Paper no: MSGHCC/121/2018 **Meeting date: 6 November 2019** **Agenda item:** 4

Purpose: **FOR ACTION**

Title:	**Framework for Community Health and Social Care Integrated Services**

Key Issues:	This paper: ▪ Describes the progress made to date in developing a framework for community health and social care integrated services; ▪ Offers an overview of the feedback received through the programme of engagement conducted during July and August 2019; ▪ Sets out a detailed description of the framework and its links to the wider proposals resulting from the review of progress with integration within ***Annex A***; and ▪ Proposes an approach to operationalising the framework that seeks to embed it within the operational planning arrangements of Integration Authorities to support delivery of their Strategic Commissioning Plans, with targeted support being made available to six Integration Authorities in the first instance. ▪ Confirms that delivery of the framework does not include any additional reporting from local systems with the proposal that progress and impact be reported through the Annual Performance Report.

Action Required:	The Ministerial Strategic Group for Health and Community Care is invited to: a) Review the progress made to date to develop the framework; b) Consider the feedback received through the engagement programme;

	c) Determine whether the resulting framework meets the original expectations of the group; and d) Subject to ratifying the content of the framework, approve the proposed approach to operationalising the framework.

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Date:	**24 October 2019**	**Date:**	**24 October 2019**

Background

1. The development of a framework for community health and social care integrated services was agreed by the Ministerial Strategic Group for Health and Community Care (MSG) as part of the response to the findings from the review of progress with integration which were published on 04 February 2019.

2. In committing to this, it was agreed that Scottish Government and COSLA would work with IJB Chief Officers and colleagues from the third and independent sectors to create a framework that would integrate services from the perspective of those who use them, while making best use of the available resources.

3. At the heart of this was a desire to see the identification, adaptation and application of good practice, in line with the original principles of integration and the National Health and Wellbeing Outcomes, to enhance people's experience of integrated care and the outcomes they are supported to achieve.

4. The framework has been developed to offer a succinct description of what good looks like in terms of the provision of effective, integrated community-based assessment, treatment, care and support. In doing so it offers a compelling basis, from which good practice can be systematically identified, collated, shared, adapted and adopted to improve outcomes at a local level.

5. Through its development, the framework has been recognised as a useful resource that Chief Officers and their senior teams can draw on and use to respond positively to the pressures they experience at a local level by:

    - Clearly articulating those aspects of assessment, care and support that published evidence and local experience indicates can improve outcomes for people as well as the health and social care system as a whole;
    - Offering a range of examples of good practice against each of these for Integration Authorities to adapt and adopt in line with local needs;
    - Helping to inform an operational planning and delivery cycle that appropriately engages with and involves communities, carers, the third and independent sectors, NHS Boards and Local Authorities in:
        - embedding the underpinning ethos, characteristics of effective integrated care and enablers for change;
        - establishing how well developed the key elements of the framework are at a local level;
        - developing and implementing any necessary plans for improvement as a result;
        - measuring and assessing the impact these have on outcomes for individuals and the local health and social care system as a whole; and
        - sharing progress and good practice through the annual performance report.

6. Chief Officers and their senior teams can therefore reflect on how the framework and associated good practice guide could be used to support operational service planning and address the identified pressures within their local system. In doing so, they can ensure that it aligns with and supports the operational delivery of extant and future Strategic Commissioning Plans and reflect the resulting actions, progress and impacts within their Annual Performance Reports.

7. This paper describes the work undertaken to date to develop the framework and an overview of the feedback received from the engagement programme. It then goes on to describe the framework in some detail at ***Annex A*** along with its links to the wider proposals arising from the review of progress with integration.

Overview of Work to Develop the Framework

8. Work to develop the framework began in March 2019 with an initial round of engagement with senior leaders and interested stakeholders clarifying three key elements that must be in place to support Integration Authorities in increasing the pace and scale of integration.

9. Firstly, there was a recognition that for the framework to be an effective tool that shares good practice to support the planning and delivery of integrated care, the overarching aim for this should be clarified. The framework therefore describes the desired transition from status quo to future state.

10. Secondly, there was broad acknowledgement of the need to support the delivery of this transition with a clear sense of purpose for those involved in the planning and delivery of services and the commitment to consistency of experience for those who need care and support. The framework is therefore underpinned by an ethos that places people, including those with caring responsibilities, at the heart of conversations about their goals, assets and needs.

11. Thirdly, there was clear support for specifying the characteristics of effective, integrated care to offer ‘touchstones’ against which Integration Authorities can assess how integrated their current models of care are and from which the impact of their plans for improvement will be measured. These characteristics are therefore clearly defined within the framework for Integration Authorities to use as they seek to develop integrated care and support through their operational service planning arrangements.

