ROUTES FOR SOCIAL AND HEALTH CARE

A simulation exercise

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Foreword

Two years ago, in the wake of a global financial crisis and the realisation that unprecedented growth in NHS resources would not continue, The King's Fund held a simulation event called Windmill to test how the NHS would respond to what was described then as a 'financial storm'. The resulting report offered important insights into the options available to policy-makers, commissioners and providers (Harvey *et al* 2009).

Since then, the scale of the financial challenges facing the NHS and other public services has become even starker, as reflected in the coalition government's emergency budget, comprehensive spending review and fiscal reduction programme. The pledge to ring-fence the NHS budget, and to direct some of this to social care services, has reflected a greater recognition of the challenges faced by the social care system and the inter-dependency of these services in addressing the relentless demands of demography, social change and technological advance.

The unveiling of radical proposals to reform the NHS – including its relationship with local government – sharpened an appetite to explore how social care and the NHS would together tackle the challenges brought about by a radically different operating environment. Conversations with leaders in local government and the social care sector suggested a growing interest in using behavioural simulation approaches similar to Windmill but with a stronger focus on social care and its relationship with the NHS.

The result was 'Routes' – commissioned by The King's Fund in partnership with the Joseph Rowntree Foundation, the Social Care Institute for Excellence (SCIE), the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA). We are very grateful to them for their financial support, advice and participation in both the design and running of the exercise and the preparation of this report.

The process was led by Richard Humphries, Senior Fellow at The King's Fund, with project management support from Clare Bawden. The simulation was designed and facilitated by Laurie McMahon and Sarah Harvey of Loop2, with support from Alasdair Liddell, a Senior Associate at The King's Fund. Their expertise and commitment has been crucial to the project. But the success of the Routes process has, most of all, relied heavily on the experience and judgement of the participants. We were fortunate in attracting the commitment of a wide range of senior managers and thought leaders from across the NHS, local government and the third sector. Their willingness to devote so much of their time to the exercise in the face of many other competing demands reflects a hunger to find new ways

of grappling with the complex challenges they experience on a daily basis. I would, therefore, like to pay tribute to all those who took part in the simulation and thank them for their ideas and contributions.

The Routes simulation was set in 2012, when many aspects of the government's NHS reforms had been implemented. At a time when the passage of the Health and Social Care Bill has been paused, the simulation can offer some important reflections for policy-makers, commissioners and providers of health, care and support services. These include: the immense challenge of moving beyond short-term efficiency savings to longer-term transformational redesign of services that releases substantial productivity gains and delivers better outcomes for people; the ongoing tension between top-down, managerially led approaches to change and devolved models in which personalised care is driven through choice and providers who are incentivised to innovate; and the potential of health and wellbeing boards to offer system leadership in moving towards different models of care – long recognised as essential, but proving so difficult to achieve.

Many of the messages from Routes support the coalition government's policy direction, including its vision for adult social care, although the potential impact of the proposed policies of 'any qualified provider' and economic regulation did not figure largely in the simulation. Routes also shows that there is no shortage of practical ideas as to how the NHS and its local government partners can use the opportunities of change at a local level to deliver better outcomes, for more people, with fewer resources. I hope this report will be a useful source of inspiration, reflection and ideas as to how these aspirations can be achieved.

Professor Chris Ham
Chief Executive, The King's Fund

Key messages

- The biggest single challenge for policy-makers, managers and clinical leaders is to see the current circumstances not as a 'perfect storm' of problems but rather a 'perfect opportunity' to achieve fundamental changes to the health and social care systems.

- Making this system shift will entail moving beyond short-term cuts and technical efficiencies to longer-term transformational change that will release substantial productivity gains and better outcomes for people and communities. There needs to be a complete rethink of how entire health and social care systems use their combined resources.

- There is no shortage of practical ideas about how to reduce costs and improve productivity. These include: integrating commissioning support across social care and GP commissioning; reducing duplicated building assets; streamlining assessment and other processes; and workforce re-profiling.

- There are significant tensions between a top-down, managerial and public sector-driven view of change and a more devolved outlook that stresses individual choice and control as drivers of bottom-up change – the opposing scenarios of 'control' or 'devolve'.

- A radical realignment of the relationship between citizens and public services will see councils 'managing less' but 'doing more' to enable communities and citizens to develop natural capacity for self-care and support.

- Health and wellbeing boards will perform a crucial role as local system leaders, seeing through contentious changes in traditional patterns of investment, design and configuration of services. But their overall strategies should recognise the different governance and accountability arrangements of local public service organisations, especially those of GP commissioning consortia.

- The traditional policy focus on achieving integration between health and social care should be eclipsed by a broader perspective of the wider interface between local government and the NHS, including the important role of health and wellbeing boards and the new public health responsibilities of local authorities.

- These messages support the coalition government's policy direction, including its vision for adult social care. But the potential impact of the proposed policies of 'any qualified provider' and economic regulation did not

figure largely in the simulation, which suggests major uncertainty about how the proposed NHS reforms will play out in practice.

■ There are important lessons to be drawn from the experience of social care. With nearly two decades of experience in managing a mixed economy of care, private and third sector providers are responsible for the majority of services provided. Local authorities have already learned about market testing, market stimulation and management, and about the benefits and risks of opening up some services to 'any qualified provider'. The experience of social care commissioning has demonstrated some of the potential benefits of a more competitive market, as well as some of the risks that need to be managed.

An introduction to Routes

Routes was the name given to a simulation-based project designed by Loop2 to explore how the evolution of the adult social care and health care systems could be managed to create real synergies between them. It was commissioned by The King's Fund, in partnership with the Social Care Institute for Excellence (SCIE), the Joseph Rowntree Foundation, the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA). The project was steered by an advisory group drawn from these bodies.

