



REBOOTING HEALTH AND SOCIAL CARE INTEGRATION

An agenda for more person centred care

Liam Booth-Smith

About Localis

Who we are

We are an independent, cross-party, leading not-for-profit think tank that was established in 2001. Our work promotes neo-localist ideas through research, events and commentary, covering a range of local and national domestic policy issues.

Neo-localism

Our research and policy programme is guided by the concept of neo-localism. Neo-localism is about giving places and people more control over the effects of globalisation. It is positive about promoting economic prosperity, but also enhancing other aspects of people's lives such as family and culture. It is not anti-globalisation, but wants to bend the mainstream of social and economic policy so that place is put at the centre of political thinking.

In particular our work is focused on four areas:

- **Reshaping our economy.** How places can take control of their economies and drive local growth.
- **Culture, tradition and beauty.** Crafting policy to help our heritage, physical environment and cultural life continue to enrich our lives.
- **Reforming public services.** Ideas to help save the public services and institutions upon which many in society depend.
- **Improving family life.** Fresh thinking to ensure the UK remains one of the most family friendly places in the world.

What we do

We publish research throughout the year, from extensive reports to shorter pamphlets, on a diverse range of policy areas. Recent publications have covered topics including building the homes we need, a sustainable healthcare service and the public service ethos.

We run a broad events programme, including roundtable discussions, panel events and an extensive party conference programme.

We also run a membership network of local authorities and corporate fellows.

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Any errors or omissions remain my own.

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Advisory Panel

This research project was supported by an advisory panel, whose members are listed below. Advisory panel members provided one on one advice, attended an editorial roundtable and provided comments on report drafts. They may not necessarily agree with every analysis and recommendation made in the report.

- Rob Whiteman, Chief Executive, CIPFA
- Sarah Pickup, Deputy Chief Executive, LGA
- David Hare, Chief Executive, NHS Partner's Network
- Paul Briddock, Director of Policy and Strategy, HFMA
- Peter Fahy, Director of Adult's Services, Coventry City Council
- Peter Hay, Former Director of People, Birmingham City Council
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Executive Summary

What are we integrating health and social care for?

To some health and social care integration offers the ‘holy grail’ of financial sustainability. To others it is a way of moving the locus of care away from the acute sector and towards the community. A minority even suggest it is an attempt by one service to take over the other. Amongst the many rationales there is a common thread however: the individual receiving care or treatment. Whether you think integration is about money, structures or sovereignty, the view that more integrated health and social care creates better experiences for the people using those services, is near universal. At a time when local partners are finally agreeing that we are integrating in order to create a system which gives the patient or service user more control over their own care, the agenda itself is under threat.

- Independent reviews have cited concerns over the lack of financial and social outcomes generated by the integration agenda.¹
- Recent policy shifts by NHS England signal a move away from health and social care integration towards greater internal integration within the NHS, with social care’s role being explicitly non-compulsory.
- Concerns over devolution have called into question how likely it is local areas will receive powers similar to that of the Greater Manchester Combined Authority, whose leaders control a pooled health and social care budget.
- Political uncertainty over how to address the funding of social care only increased during the recent general election.

It is clear from our research that the health and social care integration agenda has a future but it is dependent on moving away from notions of structural integration and reliance on central policy direction. The issue of funding and financial sustainability is critical but can only be influenced locally, not decided. To that end the funding question must be addressed centrally and health and social care integration should not be a hostage to the delays in doing so. Health and social care integration can create new value locally, but it must build on its most important point of consensus; greater person centred care.

The future of integration will be personalised

Health and social care integration should create a system which gives the person receiving care or treatment greater independence and control. However, with an aging population and continued funding pressure on services, integration is in danger of becoming an agenda whose focus increasingly narrows on a section of society (the frail elderly bouncing between the care system and the hospital) and the financial burden they create. Whilst the frail elderly are an important cohort, it would be a catastrophic error for health and social care services to limit

¹ NAO (2017) – Health and social care integration

integration efforts to their needs alone. Health and social care integration must be cast as the vehicle that will drive greater personalisation of services in health and care for all people. Unfortunately there are significant barriers to achieving this.

- Expectations of what health and social care integration could deliver in the time frames set out by politicians were overly optimistic. Full integration is unlikely to be achieved by 2020.
- Contrary to conventional wisdom recent policy initiatives, financial pressure and increasing demand has often forced local partners to step away from collaborating on integration efforts. **(For example, only £1.73 billion of the total £5.3 billion of Better Care Fund money was available to be dedicated completely to health and social care integration transformation work.² Concerns have also been raised that integration is being “sidelined” in pursuit of NHS financial sustainability.³)**
- Too many local integration efforts have stalled because discussions have focused on structures and organisational sovereignty.
- The barometers used by politicians and policy makers to decide whether a local system is ‘well integrated’, in particular ‘Delayed Transfers of Care’, are too narrow, often blind to context and encourage a focus solely on the frail elderly, when integration should cover a broader remit. **(For example, 48.19% of adult social care spending goes on those aged under 65.)**
- Basic coordination between health and social care services is still not happening in enough local areas. **(For example, as of 2015/16 less than 20% of NHS Trusts were providing digital information access to local health and care partners. In the case of healthcare professionals having access to local social care information only 9% of Trusts felt this was happening.⁴ Despite the NAO citing concerns of information sharing as early as 2003.⁵)**

How can integration create a more person centred care system?

The health and social care integration agenda should be the primary driver of creating more person centred care. But to achieve this we first must accept there have been unrealistic expectations of what health and social care integration can achieve. Positively there are many examples of local council and NHS collaboration. However the notion that integration can generate significant savings at a time of downward spending pressure, and with contradictory funding mechanisms for the NHS and social care, needs challenging.

Secondly, there must be a concerted focus on ‘coordination’ between the NHS and social care. This means focusing on issues where local professional pragmatism can make a big difference. Data sharing, estates management and staff training and development are all areas where local collaboration could make a significant difference to the long standing integration barriers cited by the NAO.⁶ Our research suggests limited progress has been made on structural integration, and whilst some areas have managed to successfully integrate budgets and engage in some forms of joint commissioning, these are limited.

2 Age UK (2017) – The health and care of older people in England - We came to this figure by taking the Department for Health and Department for Communities and Local Government figure of £5.3bn for the Better Care Fund - then we subtracted the £1.67bn noted by the Association of Directors of Adult Social Services as being spent on avoiding cuts (Ibid), and the £1.9bn NHS England and the Local Government Association specifically note as being allocated to cover “demographic pressure and costs associated with the Care Act”(https://www.england.nhs.uk/wp-content/uploads/2013/08/itf-aug13.pdf)

3 NAO (2017) – Health and social care integration

4 Source: Digital Maturity Assessment, 2015/16, NHS England

5 NAO (2017) – Health and social care integration

6 Ibid – direct quote “misaligned financial incentives, workforce challenges and reticence over information-sharing”

With NHS England now looking favourably on the idea of Accountable Care Systems, there is likely to be a pause in structural integration discussions in any case as local health systems figure out how to respond to this latest policy development.

This pause creates an opportunity to advance policies which would dramatically bend the mainstream of health and social care integration towards greater control and independence for those in receipt of care and treatment. Alongside more pragmatic coordination locally, we need fresh national policy to increase the prevalence and quality of person centred care. This should include:

- **Encouraging greater awareness and adoption of new technologies which support assisted living.** (With the level of capitalisation falling from £14bn in 2011/12 to £6bn in 2015/16⁷ there is scope for government to support greater levels of adoption by expanding and clarifying the guidance on what technology investments are open to capitalisation.)
- **Additional support for the UK's growing industry in assisted living technology.** (The British Healthcare Trades Association estimate that the value of the UK market in assistive technology will rise from £2.5 billion in 2014 to £6 billion by 2025.⁸)
- **Encourage the diversification of care providers, for example via expansion of online marketplaces which open up access.** (Research suggests as of 2015 over 25% of local authorities have digital marketplaces with purchasing functionality, and many more had plans to implement one.⁹)
- **Mandate a dramatic expansion in the use of Personal Health Budgets (PHB) for specific care pathways.** (Evidence suggests CCGs are able to adapt and improve their performance in using PHBs in a very short span of time. 12% of CCGs scored a performance benchmark of over 50 people benefiting from a PHB in September 2015. This rose to 26% within a year and a half (January 2017).¹⁰)
- **Create better support mechanisms to allow for the greater participation of family members in providing care for relatives.** (Polling commissioned for this report has uncovered a mismatch in expectations between those who have never provided care and those who have. With those who have never provided care significantly over estimating the financial cost of providing care (41% vs 19%) and underestimating the emotional cost (28% vs 37%).)

Rebooting health and social care integration

To help unlock the latent social innovation and capital that sits within the health and social care integration agenda, private market and family and community this report recommends government take the following action:

Strategic recommendations to support integration

1: In the forthcoming social care green paper government should make the question of a sustainable funding solution central. The 2014 Care Act provides a cap mechanism to protect individuals from extremely high care costs, and government should recommit to its implementation

⁷ Table 1: Local authority capital expenditure and receipts: England: 2011-12 to 2015-16 forecast and outturn, DCLG

⁸ British Healthcare Trades Association (2014) – Manifesto for healthcare and assistive technology

⁹ Ibid

¹⁰ NHS England (2017) – Transformation of care through personalisation and choice

given the political resistance to altering it. However, this means there will need to be increased state spending in order to support the system. Government should explore the widest range of options possible from hypothecated new taxes (both local and national) through to reform of age related benefits, such as the Winter Fuel Allowance.

2: Government should support better collaboration around finance and commissioning locally by simplifying departmental responsibilities. As has been recommended by others Government should transfer social care funding responsibility from the Department for Communities and Local Government to the Department for Health, where responsibility for policy currently sits. Local authorities would still retain budgetary control locally, but the alignment of funding and policy centrally would help local leaders build better relationships with the Department of Health.

3: To support the long term joining up of social, primary and community services in order to create person centred local services, government should look beyond the NHS England Five Year Forward View and, as had been recommended by the House of Lords Select Committee on the Long Term Sustainability of the NHS, set out a medium term strategy up to 2025. This plan should be devised in consultation with key stakeholders and should be focused on establishing the necessary actions to support the creation of more person centred care.

4: Government should establish a long term health and care workforce review. This should consist of NHS England, the LGA, ADASS, Royal Colleges, General Medical Council, the Nursing and Midwifery Council and other relevant partners. The purpose would be to provide a strategic assessment of the long term workforce challenges and opportunities. It should also establish a common framework by which all local areas could begin to establish local joint workforce strategies.

Policy recommendations to support integration

5: Whilst there is no likely systematic obstruction to local government's capital classification powers, our analysis suggests local authorities should be encouraged to use the capitalisation mechanism much more to invest in digital technology to support an increase in better care options for patients. To that end government should issue clarifying guidance on what is permissible for capitalisation, expanding and clarifying the remit of what its own guidance terms "a digital approach" to service delivery to include the wider transformation, training and support programmes needed to ensure that technology is effectively used and its potential maximised.

6: Government should look to encourage greater investment in businesses that create products which support assisted living (and could potentially be export businesses in a growing global market). As previously highlighted in a Localis report on the Industrial Strategy government could offer tax reliefs as part of the Enterprise Investment Scheme (EIS) and its subsidiary Seed Enterprise Investment Scheme (SEIS).¹¹ Relief on investment for both could be enhanced respectively. Currently the EIS provides investors with 30% tax relief on investments of up to £1m a tax year in shares of smaller, high-risk companies. The SEIS provides 50% tax relief on investments up to £100,000 and encourages seed investment in early-stage companies. With growing global demand for assistive technology and products these businesses should be attractive to investors already, but with this change to investment relief the profile of the opportunity would be raised.

¹¹ Localis (2017) – The Making of an Industrial Strategy

7: Subject to a positive evaluation of the pilot programmes, government should legislate to make Personal Health Budgets mandatory for the most promising specific care pathways. Personal Health Budgets should become the new default delivery mechanism for these care pathways. NHS England and the Local Government Association have collaborated on the Integrated Personal Commissioning (IPC) programme which could become the mainstream integrative model of support for the care pathways chosen.

8: Government should commission an independent review to explore the existing and potential future range of financial support incentives to encourage family members to consider providing support to a relative who needs care. These could include;

8.1 Should Government introduce a worker's right to access 52 weeks leave to provide care to a relative, government should explore the feasibility of making contributions to an employee's pension scheme over any period their leave is designated as 'unpaid' to ensure that taking a sustained period of time off work to care for a relative does not unduly hamper a person's own planning for older age.

8.2 Opening up the criteria for access to Carers Allowance, including reducing the minimum number of hours required providing care down from 35 and increasing the amount an individual can earn above £116 to £144 to reflect future increases in the national living wage.¹²

9: Government should ensure that data sharing between the NHS, social care and the relevant community partners, is set out as a strategic objective as part of the next published NHS Mandate (2018/19).

10: Government should act on the recommendations of the recent Naylor Review to achieve greater value and efficiency out of the NHS estate. However, it should also insist on greater collaboration from the NHS with other partners via the Cabinet Office and LGA backed One Public Estate's programme.

