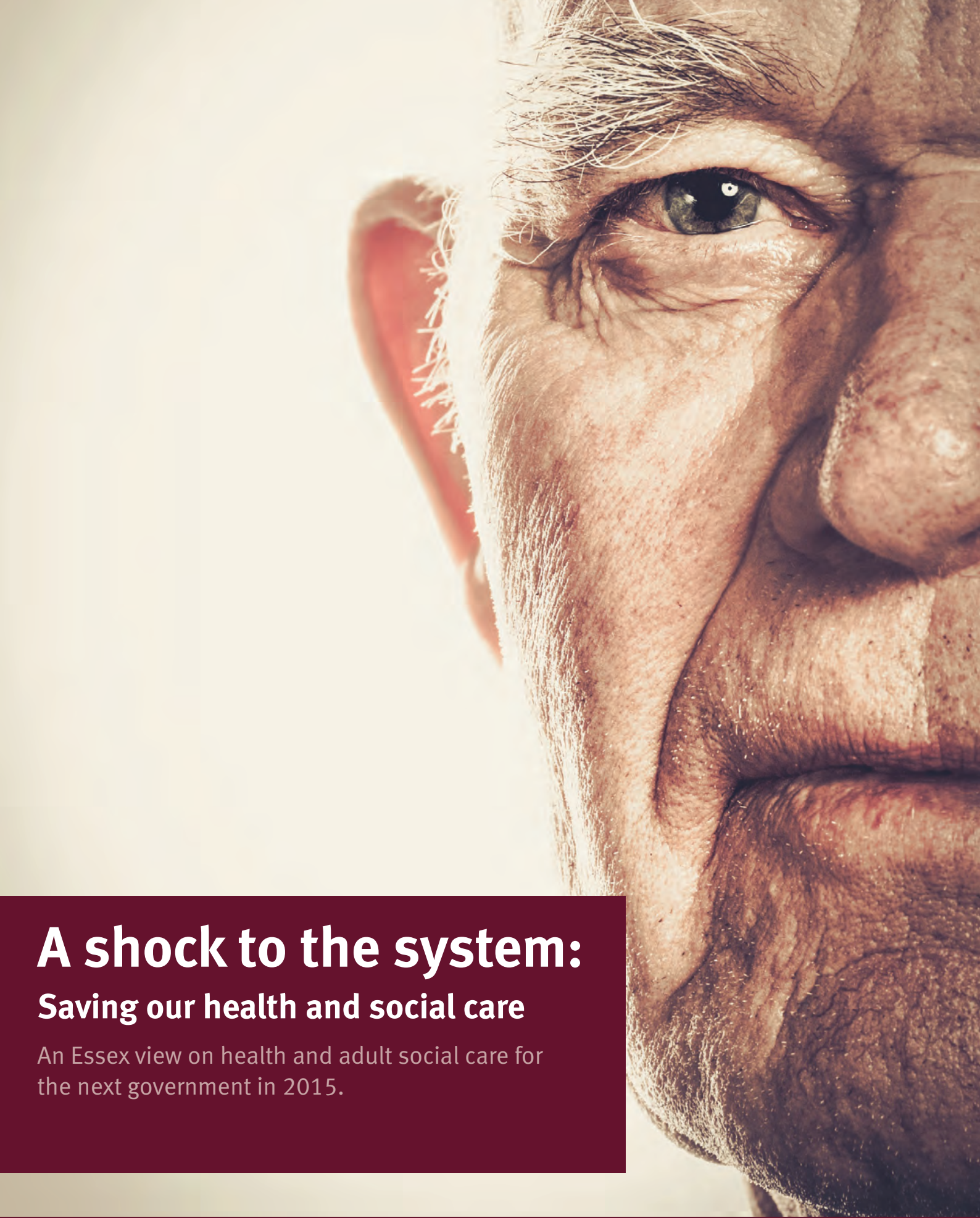


A shock to the system:

Saving our health and social care

An Essex view on health and adult social care for the next government in 2015.

Essex County Council

Contents

Foreword

Health and social care in the UK has always been an emotive subject and it is easy to understand why. We value our health and the quality of life and we are passionate about making sure that this same quality of life is maintained and improved.

But our health and adult social care systems are under increasing pressure and the voices of concern are getting louder. There is a growing consensus that our health and social care systems are unsustainable and will face a considerable funding gap by the end of this decade unless there is action. There can be no doubt that these issues must be addressed.

Essex is a large county of 1.4 million people, with 12 district councils, five clinical commissioning groups, five acute trusts and two mental health trusts serving the needs of Essex residents. The people of Essex are, on the whole, healthy but are growing older at a much faster rate than the majority of the UK. Anyone looking for evidence of the growing pressure on health and social care services need only look to Essex.

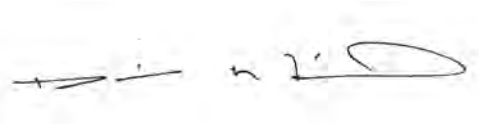
We are under no illusions that much of what needs to be done must be done locally, and we will continue working to address the issues as best we can, but some changes are not within our powers. That is why we believe the next Government must tackle some important and difficult questions about the future of health and social care in England if they are to have a sustainable future and avoid crisis.

This paper sets out our view on the actions the next government must take to improve the current system:

1. A 10 year funding settlement for health and care that would allow the NHS and local government to plan for the long-term and shift spend to prevention.
2. Local Health and Wellbeing Boards need to be given teeth and, led by local Health and Care Commissioner, be given the power to control budgets and commission health and care services, integrating health and social care in a central arena.
3. We need to have an honest conversation about how we are going to pay for health and social care going forward, before they fall over. Only Government can lead this conversation.
4. The NHS tariff system needs to be reformed to incentivise prevention and align financial incentives for providers with health and social care outcomes for individuals.
5. The legal presumption to share data in order to provide integrate health and social care services, with an individual right to opt out.

The example of Essex may seem local, but the implications of ignoring it will affect all of us nationally. Unless the next government seriously looks at these proposals, and engages in conversation, we risk losing the health services we value so much.

I hope this paper is helpful in seeking to bring some focus to an often complex debate.



Cllr. David Finch, Leader of Essex County Council

1. Introduction

We will all have health and care needs at some point in our lives. And when we do, most of us look to our National Health Service (NHS) and adult social care system for treatment and support.

Our NHS and social care systems will soon be 70 years old. During their lifetimes they have treated, nursed, cared for, and supported hundreds upon hundreds of millions of people from the cradle to the grave.

In the last year alone, the nation's GPs have been visited by an estimated 370 million people.[1] (see figure 1 on p3). Over 100 million outpatient appointments were made with our hospitals and over 18.5 million attendances were recorded at Accident and Emergency, 3.9 million of which resulted in admission to hospital for patient care.[2] Over the same period, around 2 million people contacted local authorities for support for their care needs.[3]

Every day we place our trust and our lives in the hands of both systems – one is free at the point of use for all; the other means-tested based on income – to look after and care for ourselves or our loved ones during times of need and frailty. In short, both systems are great pillars of our society.

