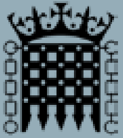

CountyAPPG

COUNTY ALL PARTY PARLIAMENTARY GROUP

The State of Care in Counties

The Integration Imperative

CCN
COUNTY COUNCILS NETWORK

LGiU
the local democracy think tank

Foreword

Henry Smith MP, Chair, County APPG

The County All Party Parliamentary Group selected health and social care integration as the topic of this inquiry a simple reason; it is one of the most important issues facing the county communities we represent.

We constantly hear of the national pressure on health and care services, but when one examines the situation in counties, you see exactly where the greatest pressures are being felt.

Both county demographics and the necessary national funding settlement means the only sustainable solution for counties is one of urgent and radical reform.

County MPs from all parties have seen the necessity of taking action during the next Parliament to ensure care services continue to meet the needs of our residents and recognise that accelerating care integration is best way forward. There really is an imperative for integration across health and social care.

Counties are achieving phenomenal results with the resources they have but they are reaching the limit to what is possible within current structures. The Government's drive for integration between health and social care, supported by the Better Care Fund, is the right approach but it needs to be even more ambitious if it is going to succeed for our areas.

Only through a rethink of the current allocation formulae and greater pooled funding can care funding be sustainable. Only with devolved powers being given to Health and Wellbeing Boards and creation of Health and Social Care Deals tailored to local needs can local communities have a proper say in the future of care services in their areas. Following the announcement on health devolution to Greater Manchester, our report sets out how and crucially why, this approach must be extended to county areas facing much greater demand-led pressures.

Talking to councils and NHS groups from around England, it is clear that the reforms outlined in this report could set the framework for care delivery for the foreseeable future. It is *imperative* that we establish a foundation today that will enable the delivery of more user centred, and cost effective, services for decades to come.

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Summary of Recommendations

The recommendations of this County APPG inquiry put forward a radical and ambitious vision of an integrated health and social care system to meet the unique challenges facing county areas. Overcoming local barriers and achieving our vision will require immediate action by the incoming Government from May 2015 in the following areas;

1) As part of the 2015 Spending Review the Government must conduct a full review of the sustainability of adult social care, including allocation formulae and with a particular focus on rebalancing the allocation of older persons Relative Needs Formula (RNF) per head of population.

2) The Government should establish an independent cross-party commission to look into the disparities in entitlement between health and social care.

3) In partnership with Monitor, the Department of Health (DoH) should review the NHS tariff system with a view to removing perverse incentives for local integration. This should include consideration of how the 'recovery, rehabilitation and reablement' (RRR) model can be properly evaluated and extended where appropriate. A payment system should incentivise quality and efficiency, but should also support wider objectives such as joint working.

4) Health and Wellbeing Boards should establish joined up workforce strategies across health and social care to plan an integrated workforce.

5) The Government should support this process joining up accreditation of professional training for those working on the frontline in health and social care through a national strategy.

6) The Government should pass legislation establishing a legal presumption for the public sector to share data, with an individual right to opt out.

7) The Local Government Association (LGA) and NHS England should provide national joint guidance on financial modelling and ROI tools for health and social care integration.

A true realisation of our vision for fully integrated health and social care will also require Government to consider more radical steps. The incoming Government from May 2015 should consider extending the principles of English devolution into the health and social care system, empowering local partners to drive innovation at a local level through the following measures;

8) DoH should introduce a shared outcome framework for health and social care.

9) DoH and Department of Communities and Local Government (DCLG) should establish a ten year shared financial settlement for health and social care.

10) The BCF should be reformed and extended for those councils who choose to continue working in this way. A pooled health and social care fund of at least £7.8bn should be established by 2019/20.

11) Local NHS/local authority partnerships in county areas should be invited to bid for greater devolution of health and social care through Health & Social Care Deals in the form of: a) larger or entirely pooled budget; b) new delivery structures; and c) enhanced local powers to commission services.

12) Health and Wellbeing Boards should be empowered to hold the integration programme to account and to drive it locally. Health and Wellbeing Boards should be given additional powers to commission primary, secondary and social care services, and empowered to hold budgets.

These recommendations are explored in detail in section six.

Introduction

The County All Party Parliamentary Group (APPG) was launched on 29 January 2014 with a remit to "consider the issues and challenges faced by county areas and communities, the current and future contribution of these areas to the overall national economy and well-being, barriers and constraints that prevent the full potential of county areas from being achieved and to raise awareness of these matters in Parliament".

Our Chairman, Henry Smith MP, is supported by a number of cross-party Vice Chairmen from the Houses of Parliament, Members of Parliament from constituencies in county areas throughout England and Members of the House of Lords. A full membership list can be found at Appendix (pg58).

The Secretariart of the County APPG is provided by the County Councils Network (CCN). CCN is a cross-party Special Interest Group of the Local Government Association (LGA) representing 37 county and county unitary authorities in England. Its members represent 47% of the English population and cover 86% of its landmass.

The Inquiry

Adult social care is at the heart of the services county and county unitary authorities provide. Caring for older, disabled and vulnerable members of the community is central to the aspirations of a council. High quality health and social care services can have a transformative impact on the life of an individual and on communities.

On average, excluding dedicated schools grants, adult social care will account for 49% of all expenditure for the average county council by 2019/20.[1]

This inquiry into integrated care and support was set up to investigate the unique challenges facing adult social care provision in county areas, and devise practical solutions to making our health and social care systems more sustainable and effective during the next Parliament. With the right services in place, we can continue to support the health and wellbeing of communities and provide better outcomes for individuals. But there are still many challenges to be faced.

Crucially, this inquiry asks whether better integration between health and social care can provide the answer to the problems we face or whether county areas require a different approach to other parts of the country. Launched by the County APPG in July 2014, it asked three key questions.

1. What are the opportunities, barriers and challenges facing counties and local partners in delivering an integrated health and social care system?

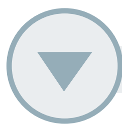
2. What precise measures and policy interventions can a) Central Government, and, b) local partnerships, do to overcome challenges, remove barriers and better integrate care and support?

3. What is the future shape of adult social care provision in county areas?

It received 40 written responses from a range of upper tier, district and unitary authorities and a number of sector bodies. It hosted two oral evidence roundtable events with Council Leaders, Cabinet Members, Directors of Adult Social Care and social care experts from CCN's Care Bill Implementation Group. This report also draws on a range of primary and secondary research, including the findings of a recent Capita and CCN survey on adult social care funding.

[1] *LGA. Future Funding Outlook (2013)*

The Challenges in Counties



SECTION 1

Counties have a common set of challenges to deal with when delivering care to their communities. This section sets out these challenges, drawing on the evidence submitted and supporting research material.

Financial Pressures and Rising Demand

Firstly, **the social care system is facing a funding crisis of epic proportions at a time of rapidly increasing demand.** A few national statistics illustrate the scale of the problem:

- The Association of Directors of Adult Social Services (ADASS) says that since 2010 spending on social care has fallen by 12%.
- At the same time, the number of those needing support has increased by 14%.
- This has forced departments to make savings of 26% in their budgets – the equivalent of £3.53bn over the last four years.[2]
- The LGA estimates that the funding gap between March 2014 and the end of 2015/16 for adult social care alone stands at £1.9 billion.[3]
- Total spending on adult social care and support accounts for just two per cent of total public expenditure.[4]

Some councils believe that pressures on adult social care means that before long the provision of statutory, let alone discretionary, services will be extremely challenging. The delivery of highways, transport, libraries, children services with face immense financial pressures, whilst leisure services, street cleaning and even bin collections could all fall victim to the combined pressures of an ageing population and shrinking budgets.[5]

Whilst all local authorities are facing similar pressures, the situation is particularly acute for county councils and county unitary authorities. Recent survey research of 74 County Leaders, Cabinet Members, Chief Executives, Directors of Adult Social Care and Senior Officers by Capita and County Council's Network (CCN) showed the extent of the financial pressures facing county care and support systems. Tellingly, 60% strongly agreed, and a further 34% agreed, that adult social care was the **biggest financial pressure facing their council.** Other key findings showed;

- Some 60% described existing funding pressures in adult social care as '**severe**'. With 17% describing them as 'critical' and only 23% as '**manageable**'.
- Financial pressures in adult social care services were viewed as a **long-term issue** by 96% of respondents.
- The driver of financial pressures in adult social care is predominately the **over 75s** and **older people**, however 54% believed that '**no single set of users**' was driving financial pressures, with costs also driven by those with working-age disabilities.
- Traditional ways of meeting the financial challenge through improved efficiency, reducing unit costs, and re-negotiating external care contracts is becoming increasingly difficult to implement, with integration, prevention and demand management regarded as the most effective means of reducing costs.

Whilst councils, especially counties, have done their utmost to protect social care budgets, there has been an inevitable impact on local services and those needing to access to care.

Latest national figures on delayed discharges, a key indicator of local pressures, show the

[2] *Social Care Services 'unsustainable', ADASS http://www.adass.org.uk/social-care-services-unsustainable-adass/*

[3] *LGA (2015) The funding gap for councils in England between March 2014 and the end of 2015/16 will be £5.8 billion. at: http://www.local.gov.uk/finance/-*

[4] *Revenue Aw ccount budget returns, DCLG, July 2014 and Budget 2014, HM Treasury, March 2014*

[5] *See Barnet's 'Graph of Doom' http://www.theguardian.com/society/2012/may/15/graph-doom-social-care-services-barnet*

number of patients ready to leave hospital but are prevented from doing so rose to record levels in England during November 2014. Patients spent a total of 143,000 days in hospital when they should have been sent home.[6]

Our analysis of the latest figures from December 2013 to December 2014 shows that the picture is worse in counties. Figures presented in Graph 1 show that non-acute delayed transfers of care are higher on average in CCN member councils and have grown over the past year, peaking in May 2014 and ending the year higher. The county average of 4 per 100,000 aged 18+ is considerably higher than the national average.

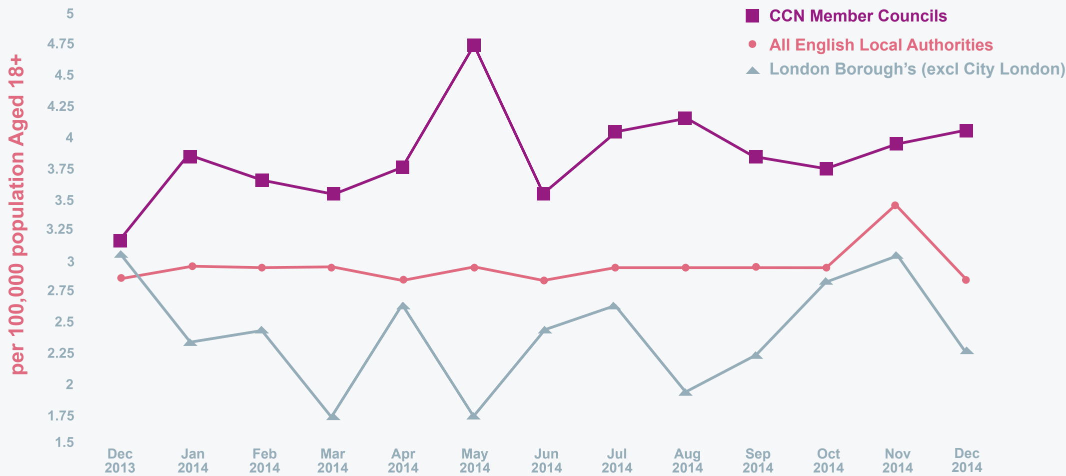
In addition, Graph 2 show the number of delayed days in county areas is also on average significantly higher; in December the average CCN member council had a total of 115 delayed days to compared to a national average for local authorities of 88.

Delayed discharge due to NHS services, rather than social care, account for a higher proportion of 'bed blockers'. However, growing pressures on social care mean there is less social care provision in the community to help reduce the level of delayed discharges, leading to higher costs for health providers in county areas and poorer care pathways for local residents.

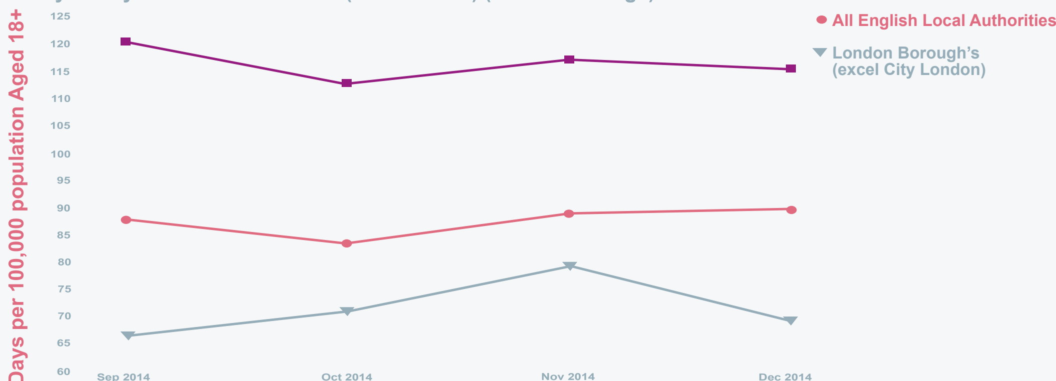
[6] BBC News, 28 November 2014

Delayed Discharges by Local Authority Type (NHS England, 2015)

Non-Acute Delayed Discharges (Dec 2013-14) (Median Average)



Delayed Days Non-acute Patients (Dec 2013-14) (Median Average)



Total ASC Revenue Expenditure of CCN Member Councils

£6.8bn

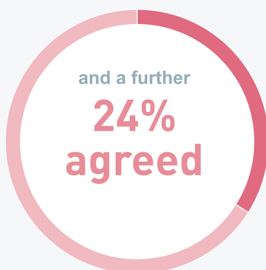
47%
of all local Government expenditure

Budget Reductions Since 2010

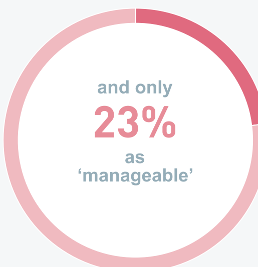
Local authority adult social care budgets have fallen

£3.53bn
(26%)

County Financial Pressures



that adult social care was the **biggest financial pressure facing their council.**

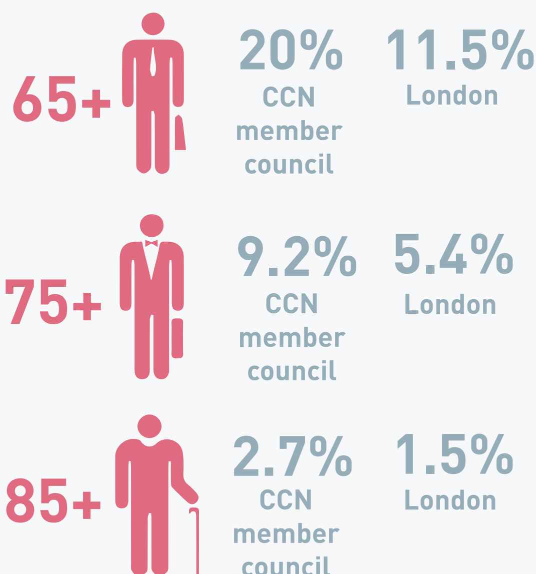


long-term issue by **96%** of respondents.

