



National Audit Office

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## **Report**

by the Comptroller  
and Auditor General

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**Department of Health, Department for Communities and  
Local Government and NHS England**

# Health and social care integration

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Department of Health, Department for Communities and  
Local Government and NHS England

# Health and social care integration

Report by the Comptroller and Auditor General

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National Audit Act 1983 for presentation to the House of  
Commons in accordance with Section 9 of the Act

Sir Amyas Morse KCB  
Comptroller and Auditor General  
National Audit Office

6 February 2017

This report examines the progress the Department of Health, the Department for Communities and Local Government and NHS England have made towards integrating health and social care services.

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## Key facts

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**£5.3bn**

total pooled budget  
in the first year of the  
Better Care Fund

**£511m**

Departments' and  
partners' estimated  
savings from the first  
year of the Better  
Care Fund

**2020**

target date for integrated  
health and social care  
services across England

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<b>87,000</b>	actual increase in emergency admissions to hospitals between 2014-15 and 2015-16, against a planned reduction of 106,000, as reported in Better Care Fund metrics
<b>185,000</b>	actual increase in delayed transfers of care between 2014-15 and 2015-16, against a planned reduction of 293,000, as reported in Better Care Fund metrics
<b>628</b>	permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population in 2015-16, exceeding the target of 659 per 100,000
<b>82.7%</b>	of older people who were still at home 91 days after discharge from hospital receiving reablement or rehabilitation services in 2015-16, exceeding the target of 81.9%
<b>£900 million</b>	NHS England's expectations of savings from the roll-out of new care models by 2020
<b>90%</b>	proportion of local areas that agreed or strongly agreed that the delivery of the Better Care Fund plans had a positive impact on integration locally
<b>£2.1 billion</b>	NHS Sustainability and Transformation Fund for 2016-17, of which £1.8 billion was allocated to covering NHS deficits rather than transformation

# Summary

**1** Integration is about placing patients at the centre of the design and delivery of care with the aim of improving patient outcomes, satisfaction and value for money. Rising demand for care services, combined with restricted or reduced funding, is putting pressure on the capacity of both local health and social care systems. The Department of Health, the Department for Communities and Local Government (the Departments) and NHS England are trying to meet the pressures on the systems. They are doing this through a range of ways intended to transform the delivery of care, one of which is to integrate health and social care services at the local level.

**2** Integration aims to overcome organisational, professional, legal and regulatory boundaries within the health and social care sectors, to ensure that patients receive the most cost-effective care, when and where they need it. Some barriers to integrated care are substantial. England has legally distinct health and social care systems. The NHS is free at the point of use, while local authorities typically only pay for individual packages of care for adults assessed as having high needs and limited means. Both systems are in turn made up of a complex range of organisations, professionals and services.

**3** The Department of Health is responsible for health and adult social care policy in England. The Department for Communities and Local Government has responsibility for the local government finance and accountability system. NHS England is responsible for supporting clinical commissioning groups and for the commissioning of NHS services overall. The two Departments and NHS England are trying to address funding and demand pressures by supporting local authorities and NHS bodies to integrate services.

**4** The Departments and NHS England do not prescribe how organisations in a local area should integrate services. Local areas can choose to integrate services in a broad range of ways and how they do so depends on the needs of the local population, and on existing care services and structures. Integration is not about organisations merging and can cover a range of types of cooperation. For example:

- at patient level, local areas can introduce joint assessments of a patient's care needs across more than one service and involving more than one care professional;
- at service level, local areas can bring together several services into one place for people with a single condition, such as diabetes; and
- at organisational level, local areas can pool budgets or jointly commission services.

**5** The Departments and NHS England have made a number of commitments concerning integration.

- The 2010 Spending Review announced the transfer of £2.7 billion from the NHS to local authorities over the four years to 2014-15, to promote better joined-up working.
- The 2013 Spending Review announced that, in 2015-16, the Departments, NHS England and the Local Government Association would create the Better Care Fund. The Fund requires local health bodies and local authorities to pool existing funding and produce joint plans for integrating services and reducing pressure on hospitals. In 2015-16, the Fund's minimum pooling requirement was £3.8 billion. This comprised a pre-existing transfer of £1.1 billion from the NHS to social care, an additional transfer to the pooled budgets of £1.9 billion from the NHS, and £0.8 billion of other health and care funding streams. Some local areas chose to pool more than the minimum requirements, resulting in a total pooled Fund of £5.3 billion.
- In 2013, the Department of Health launched the five-year Integrated Care and Support Pioneers Programme to support its commitment for "urgent and sustained action" to make joined-up and coordinated health and care the norm by 2018.
- In 2014, NHS England published its *Five Year Forward View*, setting out how it aims to achieve a financially sustainable health and care system by 2020 including through integration.
- The government reiterated its commitment to joining up health and social care in the Spending Review and Autumn Statement 2015. It stated that locally led transformation of health and social care delivery has the potential to improve services for patients and unlock efficiencies. It delayed until 2020 its target date for health and social care to be integrated across England, with local areas required to produce a plan by April 2017 for how they would achieve this.

## **Scope of our report**

**6** We looked at how integration is progressing within and between the separate adult social care and health systems and the extent to which it has benefitted patients. We examined:

- the case for integrating health and social care (Part One);
- the progress of national initiatives, including the first year of implementation of the Better Care Fund (Part Two); and
- the plans for increased integration (Part Three).

**7** Our report focuses on services providing direct care to patients and does not cover other public services that affect people's wellbeing, such as housing and leisure services.



## Key findings

The Departments' case for integrating health and social care

**8 Rising demand for services, combined with restricted or reduced funding, is putting pressure on local health and social care systems.** Between 2011-12 and 2015-16, spending by NHS trusts and NHS foundation trusts increased by 11%, while local authority spending on adult social care has reduced by 10% since 2009-10. However, the number of people aged 65 and over in England is increasing at more than twice the rate of increase of the population as a whole. This number is projected to increase by 21% between 2015 and 2025. Key measures of the performance of health and social care sectors are worsening. For example, between November 2014 and November 2016, delays in discharging patients from hospital increased by 37%. The two main reported reasons for this increase were patients waiting for a care package in their own home and patients waiting for a nursing home placement. These trends indicate that an ageing population is putting pressure on hospitals and social services (paragraphs 1.5 and 1.6).

**9 Nearly 20 years of initiatives to join up health and social care by successive governments has not led to system-wide integrated services.** Since the Health Act 1999 allowed local authorities and the NHS to pool budgets and merge care services, the Departments have supported local bodies to collaborate and trial various approaches to integrating care. However, shifts in policy emphasis and reorganisations which promote competition within the NHS, such as the move from primary care trusts to clinical commissioning groups in 2013 and the Health and Social Care Act 2012 have complicated the path to integration (paragraphs 1.10 to 1.12).

**10 The Departments have not yet established a robust evidence base to show that integration leads to better outcomes for patients.** The Departments have not tested integration at scale and are unable to show whether any success is both sustainable and attributable to integration. International examples of successful integration provide valuable learning but their success takes place in a context of different statutory, cultural and organisational environments (paragraphs 1.11 to 1.13, 2.13, 2.15, 2.18 and 2.19).

**11 There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity.** While there are some positive examples of integration at the local level, evaluations of initiatives to date have found no evidence of systematic, sustainable reductions in the cost of care arising from integration. Evaluations have been inhibited by a lack of comparable cost data across different care settings, and the difficulty of tracking patients through different care settings. As we stated in our November 2014 report *Planning for the Better Care Fund*, providers of health and social care have fixed costs. Therefore reductions in activity do not necessarily translate into sizeable savings unless whole wards or units can be decommissioned (paragraphs 1.11, 1.12, 2.5, 2.18 and 3.23).

## Progress with national integration initiatives

**12 The Departments' expectations of the rate of progress of integration are over-optimistic.** Embedding new ways of working and developing trust and understanding between organisations and their leaders are vital to successful integration. This can take many years because the cultures and working practices in the health and local government sectors are very different. Local areas that have achieved more coordinated care for patients from closer working between social care and NHS organisations have been doing so for up to 20 years. An April 2016 review of integration across England commissioned by the government found that local areas had made limited progress with integration. Local areas need to know that the Departments have a sustained commitment to integration given the length of time that it takes to establish and the investment required (paragraphs 2.5, 2.13, 2.17 and 3.22).

**13 Nationally, the Better Care Fund did not achieve its principal financial or service targets over 2015-16, its first year.** The principal financial goal for 2015-16 was that the Fund would achieve savings of £511 million, based on local plans. The principal service measure was the reduction of demand for hospital services as a clear indicator of the effectiveness of integrated local health and social care services. Local areas planned to reduce emergency admissions by 106,000, saving £171 million. However, in 2015-16 the number of emergency admissions increased by 87,000 compared with 2014-15, costing a total of £311 million more than planned. Furthermore, local areas planned to reduce delayed transfers of care by 293,000 days in total, saving £90 million. However, the number of delayed days increased by 185,000 compared with 2014-15, costing a total of £146 million more than planned. The Departments and partners did not monitor or track the achievement of savings at the local level as they had no mandate to do so. In our November 2014 report *Planning for the Better Care Fund*, we cautioned that the Fund made bold assumptions about the financial savings expected that were based on optimism rather than evidence. The Departments recognise that the Fund's performance metrics are affected by factors that are outside of the Fund's influence (paragraphs 2.6 to 2.11).

**14 Local areas achieved improvements in two areas at the national level.** They reduced permanent admissions of older people (aged 65 and over) to residential and nursing care homes. They also increased the proportion of older people still at home 91 days after discharge from hospital receiving reablement or rehabilitation services. The Better Care Fund has been successful in incentivising local areas to work together: more than 90% of local areas agreed or strongly agreed that delivery of their plan had improved joint working (paragraphs 2.6 to 2.11).

**15 The Departments are simplifying the Better Care Fund's assurance arrangements and will provide more funding from 2017-18.** In response to feedback from local areas the Departments plan to reduce the number of national conditions that local areas must meet from eight to three. Between 2017-18 and 2019-20, the Departments are supplementing the Fund with £2.4 billion of additional resources. From 2017-18, the Departments plan to allow areas with more advanced integrated working to graduate from the Fund's programme management. The Departments have not yet published guidance for Fund planning for 2017-2019 (paragraphs 2.11, 3.7, 3.8 and 3.22).

**16 The Integrated Care and Support Pioneers Programme has not yet demonstrated improvements in patient outcomes or savings.** An early evaluation of the programme found little evidence of major service change being implemented or of measurable impacts on local services, such as improved cost-effectiveness or patient experience of care. The evaluation was predominantly focused on describing the setting up of local programmes and individual projects. It concluded that it was too early to identify potential improvements at this stage in the implementation process (paragraphs 2.12 to 2.15).

**17 NHS England's ambition to save £900 million through introducing new care models may be optimistic.** The *Five Year Forward View* describes seven new care models that integrate services around the patient, including, where relevant, social care. NHS England is developing these models across England, including at 50 'vanguard' test sites. NHS England hopes to reduce growth in hospital activity from 2.9% to 1.3% by 2020-21, in part through the new care models. It expects the new care models to achieve savings of £900 million by 2020-21. However, the new care models are as yet unproven and their impact is still being evaluated. NHS England plans to have evaluated the effectiveness and value for money of the new care models programme by the end of 2018. Despite this, the NHS mandate requires NHS England to roll out the new care models rapidly; achieving 20% coverage by the end of 2016-17 and 50% by 2020 (paragraphs 1.13 and 2.16 to 2.19).

The Departments' plans for integration

**18 The Departments and their partners are still developing their understanding of how to measure progress in integrating health and social care.** They plan to agree a definition of integrated care focused on patient experience. The Departments are planning to publish an integration standard describing the core elements of an integrated health and care system, although a review of the draft standard found important gaps. The Departments plan to build on the standard with a proposed integration scorecard to measure the impact of integration on patients, their health and care outcomes, and the financial savings for organisations (paragraphs 1.9 and 3.16 to 3.18).

**19 The Departments' governance and oversight across the range of integration initiatives is poor.** The Departments and their partners have set up an array of initiatives examining different ways to transform care and create a financially sustainable care system. However, the Integration Partnership Board receives updates on progress of the Better Care Fund only with no reporting from other integration initiatives. The ministerial Health and Social Care Integration Implementation Taskforce did not meet regularly and has now been disbanded. The lack of comprehensive governance is leading to uncoordinated effort across central bodies and the Department of Health has now initiated a review of governance arrangements. The Department of Health has not clarified how the Better Care Fund aligns with the new sustainability and transformation planning process (paragraphs 3.20 and 3.21).

**20 The Departments are not systematically addressing the main barriers to integration that they have identified.** The Departments do not have specific work streams to bring together, monitor and evaluate findings from various integration initiatives and emerging best practice. The three barriers – misaligned financial incentives, workforce challenges and reticence over information-sharing – are long-standing and ones which we have identified in our reports dating back to 2003. The misalignment of financial incentives arises in part from the difference between the separate health and social care systems, which are free and means-tested respectively. It also arises in part from the creation of payment systems in the NHS that promote competition and drive activity in hospitals. Creating an integrated workforce is inhibited in many local areas by difficulty in recruiting and retaining staff, particularly in community care. In our fieldwork we found a lack of understanding at the local level about whether and how patient data could be linked (paragraphs 2.14, 3.6, 3.23 and 3.24).

**21 Without full local authority engagement in the joint sustainability and transformation planning process, there is a risk that integration will become sidelined in the pursuit of NHS financial sustainability.** There is general agreement across the health and social care sectors that place-based planning is the right way to manage scarce resources at a system-wide level. However, local government was not involved in the design and development of the NHS-led sustainability and transformation planning process. The engagement of local authorities has improved for the local planning and decision-making phase of the process, with four of the 44 local sustainability and transformation plan footprint areas led by local authority officials, but overall engagement to date has been variable (unlike their more structured engagement with the Better Care Fund). The process is widely regarded as NHS-led and NHS-focused. The Departments have dropped requirements for local areas to produce a separate plan by April 2017 showing how they would integrate health and social care by 2020. Instead, local areas must demonstrate this through their 2017–2019 Better Care Fund plans, and sustainability and transformation plans. Research commissioned by the government in 2016 concluded that local areas are not on track to achieve the target of integrated health and social care across England by 2020 (paragraphs 3.12 to 3.14 and 3.22).

**22 NHS England has not assessed how pressures on adult social care may impact on the NHS.** NHS England has noted that the widening gap between the availability of, and need for, adult social care will lead to increases in delayed discharges and extra pressure on hospitals. However, we did not see any estimate of the impact on NHS bodies of pressures on social care spending (paragraph 3.4).

**23 NHS England is diverting resources away from long-term transformation to plug short-term financial gaps.** NHS England has set up the Sustainability and Transformation Fund to pay for transformation between now and 2020, including work to integrate local care services. However, so far most funding is being used to address the deficits of NHS trusts. NHS England has used £1.8 billion (86%) of the £2.1 billion available in the Sustainability and Transformation Fund for 2016-17 to meet provider deficits. It has said it will continue to use the Sustainability and Transformation Fund to meet provider deficits in 2017-18 and 2018-19. The £0.3 billion of the Sustainability and Transformation Fund left for transformation in 2016-17 includes funding for new care models ‘vanguard’ sites and is available only where organisations meet control totals and performance trajectories (paragraphs 3.10 and 3.11).

