CIPFA The Chartered Institute of Public Finance & Accountancy

from desire to delivery

CIPFA's Round Tables on the Integration of Health and Social Care

INSIGHTS

for public financial management

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executive summary

Everyone agrees that health and social care face exceptionally tough challenges in the coming years, and everyone sees integration between them as the most promising way – short of extra resources - to deal with their financial problems as well as improving the user experience. Moreover, the advent of the Better Care Fund makes substantial collaborative working a necessity. It was timely, then, for CIPFA to organise a series of Roundtable discussions – sponsored by PwC - in which senior finance professionals from health and social care, together with other influential players, came together to consider how such integration can be moved forward most positively. Five Roundtables took place in 2014, in Leeds, Chester, Edinburgh, Cardiff and London, with more planned for 2015. Participants gave their views – with a considerable degree of consensus across varying regional and national circumstances, of:

- What successful integration would look like, emphasising the need for common care pathways and the importance of seeing integration as a means of improving care, not an agenda for its own sake.
- The financial context, concluding that finance needs to lead with a holistic view, which accepts that both health and local government are under heavy pressures and all work to benefit the system as a whole ahead of individual organisations
- What barriers stand in the way, considering attitudes and behaviours; systems and policies; and the particular characteristics of health and social care. That led to initial proposals that:

The Government should take a medium to long term view of the funding required for health and social care as a whole.

- Financial and commissioning frameworks need to be set up to incentivise pursuit of the right joined up, whole system outcomes, which might include easing the rules which inhibit locally driven use of capital receipts in health and extending the Better Care Fund beyond 2015-16, but with a more enabling and less rule-driven approach.

Three main ideas were identified for further consideration:

- Should there be a move towards the use of capitation budgets across the whole of health and social care, ie funding per head rather than according to activity?
- Should there be a more rapid introduction of personalised budgets for health than is currently planned, ie empowering patients to choose how their assessed needs are met within the funding available?
- Should Health and Wellbeing Boards be given a whole system commissioning role?

The felt that finance professionals themselves – in both local government and the NHS - should be willing to lead on ensuring a whole system view is taken, improve their measurement of investment benefits from prevention agenda, take a more positive view of and improve the measures of allocative efficiency – perhaps to include targets for % of spend on primary vs secondary vs prevention.

\ introduction

Everyone agrees that health and social care face exceptionally tough challenges in the coming years, and everyone sees integration between them as the most promising way – short of extra resources - to deal with their financial problems as well as improving the user experience. Moreover, the advent of the Better Care Fund makes substantial collaborative working a necessity. And yet matters are not so simple. The practical barriers remain considerable, so much so that academic studies have yet to produce compelling evidence that integration has yet generated cost savings.

It was timely, then, for CIPFA to organise a series of Roundtable discussions – sponsored by PwC - in which senior finance professionals from health and social care, together with other influential players, came together to consider how such integration can be moved forward most positively. Five Roundtables took place in 2014, in Leeds, Chester, Edinburgh, Cardiff and London, with more planned for 2015. What lessons have emerged from the discussions to date, which have already involved some 60 leading professionals?

Participants gave their views – with a considerable degree of consensus across varying regional and national circumstances – on four questions:

- What would successful integration look like?
- What is the financial context?
- What barriers stand in the way?
- How might those barriers be overcome and the right integrated outcomes facilitated?

the goals of integration

The Kings Fund defines integration as 'the combination of processes, methods and tools that facilitate integrated care', going on to say that 'integrated care results when the culmination of these processes directly benefits communities, patients or service users – it is by definition 'patient-centred' and 'population-oriented'. Integrated care may, then, be judged successful if it contributes to better care experiences; improved care outcomes and more cost effective delivery.

As such, integration involves more than cooperation and joint working. It requires common care pathways, if not organisational and financial merger. The Integrated Care and Support Collaborative's definition – also favoured by the Association of Directors of Adults Social Services (ADASS) – is a good way of capturing the person-centred outcome to which should lie behind that: 'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me'.

