

## Notes from the Policy Day NHS Alliance, 25 May 2010

### Clinical Commissioning Federation (CCF)

CCF has a real opportunity to translate and interpret the views from the front line back to politicians and visa versa.

We need to think about how we support practices to take on real budgets

The challenge for PBC is to go from 'haute couture' to 'high street'.

How do we get them to be multifunctional and population health rather than an individual patient level approach. It is about changing hearts and minds.

Clinical Commissioning Federation (CCF) is federated with intent to:

- Improve health and well being
- Focus on population health management
- Lead from the front
- Responsibility and accountability for money
- Create compelling narrative with a clear message; solutions focused

It is looking at:

- Care and teams without wall (TCS team)
- Productive general practice – working with NHS Institute
- Frails, falls and forgetful –national older people programme (through David Oliver, Tsar Older People – part of TCS)
- Co-ordination and collaboration – we have to work across complex systems – health and social care

A big message to Lansley is 'simplify the message; talk their language so they understand what you want to happen.

There is a lot of support for the CCF. We want to debate, connect, sift and sense check policy and test our ideas. B Fisher has identified that no patients involved. The inclusion of patients needs to be systemised within the NHS.

There will be fewer PCTs in the future. Unless we pull in clinical commissioners, we will not exist in the future.

Andrew Lansley does not understand the role of providers and commissioners. Where does the responsibility sit for provider development and service re-design. Who sits down and says, what does the data tell us and how are we going to redesign services? PCTs or clinical commissioners?

There are two games in town:

- Stopping to do some things to free up resources
- Management long term conditions ell

Mo Girach –what responsibilities lie with patients to contribute to their health within the context of the Government's Big Society?

### **Clinical leadership in PCTs: how are things working and where next?**

Clinical leaders include: PEC members, clinicians who work for the PCT e.g. Medical Director, PBC leads

### **Guiding principles for PECs (DH)**

- Focus on patient
- Drive strong clinical leadership
- Decision makers; part of governance
- A range of clinical professionals
- PCT determination of how PEC works in practice
- Oversight of strategic direction of PBC (sign off savings)

### **NHS Alliance PEC Chair survey**

152 PEC Chairs; 33 responses

- 55% a lot of influence
- 66% very or much effectiveness of PEC
- 73% PBC quite or very successful
- 25% very good; 70% reasonable understanding of the NHS financial challenge
- 94% wanted a network. Most want to use it to share ideas on how to do the job (20/31)

In the future, PCTs will commission '*residual services*' and others will be '*best taken at a wider level*' – so whether the PEC? Systematising and accelerating clinical leadership across the NHS is the answer to implementing QIPP.

Do PECs have a role? As PCTs become bigger and focus more on performance management, role in oversight? role in driving clinical leadership? If the Gov brings in locally democratically elected PCT Boards, then maybe PEC can support them in their scrutiny role?

GPs who work with PCTs are seen as 'going native'. The number of capable clinical managers in the health economy is a rate limiting step to progress. We need these people in PBC.

If there are 30% cuts in management, is the PEC vulnerable? In order to secure PECs a future role, we need to be clear about what the value of the PEC is if we are going to support their continued existence. Potential roles identified:

- Overview and scrutiny
- Quality and clinical governance
- Governance
- Dealing with poor performance
- Overseeing revalidation?
- Inputting into decommissioning care

Research (reference Donal Hynes) shows that having a influential/successful PEC correlates with achieving transformation change and successful PBC. If you didn't have a PEC, would

you need to invent one? Many things that impact on clinician's daily practice will still be decided by PCTs (performance managed by PCTs?). Do we want all those decisions made by just the CEO and Chair with no clinical input?

NHS Alliance needs to help government to work out what the future role of the PEC is if we want to support their survival. NHS A is working on the future role of PCTs – and where it fits with PBC groups. NHS Alliance could do a paper on the future of PECs or include this in its paper on PCTs.

### **PCT Chairs and Non Executive Directors: what does the future hold?**

Local authority appointed non executives – will local elections prove too expensive?

If the GP contract is held nationally, what does it mean for PCTs and non executives within them? Issues that NEDs are thinking about:

- WCC: is this the right questions to get the right answers?
- Commissioning versus decommissioning: prioritisation principles
- TCS reform or new marriage?
- Acute reconfiguration...STOP IT NOW?
- PCT & SHA reconfiguration (especially LON)
- Monitor: the new economic regulator
- Expansion of PBC
- QIPP
- NEDS as people: time, role, skill and governing risks

### **What do the public think of the NHS and how do we square the circle? Jonathan Nicholls, Ipsos Mori**

Compared to when the labour government came to power, the NHS is much less of a concern for people. However, next to the economy, it was still the second most important factor in deciding how people voted.

