Forum for co-operative approaches in care

Legacy & current context (the “Co-operative Care Forum”)

Our Sharing Care project is generously supported by Power to Change to allow us to bring together learning we have gained while setting up our care co-op, share it with others and support those who might be interested in setting up a care co-op in their own communities.

Contents

Introduction

The Co-operative Care forum formed in 2015. The stimuli were various including:

- The disturbing developments in health and care services at the time: Winterbourne View, the collapse of Southern Cross,
- The knowledge that large hierarchical corporates were delivering poor quality care
- A Co-operatives UK report: Social Co-operatives, A Democratic Co-production Agenda for Care Services in the UK. This report highlighted the success of the Social Co-operative model in Italy since 1991 (when an enabling fiscal and policy framework was enacted) and also featured other international examples from Quebec, France, Japan and Spain. It also explored care co-operative examples in the UK such as Care and Share Associates and the Foster Care Co-operative.

While the Forum took note of the Social Co-operative model in particular, it sought to put the emphasis on pursuing a co-operative *approach* to care, a way for those who are being cared for, and those who are caring (whether as a gift or a job) to co-operate with each other and achieve their mutual objectives in the most efficient and effective way to meet their common economic, social and cultural needs and aspirations. So it focussed on those who are *co-operating for the purpose of care*, not on a legal construct; *co-operative approaches in care*, not models.

The Forum also sought to keep the wider determinants of health and well-being in mind. In its social determinants of health, the World Health Organisation puts health services as number six in the order of priorities, after social connections (1), clean water (2), nutritious food (3), safe housing (4), and the means to acquire these (5).

The Forum's regular members during the period 2015-18 were: Cheryl Barrott (Change AGEnts), Mervyn Eastman (Change AGEnts), Pat Conaty (Co-operatives UK), James Wright (Co-operatives UK), Laurie Gregory (Foster Care Co-operative), Kevin Crossland (Equinox TC), Cliff Mills (Anthony Collins Solicitors), Gareth Nash (Co-operative and Mutual Solutions), Alan Dootson (Sheffield Co-operative Development Group) and Amanda Benson (Co-operative College).

The Co-operative Care Forum organised events and meetings which were attended by other contributors and interested parties including: Cath Dillon (Participle), Dave Martin (Centre for Policy on Ageing), Nick Matthews (Co-operatives UK), Clair McCarthy (Co-operative Party), Robin Murray (Co-operatives UK), Dave Nicholson (Ex-cell solutions), Clara de Santos (institute for the Solidarity Economy).

[1] http://www.socioeco.org/bdf_fiche-document-3118_en.html

1.

Context

The Forum for Co-operative Approaches in Care (the Forum) was established against a backdrop of an ageing society, fiscal constraint, the privatisation and commodification of care and related services, and a system susceptible to service and business failures, all with real human costs borne by individuals, families, and society.

This context can be broken down into demographic, economic, political, and cultural conditions:

- **Demographic:** an ageing population with multiple long-term conditions
- **Economic:** in real terms shrinking budgets to pay for health and social care, exacerbated by the demographic factor, a commoditised business approach which undermines the very essence of care, and a failure to recognise and value the contribution of family and voluntary support
- **Political:** a shrinking state, mainly through privatisation combined with a continued fixation on "Fordist" approach to personal services and commissioning, purchaser-provider split
- Within **local government** significant budget cuts, personalisation, increasing percentage of self-funding; the Care Act (2014) and particularly market shaping duties, outcome focus, promoting choice, and safeguarding; integration of health and social care, Health and Well-Being Boards, English devolution
- Within the **NHS** however, a growing acceptance of the need to change the relationship between citizen and state; a much greater emphasis on prevention; an increase in self- directed care and personal budgets; and taking down organisational boundaries (Five Year Forward View).

Cultural

- In relation to public services an embedded societal acceptance of service delivery where people sit back and have things done to or for them, with concepts of mutual self-help and communal self-responsibility largely forgotten
- Within care services (especially healthcare), a paternalistic tendency founded on medical science/knowledge, an information imbalance, and NHS domination by clinicians and their managers, resulting in disempowered citizens
- Amongst citizens a growing desire for a better deal, to be more involved and better listened to, and for care and support more personalised for their circumstances.

