

Creating a better care system

Setting out key considerations for a reformed, sustainable
Health, Wellbeing and Care system of the future

June 2015



Executive summary

Background

In Winter 2014, the Local Government Association commissioned EY to support the development of a description of better care and support.

Local Government and the NHS have made significant progress toward improving outcomes, experience and quality for individuals despite a challenging financial climate and increasing demand, expectations and market pressures. However, a number of recent publications by the LGA and partner organisations have set out the residual risk to mental and physical health, wellbeing and inclusion, quality and safety and financial sustainability as a result of chronic underfunding and barriers in the current system.

Purpose of the document

This document is developed together with the LGA and reflects a review and consolidation of existing work and national and local views. It is designed to prompt debate at a national and local level regarding:

1. The framework for the future system
2. The key system changes required to enable this vision to be delivered

The document aims to do this through setting out:

1. The vision for the future
2. Key barriers preventing this being achieved
3. Key changes that will help to remove these barriers

Approach

The document has been developed through:

1. A review of existing literature published by partners, charities and research organisations
2. Four workshops with the LGA and partners to define the vision, understand the system barriers from a range of perspectives and describe the required changes
3. Further discussion with regional contacts and the Health Transformation Task Group to sense check that barriers and key considerations are locally relevant and reflect the experience in local areas

This document is a summary of the findings and conclusion from the above activity, reviewed and approved by the LGA.

Scope and signposting

The scope of this document is to:

1. Set out the high level vision and elements of a new service
2. Define the systematic barriers to change
3. Develop a set of key areas of focus for system improvement discussions

We recognise there are limitations on the level of detail we have been able to explore in certain areas. Within the report we were keen to not repeat or dilute the extensive existing work completed or underway on certain topics for example: the full extent of prevention good practice and the future role of Health and Wellbeing Boards, Commissioning for Better Outcomes. Page 10 outlines some of the key documents that describe these in more detail and work is ongoing between LGA and NHS Clinical Commissioners (NHSCC) to define the ongoing role of Health and Wellbeing Boards (HWBs) in place-based commissioning.

Disclaimer:

In carrying out EY's work and preparing EY's report, we have worked solely on the instructions of the Local Government Association and for the Local Government Association's purposes. The views and ideas in this document are reflective of those of the sector gained through significant engagement with the LGA and partners. They have been consolidated by EY in this report. EY's report may not have considered issues relevant to any third parties. Any use third parties may choose to make of EY's report is entirely at their own risk and we shall have no responsibility whatsoever in relation to any such use. EY's work was completed in April 15 and is therefore reflective of available information at this time. EY's work has not been performed in accordance with generally accepted auditing, review, or other assurance standards and accordingly does not express any form of assurance. None of the services outlined or any part of this report constitutes any legal opinion or advice and does not form a review to detect fraud or illegal acts.

Executive summary (cont'd)

Everyone wants to see a health and care system that delivers better care for people. This means:

- ▶ People staying healthy and enabled to prevent ill health in the community
- ▶ People in control of their own care and remaining independent
- ▶ Care that is responsive to people's needs, is safe and seamless between different parts of the system
- ▶ A system that delivers better outcomes for every pound spent

There have been huge strides in improving the health and care for people:

Highest performing health system of 11 industrialised countries

Delayed transfers from hospitals due to lack of social care availability fallen

250,000 personal care budgets across England

Introduction of Integrated Personal Commissioning

But there is a lot more that needs to be done:

- ▶ The vast majority of time and resources is spent on treating people, rather than helping them to stay healthy and independent in the first place
 - ▶ The chronic underfunding of the system driven by increasing demand and changing demographics, is compounding the problem, pushing already stretched resources into firefighting the current crisis of increasing ill health
 - ▶ When people do receive care and support services, too often they experience disjointed care, moving between services without regard to the person's wider needs, abilities or home environment
 - ▶ The current commissioning structures are fragmented, preventing local commissioners from responding effectively to the needs of the local population
 - ▶ National payment systems across health and social care incentivise a focus on treatment over prevention, limiting commissioners ability to invest in long-term solutions based on the needs of the local population
 - ▶ Central rules and processes hinder the ability of local health and care systems to work together in the best interests of local people, forcing them to look 'upwards' to the centre rather than outwards to the citizen
- ▶ People with long-term or complex needs interact with both NHS and social care services, costing the whole system **£87.9bn**. Better care for these people means transforming services across health AND care AND wellbeing.
- ▶ At a local level, the needs of the whole population differ and the way people interact with services varies. This means a model of care which is flexible to local circumstances so people achieve better outcome overall is needed

Executive summary (cont'd)

Fundamentally the sector feels an integrated devolved system, supported by the right infrastructure and national framework is required. To deliver this, additional pooled funding of at least £6.6bn from 16/17 is needed, plus an injection of £5.2bn by 2020 into the health and care system to drive prevention and put the health and care system onto a sustainable footing.

Put people in control:

- ▶ Involve councils and Health and Wellbeing Boards in setting the strategic direction of primary care commissioning to include social care and public health and embed prevention across all services
- ▶ Strengthen the focus on prevention within the NHS New Models of Care
- ▶ Facilitate multi-disciplinary training of staff around personalisation, prevention and community resilience
- ▶ Expand integrated personal commissioning across health and care, with the aim of an additional 250,000 personal health and care budgets by 2020

Integrate and devolve commissioning powers, moving to a place based approach:

- ▶ Greater local control and freedom over pooled budgets, supported by integrated systems – to break down silos and to allow local innovation to better respond to local needs and outcomes whilst upholding the high quality standard and values we know are key
- ▶ Devolve national commissioning budgets across NHS England, Public Health England and Government
- ▶ Recognise Health and Wellbeing Boards, with greater local flexibility, as the vehicle for place-based commissioning, with stronger joint operational supporting infrastructure – to integrate commissioning and delivery around the needs of the local population

Fund services adequately and in an aligned way:

- ▶ Support the system through **c.£5.2bn** additional transformational funding by 2020 invested in prevention and support to stay well.
- ▶ Create a pooled budget of between **£6.6bn** rising to **£141.1bn** by 2020 to drive unified Health and Social Care Commissioning
- ▶ Align social care and health funding settlements over a five year period – recognising the fact that health and social care are inextricably linked
- ▶ Review the ability to borrow to maximise the impact of transformational funding
- ▶ Accelerate the Barker recommendations to review funding options to remove the eligibility cliff edge that exists between health and social care, and to increase entitlements for carers

Free the system from national constraints:

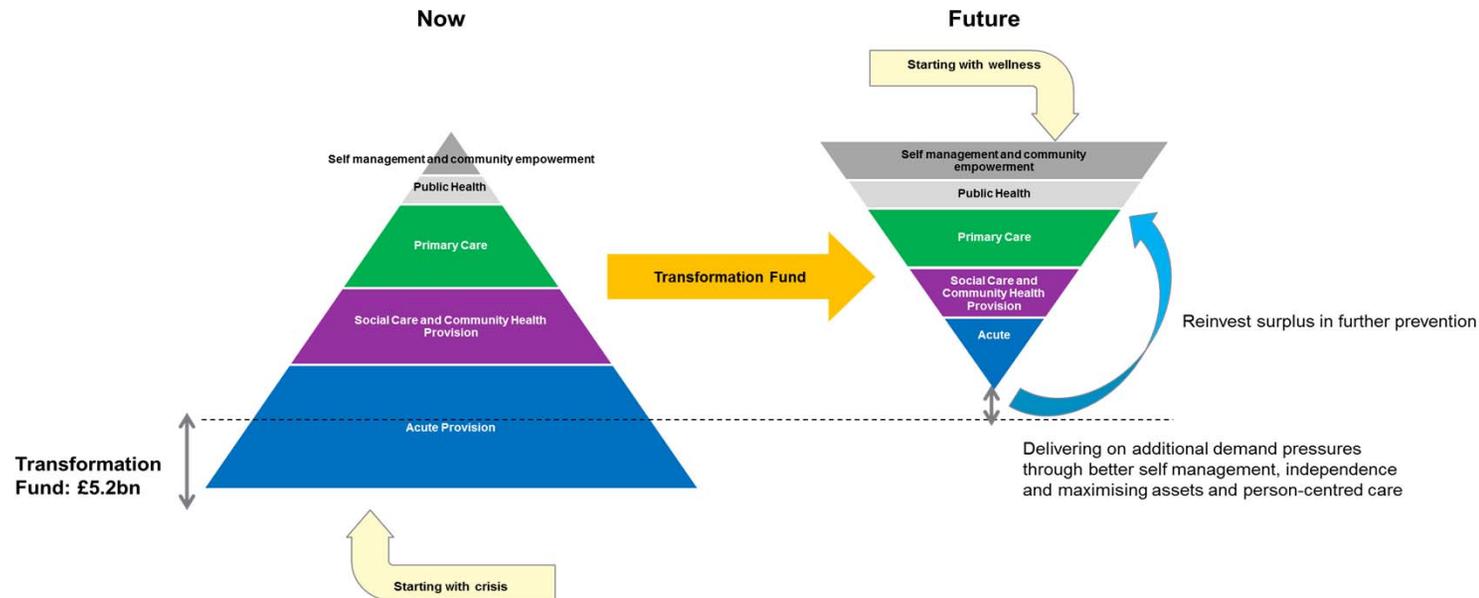
- ▶ Replace the tariff in the NHS with capitated accounting and payment mechanisms – to ensure incentives on the system are directly linked to the outcomes of an individual
- ▶ Align planning cycles across health and social care – recognising the inextricable relationship between the two
- ▶ Greater freedoms and powers for local areas to address local public health issues
- ▶ Develop a sector-led single set of tools for quality assessment across health, care and wellbeing
- ▶ Review the reporting arrangements for regulator bodies and align their mandate to support local economies to deliver on their outcomes

Executive summary (cont'd)

The sector needs to value all parts of the system to deliver a sustainable offer. The system needs to work as one and that can only be achieved when there is a recognition and acceptance of the need to ensure both are funded sustainably.

