Driving improvement and innovation in care

Local Government Association

Stepping up to the place

Part A: Review of the vision

October 2018

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1   Introduction

The Local Government Association (LGA) with its partners NHS Confederation, NHS Clinical Commissioners and the Association of Directors of Adult Social Services (ADASS) published their shared vision for integrated care Stepping up to the place in June 2016. Since that time there has been significant further work carried out across the country. This has developed our understanding of what good looks like in terms of delivering health and wellbeing outcomes for local populations and necessitated a refresh of the vision.

The LGA commissioned the Institute of Public Care at Oxford Brookes University to undertake an evidence review, which is intended to support the refresh of the shared vision, as well as provide an overview of current practice within this agenda. The review explored two questions:

- Is the original vision still valid given the current context, and learning from practice since 2016?
- Where are we now in terms of delivering the vision? What is the experience across England, what are the barriers, and what are the enablers?

The review report is provided in three sections:

Part A: Review of the vision. This provides a summary of the findings from the evidence review and explores the implications of these for the vision.

Part B: Evidence review. This sets out the review of evidence in detail, providing examples to illustrate current practice, the barriers and the enablers.

Part C: Case studies. These are a series of new case studies describing current experience and good practice in delivering integrated care.

This evidence review was carried out between March and August 2018, and considered three main sources of evidence:

- Published material including case studies or examples as well as evaluations.
- Material available but not published, as provided by the LGA.
- Discussions with individual case study sites either to clarify or update published material or to enable the development of new case studies.

Given the scope and complexity of the integration agenda, and the range of activity being undertaken across the country, this evidence review provides a sample of the

evidence and focuses, to a degree, on sites known to be developing good practice in specific areas rather than carrying out a comprehensive mapping of activity. It is important to note that due to the relatively short time scale for carrying out the review and the scarcity of information on impact, it is not possible to gauge the prevalence of these characteristics.

Stepping up to the place describes the essential characteristics of what good looks like in terms of improving people's health and wellbeing outcomes. For the purposes of this review these characteristics have been grouped across three themes:

Leadership and accountability

1. A clear vision, over the longer term, for achieving better health and wellbeing for all, alongside integrated activity, for which leadership can be held to account by citizens.
2. A shared commitment to improving local people's health and wellbeing using approaches which focus on what is the best outcome for citizens and communities.
3. Locally accountable governance arrangements encompassing community, political, clinical and professional leadership that transcend organisational boundaries, are collaborative, and where decisions are taken at the most appropriate local level.
4. Locally appropriate governance arrangement which, by local agreement by all partners and through health and wellbeing boards, take account of other governance such as combined authorities, devolved arrangements or NHS planning requirements.

Delivering integrated care

5. Services and the system are designed around the individual and the outcomes important to them and developed with people who use or provide services and their communities.
6. Everyone – leaders, practitioners and citizens – is committed to making changes and taking responsibility for their own contribution to improving health and wellbeing.
7. A shared and demonstrable commitment to a preventative approach, which focuses on promoting good health and wellbeing for all citizens.

Shared systems

8. Common information and technology – at individual and population level – shared between all relevant agencies and individuals and use of digital technologies.
9. Long-term payment and commissioning models, including jointly identifying and sharing risk, with a focus on independence and wellbeing for people and sector sustainability.
10. Integrated workforce planning and development, based on the needs and assets of the community, and supporting multidisciplinary approaches.

This review of the vision (Part A) gives a summary of the findings divided into three sections that match the three themes above. The overview of the findings from the review is followed by a discussion of the implications for the refresh of the vision.

2   Overview of findings

This section considers the findings from the review of evidence as it relates to the themes and characteristics of an effective integrated care system.

2.1   Leadership and accountability

The review found significant evidence of activity driven by formal governance structures, although only one structure, the health and wellbeing board, has a statutory responsibility for the integration agenda, including oversight of the Better Care Fund. However, despite the profile of these formal governance structures, the evidence suggests that as important, if not more important, are shared leadership behaviours, values and cultures. Also vital is leaders having an appetite for integration and the determination to make it happen.