¹² For details on data source see reference '105'

Introduction – Why Health and Social Care Integration Has A Future

Context

This could have been one of two types of report. The first addresses the funding question weighing heavily on health and care services, the other on how to reform services in order to improve quality and give people more control. This report addresses the latter. From the beginning of research in December 2016 the policy landscape surrounding health and social care has evolved dramatically. Changes in the social care precept, additional grant funding, confusion over the future of business rates localisation and most recently the general election, have made it impossible to offer a definitive view of options for a future funding solution. Should there be more clarity by the time of publication others, no doubt, will be busy addressing the question this report does not.

Near the start of the research process a former Department of Health adviser shared the following point. “If you’re flying to Singapore, but have to change airlines en route, at no point does anyone suggest the airlines merge. We put the passenger in charge and the airlines build it around them.” Whilst we should be wary of using a simplistic business analogy when discussing health and care integration, it does expose a truth hidden in plain sight. The patient, service user (or passenger) doesn’t care how it all works, as long it works.

This report is an attempt to explain why health and social care integration should be the catalyst to ‘build it around the passenger’. It focuses on making it work for the individual, not creating a more perfect system for professionals.

An inheritance worth preserving

Twenty years after claiming he’d bring it down, Frank Dobson’s Berlin wall between health and social care remains.¹³ As a recent NAO report has stated, progress with integrating health and social care has not been what practitioners or policymakers wanted, let alone what politicians promised. With continued downward pressure on social care and NHS funding, and a newly elected government with a mandate for change; is integration an inheritance worth preserving?

The NAO argue government departments “have yet to establish a robust evidence base that shows integration leads to better outcomes for patients” nor is there “compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity”.¹⁴ International comparisons similarly suggest the link between integrated care and lower costs is weak.¹⁵

However, the assumption significant cost savings and dramatically improved outcomes at population scale are reasonable measures of integration in the first

¹³ BBC News (1999) – Health carers caught in political crossfire

¹⁴ NAO (2017) – Health and Social Care Integration

¹⁵ Journal of Health Services Research & Policy (2015) Mason, Goddard, Weatherly, Chalkey – Integrating funds for health and social care: an evidence review

place needs challenging. With contradictory funding mechanisms and misaligned accountability, expectations have been too high for integration and a realistic appraisal necessary for some time. Long term financial sustainability will not be created through health and social care integration alone. But, we can make meaningful savings locally. Improving the experience of patients and service users and the laying groundwork for a future long term transformation of health and care services can be achieved via integration.

One Adult Social Care Director interviewed for this research said they were confident integration locally was already achieving improved outcomes just that at a system level local government, Whitehall and the NHS were yet to agree a way of accurately measuring them. There are many examples of good local practice, both in the UK and internationally, which have saved money and improved outcomes.¹⁶

Thus health and social care integration is caught between two competing narratives; one which says it doesn't work because it is based on the belief integration should consistently achieve savings and improved outcomes at a scale central government will recognise. The other claims it does work but that with so much pushing against it, (structures, funding cuts, demand increases, regular policy changes) it is unreasonable to think health and social care integration is the answer to long term sustainability for either service.

It stands to reason therefore, that health and social care integration has a future, but only if politicians and policymakers adopt a more realistic expectation of what it is achievable and by when.

This report will explain why and how there must be new expectations for integration whilst ensuring the best local initiatives continue to develop. We also recognise the significant new value already created by the agenda, none more so than the increase in focus on the involvement of patients and service users. Personal budgets, for example, are common place in social care, and with NHS England committing to scaling up the use of personal health budgets there are mechanisms in place to give patients and service user's still greater control. Services in some places are also going beyond personal budgets and changing the way professionals work, creating an even more personalised experience for patients and users.

Report structure

This report makes the case for a reboot of health and social care integration with fresh emphasis on better co-ordination, more personalisation and a concerted effort on unlocking social capital and innovation. It has been informed by a methodology consisting of survey work, interviews, two practitioner roundtables, a literature review, data analysis, public polling conducted by Yougov and supported by an expert advisory panel. The report has been structured into the following chapters.

In chapter 1 we explain the dominant forces which have shaped recent health and social care integration efforts and use their lesson to argue for a more realistic set of expectations.

In chapter 2 we identify the areas where local health and social care leaders should look to achieve better coordination.

In chapter 3 we explore how the health and care system, collaboratively and within individual services, can unlock greater levels of social capital and innovation.

In chapter 4 we outline the policy response needed from government to make health and social care integration a primary driver of greater person centred care.

¹⁶ Examples highlighted in later chapters

A note on the report's scope

Health and social care integration is a broad agenda, which in varying forms has been in existence for decades. Therefore any report would find it difficult to address the issue in its totality. To that end we have chosen to maintain a tight editorial focus on a select number of linked issues. Namely; (i) what more realistic expectations of health and care integration should be, (ii) examples of practical measures the NHS and local government can undertake to meet these expectations and (iii) how to build on the work already happening to create greater levels of person centred care. The last of these represents what we believe should be the long term goal of health and social care integration.

This leaves a great deal unaddressed which is important to acknowledge at the outset of the report. Firstly, we do not offer a view on how to solve funding issues. Since research began for this report in December 2016 there have been multiple iterations in policy towards funding. With so much change it was simply not possible to conduct a credible financial analysis with such an unsettled policy environment.

Secondly, we do not offer a view on the merits of emerging models of care. It is right for local areas to decide what is best for them and with new models in development it is too early to judge. Thirdly we do not assess the Better Care Fund or other funding initiatives other than in terms of using what existing evidence and plans are available to help us understand what local areas are doing and hoping to achieve.

Thirdly, we acknowledge the need for greater diversity and innovation in the care market but do not go into significant detail regarding its current instability. Others have published extensively on this and we would have been unable to contribute anything additional. Nor do we discuss issues relating to practice, either social care or clinical. This would be beyond the report's scope.

Fourthly, this research was designed in such a way as to allow for the lessons and recommendations to be applicable regardless of any future new funding arrangement, care model or market structure.

Finally, whilst it has been present in our thinking, reflections on the health and care labour market do not feature in any significant detail in this report. This too would have been an expansion of the research scope.

A note on terminology

Throughout the report refers to 'health and social care integration', from time to time it also refers to 'integrated care'. In most cases they will mean the same thing and the decision to use one over the other will have been taken because of adherence to reference material or quotes, or because it gave the sentence greater euphony. Occasionally the use of integrated care will refer explicitly to integration within the health services. Such a distinction will be clear from context.

Regularly the term 'patient and service user' is used to denote an individual in receipt of a service. This is to respect the difference in terminology used by the NHS and social care. Where possible we have used the words 'person' or 'people' and as a general rule have tried to avoid excessive use of jargon. However, a report of this type will invariably contain a lot of specialist language.

Chapter 1 — We need more realistic expectations of health and social care integration

Standing at the dispatch box in December 2016 Theresa May said “You cannot look at this question (the future of social care) as simply being about money in the short term. If we’re going to give people the reassurance they need in the long term, it’s about finding a way forward that will give a sustainable solution for the future.” Health and social care integration has long been feted as that *long term* answer. Given the general consensus amongst the major political parties that integrating health and social care remains desirable, albeit with quite different visions,¹⁷ it is reasonable to ask why it receives such strong criticism.¹⁸

In this chapter we lay out the three forces (policy, finances and demographics) our research suggests have shaped recent progress on health and social care integration and explain what lessons should be learnt. We then go onto explain what more realistic expectations of health and social care integration should be in their light.

Policy has tended to create a focus on structure

Understandably the most difficult integration discussions are often about structures. Questions of organisational sovereignty, accountability and budgets test the joint visions and strategic plans adopted by local leaders because they challenge professional control, budgets and influence. And whilst the majority of NHS and council professionals believe in the ambition of whole system integration, the evidence suggests there is a strong divergence in what that should look like in practice.¹⁹

Theoretically policy should support local areas to navigate these difficult discussions. However, evolutions in policy emphasis have had the effect of resetting conversations at regular intervals meaning time and potentially promising initiatives are lost.²⁰ Since 2010 these evolutions in policy include, but are not limited to, Clinical Commissioning Group reforms (2011),²¹ the Better Care Fund (2013), Integrated Care Pioneers (2013), Vanguard (2014), Sustainability and Transformation Plans (now Partnerships) (2015) and Accountable Care Systems (2017). Whilst only the Health and Social Care Act 2012 was ostensibly about structural change, each evolution has obliquely created new discussions about it.

The latest policy evolution announced by NHS England,²² Accountable Care Systems with a view to moving to Accountable Care Organisations, is no different in this regard.²³ Whilst 70% of councils have been involved in discussions about an Accountable Care System (as of May 2017) only a third

17 In 2017 for example, Labour proposed a National Care Service model of integration, whereas the Conservatives argued for a continuation of the local integration approaches being adopted underpinned by care cost cap

18 National Audit Office (2017) – Health and Social Care Integration

19 Health Services Journal Survey (June 2015) – Integration Survey

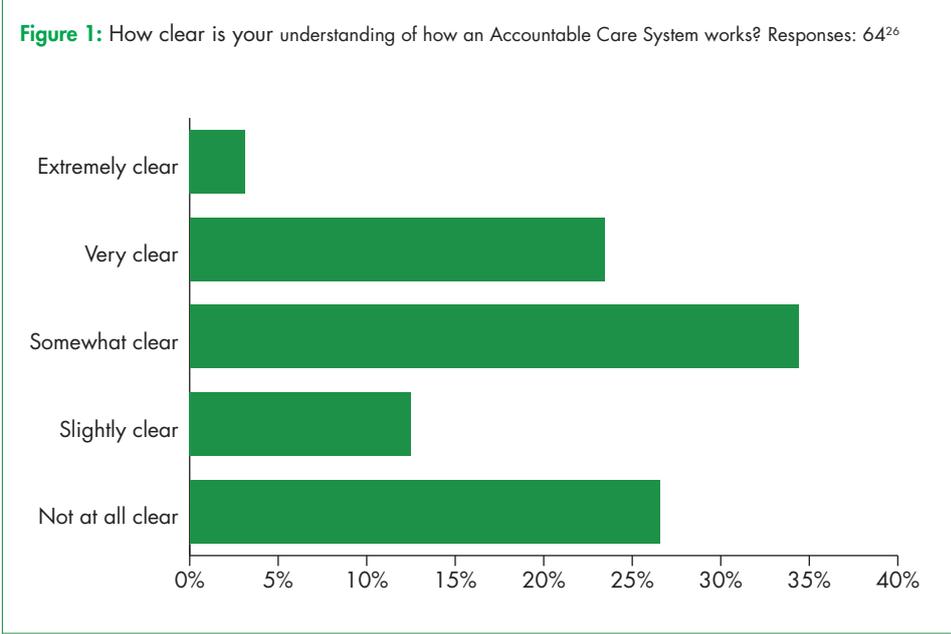
20 Ibid

21 Via the Health and Social Care Act 2012

22 NHS England (2017) – Next Steps On The Five Year Forward View

23 Sourced from research roundtable

have a clear understanding of what one is.²⁴ According to an interviewed Director of Adult Social Care the Accountable Care System discussion will “add a six month window to our integration work”.²⁵



It was also raised during the research that it wasn’t only the topics of discussion driven by structural concerns, but the behaviours of the professionals concerned too. The ‘tribal tendency’ to see ostensibly collaborative conversations as competitive has hampered some integration efforts.²⁷

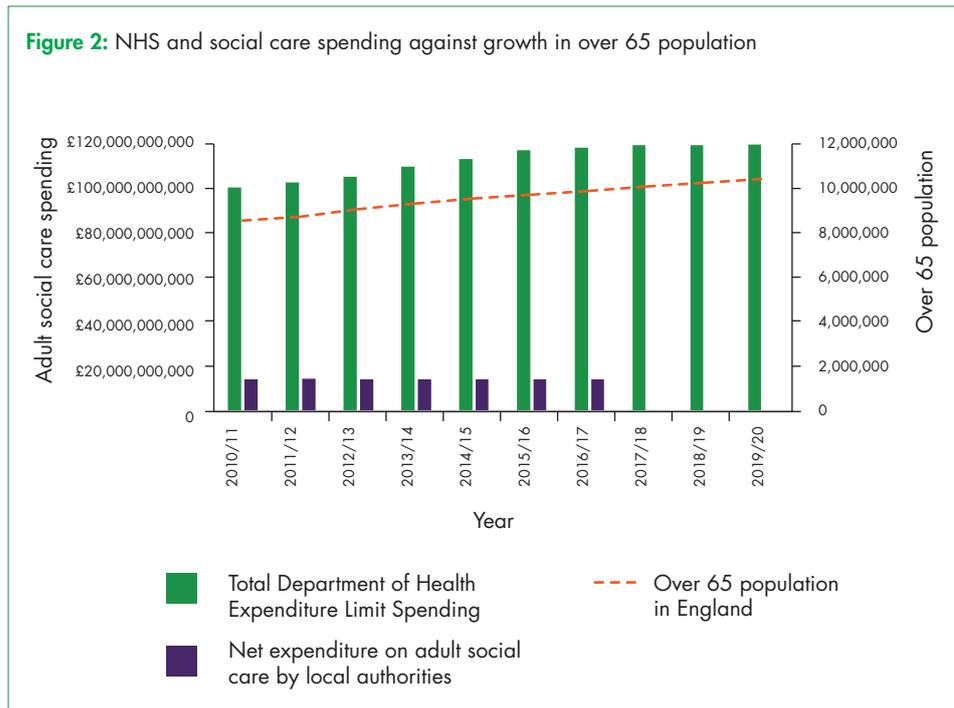
Undoubtedly structures are important but fixating on them hampers practical efforts between the NHS and local government to work together locally. In those areas where structural integration discussions are progressing well they should continue, but our research suggests they are as likely to slow progress and distract from pragmatic local measures to improve services and enhance the experience of patients and service users.²⁸

