

Unblocking: Securing a health and social care system that protects older people

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Foreword by the The Right Honourable Alan Milburn



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Foreword



Britain's care system is at an inflection point. Changing demographics and disease patterns – allied to rising public expectations and dwindling public resources – are calling into question the very sustainability of how health and social care is delivered in our country. Muddling through for another five or 10 years will no longer do. Something has to give.

This important report sets out useful proposals to address the problems faced by our health and social care system. It is welcome that the notion of integrating services around the needs of patients and citizens is fast becoming a new orthodoxy in public policy thinking. An older population with a high level of co-morbidities makes a nonsense of the current sliced system of care split as it is between primary, community, acute and social care. So too does the incidence of physical health problems amongst those in need of mental health services. Patients rarely fit the pigeon hole in which they find themselves.

It is time to turn the system on its head by starting with the needs of the patient or citizen. They should not have to fit the care system. Instead, it should be built around the very different needs of individual citizens. We are a very long way from that being the case today. Social care has accountability structures, funding methods, management structures and data systems that are separate from its health care cousin. Yet they are part of the same family of care. It is time to find ways of putting them closer together.

Doing so will not be easy. Change never is. It will require a new clarity of direction and the courage to do things differently. In the NHS, new models of care are now actively being built. But the NHS cannot do it alone. Leadership that is willing to embrace change is needed at every level. That is why it is so welcome that local government – which is busy reinventing and rejuvenating itself – is also stepping up to the plate.

It gives good grounds for optimism that our care system can be reformed and rebuilt.

The Right Honourable Alan Milburn, Former Secretary of State for Health

Executive Summary

It's almost three years since major reform of the health and social care system in the UK. With the NHS facing crisis it's clear there is more to do – this report addresses some of the issues that have recently witnessed in the health service, explores the reasons behind them and argues that recent changes need to go further.

It is older people who are suffering the most from the lack of health and social care integration. They are more likely than any other age group to face unnecessary admissions to hospital, and to experience lengthy discharge delays and poor standards of care – problems that are only likely to be compounded by shrinking health and social care budgets. And these vital issues will become ever more critical as the population of England ages rapidly.

Sadly, this level of poor care for older people is not surprising. The need for integration is well documented and the current model of delivery and service is not fit for the future. If we cannot effect change, the failure to prepare for our ageing population will undermine the many great benefits that longer lives bring to the country. This report looks in detail at the key barriers to change and draws on extensive interviews with health and social care experts from across the country and a survey of more than one hundred local health leaders. Our key findings were:

- The health and social care system still rewards activity – not outcomes, so undermining attempts to focus on the successful management of long-term health conditions.
- In fact, we financially incentivise disjointed care with short-term budgets that inevitably end up being concentrated on short-term pressures in the system, rather than thinking afresh about how to prevent illness in the first place.
- UK healthcare does not do enough to prevent avoidable injuries for older people and is conditioned to keep older people in hospital longer than they need to be there.
- Relationships between partners delivering care remain poor.
- The coalition government has acknowledged some of these problems and we have identified some glimmers of hope with positive examples of health and social care working together.
- It was revealing, however, that we found many on the ground believing that Westminster and Whitehall do not understand care for older people.

Breaking the logjam and making widespread change happen can be done but it's the biggest public service challenge facing the next government. Our key recommendations are:

1. **To shift the blame away from innocent patients** by encouraging the media to stop using the phrase 'bed blocking' and use 'preventable bed occupation' instead.
2. **To better co-ordinate care for the elderly** by introducing single, place-based commissioning budgets for 40-55 year olds (who gain the most from prevention) and care provision of those over 85 (who are the most likely to have complex medical conditions). Also the introduction of a Minister for Older People will ensure that care for the elderly is better coordinated at Whitehall.

3. **To reduce fragmentation of the health and social care system by:**
 - a. making acute trusts a statutory member of Health and Wellbeing Boards to foster local relationship building.
 - b. fast tracking a best practise accreditor to highlight innovative ideas for integrating health and social care.
4. **To provide budget stability and allow for long-term strategic planning** by the next Government committing to a fixed five-year budget. The Government should also review the wider funding mechanisms and set a five-year timetable for complete NHS Tariff review.
5. **To increase the flexibility of primary care** by ensuring that technology and innovation are supported and well documented serving as an example for local areas across the country.

Chapter 1 – Introduction

The need for greater integration between health and social care services has long been acknowledged and accepted, yet very limited progress has been made in transforming the system. After decades of health modernisation and reform, the Labour Government of Tony Blair acknowledged the 'Berlin Wall' between health and social care, calling for its demolition in 1997.¹

Yet, more than a decade and a half on from this declaration, it's clear that our current system is still not working as it should. In recent months NHS England A&E performance has been under extreme pressure, resulting in a deluge of national coverage describing a health and social care system in crisis.

These headlines are indicative of intense pressure across the whole health and social care system. The system is plagued by numerous problems including delayed transfers of care, unnecessary hospital admissions and enormous cost pressures. All of which, we argue, can be traced back to the fact that we do not have a system that considers the full range of an individual's needs. Rather we are stuck with a system that is built upon a stark, disruptive and, in the minds of many, arbitrary distinction between health and social care.

A radical rethinking of services is required in order to provide person-centred, co-ordinated care. However, despite there being widespread recognition of the need for such change, there still exists huge cultural, financial and structural barriers preventing greater integration. And the biggest impact of this impasse is on our ageing population.

1.1 An ageing population

Demand for both health and social care in England is rising significantly. This is partly as a result of an increasing population, but in particular due to the inexorable ageing of that population. Significant and very welcome improvements in standards of living and medical care over the last century have resulted in a higher number of people surviving into old age. In 1948, when the NHS was founded, 48 per cent of people died before the age of 65. Today that figure is down to 14 per cent.² By 2030 it has been estimated there will be 51 per cent more people aged 65 and over in England compared to 2010³ and that by 2037 the number of those over 80 will have doubled to 6 million.⁴

Having an ageing population is a huge asset for the country. It expands the available workforce, and offers a wealth of experience. And while many older people enjoy a well-earned retirement, that often includes other forms of contributing to society, for example through volunteering. Millions of active grandparents also provide hugely valuable support for working families, which also has knock-on benefits of supporting the family and hence wider social cohesion. In 2013 it was estimated that the value of grandparental childcare in the UK was £7.3 billion—up from £3.9 billion in 2004⁵ with one in four working families depending on grandparental care.⁶ Informal childcare provided by grandparents is particularly important for lower and middle income women who may struggle to afford formal care and are less likely to return to work after maternity leave. A report for the Department for Work and Pensions found that 54 per cent of families received regular help from grandparents to provide childcare after the mother returned to work.⁷

1 Department of Health Press Release 97/274. Select Committee on Health, First Report

2 The King's Fund, Making our health and care systems fit for an ageing population (2014)

3 Select Committee on Public Service and Demographic Change, Ready for Ageing?

4 The King's Fund, A new settlement for health and social care (2014)

5 Grandparents Plus, Policy Briefing 04, (May 2013)

6 Department for Education, Childcare and early years survey of parents 2011 (January 2011)

7 Department for Work and Pensions, Maternity and paternity rights survey and women returners survey 2009/2010 (2011)

At the same time, with more people living into old age – many with long-term, multiple or complex conditions – the demand on health and social care services is increasing exponentially. Aside from dedicated social care services for older people, our elders make up a significant proportion of health service users:

- People over 65 account for 80 per cent of hospital admissions that involve stays of more than two weeks, according to the King's Fund. And, as they go on to say, the cost of their stay tends to incur greater costs: "Older people are more likely to stay a long time in hospital, to be moved while there, to experience delayed discharge, and to be readmitted within a month as an emergency".⁸
- People over 85 incur the biggest health and social care costs. They are not just the fastest growing demographic group – the number of people over 85 has doubled in the past three decades,⁹ but they are also those most in need of care – where people under 65 use an average of 0.2 emergency bed days per year, those over 85 use an average of five bed days per year (a ratio of 25 to one).¹⁰
- As the population grows older, ageing-related diseases, such as dementia and Parkinson's disease, are becoming more common and people's needs are more likely to span across the divide between health and social care.

The growth in the older population also coincides with huge spending pressures on adult social care, despite councils' best efforts to protect budgets. Councils spent £14.6 billion on adult social care in 2013/14 – 35 per cent of local government spending.¹¹ As one of the biggest service users, older people in particular will be affected by the cuts. Over 65s currently account for 51 per cent of local authority spending on adult social care.¹² It has been estimated that there has been a growing mismatch between demand and public funding from at least 2005 and that by 2021, the spending gap on adult social care will be between £7 billion and £9 billion.¹³

1.2 Government reforms

The difficulties that this report highlights are far from hidden and the Coalition Government has taken significant steps to better integrate health and social care services. Among the main policies introduced in this parliament are:

- The Health and Social Care Act 2012 radically redistributed the national and local management of public health services, transferring responsibilities for public health budgets to local authorities and creating Health and Wellbeing Boards and Directors of Public Health. This was driven by an attempt to make commissioning more locally-driven and produce better health outcomes, more efficiently.
- After an extensive period of planning and preparation the £5.3bn Better Care Fund (BCF) is due to go live in April 2015. The BCF aims to create a single locally-pooled budget to incentivise the NHS and local government to work more closely together to support hospital discharges and prevent unnecessary emergency hospital admissions.
- The Care Act 2014 will be the biggest overhaul of social care since 1948. Most significantly the Act will cap the amount people will have to pay for care in their lifetime to £72,000 (although with accommodation and food costs not included, it is estimated that only seven per cent of men and less than 15 per cent of women will benefit from the cap¹⁴), and set a national minimum eligibility threshold, with the intention of reducing variation in access to care between different areas. Councils will also

8 The King's Fund, *Making our health and care systems fit for an ageing population* (2014)

9 Office for National Statistics, *Population ageing in the United Kingdom, its constituent countries and the European Union*, (March 2012)

10 The King's Fund, *Making our health and care systems fit for an ageing population* (2014)

11 Local Government Association, *Care crisis will require councils to divert £1 bn from other services* (January 2015)

12 Wiggins, K, "Social care spend falls by 2%" LGC (19th September 2013)

13 Demos, *Commission on residential care* (2014)

14 Institute and Faculty of Actuaries, *How pensions can meet consumer needs under the new social care regime* (May 2014)

have to offer information and advice on what support people will need and how best to plan for their future, clarifying the process of care funding. The Act also aims to raise the profile and wellbeing of carers themselves, in turn promoting better and more person-centred care.

These all mark crucial steps in transforming the way that health and social care is structured and commissioned but they are only steps along the road. As we show in this report, significant issues, in particular challenges to greater integration, persist.

1.3 Report structure

This report incorporates the results from extensive interviews with health and social care experts from around the country, and a survey of more than 100 local health leaders - Health and Wellbeing Board Chairs, Council Leaders and Chief Executives, Directors of Public Health and other senior local government figures.

The report is structured around three key strands:

- Firstly, we consider some of the main symptoms of lack of integration between health and social care services and the negative effects this has on (older) people's experience of the system, including the recent problems with delayed transfers of care;
- Secondly, we examine what the root causes of these problems are; both at a national and local level;
- Finally, we propose some solutions to enhance care provision and set health and social care policy on the right path to greater integration and more effective care.

Chapter 2 – What Are The Symptoms? Or What Are The Problems Facing Older People In Health And Social Care?

We have set the scene, describing a population which is both increasing and ageing, and the pressures that that population places on an already overburdened health and care system. In this chapter we outline the main problems that flow from this confluence of drivers.

2.1 Over occupation of hospital beds and delayed transfers of care

When asking about the key solutions that the health and social care system isn't delivering as it could, the top answer, cited in every case, is the vast number of (mainly older) people in hospital who simply do not need to be there, due to either unnecessary admission and/or being left in hospital when they should be either discharged or moved for treatment elsewhere. 'Bed blocking' – the unfortunate term used in the media that suggests those stranded in hospital are in some way culpable – puts a very significant strain on health services.

