CIPFA The Chartered Institute of Public Finance & Accountancy

let's get together

integrating health and social care

INSIGHTS

for public financial management

Contents

About the author: Paul Carey-Kent

Paul joined CIPFA as Policy Manager for Health and Social Care in October 2014. He has worked in a variety of organisations including the District Audit Service, the Audit Commission, the London Borough of Bromley and Surrey County Council. He spent 13 years at Hampshire County Council and was seconded for a year to the Department of Health as Financial Controller for Social Care.

At CIPFA he supports the work of the Health and Social Care Panels. He works closely with CIPFA's Strategic Adviser on Health, Mike Farrar to take forward our involvement in current developments such as integration between health and social care, and the Future-Focused Finance initiative in the NHS.

executive summary

With health and social care finances under increasing pressure and little sign that the government can afford to pump in the additional resources which would be needed to maintain historic arrangements, the integration of health with social care – allied to devolution – has emerged as the great hope. However, local health and social care providers don't yet have a secure basis for medium-term planning. Without that there is a danger that the promising start represented by the Better Care Fund (BCF), the Greater Manchester and Cornwall devolution initiatives and pilots linked to the five-year forward plan for the NHS will be dissipated.

Over the past year CIPFA has held a series of roundtable discussions – principally with finance directors from health and social care, supplemented by academics and relevant professionals from other disciplines – with the aim of identifying the potential obstacles to successful integration and how those might be overcome. The conclusions emerging suggest, if the best is to be made of such integration, both the government and local health and social care players need to act now.

The conclusions and possible ways forward are recommended for both government and local health and social care authorities on pages 26 and 27.

context and reasons for integration

The goals of integration in context

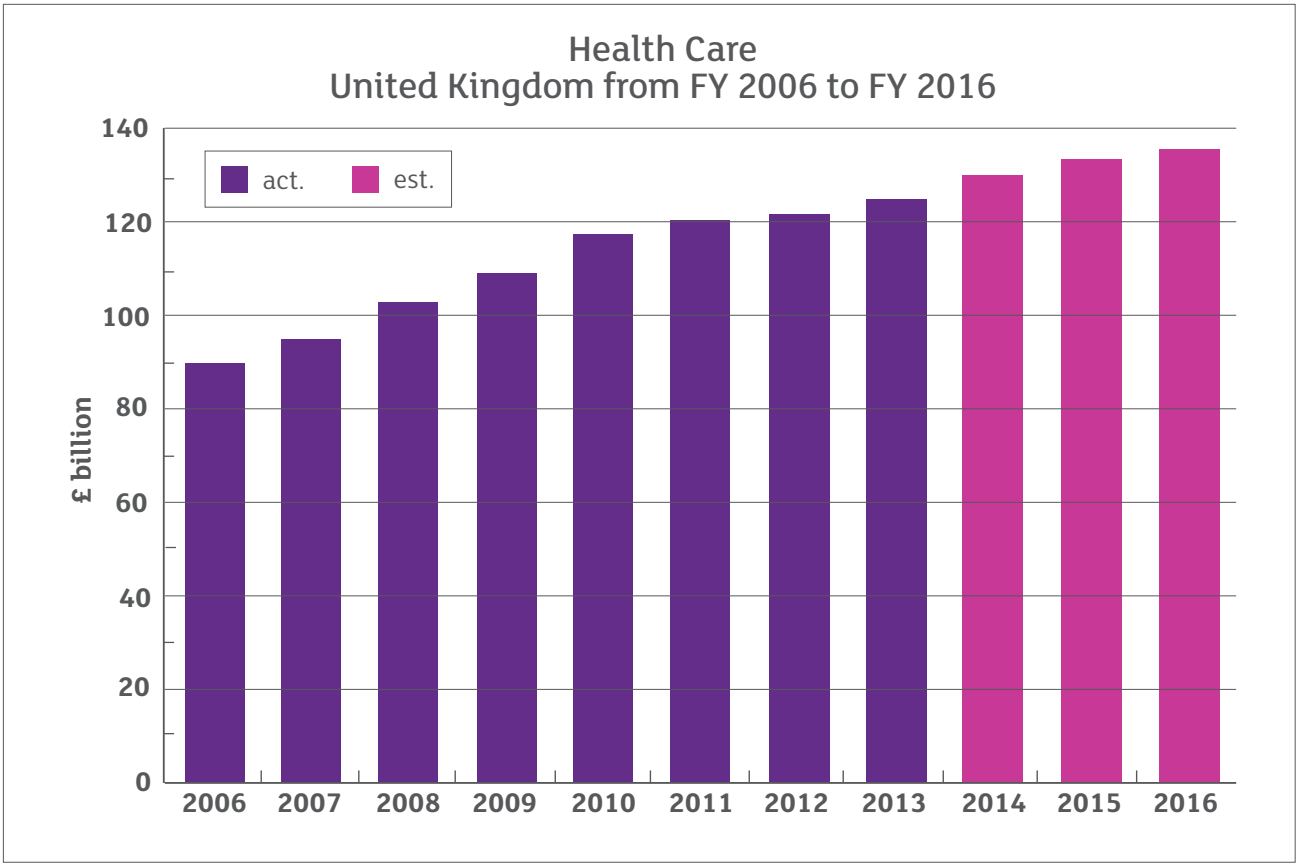
During the current Parliament the public will, unusually, experience economic growth alongside substantial, sustained cuts in public services. This challenge was emphasised in CIPFA's election manifesto[1], which noted that by the end of 2013-14, only 46% of the government's consolidation plan had been achieved, a position which was duly reflected in the July 2015 budget. The government has added to the scale of the task by introducing such high-cost plans as tax-free childcare and full seven day working in the NHS, funding which will require yet more cuts to be made elsewhere.

For some years a professional and political consensus[2] has been building that health and social care tend to be too fragmented, that services are too influenced by professional and institutional boundaries when they should be coordinated around service users' needs. The background to that consensus is an ageing population – people over 85 are the biggest users of health and social care services. This is set to double to three million over the next two decades. There is a rising number of people of all ages with long-term conditions – 15.4 million people in England (over a quarter of the population) have a long term condition and an increasing number of these have multiple conditions (the number with three or more is expected to increase from 1.9 million in 2008 to 2.9 million in 2018)[3].

The Nuffield Trust[4] states that 'Integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved coordination. Integration is the combined set of methods, processes and models that seek to bring this about'. The Integrated Care and Support Collaborative's definition, (also favoured by the Association of Directors of Adults Social Services (ADASS)), reflects the person-centred approach which should lie behind it: 'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me'. As such, successful integration involves more than cooperation and joint working; it requires common care pathways, if not organisational and financial merger.

Both health and social care are likely to need 3-4% spending growth in real terms per annum to deal with demand pressures and the costs of new medical technologies. Health funding increased by 0.8% per year on average under the coalition: a protected position, but still a severely challenging one, especially when compared to the overall increase of one third between 1995 and 2008. Increased financial pressure has through the health system, exemplified by the large number of trusts currently projecting deficits and was reflected in Simon Stevens' conclusion in the five-year forward view that £30bn of savings were needed, but only £22bn were achievable by 2020. CIPFA considers that even this position is an optimistic one[5].

