Local Government Association

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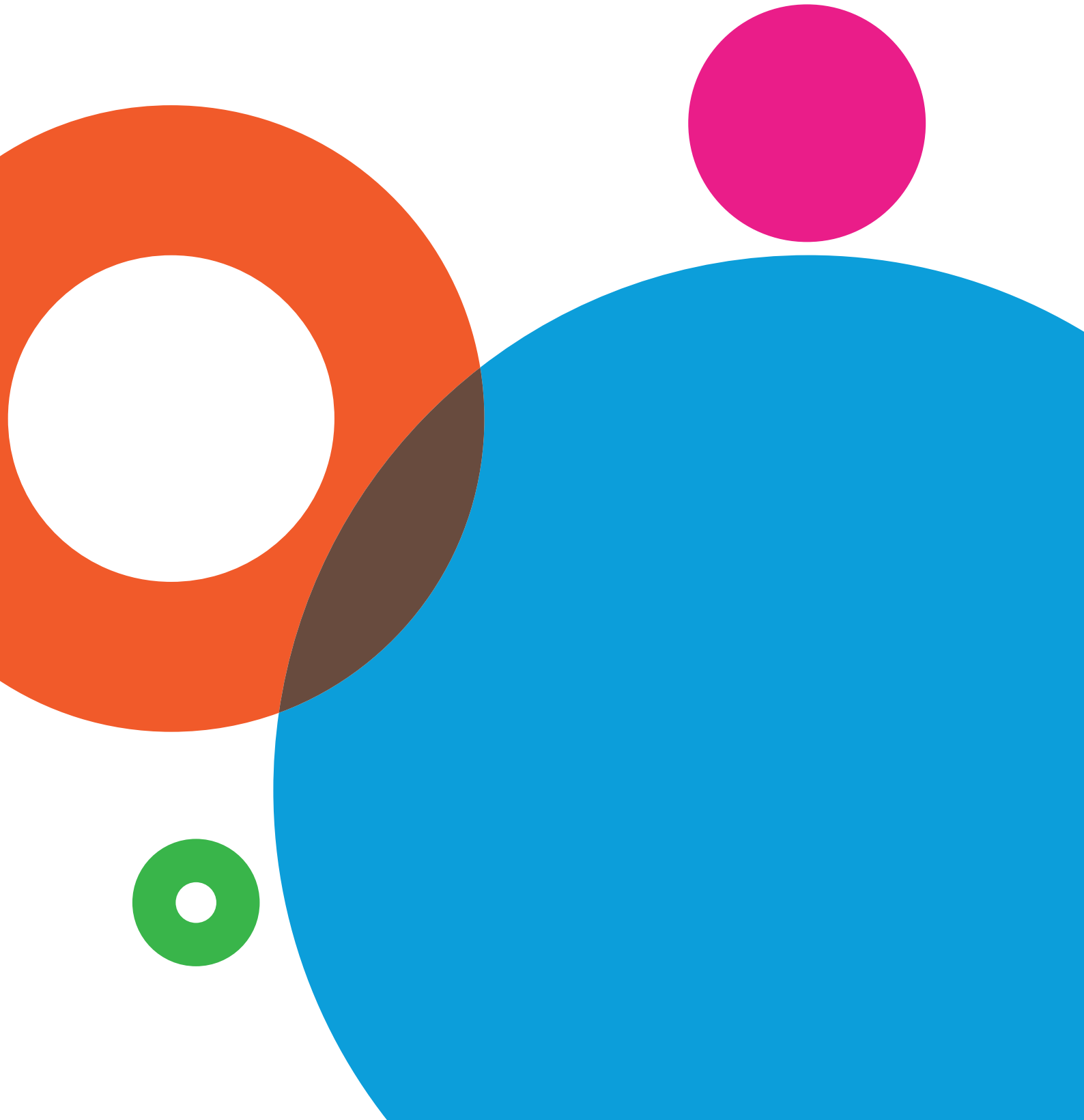

The NHS Confederation

The NHS Confederation is the membership body that brings together the full range of organisations that commission and provide NHS services.

We bring together the views of each and every part of the healthcare system to provide a strong voice for the whole of the NHS in a way that no other organisation can.