Prior to the election, Labour was still the party that was trusted most with the NHS. The gap between Labour and Conservative on this issue has narrowed very significantly, demonstrating that Cameron has been successful in 'detoxifying' the NHS.

Satisfaction levels with the NHS are at their highest levels, with 73% expressing they are very satisfied with it. 65% of people agree that the NHS is the best health service in the world. 65% agree it gives the best treatment possible. Less people – 40-50% believe that it provides a quality service. GPs are still the most trusted health professional and 91% are satisfied with the service they receive. Satisfaction with other parts of the health system also show a positive upward trend.

65% of people believe their local NHS provides a good service; 79% believe their local hospital provides a good service. This is almost 'in spite' of the Government as only 26% think that the Government manages the NHS well.

75% say the NHS is crucial and we must do everything to protect it. 78% disagree that there should be limits on NHS spending. 75% of people think the NHS should provide whatever drugs we need whenever we need them, regardless of effectiveness.

The psychological contract between the NHS and the public can be summarised as:  
“The NHS will be there for me whenever I need it.”

Only 40% of people believe that we really need to cut public services. 80% believe we just need to make efficiency savings. That is because the recession has not hit them yet on a personal level. Only 30% describe themselves as poor or very poor.

Public expectations have changed. We live in a “have it your way”; “customisation” “choice” “you can get it if you want it” society where people can google their medical condition and find out about all the available treatment options. They do not believe health professionals when they say that the treatment they expect to receive is not the best one.

The elephant in the room is the deficit. It was being subtly disguised until yesterday! Now it is stampeding into the room.

The NHS needs to make savings of 20-30% and redirect them into spend on front line services. We are 5 years away from there being more over 65s than under 16s. Medical care costs and new treatments continue to rise e.g. cancer care.

The narrative from the NHS is increasingly going to be about saying ‘no’ (and guess who is going to be holding the budget and taking the flack!!!). That is a toxic place to be, given people’s expectations. It will be almost impossible to manage it without conflict.

Two groups are key:

- The IPOD generation: insecure, pressured, overtaxed and debt ridden. They will start asking awkward questions about the cost of the NHS
- The responsible middle class: they look after themselves and stay healthy and ask, why should the NHS pay to treat the fat people or the people who smoke?

Drafting note: What about baby boomers? Silver surfers? In USA, they are changing health care provision significantly?

Jonathan predicts that these groups will start to ask more demanding questions of the NHS and why we are making the ‘treat’ decisions we are. Research shows that most people’s preferred option is for people to be ‘forced’ to change their lifestyle before they receive medical treatment.

It is a challenging in tray!!!

People tell us that what matters in terms of their experience is:

- Cleanliness
- Being kept informed about their treatment and what is happening to them
- Medical staff explaining procedures in language they understand

These are ‘transactional’ measures rather than emotional ones.

They worry about:

- Poor hygiene

- Waiting lists
- Too few medical staff
- Lack of resources and investment in the NHS

They want:

- More control of the system in the hands of doctors and nurses rather than politicians
- NHS management reduced by 1/3

### **What does this mean for commissioners?**

To keep the public on side, you need to make sure that you four things:

- Deliver the rights 'things' in terms of services
- Communicate well with the public and breed familiarity
- Keep your staff happy
- Demonstrate open, emotionally intelligent leadership

#### **1. Do the right things**

There are some things that you cannot control. PCTs with a higher ethnic population and lower socio economic profile consistently have populations who are more dissatisfied. PCTs with older population profile consistently have satisfaction levels that are higher. This is regardless of how much money is spent within the health economy; or how the health economy is rated by regulators e.g. the Health Commission.

However, there are things you. This data about what the 'right things' are come mainly to the acute sector. However, it is likely it can be extrapolated to primary care. The things that matter and consistently result in people scoring providers highly (regardless of the clinical experience or the money spent) are:

- Dignity and respect
- Privacy
- Being included in the conversation and treated as an adult
- Having the chance to co-create their care pathway
- Having pain well managed
- Cleanliness

In fact, over 90% of the variation in provider ratings can be explained by:

- Dignity and respect 59%
- Involved in decision making 28%
- Cleanliness: ?%

#### **2. Invest in communications**

Putting good communications strategies in place is vital. Familiarity breeds satisfaction. The better your communication strategy, the more familiar you will feel to your service users / the public and thus, the more satisfied they will be.