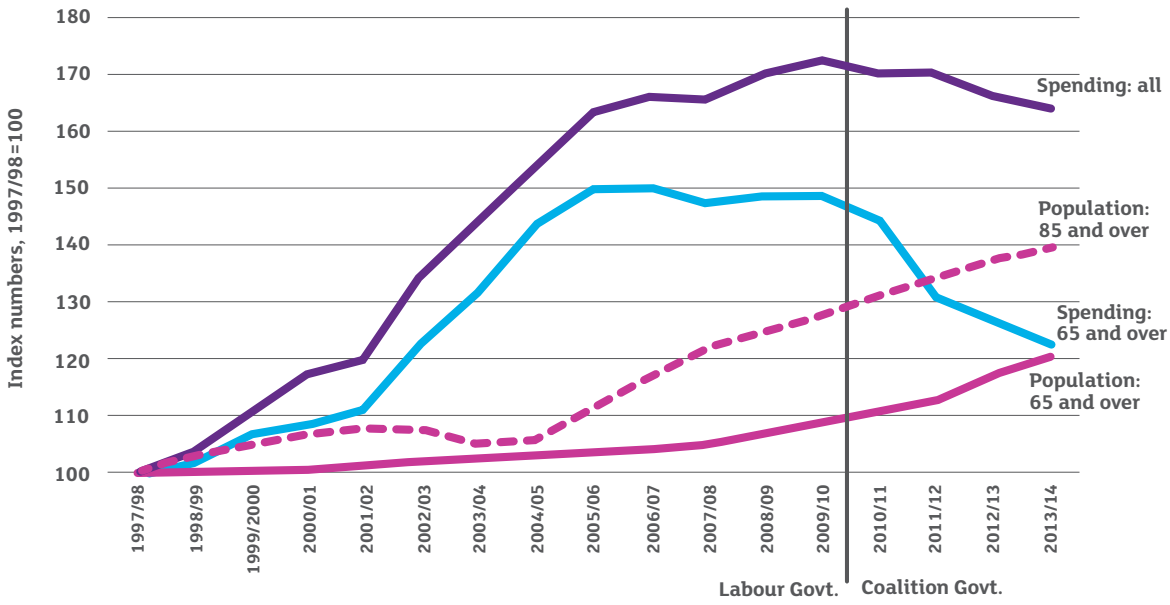
1 CIPFA Manifesto, www.cipfa.org/cipfa-thinks/manifesto2015
2 The Local Government Information Unit's analysis if the manifestos demonstrates the consensus on integration issues – www.lgiu.org.uk/briefing/manifestos-conservative-labour-liberal-democrats
3 NHS England data as at www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/
4 'What is integrated care?' Nuffield Trust – www.nuffieldtrust.org.uk/publications/what-integrated-care?
5 See 'The Health of Health Finances', CIPFA, August 2015, www.cipfa.org/cipfa-thinks/briefings



Trends in health spending 2006-16[6]

Local government saw a 40% reduction in central government support over the last parliament. Although there has been some protection for social care which has increased from 30 to 35% of total local government spend, local authority spending on social care for older people reduced in real terms by 17% during a period where the number of people over 85 has increased by 9%.

6 From www.ukpublicspending.co.uk



Sources: Personal Social Services Expenditure and UNit Cost in England 2013-14, ONS population estimates

Growth in population and changes in spending on adult social care, 1997-98 – 2012-13[7]

So will integration make a major contribution to the savings needed? The evidence to date is unconvincing; the University of York's comprehensive international study[8] failed to show any financial benefits, but there is obvious potential, just as there is behind the wider recession-driven moves to combine and align public services. The efficiency goals typically aspired to include streamlining processes, avoiding multiple collections of data and reducing the number of 'hand-offs' of tasks. Additionally, taking advantage of economies of scale, particularly in procurement and the opportunities which are presented by potential estates rationalisation lead intuitively to the conclusion that these actions ought to deliver savings.

The King's Fund[9] has concluded that it is difficult to assess the impact of integration initiatives to date, partly because these are long term issues but also because 'the impact of the government's wider health reforms' has often pulled the system in the opposite direction to integrated care. In particular, 'changes made to the structure of the NHS have introduced greater fragmentation in the way that services are commissioned, making it harder to align incentives between different providers'.

7 King's Fund analysis of government and CIPFA data as at www.kingsfund.org.uk/media_colorbox/13532/media_original/en
8 Centre for Health Economics: *Financial mechanisms for integrating funds for health and social care: an evidence review.* University of York, March 2014, www.york.ac.uk/che/publications/in-house
9 www.kingsfund.org.uk/projects/verdict/how-far-has-government-gone-towards-integrating-care

The evidence so far highlights three key issues:

- It makes little sense for either health or local government to argue for a greater share of the cake on the grounds that they are unfairly disadvantaged.
- Financial difficulties make collaboration harder, e.g. if local authorities have to carry on factoring in reductions in social care spend, this could make health partners feel they are bailing out social care.
- The importance of taking a whole system view[10], as reduced spending on social care increases the pressure on health just as failing to provide people with the medical help and support they need in the community feeds through to increased needs in social care.

The policy landscape

In addition to establishing the Better Care Fund, the government has led and supported the following initiatives to move forward integration:

- The introduction of *Health & Well-Being Boards,* which has brought together local authorities – representing social care, public health and housing – Clinical Commissioning Groups (CCG), Health Watch and other relevant players chosen locally. The boards are designed to assess the local population's needs and develop a joint strategy which promotes integration of services. However, they have thus far operated by providing overall direction rather than influencing the allocation of resources and as the King's Fund[11] has concluded 'the impact and influence of Health & Wellbeing Boards so far has been variable and generally limited'.
- The *pilot arrangements* to test various approaches linked to the integration agenda. 14 areas were named as integrated care 'pioneers' at the end of 2013, with a further 11 added a year later. The King's Fund concludes, though, that 'early evaluation suggests that it is too soon to tell whether the pioneers will be able to act as role models for the rest of the health care system'. More recently, the government has set up 29 'vanguards' to test new models of health care stemming from the five year forward view.
- The *Care Act* 2014 places a duty on local authorities to promote the integration of care and support services with health, as well as making many other changes which will directly and indirectly affect the integration agenda in practice, whether or not those prove to include the now-deferred implementation of changes to the financial regime.
- The announcement of a memorandum of understanding, as approved by the Chancellor and the Health Secretary, to *devolve responsibility for health and social care spending* totaling £6bn to Greater Manchester was followed in July 2015 by a similar announcement for Cornwall County Council. Building on the NHS five year forward view, NHS England invited all local authorities, CCGs and providers to develop plans for integration, a radical step in the direction indicated by the previous Total Place and Community Budget initiatives, which sought to obtain better value across total public spending by joining it up.

Separately, in August 2015, Northumberland CCG – one of the 29 national Vanguard sites – announced plans to hand its budget and the majority of its functions to a provider-led 'accountable care organisation'[12]. This is a landmark move towards fuller integration within health by removing the purchaser/provider split, with the key aim of incentivising providers to keep people out of hospital.

10 The NAO's November 2014 report on *The Financial Sustainability of NHS Bodies* provides more context for this and emphasises the need to plan in light of the impact on the whole health economy.
11 *The King's Fund verdict,* April 2015, www.kingsfund.org.uk/projects/verdict/how-far-has-government-gone-towards-integrating-care
12 See www.lgcplus.com/news/ccg-plans-handover-to-accountable-care-organisation/5089294.article

As a whole, these policies represent promising new directions, but we await evidence of their impact and scalability. Historically, it has not been easy to integrate successfully, for a series of well-rehearsed reasons. There has often been an over-concentration on organisational structures along with lack of front line change; there can be conflict between national targets and locally agreed benefits; there are problems in sharing patient-based information; the NHS volume based tariff system does not promote partnership working or reductions in activity; regulators tend to take an organisational view rather than looking at the whole system. None of the initiatives make the case for the scale of up-front investment which is likely to be necessary if the required changes are to be progressed at the pace implied by savings plans.

Consistent with CIPFA's argument in *The Health of Health Finance, in Making change possible: a Transformation Fund for the NHS*[13] the Health Foundation and The King's Fund support the concept of a Transformation Fund for the NHS in England. Their analysis incorporates six case studies of funding transformation, and they recommend that existing disparate strands of transformative funding should be pooled into one Transformation Fund, which would need to be topped up to ensure £1.5–2.1bn of dedicated funding is available per annum between now and 2020-21. This would be targeted at four key areas judged as being essential enablers for successful transformation: staff time, programme infrastructure, physical infrastructure and double-running costs.

Wider alignment of public services

Although we concentrate here on the links between health and social care, these need to be seen in the context of wider partnership working. Housing and transport[14] are the other most-cited interfaces between public services, but there are funding pressures across all sectors including the voluntary and charity sectors, making cooperation and alignment imperative if quality service delivery is to be maintained. It is often the case that we concentrate narrowly at how health issues enter the system, the majority of primary care interactions start in pharmacy, opticians and dentists, not with GPs; and one could also argue that housing wardens deliver a significant amount of primary care, as does the Citizens Advice Bureau where requests for help with health and social care make up 40% of their enquiries. The CIPFA project on *Aligning Local Public Services*[15], which focuses on measuring the totality of public expenditure and identifying the best whole system ways to spend the public pound, illustrates how some of these broader issues might be built in.