### **Conclusion on value for money**

**24** Joint working between the NHS and local government to manage demand and support out-of-hospital care through integration could be vital to the financial sustainability of the NHS and local government. The Better Care Fund has increased joint working and the provision of integrated services. However, in the face of increased demand for care and constrained finances, the Fund has not yet achieved its potential to manage demand for healthcare; support out-of-hospital care; improve outcomes for patients; or save money. A key assumption of the Fund – that funding could be transferred from the health sector to social care without adverse impact on the NHS – has proved not to be the case because the health service itself is under financial pressure. As a result, the Fund has not achieved the expected value for money, in terms of savings, outcomes for patients or reduced hospital activity, from the £5.3 billion spent through the Fund in 2015-16.

**25** Sustainability and transformation plans could be, but are not yet, a vehicle for joint health and care planning. Unless the Departments decide to formally align local health and adult social care planning, there is a significant risk of sidelining the Better Care Fund and missing the goal of integrating health and social care services across England by 2020. To support that process we would reiterate our 2014 emphasis on the need for robust evidence on how best to improve care and save money through integration and for a coordinated approach. The Departments do not yet have the evidence to show that they can deliver their commitment to integrated services by 2020, at the same time as meeting existing pressures on the health and social care systems.

## Recommendations

**26** The Departments, NHS England and NHS Improvement are all working on integrating health and social care services. They face two main challenges: providing the environment within which integrated services can succeed and benefit patients; and creating a robust evidence base demonstrating the scalability and replicability of cost-effective integration initiatives. The Better Care Fund has not led to the intended improvements over its first year and the other current integration initiatives are making slow progress. Nevertheless, the government has underscored its commitment to integration through announcing additional contributions to the Better Care Fund from 2017-18. We recommend that the Departments and their national partners:

- a Confirm whether integrated health and care services across England by 2020 remains achievable.** Progress with integration has, to date, been slower and less successful than expected. Financial pressures are increasing for both health services and local government and it is not clear that integration will alleviate these pressures or improve services for patients. The Departments should therefore assess the achievability and benefits from seeking integrated services by 2020.
- b Establish the evidence base for what works in integrating health and social care as a priority.** The existing evidence base does not yet support the proposition that integration saves money, reduces hospital activity or improves patient outcomes. There is much work under way to evaluate current initiatives and the timely dissemination of the outcome of evaluations will support local decision-making and allocation of resources.
- c Review whether the current approaches to integrated health and social care services being developed, trialled and implemented are the most appropriate and likely to achieve the desired outcomes.** While popular approaches, such as multi-disciplinary teams focusing on patients with multiple and complex needs, may improve the care experience for a minority of patients, the evidence to date does not suggest that they will achieve the widespread efficiencies and outcomes needed in the current financially constrained times. The Departments and their partners should support local areas by identifying, from the available evidence, which forms of integration are most likely to lead to the desired outcomes at this time. This might include focusing on particular cohorts of patients, particular pathways of care or particular groupings of health and care services.
- d Bring greater structure and discipline to their coordination of work on the three main barriers to integration – misaligned financial incentives, workforce challenges and reticence over information-sharing.** Local areas are finding these barriers difficult or impossible to overcome at the local level, and the Departments recognise that national approaches are required. The Departments and their partners should consider whether local areas need increased support and guidance to find local solutions, for example to overcome difficulties in recruiting and retaining care workers or to facilitate data-sharing and governance; or whether effort is needed at the national level, such as changes to financial arrangements to better align incentives across the health and care systems.

- e **Set out how planning for integration will be on a whole-system basis, with the NHS and local government as equal partners.** Currently, the Better Care Fund is widely regarded as an initiative that primarily benefits local government, and consequently health bodies can become disengaged. At the same time the sustainability and transformation planning process is widely regarded as an initiative to support NHS financial planning, and local authorities can become disengaged. Both initiatives have integration of health and social care services as central to reform across local areas. The Departments and partners should set out clearly how the two initiatives align and support one another, how both local government and health bodies should contribute to achieving mutually agreed goals, and how they will support local bodies where local relationships are not working well.
- f **Put in place appropriate national structures to align and oversee all integration initiatives as a single, coordinated programme.** Currently, there is no single body or board with oversight of all the ongoing initiatives, which may mean that learning is not being shared quickly and effectively, and that effort is being duplicated. Given the speed with which local areas need to move towards integrated health and social care systems, the current slow pace of progress, and the seeming intractability of some barriers to progress, it is essential that the Departments and their partners improve their central role in overseeing integration in a holistic way and in providing support to local areas.
- g **Complete their development of measures that capture the progress of implementing more patient-centred integrated care.** The Departments are expecting local areas to roll out integrated services rapidly over the three remaining years to 2020, and it is essential that they have accurate and up-to-date information on the progress being made. Local areas need to have a clear definition of what they are working towards to achieve integrated health and care services.

# Part One

## The case for integrating health and social care systems

**1.1** In this section we set out:

- the challenges faced by the health and social care systems;
- what is meant by health and social care integration; and
- how the Department of Health and the Department for Communities and Local Government (the Departments) have approached integration.

### **The challenges facing the health and social care systems**

**1.2** Demographic changes, increasing demand for care and funding constraints have increased pressures on the health and social care systems.

#### Demographics

**1.3** People generally are living later into old age. Between 2005 and 2015, the number of people aged over 65 in England rose by 21%, compared with 8% for all age groups, and is projected to increase by a further 21% between 2015 and 2025.<sup>1</sup> Younger adults with care needs, for example those with learning disabilities, are living longer, with increasingly complex conditions.

<sup>1</sup> Office for National Statistics, *Annual Mid-year Population Estimates: 2015 Statistical Bulletin*, June 2016; Office for National Statistics, *National Population projections: 2014-based Statistical Bulletin*, October 2015.



## Demand

**1.4** Improvements in living standards and clinical treatments have changed the nature of the population's health and care needs. More people are living with multiple long-term conditions. People's expectations of what the health and social care systems should provide have risen. Better treatments have been developed that are more expensive than previous options. The Department of Health estimates that:

- people with long-term conditions account for around 50% of all GP appointments, 64% of all outpatient appointments and 70% of all inpatient bed days;
- around 70% of health and social care spending is attributed to the care of people with long-term conditions, and the costs per individual increase with the number of conditions the person has; on average, someone with three or more long-term conditions in England costs £8,000 per year compared with £3,000 per year for a person with one long-term condition; and
- there will be 2.9 million people with multiple long-term conditions in England by 2018, an increase from 1.9 million in 2008 – taken together with the general cost pressures indicated above, this would add £5 billion to the annual costs of the health and care systems between 2011 and 2018.<sup>2</sup>

## Capacity and funding

**1.5** Over the period 2010-11 to 2015-16 local authorities have seen a real-terms reduction in spending power of 23.4% or 4.7% per annum. Local authorities have reduced spending on adult social care by 10% in real terms between 2009-10 (£16.1 billion) and 2015-16 (£14.6 billion).<sup>3</sup> The number of older people receiving local authority-funded social care fell 26% from more than 1.1 million in 2009 to around 850,000 in 2013-14 (the last year for which comparable data are available).<sup>4</sup> Between 2011-12 and 2015-16, spending by NHS trusts and NHS foundation trusts increased by 11%.<sup>5</sup>

<sup>2</sup> Department of Health, *Long-term conditions compendium of information third edition*, May 2012.

<sup>3</sup> Comptroller and Auditor General, *Discharging older patients from hospital*, Session 2016-17, HC 18, National Audit Office, May 2016.

<sup>4</sup> Care Quality Commission, *The state of health care and adult social care in England 2015-16*, October 2016.

<sup>5</sup> Comptroller and Auditor General, *Financial Sustainability of the NHS*, Session 2016-17, HC 785, National Audit Office, November 2016.

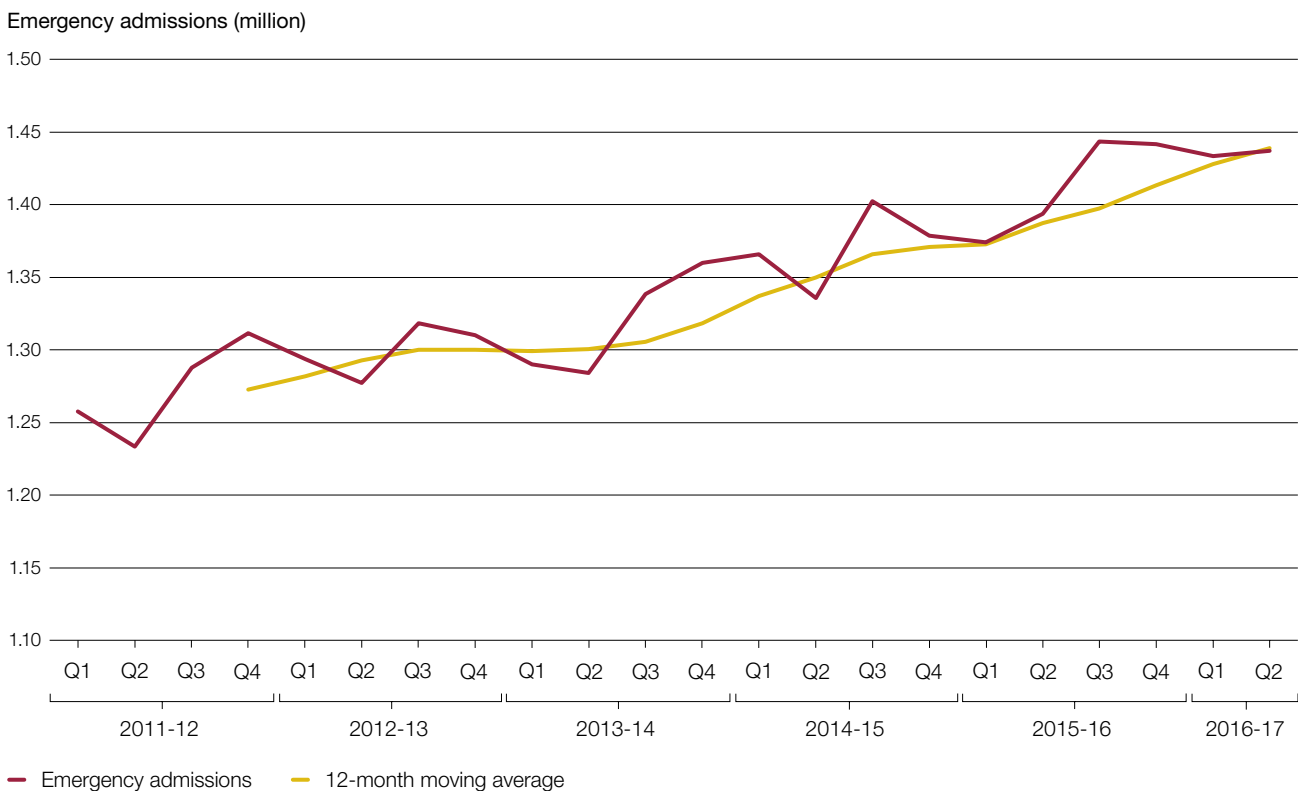
**1.6** Key measures of the performance of the health and social care sectors are worsening. Between the first quarter of 2011-12 and the second quarter of 2016-17, emergency admissions to hospital increased by 14% (**Figure 1**). Between August 2010 and November 2016 delayed transfers of care increased by 76%. Most of this increase has taken place in the past two years (a 37% increase between November 2014 and November 2016). Over this two-year period the data show:

- on average around 61% of delays have been due to health, 31% to social care and 7% to both (**Figure 2**);
- around 57% of the increase has been driven by social care, 33% by health and 11% by both; and
- the two main reported reasons for the increase are the number of patients waiting for a care package in their own home and the number of patients waiting for a nursing home placement. Delayed days increased by 119% (from 18,018 to 39,457) and 58% (from 20,285 to 32,038) respectively (**Figure 3** on page 18).

In our May 2016 report *Discharging older patients from hospital*, we noted that the delayed transfers of care data substantially underestimate the range of delays that patients experience.

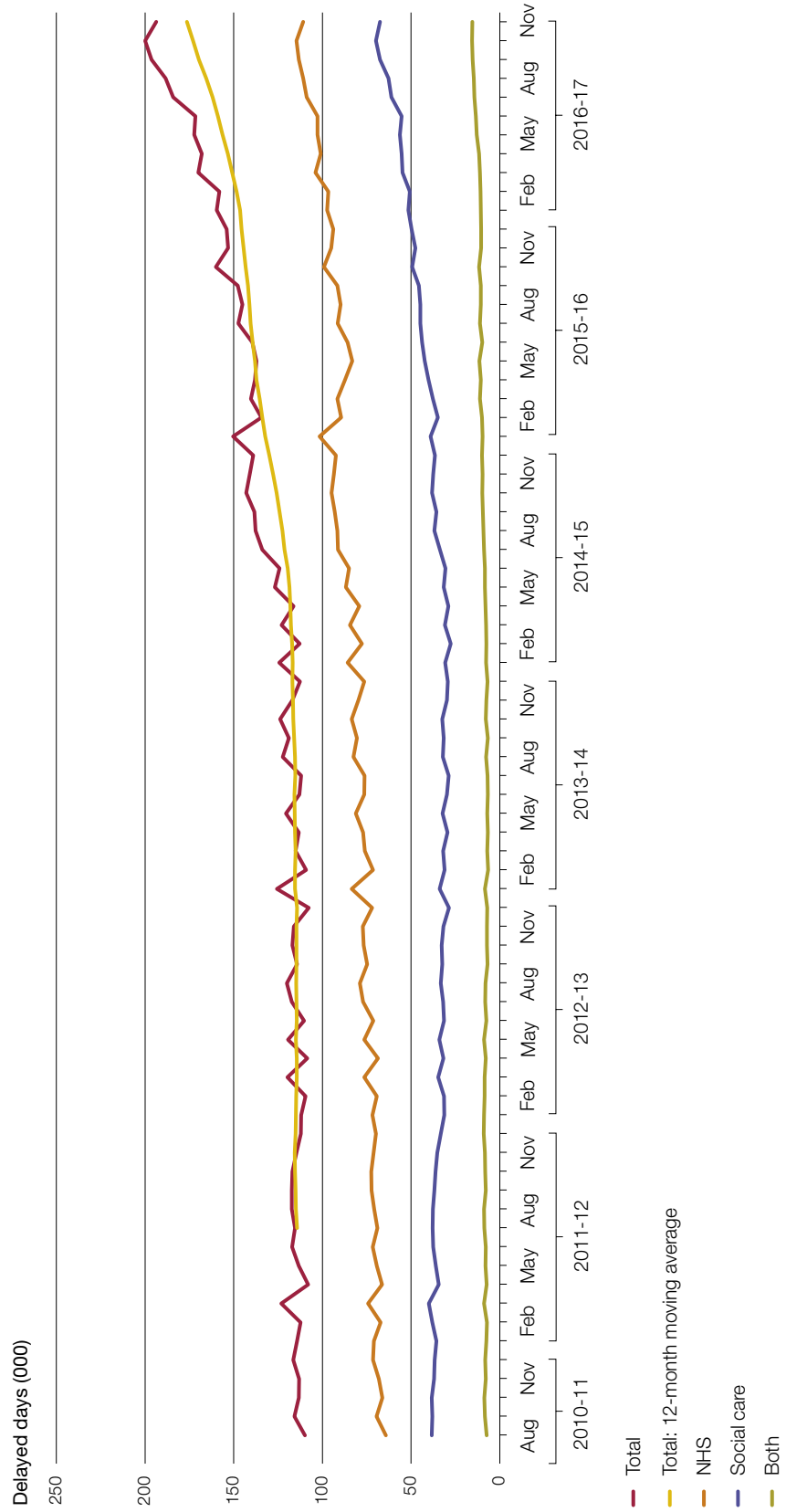
**Figure 1**  
Trends in emergency admissions

