DIGITAL HEALTHCARE COUNCIL

Digital Healthcare Council key themes

Overview

This paper draws on the experiences of DHC members to highlight opportunities and challenges across all areas health and social care sectors.

It identifies key challenges facing the system, how digital can help and what needs to change.

The themes explored in this paper, access to high quality remote consultations, empowering people across integrated care systems and optimising patient and service user flow, share many common themes and messages as summarised below:

- the quality of digital solutions currently available in health and social care varies significantly.
- We all have a responsibility to address this, and we believe it starts by clearly articulating what matters most to service users. There is a body of literature on the healthcare quality domains, but when we listen to our users (and we have millions of data points for this), we hear two overwhelming themes:
    - patients and service users want their needs quickly and effectively, so we must
    - support staff to work at the top of their skillset with easy-to-use solutions that are integrated into the wider workflow

To do this, we need a system that:

- rewards high-quality solutions and disincentivises box ticking
- is open and transparent about how digital solutions support those objectives
- is willing to change more widely to adopt smarter ways of working which may be digitally enabled, rather than seeing the digital solution as the end goal. In some cases, that will mean changing where and how we support patients.
- procures solutions by prioritising those that can be shown to achieve these goals, placing more emphasis on user-reported experiences, and less weight on extensive compliance requirements
- prioritises a genuine choice for service users and avoids arbitrary targets
- is inclusive, recognising that individual choices and preferences vary, and takes a system-wide view, noting that increasing access for one channel, can free up access for others through a different route
- provides real-time information tailored to the full range of audiences, and
- reduces delay by automating actions wherever possible
- learns from patient service user feedback
- continuously improve through rapid iteration
- works across institutional boundaries

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Introduction

During the Spring of 2020, DHC members engaged in a series of workshops examining three broad themes:

- Access to high quality remote consultations
- Empowering people across integrated care systems
- Optimising patient flow

These themes cut across care sectors and so are applicable to primary and secondary care, diagnostics, mental health and social care provision.

Those discussions examined

- why the themes are so important to health and social care
- how digital solutions can help
- what are the blocks to realising greater benefits
- what needs to change to address those obstacles

This paper summarises the outputs of those discussions. The lessons have broad applicability for our approach for the rest of the year, with relevance for all areas of health and social care, including challenges faced in primary care access, alleviating pressure in hospital services, and providing alternatives to residential social care provision.

The paper proposes narratives for all these areas which have member support and cover key issues relevant to the services they provide. It also identifies key policy asks to embed into our stakeholder engagement programme.

Finally, the paper identifies a list of key stakeholders and decision makers who we should engage, to explore the policy and operational challenges that this paper presents, and with whom we should engage as they develop wider programmes of relevance to the sector

In short, this is the core script that drives our engagement work with the media, policy, and decision makers.

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Access to high quality remote consultations

What are the issues?
When done well, remote consultations can make life better for patients and staff while simultaneously delivering a more responsive and efficient service.

The key issues limiting this area are:

- Quality of remote consultations varies significantly by provider and sector.
- Uptake of remote consultations varies hugely and despite being theoretically available to all, a full choice, including video, is rarely offered.
- In turn, the transformative potential of remote consultations is, with a few notable exceptions, largely missed.

Underlying factors
We need to understand what underlies this variation and take steps to put this right. There are several contributory factors:

- A lack of understanding about what is meant by remote consultations, among staff, patients, and the media. By remote consultation, the DHC means any consultation that occurs remotely, so includes:
    - online forms-based consultations where a response may follow, after the patient has completed the form (asynchronous consultation types)
    - chat and messaging
    - telephone-consultations
    - video consultations

  It is worth noting that the best experiences often involve a combination of the above approaches, e.g. when a patient supplies some information in advance, and a video consultation follows, with all parties clear about accompanying processes and that this is the most appropriate channel.
- There are misconceptions about virtual consultations introducing additional and avoidable steps into already pressured pathways. In practice, where problems arise, this is normally due to the selection of the wrong modality for that individual case, and/or insufficient support around the consultation.
- In many cases, remote consultations offer their most transformative potential, when pathways are significantly re-engineered. However, this insight often meets resistance operationally, and is rarely included as part of the policy context.
- NHSE access policies pose significant challenges, for example:
    - There are arbitrary targets for face-to-face consultations in general practice, singling out practices that deliver the most remote consultations for additional scrutiny.
    - Choice of consultation type is framed as rights to face-to-face consultations, rather than a choice of high-quality options that includes all modalities.
    - Policies emphasise *access* to remote consultations, but without measures of quality and uptake, this target has limited value.

