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Llywodraeth Cymru
Welsh Government

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Consultation Document

A Framework for Delivering Integrated Health and Social Care

For Older People with Complex Needs

Date of issue: **22 July 2013**
Action required: Responses by **31 October 2013**

Overview

Demographic and other trends in Wales mean that there is increased demand for both acute and community care services for older people, particularly those aged 85 and more. Frailty, dementia and the effects of multiple chronic conditions are more prevalent in this population group. Building on investment in collaborative working over the last ten years and more, Ministers believe that these changes require a new prioritised and robust response to integrate health and social services for older people with complex needs

A task group of NHS, Third Sector and local authority social care leaders has been working with and advising Welsh Government during the development of the Framework, and also considering options to support roll out and implementation. At this stage, we would welcome your views on the proposed Framework for Integration.

We are committed to further dialogue at a national and regional level to shape how integration in Wales is progressed which will be taken forward initially through the meetings of the Health Minister with LHB Chairs and the Deputy Minister's National Partnership Forum for Social Services which includes cross party local government representation. The Welsh Government led Multi-stakeholder Task Group will also need to have an on-going co-ordinating role and in supporting development and implementation of the Framework.

Ministers want to give priority and momentum to the Framework and to allow partners the opportunity to plan for implementation of integrated services during 2013/14 before implementation commences fully from April 2014. Ministers have asked that each local health board and local government partnership should on a public services foot print basis, develop an agreed Statement of Intent for integration of health and social services and submit these by the end of January 2014 for consideration.

It would therefore be helpful to receive your initial views and comments on the Framework and the way forward outlined by end October 2013. We would welcome shared responses across partnership groupings in line with locally agreed preferences.

How to respond

Please respond by email or in hard copy

Social Services Directorate
Department of Health and Social Services
Welsh Government
Crown Buildings
Cathays Park
Cardiff
CF10 3NQ

Email:FrameworkIntegratedServicesOlderPeople ComplexNeeds @wales.gsi.gov.uk

Further information and related documents

Large print, Braille and alternate language versions of this document are available on request.

Contact details

For further information:

Social Services Directorate
Department of Health and Social Services
Welsh Government
Crown Buildings
Cathays Park
Cardiff
CF10 3NQ

Email:FrameworkIntegratedServicesOlderPeople ComplexNeeds @wales.gsi.gov.uk

Data protection

How the views and information you give us will be used

Any response you send us will be seen in full by Welsh Government staff dealing with the issues which this consultation is about. It may also be seen by other Welsh Government staff to help them plan future consultations.

The Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. This helps to show that the consultation was

carried out properly. If you do not want your name or address published, please tell us this in writing when you send your response. We will then blank them out.

Names or addresses we blank out might still get published later, though we do not think this would happen very often. The Freedom of Information Act 2000 and the Environmental Information Regulations 2004 allow the public to ask to see information held by many public bodies, including the Welsh Government. This includes information which has not been published. However, the law also allows us to withhold information in some circumstances. If anyone asks to see information we have withheld, we will have to decide whether to release it or not. If someone has asked for their name and address not to be published, that is an important fact we would take into account. However, there might sometimes be important reasons why we would have to reveal someone's name and address, even though they have asked for them not to be published. We would get in touch with the person and ask their views before we finally decided to reveal the information.

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Joint Foreword

Mark Drakeford AM, Minister for Health and Social Services
Gwenda Thomas AM, Deputy Minister for Social Services

It is excellent news that people in Wales are living longer and healthier lives than ever before. We now need to ensure that our services adjust to help people of all ages enjoy their lives to the full in line with the commitment in our *Programme for Government* to '*develop high quality, integrated, sustainable, safe and effective people-centred services that build on people's strengths and promote their well-being*'.

We know that there is going to be a greater demand in future for care services for older people, particularly those aged 85 and more. *Together for Health* sets out our ambition for person-centred health services provided as close to home as possible. *Sustainable Social Services* envisages a social care service based on outcomes focused portable assessments and enabling people to make informed decisions, with more consistent care eligibility and planning. The *Social Services and Wellbeing (Wales) Bill* will significantly strengthen the legislative requirements for Health Boards and Local Government to integrate services.

Our policy aim is to improve existing services and develop a wide range of preventative services that can help people of all ages manage their own lives at home and avoid as far as possible having to go into hospital or residential care.

The core concern of this framework is to bring an end to fragmented care that confuses and frustrates providers and recipients alike. Fragmentation wastes resources, effort and opportunities. The document sets out essential requirements that we believe must be put in place as the standard model across Wales. We are not at this point looking to structural changes to achieve this, but change there must be.