12. With these elements offering a solid foundation to underpin a framework, the focus of the development programme turned to identifying the key components of effective, integrated care. This was informed by an analysis of published evidence, a review of Integration Authority Strategic Plans, Annual Performance Reports, all published joint Strategic Inspection Reports of Services for Adults and a number of targeted visits, resulting in the identification of the following 12 high impact proposals:

Promoting healthy, independent living, supporting people to:	Improving outcomes by working more effectively to deliver:	Making services more accessible and responsive by developing:
Adopt an assets based approach	Fully integrated community teams	First Point of Contact
Manage their own conditions	Teams aligned to General Practice	Anticipatory Care Planning
Connect with their communities	Seamless working with acute care	Reablement within all services
Live independently at home or homely setting	Enhanced Care in Care Homes and Supported Accommodation	Short-term, targeted interventions to meet more complex needs

13. These proposals embed approaches that support prevention, early intervention, independence, peer support and proactive care planning, as well as integrated working that improves the responsiveness and cohesiveness of care and support, in line with previously agreed goals and aspirations when needs change. In doing so, they support the delivery of the original principles of integration as well as the National Health and Wellbeing Outcomes.

14. Further, they contribute delivering against the following outcomes from the National Performance Framework:

- We live longer, healthier lives;
- We have tackled the significant inequalities in Scottish society;
- We have improved the life chances for children, young people and families at risk;
- We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others;
- Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it; and
- Our public services are high quality, continually improving, efficient and responsive to local people's needs.

15. The evidence base also indicates that, when successfully implemented these proposals will support the delivery of the following key policy goals of:

- Implementing the 2018 GMS Contract for Scotland by aligning community teams with GP Practices and realising the benefits of establishing the GP as the Expert Medical Generalist;
- Minimising delays in transfers of care by reducing avoidable admissions to hospital and supporting timely discharge; and
- Improving compliance with referral to treatment times by developing alternatives to traditional models of planned care.

16. It should also be noted that, throughout this development process, the framework has been informed by and cross-referenced with extant policy. Thus, these proposals are also seen to be consistent with and supportive of that policy, including the Social Care (Self-directed Support) (Scotland) Act 2013, the Health and Social Care Delivery Plan (2016), the National Clinical Strategy for Scotland (2016), Scotland's Digital Health and Care Strategy (2018) and the Public Health Priorities (2018).

17. At the same time, the framework has been developed to align with wider reform, for example the work underway in Adult Social Care and Primary Care. It is therefore anticipated that, as learning and good practice is identified through the operationalisation of the framework, it will inform the delivery of these wider programmes and *vice versa*.

18. The framework therefore asserts that the development and delivery of these proposals, in line with the associated good practice and informed by identified need and specific circumstances at a local level, will lead to transformation of the whole health and social care system, increase the pace and scale of integration and deliver the original goal of ensuring:

> *'people get the right care, at the right time and in the right place,*
> *and are supported to live well and as independently as possible…*
> *ensuring that people's care needs are better anticipated*
> *so that fewer people are admitted to hospital or long-term care.'*

19. In developing these proposals, it was acknowledged different contexts, circumstances, population needs, infrastructures, local strategic priorities, historic funding patterns and models of care exist within each Integration Authority. The framework can therefore be operationalised by Chief Officers and their senior teams in a way that enables them to adapt different models to the needs and circumstance of their local areas, which is in line with the strategic direction set through the Strategic Commissioning Plans.

20. COSLA was involved in this development process from the outset and offered advice and guidance throughout on the approach taken, as well as the direction, content and structure of the framework itself. In doing so COSLA was key in assisting the delivery of an initial draft proposal to the Integration Leadership Group on 11 June 2019 where the key elements were endorsed for further discussion with senior leaders and stakeholders through a wide ranging programme of engagement in July and August 2019.

Key Themes from Engagement

21. In order to create a framework that is cohesive and coherent, with broad support from Integration Authorities and professional groups, an extensive programme of engagement was undertaken throughout July and August 2019. This has included over 40 one-to-one meetings, small group work and larger workshops with the following stakeholders:

    - Integration Authorities;
    - Healthcare Improvement Scotland;
    - HSCP Chief Officers Network;
    - HSCP Strategic Planning and Improvement Managers Network;
    - NHS Chief Executives;
    - Scottish Care;
    - Social Work Scotland;
    - The Health and Social Care Alliance Scotland Staff Team;
    - The Office of the Chief Nursing Officer;
    - The Office of the Chief Social Work Adviser;
    - The Primary Care Leads Group;
    - The Royal College of Emergency Medicine;
    - The Royal College of General Practitioners; and
    - The Royal College of Nursing.

22. In addition to providing an opportunity to gather guidance, advice and feedback to inform the development of the framework, this work has been critical to building consensus around the direction, structure and content. In doing so, it has laid a strong foundation for the extensive public, carer and wider stakeholder engagement that will be required within each Integration Authority as they adopt an inclusive approach to assessing their position against each element of the framework, develop plans for improvement and measure and report impact.

23. At the same time, the Health and Social Care Alliance Scotland facilitated a workshop and webinar for their members and widely circulated copies of the framework discussion paper for comment. This has enabled the emergent direction, structure and content of the framework to be explored and tested with a wider stakeholder group. A detailed report from this element of the engagement programme has been produced by the Health and Social Care Alliance Scotland and is available on request.

24. The key themes arising from this engagement programme are presented below:

    Overarching Feedback

    Generally, there has been broad support for the direction, structure and content of the framework with agreement that it offers a strong focus for developing integrated services and a good approach to identify, adapt and apply good practice. That said, some concerns were raised in relation to the language used to describe the framework being client group and / or sector specific. The framework has therefore been adapted to reflect the desire to create a balanced, generic tool to support the development of integrated services.