From their birth, our health and social care systems have been separate. They have two different cultural and legal systems. They are separately funded and accessed. They are overseen by two different government departments (Health and Communities and Local Government). And there is a historical distinction dating back to 1948 between the 'sick' and those in need of 'care and attention'.

But like many a near 70 year old, our NHS and social care systems are starting to creak. The Britain of 2014 is vastly different to that of late 1940s Britain. Our lifestyles, our ambitions and aspirations, and our challenges have changed radically.

There is now more of us than ever before. Our population has grown from 50 million in 1948[4] to over 64 million today[5]. And we are living longer than ever before. The average man can now expect to live until he is 79[6] years old compared with 66 back in 1948[7]; the average woman can expect to live until she is 83 years old[8], compared with 70[9] back in 1948. But despite the period of great change, the NHS and social care systems haven't changed anyway near as much.[10]

The last four years have seen some of the biggest reforms to both the NHS and adult social care system since their foundation but they are still too fragmented and disjointed for the people who use them. There are widespread concerns among experts that our health and social care systems are struggling to cope with the pressures – both demographic and financial – that are bearing down on them. NHS England has estimated that there will be a £30billion gap between resources and demand by 2021 in the health system alone unless there is change[11].

We are not immune to these pressures in Essex. Whereas the credit agency Moody's have estimated[12] that the UK will become 'super-aged' by 2025 – where more than a fifth of us are over 65 – in Essex, we reached this point in 2013, and by 2025 it will be closer to one in four[13]. We expect the number of us in Essex needing social care support to grow from 35,000 now to more than 137,500 by 2030[14].

The next government will face a critical challenge: how to put health and social care onto a secure and sustainable footing for the decades ahead, while simultaneously making significant reductions in public spending to tackle the national debt.

And this requires balancing available resources against rising public expectations. After all, per capita spending on health has increased by 115% in England since 2001 (in other words, more than doubled)[15] but demographic growth means that there are still significant financial pressures

Figure 1: *Our population is living longer than before...*

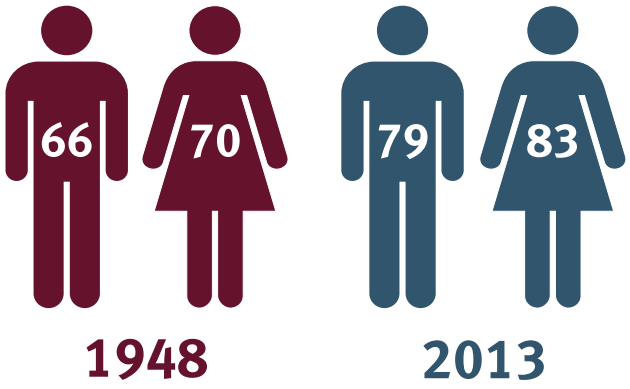


Figure 2: *370 million people visited our GPs in 2013 (or nearly 6 times the UK population!)...*

Figure 3: *Over 100 million hospital appointments were made in 2013; if this were individual people stood in a line, there would be enough people to go around the equator thirteen times.*

Figure 4: *More people are attending A&E*

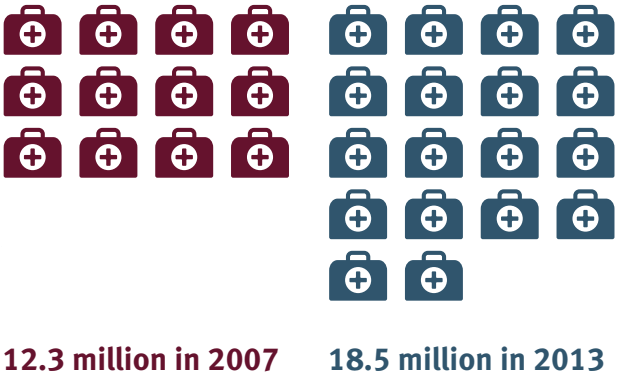


Figure 5: *Essex is already a 'super-aged' county, with more than 1 in 5 of us over 65 (England is not expected to reach that point until 2025)*

Figure 6: *Nationally, it is estimated there could be a £30 billion gap in funding for Health alone by 2021*

in both the short and long term. At present, the NHS and social care cost £130 billion per year - more than the combined total spend on education, defence and the police. Getting the answer right therefore doesn't just matter for the NHS and social care systems; it matters if other public services are not to suffer to bail them out.

Essex believes the future of our health and social care systems is so important for the future of our residents and our county – and the country at large - that we want to participate actively in this debate.

We recognise that people's expectations of health and social care need to change in the future. We recognise that we all have obligations as individuals and communities to look after our own health and to support and care for our loved ones and our neighbours. And we recognise that the health and social care systems need to join up more so that two systems act as one.

But we also recognise that the next government has the critical job of taking the important and long-lasting decisions that will secure the future of our health and care systems for the decades to come and free up local areas to innovate and change to meet their local needs. A failure to take decisions on these challenges now will only worsen – rather than help address – the problems facing our health and care systems.

Doing nothing is not an option.

This is the Essex View on that challenge. Our Essex View on the five policy decisions that need to be taken to secure the future of health and social care.

2. The pressures we face

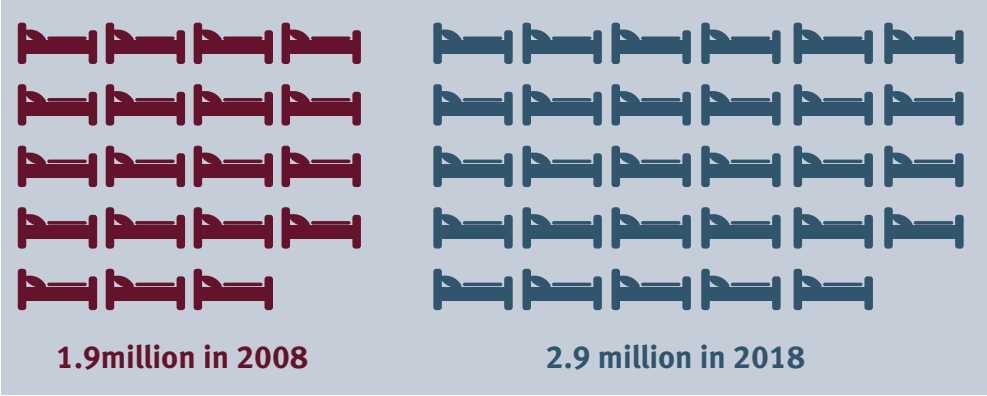
The national picture

Our NHS and social care systems need to care for more of us than ever before. The combination of rising demand for services, increasing costs, and reducing or static funding means we face a challenging equation: how to fill the gap between the money we have, and the money we need, to deliver a world class health and care system.

Population growth and demographic changes mean that the demand for health and care services is growing. Not only are there more of us, but we are also getting older. The overall population of the UK is forecast to grow by about three million between 2012 and 2020, with the population aged 60 and over growing by more than 2 million[16]. Currently one in six of us living in the UK is aged over 65; by 2050 this will increase to one in four. The number of people aged 85 or older – the people who most depend and intensively use health and social care – is set to grow fastest of all[17].