13 See: www.health.org.uk/publication/making-change-possible-transformation-fund-nhs

14 In August 2015 the Institute for Public Policy Research said bus use outside London had fallen by 36.5% since services were deregulated in 1986, attributing this to cuts in local government spending, and argued that bus travel helped to ease the strain on the social care system by maintaining and improving their independence and wellbeing – see www.ippr.org/publications/total-transport-authorities-a-new-deal-for-town-and-rural-bus-services

15 See www.cipfa.org/cipfa-thinks/aligning-local-public-services

how should we go about it?

Timescales and the Better Care Fund

Successful integration will need long-term joined-up planning, with timescales more consistent with the five year horizon of the government's Integrated Care and Support Pioneers Programme (launched December 2013) rather than the one year emphasis of the Better Care Fund.[16] Again, this is not recent news, as a look at the movement towards integration in Torbay, the best-known long-established example of single locality health and social care teams suggests. As early as 2011 a King's Fund study concluded that the results of integration include reduced use of hospital beds, lower rates of emergency hospital admissions for those over 65, and minimal delayed transfers of care. However, it took eight years to reach the point of establishing a mature and delivering partnership:

2000-02: Rapid response intermediate and care services created with Torbay Council, key role to be played by district nurses.

2003: Initial work to develop shared information systems, joint strategic management team meetings begin

2004: Torbay Primary Care Trust (PCT) and Torbay Council appoint joint directors; social services case allocations linked to GP registration rather than address.

2005: First health and social care coordinators appointed on pilot basis; integrated management structure implemented, joint commissioning teams formed; Torbay Care Trust established and contracted to provide all social care.

2006: Pilot system of care coordinators fully rolled out, joint performance team set up.

2007: Major investment in integrated intermediate care services.

2008: health and social care coordinators introduced to hospital wards.

The King's Fund[17] concludes that 'a number of the pioneers have made progress in developing more integrated services, although it's hard to attribute these successes directly to the government's programme, as much of their work to co-ordinate services has been underway for many years'.

The introduction of the £5.3bn Better Care Fund is the most significant and concrete of the government's initiatives to encourage integration. The Committee of Public Accounts' report *Planning for the Better Care Fund*[18] concluded that there is 'limited evidence that integrated care can reduce emergency admissions to hospital and even less than it can save money in the period expected. The Local Government Association has said all along that to achieve the radical transformation desired, 'saving should not be required at the same time as investment'. It is hard to judge yet whether actions on the ground are having the desired impact: possibly the first chance to assess this will be when a joint CIPFA/HFMA survey of the half-year progress is carried out in October 2015.

16 Fourteen localities were chosen to pioneer new ways to join up people's care around their needs, supported by national partners – as based the commitments set out in the Integrated Care and Support Collaborative publication *Our Shared Commitment*, which was published in May 2013. More at: www.local.gov.uk/health/-/journal_content/56/10180/6932744/ARTICLE#sthash.QdfCUcOW.dpuf

17 www.kingsfund.org.uk/projects/verdict/how-far-has-government-gone-towards-integrating-care

18 February 2015: see www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee/inquiries/parliament-2010/planning-for-the-better-care-fund and also the NAO report *Planning for the Better Care Fund.*

So what was the thinking behind the Better Care Fund? One roundtable contributor summarised it thus:

- Needs are changing, and we need to take risks in response. Resettling long stay hospital patients into the community raised similar fears of risk but succeeded.
- There is also a short-term political imperative: social care can't survive without health money, which has kept the system afloat, and it's politically easier to take this forward indirectly, and then mandate people to take this approach forward further.
- The underlying aim is to catalyse the conversations which will increase the pace and scale of transformation, encouraging development of core enablers like shared information, understanding total spend on individuals, and organising around individuals' not organisations' boundaries. Introduced performance reward to focus effort. The principal goal is stopping people going into hospital.

The discussions would suggest that, although the ideas behind the BCF may be right, the lack of new money is a problem, the mechanism doesn't balance incentives across system, and more rapid results are expected than are likely.

Strategy and governance

Organisations should agree to prioritise the interests of local people, rather than look first to their own organisational interests. This describes an issue which was mentioned regularly in the roundtable discussions; that because we have very top down government in silos, technical productivity initiatives (making the best of the money where it is allocated) have, historically, been more successful than allocative productivity initiatives (making sure spending is targeted in the most productive area). Yet in most financial models across other sectors, allocative productivity saves more money than technical productivity, which highlights another issue: the need to invest up – front in the preventative measures necessary to stabilise the long term financial position by creating wellness rather than merely treating ill-health.[19]

Governance is also critical. The Heath & Wellbeing Board, if used positively, can be an important mechanism for achieving the mutual understanding, purpose and coordination needed to make the system cohere. More specifically to the integration agenda, the HFMA/CIPFA publication *Pooled Budgets and the Better Care Fund* and the Department of Health's BCF taskforce work set out key issues[20]. In Greater Manchester (GM), governance has been the main subject of initial discussions ahead of the shadow period of operation from October 2015. It has been decided that the relevant organisations will remain accountable for their existing funding flows and responsibilities. That will set a framework within which to assess what will change and how to enable that. It is better to assess the possible concerns and areas of risk and set up arrangements for dealing with potential problems beforehand, rather than look to sort problems when they occur. It is also important to distinguish those risks which arise as a result of the collaborative action (and decide how to share them) from those risks which may be affected by the collaborative actions but are retained in the collaborating organisations (which decide how to mitigate/offset them internally).

CIPFA's roundtable discussions[21] – principally with finance directors from health and social care, supplemented by academics and relevant professionals from other disciplines – aimed to identify the potential obstacles to successful integration and how those might be overcome. The discussions identified issues concerning attitudes and behaviours, and around systems and policies – but did not suggest there is any fundamental reason why social care and health should not integrate successfully.

19 Prevention better than the cure? Public health and the public pound multiplier, CIPFA, Dec 2014 at www.cipfa.org/cipfa-thinks/health

20 HFMA/CIPFA: 'Pooled Budgets and the Better Care Fund' Oct 2014 and Dept. for Health BCF Taskforce 'How To Guides' – See www.cipfa.org/cipfa-thinks/health/better-care-fund

21 Roundtables took place in Leeds, Chester, Edinburgh, Cardiff, London, Warrington, Newcastle, Birmingham and Taunton, and involved some 200 leading professionals.

Some participants felt that the underlying vision of integration was getting lost, one saying that "collaboration has become its own agenda rather than being seen as a means to provide better services to the citizen", another emphasising that "integration isn't an end in itself but a tool to develop shared goals, which comes back to getting the vision right – and seeing if integration is the right way to deliver those goals".

Unsurprisingly, the groups felt that finance should take the lead in discussions. This needs to be a lead which takes a holistic view, which accepts that both health and local government are under heavy financial pressure, and there's no point in competitively attempting to differentiate between them. There was similarly widespread agreement that, despite the comparative scale of its budget, health can't work in its silo as there are so many interdependencies. Nor can we, said one Scottish participant "carry on spending, as typically occurs now, 90% of that health budget on illness, and only 10% on prevention – the more so when so much of that spend is accounted for by the rising cost of caring for older people who arguably don't need to be in hospital".

Integration, then, needs to be part of a move towards rebalancing expenditure. As another contributor put it "We need to move away from the political mind-set which sees 'fixing it with money' as the main means of improving services, and look more towards prevention and the concept of mutuality – people's responsibility to look after their own health. For example, a new Hepatitis drug is welcomed, but it costs £34,000 per 12 week treatment; and if the patients given it retain their lifestyles, repeats for different strains will become endemic at great cost". Although actions have been taken to deliver savings, there was also a sense that the same issues around lack of joined-up working and preventative investment have been around for 20 years. Action has never been taken, and indeed, the recent fragmentation of the NHS has set matters back. This is ground which needs to be recovered, e.g. to coordinate specialised commissioning more effectively. Participants hoped – if not with full confidence – that the difficulty of the situation will now force the right actions.

