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The governance of integrated health and social care in England since 2010: great expectations not met once again?

Abstract

Integrating health and social care has long been a goal of policy-makers and practitioners. Yet, this aim has remained elusive, partly due to conflicting definitions and a weak evidence base. This article examines the governance of integrated care in England since 2010. It focuses on the extent to which the five governance attributes (transparency, accountability, participation, integrity and capability; TAPIC) are applicable to integrated care in England. The plethora of English policy initiatives on integrated care (such as the 'Better Care Fund', personal health budgets, and 'Sustainability and Transformation Plans') mostly shows signs of continuity over time although the barriers to integrated care often persist. The article concludes that the contribution of integrated care to improved outcomes remains unclear and yet it remains a popular policy goal. Whilst some elements of the TAPIC framework fit less well than others to the case of integrated care, the case of integrated care can be better understood and explained through this lens.

Introduction

Integrated care (IC) is widely viewed as offering a potential solution to some of the major challenges facing health and social care systems across the world (Goddard and Mason, 2016). Similarly, according to Busetto et al (2016), IC is seen as one of the most promising of sustainable approaches to solve the urgent task for health systems around the globe to managing the increasing demand for complex long-term care within constrained financial circumstances.

However, the high hopes of the latest fad (Marmor, 2004) may be undermined by two factors. First, IC is used as an umbrella term for various concepts and organisational

structures (Goddard and Mason, 2016). The terms 'integration', 'coordinated care' and 'joined-up services' are often used interchangeably and in widely varying contexts. (Bickerstaffe, 2013). Shaw et al (2011) identified as many as 175 different usages of 'IC' and related terms. Curry and Ham (2010) provide a typology of integration, differentiating between horizontal (for example, community health and social care services) and vertical integration (for example, hospital services and primary/community health services); as well as real (organisational) and virtual integration (based around networks, partnerships and alliances). Finally, they identify three levels of integration: macro (for a whole population), meso (for a particular group such as older people or people with diabetes) and micro (for individuals). Interestingly, these definitions tend to imply institutional arrangements rather necessarily than the changing practices of clinical professionals (such as delegation or role substitution).

Second, the evidence base for IC is rather fragile (e.g. Cameron et al, 2012; Dickinson and Sullivan, 2014). The *potential* impacts of IC care include better access; improved satisfaction and experience for patients, carers and health professionals; more appropriate care; enhanced preventive care; reduced avoidable hospital admissions and emergency admissions; prolonged independent living and delayed admission to institutional care; improved health status and quality of life; and enhanced cost-effectiveness (e.g. Ham and Curry, 2010; Petch et al, 2013; Mason et al, 2014; Nolte and Pitchforth, 2014). In short, IC is claimed to be central to the 'Triple Aim' challenge of improving patient experiences and patient outcomes while also delivering more cost-effective (Erens et al, 2015b; Busetto et al, 2016). Moreover, reviews suggest that evaluations tend to focus on processes rather than outcomes (Dowling et al, 2004; Cameron et al, 2012; Dickinson and Sullivan, 2014; Mason et al 2014, 2015; Busetto et al, 2016). As Goddard and Mason (2016) put it, the overall message emerging from most careful evaluations is that the evidence on benefits is rather mixed. In particular, the evidence relating to improving health outcomes is weak (e.g; Mason et al, 2014, 2015; Busetto et al, 2016) – although Petch (2012) and Petch et al (2013) argue that, while early studies focusing on individual outcomes did not provide definitive evidence, more recent studies, primarily from outside the UK, have had more promising results (eg Curry and Ham, 2010).

The prevalence of the IC discourse has found particular resonance in the UK where the House of Commons Health Select Committee (2012) argued that integration has been a recurring goal in public policy since a lack of coordination between health and social services was flagged up in the 1960s (see e.g. Petch et al, 2013,; Bickerstaffe, 2013; Ham et al, 2015). There have been a series of initiatives over the last fifty years which have attempted to bring health and social care services more closely together, though with limited success (Wistow 2012, Bardsley et al 2013, Ham et al 2015; Erens et al 2015b; Wistow et al 2015). In short, as Wistow et al (2015) put it, the story of IC initiatives is one of great expectations often not met. Similarly, according to Humphries (2015), while the closer integration of health and social care has been a policy goal of successive UK governments for many years, overall progress has been patchy and limited.