Ethos of Care
Whilst recognising that this is something most Integration Authorities should be doing, there has been support for framing it strategically to focus service delivery and offer consistency of approach.

Characteristics
Strong support has been expressed for the characteristics in terms of the clear direction they offer, the basis they give to assess the extent to which services are integrated and the focus they offer for how integrated services should be developed.

High Impact Proposals
There has been a strong consensus that the high impact proposals identified offer the correct areas to focus on, with some requests to be more precise about what is actually meant in terms of deliverables. This has now been reflected in the framework.

Collection, Collation and Sharing of Good Practice
Feedback indicates the that good practice that has been collected and collated to inform the development of the framework is very useful. This is available as a separate report on request and will accompany the final framework when it is made available to Integration Authorities.

Strong support has emerged for an annual good practice sharing workshop, organised by the Chief Officers Group, along with a desire to see the development of a web-based tool to enable 'real-time' access to a central repository of good practice.

Enabling Factors
The enablers described within the discussion document have been warmly welcomed with a recurring theme from engagement that these are fundamental to the successful delivery of integrated care.

There was also a recognition that the following also need to be in place to support the delivery of effective, sustainable integrated care:

- Alignment of Strategic Planning, Financial Planning, Workforce Planning, Primary Care Improvement Planning and Operational Planning;
- Systems that support appropriate information sharing;
- Digital solutions to support independent living;
- Future premises developments should be designed to enable co-location; and
- Ongoing development support for IJB Members to participate fully in decision-making.

These additional enabling factors have now been incorporated within the framework.

Actions to Support Implementation

General support has been expressed for the proposed actions that were contained within the discussion paper. Particular benefits were identified in terms of the inclusive, engaging and transparent approach to self-assessment, improvement planning, measuring impact and reporting progress that has been suggested.

Linked to this, the need has been identified for a co-production approach to using the framework at a local level to aid operational planning, with shared accountability for establishing and delivering transformation across Integration Authorities and all partners within the health and social care system.

This has been reflected within the summary actions at the end of each section of the framework, along with a commitment to offer targeted support to Integration Authorities where it is requested.

25. Behind these key themes, stakeholders have offered invaluable detailed advice, guidance and feedback that has helped to refine, develop and evolve the framework and the actions that can help Integration Authorities realise the associated benefits.

26. While the majority of the feedback has been positive and supportive of the direction, structure, content, pitch and tone of the framework, some concerns were raised by a small number of stakeholders. These included a desire by some to see greater detail, specificity of action and stronger requirements on Integration Authorities, while conversely, others felt it was overly detailed, prescriptive and that it undermined local autonomy and accountability.

27. Given these concerns sit at either end of a spectrum, the framework retains the balance that the majority of feedback was supportive of.

28. That said, it is recognised that this framework merely represents a starting point for the collation and sharing of good practice to support the attainment of improved outcomes for people and the health and social care system as a whole. It will be further developed and refined over time and these concerns, along with the wider views that will be gathered as the framework is operationalised at a local level will be used to support this.

29. The framework, including the key linkages to the wider proposals arising from the review of progress with integration, is presented at ***Annex A***.

Using the Framework to Improve Outcomes

30. Subject to agreement of the content of the framework by the Ministerial Strategic Group for Health and Community Care, work will begin on supporting Integration Authorities to operationalise it at a local level.

31. Recognising the desire to derive the benefits offered by the framework at pace and to maximise impact, it is proposed that this support should initially be offered to the Chief Officer and senior team from six Integration Authorities who have expressed a desire to work with the Integration Division to:

    - establish how well developed the key elements of the framework are within their local system;
    - use good identified good practice to develop and implement any necessary plans for improvement as a result;
    - measure and assess the impact these have on outcomes for individuals and the local health and social care system as a whole; and
    - share progress and good practice through the annual performance report.

32. This approach will ensure that framework operationalisation is aligned with the work of the Director of Delivery. This will enable participating Integration Authorities to benefit from targeted support, tailored to their specific needs and circumstances. In engaging with this approach it is anticipated that those drawing on the support of the Integration Division in the first instance will clarify what support they need to plan, develop and deliver services that can achieve better outcomes, with a focus on adopting good practice and ensuring there are plans in place to nurture the enablers for change.

33. Such an approach, also supports the operationalisation of the framework in a phased way that reflects and respects the strategic and operational planning contexts within which it is being introduced. At the same time it makes provision for learning to be drawn from the experience of those working with the Integration Division in the first instance to clarify what support will be needed from local partners and national bodies to derive maximum benefit.

34. With that in mind, this learning will directly inform further work by the Integration Division, COSLA, Integration Authorities, the IJB Chief Officers Network, the IJB Chair and Vice Chair Network, National Improvement Bodies and others to develop:

    - Bespoke advice and support for Integration Authorities to help using the framework to support operational service planning at a local level;

    - A self-evaluation toolkit to help Integration Authorities establish how well developed the key elements of the framework are at a local level and identify priorities for action based on this;

    - A planning toolkit to support the adaptation and application of good practice at a local level;

    - Organisational Development, planning, service improvement and facilitation capacity and capability required to support new ways of working;

- Proposals to support the monitoring of progress and impact, in line with the findings from the work requested by the Ministerial Strategic Group to review data and measures;

- Systems to enable the regular development and refinement of the good practice repository, based on an assessment of how this is being applied at a local level, as reported through the Annual Performance Reports; and

- Processes to review and refine the content of the framework based on the lessons learned from its application at a local level.