Avoidable admissions are not specific to older people alone, with a recent study revealing that 87 per cent of children and young people attending accident and emergency could be better treated in primary and community care.¹⁵ There are also systematic problems. Dr Clifford Mann, president of the College of Emergency Medicine pointed blame towards the '111' NHS phone line. The '111' phone line was designed to relieve pressure on hospitals but he claims it has had the opposite effect. He said that the number of visits to accident and emergency departments rose 446,000 last year. Of these, 221,000 involved people being told to attend by the 111 service, and 222,000 cases were brought in by ambulances dispatched by the service.¹⁶

However the Care Quality Commission (CQC) found the number of people aged over 65 admitted as an emergency with 'avoidable' conditions had seen a substantial increase in five years to 530,000 in 2012/13 – up from 374,000 in 2007/8. During 2012/13 one in 10 of those aged 75 or over was admitted to hospital with potentially avoidable conditions.¹⁷ The picture is even worse for those over 90 with five admitted to hospital at least once as an emergency with 'avoidable' conditions. The CQC go on to say: "These conditions are potentially avoidable because they are manageable, treatable or preventable in the community or could be caused by poor care or neglect, such as pressure sores, bone fractures or dehydration. This suggests GPs and social care services could be working together better."

Another reason for avoidable admissions is a lack of focus on prevention – particularly with regard to falls. The King's Fund found: "Falls are a leading cause

¹⁵ Reform, Fewer hospitals, more competition (March 2010)

¹⁶ Neville, S, "Top doctor links A&E chaos to NHS advice line" Financial Times (14 January 2015)

¹⁷ Care Quality Commission, The state of health care and adult social care in England 2012/13 (2013)

of hospital admission amongst older people and often trigger admission into longer term care. Falls lead to debilitating injuries, loss of confidence, independence". It also noted an "extensive evidence base for intervention to prevent falls".¹⁸ Despite this evidence, however, a survey by the Royal College of Nursing revealed that 70 per cent of people who had been seriously injured following two or more falls in the past year reported that their doctors or nurses had not tried to understand the underlying causes of past falls.¹⁹

Finally the 'always open' nature of acute care has a significant contribution to avoidable admissions. The Select Committee on Public Service and Demographic Change notes that the health system "fails outside working hours on working days. People go by default to a hospital because it is the only part of the system that is open 24/7".²⁰ The inaccessibility of primary care during evenings and weekends is also one of the key reasons why so many calls to the 111 service are directed towards acute care. This has been accentuated by longer waiting times to see GPs—in 2014 the Royal College of GPs estimated that a total of 58.9 million patients in England have waited a week or more for a consultation.²¹

The causes of delayed transfers of care are many and varied, with the case for discharge not always clear-cut. Causes include:

- Awaiting completion of assessment
- Awaiting public funding
- Awaiting further non-acute NHS care
- Awaiting nursing or residential home placement
- Awaiting a care package in their home.²²

18 The King's Fund, *Making our health and care systems fit for an ageing population* (2014)

19 Royal College of Nursing, *Safe staffing for older people's wards* (2012)

20 Annex 13: Health and social care, *Select Committee on Public Services and Demographic Change, Ready for Ageing?* (2013)

21 Campbell, D "Patients' waiting times on NHS 'a national disgrace' - GP leader", *The Guardian* (26 September 2014)

22 NHS England, *Delayed transfers of care statistics for England 2013/14* (May 2014)

23 NHS England, *Delayed transfers of care statistics for England 2013/14* (May 2014)

24 Humphries, R, "The NHS needs more money - but social care does too" (4 December 2014)

25 Williams, D "Exclusive: Delayed transfer rate soars to highest level" (18 November 2014)

26 Williams, D "Exclusive: Delayed transfer rate soars to highest level" (18 November 2014)

27 Age UK, "Nearly 2 million NHS days lost to delayed discharge" (11 June 2014)

28 Campbell, D "Social care problems lead to hospital bed blocking, says Age UK" (11 June 2014)

Data released in 2013/14 by NHS England show that 69 per cent of delayed days in all NHS care settings were attributable to the NHS, 25 per cent attributable to social care organisations and 6 per cent a combination of both. Patients awaiting further non-acute NHS care was the main reason for the highest proportion of delays in 2013/14, accounting for 21 per cent of all delays.²³ It also should be noted that in the last four years the proportion of delayed days attributable to the NHS has risen 9 per cent whilst for social care it has fallen 8 per cent leading the King's Fund to comment that councils have "generally done a good job for the NHS in supporting people to leave hospital".²⁴

What is clear, however, is the huge financial cost of delayed transfers to the NHS. The number of delayed patient discharge days from all NHS care settings has risen 300,000 in the last year alone from 1.38 million in 2012/13 to 1.41 million in 2013/14.²⁵ 62 per cent of these delays in 2013/14 took place in an acute care setting. Based on an estimated bed day cost of around £300²⁶ these delays in 2013/14 in acute care alone equate to costs of more than £250 million per year. Age UK reported that in 2013/14 patients were remaining in hospital on average 30 days longer than necessary (and one day longer than 2010) to be transferred to residential care although this figure is disputed by the Department of Health.²⁷ And with a bed in an NHS hospital estimated to cost about £1,900-a-week compared to £530-a-week typically charged by residential homes, it is clear how greater integration could reduce inefficient spending. So it is not surprising that a King's Fund report found delayed transfers of care to be the second biggest concern for NHS trust finance directors, especially given that the number of delayed patient discharge days is expected to rise further to 1.5 million in 2014/15.²⁸

Clearly this problem is well recognised, and successive Governments have tried various approaches to tackle it. For example, the Care Act 2014 provides that if a local authority, having received a discharge notice from a NHS body, has not carried out the relevant care and support assessments or put the required

package of care and support in place within specified timescales, the NHS body can require the local authority to pay a daily charge.²⁹ Unfortunately, despite this a combination of the numerous systemic glitches we describe in the next chapter and the magnitude of the demographic drivers means that the trends are currently moving in the wrong direction, with delayed transfers of care on the rise.

The latest data shows that the numbers are continuing to rise for all patients. Numbers hit a record high in October 2014 with 96,564 bed days taken up by patients who were fit to leave but could not do so because adequate social care support was not in place. This represents a 20 per cent increase on the 78,487 seen in October 2013. In response to this in January 2014 the Government approved an emergency injection of £25 million to 65 English councils for social care for older people in areas where hospitals have large numbers of delayed discharges.³⁰

2.2 Poor care in hospitals for older people

The otherwise avoidable occupation of hospital beds places greater pressure on services, which in turn exacerbates the chances of receiving poor standards of care. For instance, 23,663 patients in England waited between four and 12 hours on a trolley in A&E in November 2014; a figure that has tripled in the last four years.³¹ This illustrates another of our key findings, a drastic variation in older people's experience of hospital.

No one enjoys being in hospital but the impact on an older person's quality of life can be especially profound. Besides the illness itself, the inconvenience caused and the exposure to further infection due to spending several weeks in hospital can cause great distress and loss of independence for many people.

And, of course, older people, like everyone else, worry about the standard of care they will receive. Cases of poor care in hospitals are well acknowledged with the failings of Mid Staffordshire NHS Foundation Trust being the most renowned example.³² The Government has quite rightly taken the failings at Mid Staffs and elsewhere very seriously, commissioning the Francis Enquiry, one of the key findings of which was the importance of responding to complaints about the quality of care.³³ So it is concerning that recent investigations have found a third of hospitals ignoring complaints for incorrect reasons.³⁴

The Care Quality Commission inspected 50 hospitals to ensure that they were meeting the standards necessary to care for elderly people. Of the 50 hospitals surveyed, only 33 met all the standards. A third of the hospitals inspected had problems including: not carrying out risk assessments, inaccurate monitoring of patients' food and fluid balance, incomplete record filling by staff (for example, incomplete 'do not attempt resuscitation' records).³⁵

Whether it is due to poor hygiene, inadequate feeding, or premature discharge and consequent readmission, many older people experience a much poorer standard of care than they should. The Royal College of Nursing considers one registered nurse to seven patients an appropriate ratio for basic safe care. On children's wards the ratio was one registered nurse for 4.6 patients but older people's wards regularly average one nurse for 10.3 patients. According to a report published by the Royal College of Nursing, older people's wards are already so badly under-staffed that it is "not enough for safe care, let alone good quality care". The report also stated that, "the vast majority of hospitals still have inadequate basic nursing establishments on older people's wards".³⁶

Older patients also face poor outcomes of care. For example, 62 per cent of people with osteoarthritis, the most common cause for disability amongst older

²⁹ Care Act 2014, Chapter 23, Schedule 3

³⁰ Brindle, D, "Councils get emergency £25m for social care to tackle hospital blockages", The Guardian (20 January 2015)

³¹ Donnelly, L and Sawyer, P, "Number of patients waiting on trolleys in A&E triples" (29 November 2014)

³² "Stafford hospital to be sentenced over poor care of diabetic patient who died" The Guardian (21 February 2014)

³³ The Mid Staffordshire NHS Foundation Trust, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive Summary (February 2013)

³⁴ Smyth, C "One in three hospitals ignore visitor complaints", The Times (5 December 2014)

³⁵ Care Quality Commission, "Time to listen in NHS hospitals" (March 2013)

³⁶ Royal College of Nursing, Safe staffing for older people's wards (2012)

- 37 National Institute on Health, What is Osteoarthritis? (Accessed December 2014)
- 38 Royal College of Nursing, Safe staffing for older people's wards (2012)
- 39 The King's Fund, Making our health and care systems fit for an ageing population (2014)
- 40 Alzheimer's Society, The journal of quality research in dementia issue 8 (accessed December 2014)
- 41 Alzheimer's Society, The journal of quality research in dementia issue 8 (accessed December 2014)
- 42 Trigg, N "Quarter of hospitals 'at raised risk of poor care', BBC News (24 October 2013)
- 43 Beckford, M "Elderly suffer poor care in half of NHS hospitals" The Telegraph (13 October 2011)
- 44 ITV News, "1/3 'experienced poor NHS care'" (14 May 2013)
- 45 Demos, Commission on residential care (2014) define: **Care home** is a housing with care setting usually with communal living and dining areas, separate bedrooms, and care staff on site. People living in care homes might be older or disabled people. The CQC defines care homes as offering accommodation and personal care for people who may not be able to live independently. Some homes also offer care from qualified nurses or specialise in caring for particular groups such as younger adults with learning disabilities.' Unless stated, this report will use 'care home' to refer to both residential care home and nursing homes. **Residential care** is all care delivered in specialist accommodation. Residential care therefore includes not only residential care and nursing homes, but also extra care and care village settings, as well as supported living. **Extra care** describes a range of settings where people have their own apartments, set around communal living and dining areas and other on-site leisure or health facilities. These are often in 'village'-style layouts but can also be more widely dispersed within neighbourhoods. **Supported living** describes apartments lived in individually or by small groups of people where care is provided on site – this might be round-the-clock support, or for part of the day.
- 46 Demos, Commission on residential care (2014)
- 47 Demos, Commission on residential care (2014)
- 48 Ipsos Mori, Your care rating 2013 survey (February 2014)
- 49 NHS England, The NHS belongs to the people - a call to action (June 2013)
- 50 ADASS, "Social care services 'unsustainable'" (2 July 2014)
- 51 LGA, Future funding outlook 2014 (July 2014)

people³⁷, said a doctor or nurse had never discussed with them how to keep the condition from worsening.³⁸ As more than two-thirds of hospital patients are over the retirement age the failure to adequately treat and care for older people in hospital has a significant impact on the public purse, as well as on patients' quality of life.