(Capita and CCN Transforming Adult Social Care Survey 2015)

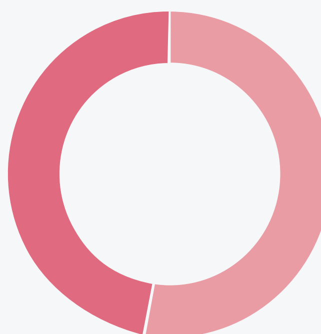
County Demand-Led Pressures

Ageing population

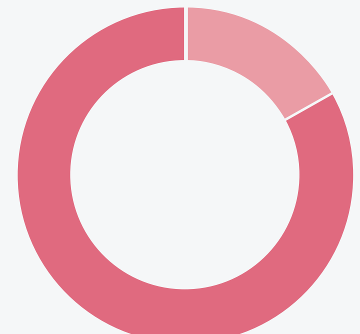


Service user profile

Counties have on average
53% self-funders

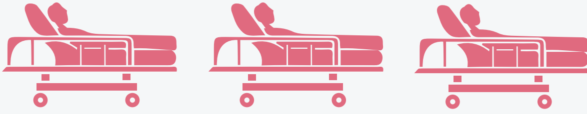


Some counties as high as
80%



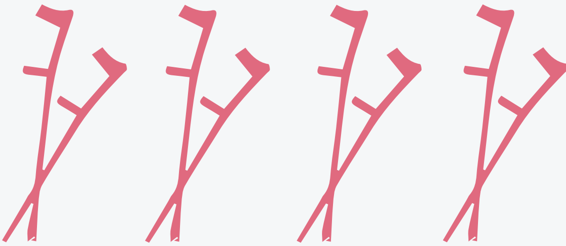
Current and future demand higher in counties

Pressures are impacting on local services...



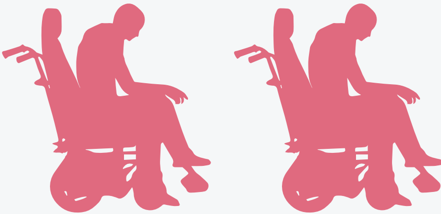
Delayed discharges up 29% in counties

Median average for CCN member councils during 2013-2014



Delayed discharge rate 43% higher in counties

Compared to national average



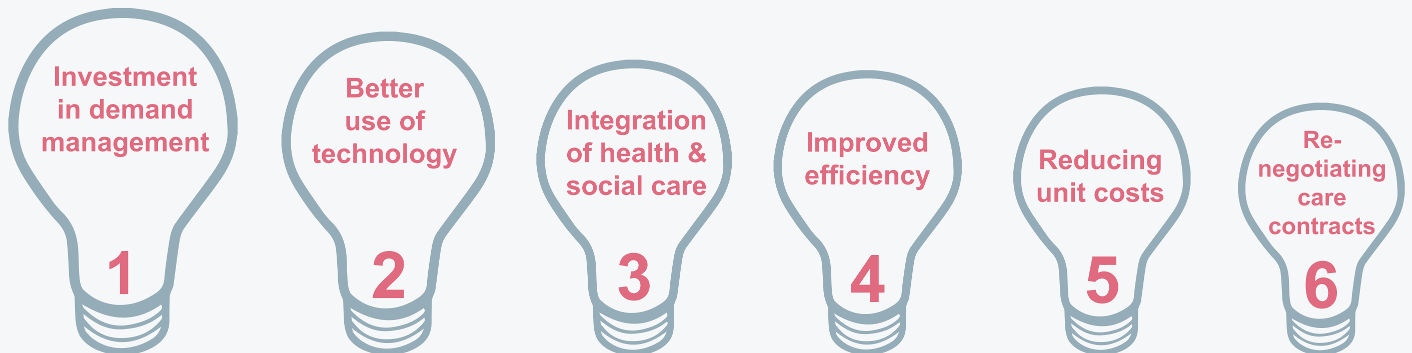
Delayed discharge days 29% higher in counties

Compared to national average

Its becoming hard to meet these challenges.....

Research shows inefficiency has already been driven out the system in counties.

Most effective way of tackling pressures in counties



(Capita and CCN Transforming Adult Social Care Survey 2015)

[7] *Table 1 show the notional amount of the relative needs block within the 2013/14 baseline for the new funding arrangements which has been allocated according to the relative needs calculation for older persons personal social services. This has been expressed as an equivalent annual amount per head of population aged 75+ (June 2012) and amount per social care client (using information from CIPFA statistics for client numbers in 2012/13 in the main areas of activity i.e. nursing care, residential care, homecare and domiciliary care).*

[8] *LG Futures. Sparsity Partnership for Authorities Delivering Rural Services (SPARSE-RURAL) Costs of Providing Services in Rural Areas (2011)*

What makes the challenge more difficult in county areas?

Evidence to the inquiry identified four main reasons why county care and support systems face a particularly difficult set of financial challenges.

Less Funding Per Head

Firstly, the CCN's recently published *Our Plan for Government 2015-20* showed that counties receive significantly less funding per head (+75) and funding per adult social care client, despite the demand pressures described throughout this report. This is largely due to weight given to deprivation top-ups in the allocation formula defined by Government at the expense of other key factors, such as age. Table 1 below shows that **county councils receive significantly less older persons Relative Needs Formula (RNF) per head of population than all other local authority areas.**[7]

Table 1	Older Persons (+75) RNF Per Head	Older Persons RNF Per OP Client
Inner London	£1,957	£11,824
Outer London	£816	£7,839
Metropolitan Authorities	£978	£8,551
Unitary	£691	£6,525
County Council	£496	£5,602

Geography and Its Impact On Care Markets

Secondly, counties can cover a vast geographical area with many different population centres and markets. The geography and polycentric nature of counties creates additional costs for both NHS and council partners, which are not always addressed within national funding formulae.

Comprehensive research undertaken by LG Futures in 2011 concluded that specific cost drivers associated with rural service delivery led to 'a substantial cost penalty' for predominately rural areas. They argued that 'the provision for sparsity within the formulae is very small compared to the size of the actual cost penalty'.[8]

This also has a direct impact on the supply of care workers in this sector. Population sparsity leads to higher delivery costs and makes it more difficult for commercial providers to keep their staff.

Nottinghamshire County Council commented that *'the challenges are compounded by the disparity in pay and Terms and Conditions of employment with health care staff generally having better T&C and pay'*.

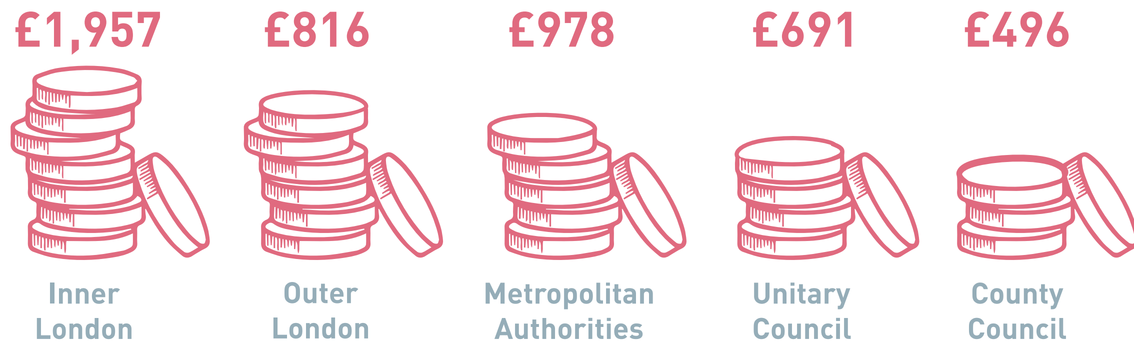
'We have a very large and fragmented care provider market, with almost four hundred care homes for older people and almost two hundred home care providers. Relating to so many providers is challenging, as is shaping and influencing such a market. Providing domiciliary services in rural areas, where fewer providers operate, travel time is much greater and staff more difficult to recruit.'

Lancashire County Council

Under the Care Act, local authorities will have a duty to manage care markets. Promoting choice, competition and sustainability has been enshrined in statute. With the increased transparency in care costs bought forward by specific aspects of the Care Act, including care accounts, coupled with increased local

[9]CCN. Counties & the Care Bill (2014)

Older Persons Relative Needs Formula



authority contact with self-funders, the impact on local markets and providers could pose real problems. Indeed, CCN research showed that 43% of member councils had 'concerns' and a further 30% had 'major concerns' over the impact of the reforms on local care markets.[9]

The potential impact of the Care Act on care markets is explored in more detail in sections 2 and 5.

Health Economies

Wide geographical areas also create a clear organisational challenge for the large and complex health economies in county areas.

Counties often have much greater complexity in their health provision landscape, particularly in two tier areas. There are approximately 85 Clinical Commissioning Groups (CCGs) and 65 Acute Trusts located in CCN member council areas. North Yorkshire's submission summarised this well;

"In the context of 1 County and 7 Borough and District Councils, 5 Clinical Commissioning Groups (plus a practice aligned with Cumbria CCG), 4 main Acute NHS Trusts and 3 Mental Health Trusts, over 4000 voluntary sector organisations and multiple independent sector providers, as well as a high proportion of people who fund their own care, there is significant complexity in the commissioning and delivery of health and social care services"

One fairly typical council (Essex) noted that they have 1.4m people, five CCGs, 12 district councils, one county council and five Acute Trusts as well as 10,000 voluntary organisations.

To add to the complication, these organisational boundaries are not usually coterminous. Within Kent County Council boundaries, there are 12 Borough/City/District councils and seven CCGs; only in one instance is there a near exact overlap between the two. In Wiltshire there are three main acute hospitals serving the county, but only one sits within the local authority boundary.

Another submission talked about having three distinct health economies based on patient flows to their three major Acute Trusts.

[10] See District Councils Network District Action on Public Health (2013)

Even within the local Government family there are also distinct challenges for many county areas. Within the 27 county councils in England there are 201 district councils. Districts are responsible for housing, local planning, Disabled Facilities Grants (DFGs), and provide wellbeing services across leisure, environmental services and parks.[10]

The District Councils Network (DCN) highlighted the importance of housing to the integration story - sustainable housing can play a huge role in preventing ill health. As the Chartered Institute of Housing told the inquiry;

"The role of the home in supporting health, wellbeing and enabling a person to manage the tasks of daily living is too often forgotten as a critical element in a truly integrated service developed around the individual."

Although respondents saw districts as having a major role in promoting wellbeing and independence, there was a clear perception that this added complexity to the system and specific challenges. Both county and district respondents described this problem.

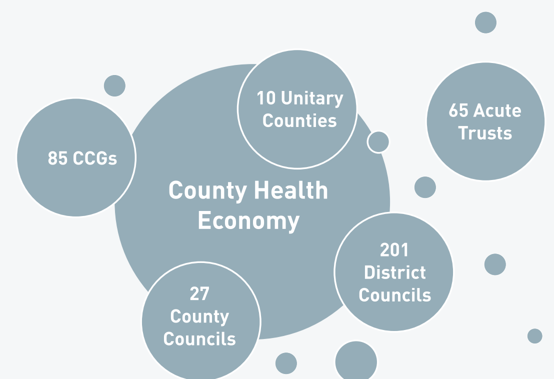
"One of the challenges in county areas is making sure that the right people are involved at the right levels and that there is communication and join up across the different districts and tiers as well as between sectors."
Blaby District Council

"Working in a two tier area presents additional complexity and resources (typically staff time) to manage it. Lincolnshire has four CCGs and 7 district/city councils. The challenge of obtaining consensus is therefore self-evident and is further complicated with a mixed political make up within the local Government system."
Lincolnshire County Council

The implications of health economies and two-tier local Government are explored further in section four.

Complex Health Economies

In CCN member councils there are:



In London there are 32 CCGs and 14 Acute Trusts.

Demographics

The most important contribution to the financial strain within county adult social care services is their unique set demographics and service-user profile.

Counties have a higher % of older people and are net importers of people with care needs. Figures show that the populations that make up the membership of the CCN have on average 20% over 65s, 9.2% aged over 75 and 2.7% aged over 85. These proportions are significantly higher than the national average and other parts of the country.

Local Authority Type	Over 65s	Over 75s	Over 85s
CCN Member Council	20.0	9.2	2.7
County Council	19.9	9.2	2.7
County Unitary	20.4	9.2	2.6
Core Cities	13.3	6.4	1.8
Metropolitan Borough	16.6	7.7	2.1
London Borough	11.5	5.4	1.5
English Unitary	16.0	7.5	2.2
England	16.9	7.9	2.3

Individual responses reinforced the impact of an ageing population in county areas and its drivers. Nottinghamshire County Council reported that the lower land value in counties attract more development by care providers, resulting in over provision in some parts of the county.

'By default, county areas become importers of people requiring building based care services such as care homes, private hospitals and supported living.'

Lincolnshire County Council has estimated the annual cost of inward migration for adult social care services to be £450,000. Gloucestershire County Council described a similar situation.

'The county has a large number of providers for people with learning disabilities – as a result 50% of those people with a learning disability in residential or nursing care in the county are not Gloucestershire residents.'

Lancashire County Council noted that such institutions

'often act, or have acted, as magnets, drawing people into the county who may be particularly challenging in terms of service provision and associated costs'.

Whether these are statutory, voluntary or privately operated they can pose additional demands for partnership working on a regional or national footprint.

Alongside higher rates of older people and the above 'pull factors', counties service user profile is also markedly different, containing much higher levels of those that currently fund and arrange their own care – self-funders. CCN research has shown that their member councils have an average self-funder rate of 54%, with some as high as 80%.[11]

In light of new duties under the Care Act, more of these self-funders will approach the council for an assessment and information, resulting in escalating demand for county care and support services in the short, medium and long-term.

[11] *CCN. Our Plan For Government 2015-20, (2014)*

Summary of Section: Key Points

Counties face a unique set of adult social care challenges.

- Financial pressures in county adult social care systems are severe or critical. Counties are under-resourced in comparison with inner city areas, receiving around a quarter of the funding per head of that received by inner cities.

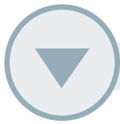
- They face exaggerated demographic trends. Their populations are older and they are net importers of people with care needs, with higher levels of self-funders presenting new demand in the years ahead.

- Their size means that their care markets are often fragmented. Private providers have their own set of challenges relating to staff retention and travel time, and there are fears the Care Act could have a significant negative impact on the market and local authorities. Service users experience significant difficulties in the cost of transport and its availability in large rural county areas.

- They operate in large, complex health economies, with many different partners across the public, private and voluntary sectors. Very few organisations have coterminous boundaries.

- Financial and demand-led pressures are impacting on service provision, with delayed discharges higher in county areas and growing over the past 12 months.

Future Trends



SECTION 2

The challenges for counties described in Section One are only set to increase in years to come, in particular, the financial implications of an ageing population. In addition to this, the implementation of the Care Act and other policy changes will create new funding pressures.

Demographic & Demand Forecasting in County Areas

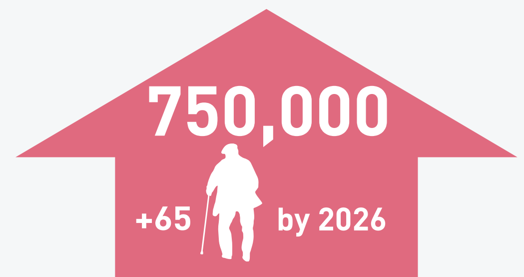
The number of people of state pension age in the UK is projected to increase by 28% from 12.2 million to 15.6 million by 2035. With its already ageing populations, the increase will be most acute in county areas. Submissions to the inquiry described some of their specific demographic challenges in **Map A.**

Cheshire West & Chester:

Approximately 63,000 people living in Cheshire West and Chester are aged over 65, with about 8,000 of these aged over 85 years, this will increase by 41%, an additional 3,000 by 2020.

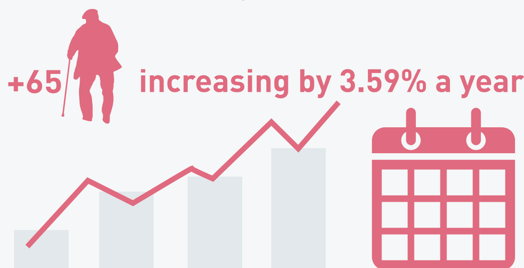
Oxfordshire:

Oxfordshire is a medium-sized county of some 654,800 people, of whom some 105,000 are aged 65 or above . By 2026 we expect these figures to rise to 750,000, and 150,000, respectively.