This article explores governance issues concerning IC in England since 2010, focusing on the extent to which the five desirable governance attributes (transparency, accountability, participation, integrity and capability; TAPIC) are applicable to IC in England, seeking to bridge the health and social care divide (Table 1, below).

Table 1 The UK health and social care divide (Glasby, 2017)

	Health care	Social care
Accountability	Executive; National (to Secretary of State)	Democratic; Local (to elected councillors)
Policy	Overseen by Department of Health (also has responsibility for adult social care policy)	Local government is overseen by the Department for Communities and Local Government
Charges	Free at the point of delivery	Means-tested and subject to charging
Boundaries	Based on GP registration	Based on geography and council boundaries
Focus	Individual (medical) cure	Individual in their wider context

Culture and training	Strongly influenced by medicine and science	Strongly influenced by the social sciences

We focus on England as the different countries of the UK are at different points on the journey towards more IC. Northern Ireland has had structural integration of health and social care since 1973, Scotland is legislating for new health and social care partnerships and Wales is still at an early stage (Ham et al, 2013; Bickerstaffe, 2013).

The TAPIC Framework

The TAPIC framework has been outlined by Greer et al (2016) and earlier in this collection. These five mutually exclusive attributes of governance (transparency, accountability, participation, integrity and capability) are thought to influence the kind and consequences of decisions a system makes that were developed inductively from a list of about 60 attributes of governance. In this section, we interpret these attributes in an English context before outlining contemporary IC policy and then the application of such policy to the TAPIC framework.

Transparency means that institutions inform the public and other actors of both upcoming decisions and decisions that have been made, and of the process by and grounds on which decisions are being made. Transparency can elide the ways in which revealed data are constructed or continue to mask other (undisclosed) data. Transparency mechanisms include:

- watchdog committees;
- inspectorates;
- Freedom of Information legislation;
- performance managing/reporting/assessment; and
- clear and useful public information.

Accountability is broadly seen as a relationship between an actor (such as an agency) and a forum (such as a legislature) in which the actor must inform the others of decisions, must explain decisions, can be mandated and can be sanctioned (Bovens et al, 2014). Essentially, accountability entails giving an account and being held to account. The former has close association with transparency, whilst the latter is resonant of the performance paradigm (Bevan and Hood, 2006). Whilst Vrangbaek and Byrkjeflot (2016) distinguish between political, administrative, professional, public, market and judicial accountabilities, various mechanisms illustrate this aspect of the TAPIC framework:

- contracts;
- regulation; delegated regulation;
- performance standards; and
- codes of conduct.

Participation means that affected parties have access to decision-making and power so that they acquire a meaningful stake in the work of the institution. Clearly, many recent health policies have sought specifically to alter the balance of power between these parties. This includes a shift towards managerial interests, and often away from professional ones.

Participation mechanisms include:

- stakeholder forums;
- consultations;
- elections; appointed representatives; legal remedies;
- advisory committees, ad hoc or otherwise;
- partnerships; and
- joint budgets, joint workforce, etc.

Integrity is a rather vague term which has many synonyms and related terms: predictability, anti-corruption, ethics, rule of law, clear allocation of defined roles and responsibility, formal rules, and stability. In a sense, integrity is good management. Integrity has connotations with trust (which has a rich conceptual history); Greiling (2016) argues that public trust is composed of credible commitment, benevolence, honesty, competency and fairness. Trust, in turn, shapes the nature and degree of participation (see above). In

particular, credible commitment denotes a public service ethos which underpins the mechanisms of integrity:

- solid and well-rewarded internal career trajectories that allow high-level officials to be rewarded for service rather than seeking profit or positions outside government;
- internal audit (to ensure that money moves appropriately);
- personnel policies (hiring, job descriptions, procedures to weed out flawed people);
- legislative mandate;
- budget;
- procedures;
- audit; and
- clear organizational roles and purposes.

Policy *capability* refers to the ability to develop policy that is aligned with resources in pursuit of goals. This covers both the information capacity upon which decisions are based and managerial capacity to enact those decisions. However, such capacity has been questioned in terms of the apparent emergence of post-bureaucratic organisations (Pollitt, 2009), with a propensity for rapid staff turnover and loss of organisational memory.

