



BRIEFING PAPER

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Health and Social Care Integration

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Summary

Health and adult social care services in England have traditionally been funded, administered and accessed separately. Health has been provided free at the point of use through the National Health Service, whilst local authorities have provided means-tested social care to their local populations.

As a result of demographic trends, including an ageing population, **an increasing number of people require support from both health and social care services.** It is argued that these patients can be badly served by the current health and social care model, and that by integrating the two services, the patient can be put at the centre of how care is organised.

As well as improving the experience for the patient, **it is argued that integration can save money by cutting down on emergency hospital admissions and delayed discharges.** This is particularly significant in light of current funding pressures for the NHS and local authorities, although the scope of potential savings has been disputed.

Successive Governments have sought to better integrate health and social care by focusing on care outside of hospital, instead delivering care as close to the patient as possible, either at home or in their community.

This briefing looks at the challenges presented by the integration of health and social care, as well as **recent Government policies to promote integration.** These have included the creation of **Health and Wellbeing Boards**, local strategic planning forums with representatives from health and social care services, and the **Better Care Fund**, a pooled budget between the NHS and local authorities, **to which the Government has committed £5.128 billion in 2017/18.** There have also been a number of smaller, pilot projects to improve integration.

Many of these policies are relatively new, and so detailed evaluation of performance is often limited in its availability. However, their impact so far, and comment from those in the health and social care sectors is examined. **In the case of the Better Care Fund, the policy has not yet succeeded in reducing the number of emergency hospital admissions and delayed discharges,** which have continued to rise in recent years.

Also examined is the relationship between recent policies to promote integration and broader NHS reforms, as set out in NHS England's *Five Year Forward View* strategy and to be implemented through local Sustainability and Transformation Plans. This briefing also looks at the devolution of health and social care powers to some local areas in England, particularly Greater Manchester.

As **health and social care are both devolved policy areas**, this briefing focuses largely on integration in England. However, the four UK nations have taken different policy paths with regards to integration. Scotland and Wales have both passed recent legislation promoting integration, including moves towards fully integrated health and social care commissioning in Scotland, whilst Northern Ireland has had an integrated health and social care system since the 1970s. **The policy landscape in Scotland, Wales and Northern Ireland is explored towards the end of this briefing.**

Further information on this subject can be found in the Parliamentary Office of Science and Technology's 2016 POSTnote, [Integrating Health and Social Care](#), and in the National Audit Office's 2017 report, [Health and social care integration](#).

1. Health and social care integration

1.1 What is meant by integration?

Broadly speaking, health and social care integration relates to the creation of a more joined-up care experience for those with both health and social care needs.

In the UK context this relates to bridging the divide created by the 1948 settlement, which saw the creation of a nationally-administered, free at the point of use NHS, with local authorities retaining responsibility for a means-tested social care system. Although health and social care are both devolved policy areas, integration challenges for all four UK nations stem from this systemic divide.

There is no set interpretation of what integration looks like or how it should function. In recent years, some of the focus of integration has been around moving care out of hospitals and more into the home or community settings. This focus is often accompanied by targets to reduce emergency admissions into hospitals and delayed discharges from hospitals.

2015 guidance from the Department of Health (DoH) on integrated care stated that in England there is no 'one size fits all' approach to integration, with services integrated according to local needs and circumstances. It gives the following advice to local commissioners:

It is for local commissioners to decide, with input from their providers and other stakeholders, (and in line with relevant regulatory frameworks), how care can be delivered in a more integrated way. This includes looking at how existing services can be better integrated, as well as designing and implementing new models of care. Delivering integrated care can extend beyond traditional perceptions of healthcare and social care into areas involving:

- early intervention
- prevention
- self-care
- promoting and supporting independent living

Where integrated care is demonstrably delivered, it is underpinned by a shared commitment to person-centred care and support. This commitment is demonstrated through clearly articulated benefits and solid plans for measuring progress against stated objectives (quality and/or efficiency).¹

To achieve the output of a more integrated patient experience, it is often necessary for health and social care providers to integrate at an organisational level. This can be through the pooling of budgets, joint commissioning or co-location of services, integration of workforces, and

¹ Department of Health, [Complying with Monitor's integrated care requirements](#), March 2015, para 1.1

the sharing of patient information. Recent Government policy to integrate health and social care providers and commissioners are explored further in sections 2 and 3.

1.2 Growing importance of integration

Whilst there has always been an interdependence between health and social care, demographic changes have arguably increased the importance of integration between the two in recent years.

The most significant change is an ageing population, with recent decades seeing older people making up an increasing proportion of the population. This trend is projected to continue in the coming decades:²

Estimated and projected population aged 65+ and 85+, United Kingdom, 1951-2039

	65+		85+	
	Thousands	%	Thousands	%
Estimates				
1951	5,451	10.8%	215	0.4%
1961	6,208	11.8%	346	0.7%
1971	7,408	13.2%	485	0.9%
1981	8,476	15.0%	603	1.1%
1991	9,059	15.8%	873	1.5%
2001	9,373	15.9%	1,130	1.9%
2011	10,458	16.5%	1,407	2.2%
2015	11,611	17.8%	1,526	2.3%
Projections				
2019	12,468	18.6%	1,693	2.5%
2024	13,725	19.9%	2,007	2.9%
2029	15,372	21.7%	2,420	3.4%
2034	16,974	23.3%	3,152	4.3%
2039	18,053	24.3%	3,565	4.8%

The 2014 interim report of the King's Fund's Commission on the Future of Health and Social Care in England (known as the 'Barker Commission') set out some of the impacts of an ageing population on the provision of health and care services:

The sheer numbers of older people now mean that within that cohort there are many more frail people who live with multiple conditions that require either health or social care, or very often both. The increase in life expectancy has also led to a rise in the numbers of people suffering from what are sometimes termed the diseases of old age – the dementias and Parkinson's disease, for example – conditions where social care is at least as crucial as health care.³

² Sources: ONS: *Annual Abstract of Statistics 1954*; *Population estimates and deaths by single year of age for England and Wales and the UK, 1961 to 2015*; *National Population Projections: 2014-based, Principal projection, Table A2-1*

³ Barker Commission, *A new settlement for health and social care: Interim report*, April 2014, p9

Younger adults with care needs, for example those with learning difficulties, are also living longer, with increasingly complex conditions.⁴

In addition to providing better care for an increasing number of patients with multiple health and social care needs, proponents of integration have argued that it can also save money for the NHS and for local authorities. As the interim report argued:

There is now good evidence that at least 20 per cent of acute admissions to hospital are not strictly necessary, and that people could be cared for better in other settings, including at home. Such care will not always cost less, though frequently it will. But better integration between primary and secondary care, and better integration between health and social care, along with better arrangements between the two at the end of life, would either avoid many of these admissions in the first place, or would allow swifter discharge once treatment was completed.⁵

Attempts to identify cost reductions are particularly significant given the NHS's target of achieving £22 billion of efficiency savings by 2020/21 and the current financial pressures faced by local authorities in providing social care services.

However, the potential of integration to produce significant savings is disputed. The National Audit Office's (NAO) 2017 report into [Health and social care integration](#) found no compelling evidence that integration in England leads either to sustainable financial savings or reduced hospital activity:

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.⁶

1.3 Delayed transfers of care

A delayed transfer of care (DTOC) is where a patient is ready and safe to leave hospital care, but is unable to do so, and remains occupying a hospital bed.

A common cause of delayed discharges from hospital is a lack of an adequate care package or care funding available for a patient outside of hospital. Given the shortages of available hospital beds in a number of NHS trusts, the issue of 'bed blocking' is often cited as a key argument in favour of integration of health and social care.

DTOCs involving patients with both health and social care needs are occurring with increasing frequency. Between December 2013 and December 2016, the number of delayed discharges from hospital attributable to local authorities (or jointly to local authorities and to the

⁴ National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011 2016-17, para 1.1

⁵ *Ibid.*, p12

⁶ National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011 2016-17, para 1.11

NHS) rose from 36,000 (32% of all DTOCs) to 86,000 (44%). Prior to December 2013 numbers had been falling.⁷

The Government has highlighted the variation in DTOC performance between local areas as indicative of varying levels of local integration. The Prime Minister gave the following response to a question on DTOCs during PMQs in January 2017:

He talks about delayed discharges. Some local authorities, which work with their health service locally, have virtually no delayed discharges. Some 50%—half of the delayed discharges—are in only 24 local authority areas. What does that tell us? It tells us that it is about not just funding, but best practice.⁸

In the [2017 Spring Budget](#), it was announced that targeted measures would be introduced to help the local areas with the highest DTOC rates.⁹ These measures were set out in more detail in the Better Care Fund (BCF) 2017-19 planning requirements, published in July 2017:

The Government has announced a package of measures to address DTOC across the health and social care system. This package includes:

- A dashboard showing how areas are performing against a range of metrics across the NHS-social care interface;
- Targeted CQC reviews to examine performance in the areas with the worst outcomes across these metrics, with a view to supporting them to improve;
- Considering a review, in November, of 2018-19 allocations of the social care funding provided at Spring Budget 2017 for areas that are poorly performing. This funding will all remain with local government, to be used for adult social care; and
- Guidance on implementing a Trusted Assessor model.¹⁰

The proposed review has been controversial with local authorities, with many questioning how achievable the targets are. In October, it was reported that the chair of the Local Government Association (LGA), Lord Porter, told local authorities that had received a warning letter about DTOC levels from the Department of Health to “throw it in the bin.”¹¹

More information on DTOCs can be found in the Commons Library briefing paper, [Delayed transfers of care in the NHS](#).

