

The background of the cover is a large, abstract graphic composed of numerous thin, light blue lines that form a wireframe-like structure of a human figure. The figure is shown from the side, with the head at the top left and the legs extending towards the bottom right. The lines are more densely packed in some areas, creating a sense of depth and movement. The overall color palette is a range of light to medium blues.

**BREAKING
BARRIERS**

Building a sustainable future for health and social care

An independent review

**Professor Lord Patel of Bradford OBE
The Rt. Hon Hazel Blears
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Executive Summary

Introduction

The aim of this report is to present a new model for integration and innovation in health and social care that uses collaboration to create a unified, cross sector strategy for estates and infrastructure as the catalyst for change to meet the current financial and service demand challenges. The model is not intended to be a one size fits all solution, in fact it is very firmly based within the context and opportunities provided by devolution and the need to recognise that place and people must be the determinants of future sustainability.

The model has been developed from a review of the key barriers to change across system, financial, outcomes, workforce and infrastructure levels for the health and social care system. The process for developing the model has been informed by a wide range of expert stakeholders from across the public, private and social sectors and includes examples of new ways of working that demonstrate the power of collaboration, integration and innovation for improving lives, reducing costs and raising quality and outcome thresholds.

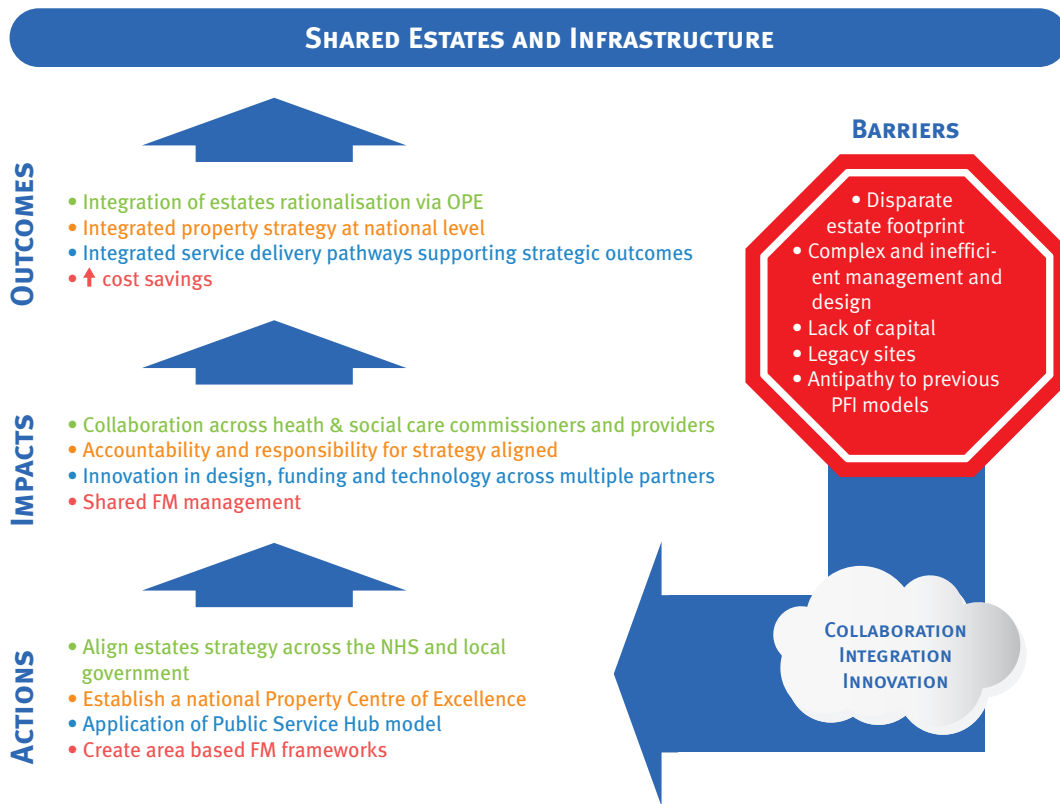
The model demonstrates how a framework for actions taken in four areas: shared estates and infrastructure; workforce development; financial and budgetary alignment and whole system leadership can provide a sustainable future for health and social care.

Shared Estates and Infrastructure

The combined NHS and local authority estates for health and social care represent one of the most significant areas for releasing capital assets that can achieve significant cost savings and generate new revenue for integrated health and social care impact investment. However, to date there has been insufficient collaboration on the strategy at local and national levels to fully realise these benefits. The model proposes an approach to establishing collaboration for shared estates and infrastructure i.e. facilities management, IT and property development and management that will enable:

- the use of estates planning as a lever for change that can address wider system and service transformation;
- increased efficiency and cost savings that can support alternative revenue streams i.e. social investment;
- new thinking and strategy for place and people based change that will create the foundation for integration and innovation in health and social care.

The framework for actions on shared estates and infrastructure is as follows:



Workforce development

The rapidly changing needs and demands for health and social care requires new skill sets, competencies and learning pathways for the health and social care workforce. Current professional divisions will need to be broken down so that workforce development can be

planned and delivered on a cross professional and competency basis. The model proposes meeting these new requirements through:

- stronger and more effective leverage of the Apprenticeship Levy at local area levels through the development of integrated health and social care apprenticeships development;

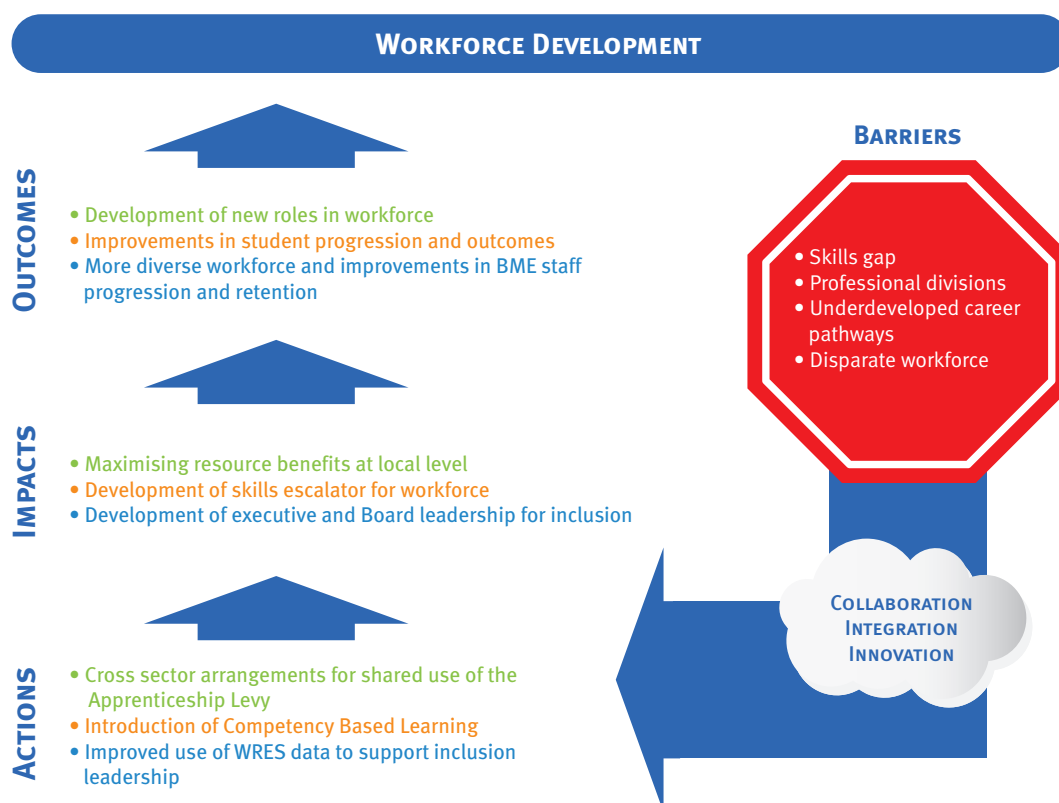
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- the introduction of Competency Based Learning into course development and training across further and higher education in order to better meet the needs of learners and employers in developing skills and competencies that service users require;
- development of inclusive leadership for cross sector and cross organisational and

professional boundary leadership that will a) provide leaders who can operate and task across organisational and professional boundaries and b) ensure that the talents and value of a diverse health and social care workforce are realised

The framework for actions on workforce development is as follows:

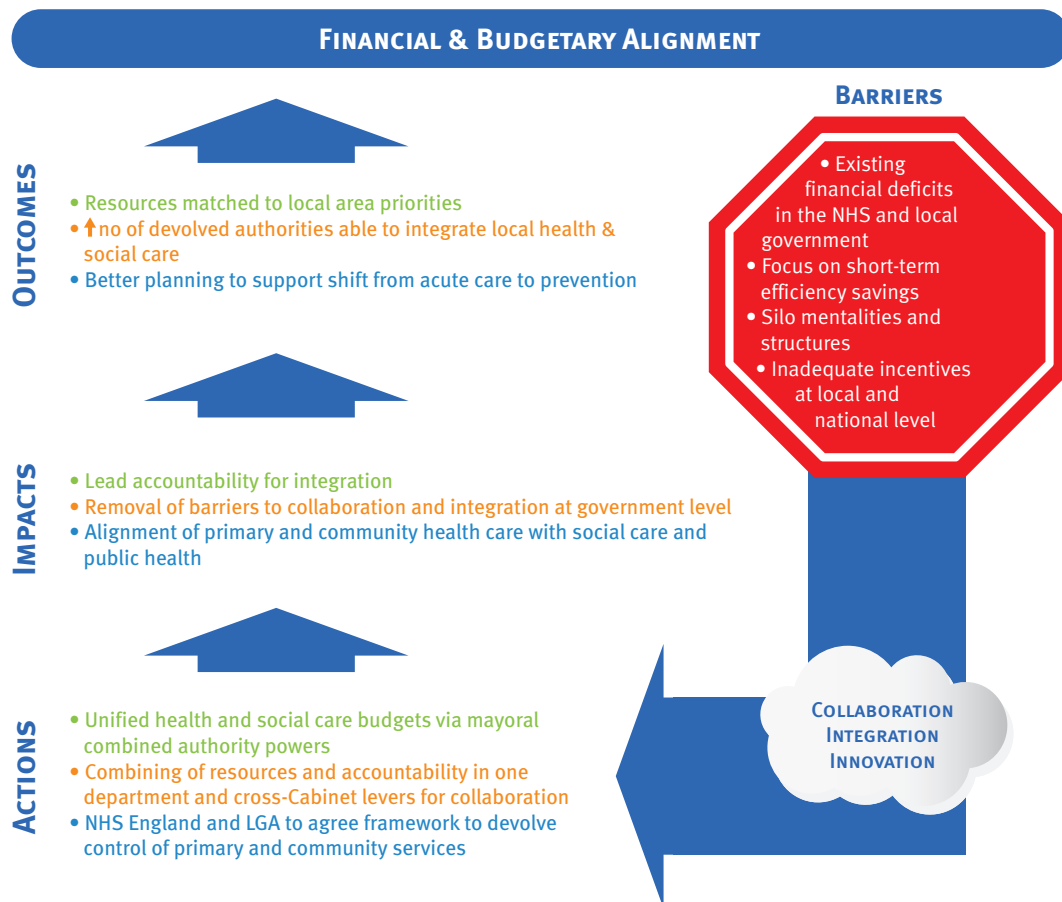


Financial and budgetary alignment

One of the biggest barriers to collaboration, integration and innovation across health and social care is the lack of alignment in financial and budgetary accountability. However, increasing devolution of health and social care financial and budgetary responsibilities is

inevitable. As these developments continue, national and local health and social care leaders will need to prepare for a unified framework by which pooled budgets and financial controls can be shared across local areas. The model proposes that the opportunities provided by devolution should be escalated so that:

- local areas can take advantage of the new



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Executive Summary

powers enabled by devolution to establish alignment of health and social care budgets as part of an integrated strategy for prosperity and growth;

- the integration of health and social care financing can help break down silo mentalities and structures thus enabling health and social care leaders to lift their sight from organisational and sovereign boundaries;
- Government Departments, Cabinet and national regulatory and commissioning agencies can collaborate and fully support devolution of health and social care finances;
- the capacity and capability of local health and wellbeing boards and combined authorities can be developed and supported to effectively manage and control an integrated health and social care budget;
- the shift in revenue from central to local government in public health through local rates needs to be aligned with an equal shift in moving the focus of health and social care expenditure from acute care and managing demand for long term illness and disability to prevention and early identification.

The framework for actions on financial and budgetary alignment is on page 5.

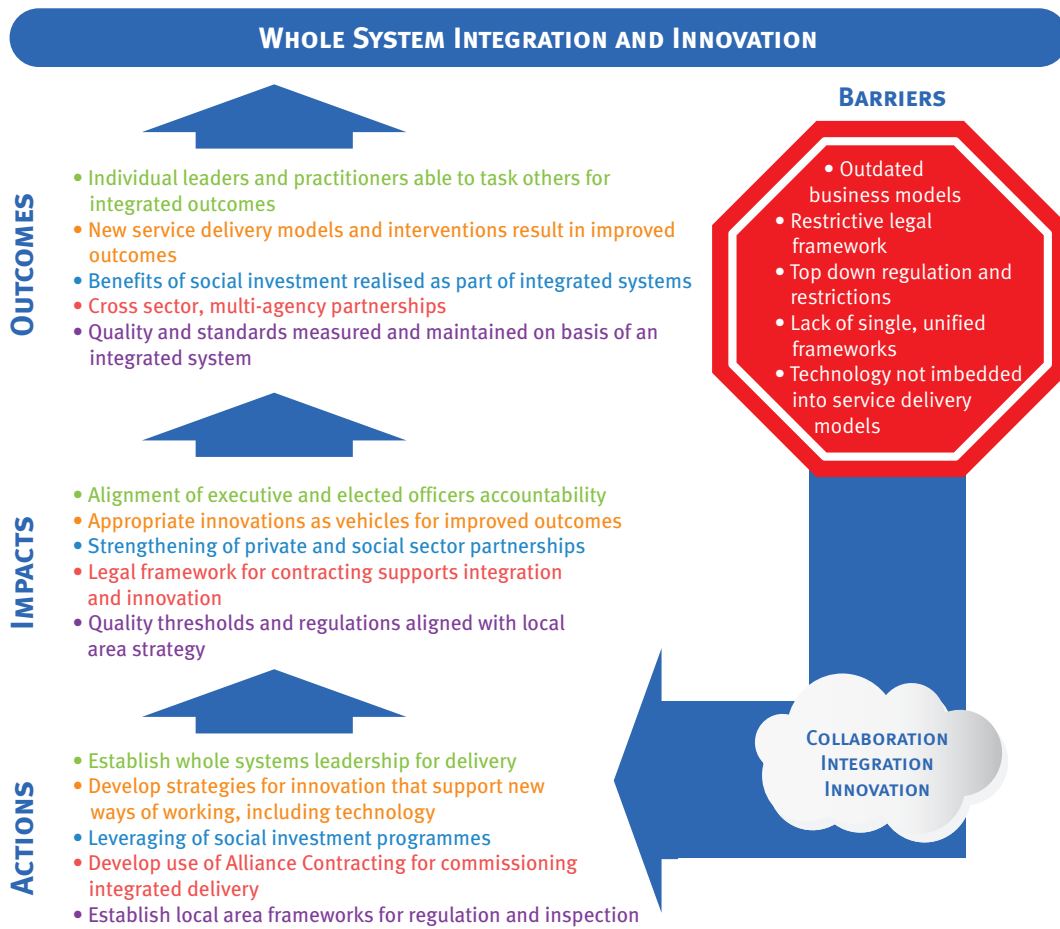
Whole system integration and innovation

New system wide business models and

leadership at executive and elected levels is needed to move from collaboration and alignment to full system integration and innovation. This means re thinking health and care services so that they act now on prevention needs and early identification as part of an integrated, area and people based system. What is needed is a new strategy for disruptive innovation in health and social care that fits with the changing business models and will support new ways of working and delivering services as part of broader structural change. In order to achieve this there needs to be:

- disruptive innovation in business delivery models to transform the health and social care system in line with the Fifth Wave thinking on health promotion;
- intelligent use of technologies for innovation in practice and interventions that are able to prevent chronic illness and thus stem demand;
- leverage of social investment that can enable new structural forms of integration and innovation;
- adopting legal frameworks that will support new ways of contracting for integrated health and social care e.g. Alliance Contracts;
- integration of regulatory and quality inspection regimes at local area levels.

The framework for actions on whole system integration and innovation is as follows:



The model for integration and innovation of health and social care services attempts to meet the critical and urgent demands of the changing needs and patterns of health and social care problems and the increasingly restricted financial resources that are available. It is not intended to be a one size fits all but rather to generate debate

and encourage NHS and Local Authority leaders alongside government and national regulatory and commissioning agencies to come together - to collaborate – so that an integrated system can be created that supports the right kind of innovations for improving lives and building a sustainable future for health and social care.

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Recommendations

Recommendation one

Collaboration needs to be strengthened between national and local leaders including between the NHS and local authorities and between the Department of Health and the Department for Communities and Local Government.

Recommendation two

Financial accountability and budgets for health and social care need to be aligned as part of a unified system under the direction and control of a single government department. This could potentially be, for example, through a new Department for Communities and Wellbeing. Cabinet level collaboration needs to be facilitated through the use of shared funding arrangements as part of a common pooled resource for health and social care. This needs to be replicated at local levels through single commissioning authorities covering both local authority and health services.

Recommendation three

Collaboration between providers and commissioners needs to be supported through new legal frameworks such as Alliance Contracting. A legal contracting framework is required that drives and incentivises collaboration rather than competition, based on a no dispute culture that provides parity for public, private and social sector organisations – an Alliance Contract can provide this essential foundation.

Recommendation four

Whole system leadership is needed at executive and elected levels with political and executive decision making power over the whole system. An elected Mayor with powers beyond health

and social care including policing, justice, skills, transport, economic regeneration and housing can bring unified budgets, coherence and democratic legitimacy to the system.

This should sit within combined authority structures under the newly mandated powers for elected mayors and be replicated in cross sector Accountable Care Organisation frameworks. In order to realise this there needs to be support for both elected officials and officers so that they are able to work across systems and professional disciplines, able to task others and develop a multi-skilled, competent and inclusive workforce.

Recommendation five

Workforce development needs to be aligned across health and social care, taking account of the new apprenticeship levy system and using Competency Based Learning modules as part of a skills escalator.

Recommendation six

A distributed service delivery model is required based on the gradual development of multi-service hubs. These could be focused on specific care pathways or service user cohorts, e.g. diabetes, dementia care etc. As these multi-service hubs are developed, the local hospital provision can be adapted with the release of hospital estates as part of a joined up OPE strategy between NHS and local authority partners. NHS England should ensure that local providers and commissioners have incorporated these approaches in Transformation and Sustainability Plans.

Recommendation seven

Inspection and regulatory regimes need to be aligned on an outcome basis at local rather than national levels.