Relevance of modern co-operative concepts

There is a lack of innovative action to address these contextual challenges, particularly within market-based approaches and the public sector. Decent care is about relationships, reciprocity and community, and so is not something for-profit business or state bureaucracies are well placed to provide. Co-operatives often emerge to plug such gaps; can this happen in relation to care in the UK?

The Forum was particularly interested in approaches to care that are rooted in communities where the starting point is nurturing the relationships between people including neighbours, family, paid carers and volunteers.

1. Context

The Forum believed that the mutual self-help, solidarity and fairness inherent in co-operative enterprise has a lot to offer those working towards such an approach, and are especially interested in multi-constituency approaches that bring together beneficiaries, professionals and the wider community in a fair and effective way.

Such co-operative approaches could:

- Enable citizens and qualified carers to work collaboratively together (co-production) to optimise limited financial resources and maximise good outcomes
- Locate mutual community-based care in a wider context that supports health and wellbeing (social relations, housing etc.), recognising the World Health Organisation determinants of health[2]
- Engage those accessing care, those providing it informally and professionally, and the local community in owning the responsibility for meeting care needs within the community
- Address disempowerment and isolation through the organisational approach to care, using the participative element of co-operation as one of the mechanisms of the therapeutic process
- Recast the role of care workers, enhance career prospects and improve public perception/ appreciation of care workers
- Address the need for a changed relationship between citizen and state, and particularly for citizens to own the problem and share in solving it, rather than looking to others to do so
- Innovate through community-based collaboration, rather than by top-down re-organisation, or competition.

Purpose of Forum

The Forum was established to **identify**, **support** and **champion** co-operative innovations through:

- Networking
- Exchanging good practice
- Education/awareness raising about co-operatives approaches
- Research and policy advocacy
- Strategic collaboration
- Optimising all available developmental resources, including access to appropriate and timely expertise and support
- Developing member-based legal mechanisms which facilitate, support and enhance co-operative approaches to care
- Practical development including a national development programme
- Influencing public policy centrally and locally.

This purpose will be approached through the collaborative contributions of:

- Pioneers of new approaches to care, particularly in the community
- People directly involved in care, including informal and professional providers
- Co-operative development practitioners
- Researchers
- Those able and willing to influence policy, including Parliamentarians, Councillors and cross-party groups.

[2] http://www.who.int/hia/evidence/doh/en/

2.

Chronology & Case Studies

An inaugural meeting was held in May 2015 and after a well-attended follow up meeting, an organising group formed. Co-operatives UK provided the secretariat. During the next 3 years, meetings were held with key speakers and participants from the sector: commissioners and providers, people giving and receiving care. Primary research was undertaken and knowledge of care 'models' was enhanced through primary and secondary research.

The following outlines some of the 'co-operative' care case studies which were discovered and examined.

Micro-enterprises

In June 2016, the Co-op Care Forum (CCF) organised an event in Ashford, Kent bringing together micro-providers of care, commissioners and people giving and receiving care. It was a well-attended event and the attached 'discussion' paper summarises what was learned from participants in the three themed conversations over the course of the day.

At the same time, the CCF contacted a team of researchers at Birmingham University who undertook an evaluation of organisations providing care and support. The study sought to investigate whether micro-enterprises outperformed larger care providers in delivering support that is personalised, valued, innovative and cost effective. It also looked at the factors which facilitated and inhibited the micro-enterprise care sector many of which are mentioned in the Kent discussion paper.

The ESRC funded research[3] explored THREE distinct types of innovation displayed by care providers: what innovations (what service is delivered), how innovations (how a service is delivered) and who innovations (who provides and receives a service). Micro-enterprises were found to be particularly good at how and who innovations. MEs were often found to be more flexible than larger providers in the way in which care in the home was delivered.

Buurtzorg Netherlands/Britain and Ireland

Buurtzorg is Dutch for 'Neighbourhood Care' and has grown from a 2006 nurse-led start up to providing support to almost 100,000 people today. Buurtzorg Nederland[4] is a not-for-profit social enterprise providing long-term home care to people in neighbourhoods across the Netherlands. The model has two defining characteristics:

1. The first is its holistic approach to care, in which nurses and nursing assistants, working in small teams, provide a wide range of personal, social and clinical care to a small number of clients.

   Continuity of care, integrated needs assessment and supporting client independence (including through informal and community-based networks of support) are all described as key features of the model (de Blok 2011, 2013; Nandram 2015). Nursing team members aim to spend 60 per cent of their time on direct client care, in an effort to prioritise 'humanity over bureaucracy' (de Blok 2016; Buurtzorg International n.d.).

