Delivering integration at pace and scale

Roundtable seminar with Bill McCarthy, National Director: Policy, NHS England

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Delivering integration at pace and scale

Reform comment

Integration of health and care is now the key objective of health reform. With healthcare needs changing because of an ageing population and the growing prevalence of chronic conditions such as diabetes, many experts and NHS leaders have advocated joining up health and care services. In recent months NHS England, the Government and the Opposition have announced new initiatives and proposals to deliver integration at pace and scale. The centre piece of the 2013 Spending Round was a £3.8 billion fund to encourage health and care services to work more closely together. Health Ministers have also announced 14 pioneer projects across the country to deliver coordinated, patient-centred and holistic care. Following the Spending Round the Health Secretary argued that “for decades we have been talking about better integrated health and social care services and today we’ve put our money where our mouth is. We need to work differently to respond to the changing needs of the population and that means making joined-up services the norm, not the exception.”

While policymakers and politicians appear to be united in the direction in travel there is still debate on how to get there and profound barriers to change. In October 2013 Reform partnered with Novo Nordisk to explore how policymakers can facilitate integration that benefits patients. The seminar was led by Bill McCarthy, National Director of Policy at NHS England.

Relationships matter

Integration has been on the agenda for years but there is still debate on what good integration looks like. There is greater recognition that integration is not about organisational form but about care that patient-centred, coordinated, holistic and tailored to individual needs. To deliver services that meet this ambition creating “transactional” coordination between organisations is insufficient; it is relationships that matter. Not just relationships between different kinds of clinicians and NHS providers and other services but critically the relationship between the patient and their caregivers. A more integrated model of care would build the capabilities of those patients most at risk to allow them to stay out of hospital for longer. This is about building “trust” in community services through harnessing a range of providers such as housing, volunteer organisations and families to improve health and not simply treatment. But at the same time integration cannot be achieved through making hospitals “the enemy”. In some health economies acute providers will be best placed to develop the capacity of community care and create better pathways.

A model of change

Such changes depend on harnessing local creativity. There is also a crucial role for NHS leaders in setting out a national vision. Getting the right balance of the national and the local has always presented a challenge for policymakers. Already the £3.8 billion Integration Transformation Fund and the 14 pioneer projects have been a catalyst for change in many areas. Raising the awareness of the challenge of particular disease areas, such as diabetes, could also help unlock barriers and stimulate local efforts. National leaders can also focus local leaders on the “quick wins” such as reducing average length of stay for non-elective admissions, or focusing on patients with both mental and physical health needs.

However national policies and pilot projects cannot become an excuse for inaction. Too often in the past local leaders have either looked towards the centre for instruction or to pilot sites to take the lead. On other occasions NHS organisations have focused on a few key initiatives such as risk stratification without linking up the different strands of reform. Integration
Delivering integration at pace and scale

has to be everywhere and all local leaders need to take the initiative and ownership of change.

**A role for the centre**

National policymakers have a critical role in tackling the barriers to change such as workforce reform. Integration requires harnessing more local assets than just the medical workforce, it was also felt that challenging and changing the medical profession will be needed. Doctors are still largely trained to deliver acute care in hospital settings and a shift in emphasis to chronic care and community settings is needed. Enabling local leaders to manage and commission primary care is also essential if the NHS is to deliver truly integrated care that meets the needs of patients. Standardisation of outcome measures and metrics can also stimulate local innovation. Other challenges such as developing leaders that can drive through change and supporting the “laggards” may also require a national response.

**Unlocking the incentives**

Currently the tariff system continues to reward isolated activities and not joined up packages of care. In many cases progress towards making services more integrated has been due to local leaders innovating with the payment system. Yet while Monitor and NHS England have recently proposed rules to allow more local experiments, some have argued the system is still too “forbidding”. This reveals the tension within the whole system between short term sustainability and long term transformation. Health and care leaders spend half their day improving services within the system and the other half looking for opportunities to transform it. Whilst there is increasingly a shared vision to achieve change, even the most visionary leaders will find it hard to take bold steps to transform their model of care if it risks financial viability in the short term. Balancing these competing objectives remains an ongoing challenge for policymakers.
Delivering integration at pace and scale

The integration revolution

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 commissioners.

