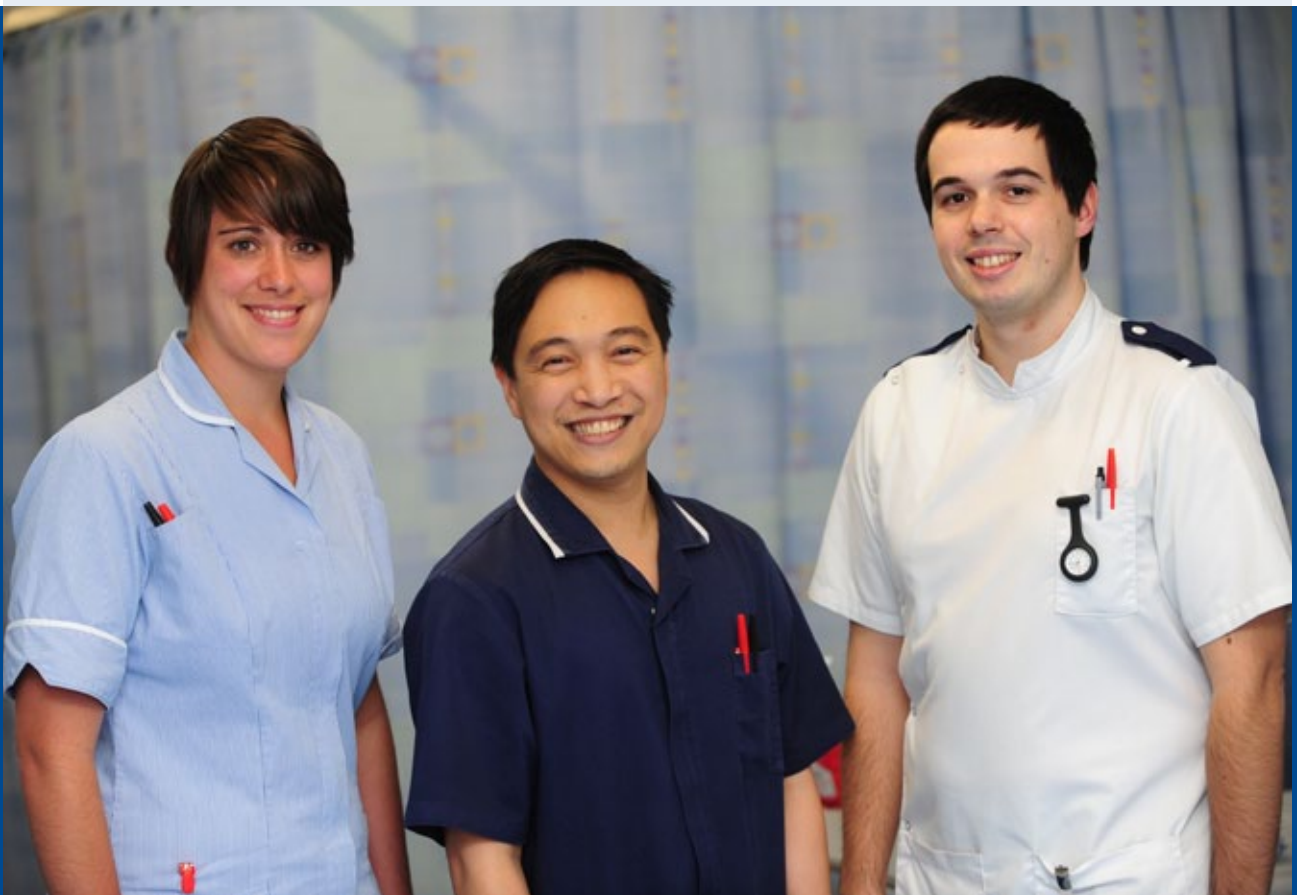


Integrated health and social care in England: the story so far



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Introduction

This briefing paper is part of a series of RCN documents examining the policies and practical arrangements surrounding the integration of health and social care.

