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Health Services Management Centre

Research that makes a real difference

All in this together? Making best use of health and social care resources in an era of austerity

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Acknowledgements

This paper was written following a University of Birmingham policy dinner held in London with a series of leading health and social care stakeholders and commentators, hosted by Vice-Chancellor Professor David Eastwood.

Although this was a private event, this policy paper summarises HSMC and Birmingham's contribution to the discussion. We are grateful to participants for their ideas and comments – although the conclusions drawn remain the responsibility of the author alone.

As suggested in the detailed references for this paper, key elements of the argument above draw directly on current and previous HSMC work such as:

- Glasby *et al*'s (2010) report on *The case for social care reform – the wider economic and social benefits* (for the Department of Health/Downing Street).
- Glasby and Dickinson's (2008) summary of *Partnership working in health and social care* (published by The Policy Press).
- Glasby *et al*'s (2006, 2010) policy papers on *Creating 'NHS local'*.

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About HSMC

HSMC has been one of the leading UK centres for research, personal and organisational development in health care for nearly 40 years. Commissioning of healthcare and provision of healthcare outside hospitals have become specific areas of expertise in recent years, underpinned by a continuing commitment to issues of quality improvement and public and patient engagement. This reputation has also started to extend to adult social care, with a growing track record in inter-agency commissioning and provision of health and social care services. HSMC has also developed a national reputation for both organisational and leadership development across all health settings. For further information visit: **www.hsmc.bham.ac.uk**

According to a survey of council social services departments published by the Local Government Association, more than two-thirds of respondents felt that financial deficits in NHS trusts are having a negative effect on council services. According to an accompanying press release:

> ***The financial deficits that are hitting NHS trusts are hurting social care services… according to a new survey… The findings also paint a pessimistic view of the next financial year with [many respondents] believing that the financial crisis will not improve in the coming year… There are grave financial pressures on both councils and the NHS that are starting to impact on the quality of service that people receive. This is not a name, blame and shame game… The only way we will overcome these worrying problems is to work closer together to deliver the right services to local people at the right time and in the right place.***

Shortly after, the NHS Confederation responded with a survey of PCT Chief Executives, suggesting that more than half of respondents had experienced a tightening of local authority eligibility criteria (with nearly three-quarters of these feeling this had an adverse impact on PCT services). Above all, these two overviews revealed three key issues:

1. Although both surveys stressed the importance of joint working, they were published as separate reports – and portrayed in the trade press and policy debates as evidence of a slightly adversarial situation (with each party running the risk of being seen as blaming the other for the issues at stake). Perhaps the fact that a more recent discussion paper on the same issues has been published jointly by the NHS Confederation and the Association of Directors of Adult Social Services (2010) shows how far we have come in recent years.

2. As far as anyone can tell, it is perfectly possible that both surveys were correct – that financial pressures in one organisation were having knock-on effects on the other agency, and that some areas of the country may have been focusing more on their own budget than on more creative discussions about how best to use both health and social care resources as effectively as possible.

3. Above all, these surveys were published in **early 2007** – at a time when health and social care spending was rising rapidly, and in an era of plenty. If financial difficulties were causing tensions in the relationship between health and social care in 2007, then the current economic outlook must seem very bleak in comparison.

Against this background, this policy paper seeks to contribute to an ongoing debate about how best to use health and social care resources to achieve the best possible outcomes in difficult financial circumstances. Although the current political and financial context is very challenging, this is probably an extreme version of a longer-term discussion about how to promote more effective joint working – and HSMC has been a key player in such debates (see, for example, Glasby, 2007; Glasby *et al*., 2006, 2010a; Glasby and Dickinson, 2008, 2009;

Ham, 2009, 2010; Ham *et al*., 2008). However, it seems undeniable that current financial challenges will add even greater complexity and urgency to these discussions. In response to these longstanding issues and in rapidly evolving circumstances, the paper highlights one approach that almost certainly will not work – and four that might.

