



BRIEFING PAPER

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Health and Social Care Integration

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Summary

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

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

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

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

This briefing looks at the challenges presented by the integration of health and social care, as well as recent Government policies to promote integration. These have included the creation of Health and Wellbeing Boards, local strategic planning forums with representatives from health and social care services, and the Better Care Fund, a pooled budget between the NHS and local authorities, to which the Government committed £7.8 billion in 2018/19. In 2019, the Government and NHS England announced a review of the Better Care Fund, which will look at concerns including the complexity of its funding mechanism and actual returns on investment.

Integration is a central goal of the NHS, as set out in NHS England's *Five Year Forward View* (October 2014) and the subsequent *NHS Long Term Plan* (January 2019). The *Long Term Plan* emphasises new models of integrated health and social care delivered via Integrated Care Systems (ICSs), which will develop from the current Sustainability and Transformation Plans (STPs). There are currently 14 ICS areas in England, and the intention is that ICSs will be in place throughout the country by April 2021.

In September 2019, the NHS set out legislative proposals for a new draft Bill, to implement the *NHS Long Term Plan* and enable different parts of the NHS to work together, and with partners, more easily. The Bill would replace the current NHS procurement framework, which is seen by commissioners and providers as a barrier to integrating care at scale. The Bill would also repeal current barriers to creating new NHS Trusts, with the intention that new NHS Trusts could be developed in the future to integrate services at scale and hold new Integrated Care Provider contracts (ICPs). Proposals for an NHS Bill were included in the Queen's Speech October 2019.

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

1. Health and social care integration

1.1 What is meant by integration?

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

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

It is for local commissioners to decide how care can be delivered in a more integrated way, with services integrated according to local needs and circumstances. There is no set definition or statutory requirements for integration. In recent years, some of the focus of integration has been around moving care out of hospitals and into home or community settings. This focus is often accompanied by targets to reduce emergency admissions into hospitals and delayed discharges from hospitals.

To achieve a more integrated patient experience, it is often necessary for health and social care providers to integrate at an organisational level. This can be through the pooling of budgets, joint commissioning or co-location of services, integration of workforces, and the sharing of patient information. The *NHS Long Term Plan* (January 2019) provides the following ambition for integrated care:

The NHS will increasingly be more joined-up and coordinated in its care. Breaking down traditional barriers between care institutions, teams and funding streams so as to support the increasing number of people with long-term health conditions, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care¹

1.2 Growing importance of integration

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

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

¹ [The NHS Long Term Plan](#), January 2019, para 1.4

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

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

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

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

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

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

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

There is now good evidence that at least 20 per cent of acute admissions to hospital are not strictly necessary, and that people could be cared for better in other settings, including at home. Such care will not always cost less, though frequently it will. But better integration between primary and secondary care, and better integration between health and social care, along with better arrangements between the two at the end of life, would

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

⁴ National Audit Office, *Health and social care integration*, 8 February 2017, HC 1011 2016-17, para 1.1

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either avoid many of these admissions in the first place, or would allow swifter discharge once treatment was completed.⁵

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

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

As we stated in our November 2014 report *Planning for the Better Care Fund*, providers of health and social care have fixed costs. Therefore reductions in activity do not necessarily translate into sizeable savings unless whole wards or units can be decommissioned.⁶

In 2018, the National Audit Office also noted in *The health and social care interface report* that it is challenging to develop a robust evidence base to show that integration of health and social care improves patient outcomes, as it is difficult to isolate the impacts of integration from other factors.⁷

1.3 Challenges for integrating services

Successive Governments have attempted to better integrate health and social care, but have faced financial, strategic, cultural and structural challenges that have hindered progress.

Some of the most commonly cited challenges include:

Funding pressures

The NHS and local government are under financial pressure. The NAO explains that government funding for local authorities fell by an estimated 49.1% in real terms from 2010-11 to 2017-18⁸, whilst the NHS is under severe financial pressure and struggling to cope with increasing demand for health services. This can deter organisations in partnerships from seeking system-wide benefits that may be financially detrimental to them as individual organisations:

These funding pressures can distract local organisations from engaging with efforts to join up services. The Social Care Institute for Excellence has described how organisations find this difficult when they are dealing with their own viability and survival. The risk of unhealthy competition has increased. The Nuffield Trust has reported that hospitals increasingly blame their local social care sector for playing a part in their deteriorating performance. The Health Foundation and The King's Fund have reported that

⁵ Barker Commission, [A new settlement for health and social care: Interim report](#), April 2014, p12

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

⁷ National Audit Office, [The health and social care interface](#), July 2018, para 1.10

⁸ National Audit Office, [The health and social care interface](#), July 2018, para 2.2

there are more incentives for organisations to shunt costs between one another.⁹

NHS treatment is free at the point of use, whilst local authority social care is means-tested. This can produce conflict over funding and funding eligibility for patients between the two services. The Barker Commission's interim report particularly highlighted potential for disputes around the provision of NHS Continuing Healthcare (free nursing support for patients with ongoing primary health needs):

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

[...]

The different funding streams mean health and social care each have an interest in pushing the funding problem on to the other. The very different entitlements provide relatives and individuals with a personal financial interest in the outcome. The differing organisations mean patients and clients can see well-loved carers changed because health and social care contract with different providers, and contract to provide different services.¹⁰

Immediate pressures in acute services can also mean that funding is diverted away from transformation of services. For example, in June 2018 the National Audit Office reported that the original ambition to expand the NHS vanguard programme was not realised because funding available for transformation was reallocated to reducing trusts' financial deficits.¹¹

Cost to providers

Concerns have been raised that local organisations may be unable to meet the significant upfront investment costs of creating an integrated service.

