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# INTEGRATING HEALTH AND SOCIAL CARE FOR HIGH NEEDS POPULATIONS: CHALLENGES AND OPPORTUNITIES FOR THE HEALTH PROFESSIONS

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# INTRODUCTION

# My background

- Former Provost/Chief Executive at UCS, Deputy Vice Chancellor at Lincoln University and Dean of Faculty of Health and Community Studies at De Montfort University in the UK.

- Published widely and involved in funded research projects nationally/internationally on professions and health and social care.

- Member/chair of many health committees – from changing workforce to R&D. Advised UK Departments of Health and professional bodies on health and social care regulation.

- Vice President/President of the International Sociological Association Research Committee on Professional Groups.

# Background to UCS

- University Campus Suffolk (UCS) educates a variety of professional groups – from social workers to nurses.

- UCS is engaged in inter-professional education, including in health and social care, with a tradition from the 1990s – and is affiliated to the Council for the Advancement of Inter-professional Education (CAIPE).

- Currently UCS provides an inter-professional learning programme for groups such as nurses, midwives, radiographers and social workers – with a longstanding nursing exchange programme with Keio University in Japan, with an inter-professional focus.

# The wider context

- UCS is part of the University of Essex and the University of East Anglia – recently defined as two of the world's top 30 universities founded in the last 50 years. Both of these universities offer a wide range of professional study from law to medicine.

- The University of East Anglia has a Centre for Inter-professional Practice, which was formed in 2002 and is also affiliated to CAIPE. Its pre- and post-registration inter-professional learning programmes focus on patient safety and inter-professional/cross-agency child protection teams.

# Introductory comments

- Growing evidence shows that integrating care for populations with ongoing, complex health and social needs is desirable.
- Greater integration promises better outcomes for people requiring multiple services from multiple providers.
- Integration can also make health care systems more cost-effective/sustainable.
- Although there are various ways of integrating services, this presentation focuses on inter-professional working.

- Integrating efforts in Canada and elsewhere are slow.

- Rethinking the roles and responsibilities of health professionals is needed as they are increasingly expected to work in inter-disciplinary and inter-sectoral teams.

- While challenging conventional professional boundaries, expanding the limits of professional practice offers new opportunities:
  - To draw upon complementary and alternative approaches to care
  - To engage consumers and informal caregivers as active participants and partners.

# Presentation overview

- This presentation draws on comparative international experience, primarily from England.

- It examines the part played by the health professions in light of ongoing efforts to reform and restructure health systems to meet new needs – not least in terms of inter-professional working.

- It highlights how structural reforms and curriculum review in higher education can facilitate such integrating projects.

# Key features of the Canadian/Ontario health system

- Canada has a universal, publicly funded single payer health care system for medically necessary services.
- The primary care service in Canada has been developed recently (especially in Ontario) but could be further extended.
- While there is federal input, provincial and territorial governments are central to health and social care in Canada
- There are similarities and differences in services and regulation across provinces and territories.
- In Canada/Ontario professional self-regulation prevails – and the health and social work professions are separately regulated/administered.

# Existing levers for integrationist change In Canada/Ontario

- A key lever for change in primary care and elsewhere has been interest-based incentives for payment of doctors at provincial and territorial level.
- Change has also been effected through employment settings, directive contracts and funding of targeted staff development and qualifying programmes.
- Finally, modifying regulatory and governance structures has been important, including measures ranging from the licensing of midwives to introducing electronic records.

What of the experience elsewhere…?

# THE CHALLENGES TO HEALTH AND SOCIAL CARE IN COMPARATIVE CONTEXT

# Background to the challenges in health and social care in England

The nature of the challenges are as follows:

- Economic recession
- Limits on funding for NHS
- Ageing population
- Rise of long-term conditions
- Multiple conditions in the elderly
- Increasingly expensive technologies
- Spiralling costs of care
- Commitment to equality and diversity
- Desire for personalised care
- Silo-based professions.