If these changes are made, people's wellbeing, care and support will be radically improved:

- ▶ More people will be supported to stay well and remain independent at home
- ▶ More people will have a greater choice and will be in control of the care they receive
- ▶ People will receive better quality, more joined-up care tailored to the them, leading to better outcomes

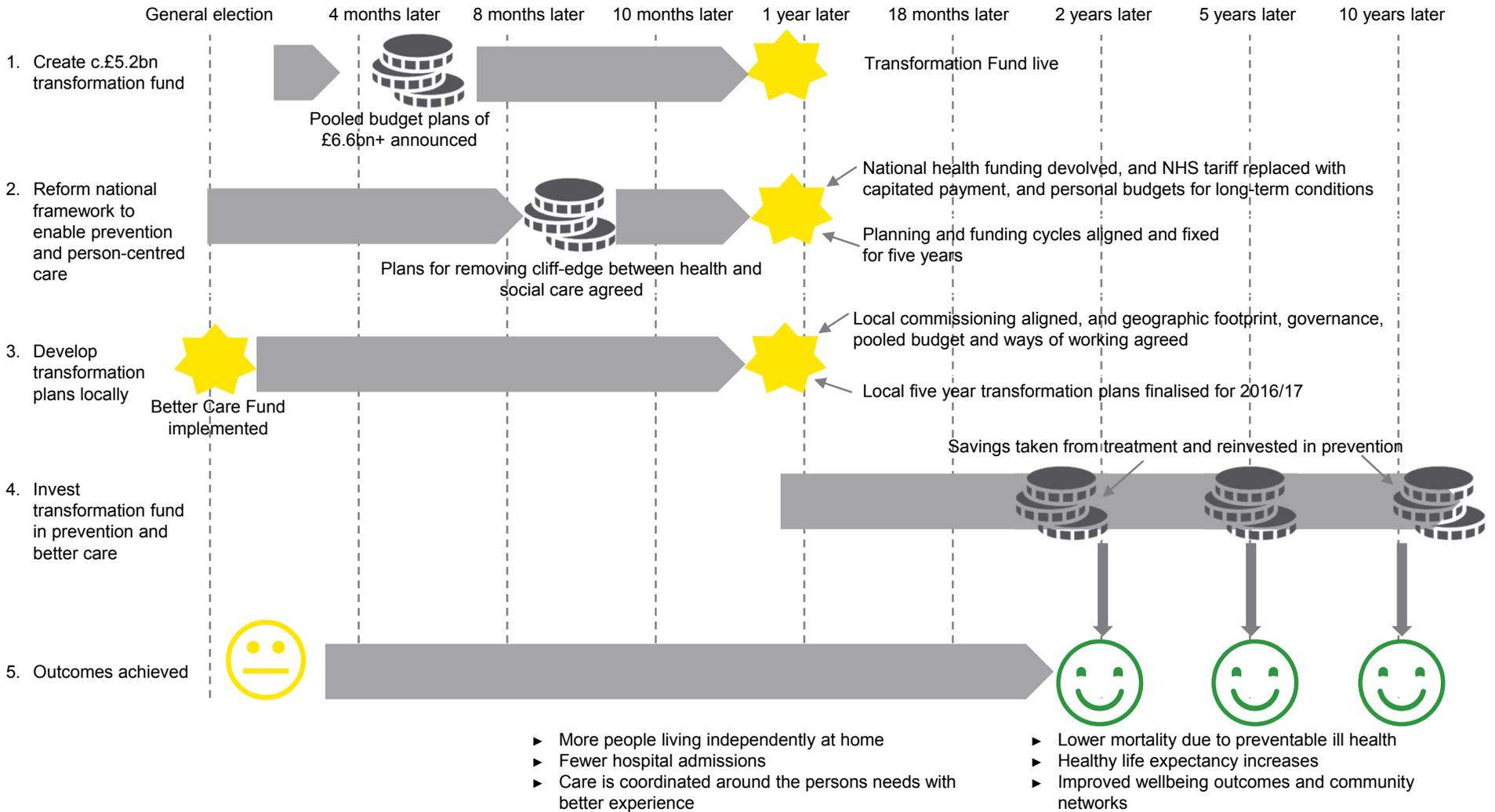


As a result, the system will be more effective:

- ▶ There will be significantly increased investment in prevention, self care and community resilience, leading to fewer costly hospital admissions
- ▶ The system will be more financially sustainable, with the potential for a financial surplus which can be reinvested into delivering even better care and support

Executive summary (cont'd)

The steps to better health, wellbeing and care driven through place-based solutions:



Executive summary (cont'd)

What will the changes mean for Mrs Brown, her son and carer Jack and her granddaughter Yasmin?

It's 2015

Mrs Brown is 75 and lives alone at home in a deprived area of Anytown. She doesn't know many people. She has had diabetes and high blood pressure for a long time. She is losing her eyesight and is becoming increasingly unsteady on her feet.

Mrs Brown receives some care from the council, and a few services from the local NHS which help to give her some independence. These include some home care, meals on wheels and telecare from the council. She also sees the diabetes specialist nurses at the hospital, the outpatients department for her vision and the district nurse is currently visiting daily to treat an injury from a fall. She has been to hospital three times in the past two months because of a fall or her conditions meaning an ambulance had to be called.

She has had to have a number of assessments, is often referred on from the people she has told her story to, has to do a lot of travelling to different services which are changed at the last minute.

Jack, Mrs Brown's son who lives on the next street cares for Mrs Brown for about 20 hours per week. He is struggling to pay his bills as he is unable to work and the carers benefit does not cover these outgoings. He may have to give up caring and try and go back to work.

Mrs Brown is worried that she will have to go into a home if Jack is unable to continue caring and her health and wellbeing deteriorates further.

This is an expensive situation for two reasons:

- ▶ Duplication of resources and;
- ▶ The likelihood that Mrs Brown situation will escalate and lead to more intense, more expensive care.

It's 2020

Mrs Brown is 80 and the transformation fund has been running for five years. She is still at home despite her fears. Following a discussion with Mrs Brown and Jack, Mrs Brown was given an integrated personal budget to help her manage her health and care needs. As part of this, a full care plan was developed jointly with Mrs Brown. As well as the planned activity, Mrs Brown now knows what to do if she gets into trouble. This is much more cost effective as her conditions require less emergency visits, she didn't have to go into a care home and their resources are planned more effectively across the system.

As the staff in the local health and care economy have had some multidisciplinary training, they are able to respond more readily to her needs without Mrs Brown having to have multiple appointments and assessments every time something happens. Equally they proactively work with her to help manage her conditions better to avoid a hospital visit due to escalation.

For the services Mrs Brown has chosen to buy with her personal budget, there is consistent information about quality that has been provided from regulator's report that helps them make informed choices about who provides the care. Her care plan also involves local neighbours and the local VCS, this has taken some pressure off Jack who is now able to find time to do some training to help him when he is ready to go back to work. He has also seen an increase to his entitlement which has enabled him to keep providing care for Mrs Brown.

Because the system has been integrated and devolved, it is now much clearer how the system works and who makes the decisions. As a result Jack wants to be a part of helping design future services. It has agreed to join a sub group of the Health and Wellbeing Board to help design services for the future and ensure individuals remain central to planning and delivery.

It's 2030

Unfortunately, Mrs Brown passed away at the ripe old age of 90, supported by an integrated end of life plan. Her granddaughter Yasmin was born in 2015, just as the transformation fund was established.

Yasmin was born in the same part of Anytown. Thankfully, the local health and social care partners had established a pooled fund that has supported the local community to develop a range of services that support Jack, Yasmin and other families to be healthy and get involved in lots of community activities. This included some cooking lessons to help understand healthy eating. Yasmin also has a leisure pass that means she can afford to go swimming three times a week – she understands it's important to stay healthy!

When Yasmin turned 15, she joined a local community group that organises lunch clubs, helps with shopping and provides a sitting service as a support to local carers. Jack has told Yasmin how important these were for her grandmother.

It's 2100

Thanks to Yasmin being active and having a healthy lifestyle, she has remained free from long-term conditions throughout her life. She rarely goes to the doctor, she uses the pharmacist for support in a lot of things. She has only had to go to hospital once when she broke her arm.

When she reached 85, Yasmin did become frail and needed some support at home. Thanks to the commitment to remove the eligibility cliff edge, this was provided for free. The local integrated health and care system can afford this even though the population as increased because the costs to the NHS have reduced.

Yasmin remained supported at home, with people who are close to her, and lives well at home into old age.

Document navigation

In this report a journey towards better health and care for individuals is set out; driven by local system leaders and supported by a more empowering and enabling system:

1

Section 1: There is a clear vision for better care

Ultimately, a reformed system needs to deliver:

1. **Better health and wellbeing more equally enjoyed**
2. **Better choice and control for all**
3. **Better quality care, tailored for each person**
4. **Better outcomes for each £ spent**

A vision articulated across key organisations and supported by the I-statements developed by National Voices and endorsed by sector partners.

2

Section 2: There are barriers preventing us achieving a reformed system:

1. **Creating dependency through the way we ‘treat’**
2. **Chronic underfunding of the system and a lack of capacity to transform**
3. **Fragmented commissioning incentivising treatment over demand management**
4. **National regulations that disempower local areas**



3

Section 3: There are four steps to better care

1. **Put people in control**
2. **Funding services adequately and in an aligned way**
3. **Devolve power to join up care, support and wellbeing**
4. **Free the system from national constraints**

Collectively this will enable localities to address challenges, deliver a better system and ultimately drive better outcomes and greater sustainability for all.

Vision for Better Care

A more empowering and enabling system for Health, Wellbeing, Care and Support is required

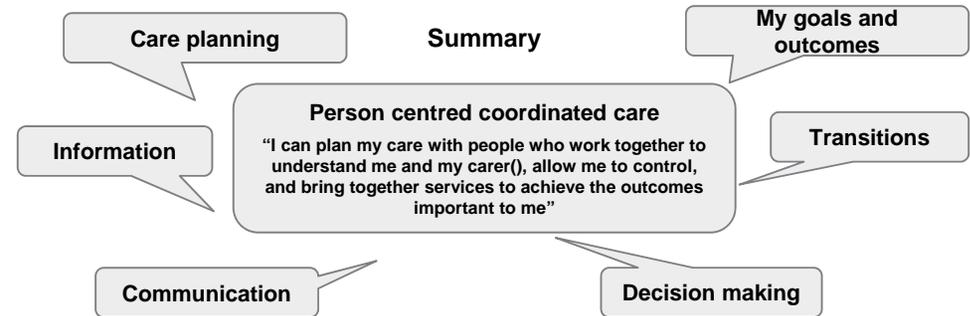
This section describes a vision and the key elements of a future system to drive better outcomes, developed with the LGA and partners.

