CIPFA BRIEFING

April 2015

moving ahead with integration

With health and social care finances under increasing pressure and little sign that the government can afford to pump in the additional resources which would be needed to maintain historic arrangements, the integration of health with social care has emerged as the great hope across all political parties. However, local health and social care providers don't yet have a secure basis for medium-term planning, and without that there is a danger that the promising start represented by the Better Care Fund, devolution initiatives and pilots linked to the five-year forward plan for the NHS will be dissipated. If the best is to be made of such integration, CIPFA thinks that three conditions will need to be met:

- First, whichever government emerges from the forthcoming election, it will need to recognise that combining two financially challenged systems will not in itself increase resources available. All the indications are that additional funding or changes to the regime for charging will also be needed
- Second, it is critical that the new government moves quickly to address the financial and policy framework for integration in 2016-17 and beyond.
- Third, central and local health and social care leaders must take the right local actions to facilitate successful integration, concentrating on frontline practice.

CIPFA The Chartered Institute of Public Finance & Accountancy

What and Why?

The Nuffield Trust[1] states that 'Integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved coordination. Integration is the combined set of methods, processes and models that seek to bring this about'. For some years a professional and political consensus[2] has been building that health and social care tends to be too fragmented, that services are too influenced by professional and institutional boundaries when they should be coordinated around service users' needs.

The background to that consensus is the ageing of the population: ONS estimates[3] that the proportion of the population aged 65 and over will increase from 17.6% in 2014 to 27.1% in 2064. The over 85's, the primary users of health and social care services, are set to double to 3m over the next two decades, and there are a rising number of people of all ages with long term conditions (some 17m), many of those with multiple conditions (3m and rising rapidly). They need to be dealt with in a joined up way, which is best achieved through an integrated care pathway.

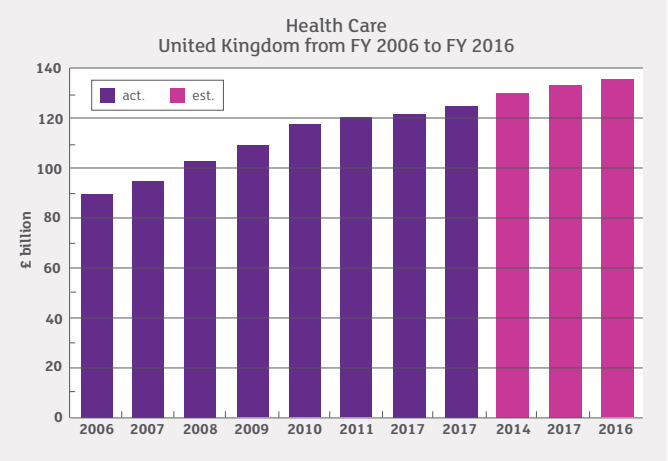
It is also widely hoped that integration will improve efficiency, either saving money or – more feasibly – allowing more needs to be met or better quality provided from the existing budget. The challenge is emphasised in CIPFA's election manifesto[4], which notes that by the end of 2013/14, just 46% of the government's consolidation plan had been achieved. During the next parliament, people will – unusually - be seeing economic growth alongside substantial, sustained cuts in public services. The Government has added to the scale of the task by introducing such high-cost plans as tax-free childcare and the Dilnot reforms to social care, funding which will require yet more cuts elsewhere.

Will integration make a major contribution to the savings needed? The evidence to date is unconvincing: the University of York's comprehensive international study[5] failed to show any financial benefits, but there is obvious potential, just as there is behind the wider recession-driven moves to combine and align public services. The efficiency goals are typically to streamline processes, avoid multiple collections of data and hand-offs of tasks, gain economies of scale – particularly in procurement - and rationalise estates.

In practice, it has not been easy to integrate successfully. There has often been an over-concentration on organisational structures along with lack of front line change; there can be conflict between national targets and locally agreed benefits; there are problems in sharing patient based information; the NHS tariff system does not feel fit for purpose and drives perverse incentives; regulators tend to take an organisational view rather than looking at the whole system. All this makes achieving clinical and financial sustainability even more challenging.

