



National Audit Office

Report

by the Comptroller
and Auditor General

**Ministry of Housing, Communities and Local Government,
Department of Health & Social Care and NHS England**

The health and social care interface

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Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

29 June 2018

In this report, we present and discuss 16 challenges to improved joint working between health and social care.

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Foreword

I am writing a foreword to this report to explain why it is different to most National Audit Office (NAO) work. It seeks to contribute and add value to the debate on how to improve joint working across health and social care. It draws upon the NAO's work on the health and social care sectors, as well as research by other organisations, focusing on the main issues that I believe will help in the creation of a long-term plan for a sustainable, joined-up care sector.

We have been reporting on efforts to promote joined-up services that support independent living, for older people in particular, for many years. For example, we published a report on general practice in December 2015 which talked about how the efficiency and effectiveness of the primary care system, and its relationship to the rest of the health and social care system, could be optimised. We recognised that, when health and social care services do not work as well together as they should, for whatever reason, people can fall through the cracks, ending up at the service level that cannot say 'no'. This is typically hospital accident and emergency (A&E) departments, acute hospital care, and even other emergency services such as police and fire, generally the most expensive resource too.

Everyone agreed with what we had to say, and it was being said by others, at the time. But we find ourselves again observing **an effort to drive forward the integration of health and social care**, because not enough progress has been made in the years between.

There are good reasons for this, some of which are more widely recognised and better understood than others. It would be excellent if this latest effort could be successful, so I will point to some of the realities that I see, and explore them in this report.

First, although the NHS may be better funded than social care across England, it does not give the impression of being **sufficiently funded in the face of the ever-growing needs** of an ageing population. Despite the significant boost to its funding just announced for the next five years, the NHS may still feel that it is not fully enough funded to meet its own commitments. It may therefore be more focused on areas where it can see that cooperation will deliver it the greatest savings.

Second, notwithstanding the desire to cooperate more that clearly exists on both sides, the **cultural style** of the NHS is naturally different from local government, and they are sponsored by different departments.

The NHS knows that it carries political clout and it makes effective use of it. Given the changes being mooted to the Lansley model, where, and how quickly, is NHS England going in terms of devolution? Equally, how devolved will local government be in reality when its largest, and growing, priority of social care, consuming well over 50% of its funding, is closely tied in with NHS priorities and planning? Local government has received short-term 'fixes' for social care. Will it be treated the same way as NHS England in the autumn and later in the Spending Review? We will soon know.

There are lots of people across health and social care working hard at both the local and national levels to address these challenges and improve the help, care and support offered to individuals and local communities. In this report, we point to the progress being made, despite the barriers and limitations created by current legislation. I can imagine that the points we make may be taken by some as discouraging, but they are made now because if they are not thought through in advance, it is likely that **we will still be agreeing violently on the need for integrated care, and wondering why it has not progressed further and faster**, in another few years' time.

Sir Amyas Morse KCB

Setting the scene

1 The population's health and social care needs have changed greatly since the National Health Service (NHS) was established in 1948. People are now living longer, often with multiple and complex conditions that require managing. However, the division of care into two separate systems – health and social care – has not fundamentally changed over that time. The NHS and social care operate under different legislation, and therefore different financial decision-making and accountability regimes. Adult social care is a local government service, and decisions about spending and service provision are made by the directly elected councillors of the 152 local authorities with responsibility for adult social care. Such decisions are affected by what they decide on local council tax rates and on the distribution of funds across different local government services. Local authorities commission social care from a range of mainly private providers. Much healthcare is also commissioned locally, by clinical commissioning groups, and provided under the umbrella of a single organisation, the NHS. NHS England supports clinical commissioning groups and is responsible for the commissioning of NHS services overall. NHS England and clinical commissioning groups commission healthcare services from NHS trusts, NHS foundation trusts and primary care providers, including GP practices.

2 Adult social care is means-tested and many people fund some or all of their care. Healthcare from the NHS is largely free at the point of use. The accountability for adult social care services rests at a local level with local authorities. The Department of Health & Social Care is responsible for policy relating to health and adult social care in England, while the Ministry of Housing, Communities and Local Government is responsible for the local government finance and accountability systems. The accountability for the NHS at a national level lies with NHS England and the Department of Health & Social Care. Despite these considerable differences, the two systems often need to work together to deliver a range of local services.

3 There is widespread consensus among health and social care professionals, the NHS and policy-makers in government that the changing needs of the population require changes to the way health and social care services are organised and delivered. Over recent years there has been a move towards planning care services around the needs of the individual, with the passing of the Care Act 2014 that enshrines the wellbeing of the individual as a key goal. There has also been a greater focus on removing the inefficiencies of a system that delivers healthcare and social care separately. For example, around a third of people stuck in hospital when fit to leave are waiting for social care services to be put in place. Better joint working between health and social care has been a government objective since the Health Act 1999, which enabled local authorities and NHS bodies

to pool budgets and enter into joint commissioning arrangements. In October 2014, the NHS's *Five Year Forward View* set out new care models that aim to integrate services around the needs of the patient.¹ But progress has been slow. Not moving towards whole-system working risks gaps, duplication and wasted resources. A patchwork of services provided along institutional lines that are not aligned to the needs of service users will not deliver the best health and wellbeing outcomes.

“...putting two leaky funding buckets together does not make a watertight health and care service. If you are going to combine budgets, you have to either allow it to be voluntary for both parties to the agreement so that people can look into the whites of each other's eyes and make sure that one person's contribution is not being used to substitute what the other party should be bringing to the table, or you have to specify a floor level of contribution that each party has to bring to the table and then allow people to do more on top of that.”

Simon Stevens, Chief Executive of NHS England, speaking at the inquiry on long-term funding of adult social care, April 2018 (Housing, Communities and Local Government Committee and Health and Social Care Committee)

4 This ‘think piece’ draws on our past work, in which we have highlighted the barriers that prevent health and social care services working together effectively, examples of joint working in a ‘whole system’ sense and the move towards services centred on the needs of the individual. We also draw on recent research and reviews by other organisations, most notably the Care Quality Commission's review of health and social care systems in 20 local authority areas, which it carried out between August 2017 and May 2018. There is a lot of good work being done nationally and locally to overcome the barriers to joint working, but often this is not happening at the scale and pace needed. Our report aims to inform the ongoing debate about the future of health and social care in England. It anticipates the upcoming green paper on the future funding of adult social care, and the planned 2019 Spending Review, which will set out the funding needs of both local government and the NHS.

What our report covers

5 In Part One of this report, we set out why closer working at the interface between health and social care is important, as well as the key strategies and initiatives that the departments and NHS England have put in place.

6 In Parts Two to Four, we discuss the challenges that have made closer working difficult, both historically and more recently. We also highlight some of the work being carried out nationally and locally to overcome these challenges and the progress that has been made. We draw out the risks presented by inherent differences between the health and social care systems and how national and local bodies are managing these.

¹ The *Five Year Forward View* was published in 2014 and sets out a vision for the NHS for the future, based around seven new models of care.

7 In this report, we present and discuss 16 challenges to improved joint working:

Financial challenges

- Both the NHS and local government are under financial pressure, which can make closer working between them difficult. This could deter organisations in partnerships from seeking system-wide benefits that may be detrimental to them as individual organisations.
- Short-term funding arrangements and uncertainty about future funding make it more difficult for health and social care organisations to plan effectively together.
- Additional funding for health and social care has at times been used to address the immediate need to reduce service and financial pressures in the acute sector.
- Current accountability arrangements, set by legislation, emphasise the need for individual organisations to balance their books.
- Different eligibility requirements for health and social care make it difficult to plan services around the needs of the individual.

Culture and structure

- Traditional boundaries between the NHS and local government, and between individual organisations within these sectors, lead to services being managed and regulated at an organisational level.
- The NHS and local government operate in very different ways, and can have a poor understanding of how the other side's decisions are made.
- Complex governance arrangements are hindering decision-making within local health and social care systems.
- Problems with local leadership can destabilise or hold back efforts to improve working across health and local government.
- The geographical areas over which health and local government services are planned and delivered often do not align, which can make it difficult for the relevant organisations and their staff to come together to support person-centred care.
- Problems with sharing data across health and social care can prevent an individual's care from being coordinated smoothly.
- New job roles and new ways of working could help to support person-centred care, but it is difficult to develop these because of the divide between the health and social care workforces.

Strategic issues

- Differences in national influence and status, as well as public misunderstanding of how social care is provided and funded, have contributed to social care not being as well represented as the NHS.
- Organisations across a local system may have misaligned strategies, which can inhibit joint local planning.
- Central government in the past has had unrealistic expectations of the pace at which the required change in working practices can progress.
- Progress to date has demonstrated that joining up health and social care can support a greater focus on preventative services and the wider determinants of health.

Part One

The case for improved working at the interface between health and social care

1.1 In this section we set out the reasons why improving working across the interface is important, and how it aims to address problems that cause patients and communities to fall between organisational and professional boundaries, in the context of today's financial and demand challenges:

- the current pressures on the health and social care systems;
- what we mean by better working at the interface between health and social care; and
- recent strategies and initiatives aimed at integrating work across the two sectors.

The overarching pressures facing the health and social care systems

1.2 Funding constraints, coupled with an ageing population and increasing demand for care, have increased pressures on both the health and social care systems. In 2012, the then Department of Health estimated that around 70% of health and social care spending is attributed to the care of people with long-term conditions, and that by 2018 the number of people with multiple long-term conditions in England would have increased to 2.9 million, from 1.9 million in 2008. Performance measures for both the health and social care sectors show this pressure. For example, between 2013-14 and 2017-18, the total number of emergency admissions to hospital increased by 14% overall.² We have previously reported that between 2013-14 and 2016-17 there was a higher increase for older people, particularly for those at risk of frailty, and for admissions that NHS England considers could have been avoided.³ Research evidence suggests that morbidity and rising complexity account for a large part of this growth.

² NHS England, *Annual A&E Activity and Emergency Admissions statistics, NHS and independent sector organisations in England*, April 2018.

³ Comptroller and Auditor General, *Reducing emergency admissions*, Session 2017–2019, HC 833, National Audit Office, March 2018.

Demographics

1.3 People are living longer into old age. Between 2006 and 2016, the number of people in England aged 65 and over rose by 23%, and the number of people aged 85 and over rose by 28%, compared with 8% for all age groups.⁴ The number of people in England aged 65 and over is projected to increase by a further 19% over the 10 years between 2016 and 2026, and by 45% over the 20 years between 2016 and 2036. For people aged 85 and over, there is projected to be a 24% increase between 2016 and 2026 and a 90% increase between 2016 and 2036.⁵ Younger adults with learning or physical disabilities are living longer, with increasingly complex conditions.⁶

Demand

1.4 Living standards and clinical treatments have improved, leading to more people living longer with multiple long-term conditions. Our analysis has estimated that between 2010-11 and 2016-17, the number of people in England aged 65 and over in need of social care increased by more than 14%, and the number in need of social care aged 18 to 64 increased by more than 9% (**Figure 1** overleaf).⁷ Analysis commissioned by the Department of Health & Social Care has estimated that the number of people aged 18 to 64 and the number of people aged 65 and over in need of social care will both increase by a further 23% between 2015-16 and 2025-26.⁸ Demand pressures exist on the health side too, for example accident and emergency (A&E) attendances increased by 10% between 2012-13 and 2017-18. Better, usually more expensive, treatments have been developed, and people have higher expectations of what the health and social care systems should provide.