Financial pressure is keeping the NHS and local government apart

Health and social care integration is built on a funding contradiction. The NHS (free at the point of use) and social care (means tested) work toward clashing financial incentives. If you consider effective health and social care integration requires a reallocation of resource from the acute setting to primary and preventative you can quickly see how this contradiction becomes debilitating. The precedent, set by the Better Care Fund, of moving money from the NHS across to social care has, unsurprisingly, not been universally popular. Concerns have been raised as to how councils might spend reallocated money, particularly the issue of whether funds for care might be spent on non-care related services.²⁹ With social care experiencing a 9% real terms reduction in funding since 2010³⁰ and the NHS budget set grow in real terms by 1.2% between 2009/10 and 2020/21 (below the post war average of 3.7%) increasing financial pressure will only

24 Online survey – n64 (from Localis (2017) – Health and social care coordination)
 25 See appendix 1 for note titled “What are accountable care organisations?”
 26 Online survey – n64 (from Localis (2017) – Health and social care coordination)
 27 Sourced from research roundtable
 28 Sourced from research roundtable
 29 National Health Executive (2014) – Keogh comments unworthy of his role
 30 NHS Digital (2016) – Personal Social Services Unit Expenditure Costs 2015/16

make complex integration discussions more difficult.³¹



Source: DfH, Annual Report and Accounts 2015-16; Nuffield Trust - Impact of the 2015 Spending Review on health and social care; Local authority revenue expenditure and financing in England

Evidence suggests it has been difficult already to integrate services under financial pressure, particularly structural integration.³² The Association of Directors of Adult Social Services reported nearly a third of the Better Care Fund went on filling in spending gaps in adult social care budgets and not on integration efforts.³³ Combined with the added spending pressure of the Care Act and increasing demand for services only £1.73 billion of the total £5.3 billion of Better Care Fund money was available to be dedicated completely to health and social care integration transformation work.³⁴

The NHS has signalled its ambition to “make the biggest national move to integrated care of any major western country” but explicitly made local government’s role not compulsory.³⁵ This suggests NHS England is interested in pushing for greater internal integration amongst health services. Given the fragmentation of the NHS and the complex layers of service it provides this shift in focus to integrating internally is understandable. Multiple research roundtable participants agreed a focus on ‘internal integration’ wouldn’t be “bad for either local government or the NHS”³⁶ and would provide the necessary space to review the configuration of services and their strategic priorities.

Both the NHS and social care require a funding solution, but social care faces an existential crisis. The service is unable to meet the population demands on current resource levels and the private market supporting it is very weak.³⁷ Add to this the variation in local tax bases and the increasing need for local authorities to fund services via them, social care is in urgent need of fundamental reform

31 Kings Fund analysis (2017) – The NHS budget and how it has changed

32 Community Care (2016) – Cuts making it more difficult to achieve integration

33 ADASS Budget Survey (2016) - Survey

34 Age UK (2017) – The health and care of older people in England - We came to this figure by taking the Department for Health and Department for Communities and Local Government figure of £5.3bn for the Better Care Fund - then we subtracted the £1.67bn noted by the Association of Directors of Adult Social Services as being spent on avoiding cuts (Ibid), and the £1.9bn NHS England and the Local Government Association specifically note as being allocated to cover “demographic pressure and costs associated with the Care Act”(https://www.england.nhs.uk/wp-content/uploads/2013/08/ifaug13.pdf)

35 NHS England (2017) - Next Steps On The Five Year Forward View

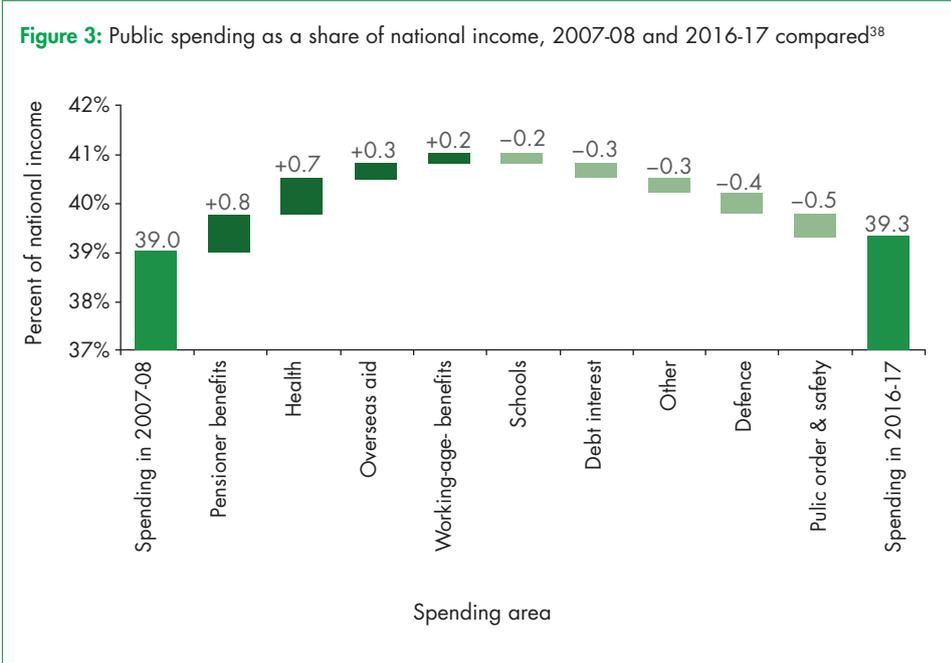
36 Sourced from research roundtable

37 The FT (2017) - UK home care industry on the brink of collapse

in its own right. This is not to downplay the funding challenge facing the NHS, but simply an acknowledgement of the reality created by the respective funding mechanisms for both services.

The financial pressure on social care and the NHS has exposed the need for greater reform of each service respectively. This shouldn't signal an end to front line collaboration locally, almost all areas will have 'locked in' a number of initiatives which are creating value. However, a pause in the strategic integration discussions over structures, budgets and sovereignty would be welcome. Conventional wisdom argues that with both services needing to make significant cost reductions this is a strong incentive to collaborate in order to do so. The evidence to date suggests that such an incentive is not strong enough.

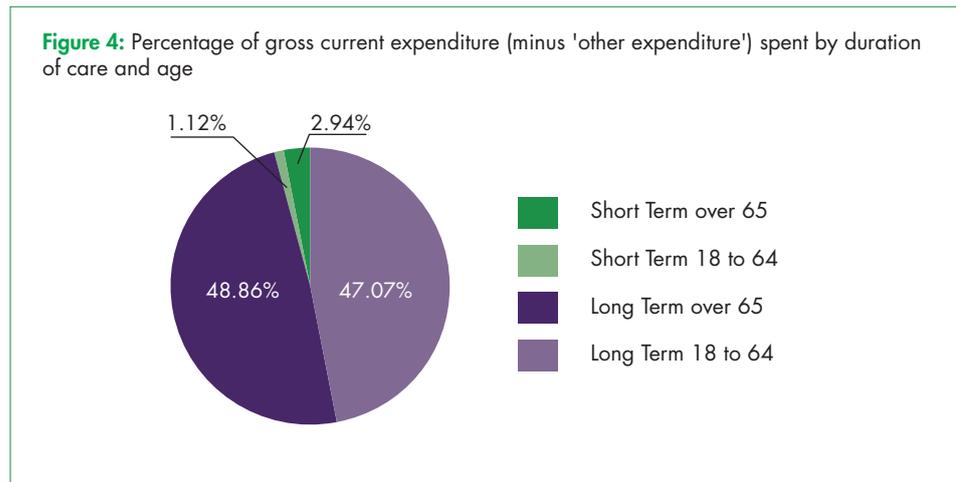
Demand pressure is coming from more than an aging population



The demand pressures of an aging population are reshaping the state. Health and welfare spending on older people is driving down spending on other areas including schools, working families, defence and criminal justice. Health and social care integration is seen as a major policy response to this challenge, but focusing solely on older people misses important opportunities to create more coordinated care for everyone else.

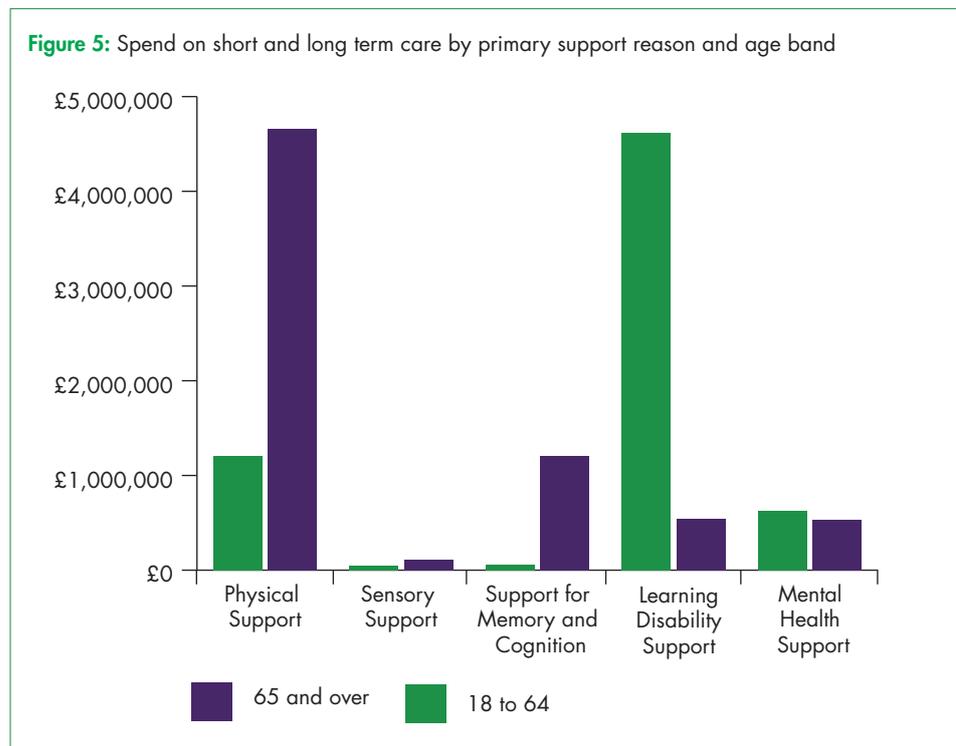
38 Institute for Fiscal Studies (2017) – Analysis of government expenditure

Source: Table 4, Personal Social Services: Expenditure and Unit Costs, England 2015/16



There are a variety of demographic groups and conditions putting pressure on social care and the NHS. Those with a learning disability (LD), for example, are a growing cohort for social care services with as much being spent on LD support for under 65s as there is on physical support for over 65s. The NHS is seeing increasing numbers of younger people presenting with issues such as diabetes and obesity. 69% of obesity related admissions to hospital in 2014/15 were for people aged between 35 and 64 and 60% of bariatric surgeries conducted on people aged between 35 and 54.⁴⁰ For adult social care 48.19% of spending goes on those aged under 65. To manage demand pressures on the health and care system we need to look beyond the over 65s towards younger people and better preventative measures.

Source: Table T5, Personal Social Services: Expenditure and Unit Costs, England 2015/16, NHS Digital



A key feature of better health and social care integration needs to be the creation of a better care system for older people, but it can't be the only the one. The focus on delayed transfers of care for example, as a key barometer of how

39 NHS Digital - Table 4, Personal Social Services: Expenditure and Unit Costs, England 2015/16

40 HSCIC Physical Activity Report (2016) – Statistics on obesity, physical activity and diet

well integrated an area's health and care is, is clearly not a reflective measure if you consider integration to be about more than a narrow focus on elderly people.

Social care services are increasingly looking to unlock social capital in the family and community to support those in need. Similarly, a great many people are now suffering from lifestyle conditions which could be supported and/or prevented by the community and public health services. There must be a wider view of what will create healthier people and communities. Health and social care integration must broaden out beyond a narrow focus on the cohort of frail elderly.

A more realistic set of expectations

Our reappraisal of health and social care integration leads to three key conclusions.

1. A focus on top down structures has been unhelpful and distracts from practical collaboration between staff on the frontlines.
2. A pause in structural integration efforts, if used to reflect on the strategic challenges each service faces and focus on pragmatic local coordination, would be helpful.
3. A focus on older people as the sole group for whom health and social care integration matters would realise only a fraction of the benefit better integrated care offers society.

Therefore, the medium term outlook for integration, as one research roundtable attendee noted, looks more like 'coordination'. It should be bottom up, focused on practical measures which improve the patient and user experience, not on structures and organisational sovereignty. It shouldn't have a myopic focus on older people but should experiment with new demographic groups and conditions.

