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Care and Health Devolution

Personal submission to The Health Devolution Commission

Peter Hay
PETER HAY CONSULTANCY LTD

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Note

The Health Devolution Commission is an independent and cross party inquiry into the value and accountability of devolved health systems.

It brings together two former, Labour and Conservative, Secretary of States for Health, Andy Burnham and Stephen Dorrell, with three former Health Ministers including Norman Lamb, Alastair Burt and Phil Hope. They are joined by senior professional figures from the health, mental health, social care and public health sectors.

You can find its work and submit your comments at https://healthdevolution.org.uk

Summary

The Commission is seeking to explore two questions about devolution.

For the first question, 'What does good health devolution look like that builds a community's health and improves a community's health and social care services?' some key criteria are suggested to describe what good devolution looks like:

- Recognises the uniqueness of communities
- Values outcomes
- Builds and keeps relationships over time
- Recognises that social care is about people as individuals who want 'a good life' within their communities and systems
- Works with choice and control from the person up

Whilst meeting individual needs is personal, many aspects of 'living a good life' are inherently social. This requires the health and care system to simultaneously develop both person centred and community approaches which require a different approach to power, control and accountability. This is potentially where devolution could make greatest impact.

For the second question 'how should the challenges of accountability, power and control between the NHS and local authorities be addressed in devolved and integrated systems?' two fundamental principles must be supported:

- to be centred on people, their hopes and their fears
- to support rights based social care

Four features of power, control and accountability should be considered as key criteria to consider devolution:

1. The recognition and exercise of the legal powers to shape 'care markets' around people and communities
2. The shaping of power with people and communities, so that the system is good for me and good for us
3. New systems of measurement, accountability and learning
4. Supporting new forms of collaborative leadership within a learning and adaptive system.

These issues are addressed through a social care lens which is the professional background and experience I bring to the work of the Commission. I have drawn on a wide range of referenced sources. Writing this paper has crystallised and moved my thinking on devolution. I hope reading it will do the same as its purpose is to provoke debate about the importance of devolution in improving our health and care. I promise to be open to your responses moving and shaping further thought.

The COVID-19 context

The timetable and the way of working set out by the Commission has been changed due to COVID-19. The Commission's core purpose to consider how devolution and accountability might better meet people's needs for health and care seems even more prescient and urgent.

This context has affected all of us and may have influenced the lens through which I see the current issues, so I thought I should specify any 'bias' :

1/. Health and care are devolved responsibilities across the UK. Media coverage has been largely focussed on England, and I am unclear about devolution within England during the COVID-19 period (Greater Manchester). There remain real opportunities to explore learning from difference within the UK. This is a previously untapped capability that requires leadership that seeks to contribute, acquire and develop knowledge.

2/. COVID-19 as a virus cannot discriminate. It has however occurred in ways that expose existing fault lines with particular regard to race, age and disability (Gender appears to be a factor too, with worldwide data showing males have a higher rate of serious infection, for reasons which are unclear.) Health status and in particular, pre-existing health inequality may have played a part in spread. Health inequality expressed in the wide divergence in the quality of years spent in later life across different communities requires sustained attention.

3/. As the Commission considers key issues about accountability, devolution and power, I would invite it to consider how these appear from the position of the powerless. It is clear that during the early stages of COVID-19 people experienced their age, disability and health status becoming framed in ways which heightened vulnerability. The narrative of strengths based work and resilience of recent social policy disappeared. Too many people with disabilities experienced the societal barriers that contribute to their exclusion appearing to rise. A founding principle of universal healthcare is that it is inclusive.

4/. My perspective is that we will emerge into a world which will need systems that are attuned to heightened risk from contagious diseases. The all party nature of the commission allows for us to think about accountability in the terms of Tom Peter's 'tight loose' model for leadership. We need a framework which is clear about what needs to be held tight at the centre, and how we simultaneously distribute other priorities to where they are best led, empowering their delivery. This framework should to be able to promote the protection of our health but also to advance every opportunity for us all to live as good a life as possible for as long as possible. [i]

The first question: What does good health devolution look like that builds a community's health and improves a community's health and social care services?