A 2015 Public Accounts Committee report on the Better Care Fund argued that there had been "minimal pump-priming investment to support the development of new community-based services." It also quoted evidence from the LGA arguing that the fund's focus on savings was unhelpful given that the integration of services required significant upfront investment from local authorities.¹²

⁹ National Audit Office, [The health and social care interface](#), July 2018, para 2.3

¹⁰ Barker Commission, [A new settlement for health and social care: Interim report](#), April 2014, pp17-18

¹¹ Comptroller and Auditor General, [Developing new care models through NHS vanguards](#), Session 2017–2019, HC 1129, National Audit Office, June 2018.

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

Additionally, current accountability arrangements, set by legislation, emphasise the need for individual organisations to balance their books. As the National Audit Office explains:

Local authorities must, by law, set a balanced budget. Local health bodies are held accountable by NHS England and NHS Improvement for meeting their individual control totals (financial targets). The mismatch between the drive to spend co-operatively and for individual organisations to meet financial requirements makes it difficult for organisations to pool budgets, share financial risks and commission services jointly.¹³

The Care Quality Commission (CQC) explained that the need for individual organisations to meet their own financial targets is precluding them from adopting a 'whole person' approach that focuses on a patient's journey through the health and social care system.¹⁴

However, the updated NHS planning guidance issued by NHS England and NHS Improvement in February 2018 requires the Integrated Care System (ICS) areas to provide single system operating plans and to work within a single system total budget,¹⁵ which may help address accounting in silos.

Workforce challenges

There can be barriers to integration through different working cultures, professional entrenchment and different terms and conditions across the health and social care sectors. The NAO reports that roles in the social care workforce suffer from low prestige and a perception that they offer less opportunities for career progression compared with similar roles in the NHS.¹⁶

A 2016 report by the King's Fund on working across boundaries also argued that joint working could reinforce and define the contrast between the two health and social care workforces' distinct professional identities.¹⁷

Information sharing

Problems with sharing data and a patient's care record across health and social care can mean that an individual's care is not co-ordinated across agencies. There can be confusion between local organisations over the legal requirements for patient confidentiality and information sharing.

Progress has been made in this area. A 2018 NAO report explains that most local areas no longer cite such concerns as a barrier to information sharing, and are instead focusing on finding ways to effectively share data:

¹³ National Audit Office, [The health and social care interface](#), July 2018, para 2.9

¹⁴ Care Quality Commission, [Local system reviews: Interim report](#), December 2017

¹⁵ NHS England and NHS Improvement, [Refreshing NHS plans for 2018/19](#), February 2018

¹⁶ National Audit Office, [The health and social care interface](#), July 2018, para 3.14

¹⁷ The King's Fund, [Supporting integration through new roles and working across boundaries](#), June 2016, p19

Local areas are having some success in developing a solution to this longstanding problem. Some have reported success in implementing a functioning shared care record across health and social care. For example, since 2017, in Leeds information from hospitals, GPs, mental health, community health and adult social care has been pulled together into a single patient record. The time saved has been equivalent to a reported £1 million per year. NHS England told us that 61 local areas have now set up information-sharing initiatives.¹⁸

Competing policy priorities

Various organisations have argued that the *Health and Social Care Act 2012*, which is designed to promote choice and competition in the NHS, can make integration of services more difficult.¹⁹ This was again identified as a problem for integration in the 2017 NAO report on [Health and social care integration](#).

1.4 Government policies to promote integration

Integration of health and social care is not a new political ambition. From the *National Health Service Act 1977* under James Callaghan's Labour Government, which encouraged health authorities and local authorities to co-operate, to the *Health Act 1999*, which allowed NHS bodies and local authorities to pool budgets, successive Governments have sought to bring the NHS and local authority social care services closer together. The 1999 Act was part of the last Labour Government's stated aim to pull down the "Berlin Wall" dividing health and social services.²⁰

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

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

In May 2013, the then Care and Support Minister announced an ambition for all local areas to have integrated health and social care by 2018.²¹ The 2013 Spending Round also saw the announcement of a

¹⁸ National Audit Office, [The health and social care interface](#), July 2018, para 3.13

¹⁹ See for example, The King's Fund, [Making sense of integrated care systems, integrated care partnerships and accountable care organisations in the NHS in England](#), February 2018.

²⁰ 'Health and social care partnerships made easier', *The Guardian*, 9 November 2000

²¹ Department of Health, [People will see health and social care fully joined-up by 2018](#), 14 May 2013

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£3.8 billion joint budget for the NHS and local authorities, the Better Care Fund (see section 3.2).

NHS funding is increasingly targeted towards more integrated ways of working. NHS England's 2014 planning document, the *Five Year Forward View* (5YFV), set out plans for 'new models of care', which were intended to "increasingly dissolve these traditional boundaries", between GPs, hospitals, social care and mental health (see section 2.2).²² The 2019 *NHS Long Term Plan* also proposed new models of collaboration, predominantly through Integrated Care Systems (ICS), as explained below. The current intention is for all areas to have an ICS by April 2021.

In September 2019, the NHS proposed a draft Bill to Government and Parliament to promote further integration of services. However, the NHS notes that there is minimal appetite from the NHS and the public for primary legislation that would trigger another wholesale administrative reorganisation of the NHS.²³ For further information, see section 2.6.