The key characteristics of effective leadership are:

- Having a shared vision and purpose that is focused on improving people's health and wellbeing, and communicating this widely (National Audit Office, 2017). The evidence supports the importance of having a shared vision for what is being sought through the care system, and this is best articulated through outcomes for citizens and communities (Shared Intelligence, 2017).
- Developing a culture of shared behaviours and values, such as mutual respect and trust, not only amongst leaders but at all levels. Doing this can be through informal meetings, job swaps, and organisational development (The Kings Fund, 2016).
- Demonstrating systems leadership (The Kings Fund, 2015). This includes: working in collaboration, distributing leadership and enabling other people to act; being prepared to give up some of one's own power and control; equality amongst the leaders of different organisations/sectors, without one organisation dominating; stepping outside 'organisational thinking' and focusing on the broader needs of 'place' and how these can be better addressed by combining resources. Alongside the commitment to place, it is essential to put the person at the centre to ensure they have more choice and control around how their health and care needs are met (Local Government Association, 2014).
- Ensuring that new ways of delivering integrated care are evaluated to enable evidence-based decision making and to build on pockets of excellence to deliver better consistency across the system[1].
- An inclusive approach to the governance, i.e. beyond health and social care to wider system partners, and in terms of health, to include GPs, community health providers and the community and voluntary sector.
- An understanding that this is not something that can be created overnight, and that it should be allowed to develop and emerge at a pace that suits local circumstances (National Audit Office, 2017). For instance, creating a new governance structure will not solve issues immediately or without the other characteristics being in place. It may well be that a more robust approach is to develop the formal governance arrangements after the non-structural elements are in place.

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[1] See, for example, the Nottinghamshire case study

⚠ An understanding that there are and will be different routes into delivering integrated care, and these will be dependent on the needs, assets and views of local communities, history, funding opportunities, and local circumstances.

Whilst individual boards and partnerships appear to be beginning to develop an understanding of the impact of their work on outcomes for local communities, this is an emerging picture, often focused more on outputs at a systems level (such as delayed transfers of care) rather than health and wellbeing outcomes for individuals.

In terms of accountability, there is a tension between the development of governance arrangements which cover large geographical areas, and the strengthening of accountability to local communities (London South Bank University 2017). In recent years there has been a proliferation of governance structures including health and wellbeing boards, sustainable transformation partnerships, devolution, integrated care systems. These are described in detail in Part B, and the examples demonstrate that different arrangements can work as long as the effective leadership characteristics described above are in place. However, for services on the ground, being accountable to multiple regulators with different performance management targets, systems and cultures can create barriers to delivering integrated care.

We found positive examples where areas are seeking to build and maintain community relationships, whether this is through active community engagement in governance activities, or through active pursuit of the principle of subsidiarity. An example of this is the development of 'mini' health and wellbeing boards covering GP localities in Dorset[2], making small scale place-based plans and responsible for local decision making. However, it is not clear to what degree this has been recognised as a critical feature of integrated care, nor of its effectiveness being actively evaluated.

The evidence suggested that effective integrated care systems are finding ways to work around regulatory systems that are not designed for integrated organisations or services. This is not necessarily easy and requires a shared focus on the outcomes around place being sought, and an agreed approach to resolving potential conflicts across regulatory systems (Health Foundation 2016). Less top down control and more local freedom would also be helpful, as would shared incentives to encourage integration.

2.2   Delivering integrated care

The evidence is clearly highlighting that there are a number of key enablers that are driving the development of transformed care systems and better health and wellbeing for all. These can be defined as follows:

⚠ Taking a wider view of health and wellbeing for individuals and communities and focusing on prevention and early intervention. This includes shifting resources and care into the community to help keep people well and at home and supports a more sustainable approach to managing growing demand for health and care services. However, while we found positive examples of prevention[3], there is also some

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[2] See the Dorset case study
[3] See, for example, the North East Lincolnshire case study

evidence that suggests this can be challenging to put into practice (Policy Innovation Research Unit, 2016).

- Working at a more local level, whether this is with individuals, communities or taking a place-based approach. This includes developing an understanding of local needs, how services are commissioned, designed and developed, and how services can be delivered differently by integrating and moving care into people's own communities[4].

- Developing a different relationship between individuals, local communities and professionals working with them, centred around the individual, and tapping into their current and potential strengths, skills and capabilities which shifts power and responsibility, and taps into a wider pool of resources. The role of community and voluntary organisations is growing in importance as statutory services shrink and they take on more of a role to divert people from care services such as care navigators, health trainers, health champions, and as providers of socially prescribed activities and support (Social Care Institute for Excellence, 2018).

- Using "I" statements to articulate and promote the importance of the design and delivery of care being personalised to an individual.