Novo Nordisk is a global healthcare company with 90 years of innovation and leadership in diabetes care. We are committed to changing diabetes through education, collaboration and innovation. We have a particular interest in emerging models of integrated care, as we know that people with long-term conditions, such as diabetes, require access to a range of treatments and support across health and social care services.

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 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 the NHS to focus on activity alone is not sustainable for patient care in an aging society and for the nation’s finances.

This needs to change. There has been plenty of discussion and we now need to move to action. Financial incentives need to positively encourage integration and break down the walls between health and social care and primary and secondary care. It is only by doing this that we can ensure that care is centred around patients in appropriate settings.

Although getting financial incentives right is very important, integration will only work if everybody plays a part. We believe that getting diabetes care “right” could be an exemplar for improving the integration of services across other areas of healthcare. Novo Nordisk is currently working with King’s Health Partners in South London to develop, design and implement co-ordinated diabetes care across the King’s Health Partners area for optimal cost-effectiveness and outcomes. We hope the best practice identified by this project can be spread as appropriate throughout the NHS and further afield.

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.

Peter Meeus, Vice President, UK and Ireland, Novo Nordisk
delivering integration at pace and scale

attendees

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<thead>
<tr>
<th>Name</th>
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<tr>
<td>Richard Alexander</td>
<td>Finance Director, University College London Hospitals NHS Foundation Trust</td>
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<td>Rt Hon Paul Burstow MP</td>
<td>Former Minister of State for Care Services</td>
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<td>Dr Patrick Cadigan</td>
<td>Registrar, Royal College of Physicians</td>
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<td>Thomas Cawston</td>
<td>Research Director, Reform</td>
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<td>Anita Charlesworth</td>
<td>Chief Economist, Nuffield Trust</td>
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<td>Professor Paul Corrigan CBE</td>
<td>Former Health Advisor to Tony Blair</td>
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<td>Merav Dover</td>
<td>Chief Officer, Integrated Care, Lambeth and Southwark, King’s Health Partners</td>
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<td>Dr Simon Eaton</td>
<td>National Clinical Lead for the Year of Care Partnerships, and, Consultant Diabetologist, Northumbria Healthcare NHS Foundation Trust</td>
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<td>Andrew Eyres</td>
<td>Chief Officer, NHS Lambeth Clinical Commissioning Group</td>
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<td>Ellen Graham</td>
<td>Policy Manager – Integration, Public Health England</td>
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<td>Jeremy Hughes</td>
<td>Chief Executive Officer, Alzheimer’s Society</td>
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<td>Peter Meeus</td>
<td>Vice President, Business Area UK and Ireland, Novo Nordisk</td>
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<td>Bill McCarthy</td>
<td>National Director: Policy, NHS England</td>
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<td>John Myatt</td>
<td>Strategic Business Development Director, Serco</td>
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<td>Catherine Pollard</td>
<td>Director of Pricing Development and Integrated Care, Monitor</td>
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<td>Sue Roberts</td>
<td>Chair, Year of Care Partnerships</td>
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<td>Dimitri Rodzianko</td>
<td>Market Access Director, Novo Nordisk</td>
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<td>Amanda Simonds</td>
<td>Strategic Alliances Manager, Novo Nordisk</td>
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<td>Tony Whitfield</td>
<td>Finance Director, Salford Royal NHS Foundation Trust</td>
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<td>Baroness Young</td>
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Bill McCarthy, National Director of Policy at NHS England, opened the seminar by setting out two key principles on how the NHS should seek to deliver integration at pace and scale.

Firstly, “at times the integration debate can disappear into a set of discussions about different organisations who, if only they were merged or if only some clever organisational form was developed here, that would be the answer.” Yet there is as much “disintegration within a number of unified organisations as there was between organisations...integration is not about organisational forms. It’s about the experience of people living in the community who at times become patients of the health service as well.”