# Addressing the challenges in health and social care in England

Given the scale of the challenges, which are similar to those in Canada and modern societies internationally, there are a number of potential paths forward:

- Economic recovery/growth
- Increasing funding for health services
- Move away from the biomedical approach
- More care in the community
- Increase use of support workers
- Encouraging multi-tasking
- Developing a generic workforce.

# Challenges internationally

- A major political strand in dealing with the crisis for the future is increasing inter-professional health and social care.

- In Japan, inter-professional care has been particularly favoured because of:
  - The longer-standing economic recession creating a greater need for more cost-effective health action.
  - The greater proportion of long-lived older people requiring complex care.

- These pressures have led over the past ten years to the increasing incorporation of inter-professional education into Japanese universities.

- What, though, of NHS England?

# THE NHS IN ENGLAND

# The NHS

- The NHS is the largest publicly funded health care system in the world, founded through the 1946 NHS Act which established the service from 1948.
- It is mainly funded through general taxation.
- It provides a comprehensive health care service to anyone legally resident in the UK, with most services free at the point of use.
- It has gone through many reforms and changes since its foundation.
- These include recent efforts to provide a more flexible fit-for-purpose workforce focused on the user, in a knowledge and skills framework.

# The current NHS reforms

- The current primary legislation is the Health and Social Care Act 2012 which was implemented in April 2013.

- Clinical Commissioning Groups led by general practitioners now have responsibility for commissioning most local NHS services – which is akin to an integrated/bundled funding model.

- The Act has also expanded private provision of NHS services – with increased private sector competition.

- The aim is to bring together a package of reforms that work together to increase efficiencies under financial pressures.

# Increasing efficiencies in the NHS

- NHS Trusts have been faced with the ‘Nicholson challenge’ which involves making £20 billion in savings across the service by 2015.
- The development of more user-centred, evidence-based health care (e.g. through NICE for best quality and value for money).
- The focus of the NHS has now shifted more to enhancing outcomes than improving processes, facilitated by the NHS Outcomes Framework.
- There is a greater degree of transparency about comparative outcomes in particular areas of health care in the public domain.

- This is not to say that all aspects of the phased English health reform agenda are desirable in terms of optimising scopes of practice.

- The latest reforms have been much criticised in England for increasing privatisation, providing too much central prescription in practice, fragmenting care and not responding sufficiently to professional or user views.

- However, they do offer food for thought for Ontario in the context of recent developments in inter-professional working in health and social care.

# INTER-PROFESSIONAL WORKING IN HEALTH AND SOCIAL CARE IN ENGLAND

# Benefits of inter-professional working

Inter-professional practice for seniors and other high needs groups has many potential documented benefits, including:

- More efficient use of staff
- More cost effective service provision
- More satisfying work environment
- Less duplication of activity
- User-centred approach.

As such, there are clear advantages of inter-professional working in the current political climate in economically challenging times.

# Drawbacks of inter-professional working

However, it is important to recognise that there can be drawbacks to inter-professional practice, as for example:

- More time consuming in task completion
- Increased complexity of communication
- Potential lack of clarity of work roles.

Although inter-professional working can have many benefits, therefore, the overall costs and benefits in specific situations need to be evaluated.

# Factors affecting the implementation of interprofessional working

Despite the general benefits of interprofessional working, it has all too rarely been achieved in practice.

This is because it is dependent on many factors:

- Attitudes of key players
- Management policies
- Level of leadership available
- Educational support frameworks
- Organisational structures.

# The role of professions

The implementation of inter-professional care also depends fundamentally on professional bodies, the politics of which have often obstructed the inter-professional agenda in the past.

Professional bodies are very influential as they set the parameters for the operation of professionals in specific areas, including inter-professional education and identity.

This presentation illustrates this with reference to the implications of professional regulation for inter-professional education – examining the politics of professionalism in  health and social care.

# Traditional conceptions of professions

Professions have traditionally been seen as:

- Differing from other occupational groups
- Possessing unique bodies of expertise
- Using their knowledge for the public good
- Acting rationally, objectively and impartially.

In this framework, based on the ideology of professional bodies, professions are held to facilitate inter-professional working when it is of benefit to society and/or clients.