- Misconceptions about what patients want, which are amplified in the media, NHSE policies, and by campaigning groups.

- Staff and services procuring remote consultation services have a choice of procurement frameworks, and impenetrably long lists of detailing functionality requirements, but they have access to little real-world evidence about the quality of those services.

- There is only limited reliable information available publicly about remote services offered by general practices, hospitals and other healthcare providers that relates either to availability, uptake, or user experience.

- Procurement frameworks focus on compliance with standards rather than outcomes.

- The absence of a focus on outcomes and user experience, combined with fixed low prices, incentivises providers to focus on ticking as many boxes as possible at the expense of developing improvements in quality and experience. In turn utilisation is lower than it should be, much of the value of remote consultations is lost and opportunity costs grow.

What needs to change?

1. Communicate a clear narrative

We need to articulate a clear narrative about the value of remote consultations that describes:

- The role of online (i.e., form-based) consultations, telephone, and video consultations, including how they relate to face-to-face encounters. This means explaining:

    - Patients' number one priority is to address their issue, in the most timely and convenient way possible.

    - When given a meaningful choice of consultation type, only around 10% request face-to-face appointments.

    - Many patients have changed their NHS primary care practice so that they can access care digitally or choose to pay for services either through insurers or on a self-pay ad hoc basis because they prefer those options.

    - Patients should be offered the full range of consultation types that are clinically and operationally appropriate.

    - Many appointments are essentially administrative or for guidance, e.g. routine prescription renewal, or asking for clarification about a particular medicine. By default, these should be remote, with many such queries would be easily addressable via messaging or chat.

    - Remote consultations offer greater flexibility allowing service providers to respond to demand pressures without geographic constraints. In turn, overstretched services can more easily flex to meet demand, and free up time for those patients who need a face-to-face appointment, increasing access for all, including those who do not want to use remote consultations.

- Remote care is a safe option, minimising the risk of picking up or spreading infections, and reducing risks for patients and staff where face-to-face care is appropriate, especially important now that general practices have been told to remove physical distancing measures introduced earlier in the pandemic.

- Video consultations offer opportunities for clinicians to identify issues that may be missed by communications limited to text or voice.

- Remote consultations allow multiple health care professionals to meet easily without needing to travel, potentially transforming the process of serial consultations, improving efficiency and effectiveness.

- Remote consultations can address accessibility issues, for example by improving access to translators who can help communicate through sign language or from other languages. Video consultations are particularly well-suited to these challenges.

- A telephone or video consultation is a conversation, just like a face-to-face consultation. Consequently, they typically take as long as face-to-face consultations. But when supported by online forms to collect routine information, the quality of the discussion be significantly enhanced allowing the clinician to work at the top of their skillset instead of using valuable consultation time entering routine data.

- Remote consultations offer an easier way to provider patients with the significant information they need to make a decision together with sufficient time to digest this in the comfort and privacy of their own homes.

- Remote consultations are particularly useful when pathways are re-engineered more widely. Examples include:
  - as an initial screening to carry out initial outpatient appointments and/or to help patients better prepare for a face-to-face consultation, e.g. as part of the pathway for elective care
  - dermatology services, where asynchronous information collection can allow discussions to focus on high-added value conversations
  - supporting PIFU
  - to allow both parents and/or to be present at paediatric consultations

- Remote working allows staff to work in more flexible ways that suit their lifestyle, in turn being able to work more shifts and increasing capacity. DHC members report that staff choose to do up to 25% extra activity per week by working flexibly and balancing family pressures.

- Remote consultations can take pressure away from other elements of the system, e.g., reducing pressure in A&E.