²² NHS England, *Five Year Forward View*, October 2014

²³ NHS, [The NHS's recommendations to Government and Parliament for an NHS Bill](#), September 2019, para 3

2. Organisational integration

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

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

2.1 Health and Wellbeing Boards

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

The legislation gave HWBs a duty to encourage integrated working. Boards were expected to have strategic influence over commissioning and to produce a Joint Strategic Needs Assessment – an assessment looking at the current and future health and care needs of the local population.²⁴

As a minimum, membership of the HWB must include:

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

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

Progress in implementing integrated care locally remains variable. Anecdotal evidence indicates increasing interest, with some parts of the country making good progress in developing and delivering ambitious plans. However, the finding from our survey that most HWBs have not identified it as a priority highlights the need for them to take a much stronger lead in driving it forward locally.²⁵

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

²⁴ DoH, [A short guide to health and wellbeing boards](#), February 2012

²⁵ Health Committee, [Public Expenditure on Health and Social Care](#), 12 February 2014, HC 793 2013-14, para 42

2.2 New Care Models

A central policy of NHS England's 2014 planning document, the [Five Year Forward View](#) (5YFV), was the development of new care models to "increasingly dissolve these traditional boundaries," between GPs, hospitals, social care and mental health.²⁶

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

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

Under the Government's mandate to NHS England for 2017/18, there was a goal for new care models to cover at least 50% of the population by 2020, as part of attempts to reduce emergency admission rates.²⁷

Vanguards

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

In September 2016, NHS England published a [summary document](#) of the plans of all 50 vanguards, with a number of vanguard sites setting out plans for integration of social care services or staff into NHS services.²⁸

The King's Fund's 2016 analysis of vanguards found that all were "building closer partnerships between primary, community, mental health and social care services as a basis for changing how staff and resources are used." It gave the example of changes implemented by the West Wakefield MCP:

During the first 18 months, the vanguard created 'connecting care hubs', bringing together groups of GP practices with a team of community nurses, social care staff, therapists and voluntary organisations. These hubs deliver joined-up services for people most at risk of becoming ill, such as those with long-term conditions, complex health needs, or people who have been in hospital for an operation or emergency.²⁹

²⁶ NHS England, [Five Year Forward View](#), October 2014

²⁷ DoH, [The Government's mandate to NHS England for 2017-18](#), March 2017

²⁸ NHS England, [New Care Models: Vanguards – developing a blueprint for the future of NHS and care services](#), September 2016

²⁹ The King's Fund, [New care models: Emerging innovations in governance and organisational form](#), October 2016, p12

£102 million was allocated to the sites for 2016/17, and £101 million for 2017/18.³⁰ Although funding to the vanguard sites stopped after 2017/18, development of new care models continued, through Sustainability and Transformation Partnerships (STPs).

2.3 Sustainability and Transformation Partnerships

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

The plans were intended to show how local services would improve quality of care, promote population health, and become more financially sustainable. There were 44 'footprint' areas across England, which consist of NHS providers, CCGs, local authorities and other health and care services, known as Sustainability and Transformation Partnerships (STPs).

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

Perhaps the most important of all the advantages is that the unacceptable gap that currently exists between healthcare and social care will be breached. That is at the centre of the whole process.³¹

The LGA stated its support for the STP process, hailing the plans as "significant milestones" in the integration of health and social care. However, it raised concerns about local authorities' involvement in the process, and about how STPs would interact with HWBs' own plans for integration (which cover a smaller geographic area than that of most STPs).³²

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

Sustainability and transformation planning is neither inclusive nor transparent enough. We heard from the Local Government Association that in some areas NHS England has not been engaging sufficiently with local government. We heard from NHS England that, conversely, in some areas local government has declined to get fully involved. Engagement can be complicated because the 44 sustainability and transformation planning areas do not all align with local authority boundaries. Nevertheless,

³⁰ NHS England, [Approved New Care Models Programme vanguard funding allocation](#), December 2016

³¹ [HC Deb 14 September 2016, cc997-8](#)

³² [Letter from Cllr Izzi Seccombe \(Chair of LGA Community Wellbeing Portfolio\) to Jeremy Hunt](#), 10 March 2016

without meaningful engagement with local authorities, integration is an impossibility.³³

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

Without full local authority engagement in the joint sustainability and transformation planning process, there is a risk that integration will become sidelined in the pursuit of NHS financial sustainability.³⁴

More information on STPs can be found in the Commons Library briefing paper, [Sustainability and transformation plans and partnerships](#).

NHS England's [Next Steps on the NHS Five Year Forward View](#) set out plans for the most integrated STPs to develop into Accountable Care Systems (now called Integrated Care Systems). These will see NHS bodies and local authorities taking collective responsibility for commissioning resources and for the health and social care of their STP area.³⁵

2.4 The NHS Long Term Plan

The [NHS Long Term Plan](#), published in January 2019, set out new service models to promote integration. The Plan was accompanied by five financial tests to demonstrate how the NHS will become more financially sustainable, one of which is that the NHS will reduce the growth in demand for care through better integration and prevention.³⁶

2.5 Integrated Care Systems

Integrated Care Systems (ICSs) are central to the delivery of the *Long Term Plan*, and will develop from the current network of STPs. The aim is to bring together different NHS organisations and local government and achieve the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care.³⁷

The benefits of moving from STP to ICS status for local areas include greater autonomy over funding, such as resources earmarked for transformation, and for services currently commissioned nationally, such as primary care and specialised services.