However, this view has increasingly been challenged…

# The recent critique of professions

Recent critics view professions as:

- Self-seeking monopolies in the market
- Insufficiently accountable/responsive
- Having a mystified knowledge base.

Despite their professional ideologies, such critics have great doubts about professions engaging productively in inter-professional collaboration – especially given their group self-interests.

# Exclusionary closure and inter-professional working

The influence of professions is greatest when they have legally constituted self-regulatory autonomy based on exclusionary social closure as they have done in England and Ontario.

Professional bodies have powers in the market in such areas as:

- Defining their core curriculum
- Controlling codes of ethics.

They can set up barriers to inter-professional working as in health and social care which some critics have viewed as a scene of tribal warfare between professions.

# Political obstacles to interprofessional working in health and social care

Historically such politics has often negatively shaped professional interactions in England through the exercise of group self-interests, illustrated by:

- The restricted development of other emerging professions/occupations in the shade of the umbrella of medical dominance (for instance, nursing, radiography and complementary and alternative medicine).
- Turf wars between medicine and other professional groups to protect professional ownership – exacerbated by the growth of increasingly narrow, fragmented specialisms.

# Current Coalition policy

- The current government in England is formally looking to create more collaborative de-regulation in relation to professions and other services under the rubric of the Big Society.

- This is set out in the government's **Better Regulation** agenda (2010) in which such a ground up interactive approach is encouraged as an alternative to traditional command and control to increase efficiency and economic growth.

# The integrated health and social care agenda

A new White Paper (Equity and Excellence: Liberating the NHS) introduced in 2010 under the Coalition government pointed in this direction.

The 2012 Health and Social Care Act provides for an integrated devolution of power to the public and professions, for example:

- There will be more patient choice of health care professionals.
- General practitioners in primary care will be given lead responsibility for commissioning.

# Inter-professional developments in health and social care

Recent ensuing structural changes in health and social care will increase inter-professional working:

- Social work will now be regulated by the **Health and Care Professions Council** rather than the General Social Care Council.
- **Health and Wellbeing Boards** are being introduced as a key forum for professions in health and care to work together to improve the health and wellbeing of local populations.
- The Council for Healthcare Regulatory Excellence is also to become more inclusive as the **Professional Standards Authority for Health and Social Care**.

# Review of health and social care professions

The current review of health and social care professions by the Law Commission including the major health professions and social work may also aid inter-professional working.

The consultation has concluded with the aim of simplifying and modernising the law to establish a more streamlined, transparent and responsive system of regulation.

This should also help to bring the health and social care professions closer together – along with the more integrative 2012 Health and Social Care Act.

# The role of the state

The role of the state in England has become politically critical:

- The state has in the past tended to defer to professional authority in the politics of health care – as witnessed by the pre-War ‘Medical-Ministry Alliance’.
- Now the state is more proactive in ensuring positive and collaborative forms of governance in health and social care.
- This is exemplified by recent shifts of power from hospital consultants to primary care, the legitimation of some forms of complementary medicine and tighter professional regulation, including in medicine.

# Inter-professional best practice

We now have a number of examples of inter-professional best practice in the UK.

One such well-publicised example is the **Marylebone Health Centre** in London where the following groups work together in an NHS commissioning arrangement closely, collaboratively and responsively to serve high needs and other populations:

- General practitioners
- Social workers
- Counsellors and psychologists
- Complementary practitioners (including herbalists, homoeopaths and massage therapists).

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# The criteria for best practice

Why is the Marylebone Centre best practice?:

- There is coordination of care.
- Doctors are not dominant.
- Practitioner hierarchies are limited.
- Coordinated referral networks exist.
- There is a spirit of collaboration.
- The environment is holistically supportive.
- It is user and carer focused.
- It is linked to University research and education.
- It is sustainable – established for many years.

# Success and sustainability

Interestingly, success and sustainability do not necessarily go together. This is illustrated by the parallel case of the **Lewisham Complementary Therapy Centre**, established in 1994 with local general practitioner support.