I have tried to identify some of the features that might be seen in 'good' devolution

Good devolution recognises uniqueness

Communities are inherently unique, yet we often think they are all the same. It is not always easy to move solutions from one place to another not least because the people and the context have as many subtleties as DNA. Communities need a perspective that recognises that they are like colour pixel charts with subtle distinct variations that make them unique. [ii]

Good devolution values outcomes more than inputs

The current approach is further hampered by the use of the term 'postcode lottery' which has placed a sanctity upon sameness of approach that has not been matched by equity of outcome : indeed health inequality has been growing. [iii]

Good devolution builds and sustains relationships over time

Relationships with people have long term value that can be built up through active place based approaches. Leeds have a long term commitment to being 'a child friendly city' which they have sought to articulate and mobilise through all walks of civic, neighbourhood, business and social life. Vitality and quality emerge through variety. [iv]

Good devolution recognises that social care is about people as individuals who live within their systems

Social care - best defined a 'living a good life' - builds from the interventions in people's lives to support them with that desire to live a good life. [v] Evidence shows that people who hold a strong personal narrative about their identity and their community can still hold personal resilience with life limiting health needs.[vi] Social work is an intention to understand how people function within the systems within which they live. Recent years have seen a welcome shift from the detection of deficits to working with strengths and building 'circles of support' around adults and children.[vii]

Good devolution values the personal and works with choice and control

Policy over recent years has developed personal choice and control, including budgets held by individuals. Evidence suggests that people benefit from this approach[viii] Further, the engagement of people to co-produce services works best on the basis of people being able to make a valued and distinctive contribution.

Just over half of residential care provision for older people, by value, is now paid for by individuals ('self-funders'), [ix]. Findings related to unfairness, poor information, inadequate

complaint procedures and opaque charging polices suggest that this represents an area of public policy where wealth may not necessarily confer advantage.[x]

This has been critiqued as an atomised, and disparate social care system, perhaps the opposite of the monolithic, controlled services it sought to replace. However, whilst meeting individual needs is personal, many aspects of 'living a good life' are inherently social. The care system requires the capacity to develop personalisation whilst simultaneously enhancing community and collective approaches.

In order to do this well, we need to consider a different approach to power, control and accountability.

The second question: How should the challenges of accountability, power and control between the NHS and local authorities be addressed in devolved and integrated systems?

There are two principles which devolution must support in order to align accountability, power and control with core purpose.

The first principle is that devolution should be centred on people, their hopes and their fears

Accountability and power should be outward facing to support achieving personalised care:

> "The essence of personalisation (is) tailoring care and support to what individuals choose as a means of helping them to live their normal life. People don't want to be defined by their condition – they are not "suffering from dementia" or "autistic" or "subject to multiple co-morbidities". They are, first and foremost, individuals with very personal hopes, fears, aspirations and relationships.[xi]" (Department of Health, 2015, p4)

The need to place people at the centre is an enduring principle for the care system, albeit that there are concerns about making the principle apply more effectively and in all settings.[xii] However, too much planning is centred on health conditions or by typologies of care needs. Devolution offers an opportunity to co-produce with people holistically and to plan by using data about needs alongside engaging with 'hopes, fears, aspirations and relationships'

Facing fear makes us uncomfortable, so not surprisingly has never had much discussion. A strengths based approach to building resilience inherently requires facing risk and fear. In the response to COVID-19 there were numerous incidents where people felt that their rights were under attack particularly related to disability, age and health status [xiii]. People in receipt of direct payments felt that they were left without proper guidance and clarity about their support.[xiv] National guidance to these people came 33 days after the first social care advice. 'Super resilient' systems of care will be needed for some time and to command the support of people, will need to be able to hear and respond better to legitimate fear.

People might want to see clearer levels of accountability and consider where devolution might make a difference.

The second principle is that devolution should support rights based social care

There are a wide range of dimensions to devolution. Of course, power and control can be effective when concentrated, as we have thankfully seen with the huge effort that was made to create sufficient acute hospital care for the first peak of COVID-19.

One of the drivers for personalisation in social care was a need to break away from 'standardised' forms of provision - the difference eloquently described by one of the pioneers of direct payments as between "attending a day centre as is expected of me or getting to choose how I spend my day". This is an approach to individual rights, recognising too that everyone in contact with a social care system based on eligibility has therefore also a set of 'protected characteristics' which our equality legislation rightly identifies.