- Remote consultations save patients considerable cost, avoidable travel time and waiting time and have a positive environmental impact by reducing pollution caused by travel.

What we need from members:

- Working with members we need to build on the points above with supporting evidence, data, and critically, with real stories that being the transformative potential of remote consultations to life. Evidence and stories would be especially helpful to illustrate:

    - How remote consultations have transformed patients' experiences of care, e.g., through greater convenience, picking up issues that may otherwise have been missed, through MDT working, and in managing/reducing elective waiting lists. I.e. remote consultations offer a rich proposition for today's challenges, not just as a Covid stopgap.

    - Ways to quantify support around remote consultations that can generate time savings, noting that the high-quality interactions within the consultation take a similar amount of time regardless of modality. We see savings in four broad areas:
        - Back-office savings, automating processes at scale
        - Collecting routine information before the real-time consultation with the clinician
        - Creating additional remote capacity in response to demand pressures by deploying resources in different geographies, allowing staff in high-pressured locations to respond to face-to-face need
        - Accessing time that would otherwise be unavailable by providing flexible working that allows staff to work more shifts that suit their lifestyles.

    - Data on patient satisfaction, including overall experience and timeliness of care.

    - Calculate cost, time, and environmental savings from a realistic remote consultation uptake goal.

    - Advice and criteria for qualifying for video consultations.

2. Policy changes

The current approach needs to incentivise high quality remote consultations placing much greater emphasis on outcome measures rather than compliance. To do this we need to:

- **Emphasise choice** based on patient preferences and clinical requirements. Empowering patients to make informed decisions is both the right thing to do and there is overwhelming evidence that where patients have better outcomes when they have control over their care.

- **Publish outcome and utilisation measures** for a limited but well-chosen dataset that matters to patients and staff. We know NHSE collects considerable data from DFOCVC providers and has plans to make some of this available, but it is currently unclear which aspects will be published, at what level and whether this will be made public or just available to a select NHS audience.

  As a starting point, the following metrics should be published:
    - Patient satisfaction with each consultation
    - Patient satisfaction with the mode of consultation
    - Timeliness, i.e. whether the consultation met each patient's needs
    - Was a choice of consultation offered? (including what were the choices)
    - Which remote consultation platform(s) were used

The DHC believes these metrics should be published at a sufficiently granular level to inform decision making. In most cases this will mean at practice-level for general practice and NHS Trust level for hospital provision, because this is the level at which patients have a degree of choice.

- **Changes to procurement approaches**

    - **reduce the number of compliance elements** in contract frameworks but instead ask for evidence of ease-of-use and provable outcome benefits

    - **encourage easy-to-use high value solutions**. We caution against moving to payment based on utilisation because this risks creating conflicts of interest to encourage patients to use one channel over another. However, we also need to acknowledge that fixed price frameworks tend to encourage races to the bottom at the expense of innovation and improvement. The only way to avoid this is to ensure greater transparency through publishing useful information to inform better decision making.

- **Changes to definition and implementation**

    - There is a world of difference between an unsupported video consultation carried out ad hoc using a free commodity service such as Skype and a remote consultation platform that ensures the choice of consultation type is clinically suitable, meets each patient's preferences on every occasion and collects vital information before the conversation begins. This approach needs to be accepted as standard practice.

      Only by taking this comprehensive approach can we avoid wasted time and frustration that arises when, for example, a patient is channelled towards an unsuitable modality be that a video consultation for which a patient has no suitable equipment or unnecessary and expensive travel for a discussion ideally suited for a remote conversation.

3. Equalities and accessibility

Objections frequently raised in opposition to digital health solutions often centre on equalities and accessibility.

Overly simplistic arguments that are often cited revolve around an assumption that everyone should be able to access precisely the same service in the same way. Although this argument does not withstand scrutiny, it often obscures more meaningful conversations.

We need to change the discussion to ensure that the equalities and accessibility debate is seen in terms of:

- Making a choice of high-quality options available to all, while noting that what works for one group is not necessarily the same as what is best suited for others – that insight is at the very essence of personalised care.
- We should assess the impact of new developments on accessibility and health inequalities by looking at their impact on all channels of provision.
- Highlighting specific examples of how digital has enabled access to care that was previously not available or hard to reach.
- Identifying metrics that illustrate a diverse adoption across different demographics.