   Buurtzorg nursing teams work with people with long-term illnesses, elderly people with multiple pathologies, people with dementia, people needing end- of-life care, and people recovering from acute treatment (de Blok 2013).

[3] https://www.birmingham.ac.uk/research/activity/micro-enterprises/index.aspx

[4] https://www.buurtzorg.com/

2. The second central feature of the model is its flat organisational structure. Small, non-hierarchical, self-managing teams of nurses and nursing assistants make their own operational and clinical decisions, with functional support (but no oversight or direction) from a small central office. Developmental support is provided by Buurtzorg coaches. Teams are responsible for recruitment, organising and delivering care, determining whether to take new clients on and managing their own performance. The central office is responsible for a range of administrative functions, including salary payments, sales contracts, IT support, and accounting (Nandram 2015). Bureaucracy and overheads are kept low: in 2016, when there were 10,000 Buurtzorg nurses and nursing assistants, there were just 45 staff in the central office (de Blok 2016).

From a single team of four nurses (2006) Buurtzorg grew to 850 teams across the Netherlands by 2016, with 10,000 nursing team staff (de Blok 2013, 2016). Organisational expansion happens from the 'bottom–up'. New teams are set up by groups of nurses and nursing assistants, who approach the organisation with an application to establish a team (Johansen and van den Bosch 2017). This means that members of new teams tend to have already bought into the Buurtzorg vision and have a sense of ownership regarding the team and their work. Additionally, team members tend to have worked together before, and tend to have at least one member with prior Buurtzorg experience (Nandram 2015).

New teams are supported heavily in getting the model up and running. Training is provided on self-management, the Buurtzorg approach to care, and the organisation's internal systems. The teams are provided with standardised plans of action and are guided by a coach throughout the process (Nandram 2015).

Buurtzorg scaled very quickly across the Netherlands from 1 to 850 teams, in just 10 years. During this time Buurtzorg grew in other areas of care such as mental health, children and families and also supported other Dutch international care organisations to take on the Buurtzorg model of care. It is active in China, Japan, Taiwan and a test-and-learn experiment was undertaken in West Suffolk in 2017-18[5]. Since that time, Buurtzorg has worked with 30 organisations in Britain and Ireland[6].

Hans Kai

The Japanese Health and Welfare Co-operative Federation (HEW Co-op Japan)[7] consists of 105 health and welfare co-operatives. Member co-ops of the federation manage 75 hospitals, 333 primary health care centres, 75 dental facilities, 24 nursing care facilities for the elderly, 185 visiting care stations, and other institutions. The Health and Welfare Co-op' s Charter of Life is the code of conduct for health and welfare co-ops. It clearly indicates that, where health/nursing care is provided, local members as service users and health/nursing care staff as service providers think and act together. The Charter stresses that users and staff are on equal terms as members while respecting each other's different positions as users and staff. Users and staff, both are members, improve the quality of health/nursing care services through cooperation with each other rather than through the provider-centred approach. This cooperative practice by health and welfare co-ops has drawn academic interest as "co-production".

In Japan, while health/nursing care services are provided through the national insurance system, preventive health care has not been adequately provided. In order to improve this situation, members of health and welfare co-ops have engaged in voluntary preventive health practice since the 1960s. Han-groups are the units for voluntary preventive health practice by members.

A Han-group is a basic unit of health and welfare co-ops, each consisting of three or more members. At each Han-group, resident members check their blood pressure, urine and body fat with the cooperation of professional members in health care and welfare. The members also learn about diseases (cancer, diabetes, stroke, heart attack, Alzheimer' s disease, etc.) and risk factors (stress, diet, drinking, smoking, etc.).