It complements the framework for developing community services issued by Welsh Government in June 2013, *Delivering Local Health Care: accelerating the pace of change.* The two should be implemented through a single process of rapid, integrated action, involving local health boards, local government and their partners in the independent and third sector partners.

This Framework has been developed with the NHS, Local Government, Directors of Social Services and the Third Sector, and others such as Care Forum Wales have indicated their support for this approach. We encourage all interests to do the same to improve the services we provide to older people in Wales. It is this practice of 'co-production' that we wish to see both in the planning and the delivery of services and extending to include those who receive the services.

We commend it to you and would ask that you let us have your views and comments on it.

1. Overview and Context

Wales already has a higher proportion of people over 85 than the other countries of the United Kingdom and it is likely to rise in the next decade. If services are to help older people have a happy, independent life, action is needed now to ensure the right services are in place, especially in light of the current financial challenges. Services that are fragmented or unreliable or undermine people's ability to live where and how they would like will neither use increasingly scarce resources well nor meet the needs of people who need support.

A new pattern of services is needed, building on, adapting and developing the good foundations already in place. Recognising the growing evidence that demonstrates the benefits of integration, this document sets out how the Welsh Government ambition for truly integrated health and social care services for older people is to be implemented. Partners across Wales are expected now to move rapidly on making this model the norm. A marked change is needed over the next three years.

The term 'integration' has many definitions which reflect the spectrum of levels at which integration can take place. Integration is the opposite of fragmentation. For people needing care and support it should mean:

> 'My care is planned by me with people working together to understand me, my family and carer(s), giving me control, and bringing together services to achieve the outcomes important to me.'

To achieve this, care delivery must be aimed at achieving improved user and patient care through better co-ordination of services. Integration requires a combined set of methods, models and processes that seek to bring about this improved co-ordination.

The essential elements are that:

- service providers take down the barriers that have prevented effective collaboration and shape the service around a common understanding of the outcomes important to the individual
- the recipient will have a greater say and more control over the care received.

This framework:

- summarises the relevant policy and key principles;
- provides clear definitions;
- sets out the Welsh Government's expectations for how all the different partners need quickly to develop and deliver integrated health and social care services, not as something extra but as the normal way of working;
- identifies what the evidence indicates as the core requirements on which to base local planning and delivery; and
- states the outcome-based indicators that will help establish the present baseline position and measure progress.

It is anticipated that this approach will make health and social care outcomes better and more consistent, and strengthen community-based care. Good multi-disciplinary assessment will become standard practice, the role of the GP more central, and

early intervention, reablement and intermediate care part of a single co-ordinated system. Dignity and privacy will be protected.

While it takes time to achieve this, there is already good practice in place on which we must build. Examples include the areas that have pioneered frailty services, joint locality teams and community resource teams, and in mental health and learning disability services. There has also been solid progress in creating integrated support for families with complex needs. The principles applied there and lessons learned will be essential in supporting rapid progress.

2. The Case for Change

People in Wales are living longer and healthier lives than ever before, and services to meet their needs must keep up. Wales has the highest rate of growth for those aged 85 years and over of the UK countries - by 2030 people aged over 85 will jump by 90%, to 85,000

Older people have higher levels of frailty, dementia and chronic conditions, often in combination with each other - already there are more than 42,000 people with dementia in Wales, which affects two thirds of older people in residential care, and by 2021 the number is projected to rise by 30% and as much as 44% in some rural areas.

This will drive a growing demand for services. Community services and home based care will have to expand at a time when real term resource increases to meet this growing demand is no longer assured.

There is research and anecdotal evidence that services are fragmented, both within and across organisational and sectoral boundaries. Like others, older people want to be in control of their own lives and continue to be part of and contribute to their community. This implies that services should offer graduated, co-ordinated support to help them live independently in their own home for as long as possible. Evidence shows how disrupting older people's usual living arrangements can very quickly undermine their confidence and capability, even to the extent of making it impossible for them to live independently as before.

Providing community-based, fully co-ordinated services that are designed to support them and give them a say and the chance retain control of their lives is clearly the model that older people want and need to experience. Services that are co-ordinated and work as one can best achieve that.

This also chimes with the wish of people working within health and social care services. They recognise the need to empower older people, and welcome models of care and support that respects people's broader sense of personal wellbeing and a strong community.

Refocusing services, then, is a high priority area. Integrated models can better meet older people needs. They can also help address the increasing demand for care and support both now and in the future. Not changing is simply not an option. Urgent action is needed.

