Bevan Commission Meeting 5 Minutes

Date of meeting: 18 October 2012

Time of meeting: 09.00 – 15.00

Venue for meeting: Keir Hardie Health Park, Merthyr Tydfil

Version: 1

Welcome and apologies

The meeting opened with words of welcome from the Chair.
The Chair welcomed all in attendance to the fifth meeting of the Bevan Commission.

The meeting was attended by the following Commission members:

- Professor Sir Mansel Aylward CB, Chair, Bevan Commission
- Professor Bim Bhowmick OBE, Consultant Physician for the Elderly in Community Care, Anglesey
- Dr Tony Calland, Chairman, BMA Medical Ethics committee.
- Dr Jo Farrar, Chief Executive, Bath and North East Somerset Council.
- Lt General Louis Lillywhite CB, MBE, QHP, former Surgeon General of the British Armed Forces.
- Professor Marcus Longley, Director, Welsh Institute for Health and Social Care, University of Glamorgan.
- Professor Ewan Macdonald OBE, Head of Healthy Working Lives Group. University of Glasgow. (joined by telephone)
- Professor Sir Anthony Newman Taylor CBE, Principal, Faculty of Medicine, Imperial College.
- Professor Donna Mead OBE, Professor of Nursing and Head of the School of Care Sciences, University of Glamorgan.
- Professor Ceri Phillips, Professor of Health Economics and Head of Research, College of Human and Health Sciences, Swansea University.
- Professor Allyson Pollock, Professor of Public Health Research and Policy at Queen Mary, University of London.
- Professor Jennie Popay, Professor of Sociology and Public Health, Lancaster University.

Apologies were received from:

- Sir Ian Carruthers OBE, Chief Executive, NHS South of England.

Abigail Harris, Director of Strategy and Policy, Department of Health, Social Services and Children, Welsh Government, also attended the meeting.

In addition the following support staff attended: Eleanor Higgins (Public Health Wales), Helen Howson (Public Health Wales), Jon Matthias (Public Health Wales) Dr Chris Riley (Welsh Government).

Update from Chair
Professor Sir Mansel Aylward updated Commission members on the following areas:

a) The Commission's note to the Minister about primary care is in the final stage of drafting and will be circulated for final comments.

b) The Chair's work in New Zealand includes co-authoring a longitudinal study on healthcare. The Chair is also advising HM Government of New Zealand on setting up a national independent commentator panel, similar to the Bevan Commission.

c) The Chair also addressed the 6th International Forum on Disability Management (IFDM 2012) at Imperial College London in September.

d) The Chair also shared some important news with the Commission regarding the consultation by health boards with the public over health services. The citizens' response has generally been understanding and helpful. Two health boards are in formal consultation and the others are in 'pre-engagement'.

Notes from last meeting on 8 August 2012
The Commission approved the notes of the previous meetings.

The Commission discussed the response to the Compact Consultation document published by the Health Minister's office. The discussion crystallised the email correspondence held between Commission members in the interim period. The Commission agreed to submit the response drafted by the Chair and his support staff, subject to some changes in language.

The PHARMAC paper submitted by corresponding Commission member, Professor Gregor Coster was welcomed by the other members of the Commission who noted the success of the New Zealand Government in maintaining a low average cost for medicines.

Integrated Care in Wales
Professor Marcus Longley presented his paper on integrated care, noting the following main points:

- There is no single policy definition of 'integrated care'
- Integration is not a simple 'more=better' trade-off
- Integration may be incompatible with patient choice
- The critical success factors for making integration work are leadership, incentives (not necessarily financial), evidence, identifying future workload
- Integration is difficult to measure

In the following discussion, Commission members raised the following points:

- Integration could enable patients to manage their own pathway

- Integration is dependent on trust, respect and healthy relationships. However the turnover of senior managers limits the establishment of trusting relationships.
- Integration may cost more – however it may also produce much better outcomes. 'Efficiency' does not mean 'lower cost'
- Integration may keep people out of hospital, but the cost of healthcare will still rise as the older population grows
- Effective leadership at all levels is important.

Integration in practice – a professional perspective

The Commission welcomed three professionals to talk about their experience of introducing integrated care. Each of the professionals were involved in setting up and running the Chronic Conditions Management Demonstrator programmes in Carmarthenshire.

They were: Councillor Meryl Gravel, Carmarthenshire;
Leo Lewis, Service Transformation Programme Manager, Hywel Dda Health Board; and Dr Alan Williams, GP, Llanelli.

The general points made in this session were:

- Blurring the boundaries between health and social care, e.g. through co-locating, enabled professionals from both sides of the divide to better understand each other, and also aided good working relationships. Co-location provides 'opportunistic conversations' that reveal issues and encourage team problem-solving.
- 'Ownership' at the frontline is key to making integration work – people will resent it if it is imposed from above. Staff engagement is a must. However, staff do not always feel free to innovate and introduce their own ideas.
- Funding and staffing is an issue. Although there are probably resources to do it, if they can be identified and released.
- Integration takes time to introduce and start working effectively.
- It takes leadership and determination to make it work, including an awareness of 'the politics'.
- Government has a role to play in ensuring health and social services have the same objectives, and are measured on the same key performance indicators.
- Social services and health board boundaries do not always tally, so this requires some flexibility on both sides.
- Information systems are not linked between health and social services and this has been a major practical problem resulting in staff having to establish "workarounds". Confidentiality issues have prevented use of predictive services, for example, to identify people at risk of falling.
- Service users were involved in service redesign.