Gloucestershire:

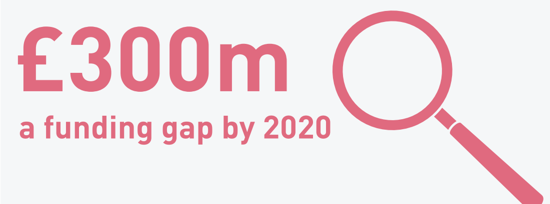
- Number of over 65s increasing by 3.6 per cent a year on average
- Will have 40% more older people to provide a service to every 10 years, even without considering the impact of the Care Act.



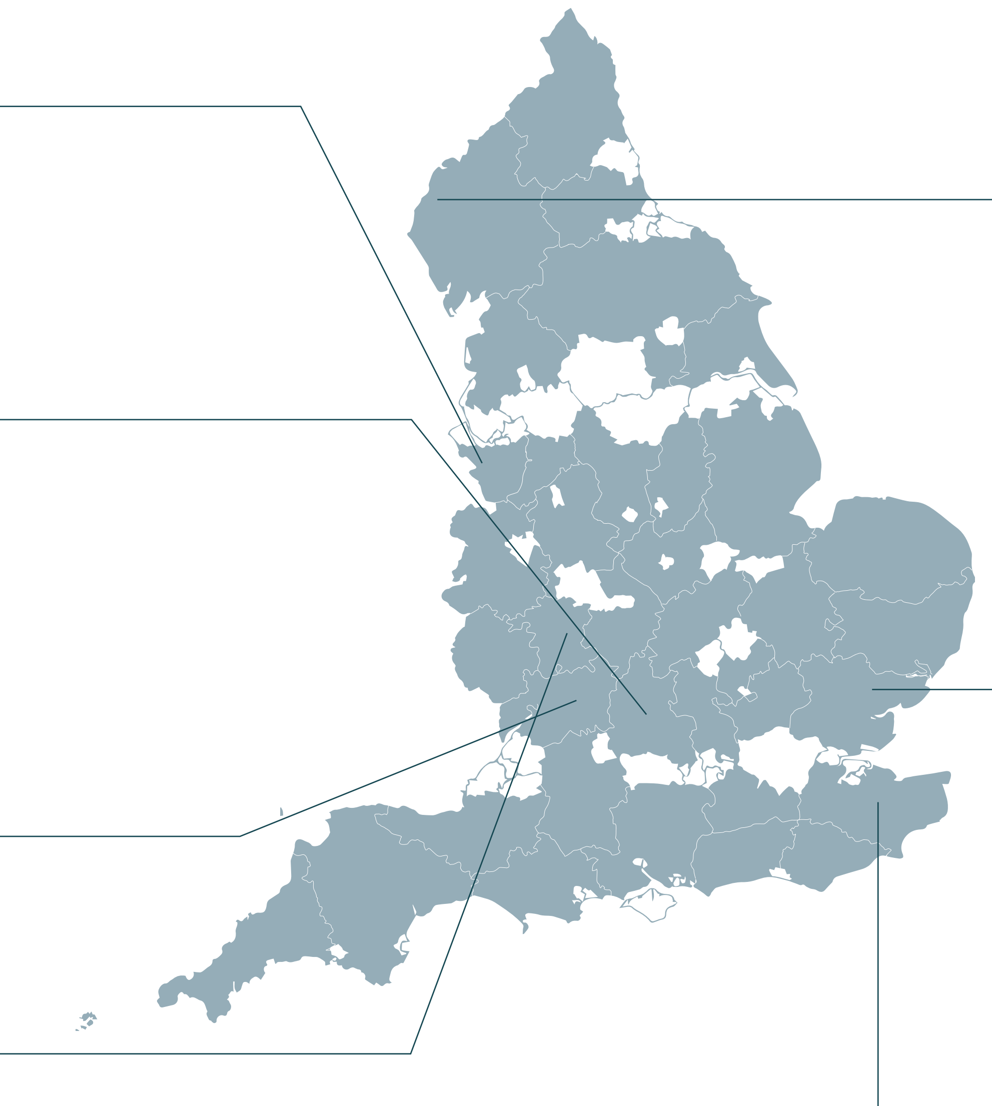
Worcestershire:

Population is ageing at a faster rate than the England average. Over the next 20 years:

- No. over 65s forecast to increase by 26 per cent
- Over 85s 43% increase.
- Local analysis based on their budgets and demographic changes shows a funding gap of around £300m by 2020.



Map A

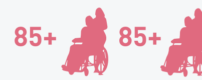


Cumbria:

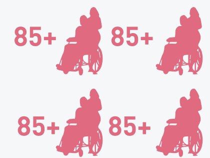
Has the fastest ageing population in the country, over half of their population live in rural communities.

→ Number of people in Cumbria aged over 85 is set to double in the next 20 years.

Now



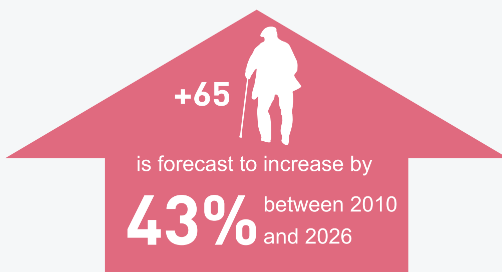
20 Years time



→ Trend will bring large increases in the numbers of people with long term conditions (LTCs) – which currently account for 70 percent of health and social care spend (at present 70% hospital beds used by people with LTCs).

Essex:

The number of people needing care and support is expected to increase nearly 300% from 2014-30. The Council has made 30% cuts to their overall budget (£30m) between 2010 and 2013 and will be making a further £23.7m worth of cuts by 2017. Their five CCGs have a cumulative pressure of £84m by 2018.



Kent:

→ Kent has a population of 1.5 million, of which just under a fifth is of retirement age (65+).

→ The number of 65+ year olds is forecast to increase by 43.4% between 2010 and 2026 in comparison to under 65 year olds increase of 3.8%.

→ Urban and rural community mix has the effect of amplifying many health and social care issues.

These changes have a huge impact on the cost of health and care. Nationally, people with more than one long-term condition account for £7 in every £10 spent on health and social care. The average cost per year to the NHS of someone with one long-term condition is approximately £1,000, with the cost of someone with three conditions £8,000. The figures provided by Cumbria (above) suggest that the number of people with more complex conditions is likely to rise dramatically in county areas.

At the same time, funding cuts are making themselves felt. Leicestershire County Council's situation was fairly representative of the whole.

"Leicestershire has the lowest net spend per head of population on Adult Social Care of any Council in England. The Council has already outsourced most care provider services and delivered savings of £35m since 2010; making the scope to deliver further savings more challenging. Each year around £5m growth p.a. is required to maintain existing service levels with demand for very high cost packages for disabled younger adults increasing at a faster rate than demand for older people. In addition to rising demand there is pressure from providers to increase fees year on year and service users are contributing proportionately less towards their own care...Consequently adult social care reported a £4.6m (3.5% of budget) overspend last year with ongoing pressures continuing to impact the current year."

The Impact of the Care Act

Recent Government legislation will do little to ease the financial and demand challenges described above. Councils are facing major changes to the way services are run over the coming years, with the Care Act providing a completely new legal, policy and funding framework for adult social care.

Under the current system, an individual was only eligible for full council funded social care if they have less than £23,250 in assets. For this reason, most home-owners self-funded their own care and had little, if any, contact with their local authority - particularly those in areas of the country where property values are high.

Under the Care Act, the means-test threshold for residential care has been extended to £118,000 and the amount an individual must spend on care costs before they are eligible for council support will be capped at £72,000 (excluding accommodation costs). This not only means councils will be providing more financial support to those who fall under the new means-test threshold and once individuals hit the cap; they will also need to provide a range of frontline services, such as assessments, information and advice to hundreds of thousands of self-funders who previously arranged and funded their own care.

Because of these changes, many self-funders will be brought into, or in contact with, the formal local authority care system for the first time, which places several new pressures on councils from April 2015.

The key changes under the Care Act that create particular challenges include;

- A new National Eligibility Criteria has been introduced to support the Care Act set at the equivalent of 'substantial' need.

- Councils must undertake new early

assessments that ‘start the clock’ on how much individuals assessed as eligible for care are spending.

- Councils will be responsible for overseeing ‘deferred payment agreements’ which means if an individual moves into a care home but does not want to sell their home in their lifetime, the council will cover the cost of care and recover the amount spent when the property is sold.

- New care market shaping and sustainability duties, with councils needing to promote and foster a functional, competitive and choice driven market.

- New enhanced rights for carers ,could lead to a significant increase in assessment work and also more and different services being necessary.

- Most importantly, thousands of individuals who would have previously funded the entirety of their care from their own assets will be eligible for council funded care earlier than before.

The higher proportion of self-funders in county areas will intensify the impact of the Care Act. The results of a joint-cost modelling exercise by the Department of Health, ADASS, LGA and CCN showed that CCN member councils account for two-thirds of the total early assessment and review costs identified. This evidence confirmed that the demand, and subsequent financial impact, of new duties is disproportionately borne by counties in the short, medium and long-term.[12]

The financial and policy impact of the Care Act on integration and the future of care and support services is analysed in section 5.

Deprivation of Liberties Safeguards

It is also worth noting there are many other financial pressures on adult social care departments which will affect their ability to care for the vulnerable in future. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home, hospital or supported living arrangements only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them.

However, the LGA and ADASS have recently warned that changes to these safeguarding rules could divert as much as £88m from care budgets. A recent Supreme Court judgement could mean that thousands more people will need to be assessed under the Deprivation of Liberty Safeguards: an estimated ten-fold increase in additional assessments. Without immediate and urgent Government funding to support the changes, this could lead to longer waiting times for assessments.[13]

Summary

In short, counties are under severe funding pressure as they strive to provide adequate care for the most vulnerable in society. These pressures are only set to increase in future and councils will have a major challenge on their hands if they are to maintain and improve

[12] CCN Response to Care Act Funding Consultation (2014), http://www.countycouncilsnetwork.org.uk/library/july-2013/file83/

[13] LGA Media Release. LGA and ADASS warn changes to safeguarding rules could take £88 million from care budgets (31st July 2014)

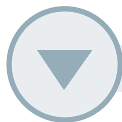
service delivery. The following sections explore some of these challenges in more detail, and ask what the solutions are for overcoming these, and how we might need to do things differently in county areas.

Summary of Section: Key Points

Counties already face serious funding problems as a result of their geographies, demographics, health economies and the shape of their care markets. These problems are only set to worsen in future:

- As net importers of people with care needs they face a rapidly ageing population and an associated pressure on adult social care services.
- The Care Act will place much higher demands on county areas compared to other parts of the country, particularly relating to self-funders.
- The recent DOLs ruling could divert as much as £88m from care budgets. Without immediate additional funding to support the changes, this could lead to longer waiting times for assessments.

Why Integration?



SECTION 3

Better integration between health and social care is almost universally accepted as part of the vision for responsive, caring services and part of the solution to the pressures on social care. More streamlined services will create a single point of delivery for service users and deliver better outcomes for individuals as well as potentially generating financial efficiencies. But integration means many different things to different people.

Integration – The answer to the crisis?

The Coalition Government has made integration a central platform of its policy for health and social care. In his very first speech as Secretary of State for Health outside party conference, Jeremy Hunt said:

> *"In my first month as health secretary the word I've heard uttered more than every other is integration. I believe that the new structures will lead and create opportunities for integration like we've never had before...the divide between the NHS and local authorities sometimes beggars belief. People fall between the cracks."*[14]

The Government's £3.8bn Better Care Fund (BCF) was announced in June 2013. It is described by NHS England as 'one of the most ambitious ever programmes across the NHS and Local Government'. It creates a local single pooled budget to incentivise the NHS and local Government to work more closely together around people, placing their wellbeing as the focus of health and care services.[15]

More recently, in October 2013 the Government has launched 14 'integration pioneers'. The aim of the Pioneers is to make health and social care services work together to provide better support at home and earlier treatment in the community and to prevent people needing emergency care in hospital or care homes.

The creation of the BCF is widely regarded as the most vivid illustration of a growing policy consensus on the need to integrate health and social care. But many policy makers, political parties and stakeholders see it as being only the tip of the iceberg.

The **County Councils Network** has placed integration at the heart of its proposals for Health, Social Care and Wellbeing.[16] In its recent *Our Plan for Government 2015-20* it calls for 'brave and radical steps on the future of our care and support system' with counties 'empowered to fully integrate health and social care'.[17] The **LGA's** 100 Days Plan also called for the full integration of the funding and commissioning of adult social care and health as a 'step towards the single point of commissioning'.[18]

The **Barker Commission**, which reported in September 2014, went further still, recommending moving to a single, ring-fenced budget for the NHS and social care, with a single commissioner for local services. It supported an extension of public funding to more social care services as a means of getting beyond questions of fairness and entitlement – how someone ending their life with cancer can receive free at the point of delivery NHS services, while someone with dementia is means-assessed.

Building on the BCF, there is an emerging political consensus about the importance of integration. The **Labour Party** has also made integration between health and social

[14] *The Guardian. October 26th 2012*

[15] *NHS England. Better Care Fund Planning http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/*

[16] *CCN, Our Plan for Government 2015-20 (2014)*

[17] *CCN. Our Plan for Government 2015-20 (2014), p. 24*

[18] *LGA. Investing in our Nation's Future: The first 100 days of the Next Government (2014)*

care a central plank of their policy. Shadow Health Secretary Andy Burnham has recently announced plans for a 'whole person care system' across an integrated health and social care system. He said an incoming Labour Government would empower Health and Wellbeing Boards to be accountable for new 'year of care budgets' which would cover the 'health and social care needs' of those 'at the greatest risk of hospitalisation'.[19]

With the main political parties, CCN, and LGA all pushing for integration as the main solution to the challenges of health and social care, this inquiry needs to ask whether this is the right solution for county areas. We studied the evidence gathered by the APPG and asked a number of key questions.

What are the financial and service gains from integration between health and social care?

One of the frequent claims made for integration is that it can generate savings for health and social care. Logically, investment in prevention *must* necessarily make savings further down the line for acute services.

Interestingly there was a degree of scepticism about this claim in the responses to the inquiry. The oral evidence session we held with the Care Bill Implementation Group (CBIG) highlighted this as a genuine challenge to the credibility of integration. Much of the academic work exploring the success or otherwise of integration suggests there is **little evidence that it results in financial gain.**[20]

Evidence to the inquiry noted the need for more evidence, while others said they had made modest savings, but nothing that would make a significant impact on the broader funding pressures they were facing. Worcestershire County Council is developing an evaluation of their integrated care programme as part of their role in the national Pioneer Programme.

"It is not yet clear if better managing demand through early intervention and prevention will deliver the required level of savings within the necessary timescales. Budget planning cycles are usually three to four years, and some of the preventive initiatives may need a generation to prove their value one way or another."

Lancashire County Council

However, there was still a sense that despite the lack of evidence there were prizes to be had in relation to efficiency. In Kent's original BCF submission, four projects geared towards the protection of social care predicted the following projected savings: Telecare - £3.63 million; Residential avoidance - £662,000; Promoting independence reviews - £2.74 million; and, Demand management project - £522,000.

Submissions to the inquiry also expressed the view that a whole systems approach to health and social care would necessarily help with the goal of maintaining preventative services and upstream investment. Hampshire County Council noted that they now have a lower funding base, so are integrating commissioning and provision to sustain a range of services '*particularly to help the system maintain early help, prevention and community based services'*. There was no evidence as to whether this had yet been successful.

Potential **service gains** generated much more consensus and enthusiasm. The vision of a seamless, person centred local service built around outcomes is seen as the most important goal for integration.

[19] *Health Services Journal. Labour reveals 10 year plan for health and social care (26 January, 2015)*

[20] *Gladsby et al.*

'Integration has the potential to lead to better outcomes for individuals, moving from fragmented, disjointed and reactive services, to a model based around people and family, where individuals only tell their story once and receive tailored services'.