Some Han-groups also engage in activities such as exercise and congregate meals. What is unique about health promotion by health and welfare co-ops is: "People get together in their neighbourhood and actively engage in programmes while receiving help from professionals." Resident members learn

[5] https://www.kingsfund.org.uk/sites/default/files/2020-03/Review-West-Suffolk-Buurtzorg-test-learn-2019.pdf

[6] https://buurtzorg.org.uk/

[7] http://www.hew.coop/english/

such skills as measuring blood pressure and body fat at Han-group meetings and Health College provided by health and welfare co-ops. These trained resident members provide health checks for local residents at supermarkets, public places, as well as health festivals organised by municipalities. High blood pressure is believed to be the most common lifestyle disease in Japan. There are 43 million patients and additional 7 million people at risk. One in every two Japanese and 2/3 of those aged 65+ have high blood pressure. Prevention is essential since high blood pressure can lead to fatal conditions such as stroke, heart attack and kidney diseases. Health and welfare co-ops in Japan actively promote low-sodium diets to prevent high blood pressure. The results of the members' longstanding efforts in health promotion have been put together as "8 healthy habits and 2 health indicators," the members' goals for the healthy lifestyle.

The Hans Kai concept was brought to Canada in 2010 by NorWest Co-Op Community Health in Winnipeg. Now there is a network of groups across the country with Canadian health care co-ops being the key partners.

Foster Care Co-operative[8]

The only co-operative in the UK offering homes to vulnerable children was set up in 1999. There was an opportunity to offer an alternative to private agencies who had been poaching public sector foster carers.

The co-operative has grown steadily with offices now in Cardiff, Bristol, Glasgow and London, and contracts with many Local Authorities in London, the West Midlands, Bristol and the South West, Staffordshire, Yorkshire, the East Midlands and throughout Wales and Scotland.

Under the terms of foster care regulations, the co-operative has regular Ofsted inspections and must conform to strict legislation.

All employees have the option to become full co-op members and carers are associate members of the co-operative. Surpluses are re-invested to provide more foster care support and training, and to recruit more foster carers: 52% of income is paid directly to carers, 24% goes on funding for support groups and training and 24% goes on agency costs, salaries and office overheads. Staff and users are always consulted about processes and the FCC operates eight support groups for foster carers and staff.

Carers are offered 24/7 support from professional social workers, with local support groups, training and web-based guidance and administrative support. The co-operative also carries out health and safety assessments in homes and offers 14 days respite to carers.

The actual process of becoming a carer usually takes between four to six months, with visits to homes from a social worker who talks through the challenges with potential carers. There are DBS and Local Authority checks, training and introductions to current foster carers and social workers. The process ends with an interview and panel assessment

It is a measure of the co-operative's success that its placement stability is nine times above the national average – which is just four months for children with foster parents.

[8] www.fostercarecooperative.co.uk

2. Chronology & case studies

2.1 Other social innovations

The Lotte Nursing Home in Denmark[9]

Lotte, the most famous nursing home in the country, has become an international shrine for anyone seeking another way … a happier way … to make a life for people with dementia. Lotte is a big old brick house on the west side of Copenhagen, where 23 men and women live like a family. Seventy per cent of the family has dementia. They take Caribbean vacations together. The 98-year-old man on the second floor has fallen in love with the 101-year-old woman.

Lotte is fully funded and fostered by the Danish government.

The underlying philosophy of care for the elderly in Denmark is well rooted. Every man or woman, no matter how ill, or how old, has the right to choose how they want to live. The world looks to Denmark: where it is illegal to imprison people with dementia in locked wards; where nursing homes regularly take their people on holiday; and where people with dementia are asked what they want to do today.

New Villages for those living with Dementia (Weesp in Holland)[10]

Hogewey in Weesp near Amsterdam is an innovative new model for how to design an elderly care environment for those experiencing severe dementia. The 'village' was built in 2010 and features a café, restaurant, theatre, minimarket and hairdressing salon. Half of the four-acre site is open space and residents are encouraged to explore. The site has a deliberately 1950s feel – this is the decade when most of the residents were children or adolescents and research shows that even in advanced dementia, long term memories can remain intact. Six or seven residents occupy each small two-storey house, alongside one or two carers – they have their own bedroom but share the living room and kitchen. Residents are grouped in houses according to one of a number of different lifestyles such as 'traditional', 'urban' or 'cultural' so that they are likely to share interests in common. There are more than 20 different clubs running at Hogewey to encourage residents to stay active as far as possible. Anyone can come and eat in the restaurant and local artists display their works in the gallery and schools use the theatre – in this way links with the surrounding community are maintained. The model is proving very effective. Long-term patients are observed to be calmer requiring less medication with more frequent moments of cognitive clarity.