- A commitment to co-production which enables individuals receiving services to have a real and equal voice, particularly at the start when the vision is being formed. An example is the work done with local people in Croydon to choose outcomes that sit at the heart of their vision[5].

- Joining up assessment of care and support needs and/or integrated budgets to give people more choice and control over their lives.

2.3   Shared systems

This section has considered the evidence at a high level across a range of whole system enablers. Whilst a more detailed analysis would provide a greater understanding of the significant variety of approaches being taken in these areas, there are themes emerging which relate to the vision:

- Developing shared outcomes (as opposed to separate organisational targets) to inform commissioning activity creates and supports a shared vision for integrated care. It provides a mechanism which helps develop a different relationship between commissioners, providers and citizens.

- The benefits of commissioning across a system are embedded within the recently published Integrated Commissioning for Better Outcomes Framework (Local Government Association and partners, 2018). An example of where this has worked well in practice is Rochdale's newly commissioned and re-designed transformative model of Intermediate Tier Services.

- The Better Care Fund has been successful in incentivising joint working in places, and this in itself will support the development amongst partners of a greater understanding of different parts of the system as well as, potentially, of building transparency (National Audit Office, 2017). However, it should be noted that in other areas the top down nature of the Fund has undermined partnership working.

- Budget sharing mechanisms are seen as a way of creating opportunities for taking joined up or integrated approaches to the commissioning and delivery of services. They require partners to resolve the challenges around risk sharing, as well as

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[4] See, for example, the Rotherham case study
[5] See the Croydon case study

requiring a clear understanding of expenditure across the system on specific issues. An example of where this is working in practice is Northumberland's integrated funding stream for the frail elderly pathway (Local Government Association, 2016). Further investigation is needed to explore how widespread these arrangements are and what might enable further development.

- The availability of the workforce is a major challenge for the delivery of integrated care, but there is limited evidence of the development of integrated workforce planning (The Kings Fund, 2016). However, there is more evidence of workforce development that either takes an integrated approach to its delivery or is designed to develop new behaviours and skills as needed to work in an integrated system[6]. In addition to developing new behaviours and skills, there is a far more basic and urgent workforce need: that is to plan for the workforce across the system. This will ensure organisations are not competing for the same limited pool of staff (iMPOWER, 2018).

- Whilst there is evidence that organisations are beginning to tackle the challenge of information sharing across systems this is still in relatively early stages. It is, however, widely recognised as a major enabler for the delivery of integrated care. There is limited evidence of areas using information technology to support whole system commissioning, nor does it appear to have been recognised as key to the delivery of integrated care. Information technology as an enabler for integrated working is also relatively under-developed in terms of the evidence found (Institute of Public Care and Local Government Association, 2016).

3   Implications for the vision

3.1   A changing context

The shared vision for integrated care was developed in 2016 to support a change of gear: "*the imperative to integrate and transform has never been greater*". The level of challenge at that time was considered significant, due specifically, but not only, to the "*unprecedented pressure on funding*" (NHS Confederation, 2016, p.8).

It is worth noting that since then the environment in which health and social care organisations are operating is significantly more challenged. The impact of the Brexit referendum on the health and care system is not yet known but it has created a climate of uncertainty, particularly around the potential impact on the workforce. Health inequalities appear to be rising. Data across 15 indicators from the public health and NHS outcomes frameworks shows that inequalities on all 15 indicators, which include for example life expectancy, mortality rates for cancer, and cardiovascular disease, and access to GP services have widened since baseline measurement in 2010/12 (The Kings Fund, 2018). Funding pressures are frequently headline news, whether this relates to the NHS or to local government, or to health and care provider failures. Given the challenges, one of our findings has been that while there is a recogntion of the importance of transforming health and care systems through developing integrated approaches, this has not always been translated into change on the ground. In other words, there is a gap between rhetoric and reality.

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[6] See, for example, the Plymouth case study

3.2 Barriers to integration

Some of the key barriers that need to be considered in relation to the vision include:

3.2.1 Funding

Pressures facing local services are significant and growing. Transforming systems in a way that will really make a difference needs financial support. In a recent LGA survey, 33% of the council leaders and cabinet members for adult social care who responded identified financial challenges as the top barrier to integration (Local Government Association, 2018, p.67). It is worth noting that Manchester has acknowledged that being able to access its share of the national sustainability and transformation fund to pump prime improvements in care, has helped enable the area to make faster progress.