In June 2017, NHS England announced ten areas, made up of the leading STPs, to develop the first ICSs. A further four were selected in May 2018, meaning that ICSs now cover more than a third of the

³³ Public Accounts Committee, [Integrating health and social care](#), 27 April 2017, HC 959 2016-17, conclusions 4-5

³⁴ National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011 2016-17, para 21

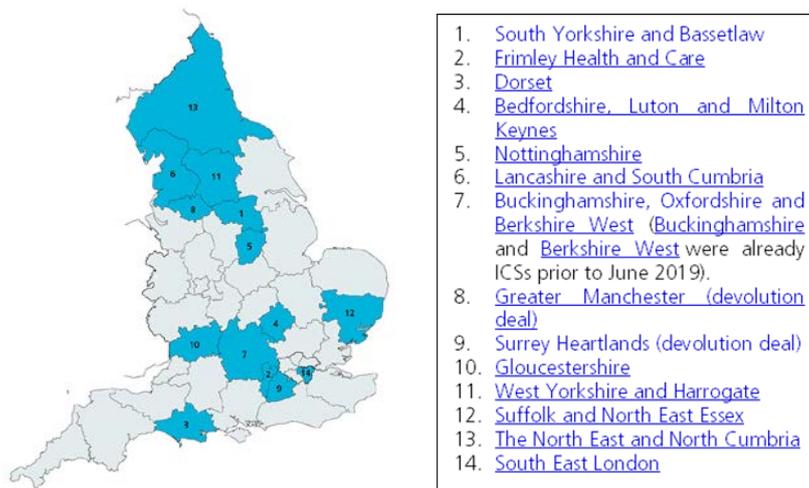
³⁵ NHS England, [Next Steps on the NHS Five Year Forward View](#), March 2017, pp35-7

³⁶ NHS England, [The NHS Long Term Plan](#), 7 January 2019, Chapter 6

³⁷ NHS England, [The NHS Long Term Plan](#), 7 January 2019, para 1.50

population of England.³⁸ The NHS proposes that all STPs will evolve into ICSs by April 2021, with a single CCG for each ICS area. However, as with STPs, ICSs are non-statutory, and rely on the voluntary commitment of local organisations and leaders to work collaboratively.

The following map shows the 14 areas of England where STPs have developed into ICSs:



[Source: NHS England, [Integrated Care Systems](#)]

ICSs are at various stages of development and vary widely in the size of populations they cover. In September 2018, the King's Fund published a review of the [Integrated Care Systems](#) during their first year. The review highlighted positive progress, including more integration between health services and local authorities, closer working across health and social care, and opportunities to act on the wider determinants of health.³⁹ Given the short time that the ICSs have been in existence, the report did not seek to assess their impact or draw conclusions on their success.

2.6 Integrated Care Provider contracts

The *NHS Long Term Plan* also proposed Integrated Care Provider (ICP) contracts. These would see commissioners bring together a range of health and care services under a single contract, with the provider of those services becoming an 'Integrated Care Provider' (previously referred to as an 'accountable care organisation') that is responsible for the quality of care and health outcomes for a defined population.

The Health and Social Care Select Committee recommended that legislation should rule out the option of non-statutory providers holding an ICP contract⁴⁰. It is hoped that doing so will allay fears that ICP contracts could provide a vehicle for extending the scope of

³⁸ A map of current STP and ICS areas is available from NHS England – see [Integrated Care Systems](#) (last accessed 29 November 2019)

³⁹ The King's Fund, [A year of integrated care systems: Reviewing the journey so far](#), September 2018

⁴⁰ Health and Social Care Committee, [NHS Long-term plan: legislative proposals](#), 18 June 2019, HC 2000 2017-19, para 79

privatisation. NHS England, in recognition of this recommendation and the expectation that ICP contracts will be held by statutory bodies, published a version of the ICP contract suitable for award to statutory bodies only.⁴¹

Although NHS England's current expectation is that the ICP contract will 'most likely' be held by statutory bodies, it has not ruled out the possibility of non-statutory organisations being awarded an ICP contract in the future:

If, within the current legislative framework, pre-procurement market engagement by commissioners indicated that a non-statutory organisation was interested in bidding for an ICP Contract, further conversations would be necessary.⁴²

The first ICP contract is expected to be awarded by Dudley CCG to an existing NHS partnership, by April 2020.⁴³

2.7 A new NHS Bill

Following extensive consultation, in September 2019 NHS England and NHS Improvement published [recommendations to Government and Parliament for an NHS Bill](#), for which the overarching purpose is to enable different parts of the NHS to work together and with partners more easily. The NHS proposed that an NHS Bill should be introduced in the next session of Parliament. This Bill would have a targeted scope, rather than be a comprehensive reorganisation of the NHS.

The plans directly reflect the recommendations of Health and Social Care Committee inquiry into [legislative proposals to support the implementation of the NHS Long Term Plan](#) (June 2019).

The legislative proposals aim to remove barriers to joint working between NHS organisations and their partners, and include:

- A new NHS **'triple aim' for better population health, better quality of patient care, and financially sustainable services**. This triple aim duty should reflect the need to engage with local communities and build on the existing duties of local authorities and CCGs to engage patients and citizens, collaborate in the delivery of their functions and integrate care for patients.
- **Replacing the existing NHS competition and procurement framework** to ensure that commissioners can exercise more discretion about when to carry out a formal procurement process. Specifically, NHS England and NHS Improvement have proposed the repeal of section 75 of the *Health and Social Care Act 2012* and the removal of the NHS from the *Public Contract Regulations 2015*. This would remove the current procurement and tendering rules which, in the view of providers and commissioners, can "frustrate attempts to integrate care at scale, disrupt the development of stable collaborations, and involve protracted

⁴¹ NHS England, [Integrated Care Provider contract](#), last accessed 3 December 2019

⁴² NHS England and NHS Improvement, [ICP contract](#), August 2019

⁴³ Health and Social Care Committee, [NHS Long-term plan: legislative proposals](#), 18 June 2019, HC 2000 2017-19, para 70

processes with wasteful legal and administration costs.”⁴⁴ The NHS intends to set out draft proposals for a new procurement framework.⁴⁵