What prompted the exercise was the recognition that the sheer scale of the transformation facing local social care and health systems makes it difficult to comprehend. There are three inter-related sets of challenges. First, there are significant financial challenges. Social care budgets are shouldering their share of the reduction in public funding for local government and, while the NHS has been promised a small real-terms increase in funding for the life of this Parliament, it has been told to find £20 billion worth of productivity gains over the next few years to cover the rising costs associated with demographic changes and technological advances. Second, there are significant challenges associated with having to make a number of quite deep structural shifts in the organisation of both health and social care. These include the new public health role for local authorities; the creation of potentially powerful health and wellbeing boards; the establishment of GP commissioning consortia and new relationships with a National Commissioning Board; as well as the consequences of a stronger regime of competition and contestability in health care markets. The third set of challenges is the push towards 'personalisation' both in social care and (if the signs are right) the extension of 'personalisation thinking' to health care, especially for people with long-term conditions. Linked to this is a set of changes designed to shift relationships between the statutory sectors and the public and third sector – so-called 'Big Society' thinking. These three sets of drivers create the 'challenge triangle' (*see* Figure 1 overleaf).

However, the demand for radical improvements in productivity across the social care and health systems, while both are in a state of flux, could be seen as an opportunity. The economic challenges are not going to be met simply by doing the same things better. This means that the incentives and opportunities to achieve better value for money for health and social care are greater than they ever would be in more stable times.

That *might* be a possibility, but for one thing. Everybody – policy-makers, commissioners, providers, citizens, regulators and public representatives – seems

Figure 1 Three inter-related 'challenges'
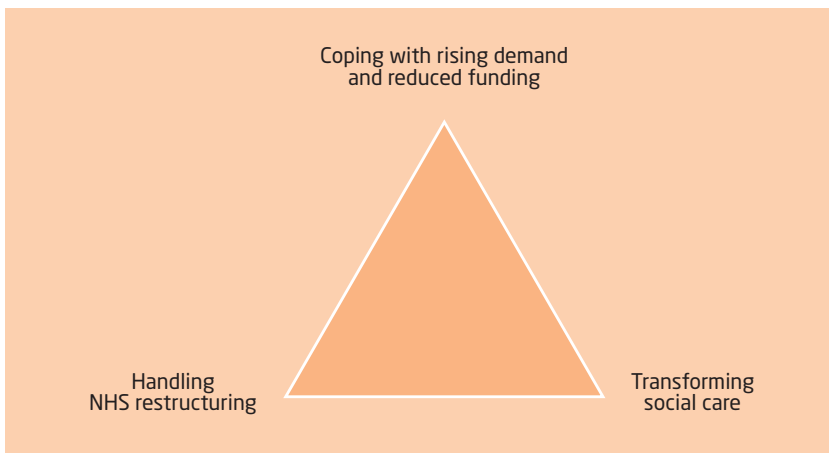
to be so involved with coping with day-to-day challenges that it can be hard to pause and consider what this long-overdue realignment of health and social care should actually look like. Without a clear and shared vision to guide the evolution of the systems, there is a real risk that the opportunity will be missed and hurried changes will be made in a piecemeal fashion. If that were to happen, there would be a danger of ending up with health and social care systems that are even more poorly integrated than they are now. As the Routes steering group said: '*Better integration has to happen, but we have to become clearer about the route to take.*'

Creating a 'space' to contemplate radical realignment was what Routes was all about. We used a behavioural simulation to bring together some of the foremost thinkers from the real world of health and social care and have them 'play out' remodelling the systems in a safe learning environment. We created an imaginary but highly realistic metropolitan borough called Crafton, which exhibited all the difficulties, constraints and tensions that exist in any local system. Because there was no role play (all of the players were in positions that were very familiar to them in real life), the simulation allowed us to play out the gradual evolution of health and social care in a highly realistic way, in a short space of time.

The simulation device also allowed us to step forward in time during the play to a point where most of the structural changes – like GP commissioning and the new health and wellbeing boards – were in place. This made it easier to see how the new arrangements for social care and health might be used to create closer alignment between these two sectors. A fuller explanation of the process is given later in the report.

The Routes partners were clear that this is not a time for incremental change. What is required is a radical rethink about the balance between the state, society and the citizen, between social care and health, between formal and informal methods of supporting people, and the balance of investment in prevention versus responses to immediate need.

The remainder of this report is organised into three sections. The first section gives an overview of the underlying challenges facing social care and health systems and some of the opportunities they present for greater integration; the second section describes the Routes process and sets out the recommendations that emerged from the simulation in terms of greater alignment between the two systems. The final section presents the Routes participants' advice for different stakeholders as they play their part in planning and implementing this new phase of social and health care reform.

The underlying challenges

Managing another set of changes to health and social care: more of the same?

When we began to design Routes, the steering group stressed the importance of understanding the context in which the challenge triangle was being addressed, both generally and at a local system level. They noted that the social care and health sectors were not unused to large-scale change and exhortations to transform the way that care is delivered. There have been cycles of investment, overspend and rebalance since the NHS was established more than 60 years ago, and numerous policy changes that have altered the structure of planning, commissioning and delivery in both sectors. The closure of long-stay psychiatric hospitals and the introduction of community care, for example, can be seen with hindsight as significant programmes of transformation.

Routes participants highlighted three fundamental features of the current context that make this latest 'transformation' agenda quite different to anything experienced before.

The first difference is *the depth and scale of the financial challenge facing public services.* Since 2000, real spending on the NHS in England has almost doubled, yet productivity fell during this period (Appleby *et al* 2010). While the current government has allocated a very small (and debatable) real-terms annual increase in health care funding, trends in demand, demography and costs mean that there will be a gap between what the NHS needs and what is available. This means that the NHS must deliver significant improvements in productivity of around 4 per cent per year. However, productivity gains of this scale have not been delivered by the NHS since its inception, let alone for several consecutive years.

Local authorities are similarly challenged, coping with a reduction in the core local government grant of 27 per cent over four years. Given the scale of this reduction, most councils are already finding it difficult to protect funding for social care, which is perhaps the largest area of controllable spend. Despite the additional resources the government has earmarked for social care – including £1 billion from the NHS – The King's Fund has warned of a potential funding gap of at least £1.2 billion by 2014 if councils are unable to protect social care funding and make unprecedented efficiency savings (Humphries 2011). The fact that the cuts in the local government grant are 'front-loaded' adds further pressure to 'cut quickly' rather than seek transformational changes over a longer timescale.

As well as these financial challenges, changes to the welfare and benefits system and reduced employment opportunities as a result of the recession are likely to magnify the pressures on the health and social care systems (Hossain *et al* 2011).