The quality of rehabilitation and dementia care is also dramatically below what it should be. People with dementia on average stay in hospital seven days longer than those without³⁹ and are at higher risk of developing major complications including pressure sores, falls and incontinence while there.⁴⁰ The Alzheimer's Society also claims that statistics show that half of those with moderate dementia who are admitted to hospital with an acute illness, such as hip fracture or pneumonia, will die within six months.⁴¹

The Care Quality Commission's 'Hospital Intelligent Monitoring: 2013' survey found that 44 out of 161 trusts fell into the two highest risk categories; a rise on previous figures.⁴² However, the issue of poor care is not resigned to a single area, cutting across care in hospitals. After carrying out spot checks at 100 geriatric wards, The Care Quality Commission found that 35 hospitals needed to make improvements.⁴³ An ITV News Index carried out by ComRes revealed that 34 per cent of the people polled said that they, or someone they knew, had experienced poor standards of care in the past two years.⁴⁴

2.3 Cases of poor care outside a clinical setting

While much social care is excellent, the media has highlighted a number of high profile scandals. For example, the BBC Panorama documentary exposed mistreatment at Winterbourne View hospital, with police arresting four people. Such scandals have encouraged negative public perceptions of social care. There are various forms of social care. In this report we use the phrase 'housing with care' as defined in a recent report by Demos as care homes, residential care, extra care and supported living.⁴⁵ A survey commissioned by Demos found that only one in four people would consider moving into a care home if necessary in old age, while 43 per cent said that they would definitely not move.⁴⁶ It is also possible that the almost solely negative coverage of the care industry has contributed to people's reluctance to save for their future care (see below).

However, such perceptions do not reflect the norm of social care as experienced by many hundreds of thousands of vulnerable people. In other words there is a significant gap between perception and reality. This perception gap is boosted by the rare but shocking recent failures in care allied to the lack of media interest in the vast majority of those who receive excellent care. For example, while fear of abuse was one of the most commonly cited reasons against wanting to move into housing with care (54 percent of members of the public cited this⁴⁷) a 2013 survey of 20,000 care home residents from 1,000 care homes found that 92 per cent of care home residents said they were happy living in their care home, 97 per cent of residents agreed that staff treated them with kindness, dignity and respect and 95 per cent were happy with the care and support they received.⁴⁸

2.4 An unaffordable system

The financial pressures on councils seem set to continue. The NHS is projected to have a £20bn funding gap by 2020/21.⁴⁹ And despite the fact that the Association of Directors of Adult Social Services (ADASS) survey recently reported that more than £3.5 billion has been saved from Adult Social Care budgets during the past four years,⁵⁰ councils are still facing a £12.4bn funding gap by 2020.⁵¹ This is largely as

a result of spiralling social care costs – the estimated funding gap for adult social care by the end of the decade is £4.3bn (29 per cent of the budget).⁵²

It is clear from these figures that the existing model of health and social care is unsustainable. While pumping extra cash into the system can plug gaps temporarily, it is not a long-term solution. Indeed it may mitigate against a longer term approach, with short-term funding boosts inevitably going to be directed towards those patients with immediate pressing needs rather than those whose care needs are currently at a lower level but are likely to escalate in the absence of preventative steps. To quote NHS England Chief Executive Simon Stevens: “A growing and ageing population means we’re going to have to supercharge our work on prevention, on care integration, and on treatment innovation”.⁵³ However, we argue that prevention can only happen if health, housing and social care are closely integrated at a local level.

2.5 Change is hard

Given the magnitude of the symptoms described above, no one in Westminster quibbles with the need to make the care system work better. But, as we have seen, this has been acknowledged as a problem for many years yet remain unresolved. The scale of the systemic flaws which we describe in the next chapter is such that it will take years of continuous political effort to get the requisite momentum. In other words, acknowledging the problem is the easy part, effecting change has proved rather more tricky.

So it is worth noting that, while recent government policies take important steps towards reforming services, many of those policies will not take effect for several years. For instance, many elements of the Care Act are not due to be implemented until April 2016,⁵⁴ leading to the possibility that whoever forms the next Government may find themselves toning down the more controversial elements of the proposed reforms.

⁵² LGA, ADASS, Adult social care funding: 2014 state of the nation report (October 2014)

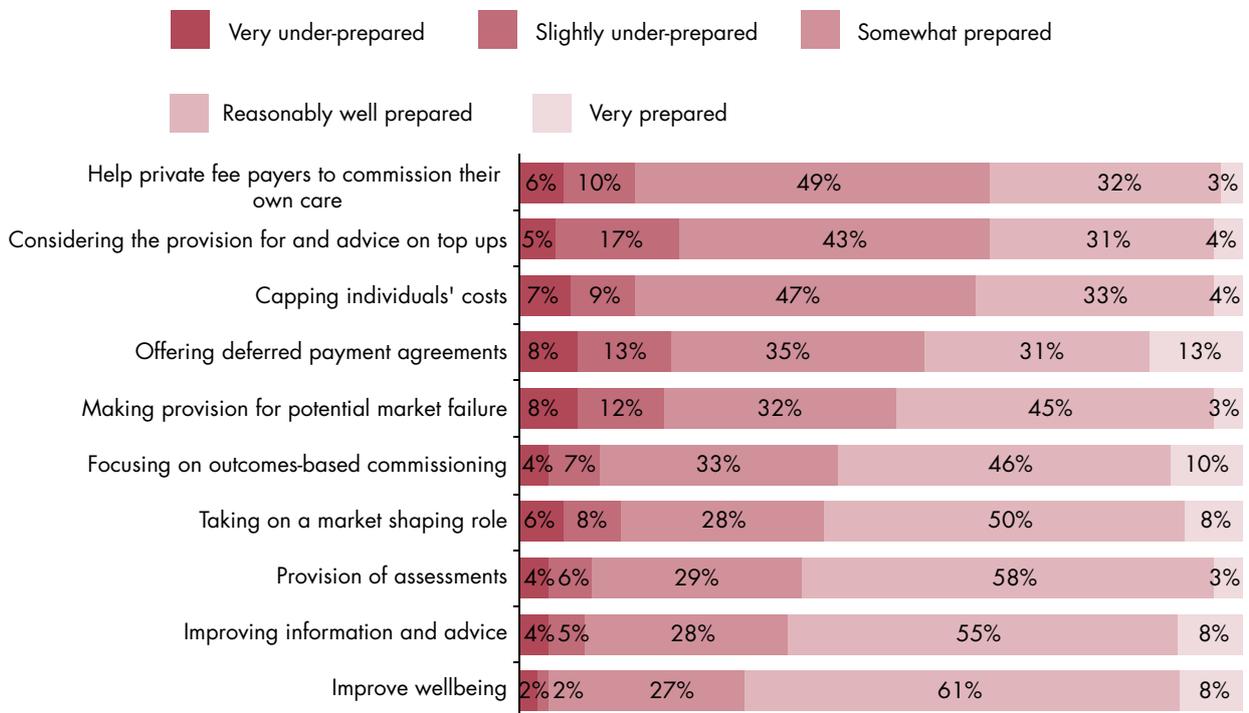
⁵³ Williams, D, "NHS cash boost includes funds for out-of hospital care" LGC (2 December 2014)

⁵⁴ LGA, Care Act clause analysis (accessed November 2014)

How prepared are you for aspects of the Care Act 2014?

We asked 100 local health leaders how prepared they were for aspects of the Care Act 2014 (See figure 1). The survey revealed a significant percentage of local authorities were unprepared for capping individuals' costs (62 per cent), considering the provision for and advice on top ups (65 per cent) and the provision of assessments (38 per cent). It should be borne in mind that aspects for which the local authorities are least prepared are last to be implemented.

Figure 1: How Prepared are you for aspects of the Care Act 2014?



Chapter 3 – What Is The Diagnosis? Or Why Are We Failing Our Elderly?

There are clearly substantial problems in the health and social care system but if we are to have any chance of successfully addressing these problems, we need to identify the reasons that lie behind them. Our research has identified a number of root causes of the dysfunctionality of the care system in its current state which we have grouped into seven headings below.

3.1 “Bed blocker” terminology

The terms ‘bed blocker’ and ‘bed blocking’ are much used in the press. It is instructive, however, to consider exactly what is meant by this and, in particular, to recognise that there are two sources of ‘bed blockers’—those coming into the acute sector for otherwise avoidable admissions, and those who no longer need to be in hospital but are being kept in anyway. While no one would deny this is a big problem for the health service, we believe that the term ‘bed blocker’ is extremely unhelpful and demeaning in implying that the blame should fall on patients themselves rather than the systemic faults that led to them being in hospital when they didn’t need to be. The term also carries an assumption that the patient may be well enough to care for themselves but is somehow choosing not to do so. ‘Bed blocking’ or ‘bed blockers’ dehumanises those who often face poorer outcomes of care because they have slipped through the cracks of the fragmented health and social care system. As such the use of ‘bed blocking’ unhelpfully diverts attention away from those whose responsibility it is to design and operate the healthcare system.

3.2 Lack of focus on prevention

When talking about how the care system should operate, one word was used far more than any other in our interviews – prevention. Prevention at an early stage is better for patients and much more cost-effective compared with treatment for existing medical complaints. If the NHS and care providers were to focus more on preventative care then significant cost savings could be made by reducing future pressures on the acute end of the system, and so cut the number of delayed transfers of care. A report by NHS England estimated that for every £1 spent on preventative care it saved £12 in primary care.⁵⁵ Putting preventative measures at the front of the health agenda needs to be a priority for the NHS and social care systems and would help to close the estimated £30 billion funding gap by 2020/2021.

These figures seem unarguable but currently only 4 per cent of the total NHS England healthcare budget is spent on prevention – why? The unfortunate truth is that the system is just not designed to think about illness in this way. The system is reactive in that it looks to treat patients rather than encouraging them to lead healthier lives. One expert said to us: “The current [health and social care] system deals well with problems of last century – helping those who fall sick. But [it is] now about living with longer term conditions... [And the] NHS is very bad at

⁵⁵ NHS England, *The NHS belongs to the people - a call to action* (June 2013)

longer term conditions such as dementia". Change needs to happen at the local level as well. Our 2013 report 'In Sickness and in Health' highlighted the role that local authorities could play in using public health funds to help address the wider determinants of health including housing, employment and transport.⁵⁶

Additionally the inability to focus on prevention is underpinned by short termism in the budget setting as 12 month budget cycles make organisational planning more difficult and can shift focus to short-term spending. Yearly budgets make it harder to show a return on investment and encourage a short-term approach to every aspect of the planning cycle.

To its credit, the NHS is now beginning to think about a strategic shift in resource towards averting illness before it starts, or gets worse, and it is well aware of the need to make this shift work. To quote the NHS Forward View: "the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all depend on a radical upgrade in prevention and public health."⁵⁷

The Forward View also acknowledges that NHS needs to "adapt",⁵⁸ including working in partnership more closely with its colleagues in the local authority, private and the voluntary and community sector worlds. It recognises that budgets will be tough and that ongoing demographic change will continue to bolster demand, but strikes an optimistic note in pointing out that other societies manage with older population. In this it concurs with one Director of Public Health who summed it up with: "Detect and manage; to predict and prevent – it can be done".

3.3 Two worlds

If this strategic shift to prevention is to be achieved, the single biggest challenge will be in overcoming the very profound cultural and organisational differences between the health and care elements of the system – ending what Care Minister Norman Lamb has called the "ridiculous divide" between health and social care.⁵⁹ The roots in the division go back to 1948, which separated the new National Health Service from councils and social care provision.

Sixty-five years later, there remains a fundamental dichotomy between the NHS, which as the name suggests is resolutely national in its organisation and funding, and social care provision, which is locally controlled and run. The NHS is well known, popular, and largely free at the point of use, whereas social care remains both heavily needs and means-tested, and thresholds are variable between local areas. Moreover, while the NHS is predominantly paid for through general taxation, social care is paid for either privately or by local authorities. Currently, more than half of social care is paid for privately, as access to publicly-funded social care is rationed.

This separation between the two systems comes through in numerous ways, which we discuss in the next four subsections:

3.3.1 Communication breakdown

Whereas the NHS has historically been driven from Whitehall and sees itself as answerable to Ministers, local government is directly accountable to its electorate. Because of this, the two environments inevitably have very different outlooks: while the NHS is not known for looking outside itself to the wider community, by comparison local government is externally focused.