Secondly, there is a danger that pilots “start becoming the end in themselves and an excuse for everyone else to kind of breathe a bit of a sigh of relief and say well, there are some pilots. There will be evaluation in a few years. We’ll wait and see what happens and then we’ll take all of that rich learning and do something ourselves.”...“What I don’t like is hiding behind someone else doing a pilot as an excuse not to do anything yourself.”

To achieve “integration everywhere” there are six major opportunities for the NHS:

1) “Measure what matters”. Ensuring “integration is framed through the experience of patients...If it’s not improving their experience of care, then it’s not an authentic piece of work... And if you don’t measure it, we know in the NHS we tend to ignore it. So let’s get the measures right. Let’s base them on the experience of patients, their outcomes from care. And let’s make those public and every bit as important as, for example, a waiting list target.”

2) “Commissioning for outcomes” and “commissioning with the right money”. “That means not just integrated care funding... It means bringing together primary care investment”. Bill pointed out the importance of treating the pooled Integration Transformation Fund (ITF) as “a catalyst to bring other relevant funds in” such as housing.

3) “Don’t forget about the workforce”. There is a need to consider not only “how we support our own teams in hospitals and outside”, but “to look jointly at all of the workforce who will be involved in supporting that better...”
Delivering integration at pace and scale

Integration needs to be everywhere but differently everywhere... because the clients and the people we work with are going to be different and will have different aspirations.

experience, more efficient experience of care”. This “points towards joint training, joint standards, shared roles and…much greater permeability between different professional groupings.”

4) “Integration needs to be everywhere but differently everywhere”. Integration “is going to be different because the clients and the people we work with are going to be different and will have different aspirations” and national policy needs to “be able to understand and adapt to that.” He added that “we need to be smart about the outcomes but…very pragmatic about the best vehicles that will work.”

5) “Currencies and incentives”. Under NHS England’s and Monitor’s new guidelines “there will be explicit freedom given for local price variation for stepping away from tariff in the coming year, where the commissioners and providers locally are saying we can do something better for outcomes for a group of people by stepping to this different funding mechanism.”

we should take those opportunities, learn from it, and again that will help feed into the development of tariff more generally but also will remove an existing barrier just to getting on and doing some good stuff”.

6) “Technology”. The NHS needs “to be much better at sharing information, the right information across different agencies or else all of that good joint training we talk about will be for nought if people don’t share a common understanding and a common way of understanding whether they’re doing the right things. But also we need to be quite creative about what technology can offer”.

Peter Meeus, Vice President, Business Area UK and Ireland, Novo Nordisk, drew attention to Novo Nordisk’s collaboration with King’s Health Partners to improve the integration of primary and secondary care. There is considerable opportunity in “identifying what best practices are and seeing if you can…multiply these best practices. And then people in other areas can take that over and build further on that.”

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Yet there is also a concern that there is a “lack of vision” in terms of what integrated care means locally, suggesting that unless there is an understanding of the benefits of integration at a local level, there can be no motivation of colleagues and partners. Existing incentives also currently promote “isolated”, not integrated, activities.

In the case of diabetes the persistence of funding and organisation silos means “the long term complications of diabetes in particular are underestimated and are not being dealt with optimally”. He warned that “if we don’t act soon, this will only get worse because diabetes is growing in prevalence”. Three million people in the UK – five per cent of the total population – have been diagnosed with diabetes, and of those, 40 per cent of these are out of control. “Their long term consequences will get worse and worse and providing care will get more costly as well”.

Baroness Young, Chief Executive of Diabetes UK, challenged the vision of “a thousand flowers blooming” with regard to local CCGs, “because one of the problems we’re facing with CCGs is that some of them aren’t blooming. Quite a lot of them aren’t blooming”. What’s missing is “a kind of theory of change” in the NHS, “a model of change that means that it doesn’t become an optional thing to search after best practice and implement it. There are plenty of good examples of good practice. The problem is we haven’t got enough examples of plagiarism in implementation”.