Ultimately, a reformed system needs to deliver:

- ▶ **Better health, more equally enjoyed** – The Marmot Review demonstrated a difference in healthy behaviours and health outcomes across low and high income households. Services and support needs to be targeted and appropriate to address this issue recognising the positive impact population or community level activity has and the role of the wider system in enabling this
- ▶ **Better choice and control for all** – Work by National Voices, an organisation that brings the voices of patients, service users and carers together, has demonstrated the importance of user involvement in decisions about their care. People should have choice and control over how their needs are met and be supported to be as independent as possible through the process
- ▶ **Better quality care, tailored for each person** – Quality care that is clinically effective in the eyes of clinicians and patients, is safe and provides as positive an experience as possible is the desired standard. Care should be person-centred and focused on outcomes. The National Collaboration for Integrated Care and Support has identified this as a key theme in improving how individuals engage with the system
- ▶ **Better outcomes for each pound spent** – Demand and needs are rising and the system is currently under-resourced. Our future health and care system needs to be more sustainable. Using place-based commissioning driving better use of collective resources and a focus on prevention and demand management through investment in these key services. The NHS Confederations 'All Together Now' and NHS England's Five Year Forward View reflect these challenges and the need to identify new ways of working to deliver this

These outcomes should not be mutually exclusive and instead complementary. By better engaging people in the system and focusing on driving wellness we should see improvements in outcomes, experience and sustainability.

Work by National Voices, fully endorsed by TLAP, LGA, NHSE, DH and Monitor, best describes what good looks like in citizens' own words:



This is supported by a framework for person-centred care based on a series of 'I-statements' which are an assertion of what older and disabled people as well as carers and citizens expect to feel when it comes to care and support. Examples include:

My Goals and Outcomes – Taken together, my care and support help me live the life I want to the best of my ability.

- ▶ **Decision Making** – I am as involved in discussions and decisions about my care, support and treatment as I want to be
- ▶ **Care Planning** – When something is planned, it happens and I have systems in place to get help early to avoid crisis
- ▶ **Information** – I have information, and support to use it, that helps me manage my condition(s)
- ▶ **Communication** – I have one first point of contact. They understand both me and my condition(s) and I can go to them with questions at any time.
- ▶ **Transitions** – If I need contact with previous services/professionals, this is made possible. If I move, I don't lose entitlements to care/support.

This narrative underpins the recommendations made in this report. These jointly owned principles for service design should be the driving force behind the way people are supported going forward.

There is cross-sector consensus on the need for transformation

Building out from the I-statements and the strong platform created by sector representatives and statutory bodies through recent publications a direction for health, wellbeing and care has been set out. This is a vision across all ages and types of need (mental health, physical health, wellbeing and the social, environmental and economic factors that contribute to these). It also reflects the interdependency between elements of the system that may currently be commissioned separately. This will drive a transformation in the system over the next five years. Outlined below is our vision for the Future of Health, Wellbeing and Care and what this means for individuals, communities and therefore the system.

Individuals:

- Support to stay healthy and well throughout their life
- Better connections with local communities, friends and family
- Control of their own care and support

Communities:

- At the heart of support networks
- Able to support people through networks

The system:

- More affordable, efficient and effective
- Inclusive

Building on a shared vision

Public Health England's 'From Evidence into Action' sets out a clear case for prevention and early intervention forming a fundamental part of a new system.

NHS England's Five Year Forward View described the importance of prevention, social action and more freedom for local areas to design the right model for care and support to meet local needs and improve outcomes.

NHS Confederation's (with the LGA) '**All Together Now**' identified the need for more flexibility for providers on new model delivery. Self care needs to undergo a national, sector led programme to improve practice and the importance of local leaders driving change within a national framework including simplified performance regimes is acknowledged.

The LGA's 'Investing in Our Nation's Future- The first 100 days' of the next government outlined a number of recommendations in relation to health, wellbeing and care which should be addressed as part of developing a new system. In addition, **Commissioning for Better Outcomes (ADASS)**, the Integration Pioneers, the Better Care Fund and Integrated Personal Commissioning are all pushing forward improvements to outcomes and services. However, enacting change in a complex, multifaceted system is difficult without a more localised approach.

All partners agree there is chronic underfunding in the system, despite the delivery of significant efficiencies to date along with a further £22bn described in the Forward View.

In addition to the remaining £8bn NHS deficit identified, work on the funding challenge by **ADASS** and the **LGA** describes a further gap of £4.3bn in adult social care.

To drive a better use of resources and address some the demand and funding issues described, **ADASS** and the **LGA** have outlined a need for Health and Wellbeing Boards to play a stronger system leadership role.

This is supported by the eight key asks in **NHS Clinical Commissioners 2015** manifesto which in addition, described better required linkages between national and local commissioning.

This report builds on these foundations, setting out an improved system and the conditions required to make it happen.

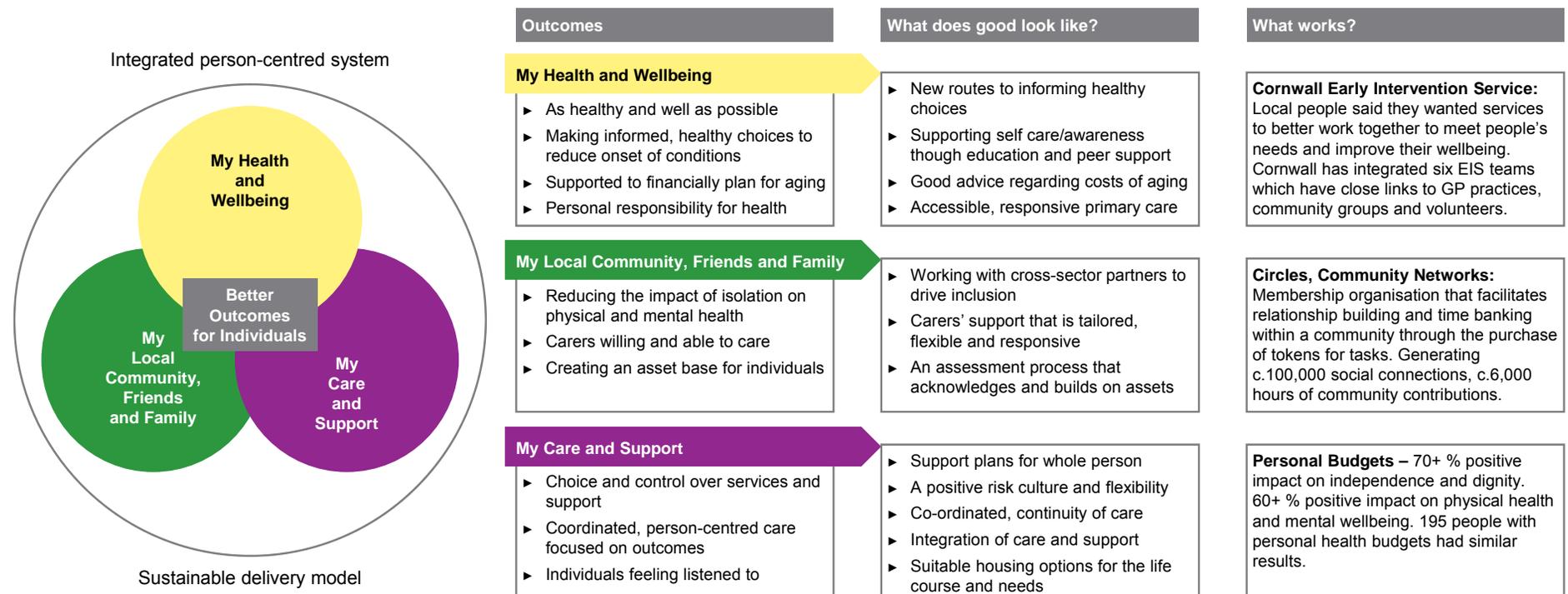
For individuals, it means people are supported to take responsibility for staying well, be socially included and have choice and control

A framework supporting individuals

Better health, wellbeing and care for people means much greater individual independence, responsibility and support for health and wellbeing, support from friends and family and community services that genuinely respond to what people want. All aspects are dependant on each other to be effective in achieving better outcomes. The I-statements should be the driving force of service design. Which underpin the framework for the future system, described below:

- ▶ **My Health and Wellbeing** – The right advice and support to help me make informed choices and take responsibility for my health and wellbeing.
- ▶ **My Local Community, Friends and Family** – I am supported to find opportunities to get involved either through work, volunteering or activities. My families and carers needs are considered.
- ▶ **My Care and Support** – Personalised, coordinated care and support to help me achieve my outcomes, and control how my care and support is delivered. Decisions about me involve me and are made by me.

Services focused on enablement, choice and control can improve outcomes



For local communities it means additional capacity to support people to get better care

To do this we must – harness the potential of communities in supporting preventative action

For example, a significant proportion of the long-term conditions that generate so much demand for health and social care services are preventable or could be better managed. Addressing lifestyle factors related to strokes, heart disease and diabetes, for example, is a critical national priority in which communities can take an active part in delivery. Supporting aspects of care for those with long-term conditions can free up otherwise engaged capacity in the system. This is most effective when there is:

- ▶ Significant investment in building community capacity, this includes the supporting infrastructure to create networks and the resources for them to use
- ▶ Support delivered directly to local communities take on this role
- ▶ Signposting, information and advice for individuals to be directed to these options by professionals
- ▶ Patient activation – engaged in decision about their own/family care
- ▶ A supportive approach to primary prevention – ensuring the rest of the system is empowered to make the required changes at a community and population level, e.g., addressing worklessness and poverty, changes to food and physical activity policies for schools or legislation on composition of processed foods.
- ▶ Working with employers, the third sector and the local health and social care market to ensure that people with long-term conditions are connected to their community, feel valued and don't face isolation.

To do this we must – help communities to build networks that can support people

Volunteering and neighbourliness are a critical part of truly person-centred care, particularly at a time of increasing demand with fewer or fixed resources. Person-centred care can be delivered through volunteers being trained and supported to provide regular/informal care to those who need it and community champions playing a key role in building awareness of and responsiveness to care needs.

At a local level, it means investing in community groups and the third sector to provide low level support. This comes in many forms:

- ▶ Local employers engaging in schemes to support people back to work
- ▶ Third sector opportunities for volunteering, becoming part of a community or group helping to reduce isolation and promote wellbeing
- ▶ The creation of networks, for peer support or to simply connect
- ▶ Time-banking schemes providing support and access to handy people or other types of support
- ▶ Educating community or faith groups in Health and Wellbeing
- ▶ The use of public sector assets as cost effective hubs for provision

In addition the aging population should be seen as an asset due to the life skills, experience, good health and time brought. Opportunities to 'step down' but not out of the world of work through volunteering and inter generational life experiences that will benefit all should be optimised.

What works: Social Prescribing

Programmes such as the initiative in Rotherham have achieved lasting success by linking patients in primary care to non-clinical support (e.g., befriending and advice) within the community, capitalising on the expertise and compassion found in the voluntary sector. Analysis on the impact of the programme has shown a significant reduction in the use of hospital resources, including a 21% reduction in inpatient admissions. Harnessing community capacity to play a more central role in supporting those in receipt of care will be critical in securing a sustainable future for health and social care.