Some participants felt that this underlying vision was getting lost, one saying that "collaboration has become its own agenda rather than seen as a means to provide better services to the citizen", another emphasising that "integration isn't an end in itself but a tool to develop shared goals, which comes back to getting the vision right – and seeing if integration is the right way to deliver those goals. Another warned that "combination without changing the model of care is likely to fail", and also emphasised the need for a clear vision – in which context the recent Five Year Forward View for health is promising, but "has yet to be adequately brought together and communicated across the whole system and translated into implementation approaches".

the financial context

Central as the user experience is, the intense financial pressures faced by both social care and health make cost factors particularly critical at present. The difficulties faced by social care are well documented: a natural growth rate of 4% per year for demographic change and inflation has been set against 40% reductions in central funding for local government, making real terms reductions inevitable in what is by far local government's biggest controllable area of spend. Moreover, there is a real danger that Care Act implementation could increase the problem. But Roundtable participants also emphasised the pressure on health, regardless of its protection in cash terms. One illustration cited was that, although health spend as a share of GDP was / is on a natural course to trade places with defence spend over a 75 year span - in 1945, health was 2% of GDP, defence 10%; now, it is Health 8%, Defence 2% - but is due to fall back to 6% of GDP by 2020, as the economy grows faster than public sector. Yet both demographics and advances in medical science will push in the opposite direction, and international comparisons already show that the United Kingdom already spends a lower percentage of GDP on health than similarly developed economies.

A further point of consensus was that local government and health should see each other's pressures as just as concerning as their own. Finance needs to lead with a holistic view, which accepts that both health and local government are under heavy pressures, and there's no point in competitively attempting to differentiate between them, which would be to argue for one part of the system against the whole. There was similarly widespread agreement that, despite the comparative scale of its budget, Health can't work in its silo – there are so many interdependencies. Nor can we, said one Scottish participant "carry on spending, as typically occurs now, 90% of that health budget on illness, and only 10% on prevention – the more so when so much of that spend is accounted for by the rising cost of caring for older people who arguably don't need to be in hospital".

Integration, then, needs to be part of a move towards rebalanced spending. As another contributor put it "We need to move away from the political mind-set which sees 'fixing it with money' as the main means of improving services, and look more towards prevention and towards the concept of mutuality – people's responsibility to look after their own health. For example, a new Hepatitis drug is welcomed, but it costs £34,000 per 12 week treatment; and if the patients given it retain their lifestyles, repeats for different strains will become endemic at great cost".

Nonetheless, it will be increasingly difficult to deliver a place-based approach to public spending, one view being that "Total Place was first considered in a time of fiscal growth. We could see all this new money going into different funding streams leading to multiple interventions, and therefore a lot of Total Place was built around 'how do we get better value from all this extra money?. That's fundamentally changed. In austerity, everyone has accountabilities to balance their own books and make sure their own organisations are sustainable. The only way a Total Place approach will happen is if realistic timescales are set – this is about the medium term, not putting things right in a year. And that involves new money if it's going to be transformational as well; otherwise, government should be more honest and say we can't afford transformation at the moment – this is about trying to balance the books".

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

barriers to integration

Participants identified a range of barriers which could limit the success of moves towards integration. They might be broadly classified as concerning (a) attitudes and behaviours (b) systems and policies and (c) the particular characteristics of health and social care.

Attitudes and Behaviours

The key barrier is 'organisational' rather than 'whole system' thinking. The assertion 'that's my money' was cited, i.e. not the collaborative behaviour needed. In part, that's a natural – if misguided – part of organisations' determination to survive, but those wrong behaviours form an insurmountable barrier if it's the system leaders who exhibit them. Leaders need to play a central role in the success of integrated care by sustained long-term commitment, enthusiasm and involvement, and by fostering excellent working relationships across organisations.

Public opinion, and its effect on political decision makers, can lie behind some resistant behaviour. Integration often involves centralising services, but that is difficult to sell to the public. One contributor explained that "Even if we can say to people, 'If we integrate these services and do it from York, not Scarborough, we will save this much' the people of Scarborough are not interested in the money because they still want the service. So the narrative around integration and money is always going to be difficult". It was also pointed out that preventative investment can, in traditional terms, lead to spending which is not directly on what is budgeted for, especially if the spend counts against other service areas, e.g. social care spend to health benefit. Participants felt it possible that the public are more in tune with this thinking than is generally assumed. Health hasn't been as good as local government in consulting on budget choices – should we do this or that or that? – Rather than just on binary questions such as whether or not to close a facility. "We need" suggested one voice "to move from 'what does the NHS system think?' to 'what the does the patient want?".