The paper offers an overview of the current call for integrated health and social care services in England, the rationale behind the push for integration, the facilitators and barriers to this way

of working, and the related workforce and funding issues. In addition to providing a summary of the story so far, the paper also highlights some of the major issues the RCN sees as imperative for future discussions.

As the integration story unfolds, the full implications for nursing will be examined and discussed later in the series.

Why now?

The recent focus on the integration of health and social care, and its potential to provide better, more cost-effective services, is in direct response to three pressing issues. Firstly, spending cuts and a need to deliver further efficiency savings. Secondly, demographic changes, with a predicted rise in demand for health and social care services due to an ageing population and a greater number of people living with long-term conditions. Thirdly, a recognition that too many people are not getting the services they need, or not receiving them in the most suitable setting.

This call for co-ordinated working is not a uniquely UK phenomenon as a number of countries see the 'integration of health and social care as a way to reduce costs, make more efficient use of resources and achieve better outcomes for the individual' (Burgess, 2012). A recent King's Fund report (Goodwin et al, 2013) highlights the growing interest in 'co-ordinated' and 'person centred' care in both the US and the UK, despite their significantly different systems of care; it also highlights how this approach is rapidly becoming the default option for the provision of care for ageing populations with complex needs.

However, the challenge is more than just a policy debate on how to meet predicted future needs; it is also a pressing current issue. When services are duplicated or organisational boundaries prevent access to care, as is the case with the current health and social care systems in England, patients' fundamental needs are not met and resources are wasted. The excessive assessment and eligibility arrangements that exist in both health and social care see most patients having to repeat their histories to both sets of professionals. In order to avoid falling through the gaps of the fragmented

systems, many are forced to become self-taught experts at navigating between the two care settings (Bernard et al, 2010).

To date, the integration of health and social care services in England has been very much piecemeal and individually programme based. While there are some excellent examples of integrated care delivery across the country, including specific teams, projects and processes, many of which are led or designed by nurses, there is wide variation, inconsistencies in policy and project implementation, and often no significant learning mechanisms in place to aid the transference of best practice (RCN, 2011).

The Care Act, recently granted royal assent, provides a mandate for more formalised, integrated ways of working between the two sectors, not least by giving local councils a duty to promote integrated services. Unfortunately, the current plethora of definitions used in relation to the term 'integrated care' makes it difficult to set a clear pathway; for instance the term is often used interchangeably with 'co-ordinated care' or 'joined-up care', as well as being applied in many and widely differing settings. Agreement on an unambiguous definition is therefore vital to ensure patients, staff, carers, governing authorities and external agencies have a common understanding of both the term and its desired outcomes, allowing everyone to work individually and collaboratively towards a common aim (RCN, 2013).

The RCN believes that integrated health and social care should be seamless in its delivery, irrespective of which service sector is providing it, be of high quality, meet all of an individual's needs and be provided at the right time and in the right setting.

The call for increased integrated care in England

The call for a more formalised approach to integrating health and social care in England needs to be seen in the context of current competing imperatives.

Although the funds for the NHS in England have been ring-fenced, the so-called 'Nicholson challenge' has committed the service to deliver £50 billion in efficiency savings by 2020. There are also predictions that demand for NHS services in England will rise substantially during the next decade, with 'the number of people with more than one long-term condition such as diabetes, asthma or dementia set to rise from 1.9 million in 2008 to 2.9 million in 2018' (Lamb, 2013).

The UK Government has stated that it is committed to making evidence-based integrated care and support the norm in England over the next five years and plans to invest £1 billion in 2014/15, rising to £3.8 billion per annum from 2015/16, through the new 'Better Care Fund' (BCF). This is a pooled fund intended to be used for partnership working between health and social care services, based on plans agreed between the NHS and local authorities, to enable more people to be cared for in the community and therefore, in theory, save the health service money. However, this is not new money, 'for most CCGs finding money for the 'Better Care Fund' will involve redeploying funds from existing NHS services' (Humphries & Bennett, 2014).