Change is achievable. There are already many examples across Wales of good integrated working including through: single agency responsibility for certain mental health services, integrated children's services - Integrated Family Support Service and Families First, integrated hospital discharge services, joint reablement and rehabilitation services and joint equipment stores. The Welsh Government 'Invest to Save' funding already supports frailty service models across much of Wales. On an on-going basis, the Invest to Save process, the Regional Collaboration Fund and the Wales Council for Voluntary Action's Wales Wellbeing Bond provide partners with access to resources to support further development.

Further progress is essential, and quickly. LHB and related Councils must plan a year on year increase in shared budgets and resources and set a specific locally agreed target for the proportion of resources relating to older people that are committed to a pooled budget. Action is essential now on what the King's Fund describe as a 'burning platform' with no alternative but to accelerate the pace and scale of developing integrated health and social care as core services.

3. What do we want to achieve?

The recognition that change is essential opens an opportunity to create a new truly integrated system. It should have two main characteristics.

1. It should be a consciously planned and managed system, built on ambition. Working closely together to reduce barriers between them, local partners will need to refocus their activities around those receiving care. This will require attention to:

    - preventative interventions that stop an avoidable slide into increasing dependency upon services;

    - locating and linking services in community settings with smooth transitions between different elements and into more specialised services;

    - creating fully integrated referral pathways that enable service users too easily cross organisational and sectoral boundaries without any harm or loss;

    - capturing once, and addressing all the needs of the service user

    - a balanced set of services operating where necessary 24 hours a day, integrating early intervention services, support for independent living, rehabilitation and reablement, intermediate care, end of life care and pathways into specialist services and less often used services;

    - full engagement all parts of secondary care focusing especially on those points of the pathway where the risk of undermining independence is greatest;

    - enabling service users to take part in developing their plan of care, with a named single point of contact, and to express their views regarding how the care is delivered;

- enabling carers to take part in developing the plan of care, receive an assessment of their support needs, have access to relevant, up-to-date and targeted information at every stage and express their views regarding how the care is delivered;

- initiate joint action when young carers are identified who may appear to be at risk or a 'child in need' because of their caring role are identified

2. It should be built with and for service users and the local community. Services should not be designed and run with out reference to the people they serve. The definition of integration in Section 2 focuses on the experience of the recipient of services.

   There must then be a strong commitment in developing services to increase the voice of the users and the community. This should aim both to support and facilitate community wellbeing in the broader sense and also to encourage and help individuals and communities to take more responsibility and control for themselves.

   Services should recognise that communities and individuals are themselves assets. Together service providers and recipients can help create a more effective service. Professionals have specific training, experience and skills while the recipient of care knows best his or her needs, preferences and situation. Planners and others need to build on this potential to 'co-produce' the best service and best outcomes.

   The same idea of co-production can apply in developing healthier communities and reducing dependency. A fully integrated approach can also build on community-oriented actions such as:

   - specific initiatives to develop social networks;
   - encouragement for volunteering, including time banking;
   - working on 'community currencies' which not only strengthen the social resilience of communities, but also local economies;
   - developing models of social enterprise.

3. There must be a real commitment to constant monitoring and improvement. Explicitly moving to a more integrated approach means that responsibilities are sometimes not so clear. The partners will need to work closely together to ensure there are safe and clear governance arrangements for delegating responsibilities, sharing resources, and ensuing accountability. There must be careful attention to reviewing quality and outcomes, even more important when services are in flux.

4. Making it Happen

In making the necessary changes, a decision has been made that at this point reforms to structures are ruled out, but change there must be. The requirement therefore is that local bodies now progress along a clearly defined path, linking at each stage their actions to those being delivered in parallel in response to *Delivering Local Health Care.*

In doing so they should draw on the mass of evidence that suggests that, while there are many ways of integrating care, the key principles remain consistent. These have been helpfully summarised by the King's Fund[1] and based on their work sixteen issues are set out in the box below that must be taken into account in developing and mainstreaming integrated services for older people over the next three years.

The core planning issues

To be clear about:

1: our common cause – why we are doing this
2: our shared narrative - why integrated care matters
3: our persuasive vision – what it will achieve
4: shared leadership – how we are going to do this
5: how to build true partnership
6: what services and user groups offer the biggest benefits
7: how to build from the bottom up and the top down
8: how to pool resources
9: how to use commissioning, contracting, money and the independent sector to create integration
10: how to avoid the wrong sort of integration
11: how to support and empower users to take more control
12: how to share information safely
13: how to use the workforce effectively
14: how to set objectives and measure progress
15: how to avoid being unrealistic about the costs
16: how to build this into a strategy

Actions required:

1. Local partners must **by end of December 2013** assess their current situation and action required, both at footprint and locality/cluster level, against the 16 issues in the box above, and define local action required.