Mechanisms to improve policy capacity include:

- intelligence on performance;
- intelligence on process;
- research/analysis capacity ; hiring procedures, to improve the quality of the policy bureaucracy; and
- procedures to incorporate specialist advice (such as management consultants).

The five components of the TAPIC framework adhere in the sense of a diagnostic or prospective analysis of health systems governance.

English health policy towards IC since 2010

The period since 2010 can be divided into the Coalition government (Conservative-Liberal Democrat; 2010-2015) and the Conservative government (since 2015). Elements of continuity and discontinuity are apparent between all periods.

IC was not originally a major part of the Coalition government's plans for National Health Service (NHS) reform (Ham et al, 2015), but became an explicit policy priority following the work of the NHS Future Forum in 2011, prompting a number of amendments to the Health and Social Care Act (HSCA) 2012 (Exworthy et al, 2016; Glasby 2016, 2017; Miller and Glasby 2016).

The NHS Future Forum (Alltimes and Varnam, 2012) had highlighted the tendency for 'integration' to be used by different people in different settings to mean different things. National Voices (2013) – a national coalition of patient charities - produced a definition of IC from the perspective of service users:

“My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes.”

Along with its accompanying narrative on person-centred, co-ordinated care, this was endorsed by Ministers in the foreword to an official report on 'Integrated Care and Support: Our Shared Commitment' (2013). The adoption of this definition meant that 'for the first time...we have an agreed understanding of what good integrated care and support looks and feels like for individuals', and provided a 'shared vision.....for integrated care and support to become the norm in the next five years' (National Collaboration for Integrated Care and Support 2013). Contrary to the tendency described above to focus on IC in terms of organisational structures, this definition adopted a more person-centred approach.

However, Ham et al (2015) note that, despite Coalition reforms designed to explicitly support joint working, a number of barriers to IC have persisted since 2010, and in some have been reinforced by the Coalition's own reforms. In particular, the fragmentation of commissioning responsibilities created by the HSCA 2012 has meant that budgets are widely

dispersed across the health and care system, making it difficult to align incentives across different providers of care. In 2014, the House of Commons Health Committee argued that existing fragmented commissioning structures ‘significantly inhibit the growth of truly integrated services’ (HoCHC, 2014).

Miller and Glasby (2016) identify a series of national initiatives and local pilot projects, but with an overall health and social care system that was arguably less integrated by 2015 than it had been in the late 2000s (see also Glasby 2016, 2017).

(i) Better Care Fund (BCF): is a universal mechanism for creating pooled budgets to protect adult social services and reduce demand for acute beds. It consists of a formula-based allocation of £3.8bn to fund locally agreed integration plans for 2014/15 and 2015/16. The funding is held under joint governance by NHS Clinical Commissioning Groups (CCGs) and local authorities through their Health and Well-being Boards (HWBs) (Erens et al, 2015b). Access to the Fund was dependent on a local plan which was signed off nationally. However, planning for the BCF was heavily criticised by the National Audit Office (2014). Ham et al (2015) state that the impact of the BCF will not be known until local plans have been implemented in 2015/16. So far, plans from 146 out of 151 local areas have been approved by NHS England, projecting savings of around £500 million for the NHS and a reduction of just over 3 per cent in emergency admissions. Despite this optimism, it remains to be seen if the very ambitious expectations for the BCF’s impact will be met.

(ii) Integrated Care Pioneers (ICPs): in spring 2013, expressions of interest were invited from the ‘most ambitious and visionary’ local areas to become ‘Pioneers’ to drive change ‘at scale and pace, from which the rest of the country can benefit.’ Fourteen Pioneers were announced in November 2013, with a second wave of 11 Pioneers announced in late January 2015 and officially started in April 2015. While the Pioneers were given access to expertise and support from national partners and international experts, only minimal additional funding was provided initially (£20,000), with an additional £90,000 made available to each first wave Pioneer in June 2014 (Erens et al, 2015b). Aims of this initiative included the improvement of outcomes (notably patient/user experience) and the shift towards a model of care much less centred on hospital services.

