Integrating health and social care

A comparison of policy and progress across the four countries of the UK

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Acknowledgements

Contents

Key points

- Each of the UK's four countries has a long-standing goal to integrate health and social care services, which has been a principle of successive major reforms by each government since devolution. Despite this, we found there is limited evidence that policies in any of the UK countries have made a difference to patients, or to how well services are integrated.

- Across countries, there has been a persistent mismatch between some of the stated objectives of integration, and what better collaboration between health and social care can meaningfully achieve. Improving quality, efficiency, and population health have all been aims of integration, but are rooted in complex problems heavily constrained by broader government policies that influence the distribution of resources across health and social care, and ability for people to lead independent, healthy lives.

- The data to measure integration effectively are limited, particularly for Northern Ireland, and variable targets have been used. However, across England, Scotland and Wales, we found that satisfaction with care and support has been stable or falling, improvements in delayed transfers of care have not been sustained and the age-adjusted rate of emergency admissions to hospital has not fallen.

- That over 20 years of reforms has translated into only modest improvements for patients across each country raises important questions about what integrated care can realistically deliver, how it's been implemented and at what scale, and why countries with significant contextual differences in their approach appear to have similar results. Policy-makers bringing forward new reforms need to learn from the fact that similar earlier initiatives often failed to demonstrate success. Without significant changes to the broader context in terms of system incentives and the distribution of resources, the latest reforms are unlikely to yield more favourable results.

- Part of the explanation may be each country's reliance on structural and organisational levers to drive integration, including joint governance arrangements and pooled finances. While these have been applied and

designed differently across countries, they are similar in that they focus on how services are planned and financed in hopes that more coordinated service delivery will naturally follow. Yet in practice, they have been insufficient to address the culture, norms, systems and processes needed to support integrated ways of working and fundamentally change the way services operate.

- One of the key differences in how levers have been applied is the degree of statutory power or legal accountability integrated partnerships hold in each country. England is an outlier in that integrated care systems are not legal entities – though proposals have been introduced that would place them on statutory footing. The Scottish, Welsh and Northern Irish experience make clear, however, that having a legal duty to collaborate does not in of itself lead to effective collaboration, which also relies on having sufficient resources, incentives, regulatory and outcomes frameworks – and consistent leadership and cultures across health and social care.

- Policymakers have also sought to reduce costs and improve efficiency by pooling health and social care budgets. There is limited evidence from any country that integrating finances have led to cost savings – especially in the short-term – although they may help improve patient outcomes and experience. Nor have they encouraged more money to flow to social care and prevention – in fact real terms funding to social care fell over the decade in all countries, except Northern Ireland.

- Another common challenge has been the tendency for successive governments to establish new integrated partnerships without due regard for existing relationships and structures, and how different bodies will connect or evolve from what preceded it. This has made it difficult to measure impact over time, and for partnerships to fully embed and support change over the long-term. No matter how sensible the rationale for organisational restructuring may be, it takes time and headspace to deliver and can divert attention away from the core aim of improving service delivery for people.

- While performance management levers and incentives have been applied in some cases, such as for integration authorities in Scotland, these have had limited impact. The performance management environment has been dominated by organisational-level targets, particularly those driving activity and performance in acute hospital settings.

1 Introduction

The integration of health and social care (see Box 1) has been a long-standing policy priority in each country of the UK, driven by the needs of a population that is living longer and with more long-term health conditions.

The aims of integrated policy reform in the UK have largely been consistent: that is, to improve patient and service user experience, quality, and efficiency by reducing fragmentation within and across services and improving population health and wellbeing – an ever-more pressing concern for a population whose needs are increasingly complex and inequalities stark.

The different paths taken across the UK to achieve these aims create a natural experiment from which to draw insight and learning on how integration can work most effectively, and how different approaches to implementation or emphasis within policy may have contributed to different outcomes for communities.

However, the extent to which integration has been achieved in any of the UK countries – and what benefit, if any, that has had for patients – is open for debate.[1]

In the context of all UK countries continuing to develop their integration policy, in this report we examine the evidence for the impact of integration across the four countries, and compare the policies and approaches each country has trialled to deliver their goals. The report builds on important earlier research by The King's Fund[2], Nuffield Trust and the Health Foundation[3] comparing the health systems of the four UK countries, and our recent work on social care across the UK.[4]

In the remainder of this chapter, we briefly set out our approach. In Chapter 2, we describe the context and challenges for health and social care systems in the UK. In Chapter 3, we track how the integration of health and social care has evolved in each country of the UK, and the current structures in place. In Chapter 4, we present trends in measures of the impact of integration. In Chapter 5, we examine how the countries have tried to achieve change, and why this might have been difficult. Finally, in Chapter 6, we consider themes and lessons that are relevant to all four of the UK countries.

Box 1: What is meant by integration?

In this report our focus is on the integration of health and social care services, although we recognise that integration within the NHS, for example between primary and secondary care, has also been an important policy area in the last 20 years.

The term 'integration' has so many definitions that it can feel it means everything and nothing all at once. Indeed, even 11 years ago, one review of the literature found nearly 175 definitions and concepts related to care integration.[5]

Integrated care policy in the UK has tended to focus on the following types of integration to better link up NHS and social care services, each of which involves different processes and occurs at different system levels:

- **Organisational integration** focuses on coordinating structures, governance systems and relationships across organisations. It can include organisational mergers, or developing contractual or cooperative arrangements such as an umbrella organisation, pooled budgets or joint commissioning (that is, the strategic planning and purchasing of health and social care services).
- **Administrative or functional integration** involves the alignment of non-clinical support and back-office functions, for example accounting mechanisms or sharing data and information systems across organisations.
- **Service integration** involves the coordination of different services at the organisational level, such as through multidisciplinary teams, single referral structures or single clinical assessment processes.
- **Clinical integration** involves the coordination of care into a single or coherent process, either within or across professions. This could involve developing shared guidelines or protocols across boundaries of care.

Source: Adapted from Fulop N et al. (2005) Building Integrated Care: Lessons from the UK and elsewhere. London: NHS Confederation

Research and evaluations have suggested that culture, norms and processes between the services play an important role in facilitating all of these.

Service integration and clinical integration, which directly affect patients, have typically been the ultimate goal of recent reforms, at least in theory. However, policy-makers have usually relied on national policy levers and approaches to make integration happen on a large scale. In the reforms we consider in this report, the direct focus has been on organisations, funding and governance.

Approach

To understand the policy goals of, and approaches to, integrated care reform across the four countries of the UK, we mapped key policy documents and legislation in each country published since devolution in 1999 (see timelines for key reforms), and thematically analysed them according to the types of integration described in Box 1. We also reviewed available evaluations, consultations and audits of integrated care initiatives to identify the key policy and practice levers used to drive collaboration, and how these compare across the UK. We identified four main policy levers and approaches that each country of the UK has relied on to make integration happen at scale:

- joint governance and organisational structures

- integrated finances

- transformation funding and support to develop and scale integrated services models

- performance management and accountability

We recognise that policy does not dictate how services are delivered at the front line, and that there is a range of interventions happening locally and within organisations at the patient level to better integrate service delivery. However, these are often relatively disconnected from national policy, and as such are outside the scope of this report – except insofar as they reflect national initiatives. We have also not examined developments to better integrate services within the NHS (for example, between acute, community, mental health and primary care services). A separate briefing, due to be published in 2022, addresses digital health policy across the four countries of the UK, which also has implications for integration and the ability of services to share data and develop collaborative approaches.

Within the scope of this project we have not asked: 'Which approach to integrated care works best and why?' – given the large body of evidence which shows that the complexity of change and the contextual differences involved make this a futile question to answer unequivocally.[6,7,8,9] Rather, we try to

draw out where there are similarities and differences in approach, and where clear patterns have emerged in how integration has been implemented, so that all UK countries can learn from different historical attempts to integrate care.

Alongside our comparison of policies, we have identified measures of integration related to the policy goals of each country of the UK. There are no UK-wide agreed measures of integration, so the indicators we have analysed are derived from our thematic analysis of the outcomes each UK country was aiming to achieve, previous Nuffield Trust work across the four countries[10] and a practical appraisal of the data available across the countries. We grouped our chosen indicators into three domains: satisfaction and experience; inequalities and population health; and system efficiency.

As we discuss later in the report (see section on performance management on page 60), there is a gap between the stated aims of integration, which have been broad and ambitious (for example, improving population health outcomes, tackling inequalities in health and enhancing productivity, in a recent NHS England and NHS Improvement consultation on the purpose of integrated care systems[11]), and the performance management approach that has operated in practice. The measures we have been able to compare do not cover all the areas we hoped to include – for example, we could not identify measures of the quality of integrated care to compare across the four countries.

Where data are available, we have compared the trends across countries, using data going back to at least 2010 where possible. This covers a period during which integration has been a feature of the health and social care policy landscape. We have not been able to pinpoint measures relating to specific initiatives. Due to differences in data collection and definition between the UK countries, we do not have comparable measures for all policy goals. We had to exclude some measures where data were only available for one country, and in some cases we have compared change against each country's baseline, if definitional differences mean that absolute measures are not directly comparable. More details on the indicators considered and used, and data caveats, are included in Appendix A.

2 The health and social care system challenge across the four UK countries

Population health

While UK countries share many of the same challenges, it is important to note that, relative to its neighbours, England has a healthier population, as indicated by higher life expectancy (see Table 1). England compares favourably with the other UK countries on measures of illness and mortality for most major diseases, including cancer and cardiovascular disease (although there is wide variation across regions and by population demographic within England).[12]

Increasing levels of chronic health conditions have added to the burden of illness in the UK, and result in more complex health and care needs, which integrated services are intended to meet. More than a quarter of adults now experience more than one long-term health condition,[13] with this proportion set to double between 2015 and 2035.[14] People with long-term conditions use more health services, and in deprived areas experience multiple long-term conditions 10–15 years earlier than those in wealthier neighbourhoods.[15] Living with long-term conditions has a significant impact on individuals' lives, and their wider social circumstances also impact on the support they need from health and social care services.[16]

Table 1: UK health and social care systems overview: population health

	England	Wales	Scotland	Northern Ireland
Population (million)	56.5	3.2	5.5	1.9
Life expectancy at birth in years – males, in 2017–19	80	79	77	79
Life expectancy at birth in years – females, in 2017–19	83	82	81	83

Sources: Office for National Statistics, 'National life tables – life expectancy in the UK, www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2018to2020#life- expectancy-at-birth-in-uk-countries; Office for National Statistics, 'Overview of the UK population', www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/ populationestimates/articles/overviewoftheukpopulation/january2021.

All four countries have experienced long-term improvements in health, although improvements in life expectancy have slowed down (or in some cases reversed) in the last decade (see Figure 1). The reasons for this are complex and hotly debated.[17] Reasons identified for England[18] include increasing numbers of older people vulnerable to flu and other winter risks, slowing improvements in mortality from heart disease and stroke, widening health inequalities and rising death rates from accidental poisoning among younger adults (mainly due to drug misuse).

The relative positions of the countries have changed little, suggesting that drivers of population health have changed in a similar way in each country over this period. These wider trends in health are an important part of the context for considering whether integrated care policies over the last two decades have had a measurable impact.

Figure 1: Trend in age-standardised mortality rate, UK countries, 1999–2019
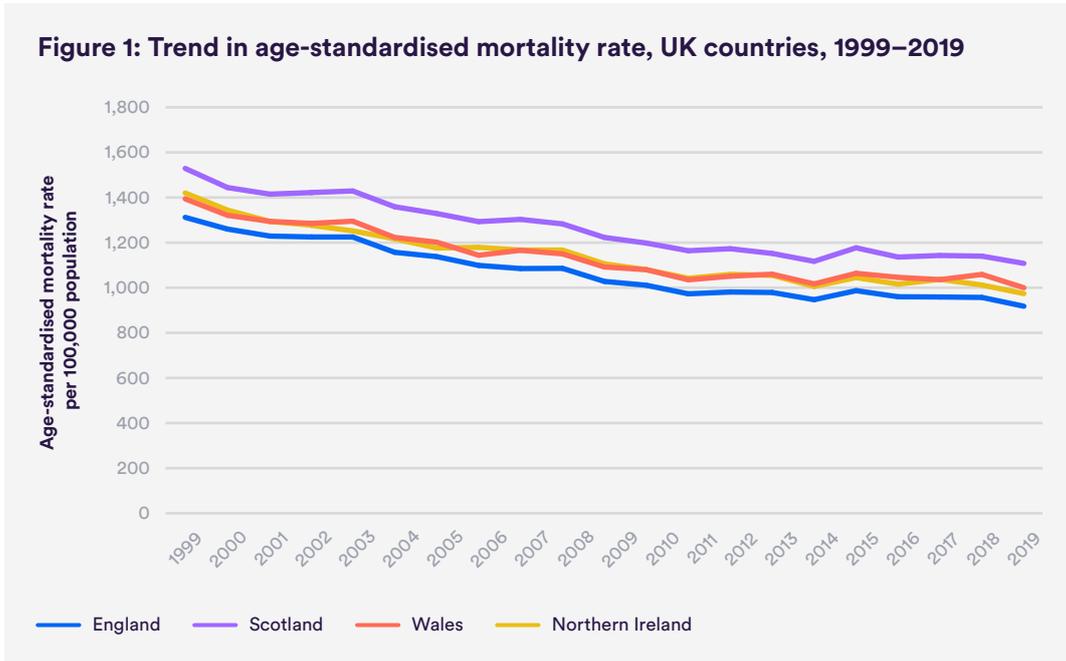
Source: Nuffield Trust analysis of Office for National Statistics, 'Vital statistics in the UK: births, deaths and marriages'. www.ons.gov.uk/peoplepopulationandcommunity/ populationandmigration/populationestimates/datasets/ vitalstatisticspopulationandhealthreferencetables.

Funding

England spends least per head of the population on both health and, more starkly, social care (see Table 2), although spends the highest proportion of public spending on health.
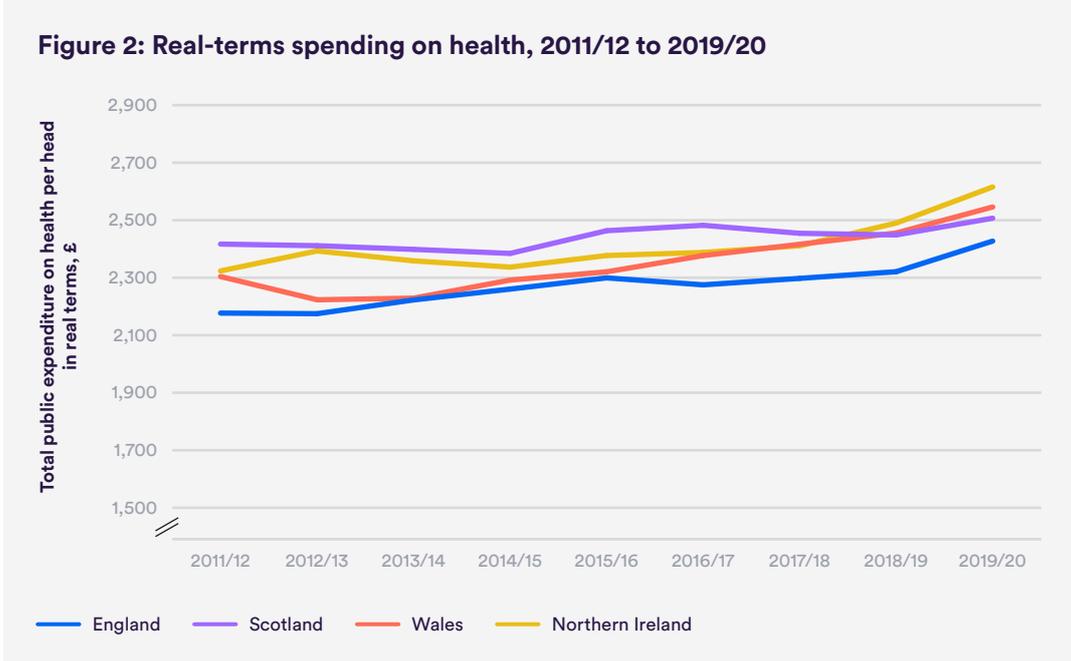
Table 2: UK health and social care systems overview

|	England	Wales	Scotland	Northern Ireland
Spending per person on health services, 2019/20, £	2,427	2,546	2,507	2,616
Spending on health services as a share of total public spending	25%	23%	22%	22%
Social care* spending per person, 2019/20, £	318	416	476	521
Spending on social care as a share of total public spending	3.3%	3.8%	4.1%	4.3%

Note: * Social care spending combines old-age and sickness and disability spending

Sources: Nuffield Trust analysis of HM Treasury, 'Country and regional analysis', www.gov.uk/government/collections/country-and-regional-analysis; Office for National Statistics, 'Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland', www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland; Office for National Statistics, 'GDP data tables' – GDP deflators at 2019/20 market prices, www.ons.gov.uk/economy/grossdomesticproductgdp/datasets/uksecondestimateofgdpdatatables.