The conclusion from Routes is that funding challenges on this scale are unlikely to be met by attempts to deliver 'the same for less'. They will require a complete rethink about the way that entire health and care systems use their combined resources.

The second significant difference affecting public services is *the growth of 'people power'*. The policy of personalisation in social care is a reflection of a much wider social trend in which citizens want and expect to have care, support and services that are more tailored to their needs (Carr 2010). Expectations of choice and quality will grow; experience of websites such as eBay and TripAdvisor will drive different aspirations for how people interact with their public services. The growth of social networking media and integrative platforms has the potential to transform the range of support options available, and to improve people's insights into their needs and conditions, and their ability to choose the support they need – as well as offering tools for planning and prioritisation. The use of social networking media in mobilising public and political demonstrations across the world has also been a reminder to public bodies that, while they may be able to tap the potential of these resources, they will not be able to control their impact. Many of these trends are reflected in the government's vision for adult social care. The 'Think Local, Act Personal' initiative has been developed to offer a framework for commitment to, and delivery of, some of these aspirations (Department of Health 2010).

The third big difference is *the devolution of power and responsibility from central government to local systems*. The combination of the Localism Act, the additional powers that local authorities will have for public health and well-being, the 'delayering' of accountable public bodies in the NHS and the creation of 'local' GP commissioning consortia provide a context in which there should be far greater scope for local discretion and innovation in how public money is used and generated. The incentives to establish social enterprises and measures to stimulate the 'Big Society' are a further reflection of this underpinning philosophy.

The legacy of the current interface between social care and health

In designing Routes, we decided against taking a 'blue sky' approach to creating some idealised future for social care and health. It would be an interesting exercise perhaps, but ultimately of limited practical value for those working in the turmoil of real and stormy 'weather systems'. Instead, we sought ideas and insights from leading-edge thinkers and practitioners about the state of play on the ground, and then built that into our hypothetical but realistic social care and health system.

The simulation patch – an imaginary metropolitan borough in central England called Crafton – was designed to include a range of legacy issues that our sponsors had highlighted as particular impediments to establishing joined-up solutions to health and social care and support. These are summarised in Table 1 below, together with suggestions from participants as to how these situations might be turned into opportunities for improving health and social care for local citizens.

Table 1 Legacy issues in transforming health and social care systems

Issues	Opportunities for improvement
Joint Strategic Needs Assessments provide insufficiently granular information to really inform decisions about future investment of health and social care resources	Information needs to be available for different levels of aggregation - from whole council areas to neighbourhoods and GP commissioning consortia areas. Information also needs to be shared across organisations more freely. There should be greater use of predictive modelling of trends in needs and demand linked to resourcing and capacity requirements
Too much public money is tied up in buildings	There is scope to realise savings by reducing duplication in assets, both within the health sector and between health, social care and other public services. These assets can be redeployed to provide a new source of revenue income. NHS trusts can consider renegotiating the terms of private finance initiative (PFI) contracts to give greater flexibility in planning how they use space
Voluntary sector organisations have had their funding cut and feel they are being forced to choose between their roles as advocates and service providers	In many places, the voluntary sector is quite fragmented. While cuts to voluntary organisations may be a somewhat short-term response to achieving the necessary budget reductions, councils and health and wellbeing boards can consider how they can help voluntary organisations to reduce their operating costs and overheads by sharing infrastructure and back office support and improving management systems
The drive to improve procurement processes and contracting can inhibit collaboration between suppliers	Competition can be a lever for service improvement, but the procurement process and contract incentives can also be designed to encourage providers to collaborate with each other so that they can combine to offer a more integrated approach to meet client and carer needs
Approaches that engage local citizens in decisions about budget reductions reach a limited section of the community and have not always been transparent about the case for change	The new focus on the Big Society is an opportunity for more mature, deliberative dialogue with citizens and communities. Devolving some resources and responsibilities to neighbourhoods can also provide the basis for greater engagement
Health and social care regulators focus on organisational performance rather than on impacts and outcomes for service users. The standards used to assess community foundation trust applicants are proving a barrier to service integration	The performance regime will shift when Monitor's role is focused on economic regulation. With both regulators covering health and social care, there are opportunities to align the outcomes and operating frameworks with regulatory levers and incentives. There is a case for a single outcomes framework covering health care, social care and public health

The differences between the health and social care sectors: a source of tension or an opportunity for innovation?

Despite decades of policy initiatives designed to support greater integration between the health and social care sectors, progress has been patchy, with wide variations in performance. Routes participants felt that, on the one hand, there was a tendency for the differences between these sectors to be misunderstood, underplayed or ignored but, on the other hand, the differences can be deliberately exploited by one side or the other to protect their own position and prevent the achievement of integrated care.

While health and wellbeing boards may reach agreement about the outcomes that they want to achieve, or the groups that should be given greater priority or resources, they cannot get over the fact that the levers that the partner members have to achieve these ends and their respective responsibilities to local citizens are very different.

For example, local authority-funded social care services are subject to means-testing and rationing through eligibility criteria, whereas the NHS is still seen by the public as a largely universal service, with little charging. By contrast, the greater political legitimacy of local government may make it easier for these bodies to take controversial decisions than it is for health care commissioners. The tighter financial climate is likely to amplify some of these differences.

Local authorities and GP commissioning consortia have a shared interest in promoting the health and well-being of the citizens for whom they have a shared responsibility. However, health and wellbeing boards need to formulate strategies and plans that are based on a clear recognition of the *differences* between the governance and accountability of the health and social care sectors if they are to make best use of the assets and resources available. The financial situation has the potential to either exacerbate these differences and tensions or to incentivise new approaches to investment, demand and risk management that overcome these challenges. The following areas were identified as being either a shared area of interest or a source of tension between the partner members of health and wellbeing boards.

- The priority to be given to preventive, universal support, and who will fund it.

- Decisions about how best to stimulate and support community capacity and self-care.

- The degree to which real money can be devolved to citizens and communities to fund health services, care and support.

■ The consequences of raising eligibility thresholds for public funding and how best to support those who can no longer rely on local authority-funded care.