4 Office for National Statistics, *Annual Mid-year Population Estimates: 2016 Statistical Bulletin*, June 2017.

5 Office for National Statistics, *National Population Projections: 2016-based Statistical Bulletin*, October 2017.

6 Comptroller and Auditor General, *Adult social care in England: overview*, Session 2013-14, HC 1102, National Audit Office, March 2014.

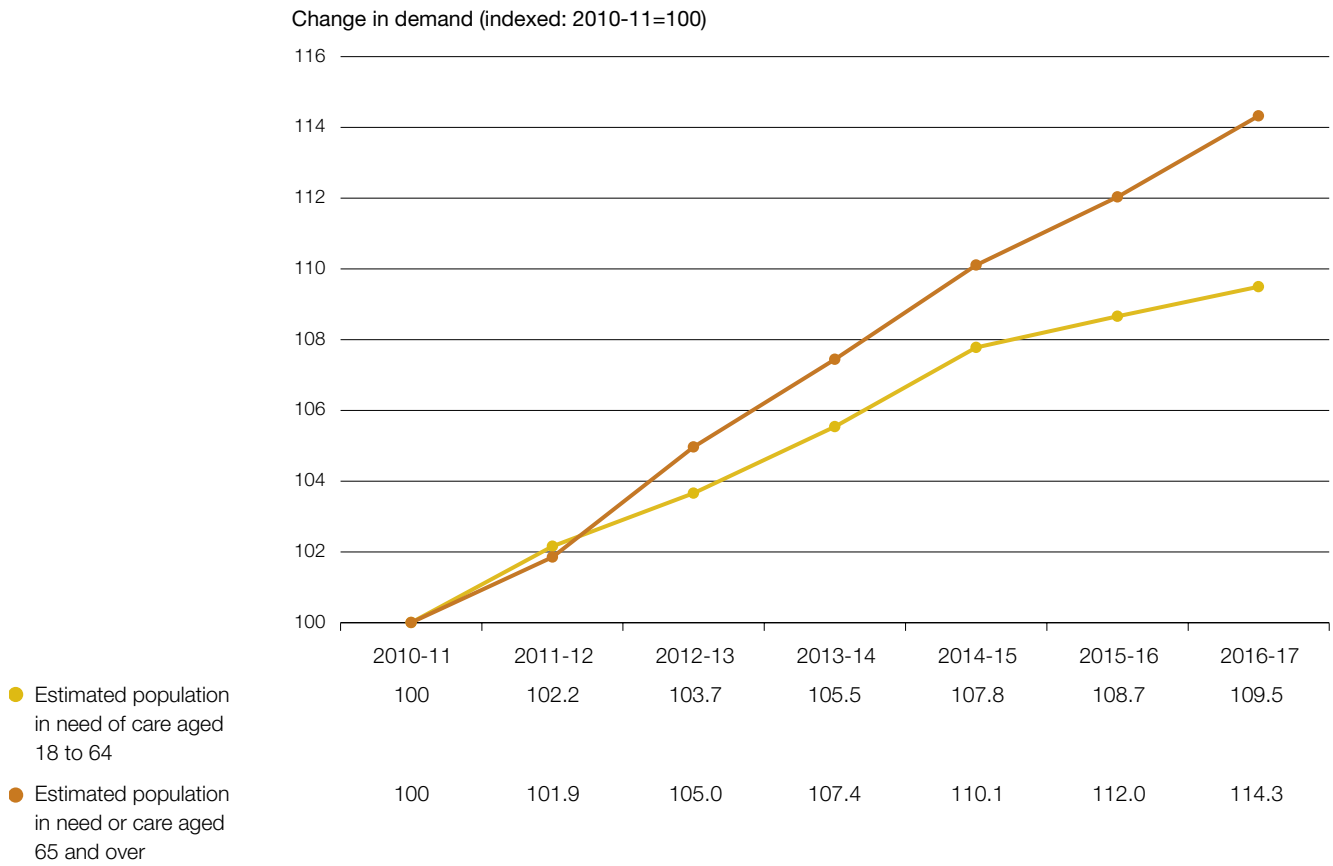
7 Comptroller and Auditor General, *Financial sustainability of local authorities 2018*, Session 2017-2019, HC 834, National Audit Office, March 2018.

8 Wittenberg R, Hu B and Hancock R, *Projections of demand and expenditure on adult social care 2015 to 2040: Personal Social Services Research Unit discussion paper*, June 2018.

Figure 1

Growth in demand for adult social care services, 2010-11 to 2016-17

The number of people in England aged 65 and over in need of social care increased by over 14%, and the number in need of social care aged 18 to 64 increased by over 9%



Note

1 Figures for those aged 18 to 64 in need of care are based on estimates of the number of people with a severe learning disability, mental health issue or physical disability. For those aged 65 and over, estimates are based on rates of population with one or more limitations of activities of daily living.

Source: National Audit Office analysis of NHS Digital data

Funding

1.5 Over the period 2010-11 to 2017-18, local authorities experienced a real-terms reduction in spending power of 28.6%.⁹ Between 2010-11 and 2016-17, local authorities reduced real-terms spending on adult social care by 5.3%.¹⁰ In contrast, the health budget has been protected compared with most other areas of government spending. Between 2013-14 and 2018-19, NHS England's budget increased by an average of 2.1% per year, although this was lower than the long-term average growth in health spending of 3.7% per year. Funding per person, once adjusted for age, increased in this period by 0.9% per year on average. A report chaired by Lord Darzi estimated that the health and social care system will need up to an additional £60 billion a year by 2030.¹¹ A May 2018 report by the Institute for Fiscal Studies, the Health Foundation and the NHS Confederation concluded that over the next 15 years the NHS could require funding increases of 4% per year, while keeping up with the ageing population and growth in the number of young adults with disabilities will require public funding to increase by 3.9% per year.¹²

The objective of closer working across health and social care

1.6 People, particularly those with complex needs, get health and social care from a range of organisations, professionals and services. However, care can be uncoordinated and fragmented, for example, it can involve multiple assessments and uncoordinated visits from different health and social care professionals, or several trips to hospitals for tests, diagnostics and treatment. Better working between health and social care aims to ensure that people receive the right care, when and where they need it, in a coordinated way that minimises duplication of effort by both the person and the professionals who provide care. **Figure 2** overleaf illustrates some of the care services that an older person suffering from dementia might receive at different times.

1.7 Planning services around the needs of individuals, so that they experience a unified service, is how the Department of Health & Social Care intends to improve people's experience of care services and the outcomes they achieve. In our March 2016 report *Personalised commissioning in adult social care*, we found that giving users more choice and control over the design and delivery of their care can improve their experience of care and their quality of life.¹³ In 2013, the then Department of Health and national partners, including NHS England and the Local Government Association, placed user and patient experience at the centre of an agreed definition of integrated care (**Figure 3** on page 15).

⁹ See footnote 7.

¹⁰ NHS Digital, *Adult social care activity and finance: England 2016-17*, October 2017, available at: <http://digital.nhs.uk/catalogue/PUB30121>. Based on Table C1: Net current expenditure on adult social care services in cash terms: by source of funding. (Includes net current expenditure by local authorities and certain funding streams from the NHS, including Valuing People Now, NHS transfers to local authorities, Better Care Fund expenditure on social care and winter pressures' transfers).

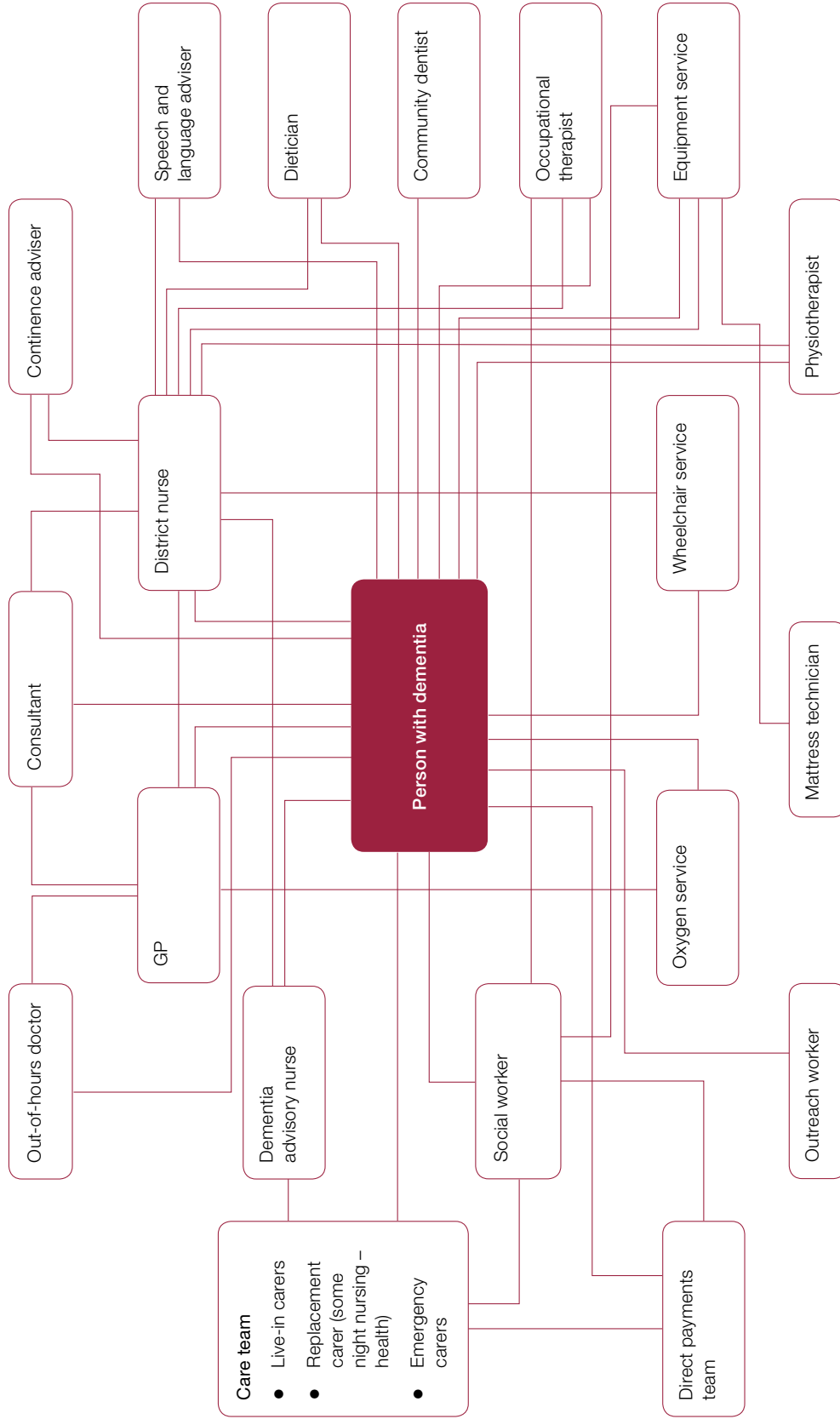
¹¹ Institute for Public Policy Research, *The Lord Darzi Review of Health and Care: Interim Report*, April 2018.