Real-terms spending on health services increased in all four countries over the decade (see Figure 2), although growth was strongest in Wales, and slowest in Scotland. In contrast, real-terms spending on social care fell in England and was stagnant in Scotland and Wales, but did increase in Northern Ireland (see Figure 3). Health and care services have not kept pace with demand. Population growth, demographic change, increasing morbidity and the advances in medical technology have contributed to an increase in health care needs. The gap between resources and demand is reflected in deteriorating performance on measures of quality such as waiting times for treatment.[19]

Figure 2: Real-terms spending on health, 2011/12 to 2019/20

Sources: As in Table 2

Figure 3: Real-terms spending on social care, 2011/12 to 2019/20
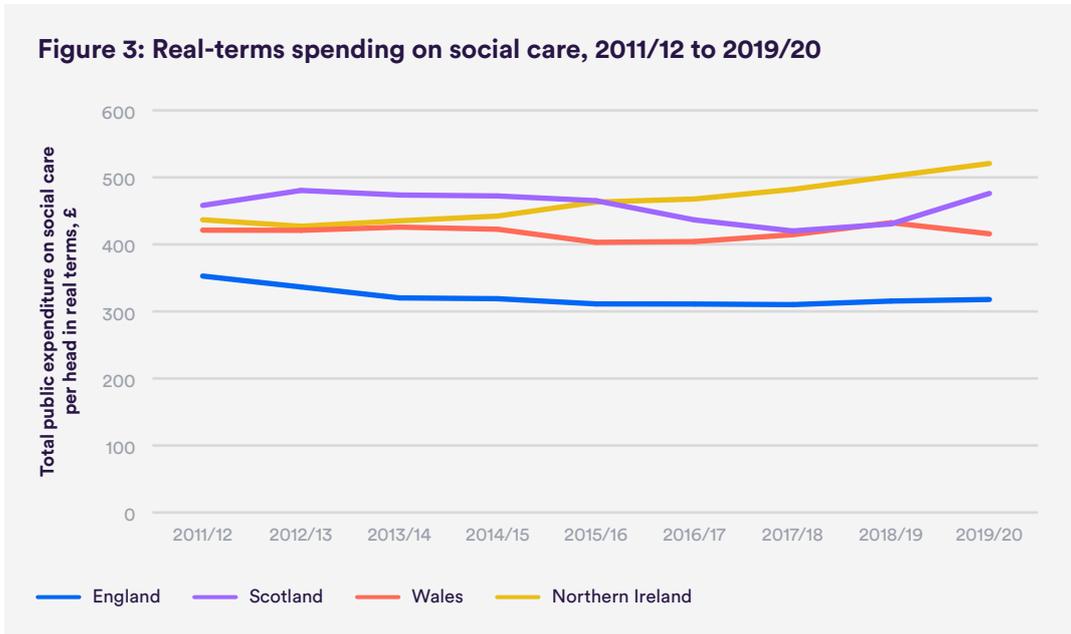
Sources: As in Table 2

Each country has, to some extent, different funding and financing systems for health and social care. Each of the four National Health Services is funded primarily from general taxation gathered at a UK level, distributed to the Scottish, Welsh and Northern Irish governments through the 'Barnett formula', based on current and historical population size.[20] The Scottish and Welsh governments also set some devolved taxes such as stamp duty, and have limited powers to raise or lower income tax bands with revenue going to them. This gives them an autonomous ability to increase the size of funds available. In September 2021, the UK government announced a 'Health and Care Levy', which would weakly hypothecate an effective increase in National Insurance to pay for health and social care; how and with what limitations this will be passed to Scotland, Wales and Northern Ireland remains to be determined.[21]

Finances of health care

Within each UK country, the bulk of the revenue budget (covering day-to-day costs such as staff and medicines) is allocated to different areas based on formulae which aim to estimate the health needs and cost of local populations. Each country has one formula allocating the budget for hospital, mental health and community services, and another for general practitioners – reflecting their historic roles as contractors.

In Scotland and Wales, allocated health funding for each area of the country goes directly to the relevant health board that is operationally responsible for delivering these services. In England it goes to clinical commissioning groups, which do not deliver care but purchase services from NHS trusts and the independent sector through a marketised system. Northern Ireland nominally has a comparable system of commissioning boards and trusts in five regions, but the policy intention is to abolish the commissioner layer and move to allocate funds directly to trusts.[22]

In England, before the Covid-19 pandemic, funding for acute hospitals was allocated through a 'tariff', which paid trusts and private providers a rate for each episode of care they provided, calculated based on the historic costs of the relevant treatment as a national average. But the pandemic saw a shift towards block funding, where trusts and other providers were given a pot of money based on total historic costs without regard to the exact amount of care they provided. NHS England and NHS Improvement are now working

towards a 'blended' system, combining elements of tariff and block funding.[23] Community and mental health trusts have always been funded using block contracts.

Finances of social care

In England, Scotland and Wales, local authorities hold a statutory responsibility for social care. Local authority budgets are derived from a combination of a central grant and local revenue raising such as Council Tax. Local revenue-raising powers are devolved and so vary across the three countries – for example, only England allows extra 'precept' increases in the tax rate specifically to pay for care. In Northern Ireland, health and social care trusts organise social care,[24] which is delivered by a mix of private (for-profit and not-for-profit), public and voluntary providers.

Conversely to health care, each of the four UK countries uses some form of needs and means testing to determine state-funded access to social care (see Table 3).[25] Anyone with means (income, savings and property) above the upper threshold is required to meet most of the costs of their care (although what must be paid for varies across the four countries; see below). Those with means between the upper and lower thresholds have their care partly supported by the state, and those with means below the lower threshold can access full funding, depending on their level of need.

The devolved administrations also have other formal additional support for citizens based on eligible need. In Scotland, personal and nursing care is free for all people assessed as having an eligible social care need, although the scope is tightly defined, and does not include hotel costs, for example. In Wales, there is a cap on non-residential care costs, currently set at £100 a week.[26] In Northern Ireland, home care is usually free.[27] Across the four countries, some people have the costs of their health and associated social care needs fully met by the NHS (or equivalent). This is subject to a strict eligibility assessment to assess whether the person has a complex long-term health condition. However, tensions between NHS and local authority services have restricted widespread access. Differences in the level of provision, and disputes over the boundary of rationing, have been raised both in England[28] and in Scotland, where reforms have now limited this to hospital inpatients.[29]

Table 3: Thresholds for means-tested social care

Means test	England	Wales	Scotland	Northern Ireland
Upper threshold	£23,250*	£50,000 (residential care)	£28,750 (non-personal/ nursing care)	£23,250 (non-domiciliary care)
Lower threshold	£14,250**	£24,000 (non-residential care)	£18,000 (non-personal/ nursing care)	£14,250 (non-domiciliary care)

Note:
* This is increasing to £100,000, with a cap on care costs set at £86,000.[30]
** Increasing to £20,000.[31]

Sources: Oung C, Schlepper N and Curry N (2020) 'Offer and eligibility: who can access state-funded adult care and what are people entitled to?', www.nuffieldtrust.org.uk/news-item/offer-and-eligibility-who-can-access-state-funded-adult-care-and-what-are-people-entitled-to#key-points; and annual adjustment figures for Scotland – see: Advice on Care (no date) 'Paying for care in Scotland', www.adviceoncare.co.uk/paying-for-care-in-scotland.html#:~:text=Means%20Testing,all%20of%20their%20accommodation%20costs.

3　How has the integration of health and social care evolved in each country?

Health has been a devolved function in the UK since 1999. Successive governments in each country of the UK have pursued a range of approaches to achieve closer integration of health and social care services.

The timeline for integration policies shows a history of often-overlapping policies, targeting different aspects of integration. Here we summarise key events and distinguishing features of the policies in each UK country.

England

England has maintained separate systems for commissioning and delivering health and social care, with different geographical boundaries, budgets, legal frameworks and cultures across the NHS and local authorities. Unlike in Wales and Scotland, there is also a 'purchaser/provider' split in English health services, meaning that commissioners contract with NHS organisations or independent providers to deliver services rather than run them directly. Adult social care in England is also more predominantly provided by the private and voluntary sectors than in the other countries, with councils generally purchasing care rather than actually providing it.

Several national policy initiatives over the past 30 years have aimed to bridge the gap between health and social care, and improve coordination. Significant focus has been placed on changing the institutional architecture or organisational boundaries to drive change. Some initiatives sought to

formally merge health and social care delivery and commissioning into one organisation, such as care trusts in the early 2000s (although they were only ever small in scale, covering 10 of about 150 health and social care footprints across the country).

More commonly, approaches have focused on facilitating integrated commissioning, strategic planning and aligning resources across sectors through joint boards, forums and committees. These have come together formally over time through various planning bodies, including health and wellbeing boards, sustainability and transformation partnerships and now integrated care systems – 42 area partnerships between NHS commissioners, providers, local government and other local partners. Within integrated care systems, which typically range from a population of one to two million, some integration activities are planned to be undertaken at a smaller 'place' level – though how that is defined varies across locality.

Each of these bodies has attempted to facilitate greater collaborative working across sectors and join up local services, but has had limited formal powers for doing so. Furthermore, since 2012, these bodies have had to operate in a legislative framework that emphasised competition rather than collaboration across providers. In 2018, the National Audit Office found that sustainability and transformation partnerships varied considerably in how much progress had been made in working jointly.[32] To overcome these legal barriers and accelerate integrated ways of working, the Health and Care Bill currently before parliament would remove competitive tendering requirements to make it easier for the NHS and local partners to agree local purchasing decisions.

This legislation also formalises the powers of integrated care systems, introducing two statutory bodies. First, integrated care boards will directly hold local budgets and oversee health care delivery and changes. They will be comprised of NHS organisations responsible for commissioning health care services, representatives of provider trusts, general practitioners (GPs) and councils. Second, integrated care partnerships will bring together these groups with local authorities, the NHS and broader partners to align ambitions and develop a common integrated care strategy for their local areas. These proposals would also place duties on the NHS and local government to collaborate and mandate that NHS hospitals consider the health and social care system's financial objectives.

See Figure 4 for a diagrammatic illustration of funding and accountability in the health and social care system in England.

Figure 4: Funding and accountability in the health and social care system in England
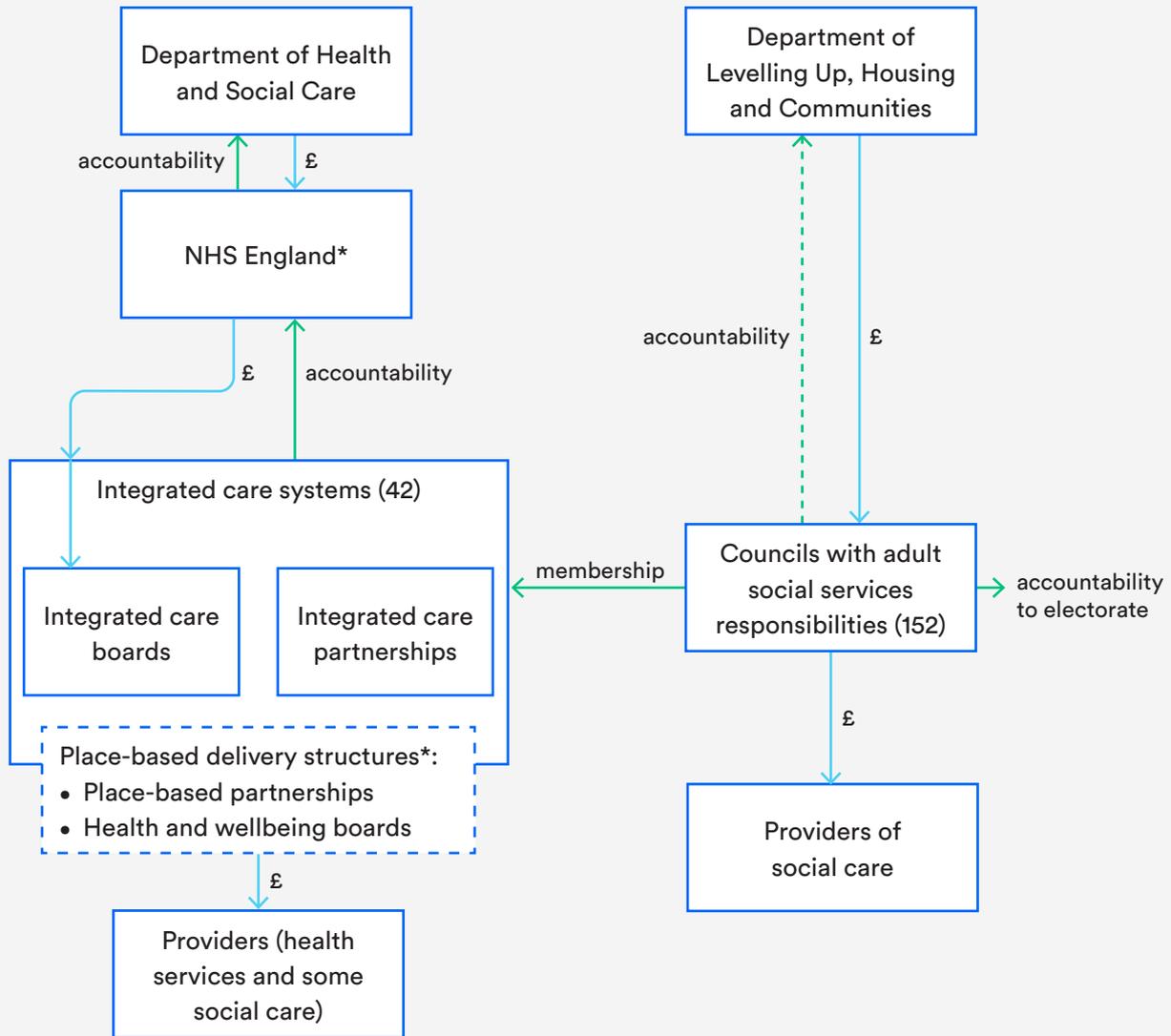
*to be established pending legislative approval. NHS England and NHS Improvement to be formally merged into a single legal organisation.

→ Resources and direction   → Other flows

Wales

Since devolution, Wales has emphasised collaboration and moved away from the purchaser/provider split seen in England much earlier.[33] Legislation in 2002 mandated that 22 local health boards work together with their coterminous local authorities to develop a joint health, social care and wellbeing strategy in each area.

A reorganisation of services in 2009 eliminated the purchaser/provider split, and consolidated local health boards into seven bodies, which had a legal duty to work collaboratively with local authorities to plan services. The Social Services and Well-being (Wales) Act 2014 formalised these partnerships into seven regional partnership boards (RPBs) to accelerate integration across health and social care. These are coterminous with each local health board and local authority boundaries (with some covering multiple local authorities). The government expected RPBs to undertake population health assessments, implement joint area plans (co-developed by local authorities and local health boards) and pool budgets in key service areas.[34] The Act also gave local authorities the ability to delegate a number of their social care functions to local health boards, and vice versa. Commissioning responsibilities for health and social care remain split between local health boards and local authorities, but joint and collaborative commissioning arrangements are in place for certain services, and are required at a minimum for care for older people and children with complex needs and long-term conditions, people with learning disabilities, carers and family support services. (Despite being required, they are not always applied in practice.)

A parliamentary review board in 2018 found that despite these efforts, Welsh health and social care services had a way to go in delivering collaborative, seamless care and lacked a clarity of vision of what care needed to look like to meet the needs of the population.[35]

In January 2021, the Welsh government proposed changes to strengthen RPBs, and therefore the degree of regional integrated planning, by establishing RPBs as legal entities.[36] RPBs would then be able to directly employ staff, hold budgets and directly undertake joint commissioning where local partners agree. When it comes to social care services, local health boards

and local authorities would remain the primary commissioning bodies, so the proposals also call for a new national framework that sets common commissioning practices and fee methodologies across local authorities and local health boards.

Beyond the delivery of health and social care services, local health boards and local authorities are also expected to work closely together and with broader public services to improve the wellbeing of communities through public service boards. Public service boards are statutory bodies established through the Well-being of Future Generations (Wales) Act 2015, which are tasked with conducting local assessments and setting local plans for how services will come together to support wellbeing, tackle poverty, improve health inequalities and promote sustainability.[37] There are currently 19 public service boards, coterminous with local authority boundaries.

See Figure 5 for a diagrammatic illustration of funding and accountability in the health and social care system in Wales.