**Emergency admissions have increased by 14% between Quarter 1 2011-12 and Quarter 2 2016-17**



Source: National Audit Office analysis of non-elective (emergency) admissions statistics published by NHS England

**Figure 2**  
Trends in delayed transfers of care: responsible organisation  
Delayed transfers of care have increased by 76% between August 2010 and November 2016



**Note**

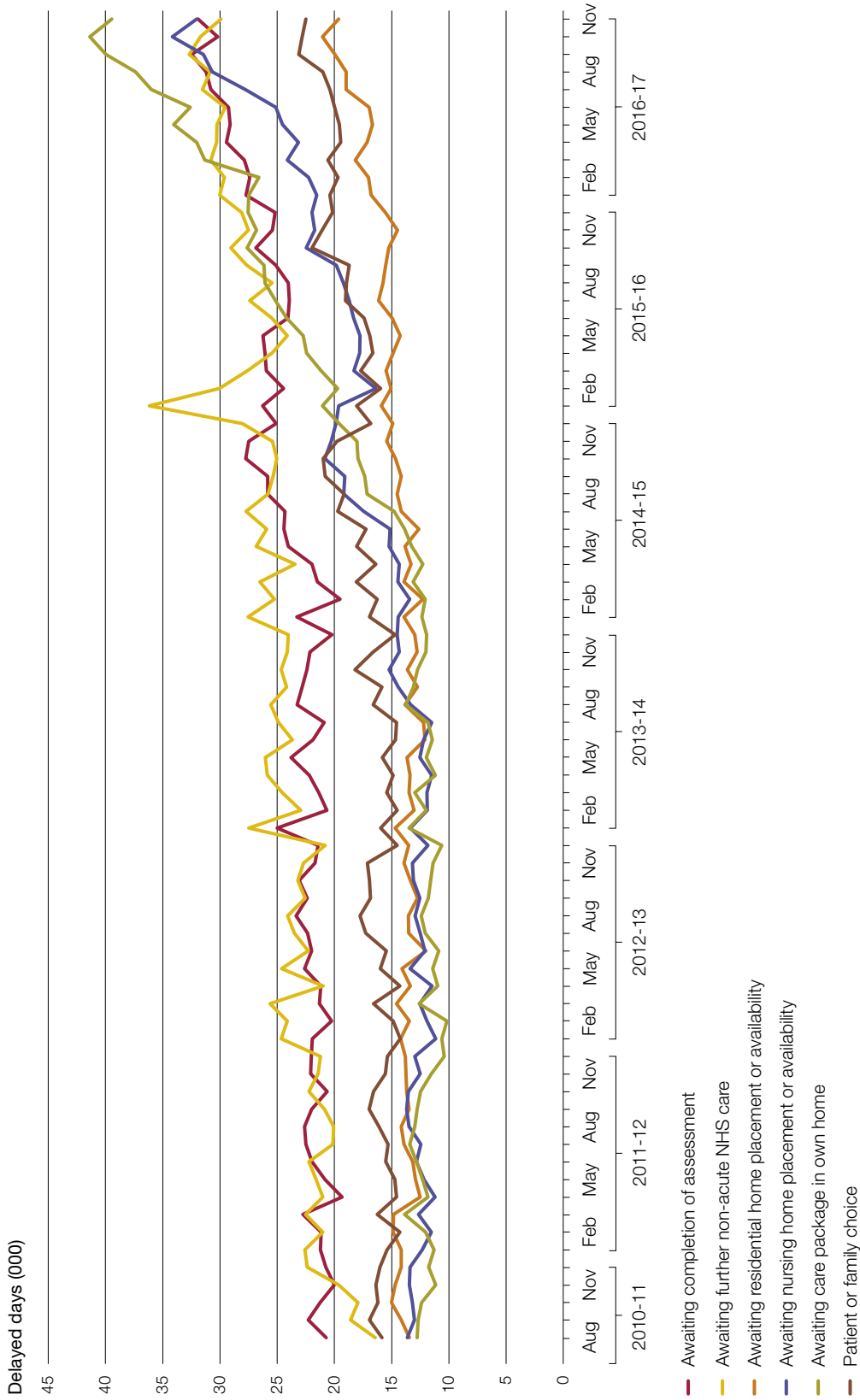
1 Number of delayed days includes acute and non-acute for NHS organisations.

Source: National Audit Office analysis of delayed transfers of care statistics published by NHS England

**Figure 3**

Trends in delayed transfers of care: reasons for delay

The main reported reason for the rise in delays is an increase in the number of patients waiting for a care package in their own home



Source: National Audit Office analysis of delayed transfers of care statistics published by NHS England

## What is meant by health and social care integration?

**1.7** Patients can receive their health and social care through a complex range of organisations, professionals and services. This can lead to uncoordinated and fragmented care, particularly for older people who are more likely to have multiple needs, and who are the biggest users of health and social care services (**Figure 4** overleaf).

**1.8** The impact of fragmentation can be just as much of a problem between different NHS services as it is between NHS and social care services. Such fragmentation has the potential to lead to:

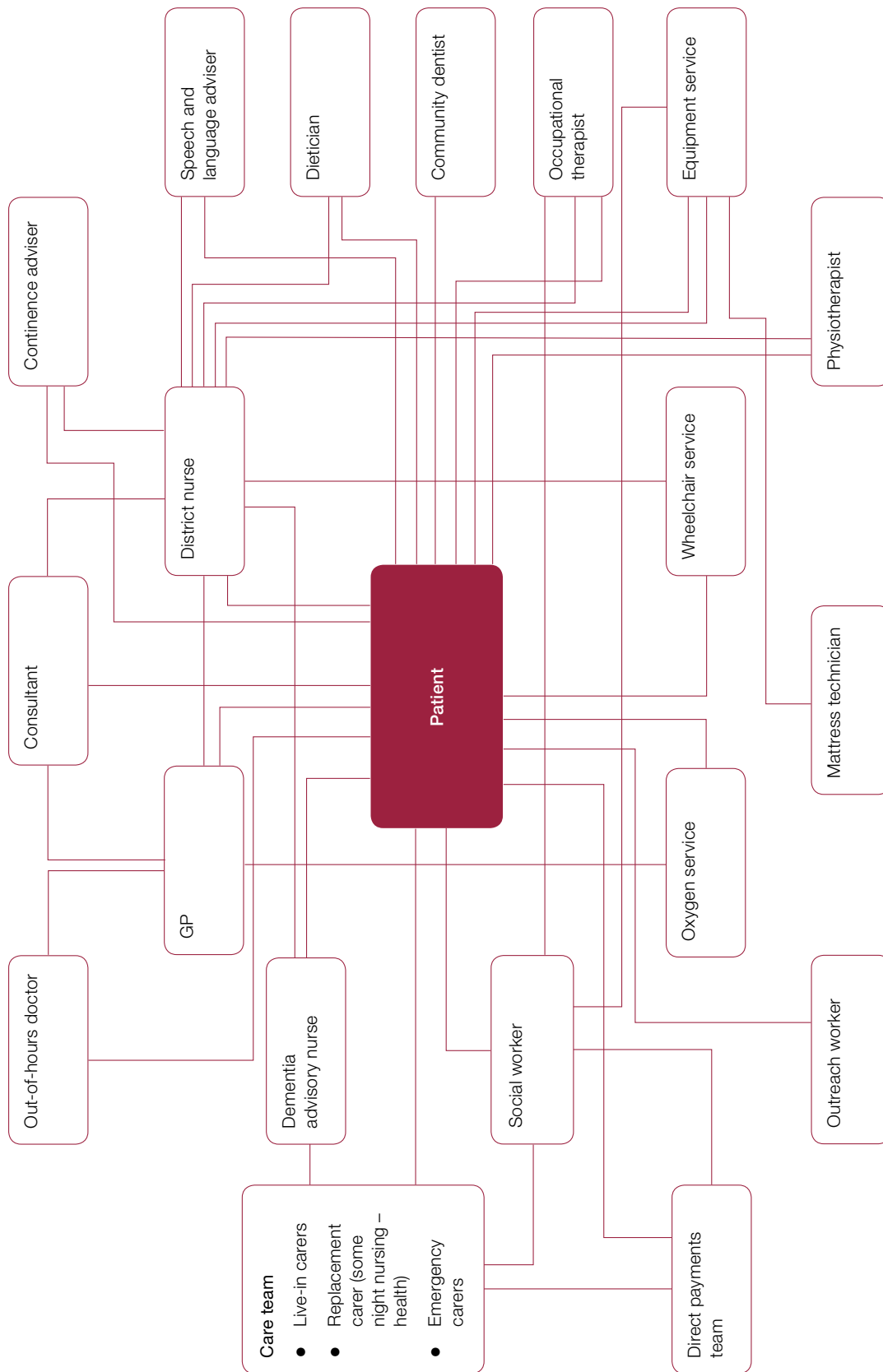
- multiple and uncoordinated assessments from health and social care, resulting in delay to provision of services;
- multiple and uncoordinated visits from health and social care professionals;
- multiple trips to hospitals for tests, diagnostics and treatment;
- unreliable transitions through care pathways, including from childhood to adult care;
- emergency admissions to hospital, for example after avoidable worsening of a condition or an avoidable fall; and
- delayed discharges from hospitals.

**1.9** Integration is about placing patients at the centre of the design and delivery of care. In doing so, patients should receive the right care, when and where they need it, to promote good health and prevent their needs increasing. In 2013, the Department of Health and national partners agreed a definition of integrated care focused on patient experience (**Figure 5** on page 21). In 2016, the Local Government Association, the NHS Confederation, NHS Clinical Commissioners and the Association of Directors of Adult Social Services published a joint vision for a fully integrated health and care system.<sup>6</sup>

<sup>6</sup> Local Government Association, NHS Confederation, NHS Clinical Commissioners and the Association of Directors of Adult Social Services, *Stepping up to the place: The key to successful health and care integration*, June 2016.

**Figure 4**  
An example web of care for a patient with dementia

The patient required input from 19 different services

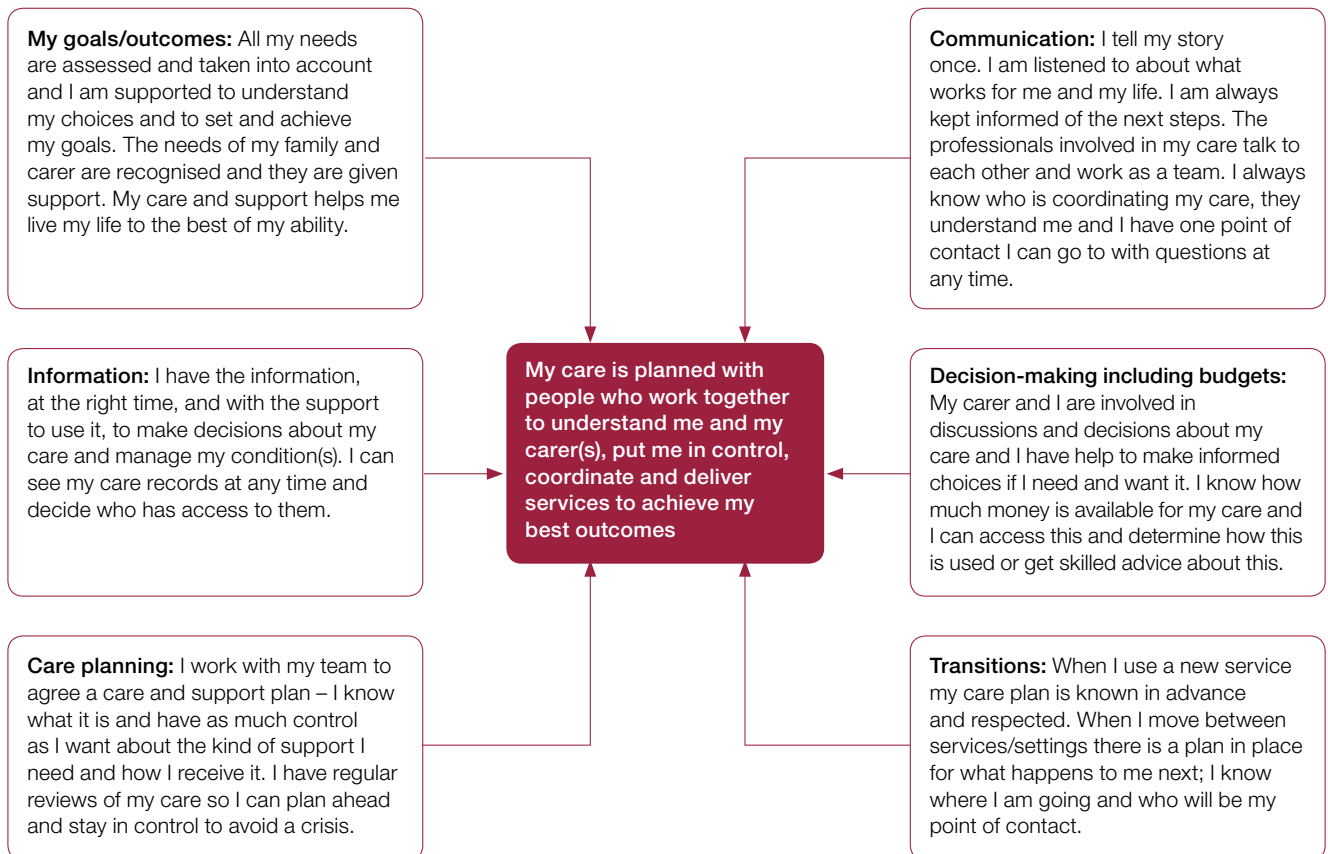


Source: Based on material published by National Voices

**Figure 5**

## Definition of integrated care

The Department of Health and national partners have defined what integrated care and support looks like from a user's perspective