This welcome debate should therefore think about the way in which devolution would support and enhance the fundamental role social care plays in promoting rights. However to do so through a lens which looked solely at individual rights would diminish the definition of 'a good life' which needs a social, community or collective dimension. I am assuming that aside from hermits, no one would see a good life as one lived completely alone. Indeed, concern about loneliness has been mounting for some time, with growing evidence that it shortens mortality and plays a large part in poorer health[xv]. Positive approaches, such as the idea of people as agents in 'health creation' are driven by connection, control and confidence. [xvi]

Four features of power, control and accountability

These represent some possible key criteria against which to consider devolution:

1. The recognition and exercise of the legal powers to shape 'care markets' around people and communities
2. The shaping of power with people and communities, so that the system is good for me and good for us
3. New systems of measurement and in particular to take accountability for learning
4. Supporting new forms of collaborative leadership within a learning and adaptive system.

First Feature: Devolution should recognise the power to better shape the care and health system

The Department of Health and Social Care estimates there are 25,000 independent providers of care. [xvii]Furthermore, around 237,000 adults, older people and carers received direct payments from councils' social services departments in 2017/2018. It is estimated

that approximately 75,000 (31%) of these recipients were employing their own staff. (Skills for Care) [xviii]

In the Care Act, Government put in place ways of working with the 'market' in adult social care that had been in place since the Community Care reforms. This included new duties for 'market shaping' to shape, influence and procure the best types of support to meet the needs of a population. The King's Fund suggest that few Councils have taken this role 'as broadly as it was intended' and that very few councils are pursuing broad social value objectives or supporting and developing care providers.[xix] The fragility of the market and the unacceptable variation in services to support people at home, needs more than better funding alone.

The Institute of Public Care argue strongly for the importance of developing a place based approach to shaping the care market. [xx] Together with the King's Fund[xxi], IPC stress the importance of collaborative approaches to place based systems of care, which at their best go beyond the boundaries that are set by organisations and services. A single integrated system of care and health will never fully fit the needs which might matter to people most. For example, Extra Care Charitable Trust is now showing clear evidence that its care villages reduce demand for health and care services alongside improving personal wellbeing.[xxii]

A renewed drive to better shape care systems needs ownership and vision combined with the ability to corral, facilitate and orchestrate systems and people. None of this is quick, or short term, so perhaps above all , 'market shaping' needs to be held accountable over time: to show that plans are making a difference to people's lives

Second Feature: Devolution should share and promote power collectively

'Market shaping' is not a term that health colleagues readily recognise, nor a skill set that is called upon. Understandably this mindset sees 'market shaping' to imply privatisation, and therefore the vital stimulation of community based care has not fitted easily into the drive for integration between care and health, especially joined up commissioning.

There are arguments that personalisation drives privatisation of care, for example Whitfield sees it as one of four factors (alongside marketisation, financialisation and privatisation) [xxiii] in a shift away from collective shapes of services and shared rights. In my view, this is both a flawed analysis and a legitimate concern which must be addressed to create simultaneously a system that is good for the individual but also good for all of us. The focus on 'personalised' and 'individual' need must be balanced with a simultaneous attention on the community.

Outsourcing (an organisational decision) and the growth of self-funded care (a Government decision) account for more of the supply of care and health services than self- directed support. Self-directed support tends to purchase locally and offers alternative models of employment, and although data is not available to verify, the potential to stimulate communities is significant. Local authorities have led excellent work in micro-commissioning, local area coordination, community wardens, circles of support and through

co-production forums, all of which link the ambitions of people with self-directed support to local connections.

There is a considerable sense of the collective within my experience, admittedly within the not for profits. This ranges from the ground-breaking work by Community Integrated Care with rugby league [xxiv] to the strong sense of belonging and 'family' with Anchor Hanover and Turning Point. Extra Care Charitable Trust have an explicit model of ' community building' within their village provision through the use of volunteers and co-production and in cross-subsidising a mix of sale, part sale and rental housing. In areas like bereavement in dementia, a partnership of Big Lottery, Extra Care, Cruise and people with experience have led excellent collective work and community support[xxv]. These examples, and many more, would benefit from a bigger platform around place and a culture of shared peer learning.

This is about tension and balance within the system: Whitfield's legitimate concern about a personalised model can be matched by the concerns about collectivised models, especially the failure to 'transform care' that was promised after Winterbourne View for people with mental health and learning disability[xxvi] . The 2095 people in such provision at the time of writing hold echoes of 'out of sight, out of mind' models which an inclusive, engaged community model would avoid. This is another gap in the system which devolution can address.

Finally, social care matters collectively through its economic impact upon areas. A number of Councils have followed Wolverhampton and analysed the size of their care and health economy at usually around 12/15% of the total and usually in the top three economic sectors. The economic and 'levelling up' agendas are significant in their own right, but there is still a way to go in recognising the scale of the care and health contribution. Tackling low pay in care is a local economic issue and the future will need to address how economies thrive with more older people than of working age, particularly in rural areas.