Recommendation eight

There needs to be a national and local commitment to long term outcome commissioning – beyond existing political horizons. This should include recognition that significant system change is being undertaken with longer timeframes for improvement according to the scale and pace of change, e.g. over 5 and 10 year timeframes.

Recommendation nine

Development of integrated health and social care services should include parity amongst partners from across the public, private and social sector with an explicit aim of using transformation in service models to help build the social sector.

Recommendation ten

There needs to be acceptance and understanding across the system that willingness to innovate and make effective change means learning from new ways of working and that in the process of change some things will work and some will not. To better support the process of change there needs to be resources for research, development and evaluation, including local area feasibility studies.

Recommendation eleven

Local change programmes need to harness the impact of digital innovation on services and outcomes as part of a strategic drive towards prevention and public health improvement.

Recommendation twelve

Local area change and transformation plans need to maximise the possibilities and potential provided by social investment to help drive transformation.

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Introduction

This report is the result of a review of the key barriers to building a sustainable future for health and social care. The review was undertaken by Professor Lord Patel of Bradford OBE and the Rt. Hon Hazel Blears and took place between February and June 2016. A wide range of individuals were consulted for the review including leaders, practitioners, clinicians and managers from across the public, private and social sectors. In particular the review focused on four principal barriers:

- **Estates and facilities** e.g. how the infrastructure and locations for service delivery are costly and no longer fit for purpose.
- **Workforce** e.g. how professional barriers can impede joint working and prevent whole system practitioner and leadership development;
- **Financial barriers** e.g. the way in which health and social care budgets are separated;
- **System barriers** e.g. the way in which health and social care systems are currently governed, structured, organised and inspected;

The report explores the current context and drivers for change, including the NHS Five Year Forward View, the Fifth Wave of public health, regional devolution and the One Public Estate strategy, and how technological advances and new models for social investment are providing opportunities for transforming care and improving lives.

A model for integration and innovation is presented that addresses the current context

and barriers to change, including case examples of how different ways of working can contribute to building a sustainable future for health and social care. The model demonstrates how **collaboration, integration and innovation** can be used to overcome barriers to change and support local area plans and strategies for sustainability and transformation. The model also highlights the need for greater collaboration and integration at government levels including Cabinet, if health and social care budgets are to be aligned in a way that would be effective for the challenges faced by the system.

The final section of the report includes recommendations on how improvements can be made that will enable a whole system approach to building a sustainable future for health and social care.

We hope the report will be a catalyst for wider debate and change.

The Vision

Our vision is for an integrated health and social care system that uses its estates and infrastructure wisely and collectively within a single, unified financial and budgetary framework at local and national levels. This requires a workforce that is skilled and competent to deliver services on the basis of need rather than professional status or role, and whole system leadership at both elected and executive levels that can operate effectively across the public, private and social sectors.

This vision can be realised if we accept that there is a crisis and we have the political and moral courage to do something about it. In particular, we need:

- to ensure that we have the right incentives for collaboration, supported and encouraged by government and regulatory agencies;
- to have joint strategies for NHS and local authority estates, so that the sale of assets can be used to support change and development rather than as a short term plug for revenue funding gaps;
- to be less concerned with individual and organisational sovereignty and more focused on positive outcomes for people and places;
- a commitment to overcome professional differences and interests, so that we can build a workforce equipped and competent to address the health and social care demands for today and in the future;
- to shift the focus and investment for health and social care to prevention and early identification in order to reduce the demand for hospital and residential services;
- to start working now for the health and wellbeing of all, so that we can improve lives and build a sustainable future for health and social care.

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Background

This is a critical time for the provision of health and social care. The NHS faces a funding gap of £30 billion¹ and there is a £700 million gap, and rising, in the provision of social care². At the same time demand for higher quality and more responsive services is growing for a population that is at one end increasingly older, with more long term conditions and more complex needs, while at the other end, consists of growing numbers of young people who are building up future serious health needs through lifestyle factors that are likely to result in long term conditions such as obesity.

Too many organisations are trying to do too much with too little and there is an urgent need for change. But people are tired of top down, wholesale reform in the NHS and many local authorities are struggling to keep basic services operational. In the climate of austerity, budget cuts and a slower than expected economic recovery it is hard for those who lead and deliver services to think long term. The NHS is rightly held in high esteem and is widely regarded as one of the greatest achievements of the last century. And despite the current challenges it is still regarded as one of the most cost effective health systems in the world.

However, it is also clear that the NHS and local authorities will not be able to continue to meet rising demands for health and social care within current resources without transforming the way that services are delivered. Debates continue about the best way to structure, organise and fund a national health and social care system and whether there should be a unified way of providing this.

The history of reform of the NHS has not been widely welcomed or perceived as successful in addressing the basic issues. Top down, whole system transformation is not the way forward. What are needed are alternative delivery models that come from the ground up, are **place based** as opposed to **system based** and provide realistic, practical and replicable solutions that put people and those who use and deliver services at the heart.

Now is the right time for a new approach that will put those who use services at the centre and build a sustainable future for health and social care. Barriers will need to be broken in order to achieve this and this can be done through collaboration, integration and innovation.

“Success will require us all to think beyond our statutory and organisational borders to meet the needs of the people we serve.”

(NHS Five year Forward View: Time to deliver)

1. NHS England, ‘NHS Five year Forward View’, 2014

2. Local Government Association, ‘Adult social care, health and wellbeing: A Shared Commitment’ Spending Review Submission, 2015

Methods

The review was conducted in two stages. A focused inquiry first explored the barriers and drivers for change in integration of health and social care, including a number of site visits to demonstration projects where new ways of collaborating and managing infrastructure, services, estates and IT were being practiced. The second stage of the review involved developing a model for integration and innovation and testing its potential value and applicability amongst a number of key stakeholders from across the public, private and social sectors. These interviews were conducted on a confidential basis and where quotations are used in the report these are signified only by the sector from which the speaker came i.e. public, private or social sector stakeholder.

Contributors to the review

Asian Media Group
 Big Lottery Fund
 Cabinet Office
 Chiltoning Land
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 Government Property Unit
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 KPMG
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 Local Government Association
 McLaren Group
 London Legacy Development Corporation
 MJ Mapp
 NHS Confederation
 NHS England
 NHS Property Services
 NHS Trust Directors, managers and lead clinicians
 PA Consulting
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Context

The barriers to change

There are always barriers to change; people fear the unknown and ‘better the devil we know’ attitudes prevail. For those tasked with leading and delivering change on the ground the scale of the task can seem daunting and the challenges insurmountable. Engrossed in the day to day delivery of an increasingly complex system where literally lives are held in the balance, NHS and social care leaders and practitioners have too few opportunities to raise their sights and see the horizon. History becomes a barrier as previous attempts at change are viewed as having failed to deliver their promise or are regarded with negativity and hostility, for example:

- Public Finance Initiative (PFI)
- The purchaser/provider split
- Health Action Zones
- Community Care

Organisational structures have been re-organised, re-structured, reformed, abolished and re-built again – Area Health Authorities, Strategic Health Authorities, Primary Care Trusts, Health and Social Care Trusts. The pace of change has been breathless and at times agonising and yet still we need to think beyond the current statutory and organisational boundaries.

Barriers to change in the context of health and social care are also political. In recent debates on the devolution of health and social care powers Lord Warner questioned whether the ‘N’ was being removed from the NHS.

There remains an antipathy to closer working partnerships with the private sector despite the fact that there are clear skills and expertise deficits that could best be met by the private sector e.g. estates management, facilities, property development and Information Technology. Where positive changes are made, they often remain local and ‘what works’ is not readily shared with other councils and health agencies.

There are skills deficits too in the workforce. Change doesn’t just happen; it needs skilled staff who are equipped to deliver new ways of working. But staff also need to be engaged in the process of change and to feel that they have a firm stake in the future. As do patients and public who too often feel that they have been unable to participate in the process or feel they have not been adequately and effectively involved in decision making.

Changing patterns of health and social care needs

The patterns of health and social care needs are changing rapidly and are significantly different to when the NHS was first conceived. The NHS is no longer primarily about curing illnesses: for example, nearly three quarters (70%) of the health service budget is taken up by long-term health conditions. In fact, the demands being placed on health services are increasingly social in nature or causation – lifestyle factors such as obesity and smoking, risk behaviours such as those associated with alcohol or drugs - deprivation, poverty, poor housing, low educational achievement - are all increasingly recognised as principal causes of ill health or contributing factors.

General Practitioners (GPs) spend around 40 per cent of their time dealing with non-medical issues.

At the same time the demands being made on social care are more complex – rising numbers of infirm, frail elderly require higher levels of support, including medical assistance to remain at home or in the community. Increasing numbers of vulnerable children and adults including those with mental health and learning disabilities are being cared for in local communities rather than in hospital.

There is an urgent need to shift the emphasis of care from treatment to prevention:

- one in five adults still smoke - smoking rates during pregnancy range from 2% in west London to 28% in Blackpool;
- a third of people drink too much alcohol;
- a third of men and half of women don't get enough exercise;
- almost two thirds of adults are overweight or obese - fewer than one-in-ten children are obese when they enter reception class but by the time they're in Year Six, nearly one-in-five are then obese³.

These figures on obesity and lack of exercise, especially amongst children and young people demonstrates starkly why a radical step change in health promotion is needed to tackle the underlying causes and not just the symptoms:

“If diabetes was a country it would be the fifth largest country in the world. That’s how

many people across the globe are affected”.
(USA Federal Assistant Minister for Health, Ken Wyatt)

“Put bluntly, as the nation’s waistline keeps piling on the pounds, we’re piling on billions of pounds in future taxes just to pay for preventable illnesses.”
(NHS Five Year Forward View)

The fifth wave of public health

Public health has been characterised as having developed in four waves:

1st Wave: formed the origins of public health with programmes to provide clean water and sanitation in response to rapid urbanisation of populations.

2nd Wave: concerned the development of medicine as a science associated with the development of hospitals and new approaches to combat diseases with medical treatments.

3rd Wave: saw the development of large social programmes such as the establishment of the welfare state and the NHS with a focus on population health.

4th Wave: recognition of the social determinants of ill health and factors associated with lifestyle choices such as alcohol, drugs and obesity.

It is now being suggested that we are at the point of a **Fifth Wave** of public health⁴ where greater emphasis needs to be placed on individuals making decisions about maintaining their own health in cooperation with health and social care professionals. Public health outcomes from the Fifth Wave will be determined

3. NHS England, ‘NHS Five year Forward View’, 2014

4. Lyon, A. ‘The Fifth Wave’, Scottish Council Foundation, Edinburgh, 2003

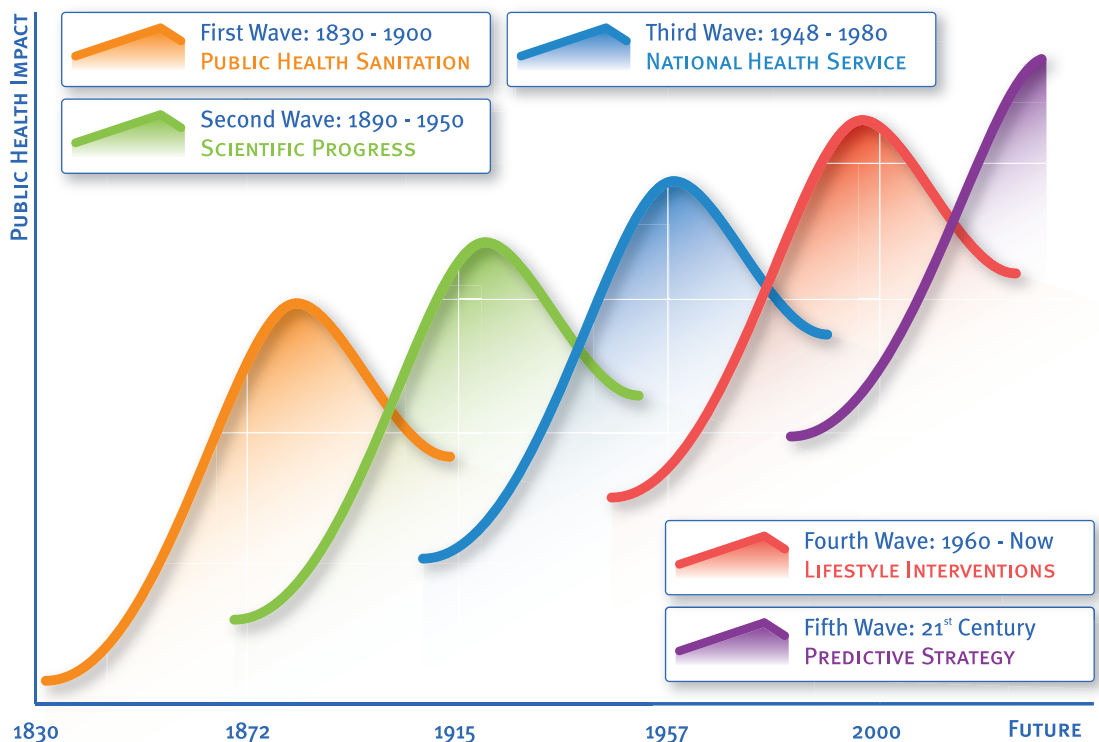
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Context

by enabling government and collaboration across the health and social care sectors.

The Fifth Wave of public health takes greater account of the changing nature of health and social needs and demands. It also points towards the need for a new way to think about service delivery i.e. integration of health and social care and greater use of innovations that give the service user greater control of their health care. The Fifth Wave of public health has been characterised in various ways but some of the key aspects that will influence health and social care systems include:

- more complex care pathways that can facilitate multiple entry and exit points rather than one linear path;
- health and social care outcomes will be negotiated between practitioners, service users and carers;
- the lived experience of service users will be more central to service planning and delivery;
- the pace of change for innovations will be more rapid and services will need to be more adaptive and forward looking to take account of this.



The Fifth Wave of public health is about culture change, where healthy behaviours are supported and sustained through collaboration and integration across the physical, social and economic environment.⁵

NHS Five Year Forward View

The NHS Five Year Forward View sets out a shared vision for the future of the NHS based around new models of care. It was developed by NHS England and the partner organisations that deliver and oversee health and care services including the Care Quality Commission, Public Health England and NHS Improvement (previously Monitor and National Trust Development Authority). The Five Year Forward View presents three critical arguments for developing the future of health care:

Firstly – future health, sustainability of the NHS and thus economic prosperity will rest upon a radical upgrade in prevention and public health;

Secondly – patients need greater control over their care and the NHS needs to be a better partner with voluntary sector agencies and local communities;

Thirdly – decisive steps must be taken to break down the barriers to care including between primary and acute care, between health and social care and between mental and physical health.

There is recognition that ‘one size does not fit’ all – and that there will need to be a range of solutions across different health communities. At the same time this does not mean that ‘a thousand flowers should bloom’ but rather there should be a small number of radical new care

delivery options that are supported by the NHS’ national leadership so that a selected number can be given the resources and support for implementation where that makes sense.

Some of the options that are being considered include:

- **Multispecialty Community Providers** - consisting of GPs, nurses, other community health services, hospital specialists and mental health and social care providers, these new provider models can create integrated out-of-hospital care. This could result in direct employment of hospital consultants, having admitting rights to hospital beds, running community hospitals or taking delegated control of the NHS budget.
- **Accountable Care Organisations (ACOs)** – integration of primary and acute care systems (PACS) is envisaged on the lines of an Accountable Care Organisation (ACO) such as those in the USA, Europe and elsewhere. The NHS Five Year Forward View is suggesting this kind of vertical integration although the complexities of achieving this are recognised:

“PACS models are complex. They take time and technical expertise to implement. As with any model there are also potential unintended side effects that need to be managed. We will work with a small number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.”

(NHS Five Year Forward View. NHS England. 2014)

5. Davies et al, ‘Public health workforce of the future: A 20-year perspective’, Centre for Workforce Intelligence, March 2016

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- **Integration of urgent and emergency care** – this will include redesigning the way in which A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services are delivered.
- **a shift in investment from acute to primary and community services** – including stabilising core funding for general practice nationally over the next two years and enabling Clinical Commissioning Groups to have the option of more control over the wider NHS budget.
- sustaining social care services, and
- over time, seeing a bigger share of the efficiency coming from wider system improvements.

One of the key challenges will be ensuring that these efficiency savings can help close the projected £30 billion funding gap:

“Delivering on the transformational changes set out in this Forward View and the resulting annual efficiencies could - if matched by staged funding increases as the economy allows - close the £30 billion gap by 2020/21.”

(Five Year Forward View. 2015 NHS England)

The Forward View also recognises that there needs to be national support and leadership to enable these new care models to be developed effectively. This will include the national leadership of the NHS acting coherently together to provide meaningful local flexibility in the way payment rules, regulatory requirements and other mechanisms are applied. This does not mean further national structural reorganisation but rather supporting diverse solutions and local leadership to develop services as they need to. This is key to innovation, which has often been hampered by restrictive regulatory controls and the lack of freedoms to integrate budgets and work more collaboratively with partners from within and outside the NHS family.

Contrary to appearances the NHS actually has a strong record of performance improvements and efficiency savings ranging from 0.8% over the long term to 1.5% - 2% in recent years. The Forward View believes that an efficiency target of 3% could be possible by the end of the next decade but this will depend on:

- investment in new care models;
- sets out seven approaches to a radical upgrade in prevention of illness, with England becoming the first country to implement a national evidence-based diabetes prevention programme;
- explains how £480 million of the extra funding will be used to support transformation in primary care, mental health and local health economies;

NHS England set out new steps to be taken during 2015/16 to deliver the NHS Five Year Forward View. This was the first time that the annual planning guidance has been jointly produced by NHS England, Public Health England, Monitor, the NHS Trust Development Authority, the Care Quality Commission and Health Education England. As part of the allocation of an additional £1.98 billion for every locality across England the joint annual plan:

- sets out seven approaches to a radical upgrade in prevention of illness, with England becoming the first country to implement a national evidence-based diabetes prevention programme;
- explains how £480 million of the extra funding will be used to support transformation in primary care, mental health and local health economies;

- makes clear the local NHS must work together to ensure patients receive the standards guaranteed by the NHS Constitution;
- underlines the NHS's commitment to giving doctors, nurses, other staff and carers access to all the data, information and knowledge they need to deliver the best possible care;
- details how the NHS will accelerate innovation to become a world-leader in genomic medicine and testing and evaluating new ideas and techniques

Simon Stevens, the Chief Executive of NHS England, said:

*"...the health service can't just keep running to catch up. Instead we need to begin to radically reshape the way we care for patients, which is why there is such widespread support and enthusiasm for the NHS Five Year Forward View."*⁶

It is clear that collaboration, integration and innovation are at the heart of the NHS Five Year Forward View and these principles are key to realising the long term sustainability of the NHS and social care.

Cities and local government devolution

Integration and sustainability should also be viewed in the context of devolution, which provides an opportunity to deliver services differently through local empowerment. The Cities and Local Government Devolution Act 2016 received Royal Assent in January 2016. The

main provisions of the Act allow for the devolution of powers from the UK government to some of England's towns, cities and counties. This includes: the introduction of directly elected mayors to combined authorities and allowing directly elected mayors to replace Police and Crime Commissioners (PCCs) in these areas.

