



RCN Policy and International Department
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Policy seminar

Integration: the future of health and social care

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Introduction

There is a broad and growing consensus on the merits of integrating health care and social care to improve the quality of care that individuals receive, and to make the best and most efficient use of limited resources. Nursing staff are at the forefront of this debate because they often work at the interface of the two care systems. Through this experience many have developed a good understanding of the challenges, and have gained the expertise necessary to develop and run integrated care programmes.

Context

Integration is dominant in many of the current health care policy debates, and the Royal College of Nursing (RCN) has been robust in developing evidence based responses to recent consultations issued by the English Department of Health and the King's Fund.

Most recently the RCN hosted a policy seminar on 24 September 2013 attended by a number of executive nurses and directors of nursing (held under the Chatham House rule), to discuss the facilitators and barriers to creating an integrated health and social care system, and to share some international examples of integrated care to inform the debate.

This briefing provides an overview of the seminar discussion, which has contributed to the College's responses to the NHS England 'call for action', the King's Fund Commission on the Future of Social Care, and the Labour review on the integration agenda, as well as supporting the development of the RCN's broader policy work on health and social care.

Learning from overseas

As the UK debate around integration intensifies, questions are now being asked about the applicability, portability, and adaptability of integrated models used in the United States (US), to the English health system. Those garnering most attention are the California-based Kaiser Permanente (KP), the Pennsylvania-based Geisinger Health Care (GHC), and the US-wide Veterans Health Administration (VHA).

The US 'insurer-provider systems' (KP and GHC) have received worldwide recognition as exemplars of innovative and integrated models for delivering health care services for local populations. Nursing is fundamental to these models, with significant emphasis being placed on creating and developing a healthy work environment in which nurses can excel in delivering excellent care, as well as being supported in developing their skills and competences in education, leadership and research. It is notable that these models also have a very strong focus on integration across primary, secondary and preventative care.

The VHA model encompasses health and social care service provision, and is underpinned by well-funded e-health and electronic health record systems. It also aligns financial incentives across the system to encourage collaboration between the different elements; has a whole-systems sensibility; and a strong focus on self-directed care.

In all three models, great importance is given to investment in nursing capacity and competence, in recognition of the positive influence this has on the provision of care. For example, through having a commitment to nursing within structures and governance systems, working closely with universities in offering high quality clinical placements, and having defined clinical nurse leader as well as integrated social worker roles.

While it must be acknowledged that the US health system varies substantially in both funding and provision from the English (and the overall UK) model, there are lessons to learn from the way the three models analysed are able to deliver integrated services, and make full use of the skills and aptitudes of their nursing workforce.

The RCN is currently working on a policy brief that compares the three US models. This will be made available publicly at www.rcn.org.uk once finalised.

Integration and the nursing voice

The policy seminar discussion focused on areas where nurses, and by extension the RCN, could provide a lead in terms of delivering integration, and identified some specific examples of where this knowledge and expertise can best be used.

Key discussion points were:

US comparisons

- US models may work better as they are not influenced by the same political cycles. However, the 14-month electioneering process in the UK could be an opportunity to lobby for more emphasis to be brought on integration. It will be difficult to unpick the Health and Social Care Act now, meaning there should be a longer period of stability.
- As highlighted by the US models, prevention is a key consideration for integrated care. The drivers in the UK are slightly different. The inputs into public health need to be much stronger to prevent the level of need for health and social care in the future.

Definitions

- Most definitions of integrated care, for instance National Voices¹, are really just a description of 'good care', and so the focus should be on what needs to be done to enable the provision of universally good person-centred care.

Education and training

- For integration to work well there needs to be sufficient skills developed in home-based care. Skill mixes in the community can also be improved through the use of 'educator' or 'development' roles that encourage nurses to think about succession planning, skills and training.
- The changes brought in through the Health and Social Care Act provide an opportunity to improve the conceptual understanding of integrated care through education and training. There are some challenges around levels of education and curriculums meeting the need for greater emphasis on care coordination; however the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) each have a vital role to play in changing the system to meet them, for example through designing training and education standards.

¹ National Voices' definition of person centred co-ordinated care: "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." See: <http://www.england.nhs.uk>.

Workforce

- There are challenges in the current arrangements or the lack of them, for workforce planning. It is difficult to consider the numbers of staff required currently *and* in the future as there are many contributing factors. This is particularly badly understood in primary and community care, which are fundamental to future planning.
- The social care workforce is large, dispersed and commonly undervalued for the difficult and complex care it gives. This creates further workforce planning and integration issues.
- Community nursing is in crisis. There are huge workforce issues and concerns that education provision may not be fit for purpose. Numbers are not the only issue; there are also problems relating to leadership, confidence, organisation and competence, all of which are non-cost issues.
- Community nursing has traditionally been seen as an area to which nursing staff move following a career in acute care. The reduction in people following this pathway, combined with a wave of retirement in this area now and a lack of succession planning is leading to a 'perfect storm'. There is an urgent need for work to reinvigorate the community nursing workforce, for example by recruiting directly from colleges to attract those finishing their training, so that community nursing experience is not lost as the current workforce retires.