We can choose our models of care . The 'care market' we have is not inevitable, rather it's a consequence of decisions and actions that we take. There is much attention on 'large private companies' but Savills' 2019 market report showed the Big 5 providers of residential care for older people (all private companies) had a declining market share down to 13% from 16% in 2014. [xxvii] Whilst this might reflect a provider decision to focus upon self-funding, it illustrates a rarely discussed point that it is possible to consider that we can shape who is in the market, why and how much. The fact that people feel that this choice of models is absent merits consideration of whether devolution could close this gap.

Third Feature: Devolution should support new systems of measurement, accountability and learning

Greater capability is needed to enhance learning and adaption through collaborating in exchanging information, ideas and experience. This is the difference between a focus upon services or thinking about outcomes. Current performance data has its place in managing effectiveness, but its focus is narrow and tends to be based upon single organisations. Outcomes are hard to measure, and they tend to need contributions across organisations, thereby leading to approaches like "Human Learning Systems"[xxviii]. Our society faces

complex multi-dimensional challenges that cross sectors to explore questions such as "how do we age well?" Of course, social care particularly needs some policy and funding answers that can only come from national government. But questions about good lives, led in great places to live, need a space where we know we are exploring the learning. We need to someone to be accountable for that happening and a devolution debate allows us to consider this missing layer from current approaches.

This suggests it is time for a new form of accountability that has the courage to not pretend to know the answers, rather it seeks to explore ways of making a difference and to show what it has learnt. It is accountability that has the integrity to learn from mistakes and to show things that could be done better. It is accountability that will reward the integrity to admit that whilst it makes mistakes, it is self-aware and receptive to feedback where awareness faltered. I want that for myself in thinking through what it looks like to age well, I suspect we might also want to think whether this accountability is what we need to maximise our shared learning across a wide range of social issues.

Fourth Feature: Devolution should support new forms of leadership

Public service leaders are having to be not just good at managing their own organisation but increasingly having to work across networks with distributed leadership models. To do this well, Michael West at The Kings Fund argues that there must be compelling overarching vision, supported by persistent attention to the progression towards shared goals. This needs to be supported by sustained and regular contact, including addressing conflict and the development of mutual support, appreciation and trust. [xxix] The need to overcome natural complex human behaviours and loyalties towards organisations requires a strong articulation of place that inspires the sense of belonging to something bigger as well as some guiding force to hold purpose and mould behaviours.

There is a great deal of material on collaborative leadership, which is an area of study in its own right. In the context of developing whether devolution would add value, of note is the work from SCIE and The NHS Leadership Academy. Their work highlighted that leaders are asking for support which offers facilitation, shared spaces, problem solving, learning from each other and opportunities for further personal and leadership development. [xxx]

Experience from Greater Manchester suggests that devolution has helped it pay attention to the type of factors which support collaborative leadership as well as developing 'middle out' learning across peers. [xxxi]Its leadership model recognises that different actions are needed at different levels – that it is possible to work at local level, at Borough or City level and also to be part of GM. Its work to develop the power shifting tools from the New NHS Alliance illustrated the ability to support from the top activity done at the local level and to recognise the third sector as equals in community leadership.[xxxii] That's collaboration!

Leadership of developed and integrated systems has to be inclusive and adaptive. There is no magic structure that pulls all of social care into one single system. Even if social care reform actually happens and even if that reform stopped anyone from self-funding, people's own resources will shape issues like housing choices which can affect their personal

wellbeing and the demand they will make on public services. The work of the King's Fund already referenced shows just how hard it is to build collaboration across health and care organisations: real leadership would take us to that point and beyond.

Conclusion

This is not an argument for devolution for devolution's sake. Rather it's a set of criteria which help us assess where devolution can be part of improvement by making a difference to what is done now.

Place matters and shaping place means working in ways which affect people's lives. For people with care needs this can promote their opportunities and their rights. Changing and improving outcomes is careful long term work that needs new shapes for leadership to support changing patterns of collaboration and co-production.

What has been missing in this space for social care is accountability – a pinch point where someone 'owns' the issues and has the autonomy to enable longer term shaping of services and collaborations to influence outcomes. The case for a new form of accountability that supports learning, mistakes and collaboration is particularly strong and could make a major contribution to further improving health and care for all. Of course government plays a role, not least as it has always 'owned' the national in NHS. Local government at a council level and importantly at the level of communities plays its role too. These layers however are not working fully effectively for the systems that people need and deserve for the challenges and opportunities that face us ahead. This debate about devolved systems and the role that they may play is overdue and I look forward to continue to playing my part in taking it forward.