The current consensus is that 'something has to give' – e.g. local government must raise council tax above 2%, or income must be generated for the NHS, or a fundamental review must take place of what can be expected from the state. In the medium-term, unless such apparently fixed commitments as the triple lock on pensions are changed, the national budget won't balance.

Such challenging circumstances don't undermine the logic of working together for the good of the whole system. If all players make investment decisions by reference to benefits for the whole system, not just for their part of it, then results from a given level of investment should be significantly improved. What integration does challenge, though, is organisational independence.

Barriers to integration

Roundtable participants identified a range of barriers which could limit the success of moves towards integration. The key ones concerned behaviours and systems and policies.

Behaviours

The key barrier of 'organisational' rather than 'whole system' thinking is discussed elsewhere. Public opinion, and its effect on political decision makers, can also lie behind some resistant behaviour. Integration often involves centralising services, but that is difficult to sell to the public. As one contributor explained "Even if we can say to people, 'If we integrate these services and do it from York, not Scarborough, we will save this much' the people of Scarborough are not interested in the money because they still want the service. So the narrative around integration and money is always going to be difficult". It was also pointed out that preventative investment can, in traditional

terms, lead to spending which is not directly on what is budgeted for, especially if the spend counts against other service areas, e.g. social care spend to generate health benefit. Participants felt it possible that the public are more in tune with this thinking than is generally assumed. Health hasn't been as good as local government in consulting on budget choices – rather than just on binary questions such as whether or not to close a facility. "We need" suggested one voice "to move from 'what does the NHS system think?' to 'what the does the patient want?".

Inevitably, conversations turned to risk, and the difficulties of discussing it with politicians and the public. Ministers tend to react to failure by imposing more regulation, which drives up costs by fettering professional discretion in a never-ending drive to eliminate risk. The consensus was that risk must be accepted as important in getting the best out of staff by giving them the support, trust and autonomy to come up with solutions. With the prospect of austerity stretching on until at least 2020, taking risks will be an essential part of the finance manager's job. As one contributor put it: "None of us are sustainable in our current form". That said, another participant, did feel that "resistance is weakening, with recognition of the need to set aside organisational differences and move forward on the things we really need to do. We have no option but to do something big and different".

Systems and policies

It's worth mentioning one often tried tool which contributors generally rejected is reorganisation. "There has been too much emphasis on structure", said one Welsh participant "which the Williams Report and subsequent Welsh Government White Paper, seeking mergers of authorities, look likely to perpetuate". Elsewhere, there was less fear that restructuring was likely, but equally little taste for it. The extra costs (including dual running when changing systems) and deflection from priority concerns were seen as outweighing any feasible benefits. The preference was for doing things differently within the current set-up, not changing the structure. Several participants said that this could be improved by strengthening the way in which Health and Wellbeing Boards, currently seen as rather variable in their roles and effectiveness in practice, play into the system.

Data problems were raised unanimously as an issue in the discussions. Yes, there is a problem; the Better Care Fund requirement for shared use of the NHS number is a step in the right direction; a single electronic care record with full data sharing and improved use of consistently defined data would all be immensely helpful. It was widely accepted that significant financial savings could be made across the public sector through sharing and integrating systems. At a strategic level data sharing agreements are often in place between organisations which regularly share information, but at an operational level, staff are genuinely concerned about the consequences to them and their organisation if they share data inappropriately (these include Information Commissioner's Office (ICO) monetary penalties, disciplinary action, media interest, reputational damage and harm to the individual whose data was incorrectly disclosed). In order to harness the benefits of data sharing the concerns of staff need to be addressed and put into perspective. Organisations need to understand data protection legislation and support their staff by providing the necessary physical, technical and governance arrangements backed by adequate training.

There was also a strong feeling among some participants that the competition laws enshrined in the NHS reforms impede public sector collaboration. This included a concern that contracts may need to be longer term than current procurement rules allow in order to provide the right payback periods for innovation to occur.

Some contributors emphasised the limitations which annualised budgeting imposes on the NHS, by providing an environment unconducive to long-term planning. The differences in the capital regime is another constraint. Local government colleagues find it difficult to understand why NHS capital assets can't be re-used to local benefit, thus incentivising action. Given that there is said to be £7.5bn of realisable NHS assets that could make a big difference.

How can we make the best use of NHS Capital?

The NHS Five Year Forward View describes various models of care which could be provided in the future, for example, 'far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions'. This is with a commitment to taking decisive steps to break down the barriers of how care is provided. As well as being able to make optimal decisions for care models and how they are funded, decisions need to be made in the best possible way to maximise the use of NHS and social care estate. Whilst there are examples of good practice, this all too often remains in the 'too difficult' box.

In local government, resourcing decisions relating to estates are made and decided at a local level with the proceeds from the sale of any of the estate retained. In health, receipts are invariably centrally routed. Ex-Primary Care Trust estate not transferred to providers is owned by NHS Property Services Ltd – a limited company set up by the Department of Health with the legal title to 4,000 assets valued at around £3bn. Much of the primary care estate is owned by GPs. Local government asset sales are forecast to total £13.3bn between 2015-16 and 2017-18. Integrating the local management of estate issues is therefore very challenging. It would make sense to extend the local approach to health, which would support the rationalisation and transformation of the estate portfolio, and with some careful planning, support some of the transition costs of implementing new models of care.

In July 2015, the government directed every CCG in England to evaluate estate within its area to work out how much capital funding could be released by property sales with the aim of using the money raised to support new care models. The work is being coordinated by the Department of Health's two property companies: NHS Property Services and Community Health Partnerships. Each CCG will review all the property within its area which is owned by the two bodies, this usually includes mostly community services estate, the offices used by commissioners, and some GP practices. Property sales will be pooled nationally and allocated to areas in need of investment, this reallocation will be informed by returns to be made by each CCG setting out the upfront investment needed to establish new care models in their area, and assessing how much can be saved by using estate more efficiently. Local plans are expected to be finalised by the end of 2015. It is intended that figures on the potential income from land receipts, and the cost of investing in new care models, will be aggregated to give national level data, which would inform NHS England's planning for 2016-17.

The aims of this approach are laudable, but the absence of a direct link from local sales to local investment adds a level of bureaucratic complexity and reduces the immediacy of the incentive. Consideration could be given instead to the development of local property vehicles which own and optimise estate across health and social care, and make those direct local connections.

The ideal enabling policy environment for integrated care would need to cover the nature of the regulatory and financial frameworks, support for innovative approaches to commissioning integrated services, and national outcome measures that encourage integrated service provision. The consensus of the roundtables was that movement in those directions may not be complete, but is encouraging. Nonetheless, concerns remain around the tariff payment policy, which encourages acute providers to concentrate activity within hospitals rather than across the whole care continuum, and bases payment on episodes of care in particular institutions, rather than focussing on care pathways or the care needs of individuals. None of that sits comfortably with a whole system, integrated view. Many policies, it was said, "can be traced back to the need to help poor pensioners in the early days of the welfare state – but average pensioner income is now higher than average income".

More challenging ideas were also put forward. The roundtables believed there are potentially cases for:

- planning on the basis that short-term performance may need to deteriorate in order to free up the resources to enable investment up-front for long-term benefit. Performance would then follow a 'J curve' – something which regulators would have to be primed to accept.
- the NHS asking the question 'what quality of service should we provide, given available resources?' – a process followed by local government. The starting premise in health planning is closer to 'how much do we need to pay for what we have to do?'

where does devolution fit in?