The Act also removes the current statutory limitation on the functions of these local authorities, e.g. these are no longer limited to economic development, regeneration, and transport. Finally, the Act enables local authority governance to be streamlined as agreed by councils.

The negotiations between the UK government and local authorities (or groups of local authorities), to bring any transfer of budgets and/or powers into effect known as devolution deals took place during 2014-15, and by March 2016 twelve devolution deals had been agreed: Cornwall, East Anglia, Greater Lincolnshire, Greater Manchester, Liverpool City Region; London, North East Combined Authority, Sheffield City Region, Tees Valley, West England, West Midlands Combined Authority and West Yorkshire Combined Authority.

Following the initial deal in 2014, Greater Manchester and NHS England signed up to arrangements to bring together £6 billion of NHS and social care budgets so that joint planning of these services deliver better care for patients.

Other devolution deals that include plans for health and social care include: a London Health and Social Care Devolution Programme Board established in January 2016, accounting to the London Health Board and The North East Combined Authority establishment of a

6. NHS England, 'Health leaders set out new year plan for a sustainable NHS', 2014, <https://www.england.nhs.uk/2014/12/forward-view/#> (accessed June 2016)

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Commission for Health and Social Care Integration (in partnership with the NHS).

Although Greater Manchester is at the most advanced stage of planning for devolution of health and social care the potential advantages of this approach are being keenly watched by many other towns and cities.

Leaders of health and social care across Greater Manchester are making progress on work in a number of areas, including: extending seven day access to primary care, radically upgrading prevention and public health, helping those with mental ill health into work, transforming treatment, care and support for people living with dementia and making Greater Manchester's Academic Health Science System a national leader:

“By the end of this year they will have a Strategic Sustainability Plan in place to show how they will deliver a clinically and financially sustainable set of health and social care services for the people of Greater Manchester. The production of the Strategic Sustainability Plan will be aligned with the Spending Review process that applies to NHS, Public Health and Local Authority social care funding.”⁷

One Public Estate

One Public Estate (OPE) is a pioneering initiative delivered in partnership by the Cabinet Office Government Property Unit (GPU) and the Local Government Association (LGA). It provides practical and technical support and funding to councils to deliver ambitious property-focused programmes in collaboration with central government and other public sector partners.

The Government published its first estates strategy in 2013 and updated this in 2014 to encompass an expansion of the scope of work including a leap in the scale of the ambition that will use the estate strategy to deliver improved and integrated public services and as an enabler for growth:

“In line with what many private sector organisations have achieved, we expect this to increase productivity, reduce costs, improve wellbeing, and contribute to wider objectives such as localism, sustainability, and reducing pressure on the transport system.”

(Government's Estate Strategy, 2014. Cabinet Office)

Between now and 2020 the government expects to reform how the state uses property, so that it:

- removes artificial boundaries between departments, local authorities and other public bodies;
- works in ways that minimise the need for office space;
- uses estates efficiently, and
- gets rid of surplus in a way that maximises receipts, boosts growth and creates new homes.

The potential gains from the One Public Estate programme are significant, for example, the Office for Budget Responsibility estimates local authority capital receipts to be £11.2 billion between 2015 – 2020. Councils have already sold £10.6 billion land and property between

7. HM Treasury, 'Further devolution to the Greater Manchester Combined Authority and directly-elected Mayor' https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/443087/Greater_Manchester_Further_Devolution.pdf (accessed June 2016)

2010-2015 and local authorities in England hold £225 billion of assets, including over £60 billion in property not used for schools or housing. By using assets more effectively councils can create local economic growth, and deliver more integrated public services including health and social care:

“At its heart, the programme is about getting more from our collective assets – whether that’s catalysing major service transformation such as health and social care integration and benefits reform, unlocking land for new homes and commercial space, or creating new opportunities to save on running costs or generate income.”

(One Public Estate. April 2016. Invitation to apply)

The OPE specifically recognises the strategic value in **using estates as a lever for greater transformation**. This is one of the key essential insights that the model for integration and innovation is based on, alongside recognition that:

- seeing property as a strategic asset can reap significant rewards. It can be an effective catalyst or enabler for reforms such as health and social care integration, benefits reform and digitisation; and for local economic growth;
- local priorities should be the driver with property the facilitator to achieving goals;
- Councils are at the heart of successful delivery – they have the democratic legitimacy, dedicated interest and breadth of responsibilities to lead local partnerships.

The NHS Estate

It is estimated that the NHS has a total land area of just over 6,500 hectares, a mass that equates to the size of Wolverhampton and its local authority boundaries. With total occupied floor space equalling nearly 25million m² it is the biggest organisational occupier in the UK.⁸ The scale and size of the NHS estate comes at considerable cost i.e. estates running costs are the **third largest expenditure for the NHS** after staffing and drugs.⁹ When facilities management and maintenance services are included the costs of financing the NHS amounts to **£9bn**. On top of this there are an estimated **£4.3bn** costs to eradicate the current NHS backlog in maintenance.

This in part can be attributed to the building’s age profiles. For example, over **15%** of the NHS estate was built before 1948, prior to when the NHS was established and before around **80%** of the UK population were even born.¹⁰ In addition across NHS trusts, on average 4.18% of their occupied space is currently under-utilised. Nevertheless, despite this context of a complex, costly and inefficient estate, the NHS is asset rich and there is significant potential for the financial benefits of these assets to be unlocked. The Department of Health, writing in 2014, explains that:

“... [The NHS] estate has important contributions to make in delivering savings and reducing running costs. These must be undertaken to meet the challenges of funding the NHS in the future and will form part of the government’s drive to increase the efficiency of the public sector estate.

8. Health & Social Care Information Centre, ‘Estates Returns Information Collection – ERIC 2014-15’, June 2016

9. Department of Health, ‘Hospital Estates and Facilities Statistics 2013-14’, (2014, accessed June 2016)

10. The EC Harris NHS Estate Efficiency Annual Review, ‘NHS Estate Efficiency Annual Review: Delivering Better Healthcare Outcomes More Efficiently’ 2013

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Accordingly, a significant step change in the way this estate is managed has to be achieved.”¹¹

With just under **700 hectares** of NHS land identified as surplus or potentially surplus in 2015, releasing capital from disposal is one avenue of revenue generation.¹² For example, NHS Trusts reported in 2014-15 an income of just under **£156m** from building and land sales.¹³ This potential can be used to support:

- Revenue generation
- Efficiency savings
- Better health outcomes

However disposals have been contentious as they have been associated with the notion of “selling off the family silver” and using asset sales to plug revenue gaps. There are alternative approaches that could bring more substantial, longer term benefits, for example, as argued in a joint Health Foundation and Kings Fund paper:

“... the greatest opportunity for realising value from the NHS estate is, in fact, likely to be the generation of new revenue streams (from both used and unused estate), rather than capital receipts from sale of surplus land and buildings.”¹⁴

These new opportunities include developing leaseback arrangements with property developers or using land for community good and social impact investment e.g. leasing to other local public service providers or developing social housing stock.

Social investment and impact

Social Investment including Social Impact Bonds (SIBs) are designed to transform the outcomes of publicly funded services by using payments by results to focus on social impact e.g. improved health and social well-being rather than inputs (numbers of doctors or social care workers) or outputs (numbers of hospital operations or residential care placements).

The Centre for Social Impact Bonds in the Cabinet Office sets out the benefits of the approach:

“SIBs can increase the diversity of organisations able to deliver public services, including social enterprises and charities. Funds like the Youth Engagement Fund have contributed towards the development of 32 Social Impact Bonds across the UK, supporting tens of thousands of beneficiaries in areas like youth unemployment, mental health and homelessness.”

(Centre for Social Impact Bonds, Cabinet Office)

11. Department of Health, ‘Part A: Strategic framework for the efficient management of healthcare estates and facilities’, October 2014

12. Department of Health, ‘2015 Surplus Land Data Collection’, (2015) accessed at <https://www.gov.uk/government/publications/release-of-nhs-owned-land-for-development>

13. Health & Social Care Information Centre, ‘Estates Returns Information Collection – ERIC 2014-15’ (accessed June 2016)

14. The King’s Fund & The Health Foundation, ‘Making change possible: a Transformation Fund for the NHS’, July 2015

The transformative features of SIBs include:

- Aligning financial rewards with social outcomes. SIBs focus payments on the social outcomes that services achieve, such as improved employment rates or lower hospitalisation levels.
- Bringing together distinct expertise from different sectors. Service providers often have deep understanding of a particular cohort of people and the type of interventions that are effective. Socially minded investors may have both finance and contract measurement experience, as well as a desire to have a social impact. SIBs allow commissioners to bring together these complementary requirements.
- Driving innovation in the social sector. SIBs shift the financial risk of new interventions away from the public sector, towards investors, resulting in innovation and diversification of service provision.
- Improving value for money of public spending. SIBs enable government to only pay for interventions that are effective.

(Centre for Social Impact Bonds, Cabinet Office)

A broader approach to social investment would enable commissioners to leverage public funds alongside attracting private investors to fund early and preventative action on complex and expensive social problems. This is also important in breaking down public perceptions about the role and contribution of private investment in health and social care as the approach to social investment sets out clear

benefits that are driven by social outcomes rather than financial gains.

Combining public transformation funds with private investment provides a way by which new services can be tried that allows greater flexibility for those providing the services to adapt and change the service according to their experience and means that they don't have to shoulder the whole burden of costs if they don't work.

In this way new models of health and social care delivery can benefit from social investment by leveraging private and public investment for better outcomes on a shared risk basis. It also helps services have a greater emphasis on prevention and brings in a wider range of agencies from across the social sector including social enterprises who can bid for and manage projects under government covenant protection. One of the most significant advantages of social investment approaches are that they enable growth in the social sector and support social sector agencies to play a part in service transformation as equal partners:

“The voluntary sector are only brought in at last minute as an after thought but we provide essential services and need to be at the heart of change and transformation.”

(Social sector stakeholder)

“The social sector is growing and has a strong record of innovation and providing services that are closer to people and more in line with their needs.”

(Social sector stakeholder)

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New technology

Digital technologies and services are maturing at a pace that provides opportunities to create and consume services in a more personalised and targeted way. By placing the individual at the heart of the transformation, helping them to understand their own needs, and link into smarter digitally enabled technology, the health and social care sector can continue transforming to meet the demands of both the individual citizen and the populace. However, the focus should be on IT enabled business transformation, so that new technologies are applied in the right context:

“In areas such as health, understanding the environment in which the technology must work is as critical as the technology itself. Third party organisations need to be able to understand the health environment, such as things like ‘Infection Control’ so that solutions are fit for purpose. Organisations need to work collaboratively with third parties who clearly understand the full business environment and can advise and adapt their solutions as needed.”
(Private sector stakeholder)

“It is important that projects are driven by business need and requirements and are not purely focussed on the physical technology, otherwise, this can and does compromise how people want to work and the benefits which could be achieved. Organisations should put the business first and IT should support what is needed to change the business functions.”
(Private sector stakeholder)

“In certain organisations there is a cultural problem with people not willing to adapt and change their ways of working for a number of factors, the main one being fear of the unknown. When looking into a digital programme of change, organisations need to bring the employees along on the journey and should get them involved as soon as possible to gain backing and adoption. Adopt the ‘do it with them’, rather than ‘do it to them’ approach.”

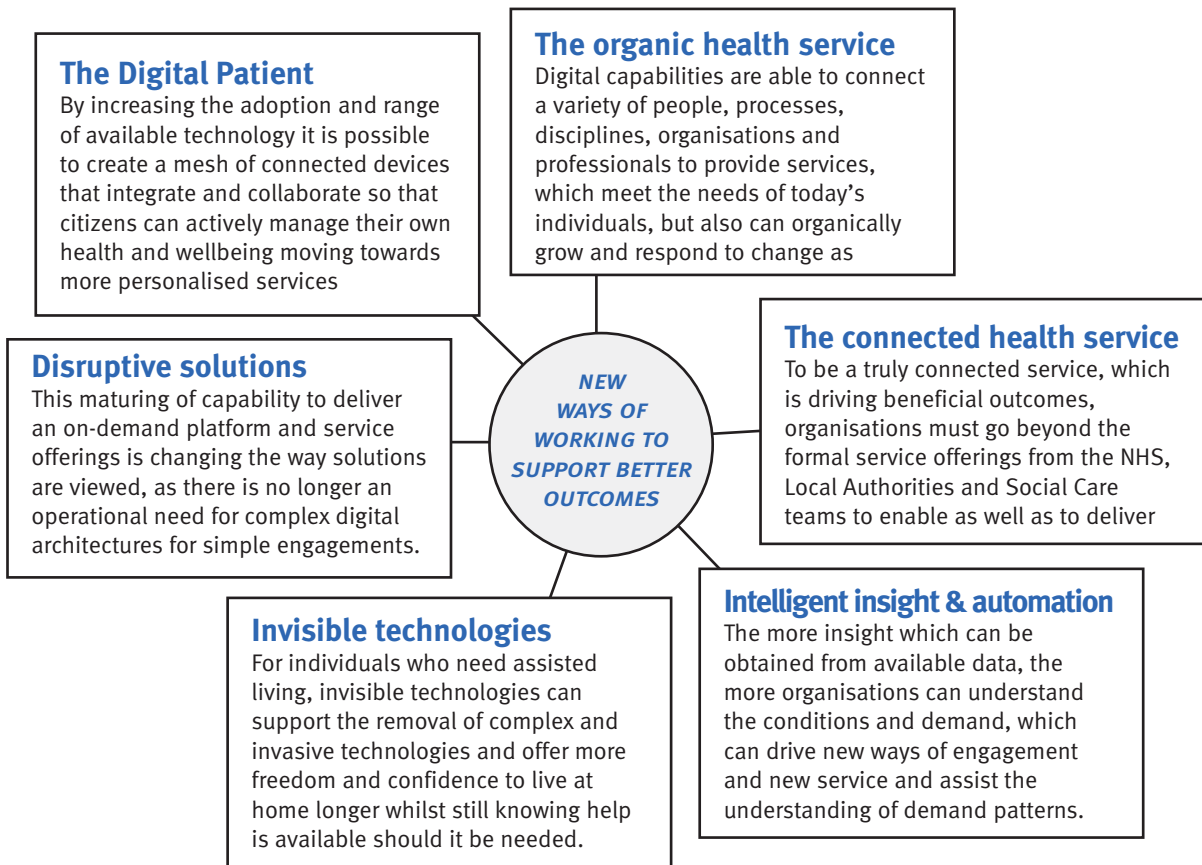
(Private sector stakeholder)

The following model (developed by Sopra Steria, one of the sponsors for the Breaking Barriers programme) is broken into six interlinked topic areas to describe how new ways of working and emerging technologies can deliver a better outcome for the health and social care sector, as well as the citizen experience.

These topics cover a number of core outcomes and benefits relevant to the utilisation of technology within Health and Social Care to improve health and wellbeing such as:

- Contributing to better economic outcomes, through demand management and automation of non-critical processes
- Adding value with improved performance through the introduction of digital services and self-help solutions
- Joining-up data to enable secure and informed management of complex demands
- Equipping the right resources at the right place to save lives

- Achieving interoperability for seamless communication
- Enterprise-wide visibility for improved financial control



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Building a sustainable future – a model for integration and innovation

Achieving greater integration of health and social care is a long standing policy and legislative ambition but substantial progress in achieving this has proved elusive. A new model for integration is needed that can address the barriers to change across system, financial, outcomes, workforce and infrastructure levels. The model needs to build from the ground up starting with collaboration on estates and infrastructure that enables integration of workforce, budgets and the system of service delivery and accountability. In this way greater innovations can be realised that will result in improvements in people’s lives and better outcomes in services and interventions that are sustainable for the future.

Collaboration

COLLABORATION noun:

1. the action of working with someone to produce something; synonyms: cooperation, alliance, partnership, participation
2. traitorous cooperation with an enemy; synonyms: fraternization, colluding, collusion, conspiring

Unfortunately the history of collaboration in health and social care is more one of ‘traitorous cooperation with an enemy’ than working together to produce something. This is in part due to the way that health and social care is structured with separate organisational forms: governance, funding and accountability. While any successful change needs leadership, it is also possible for leaders themselves to become barriers to change. This is best illustrated by the so called ‘prisoner’s dilemma of game theory (see below). The prisoner’s dilemma is a metaphor used in game theory to explain why

two completely ‘rational’ individuals might choose not to cooperate, even when everything says it is in their best interests so to do.

The Prisoners’ Dilemma

Two members of a criminal gang are arrested and imprisoned. Each prisoner is in solitary confinement with no means of communicating with the other. The prosecutors lack sufficient evidence to convict the pair on the principal charge. They hope to get both sentenced to a year in prison on a lesser charge. Simultaneously, the prosecutors offer each prisoner a bargain. Each prisoner is given the opportunity either to: betray the other by testifying that the other committed the crime, or to cooperate with the other by remaining silent. The offer is:

- If A and B each betray the other, each of them serves 2 years in prison
- If A betrays B but B remains silent, A will be set free and B will serve 3 years in prison (and vice versa)
- If A and B both remain silent, both of them will only serve 1 year in prison (on the lesser charge)

(Poundstone, 1992)

For leaders of health and social care the dilemma is one of accountability and shared responsibility with national regulators such as the Care Quality Commission (CQC) and NHS Improvement playing the part of the police. So, in the case of patients such as the frail elderly, or those with long term conditions and rehabilitation needs, who are in hospital beds

but who would be better placed in the community or at home, where does the responsibility lie for the failure to make this happen? Is this a health issue or is it one of social care?

The prisoner's dilemma only arises because there are two prisoners locked into the dilemma. If there were one clear line of accountability and responsibility for both health and social care in the local system, entirely new approaches to resolving the issues will arise:

"We need to be focused on outcomes across the whole system and not our own organisations."

(Public sector stakeholder)

"There are too many players and they are all competing with each other, why can't there be one single body responsible for the entire local system?"

(Social sector stakeholder)

Integration

INTEGRATION noun:

the action or process of integrating – "economic and political integration": Synonyms: combination, amalgamation, incorporation, unification, consolidation, merger, fusing, blending, meshing, homogenization, homogenizing, coalescing, assimilation

There are many examples of health and social care organisations combining, amalgamating or incorporating different services. Others have sought to create unified systems through greater consolidation, organisational mergers, fusing or meshing of service elements.

There are few examples that have fully succeeded in homogenising or assimilating health and social care in a way that is truly integrated. The most recent examples of integration consist of services that have taken over the functions and delivery of another through legislative permission, such as the competitive procurement rules under section 75 of the Health and Social Care Act.

But these are mostly transfers of existing health services to another contractor rather than integration of core service elements across different parts of the health and social care system. They are focused largely on vertical integration when what is required is a stronger focus on horizontal integration.

Vertical and horizontal models for integration

Both vertical and horizontal models of integration are proposed in the NHS Five Year Forward View. However, these are largely conceived within the context of health care organisations and systems with only limited scope for vertical integration between the NHS and local authorities.