1.4 Challenges for integrating services

Successive Governments have attempted to better integrate health and social care, but have faced a number of structural, cultural and financial challenges that have slowed progress on this front. Some of the most commonly cited challenges include:

⁷ NHS England, [Delayed Transfers of Care Data 2016-17](#), February 2017

⁸ [HC Deb 11 January 2017, c308](#)

⁹ HM Treasury, [Spring Budget 2017](#), HC 1025, March 2017, para 5.5

¹⁰ DoH & DCLG, [Integration and Better Care Fund planning requirements for 2017-19](#), July 2017, para 29

¹¹ [“Bin’ DTOC warning letters, says local government leader’](#), *Health Service Journal*, 13 October 2017

- **Different financial incentives**

Healthcare providers are currently paid for each patient seen or treated, which it has been argued encourages increased hospital activity, whilst integration attempts to reduce hospital activity. The misalignment of financial incentives has been highlighted by the 2017 NAO report as a key barrier to integration.

The Government has acknowledged the potential difficulties caused by differing financial incentives, and since 2014 the national tariff payment system has allowed providers and commissioners to agree local variations to nationally determined payments.¹²

- **Different funding models**

NHS treatment is free at the point of use, whilst local authority social care is means-tested. This can produce conflict over funding and funding eligibility for patients between the two services.

The Barker Commission's interim report particularly highlighted this potential for disputes around the provision of NHS Continuing Healthcare (free nursing support for patients with ongoing primary health needs):

In practice, over the years, a large amount of continuing care has also been moved out of the NHS and into the means-tested sector. That has produced angry protests from the families of those who cannot but see that their relative still has significant health as well as social care needs, even if their condition is not remediable. It has led over the years to a number of court judgements, a scathing report from the Health Ombudsman, and a series of attempts to redefine what should remain as free NHS care, even if paid for in private provision, and what should be means tested.

[...]

The different funding streams mean health and social care each have an interest in pushing the funding problem on to the other. The very different entitlements provide relatives and individuals with a personal financial interest in the outcome. The differing organisations mean patients and clients can see well-loved carers changed because health and social care contract with different providers, and contract to provide different services.¹³

- **Workforce challenges**

The NAO identified barriers to integration through different working cultures, professional entrenchment and different terms and conditions across the health and social care sectors.

A 2016 report by the King's Fund on working across boundaries also argued that joint working could reinforce and define the

¹² Department of Health, [Complying with Monitor's integrated care requirements](#), March 2015, para 5.2

¹³ Barker Commission, [A new settlement for health and social care: Interim report](#), April 2014, pp17-18

contrast between the two health and social care workforces' distinct professional identities.¹⁴

- **Information sharing**

In a fully integrated system, a patient's care record would move with them throughout the health and care system, so that they would not have to repeat information or go through unnecessary processes.

However, the NAO found confusion between local organisations over the regulatory framework on information sharing, meaning that this remained a barrier to integration. It noted that in 2015/16, nearly one third of areas were not using an NHS number as the main way of identifying patients.

Under the [Health and Social Care \(Safety and Quality\) Act 2015](#), health and social care providers have a duty to share information with each other, where this will facilitate care for an individual.¹⁵

- **Inspection framework**

The inspection and performance framework can currently focus on the quality of care provided by individual organisations, rather than the patient's experience of the system as a whole. To help counter this, the Care Quality Commission's 2016 report into integrated care for older people called for the creation of validated data metrics by NHS England's National Quality Board to better measure person-centric outcomes of integrated care.¹⁶

The [Breaking Barriers](#) report into health and social care also recommended that inspection regimes are aligned on an outcome basis, at a local rather than national level.¹⁷

- **Competing policy priorities**

Much of the Coalition Government's health reforms sought to promote patient choice and competition within the NHS. At the time of the 2012 reforms (see section 1.4), organisations such as the King's Fund warned that this could make coordination of care across multiple providers more difficult.¹⁸ This was again identified as a problem for integration in the 2017 NAO report.

The NAO also raised concerns about the interaction of integration with another Government policy priority, Sustainability and Transformation Plans (STPs), which are plans to rearrange local health services over the next five years. Its report highlighted local authority concerns that STPs were NHS-led and too NHS-focused.

- **Cost to providers**

As well as the financial costs of integration through the payment by results tariff, concerns have been raised that local authorities

¹⁴ The King's Fund, [Supporting integration through new roles and working across boundaries](#), June 2016, p19

¹⁵ See Information Governance Alliance, [The Health and Social Care \(Safety and Quality\) Act 2015: Duty to share information](#), for more information on the duty.

¹⁶ Care Quality Commission, [Building bridges, breaking barriers](#), July 2016

¹⁷ Breaking Barriers, [Building a sustainable future for health and social care: An independent review](#), June 2016, p8

¹⁸ The King's Fund, [Briefing: Health and Social Care Bill](#), January 2011

may be unable to meet the significant upfront investment costs of creating an integrated service.

A 2015 Public Accounts Committee report on the Better Care Fund argued that there had been “minimal pump-priming investment to support the development of new community-based services.” It also quoted evidence from the LGA arguing that the fund’s focus on savings was unhelpful given that the integration of services required significant upfront investment from local authorities.¹⁹

- **Departmental oversight**

As well being administered by different organisations, health and social care are also funded and overseen differently at Departmental level. The NHS is funded by the DoH whilst local authority funding is provided by the Department for Communities and Local Government (DCLG). The NAO report highlighted the impact this lack of cohesive oversight was having on integration:

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.

Both NHS England and the Department of Health told us that this lack of senior-level leadership had caused delays in implementing its policies.²⁰

1.5 Recent Government policy

Integration of health and social care is not a new political ambition. From the *National Health Service Act 1977* under James Callaghan’s Labour Government, which encouraged health authorities and local authorities to co-operate, to the *Health Act 1999*, which allowed NHS bodies and local authorities to pool budgets, successive Governments have sought to bring the NHS and local authority social care closer together. The 1999 Act was part of the last Labour Government’s stated aim to pull down the “Berlin Wall” dividing health and social services.²¹

¹⁹ Public Accounts Committee, [Planning for the Better Care Fund](#), 26 February 2015, HC 807 2014-15, recommendation 6; para 12

²⁰ National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011 2016-17, para 3.20

²¹ [‘Health and social care partnerships made easier’](#), *The Guardian*, 9 November 2000

As part of broader health and social care reforms, the 2010 Coalition Government introduced new legislation to further promote integration:

- **The Health and Social Care Act 2012** established Health and Wellbeing Boards in each local authority, with a “duty to encourage integrated working,” and required NHS England and Clinical Commissioning Groups (CCGs) to promote integration of health services where this would improve quality or reduce inequalities.
- **The Care Act 2014** required local authorities to promote the integration of health and care provision where this would promote wellbeing, improve quality, or prevent the development of care needs.

In May 2013, the then Care and Support Minister announced an ambition for all local areas to have integrated health and social care by 2018.²² The 2013 Spending Round also saw the announcement of a £3.8 billion joint budget for the NHS and local authorities, the Better Care Fund (see section 2.2).

NHS funding is also increasingly targeted towards more integrated ways of working. NHS England’s 2014 planning document, the *Five Year Forward View* (5YFV), set out plans for ‘new models of care’, which it was intended would “increasingly dissolve these traditional boundaries”, between GPs, hospitals, social care and mental health (see section 3.2).²³

The commitment to integration of health and social care remained when the Coalition Government was replaced by the 2015 Conservative Government. However, the 2015 Spending Review pushed the target for full integration of local areas through the Better Care Fund back to 2020, with all areas to have a plan for integration in place by 2017.

