The King's Fund

Ideas that change health and care

Making care closer to home a reality

Refocusing the system to primary and community care

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Nothing is impossible. If we wanted to make it work, you're not telling me that the combined expertise, drive, passion and enthusiasm and experience of folks in the public sector in the UK couldn't solve this problem. Of course they could.

Provider leader

Contents

Key messages

- Despite successive governments repeating a vision of health and care services focused on communities rather than hospitals, that vision is very far from being achieved.
- The failure to grow and invest in primary and community health and care services ranks as one of the most significant and long-running failures of policy and implementation in the NHS and social care for more than 30 years.
- Evidence shows that financial and workforce growth is not aligned to the vision, with larger growth in acute hospital sectors than in primary and community sectors.
- There are a range of reasons why the vision has not been implemented consistently to date:
    - a lack of agreement about the purpose underpinning the vision, and in particular the financial impact it will have in the short term
    - a 'cycle of invisibility' for primary and community health and care services, where they are hard to quantify and easy to overlook
    - hierarchies of care, with urgent problems taking priority over longer-term issues
    - misconceptions that the public prioritise hospital services over and above primary and community health and care services
    - a financial architecture for health and care that does not support a focus on primary and community health and care
    - short-term approaches to return on investment
    - a health and care system that is not set up to deal with the complexity of people's needs
    - policies and strategies that are not aligned to the vision.
- Just as the system is complex, so are the solutions. Although in this report we identify some specific actions that are required – for example, changes to training or to financial and incentive systems – it is not sufficient to selectively implement a few changes; the shift that is required is wholesale, which helps to explain why it has not been achieved thus far.

- This report is not about the closure of hospitals or just about moving existing services from one location to another, although it may sometimes be appropriate to move services. Rather, it is about changing the focus of the health and care system towards primary and community health and care across the domains of leadership, culture and implementation, so that each sector is freed up to provide the care that it is best equipped to deliver.
- There needs to be more alignment between policy and vision so that funding, regulation, workforce and performance policies match the intention of changing the focus of the health and care system towards primary and community health and care services.
- National leaders need to prioritise primary and community health and care services, including having more national and system leaders with experience in these sectors.
- It is not viable to consider reducing funding for acute hospital services; rather, future growth in funding and staffing needs to be directed proportionately more to primary and community health and care services rather than to acute hospitals.
- National bodies should give integrated care boards (ICBs) more trust and devolved decision-making, with ICBs in turn focusing on greater engagement with staff and wider sector partners, and providers focusing on greater engagement with people and communities.
- There should be a greater focus on operational integration at service level rather than organisational integration, and a greater focus on local-level development and priorities.

Specific enablers

Addressing the failure to achieve the long-held vison will require a wholesale shift of focus from political and other national leaders towards primary and community health and care services, maintaining that focus and aligning subsequent policy and strategy. Individual policies, levers or initiatives will not miraculously unlock change. In our work we identified some actions and areas for policy development that will be important to explore further and have highlighted these in our report. They include the following.

Workforce

- NHS England should ensure that leaders are encouraged to work in community settings and develop experience across a range of sectors.
- Professional bodies and professional regulators need to review training and continuing professional development so that practitioners have the skills needed to work in multidisciplinary teams.
- Training providers need to explore how to increase meaningful experience of primary and community care, for example through compulsory placements for both clinical and managerial staff.
- NHS England, training providers and professional regulators need to work towards creating clear career paths that can provide high-status roles in primary and community settings and that reflect the skills needed for working in primary and community settings.

Planning, contracting and delivery

- ICBs and providers of health and care services should put much greater focus on active, meaningful engagement with people and communities, and also with staff and wider sector partners.
- Government should explore how it can enable integrated care systems (ICSs), and local authorities in particular, to plan for more than a single financial year in order to support a greater shift to preventive care and interventions with longer-term impact.
- NHS England and the Department of Health and Social Care should consider changes to the current national contract approaches for primary care, creating more flexibility for local commissioners to drive change based on local need.
- Rather than focusing performance management on the hospital and emergency care system, NHS England should focus on holding ICBs to account for their achievements in growing primary and community health and care services.
- To better understand the progress of delivery of integrated and community-based care, ICSs should develop patient experience data and data about whole pathways of care rather than data for individual organisations.

Capital and estates

- The Department of Health and Social Care and NHS England need to prioritise capital and revenue investment in technology and estates for primary and community health and care services.
- ICSs need to ensure that the estate available to primary and community services is planned and developed to facilitate teamworking at neighbourhood and place levels.
- Local public services should be able to use their facilities and estates to support joined-up, integrated working locally between partners, and government departments should review relevant contracts and rules to better allow and support this.

There will be many other changes needed and areas to explore further, but our work is clear that a total change in focus is needed to finally realise the vision.

1 What's the problem?

Since at least 1974, and arguably earlier (*see* annex 2), successive governments have aimed to make the health and care system less hospital-focused and more focused on primary and community care. This goal has been shared by health and care systems across the world. The World Health Organization has argued that this approach is the most inclusive, effective and efficient way to enhance people's physical and mental health and wellbeing. It will help to provide integrated services that meet people's health needs throughout their life, address the broader determinants of health, and empower individuals, families and communities to take charge of their own health (**World Health Organization 2019**). This is not – or certainly should not be – an anti-hospital agenda. It is about improving both the experience and the quality of care that people receive, while boosting prevention or, at the very least, reducing the speed of onset of disease. It is also about meeting people's needs and making sure each part of the health and care system is freed up to provide the care it is best placed to offer. The aim – in more recent jargon – has been to 'bend the curve' on predicted trends (**NHS England *et al* 2014**), which imply an ever-greater reliance on high-cost, reactive and hospital-based care rather than preventive, proactive care delivered closer to people's homes.

However, it is clear that despite this oft-repeated vision, there has been a consistent failure to deliver or put in place the longer-term strategies needed to create the workforce and services required to deliver it. There are, of course, pockets of good practice, and the recently published long-term workforce plan (**NHS England 2023b**) aims to increase the primary and community health services workforce, but overall the health and care system in England is centred on hospitals and emergency care. This must rank as one of the most significant failures of policy, leadership and implementation in the recent history of the NHS and social care.

As Simon Stevens, then Chief Executive of NHS England, put it starkly in 2016:

> *If anyone ten years ago had said: 'Here's what the NHS should now do – cut the share of funding for primary care and grow the number of hospital specialists three times faster than GPs', they'd have been laughed out of court. But looking back over a decade, that's exactly what's happened.*
>
> **NHS England *et al* 2016**, p 4

In subsequent years, not much has changed. In this report we explore the underlying factors that have prevented change, and what might need to be done if the vision is finally to be achieved. To do this, we took several different approaches to engage with perspectives across health and care. These included: people who use health and care services; a literature review exploring existing research and evidence on these topics; analysis of national datasets; and interviews with stakeholders across diverse roles relating to health and care. We also engaged with stakeholders, including practitioners, patient representatives, managers and policy-makers, throughout the process, holding workshops to test and refine initial findings. Full details of the methodology can be found in annex 1. Below we share our insights from this research.

Definitions

There is no one phrase that can capture the complexity involved in the shift in focus that is needed. What is important is to be clear what we mean when we use a particular term.

'Shifting services out of hospital', 'shifting the balance of care', 'care closer to home' and 'moving to community services' are just a few of the ways that this topic has been described in recent years. Different stakeholders have different associations with these terms, and may have strong views about them:

> *I never, ever want to hear anybody talk about 'out of hospital', I don't live out of hospital remarkably, I live in this place called a community.*
>
> Provider leader

Others have pointed out that hospitals are part of their local communities, or that the term 'community services' is not well understood and does not capture the range of primary, social care and voluntary services that are also delivered 'out of hospital'. It is also the case that acute care can be provided in settings other than a hospital.

In this report we use the term 'primary and community health and care services' to refer to health and social care provided to people in their own home or in other settings outside a hospital environment. This includes a broad range of services, from the first point of contact for people seeking health care, to care at the end of

life. It covers multiple services provided by many different organisations, including NHS bodies, local authorities, for-profit and not-for-profit providers.

For the purposes of this report, 'health and care' includes social care. We think this makes sense in a report that is about shifting the focus of the health and care system from acute hospital care to primary and community care, given that social care has an important role to play in this shift.

However, we do also recognise the risk of talking about health and social care as one system when, in many ways, social care is a system in its own right. We recognise that the social care 'system' differs from health care in many ways. The most obvious distinction is that social care is means-tested whereas health care (via the NHS) is largely free at the point of need. And unlike health care, public social care is commissioned by local authorities and (typically) delivered by private providers. The underpinning purpose of social care is much broader than improving physical and mental health; it encompasses issues such as maintaining personal dignity, participation in society, and control over everyday life. Put more simply, social care aims to help people to achieve the outcomes that matter to them in their life. This focus on 'what matters to people' is often contrasted with a more health-based approach that focuses on 'what's the matter' with people.

This distinction matters greatly to people who commission, provide and draw on social care services. They are, understandably, wary about bundling social care together with health care as one 'thing', with a single ethos. They are particularly wary of policies and practices that assume social care exists simply to support the NHS to deliver on its objectives or the tendency to add 'and social care' to documents and policies without in fact addressing its particular purpose and structure.

We have tried hard in this report not to make this mistake but rather to acknowledge – and even celebrate – the role of social care in helping people live their lives as comfortably and independently as possible (**Think Local Act Personal undated**). We believe this is a key part of 'refocusing' the health and care system in England.

Throughout this research we were continually reminded to think about the whole health and care system, not simply acute hospital, primary and community health

and care contexts. Although the report mostly focuses on physical health care because of the continued difficulty in shifting the balance in this context, it is important to acknowledge that access to quality mental health care needs to be an integral part of planning to deliver more services 'closer to home'. We do not explicitly cover specialist mental health services in this paper.

In this context, the term 'patients' does not adequately encompass everyone with care and support needs. We use the term 'people who use health and care services' as a general descriptor in this report, except where describing specific data or quoting other research.

Finally, the terms used to describe geographic areas vary between the NHS, local authorities and individuals. For the purposes of this report, we use the term 'neighbourhood' to refer to a natural community such as a village, town or ward, 'place' to refer to an area of around 250,000 to 500,000 people (or a local authority), and 'system' to the area covered by an integrated care partnership (usually around 1 million people).

The evidence that there's a problem

Although we started with the question of 'why hasn't the vision been achieved', there have been shifts of focus in some geographical or clinical areas. Examples include the sweeping changes in mental health services that came with the closure of asylums from the 1980s, and the investment in chronic disease management in primary care in the 2000s. It is also possible that the focus could have been even more skewed towards hospital care had there not been increased numbers of appointments in general practice, more medicines dispensed in community pharmacies, and investment in social prescribing and community link workers, among other initiatives.