Cheshire West and Chester Council

'We do believe there are (and will be further) service gains by integration. By wrapping community teams around GPs we can see risk stratification and case management delivering a more proactive service to those who need it most. At the same time, joining up social, normalisation models with good clinical practice should improve self-care'.

Gloucestershire County Council

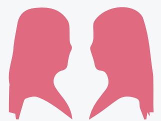
Despite the uncertainty about the potential for savings, there was almost complete agreement that integration had the potential to transform the way we work and to provide service users with a simpler and more joined up service; a service in which health and social care practitioners operate flexibly together to make every contact count and to deliver the best possible outcome for an individual.

There is significant evidence to show this is achievable; counties have done it before. Most of the submissions could point to good practice in the past where integrated working had been achieved with some success.

- Cheshire West and Chester described their experience as a Whole Place Community Budget area. One of their biggest achievements was their success in reducing conflicting incentives across partners. Some examples of existing integrated services in their locality include the Hospital at Home programme, end of life care and reablement services.
- Lancashire County Council noted they had a positive history in the joint commissioning of learning disability services and an almost fully integrated adult mental health service with the Lancashire Care Foundation Trust.

The Benefits of Integration

Removing duplication between health and social care systems



Seamless user experience keeps people from being passed from service to service

Investment in prevention across the whole system and sharing the rewards

Sharing risk more effective indentification and mitigation

- In Lincolnshire learning disabilities, mental health and a number of children's service areas were also fully integrated. They stressed the need for long-term support for cultural and workforce change to be effective, but experiences like this suggest that greater integration is achievable.

- Hertfordshire County Council works with the Hertfordshire NHS Community Trust and private care providers on their 'Homefirst' service. This service is fully integrated and uses both health and social care professionals to identify those at risk of hospital admission and support them in the home. This model is now being extended to mental health.

All these examples of integration show the ability of health and social care departments to work together around shared goals. But they are relatively small in scale and service specific. Is a more comprehensive version of integration realistic? And do we even mean the same thing when we talk about integration?

What do we mean by integration?

Integration could mean a lot of things. At one end of the spectrum, some have argued for a single, structurally discrete health and social care service. One organisation united under either the NHS or the Health and Wellbeing Board, with services either funded publicly or by various models of private insurance.

The recent King's Fund report led by Kate Barker calls for a single, ring-fenced budget for the NHS and social care, with a single commissioner for local services. It also recommends the extension of public funding to social care services to make them free at the point of delivery. While the suggested cuts to Winter Fuel Allowance and TV license exemptions are likely to be politically unpalatable ways of paying for this, some of the ideas have gained traction. Specifically it has been suggested that a Labour Government might bring social care into the NHS.

There was very little support for this form of integration in the submissions to the Inquiry, and particular hostility to the idea of the NHS taking control of social care. This is for three main reasons.

Firstly, some councils feel that the NHS has a poor track record in valuing and investing in social care services. Their incentives (and indeed their ethos as an organisation) revolve around the provision of acute care and the achievement of clinical outcomes. Full integration on this model could put at risk the progress towards preventative services and emphasis on user outcomes made by social care in recent years.

Secondly, social care has progressed a long way down the road to personalisation, giving recipients of care personal budgets and far greater freedom to choose the sort of services they want. Coproduction with the service user plays a central role in the way social care services are planned and delivered. The NHS has made far less progress in personalising their services and the Care Act enshrines personalisation as a key policy driver for social care.

Thirdly, the NHS is still highly centralised and is not democratically accountable to residents at a local level. Bringing social care under a centralised NHS would be working against the commitment of all the main political parties to

delivering localism and wider arguments for economic and social 'devolution'.

Submissions to the inquiry broadly supported shared commissioning and budget pooling, **but were not in support of the full structural integration of health and social care.**

Worcestershire County Council argued that the organisational structures of local Government and the NHS would make full integration unrealistic:

"The Governance and Accountability mechanisms within local Government and the NHS are worlds apart. Elected representatives set strategic direction for local authorities and are accountable for the means of achieving the success of that direction and its affordability as well as for ensuring public accountability. The NHS appoints board members to oversee a strategic direction that is set by contracted appointed chief officers who are also accountable for the delivery of that direction. These two systems are incompatible."

Norfolk County Council's combined response with local health providers said:

"When adult social care services are structurally integrated with the NHS, our experience is they tend to just get lost. The upheaval involved also creates an expensive and time-consuming distraction. We believe that a strategic alliance with some integrated structure that enables both organisations to drive the agenda is the best way forward – not full structural unity entailing wholescale transfer of staff and pensions responsibilities but some pooled funding and integrated line management and commissioning arrangements."

Cheshire West and Chester identified a single point of entry to the health and social care system as a major priority, while Hampshire argued that 'delivery should be fully integrated but not the organisations'. This would involve a single assessment, pooled budgets, colocation of services and joint commissioning.

Does 'localism' matter?

It is worth pointing out that integration might not be the same in different areas of the country. Nottinghamshire County Council argued that *'integration is a means to an end, not an end in itself – form should follow function and needs to be determined at the local level based on the area's health and wellbeing priorities'.*

Oxfordshire County Council noted that definitions of 'integration' in health and social care can vary:

'For some, integration means primarily the co-location of services in single points of access for the service user. For others, integration is around a smooth process for the 'handover' from one service to another as needs change, and for others a 'team around the client' approach is most important, regardless of the precise organisational structure. Another approach, likely to be particularly appropriate for chronic conditions, is to increase the use of personal budgets in health, as has taken place in social care, and therefore enable individuals to purchase an integrated suite of services.'

As long as all the partners within a local area have a shared understanding of what they mean by integration, this does not have to be a problem: localism can take different forms in different areas in response to local patterns of need and local consultation.

Alongside the need for rapid integration across health and social care and a 'radical upgrade

in prevention and public health' services, the NHS Five Year Forward View accepted the need for localism to be injected ino the health service, arguing that England is too diverse for a 'one size fits all' care model to apply everywhere:

"Times have changed since the last such major blueprint, the 1962 Hospital Plan for England and Wales. What's right for Cumbria won't be right for Coventry; what makes sense in Manchester and in Winchester will be different." [21]

We have recently seen enhanced local devolved powers and funding as a means to stimulate greater economic growth. City Deals were established as agreements between central Government and cities to give them more freedom to do what they think is best to help businesses grow and decide how public money should be spent.

The new devolution settlement for Greater Manchester is the logical extension of this policy and gives the city its own directly elected mayor with more comprehensive powers over transport, housing, adult social care and policing in a devolution deal worth more than £1bn. Ahead of the publication of our inquiry, Government plans were revealed to go further than this, with the entire £6bn NHS budget to be devolved to 10 local authorities in Greater Manchester under the accountability of the directly Elected Mayor from April 2016.[22]

Whilst precise details were yet to be released at the time of writing, the Chancellor was expected to announce NHS England would hand decision-making for spending on hospitals, GPs surgeries and drop-in centres to local politicians to drive forward health and social care integration.

If the Government believes that the devolution of more powers and budgets to a local level can provide a solution for health and social care integration in City areas, why not extend these principles to county areas? Our evidence shows that the challenges facing health and social care systems in county areas are greater and require similar radical action.

The organisational landscape for health and social care differs greatly from one area to the next and a 'one-size-fits-all' model of integration will never have a universal application. The CCN has suggested that for localist approach to devolution to work we must take the current changes a step further and completely rethink the relationship between central and local Government.

"The Government must enact a new constitutional settlement with the County and City Regions of England. Fundamental reforms to rebalance the relationship between counties and Westminster must include the fiscal and economic devolution proposals... alongside a structural and culture shift in Whitehall departments that supports, rather than impedes, devolution in England."

In responding to CCNs recent survey on County Devolution, Leaders, Deputy Leaders and Chief Executives stated that they were very confident or quite confident in making savings or improving outcomes if appropriate budgets and powers were devolved to a local level. Added to this 88% of respondents to the survey were also keen to see primary and secondary health commissioning devolved to local areas.[23]

It is clear from the submissions to this inquiry that plans for integration must be driven by

[21] NHS England. NHS Five Year Foreword View (2014)

[22] BBC News, 25th February 2015

[23] CCN. County Devolution Interim Findings (2014)

local need, based around the principles of devolution. Serious consideration should be given to how the devolution of extensive powers and responsibility can be extended to county areas in response the challenges in health and social care.

Integration and Partnership, Not Merging

In summary there is agreement in the responses that integration should not mean full structural integration, whereby social care becomes part of the NHS. There is strong support for other forms of integration including pooled budgets, joint-commissioning, colocation, shared management structures, and inter-disciplinary teams. **This might look different from area to area, but establishing a single point of access for service users is the ultimate goal.**

Summary of Section: Key Points

- Integration will improve services. We are moving towards seamless, joined up services at the point of delivery and integration between health and social care is crucial to this vision.
- There is still a lack of evidence on the financial impact of integration. Removing duplication must logically make savings, but these savings are small next to the wider financial crisis in health and social care. Investment in prevention will generate savings in acute care, but they may take time to realise.
- Councils do not support full structural integration of health and social care under the NHS. But delivery should be integrated from the perspective of the service user.
- Integration should follow function and should be appropriate to local needs. This can best be determined at a local level and serious consideration should be given as to how greater devolution in both health and social care can enable integration.

SECTION 4

Barriers to Integration

If integration is part of the solution to the challenges facing county health and social care systems, we need to understand the barriers holding back implementation on the ground. Articulating a vision for fully integrated care and support requires an analysis of what is already holding the consensus back.

Despite the strong arguments in favour of integration, progress has been relatively limited so far. There have been strong case studies of shared working on a small scale or within specific services, but relatively few examples in this area of integration being taken further. Why is this the case? Submissions to the inquiry identified a number of important barriers to be overcome.

What are the main obstacles to greater integration? Can these barriers be overcome?

Structural and Cultural Differences

'Health and social care have two different cultural and legal systems, compounded through oversight by two different Government departments, as well as a historical distinction dating back to 1948 between the sick and those needing care and attention."

Essex County Council

Perhaps more importantly than anything else, health and social care have been set up on historically different models. They have different funding agreements, different models of governance and accountability, different legal frameworks and different traditions. This has a huge impact on the way they work and makes integration awkward from both a structural perspective ('how can we reconcile this organisational architecture into something coherent?') and from a cultural one ('how can we learn to work together and understand each other's ethos and priorities?").

Health is still deeply centralised and is more susceptible to the whims of the national Government of the day. Social care is more flexible, responsive and localist in nature, but receives far less funding and is the weaker partner in terms of money and its ability to influence the other. Worse still, the NHS is often used as a political football, particularly in the run-up to elections, as each party competes over their vision for the future of the service and their commitment to health spending.

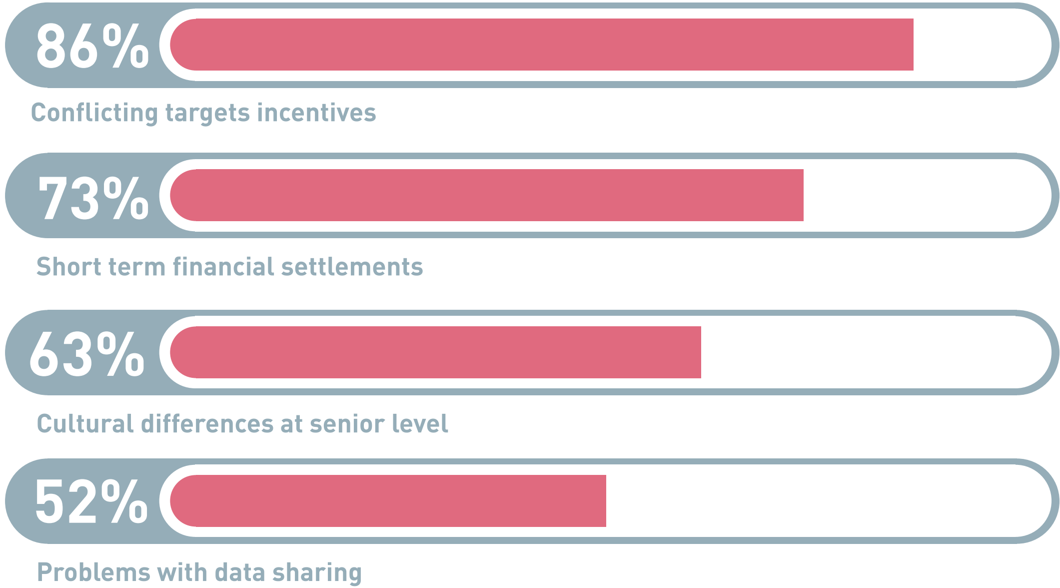
Consequently health is more politically sensitive at a national level and there appears to be little political appetite for releasing central control to a local level. Ultimately this is the biggest barrier to greater integration. Until local leaders have full power to determine how both health and social care interact locally, integration will remain limited in scope.

Culturally, social care services have made far greater progress in relation to personalisation, coproduction and user voice than is the case in the NHS. The use of personal budgets has been very successful among certain groups of service users, but this model does not always sit comfortably with models of funding in the acute health sector.

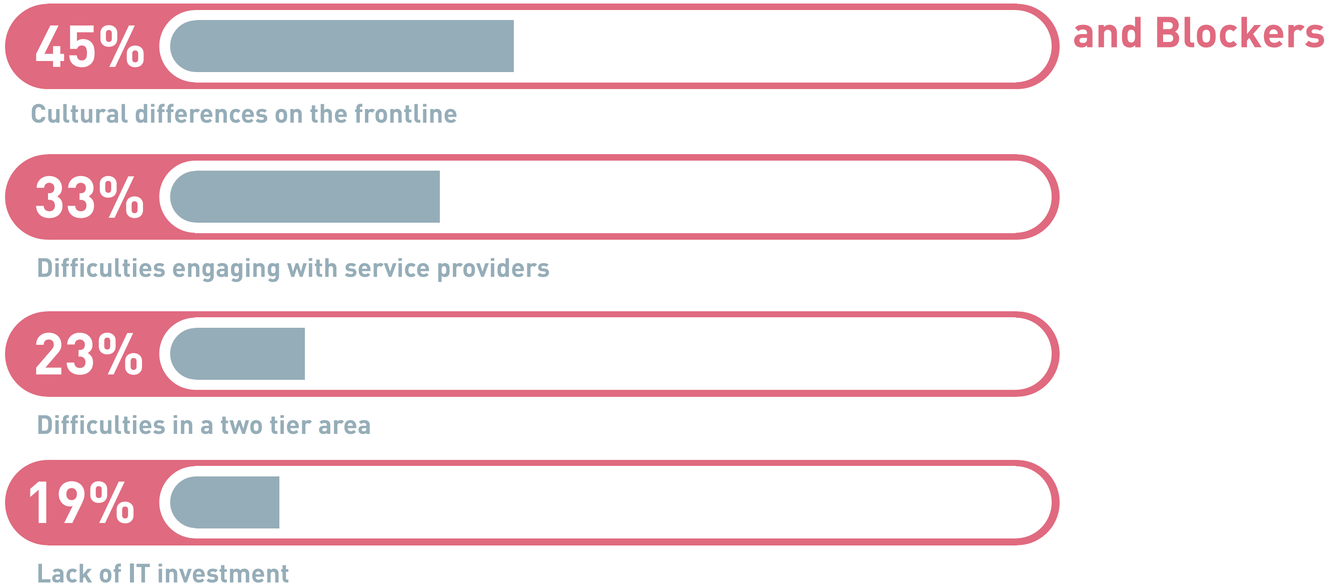
Underlining this challenge is the difficulty of entitlement. NHS services are free at the point of delivery, while social care services are means tested. In addition, the eligibility criteria for social care has been tightening in most areas of the country as a result of funding reductions and it remains unclear how the new national threshold will impact on access to services. This makes a commitment to a 'single point of access' to services more challenging.

Barriers to Integration

Major Barriers



and Blockers



(Capita & CCN Transforming Adult Social Care Survey 2015)

[24] Capita and CCN Transforming Adult Social Care Survey, 2015

[25] Joint submission from Norfolk County Council, Norwich CCG, Norfolk Community Health and Care NHS Trust and Norfolk and Suffolk Foundation Trust.