35. Some aspects of this work will be complex and challenging in terms of developing new tools, techniques and approaches and embedding these within existing planning and performance systems. This could potentially result in the re-prioritisation of work programmes within some of the national improvement and scrutiny bodies. There is therefore a firm commitment to regularly report progress against plan, along with any associated risks and plans for mitigation, to the Integration Leadership Group, with periodic assurance reports being submitted to the Ministerial Strategic Group.

Critical Linkages

36. The operationalisation of the framework is dependent on many of the other 24 proposals contained within the Integration Review, particularly in relation to the development of collaborative leadership, integrated strategic and financial planning, relationship development and community engagement. A high level assessment of these linkages is presented in ***section 8 of Annex A***.

37. The development aspects of these proposals will need to be closely managed to ensure congruence across the programme as a whole. This will require close working between those leading each element of the Delivery Plan, with progress being reported across the work programme regularly to the Integration Leadership Group and the Ministerial Strategic Group.

Conclusion

38. The work to develop a framework for community health and social care integrated services has delivered a succinct description of what good looks like in terms of the provision of effective, integrated community-based assessment, treatment, care and support. In doing so it offers a compelling basis, from which Integration Authorities, through their Chief Officers and senior teams, can identify, adapt and adopt good practice that supports the operationalisation of their Strategic Commissioning Plans to address recognised service pressures and opportunities.

39. In support of this, the framework sets out high impact proposals that when implemented effectively, will improve outcomes for people, increase the pace and scale of integration, deliver benefit at a whole system level and contribute to the realisation of key policy goals. At the same time, it clarifies those enabling factors that need to be developed to ensure the associated benefits can be effectively realised.

40. Feedback from the programme of engagement has confirmed support for the direction, structure and content of the framework. At the same time, this work has confirmed a desire for Integration Authorities to use this as a tool to determine where they are in relation to what is required for effective integrated care, implement any necessary improvements, measure the impact of this locally and report progress through their Annual Performance Reports.

Recommendations

41. Members of the Ministerial Strategic Group for Health and Community Care are asked to consider whether the work to date delivers on their expectations for the framework for community health and social care integrated services and, if so, endorse the next steps that have been proposed to realise the associated benefits.

Annex A

A Framework for Community Health and Social Care Integrated Services

1 Purpose

The response to the review of progress with integration was agreed and published by the Ministerial Strategic Group for Health and Community Care (MSG) on 04 February 2019, setting out 25 inter-related proposals designed to improve the pace and scale of integration.

The framework for community health and social care integrated services is one of these proposals and supports the improvement of outcomes for people by informing the design and delivery of assessment, care and support at a local level, ensuring that services feel integrated from the perspective of those who use them. It will therefore be necessary to adopt a whole system approach to operationalising the framework, ensuring transformation plans across organisational and sectoral boundaries are consistent and cohesive to deliver positive impacts for local people.

Generic in nature, with its key elements and principles being applicable across the populations served by Integration Authorities, this framework describes what good looks like in terms of the provision of effective, integrated community-based assessment, treatment, care and support.

In doing so it offers a compelling basis, from which Integration Authorities, through their Chief Officers and senior teams, can identify, adapt and adopt good practice that supports the operationalisation of their Strategic Commissioning Plans to address recognised service pressures and opportunities.

Specifically, it is believed that the framework can help Chief Officers and their senior teams to respond positively to the pressures they experience at a local level by:

- Clearly articulating those aspects of assessment, care and support that published evidence and local experience indicates can improve outcomes for people as well as the health and social care system as a whole;
- Offering a range of examples of good practice against each of these for Integration Authorities to adapt and adopt in line with local needs;
- Helping to inform an operational planning and delivery cycle that appropriately engages with and involves communities, carers, the third and independent sectors, NHS Boards and Local Authorities in:
    - embedding the underpinning ethos, characteristics of effective integrated care and enablers for change;
    - establishing how well developed the key elements of the framework are at a local level;
    - developing and implementing any necessary plans for improvement as a result;
    - measuring and assessing the impact these have on outcomes for individuals and the local health and social care system as a whole; and
    - sharing progress and good practice through the annual performance report.

In doing so, and in order to support the continued the sharing, adaptation and adoption of good practice, Chief Officers and their senior teams can reflect the resulting actions, progress and impacts within their Annual Performance Reports. This approach will ensure the operationalisation of the framework is monitored and reported by Chief Officers and their senior teams in a manner that is consistent with how performance is tracked and impact demonstrated across all other aspects of delivery.

With its focus on community development, improving personal and community resilience and enhancing care planning and delivery, as well as growing inter-professional and sectoral working, it supports Integration Authorities to engage others in improving outcomes for people and delivering tangible improvements at a whole system level.

To that end, Integration Authorities can work with all partners in the local health and social care system, including local communities, carers, the third and independent sectors, Local Authorities and NHS Boards to embed the elements of framework in the local planning arrangements and inform their transformational change programmes.

The framework has been designed to complement and support the delivery of a range of current policy, including the Social Care (Self-directed Support) (Scotland) Act 2013, the Health and Social Care Delivery Plan (2016), the National Clinical Strategy for Scotland (2016), Scotland's Digital Health and Care Strategy (2018) and the Public Health Priorities (2018).