What works: Dementia Friends

An organisation that supports citizens to understand more about dementia and the small things you can do to help people with the condition. People with dementia want to feel included in their local community, but they sometimes need a hand to do so. Dementia Friends learn about what it's like to live with dementia and turn that understanding into action. This could be helping someone find the right bus or being patient in a till queue if someone with dementia is taking longer to pay. There are now over 1,000,000 Dementia Friends.

Achieving this means the system will be sustainable and people will receive better care and support

There have been big changes to health and care provision that is starting to shift the balance of care

- ▶ Introduction of pooled budgets across health and social care in £5.3bn BCF
- ▶ 250,000 personal budgets across England
- ▶ Introduction of Integrated personal commissioning (IPC)
- ▶ Primary care at the heart of the new system through CCGs
- ▶ Transition of public health to local government

Continue join up health and social care and focus on prevention to ensure that the system will be more affordable and deliver better outcomes for people

People are living longer and with more complex conditions. This is resulting in increased demand for both health and social care services. In the UK life expectancy rose by almost a decade in the first 50 years of the NHS. The number of people aged 80 and over will more than double by 2037 and those over 90 will more than triple. Equally the number of people with multiple long-term conditions is set to rise to 2.9mn by 2017. Long-term conditions account for 50% of GP time and 70% of bed days. In addition, 12-18% of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing, demonstrating the importance of supporting the person not just a single condition.

(Source Kings Fund)

This additional pressure is unaffordable due to a primary focus on reaction, crisis management and the treatment of illness. By **supporting people to take responsibility for their health and wellbeing** and **empowering communities** to realise their potential to support the care system; costs to the NHS and adult social care can be reduced to a financially viable level.

Shift the focus to local systems, to give better, more inclusive care that is more responsive to need

Local areas have **variable levels of need** as a result of socio-demographic, geographic, physical needs and mental wellness. In different places, people engage with services in different ways, and the culture and the approach can be quite different. This means that **a solution that works in one place does not necessarily work in another.**

The current variations in provision are resulting in inequality; flexible locally tailored solutions should focus on addressing this, stimulating a race to the top and lead to better outcomes all round.

In the next section the report explores health inequalities and how the current inadequate targeting of **provision and lack of funding and local control over enacting change** is preventing better alignment between support and needs.

This will be enabled through a place-based, integrated approach to care, with **more power devolved** to practitioners, working with people and communities, forcing the system to make the step change in service and investment mix that will put the health, wellbeing and care system onto a more sustainable footing.

So what is the problem?

There are a number of barriers in the system that are preventing local economies from getting to the heart of the problem and overcoming the challenges faced. **Culture, chronic underfunding, fragmented commissioning and central rules and regulations** are all shackles which local economies are asked to wear whilst also focusing on trying to deliver on the priorities in their local areas.

Four steps to better health, wellbeing and care:

1. **Put people in control** – through investment in prevention; local, jointly commissioning of primary care; and skills and capability to drive behaviour change being built in partnership with citizens
2. **Funding services properly and in an aligned way** – making sure services are properly funded in the longer term; removing the silos created by counterintuitive budget setting; and providing transformation funding that gives prevention time to work
3. **Integration and devolution of commissioning powers to drive a place based approach** – devolving commissioning powers; expanding integrated budgets; and providing health and wellbeing boards with the infrastructure to take on new responsibilities
4. **Free the system from national constraints:** ensuring local economies remain focused on local priorities through a more flexible, localised approach to payment mechanisms; planning cycles aligned to longer term budgets; and devolving additional powers to local areas to drive healthy behaviours

Barriers to better care

The current system is failing to improve outcomes, this impacts individuals and communities

This section describes the barriers to good outcomes identified through stakeholder engagement across the sector. These have been consolidated into a set of key barriers in partnership with the LGA.

Health and social care outcomes have improved significantly in recent years

Over the past 15 years, our health and care system has improved dramatically, whilst at the same time largely weathering the restraint placed upon it.

- ▶ Reduction in premature death from disease
- ▶ Delayed transfers from hospitals due to availability of social care fallen by 7%
- ▶ Personal Budgets survey shows a positive impact on choice and independence
- ▶ Waiting times from 18 months to 18 weeks and public satisfaction doubled
- ▶ Highest performing health system of 11 industrialised countries

The demand, demographic and cost pressures in the system are well publicised and acknowledged across sectors

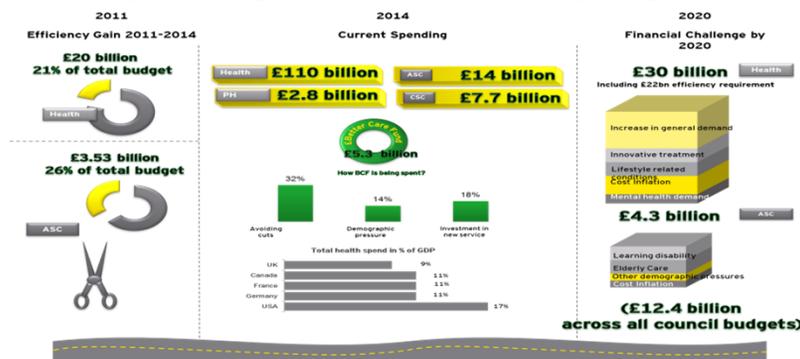
Public Health England's 'From Evidence to Action' highlights the current health issues the system must address:

- ▶ 1/5 –of children are obese in year six of school
- ▶ 62% – adults overweight or obese
- ▶ 1950s – comparable life expectancy for clients with serious mental illness
- ▶ 8mn – people still smoke
- ▶ 800,000 – people living with dementia

The NHS England Five Year Forward View outlines the three key pressures that will put the system under excessive strain and risk outcomes and service quality:

- ▶ **The Health and Wellbeing gap** – getting serious about prevention
- ▶ **The Care and Quality gap** – focusing in on the current variations
- ▶ **The Funding and Efficiency gap** – recognising even if the system can make significant efficiencies additional funding is still needed to ensure the level of care remains safe and effective.

Funding for local government has been cut by nearly 40% since CSR10. Efforts were made to protect care budgets but funding reductions have been such that significant efficiencies are still required in Adult's and Children's Social Care. In addition, local government is expecting a further review, implemented from 15/16, which may seek to reduce local public services by an additional 8-12%. With most local authorities spending 50-60% of their budgets on protecting vulnerable adults and children, the level of protection offered through CSR10 would be unsustainable. The LGA and ADASS have estimated a funding shortfall of £4.3bn for adult social care by 2020. At the same time, NHS England have forecasted an £8bn shortfall by 2020, taking into account £22bn of efficiency savings.



In order to continue to improve the health, wellbeing and care system for people to address the pressures on the system, and to put it onto a sustainable footing, more local powers are required to match provision to need. **There are four key barriers** to delivering better care:

1. **The creation of dependency** in individuals and communities preventing a move to greater health equality and sustainability
2. **Chronic underfunding** of the system, impacting quality and sustainability
3. **Fragmented commissioning**, silo working and perverse incentives reducing choice, control and positive experiences of care
4. **A set of national rules and regulations** that don't enable and empower local economies to provide choice and control, drive sustainability and reduce health inequality through better incentives

Barrier 1: The current culture drives dependency, risk aversion and doesn't facilitate joint working

The sector is focused on treatment and crisis management and not an individuals broader life journey

Despite a gradual shift towards more personalised community-based care, the vast majority of funding is still focused on treatment and crisis management.

- ▶ **30% (15mn) who have one or more long term conditions account for £7 out of every £10 spent on health and care in England.** (NHSE Call to Action)
- ▶ **£5bn year spent on obesity related problems**
- ▶ **£8.8bn a year on treating Type II diabetes**
- ▶ **3,000 alcohol related admission/day to A&E**
- ▶ **£22bn a year is the cost of sickness absence**

The crisis in the current system is exacerbated by:

- ▶ People with an existing illness or long-term condition too often not supported to remain independent, or not receiving coordinated care based around need
- ▶ People at medium or high risk of developing a long-term condition in the future not receiving targeted support and therefore taking responsibility through their behaviours to prevent them
- ▶ The wider population not receiving sufficient information and advice about remaining healthy and independent
- ▶ Reactive, episodic and unplanned care
- ▶ Lack of available appropriate housing options and opportunities to plan this for people with changing needs

- ▶ **Only 50% of patients say they are as involved in their care as they would like to be**
- ▶ **1.1mn people are admitted to hospital where this could be avoided**
- ▶ **20% delayed transfers due to waiting for non-acute care and support**

Work undertaken by Public Health England has clearly shown the **significant impact of people's health choices on their health outcomes in later life**. The Global Burden of Disease study demonstrates the impact on our health of lifestyle. This is in addition to environmental factors such as good employment, safe surroundings and connected communities. A greater recognition that local services, including primary care, have a key role to play in preventing the onset of ill health is critical.

Reframing the relationship between individuals and the state demands overcoming significant **behavioural challenges**. How we communicate, work with and support individuals to take responsibility and make appropriate decisions about their wellbeing will be key. Feedback from the frontline of service delivery points to the persistence of indifference to messages or a dependency culture, where citizens do not feel empowered to take action. Having a **shared approach** to targeting, communicating and where appropriate supporting people within high-risk groups across a local community will be crucial.

For those people with existing conditions, **the system needs to work more seamlessly**, recognising the potential for people to remain independent and in control, and the availability of support from family, friends and communities. Care plans need to be reflect this and be effective across health and care services.

Local variation

The level of need varies significantly across local areas, demonstrated at a high level in the table below (see appendix for explanation of the categorisation). Areas within the 'Hard-Pressed Living' group, for example, have a higher proportion of individuals living with long-term conditions or disabilities that limit day-to-day activity than the national average.

	% Long term condition/disability	Adult Physically Active	Child Obesity (Year 6)	Adult Obesity	Smoking Prevalence/ 100k population
Cosmopolitans	14%	52%	16%	13%	15
County Council	17.0%	58%	17%	23%	18
Ethnicity Central	14%	59%	24%	18%	21
Hard-Pressed Living	20.9%	49%	20%	26%	22
Multicultural Metropolitans	16%	53%	22%	23%	19
Rural Residents	18%	50%	15%	21%	16
Suburbanites	18%	56%	18%	23%	19
Urbanites	16%	56%	18%	22%	20
Variation	7%	10%	9%	13%	7

The way people access services also varies from place to place, depending on proximity to services, the availability of information and advice and the levels of patient activation and local demographics.

Even within a locality these factors can vary significantly. Local health, wellbeing and care economies therefore need to respond differently in how they deliver and commission services that best meet local needs. We also need to recognise local demography and the age profile is changing, services need to be designed to service the population of the future and changing communities.