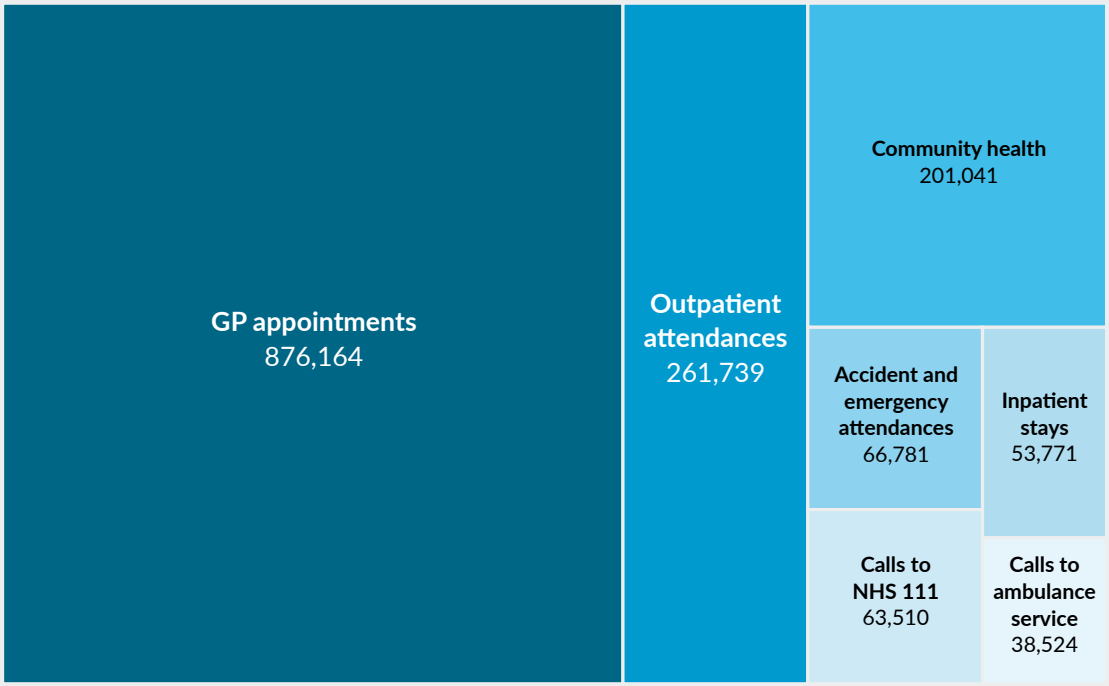
But these shifts have not been wholesale. The system focus overall has still prioritised hospital and emergency care, and inputs have not matched the policy intent. The majority of health and care activity happens within community settings, with activity increasing both in terms of the number of people seen and the complexity of care provided. The proportion of spending on primary and community health and care has seen slower growth compared with the acute and emergency care sector in recent years. The public health grant has been cut by over a quarter since 2015/16, and

despite the commitment in the NHS Long Term Plan, the NHS Five Year Forward View and the General Practice Forward View to ensure that the proportion of spending for primary and community care would grow, this has not been the case.

Like other services, acute hospitals are currently under intense pressure, but unlike other services, this has led to a larger increase in the proportion of NHS money allocated to them. Despite the stated policy intention, the response to stretched services across the whole system has been to boost the supply of acute hospital services, rather than seeking to manage demand by bolstering primary and community services.

In health care, the majority of NHS activity takes place in settings other than acute hospitals (*see* Figure 1).

Figure 1 The majority of daily NHS activity happens in general practice and the community

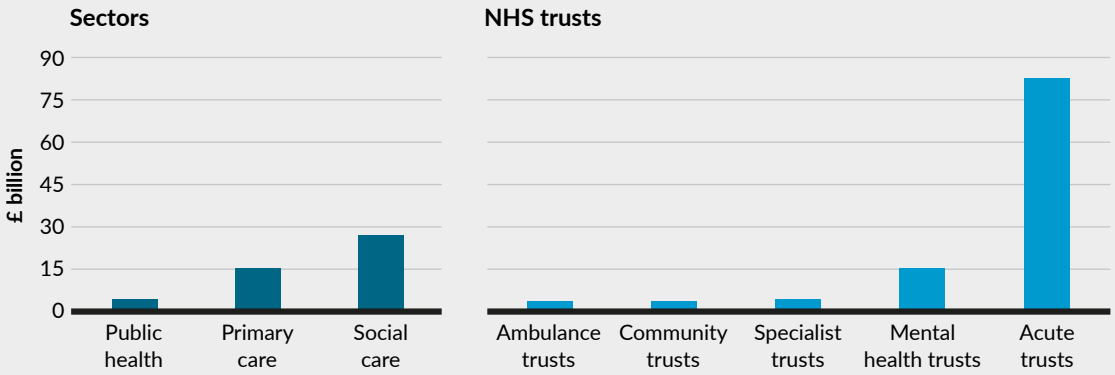


Sources: NHS Digital 2023b; NHS England 2023c

Does not include all NHS activity, eg, equivalent data is not available for dentistry, community pharmacy and optometry.

However, the largest proportion of spend (Figure 2) is with acute trusts (noting that some of these trusts also provide community-based services).

Figure 2 A large proportion of expenditure on health and social care goes towards acute trusts

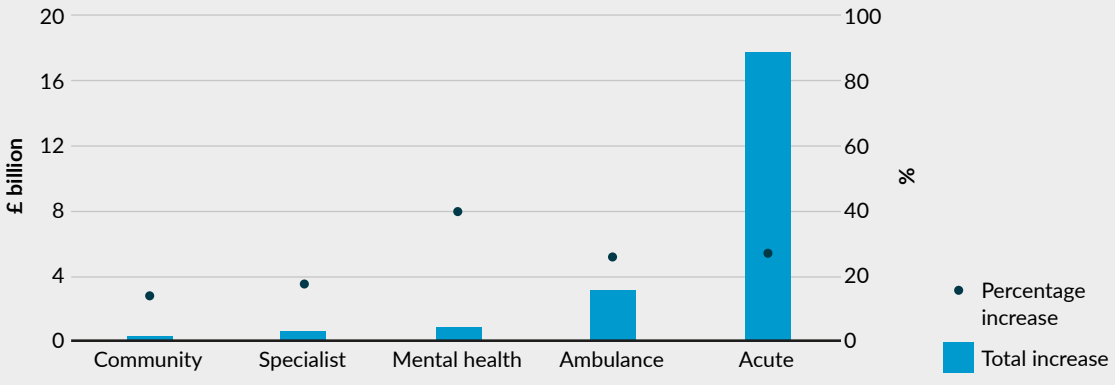


Sources: Department of Health and Social Care 2023; NHS Digital 2023b; NHS England 2023a

Only includes local authority spending on public health and adult social care. This is only a sample of the Department of Health and Social Care expenditure in 2021/22.

Acute trusts have also seen the largest increases in expenditure over the past five years (Figure 3) compared to other types of NHS trusts.

Figure 3 Acute trusts have seen the largest increases in expenditure over the past five years

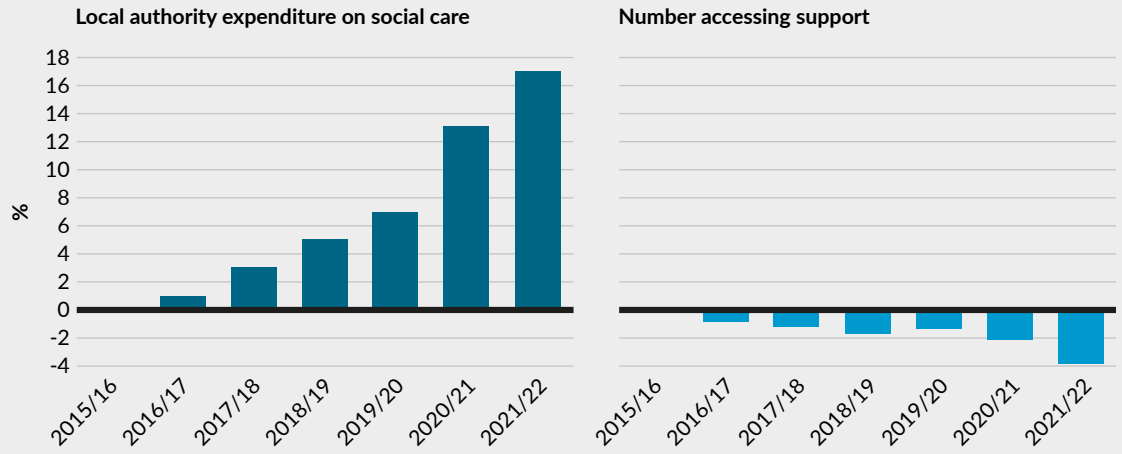


Source: NHS England 2023a

Adjusted to 2021/22 prices. Spending split by trust type only – some providers may provide more than one type of patient care, eg, acute and community care. Does not include spending on non-NHS providers of care.

Although local authorities have been spending more on social care, fewer people are receiving support (Figure 4).

Figure 4 Compared to 2015/16, local authorities are spending more on social care, but fewer people are receiving support



Sources: Bottery and Mallorie 2023; NHS Digital 2023b

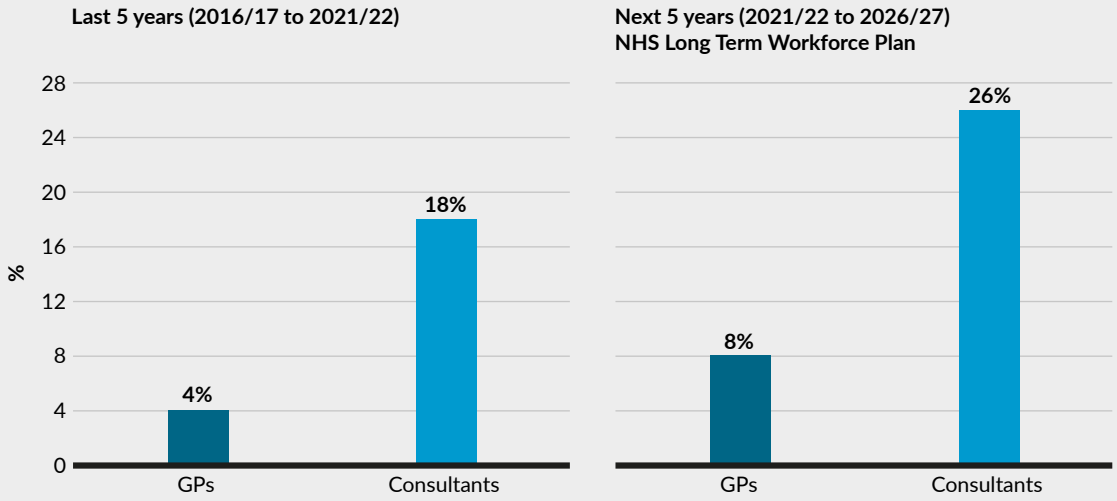
Expenditure adjusted to 2022 prices. Includes people receiving short- and long-term care support.