The Financial Challenge

Those savings hopes are driven by the financial context. Both health and social care are likely to need some 3-4% real terms growth per year to deal with demand pressures and the costs of new medical technologies. Health funding increased by 0.8% per year on average under the coalition: a protected position, but still a severely challenging one, especially if compared to the growth by a third during1995-2008. That pressure is fed through to the large number of trusts currently projecting a deficit, and was reflected in Sir Simon Stephens' conclusion in the five-year forward view that £30bn of savings were needed, but only £22bn were achievable by 2020. CIPFA consider that even that position is an optimistic one. Former NHS Chief Executive David Nicolson opined recently that the NHS faced "serious short-term financial problems" such that the £8bn boost needs to be "frontloaded" by being brought into effect from this year rather than merely made an ambition for five years' time[6], while a King's Fund survey of NHS finance directors found concluded that the £22bn was unlikely to be delivered.[7]

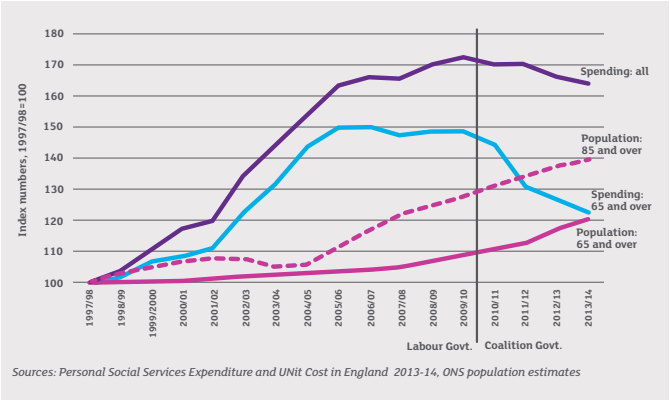


Trends in health spending 2006-16[8]

Local government has seen a 40% reduction in government support over the parliament just ending, and although there has been some protection for social care – which has increased from 30 to 35% of total local government spend – local authority spending on social care for older people has fallen in real terms by 17% at a time when the number of people over 85 has increased by 9%. The consequence has been that the number of people receiving publicly funded social care has fallen from 1.7m to 1.3m. The regular surveys carried out by the Association of Directors of Adult Social Services (ADASS)[9] show that directors feel gloomy about the future, with the sharp pace of adult social care savings projected to continue. Looking ahead:

- some 50% of directors think that fewer people will be able to access care services
- a similar proportion believe that people will get smaller personal budgets
- over a half think care providers are facing financial difficulty, and
- 60% think there will be increased costly legal challenges.

Local Authorities are also troubled by the current uncertainties around the funding for the responsibilities in the Care Act.



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

Growth in population and changes in spending on adult social care, 1997-98 – 2012/13[10]

Three conclusions can be drawn from these mutual financial difficulties. First, it makes little sense for either health or local government to agitate for a greater share of the cake on the grounds that they are unfairly disadvantaged. Second, financial difficulties may make collaboration harder, eg if local authorities have to carry on factoring in reductions in social care spend, this could make health partners feel they are bailing out social care. Third, given the interrelationships between the services, it is important to take a whole system view[11]: reduced spending on social care increases the pressure on health just as failing to provide people with the health and support they need in the community feeds through to increased needs in social care.

The Government's Response

The Government, recognising the problems and the financial position, has taken forward policies designed to improve integration – principally the Better Care Fund, but also:

- The introduction of *Health & Well-Being Boards* has brought together local authorities - representing social care, public health and housing - clinical commissioning groups, health watch and other relevant players chosen locally. They are expressly designed to assess the local population's needs and develop a joint strategy which promotes integration of services. Their role is, however, to set overall direction rather than determine the allocation of resources and as the King's Fund[12] has concluded that 'the impact and influence of Health & Well-Being Boards so far has been variable and generally limited'.
- The *pilot arrangements* to test various approaches linked to the integration agenda. 14 areas were named as integrated care 'pioneers' at the end of 2013, with a further 11 added a year later. The King's Fund concludes, though, that 'early evaluation suggests that it is too soon to tell whether the pioneers will be able to act as role models for the rest of the health care system'. More recently, the government has set up 29 'vanguards' to test out new models of health care stemming from the five year forward view, and these also address related agendas around integration and personalisation.
- The *Care Act* 2014 places a duty on local authorities to promote the integration of care and support services with health – as well as making many other changes which will directly and indirectly affect the integration agenda in practice. However, the uncertainties around funding for their new responsibilities under the Act are causing concern among local authorities in terms of the impact on their longer term financial planning.
- The new development with most recent headlines has been the announcement of a memorandum of understanding, as approved by the Chancellor and the Health Secretary, to devolve responsibility for health and social care spending totaling £6bn to Greater Manchester. Building on the NHS five year forward view, NHS England invited all the local authorities, CCGs and NHS trusts to develop plans for integration. That represents a radical step in the direction indicated by the previous Total Place and Community Budget initiatives, which sought to obtain better value across total public spending by joining it up. 2015/16 will be a transitional year as the details of collaboration behind the headlines are sorted out with a view to implementation from the following financial year.

As a group, these represent promising new directions, but the evidence is awaited of their practical impact and scalability.

The Theory and Practice of the Better Care Fund

The introduction of the Better Care Fund is the most significant and concrete of the Government's initiatives to encourage integration. The Committee of Public Accounts' report *Planning for the Better Care Fund*[13] summarised how this has panned out to date. The BCF aims 'to deliver better, more joined up local services to older and disabled people to care for them in the community, keep them out of hospital and avoid long hospital stays. Initially the Departments

and NHS England expected savings to come to the NHS from this initiative. However when local plans were stress tested savings of £55m were identified against an initial and initial expectation of £1bn. The Departments and NHS England redesigned the fund and asked local areas to submit revised plans in September 2014. The latest plan suggests that local areas are expected to pool £5.3bn and save £532m in 2015-16.' The Committee was critical of the planning, and unconvinced that the savings identified would be achieved. There is, it concluded, 'limited evidence that integrated care can reduce emergency admissions to hospital and even less than it can save money in the period expected. The Local Government Association has said all along that to achieve the radical transformation desired, saving should not be required at the same time as investment'.

Such criticisms represent no challenge to the goals of the BCF, and it has already pushed the agenda forward by facilitating - indeed, forcing - joint working. The doubts are more around the timing of current expectations, the degree of detailed planning and reporting requirements, the realism of performance expectations and the difficulties in making long-term plans given that the Fund has only been announced for one year. Moreover, the BCF does not provide new money but recycles some 4% of the existing health and social care spending streams into a different framework. If it is to have a transformative impact, funding will have to continue to be directed into this area, and the proportion of the system dealt with in this way will need to expand.

That is where the devolution in Manchester has particular potential. The key is organisations agreeing to prioritise the interests of people in GM as a whole, rather than look first to their own organisation's interests. That may enable 'DevoManc' to tackle the problem that, because we have very top down government in silos, technical periodicity initiatives have been successful whilst allocative productivity initiatives such as 'Total Place' don't get beyond pilots and research. Yet in most financial models across other sectors, allocative productivity saves more money than technical productivity. That plays into another issue which CIPFA has emphasised and which integrated services are more likely to sort: the need[14] to invest up front in the preventative measures necessary to stabilise the long term financial position by creating wellness rather than merely treating ill-health.

The Centrality of Governance

Governance is also critical. The Heath & Wellbeing Board, if used positively, is an important mechanism for achieving the mutual understanding, purpose and coordination needed to make the system cohere. More specifically to the integration agenda, the HFMA / CIPFA publication *Pooled Budgets and the Better Care Fund* and the Department of Health's BCF taskforce work set out key issues[15]. In Manchester, governance will be an important part of discussions in the coming months. It has been decided that the relevant organisations will remain accountable for their existing funding flows and responsibilities: that, then, will set a framework within which to assess what will change and how the governance will enable that. Experience has indicated that it is better to assess the possible concerns and areas of risk and set up arrangements for dealing with potential problems beforehand, rather than looking to sort things when they occur. It is also important to distinguish those risks which arise as a result of the collaborative action (and decide how to share them) from those risks which may be affected by the collaborative actions but are retained in the collaborating organisations (which decide how to mitigate / offset them internally).