Peter Hay
April 2020

References and web links

[i] Tom Peters: In Search of Excellence, 1982

See also this from a short article, In Search of Autonomy, 1990 https://tompeters.com/columns/in-search-of-autonomy/

Simultaneous Loose-Tight Properties. This was an ugly phrase in 1982, and it's an ugly phrase in 1990. But wise practitioners got the point. Concentrate on a few things (e.g., quality comes first; if you agree to a budget or profit target, you've got to make it happen or suffer some consequence), but allow astonishing freedom for

people to play the game within those few bounds. To be sure, "loose-tight" amounts to centralization as well as to decentralization. But given the nature of our staff- and paper-driven empires, the unmistakable tilt is toward much greater autonomy, much less centralization.

[ii] Peter Latchford, 'African Igloos and Public Service Heroes' 2010

[iii] Health Equity in England The Marmot Review Ten Years On, February 2020
https://www.health.org.uk/funding-and-partnerships/our-partnerships/health-equity-in-england-the-marmot-review-10-years-on?utm_source=google&utm_medium=cpc&utm_campaign=marmot2020&gclid=Cj0KCQjws_r0BRCwARIsAMxfDRjozqZqTMu_NTAG5BArQ6t2-9MJWyjMnEz3KgzhcKrwGaEzAnDTNOgaAuJREALw_wcB

[iv] Child Friendly Leeds: the Blog https://childfriendlyleeds.wordpress.com

[v] TLAP: 'What good looks like: fresh perspectives on personalised care and support' (October 2018)
https://www.thinklocalactpersonal.org.uk/News/What-good-looks-like-fresh-perspectives-on-personalised-care-and-support/

[vi] University of Birmingham, Health Ageing in the 21st Century, the best is yet to come (February 2014)
https://www.birmingham.ac.uk/research/impact/policy-commissions/healthy-ageing/index.aspx

[vii] Mental Health Foundation, A Guide to Circles of Support
https://www.mentalhealth.org.uk/sites/default/files/a-guide-to-circles-of-support.pdf

[viii] SCIE: Integrating Personal Budgets for people with mental health (December 2014)
https://www.scie.org.uk/publications/guides/55-integrating-personal-budgets-for-people-with-mental-health-problems/integrating-personal-budgets.asp

[ix] Laing Buisson Care Homes for Older People UK Market Report. (December 2019)
https://www.laingbuisson.com/laingbuisson-release/care-homes-for-older-people-a-tale-of-two-markets/
The data sets out 45% of all people in older people's care homes are now self-funding and that they makeup 51% of the payment top providers

[x] Competition and Market Authority: Care Homes Market Study (update March 2018)
https://www.gov.uk/cma-cases/care-homes-market-study#update-paper

[xi] Department of Health, Voice, Choice and Control, November 2015
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/474253/VCC_acc.pdf

[xii] National Voices Person Centred Care Centred Care in 2017
https://www.nationalvoices.org.uk/sites/default/files/public/publications/person-centred_care_in_2017_-_national_voices.pdf

[xiii] Disability Rights UK (7th April 2020)
https://www.disabilityrightsuk.org/news/2020/april/covid-19-and-rights-disabled-people

[xiv] The Disability News Service (23rd April 2020) provides a summary of the concerns
https://www.disabilitynewsservice.com/coronavirus-pa-guidance-is-finally-published-five-weeks-late/

[xv] Claire Pomeroy, Blog on Scientific American, (March 2019)
https://blogs.scientificamerican.com/observations/loneliness-is-harmful-to-our-nations-health/

[xvi] New NHS Alliance, Place Shapers and National Housing Federation, Health Creating Practices (September 2018)
https://www.nhsalliance.org/leading-housing-bodies-call-for-adoption-of-health-creation/

[xvii] COVID-19; our action plan for adult social care (16th April 2020)
https://www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan/covid-19-our-action-plan-for-adult-social-care

[xviii] Skills for Care: the state of the adult social care sector and workforce in England. Sept 2019
https://www.skillsforcare.org.uk/adult-social-care-workforce-data/

[xix] Simon Bottery, Kings Fund: 'What's your problem, social care? (December 2019)
https://www.kingsfund.org.uk/publications/whats-your-problem-social-care