¹² Institute for Fiscal Studies, the Health Foundation, the NHS Confederation, *Securing the future: funding health and social care to the 2030s*, May 2018.

¹³ Comptroller and Auditor General, *Personalised commissioning in adult social care*, Session 2015-16, HC 883, National Audit Office, March 2016.

Figure 2
An example of potential care services for a person with dementia

This person may access up to 19 services at different times



Note

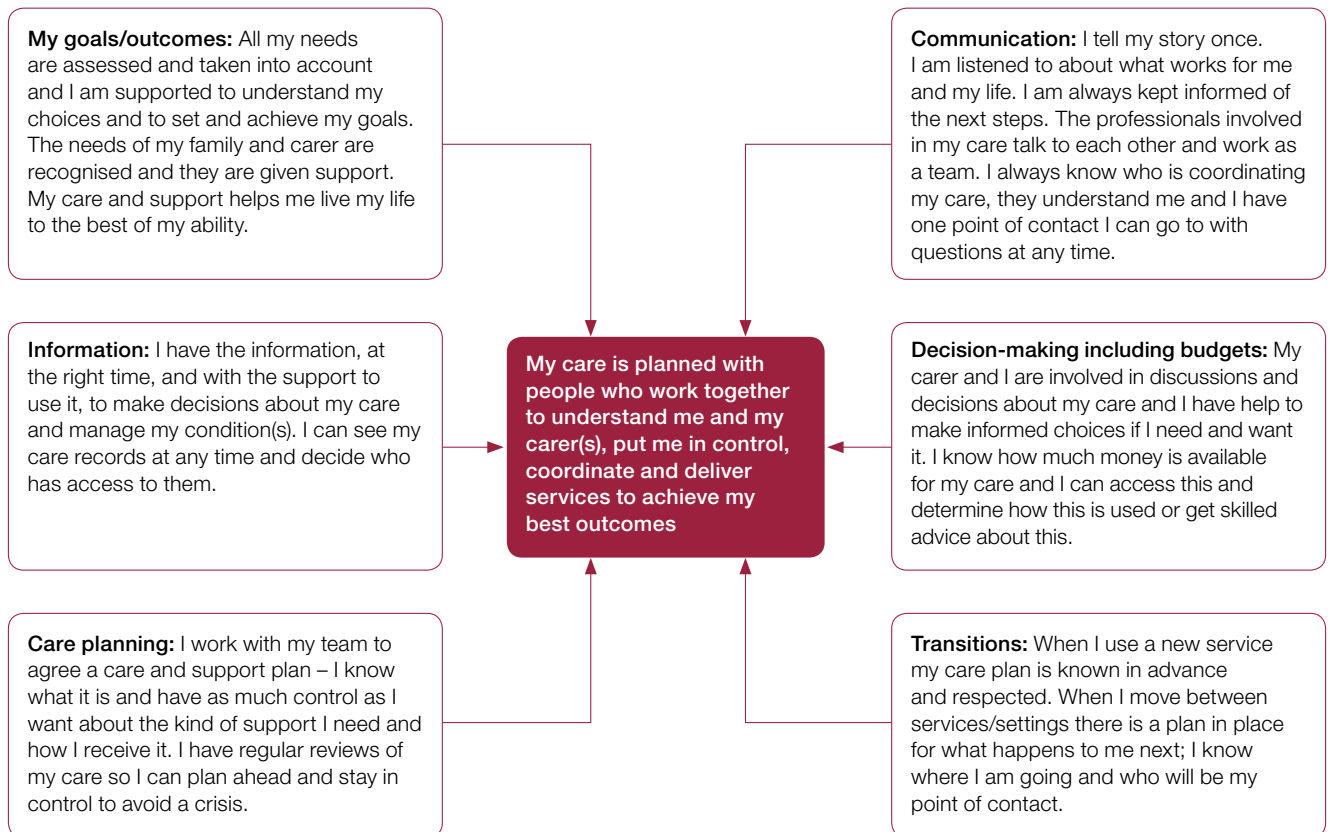
- 1 National Voices, a coalition of more than 140 health and social care charities in England, asked patients, carers and charities to draw their interactions with services and support. The example shown is based on interactions over seven years for a person living with dementia.

Source: Based on material published by National Voices

Figure 3

Definition of integrated care

The Department of Health & Social Care and national partners have placed user and patient experience at the centre of an agreed definition of integrated care

**Note**

- 1 The National Collaboration for Integrated Care and Support comprised 12 national partners: Association of Directors of Adult Social Services; Association of Directors of Children's Services; Care Quality Commission; Department of Health; Local Government Association; Monitor; NHS England; Health Education England; National Institute for Health and Care Excellence; Public Health England; Social Care Institute for Excellence; and Think Local Act Personal, in association with National Voices.

Source: National Collaboration for Integrated Care and Support

1.8 More joined-up health and social care offers the prospect of saving money, across the whole system, in the longer term. A 2016 review by the Local Government Association concluded that efficiency savings of £1 billion nationally each year could be realised through better integration of health and social care services. The review claimed that most of these savings could be achieved by shifting resources from hospitals to community settings and ensuring the most effective care pathways for patients and service users. This can ensure patients do not end up in the most expensive settings such as A&E or a hospital ward simply by default. However, the inability to move funding to the appropriate setting was a major obstacle to change.¹⁴

¹⁴ Local Government Association, *Efficiency opportunities through health and social care integration: Delivering more sustainable health and care*, Final report, June 2016.

National approach

1.9 Better joint working between health and social care has been a government objective since the Health Act 1999, but progress has been patchy and not sustained, partly because it is difficult to achieve and partly due to shifts in policy focus. In the past 20 years alone, there have been 12 white papers, green papers and consultations, and five independent reviews and commissions. Recent policy has given fresh impetus to the drive to better coordinate and integrate services across health and social care. Notably, in the Spending Review 2015, the government made a commitment to integrate health and social care services across England by 2020. The *Five Year Forward View* sets out the vision for the NHS up to 2020-21 and the actions needed to get there. It sets out initiatives to integrate health and social care services around the needs of the individual, such as integrating the various strands of community services and moving specialist care into the community.

1.10 Developing a robust evidence base to show that integrating health and social care leads to better outcomes for patients is challenging, because it is difficult to isolate the impacts of integration from other factors. While not suggesting that integration does not lead to such benefits, in our 2017 report *Health and social care integration*, we concluded that central government has not yet established such an evidence base.¹⁵ The government has not tested integration at scale, or demonstrated that any local improvements are both sustainable and can be attributed to integration. We cautioned that international examples of successful integration, often used in England to support the policy, provide valuable learning but their success takes place in a context of different statutory, cultural and organisational environments.

1.11 **Figure 4** on pages 18 and 19 shows the key policies and initiatives that have been introduced by central government and NHS England to improve working between health and social care since 2012. Throughout this report, we focus on four of these initiatives, to describe both what is being done to improve integration but also the challenges faced:

- **Better Care Fund**

Since 2015-16, local authorities and clinical commissioning groups have been pooling budgets to enable health and social care services to work more closely together. More than £11 billion was pooled in the Fund's first two years. The 2017 Spring Budget announced an extra £2 billion for adult social care between 2017-18 and 2019-20, to be distributed through the Better Care Fund. This has partly been used to support more people to be discharged from hospital when they are ready.

¹⁵ Comptroller and Auditor General, *Health and social care integration*, Session 2016-17, HC 1011, National Audit Office, February 2017.

- **NHS vanguards**

The *Five Year Forward View* set out new models of care that would better address the health and wellbeing of the population and integrate services around the patient's needs. Between April 2015 and March 2018, NHS England funded 50 pilot sites to test and develop these new models, with the aim of replicating them elsewhere. While all of the models support improvement and integration of services, some are more explicit about integrating health and social care, particularly the enhanced health in care home vanguards, which offer better joined-up health, social care and rehabilitation services to care home residents.

- **Sustainability and transformation partnerships**

In 2016, clinical commissioning groups, trusts and local authorities in England formed 44 footprint areas to produce strategic plans covering health and social care for the period 2016-17 to 2020-21. These plans set out how local services will change and improve to meet rising demand within the resources available. These footprint areas have since developed into partnerships, with more formalised arrangements such as a board and system leader. These partnerships are not new statutory bodies, but are increasingly recognised across the NHS as systems for overseeing and coordinating local planning.