We work with our members and health and social care partners to help the NHS guarantee high standards of care for patients and the public by:

- influencing health policy by representing our members' views to Government, Parliament, policymakers and the public
- making sense of the whole health system with our publications and information services
- championing good practice at events, in workshops and forums, and through partnerships
- supporting the health industry with the help of the NHS Employers organisation and the NHS European Office.

For more information, visit **www.nhsconfed.org**

The Local Government Association (LGA)

The LGA is the national voice of local government. We work with councils to support, promote and improve local government.

We are a politically-led, cross-party organisation that works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.

We are a membership organisation. In total, 415 authorities are members of the LGA for 2014/15. These members include 351 English councils, the 22 Welsh councils via the Welsh LGA, 31 fire authorities, ten national parks via corporate membership through ENPAA and one town council.

For more information, please visit **www.local.gov.uk**

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Key actions for Government to support local leaders to deliver integrated care

This table summarises the joint NHS Confederation and Local Government Association policy asks for Government in order to deliver integrated care.
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Demonstrate political leadership by encouraging discussions at all levels about the future of health and care services to focus on getting the best outcomes for people with limited money.	Set up a national sector-led programme to support health and social care organisations to adopt participation and self-management approaches for all who would benefit.
Align financial incentives. Payment system reform will need to remove barriers to new, more integrated models of care that focus on prevention and early intervention and often delivered at, or close to, home.	Make health and wellbeing boards the focus for joined-up commissioning of primary, secondary and social care.
Enable shared accountability by introducing a simpler, unified framework with fewer measures for the whole system, which would help ensure each part of the system works together to achieve shared goals.	Make a concerted effort to develop future workforce and the staff we already have to work within the emerging integrated models of care.
Enable improvements in data sharing. To achieve this, the Government will need to develop easy-to-follow clarification of the legal position on data sharing.	Ensure that the development of new models of integrated care is properly supported through providing extra funds to ease transition and longer-term financial settlements to provide up-front investment for service change.

Introduction

This report sets out the case for change, our shared vision for integration and the action Government needs to take to make real and sustainable progress. We also identify what we, as national membership organisations for the NHS and local government, will do in partnership to support local system leaders to drive forward local plans for integration. We believe that greater integration delivers the triple benefit of improving the quality of services, improving health and social care outcomes and enhancing the experience of staff working in health and social care.

2014 is a crucial year to refine local plans, provide support and further develop our evidence and practice to make integrated, person-centred services a reality in all areas. We recognise that there are significant challenges and systemic barriers that need to be addressed at local and national level. But equally, there is a strong commitment to finding solutions and we are committed to working with Government, local system leaders and national stakeholders to do so.

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The case for change

In a nutshell, the case for change is that no change is not an option. The current system of health and social care is both unsustainable and sub-optimal.

As the 'value case' for integrated care[1] states, "NHS services that were set up to provide episodic care – to help sick people get well, often in a hospital setting – are now struggling to meet the changing nature of demand, including increasing numbers of people requiring long-term care. In many cases those individuals are the very same people requiring support from local authority social services to help them stay independent and well."

It is widely acknowledged that poorly joined-up care risks distress and harm and is also hugely frustrating for patients/service users and carers.[2]

Recent analysis by Monitor outlines that integration and closer working between the NHS and social care, to improve productivity and deliver care in the right settings, would make a vital contribution to closing the estimated £30 billion funding gap the NHS faces by 2020/21.[3] However, it is crucial not to underplay the financial challenges facing the NHS, adult social care and local government. Although there is much evidence to show that greater integration and personalisation improves outcomes, the evidence that it delivers financial savings is still in its early stages and there is currently a lack of empirical evidence to show it will be more cost effective. It is also unlikely that greater integration alone can address the funding issues facing some local health and social care economies. In our view, this does not undermine the case for greater integration, but underlines the importance of ensuring that we create the right conditions to allow the full extent of the potential benefits of integration to be realised.

The benefits of integrated care include improvements in service quality and patient experiences and satisfaction, as well as a reduction in pressure on NHS acute services (evaluations of many projects have shown reductions in expensive acute sector bed use and/or emergency hospital admissions) and residential adult social care. Integrated care will tend to be most beneficial for people with ongoing and complex needs, including frail older people, children and adults with disabilities, people with addictions, those with multiple chronic and mental illnesses and some people needing urgent care – such as stroke – where a well-coordinated response can significantly improve health and wellbeing outcomes.