Figure 5: Funding and accountability in the health and social care system in Wales
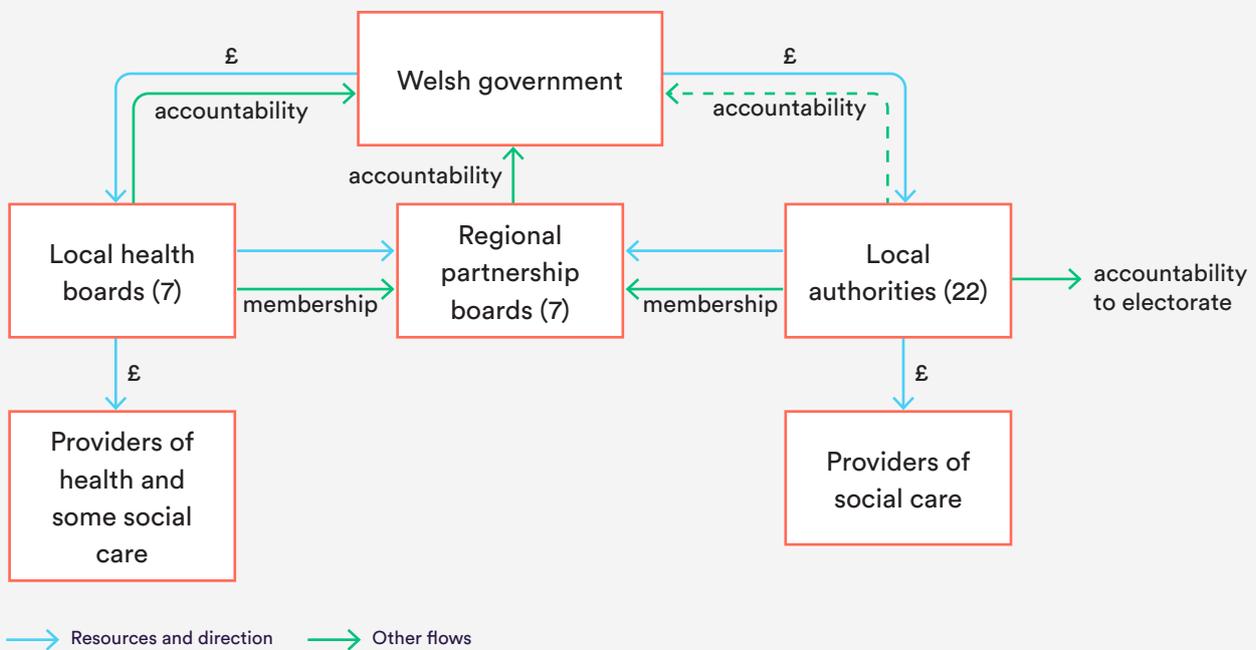
Scotland

There have been several attempts over the last 20 years to promote joint working between the Scottish NHS health boards and local authorities. Since 1999, Scotland has taken a 'Scottish approach' to integration and policy-making more broadly, and has attempted to have a single vision across government departments, with an ambition to reduce inequalities in access to health care and an increased emphasis on prevention.[38]

The Community Care and Health (Scotland) Act 2002 maintained separate statutory responsibilities for health boards and local authorities, but conferred power to transfer specific functions between them, and the power to create pooled budgets. This was followed by the NHS Reform (Scotland) Act 2004, which required health boards to create community health partnerships in an attempt to further develop integrated primary care, community health and social care services.

The Public Bodies (Joint Working) (Scotland Act) 2014 created 31 statutory health and social care partnerships ('integration authorities'). These integration authorities would commission health and social care services from health boards and local authorities.[39] Integration authorities hold responsibility over funds for urgent care, mental health care, community services and social care previously held separately by NHS boards and local authorities. They produce strategic integration plans and commission services in line with the plans. There are also 30 integration joint boards with jointly funded strategic plans between the NHS and local authorities; the Highland region has a different arrangement where the local NHS acts as the 'lead agency'.

It was hoped that integration authorities would deliver efficiency savings and improve the quality of health and social care, in line with the framework of national health and wellbeing outcomes published in 2015.[40] This has been the operating model since. However, a 2018 Audit Scotland report[41] and a 2019 ministerial progress review[42] both found significant challenges with progress to date, especially around measurement, variation and financial planning. The Ministerial Strategic Group set out a number of proposals[43] to alleviate these challenges; these are still underway.

The Scottish government is currently consulting on proposals for a National Care Service[44] following recommendations from the Independent Review for Adult Social Care.[45] These would see integration joint boards reformed into community health and social care boards – commissioning bodies funded directly by the Scottish government through a transparent allocation formula. The boards would hold statutory responsibility to oversee delivery of all community health and social care services. Community health and social care boards would also replace integration joint boards on community planning partnerships, which bring together the integration of wider services (including housing and criminal justice).

Figure 6 presents a diagrammatic illustration of funding and accountability in the health and social care system in Scotland.

Figure 6: Funding and accountability in the health and social care system in Scotland
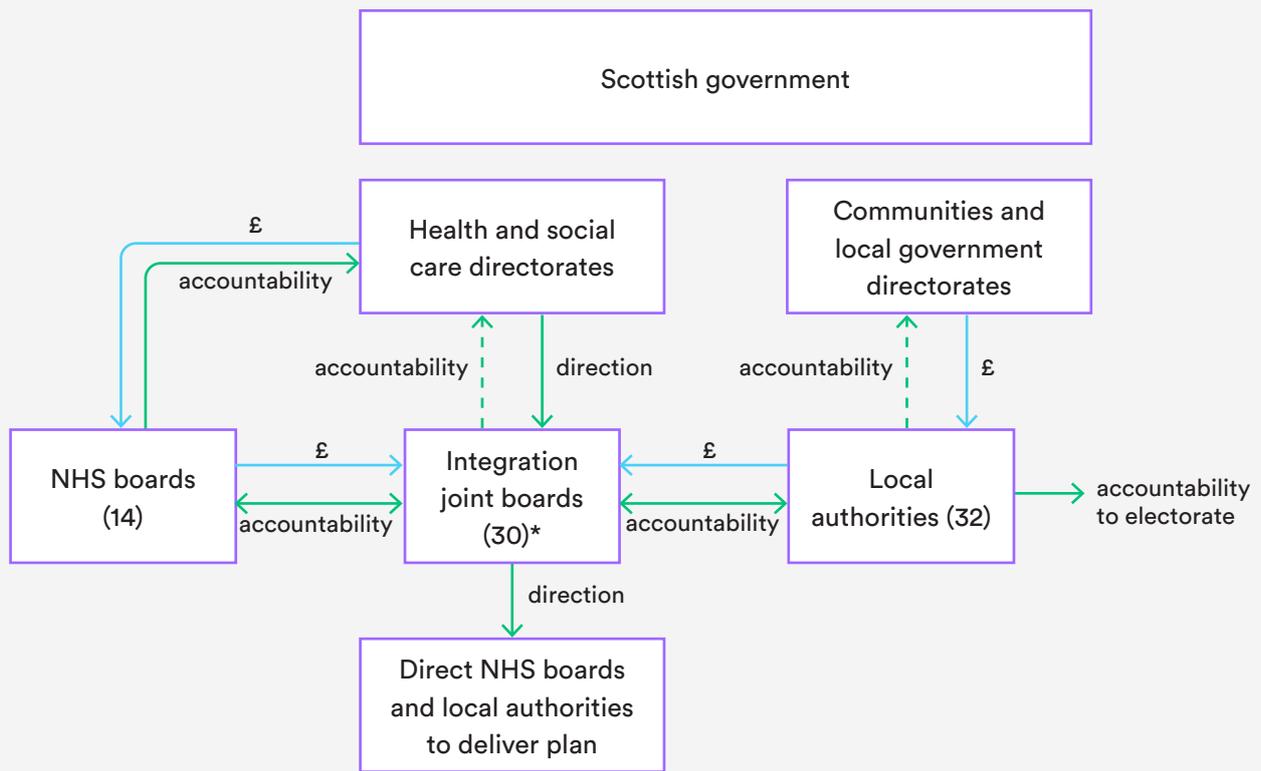
*NHS Highland operates a Lead Agency model

→ Resources and direction   → Other flows

Northern Ireland

Northern Ireland has had full structural integration since 1973 as a result of local government reorganisation.[46] The early 2000s marked a shift in policy strategy towards an inequalities and a population health approach, with similar approaches seen elsewhere in the UK with local health and wellbeing plans, coupled with a structural simplification in an attempt to reduce bureaucracy.

The Health and Social Care (Reform) Act (Northern Ireland) 2009 created one single Health and Social Care Board responsible for the commissioning and financial and performance management of five health and social care trusts (with five coterminous local commissioning groups). The Act placed a statutory duty on the Department of Health, Social Services and Public Safety (now the Department of Health) to promote integrated health and social care, and created a Public Health Agency to work alongside the Board on prevention issues.

The *Transforming Your Care review* in 2011 established 17 integrated care partnerships, led by general practitioners, focused on elderly care and long-term conditions but had limited focus on health and social care integration.[47] In 2016, the Department of Health commissioned *the Systems, not Structures* report, which recognised the challenges Northern Ireland had experienced to date with structural integration.[48] The report put forward recommendations to develop accountable care systems, which would consist of partnerships focused on care planning, and which would integrate by agreement rather than through structural reform. Although the 2017 *Health and Wellbeing 2026: Delivering together* policy strategy[49] drew upon a number of recommendations that the *Systems, not Structures* report made, accountable care systems have not come into practice. A further reform strategy in 2017, *Power to People*, focused on social care and outlined ambitions for collaborative care and single-point-of-contact multidisciplinary teams.[50]

Instability in government, with sustained periods without a power-sharing agreement (most recently between 2017 and 2020), and a reluctance to undertake politically difficult decisions, has delayed the implementation of these strategies.[51] However, the 2020 *New Decade, New Approach*

power-sharing agreement has, committed to delivering the health and social care reforms set out in the *Systems, not Structures, Delivering Together* and *Power to People* policy papers.[52]

The Department of Health consulted in 2021 on a Future Planning Model based on integrated care systems, with integration at multiple levels.[53] Proposed reforms will abolish the current Health and Social Care Board and replace it with a regional group providing oversight and producing a regional population health and wellbeing plan based on the strategic direction set by the ministry. Five area integrated partnership boards will be coterminous with the five health and social care trusts and will have mandatory representation from a wide variety of stakeholders, including from carers, service users and the voluntary sector. The new planning and delivery arrangements will be based on collaborative agreements and build on existing statutory structures – although there is a suggestion that some new partnerships may have a statutory underpinning.

Figure 7 presents a diagrammatic illustration of funding and accountability in the health and social care system in Northern Ireland.

Figure 7: Funding and accountability in the health and social care system in Northern Ireland
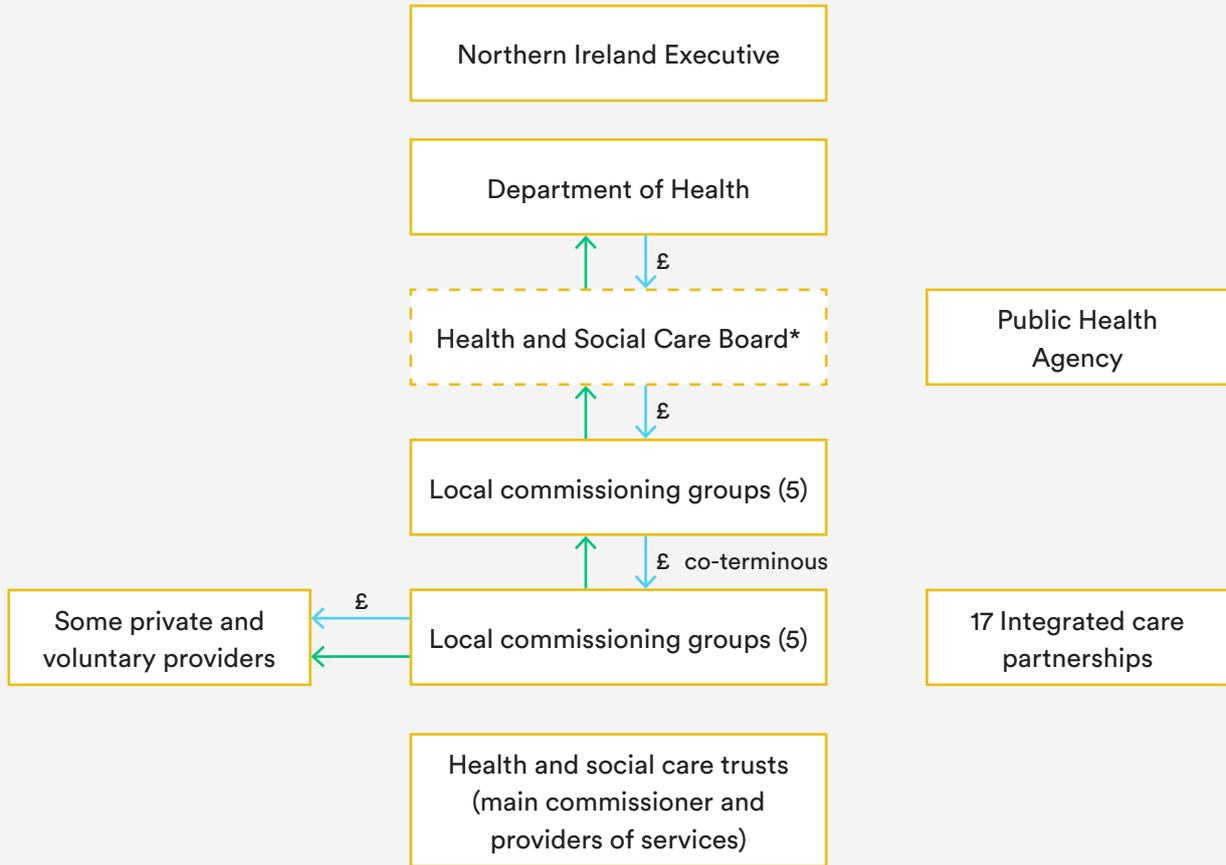
*To be abolished April 2022

→ Resources and direction   → Other flows

4 Have integration policies had a measurable impact?

Despite the limitations in terms of consistent measures and data sources, we identified 10 measures relevant to the four UK countries' goals for health and social care integration. They comprise one indicator of service user satisfaction (see Figure 8), four relating to inequalities and population health (see Figures 9–12) and five which track spending (see Figures 13 and 14) and system efficiency, including care delivery (see Figures 15–17). As noted above, in the absence of clear policy targets for integration, we identified measures linked to the stated goals of integration policies: improving population health and reducing inequalities, improving experience of care and increasing system efficiency, by reducing fragmentation in care and treating people at home and in community settings (see Appendix A).

Has there been improvement over time?

Overall, changes over the time period we examined were modest. The direction of change was variable, with few consistent patterns of improvement, either across countries for the same indicator or across indicators for individual countries.

The position deteriorated over time for England on satisfaction with social care, delayed transfers of care from hospital and emergency admissions. And while real-terms spending on health increased, spending on social care decreased. There were improvements in healthy life expectancy at age 65, but the gap between the most and least deprived areas increased for men. Mortality rates from treatable causes fell, and access to employment for people with a long-term health condition improved slightly. Length of hospital stay reduced over time.

For Scotland, satisfaction with social care and delayed transfers of care worsened over time, while there was no change in emergency admissions. Meanwhile, length of hospital stay decreased, and healthy life expectancy at age 65 improved for men. Inequality on this measure fluctuated, although inequality for men in Scotland was substantially greater than for their counterparts in England or Wales. Treatable mortality and access to employment for people with a long-term health condition improved. Spending on social care fluctuated but held at a similar level overall, while health spending increased the least across the four countries.

Emergency admission rates worsened in Wales, and there was no consistent change in delayed transfers of care or satisfaction with social care. Length of hospital stay decreased. Treatable mortality and healthy life expectancy at age 65 improved for men and women, although there was no consistent change in inequality in healthy life expectancy. Access to employment for people with a long-term health condition improved. Spending on health increased over the period while spending on social care fluctuated without changing overall.

The measures available for Northern Ireland were limited. Treatable mortality and access to employment for people with a long-term health condition both improved. Healthy life expectancy at age 65 fluctuated but was higher at the end than the start of the decade. Spending on both health and social care increased.

How do the countries compare?

Differences between the countries need to take account of the different starting points (Table 1), and in particular the better health of the population of England as a whole in comparison with the three other countries of the UK. Further, for some measures we were only able to look at relative change, because of differences in the definition of measures. These factors limit the comparisons we can make for patient experience and population health measures.

The most notable difference between the countries was on spending: England, which had the lowest health and social care spending in 2019/20 (see Table 2), experienced the biggest decline in social care spending, particularly between 2011/12 and 2013/14. Health spending in Scotland increased the least, although from a higher starting point. In addition, emergency admissions remained stable in Scotland, but increased in England and Wales.

Satisfaction and experience

Among people who have received services, satisfaction with social care services declined slightly in England, and more so in Scotland, particularly in 2019/20. It remained stable in Wales.