- **Integrated care systems**

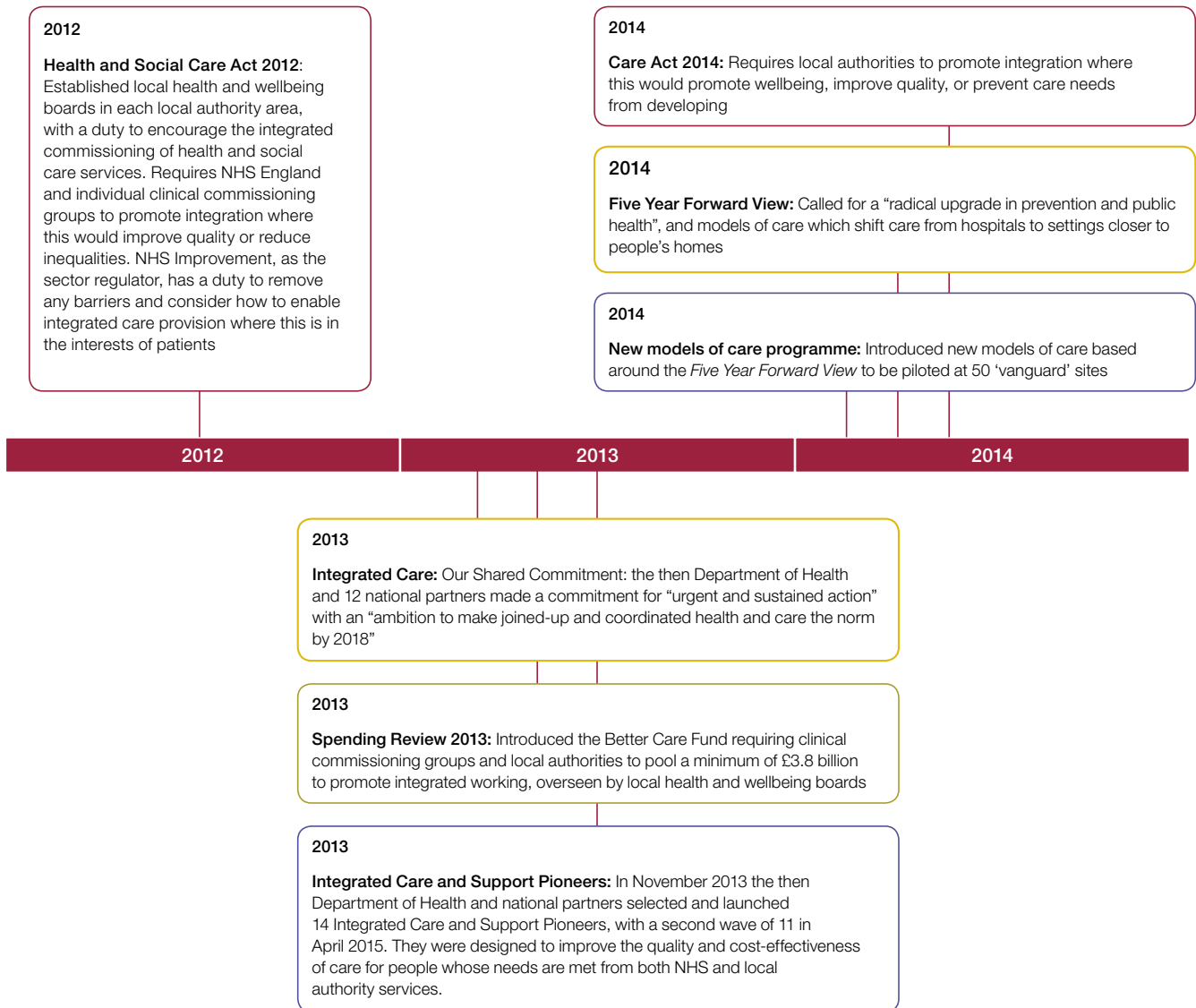
NHS England and NHS Improvement are encouraging sustainability and transformation partnerships to go further and form integrated care systems. This involves commissioners and trusts being collectively responsible for the population's health in an area, in exchange for greater control and freedom over funding and regulating their own performance. In June 2017, NHS England and NHS Improvement selected eight local systems to try this new approach, and in May 2018 added a further four. In addition, two systems have become devolved health and social care systems: Greater Manchester and Surrey Heartlands. Local authorities are involved in the development of both sustainability and transformation partnerships and integrated care systems, to a greater or lesser extent.

1.12 In April 2017, the then Department of Health commissioned the Social Care Institute for Excellence to produce a framework for a joined-up health and social care system, and to propose a set of metrics for measuring progress towards such a system. The resulting model was published in November 2017 (**Figure 5** on pages 20 and 21) and is intended for local areas to use to plan and monitor performance towards an integrated system. It showed:

- how an integrated system might be structured;
- how it might function;
- what interventions and services it might consist of; and
- the outcomes and benefits it would be expected to produce.

Figure 4
Timeline since 2012

The Department of Health & Social Care and the Ministry of Housing, Communities and Local Government have encouraged integration through new powers and legislative duties, funding transfers and pilot programmes



- New powers and legislative duties
- Policy commitments
- Funding transfers and mechanisms
- Programmes

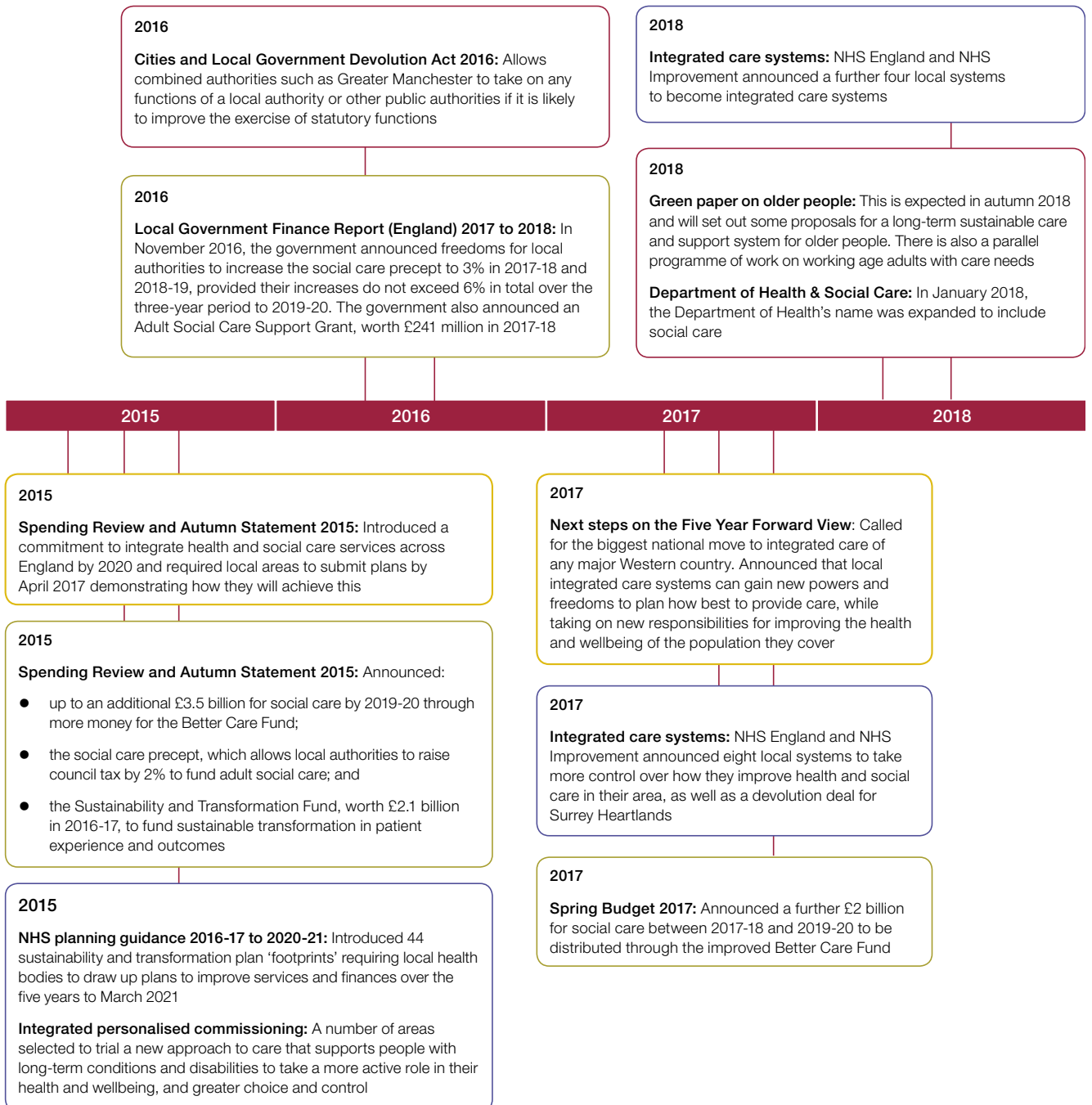
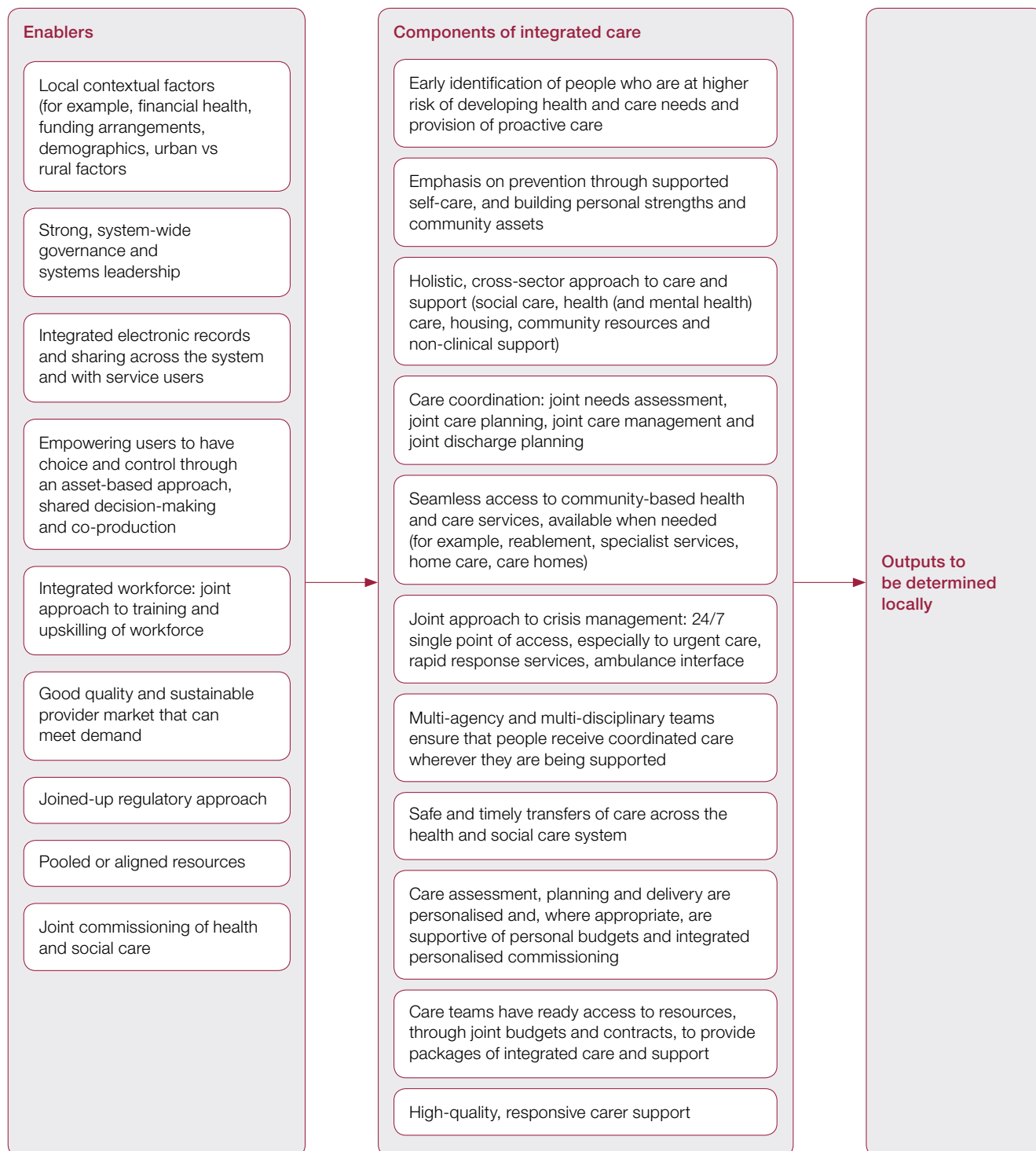