■ Decisions about the role of the social care and health sectors in supporting the wider life circumstances of clients (eg, housing and employment) that may impact on their health and care needs. For example, young people, or people with mental health problems or learning disabilities, are likely to be disproportionately affected by employment prospects in the economy, and by changes in benefits for disability and housing, in addition to any shifts in the way that health, care and support is provided.

The Routes simulation

An overview of the simulation

Simulations are effectively a simplification of the real world, so can lose their illustrative power if they are drawn too wide. Early on in the process, we decided to concentrate Routes on the health, social care and support needs of older people and people with mental health problems as exemplars.

The Routes simulation brought together around 50 senior clinicians, leaders and managers from public and private health and social care organisations, and people representing citizens and carers.

The simulation was based on a hypothetical but realistic 'patch' called Crafton, at a time, when many of the structural changes to social care and health had been introduced and the impact of the cuts in public spending had become all too real.

In the face of mounting concern about the interfaces between different strands of public sector reform, the Department of Health had launched an *Expert Review of Social Care and Health Futures*. The review was to be carried out by three independent advisory panels that brought different but complementary perspectives. The first (the professional panel) comprised health and social care commissioners and NHS and independent sector (for-profit and not-for-profit) providers. The second (the citizens' panel) comprised representatives of citizens, carers, advocates and third sector support bodies. The third (the policy panel) comprised people with a system-wide perspective such as researchers, regulators and policy commentators. Their task was to draw up proposals for social care support for older people and people with mental health problems that took account of the challenging financial situation and new arrangements for the commissioning of health and well-being and health care. To ensure that their proposals were grounded in the reality of delivering health and social care services, the advisory panels were asked to demonstrate how their ideas would work in the Borough of Crafton, a borough considered to have many of the typical characteristics and challenges that have beset social care and health systems across the country. The simulation participants therefore comprised the three advisory panels and a local expert group – people representing the citizens, commissioners and service providers in Crafton.

The independent advisory panel device enabled us to tap the insights of a diverse range of contributors from the social care and health fields. Inviting them to offer practical advice and insights for the Crafton system meant that we took the current financial and policy trajectory as a set of givens. The intention was also

to keep the discussion focused on positive ways of helping local social care and health systems to navigate the latest set of policy reforms. In contrast to the two previous Windmill simulations, in 2007 and 2009, which asked 'What will happen to the health system?', the Routes simulation considered the question, 'How can local systems make the best of these challenging circumstances?'.

The simulation was a means to trigger learning, rather than an end in itself, so the remainder of this chapter focuses on the main recommendations that were generated by Routes participants, rather than the details about what took place. As there was a good deal of commonality in the proposals from the three advisory panels and in the comments made by the local expert group, we have presented these as sets of themes rather than detailed points made by the different groups.

The simulation patch

The simulation focused on the social care and health system in Crafton – a large metropolitan borough in central England, serving 310,000 citizens. The council had reduced its net expenditure considerably in the previous two years to the tune of £46 million but was continuing to face pressures on budgets in most council departments. The simulation participants joined Crafton in 2012/13 following a decision to reduce the budget for adult and community services by 20 per cent over the next two years.

The Crafton system was, by most indicators, performing reasonably well. But it had already been forced to make some difficult decisions. It had put in a good deal of groundwork to support volunteering and to stimulate microenterprise, yet it had also had to cut back its funding to some voluntary organisations. It had set out some clear priorities for health and well-being but had yet to forge a whole-council approach to delivering them. Its flagship 'Supporting People' programme had been dramatically scaled back. The social care market was a developing one, as the borough had recognised it needed a more diverse range of products and services to respond to the personalisation agenda.

On the health side, the primary care trust (PCT) had been replaced by a single GP commissioning consortium. Despite achieving some early successes in streamlining services and reducing its commissioning spend, the consortium was facing growing demands from people with mental health and drug and alcohol problems, and because of the rising number of older people with dementia. Also represented in the system was a range of NHS and private and voluntary sector providers of housing, social care and support, and an advisory group comprising Crafton citizens.

Alternative routes to managing change across social care and health systems

The Routes participants were in agreement about the scale and nature of the change agenda facing local social care and health systems like Crafton. They were equally clear that there was no single 'eureka' solution to these complex challenges. Managing the combination of structural change, the realignment of responsibilities between the health sector and local government, and budget reductions requires very strong and trusting relationships between the local authority and GPs, between commissioners and providers, and between citizens and their representatives.

The complexity and timescales are such that it is highly unlikely that local systems will be able to establish a clear, compelling vision for the future that is capable of guiding or being applied consistently to all decisions. There may need to be compromises and decisions that do not fit precisely with the vision and values to which local systems aspire. However, the extent of such compromises, and the pace at which responsibility should be devolved to individuals and communities, divided opinion within the group.

There were different views within both the local expert group and across the advisory panels about how the situation should be addressed. Two contrasting viewpoints emerged.

One group took a strongly managerial perspective that recognised the need for immediate decisions to be taken to reduce expenditure while putting in place the conditions for a radical transformation in the way that people get care and support for the longer term. In this scenario – which we describe as 'control' – the 'managerialists' argued for better intelligence and evidence to inform the planning process so that they could make decisions with a more informed view about current and projected needs and spending, and the impact of alternative decisions. They also prioritised improvements in management systems, eg, for procurement, contracting and contract monitoring, and to make it easier for people to handle the financial aspects of personal budgets.

Streamlining assessments also featured as a way of reducing duplication between different organisations and providing citizens with a more joined-up approach to planning their health and care needs. It was suggested that the leaders of the various public bodies should come together at a leaders' summit to negotiate and agree public commitments about how best to balance total health and care resources and make the inevitable cuts, drawing on the experiences of the 'Total Place' initiative. The managerialists also highlighted the need to secure additional resources for health and social care. They argued for increases in co-payment requirements and formed alliances with housing associations to make better use

of housing resources and develop new forms of equity release, making it easier for people to tap into their capital assets to fund their immediate care needs.

For the managerialists, commissioning health care and support meant driving down prices through improved quality and efficiency and tight monitoring of contracts, and using all the flexibilities of joint funding and commissioning to get the best use of public money.