Further to this, while the NHS has an inherently clinical mindset, viewing people as 'patients to be treated', local authorities adopt a more holistic approach,

⁵⁶ Localis, In sickness and in health (September 2013)

⁵⁷ NHS England, Five year forward view (October 2014)

⁵⁸ NHS England, Five year forward view (October 2014)

⁵⁹ Peters, D, "Lamb roars against 'ridiculous' health and social care divide" The MJ (31 October 2014)

tending to see people as citizens and community members.⁶⁰ And the two systems have very different relative strengths, with local government good at market shaping and accountability, and the NHS is good at processing health information to aid patient care and clinical leadership.

These cultural differences have somewhat inevitably resulted in longstanding and ongoing difficulties in communication and understanding between the two systems. Almost two-thirds (65 per cent) of survey respondents cited cultural differences when asked for reasons that wholesale integration of health and care services nationwide has taken so long to develop. One HWB Chair told us that the failure of individuals to understand the work of other bodies – they cited the example that they had discovered some doctors have never met a social worker – can forge an environment of distrust and ignorance of the broader picture. And this was underlined by Communities Secretary Eric Pickles who has said there is an “enormous” [amount of] “distrust and arguments between local authorities and the NHS.”⁶¹ This distrust and poor communication is another key element in delayed transfers of care.

This failure to effectively communicate can also take a technological hue, leading to a lack of healthcare information sharing between services and partners. One interviewee said: “[The fact that] we have no integrated information system is bizarre”. The result is, as another HWB Chair told us: “Not really knowing and tracking people through their lives [resulting in] people coming in having previously not seen us and then needing lots of care immediately”. Indeed, our survey of local health leaders confirms this with 52 per cent of respondents saying that relationships between relevant partners are one of the main underlying causes of delayed transfers of care.

Predictably, such different cultures can also make change management across the whole system even trickier than usual. The more organisations involved (and in some local authority areas it can easily be dozens), the more different processes and specific corporate cultures that have to be aligned, and the more complex any change attempted.

3.3.2 Fragmentation

The institutional and historic separation of the NHS and local government has resulted in fragmentation of healthcare provision at the local and national level resulting in significant barriers to integrating services. At the national level leaders have faced a tough challenge, managing wide-reaching change throughout the NHS while themselves split across Department of Health, NHS England and Public Health England (Plus Monitor, the Care Quality Commission and national Healthwatch).

Although the structural changes were introduced for sound reasons, attempting to radically reform the shape of the NHS to make it more locally and clinically led, some local health leaders found the fragmentation a challenge. Nearly half of our survey respondents thought that the impact of changes to the NHS were a reason for why wholesale integration of health and care services nationwide had taken so long to develop. Fragmentation has been observed as a significant problem at the national level as well. In a recent interview with the Guardian Sir Bruce Keogh, medical director for NHS England, said: “Too many patients find the NHS fragmented [and] confusing. They find that they get pushed from pillar to post, they feel like a ball in a pinball machine at times.”⁶²

Local government and health authorities are not structured along the same geographic lines - in the jargon they are not co-terminous - and this was another

⁶⁰ Localis, *In sickness and in health* (September 2013)

⁶¹ Wiggins, K, “*Hunt: NHS has ‘responsibility to help councils’*” LGC (31 October 2014)

⁶² Campbell, D, “*NHS cannot cope with ageing population, warns top doctor*” The Guardian (19 January 2015)

hindrance mentioned by several interviewees. At the same time, several local health leaders questioned the robustness of Clinical Commissioning Groups, arguing that some are too small, which they felt made it almost inevitable that they would find themselves operating in deficit.

Fragmentation also increases the costs of providing services across health and social care. Government ministers are aware of the problems. As Jeremy Hunt said: "...the interconnected relationship between the services we both [NHS and local government] offer to vulnerable people means that we in the NHS have a responsibility, as we move to fully integrated services, to help you [in local government] deal with a tough financial settlement. If we operate in financial silos, the costs will be higher for both of us."⁶³ His colleagues Norman Lamb and Paul Burstow have echoed these views and championed an interconnected relationship between the NHS and local government.

Cheshire West and Chester Integrated
Neighbourhood Teams

Case Study: Cheshire West & Chester Council



There are approximately 63,000 people living in Cheshire West and Chester (CWC) aged over 65, with about 8,000 of these aged over 85 years, and those numbers are set to go up substantially. They live predominantly in the rural areas of the borough so creating additional pressure on services and increasing the importance of outreach and community-based provision.

CWC has committed to work with partners to fundamentally reshape the delivery of care to this population to make it 'client centric', working with patients, their carers, local clinicians, our staff and the numerous partner organisations (from all sectors) to design a new model of care provision. In so doing they have built a far deeper understanding of the needs of their communities, not just in terms of clinical requirements, or those known to social care services, but in all aspects of personal and community wellbeing. It is this that drives truly integrated working and the delivery of whole-system, seamless care. Importantly, this is also driving a fundamental shift from reactive, acute care to proactive care closer to home.

The transformation work is split into four major strands, all of which deliver complimentary changes to service delivery and budgetary alignment. Crucially, in moving toward a whole-system approach, no single element of delivery is undertaken in isolation:

- Service integration between CWC and Cheshire and Wirral Partnership NHS Trust - removing the boundaries that used to exist between the major providers of care.
- Roll-out of Integrated Community Care Teams - delivering care and support in the community, in a co-ordinated and client-centred manner. Teams

⁶³ Wiggins, K, "Hunt: NHS has 'responsibility to help councils'" LGC (31 October 2014)

consisting of a variety of professionals from both Adult Social Care and Health, including District Nurses, Social Workers, Community Matrons, Care Coordinators and other specialised services, are already fundamentally closing the ‘gaps’ that used to exist in service provision.

- Development of an integrated ‘Front of House’ - ensuring that there is a co-ordinated approach to signposting, assessment, triage and support management in partnership with voluntary and community sector groups.
- Transitional Care and Support to Acute Services – implementing a new, radical approach to care categorisation, fundamentally shifting support to home and community based support and away from the hospital.

The result has been a significant increase in the effective time spent in delivering transitional care services, in particular reablement, and a clear ongoing improvement in patient, client and staff satisfaction across their communities and within the organisations involved.

3.3.3 Lack of Integrated Care Pathways

A lack of co-ordination between health and social care systems has led to poorer outcomes for patients as opportunities are missed to prevent avoidable escalation of healthcare needs. This is a particular concern for the older population who often have long-term and complex medical conditions requiring multiple interactions with various parts of the system. The Department of Health estimated that people with one or more long-term condition cost NHS England about 70 per cent of their budget but account for only 30 per cent of the population.⁶⁴

It is clear therefore that integrating care would not only improve patient outcomes but would also save considerable money. There are already a few pilot schemes that attempt to introduce more integrated care—in the form of what are called Integrated Care Pathways (ICP). One such example is the two North West London Integrated Care Pilots that cover inner and outer London which were established in 2011. Three key elements to this and other ICP pilots are the provision of multi-disciplinary teams, information sharing between services and named care co-ordinators for each patient.

The North West London ICP pilot in particular improved outcomes for old people. 77 per cent of elderly patients in the pilot were screened for their risk of falls and 69 per cent were screened for cognitive decline allowing for proactive discussions with multi-disciplinary teams about how to manage health in the future. Such screening had a significant short-term impact on institutional care with a 15 per cent reduction of non-elective admissions in those aged over 75 in 2011–2012 and a 14 per cent decrease in emergency activity in inner North West London. It will also have a long-term impact on institution care as 88 per cent of patients in the pilot had discussed their health goals for the future and had developed a future action plan to reach these goals and 38 per cent of patients had started anticipatory care planning.⁶⁵

Whilst this sort of approach to addressing the demand coming in through hospital front doors shows promising results, it remains very much the exception rather than the rule. In the future much greater use of integrated care pathways

⁶⁴ Department of Health, Long term conditions compendium of information third edition (30 May 2012)

⁶⁵ LGA, Integrated care value case North West London, England (October 2013)

will be needed to improve patients' health outcomes and so ensure that we have a genuinely sustainable health and social care system.

3.3.4 Lack of political leadership at the local level

The fragmentation and failure of the two systems to integrate structurally has resulted in a lack of joined-up leadership and people in charge at the local level. This lack of oversight ultimately leads to a failure to act on health inequalities as well resulting in a poor return on investment (48 per cent of Clinical Commissioning Group spend is on 3 per cent of the population). By contrast, strong collaborative leadership can open up opportunities to do things that others, who haven't invested the time to build those relationships, wouldn't have been able to make happen (for example, see the case study below).

Case Study: Northumberland County Council

Northumberland County Council and Northumbria healthcare have developed a strong working relationship over a number of years. For example, they currently share a director who covers public health, children's services and adult care for the council, and also manages the community health service within Northumberland Healthcare. As a result of these close working relationships there have always been meetings between senior management teams to explore how the two organisations can further work together in a mutually beneficial way.

For example, Northumberland Healthcare Trust had done a lot of work to demonstrate they could secure significant efficiency savings if they could terminate their Private Financial Initiative contract. This led to discussions with Northumberland County Council around how they could raise the necessary finance to achieve this. Steven Mason, the Lead Executive Director of Northumberland County Council, suggested that the council could use prudential borrowing powers to provide the funding.

Hexham General Hospital, Northumbria



Initially, Northumberland County Council embarked on a scoping exercise to explore the feasibility of these proposals, including seeking joint counsel opinion on whether the Trust and the Council had the legal powers to reach such an agreement. There were a number of stages to getting the deal done, one of which was obtaining approval from councillors to grant the loan. One of the main concerns of members was the question of security and what would happen

if the Trust got into financial difficulties but, having weighed up the risks, they concluded that protecting healthcare services and jobs within Northumberland was vital and was a risk worth taking.

It is worth noting that the clearance process was rather less straightforward for the Trust who had to obtain clearance from the Treasury, the Department of Health and Monitor, the sector regulator for health services in England.

The result was that Northumberland County Council approved a £114 million loan to Northumbria Healthcare Trust allowing them to cut their overall borrowing costs for Hexham General Hospital and focus their cash where it's needed most – in front line healthcare. It is expected that this will lead to savings of about £3.5 million every year for the next 19 years.

This lack of joint local leadership has hampered efforts to focus on preventative community care away from an acute setting and reduce pressure on primary care providers. Time and again the local authority experts that we interviewed suggested that one of the reasons for the lack of integration between health and social care services is because there is too much focus on hospital provision. There are several possible explanations for this. Firstly, hospitals are large, well-known buildings and as such are much more visible than community services, which is one of reasons that, over generations, hospitals have become seen as cultural embodiments of the NHS. Additionally in recent times we have seen substantial increases in people going to hospitals to get healthcare provision – both due to misunderstanding of the critical nature of A&E services and due to actual or perceived difficulties in accessing primary care.

These absence of local leadership is especially clear when it comes to clinically-led programmes to reform A&E services, where local politicians of all colours rush to the barricades to fight any change, no matter how rational, and there is no-one at a local level who can explain why every hospital providing every service is an inherently flawed approach. As some have argued, it would also help if there was a bit more of a concerted attempt at a national level to make the case for A&E reform.⁶⁶

But the acute sector itself has faced criticism for being self-interested and fighting changes that would improve outcomes for patients. For example, when recent research studies revealed that patients were 16 per cent more likely to die if they were admitted to hospital on a Sunday NHS England's national medical director announced plans for hospitals to have access to x-rays, ultrasound scans and emergency general surgeries at weekends. These plans were met with criticism by the British Medical Association who said: "a full NHS service 24 hours a day, seven days a week, is neither desirable nor feasible".⁶⁷

The NHS Five Year Forward View, published in 2014, called for greater local democratic leadership on public health matters.⁶⁸ It suggested that the NHS would work with "ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government".⁶⁹ As part of that it agreed with the Local Government Association (LGA) proposals that local authorities should be granted enhanced powers to allow local democratic decisions on public health policy (e.g. on alcohol, fast food, tobacco and other physical and mental health issues) that go further than prevailing national law.⁷⁰ The shortcomings of the current arrangements are thus well recognised but public health, while important, is only a small fraction of the total health and care budget.