Another participant believed that a place-based approach had "never quite worked", in part because of the difficulty of agreeing what constitutes a good outcome, and because specific organisations were accountable for particular budgets. "We've got to have a set of outcomes agreed locally that relate to what people want on the ground and what the government wants at the top. "It's about bringing the different aspects together in a workable model. We've never seen that." That relates to another consensus: that there should be more focus on 'allocative' (as opposed to 'technical') efficiency – are we putting the money in the system at the place which will have most effect?

Inevitably, conversations turned to risk, and the difficulties of discussing it with politicians and the public. Ministers tend to react to failure by imposing more regulation, which drives up costs by fettering professional discretion in a never-ending drive to eliminate risk. The consensus was that risk must be accepted as important in getting the best out of staff by giving them the support, trust and autonomy to come up with solutions.

With the prospect of austerity stretching on until at least 2020, taking risks will be an essential part of the finance manager's job. As one contributor put it: "None of us are sustainable in our current form". That said, a typical participant did feel that "resistance is weakening, with recognition of the need to set aside organisational differences and move forward on the things we really need to do. We have no option but to do something big and different".

Systems and Policies

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

Nor was England's bureaucratic and inherently oppositional Better Care Fund seen as particularly helpful, with Wales and Scotland's less constrained equivalents appearing preferable. The idea of setting up integrated investment is good, but funding it from currently committed spend on a short term basis, and then tying it in to a financial framework which requires significant returns from year one, doesn't help the cause of integration. As another participant opined: "The Better Care Fund has driven some helpful joint working, but is in itself a diversion from that" – and one which only deals directly with 3% of total system spend. Using it imaginatively to go beyond that – as the Government encourages – makes obvious sense.

Data issues are another which generates a unanimous view. Yes, it is a problem: the Better Care Fund requirement for shared use of the NHS number is a step in the right direction; a single electronic care record with full data sharing and improved use of consistently defined data would all be immensely helpful.

It was widely accepted that significant financial savings can be made across the Public Sector through sharing and integrating systems. At a strategic level data sharing agreements are often in place between organisations which regularly share information, this provides a framework on how and why information will be shared. However, at an operational level, staff are genuinely concerned about the consequences to them and their organisation if they share data inappropriately (these include Information Commissioner's Office monetary penalties, disciplinary action, media interest, reputational damage and harm to the individual whose data was incorrectly disclosed). In order to harness the benefits of data sharing the concerns of staff need to be addressed and put into perspective. Organisations need to understand data protection legislation and support their staff by providing the necessary physical, technical and governance arrangements backed by adequate training.

There was also a strong feeling among some participants that the competition laws enshrined in the NHS reforms impede public sector collaboration. They believed that the divisions between local and national healthcare commissioning are causing fragmentation. Local health bodies wanting to work more closely are unable to set aside competition rules even where that would benefit local people. Consequently, according to one participant "competition is getting in the way of us doing the right thing for our patients. We are being forced down that path rather than working with partners. The confusion that is creating is significant. We're struggling to get everyone around the table because those governance and regulatory issues keep getting in the way." Another aspect of that was that contracts may need to be longer term than current procurement rules allow, in order to provide the right payback periods for innovation to occur.

Some contributors emphasised the limitations which annualised budgeting imposed on the NHS, by providing an environment unconducive to long term planning. And the capital regime is another constraint. Local government find it difficult to understand how NHS capital assets can be re-used to local benefit which would incentivise action. CCGs aren't really empowered – closing a hospital is of little help in those terms, as assets sold locally give no local benefit. Given that there is said to be £7.5bn of realisable NHS assets, that could make a big difference.

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

The Nature of Health and Social Care

No participants suggested that health and social care as such are unsuited to collaborative activity. However, the particular problems of the whole system were acknowledged. One crucial underlying issue highlighted is the number of people (15m) with long term conditions, including multiple conditions (3m expected to rise to 5m) who are not best dealt with by an NHS set up to deal with episodic care rather than long term conditions. Others pointed to the unsustainable acute sector causing whole system problems, the more so when its demands reduce the capacity for community and primary care to take on new services.