Vertical integration is characterised by:

- Top down, command structure
- Linear collaboration
- Focus on efficiency savings rather than strategic change
- Limited flexibility for innovation
- Rule bound
- Narrow integration

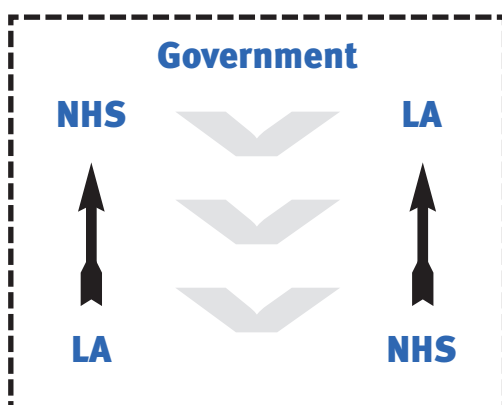
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Building a sustainable future – a model for integration and innovation

Vertical integration

Government or a national agent usually initiates vertical integration. It is a closed system with a tight rule structure that restricts scope for collaboration, innovation and further integration especially for partners not within the closed structure.

Vertical integration is based on systems and organisations rather than place and people. The key driver is efficiency savings rather than strategic transformation.



Horizontal integration

Horizontal integration involves government or national agents acting as a facilitator and enabler. Horizontal integration is place and people based rather than systems and organisations.



It is an open, negotiated system with maximum scope for collaboration, innovation and further integration including stakeholders who might otherwise be unable to take part, e.g. public, private and social sector providers, employers, communities. The driver is strategic change rather than a sole focus on efficiency.

Horizontal integration is characterised by:

- Shared control
- Focus on strategic change rather than efficiency
- Networked collaboration
- Maximum flexibility for innovation
- Negotiated rules

Innovation

INNOVATION noun:

The action or process of innovating:
 Synonyms: change, alteration, revolution, upheaval, transformation, metamorphosis, variation
 Innovations have also been described as better ways of meeting new requirements or needs; and as an original, more effective method for breaking into new markets.

If there is one term that is at risk of being over used and is probably least understood in health and social care - it is innovation. A term that is “crucial to the continuing success of any organisation” it is also variously defined as being about change, revolution, upheaval, restructuring and variation including new ways of using technology.

Almost anything new can be seen as innovation and that is part of the problem in seeking to define innovation as an essential principle in a model of change and transformation. The risk is that in the drive for innovation we seek change for change's sake. Rather, innovation should be seen, as a means to achieving an aim that otherwise could not be realised without a new way of conceiving the problem and/or solving it.

Innovation is clearly about new ways of doing things and whether revolutionary or altering, innovation needs to be considered in terms of outcomes, i.e. innovation should serve purpose rather than the purpose being innovation. So, rather than approach innovation as something good in itself we need to ask first what any particular innovation is meant to achieve?

Innovation should be judged by whether or not it delivers the promised outcome. And herein lies another problem. To be clear about the purpose of innovation we need to understand the desired outcome:

“If you want something new, you have to stop doing something old”
(Peter F. Drucker)

“Organisations can jump on specific technology without understanding or defining why they need something different. There needs to be a clear definition and understanding of the outcome which is being aimed at.”
(Private sector stakeholder)

“Everyone is talking about Digital this and Digital that, vendors are pushing their versions of products and tools and

organisations are finding it increasingly difficult to understand what is most appropriate. Organisations need to be very clear of what the outcome is they are trying to achieve and then find a service/company/product, which can deliver the outcome. Trying to investigate all possible options will simply confuse the situation further.”
(Private sector stakeholder)

Collaboration, integration and innovation are interdependent steps for addressing the critical challenges facing health and social care services. The model provides a new way of thinking about health and social care that goes beyond the current narrow conceptions of discreet services and population groups. The model recognises that health and social care needs have changed and it is focused on positive outcomes in terms of improving lives rather than solely treating illness or managing infirmity in line with the Fifth Wave of public health.

The model uses collaboration, integration and innovation as levers for change in designing and implementing new ways of delivering services that are more cost effective and are better aligned with local area Sustainability and Transformation Plans. This will be possible through the new powers being granted to elected mayors that will enable local area system transformation and leadership across the public, private and social sectors. The model demonstrates how actions taken in four areas: shared estates and infrastructure; workforce development; financial and budgetary alignment and whole system leadership can provide a sustainable future for health and social care.

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Building a sustainable future – a model for integration and innovation

1. Shared Estates and Infrastructure

The physical environment in which many health and social care services are provided are disjointed and in many cases no longer fit for purpose. Ownership is split between local authorities, individual trusts, GPs and NHS property bodies such as NHS Property Services and Community Health Partnerships. Many hospitals retain their Victorian infrastructure with all the problems that accompany this, for example inefficient and wasteful heating and waste systems, deteriorating buildings that are inaccessible and have poor or little use of natural light. The buildings and infrastructure for social care services are often little better and individual service teams are located away from their counterparts in health and related services:

“In the event of a fire or natural destruction no one would re-build these estates in the same way.”

(Public sector stakeholder)

However, despite these deficiencies health and social care estates represent one of the most significant areas for releasing capital assets and achieving significant cost savings. But the increased efficiency and cost savings that an integrated approach to health and social care estates could bring, is not just about the rationalisation of the estate but using estates as a lever for collaboration that can address wider system and service transformation:

“The health estate is a hugely valuable and relatively untouched portfolio which has significant potential to reduce cost and release value back into the system, as

well as be a catalyst for operational change by delivering a reconfigured real estate infrastructure platform to support the delivery of new models of care.”

(Public sector stakeholder)

Collaboration is critical to unlocking the potential benefits from the combined health and social care estate. Asset ownership is currently fragmented so there is a need to review the combined estate in terms of creating a single portfolio or a sub set of scale portfolios. A more dynamic portfolio, moving from fixed to variable use should be incorporated into the local Sustainability and Transformation Plans. This would also ensure that the plans are more aligned on an integrated basis with shared responsibility across the NHS and local authority partners. In this way the STP property strategies will have a clearer service strategy for an integrated health and social care estate.

Collaboration of this kind, between public, private and social sector agencies, on a more strategic and focused approach to area based change for health and social care would enable the following:

- realisation of greater cost savings through shared facilities and buildings development and management;
- alignment of strategy for local area regeneration and development and Sustainability and Transformation Plans;
- release of assets for pump priming of ring fenced investment to support service re-configuration and integration in line with the NHS Five Year Forward View and the One Public Estate;

- integration of service delivery across organisational boundaries;
- improved access and use of services that are delivered closer to where people reside and work;
- innovations in design and infrastructure development that would support improved outcomes from health and social care;
- more flexible use of buildings and facilities to enable change and adaptation as service needs and demands change.

This is already in evidence through the government's approach to One Public Estate and moves towards colocation across local authority services, benefit services, jobcentres and housing associations. However, much less attention has been paid to the needs of primary care provision and there has been much less collaboration between the NHS and local authority partners about area based planning and needs. Sustainability and Transformation Plans go some way towards this but these plans need to be better aligned with local authority development and transformation strategies. The complexity of design, delivery and managing a modern, integrated health and social care estate requires a model that provides flexibility, financial robustness and ensures property is not an outcome, but a catalyst for future change.

1.1 Designing and delivering a future estate footprint

One of the greatest barriers to designing and delivering a future estate footprint for health and social care is the poor history of collaboration between NHS and local authority partners:

“Collaboration at a strategic level is lacking. As a local authority we are much more advanced in this than our NHS colleagues – there has been a reluctance to engage on a strategic level.”
(Public sector stakeholder)

“We need a partnership approach - thinking differently, more strategically so we can scan the horizon and start thinking where do things need to be in 10 15 years time?”
(Private sector stakeholder)

The key factors that result from this lack of collaboration, as discussions with a number of key stakeholders in the review process have highlighted, are:

- poor integration of strategy between NHS and local authority partners;
- lack of service co-design between NHS organisations, local authorities and the social sector;
- few ideal sites for integration at local levels with the consequence that new funding models to support new build developments are required.

Despite a positive direction of travel with local health and wellbeing boards, NHS property companies and the planning for local Sustainability and Transformation Partnerships, these are fundamentally operating in an environment of silos with the key focus on individual organisational sovereignty between providers. This is despite the fact that there are shared strategic objectives across providers, commissioners and local authorities:

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“NHS bodies ought to work with local authorities and property developers when undertaking estate rationalisation.”
(Public sector stakeholder)

“Short-term decision-making was one of the main problems preventing a more strategic approach to estate management.”
(Public sector stakeholder)

Health services have tended to design and plan their estates in isolation from other local partners with acute hospitals taking the main share of development funding and infrastructure costs. Developments have also been focused on historical service delivery patterns rather than from the perspective of service use. This has inhibited the development of an estates and infrastructure strategy that is forward looking and able to better meet the changing patterns of demand and needs for services:

“We need to link top strategy and demographic mapping with the local area in a practical demonstration of change – It’s not about facilities management being done better, but better health outcomes and prevention.”
(Public sector stakeholder)

There is a growing consensus that the design of health and social care estates and infrastructure at local levels must change to continue to support the health and social care needs of the current and future population. This approach is being promoted by the Five Year Forward View with the development of NHS England’s ‘Healthy New Towns’, which look to design modern health care services and estates at the inception of

town planning. These kinds of initiatives show how policy permission to rethink estates and infrastructure strategies is increasingly coming to the fore:

“The difference is how we can start to use the One Public estate strategy to create wider change in health and social care, including more multi-disciplinary working practices, partner roles, breaking down the silos – there hasn’t been enough thought about this from our NHS partners.”
(Public sector stakeholder)

Similar new thinking (as proposed by Lord Darzi of Denham in his reviews of both national and London healthcare systems¹⁵ and supported in the NHS Five Year Forward View) on better ways to utilise NHS primary care estates can be seen in alternative GP led health centre models, such as ‘polyclinics’ which are moving routine acute services to primary and community care-based settings, producing an accessible one-stop-shop model:

“We need to really re-think the acute hospital model.”
(Public sector stakeholder)

One-stop-shop models, or more widely, Public Service Hubs, which combine services, staff and budgets from a range of related providers, is the direction of travel being pursued by the Government Property Unit with their Government Hubs programme with local authorities:

“A Public Service Hub is more than just about delivering a cost-effective property solution for the public sector. It is about

15. Darzi, A., ‘Healthcare for London: A Framework for Action’ July 2007,

creating modern, appropriate space for organisations to proactively respond to new demands on their finances and services.”

(Private sector stakeholder)

The Public Service Hub model, as illustrated in the OneHub Bradford case study, is a potentially powerful vehicle for integration of health and social care services. The process involves three elements:

1. Development of a delivery and financing partnership between a head lease holder (usually the local authority) and a private development agency with access to institutional funds

Initial collaboration on the delivery partnership is key. This works best when a lead public agency, usually a local authority, takes a head lease role providing land for new build development. As the holder of the head lease the local authority can provide a government covenant assurance that enables a property development agency, with access to institutional funds for the capital costs, to be engaged as a partner:

“New property leases ought to be more commercial in order to offer good value for the taxpayer.”

(Public sector stakeholder)

On the basis of the government covenant the development partner can provide the new build on a long term lease at the end of which it is returned to public ownership. Because the occupancy is being designed for multi-agency use the revenue costs i.e. rental can be sustainable and depending on the number of agencies involved could provide funding for further social investment:

“Close down isolated, out dated hospital buildings and reinvest for better facilities that are closer to the patient.”

(Public sector stakeholder)

It is important at the planning and development stage that partners recognise the need to move to execution and delivery of outcomes and not remain too fixed on planning:

“A collaborative approach between health and social care leaders with a robust understanding of the financial imperatives for each will focus minds and support joint decision making.”

(Public sector stakeholder)

2. Engagement with key services across the public and social sectors that will take up occupancy as lease holders

The second element promotes collaboration at the level of service providers across health and social care. This involves thinking about the changing demands and needs for social care and new ways of working i.e. combining primary and community care services with hospital outpatients and social sector partners to deliver an integrated early identification and prevention service model. However, this needs to be facilitated and supported to overcome the challenges and barriers to culture change:

“The big challenge is to make the ‘doing’ happen, it needs culture change and leadership.”

(Public sector stakeholder)

“There needs to be the appetite to do it at CEO level - then a tough skinned person to make it happen at the ground.”

(Public sector stakeholder)

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3. Analysis of current and future service use and workforce practices to ensure agile working and maximisation of environmental and technological innovation in design

The third element uses the application of agile working principles for shared space and services. The ‘actual’ space usage of staff and organisations can be understood and designed for the new ways of working. Intelligent design principles enable colocation to reduce individual running costs and ensure that the facility is flexible for changing and future development of service delivery, needs and quality outcomes. Colocation also promotes collaborative working between agencies with wider savings achieved by reducing duplication and increasing understanding across previously disparate elements in care pathways.

This approach to shared estates and infrastructure supports the direction of travel being promoted by the Department of Health and the Cabinet around estate management and allows for service transformation, major regeneration and property development to take place, with no risk placed on the public sector or spending of taxpayer money:

“The provision of suitable estate for NHS services should fully exploit the benefits of integration and colocation with other relevant organisations. Engagement with local authorities and other public sector organisations could lead to joint rationalisations of assets and associated services.”¹⁶

The design function can apply not only to agile working practices but also to energy saving and the standardisation of business processes. These principles have been put to good effect in the ‘*design for function*’ approach of modern hospitals in Holland.

Case Study- OneHub Bradford

The challenge

Despite being one of the UK’s biggest and fastest growing economies, Bradford has historically been an underdeveloped city with high levels of deprivation, unemployment and disparate public services.



The local authority, City of Bradford Metropolitan District Council, realised they needed to undertake a large-scale program of transformation to regenerate public spaces, improve services and deliver economic growth. Alongside this, the council understood that their own estates were unwieldy and inefficient and required rationalisation and modernising.

Solution

The local authority recognised the need for a new approach that would develop more effective working practices and sustain private and public sector jobs. The initial solution envisaged better use of existing local authority buildings such as the library, which was underutilised and occupied prime city centre space.

Using the Public Service Hub model as its starting point, a unique development partnership, OneHub Bradford, was established involving the Council and a Private Development Consortium made up of three Companies: McClaren Group, Chilton Land Ltd. and DragonGate as dedicated programme managers. It focuses upon the re-use of the Jacobs Well site which

16. Department of Health, ‘Part A: Strategic framework for the efficient management of healthcare estates and facilities’, October 2014

until May 2016 was home to the Authority's corporate service HQ. The location provides the opportunity for a central, accessible and ambitious base for public service integration.

OneHub Bradford is in the process of developing this significant opportunity for key public service providers. It maximises the value of government as an occupier of choice, a process that is designed to ensure deliverability but minimises capital costs for occupiers and risk for the council.

Crucial to the process is the programme management. The programme involves a comprehensive engagement process with multiple service providers on their current challenges and future needs. In addition to ensuring the future is built around the citizen and service, and not short term expediency, the programme identifies opportunities for investment in modern working, shared space and longer term integration patterns, and places these into the Hub's blueprint. This in turn enable an affordable BREEAM Excellent facility that avoids the punitive financial constraints of PFI. By maximising the benefits of modern agile working, the purpose built Hub saves money for the occupiers through intelligent use of flexible space. The lease arrangements include an optional turnkey facilities management package and standardised fit out, to ensure collaboration is encouraged at every level. An HM Treasury Greenbook business case for each potential occupier is undertaken at 'no cost, no commitment', to provide transparent value for money comparisons at each key stage.

Benefits

Although still at a relatively early stage

OneHub Bradford, based on the Public Service Hub business model, is successfully engaging a range of public, private and third sector partners through service redesign and greater integration. Pre-occupational analysis for organisations going into the hub, project average savings of 42% from existing usage.

It has also enabled the council to reuse a legacy site to develop a modern and dedicated facility for key public service providers to work in. Ultimately it will achieve a collaborative environment through shared space and co-location.

The Report Authors would like to acknowledge the contribution of DragonGate, Chilington Land Ltd. McLaren Property and City of Bradford Metropolitan District Council for this case study

The Dutch experience 'Design for Function'

The Challenge

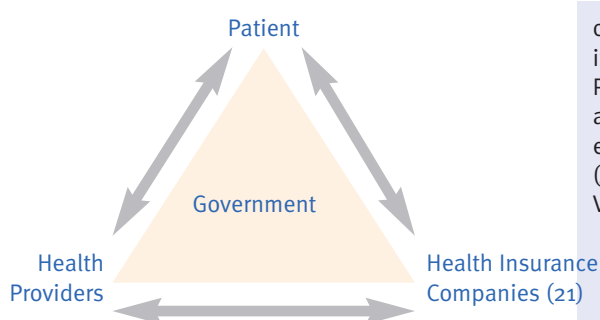
Whilst the emphasis inevitably differs in individual cases, the challenges faced in healthcare today are broadly the same in each country: an aging population, a surge in chronic disease, technology advances in the diagnosis and treatment of disease and more informed patients – all factors which are leading to a rise in the cost of healthcare. This is often seen together with a rise in patient numbers, budgetary pressures and an ailing infrastructure, which all leads to a huge challenges for hospital administration.

The Dutch healthcare system relies on a



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framework between patient, care providers, health insurers and the government as overseer. Prior to 2006 there was widespread public dissatisfaction with the healthcare system related to the combination of lengthening waiting lists and spiralling costs that were characterised by a supply-based and densely regulated system. Healthcare reforms put into place in 2006 liberalised the Dutch hospital market.

The Solution

The solution in this context lies in the implementation of smart solutions, understanding different behaviour in hospital processes and an intelligent and flexible design of healthcare facilities. It usually starts with clear planning of a facility and a master plan. Part of the solution is also found in standardising processes and design which can help improve the quality of care, patient safety and costs.

We have found that in some hospitals in the Netherlands, a target for standardisation of 80% of hospital processes leaves the organisation free to focus on the remaining 20% that are not standardised, to improve and optimise their processes. The standardised processes also

offer monetary savings in the training of staff. Processes where staff are not essential can either be automated (Automated Goods Vehicles), or outsourced.

New ways of combining infrastructure and IT also leads to improvements. The tracking of people can determine the amount of climate control needed in a building. We have seen examples where this “pull effect” of a climate need has led to a 30% reduction in energy costs in specific buildings. Royal HaskoningDHV implemented such a system at Amsterdam Airport Schiphol, and the same technology could be utilised across hospitals.

Design also plays a role in the optimisation of the hospital, specifically if it is a Greenfield project, but also in refurbishment projects. The planning process is one of the most crucial aspects of the hospital. Decisions made at an early stage will inevitably influence the rest of the project. Decisions on the functionality need to be made at the beginning of the design process and should offer flexibility to be able to adapt to any future changes in healthcare.

Benefits

Alone or in combination, the design and process improvements should lead to an optimised initial cost as well as operational cost.