⁶⁶ White, M, "Our creaking A&E system needs restructuring, no ifs, and - or butts" The Guardian (13 November 2013)

⁶⁷ BMA, Best for patients, fair for doctors, sustainable to the NHS (December 2014)

⁶⁸ NHS England, Five year forward view (October 2014)

⁶⁹ NHS England, Five year forward view (October 2014)

⁷⁰ NHS England, Five year forward view (October 2014)

3.4 Failure of incentives

To recap, in the words of one interviewee: “We have a system designed to cope with demand when it happens, not prevent demand – probably more than two-thirds of those in hospitals are there with long-term conditions, most of which could be managed much more effectively in the community if you had neighbourhood and community based/social support systems. The evidence is there.”

But the system is conditioned to look to hospital provision for all the solutions. And one of the main reasons that is proving hard to shift towards meaningful integration, according to our survey of local health leaders, are perverse financial incentives, named by 61 per cent. Norman Lamb agrees, saying: “We incentivise acute hospitals to do more and don’t incentivise the system to prevent ill health or a deterioration of health. There needs to be a fundamental shift.”⁷¹

This echoed concerns articulated by a large proportion of the local health leaders that we surveyed and interviewed as part of this report. Many interviewees were firmly of the view that there was a built-in incentive for acute trusts to keep patients in hospital for longer than was strictly necessary, with one director of public health suggesting that: “hospitals need to keep people in their beds in order to survive [financially].” Where there is spare bed capacity in a trust, the trust is incentivised through the tariff system to ensure that those beds are filled, they argued. In 2006-7 the Government introduced a system called Payment by Results (PbR). PbR governs transactions between commissioners and secondary healthcare providers representing more than 60 per cent of income for the average acute hospital.⁷² The intention for PbR was for it to align payment for work done by delivering on the promise that ‘money will follow the patient’.⁷³ However, several of our interviewees felt that the scheme was not working as planned, with one calling it an ‘unmitigated disaster’. These interviewees all agreed that, contrary to its name, PbR was not paying for results (i.e. making people to get better) but was instead paying for activity.

Indeed protection of individual service budgets was the number one answer in our survey when asked what was holding back health and social care integration, with one interviewee adding: “[Hospital] Trusts are currently the main beneficiaries of this model and are thereby disincentivised to work in a more joined up way.”

That said, the cost profile is also more complex than is often cited, as one interviewee explained that: “non-elected admissions for older people who do not actually need to be in hospital are funded at a 30 per cent rate of the normal tariff”. But 30 per cent is still more than zero per cent.

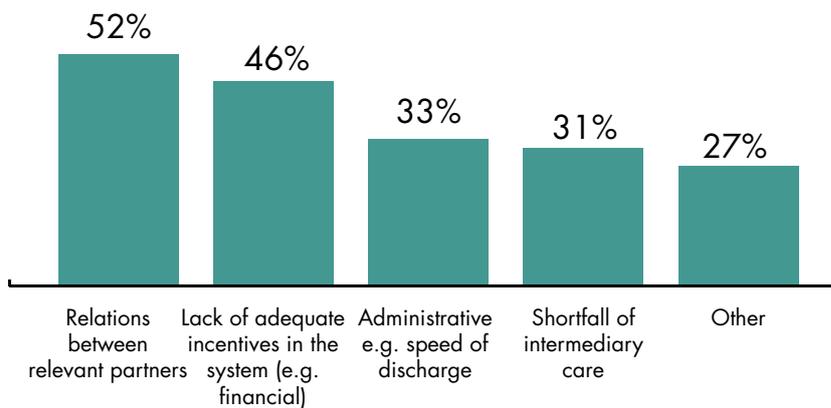
Again and again the subject of financial incentives came up. One of the top issues that interviewees cited when asked if they could reverse one disincentive towards more integrated care was financial incentives. And nearly half (46 per cent) thought that the lack of adequate incentives in the system were one of the specific underlying causes of delayed transfer of care (see figure 2).

⁷¹ Peters, D, “Lamb roars against ‘ridiculous’ health and social care divide” The MJ (31 October 2014)

⁷² Department of Health, A simple guide to Payment by Results (2012)

⁷³ Department of Health, A simple guide to Payment by Results (2012)

Figure 2: In your view, what are the main underlying causes of delayed transfers of care?



The care provided to those in hospital has been designed around treating individual isolated problems. However, older people are most in need of co-ordinated care and are most likely to experience transitions between types of care. Payment systems do not lend themselves to treating patients with multiple conditions, as patients with multiple needs may require longer appointment times.⁷⁴

As one interviewee said: “We need to move towards a system that rewards outcomes rather than activities. The existing system pays if patients don’t get better, get worse, or even die.” Or, as another put it, “independent funding streams provide no reason for Health and Social Care to change the way they operate and should be replaced with pooled budgets that foster greater integration.” A significant number of interviewees mentioned significant failures in the incentive structure. Clearly if what we were told is correct and these reports are accurate then the system is mitigating against the right results for older people.

An attempt to introduce a more rational incentive is the Better Care Fund (BCF), announced in 2013. The BCF is designed in to be used for joint NHS-local authority commissioning of integrated health and social care services.

However, of the total £3.46 billion allocation in 2015/16, £1 billion is made up of ‘payment for performance’ incentives. The incentives are only received if Health and Wellbeing Boards can hit a set target for a reduction in total emergency admissions of at least 3.5 per cent for the year.⁷⁵ Where this target isn’t achieved, this proportion of the funding (almost a third) will be handed back to the NHS leaving local authorities even more financially stretched.

Indeed when giving evidence to the Public Accounts Committee in December 2014, the chief executive of the Local Government Association (LGA) Carolyn Downs said that the LGA had considered walking away from the Better Care Fund programme due to the burden of risk placed on councils.⁷⁶ The concept behind the creation of the Better Care Fund – to catalyse the integration between health and social care that we argue is so desperately needed – is very welcome. However, it is to be hoped that future iterations of the programme can achieve a more equitable balance of risk and reward for both sectors.

Promisingly, Samantha Jones, the recently-appointed Director of Care Models NHS England’s, stated in her first interview that proposals to develop pioneering health and social care models will need to demonstrate meaningful clinical

⁷⁴ The King’s Fund, *Making our health and care systems fit for an ageing population* (2014)

⁷⁵ Department of Health, Department for Communities and Local Government, *Better care fund policy framework* (December 2014)

⁷⁶ Peters, D, “Councils ‘were close’ to dumping the BCF” *The MJ* (2 December 2014)

and patient involvement to win approval. She mentioned specifically that there were, “a number of incentives that don’t support lifetime care for an 82-year-old sitting at home. It doesn’t make sense with what we have at the moment”.⁷⁷

3.5 Shortfall of housing for older people

The under-occupation of housing and the lack of viable alternatives for older people looking to downsize are potentially preventing significant savings to health and social care costs and adding to delayed transfers of care.

The Office for National Statistics General Lifestyle Survey found that nearly 2.5 million people over 75 live alone; 1.8million of these are women.⁷⁸ This vast cohort of the elderly are at more risk of social isolation and loneliness, which can have serious repercussions. A study of 6,500 UK men and women aged over 52 found that being isolated from family and friends was linked with a 26 per cent higher death risk over seven years.⁷⁹

It has been estimated that if all of those interested in buying retirement properties were able to do so then it would mean more than three million properties would be released.⁸⁰ Large numbers of elderly people living alone are also living in what was family housing and this means firstly that the housing is not suitable and secondly it adds pressure to the housing market. Living in unsuitable housing results in a greater risk of accident or injury. Falls and fractures in people aged 65 and over account for more than four million hospital bed days each year in England alone.⁸¹ Lack of housing adaption also results in problems in discharging old age patients. 40,000 needless days per year are spent in hospital by patients awaiting home adaptations before discharge.⁸²

On the latter as well as preventing significant savings to health and social care costs housing under-occupation also aggravates the problems within the housing market. Shelter calculated that if 20 per cent of those older households which are currently under-occupied were to downsize, around 840,000 family-sized homes would be released, including 760,000 in the owner-occupied sector.⁸³ This would benefit first time buyers as people above them move up the housing ladder.

So why are these older people not moving to more suitable accommodation? Retirement housing provides safer accommodation and access to professionals who can offer falls awareness advice and other forms of support which ultimately prevents hospital admissions. Older people are aware that they are living in unsuitable housing—a recent report found that 58 per cent of over-60s wanted to move to more specialised accommodation but felt restricted by a lack of suitable alternatives or fear of an unfamiliar environment.⁸⁴

And they are right to wonder if the right housing is out there for them. 77 per cent of respondents to our survey thought that there was not enough appropriate later life housing in their area. Just 2 per cent of English housing stock is retirement housing and homes built specifically for older people have decreased from 30,000 per year in the 1980s to 8,000 per year today.⁸⁵ More generally, a quarter of over-60s expressed particular interest in buying a retirement property - a total of 3.5 million people - though the availability of such property at the time of the report’s publication - 100,000 - is a tiny percentage of that number.⁸⁶

What lies behind this shortfall? England's current housing stock is fully accessible to older people. And with those over 85 set to grow by 33 per cent over the next ten years, demand for specialisit housing is bound to outstrip supply. But

⁷⁷ Lintern, L, "New care model proposals 'must involve patients' LGC (16 January 2015)

⁷⁸ Office for National Statistics, General Lifestyle Survey 2011 (7 March 2013)

⁷⁹ Demos, The top of the ladder (2013)

⁸⁰ Demos, The top of the ladder (2013)

⁸¹ Age UK, "Nearly 2 million NHS days lost to delayed discharge" (11 June 2014)

⁸² Age UK, "Nearly 2 million NHS days lost to delayed discharge" (11 June 2014)

⁸³ Demos, The top of the ladder (2013)

⁸⁴ Demos, The top of the ladder (2013)

⁸⁵ Demos, The affordability of retirement housing (2014)

⁸⁶ Demos, The top of the ladder (2013)

that doesn't explain the current paucity of age-appropriate housing. Why is the housing market not delivering what people want and need?

Some have pointed to planning related reasons. A National Housing Federation report in 2011 found that only 45 per cent of surveyed local authorities had a housing strategy for older people⁸⁷, and another study found two-thirds of planning applications for new retirement housing were initially refused first time round⁸⁸ (by comparison, nearly 90 per cent of applications are accepted⁸⁹). What is clear is that central and local government are not prioritising the promotion of an adequate market for social housing for older people.

3.6 Issues with the provision of care

One key underlying tension in the current system is that while health is free at point of entry; social care is means tested.⁹⁰ And state support for care is falling—according to the Nuffield Trust real-term net spending on social care for older adults in England fell by 15 per cent between 2009/10 and 2012/13 (from £7.8 billion to £6.6 billion). The King's Fund reported that 26 per cent fewer people aged over 65 now receiving publicly funded social care in 2012/13 than were five years earlier, with further cuts still to hit. With more than half of social care being paid for privately, and as care costs continue to rise, ever greater pressure is placed on individuals to support themselves in old age.

So are they saving? Research by Anchor found that 48 per cent of adults have not given any thought at all to how they will pay for their own care. The survey also found that only 6 per cent of Britons have begun to set money aside for their future care needs.⁹¹ The answer is a pretty clear no. Ultimately, there is a lack of debate/understanding about the need to save and pay for care. There is therefore a pressing need to inform the public and especially younger people about the cost of care and the need to save for their future care needs. If future generations are unable to access good quality care then this will greatly increase the pressure on primary health and social care providers.

3.7 Options for post-hospital care

Between 2013 and 2014 NHS England estimated that around 32 per cent of delayed transfers of care days were attributable to patients awaiting residential home placements (11 per cent), nursing home placements (11 per cent) or a care package in their own home (10 per cent).⁹² These figures show that a significant number of delays are attributed to the inability to find care.

The reasons for these delays in post-hospital care are not straightforward. Care England – the representative body for independent care providers – rejected the claim that there isn't enough capacity in the market.⁹³ Our interviewees told us that often there was a lack trust and understanding of the post hospital care options available. And in some instances local authorities are not moving quickly enough to sort out care packages.