Integration in practice – a patient perspective

Three people with experience of using NHS Wales and social services presented their stories to the Commission. Those invited to contribute were Katrina Selway, Education Programmes for Patients (formerly Expert Patient Programme) Tutor, Caroline Davies, Education Programmes for Patients and Margaret Rennocks, NHS Wales Self Care Programme Manager..

The Commission were asked to consider the following points:

- The 'benefit' of integration must be everybody's business. For example, work by social services may reduce health board expenditure but, in turn, may increase social services expenditure meaning there is reluctance from social services to spend money because it sees little return on its investment. Organisations have to stop seeing the money in the pot as "theirs" and be more willing to share money between departments. Education, in particular, "hold onto money as if it's gold dust."
- Continuing healthcare is inflexible. Health services only see the bit they deal with. It is not holistic.
- Divisions run deep – health and social services will not share resources, or even expertise.
- Services need to be more innovative but the 'worst possible thing' is to remove what is working well. Those depending on the services should be asked before services are withdrawn.
- Investment should be proactive. Responding to crisis situations is not cost effective for healthcare organisations.
- There is poor signposting to services.
- A single case manager would be a great help. People feel that there is a culture of assessment with similar questions being posed by different departments. This is frustrating and time consuming. Many of these assessments result in no benefit to the person being assessed and therefore appear pointless.
- There are problems with recruiting and retaining carers. There are also training silos – health boards are not allowed to train social services staff.
- Even those who say they have 'good experiences' of health and social care say they have had to "fight for" the people they care for in a "mostly uphill battle".

Ageing and aged population

Professor Bim Bhowmick presented on his work in Torfaen and latterly Anglesey, to improve patient experience and provide a higher quality service to elderly people. He has pioneered the use of a multi-disciplinary team to improve treatment closer to home and reduce hospital admissions. He has managed this with no additional funding, for example, by 'borrowing staff'.

Professor Bhowmick identified leadership and engagement with staff as key to making these projects work. The impact has been positive – in Torfaen, a report by

NLIAH recorded patient satisfaction at 100%. Additionally, the Audit Commission reported Torfaen's social services underspending for the first time ever, with reduced admissions to care homes the main focus on savings. This was a direct result of the interventions by the multi-disciplinary team that resulted in fewer admissions to hospital. Professor Bhowmick also informed the Commission that the health board redeployed a discharge planner from a large hospital due to the reduced workload following the reduction in admissions of elderly patients.

Professor Bhowmick's work provides a clear safe choice for elderly people with an alternative to hospitalisation. It has resulted in a change of culture among patients and among professionals, especially in primary care.

At lunchtime the members of the Commission were able to take a tour of the health park and converse with members of staff. Many staff reported the benefits of being co-located with different teams and disciplines.

Integration in practice – a professional perspective (cont'd)
Dr Sharon Hopkins, Executive Director of Public Health Cardiff and Vale UHB, attended the Commission to talk further about integration in practice. The following points were made:

- From a health improvement perspective, integration is seen as a way of embedding that perspective across multiple organisations.

- The differences between integrated purpose, structures and functions were clarified. Integrated purpose alone is not enough and true integration only comes when structures and functions are integrated as well.

- Successful integration is highly dependent on the personalities involved. Often primary and secondary care experts do not see themselves as on the same pathway. Individuals may need incentives to take part – not necessarily monetary. Integration also depends on trust between the partners involved, and removing the fear of losing control.

- Public engagement needs to be improved in order to support integration.

Concerns over the influence of the pharmaceutical industry
Professor Allyson Pollock was invited by the Chair to share her concerns over the pharmaceutical industry and to introduce the issue of whether Wales needs a central body to negotiate prices of medicines with the industry.

Professor Pollock noted concerns over the trading practices of pharmaceutical companies in promoting patented drugs which had little advantage over drugs that were off-patent, along with the possibility of over-prescribing and over-treatment in NHS Wales.

There was a comparison with Norway where a central purchasing unit negotiates the price of drugs, resulting in a lower percentage of healthcare expenditure being spent on medicines. Professor Pollock asked for research on this to be presented to the Commission and the Chair instructed the support staff to this effect.

Note on Integration to be submitted to the Minister
The meeting concluded with a discussion of themes arising from the evidence presented about integration that would be included in a note to the Minister.

Future areas of investigation
In its discussion on the note to the Minister, the Commission identified several areas that would be worth exploring further in future meetings. These included:

- The working age population, rehabilitation, and functionability
- Public user involvement in NHS Wales
- The role of the voluntary sector as regards healthcare
- Re-engineering the NHS Wales workforce – a high level view

Action Points

Number	Action	Who	Action taken
BCAP 5.1	The Commission agreed to invite Kevin Flynn, Andrew Goodall and Elwyn Price Morris to talk to about performance	MA	Will be agreed once priorities for 2013 have been agreed.
BCAP 5.2	Professor Marcus Longley to update his paper on integration, following discussions	ML	Complete
BCAP 5.3	Circulate evaluation reports from Chronic Condition Management Demonstrator pilots in West Wales	EH	Complete
BCAP 5.4	Further discussions on pharmaceuticals to be held at next meeting. Extend invitation to Professor Phil Routledge from All Wales Medicines Strategy Group.	MA	Will be agreed once priorities for 2013 have been agreed.
BCAP 5.5	Include the following in future discussions: • The working age population, rehabilitation, and functionability • Public user involvement in NHS Wales • The role of the voluntary sector as regards healthcare • Re-engineering the NHS Wales workforce – a high level view	MA	Will be agreed once priorities for 2013 have been agreed.