- Allowing the **formation of joint decision-making committees** on a voluntary basis, rather than the alternative of creating Integrated Care Systems (ICS) as new statutory bodies, which would ‘require a major NHS reorganisation’.⁴⁶
- Enable the Secretary of State to **establish new NHS Trusts**. This would allow the creation of suitable NHS bodies to hold an Integrated Care Provider contract (ICP), in areas where commissioners wish to bring integrated services together under a single contract.⁴⁷ Legislative change would be needed to revoke the provisions of the *Health and Social Care Act 2012* – the legislation did not envisage the creation of any new NHS trusts (it provided for the abolition of NHS trusts, although those provisions have not been brought into force).⁴⁸

The NHS notes that although the proposals relate specifically to NHS legislation, they agree with the Committee that closer collaboration with local government is needed. This includes the role of Health and Wellbeing Boards in developing joint health and wellbeing strategies, and actively encouraging local authorities to join ICS committees.⁴⁹

Plans for a [draft Bill](#) were subsequently included in the October 2019 Queen’s Speech.

⁴⁴ NHS, [The NHS’s recommendations to Government and Parliament for an NHS Bill](#), September 2019, para 65

⁴⁵ NHS, [The NHS’s recommendations to Government and Parliament for an NHS Bill](#), September 2019, para 100

⁴⁶ NHS, [The NHS’s recommendations to Government and Parliament for an NHS Bill](#), September 2019, pages 3-4

⁴⁷ NHS, [The NHS’s recommendations to Government and Parliament for an NHS Bill](#), September 2019, para 138

⁴⁸ NHS, [The NHS’s recommendations to Government and Parliament for an NHS Bill](#), September 2019, para 137

⁴⁹ NHS, [The NHS’s recommendations to Government and Parliament for an NHS Bill](#), September 2019, para 13

3. Integration of budgets

3.1 Funding for health and social care

Health and social care are funded differently. The Department of Health and Social Care (DHSC) provides funding to NHS England and to 191 local clinical commissioning groups (CCGs) to commission health services for their populations.

Adult social care is primarily funded through local authorities. Local authority funding consists of several funding streams including central Government grants, the business rate retention scheme and council tax. The majority of adult social care funding is not ring-fenced and it is for local authorities to decide how to prioritise their spending based on local priorities and need. Local authorities can also raise council tax by a set percentage per year to be ring-fenced for spending on adult social care (known as the social care precept).⁵⁰

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

3.2 Better Care Fund

The Better Care Fund (BCF) is a funding mechanism specifically for the integration of health and social care. It was announced in the [2013 Spending Round](#), with the aim of “delivering better, more joined-up services to older and disabled people, to keep them out of hospital and to avoid long hospital stays.”⁵¹

The BCF is a pooled budget which is intended to shift resources out of hospital into social care and community services, for the benefit of the NHS and local authorities. The power to create a pooled budget was introduced by the *Care Act 2014*, which amended the *National Health Service Act 2006*. The Fund has increased from a total of £5.3 billion in 2015/16 to a total of £7.8 billion in 2018/19.⁵²

Effectiveness

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

- Local areas planned to reduce delayed transfers of care by 293,000 days in total, saving £90 million. However, in 2015-16 the number of delayed days increased by 185,000 compared with 2014-15, costing a total of £146 million more than planned.
- Local areas planned to reduce emergency admissions by 106,000 in 2015-16, saving £171 million. However, in 2015-16 the number of emergency admissions increased by

⁵⁰ For more information see the Commons Library briefing paper, [Adult Social Care Funding \(England\)](#), CBP-7903

⁵¹ HM Treasury, [Spending Round 2013](#), Cm 8639, June 2013, para 1.30

⁵² [MHCLG Update](#): Written statement - HLWS98, 5 November 2019

87,000 compared with 2014-15, costing a total of £311 million more than planned.

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

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

However, in terms of savings, the NAO estimated that the higher than planned for number of delayed transfers of care and emergency admissions would have impacted on the £511 million of savings set out in the local BCF plans. Analysis was based on NAO estimates, as the NAO found no evidence that the (then) Department for Communities and Local Government (DCLG) or the Department of Health (DH) monitored or followed up on whether these planned savings were achieved.⁵⁴

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

It is deeply unsatisfactory that the Departments and NHS England washed their hands of any accountability for the Better Care Fund. NHS England's Chief Executive seemed to reject any accountability for the performance of the Fund over its first year. He dissociated himself from the targets set for its first year, saying that it had not been designed by any of the witnesses at our evidence session. No other witnesses demurred from this assertion. The Committee is very disappointed by this response; as we reported in February 2015, the arrival of NHS England's new Chief Executive in April 2014 was the stimulus for the pause and redesign of the Fund. Accounting officers cannot disown the plans of their predecessors.

Recommendation: The Departments, NHS England and the Local Government Association must take responsibility for the performance of their programmes, including the Better Care Fund while it continues. We expect greater accountability and more realistic objectives, which the Departments and partners will stand by.⁵⁵

⁵³ National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011 2016-17, para 2.6-2.8

⁵⁴ National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011 2016-17, para 2.7

⁵⁵ Public Accounts Committee, [Integrating health and social care](#), 27 April 2017, HC 959 2016-17, conclusion 6

Comment

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

The initial planning for the Fund was deeply flawed. The Department of Health and the Department for Communities and Local Government (the Departments), and NHS England changed the rules in the middle of the planning phase, after failing to tell planners they needed to identify £1 billion in savings. As a result, all 151 health and wellbeing boards had to submit revised plans resulting in wasted time, effort and money. Local areas are now at greater risk of not being able to implement the policy.⁵⁶

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

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

- The level of bureaucracy: the BCF is seen as unwieldy, consumes a disproportionate management time, and comes with demanding metrics and oppressive reporting requirements
- The unrealistic expectations for the BCF, fuelling disputes between partners and 'giving integration a bad name' in the words of one respondent
- The pressure it added to already-stretched health finances, essentially because the BCF merely reuses existing funding while assuming it creates additional investment.⁵⁷