The limits of structural 'solutions'

Over time, a common response has been to look to organisational restructuring as a potential solution. This is despite the fact that the literature on structural change and reorganisation suggests that (see, for example, Craig and Manthorpe, 1999; Edwards, 2010; Field and Peck, 2003; Fulop *et al*., 2002, 2005; Peck and Freeman, 2005; Social Services Inspectorate/Audit Commission, 2004):

- Structural change alone rarely achieves its stated objectives.
- In addition to stated drivers for the merger, there are usually unstated drivers (such as addressing managerial or financial deficits and responding to local or national politics).
- The economic benefits are modest at best, and may be out-weighed by unanticipated direct costs and unintended negative consequences (such as a decline in productivity and morale).
- Senior management time is often focused on the process of merger, and this can stall positive service development for at least 18 months (if not longer).
- The after-effects of mergers can continue for many years after the change has taken place.

On some occasions, there can be a tendency for policy makers seeking to develop and improve public services to look to the private sector for successful models and approaches. As Field and Peck (2003, p.743) have demonstrated, however, "one of the key messages in the literature on [private sector] mergers is that they have happened at an astonishing pace despite the fact that they do not appear to be beneficial when judged on economic criteria." According to one source, for instance, 54 per cent of acquisitions were regarded as failures (Coopers and Lybrand, 1993). Consequently, many commercial organisations considering mergers have increasingly begun to pay attention to the human (cultural) factors involved in this process, rather than simply trying to create better results by changing structures.

Despite the overwhelming evidence about the limits of structural change, it seems more than a little ironic to note that this still seems to be a common approach - particularly in the NHS. As Walshe (2003) has demonstrated, the NHS has been reorganised on an almost constant basis for the last two decades or so, with four main impacts:

1. The proposed benefits of each reform are never achieved in practice, as the system has always been reorganised again before any meaningful evaluation can take place.

2. Significant resources (both financial and human) are wasted (through the diversion of senior management time, new offices, new letterheads, new signs etc).
3. The process of reform is commonly circular, with similar structures and solutions re-emerging over time.
4. Constant change ironically makes the system highly change-resistant, as staff become increasingly cynical and short-term in their focus.

The overall result, as Walshe suggests in a vivid and depressingly accurate summary (p.108), is that the NHS is "an organizational shantytown in which structures and systems are cobbled together or thrown up hastily in the knowledge that they will be torn down in due course". Against this background, it seems unlikely that structural change (by itself) is likely to be a good way of utilising health and social care resources as effectively as possible – indeed one of the often quoted 'five laws of integration ' is that "integration costs before it pays" (Leutz, 1999). Following the recent NHS White Paper, there seems a definite case of history repeating itself, with the risk that joint working between health and social care becomes more difficult in the interim.

Focusing on outcomes

Rather than dictating how local health and social care organisations should be structured, our research into adult social care reform (Glasby *et al*., 2010b) reveals a potentially indefensible and unsustainable variation in the use of health and social care resources, with variable access to care, variable outcomes for patients and mixed performance in terms of value for money. This seems to be about much more than local areas making legitimate decisions about local priorities, with different levels of spend, performance and success in apparently similar-looking health and social care communities (see also Department of Health, 2009). Thus, the issue may be one of how best to tackle variations in care and to embed good practice in everyday practice – rather than an issue of 'integration' or of 'joint working' per se. Overall, our research in older people's services suggests that:

- There is wide variation in levels of spending on adult social care and the composition of this spending.
- There is also wide variation in the use of hospital services by older people with much higher rates of emergency hospital admission and bed use in some areas than others.
- Analysis of routine data by the Care Quality Commission (unpublished, personal communication) and Department of Health, (2009) shows that some areas appear to be using their resources more efficiently.
- Linked to this, our review of the evidence around scope for greater prevention, rehabilitation, personalisation and integration suggests that more efficient use of resources might mean lower than expected use of institutional forms of service provision; this is beneficial because such services are expensive and (in the case of hospitals) not especially safe places for older people to be.

As our previous review concluded (Glasby *et al*., 2010b, p. 69-70):

> ***In the face of this evidence, one of the policy challenges is how to generalise best practice, and particularly to free up resources that are spent in more institutional forms of support (for example, hospitals) for use on care closer to home, prevention, personalised support and independent living. In our view, this might best be tackled through greater transparency in existing variations in use of resources, with the Care Quality Commission and/or the point Audit Commission publishing available data and raising further awareness of inequities in care. The regulators also have a major part to play in drawing attention to these issues and stimulating action at a local level to reduce the variations that exist. It is also essential that lessons are drawn from areas that have made most progress and are shared more systematically.***