The Spending Review also reaffirmed the Government’s policy of allowing the specific design of integration to be locally-determined, rather than imposed by central Government:

The government will not impose how the NHS and local government deliver this. The ways local areas integrate will be different, and some parts of the country are already demonstrating different approaches, which reflect models the government supports.²⁴

1.6 Debates on further integration

Single budget for health and social care

The [final report of the Barker Commission](#), published in September 2014, set out a number of recommendations for substantial reform of the health and social care systems.

²² Department of Health, [People will see health and social care fully joined-up by 2018](#), 14 May 2013

²³ NHS England, [Five Year Forward View](#), October 2014

²⁴ HM Treasury, [Spending Review and Autumn Statement 2015](#), Cm 9162, November 2015, para 1.113

The most significant of these was the recommendation of a single, ring-fenced budget for health and social care, with a single commissioner at the local level. It was proposed that the commissioner could be local Health and Wellbeing Boards.²⁵

A January 2016 Commons debate on health and social care saw support for the Commission's single budget proposal from MPs including Maria Caulfield and Jeremy Lefroy.²⁶ In June, the former Health Minister Lord Warner also called for a joint budget at a Departmental level:

We should speedily convert the Department of Health into a department of health and social care, with all social care responsibilities transferred to it from the DCLG, and we should make it responsible for an integrated health and care budget. At least that would give us a bit of time for longer-term planning.²⁷

The Government's current approach, as set out by the then Health Minister Alastair Burt during the January debate, is to promote the Better Care Fund, which gives local areas discretion on how much funding to pool. However, as the fund develops, it may move closer to the Barker recommendation as an increasing proportion of funding is pooled. The 2016/17 policy framework makes clear that the pooled budget can extend to cover "the totality of the health and care spend in the Health and Wellbeing Board area."²⁸

The Barker Commission also recommended that Attendance Allowance (AA), a benefit for older people with care needs administered by the Department for Work and Pensions, be brought within the new single budget.

In 2015, the Government proposed devolving the administration of AA to local authorities to better integrate services for people with social care needs. However in 2017, following concerns from the LGA that the plans could be costly for local authorities, the Government dropped the proposal.²⁹ The impact of this decision for health and social care integration may mean that future Governments are more cautious around any proposed changes to AA.

Addressing different funding models

Another Barker recommendation looked at addressing one of the major barriers to integration, differing funding models between health and social care (as discussed in section 1.3). It proposed making social care free at the point of use for those with critical care needs, whilst making accommodation costs for NHS Continuing Healthcare recipients means-tested. This was intended to rationalise whether treatment or care was free or means-tested dependent on the type of care, rather than on who provided it.

²⁵ Barker Commission, *A new settlement for health and social care*, September 2014

²⁶ [HC Deb 28 January 2016, cc482-90](#)

²⁷ [HL Deb 1 December 2016, c384](#)

²⁸ DoH & DCLG, *2016/17 Better Care Fund: Policy Framework*, January 2016

²⁹ More information can be found in the Commons Library briefing paper, [The future of Attendance Allowance](#), CBP-7729

However, the Commission did note that changes to the funding of social care came with philosophical as well as practical considerations:

There are obvious problems in making all social care free at the point of use. That would carry a huge cost to the taxpayer, while potentially destroying some of the basic bonds of society: the role of families and carers in supporting those closest to them at a time of need.³⁰

The Nuffield Trust also raised concerns about the financial impact of increasing universal social care funding for those with critical care needs:

But as we don't know how many people with critical care needs are currently paying for their own care or receiving it informally, there is a risk that the Commission's central proposal may result in new battlegrounds emerging if numbers eligible exceed the budget available for free care.³¹

Full integration of health and social care would need to address the discrepancies between the free at the point of use and the means-tested models, but as set out above, this would not be without challenges.

Integration beyond health and social care

Beyond Barker, other debates on integration have looked at whether it is enough to just integrate health and social care, in order to create a fully integrated experience for service users.

Reports such as the King's Fund's *Population Health Systems*, have argued that public health services (currently commissioned by local authorities in England) such as exercise programmes and smoking cessation can also be integrated to create a more joined-up experience for service users. It also highlights examples of integration from around the world that go further, integrating housing support, education programmes, vocational services and employment advice.³²

The importance of integration beyond health and social care is acknowledged by the Government. For example, in 2014 various organisations including DoH, DCLG, Public Health England, NHS England, the LGA and the Association of Directors of Adult Social Services signed a Memorandum of Understanding to support joint action on improving health through the home, which stated:

The right home environment is essential to health and wellbeing, throughout life. We will work together, across government, housing, health and social care sectors to enable this.³³

Future debates on integration may look at how to better systemically integrate health, social care and other areas, including housing. The

³⁰ Barker Commission, *A new settlement for health and social care: Interim report*, April 2014, p4

³¹ The Nuffield Trust, *The Nuffield Trust's response to the Barker Commission Report*, September 2014

³² The King's Fund, *Population Health Services: Going beyond integrated care*, February 2015, p22

³³ *A Memorandum of Understanding (MoU) to support joint action on improving health through the home*, December 2014

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inclusion of the Disabled Facilities Grant (which funds modifications for disabled people's homes) in the Better Care Fund is explored in section 2.2.

2. Integration of budgets

2.1 Funding for health and social care

Health and social care are funded differently, and funding is provided from different Government departments (DoH and DCLG respectively).

Department of Health funding is provided to NHS England and to 209 local CCGs to commission health services for their populations.

Adult social care is primarily funded through local authorities. Local authority funding consists of several funding streams including central Government grants, the business rate retention scheme and council tax. The majority of adult social care funding is not ring-fenced and it is for local authorities to decide how to prioritise their spending based on local priorities and need. Local authorities can also raise council tax by a set percentage per year to be ring-fenced for spending on adult social care (known as the social care precept).³⁴

Although both services have distinct funding streams, some policy developments have sought to allow greater integration of budgets. The main developments are set out below.

2.2 Better Care Fund

The Better Care Fund (BCF) is the Government's primary funding mechanism specifically for the integration of health and social care. It was announced in the [2013 Spending Round](#), with the aim of "delivering better, more joined-up services to older and disabled people, to keep them out of hospital and to avoid long hospital stays."³⁵

£200 million was made available to local authorities up front in 2014/5, with the fund fully introduced in 2015/16.

According to a 2015 speech by the Health Secretary Jeremy Hunt, the 2015/16 BCF plans aimed to achieve:

84,000 fewer hospital bed days; around 13,000 more older people remaining at home after discharge; and 3,000 more people being supported to live independently.³⁶

How the fund works

The BCF is a pooled budget which is intended to shift resources out of hospital into social care and community services, for the benefit of the NHS and local authorities. The power to create a pooled budget was introduced by the *Care Act 2014*, which amended the *National Health Service Act 2006*.

The Government allocated £3.8 billion to be pooled for 2015/16. Local areas can also choose to pool more than their allocated minimum from their budgets, and an additional £1.5 billion was pooled voluntarily in

³⁴ For more information see the Commons Library briefing paper, [Adult Social Care Funding \(England\)](#), CBP-7903

³⁵ HM Treasury, [Spending Round 2013](#), Cm 8639, June 2013, para 1.30

³⁶ Rt Hon Jeremy Hunt MP, [Personal responsibility](#), 1 July 2015

2015/16 by 72 local areas.³⁷ £3.9 billion was allocated for 2016/17 (with £5.8 billion in total including voluntary pooling).³⁸

For 2015/16, it was required that £1 billion of the £3.8 billion was set aside for 'payment by performance', requiring the fund to be spent on NHS care (community care or A&E) if admissions unexpectedly rose during the year. The 'payment by performance' requirement was removed for 2016/17, with local areas able to spend all of the fund according to local plans.

Health and Wellbeing Boards (HWBs) jointly agree plans for how the money will be spent, with plans signed off by the relevant local authority and CCGs. Plans must also be approved by NHS England.

Local plans must demonstrate how the area will meet set national conditions. For the period 2017-19, these include:

- Maintaining NHS contribution to adult social care in line with inflation;
- Investment in NHS commissioned out of hospital services;
- Managing transfers of care.³⁹

A number of conditions from 2016/17 have been removed (see *Better Care Fund to 2020* section below).

The majority of the funding comes from CCG allocations, although the BCF also includes other funding streams such as the Social Care Capital Grant (in 2015/16), funding previously earmarked for reablement and the provision of carers' breaks, and the Disabled Facilities Grant (DFG) for funding modifications to disabled people's homes.

Inclusion of DFG funding within the BCF is intended to bring housing into the integration process, for example in making homes accessible to allow patients to safely be discharged from hospital.⁴⁰ However, it also highlights the complexities of integrating budgets across different policy areas. Local housing authorities have statutory duties to allocate DFG funding, and in two-tier authorities, the housing authority is the lower-tier, as opposed to the upper-tier HWB. As a result, in these authorities, the DFG element of BCF funding must be allocated directly to the lower-tier authority.