We are therefore facing a situation whereby funds are being transferred from the NHS for integrated health and social care with no guarantee that the money will be spent on care provision.

In addition to creating the BCF, 14 initiatives throughout England have been selected to 'pioneer' new ways of delivering integrated care, including creating a single access point for patients or a multi-agency response to emergencies, seven day services, telehealth and telecare. The UK Government has stressed that the 14 pioneer initiatives are not pilots, and that they should be seen as 'an opportunity to inform the rest of the system about how integrated care can be practically implemented and learning will be disseminated across the NHS' (Williams, 2013).

Almost all of the pioneer initiatives state their

aim as being to make health and social care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care. Some of the initiatives will also test new models of commissioning and payment arrangements, both of which are expected to encourage organisations to work more collaboratively (DH, 2013). This will be particularly interesting to monitor, considering the difficulties we know to be inherent to the task of encouraging integrated care within an environment that is increasingly made of markets and subject to competition. Indeed when asked by the Health Services Journal (HSJ) if there would be changes to the law on competition, the Care and Support Minister, Norman Lamb, replied that it would have to be monitored very closely, "we must not allow a purist view of competition to frustrate what we collectively know needs to happen" (Williams, 2013).

All localities must produce a plan for spending the BCF. Final drafts of these plans were submitted to NHS England in April. However, the lack of credible data, about how savings would be delivered in many of the plans, coupled with concern that local councils and CCGs did not consult with hospitals enough when drawing them up, has prompted a review of the BCF plan process. It is now expected that tougher tests will be introduced to ensure individual plans' proposals are underpinned with robust evidence.

While the RCN is in principle supportive of integrated care and support becoming the norm, it is mindful of the impact its implementation may have on nursing; in particular on roles and workload.

We would want to see service plans aligned with workforce plans, the provision of sufficient funding for any necessary training and development, and full and transparent consultation with staff and trade unions on any proposed changes. It is noteworthy that implementation is once again being adopted via a piecemeal approach, based primarily on individual initiatives. While we recognise that localised services best serve local needs, and as such require the flexibility to ensure services match requirements, any new integrated services need to be measured against a country-wide set of standards, to ensure people have

equitable access to equitable standards of care. As well as being a point of principle, this will also help those in receipt of care to be able to move from one

location to another, confident that doing so will not compromise, reduce or remove their care.

The nursing contribution to integrated care delivery

Formal approaches to integration aside, two key statements from the RCN's Principles of Nursing Practice show how nursing staff already promote the delivery of integrated, person-centred care, routinely in their everyday work (Manley, 2011).

- To work closely with their own team and with other professionals, making sure patients' care and treatment is co-ordinated, is of a high standard and has the best possible outcome.
- To provide and promote care that puts people at the centre, involves patients, service users, their families and their carers in decisions and helps them make informed choices about their treatment and care.

Nursing staff are vital to delivering integrated care, as care co-ordinators they often work at the interface of health and social care systems and services, and in addition to their clinical expertise, they can have a unique insight into a patient's holistic needs.

In the community, district nurses and community matrons are notable examples of where nurses take the lead in co-ordinating care and case management. They can and frequently do work across boundaries, and often collaborate with social services and secondary health care staff in the planning, managing and co-ordinating of care for people with complex long-term conditions and needs (RCN, 2006). Nurse-led teams in the community can act as single entry points. For example, an adult integrated community mental health and social care team led by a senior community mental health nurse enables individuals to access health or social care services through one person or team, this can be facilitated by a single electronic record system.

Care for people with long-term conditions predominantly involves nurse specialists and health care support workers. The quality of care and support that specialist nurses offer is instrumental in reducing unnecessary hospital admissions and re-admissions, reducing waiting times, freeing up consultant time, improving access to care, educating other health and social care professionals and supporting patients in the community (RCN, 2010, & Fletcher, 2011). For example, neurology nurse specialists are able to contribute to all elements of care for people with long-term neurological conditions. Research has found that integrated care works most effectively when nurse specialists act as 'key workers', engaging in active care co-ordination and advocacy to ensure that people with long-term neurological conditions can access a broad system of support. With their specialist knowledge and accessibility, the nurse specialists are often an individual's first port of call, able to answer questions, allay fears, and help access further support as and when need arises (Bernard et al, 2010).