Figure 5
Social Care Institute for Excellence model for integrated care

The model is intended for local areas to use to plan and monitor performance towards an integrated system



Outcomes**People's experience**

Taken together, my care and support help me live the life I want to the best of my ability

I have the information, and support to use it, that I need to make decisions and choices about my care and support

I am as involved in discussions and decisions about my care, support and treatment as I want to be

When I move between services or care settings, there is a plan in place for what happens next

I have access to a range of support that helps me to live the life I want and remain a contributing member of my community

Carers report they feel supported and have a good quality of life

Services

The integrated care delivery model is available 24/7 for all service users, providing timely access to care in the right place

The model is proactive in identifying and addressing care needs as well as responsive to urgent needs, with more services provided in primary and community care settings

Professionals and staff are supported to work collaboratively and to coordinate care through ready access to shared user records, joint care management protocols and agreed integrated care pathways

Integrated assessment, care and discharge teams report they are readily able to access joint resources to meet the needs of service users

Transfers of care between care settings are readily managed without delays

System

Integrated care improves efficiency because, by promoting best value services in the right setting, it eliminates service duplication, reduces delays and improves services' user flow

Effective provision of integrated care helps to manage demand for higher-cost hospital care and to control growth in spending

Integrated care shifts service capacity and resources from higher-cost hospital settings to community settings

The system enables personalisation by supporting personal budgets and integrated personal commissioning, where appropriate

Impact**Improved health and wellbeing**

- Improved health of population
- Improved quality of life
- Reduction in health inequalities

Enhanced quality of care

- Improved experience of care
- People feel more empowered
- Care is personal and joined up
- People receive better quality care

Value and sustainability

- Cost-effective service model
- Care is provided in the right place at the right time
- Demand is well managed
- Sustainable fit between needs and resources

Part Two

Financial challenges

2.1 In this part, we look at the financial challenges that may inhibit closer working across health and social care. If health and social care organisations are to adopt effective integrated, person-centred ways of working, then funding, commissioning and payment arrangements must provide incentives for them to do so, rather than motivate people to work within organisational silos. NHS England is developing integrated care systems as a way of achieving this. It is emphasising joint commissioning and shared financial risk. However, the current financial environment and legislative framework do not make this easy. Below, we consider: funding pressures on both sectors; the short-term nature of current funding arrangements; current funding priorities; organisation versus system-wide financial control totals; and the differences in eligibility for health and social care services.

Funding pressures

2.2 Both the NHS and local government are under financial pressure, which can make closer working between them difficult. This could deter organisations in partnerships from seeking system-wide benefits that may be detrimental to them as individual organisations.

- As we reported in March 2018, government funding for local authorities fell by an estimated 49.1% in real terms from 2010-11 to 2017-18, equal to a 28.6% real-terms reduction in local authority ‘spending power’ (government funding and council tax).¹⁶ Local authorities have protected spend on social care; nevertheless, between 2010-11 and 2016-17 overall spending on social care reduced by 5.3%. This reduction has varied across local authorities, for example in April 2017 the Institute for Fiscal Studies reported that between 2009-10 and 2015-16 one in 10 local authorities reduced spending on adult social care by more than a quarter, while one in seven managed to increase spending.¹⁷

¹⁶ Comptroller and Auditor General, *Financial sustainability of local authorities 2018*, Session 2017–2019, HC 834, National Audit Office, March 2018.

¹⁷ Institute for Fiscal Studies, *National standards, local risks: the geography of local authority funded social care, 2009-10 to 2015-16*, April 2017.

- On the health side, the NHS is struggling to cope with increased demand. Funding per person, once adjusted for age, increased by 0.9% per year on average between 2013-14 and 2018-19. Short-term funding boosts have been necessarily used to cope with current financial pressures rather than being used for the transformation that is needed to make the system sustainable. We reported in January 2018 that the NHS increasingly relies on additional financial support and non-recurrent savings.¹⁸

2.3 These funding pressures can distract local organisations from engaging with efforts to join up services. The Social Care Institute for Excellence has described how organisations find this difficult when they are dealing with their own viability and survival.¹⁹ The risk of unhealthy competition has increased. The Nuffield Trust has reported that hospitals increasingly blame their local social care sector for playing a part in their deteriorating performance.²⁰ The Health Foundation and The King's Fund have reported that there are more incentives for organisations to shunt costs between one another.²¹ Despite this increased risk, there are examples across England of health and social care recognising the need to work together as a solution to funding and demand pressures.

2.4 Funding pressures can similarly divert local authorities and health bodies from focusing on efforts to transform services. There has been a shortage of funds for transformation. In June 2018 we reported that the original intention to expand the NHS vanguard programme was not realised because funding available for transformation was reallocated to reducing trusts' financial deficits. In 2015, NHS England modelled a programme with six waves of vanguards, with an early planning assumption of around £2.2 billion in funding for new care models between 2016-17 and 2020-21. However, actual direct funding of vanguards was £329 million over three years from 2015-16.²² Between 2014-15 and 2017-18, the Department of Health & Social Care (the Department) transferred £3.79 billion of capital to its revenue budget to fund day-to-day services. This has restricted the capital funding available for longer-term transformation. In addition, the public health grant paid to local authorities is set to be cut in real terms by around 4% per year from 2016-17 to 2020-21.

18 Comptroller and Auditor General, *Sustainability and transformation in the NHS*, Session 2017–2019, HC 719, National Audit Office, January 2018.

19 Social Care Institute for Excellence, *Integration 2020: Scoping research*, February 2017.

20 Nuffield Trust, *Managing the hospital and social care interface: interventions targeting older adults*, March 2018.

21 The Health Foundation and The King's Fund, *Approaches to social care funding: Social care funding options*, February 2018.

22 Comptroller and Auditor General, *Developing new care models through NHS vanguards*, Session 2017–2019, HC 1129, National Audit Office, June 2018.

Future funding arrangements

2.5 Short-term funding arrangements and uncertainty about future funding make it more difficult for health and social care organisations to plan effectively together.

- **Short-term funding arrangements**

Local authorities undertake medium-term financial planning and virtually all have signed up to a four-year funding settlement. However, as we reported in March 2018, funding following the 2015 Spending Review has been characterised by one-off and short-term initiatives, such as the option for local authorities to raise additional funds dedicated to social care through council tax (the ‘social care precept’) between 2016-17 and 2019-20.²³ The NHS, in contrast, has typically run on a one-year cycle, although this has now been extended to two years. In recent years, it has also relied on a series of reactive fixes such as the Sustainability and Transformation Fund.²⁴ In June 2018, the government announced that NHS England’s budget would increase by 3.7% on average between 2018-19 and 2023-24. NHS England is drawing up a plan for how this additional money will be spent.

- **Uncertainty over future funding levels**

There is at present much uncertainty about how social care will be funded in the future. Current arrangements for the additional social care precept flexibility and the Improved Better Care Fund will be reviewed and their futures determined as part of the 2019 Spending Review.²⁵ The government has promised a green paper on the future funding of social care for older people, previously planned for publication in July 2018 but now delayed until autumn 2018. However, until this is published, the consultation process completed and legislation proposed, there will be great uncertainty about how local authorities will fund care and how much funding they will have. The government has confirmed that it intends to implement the results of the current Fair Funding Review in 2020-21 and to allow local authorities to retain 75% of business rates.²⁶ However, the implications of these changes locally are unclear, as local tax bases may evolve in a different way to local spending needs. It is also unlikely that overall increases in tax revenues from business rates will match the demand for social care.²⁷

23 See footnote 16.

24 In April 2016, the NHS introduced the Sustainability and Transformation Fund to support the financial recovery of trusts and give the NHS the stability to improve performance and transform services.

25 The Improved Better Care Fund was first announced in the 2015 Spending Review, and was paid as a direct grant to local government, with a condition that it is pooled into the local Better Care Fund plan.

26 The Fair Funding Review is an updated assessment of the relative needs of local authorities that will set new baseline funding allocations for local authorities, which the government intends to implement from 2020-21.

27 Institute for Fiscal Studies, *Adult social care funding: a local or national responsibility?*, March 2018.

Funding priorities

2.6 Additional funding for health and social care has at times been used to address the immediate need to reduce service and financial pressures in the acute sector.

Given the scale of the operational pressures and the imperative on meeting patients' needs for urgent and emergency care, the NHS has been inclined to focus cooperative efforts on tackling these pressures and where it can achieve the greatest immediate savings. For example, in 2017-18 the Better Care Fund placed a greater emphasis than before on reducing delayed transfers of care. We reported in May 2016 that the NHS spends around £820 million per year treating older patients who no longer need to be in an acute hospital.²⁸ We also reported that older people can lose 5% of muscle strength per day of treatment in a hospital bed. The Better Care Fund has had considerable success in tackling this issue, with the total number of beds used for delayed transfers of care falling from 6,660 in February 2017 to 4,987 in March 2018. The programme helped bring health and social care partners together to tackle a key issue, supported by a high impact change model. The Department, the Ministry of Housing, Communities and Local Government and NHS England are supporting those local areas that have struggled to improve performance.

2.7 This success has not, however, been without its complications. Several stakeholders, including the Care Quality Commission in its review of local systems, have warned against focusing on delayed transfers of care in isolation, although in reality local areas spent the majority of pooled funds on addressing other issues. The Nuffield Trust raised the risk that it may have a negative impact on local relationships.²⁹ The Local Government Association told us that the focus created a public image of social care as simply existing to relieve pressure on hospitals.

2.8 Immediate pressures in the acute sector can also divert funding and focus from primary care services. As a proportion of total health spending, spending on general practice fell in three of the four years between 2010-11 and 2014-15. This proportion has though increased since, and NHS England plan to increase it further, with a 14% real-terms increase in spending on general practice between 2015-16 and 2020-21.³⁰ We reported in November 2015 how GPs are often at the heart of integrated health and social care planning for patients with long-term conditions. But if patients cannot access general practice they are more likely to suffer poorer health outcomes, or to use other, more expensive, NHS services such as accident and emergency (A&E) departments.³¹ We reported in January 2017 that the Department has recognised the importance of improving access to general practice and has committed to evening and weekend access for all patients.³² NHS England reports that more than half the population now benefits from this, and aims to achieve evening and weekend access for everyone by October 2018. NHS England is also supporting the development of new ways of providing services, including funding to support new job roles such as clinical pharmacists.