2. All local partners must **by end of January 2014** sign off and publish a Statement of Intent on Integrated Care.

[1] *Making integrated care happen at scale and pace: Lessons from experience.* London: King's Fund, March 2013

The Statement must include the baseline assessment required under 1 above and set out clearly how:

- they will build an appropriate workforce across all partners as an early opportunity to enhance the citizen's experience;

- they will ensure a relentless focus on delivering locality based citizen centred, co-produced services, focusing upon the pivotal role of primary care services in delivering person centred care.

- they will maintain robust local partnership arrangements that reflect a willingness to delegate responsibilities;

- they will provide leadership and commitment at all levels and across all sectors, with explicit governance and accountability arrangements;

- a single commissioning plan will operate across partners, moving over time to a consistent approach across Wales;

- collaborative resource management will be managed through options such as a financial governance framework; joint commissioning plans and intentions; pooled and/or integrated budgets.

- how pooled budget arrangements will be extended, stating first what these currently are .

3. The Welsh Government will use the baseline assessments in the Statement of Intent as a means of reviewing progress in delivering the requirements in this document.

4. Also **by end of January 2014**, in developing the service, partners should, using the evidence base and their own experience and assets, develop shared local health and social care outcome measures that will demonstrate the impact of integration and drive further progress.

5. Partners should ensure **by September 2014** that local planning mechanisms reflect the requirement that collaborative planning at local level is based upon a citizen-centred model that allows older people in Wales to have a voice and to retain control of their life.

6. Partners need to **by December 2014** to have developed within mainstream services for older people integrated services for older people with complex needs, designed in line with this Framework will be embedded**.**

The maturity matrix included at Annex A in this Framework provides an additional tool for partners to use to establish the current position of collaborative service planning and delivery locally, and to organise the journey forward and capture progress.

5. Measuring Success

Recognising and reporting success in integrating health and social care services is essential. All partners will already have performance targets and outcome measures in place that gauge progress in developing integrated services.

As stated above local partners will be expected to establish their baseline position, both at a public service footprint and locality/cluster level against the 16 issues and to set these out in the Statement of Intent and also to agree their own priorities and measures for use in assessing the pace of change. These should be reported to the LHB Board and the Local Authority and to other interested bodies on a regular basis.

In addition, the Welsh Government will use the key indicators below adapted from the Audit Commission's '*Joining up health and social care: Improving value for money across the interface*' (December 2011), along with data available on carers to monitor progress.

The Performance Indicators: Indicator		**Anticipated direction of travel**
1	Emergency admissions to hospital for people aged 65 and over	Decrease
2	Emergency bed usage for people aged 65 and over	Improved performance benchmarked against CHKS © Peer Group
3	Shift in balance from care home to home care provision	More people supported to live in their own homes
4	Admissions and re-admissions avoided by appropriate community based intervention models	Increase
5	Falls data captured and submitted to the Reducing Harm from Falls Collaborative	Continuous improvement Benchmarked with collaborative
6	Admissions to care home direct from acute hospital	Decrease
7	Discharge to usual place of residence	Increase
8	Number of people choosing where to die (end of life services)	Increase
9	Unplanned hospital attendances	Decrease
10	Readmission within 14 days of discharge	Decrease
11	Delays in transfer of care due to waits for packages of care or modifications to the home environment	Decrease
12	The proportion of carers assessments undertaken	Increase

6. The next steps

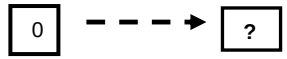
A 12 week consultation process will now commence. This will seek not only responses to specific issues, for example how best to capture and measure success, but will also give people using services and carers, the public, interested organisations, local statutory bodies and providers, and others an opportunity to share their views on the overall intentions and the proposed approach.

Responses should be sent by 31 October to:

Social Services Directorate
Department of Health and Social Services
Welsh Government
Crown Buildings
Cathays Park
Cardiff
CF10 3 NQ

A Maturity Matrix to Support Health and Social Care Integrated Care Partnerships

Using the matrix: Identify the level you believe your partnership has reached for each key element and then draw an arrow to the level you the level you intend to reach within the next 12 months. Review the partnership's maturity matrix position on a frequent basis.