Figure 8: Satisfaction with social care services, 2013/14 to 2019/20
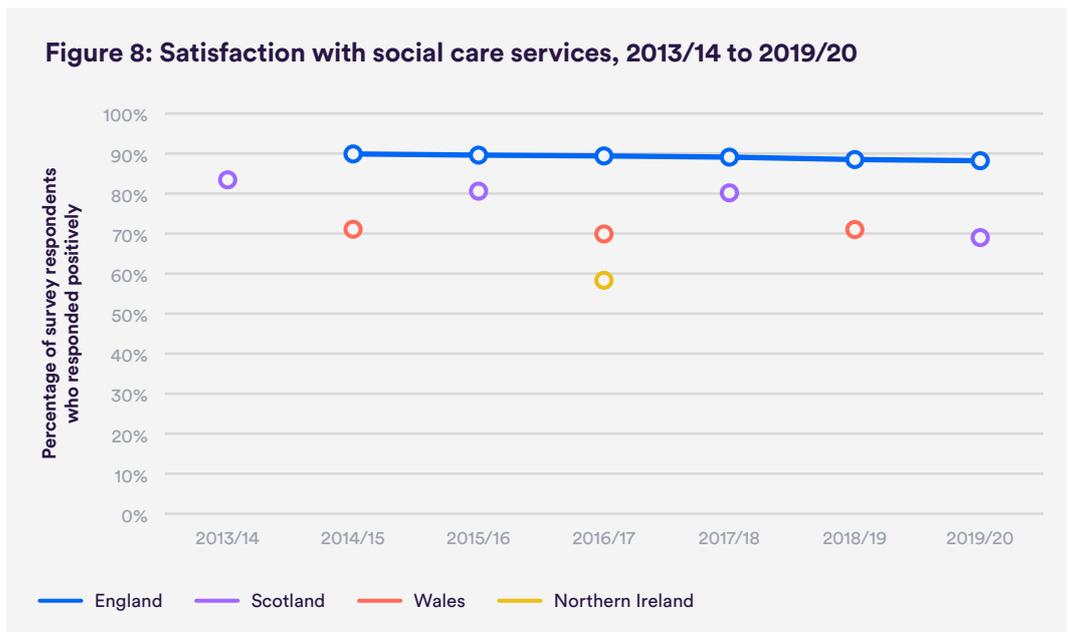
Notes:
- In England, respondents were asked: 'Overall, how satisfied or dissatisfied are you with the care and support services you receive?'
- In Scotland, respondents were asked: 'Overall, how would you rate your help, care or support services?' Data for 2019/20 were not comparable to previous years due to a change to the introductory text before the question.
- In Wales, respondents were asked: 'How would you rate the care and support services overall?'
- In Northern Ireland, respondents were asked: 'Thinking about all social care services, which include social work, domiciliary care and residential and nursing home care, overall, what is your view on the quality of these services?'

Sources: For England: NHS Digital, 'Personal Social Services Adult Social Care Survey', https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey. For Scotland: Scottish Government, 'Health and Care Experience Survey', www.gov.scot/collections/health-and-care-experience-survey. For Wales: 'National Survey for Wales', https://statswales.gov.wales/Catalogue/National-Survey-for-Wales. For Northern Ireland: Department of Health, 'Tables from the health survey Northern Ireland', www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland.

Inequalities and population health

One of the goals of integration policies has been improving population health, by preventing health problems escalating, reducing time spent living with illnesses, narrowing health inequalities and supporting people with long-term health conditions and complex needs. We identified four measures related to this goal. These measures will be impacted by wider social and economic factors which are determinants of health.

Mortality from treatable conditions

Treatable mortality, sometimes referred to as amenable mortality, measures the effectiveness of timely health care interventions, including secondary prevention and treatment. Across all countries this largely followed the same trend as overall mortality, with an earlier decline between 2001 and 2010 being followed by little change in the last decade (see Figure 9). The relative advantage of England in 2001 has reduced.

Figure 9: Mortality from treatable conditions, 2001–19
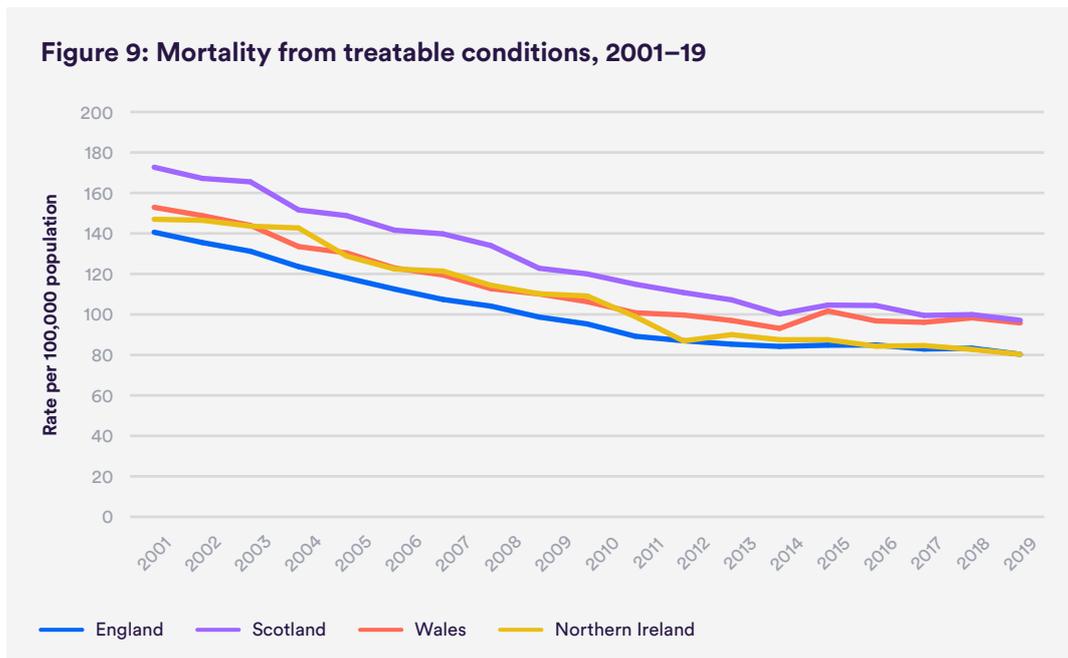
Source: Nuffield Trust analysis of Office for National Statistics, 'Avoidable mortality in the UK'. www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2019#treatable-mortality-in-clinical-commissioning-groups-ccgs-in-england-and-health-boards-in-wales

Healthy life expectancy at age 65

Healthy life expectancy at age 65 measures years lived in good health, based on current healthy life expectancies for people in each population. This measure of healthy life expectancy was selected as likely to be most sensitive to interventions to reduce the impact of long term health problems. It is slightly higher for women than men (see Figure 10). For men it was consistently highest in England, and there have been improvements in all countries over the decade. There have been smaller improvements over the decade for women.

Figure 10: Healthy life expectancy at age 65, 2009–11 to 2017–19
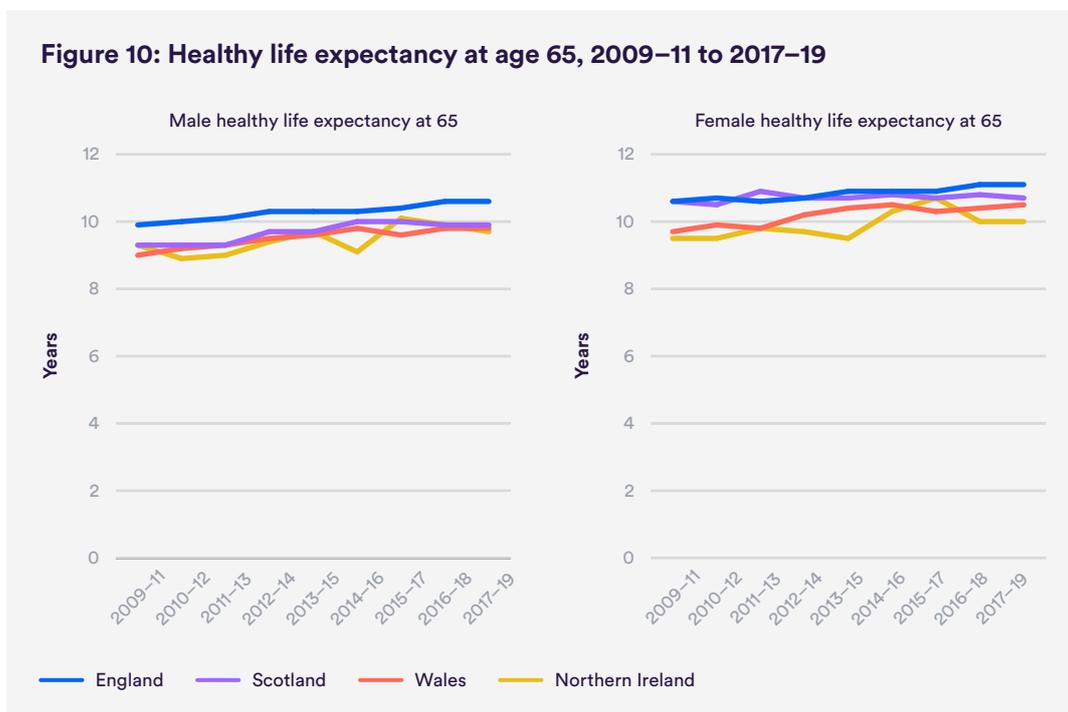
Source: Nuffield Trust analysis of Office for National Statistics, 'Health state life expectancies, UK'. www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2017to2019.

Inequalities in healthy life expectancy at age 65

This measure compares the healthy life expectancy at age 65 in the most and least deprived populations.

Healthy life expectancy at age 65 was twice as high in the most deprived as the least deprived areas in England and Wales, for men and women, and for women in Scotland. For men in Scotland it was three times higher in the most compared with the least deprived (see Figure 11). The inequality gap was not available for Northern Ireland.

**Figure 11: Inequality gap in healthy life expectancy at age 65, 2011–13 to 2017–19**
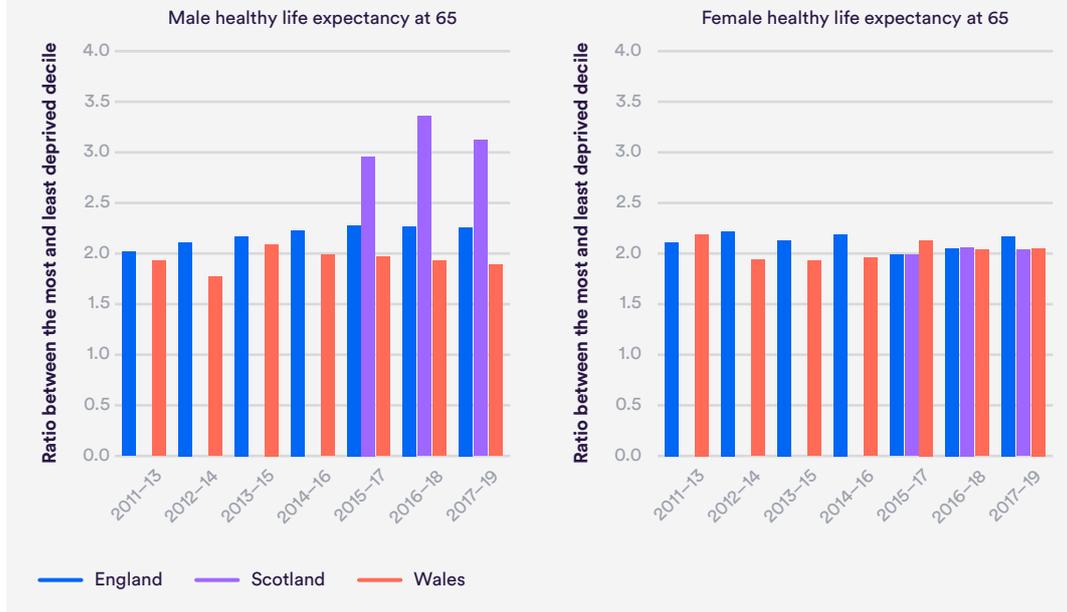
Note: To calculate the inequality gap, we divided healthy life expectancy in the least deprived decile by healthy life expectancy in the most deprived decile. A score of 1 would mean that healthy life expectancy is the same in the most and least deprived deciles.
Sources as Figure 10.

Access to employment for people with a long-term health conditions

Under a half of people with long-term health conditions were in employment at the end of the decade, but this proportion had steadily improved from 2013/14 (see Figure 12). The rate in Northern Ireland was much lower than in the other UK countries, at only a third. This indicator will be impacted by wider external factors, such as changes to labour market conditions.

Figure 12: Access to employment for people with a long-term health condition, 2013/14 to 2019/20
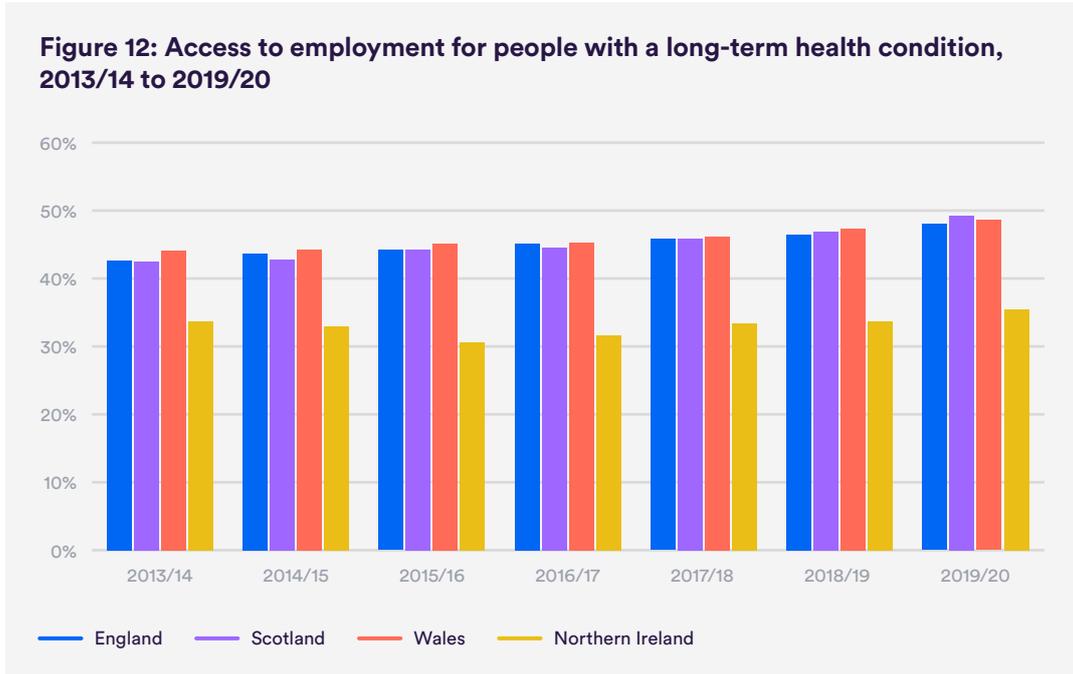
Source: Nuffield Trust analysis of Office for National Statistics, 'Labour market overview, UK'. www.ons.gov.uk/employmentandlabourmarket/peopleinwork/ employmentandemployeetypes/bulletins/uklabourmarket/january2021.

System efficiency

Integration policies have been partly aimed at shifting the delivery of care away from hospitals and to locations closer to home, and in doing so, using public funding more efficiently. In this subsection we consider process measures – such as rates of emergency admissions, length of hospital stay and delays in discharging patients from hospital – that have often been used to evaluate individual initiatives.

First we consider overall trends in real term spending on health and on social care. Trends in spending reflect decisions by policy makers and shed light on the relative priorities of each sector as well as the resources available to deliver services.

### Spending on health and social care
Change in real terms spending per head of population from 2011/12 to 2019/20 is shown for health (see Figure 13) and social care (Figure 14).