> ***As this and other work (Ham, 2009) suggests, there are different ways of making improvements in care and shifting resources away from institutional provision and into the community. It would therefore be unhelpful for government to prescribe a single pathway to reform and this should remain a matter for local choice making use of the legislative flexibilities already available. Instead, government should be prescriptive about the desired outcomes of care and hold local authorities/PCTs accountable for delivering these outcomes. Intervention by regulators and others should then follow from the consistent failure to deliver acceptable outcomes of care. It is likely that a basket of outcomes will be needed encompassing not only the use of health and social care services, but also outcomes that matter to service users themselves (see, for example, Glendinning et al., 2006).***

Translating this into practice might require some sort of 'Every Adult Matters' agenda, similar to the five high-level outcomes previously set out in children's services. This would give a clear sense of what success would look like, whilst allowing local services to organise in a way that makes best sense locally in order to achieve such outcomes. In the current policy context such an approach could be fully consistent with White Paper debates about focusing on outcomes rather than process-based targets, publishing transparent data about performance, establishing a national commissioning board and making regulation as fit for purpose as possible. In an era of GP-led commissioning, moreover, there may be scope to embed such high-level outcomes much more fundamentally into future GP contracts and the Quality and Outcomes Framework, trying to find ways of holding the whole system to account for its achievement (or otherwise) of these key outcomes. In an era of resource constraint, this might also help to provide something of an overarching narrative about what health and social care are trying to achieve for local people (and equally what is beyond the remit of local health and social care).

Social care as social and economic investment

Although policy makers have pledged to increase spending on frontline NHS services, the corresponding danger is that other public services that support the work of the NHS may experience even greater cuts. Thus, a policy measure that might look positive at first glance, could actually end up being self-defeating – a form of false economy. In work commissioned by the Department of Health and Downing Street (Glasby *et al*., 2010b), our previous research has suggested that spending on adult social care should not be seen as 'dead money' that we can no longer afford following the recession – but as a form of social and economic investment that can improve people's lives whilst also generating significant savings in other areas of the welfare state. Having modelled three different scenarios for future spending and reform, the report suggested that:

- It may be possible to save up to £1.20 on emergency hospital bed days for every £1 spent on prevention.
- **If** some of the gains from high performing integrated health and social care communities could be achieved more generally, there may be scope to achieve 2.7 million fewer hospital admissions among the over-65s each year (a 22% reduction overall).
- Supporting social care service users to engage in paid employment could generate additional earnings of up to £800 million each year plus a reduction in benefits spending of £300 million (as well as extra income from tax and National Insurance).
- Greater support for carers could lead to additional earnings of £1500 million for working carers.

Thus, any future scenario in which health services were protected but adult social care budgets hit hard could undermine key NHS priorities – as well as damaging our ability to achieve these wider social and economic goals. Even more importantly, future policy will need to find ways of encouraging community health and social care to invest resources in longer-term preventative work, even though the benefits might accrue to different agencies. Over time, this might involve finding ways of incentivising more preventative social care and community health spending in order to reduce the amount of money spent in acute care and via the social security budget – with all the complexities and controversies that this might entail.

The power of personalisation

Following promising early results, all three main political parties are committed to rolling out direct payments and personal budgets in a fundamental reform of adult social care (see Glasby and Littlechild, 2009 for a summary; see also Poll *et al*., 2006; Hatton *et al*., 2008; Glendinning *et al*., 2008, 2009). While this is debated in more detail elsewhere (see **http://www.hsmc.bham.ac.uk/work/personalisation_health_social_care.shtml**), the early evidence suggests that being clear with people how much is available to spend on meeting their needs and allowing them greater control over how these resources are spent can lead to:

- A greater sense of choice and control over people's services and hence over their lives.
- Greater satisfaction, greater continuity of care and fewer unmet needs.
- A more creative and innovative use of scarce resources.
- A possible reduction in the costs of expensive, complex care packages and scope to reinvest in lower levels of support.
- Greater use of community-based forms of support and a reduction in use of institutional service models.
- A sense of being more fully connected to people's friends, families and communities.
- The ability for people to have their needs met in a way that helps them make desired changes in their lives.