Pioneer governance arrangements primarily involved project boards without formal authority and powers, reporting to HWBs or separately to CCGs and local authorities. As a result, it was reported that, on some occasions, the Pioneer board struggled to get the formal governing bodies to take decisions necessary to progress the Pioneer (Erens, 2015b). Involving patients, service users and the public was seen as important in all of the Pioneers, although the extent and nature of patient and public involvement (PPI) varied in different localities from extensive and well-developed to under development (Erens et al, 2015b).

Ham et al (2015) report that some ICPs reported progress in co-ordinating services for their local populations. They claim that early reports are promising, offering some hope of progress in reducing inappropriate use of hospitals and delivering more care in people's homes. However, early insights from the official national evaluation are more cautious and under-whelming, with many sites struggling to make as much progress as initially anticipated towards very ambitious aims (Erens et al, 2015a, 2015b). In addition, there has been an evaluation of the Whole Systems Integrated Care (WSIC) programme in North West London, the largest ICP (Wistow et al, 2015)

(iii) Vanguard: in January 2015, NHS England called for local proposals to become 'vanguard' areas to prototype some of those models. Twenty-nine vanguard sites were announced in March 2015, and a further eight 'urgent and emergency care vanguards' were announced in July 2015. Three of the vanguard sites (partially) overlap geographically with the first wave Pioneers. Areas with a track record of joint working receiving additional funding/support to test new ways of integrating care within the community and between hospitals and the community. This was a key feature of the NHS England (2014) *Five year forward view*, a strategy produced by the new Chief Executive of NHS England to set out the direction of travel for the NHS in a difficult policy and financial context. Whilst the allocation of additional resources and support to areas which have a history of collaborative working may be welcomed (not least by these areas themselves), it is far from clear whether the policy learning can be effectively transferred to other areas. Areas without such a collaborative legacy are likely to face qualitatively different barriers (and facilitators) to IC.

There is also significant overlap and confusion between the Pioneers and the Vanguard – with two similar but slightly different initiatives launched in quick succession.

(iv) Personal budgets (PBs)/personal health budgets (PHBs): the desire to promote greater personalisation (by enabling people using health and social care services to know how much is available to spend on their care and to exercise greater control over this money) has been well-established in adult social care (Needham and Glasby, 2014). Alakeson (2013) notes that PHBs regard ‘the individual as service integrator’, with integration at the level of the individual, driven by the individual. This is a relatively new approach to the creation of IC that presents an alternative to structural integration and (professionally-led) care coordination. The PHB initiative was proposed in the NHS Next Stage Review (Darzi, 2008) as a way to encourage the NHS to become more responsive to the needs of patients, and re-affirmed in the 2010 White Paper ‘Equity and Excellence’ (DH, 2010) (Jones et al, 2013). The evaluation of the PHB pilot in England reports that they did not appear to have an impact on health status, mortality rates, health-related quality of life or costs at 12 months, but was associated with significant improvement in patients’ care-related quality of life and psychological well-being over the same period (Forder et al, 2012; Jones et al, 2013).

(v) Health and WellBeing Boards ((HWBs) are formally local government committees, and comprising representatives from local authorities, CCGs and local Healthwatch organisations (representing patient interests), and other members appointed at the discretion of local areas. HWBs were a core part of the government’s vision for enabling whole system working (Coleman et al, 2016). Boards were tasked with assessing the needs of their local population, developing a joint health and well-being strategy to offer a strategic framework for local commissioning decisions, and promoting greater integration of services – for example, through encouraging joint commissioning and the use of pooled budgets (Ham et al, 2015). HWBs are the point at which all local stakeholders with an interest in the community’s well-being should come together, having local responsibility for leading integration. Sitting within local authorities, the Boards have a democratic underpinning, as they include elected councillors; most have senior-level shared leadership, with a senior Councillor chair and a representative of the CCG acting as vice-chair (Humphries and Galea, 2013; Bickerstaffe, 2013).

Positive features of HWBs included GP involvement, better governance and accountability, encouragement of wider inter-organisational linkages, and the re-location of public health from the NHS to local government. However, previous initiatives have similarly promised much but have delivered less. This may be in part, due to the lack of a commissioning role for HWBs; instead, they are supposed to be stewards of the local health and social care system (Coleman et al, 2016). As HWBs cover areas equivalent to the upper tier of local government (county councils or unitary authorities), they offer a place-based approach to system planning. Arguably STPs (below) also play this role. Moreover, there were difficult discussions in many local areas as to whether HWBs should be commissioning-led (or even commissioning only) bodies, or whether they should bring commissioners and providers together to develop a shared vision for local services.