We also need to understand the specific concerns that NHSE has around accessibility standards.

Optimising patient flow across the system

Context

One of the most significant overarching challenges facing health and social care is to optimise the flow of patients and service users along their care pathways.

Even in a system with considerable additional capacity, patient care suffers considerably if it is repeatedly snarled up by multiple bottlenecks. In a system that faces unprecedented demands, the only way to maximise existing capacity, and make the most of new investments, is to optimise flow.

There are numerous areas where bottlenecks in patient flow frequently creates avoidable pressure backing up throughout the system. Delays in discharging patients from hospitals affects patients throughout the hospital. The impact is felt both by those who are unable to be discharged and by those elsewhere in the system who cannot access resources snarled up with bottlenecks. And all too often, the surges we frequently see in A&E departments across the country have widespread effects in other services as well as directly on those who need urgent care. These are just two high profile examples among many.

To solve flow issues, we must work across and within all the providers that contribute to an individual's care pathway.

Addressing flow

There is a dense literature on different methodologies to ensure flow in health and social care and beyond. They all have share common elements including:

- a clear understanding of what is important – how value for patients and service users is achieved
- an accurate, real-time picture of the current situation mapping resource utilisation
- a system that supports the provision, allocation and freeing up of resources when and where they are needed – embedding anticipation and automation wherever possible, and freeing staff to work at the top of their skillsets
- feedback – that constantly updates the real-time picture, keeping it accurate, with rapid insight into problems as they arise and informing continuous improvement.

Each of the above steps can be enhanced through digital solutions. For example:

- Understanding how value for patients and service users is achieved has many aspects, but the collection and intelligent analysis of patient feedback, monitoring of outcomes and ease of access all feed into this picture.
- Real-time situation mapping requires the flow of accurate data about resource availability, much, if not all of which can be collected automatically. In turn this information can be scrutinised with powerful analytics and presented back in an intuitive form. It's crucial that any dashboards are action-oriented, and that wherever possible these actions are automated, reducing delay and avoiding the need for highly skilled healthcare professionals to plough through endless mundane administration. Instead, systems should only require manual intervention to manage difficult decisions that require professional judgement and to expedite exceptional occurrences. If expediting similar scenarios becomes the norm, this is a clear indication that there is an opportunity for either re-engineering and/or automation.

Clinical insight and opportunities

There are significant clinical opportunities that follow in addition to the obvious benefits that optimising flow directly achieves: ensuring a much smoother patient experience and far more efficient resource utilisation.

Examples and opportunities span all health and social care sectors. For example:

- Primary care – triaging into general practice and directly to other primary care providers where appropriate
- Diagnostics – widening access and availability of testing, and sharing information about test results to inform other parts of the system, especially to tests that can be carried out remotely, e.g. swab-based or non-invasive tests, such as sexual health testing, or tests that require a photo, e.g. screening for dermatology
- Acute inpatient – identify and plan resource requirements throughout stay, including bed utilisation and anticipating discharge requirements
- Secondary care outpatient – managing patients remotely through hospitals at home or virtual wards, providing regular monitoring and face-to-face support when needed
- Mental health provision – providing access, often out of traditional hours, to patients when they need it, often remotely to respond to crises, rather than waiting for daytime opening hours
- Social care – increasing the range and availability of step-down options

Cross-cutting clinical opportunities that cross sector boundaries include:

- Scope to cohort patients by risk, or other clinical factor, rather than ward or geographic proximity
- Continuous and consistent support for patients along the pathway regardless of setting
- Immediate capacity planning ready to respond to predictable clinical demands arising from the signals that may have been generated elsewhere and at a much earlier time, e.g., acute demand arising from community-based testing
- Continuity of clinical measures within a healthcare setting and across organisational boundaries
- Development of comprehensive personalised discharge plans including community-based or residential support, potentially from before the point of admission, and certainly long before discharge is imminent
- Provision of new services for specialties such as dermatology that have historically been provided in a hospital setting, with considerable waiting times for access, but could largely be provided remotely, freeing up vital face-to-face capacity for those who need it.