[xx] IPC: Place based market shaping; coordinating health and social care July 2016
https://ipc.brookes.ac.uk/docs/market-shaping/Place-based%20Market%20Shaping%20-%20co-ordinating%20health%20and%20social%20care.pdf

[xxi] Kings Fund, Place based systems of care, November, 2015
https://www.kingsfund.org.uk/publications/place-based-systems-care

[xxii] The research programme by Extra Care Charitable Trust and Aston University
https://www.extracare.org.uk/research/our-approach/

[xxiii] D. Whitfield, The Mutation Of Privatisation, European Services Strategy Unit, (2012)
https://www.european-services-strategy.org.uk/wp-content/uploads/2012/07/mutation-of-privatisation.pdf

[xxiv] Community Integrated Care and the Rugby league have combined to promote Learning Disability Rugby League across eleven clubs
https://www.c-i-c.co.uk/learning-disability-super-league-announced

[xxv] Extra Care, Cruse Bereavement Support and the Big Lottery
https://www.extracare.org.uk/newsroom/news/extracare-partners-with-cruse-bereavement-care/

[xxvi] Mencap is one of many organisations that have condemned this failure of policy, and is referenced here for its constant monitoring and updates on the position

The human rights scandal continues

#HumanToo #StrippedofHumanRights

The latest data shows there are **at least 2,095** people with a learning disability and/or autism in inpatient units.

NHS Digital Assuring Transformation data, March 2020

Shut away for too long

People with a learning disability and/or autism who are sent to inpatient units are there for an average of

5.6 years

NHS Digital Assuring Transformation data, March 2020

At risk

3,885 Within January 2020

reported uses of restrictive interventions in one month e.g. **physical, chemical, mechanical restraint** and being **kept in isolation.**

Of these, **745** were against **Children** (under 18s)

NHS Digital MHSDS Data: January 2020, published April 2020

Children in units

Under 18s

The number of children with a learning disability and/or autism in inpatient units has **increased** since the start of the Transforming Care programme.

March 2020 **205**

March 2015 **110**

NHS Digital Assuring Transformation data, March 2020

Equality and Human Rights Commission (EHRC)

A legal challenge has been launched against the Secretary of State for Health and Social Care for failing patients with learning disabilities and autism: "We cannot afford to miss more deadlines... We cannot afford to risk further abuse being inflicted on even a single more person at the distressing and horrific levels we have seen. We need the DHSC to act now. These are people who deserve our support and compassion, not abuse and brutality...". Rebecca Hilsenrath, Chief Executive of the EHRC

Potential impact of Emergency Measures to deal with Covid-19 - on Transforming Care

Any emergency changes to the Care Act and Mental Health Act must not result in more people with a learning disability and/or autism being locked away in inpatient units. The health, care, quality of life and safety of people with a learning disability and/or autism must be prioritised in both the short and the long term. #socialcareneedscashnow

Delayed discharge

125 people had their discharge delayed.

Main reasons: **lack of social care** and **lack of suitable housing** in the community.

NHS Digital Assuring Transformation data, March 2020

Challenging Behaviour foundation

mencap The voice of learning disability

April 2020

Registered charity number 222377 (England and Wales); SC041079 (Scotland) 2020.016

https://www.mencap.org.uk/get-involved/campaign-mencap/governments-broken-promise-transform-care

[xxvii] Savills: Market in minutes, elderly care homes (October 2019) https://www.savills.co.uk/research_articles/229130/291740-0/market-in-minutes--elderly-care-homes---q4-2019

[xxviii] Toby Lowe/Collaborate :Exploring the New World, practical insights for funding, commissioning and managing in complexity https://collaboratecic.com/exploring-the-new-world-practical-insights-for-funding-commissioning-and-managing-in-complexity-20a0c53b89aa

[xxix] Michael West: Conflict and Collectivism, The Kings Fund (March 2015) https://www.kingsfund.org.uk/blog/2015/03/conflict-and-collectivism-challenges-working-across-boundaries-health-care

[xxx] SCIE: leadership in integrated care systems (ICSs) (November 2018) https://www.scie.org.uk/integrated-care/leadership/systems

[xxxi]Anna Charles: Bottom Up, top down, middle out.
https://www.kingsfund.org.uk/blog/2017/11/transforming-health-care-greater-manchester

[xxxii] The NHS Alliance has developed a power shifting toolkit which can be downloaded for free (January 2020)
https://www.nhsalliance.org/?s=power+shifting