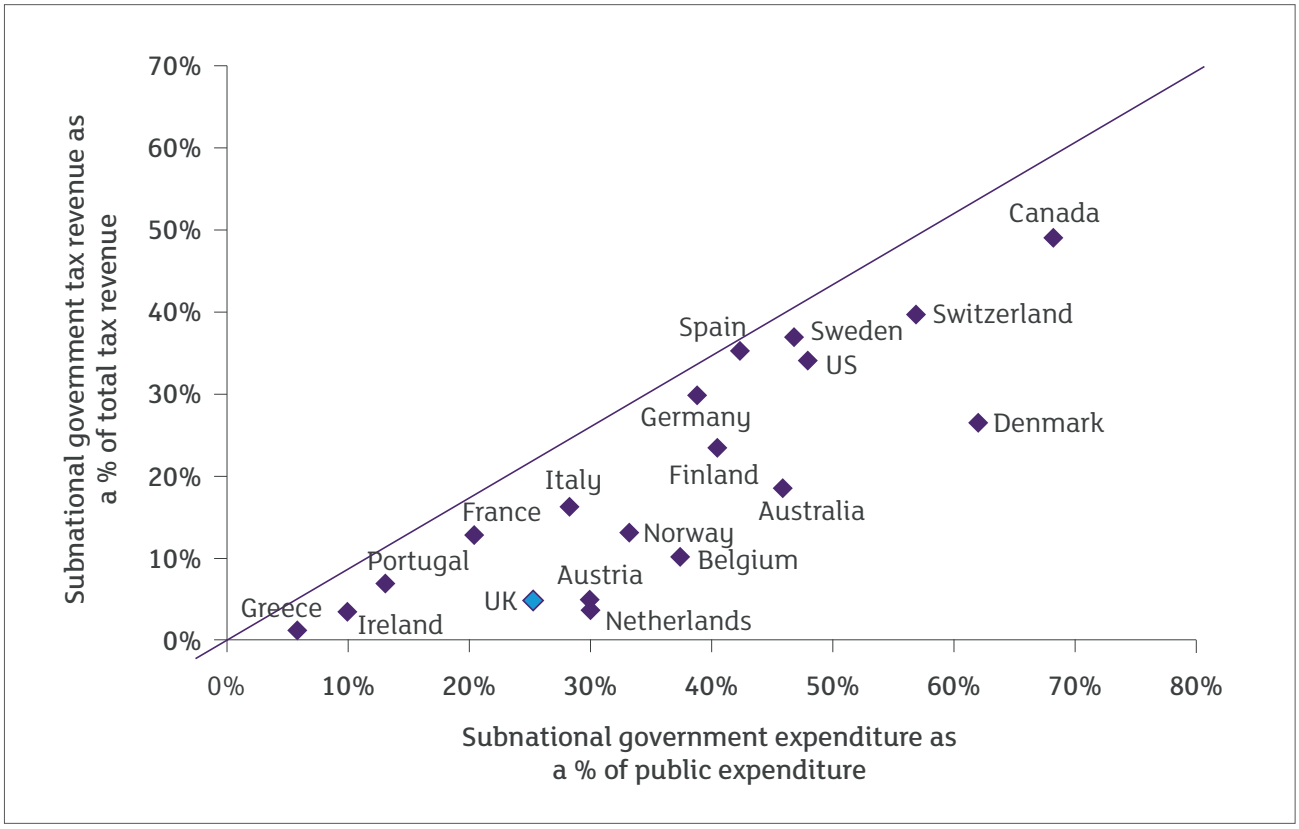
The policy background

The government wants the approach represented by the Better Care Fund to spread well beyond its defined minima, and the context provided by the announcement of moves towards devolution could be the way to achieve that. A survey of health and local authorities as far back as 2012 suggested that the main factors promoting integrated working are locally determined: local leadership, vision, strategy and commitment. Conversely, with the exception of changing leadership, the top factors that respondents felt hindered integrated working are more nationally determined: performance regimes, funding settlements and financial complexity [22]. In the context of those views, it makes sense that the locally-driven and permissive approach to devolution has recently emerged as an effective driver of integration – as opposed to the more prescriptive approach of the Better Care Fund.

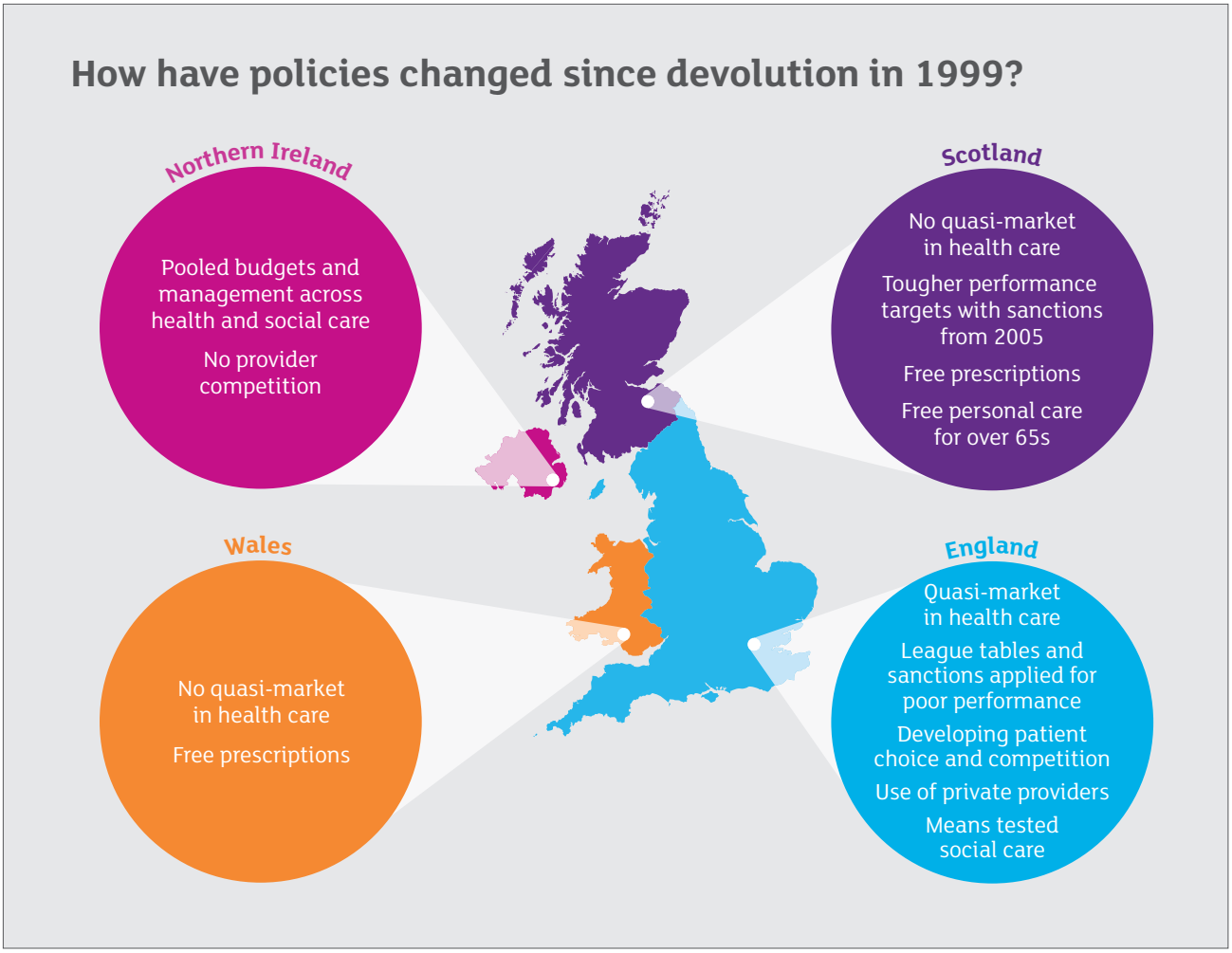
Politically, the government is attracted to devolution for two main reasons. First, to solve the 'English problem' – why can't London or Midlands set their own policies if Scotland, which has fewer people, can? And second, for fiscal reasons: the Chancellor is arguably the first politician since the war to countenance devolution because he believes in it for fiscal purposes. Consistent with that, he wants devolution only where there is a 'metro-mayor', because this model ensures the drivers are economic entities rather than 'people who get on with each other politically'. Moreover, if at some point it is judged feasible to devolve tax-raising powers to go with the spending, as in Scotland, then the government will want a mayor who can be held to account. The context for that is the UK Central government's atypically large proportion of the tax take. In New York, for example, 50% of taxes are collected at city level, as opposed to 7% in London, and the international picture is clear[23].

22 NHS Confederation survey as quoted at www.kingsfund.org.uk/sites/files/kf/integrating-health-social-care-where-next-kings-fund-march-2011_0.pdf

23 From the Smith Commission report on Scotland: www.scottish.parliament.uk/S4_ScotlandBillCommittee/Reports/dfpr15-03-image4.PNG



The NHS has been one of the most centralised health services in the world compared to Denmark or the Netherlands, where the Ministry of Health is small and health is run by local government. The degree of centralisation has already started to change significantly, with the four nations within the UK having very different arrangements for health, and the question is now how far the English position will change?