To reboot health and social care integration as a primary driver for creating more person centred care there must be more realistic expectations of what the agenda will achieve.

1. Better coordination

A long term goal of all areas should be for health and care budgets to be subject to a single commissioning process in order for areas to commission services on the basis of the outcomes they wish to achieve. However, to do this effectively, the NHS and local government need to be devising strategy based on the same (level) of data and insight. This means common bases of information and better mechanisms for sharing data. It should also mean a more joined up approach to a local workforce strategy, and collaboration on leadership and development training. This would also stretch to a shared understanding of how each service's legal and regulatory obligations are being met.

By taking a pause from integration's policy driven structural discussions, the NHS and local government have the opportunity to take a strategic view of what their services (and organisations) need to be in the future. This includes exploring new service configurations, the evolving demands of local populations and the need to make savings at a time of budgetary pressure. This isn't simply a matter of trimming budgets, however. The expectation is for organisations to take advantage of opportunities to use disruptive influences (technology, social innovation, personalisation, etc...) to improve the quality of patient/user experience and financial sustainability.

Whilst these ambitions might seem modest to some, they do address issues which have been hampering integration efforts first cited by the NAO in 2003. Namely data sharing and quality, culture and shared professional networks.

2. Unlocking social capital and innovation

The assumption has been that the major external forces pushing against health and social care integration would force the NHS and local government closer together. This has proven not to be the case. Positively, integration efforts have created better local conversations and increased confidence in collaboration, but as yet have not delivered the system wide transformation some thought was possible in a relatively short period of time (it is too early to definitively state population wide outcomes are not being achieved). Local areas need to build on the progress achieved and look at new ways of unlocking greater levels of social capital and innovation, and government should consider the ways in which it can support that to happen.

Chapter 2 — Encouraging better coordination

“The three barriers – misaligned financial incentives, workforce challenges and reticence over information-sharing – are long-standing and ones which we have identified in our reports dating back to 2003.”

NAO report into the state of health and social care integration 2017

To achieve the more realistic expectations for integration outlined in the previous chapter, whilst allowing patients to gain more power and control over their care, local areas must better coordinate their services within and between health and social care. This chapter highlights three areas where there is scope for coordination that does not affect the overlying structure of either sector. It highlights good practice within each area and offers a view on the potential for improvement. There are many areas we could have concentrated on, as such we do not believe better coordination should be limited to the three we have analysed, namely: improving estates management, establishing better practices to share data, shared development and training, as well as the use of local forums and networks between professionals in health and care. However, better coordination in the areas we have chosen does not require a lever to be pulled from the centre, all of these things can happen locally.

Estates management

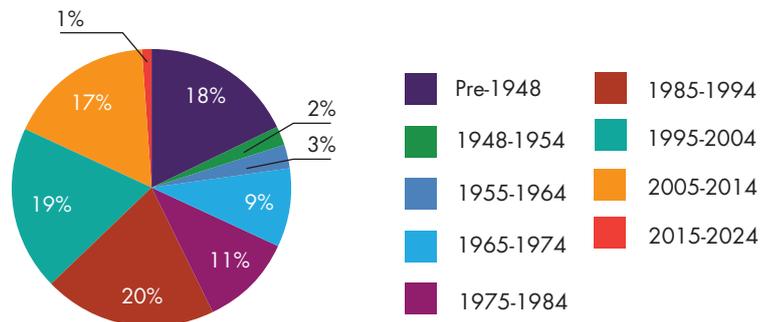
There is scope to increase coordination in the management of the estates held by both local government and the NHS. Both hold very large quantities of land and buildings and cost savings could be achieved through a better coordination in land and property sales and maintaining existing buildings. Given local authorities also control the planning system we believe there is significant scope to collaborate better on the use of estates.

The NHS alone occupies a substantial amount of property. Provider trusts occupy over 1,200 sites, totalling 6,500 hectares of land. This is on top of over 7,600 GP practices and over 100 licenced independent providers.⁴¹ The quality of these estates are also very variable. 18% predates the formation of the NHS and 43% is more than 30 years old. Although the date of buildings are not necessarily an indicator of their quality (since many have been upgraded to meet modern standards), the Naylor review has highlighted that “it is still too often the case that the NHS is operating in inadequate facilities”. The levels of backlog maintenance have risen by over 9% between 2014/15 and 2015/16, totalling £5 billion.⁴²

41 NHS Property and Estates (2017) - Naylor review

42 Ibid.

Figure 6: Age profile of NHS provider estate



Source: Naylor review analysis of ERIC data, 2014/15

NHS estate management has tended to be discussed within the integration debate as a means of shifting focus from acute settings towards primary and broader ‘community’ care.⁴³ Yet, the ability to deliver such a shift through reducing capacity within acute settings is limited. The Naylor review quantified the costs of delivering the Five Year Forward View and found this to be “in the region of £5bn”. Furthermore, it found no evidence to support a reduction in acute capacity in the context of a rising population. It is clear that estate management is not a way of delivering substantial cost efficiencies for the purpose of shifting services towards non-acute settings. But, more pragmatic savings can be achieved.

On the local government side of the equation, there has been an increased focus on creating cost savings through land and property sales. For example, increased collaboration by local government through the One Public Estate Programme has put participating local authorities on course to raise £138 million in capital receipts from land and property sales and save £56 million in running cost savings.⁴⁴ However, this initiative has been siloed into local government without taking into account the wider scope for estate improvement in local NHS-managed property. This national attempt at reforming the management of estates has achieved cost savings but not improved coordination between these two services. A better way of achieving these aims can be done through encouraging NHS and local government to share best practice on managing estates to reduce costs and release some land for their capital to support the building of community-based provision.

The North Central London Devolution Pilot, as one example, has highlighted what can be achieved in estate management through effective coordination between both local healthcare and government bodies. This pilot, coordinated between North London CCGs and local authorities aims to “develop the estate we need for new models of care, by optimising assets to reinvest in health and care and support wider benefits for local communities”.⁴⁵ Such an initiative is particularly welcome in London given the larger opportunity of releasing value from the higher property prices in the region: £1 billion out of the £1.8 billion identified in the Naylor review that could be released in the acute estate comes from London-based estates.

As this pilot is in its early stages, there is limited information on its outcomes. It is intended to provide “proof of concept ... to produce a clear capital and estates plan for each sub-region” in London. Such a concept has proven successful outside of London; CCGs and local authorities in Mid and South Essex have established a Growth Infrastructure Framework to provide joined up

43 Sourced from research roundtable

44 The One Public Estate Programme (2016) – Government press release “150 councils join the programme”

45 London Mayor’s Office et al (2015) – London Health and Care Collaboration Agreement

planning for assets and investments over the next 20 years.⁴⁶ The broad aims of the North Central London Pilot roughly coincide with the aims that other estates management projects have had: reducing costs of estates maintenance, improving the overall value and releasing capital to reinvest into health and care. By achieving such aims through closer coordination from NHS and local government it is also able to promote “higher quality and more accessible locations for health and care services”.⁴⁷ The examples cited above highlight how better collaboration on estates can improve the management of the state’s assets and how leveraging these assets better can create benefits which improve the quality of service an individual receives.

Improving coordination through existing technology: data sharing and IT systems

The use of technology, through the sharing of data and use of common IT systems, can encourage greater coordination between health and care. Effective use of data sharing can be used for two purposes. Firstly, it can allow health and care professionals to more easily access necessary data on patients that are held in the other sector. Secondly, data sharing at a population level allows “a systematic approach to managing population risk, improving health outcomes and reducing hospital utilisation; [and] develop[ing] information management systems”.⁴⁸ These wider improvements are not just about the convenience of having shared data for professionals within health and care but show how the effective utilisation of shared data can help create value for money.⁴⁹

Currently, there is a mixed approach to data sharing across local areas. There is a feeling, highlighted in a report by the National Audit Office, that people locally do not understand whether and how patient data could be linked.⁵⁰ Whilst there are no policy constraints on information sharing between local government and the NHS, the Department of Health has admitted that “it had not done enough to explain the rules around information governance”⁵¹ which has led to an “opaque legal framework”.⁵² This could potentially be reinforced by the new integration policy framework which has removed better data sharing as a condition of the Better Care Fund.⁵³

46 Mid and South Essex CCG (2016) – A programme to sustain services and improve care

47 London Mayor’s Office et al (2015) – London Health and Care Collaboration Agreement

48 Nuffield Trust (2011) – Towards Integrated Care In Trafford

49 Reform (2017) – Faulty by design: The state of public-service commissioning

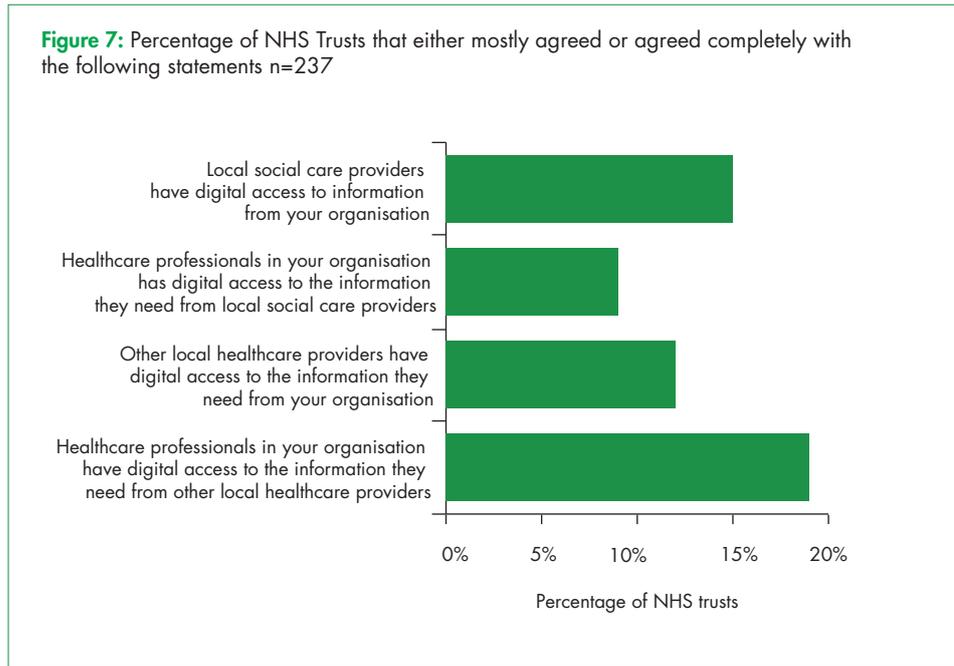
50 NAO (2017) – Health and Social Care Integration

51 Ibid

52 Sourced from research roundtable

53 Department for Health/Department for Communities and Local Government (2017) – 2017 – 2019 Integration and Better Care Fund

Source: Digital Maturity Assessment, 2015/16, NHS England



The result of this confusion is not just poor levels of access to relevant data between health and social care but also within health and social care themselves. The graph shows that as of 2015/16 less than 20% of NHS Trusts were providing digital access to information to either other local health and care partners and vice versa. In the case of healthcare professionals having access to local social care information only 9% felt this was the case. Given this lack of understanding and a reticence in some local areas to employ data sharing on grounds of perceived constraints, there is large variation in the types of sharing agreements that have been achievable in local areas. For example, in 2013 the King’s Fund conducted five case studies on care co-ordination programmes and found a different method of sharing electronic medical records in each area.⁵⁴ Some practical considerations also hamper effective data sharing, such as social care data not always being coded with an NHS identifier.⁵⁵

Lambeth and Southwark: a case study

Although data sharing could be more effectively used in many areas there are some examples where local areas have been able to move towards a more coordinated use of digital. Lambeth and Southwark have been able to collectively coordinate their health and care data to not only allow the sharing of information between health and care professionals but to allow patients to better access information and gain control over their own health and care service.

Lambeth and Southwark have established many initiatives to encourage better coordination. These include a Local Care Record to share information electronically between GPs and hospital-based doctors, a Digital Director of Services to allow healthcare professionals and local people to readily access information about local services and a Catheter Passport to allow better information sharing between care settings and patients to allow patients to become more empowered to use their catheter at home.

⁵⁴ Kings Fund (2013) – Co-ordinated care for people with complex chronic conditions

⁵⁵ Reform (2017) – Faulty by design: The state of public-service commissioning

These efforts at coordination have all led to improvements in data sharing from different services. For example, the Local Care Record resulted in a “75% reduction in calls from GP practices to hospitals chasing information, and a reduction of around 25 unnecessary or duplicate test requests per practice per month”.

These all offer examples of what areas can achieve at a local level to allow better coordination between different services.

Not only are there perceived policy constraints on the sharing of data between health and care, but ethical (and associated legal) concerns over the use of patient data across multiple services. Any coordination between the two services in this area must make ensure that patients are aware that their data is being used in both and are, crucially, aware that they can opt out. For example, in North West London a Whole System Integrated Care record has been created “on the basis of implied consent”, with explicit consent gained from the patient before their record is accessed by, for example, a health professional needing information that originated from the care sector.⁵⁶

The public as a whole are not against the use of health data in certain contexts. For example, research undertaken by Ipsos Mori showed that 54% would support their health data being accessed by commercial organisations for the purpose of health research.⁵⁷ Although this polling did not look at the sharing of data between health and care the principle that the public can support the use of their personal health data for certain contexts still stands.