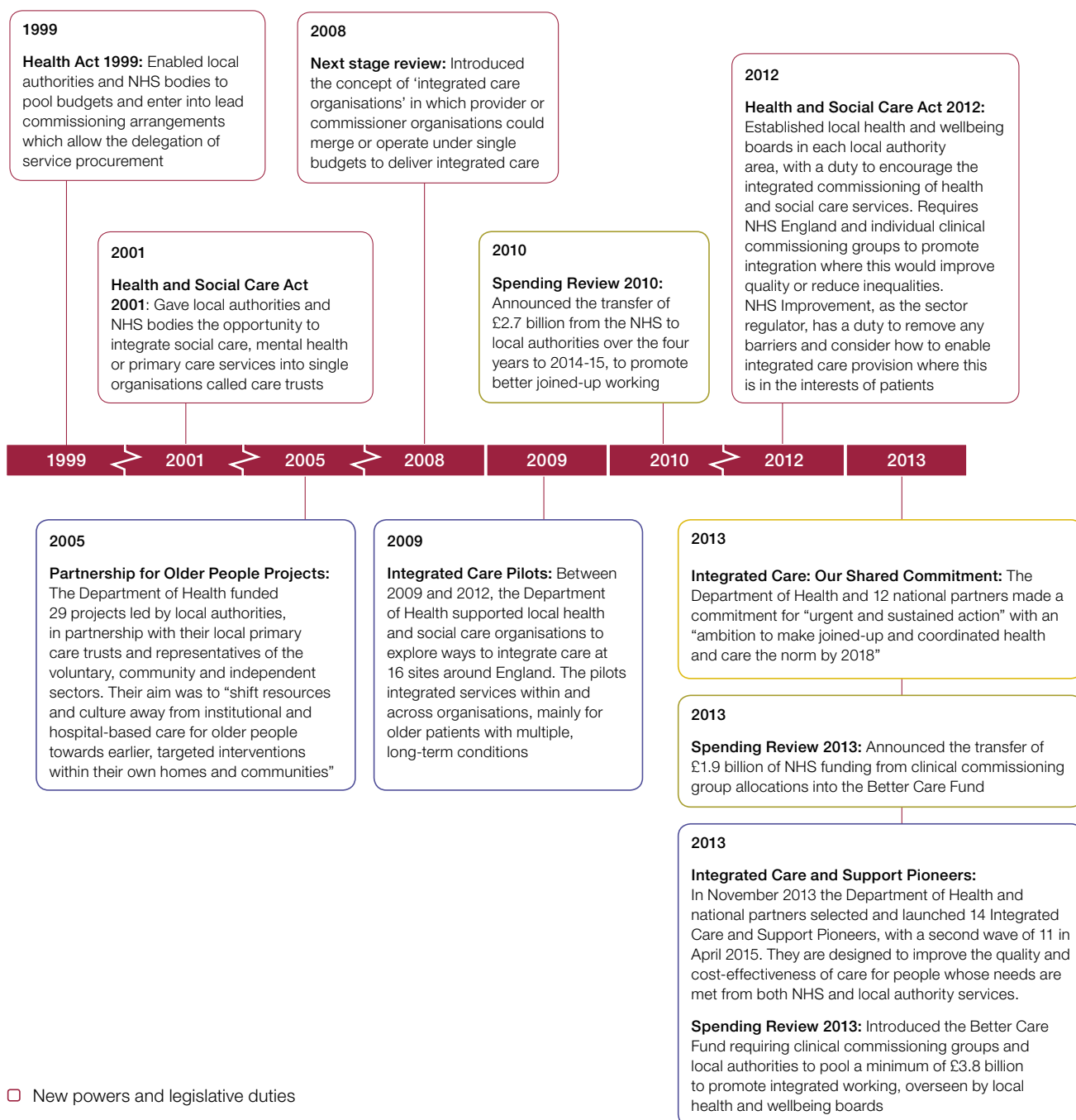
Source: National Collaboration for Integrated Care and Support

**How the Departments have approached integration**

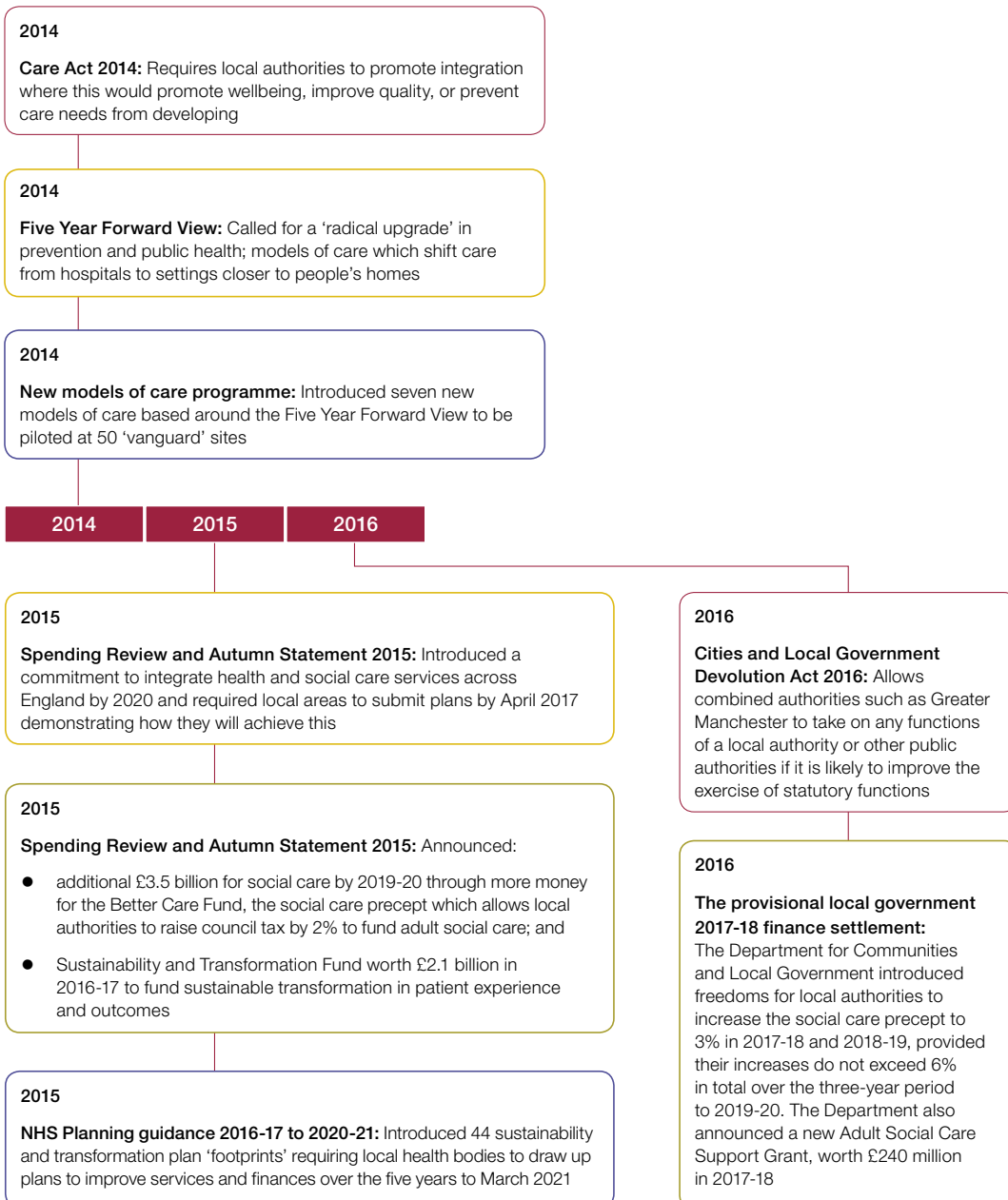
**1.10** Integration of health and care services has been a long-standing policy objective to which the Departments have given increased momentum by recent legislation and policy (**Figure 6** on pages 22 and 23).

**Figure 6**  
Integration timeline

The Departments have sought to incentivise integration through new powers and legislative duties; funding transfers; and pilot programmes







**1.11** A 2016 review of patient records by the Local Government Association concluded that annual efficiency savings of £1 billion nationally could be realised through better integration of health and care services. The review considered the majority of the potential savings could be achieved by shifting resources from hospital to community settings. However, the inability to move funding to the appropriate setting was a major obstacle to change.<sup>7</sup> The Better Care Fund was just such a transfer of funding from hospital care to community settings. The 2013 Spending Review assumed the Fund would deliver £1 billion of savings. We look at the outcomes from the first year of the Fund in Part Two. As we said in our November 2014 report *Planning for the Better Care Fund*, hospitals have fixed costs.<sup>8</sup> Reductions in activity, therefore, do not necessarily translate into sizeable savings unless whole wards or units can be decommissioned.

**1.12** While there are some positive examples of integration at the local level, to date many of the Departments' attempts to integrate have been small scale in nature and evaluations have not demonstrated their effectiveness. We have looked at published research on the quantified and sustainable impact of integration schemes, recognising that some local schemes do show early promise which is not sustained or may not be replicable at scale.

- The evaluation of the 16 Integrated Care Pilots, published in March 2012, concluded that improvements in emergency admissions and the quality of care were not likely to be evident in the short term, and that NHS regulations inhibited organisational integration.<sup>9</sup>
- The House of Commons Health Committee's inquiry into the care for people with long-term conditions, published in July 2014, found a lack of studies looking at the long-term clinical effectiveness and cost-effectiveness of integration. It reported that commissioning of services for people with long-term conditions remains fragmented and that care centred on the person is remote from the experience of many.<sup>10</sup>
- A 2013 evidence review of integration, commissioned by the Local Government Association found a lack of robust systematic reviews or peer-reviewed articles providing quantitative evidence, particularly of the cost-effectiveness of integrated care. The review found that there were some examples of integration that documented improved health, wellbeing and financial outcomes.<sup>11</sup>

7 Newton and Local Government Association, *Efficiency opportunities through health and social care integration: Delivering more sustainable care, Final report*, June 2016.

8 Comptroller and Auditor General, *Planning for the Better Care Fund*, Session 2014-15, HC 781, National Audit Office, November 2014.

9 RAND Europe, Ernst and Young LLP, *National Evaluation of the Department of Health's Integrated Care Pilots*, March 2012.

10 HC Health Committee, *Managing the care of people with long-term conditions*, Second Report of Session 2014-15, HC 401, July 2014.

11 Local Government Association, *Integrated Care evidence review*, November 2013, available at: [www.local.gov.uk](http://www.local.gov.uk)

- In 2013, the Nuffield Trust published a summary of more than 30 different forms of community-based care it had evaluated over the preceding five-year period. Measured against whether service changes had led to a reduction in emergency admissions and the associated cost to the NHS, the results were “almost overwhelmingly negative”.<sup>12</sup>
- A 2014 review, commissioned by the Department of Health concluded that schemes that integrated funds and resources to support integrated care seldom led to improved health outcomes. The review found no evidence that integrated care sustainably reduces hospital use.<sup>13</sup>

**1.13** Two international examples – the integrated health and care system in Canterbury, New Zealand and the Medicare Shared Savings Program in the United States of America – are widely referred to as evidence that integration works.<sup>14,15</sup> Both these models have made savings and improved outcomes by shifting care out of hospitals and into community settings. However, the health and social care systems are significantly different in these countries. For example, in the NHS in England, local clinical commissioning groups have traditionally purchased health services required by the local population from separate provider organisations such as hospitals or community care providers. To date, NHS England has not been able to demonstrate that the international models can be readily replicated in England and would lead to improved performance. This is one of the goals of the new models of care programme described in Part Two. It is important to note that the success of both the Canterbury and Medicare models depends on sustained investment and on the development of trusting relationships and collaborative organisational cultures.

<sup>12</sup> Nuffield Trust, *Evaluating integrated and community-based care: How do we know what works?*, June 2013.

<sup>13</sup> University of York, Economics of Social and Health Care Research Unit, Centre for Health Economics, *Financial mechanisms for integrating funds for health and social care: an evidence review*, 2014, available at: [www.york.ac.uk](http://www.york.ac.uk)

<sup>14</sup> The Kings Fund, *The quest for integrated health and social care: a case study in Canterbury, New Zealand*, September 2013.

<sup>15</sup> Health Affairs Blog, *Medicare Accountable Care Organization Results For 2015: The Journey To Better Quality And Lower Costs Continues*, September 2016, available at: <http://healthaffairs.org/blog>

# Part Two

## Progress with integration

**2.1** In this section we examine the progress of the principal current national integration initiatives:

- the Better Care Fund;
- the Integrated Care and Support Pioneers Programme; and
- new care models.

### **The Better Care Fund**

**2.2** In April 2015, the Department of Health and the Department for Communities and Local Government (the Departments), NHS England and the Local Government Association launched the Better Care Fund (the Fund). The Fund requires local health bodies and local authorities in each health and wellbeing board area to pool funding, a minimum of £3.8 billion in 2015-16 and £3.9 billion in 2016-17 across England. Local bodies must produce joint plans for integrating services and reducing pressure on hospitals, and agree targets against a set of national performance metrics. Local areas submit plans to NHS England and the Departments to show how they will use their pooled budget to meet a series of national conditions. In 2015-16, the £3.8 billion pooled fund comprised the existing £1.1 billion transfer from the NHS to adult social care, a further £1.9 billion of NHS funding transferred from NHS budgets to the pool, £130 million carers' breaks funding, £300 million reablement funding, and £354 million capital funding (including £220 million Disabled Facilities Grant). Many areas chose to go beyond the minimum pooled funding requirements, resulting in a total of £5.3 billion being pooled in 2015-16 and £5.8 billion in 2016-17.<sup>16</sup>

**2.3** The Fund's main aim is to drive the transformation of local services to ensure that people receive better and more integrated care and support. The Departments and NHS England sought to do this principally by reducing demand for hospital services – the biggest cost for local health economies – as a clear indicator of the effectiveness of integrated local health and care services.<sup>17</sup> At the time of planning for 2015-16, local areas committed to reductions in emergency admissions, delayed transfers of care, and other improvements through integration. In addition, the Departments and NHS England required a portion of the Fund (£1 billion nationally) to be ring-fenced for spending on NHS commissioned out-of-hospital services. They asked each local area to set a target for reducing their emergency admissions and to set aside an amount equal to the value of those admissions. The money was to be kept outside of the pooled fund in a payment-for-performance pot. Local areas would then be able to spend the money according to their Better Care Fund plans, subject to performance against these targets.

**2.4** NHS England told us that the Fund required clinical commissioning groups to pull funding out of budgets used to fund hospital emergency admissions and put the funding into the budget pooled with a local authority. It considered that, as a result, the scheme would only be viable if the pooled funds could still be used to pay for emergency admissions if they did not abate in-year. This was because NHS England considered the same pound could not be spent twice in one year – on social care and on hospital emergency admissions. This was the background to setting the targets for reductions in emergency admissions. Without such reductions, there would be additional pressure on the NHS as clinical commissioning groups remain responsible for funding all emergency admissions.

**2.5** In our November 2014 report *Planning for the Better Care Fund*, we concluded that the Fund contained bold assumptions about the financial savings expected in 2015-16 from a reduction in emergency admissions.<sup>18</sup> The Association of Directors of Adult Social Services told us that plans for the Fund were overambitious, with unrealistic expectations at a time when local areas were still planning and setting up interventions. Our 2014 report found that the Fund had the potential to help integrate health and social care but the Departments needed to ensure that there was:

- more effective support to local areas;
- better joint working between health and local government; and
- improved evidence on the effectiveness of integration schemes.