And as our life expectancy increases, so does the incidence of complex long term conditions; these extra years of life will often involve poor health, dementia or disability. Numbers of conditions such as dementia, diabetes and numbers of people living with cancer are all set to increase; as is the number of people who suffer from multiple conditions from 1.9 million in 2008 to 2.9 million in 2018.[18] This will significantly increase the demand for the services provided by health and social care agencies.

***Figure 7**: Complex needs are set to increase in the UK*



Nationally, it has been estimated that people with more than one long-term condition account for £7 of every £10 spent on health and social care[19]; so the increase in older people with multiple conditions will increase the pressure on services disproportionately.

Meeting our needs within ever stretched financial resources is becoming a significant challenge to our health and care systems. Research papers over the last 18 months have estimated the funding gap by 2021 ranges from between £30bn[20] for health alone (although this could be worse if the health budget is not protected in real terms[21]) and between £1.9bn[22] and £7bn[23] for social care. A recent review[24] conducted by the Audit Commission highlighted the impact of the pressures faced by many NHS trusts. Of the 98 trusts reviewed, 19 were referred to ministers as a result of concerns about their finances – including two in Essex.

The Local Government Association has identified a 40% real terms reduction in local government funding over the course of the current parliament, with more to follow in the next one, creating a budget gap for local authorities of £12.4bn by 2020.[25]

In addition, the Care Act 2014 will implement the most radical reform of the social care system since the 1940s from 2015 onwards. This introduces welcomes changes but also threatens to add further cost pressures onto social care. In Essex, we estimate it could cost nearly £30 million in largely unfunded costs in 2015/16 alone.

The picture in Essex

Essex is a large and relatively healthy county. But in Essex, we can also see locally an example of the problems faced nationally. The county area covers a population of 1.4 million people. There are five clinical commissioning groups, 12 district councils, one county council, five acute trusts and two mental health trusts.

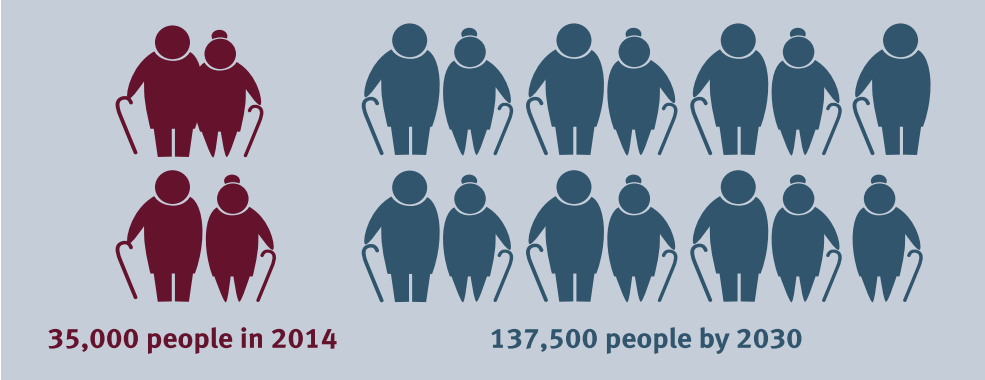
Our challenges are largely driven by demographic pressures:

- The Essex population grew 6% between 2001-11 and is forecast to grow by 20% up to 2033
- Essex has an older population than the national average (20% vs 16%)

***Figure 8**: Essex has an older population than the national average*

- By 2031, people aged 65 or over will make up 28% of the total of Essex population[26]. The number of Essex residents aged 90 or over in 2011 was nearly 44% higher than at the time of the last census in 2001
- We expect the number of people in Essex needing care and support to grow from 35,000 now to more than 137,500 by 2030.[27]

***Figure 9**: More social care will be needed in Essex*



That is why Essex set up an independent commission under the chairmanship of Sir Thomas Hughes-Hallett in 2013, to look at the issues facing the future of health and social care in Essex. His report, entitled 'Who Will Care?', is focusing the minds of Essex public sector and voluntary sector agencies on how to address the particular problems in Essex.

As the 'Who Will Care?' report argued:

"The problem is a simple one. More people need care and there is not enough money to go around."[28]

Increasing numbers of adults with care needs

It is not only at retirement age that we face pressures. The numbers of working age adults with physical disabilities or sensory impairments are high and increasing[29] and the trend in Essex is no different.

The number of adults with learning disabilities and physical impairments is also increasing. By 2020 the number of adults with a physical disability and personal care need in Essex is set to increase by 7.5%; by comparison the same population in England is only set to increase by 5.9%[30]. This means Essex will feel the pressures of a demographic shift far sooner than the country as a whole.

In short, more and more of us are likely to be coming into contact with health and social care services over the next decade, whether that be for home care or residential care.

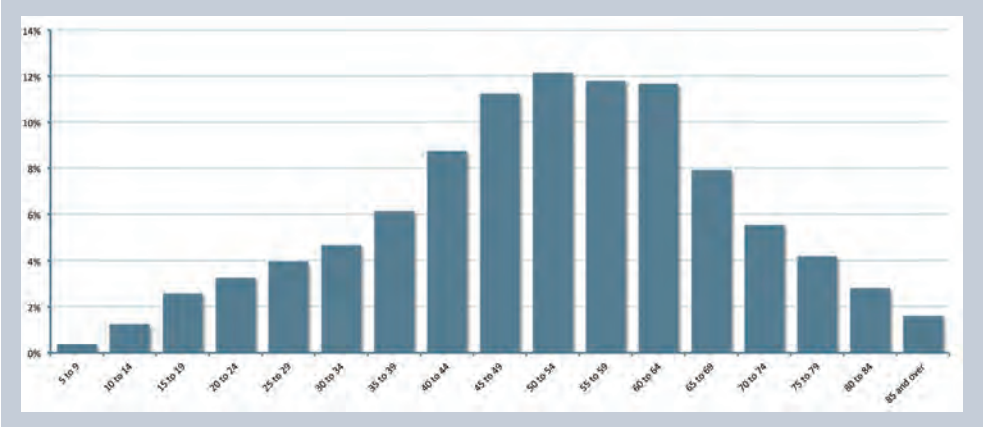
Workforce succession and a reliance on informal carers

Increasing demand for services places an increasing demand on health and social care workforces. Workforce succession is a looming issue for social care and health with a lack of adequate replacements for retirees placing strain on the system.

GP surgeries are struggling to meet rising demand due to a deficit in the number of GPs - 8,000 more family doctors are now needed in England.[31] In Essex almost half our GPs are due to retire within 15 years. GP practices are stretched, with one quarter of them being 'single-handed'. Essex is already 'under-doctored' and we would need 143 more GPs now to reach the national average of GPs per person.

We are also increasingly reliant on informal care arrangements, with 5.8 million of the population in England (10%) providing unpaid care for someone with an illness or disability.[32] The highest share of the unpaid care burden falls on men and women aged 50-64 (see graph below).