Funding

- Funding flows are too complex, which makes it difficult to identify accessible funds, for example through local enterprise providers. Pilots may be able to assist.
- The ideological view of the benefit to be had from moving more care into the community is at odds with reality. The proposed policy line is that such a move should reduce costs and improve service provision. In reality costs are not necessarily falling and instead the *size* of acute trusts (ie the number of services they provide) is growing, along with demand for emergency services. This may be partly due to seasonal pressures and issues with GP out-of-hours services and other NHS direct services (such as 111).
- In some cases it may not be cost effective to move to more integrated services or to move to more care being provided in the community; at present there is a paucity of data to fully support either position, and some that undermine the underlying principle. For example, the findings of the whole-system demonstrator programme. Consideration of patient experience might also lead to a position of conflict in situations where people actually prefer to receive their care in a hospital.

Structural arrangements

- Current contracting arrangements run counter to delivering integrated care, and would have to be reset or scrapped in order to be able to create integrated services.
- In fact in many places the previous arrangements for delivering care were actually more integrated, with nurses and social workers working together to deliver patient-centred care. However, this was largely dependent on the locality arrangements, and the individual staff members, and was neither system-wide nor embedded via regulation or legislation.

- The creation of Clinical Commissioning Groups (CCGs) has caused fragmentation of the health care system, and has made it harder to plan whole-system change. However Health and Wellbeing Boards may provide a solution at the local health economy level.
- GPs only see those who are referred to them and may miss developing problems and issues in the community. While there is an opportunity with GPs in the commissioning seat as they understand their patients on the frontline, they also miss the conversations about patients with nursing staff. Commissioning may provide an opportunity to tap into that power base, and this would also work for social care.
- Community nursing has been at the receiving end of all of the restructures of the last two decades, but sufficient time has not been allowed for it to absorb and adapt to each new wave of change.

Technology

- Electronic records could be a key to delivering integration; however ownership needs to be given to patients.
- There are a lot of 'simple' measures that could be easily implemented at low cost, being based upon the technology people already have within their homes and are accustomed to using (for example smart phones).

What could the RCN do to facilitate change?

- The RCN could develop model solutions for delivering the changes necessary for integration, for example how to create the necessary skills and capacity in the nursing workforce. This would build on recent related work in which the nursing voice has been prominent, for example the Caldicott Review on the use of electronic records.
- In relation to district nursing, the RCN could look at developing the idea of an 'accountable practitioner' model that also gives the power to make resource decisions. There is also scope to look at the clinical nurse leader role, as used in the in the US models. However, for this to be successful the practitioners would need to be given clear authority and autonomy, and be enabled to overcome any referral barriers.
- The 'Safe Staffing Alliance' model could be adapted to help drive further changes; there are also opportunities to work more closely with other Royal Colleges, most obviously the Royal College of General Practitioners (RCGP) in furtherance of the integration agenda.
- The RCN could develop commissioning tools that would assist commissioners in creating integrated care systems and structures.
- The RCN has a role to play in supporting individual members to write articles and commentary which present and champion the 'nursing narrative' in the integration debate.

What's next?

As discussed, the RCN is already involved in a broad remit of work encompassing the integration agenda. Understanding how these pieces of work connect is critical. Over the coming months, the RCN will continue to monitor policy developments in the integration of health care and social care,

while working to provide linkages across various work streams. This will include areas such as the future funding of social care work (and thinking beyond the Dilnot Commission's work) and coverage of the ratings review; as well as continuing to look at international comparisons as a way of broadening our knowledge of the best way forward, to deliver more effective, patient-centred care. The policy seminar will help to inform future work.

Tell us what you think

This briefing is intended to provide an overview of the policy seminar discussion on integration and the future of health and social care. The Policy and International Department welcomes comments and feedback from members on these issues, to support the further development of the RCN's broader policy work on health and social care (policycontacts@rcn.org.uk).

Further reading

RCN response to consultation on: *Caring for our future: Implementing funding reform*, <http://www.rcn.org.uk>

King's College, *District nursing – who will care in the future?* <http://www.kcl.ac.uk/nursing>

Commission on the Future of Health and Social Care in England, *Call for evidence*, <http://www.kingsfund.org.uk>

King's Fund, *Submission to the call for evidence on the future funding of care and support*, <http://www.kingsfund.org.uk/submission-call-evidence-future-care-support>

NHS England, *The NHS belongs to the people: a call to action*, <http://www.england.nhs.uk>

Labour review on the integration agenda, <http://www.yourbritain.org.uk/agenda-2015>

National Voices, <http://www.nationalvoices.org.uk/>

Safe Staffing Alliance, <http://www.safestaffing.org.uk>

US Comparisons:

Geisinger Health System, <http://www.geisinger.org/>

Kaiser Permanente, <https://healthy.kaiserpermanente.org>

Veterans Health Administration, <http://www.va.gov/health/>