At the same time, the framework has been developed to ensure strong congruence to wider reform, for example the work underway in Adult Social Care, as well as that to deliver the 2018 General Medical Services Contract and the 2030 Vision for Nursing. It is therefore anticipated that, as learning and good practice is identified through the operationalisation of the framework, it will inform the delivery of these wider programmes and *vice versa*.

The Good Practice Guide that will sit alongside this framework will be developed and refined over time to identify, capture and share what is working well within Integration Authorities and in other areas in relation to each client group. It is this document that will therefore make the framework relevant to how services are designed, planned and delivered to meet the needs of each element of their local population.

2 Overarching Aim

In essence this framework is designed to inform the development of local transformation plans, drawing on what is known to work in other areas to inform responses to identified local priorities. At the same time, it supports the delivery of extant national policy, emergent reform programmes and the high level aim of shifting to the following desired future state:

Status Quo	→	**Future State**
Focus on pathways into hospital for specialist assessment and care planning		Focus on specialist assessment, treatment, care and support at home and in community settings
Focus on the roles, skills, competencies and professional boundaries of practitioners		Focus on supporting and caring for a person as far as skills and competencies allow while looking to develop these further
Focus on reactive interventions and episodic treatments		Focus on early engagement to support prevention and early intervention with well-established anticipatory care planning
Focus on treatment, support and care based on a professional assessment of need		Focus on having conversations to understand a person's strengths and resources, needs and preferences while adopting an ethos of co-production in jointly exploring options to meet these
Focus on traditional model of service commissioning		Focus on an outcomes based model of strategic and service commissioning

To that end, this framework is comprised of four key elements that are designed to support Integration Authorities and all partners within the health and social care system in progressing the integration of community health and social care a local level.

3 Establishing A Foundation for Transformation

To be effective, the transformation plans that will be developed by Integration Authorities should be underpinned by strong foundation.

In doing so, it is important that there is a clear and common sense of purpose for managers, frontline practitioners and support staff, along with a corresponding commitment to consistency of experience for those who need care and support.

The framework therefore encourages the adoption of an ethos of **CARE** and a clear commitment to:

Come together with children, young people and adults, as well as those with caring responsibilities to understand their strengths and assets; their goals, preferences and needs and plan the support that is right for them, now and into the future;

Adopt a Co-ordinated approach to care and support which offers a consistent point of contact for the person, those who care for them and other professionals involved in their care, co-ordinating care and support to meet changing needs;

Respond positively and proactively to the needs of people, including those with caring responsibilities, as they change, ensuring their wishes and preferences are respected; and

Empower, encourage and enable people, including those with caring responsibilities to express choice and take control of decision-making about their needs and the options to meet these.

In seeking to realise the benefits associated with this framework, Integration Authorities will derive value from engaging others, including local communities, carers, the Third and Independent sectors, NHS Boards and Local Authorities, to define what this means at a local level and develop the ethos across all service areas.

4 Embedding Characteristics of Effective, Sustainable Integrated Care

A review of the evidence base and identified good practice, clarified that where integrated care is most effective, in terms of improving outcomes for people and having a positive impact on the health and social care system, certain key characteristics are well established.

There is therefore benefit to be derived from Integration Authorities drawing on this learning to secure maximum benefit for people who need assessment, care and support by considering the extent to which the following characteristics are embedded in all aspects of service delivery:

- People are actively engaged in conversations about their goals, assets, safety, strengths and needs, with care and support centred around people's own health and wellbeing priorities and with a strong focus on early intervention and prevention;

- People have access to clear and simple information, advice and support reflecting specific communication needs and preferences, including any issues with literacy, health literacy or transitions away from language, so they can care for themselves and their families at home and know how to access help, support and services when they need to;

- People who require assessment, treatment, care and support and those involved in their care have access to local services free from barriers, behaviours and discrimination that may impact negatively on them, ensuring a positive contribution to their safety, tackling inequalities and promoting equality of opportunity and outcome;

- People with the most complex needs benefit from longer appointments with GPs who will adopt the Expert Medical Generalist role described within the 2018 GMS Contract for Scotland to better understand and manage their needs;

- Integrated multi-disciplinary teams are available in communities so people can access a wider range of professionals and services in local GP Practices and localities, closer to their home, e.g. link workers, physiotherapists, mental health practitioners, social workers and pharmacy services;

- Sustainable services for community-based urgent unscheduled care, aligned with wider community services and teams around General Practice and comprising advanced practitioners and care staff to respond rapidly to changing needs, offering people alternatives to acute hospital admission;

- Clear pathways are established between primary care and locality teams, intermediate care, specialist services and acute care so that people benefit from access to the right care, from the right person at the right time as their needs change;

- A range of short-term, targeted and specialist care and support services are available, offering alternatives to hospital admission and supporting timely hospital discharge to support people to live healthy, independent life at home or in a homely setting;

- There is a focus on supporting people in their home environment with a home first approach adopted at all times, supported by seamless transitions through rehabilitation and reablement to long-term support and care, as well as high quality palliative and end of life care;

- All practitioners involved in the provision of assessment, care and support services have appropriate awareness of their statutory roles and professional responsibilities in terms of safety, public protection Child Protection and Adult Support and Protection, ensuring these are discharged appropriately; and

- The development of skills and practice to ensure the adoption of a human rights based approach to assessment, treatment, care and support, with a clear focus on prevention, early intervention and tackling inequalities, aimed at supporting Scotland's Public Health Priorities.