Blockers to optimising flow

Digital healthcare Council members have experienced numerous blocks to implementing services that could significantly enhance patient flow. These include:

- Ambiguities and misunderstanding around key terms such as triaging, especially in primary care, can limit opportunities. For example, triaging is a term that can be used to mean a simple online form for later manual review; a decision tree to channel patients with a reasonably narrow set of conditions to a restricted set of options; right through to a comprehensive AI tool assessing a wide range of patients, solving complex problems to direct patients to specific care options. Such a broad range of scope gives rise to misunderstandings about expectations, appropriate regulation and, when applied to procurement processes, can lead to comparisons of apples and pears. Moreover, solutions that fall within medical device definitions are heavily regulated whereas other triaging solutions are not, and can therefore use terminology far more liberally.

- Perverse incentives caused by existing metrics and that hinder innovation. For example, NHS 111 standards for responsiveness incentivise sending patients to local A&E departments. A better approach would be to:
    - provide a wider range of signposted services and reduce the reliance on NHS 111 as an entry point for patients, instead allowing for wider range of charging services
    - shift the balance of measures away from system-oriented metrics and towards measures that patients say are important to them, for example ease of access.
    - Consider and quantify lost opportunities. For example a system that has a bottleneck around urgent care access directly leads to patients waiting in corridors or ambulances. While we routinely collect patient safety incident information about harm that is done to patients, as a system, we are far less likely to consider and report harm that arises because care was denied due to access issues.
- Deliberate obstruction by individual decision-makers for ideological reasons or conflicts of interest. For example, GPs refusing to support new facilities because it will "take business away"
- A lack of clarity on how Integrated Care Systems are engaging independent providers, despite the requirement from NHSE so to do.
- General cultural hesitancy around change, made more difficult by a rhetorical direction at the centre, not necessarily supported by levers at an operational level. E.g. the centre stating that funding has been made available for transformational initiatives, but little or no knowledge of such funding elsewhere in the system.
- As with remote consultations, procurement frameworks rarely provide a platform that supports genuine innovation or system re-engineering. Instead, purchasers report that they struggle to navigate through the available options and providers frequently report only limited business is won through these routes.

Lessons for the DHC's narrative on optimising flow

We need to create a narrative that:

- Quantifies the scale of the problem
- Explains what we can change
- Communicates transformational stories supported by data

To quantify the scale of the problem we can draw on existing datasets, e.g.:

- A&E waiting time data – increase in long waits
- Delayed discharge data – number / proportion of patients ready to discharge but staying overnight
- Measures of specific metrics, e.g., unused bed capacity
- Increased pressure on diagnostics, as measured by waiting duration, compared to relatively static activity

Our narrative on change should cite examples supported by stories that explain what these figures mean to affected individuals. Specific data points include:

- Improve bed capacity by 7,000 beds per day, equivalent to 440K admissions per year (same admissions capacity as 40 hospitals size of Barnsley) (Teletracking)
- Redirecting patients with minor ailments suitable for self-care to a pharmacist instead of the GP, the NHS could save around £812 million (ada)
- Community testing: 10% drop in face-to-face sexual health consultations in 2020 outweighed by extra 1million remote tests, with increased representation among minority groups and most deprived communities (preventx)
- 37% reduction in dermatology waiting list at an NHS Healthcare Trust over a 12-week period following the introduction of a virtual dermatology service (HBS UK)

- 42% of patients redirected away from urgent care to more suitable provision; 51% of assessments completed outside of clinic hours; and triage found by a Stanford University study to be of a comparable standard to human triage nurses (ada/Sutter Health)

Our narrative should emphasize the following themes:

- Shift the focus towards benefit to patients, and the value delivered both to them into the system.
- Support this approach through greater transparency through metrics that quantify what matters to patients, e.g., access and responsiveness. For example:
    - PREMs
    - Assessment turnaround / speed of diagnosis
    - Diagnosis accuracy
    - Journeys saved
    - Waiting time