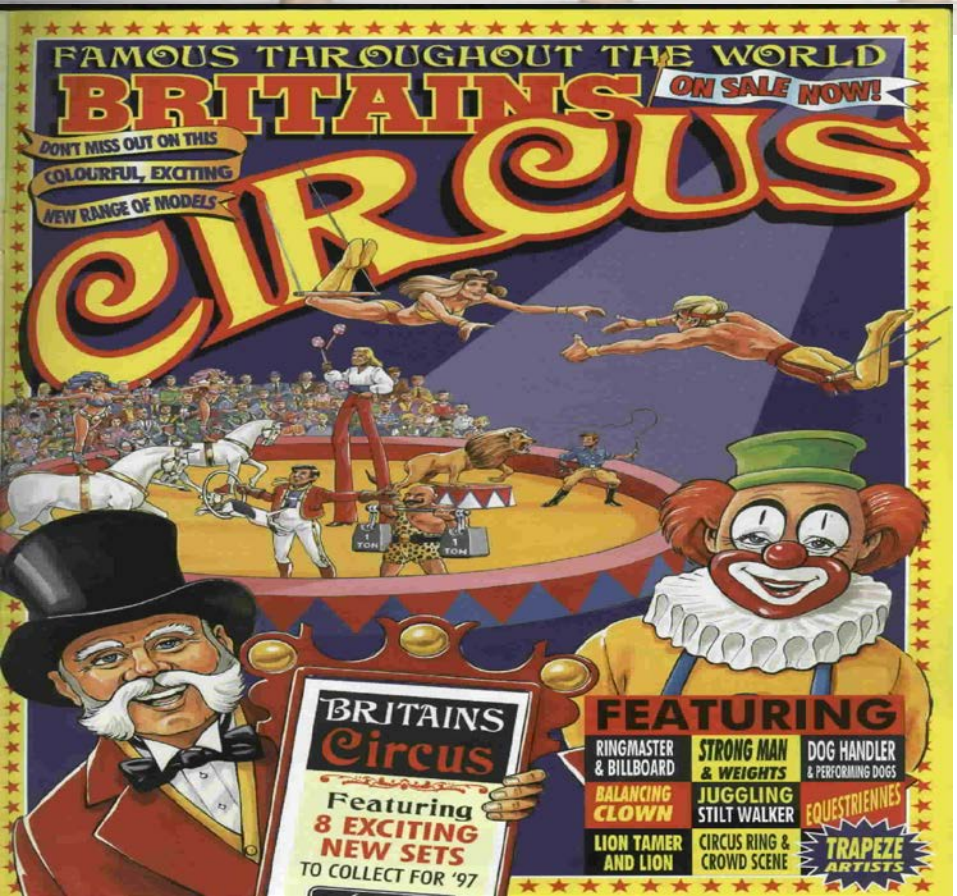
This had common features to the Marylebone Centre with clear referral guidelines, a research base and very good service evaluation by users – introducing a range of complementary therapies into the NHS (e.g. acupuncture and osteopathy).

However, in 2003 NHS funding was withdrawn by the local health authority despite positive therapeutic outcomes – underlining the importance of politics in integrative developments in health and social care…

# Metaphors, professional regulation and the state

- In terms of the changing landscape, in England we are now metaphorically seeing a shift away from the **zoo**, where professions historically built their own separate enclosures.
- This shift has been in the direction of a **circus** where the state increasingly acts as ringmaster in regulating professions.
- More excitingly, from an inter-professional viewpoint, as has been seen, there have been increasing moves to encourage inter-professionalism which signals the emergence of a **safari park**.


WILDLIFE CONSERVATION SOCIETY
BRONX ZOO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# (A) Regulating the professional zoo under the Conservative government

The reforms up to the late 1990s in England illustrate the challenges involved in policing professions – particularly in relation to medicine, a ‘top dog’ profession.

From the late 1970s, the Conservative government (1979-97) saw professional groups as hindering the operation of market forces, leading to regulatory reform such as:

- Introduction of general managers in the NHS (Griffiths reform)
- Creation of an internal market in the NHS (purchaser/provider split)
- Development of a Citizens’ Charter.