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Escalating the scale and pace of integration

The Better Care Fund (BCF) attempts to significantly escalate the scale and pace of local integration initiatives by specifying a minimum amount of resources that will be redirected from existing NHS and local government arranged services into integrated information, commissioning and delivery of health and social care. The aims of the BCF are not new: to increase integration in order to improve services; improve health and wellbeing outcomes; and reduce demand on the acute sector. What is new is the growing imperative to use integration as the primary means of delivering long-term financial sustainability of health and social care services.

The June 2013 spending round forecast that the BCF would be £3.8 billion. Current local BCF plans identify a total of £5.4 billion. This is a strong indicator that local government and clinical commissioning groups (CCGs) see the benefits of redirecting resources to integration. In each local area, the integration plans for the introduction of the BCF make the detailed case for change in respect of the need to increase personalisation of services while maintaining financial sustainability of the local health and care system. All 151 health and wellbeing boards submitted plans in April, as part of an iterative process to deliver transformational change over the next five years and beyond. Each BCF plan is unique, with differences in detail due to variation in local populations, existing patterns of health and care service provision, and the extent to which integrated working is already happening.

The Integration Pioneer programme, launched in May 2013 by national partners, has identified 14 local areas to demonstrate the use of ambitious and innovative approaches to deliver person-centred, coordinated care and support. Over 100 expressions of interest were received, with the final selection of the pioneers being made by a panel of UK and international experts. This has been a rigorous process to ensure only the most innovative and committed localities were selected to become pioneers. The aim is to make health and social care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes.

The evidence so far suggests that the BCF and Pioneer Programme have been important catalysts for local commissioners and system leaders to start having open and honest conversations about the need for system transformation.

Plans are still being developed to ensure that projected savings are based on robust evidence and have the support of local commissioners and providers. They are actively working to address concerns about the lack of provider engagement in some areas. This makes it even more important that, as well as grasping the opportunities that integration presents, we also need to be fully aware of the challenges – operational, financial and political – in driving forward such a significant programme of service redesign and we need to work together continually to mitigate them.

The demographic and financial challenges facing the NHS and local government cannot be emphasised too heavily and there is a risk that integration and the BCF is seen as the 'magic bullet' to deliver the combined benefits of better services, better health and wellbeing outcomes and reduced health and social care costs. While there is some promising evidence on the potential of integration to deliver cost savings, we need to continually critically assess and build a robust evidence base on the benefits of integration. We need to be realistic about what integration can achieve. Even where plans are ambitious and successful, they are unlikely to turn around the financial fortunes of areas where the health economy has been in severe difficulties for many years.

This point was strongly acknowledged in a recent joint letter from the LGA, NHS Confederation, the Association of Directors of Adult Social Services, the Foundation Trust Network, NHS Clinical Commissioners and the Society of Local Authority Chief Executives, which highlighted the shared view that greater integration brings with it real challenges for every part of the system locally. Key among those challenges are the financial pressures, the complexity of local systems and the time pressure that health and social care partners are under to deliver credible and ambitious plans.

What should the future health and care system look like?

The health and care system we need for the future will see people as individuals in their family context and neighbourhoods. Recognising the broader community resources will shift the focus towards maintaining people's abilities, capacities and independence, and treating them with respect and dignity, not as a series of isolated and episodic problems and crises to address in the short term and in isolation to the rest of their lives. The system will invest more to prevent ill health and debilitating conditions, in order to improve lives and reduce the financial and social costs of treating sickness and long-term conditions.

Integration will lead to care and support being available in different ways and in different settings. Health and wellbeing boards, and the political, clinical, professional and community leaders of whom they are comprised, will need to have honest conversations with local patients, carers, citizens and providers on how greater integration will impact on the commissioning and provision of local services. An increasing proportion of resources will go to community-based interventions, prevention, social support and primary care. Hospital trusts may need to be supported to transfer services, and support should be provided to communities in a managed way that does not compromise access to services or outcomes for individuals.

Our current work on integration adopts the definition of integration developed by National Voices from a patient/service user perspective: "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."* Health and social care will work with individuals, their families and communities to commission and provide care with a strong overall focus on preventing illness and improving health and wellbeing outcomes.

Good integrated care will require local freedom, flexibility and agility to meet local need, which will require innovation and system-wide new ways of working with different partners. It is vital that leaders from health and social care can work together, focused on a shared set of priorities that are grounded in the needs of their locality and not just in the interests of individuals or their organisations. We also need political, clinical and community leaders who are also able to work collaboratively to make the most of all the potential resources in their locality, to improve the health and wellbeing outcomes of the population they serve.