Since April 2016, local areas have also been permitted to include primary medical services in their integration plan, following the introduction of new regulations. This change allows NHS England to participate in partnership arrangements with CCGs and local authorities with respect to their primary medical care functions, if this is agreed by all parties.⁴¹

³⁷ Rt Hon Jeremy Hunt MP, *Personal responsibility*, 1 July 2015

³⁸ DoH & DCLG, *2017-19 Integration and Better Care Fund Policy Framework, March 2017*, p11

³⁹ DoH & DCLG, *2017-19 Integration and Better Care Fund Policy Framework, March 2017*, Annex A

⁴⁰ [HC Deb 12 June 2014, c284-6W](#)

⁴¹ [The NHS Bodies and Local Authorities Partnership Arrangements \(Amendment\) Regulations 2015, SI 2015/1940](#)

Better Care Fund to 2020

The [2015 Spending Review and Autumn Statement](#) announced new funding for the BCF from 2017/18, sometimes referred to as the improved Better Care Fund (iBCF):

The government will continue the Better Care Fund, maintaining the NHS's mandated contribution in real terms over the Parliament. From 2017 the government will make funding available to local government, worth £1.5 billion in 2019-20, to be included in the Better Care Fund.

The Better Care Fund has set the foundation, but the government wants to further, faster to deliver joined up care. The Spending Review sets out an ambitious plan so that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020. Areas will be able to graduate from the existing Better Care Fund programme management once they can demonstrate that they have moved beyond its requirements, meeting the government's key criteria for devolution.⁴²

An additional £2 billion funding for local authority social care was announced in the [2017 Spring Budget](#), although it was later clarified that this would be directed through the Better Care Fund as additional iBCF funding.

The [2017-19 Integration and Better Care Fund Policy Framework](#) confirmed that the final minimum BCF allocations would be:⁴³

BCF funding contributions 2017-19 (£ bn)		
	2017/18	2018/19
Minimum NHS (CCG) contribution	3.582	3.650
DFG (capital funding for adaptations to houses)	0.431	0.468
New grant allocations for adult social care (iBCF)	1.115	1.499
Total	5.128	5.617

The 2019/20 iBCF allocation for adult social care will be £1.837 billion.

Although their importance is still emphasised in the policy framework document, a number of mandatory criteria for accessing BCF funding have been removed for 2017-19. These include better data sharing between health and social care, and agreement for the delivery of seven-day services.

The 2017-19 documents also sets out some basic information on the 'graduation' process from the BCF. For the most integrated areas, they will have an opportunity to 'graduate' from the existing programme management, to a model with less oversight and fewer reporting and

⁴² HM Treasury, [Spending Review and Autumn Statement 2015](#), Cm 9162, November 2015, para 1.111-1.112

⁴³ DoH & DCLG, [2017-19 Integration and Better Care Fund Policy Framework, March 2017](#), p15

planning requirements. The Department of Health plans to initially trial the graduation process in a first wave of six to ten areas.⁴⁴

Effectiveness

The NAO's 2017 report into [Health and social care integration](#) looked at the performance of the BCF in its first year, and found a mixed picture in terms of performance against its metrics:

- 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.
- 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.
- 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.⁴⁵

The report also found a significant majority of local areas agreed that the BCF had had a positive impact on integration of health and social care and had led to more joined-up health and social care provision.

However, in terms of savings, the NAO estimated that the higher than planned for number of delayed transfers of care and emergency admissions would have impacted on the £511 million of savings set out in the local BCF plans. Analysis was based on NAO estimates, as the NAO found no evidence that the DCLG or the Department of Health monitored or followed up on whether these planned savings were achieved.

In a 2017 report, the Public Accounts Committee criticised NHS England for a perceived lack of ownership of the BCF's performance, after its Chief Executive Simon Stevens appeared to indicate that the target to reduce emergency admissions by 3.5% target was not one that it had itself designed:

It is deeply unsatisfactory that the Departments and NHS England washed their hands of any accountability for the Better Care Fund. NHS England's Chief Executive seemed to reject any accountability for the performance of the Fund over its first year. He dissociated himself from the targets set for its first year, saying that it had not been designed by any of the witnesses at our

⁴⁴ DoH & DCLG, [2017-19 Integration and Better Care Fund Policy Framework, March 2017](#), chapter 4

⁴⁵ National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011 2016-17, para 2.6-2.8

evidence session. No other witnesses demurred from this assertion. The Committee is very disappointed by this response; as we reported in February 2015, the arrival of NHS England's new Chief Executive in April 2014 was the stimulus for the pause and redesign of the Fund. Accounting officers cannot disown the plans of their predecessors.

Recommendation: The Departments, NHS England and the Local Government Association must take responsibility for the performance of their programmes, including the Better Care Fund while it continues. We expect greater accountability and more realistic objectives, which the Departments and partners will stand by.⁴⁶

Comment

The Public Accounts Committee's 2015 report, [Planning for the Better Care Fund](#), was critical of the information given to local areas in the initial planning stages:

The initial planning for the Fund was deeply flawed. The Department of Health and the Department for Communities and Local Government (the Departments), and NHS England changed the rules in the middle of the planning phase, after failing to tell planners they needed to identify £1 billion in savings. As a result, all 151 health and wellbeing boards had to submit revised plans resulting in wasted time, effort and money. Local areas are now at greater risk of not being able to implement the policy.⁴⁷

It also highlighted concerns from organisations such as the LGA as to whether the BCF should have focused on savings at all, given the costs of delivering effective integration and the financial pressures on local authorities caused by the focus on reducing emergency hospital admissions.

A survey of NHS bodies and local authorities carried out by the Chartered Institute of Public Finance & Accountancy (CIPFA) also found a number of concerns with the implementation of the BCF. The main ones it found were:

- The level of bureaucracy: the BCF is seen as unwieldy, consumes a disproportionate management time, and comes with demanding metrics and oppressive reporting requirements
- The unrealistic expectations for the BCF, fuelling disputes between partners and 'giving integration a bad name' in the words of one respondent
- The pressure it added to already-stretched health finances, essentially because the BCF merely reuses existing funding while assuming it creates additional investment.⁴⁸

A joint statement on health and social care by the Nuffield Trust, the King's Fund and the Health Foundation stated that only 33% of the BCF

⁴⁶ Public Accounts Committee, [Integrating health and social care](#), 27 April 2017, HC 959 2016-17, conclusion 6

⁴⁷ Public Accounts Committee, [Planning for the Better Care Fund](#), 26 February 2015, HC 807 2014-15, p3

⁴⁸ CIPFA, [The better care fund – six months on](#), November 2015

was used for social care in 2015/16, which did not offer adequate protection for social care services in light of budgetary pressures.⁴⁹

In response to concerns about funding for social care and excessive bureaucracy, the Government removed the £1 billion 'payment for performance' requirement, and simplified reporting arrangements for 2016/17, with plans for further simplification in 2017-2019 (see the *Better Care Fund to 2020* section).⁵⁰

Despite these changes, a 2017 report by the Public Accounts Committee, [Integrating health and social care](#), argued that the BCF was:

...little more than a ruse to move money from the health sector to social care, disguised within an overly bureaucratic initiative that purported to integrate health and social care services.⁵¹

It argued that the overly bureaucratic nature had actually disrupted existing integration work in some areas. The report also criticised DoH and DCLG for not having carried out sufficient research into the most effective balance of funding across health and social care, as well as arguing that BCF had been "rendered largely redundant" by Sustainability and Transformation Plans (see section 3.4).⁵²

2.3 Integrated Personal Commissioning

As part of the delivery of the *Five Year Forward View*, in 2015 NHS England and the LGA launched the [Integrated Personal Commissioning](#) (IPC) programme.

IPC, which was launched across nine 'demonstrator' areas,⁵³ gives high-needs individuals personal budgets to commission integrated health and social care services themselves, as well as offering them planning support. Ten additional areas had joined the programme as of March 2017.

