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Roundtable series on national standards of care: integration and system alignment

Insights from the third SCIE and The Access Group roundtable

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About SCIE

The Social Care Institute for Excellence (SCIE) is an independent social care charity with deep experience of bringing partners and people with lived experience together to collaborate and innovate to improve people's lives (e.g. national government, DHSC, local authorities, care providers, academics, foundations). Working across social care, health and related services such as housing, for adults, children and families, we contribute to the development and implementation of better care, support and safeguarding at local and national level.

As we are not-for-profit, our income goes towards improving social care. We deliver four main offers, across all of which we support the DHSC annually:

- **SCIE Consultancy** – working with local and national organisations to identify and implement improvements
- **SCIE Insights** – research, evidence and policy insights to drive improvements and innovation, and influence national policy and practice
- **SCIE Training** – bespoke online or face-to-face learning and development, including safeguarding, co-production and strengths-based approaches
- **SCIE Resources** – guidance and tools to support best practice, co-production and innovation.

Co-production with people with lived experience of social care underpins and informs what we do, and with over 20 years' experience we bring a wealth of trusted, evidence-based expertise to work together to help transform care. Our staff – former practitioners in social care, researchers, experts in training – bring immense depth of experience and passion for the cause, based on frontline work, using the best available knowledge about what works in practice.

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Executive summary

Building on the insights drawn from the first and second roundtables, this third roundtable focused on integration and system alignment, exploring how national standards could support joined-up, preventative and relational care across health, social care, housing and community services. Discussions were organised around three themes:

- **Joining the dots** – the potential for national standards to enable system alignment and improve care at key touchpoints where social care interacts with different services and systems.
- **Making integration real** – what shared outcomes and measures of success are needed to underpin integration.
- **People not process** – how co-production, lived experience, and equity can shape standards so that integrated care delivers what matters to people.

Across these themes, the conversation revealed that integration is most powerfully shaped by relationships, culture, shared outcomes and early intervention. In order to make this a reality, integrated care requires investment in community-based support, data interoperability, workforce capability and cross-sector leadership.

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Joining the dots

The issue

People regularly move between services and settings – health, social care, mental health, housing, community and voluntary organisations. Yet these systems often operate in parallel, and sometimes at odds, rather than in ‘concert’, leading to avoidable crises, fragmented experiences and inefficiencies Local areas generally describe the following success factors for service integration: shared leadership and common purpose; data sharing; dedicated capacity and alignment of resources; clear, shared and measurable goals; and involving those with lived experience.

Participants described how natural “touchpoints” between services – hospital discharge, escalation in housing needs, mental health crises, transitions into adulthood – are where the system is most disjointed. This is a consequence of a multitude of factors, from government department ownership to competing and perverse incentives in the system. Participants argued that national standards must explicitly define expectations at these touchpoints so that services are organised around the person, not organisational boundaries.

Where agreement exists

Natural touchpoints shift towards prevention

Participants agreed that cross-system ‘moments’, such as hospital discharge, safeguarding, or housing-related risks, should be the first areas where national standards create clarity on roles, timelines and data sharing. Participants agreed that current touchpoints occur far too late, with support offered only in crisis. Standards should incentivise preventative and community-based interventions. Evidence from SCIE demonstrates that when reablement and intermediate care are employed, they lead to reduced hospital admissions and improved independence for people needing support.

Success depends on people and relationships, not just systems

Strong consensus emerged that integration failures stem from people working in silos rather than system or technology limitations. Successful integration typically involves specific individuals who built relationships across organisational boundaries - whether through co-location, key workers, or named contacts who actively connected different parts of the system.

Data sharing barriers are organisational, not technical

Participants agreed that the technology exists to share data effectively between health and social care systems. The barriers identified were around consent, ownership, General Data Protection Regulation (GDPR) being used as an excuse, and organisations refusing to share records – particularly health services not sharing with social care. Consensus was that mandating this and enforcement should be considered, along with a consistent “identifier’ such as NHS number.