"Health and wellbeing boards, and the political, clinical, professional and community leaders of whom they are comprised, will need to have honest conversations with local patients, carers, citizens and providers on how greater integration will impact on the commissioning and provision of local services"

* This statement is at the core of the Narrative for Person Centred Coordinated Care, developed by National Voices and supported by both the Local Government Association and the NHS Confederation.

Essential components of effective integration

There are some common features that characterise effective integrated working.[4] They are:

- individual participation and self-management
- a population-based approach, including early identification and coordinated support to individuals who may be at risk of developing long-term conditions so that they can maintain their health, wellbeing and independence
- shared accountability for performance and a single reporting framework to local communities for all stakeholders
- sharing the financial returns on investment in integrated services but developing financial flows that support providers to work collaboratively by avoiding activity-based payments; promote joint responsibility and accountability for the prudent management of financial resources; and encourage the management of ill health in primary care settings that help prevent admissions and length of stay in hospitals and nursing homes
- multidisciplinary groups of health and social care professionals, specialists and generalists, working together to deliver integrated care in the best interests of and in partnership with the individual receiving support
- use of guidelines/pathways to promote best practice, support care coordination across care pathways and reduce unwarranted variations or gaps in care
- information sharing that supports the delivery of integrated care, especially via the electronic record, decision support systems, systems to identify and target 'at risk' patients at an early stage
- professional, clinical and managerial partnership linking the skills of healthcare and adult social care professionals with the organisational skills of executives
- effective shared leadership at all levels with a focus on continuous improvement of quality and outcomes
- a place-based leadership approach, in which leaders from across health and social care work on a clear shared set of priorities to improve health and social care outcomes
- a collaborative culture that emphasises team working and the delivery of highly coordinated and person-centred care.

How can Government and national organisations support local leaders to deliver integrated care?

Several commentaries reviewing integrated care have identified some systematic barriers to integration. In many local health and care systems local leaders have found ways to work around these issues, but we should be designing a system that is fit for the future and places integration and personalisation at its heart.

We need a resolute and prime focus on health and wellbeing outcomes for individuals and communities (as opposed to processes, systems or structures).

Behaviours, incentives and models of commissioning and provision should reflect these ambitions and enable local leaders to work together in the interests of local populations.

Local leaders of the health and care system are committed to escalating the scale and pace of integration but there are various shared barriers. The task could be made easier if Government made a commitment to address issues raised in the table below.

Actions for Government	Actions for the LGA and NHS Confederation
Demonstrate political leadership Government needs to provide political leadership in encouraging discussions at all levels about the future of health and care services to focus on getting the best outcomes for people with limited money, rather than looking mainly at the implications for individual organisations. Furthermore, national politicians should respect that local decisions about future shape of services are best led by local politicians.	The LGA and NHS Confederation will support local political, clinical and community leaders to develop the skills and knowledge to lead the local debate and take responsible decisions about the future shape of services.
Align financial incentives Current NHS payment mechanisms are poorly designed for integrated care pathways that go across health and social care. They also do not currently measure and reward the achievement of better outcomes for people. Payment system reform is vital to remove barriers to new, more integrated models of care, focused on prevention and early intervention and more often delivered at, or close to, home. A combination of approaches is likely to be required. The 'year of care',* capitated budgets and incentives for prevention are all important approaches to consider. Monitor and NHS England have recognised the main problems in their early work on payment system reform. Mental health and community services providers have been looking at options in this space, and personal budgets are a material factor too. This is an essential area of change.	The LGA and NHS Confederation will provide Government and the sector with robust examples of local health and care systems that have developed innovative ways of reinvesting in prevention and early intervention so that health and wellbeing boards can see benefits of services redesign.

* This is an initiative designed to show how to deliver personalised care in routine practice for people with long-term conditions, using diabetes as the exemplar.