Progress Levels / Key Elements	0	1	2	3	4	5
	No	Basic level Principle accepted and commitment to action	Early progress Early progress in development	Results Initial achievements evident	Maturity Comprehensive Assurance in place	Exemplar Others learning from our consistent achievements
Purpose and vision		Purpose debated and agreed. Values and priorities agreed, and documented. Political agreement to integration confirmed and documented cross Health, Social Care, Third Sector and Partners. 'Health and Social Care Integration Partnership' (H&SCIP*) understands its role.	Priorities and stretch goals have been agreed with stakeholders =. Robust mechanism for adding and removing services and/or care settings agreed. Plans rooted in local population needs.	Evidence priorities are being met, with progress towards stretch goals in some areas. Evidence of citizen engagement and public accountability testing purpose and vision. Existing partnership work considered.	Systematically match how purpose dovetails with population needs. Evidence that integrated care is enhancing the quality of services and experience for the citizen	Confidence in achieving purpose and vision as population health benefitting in accordance with plans. Local health planning, local authority commissioners, third sector and other partners have been influenced. Evidence of reduction of waste and duplication through tackling duplication and fragmentation
Strategy		All stakeholder strategies relevant to work gathered and timetable set for developing integrated strategy. Base for all 'H&SCIP' strategic decisions. Political sign-off of strategy by all partners	Strategy development underway. Arrangements in place for areas of joint planning/commissioning and investment opportunities.	'H&SCIP' has a current published strategy, which includes improvement milestones and how they will be measured and monitored.	Strategy refined in light of successful achievement of milestones, and new intelligence and aspirations	Strategy has benefitted other health and social care economies, as well as influencing the strategic direction of all local partner organisation.
Leadership of the local health and social care integration economy		'H&SCIP' leadership agreed and appointed. Key stakeholders aware of leaders and how to contact. Relevant stakeholders identified and invited to participate. Local health, social care, third sector and partner resources understood.	Leadership development for 'H&SCIP' discussed and agreed. Development plans initiated. Stakeholders understand leadership issues. Relevant stakeholders regularly attend and provide input into work programme	Results of partnership working systematically reviewed. Relationships with partners are positive and ongoing dialogue about planning, commissioning, contracting decisions and joint investment opportunities. Public health voice is evident in decisions.	Review of success of leadership approach. Ongoing succession plans in place. Benefits of partnership working have enabled the majority of stakeholders to meet their improvement objectives and resource allocation.	Benefits of partnership working have enabled majority of stakeholders to exceed their improvement objectives. Outcomes improved and this is traceable back to initiatives from the 'H&SCIP'
Governance		Membership and terms of reference for the 'H&SCIP' Board drafted and shared.	'H&SCP' board set up and first annual cycle of business agreed. Relationships with relevant local organisations being developed.	Local stakeholders have clearly incorporated 'H&SCIP' Board accountabilities into their own governance arrangements.	'H&SCIP' Board has reviewed its first year of working through a structured annual review process and made improvements to structure and organisation	Good governance benefits identified and the 'H&SCIP' Board know better governance practice has influenced local partner organisations.
Information and intelligence		Information requirements identified and format of initial dashboard agreed	Developed a dashboard of key information and information improvement continues. KPIs reflect shared performance objectives across health, social care and partners	'H&SCIP report confidence with levels of intelligence they receive, and that information systems are reliable and working. H&SCIP receiving evidence of performance improvement against KPIs.	'H&SCIP' informed by real-time intelligence, demonstrating improved outcomes, quality and efficiency across health and social care.	A single information system established and utilised across the partners. Outcomes and performance benchmark against best performers.
Expertise and skills		Skills and expertise for 'H&SCIP' have been identified and agreed	Induction and development plans for 'H&SCIP' partners and staff are up and running	The 'H&SCIP' influencing skills are evident by success in positive change to local planning and the pattern of local service provision.	The 'H&SCIP' supports LHBs, Local Authorities, Third Sector and partners by valuing key planning/skills. The H&SCIP Board acts as a forum to bring in specialist skills and expertise to support planning/commissioning.	The 'H&SCIP' influences the organisational development of partner organisations. The local health and social care economy is recognised as being a good career choice for planning/commissioning professionals.

*The H&SCIP is generic term for the purpose of this matrix. Please replace with your local equivalent.

Source: Adapted from the London Health and Wellbeing Board Maturity Matrix

Consultation Response Form

Your name:

Organisation (if applicable):

email / telephone number:

Your address:

Question XX: We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

Please enter here:

Responses to consultations are likely to be made public, on the internet or in a report. If you would prefer your response to remain anonymous, please tick here: ☐