In working with others, including communities, carers, third and independent sectors, the local NHS Board and Local Authority, to realise the benefits associated with this framework, Integration Authorities may derive value from assessing the extent to which these characteristics are evident in local services. Based on this, Integration Authorities may identify priorities for improvement and / or transformation as well as measure and report the impact of these through their Annual Performance Report to further share good practice.

5 Delivering Components of Effective, Sustainable Integrated Care

A review of effective models of integrated care and an analysis of the published evidence base has confirmed that there are a number of key components that are consisently in place where services are improving outcomes for people and the performance of the health and social care system as a whole.

While recognising that this is not an exhaustive list, it represents a description of the core compoents of effective integrated service models, which, along with the accompanying Good Practice Guide, offers Chief Officers and their senior teams a basis to inform how local services can be planned to improve how people are supported:

- to identify, set and achieve personal goals, making best use of the resources available to them through an **assets or strengths based assessment**, involving a Family Group Decision Making methodology where appropriate and underpinned by a Human Rights based approach that promotes **P**articipation, **A**ccountability, **N**on-Discrimination and **E**quality and **L**egality;

- to live well, care for themselves, meet their own needs, effectively **manage their own conditions**, and maximise their wellbeing as far as possible, and that those with a caring role are supported to continue to care in good health and wellbeing, and to have a life alongside caring;

- to **connect with networks** within their communities, where community asset based approaches are developed and nurtured;

- to live independently at home or in community or homely settings using **technological solutions, equipment, minor adaptations and supported accommodation** where necessary;

- by **fully integrated Multi-Disciplinary Teams** (MDTs) with integrated line management and appropriate professional governance arrangements, adopting a 'One Team'[1] approach to offer seamless care;

- by **MDTs aligned to GP Practices** to provide targeted support for those with greatest need and an early, concerted response when a member of the team identifies a 'trigger' that something may have changed in a person's life and / or condition;

- by **expert Nursing and Consultant advice within MDTs** and by those teams during any hospital stay to improve continuity of care and support and reduce avoidable admissions and length of stay;

[1] Work is underway with the Office of the Chief Nursing Officer, the Office of the Chief Social Work Adviser and the Primary Care Division to develop guidance on the development of the 'One Team' Concept

- by enhanced **MDT liaison within care homes, residential settings and supported accommodation**, as well as the supported development of staff who work in these settings, to enhance the quality and level of care and support available;

- to access the right professional, at the right time by adopting a ***First Point of Contact*** approach that ensures the professional an individual engages with assumes responsibility for getting them to the person who can best meet their assessed needs;

- to express their preferences for care and support when their needs change and have these respected through **Anticipatory Care Planning,** or the development of **Adult Carer Support Plans and Young Carer Statements** where they have a caring role, to ensure the development of robust, comprehensive care and support plans;

- to attain, regain and sustain independence by **embedding reablement approaches** and other slower stream rehabilitation support across all teams; and

- to have more of their needs met at home or community settings and to return home more quickly when admitted to hospital by providing a range of ***specialist, short-term, targeted interventions*****.**

It is recognised that there are significant differences in population need, georgraphical nature, service infrastructure, locally strategic priorities, historical funding patterns and associated environments for service provision across localities within each Integration Authority.

Against that backdrop, the framework can be used by Integration Authorities to adapt and adopt good practice and deliver evidence-based service models that are right for their area. In doing so, the planning and delivery of these components can be embedded within the existing Locality Planning arrangements, drawing on the knowledge, experience, expertise and data sources from GP Clusters, to ensure alignment with local population needs and the resources available within the locality.

When seeking to realise the benefits associated with this framework at a local level, Integration Authorities will derive value from working with others, including communities, carers, third and independent sectors, the local NHS Board and Local Authority to establish how well developed these components are, establish continuous improvement plans for their development and measure the impact of this.

6 Creating an Environment for Effective, Sustainable Integrated Care

The successful delivery of these commitments will be as much about engaging the hearts and minds of those who provide and receive care and support as it will the allocation of resources and establishing the required systems and processes.

This requires leadership that promotes trust, respect, innovation and action to improve outcomes. At the same time, there will be a need for open and honest discussion across the health and social care system about the challenges and opportunities that exist, underpinned by a robust analysis of the current and anticipated future demand for assessment, treatment, care and support.

These discussions should inform the formation of and commitment to a clear vision for improving outcomes by integrating community health and social care services. This should, in turn, drive the development of the associated transformation, financial and workforce plans required across the health and social care system. In doing so, there should be a clear commitment to delivery by all partners involved, through which shared accountability can be established.

This will necessitate Integration Authorities, Local Authorities, NHS Boards, Third and Independent Sectors, local communities and carers coming together to co-produce plans for integrated care and support. This approach should be underpinned by a collective assessment of local need and shared understanding of local circimstance, with a clear commitment to joint delivery.