Passion for Life, Sweden[11]

Passion for Life originated in Sweden and is a programme aimed at empowering older people to achieve a healthy lifestyle. PfL aims to prevent poor health and improve quality of life by encouraging positive changes to habits and lifestyle patterns. Passion for Life is based on the Plan, Do, Study, Act (PDSA) model of behaviour change, encouraging participants to implement changes in their daily routines to improve their lifestyles. Specifically PfL is designed to encourage participants to consider their own situation in relation to 4 topics likely to have the greatest effect on their health and independence:

1. Safety at home
2. Social networks
3. Food and drink
4. Physical activity

The programme is designed as a series of 'Life Cafes' examining the above areas.

[9] https://dementia.stir.ac.uk/blogs/dementia-centred/2017-03-13/view-meaningful-activities-practice-denmark

[10] https://www.vivium.nl/hogewey

[11] https://www.changemakers.com/innovationinageing/entries/passion-life

2. Chronology & case studies

Shared Lives Plus[12]

Many local Shared Lives schemes in the UK have been going for 40 years on a small scale. But over the last five years has grown by 30%.

Sue Newton, from an organisation called PSS started what became the UK network of Shared Lives schemes in 1992 – back when they were called adult placement schemes. All the schemes in the UK were gathered together to set up the National Association of Adult Placement Services in 1992. In 2010, NAAPS became Shared Lives Plus.

Shared Lives Plus has worked to promote the value of very small localised services, and ensured that legislative and regulatory requirements were appropriate and did not place unnecessary barriers in the way of people establishing and delivering local small scale enterprises.

Shared Lives Plus has partnered with Homeshare. It brings people with spare rooms together with people requiring accommodation. So people who are happy to chat and lend a hand around the house get affordable, sociable accommodation. So householders and homesharers share home life, time , skills and experiences. There are currently 20 organisations delivering Homeshare in the UK.

Camphill Communities[13]

Camphill Communities in England and Wales offer opportunities for people with learning disabilities, mental health problems and other special needs to live, learn and work with others of all abilities in an atmosphere of mutual care and respect.

The 23 communities in England and Wales include independent residential and day schools, specialist colleges of further education and adult communities where each individual's abilities and qualities are recognised and nurtured as the foundation for a fulfilling life.

Each community is different. Some are large; some are small. Some are in towns and cities; some are in quiet rural areas; some are on the urban fringe where town meets country. Some are independent charities; some are part of larger charities.

All Camphill Communities seek to be caring, life-sharing communities, where the contribution made to community life by each person is valued, where everyone is appreciated for who they are, for their unique personality and the special qualities they bring to community life.

The Camphill philosophy is that no matter what anyone's outward disability may appear to be, the spirit - the essential core that makes us all human - always remains whole. So everyone is deserving of equal respect and opportunities in life so that all may be able to fulfil their potential.

Artistic and cultural themes run through the daily lives of all Camphill communities where life is based on Christian values and inspired by the philosophy of Rudolf Steiner.

[12] https://sharedlivesplus.org.uk/

[13] http://www.camphill.org.uk/

3.

Current context & recent developments

COVID-19 has thrown the social care system's many deficiencies into sharp relief and prompted calls for long overdue and long promised reform.

Fractured and Forgotten, The social care provider market in England (April 2021)[14], a report by the Nuffield Trust[15] an independent health think tank, argues that a singular focus on funding (while important) ignores the fact the provider market is not functioning. It suggests that comprehensive reform to the entire system is required and lists the following as key issues:

1. Downward pressure on fees paid by councils creates uncertainty and variation
2. Lack of effective 'market shaping' limits innovation and drives short termism
3. There are few proactive drivers of improvement or market management in the system
4. The ownership structure of many provider organisations creates instability in residential care
5. Social care has suffered from a lack of prioritisation within government

The White Paper for health and social care, Integration and Innovation published in February 2021 did not set out the Governments social care plans and the Budget (March 3rd 2021) made no reference to social care. In September 2021, The Government published Build Back Better. Our Plan for Health and Social Care[16]. The government promises to:

1. Introduce a cap on Personal care costs
2. Provide financial assistance to those without substantial assets
3. Deliver wider support for the social care system, particularly .... social care staff
4. Improve the integration of health and social care systems

Fractured and Forgotten highlights the fact that the dynamics vary according to a number of different factors:

1. Whether the care user is a working age adult or an older person
2. Whether they fund their own care or their care is funded by the council/NHS or a blend
3. Whether the care is residential, home or community based
4. Whether the care user holds a personal budget (inc direct payments) or not