(vi) Sustainability and Transformation Plans (STPs) are plans for the future of health and care services in England. NHS organisations in different parts of the country were to collaborate to respond to the challenges facing local services. Forty-four areas were identified as the geographical ‘footprints’ on which the plans would be based, and final plans were due to be completed in October 2016. This is seen as marking ‘a decisive shift’ from the focus on competition as a means of improving health service performance in the HSCA 2012 towards ‘place-based planning’ (Alderwick and Ham, 2016; Alderwick et al, 2016). In practice, some emerging plans contain a series of ambitious and controversial proposals (for example, reconfiguring acute care, downgrading local emergency departments and/or relocating maternity services) – and there has been widespread criticism that such plans seem to have been developed ‘behind closed doors’ with little public involvement or external scrutiny (see below for further discussion).

Discussion: insights on IC from the TAPIC framework

We now apply the TAPIC framework to these recent and current policies. Whilst this is inevitably reductionist, we therefore highlight the strengths and weaknesses of the framework and its value in such an application.

Transparency

One of the key legacies of the HSCA 2012 is the confusing and fragmented accountabilities which it has created (see 'accountability' below). In turn, this has led to a situation where there are lots of different initiatives, pilots and plans – each of which may seek to be as transparent as possible – but which create such complexity and organisational chaos that subsequent decisions and policies will inevitably seem opaque. In some local areas, there will be plans drawn up under the BCF, overseen by a HWB – but with additional activities being developed by an ICP, a Vanguard and a more regionally-focused STP.

Critics have argued that STPs lack of transparency and participation (Iacobucci 2016, see below). Alderwick et al (2015) report that STP plans have attracted growing political attention, including a large number of parliamentary questions; an opposition day debate in the House of Commons in September 2016, when many Members of Parliament (MPs) voiced concerns about potential cuts to services and the 'secrecy' of the STP process; and questions about STPs have also been raised at the Public Accounts Committee and the Health Select Committee. They state that 'despite the importance of STPs for the NHS and the public, little is known about the process of developing the plans and how the initiative has worked in practice'.

Alderwick et al (2016) point out that while the process of selecting a named individual to lead the STP varied between their four areas studied, it was rarely seen as being open or fair. NHS England and NHS Improvement played a significant role in selecting STP leaders, and the strong role played by national bodies also seemed at odds with the original emphasis on the STP process being locally led. As well as tight timelines creating a barrier to meaningful public engagement, national NHS bodies had also asked STP leaders to keep details of draft STPs out of the public domain. This included instructions to actively reject Freedom of Information Act requests to see draft plans (Alderwick et al, 2016). Interestingly, one of the few STPs to be led by a local government chief executive rather than an NHS leader chose to publish their local plan on the Council website. As noted in one national newspaper (Vize, 2016):

At least five councils have now published the STP, despite NHS England asking local areas to keep them hidden until the central bodies have given their verdict. This pointless subterfuge has put local politicians in an invidious position.

Accountability

According to Bickerstaffe (2013), the local bodies created by the HSCA 2012 have created a confusing landscape, and it is not clear who has responsibility – and the power to make decisions – for what. Ham et al (2015) report that governance and accountability not only changed as a result of the reforms but also became more complex. This was partly because of compromises made during and immediately after the Coalition was created and partly because of concessions made by the government during the passage of the Bill through parliament. A set of policies designed to streamline and simplify the organisation of the NHS ended up having the opposite effect. Parliamentarians, among others, were openly and frequently critical of the confused accountabilities created by the Act. However, predictions that the Health Secretary would no longer be held to account for the NHS proved wide of the mark (Ham et al, 2015).

