New Statesman

At the crossroads of health and social care

A new role for local government

In collaboration with

Pfizer

Geoff Alltimes CBE
Chair, LGA Multi-Agency Task Group on Health Transition

Clare Bambra
Director, Wolfson Research Inst for Health and Wellbeing, Durham University

Martin Barrow
Health Editor, *The Times* (Chair)

Rt Hon Andy Burnham MP
Shadow Secretary of State for Health

Dr Peter Carter OBE
Chief Executive and General Secretary, Royal College of Nursing

Andrew Gwynne MP
Shadow Minister for Health

Richard Humphries
Assistant Director, Policy, The Kings Fund

Michael Lockwood
Chief Executive, Harrow Council

Dr Kay Nolan
Associate Director, National Institute for Health and Care Excellence

Don Redding
Director of Policy, National Voices

Dr Fiona Sim
Chair, Royal Society for Public Health and Joint Editor of Public Health

Sam Taylor
National Policy Lead, Pfizer

Matt Tee
Chief Operating Officer, NHS Confederation

Alex Thomson
Chief Executive, Localis

PHOTOGRAPHER SOPHIA SCHORR-KON

New Statesman
John Carpenter House
Carmelite Street
London EC4Y 0AN
Tel 020 7936 6400
Fax 020 7936 6501
info@newstatesman.co.uk
Subscription enquiries, reprints and syndication rights:
Stephen Brasher
sbrasher@newstatesman.co.uk
0800 731 8496

Supplement Editor
Caroline Stagg
Art Director
Anja Wohlstrom
Picture Editor
Rebecca McClelland
Design and Production
Leon Parks
Graphics
Lauren Messerby

Partnerships and Events Manager
Rosalind Goates
020 7936 6456
Commercial Director
Peter Coombs
020 7936 6753

One budget for the benefit of all? P7

Delivering integrated care

Although the health needs of the UK have changed dramatically since the inception of the NHS, our health-care system remains largely unchanged. This leaves us with a National Health Service that is designed to meet the needs of a society that no longer exists. There is wide agreement that the NHS needs to prioritise preventative care to take the strain off front-line services.

In the 20th century, before the NHS, many urban local councils started off as "local boards of health", then becoming district councils, and local authorities. At each stage of reorganisation these bodies lost a little bit more of their role in health until today the care they mostly deliver is adult social care and children's services; any other health care is delivered by other bodies.

The Health and Social Care Act has placed a large emphasis on local government driving improvements in public health with a renewed focus on prevention. With responsibility for public health having being transferred from the NHS to local government on 1 April this year, we can expect our health landscape to change quite dramatically. Local government seems to be rising to the challenge and coming up with some innovative solutions but it is difficult to see the scale of its aspiration to drive change and deliver innovative health services.

Labour is proposing a single holistic system, integrating physical, mental and social care. To deliver this, local government would hold an integrated budget for most health and social care services – likely to amount to about £89bn. But are local governments really capable of commissioning and delivering these ambitious plans?

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COVER BY LEON PARKS

Health care gets back to its roots

by **Richard Humphries**

Local government is no stranger to the world of health care – its illustrious track record in public health improvement is matter of historical record

Amid the controversy that raged around the passage of the Health and Social Care Bill, one aspect of the reforms that commanded almost unanimous support was the transfer of roles to local government, recasting its relationship with the NHS. From 1 April this year, councils became responsible for public health (although this is muddied by the role of a new national quango, Public Health England). They have to commission a local HealthWatch service to articulate the public and patient voice, and establish a health and wellbeing board. These boards bring together local partners, ensuring that different pieces of the jigsaw – health services, adult care, children's services and public health – are better integrated to meet individual and community needs. The new boards must carry out a joint assessment of the needs of their local population and agree priorities through a joint health and wellbeing strategy that will set the framework in which local services are commissioned.

Before 1948, three out of four hospital beds operated under local authority management (local government was a big loser when the NHS was created), and most community health services continued to be council responsibilities until the 1974 shake-up. Until then every upper-tier local authority had a directly appointed medical officer of health – public health has spent more its history in local government than it has under the NHS.

So these NHS reforms reverse the nationalising tendencies of past reorganisation. In the words of one official quoted in Nick Timmins' account of the reforms, *Never Again*, in the negotiations between coalition partners about the Bill, the Conservatives "had to have something to give the Lib Dems". It is a longstanding Lib Dem desire to improve the political legitimacy of the local health service.

But the world has been transformed since 1948. Local government will gain little succour from former glories as it begins

> Will local authorities rise to the challenge of leading public opinion?

to grapple with its formidable new brief.

The NHS budget continues to enjoy "protection" from cuts in real terms but this risks creating an illusion in the minds of the public that it is somehow insulated from financial pressures when it actually faces a £20bn shortfall between what it needs just to stand still and what it will get. Local government faces some of the severest cuts in the public sector (33 per cent in the current review period and 10 per cent more in 2015-16). This will test to break point the limit of financial sustainability of many local authorities.

The £3.8bn extra money for integrated social care announced in the spending review may alleviate some obvious hotspots, such as people delayed in hospital for want of follow-up care, and those who might never have been admitted in the first place had the right support been available. But most of that money is coming out of NHS budgets and these different financial settlements for local government and the NHS design financial stress into their relationship at a time when the need for collaboration has never been greater. Will councils be able to lead vibrant new partnerships to improve health and wellbeing, tackle health inequalities with renewed vigour and set the pace on local public service leadership while grappling with the biggest cuts in their history?