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

29 See footnote 20.

30 This is based on committed health funding prior to the government's announcement in 2018 that NHS England's budget would increase by 3.7% on average between 2018-19 and 2023-24. NHS England has not yet set out how it will allocate this additional funding.

31 Comptroller and Auditor General, *Stocktake of access to general practice in England*, Session 2015-16, HC 605, National Audit Office, November 2015.

32 Comptroller and Auditor General, *Improving patient access to general practice*, Session 2016-17, HC 913, National Audit Office, January 2017.

Organisational financial controls

2.9 Current accountability arrangements, set by legislation, emphasise the need for individual organisations to balance their books. Local authorities must, by law, set a balanced budget. Local health bodies are held accountable by NHS England and NHS Improvement for meeting their individual control totals (financial targets). The mismatch between the drive to spend co-operatively and for individual organisations to meet financial requirements makes it difficult for organisations to pool budgets, share financial risks and commission services jointly. One local authority director of adult social care told us that within their sustainability and transformation partnership, NHS England had prevented a clinical commissioning group pooling money with a local authority to develop an integrated service because of concerns over the former's financial health. Some local areas have found ways to work within the limitations set by legislation to maximise the benefits of pooled budgets, for example Tameside and Glossop Care Together partnership's financial framework (**Figure 6**). The refreshed NHS planning guidance issued by NHS England and NHS Improvement in February 2018 requires the integrated care system areas to prepare single system operating plans and to work within a single system control total.³³ Reconciling this system control total with trusts' and clinical commissioning groups' existing statutory requirements is complicated.

Figure 6

Tameside and Glossop Care Together financial framework

Some local areas have found ways to work within the limitations on pooling budgets set by legislation

Section 75 of the National Health Service Act 2006 restricts certain services from being formally pooled under Section 75 agreements. Tameside and Glossop Care Together partnership therefore developed an alternative financial framework for pooling total funds across the clinical commissioning group and local authority into an Integrated Commissioning Fund. This comprises three distinct elements, which are monitored and reported on individually and combined to give a grand total.

Fund element	Coverage
Section 75	Includes all funds that can be legally pooled under the Section 75 legislation, for example local authority adult social care funding.
Aligned	Includes all funds that Section 75 legislation does not permit to be pooled, for example surgery and radiotherapy.
In collaboration	Includes delegated co-commissioning primary care budgets from NHS England. This is a ring-fenced element of the Fund, because NHS England is ultimately accountable for these funds.

Source: Tameside and Glossop Care Together partnership

2.10 Partnership working in the past has been inhibited by a lack of incentives for an organisation to operate in a way that benefits other partners and the system as a whole, but might not benefit that organisation individually. We have previously reported on how the different ways in which organisations are funded and paid are not complementary and do not encourage system-wide efforts to reduce demand.³⁴ For instance, for most services health commissioners pay trusts for the level of hospital activity they provide. This does not give hospital trusts an incentive to help support patients to live independently in the community. The King's Fund and the Nuffield Trust have concluded in the past that stronger incentives are required if health providers are to collaborate to address the fragmentation and duplication in care.³⁵

2.11 National and local bodies have been trying to overcome these barriers, although their efforts are limited by the legislation within which the health and social care sector must operate. The King's Fund has said that the Health and Social Care Act 2012 does not make partnership working easy, as it was designed primarily to promote competition.³⁶ Two broad developments designed to better integrate funding and contracting arrangements are population-based contracts and system control totals:

- **Population-based contracts**

The King's Fund has predicted that commissioning in the future will make use of longer-term, outcome-based contracts.³⁷ NHS Providers has reported that the NHS vanguards have started to adopt these. The vanguards have introduced payment systems based on the needs of the whole population.³⁸ These focus on supporting people to stay well, and move away from payment for disease-specific treatments or activities. However, progress with the vanguards has not been easy. NHS England is developing a contract (the Accountable Care Organisation (ACO) Contract) to allow commissioning of services in a more integrated way, but it has not yet been implemented.³⁹ NHS England has been subject to two judicial reviews over the contract. As a result, work was paused on the consultation on the contract and on the enabling regulations required. As of April 2018, two vanguard areas had started a procurement process but neither have adopted the contract. NHS England told us that no contract will be entered into until the forthcoming consultation has been concluded.⁴⁰

34 See footnote 18.

35 The King's Fund and the Nuffield Trust, *Integrated care for patients and populations: Improving outcomes by working together*, January 2012.

36 The King's Fund, *Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England*, February 2018.

37 See footnote 35.

38 NHS Providers, *Learning from the vanguards*, January 2018.

39 An accountable care organisation is a single organisation working under a new contract that delivers most of the health, care and population health services in a locality.

40 See footnote 22.

- **System control totals**

To encourage local health bodies to share financial risk, NHS England and NHS Improvement are suggesting partnerships and integrated care systems work towards a system control total. In principle, NHS organisations within the same system will be able to adjust their individual financial control totals to reflect relative pressures and performance, as long as they meet the system control total. However, we reported in January 2018 that some partnerships had outlined the difficulty of making system control totals work in a challenging financial environment.⁴¹ Furthermore, the fundamentally different financial regimes under which health and local government operate will make expanding this in the future to be a truly system-wide control total a significant challenge.

Eligibility for publicly funded care

2.12 Different eligibility requirements for health and social care make it difficult to plan services around the needs of the individual. Healthcare is provided universally, whereas social care commissioned by local government is normally restricted to people with substantial or critical care needs. In addition, the NHS is largely free at the point of use, while local authorities typically only pay for those individuals with both high needs and limited financial means. We have previously reported on misaligned financial incentives between the sectors, with the national payment-by-results system encouraging increased activity in hospitals, while local authorities are seeking to reduce the number of people in hospital through the provision of social care.⁴²

2.13 This challenge is exemplified by local disagreements, which in some cases end up in court, about whether care is healthcare or social care, and therefore whether the NHS should pay or whether the local authority has to determine whether the patient is entitled to care. Our investigation into NHS continuing healthcare in 2017 found that of an estimated 207,000 individuals who were screened in 2015-16 to have their care paid for by the NHS, around 18% were assessed as eligible.⁴³ NHS England accepted that the assessment process raises people's expectations about whether their care will be paid for. In March 2018, the Department published a revised national framework for NHS continuing healthcare, which provided additional advice for staff on when individuals do and do not need to be screened.

41 See footnote 18.

42 Comptroller and Auditor General, *Health and social care integration*, Session 2016-17, HC 1011, National Audit Office, February 2017.

43 Comptroller and Auditor General, *Investigation into NHS continuing healthcare funding*, Session 2017-2019, HC 239, National Audit Office, July 2017.

Part Three

Culture and structure

3.1 Culture often trumps strategy, no matter how well set out. In this part, we consider a range of cultural and structural challenges to improved joined-up working. Strong leadership and effective local relationships across health and social care are essential to improve joint working. We also look at differences in structural and practical arrangements between the two sectors: geographies, workforces and information management.

Organisational focus

3.2 Traditional boundaries between the NHS and local government, and between individual organisations within these sectors, lead to services being managed and regulated at an organisational level. The Care Quality Commission concluded that the drive for individual organisations to meet their own targets is preventing them from adopting a ‘whole person’ approach that focuses on a person’s journey through the system.⁴⁴ The Nuffield Trust adds that, to date, regulatory inspection and performance measurement have focused on the quality of care that individual organisations provide, rather than the patient’s experience of the system as a whole. It adds that much of the national guidance being produced at present focuses on integration and planning between, and performance management of, NHS organisations, rather than focusing on the NHS and local government.⁴⁵ Integrated care systems are an attempt to develop approaches spanning health and social care, although some new systems are focusing on ensuring that local health bodies work together first, before extending arrangements to local government at a later date.

3.3 One way in which the NHS and local government hope to focus care on the needs of individuals is through integrated personalised commissioning and integrated personal budgets. Integrated personal budgets enable individuals to choose how to use funding from both health and social care to achieve health and wellbeing outcomes, set out in an agreed care plan. NHS England has a target that 300,000 people will benefit from integrated personalised commissioning by the end of 2018-19. NHS England reports that it is on track to achieve this, with 180,402 people on the integrated personal commissioning programme as at March 2018. It also has plans to greatly increase the scale of the programme, opening up integrated personal commissioning to a broader range of people.

⁴⁴ Care Quality Commission, *Local system reviews: Interim report*, December 2017.

⁴⁵ Nuffield Trust, *Managing the hospital and social care interface: interventions targeting older adults*, March 2018.

Mutual understanding

3.4 The NHS and local government operate in very different ways, and can have a poor understanding of how the other side's decisions are made. There can be confusion on the NHS side about whether decisions are made by the executive or elected members on the local government side. Similarly, there can be confusion on the local government side about whether decisions on the health side are made by commissioners, trusts or national bodies. Training, for example on financial management, is delivered within individual sectors, which does not help to allay this confusion. Terminology can mean different things in the two sectors, particularly financial terms, for example a 'balanced budget'.⁴⁶ Stakeholders told us that some NHS partners do not appreciate the importance of local democratic accountability within local government, or have experience of navigating and managing local politics. Similarly, some local government partners do not appreciate the strength of national oversight and monitoring within the health service. This was evident in the delayed transfers of care programme, with the Local Government Association expressing the view that NHS England should not have a role in determining local government's priorities.

3.5 We reported in January 2018 that new sustainability and transformation partnership arrangements have encouraged openness and transparency, and helped the partnership organisations to develop better relationships.⁴⁷ Their development has not been without issues: some local authority partners have felt sidelined in a process that has appeared NHS-led and focused, whereas others have resisted involvement for other reasons, for example, lack of local democratic accountability in health decision-making. To support better working between both sides and to improve mutual understanding, the national bodies have been supporting local areas in various ways. For example, NHS England and the Local Government Association, along with other partners, have arranged a webinar between clinical leaders and senior councillors, and a series of case studies showcasing examples of good and promising collaboration between NHS organisations and local authorities.

⁴⁶ In the NHS, a balanced budget is a budget that delivers break-even or a surplus; in contrast local authorities are required to set a budget that is sustainable and balanced, that is to say, not making a surplus or a deficit after transfers to or from reserves.

⁴⁷ Comptroller and Auditor General, *Sustainability and transformation in the NHS*, Session 2017–2019, HC 719, National Audit Office, January 2018.