[26] CCN. Our Plan for Government 2015-20 (2014), p.27

[27] Kings Fund. The NHS under the coalition Government Part one: NHS reform (2015)

Misaligned Incentives

Structural challenges are compounded by a lack of alignment between the incentives of the various players. In a recent survey commissioned by the CCN, more than 85% of respondents identified 'conflicting targets/ incentives' as the number one barrier to health and social care integration.[24]

In principle all partners are in support of greater investment in prevention, but Norfolk's submission gave a fascinating description of how inbuilt incentives can work against this in practice.

"The way NHS organisations are paid also creates problems for integration. Acute Trusts are paid based on episodes and community providers are paid in block. This means that if Acute Trusts lose work, they lose money. If community providers gain work, they don't gain money. This means the incentives are not there for organisations to work together to reduce the use of acute services and increase provision within communities."

Norfolk County Council and Health Partners[25]

The current NHS payment by results National Tariff system has been criticised for paying the NHS for each clinical contact, regardless of the benefit to the patient. This model does not incentivise prevention and is a barrier to further integration of the health and social care systems. Worse still, it can actually operate against greater investment in prevention as Acute Trusts stand to lose money if patients are diverted away from their services. CCN has argued that the Government should develop a whole-system tariff system that allows local councils and NHS partners to agree to a localised and flexible settlement.[26]

The Health and Social Care Act radically changed and further fragmented commissioning arrangements (and included public health LA teams as commissioners). There is therefore a huge challenge in devising a system is to take account of this fragmentation in designing a payment system for NHS care which supports joint working.

Until this is addressed to reward outcomes rather than activity, the commitment to preventative approaches expressed in the Care Act cannot become a reality.

Challenges Working with a Range of Providers

Health and social care 'integration' suggests an image of partners working together. In reality of course it is much more complicated than that. This is particularly important in the context of county areas, given their more complex health economies, wider range of social care providers and partnership landscape with district councils described in Section One.

The health sector is increasingly complex, incorporating Acute Trusts, mental health trusts, community trusts and CCGs to name a few. Acute Trusts alone are very diverse organisations with many departments and disciplines.

A recent King's Fund analysis of the Government reforms concluded that whilst integrated care emerged as an explicit priority policy in reforms, new systems of governance and accountability resulting from the reforms are complex and confusing, with an absence of system leadership.[27] Lancashire County Council described the changes in the commissioning landscape:

"There have been three organisational changes to NHS commissioning in Lancashire in the past ten years. Another may be in the offing after the Election. Such structural changes are distracting for NHS colleagues and partners and do little for continuity and stability of relationship. There has generally been reluctance from NHS partners to agree a single course of action. This invariably requires us to have different arrangements with each CCG, which is a drain on our capacity and risks inequity across the county.'"

With the vast majority of social care provided by private and third sectors, diverse markets can pose equal challenges. Worcestershire County Council reported that 85.7% of their adult social care services are delivered by external providers. This can cause its own challenges in terms of misaligned incentives. Leicestershire County Council noted that home care providers should be incentivised on quality of outcomes, not time and task inputs. A joint programme of work is now underway to review and re-commission domiciliary care across the NHS and local authority partners over the next 18 months in the county.

Alongside complexity in health and social care provision, the relationship between district and counties could act as a barrier.

Disabled Facilities Grants, which provide funding for home adaptions, mainly to the elderly to promote independent living were highlighted as an area of concern. As the county council leads on the delivery of adult social care, ambiguity can occur in two tier areas that do not affect places with unitary status. As a joint submission by the district councils in North Yorkshire told us:

"The responsibility and accountability for the DFGs lies with the Local District Council and it is simpler to provide integrated services if the funding is directed to the responsible Authority / Organisation. There is more to be done to integrate the prevention agendas with DFG and the wider determinants of health to ensure efficiencies are delivered there are real possibility to integrate better."

The inclusion of district DFG funding within the BCF was also seen to have generated difficulties. A number of district or city councils, assuming that responsibility for DFGs may transfer to county level, have begun to withdraw their discretionary top-ups to local allocations. This has created an immediate and significant funding pressure.

While some authorities, such as Worcestershire County Council, had a positive story to tell on their relationship with district councils, many respondents frustrated by the lack of coordination between counties and district councils, particularly on joined up housing strategies. They felt that the potential to generate economies of scale from the size of a county was being undermined by the number of players and the failure of districts to work together.

Workforce Issues

The difference between how people operate on the frontline was also identified as a barrier. Hampshire County Council said that 'the education system perpetuates silos in how people are prepared for practice.' This often results in people being repeatedly referred on to the next service, rather than staff stepping outside their own professional sphere to resolve a problem. More generic training and better coordination of training between health and social care would help to break down these silos.

[28] LGiU. Key to Care: Report of the Burstow Commission on the Future of the Home Care Workforce (2014)

[29] Capita and CCN Transforming Adult Social Care Survey, 2015

Another barrier relates to pay and conditions. The majority of care workers are employed by third-party providers and there has been a lot criticism of working practice in the sector. The 2014 Burstow Commission found that 60% of home care workers are on zero-hours contracts and up to 220,000 are paid less than the minimum wage, while annual staff turnover is over 20% - more than twice the national average.[28] Council submissions to the inquiry noted that pay and conditions in the health service are broadly better than in social care, making recruitment and retention difficult for the latter.

It is worth noting however that once integrated working is in place, frontline workers usually work together with great success. Numerous examples of coordinated working in a specific service were cited in evidence to the inquiry. In a recent survey by Capita and CCN, ‘cultural differences at a senior level’ were seen as a barrier to integration by more than 60% of respondents, while ‘cultural differences on the frontline’ were seen as a barrier by 45%.[29]

Data Sharing Rules and IT

“Care services are probably about 25 years behind where they should be in making use of modern technology to support more efficient mobile working. Many staff still write notes by hand and type them up later.”

Norfolk County Council and Health Partners

Out of date IT is still a problem for both health and social care and slows down plans to share information and integrate records. Norfolk also reports that:

“there are too many different care records and they are in different formats – some paper, some electronic, some open, some closed. The systems we have don’t talk to each other. Some staff have to enter the same data on three different systems. We are still a long way from being able to share information and this is preventing us from having a single care team that can fully assessing all the risks facing individuals.”

This view was echoed in many of the submissions. But creaky IT infrastructure is only one of the barriers to integrated working. Data sharing is also a challenge. At present, in most cases shared data can only be achieved by getting consent on an individual basis from service users. This is costly, time-consuming and results in only partial completion.

Encouragingly there are many examples of progress on this front.

- The Cheshire Pioneer Integrated Digital Care Record is seen as ‘fundamental to achieving integrated care’.
- Hampshire has a Hampshire Health Record data repository as a foundation for a shared approach.
- Hertfordshire has a data sharing agreement with consent from social care clients. Their East and North CCG is working towards a single IT platform across general practice.
- Dorset County Council is waiting for the results of a £2.5m bid to develop an integration platform and portal for the NHS and social care organisations to use to enable the secure sharing of data.
- In Norfolk the county council is building a cloud based platform for sharing

health and social care information and in West Norfolk they are piloting a system that will enable the acute trust, community trust, GPs and the ambulance service to share information.

However, the legal basis for sharing social care data is a major problem. Information intelligence is integral to evidence-based integrated commissioning. The citizen must retain control of their data, but there must be a statutory presumption to share data between organisations. There are legitimate concerns over the public's perceptions of the risk and the willingness for data to be shared. Nevertheless, the benefits of data sharing – underpinning a seamless service, allowing outcomes to be more effectively measured and holding providers to account – arguably outweigh the challenges.

The Limitations of Health and Wellbeing Boards

Health and Wellbeing Boards were originally set up as forums for health and social care leaders to improve the health and wellbeing of their local population. Their statutory duties included the preparation of a health and wellbeing strategy, joint strategic needs assessment and to encourage integrated working between health and social care partners. Now that they are overseeing the BCF, these boards need a new governance framework. They play a crucial role in bringing together a range of health and social care partners around a table, but in some cases have become a talking shop. They do not commission services, they cannot hold a budget and they have no delegated powers to require local partners to participate in the integration process.

Oral evidence given to this inquiry by the Care Bill Implementation Group meeting suggested that some Health and Wellbeing Boards are hampered by the need to balance inclusiveness with effectiveness: at present they tend to favour the former at the expense of the latter. This is particularly a problem in county areas where district councils are represented alongside the range of health organisations.

With greater powers and focus, they have the potential to be much more and to perform a coordinating role on the road to integration. One contributor to our oral evidence roundtable commented that:
'We are putting lots of energy into the BCF which would be better employed in improving Health and Wellbeing Boards.'

Lack of Pump Priming

'Funding for adult social care and health services has not kept pace with demand and currently offers little incentive for risks to be taken in developing innovation solutions…. Pioneer status has brought with it the need for additional time consuming examination but no benefit of additional funding to test out innovative solutions for change... Not every potential innovation will succeed and so the appetite for innovating has to balance against the risk in changing the funding envelope for existing service provision.'

Worcestershire County Council

Investment in preventative services is a central plank of the Care Act, with its focus on wellbeing and prevention, reducing and delaying the onset of need. Funding adult social care and other preventative services will almost certainly help to reduce spend on acute services further down the line. But these savings will not materialise immediately. In simple terms, hospital beds still need to be

funded while the social care measures that will ultimately relieve pressure on them are being introduced and embedded. Hospitals cannot immediately reduce spend on accident and emergency, because a new programme to prevent falls has been introduced.

Councils recognise the need to invest in prevention. CCN and Capita's recent survey of county authorities found that 'investment in managing demand/changing the mix of care away from expensive options' was rated as the most 'effective' way for councils to manage the funding crisis in these services. It was also identified as the method they were most likely to actually implement. However, nearly 80% identified 'funding pressures' as the barrier most likely to restrict their ability to make these changes.

Major change programmes need to be well funded. The BCF is not a new pot of money, and is set in the context of the funding crisis described earlier in this report. Almost all the submissions to the Inquiry identified this as a major challenge to the future of integration.

In our oral evidence roundtable, Paul Carter, Leader of Kent County Council, commented:

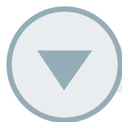
'We don't want lowest common denominator solutions. We should trial an innovation fund for those who have the ambition to deliver something different – backed up by academic evaluation.'

Summary of Section: Key Points

Submissions to the inquiry highlighted a number of barriers to integration

- Structural and cultural differences
- Misaligned incentives
- Challenges working with a range of providers
- Workforce issues
- Data sharing and IT
- The limitations of Health and Wellbeing Board
- Lack of pump priming

Helping or Hindering: How does Government policy affect integration?



SECTION 5

Recent years have seen a huge upheaval in the way social care works. The Care Act is the most fundamental change to the law on adult social care for more than two decades, providing a new legal and policy framework for care and placing a new emphasis on wellbeing and prevention. It will have far reaching implications for the whole sector.

At the same time, the £3.8bn BCF has been established to create a single pooled budget that will incentivise the NHS and local Government to work more closely together. Most importantly, it is intended to shift spending on acute services towards prevention and, ultimately, to secure the future of adult social care.

How are these changes playing out at a local level and are they helping the objective of integration?

The Better Care Fund

Since the announcement on the BCF there has been intense activity at a local level in counties to develop joint plans. The CCN told the inquiry that they;

> *"strongly supported the introduction of the BCF and the Government's focus on health and social care integration as part of the solution to the long-term sustainability of adult social care."*

CCN has undertaken extensive research and engagement with the council areas represented by County MPs on the BCF to inform their view. Their May 2014 publication, Delivering the BCF in Counties, argued that the process of developing BCF plans has accelerated collaboration. The evidence suggests it has energised partners and provided a new impetus to work together.

Their survey of member councils showed that the BCF and 'Integration Pioneer' pilots, alongside pre-existing activity and well established cross-sector collaboration, have driven new integration activity. Some 57% of CCN member councils agreed, and a further 23% strongly agreed, that the BCF will help improve health and adult social care integration.[30]

Some evidence submitted to this inquiry supported this view. Several submissions noted that it had provided a new impetus and direction for plans that were already underway. Others said it had brought the key players around the table in a way they had been unable to accomplish previously. North Yorkshire County Council had had a particularly positive experience and reported that as a result of this programme there would be a new prevention service, fast response, joined up falls prevention service and support for dementia in the county. Overall, oral and written evidence showed that with its emphasis on prevention and pooled budgets, the BCF represents a step in the right direction.

The BCF is clearly a welcome catalyst and focal point for integration. Nevertheless evidence to this inquiry suggests that there are still many challenges to be overcome before it can represent a real step towards fuller, faster and more fundamental integration.

Written and oral evidence to this inquiry shows that the potential of the BCF programme is being held back by an over-centralised approach which generates bureaucracy and threatens to scupper local working relations.

While submissions to this Inquiry were broadly

[30] *CCN. Delivering the Better Care Fund in Counties (2014)*

supportive of the objectives of the BCF, they made four main criticisms of the programme:

- Too much central control
- Bureaucracy
- The pressures of the scheme
- Conflicting objectives

1) Too Much Central Control

Most of all, the BCF was criticised for being over-centralised and restrictive for local relationships.

"A one size fits all centralised approach may not reap the greatest benefits and could detract from driving this agenda through local system leadership."
Leicestershire County Council

The most important example of this was introduced to the BCF during 2014. Since the original plans were submitted, significant changes have been made to the BCF, largely as a result of concerns from NHS England that anticipated savings from hospital activity will not be sufficient to cover their contribution to the BCF in 2015/16. As a consequence, Health and Wellbeing Boards were required to revise plans to:

- Agree a target reduction in emergency admissions around 3.5 per cent from anticipated levels for 2015/16, though several local areas have agreed a target that is significantly lower than 3.5 percent;
- Agree the savings that would accrue from such a reduction.

The LGA strongly disagreed with the revisions to the BCF which 'undermine the core purpose of promoting locally led integrated care'.[31]

Evidence to this inquiry supports this assertion by the LGA.

The new expectations were seen as unrealistic and unhelpful to local partnerships. As Dorset County Council told the inquiry;

"Change in emphasis in June on avoidable admissions and short timescales to resubmit and funding not transparent, this has not helped local relationships LA - CCG and substantial financial risk to Adult Social Care and County Council"

In many areas this has undermined working relationships and damaged the deliverability of the scheme. Kent County Council said that up until the latest proposals, the earlier incarnation of the BCF had been far more capable of integrating health and social care budgets over the next five years:

"This new guidance for 'pooled budgets' under the BCF identifies discrete elements of the budget that are reserved for mitigation of risks within the NHS system (excluding social care) and destroys the principle of a properly constituted pooled budget that can be applied through agreement of the parties concerned. It is now therefore rendered incapable of being built upon to deliver fuller integration and another arrangement will need to be devised."

Others noted that the new incentives under the new BCF arrangements are unhelpful. Gloucestershire County Council commented that the new drivers are 'not conducive to blame free partnership working'.

Worst of all, these changes have undermined efforts to work together more closely outside

[31] LGA. Adult social care funding: 2014 state of the nation report (2014), p. 26

the BCF scheme. Oxfordshire County Council said:

"The local impact has been to raise a range of questions around finance and risk-sharing which did not, objectively, need to be addressed at this stage of our integration journey, putting at risk the substantive progress being made on the ground outside of the central Government framework."

Any proposals to extend the scope of the fund should allow more local flexibility, reforming the centrally imposed performance management framework so that local organisations can work together freely to use the resources at their disposal. As Hampshire County Council put it, the Department of Health should stop making changes to the BCF framework and '*allow councils to get on with it'.*

2) Bureaucracy

'It is now an even more bureaucratic process and an onerous expensive assurance system for a disproportionate amount of money. All of this suggests local authorities cannot be trusted with NHS money. The BCF should have been top sliced from the budget and allocated as new money. As this isn't the case, local authorities will be left to decommission NHS services in order to create financial capacity for change and innovation and accordingly carry the blame.'