But the new relationship between the NHS and local government faces a bigger test. The current model of care is broken. More of us live longer and with long-term conditions, with treatments which defy categorisation as simply "health" or "social care". The number of over-85 year olds and people with dementia will double over the next two to three decades. More younger people will need lifelong support for complex needs, such as learning and physical disabilities. A 21st century business model for health and care will rely less on single episodes of cura-

In the early 20th century, local authorities had a duty to attend to the health and physical condition of schoolchildren

tive care in hospitals and demand a higher volume of long-term care and support at, or closer to, home.

Integration and co-production are the new watchwords. More of us will want to be active in shaping our care, support and treatment arrangements, not passive recipients of professional paternalism. Instead of a care system with one-sixth of the budget of the NHS, we need a strong, effective care and support system that reduces the need for formal care, supported by the right balance of primary, community and hospital provision. Last month, The King's Fund launched a Commission on the Future of Health and Social Care in England which will consider whether and how the post-war settlement could be realigned by bringing NHS and social care closer together.

Although the case for fundamental change is widely accepted among policy makers and politicians', awareness and acceptance among the general public is much lower. Reorganising stroke services in London resulted in a far better service, saving more than 200 lives a year and reducing disability but it was implemented in the face of intense hostility to necessary changes in local hospital services. Will local authorities rise to the challenge of leading public opinion rather than following it? The track record of politicians in grasping the nettle of controversial service reconfiguration does not inspire confidence.

Persuading cynical local communities that changes to local services will actually improve chances for better treatment and outcomes will always be tough. Engaging with people much earlier and demonstrating more clearly the trade-offs between different options is a smarter strategy than announcing a single preferred proposal. In turn, populations will need to take more responsibility for looking after themselves and using services in an appropriate way. Public engagement also nurtures communities that can give informal support to promote active ageing and tackle social isolation and loneliness.

We will also need to have a frank debate about how we find the bigger share of GDP needed to pay for our ageing population, a success story summarised in the recent House of Lords report *Ready for Ageing?*. How much of this should come from our own personal wealth and how much from the public purse? And, when care is funded publically, what "switch spends" from other public services or benefits could be made? Is there a case for additional taxation or charges? NHS bodies and local authorities should embrace more imaginative ways of discussing these using digital technology and social media.

It will never be possible to insulate more than £110bn of public money from the hurly-burly of party politics. The scale of the operation is huge – the NHS and social care system together have a workforce of more than three million – even small failings can have big consequences. The complexity of modern health care means local government will depend on NHS clinical knowledge as much as the NHS will need the political literacy of local government. The next stage in their relationship should be about partnership not take-over.

Richard Humphries is Assistant Director, Policy, 'The King's Fund'

Working together for Britain's national health

by **Sam Taylor**, National Policy Lead, Pfizer

The health needs of the UK have dramatically changed over the last 60 years. The demands of an ageing population, the changing burden of disease and rising patient expectations have put the National Health Service under immense pressure – particularly in front-line services. Reducing hospital admissions, ensuring that patients don't remain in hospital unnecessarily and delivering routine care to patients outside of the hospital setting can all go a long way to relieving this pressure.

Integration of the health and social care system is increasingly seen to be the key to achieving this – focusing much more on preventing ill health, supporting self-care, enhancing primary care, providing care in people's homes and the community, and increasing co-ordination between primary care teams and specialists as well as between health and social care.

While this is intuitively attractive, we must be careful to ensure that the health budget is not simply used to prop up the social care budget – this is an opportunity for us to be much more ambitious. However, it may be difficult for us to realise these ambitions unless some systemic barriers are addressed. One such barrier is the resistance from many parts of the health and social care system to embrace innovative practices at scale and pace. This is a barrier we face with medicines every day.

Medicines will have an important role in an integrated health and social care system. They can prevent disease, or slow its progression, as well as enabling the routine management of people with complex conditions to be delivered in different settings, such as GP surgeries.

Big savings can be delivered as well – in one therapy area alone, medicines are saving the NHS in England and Wales £223m each year by preventing heart attacks and strokes.

However, the NHS has traditionally been slow to adopt innovative medicines. A report, commissioned by the Department of Health highlighted that patients are still not getting access to new cost-effective medicines recommended by the National Institute of Health and Care Excellence (NICE). Indeed, a poll by Populus and Pfizer Ltd found that more than two-thirds of MPs believe that patients in the UK suffer a "postcode lottery" when trying to access the medicines that they need. NICE needs to promptly evaluate new medicines and the NHS needs to adopt those of proven cost effectiveness at both pace and scale.

> Two-thirds of MPs believe patients in UK suffer a postcode lottery

In recent years, responsibility for making decisions about patient care has been transferred to local groups of general practitioners in clinical commissioning groups. Also, the responsibility for improving public health has returned to local authorities. This increased local autonomy is seen as being a vital way of stimulating further integration of care.

However, for a "National" Health Service, there has always been a curious tension between national control and local autonomy. We know that, whatever structure the NHS has had, it has always been difficult to control the health service from the centre. But, there is a risk that the drive to increased local autonomy could result in variations in the decisions made by clinical commissioning groups and local authorities for the populations that they cover.

For example, we are already seeing a wide variation in how smoking cessation is being tackled by local authorities. Some are devoting considerable attention to it, while others indicate that they will simply focus on meeting the needs of very specific population groups or, indeed, not focus on it at all.

This is despite the government's strategy on tobacco control setting an ambitious new target of reducing the proportion of adults who smoke because it is the single greatest cause of death in England – with 80,000 deaths from smoking in England during 2011.

We need to ensure that progress in areas, such as reducing the proportion of adults who smoke, doesn't stagnate or regress over the coming years.

So we think it is really important that the devolution of responsibility also comes with accountability and measurement, ensuring that the service and treatments delivered meet the needs of patients and achieve the best outcomes possible. For medicines, it is vital that recommendations from NICE are not ignored, but are fully implemented.