Anita Charlesworth, Chief Economist at the Nuffield Trust argued the need to focus on the “big wins” and to ask “where are the big changes that need to be nationally driven that will enable that local innovation actually to really get going and get going quickly?” Research shows that the focus on avoiding hospital admissions through integration has not been truly effective. She asked, “are we right to continue to focus initially on admission avoidance, or should we not really have some pretty tough action on average length of stay, which would give us a financial win as well?”

where are the big changes that need to be nationally driven that will enable that local innovation actually to really get going and get going quickly?

Anita also drew attention to “the co-morbidity of mental health and physical health and the appalling outcomes for people with mental health alongside physical health”, a key example of the ways in which integrated care can bring real improvement. She
argued that if we want to see interoperability of systems and portability for patients, there needs to be a degree of standardisation. At the moment there is too much flexibility, particularly around metrics and tools to develop currencies.

Rt Hon Paul Burstow MP, former Minister of State for Care Services, seized on the theme of co-morbidity between physical and mental health and argued for the importance of reaching “parity between physical and mental health in practice, not just in rhetoric”. This can be achieved by ensuring that data can be shared between physical and mental health and “embedding mental health within in primary care settings, using the psychiatrist both as a direct member of the team but also for up-skilling the team”.

Paul further argued that what is missing from “big reconfiguration type questions” is democratic legitimacy and engagement. He noted the potential to learn from local government about how it has sought to reconfigure services.

Finally, Paul raised the issue “that too much of the design of systems has been around transactions and not enough has been around relationships”. Putting relationships at the heart of the system is an “essential ingredient”, particularly in managing co-morbidity and morbidity.

Jeremy Hughes, Chief Executive of the Alzheimer’s Society, highlighted the pivotal role of “clear and demonstrable national leadership”, which he argued is currently lacking in the debate on integration. He pointed out that the Prime Minister’s Dementia Challenge had “unlocked a lot of doors and has actually made things happen”.

Jeremy also noted the importance of the “care force”, those “voluntary carers and home carers”, who are “essential to the system”. He argued that investing in improving training and support for carers will mean that they will be able to support people living at home for longer, preventing some avoidable admissions and reducing pressures on hospitals and nursing homes.

Bill McCarthy suggested the Integration Transformation Fund could be a “catalyst” to develop national leadership and stimulate change, since the fund necessitates a discussion about which existing commitments will be released in order to invest in a different model. He pointed out that this will likely bring to the fore other
“Delivering integration at pace and scale”

Andrew Eyres, Chief Officer of NHS Lambeth Clinical Commissioning Group, pointed to the existence of a “patchwork quilt” of progress among health economies, meaning that the Integration Transformation Fund, as a tool, “will be adapted in different ways”. He argued that good partnerships, as well as a joint commitment and vision, already exist, and that the ITF will push the NHS along and provide a focus, “driving on rather than creating…that vision and that partnership and the relationships”. The “central vision has to be based around the citizen, based around improving health, not treatment, and based around activating people to care for and support them to care for their own health.”

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Questions about funding in training, support, and development and “stranded assets” which may have to be used differently.

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While the ITF can help some things, other improvements will need national action such as defining outcome measures, incentivising change in primary care and aligning education and training budgets with commissioning intentions. He concluded that the situation was complex, “because the scope of what needs to be done is great”, but that getting the vision right from the outset, and focusing on this vision, will be key to success.

Merav Dover, Chief Officer of Integrated Care, Lambeth and Southwark, King’s Health Partners, highlighted the opportunities to build on community assets and transform how general practice works. National help on measurement and commissioning will be important: “We can’t put much of what we want in place unless we really direct how money is spent so that it is spent proactively and preventatively”

Merav also noted that “leaders in each of our organisations are doing two things, they are improving what they’re doing in the current system, and they are transforming the system.” Policymakers need to consider how to balance these two objectives and what can be done to “prevent the constant gravitational pull back to improvement within the current system because people need short term results.”