3.2.2 Timescales

The pressure to develop and implement plans at pace and demonstrate positive impacts quickly is not helpful. A carefully planned and step by step approach, testing new ways of working in a small way first leads to more sustainable and evidence based change. It takes time to change behaviours and cultures which are at the heart of the new approaches. Involving people from all parts of the health and care system particularly clinicians and frontline staff, as well as local communities and their elected representatives in the planning is more likely to make change happen but is time consuming. Developing measures of success and testing whether the new approaches are working is vital as to date there is still a lack of widespread demonstrable evidence that the delivery of new integrated care models is having a positive impact on the individual. This too takes time.

3.2.3 Change in emphasis nationally of the purpose of integrating health and care

The original goals for integration included health and social care joining up to deliver better prevention and public health to keep people well, both to enable a better quality of life but also to reduce demand for costly treatment and support. However, in response to the worsening state of public finances, the emphasis has shifted over time to how the new models can bring the NHS into financial balance (quickly). For example, measurements of success in the Better Care Fund are now mainly focused on reducing pressure on acute hospitals.

3.2.4 Regulation

Currently, regulation is largely organisation based rather than looking across the system. There is no one set of performance measures, outcomes frameworks or inspection regimes. Being accountable to multiple regulators with different performance management targets, systems and cultures creates obvious barriers to delivering integrated care. The move towards more top down command and performance management from above is equally cumbersome and inhibiting on local creativity to find the right solutions through a bottom up approach.

3.2.5 Split accountability

While social care is accountable to its local communities through the democratic processes of local government, the NHS is accountable upwards to NHS England, and some question the democratic deficit that this implies. Having two separate plans (sustainability and transformation partnerships (STP) and health and wellbeing strategies) that focus on improving the health and wellbeing of local populations, overseen by two separate bodies, is not the best starting point for an integrated

approach. Even where areas have managed to align the two and create partnership boards, the bureaucracy involved is inefficient and unhelpful.

3.2.6   Workforce

One of the biggest barriers to integrated care is the difficulty of recruiting and retaining staff in the health and social care sectors. Plans for innovative new ways of working will fail if the right staff are not in place. Strategic system-wide workforce planning is needed to address shortages in the health and care workforce. This will ensure organisations are not competing for the same limited pool of staff and enable development opportunities across local areas.

3.3   Forthcoming legislation

The Social Care Green Paper is expected to describe a transformed system in line with seven principles (Department of Health and Social Care 2018), which include a commitment to integrated care:

1. Quality and safety embedded in service provision
2. Whole-person, integrated care with the NHS and social care systems operating as one
3. The highest possible control given to those receiving support
4. A valued workforce
5. Better practical support for families and carers
6. A sustainable funding model for social care supported by a diverse, vibrant and stable market
7. Greater security for all, for people of all ages with social care and support needs

Commentators highlight the difficulty of the task ahead "*the case for change is overwhelming – patching up the current system would be costly and would not tackle its fundamental flaws… there is no silver bullet – the road to reform will be difficult and costly, whichever option is chosen*" (Simon Bottery, 2018).

3.4   Implications of the evidence review

The vision for integrated care has been articulated by the LGA and partners as key characteristics displayed by an effective care system. This review has explored whether these characteristics are still relevant based on evidence found of approaches being taken across the country, including evaluative work where appropriate. The following commentary provides the researchers' views of the implications of this review for the proposed refresh of the vision.

3.4.1   Leadership and accountability

- There is a strong sense of the importance of effective leadership. By this we mean a different kind of collaborative leadership focused on place and people, not organisation. This style of leadership is based on honesty, trust, and respect for everyone's unique contributions.
- The original vision for shared leadership and accountability still stands. However, rather than focusing on governance arrangements and structures, we recommend that the emphasis shifts towards shared leadership behaviours which include:

distributing leadership and enabling other people to act, being prepared to give up some of one's own power and control, stepping into each other's shoes to build mutual understanding and trust. Leaders are responsible for role modelling these behaviours and ensuring that they become embedded at all levels across the system to change unhelpful cultures and attitudes. Organisation development for all staff can be a helpful tool to make this happen. Effective leadership creates the right conditions for change and transformation to integrated ways of working that deliver improvements for people and places.

- The evidence supports the importance of having a shared vision for what is being sought through the care system, and this is best articulated through outcomes for citizens and communities. Evidence suggests the understanding of what is being delivered is less robust, and there is less evidence of the impact of effective leadership arrangements or behaviours. Our recommendation is that within the characteristics of effective leadership there should be agreement about how systems will measure impact of effective leadership as expressed in the experience of the individual receiving a service (not impact on systems).