One speaker believed the absence of evidence-based models for integrating services had hindered progress: "There's a lot of dipping toes in water because there's no confidence that the model you're choosing is the right one. Health is all about evidenced research. There isn't something great out there that's worked for a number of years that we can pick up, shift and localise". That plays to the need for more risk taking, including accepting that there may sometimes not be the amount of evidence one would want for change, but that doing nothing could well lead to worse outcomes. Accountants aren't good, it was said, at assessing the cost of doing nothing as opposed to the cost of doing something – as a result, action is often wrongly seen as riskier than inaction.

The lack of understanding between the sectors was also acknowledged as a historic barrier. The roundtable conversations are, of course, partly about countering that, and it was also conceded – even by those who found the Better Care Fund regime unhelpful – that it had compelled joint work and joint tackling of difficult issues which has considerably increased mutual understanding.

possible ways forward

There is some cross-over, but is perhaps worth considering separately what the Government might do, what local health and social care might do, and how finance professionals might help. The initial round of discussions suggested the following ways forward, many of them congruent with issues flagged by the CIPFA project on Aligning Public Services, which focuses on measuring the totality of public spend and identifying the best whole system ways to spend the public pound to improve outcomes for local communities.

Government

A medium to long term view should be taken of the funding required for health and social care as a whole.

Financial and commissioning frameworks need to be set up to incentivise pursuit of the right joined up, whole system outcomes:

- A sensible start would be for the Department of Health simply to signal – without rules or targets – that an interest would be taken in the proportion of budget integrated, and the amount held as individual budgets. That would encourage progress without new bureaucratic impositions.
- Ease the rules to facilitate locally driven use of capital receipts in health
- Extend the Better Care Fund beyond 2015-16, but with a more enabling and less rule-driven approach.

Three ideas are worthy of further consideration, including in CIPFA's future Roundtables:

- Should there be a move towards the use of capitation budgets across the whole of health and social care, ie funding per head rather than according to activity?
- Should there be a more rapid introduction of personalised budgets for health than is currently planned, ie empowering patients to choose how their assessed needs are met within the funding available?
- Should Health and Wellbeing Boards be given a whole system commissioning role?

Health and Social Care locally

We must create wellness, not just treat illness. This need not require big spending: e.g. making sure children run round the playground, or setting up Early Years Clubs to talk to and involve people who have the life styles which lead to long term health problems. England's Troubled Families programme is a good model of wide integration, which plays to what many professionals have felt – that 'I know the 10 families who cause trouble in this town and need to be helped'.

One way to cut through the system problems and link to social services, which is set up to deal with long term conditions, would be to take forward joint personal budgets in health and social care, and build community capacity to back them up. Then overall personal needs would be the driver. The Government is trialling that, but slowly, as the current ten pilots are due to run for three years. The danger is if we don't understand where we're headed – which may be there - when we join up the money, we'll do it in the wrong way.

Finance Professionals

Finance professionals – in both local government and the NHS - should be willing to lead on ensuring a whole system view is taken if others do not.

We should carry out the research and training needed to improve the value of finance's contribution to the integration agenda. We need to:

- Develop the tools to measure investment in people in as persuasive a way as we measure the investment in buildings or highways. It's accepted that for a highway the key is to intervene at right time before we incur the exceptional costs of replacing the road. But how does that translate to people? How, for example, do we measure return on investment on school meals?
- Improve our measures of allocative efficiency. Those might include targets for % of spend on primary vs secondary vs prevention. The right combination is long term whole system allocative efficiency combined with allowing maximum flexibility to achieve technical efficiency at the local level. This thinking should embolden the finance profession to challenge the allocative efficiency of short term fixes, narrow views of investment and unaffordable universalism.
- Equip finance professionals to do the right things: participative budgeting, long term thinking, outcomes focus, transparent presentation of the long term effect of decisions; and encouraging, not discouraging, the taking of appropriate risks.
- Improve our and our audiences' understanding of what's happening across time and across whole systems.

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