Governance arrangements

3.6 Complex governance arrangements are hindering decision-making within local health and social care systems. These arrangements are often a consequence of the current statutory framework. We reported in January 2018 that partnerships felt hampered by the number of organisations that needed to approve decisions.⁴⁸ Many had created mechanisms, typically joint committees or committees-in-common, by which these decisions could be delegated to a single decision-making forum. However, these committees may have no statutory basis, so they depend on trust and goodwill to enforce decisions. A survey of NHS finance directors in November and December 2017 suggested that difficult decisions are not yet being made in partnerships, and so governance arrangements remain untested.⁴⁹

3.7 Health and wellbeing boards should be a key part of local governance arrangements, as they are currently the main statutory mechanism for overseeing efforts to join up health and social care services. However, the Care Quality Commission concluded that boards vary in their effectiveness as fora for exercising wider oversight of the system and for promoting transformational change.⁵⁰ While there is evidence that the effectiveness of boards is improving, some concerns remain. The Local Government Association told us that in some areas health and wellbeing boards are joining up within a sustainability and transformation partnership, but in other areas they are underused, and in effect sidelined by new and emerging arrangements set up to serve partnerships or integrated care systems.

48 See footnote 47.

49 Healthcare Financial Management Association, *Sustainability and transformation partnerships (STP) survey findings*, March 2018.

50 See footnote 44.

Leadership

3.8 Problems with local leadership can destabilise or hold back efforts to improve working across health and local government. A recurring theme in our conversations with local bodies has been the importance of high-quality, stable leadership that is able to motivate both health and local government. This is identified by many as important to building up trust across the system. However, as we have previously reported, progress with some sustainability and transformation partnerships was disrupted when system leaders changed.⁵¹ The Care Quality Commission reported that in the local systems it has reviewed it was difficult to identify where system-level leadership accountability lay.⁵²

3.9 There are indications that this system leadership is emerging. In several areas, the boundaries between health services and local government are being eroded, and the emphasis is shifting towards ensuring that the right leader is in place, rather than a leader from the right organisation. For example:

- the chief executives of some local authorities, for example Tameside and North East Lincolnshire, now also head up the clinical commissioning groups in their respective areas, and more areas are in the process of planning this arrangement;
- four of the 44 sustainability and transformation partnerships are led by local authority personnel, as well as many work programmes within partnerships. The Local Government Association told us that partnerships are, in general, getting better at involving local authority partners and at incorporating health and wellbeing boards into their governance arrangements; and
- there are now leadership programmes that span both health and social care, including local programmes such as Frimley Health and Care Sustainability and Transformation Partnership's 2020 Leadership Programme, and national programmes such as within the peer support programme for partnerships being developed jointly by the Local Government Association, the NHS Confederation, NHS Clinical Commissioners and NHS Providers.

⁵¹ See footnote 47.

⁵² See footnote 44.

Health and local government geographies

3.10 The geographical areas over which health and local government services are planned and delivered often do not align, which can make it difficult for the relevant organisations and their staff to come together to support person-centred care. Local authorities commission and provide services, including social care, to residents generally within the defined local authority area, whereas health services for different conditions can have very different patient catchment areas. For example, a hospital service for specialist stroke care will have a much greater catchment area than that for hip replacements. Furthermore, the 209 clinical commissioning groups in the NHS are working with 152 local authorities with social care responsibilities, with boundaries that often do not align.

3.11 The 44 sustainability and transformation partnerships were created to improve alignment with the pathways for care services of NHS patients in a particular area. Increasingly, the NHS and local government are shifting their thinking away from organisational boundaries that cover existing service areas and instead considering 'place'. This means designing and managing services for the most appropriate area or community for each service. In some areas, local governance arrangements are developing to ensure that decisions are made and services are planned at the geographical level best suited to that particular service. For example, in Greater Manchester some services are delivered through neighbourhoods serving populations of 30,000 to 50,000 people.

Information systems and data-sharing

3.12 Problems with sharing data across health and social care can prevent an individual's care from being coordinated smoothly. We have previously cited data-sharing and information governance as a barrier to working effectively at the interface between health and social care.⁵³ We have heard in the past about concerns with patient confidentiality and the legal requirements for data-sharing. NHS England and bodies representing local authorities told us that most local areas have now moved on from citing these legal and ethical barriers. Instead, they are focused on solving the practical problems of getting different information systems to work effectively together to share data.

⁵³ Comptroller and Auditor General, *Health and social care integration*, Session 2016-17, HC 1011, National Audit Office, February 2017. Comptroller and Auditor General, *Discharging older patients from hospital*, Session 2016-17, HC 18, National Audit Office, May 2016.

3.13 Local areas are having some success in developing a solution to this longstanding problem. Some have reported success in implementing a functioning shared care record across health and social care. For example, since 2017, in Leeds information from hospitals, GPs, mental health, community health and adult social care has been pulled together into a single patient record. The time saved has been equivalent to a reported £1 million per year. NHS England told us that 61 local areas have now set up information-sharing initiatives. Together with the Local Government Association, it is supporting some of these initiatives to become local health and care record exemplars. This involves developing the standards needed for information to be shared safely and securely. Other initiatives are also in place, including work to increase the number of social care providers with access to the NHS secure email service.

Separate workforces

3.14 New job roles and new ways of working could help to support person-centred care, but it is difficult to develop these because of the divide between the health and social care workforces. Typically, these workforces are separate and have different roles. We have previously reported that roles in the social care sector suffer from low prestige and a perception that they offer fewer opportunities for career progression compared with similar roles in the NHS.⁵⁴ Barriers to integrating the health and social care workforces include differences in working culture, professional boundaries, and different terms and conditions across the health and local government sectors.

3.15 Figure 7 sets out ways that local areas have tried to overcome these barriers, although these are not without issues. For example, The King's Fund highlights that a culture of protecting professional and organisational identities can prevent care roles from being reconfigured and new ways of working from being put in place.⁵⁵ Different pay rates for similar roles in health and social care can exacerbate the challenge of supporting roles that span the health and social care boundary. For example, in 2016-17, the average annual pay for a nurse working in social care was £27,900. The average for a nurse working in the NHS was £31,000.⁵⁶ This disparity will widen if the fully funded pay rise planned for the NHS in the next financial year is not replicated for similar roles in social care. There is debate on the degree to which new roles and new ways of working are needed, or whether the emphasis should be on supporting people in existing roles to work together better.

54 Comptroller and Auditor General, *The adult social care workforce in England*, Session 2017–2019, HC 714, National Audit Office, February 2018.

55 The King's Fund, *Supporting integration through new roles and working across boundaries*, June 2016.

56 See footnote 54.

Figure 7

Approaches to workforce collaboration

Local areas have tried various approaches to tackle the barriers to integrating the health and social care workforces

Multi-disciplinary teams	Many of the NHS vanguards have developed multi-disciplinary teams that work across organisational boundaries, often co-locating staff to enable them to work together more effectively.
New roles	New roles that focus on coordinating care or providing a single point of access can help to bridge the gap between health and social care and help link local health and social care teams to wider community services.
Expanded roles	Expanded care roles can help to reduce duplication and inefficiencies, and to improve care outcomes. For example, in Hertfordshire, there was a reported 11% drop in hospital admissions from care homes where the care workers were trained to undertake some clinical procedures.

Source: National Audit Office

3.16 Traditionally, workforce planning has been carried out within organisational and sector boundaries. In 2016, Health Education England set up Local Workforce Action Boards aligned to sustainability and transformation partnerships, which aim to ensure that decisions made about the workforce across health and social care are planned effectively. However, the Care Quality Commission has reported an absence of effective joint workforce strategies across systems to address issues with workforce capacity.⁵⁷ In December 2017, Health Education England published, for consultation, a draft workforce strategy for health and social care services in England to 2027, the first ever system-wide draft strategy. It initially intended to publish the final strategy in July 2018, although this has now been delayed until later in the year. However, in our report *The adult social care workforce in England*, we found that the draft strategy “is mainly concerned with the health sector, and coverage of the care sector is short and lacking detail”. In recognition of this, the Department of Health & Social Care commissioned its delivery partner on workforce matters, Skills for Care, to consult with the adult social care sector on how to improve support to care providers and address the workforce issues they are experiencing.

57 See footnote 44.

Part Four

Strategic issues

4.1 In this part, we look at the shift to a health and care system that has a greater emphasis on preventing people's care needs developing, and consider the public's understanding and perception of the two sectors. We consider issues at the strategic level that affect and influence progress towards a joined-up health and social care system. For partnerships to work most effectively, partners need to have comparable status and influence, and individual organisations' strategies and policies need to align with, and flow from, an overarching system-wide vision and strategy that applies to the whole system.

"We are pleased with the acknowledgement that councils need to be equal partners in plans to join up services... further integration plans are being severely hampered by current funding pressures in social care and the NHS and the continued focus on reducing pressure on acute and inpatient services. The long-term future of the NHS can only be assured if social care is adequately funded in the short and long term, with both services put on an equal footing, which will improve prevention work and better manage demands on councils and hospitals."

Councillor Izzi Seccombe, Chairman of the Local Government Association's Community Wellbeing Board, responding to the Health and Social Care Committee's report on Integrated care: organisations, partnerships and systems, June 2018

National voice

4.2 Differences in national influence and status, as well as public misunderstanding of how social care is provided and funded, have contributed to social care not being as well represented as the NHS. There is widespread and deep-rooted public loyalty to the NHS as a longstanding and vitally important public institution. In an Ipsos MORI poll conducted in March 2018, the NHS topped the list of things that make people proud to be British, and 14% of those polled regarded the future of the NHS as the country's biggest issue.⁵⁸ In the same poll, only 2% of people regarded the ageing population and social care for the elderly as the most important issue facing the country. The higher status given to the NHS partly explains why spending on health has been protected compared with most other areas of government spending and why it has secured a significant funding boost from 2019-20 onwards. The public also tends to feel more protective of the NHS, exemplified through local opposition to perceived attempts to privatise some health services. In contrast, social

⁵⁸ Ipsos MORI survey on behalf of Deloitte LLP, *The State of the State 2017-18*, March 2018.

care is generally perceived as the NHS's minor partner, and there is little understanding of how it operates (**Figure 8**). Further research carried out by The King's Fund found that the public had very low awareness of how social care is currently funded.⁵⁹

4.3 Management, leadership and accountability arrangements for health and social care are very different. The NHS benefits from a centralised leadership that is able to give a single voice to the health service. In contrast, local authorities are not accountable to an equivalent national body. As a consequence, social care issues have historically not been as well represented within the national debate. The Local Government Association is a voluntary membership organisation that represents local authorities' views.⁶⁰ It told us that while it is involved in the right national forums, it sometimes does not have the influence to ensure that social care is well represented. The Association of Directors of Adult Social Services, also a membership organisation, told us that NHS England does not engage effectively with it or involve it enough in decision-making around health services that may affect social care. However, both associations are included in forums to share views and align work at a national level, including the Integration Partnership Board and the Delayed Discharge Programme Board. Social care policy is the responsibility of the Department of Health & Social Care (the Department), which changed its name from the Department of Health in January 2018. This name change might signify that the Department is moving towards giving social care equal prominence to the health service.

