’ve got a Bill going through Parliament. How do you want the legislature to actually change the pricing system in that Bill to create the incentives you want to see?

**Nick Seddon:** Can we just go for one more, a couple of seats down.

**Richard Edwards:** Good morning. I’m Richard Edwards from Boots Opticians. We are the current holders of The Sunday Times’ Best Big Company to Work For, and we did that at a time when we were integrating with a competitor. And the background to my question is in terms of the holistic view and the integration in terms of change, one of the things that we had to focus on was being really, really focused on our customers and our colleagues ahead of our systems and processes. And my concern around this whole change that’s going on in the NHS is do the panel believe that there are mechanisms in place to truly engage the workforce in the change that they are going to be asked to deliver?

**Nick Seddon:** Brilliant. Thank you. Well I won’t try and force you to try and answer any particular questions. But can I start with Viggo – answer whatever you want, Viggo, but I will steer you slightly on the differences between 14 services and four commissioners and the accountability structures within the system.

**Viggo Birch:** I think that’s a good point. I think coming back also to Mr Lansley again, he was very proud of his organisation. And it has all to do with the management. We are talking about financial management. We are talking about processes. We are talking about systems, you know. And I have a very pragmatic perception of all that and structures. It’s like religion. It depends on what you believe in, right? Because what really counts at the end of the day is how it’s being managed. And we haven’t talked about quality of management, how you make your employees proud of it. And I think pharma can play a role there in working together on business premises with the NHS in developing better management structure. And that also goes for incentive systems. Incentive systems, I think, should be the same for all. They should be based on outcomes and not on activities and processes, but on final outcomes because that, at the end of the day, is what counts. So I think – and that’s coming back to my concrete example. It’s really a matter of managing, and we have not addressed that in the whole process. And you cannot legislate about that either, but we need to address that much better.

**Nick Seddon:** Thank you. Matthew, do you want to reflect on any of those particular themes, and I suppose perhaps Norman’s point about the pricing mechanism and any recommendation?
Matthew Swindells: Yes, I’ll pick that one up, and I’ll pick up Andy’s question about whether this is anything to do with commissioners. Let me just talk about that first because my view is the reason that this isn’t solely a commissioner point. We frequently make the mistake in the NHS of reducing questions to something that’s simple enough to answer rather than trying to solve the question as complex as it really is. So from a commissioner’s point of view we need to create an environment where doing the right thing is the right thing to do for your organisation as well as for the patient. Otherwise you’re in a constant struggle between what’s right for the patient and what is right for your organisation. And Andrew Lansley standing up and saying if you don’t balance the budgets I will sack the management team, well I’m pretty confident the management teams will be sitting around talking about their budgets first and the design of patient care last unless we can align those two things in such a way.

So commissioners need to create mechanisms whereby they’re commissioning capitated risk around groups of patients where they’re creating a different structure. I would say if I was a Clinical Commissioning Group commissioning diabetes, I wouldn’t be commissioning it from a hospital at all. I would be commissioning it from people who provide diabetes services, who may pick up a bit of support from an acute hospital as part of that. And I would like to see patients being able to choose which of those organisations they go to for their years’ worth of care to support them in managing their own diabetes. Now I think that’s a commissioning issue. That’s not simply hospitals should just redesign it and get on with it. And I think if you look into the States and what they’re doing around Accountable Care Organisations – what Don Berwick is trying to do with Medicare – they’re trying to make that step across as well about saying it’s about a population and the total cost of health, not the cost of an individual episode.

So that runs into the answer to Norman’s question, that we have to get to a point where commissioners are able to contract for things but aren’t hidebound by do a hip replacement, you get paid £2,000 for it, and into here is a group of patients who are at risk of falls. What is the structure and the payment mechanism that will allow us to stop them from having a fall and ending up in hospital? And the success – when I ran a mental health service, service failure was a patient being admitted to hospital. We had community based teams whose target was to stop people from being admitted. You turn it into a payment by finished consultant episode and what you’re doing is you’re building wards. So we need to create within the payment mechanism the ability to structure not around just the event but around a year’s worth of care or five years’ worth of care.


Zack Cooper: I’m going to try to answer Andy’s and then Lord Warner’s, and Richard, we can hopefully talk after. I wear my reductionist label with pride. We talk a lot about why commissioners fail, and part of it is we’re bad at commissioning everywhere: in the US, here, in the Netherlands, everywhere else. For me it comes down to data, that until you can tell what good care and bad care looks like you can’t purchase effectively. And so I think the solution to fixing commissioning isn’t to reorganise commissioning. I think it’s to measure and then get better at that, and then we’ll be able to purchase.

Lord Warner, I want to give three concrete steps. Now I got into a little kerfuffle with the Secretary of State for Health about price competition versus fixed competition.

Norman Warner: You’re in good company.

[laughter]

Zack Cooper: Indeed. First step is you expand the tariff everywhere. You start rolling it out more broadly. To get from one to 10 you’ve got to crawl through two, three, four, five etc. So you expand the tariff out. That’s the first thing. And then you start playing with the tariff. You pay more for following evidence based guidelines. You make it more profitable to do a hip replacement according to NICE guidelines. And once you’ve got the information in place – you know, and this was my issue with price competition – you couldn’t have price competition with bad information. But in five or ten years when we’re great at measuring patient outcomes, when we know what good care looks like, then you can start dipping your toe in the price competition water.
very, very clear sense of what good care looks like. So you expand the tariff and you then tier and steer so that it rewards evidence based guidelines. You promote quality. And then over time you transition to price competition where you can really measure quality.