It is therefore a confused picture with doubtless all of these factors playing a part. However, there are a number of improvements that could be made to bring greater clarity about the provision of post hospital care. For example, better communication and understanding of all the post-hospital care options across all sectors would improve patient outcomes and increase the efficiency of the system. Additionally, and to echo a point made above, there is a need for financial incentives to be improved to ensure that the needs of the patient come before the pressures facing services providers—financial or otherwise.

⁸⁷ National Housing Federation, *Breaking the mould* (February 2011)

⁸⁸ Professor Ball, M, *Housing markets and independence in old age* (May 2011)

⁸⁹ Department for Communities and Local Government, *Planning applications April to June 2014 England* (2 October 2014)

⁹⁰ King's Fund, *A new settlement for health and social care* (2014)

⁹¹ ICM research conducted for Anchor, 2011

⁹² NHS England, *Delayed transfers of care statistics for England 2013/14* (May 2014)

⁹³ Care England, "A&E crisis not due to shortage of residential care home beds" (7 January 2015)

What is true is that the right solutions the system can get people out of hospital when they don't need to be there, free up beds and provide them with the care that they need. It can also deliver considerable savings (See case study below). If similar savings could be achieved across the country the impact could be sizeable.

3.8 Care workforce

The split between health and social care also creates an artificial divide in a non-acute setting. The NHS continues to fund a significant level of free nursing care in the community through its 'Continuing Healthcare' programme. But the programme is only eligible to those who have complex medical conditions and substantial and ongoing care needs— leaving basic care to the local authority

Case Study: Birmingham pilot scheme

Anchor, a UK housing and care provider, has piloted an enhanced assessment scheme in partnership with Birmingham City Council and Birmingham CrossCity Clinical Commissioning Group: since mid-December last year, four of Anchor's care homes have offered a total of 12 enablement beds to the Birmingham City Council and the CCG.

It has been estimated that it costs £1,610 to have a patient in a rehabilitative hospital bed for a week. The enablement beds that Anchor provides for the hospital cost £550 a week for each patient which excludes costs for therapy, medical cover, etc. The estimated savings could be up to £300,000. These pilot schemes, which encourage older people to lead more independent lives, have resulted in a reduction in permanent care home placements across the city. Given this initial success Birmingham City Council and CCG have expanded the contract with Anchor to provide up to 19 enablement beds in two care homes: Kerria Court and Madeleine House.

Kerria Court, Birmingham



and the individual.⁹⁴ The Alzheimer's Society has criticised the 'Continuing Healthcare' programme for not ending the postcode lottery of care funding—claiming that: "statistics show a variation in the number of people receiving NHS continuing healthcare across different areas even when there is not a vast difference in the demographics of their population."⁹⁵

But the trend in hospitals is moving away from extensive nursing care, with healthcare assistants now spending more time at a patient's bedside than nurses (and making up around a third of the hospital workforce).⁹⁶

Not only is nursing care more expensive than basic care needs - £347 per care home resident per week for nursing care compared to £197 for residential care⁹⁷ - but critically it effectively operates without a spending limit, as it is classified Annually Managed Expenditure (AME).⁹⁸ This stands in stark contrast to local authority commissioned care which is under significant financial pressure. Considering whether nursing care can be provided in a more efficient way – particularly given the close links with wider care services – is of significant importance.

At the same time, the Government-commissioned Cavendish Review found the high levels of staffing turnover in care homes 'worrying', with nearly one in five staff changing every year. The review also concluded that social care employers found it "burdensome to navigate the sea of vocational qualifications and training courses which has developed in response to changing fashions in government funding."⁹⁹

Care workers face a number of challenges in the workforce. They are typically low paid and a report by the International Longevity Centre found that 93 per cent of care workers have faced verbal abuse and 53 per cent physical abuse at work.¹⁰⁰ The report also revealed that the prevalence of training and qualifications across the care sector was low—adding to a perception of a sector where there are few learning and development opportunities.¹⁰¹

Despite these challenges the adult social care sector will need to add one million workers by 2025 in response to population ageing and increasing numbers of people with disability associated with an older population.¹⁰² Clearly, more could be done to support a better trained and motivated workforce.

⁹⁴ NHS Choices, What is NHS continuing healthcare (accessed December 2014)

⁹⁵ Alzheimer's Society, NHS continuing healthcare (accessed December 2014)

⁹⁶ The Cavendish Review, An independent review into healthcare assistants and support workers in the NHS and social care settings (July 2013)

⁹⁷ LaingBuisson, "Councils rely on a 'hidden tax' on older care home residents" (15 January 2013)

⁹⁸ Department of Health, Annual report and accounts 2012-2013 (July 2013) p22

⁹⁹ The Cavendish Review, An independent review into healthcare assistants and support workers in the NHS and social care settings (July 2013)

¹⁰⁰ International Longevity Centre, The future care workforce (25 February 2014)

¹⁰¹ International Longevity Centre, The future care workforce (25 February 2014)

¹⁰² International Longevity Centre, The future care workforce (25 February 2014)

Chapter 4 – What Are Our Proposed Solutions?

It is clear that there are very substantial problems hard-wired into the health and social care system. As such, it would be foolish to assume that with the sweep of a wand everything will be better in the next few months. But an acknowledgement of the scale and complexity of the challenge is not a reason to delay the drive to make the constituent parts of the system interact in a way that works for, rather than against, the interests of the most vulnerable. So while we do not suggest that the recommendations we make in this chapter would be a collective panacea, they will definitely move the country further down the right path.

4.1 Changing the language around “Bed blocking”

We argue that ‘bed blocker’ and ‘bed blocking’ are unhelpful terms that point the blame for a serious problem at the patients rather than the real culprits, the systemic problems of the health and social care system. We therefore believe that it we need to change the language around this issue in order to make clear who is and is not responsible. Whilst the term ‘delayed transfers of care’ is used often instead of ‘bed blocking’ we believe it doesn’t portray the whole picture. This is because ‘bed blocking’ has two aspects— too many people coming into acute care with avoidable conditions and too many people waiting to be discharged. We therefore propose that the phrase ‘preventable bed occupation’ is used instead to describe the phenomenon.

Recommendation: Encourage the media to use the phrase ‘preventable bed occupation’ instead of ‘bed blocking’.

Impact: This would:

- Emphasise the importance of prevention in controlling avoidable demand for acute services.
- Re-focus the culpability away from blameless patients and onto the flaws in the system.

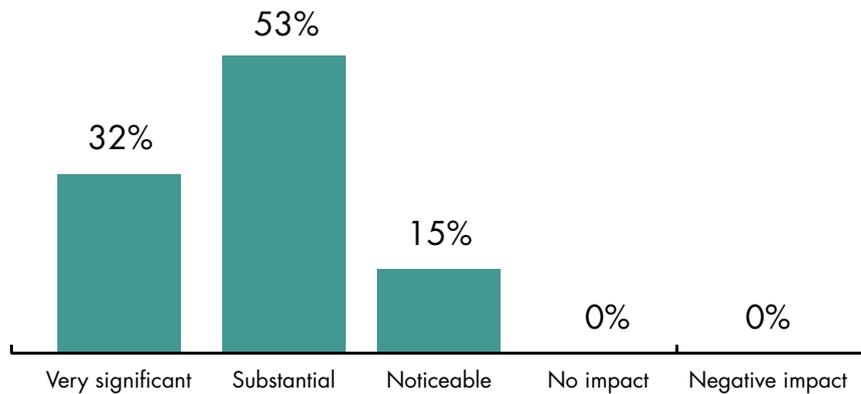
4.2 Increased powers for Health and Wellbeing Boards

Health and Wellbeing Boards (HWBs) have been a positive local structural lever for change but they are still in their infancy. Despite their relative nascence most of those we interviewed said they thought they are playing a very positive role and this is backed up by our survey which found that 75 per cent thought that their HWB had made a noticeable or substantial improvement to health and social care in their local area. The most common reason ascribed to the success of HWBs was that they bring together leaders at the local level – as one interviewee said: “health and wellbeing boards literally got representatives from different organisations sitting round the table, and that’s a crucial first step”.

We believe that HWBs are well placed to play a key role in leading the required strategic shift to prevention if, as one Director for Public Health put it, they are: “given the teeth to do it.” We also agree with those we spoke to who argued that enhanced powers for HWBs would be most effective when such powers were combined with “strict criteria” for what success looked like.

Such a change would enable a greater shift towards true integration from above—not a board governing a system at arms’ length, but to actually be a management board of an integrated budget/system.

Figure 3: How great a positive impact could your Health and Wellbeing Board have on improving health and social care outcomes, were it to be given more powers and responsibilities?



Stakeholders think this could work—from a survey of more than 100 local health leaders, a third of respondents thought that a strengthened HWB would have a ‘very significant’ impact on health and social care outcomes, and a further 53 per cent thought it would have a ‘substantial’ impact (see figure 3). As one interviewee said, a strong HWB Board chair could “pull council, CCG, acutes together in a room” and “take the silliness out of the way”. But to have the requisite teeth, we believe it is essential that everyone is engaged, and for this to happen, we believe there needs to be statutory seat on HWBs for acutes.

Recommendation: Acute trusts to be made a statutory member of the HWB.

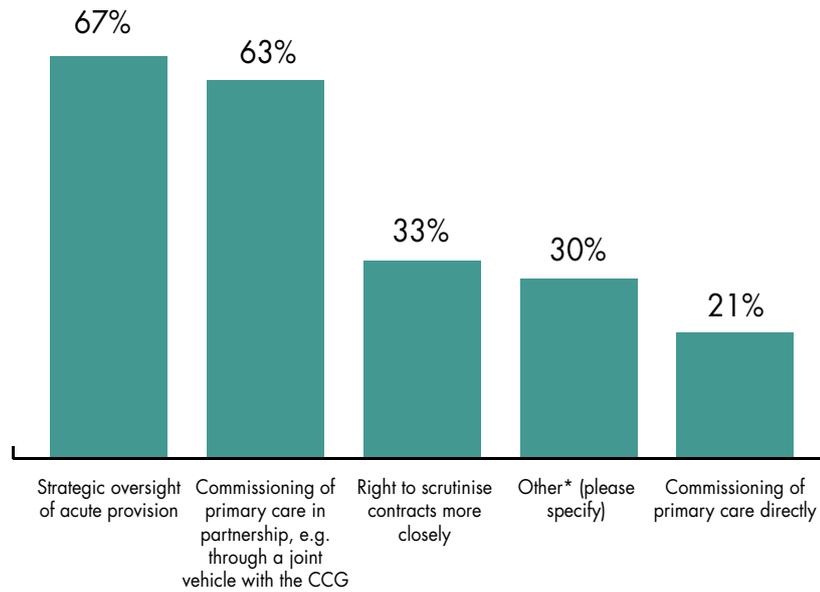
Impact: This would:

- Help to break down the fragmentation that exists between the NHS and local government by building stronger relationships at the local level.
- Enhance local healthcare system leadership.
- Improve the co-ordination of care and delivery of local services.
- Develop greater understanding and more effective communication between the sectors.

4.3 Integrated commissioning budget for older people

But what additional powers should HWBs get? Our survey responses were interesting, and it is worth noting that only one respondent felt that HWB’s should have no further powers and responsibilities.

Figure 4: What additional powers/responsibilities do you think Health and Wellbeing Boards should take on?



The right to scrutinise contracts more closely was supported by a third of our survey respondents (see figure 4), and was raised in some interviews as the only way that HWBs would be able to truly influence primary commissioning decisions. But the most popular responses by some way were to allow HWBs to have strategic oversight of acute provision and to commission primary care in a partnership. This would chime with Labour's proposals.¹⁰³ In order for HWBs to hold NHS England accountable for commissioning our 2013 report 'In Sickness and in Health' recommended that a body for HWBs should be created to represent their interests within NHS England.¹⁰⁴

Our conclusion is that if the sector wants to go for all-out integration, then it should build on the spirit and intention of BCF and do it wholesale. This would chime with our survey respondents who by an overwhelming margin (85 per cent) were in favour of "increased financial incentives for closer integration e.g. an expansion of the BCF"

Co-location of services, aimed at reducing unnecessary acute admissions – for example, by putting GPs and social workers in hospitals full time – were seen by several interviewees as a worthwhile investment. A case in point is Barnet, where there are social care workers and more than 70 GPs and 60 nurses providing 24-hour cover in three hospitals and one primary care centre.¹⁰⁵ The expansion of this gatekeeper role could play a critical part in supporting older people outside of an acute setting.