NHS England plans for IPC to become a model of care for around five percent of the population once it is fully rolled-out. By 2019, it is anticipated that it will be operational in half of the Sustainability and Transformation Plan footprint areas (see section 3.4).⁵⁴

National Voices, a coalition of health and social care charities in England, has argued that IPC could also drive innovation and efficiencies in commissioning, in a way that has not happened with CCG commissioning:

Separating commissioning from provision was in part justified by the notion that commissioners would act as a proxy for people

⁴⁹ The Nuffield Trust, the King's Fund & the Health Foundation, [The Autumn Statement: joint statement on health and social care](#), November 2016

⁵⁰ National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011 2016-17, para 2.11

⁵¹ Public Accounts Committee, [Integrating health and social care](#), 27 April 2017, HC 959 2016-17, conclusion 2

⁵² Public Accounts Committee, [Integrating health and social care](#), 27 April 2017, HC 959 2016-17, conclusions 1-3

⁵³ Stockton on Tees, Barnsley, Cheshire West & Chester, Lincolnshire, Luton, Tower Hamlets, Hampshire, Portsmouth and South West Consortium

⁵⁴ DoH & DCLG, [2017-19 Integration and Better Care Fund Policy Framework, March 2017](#), p13

who use services to redesign services. Although there are increasing numbers of small scale innovations in this respect, there is so far little evidence that commissioners can enact rapid change towards personalisation at any sort of scale. Commissioning remains dominated by the annual churn of the larger block contracts that use up most of the budgets.

Greater control for people who use services, supported by a process of care and support planning is therefore seen as more likely to drive change in the way services are designed so they become more tailored to individual needs. This in turn is likely to result in greater productivity and efficiencies across the system.⁵⁵

A full evaluation of IPC has been commissioned by NHS England and the DoH, and will report in 2019.⁵⁶

⁵⁵ National Voices, [*Personal Budgets as an integral form of NHS care: A discussion paper*](#), December 2015

⁵⁶ [PQ 58418, 11 January 2017](#)

3. Organisational integration

Government policy is for the specifics of integration to be locally-driven, and as a result the design and scope of integrated organisational structures will vary by local area. However, the Government and NHS England have also driven some structural integration from above, the main examples of which are explored below.

An integration governance diagram for England, produced by the National Audit Office in their 2017 report on [Health and social care integration](#), is reproduced in Annex 1.

3.1 Health and Wellbeing Boards

Upper-tier local authorities were required to create Health and Wellbeing Boards (HWBs) under the *Health and Social Care Act 2012*. HWBs are local forums consisting of representatives from health and social care organisations.

The legislation gave HWBs a duty to encourage integrated working, and boards were expected to have strategic influence over commissioning and to produce a Joint Strategic Needs Assessment – an assessment looking at the current and future health and care needs of the local population.⁵⁷

As a minimum, membership of the HWB must include:

- A local authority councillor (which could be the elected mayor in authorities with this system)
- The Director of Adult Social Services
- The Director of Children’s Services
- The Director of Public Health
- A representative of the Local Healthwatch organisation
- A representative of each relevant CCG

In their evidence to a 2014 Health Select Committee inquiry, the King’s Fund argued that many HWBs were limited in their ambition towards integration:

Progress in implementing integrated care locally remains variable. Anecdotal evidence indicates increasing interest, with some parts of the country making good progress in developing and delivering ambitious plans. However, the finding from our survey that most HWBs have not identified it as a priority highlights the need for them to take a much stronger lead in driving it forward locally.⁵⁸

The Committee itself recommended that HWBs needed a larger commissioning role for health and social care. This role has grown with the development of the Better Care Fund, as HWBs have final sign off for a local area’s BCF plans.

⁵⁷ DoH, [A short guide to health and wellbeing boards](#), February 2012

⁵⁸ Health Committee, [Public Expenditure on Health and Social Care](#), 12 February 2014, HC 793 2013-14, para 42

3.2 New Care Models

A central policy of NHS England's 2014 planning document, the [Five Year Forward View](#) (5YFV), was the development of new care models which it was intended would "increasingly dissolve these traditional boundaries," between GPs, hospitals, social care and mental health.⁵⁹

Seven new care models were set out in the 5YFV. Although some relate solely to the integration between different parts of the NHS, a number also relate to the integration of social care. The seven models are:

- Multispeciality community providers
- Enhanced health in care homes
- Primary and acute care systems
- Urgency and emergency care networks
- Acute care collaborations
- Specialised care
- Modern maternity services

Under the Government's mandate to NHS England for 2017/18, there is a goal for new care models to cover at least 50% of the population by 2020, as part of attempts to reduce emergency admission rates.⁶⁰

NHS England has estimated that this rollout of new care models will save £900 million by 2020.⁶¹

Vanguards

In 2015, 50 'vanguard' sites were chosen to develop these new care models (vanguards are only for five of the seven new models, maternity and specialised care were not included). Sites are located around a geographic area, and often consist of partnerships between NHS bodies and local authorities.

It is intended that vanguards will share lessons and best practice across the health system, as part of the broader rollout of the new models of care.⁶²

In September 2016, NHS England published a [summary document](#) of the plans of all 50 vanguards, with a number of vanguard sites setting out plans for integration of social care services or staff into NHS services. This was particularly the case for the multispeciality community providers (MCP), enhanced health in care homes and primary and acute care systems (PACS) models.⁶³

The King's Fund's 2016 analysis of MCP and PACS vanguards found that all were "building closer partnerships between primary, community, mental health and social care services as a basis for

⁵⁹ NHS England, [Five Year Forward View](#), October 2014

⁶⁰ DoH, [The Government's mandate to NHS England for 2017-18](#), March 2017

⁶¹ National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011 2016-17, para 2.16

⁶² [PO 39885, 14 June 2016](#)

⁶³ NHS England, [New Care Models: Vanguards – developing a blueprint for the future of NHS and care services](#), September 2016

changing how staff and resources are used.” It gave the example of changes implemented by the West Wakefield MCP:

During the first 18 months, the vanguard created ‘connecting care hubs’, bringing together groups of GP practices with a team of community nurses, social care staff, therapists and voluntary organisations. These hubs deliver joined-up services for people most at risk of becoming ill, such as those with long-term conditions, complex health needs, or people who have been in hospital for an operation or emergency.⁶⁴

£102 million was allocated to the sites for 2016/17, and £101 million for 2017/18.⁶⁵ Although funding to the vanguard sites will stop after 2017/18, development of new care models will continue, largely through Sustainability and Transformation Plans (STPs) (see section 3.4), with a target that 50% of the population of England will be covered by a new care model by 2020.

In order to increase accountability, 2017/18 funding may also be passed from vanguards to STP areas, where vanguard areas are not meeting their agreed reduction of emergency admissions. NHS England’s [Next Steps on the NHS Five Year Forward View](#) states that MCP, PACS and urgent and emergency care vanguard funding can be made available to STPs in these circumstances.⁶⁶

The NAO’s 2017 report into health and social care integration notes that some vanguards are showing some early positive results. However, without evaluation, it is not yet clear whether the results can be delivered sustainably or be replicated on a larger scale and in other areas.⁶⁷

3.3 Integrated Care Pioneers

The Integrated Care Pioneers (ICP) programme was launched in 2014, providing support for 14 local areas looking to more effectively deliver integrated health and social care. Another 11 local areas joined the programme in 2015.

As with the vanguard sites, implementation of ICP varies by local area. Islington for example looked at the provision a named professional to take responsibility for the co-ordination of each patient’s care plan.⁶⁸ NHS England’s assessment of the first year of the ICP programme showed some positive results:

In just the first year, the pioneers are showing how integrated care, albeit not yet at significant scale, can improve their communities’ health and experience of care. These improvements have often focused on reducing the number of times people require hospitalisation, which eases pressure on the system. An evaluation by Cornwall of one of its pilot sites, in Penwith, for

⁶⁴ The King’s Fund, [New care models: Emerging innovations in governance and organisational form](#), October 2016, p12

⁶⁵ NHS England, [Approved New Care Models Programme vanguard funding allocation](#), December 2016

⁶⁶ NHS England, [Next Steps on the NHS Five Year Forward View](#), March 2017, p46

⁶⁷ National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011 2016-17, para 2.19

⁶⁸ [HC Deb 24 March 2016, c691WH](#)

example, has shown the number of people being admitted to hospital falling by nearly 50% – this builds on a 40% fall achieved in Newquay. In addition, the evaluation showed that quality of life indicators increased by 18%, and with a return on investment estimated at 4:1.

Kent has found similar success through its Proactive Care service, with the first group of 134 patients experiencing a 55% reduction in non-elective admissions alongside improved patient experience. Savings so far are estimated to exceed £200,000. Greenwich, meanwhile, found its integrated health and care teams brought a 35% reduction in admissions to care homes in their first year.⁶⁹

However, early analysis of the programme by the Policy Innovation Research Unit heard that many local areas had found it difficult to access external support:

One of the ostensible advantages of becoming a Pioneer was not only sharing learning with other sites, but also obtaining access to key decision-makers, and receiving advice and support from national and international experts. Access to external advice and support has continued to be perceived as patchy (at best) by many sites.