When caring for people with one or more long-term condition it is essential that community and specialist nurses work in close collaboration. Keeping the patient at the forefront of care at all times and having a clear understanding of each other's roles help avoid any tension that may arise between generalist and specialist. Similarly, when working collaboratively with health care support workers a clear understanding of roles and responsibilities is paramount.

In addition to caring for those with long-term needs, nursing staff also provide episodic care, via general practice (including advanced nurse practitioners), at walk-in centres and through telephone triage services such as NHS 111.

Facilitating integrated care

In its report on integrated care the Nuffield Trust states that ‘achieving integrated care requires those involved with planning, financing and providing services to have a shared vision, employ a combination of processes and mechanisms, and ensure that the patient’s perspective remains a central organising principle throughout’ (Shaw et al, 2011).

The King’s Fund’s comparative analysis of five UK based care co-ordination programmes identified the following facilitating factors to the delivery of integrated working: a political narrative that supports a shift to person-centred care; local leadership and commitment; a clearly defined, shared vision of what better patient care looks like; being able to react flexibly to patients’ changing needs; and investment in supporting carers and ‘low-level’ community support services (Goodwin et al 2013).

The RCN believes there are a number of nurse-led working practices and processes that can aid the delivery of best practice integrated care for individuals accessing the health and social care systems (RCN, 2011); they include: single entry points, single assessments, having multidisciplinary teams (MDTs), early intervention and regular needs reassessments, and good discharge planning.

Discharge planning is worthy of further discussion, as it is a key process when seeking to move patients seamlessly and safely from the acute sector into the community. However we are aware, through member feedback, that there are now notable systemic problems affecting the ability of nursing staff to provide safe and effective discharge; many resulting from the fragmentation of health and social care consequent from the changes brought in by the Health and Social Care Act of 2012.

Discharge planning is often a nursing responsibility, and RCN work on the subject has identified some key points that we believe are vital to achieving better quality discharge, as well as facilitating integrated working between health and social care services.

- Start discharge planning as soon as notified of a patient’s arrival, whether pre-planned or as an emergency admission.
- Identify one key lead responsible for discharge planning.

- Use a discharge checklist to ensure that simple things such as front door keys and medications are not forgotten (Lees, 2011).
- Identify all staff who will play a role in discharge.
- Regularly update the patient and relatives or carers throughout the process.
- Embrace the holistic needs of a patient, including physical, psychological and social needs of the patient and their carer.
- Ensure there is clarity over who does what; define the tasks and then allocate responsibility.
- Ensure all care need is clearly and fully documented prior to a patient’s discharge.

Barriers and challenges to integrated care

The King's Fund comparative study also found the following common challenges to integrated care:

- lack of funding
- lack of GP engagement
- inability of the wider health systems to see innovation as 'core business'
- lack of integrated IT systems
- problems caring for people in remote and rural locations.

The cultural issues that often exist between workforces of different sectors are another barrier to providing integrated care and services. Indeed a recurring theme in the five case studies was a 'strong reluctance to refer patients to programmes that were seen as outside existing professional norms and values, which is why all five sites emphasised the need to "win hearts and minds" to ensure that their service was accepted and used' (Goodwin et al, 2013).

This cultural divide is not unique to health and social care. Across, and sometimes within, many different public services and systems there is often an inherent tension between meeting the goals of the organisation or department, and meeting those which would ultimately best serve the needs of the end user (in the case of health and social care, the patient or service user). It is therefore imperative that health and social care services identify clearly and upfront a common vision, and establish a commitment to work together for the best outcomes of their end users. Such agreement requires service leaders to enable their staff to work effectively across boundaries, which in turn necessitates being clear on everyone's role and responsibilities (Ham et al, 2011).