'Control' scenario

Quick and potentially unpalatable decisions will be made to ensure that social care delivers its part of the expenditure reductions that councils must make. Efficiency savings will be secured through tighter procurement, tough contract negotiations and better performance management systems. Despite nods to the 'Big Society', cuts will be made to community projects and third sector organisations, recognising that short-term expediency usually trumps longer-term sustainability. Personalised budgets will be cut, eligibility for public funding will be further tightened, and user co-payments will be raised.

When it comes to working with the new GP commissioning partners, the strategic plans for health and well-being will show a similar flavour of control, with ambitious joint objectives, council-wide targets, and a vast array of indicators. The NHS National Commissioning Board may push GP consortia to deliver savings by prescribing restrictions to services, squeezing providers through detailed contracts and tight performance management. The overall approach will be to use short-term, transactional changes to generate immediate savings.

The other group took a more 'devolutionist' perspective. They argued that the financial challenges across health, social care and housing, and the changes that will be introduced in the welfare system, could not be managed through a top-down approach. It would work only through a radical acceleration of personalisation and community engagement. The 'devolve' scenario was underpinned by a new form of mature, open and deliberate citizen engagement to enable citizens to understand and contribute to decisions about immediate cuts.

The devolutionists focused on maximising devolution of budgets to service users; this included devolving health budgets to people with long-term conditions, where this was feasible. Information and online booking and payment systems like 'shop for support' would be made available to all citizens – self-payers as well as those in receipt of local authority support. This approach should enable savings to be made on administrative costs, so a proportion of those savings would be top-sliced for investment in community development. Here, the devolutionists pointed to 'Big Society' initiatives such as incentives for volunteering, time banks,

and using each encounter with the health and care system to 'nudge' people to contribute to their communities. GP practices were encouraged to become community hubs where people would be able to access information and support from a range of sources, not simply the formal health and social care services.

The devolutionists also suggested that the local authority take on the commissioning support to the GP commissioning consortium, opening up the possibility of a single system being used for health and social care transactions. They recommended devolving a significant proportion of the public health budget to local communities/neighbourhoods so that local people could decide how best the resource should be used, working within a clear outcomes and governance framework and accountability to the health and wellbeing board.

'Devolve' scenario

The alternative approach is a radical and rapid realignment of the relationship between citizens and public services. Councils choosing this route will be 'managing less' but 'doing more' to support citizens in taking more responsibility for the resources used to support their needs and contributing to the effective functioning of their communities. Their attention will shift from a narrow focus on those entitled to publicly funded care towards improving the well-being of the whole local population.

This shift means: accelerating personalisation, devolving resources to communities or neighbourhoods; providing people with the tools, information and support they need to manage their care and for communities to self-organise; and facilitating a plural and dynamic supplier market, and incentivising health and social care providers to innovate and collaborate to secure better outcomes for people. At the interface between social care and the NHS, the focus will be less on writing joint plans and more on negotiated risk-sharing and budget-pooling between commissioners so that their combined resources can be used to best effect, for either individual clients or specific care groups. Priority will be given to investments that prevent or delay the use of formal services or enable people to regain independence after acute treatment. The overall approach will be longer-term, transformational change to secure sustainable improvements in productivity and better outcomes.

For the devolutionists, commissioning was about shaping and managing the market so that there was sufficient choice and capacity to meet citizen needs but also ensuring the right connections between providers so that they could offer joined-up solutions. While there would need to be a degree of competition

within the market, the devolutionists also argued for high levels of co-operation and partnering. They were comfortable with the concept of 'any willing provider' but stressed that the most successful providers would be partnering with other suppliers who offered complementary services or approaches.

There are two possible explanations for these contrasting perspectives. One factor may be the differing perceptions that people have about the risks involved in large-scale change and the most effective ways of managing that change. Both groups of participants were committed to seeing a future health and care system that has high levels of citizen engagement, both in decisions about their own care and support needs and also in macro policy decisions about resourcing and priorities. However, whereas the devolutionists felt that this approach was also a *means* of addressing the immediate financial challenges and tensions, the managerialists were not convinced that devolving budgets would solve these issues quickly and effectively.

An alternative explanation may lie in attitudes to the use of market forces in public services. The devolutionist future requires a richer and more diverse supplier market, which runs counter to the values that some people have about the importance of keeping public services in public management and ownership. It is worth noting that, since the community care reforms of the early 1990s, the majority of adult social care services are delivered through independent sector providers. In this sense, the social care sector is more at ease with the notion of 'any willing provider' than the NHS.

It may be that in places where there is a strong track record of close partnership, openness and trust between the health and social care sectors, rapid devolution is likely to work more effectively than in places where there are ongoing tensions and misunderstandings between the two sectors about their different responsibilities and obligations. The situation in Crafton, like many parts of the country, was somewhere between these two poles.

The dilemma for organisations adopting the managerialist perspective in the short term is how they make space to progress on the transformation agenda. Routes participants had a pragmatic solution. There needed to be parallel systems; short-term system improvement and financial balance needed to be led by different people with a different set of skills to those leading the transformation of care and support. The health and wellbeing boards, as system leaders, would need to balance and manage the creative tensions between these approaches. They would then adjust the pace of change according to local circumstances and the capacity and capability of local citizens and communities.

The key message for politicians, managers and clinical leaders is to make the shift from seeing current circumstances as a 'perfect storm' of challenges to social care

and health, to using them as the 'perfect opportunity' to fast-track to the 'devolve' scenario. This route is potentially the course of least resistance and the best means of securing better outcomes for citizens.

The 'devolve' scenario requires a different set of skills and behaviours at all levels – from public service leaders to the professionals and others involved in the delivery of care and support, and from the people who use health and care services. The pressure of time and resources means the only option is to 'learn by doing'.

The role of health and wellbeing boards in setting health, care and support strategies

Health and wellbeing boards have a crucial integrative role in establishing not only the strategic framework for health and social care but also the style and philosophy that will underpin the way the system will operate.