March 2021	Number of locations registered with the CQC	Number of provider organisations registered with the CQC
Community care, including:	**11,021**	**7,861**
• domiciliary care services	10,014	
• supported living services	2,103	
• extra care housing	540	
• Shared Lives Plus services	130	
Residential care, including:	**15,407**	**7,461**
• care homes	11,233	
• nursing homes	4,366	

Figure 1: Social care-providing organisations registered with the CQC, Fractured and Forgotten, page 8

[14] https://www.nuffieldtrust.org.uk/research/fractured-and-forgotten-the-social-care-provider-market-in-england

[15] https://www.nuffieldtrust.org.uk/

[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1015736/Build_Back_Better-_Our_Plan_for_Health_and_Social_Care.pdf

3. Current context & recent developments

Within the broad categories of providers in the table above (from Fractured and Forgotten, page 8), the services offered are very diverse. Beyond residential, nursing and domiciliary care, people are increasingly turning to personal assistants, supported living, new models of care such as Shared Lives plus and extra care housing. Shared Lives schemes have increased by 4% between 2019 and 2020 and the CQC assessments indicate a high quality of care. This indicates that there are opportunities for organisations like Co-operative Care Colne Valley to enter and succeed in the marketplace.

Public funding for social care comes from 3 main sources:

1. National grant from the Ministry of Housing, Communities and Local Government to local authorities
2. Revenue that local authorities raise themselves from sources as Council tax, the Precept and business rates
3. NHS through funds such as the Better Care Fund and NHS continuing Care