Figure 10: *Unpaid carers by age range*



Carers UK estimated that we will see a 40% rise in the number of carers needed by 2037 – an extra 2.6 million carers, meaning the carer population in the UK will reach 9 million.[33]

Financial pressures in Essex

The national drive to make savings as budgets are reduced has impacted on local authorities and the NHS in Essex. Essex County Council has already made £364 million savings over the last four years but has to save at least a further £235 million over the next three years; with £75 million to be saved in adult social care.[34]

The five Clinical Commissioning Groups in Essex have also identified cumulative pressures, with £84million needing to be saved by 2018.[35] Two of the five Essex hospital trusts – Mid Essex Hospital Services NHS Trust and The Princess Alexandra Hospital NHS Trust – were highlighted by the Audit Commission as having stretched finances. Mid Essex Clinical Commissioning Group – covering growth towns such as Chelmsford and Braintree – faces particular financial pressures and is the 9th lowest funded CCG per population in the country.[36]

At local authority level we are predicting that spending on social care alone will soon take up all of our available resources within a decade unless there is change.

Conclusions

We face a significant national challenge in meeting the ever growing demands for care and support with the limited resources available. Areas such as Essex are likely to face these pressures sooner than the rest of the country as a result of their demographic profiles. The question is: how does provision need to change with the times to remain viable? Or will services need to be rationed in the future?

3. What we are doing in Essex

Essex is a large and complex health economy. But despite the complex arrangements and the challenging demographic pressures, we are committed to working together to tackle the problems we face.

Who Will Care?

In January 2013, Essex partners tasked an independent commission of five independent commissioners to answer the question: how will we care for ourselves and our communities right now and in the future?

The commissioners, under the chairmanship of Sir Thomas Hughes-Hallett, developed five high impact solutions in their September 2013 report 'Who Will Care?':

1. Agree a new understanding between the public sector and the people - the public sector needs to be up-front and honest with us, clarifying the extent of the 'care offer' available to us
2. Prevent unnecessary crises in care - a new approach to change the focus of care from treating disease and chronic conditions to supporting individuals earlier
3. Mobilise community resources
4. Use data and technology to the advantage of the people of Essex
5. Ensure clear leadership, vision and accountability

Essex partners are committing to taking forward these recommendations with a strong emphasis on building strong and resilient communities.

Innovation and Community Agents

The Essex public sector is working with the local voluntary sector to deliver innovative projects such as The Community Agents Essex scheme which supports vulnerable older people and informal carers within their own communities. The Community Agents will help individuals to identify, source and implement solutions to the issues they face, helping them to find support from within their own natural and community networks. This could be help to address increasing frailty, loss of confidence, social isolation, mobility issues etc, enabling the individual to manage their own lives and remain independent in their own home for longer. There will be 36 Community Agents across Essex, supported by volunteers who are aiming to support around 6000 people in a year..

Essex is rolling out a new Time and Care Banking Scheme, where those who undertake community volunteering can 'bank' time as credit which can later be used for skills exchange, or donated to others in need.

Working similarly, Care Banking focuses on specific groups within the community and activities that may relate to low level care, working specifically with older people, people with long term health conditions and carers.

Youth volunteering pilots are also being developed across Essex. These opportunities will offer young people the chance to develop their skills, self-esteem and overall employability while also contributing to their local communities.

A £1.4 million Community Resilience Fund has been implemented to help local communities and organisations, families and individuals develop the skills and resources needed to look after themselves.

Joint commissioning and the Better Care Fund

With such a large and complex county, it is important we get our governance right and ensure we can get input from across the sector. The Essex Health and Wellbeing Board has added acute and mental health trust representation, and Essex councillors are now represented on each of the five Clinical Commissioning Groups (CCGs) to enable local joint commissioning decision-making.

ECC and CCGs have jointly re-commissioned disability services for working age adults (making savings of £24.8 million), continuing health care, and redesigned integrated Child and Adolescent Mental Health Services (CAMHS).

The Better Care Fund, created by government to help support greater integration in health and social care, has provided an opportunity for the service delivery stakeholders in Essex to work together. In Essex, the Fund will support:

- new provider models of integration between community health, community care and primarycare providers;
- investment in reablement funding on community based services and in integrated health and social care residential and domiciliary reablement models;
- investment in effective hospital discharge support.

Conclusions

But Essex cannot tackle the fundamental problems confronting the health and social care system alone. The harsh reality is that not only are difficult decisions required but that the most fundamental of these require decisions and policy change by national government: decisions about how the health and care system is funded and how it is accessed. Local health and well being boards and local councils simply do not have the legal authority to make the fundamental changes that may be required.

4. The constraints we face

To meet the challenges of a growing population and stretched financial resources, some fundamental constraints need to be tackled.

From their birth, our health and social care systems have been separate. They have two different cultural and legal systems. They are separately funded and accessed. They are overseen by two different government departments (Health and Communities and Local Government). And there is a historical distinction dating back to 1948 between the 'sick' and those in need of 'care and attention'.[37]

As citizens, we can be left confused – and frustrated – at having to speak to different agencies. Why don't they communicate with each other? Why do they have different rules, procedures and practices? Why can't I just have a single package of healthcare and support?

There is consensus that the two systems need to work more closely together and the Government has set a target of health and social care being integrated by 2018. The combination of growing demand and reducing funding means that integration is a necessity. Both local government and the NHS are committed to delivering significant savings and efficiencies to make every pound go further. But this is unlikely to be enough to meet the demands of an ever growing and ageing population. A number of constraints need to be tackled at a national level to allow real progress to be made.

Different funding systems

The first problem is that health and social care are two separate systems which are funded separately. Money is seen as either belonging to health or to local government.

Local authorities have a wide array of responsibilities and need to balance spending decisions against local priorities – whether they be looking after vulnerable adults or children, or investing in highways or education. In other words, local authorities choose the amount they spend on social care; they do not have a set amount to spend on it.

The Barker review's interim report for the Kings Fund[38] suggests the lack of a ring-fenced social care fund allows for a high level of discretion, and that funding responsibilities are a source of conflict between the NHS and local authorities. It suggests the different funding arrangements act as an incentive for the NHS and Local Authorities to try to pass the cost on to each other.

The House of Commons Health Select Committee has called for a real terms ring-fence to prevent funds being treated as being owned by a single part of the system, and instead as belonging to the health and social care system as a whole.[39]

Different accounting rules between the NHS and local government and the inability of NHS organisations to carry forward resources also contribute complexity.

Short term planning

While health and social care have to deal with long-term demographic changes, both systems are funded on a short-term basis. In other words, while our health and social care systems struggle with the problems of today, they are not able to adequately plan ahead for the future.

The Lords Committee on Public Service and Demographic Change has suggested that longer funding cycles are required to support long term planning to enable health and social care systems to plan more strategically and systematically for changing long-term needs.[40] This argument has been echoed by the Local Government Association (LGA) who recently called for

a larger and longer term Better Care Fund to cover a five-year period.[41]

Recent difficulties with the Better Care Fund – with the NHS and local authorities understandably concerned about where financial risk lies – is an example of how the funding system does little to incentivise risk sharing or incentivising spend in preventative services, the benefits of which are unlikely to be realised instantly. The same is true of integration with Torbay (often cited as an example of the potential of Health and Social Care integration) only seeing the benefits of their approach over a 10-15 year time period.[42]

Different eligibility criteria

Our care needs are paid for differently depending on whether they are deemed to be health based or social care.