While the pros and cons of personal health budgets are debated elsewhere (see, for example, Alakeson, 2007; Glasby *et al*., 2009), it is possible that a more integrated system of health and social care personal budgets could allow people to join up their own care and support, making best use of scarce resources without the need for more top-down organisational or structural changes. In the longer-term, such an approach might also help to promote a greater sense of transparency and entitlement, of rights and responsibilities, and of citizenship – with people no longer seen as passive recipients of other people's services, but as active citizens helping to co-produce their own solutions and support. In addition to using current health and social care resources in new ways, such a cultural shift might also allow us to find ways of building on people's (often untapped) skills, strengths, aspirations and networks – approaches which seem fully consistent with greater public engagement around the difficult spending decisions that may need to be taken and with current debates about 'the Big Society'.

Creating 'NHS Local'

In previous policy papers (Glasby *et al*., 2006, 2010a), HSMC has argued that the NHS and local government need each other now more than ever:

- With local government tasked with being responsible for 'place-shaping' and for promoting social and economic well-being, it is crucial that local authorities have a strong relationship with and influence over local health services. Indeed, people in around 80 per cent of local authorities suggest that the quality of health services are either the first or second most important factor in making somewhere a good place to live (Lyons, 2006, p.22).
- Perhaps more controversially, we have argued that the NHS needs to learn from the best of local government if it is to be seen as the locally legitimate organisation to take some of the very difficult decisions that need to be taken (especially in a challenging financial context). When downgrading an A&E department or deciding whether or not to fund expensive new medications, it is not just the technical aspects of the decision that matter, but the ability to be seen by local people as the locally legitimate organisation to take such difficult decisions in the first place. This is an issue of place, of identity and of legitimacy – and it has been very difficult for NHS organisations to have this kind of relationship with local people over time due to the national nature of NHS accountability and due to a series of changes in geographical boundaries.

If this is the case, our *Creating 'NHS Local'* work suggests the need to more fundamentally rethink the nature of the relationship between the NHS and local government. Having reviewed options such as direct elections to NHS boards, membership of Foundation commissioning trusts or hybrid models such as police authority or University governance structures, our 2006 policy paper in particular emphasised the benefits of a local government-led approach. This might involve integrating both health and social care commissioning into local government, leaving PCTs intact if appropriate as provider organisations. This would have the advantage of separating commissioning and provision, whilst also integrating health and social care, promoting health and well-being and increasing local democratic accountability. With the NHS on the local ballot box, moreover, such an approach could also help to reinvigorate local democracy and attract new people into local politics and debates. While our 2006 and 2010 papers explore these issues in more detail, the key issue is probably our diagnosis of the problem to be solved, rather than the actual solutions we put forward. Of course, such a proposal seems very consistent with the emphasis of the 2010 White Paper on local democratic legitimacy (Department of Health, 2010) – although it remains to be seen exactly what mechanisms will be put in place in practice to enable greater local democratic oversight of local health services.

What next?

Behind the four mechanisms discussed above is a sense that current approaches to spending health and social care resources will be insufficient to respond to the current financial, demographic and social challenges we face. If the NHS and local government are going to find a positive way forward then they will have to avoid some of the issues raised at the start of this paper in the two 2007 surveys. In the past, our experience suggests that health and social care policy has often tried to change frontline behaviour through **the power of ideas** – telling people why they should practise differently and hoping that this will alter what they do. In reality, this seems a very limited way of trying to change the system, and its impact has been minimal. In the NHS in particular, we have often sought to change services by changing **structures** – but (as discussed above) this has tended to damage local relationships, to give only a false impression of change and, ironically, to make some staff more change resistant. More recently, there has been growing debate about how to change behaviour by changing the **incentives** that govern the system – and current discussions about GP-led commissioning are in part a response to the desire to find stronger incentives to engage clinicians in leading and changing the system. In contrast, there has been a lot less said about ways of changing behaviour by trying to change the underlying **accountabilities** of local services and of health and social care professionals (although the recent White Paper has some positive statements about this and further detail is awaited). While this paper has focused on four promising approaches to promoting more effective use of joint resources, deep down many of these mechanisms seem to rely on changing the accountabilities on a number of different levels:

- Between services and local communities
- Between local agencies and professions
- Between the state and the individual

Ultimately, the main contention of this policy paper is that something fundamental needs to change if health and social care are going to survive, adapt and ultimately prosper in the current financial context. What will not work is simply doing more of the same. Borrowing a quote often attributed to Einstein: insanity is "*doing the same thing over and over again, and expecting different results".*

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