Gloucestershire County Council

The evidence to the APPG suggested that the BCF can rapidly become a very bureaucratic operation in a two-tier county.

Nottinghamshire County Council has seven district/borough councils, six CCGs, three Acute Trusts and two NHS Local Area Teams. BCF has the task of bringing this all together, but as a result of this complexity has had to split the county into different planning areas. There are now 26 separate schemes in place to meet the BCF requirements.

Lancashire County Council welcomed the urgency and focus the BCF brought with it, but said that *'BCF has been seen in some respects as an additional burden, duplicating much of what is included in CCG and Local Authority plans'. They added that 'BCF has probably not been designed with due consideration for county/NHS complexity, as it assumes a level of collaboration between NHS organisations that is not necessarily evident'.*

Some councils expressed a concern that dispersed accountability means that no one takes the lead. Robust governance is needed, which is difficult given the number of schemes in operation.

3) The Pressures of the Scheme: No new money and short timescales

The BCF is not 'new' money and is by no means regarded as a sustainable solution to the long-term funding crisis facing adult social care. The recent Capita/CCN survey of 74 County Leaders, Cabinet Members, Chief Executives, Directors of Adult Social Care and Senior Officers showed the extent to which counties held this view.

Some 63% were 'not very confident', with a 15% 'not confident at all' that the BCF, **when announced**, would help meet the financial challenges facing adult social care. When considering its financial impact following recent changes to BCF allocations, the level 'not at all confident' rose to 29%, with 63% remaining 'not very confident'.

The evidence to the inquiry showed that a lack of upfront 'new' funding, alongside limited committed resources as a key driver of such pessimism over the financial impact of the BCF.

With existing contracts and services in place, there is limited opportunity to free up resources within the short timeframes available. There are tight deadlines for getting the scheme in place and for its delivery, leaving little room for meaningful discussion and engagement with partner organisations. Currently there is only security within the funding settlement for BCF for two years. The short-term nature of this settlement has not allowed the NHS and local authorities to share risks and rewards in the way in which would have occurred if longer term funding guarantees been forthcoming from Government.

As Leicestershire County Council commented:

'It is very challenging to undertake a planned shift of activity from the acute sector, investing at the same time in community based services to receive the activity, and achieving this effectively within 1-2 financial years – which is at the core of the BCF.'

4) Conflicting Objectives

Conflicting objectives resulting from funding arrangements and the complexity of local health economies, were evident in submissions to the inquiry. Others echoed concerns about duplication. Each CCG has their own plans, priorities and approaches and these can come into conflict with BCF, which operates on a county-wide footprint.

Kent County Council called for better alignment of national initiatives, which can overlap and work against each other. For example Year of Care, BCF and over 75 funding are all working towards the same aims but not necessarily aligned. Development of a clear integrated health and social care outcomes framework would support this.

People reported a lack of detailed financial information and projected demand analysis, making some of the variables difficult to quantify. Some of the submissions called for a better mechanism to share best practice and avoid reinventing the wheel.

In summary, the BCF has in many cases provided a helpful catalyst for greater integration and offered a supportive structure for formalising discussions between health and social care. But recent changes to the programme have been damaging to working relations in some areas and there is still a great deal of work needed to help the scheme to reach its full potential.

Financial Challenges

Top county leaders say the BCF won't ease the funding pressures on its own.

As originally announced

With modified funding allocations

Few were confident that the BCF would help meet the challenges of adult social care, fewer still after changes to funding allocations.

(Capita and CCN Transforming Adult Social Care Survey 2015)

[32]CCN Statement: http://www.countycouncilsnetwork.org.uk/news/2014/oct/ccn-statement/

The Care Act

Most authorities have welcomed the opportunity to streamline years of piecemeal legislation and the chance the Care Act provides to focus on prevention. But there remained some serious concerns about the funding and policy implications of these changes and how this might affect hopes for further integration locally. As the CCN described to the inquiry;

"CCN strongly supports the ambition and policy context of the Care Act, particularly its focus on personalisation, prevention and early intervention, and the introduction of a cap on care costs of £72,000. However, CCN has always maintained that achieving the ambitions of the Care Act requires a sustainable and fair funding settlement, and secondary legislation to be developed in collaboration with the local Government sector."

Funding

Funding concerns, in the short, medium and long-term for new duties and introduction of 'Dilnot' funding reform from April 2016 continue to be a serious topic of debate locally and nationally.

Despite a joint-cost modelling exercise on 2015/16 costs by the Department of Health, ADASS, LGA and CCN, their remains considerable concern that new duties will not be fully funded. CCN have highlighted a potential funding gap of at least £14.5m just for early assessments during 2015/16, stating after the joint exercise;

"Given this potential funding gap for CCN member councils, and continuing uncertainty over the totality of Care Act costs…. We disagree that that the cost modelling exercise demonstrates the Care Act is fully fund for 2015/16. Based on our engagement with member councils there remains considerable uncertainty over additional costs associated with the new eligibility criteria, advocacy, prisons and safeguarding duties." [32]

The recent Capita/CCN survey showed that 29% felt Care Act duties from April 2015 would increase funding pressures 'slightly', with a further 68% suggesting it would increase them 'significantly'. The financial pressures are seen as even greater from April 2016 and the introduction of Dilnot funding reform, with 80% suggesting it would increase them 'significantly'.

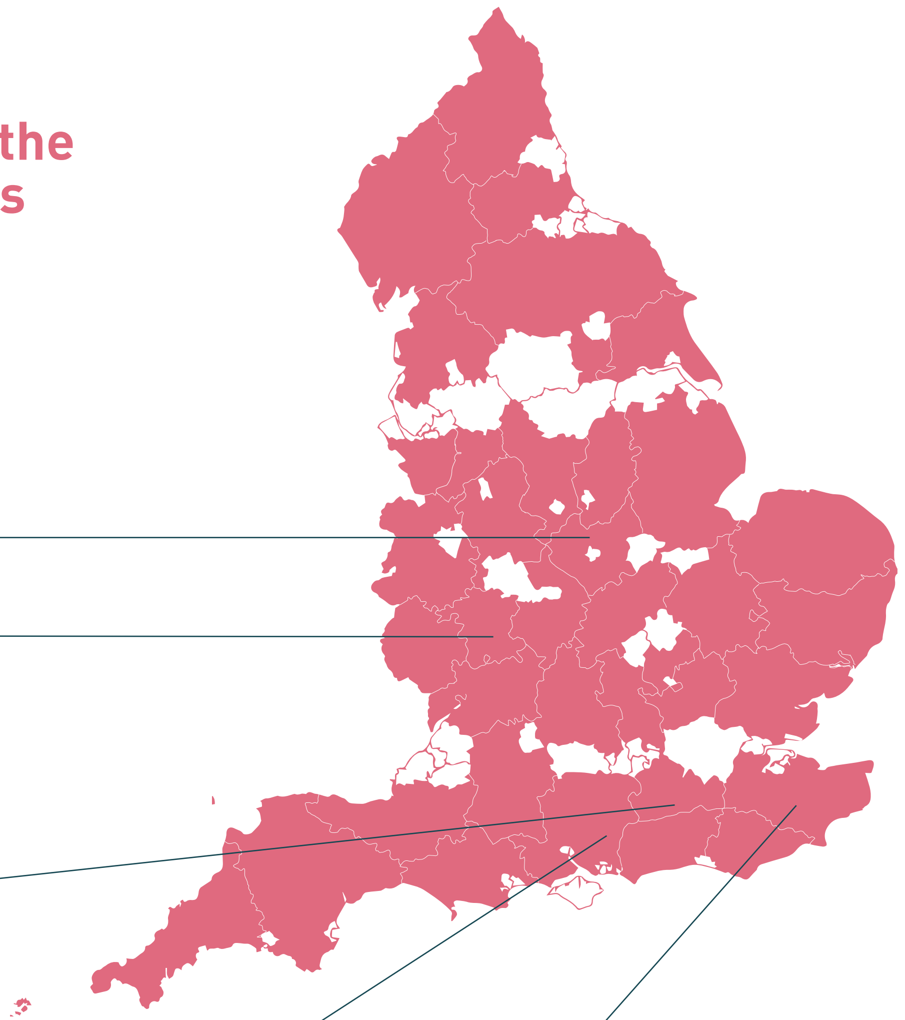
Evidence to the inquiry confirms the view that Care Act represents a significant financial concern for councils. This risk is neither understood nor potentially fully funded in county areas. Map B demonstrates some of the local financial impacts outlined to the inquiry.

People reported a lack of detailed financial information and projected demand analysis, making some of the variables difficult to quantify. Some of the submissions called for a better mechanism to share best practice and avoid reinventing the wheel.

On the same theme, there is again a lack of funding to support councils implement specific elements of the reforms. Rolling implementation funding into the BCF, for instance for advocacy duties and carers, without a ring-fence was seen as a potential problem that would prevent councils from being compliant with the Act.

Government has recently sort to address concerns over carers funding, redirecting £35.2m of total funding for carers. While this was broadly welcomed, there is little confidence, particularly amongst counties, that it will be enough to manage these new demands.

Map B - Implications of the Care Act in County Areas



Leicestershire:

Has calculated that there will be around a **£2m shortfall** in funding in 2015/16 as a result of new responsibilities under Care Act. Complex modeling is underway to establish the impact from 2016/17.

Worcestershire:

Has estimated that the impact of universal deferred payments and early assessments related to the cap on the lifetime cost of care will have an **annual unfunded impact of circa £13m.**

Surrey:

Approximately **75-80%** of all people using social care currently **pay for it themselves**. This will be very challenging when implementing the new cap on care costs, which will bring many of these people into council funded care earlier on.

Hampshire:

Has estimated the **additional cost** of the Care Act reforms to the council at **£92m** cumulative **by the fifth year**. This does not include the cost of care assessments or prison reforms.

Kent:

Have developed a detailed modelling report setting out the likely increases in demand and costs resulting from the Care Act. Costs in 2016/17 are expected to rise significantly, including the impact of the increased capital threshold, to an additional £22.9m. The fact that the Care Act is being introduced over two years means that a steady state of demand, and therefore more predictable costs, is not likely until 2018.

Funding and Policy Changes

County leaders say the Care Act will increase financial pressure.

How the Care Act changes things

97% of respondents thought that Care Act duties from 2015 would increase the funding pressures.

80% thought that changes from 2016 - the Dilnot reforms - would increase pressures significantly

(Capita & CCN Transforming Adult Social Care Survey 2015)

Guidance and Regulations

The ethos of the Care Act, with its emphasis on wellbeing and prevention has been strongly welcomed. It brings together years of piecemeal social care legislation and offers an opportunity to move forward with a clearer legal framework. But as Buckinghamshire County Council told the inquiry, there remains uncertainty over how Policy Changes will impact locally:

"The Care Act will produce some real benefits for service users, carers and communities; this is welcomed in Buckinghamshire but effective implementation presents real challenges and additional burdens for the local authority and its partner agencies."

Recent consultation responses on secondary legislation raised a number of concerns on specific parts of 2015/16 regulations. These ranged from the practical implication of

the 'wellbeing' principle, safeguarding and advocacy duties, charging, and deferred payments.[33] Of particular concern for county areas was the specific issued raised in relation to new prison duties and national eligibility criteria. These were widely regarded as potentially producing added complexity and additional costs for local authorities, impacting on the wider sustainability of the social care system.[34]

Government has sort to address these concerns through amendments to final regulations and guidance; but the real policy implications will only be known once authorities begin to implement the reforms from April 2015. The formation of a joint Programme Management Office (PMO) by the DoH, ADASS and LGA is providing direct support for councils implementing the new legislation. The PMO support programme and dialogue with counties was welcomed during our CBIG oral evidence session.

Care Market Impact

A growing concern is the Care Act's potential impact on the sustainability of local care markets. Evidence to the inquiry highlighted concerns over 'market equalisation' and the erosion of the cost-differential between privately and publicly funded care.

On behalf of its members, CCN has continuously highlighted this specific policy concern to Government. With higher levels of self-funders in county areas, counties are far-more exposed to any erosion of the cross-subsidy from self-funders gaining access to local authority contracts or changes in purchasing behaviors. Lancashire County Council told the inquiry that due to the Care Act:

"Residential / Nursing Care Home Providers, the uncertainty over future fee levels and the impact on the self- funder market may means new investment will be concentrated".

CCN have argued in their recent consultation response that the impact of the Care Act on care markets could lead to the erosion of the cost-differential between private and publically funded residential care, 'potentially leading to higher local authority care fees, provider failure, or provider exit'.[35] The concern is brought to the fore by a consortium of 12 county council and county unitary authorities commissioning an in-depth market-impact analysis.

The Government recently announced that following the concerns raised by CCN in relation to Section 18(3) 'duty to meet needs of self-funders' would be delayed until April 2016 while the Government undertakes further detailed analysis on market stability.

Submissions to the inquiry emphasised that need for Government to continue to engage with stakeholders in understanding the potential financial impact of the Care Act on local care markets. This includes impact of the Duty to Meet Needs and the Dilnot related aspects of market equalisation, such as the calculation in Independent Personal Budgets (IPBs), hotel costs, and operation of care accounts, which the Government is currently consulting on.

The Care Act and Integration

There was some concern about how the Care Act would influence progress towards greater integration. It is uncertain how well the changes have been communicated to a health audience and other partners, and how

[33] *See Joint LGA and ADASS Response to Care Act: regulations and guidance (2014)*

[34] *See CCN Response to Care Act 2015/16 Regulations and Guidance. (2014)*

[35] *CCN Response to Care Act 2015/16 Regulations and Guidance (2014)*

[36]See CCN Response to Care Act 2015/16 Regulations and Guidance and Joint LGA and ADASS Response to Care Act: regulations and guidance (2014) (2014)

[37]CCN Response to Care Act 2015/16 Regulations and Guidance (2014)

this will affect how their services fit with local authorities.

While the Act places statutory duties on local authorities with social care responsibilities, it does not compel other statutory agencies to contribute to successful delivery of the new responsibilities. This concern has been raised in response the DoH recent consultation, with some arguing that integration needed greater prominence within statutory guidance, and concerns over delayed discharges and the boundary with health services.[36]

What is Market-Equalisation?

The current provider cost model relies on self-funders paying a higher rate, with local authorities able to 'bulk' buy care at a lower rate based upon a fair price for care.

Consequently self-funders cross subsidise publicly funded service users and keep care providers in business. Leaving aside debate on the fairness of this situation, it has become ever more important for providers in the context of shrinking public funding.

The Strategic Society Centre has observed that in the context of the Government's deficit reduction programme, and substantial reductions in local authority budgets, this type of 'cross-subsidy' has increased in importance.

One submission noted that 'the fundamental issue is that the Care Act and the regulations and guidance issued under it are all drafted on the basis of a model of social care as a separate activity with its own rules, which cooperates with, but isn't in any serious sense integrated with, the NHS.'

For example, there is no reference anywhere in the Care Act guidance to the possibility that a needs assessment could be carried out by a community nurse. This has been happening for many years in some localities, but could be hampered by the prescriptive nature of how assessments must be carried out under the new Act. If this is the case then parts of the Act may be inadvertently responsible for promoting fragmentation rather than integration.

Of particular concern for county councils, was the partnership role with district housing services and wider wellbeing services.

CCN has previously argued that this area of Care Act guidance was weak and poorly drafted, indicating a failure to ensure sufficient collaboration between local authority tiers will significantly holdback the integration principles and duties introduced by the Care Act.[37]

Others, including Buckinghamshire County Council, supported this view in their evidence:

"The [Care Act] guidance could be strengthened in relation to its relationship with the wider 'whole-system' approach to prevention, its links to the built environment, and the promotion of individual wellbeing".

In line with our analysis in section one and four, the role of good quality housing, sheltered accommodation, DFGs and wider health and wellbeing services has been identified in all our evidence as essential to ensuring successful integration under the Care Act. However, this may create some organisational challenges in two-tier areas.