We recognise the scale of the challenges facing the NHS, but we are encouraged by the enthusiasm to tackle them. Alongside our partners in the health and social care system we, at Pfizer, are committed to working together for Britain's national health.

Sam Taylor is National Policy Lead for Pfizer UK

A paradigm shift for good health

Participants discuss the erosion of the roots of local government that started with public health, and consider how to commission the holistic care that we want and need

Martin Barrow
Welcome to what I hope will be a lively discussion about the NHS, its relationship with local government, and how health and social care can be best be provided in a time of increasing financial pressure.

Andy Gwynne will start us off with Labour's perspective.

Andy Gwynne
I was asked to be here to stand in for Andy Burnham at the start of this event because he has to prepare to speak on a few news stories today, such as the statement on the children's' heart surgery reform.

I've been a shadow health minister since 2011 but my background is actually in local government. I spent 12 years as a local government councillor in Greater Manchester. I believe passionately in the power to deliver national services at a local level. I think there's a tendency for all governments in opposition to say that they're going to give more power to local government. And then when they get into power in Westminster, they tend to hold on to all the power they've got in Westminster and sometimes even take it away from local government.

So, I'm passionate about it but I believe there are huge challenges for local government at the moment…

Shadow Health Secretary Andy Burnham enters meeting

Andy Burnham
Apologies everyone. I can stay about half an hour…

Yesterday we had the announcement on death rates from the big killers [Public Health England's *Longer Lives* project]; and the A&E crisis [the four-hour A&E target] was also in the news. If you look at both those stories you will quickly see that the interests of the NHS and local government are intrinsically bound up together.

The data on survival takes you back to Michael Marmot's report – the determinants of health are much broader than the health service. It's work-related, it's about family, relationships, and lifestyle of course. So the health service deals with the consequences of provision or lack of provision in any community.

The reasons for pressure on A&E are not simplistic, it's multi-factorial. However, I would say that social-care factors are a major driver of the pressure that we're seeing at the moment, both at the front door and the back door of A&E.

In this job you get a blizzard of statistics coming at you but sometimes one statistic comes along that makes you stop and think. And that happened to me this week with one I saw on admittance to A&E by ambulance. Between 2009/10 and 2011/12, there was a 66 per cent increase in the number of people over the age of 90 coming into A&E by ambulance. That's over 100,000 very frail elderly people. When you look at something like that, it's obviously intensely sad and a failure of the system, and you think "what lies behind it?"

It must be linked to withdrawal of social care and support across the country – that has a "front door" impact on A&E. ▶

▶ But, arguably, the bigger impact on A&E from social care is the way hospitals become full and lose the ability to move people through. There is delay putting together discharge plans and that keeps beds occupied. So A&E can't admit to the ward and it becomes full. When A&E is full, the ambulance service can't hand over to A&E and the pressure gets backed up throughout the system.

Bed occupancy should be ringing loud alarm bells. For the first part of this year hospitals have been routinely running at about 95 per cent occupancy and up to 100 per cent. That tells you that there isn't any slack in the system at all. How will we get through the next winter if pressure increases?

This comes back round to local government and the way in which the interests of the NHS and local government are bound up together because, in my view, this problem is largely outside of the control of the NHS.

There is a lack of appropriate home-based support and it's creating a large problem now, on the doorstep of the NHS. The idea of protecting the NHS by making cuts to local government is, in the end, a false economy. All it does is push people to the expensive end of the care system – hospital beds.

Actually it is a policy that is about cutting prevention because social care is prevention. It's the human side of care; it's the help with daily living – the washing, dressing, getting out of bed, getting up and about – all of the things that might delay the day when you need more intensive support from an institution. Yet that is the bit that is being severely cut. I just don't think it's possible or sensible to carry on with this mentality of "the NHS is here and councils are over there" and that they live in different worlds and do different things.

I arrived in the Department of Health in the summer of 2009 and was clear that I wanted to make social care funding my main priority. I was struck by how lowly a place social care policy has within the Department of Health and how much I was going against the grain in trying to make it the department's top priority. It lives on the fringes of the department in a separate box that doesn't get opened very often by the Secretary of State. This compartmentalised view of the system comes down right from the top. And that is why people talk about "meeting targets and missing the point" because this system, from the top, is not geared up to look at the whole person. If we take the needs people have: physical, mental, social, we have three systems to deal with one person's needs. Physical, through the NHS; mental, through a system on the fringes of the NHS; social, in an entirely separate system, means tested and often charged for and run by councils.

"Ageing society brings a complexity we're not geared up to deal with"
Andy Burnham

In any part of this "care system", because of the culture of separateness, the likelihood is that some parts of anyone's needs are being neglected. And that is patently true for people who live at home; we hear many stories of failure in home care. Sadly, social care has become a malnourished minimum-wage business that can't provide the standards of care we aspire to.

In mental-health settings, people's physical health needs are neglected and they die, on average, 15 years earlier if they spend a lot of time in these settings. It's also true in the acute setting – you hear of the old person lost in the acute setting, falling through the gaps in hospital. The ageing society is bringing a complexity that we're not geared up to deal with. People in their late 80s and 90s have needs that are a blur of physical, mental and social – a continuum of very complex needs. If you think about the acute hospital, the minute an old person enters the acute hospital environment, two-thirds of their needs – their mental and social needs – are likely to be being neglected. That explains why the older person often drops like a stone in the acute environment and, in many cases, they never quite recover.

In the 21st century an ageing population is a big challenge but mental health will also be a bigger challenge than it was. We need to be able to see all of one person's needs and, to do that, we need a budget that is able to see all of their needs too. The finances need to work in such a way that they support prevention, with people living as independent a life as possible.