In principle, the Coalition's reforms expressed an intention to free the NHS from political micromanagement and increase local accountability through an independent NHS Commissioning Board (which later became NHS England), Healthwatch England and Local branches of Healthwatch, local Health and WellBeing Boards, and CCCs which have a statutory duty to involve patients and the public in their decision-making and have a lay member on the board with accountability for patient and public engagement (Ham et al, 2015):

Despite all this, the landscape around governance and accountability is complicated. Commenting on the £95.6 billion that NHS England is responsible for, the chair of the Public Administration Select Committee has said that 'it is simply not acceptable that there is no clarity or clear accountability for that kind of public expenditure' (House of Commons Public Administration Select Committee, 2014). Moreover, most existing accountability arrangements are single agency in nature (for example, holding the Board of a Hospital Trust accountable for quality, safety and performance), but developments such as the Pioneers,

Vanguards and STPs arguably create blurred accountability and make it harder to scrutinise key decisions. By making joint working everybody's business, perhaps the government has made it no one's responsibility.

Participation

Since 2010, the government has committed itself greater participation, summed up in the mantra: 'shared decision-making will become the norm: no decision about me without me' (DH 2010). This has included greater involvement of democratically elected Councillors in decisions about health care commissioning through HWBs, as well as a significant emphasis on public engagement in initiatives such as the Pioneers and Vanguards. As Forder et al (2012) argue, PHBs have scope to improve patient outcomes, by placing patients at the centre of decisions about their care. In individual localities, Wistow et al (2015) write that the involvement of lay partners (patients, service users and carers) in the WSIC programme has been a striking aspect of its inclusive approach, with significant time, attention, resource and support being provided to it. Indeed, this element of the co-design phase appeared to be one of the programme's defining characteristics. This has been highly valued by those working within the WSIC programme, but how far it has enabled wider involvement of communities beyond the individual lay partners themselves is yet to be seen.

However, despite these efforts, problems remain. Both the Pioneers and the Vanguards remain local pilots, with a lack of clarity as to how new ways of working (and current engagement mechanisms) may be mainstreamed. In terms of STPs, Alderwick et al (2016) report that it has been difficult for local leaders to meaningfully involve all parts of the health and care system – particularly clinicians and frontline staff – in developing STP plans. The involvement of local authorities has also varied widely between STP areas, ranging from strong partnership between the NHS and local government to almost no local government involvement at all. Moreover, patients and the public have been largely absent from the STP process so far. This was partly because of the limited time available to develop plans, and partly because national NHS bodies had asked leaders to keep their draft STPs out of the public domain. Alderwick et al (2016) report one interviewee asking themselves in a STP meeting: 'where are the real people in this?', adding that the same question could be asked

for the STP process as a whole. However, being 'consulted' on largely formed plans does not seem to be a meaningful type of participation.

Integrity

Of all the areas of the TAPIC framework, integrity raises the most questions in terms of approaches to IC. Despite Conservative promises of no more top-down reorganisations of the NHS, the Coalition oversaw one of the biggest reorganisations in the history of the NHS. While initial reforms seemed to focus on promoting competition, the sudden conversion to the notion of IC after the work of the NHS Future Forum could be viewed as an opportunistic attempt to save the Bill rather than a genuine attempt to integrate care.

Moreover, the advent of clinical commissioning raises interesting issues about potential conflicts of interest, with GPs having a role as both commissioners and providers, and functioning both as leaders of public bodies (CCGs) and as small business people running their own individual practices (Glasby and Skelcher, 2012). STPs have also been accused of lacking integrity given the emerging perception that potentially radical changes to services could be being developed in very rapid timescales and behind closed doors.

Capacity

There are significant questions as to whether the current health and social care system has sufficient capacity to deliver government policy in practice. Coalition reforms removed much of the capacity at regional and strategic levels, creating a vacuum of system leadership (Ham et al, 2015). For Bickerstaffe (2013), there are four factors, arguably lacking in our current system, which will be needed to deliver IC successfully: a long-term investment mind-set; aligned incentives; effective use of technology; and flexible workforce) are likely to be necessary for delivering integrated systems and more coordinated care successfully.

For Wistow et al (2015), local initiatives such as the WISC programme has been characterised by strong and effective leadership, clear management and governance structures and the influence and credibility of key senior figures. However, changes to the leadership of the programme near the end of the evaluation period were seen to have

weakened the programme's strategic management capacity and had become a cause for concern. In common with other UK and international programmes of IC, the WSIC programme team also found that issues of data sharing, governance and IT have caused delays to the overall programme of service change. A commonly agreed need to share data for the purposes of improved care coordination so often runs into difficulty when the practicalities of interoperable systems, data-sharing agreements, and professional or organisational culture come into play. These and other barriers, including payment systems, governance structures and organisational fragmentation, cannot be fully removed without national action, such as that promised (but not yet delivered) when the national Pioneer programme was announced.