The Routes simulation highlighted that health and wellbeing boards need to take a very different approach to their task than some of the current strategic partnership arrangements between the health and care sectors. Effective health and wellbeing boards should:

■ work as a board of equal partners striving to achieve shared outcomes, as opposed to local authority officers and members trying to hold GP commissioning consortia to account

■ establish governance arrangements that are more open to public scrutiny and engagement. Meeting in community venues other than the town hall was suggested as one way of signalling a shift in approach. Sub-board arrangements at neighbourhood/consortium level were also suggested as a way of ensuring that local circumstances and differences are given appropriate consideration, and as a means of encouraging closer working between GPs and councillors

■ engage meaningfully with citizen groups and third sector organisations. Health and wellbeing boards need to use broad, deliberative engagement processes to help establish the vision, priorities and outcomes that are important to local citizens. The board itself must take clear responsibility for deciding how conflicts are resolved, either between community interests or between the statutory organisations

■ make routine use of citizen experiences to understand the impact of health and social care services on people's lives

■ redefine the local authority scrutiny role so that it focuses on specific issues and concerns (a select committee model) rather than attempting to oversee the whole agenda

- consider the leadership skills and behaviours required to work with the changing context of devolved responsibility, as well as the governance and accountability framework. Health and wellbeing board members will need to be more tolerant of uncertainty and ambiguity and more trusting that communities and individuals can play their role in the revised arrangements.

Health and wellbeing boards will need good data to inform their strategies and plans and establish an agreed 'balanced scorecard' of indicators so that they can both understand and monitor the impact and outcomes of investment decisions.

While the early iterations of Joint Strategic Needs Assessments (JSNAs) have been a step forward, most will need to be overhauled if they are to provide effective intelligence to inform decisions. JSNAs need to:

- concentrate on the issues, priorities and outcomes identified by the health and wellbeing board

- provide analysis at a finer level of social and geographic aggregation than the whole council

- include more predictive modelling and scenarios to enable alternative courses of action to be evaluated

- make better use of data from primary care and show how this links to people in need of social care support.

To help them support and utilise community capacity, health and wellbeing boards also need to establish better baseline information on neighbourhood assets such as the range of voluntary, community and faith organisations that exist, and the types of support they offer. This is something that could also be used as a resource for citizens – a directory of locally available expertise and interests.

Finding the early solutions to budget reductions

The financial situation facing public services is unpalatable for many, not least those who are most directly affected. But on a more positive note, widespread public awareness of public expenditure decisions in local government and health could be utilised as a 'burning platform' – an opportunity to make the case for radical shifts in the way care is delivered. While it is too much to expect that health and wellbeing boards can achieve a complete consensus around reforming health and social care, they may find it easier to gain sufficient acceptance of, if not support for, their plans during this difficult period.

Having completed several years of cost improvements, most public service organisations feel they have already picked the 'low-hanging fruit'. The front-loading of the cuts is an additional challenge. However, Routes participants

identified several areas where there may still be scope to secure cost reductions and productivity gains. The suggestions favoured by participants included:

■ reassessing social care client needs and levels of support

■ increasing co-payments

■ integrating commissioning support for social care and GP commissioning consortia

■ reducing duplicated assets across health and social care and potentially using them as a source of income generation

■ streamlining business processes and management systems

■ reducing duplications in assessments and devolving this function to providers where possible

■ workforce re-profiling.

It was felt, however, that these 'first loop' changes are unlikely to be sufficient in the medium to long term to meet the twin challenges of rising costs and demands. More fundamental 'second loop' changes would be needed.

Capable communities and empowered citizens

The simulation highlighted the need for more extensive, inclusive and imaginative approaches to engaging citizens. However, a history of poor prior experience of engagement practices in some places and heightened public awareness of the need for cuts in funding can make it difficult to get citizens to contribute their time and opinions. Some will be disillusioned or cynical about whether their input will have any constructive value. Others will be unwilling to engage in debates about cuts that they see as a foregone conclusion. It was suggested that local systems may need to try to draw a line under the old order and use different formats to engage people to signal a new way of working. Neutral external facilitation was felt to be helpful in brokering new relationships between public services, citizens, communities and clients.

A significant dilemma for Crafton and for many other places is how to provide ongoing support for voluntary sector organisations at a time when there is a need to both reduce resources and stimulate community capacity. Some reductions may be necessary or inevitable, but councils need to make these decisions with a more explicit picture of the role the voluntary sector will play – the balance between citizen advocacy and advice or service provider. For their part, voluntary sector organisations that take a service provision role need to recognise that they are unlikely to be able to avoid being subject to market disciplines and competition from other 'willing providers'. Local authorities can support third

sector providers through sensitive and non-bureaucratic procurement, business advice on responding to tenders, and facilitating alliances between third sector organisations and with other public and private providers.

Managerialists and devolutionists alike agreed that Big Society capacity will not emerge to the scale and extent required without support. It will require investment, both to stimulate people to contribute and to support initiatives, on an ongoing basis. The practical support measures that councils and GP commissioning consortia should consider include:

- encouraging mutual volunteering through methods such as timebanks/slivers of time marketplaces

- providing local space for groups and communities to associate

- developing navigation tools to help connect volunteering needs and offers locally

- funding community navigators that GPs and others can refer clients to. Community navigators can help connect people to the support available to meet their needs

- using GPs and other influential leaders such as community nurses, teachers or youth workers to 'nudge' people to connect with and contribute to community resources in their area.

Shaping the future market for health and social care and support

Driving forward personalisation in social care and support will require more diversity and capacity on the supply side. In the health sector, increasing choice and capacity may not be appropriate for some situations, particularly concerning people with rare or complex conditions.

Health and wellbeing boards should aim to reach an early agreement about how they want to use market levers and the circumstances where there should be competition for a market versus competition within a market. Irrespective of national policy, health and social care professionals and politicians can have quite divergent views and experiences about the value of competition and the role that 'for-profit' organisations may play. Having a wide range of suppliers of care and support theoretically offers citizens greater choice, but it is the range of support options that is of greater importance – there is little point having many different providers if they all provide the same or similar services.

As commissioners, councils need to consider the impact that choice and competition will have on clients and providers. Having a choice of personal care at home, for example, is of little value to people if none of those providing care in

the area have the capacity to offer support first thing in the morning or last thing in the evening. Equally, if there is a large number of competing providers for a relatively small market, it will be difficult for them to achieve economies of scale or take a risk to invest in developing their business.