Amanda Simonds, Strategic Alliances Manager at Novo Nordisk, noted that mental health problems are particularly significant for patients with diabetes. “You can’t look at one without the other.” Patients with diabetes spend up to two or three times the average length of stay in hospital and a global survey of 17,000 patients with diabetes highlighted the importance of a mental health condition in leading to a higher length of stay. She asked for any thoughts about how to reduce length of stay, explaining that “under the diabetes header we could really make a difference”.

Tony Whitfield, Finance Director at Salford Royal NHS Foundation Trust, responded by suggesting two ways to reduce length of stay. Firstly, seven days services which would allow rapid turnaround to “get somebody out with the right care and support”, minimising the “very little things” which act as obstacles to efficient services.

Secondly, Electronic Patient Records (EPRs) which “follow the patient” whether in a home, a care home or at hospital. EPRs are “going to be the future of how we are able to…close more of our beds and get into the community” as they will facilitate “a universal look at what’s going on with them at that moment and what needs to come in front and what went behind”.

Anita Charlesworth added a further two suggestions. Firstly, a focus on recovery, “which is not just about getting people out earlier to replace an acute care need with a community health service and social care need, but…a whole approach to hospitalisation which is rapid mobilisation which stops deterioration in the first place and reduces the social care need”. Secondly, she advocated care planning and integrated assessment which looks at all the patient’s needs.

Bill McCarthy added that NHS organisations should not get overly focused with one key idea, as you “have to do them together”. For example “sometimes someone has a go at risk stratification and you get a nice model but you don’t do the care co-ordinator to make common assessments and the financial flows. It actually is a systematic thing. It’s a package of things. I don’t think it’s one of those where you can try a little bit of it for a little bit of time.”

Dr Patrick Cadigan, Registrar, Royal College of Physicians, spoke on the future of the workforce and argued...
Delivering integration at pace and scale

the need for generalists to help coordinate care for elderly patients with multiple conditions, which would give better care and reduce length of stay. As the Shape of Training Review recommended, the NHS should “train many more doctors to espouse a generalist approach and many more doctors should train in the community”.

For example there could be a role “for hospital physicians working in the community alongside colleagues, providing the sort of expertise that will be necessary in people with complex, interdependent medical conditions. We probably need a new sort of doctor. We probably need somebody called a community physician who is halfway between a GP in knowledge of the community, the way the community works, and an expert physician in their knowledge of disease.”

Patrick also noted that where integration has been successful it has usually been driven by “local clinical enthusiasts interested in a particular condition… by people who have dismantled current payment structures.” However the line from Monitor might still appear too “forbidding” of local attempts to experiment with tariff.

Professor Paul Corrigan CBE, former Health Advisor to Tony Blair, described how the challenge is in patients’ level of confidence in different care settings, be that their home or a hospital. “The location of most care is in the home. That’s the place that people leave when they go in, and it’s the place that they go to when they come out. Because the home can’t deal with high acuity, people feel that they have to go to hospital. Because the home can’t deal with recovering high acuity, they stay inside for longer.”

Because the home can’t deal with high acuity, people feel that they have to go to hospital. Because the home can’t deal with recovering high acuity, they stay inside for longer.
So the challenge then is how “do we surround those people in their home with a capacity to deal with higher acuity than they can deal with at the moment. And a lot of that has to be their confidence in our system. At the moment they have confidence in our hospital system and they don’t have confidence in anything else. And that’s the problem.”

Jeremy Hughes highlighted the importance of assigning elderly patients with complex needs a single named clinician responsible for them. But this need not be a GP. “I think it should be the person who is best placed to support that patient and who often has the most confidence with that patient.”

For example, “physiotherapists spend longer talking to patients than probably anybody else because while they’re doing the physio they’re talking. And maybe they’re the person that the patient trusts, and they could be the named clinician or named care navigator”.

Sue Roberts, Chair of the Year of Care Partnerships set out areas where more was need on “currencies and incentives”. With reference to tariff design, Sue noted that policymakers continue to “concentrate a lot of effort at the moment on only one part of this whole system…and everybody has been saying we need to look at the whole system.”