There have been widespread staff shortages in services across the health and care system. Although the overall number of staff has increased in recent years, most of that growth has been in the hospital sector, far more so than in primary, community health and social care.

The consultant workforce has grown more quickly than the GP workforce. Differences between sector pay, especially between health and social care (even for similar roles), pension differences, and the overall level of pay have been some of the reasons for a loss of workforce.

The NHS Long Term Workforce Plan (NHS England 2023b) has identified the need to grow the primary and community health and care workforce faster than the acute workforce (2.7%, 3.9% and 2.1% annual growth respectively over the next 15 years). Based on projections, community nurse and GP staff will need to grow faster over the next 10 years than they have during previous decades. This is equivalent to 3,000 more GPs and 9,000 more community nurses by 2026/27 (*see* Figures 5 and 6).

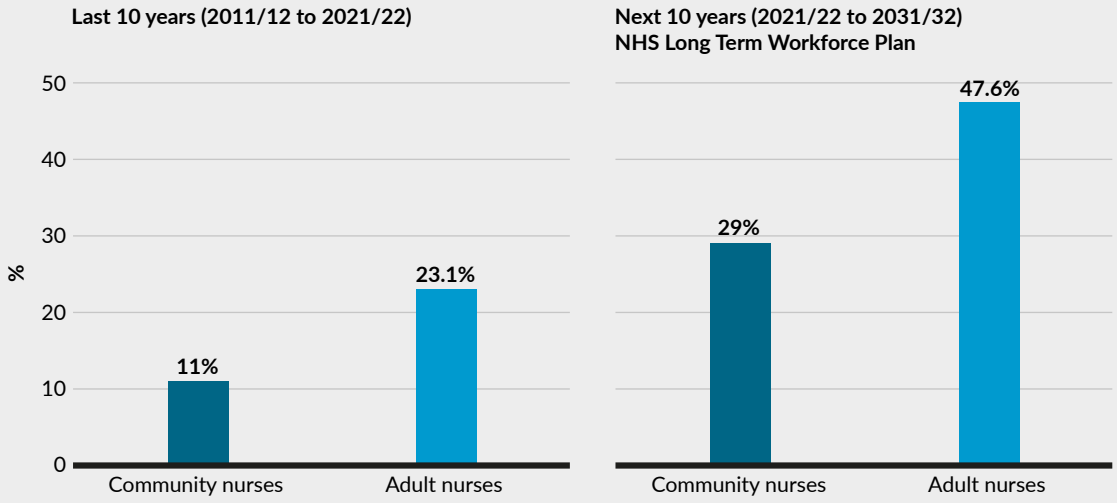
Figure 5 Growth in the number of NHS doctors in the past five years compared with the next five years



Sources: NHS Digital 2023b; NHS England 2023b

Full-time equivalent workforce, including both fully qualified GPs and GPs in training. Past growth based on average total workforce numbers each financial year. Next five years based on planned total workforce numbers in 2026/27 in the NHS Long Term Workforce Plan.

Figure 6 Growth in the number of NHS nurses in the past 10 years compared with the next 10 years

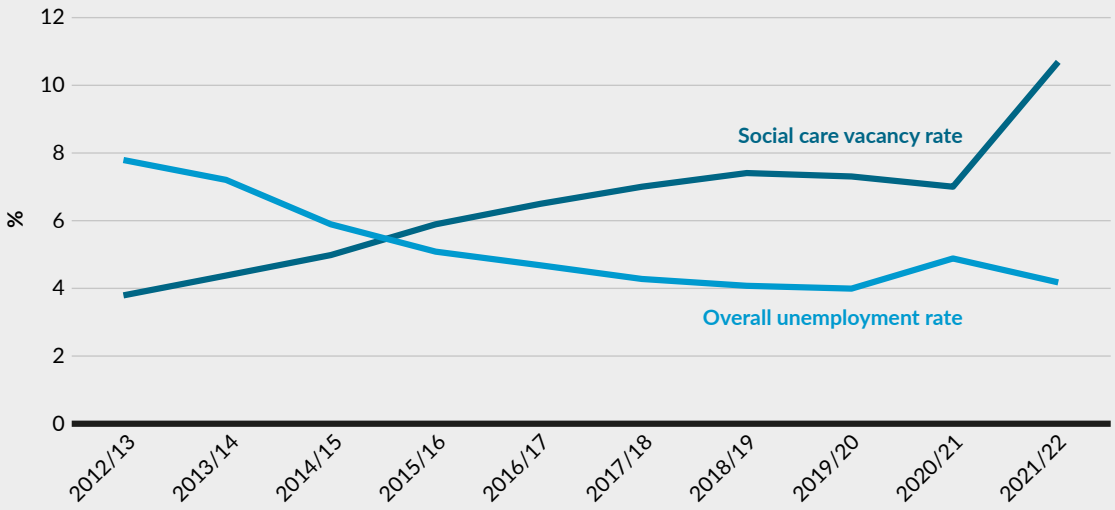


Sources: NHS Digital 2023b; NHS England 2023b

Full-time equivalent workforce. Past growth based on average total workforce numbers each financial year. Next ten years based on planned total workforce numbers in 2031/32 in the NHS Long Term Workforce Plan.

The picture for the social care workforce is also challenging, as there are high vacancy rates (*see* Figure 7).

Figure 7 The social care vacancy rate is rising while the overall unemployment rate in England is falling



Source: Skills for Care 2022

Reproduced from Skills for Care analysis. Social care vacancy data are for the independent and local authority sectors only.

Pay for social care workers has increased in real terms since 2012, but pay in other sectors has been increasing more quickly. In 2012/13, care workers were paid more than retail sales assistants, but by 2019/20 this situation was reversed, such that many care workers would earn more in entry-level posts in supermarkets (Bottery 2022). The NHS Long Term Workforce Plan does not cover social work or social care, which will require an estimated 480,000 additional staff by 2035 (Bottery 2023).

Why has this happened?

In this section we explore the reasons behind the lack of wholesale change towards a health and care system that is more oriented to primary and community care. These reasons can be summarised as follows.

- A lack of agreement about the purpose underpinning the vision, and in particular the financial impact it will have in the short term.
- A 'cycle of invisibility' for primary and community health and care services, where they are hard to quantify and easy to overlook.
- Hierarchies of care, with urgent problems taking priority over longer-term issues.
- Misconceptions that the public prioritise hospital services over and above primary and community health and care services.
- A financial architecture for health and care that does not support a focus on primary and community health and care.
- Short-term approaches to return on investment.
- A health and care system that is not set up to deal with the complexity of people's needs.
- Policies and strategies that are not aligned to the vision.

A lack of agreement about what the vision is and why it is needed

There is a lack of agreement about the purpose underpinning the vision for the health and care system. In practice, it conceals several different sets of assumptions, aims and asks. These include:

- cost savings
- reducing demand on hospitals (waiting lists, emergency admissions)
- better experiences and outcomes for people who use health and care services
- improved service alignment or integration
- developing population health and prevention at scale, including wellbeing, and tackling inequalities.

This means that often, different people use 'care closer to home' as a shorthand for achieving particular outcomes, without aligning these with the aims or objectives of other people and organisations they are working with.

Where the desired outcome is short-term cost saving, our research found particular disjunct, and this is clearly evidenced in the literature (Bramwell *et al* 2023; **Imison *et al* 2017**; Lewis 2006; O'Cathain *et al* 1999). The direct costs of providing care in community services may not be very different from the direct costs of providing care in hospitals; rather, it is the capital and other overheads that makes the difference and so the only way to release savings is to be able to close hospital estate. In a health system that already has fewer hospital beds per capita than other similar systems (**Anandaciva 2023**), this is not likely to be achieved. Whereas in the longer term a system that requires more hospitals to be built to manage acute needs will be more expensive, savings in new service models can be expected in a very short timescale. When these do not materialise as anticipated, new models are abandoned. The implementation of new service models often requires double-running costs for significant periods, which is rarely funded.

The changes in mental health services were frequently mentioned during our research, both because of the lessons that might be drawn from the huge shift achieved in moving people out of hospitals into the community from the 1980s to the 2000s but also the ensuing challenges around lack of inpatient beds (**Gilburt *et al* 2014**) and insufficient community services to meet demand (**Care Quality Commission 2021**). Double-running was highlighted as important in ensuring a successful transition, but the (well-founded) concerns of some professionals about the reduction in numbers of mental health hospital beds were not properly considered (**Gilburt *et al* 2014**).

Given that more broadly, England already has a low hospital bed base compared to other comparable countries (**Anandaciva 2023**), a reduction in beds does not seem a likely solution in delivering care 'closer to home'.

Care that better meets people's needs often unlocks 'hidden' unmet demand, and so reducing demand is not straightforward. Moving activity from hospital to the community is possible, and longer-term evaluations of new care model initiatives undertaken in the 2010s began to show some changes in activity, but this was often some years later, and not always in expected ways (**Clarke *et al* 2020**).

Better experiences and outcomes for people who use health and care services are a clearer aim for the change of focus from hospital to care delivered closer to home (Charles *et al* 2018; NHS Providers 2015; Robertson *et al* 2014; Salisbury *et al* 2010; Wistow *et al* 2009; Harvey and McMahon 2008), and are often cited as potential benefits of the change alongside cost savings and demand reductions. Although there is more evidence for improvements in people's experiences of care and care outcomes, this is also not something that is easily measured. Even when such improvements are a stated aim, the processes for developing business cases within the public sector often lead to an overemphasis on financial savings – by default narrowing the interpretation of what the aim should be.

This difficulty in evidencing qualitative rather than quantitative outcomes can also lead to a focus on hospitals as the main beneficiaries of any changes – for example, statistics on avoiding hospital admissions – as hospital activity more readily lends itself to the measurement of quantitative outcomes.

Prevention and population health goals inevitably take a much longer time to materialise and, again, can be hard to evidence in the short term, which means it is hard to sustain the focus if change is not quickly evident (Buck *et al* 2018).