At the moment that is going in entirely the wrong direction. Councils have an incentive to cut, to keep council tax low. The NHS has an incentive to admit because that's how it gets paid. Consequently we're paying for failure; paying for the wrong results. Until the finance is right we won't make any progress. If we have a single budget/single-service approach, we could tilt the system towards prevention. You could create an incentive to keep people out of hospital rather than bringing them in. That is what urgently has to happen – tilting the system to support people before they fail.

What is the role of local government in a more integrated system? It's time to make a paradigm shift in the way that we're commissioning good health. We seem to have become trapped in a very narrow medical model of commissioning. Health service commissioning today is one group of health-service professionals commissioning services from another group of health-service professionals. That's not going to deliver the goods when lifestyle and ageing and mental health are the challenges we face. The paradigm shift needs to be to a social model. People forget that Nye Bevan was Secretary of State for Housing and Health. He had a very clear understanding about the wider determinants of health. Somewhere along the line that's been lost. Until you can make the link between commissioning good health and

housing policy, education policy, social policy and leisure – all those things – I don't think we will truly start commissioning for population health.

Councils, with all their imperfections, understand their local communities better than the NHS does; I think they understand prevention better than the NHS does. I also think they give a degree of accountability that I'm not sure is there in the clinical commissioining groups (CCGs). Councils are run by people who are generally known in the local area.

So, the model is that the NHS leads on provision for the whole person, including social care. That might mean providing that care or it could mean co-ordinating that care – a single point of contact will be provided to the public. What holds that to account is local government in the lead on commissioning. This also gives local government a future that it doesn't have at the moment. Local government has been overwhelmed by the costs of care. Andrew Gwynne and I are Greater Manchester MPs; Manchester's saying it'll just be doing "care and bins" by 2023/24 if nothing changes. All the other things that promote good health – libraries, parks, leisure centres, trips out of the school gates, outward-bound courses – will be washed away by the care crisis.

Martin Barrow

Am I correct in saying that you think none of this can be done within the terms of the Health and Social Care Act? You will repeal the Act and start again? There would have to be a legislative change. And would this include the new provisions for public health which have been transferred to local government?

Andy Burnham

It doesn't imply a *structural* reorganisation. I can work with the organisations I inherit. But yes, the Act does have to go. Why? Because I think this government has legislated for fragmentation. The logical consequence of "any qualified provider" is to bring an ever-increasing number of providers onto the pitch, dealing with ever smaller elements of one person's care, increasing the complexity of that provision, and probably the cost as well. For me, the 21st century demands integration, not fragmentation; it demands that whole-person approach.

An illustration of that is Torbay, where they are doing things on integration the rest of the country isn't. In Torbay they have more people dying at home than anywhere else in England. That has been brought about by a system based around the person. Torbay is mounting a judicial review to "any qualified provider" because it believes the logic of the Bill will break apart what it's been trying to do.

There are things I support in the Bill. I support the passing of public health to local government. But I want to go massively further than that. Everything the council does should be about the health of the local population. I would make CCGs advisory to the health and wellbeing boards, providing specialist medical input. But the Act does have to go.

"There's a risk that prevention will get lost in the medical model"
Sam Taylor

Sam Taylor

As a pharmaceutical company we have a slightly different perspective. I wanted to touch on three themes.

The first one is partnership. We have a long legacy of working with the NHS. What all this means to us is that we've got a new player in the game, a new person we've got to work with. So what does that look like and what does it mean?

On bed occupancy, one of the things we've been doing recently is spending a lot of time looking at enhanced recovery and how we can help people recover; how we can take people out of acute care and put them into community management. It's good to see this flagged up as a priority, moving forward.

We need to think carefully how we get patient voice into the system. There's a lot of rhetoric around it but I don't see it being pulled through in the way we'd like to see it. Certainly local government provides that voice in the system. We need to explore that and support it.

Prevention is a huge aspect that we need to think about. We've got the *Burden of Disease* report and now the *Longer Lives* report from yesterday. From our perspective we see the challenge of risk being in the way resources are used properly and appropriately in order for prevention to happen. We see a risk within the "Quit" smoking cessation programme, where medicines seem an easy area to make savings. But people are not necessarily thinking about the downstream effect of that. We need to have a proper conversation with local government about what it means to do prevention properly. There's a risk that prevention will get lost in the medical model.

Finally: variation. From a commercial perspective, localism can make it difficult to control how things happen. We need to get some accountability in that. For example, having recently done an audit of smoking cessation services, one of the things we found was that 93 per cent of the Joint Strategic Needs Assessments (JSNAs) reference smoking cessation as you would like to expect they would. But, when you get into the detail of it, only three-quarters of them prioritise it; and only one-quarter of them have any targets on progress. So we see local areas responding very differently. Particularly in issues like smoking cessation, where the benefits are so huge, we need a tighter understanding of the role of local government and healthcare alongside it.

Peter Carter

Andy has talked about our health needs being multi-factorial. But for us at the moment, the biggest issue is the care of ▶

▶ older people. That's what's putting this massive strain on the system. Last year I made a speech in the same week that we were celebrating the 60th anniversary of the Queen coming to the throne. I looked up how many people received a telegram from the Queen when they turned 100 in 1952; it was 350. The latest figures from 2010 showed that over 12,000 people got a telegram. So we've gone from something that was an incredibly rare event to something that is now commonplace. But services just have not changed to reflect that. People are coming into hospital when, with good home nursing, good preventative stuff, they could be kept at home safely. This is the major challenge.