Health spending increased in all four countries, but increased the least in Scotland.
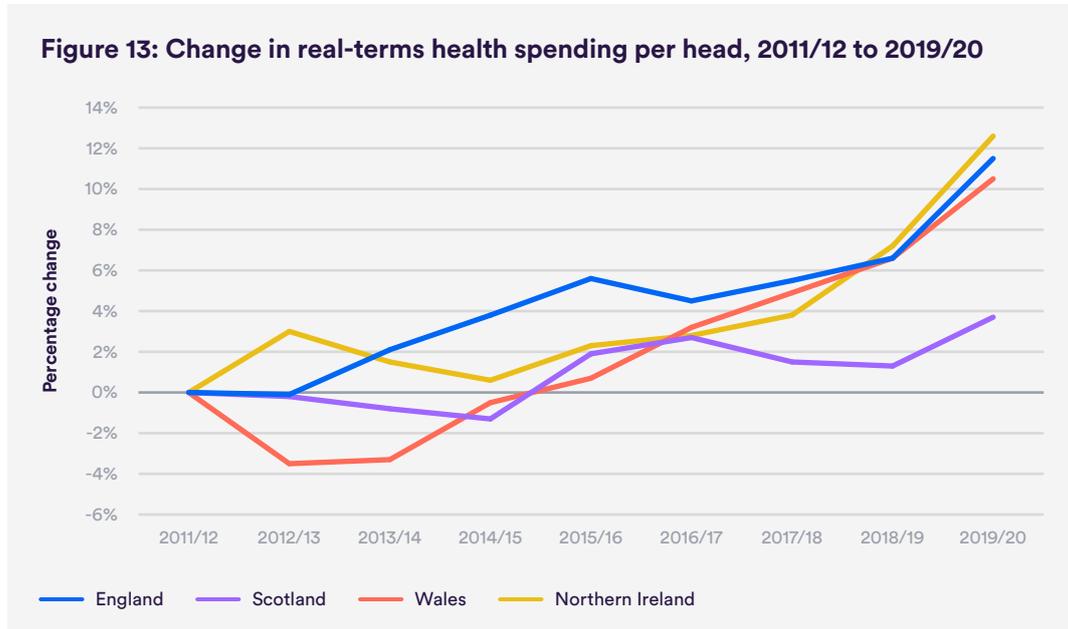
Figure 13: Change in real-terms health spending per head, 2011/12 to 2019/20

Sources: Nuffield Trust analysis of HM Treasury, 'Country and regional analysis'; Office for National Statistics, 'Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland'; Office for National Statistics, 'GDP data tables' – GDP deflators at 2019/20 market prices.

Social care spending declined in England from 2011/12 to 2017/18 and remains below the baseline level (see Figure 14). In contrast, social care spending in Northern Ireland increased over the period, although it should be noted that it is difficult to differentiate health and social care expenditure due to the integrated nature of budgets.

Figure 14: Change in real terms social care spending per head, 2011/12 to 2019/20
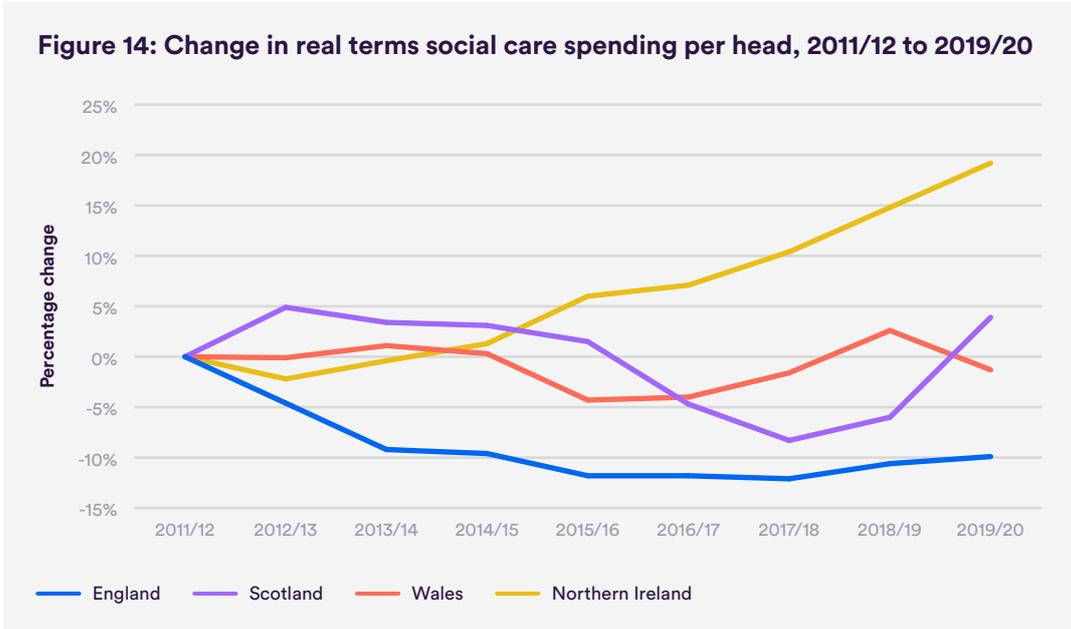

Note: Adult social care spending is defined as the sum of personal social services spending on sickness and disability and personal social services spending on old age.

Sources: Nuffield Trust analysis of HM Treasury, 'Country and regional analysis'; Office for National Statistics, 'Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland'; Office for National Statistics, 'GDP – data tables' – GDP deflators at 2019/20 market prices.

Emergency admissions

The rate of emergency admissions per 100,000 population remained stable in Scotland, but increased slightly in England and Wales (see Figure 15).

Figure 15: Age- and sex-standardised rates of emergency admissions, 2011/12 to 2019/20
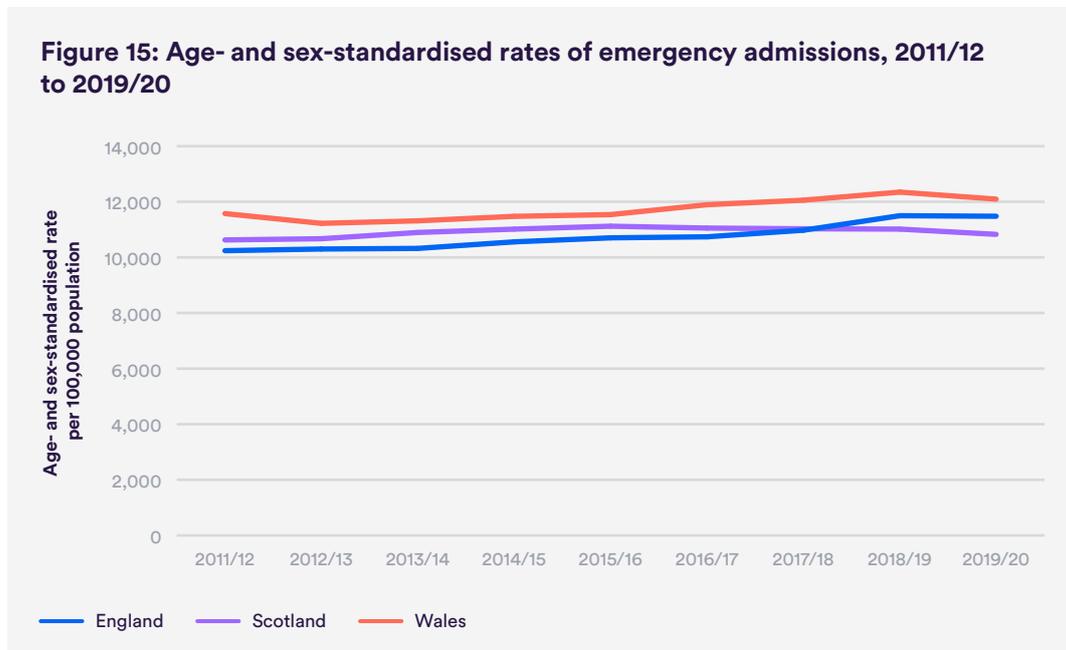
Sources: Nuffield Trust analysis of NHS Digital, 'Hospital episode statistics; Office for National Statistics, 'Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland'; Public Health Scotland, 'Acute hospital activity and NHS beds information'; Welsh Government, 'Emergency admissions in NHS hospitals in Wales by sex and age group, April 2011 to March 2019'.

Average length of hospital stay

Length of stay in hospital declined over the decade in all countries of the UK, but the drop was larger and more consistent in England and Scotland (see Figure 16). This length of stay measure includes planned as well as unplanned care, so will also reflect shifts towards more day case surgery and treatments.

Figure 16: Average length of hospital stay, 2010/11 to 2019/20
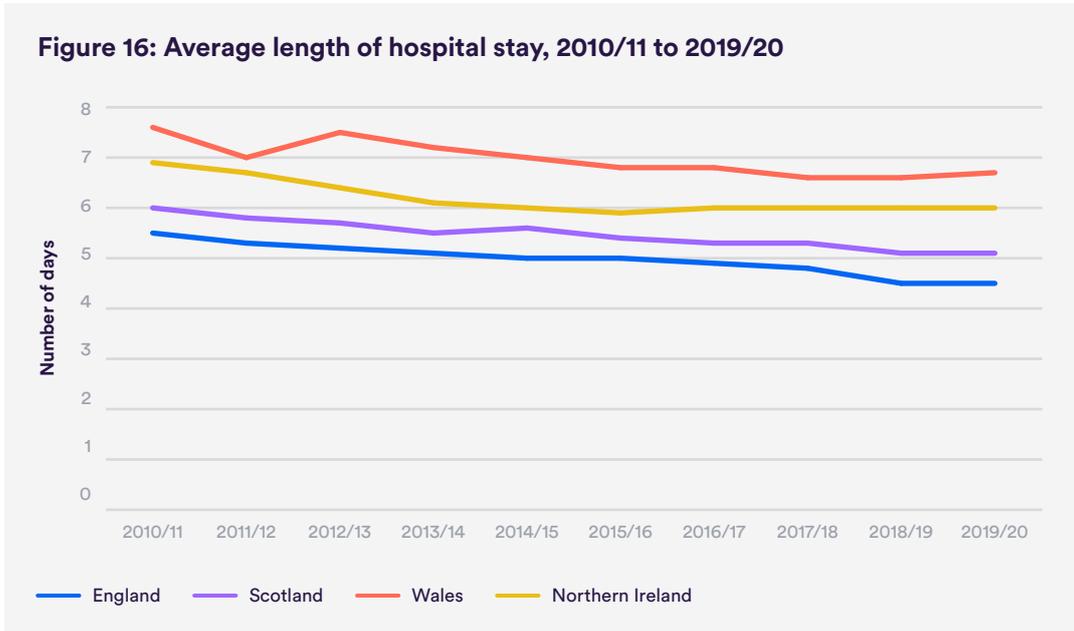
Sources: Nuffield Trust analysis of Department of Health, Northern Ireland, 'Hospital statistics: inpatient and day case activity'; NHS Digital, 'Hospital admitted patient care activity'; NHS Wales Informatics Service, 'Annual PEDW data tables'; Public Health Scotland, 'Acute hospital activity and NHS beds information.

Delayed transfers of care from hospital

Delayed transfers of care from hospital were higher in England and Scotland in 2019 – the last time for which data were reported – than in 2012, but they were at a similar rate in Wales (see Figure 17). Rates in England increased rapidly in 2015 and 2016, and although they had fallen by 2019, they were still the highest relative to the baseline.

Figure 17: Delayed transfers of care, 2012–2019
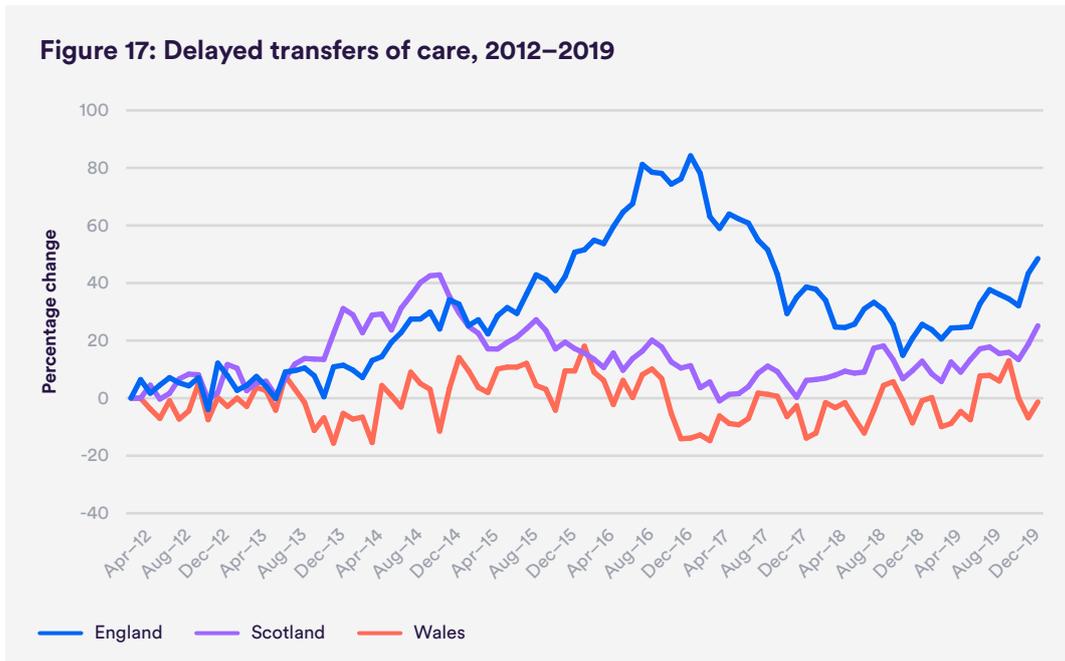
Notes:
- In England, data are published as the average number of people delayed each day.
- In Scotland, data measure delayed discharges from acute settings.
- In Wales, data are published as the number of people experiencing a delayed transfer of care each month.

Sources: For England: NHS Digital, 'Delayed transfers of care'. For Scotland: Public Health Scotland, 'Delayed discharges'. For Wales: StatsWales, 'Delayed transfers of care'.

What can the data tell us?

National integration initiatives have largely sought to achieve change in health outcomes related to quality, population health, patient experience and system efficiency. But as we have seen in this chapter, the outcomes do not seem to show any conclusive evidence that these initiatives are having their desired impact. The link between policy decisions, for example on spending, can be weak – although in the case of Wales, maintaining relatively higher spending on social care may be reflected in consistent satisfaction with social care and a steady level of delayed transfers of care.

There are many difficulties in measuring the impact of local integration initiatives,[54,55] and we found the same picture with this national analysis. We excluded more measures than we were able to include, because of data quality issues in terms of missing data, or because the measures were not sufficiently relevant to the goals of integration.

Further, while integration policies have been implemented over the last 20 years, for many of the indicators we looked at, data have only been published, or are only comparable, over the last five to 10 years. It may be the case that the impact of integration policies on these measures takes longer to be seen. Additionally, we only looked at national-level data. Regional data within each nation may show more variation and change over time.

Paradoxically, the majority of available data cover hospital services, with a lack of data from social care[56] and community services. Improved data from primary and community services are needed in all four UK countries, as well as collaboration across the UK to ensure health and social care data are easy to access, provide clarity on the methods used and improve comparability. This will allow us to learn what works from different policies implemented across the UK. The lack of comparable data is a long-standing issue, which policy-makers seem to have made little progress in addressing.[57]

Some of the indicators we selected for this research – for example, healthy life expectancy at age 65, inequalities in healthy life expectancy at age 65, and access to employment for people living with a chronic health condition – are driven by broader social, economic and environmental factors that determine an individual's life circumstances and their ability to lead a healthy life. It is unlikely that they would ever be improved by better coordination and integration of services on their own.[58] We chose to include these indicators, however, as consistent aims of integration policies have been to prevent ill health, keep people living healthily and independently for longer, and narrow the health inequalities gap (see Appendix A). This reflects a broader mismatch between some of the stated objectives and rhetoric of integration and its ability to resolve complex problems that are more influenced by broader government policy and wider determinants of health.

That integrated care appears to have only translated into modest improvements for patients across each country of the UK raises questions about what integrated care can realistically achieve, how initiatives have been implemented and at what scale – and why countries with significant contextual differences in their approach to integration appear to have similar results.

5 How has each country sought to implement integration policies?

The journey between a policy goal and implementation in practice is significant for many areas of health policy, and has been particularly challenging for integration. While much has been written about the divergent approaches taken in the four constituent countries of the UK to deliver health and social care integration,[59,60] these countries have also depended on common levers for change.

Looking across the main policy initiatives and reforms implemented since devolution, we have identified four main approaches taken in the UK to drive collaboration between health and social care:

* joint governance and organisational structures

* integrated finances

* transformation funding and support to develop and scale integrated service models

* performance management and accountability.

In this chapter we summarise how each of these approaches has been applied, drawing out key differences and similarities and the key challenges to their implementation – which may account for the limited progress we observe across the four countries of the UK.

We focus on the levers that national bodies and policy-makers in each country have relied on to make integration happen at scale, appreciating that many efforts will also be happening within local areas at the patient level to join up services, which will not be fully reflected here.

Joint governance and organisational structures

The broad aim of joint governance structures has been to align services to achieve better outcomes, within both health and social care, by overcoming barriers caused by a lack of shared accountability and misaligned objectives and purpose in different sectors.

Each country of the UK has made different design choices about how health and social care structures are organised, including differences in the degree of autonomy or statutory power permitted, which organisations are involved and how territorial boundaries are drawn (see Table 4). These differences stem in part from variations in the political context and history distinct to each country, but they also illustrate different approaches to making integrated care structures work well in practice.

Despite the four countries' different approaches to organisation, common challenges have surfaced that have hampered progress, and raise questions for integrated care reform efforts moving forward.

The limitations of statutory responsibility

One of the key differences that distinguish the governance arrangements in each country is the degree of statutory power or legal accountability they hold. In England, integrated commissioning bodies such as integrated care systems are not yet statutory organisations, although proposals have been introduced to establish these bodies as legal entities.[61,62] Without a statutory basis, health and social care partnerships often rely on voluntary commitment, including memoranda of agreement, and lack designated resources to fully deliver integrated ways of working.