<sup>17</sup> NHS England, Local Government Association, *Better Care Fund – revised planning guidance*, July 2014.

<sup>18</sup> Comptroller and Auditor General, *Planning for the Better Care Fund*, Session 2014-15, HC 781, National Audit Office, November 2014.

## Progress over the Fund's first year

**2.6** In September 2016, the Departments and partners reported on the first year of the Fund. They reported generally positive responses on local views of the effectiveness of the Fund:

- Around 90% of areas agreed or strongly agreed that the delivery of their plan had a positive impact on integration of health and social care in their area.
- Around 91% of areas agreed or strongly agreed that delivery of their plan had improved joint working.
- Around 76% of areas agreed or strongly agreed that implementation of a pooled budget had led to more joined-up health and social care provision.<sup>19</sup>

**2.7** In February 2015, the Departments and their partners estimated that the Fund would achieve savings of £511 million in 2015-16, based on local plans.<sup>20</sup> We found no evidence that they monitored or followed up on the achievement of these savings. NHS England told us this was because they had no mandate to do so. The Departments told us that they recognise that the Fund's performance metrics are affected by factors that are outside of the Fund's influence. Our analysis of Fund metrics reported for 2015-16 shows that the savings target was not achieved due to significant increases in emergency admissions and days lost to delayed transfers of care (**Figure 7**).

- Local areas planned to reduce delayed transfers of care by 293,000 days in total, saving £90 million. However, in 2015-16 the number of delayed days increased by 185,000 compared with 2014-15, costing a total of £146 million more than planned.<sup>21</sup>
- Some 75% of local areas did not reduce delayed transfers of care as much as planned.
- Local areas planned to reduce emergency admissions by 106,000 in 2015-16, saving £171 million. However, in 2015-16 the number of emergency admissions increased by 87,000 compared with 2014-15, costing a total of £311 million more than planned.<sup>22</sup>
- Some 73% of local areas did not reduce emergency admissions as much as planned.

**2.8** Local areas did achieve improvements in other metrics.

- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes reduced to 628 per 100,000 population, against a target of 659 per 100,000. Around 53% of local areas achieved their target reductions.
- The proportion of older people who were still at home 91 days after discharge from hospital receiving reablement or rehabilitation services increased to 82.7%, against a target of 81.9%. Around 31% of local areas achieved their targets.

<sup>19</sup> Department of Health, Department for Communities and Local Government, NHS England, Local Government Association, *Better Care Fund progress in 2015-16 v.1.0*, unpublished.

<sup>20</sup> The original planning assumption was that the Fund would achieve savings of £1 billion for the NHS, but was revised down to £532 million at the time of our November 2014 report and was reduced further to £511 million following scrutiny of the local areas' initial plans in February 2015.

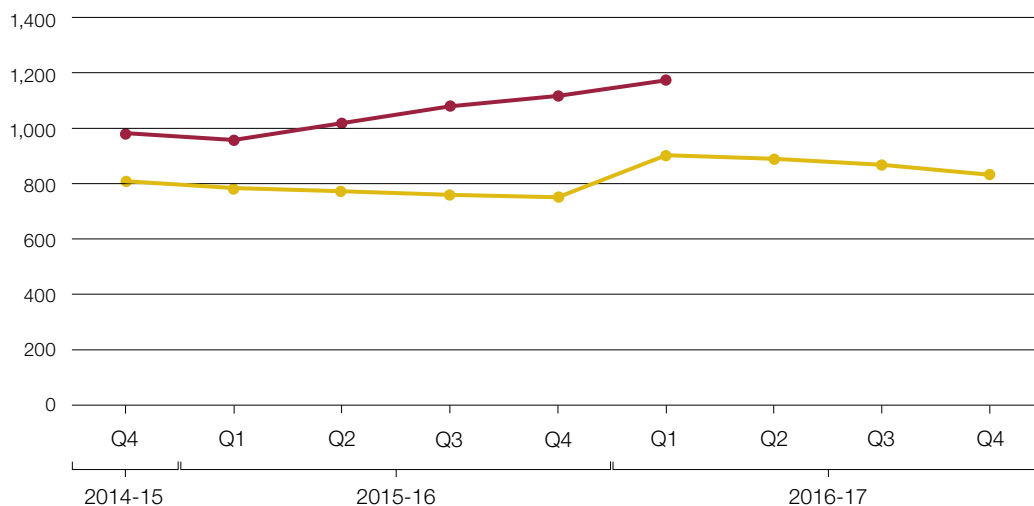
<sup>21</sup> Based on Department of Health 2015-16 excess bed day cost of £306 per day.

<sup>22</sup> Based on Department of Health non-elective inpatient cost for 2015-16 of £1,609 per day.

**Figure 7**  
Better Care Fund 2015-16 performance

Delayed transfers of care continue to rise despite local plans to reduce them

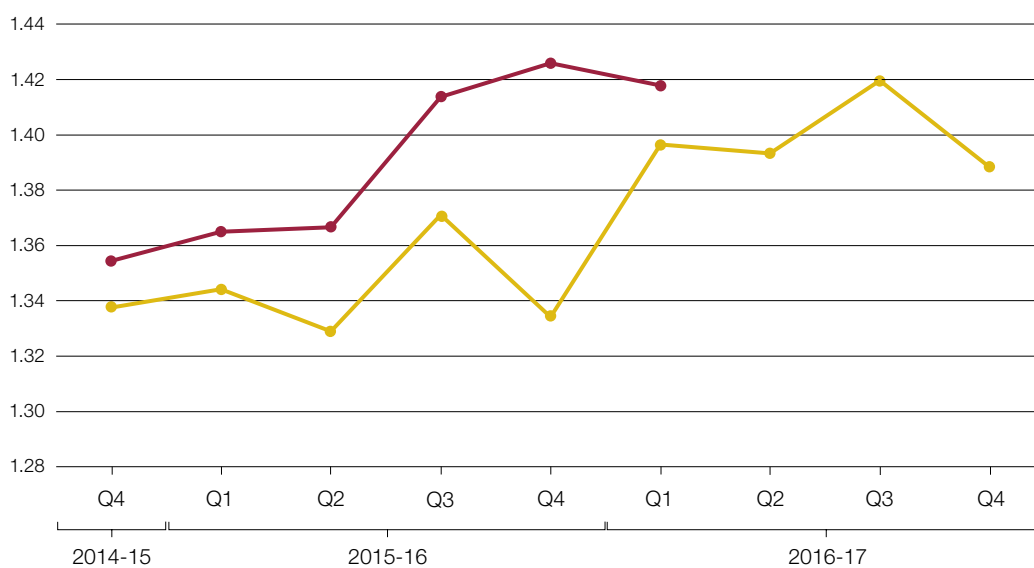
Delayed transfers of care per 100,000 population



● Actual performance  
● Planned performance

Emergency admissions continue to rise relative to local plans to reduce them

Emergency admissions (million)



● Actual performance  
● Planned performance

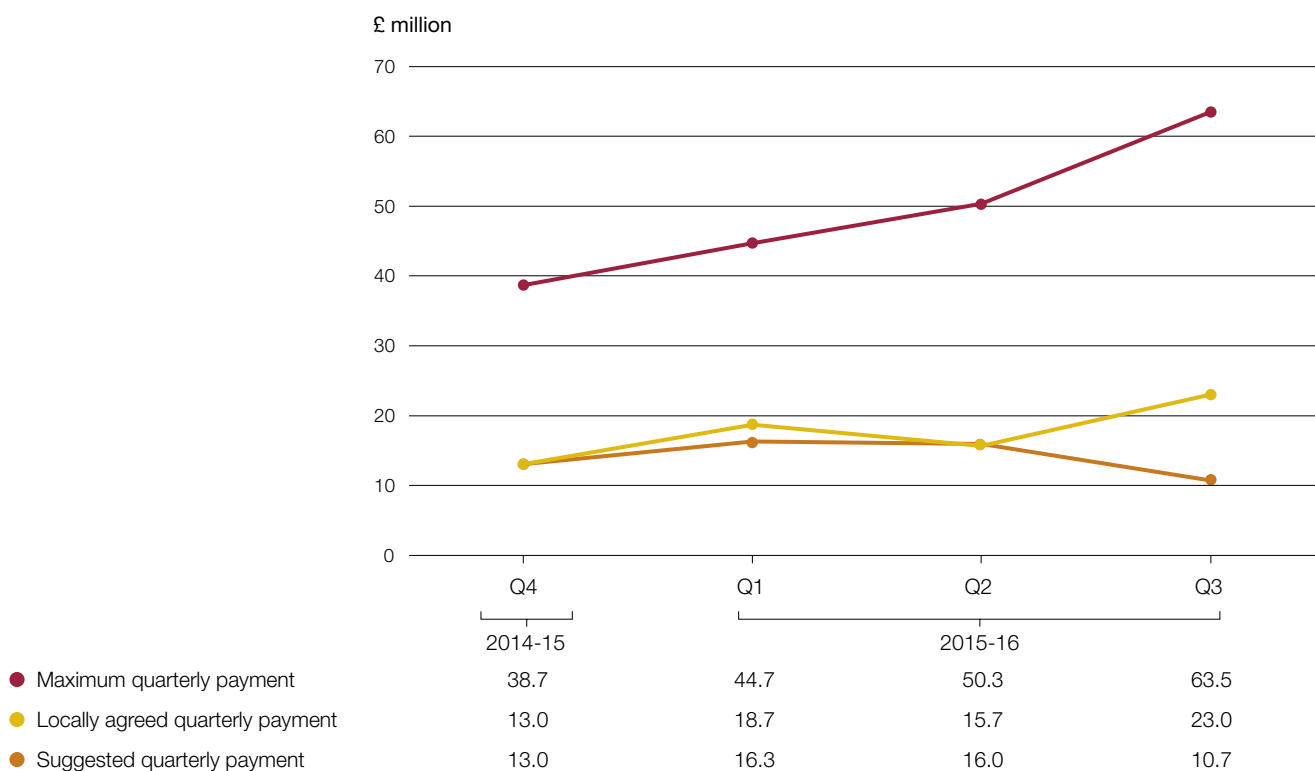
Source: National Audit Office analysis of NHS England Quarter 4 2014-15 – Quarter 1 2016-17 Better Care Fund data

**2.9** A total of £197 million was put into local areas' pay-for-performance pot based on their planned reductions in emergency admissions of 3.1%. Local areas received around £70 million, less than initially planned but more than the £56 million expected based on actual performance (**Figure 8**). The Fund's metrics show only around half of local areas received the amount of funding they were due based on actual performance; 28% were paid more (around £33 million) and 21% paid less (around £19 million) than expected. NHS England told us that this difference was caused by local areas making payments based on local agreements as they were entitled to do under the rules of the Fund.

### Figure 8

#### National quarterly payments from the pay-for-performance pot

Local areas received around 36% of the amounts available to them from the pot, £14 million more than they would have received based on actual performance



#### Notes

- 1 Maximum quarterly payment is the amount that would have been payable based on achievement of planned reductions.
- 2 Locally agreed payment is the amount actually paid out.
- 3 Suggested quarterly payment is the amount that would have been payable based on Better Care Fund metrics.

Source: National Audit Office analysis of NHS England Quarter 4 2014-15 – Quarter 3 2015-16 Better Care Fund data

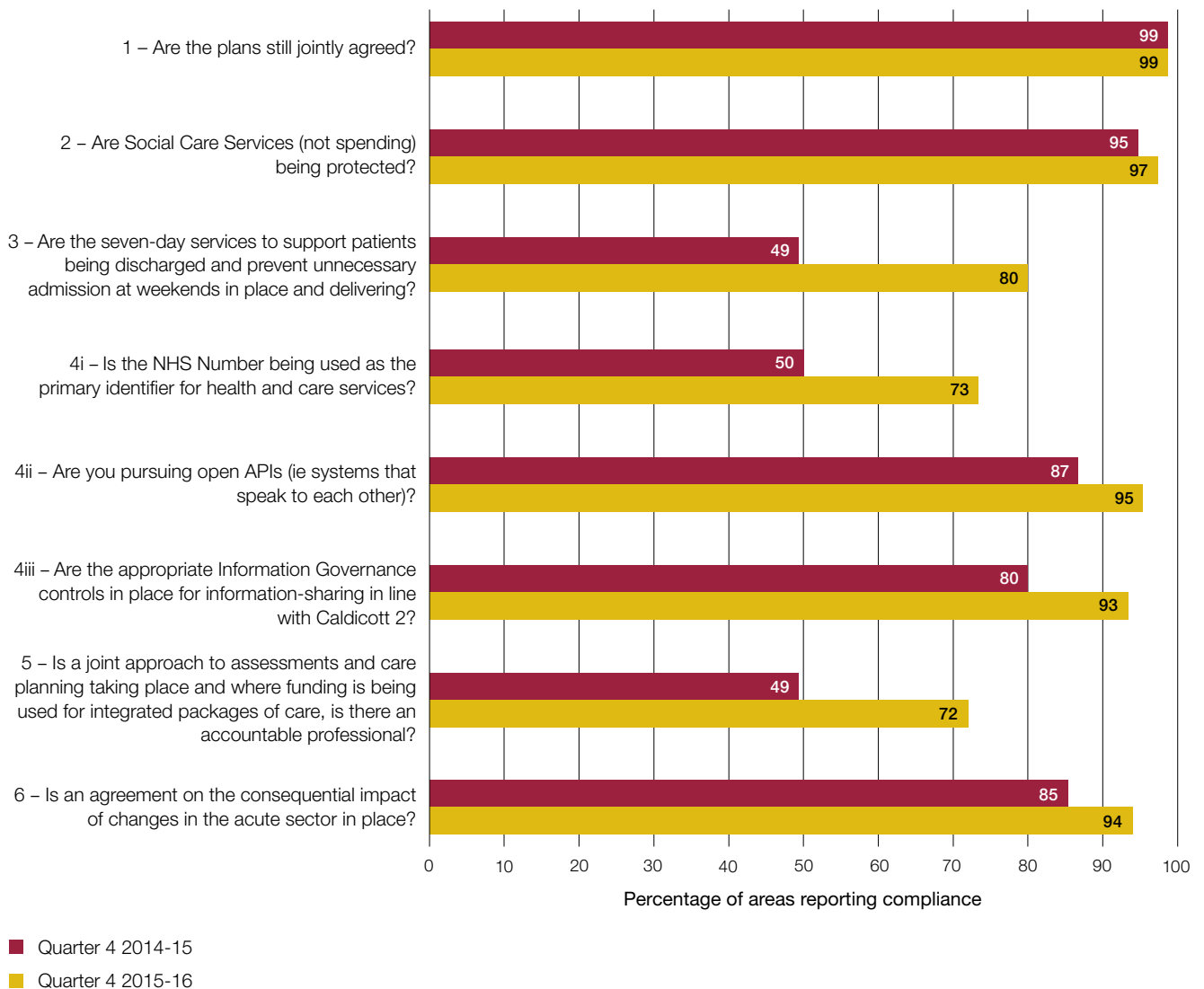


**2.10** There was an improvement in local areas meeting the national conditions – the requirements and enablers of effective integrated care – that applied in 2015-16. Progress against five of the six conditions improved, while the condition about joint agreement of plans remained constant (**Figure 9**). From our case studies and stakeholder interviews we heard that the Fund has helped initiate joint working in areas with no history of doing so. Total amounts pooled by the Fund were 39% and 49% more than the minimum in 2015-16 and 2016-17 respectively. This represents a positive endorsement of the Fund by local areas.