Comparative health arrangements[24]

The practical consequences

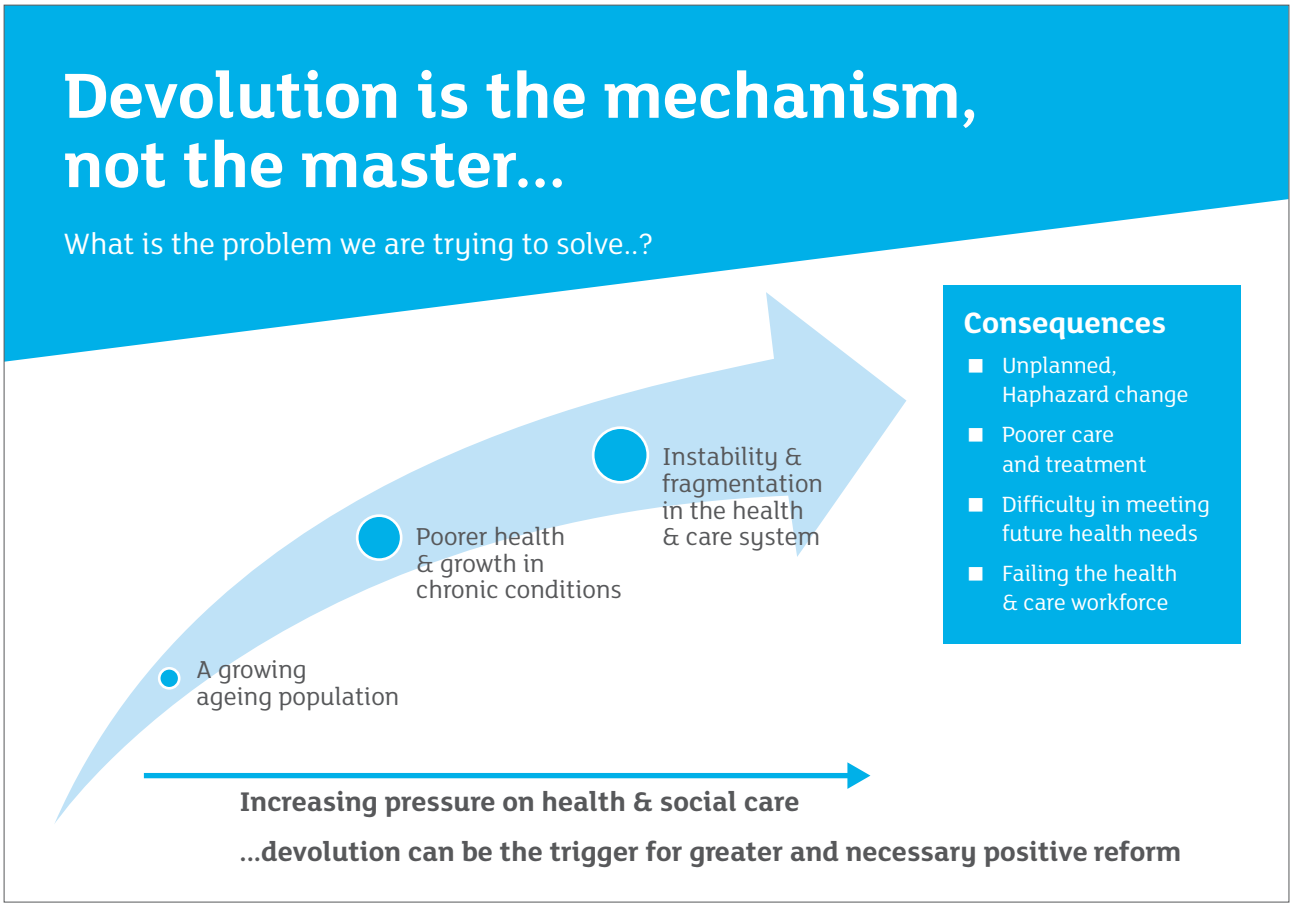
From 2016-17, both Greater Manchester and Cornwall will have local input into deciding how the majority of health spending occurs in their areas, and the government invited bids (by 4 Sept 2015) from other areas which would like to pursue a similar path. The discussions following on from the 38 bids made look likely to enhance considerably the scale and radicalism with which integration can be pursued.

At CIPFA's North-West roundtable, Manchester City Council explained key features of the potentially game-changing plans. There is a high contextual importance for:

- the NHS's Five Year Forward View
- the legacy of authorities working together in Greater Manchester (GM)
- the shared belief that good health and social care and closing health inequalities are essential to improving productivity and maximising economic growth and gains to the exchequer
- the need to start to change the relationship between the individual and the state to increase resilience and reduce dependency.

24 *The four health systems of the UK: How do they compare?* – Nuffield Trust and Health Foundation, 2014, www.nuffieldtrust.org.uk/compare-UK-health

The roundtable considered the role of whole system thinking which aims to change behaviours to focus on the people of GM rather than on the various organisations which serve them. GM's set-up is not about changing the autonomy of the decision-making bodies involved, but rather defining goals as 'the health of the population' seeks very different outcomes from policies trying to achieve 'the best distribution of services within the NHS', and plays local authorities much more clearly into the picture. The view was strongly expressed that devolution must be 'the mechanism, not the master'[25].



It isn't easy to reach the right arrangements, and GM have flagged some real technical issues with integration:

- What are the right roles and accountabilities of local members, and how can those best be achieved?
- What are the alternative structures e.g. Accountable Care Organisation or Integrated Care Organisation – remembering form should follow function?
- How to deal with the very different accounting regimes – surpluses, treatment of deficits, HMRC concerns with pooling at scale, charging etc?
- Are budgets to be set using GP or resident population?
- How to deal with the perverse incentives with the current charging and contracting mechanisms and the NHS's internal market?

Those issues need to be addressed with a focus on delivering maximum VfM and what makes most sense for the patient.

25 www.slideshare.net/hwbpolicyleeds/nhs-5-year-forward-view?next_slideshow=1

Such a devolution initiative, like integration, needs to start from the question 'what is our shared purpose?' That may not suit a 'top down' consistent model of devolution – while the purpose might be common, the appropriate means of response might not be: we're used to doing things where everything looks the same, but we might be in a different place here.

Subsequent roundtables considered the potential applicability of the GM model in different regions. It was not felt that a simple 'lift and drop' of DevoManc was likely to be the solution to their own severe challenges. The participants all agreed that the major advantage of devolution would be to escape the relentless short termism of health planning, in which:

- allocations are never secure for more than two years
- the top-down targets to be delivered are subject to annual change, making it likely that long-term contracts turn out to seek the wrong thing in their later years
- there can be in-year requirements to change planned spending to help balance the system as a whole.

What does radical reform look like?

- Shifting the balance of investment towards proactive, early help and away from a crisis response
- Health & care defined by an approach based on prevention
- Intelligence led, highly targeted preventative action based on a deep knowledge of our communities and their strengths
- More integrated public services responding to all forms of vulnerability
- Increased healthy life expectancy

Wanless* for GM 2022...

"Levels of public engagement in relation to their health are high. Life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the health system and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. Use of resources is more efficient."

* Derek Wanless's final report, Securing Good Care for Older People, published in March 2006, looked at the challenges facing social care over the next 20 years and made proposals for how to deal with many of the issues which GM now hope to tackle through the devolution initiative.

GM's summary of what radical reform through devolution and integration will look like.[26]

There was also consensus on the relative weakness of commissioning arrangements in the current health system, and the related absence of coherent system leadership. Again, devolution might assist if it enables, for example, the Health & Wellbeing Board or alternative joint arrangements to take on a broader commissioning role. However, experiences were varied and there was no obvious solution which would work everywhere. All agreed that such a programme needs to be linked to sufficient transformation funding to facilitate investment and cover the double running costs which are necessary in order to achieve the long-term savings of the Five Year Forward View.

26 www.slideshare.net/hwbpolicyleeds/nhs-5-year-forward-view?next_slideshow=1

what's required for successful system leadership?