Routes participants stressed how important it was for councils to help shape the market for growing numbers of self-payers, as well as those people who are eligible for local authority financial support. To do this, they need to be capturing, analysing and sharing information on the choices, experiences and aspirations of service users. Integrative platforms that provide users with information and access to different products and services, combined with consumer ratings, billing and invoicing functions, are starting to be offered in some council areas and provide a means of collecting information from self-payers that would be more challenging by other means. Providers also stressed they need better information about future needs, capacity and priorities so they can plan their businesses appropriately.

Traditional equity release schemes offered by insurers have not always offered consumers good value for money. However, an increasing proportion of older people who could potentially pay for their care have significant assets tied up in property. Housing sector representatives argued that councils and housing associations need to work together to develop attractive and flexible ways of unlocking these assets, both as a source of revenue and to provide a housing resource for potential tenants. Given the shortage of housing stock, rising numbers of households, and the funding constraints on social care, it was felt to be an area well worth exploring, both nationally and locally. Some felt that this might prove too controversial a policy for many councillors without a wider national debate about the use of housing assets to fund care in later life. There was agreement, however, that councils should encourage providers offering 'housing with care' into the local market. Many participants felt that housing-based models of care and support have substantial potential to promote greater independence, reduce reliance on formal services, and achieve better outcomes for people.

Micro enterprises, including those run by service users themselves, have a part to play in the delivery of care and support, but experience shows they are unlikely to flourish without business advice and support and, potentially, a source of seed capital. Councils need to be careful – where they have to take decisions to restrict access to social care support on the basis of means-testing – that they do not create disincentives for service users to set up or continue to run these enterprises.

There was some debate about what commissioning means in a system that is more geared toward self-directed support and choice. Social care providers argued that they were not risk averse, but a system run entirely on individual transactions or even framework agreements, with no guarantee of volume, may not be the most efficient approach, as it provides little incentive for providers to make long-term

investments in their business or to offer favourable terms and conditions to purchasers. Contracts are likely to have a continued role in the social care market, but will require councils to become more adept at predicting demand and capacity and structuring risk-sharing agreements with suppliers.

Aligning health and social care systems

There were four ways in which the simulation participants referred to the alignment of health services with social care and support.

First, there was alignment through *making services available in the same places*. Crafton, like many places, had a good deal of investment tied up in buildings, yet insufficient resource to support people at home. A rationalisation of the health and care estate is unlikely to release resources for reinvestment in the short term, as it may need some pump priming (eg, for removals, adaptations and dilapidations); but it should be part of the future agenda for health and wellbeing boards. It was recognised that, in the health sector in particular, the public can be overly protective of NHS buildings. Health and wellbeing boards may need to seize the opportunity of the 'burning platform' referred to earlier to encourage a stronger focus on care and support for people and communities rather than bricks and mortar.

In the health sector, some trusts have signed very long-term, inflexible private finance initiative (PFI) contracts for health estate, which may inhibit their ability to share assets with other public service bodies or shift services to community settings or direct to people's homes, which are less expensive options. The Routes simulation took place shortly after a mental health trust had announced the re-negotiation of its PFI contract. Participants suggested that there may be situations where it would be more cost-effective to secure an early pay-off of a PFI contract in order to gain greater flexibility over the way assets are used.

The second form of alignment was through more *collaborative planning of the total health and social care spend*, and greater awareness of the consequences of spending reductions on other budget lines. Several points were made here.

At a minimum, the health and social care sectors need to have a mature debate about which budget reductions will be made, and they need to agree how to mitigate the knock-on effects on other services and budget lines. There is an ongoing need and perhaps an even stronger case to use current devices such as pooled budgets and joint commissioning, although this may now prove more difficult where GP commissioning consortia and council boundaries are not coterminous. GP commissioning consortia may also need to be willing to use some of the commissioning budgets to fund support for people that may have traditionally been seen as the responsibility of social services.

Health and wellbeing boards may need to challenge GP commissioning consortia to consider the scale and pace of changes they make to services. Practice-based commissioning (PBC) proved effective where GPs concentrated on specific service redesign initiatives, but PCTs were available to commission the remainder of services that the PBC group chose not to concentrate on. GP commissioning consortia, as publicly accountable bodies, have to consider the total commissioning resource. If they are to have a significant impact on the way care is delivered by large acute and mental health trusts, a small-scale and sequential approach, in which individual pathways are changed, may not offer a sufficient incentive for providers to undertake a fundamental realignment of the way they work or to establish new relationships with supply chain partners. With their experience in large-scale commissioning and market management, local authorities have a good deal to offer by way of support and advice to GP commissioning consortia partners.

The third form of alignment concerned *designing health and social care services around individual client needs*. For people with long-term conditions, including mental health problems, and those who need both health and social care and support, commissioning should increasingly focus on whole life pathways. In the context of a person's whole life circumstances, a pathway is not a single best way but rather a menu of flexible options designed so they can fit around the individual. During the simulation, there was a good deal of discussion about the value of 'commissioning for outcomes'. The message here was that commissioners need to resist the temptation to design the precise pattern of care and the range of services that should be offered to clients in different circumstances. Defining outcomes that are important to clients ensures that providers focus on the right things, and allows them freedom to explore different approaches to deliver what clients want and need. The commissioning role in this context is about ensuring that citizens have been fully involved in defining that outcome framework, and on facilitating links between providers of different types so that they are able to offer an integrated approach to care delivery. The challenge, however, lies in establishing an appropriate way of funding providers – while local authorities and GP commissioning consortia may commission outcomes, at some point money is exchanged for the delivery of services. Pathway tariffs and the work that has been done to define a 'year of care' for people with different conditions offer potential frameworks that could help in joining up health and care budgets for individuals and securing a closer link between client outcomes and provider funding.

Finally, it was suggested that **establishing a shared management infrastructure** for local authority social care and health commissioning undertaken by GP commissioners could help to build greater synergy between these two systems.

Advice to health and social care and support systems

Building on the insights gained from the simulation, Routes participants went on to provide advice about how the triangle of challenges might best be tackled by the different interests that have a leading role in the planning and delivery of social care and support and health services.