The Scottish, Welsh and Northern Irish experience makes clear, however, that having a legal duty to collaborate does not in and of itself lead to effective collaboration.

Table 4: Comparative overview of health and social care partnership structures across the UK

	England	Wales	Scotland	Northern Ireland
Legal status	Proposals to make integrated care systems statutory subject to the Health Bill Previous arrangements include non-statutory organisations, for example sustainability and transformation partnerships and shadow integrated care systems, as well as Section 75 agreements, which provide a legal framework for partnership working	Yes The 7 RPBs have a statutory basis, with a legal duty to undertake and respond to population health needs assessments, promote pooled funds where appropriate and implement joint plans There are also 19 statutory public service boards to support coherent strategy across public services to improve population health and wellbeing – but their remit goes beyond integration	Yes Integration authorities have been statutory bodies since 2014, with responsibility to commission services from health boards and local authorities	Yes Full structural integration since 1973, with 1 regional Health and Social Care Board (HSCB), which directs 5 health and social care trusts
Coterminous boundaries	Variable Boundaries follow principle of coterminosity, save for exceptional circumstances. 13 local authorities are split across more than one integrated care system, affecting 15 of 42 integrated care systems	Coterminous RPBs and public service boards align with local authority boundaries, although some cover multiple local authorities	Variable 31 integration authorities are formed of partnerships between 32 local authorities and 14 NHS boards Arrangements are complex: one integration authority covers 2 councils; 7 NHS boards relate to more than one integration authority There are several integration authorities to one NHS board, except in the Highlands where NHS Highland acts as the 'lead agency'	Boundaries are aligned 5 local commissioning groups are aligned to 5 health and social care trusts (note: local authorities do not have responsibility for social care)
Membership	Integrated care partnerships will include representatives from the NHS, local authorities, Healthwatch and other local representatives. Place-based partnerships at more local 'place' level may include members from integrated care partnerships, carers, local authorities, voluntary sector organisations, NHS trusts, primary care, and Healthwatch.	RPB membership is different in each region, but must include representatives from local health boards, local authorities (including representatives from education and housing), social landlords, third sector organisations, members of the public and carers	Integration joint boards: required voting members include representatives of the local authority and NHS board, and non-voting members include representatives of various professional groups, social care providers, people who draw on social care and unpaid carers	Members of local commissioning groups are appointed by the Health and Social Care Board – 17 people, including 4 GPs, 4 district councillors, 2 voluntary representatives, 2 social workers, 1 dentist, 1 pharmacist, 1 nurse and other public health and allied health representatives

Sources: Nuffield Trust analysis of various sources

In Wales, RPBs have a legal basis, but still lack the ability to employ staff and hold integrated budgets, or fully set their own priorities. A government review suggests that this has undermined their ability to jointly commission and plan services, and is why proposals are in place to extend their functions.[63] Northern Ireland has had structural integration since 1973, and an integrated commissioning board since its major reforms in 2009. Even though integration has long been legislated for, it has often been described as statutory rather than delivered in practice, with limited evidence of it operating on the ground.[64,65] Health continues to dominate over other integrated services, including social care.

In Scotland, integration authorities have been statutory since 2014. The integration joint boards are accountable for the planning of health and social care services, and hold responsibility for a budget to do so.[66] But despite their statutory status, various reviews have found limited progress towards integration objectives, revealing challenges around collaborative working and strategic planning.[67,68,69,70]

Several factors could be impacting on the progress of integrated joint boards in Scotland, including the scope of their responsibilities and capacity. Boards do not hold responsibility for the procurement and contracting of services and, as such, are quite removed from on-the-ground operational delivery and service change.[71] A similar concern has been raised for non-statutory partnerships in England.[72]

Differences in pay, terms and conditions and working practices across staff in health and social care can have an adverse effect on partnership working. Previous research highlighted, for example, a pay differential of £5,000 a year for senior managers in the same post across health and social care.[73] Chief executive officers and chief finance officers have also had to balance multiple roles, work part-time, with integration only one among many duties, and have limited accountability around their integration responsibilities.

The challenges in Scotland and Northern Ireland highlight that establishing integrated care bodies as statutory organisations may also not make up for the fact that partner organisations continue to operate as autonomous agencies with competing interests, pressures and obligations.[74] For example, local authorities in Scotland (which hold responsibility for social care) are

democratically accountable to the local electorate, whereas health bodies are not directly – meaning that organisations tend to default to distinct accountabilities rather than system working.[75]

Proliferation of partnership structures that lead to complexity

The focus on structural reform to deliver integration has contributed to a complex web of partnership structures and joint commissioning arrangements across the UK, with governance arrangements for integration adding additional layers to health and social care structures. This can obscure which decisions need to be made where, confuse lines of accountability, and add to bureaucracy and inefficiency if the same individuals are required to sit on multiple boards with overlapping scope. For example, in Wales, public service boards and RPBs have a distinct, but interconnected strategic focus on health and wellbeing, and a review of existing partnership arrangements in Wales found that there can be unclear operational relationships between the two, adding to complexity and duplication.[76] In general, there have been concerns in different countries of the UK that strategic partnerships have been established by successive governments without due regard for existing relationships and structures already in place, and how different bodies will connect with or evolve from what preceded them.

In England, questions remain about how proposals will work in practice, and it is not yet clear how the various decision-making bodies – such as health and wellbeing boards, integrated care boards and integrated care partnerships – will interact with each other and other parts of the system, and how this might vary across localities.

Although the structural merging of health and social care in Northern Ireland came about for reasons unrelated to integrated care reform, the unity this created has been pointed to as a clear benefit of the Northern Irish model.[77] But even here, the system still holds complex partnership arrangements and structural reorganisations have not always had a clear purpose or been successfully implemented.[78]

Coterminosity and scale of partnerships

There are also tensions about the appropriate size of integrated care bodies, with a shift in England and Wales for planning and commissioning to take place across larger areas. In Wales, some RPBs involve up to 40 members, which at times has made it difficult to engage meaningfully and reach clear consensus.[79] As they have developed, this has led to some RPBs establishing delivery or implementation groups to ensure local focus and to operate more effectively.

Relatedly, in bringing health and social care organisations closer together, decisions also have to be made about membership and where to define boundaries, where these are not shared by health and local authorities. In Scotland, integration authorities are not coterminous with NHS boards and local authorities: some NHS boards are working across several local authorities.[80] This has made it difficult in some areas to make use of 'set-aside' budgets – ie, money for services that are provided by large hospitals but intended to be managed by integration authorities.[81]

Balance of partnership

A shared challenge has been how to facilitate equal partnership and balance across local partners. In the English context, a key concern in the formation of integrated care systems has been the loosely defined role for local government, and the risk that the NHS crowds out local authority input.[82] Local authorities have inconsistently been involved in the formation of integrated partnerships, which at times has exacerbated tensions and frustrated efforts to collectively improve population health and wellbeing.[83]

England's earlier experience with care trusts in the early 2000s is also instructive here. Care trusts gave local councils and NHS trusts the option to formally merge health and social care services, including establishing a global commissioning budget, but only very few localities – 10 out of 150 health and social care communities – ever opted for this model.[84] Some of the resistance stemmed from fears that social care priorities would be subsumed by the NHS, given that social care powers and responsibilities essentially would be delegated to the health service. Areas that adopted this approach tended to do so in places that already shared a long history of joint working and stable boundaries so found the reorganisation less disruptive.[85]

Beyond health and local government partners, there is also a balance to be struck with broader community and voluntary sector partners. In each country of the UK, boards tend be composed of both statutory and non-statutory members, which can add to complexity and contribute to uneven participation. For instance, in Wales, RPBs include statutory membership from broader public services such as housing, and carers, but leave out criminal justice membership, which has been raised as a missed opportunity to better align mental health support.[86] For example, proposals in Scotland[87] and Northern Ireland[88] include provisions to extend membership on integration boards to broader public services (for example, carer representatives in Northern Ireland and criminal justice services in Scotland) in recognition of the role broader public services in improving population health.

Another key challenge for partnerships is ensuring citizen participation and that the diverse views of staff and service users are fully considered within partnerships. Integrated partnerships in both Wales and England have varied in their degree of patient and public involvement, with a recognition that more needs to be done to promote transparency and proactive participation within partnerships.[89,90] In Scotland, joint co-production with stakeholders has been an explicit approach to policy-making, with clear objectives to involve staff and service users in the membership of integration joint boards. However, this has not always been implemented effectively in practice and there is limited evidence to demonstrate how patient and public involvement has impacted decisions about health and social care.[91]

Key points and implications for future governance structures

While the design and organisation of health and social care partnerships look different across each country of the UK, they reveal common challenges that have implications for the future of integrated care policy in each one.

Health and social care partnerships differ in their degree of formalisation and legal status in each country. As England and Wales seek to establish integrated care bodies as legal entities, the experiences of Scotland and Northern Ireland should caution that this is not a shortcut to effective partnership working and collaboration. However, formalising health and social care partnerships can help resolve other challenges. For example, if statutory integrated care bodies are better able to control resources and hire dedicated staff, this means they may be less reliant on stretching existing capacity to accelerate progress.

In each UK country, a focus on organisational and structural changes has led to complex governance structures that often hinder rather than help integrated decision-making. It is important that, as integrated care partnerships continue to evolve in each country, clear lines of accountability are established while avoiding unnecessary bureaucracy. Within governance structures, it is also essential that the right balance of voice and influence is given to different perspectives from across local authorities, the NHS and third sector organisations, and that processes are in place to avoid any one sector's priorities taking precedence over other equally valid goals. At the same time, structural reorganisations – no matter how sensible the rationale for them may be – take time, cause disruption, divert focus and energy and can delay the path to integration. They also make assessing change over time difficult.

Moreover, underlying challenges – such as social care being more financially overstretched than health relative to the level of need, cultural differences between locally accountable social care services and centralised health services, and variability in leadership capacity – are not fundamentally addressed by joint arrangements.

There is also a limit to what joint governance and organisational structures can achieve in terms of meaningful integration and more collaborative ways of working. In each country of the UK, effective partnership working has depended more on the maturity of relationships and scale of ambition for integration, regardless of how governance structures were designed and the legal accountabilities they were afforded.

Integrated finances

Alongside more integrated planning and governance structures, integrated finances have also been consistently turned to across the UK as a key driver of integration and as a way of facilitating collaborative working across health and social care. The rationale is that integrated finances can help improve efficiency by better aligning financial risk, reward and accountability across sectors. However, the evidence is weak that pooled budgets and other forms of integrated finance achieve cost savings or higher productivity, although they may deliver benefits to patient outcomes and experience.[92,93]

Integrating finances can take many forms, including:

- **lead commissioning/delegated commissioning arrangements**: where one partner leads the commissioning and procurement of services but according to a jointly agreed set of terms

- **pooled budgets**: where each partner makes contributions to a common pot of money for spending on agreed projects or services

- **cross-charging/financial penalties**: where one partner is fined if solely responsible for poor performance on agreed metrics (for example, local authorities compensating for delayed discharges in acute care when social services are solely responsible for or unable to provide continuation of service)

- **aligned budgets**: where partners align resources and work towards an agreed budget (each identifying their own contribution) – financial performance is jointly monitored, although the management of and accountability for health and social service funding remain separate

- **full structural integration**: where health and social care responsibilities are combined in a single organisation with a common budget.

These approaches have been applied across the four countries of the UK to varying extents, and have often been used alongside one another. Table 5 provides an overview of the key mechanisms currently in place, and the subsections that follow summarise how these have been implemented and the challenges they have surfaced, with implications for reform efforts in the future.

Table 5: Current integrated finance initiatives/structures

England	Wales	Scotland	Northern Ireland
Pooled budgets, lead commissioning and aligned budgets: Various initiatives and mechanisms to allow NHS organisations and local councils to jointly fund and commission services. Notable schemes include the Better Care Fund. Initiatives have tended to be limited, representing a small proportion of overall budgets, and apply to specific outcomes or conditions. **Aligned budgets/financial targets:** System control totals are in place to encourage risk sharing, meaning all organisations within integrated care systems must meet individual financial targets and the overall financial target for the area. This is intended to align organisational and system priorities	**Pooled budgets and lead commissioning:** Since 2016, local health boards and local authorities on each RPB are required to pool budgets for care home accommodation and family support services (with the option to expand into other services as agreed locally) – although there is variation in how this has been applied in practice There are annual allocations to RPBs to finance regional capital and revenue-based schemes that support integrated working through the Integrated Care Fund	**Pooled budgets:** Integration authorities pool budgets agreed by the NHS and local authorities, at a minimum around social care, primary and community health care, and unplanned acute care Integration authorities directed almost £9 billion in 2018, with about 70% coming from the NHS and about 30% coming from local authorities	**Full structural integration:** Formal structural integration means health and social care trusts receive funds in one single allocation for health and social care activities

Sources: Nuffield Trust analysis of various sources. For details on historic efforts to integrate finances across health and social care by country, see timelines of integrated care reform.

Size, scope and broader financial incentives

Across the UK, efforts to integrate finances have varied in their size and the scope of services covered. In England and Wales, pooled budgets have been more limited – applying to specific outcomes or services – whereas in Scotland and Northern Ireland, budgets are more broadly defined and apply to most health and social care services (at a minimum, acute, community and social care services).

Each of these options brings different trade-offs. In Wales, legislation only requires RPBs to pool budgets for some services, such as care homes for older people, although areas have the option of expanding pooled funds into other services, and there have been different interpretations of what this means in practice. An evaluation of early experience with pooled budgets showed that they had helped to facilitate greater data sharing and joint commissioning in some areas, but that most RPBs only met the minimum requirements, with very few physically integrating funds and sharing risk across commissioners as intended.[94]

A part of this has to do with the limited scope of the pooled fund, with some RPBs highlighting care homes as a particularly challenging area to implement the approach, given the diverse levels of need across localities, which made subsidising the costs of services across local authority boundaries more likely. Even though sharing and redistributing resources is a key aim of pooled budgets, existing legal frameworks in Wales make this kind of cross-subsidisation difficult, and budget pressures across councils means that some local authorities have been reluctant to give up control of local resources.

In England, pooled budgets have similarly only represented a small percentage of overall commissioner spend, which may have limited their effectiveness. Initiatives to support pooled finances and integrated planning go back to at least 2000 in England, when the government introduced legal flexibilities to support integrated financing arrangements. Legislation in 2006 strengthened these arrangements, establishing Section 75 partnerships (which allowed resources to be pooled across health and social care), with the aim of making services more tailored to population needs. However, in the years following the legislation, formal joint financing expenditure remained only 3.4% of total health and social care expenditure (2007/08).[95]

Since then, other large-scale programmes have emerged, including most recently the Better Care Fund, but here too the fund has only ever represented a small share of overall health and social care spending (in 2021/22, the total pooled budgets equalled £6.9 billion, which is less than 5% of the overall health and social care budget).[96]

The scheme works by transferring NHS funding into social care to ensure that people receive better integrated care and support closer to home, and avoid unnecessary time in hospital. While localities have flexibility in how to apply the funding, plans are required to focus on key outcomes – including reducing delayed transfers of care and avoidable admissions. Evaluations of the scheme to date show that while areas agree that joint working across health and social care has improved since the scheme's introduction, it has had a limited effect on delivering these primary objectives.[97,98]

Given the limited size and scope of the Better Care Fund, experts have argued that it may have never been a strong enough catalyst to meaningfully shift care out of hospital.[99] Evaluations of the scheme underscored how integrated finances could not make up for the lack of community care capacity and the insufficient numbers of staff needed to reduce emergency admissions or safely transfer patients out of hospital.[100] The fund redistributed money from the acute sector, so there were limited resources with which to invest in new initiatives or try to redress capacity imbalances across health and social care.[101] Nor could the fund counteract broader misaligned financial incentives, such as England's volume-based 'tariff' payment system, which rewards growth and higher volumes of acute hospital activity, often at the expense of prevention, community care or social care.

England is now moving towards block contracts or capitated budgets – that is, giving providers a lump sum to deliver a specified service or services for a defined population. However, the experience of financial integration in other UK countries that have not used volume-based payments for hospitals shows that this is not a panacea for encouraging more money to flow to social care or prevention.