Integration Authorities may therefore benefit from considering the extent to which the following enablers for organisational development, service planning and service delivery are well established to support their transformation plans:

Enablers for Organisational Development

- Collaborative, collective and visible leadership across all of the partners and at all levels of the organisation, recognising the importance of nurturing and developing front line leaders to deliver change;
- Shared accountability across all of the partners for delivery of change;
- Well developed, positive relationships across all of the partners;
- Clarity and consistency of vision, direction and purpose;
- Strong, positive and consistent culture and values shared across Integration Authority, Local Authority, and NHS Board, as well as the Third and Independent Sectors;
- Autonomous team working underpinned by equality, trust and respect;
- Capacity and commitment, including that required from the third and independent sectors, to participate in the planning of integrated care and support, as well as in the resulting integrated team meetings;

- Positive behaviours that encourage innovation and constructive challenge;

- Organisational Development support made available to partners from statutory, third and independent sectors to build all of the above;

- Robust clinical and care governance arrangements to enable issue identification, escalation and resolution; shared learning to improve practice; peer review and support; and the development of and adherence to policies, guidelines and protocols to support fully integrated working;

Enablers for Strategic Planning

- Clear alignment between the strategic plan, financial plan and operational plans to deliver the high impact proposals, with full quantification of anticipated impact in terms of outcomes for those who require care and support, the impact on the wider health and care system and the overall financial consequences;

- Strong alignment between the plans to implement this Framework and the developments originating from the Primary Care Improvement Plans

Enablers for Service Delivery

- Streamlined systems and processes to facilitate information sharing and recording, including short-term options to reduce bureaucracy, with robust data aggregation, collection and reporting systems to enable effective service management;

- Appropriate, modern facilities that offer viable alternatives to traditional hospital care and enable co-location of team members as well as alignment with GP Practices;

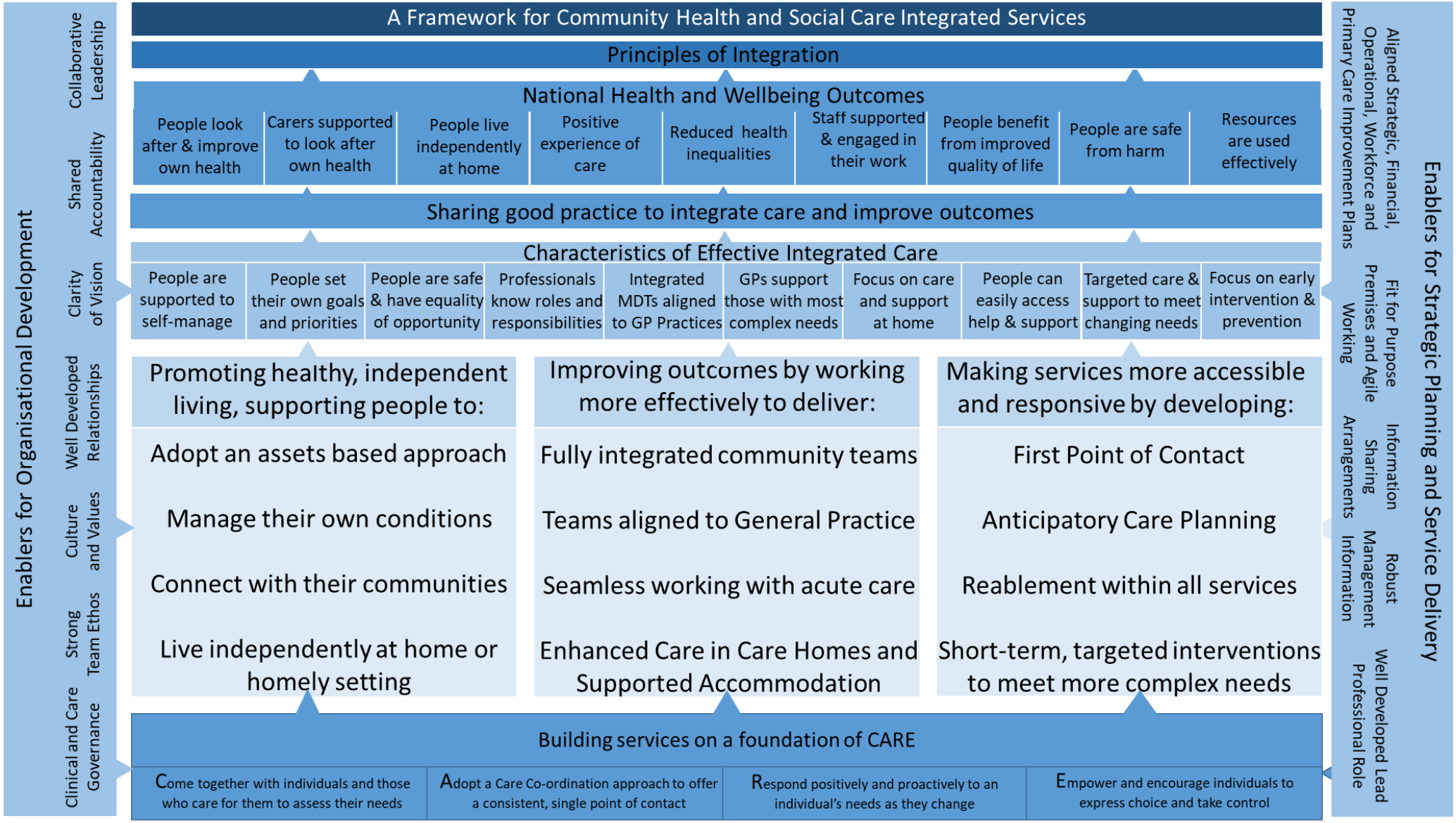
- A detailed workforce plan based on the new National Workforce Plan and covering all community health and social care services, including those provided by the third and independent sectors, that describes:
    - the skills and competencies required to deliver new models of assessment, treatment, care and support
    - the training and development opportunities that will be created to support staff attain these, including joint training opportunities for future members of the workforce who will come through different professional routes
    - the plan to realign and re-prioritise resources to create additional capacity within integrated community teams
    - the anticipated benefits to be realised from integrated working and how efficiencies will be re-focused to meet changing needs and demands over time