A number of barriers to greater integration are being gradually resolved at local level, but a number require changes led from the centre that Pioneers cannot initiate, in particular, in relation to workforce and information governance. Some participants in the Pioneers were critical of the extent to which national partners had thus far helped them address the obstacles that related to national policies and systems, such as, for example, data sharing, payment systems, procurement, provider viability and the foundation trust 'pipeline'.⁷⁰

3.4 Sustainability and Transformation Plans

In December 2015, NHS England published planning guidance which asked NHS organisations and their partners to create area-based plans for the five year period from October 2016 to March 2021. These blueprints, called Sustainability and Transformation Plans (STPs), are intended to accelerate the implementation of the 5YFV.

STPs are expected to show how local services will improve quality of care, promote population health, and become more financially sustainable. There are 44 STP 'footprint' areas across England, which consist of NHS providers, CCGs, local authorities and other health and care services.

The partnership of NHS bodies and local authorities could have a significant impact on health and social care integration, as set out by the then Health Minister David Mowat, during a 2016 debate on STPs:

Perhaps the most important of all the advantages is that the unacceptable gap that currently exists between healthcare and social care will be breached. That is at the centre of the whole process.⁷¹

⁶⁹ NHS England, *Integrated Care Pioneers: One Year On*, February 2015, para 4.1

⁷⁰ Policy Innovation Research Unit, *Early evaluation of the Integrated Care and Support Pioneers Programme: Interim Report*, November 2015, para 13.2-13.3

⁷¹ [HC Deb 14 September 2016, cc997-8](#)

NHS England's [Next Steps on the NHS Five Year Forward View](#) set out plans for the most integrated STPs to develop into Accountable Care Systems. These will see NHS bodies and local authorities taking collective responsibility for commissioning resources and for the health and social care of their STP area.⁷²

The LGA has stated its support for the STP process, hailing the plans as “significant milestones” in the integration of health and social care. However, it raised concerns about local authorities’ involvement in the process, and about how STPs would interact with HWBs’ own plans for integration (which cover a smaller geographic area than that of most STPs).⁷³

Similar concerns were highlighted in the Public Accounts Committee’s 2017 report, *Integrating health and social care*, which argued that the Better Care Fund had been “rendered largely redundant as a means of building integration by the sustainability and transformation planning process.” It also echoed LGA concerns about local authority involvement:

Sustainability and transformation planning is neither inclusive nor transparent enough. We heard from the Local Government Association that in some areas NHS England has not been engaging sufficiently with local government. We heard from NHS England that, conversely, in some areas local government has declined to get fully involved. Engagement can be complicated because the 44 sustainability and transformation planning areas do not all align with local authority boundaries. Nevertheless, without meaningful engagement with local authorities, integration is an impossibility.⁷⁴

In addition, the Committee stated it was unconvinced that STPs were any more likely to build integrated services than the Better Care Fund; particularly as 68% of the Sustainability and Transformation Fund for 2016-19 was allocated to offset hospital deficits, rather than on service transformation. This reflects concerns raised previously by the NAO in their health and social care integration report:

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.⁷⁵

The BCF 2017-19 policy framework encourages local areas to align their approach to health and social care integration with STP geographies, where appropriate.⁷⁶

More information on STPs can be found in the Commons Library briefing paper, [The financial sustainability of the NHS in England](#).

⁷² NHS England, [Next Steps on the NHS Five Year Forward View](#), March 2017, pp35-7

⁷³ [Letter from Cllr Izzi Seccombe \(Chair of LGA Community Wellbeing Portfolio\) to Jeremy Hunt](#), 10 March 2016

⁷⁴ Public Accounts Committee, [Integrating health and social care](#), 27 April 2017, HC 959 2016-17, conclusions 4-5

⁷⁵ National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011 2016-17, para 21

⁷⁶ DoH & DCLG, [2017-19 Integration and Better Care Fund Policy Framework, March 2017](#), p26

4. Devolution of health and social care integration (England)

The Government's devolution of powers from central Government to local authorities in England was at first primarily focused on economic growth. However, since the devolution of health and social care to Greater Manchester through the February 2015 [Memorandum of Understanding](#), integration of services has begun to increasingly feature in the devolution debate.

As locally-driven integration further develops through the Better Care Fund and through STPs, many local areas are looking to devolution agreements to strengthen their powers in this area.

Whilst devolution can substantially transform local health and social care governance arrangements, the powers that can be devolved are limited by legislation. Section 18 of the [Cities and Local Government Devolution Act 2016](#) states that devolution agreements cannot include any of the Secretary of State for Health's core duties.

In addition, a 2015 NHS England board paper made clear that devolved areas are not exempted from any national NHS requirements:

An overarching principle that all areas will remain part of the NHS, upholding national standards and continuing to meet statutory requirements and duties, including the NHS Constitution and Mandate.⁷⁷

More information on health and social care devolution can be found in the Commons Library briefing paper, [Devolution to local government in England](#).

4.1 Greater Manchester

Greater Manchester was the first local area to receive a devolution deal from the Government, which was announced in November 2014, and its deal in terms of health and social care integration remains the most substantive.

As of 1 April 2016, health and social care commissioning budgets from all Greater Manchester CCGs and local authorities are pooled across the combined authority area, and commissioning decisions are made by a Joint Commissioning Board (JCB). The JCB consists of the 12 CCGs, 10 local authorities and NHS England.

The Greater Manchester mayor has no formal role in health and social care devolution. However, the previous (interim) mayor, Tony Lloyd, attended every meeting of the Greater Manchester Health and Social Care Partnership Board.

According to the Memorandum of Understanding published in February 2015, the scope of the JCB across the health and care system will cover:

⁷⁷ NHS England, [Board Paper: Devolution – Proposed Principles and Decision Criteria](#), September 2015, para 3.3

- Acute care (including specialised services);
- Primary care (including management of GP contracts);
- Community services;
- Mental health services;
- Social care;
- Public Health;
- Health Education;
- Research and Development.⁷⁸

The estimated size of the health and social care budget for 2016/17 is £6.2 billion.

Commissioning of services that are the responsibility of NHS England, such as specialised services and some public health services, will still be carried out by NHS England. However, Greater Manchester will take decisions about service changes, finances, quality and performance.⁷⁹

At local (borough) level, Health and Wellbeing Boards will ensure that health and social care services are provided in a joined-up fashion.

It is important to note that the Greater Manchester combined authority is covered by a single STP footprint area, simplifying the integration of the two processes (devolution and STPs).

The Chief Executive of NHS England, Simon Stevens, said in December 2015 that 'not many' other areas were likely to take on similar health responsibilities in the near future.⁸⁰

4.2 London

In December 2015, the Mayor of London, along with 32 London CCGs, 33 London local authorities, Public Health England and NHS England signed the [London Health and Care Collaboration Agreement](#).

The agreement covers a larger area than the Greater Manchester devolution agreement, and therefore operates across a number of spatial levels:

- At a local (borough) level, HWBs will carry out local integration planning, with an aspiration to achieve full pooling and joint commissioning of health and social care services.
- At a sub-regional level, strategies to develop new models of care will be produced (these models are discussed further in section 3.2).
- At a pan-London level, the London Health Board, chaired by the Mayor of London, will provide oversight and support. A Devolution Programme Board will provide steering of the

⁷⁸ Greater Manchester Combined Authority, [Greater Manchester Health and Social Care Devolution: Memorandum of Understanding](#), February 2015

⁷⁹ Greater Manchester Health and Social Care Partnership, [GM Devo: Internal delegation by NHS England to GM Chief Officer](#), March 2016

⁸⁰ 'Exclusive: Stevens casts doubt over NHS devolution outside Manchester', [Health Service Journal](#), 14 December 2015

devolution programme and support for five devolution pilot programmes.

Three of the five pilot programmes are looking at care integration (Outer North East London at a sub-regional level, Hackney and Lewisham at a local level).

The timetable for action sees the pilots commencing devolved arrangements by April 2017, with wider progress on transformation by April 2019.⁸¹

The London agreement covers five STP footprint areas. It is notable that unlike Greater Manchester, the agreement does not state that its ultimate integration aim is joint health and social care commissioning across the whole city.

4.3 Cornwall

Under the Cornwall devolution agreement published in July 2015, Cornwall and the Isles of Scilly local authorities, along with local NHS bodies, will produce a business plan to move towards integration of health and social care.

Once this plan is put into effect, central Government and NHS England will consider whether its effective implementation requires the devolution of any additional powers.⁸²

According to Cornwall Council, the final plan will likely cover other areas in addition to health and social care:

Work is currently underway on developing a place based strategic plan for the whole health and social care system which is both clinically and financially sustainable. The plan, which is being co-produced by the two Councils and health partners, will also consider public health services and the impact of housing, education and employment on the overall health and wellbeing of people in Cornwall and the Isles of Scilly.⁸³

The Cornwall devolution agreement covers the same geographical area as the Cornwall and Isles of Scilly STP.