The issue

A particularly consistent message across all the roundtables was the importance of system leadership. In the health context the removal of an intermediate planning tier (e.g. strategic health authorities) has thrust some reluctant systems leaders forward. In order to make progress, management thinking needs to extend beyond the boundaries of existing organisations. It's no surprise that in a recent HFMA survey of 188 NHS finance directors, designed to understand emerging challenges, 107 out of 129 provider trust finance directors and 43 out of 63 CCG chief financial officers highlighted system leadership as something they were concerned or very concerned about [27]. The HFMA attributed this to:

- the reorganisation of commissioning organisations has created a deficit in system leadership
- there are varied approaches to system leadership in different areas – some are not working as well as others
- there is a danger that the different priorities of providers and commissioners will result in a risk-averse system, unable to make changes to meet the quality and financial challenges
- there may be some work to do to ensure that CCGs have the necessary powers to work collaboratively – for instance, to set up joint arrangements with delegated powers.

CIPFA's roundtable discussions raised similar issues.

One way of achieving that whole system leadership approach might be through structural reorganisation to create fewer bodies. This is not simple to achieve as:

- there is no appetite for incurring the costs and transitional disruption of standardised, compulsory restructuring
- voluntary restructuring, mergers, for example, may make sense, but how will progress be achieved where this is, for example, not politically feasible?
- even if organisational combination occurs, it is still an all-too-familiar outcome to find that work persists within silos rather than taking the whole system (and whole organisation) view.

27 HFMA: *System leadership in the NHS,* Oct 2014 at www.hfma.org.uk/publications-and-guidance

It's more promising to address the best way to work and manage, rather than the structures in which to do so, turning the focus from optimising processes, which will naturally vary across multiple organisations, to achievement of common goals. What is needed is 'system leadership' rather than 'organisational leadership', where decisions are taken in the best interest of the system as a whole, not for the potentially incompatible goals of the various organisations within it. This represents a move beyond the established negotiation goal of securing a 'win – win' outcome, to accepting that a valid goal is 'We win, even if I lose'.

What is systems leadership?

The approach required might be summarised as 'leading when you are not in charge' – a collaborative rather than a directive form of leadership, and one which crosses organisational, geographic and professional boundaries. Organisations working together in this way will identify their core value as delivering maximum benefits to the people of the area, an aim which can only be achieved by working together across the whole complex of organisations. In Greater Manchester, for example, and this is by no means exceptional, there are 10 councils, 10 CCGs and 15 hospital trusts simply in the core local health and social care system. Add the important roles of the separate police and fire services, the national interfaces required, and the inputs of the voluntary and private sectors and the complexity of working across the whole system is readily apparent.

The Office of Public Management, Public Service People Managers' Association[28] and the Leadership Centre have worked extensively on the issues involved, which they summarise as 'an attempt to effect change for positive social benefit across multiple, interacting and intersecting systems'. As such, the key characteristic is that although 'leading' you are not 'in charge'. Such leadership is particularly likely to be needed when:

- no one organisation can deliver the solution
- the extra resources available by pooling several organisations' resources can make a critical difference
- potentially avoidable boundary issues make a significant difference
- there is particular volatility, uncertainty, complexity and ambiguity in the system
- innovative, and most likely risky, approaches are needed
- the particular framework (eg the Better Care Fund) requires it.

28 www.opm.co.uk/category/types-of-work/leadership-and-organisational-development/systems-leadership

In 2013, the NHS Leadership Academy joined with other like-minded partners in public service to found the systems leadership steering group. The group identified key differences between the traditional organisational approach to leadership and the collaborative approach which is increasingly needed:

Differences between traditional and collaborative models of leadership[29]

1. Power

Traditional Leaders: power derives from a position of authority.
Collaborative Leaders: power is greatest in a collective, participative team.

2. Information

Traditional: information is released on a "need to know" basis.
Collaborative: open information sharing and cross training to encourage creative approaches to problem solving.

3. Idea generation

Traditional: decisions come from the executives who are – as above – best-informed.
Collaborative: leaders open to suggestions as different perspectives can bring insights.

4. Problem solving

Traditional: executive decisions approved and passed on.
Collaborative: solutions brainstormed among teams and facilitated by management.

5. Resource allocation

Traditional: resources provided as deemed necessary, typically through slow, reactive approval mechanisms.
Collaborative: resources may be delivered proactively and fast to allow projects to develop more rapidly.

6. Roles and responsibilities

Traditional: pre-specified roles and responsibilities for managers and their teams.
Collaborative: teams are encouraged to work together, with roles and responsibilities evolving and fluctuating based on the greater good.

7. Resolving issues

Traditional: sorted on an individual basis through due process with little regard to root cause of problems.
Collaborative: leaders look for the root cause of conflict as it arises, and address solutions promptly to keep work moving forward.

8. Performance and feedback

Traditional: semi-annual or annual review process based on corporate policy.
Collaborative: working closely together facilitates immediate feedback, praise, constructive criticism – coaching.

29 Summarised and adapted from NHS Systems Leadership steering group

How can systems leadership be developed?

As emphasised earlier in this paper, it is changes in practice which will deliver the benefits of integration, not structures or indeed leadership in itself. However, system leadership is a key driver to facilitate achieving successful integration on the ground. That raises the question: how can we move from a position in which successful integration occurs where the right leaders happen to be in place, to one in which leaders as a whole are typically inclined towards taking a whole system view? Reaching this position is likely to require a combination of attitudes, skills and knowledge.

Attitudes

The NHS Systems Leadership steering group has found that a particular mind-set and way of thinking about and approaching leadership is found in leaders who managed successfully in the way required:

- Their personal core values – such as inspiring shared purpose by taking risks to stand up for a shared purpose.
- How they perceive – such as evaluating information by gathering data from outside their area of work or applying fresh approaches to improve current thinking.
- The way they think and analyse – such as sharing the vision by communicating to create credibility and trust or holding to account by managing and supporting performance.
- How they relate to others – such as connecting services by adapting to different standards and approaches outside their organisation.
- Their behaviours and actions – such as developing capability by creating systems for succession.
- Their personal qualities and way of being – such as influencing for results by developing collaborative agendas and consensus.

In the HFMA survey[30], finance directors identified several levers in the current system that could be used to improve local system leadership, these were around:

- managing the system with the same money by revising pricing for services through locally agreed prices and payment mechanisms.
- exploring whole area budgeting by examining the totality of healthcare spending in an area, rather than individual organisations, and allocating resources in the optimal way.
- strengthening CCG commissioning leadership.
- making sure the legal structures and CCGs' powers are sufficient.