Barrier 2: Chronic underfunding of the system means it will struggle to cope with rising demand

- ▶ **Across the sector the challenge of underfunding has been recognised.**
- ▶ **The LGA and ADASS have highlighted a funding gap of £4.3bn for ASC**
- ▶ **NHSE described a shortfall of £8bn, assuming the £22bn of required efficiencies can be found**

Starting well services are being reduced in a time of rising demand

As the structural issues of a recession such as unemployment and poverty place further strain on family life, emotional health and well being, domestic violence and substance usage can be exacerbated. The Adolescent and Children's Trust reports that referrals from local authorities more than doubled over the course of a year creating huge levels of demand for Children's Services. Care applications have risen by 70% between 2008 and 2013. Spending reductions on preventative services mean significantly less support is available for parents to provide a successful start for their families. Services such as Sure Start and Children's Centres have seen significant disinvestment nationally. In 2011 **c.42% of councils reported planning closures to children's centres.** The un-ringfenced **Early Intervention Grant has been cut by 0.8bn** between 2012 and 2015. Cuts in services such as libraries and public transport will also have a heavy impact on children and families particularly in areas of high deprivation and cuts to schools budget may mean the pupil premium may be subject to competing demands, reducing the targeting of support to those most in need.

The numbers of individuals living longer with complex needs is also increasing

With advances in medicine, technology and life sciences, both the survival rates and the life expectancy of individuals with life limiting conditions has increased. A significant proportion (c.50%) of Adults and Children's Social Care Budgets are spent on a relatively small proportion of people. The cost of supporting each individual is relatively high, e.g., **lifetime care costs of one individual** with a Learning Disability in Residential Care can be in the region **£2mn** (18 upwards). With Adult Social Care seeing double digit transitions, and Care Act charging reforms meaning no cost recovery from this client group regardless of resources, further cost pressure on the long-term care system is expected.

There is also general underinvestment in preventative action; councils spend c.7% of ASC budgets on prevention, the NHS is approximately 4%. The Department of Health funding for Public Health was £5.6bn in 2013/14. A strong case was put for investing more in public health as long ago as 2002 (Wanless) with projected **savings of £30bn a year by 2023 through effective public health policy.** But despite warnings, spending has remained fairly static.

Services have already absorbed significant funding reductions and the additional demand is having a compound impact

Savings from Health and Wellbeing Portfolios have often been achieved through efficiencies in contracting and service reconfiguration. This is not without risk and the sector has seen a manifestation of quality issues, contraction and difficulties with provider recruitment. Staff recruitment and retention are a challenge as a result of the increasing pressure on the sector. The frontline care workforce is already a workforce on low pay, low social status. According to Skills for Care, in 2012 adult care workers were paid an average of 91p per hour above the £6.19 National Minimum Wage for adults (Skills for Care, 2013). There is a risk that further disinvestment will put at risk performance, quality and safety.

These scenarios ring true in the NHS as well; the number of providers in challenged economies, special measures or under TSA arrangements is increasing as the provider market is already seeing the impact of financial and demographic pressure. With a number of commissioning schemes looking to divert activity (income) away from these 'at risk' trusts, the problem will only worsen as organisations try to survive

Analysis from the LGA and ADASS shows that for the three months ending 30 June 2014 the Foundation Trust sector reported a deficit of £167mn; more than double the planned deficit of £80mn.

Workforces and market capacity are already stretched. Given the clear interdependencies between health, wellbeing and care, the wider system needs to work together to collectively deal with the pressures and demands before it.

Barrier 2: Chronic underfunding of the system means it will struggle to cope with rising demand (cont'd)

Different funding settlements across health and social care do not create a collaborative environment

This can be demonstrated acutely at one of the key touch points of health and social care – hospital discharge. With the reduction in the number of acute beds and demand on the same, effective discharge is important to ensure the system has capacity to manage.

There has been a 26% reduction in social care over the past four years and overall the proportion of delays attributable to social care has gone down from 33%-26%. However, the overall number still goes up meaning addressing the 26% attributable to social care must be a priority.

This brings into question whether it is sensible to protect the health budget when there will have to be further cuts to social care. The evidence in the 2014 State of the Nation report demonstrates that the Government's solution for ASC funding over the current CSR period has failed. Transferring money from health to social care may have helped alleviate some of the demand pressures but it has not proved to be the panacea presented in 2010.

Social care has a big part to play in community provision, which will alleviate pressure on acute services. The gap of **£4.3bn** needs to be addressed alongside the gap in the health budget if sustainability and system change is to be achieved across the whole system. People don't see a differentiation between health and social care services so why should they be separate nationally.

Different eligibility and funding structures for people and carers

Different eligibility and funding structures across adults, children's social care and the NHS also create problems. As the Barker Commission identified, the NHS is paid for out of general taxation and operates within a ring-fenced budget. Social care is paid for either privately or from non-ring-fenced local authority budgets. Who pays for what is a constant source of friction, with enormous and distressing impacts on individuals and families'. This statement captures the inherent inadequacy of the current blueprint for integration and shows that funding structures need reform.

- ▶ **NAO estimate the value of informal care at £55bn in 2011,**
- ▶ **There are approximately 3mn health volunteers nationally**
- ▶ **There are currently 5.5mn carers in the UK**

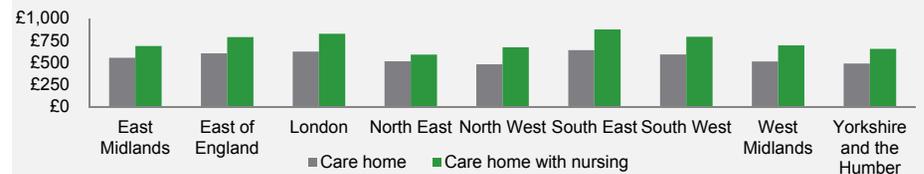
The Dilnot review found that the willingness of family and friends to provide care is diminishing.

- ▶ **1/3 carers cannot afford to pay their utility bills**
 - ▶ **44% of carers have ended up in debt as a result of caring**
 - ▶ **Carer's Allowance is the lowest benefit of its kind, it is worth less than £1.75 a hour for carers caring 35 hours a week**
 - ▶ **20% carers receive no practical support**
- (Source: Carers UK)

Informal carers are being asked to do more with limited support, facing greater strain on their own wellbeing and financial circumstances; as a demographic, they are getting older and less able to support family members, friends and neighbours. This is likely to place additional strain on the system.

Local variation

- ▶ There is variation of healthcare expenditure across the groups, with 'Rural residents' on average having £350 per head less than those living in 'Cosmopolitans'
- ▶ Residential care fees vary significantly across England as a result of land and property prices and availability of labour



(Source: Paying for care.org)

GPs availability varies by >40%, The underserved areas are linked to deprivation and correspond to the PHE heat map of reduced life expectancy. GP coverage is especially critical in the North West and North East. GP workforce supply is inversely related to population healthcare need

(Source: GP Taskforce 2014, Securing the Future GP workforce)

There is a variation of 4% between areas of Hard Pressed Living and Cosmopolitan areas in the proportion of people who are providing informal care of more than 20 hours per week

Barrier 3: Fragmented Commissioning is driving silo-working and dis-incentivises investment in longer-term demand management

Lots of organisations are involved in commissioning which can make it difficult to provide person centred support

Localities wanting to organise health and social care services according to local needs and priorities have a number of stakeholders to coordinate. Not only are community health and social care services commissioned separately (e.g., intermediate care and reablement), there is inconsistency around national, regional and local organisations, undermining coordinated efforts to reduce demand and improve outcomes. For example, prior to the devolution deal, of the £22bn spent on the public service in Greater Manchester only 16% is controlled by bodies based in Greater Manchester.

Aspects of primary care, dentistry and pharmacies, for example, are not commissioned at a locality level. Specialist commissioning is undertaken by NHS England. This is compounded by acute provision operating across different patches and trying to align commissioning intentions of multiple Health and Wellbeing Boards whilst developing plans to remain viable in the wake of reduced tariff income.

Even at a local level there are challenges: CCGs, for example, work from fixed annual budgets that push commissioners into the wrong behaviours and prevent the adoption of more long-term prevention focused measures and closer cooperation with councils.

The role and relationships of health, wellbeing and care within the wider system (housing, employment, community capacity building) also requires further definition if interdependencies are to be managed. An example of this is appropriate housing and adaptations. This is often commissioned separately but is fundamental to wider health and wellbeing outcomes and demand management.

There is much which is currently devolved to localities through LA or NHS routes but this still results in separate LA and NHS arrangements; with the planned devolution for primary care through a parallel structure this will only add to this pressure. Capabilities are not spread evenly across the health and social care landscape, with the NHS better in some areas than local authorities and vice versa. Currently, however, despite the clear advantages of pooling skills and resources both sides lack the freedom to do so to the extent that would generate significant benefit. In essence, it is a complex picture and commissioning bodies are required to work in partnership with a number of other organisations.

Where commissioning capacity has been under continual pressure to streamline, the sheer volume of stakeholder management across commissioners, providers, development agencies and regulators can put significant pressure on the ability to develop cohesive, deliverable local plans and manageable transitions.

In terms of delivering on local needs and priorities where capacity may be stretched, there are examples of where specific sub-structures have been put in place within areas, specifically with the aim of tailoring services to meet the needs of diverse populations.

Local variation

Assessing the alignment of commissioning structures provides some insight into the complexities and challenges in coordinating local systems. Health and Wellbeing Boards provide an interesting example: there are currently 49 Boards that do not map exactly to a CCG structure. Of that 49 there are 27 that represent only one of multiple local authorities covered by the CCG in question. Even where boundaries appear coterminous there can still be challenges, e.g., areas with two or three CCGs overall within one local authority boundary, these arrangements are common in the County Council groups.

Classification	Average proportion of CCG population covered by LA	Average proportion of LA population covered by CCG	CCG to LA Ratio
Cosmopolitans	64%	86%	1
County council	84%	27%	3.4
Ethnicity central	100%	100%	1
Hard-pressed living	92%	94%	1
Multicultural metropolitans	91%	81%	1.2
Rural residents	69%	89%	1
Suburbanites	95%	78%	1.3
Urbanites	89%	91%	1.1

The nature of the local commissioning landscape will inevitably require local areas to adapt, underlining the importance of a locally empowered system, across an appropriate foot print, supported by a simpler framework sitting around it.

Barrier 4: Central rules and regulations do not enable local economies to prioritise the interventions that will have the biggest impact

Payment systems incentivise treatment not prevention and drive activity to the wrong places

Despite the increasing move to pooled budgets, commissioners focused on closely related areas often operating under very different terms, which is undermining their ability to work effectively together towards shared objectives with a locality.