A joint statement on health and social care by the Nuffield Trust, the King's Fund and the Health Foundation stated that only 33% of the BCF was used for social care in 2015/16, which did not offer adequate protection for social care services in light of budgetary pressures.⁵⁸

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

...little more than a ruse to move money from the health sector to social care, disguised within an overly bureaucratic initiative that purported to integrate health and social care services.⁵⁹

It was argued that the overly bureaucratic nature had actually disrupted existing integration work in some areas. The report also criticised DH and DCLG for not having carried out sufficient research into the most

⁵⁶ Public Accounts Committee, [Planning for the Better Care Fund](#), 26 February 2015, HC 807 2014-15, p3

⁵⁷ CIPFA, [The better care fund – six months on](#), November 2015

⁵⁸ The Nuffield Trust, the King's Fund & the Health Foundation, [The Autumn Statement: joint statement on health and social care](#), November 2016

⁵⁹ Public Accounts Committee, [Integrating health and social care](#), 27 April 2017, HC 959 2016-17, conclusion 2

effective balance of funding across health and social care, as well as arguing that BCF had been “rendered largely redundant” by Sustainability and Transformation Partnerships (see section 2.3).⁶⁰

The *NHS Long Term Plan 2019* announced a review of the Better Care Fund, in light of such concerns:

The BCF is regarded as a success in many areas, with local authorities and CCGs contributing more than their minimum required investment to support integration. However the National Audit Office has reported that the funding mechanism is overly complex, and there is a lack of clarity on the return from investment. The funding has also sometimes been used to replace core council funding rather than add to investment at the interface between health and care services. The Department of Health and Social Care and the Ministry of Housing, Communities and Local Government with NHS England are therefore reviewing the BCF to ensure it meets its goals. The review will conclude in early 2019, and 2019/20 will continue to include clear requirements to continue to reduce DTOCs [delayed transfers of care] and improve the availability of care packages for patients ready to leave hospital.⁶¹

⁶⁰ Public Accounts Committee, [Integrating health and social care](#), 27 April 2017, HC 959 2016-17, conclusions 1-3

⁶¹ NHS Long Term Plan, January 2019

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

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

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

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

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

An overarching principle that all areas will remain part of the NHS, upholding national standards and continuing to meet statutory requirements and duties, including the NHS Constitution and Mandate.⁶²

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

The [October 2019 Queen's Speech](#) also contained a commitment to publish a White Paper on devolution.

Devolution deals

Greater Manchester is one of the most developed areas of devolution. The Government published the [Greater Manchester Health and Social Care Devolution Memorandum of Understanding](#) on 27 February 2015, which envisaged a new Greater Manchester Health and Social Care Partnership Board which would produce the joint health and social care strategy for Greater Manchester.

The Partnership Board has two sub-groups: a Greater Manchester Joint Commissioning Board (JCB) and an Overarching Provider Forum. Members of the former are the 12 CCGs in Greater Manchester; the 10 Greater Manchester boroughs; and NHS England. Members of the latter are service providers: acute care trusts, mental health trusts, ambulance trusts, LMCs (local medical committees), and others.

Through the JCB, strategic decisions regarding commissioning of health and social care services in Greater Manchester are agreed by NHS

⁶² NHS England, [Board Paper: Devolution – Proposed Principles and Decision Criteria](#), September 2015, para 3.3

England, CCGs, and local political actors. [A strategy](#) was published in December 2015. The JCB commissions health and social care services across Greater Manchester on behalf of its constituent organisations, pooling the commissioning budgets of the CCGs and the social care budgets of the boroughs.

The current estimated size of the annual health and social care budget is £6 billion.⁶³ Greater Manchester has also been awarded £450 million health service transformation funding over five years (2016-21).⁶⁴

Commissioning of services that are the responsibility of NHS England, such as specialised services and some public health services, are still carried out by NHS England. However, Greater Manchester takes decisions about service changes, finances, quality and performance.⁶⁵

As noted above, Greater Manchester is currently developing as an ICS, and again is considered to be one of the most advanced areas.⁶⁶

London also has devolved powers through the [London Health and Care Collaboration Agreement](#). The London Health Board, chaired by the Mayor of London, provides oversight and support, and a Devolution Programme Board provides steering of the devolution programme and support for five devolution pilot programmes. The pilots are focusing on three priorities: prevention, health and care integration, and making best use of NHS buildings and land. Three of the [five pilot programmes](#) are looking at care integration (Outer North East London at a sub-regional level, Hackney and Lewisham at a local level).

Devolution deals have also been agreed in North of Tyne; Cambridgeshire and Peterborough; Cornwall; Liverpool City Region; Tees Valley; West Midlands and West of England. Further information on these deals is available from the Government website – see [Devolution and mayors: what does it mean?](#).

In the **Surrey Heartlands** area, devolution of a limited range of powers to a joint body took effect from 1 April 2018. The [trilateral agreement](#) provides the formal commitment of NHS England and NHS Improvement, three CCGs (NHS North West Surrey CCG, NHS Guildford and Waverley CCG, NHS Surrey Downs CCG) and Surrey County Council to the progressive implementation of devolution in this area. The area has formed an integrated care partnership through the [Surrey Heartlands health and care partnership](#).