Photo with permission Zuiderland hospital

Process improvements on the other hand leads to higher quality of care and even a reduction of the average length of stay (ALS) in a hospital. The California Healthcare Foundation uses tracking tools to increase patient flow, and has shown that for a 275 bed hospital, reducing the ALS by 4 hours is equivalent to increasing physical capacity by 10 beds. These improvements should in the future lead to less bricks, more bytes and a different behaviour in our way of working in the hospital of the future!

The Report Authors would like to acknowledge the contribution of Dirk Joubert from Royal HaskoningDHV for this case study

1.2 Managing services for the future

Ensuring sustainability for a future shared estate model for health and social care requires being more creative with how facilities are managed and maintained. This includes planning for future change of service demands and needs so that estates are managed flexibly and able to adapt to these changing requirements. In order for this to be effective it needs to be done on the basis of area planning and integration of health and social care.

Some new building and facilities management services have been enabled in the past through programmes such as the Public Finance Initiative (PFI). However, these are often perceived to have left public services with unsustainable levels of debt and high interest payments, while being caught up in overly restrictive procurement contracts that have prevented changes and adaptations to meet new circumstances and service demands. New ways of thinking about partnership between public, social and private sectors on facilities management are needed:

“One of the key problems is the failure of the NHS to understand what private sector companies could offer, it is because they lacked expertise and didn’t understand the implications of large compound interest rates in PFI contracts.”

(Public sector stakeholder)

“There is a lack of shared thinking in the NHS, multiple single service contracts that are inflexible and don’t support innovation; little collaborative procurement. This is despite the wider market moving forward with total facilities management estates contracts and combined partnerships for energy that work on the lifecycle of needs.”

(Private sector stakeholder)

Facilities management services are normally provided on an organisational basis rather than thinking about the potential cost savings and improvements that could be made from having a unified, system wide approach to facilities:

“To be more sustainable in the future estates teams need to take a more commercial and strategic approach through more flexible, longer term contracts.”

(Public sector stakeholder)

The Carter Review estimates that minimum savings of £1bn could be realised through better and more efficient estates and facilities management, including better use of space and investing in energy saving schemes.¹⁷ This in part can be attributed to a lack of relevant expertise:

“Many estates directors in CCGs and Trusts have engineering or facilities

17. Lord Carter of Coles, ‘Operational productivity and performance in English NHS acute hospitals: Unwarranted variations’, February 2016, p.13

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management backgrounds, they lack the experience to manage property effectively and make savings in the long run. Chartered surveyors and other property professionals would be better placed to manage NHS estates”
(Public sector stakeholder)

Placing estates and facilities management in the hands of those who are expert to lead this can bring significant benefits:

“Good facilities management is about the patient - everything we do is from the patient perspective and this can overcome the private public sector barriers.”
(Private sector stakeholder)

“We need to apply professional capability and expert management to this challenge to achieve better outcomes.”
(Public sector stakeholder)

The private sector does have this dedicated expertise and there are increasing examples of how this is being used and developed within public sector services. But the history of antipathy to perceived private sector encroachment in the NHS can also be a barrier to the NHS and local government fulfilling its purpose of delivering high quality care and ensuring “that valuable public resources are used effectively to get the best outcomes for individuals, communities and society for now and for future generations”.¹⁸

Managing facilities from within each separate organisation also means that leaders are distracted from their core tasks of providing health and social care:

“There is no use of property management services currently in the NHS, instead they have in-house estate teams and the only area of outsourcing is facilities management.”
(Private sector stakeholder)

“Because the estates teams are all in-house, hospital senior management are not able to just focus on patient care and health outcomes, which is detrimental.”
(Private sector stakeholder)

“Relieve the executive from worrying about leaky pipes.”
(Private sector stakeholder)

Re-procurement of facilities management on a broader basis (area or sub-regional) would enable leveraging of economies of scale, whilst ensuring local, high quality delivery on an integrated basis. Estimates of potential savings are significant i.e. approximately 20%.

Case Study: Leeds Generating Station Complex

Challenge

Energy supply for Leeds General Hospital came from a large generating station that had been constructed by the then Yorkshire Regional Health Authority. It was originally built to supply only the Leeds General Hospital (LGI), but later, in the 90s, it was adapted to take on the adjacent University of Leeds campus. The contract for the station came to an end in 2015 and was reaching the end of its expected life. One of the main challenges was



18. NHS England, <https://www.england.nhs.uk/about/our-vision-and-purpose/> (accessed June 2016)

to reconfigure the station from what was to what it needed to be to meet the future requirements. This part of the process needed to be very carefully project managed to ensure any interruptions to supply during service changeovers would not affect patient care. The Trust and University agreed five common objectives:

- To provide a resilient and secure utility supply
- Maximise the cost/benefit opportunities offered by the procurement
- To make a major contribution towards the Trust's and University's carbon saving targets
- To provide a contract which offers flexibility to respond to commercial change
- Maximise the associated commercial opportunities which may exist for both organisations

Solution

A joint Trust and University Project Board was established, with each organisation having a nominated senior responsible officer and a joint working group within each organisation. The model works on standard OJEU procurement documentation, but uses a tripartite agreement between ENGIE, Leeds Teaching Hospitals and the University of Leeds to provide a clear contractual structure. The technical challenge was to design, build and operate critical energy infrastructure upgrades including the replacement of all generating and boiler plant infrastructure.

Benefits

- Two equal partners Leeds Teaching Hospital NHS Trust and Leeds University
- £30m of public sector investment
- 25 year contract to provide services
- £3.5m pa of guaranteed savings

“We must never forget that the secure, resilient supply of utilities is key to patient care. Without this service the quality of that care must never be reduced. Whilst I’m a professional engineer, I’m never far away from the people who are reliant on the service.”
 (Mick Taylor, Deputy Director of Estates and Facilities/ Head of Estates – operational services)

The Report Authors would like to acknowledge the contribution of ENGIE for this case study

Case study: Collaboration to save energy costs - Liverpool Energy Collaboration

Challenge

Using £12.4 million of private investment, ENGIE will construct, operate and maintain gas-fired CHP energy centres for the three NHS Trusts, as well as carrying site-wide upgrades to energy-consuming services.



Solution

The Liverpool Energy Collaboration was established as a procurement partnership

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involving three NHS Foundation Trusts: Aintree University Hospital, The Walton Centre and Liverpool Women’s Hospital.

“In upgrading the energy infrastructure for each of the Trusts, we will ensure they have a more reliable, resilient and responsive energy services. In parallel, by making optimum use of low carbon energy sources as well as upgrading services in the building to maximise efficiency, we will deliver guaranteed savings with a fast return on investment, while also reducing environmental impact.”

Paul Rawson, ENGIE’s Divisional CEO for Energy Solutions

Aintree University Hospital - The project works will take place over 2 years and will incorporate:

- Steam conversion of the entire site with a new Low Temperature Hot Water heat network
- Installation of a 1.2MWe combined heat and power unit to provide significant financial savings
- Installation of 14 MW of boiler capacity to provide thermal resilience to the site
- Provision of laundry equipment to enable the Trust to continue to generate revenue from providing external services
- Replacement of heating, ventilation and air condition theatre equipment

The Walton Centre - The project works will take place over 1 year and will incorporate

- Enhancing resilience and making savings through the integration of both the Trust’s buildings in the new Aintree University Hospital heating network

Liverpool Women’s Hospital - The project works will take place over 1 year and will incorporate:

- Enhancing resilience and improving efficiency through the installation of a two new burners for the Trust’s boilers.
- Installation of a 380kWe CHP to provide significant financial savings.
- Installation of a new chilled water assets to provide financial savings and enhance resilience.

Benefits

The collaboration managed to achieve economies of scale for the three trusts through a single procurement and a two trust single site CHP, along with the control and assurance for each trust of separate contractual arrangements.

- Guaranteed financial savings of over £1.2 million per annum across the entire Aintree/Walton Centre site.
- Reduced the demand on energy by upgrading lighting and improving various pumps
- Combined yearly reduction in carbon emissions is projected to be nearly 5,000 tonnes, representing an average carbon saving of 29%.

- Value through the collective project and service delivery across their three sites.
- £1.2m annual guaranteed savings

The Report Authors would like to acknowledge the contribution of ENGIE for this case study

Case Study: Croxley Green Business Park, Watford



The challenge

Rejuvenating a dated, out of town Business Park to provide a modern and effective working environment with a community feel, working off an environmentally friendly and sustainable platform. Croxley Green Business Park is a 75 acre estate that comprises of 9 office blocks and an industrial area with 25 units. The site is home to over 50 companies and 2,500 employees with a total area of 710,000 square feet. The annual service charge budget of £2.4 million, giving an overall figure of £3.40 a square foot.

There was a feeling that occupiers were finding the Business Park inaccessible without a car, which limited their movement during the working day. There were also issues with on-site amenities such as waste management with no recycling facilities available and just one small café within the facility.

Solution

The first step was to obtain feedback from the stakeholders in the park, which included occupiers and service providers. There was a clear need for major infrastructure and accessibility improvements. The overall

achievement of the works carried out in response to the feedback was to create a significantly improved working environment in which occupiers had the ability to work and play, whilst improving access to the site for all and driving up the park's sustainability credentials at the same time. Newly developed amenities developed on site included catering and café facilities, an indoor gym and outdoor sporting areas, along with a recycling centre.

Benefits

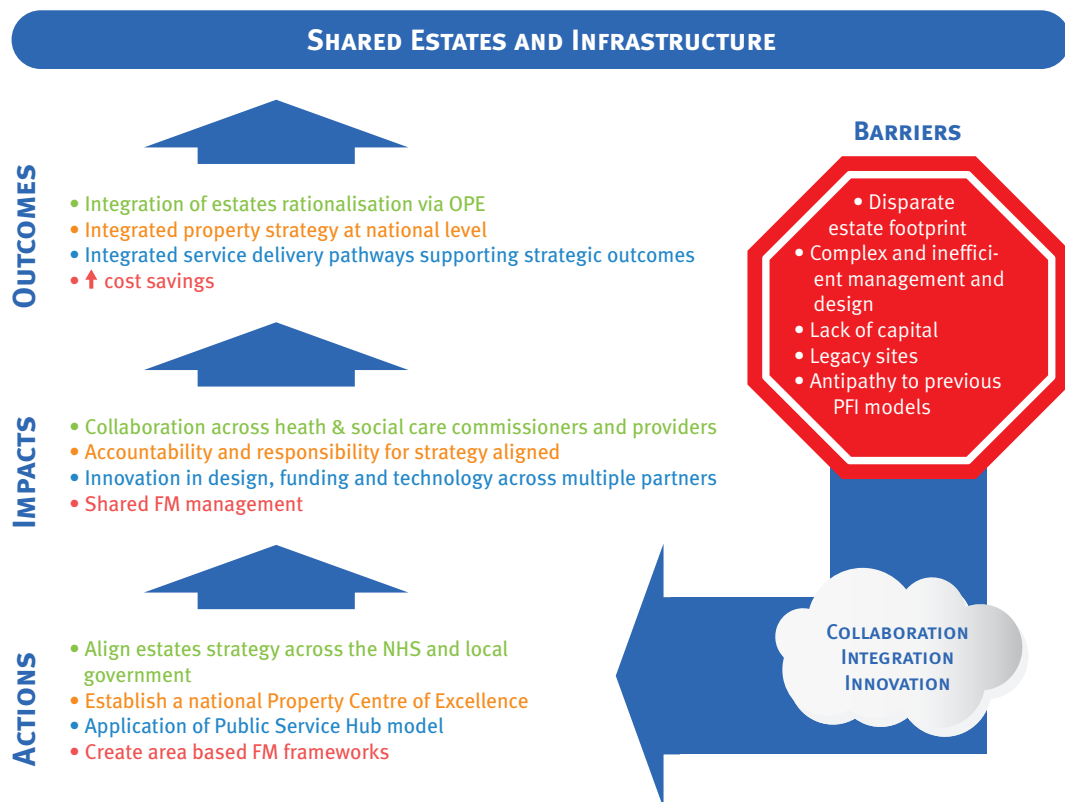
Existing on-site facilities were greatly improved which led to the benefits of inward investment from new businesses to increase the capacity of the Business Park. The community feel of the park became significantly stronger through shared activities and the use of communal areas by all. The engagement and education of the tenants was pivotal in the success of the parks' waste management solution and the hard work by all involved was acknowledged in 2012 by receiving the Waste Industry award for 'Waste Management Initiative in the Commercial & Public Sector'.

Significant cost savings have been obtained given the reduction in landfill tax payments and recycling credits achieved from cardboard, plastic and wood. These savings have been recycled into the service charge - cardboard is currently fetching up to £100 per tonne. Collaboration with the local authority saw bus services improve greatly from a single bus service at either end of the working day, to a frequent bus route that was free of charge for staff of the companies occupying the park.

The Report Authors would like to acknowledge the contribution of M J MAPP for this case study

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2. Workforce development

Meeting the changing demands and needs for health and social care will require new ways of working and a workforce that is equipped with the right competencies to deliver these:

“There are too many barriers to get people

into a registered nursing profession - give them different routes into care - new roles and functions - new skills.”
(Private sector stakeholder)

Current professional divisions will need to be broken down so that workforce development can be planned and delivered on a cross professional and competency basis.

2.1 New ways of working

There are significant differences in the health and social care workforce that will need to be addressed if more collaborative and integrated ways of working are to be achieved. For example:

- the social care workforce is larger than the NHS e.g. 1.363 million employed by the NHS compared to 1.63 million in social care;
- the social care workforce is more disparate and located across a number of different agencies and employers including those in the private and social sectors;
- Health Education England (HEE) provides block training contracts for NHS Trusts, but the mechanisms for ensuring that social care staff responsible for NHS patients receive training are poorly developed with many Trusts acknowledging that they cannot cope with the disparate nature of the local area social care workforce;
- career pathways for social care staff are less well developed and this has an impact on retention;
- there is an enormous growth potential to train and educate social care staff that to date have not had the same opportunities as their NHS counterparts;
- there is a need for the skills gap to be filled between nurses or allied professionals and the care assistant level;
- there is an urgent need to address diversity and equality in the health and social care workforce, e.g. poor progression amongst black and minority ethnic staff (BME) and experiences of discrimination.

The social care sector has one of the worst records of any sector for training and development of their staff. This has clearly been impacted by budget restrictions, but the spotlight is on the sector as there is a move towards integration of health and social care and an emphasis away from the acute sector to community provision.

There is a significant demand for more highly trained care assistants to take on more of assistant practitioner roles. This is due to a number of factors:

- The social care sector is dealing with higher levels of demand for people with increasingly more complex and multiple conditions, especially amongst older people who would previously have been in long stay hospitals. However, the majority of staff in residential care are trained to Level 3 at best.
- Previous regulatory requirements stipulated that 50% of care assistants in any one establishment should be trained to level 2 or above but this was abandoned as unworkable due to the high levels of turnover. As a consequence nearly all of the Skills for Care money has been spent on apprenticeships at Levels 2 and 3.
- Health Education England have a £5 billion budget which has traditionally exclusively gone to the NHS even though there are continuing care patients (NHS funded) in nearly every care establishment.
- There is a shortage of nurses in all care settings (there is likely to be a 30,000 shortfall nationally in the next two years. The Centre for Workforce Intelligence (CWI) estimate it could be as much as 64,000 nationally.

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Not having skilled staff has serious consequences for the health and social care system.

“Without the necessary skills in residential care, there is lack of preventative care, which leads to emergency admissions and also leads to bed blocking as the homes cannot look after the elderly when they return from hospital. Up-skilling of care assistants is therefore extremely important, as recourse to the acute sector is extremely expensive and inefficient.”

(Public sector stakeholder)

In order to compensate for the lack of nurses, care assistants will need to be skilled up as Assistant Practitioners and eventually nurses so that the social care sector can generate its own skills and not be overly dependent on trained staff from the NHS.

Some national developments are being planned on this basis e.g. the Nursing Associate role that is due to be introduced from 2017. The proposal for a new support role that could bridge the gap between nursing and social care arose from the Shape of Caring Review¹⁹ and the recommendations of the Cavendish Review²⁰. This included proposals for a new Care Certificate and training to develop additional skills and knowledge for working alongside Care Assistants and Registered Nurses.

The role is aimed at developing the scope of practice so that it enables associates to work alongside care assistants and registered nurses to provide high-quality person-centred care across health and care settings. A national

curriculum and the establishment of test sites will support the role across England. It is anticipated that 1,000 individuals will be recruited to the test sites in 2017. Health Education England have stated that a new care role with a higher skillset could achieve the following:

- supplement, augment and complement the care given by Registered Nurses;
- build the capacity and capability of the health and social care workforce to care for service users across different settings;
- widen access and entry to the nursing profession for Care Assistants and making caring a career;
- support career progression enabling a greater skill mix in the caring and nursing workforce to work flexibly and responsively.

2.2 The Apprenticeship Levy

New ways of working and new roles for the health and social care workforce can be supported through apprenticeships. The way in which the government funds apprenticeships in England is changing from April 2017:

- Employers with a pay bill over £3 million a year will be required to make an investment in apprenticeships through a levy.
- The levy will be charged at a rate of 0.5% of the annual pay bill including a levy allowance of £15,000 per year.
- The levy will be paid direct to HM Revenue

19. Lord Willis, ‘Raising the Bar - Shape of Caring: A Review of the Future Education and training of Registered Nurses and Care Assistants’ March 2015

20. The Cavendish Review, July 2013.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf, (accessed June 2016)

and Customs (HMRC) through the Pay as You Earn (PAYE) process.

From January 2017, employers eligible for the Apprenticeship Levy will be able to register with the new digital apprenticeship service and create a digital account. Funds will enter the digital account on a monthly basis, and a 10% top up will be applied at the same time. This means for every £1 that enters an organisation's digital account, they can access £1.10 to spend on apprenticeship training.

The NHS will be the largest provider for the Apprenticeship Levy but some concerns have been raised about the Levy with regard to the NHS:

- traditionally NHS workforce roles have not been suitable for an apprenticeship model;
- applying a levy based on employee earnings may not take adequate account of the range of training and skills required in particular sectors;
- given the size of the workforce and the diversity of roles, the NHS would be unable to get back what it has paid in.

However, the fact that in the short term at least the NHS will be a net contributor to the fund with spare capacity, provides an opportunity for closer working with partners in the public, private and social sectors to develop apprenticeships that can better meet the demands and needs for health and social care. This will require formal collaboration between health and social care partners and local Further Education (FE) and Higher Education (HE) establishments to develop a framework by which

the potential benefits of the Apprenticeship Levy can be realised. This could include:

- the establishment of specific health and social care pathways to support future employment needs;
- education pathways for adults to retrain under the new apprenticeships. Existing health and social care staff could participate in these programmes and work experience opportunities could be enhanced to ensure the right people are employed;
- the apprenticeship route could provide new ways of developing skills escalators for entry into professional qualifications e.g. this may be advantageous with respect to nurse education which will in future be funded via a system of loans, rather than bursaries;
- FE and HE institutions could offer part of the adult learning budget as a shared vehicle to support health and social care workforce development;
- opportunities to develop on the job training programmes using a combination of NHS and local authority apprenticeship funds;
- pooling of NHS and local authority training teams so as to maximise efficiency of delivery.