Summary of Section: Key Points

Both the Care Act and the BCF represent a move in a generally positive direction. The BCF is a welcome catalyst for integration and the Care Act brings together years of piecemeal social care legislation under a more coherent legal structure. However, there are some aspects of both that could potentially threaten integration if they are not resolved.

- The BCF is too heavily centralised and bureaucratic, timeframes and funding are too tight, and recent changes to the programme are undermining local working relations.
- The Care Act creates substantial new financial burdens for local authorities, which are currently unfunded. Achieving the ambitions of the Care Act will require supporting secondary legislation to be developed in collaboration with the local Government sector.
- The impact of the Act on care markets (and particularly the erosion of the cost-differential between private and publicly funded care) needs to be considered more carefully.
- Some of the Act guidance does not adequately consider how it joins up with the move to greater integration between health and social care.

SECTION 6

The Future

This inquiry set out to investigate whether integration was the answer to the historic challenges facing health and social care services in counties; a dilemma of epic proportions that must be tackled by public policy makers across the political spectrum.

In response, **this inquiry concludes that integration is the only sustainable answer to the long-term provision of health and social care services in county areas.** Although integration may be the answer, this inquiry also concludes **that both incremental and more radical change is needed to drive forward the integration agenda in county areas.**

As we head toward the General Election in May 2015 political parties will be setting out their plans for health and social care reform. Thus far, while the Conservatives, Labour and Liberal Democrats have committed to strengthen the integration agenda, there remains a lack of clarity of how they will implement this shared agenda across all local areas.

Whoever the incoming Government is in May, they must learn from lessons described to our inquiry and acknowledge the challenges articulated in the evidence presented. Most importantly, they must embrace the vision and recommendations outlined in this final chapter.

What does a vision of Integrated Care and support look like in county areas?

The evidence to this inquiry described a vision for health and social care that was both seamless, and person centred, with prevention and independence at its heart. It must be **localist** in its nature, focused on empowering rather inhibiting local partners in driving forward innovation. Crucially, it must be built on achieving better outcomes for individuals, be financially sustainable and also incentivise efficient service delivery across local partners.

The twin drivers of an ageing population and shrinking budgets are making the current system unsustainable in county areas. The changes brought in by the Care Act will reform and consolidate the legal structure of adult social care, but may potentially exacerbate underlying financial pressures for some councils. The BCF will undoubtedly progress local integration, but does not provide the silver bullet for integration.

A crucial part of the integration solution must relate to managing demand for services. Almost all the submissions to the inquiry talked of creating more flexible services that promote independence, early intervention and community-based services that recognise the latent potential for communities and people to care for one another and that manage expectations.

It is also clear that integration **should not** mean full structural integration, whereby social care becomes part of the NHS. Structural integration can lead to wasted energy, additional and unnecessary cost and managerial loss of focus.

There is strong support for other forms of integration including pooled budgets, joint-commissioning, colocation, shared management structures, and inter-disciplinary teams. **This might look different from area to area, but establishing a single point of access for service users and better community care options** should be the ultimate goal for residents.

We believe that there are a number of reforms that could be enacted by an incoming Government ***immediately*** that would help local partners to better implement these policy changes and upscale integration activity currently taking place with the BCF and Integration Pioneers;

- **Reforming the funding of adult social care and reviewing entitlements.**
- **Shifting incentives by reforming the NHS Tariff System**
- **Supporting an integrated workforce**
- **Providing better financial modelling and Return On Investment (ROI) tools**
- **Improving Data Sharing & IT**

However, our inquiry has also shown that while these reforms will allow local authorities to upscale existing integration, in many areas it will not address more fundamental issues associated with an over-centralised health service, under-investment in preventive services and fragmented local provision. It will also not exploit the potential of ambitious localities willing to come together to join-up and integrate services in new innovative ways.

The future of an integrated system will mean those **county** health economies *able and willing to do* so coming together to **deliver a devolved, decentrialised, locally-led health and social care system.**

Funding Reform & Entitlements

The evidence presented in section one illustrated the unsustainable nature of adult social care funding. The situation is particularly acute in county areas, with a unique set of challenges, including an ageing population and historical under-funding placing additional strain on local services.

All political parties have indicated that they will implement significant reductions in public spending during the next Parliament to continue to reduce the national deficit. All major parties have also committed to exempt the health budget from cuts, committing to real terms increases in spending.

With health ring-fenced, it is inescapable that local authorities, including adult social care departments, will need to continue to find efficiency savings independent of further policies to integrate health and social care.

However, **the social care funding system can be made more sustainable, and importantly,** fairer. It is clear that the 2015 Spending Review must address the long-term viability of social care funding, providing a settlement that is sustainable over the long-term. This must include adequate long-term funding to implement Care Act duties from April 2016.

The evidence to this inquiry also demonstrated that the distribution of adult social care funding via the Relative Needs Formula is both outdated and regressive.

County councils currently receive four times less funding per head of population (+75). With the Care Act introducing new patterns of demand, which are more closely related to affluence and age than deprivation, it has become even more urgent that the formula is replaced with a fairer allocation system.

In addition to sustainability and fairness, an

incoming Government must conduct a review in the difference in entitlements between health and social care services.

The fact that NHS interventions are free at point of delivery while social care is heavily means tested is an obstacle to integration. Continuing Healthcare means that someone can transfer across to social care and suddenly be required to pay for a service they were previously receiving for free. This creates confusion for service users and acts as an impediment to integration. A closer entitlement across health and social care would be beneficial, but would need to be funded centrally.

Personal health budgets may provide an opportunity to integrate health and care provision and combine or align key processes and systems while also simplifying funding streams for service users.

Recommendations

1) As part of the 2015 Spending Review the Government must conduct a full review of the sustainability of adult social care, including allocation formulae and with a particular focus on rebalancing the allocation older persons Relative Needs Formula (RNF) per head of population.

2) The Government should establish an independent cross-party commission to look into the disparities in entitlement between health and social care.

Shifting Incentives

Providing sustainable and fairer funding must be accompanied by a shift in incentives across health and social care. We need to realign incentives in the NHS to support the shift towards prevention and upstream investment described in the Care Act.

The tariff based rewards system in the NHS currently provides no incentive for health providers to try and reduce demand on their services. As a consequence, hospitals consume a far greater proportion of local resources than should be the case.

Changes are needed to the current rigid NHS tariff system to enable commissioners to buy packages of integrated care based on outcomes across care settings and to reward achievement against outcomes rather than activity. This also relates to the need for a shared outcomes framework outlined below.

Recommendations

3) In partnership with Monitor, the Department of Health should review the NHS tariff system with a view to removing perverse incentives for local integration. This should include consideration of how the 'recovery, rehabilitation and reablement' (RRR) model can be properly evaluated and extended where appropriate. A payment system should incentivise quality and efficiency, but should also support wider objectives such as joint working.

Supporting an Integrated Workforce

For integration to work we need an integrated workforce. We must break down the silos that exist between workers in health and those in social care and establish integrated professional training for those who work together: social workers, nurses, occupational therapists, physiotherapists and care workers for example. This is particularly important in a

county setting. Large rural locations are more difficult for community based staff who often travel long distances, making the development of a cross-trained, multi-disciplinary workforce with access to effective mobile IT solutions essential.

In future, Primary Care and other community based services will need to be capable of dealing with the greater numbers of more complex patients currently treated within hospitals. To allow this to happen, specialist skills and experience that currenty reside in hospital services will need to be relocated into primary and community care settings. This is not just an issue for clinical services but also nursing and other therapies that simply do not exist within primary care at the moment.

Conversely, acute services will need to include elements of general practice to enable them to understand how patients can best be diverted to more appropriate services outside of hospital. These changes are radical and will pose serious challenges for staff accustomed to working in particular ways.

The development of integrated neighbourhood teams will require new types of worker, with more generic skills to assess, support and help people access health and social care services and link to appropriate community resources. The distinctions between nursing, social work and therapists need to be further blurred, not to lose professional expertise but to dispense with the need for multiple assessments and handoffs.

As a starting point we need to have joined up workforce strategies across health, social care and the voluntary sector at a local level. The biggest impact can be felt through changing practice on the ground by promoting joint working between disciplines and agencies. Developing workforce planning between agencies though challenging, is essential in delivering new models of care.

Commissioning and provider organisations will also need to jointly consider and agree their own training and induction packages for qualified staff to reflect the national agenda. Workforce gaps in key areas such as domiciliary care are having an impact on the whole health and social care system. The issue of the pay imbalance between health and social care needs to be considered as part of a local strategy. Encouraging apprenticeships in care would help to address shortfalls in the workforce.

Recommendations

4) Health and Wellbeing Boards should establish joined up workforce strategies across health and social care to plan an integrated workforce.

5) The Government should support this process by joining up accreditation of professional training for those working on the frontline in health and social care in a national strategy.

Improving Data Sharing & IT

The legal basis for sharing social care data is a major problem for integration. At present, shared data can only be achieved by getting consent on an individual basis from service users. This is costly, time-consuming and results in only partial completion. There must be a statutory presumption to share data between organisations.

The Southend-On-Sea Integration Pioneers have recently submitted an application to

the Confidentiality Advisory Group (CAG) requesting exemption from the constraints of Section 251 of the 2006 Health and Care Act which limits data sharing for risk stratification purposes. With other Pioneers, Worcestershire is also seeking similar exemption. We support this as a short term measure, but in the long term a more comprehensive solution is needed.

Recommendations

6) The Government should pass legislation establishing a legal presumption for the public sector to share data, with an individual right to opt out.

Support for Planning Services

It was clear from responses to the inquiry that more support was needed for financial modelling and return on investment analyses. Many councils have begun to undertake their own analysis of the financial impact of integration and the benefits of upstream investment, but national support would be helpful for the sake of consistency and to prevent local authorities from 'reinventing the wheel'. New mechanisms to share findings across NHS and local authorities partners locally and nationally would be valuable. Both the Local Government Association (LGA) and NHS England will be key in this regard.

Public health teams also have an important role to play in supporting the work of integration. Their expertise in evidence based strategies, promotion of best practice, scenario modelling and effective evaluation could be valuably brought to bear on questions of health and social care integration.

Recommendations

7) The LGA and NHS England should provide national joint guidance on financial modelling and ROI tools for health and social care integration.

Decentralising the NHS - Health & Social Care Deals?

In many ways, the biggest barrier to local integration is the massive disparity between a highly centralised NHS and a localised social care model.

The majority of the money spent locally resides within the NHS. It is not democratically accountable at a local level, its services are less personalised than those in social care and it is subject to far more prescriptive national guidance and legislation.

These are not simply barriers of structure and process, but those of power, money and fragmentation. The focus of power in the NHS is still very much at the centre and this plays out at a local level.

We need a wholesale shift away from acute spend towards community based, preventative solutions, as described in the Care Act.

Many of the reforms outlined above will help achieve this; but agreeing to this in principle and being prepared to take the risk of opening up organisational budgets locally are very different things.

Unless this problem is addressed, health will continue to be organisationally resistant to attempts by social care to shift the emphasis towards prevention.

There are two short-term changes an incoming government could make that would progress all areas in this direction;

- There is a need to better **align settlement periods** for Clinical Commissioning Group and the local authority. The ability to use an underspend from one year in the next allows far greater flexibility at a local level.

- We need to develop **new commissioning frameworks** to promote collaborative working between health and social care. Recent innovations on outcomes based commissioning such as alliance contracting have clearly built on the importance of collaboration, but there are practical constraints on NHS procurement, patient choice and competition regulations. A shared outcome framework for health and social care would go some way to addressing these problems and would help consistent reporting and evaluation of impact.

In the long term, however, more detailed work and policy interventions are needed to overcome how NHS centralisation and local fragmentation is holding back integration locally.

Recommendations

8) DoH should introduce a shared outcome framework for health and social care.

9) DoH and CLG should establish a ten year shared financial settlement for health and social care.

Extending Pooled Budgets

There is a strong case to be made for extending pooled budgets such as the BCF to help to continue to drive integration. However, the pooled BCF pot is very small when the level of time and energy invested in the programme is taken into consideration. It is also evident from this inquiry that the BCF has encountered a number of challenges and will require significant reform to its administration and performance management framework.

In Lincolnshire the value of the BCF excluding capital is broadly £48m in 2015/16 against a total spend across health and social care approximating £1.3bn. They commented that

'frankly the amount of time taken to construct an appropriate BCF submission for £48m could, it might be argued, have been better spent on a larger sum'.

The Coalition Government has recognised the need to extend the concept of pooled budgets, recently launching a consultation on additional flexibilities to include funding for primary medical care within pooled budgets arrangements.[38] We agree that this will encourage greater integration across community health, social care and primary care, but believe that the total funding for pooled budgets must be increased.

In the past, CCN has argued for a pooled health and social care fund of at least £7.8bn by 2019/20.[39] The evidence to this inquiry supports this financial extension within a *reformed* BCF. Reforms should aim to address the criticisms outlined in Section Five.

Recommendations

10) The BCF should be reformed and extended for those councils who choose to continue working in this way. A pooled health and social care fund of at least £7.8bn should be established by 2019/20.

[38] *DoH. NHS Bodies and Local Authorities Partnership Arrangements (Amendment) Regulations 2015: public consultation (2015)*

[39] *CCN (2014), Our Plan for Government 2015-20*

The Next Phase: Health & Social Care Deals

Does the BCF go far enough and can it be the vehicle for truly integrated services? Respondents to the inquiry were sceptical. It remains a **'top-down'** model of change management and approaches the question of integration with a one-size-fits-all solution. In two-tier areas it has become over-complicated and a potential distraction from the real business of integration.

The key finding from this inquiry is that integration will look different from one area to another and the centralisation of the health service needs to be tackled. We can make some progress through a reformed BCF, but it will restrict more ambitious, locally driven, innovation.

A reformed BCF would work for some county areas and should be extended for these councils. But Government, as it is planning in Greater Manchester, must also offer local partners in counties the opportunity to put forward their own local radical plans for devolved health and social care.

In recent years **devolution** has been seen as a potential driver for local economic growth. City Deals have offered local partners greater financial autonomy and new powers over the economy of their city.

But the benefits of devolution go beyond cities, and beyond economic growth. **The crisis facing elderly care is a national priority of equal importance to enhancing economic output and productivity.** Moreover, they are mutually reinforcing; reducing the deficit to support continued economic growth cannot be achieved unless we tackle the escalating costs of health and social care failure.

Devolution holds direct relevance for the integration debate and is at heart of meeting this duel challenge. The more complex the problem, the more we should seek to address it with local solutions, and there are no public policy problems more complex than those facing health and social care at this time.

There is appetite for a more localist approach within Whitehall, local government and the NHS. The NHS Five Year Forward View recently stated that localist approach can improve outcomes and drive efficiency;

> *"to meet the changing needs of patients, to capitalise on the opportunities presented by new technologies and treatments, and to unleash system efficiencies more widely, we intend to support and stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England."* [40]

NHS England Chief Executive Simon Stevens has personally back the idea a 'mixed model' of health economy accountability, where some clinical commissioning groups could delegate responsibilities to local authorities or providers of new care models.[41]

The Government has now acted. Our arguments on the need to pursue **devolved** integration have been accepted at the time of finalising this inquiry report. It has announced its intention to devolve the entire £6bn NHS budget to the 10 local authorities in Greater Manchester under the leadership of an Elected Mayor from April 2016.

If the case for devolution in Greater Manchester can be made where current demand is less acute, geographies and service provision *less* complex and future

[40] NHS England. NHS Five Year Forward View (2015), p. 17

[41] HSJ. Simon Stevens Interview (10 February, 2015)

pressures *less* severe it is absolutely essential the Government turns its focus on county areas following the findings of our inquiry.

With the pressures on health and social care greater in county areas, we must therefore capitalise on the direction of travel and devolve health provision through ***Health and Social Care Deals*** in county areas.