One concern was that the Year of Care Tariff focused exclusively on “relationship between particularly hospital care and community care” and did not address primary care “because, quote, ‘it was too difficult’”. She also highlighted the need for currencies and incentives which to reach out to “the assets in the community” such as volunteers, families and housing providers.

Dr Simon Eaton, National Clinical Lead for the Year of Care Partnerships, and, Consultant Diabetologist, Northumbria

“How are we going to incentivise the system that you are going to be allowed to do short term incentives which will look after the long term outcomes so you incentivise both?”
Healthcare NHS Foundation Trust, used the example of diabetes patients to illustrate the need for an individual focus: “integration for everyone but differently for everyone”.

“Lots of things out there that can be done and should be done and would save money and improve quality and increase integration. But it is lamentably difficult in many health economies to get that process to happen.”

Integration also needs to encompass more than healthcare. “Diabetes patients spend just a few hours a year in connection with health services and thousands of hours managing their conditions themselves.” Integrating these episodes is “perhaps not as important as the co-ordination of how it fits with their life and their community”. The “big incentives in the systems and the organisations” need to “allow these little conversations to flourish on a daily basis with numerous people all the time”.

Tony Whitfield argued that the reason there is “institutional confidence” in hospitals is because “it’s the only place where if you knock on the door it’s going to be open… it’s the one place the public knows they can knock on the door of. The other systems kind of don’t make it that easy”. For example, in Salford, there were a lot of walk-in centres, which were closed due to their small impact. “So, we moved them to the front of the A&E department so the people can get streamed but can have the confidence that they’re turning up to somewhere that will look after their needs”.

Dimitri Rodzianko, Director of Market Access at Novo Nordisk, raised the key concern undermining attempts to transform services: “short term incentives starving long term outcomes”. “How are we going to incentivise the system that you are going to be allowed to do short term incentives which will look after the long term outcomes so you incentivise both?”

Merav Dover added that “we just do not have sufficient people within public services who really know how to take a very well-conceived strategic plan that’s about system change and translate that to making a difference for people and communities” claiming that the NHS needs national support to attract this “cadre of people, who perhaps are currently outside the public services but are willing to come in and do this with us”.

Baroness Young then suggested that there are “lots of things out there that can be done and should be done and would save money and improve quality and increase integration. But it is lamentably difficult in many health economies to get that process to happen”. She argued that what’s required is “somebody to help the laggards”.

At the moment they have confidence in our hospital system and they don’t have confidence in anything else. And that’s the problem.”

Richard argued in favour of prioritising an area, “something around small groups of clinicians being given the freedom to try something, cut enough financial slack by commissioners in the regime such that it’s not going to jeopardise the sustainability for something like UCLH. I’m not going to sign off something that’s going to put £10 million of income at risk.”

Bill McCarthy offered two concluding thoughts. First, health and care organisations need to work collectively to develop long term visions. “In this coming planning round I’m not really interested in hearing about what is your next year’s activity level until I understand how it’s a step towards some kind of shared vision…if you can’t see your high quality, sustainable place in your health economies you serve in more
“There are always going to be some priorities that we must do. But we need to keep them to a few because we know in any economic setting the big national public target set will crowd out the creativity and the innovation and the local ownership for change.”

Secondly, policymakers need to make sure not to crowd out the process enabling people to take a more medium term view. “There are always going to be some priorities that we must do. But we need to keep them to a few because we know in any economic setting the big national public target set will crowd out the creativity and the innovation and the local ownership for change”.

Peter Meeus concluded that “we are not emphasising enough the consequences of diabetes and specifically long term consequences… because there are three million people suffering from diabetes day in, day out, and this will go exponentially up in 2020 to five to six million people”. He went on to say that “a clear vision is very much needed in the NHS for improving and integrating care for patients with diabetes because too often, when faced with uncertainty about what to do, “people stand still and just do what by default they planned to do from the past.”

Peter argued that change has to be multi-directional: “It’s not just one way. It’s not top-down or bottom-up. It’s both ways”. Policymakers should also identify “the top ten things you would like to do and let people work around or rally around those top ten things… How you get there is basically up to local leaders.”