One of the ways by which local areas could support the above is through the establishment of Apprenticeship Training Agencies (ATAs) based on the shared employment opportunities that would come from collaboration across health and social care, hospitals, councils, housing associations and colleges. In this way,

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Apprenticeships could be delivered on a cross sector basis e.g. placements in the NHS, the local authority and other partners and with a local College.

This approach requires taking a different mind-set to the potential for partnership working and collaboration across FE and HE. To do this correctly, a team of people who are willing and able to understand FE, Apprenticeships, professional accreditations and other ways of thinking about training and skills will be needed at local levels. These individuals will also need to be able to adapt current systems to a new student market in HE so that students are able to move up from lower skill based programmes into a HE environment.

For example, Colleges could provide Level 2 & 3 qualifications as well as assessments of prior learning for students to come on to a programme, which includes Levels 4 - 6. In other cases, they may offer a foundation degree where students then transfer to HE to complete their degree. This could be achieved by using the Apprenticeship Levy and other employer funded places for these programmes by which public, private and social sector employers pool their resources to meet the training needs for their communities. This approach is being developed at the University of East London.

2.3 Competency based learning

Competency based learning (CBL) is an approach to life-long learning that focuses on specific competencies rather than time spent in class rooms or on pre-defined courses. It uses a range of learning techniques and assessments that enable students to build up credits as they progress through a skills escalator that recognises when students have achieved a particular competency:

“Competency based learning approaches have a lot to offer, not a job for life but life for job - give people escalators and develop a workforce that can be grown and controlled for the future needs - connect up all the partners with local FE to do things differently.”

(Public sector stakeholder)

There is increasing recognition of the value that Competency Based Learning (CBL) can bring to professional development and the model is ideally suited to apprenticeships. Other advantages of CBL include:

- recognition of prior accredited learning, e.g. students with existing competencies will only need to demonstrate these rather than complete a new course;
- students can work at their own learning pace and potentially complete placements and competencies in a shorter time frame than with traditional classroom based education;
- the CBL approach is attractive to adult learners who struggle to maintain commitment to traditional based learning opportunities;
- curriculum development can be more closely aligned with employer requirements so that competencies better meet the demands and needs of service users;
- flexible learning approaches have been shown to improve retention and progression amongst students from different ethnic groups;
- employers can have greater confidence that they will be able to fill skills gaps and have a workforce that is fit for practice.

Competency Based Learning at the University of East London

The challenge

There is a growing population with complex long term health needs requiring expert health and social care skills. Sixty-five per cent of people in hospital are over 65 and Eighty per cent of people in care homes have dementia or cognitive impairment. In England and Wales from 2010-2013, demand for health and social care for those aged 65 and over is expected to increase by over 80% to 1.96 million. (House of Lords, 2013)



These figures show the importance of improving the care available for older people, yet there is often a disparity between the skilled staff and practitioners needed, and those available on the ground. Staff with specialist knowledge and skills remain seriously under resourced which too often leads to unnecessary hospital admissions, under-diagnosis and lack of preventative approaches to health and wellbeing. These issues are particularly prevalent within the care of older people.

The solution

A Competency Based Learning (CBL) Health and Social Care programme has been designed at the University of East London (UEL), creating a career pathway that leads to qualifications for those wishing to work with elderly people. The programme is work-based with elements of e-learning, and has been designed for care workers from a variety of settings who wish to specialise in health and social care.

The Health and Social Care Programme, devised in response to the growing and ever more

complex needs of older people aims to give the work with older people the status it deserves, whilst creating a career pathway from Apprentice to Registered Professional. The curriculum is based on a patient-centred care framework of standards (the 360 Standards Framework) and has been developed with extensive input from employers, the older person and their families. The programme embraces integration as the pathway can be used across all allied health disciplines, social, domiciliary, community care and within acute hospital settings.

Benefits

The CBL programme emphasises practical application of knowledge in the workplace, and timely completion will make a huge difference to the up-skilling of care workers. This programme will contribute towards either a Foundation degree for the Specialist Older Persons Care worker or a BSc Hons degree in Health and Social Care. Foundation and Honours degree students are taught together for a number of the modules but assessment methods will differ for each type of degree. This will enable a better understanding of each other's role and promote better working between each group, as studies have shown there are often difficult working relationships between the two sets of staff.

“Our aim is to help promote integration in health and social care as the model can be used in all care settings and students from different settings are taught together promoting a shared understanding of person centred care in their different settings.”

The Report Authors would like to acknowledge the contribution of the Professor Nora Colton from University of East London for this case study. For further information please email n.a.colton@uel.ac.uk

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2.4 Inclusive leadership

Health and social care leaders at executive, elected and Board levels will need to develop an inclusive leadership style and competencies. This means being able to operate across sectors, organisational and professional boundaries and diverse communities and interests:

“The importance of leadership and shared purpose underpinned by ongoing dialogue with all stakeholders in the community cannot be overstated.”²¹

In addition to ensuring that leaders can be effective in collaboration, integration and promoting innovation for health and social care, inclusive leadership will bring benefits in ensuring that the full range of talents of a diverse workforce are supported and developed. This is essential for ensuring that health and social care organisations meet their duties under the Equality Act 2010 and for demonstrating continuous improvement under the NHS Equality Delivery System (EDS). It is also essential for ensuring that high quality care outcomes are achieved for all the population and in meeting key targets for reducing health and social care inequalities.

The need for inclusive leadership is highlighted in the first NHS Workforce Race Equality Standard (WRES): 2015 Data Analysis Report,²² which was published in May 2016. The WRES was included in the 2015/16 NHS Standard Contract for NHS providers, and from 1 July 2015, provider organisations submitted their baseline data against the nine WRES Indicators. The aim of the WRES is to ensure that black and minority ethnic employees have equal access to career

opportunities and receive fair treatment in the NHS workplace:

“In its simplest form, the WRES offers local NHS organisations the tools to understand their workforce race equality performance, including the degree of BME representation at senior management and board level. The WRES highlights differences between the experience and treatment of White staff and BME staff in the NHS. It helps organisations to focus on where they are right now on this agenda, where they need to be, and how they can get there.”
(Sir Keith Pearson. Chair, Health Education England and Chair, WRES Strategic Advisory Group)

By using and understanding the WRES data NHS organisations are expected to develop evidence-based action plans that will lead to continuous improvements on the workforce race equality agenda:

“Research and evidence strongly suggest that less favourable treatment of Black and Ethnic Minority (BME) staff in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by all patients.”
(Yvonne Coghill and Roger Kline. Co-directors WRES Implementation Team, NHS England)

The first report on this data shows that while some organisations are making good progress

21. NHS Confederation, ‘Stepping up the Place: The Key to Successful Health and Care Integration’, June 2016

22. NHS England, ‘NHS Workforce Race Equality Standard’, May 2016,

<https://www.england.nhs.uk/about/gov/equality-hub/equality-standard/>, (accessed June 2016)

and have embraced the agenda for change, there are many others that have yet to make significant progress. Some of the key findings include:

- Higher percentages of BME staff report the experience of harassment, bullying or abuse from staff, than white staff, regardless of trust type or geographical region. Community provider and ambulance trusts are more likely to report this pattern.
- BME staff are generally less likely than white staff to report the belief that the Trust provides equal opportunities for career progression or promotion. This pattern is strikingly widespread regardless of type of Trust or geographical location.
- BME staff are more likely to report they are experiencing discrimination at work from a manager, team leader or other colleague compared to white staff, regardless of trust type or geographical location.
- Sharing replicable good practice and processes will be an essential element to help facilitate system-wide improvements in workforce race equality.

Having the right commitment to promoting equality and improving diversity amongst the health and social care workforce is essential to the future sustainability of these services. For example, it is associated with more patient-centred care, greater use of innovation, higher staff morale and access to a wider talent pool that can support the required changes in skills and competencies. One of the key factors that will influence change in this area is inclusive leadership:

“Work on the WRES will only make an impact when it is located within mainstream business and governance structures, and when NHS Boards and senior leaders lead the way through not only what they say but also what they do within and outside of their organisations. Boards are encouraged to avail themselves to developmental initiatives and leadership programmes where the emphasis is on inclusive workforces and healthcare services.”

(NHS Equality and Diversity Council. May 2016. p73)

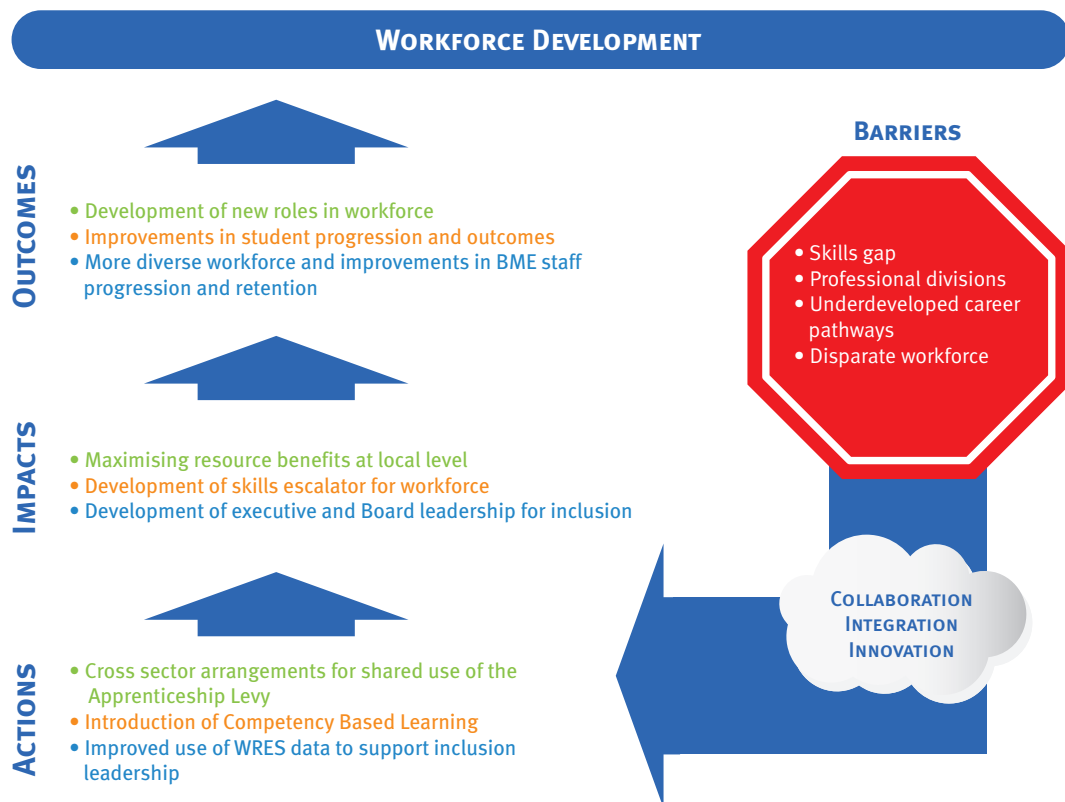
Inclusive leadership will only be fully achieved through effective collaboration and partnership working. This means establishing new ways of thinking and fresh strategies for partnerships and collaboration to break patterns of ingrained discrimination and disadvantage. This is an essential step in making integration work:

“Inclusion is not a soft option; it requires strong leadership and needs to be matched with resources and commitment. However, the rewards are immense. Health and social care organisations that make inclusion part of their day to day business will be able to demonstrate that they are adding public value and that the voices and opinions of those who use and rely on health and social care services matter and are being taken account of in decision making throughout the organisation.”

(Professor Lord Patel of Bradford OBE. The Leicestershire Inclusion Leadership Development Programme – IncLeaD the Toolkit - a guide for NHS leaders. June 2012)

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3. Financial and budgetary alignment

One of the biggest barriers to collaboration, integration and innovation across health and social care is the lack of alignment in financial and budgetary accountability:

“We have to be bridging the gap between health and social care if we want to

address the budget shortfalls. It means front loading public health and making prevention the priority but we have to create the right financial incentives to promote this.”

(Public sector stakeholder)

“We need to join health and social care budgets to make services more integrated.”

(Private sector stakeholder)

This is a problem at a national level in terms of the legislative framework for health and social care, whereby budgetary control is split between the Department of Health and the Department for Communities and Local Government. The Barker Commission addressed the issue in 2014 and recommended that England moved towards a single, ring fenced budget for health and social care. This finding has been further supported by the House of Commons Health Committee's inquiry on the future of social care, which concluded that trying to address the problem through piece meal solutions that seek to build bridges across the divide had not worked and were insufficient to meet the demands and needs of the system (House of Commons Health Committee 2012).

Some legislative freedoms have been created to try and alleviate this division such as those that enable joint funding through the Better Care Fund. ***But as yet there are still inadequate incentives to encourage NHS and local authority leaders to collaborate and work together in an effective and integrated way.*** Given the stark economic pressures being faced by all sides of the system it is clear that new ways of working together are required and these will need to go beyond the sharing of piecemeal budgets.

The Better Care Fund was initially allocated £3.8bn and this could be further supplemented by additional voluntary contributions, bringing the fund up to £5.3bn. In November 2015 the Chancellor announced in the spending review that a further £1.5bn would be allocated to the Fund by March 2020. However, despite the promised increase in funding, a recent survey of Directors of Social Care found that almost half (43%) believed that the Better Care Fund has had virtually no impact on care budgets or service quality.

Arguments about which department should cede control of its finances continue for example, the Kings Fund²³ argued that control of social care finances should be placed in the Department of Health. The suggestion is that local Health and Wellbeing Boards should have control of an integrated health and social care budget for their area, although the Kings Fund survey findings questioned whether these Boards are currently fit for this purpose:

"...although many health and wellbeing boards were making good progress in developing relationships and were beginning to address public health issues, there were wide variations in how well they were performing and in their capacity for future development. Most health and wellbeing boards signalled an aspiration to play a bigger role in commissioning both health and social care services for their local population but there was little sign that they had begun to grapple with the immediate and urgent challenges facing their local health and care economy."
(Humphries, R & Wenzel L. 2015. p. 23)

In particular the Kings Fund concluded that:

"...far more work would be needed to build the confidence that NHS organisations have in the potential of health and wellbeing boards to become a single commissioner."
(Ibid. p. 37)

Health and Wellbeing Boards are relatively new and so it might be expected that they are still developing and that in time they can become better able to manage the responsibilities of an integrated budget and system as part of Sustainability and Transformation Plans. The LGA is actively working to support this and to strengthen local political leadership across the health and social care system.

23. Humphries, R. Wenzel L. 'Options for Integrated Commissioning: Beyond Barker', The King's Fund, London, 2015

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3.1 Devolved budgets for health and social care

There are precedents for integration of health and social care in the devolved nations of Scotland and Northern Ireland. Health and social care has been aligned in Northern Ireland since 1973 through five regional Health and Social Care Trusts. In Scotland the Public Bodies (Joint Working) (Scotland) Act 2014 provides a new legislative framework by which health and social care commissioning and delivery will be integrated. The Act requires Health Boards and local authorities to work together in partnerships with integrated budgets that as a minimum will cover adult social care, community care and some aspects of adult hospital care. Locality planning will take place at a sub-partnership level with joint commissioning including national and local outcomes.

In Wales the Wellbeing of Future Generations (Wales) Act 2015 (WFG Act) is being introduced. The WFG Act will encourage public bodies to work in more integrated ways for the wellbeing of the population. The Act also establishes a single statutory Future Generations Commissioner for Wales and new Public Service Boards in each local authority area. The Commissioner and the new Boards will work towards improvement goals across economic, cultural, and environmental wellbeing including health and social care.

In England new models, strategies and structures are evolving for Combined Authorities to take on responsibilities for integrated health and social care budgets. Although we may see different models develop in different areas one of the most advanced currently is Greater Manchester.

3.2 Devolution of health and social care - Greater Manchester

In Greater Manchester devolution of the £6 billion

health and social care budget is being placed under the control of the Combined Authority although regulatory control will not be devolved. The plan for integration of health and social care in Greater Manchester provides a potential model by which other combined authorities under the leadership of elected mayors could align the budgets for health and social care with a primary focus on prevention and increasing wellbeing and prosperity for residents.

The local authorities and CCGs across Greater Manchester have agreed to work collaboratively, building on the Better Care Fund. Once full devolution is achieved in 2016/17 it is envisaged that health and wellbeing boards will agree the strategic priorities for the delivery of integrated health and social care. The arrangement includes the establishment of a Greater Manchester Strategic Health and Social Care Partnership Board that will work to ensure consistency across local areas with pooled budgets being used where relevant.

DevoManc was one of the first Devolution Combined Authorities with the Greater Manchester Combined Authority (GMCA) established across all ten local authorities in April 2011. In 2014 the Growth and Reform Plan was agreed building on the long history of collaboration and underpinned by the shared political agreement of each of the authorities to provide stable, efficient and effective governance that will increase prosperity for all of people living in Greater Manchester.

The Greater Manchester Association of CCGs involving all 12 Clinical Commissioning groups across Greater Manchester was established in 2013. In February 2015, the Government, the GM health bodies and local authorities and NHS England agreed a Memorandum of Understanding

giving local control over an estimated budget of £6 billion each year from April 2016. Local businesses were aligned with the strategic plan for growth and reform through the Greater Manchester Local Enterprise Partnership (LEP). The alignment of health as a key political and economic concern was critical to gaining wide consensus on the inclusion of health in the strategic plan.

Recognising that health is a key lever in realising growth and prosperity is one of the principles for successful integration. This is also key to the central vision for DevoManc, which seeks from the outset to have an approach that is focused on people and places rather than organisations.

Silo mentalities and structures are one of the biggest barriers to integration and overcoming these requires leaders to lift their sight from organisational boundaries and to start to view health and social care from a much wider perspective. This brings fresh insights to thinking and strategic planning but it also enables a framework in which collaboration and innovation become the drivers for greater integration. This can be seen most clearly in the breadth of ambition contained in the DevoManc plan:

- whole system transformation including new hospital models for acute and specialised services;
- the alignment of primary care, community and mental health services, social care and public health to shift the focus up stream for greater prevention and early identification;
- a single estates function
- single workforce transformation plan
- single information governance and data sharing agreement

“Addressing together the issues of complex dependency will help those further away from the job market to move towards jobs and assist the low paid into better jobs. Reform of Early Years provision is key to increasing productivity of parents and, in the future, their children.”

(Greater Manchester Strategic Plan December 2015)

There are nine early implementation priorities:

- public health place-based agreement and programmes;
- seven-day access to primary care;
- a dementia programme to transform treatment care and support for people with dementia and their carers and families based in Salford with GM wide collaboration and implementation.
- realignment of hospital services as set out in the Healthier Together programme;
- transforming children and young people’s mental health services;
- alignment of workforce policies;
- improving independence for people with learning disabilities and/or autism;
- supporting people with mental health-related barriers into work;
- establishing an academic health science system known as Health Innovation Manchester (HIM).