The NHS is a universal service and in the majority is free at the point of use. Charges for dental service and opticians were introduced in the early 1950s, not long after the free-at-the-point of use NHS was established. Prescription charges followed in the 1960s.

But social care support is different. How our social care needs are paid for is based on whether we are eligible and / or based on our financial means. From 2016, there will be a cap on eligible care costs of £72,000 for those aged over 65.

However the split between services made in the 1940s is no longer clear. Many needs overlap both health and social care and in some cases the lines are blurred as to who has responsibility. Continuing Health Care (CHC) is a prime example of this[43] where those whose primary need is health related will receive the care (including the social care aspects) free of charge, while those with primarily social care needs such as those suffering from dementia would likely have to pay for their care.

The final report of the Barker Commission has recommended that there should be "more equal support for equal need". The report argues that "in the long run that means making much more social care free at the point of use.[44]"

The wrong incentives

To relieve pressure on our health and social care system, we need to get better at preventing or delaying the onset of needs. This principle is at the heart of the Care Act and is welcomed. But despite this, NHS tariffs reward throughput, they do not support preventative action and as such provide no incentive to reduce the number of people needing support, often creating perverse incentives and inhibiting service change.[45]

The current health system is still largely incentivised by activity, not outcomes; the tariff system and nationally commissioned GP contracts are frequently cited as constraints by commissioners and problems with adopting a payment by results (PbR) or using diagnosis-related groups (DRGs) to pay hospitals have been identified in research.[46]

The approach to payment by results also appears to differ. While the NHS tariff approach focuses more on outputs, social care commissioning is becoming increasingly outcomes focussed making it difficult to marry the two systems at a local level. In addition annual changes to the tariff mean it is hard to align funding and plan for long term integration

The current tariff system does little to incentivise the right choices and behaviours in the system

Leadership and fragmented commissioning

We should all be able to hold those responsible for our health and care services to account. The measures in place to ensure those responsible for arranging our health services are

accountable is an important part of the system, and it is vital that local people are able to see failure being tackled and hold the organisations to account. Recent reviews such as the Francis Review have highlighted the importance of transparency in the system.

However the current system has so many layers of accountability that it has lost its transparency and made integration more difficult. CCGs alone are accountable to at least six external bodies, and three internal groups.[47] Evaluation of integrated care pilots has also highlighted complicated internal processes and sign off arrangements as a source of complexity and difficulty in integrated systems.[48]

Health and Wellbeing Boards were originally intended to provide a level of local accountability, however they do not currently have the tools, or even the role and responsibilities to ensure joined up local commissioning.

Commissioning and the market

Commissioning in the current system is fragmented, with the overlap of health and social care and geographic boundaries leading to variable provision across the country, and even within individual counties.

The complex arrangements and vast distribution of duties and responsibilities have been highlighted as a difficulty within the current system.[49] For example health responsibilities are divided across 221 clinical commissioning groups, commissioning support organisations, NHS England, clinical senates, clinical networks, local authorities and Public Health England. That is at least eight organisations with key roles to play in commissioning activity before social care and the wider wellbeing agenda are considered.

Such a fragmented approach creates additional cost in the system. It was recognised by the Nuffield Trust that such an approach cannot continue. The Trust suggested collaboration and larger commissioning units would allow greater economies of scale, greater oversight of the financial situation, and more effective management of risk. [50]

A number of papers[51, 52] have called for existing cross-system bodies such as health and wellbeing boards to be given extra powers and functions. The House of Commons Health Committee has argued for health and wellbeing boards to develop their role and provide an integrated commissioner's view of the changes required in the system and would like to see a consolidated commissioning process through the boards.[53] Most health and wellbeing boards have also suggested they would like to take a more active role in commissioning.[54]

CCG and local authorities already have the legal power to put in place arrangements for a more integrated approach to commissioning. And it has been suggested that through these powers health and wellbeing boards roles may evolve to incorporate commissioning across health and social care.[55]

Conclusions

There are a number of barriers and constraints that need to be addressed if the health and social care systems are to have a sustainable future.

A number of national policy reports have recently been published on the challenges and pressures. But while many of these reports are starting to touch on similar issues, there is no consensus on the answers. Moreover, the various reports include a large number of recommendations meaning there is little focus. It is therefore important that any government directs its energy on a few fundamental changes, rather than distracting itself by pursuing lots of different policies. Essex wants to help bring this focus.

5. Recommendations

So what needs to be done? We set out here our view on the most important reforms that we believe the next government must look to implement during the lifetime of the next parliament to put health and social care onto a sustainable footing for the decades ahead.

1. A 10 year funding settlement for health and care.

A long term funding settlement that is aligned across both health and social care would give more certainty and greater time to realise the benefits from investments in preventative services. The short term nature of the recent Better Care Fund has not helped either the NHS or local government to fundamentally share risks and rewards. Longer term funding plans from Government are both possible and effective; Transport for London got a 10 year settlement in 2008 to enable the refurbishment of the London transport system (although it was later reduced to a five year settlement).[56]

Health and social care integration takes time. It is highly unlikely to be achieved within the 5 year cycle of a parliament, except for on a superficial basis. The short-term nature of the current planning cycles, with annual budgets, incentivise organisations to shift patients and other users to other settings so as to relieve their own costs within the budget cycle, even where these are not the most appropriate care settings. The example of Torbay shows the benefits that can be realised over a longer period of time, which developed over a 10-15 year time period.[57] A 10 year funding settlement will help support progress towards real integration.

We are not alone in calling for a longer term settlement – both the LGA and the NHS Confederation have made similar calls for 5-10 year funding settlements.[58] [59] A 10 year settlement (with a review at the start of the 2020 parliament) would give NHS and social care planners the time and breathing space to plan for the challenges of the future, rather than just fire-fighting the challenges of today.

The final report of the Barker Commission also stresses that fundamental change will take time to deliver. "Change on this scale cannot possibly be introduced overnight. Indeed, given the state of the public finances, getting to our fully implemented vision is likely to be a journey of a decade.[60]"

A 10 year funding settlement should extend the principles of the Better Care Fund with a requirement for pooled budgets and equitable risk sharing between health and local government, and require increased investment in preventative services. A 10 year settlement will give certainty and time to move the systems on to a sustainable footing.

2. Local Health and Wellbeing Boards (HWBs) should hold budgets for health and social care and direct the commissioning of health and social care services. An empowered health and wellbeing board should be chaired by a local Health and Care Commissioner.

It is clear that leadership and accountability over local health and care services is fragmented. Local health and wellbeing boards are new creatures of statute but they have the potential to bring leadership and budgets together in a natural arena. Local areas should be free to determine the specific local arrangements but there should be a clear duty on HWBs to reduce variability in outcomes within their boundaries and an explicit assumption that joint commissioning is a way of achieving this. It would be beneficial if health and well being boards could work towards a single national outcomes framework for health, public health and social care, setting a common understanding and expectations from consumers, providers and commissioners, while providing an opportunity for national and regional accountability, transparency and quality.