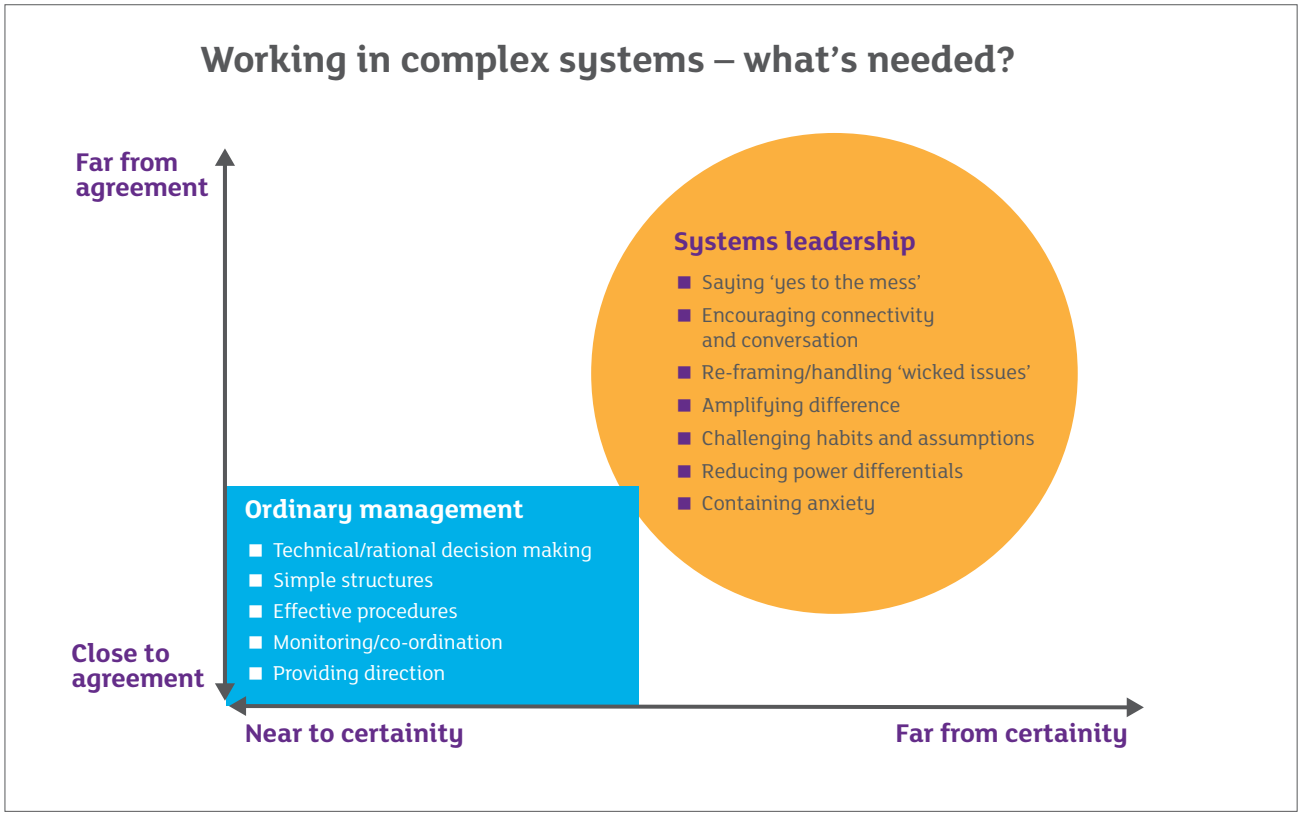
The strongest message was that there needs to be collective responsibility across organisations to incentivise managers to understand that if one organisation fails then every organisation fails – very much the key whole systems approach highlighted by CIPFA's roundtable discussions.

Skills

The skills required to back up these attitudes are around personal relationships, building trust, accepting risks and dealing with complexity. This does not sit comfortably with the traditional view of financial managers as being individuals who apply technical expertise to generate clarity. Whilst this is a somewhat outmoded view, it is worth checking that skills are being developed for more collaborative application.

30 HFMA: System leadership in the NHS, Oct 2014 at www.hfma.org.uk/publications-and-guidance

The Virtual Staff College has summarised the issues[31] in working with such complex situations as follows:



The Advancing Quality Alliance (AQuA) has developed a framework setting out the knowledge and skills needed for successful leadership across integrated systems which suggests that there are three important dimensions, aspects of which should apply at the operational and leadership levels – in the integrated teams working on cases and through the governance arrangements seeking to ensure the programme moves forward[32]:

Knowledge and skills framework for integrated working

Technical know-how

- Service design
- Governance arrangements
- Innovative contracting and financial mechanisms
- Technological 'savvy'.

31 From www.opm.co.uk/category/types-of-work/leadership-and-organisational-development/systems-leadership/
32 See www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/system-leadership-october-2014.pdf for lessons and learning from AQuA's Integrated Care Discovery Communities

Improvement know-how

- Systems thinking
- Improvement science
- Large-scale change

Personal effectiveness

- Interpersonal skills and behaviours
- Coaching ability
- A visionary and participative style

Developing the system leaders of the future

Knowledge

CIPFA's roundtable discussions suggested that there was insufficient mutual understanding of the financial and governance mechanisms and agenda between health and local government. In part, that was attributed to the rarity of finance professionals moving between health and local government sectors. This is in contrast with the position 20 years ago, and may reflect the increasing complexities of both systems, which tends to drive specialism within one rather than the development of generic understanding applicable across both.

Such a lack of understanding and knowledge can obstruct successful partnership working through:

- Lack of empathy, a natural consequence of knowing a great deal about one of the problems and comparatively little about another. Take the 'lazy assumption' in local government that health's financial problems cannot be too bad because its funding has not been cut in real terms as local government's has been; or contrarily the lazy assumption in health that if only local government would prioritise social care sufficiently over other services, there would be less of a problem.
- Lack of appreciation of what is possible, so reducing the ability to take forward collaborative opportunities. It is useful for all to be aware of the regimes in place which affect such matters as how funding is obtained and spending prioritised, the nature of the political input to decisions, and extent of year-end flexibilities.

There is a sharp illustration of the differences in the financial management regimes when considering the overriding priorities of the various bodies. It is illegal to have deficit in local government, and it's the Section 151 officer's job to ensure that doesn't happen. Service failure will precede financial failure; whereas it is the other way around in the NHS: 50% of trusts are currently projected to be in deficit in order to avoid service failure.

The roundtables recognised the need for better understanding between local government and health of each other's finances: in the short-term, that is a training need; in the long-term, more commonality would make sense. CIPFA and HFMA are working to bring practitioners together and to provide tools such as a glossary of terms for health and social care; these developments alongside the Welsh initiative of employing cross-organisational 'whole of public sector' trainees, were strongly supported at the roundtables.

conclusions and possible ways forward

CIPFA's roundtables showed that there is a strong desire to take integration forward, and that devolution will provide a helpful context for that. However, both the government and the local health and social care players need to act.

The government should:

- recognise that combining two financially challenged systems will not in itself increase resources available. All the indications are that additional funding or changes to the regime for charging will also be needed[33].
- move quickly to address the financial and policy framework for integration in 2016-17 and beyond.
- accept that there are significant transitional costs, and that benefits may take some years to come through in full. That means local health and social care bodies must be funded to enable them to Invest to Save.
- non-prescriptively encourage increased integration, for example by indicating – without rules or targets – that an interest would be taken in the proportion of budget integrated, the proportion spent on prevention, and the proportion held as individual budgets across the whole of a local health and care system.
- help devolution to work optimally as a means of progressing integration more radically and rapidly than has happened to date, by linking it to increased local control of tax income.
- equalise and free up the capital funding regimes across health and social care.

The local health and social service authorities need to take the right local actions to facilitate successful integration, concentrating on frontline practice:

- Create wellness, not just treat illness. Unless the investments are made to tackle emerging health and social care issues 'upstream', a stable longer-term financial position will remain unobtainable – and integration offers the best framework within which to progress that agenda.
- Develop the tools to measure investment in people in as persuasive a way as we measure the investment in buildings or highways. It's accepted that for a highway the key is to intervene at the right time before we incur the exceptional costs of replacing the road. How does that translate to people? How, for example, do we measure return on investment on school meals?
- Improve the measurement of allocative efficiency to encourage the right combination of long-term whole system allocative efficiency combined with allowing maximum flexibility to achieve technical efficiency at the local level. In turn, this should lead to appropriate challenge short-term fixes, narrow views of investment and unaffordable universalism.
- Take forward joint personal budgets in health and social care (so that overall personal needs are the driver) and build community capacity to back that up.

33 'The Health of Health Care', CIPFA www.cipfa.org/cipfa-thinks/briefings

- Take seriously the need to set up the conditions to facilitate successful systems leadership across the whole of health and social care. That will include:
  - securing political buy-in
  - building those expectations into governance arrangements
  - specific action, including training, to ensure that staff have the appropriate attitudes, skills and knowledge to work collaboratively.
- Equip finance professionals to do the right things: participative budgeting, long term thinking, outcomes focus, transparent presentation of the long term effect of decisions; and encouraging, not discouraging, the taking of appropriate risks.
- Improve finance and its audiences' understanding of what's happening across time and across the whole health and social care system. That requires action to enhance mutual understanding, for example:
  - work to improve mutual understanding of differences in approach, i.e. accounting arrangements, in order to work together more easily
  - collaborate locally to employ cross-organisational 'whole of public sector' trainees.

The central and local focus should be on front line experience and the agreed benefits, as these should outlast organisational fashions and restructures. The Better Care Fund may not be an ideal vehicle, but if the plans drawn up through it are broadly based, they can provide the right platform.

CIPFA The Chartered Institute of Public Finance & Accountancy

Registered office:
77 Mansell Street, London E1 8AN
T: +44 (0)20 7543 5600 F: +44 (0)20 7543 5700
www.cipfa.org

10/2015