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Case Study: Redesigning care pathways for dementia care

The Challenge

Dementia has been identified as a key priority as part of the Greater Manchester (GM) Devolution agreement. The ambition over the next five years is to improve the lived experience of people with dementia and their carers whilst reducing dependence on the health and social care system. People with dementia and their carers will be at the heart of this transformation programme.



Solution

Dementia United is central to the GM programme of reform for mental health services and will engage with health and social care commissioners, providers and practitioners across the public services. The dementia challenge in GM is one of standardisation, care pathway re-design and new care models and implementation. The following objectives will be crucial to achieve the Dementia United goals by 2021:

- **Identify patients early** - supporting them to live well and to manage their health
- **Prevent deterioration and social isolation** - through regular monitoring and support to avoid unplanned admission to hospital and long-term residential care
- **Provide high quality healthcare in the community** - to prevent unnecessary hospital admission
- **Provide high quality hospital care** - to

enable short and efficient hospital stays

- The operational delivery of this work relies on coordinated programme support and the active participation of GM's 10 local authorities and 12 Clinical Commissioning Groups. Nominated locality leads are working in cross-GM partnership to co-design this work and ensure it is integrated into locality plans.

Benefits

The programme aims to cover 5 broad areas, reflected by a series of 'pledges':

1. Improve the lived experience for both patients and carers
2. Reduce the variation of care delivery and outcomes
3. Co-production and redesign of services
4. Each newly diagnosed individual to receive 'key worker' support
5. Adoption of digital technology

The programme not only reduces dependence on health and care services but also aids financial sustainability within the region. If successfully implemented, the initial cost-benefit of the Dementia United programme is an estimated gross fiscal benefit £49m to local authorities and the NHS of over five years. Dementia United's work with local commissioners will test new payment models for dementia care. For example, a shift in contracting from activity based to outcomes based commissioning will be tested as part of

the programme. This shift will enable conversations with social financiers who will be

approached to invest in dementia services in GM, bringing in social investment alongside public money to ‘ignite’ the transformation work and deliver improved outcomes.

The aim of the Dementia United programme is not only to transform the experience of those living with dementia today, but to be at the vanguard of how health and care services are funded, commissioned, designed, delivered, experienced and evaluated in the future.

The Report Authors would like to acknowledge the contribution of Professor Maxine Power of Haelo for this case study

3.3 Public health financing

Public health was moved under the control of local authorities in 2013, however cuts in the budget allocation for public health have already taken place for example, £3.38bn was made available in 2016/17 (£77m less than 2015/16) and this will be further cut in the subsequent year by £84m to £3.3bn. This comes on top of £200m in-year cuts for 2015/16.

The Comprehensive Spending Review (CSR) also set out plans for public health expenditure to fall by an average of 3.9% up to 2020 and for the current ring fencing arrangements of the public health budget to end after 2017/18. In the longer term it is anticipated that public health funding will come from the retention of local authority business rates.

There are potential threats and opportunities to these developments. On the one hand shrinking public health expenditure could undermine attempts to shift the focus of health and social care up stream to prevention. But on the other hand greater local area control of public health expenditure could be used to incentivise the movement towards integrated health and social care recognising that public health and wellbeing is central to local area prosperity and wealth.

Case Study: Argenti - Efficiency and Innovation in Social Care Hampshire County Council & PA Consulting:

The Challenge

Local government will experience a real reduction in spending power until 2019-20, despite the recently announced £416 million package of transition measures. For those with social care responsibilities, the ability to increase Council Tax by 2% has offered some degree of respite. However, for a number of authorities it has neither proven politically acceptable to increase the bill nor been sufficient to meet service funding needs. Similarly, service pressures and community expectations are demanding more from local authorities. As a result, alternative approaches to providing care services need to be considered. Like all providers of adult care, Hampshire County Council faces this combination of significant cost pressures and rising demand. Of the county’s total population, around 15,000 vulnerable adults have been assessed as having eligible social care needs. The majority of this group, approximately 10,000 people, are receiving services at home.



Solution

Care providers must radically rethink the role care technology plays in both mainstream social care provision and within the wider care system. Following the Official Journal of the European Union’s new approach to telecare, Hampshire appointed “Argenti” (a consortium led by PA consulting which included Medvivo, Tunstall Healthcare and CareCalls) to take complete responsibility of the service from its redesign through to assessments, installations, equipment provision and

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monitoring – up until 2018. The service now manages the increasing demand of those in need of ‘lower-level’ care, who are not yet eligible for Council support, but have their own resources. Referred to as the “private pay” offering, the Council has been able to signpost such individuals to a separate but jointly branded service since October 2014.

Benefits

The council supports a substantial growth in this service as it helps alleviate the pressure on publicly funded services. Indeed within two years of operations, 4200 users received telecare as part of their mainstream care package - well above the initial target of 2000 users and resulted in a NET saving of £2.7m. It is also likely that an additional NET saving of £1.4m will be delivered by the end of the third year in the summer of 2016. Importantly, these savings have not been at the expense of service quality - 95% of users surveyed felt the new approach increased their feelings of safety and security in their home and 98% said they would recommend the service to others. A further advantage is that these individuals not only receive the same recognised high quality service that Council service users enjoy but also, should their financial circumstances change and they become eligible for publicly funded services, the individual can seamlessly transition into those services.

As the service has developed into its third year, the positive impact of the partnership has now been seen beyond the Council. Telecare greatly reduces the occurrence of people with dementia becoming lost or confused within the community and costs a fraction of the £6,000 police search cost. In addition, there are large financial benefits to the local health system as the service leads to a reduced rate of ambulance call outs, hospital transport, admissions and stays. What Hampshire’s experience clearly shows is

that thinking differently about service provision can secure significant financial savings and improve the quality of care for vulnerable people.

The Report Authors would like to acknowledge the contribution of PA Consulting for this case study

3.4 Creating a unified health and social care budgetary framework

Further devolution of health and social care financial and budgetary responsibilities is inevitable. As these developments continue, national and local health and social care leaders will need to prepare for a unified framework by which pooled budgets and financial controls can be shared across local areas. This will require the following:

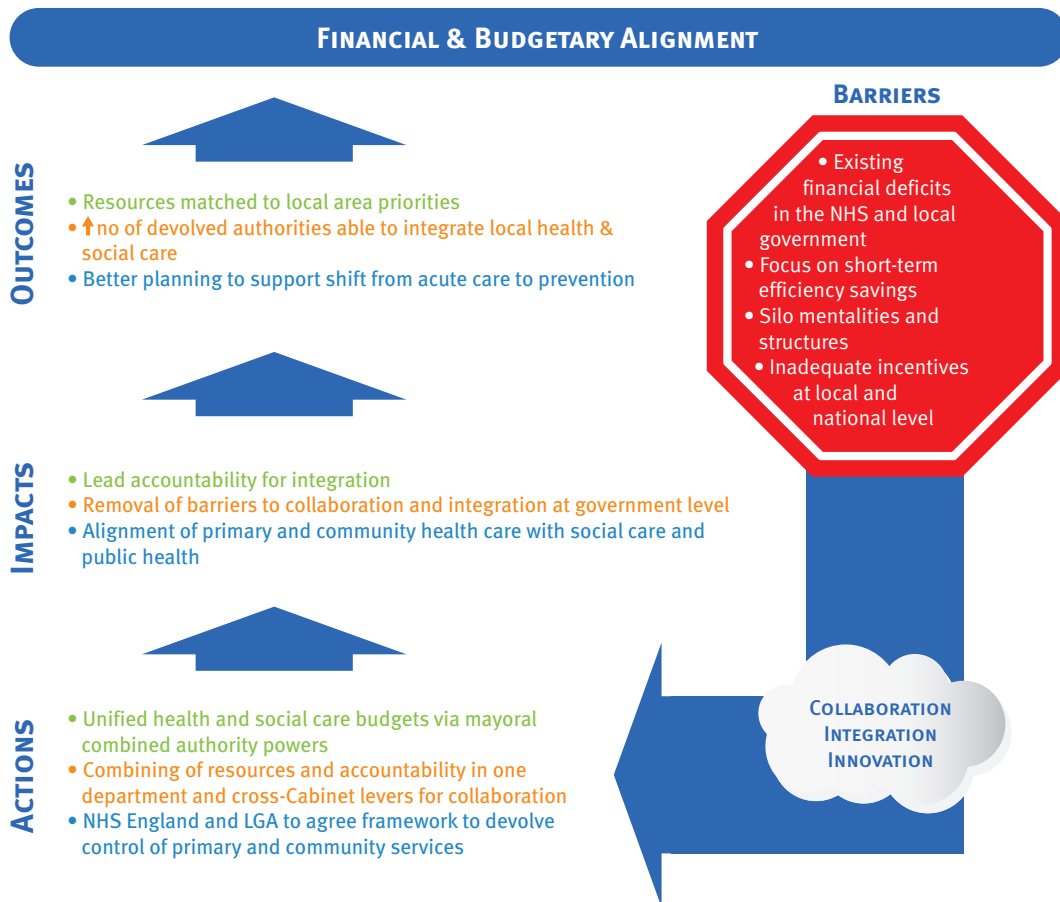
- collaboration between the Department of Health and the Department for Communities and Local Government – agreement will be needed that a single department takes control for an integrated health and social care budget. This could, for example, be a new Department for Communities and Wellbeing. Collaboration also needs to be supported at Cabinet level in line with the proposed Cross Government Life Chances strategy and fund, based on outcomes and social finance principles with investment and savings being shared across the system. A similar approach for health and social care could facilitate Cabinet colleagues to collaborate, e.g. top slicing budgets and allowing Departments to participate in a shared communities and wellbeing fund on condition that they collaborate and integrate;
- collaboration between NHS England and the Local Government Association on the devolution of budgetary control for primary and some aspects of specialist care to local and sub-regional areas – this will need to be

considered on the basis of localities where combined authorities have been established rather than single CCGs;

- collaboration between local authorities and CCGs – the local area budget for health and social care will need to be configured on the basis of devolved administrations with combined authorities and elected mayors taking overall control for the integrated

health and social care budget.

Creating a unified health and social care budgetary framework is one of the most challenging aspects of the model. It requires collaboration and leadership at national, regional and local levels but the political commitment and public support for the Greater Manchester devolution plan for integrated health and social care shows how it can be achieved.



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4. Whole system integration and innovation

Whole system leadership at executive and elected levels is needed to move from collaboration to integration and innovation. As local area health and social care leaders act to collaborate on shared infrastructure and facilities management, workforce development and a unified framework for financial and budgetary control it will be possible to establish integrated service delivery models. This will in turn enable innovation in the business model and delivery mechanisms for services that improves lives, increases quality and outcomes and builds a sustainable future for health and social care.

4.1 New ways of doing business

If the NHS were being created today it is unlikely that it would be established on the same business model, i.e. as a single encompassing system that seeks to be all things for all people. Across the service sector new business models and disruptive innovations have shifted service delivery from ‘one shop fits all’ to tailored, bespoke services that are increasingly delivered directly in the home:

- we email, text, message and share photos from wherever we are with mobile devices.
- we purchase books, food and houses from the comfort of our living rooms using laptops and tablets.
- we book and pay for travel and holidays on line and know exactly where we will be and when.

And yet, we cannot book an appointment with a GP on the day we need it, or in some cases in the next few weeks and we spend hours of our time in uncomfortable and unfriendly waiting areas in hospitals with no knowledge of how long a wait it will be before we see a doctor.

At any one time our health and social care system is operating at least three distinct business models simultaneously:

1. **The retail clinic** – this may be a GP Practice or a consultant’s waiting room. It is the shop front where the highly intuitive, diagnostic work is done.
2. **The business process clinic** - this is where the application of standardised, evidence based treatment and care practices take place.
3. **The facilitated network** – much less common in practice though increasingly desired by patients and public - this is where prevention and early intervention is paramount. Decision making is shared and service users and carers are enabled to manage their own health and care.

(Clayton M Christensen, The Innovator’s Prescription)

Each of the above business models is valuable and each can be improved. But to provide all three from within a single organisational structure is no longer sensible or sustainable. Likewise, making improvements in one without adequate awareness of the alternative advantages of the others, risks spending time and resources in one way that may be better spent in another.

“There are more than 9,000 billing codes for individual procedures and units of care. But there is not a single billing code for patient adherence or improvement, or for helping patients stay well.”

Clayton M. Christensen, The Innovator’s Prescription: A Disruptive Solution for Health Care

The Carter review is focused on business process improvements and has identified significant savings that could be realised through greater standardisation and common adoption of routine transactions and treatments. There is no question that this approach is needed and the promise of financial savings and better care outcomes is essential. However, there may be a need for more radical thinking alongside this about where best to place business process improvements and whether alternative business models are in fact a better way to deliver these. For example, moving the simplest procedures now performed in expensive hospitals to outpatient clinics, GP Practices, and patients’ homes.

This also means re-thinking health and care services so that they act now on prevention needs as part of an integrated, area based system, make intelligent use of new technologies and are focused on innovation in service user outcomes.

‘Game Changer’ – Halton Clinical Commissioning Group

The Challenge

Obesity reduces life expectancy by an average of three years and cost the UK economy an estimated £15.8 billion per year in 2007. Indeed around 8% of deaths in Europe are now attributed to



people being either overweight or obese. Research has shown that developing good habits in childhood can reduce the occurrence of obesity later in life. With this in mind, Halton Clinical Commissioning Group (CCG) in the North West of England have set themselves the challenge of reducing the obesity rates in Halton’s year 6 children - currently at 36.2%.

Solution

The ‘Game Changer’ scheme has been developed to harness the power and branding of professional sport clubs with the aim of transforming how primary-school children approach physical activity. Commercial companies provide sponsorship and support to ensure the project has long-term sustainability and ongoing value. For example, Sopra Steria are supporting the programme management and governance as well as assistance in areas such as website management, data collection mechanisms and data analytics.

Key components of the programme include:

- Children will be challenged to be active for 80 minutes per day
- Each School will sign a ‘Game Changer’ pledge to commit to embedding more physical activity and exercise in the school day
- The Widnes Vikings rugby league team will work with schools to assess impact across an agreed 24 week focus period based around physical activity and healthy eating
- School staff will be upskilled to understand how they can embed more physical activity within the classroom

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- All schools, pupils and parents will have access to the ‘Game Changer’ App, which will be developed with Halton CCG, Sopra Steria and LJMU
- Commitment to exploring how fitness devices can be incorporated to support participant engagement, the App and assist broader participant measurement, monitoring and evaluation procedures

‘The Game Changer project helps to improve the long term health and life expectancy of children in the Halton area by encouraging better health. The project can be more widely introduced to address a growing national problem’

Benefits

- Increase in physical education and exercise
- Behavioural change and improved eating habits
- Development of long term health benefits for the children of Halton as they grow into Adulthood
- Reduction in obesity in children and adults
- Improved life expectancy
- Long term decrease in healthcare costs associated with obesity

The Report Authors would like to acknowledge the contribution of Sopra Steria for this case study

4.2 Understanding innovations as part of strategic change

An area based approach to integration for health and social care would also enable innovations in service delivery models that make greater use of technological advances. However, these need to be understood within the right context and strategy in order to ensure that technological innovations are embedded and used to their best effect:

“Fear and lack of understanding about technology is a barrier. Embedded technologies can be used to transform care such as use of fit bits and motion trackers for monitoring elderly care needs.”

(Private sector stakeholder)

“Organisations don’t understand what digital technology and capabilities can be utilised for, they are sometimes seen as just an expensive gadget. It is vital to ensure that organisations understand what the technology is capable before embarking on a change.”

(Private sector stakeholder)

Disruptive Innovation

One of the primary purposes of collaboration should be to create an environment in which innovation can thrive. This means working together with the explicit recognition that innovation can be disruptive:

“The challenge both for the NHS and for its industry partners is to pursue innovations that genuinely add value but not cost – the NHS for its productivity and quality goals and industry for its international competitiveness. Indeed, adding value

and reducing cost is the basis of the NHS QIPP challenge. This puts a premium on game-changing innovations that change patient pathways and traditional delivery systems, and that are implemented in a way that strips out the processes that no longer add value.”

(Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS. DH. 2011)

New approaches to integration and technological innovation can be further strengthened through disruptive innovations, i.e. responses to new business models that demonstrate change in practical, realistic and replicable ways. Not change for change's sake but change that:

- shifts the focus of care up stream into prevention and early identification – this is not about new interventions, though it may include these, but rather, the need to reduce and manage demand on the high end, high cost elements of service delivery;
- uses the levers for change, e.g. the release of assets through estates rationalisation, improvements in facilities and IT management, energy consumption and waste disposal to realise environmental and social impacts alongside improvements in quality and outcomes from care;
- creates new funding opportunities through the leverage of institutional funds combined with government covenant assurances, e.g. enabling private development of new purpose built, smart health villages and public procurement hubs.

The term disruptive innovation (first coined by Clayton Christensen over twenty years ago) referred to the way that new, less expensive and better products replace older ones and in so doing creates a new market that is more flexible, more cost effective and closer to the consumer. The classic example is the personal computer but more recent examples have been seen in digital music downloads and streaming, e-books and the iPad.

However, disruptive innovations are often misunderstood as only applying to commercial markets or being solely about technological innovations, though the latter are often key. In fact, disruptive innovation needs to be understood within the context of business strategy and this is increasingly being recognised as a valuable concept for health and social care.

Within a changing system different forms of innovation require different strategic approaches. For example, in health and social care there are many examples of innovations that have reduced costs and improved outcomes such as new surgical procedures, use of telemedicine, advances in drug therapies and technical aids to support independent living. Some of these have been disruptive, i.e. they have radically changed the way services are delivered and structured. However, others operate as additions to existing services without actually altering the way the service operates.

What is needed is a new strategy for disruptive innovation in health and social care that fits with the changing business models and will support new ways of working and delivering services as part of broader structural change. In order to

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achieve this there are certain factors that will need to be considered:

1. **Disruptive innovations start within new service pathways** – rather than seeking to overhaul an existing service pathway, a disruptive innovation would seek to identify a new way of meeting the needs of existing and potential users more effectively through an alternative pathway. An example of this would be using new technologies and interventions for prevention and early identification of diabetes.
2. **Disruptive innovation is a process** – a disruptive innovation usually starts small and builds up scale as it becomes recognised as something that is more cost effective and of higher value to the end user. In this case the disruption is less about the product or the system and more about the gradual acceptance that the new way of working is better. This takes place over time but it is also influenced by the degree of resistance from existing service providers who fear loss of influence and/or are slow to recognise the benefits of the innovation.
3. **Disruptive innovations may lead to shifts in investment** – this is why disruptive innovations need to be considered within the context of business strategy, because as the innovation demonstrates higher quality and greater cost effectiveness it will require a shift in investment to become sustainable.

This may be part of a longer term strategy but it needs to be built into planning for innovation at the outset. In terms of health and social care this is about moving the focus of interventions

upstream and reducing demand and need for the high end, more costly interventions and treatment.

This is particularly important when thinking about the transformation needs for hospital design and delivery. Hospitals are currently monolithic structures occupying large areas of estates with an all-encompassing service delivery model.