⁶³ NHS England, [Greater Manchester Health and Social Care Partnership](#) (last accessed January 2020)

⁶⁴ Greater Manchester Health and Social Care Partnership, [Transformation Funding](#)

⁶⁵ Greater Manchester Health and Social Care Partnership, [GM Devo: Internal delegation by NHS England to GM Chief Officer](#), March 2016

⁶⁶ See King's Fund, [What has the STP or ICS ever done for me?](#), 17 May 2018

5. Scotland

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

Achieving the twin aims of integration within health care and between health and social care has long been an objective of government in Scotland. Its importance has grown significantly since 1997 and has been a major feature of all the strategic documents that have been published on the structure and functioning of the NHS, underpinning both the creation of unified NHS boards integrating planning and delivery of services, and the development of collaborative and partnership working.⁶⁷

In contrast to the NHS in England, since 2004 Scottish health commissioning and provision has been integrated under the management of NHS Boards. The *NHS Reform (Scotland) Act 2004* also required NHS Boards to set up community health partnerships as a means of achieving greater integration within the NHS and between health and social care.⁶⁸

The *Public Bodies (Joint Working) (Scotland) Act 2014* introduced significant legislative changes to bring about further integration of health and social care. Under the 2014 Act, local authorities and NHS Boards are required to delegate a wide range of functions to an integration authority. The overall aim of the integration authority is to create a single system for the joint commissioning of health and social care services. Since 2016/17, integration authorities have had annual budgets of almost £9 million.

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

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

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

- is integrated from the point of view of service-users,
- takes account of the particular needs of different service-users,
- takes account of the particular needs of service-users in different parts of the area in which the service is being provided,
- takes account of the particular characteristics and circumstances of different service-users,
- respects the rights of service-users,

⁶⁷ The King's Fund, [Integrated care in Northern Ireland, Scotland and Wales: Lessons for England](#), July 2013, p31

⁶⁸ Scottish Parliament Information Centre, [The National Health Service in Scotland: Subject Profile](#), June 2011

- takes account of the dignity of service-users,
- takes account of the participation by service-users in the community in which service-users live,
- protects and improves the safety of service-users,
- improves the quality of the service,
- is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care),
- best anticipates needs and prevents them arising, and
- makes the best use of the available facilities, people and other resources⁶⁹

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

Further information can be found in the Scottish Parliament Information Centre briefing, [Health and social care integration: Spending and performance update](#) (June 2019).

⁶⁹ Section 4, [Public Bodies \(Joint Working\) \(Scotland\) Act 2014](#)

6. Wales

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

The NHS must work well with its local partners, including the public, to design services around people, not organisations. It must work closely with the whole public sector to secure the best possible services and best use of available resources.⁷⁰

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

The NHS needs to reflect the need of our modern society, with closer links between health and social services, strengthened community provision and better organisation of general hospital and community services.⁷¹

Most recently, the [Parliamentary Review into the future of Health & Social Care in Wales](#) (January 2018) set 10 top-level recommendations, the first of which is to develop "one system of seamless health and social care for Wales." This emphasises that care and support should be seamless, without artificial barriers between physical and mental health, primary and secondary care, or health and social care.

Legislative changes

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

In April 2014, the Intermediate Care Fund (ICF) was launched. The ICF aims to enable integrated and collaborative working between social services, health, housing, the third and independent sectors.⁷² The Fund has a particular focus on older people with complex needs and long-term conditions, including dementia; people with learning disabilities; children with complex needs; and carers, including young carers.

The 2019-21 guidance sets the following priority objectives:

- enable older people to maintain their independence and remain at home, avoiding unnecessary hospital admissions and delayed discharges;
- enable families to meet their children's needs and help them to stay together;
- support carers in their caring role and enable them to maintain their own wellbeing;
- support the development of integrated care and support services for individuals with complex needs including

⁷⁰ Welsh Government, [Together for Health: a Five Year Vision for the NHS in Wales](#) February 2012, p7

⁷¹ Welsh Government, [Taking Wales Forward 2016-21](#), November 2016, p7

⁷² Welsh Government, [Integrated Care Fund Revenue, Capital and Dementia Guidance](#), para 7

- people with learning disabilities, children with complex needs and autism;
- offer early support and prevent the escalation of needs; and
- promote emotional health and wellbeing as well as prevent poor mental health.⁷³

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

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

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

It also required the establishment of partnership boards between local health boards and local authorities. Boards are required to share information and to establish pooled budgets for their care home and family support functions, and any other functions they wish the pooled funds to cover.

Regulations under the Act give local authorities the ability to delegate a number of their social care functions to local health boards, and vice versa.⁷⁴

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

The Act required all local authority areas to create a Public Service Board (PSB), including representatives from local authorities and local health boards.

Under the Act, PSBs are required to produce a local well-being plan. The Welsh NHS Confederation has highlighted the potential of PSBs to allow for greater collaborative commissioning and planning between public services, including health and social care.⁷⁵

The BMA has published a [timeline](#) of developments in health and social care integration in Wales.

⁷³ Welsh Government, [Integrated Care Fund Revenue, Capital and Dementia Guidance](#), para 10

⁷⁴ [The Partnership Arrangements \(Wales\) Regulations 2015, SI 2015/1989](#)

⁷⁵ The Welsh NHS Confederation, [The 2016 Challenge: A vision for NHS Wales](#), October 2015, p9

7. Northern Ireland

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

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

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

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

Integration in the delivery of services in NI is mainly achieved through the division of care into nine 'programmes of care' to which resource procurement and finance are assigned.⁷⁶ A 2013 report by the King's Fund found that within these, trusts tended to prioritise spending on health programmes over social care programmes.⁷⁷

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

While we found positive examples of integration between health and social care services in their approach to emergency care, significant obstacles still impede a truly joined-up approach to avoiding unnecessary hospital admissions and facilitating timely discharges. We found that many patients who are ready to be discharged remain in hospital because of difficulties at the interface between health and social care organisations.⁷⁸