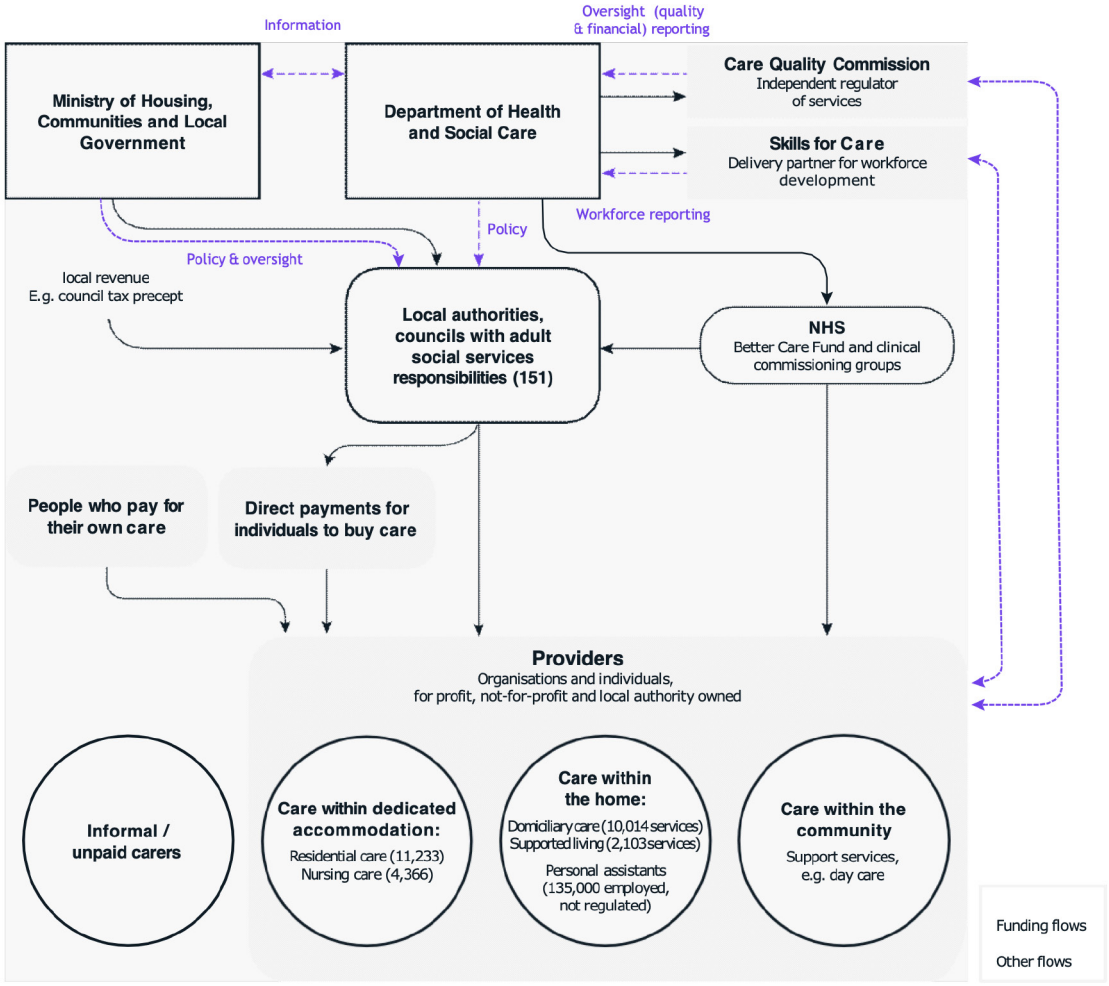


Figure 2: Funding and other flows in the social care system, Fractured and Forgotten, page 12

The Kings Fund[17] produces the Social Care 360 report[18] which uses the latest available data (2019/20) to describe the key trends in adult social care as the Covid-19 pandemic struck and to suggest what the impact of the pandemic might be. It paints quite a bleak picture of adult social care in England, with many key indicators already going in the wrong direction before the pandemic struck.

- Demand was increasing but receipt of long-term care was falling. Between 2015/16 and 2019/20, 120,000 more people requested social care support but around 14,000 fewer people received either long- or short-term support.

[17] https://www.kingsfund.org.uk/
[18] https://www.kingsfund.org.uk/publications/social-care-360

- The means test continued to get meaner because thresholds were not rising in line with inflation.
- User satisfaction with publicly funded care was showing a small, long-term decline.
- Fewer people were using direct payments, suggesting a fall in personalisation of care.

Even where indicators were going in the right direction, there were caveats.

- Total expenditure had finally returned to a similar level to that of 2010/11 but not if population growth is taken into account – per person spending was still well below that seen a decade ago.
- As a result of the National Living Wage, care worker pay was rising by more than inflation but was not keeping pace with other sectors.
- Staff vacancies were falling but remained at a high level.
- More carers were getting support but this was mainly in the form of advice.

Unsurprisingly, The Kings Fund expects Covid-19 to make the situation worse. Demand will increase but receipt of care will, likely, not. Costs will go up but expenditure is unlikely to keep pace. It states that if the Kings Fund is to avoid reporting on a further bleak round of indicators in future years, six things need to happen as part of a long-term wide-ranging reform programme for adult social care.

1. **More money is needed to fund the current system**. The Health Foundation estimates that an extra £1.9 billion will be needed simply to meet demand for adult social care by 2023/24, while funding is also needed to meet existing unmet need and improve the quality of services. Further funding will be necessary to cover the additional costs of Covid-19, support the provider market, fill vacancies and pay staff a fairer wage.
2. **Eligibility needs to be improved**, in the short term by easing the financial pressure on local authorities and allowing them to apply existing rules more fairly and in the longer term by changing those rules to make more people entitled to support.
3. **Workforce reform is essential.** While vacancies may fall in the short term due to unemployment in the wider economy, the sector needs better pay, training and development to compete with other sectors and deliver the care needed.
4. **Personalisation needs re-invigoration**. If the 2014 Care Act's principle around self-directed support has meaning, government needs to establish clear oversight so that the number and quality of direct payments, and other routes to choice and control, increase rather than decline.
5. **Prevention needs to take centre stage.** Services such as reablement should be an even greater focus for local authorities and national government.
6. **Carer support needs urgent attention**. As formal services closed during Covid-19, carers took on much of the heavy lifting (sometimes literally) of support. A new settlement for them ought to be part of reform.