A new Health and Care Commissioner role could oversee local integration, giving clearer leadership and accountability. There are different models that a commissioner could take; commissioners in other public service areas, such as an elected Police and Crime Commissioners or the appointed Transport for London Commissioner are two examples. Importantly, such a role would provide an accountable and visible figure for local populations.

3. Establish an Independent Commission to hold a National Conversation about the future of health and social care and how it should be accessed and funded.

This should be supported by all political parties and should report within 12 months of a new government being formed, to enable its agreed proposals to be enacted from 2020 onwards.

Various publications have started to question the sustainability of future health and social care. Reports by the Kings Fund and Reform have both highlighted a range of different funding options that could be considered to generate the income necessary to cover costs.[61,62] and the funding of health services are constantly being reported in the both the local and national news as an issue[63,64.] Some senior MPs have also highlighted the need for an urgent cash injection.[65] A recent survey on raising additional funding suggested 48% of voters back tax-funded spending increases, while 21% would prefer charges for some services.[66] A Social Care ISA is one idea that could be looked at and which Essex County Council has mooted, giving tax incentives to save for the care costs of the future.

But while the debate is extremely active in academic and professional circles, no one is having the conversation with the British public. As politically sensitive as health and social care is, it is better to have an honest and open difficult conversation with the public than to run the systems into the ground.

An Independent Commission could explore what a universal service offer should look like, what people can expect of health and social care, and a range of funding options, including the role of taxes, extending charges and looking at insurance models. It is important that any financial solution is sustainable, fair, incentivises positive behavioural change and investment in prevention, and has public support and buy-in. Only government can lead this conversation but it is important that it is backed by all political parties.

4. Radically reform the NHS tariff system to incentivise prevention and align financial incentives for providers with health and social care outcomes for individuals.

The NHS tariff system is highly complex and not without its critics. It is not structured to incentivise the right choices and decisions.

As the Nuffield Trust argues:

"The predominance of activity-based payment in the acute sector, introduced at a time of long waiting lists, encourages activity in hospitals; at the same time, block budgets in community services and capitated budgets in primary care offer little incentive to increase activity or efficiency in these settings. [67]**"**

In other words, we have a system that incentivises activity in high cost, acute settings and does little to incentivise a shift towards community-based services.

We support the Nuffield Trust's recommendations that Monitor and NHS England develop an approach that has the following features:

Comprehensive – it needs payment systems that cover the continuum of care and which create incentives for providing the 'right care in the right setting'.

Focused – the payment system should be used to incentivise aspects of care for which there is evidence that payment systems are an effective lever (these being provider efficiency, transparency and accountability).

Aligned with wider system changes – to be effective, the payment system must be part of a wider package of aligned incentives, regulation, data and information improvements, plus investment.

Transparent and evidence-based – incentive schemes can only work if the organisations and clinicians whose behaviour they are trying to change understand what is required.

Predictable and credible – delivering productivity improvements and service innovation takes time, so health care organisations need to be able to plan with greater clarity about the financial environment.

Such a reform will be complex and will take time. But it is absolutely necessary if the tariff system is to drive the right behaviours and create the right incentives.

5. Introduce a legal presumption to share data in order to facilitate integrated health and social care services, with an individual right to opt out.

The current risk aversion to sharing data within public services remains a critical hurdle to vertical and horizontal health and social care integration.

As the Sir John Oldham Review recommends:

"The default assumption should be of implied consent for people's information to be shared across health and care providers for their direct care. People should be able to 'opt out' of the automatic sharing of their information."

"As part of this drive towards national interoperability, it must be a requirement for all organisations providing (health and social) care to use the NHS number.[68]*"*

New Zealand has in place an Electronic Care Share Record View[69], which is a portal that draws in information from existing sources of data showing that with consensual access it is both possible and easy to share data at the individual level for the benefit of service users. It took six months from conception to implementation.

The case for data sharing has been made before; however, as previous experience as shown, in practice this will require careful consultation on what data could be shared and who with and by.

Essex believes that implementation of these measures can help put health and social care onto a sustainable footing. We recognise that these will not be the only answer – the NHS and local government need to continue to get more efficient; the potential of technology needs to be radically explored and promoted in health and social care; and more needs to be done to ensure a steady supply of GPs.

But we believe that these five steps can help the next government to take a significant stride towards integrating health and social care and addressing the considerable pressures facing our health and social care systems. We believe they represent a focused programme of action for the next government.

6. Conclusion

There is wide consensus that our health and social care systems face huge challenges.

There is a danger that these systems will be financially unsustainable as need increases and resources continue to diminish. The growing pressures on the system need to be addressed. Doing nothing is not an option.

Essex is working to address these issues locally but the harsh reality is that local authorities and local health and wellbeing boards simply do not have the powers or authority to take the fundamental decisions that need to be taken. That is why the next government must act - and must act decisively - to take the decisions that are required to put health and social care onto a sustainable footing for the 2020s and beyond.

The asks of government set out in this paper are an attempt to give some focus to the decisions that need to be taken.

There is no doubt that local authorities and the NHS need to continue to become more efficient. But a more efficient system will not be enough to generate the resources that will be needed to meet expected demand.

So the question of adequacy of funding needs to be addressed. This must include an honest conversation with the public about what health and social care is; what is a universal service that is free-at-the-point of use; and what options there are to raise the funding to ensure everyone can continue to benefit from a world class NHS and social care system. Only national government can lead this discussion but it is one that needs to be backed by all political parties.

The health and social care systems need to be more joined-up, invest more in prevention, and plan more for the long-term, rather than just fire fighting the challenges of today.

That is why we believe a long-term 10 year funding settlement for health and social care is so important. Long-term settlements can give the certainty of funding to allow better planning and long-term investment decisions to be taken. But this cannot just be money with no strings attached; local areas would need to commit to pooling resources; investing more in prevention; delivering improved outcomes for local residents; and sharing risks and benefits between local authorities and the local NHS.

An empowered local health and wellbeing board, headed by a local Health and Care Commissioner, could be responsible and accountable for how money is spent in a local area. This would give clear leadership and clear lines of accountability.

Such decisions could lead the way to a future where health and social care act as one system, rather than as two; where petty disputes between local government and health over finances would be a thing of the past; and where spend is focused on improving health outcomes and preventing the onset of avoidable needs, rather than simply rewarding activity for activity's sake.

Health and wellbeing boards would have the power to hold budgets and, led by a Health and Care Commissioner, would oversee the joint commissioning of services with the input of all health and social care partners in one arena.

Services would be singly commissioned at the local level, accountable and responsive to local needs. There would be a genuine focus on prevention, with different parts of the wider system taking responsibility for different actions; sharing both information and benefits. There would be a sea-change to proactive prevention with all systems working together to put the user at the centre of care.