Geoff Alltimes

I believe in the sort of things Andy was talking about – that local government and CCGs can build a different system. But one of the issues for you, Andy, if you were the Secretary of State is whether you would be able to bear to let localities get on with making it work locally. In my experience as director of social services and then joint chief executive of a PCT there was an absolute contrast in the model of operation and the constant bombardment of instruction which was a distraction to us getting on with doing the sort of things we've been talking about in terms of providing that better care. Ownership in relation to local care needs to be local and we, locally, are answerable for delivering that jointly.

Andy Burnham

Geoff's raised a really important point. You're absolutely right about that culture. People say it comes from the very start of the NHS – the bedpan echoing in Whitehall. Maybe there was a reason for that at the time, when national standards needed to be brought to bear, but that culture has lingered.

I'm actually not somebody who believes necessarily in untrammelled localism. The public don't want it either. It's postcode lottery when it comes to care. That is always at the top of the public's fears in polls. In social care it's the ultimate lottery because the point at which the eligibility criteria are funded is decided by local government.

So it's made me ask "what is the job of a national politician and what is the job of a local politician?" The clearest way I can put it is: it's my job to set out the "what" and it's your job to decide the "how". Whole-person care: physical, mental, social should be set out at national level – the entitlement to care and support of every citizen in England. But then it shouldn't be my job to say how you deliver that in every community. There are some caveats with that: it would be through an NHS preferred-provider model but by asking the provider to work towards a very different future, giving the stability on which to work so they can really plot a different course.

> "Could you bear to let localities get on with making it work locally?"
> Geoff Alltimes

I would also have perhaps an even clearer stipulation around NICE guidance. When I was a junior minister, the appraisal came up for Alzheimer's drugs. These drugs weren't going to cure Alzheimer's, but they were going to delay its onset. The consequence of that is that you would delay the need for social care and would be a consideration for councils as well as individuals. But NICE couldn't take that into account. And that almost embodies what is wrong with the current approach. So I would want councils to take more notice of NICE but for NICE to have broader appraisal of whether or not a treatment makes sense. At the moment we only take a very NHS-centric view of things.

So: local government doing its proper job, which is deciding how to implement national priorities.

Kay Nolan

NICE has changed its name and now has a responsibility for social care too. I'm in the public health team and we have been thinking about some of the points that Andy's raised and trying to move forward with them over the past few years. Local government needs different metrics to help it decide what its return on investment is. So, as a public health team, we are trying to make a case for investment in public health areas of prevention through the use of tools that have been developed, for example, on tobacco and now on alcohol and obesity, so that we can see the link with other departments, not just health.

The more you look, the more savings you attach to this information; it's about finding the important ones. Speaking from personal experience with a family member who is chronically ill, the NHS is only picking up the medical part of the cost of their care because the family are picking up the rest – but that isn't recorded. If you look more, you'll find more savings.

Matt Tee

The analysis of the split in care types is absolutely compelling. We are beginning to see nuance with care and I see moves to deal with the split in all parts of the country. There are two things I would say and they are cautionary. The first is to say that it is tempting to say that a single commissioner will give you integrated commissioning but our experience tells us that this isn't necessarily the case. We shouldn't jump to the conclusion that because it is the local authority what you'll get is integrated care. In the same way that putting social care in the Department of Health hasn't made the department take social care more seriously.

I would urge Andy to talk to CCGs about their role because there are quite a few looking at your proposals saying "What do CCGs do if you give commissioning to the local authority?"

Claire Bambra

I wanted to talk a little bit about research evidence around integration. We conducted an evidence review which showed that it does improve quality and choice for people. Torbay is an example of this. Also, commercialisation and fragmentation that Andy was talking about with relation to the Health and Social Care Act is the same as other international research evidence, which is that quality actually decreases as does choice, particularly for lower income groups, who don't exercise choice and don't get the benefits.

I also wanted to mention the democratic deficit in the NHS and how moving healthcare over to local authorities might be a way of making the NHS more accountable to the community. I think we need to talk a little bit about some of the risks that might come from that. At the moment the NHS is largely about delivering health need and takes advice from NICE around that. Once you get politicians, we might say "interfering", from a professional perspective, then we might get the case, as has arisen in the north-east, where people are asking "why are we spending so much on drug and alcohol treatments when it's for a minority of people who only have themselves to blame and we could be making that investment in childhood obesity instead?" It could have very big implications over the long term if you made that decision based on who deserves help; it undermines the principles of our current NHS.

Andy Burnham

I want to stress that we don't think we have all the answers, and we are listening and trying to build this with people. This has to be something that feels right to people and be built upwards. Claire made a point that we didn't get when we were in government. When you have true integration you have a more sophisticated notion of choice. It's a lazy assumption that competition means choice.

Torbay didn't make a target for more people to be able to die at home. It just happened naturally from treating the whole person. It requires a larger, more integrated range of providers.

There's been a rhetoric of distrust of local government for a long time and what we've seen is the progressive enfeeblement of local government. But often local politicians are more pragmatic and open to local views where Westminster isn't and Westminster needs to put more trust in people who are expertly advised and locally accountable. It's the best option we've got.

Andy Burnham leaves the meeting

Michael Lockwood

Some words of context; as a sector, the public sector is second only to welfare in the amount of cuts we're facing – we're looking at 40 per cent cuts in our budget and that's going to carry on until 2021. Related to that, we have a health sector that's treated like a political pawn.

There's an enormous contribution that we in local government can make to health that we haven't really been allowed to make. For example, the number of old people in hospital – occupying over 50 per cent of beds. Those people don't want to be there and it's more expensive than them being at home, which is where they want to be.