In 2011, the Government-commissioned [Transforming Your Care](#) report highlighted an overreliance on inpatient hospital care for patients over treatment closer to home or in the community, and concluded that this model was unsustainable in the long term.⁷⁹

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

⁷⁶ Acute services; maternity and child health; family and child care; elderly care; mental health; learning disability; physical and sensory disability; health promotion and disease prevention; and primary health and adult community

⁷⁷ The King's Fund, [Integrated care in Northern Ireland, Scotland and Wales: Lessons for England](#), July 2013, p16-17

⁷⁸ Northern Ireland Audit Office, [Managing Emergency Hospital Admissions](#), November 2016, para 4.19

⁷⁹ Department of Health, [Transforming Your Care: A Review of Health and Social Care in Northern Ireland](#), December 2011, p27

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

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

Based on one of the Donaldson recommendations, in early 2016, the Government appointed an expert, clinically-led panel to lead debate on the best configuration of health care services for NI.

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

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

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

These teams will include GPs, Pharmacists, District Nurses, Health Visitors, Allied Health Professionals and Social Workers, and new roles as they develop, such as Advanced Nurse Practitioners and Physician Associates.⁸⁰

Also included in the strategy was an ambition to make Acute Care at Home (ACH) available to the whole population within three years. ACH, developed by East Belfast ICP, is an example of a more community-based integrated service, which allows patients to receive specialist tests and consultant led treatment at home, along with social care services.⁸¹

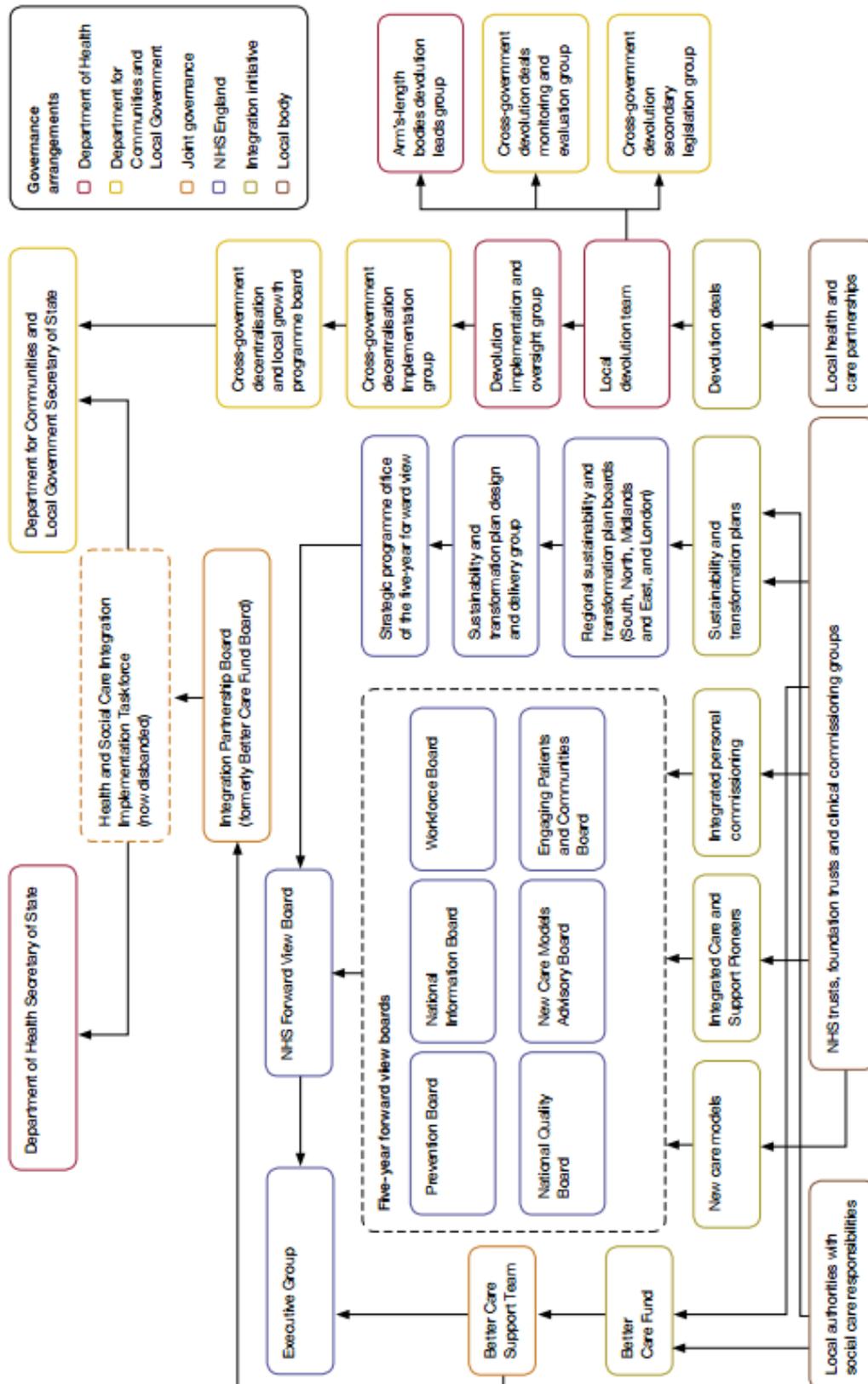
More information on health and social care policy can be found in the Northern Ireland Assembly Research and Information Service briefing, [*Transforming Health and Social Care in Northern Ireland – Services and Governance*](#).

⁸⁰ *Ibid.*, p14

⁸¹ Department of Health, [*Health and Wellbeing 2026: Delivering Together*](#), October 2016, p15-16

Annex 1: Integration governance

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



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