Regulatory accountability must span the whole system

Both groups agreed that national standards need regulatory teeth and must hold all parts accountable – commissioners, providers, and local authorities. Care Quality Commission (CQC) should assess how systems work together, not just individual organisations.

Integration requires aligned objectives and shared funding

Participants identified that social care often bears costs for interventions that benefit health budgets (preventing hospital admissions), but local authorities are the primary funders of care, so see limited benefit and therefore struggle to justify investment in such interventions. There was agreement that without aligned incentives and potentially pooled budgets, different parts of the system would continue working to conflicting priorities.

Areas of tension

- The balance between national standards and allowing local flexibility.
- Conflicting organisational priorities (e.g. NHS waiting lists vs local authority wellbeing duties).
- The measures of success between different parts of the health and social care systems. There was a point made that the NHS typically deals in the currency of activity levels, whereas the social care sector deals in outcomes for people.
- Geographical misalignment between ICBs, PCNs and local authorities and how this layers against local government reorganisation changes
- Professional cultures and vocabulary that hinder collaboration.
- Funding flows that are weighted towards crisis response rather than prevention.

Unresolved questions

- How might national care standards incorporate housing, given its centrality to preventing escalations?
- How can national care standards influence and improve data-sharing practices between the NHS, primary care, local authorities and independent care providers?
- Should standards require pooled or aligned budgets at place level?

What SCIE and The Access Group think

Creating a common currency or language for care standards

SCIE and The Access Group believe national standards should create a common currency or language which sits across cross-system touchpoints – such as hospital discharge, transitions to adulthood, mental health crises and urgent housing issues. This could look like shared priorities or agreed outcomes. A common language would deliver immediate, measurable benefits while signalling the purpose of national standards: to organise systems around people rather than around institutions.

Standards for these touchpoints could address:

- Clear roles and responsibilities;
- Timebound expectations for joint assessments or safe discharge;
- Minimum data requirements to be shared consistently between agencies; and
- Expectations for co-produced escalation pathways at neighbourhood level.

This approach reflects the Roundtable 1 finding that the Care Act already sets strong principles but lacks consistent implementation. National standards should therefore clarify and enforce existing duties rather than create parallel requirements.

New financial levers

To support implementation, standards must be enabled by financial levers. Prevention often benefits NHS budgets while incurring costs for social care or housing. SCIE and The Access Group therefore recommend that standards enable local areas to more efficiently pool or align budgets, or at a minimum, gain-share arrangements where savings in one system contribute to funding preventative activity in another.

Learning cycles

Standards must be implemented through a model of focused local learning cycles. Regulators such as CQC should be assessing the quality of system-wide collaboration at these touchpoints, supporting improvement rather than simply driving compliance. This reflects participants’ desire for standards that promote culture change and learning, not punitive bureaucracy.

Making integration real

The issue

Despite decades of integration policy, participants agreed that integration of health and social care often remains elusive. Sustainable change requires shared outcomes, aligned budgets, interoperable data, and leadership behaviours that prioritise collaboration. Without these foundations, structures alone cannot deliver seamless health and care experiences for people.

Participants supported having national care standards because they could help shift integration from aspiration to reality, but only if they focus on shared outcomes, clarity of responsibility and mechanisms that distribute accountability across organisations and sectors.

Where agreement exists

Need for clear, common objectives and shared language for local care systems

Integration requires clear, shared objectives that all parties work towards – whether framed as ‘population health’, ‘life expectancy’, or ‘people living good lives’. Participants emphasised that without common metrics and language that crosses system and organisational boundaries, different health and care professionals will continue working in silos.

Barriers to collaboration – often related to funding – work against shared outcomes

Social care providers and VCSE organisations often bear costs for interventions that save NHS money (like preventing hospital admissions), but their funding comes from local authorities. This misalignment prevents innovation and interferes with collaboration. Participants cited examples where integration worked only when leaders chose to "elevate themselves above the system" despite financial disincentives.