A cycle of invisibility reinforces inaction

One of the reasons for a lack of agreement about how or why to change services is the 'cycle of invisibility' of primary and community health and care services. This is notable in terms of data, whereby a lack of political and leadership focus on primary care (and particularly community services) has led to a lack of incentive to collect data. Several participants in our research, during interviews and in challenge groups, reflected that despite recent improvements, data is still not comprehensive and still lacks quality. This means that system leaders do not have the data they need to make fully informed decisions, so investment in community services is overlooked, and then the cycle continues:

> *So ambulance queues, people in pain – it's all much more visible than the impact of something preventive that may not be obvious at all. In fact, you may never know what would have happened if you didn't put the preventive service in.*
>
> National leader

The data that does exist is mainly limited to the number of contacts with services; there is relatively little data on demand, patient and staff experience, patient outcomes and quality of care. As a result, commissioners can be led to use hospital sector data as a proxy for measuring the impact of community services, such as the number of delayed discharges or number of readmissions. This lack of data translates into a very limited number of national targets for care 'closer to home' such as the 2-hour urgent community response, whereas there are numerous targets for hospital and acute care. Targets often create focus, visibility and accountability, although evidence from participants and the literature suggested that targets were not necessarily the answer for community care, unless they were focused on people and on patient outcomes.

As with the data, there is a cycle of invisibility of community services in senior NHS leadership. Many of those we interviewed felt that the most senior leaders in the NHS mainly had career backgrounds working in hospitals, partly because of the perceived high status of working in large teaching hospitals. Limited experience of primary and community health and care services, and limited data on those services, means that leaders' understanding of the issues and how to address them will be necessarily partial, leading to at best partial solutions.

The language of 'out of hospital' implicitly reinforces the hospital as the default and centre of health services, as does the fact that the majority of commissioner spend is on acute hospitals. This means that leaders of integrated care systems (ICSs) spend more of their time thinking about acute hospitals than about primary or community health and care services:

> *I probably spend a lot more time… dealing with the hospitals, because the hospitals absorb all the money, and unless I can control the money, I can't do anything. But I think it's the money that sucks me more into the hospital side.*
>
> System leader

Research into sustainability and transformation partnerships (STPs), the forerunners of ICSs, also found they were focused on demand and on reconfiguration of hospital services, rather than planning to strengthen and expand primary and community services (**NHS Providers 2018**).

Hierarchies of care that prioritise crisis over long-term care

It is hard not to prioritise immediate life-saving treatment over prevention. It was clear from our research that the financing of hospital services takes priority for politicians and system leaders over financing for prevention or care services. For example, interviewees told us there were always more pressing issues or areas of the system to fund, and they also described how it was not really a 'fair fight' between critical care and wellbeing services.

Another example we heard about is the difference in value reflected in the overall level of pay for staff working in primary and community health and care services compared with staff working in acute hospital roles. Staff working in GP practices, community pharmacies and voluntary, community and social enterprise (VCSE) sector organisations are not covered by the Agenda for Change pay scales that are generally more attractive, and so equivalent roles in those sectors may be less attractive. We also heard a particular issue about the way in which homecare is commissioned, which results in pay being less attractive than for similar roles in hospital settings:

> *In homecare everything is measured in minutes, so if you imagine in a hospital, if a nurse was only paid for the minutes that they've spent by a patient's bed, and they're not paid when they walk from one patient's bed to another, they're not paid when they walk to another ward, they're not paid when they're training, they're not paid when they're supervised, and nobody actually asks them, 'what happened to your patient, did your patient live or did your patient die? Oh, I don't know but I spent four minutes by their bed', there'd be an absolute outcry. But that's what happens in homecare every day.*
>
> Provider leader

Concern among leaders and politicians about public perception of services

Electoral politics can make it difficult to contemplate what politicians believe may be unpopular decisions. Although the authors argue in this paper that a change of focus of the health and care system does not mean closure of hospitals, that is not how investment in primary and community services may be perceived by others. Participants in our research suggested that politicians particularly felt that the public 'don't understand' or 'don't see' social care and community care, have a very basic understanding of the NHS (centred around hospitals), do not understand the safety

issues of being in hospital, and prioritise hospitals above other care. Participants gave examples where local hospital closures were cited as the reason for poor election results. A lack of understanding of how social care in England works has, however, been found in other research (Scobie and Kumpunen 2023; Bottery *et al* 2018), and we heard that letters politicians receive tend to talk more about the NHS than social care.

However, despite politicians' assumptions about public opinion, and media representations of health and care services that are often focused on hospitals and emergency settings (Fanning 2019), this view of the public lacks nuance about the diversity of views, or indeed how those views can change. Evidence from Healthwatch England, for example, found that primary care services is far and away the biggest issue that the public contact them with concerns about, and that they do not want to go to a hospital unless absolutely necessary (Healthwatch England 2023). Evidence also shows that patient and public views are not static, and that meaningful engagement – for example, through deliberative consultation – often surfaces more nuanced views (Bottery *et al* 2018; Burkitt *et al* 2018).

The financial architecture of health and care does not support a focus on primary and community health and care services

Commissioners may be concerned that shifting funds to prioritise primary and community health and care services will destabilise hospitals. This also means that when money is needed in the system to balance overspends or to meet efficiency targets, it is often easier for commissioners to take it out of smaller local contracts with primary and community care providers, or to withhold discretionary spend with these providers.

> *Hospitals know they'll get growth money: [the commissioner] would say, 'right, we're going to give our hospital a budget that means they can afford a 2% growth in demand, and we're going to invest the rest of the money in these wonderful community services, which is going to prevent hospital admissions'. The hospital… knows that there won't be 2% demand, there'll be 4% growth in demand, or whatever, and they know that the commissioner will end up paying them for that care.*
>
> National leader

Although moving services from hospitals to other settings may occasionally be the result of a changed focus of care, interviewees highlighted that the way in which

acute trust finances are structured, the high fixed-cost base, and the reliance on cross-subsidisation and inter-dependencies between services within hospitals all make it hard to disentangle hospital finances. They indicated that if one service is reduced or changed, this may have significant adverse effects on the rest of the hospital:

> *There is so much fear that if the money follows the patient, which you feel it should, then the hospital services will be destabilised to such an extent that they'll fall over.*
> National leader

Financial policies and strategies have also failed to support a shift of focus towards primary and community provision of health and care services.

The impact of the original financing model for NHS foundation trusts, which required maximisation of income and margins, remains. Payment by Results was designed to drive additional activity in hospitals, and was therefore a barrier to shifting towards community provision (**Ham and Smith 2010**). The way in which competition law was applied in the NHS during the 2010s also resulted in disruption and uncertainty for community services, and disincentivised investment. Community services were often broken off into individual tenders, and went through frequent re-tendering, which was destabilising (**NHS Providers 2018**). This was echoed by several interviewees:

> *For a number of contracts, we've been able to persuade commissioners to commission for three to five years, just to give us some certainty, otherwise people are constantly on short-term contracts, which is not ideal for them, and it just causes a lot of churn within the services.*
> Provider leader

Competitive tendering has been applied to social care services for an even longer period, often with the same concerns (**Drinkwater 2011**). Despite changes made by the Health and Care Act 2022 to soften the competition requirements within health care, our interviewees perceived that the legacy remains.

The financing models within the NHS are also largely unable to support care that crosses pathways or organisations. Rather, they are focused on episodes of care and activity provided by specific organisations.

> *The NHS often uses a vernacular of treatment and patients, each of which is a wholly contained specific intervention to deal with a problem. While this language is often useful and accurate for those types of situations, it is constraining for care and support provided outside of institutions and as part of long-term relationships.*
>
> NHS Providers 2015

A move towards blended payments may help to address this issue but it was still raised as a barrier by those who participated in our research. The fact that primary care providers are predominantly funded on a capitation basis, community providers on block contracts, and acute hospital services on activity-based contracts, has proved challenging when aligning services:

> *How do you reconcile this sort of dilemma in all health care systems where predominantly community and primary care services are funded on a capitation basis, and hospital services are funded on a per case basis? Those two things rub against each other and it's very hard… where is risk held there?*
>
> National leader

> *We don't have contractual mechanisms where we can integrate specialist care into primary care. So that's a big barrier. As I say, people have done it, you know, by breaking the rules… and [the service] hasn't been sustained in the same way, because the contractual models don't enable it.*
>
> Practitioner leader

In particular, the financing model for primary care (general practice and community pharmacy through mainly national contracts) does not allow easy flexibility or change, or larger-scale local investment, as commissioners have less ability to direct funds to meet local need (**House of Lords Integration of Primary and Community Care Committee 2023**).

Large-scale integrated contracts – which have been used in other health systems (**Addicott 2014**) and which could address some of the issues of funding across services – were trialled in the 2010s. They were largely unsuccessful, often because of an underestimation of the funding that would be required (**House of Commons Committee of Public Accounts 2016**).

Short-term approaches to return on investment

There are always challenges inherent in prioritising approaches that will take a longer time to reveal benefit. Election cycles, budget constraints, annual financing and unexpected crises all lead to short-term approaches to financing and planning of new services.

> *Effective planning is extremely difficult with short-term funding. I go to a lot of meetings where they are like, 'oh guys, we've got this money, everyone gives their ideas but we've got to get it out by March'. They don't actually care, nobody cares about the longevity of the service, what is going to happen, they just need to get the money out of the council pot into this other organisation by 31 March.*
>
> Provider leader

Recent research into the use of extra winter funding found that it came with insufficient advance notice for effective planning, sometimes having to be spent on residential care that was available at short notice rather than developing more services to support people at home. In addition, the money could not be spent on services that would prevent admission, only on helping with discharge from hospital (**Baylis *et al* 2023**).

Community health services and voluntary sector contracts seem to be particularly insecure, which means that it is also hard to retain staff or grow services for the longer term:

> *A number of our contracts are run on an annual basis, so for our staff… they don't know whether in April they will have a job. It does affect retention.*
>
> Provider leader

> *If we try and continue to do it in the way that I describe, where the health secretary, or senior political figures might say, 'let's try a pilot here, a pilot there', it works, but then it's never rolled out, because there's no specific ring-fenced funding for the transformation of community services nationally. It's never going to happen.*
>
> Practitioner leader

This short-term approach also disrupts consistency of leadership and purpose:

> *Consistency of leadership is important. I do worry that in terms of national policy, the desire to create new policy means that sometimes we don't learn from what we*

> *had before, or we partly implement something and then we move on to having to create a new policy.*
> National leader

The health and care system is not set up to deal with complexity of people's needs

It was clear from our research that system complexity was one of the prime reasons why the shift in focus towards primary and community health and care services had not happened; and that system complexity mirrored the complexity of people's experiences and conditions.

> *If you went out of your way to try and create a system that was designed to prevent people collaborating with each other, you probably couldn't do much better than the system we've created.*
> National leader

The health and care system that was developed in the twentieth century is hospital-centric, with increasing specialism and subspecialism of health and care and investment in hospitals.