Government

The government has set out the broad direction of policy for health and social care, although important details have yet to emerge following the government's decision to pause the further passage of the Health and Social Care Bill. There are some practical actions the government should consider in order to support the smooth implementation and integration of these different policy strands. They include:

- producing an integrated health and social care operating framework and integrated health, public health and social care outcomes frameworks

- encouraging a national debate about the contribution of housing-based models of care and ways in which people can access their housing assets to support their care needs in later life. The government should consider this in the context of its response to the recommendations made by the Dilnot Commission on the future funding of care and support

- ensuring that the emerging plural health and social care markets are regulated in a way that allows easy market entry and exit. Regulators also need to design their systems so that there is tolerance of variation in the types of services available across the country and in the way resources are used. As health and social care systems become more driven by consumer needs and choices, it is inevitable that the landscape of delivery is likely to become more diverse

- continuing to support shifts in public opinion about the appropriate balance between citizens and the state. The trend towards personalisation in social care has already taken several years, but we have not yet reached the tipping point where all citizens can take responsibility for their care or be supported to do this

- addressing tensions between its vision of a 'Big Society' and the effects of the fiscal reduction, noting that the notion of capable communities and

social capital envisaged in the government's Vision for Adult Social Care will require the stimulus of public funding support.

Citizens

The policy changes in health and social care emphasise the pivotal role that individuals will play in decisions about their care. This has the potential to deliver services that are far more in tune with citizens' social circumstances and change the power balance between professionals and the people that use health and social care services and support. But these positive outcomes require individuals and communities to be prepared to play their part. Citizens need to be:

■ proactive in defining their needs and preferences and in contributing to their own care and to the needs of others in their community

■ generous in sharing their experiences of different care and support providers to help others make informed decisions.

Local authorities

The key message for local authorities is that they need to move beyond short-term efficiency savings and transform their organisations so that they are more focused on 'enabling' rather than 'doing' (ADASS and LGA 2010) This requires a good deal of trust in communities and citizens, but 'letting go' does not mean doing nothing. Local authorities must take active measures to put in place the right information and management systems and to pump prime resources to create the underpinning infrastructure to give citizens and communities the confidence and safety to take on new roles. Specific actions they should consider include:

■ establishing health and wellbeing boards with a broad remit to cover all levers within the council's remit that have the potential to influence the physical and mental health of local citizens

■ reviewing the level of social care services provided 'in-house' and how they can make best use of their leverage as commissioners to shape the market

■ being creative in identifying and generating resources to stimulate community enterprise and support

■ working with GP commissioning consortia to establish a common approach to commissioning that taps the creativity of providers and incentivises them to design and deliver care that is in line with both general care pathways and individual patient/citizen journeys

■ making the necessary cuts in funding so that, as far as possible, they:

- are in line with the future vision of how the delivery of health and social care should operate post-2013

- are negotiated with other public service partners so that the impacts and consequences of the cuts can be managed

- do not contribute to higher levels of need/dependency in the medium to longer term – ie, they reduce or delay the need for formal services.

GP commissioning consortia

GP commissioning consortia have to map out a development trajectory that will take them to the point at which they can be fully authorised as accountable public bodies managing live commissioning budgets. In planning their development, GP commissioning consortia should:

- ensure that they have a detailed understanding of their population's needs and the pattern of inequality locally, and how these might be expected to change in the future

- develop their relationships with local authorities so that they become allies and partners. This will involve taking time to understand how the local authority works and makes decisions

- enable and encourage practices to be significant players in their communities

- build care pathways that link to patients' home and life circumstances, not simply their medical conditions. This is particularly important for people with long-term conditions

- develop skills in shaping and influencing the market for provision in addition to the formal processes of contracting and procurement. Local authority partners have some experience here that may be of value to GP commissioning consortia

- encourage provider innovation and patient engagement in designing health care. GP commissioning consortia need to resist the temptation to commission through detailed specifications of inputs, processes and outputs, and instead focus service providers on delivering better outcomes for patients.

Health and social care providers

Public and private providers need to recognise that the combination of competition, personalisation and choice will require them to be more flexible in the way they design their services so that they can deliver both quality and productivity improvements. Health and social care providers should:

- build better skills to gain a deeper understanding of customer needs and the impact of services on their experience and outcomes

- begin to market services directly to customers so that they can understand what is available and how it can address their needs

- make links with other providers as supply chain partners who together can offer an integrated approach to meeting people's care and support needs.

Concluding comments

The NHS and the social care and support system are facing a formidable triple challenge of achieving more with less, organisational upheaval as a result of the Health and Social Care Bill, and stronger public expectations of more personalised care.

It was clear from the Routes simulation that there is no new big idea, no 'eureka' moment that unlocks solutions to these profound challenges in a way that has eluded previous attempts. However, given the substantial experience and knowledge of the participants, it is possible to identify the strategic routes that might be followed to achieve change on the scale required – even though there is not always a consensus about which signposts are the right ones to follow.

The reduction in funding available to support health and social care is a shared challenge for both sectors. Local health and social care systems have to find a way of working together effectively if they are to minimise the negative effects of financial constraints on local citizens. This requires both local authorities and GP commissioning consortia to approach this task with a full appreciation of the differences between the financial regimes that underpin social care and health funding, and a willingness to use their combined resources flexibly and creatively to commission support for local citizens. In their commissioning role, both local authorities and GP commissioning consortia need to give greater attention to shaping the supplier market to get an effective balance between having a sufficiently diverse and responsive range of services to meet citizens' needs and preferences and a critical mass of provision that allows and incentivises improvements in productivity.

Transforming the way they engage with citizens – whether patients, service users, carers or community members – is a further shared challenge. It will be tempting for health and social care commissioners and providers alike to try to contain financial pressures by keeping a tight rein on resources. The Routes simulation highlighted that this is unlikely to be a sustainable solution; it is an approach that will inevitably be challenged by the individuals and communities that are intended to be at the centre of decisions about how social care and health should operate in future.

Health and wellbeing boards have a tremendous opportunity to steer a positive course through these twin challenges. Agreements about the vision for a more devolved and participatory system for health and social care should be an early priority.

Appendix 1: Routes participants

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Fiona Smith, Director of Planning and Performance, Whittington Hospital NHS Trust

David Sprason, Cabinet Lead Member, Adults and Communities, Leicestershire County Council

Ruth Sutherland, Executive Director, Scope

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Ian Turner, Chair, Registered Nursing Home Association

David Walden, Director of Adult Services, Social Care Institute for Excellence

Andrew Webster, Chair, Turning Point

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