# Insights from the HFMA/CIPFA integration summit

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The second **HFMA/CIPFA integration summit** took place against a challenging background: first, the increasing concern, reflected in mounting media attention, for the state of health and social care services; second, the just-issued report of the National Audit Office which concluded that there was little evidence to date that integration would in itself do anything to deal with the financial challenges, and that insofar as it might, the timescales would be much slower than the five year forward view requires.

The speakers took these challenges on board, seeing integration as a good in itself (for the patient/customer experience, for which there is evidence) and a facilitator for the changes which will save money – though it can't be said that there was any confidence that the current financial challenges in health or social care will be met by the actions now in train.

## Rob Whiteman, Chief Executive, CIPFA

**Rob Whiteman** opened the conference with an **overview of STPs** from his perspectives of heading a national finance body and chairing North East London STP. Speaking of the 'tectonic plates' which form the NHS, he identified a danger that the commissioner and provider savings built into QIP and SIP overlapped, leading to a danger of double counting. He emphasised that the task was not just to get at the relatively straightforward gains in 'technical productivity' – improving how money is spent by sharing services, redefining pathways etc – but also to improve 'allocative productivity' – spending in the right place to get better productivity overall. That meant spending more preventatively and upstream, which is not yet happening due to short-term pressures.

Those same pressures make it harder for people to develop the institutional trust which will enable them to transact better on a sustainable partnership basis. In East London, he said, the word 'sovereignty' had to be banned as partners strove to move towards genuine collaboration. He mentioned hearing some local authorities, on the back of a better constitutional settlement that means they can't overspend, giving the impression that they could manage health budgets better than health – he felt this is wrong as well as unhelpful.

In some areas, moreover, STPs have become a ‘toxic brand’, seen as secretive means of making closures. North East London is looking to move beyond that by rebranding itself with a social media presentation, and by setting up a ‘mayors and leaders board’ to help shape things, without making the formal decisions so that politicians (who must be involved, alongside the public) don’t need to feel they will be blamed for difficult decisions needed.

## John Jackson, former Director of Adult Social Services, ADASS

**John Jackson**, an accountant by training who has just moved on from ten years as a **director of adult social services**, concurred that integration is a good thing for care users, and to some extent for those who work in health and social care, but that attitudes create barriers. ‘Frank rows’, he suggested, are a healthy sign, in the context of a proper appreciation of the problems faced across the whole system.
Moreover, neither health nor local government are integrated internally. The key, he suggested, was to ‘work together’ to ensure that, for example:

- we are attuned to how people don’t, typically, make rational decisions about care, as they are at point of crisis
- we use a full and appropriate range of skills – better nurse than doctor, better phlebotomist than nurse to take blood samples, for example
- look at the lessons from the joint publication Stepping up to the Place, which sets out the ‘soft stuff’ keys to successful integration.

## Norman Lamb, former minister, Liberal Democrats

Liberal Democrat **former minister Norman Lamb** reminded delegates that the health and care system is essentially still the one designed in the 1940s for very different population needs which, despite plenty of subsequent reorganisation, was unlikely to match current needs. Problems are clear, including: two year waiting list for some mental health specialities; increasing numbers opting out by paying for faster treatment; over a million older people not getting the care they need and the number of people with three or more chronic conditions expected to increase by 50% by 2030. We fail to address the psychological issues of people with long term conditions, and we don’t address adequately the physical problems of people with mental health problems, who die 15 years earlier on average.

Partisan politics has spectacularly failed to come up with solutions – because all the solutions are difficult, and parties are too anxious to make the case for raising taxes and/or undermining the ‘national religion’ of the NHS, so no one says anything of substance. We need a process analogous to that led by Adair Turner on pensions, trying to get all party buy-in to have a mature debate with the public about the future challenges in health and care. He explained that 23 MPs from across the three main parties met with the government last week, with the prime minister agreeing to facilitate a dialogue.

Norman felt that the plethora of initiatives has burdened the local managers, but in the current system is often the only way to make progress. The Integration Pioneer Programme was a more enabling alternative of giving permission and removing barriers, but without the full confidence of NHS England it has been replaced by the more prescriptive Vanguard Programme.