Shared professional development, training and networks

Shared professional development opportunities for health and care professionals from the start of their training can support the alleviating of tension created by the different cultures in health and care. Data on this aspect of coordination is limited, however. This was highlighted by a Skills for Care evidence review that, in 2013, found that there was not enough evidence to either support or reject the idea that “joint workforce planning increases the ability to provide effective services”.⁵⁸

However, it seems a reasonable assumption that creating shared learning experiences can do much for establishing common practices and understanding of the work done by professionals working in the other sector. This is supported by the same review highlighting how there is “some evidence” to support that an understanding of different roles and responsibilities is important to successful integration within a team. Ergo, we believe the same principle could apply across an organisation or even system.

For example, local health and care partners in Suffolk have developed a whole system provision around workforce development across health and social care through the appointment of a joint workforce development lead. Some of the outputs from this joint role have included teams getting to know each other through, for example, workplace shadowing, learning lunches, shared training events and the development of a shared core competencies and skills base.⁵⁹ Aligning training between NHS and social care staff, possibly co-producing certain programmes, could also be a useful part of what would ultimately be a joint workforce strategy.⁶⁰

A potentially more radical method of increasing coordination from the workforce is through supporting the creation of new roles working across

⁵⁶ National Data Guardian (2016) – Review of data security, consent and optouts

⁵⁷ Ipsos MORI (2016) – Commercial access to health data

⁵⁸ Skills for Care (2013) – Evidence review: integrated health and social care

⁵⁹ East of England LGA (2015) – Whole System Transformation and Integration

⁶⁰ Sourced from research roundtable

professional boundaries that help integrated delivery. These “boundary-spanning roles”, such as physician associates and advanced nurse practitioners, have been supported as the result of increased need to deliver specialist care in the community and generalist care in hospital settings.⁶¹ A report by the King’s Fund highlighted that people filling these new roles need a larger skillset than traditional services.

The need to work across health and social care means that they need to have, for example, effective relationship management skills and the ability to co-ordinate networks of service providers. The promotion of joint staff development, such as that conducted by local health and care partners in Suffolk, has the potential to allow these skillsets required by a truly coordinated workforce to prosper, allowing the needs of patients to be put at centre place rather than them not receiving the correct care due to organisational barriers.

Canterbury, New Zealand ‘One System, One Budget’ – A case study

In 2007 the District Health Board for Canterbury in New Zealand undertook a series of reforms to create an efficient, high quality, person centred, integrated health and care system which has seen it move from regular ‘gridlock’ to one where there is now low acute medical admissions, low waiting times and dramatically improved primary care service. More elderly people are receiving care in their own homes as opposed to entering a care home. Finally, its financial position has moved from being a NZ\$17m deficit, to being in line for NZ\$8m surplus in 2010/11. According to an independent analysis by the Kings Fund it achieved this via the following goals and principles;

1. Goals:

- Services should enable people to take more responsibility for their own health and well-being.
- Where possible people should stay well in their own homes and communities.
- When people need complex care it should be timely and appropriate.

2. Principles:

- Those in the health system – from primary to community to hospital to social care, and whether working as public employees, independent practitioners, or private and not-for-profit contractors – had to recognise that there was ‘one system, one budget’ in Canterbury.
- Canterbury had to get the best possible outcomes within the resources available, rather than individual organisations and practitioners simply arguing for more money.
- To deliver ‘the right care, right place, right time by the right person’ – and that a key measure of success was to reduce the time patients spent waiting.

In practice this was a complex and long journey of improvement, but included as being “central” a system wide approach to training and development to promote higher performance and cut across professional cultures to encourage “teamwork, continuous improvement and patient engagement”.

⁶¹ King’s Fund (2016) – Supporting integration through new roles and working across boundaries

In a similar way in which Health and Wellbeing Boards have been able to establish better coordination between health and care at the strategic level of commissioning, areas can utilise local forums for professionals themselves to encourage better joint working practices between health and social care. The Hackney and City Health and Social Care Forum have been attempting to utilise such a forum to achieve a better understanding between health and social care. This forum, a network of 130 local organisations across health, wellbeing and social care, aims to share good practices and develop partnerships.⁶²

⁶² City and Hackney Health and Social Care Forum - <http://www.hscf.org.uk/>

Chapter 3 – Unlocking social capital and innovation

In this report so far we have explained how current policy, financial and demographic pressures have combined to create a moment of pause in structural integration discussions. We have suggested that the expectations of what successful health and social care integration can achieve must be more realistic. We have explained how local areas should use this moment to focus on better co-ordination of services, addressing long standing barriers to integration. But this activity only creates a stable platform from which to build a future health and social care integration agenda, greater value must still be created.

The key goal of a rebooted health and social care integration agenda should be to give patients and service users more control over their own care. Individual agency and independence should be encouraged by professionals and made easier by services. Progress has been made with the expansion of personal budgets in social care and the growth of personal health budgets in the NHS but more must be done.

In this chapter we identify three branches of reform which should be core to a rebooted health and social care agenda. All three, *reshaping the care market*, *the role of technological innovation* and *supporting greater involvement of the family*, are based on the idea that whilst the state has a central role to play, it is an enabling one that encourages greater resilience and independence. Whether through a radical expansion in personal health budgets, new forms of digital technology or enhanced support for peer to peer or family caring, the goal is to unlock social capital and innovation, drawing in resource, ideas and energy from outside the boundaries of the state.

Shape of the health and care market

Encouraging diversity in an overheated market

The care home market is currently overheated. The tightening of local authority budgets to finance social care have put a squeeze on providers' levels of income, with some local authorities having "driven free rates down to potentially unsustainable levels".⁶³ Government policies, such as rises in the National Living Wage, have also affected the profitability of care providers. The NAO has highlighted the impact of this squeeze on local areas. For example, one local authority had incorporated year-on-year reductions in fees in its contracts to encourage efficiency without having a clear idea of the impact of such a clause will have on meeting user's needs or on the sustainability of providers. Furthermore, in October 2015, the LGiU found that 77% of local authorities that responded to a survey had experienced provider failure within the year.⁶⁴

These budgetary pressures are even more significant in the context of an increased volume of demand. Not only is there a significant rise in the over 65 population, providers are facing a rise in diseases requiring many under 65s to be cared for (such as obesity and diabetes). Over 3 million people in England have some form

⁶³ NAO (2016) – Personalised commissioning in adult social care

⁶⁴ LGiU (2015) – Care and Continuity, cited in NAO (2016) – Personalised commissioning in adult social care

of diabetes and 5 million are at high risk of developing Type 2 diabetes.⁶⁵ Based on current trends, 1 in 3 of the population will be obese by 2034 and 1 in 10 will develop Type 2 diabetes.⁶⁶ Volume of demand, coupled with squeezes on finance, has made it difficult for providers to maintain quality.

Despite these pressures, local authorities are still responsible for shaping their adult social care markets, are required to encourage a diverse range of services and to step in when there is risk of provider failure (to ensure that people still receive care in cases of provider failure).⁶⁷ Not only are providers finding their services unsustainable but, in sharp contrast to the aims of the personalisation agenda, these funding levels are reducing the choice that users have between providers. With local areas reducing the number of providers they contract with to produce economies of scale and save money, more needs to be done to increase diversity in the market to encourage innovation and competition.⁶⁸ Even those areas who have increased payments to care providers in recent years have done so after a prolonged period of holding them down in response to centrally imposed budget reductions.⁶⁹

Within the contexts of squeezed budgets and increasing volume of demand, there are credible alternatives which local authorities should be encouraging to help promote new ways of providing for those requiring social care, however. For example, the Shared Lives programme is a relatively new innovation that allows approved carers to share their own homes and family life with those in need of care in the home.⁷⁰ There are currently over 8,000 approved carers sharing their own homes with over 10,000 adults; breaking the idea that someone must either be cared in a residential setting or in their own home. There have also been initiatives whereby students care for older people in return for cheaper accommodation whilst studying. Broadening local social care markets is not just about increasing the number of providers offering similar types of care. Initiatives like the Shared Lives programme allow local authorities to genuinely broaden the choice of care for local authorities through allowing people to be cared outside of residential settings or in their own home.

The types of providers that can genuinely increase the choice available for users tend to be smaller and less well known. As shown by the example of local authorities reducing the number of providers in order to cut costs and provide economies of scale,⁷¹ “traditional commissioning processes and block contracts favour large, well-established providers offering a set service to everyone, rather than more personalised and varied services”.⁷² One method of encouraging the choice for service users would be through encouraging local areas to better utilise digital marketplaces to make it easier for smaller providers to gain access to customers whilst providing users with knowledge of the variety of choice available to them. Such marketplaces have now had the time to develop. Research by IPPR in 2015 estimated that over 25% of local authorities have digital marketplaces with purchasing functionality, and many more had plans to implement one.⁷³ Since 2015, these marketplaces have developed further. For example, Capita’s ChooseCare product allows those receiving Direct Payment funding to “search, select, book and pay” for services within a single marketplace.⁷⁴ The requirement for providers to ‘sell’ their services directly to service users, rather than through the intermediary of a local authority, encourages providers to have a user-centred focus. Whilst there is no specific policy recommendation on this issue, we do believe local government should

65 Diabetes UK (2016) – State of the Nation

66 Ibid

67 Department for Health (2017) – Overview: Adult social care market shaping

68 NAO (2016) – Personalised commissioning in adult social care

69 Sourced from interview

70 Nesta (2015) – Transforming health and care through social action

71 NAO (2016) – Personalised commissioning in adult social care

72 IPPR (2015) – Next Generation Social Care

73 Ibid

74 Capita (2016) – Introducing ChooseCare

encourage greater usage of digital marketplaces. Not only do they offer the service user greater control over their own care, they are also an important way in which we can open up the care market to new and innovative providers. A number of private companies, certified by the Care Quality Commission, are attempting to improve the efficiency in matching patients to carers or support which better fit their needs already.⁷⁵

Encouraging personalisation through personal health budgets

The expansion of personal budgets on the health side of the integration question should be encouraged. The use of personal health budgets, mirroring the approach taken in social care, would allow more effective coordination through the use of a common mechanism that allows users greater control of their care.

Personal health budgets (PHBs) have proven to be effective and their usage is increasing. The 2012 evaluation of the PHB pilot programme tentatively concluded that there were three ways in which PHBs “might have an impact on outcomes”:

- through the benefits of having more choice
- improved health from allowing support to be tailored to someone’s own needs and preferences (although ill-informed choices could lead to worse outcomes)
- from increases in the overall level of funding delivered to users of PHBs compared to what would have been received under “conventional service arrangements”.

Off the back of these successful initial outcomes, the PHB agenda was extended and is expected to continue to do so. Government has set a target that, by 2020, 50,000-100,000 patients within the NHS should be using a personal health budget and recent projections suggest that the NHS is on course to reach this target.⁷⁶ The disparity between the NHS mandate for 0.1% - 0.2% of a CCG population to be receiving a PHB by 2020⁷⁷ and estimates that up to 5% of the population could benefit from Integrated Personal Commissioning models⁷⁸ suggests that there is even more room for improvement. Not only is there potential scope to further expand the raw number of patients using PHBs but the evidence suggests that CCGs are being able to adapt and improve their performance in using PHBs in a very short span of time. 12% of CCGs scored a performance benchmark of over 50 in September 2015. This rose to 26% within a year and a half (January 2017).⁷⁹ This suggests increasing usage of PHBs won’t lead to a decline in quality. To achieve the scale needed their use must be expanded from relatively low volume care pathways to high volume pathways. The current plan for PHB diversification includes the following areas; ‘Transforming Care’ cohorts and others with a learning disability, end of life care, maternity services through personal maternity care budgets (PMCBs), NHS Continuing Healthcare (CHC) by default, for Children and looked after young people, in support of a reform of wheelchair services, specialist equipment such as in hearing services and in mental health support.