Voices of people drawing on care must be central to developing shared outcomes and measuring progress towards them

Standards must be driven by people's lived experience and aspirations, not just system metrics. Co-production should be an integral component of the commissioning process and standard-setting, with multiple participants noting that without lived experience involvement, standards become disconnected from what matters to people.

Brave leadership and strong local relationships drive success towards shared outcomes – much more than structures and top-down processes

Successful integration depends on individual leaders and relationships rather than systems, technology and top-down processes. Examples of success consistently involved specific people who built trust across boundaries – whether through co-location, key workers, or simply committed individuals who prioritised outcomes over organisational boundaries. This was caveated against the risk that when good local leaders leave their role, the strong professional relationships – and good practice – are lost as well.

Balance needed between national consistency and local flexibility – shared outcomes may reflect local needs as much as national priorities

Standards should set clear principles and minimum floors for services while allowing local areas to determine how to achieve them based on their specific context. Participants warned against overly prescriptive approaches whilst acknowledging the need for accountability mechanisms to ensure minimum standards are met everywhere.

Areas of tension

- Ensuring accountability without creating excess bureaucracy. In other words, determining how partners will hold each other to account for shared outcomes.
- Balancing quick wins with prioritising transformational changes that promise long-term impact, such as preventative services. Care standards should have lasting value and durability across political cycles.
- Allowing for innovation while reducing variation. Local area leaders should know what interventions will best meet the needs of their local population. They should have the flexibility to develop or commission innovative solutions.

Unresolved questions

- Should shared outcomes be identical nationwide or adapted locally? Successful outcomes for people in different parts of the country look different.
- What data is needed to track progress meaningfully? There are current mechanisms in place, such as ASCOF, but would this work in the context of national standards, which sit across different parts of the system? Better metrics may need to be developed.
- What lessons can be drawn from cross-country learning, such as Spain, and how might we explore or adapt these?

What SCIE and The Access Group think

Define a concise set of shared, person-centred outcomes

Discussions showed that too many metrics and measures of ‘what good looks like’ fragment attention and hamper outcomes.

A starting point would be a core set of national shared outcomes, co-produced with people drawing on care and support and aligned with Think Local Act Personal (TLAP)’s ‘'Making It Real’ “I statements”. A further step forward would be a minimum dataset and interoperable data standards, drawing on the Roundtable 2 insight that current data is fragmented, inconsistent and often unrelated to what matters to people. National care standards would therefore require:

- adoption of existing health and care data vocabularies, but with attention to shared language and understanding

- co-produced outcome indicators, including improved metrics for people’s care experiences
- a place-based dashboard that tracks progress towards achieving standards and locally agreed shared outcomes
- consistent use of shared records across health and social care sectors for the key touchpoints at system interfaces.

Align financial incentives

Given the persistent problem of misaligned incentives, standards should further enable local areas to work in partnership with pooled budgets or gain-share arrangements that reward prevention. This reflects Roundtable 1 and 2 findings that integration fails without aligned financial incentives.

Leadership development for shared outcomes

We recommend embedding expectations for cross-sector leadership development, shared training, and professional exchanges. SCIE’s prior work on strengths-based practice shows that investment in relational capability is a critical enabler of integrated care, starting with system leaders and their shared vision.

People not process

The issue

Integration must start with people’s lives, not system structures. Participants were clear that national standards must be rooted in co-production, equity and lived experience. This echoes Roundtable 1’s emphasis on purpose and Roundtable 2’s emphasis on agency and data rights.

Yet current systems often prioritise organisational processes, risk management and compliance, leaving people to navigate fragmented pathways and repeat their story multiple times. Integrated care adds further complexity. Participants called for standards that reflect people’s lives as well as experiences of care and support across the different systems. The delivery of personalised, relational support should remain a key principle.