> *When illness was experienced as a random catastrophe, and medical discoveries focussed on rescue, insurance for unanticipated, episodic needs was what we needed. Hospitals and heroic interventions got the large investments…*
> Gawande 2017

Now, almost 25 years into the twenty-first century, health and care is more complex. Older people rarely live with only one health condition, and the evidence for one health condition to impact another (eg, depression and diabetes) is clear. Some common themes in our interviews were the issues of comorbidity and complexity, and the need to provide for the biopsychosocial needs of people who use health and care services. We heard that staff do not always understand the concept of supporting people's holistic needs, and there can be contractual barriers to working in this way. Community services have often mirrored the growth of specialists in hospital, with increasing numbers of specialist teams or specialist nurses being commissioned to provide services to people in their own homes contrasted with more generalist district nursing (Drennan 2019).

Many interviewees talked about hospital pathways being organised around a single disease, and yet most people who use health and care services in community and primary care settings have multimorbidity. Evidence shows that people over the age of 85 have on average 5.2 long-term conditions each (**Watt *et al* 2023**). The health and care system relies on people to navigate their way through appointments, and rarely looks at their preferences in the round. People using health and care services experience being 'bounced' around the system. We were told that people need 'practitioners who can solve their problem, not having to go to six people to solve different problems' (provider leader). Another interviewee described this dilemma:

> *If you've got a patient with a cardiac problem and COPD [chronic obstructive pulmonary disease], for example, where do you send them in the community? Which service do you send them to? You either send them to both, and it becomes incredibly inefficient, or you pick the worst problem and send them there. So, that condition-specific silo underpins a lot of this, I think, because it does limit the way that people move through services.*
>
> Practitioner leader

Data for community services is not set up to capture this system complexity. The Community Services Data Set (CSDS) predominantly measures contacts, and while individual GP practice information systems capture detail about a person's whole care journey, this is usually not available to the wider system.

Since the advent of commissioning in the 1990s there has been an imbalance of power between commissioners and large acute hospitals. Many large acute hospitals have multiple small commissioners, amplifying this imbalance and making it difficult for commissioners to challenge the traditional pattern of spending (**Ham and Smith 2010**). In 2023/24, ICSs have been required to make 30% cost savings in their running costs, which will undoubtedly affect the capacity of ICS leaders to focus on the complex structural and cultural changes that will be needed.

> *So what we had with integrated care, now we've got all of the new structural changes, then everyone's got to make 30% [cuts]. So if you've got to make 30% when you've only recently formed, it consumes a lot of your time, doesn't it? So how much time have you actually got to spend out doing what the day job is?*
>
> National leader

Policies and strategies are not aligned to the vision

Many of the policies and strategies of recent years have not supported the stated objective of shifting the focus to primary and community health and care services, causing a lack of coherence and contributing to the failure to deliver the overall objectives. This includes competition policies and approaches to performance management (Charles *et al* 2018).

> *Have we got a coherent set of policies which speak to the system and improvements in the integrated support of people outside of hospital, and is that backed by discipline when it comes to implementation through the processes of planning and delivery? The answer to both of those questions is no. We don't have a coherent set of policies, and we're not incentivising the things that we want to incentivise in the system.*
>
> System leader

This situation has been exacerbated by the Covid-19 pandemic, which has resulted in a focus on reducing the elective care backlog in hospitals rather than similar efforts to prioritise backlogs in community services (NHS Confederation 2022).

Participants working in health and care highlighted the need for 'headroom' and stability of policy to focus on longer-term issues, alongside the immediate challenges they have to tackle, such as winter pressures. Specifically, ensuring that national policy and accountability is not just focused on short-term crises would help facilitate this headroom and show that there are wider priorities than simply waiting times and urgent and emergency care, which currently reinforce a focus on hospitals and diagnostics rather than rebalancing investment toward primary and community health and care services. As one national leader commented, 'we've never created the headroom to be able to do this'.

The experience of mental health services has also seen a mismatch of vision and policy. Although the Mental Health Act 1959 first signalled the intention to expand community services and run down psychiatric hospitals, and policies in the 1960s and 1970s supported this change, financial constraints meant that few community services were developed. Significant changes, including large-scale closures of asylums, did not take place until the late 1980s when new funding arrangements supported this shift, transferring resources from hospitals to local authorities as beds were closed (Gilburt *et al* 2014).

2 What's the solution? A refocusing of the health and care system

> *This is not something we can do in a sudden burst… you need to be quite patient, and steadily build the headroom.*
>
> National leader

Just as the health and care system is complex, so are the solutions to its challenges. The work to deliver solutions is also complex, with interrelated rather than immediate targeted solutions to single issues.

Our findings indicate that the focus needs to be on creating the environments necessary for primary and community health and care services to flourish rather than specific integration proposals or pathways. The changes required are multiple, interconnected, layered and difficult; they will take time and require a willingness to implement (Kozlowska *et al* 2018). It will not be sufficient to selectively implement a few changes; the shift required is wholesale, which helps to explain why it has not been achieved thus far.

This report does not call for the closure of hospitals and the shift of hospital-based services into the community; the NHS in England already has low inpatient bed numbers (Anandaciva 2023). It is also not just about moving existing services from one location to another. Rather, we see the solution as rebalancing the focus of the health and care system towards primary and community care, through a focus on leadership for change, on culture and on implementation, which we explore in more detail below.

A focus on leadership for change

The first area highlighted by our research was a rebalancing of the leadership of the health and care system towards one that is focused on primary and community care services and allows these types of services to flourish.

More leadership focus on primary and community health and care services, less on acute hospital services

The importance of leadership in facilitating (or blocking) change is well established (Naylor and Charles 2018; Pearson *et al* 2015; Singh 2006; O'Cathain *et al* 1999) and can be seen in successful international examples of more community-based care. But our research participants spoke about the qualities of system and place-based leaders who could facilitate this kind of work. These leaders may have clinical or non-clinical backgrounds; what matters is that they value and actively seek other perspectives (particularly those outside their own experience) and that they have a good understanding of different roles in the system. This leadership is proactive and embraces change, including changing power relationships, and puts the people who use health and care services first.

> *You understand the whole pathway, and where people need to go to and from, and that's a real advantage… having people that work across both sectors is an absolute enabler.*
>
> Practitioner leader

Many interviewees were positive about the potential of integrated care boards (ICBs) to enable the required shift in care, bringing together different parts of the sector and devolving responsibilities to place level. However, it was clear that this requires a great deal of time and investment. As yet, ICBs have not been able to focus on this agenda, because elective recovery has taken priority. Consistency of purpose requires senior leaders and decision-makers from across sectors, rather than senior leadership that is dominated by hospital experience. NHS England and the NHS Management Training Scheme should ensure that leaders are encouraged to work in community settings, and develop experience across a range of sectors.

More alignment, less mismatch between vision and policy

Addressing the issue of what one of our participants named 'process discipline', whereby the stated vision is aligned with subsequent policy interventions, is key. We heard from several interviewees that the legal establishment of integrated care systems (ICSs) gave them reason for optimism and had potential to catalyse change. But there was a risk that they become simply talking shops or that worse, they revert to a focus on the hospital sector and on performance management. This again speaks to the importance of a change in leadership approach, not just a structural change (Irani *et al* 2007). Rather than focusing performance management on the hospital and emergency care system, NHS England should focus on holding ICBs to account for their achievements in growing primary and community health and care services.

Reiterating a clear vision of what a renewed focus on primary and community health and care services would look like, and a clear, agreed and realistic understanding about the reasons for that vision, is absolutely fundamental. And once the vision is clear, subsequent policies – whether funding, workforce, structural or regulatory – need to support the achievement of that vision. This will require an ongoing conversation with people who use health and care services and the public, so that views and goals are aligned.

More long-term strategy, less short-term reactivity

It was striking how frequently participants highlighted prevention and longer-term outcomes as areas that needed greater focus. This includes primary, secondary and tertiary prevention, ensuring early access to diagnosis, and keeping people with existing conditions as healthy as possible. They also emphasised the important role that primary and community health and care services (including social care, community pharmacy and the voluntary, community and social enterprise (VCSE) sector) play in this, but currently have limited headspace to do so while dealing with short-term demands. Those services also have limited incentive to take risks where the impact may be uncertain or the rewards longer term. Government should explore how it can enable ICSs, and local authorities in particular, to plan for more than a single financial year in order to support a greater shift to preventive care and interventions with longer-term impact.

Several participants talked about the need to ensure that NHS England and health policy more generally is separate from the electoral cycle and short-term political influence. Given the significant proportion of taxpayer money (around 20% of public expenditure) spent on health and care, political influence is inevitable and appropriate, and there will always be a need for clear accountability for how money is spent. However, particularly where a longer-term approach to implementation and investment is needed, greater cross-party consensus on issues such as social care funding reform and prevention would be beneficial. Given the recent history of discussion on adult social care reform, this consensus may seem hard or impossible to attain, but there are recent examples of where it can be done – for example, the NHS Long Term Workforce Plan, published by the Conservative government and backed by Labour in opposition.

Far from being a one-off transformation, what the current state of mental health care (**Gilburt and Mallorie forthcoming**) indicates is that transformation is an ongoing process – with a need for a consistent vision and dedicated investment that matches demand.

More focus on growth in primary and community health and care services, less on growth in the acute hospital sector

A health and care system that is refocused on primary and community services will not allow money to be released from hospitals in the short term – not least in a system that already has a very low bed base and faces growing demand. However, failing to rebalance by investing in primary and community health and care services will mean in the long term that more and more expensive hospitals have to be built, which will simply not be sustainable.

The solution is likely to be achieving differential growth for each part of the system as the NHS Long Term Plan intended, and there will be a need for a longer-term strategy for investing growth monies into primary and community health and care services over a sustained period. As one interviewee put it:

> *A shared commitment that this year, we are going to, rather than growing our acute base by 4%, we're going to grow it by 2%, and the balance of the resource we're going to put into these services, and we expect that to have this impact.*
>
> National leader

The major transformations achieved in mental health services were also accompanied by financial models that supported change (**Gilburt *et al* 2014**) through significant investment in community services.

In order to avoid destabilising services in the short term, the attention should be on differential growth to allow for a careful and balanced restructuring of the financial architecture of the NHS so that it aligns with the stated policy intentions. This might mean that NHS England and the Department of Health and Social Care should consider changes to the current national contract approaches for primary care, with more flexiblity for local commissioners to drive change based on local need.

The Department of Health and Social Care and NHS England need to prioritise capital and revenue investment in technology and estates for primary and community health and care services. Although participants recognised the potential of innovative technologies such as remote monitoring, artificial intelligence (AI) and even robotics, the state of technology in primary and community health and care services is often very underdeveloped, reflecting a lack of investment in hardware and software (**Community Network 2021**). For many interviewees, investment – to at least have basic infrastructure in place – was a priority:

> *It's slightly depressing hearing about district nurses with laptops they can't turn on, where they've got to drive 20 miles back to base to be able to log on to get any notes uploaded. We're not talking advanced digital here.*
> National leader

> *We're a very long way from the digital tools and connectivity that a modern health care system absolutely depends on.*
> National leader

It is important to note too that while people are generally positive about digital approaches to care, the system still needs to provide channels for those who are not able to use these methods.