4.4 Other devolution agreements

The Liverpool City Region combined authority's [further devolution agreement](#) from March 2016 set out the following proposals on health and social care:

In order to engage fully in this process (*greater health and social care integration*) the clinical commissioning groups across the Liverpool City Region have formed a Committee in Common.

The city region, with the full engagement of health partners, will shortly publish an interim report on the case for change across a number of priority health conditions and will now develop a strategy for tackling the issues raised in the report. This will be complemented by the sustainability and transformation planning

⁸¹ London Partners, [London Health and Care Collaboration Agreement](#), December 2015

⁸² HM Government, [Cornwall Devolution Deal](#), July 2015, para 37-38

⁸³ Cornwall Council, [Accelerated health and social care integration](#), January 2017

process, whereby organisations across the locality are working in partnership with others to improve delivery and outcomes.⁸⁴

The Liverpool City Region combined authority area only partially covers the Cheshire and Merseyside STP area.

Cambridgeshire and Peterborough's devolution proposal commits to further integration of health and social care, but does not set out any mechanisms for this outside of the existing Cambridgeshire and Peterborough STP.⁸⁵

The North East devolution agreement committed to the establishment of a Commission for Health and Social Care Integration, although the deal itself was taken "off the table" in September 2016.⁸⁶ Other rejected deals, in Norfolk & Suffolk and in Greater Lincolnshire, also included commitments to further integrate health and social care.

⁸⁴ HM Government, [*Further Devolution to the Liverpool City Region Combined Authority and to the Directly Elected Mayor of the Liverpool City Region Combined Authority*](#), March 2016, para 4-5

⁸⁵ Cambridgeshire and Peterborough, [*Cambridgeshire and Peterborough East Anglia Devolution Proposal*](#), June 2016

⁸⁶ ['Sajid Javid ends North East devolution deal'](#), *BBC News*, 8 September 2016

5. Scotland

The integration of health and social care has been a long-term policy objective of successive Scottish Governments. As the King's Fund argued in 2013:

Achieving the twin aims of integration within health care and between health and social care has long been an objective of government in Scotland. Its importance has grown significantly since 1997 and has been a major feature of all the strategic documents that have been published on the structure and functioning of the NHS, underpinning both the creation of unified NHS boards integrating planning and delivery of services, and the development of collaborative and partnership working.⁸⁷

In contrast to the NHS in England, since 2004 Scottish health commissioning and provision has been integrated under the management of NHS Boards. The *NHS Reform (Scotland) Act 2004* also required NHS Boards to set up community health partnerships as a means of achieving greater integration within the NHS and between health and social care.⁸⁸

2014 reforms

The Scottish Government introduced significant legislative changes to bring about further integration of health and social care, through the *Public Bodies (Joint Working) (Scotland) Act 2014*.

Under the 2014 Act, local authorities and NHS Boards are required to delegate a wide range of functions to an integration authority. These can either be delegated to a new body corporate, known as an 'integration joint board' (IJB), or a local authority can delegate its powers to a health board to administer the integrated working (or vice versa). The overall aim of the integration model is to create a single system for the joint commissioning of health and social care services.

As of 1 April 2016, the integration authorities took responsibility for around £8 billion of health and social care funding. The Local Government Information Unit (LGIU) called this the most significant change to the structure of the Scottish public sector "since the establishment of the Scottish Parliament in 1999."⁸⁹

Of the 33 local authorities, 32 are adopting an IJB model (with Clackmannanshire and Stirling creating a joint IJB). Highland is adopting a 'lead agency' model, with NHS Highland leading on all adult health and social care services, and Highland Council leading on all children's health and social care services. Under the 2014 Act, areas are not required to integrate children's services, but can choose to do so where there is local agreement.

⁸⁷ The King's Fund, [Integrated care in Northern Ireland, Scotland and Wales: Lessons for England](#), July 2013, p31

⁸⁸ Scottish Parliament Information Centre, [The National Health Service in Scotland: Subject Profile](#), June 2011

⁸⁹ LGiU, [An overview of health and social care integration in Scotland](#), May 2016

Unlike England where the design of integration is largely driven by local areas themselves, integration in Scotland is led by principles defined in legislation. The 2014 Act sets out the principles for integration planning:

That the main purpose of services which are provided in pursuance of integration functions is to improve the wellbeing of service-users,

That, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible—

- is integrated from the point of view of service-users,
- takes account of the particular needs of different service-users,
- takes account of the particular needs of service-users in different parts of the area in which the service is being provided,
- takes account of the particular characteristics and circumstances of different service-users,
- respects the rights of service-users,
- takes account of the dignity of service-users,
- takes account of the participation by service-users in the community in which service-users live,
- protects and improves the safety of service-users,
- improves the quality of the service,
- is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care),
- best anticipates needs and prevents them arising, and
- makes the best use of the available facilities, people and other resources⁹⁰

Principles for outcomes are (known as '[national health and wellbeing outcomes](#)') are also set out in regulations.

The Scottish Government has allocated £500 million for 2015/16 and 2016/17 to help establish the new integration models. The funding is divided as follows:

- £300 million is an integrated care fund to help partnerships achieve the national health and wellbeing outcomes and move towards preventative services
- £100 million to reduce delayed discharges
- £30 million for telehealth
- £60 million to support improvements in primary care
- £51.5 million for a social care fund.⁹¹

Further information can be found in the Scottish Parliament Information Centre briefing, [Integration of Health and Social Care](#).

⁹⁰ Section 4, [Public Bodies \(Joint Working\) \(Scotland\) Act 2014](#)

⁹¹ Audit Scotland, [Health and social care integration](#), December 2015, para 34

6. Wales

Over the past decade, the Welsh Government has published a number of strategy documents and frameworks advocating greater integration of health and social care, such as 2012's [Together for Health](#) which stated:

The NHS must work well with its local partners, including the public, to design services around people, not organisations. It must work closely with the whole public sector to secure the best possible services and best use of available resources.⁹²

Likewise, in 2013 [Delivering Local Healthcare](#) called for greater integration between health and social care and in 2016 [Taking Wales Forward](#), the Welsh Government's programme for the next 5 years, set out that:

The NHS needs to reflect the need of our modern society, with closer links between health and social services, strengthened community provision and better organisation of general hospital and community services.⁹³

Prior to 2009, the 22 Welsh local authorities and 22 Welsh health boards were organised around the same geography. However, the 2009 reforms that removed the provider-purchaser-split in the NHS created new, larger Local Health Boards (LHBs), now spread across multiple local authorities. Although local authorities and the new LHBs could coordinate joint working at local authority level through Local Service Boards (LSBs), these had no statutory basis.

Since 2014, a number of policy and legislative changes in Wales have advanced the integration agenda further.

In April 2014, the Intermediate Care Fund (ICF) was launched. The 2016/17 ICF is intended for the integration of a range of services including for autism, people with learning difficulties and for older people, with a particular focus on avoiding unnecessary hospital admission and preventing delayed discharges. £50 million has been allocated for revenue spending, with a further £10 million for capital spending (for "accommodation-based solutions").⁹⁴

In terms of legislative changes, two recent pieces of legislation have impacted upon health and social care integration in Wales:

- ***Social Services and Well-being (Wales) Act 2014***

The Act introduced a legal duty on local authorities to promote integration of health and social care when carrying out their social services functions.

It also required the establishment of partnership boards (organised along LHB geographies) between LHBs and local authorities. Boards are required to share information and to established

⁹² Welsh Government, [Together for Health: a Five Year Vision for the NHS in Wales](#) February 2012, p7

⁹³ Welsh Government, [Taking Wales Forward 2016-21](#), November 2016, p7

⁹⁴ Welsh Government, [Intermediate Care Fund Guidance 2016-17](#), April 2016

pooled budgets for their care home and family support functions, and any other functions they wish the pooled funds to cover.

Regulations under the Act give local authorities the ability to delegate a number of their social care functions to LHBs, and vice versa.⁹⁵

- ***Well-being of Future Generations (Wales) Act 2015***

The Act required all local authority areas to create a Public Service Board (PSB), including representatives from local authorities and LHBs. This replaced the previous, non-statutory LSB model.