**Figure 9**

Local areas' performance against Better Care Fund 2015-16 national conditions

Between Quarter 4 2014-15 and Quarter 4 2015-16 local areas made improvements in five out of six conditions



Source: National Audit Office analysis of NHS England Quarter 4 2014-15 – Quarter 4 2015-16 Better Care Fund data

**2.11** From our case studies and stakeholder interviews, we found that the Fund had created a significant bureaucracy, which some local areas found was disproportionate and had in some cases disrupted other integration work. Local areas that were more advanced with their integration work told us that the Fund had acted as an inhibitor by requiring protracted negotiations to commit money that they felt could be better used elsewhere. These limitations were recognised by the Departments; as a result, requirements on local areas and reporting arrangements for the Fund were simplified for 2016-17 and will be further simplified for 2017–2019.

### **Integrated Care and Support Pioneers Programme**

**2.12** The Department of Health launched the Integrated Care and Support Pioneers Programme in November 2013, on behalf of the National Collaborative, which includes NHS England, the Association of Directors of Adult Social Services, the Association of Directors of Children’s Services, Monitor (now part of NHS Improvement), Public Health England and the NHS Confederation. The five-year programme is designed to improve the quality and cost-effectiveness of care for people whose needs are met best when the different parts of the NHS and local authority services work together. The Department of Health called for the most “ambitious and visionary” local areas to become pioneers to “deliver change at scale and pace from which the rest of the country could benefit”. It launched the programme alongside its definition for integrated care (see Figure 5). It also announced an ambition to “make joined-up and coordinated health and care the norm by 2018 – with projects in every part of the country by 2015”.<sup>23</sup>

**2.13** A total of 25 Integrated Care and Support Pioneer sites were selected and launched in two waves: 14 in November 2013; and 11 in January 2015. An early evaluation based on data up to June 2015 (some 18 months into the programme) found that:

- local areas were making slow progress in implementing their plans and were not integrating services at the scale and pace envisaged;
- some areas were scaling back their ambitions, increasingly focusing on integrating services for older people with substantial needs, rather than on wider population-based health as first envisaged, and on addressing short-term, financial goals;
- there was little evidence to date of major changes in services or measurable impacts, such as improved cost-effectiveness or patient experience of care;
- financial constraints were a substantial barrier to further integration: pioneers were given limited funds to support initial programme management costs and received no dedicated funding for service transformation and development – this limited their ability to bring about major service change; and
- areas expected that it would take five years or more to produce demonstrable impacts.<sup>24</sup>

<sup>23</sup> Department of Health, *People will see health and social care joined up by 2018*, Press release, May 2013, available at: [www.gov.uk](http://www.gov.uk)

<sup>24</sup> Policy Innovation Research Unit, *Early evaluation of the Integrated Care and Support Pioneers Programme: Final Report*, September 2015.

**2.14** The evaluation concluded that areas had made progress in identifying and resolving barriers to integration. However, they had identified some barriers that required attention at a national level.

- **Financial incentives:** There was conflict between the NHS Trust Development Authority (now part of NHS Improvement) objectives that promote growth and increased hospital activity, while local systems were seeking to shrink this as part of integration.
- **Workforce challenges:** Health care and social care continued to be separated by cultural and professional boundaries as well as by different systems of accountability. Changes were needed, for example being able to modify training to meet the demands of integrated working.
- **Information-sharing:** Local bodies found the regulatory framework confusing and there was insufficient support from the centre to tackle information governance issues.<sup>25</sup>

**2.15** Integrated Care and Support Pioneers have tended to concentrate on specific sets of interventions for older people with substantial needs; typically, multi-disciplinary teams based in primary care that identify and manage patients at risk of hospital admission. From our case study visits and stakeholder interviews we found that this was the most common method of integrating care being used. A recent review found more than 80% of clinical commissioning groups were involved in such work.<sup>26</sup> While this approach has been shown to improve patient satisfaction there is, however, little evidence to suggest that such an approach can achieve significant health benefits or cost reduction. The relatively small numbers of such patients, and the complexity of their health and care needs, make it difficult to see an impact on emergency admission numbers.<sup>27</sup> Concentrating integrated services on the neediest patients may improve the coordination of services for such patients, but may not reduce the total amount of service they receive, or the health benefits they derive from them.

## New care models

**2.16** NHS England's *Five Year Forward View*, published in October 2014, aims to move care from hospitals to settings closer to people's homes, and from reactive care to preventative and proactive models based on early intervention. It sets out plans to develop seven new care models that integrate services around the patient, including, where relevant, social care (**Figure 10** overleaf). NHS England expects the new care models to achieve £900 million in savings by 2020, as well as to improve patient experience and outcomes. NHS England is testing the new care models through 50 'vanguard' sites. These are locally created health and care partnerships, comprising hospitals, clinical commissioning groups, GPs, care homes and others.

<sup>25</sup> See footnote 24.

<sup>26</sup> J Stokes et al., *Integrated care: theory to practice*, July 2016.

<sup>27</sup> J Stokes et al., *Effectiveness of case management for 'at risk' patients in primary care: a systematic review and meta-analysis*, July 2015.

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## Figure 10

### New care models

#### NHS England's seven new care models set out in the *Five Year Forward View*

- 1 **Multispecialty community providers:** Expanding GP practices; bringing in nurses, community health services and hospital specialists to provide integrated out-of-hospital care, shifting the majority of consultations and ambulatory care out of hospitals.
- 2 **Primary and acute care systems:** Hospital and primary care providers come together to provide NHS list-based GP and hospital services, together with mental health and community care services.
- 3 **Urgent and emergency care networks:** Urgent and emergency care services are redesigned to provide better integration between accident and emergency departments, GP out-of-hour services, urgent care centres and other services.
- 4 **Enhanced health in care homes:** Care homes and local authority social services departments work together to develop new shared models of care and support. This will cover medical and medication reviews and rehabilitation services.
- 5 **Acute care collaborations:** Sustainable cost structures are put in place for smaller hospitals, for example by using new models of medical staffing, forming 'hospital chains' or allowing some services to be offered by specialist providers on satellite sites.
- 6 **Specialised care:** Specialist care for rare diseases is consolidated into specialist centres, to improve coordination for patients.
- 7 **Modernised maternity services:** A new care model for maternity services drawing on the recommendations of a review on how to sustain and develop maternity units across the NHS.

Source: NHS England

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**2.17** NHS England has made some bold assumptions about the savings it will achieve from the new care models. Alongside other savings programmes, NHS England assumes the new care models will help reduce growth in hospital activity from 2.9% per year to 1.3% per year by 2020-21. The Nuffield Trust has estimated that activity growth of 1.5% per year would just keep up with population growth and ageing.<sup>28</sup> This would leave little room for increased activity driven by other factors such as improvements in healthcare technology, rising expectations and improving access to care.

**2.18** NHS England and its national partners NHS Improvement and Health Education England are providing a wide range of support to 'vanguard' sites to help them identify successful elements of the new care models that can be scaled up and replicated elsewhere. This support includes providing data and funding for local evaluations, as well as analytical support and publishing best practice as it emerges. NHS England has provided us with information that indicates that some of the 'vanguard' areas are showing early positive results. However, because the 'vanguards' have not yet been evaluated, NHS England has not yet demonstrated that the results can be delivered sustainably or replicated on a larger scale and in other areas.

**2.19** NHS England is undertaking a series of impact studies to examine the evidence on specific interventions. The Department of Health has also commissioned an independent four-year long-term evaluation. NHS England plans to publish three impact studies and start its evaluation by March 2017 with a further 9–12 impact studies due by March 2018. NHS England’s funding for ‘vanguards’ sites will stop at the end of 2017-18, but the roll-out of new care models will continue. From 2017-18, a majority of funding for transformation will be directed through sustainability and transformation plan footprints. The NHS mandate requires a rapid roll-out of the new care models, with objectives to increase coverage from the current 9% of the population to 20% by the end of 2016-17 and 50% by 2020.<sup>29</sup>

### **Integrated personal commissioning**

**2.20** Personalisation aims to tailor services to individuals’ needs and wishes, to give them more control over their lives. One way of doing this is through personal budgets – a sum of money allocated to a user to meet their assessed care needs. The *Five Year Forward View* introduced the concept of integrated personal budgets that combine funding from health, social care and education for patients with complex needs. NHS England began piloting integrated personal budgets at nine demonstrator sites in April 2015. It has plans to add a further 10 sites by March 2017 and for integrated personal commissioning to be operational in 50% of sustainability and transformation footprints by 2019, covering 5% of the population. NHS England has commissioned a two-year evaluation of the programme, starting from January 2017.

### **Devolution**

**2.21** Devolution can broadly be defined as the redistribution of power and funding from central government to a local level. The Cities and Local Government Devolution Act 2016 allows combined authorities to take on any functions of a local authority or other public authorities if doing so is likely to improve the exercise of statutory functions. For example, on 1 April 2016 the Greater Manchester Combined Authority took control of the health and social care budgets of the 10 boroughs and 12 clinical commissioning groups within its area. While it is still too early to evaluate this work, a December 2016 review of health and social care integration commissioned by the Department of Health found:

- the sustainability and transformation plan process, which does not always cover the same geographic area, can divert attention away from realising the benefits of devolution locally; and
- devolution is not a quick solution and requires complex governance arrangements which can take many years to develop.<sup>30</sup>

<sup>29</sup> Department of Health, *The Government’s mandate to NHS England for 2016-17*, January 2016.

<sup>30</sup> Social Care Institute for Excellence, *Integration 2020: Scoping research Report to the Department of Health*, unpublished.

## Part Three

### The Departments' plans for integration

**3.1** In this section we examine:

- plans for the Better Care Fund;
- plans to take integration forward through the sustainability and transformation planning process;
- the target for integrated health and social care across England by 2020; and
- the Department of Health and the Department for Communities and Local Government (the Departments) oversight of integration initiatives.

#### **The Better Care Fund**

**3.2** The government has confirmed that the Better Care Fund (the Fund) will continue until 2019-20. From 2017-18, the Departments will supplement the Fund with additional money, announced in the Spending Review and Autumn Statement 2015 (**Figure 11**). This also introduced the option for local authorities to increase council tax by an additional precept of 2% dedicated to spending on adult social care.<sup>31</sup>

**3.3** In the provisional local government finance settlement 2017 to 2018, published on 15 December 2016, the Department for Communities and Local Government introduced the freedom for local authorities to increase the precept to 3% in 2017-18 and 2018-19, provided that the increases do not exceed 6% in total over the three-year period to 2019-20.<sup>32</sup> The Department also introduced a new Adult Social Care Support Grant, worth £240 million in 2017-18. This is a transfer of funding from the New Homes Bonus scheme and is not extra money for local government.

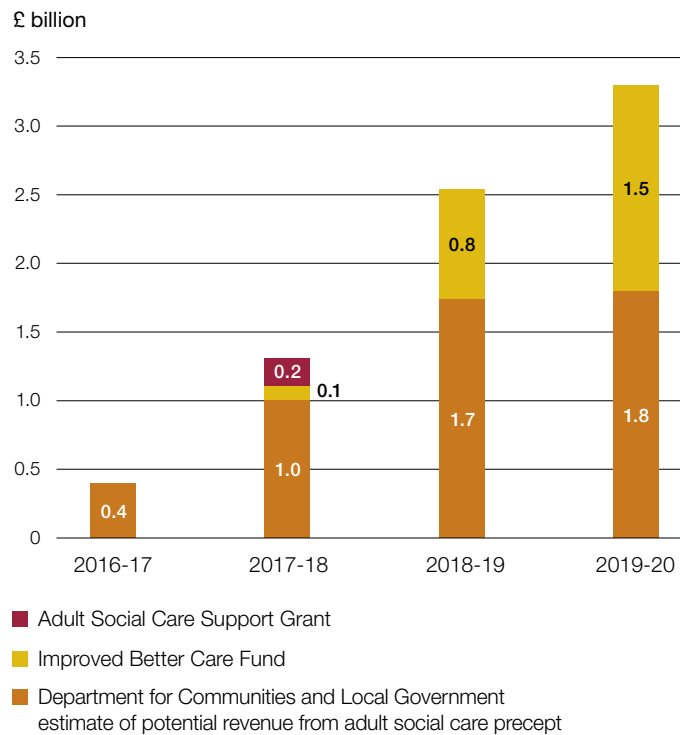
<sup>31</sup> HM Treasury, *Spending Review and Autumn Statement 2015*, Cm 9162, November 2015.

<sup>32</sup> Department for Communities and Local Government, *The provisional 2017-18 local government finance settlement: confirming the offer to councils*, consultation paper, December 2016.

**Figure 11**

New funding for adult social care announced in the Spending Review and Autumn Statement 2015 and provisional local government finance settlement 2017-18

**An estimated additional £3.3 billion by 2019-20**



Source: Department of Health and Department for Communities and Local Government

**3.4** The Departments consider that this additional funding will be enough to support local authorities to meet increasing demand for social care. However, the Departments and their partners have not established that this will be enough to meet increased demand for social care, nor estimated the impact of pressures from social care spending on NHS bodies. The accounting officer for NHS England told the Committee of Public Accounts that the effect of social care pressures “is not costed into the NHS funding envelope for the next five years”.<sup>33</sup> He also said that “over the next two or three years, there is likely to be a widening gap between the availability of adult social care and the need for social care. That, will, inevitably show up as delayed discharges and extra pressure on hospitals.”

### Lessons from the first year of the Fund

**3.5** A review by the Policy Innovation Research Unit found that NHS providers often felt insufficiently included in Fund planning and generally expressed more concerns about the feasibility of delivering the planned activities.<sup>34</sup> A 2015 survey of local areas by the Chartered Institute of Public Finance and Accountancy in 2015 found that only around half of local areas had at least one provider involved in their arrangements.<sup>35</sup>

**3.6** The feedback from local areas suggested that further work is needed to address key barriers to integration.

- **Financial incentives:** “Aligning systems and sharing benefits and risks” was the most reported challenge by local areas. The Department of Health told us that the pay-for-performance pot did not work as planned because it was too complicated and was not suited for the purpose it was intended. Pay-for-performance mechanisms are generally used by commissioners to incentivise providers, whereas the Fund is a relationship between commissioners – the local authority and clinical commissioning groups.
- **Workforce development:** Despite improvements in 2015-16, nearly one-third of areas said they were still not taking a joint approach to health and social care assessments.
- **Information-sharing:** Despite improvements in 2015-16, nearly one-third of areas reported that they were still not using the NHS number as the main way of identifying patients.<sup>36</sup>

<sup>33</sup> HC Committee of Public Accounts, *Discharging older patients from hospital*, Twelfth Report of Session 2016-17, HC 76, July 2016.