- The ‘Lead Professional’ role, who people and their families can choose from those who have a lead role in their care to offer a consistent point of contact, help with anticipatory and other care planning and link with wider members of the fully integrated, multi-disciplinary team to co-ordinate care and support where it is required.

When seeking to realise the benefits associated with this framework, Integration Authorities will derive benefit from working with others, including communities, carers, third and independent sectors, the local NHS Board and Local Authority, to assess the extent to which these enablers are sufficiently well developed to support integrated care at a local level, establish plans for their development where necessary and measure the impact of this.

7 Framework Summary

The key components of effective, sustainable integrated care, along with the foundation required to create a clear sense of purpose and consistency of experience; the enabling factors required for their successful delivery; and the characteristics they are designed to deliver are summarised in the diagram below:


Enablers for Organisational Development
Collaborative Leadership
Shared Accountability
Clarity of Vision
Well Developed Relationships
Culture and Values
Strong Team Ethos
Clinical and Care Governance
A Framework for Community Health and Social Care Integrated Services
Principles of Integration
National Health and Wellbeing Outcomes
People look after & improve own health
Carers supported to look after own health
People live independently at home
Positive experience of care
Reduced health inequalities
Staff supported & engaged in their work
People benefit from improved quality of life
People are safe from harm
Resources are used effectively
Sharing good practice to integrate care and improve outcomes
Characteristics of Effective Integrated Care
People are supported to self-manage
People set their own goals and priorities
People are safe & have equality of opportunity
Professionals know roles and responsibilities
Integrated MDTs aligned to GP Practices
GPs support those with most complex needs
Focus on care and support at home
People can easily access help & support
Targeted care & support to meet changing needs
Focus on early intervention & prevention
Promoting healthy, independent living, supporting people to:
Adopt an assets based approach
Manage their own conditions
Connect with their communities
Live independently at home or homely setting
Improving outcomes by working more effectively to deliver:
Fully integrated community teams
Teams aligned to General Practice
Seamless working with acute care
Enhanced Care in Care Homes and Supported Accommodation
Making services more accessible and responsive by developing:
First Point of Contact
Anticipatory Care Planning
Reablement within all services
Short-term, targeted interventions to meet more complex needs
Building services on a foundation of CARE
Come together with individuals and those who care for them to assess their needs
Adopt a Care Co-ordination approach to offer a consistent, single point of contact
Respond positively and proactively to an individual's needs as they change
Empower and encourage individuals to express choice and take control
Enablers for Strategic Planning and Service Delivery
Aligned Strategic, Financial, Operational, Workforce and Primary Care Improvement Plans
Fit for Purpose Premises and Agile Working
Information Sharing Arrangements
Robust Management Information
Well Developed Lead Professional Role

8 Delivering the Framework

From the preceding sections, it is evident that the framework cannot stand alone. Rather, to be delivered effectively, it must be progressed in line with the other 24 proposals arising from the review of progress with integration, with particular attention being paid to:

Leadership and Relationship Development	That will be critical to developing the collective, collaborative leadership and shared accountability, as well as the high engagement, involvement and trust required across all partners for the effective design, delivery and evaluation of change programmes.
Financial Arrangements	That will be critical to the timely confirmation and delegation of budgets, along with the resources and flexibility required to develop robust Financial Plans across traditional organisational boundaries that complement and underpin the planned change programmes.
Local Support Arrangements	That will be critical to ensuring the capacity and capability required to support the planning, delivery, commissioning and monitoring of change programmes is available to Integration Authorities.
National Support Arrangements	That will be critical to ensuring independent, objective assessments and inspections of service provision, as well as specialist improvement skills and capacity are appropriately aligned with the integrated space and offered in a more consistent and complementary way to support delivery and monitoring of the planned change programmes.
Governance Arrangements	That will be critical to establishing clear accountability for delivery of the planned change programmes, as well as for supporting the associated changes in policy and practice.
Information Sharing Arrangements	That will be critical to monitoring, reporting and sharing the impact of the planned change programmes, ensuring learning is drawn to further refine and develop the framework.
Engagement Arrangements	That will be critical to ensuring public, carer and community influence is at the heart of planning, delivering, monitoring and reporting the change programmes.

It is therefore suggested that, where Integration Authorities are seeking to realise the benefits associated with this framework, there will be value to be derived from reflecting their experience within future assessments of their position in relation to the Ministerial Strategic Group proposals.