75 The FT (2017) – NHS enlists Uber-style start up to kick start social care

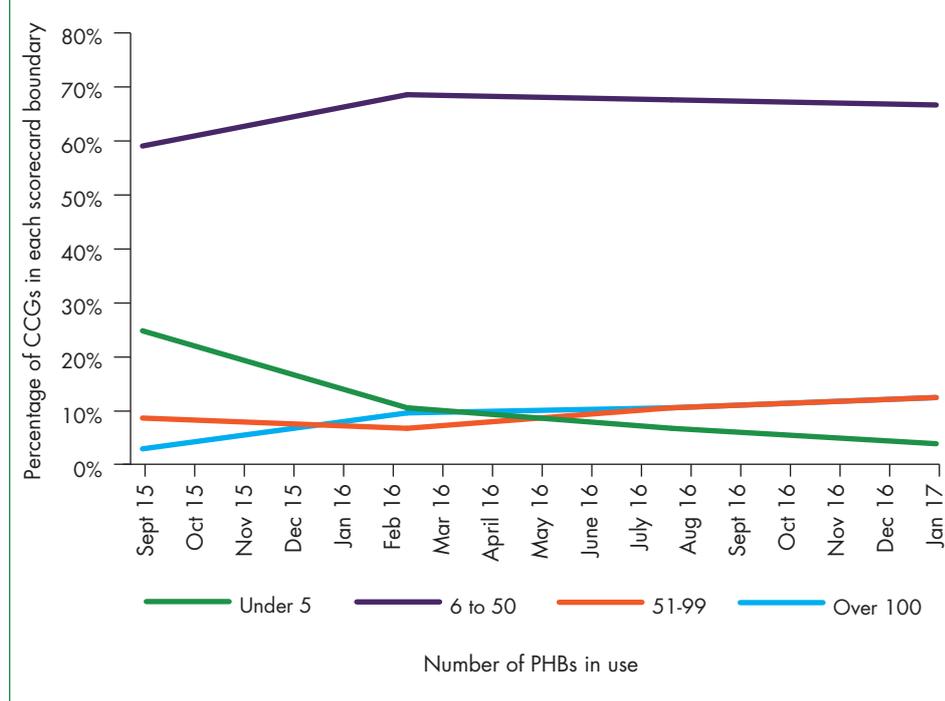
76 NHS England (2017) – Transformation of care through personalisation and choice

77 Newark and Sherwood CCG & Mansfield and Ashfield CCG (2017) – PHB and IPC Update Report

78 LGA and NHS England (2016) – Integrated Personal Commissioning: Emerging Framework

79 NHS England (2017) – Transformation of care through personalisation and choice

Figure 8: CCG performance over time



Source: NHS England (2017) – Transformation of care through personalisation and choice (NHS England)

NHS England should build on the progress achieved since the 2012 evaluation and continue its expansion of personal health budgets, providing more patients receiving healthcare with the freedom of choice to determine their own treatment. This increased usage would also improve efforts at coordination by establishing a common framework between health and care. This expansion should be treated very carefully. Whilst it would be beyond the remit of this report to tackle the series of challenges that arise from the expansion of PHBs, we list the most important below:

1. Social care personal budgets and personal health budgets must be effectively integrated. The challenges that arise in doing this, such as the difference in funding arrangements between health and care, can be overcome through ensuring that a precise procedure is in place for the joining up of health and care budgets. For example, given the work being done on the NHS Transforming Care for people with learning disabilities and the significant role social care plays in providing support to the same cohort there is a clear synergy which could be better exploited.
2. Expansion of personal health budgets should be based on what emerging evidence arises in areas piloting care pathways (e.g. maternity care, for children in the looked after system, people with a learning disability, etc.). This may mean that PHBs should not be expanded in certain care pathways where they may not yet be working as effectively as they should be.
3. CCGs must ensure, as local authorities do with personal budgets, that they are able to provide a genuine wide choice of provision for those using personal health budgets. The 2012 evaluation highlighted that “policy makers should anticipate” a greater use of ‘non-conventional’ (i.e. non-NHS) providers.

Recommendation: Subject to a positive evaluation of the pilot programmes, government should legislate to make Personal Health Budgets mandatory for the most promising specific care pathways. Personal Health Budgets should become the new default delivery mechanism for these care pathways. NHS England and the Local Government Association have

collaborated on the Integrated Personal Commissioning (IPC) programme which could become the mainstream integrative model of support for the care pathways chosen.

The role of technological innovation

For the purpose of this report we split the idea of technological innovations which have the ability to improve the lives of people in receipt of social care and health services into two forms. The first focusses on futuristic technologies, such as 'smart drugs' and medical chatbots that can remind users what medication to take and when.⁸⁰ These have the *potential* to be transformative; but not just yet. Although the creation of such technologies is likely their widespread adoption is still far away. The second are those which are on, or close to, the market currently.

Encouraging the local adoption of existing digital technology

There are technologies whose usage could be practically scaled-up to provide help in the short to medium term. Rather than specific technological devices that take time and are expensive to develop, the use of existing digital technology can be better utilised to create quick change that could help promote a more person centred care services. Given our view that there must be a dramatic scaling up in the use of Personal Health Budgets and an increase in the general personalising of health and care services, the role played by technology in enabling this will be central. The HSCIC predict that by 2020, "technology and data in the form of digitally enabled care will be used by most citizens and will help to meet their demand for better and safer care".⁸¹ Such digitally enabled care should, for example, include the creation of patient data records that can be accessed by the patient and health and care professionals alike; allowing the patient to be more confident in the use of their data records and making access easier for those working with them.⁸² Whilst this has proven difficult to date, there remains a pressing need to improve the quality and accessibility of health and care data as exemplified in Chapter 2. Local areas could also choose to invest in mobile working solutions for staff, for example in order to allow community nurses to access to all the information they need whilst visiting patients at home. The use of this technology has, according to Deloitte analysis, reduced paperwork time by 60%, increasing patient face time by 29% which leads to each nurses seeing two more patients, on average, every day.⁸³

There are local areas that already investing in new technologies to create a better care service. For example, Barnet's Commissioning Plan in 2013 contained provision to ensure that "Telecare and Equipment become the norm and are considered for every care package where appropriate".⁸⁴ However, local health and care commissioners can be reticent about investing in digital and technological innovations. Firstly there are concerns about interoperability of digital technology and systems.⁸⁵ Whilst many of the new products available on the market address this issue, there remains a perception that it is a risk. Linked to this point, a concern was raised during the research about the ability of some organisations to adequately understand what they purchasing and/or think thoroughly about how they would train and support their staff to use new technology. "There's a long history of councils buying technology but not using it as effectively as it should and in some cases not using it all."⁸⁶ Secondly, there are concerns about the costs of such technology. Analysis by the Swedish government, collated by the King's Fund, show that the

80 King's Fund (2016) – The digital revolution: eight technologies that will change health and care

81 HSCIC (2015) – Information and Technology for Better Care

82 PWC (2015) – Digital enabling of patient centric care in 2015 and beyond

83 Deloitte (2015) – Connected health: How digital technology is transforming health and social care

84 Barnet's Market Position Statement (July 2013)

85 Sourced from research roundtable

86 Sourced from interview

projected health and social care spend as a percentage of GDP rises from 2010 to 2050 when assumptions about improvements from technology are included, on account of increased public and patient expectation from the use of technology.⁸⁷ This is in contrast to a much smaller rise when these assumptions are removed. However, experts suggest “there are now fewer concerns about the cost-effectiveness of TEC [technology enabled care]” due to the improved quality of devices and falling cost of digital technology.⁸⁸ These issues about cost reflect a point raised by the Nominet Trust: that technological advancements tend to be “isolated, very small-scale pilots or developed outside of mainstream social care practice” which creates a challenge of scaling up such innovations to be useful on a larger scale.⁸⁹

Local government could be encouraged to better invest in technological advancements in health and care by allowing them to invest in these through capital spend rather than revenue. The ability to borrow to meet the cost of capital spending would mean that such advancements, which will have medium to long term benefits, are not competing with resources for existing services. A precedent also exists through current regulation over capitalisation. Capitalisation, whereby local authorities may (subject to central government criteria) “transfer money from their capital account into their revenue account” would increase the availability of finance to invest in technology.⁹⁰ Currently, local bodies are permitted to transfer such money for projects “designed to generate ongoing revenue savings...and/or transform service delivery to reduce costs and/or...[reduces] demand for services in future years”.⁹¹ These include projects that drive “a digital approach to the delivery of more efficient public services and how the public interacts with constituent authorities where possible”.⁹²

There is a suggestion, based on local authority capital expenditure figures, that this method of utilising capital spending to drive digital approaches to care is not being used. Total capital expenditure by virtue of a section 16(2)(b) direction (the clause in the Local Government Act 2003 allowing certain types of expenditure to be treated as capital despite not falling in the definition of capital) has fallen from £14bn in 2011/12 to £6bn in 2015/16.⁹³

Recommendation: Whilst there is no likely systematic obstruction to local government’s capital classification powers, our analysis suggests local authorities should be encouraged to use the capitalisation mechanism much more to invest in digital technology to support an increase in better care options for patients. To that end government should issue clarifying guidance on what is permissible for capitalisation, expanding and clarifying the remit of what its own guidance terms “a digital approach” to service delivery to include the wider transformation, training and support programmes needed to ensure that technology is effectively used and its potential maximised.

Supporting the domestic market in social care-related technology

There are very few available public resources to encourage spend in developing new forms of technology that will aid those in receipt of health and care services. The total spend of all live government-funded projects in 2015/16, across the lifetime of each project, equates to £72 million.⁹⁴ Amongst these projects are innovative solutions to help increase the independence of service users. For example, Innovate UK are

87 Ministry of Health and Social Affairs Sweden (2010), cited in The King’s Fund (2013) – Spending on health and social care over the next 50 years? Why think long term

88 Deloitte (2015) – Connected health: How digital technology is transforming health and social care

89 Nominet Trust (2013) – Can online innovations enhance care?

90 House of Commons briefing paper (2016) – Local government in England: capital finance

91 Department for Communities and Local Government (2016) – Statutory Guidance on the Flexible Use of Capital Receipts

92 Ibid

93 Table 1: Local authority capital expenditure and receipts: England: 2011-12 to 2015-16 forecast and outturn, DCLG

94 Department of Health (2016) – Research and development work relating assistive technology

currently contributing £2,155,780 to fund CHIRON-care; an intelligent set of robotics to “enable people to stay independent for longer, supporting them to undertake their own personal care tasks.”⁹⁵ However, given limited funds the government should support and bolster the domestic market in social care-related technology.

The incentive for businesses is clear. The market is large and, owing to demographic changes, is increasing. Scope, for example, has estimated the specialist equipment market for disabled people in the UK is worth over £720 million a year⁹⁶ whilst the British Healthcare Trades Association estimate that the value of the UK market in assistive technology will rise from £2.5 billion in 2014 to £6 billion by 2025.⁹⁷ With an estimated 15% of the world’s population living with some form of disability there is also scope for businesses to develop their products in the UK and reach into the global market.⁹⁸

Recommendation: Government should look to encourage greater investment in businesses that create products which support assisted living (and could potentially be export businesses in a growing global market). As previously highlighted in a Localis report on the Industrial Strategy government could offer tax reliefs as part of the Enterprise Investment Scheme (EIS) and its subsidiary Seed Enterprise Investment Scheme (SEIS).⁹⁹ Relief on investment for both could be enhanced respectively. Currently the EIS provides investors with 30% tax relief on investments of up to £1m a tax year in shares of smaller, high-risk companies. The SEIS provides 50% tax relief on investments up to £100,000 and encourages seed investment in early-stage companies. With growing global demand for assistive technology and products these businesses should be attractive to investors already, but with this change to investment relief the profile of the opportunity would be raised.

The role of family in providing care and support

“Family planning,” stated Health Secretary Jeremy Hunt, “must be as much about care for older generations as planning for younger ones.”¹⁰⁰ Governments of all political persuasion have looked at the family as a possible answer to increasing demand for care services. That the informal social care market is estimated to be worth £119bn compared to combined social care expenditure (of state and private contributions) of £30bn, suggests there is a significant amount of care being provided by families already.^{101,102} Based on polling commissioned for this report 1 in 10 people currently provide care for a relative.¹⁰³ (Full data for all polling questions and responses can be found in Appendix 3.)

95 Ibid

96 Scope (2015) – Extra Costs Commission Final Report

97 British Healthcare Trades Association (2014) – Manifesto for healthcare and assistive technology

98 World Health Organisation (2011) – World report on disability

99 Localis (2017) – The Making of an Industrial Strategy

100 Local Government Association Conference (2015) – Speech by Rt. Hon Jeremy Hunt MP

101 Carer’s UK (2011) – Valuing Carers 2011: Calculating the value of carers’ support

102 SMF (2015) – Putting Patients in Charge: The future of health and social care

103 Yougov Commissioned Polling - Localis commissioned Yougov to test the attitudes of the British public to family involvement in care. Fieldwork was conducted over 24/25 May 2017 and a full breakdown of the data and questions can be found in appendices of this report.

Other than childcare, do you currently provide care for a relative, or have you done so in the past? (n=2052)	
I do not currently provide care for a relative and have not done so in the past	61%
I do not currently provide care for a relative but have done so in the past	24%
I currently provide care for a relative	10%
Don't know	5%

The current state support available for family members caring for relatives is a combination of centrally determined benefits such as ‘Carers Allowance’ and locally determined mechanisms such as ‘Council Tax Reductions’. The recent Conservative manifesto included the pledge to provide workers with the right to request up to 52 weeks leave to care for a relative. Whilst it’s right to provide more flexibility for employees the current financial support available to those whose job is full time care, but who are not yet old enough to access a pension or other benefits, is small. For example the carers allowance is worth £62.70 per week in 2017/18 which is not means tested and is taxable.¹⁰⁴ There are also additional requirements linked to the time spent providing care, whether you are in education or employment and the disability status of the person you are caring for. There have been long standing concerns from independent agencies such as Carers UK and Citizens Advice that the financial and emotional pressure supporting a relative puts on a carer; “whilst the carer’s allowance isn’t a wage, caring is a full time job”.¹⁰⁵ If government wishes to unlock more social capital from families in order to provide support, policy needs to change.

Are the public open to families providing more care and support?