The RCN believes that concerted effort to break down a number of key barriers would help staff to deliver better and more integrated care to patients whose needs cross the two care systems; these include complex and burdensome bureaucracy, slow decision-making processes on funding, and a lack of resources in the community. The major impediment however remains the overall existing arrangements for social care funding, which all too often impede the delivery of quality and timely care.

Other issues

Workforce

Effective workforce planning is fundamental to being able to anticipate and hopefully address, the impact of demographic, technological and policy trends on future service requirements.

However, workforce planning is too often seen as a separate and distinct exercise from service and financial planning; and is generally introduced as an afterthought in service and policy development.

Workforce planning should be influencing funding allocation, service reconfiguration and staffing decisions to assist organisations or system's planners to make better use of their internal labour market, as well as to map their positions within the wider labour market.

It is also important that planning takes into account the whole workforce, rather than treating each profession or group as a separate silo, as this inhibits innovation and means that the plans do not cohere. Planners also need to consider health and social care as a whole system, which means including the widest range of service providers across both the public and private sector

The RCN believes that nursing roles are central to meeting challenges such as the impact of an ageing population. However, meeting these challenges will require existing nursing staff to develop skills and enhance their roles, within the full variety of work settings, including local authorities. It's crucial therefore that the redesign and reorganisation of the health and social care structures fully take into account workforce implications, and ensure that staff are suitably supported and developed to deliver safe, effective and high-quality care that fully meets patients' needs.

Funding

Funding arrangements also impact on the ability to integrate services. Reduced spending on adult social care leads to high levels of unmet social care needs, which in turn leaves NHS nursing staff, both in the acute and community settings, having to fill the gaps in social care provision; 75 per cent of RCN members responding to a 2012 survey on community nursing said that the pressure on their team had increased as a result of cuts to social care provision made by local authorities (RCN, 2012).

The King's Fund's report, *Making integrated care happen at scale and pace* (Ham & Walsh, 2013), highlights how local leaders' capacity for action would be greatly enhanced if they are supported by some key funding policy changes, including:

- moving beyond 'Payment by Results' and testing the year-of-care tariff, capitated budgets and pooling of resources in order to put in place the right financial incentives
- regulation by Monitor, the Co-operation and Competition Panel and the Office of Fair Trading to support integrated care by avoiding inappropriate application of competition policy to health and social care
- regulation of financial performance and the quality of care by Monitor and the Care Quality Commission to focus on system performance, not just organisational performance
- alignment of the outcomes frameworks for public health, health and social care.

The chief executive of the UK Homecare Association, the professional association for homecare providers, has criticised the current situation, describing 'current separate health and social care budgets, with fragmented responsibilities for planning, commissioning and funding services as systemic barriers to the design and delivery of integrated services. By definition, integrated services require integrated thinking from the outset, with this strategic level planning then flowing through to the operational, workforce and budget planning, which in turn can be translated into a coherent, integrated commissioning and delivery policy' (Warr, 2013).

In response to the findings of a recent report from the Health and Social Care Information Centre, which shows a significant drop in the number of people receiving support from social services in England, the Charity Director at Age UK similarly criticised the current situation stating that 'nothing will change until the Government accepts the fact that the funding system has failed and acts so that adequate funds are made available. Legislative reform is vital but pointless with insufficient funding in place' (O'Connor, 2013).

Health and Wellbeing Boards

Health and Wellbeing Boards (HWB) were one of the better received changes made by the Health and Social Care Act 2012. While they are legally local authority committees, they are hosted rather than 'owned' by them and bring together a wider range of players from across the local health economy, including elected representatives, local commissioners, leaders from the NHS, public health and social care, and representatives of local Healthwatch. They have three legal objectives, one of which is to support the delivery of integrated care, and have an overall responsibility for devising community-wide plans that can meet the health and wellbeing needs of their local population and reduce health inequalities across their area.