# Rogue practices

These regulatory measures did not prove a total success in controlling the animals in the professional zoo, as exemplified by a series of later rogue practices, which were not constrained by professional codes or disciplinary procedures, for instance:

- High child mortality rates at Bristol Infirmary
- Non-consensual child organ removal at Alder Hey
- Nurse serial killer Beverly Allitt
- Commission for Social Care Inspection report on elderly restraint
- The case of Dr Harold Shipman – most victims of whom were seniors.

# The Shipman Inquiry

Further scope for professional regulatory reform was particularly highlighted by the fifth report of the Shipman Inquiry in 2004 on Safeguarding Patients: Lessons from the Past – Proposals for the Future.

This report focused on the systems and organisations for monitoring the work of doctors following the Shipman case.

Although the earlier Shipman Inquiry reports suggest the regulatory mechanisms of the medical profession were not the only factors, significant changes were clearly needed.

# (B) Regulating the professional circus under Labour

This and other cases led the Labour government (1997-2010) as ringmaster to modernise the health and social care professions, following the 2006 Donaldson and Foster reviews, through:

- Revalidation and registration procedures
- Increasing lay representation on the General Medical Council
- Replacing the UKCC/ENB by the more accountable Nursing and Midwifery Council
- Replacing the Council for the Professions Supplementary to Medicine by the more effective Health Professions Council.

# The 2007 White Paper

The government introduced the White Paper Trust Assurance and Safety: The Regulation of Health Professionals in the 21st Century in 2007. It focused on:

- Assuring continuous fitness to practice
- Harmonising regulatory practice (including in new professions and complementary medicine)
- Improving information for professions.

The White Paper aimed to raise professional standards and ensure public safety in relation to conduct/competencies in health and care professions – in much the same manner as happened in circuses generally at this time.

# (C) The rise of the professional safari park under the Coalition

- The current rise of the professional safari park is underlined by the new integrative body established under the Coalition (2010-) – the **Professional Standards Authority for Health and Social Care**. It is significant that its title has changed from being the Council for the Regulation of Healthcare Professionals under the previous Labour government.

- The shift in regulatory focus is highlighted by the growing recognition of the **Council for the Advancement of Inter-professional Education** which has for long championed inter-professional working.

# International support for integrating health and social care

This shift in government policy therefore provides very good opportunities to develop inter-professional collaboration in health and social care – not least through inter-professional education, as indicated by the World Health Organisation (2010):

> "Interprofessional education is a necessary step in preparing a collaborative, practice-ready health workforce that is better prepared to respond to local health needs."

# Education for inter-professionalism

Ongoing research in the UK suggests that inter-professional education is crucial and that, to encourage its practical application, the curriculum should ideally be:

- Theoretically oriented
- Practice/placement based
- Pivoted on the service user
- Centred on online techniques
- Case study focused
- Based on mixed methods research.

# Maximising the effectiveness of the safari park

- To be maximally effective as well, further changes in higher education need to be supported in the workplace by managers and professional bodies.

- Having said this, the currency of the safari park metaphor is increased by the fact that such establishments have controlled segregation of animals, like the present health and social care professions.

But even in safari parks there are still risks…

– although these currently seem to be outweighed by the benefits!

## A twist in the tale?

If we are going into a more open mode, do we need such segregation – or by extension professional regulation in health and social care or elsewhere?

Should we not just go back to the law of the jungle in de-regulating the professions – and let the market determine the public interest…?

# (D) The law of the jungle

The government is clearly still concerned that in the safari park the health professional animals do not escape from their compounds and run wild, causing damage to clients and the public.

However, it is possible to conceive of a de-regulated world without professional zoos, circuses or safari parks – based on the law of the jungle.

Would this work better…?

# Arguments for de-regulation

The positive side of completely de-regulating the professions is that it could:

- Cheapen further the cost of services.
- Reduce central state intervention.
- Give greater credence to other staff in the health care division of labour (e.g. health support workers).
- Result in more direct consumer control, albeit with *caveat emptor* ('let the buyer beware').