You need to have a relationship with your population and they need to feel they know you before you tell them bad news (which you are going to have to do) so it is going to be a key part of keeping the public on board through difficult times.

PCTs have absolutely no profile with the public. 1 in 8 NHS trusts (acute and primary care) spend less than £20,000 a year on communications. The best performing trusts spend more and there is a correlation between spend on marketing and performance. Excellent/good trusts have marketing plans that include PPI (it is not just about advertising).

We need to recognise that there is going to be an audience out there who are going to be very unhappy about the NHS having to say 'no'. You must invest in communications to make change happen and deliver this agenda successfully.

### **3. Get your staff on board**

There is a strong correlation between happy staff and good patient experience.

Staff bad mouthing their organisation is a warning sign for an organisation that is failing to engage staff fully. Your staff is your greatest patient experience asset and PR/communications/marketing tool.

70% of doctors and GPs are critical of the NHS. In fact, the closer you are to someone who works in the NHS, the less satisfied you are likely to be with it (and given that it is one of the largest employers in the country, that is worrying!).

Staff satisfaction is not just about pay and conditions. More importantly, it is about:

- How my role fits in to the bigger picture 56%
- Senior managers care about my work 75%
- I am able to realise my potential 59%

Research shows that everyone is an advocate of their own team; fewer are advocates of their employer (NHS trust). Trusts with high staff advocacy levels perform better.

### **4. Open, emotionally intelligent leadership**

This is about the 'what and how' of leadership.

"The way to manage the big issues is to be out on the lunatic fringe".

IPSOS Mori is often asked to run consultations for PCTs. It is easier to delegate consultation than to go out into the fray. Patients are seen as the 'enemy' who can make trouble for the trust and get them damaging headlines in the press. They are another way. Use their resistance as an asset.

Gloucestershire PCT did this. They invited the pressure groups in to the; agreed Chatham House rules and shared the rationale for service reconfiguration. There were some leaks; they overcame those and started to issue joint press releases with the campaign groups. This resulted in a collaborative approach.

- The key thing when dealing with big changes is getting the story right.
- Involvement is also key; especially of opponents. Do it early and well.

- You also need to show empathy and understand other people's perspective. Especially on an emotional level. Managing the emotion in the room is key. Once you allow people to voice their anger, they will listen.
- You need to recognise the tipping points and 'moments of truth' and build and consolidate support after those. That is when people 'get it' and will commit to working with rather than against you.
- We need to see the world we are working in as an emotional one and manage the emotion amongst stakeholders especially when we are doing difficult/unpopular things.

In summary, to get better ratings from the public:

- Recognise people have unrealistic expectations and don't get the size of the challenge
- Manage the backlash through strong, emotionally intelligent leadership
- Recognise that the Tories are becoming more trusted in terms of NHS
- Focus on improving patient experience, especially: dignity and respect; involvement in decision making; cleanliness
- Invest in communications – both money and new methods. Develop compelling stories; have key people media trained; be proactive.
- Invest in staff engagement. Make sure they understand where they fit into the bigger picture
- Demonstrate visible, flexible "personal leadership". Recognise that increasingly, leadership in the NHS is about dealing with complex political situations and managing stakeholders
- Use PPI to help you to deal with opposition in your local community. Proactively develop your profile as an investment for later.

### **Practice managers network**

- Practice managers are key to delivery of the new agenda. Within our network, there are 10 practice managers, linked to SHAs, who are taking a strategic approach and working to raise the profile of practice managers.
- There is a key role for practice managers in practice based commissioning and in delivering reconfigured primary care.
- NHS A is going to create regional hubs, led by the NHS Alliance's practice managers. SHAs lead to develop regional networks of PMs.
- There is a great passion out there and being a PM is seen as a privilege as is helping to improve care of long term conditions and health inequalities
- PMs spend a lot of time working with patients and clinicians. We are a key link between patients and clinicians and work with both. We are working closely with Brian Fisher on PPI and want to increase this work.
- We think we need to make and buy; and we are the ones who will be managing conflicts of interest.
- We are keen to continue to develop our relationship with DH and have done a lot on that this year.
- We need formal career pathways for practice managers and for managers who work in PBCs. There is a definite need to consider this and how PMs can get support to develop.

- Can we look at managing practices through clusters by sharing workload of practice managers to free up time?