But by the same token, pilots have shown that integrated, preventative care outside hospitals can work, too. For example, Leeds has been chosen as one of 14 sites across the country to pioneer integrated care. Twelve health and social care teams in Leeds coordinate the care for older people in a recovery centre. This centre offers rehabilitative care to prevent otherwise avoidable hospital admission, facilitate earlier discharge and promote independence. In its first month of operation the centre reported a 50 per cent reduction in length of stay at hospital.¹⁰⁶ Smaller schemes can also have a large impact. An interviewee told us that taking an acute cardiologist out of the local hospital and into the community led to a 25 per cent reduction in hospital admissions.

¹⁰³ HSJ "Burnham sets out integration vision" (24 September 2014)

¹⁰⁴ Localis, In sickness and in health (September 2013)

¹⁰⁵ Barndoc Healthcare, About us (accessed January 2015)

¹⁰⁶ Department of Health, "Integration pioneers leading the way for health and care reform" (1 November 2013)

Integration need not stop at clinicians and service professions. For example, Community Health Centers in America have been developed to integrate primary care services with health promotion programmes, prevention programmes and community development initiatives. Community Health Centers are estimated to save \$1,263 per patient per year compared to traditional primary care provision. They also have 64 per cent lower rates of multi-day hospital admission in comparison to non-health centre patients and one quarter of the total inpatient bed days. Health centres such as these build on the extant community capacity, to become essentially a rewired community support system; so community health not clinical health.

This is particularly important in rural, sparsely populated areas where the cost of delivering services over an area of low population density is a big driver towards better supported stimulation of local, voluntary provision. Many of these examples could be developed, but would naturally require a commitment from multiple partners to fund the enterprise. But, as we have highlighted, the current system remains woefully fragmented – in part due to the funding mechanisms.

Some have suggested capitation – i.e. the payment for services on a per capita basis, as opposed to payment by activity – as a way to encourage a more holistic approach. Croydon is among areas looking at implementing an outcomes-based capitation model for commissioning services for those over 65.¹⁰⁷ This would, of course, represent an utterly fundamental shift in the NHS payment system so it will be interesting to see what comes out of the NHS Integrated Personal Commissioning programme, which is looking to pilot such an approach.¹⁰⁸

What is perhaps more realistic in the medium term is, as one HWB Chair suggested: “a five-year programme of investment shift, with overarching focus on early intervention and prevention”. We know this is achievable because they have done something similar in Kent through the work of the Kent Health Commission, where local health and care partners agreed to a 5 per cent shift in preventative care.¹⁰⁹

What would this look like? One approach would be to budget by age groups and then commission them jointly, though care would be needed to ensure that it did not cut across existing integration efforts.

To tackle the two most important age groups that would benefit the most from a whole system approach, this could be: 1) single commissioning budget focused on prevention around the 40-55 age group; 2) single commissioning budget focused on care provision for 85+ year olds. This pooled budget approach has got huge potential to promote truly integrated care and eliminate perverse incentives. However, steps must be taken to ensure that decisions are not shaped by short-term ‘political’ drivers and instead focus on the long term.

Recommendation: Introduce single, place-based commissioning budgets for 1) prevention work for 40-55 year olds; 2) care provision for those over 85 – accountable to strengthened Health and Wellbeing Boards – as part of the ongoing integration of health and social care budgets.

Recommendation: Review of wider funding mechanisms and set a five-year timetable for complete NHS Tariff review.

¹⁰⁷ Barnes, S, "Croydon CCG creates £1.7bn plan for health and social care services" LGC (9 October 2014)

¹⁰⁸ NHS England, "NHS and social care bodies take next step towards integrated health and social care for individuals" (4 September 2014)

¹⁰⁹ County Councils Network, CCN submission to the Health Select Committee public expenditure on health and social care (February 2014)

Impact: This would:

- Improve the poor care faced by older people in the health and social care system.
- Promote much needed integration between health and social care providers.
- Ensure that incentives are aligned within single commissioning budgets to focus on patients, thus reversing the perverse incentives that currently exist.

4.4 Flexible primary care provision

In this new landscape, stronger primary care provision is both a positive outcome but also a necessary underpinning service. Several interviewees argued for a far more flexible approach, drawing on often cited international examples of best practice (see box below).

International Examples of Best Practice

Kaiser Permanente: The largest non-profit health maintenance organisation in the United States which serves nearly 9 million people in eight regions. It is a virtually integrated system in which the health plans, hospitals and medical groups in each region remain distinct organisations and work together using exclusive interdependent contracts. The key feature of the model is an emphasis on the integration of care— combining the roles of insurer and provider, and providing care both inside and outside hospitals. This enables patients to move easily between hospitals and the community and allows for the active management of patients in primary care through care pathways.¹¹⁰ A report found that by providing a multi-disciplinary and integrated approach to cardiac care for 12,000 patients Kaiser Permanente has seen a 76 per cent reduction in all-cause mortality, a 73 per cent reduction in cardiac mortality and \$30 million in annualised cost savings.¹¹¹

ChenMed: ChenMed is an innovative primary care-led group practice serving those who are older and which has optimised its delivery system for risk- and value- based payments, as opposed to fee-for-service.¹¹² Operating in the United States it differentiates itself through providing specialists at every clinic, door-to-door transportation and limited ratios of patients to doctors (375:1 compared to the typical 2000:1¹¹³) A report found that through this model the practice when compared to its peers had increased patient satisfaction, boosted the amount of time doctors and patients spent together, improved patients' medical adherence and achieved lower rates of hospital use with 40 per cent fewer days in hospital than the national average.¹¹⁴

Gesundes Kinzigtal: Whilst a key feature of the German health service system is its institutional fragmentation, Gesundes Kinzigtal is a population-based integrated care approach. It organises care across all health service sectors and is run by a regional health management company in cooperation with the regional physicians' network and two statutory health insurers. The population-based integrated care approach is designed to lead to a substantial population health gain realised by patients' enhanced self-management capabilities combined with intensified health promotion and prevention within an integrated care framework.¹¹⁵ A recent medical report found that this was a "promising approach" which would lead to substantive comparative savings in relation to normal healthcare.¹¹⁶

110 King's Fund, Clinical and service integration (2010)

111 McKinsey, What health systems can learn from Kaiser Permanente: An interview with Hal Wolf (July 2009)

112 The Economist, "The problem-solvers" (20 September 2014)

113 Moukheiber, Z, "Concierge medicine for the poorest", Forbes (23 February 2012)

114 Health Affairs, The care span: Innovations at Miami practice show promise for treating high-risk Medicare patients (June 2013)

115 International Journal of Integrated Care, Gesundes Kinzigtal Integrated Care: Improving population health by a shared health gain approach and a shared savings contract (23 June 2010)

116 International Journal of Integrated Care, Gesundes Kinzigtal Integrated Care: Improving population health by a shared health gain approach and a shared savings contract (23 June 2010)

All these demonstrate a far more tailored, person-centric and integrated approach to delivering community-based care. Part of the concern about integrating care in England hinges on the fixed approach to primary and community-based care. Indeed, concerns about capacity in general pose a threat to integration. The Nuffield Trust, for example, has suggested that: “significant reform is needed to develop capacity in primary and community care.”¹¹⁷

There are some promising examples of technology playing a role in English hospitals to increase flexibility. For example, Airedale General Hospital in Yorkshire which serves a rural population rolled out a telemedicine service. This provides patients with instant access to medical tests and advice 24 hours a day, plus a ground-breaking videoconferencing service which allows nurses to monitor their patients remotely through webcams installed in their homes. A study of 17 nursing and residential care homes linked to Airedale’s telemedicine service compared the 12-month periods before and after the introduction of telemedicine. The study found that the use of telemedicine had resulted in a 60 per cent reduction in the total use of bed days, 69 per cent reduction in A & E visits and a 45 per cent reduction in hospital admissions.¹¹⁸

Technology can also facilitate increasing access to GP services and primary care. For example, a single GP ‘super-practice’ with 13 different locations around the West Midlands – the Vitality Partnership – is piloting an online healthcare service with a digital healthcare company. Supported by the Prime Minister’s Challenge Fund – created to pilot innovative ways of increasing access to primary care – the online service makes it possible for 60,000 patients (regardless of whether they are registered with one of the group practices) same day access to their local GPs or nurses via instant messaging, telephone or Skype both within and outside normal practice hours. So far up to 70 per cent of appointments to the GP practices have been dealt with via a telephone or Skype consultation and more than 1,000 patients a day access the clinical contact centre which provides information on out-of-hours services and location.¹¹⁹ Another pilot scheme supported by the Prime Minister’s Challenge Fund aims to provide 43,000 patients across England with 24/7 telephone access to GP practices which has seen a reduction in unscheduled registered patient use of walk-in services.¹²⁰

But it doesn’t even have to rely on technology. Just applying resources in the right place can help the system to work better together. For example, GPs are working within Royal Free Hospital in North London to intercept avoidable A&E patients by treating minor injuries, doing blood tests and X-rays and dealing with those who are drunk. They have had particular success with those who have never registered with a GP.¹²¹

Despite promising examples, what remains clear is that primary and community care reform is not complete and that relevant local bodies must work together to come up with new solutions. As Norman Lamb put it: “There is, in my view, a pent up energy in the system to work innovatively and to work collaboratively”.¹²²

CCG, council and community services – all three need to be signed up as a tripartite – perhaps as a joint delivery vehicle for primary care reform. With the NHS Forward View talking about “Multispecialty Community Providers” – hinting at the future potential to “employ hospital consultants...or take delegated control of the NHS budget,” it looks like health leaders acknowledge the opportunity, and local areas should make the case for it.

Recommendation: Ensure that primary care best practice (for example, Airedale Hospital, the Vitality Group, and Royal Free

117 The King's Fund, Nuffield Trust, A report to the Department of Health and the NHS Future Forum (January 2012)

118 Airedale NHS Foundation Trust, "Sharing success at global event" Telehealth Talk (Winter 2014)

119 NHS England, PM Challenge Fund, Health United Birmingham Pilot (Accessed January 2015)

120 NHS England, PM Challenge Fund, Care UK Pilot (Accessed January 2015)

121 Camilla Cavendish, "Making the grazed knees and twisted ankles wait longer will help heal A&E", The Sunday Times (11 January 2015)

122 Peters, D, "Lamb roars against 'ridiculous' health and social care divide" The MJ (31 October 2014)

Hospital described above) is supported and well documented—serving as an example to the whole health and social care sector.

Impact: This would:

- Place primary care at the heart of a prevention agenda.
- Pave the way for the introduction of care pathways which promote an integrated approach to care.

4.5 Bringing budget stability to the NHS – five year budgets

Building on the above, after decades that have seen wave after wave of reform in NHS structures, we believe the next Government should try something new and commit to a plan and budget for a whole parliamentary term, in an attempt to see a return on investment and provide stability. It is an inescapable truth that continually operating to one-year horizons makes organisational planning much more difficult than it needs to be. Eliminating the requirement to balance the books over a 12-month cycle, and hence the flexibility to roll funds over year ends, would remove the perverse situation where savings/underspends are disincentivised because they are taken away to the centre and next year's budgets shrinks.

The good news is that in the 2014 Autumn Statement the current Government pledged, if re-elected, to giving CCGs (and local authorities) indicative multi-year budgets "as soon as possible after the next Spending Review".¹²³ But, as the International Longevity Centre has recently argued¹²⁴ – and at least one of our DPH interviewees agreed: "if we had five years, we could really make a difference" – we should be looking for budgets that match national political cycles.