"NHS picks up the medical cost of care, family picks up the rest"
Kay Nolan

The frustration for me is the compartmentalised way it's done. All we want is patient-co-ordinated, integrated care with a pooled budget. I want to get off the agenda of battling with people about whose budget it is to one where we talk about how we can work together. I put public health at the centre of the council, so it's got links with leisure, housing, environmental health, schools – all the things we think will allow it to exercise its role better.

We've also tried to put a greater emphasis on prevention rather than cure. That is tough – we don't have the money to get on the prevention side. Our financial system encourages us to make money tomorrow rather than over five years, so the system wants savings tomorrow where prevention takes somewhat longer.

I think there's a trust challenge with the public sector about the way public services are run. I think that, run locally with local transparency, we can deal with that issue. We're very keen to up the ante.

Don Redding

Financial resources are limited but sources of value are not fully exploited. For example, people who have long-term conditions are not in touch with services most of the time; they're just living their lives. Family or carers are supporting them, but they make management decisions every day about what they can do and what they are capable of. We need to ensure that the strengths that people can bring to that are used.

A simple example is that an awful lot of medicines are wasted because they're not taken correctly or at all, because people don't understand what they've got. The route to people getting the most out of their treatment comes through involving them in those plans and decisions about how they're going to be cared for and treated. There is reasonable evidence to show that the more involved they are, the better. They have a better experience and use resources more appropriately, so they will take up prevention offers. This means they will be less likely to choose high-end resource treatment.

The second group that provides value that we're not using properly (referred to by Kay) are families and carers, who actually provide the bulk of care, and without whom the bills for care would be even more astounding. Yesterday I was ▶

looking at the statistics from the last inpatient survey and only about half of people who have had a recent inpatient episode say that their family and carers were given the information they needed to help them once they left the hospital.

A third source of value that could deliver much more are the voluntary and community organisations. Holistic approaches to care use all kinds of inputs that help people to manage as best they can; these don't just come from statutory health and social care services. These are things like peer support, education and self-management, support for family and carers, looking at the financial impact of their developing condition and how they manage that. Those approaches get developed in the voluntary and community sector. But we fear we are going to be squeezed out in the current concept of commissioning.

Andy Gwynne

One of the things that Andy's had all of the shadow health team doing over the last few months is work shadowing. I have had the privilege of shadowing a Red Cross volunteer in Darlington. It's her job to help people move from hospital back into home when, without that help, they would probably be bed blocking. She can give these people extra help and assistance; taking them to appointments, taking them shopping. In this way, they're able to go home at a much earlier time than they would otherwise be able to, saving the NHS thousands of pounds in the process. But she also became a friend to the individuals she was helping and it was really pleasing to see just how trusted this Red Cross volunteer was by the people she was helping – some had mental health needs, some just had physical needs. But their funding is being cut; and a decision was due to be made jointly by the CCG and the acute trust about whether they would commission these services in the future.

I'm a patron of the new Home Start in my constituency and that's another example of where volunteers are doing some fantastic things that are saving the local authority and the NHS thousands of pounds.

On Michael's point about local government cuts, we need to break down that silo mentality. We need to look at funding as one purse rather than NHS money and local government's money – and even within local government there are different competing departments.

For example, for the sake of saving a couple of quid on a handrail an elderly person then falls and breaks their hip.

"Closing hospitals is never popular: all local MPs come out against it"
Claire Bambra

You've saved your £2 in adult social services, but you've pushed thousands of pounds of cost onto the acute sector. We've got to look more holistically.

Claire mentioned the added challenges that democracy can bring. My local primary care trust spent £5,000 on an advertising campaign in conjunction with what was then known as Age Concern, to raise awareness about the dangers of ill-fitting slippers. It's hugely important because there are a number of falls caused by ill-fitting slippers and that pushes cost on to the NHS. But the local taxpayers' alliance jumped up and down about it because they thought it was a waste of money. The *Daily Mail* and the *Daily Express* picked up on it, as did the local media. By giving this responsibility to the local authority, you also give them the responsibility to explain why this is money well spent.

Claire Bambra

I think there are bigger examples too, such as specialisation and having bigger hospitals taking on more responsibilities. Closing local hospitals is never popular – all the local MPs will come out against it, regardless of their national policy.

Alex Thomson

On decentralisation and localism, we're currently working on a report of local authorities' views on the opportunities and challenges around that. We're launching that in September but I can give you a couple of relevant points it has revealed. We did a round table the other week, with various companies, health professionals and MPs. It was quite striking that there was a consensus that local government should either divest itself of social care by giving it to the NHS and walking away from it, or that we should do some sort of version of what Andy Burnham was talking about and integrate the two.

We've done a survey of chief executives and leaders about this stuff and 95 per cent think that linking local government with health services would have a positive effect; 88 per cent think they can deliver more joined-up services; 62 per cent think they would increase accountability; 43 per cent think it would lead to a more patient-driven service; and six times as many people thought prevention would be more likely than those who thought it less likely.

Don Redding

If you look at the record on what has been tried on integrating care over the last 20 years, there's been no convincing period of demonstrable benefits to people who need proper co-ordinated care from any of the models that have been tried. So while the enthusiasm is welcome, and the same enthusiasm is there from the CCGs as one of their top priorities, there is no history of delivering measurable benefits to people who need to use services. So we've still got to look for new models of delivery that focus on what people need. We've got to focus on people's needs and how they can play an active part in delivering that. We won't be bowled over by any one thing. There's something more radical and fundamental that needs to happen, which is about realising the goals and aspirations that people have for their care,

and organising services around that, not some new legislative goals of the system.

Michael Lockwood

We've just done a number of integrated-care pilots focused around the patient, a 360-degree view of that individual. We get GPs, social workers, the hospital consultant and so on round the table and we do a single risk assessment and write a single pathway of care. This has meant clearer pathways, more integrated care, better connectivity and better use of money. So we believe we've got examples of where that integration is working.