Figure 8

Public understanding of adult social care

Large sections of the population wrongly think that social care services are free and provided by the NHS

	True	False	Don't know
The NHS provides social care services for older people	63%	34%	4%
Social care services are free at the point of need	49%	47%	4%

Notes

- Both statements are false.
- Percentages may not sum to 100 due to rounding.
- Approximately 1,000 UK adults were surveyed.

Source: Ipsos MORI survey on behalf of Deloitte LLP, *The State of the State 2017-18*, March 2018

⁵⁹ The King's Fund, *A fork in the road: Next steps for social care funding reform*, May 2018.

⁶⁰ The Local Government Association describes itself as a politically led, cross-party organisation that works on behalf of local authorities to ensure they have a strong, credible voice with national government. It aims to influence and set the political agenda on the issues that matter to local authorities so they are able to deliver local solutions to national problems.

Local strategies

4.4 Organisations across a local system may have misaligned strategies, which can inhibit joint local planning. In its local system reviews, the Care Quality Commission looks for a shared vision and system-wide strategy to which the individual organisations' strategies are aligned. Where these are in place, it has found that they have a positive impact on promoting a culture of joint working across health and social care boundaries. However, the Care Quality Commission found that this is not common.⁶¹ The Nuffield Trust has reported that the NHS largely views social care as supplementary to health services, enabling it to achieve its goals, rather than as a separate service with a wider range of distinct purposes.⁶²

4.5 To ensure support for changes to how services will be delivered, there must be close consultation and planning of future health and social care arrangements with staff and the public. We have previously reported on how the pace and scale of changes have made it difficult for sustainability and transformation partnerships to consult effectively and engage with clinicians, patients and the public.⁶³ The Social Care Institute for Excellence highlighted a potential problem with motivating staff that have had a poor experience with previous integration attempts.⁶⁴ Staff need to be consulted and feel empowered to lead the change. As NHS Providers has identified, leaders can set an example by investing in relationships at the highest level, and inspire staff at the front line to do the same.⁶⁵

4.6 We heard of examples of good local consultation. For example, the health and social care system in Surrey Heartlands, a devolution area that is developing an integrated care system, has set up a residents' online panel to regularly seek views on health, social care and other interconnected council services. We have reported previously on how NHS England has been supporting sustainability and transformation partnerships with their plans for communication and public engagement.⁶⁶

61 Care Quality Commission, *Local system reviews: Interim report*, December 2017.

62 Nuffield Trust, *Managing the hospital and social care interface: interventions targeting older adults*, March 2018.

63 Comptroller and Auditor General, *Sustainability and transformation in the NHS*, Session 2017–2019, HC 719, National Audit Office, January 2018.

64 Social Care Institute for Excellence, *Integration 2020: Scoping research*, February 2017.

65 NHS Providers, *Learning from the vanguards*, January 2018.

66 See footnote 63.

Targets and expectations

4.7 Central government in the past has had unrealistic expectations of the pace at which the required change in working practices can progress.

In our report *Health and social care integration*, we found that embedding new ways of working, and developing trust and understanding between organisations and their leaders, can take many years.⁶⁷ Such trust is needed to get to a position where partners are comfortable making decisions on spending their own organisations' money collectively, and sharing exposure to risks. We reported how local areas that have achieved more coordinated care have been doing so for up to 20 years. It takes time to run pilots, assess the impact of changes and develop and reinforce relationships. It also takes time for teams without a history of working together to feel able to communicate honestly and challenge each other openly. New arrangements need sustained financial and non-financial support to give them the best chance of success. Examples of improved outcomes through NHS vanguards show the value that committed central and coordinated support can bring.

4.8 In June 2018, we reported on the progress that local areas have made in piloting the new care models through the NHS vanguard programme.⁶⁸ The timeframe for the programme funding was three years, to be followed by fuller, longer-term transformation including scaling up and spreading of the models. We reported that a number of stakeholders said that the vanguards needed more time than that. They pointed out that transforming services is complex, often taking 10 years or even longer. Developing and testing replicable models in only three years was always likely to be a challenge, although many of the areas involved had already started developing new models of care before being accepted as a vanguard: 20 of the 29 vanguards that responded to our survey said their new care models were not entirely new. The Health Foundation has highlighted how adopters and followers within national programmes may need just as much, if not more, support to implement new care models as innovators, vanguards and pioneers.⁶⁹ However, in our report we identified a pattern of initiatives being continually folded into a successor initiative, sometimes before their objectives are fully achieved.

67 Comptroller and Auditor General, *Health and social care integration*, Session 2016-17, HC 1011, National Audit Office, February 2017.

68 Comptroller and Auditor General, *Developing new care models through NHS vanguards*, Session 2017-2019, HC 1129, National Audit Office, June 2018.

69 The Health Foundation, *Health Foundation submission to House of Commons Health and Social Care Committee inquiry into integrated care: organisations, partnerships and systems*, March 2018.

Increasing preventative care

4.9 Progress to date has demonstrated that joining up health and social care can support a greater focus on preventative services and the wider determinants of health. Through the *Five Year Forward View*, the NHS committed to take a broader approach to improving wellbeing and to move towards models focused on population health, as explored through the NHS vanguard programme. Over recent years, local government has been given a bigger role in supporting residents' wellbeing, for example through its new responsibility for commissioning public health services. However, as the Health Foundation has highlighted, there is a danger that new plans, structures and systems continue to support patterns of care that are fragmented and too focused on the acute sector.⁷⁰ The Care Quality Commission has concluded that health and social care organisations need to focus more on keeping people well.⁷¹ They should introduce joined-up processes to identify and support people to stay safe and well in their usual place of residence through effective prevention approaches.

4.10 Some local areas are demonstrating the benefits of taking a broader approach, for example by collaborating with housing partners. Many have reported sizeable, quantifiable improvements to outcomes such as rates of admission to accident and emergency (A&E) and hospital (**Figure 9**). NHS England is supporting local areas in adopting these initiatives. However, there remains a challenge in ensuring they receive continued and increased backing from national and local bodies, particularly if the savings are made in a different sector to where the investment was made. General practice and the voluntary sector often play a pivotal role in these approaches, whether making or receiving referrals into appropriate services. The Nuffield Trust recommends that a vibrant and diverse voluntary and community sector be nurtured to support effective interfaces between health and social care.⁷²

Figure 9

Local examples of joint working to tackle wider determinants of health

Local areas have reported sizeable, quantifiable improvements to outcomes such as rates of admission to A&E and hospital

Local area	Description	Outcomes
South Norfolk	Patients in GP practices have accessed the local authority's social prescribing service	45% of patients had their identified needs met in the initial appointment through receiving tailored information and advice
Blaby, Leicestershire	A housing support service to identify immediate housing safety risks, make adaptations, and tackle problems such as poor heating and hoarding	Estimated to have saved the NHS more than £435,000, including savings from lower A&E attendances and emergency admissions
Buckinghamshire	Local scheme designed to increase activity levels through activities including health walks and bush craft	17% reduction in inactivity levels, 20% more people achieving recommended activity levels, and improvements in mental health and social cohesion

Source: NHS England

⁷⁰ See footnote 69.

⁷¹ See footnote 61.

⁷² See footnote 62.




4.11 The Greater Manchester Health and Social Care Partnership is perhaps the local area that is most advanced with its plans to join up health and social care, as part of the Greater Manchester Devolution Agreement, and is taking a broad view of the range of public services that need joining up (**Figure 10**). The overarching aim is “to deliver the greatest and fastest possible improvement to the health and wellbeing of the 2.8 million people of Greater Manchester”.

Figure 10

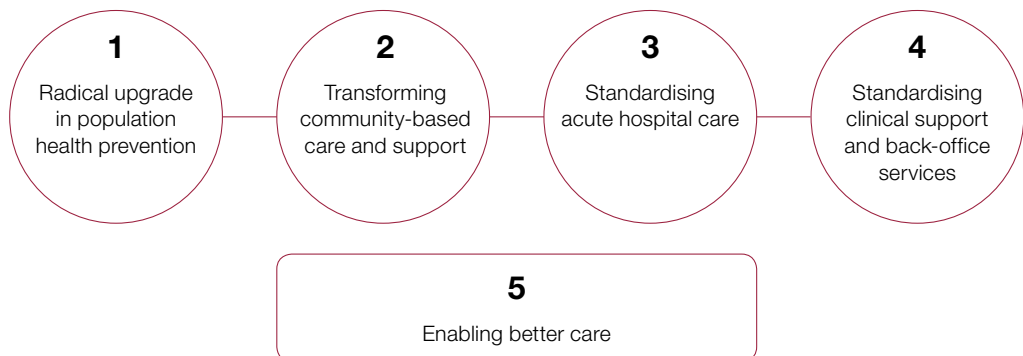
The Greater Manchester Health and Social Care Partnership

Vision: To deliver the greatest and fastest possible improvement to the health and wellbeing of the 2.8 million people of Greater Manchester.

Aims:

<p>More Greater Manchester children will reach a good level of development cognitively, socially and emotionally</p> 	<p>Fewer Greater Manchester babies will have a low birth weight resulting in better outcomes for the baby and less cost to the health system</p> 
<p>More Greater Manchester families will be economically active and family incomes will increase</p> 	<p>More people will be supported to stay well and live at home for as long as possible</p> 
<p>Fewer will die early from cardio-vascular disease Fewer people will die early from cancer Few people will die early from respiratory disease</p> 	

Transformation themes:



Source: Greater Manchester Health and Social Care Partnership

Appendix One

Our audit approach

Scope

1 This report sets out our thinking on what is needed to improve joint working between the NHS and local government so that patients and service users receive a better experience at the interface between health and social care. It covers:

- the benefits that improved working at the interface should bring;
- the challenges to achieving improved joint working; and
- examples of recent successes at overcoming these challenges.

2 The report draws heavily on previous National Audit Office work. We carried out additional fieldwork between March and May 2018.

Methods

3 We **interviewed relevant officials** from the Department of Health & Social Care, the Ministry of Housing, Communities and Local Government and NHS England. We also interviewed other stakeholders including the Association of Directors of Adult Social Services, the Chartered Institute of Public Finance and Accountancy, the Healthcare Financial Management Association, the Local Government Association and The King's Fund. These interviews were designed to understand:

- the cultural and structural barriers between the NHS and local government and how these impact on patients and staff;
- challenges in improving joint working at the interface between health and social care; and
- the progress of programmes and initiatives designed to improve joint working.

We also spoke to leaders from a small number of local health and care systems.

4 We **liaised closely with the Care Quality Commission** to understand the emerging findings from its review of 20 local health and social care systems. It published an interim report in December 2017 based on its first six reviews, and is due to publish its final report in July 2018.

5 We **reviewed relevant literature** on the interface between health and social care. This included publications from the Health Foundation, the Healthcare Financial Management Association, NHS Providers, the Nuffield Trust, the Policy Innovation Research Unit, the Social Care Institute for Excellence and The King's Fund.

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