The discussions focused on core principles first. These points will be relevant to efforts by local partners to address service fragmentation, system alignment and joined-up care arrangements.

Where agreement exists

Co-production must be genuine, not tokenistic

Lived experience must be at the heart of developing standards, but emphasised that this needs to be meaningful engagement, not box-ticking. Participants stressed the importance of including diverse voices – particularly those often unheard, like people with dementia, learning disabilities, or complex needs – alongside those most experienced and are comfortable speaking up.

Standards should focus on outcomes and values, not prescriptive processes

Standards should define what good looks like in terms of outcomes people want (living in a place called home, maintaining hobbies, social connections) rather than detailed specifications. Outcome-focused standards should allow innovation while ensuring fundamental rights.

Current system barriers prevent integration, particularly separate budgets

A fundamental barrier to integration is separate budgets across health, social care, housing, and benefits. Participants consistently noted that there are no incentives for one part of an “integrated” system (e.g. social care) to spend more on an early intervention that might save money for the NHS, where social care budgets are tight and managed in a silo. Without pooled budgets or aligned incentives, integration cannot succeed. Culture and people were posited as equally fundamental, e.g. a pooled budget could still be sucked into primary or secondary care if the people and the systems don’t fundamentally change thinking and cultures.

Data interoperability is technically possible, but blocked by culture

Technology exists to share data effectively. The barriers are human, not technical but the data also needs to be meaningful and about living good lives. Participants argued for mandatory data standards and interoperability requirements, with one noting "integration's not actually essential, interoperability is". The issue is people not sharing data and wrong types of data being collected, not systems being technically unable to share. Beyond this, the benefits of data sharing need to be articulated better, or there won't be trust from citizens.

Equity requires national minimum standards while allowing local flexibility

National standards should set a foundation (fundamental rights and expectations) that addresses postcode lottery issues, while allowing local innovation and personalisation above that baseline. Participants warned against standards becoming either too prescriptive (stifling innovation) or too aspirational (allowing minimum standards to be seen as the ceiling).

Areas of tension

- Standardisation vs personalisation in the context of 'national' standards.
- How standards can ensure fundamental rights (where, for example, the Care Act 2014 missing an open quote mark hgermissinand the law haven't).
- Ensuring co-production is meaningful and authentically defined – when people say co-production, they actually mean co-production, not shorthand for other types of engagement with less sharing of decisions.
- Measuring what success looks like from a person's perspective, not just the systems.

Unresolved questions

- How should local accountability be embedded within standards?
- How should standards speak to a person's whole life not just where they access more formalised care and support?
- What metrics can meaningfully capture lived experience?
- How do we support autonomy alongside safeguarding?

What SCIE and The Access Group think

Measurable outcomes

National standards must be grounded in co-production, equity and measurable lived-experience outcomes, ensuring that people remain at the centre of integrated systems. Co-production should be mandated in the design, implementation and monitoring of standards. This means not only consulting but sharing power – using inclusive outreach and co-chairing approaches to ensure diverse lived-experience perspectives shape both standards and their implementation.

Use what already exists

There is a strong foundation to work from in the form of the ‘Making it Real’ “I/We Statements”, designed to capture what matters to people – such as feeling connected or having control. There is a risk that new I/We statements will confuse an already complicated picture, when ‘Making it Real’ is already used within CQC regulation and have been fully co-produced. National standards should not duplicate the work already done and instead embed these as part of a national approach to better aligning system outcomes with outcomes for people.

Proportional implementation

Standards should be implemented proportionately. Much of why people want to use micro providers and personal assistants is because they are flexible, put individuals more in control of the care and support they want to live life their way. They don’t want extensive compliance requirements even if they had the infrastructure. This is a very sensitive and political space and a strong area of tension between regulated providers, and unregulated micro/personal assistant provision. There is a genuine fear that standards will kill self-directed support. As such, standards must protect people's right and ability to choose the type of provision that best meets their desires and needs.

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