<sup>34</sup> Policy Innovation Research Unit, *Early evaluation of the Integrated Care and Support Pioneers Programme: Final Report*, September 2015.

<sup>35</sup> Chartered Institute of Public Finance and Accountancy, *The better care fund – six months on*, November 2015.

<sup>36</sup> Department of Health, Department for Communities and Local Government, NHS England, Local Government Association, *Better care fund progress in 2015-16 v.1.0*, unpublished.



**3.7** The Departments plan to respond to feedback from local areas by rationalising the assurance arrangements for the Fund. They plan to extend the Fund's planning period to two years for 2017–2019, in line with the main NHS planning period. This gives local authorities greater certainty over funding. The Departments plan to reduce the number of national conditions from eight to three, removing those conditions covered by other policy areas. For example, the Departments plan to take out the condition about using the NHS number to share patient data because information-sharing is covered by the local digital roadmaps initiative. The remaining three national conditions for 2017–2019 are planned to be:

- plans to be jointly agreed;
- NHS contribution to adult social care to be maintained in line with inflation; and
- agreement to invest in NHS-commissioned out-of-hospital services, which may include a wide range of services including social care.<sup>37</sup>

**3.8** For 2016-17, the Departments have removed the pay-for-performance element of the Fund. It has been replaced by an option for local areas to set aside contingency funding to cover the cost of emergency admissions over and above their target levels. In 2016-17, only 36% of local areas reported having contingency arrangements in place. Around 20% of local areas had planned higher reductions in emergency admissions than those already in clinical commissioning group plans. The estimated savings from these additional reductions total around £42 million.<sup>38</sup>

**3.9** The main metrics used by NHS England to measure the Fund's impact – reductions in emergency admissions and delayed transfers of care – are affected by many factors. Changes in these cannot be solely attributed to integration. The Department of Health told us that it recognises that the Fund's metrics do not have enough emphasis on outcomes and prevention, and that the Fund needs to focus on promoting stronger services in the community. In our report *Planning for the Better Care Fund*, we recommended that the Departments develop indicators to measure the extent and effectiveness of local service change and integration.<sup>39</sup> The Departments are developing an integration standard and associated indicators to measure the extent and effectiveness of local integration (paragraph 3.16). NHS England has commissioned an evaluation of the Fund, which is due to report at the end of 2017.

<sup>37</sup> Department of Health and Department for Communities and Local Government, *Integration and Better Care Fund, Policy Framework 2017–2019*, Draft.

<sup>38</sup> Department of Health, Department for Communities and Local Government, NHS England, Local Government Association, *BCF planning 2016-17: analysis of plan submissions v1.1*, unpublished.

<sup>39</sup> Comptroller and Auditor General, *Planning for the Better Care Fund*, Session 2014-15, HC 781, National Audit Office, November 2014.

## Sustainability and transformation plans

**3.10** To implement the *Five Year Forward View*, NHS England has established 44 sustainability and transformation ‘footprints’. Local health bodies within these footprints must draw up sustainability and transformation plans to improve services and finances over the five years to March 2021. The Spending Review and Autumn Statement 2015 introduced the Sustainability and Transformation Fund. NHS England said it intended to use the £2.1 billion available in 2016-17 “not just to prop up individual institutions for another year, but [...] to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer term”.<sup>40</sup>

**3.11** However, in 2016-17, NHS England has set aside £1.8 billion (86%) of the Sustainability and Transformation Fund to help hospitals sustain services and meet expected deficits. With hospital deficits continuing to be higher than expected, NHS England announced in September 2016 that it again planned to allocate £1.8 billion for sustainability in 2017-18 and 2018-19 (**Figure 12**). There is a risk that if plans for achieving financial sustainability do not deliver the expected savings in 2016-17, there will be less money for transformation and integration in future years. In an October 2016 survey of hospital leaders by NHS Providers, 79% said they were worried or very worried that their local area was not transforming quickly or effectively enough to provide sustainable, integrated patient care and financial balance.<sup>41</sup>

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### Figure 12

#### Sustainability and Transformation Fund

##### NHS England plans to continue prioritising funding towards sustainability until 2018-19

	2015-16 (£bn)	2016-17 (£bn)	2017-18 (£bn)	2018-19 (£bn)	2019-20 (£bn)	2020-21 (£bn)
Sustainability	0.0	1.8	1.8	1.8		
Transformation	0.2	0.3	1.1	1.1	3.4	3.4
<b>Total</b>	<b>0.2</b>	<b>2.1</b>	<b>2.9</b>	<b>2.9</b>	<b>3.4</b>	<b>3.4</b>

##### Note

1 For 2019-20 and 2020-21, NHS England has not allocated the Fund between sustainability and transformation.

Source: NHS England

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40 NHS England, Letter to Clinical Commissioning Group accountable officers; chief executives of NHS trusts, NHS foundation trusts and local authorities; and Local Education and Training Board geographical directors, *Re: Developing Sustainability and Transformation Plans to 2020/21*, February 2016, available at: [www.england.nhs.uk](http://www.england.nhs.uk)

41 NHS Providers, *The state of the NHS provider sector*, November 2016.

**3.12** Leaders of health bodies and local authorities whom we met broadly agreed that place-based planning within the 44 sustainability and transformation planning footprints is the right way to manage scarce resources at a system-wide level. Bodies representing the sector are broadly supportive of the initiative. In our November 2016 report *Financial Sustainability of the NHS*, we presented some concerns with the process:<sup>42</sup>

- **Timetable:** The original timetable for completing sustainability and transformation plans was ambitious. It did not allow enough time to build relationships across local areas and to determine the changes needed. For example, leaders of health and care organisations in Northumberland told us that their success in integrating services was the result of more than 25 years of effort. They had been building trusting relationships between health and local government organisations, and integrating front-line services, for at least a decade before creating a care trust in 2002, which was the starting point for the local authority's current partnership with Northumbria Healthcare NHS Foundation Trust.
- **Financial incentives:** Local NHS bodies must meet financial targets to receive sustainability and transformation funding. In September 2016, NHS England and NHS Improvement announced financial targets from April 2017 at the footprint level, based on the sum of the targets from individual NHS organisations. All organisations will be held accountable for delivering both their own target as well as the footprint target. It is, however, unclear how individual bodies will be held to account for both targets. A survey of hospital and clinical commissioning group leaders in October and November 2016 found limited confidence in the simultaneous delivery of footprint and organisational financial objectives. Only 6% of hospital finance directors and 17% of clinical commissioning group finance directors said they believe both are deliverable.<sup>43</sup>
- **Governance and accountability:** The legislative and accountability framework for local NHS organisations was seen as a barrier to collaboration. NHS organisations are accountable for their individual organisational plans and financial performance. The Care Quality Commission has statutory responsibility for regulating health and social care services within individual organisations, but not across partnerships of organisations. A 2016 review of integrated care by the Social Care Institute for Excellence found that the regulatory system needed to adapt to account for more complicated and integrated services.<sup>44</sup>

42 Comptroller and Auditor General, *Financial Sustainability of the NHS*, Session 2016-17, HC 785, National Audit Office, November 2016.

43 Healthcare Financial Management Association, *NHS financial temperature check – briefing*, December 2016.

44 Social Care Institute for Excellence, *Integration 2020: Scoping Research Report to the Department of Health*, unpublished.

**3.13** Among the local authorities we spoke to, some regard the sustainability and transformation programme as NHS-led and NHS-focused, and feel it has not adequately engaged with local authorities. The design and development of the programme did not include the Local Government Association or the Department for Communities and Local Government. Some local authority leaders told us, and others have said publicly, that they did not feel adequately involved in the development of the sustainability and transformation plans. NHS England has been clear that the process is NHS-led and works to deliver NHS financial control totals but has encouraged local NHS bodies to engage with local authorities. For the local planning and decision-making phase of the programme, four sustainability and transformation plan footprints are being led by local authority officials. The Local Government Association is now represented on the governance board for the programme.

### **Spending Review and Autumn Statement 2015**

**3.14** The Spending Review and Autumn Statement 2015 set out an aim for health and social care to be integrated across England by 2020. It required local areas to produce, by April 2017, a plan for how they would achieve this.<sup>45</sup> However, the Departments told us in September 2016 that they plan to drop this requirement. Instead, the Departments plan to require local areas to set out how they expect to progress to integrated services by 2020 in their Better Care Fund 2017-2019 plans. They will also be required to include a statement in their sustainability and transformation plan to explain how it supports the integration 2020 objective.

**3.15** The Spending Review and Autumn Statement 2015 introduced the opportunity for six to 10 local areas to graduate from the Better Care Fund's programme management arrangements from April 2017. Graduation is dependent on local areas demonstrating that they have mature systems of integrated health and care services and have performed well against Fund performance metrics. Graduate areas will no longer have to submit a Fund plan and will be exempt from other requirements.<sup>46</sup>

**3.16** The Departments' draft *Integration and Better Care Fund, Policy Framework 2017–2019*, sets out their plans to support the government's objective of integrated care by 2020. It includes:

- an integration standard consisting of the characteristics important for integrated health and care systems – this is described through statements of the required improvements to people's experience of care and corresponding changes needed in the health and care system (**Figure 13**);
- plans to produce an integration scorecard for assessing progress towards the government's integration objective; and
- an example of how integration can be given impetus through devolution deals such as the Greater Manchester Combined Authority.<sup>47</sup>

<sup>45</sup> See footnote 31.

<sup>46</sup> See footnote 37.

<sup>47</sup> See footnote 37.

**Figure 13**

## Draft integration standard

The draft standard comprises seven domains that support the commitment to integrating health and social care services by 2020

Objective	Improvement to person's experience	System change needed to deliver this objective
1 Digital interoperability	"I have access to a digital integrated care record that moves with me throughout the health and care system. All professionals involved in my care have access to this record (with appropriate safeguards in place to protect my personal data)."	Areas to reach digital maturity, including universal use of the NHS number as the primary identifier, and fully interoperable IT across providers and commissioners.
2 Resource targeted at key cohorts to prevent crises and maintain wellbeing	"If I am at risk of emergency hospital admission I will receive the right care at the right time to help me to manage my condition and to keep me out of hospital."  "If it would benefit me, I will be able to access a personal budget, giving me greater control over money spent on my care."	Areas use health and social care data to risk stratify their populations, identifying those most at risk of unplanned admissions and allocating resources according to need.  Areas will allow greater access to integrated personal commissioning, for identified groups who could benefit.  Areas to use capitated budgets as appropriate.
3 Value for money	"I receive the best possible level of care from the NHS and my local authority."	Areas deliver against a clear plan for making efficiencies across health and care through integration.
4 Single assessment and care plans	"If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care."	
5 Integrated community care	"My GP and my social worker or carer work with me to decide what level of care I need, and work with all of the appropriate professionals to make sure I receive it."	Areas use multi-disciplinary integrated teams and make use of professional networks to ensure high quality joined-up care is delivered in the most appropriate place seven days a week.
6 Timely and safe discharges	"If I go into hospital, health and social care professionals work together to make sure I'm not there for any longer than I need to be."	
7 Social care embedded in urgent and emergency care	"If I have to make use of any part of the urgent and emergency care system, there are both health and social care professionals on hand when I need them."	

**Notes**

1 To 'risk stratify' means to identify the relative risk to patients in a population by analysing their medical history.

2 A 'capitated budget' is based on a sum per patient within a population.

Source: Department of Health

**3.17** The Department of Health commissioned the Social Care Institute for Excellence to test the draft integration standard with a number of local areas. The Institute concluded that the standard was a confusing mix of measures too focused on processes, structures and the hospital sector. It also found that important aspects were missing from the standard including user perspective, system leadership, integrated workforce and the involvement of the third sector.<sup>48</sup>

**3.18** The Departments plan to build on the integration standard with a proposed integration scorecard. The scorecard will combine outcome metrics, financial performance, user experience and process measures to help local areas understand their progress; it will be based on learning from the first wave of Better Care Fund graduates. In response to its consultation on the NHS Patient Survey Programme, the Care Quality Commission is undertaking a feasibility study for a new national survey of integrated care services focusing on patient experience that spans organisational boundaries. The Departments plan to incorporate any proposed new user experience measures arising from this work into their scorecard.

**3.19** The Department of Health has commissioned the Local Government Association to provide peer support for integration through its Care and Health Improvement Programme. As part of the programme, in December 2016 the Local Government Association published the integration resource library on its website.<sup>49</sup> The library contains definitions, frequently asked questions, tools and other resources to support the development of local integrated health and care services.

### **The Departments' governance of integration**

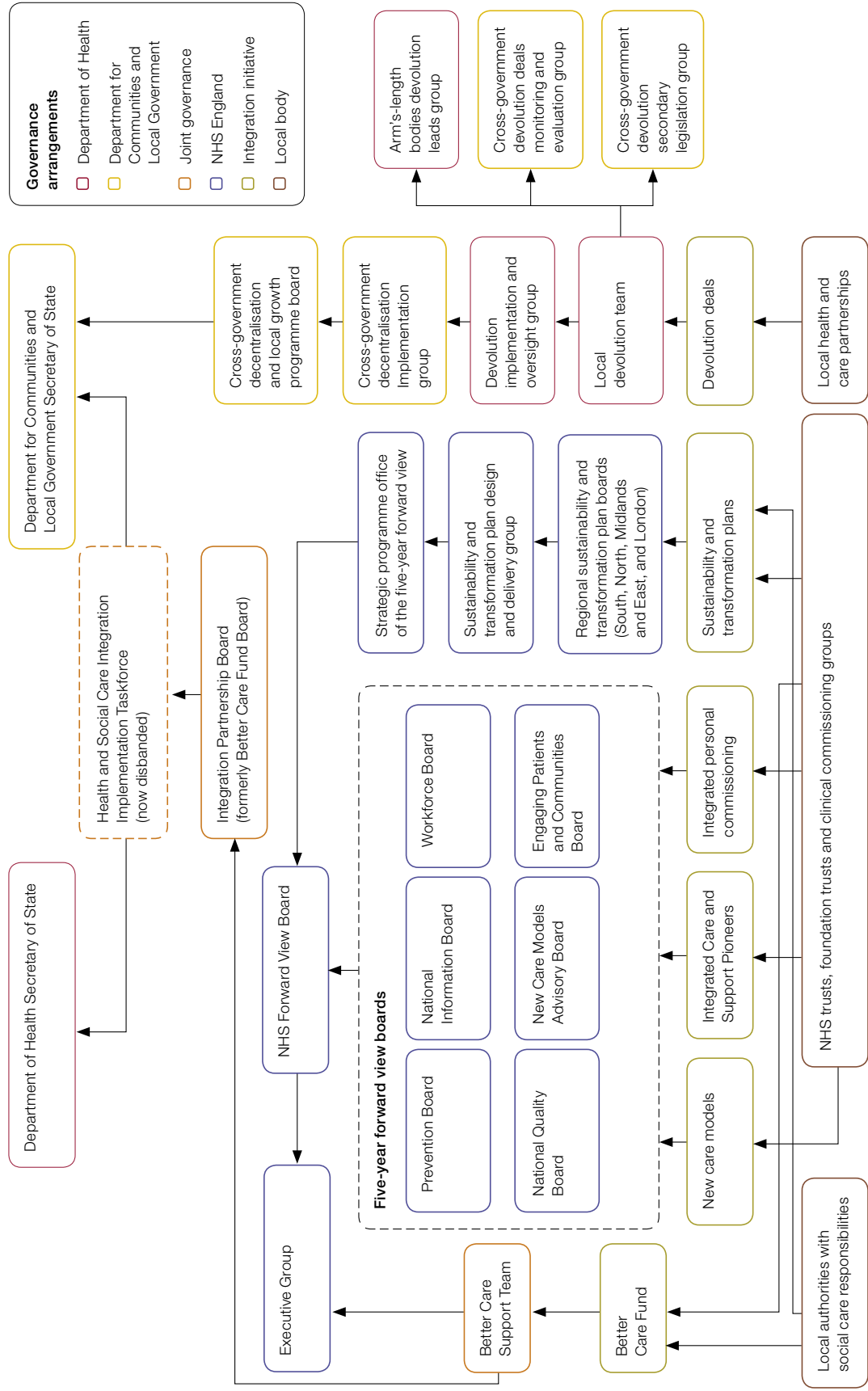
**3.20** We reviewed the Departments' arrangements for managing health and social care integration and found limited oversight of ongoing work. In December 2015, the Departments established the Integration Partnership Board, and changed the focus of the ministerial Health and Social Care Integration Implementation Taskforce. The Departments intended both groups to focus on the main barriers to achieving the commitment to integrate health and social care across England by 2020. The Taskforce did not meet regularly and was eventually disbanded. Despite a remit to oversee all integration activity, our review of the Integration Partnership Board's minutes shows that it receives updates only on the Better Care Fund. We found no evidence of reporting lines from other integration work (**Figure 14**). Both NHS England and the Department of Health told us that this lack of senior-level leadership had caused delays in implementing its policies. In January 2017, the Department of Health said it was reviewing the Integration Partnerships Board's governance of integration pending publication of our report.