### **What will clinical commissioning look like in the future? Julie Woods**

Some of the NHTA/ Nuffield report is consistent with what we are hearing from the Government.

The fact is, we have not managed to deliver. PBC has not delivered true engagement with clinicians. PCTs have also not managed to transform services. The absence of real budgets mitigates against a feeling of ownership within PBC. PCTs still control secondary care and the levers PBC provides with secondary care are not strong enough to make change happen. There is very little autonomy in decision making for PBC group; they are still beholden to PCTs. There is confusion about who the commissioner is in many health economies. There is also a big challenge to translate changes into contractual arrangements. It cannot continue this way.

### **What can we do differently?**

Our proposed new approach that builds on what works. It is based on a partnership of empowered local clinicians; clinician led – team without walls – everyone working together.

- We see the ‘make and buy’ roles being combined. Any profits over and above cost need to be ploughed back into patient care – more co-operative and less vested interest.
- GPs will sign up to a particular commissioning consortia; hard budgets; must commit to what the commissioning group decides to do. NHTA wants budgets at locality (PBC group) level; minimum 100,000 people. 150,000 is the word on the street about current Government thinking.
- There needs to be asset locking arrangements for use of any freed up resources to ensure trust and confidence in new PBC.
- PBC groups need to take decisions quickly and just be able to ‘do it’.
- PBC groups have got to think about the risks and rewards and where it makes sense to hold that risk and where not. People need to be paid for working with the PBC group. We need to reinvest in services closer to home.
- Reward, risk, remuneration and reinvestment are the watch words.
- Clinicians and managers need to work together and take a population approach. It is about partnership working with everyone and aligning incentives.
- We need to be big enough to manage risk; with no forced marriages (they do not work) and local enough to feel engaging and ‘real’.
- We need to commission for outcomes.
- We propose bottom up design of the commissioning model; let a thousand flowers bloom.
- Social enterprise models may flourish within PBC.

The NHTA/Nuffield paper was developed prior to this Government. Some elements of health policy on PBC are becoming clearer. A lot is still unclear e.g. delegated authority or return to fund holding? This will impact on PBC consortia’s form and function.

NHTA Alliance wants to show the way on clinical commissioning

## Thoughts / questions from the floor

- NHTA/RCGP/NAPC/Nuffield/Kings Fund/NHS Confederation are working on a joint paper on making PBC work
- We need to have primary care budgets as well as secondary care to transform care.
- Finance is crucial; as is delegated responsibility to making PBC work
- Will there be a mandate to become part of commissioning; will GPs be providers and commissioners? Will the GP contract for provision mandate commissioning engagement?
- Can we change the culture and behaviour of the different players in the system?
- How will we shape what happens if GPs overspend?
- Health outcomes take longer than a year to measure; yet there is still annual budgeting.
- Where does role of GP provider sit?
- We need to include and recognise we will be engaged with clinical decommissioning.
- Programme budgeting – where does that fit with this approach? Lewisham are doing this.
- What incentives will there be in the GP contract – how do we incentivise GPs to do PBC?
- What is the change in GP business model that comes hand in hand with the greater role in commissioning?
- How will performance management of other contracts (PhS, Optom, dental) fit in with PBC?
- If there is profit in the PBC system, what does that mean for GPs reputation?
- Having a real budget is not the same as carrying financial risk; experience from the US is that carrying financial risk often fails. If it happens, you might well fail 'en masse'. Beware
- You must incentivise everyone to engage (primary and secondary care). There must be strong incentives; improving quality for patient experience must be rewarded. Do not rely on altruism. There must be a financial upside for providers; 'better for patients' is not enough...
- How will you manage communications if you are the ones that have to say 'no' to patients?

The die will be cast on this on the next few weeks on PBC. We need ideas fast. Write to Julie with your thoughts.

The Tories are talking about losing your provider contract if you do not do PBC as a stick. The principle is that all NHS providers should be held to account for efficient and effective resource allocation. By making all providers accountable for this, it provides a common currency across the system – actually, if you add in patient experience, you can say quality (Darzi definition)!!!