This is exacerbated by the current range of payment mechanisms across the health, wellbeing and care system, which do not support efforts to make care more person-centred and prevention focused. Incentives are often ineffective and, in the worst examples, actively work against efforts to increase user independence and service sustainability. Payment systems have, in many respects, been left out of the integration discussion and the consequences of this are beginning to materialise.

There is at present only a loose relationship between the actual cost of care to service providers and the prices charged to individuals or back into the system. As a consequence, commissioners and providers are not allocating resources or employing care and support to produce the best outcomes for users in the most efficient way. This is acutely realised through the use of national prices within the national tariff, which translates into payment for activity. Many trust's forward plans are seeking to generate income, which may not be aligned with local commissioning plans. This means there is limited incentive for providers to engage and invest in prevention and the wrong contracting models can risk provider viability.

Block contracting separately for community services creates the need for demand management into community service to help manage operating costs. Where more people should be supported in the community, the contracting mechanism can hinder this through limiting capacity to respond.

Equally, many providers are not incentivised on prevention, which often leads to reliance on hospital admissions as a catch-all solution for an individual's worsening circumstances. This can be equally complex from a commissioner perspective, agreeing the 'deal flow' can be complex – it means recognising the organisation providing the preventative support might not be the only one to benefit.

- ▶ A research report by Social Care Institute for Excellence in 2011 showed reablement improves independence, prolongs people's ability to live at home and lasting benefits have been demonstrated across health and social care.
- ▶ An Australian study by Lewin looked longer term:
- ▶ 78% of those receiving reablement no longer required a support service after three months
- ▶ 85.8% no longer required a service after 12 months.
- ▶ Over two years, the reablement group was less likely than the control group to use hospital emergency services.

Planning cycles impact on both capacity and ability to prioritise local, integrated transformation

With any complex system it is essential to ensure services are joined up and operating in line with shared goals and performance measures. Currently, decision making is hampered by complex, multiple frameworks making it difficult for commissioners to evaluate the collective effectiveness of care. Joint planning has been encouraged through the Better Care Fund and Section 75 arrangements however these are in addition to, not instead of existing operating arrangements.

Planning cycles exacerbate this, sending health and social care organisations travelling in different strategic directions. For example, where organisations, in partnership with national bodies construct growth plans to address financial deficits, but local commissioners are seeking to drive different types of care. This represents a serious barrier to meaningful integration and personalisation, as organisations face a multitude of planning obligations restricting the ability to align strategic objectives.

Central intervention is not always fit for purpose to local needs

Local accountability is also undermined by the role currently played by regulators. The community-based health and social care perspective is that regulators are often misaligned in their requirements and should do more to consult local partners when developing them. The regulatory system can be cumbersome and takes focus from service delivery. Trying to harmonise the demands set down by different regulators is creating an increasing burden on commissioners and providers, limiting the effective integration of services and to operate more strategically.

Barrier 4: Central rules and regulations do not enable local economies to prioritise the interventions that will have the biggest impact (cont'd)

Priorities that are set out by Whitehall are not always matched to things that will have the biggest impact and are deliverable locally. This is a barrier to local areas needing to address improvement of outcomes, demand management and enact the changes to the local system to drive sustainability and reduce health inequalities in line with the complex conditions found in their area.

This informal support is less available in rural settings where geographical distance and the emigration of the young and middle-aged can leave a gap in care provision that needs to be filled by the state. In such circumstances, building up highly mobile and effective teams of professional carers to support a sparser population of those in need is likely to be a priority.

There are additional examples within the results that show how health and social care demand and activity vary significantly across England, creating distinct priorities for different localities. These findings reflect the very different starting points for local health, wellbeing and care economies and how different types of provision have emerged over time.

What can be taken from this picture is the need for system change to be locally driven, to effectively plan what new and improved models of care would look like, how and where these will be more cost effective and deliver better outcomes and help to coordinate across the footprint of different organisations.

Local variation

Local areas do have different needs as a result of their population, different geographic footprints and different provision structures. Looking at the current system demonstrates that different economies have very different profiles of health and social care activity.

Area Classification	Number of Local Authorities	Mental Health Admissions	A&E Admissions	EMGIP Admissions	Alcohol related hospital stay
Cosmopolitans	6	279	35,116	8,429	476
County Council	27	188	27,709	9,233	583
Ethnicity Central	10	318	42,833	8,343	655
Hard-Pressed Living	29	240	38,080	11,889	748
Multicultural Metropolitans	30	185	36,159	9,288	621
Rural Residents	8	174	28,257	8,755	500
Suburbanites	21	202	31,205	10,340	661
Urbanites	21	201	28,328	9,192	594
National Average	152	213	33,240	9,782	630

Inevitable differences in demographic, population density, geography and the historic creation of health and care infrastructure will have an impact on how the system can respond to the varying levels of need.

Suburbanite areas have a smaller proportion of their population living in residential care homes or in-hospital care than localities defined under 'Rural Residents'. In practice therefore the two areas would likely adopt different approaches towards providing care for those with long-term conditions.

Suburbanite local authorities can rely more on informal care provided by family members, friends and the wider community, and may therefore prefer to invest in programs that build capacity to continue providing such a vital social service.

Recommendations for better care

To unblock the barriers for local economies to drive better outcomes, there are four steps to better care

This section describes the key consideration to change the system for the better. The considerations pulled out in each section have been developed through collaboration with the sector and partner stakeholders and consolidated into a set of recommendations.

The barriers in the system are hindering local economies from making the step change required

Described in the previous section are the range of barriers that combine to disempower local system leaders. In this section, the report explores what needs to change to enable local economies to transform health, wellbeing and care to deliver the vision outlined in the first section.

At the heart of this is a need to **redefine how individuals interact with the system**, empowering citizens to take greater control of their individual wellbeing as well as that of the broader community. Health and social care, leaders, commissioners and providers have a critical role in making this a reality by supporting individuals to become more proactive in supporting themselves and those around them, and in delivering more person-centred care in an appropriate home-based setting.

Mechanisms may include **joined-up assessment and support planning processes**, with a focus on enablement, will ensure a **recognition of individual ability**, potential and assets or good advice and guidance to help make informed decisions about support. This must be supported by a **positive risk culture** across organisations allowing individuals to have more **control and flexibility and availability of suitable housing options**.

There is promising emerging evidence that integration of health and social care will produce a more effective and efficient system but there is an equal need to remain realistic about how much it can achieve with the current landscape. Many proposals are being tested in a restricted environment and as a result will have a less than optimal practical impact. We need to be bolder about devolved, integrated systems focused on the place and considerate of what an appropriate commissioning footprint is.

The **locality is where experience and knowledge are concentrated**: councils and local healthcare providers and commissioners are best placed to make choices about the totality of services required locally. However, expanding person-centred care is made more difficult without giving **local areas more power and a supportive framework** to make lasting improvements.

Arguably the most critical barrier facing the system is balancing the national policy of reducing the deficit in contrast to the rising demand as people live longer with long-term conditions. This means currently inadequate funding is available for the system.

This must be addressed in tandem with some **fundamental reforms of how commissioning and funding is structured, driving further devolution to local areas to drive personalisation and sustainability**.

System leadership and the supporting infrastructure of information technology, data sharing, workforce development and the 'Commissioning for Better Outcomes' approach are all key enablers currently being tested and developed through a number of live programmes such as BCF and the pioneers. As such, these have not been explored in detail in this report but are recognised as key dependencies and fundamental levers to support unblocking the current systemic barriers outlined.

In this section detail is provided on the **Four Steps to Better Health, Wellbeing and Care** and how these will help to overcome the barriers identified.

Four steps to better health, wellbeing and care:

- 1. Put people in control** – through investment in prevention; local, jointly commissioning of primary care; and skills and capability to drive behaviour change being built in partnership with citizens
- 2. Funding services properly and in an aligned way** – making sure services are properly funded in the longer term; removing the silos created by counterintuitive budget setting; and providing transformational funding that gives prevention time to work
- 3. Integration and devolution of commissioning powers to drive a place-based approach** – devolving commissioning powers; expanding integrated budgets; and providing health and wellbeing boards with the infrastructure to take on new responsibilities
- 4. Free the system from national constraints**: ensuring local economies remain focused on local priorities through a more flexible, localised approach to payment mechanisms; planning cycles aligned to longer-term budgets; and devolving additional powers to local areas to drive healthy behaviours

Recommendation 1: Reforming the citizen relationship is key to changing culture

Embed personalisation of health, wellbeing and care into local systems

Personal budgets in social care have been successful to date in improving choice, control and outcome for those in longer-term care and support.

- ▶ 2/3 of survey respondents said a personal budget had made things better
- ▶ 80%+ said improvements in dignity
- ▶ >2/3 of carers said things had improved

They have been critical in enabling people to make decisions over how needs and outcomes are met. This is now being further tested through Integrated Personal Commissioning (IPC). This new initiative blends health and social care funding by identifying the totality of expenditure at an individual level. It has two core elements:

- ▶ A care model that provides person-centred care planning, and optional health and social care budget
- ▶ An integrated 'year of care' capitated payment for those with complex needs

A significant expansion of the IPC initiative is required, putting it on a par with personal budgets in social care. This could be achieved by:

- ▶ A rapid national review of the opportunities for IPC delivery, including a clear framework to help navigate the tension between clinical guidance and choice
- ▶ Accelerated support to develop and implement plans for selected IPC sites
- ▶ Greater publicity of the potential benefits and shared learning from the programme, supporting other sites to accelerate implementation

“My care is planned with people who work to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes”

(National Voices)

1. Personal Budgets for health and social care should be driven with the aim of increasing take up to equivalent levels found in social care (250,000 in England)

Embed a culture of prevention into local transformation initiatives

- ▶ 57mn GP attendances could be dealt with in pharmacy if model is revised
 - ▶ 3mn falls per year of which a proportion could be preventable
- If the system:
- ▶ Uses the surplus of pharmacies to alleviate pressure on GP time
 - ▶ Includes GP in Multi Disciplinary Teams to deal with frailty
 - ▶ Works with patients to change perspectives and create shared understanding
(Rob Webster, NHS Confed, HSJ)

As well as local authorities broader public health role, primary care is key to embedding prevention into local communities and driving a shift in the way services are used. The review of Primary Care commissioning, along with the NHS's **New Models of Care** present a real opportunity for the NHS to work with councils to manage demand and ultimately reduce the volumes of need for crisis or high intensity services through a more serious focus on prevention across services. This is in addition to providing a local approach to addressing the local variation in resourcing experienced from area to area. However, this needs to be system wide.

The health and social care workforce will also need to develop new ways to engage with residents to promote independence, community resilience and self care, including direct conversations and brokering relationships between family, friends, neighbours and the wider community. At a national level this will require joined-up working with representative workforce professions.