Unless government takes action on these issues in the next five years, we will face a growing pressure on our health and social care systems. The Government needs to focus on practical ways to free up local government to better work with Health partners and serve our residents.

The status quo is not an option.

We urge the next government to take decisive actions.

7. References

1. Royal College of General Practitioners, news item 28 July 2014 *'Crisis hit GP surgeries forced to turn away millions of patients'*
http://www.rcgp.org.uk/news/2014/july/crisis-hit-gp-surgeries-forced-to-turn-away-millions-of-patients.aspx

2. Health and Social Care Information Centre (2014), *Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatients and Accident and Emergency Data - April 2014,*
http://www.hscic.gov.uk/catalogue/PUB14568

3. Health and Social Care Information Centre, *Community Care Statistics, Social Services Activity, England 2013-14,* Provisional release, July 2014
http://www.hscic.gov.uk/catalogue/PUB14397

4. Ipsos Mori, *All Change In Britain 1948 -2012*, July 2012 p5.
http://www.ipsos-mori.com/DownloadPublication/1481_ipsos-mori-britain-2012-who-do-we-think-we-are.pdf

5. Office of National Statistics, *UK population estimates 2013,* June 2014
http://ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/2013/sty-population-estimates.html

6. Office of National Statistics, *Statistical bulletin: National Life Tables, United Kingdom, 2010-2012,* March 2014
http://www.ons.gov.uk/ons/rel/lifetables/national-life-tables/2010---2012/stb-uk-2010-2012.html

7. Ipsos Mori (2012), *All Change In Britain 1948 -2012*, p5.
http://www.ipsos-mori.com/DownloadPublication/1481_ipsos-mori-britain-2012-who-do-we-think-we-are.pdf

8. Office of National Statistics (2014), *Statistical bulletin: National Life Tables, United Kingdom, 2010-2012*
http://www.ons.gov.uk/ons/rel/lifetables/national-life-tables/2010---2012/stb-uk-2010-2012.html

9. Ipsos Mori (2012), *All Change In Britain 1948 -2012*, p5.
http://www.ipsos-mori.com/DownloadPublication/1481_ipsos-mori-britain-2012-who-do-we-think-we-are.pdf

10. NHS Confederation (2014), *The 2015 Challenge Declaration*, p2.
http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/2015_Challenge_Declaration_report.pdf

11. NHS England (2013), *The NHS belongs to the people: A call to action*. p15.
http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

12. Moody's Investor Services, Announcement 6 August 2014 *'Population Aging Will Dampen Economic Growth over the Next Two Decades'*
https://www.moodys.com/research/Moodys-Aging-will-reduce-economic-growth-worldwide-in-the-next--PR_305951

13. Office of National Statistics (2014), 2012-based sub national population projections

14. Sir Thomas Hughes-Hallett Commission (2013), Who Will Care? p15.
http://essexpartnership.org/sites/default/files/130911%20Who%20will%20care%20v.FINAL__1.pdf

15. The Nuffield Trust (2014) The four health systems of the United Kingdom: how do they compare? p11.
http://www.nuffieldtrust.org.uk/sites/files/nuffield/140411_four_countries_health_systems_full_report.pdf

16. Office for National Statistics (2013), *National population projections, 2012-based projections*.

17. Commission on Funding of Care and Support (2011), *Fairer care funding: The report of the Commission on Funding of Care and Support*. p17.
http://webarchive.nationalarchives.gov.uk/20130221130239/https:/www.wp.dh.gov.uk/carecommission/files/2011/07/Fairer-Care-Funding-Report.pdf

18. Department of Health (2012a). *Long Term Conditions Compendium of Information, 3rd ed. London: Department of Health*. p6.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

19. Department of Health (2012), *Long Term Conditions Compendium* (3rd edition). p3.
https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition

20. NHS England (2013), *The NHS belongs to the people: A call to action*. p15.
http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

21. The Health Foundation (2014), *Closing the NHS funding gap: can it be done through greater efficiency?* p3
http://www.health.org.uk/public/cms/75/76/313/4700/Closing%20the%20NHS%20funding%20gap%20-%20Can%20it%20be%20done%20through%20greater%20efficiency.pdf?realNameZLAruR.pdf

22. Macauley. A, (2014), *LGA reveals extent of council funding 'black hole'. Localgov.co.uk*
http://www.localgov.co.uk/LGA-reveals-extent-of-council-funding-black-hole/36634

23. Boffey, D. (2014), *NHS tax is floated by Liberal Democrats to fill £30bn hole*. The Guardian.
http://www.theguardian.com/society/2014/jul/27/nhs-tax-health-service-hypthecated

24. Triggle, N. (2014), *Rise in NHS trusts in financial difficulties*. BBC News
http://m.bbc.co.uk/news/health-28439323

25. Local Government Association (2014), *Future Funding Outlook* pp.4-12.
http://www.local.gov.uk/documents/10180/5854661/L14-340+Future+funding+-+initial+draft.pdf/1854420d-1ce0-49c5-8515-062dccca2c70

26. *Essex 5 year health and care plan 2014–2019* p11.

27. Sir Thomas Hughes-Hallett Commission (2013), *Who Will Care?* p15.
http://essexpartnership.org/sites/default/files/130911%20Who%20will%20care%20v.FINAL__1.pdf

28. Sir Thomas Hughes-Hallett Commission (2013), *Who Will Care?* p14
http://essexpartnership.org/sites/default/files/130911%20Who%20will%20care%20v.FINAL__1.pdf

29. Department of Health (2012), *Long Term Conditions Compendium* (3rd edition).
https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition

30. PANSI, Projecting Adult Needs and Service Information, Oxford Brookes University
http://www.pansi.org.uk/

31. Royal College of General Practitioners, news item 28 July 2014 *'Crisis hit GP surgeries forced to turn away millions of patients'*
http://www.rcgp.org.uk/news/2014/july/crisis-hit-gp-surgeries-forced-to-turn-away-millions-of-patients.aspx

32. ONS Statistical Bulletin Detailed Characteristics for England and Wales, March 2011, p.18.
http://www.ons.gov.uk/ons/dcp171778_310514.pdf

33. CarersUK - *Facts about carers 2014*
http://www.carersuk.org/for-professionals/policy/policy-library/facts-about-carers-2014

34. Essex 5 year health and care plan 2014–2019 p16

35. *Essex 5 year health and care plan 2014–2019* p16

36. Mid Essex CCG, *Financial position statement* February 2013 p5.
http://www.midessexccg.nhs.uk/about-us/our-key-documents/doc_download/500-008-4-m11-finance-report-280313&rct=j&frm=1&q=&esrc=s&sa=U&ei=qGMEVPSlN9bjauutgrAN&ved=0CBoQFjAB&usg=AFQjCNH9mLypxj_3gmZIE5383p8CLAiVZw

37. British Medical Association– *Health Policy and Economic Research Unit (2012). - The integration of health and social care* p4.