As disruptive innovations are put in place the challenge to existing hospital provision will be in re thinking the use of these estates so that they support integration and innovation rather than be seen to act against it:

“Why is Outpatients in the hospital? Bring it forward into the community where people are, we don’t need this in the hospital.”

(Public sector stakeholder)

“Hospitals have to change, we should be thinking about creating a health campus - have all things on one site. It’s also about how we change expectations - what public think/expect a hospital can do.”

(Private sector stakeholder)

Case Study: My Nearest application

The Challenge

Many public sector services have low rates of accessibility and availability, meaning that regularly performed tasks are often hard to carry out. Hinckley and Bosworth Borough Council were looking to extend the availability and accessibility to services and provide mobile access to a number of regularly performed tasks. This included the need to access content specific to a user's location, make payments, report issues and request services.



Solution

The development and implementation of a mobile web solution, which can be accessed from smart mobile devices. Users set their location, and the app then personalises content and gives them access to the most regularly used services such as:

- Information on services or planning applications
- Paying council tax and other bills
- Report missed bin collections
- Request the collection of large items or waste
- Contact the council
- News

The application has subsequently been tailored for use by other council's to provide similar information for their own citizens. The ability to tailor the application allows it to be used within the healthcare sector to provide patients and citizens with specific information to support their health needs. For example, to find your nearest healthcare provider, order prescriptions or find other health-related information.

Benefits

This solution builds on the council's existing investment in CRM and the website by:

- Supporting channel shift
- Delivering efficiency savings
- Delivering more accessible and inclusive services
- Meeting increased customer demand for mobile access to services

"HBBC's website is four star and is listed in the top 20 best websites in the country. Their mobile solution is also commended and reviewed as 'completely hassle-free'."
(SOCITM 2014 Better Connected.)

The Report Authors would like to acknowledge the contribution of Sopra Steria for this case study

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Case Study: 7 Day Access- Answering the Prime Minister’s Challenge through practical strategy

The Challenge

Bury GP Federation Limited, a Federation of 30 GP practices across Bury in Greater Manchester, successfully secured support for its ‘Easy GP Programme’ under the Prime Minister’s Challenge Fund to improve access to GP services and stimulate innovations in the way primary care services were delivered. The main element of Bury’s proposal was providing extended access to GP services – offering 8am to 8pm on weekdays and 8am to 6pm on weekends and bank holidays. Bury GP Federation approached PA to be its design and delivery partner for the new service and to lead on the launch



Solution

The approach was to design and launch a new Primary Care service for the population within 6 months, then scaling up to full capacity within a further four months. The approach focussed on:

- **Co-designing the service with the Federation and its key stakeholders:** A collaborative approach to the design process was undertaken to create early buy-in and joint ownership, ensuring local insights were used to consider the options for the range of services and approaches to delivery.
- **Combining analytical and intuitive thinking:** Access to clear, objective data

on patient behaviour and service demand across Bury to guide decision making was secured to ensure local insights.

- **Patients and Service First:** The focus was on creating a service that was clinically and commercially sustainable and delivers the right customer experience. The pilot was launched with only the most essential organisational infrastructure required to deliver this experience, providing patients with the opportunity to experience the service at the earliest opportunity.
- **Rapid & rigorous testing and refinement:** A flexible business model was built that enabled different elements of the service to be tested, refined and improved rapidly with limited sunk costs. The sequential launch enabled actionable data to guide decisions about how best to further improve the service.

Benefits

The main focus of Bury’s proposal was on ‘patient convenience’, making GP services more available and responsive to the patients’ needs. There were four key strands to the programme, namely:

- Extended working hours for GP services
- Routinely offering patients the choice of a telephone consultation as an alternative to a face to face appointment at the surgery
- Increasing the number of patients registered to use online services to access GPs
- A comparison website for GP practices

Through this locally and nationally important programme, Bury GP Federation introduced a new service within 6 months that offers up to 1,400 additional GP appointments per week and provides patients with flexibility of access to GP services. Through the process the Federation also became more operationally resilient through delivering this borough wide service and established itself in a leading role for transforming how services can be delivered at scale within the local health system. The service is popular with patients and recognised as one of the most Successful 7 day access pilots in the country, with visits from key stakeholders including the Prime Minister and the Health Secretary.

The Report Authors would like to acknowledge the contribution of PA Consulting for this case study

4.3 Social investment as a tool for integration and innovation

Social investment models have also been used to provide large scale facilities management services on sites for example, at the the Olympic Park in London public, private and social sector partners have developed a Community Interest Company (CIC), which is responsible for the onsite management of the Olympic Park. The CIC ensures social investment through the recruitment and use of local volunteers, many of whom have been long term unemployed.

This model holds particular value for thinking about transformation and development of estates in health and social care, in particular the approach to procurement:

“It is about the development of people and relationships not just land and estates, the

procurement process was clear that you couldn’t win the contract unless you went beyond corporate social responsibility, it needed to be about making a genuine relationship with local people.”

(Public services stakeholder)

The process for establishing the CIC at the Olympic Park included getting the local supply chain partners on board so that sustainable and realistic employment and work place opportunities could be provided for volunteers. At the same time the procurement process was not overly restrictive but involved flexibilities for innovation:

“Be clear about outcomes and objectives but don’t get too hung up on the targets and specification, you can’t ignore these but they can be used to understand what the key issues are and how to make improvements in priority areas.”

(Public services stakeholder)

What is also apparent from the Olympic Park model is that local commissioners often have greater freedoms to innovate than they may realise or want to acknowledge:

“It’s the public sector commissioners that are the block to real change not the business sector. They are either too timid or they don’t really want to make change on the right scale.”

(Public services stakeholder)

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Case Study: Our Parklife - Social Impact, Legacy and Communities

Challenge

To help deliver the legacy of the 2012 London Olympic and Paralympic Games whilst creating measurable social impact for local people, connecting them to park services and providing employment, volunteering and training. Promotion of the park's sustainable legacy through whole-life management of the landscape, essential infrastructure and social assets for the clients and communities.



Solution

The establishment of “Our Parklife”, a Community Interest Company (CIC) that was proposed to bring together skills and experience from the private, charitable and social enterprise sectors in one organisation. This approach is built on the belief that a successful park is connected to its local community. To achieve this, the vision for delivering the Energy Facilities Management contract has to be linked to the delivery of the London Legacy Development Corporation’s “Priority Themes” for social, economic and environmental regeneration in the local area that represent the regeneration legacy. Our Parklife’s founding partners bring together the range of technical skills and experience required to deliver the range of activities and related outputs needed by the contract. From these outputs the overall outcomes and social impact can be assessed and measured.

Social impact is the effect of an activity on the social fabric of the community and wellbeing of individuals and families. In trying to measure

social impact the CIC are looking beyond the usual financial measures to try and assess the additional social, environmental value created as a result of activities.

Benefits

The park created approximately £1.255 million of economic value for the local economy by employing 70% of their staff from the local area, 50 of whom were previously unemployed. This enabled reduction of benefit payments and increased incomes. Over 200 Volunteers regularly help on the Park giving over 6,000 hours annually creating £1.8 million of value.

Why a Community Interest Company?

The structure of a Community Interest Company (CIC) was chosen because it:

- Brings together the skills and experience of the private, social and charity sectors
- Provides a focus on Priority Themes
- Utilises existing networks of funding via partners
- Asset and profit locked
- Can benefit from other sources of funding
- Encourages community ownership
- Is for a specific community purpose
- Can deliver revenue generating services to support its aims

The Report Authors would like to acknowledge the contribution of ENGIE for this case study

4.4 Alliance Contracting

New legal frameworks are required to support contracting and procurement for integrated services. One such framework is Alliance Contracting.

Alliance contracts are a way of procuring a contract where all parties are committed to finding the solutions to problems rather than fixated on setting and following specifications. They originally developed from the oil and construction industry in Australia. Clients needed a better and faster system than the traditional way of having several contractors on a major project each waiting for one to finish before they could start their part. The Alliance gives them a joint ownership of the project and, sometimes, a risk/reward system that incentivises them to work to a shared goal and resolution of problems:

“There is a perception of public versus private sector, it can be a struggle to build relationships because it’s demoralising so everything is very task focused.”

(Private sector stakeholder)

“Business partners need to align with and understand the NHS - walk in their shoes, clinical engagement is needed at the start.”

(Private sector stakeholder)

“We have to realign the interest of both parties to share benefits, for example car park charges. But it means bringing flexibility in to the system - a sensible discussion about what works and how to do it best.”

(Private sector stakeholder)

The contracts have a governance structure that involves all parties in the decision making needed

to create beneficial outcomes. In the governance the client/commissioner can also be part of the contractor/provider and has as much involvement in delivery as other parties. This can be especially important for social care partners who often feel less able to participate as equal partners:

“Voluntary and independent sector partners need to be at table as equal partners, we should be recognised for what we can do for service users and not just as an add on, we are fundamental to care.”

(Social sector stakeholder)

“The NHS and local authorities need us more than we need them.”

(Social sector stakeholder)

Within an Alliance there is a sharing of the risk and the rewards within the contract and there can be added benefits to all parties and the wider community of service users and others. In addition, as providers develop their own systems and service delivery mechanisms they can allow the contract to evolve and vary without the need for technical contract variations and the inherent risk of claims that comes with variations.

All parties are represented within the strategic and practical decision making teams that can be set within the governance structure. It is essential that all parties have ownership of any problems that arise and in the solutions used to solve them.

The NHS Standard Contract

Currently the NHS Standard Contract is not compatible with some forms of Alliance Contracts although since 2014/15 it has been acknowledged as a potentially valuable framework for the NHS:

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“Some forms of Alliance Contracting are not currently compatible with the NHS Standard Contract, specifically where multiple providers are signatories to a single commissioning contract – but the key characteristics of alliance contracting can be accommodated in a structure involving one or more NHS Standard Contracts. Any commissioners who are keen to discuss an Alliance Contracting approach are encouraged to contact the NHS Standard Contract Team.”

(NHS Standard Contract 2014/15 - Technical Guidance final version. March 2014. NHS England).

The latest technical guidance is the same, however, it does state that NHS England have produced a model Alliance Agreement, which commissioners may use as a starting point for development of their own alliancing arrangements with providers. This is a welcome initiative and one that will support integration across NHS and social care services, although it could be strengthened by ensuring that the NHS Standard Contract is made fully compatible with the use of Alliance Contracts.

4.5 Regulation and inspection

There is widespread recognition of the critical issues and challenges facing the NHS and local authorities, in particular with respect to the need for greater collaboration, integration and innovation in health and social care. However, significant barriers remain in providing the right regulatory support for those responsible for leading and delivering health and social care services to make the required structural and organisational changes to address the fundamental issues:

“Regulatory changes are required, especially with respect to the health technical memorandums which are overly restrictive and prevent better ways of working.”

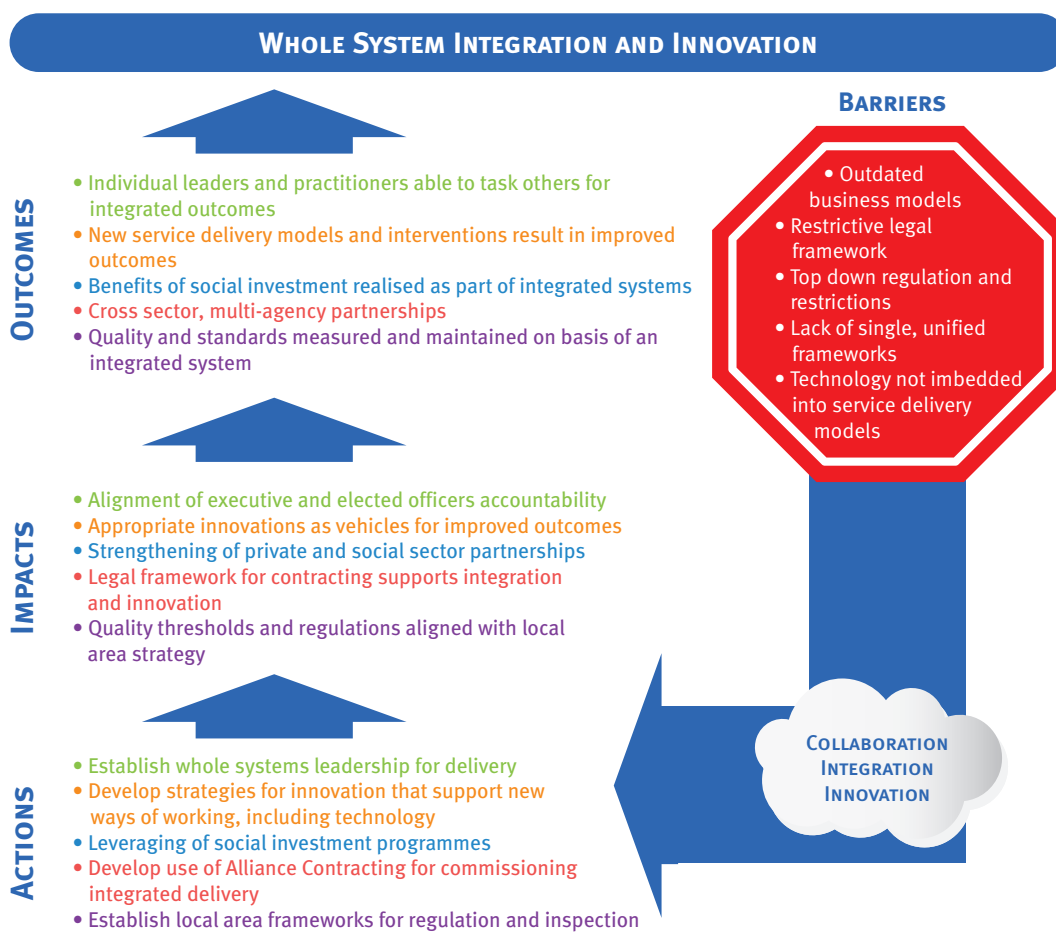
(Private sector stakeholder)

“The regulatory and legal framework can kill innovation and collaboration - it creates disincentives.”

(Private sector stakeholder)

Regulatory and inspection regimes need to be integrated at local levels in order to support the process of change and enable innovations and new ways of working to become the norm. This does not mean weakening or relaxing the thresholds for high quality services.

Central regulatory and inspection agencies need to be prepared to work with local lead commissioning agencies and Combined Authorities to negotiate an appropriate approach to inspection and regulation that fits with the local area strategy and priorities for integration of health and social care.



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Conclusion

The challenges facing health and social care are unprecedented and represent a significant threat to the long term sustainability of services. What is clear is that change is urgently needed and the system cannot continue in the same way. Health and social care needs have changed with far greater demand and need for up stream interventions that are focused on prevention and early identification. At the same time the financing for health and social care is in need of reform and the need for smarter, more effective ways of working and delivering services are imperative.

There is wide spread support for greater integration between health and social care services including shared use of estates and resources, joint workforce development, single financial and commissioning structures and alignment across the whole system with cross sector leadership and accountability. However, various barriers stand in the way of this including:

- the perceived failures at past attempts to reform health and social care;
- political and public fears about the perceived encroachment of private sector interests in health and social care delivery and antipathy or distrust of public and private partnerships;
- workforce development and skills gaps, in particular the need to equip staff with the competencies to deliver new ways of working;
- failure to adequately engage and involve patients, service users and the public in the process of change and development so that they feel able to participate in decision making;
- inappropriate or outdated business models

and regulatory frameworks that do not meet the changing patterns of demands and needs for services;

- cultural barriers that reduce the willingness and responsiveness to change and the need for more inclusive leadership.

Many new initiatives in support of integration are underway but in order to build a truly integrated system it is necessary for outcomes, budgets, workforce skills, commissioning and inspection to be fully aligned. The model demonstrates how estates rationalisation and colocation can be used to encourage and drive collaboration, integration and innovation and above all be a catalyst for developing political and executive leaders who can operate across the public, private and social sectors.

The model is not intended to be a ‘one size fits all’ approach but rather to act as a vehicle by which local areas can adopt elements of the model to fit with their local area needs and demands for health and social care. The following recommendations are intended to generate debate and to provide potential solutions to overcoming some of the most significant barriers to achieving effective change that can improve lives and build a sustainable future for health and social care.

Recommendations

Recommendation one

Collaboration needs to be strengthened between national and local leaders including between the NHS and local authorities and between the Department of Health and the Department for Communities and Local Government.

Recommendation two

Financial accountability and budgets for health and social care need to be aligned as part of a unified system under the direction and control of a single government department. This could potentially be, for example, through a new Department for Communities and Wellbeing. Cabinet level collaboration needs to be facilitated through the use of shared funding arrangements as part of a common pooled resource for health and social care. This needs to be replicated at local levels through single commissioning authorities covering both local authority and health services.

Recommendation three

Collaboration between providers and commissioners needs to be supported through new legal frameworks such as Alliance Contracting. A legal contracting framework is required that drives and incentivises collaboration rather than competition, based on a no dispute culture that provides parity for public, private and social sector organisations – an Alliance Contract can provide this essential foundation.

Recommendation four

Whole system leadership is needed at executive and elected levels with political and executive decision making power over the whole system. An elected Mayor with powers beyond health and social care including policing, justice, skills, transport, economic regeneration and housing

can bring unified budgets, coherence and democratic legitimacy to the system.

This should sit within combined authority structures under the newly mandated powers for elected mayors and be replicated in cross sector Accountable Care Organisation frameworks. In order to realise this there needs to be support for both elected officials and officers so that they are able to work across systems and professional disciplines, able to task others and develop a multi-skilled, competent and inclusive workforce.

Recommendation five

Workforce development needs to be aligned across health and social care taking account of the new apprenticeship levy system and using Competency Based Learning modules as part of a skills escalator.

Recommendation six

A distributed service delivery model is required based on the gradual development of multi-service hubs. These could be focused on specific care pathways or service user cohorts, e.g. diabetes, dementia care etc. As these multi-service hubs are developed the local hospital provision can be adapted with the release of hospital estates as part of a joined up OPE strategy between NHS and local authority partners. NHS England should ensure that local providers and commissioners have incorporated these approaches in Transformation and Sustainability Plans.

Recommendation seven

Inspection and regulatory regimes need to be aligned on an outcome basis at local rather than national levels.

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Recommendation eight

There needs to be a national and local commitment to long term outcome commissioning – beyond existing political horizons. This should include recognition that significant system change is being undertaken with longer timeframes for improvement according to the scale and pace of change, e.g. over 5 and 10 year timeframes.

Recommendation nine

Development of integrated health and social care services should include parity amongst partners from across the public, private and social sector with an explicit aim of using transformation in service models to help build the social sector.

Recommendation ten

There needs to be acceptance and understanding across the system that willingness to innovate and make effective change means, learning from new ways of working and that in the process of change some things will work and some will not. To better support the process of change there needs to be resources for research, development and evaluation, including local area feasibility studies.

Recommendation eleven

Local change programmes need to harness the impact of digital innovation on services and outcomes as part of a strategic drive towards prevention and public health improvement.

Recommendation twelve

Local area change and transformation plans need to maximise the possibilities and potential provided by social investment to help drive transformation.

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