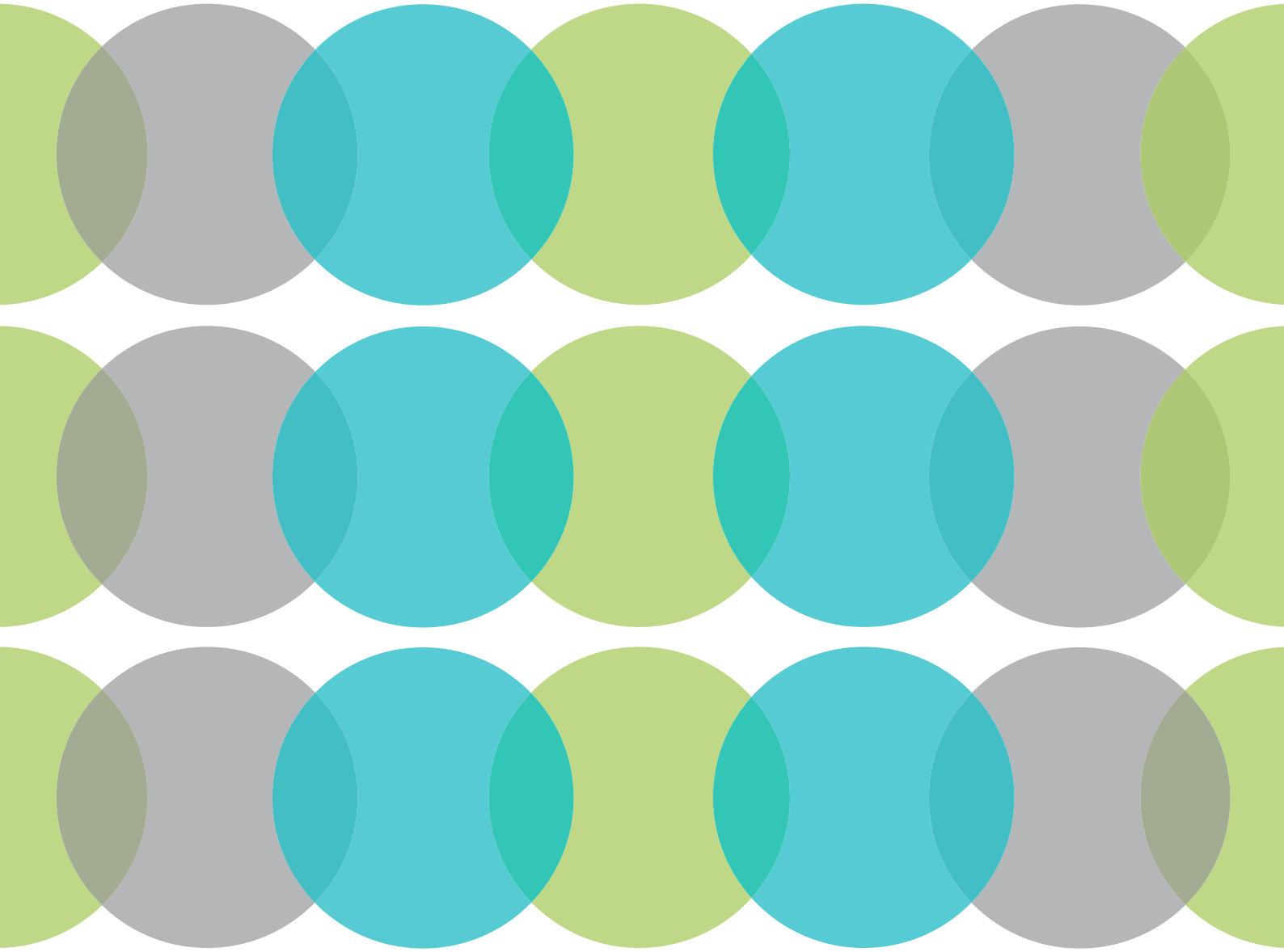
3.1 Integrated Care Systems (ICSs)

Integrated Care Systems[19] are the latest in a long line of initiatives aiming to address the changing health and care needs of the population. They have grown out of Sustainability and Transformation Partnerships (STPs) and a move away from organisational autonomy, competition and the separation of commissioners and providers. ICSs seek to encourage collaboration and focus on places/local populations delivering joined up support for growing numbers of older people and people living with long term conditions.

Integrated Care Systems have the potential to drive improvements in health including tackling wide health inequalities by working alongside local authorities and other partners to address the key social and economic determinants of heath: homes, financial resources, education and employment, access to public services.

A key premise of ICS policy is that much of the activity to integrate care and improve population health will be driven by commissioners and providers collaborating over smaller geographies (often referred to as places) and through teams delivering services working together on even smaller footprints (usually referred to as neighbourhoods). ICSs typically tend to cover large geographical areas (more than 1m people).

[19] https://www.kingsfund.org.uk/publications/integrated-care-systems-explained



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