Recommendation: The next Government to commit to a fixed five-year budget – start with the integrated budgets set out above, but looking to extend further in the medium term. The government should also link NHS and social care settlements.

Impact: This would:

- Introduce a common narrative across local government and the NHS.
- Stabilise planning horizons.
- Allow a mind-set shift away from short term thinking.

4.6 Personalisation – integration of health and care services from the bottom up?

We support the development of personal health budgets and the wider personalisation agenda (as highlighted in the NHS five-year vision), as a way of pushing and developing integration from the bottom up. While there perhaps may be more fragmentation in the short term, it will help drive some of the crucial integrated pathways. Individuals don't see (or care about) organisational silos, they just want an integrated suite of services and a clear route to feeling happy and healthy.

However, the increase of personalisation and the impact of personal choice also generate an increased need for greater information and advice for older people. Councils are starting to take on this role, but could this be expanded to include health advice? Alternatively are GPs better suited? In any case, provision of information and advice should be considered and commissioned locally (again, possibly through a tripartite approach).

¹²³ HM Treasury, Autumn Statement 2014 (accessed January 2015)

¹²⁴ ILC, Public health responses to an ageing society (November 2014)

Recommendation: Support the vision of NHS five-year view and promote personalisation as a way of driving integration from the bottom up. Additionally, to move towards joint commissioning of information and advice services across health and social care spheres.

Impact: This would:

- Bring commissioning responsibility down to the individual level.
- Improve health and social care outcomes.
- Require less intervention from local government and the NHS.

4.7 Bringing together NHS and care leaders at the local level

Our survey showed very strong support (85 per cent) for a joint training programme for NHS and wider public sector leaders. There are many examples of similar such programmes, e.g. the Leeds Castle Leadership programme and the Government's Commissioning Academy (introduced in 2013), but the necessary move towards strong integration between health and social care sectors necessitates a more widespread approach. There are examples of this locally: Hertfordshire has a multi-agency commissioning academy, which every commissioner in the county will go through, but should be rolled out nationally as an essential part of ensuring that leaders "speak the same language", as one interviewee put it.

Recommendation: Government to support local areas in establishing local commissioning academies, of an appropriate scale, building on existing models. This would involve mandating local health commissioners and critical providers to attend.

Impact: This would:

- Improve communication and co-ordination of services at the local level.
- Build trust across the health and social care sectors.

4.8 Greater understanding in NHS of care options available

While Government has recently announced a 'What Works Centre for Wellbeing',¹²⁵ this is envisaged as a university research-based centre, focused on long-term evidence of "the impact that different interventions and services have on wellbeing." While this is helpful, several of our interviewees highlighted an urgent need for greater understanding within the wider NHS (and, to an extent, within local government) of what alternative options are available in the community. This could, for example, include better training of 111 operators so that they are better at identifying those cases that do not require acute care – for example, those for whom a visit to a community nurse or approaching their council about social care would be the best response – and so reducing pressure on A&E services.

Our survey of local health leaders revealed that the main underlying cause of delayed transfers of care was due to the relationship between the relevant partners— identified by 52 per cent of respondents. Delayed transfers of care from hospital for old people would be reduced if the NHS had a greater knowledge, communication and understanding of local specialist housing and housing with care within the NHS.

While an increase in cross-sector training, as proposed above, would improve local understanding, arguably more is required at the national level. We therefore propose a practical, NHS-focused centre to promote the latest understanding that

¹²⁵ Public Health England, "What Works Centre for Wellbeing announced" (29 October 2014)

can highlight, for example, positive examples of primary care provision such as Airedale Hospital and Royal Free Hospital in London (see section 4.3). Fostering cross sector understanding is critical to bring about a shift in health and care services towards self-care and prevention.

We welcome Monitor's new guidance which will help patients receive more joined-up care. A core principle of this new guidance is that NHS providers should work effectively with other health and social care organisations locally in order to identify and improve ways of delivering person-centred, coordinated care for patients. For the first time NHS providers could lose their licence if they are seen to block the delivery of integrated care when it can benefit patients. The guidance also states that if NHS providers must 1) work with commissioners to identify better coordination of services, 2) discuss shared care plans for patients, or 3) avoid unnecessary delays in the handover of patient records. Failure on any of these grounds will lead them liable to action from the regulator.¹²⁶

We also support Demos' recommendation in their 'Commission on Residential Care' report that the Government should sponsor grants to stimulate innovation in the housing with care sector to make it "more personalised, more connected and more preventative" by increasing wellbeing, reducing unnecessary hospital admissions and helping people to stay in their own homes.¹²⁷

Recommendation: Fast track a practical and NHS-focused What Works Centre for Integration. This would be a best practise accreditor, staffed by national health, GP and council policy professionals, that would highlight innovative ideas that help integrate health and social care.

Impact: This would:

- Tackle the perceived shortfall in step down care.
- Improve the communication and culture differences between health and social care providers.
- Better the co-ordination of local services.

4.9 National leadership – Introducing a Minister for Older People

Despite repeated public acknowledgement of the potency of the demographic change we are experiencing, and the scale of the concomitant challenge that the country faces, it is revealing that our survey found that 85 per cent of health practitioners felt that the health and social care aspects of ageing are not sufficiently well understood in the corridors of Westminster and Whitehall. We believe this is because cross-cutting issues like ageing are all too easily lost in the cracks between Government Departments.

Therefore we propose the introduction of a Minister for Older People. But not just a title, this needs to be a post with the power to influence policy. The key point here is that it is cross departmental so as to reach beyond existing silos and make things happen. This reform would be cost neutral as we are not advocating the creation of a new ministry but instead to expand the remit of a current Secretary of State to include the post.

In addition to this, taking on board the concerns of local health leaders, NHS England and Public Health England need to consider when and where leadership and guidance is appropriate... The view of several Directors of Public Health

¹²⁶ Monitor, "Monitor guidance to help patients receive more joined-up care" (14 January 2015)

¹²⁷ Demos, Commission on residential care (2014)

was that national leadership bodies “need to take a back seat.” Longer term, the government should consider whether the fragmentation at a national level is providing best value.

Recommendation: Introduce a cross-cutting Minister for Older People.

Impact: This would:

- Allow an individual to reach across government silos.
- Provide a single figurehead with the power to influence policy.
- Increase the accountability for future examples of poor care for older people.

4.10 Raise awareness of the need to save for care

As research has suggested that not enough of the population are aware that the Government does not fully fund social care for older people more must be done to improve public understanding about the cost of care to ensure that future generations are prepared. Financial advice should be a key part of the long-term care system. Private funding options for care should also be promoted to give people greater choice about how they pay for care—for example the Joseph Rowntree Foundation proposed a national equity release scheme be piloted to help keep people in their homes.¹²⁸

Recommendation: Care home providers, local authorities and the Government should work together to increase the level of public information about the need for people to start saving for care. This would include greater accessibility to financial advice and different private funding options.

Impact: This would:

- Better prepare individuals for their future care.
- Reduce pressure on avoidable admissions to primary and acute care providers.
- Mitigate against future reductions to local government social care funding.

4.11 Incentivise an increase in the provision of age-appropriate housing

While there is no single answer, we think that the planning system holds the key to facilitating the creation of more age appropriate housing to counter-balance the shortfall illustrated in section 3.4. We welcome the recent agreement made between NHS England, various UK government departments, the National Housing Federation and the Chartered Institute of Housing which aims to set out a framework for cross-sector partnerships at local and national level and to enable: “improved collaboration and integration of healthcare and housing in the planning, commissioning and delivery of homes and services”.¹²⁹

From a top-down systemic perspective, we echo some of the recommendations of Demos’ ‘Commission on Residential Care’.¹³⁰ In particular, we agree that local plans should be co-produced with care commissioners and those responsible for drafting local Joint Strategic Needs Assessment. We also concur that these local plans should include an assessment of the population’s future housing with care and retirement housing needs along-side an assessment of need for general accessible (disabled-friendly) housing. These changes should help developers of housing with care compete for land and planning permission on a more level playing field.

¹²⁸ JRF, Paying for long-term care: Moving forward (April 2006)

¹²⁹ National Housing Federation, “Landmark agreement’ between housing and health bodies” (19 January 2015)

¹³⁰ Demos, Commission on residential care (2014)

Creating new age-appropriate housing and housing with care isn't just about building new sites but it can also involve adapting existing buildings. We therefore also agree with Demos about extending the measures that were introduced in 2013 to relax change of use regulations around converting offices to housing, in order to allow various types of buildings to be converted into housing with care models more easily. This would be aided by the implementation of a dedicated planning designation – in the jargon use class - covering all housing with care which would help providers offer more flexible, innovative and multi-use developments.¹³¹

Moreover we strongly believe that the planning system should encourage the development of more age-appropriate housing from the bottom up, and that neighbourhood plans could be an immensely powerful mechanism for achieving this. Introduced in the Localism Act 2011, neighbourhood plans allow local people to get directly involved in determining the quantity and type of development that their community needs. Currently there are more than 1500 communities engaging in the process of producing neighbourhood plans, with more than 30 having 'gone live' after having been approved in local referendums. We are confident that neighbourhood plans are an ideal vehicle for using the planning policy changes described above to exercise a positive influence over the planning regime in local areas and push the case for more housing with care. For example, it seems likely that in many areas local people would seize the opportunity to ensure that there is suitable housing with care in their community for their elderly relatives. This would be boosted if planning categories were changed to create a dedicated use class covering all housing with care and if change of use measures were relaxed.

Recommendation: Local plans should be co-produced with care commissioners and those responsible from drafting local Joint Strategic Needs Assessments. Change of use measures should also be extended to allow more buildings to be converted into housing with care models. Finally neighbourhood plans should be promoted as a way to ensure that local demand for housing with care is satisfied.

Impact: This would:

- Ensure that need for care is covered in the planning system and land is put aside.
- Make it easier to convert existing buildings into age-appropriate housing.
- Allow communities to have a greater say in the provision of age-appropriate housing from the bottom up.

4.12 A more sustainable care workforce?

With the increasing emphasis on high quality 'basic care' – not just for the sake of the patient, but with poor care costing the NHS £2.5 billion a year¹³² – on the back of the Cavendish Review, the Government plans to introduce a new 'Care Certificate' from April 2015. This hopes to give greater confidence that Health Care Assistants and social care support workers will have "the required values, behaviours, competences and skills to provide high quality, compassionate care."¹³³ The 'Care Certificate' – as a central quality assurance mechanism – would also help carers by allowing them to take their qualifications from one employer to the next.

Given the challenging nature of work, low pay and high staff turnover care providers should ensure that their care workforce have the right support structures

¹³¹ Demos, Commission on residential care (2014)

¹³² Department of Health, "Good care costs less" (16 October 2014)

¹³³ Skills for Care, Care Certificate (accessed November 2014)

to promote career development. In a world where carers are better trained and supported, the Government should consider whether more care could be provided by qualified carers, as opposed to NHS-funded nursing care.

Recommendation: Government to develop carer support and training along the lines set out in the Cavendish Review, as a basis for replacing a proportion of nursing care provision with support worker provision.

Impact: This would:

- Allow for a more qualified and confident care workforce, better tasked to provide early interventions to prevent unnecessary admissions to hospital.
- Help meet the expected growth in demand for care as a result of demographic change.

4.13 Strengthening the powers of Local Healthwatch – an honest broker?

Finally, a check and balance is required. To boost powers at the local level, some measure of reassurance should be provided – this should not be about top-down scrutiny, but a bottom-up challenge over whether the needs of patients and residents are being met. While a local Healthwatch representative is already a statutory member of Health and Wellbeing Boards, Northumbria, amongst others, have taken their representation one step further by making them the Board Vice Chair.

But more than simply keeping partners focused on patient/resident need at a strategic level, a more empowered Local Healthwatch could act as the broker between local partners, helping them feel more comfortable in giving up commissioning power and/or budget responsibility for the wider good.

Recommendation: Give Local Healthwatch the responsibility to promote integration.

Impact: This would:

- Make sure that patients of the health and social care system have a voice.
- Bring local partners together.



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