<sup>48</sup> See footnote 44.

<sup>49</sup> Local Government Association, *Integration resource library*, December 2016, available at: [www.local.gov.uk](http://www.local.gov.uk)

**Figure 14**  
Integration governance

The Integration Partnership Board receives updates only on the Better Care Fund with no reporting lines from other areas of integration work such as the new models of care



**3.21** The Department of Health and NHS England have not clarified how the Better Care Fund aligns with the sustainability and transformation plan process, which has a five-year planning timeframe compared with the Fund's two-year timeframe.

**3.22** As of 8 February 2017, 14 months after the Spending Review and Autumn Statement 2015, the Departments still have not published plans to support the objective of integrated health and social care by 2020. The Local Government Association told us that it was important that the government set out its intentions as soon as possible to give the sector time to plan how to meet the target. In April 2016, the government commissioned a review of health and social care integration across England comparing it with international best practice. The review found that local areas were at different stages in their development towards integrated care, with few currently exhibiting best practice. The review concluded that limited progress had been made, and, on current trajectories, local areas would not deliver the target by 2020.<sup>50</sup>

### **Barriers to integration**

**3.23** The Departments have identified three main barriers to integration encountered by local areas. In addition to the findings from evaluations of integration initiatives covered earlier in this report, we have identified other evidence to support the need for the Departments to prioritise action to overcome these barriers.

- **Financial incentives:** The national tariff – the mechanism by which hospitals are paid for each patient seen or treated – encourages hospitals to increase their activity. This mechanism works against local systems trying to reduce hospital activity through integration. From our case study visits, local bodies told us this mechanism was using up resources that could be spent on increasing community care capacity, or preventative work. In September 2016, NHS England's accounting officer announced that he was open to health economies dropping the national tariff in favour of alternative funding systems.<sup>51</sup> NHS Improvement is working with NHS England to develop payment systems that incentivise integration. It is not clear how these would work in practice alongside existing regulation on choice and competition within the NHS.

<sup>50</sup> Oliver Wyman, *Integration of Health and Social Care by 2020*, unpublished.

<sup>51</sup> W Hazell, Exclusive: NHS free to 'abandon payment by results', *Health Service Journal*, 28 September 2016, available at: [www.hsj.co.uk](http://www.hsj.co.uk)



- **Workforce challenges:** As part of its inquiry into caring for people with long-term conditions, the House of Commons Health Committee recommended that Health Education England set out its strategy for adapting the workforce to integrated care.<sup>52</sup> From our case studies, we heard that differences in working culture, professional entrenchment and different terms and conditions across the health and local government sectors remained barriers to integrating and developing the workforce. We also found recruitment and retention of staff, particularly in community and domiciliary care, continued to be a significant issue. Care Quality Commission data show vacancy rates as high as 20% in domiciliary care and 11% in residential care and NHS workforce statistics show a 41% fall in district nurses between 2009 and 2015.<sup>53,54</sup> Our report on NHS workforce planning highlighted that hospitals' plans do not always take into account possible changes to services, such as a shift to providing more services in the community.<sup>55</sup>
- **Information-sharing:** An April 2016 review by the Local Government Association found that there were no policy constraints preventing information-sharing. However, the Department of Health told us that it recognised it had not done enough to explain the rules around information governance and had commissioned a further report from the National Data Guardian. From our case study visits we found that the local bodies we spoke to were still unsure of the legal requirements for data-sharing and felt this was still acting as a barrier. They found it difficult to track patients through different care settings, compare costs and establish whether integration was saving money.

**3.24** These barriers are long-standing ones that we have covered in our reports dating back to 2003.<sup>56</sup> The Department of Health told us that its priorities were to address these barriers. However, the Departments do not have work streams to bring together, monitor and evaluate findings from the various integration initiatives or to assess emerging best practice on these barriers.

52 HC Health Committee, *Managing the care of people with long-term conditions*, Second Report of Session 2014-15, HC 401, July 2014.

53 Care Quality Commission, *The state of health care and adult social care in England 2014-15*, October 2015.

54 Health and Social Care Information Centre, *NHS Hospital & Community Health Service (HCHS) monthly workforce statistics – Provisional Statistics*, March 2016.

55 Comptroller and Auditor General, *Managing the supply of NHS clinical staff in England*, Session 2015-16, HC 736, National Audit Office, February 2016.

56 Comptroller and Auditor General, *Ensuring the effective discharge of older patients from NHS acute hospitals*, Session 2002-03, HC 392, National Audit Office, February 2003.

# Appendix One

## Our audit approach

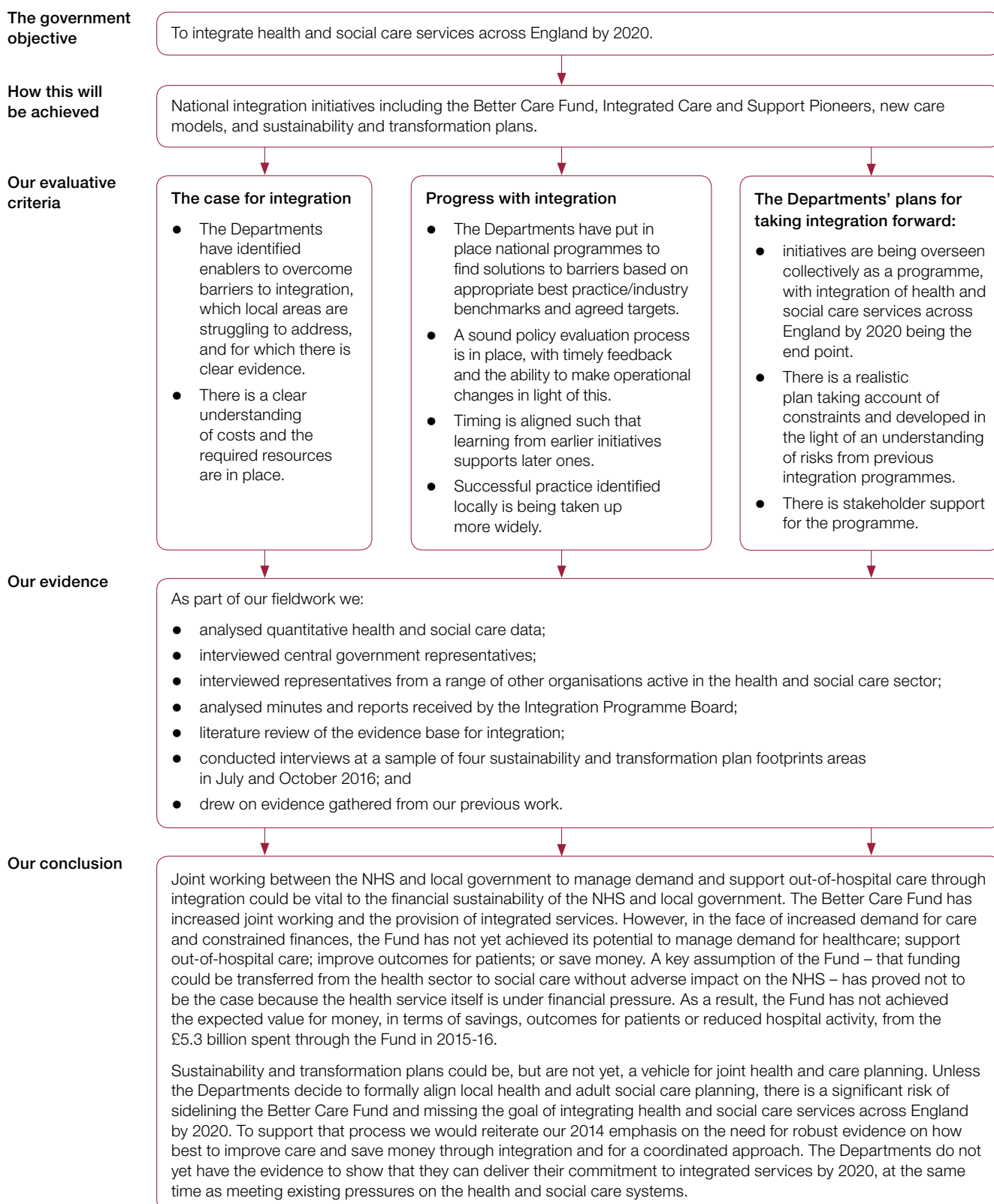
**1** This study examines the progress the Department of Health, the Department for Communities and Local Government (the Departments) and NHS England have made towards integrating health and social care services. We examined:

- whether the Departments know what works in integrating health and social care;
- what progress have the Departments made through their national initiatives;
- what barriers to integration remain at a local level; and
- whether Departments have a cogent programme for taking integration forward.

**2** There were three main elements to our work:

- The case for integration.
- Progress with integration.
- The Departments' plans for taking integration forward.

**Figure 15**  
Our audit approach



# Appendix Two

## Our evidence base

**1** We reached our independent conclusions on whether the Department of Health, the Department for Communities and Local Government (the Departments) and NHS England are on track to achieve integrated health and social care across England by 2020 from evidence we collected between May and November 2016. Our audit approach is outlined in Appendix One.

**2 We analysed quantitative health and social care data:**

- NHS England statistics on the numbers of patients admitted to hospital as emergencies and the numbers of days patients remain in hospital after they are assessed as ready to be discharged.<sup>57,58</sup>
- NHS Digital statistics on the number of permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population; the proportion of older people who were still at home 91 days after discharge from hospital receiving reablement or rehabilitation services; local authority net total expenditure on adult social care.
- NHS England Better Care Fund metrics for 2015-16 and Quarter 1 of 2016-17.
- Office for National Statistics population data.

**3 We interviewed central government representatives** from the Department of Health, the Department for Communities and Local Government, NHS England, NHS Improvement and Health Education England. We sought to understand their evidence base for integration and how they developed their policies to take forward integration.

**4 We interviewed representatives from a range of other organisations active in the health and social care sectors**, including: the Local Government Association, Association of Directors of Adult Social Services, the Social Care Institute for Excellence, NHS Providers, the King's Fund, Age UK, the Policy Innovation Research Unit, the Personal Social Services Research Unit, and the Chartered Institute for Public Finance and Accountancy.

57 NHS England non-elective admissions statistics, available at: [www.england.nhs.uk](http://www.england.nhs.uk)

58 NHS England delayed transfers of care statistics, available at: [www.england.nhs.uk](http://www.england.nhs.uk)

**5 We analysed minutes and reports received by the Integration Programme Board** to understand how the Departments were managing the progress of integration across the health and social care sectors.

**6 We reviewed government policy documents relating to integration and integration initiatives.**

**7 We conducted a literature review of the evidence base for integration.** We looked at: published guidance and other documentation relating to integration initiatives; published systematic reviews of integration interventions; and House of Commons committee reports.

**8 We conducted interviews at a sample of four sustainability and transformation plan footprints areas in July and October 2016.** We spoke with local authority directors of adult social care, hospital chief executives and clinical commissioning group accountable officers. This work was designed to understand:

- how local bodies are working together to integrate health and social care services and the challenges they are facing;
- what support the Departments and partners are providing to help local bodies; and
- what impact specific integration initiatives such as the Better Care Fund are having.

We selected our sample of four sustainability and transformation plan footprints by considering the following factors:

- a diverse range of relative financial performance, selecting two footprints with relatively high financial performance across all constituent NHS bodies, two footprints with relatively low financial performance across all constituent NHS bodies and two footprints where trusts with relatively high financial performance were grouped with trusts with relatively low financial performance;
- a broad geographic spread across England;
- a range of rural and non-rural footprints;
- footprints with and without 'vanguards' (sites receiving support from NHS England for early implementation of new care models) and Integrated Care and Support Pioneers; and
- a range of leadership including where the sustainability and transformation plan leader was from a trust, clinical commissioning group or local authority.

**9 We drew on evidence gathered from our previous work:**

- Ensuring the effective discharge of older patients from NHS acute hospitals.<sup>59</sup>
- Planning for the Better Care Fund.<sup>60</sup>
- Managing the supply of NHS clinical staff in England.<sup>61</sup>
- Discharging older patients from hospital.<sup>62</sup>
- Financial sustainability of the NHS.<sup>63</sup>

59 Comptroller and Auditor General, *Ensuring the effective discharge of older patients from NHS acute hospitals*, Session 2002-03, HC 392, National Audit Office, February 2003.

60 Comptroller and Auditor General, *Planning for the Better Care Fund*, Session 2014-15, HC 781, National Audit Office, November 2014.

61 Comptroller and Auditor General, *Managing the supply of NHS clinical staff in England*, Session 2015-16, HC 736, National Audit Office, February 2016.

62 Comptroller and Auditor General, *Discharging older patients from hospital*, Session 2016-17, HC 18, National Audit Office, May 2016.

63 Comptroller and Auditor General, *Financial sustainability of the NHS*, Session 2016-17, HC 785, National Audit Office, November 2016.

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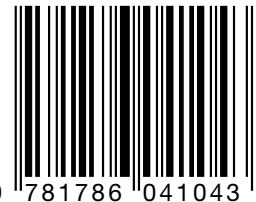


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