**Nick Seddon:** Fantastic. Thank you. Charles, to all those questions really and as an opportunity for follow-up, but also just to this question about primary care as productive integration again, and I suppose partly on an earlier question about new entrants and how under the last government there was the institution that couldn’t be named – the polyclinic – which was an idea to integrate services in a community setting. I suppose I’m just kind of interested in whether history repeats itself and your thoughts on that. But as I say on anything else that’s come up.

**Charles Alessi:** Andy, will it work? Well I think I’ll ask a rhetorical question. Would you really start from here with completely separate budgets for health, for local authorities for social services? I think we’re in a particularly difficult place. But there is something about, again, doing the right thing. In other words there is something around trying to manage the processes we have to somehow deliver the care we need for our patients. And I think the opportunity is there as long as we can manage our behaviours, because in essence that is what is at the root of a lot of these things. And what I’ve learnt over the years is if we manage our behaviours – especially our behaviours in terms of the relationships of different organisations – it’s amazing what is possible, because actually living in sin is an extraordinarily good thing to do. And if any of you haven’t done it, I would really suggest that you do it.

So I think that’s my answer to Andy. And secondly, around the incentives, clearly we need incentives. Absolutely. But those incentives need to be around quality. And quality needs to be around value which includes fiscal responsibility but is not limited to fiscal responsibility. We have some examples already which are emerging around commissioning around spells, moving away from activity specifically towards assessment of function between different periods.

And that ties into Niti’s point around people with more than one condition because most people have more than one long term condition. And if we develop means using PROMs and PREMs to actually measure functional improvement of individuals, I think we’ll get a lot further. There is one particular patient who is part of our practice who had a knee replacement and who was desperate to get it undone after they had it and we couldn’t figure out why. This was a person who couldn’t pray because they couldn’t kneel down anymore. Now that was never considered by anybody to be something which was important. But in essence that destroyed their lives. Having that operation destroyed their lives. And I think that’s a real salutary lesson to all of us.

**Nick Seddon:** Thank you. It’s time to sum up and time to finish. I know that Michael Izza is gone. Is somebody else from ICAEW going to say a word or two? Graham, do you want to say a word? Sorry, just to say I’m not going to even begin to attempt to sum up what has been such a fantastic and varied discussion. I will say one or two words right at the end, but I’ll keep them brief.
Close

Graham Dale: Thank you, Nick. And just a few reflections from me. Three words, all beginning with I from the organisation that’s about to buy you lunch. So here we go.

Innovation. I took my son to Watford General on Monday – it’s half term – and the doctor said to me, the paediatrician, “I can prescribe you hundreds of pounds worth of drugs, but I cannot prescribe you a £20 piece of kit that you probably need.” So just one reflection on innovation. If as a result of this morning’s conference that doctor can do that in future, that would be great – under clinical commissioning.

Second word beginning with I: incentives. We’ve heard a lot about that and we’ve heard about patient pathways and reflecting on your expression, Nick, there are also money pathways, and that’s partly where ICAEW fits in, and we already support – well one of my colleagues sitting down there already supports 50 people who are on these Clinical Commissioning Groups already. So that’s where ICAEW can help.

And then finally inspiration – third word. I’ve been inspired this morning. I hope you have been too. Thank you to Nick. Thank you to Reform. Thank you to the speakers. Especially thank you to for coming here and giving your time, and I hope you’ve been inspired by it. We certainly have. Thank you.

Nick Seddon: Right, thank you all so, very much for giving up a whole morning, and I hope you’ll stick around to discuss over lunch. I thought your third was going to be information, though I agree with you about innovation, integration and inspiration. But information, my goodness me. Information was another big theme for me today, I think, and particularly perhaps in the last session in terms of quality information. I was very struck by the, I suppose, drilling down on to the theme of what you measure is what you manage and also of course what you pay for and therefore how the system works. And I thought that was a very strong theme.

My goodness, for me what a fantastic session, and from Reform’s point of view what a fantastic set of discussions we’ve had today. I mean my notes are completely higgledy piggledy so I won’t even try to read them through. But I think what’s really marked it out has been that the discussion has been so heavy duty. We’ve really talked in an interesting and engaging way about some of these themes. It has not been a kind of soundbite discussion. Even in fact the Secretary of State I think really engaged quite clearly and seriously with some of the questions that came his way. And I sort of do feel that these heavy duty discussions are rare and really important.

We will transcribe this. We will, as I said, send you all a copy of it with a little introductory section which explains what we in the cold light of day have thought about it and what we take away from it. I’m sure you’ll take your own thoughts away. Thank you so much for coming. Thank you to our speakers and to our sponsors for making – for such fantastically engaging discussion. Thank you, the last panel, so much. I didn’t thank you properly as soon as we finished. And please all just stay in our network and keep feeding into our thinking and keep coming to events like this because the contributions that you make to our discussions are how we come up with any useful ideas at all. So thank you to the sponsors, and thank you to you.

[applause]