Social care took centre stage in the recent election and there is strong consistency across the all regions and social grades that more involvement of the state in providing care is desirable. (71% of people want either much more or slightly more.¹⁰⁶) Also, a significant proportion of voters want more involvement from the family, approximately 42% of voters feel the family should be much more or slightly more involved.¹⁰⁷ There is a noticeable split when broken down by party affiliation with an overall majority of Conservative voters favouring more involvement of the family in providing care (52%) versus only 36% of Labour voters.¹⁰⁸ Overall a plurality of the British people are in favour of more family involvement in providing care to relatives.

¹⁰⁴ Carers UK – Information on carers’ allowance

¹⁰⁵ Citizens Advice (2015) – The role of carer’s allowance in supporting unpaid care

¹⁰⁶ Yougov Commissioned Polling

¹⁰⁷ Ibid

¹⁰⁸ Ibid

Thinking about society in general, do you think that family members should be more or less involved in providing care for those who need it, or do you think their current level of involvement is about right? (n = 2052)	Ovr	Con	Lab	Lib Dem	Ukip
Much more involved	14%	19%	12%	14%	14%
Slightly more involved	28%	33%	24%	30%	26%
TOTAL MORE INVOLVED	42%	52%	36%	44%	40%
Current involvement is about right	33%	34%	36%	35%	36%
Slightly less involved	7%	5%	9%	10%	7%
Much less involved	2%	1%	4%	0%	2%
TOTAL LESS INVOLVED	9%	6%	13%	10%	9%
Don't know	15%	8%	15%	12%	14%

(We took the decision to include the political breakdown of the polling responses to highlight the difference between Conservative and Labour voters given the issue of family involvement in care being a significant issue during the 2017 general election.)

What barriers should policy address to encourage more family participation?

Our polling has highlighted an important challenge working against greater involvement of the family in providing care; people's understanding of what the challenges to providing care will actually be. Essentially, those who have never provided care before, the majority of the adult population, overestimate the financial impact of providing care as a challenge and underestimate the emotional cost compared to those who have experience of providing care or currently do so.¹⁰⁹

¹⁰⁹ Ibid

Thinking about the care that you currently provide for a relative, or that you have provided in the past, which of the following things, if any, have been the biggest challenges when providing that care? Please select up to three options: *[This question was only asked to respondents who do not currently provide care for a relative but have done so in the past and those who currently provide care for a relative; n=717]*

The physical demands of caring for someone	44%
The emotional costs of offering care	37%
Being busy with work or career	33%
The severity of the condition of the person being cared for	32%
Other commitments in my life	28%
Living away from the person who needs care	21%
The costs associated with caring for someone	19%
Childcare responsibilities	10%
The provision of existing state care	7%
Other	3%
None of the above	7%
Don't know	3%

If you had a relative who needed care, which of the following things, if any, do you think would be the most important barriers to you providing it? Please select up to three options:
[This question was only asked to respondents who do not currently provide care for a relative and have not done so in the past; n=1259]

The costs associated with caring for someone	41%
The physical demands of caring for someone	39%
Being busy with work or career	37%
I don't live near most of my relatives	32%
The emotional challenges of offering care	28%
Other commitments in my life	20%
Childcare responsibilities	12%
The provision of existing state care	6%
Other	2%
None of the above	4%
Don't know	9%

This suggests that to encourage greater family participation in providing care any policy prescription will need an initial financial incentive followed by ongoing support to address the emotional cost of providing care. Given those currently providing care report financial difficulties any increased financial support or flexibility on accessing it would also likely help them too.

There is a great deal of variability in the type of care someone might require, ranging from as little as regular company to combat loneliness through to intensive round the clock support. There is no one shot policy, therefore, which would address the concerns of family members considering providing support to a relative. Government will need to take an iterative approach to increasing family participation. Opening up access to existing financial support mechanisms, such as carers allowance, and expanding discretionary schemes supported by local authorities, such as council tax reductions, would be a sensible first step.

Recommendation: Government should commission an independent review to explore the existing and potential future range of financial support incentives to encourage family members to consider providing support to a relative who needs care. These could include;

- Should Government introduce a worker's right to access 52 weeks leave to provide care to a relative, government should explore the feasibility of making contributions to an employee's pension scheme over any period their leave is designated as 'unpaid' to ensure that taking a sustained period of time off work to care for a relative does not unduly hamper a person's own planning for older age.
- Opening up the criteria for access to Carers Allowance, including reducing the minimum number of hours required providing care down from 35 and increasing the amount an individual can earn above £116 to £144 to reflect future increases in the national living wage.¹¹⁰

¹¹⁰ For details on data source see reference '105'

Chapter 4 – Recommendations

We opened this report with the clear aim of recasting health and social care integration as a vehicle to drive more person centred care. Whilst we will not offer recommendations to councils or the NHS directly on how to transform services, we make a number of strategic and policy recommendations to government in order to support local health and care partners achieve their outcomes and reboot health and social care integration.

Strategic recommendations to support integration

1: In the forthcoming social care green paper government should make the question of a sustainable funding solution central. The 2014 Care Act provides a cap mechanism to protect individuals from extremely high care costs, and government should recommit to its implementation given the political resistance to altering it. However, this means there will need to be increased state spending in order to support the system. Government should explore the widest range of options possible from hypothecated new taxes (both local and national) through to reform of age related benefits, such as the Winter Fuel Allowance.

2: Government should support better collaboration around finance and commissioning locally by simplifying departmental responsibilities. As has been recommended by others Government should transfer social care funding responsibility from the Department for Communities and Local Government to the Department for Health, where responsibility for policy currently sits. Local authorities would still retain budgetary control locally, but the alignment of funding and policy centrally would help local leaders build better relationships with the Department of Health.

3: To support the long term joining up of social, primary and community services in order to create person centred local services, government should look beyond the NHS England Five Year Forward View and, as had been recommended by the House of Lords Select Committee on the Long Term Sustainability of the NHS, set out a medium term strategy up to 2025. This plan should be devised in consultation with key stakeholders and should be focused on establishing the necessary actions to support the creation of more person centred care.

4: Government should establish a long term health and care workforce review. This should consist of NHS England, the LGA, ADASS, Royal Colleges, General Medical Council, the Nursing and Midwifery Council and other relevant partners. The purpose would be to provide a strategic assessment of the long term workforce challenges and opportunities. It should also establish a common framework by which all local areas could begin to establish local joint workforce strategies.

Policy recommendations to support integration

5: Whilst there is no likely systematic obstruction to local government's capital classification powers, our analysis suggests local authorities should be encouraged to use the capitalisation mechanism much more to invest in digital technology to support an increase in better care options for patients. To that end government should issue clarifying guidance on what is permissible for capitalisation, expanding and clarifying the remit of what its own guidance terms "a digital approach" to service delivery to include the wider transformation, training and support programmes needed to ensure that technology is effectively used and its potential maximised.

6: Government should look to encourage greater investment in businesses that create products which support assisted living (and could potentially be export businesses in a growing global market). As previously highlighted in a Localis report on the Industrial Strategy government could offer tax reliefs as part of the Enterprise Investment Scheme (EIS) and its subsidiary Seed Enterprise Investment Scheme (SEIS).¹¹¹ Relief on investment for both could be enhanced respectively. Currently the EIS provides investors with 30% tax relief on investments of up to £1m a tax year in shares of smaller, high-risk companies. The SEIS provides 50% tax relief on investments up to £100,000 and encourages seed investment in early-stage companies. With growing global demand for assistive technology and products these businesses should be attractive to investors already, but with this change to investment relief the profile of the opportunity would be raised.

7: Subject to a positive evaluation of the pilot programmes, government should legislate to make Personal Health Budgets mandatory for the most promising specific care pathways. Personal Health Budgets should become the new default delivery mechanism for these care pathways. NHS England and the Local Government Association have collaborated on the Integrated Personal Commissioning (IPC) programme which could become the mainstream integrative model of support for the care pathways chosen.

8: Government should commission an independent review to explore the existing and potential future range of financial support incentives to encourage family members to consider providing support to a relative who needs care. These could include;

7.1 Should Government introduce a worker's right to access 52 weeks leave to provide care to a relative, government should explore the feasibility of making contributions to an employee's pension scheme over any period their leave is designated as 'unpaid' to ensure that taking a sustained period of time off work to care for a relative does not unduly hamper a person's own planning for older age.

7.2 Opening up the criteria for access to Carers Allowance, including reducing the minimum number of hours required providing care down from 35 and increasing the amount an individual can earn above £116 to £144 to reflect future increases in the national living wage.¹¹²

9: Government should ensure that data sharing between the NHS, social care and the relevant community partners, is set out as a strategic objective as part of the next published NHS Mandate (2018/19).

10: Government should act on the recommendations of the recent Naylor Review to achieve greater value and efficiency out of the NHS estate. However, it should also insist on greater collaboration from the NHS with other partners via the Cabinet Office and LGA backed One Public Estate's programme.

¹¹¹ Localis (2017) – The Making of an Industrial Strategy

¹¹² For details on data source see reference '105'

Appendices

Appendix 1 – What are ‘Accountable Care Organisations’?

Accountable Care Organisations (ACOs) have grown in the USA off the back of Obamacare. In 2013, there were over 400 ACOs in the USA (including Medicare and private ACOs), covering c. 14% of Americans.¹¹³ Their composition is quite mixed. Initially (between 2010 and 2012), they were mainly formed by hospital systems but, in 2013, physician-led groups accounted for 51% of all ACOs.¹¹⁴ Most ACOs are also very small and are composed of less than 100 physicians.¹¹⁵

Whilst they are very new and still “finding their feet”, initial evaluation of ACOs in America have been mixed – “some have reported hitting quality targets and reducing hospital admissions, while others have suffered financial losses”.¹¹⁶ One report concluded that “a word of caution is needed. ACOs should not be expected to make large improvements in health care performance”.¹¹⁷

First Practice Management have suggested that ACOs can work most effectively when they focus on the small percentage of patients who use the most services and “tailor a care package for them”.

ACOs that are doing well have been able to expand their services beyond traditional clinical services and the population that they are contracted to help. For example, “some ACOs have teamed with employers and local gyms to offer exercise and nutrition-based counselling to address preventative health needs”.¹¹⁸

One of the biggest challenges for ACOs, according to the Nuffield Trust, is in “shifting the mindset of physicians from a fee-for-service model to a more integrated approach”.¹¹⁹ Another challenge suggested was the need to find the right balance of risk as some ACOs do not accept a lot of risk and therefore don’t engage in prevention and health promotion.¹²⁰

Cost savings under ACOs

Like other outcome measures, ACOs have had mixed financial outcomes. One academic article, in the New England Journal of Medicine (based on a small sample) found that there were early savings for ACOs entering the programme in 2012, but not for those that entered a year later. The financial analysis from this article concluded that “the aggregate \$238 million spending reduction suggested by our estimates for the 2012 MSSP [Medical Shared Savings Program] cohort did not result in net savings to Medicare, because Medicare paid \$244 million

113 Health Policy Journal (2014) – Accountable care organisations in the USA

114 Ibid

115 Nuffield Trust (2016) – US healthcare reform: lessons for the UK

116 First Practice Management (2016) – A new care solution for the NHS

117 Health Policy Journal (2014) – Accountable care organisations in the USA

118 Ibid

119 Nuffield Trust (2016) – US healthcare reform: lessons for the UK

120 Health Policy Journal (2014) – Accountable care organisations in the USA

in bonuses” – i.e. the bonuses given to the ACOs for meeting benchmarks were worth more than the spending reductions achieved. These savings also varied by the type of ACO – with more savings from independent primary care groups compared to groups integrated within hospitals.

In 2015, it was reported that nearly half of ACOs were “costing more than the government estimated their patients would normally cost”.¹²¹ This bottom line, it was suggested, “has been hurt by the reluctance of most ACOs to accept financial responsibility for their patients”: only 7% of ACOs in 2014 opted for a “high-risk/high-reward deal” where they could earn larger bonuses but would have to reimburse the government if their patients cost Medicare more than expected.

ACOs in England

Since ACOs are new in England there has been no ‘official evaluation’ of their effectiveness. At present NHS England has laid out a plan for a select number of areas to go forward as Accountable Care Systems which over time could morph into Accountable Care Organisations. For such an approach to work in the UK health experts at the Kings Fund have argued for the need to build stronger relationships within the NHS system, accelerate the implementation of electronic care records and predictive tools to identify patients with higher than average health care costs and be more patient in when results are likely to be achieved as collaboration takes time.

Appendix 2 – List of research roundtable attendees

The following people attended research roundtables for this report.