Estates was another area where investment is needed, particularly to accommodate multidisciplinary team working. In recent years, there has been a trend towards centralising community teams into a central base, often covering very large areas.

A growing recognition of the need for teams to be integrated at neighbourhood level means that a different approach may be needed from NHS trusts providing community services, which recognises that integrated neighbourhood teams may require multiple smaller sites (Fuller 2022). Significant growth in new roles in primary care services, and more broadly the estates needs of the NHS Long Term Workforce Plan, will also require adequate estate to accommodate these new teams.

During our research, we heard that the financial rules for different sectors and organisations often hamper collaborative use of public sector estate. For example, GP rent reimbursement rules have restricted the ability of GP practices to host community or secondary care services. Local authorities have also faced challenges in balancing their remit to maximise revenue from estate with providing affordable access to estate for VCSE sector services (Collins 2020; NHS England and NHS Improvement 2019). Local public services should be able to use their facilities and estates to support joined-up, integrated working locally between partners, and government departments should review relevant contracts and rules to better allow and support this.

A focus on culture change

A primary- and community-focused health and care system will require a change in culture, particularly in the approach to care delivery and how the workforce is trained and equipped for this change in focus.

More focus on people and outcomes as a whole, less on processes and outputs for single conditions

The increasing complexity of people's health and care needs requires an integrated, holistic response, rather than a 'body part' or single condition response. There needs to be more of a focus on people and outcomes, rather than processes and outputs, both in how care is delivered and how it is measured and commissioned.

> *You're more than the sum of your disease… In the same way, the care and support you need is more than the sum of just individual transactions, it needs to be seen in the context of helping you as a person… So there needs to be a match between*

> *seeing you as a whole person and then the services and support that you need to reflect that and be holistic and relational as well as transactional.*
> Patient leader

The care needed to support people in local settings over many years and with varying needs will require practitioners to be both adaptable and co-ordinated to deal with this complexity. Staff will need to have generalist skills but also understand how to call upon others when required as part of a multidisciplinary team, and co-ordinate the care required (**NHS England 2023b**). Working in an integrated way requires different working practices and a change in organisational culture. The skills, knowledge and behaviours needed for a multidisciplinary environment to flourish will need to be taught and maintained (**Hussain and Dornhorst 2017**). This will need sustained effort from leaders, to persuade practitioners to step out of the comfort zones of individual professions and approaches.

The aim is not for completely generic community workers; rather, it is for professionals that are trained in how to work in multidisciplinary teams. The NHS Long Term Workforce Plan acknowledges the need for staff to work in multidisciplinary teams but does not address the need to train professionals to work in this way (**NHS England 2023b**). Professional bodies and professional regulators need to review training and continuing professional development so that practitioners have the skills needed to work in multidisciplinary teams. For many people who use health and social care services, the issues they face are about the lack of co-ordination of services around their needs (**National Voices 2021**). If multidisciplinary teams are to be effective, there will need to be a focus on better communication and navigation between services, facilitated by professional care navigators who can help individuals manage the complexity of appointments, medications and processes.

Despite numerous strategies that refer to the importance of personalisation and holistic care, the NHS as a whole often uses a biomedical approach. This does not take into account the importance of what matters to people, which may not be the same as what matters to the health and care professionals who deal with them.

> *At the minute, my GP surgery are obsessed with my blood pressure. And I'm just like, frankly, I couldn't care less about my blood pressure at the moment. Yes, I don't want to have a stroke and a heart attack in 30 years' time but actually right now,*

> *there's about five other things that impact my quality of life on a day-to-day basis I care about that you never contact me about, but all you nag me about is sending in my blood pressure readings.*
>
> Patient leader

Too often, data drawn from the experiences of people who use health and care services is not given as much importance as other operational data such as admissions to accident and emergency (A&E) or waiting times (**Thorstensen-Woll *et al* 2021**). Research into quality of district nursing found that national mechanisms of quality assurance and accountability were largely designed to assess hospital care and poorly suited to measuring quality of primary care services (**Maybin *et al* 2016**). Placing people's voices on an equal footing with other key operational data demonstrates both its importance and how it can add understanding and meaning to other data and information collected, rather than being treated separately (**Wellings and Thorstensen-Woll 2022**).

More focus on holding risk rather than avoiding risk

We heard in our research that the ability to hold risk is key to primary and community health and care services but requires agreement between sectors about how risk is held and managed to avoid misunderstandings and apportioning of blame.

When risk is appropriately held and managed, care meets an individual's needs but often reduces the amount of care required, which in turn has a huge bearing on the use of resources for organisations and the system as a whole. If the risk from complexity is managed with multiple referrals, pathways and care inputs, costs can increase, as opposed to supporting practitioners who are able to hold risk with a focus on outcomes and person-centred care.

The level of risk involved in working in the community is significant:

> *It is far riskier working in the community, and I mean that in the sense of risk to the individual, and risks in terms of the support around you.*
>
> Practitioner leader

The skillset required for working in the community is different from that required for a hospital setting (NHS Providers 2015). It includes being able to deal with uncertainty, and without the immediacy of other colleagues (Drennan *et al* 2005) or support, both technical and emotional (Haycock-Stuart *et al* 2010). This is not just the case for frontline staff; interviewees who had worked in various settings described how leadership positions in the community are also more difficult than those in hospital settings. Again, the ability to work in effective multidisciplinary teams, and to work easily across boundaries, will be important to managing risk.

More focus on raising the status of working in primary and community health and care services, less on working in acute hospital services

We heard frequently that working in primary and community health and care settings was often seen as lower status than working in the acute hospital sector – a perception that often began during training:

> *Acute was sexy, community was for failed clinicians, or females who wanted to go part-time to have children.*
>
> Practitioner leader

Another commented:

> *There is a view, which I often hear, which is 'I don't want to go to community to retire, you know, doss around having cups of tea'. It's so offensive. It's usually from people who don't understand what it's really like.*
>
> System leader

Other interviewees indicated that the reverse was true for previous generations:

> *It was the complete reverse 40 years ago. If you moved to the community it was high status, you got paid more and you were recognised by your colleagues as having moved up in the world, in nursing, in your career, because you were autonomous as a practitioner, taking a risk out there… Sometimes I cannot believe how much that has changed in 40 years.*
>
> Practitioner leader

Training providers need to explore how to increase meaningful experience of primary and community care, for example through compulsory placements for both clinical and managerial staff.

As our research highlighted, there can be a difference in pay in primary and community health and care services, resulting from the way in which services are structured and commissioned. Recognising the complexity and the skills needed to hold significant levels of risk in the community is one way in which the status might be raised so that the skills required are 'understood, planned for, promoted and rewarded' (NHS Providers 2015). NHS England, training providers and professional regulators need to work towards creating clear career paths that can provide high-status roles in primary and community settings and that reflect the skills needed for working in primary and community settings. A better-paid workforce would increase both the quality and availability of care (Gentry *et al* 2023).

More trust and devolved decision-making from national bodies, less top-down direction and control

As one participant pointed out, it is a lot easier for national bodies to conceptualise and engage with a few hundred acute trusts than to try to understand the complexities of primary and community health and care services. That same participant also highlighted the potential for ICBs to engage differently and the need for them to be empowered to do so.

> *I don't think you can sit down and design a new payment system on paper. And because increasingly I think nothing should be designed by way of policy or process at the centre without ICS… and I mean ICS key people being really, really involved in a genuine co-production process.*
>
> National leader

NHS England often does set the organisational culture, but this is not always experienced positively. Despite evidence of the need to engage with those doing the work in place, participants also told us that currently, NHS England still approaches design from the 'top down'. One participant told us about a task force 'not working with providers on the ground… they're coming up with this national framework… and then they're basically going to say, "right, here you are, this is

what you've all got to do"' (provider leader). The implications of this are that the framework might not be appropriate or practically implementable, and that even if it is, the goodwill of providers may be lost due to a lack of buy-in to the framework.

> *What have we done since? Well, we're now in a position where we're not trusted to do anything. You've created ICSs with very senior, highly paid, experienced people right across the country and you're treating them like kids. Trust chief executives on boards get treated the same.*
>
> System leader

Some quite distinct language was used to describe the way chief executives were held to account – variously 'poked in the ribs' (provider leader), 'hauled over the coals' (national leader), and 'rung by the [Secretary of State] or their officials, screaming blue murder' (system leader). We heard from a participant about a 'bullying culture' (national leader) at the national level, which these kinds of descriptions also reflect. It can be difficult to talk about such negative behaviours, often because individuals generally want to think the best of people. But treating staff in this way will undermine efforts to develop a more collaborative way of working and autonomy for leaders to make the best decisions for their local populations.

Additionally, leaders cannot do this work in a vacuum; working in a pressured system means they often do not have the 'headspace' for thinking about longer-term goals. And they need the right levels of support and autonomy to make the decisions that are right for their local context. Several interviewees highlighted the change in managerial approach at the height of the pandemic, and the hospital discharge support fund that supported people out of hospital with packages of care in the community, as an exemplar of what might happen with a more devolved system of decision-making.

> *I would say during the pandemic people said, 'oh, it was command and control'. Well I said, no, it wasn't, we had a huge amount of freedom to do the right thing, and we were trusted to get on and do the right thing without filling in any assurance templates. But we had to have the right governance arrangements in place and be held accountable, which is fine.*
>
> System leader

More engagement with staff and wider sector organisations, less NHS system direction

Ongoing engagement of staff in service transformation is fundamental to achieving this work, and a consistent feature of successful examples (NHS Confederation 2021; Kozlowska *et al* 2018; Mulla *et al* 2018; Hussain and Dornhorst 2017; Ham and Smith 2010; Ham *et al* 2008; Parker 2006; Singh 2006). Engaging with frontline staff and building a shared vision is the most effective way to deliver change (Baird *et al* 2022; Kozlowska *et al* 2018). The importance of enabling staff to take risks and shape services themselves, giving them a sense of control, was highlighted by several participants and in the literature (Parker 2006). One participant described how this trust and permission more generally for staff to 'do the right thing' was seen during the Covid-19 pandemic, but had not been sustained.

Participants also highlighted the benefits of engaging staff – for example, co-production that gives people a sense of control and enables them to contribute to solving the problem too. Bringing 'care closer to home' into discussions about place is another way to bring people together around a shared objective (Wistow *et al* 2009). We heard about the importance of involving staff at the start of service changes – in designing those changes as well as to share learning.