Improving the Prospects

Overall, the King's Fund conclude that it is difficult to assess the impact of these integration initiatives, partly because these are long term issues but also because 'the impact of the government's wider health reforms has often pulled the system in the opposite direction to integrated care. In particular, changes made to the structure of the NHS have introduced greater fragmentation to the way that services are commissioned, making it harder to align incentives between different providers'. Over the past year CIPFA has held a series of roundtable discussions[16] - principally with finance directors from health and social care, supplemented by academics and relevant professionals from other disciplines - with the aim of identifying the potential obstacles to successful integration and how those might be overcome. The Roundtables identified issues around attitudes and behaviours, and around systems and policies - but did not suggest there is any fundamental reason why social care and health should not integrate successfully.

CIPFA's position on integration

CIPFA is pleased to see the wide range of complementary initiatives to develop good integration practice. However, it thinks that the new government should:

- take a medium to long term view of the funding required for health and social care as a whole, extending the Better Care Fund beyond 2015-16, but with a more enabling and less rule-driven approach
- not make further changes to the structure of the NHS, but set up financial and commissioning frameworks to incentivise pursuit of the right joined up, whole system outcomes, perhaps by encouraging – but not regulating for – maximum pooling and use of personal budgets; reducing the perverse incentives of the tariff system; and making it easy for local players to sort out sharing information
- ease the rules to facilitate locally driven use of capital receipts in health.

At the same time, the local players need to:

- actively lead system integration and be clear about the governance
- maximise preventative investment, including through the Better Care Fund
- work with CIPFA to improve their mutual understanding of differences in approach, for example accounting arrangements, in order to work together more easily
- equip finance professionals to do the right things in support: participative budgeting, long term thinking, outcomes focus, transparent presentation of the long term effect of decisions; and encouraging, not discouraging, the taking of appropriate risks.

The central and local focus should be on front line experience and the agreed benefits, as these should outlast organisational fashions and restructures. If the BCF is broadly based, it can provide the platform for that.

References

1 'What is integrated care?' at **www.nuffieldtrust.org.uk/publications/what-integrated-care?**

2 The Local Government Information Unit's analysis if the manifestos demonstrates the consensus on integration issues – see **www.lgiu.org.uk/briefing/manifestos-conservative-labour-liberal-democrats**

3 Office for National Statistics analysis of *Ageing in the UK Datasets* at: **www.ons.gov.uk/ons/rel/mortality-ageing/ageing-in-the-uk-datasets/1992---2037/index.html**

4 CIPFA Manifesto at **www.cipfa.org/cipfa-thinks/manifesto2015**

5 Centre for Health Economics: *Financial mechanisms for integrating funds for health and social care: an evidence review.* University of York, March 2014 at **www.york.ac.uk/che/publications/in-house**

6 Interview on Today programme, 15 April 2015

7 As summarised on 23 April at **www.theguardian.com/society/2015/apr/23/nhs-miss-22bn-efficiency-target**

8 From **www.ukpublicspending.co.uk**

9 The last completed annual ADASS Budget Survey of English adult social services was conducted through May 2014, and reviewed by CIPFA. See **www.adass.org.uk/adass-budget-survey-2014**

10 King's Fund analysis of Government and CIPFA data as at **www.kingsfund.org.uk/media_colorbox/13532/media_original/en**

11 The NAO's November 2014 report on *The Financial Sustainability of NHS Bodies* provides more context for this and emphasises the need to plan in light of the impact on the whole health economy.

12 *The King's Fund verdict*, April 2015 at **www.kingsfund.org.uk/projects/verdict**

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

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

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

16 See the summary and essays collected in From Desire to Delivery at **www.cipfa.org/cipfa-thinks/health/roundtable-papers**

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