In Scotland, integrated joint boards oversee a broader pooled budget of around £9 billion (2018), of which around 70% is funding from the NHS and

30% is funding from local authorities.[102] This includes an expected 'set-aside' budget in large hospitals, managed by the integration joint board but held by the NHS board, to provide more collaborative services between acute and community and preventative services and help shift more services out of hospitals.[103] The funds in set-aside budgets represent around 9% of total expenditure held by integration joint boards.[104]

However, even with this wider scope and responsibility, the impact of integrated finances has been constrained and they have not worked as intended. Different timings of budgets in the NHS compared with those in local government, and a misunderstanding of each organisation's financial structures, have been cited as reasons for reluctance on both sides to commit to budget sharing.[105] In practice, 'set-aside' budgets have remained under the control of NHS boards rather than passed on to integrated authorities, making it very difficult to redirect resources away from acute care and shift more resources to community or preventative services.[106] This is partly due to financial pressures and expenditure on acute services being higher than anticipated. Despite these challenges, ministerial reviews have seen it as a key priority for fully delivering integration and have reinforced that delegated budgets must be fully implemented.[107]

Northern Ireland – where health and social care budgets are fully integrated – has also confronted similar challenges with integrating finances. Even though full structural integration avoids the challenge of integrating funds from separate organisations with competing financial priorities, studies show that pooled budgets have not succeeded in shifting more resources towards community and social care services to help keep people out of hospital.[108] The social care sector especially has suffered from funds being reprioritised towards acute services, with consequences in service provision, for example in domiciliary care.[109,110]

Technical complexity

Assuming that health and social care organisations are able to agree budgets and strategies for integrating finances, there are a number of technical hurdles that must be worked through in order for pooled budgets to operate effectively. One example is different tax rules – NHS organisations do not

pay Value Added Tax (VAT), whereas independent sector organisations do, and local authorities may do for some activities. Differences in charging arrangements also add complications – NHS care is generally not chargeable to individuals, whereas the majority of local authority-delivered services are means tested and chargeable (see Table 3).

Apart from in Northern Ireland, health and social care organisations remain separate organisations in each country of the UK, and financial integration does not override any individual organisation's statutory responsibilities or lines of accountability. This means that pooling budgets has involved the complicated task of overcoming differences in ledger systems, reporting requirements, reporting periods and other accounting system variation.[111] For example, a barrier to pooling budgets in the English context has been how to deal with overspend and underspend when accounting practices differ across the NHS and local authorities. Unlike NHS trusts, local authorities are not legally or in practice permitted to overspend, but they are allowed to establish reserves and carry over underspend, which NHS clinical commissioning groups are not.[112]

Managing these arrangements is labour intensive and also involves reconciling often significant cultural and organisational differences. This includes things like different pension schemes across health and social care, which make it difficult to shift staff and resources across sectors. These operational and cultural differences, although not insurmountable, introduce new administrative complexity that can be difficult to overcome, especially when the financial gains and potential savings of setting up pooled budgets are diffuse or may never be realised. This is why previous evaluations of schemes in the UK have consistently highlighted the importance of dedicated management and resources to oversee these organisational changes and work through administrative requirements if integrated finances are to work.[113,114]

Establishing adequate joint governance can also be a challenge. The benefits of integrated finance can only be realised if arrangements are in place so that both health and social care partners are able to make decisions on equal information, and share equal power in how resources are allocated (otherwise the same dynamics will exist as under separate budgets).[115] Evaluations of initiatives in both Wales and England found that previous efforts to integrate finances have struggled in the absence of clear governance arrangements

and data-sharing agreements that made it possible to track patients through different care settings, compare costs and understand the full resource implications of integration.[116,117,118] In Scotland, progress towards integrating finances has been more successful where NHS boards and local authorities have been better able to share information to support strategic planning and more willing to work collaboratively. Nonetheless, this progress is not consistently spread across Scotland.[119,120]

Key points and implications for future financial incentives

While integrated finances have long been turned to as a means of accelerating collaboration (Table 5), experiences from each country of the UK make clear that they have been insufficient in and of themselves to drive more collaborative care. The shift towards integrated care systems in England comes with a new 'system-by-default' approach to financial planning, which promises to move away from an organisation-based judgement of financial performance to one that focuses on integrated care systems as a whole, and introduces system-wide control totals or caps.[121]

While this may remove some of the perverse incentives that undermine collaboration, the organisational and cultural challenges of combining finances will still exist and must be carefully thought through. For these efforts to be successful, proportionate and appropriate governance arrangements will be needed to support transparency and ensure that power is balanced across partners and that each one can understand and see the benefits of collaboration.

Integrating finances effectively requires reliable information sharing across health and social care, joint assessments that account for differences in workforce between the two sectors, and a financial framework that can adequately share risks and benefits across different commissioners. While progress has been made in some of these areas, more is required to give pooled budgets every chance at success. Better data than currently exists on activity and cost for non-hospital services are likely to be required for financial decisions from pooled budgets.

It is also important to be realistic about the benefits of integrated finance arrangements, which may lead to improvements in collaborative working but

will not necessarily lead to financial savings – especially in the short term. This implies that delivering savings should not be adopted as an immediate core outcome or objective of integration – especially as improvements in service delivery can also identify unmet need, and demand for care is also rising. Pooled budgets will have a limited impact if they don't override any individual organisation's statutory responsibilities or lines of accountability, or if they only represent a small share of the overall commissioning budget.

At the same time, integrated finances are unlikely to make much difference until underlying funding pressures are addressed. In Scotland, for instance, budgets intended to be allocated to integrated care boards to support integration have ended up offsetting overspends in acute care, the exact opposite of the intended direction towards spending more on keeping people healthy. In each country of the UK, pooling budgets has thus far not succeeded in tipping the funding balance away from acute services towards primary, community and social care. Social care across all four countries of the UK is experiencing severe pressures and instabilities as a result of the ever-declining funding. Broadening the size and scale of pooled budgets might risk more of social care resources being diverted into acute services, at a time when social care services need substantial financial investment.

The focus on structural and organisational changes misses out long-standing and systemic barriers to integrated service delivery. These include misaligned financial incentives, workforce challenges, the visibility and political appeal of hospital care and insufficient information sharing across sectors – all of which date back many decades.

Transformation funding and support to develop and scale integrated service models

Some countries of the UK have also attempted to accelerate integrated care delivery through large-scale funding schemes and pilots. These programmes have offered upfront investment and/or technical support to facilitate experimentation and innovation in developing new integrated service models – for example the Integrated Care Pioneers and Vanguard New

Care Model programmes in England, and the Integrated Care Fund and the Transformation Fund in Wales.

Each initiative has tested different ways of developing integrated approaches at pace, with the intention that these approaches would be mainstreamed in practice and accelerate the spread of integrated care delivery. While each programme has had a different focus, a key aim has been to avoid 'one-size-fits-all' approaches, and allow greater flexibility to areas to develop models for integration that suit local contexts and priorities. Throughout time, pilots have tended to focus on interventions that improve health and social care integration through:

- integrated, multidisciplinary teams

- greater partnership working with voluntary sector organisations

- service designs that support greater prevention and self-management

- coordinated clinical processes, such as joint needs assessment and greater case management

- personalised care and support planning

- integrated commissioning and contracting.

Table 6 summarises the main programmes in each country of the UK, while the subsections that follow look at sustainability, time and complexity, and discuss key learning from these initiatives and implications for future efforts. While each programme surfaced valuable insight on how to make integrated service delivery work at the patient level, the themes we draw on here focus on the key lessons for policy-makers on how to make integrated care happen at scale.

Table 6: Transformation funding and support programmes across the UK

England	Wales	Scotland	Northern Ireland
Successive schemes often overlapping one another in time and place, including: • Partnership for Older People projects (2006–09): 29 projects with funding of £60 million in total • Integrated Care Pilots (2008–12): 16 projects (£79,000 to £180,000 for each project) focused on supporting greater continuity of care and reduced use of hospitals • Integrated Care and Support Pioneers (2013–19): funded 25 projects in total, costing £83.3 million annually – focused on integrating services for patients and service users living with complexity and high risk of admission • Vanguard New Care Models programme (2015–18): funded 50 sites, costing £380 million, to test three models of integration (enhanced care home, multispeciality community providers, and primary and acute care systems) • People at the Heart of Care white paper for social care (2021): at least £300 million over three years for integrating housing with health and care, and funds for implementation and transformation activities	Successive funding schemes designed to encourage innovation and new ways of integrated working, including: • Invest to Save Fund (2009–): has funded more than 180 projects with an aggregate value of £14 million between 2009 and 2018 – focus is on reducing waste across public services and supporting greater administrative integration • Integrated Care Fund (2014–): provided £129 million in 2021–22 in 'pump prime' funds to test new models for integrated service delivery • A Healthier Wales Transformation Fund (2019–): provides £100 million a year to spread models of seamless health and social care delivery	'Pump priming' funds to embed change in 2017/18: • A £70 million transformation fund for self-directed support in social care • Integrated Care Fund: three-year funding allocation by the Scottish government to support integration roll-out (£100 million) • Support for delayed discharges (£30 million in 2018) • £250 million to support integration in its first year and staff costs at the living wage Some integration authorities have since committed specific funding for transformation as ring-fenced funds within their budgets	In 2018, £100 million of transformation funding was announced, including £15 million workforce funding across health and social care to support collaborative working

Sources: Nuffield Trust analysis of various sources

Sustainability

Relying on pilot schemes to scale integration has some natural limitations inherent to any grant-funded programme. Funding programmes offer time-limited support and a short duration in which to deliver results. Integrated care models are unlikely to demonstrate effectiveness within their funding window, which can threaten long-term sustainability and cause disruptions to service delivery. Experience of the Integrated Care Pilots and the Integrated Care Pioneers programme in England has shown the value of allowing innovations time to evolve and adapt – something that is difficult in the NHS with consistent changes to leadership and policy direction. However, dedicated transformation funding can be helpful when it provides a protected resource to support the double-running of costs as services move to more integrated models models, which has been a limitation of the Better Care Fund.[122]

But even where funding programmes have been multi-year and allowed for this type of double-running, they have not necessarily always been sustained beyond the lifespan of initial funding. This has been a challenge with the Integrated Care Fund in Wales, which distributes funds to each of the RPBs to support new integrated care initiatives or extend existing innovations to a broader area – the expectation being that successful interventions will be mainstreamed and budgeted through organisations' core business.

While the Welsh Integrated Care Fund has helped support greater partnership working, there is little evidence so far of effective projects being sustained through the core budgets of RPB members. Evaluations suggest this is partly because the scope of the fund has lacked consistency, making it challenging to maintain projects (for example, the original scheme focused on interventions to support older people and avoid unnecessary admissions, but has expanded to include a focus on children and adults with complex needs and learning disabilities).[123] The annual nature of the funding has also contributed to a short-term approach, although the Welsh government is taking steps to modify the programme to support more long-term, strategic planning. In England, there have been a series of large-scale programmes with overlapping scopes and sites that have been criticised for failing to build off one another – leading to disjointed planning and an inconsistency of purpose across initiatives.[124]

There is a possible risk that short-term funding conceals the need to decide on priorities between hospitals and other services, only for this tension to return when funding ends, with the possibility of the latter losing out.

There are other examples, including from England's own history, where initial pilots have been mainstreamed and scaled in practice. This has tended to happen in areas with pre-existing relationships between health and social care and a history of multidisciplinary working, and where there is organisational stability and continuity of leadership.[125,126]

Time and complexity

Early experience with funding programmes has shown a tendency to underestimate the amount of complexity required, and the administration and management skills therefore required, which adds to the difficulty in scaling them. Evaluations of the three major pilot programmes in England consistently found that larger and more complex interventions had most difficulty achieving desired changes[127] – which is intuitive, but has not always been considered when establishing the capacity and resources needed to manage and deliver projects. A striking finding from a recent review of evaluations of previous initiatives has been the lack of mutual understanding of the aims of integration within programmes, given its complexity and multi-varied nature. This might impede progress and distract focus from developing solutions that work for patients and service users.[128]

Organisational partnerships also involve significant time and commitment, and cultural differences discussed elsewhere in this report are not easily resolved with funding and similarly need time to develop solutions. Pilot programmes can be instrumental in supporting local areas to test new approaches to and thinking about integrated care, and providing dedicated time, headspace and political cover to develop these changes.

But projects also have to work within existing health and social care infrastructure, and are likely to be insufficient to make up for broader barriers to integration that have limited the effectiveness of other policy levers. These include:

- the different funding approaches to health and social care that prevent the services from bring truly integrated

- local political accountability for social care as opposed to national political accountability for health

- inadequate funding in social care.

For example, projects have found it difficult to establish multidisciplinary service models when requiring the sharing of staff across organisations that follow different approaches to pay, holiday and pensions. Information technology and data-sharing barriers have also impeded progress. Integration is also highly context-specific, so what works in one area will not be easily spread or scaled to another,[129] given how factors such as pre-existing relationships and consistency of leadership are hard to replicate.

Key points and implications for future transformation programmes

Transformation programmes have been an important vehicle for spreading learning and facilitating bottom-up approaches to better coordinate services across health and social care. They have also in some cases injected much-needed funding to test and scale new models, which would not have been possible within existing resources.

However, experience from past efforts reinforces the complex nature of integration, and how difficult it is to produce firm results in terms of effectiveness in short timescales. This runs counter to how many programmes have been designed with the expectation of quick fixes to complex, systemic problems. For future efforts to be successful, it is essential that they adequately account for and build off the programmes that have come before them. There has been a pattern of developing successive initiatives with overlapping aims and sites – each requiring significant time and resources to set up – before fully understanding whether or why objectives have not already been realised.

Efforts have been most successful when stakeholders had strong pre-existing working relationships and focused on discrete interventions rather than whole-system changes. Broader contextual barriers – such as evolving political

landscapes, lack of data integration and unbalanced funding across health and social care – have consistently impeded progress. Contextual differences within and across areas can also be underappreciated and make it difficult to pinpoint why or how integration works. There is a limit to how generalisable learning can be, given differences in organisational and local experience – a challenge inherent to the spread and scale of any complex system change.

Performance management/accountability

Performance management has been a key tool for policy-makers to incentivise the NHS to deliver policy goals. All countries of the UK collect and publish activity and performance measures; however, the measures used vary between the countries, in part reflecting different thresholds and targets for performance. As the Nuffield Trust, Health Foundation and Institute for Government have noted, these differences make understanding and accountability difficult, and it is regrettable that they have been increasing.[130,132]

The extent to which breaches of performance targets are acted upon has varied over time and between the UK countries. England has placed the most reliance on performance targets to drive improvements, although the approach in Scotland has strengthened over time.[131]

However, despite all UK countries having long-standing aims to increase service integration, the outcomes of integration have been poorly defined and have only been reflected to a limited extent in the performance and outcomes frameworks within the four countries (see Table 7). Further, while national bodies – such as the Department of Health and Social Care and NHS England and NHS Improvement in England – have experience of how performance management can be used as a lever to influence the performance of health services, knowledge of social care is more limited.

Table 7: Progress with performance frameworks for integrated care across the UK

England	Wales	Scotland	Northern Ireland
The highest-profile targets have been organisational, not system wide.

The Department of Health and Social Care is developing an Integration Scorecard to measure individual experience of integration.

Care Quality Commission (CQC) regulation now covers provider collaboration.

Inequality monitoring requirements have been in place from March 2021. | Health and social care are inspected and regulated separately, but in 2020 Wales introduced a single national outcomes framework for health and social care, with joint inspection to assess the degree of partnership working, pooled budgets and joint commissioning. | A number of indicators in the National Performance Framework are used to asses the performance of integration.

Integration authorities report against a number of different measures, but these are not consistently reported at the national level. No data are routinely collected to show outcome improvement. | The Programme for Government draft outcomes framework (2016–21) measures performance on a number of relevant issues to health and social care, such as the number of people receiving care at home. A consultation is currently underway over a performance; concerns have been raised about its adoption, especially given the narrow choice of indicators for analysis.

Health and social care trusts report areas of performance including service delivery and financial performance. |

Sources: Nuffield Trust analysis of various sources

Lack of measures

Across all the UK countries, a shared issue is a lack of suitable data and measures, as we found in this study. Many of the outcomes that integration initiatives have sought to achieve cannot be easily measured with existing data. In Northern Ireland, where structural integration has been in place since 1973, there has been very limited research on its impact, and the Programme for Government only has a small number of indicators.[133] Data on the performance and outcomes of community health services or social care are limited. Measures of patient experience are still not comprehensive, even for hospital or primary care settings, but they are particularly lacking elsewhere.[134] Further, data are often not comparable across areas or time periods, or match the boundaries of integration structures.[135]

A broader challenge is that there is often no available counterfactual against which to assess whether change can be attributed to the integration initiatives. Systematic reviews of evidence around integration similarly suggest that evaluations of integration often struggle to establish causal links between the initiatives and positive outcomes.[136] The overlap of multiple integration structures in England – from pioneers to vanguards to clinical commissioning groups – has made evaluating their success difficult.[137]

NHS England and NHS Improvement have commissioned a guide to support systems in evaluating integrated care from the user perspective locally.[138] Work is also in progress to collect data from patients and service users about their experiences of integrated care. This data collection, currently referred to as the 'integration index', is being piloted with people who have a range of long-term health and care needs.