To support this, a culture change is required if individuals and communities are to play a role in improving their health outcomes. This can be delivered practically through:

- ▶ Education of the wider population;
- ▶ Case finding to target support/education;
- ▶ Improved condition management through supported self care with appropriate professionals (small changes in contact type can have a big impact).

Recommendation 1: Reforming the citizen relationship is key to changing culture (cont'd)

Citizens UK 2015 Manifesto, for example, recommended training more health champions to deliver educational programmes should be explored.

Expert Patient Programmes have been shown to deliver a return on investments of 3:1 for the health sector as well as a wider social return of 6:1 depending on the interventions.

The system should also recognise the wider preventative impact of service such as leisure or neighbourhood services and look to optimise the contribution of these services.

For individuals this means they are able to stay well, healthy and prevent, delay or reduce the impact of conditions on their life. For the system it means a greater footprint to support the improvement of health and wellbeing. To deliver it requires:

- ▶ More involvement of partners in healthy choices communication
- ▶ Pharmacy as a key point of access for LTC
- ▶ Good advice regarding retirement, care costs and accommodation
- ▶ Accessible and responsive primary care

- 2. To ensure a focus on prevention and social care, encourage NHS bodies to involve councils and Health and Wellbeing Boards in setting the strategic direction of primary care commissioning**
- 3. Through 'New Models of Care', encourage local areas to identify the population most at risk of ill health and develop a plan to manage demand**
- 4. National bodies to facilitate multi-disciplinary training of local staff around personalisation, prevention and community resilience**

Recommendation 2: Address Chronic underfunding to drive person centred care

Provide transformational funding to give prevention chance to deliver

This is a complex, long-term transformation. Initiatives will work but take time to take effect. The connection between commissioners managing demand and hospitals/accommodation based services managing operating costs is essential. If further trusts are to be prevented from overheating in terms of capacity, quality and finances, the model of care needs time to be changed.

- ▶ **Every £1 on friendship networks saves £3.75 on mental health services**
- ▶ **Every £1 on support networks for people with drug and alcohol dependency saves £5 on health, social care and criminal justice services**
- ▶ **Every £1 on parenting programmes to prevent conduct disorder pays back £8 over six years**
- ▶ **Every £1 spent on school-based smoking and bullying prevention can save as much as £15**

This takes time, investment and significant engagement of commissioner, providers and citizens. There are three key things that transformation requires:

- ▶ Firstly recognising the system would benefit from investment in prevention services
This is to increase prevention and wellness, community-based alternatives and work with providers to redesign models of care, equating to c. **£5.2bn** over four years or c. **£1.3bn** annually. Based on previous proportional estimates, spending on prevention is c.£8.2bn across the health and care Economy, approximately 6% of the total spend on health, public health and social care (£139.8bn). If we were to align this proportion with ASC, estimated at 7% of total spend (£9.5bn), this would mean an additional c. £1.3bn annually.
- ▶ Secondly, creation of a pooled budget, a 'BCF plus'.
The Transformation Fund (£1.3bn/year), combined with the existing £5.3bn of pooled Better Care Fund money could result in an annual pooled budget for transformation of health, wellbeing and care of c. **£6.6bn**. Including all NHS, Adult Social Care and Children's Social Care would raise this pooled budget to **£141.1bn** that could be devolved to local areas to develop new health and care systems.
Full integration should be the ambition by 2020, until then, above the £6.6bn areas can define their local pooled budgets, using proportional match funding from health and social care (i.e. if local government contribute 40%, health contribute 40%)

- ▶ Thirdly, transformational funding support should be focused on the right things, delivering demand management initiatives for the medium and immediate term.
- ▶ Lastly, the targets attached to transformational funding should be realistic in setting the timeframe for results and expected savings. Otherwise recreating the current challenge again in 2,5 and 10 year's time is a risk.

A transformational fund should be announced within the first year of a new Government, established in 16/17 and should be included within the baseline for future years. This funding assumes that the 13/14 projections for the ASC gap are funded, no additional funding cuts to social care in the Spending Review, and that wider local public services are protected.

5. Government should provide a £5.2bn Transformation Fund and create a pooled budget of £6.6bn – £141.1bn to deliver the significant change required to deliver a more equitable system

Align the funding settlement for health and social care

Health and social care are inextricably linked.

- ▶ **30% of health and care users cost 70% of the NHS and social care budget**
(NHSE Call to action)
- ▶ **15.4mn people driving cost in ASC and health nationally (£87.9bn), however, the BCF pooled budget is only £5.3bn/£124bn health and ASC budget**
- ▶ **26% delayed discharges attributable delays in social care**

In recognition of the link, both health and social care budgets should be properly funded but subject to the same protective arrangements and percentage changes over a Comprehensive Spending Review period.

Many local areas have identified the need to have better line of site to funding to enable more sustainable planning. A five-year settlement for funding across NHS and social care would allow local areas to make more robust investment decisions, focus resources on the things required to better manage demand over the medium term and have a structured approach to delivering the required efficiencies. In addition, consideration should be given to reviewing the use of prudential borrowing to maximise the impact of transformational funding

6. Government should align the level of protection across health and social care budgets and provide a five-year settlement for both health and social care

Recommendation 2: Address Chronic underfunding to drive person-centred care (cont'd)

Remove the eligibility barriers between health and care

Finally, to break down silos, the national eligibility boundaries that separate health and care need to be reviewed. Care defined as critical should become free at the point of use to end the problematic distinction between NHS Continuing Healthcare and social care and address the ongoing inequalities facing individuals.

As per the Barker report, out-of-hospital accommodation costs should be covered by the individual up to the £12,000 cap introduced by the Care Act from 2016. This measure would help to create a more equitable, sustainable system by incentivising individuals and care professionals to seek at-home solutions. Local Communities should be able to apply this where it is judged to provide better value than current arrangements.

In addition, more needs to be done to support carers. Reviews of eligibility, entitlements and funding for individuals and carers need to be undertaken in tandem. This valuable part of the health, wellbeing and care economy should be in receipt of appropriate support, education and access to resource to help maintain the vital contribution made to the individuals independence and the sustainability of the system as a whole.

In the Carers UK manifesto, carers set out what they want in terms of support, some examples are set out below:

- ▶ **For their role to be recognised and respected as a crucial part of society**
- ▶ **For carers' benefits to recognise their huge contribution to society**
- ▶ **A social security system which supports rather than prevents work/study**
- ▶ **Health services which recognise that carers have their own health needs**
- ▶ **Rights at work which recognises caring as much as other family responsibilities**
- ▶ **Support to return to work when caring comes to an end**
- ▶ **For caring to be given the same political and economic prominence as alongside becoming a parent**

Low pay and low status were outlined in research by the Joseph Rowntree Foundation as challenges that are also apparent in the care workforce too (formal carers). Some key areas to change going forward to improve recruitment, retention and care quality for individuals:

- ▶ Care workers do demanding work for low pay. Research shows the importance of making staff feel valued and chances for progression and development
- ▶ The low social status accorded to care work needs to be addressed as it influences how the whole sector is perceived and reward understood
- ▶ Conditions and culture, such as paying for travel time are important in staff feeling valued in their roles

Changes to eligibility, entitlements and funding needs to be financed somehow. The Barker Commission identified a range of options to secure additional funding to meet the increasing costs of providing health and social care. These included measures such as a change to prescription fees and the introduction of means testing for winter fuel payments and TV licences for the over-75s.

There are advantages and challenges in pursuing any of these but it is clear that a full and frank debate is required on how more resources can be freed up to invest in health and social care to respond to rising demand.

- 7. The Government should review options for additional funding and set out in the Barker Commission, identifying funding options to remove the cliff edge between health and social care**
- 8. As part of the review of funding options, the Government should also identify additional resources to fund increased entitlements for carers**
- 9. Ensure the formal care workforce is supported through changes to conditions, culture and development opportunities**

Recommendation 3: Local areas need to be in control of their whole economy

Driving a place-based approach through integrated commissioning systems with devolved pooled budgets, shared outcomes and commissioning powers

Local commissioners have a key role as agents of change. To deliver this properly they need the freedom and capacity to shape their local health and social care economy.

There are a range of potential options for reform at a local level:

- ▶ The Barker Commission, for example, recommended a single ring-fenced budget for health and social care run by a single commissioner.
- ▶ Community budgets begin with citizen experience; they look at the whole system rather than discrete services; they are rooted in evidence; and they demand new models of investment to set up and sustain the most effective interventions.
- ▶ The Better Care Fund also made progress through pooling funding already controlled at a local level in a range of Section 75 agreements that encouraged joint working, joint commissioning and sharing the benefits of services focused with individuals at the centre. This has projected savings of £500mn in the first year.

The scope of an integrated system (outcomes, budget and commissioning arrangements) should be defined locally by those best placed to respond to local needs. This should include considered devolution of other funding in the NHS, for example specialised commissioning and primary care; and nationwide benefits, such as Attendance Allowance and the Personal Independence Payments. Bringing these entitlements under local control will result in better outcomes and alignment when supporting people to meet their outcomes, both for those who access care services and those who don't.

This should be conducted in tandem with a discussion about viable footprint to ensure areas are able to achieve the economies of scale whilst still gaining the advantage of local control and clarity on the funding arrangements and agreements as further Comprehensive Spending Review challenges take hold.

Greater Manchester Devolved health and social care

Greater Manchester has recently negotiated the devolution of £6bn of health and social care funding into a pooled budget.

- ▶ This includes NHS England, 12 NHS clinical commissioning groups, 15 NHS providers and ten local authorities
- ▶ It should facilitate joint decision-making on integrated care to support physical, mental and social wellbeing
- ▶ The scope of the memorandum includes adult, primary and social care, mental health and community services and public health
- ▶ In addition a framework for strategies around governance and regulation, resources and finances, the property estate, health education, workforce and information-sharing and systems being brought together is set out
- ▶ A £1.1bn funding gap will need to be addressed through the new service models developed

A transition plan will provide the foundations for joined-up business and investment proposals, along with a joint Greater Manchester Health and Social Care Strategy – until full devolution of health and care services is in place by April 2016

10. Give local areas greater control and freedom over pooled budgets, including flexibility over the planning footprint, performance monitoring, governance arrangements and scope to include existing devolved budgets within the pooled budget
11. Government and national bodies should review options to further devolve national commissioning budgets across the NHS, Public Health England and other relevant Government Departments

Recommendation 3: Local areas need to be in control of their whole economy (cont'd)

Health and Wellbeing Boards focal point of devolved, integrated commissioning

Health and Wellbeing Boards (HWBs) are ideally placed to provide system leadership of integrated commissioning. They provide an established governance arrangement, are focused on improving the health and wellbeing of the whole place and are able to provide political leadership and steer through complex decisions about local priorities and policy.