# Arguments against de-regulation

The negative side of such de-regulation is that there may be:

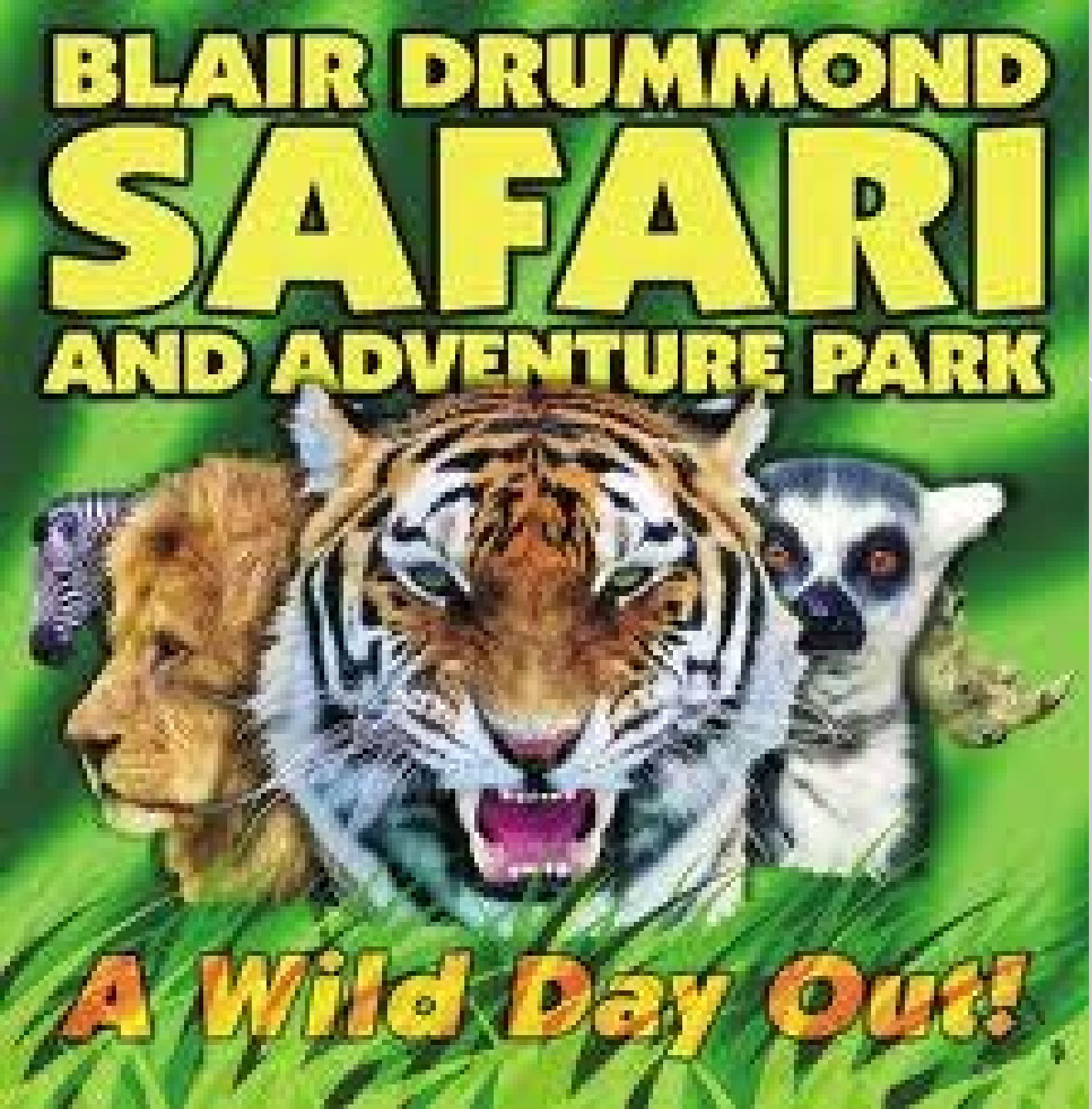
- Risks to the consumer without the protection of certified expertise/codes of ethics.
- Financial issues raised by the loss of subscriptions of professional bodies.
- The lack of a buffer between consumers and the state.
- Increased bureaucracy and possibly less collaboration between professional groups.