Devolving through Health and Social Care Deals would not solve the underlying funding problem in social care, and would require greater localisation of elements of the NHS, but it would allow local areas to develop their own solutions to their local challenges. **Crucially, it would allow local areas the freedom and flexibilities to improve outcomes and drive savings and efficiencies across local public services.**

Councils (including groupings of councils) and health partners, including CCGs and Acute Trusts, should be invited to suggest their own plans for integration at a local level, based on local need and their own organisational landscape (including health economy boundaries). Deals should build on the proposals announced in Greater Manchester, but reflect the unique nature of local authority and health arrangements in county areas described in this report.

There should not be a one-size-fits all approach, and groupings of councils may need to work together. But Deals should explore the full range of devolved budgets, freedoms and flexibilities to be granted to Greater Manchester for those areas ready and willing to implement radical reform.

If locally designed plans for integration can secure support from both NHS and local authority partners, they should be supported by the Department of Health and NHS England, receiving;

- Devolved funding in the form of a larger, or entire, pooled budget for their area;
- Enhanced powers to strengthen local leadership and democratic accountability;
- More local flexibility to reorganise services, co-commission services, pool resources and join-up services;
- The ability to agree and align funding incentives, targets and performance management;
- And greater flexibility to share and invest efficiency savings across local partners.

Such plans could be inventivised through a pump priming fund, while Health and Wellbeing Boards would need greater powers to commission services and administer a pooled budget in this way.

Greater Manchester could be a trail blazer in the devolution of health and social care. However, given the scale of the challenges facing county health and social care systems described in sections one and two, those county areas wishing to negotiate devolved health and social care arrangements should receive preference over other parts of the country.

Recommendations

11) Local NHS/local authority partnerships in county areas should be invited to bid for greater devolution of health and social care through *Health and Social Care Deals* in the form of;

a) Larger or *entirely* pooled budget;
b) New delivery structures and;
c) Enhanced local powers to commission services.

'Health System Boards'

Delivering a devolved health and social care system doesn't require further top-down structural change or a formal renaming partnership boards; but a *bottom-up* ambition to work together through truly empowered local partnerships. H**ealth and Social Care Deals** can be implemented by maintaining existing organisations and boards, but changing their **remit** so they become *Health System Boards.*

Health and Wellbeing Boards were originally established, in part, to set the health and wellbeing strategy based on a needs assessment. As their functions have developed with the oversight of the BCF, their powers should also change. They can provide accountability in the absence of local *democratic legitimacy* in NHS organisations, an issue which is currently at centre of the English Devolution debate and the role of regions in redesigning public services.

There is huge potential for more powerful Health and Wellbeing Boards to play a central role in coordinating integration and overseeing a shared commissioning strategy at a local level, but they need the appropriate tools to fulfil this function.

Health and Wellbeing Boards should be empowered to hold the integration programme to account and to drive it locally, whether within a Health and Social Care Deal or continuation of a reformed BCF pooled budget.

What tools the Health and Wellbeing Boards require will depend on the functions they need to perform under a devolved Health and Social Care Deal or extended BCF. For example, if they are to hold the BCF budget, they would need delegated authority from their partner organisations, which is not possible at present.

Recommendations

12) Health and Wellbeing Boards should be empowered to hold the integration programme to account and to drive it locally. Health and Wellbeing Boards should be given additional powers to commission primary, secondary and social care services, and empowered to hold budgets.

The functions the Boards perform may well need to differ from area to area. We would argue that the power to both hold budgets and commission services should be made possible for these Boards. It should not be a requirement for them to do either, but the option should be available for those localities which choose it.

Empowering Health and Wellbeing Boards will not mean that CCGs and health providers are replaced or downgraded. As emphasised previously, these proposals go with the grain of both local government and NHS policy making.

In many ways, **this would be the completion of successive Government reforms to put GPs, local commissioners and experts in the driving seat of providing clinically-lead services.**

It will allow local health commissioners and providers to focus on their core aims of providing good quality care and support services, allowing partners to rationalise commissioning, support and back-off functions. Moreover, it will intensify the focus on 'system-wide' services across social care, housing, the built environment and public health, especially across two-tier areas.

Case Studies: How our reforms would help integration

Kent County Council

Kent's Integration Pioneers Programme is a whole system partnership involving Kent's seven Clinical Commissioning Groups (CCGs), the County Council's adult social care teams, the community health trust, mental health, acute sector and district councils. As a Pioneer, Kent is exploring how the barriers to successful health and social care integration can be removed thus delivering integrated services at pace and scale. Local schemes include:

- **North Kent - Integrated Discharge Team:** A multi-disciplinary Integrated Discharge Team with the aim of reducing admissions, ensuring patients are proactively managed to reduce length of stay and to enable patients that are medically stable to leave in a timely manner. Significant results have been achieved including decreasing trends in emergency admissions and reduced waiting times.

- **West Kent - Enhanced Rapid Response Service (ERRS):** The scheme is enabling more complex patients to remain at home through enhanced decision making via a multi-disciplinary team of medics, paramedics and clinicians. Key to the success of ERRS is the collaborative working between health, social care and ambulance services and by providing a fast response to patients.

- **Ashford and Canterbury - Health and Social Care Coordinators:** Supports coordination of activity around multi-disciplinary teams and between GPs and community services. The current service has had over 3,363 contacts, with 1,920 A&E attendances avoided and 1,443 admissions avoided with a cost saving to the local health economy being identified as over £200K.

Building on our successes so far and the recommendations of the County APPG, there would be great value in developing a proposal to the Health and Wellbeing Board to establish joined up workforce strategies across health and social care to plan an integrated workforce. This will help us make a real difference to how people experience local service delivery by keeping the number of transfers between services to a minimum and will support us to manage our workforce more effectively.

The BCF is seen as a key tool in delivering integration and underpins the implementation of the Pioneer programme. To reflect the complex picture of health and social care within Kent, the BCF is built from a local level, with seven area (CCG-level) plans, across three care economies (north, east and west), giving a complete Kent plan.

The Kent vision is to put the citizen at the centre of everything we do, with services wrapped around them providing support when they need it, within their communities.

To support this Kent has signed up to Making it Real[42] which sets out what people who use services and carers expect to see and experience if support services are truly personalised. What would greatly assist our closer working between partners is legislation establishing a legal presumption for the public sector to share data, with an individual right to opt out, as recommended by the County APPG report. Data sharing is one of the most intractable barriers to integration and adopting this approach would support our efforts to overcome this issue.

[42] *Making it Real, Think Local Act Personal.*

Essex County Council

Health and care partners are working closely to pursue integration. The County Council has aligned commissioning directors to each of the five CCGs. An elected councillor also sits on each CCG Governing Body. The Essex-wide Health and Wellbeing Board membership has also been expanded to include representation from Acute Trusts and the provider market.

Progress has been made at integrating commissioning. Essex County Council holds the budget and leads for commissioning learning disabilities care. West Essex CCG acts as lead commissioner for child and adolescent mental health across Essex, compared with the previous position of 10 separate commissioning leads across Essex for Child and Adolescent Mental Health Services.

Essex has chosen to focus much of its BCF Plan on developing integrated pathways for frail, older people and developing multi-disciplinary teams of professionals based around GPs with a lead accountable professional who will be their key contact and the person who co-ordinates all their care needs.

However, Essex believes that policy change is needed not just to make integration easier (after all, integration is just a means to an end) but also to lock in a sustainable health and social care system for the future.

Essex CC published A Shock to the System: Saving Our Health and Social Care in September 2014 setting out the five key actions we believe the next government must take to put health and social care onto a sustainable footing and to aid the process of integration, which include:

- Allocate 10 year, place-based funding settlements to local areas for health, social care and public health. In Essex, this would be worth £3.5bn a year.
- Empower local Health and Wellbeing Boards to hold the place-based budget for an area and set strategic priorities and direct the commissioning of health and social care.
- Reform the NHS tariff system to incentivise prevention and align financial incentives for providers with health and social care outcomes for individuals.
- Introduce a legal presumption to share data, with safeguards.
- The need for a sensible national conversation about what a universal service offer should look like, about how eligibility for health and social care services could be more aligned, and about how it could all be paid for.

We believe taking these five steps represent a focused programme of action for the next Government towards a more integrated and sustainable health and social care system.

The APPG's call for a full review of the funding allocation formulae with a particular focus on rebalancing the allocation of older persons Relative Needs Formula (RNF) per head of population will be particularly important if adult social care is to have a sustainable future and one that reflects the specific pressures that counties are under.

Local areas cannot tackle the fundamental problems confronting the health and social care system alone. Local Health and Wellbeing Boards and local councils simply do not have the legal authority to make the fundamental changes that may be required. It's time to start getting honest about the structural weaknesses in our health and social care system.

Lincolnshire County Council

In times of crisis people need access to the right care at the right time, without having to provide duplicate information. We have identified from users of the services in Lincolnshire that there are multiple access points in the system and multiple forms to complete. This causes confusion for both professionals and patients alike. As a result, care has been fragmented and uncoordinated.

Neighbourhood teams consist of key health and care professionals; GP, Social Worker, Community Nurse, Community Psychiatric Nurse and the Independent Living Team (Physiotherapy and Occupational Therapy). Neighbourhood Teams have provided the platform to enhance links to wider community services, such as, St Barnabus, Age UK, Care Providers, Carers organisations, District Councils and others. However, it has proven challenging due to the quantity of organisations involved, which all have separate policies, protocols and processes.

Lincolnshire has recognised that to support the development of an integrated approach, co-production and delivery is necessary, especially with regards to the workforce. As a result a workforce plan is being developed collaboratively with partner organisations across health and social care. One aspect of this is the co-development and delivery (by Lincolnshire County Council (LCC), Lincolnshire Community Health Services (LCHS), Lincolnshire Partnership Foundation Trust, United Lincolnshire Hospital Trust (ULHT) and primary care, of an organisational development plan for Neighbourhood Teams. The purpose of this plan is to develop the necessary culture, behaviour change and leadership capabilities of staff. This is required to embed joint working, a shared understanding of the complex organisational pathways and to coordinate work demand.

Consent and data sharing has also been a major issue for organisations and one which has been raised specifically from an operational perspective. Extensive work has been done to develop a joint consent form. However, this could not be agreed due to the requirements of individual organisations. To work around this, a joint consent process has been developed to recognise individual difference, including how data will be shared. National policy change would give organisations the confidence and capability to share data, knowing that they would not be in breach of any legislation.

Short term benefits of neighbourhood teams in Lincolnshire include an improvement to working relationships and referral processes between the organisations, shared knowledge and skills transfer and joint assessments and visits where appropriate. The long term benefits of Neighbourhood Teams will see a whole system reduction in non-elective admissions, fewer people attending accident and emergency and a reduction in emergency readmissions.

Working in this new way, having shared information systems and producing joint assessments (especially for those who are at high risk), has provided the opportunity to have a multi-disciplinary team who can support each other in their core activities. By proactively identifying a cohort of people, (either by risk stratification, adult care vulnerable person modelling tool or professional judgement) before they become high risk, appropriate services which offer the opportunity to self-care can be put in place.

Worcestershire County Council

Worcestershire has a five year strategy to integrate and improve health and care. A key part of the strategy is the development of pooled budgets for the care of the highest risk individuals and commissioning of 'end to end' services from a multidisciplinary community provider. Provision will be built around general practice, as the most natural point of contact for local people, and include an extended range of services including social work, community nursing, specialist and voluntary and community sector support . The recommendations of this APPG inquiry report synergise with our challenges and experience in a number of ways:

- Local government funding has fallen, which has resulted in reduced expenditure on adult social care at a time when demand is rising. A review of the sustainability of adult social care will help ensure that we have sufficient funding across the health and care system to resource our new model.

- A ten year settlement would be very welcome. We are embarking on a huge change in services and a period of stability would help give us the confidence to make these changes.

- We are working on mechanisms for pooling budgets, and any national support to this including extension of the BCF and development of new ways of devolving budgets would support our local work.

- We are also using risk stratification and population segmentation to identify the highest risk individuals who would benefit most from integrated care and support so that we can focus our efforts on this group – again national support for this would be welcome.

- Further we intend to develop a capitation approach with commissioning of services from an integrated provider/ collaboration of providers on the basis of outcomes, quality and with a shared financial 'risk and reward' approach. A review of the current NHS payment tariffs would help us eliminate the current perverse incentives and shift more resources into prevention and community based care.

- One of the barriers we are experiencing at the moment is sharing of data, due to the current information governance restrictions. We are working with cross government departmental teams to resolve the issue but legal reform to facilitate data sharing would help us to identify and focus on the people who need services the most.

- We recognise the need for planning a new workforce to meet the care needs of the future and would welcome a greater role for the Health and Wellbeing Board in strategic workforce planning and joining up of professional training for frontline staff.

Jonathan Carr-West, Chief Executive, LgiU

Progress towards health and social care integration has been uneven across the country. In Manchester we have seen a commitment that the £6bn health and social care budget for Greater Manchester will be taken over by regional councils under devolved NHS powers, in a plan that will come into force from April 2016.

It's encouraging that the Government is recognising that big challenges like health and social care integration can only be solved at a more local level. One of the key messages to come out of responses to this inquiry is that the highly centralised nature of the NHS acts as a barrier to better integration of health and social care locally.

But it raises a serious question – if this approach works for Manchester, then why not for other parts of the country? The pressures on adult social care and health are much greater in counties than in a city region like Manchester, as this report reveals.

Counties provide a home to far greater number of older people, and they receive a far smaller proportion of the funding per head of population. Their organisational landscapes are also much more complex and sit less comfortably under a top-down integration programme like the BCF.

More local control of pooled budgets would cut through some of these challenges and allow more locally tailored responses.

Strong governance arrangements are a must, but this comes best from local leaders, and responses to this inquiry show there is a lot of appetite for more local autonomy on the health and social care agenda.

Manchester has shown the way – we must take up the challenge and call for similar Health and Social Care Deals to be extended to county regions. The recommendations in the report only mark the starting point of what we hope will be a transformative discussion.

Appendices

Written Evidence

County Councils
Buckinghamshire County Council
Essex County Council
Hampshire County Council
Hertfordshire County Council
Kent County Council
Norfolk County Council (incorporating views from Norfolk and Suffolk Foundation Trust, Norfolk Community Health and Care NHS Trust and Norwich CCG)
North Yorkshire County Council
Nottinghamshire County Council
Worcestershire County Council
Dorset County Council
Cumbria County Council
Gloucestershire County Council
Lancashire County Council
Leicestershire County Council
Lincolnshire County Council
Oxfordshire County Council
Staffordshire County Council
Surrey County Council
Warwickshire County Council
West Sussex County Council

County Unitaries
Cheshire West and Chester Council
Wiltshire Council

District Councils
Blaby District Council
Castle Point Borough Council
East Lindsey District Council
King's Lynn and West Norfolk District Councils
Mid Sussex District Council
North Yorkshire District Councils (Joint Submission)
Pendle District Council
South Norfolk District Council
Tendring District Council

Partner organisations
Chartered Institute of Housing
County Councils Network
District Councils Network
Lincolnshire Health and Care
Royal College of Physicians
South East Strategic Leaders, South East England Councils and South East Councils Adult Social Care
Skills for Care

Oral Evidence

County APPG Roundtable, 14th October 2014
Care Bill Implementation Group (CBIG), 14th November 2014

APPG Members

MPs
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Mr David Ruffley, Bury St Edmunds, Conservative
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Mr Ben Wallace, Wyre and Preston North, Conservative

MHL
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The Lord Berkley OBE, Labour
The Lord Liddle, Labour
The Baroness Howarth of Breckland OBE, Crossbench
The Lord Ahmed, Non Affiliated
The Lord Walpole, Crossbench
The Lord Best OBE, Crossbench

CountyAPPG
COUNTY ALL PARTY PARLIAMENTARY GROUP

The Secretariart of the County APPG is provided by the County Councils Network (CCN). CCN is a cross-party Special Interest Group of the Local Government Association (LGA) representing 37 county and county unitary authorities in England. Its members represent 47% of the English population and cover 86% of its landmass.

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