Actions for Government	Actions for the LGA and NHS Confederation
Enable shared accountability At present, different parts of the system are working to different outcomes frameworks and are held to account by different national bodies and regulators. A simpler, unified framework with fewer measures for the whole system would help ensure each part of the system works together to achieve shared goals. Health and wellbeing boards could use the single outcomes framework as a way of monitoring/performance managing the local system against these measures. This would also need to be supported by improved information sharing (see below). Furthermore, we need to ensure that a single national outcomes framework enables local decision-makers to focus on and develop their own local priorities.	The LGA and NHS Confederation will work with our respective sectors to call on Government to develop a single unified framework that sets out key shared outcomes for health, social care and wellbeing.
Enable improvements in information sharing Lack of clarity on the legal framework for data sharing and a plethora of guidance continue to be barriers to effective integration. Government has an important enabling role in developing easy-to-follow clarification of the legal position on data sharing in response to Caldicott[5] and other relevant factors such as competition law.	The LGA and NHS Confederation will work with Government to clarify existing guidance on data sharing, remove national barriers and highlight local examples of good practice.
A national sector-led programme should be set up to support health and social care organisations to adopt participation and self-management approaches for all who would benefit There is significant evidence from Nesta[6] and other organisations that supported self-care improves outcomes and reduces costs. It is time for a sector-led programme that gives self-care parity with direct care delivery. This should embrace all potential providers, including the third sector, social enterprises and private sector providers, who may be well placed to engage in people's lives more meaningfully.	The LGA and NHS Confederation will call for a national sector-led programme spanning health and social care.

Continued overleaf

Actions for Government	Actions for the LGA and NHS Confederation
Health and wellbeing boards must become the focus for joined-up commissioning of primary, secondary and social care NHS England local area teams and CCGs should work more closely with other commissioners at the health and wellbeing board to commission primary care. Health and wellbeing boards must become the focus for joined-up local decision-making, a space where CCGs, local government and NHS England examine their commissioning intentions in the round and work ever more collaboratively to commission models of care that make full use of the potential of GPs and other primary care services to keep people well and out of hospital.	The LGA and NHS Confederation will provide robust examples of health and wellbeing boards shaping the commissioning and redesign of local health, public health and care services to reduce costs, improve services and improve outcomes.
A concerted effort is needed to develop the future workforce and the staff we already have to work within the emerging integrated models of care This will mean breaking down the cultural barriers that exist between professionals and organisations – developing a new shared culture and agreeing shared goals between them, in a coordinated manner. It will require reforming health and social care training to enable working across and with different sectors and instilling a willingness to do so. It will also require the right sort of skills to provide different types of care to patients during a single contact with a service. It will be crucial for national organisations – Health Education England, the LGA and professional representative groups – to provide national leadership, ensuring there is recognition of the need for health and social care training to be more closely connected in order to facilitate a 'single team' approach. There is also greater scope for the medical and social work regulators and training bodies to work together in order to assist in facilitating this approach.	The LGA and NHS Confederation will work collaboratively to align workforce development in health and social care to support integration.

Actions for Government	Actions for the LGA and NHS Confederation
Ensure that the development of new models of integrated care is properly supported through providing extra funds to ease transition and longer-term financial settlements to provide up-front investment for service change Establishing new models of care will take time and require investment and stability. We recognise that health and social care resources are more constrained than ever, but that the cost of doing nothing will be greater in the long term. We will need sufficient safeguards to mitigate the potential risks of removing funding from provider budgets if demand for those services is not reduced. For the longer term, the move to two-year allocations and medium-term planning in the NHS is helpful. This needs to be reflected across the piece with local government. This would make it easier for local partners to front-load investment on the basis of plans that might realise savings and value dynamically, such as integrated models of care. Government should look at ways in which we might be able to add greater certainty and security for commissioners and providers, which would aid them in planning strategically. This could include longer-term spending settlements, multiple-year CCG allocations, extended tariff prices and longer local contracting. Furthermore, Government needs to develop a robust evidence base to support the financial case for integration.	The LGA and NHS Confederation will continue to work with local health and care system leaders to highlight good practice and local concerns regarding the financial evidence base.

References

1. Local Government Association (2013), *The value case for co-ordinated health and social care*. The NHS Confederation was part of the working group supporting the development of this work.
2. The King's Fund and Nuffield Trust (2012), *Report to the Department of Health and NHS Future Forum*.
3. Monitor (2013), *Closing the NHS funding gap: how to get better value health care for patients*.
4. The King's Fund (2011), *The evidence base for integrated care*.
5. Caldicott, F (2013), *The information governance review*.
6. Nesta (2013), *Health for people, by people and with people;* and Nesta (2013), *The business case for people powered health*.

Further information

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