Richard Humphries

I think everybody agrees that the current model of care is bust. What we need is a model of long-term care that is closer to home, integrated across a range of services and disciplines. But how do we do it without turning everything upside down? And how do we do that within the tramlines of a 1948 settlement?

At the Kings Fund next week we will be launching a new piece of work that aims to revisit the 1948 settlement, and asks: "Can we come up with a better way of configuring the offer?"

I see two short-term issues. A current blight on the landscape is that the NHS budget is ring-fenced, creating the illusion that the NHS doesn't have the same financial pressures as everybody else, which is nonsense. Then you've got local government getting clobbered by more than 28 per cent cuts. This almost designs in financial stress to the relationship between the NHS and local government at a time when government is giving other policy messages that they've got to get closer together. There should be a single spending review settlement for health and social care, not two separate ones.

Our research tells us very clearly that the Health and Wellbeing Boards that seem to be making the most progress are the ones that see their role as being a partnership with CCGs, rather than a takeover. And I would worry at any perception that the work of CCGs is being downgraded. The engagement of GPs has been a very positive thing for the boards so far.

Where we need to get boards to is taking an overview of the total commissioning resource in their locality, not just the £1bn that's transferred from the NHS, but the whole lot. But that needs to be done on a partnership basis in which CCGs are engaged.

Andy Gwynne

Richard has made a really good point there about taking into account total resource within a locality. The locality needs to be able to plan for all services in the future – health, social, housing, leisure, planning, public health, environmental services and so on. We need a proper health plan for each individual area that everyone works towards and understands. That single resource then allows you to deliver the health plan for the locality.

Alex is right about it almost being a return to the historic powers of the NHS because we all forget that local government was born out of health. My own local council started off life in 1855 as a "local board of health", that then became an urban district council, and then became a metropolitan borough council. At each stage of reorganisation it lost a little bit more of its role in health until the point today where it delivers adult social care and children's services and, other than that, the rest is delivered by somebody else. Really we've got to get back to that joined-up thinking that is more patient focused, that is more electorate focused as well. Local councillors want to deliver services that the electorate wants to see. Voters don't understand why councils can't do this, that, and the other; why somebody else is responsible for it. When people come to a councillor's surgery, they automatically assume that the council is responsible for health services anyway.

"Engagement of GPs has been very positive for the boards so far"
Richard Humphries

Fiona Sim

I want to go upstream and engage people. It think the late Derek Wanless was right, about a fully engaged scenario being the only way to an affordable service for the future of both health and social care. And I don't think we've made much progress since he spoke in 2002 about engaging people so that they understand their own health.

Proper primary prevention has got to be a sensible way forward. Linked with that, I'm particularly interested in building capacity. We have a number of qualifications but they're at the very basic level of Level 1/Level 2 stage for improving people's understanding of health, whether they're ordinary members of the public or whether they're working in local authorities at any level, or are in health care. They've been very popular, they've been taken up. We're not the only organisation that does those but I think the downward pressure on training budgets – and budgets in general – is a real issue for building that basic capacity, and this needs to be thought about in terms of return on investment. "We can't afford training" tends to be a bit of a short-term response.

Another thing about capacity that someone said to me yesterday is that, not only have we fragmented the NHS across the UK, we're fragmenting our public-sector values. So, for example, business leaders are encouraged to become leaders in the NHS, skilled in business, in competition, in entrepreneurship, which isn't necessarily social entrepreneurship. Someone said to me, "Please don't bring those values across to Scotland, where we don't have competition, we embrace collaboration and work in partnership". What we've heard here today is that it's the collaboration and partnership that ▶

▶ we need to be embracing and promoting, rather than those other skills necessarily. I suspect there is space for some business acumen but not at the exclusion of working in partnership and understanding how to collaborate. So we need to understand the sort of people that we're developing and building to take the whole system forward, regardless of whether it's run by local government or some other sector.

Another point I'd like to make is that, having moved public health into local government, it's working in some places beautifully, and less beautifully in others. There are all sorts of complex reasons for that so I'd like to make a plea for some evaluation, rather than just changing things for the sake of changing them, dare I say it, on a political whim.

Where it's working well, public health people have learned the language of local government and how to use the levers and drivers. Local government has understood health for centuries but public health and the NHS haven't understood local government.

"It's the collaboration and partnership that we need to be embracing"
Fiona Sim

Geoff Alltimes
I agree with that – adopting models that have something to offer. There is lots of evidence about things that do work for patients, and patients have been part of the evaluation that says they have worked. The problem is that we do not have many places where that's done as a whole system, we have lots of individual pilots – Torbay's one of the few that went for the whole system, and the evidence is good in terms of their results for patients.

I'm familiar with two Total Place community budget pilots, one I was part of starting in the three boroughs of Hammersmith, Kensington & Chelsea; and Westminster, which is very much connected to the model in Greater Manchester. What's important to me is that these pilots are work that is between CCGs, the NHS and local government; and they have said "actually we can see a way in which we can do better with a combination of services and we can do it more cheaply". Those pilots are poised to go and are being taken forward. My frustration is that the system, the collective system – who owns which bits of it I'm not sure – but the collective system has not said "Yes, we ought to be using those examples, evaluating them and pushing them to the next stage because they're the sort of model we need in the system." Not least because, as well as looking at the issues of providing better care, they've also been prepared to grapple with that most difficult issue of reconfiguration. The fact that you've got to take populations with you, down the road of saying, "Yes, we need less of some of these institutions, less of the big hospitals and more care in the community."