Tuesday 25th April 2017, 10.00am – 12.00pm, Birmingham

- **Cllr Faye Abbott**
Cabinet Member for
Adult Services,
Coventry City Council
- **Anne Baines**
Director of Strategy and
Performance,
The Dudley Group of Hospitals
NHS Foundation Trust
- **John Dixon**
Strategic Director of People Group,
Warwickshire County Council
- **Paula Furnival**
Executive Director – Adult
Social Care,
Walsall Metropolitan
Borough Council
- **Cllr Karen Ginsell**
Portfolio Holder for Adult
Social Care and Health,
Solihull Metropolitan
Borough Council
- **Cllr Paulette Hamilton**
Cabinet Member for Health and
Social Care,
Birmingham City Council
- **Anna Hargrave**
Director of Strategy and
Engagement,
South Warwickshire CCG
- **Martin Samuels**
Director of Adults and Wellbeing
Service Transformation,
Herefordshire Council
- **Linda Sanders**
Strategic Director: People,
City of Wolverhampton Council
- **Lorraine Thomas**
Interim Director of Business and
Organisational Development,
Birmingham Community Healthcare
NHS Trust

¹²¹ Kaiser Health News (2015) – Medicare yet to save money through heralded medical payment model

Wednesday 26th April 2017, 2.00pm – 4.00pm, London

- **Cllr Jason Arthur**
Cabinet Member for
Finance and Health,
London Borough of Haringey
- **Margaret Bracey**
General Manager Older People's
Mental Health West Sussex,
Sussex Partnership NHS
Foundation Trust
- **Cllr Janet Burgess**
Deputy Leader of the Council,
London Borough of Islington
- **Helen Charlesworth-May**
Strategic Director Adults
and Health,
London Borough of Lambeth
- **Cllr David Coppinger**
Deputy Chairman of Cabinet and
Lead Member for Adult Services
and Health,
Royal Borough of Windsor &
Maidenhead
- **Durand Darougar**
Clinical Services Manager for
Older Adults,
South London and Maudsley NHS
Foundation Trust
- **Cllr Krupesg Hirani**
Lead Member for Community
Wellbeing,
London Borough of Brent
- **Lucja Kolkiewicz**
Associate Medical Director for
Recovery and Wellbeing,
East London NHS Foundation Trust
- **Cllr Jonathan McShane**
Cabinet Member for Health, Social
Care and Devolution,
London Borough of Hackney
- **Pete Raimes**
Service Director,
Central and North West London
NHS Foundation Trust
- **Cllr Luke Stubbs**
Deputy Leader of the Council,
Portsmouth City Council
- **Frances Tippett**
Programme Director,
South West Integrated Personal
Commissioning Programme

Appendix 3 – Full results and questions from commissioned Yougov polling

Background

This spreadsheet contains survey data collected and analysed by YouGov plc. No information contained within this spreadsheet may be published without the consent of YouGov Plc and the client named on the front cover.

Methodology: This survey has been conducted using an online interview administered members of the YouGov Plc GB panel of 185,000+ individuals who have agreed to take part in surveys. An email was sent to panellists selected at random from the base sample according to the sample definition, inviting them to take part in the survey and providing a link to the survey. (The sample definition could be “GB adult population” or a subset such as “GB adult females”). YouGov Plc normally achieves a response rate of between 35% and 50% to surveys however this does vary dependent upon the subject matter, complexity and length of the questionnaire. The responding sample is weighted to the profile of the sample definition to provide a representative reporting sample. The profile is normally derived from census data or, if not available from the census, from industry accepted data.

YouGov plc make every effort to provide representative information. All results are based on a sample and are therefore subject to statistical errors normally associated with sample-based information.

For further information about the results in this spreadsheet, please contact YouGov Plc (+44)(0)20 7 012 6000 or email enquiries@yougov.com quoting the survey details.

YOUNG GOV/ LOCALIS SURVEY RESULTS

Fieldwork dates: 24th – 25th May 2017
Prepared by YouGov plc on behalf of Localis
Sample size: 2052 GB Adults

		EU Ref 2016		Vote in 2015				Gender	
	Total	Remain	Leave	Con	Lab	Lib Dem	UKIP	Male	Female
Weighted Sample	2052	806	876	579	480	123	198	993	1059
Unweighted Sample	2052	960	871	589	511	135	204	916	1136

% % % % % % % % %

To what extent do you think the state should be more or less involved in providing care for those who need it, or do you think its current level of involvement is about right?									
Much more involved	36	38	37	28	44	41	43	35	37
Slightly more involved	35	38	32	36	34	40	32	35	35
TOTAL MORE INVOLVED	71	76	69	64	78	81	75	70	72
Current involvement is about right	13	13	16	21	11	8	12	14	13
Slightly less involved	2	2	2	3	1	2	2	2	1
Much less involved	1	1	2	2	0	1	0	2	1
TOTAL LESS INVOLVED	3	3	4	5	1	3	2	4	2
Don't know	13	9	12	10	9	8	11	12	14
Thinking about society in general, do you think that family members should be more or less involved in providing care for those who need it, or do you think their current level of involvement is about right?									
Much more involved	14	12	18	19	12	14	14	15	14
Slightly more involved	28	28	29	33	24	30	26	28	28
TOTAL MORE INVOLVED	42	40	47	52	36	44	40	43	42
Current involvement is about right	33	37	33	34	36	35	36	34	33
Slightly less involved	7	9	5	5	9	10	7	7	7
Much less involved	2	2	2	1	4	0	2	3	1
TOTAL LESS INVOLVED	9	11	7	6	13	10	9	10	8
Don't know	15	12	13	8	15	12	14	14	16

Age				Social Grade		Region				
18-24	25-49	50-64	65+	ABC1	C2DE	London	Rest of South	Midlands /Wales	North	Scotland
238	876	507	431	1170	882	246	681	441	495	189
237	894	531	390	1241	811	208	677	460	497	210

% % % % % % % % % % %

26	32	45	39	34	39	33	37	33	38	36
43	32	32	38	37	31	39	35	33	35	31
69	64	77	77	71	70	72	72	66	73	67
9	14	12	16	15	12	14	11	17	13	12
4	2	1	2	2	1	0	3	1	2	2
3	1	1	0	2	1	2	0	1	1	3
7	3	2	2	4	2	2	3	2	3	5
15	19	9	6	10	17	11	14	15	11	15
9	12	15	20	16	13	20	16	12	12	12
32	28	27	28	29	27	26	27	29	27	32
41	40	42	48	45	40	46	43	41	39	44
32	30	35	38	33	34	30	33	34	35	34
10	6	9	5	8	5	9	6	6	8	5
0	2	4	0	2	2	3	1	2	3	2
10	8	13	5	10	7	12	7	8	11	7
17	21	11	8	12	19	13	16	17	15	15

		EU Ref 2016		Vote in 2015				Gender	
	Total	Remain	Leave	Con	Lab	Lib Dem	UKIP	Male	Female
Weighted Sample	2052	806	876	579	480	123	198	993	1059
Unweighted Sample	2052	960	871	589	511	135	204	916	1136

% % % % % % % % %

Still thinking about society in general, which of the following things, if any, do you think are the most important barriers to family members providing care for those who need it? Please select up to three options:

Being busy with work or career	42	46	41	46	39	51	42	42	41
The severity of the condition of the person being cared for	41	41	45	44	44	41	47	36	46
The physical demands of caring for someone	40	40	44	40	43	38	40	39	42
The costs associated with caring for someone	37	41	35	30	41	35	47	39	34
Living away from those who need care	34	38	33	41	33	43	31	30	37
The emotional costs of offering care	17	18	15	13	22	18	17	16	18
People prioritising their own lives	15	15	18	21	13	9	18	17	14
Childcare responsibilities	13	16	13	12	16	16	13	11	16
The provision of existing state care	7	7	6	5	9	6	6	8	5
Other	1	1	2	2	1	1	1	1	1
None of the above	1	1	1	2	1	0	2	1	1
Don't know	10	6	9	7	7	11	4	11	9

Other than childcare, do you currently provide care for a relative, or have you done so in the past?

I do not currently provide care for a relative and have not done so in the past	61	67	56	59	63	62	58	66	57
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Age				Social Grade		Region				
18-24	25-49	50-64	65+	ABC1	C2DE	London	Rest of South	Midlands /Wales	North	Scotland
238	876	507	431	1170	882	246	681	441	495	189
237	894	531	390	1241	811	208	677	460	497	210

%	%	%	%	%	%	%	%	%	%	%
48	42	43	37	47	35	40	43	40	42	42
32	34	46	55	41	42	34	40	46	45	36
33	37	44	48	41	40	41	39	39	42	44
48	38	36	28	39	34	43	36	36	33	42
23	28	36	48	39	27	34	36	29	35	33
18	20	16	13	16	18	19	16	18	16	17
13	13	18	17	17	13	15	15	13	16	19
16	14	11	13	14	13	20	13	11	12	14
7	6	7	6	6	7	7	6	7	6	8
1	1	2	2	1	1	1	2	1	1	1
1	2	1	0	1	3	0	2	3	1	1
13	13	7	6	7	13	9	9	10	11	9
80	69	50	49	66	55	68	61	56	60	70

		EU Ref 2016		Vote in 2015				Gender	
	Total	Remain	Leave	Con	Lab	Lib Dem	UKIP	Male	Female
Weighted Sample	2052	806	876	579	480	123	198	993	1059
Unweighted Sample	2052	960	871	589	511	135	204	916	1136

	%	%	%	%	%	%	%	%	%
I do not currently provide care for a relative but have done so in the past	24	22	29	28	25	27	26	20	28
I currently provide care for a relative	10	8	11	10	9	8	14	10	10
Don't know	5	3	4	3	3	3	3	5	5

Thinking about the care that you currently provide for a relative, or that you have provided in the past, which of the following things, if any, have been the biggest challenges when providing that care? Please select up to three options:

The physical demands of caring for someone	44	41	48	42	43	47	51	46	43
The emotional costs of offering care	37	36	39	37	42	27	38	35	39
Being busy with work or career	33	35	32	39	26	44	35	32	34
The severity of the condition of the person being cared for	32	32	33	28	36	29	31	28	34
Other commitments in my life	28	24	28	31	27	24	27	21	32
Living away from the person who needs care	21	25	18	20	22	24	17	19	22
The costs associated with caring for someone	19	20	18	13	24	20	30	23	15
Childcare responsibilities	10	15	5	5	15	19	1	6	13
The provision of existing state care	7	7	6	6	6	5	5	6	7
Other [For all open responses, please see Tab2]	3	3	4	3	5	2	2	2	4
None of the above	7	7	5	7	5	12	5	9	5
Don't know	3	3	3	4	1	3	1	3	2

Age				Social Grade		Region				
18-24	25-49	50-64	65+	ABC1	C2DE	London	Rest of South	Midlands /Wales	North	Scotland
238	876	507	431	1170	882	246	681	441	495	189
237	894	531	390	1241	811	208	677	460	497	210

%	%	%	%	%	%	%	%	%	%	%
8	16	33	38	23	25	22	24	26	25	20
7	8	14	10	8	13	8	10	11	11	7
5	7	2	2	3	7	2	5	6	3	3

[This question was only asked to respondents who do not currently provide care for a relative but have done so in the past and those who currently provide care for a relative; n=717]

31	37	48	48	41	47	33	38	51	47	53
29	36	38	38	37	37	39	40	31	35	46
19	34	40	26	36	30	39	33	30	33	35
23	25	32	39	31	32	19	32	31	37	31
29	27	30	25	28	27	28	26	30	28	26
11	26	18	21	24	18	26	24	18	18	18
30	21	17	16	18	19	20	22	14	18	20
7	16	10	4	10	10	19	7	8	11	12
0	8	6	7	7	6	6	6	4	9	11
0	1	6	2	3	3	6	1	2	4	5
14	6	4	9	7	7	5	5	10	9	2
14	3	0	3	3	2	4	3	4	1	2

		EU Ref 2016		Vote in 2015				Gender	
	Total	Remain	Leave	Con	Lab	Lib Dem	UKIP	Male	Female
Weighted Sample	2052	806	876	579	480	123	198	993	1059
Unweighted Sample	2052	960	871	589	511	135	204	916	1136

% % % % % % % % %

If you had a relative who needed care, which of the following things, if any, do you think would be the most important barriers to you providing it? Please select up to three options:

The costs associated with caring for someone	41	41	42	38	40	35	45	41	41
The physical demands of caring for someone	39	39	46	44	43	37	48	35	44
Being busy with work or career	37	44	29	35	37	41	22	41	34
I don't live near most of my relatives	32	36	30	30	34	47	34	30	34
The emotional challenges of offering care	28	30	26	26	32	32	21	23	34
Other commitments in my life	20	22	16	20	16	22	19	24	15
Childcare responsibilities	12	13	8	7	11	16	8	9	15
The provision of existing state care	6	6	7	6	7	5	8	7	6
Other [For all open responses, please see Tab3]	2	2	2	2	1	2	4	1	2
None of the above	4	3	6	5	4	2	5	4	5
Don't know	9	7	9	9	10	6	11	11	7

Age				Social Grade		Region				
18-24	25-49	50-64	65+	ABC1	C2DE	London	Rest of South	Midlands /Wales	North	Scotland
238	876	507	431	1170	882	246	681	441	495	189
237	894	531	390	1241	811	208	677	460	497	210

% % % % % % % % % %

[This question was only asked to respondents who do not currently provide care for a relative and have not done so in the past; n=1259]

49	41	35	39	40	41	44	41	40	38	41
26	29	49	68	38	42	44	39	36	40	36
53	46	31	6	43	28	38	35	41	36	40
29	33	36	29	36	27	40	33	28	29	34
27	27	27	36	28	30	27	27	30	28	31
31	21	15	13	22	16	17	19	22	20	21
6	19	5	3	14	8	15	12	10	11	11
9	4	7	10	6	6	11	5	5	7	5
2	1	2	4	2	2	3	2	1	2	2
1	4	7	4	3	6	6	5	4	3	4
12	8	9	10	7	13	4	10	10	11	10



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