## Choice Mike Dixon

- Feel NHTA needs to be looking more at choice
- It is so much more than people choosing between providers for a service; it is more about engaging people in choices about their care. There is a lot of evidence that informed choice helps improve quality of care
- Involving patients in PBC is also going to be key to choice agenda

### **Issues from the floor**

- There are a lot of people who are dissatisfied with the provider – how do we deal with this within PBC? We are limited to the providers we have
- People who need better information to make informed choices
- Transparency is important to improving quality (“if you are going to go naked, get fit first”)
- We need to balance choice and value for money; democracy and responsibility
- We won’t have much choice about the choice of agenda. It is happening in social care. People will use their personal health budget to unpack the system e.g. more convenient diagnostic services
- We need more competition between providers to improve quality

### **PPI Brian Fisher**

This is where we are heading:

- We have been training and talking to PBC groups about PPI. It has been a moderately depressing experience; especially at PBC level. As PBC develops, we need stronger PPI within it. We may need more training events
- We have set up an NHTA network for PPI leads across national organisations. This group has done a number of things:
  - Whose NHS is it anyway consultation? This will be launched at the end of June. We have woken up to co-production. The ‘Big Society’ document resonates with the co-production agenda; community activists driving change. We have about 10 organisations signing up to the document. We are making a lot of noise with DH about this
  - Shared decision making. There is masses of evidence to support this. We are talking to DH and Kings Fund about a workshop on this. A document has been written to be published. We know what to do; we need to get commissioners to commission it and get providers to implement it so that we need to get it to become ‘the way we do things around here’. Patient access to records is a ‘best buy’ in terms of shared decision making.
  - How to get PBC and providers to be more responsive; working with CQC to think about how to measure responsiveness. No one knows how to do this.
- We are looking at how community development can reach out to people and make a difference to people. This is DH funded and is called the HELP project.

### **Questions from the floor**

- How do we avoid health inequalities with improved PPI?
- Are there anything lessons we can learn from other sectors?
- We need to do proper engagement with the relevant people to the area of care we want to improve and aware of those who shout loudest many not always be representative of the general view
- People see the world differently from doctors you need to hand over some of your power if you do this well.

**Chris Drinkwater – Public Health**

Public health can tell you what the problem is. It does not know how to do anything about how to solve it. Primary care is the delivery vehicle for solutions, in partnership with the third sector.

I recently attended the Core Cities event in Newcastle on obesity. There is talk of financial incentives to get people to lose weight. What nonsense.

4 key things need to be tackled:

- Obesity
- Alcohol
- Mental health
- Older people

**Weight:** Can we do something about this? We set up a healthy living centre and have 24 health trainers who are working with the PBC cluster across the community, addressing the issues. Currently we spend all our money on surgery and treating diabetes. Most common cause of death post bariatric surgery is suicide. Weight loss can have a huge impact on people's lives. We need to think about how to work with local authority and third sector... In weight management there is a lot of emphasis on guidelines and referral guidance; rather than on developing the soft skills to encourage and support people to lose weight.

**Alcohol:** 'Total place' work in Leicester shows that more money is spent on dealing with drug misuse than alcohol even though the cost of the health problems associated with alcohol misuse is much greater. We need to redress the balance. There is a national agenda on price of alcohol that also factors here.

**Mental health:** People consume alcohol and food because of depression and poor self esteem. It is not just about access to cognitive behavioural therapy; unless you change the environment, can you change how they feel about themselves?

**Older people:** We tend to focus on single long term conditions. Many people have several and we need to focus on managing co-morbidity much better. These individuals are also more likely to be depressed and helping them to manage their health in the context of their social environment is crucial; helping them to maintain social networks is a key part of this. People aspire to a long, active life with good social life and then dropping dead. End of life care is a big part of this agenda as well. Volunteer support networks are a potential solution; and we could reward people by offsetting the investment they make in voluntary work against their future care costs. We have moved away from integrated working with care of older people specialist. They should be community care of older people specialist. We need to join up work between social and health for older people.

#### **Issues from the floor**

- Should NHTA support a fat tax on fatty foods?
- Should NHTA have a public health policy?
- Media campaigns undertaken by PBC groups to promote healthy living
- Investment in an allotment scheme for little money and big public health benefits

- The Coalition's health document says that GPs will have incentives to improve public health – what does that look like?
- We need new incentives to drive different behaviour amongst people and the NHS system

### **Community services: Mike Sobanja**

The last year or so has been about reconfiguring services rather than what is going to be provided. David Nicolson and SHAs were encouraging vertical integration. The new Government has not made much noise about transforming community services. They are married to keeping GPs happy. NHS Alliance has been organisationally agnostic. We opposed the one size fits all solution. We are encouraging this to remain NHTA policy. Strong commissioning should be the king with TCS.

Notes prepared by: Georgina Craig