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There remain barriers to an integrated system due to perverse financial incentives favouring additional acute activity, and the targets and standards regime also driving money into one part of the system. Information sharing also needs to go further with a 'duty to share' – people don't die from sharing information as they do from not having enough data available. We should also think about the social determinants of health, especially housing. It's scandalous if people are kept in institutions because there is no housing.

Ultimately, we need a single pooled budget, single commissioner, and democratic accountability in place. In answer to questions from delegates he explained he wouldn't support imposition of a single solution, rather being clear about the need for each area to set out a local model to achieve this by 2020; for example, some might choose to adjust a health and well-being board to become an executive board. We also need to relook at where the divide falls between free and means tested services: it is arbitrary whether you end up with cancer or dementia, but the personal financial effects are very different.

## Integration case studies

**David Northey, Head of Integrated Finance,** Plymouth City Council and **Caroline Rassell, Accountable Officer,** Mid Essex CCG described two different aspects of integration – one focusing on the technical role of joint finance teams and the other on the role of integrated teams. What was striking about the two presentations was both the positivity of the presenters in the impact they felt integration had brought about, and their emphasis on the importance of having a shared purpose or 'vision' in helping to overcome the inevitable challenges and difficulties.

David described how in Plymouth the vision of 'One System, One Budget' helped to ensure 'the right care, at the right time, in the right place' through the creation of one system which brings together the relevant partners supported by a clear governance system. A large integrated fund has been created from the formal pooled (Section 75) budget and the aligned budget for other related (but not formally poolable) areas of spend. The integrated fund covers a broad area of services including: public health, housing, leisure, adult social care, children's services, primary care, community and acute health services.

The close working of the finance teams of the local authority and the CCG had progressed to such an extent that staff felt comfortable with cross covering at meetings such as audit committee. A detailed financial framework is in place setting out the risk management risk share arrangements which had been key to developing trust between the organisations – but it was testament to the impact of the service changes put in place that the overall level of net risk payment had been as little as £39k at the end of 2015/16, the CCGs control total had been achieved, and the adult social care budget was in balance.

Caroline explained how many of the problems lie in moving straight to the 'what' and the 'how' rather than thinking about 'why' we are doing things. She quipped that in the NHS "forms often follow function" illustrating how the need to follow the laid-down processes and systems often becomes the driving force itself rather than acting as an enabler to change. Simply giving the name 'integrated team' had not changed previous working practices and a game of 'pass the parcel' often resulted as the various individual elements decided how best to deal with individual patients.

To encourage people to concentrate on what really matters, Mid and South Essex has invested a significant amount of time and resources working with staff and clinicians who will ultimately be responsible for sustainable delivery: noting the importance of understanding and agreeing on the 'why' because the details of what and how could follow afterwards. The 'LiveWell' campaign in Essex

does just what it says on the tin: helping people to live well through making personal choices about care and lifestyle. Through concentrating on the main areas of pressure, such as redesigning primary care to respond to the shortage of GPs, Essex is looking to change the way services are delivered on the ground.

## Integrated personal commissioning (personal health budgets)

**Mike Haslam, Senior Strategic Finance and Contracting Manager,** NHS England and **Sarah Day, Senior Strategic Finance Lead,** NHS England brought life to this technical subject, explaining in simple terms how personal budgets for patients are being rolled out in the NHS and how these differ from, while interacting with, the more familiar personal budgets in social care to create integrated personal budgets. They explained a number of actions in train to increase the number of individuals managing personal health budgets (or integrated personal budgets) from the current circa 4,000 to over 50,000 by 2020, and how they form a key plank in the delivery of the NHS five-year forward view.

The objectives of this initiative are to improve the quality of life for people with complex needs and their carers, to reduce the need for crisis management and to improve service quality and integration. The target groups are children and young people with complex needs, people with multiple long-term conditions (particularly frail older people), people with learning disabilities and people with significant mental health needs – such as those eligible for the Care Programme Approach. While the numbers involved is small relative to the total numbers accessing services, the overall resource usage of these cohorts is high, particularly in emergency services and there is potential for a win-win with increased quality and reductions in overall system costs.

## Ashley Brooks, National Patient Champion, NHS

The day concluded by hearing National Patient Champion Ashley Brooks share his reflections and experiences as a former patient and latterly an advocate for NHS development, highlighting the importance of communication and celebrating the crucial roles played by finance teams in health and social care in keeping the system running.

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