Andy Gwynne
Speaking from local experience, one of the wards in my constituency, Denton South, is part of Greater Manchester Total Place pilot, and it's worked incredibly well. Denton South Partnership is operating out of what was a PCT building in the heart of the community, delivering services to a whole range of people; in partnership with the local housing providers; in partnership with the police, the local authority, probation services and with the NHS. And we are starting to see huge improvements in job opportunities, in housing, in standards – a whole range of factors in that community.

That pilot is about to end and what really concerns me is that we might move back to the silo mentality.

With Sure Start for example, some of the opponents are saying that things haven't improved on this outcome and that outcome. And I say that, in 20 years' time, when those children who have gone through Sure Start over the past few years are parents themselves, that is what will show whether or not it's paid dividends. It was never meant to be a quick fix. That's true of the Total Place pilots as well. Some of the benefits of Total Place have been immediate but some of them will be much longer term.

I think there are some good examples of where public health has fitted very neatly back into local government because those particular councils have taken the role of public health seriously – it's not seen as a secondary issue. Actually it's seen as the lynchpin of everything that the council does. Public health has an umbrella role for many other services that councils offer. It makes local government tick. Where councils "get" that, public health will be the key role in the future that ties everything together.

Sam Taylor
To pick up on Fiona's comment about commercial aspects and bringing those skills in, being on the commercial side I find that our focus at the moment is less and less on the commercial aspect and about competition, and more and more on partnership. Our cultural mantra is about working together for Britain's national health.

We have a role to play around risk-taking. As an organisation, we reward risk-taking because we can see the benefit of doing it. Failure is not a problem as long as it's managed. There's an opportunity for bringing that into the system in terms of how we integrate, how we change services for the future and how we adapt. It's been interesting to hear the different approaches for the different parties here today and that there are an awful lot of things that people are saying together and we need to actually play that out.

Martin Barrow
Thank you all very much. It's been highly interesting.

£ £

'09-10 '11-12

Budget: Total social care budget fell by £1.7bn

Source: *Health Survey for England*, NHS Information Centre for Health and Social Care

If local government were linked with health services:

6x as many think prevention would be more likely than those who think it would be less likely

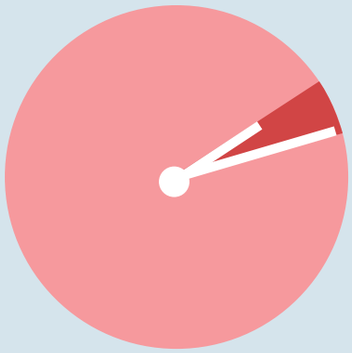
95% of local authority chief executives and leaders think that it would have a positive effect

88% think they would be able to deliver more joined-up services

62% think it would increase accountability

43% think it would lead to a more patient-driven service

Source: Localis



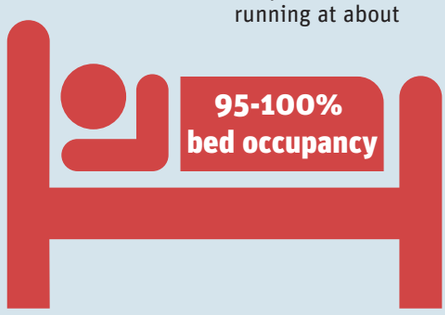
Waiting time:

6% of all patients waited for 4 hours or longer at A&E during the first three months of this year

Source: *Health Survey for England*, NHS Information Centre for Health and Social Care

Bed occupancy:

For the first quarter of 2013 hospitals have been routinely running at about

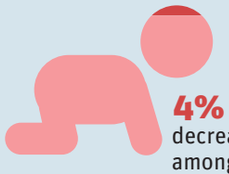


Source: *How is the health and social care system performing?* Kings Fund

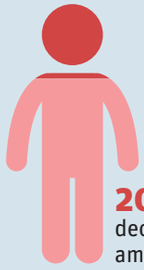
Ambulance transportation:

'09-10
165,910 people aged over 90 taken to A&E by an ambulance

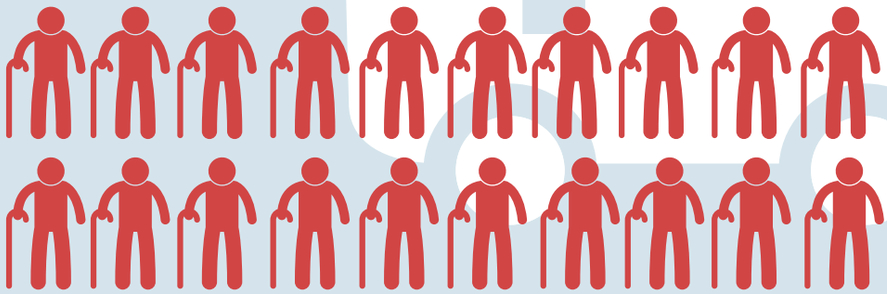
'11-12
275,883 people aged over 90 taken to A&E by an ambulance (66% increase)



4% decrease among the under-10s



20% decrease among 10-19 year olds



'09-10
635,834 people aged 80-89 taken to A&E by an ambulance

'11-12
757,555 people aged 80-89 taken to A&E by an ambulance (19% increase)

GRAPHICS BY LAUREN MESSERBY

Source: *Health Survey for England*, NHS Information Centre for Health and Social Care

This round-table report forms part of the **New Statesman & Pfizer Policy Forum**, a programme of events and publications launched in April 2005.

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The *New Statesman* selects participants and manages the event, and has sole editorial responsibility for the content of the supplement and the text that appears on the website.

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NewStatesman
7th Floor
John Carpenter House
John Carpenter Street
London EC4Y 0AN
Tel 020 7936 6400
Fax 020 7936 6501
Email: events@newstatesman.co.uk