  Crucially, these metrics should be compared with current models of care to give insights into relative strengths and weaknesses of innovative approaches.
- Cite examples of successful partnerships where trust and relationships have been built and delivered measurable benefits to patients
- Call for specific initiatives commissioned by the centre designed to tackle identified local problems, learning lessons from both the ISTC programme of the mid-2000s which created genuine additional capacity and led to significant reductions in elective waiting times; and the recent community diagnostic initiative which is yet to demonstrate notable impact on waiting times or volume, and that that largely channels resources into existing facilities.
- Emphasise benefits to staff, i.e., this is about giving time back to staff, freeing them to provide care, rather than wasting time on tasks that could be automated, or removed altogether
- Provide feedback to purchasers to enhance information made available through frameworks. This should include feedback from users, potentially capturing both staff and user experiences and ratings.
- Recognise that we can learn from approaches not developed in the NHS, including other countries and sectors

Empowering people across integrated care systems

Context
For many years, it has been clear that the key pillars of our health and social care system, i.e., healthcare, public and preventative health services, and social care too often operate in silos. The numerous underlying intertwined historic and institutional reasons are beyond the scope of this paper, but overall, the result has been disjointed services which, to the frustration of those working within them, can leave patients and service users with disjointed care, unavoidably poor outcomes, and incur unnecessary costs.

The creation of Integrated Care Systems, and their underlying institutions, are designed to tackle some of these issues at an organisational level, but we need to focus on addressing specific areas if we are to see genuine transformative change.

Specific integration issues that can be addressed by digital health and social care solutions
We believe many significant opportunities exist to improve services and save money, for example, we could:

- **Tackle delayed discharge** to improve acute hospital capacity and patient experience through better coordinated stepdown services[1].
- **Support more people to live independently** for longer by bringing social care into people's homes, rather than forcing people who need care to move into long-term residential provision (and save significant amounts of money in the process).
- **Improve access to testing and screening** with more responsive, convenient, inclusive, and personalised public health services, for example sexual health screening, at a considerably lower cost than traditional models of provision.

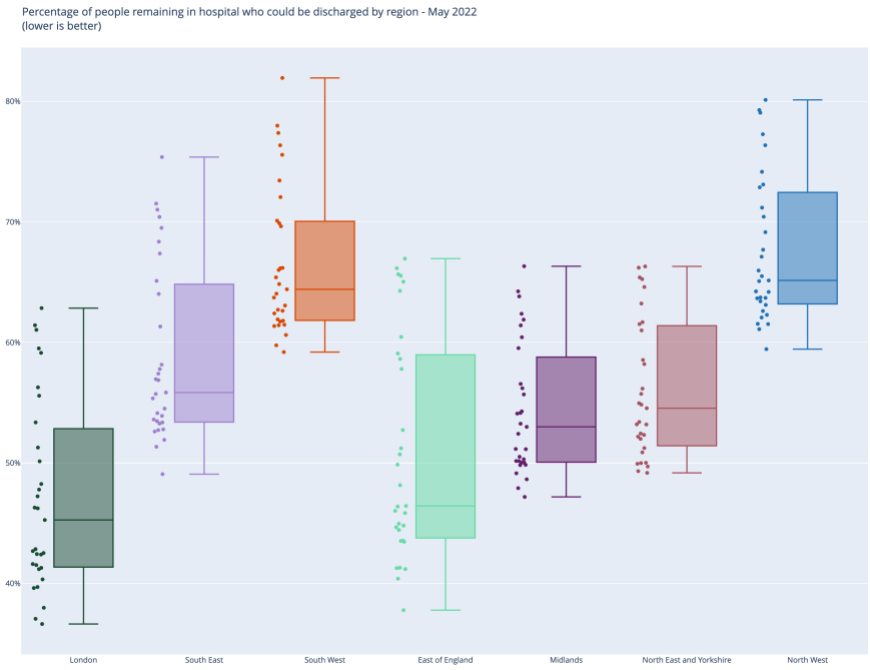
The technology and services to achieve these objectives are already available and working, but utilisation varies hugely leaving a postcode lottery of available provision.