In terms of the ICP, Erens et al (2015b) note that many of the barriers to integration identified were familiar from previous research into health and social care integration. They set out: national barriers (national issues outside Pioneer control; national leadership; financial issues); organisational, professional and cultural barriers (organisational structures; professional boundaries and cultural differences); and local barriers. The identified factors appear to have some relationship with policy capacity, with aspirations thwarted by issues such as competing visions, leaderships and operational policies; incompatible IT systems; concern about sharing individual data; financial uncertainty; and labour market difficulties. In the process, Erens et al (2015b) cite the results of a survey which contrasted the factors reported to promote and hinder joint working at local level. The leading factors that respondents considered to help integrated working were described as 'locally determined' – local leadership, vision, strategy and commitment. Conversely, those identified as hindering integrated working were predominantly interpreted as 'nationally determined' – performance regimes, funding pressures and financial complexity. They concluded that the centre might have 'more capacity to do harm than good.' More generally, the National Audit Office (2014) has issued a highly critical report of planning the Better Care Fund.

Alderwick et al (2015) write that the STP areas involved in their research had not received any additional money from national NHS bodies to fund the development of their plans. This meant that local leaders needed to rely on existing staff and resources to manage the STP process, with management consultants were being used to support the development of

STPs in three out of their four areas. Some leaders felt that STPs had ‘created an industry’ for management consultants and questions were raised about why money is being invested in advice from private companies instead of in frontline services. Perhaps the largest problem associated with policy capacity relates to implementation. Alderwick et al (2016) report that across all STP areas, leaders were concerned about their ability to turn the vision being articulated in their STP into reality. Finally, it should be noted that ‘policy capacity’ may be associated with a selection effect. For example, one of selection criteria for Pioneers involved ‘demonstrated capability and expertise to successfully deliver a public sector transformation project at scale and pace’ (Erens et al 2015b). This limits the transferability of lessons for ‘pioneer’ sites elsewhere.

Conclusion

It is difficult to examine how the TAPIC framework contributes to better health outcomes in the case of IC in England since 2010. First, there is a weak evidence base, particularly relating to improved outcomes. Most studies focus on formative evaluation and on process elements, arguing that it is too early to detect any outcome improvements within summative evaluation. Second, the elements of TAPIC tend not to appear to any great degree within the evidence base. However, this is arguably a failure of the evidence base, and does not necessarily negate the usefulness of TAPIC.

However, it does appear that all five of the TAPIC domains (transparency, accountability, participation, integrity and capability) are lacking to some degree for many of the IC initiatives in some places, and so the optimistic view of introducing integration above is probably unlikely to lead to significant increases in desired outcomes. This may be a case of history repeating itself with the great expectations of IC initiatives often not met (Wistow et al 2015) yet again. However, as some of these initiatives are based on pilots (or Pioneers or Vanguard) there may be a positive ‘twist’ in the tale of two initiatives which may lead to lessons being learned in a future implementation to the wider health and social care system. On the other hand, wider policy capacity may not match that in the selected sites.

We observe an imbalance between them in terms of evidence and implementation. Whilst TAPIC potentially offers a collective assessment of IC, there is doubt as to whether each element is necessary and sufficient to describe and explain IC. There is some doubt too whether each carries equal weight. Historically, issues of accountability have tended to dominate English policy debates, usually towards central government rather than downwards to users and the public. Yet a synergy between them is possible whereby, for example, transparency can support accountability, or participation can enhance integrity (or vice versa). We have noted the partial evidence base means gaps in knowledge about the process and outcomes of IC policies. Longitudinal studies would ameliorate this but the use of pilot programmes (Ettelt et al, 2015), rapid organisational change (Pollitt, 2009) and the legacy of previous efforts at IC militate against the learning from and transferability to the wider system.

Both TAPIC (as a framework) and IC (as a case-study) offer insights into wider debates about the changing relationship between the state, its institutions, actors, users, and citizens. If the expectations of IC are to be met, then TAPIC framework may well have a value in understanding and explaining progress in that previously illusory goal.

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