> *Which is why, when we subsequently were introducing quality improvement and a different way of doing, it ignited something in the organisation because suddenly people had a bit of permission to just get on with stuff that they saw in front of them that they wanted to change. And it started to unlock and get some movement.*
>
> National leader

Whenever staff are not consulted on major changes to services, this damages relationships and interdisciplinary working. One participant gave a local example where staff were not consulted on a major structural change in the early 2010s, when district nurses and health visitors were taken out of GP practices and moved to a central location, damaging local relationships. Research into the changes in mental health services found that the initial 'change champions' were unsympathetic to professional resistance rather than trying to understand its sources and work with them. Only later did it become apparent that some of

this resistance – particularly concerns about a reduction in acute hospital bed numbers – may have been well-founded (**Gilburt *et al* 2014**).

Engagement at provider level is also vital but not happening enough. Participants shared examples of acute hospital providers failing to engage with primary and community health and care service providers. One participant highlighted how, in a successful merger of acute hospital and community services, a lot of work was done with staff to understand the value of it so they could also articulate this. In particular, we heard that acute hospital buy-in is crucial for any change. We heard mixed views about whether this change should be led by hospitals or come from primary and community health and care – reflecting the different backgrounds of participants. We also heard about the need to engage more with pharmacies, because of their accessibility to the public and potential to work on prevention.

Several participants also highlighted the need for providers of health care to work with local authorities, citing the benefits when this happened – for example, being able to link a musculoskeletal (MSK) service and local leisure centres to provide more holistic and preventive care. But more often, they talked about how the 'hollowing out' of local government – the loss of funding from reduction of central government grants since 2010 and subsequent loss of experienced staff – meant it was harder for local authorities to be 'active players' in their local systems or respond before people hit crisis point.

One participant talked about a culture of expecting local authorities and VCSE sector services to support the NHS, rather than thinking about 'what can we do to help' (national leader). They highlighted the importance of framing conversations in terms of the benefits for all involved, rather than just talking about the benefit to local NHS services. Part of this is also about understanding that the NHS cannot solve everything by itself and needs to work in partnership. We also heard that local government was better at understanding and being accountable to local communities, and the NHS could learn from this if local government was valued and received more support from national stakeholders.

> *There's a real desire, enthusiasm and expertise out there that we don't always tap into.*
>
> Provider leader

Several participants highlighted the need for health services to engage more with the VCSE sector – and to recognise it as a valuable contributor to improving local people's health, in particular its strengths in terms of person-centred support. And often, VCSE organisations want to work with health and care services too. But as one participant pointed out, VCSE organisations also need to be clearer about what is on offer; it is very difficult for large statutory organisations to keep track of what is often a lot of small and sometimes temporary organisations. VCSE sector leaders can address this by building their relationships with people in relevant statutory roles to mutually develop understanding of how the different organisations work.

More engagement with people and communities, less service-driven approaches

When it is done well – that is, going beyond one-way broadcasting of information and instead moving towards authentic involvement – engagement can promote buy-in and support for change across the health and care system. However, there are complexities involved in engaging with such a wide range of stakeholders.

There was consistent evidence of the importance of meaningful and effective public engagement both from our participants and the literature (Simpson *et al* 2022; Hussain and Dornhorst 2017; Monitor 2015; Edwards 2014). Evidence shows that as the context of care changes, public opinion may shift. If more people experience challenges with caring for loved ones, this will increase exposure to the issues and understanding of what might need to change to improve that care. For example, research by Bottery *et al* (2018) pointed to an increased understanding of social care compared with the previous decade.

Research shows that the public mostly do want to receive care closer to home, except in emergencies; they do understand end-of-life care; they do want resources focused on prevention (Buzelli *et al* 2022); and they do have increasing expectations of the quality of care they receive (Tallack 2023). The Netherlands was cited as a good example of where public engagement had been carried out before any changes were made to existing health and care systems to enable people to understand what was happening and why.

> *The Netherlands did a lot of work with the public to understand why hospitals were bad places, they would save your life, but you ought to get out of there as quickly as*

> *you could… [They] did a very good piece of work really working with the public to understand, this wasn't about saving money.*
> Provider leader

We also heard that NHS communications teams can play a key role in terms of influencing the public narrative – that is, helping people to understand the issues and what changes might mean for them. However, a few participants also shared examples where national NHS communications had focused on acute hospital stories and opportunities to the exclusion of those in other settings – for example, an article promoting roles in nursing that did not mention primary care.

Deliberative work – where people learn about and discuss a topic together before being asked for their views on it – also shows that public opinion need not be static. Bottery *et al* (2018) highlighted the ability of members of the public to engage in deliberation about social care reform. Similarly, we heard about how a deliberative event discussing care closer to home ended with a majority in favour of this, even if it meant local hospital reconfiguration. Virtual wards were another important example of how framing and supporting people to understand service change was showing positive impacts. In particular, we heard that when described as 'monitoring your own health in your home using technology, rather than going to hospital' (patient leader), people were much more likely to view it as a positive thing. Wellings and Thorstensen-Woll (2022) developed a guide for ICSs and partners to listen and learn from people and communities, setting out some practical suggestions for how to go about this.

Engaging with people about their own care is also key to changing the focus of the health and care system. We heard from leaders of patient representative groups and people who use health and care services involved in this project about the importance of an asset-based model rather than a deficit model (supporting a person with what they can do, not just focusing on what they cannot do, and what the health and care system needs to do). Whereas from the health and care perspective the system is very visible, from an individual's perspective it might be a very small interaction among a much wider context of informal social and individual resources (Hughes *et al* 2022). The interviews we conducted and the literature both reinforced the fact that people feel they have more of an equal partnership with staff when being cared for at home compared with in hospital (*see also* Drennan *et al* 2005).

It is also important to remember that 'home' does not have the same meaning for everyone (Pearson *et al* 2015). In the current economic climate, increasing numbers of people are living in poor-quality accommodation (**Halliday 2023**) and unable to heat their homes or power basic appliances (**Butler 2023**). In this context, home may not be the most appropriate place to receive care. While this speaks to the need for a much wider approach than we can address in this piece of work, at a basic level it is important for health and care professionals to understand what an appropriate care environment would be for a particular individual, and to do this in conjunction with the people using their health and care services, rather than simply making assumptions (Pearson *et al* 2015).

A clear focus on implementation

A coherent approach to implementation will be absolutely critical if the rebalancing of services towards primary and community health and care is to be achieved.

More focus on operational integration, less on organisational integration

Often, the response to improving integration is to create bigger single organisations. There was almost total agreement across the participants in our research that a restructuring of the current system was not necessary. A 2009 report found that care closer to home was not necessarily better developed in areas where there was formal integration, but rather if there was operational integration – for example, good teamworking and information-sharing (**Wistow *et al* 2009**).

The experience of the Covid-19 pandemic – for example, in the roll-out of the vaccination programme – showed that at local level, organisations could come together and work together without structural reorganisation (**Timmins and Baird 2022**). More broadly, we heard that where local systems had made strides forward, this was often a case of leaders coming together without boundaries and then working out funding and structures later:

> *I've always been a big advocate of try and sort the problem out that you've got and focus on that together, then worry about the structures later. Because if you start with the structures you'll have a fight about who's in charge… We've gone miles because of that approach.*
>
> National leader

Organisational stability is important in supporting the development of relationships, and there is clear evidence that frequent changes to organisations hinder service improvements and create 'bureaucratic paralysis' (Parker 2006).

Rather than structural change, the answer lies in promoting better operational integration at team level, focusing on multidisciplinary teams working together. One innovation that providers should consider is the creation of dedicated integration roles at local level that are able to navigate across boundaries. Integrator roles have been shown to improve interdisciplinary working (Kozlowska *et al* 2018), relationships (Irani *et al* 2007) and care design (Parker 2006). These roles facilitate not only multidisciplinary teamworking but also inter-organisational dynamics, ensuring that organisational budgets and contracts do not prevent staff from meeting the holistic needs of people using health and care services.

> *The system feels like people are just really keen to palm you off and say 'this isn't our role', like, 'this is that role, this is that role, oh, that's their department, that's their budget'.*
>
> Patient leader

Differing thresholds for accessing and providing care between different sectors and organisations add to the barriers to collaboration. It is no wonder that it can be difficult to build neighbourhood teams, as one interviewee commented: 'it was hard, people were from multiple employers with different incentives, brought together as a team' (practitioner leader).

Allowing staff to use resources across organisational boundaries will mean that financial and clinical risk can be managed based on what is best for the person, rather than based on organisational boundaries. This entails delegation of budgets well below place level. Trusting the local workforce to provide care based around the person–practitioner relationship rather than rigid organisational protocols will lead to more effective and efficient use of resources.

This increasing focus on working fluidly across boundaries will also require continued change in the regulatory regime to assess the performance of local systems of care rather than individual organisations. The Care Quality Commission (CQC) is developing guidance on how to measure and assess integrated care, and this will also need to be supported by ICSs developing patient experience

data about whole pathways of care rather than for individual organisations, as is currently the case (Wellings 2019).

The tendency towards large scale in organisations, particularly community health services, can make it more difficult to manage local complexity, and to reflect the needs of natural geographies and communities. When one trust provides community NHS services for 50 or more primary care networks (PCNs), work to develop integrated neighbourhood teams around PCN footprints may be much more difficult.

More focus on local, less on system and national

Implementing this shift in focus to primary and community health and care services will need to be rooted in neighbourhoods and communities:

> *As care closer to home has been increasingly understood to include wellbeing and inequalities in health and place, it should be dealt with as a cross cutting and cross sectoral issue rather than the exclusive province of social care and health. The implementation of care closer to home could be reinforced if it is seen as a key component of the local 'story of place' and, therefore, a shared objective for all partners including politicians and the public.*
>
> Wistow *et al* 2009, p 9

The current tendency towards scale, among health care providers in particular, also risks losing focus on neighbourhoods and communities. Managing complex needs when many agencies are involved is easier in small geographies where relationships can be developed within the combined workforce. This facilitates building from the bottom up (Bramwell *et al* 2014) by valuing local community depth rather than organisational width. It is also important for these local geographies to be recognised by local people (Edwards 2014). People's understanding of neighbourhoods is often quite different from the health and care system's view, seeing neighbourhoods as just a few streets. In ICS terms, this is likely to be at the larger neighbourhood and smaller place level, or for local authorities, more akin to the district and borough where there are examples of successful co-location of integrated care teams (Tiratelli and Naylor 2023).

3 Conclusion

The failure to grow and invest in primary and community health and care services despite the often-avowed intention to do so must rank as one of the most significant and long-running failures of policy and implementation in the NHS and social care over the past 30 years. There have been failures at multiple levels, particularly due to factors rooted in institutional and organisational culture, which have combined to frustrate progress. People are now paying the price for this in terms of gaps in services for patients and the public, with failures all-too-evident in severe staff shortages and queues of ambulances outside hospitals. It is still not clear that the lessons have been learnt from these failures, or that the policy, leadership and focus of the NHS is any more ready to make the promised shifts in care than they have been over the past 30 years.