- The importance of health and wellbeing boards is specifically mentioned in the vision for effective governance arrangements. We found examples where the board is playing an effective role in bringing key players together and driving the vision for integrated care, using its statutory responsibility for overseeing and signing off Better Care Fund plans to ensure money is spent wisely to improve outcomes for local people in a difficult financial climate. However, in other localities the board is not necessarily driving the agenda and, in some places, sits in the background with other joint or integrated bodies taking the lead. The approach will reflect local history, local circumstances, and, as importantly, which leaders are driving the agenda. We found evidence of some health and wellbeing boards taking a more flexible and pragmatic approach to 'place' with some agreeing to act come together across STP or Integrated Care System footprints on strategic issues, and others agreeing to create more local boards reflecting local communities. This is what the existing vision already says. The key point is that the focus remains on finding the best ways (within different structures) to be accountable to local communities and the individual.

3.4.2   Delivering integrated care

- The evidence supports the importance of designing the care system around the individual and taking co-productive approaches. It is less clear that this is happening consistently across the whole system, or consistently around the country.

- The importance of changing the relationship between leaders, practitioners and citizens with co-production and taking person-centred and asset-based approaches is clear within the evidence. There is less clarity about the extent to which this has been implemented successfully or the impact it is having on the experience for the individual or the outcomes they achieve. We recommend that the characteristics within the vision could be strengthened to more clearly reflect these approaches.

- There are examples of local areas developing "I" statements to articulate the impact of the transformed system, and there are national "I" statements that could be incorporated in the vision. The vision as it stands is not strong on the experience for the individual and this may be a way of improving this. For example, there is little mention of the experience for individuals of services as 'seamless' which arguably is a key characteristic of integrated care.

⏏ Whilst the vision implies the inclusion of both physical and mental health and wellbeing, the evidence is not always clear that these are given equal weight or consideration. It may be worth being explicit about this within the characteristics.

⏏ It is clear from the evidence that there are many approaches and models being adopted, apparently effectively, in terms of moving towards integrated care: different places are taking different journeys. These are ideally driven by local circumstances, but can be a response to funding opportunities, and even the interests of individual system leaders at a given time. It would be helpful for the vision to clearly articulate the message that there is not a 'one size fits all' approach to this. This may also mean that care needs to be taken around providing detailed descriptors of the ideal system as these could never be as comprehensive as needed to allow for local variations.

3.4.3   Shared systems

⏏ There is strong evidence of the importance of developing shared outcomes to drive commissioning activity across the system; these outcomes will help define the vision that partners will be working towards. It would be helpful if there was a clear link between commissioning activity and the delivery of these shared outcomes. It would also be useful to mention the need for impact evaluation to demonstrate what difference the shared approaches are having for individuals as well as the system as a whole.

⏏ There are critical workforce challenges facing both health and social care. The vision includes a characteristic about integrated workforce planning and development but given the challenges it may be that this needs to be more ambitious. For example, a care system which looks for innovation in the way it tackles skills shortages or is flexible about how tasks are delivered across professional boundaries to make best use of resources.

⏏ The evidence suggests that the use of information technology is still relatively immature, whether this is to support information sharing, to enable whole system commissioning, or to support new ways of working. It might be helpful for the vision to be clearer about the different ways information technology can facilitate the delivery of the vision.

4   Conclusion

This section of the report has explored the implications of the evidence review findings for the proposed refresh of the LGA and partners' vision statement for integrated care. It sets out the implications in line with three main themes and considers how these are described within the original statement. It provides suggestions and recommendations for how the statement could be varied to reflect these findings.

In addition to the detailed implications above, we recommend that in developing the refresh of the vision, partners should agree some key principles for what the statement itself should look like. So, for example:

The vision statement will model the overall approach which it expects of an effective integrated care system. This will mean, for example:

⏏ Having a clear and succinct vision which is shared and agreed across the different parts of the system (for example, a one-page summary).

- Having a shared language which all partners recognise and understand and is used consistently.
- Having the individual as its focus, whether this is in terms of their health and wellbeing outcomes or their experience of services.
- Being aspirational but conscious of the challenging environment within which partners are working.

There is clearly a challenge in developing a statement that reflects the position for each partner organisation, but, as within local care systems, it seems reasonable to start with agreed principles about what the vision needs to do.

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