Boards provide an ideal shared platform, including links to other bodies such as Local Enterprise Partnerships and Passenger Transport Executives, meaning they can capitalise on opportunities to work collaboratively across local areas, for example on community wellbeing, housing, employment and skills.

To deliver this stronger role, Boards need to be made up of the right people that will enable them to deliver accountability, accessibility and, critically, to be of a size to make decisions. This should include a stronger link to citizen involvement in local governance, ensuring local strategies and decision making is more person-centred. This is demonstrated in some areas through wider system partnership arrangements enabling carers, users and volunteer bodies to participate whilst maintaining the forum to make decisions.

Any strengthening of the role of HWBs must be supported by skill development and supporting infrastructure. Members will be required to take on a greater management and budget responsibility. For this to be successful they will require additional expertise in managing new relationships and administrative capacity currently not available to them.

NHS Clinical Commissioners and the LGA are currently taking forward to define the role of Health and Wellbeing Boards in a more localised, devolved system.

12. Health and Wellbeing Boards to become the vehicle for devolved place-based commissioning
13. Local economies should be given the freedom to make appropriate changes to Health and Wellbeing Boards, including changes to the geographic footprint to match strategic planning
14. Additional resources and support should be made available to HWBs to take on an expanded role, including support to establish locally determined Joint Management Teams to support the Board in commissioning

Recommendation 4: Reform the framework set by National Bodies to support local success

Use different payment mechanisms to incentivise prevention and person centred care

Capitation can work as an enabler for integrated care by incentivising providers to develop an end-to-end approach when delivering services. A capitated system replaces activity based payments with a mechanism that motivates providers to reduce hospital admissions and long stays, focusing instead on meeting an individual's holistic needs.

It also encourages different providers to work together towards shared outcomes, as they all share a stake in improving outcomes for users with long-term conditions under this payment model. Similarly for commissioners the benefits of capitation can only be realised over the long term, encouraging an approach rooted in building provider relationships with clear outcome-based targets.

In the **Five Year Forward View**, NHS England confirmed plans to roll out Integrated Personal Commissioning to improve the sustainability of the health and social care system by optimising use of resources. This will, above all, spearhead the move to a more person-centred model of care.

The ultimate aim is the development of a diverse market from which individuals can choose support, delivered through improved joined-up commissioning, investment in developing new community options and providers driven by the right incentives. This change will take time as providers will need to be engaged to work through proposals.

15. Support areas to replace or deviate away from the tariff based system, including through a capitated planning and payment approach to incentivise provider behaviour change

Planning cycles should be aligned across Health and Social Care

Planning cycles should be aligned more closely and annual planning requirements for healthcare providers removed so that they can more effectively integrate their planning processes with social care partners. This will create additional capacity in the system to get on with delivering the changes and allow an integrated approach to delivering a joint set of outcomes.

Both of these changes need to be negotiated with stakeholders. Providers are often the innovators, gaining provider backing is essential for a unified performance framework and so they should be closely consulted while it is developed to better place them to respond to new measures. This links to the required discussion on units of planning and viability to ensure established providers are supported to transition and transform.

16. Align planning cycles to a five year cycle in line with the proposed budget settlement

Recommendation 4: Reform the framework set by National Bodies to support local success (cont'd)

Local areas need freedom to be more ambitious in local public health policy

Areas need to be empowered to get local incentives right. Local commissioners are best placed to define what will work to meet local need.

1. Opportunities such as the ability to vary the tariff for services locally or more flexible use of NHS estate will support change to be driven through.
2. Enhanced powers should be devolved to local areas for public health policy that goes further and faster than current national law – on alcohol, fast food, tobacco and other issues that affect physical and mental health. Practically this means:
 - ▶ Unity and dedication from providers, commissioners and policy makers. Sincere and lasting commitment must underwrite such a critical change in public health policy making. National politicians being comfortable with difficult local policy decisions being made for the benefits of population health.
 - ▶ The enhanced role of public health: reaffirming the importance of the role of public health in influencing and assuring the shape of services across the local public service environment.

17. Additional devolved powers to set public health policy that is more ambitious than national law

Performance improvement should be locally driven and sector led

Within health and care there are a range of regulators: system regulators, financial regulators and professional regulators. There needs to be proper dialogue with these bodies to align performance improvement initiatives across the system. Regulators should be accountable to local commissioners, the responsibilities devolved and driven by the framework set out in partnership with citizens. The **Five Year Forward View** is supportive of a whole-system, geographically-based approach.

There needs to be a simpler way to measure performance across health and social care. Within a local area there should be one single performance framework against which all providers' performance is benchmarked. This should include core mandatory elements alongside optional measures that can be driven by local priorities set out by the HWB. Unifying these frameworks will create a single definition of success for all partners within a locality and help them to work towards shared goals.

Agreement is required across the system as to what constitutes quality, including the key metrics for quality outcomes. Equally the move to a more common set of assessment tools with a focus on use of evidence and intelligent decision making will be beneficial. To achieve this sector-led national collaboration is required on the development of tools and standards, but then supported by the development of local implementation plans to ensure provider improvement programmes are aligned to local priorities. Transforming Excellence in Adult Social Care (TEASC) provides an excellent example of how sector-led improvement can be a powerful tool in improving outcomes and quality standards.

18. Develop a sector led single set of tools for quality assessment across health and social care

19. Review the reporting arrangement for regulator bodies and align their mandate to support local economies deliver on their outcomes

Appendix A

Categorisation of Health and Care Economies

Categorisation of Health and Care Economies

At the same time, however, there are localities with common characteristics, creating opportunities to form networks that share information and best practices and lobby central government and NHS England for reform together.

England's diverse range of health and social care economies are best illustrated through data. The Office for National Statistics has developed eight area classifications in which to group the population on the basis of a range of social and economic factors. The area classifications, known as 'supergroups' are:

- ▶ Cosmopolitans
- ▶ Ethnicity Central
- ▶ Hard-Pressed Living
- ▶ Multicultural Metropolitans
- ▶ Rural Residents
- ▶ Suburbanites
- ▶ Urbanites
- ▶ County Council

The eighth supergroup developed by the ONS, 'Constrained City Dweller', has not been included in this analysis. This is because the ONS data is collected at ward level, whereas the health and social care data applied to the supergroups exists at local authority level. Local authorities were categorised into supergroups depending on which supergroup applied to the majority of wards within that area.

The 'Constrained City Dweller' was never a majority at ward level and so has not been included in the data. In addition, a number of local authorities for whom there was no applicable supergroup have been classed in a separate category known as 'County Council'.

In addition, those local authorities that did not fall comfortably under the ONS area classifications have been grouped under the heading 'County Council'. The qualities they share are:

- ▶ Above average proportion of people aged 65+
- ▶ Below average unemployment rate
- ▶ Predominantly living in urban areas and living in detached or semi-detached housing
- ▶ Ethnic mix is below UK average, with higher proportion of UK and Irish born residents
- ▶ Individuals are likely to have a level of qualifications in line with the national average

Each supergroup has distinct socio-economic qualities that distinguish it from the rest of the population. Metrics for defining the supergroups include:

- ▶ Urban/rural living
- ▶ Housing
- ▶ Age and family size
- ▶ Educational background
- ▶ Ethnic diversity
- ▶ Employment

Categorisation of Health and Care Economies (cont'd)

ONS Supergroup classifications

Cosmopolitans

Live in densely populated urban areas

More likely to live in flats and communal establishments

High ethnic integration, with below average proportion of persons stating their country of birth as the UK or Ireland

Population of the group is characterised by young adults, with a higher proportion of single adults and households without children

Workers are more likely to be employed in the accommodation, information and communication, and financial related industries

Lower than average proportion of people aged 65+

Lower than average unemployment rate

Ethnicity central

Predominately located in the denser central areas of London and other inner urban areas across UK

Non-white ethnic groups have a higher representation than the UK average

Residents are more likely to be young adults with slightly higher rates of divorce or separation than the national average

Lower proportion of households having no children or non-dependent children

Residents are more likely to live in flats and more likely to rent

Higher proportion of people use public transport to get to work, with lower car ownership

Below average proportion of people aged 65+

Above average unemployment rate

Hard-pressed living

Most likely to be found in urban surroundings, predominately in northern England and southern Wales

Less non-white ethnic group representation than elsewhere in the UK

Rates of divorce and separation are above the national average

Households are more likely to have non-dependent children and are more likely to live in semi-detached or terraced properties, and to privately rent

Smaller proportion of people with higher level qualifications

More likely to be employed in the agriculture, mining, manufacturing, energy, wholesale and retail, and transport related industries

Proportion of people aged 65+ matches national average

Above average unemployment rate

Urbanites

Found in predominantly urban areas across the UK, with greater tendency to be clustered together in parts of southern England

More likely to live in either flats or terraces that are privately rented

Ethnic mix is comparable to the UK average

Households are more likely to speak English or Welsh as their main language than other areas in UK

More likely to be working in the information and communication, financial, public administration and education related sectors

Proportion of people aged 65+ matches national average

Below average unemployment rate

Categorisation of Health and Care Economies (cont'd)

Multicultural metropolitans

Concentrated in larger urban conurbations in the transitional areas between urban centres and suburbia

Likely to live in terraced housing that is rented – both private and social

The group has a high ethnic mix, but a below average number of UK and Irish born residents

Residents are likely to be below retirement age

Above average number of families with children who attend school or college

Level of qualifications is just under the national average

More likely to work in the transport and administrative related industries

Below average proportion of people aged 65+

Above average unemployment rate

Rural residents

Live in rural areas that are less densely populated compared with elsewhere in the country

Tend to live in large detached properties which they own and work in the agriculture, forestry or fishing industries

There is less ethnic integration in these areas and households tend to speak English or Welsh as their main language

Each household is likely to have multiple motor vehicles, and these will be the preferred method of transport to their places of work

Population tends to be older, married and well educated

Above average proportion of the population in these areas provide unpaid care and an above average number of people live in communal establishments (most likely to be retirement homes)

Above average proportion of people aged 65+

Below average unemployment rate

Suburbanites

Most likely to be located on the outskirts of urban areas

More likely to own their own home, and to live in semi-detached or detached properties

Mixture of those above retirement age and middle-aged parents with school age children

Number of residents who are married or in civil-partnerships is above the national average

Individuals are likely to have higher-level qualifications than the national average

All non-white ethnic groups have a lower representation when compared with the UK

More likely to work in the information and communication, financial, public administration, and education sectors

Slightly above average proportion of people aged 65+

Slightly below average unemployment rate

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