The changes required to shift the focus to primary and community health and care services are multiple, interconnected, layered and difficult; they will take time and require a willingness to implement (Kozlowska *et al* 2018). Although we have identified some specific actions in our research – for example, changes to training or to financial and incentive systems – these will not be enough on their own. It is not sufficient to selectively implement a few changes; the shift that is required is wholesale, which helps to explain why it has not been achieved thus far.

If governments, health and care system leaders and practitioners are serious about moving to a system that is centred on the community rather than hospitals, then there needs to be a renewed shift in focus across leadership, organisational culture and implementation. Although this may seem like an impossible task, as one provider leader commented:

> *Nothing is impossible. If we wanted to make it work, you're not telling me that the combined expertise, drive, passion and enthusiasm and experience of folks in the public sector in the UK couldn't solve this problem. Of course they could.*
>
> Provider leader

Annex 1: Methods

This research was conducted between May and December 2023. We took a broad approach, aiming to gather an overview of what had happened over the past three decades and ideas on solutions or 'ways forward' based on our main research question:

> *There is a long-held, often-stated vision of services that provide proactive, co-ordinated, personalised and responsive care closer to where people live, moving care away from hospitals and with an increasing focus on individual and local community assets:*
>
> - *Why, despite this shared vision, has it not been achieved?*
> - *What are the structural, political, financial, cultural and other barriers that have prevented it?*
> - *How might these be overcome?*

We used several research methods, engaging widely with people from across the health and care system. The perspectives of people who use health and care services were a key part of this work, and we ensured that they were included in the advisory group, interviews and workshops. However, because of the small sample size (*see* below), when using illustrative quotes in the text, we have not distinguished between health and care professionals and people who use health and care services.

Literature review

We conducted a review of available literature related to debates and attempts to move care 'closer to home'. The research team identified a series of questions to help focus the literature search, exploring the structural, political, financial and cultural barriers that have prevented that vision being achieved.

Various electronic databases were used, including The King's Fund databases, Emcare and Social Policy and Practice, using search terms derived from our list of questions. Our search covered the period from 1995 to the present day, and

was primarily focused on the United Kingdom (with an exception made for any international examples relating to moving care closer to home, as well as studies of how England performs in comparison with other countries).

The search returned 195 results, which the research team then reviewed by abstract and ranked by priority, to select papers to read in full. A total of 84 items ranked 'high priority' or 'very high priority' were included for full review, and key findings and themes that related to the research questions were summarised to contextualise and enhance the research.

Stakeholder interviews

We completed 24 semi-structured interviews with 26 individuals in our three-month fieldwork period, from June to August 2023. The purpose of these interviews was to understand in more detail why the vision of care closer to home had not been achieved, and what might make the difference in future.

We undertook purposive sampling aiming to target a diverse range of stakeholder perspectives from different roles in the health and care system. We created a list of 10 roles, and aimed to interview a maximum of three people in each category (30 interviews in total) who had worked in health and/or care over the past three decades, and those with lived experience of using health and care services:

- politicians
- civil servants
- clinicians
- finance and regulation
- international perspective
- national bodies
- lived experience of using health and care services
- private sector (social care and pharmacy)
- system leaders
- voluntary sector.

For the purposes of the report, and to preserve anonymity, we identify quotes as being from system leaders, national leaders (including civil servants, politicians, and those from other national arm's length bodies), provider leaders (including NHS, private sector, social care and voluntary, community and social enterprise (VCSE) sector providers), practitioner leaders (including medical, nursing, therapy and social work professionals) and patient leaders.

We recruited stakeholders through our existing networks and also snowballing from successful contacts. Although we did not manage to interview everyone on our list during the fieldwork, we did begin to achieve data saturation towards the end, with no new themes or topics emerging in latter interviews.

We developed our interview topic guide based on our overarching research question. The open-ended questions enabled broad discussions at the start of the interviews, with prompt questions and in-depth discussions as the interviews progressed. The interviews were recorded and transcribed. A descriptive approach was used to analyse the transcripts using MAXQDA software. The research team identified key points highlighted by the interviewees and these were summarised and grouped wherever the same or related points came up.

Online workshops

We undertook online workshops with around 40 stakeholders (from within and beyond The King's Fund, including members of our advisory group) to explore and test initial findings under four themes. We chose themes that we felt would be of most use to explore further: finance, workforce, data, and public and patient opinion. For each workshop, we prepared a short briefing with our initial findings and some emerging questions, and asked participants to help us answer these and challenge any assumptions or inaccuracies. These workshops helped to refine our thinking and focus on these four topics.

Quantitative data analysis

The quantitative data analysis draws on a range of publicly available datasets, mainly from NHS England. Data on finances and funding has been sourced from publicly available accounts, including the Department of Health and Social Care annual accounts (Department of Health and Social Care 2023), NHS provider

accounts (NHS England 2023a and 2022b) and NHS cost collection data (NHS England 2022a). Workforce data has mainly been sourced from NHS workforce datasets (NHS Digital 2024b) and vacancy datasets (NHS Digital 2023c). Analysis of activity has a range of data sources, including the Community Services Data Set (CSDS) (NHS Digital 2023a) and the community services waiting list dataset (NHS Digital 2024a).

Most of the datasets available have a limited time series, and therefore trends over time are often only based on 5–10-year timeframes. Where possible, comparisons have been made to the most recent data available. In some cases, particularly in the financial accounting data, the most recent data available is only up to the 2021/22 financial year.

In most cases, the additional non-recurrent funding that was allocated to the Covid-19 pandemic has been excluded from figures. This is so that long-term trends are not skewed by the additional funding allocated in 2020/21 and 2021/22. Where prices have been adjusted to real terms, they have been adjusted to 2021/22 prices using the HM Treasury GDP deflator from March 2023 (HM Treasury 2024).

Validation

We used two main routes to review our work and validate our findings – an external advisory group and The King's Fund General Advisory Council.

We used The King's Fund General Advisory Council as part of our scoping work (as a group with cross-sector membership, they were able to advise and challenge us through a variety of different lenses). We also presented initial findings to the General Advisory Council, and their rigorous feedback informed how we approached developing our findings.

We convened an external advisory group, using a similar framework to that of our interview sample and including several people with lived experience of using health and care services, to advise on our approach to the work. Some group members also attended our online workshops to provide support and challenge. We also met with them online on two occasions: first, in the scoping stage, to guide our approach to the research; and second, with our overall draft findings, to help us decide how to frame our messages and disseminate the work.

Annex 2: Policy history

The ambition to deliver more and better health services in the community, closer to home, is not new. In this section, we highlight some of the policies that have aimed to achieve this, building on previous work (**Charles *et al* 2018**).

1948 Community health services are the responsibility of the public health arm of local authorities.

1962 The Hospital Plan emphasises the need to expand services in the community.

1963 *Health and welfare: the development of community care* highlights wide variation in local authority community services provision.

1963 *The Gillie report (The field of work of the family doctor)* emphasises the importance of GPs being supported by a wider primary care team and the need for closer integration between GPs and other services.

1965 The report of the Seebohm Committee calls for better co-ordination between social care and other health and welfare services in the community.

1968 The Health Services and Public Health Act enables local authorities to expand adult social care provision and allows them to commission voluntary organisations to provide social care for older people.

1974 Responsibility for community health services is transferred to the NHS to tackle poor co-ordination between community and hospital services. Area health authorities are created, and joint planning and consultative committees are formed with local authorities.

1977 Joint finance – earmarked health services money intended to be spent on joint projects with the local authority – was introduced, alongside joint care planning teams.

1987 The *Promoting better health* White Paper proposes the development of primary care teams, with GPs working alongside health visitors, community nurses and other professionals.

1988/89 *The Griffiths report* and the White Paper *Caring for people: community care in the next decade and beyond* highlight fragmentation of community services and emphasise the need for collaboration between the NHS and local government. They set out proposals for local authorities to plan and manage social care, but not necessarily to be direct providers. This leads to significant growth in independent sector provision.

1989 Following the publication of the White Paper *Working for patients*, community services increasingly establish themselves as standalone NHS community trusts.

1990 The NHS and Community Care Act gives responsibility for organising community care to local authorities, emphasising support for people in their own home where possible.

1997 The White Paper *The new NHS: modern, dependable* describes the aim to deliver more integrated health and social care services in the community. Primary care trusts (PCTs) are established and most community health services are effectively merged into PCTs.

2000 *The NHS plan: a plan for investment, a plan for reform* proposes redesigning primary and community services, creating 500 new 'one-stop' primary care centres, and investment in intermediate care. The option to form care trusts is introduced, but relatively few are set up.

2006 *Our health, our care, our say: a new direction for community services* sets out a wide-reaching strategy to shift care out of hospitals and expand community provision, including by shifting resources. A variety of measures are introduced to promote integration, improve access and strengthen prevention.

2008 *High quality care for all: NHS next stage review* recommends the separation of PCT commissioner and provider functions, and PCTs are directed to consider a range of organisational models for community services.

2008 *NHS next stage review: our vision for primary and community care* encourages greater pooling of resources by PCTs and local authorities, and the development of new tariffs to encourage more provision of health care in the community.

2009 *Transforming community services: enabling new patterns of provision* requires PCTs to come up with a strategy for community services and to identify future organisational models separating their commissioning and provider functions.

2012 The Health and Social Care Act transfers responsibility for commissioning community health services from PCTs to newly formed clinical commissioning groups (CCGs). Some services – for example, public health and health visiting – are transferred to local authorities.

2014 The *NHS five year forward view* sets out a vision of how NHS services need to change to meet the future needs of the population, arguing for greater emphasis on prevention, integration, and putting patients and communities in control of their health. It calls for a shift in investment from acute hospital care to primary and community services, and outlines several 'new care models'.

2015 NHS organisations are directed to come together with local partners to develop sustainability and transformation plans (STPs) – five-year plans for health and care services in their area.

2016 The 44 STPs are published. All include proposals to redesign primary care and community services, and it is often expected that this will reduce demand for hospital care.

2019 The NHS Long Term Plan sets the vision for integrated, place-based care and commits to each strategic transformation partnership becoming an integrated care system (ICS) to support greater collaboration across the NHS and local authorities.

2021 The White Paper *People at the heart of care: adult social care* sets out a 10-year vision for adult social care to improve the level of care and support in communities.

2022 The Health and Care Act creates two new statutory bodies: the integrated care board (ICB) and the integrated care partnership (ICP), with responsibility for developing a health and care strategy for the ICS.

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