HWBs are required to sign off local plans, prior to submission to NHS England, for accessing the Better Care Fund for its constituent councils and CCGs. HWBs are therefore fundamental to the Government's vision of integrated health and social care and have a clear role to play in ensuring that a nursing perspective, especially in relation to community and district nursing, is at the forefront of integrated care planning and commissioning. Further to this is the recognition of the RCN's long held view, that improving outcomes across the health and social care systems cannot be achieved without the fullest involvement of nurses in the commissioning process. Nurses offer invaluable insight into the practical issues of service delivery, including providing advice on value for money, and the effective delivery of safe and high quality care.

Personal Health Budgets

Following a number of pilots and reviews Personal Health Budgets (PHBs) are now being introduced across the NHS in England. They are based on the personal budgets that have been used in social care for quite some time. In simple terms a PHB is an amount of money given to a patient to pay for identified health and wellbeing needs agreed between the patient, or their representative, and their local NHS team (for example, care manager or GP), and set out in an individual's care plan (NHS England, 2013).

The Government's rationale for the increasing use of PHBs is that it wants 'people to choose what services are right for them and believes that it is more efficient for people to have control over their own budget for health and social care, because they are less likely to duplicate services or choose services that aren't right for them' (DH, 2013).

Recent legislative changes mean that from April 2014, anyone receiving NHS continuing health care has a 'right to ask' for a personal health budget and from October 2014 they will have a right to have one. The UK Government has also proposed that by 2015 PHBs could be rolled out to other people living in England who are identified as being likely to benefit from them (NHS England, 2013). PHBs can be seen as drivers of integrated care, since they allow individuals to create and co-ordinate their own care packages and one of the 14 pioneer initiatives is using fully integrated personal budgets that cover both health and social care services (DH, 2013).

The RCN has always maintained that PHBs must be optional, in recognition of the varying and differing need that each individual will have, regardless of the similarities of their diagnosis or condition and that this necessitates them being considered on a case-by-case basis. We are also aware that there is local variation in the eligibility criteria used to allocate PHBs, something which is not only confusing for individuals needing to move from one local authority area to another, but also has the potential to lead to inequity of service access across the country. (RCN, 2013).

Key messages and future issues

The following key messages can be drawn from the story so far.

- Skilled nurse leadership is fundamental to the integrated care setting, through management roles, providing input into decision-making processes (for example, organisational structure, staffing and commissioning) as well as clinical leadership and care delivery.
- Nursing expertise must be recognised and utilised at all levels of the commissioning process. The ability of nursing staff to view whole care pathways and to take holistic perspectives that go beyond day-to-day clinical issues affords them a vital role in supporting commissioners in their decision making.
- Effective multidisciplinary and multi-sector workforce planning coupled with sufficient funds to train the workforce for new ways of working, will be fundamental to achieving the goal of creating effective, safe and high-quality integrated services.
- Any philosophical and ideological differences between the professions brought together within MDTs need to be addressed in order for the team to be able to work in a truly integrated way.
- There needs to be greater clarity about how the £3.8 billion given to the Better Care Fund is actually being spent and more information on the resulting outcomes, both positive and negative.
- There must be consistent political focus and strong leadership provided at local, regional and national levels, to ensure appropriate mechanisms including funding, are created that will enable the delivery of effective, safe and quality integrated care, for everyone who needs it (RCN, 2013).

In addition to these system issues, the RCN sees the following issues as crucial in the further development and promulgation of integrated care services.

Care planning

At present, this is more generally used for people with long-term conditions and creates an opportunity for them to participate in a discussion about their desired aims and goals in relation to their care. This discussion is then used to draw up a care plan, which clearly identifies the staff and services

required to meet their individual care needs.

A well-devised care plan, drawn up with the involvement of patients, carers and care staff, not only has the potential to meet a person's total care needs but can also act as a catalyst for effective multidisciplinary working. It can help to eliminate wasteful practices, such as patients having to repeat their histories, as well as instilling a collective responsibility for care provision and ensuring that roles and responsibilities within the MDT are clearly defined. The RCN sees MDTs as being central to the delivery of effective, integrated care and see community and specialist nurses as playing an integral role as care co-ordinators and team leaders.