38. The King's Fund *independent Commission on the Future of Health and Social Care in England* (2014) Interim report, p3.
http://www.kingsfund.org.uk/publications/new-settlement-health-and-social-care

39. House of Commons Health Committee (2014) *Seventh Report of Session 2013–14: Public expenditure on health and social care*. pp23-24.
http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/793/793.pdf

40. House of Lords Committee on Public Service and Demographic Change (2013) *Report of Session 2012–13: Ready for Ageing?*
http://www.publications.parliament.uk/pa/ld201213/ldselect/ldpublic/140/14016.htm

41. LGA press release 3 June 2014 *'LGA calls for five-year commitment to health and social care funding'*
http://www.local.gov.uk/media-releases/-/journal_content/56/10180/6235157/NEWS

42. See for example, Madeleine Knight, *'Developing integration of health and social care in England'*, Social Policy Review 26, ed by Farnsworth, Irving and Fenger, 2014

43. The King's Fund *independent Commission on the Future of Health and Social Care in England (2014) Interim report*, p18.
http://www.kingsfund.org.uk/publications/new-settlement-health-and-social-care

44. Commission on the Future of Health and Social Care in England, A new settlement for health and social care, September 2014, p15

45. House of Commons Health Committee (2014) *Second Special Report of Session 2014–15: 2013 accountability hearing with Monitor: Monitor's Response to the Committee's Ninth Report of Session*. pp4-6. http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/511/51102.htm

46. NHS Confederation, *Health Services Research Network Briefing October 2013 Issue 16. Lessons from Europe: the value of tariff redesign*
http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Lessons-Europe-value-tariff-redesign.pdf

47. Checkland K, Allen P, Coleman A, et al. *Accountable to whom, for what? An exploration of the early development of Clinical Commissioning Groups in the English NHS*. BMJ Open 2013;3:e003769. doi:10.1136/bmjopen-2013-003769
http://www.bmjopen.bmj.com/content/3/12/e003769

48. British Medical Association– *Health Policy and Economic Research Unit (2012). - The integration of health and social care* pp12-13.

49. The King's Fund (2013). *Health and Wellbeing Boards – one year on*. p13.
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/health-wellbeing-boards-one-year-on-oct13.pdf

50. Nuffield Trust (2013) *Managing financial difficulties in health economies: lessons for clinical commissioning groups* p30.
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/131027_health_economy_finance.pdf

51. *Relegate CCGs to advisory role, says Burnham'*, *HSJ*, 13 June 2013

52. House of Commons Health Committee (2014) *Seventh Report of Session 2013–14: Public expenditure on health and social care*. pp23, 31, 35, 42, 43.
http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/793/793.pdf

53. House of Commons Health Committee (2014) *Seventh Report of Session 2013–14: Public expenditure on health and social care*. pp23, 31.
http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/793/793.pdf

54. The King's Fund (2013). *Health and Wellbeing Boards – one year on*. p2.
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/health-wellbeing-boards-one-year-on-oct13.pdf

55. The King's Fund (2013). *Health and Wellbeing Boards – one year on*. p18.
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/health-wellbeing-boards-one-year-on-oct13.pdf

56. Transport for London Business Plan, 2009/10 – 2017/18
http://data.london.gov.uk/datastore/package/tfl-business-plan-200910-201718

57. See for example, Madeleine Knight, *'Developing integration of health and social care in England'*, Social Policy Review 26, ed by Farnsworth, Irving and Fenger, 2014

58. See for example, *Local Government Association (LGA) briefing for the debate on the financial sustainability of local government*, 7 January 2014,
http://www.local.gov.uk/documents/10180/5533246/LGA+briefing+on+LG+financial+stability+-Jan+2014/db1c1615-a913-4c4d-b5a7-6b823cc61735

59. See *'Confederation chief calls for 10-year NHS funding settlement'*, 4 June 2014,
http://www.hsj.co.uk/news/finance/confederation-chief-calls-for-10-year-nhs-funding-settlement/5071621.article

60. Commission on the Future of Health and Social Care in England, A new settlement for health and social care, September 2014, p40

61. Reform, *Solving the NHS care and cash crisis,* March 2014
http://reform.co.uk/content/32643/research/health/solving_the_nhs_care_and_cash_crisis

62. Kings Fund, Independent Commission on Health and Social Care, *A new settlement for health and social care: Interim report*, May 2014
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/commission-interim-new-settlement-health-social-care-apr2014.pdf

63. The Express, *Millions to suffer as NHS is 'about to run out of cash'*, Jo Willey, 1 May 2014
http://www.express.co.uk/life-style/health/473325/Millions-to-suffer-as-NHS-is-about-to-run-out-of-cash

64. The Guardian, '*Only an injection of cash can avert an NHS crisis,* Denis Campbell, 4 June 2014
http://www.theguardian.com/society/2014/jun/04/cash-avert-nhs-crisis-simon-stevens-coalition-bailout

65. BBC News, *NHS needs more money, say senior Tory and Lib Dem MPs*, 29 June 2014
http://www.bbc.co.uk/news/health-28079720

66. The Guardian, *Poll shows support for raising taxes to sustain NHS*, Tom Clark, 16 July 2014
http://www.theguardian.com/society/2014/jul/16/poll-raise-taxes-nhs-funding

67. Nuffield Trust, *The NHS payment system: evolving policy and emerging evidence,* Jan 2014, p3.
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140220_nhs_payment_research_report.pdf

68. Sir John Oldham Review, *'One Person, One Team, One System'*, March 2014, p78.
http://www.yourbritain.org.uk/uploads/editor/files/One_Person_One_Team_One_System.pdf

69. Kings Fund, *The quest for integrated health and social care: A case study in Canterbury, New Zealand*, Timmins and Ham, 2013
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/quest-integrated-care-new-zealand-timmins-ham-sept13.pdf

8. Authors

Peter Fairley is Head of Policy and Strategy at Essex County Council.
Peter has worked at Essex County Council since 2008 in a variety of roles, including formerly Head of the Cabinet and Leader's Office.

Adam Boey is a Senior Policy and Strategy Advisor at Essex County Council.
Adam has previously worked in the UK Cabinet Office and Southwark Council.

Will Herbert is a Policy and Strategy Advisor at Essex County Council.
Will has worked on a variety of projects involving adult health and community wellbeing, as well as work supporting Essex County Councils preparations for the Care Act 2014.

Jessamy Hayes is a Policy and Strategy Advisor at Essex County Council.
Jessamy recently joined Essex County Council, having previously worked for the NHS and Department of Health.

Michael Cleary is a Fast Track Manager at Essex County Council.
Michael joined Essex County Councils fast track scheme in September 2013.

DS14_4673

This information is issued by
Essex County Council, Strategy and Communications
You can contact us in the following ways:

By email:
peter.fairley@essex.gov.uk

Visit our website:
essex.gov.uk

By telephone:
0333 013 6159

By post:
Strategy and Communications
Essex County Council
PO Box 11, County Hall
Chelmsford
Essex
CM1 1QH

Read our online magazine at **essex.gov.uk/youressex**

Follow us on **Essex_CC**

Find us on **facebook.com/essexcountycouncil**

The information contained in this document can be translated, and/or made available in alternative formats, on request.

Published September 2014

recycle for Essex

Essex County Council