Relative priority of integration measures

Pressures to achieve financial balance and meet other organisational targets have consistently trumped system-level integration efforts in England and Wales.[139]

Single organisation performance measures have dominated in England, to the extent that measures for waiting times or breach of targets have been colloquially described as 'P45' targets, which could lead to job losses for

senior hospital managers. Recently the NHS in England has sought to move away from single organisational measures, such as the four-hour waiting-time target for Accident & Emergency (A&E), towards a basket of performance measures, although this has yet to be formally implemented.[140] Further, few historic measures are relevant outside a hospital setting – measures of urgent community services' response are yet to come into effect, although ambulance service targets and targets for mental health services are operational.

A parliamentary review of health and social care in Wales in 2018 noted weaknesses in local and regional governance, which lacked harmonisation and joint accountability.[141] The different regulatory landscape across health and social care meant that services would be required to respond differently to recommendations for action. Wales has since developed a Single Integrated Outcomes Framework for health and social care to support integration, with indicators defined at the national, regional and local levels.[142] However, the framework was only introduced in 2020, so more time is needed to understand its impact and the extent to which it facilitates greater system-level collaboration.

In Scotland, multiple outcomes and indicator frameworks are used to assess the performance of integration authorities. A National Performance Framework[143] was introduced in 2007 and updated in 2018, and includes several indicators related to integration objectives (see Exhibit 4).[144] Integration authorities are also required to report against six performance indicators set by a Ministerial Strategic Group.[145] A review of targets in 2017 recognised the difficulties of setting measures for complex systems that were sufficiently detailed to monitor and assess the extent of change.[146] Further challenges include an overreliance on acute measures, to the detriment of social and community care, hindering opportunities for greater integration with the voluntary sector.[147,148] Another difficulty in the Scottish context is that integration authorities choose to report against the outcomes that are important to their local context.[149] This has led to concern that there is no clear relationship between spending and outcomes[150] and that comparisons and the identification of good practice across integration authorities are difficult.[151] As a result, it is not always clear on what basis ministers hold integration authorities and NHS boards to account.

The balance between meaningful local measures, which are relevant to local priorities, and the requirement for consistent national performance reporting has also been apparent in Wales. There has been a desire for RPBs to be able to determine their own priorities to address regional needs, but funding decisions are still set nationally, undermining local autonomy.

Northern Ireland is notable as a nation where formal structural integration has existed for several decades, yet there has been relatively little evidence of actual change in practice or impact, and an absence of national audits or evaluations through which to identify successes and barriers.[152] Previous research has suggested an unwillingness in Northern Ireland to open up the health and social care system to scrutiny, the consequence of which is limited sharing and spread of good practice.[153] Current proposals for integrated care systems do, however, include plans to develop a Strategic Outcomes Framework, based on priorities identified by the Department of Health, along key strategic themes and following an outcomes-based approach.[154]

Key points and implications for future performance frameworks

Performance frameworks, where they have been influential levers for implementing policy, have focused on organisational targets. The absence of robust measures of integration partly reflects practical challenges, including a relative lack of data about community health and social care services, or measures of coordination and care from a patient or service user perspective. Differences in organisational units and ill-defined goals are have also made tracking integration a challenge.

However, the lack of focus on measuring integration, and action to address these challenges, points to a more fundamental gap between the rhetoric of integration policy and the reality of service delivery at a local level.

There are some developments in progress, with plans for new joint health and social care outcome measures in England.[155] But given how stretched NHS and social care services are now, dealing with the repercussions of the Covid-19 pandemic after years of funding challenges, there may be limited change in the relative priority of these population and integration measures, compared with service-focused performance measures.

6 Conclusions and key lessons

Across all countries of the UK, there has been a disconnect between the policy ambition of integration and the difference it has made to patients. Despite some divergence following devolution, the four UK countries have tended to rely on similar mechanisms to drive forward integration – which may account for this gap. Here we summarise what the experience of integration across the UK tells us about how policy needs to adapt for the future.

Structural reform is insufficient to counteract systemic barriers to integration

A common thread that unites policy in each UK country has been a reliance on structural and organisational changes to deliver integrated health and social care at the user/patient level. While those structures have looked different in each context, each has failed to address long-standing and fundamental barriers to integrated service delivery. In each country, integration has been challenged by systemic factors, including:

- a lack of resources, infrastructure and staff to meaningfully integrate services and move more care out of hospital

- competing accountabilities and inadequate incentives to reduce fragmentation

- divergent cultures and priorities across health and social care

- the broader economic and political contexts, which have affected the extent to which and the way in which integration has been implemented

- insufficient regulatory and outcomes frameworks to understand system performance to promote collaborative working.

None of these can be easily resolved through organisational changes alone, and is one key reason why integrated reform is still found wanting in each country of the UK.

Integration is more relational than organisational – and cannot easily be legislated for

Structural change is also unlikely to lead to improved collaboration in practice, which comes down to relationships and partnership working, which cannot be legislated for. The ability of health and social care partnerships to collaborate effectively has depended more on the scale of their ambition and the maturity of their partnerships than their design and structure, with policy consistently emphasising the latter, sometimes at the expense of the former. There is hope that legislation in England will help accelerate greater partnership working in areas that do not have that shared history, but legislation alone will likely be insufficient to drive cultural changes.

Previous research and audits have highlighted the importance of 'soft skills' in integration to encourage and facilitate a culture of collaborative working and overcome the traditional silos of health and social care. A key limitation of efforts in each country of the UK is that they have not fully invested in capacity and skills among integration partners – ensuring for instance that members of integrated boards are paid equally, are committed to collaboration and are supported to manage their work if this is balanced against other duties.

Experience across the four UK countries has shown the value of transformational funding in supporting integration boards to develop capacity for change – for instance through collaborative leadership development and building the necessary skills to drive integration forward at regional and local levels, paying special attention to shared training for professionals on the ground. However, difficulties in evaluation make telling whether it has been used at the optimal scale, or at the optimal amount, difficult. Transformational funding has often provided the upfront investment, time and headspace needed to establish new approaches – but also needs to be given adequate time to deliver results.

Realistic expectations are needed about what integration can actually deliver – and the time it will take to get there

It is also worth reflecting on whether structural or organisational integration can ever meaningfully lead to improved experiences and health outcomes for patients, or the financial efficiencies that policy-makers would like to see – at least in the short-term.

Integration – for all its allure – creates complexity that must be fully accounted for when setting expectations about what it can deliver. Integrated care models bring together multiple complex variables such as new governance, funding and commissioning structures. Planning and implementing integrated care structures at a large scale takes time.[156] Despite being such a consistent focus across the four UK countries (the policy timelines of integrated care efforts are a testament to this), it is not clear whether each integrated care initiative has been sustained for long enough to become properly embedded and achieve a positive impact.[157] Even when successive initiatives have a consistent focus, the stop-and-start nature of funding or support can disrupt progress and make it difficult to show impact. Integration also means blurring lines between professional and organisational boundaries, which could lead to shifting the specialisation and professional identity of staff, functions, cultures and organisations – this may have costs and disadvantages.

When initiatives have been implemented, there has often been a mismatch between the scope of the mechanism and what it is intended to achieve. For example, pooled budgets and other forms of integrated finances are unlikely to result in cost savings if they help lead to service delivery changes that identify unmet need and increase activity as a result.[158] Moreover, integrated finances are unlikely to be able to shift more services out of hospital if there are insufficient numbers of social care staff to support new models of care and ways of working.

Wider population health trends also need to be considered. It is possible that integrated care is happening, may be working and might have a measurable effect – but other factors are having an increasingly negative effect, leading to little change overall.

There is some evidence consistent with this. While many of our indicators are age-adjusted, the rate of multimorbidities within individual age groups has been increasing in recent decades.[159] Investment in services is key to integration. Notably, investment in social care[161] and public health[162] has decreased over the last decade of austerity and is likely to have had a negative impact on people's health and wellbeing. While these trends have pre-dated some integration efforts, it is clear that benefits will be mitigated, or at least hidden, if other determinants of health are worsening.

Further, the mechanisms discussed in this report have had a limited impact relative to other factors likely to impact health, such as housing, deprivation education, and other wider determinants. There is a growing trend across some of the UK countries (such as Scotland and Wales) to develop more aligned policy across all public services. It will be interesting to see whether this trend can be translated into practice as a more holistic approach to integration.

We can never know the impact of integration if we cannot measure it

Integration is hard to define, measure and evaluate – in 20+ years of integration efforts across the UK, we still have relatively little understanding of its impact. Therefore much more needs to be done to improve measures of integration.

Future integration initiatives should set out with clarity how mechanisms for integration create the pathway to improved outcomes, and at what level. And alongside this, they should consider how these outcomes are to be evaluated and compared – the lack of available and comparable data against which to assess outcomes is a clear barrier to fully understanding the impact of integration.

It is also important to ensure that the outcomes against which integration is measured are reflective of what it is intended to achieve. The overreliance on hospital-based measures has inhibited change within community and social care services. If we intend to create meaningful change for service users,

then more attention needs to be paid to these services and the experiences of those who use them. While new measures of people's experiences of care are being developed, there is much more to be done across the UKs to effectively understand the challenges that patients, clients and carers face in negotiating the maze of services, organisations and funding entitlements, and use this knowledge to deliver better care.[163]

The potential for using performance frameworks to drive integration has been an unexploited lever. Out of all the countries of the UK, England has had the greatest reliance on centrally mandated targets, but these have been directed at individual NHS organisations, and have incentivised organisational activity and de-prioritised shared goals.

Next steps with integration policies

At the time of writing, each of the four countries of the UK is in the process of introducing new policy or legislation intended to further deepen health and social care integration, including changes in organisational and partnership structures aimed at improving coordination and collaborative planning.

In England, integrated care systems will bring NHS providers, NHS commissioners and local authorities more formally together to develop and deliver integrated care strategies. The Welsh government is attempting to accelerate joint planning and commissioning by extending the powers of RPBs to directly hold integrated budgets and employ staff. In Northern Ireland, proposals are in place to establish new area integrated partnership boards to improve joint planning between health and social care trusts and wider sector partners at the regional level. And in Scotland, organisational reforms have proposed transferring existing integration authorities into new community health and social care boards, which could be directly funded and accountable to Scottish ministers in the hope of rebalancing budgets between acute, community and social care services.

Each of these efforts – while a product of very different histories – relies on structural levers such as shared budgets with joint accountabilities across still separate health and local government bodies to drive change. The evidence to date from across the UK suggests that this alone will not be enough to

overcome the complex barriers to integrated working, to create the cultural change that would enable deep cooperation, to deliver strong enough benefits in terms of population health or to deliver financial savings that are noticeable.

This has been a consistent finding in evidence and previous examinations of why integration in the UK has fallen short. While the aims of integration are worthy – and the alternative of disjointed and uncoordinated care is highly undesirable – real progress will require shifting the focus away from organisational and structural reform towards the behaviours, incentives, skills and resources needed to integrate services at the front line. Otherwise, we risk repeating the cycle of successive reorganisations that change how services are planned and coordinated – and come with a significant opportunity cost and disruption – but fail to address the fundamental and deep rooted changes needed to integrate services at the front line. There is an opportunity now, as each country of the UK embarks further on its journey towards integration, to much more actively reflect and learn from the efforts that have come before it – within each country of the UK and across them.

Appendix A: Thematic analysis and indicators considered

To identify the main aims and approaches to integrated care reform in each country of the UK since devolution, we conducted a thematic analysis of policy visions, legislation, reforms and major national programmes that took place in each country of the UK between 1999 and 2021.

We used a coding framework adapted from N Fulop et al.'s typologies of integration (2005) to identify the different ways integration has occurred and the main focus of initiatives:

Table A1: Typologies of integration – coding framework (adapted from Fulop and others, 2005)

	Definition	Examples
Systemic	Coordinating and aligning policies, rules, and regulatory frameworks at all organisational levels.	Integrated Care Systems, national incentive/performance schemes
Normative	Developing shared values and culture and vision across professional groups and individuals	Common value statements and goals, coproduction
Organisational	Coordinating structures, governance systems and relationships across organisations	Informal and formal contractual or cooperative arrangements, such as pooled budgets or commissioning agreements; developing umbrella organisational structures like local clinical partnerships or GP federations, etc.
Clinical	Coordinating information and services and patient care within a single process, within and across professions	Shared guidelines and protocols, integrated care pathways

	Definition	Examples
Service	Different clinical services are integrated at an organisational level, such as through teams or multidisciplinary professionals	New care delivery models that bring services together in one place or system
Functional	Aligning back-office or administrative functions across organisations	Developing shared electronic health records, information systems, funding or procurement processes, accountability mechanisms, etc.
Horizontal	Organisations delivering care at the same level come together	Acute care mergers; health + social care collaboration
Vertical	When care delivered at different levels come together	Merging acute and community hospitals; tertiary providers working with secondary providers

Source: Fulop N, Mowlem A and Edwards N (2005) Building Integrated Care: Lessons from the UK and elsewhere. London: NHS Confederation

We identified 68 major initiatives across the UK that met the scope of our review: (29) England (16) Wales (16) Northern Ireland (17) Scotland. Full details and analysis are available upon request.

We used these initiatives to identify major themes and objectives in what integrated care efforts have been trying to achieve to inform the selection of indicators for our quantitative analysis. Where they exist, we also cross-referenced against relevant outcomes frameworks for integration.

A long-list of measures was developed relevant to the main aims of integration (see Table A2). The availability of data for each measure across countries was reviewed, taking account of comparability and consistency over time. We sought to achieve a balance of measures across domains, so within each selected those most relevant to the broad aims of integration policy.

Patient and service user experience and satisfaction

One measure was included for satisfaction with social care, although covering different time periods for each country. There were also some differences in the question wording, so while trends over time can be compared, the measures are not directly comparable between countries.

We were not able to identify relevant measures for patient experience of integration of care. While there are relevant individual country measures, such as the England GP Patient Survey question on support for long-term conditions, there are currently no comparable measures across UK countries.

Additional measures considered were population wellbeing and satisfaction with the NHS. These were both excluded on the basis that they were general population surveys and unlikely to be sensitive to changes in integration of services.

Inequalities and population health

Four measures were identified for this domain, three of which are directly comparable across the four UK countries. Health life expectancy at age 65 by deprivation is not available for Northern Ireland.

We used healthy life expectancy at age 65 rather than at birth because of the focus of integration policies on improving care for people with more complex health and care needs. A number of more specific health measures were considered, including hospital admissions for hip fractures, alcohol related harm and obesity in older people. Although these measures may be relevant for evaluation of specific, targeted interventions, we felt that the selected measures were a more balanced set to use to track the broader aims of integration.

System efficiency

We identify three measures which relate to how well the health and care system ensures that people are cared for outside of hospital settings, although these are all based on hospital data.

Other measures which we considered for inclusion were only available for one of two of the countries.

Health and social care spending were also included, as indicators of the relative funding for services over the period. These could also be considered contextual measures, but given the emphasis within integration policy and

directing resources to support integration, it is important to track how funding changed in reality.

Quality of integrated care

We were unable to find measures of quality of integrated care which were distinct from those measures already identified for other domains. For example, survey data on patients experiencing a delay in hospital discharge was excluded because the data is only available at limited time points and the issue of discharge is already covered by delayed transfers of care.

Table A2: Potential outcomes of interest considered and included

Domain	Indicator	Available for at least three countries?
Patient experience	Quality of care experience (at GP level, care home level, hospital level)	Only population level survey (British Social Attitudes) available – not included as not specific to service users
	Self-confidence of older adults	Not available
	Satisfaction with health and social care	Satisfaction with social care included
	Life satisfaction among older people or people with complex care needs	Not available
	Level of involvement in decisions of care	Not available
	Quality of life (degrees of loneliness, happiness, and self-reported health states)	Only population level survey of wellness available, not included
Inequalities and population health	Healthy life expectancy	Included (at age 65)
	Healthy life expectancy by level of deprivation	Included (at age 65)
	Years of life lost among adults to amenable conditions, by level of deprivation	Not available after 2016
	Employment of people with long-term conditions	Included
	Amenable mortality, by level of deprivation	Included (treatable mortality)
	Hip fractures among older people	Not included – more relevant measures available
	Older people of healthy weight	Not included – more relevant measures available
System efficiency	Proportion of older people still at home 91 days after discharge	Not available
	Emergency hospitalisation for chronic healthcare-amenable and acute avoidable conditions	Not available after 2013
	Emergency readmissions within 30 days	Not available
	Delayed transfers of care and critical care bed days lost to delayed transfers	Delayed transfer of care measure included
	Allocation of resources (funding/ staff/capital)	Overall spend included
	Growth rate of health care spending	Included (health and social care)
	Rates of unplanned admissions	Included

Domain	Indicator	Available for at least three countries?
Quality	Avoidable readmissions	Not available
	Delayed transfers of care	Included in efficiency
	Wait times for clinical assessments	Not available
	Life expectancy at 75/Older people in good health	Included (at age 65)
	Older people free from limiting long term illness	Converse of HLE at 65
	Admission to residential or nursing homes	Not available
	Total time spent at home (not in hospital) for older people with care and support needs	Not available

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