Care delivery

Working in community-based integrated services can raise a number of issues for nursing staff, (including nurse prescribers) with regard to delivering care. These challenges include: managing clinical risk; the supervision, delegation and accountability of health and social care staff; monitoring of prescribing budgets and the lack of applicable clinical guidance for non-acute settings.

Geographical boundary constraints also impact on delivering integrated care, in that health staff are relatively flexible in where they can deliver care but social workers cannot legally provide care outside their local authority boundary.

One solution to the difficulties associated with having to co-ordinate unregistered staff, who may also be employed through a number of different agencies, would be to use a single budget and standard employment terms.

Integrated care steering groups and HWBs can also help, by streamlining the monitoring of integrated care services, so that teams are not overburdened by too many or competing Key Performance Indicators (KPIs), with the ideal scenario being to have one KPI per service, as well as one generated by the person being cared for.

Education and training the future workforce

By its very nature, providing integrated health and social care increases the demand for clinical nurse specialists and community nurses, a workforce which is both ageing and declining in numbers. When coupled with the pressures

facing the social care workforce, which has long suffered from high turnover, skills' shortages and a lack of standardised training, it presents a clear case for the provision of a comprehensive workforce planning strategy, one that will ensure an appropriately sized and suitably trained multi-professional workforce that is able to meet the needs of the population, as well as undertake leadership roles.

There is a need for specialist curricula to support future nursing and care staff to work in an integrated system. Such curricula will need to be delivered by both health and social care educators and will need to be supported by placements in integrated care settings.

Mentoring should also be provided for those trained staff moving from the acute sector into the community setting. In turn community nursing staff can also play a role in supporting patients with self-management, and in helping and educating families and relatives in their caring roles.

The RCN has welcomed the establishment of Health Education England (HEE) and it having the responsibility for the co-ordination of health workforce planning at country level. We believe that HEE, working closely with stakeholders, should take a leading role in securing a future workforce with the right skills to facilitate the integration of health and social care. However this does not address our entire workforce concerns, most especially in relation to health care support workers (HCSWs), where despite welcoming the introduction of a new national certificate for care, we remain convinced of the need to ensure that all HCSWs are regulated.

This is important to ensure that all health and social care staff receive the training and education necessary to ensure that universal standards of quality and competence exist across the health and social care system.

The role of technology

In many places paper health records remain the basis of care management being drawn up with the patient and kept at their home so that they remain in control of who sees them. Of course the era of the internet is fast pushing electronic health records (EHRs), patient record access and record sharing more firmly onto the agenda.

Comprehensive care planning highlights even more the role that technology (for example, telehealth) and EHRs can play, not only to aid communication but also to support more efficient use of resources and reduce duplication of services and referrals.

The delivery of integrated care demands a robust IT system, one that is simple and quick to use, which is able to connect across different care structures and settings interoperability, ie health, social and pharmacy, encourages patients to manage their own health and is able to be used nationwide to ensure seamless transition in those cases where individuals wish to move to a new area.

What's next?

There is a real danger that integrated care will be seen politically as a quick fix panacea for the many problems that face a health and social care system created for very different times and circumstances.

Achieving real and long-lasting change will take time, as well as prolonged effort to establish and maintain successful integrated working practices (Timmins & Ham, 2013). It is extremely likely that these issues will increase in profile as we move towards the next general election in 2015.

The RCN will continue to monitor the various programmes and policies being implemented to support the development and uptake of integrated care. In the first instance, that will mean maintaining a focus on the integrated care pioneer initiatives and on the two stage implementation of PHBs, assessing how they impact on the safety, efficacy and quality of patient care and just as importantly on the workload of those nurses and health care support workers providing the care.

We plan to publish a series of papers on integrated care. These will include an international perspective on integrated care, a more detailed look at the implications for nursing of integrating the health and social care systems in England and the findings of a survey of district nurses.

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