What needs to change?

1. We need to strengthen and clarify our story about the scale of what can be achieved

Patient discharges from hospital. We know from hospital discharge data that every day last month (May 2022) at least half the patients who were ready to be discharged from acute settings stayed in hospital longer than necessary. The box plot below shows the daily variation across each region.

[1] These are some of many improvements to optimise patient and service user flow that we will explore in a separate paper.



The government has made a policy decision to make this information available, so the scale of the challenge to ICSs is an accepted issue.

From data released so far covering April and May 2022, we would expect that the total number of unnecessary bed days per annum due to delayed discharge is likely to be around 4.5million. At a cost of around £400 per night[2] this equates to around £1.8 billion per year.

While we can amplify this issue by highlighting variation and drawing attention to insights from the data, we must add to this by explaining how we already support care planning so that patients can more easily return home when they are ready to leave hospital. Our case must both:

- quantify what can realistically be achieved based on existing practice
- tell compelling stories of people who have benefited from these services

Supporting more people to live independently. We know that we can reduce the number of people who need to go into long-term residential care by using integrated personal budgets to provide in-home support – "bringing social care to granny, instead of putting granny in social care". This is a compelling narrative that has obvious appeal, so we need to articulate this in terms of

- Case studies that tell the story of people who are living supported but independent lives who otherwise would be in long-term residential care
- Quantifying realistic improvements at scale that could be achieved against key measures, expressing this both nationally and locally:
    - improvements on the two-hour two-day target,
    - quantifying how many people could be supported to live independently, and for how long, who otherwise would need to go into long-term residential care
    - calculating the financial savings to the system arising from improvements on 2hr2day and residential care savings

Improved access to testing and screening by taking services out of buildings and bringing them to people. The traditional model of testing and screening involved patients typically travelling to have

[2] Source: BBC referencing DHSC but original DHSC link no longer available. Alternatively, Age UK referenced a cost of £346 per day from 2017-18.

tests carried out at a physical location, and then waiting for results to be returned, possibly with a further journey involved. As the population has become all too familiar with home testing through Covid LFTs, we can take advantage of that familiarity by changing our model of where many tests are typically performed. Moving away from physical locations to a remote model would be far more efficient by freeing up considerable resources currently used to support public-facing buildings.

As well as financial savings and greater convenience, remote and home-based testing offers a more responsive, convenient, and personalised approach for many.

We need to tell this story through case studies that explain the intangible benefits such as greater convenience, personalisation, and inclusivity, while supporting this with quantitative information such as:

- the range of tests and volume that could easily transition to a remote/home-based model
- the number of unnecessary journeys that could be avoided
- improvements in turnaround time
- the amount of time that could be freed up at existing centres to support other activity
- the number of locations that could benefit from moving services to remote model
- improvements in access to testing
- variation in outcomes performance across systems mapped to either the policy levers we want to utilise, such as uptake of personal budgets, and/or uptake of services that we provide

2. Policy and operational changes

From discussions with members, we believe the major blocks to implementation include:

- Variation in the effective and consistent utilisation of existing policy vehicles such as personal health budgets.
- In part this is due to a lack of knowledge about what can be done, even though, for example, the NHS Long Term Plan sets out the ambition for care to be personalised and tailored around the needs of the individual, allowing people to have more autonomy over their health and wellbeing through vehicles such as personal health budgets.
- There are also cultural obstacles including a general resistance to doing things differently and a lack of willingness to give up control.
- Frameworks often mandate regulatory requirements that are more appropriate for existing approaches rather than more innovative models. For example, CQC registration is rightly required for care providers, but the missing piece of the jigsaw is to match service users with registered providers. In turn, this matching service falls outside of the CQC's remit, so procurement frameworks and processes should not demand registration as an essential eligibility criteria.

Given these hurdles are largely oriented around awareness and uptake, rather than requiring specific policy changes at a national level, our approach should be to:

- draw attention to the scale of the opportunity through the narrative described above
- call for the centre/ICSs to support the development of a market in home-based care supported by personal budgets
- highlight geographic variations, drawing attention to areas of good practice and calling out those that are under serving their communities.