# All animals together?
# An idyllic view of professional collaboration in a de-regulated jungle

# The need for realism

But there is a need for realism as to what can be achieved. It is very important that, despite the rise of the Big Society with the Coalition in England, inter-professional care is not governed in an unregulated way by the law of the jungle – as professional self-interests may damage inter-professional working.

In other words, it could be a wild development…


BLAIR DRUMMOND
SAFARI
AND ADVENTURE PARK
A Wild Day Out!

# Professionalism as a positive way forward

There are supporters and detractors of the role of professions in society in terms of fostering inter-professional working in response to challenging times.

However, professionalism can still in principle be liberating in terms of dealing with the crisis in health and social care through inter-professional practice.

If it is to be liberating, it is vital that positive rather than negative features of professional regulation are used for the common good – such as certified expertise, peer review, public service ideologies, systems of accountability and codes of ethics.

# IMPLICATIONS FOR INTEGRATED PRACTICE BASED ON INTER-PROFESSIONAL WORKING IN ONTARIO AND BEYOND

# General implications

The NHS experience in England suggests that – despite policy legacies – greater emphasis in Ontario may be needed on:

- Government investment in the political positioning/funding of primary care.
- Decreasing inequalities in health care access.
- Further improving the coordination of care in primary and other settings.
- Systematic and timely evaluation of reform and making evaluation results more public against key performance indicators.
- Increasing user centrality in health care.
- Spreading good practice across provinces and territories in a more fragmentary system.

# Inter-professional implications

More focus here may also be needed on:

- Enhancing inter-professional working between physicians and other groups.
- Increasing bridging between health and social care.
- Improving the inter-related governance of the health and social care professions.
- Changing workforce roles (e.g. generic professional workers vs. specialists).
- Reviewing the role of higher education in supporting inter-professional working (e.g. undergraduate vs. postgraduate focus).
- Ensuring that boundaries between professions are drawn on an evidence base.

# The politics of scopes of practice

Finally, there are delicate national/local balances in both countries and, as in England, incremental change in inter-professional working may be easier to effect than revolution…

Nonetheless the following is commended:

- Avoiding simply incentivising doctors to cooperate as this may limit change to the consensual.
- Top down reforms of professional bodies may be required too – following the latest NHS reforms.
- Reducing/enhancing medical professional self-regulation – with greater formal external accountability as in the NHS.
- As in the NHS too, critically scrutinising professional regulation in other health areas.

# CHALLENGES AND OPPORTUNITIES IN MOVING FORWARD THE INTER-PROFESSIONAL AGENDA FOR HIGH NEEDS POPULATIONS

# Challenges

- Grasp the reform nettle in moving the inter-professional integrationist agenda forward.
- Engage professions (including physicians), other health workers and carers/users.
- Make judgements about situations where integration is/is not appropriate.
- Ensure that integrationist developments are evidence based.
- Overcome the legacies of previous organisational frameworks in making change.
- Increase professional accountability.
- Ensure coordinated regulatory adjustments across health and social care.
- Avoid the dangers of creating excessive and counterproductive system complexity.

# Opportunities

- Draw on positive change leadership.
- Share good practice in Canada and beyond.
- Legislate for greater integration.
- Improve care for end users.
- Reduce the costs of the service.
- Work within budgetary constraint.
- Counter demographic trends.
- Develop primary care as a fulcrum.
- Improve the use of new technology.
- Develop responsive/flexible health working.
- Draw on the positives of professionalism.
- Provide education for inter-professionalism.
- Recognise the strengths/weaknesses of biomedicine.

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**We look forward to more integrative, inter-professional working in Canada in general and in Ontario in particular among professions and other health/care groups in relation to those in high needs populations in future…**












**Thank you for listening – are there any questions or comments?**