Under the Act, PSBs are required to produce a local well-being plan. The Welsh NHS Confederation has highlighted the potential of PSBs to allow for greater collaborative commissioning and planning between public services, including health and social care.⁹⁶

⁹⁵ [The Partnership Arrangements \(Wales\) Regulations 2015, SI 2015/1989](#)

⁹⁶ The Welsh NHS Confederation, [The 2016 Challenge: A vision for NHS Wales](#), October 2015, p9

7. Northern Ireland

Northern Ireland (NI) has had an integrated health and social care system since 1973, with both services provided by the same body.

Since the passing of the *Health and Social Care (Reform) Act (Northern Ireland) 2009*, one regional Health and Social Care Board (working in conjunction with the Public Health Agency in NI) commissions services from five regional Health and Social Care Trusts (Western, Northern, Southern, South Eastern and Belfast).

The 2009 Act also established five local commissioning groups (LCGs), which function as committees of the Board. Each LCG is co-terminus with its respective Trust area and is responsible for assessing needs and commissioning health and social care for its local population.

Although the system is integrated, there remain funding differences between health and social care. As in England, health services are free at the point of use whilst social care services are means-tested.

Integration in the delivery of services in NI is mainly achieved through the division of care into nine 'programmes of care' to which resource procurement and finance are assigned.⁹⁷ A 2013 report by the King's Fund found that within these, trusts tended to prioritise spending on health programmes over social care programmes.⁹⁸

The King's Fund report did however argue that the Integrated Northern Irish system provided real benefits in managing delayed discharges from hospital, although a 2016 NI Audit Office report found that delayed discharges were still a significant problem:

While we found positive examples of integration between health and social care services in their approach to emergency care, significant obstacles still impede a truly joined-up approach to avoiding unnecessary hospital admissions and facilitating timely discharges. We found that many patients who are ready to be discharged remain in hospital because of difficulties at the interface between health and social care organisations.⁹⁹

In 2011, the Government-commissioned [Transforming Your Care](#) report highlighted an overreliance on inpatient hospital care for patients over treatment closer to home or in the community, and that this model was unsustainable in the long term.¹⁰⁰

To counter this, the report proposed the creation of 17 Integrated Care Partnerships (ICPs). ICPs are networks of care providers, consisting of healthcare professionals, local authority representatives, voluntary sector representatives, and service users and carers. The intention, as set out in

⁹⁷ Acute services; maternity and child health; family and child care; elderly care; mental health; learning disability; physical and sensory disability; health promotion and disease prevention; and primary health and adult community

⁹⁸ The King's Fund, [Integrated care in Northern Ireland, Scotland and Wales: Lessons for England](#), July 2013, p16-17

⁹⁹ Northern Ireland Audit Office, [Managing Emergency Hospital Admissions](#), November 2016, para 4.19

¹⁰⁰ Department of Health, [Transforming Your Care: A Review of Health and Social Care in Northern Ireland](#), December 2011, p27

Transforming Your Care, was that ICPs would develop and coordinate local health and social care services to be delivered as close to home as possible.

In April 2014 the focus of reform moved to ‘governance’, when the then Health Minister, Edwin Poots MLA, commissioned the former Chief Medical Officer of England, Professor Sir Liam Donaldson, to advise on health and social care governance arrangements. His report [*The Right Time, The Right Place*](#) was published in December 2014.

Based on one of the Donaldson recommendations, in early 2016, the then Health Minister, Simon Hamilton MLA, appointed an expert, clinically-led panel, chaired by Raphael Bengoa, to lead debate on the best configuration of health care services for NI.

Following the expert panel report on health and social care reform, [*Systems, Not Structures*](#), the Department of Health published its 10 year strategy in October 2016, [*Health and Wellbeing 2026*](#). This reiterated the commitment to increasing home and community treatment, and to more preventative work.

The strategy envisaged a future model of primary care based on integrated multidisciplinary teams embedded around general practice. According to the strategy, these teams would:

Work together to keep people well by supporting self-management and independence, providing proactive management of high risk patients. They will identify and respond earlier to problems that emerge whether related to health or social circumstances or the conditions in which people live, providing high quality support treatment and care throughout life.

These teams will include GPs, Pharmacists, District Nurses, Health Visitors, Allied Health Professionals and Social Workers, and new roles as they develop, such as Advanced Nurse Practitioners and Physician Associates.¹⁰¹

Also included in the strategy was an ambition to make Acute Care at Home (ACH) available to the whole population within three years. ACH, developed by East Belfast ICP, is an example of a more community-based integrated service, which allows patients to receive specialist tests and consultant led treatment at home, along with social care services.¹⁰²

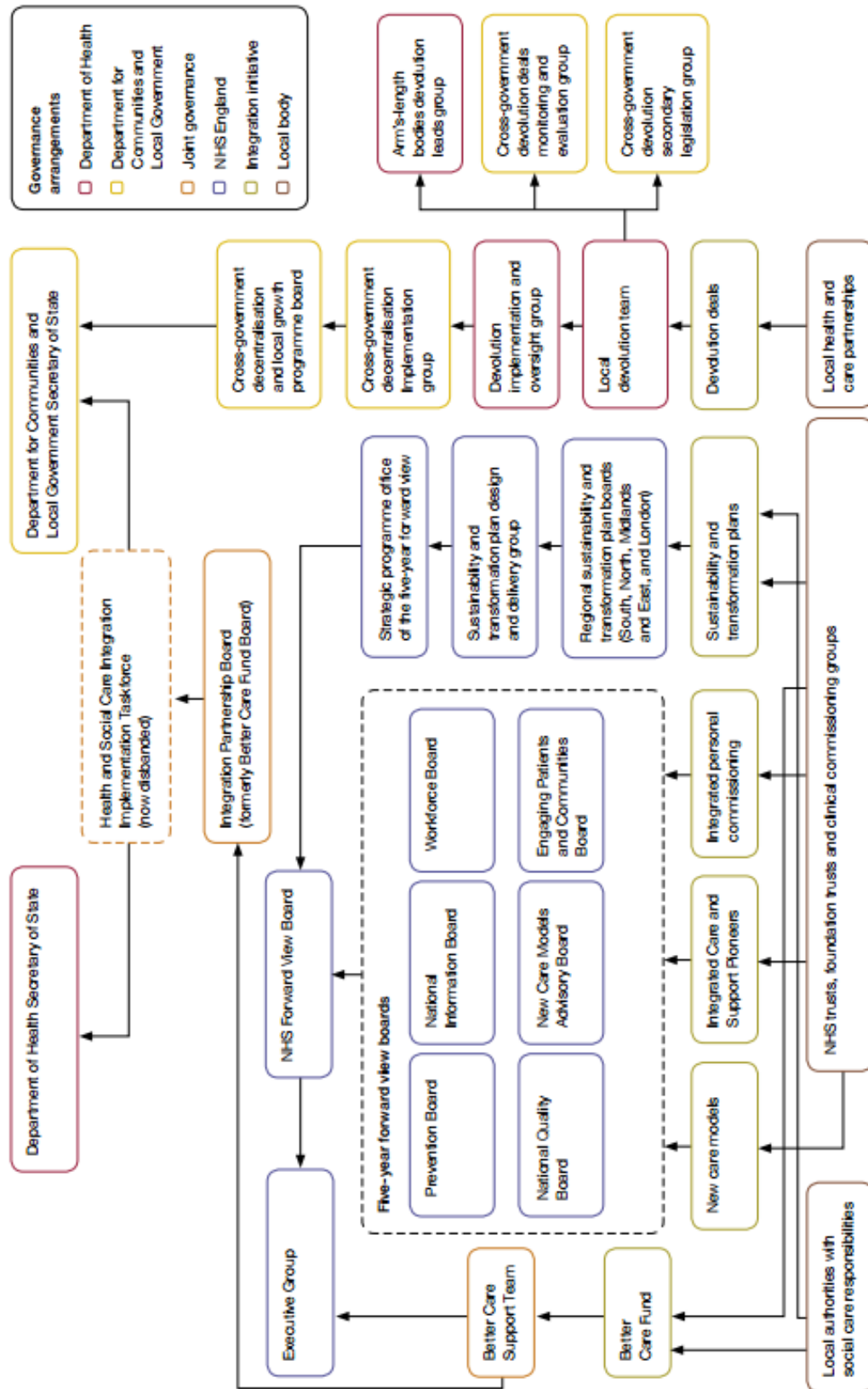
More information on health and social care policy can be found in the Northern Ireland Assembly Research and Information Service briefing, [*Transforming Health and Social Care in Northern Ireland – Services and Governance*](#).

¹⁰¹ *Ibid.*, p14

¹⁰² Department of Health, [*Health and Wellbeing 2026: Delivering Together*](#), October 2016, p15-16

Annex 1: Integration governance

The NAO's 2017 report on [Health and social care integration](#) provides the following diagram on the governance of integration in England:



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