A Framework for Delivering Integrated Health and Social Care For Older People with Complex Needs

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

We have committed 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’.

The Social Services and Well-being (Wales) Bill will give people a strong voice and real control over the social care services they use. It will drive the development of new models of service to maintain and improve the health and wellbeing of people. There will also be a stronger focus on preventative and early intervention services. This will be achieved through greater partnership working and integration of services.

The focus of this Framework is on integrated services, care and support for older people, particularly frail elderly people or those with complex needs. This means ensuring older people have a strong voice and control over their care and support. It places a strong focus on preventative services and support to maintain well-being.

Older people across Wales deserve high quality services, care and support which are designed and delivered to meet their specific needs. We must ensure they are designed, co-ordinated and delivered effectively, to meet the outcomes that are important to people and their carers.

This Framework has been developed with a wide range of partners and stakeholders and reflects the feedback from the public consultation process. We must now all work together to ensure delivery and provide high quality services, care and support to meet the needs of older people living in Wales.
Chapter 1: Introduction

Wales already has a higher proportion of people over 85 than the other countries of the United Kingdom and the numbers of very elderly are likely to rise significantly in the next decade. Integrated services must therefore be developed to better meet the needs of people – to enable them to have a happy and independent life and to maintain their well-being. Integrated services also need to be developed to deal with increased demand and to ensure sustainability.

The term ‘integration’ has many definitions but 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.

The purpose of developing integrated services is to improve care and support for people. This means ensuring people have more say and control over the care they receive. People should experience care and support that is seamless. Not a fragmented series of interventions than can lead to confusion, disruption and poor outcomes.

The aim of the Framework is also to shift the focus towards prevention and early intervention, to reduce, or delay, people becoming frail or developing complex needs.

Integrated services will ensure easy and rapid access to services and support that are effectively co-ordinated and simple to use. This requires integrated working between local authorities, health and housing, with the third sector and independent sector. Primary care has a key role to play in relation to supporting people within the community setting. This includes GPs working with the extended primary care team of nurses, therapists, community pharmacists, dentists and optometrists. It is essential therefore that all partners are involved in the development and delivery of services, care and support. It is also important to make effective use of the resources and skills each sector can contribute.

The focus of this Framework is about integrated services, care and support for older people, particularly frail elderly people or those with complex needs, including dementia. This also includes their carers. GPs play a key role in identifying older people with complex needs.
The Framework focuses on older people with complex needs because they require higher levels of support and care from a range of service providers. The role of care co-ordinators is increasingly important for this cohort of people, to ensure their care and support is effectively planned and managed to best meet the needs of the individual.

It is recognised that the general principles of integrated services will apply equally to people of all ages. Where appropriate, partners are encouraged to adopt the principles in the Framework and develop integrated services on a wider basis.

The Social Services and Well-being (Wales) Bill will give people a stronger voice and real control over the social care services they use. It will drive the development of new models of service to maintain and improve the health and wellbeing of people. There will also be a stronger focus on preventative and early intervention services. This will be achieved through greater partnership working and integration of services.

In partnership with the document Delivering Local Health Care, this Framework aims to build on the progress to date and accelerate the pace and scale of change in a way that:

- shapes services around a common understanding of the outcomes important to the person.
- strengthens person centred service planning, co-ordination, and delivery - increasing the focus on prevention and rapid intervention.
- strengthens the development of community based models of care to enable people to remain at home, avoiding unnecessary hospital admission or long-term residential care.
- ensures people are not delayed unnecessarily in hospital and can return home, supported by an appropriate package of care and support.
- removes barriers that have prevented effective collaboration.

This Framework:

- summarises the relevant policy and key principles.
- sets out the Welsh Government’s expectations for all partners (local authorities, health, housing, third and independent sectors) to work together to develop and deliver integrated services.
- identifies the evidence and core requirements on which to base local planning and delivery.
- identifies key actions for delivery and high level outcomes, against which progress will be measured.

Whilst it will take time to achieve full integration of services for older people with complex needs, we can build on the good practice already in place across Wales. Examples include frailty services, joint locality teams and community resource
teams, and, in mental health and learning disability services, the community based support models that continue to develop. There has also been progress in creating integrated support for families with complex needs. The principles applied in these service models and the lessons learned will be essential in supporting rapid progress.
Chapter 2: The Case for Change

People in Wales are living longer and healthier lives than ever before. Wales has the highest rate of growth for people aged over 85 in the UK. By 2030 people aged over 85 will increase by 90%, to 85,000. Whilst people are enjoying healthier older age, as people enter very old age (aged 85 years and over) it is highly likely that they will have higher levels of frailty, dementia and chronic conditions, often in combination with each other. This will require increased levels of care and/or support.

Already there are more than 42,000 people with dementia in Wales, with two thirds of older people in residential care affected by this. By 2021 the number of people in Wales with dementia is projected to rise by 30% and as much as 44% in some areas. The increasing incidence of cognitive impairment with age, is recognised as a contributory factor to frailty. This is likely to lead to the need for care and support from both health and social care services.

The increase in numbers with frailty and multiple morbidities will, over the coming decade, lead to a growing demand for services. Community services and home based care will have to be responsive to this. Residential services, from supported housing through to specialist care homes, will also need to be engaged in the process of planning services that will be sustainable over time and able to meet the increasing demand.

There is both published research and anecdotal evidence that services for those older people who are frail and/or with complex needs are fragmented, both within and across organisational and sectoral boundaries. Older people want to be in control of their own lives and continue to be part of and actively contribute to their community. This means that services must be designed to offer graduated, co-ordinated support to enable people to 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.

Providing community-based, co-ordinated services that are designed to support people and give them a say and the chance to retain control of their lives is clearly the model that older people want and deserve to receive.

This view is also reflected amongst those people working within health and social care services. They recognise that older people should be empowered. They also welcome models of care and support that respect people’s broader sense of personal wellbeing and the contribution of a strong and participative community.

Refocusing services, then, is a high priority area. Integrated service models can better meet the needs of older people. 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 now, in advance of the approach that will be embedded within the Social Services and Well-being (Wales) Bill.
Chapter 3: What do we want to achieve?

The purpose of this Framework is to focus on older people with complex needs and ensure they have a strong voice and control over their care and support. It places a strong focus on preventative services and support to maintain well-being. It is about ensuring services, care and support are designed, co-ordinated and delivered effectively, to meet the outcomes that are important to people and their carers.

We have the opportunity to create a truly integrated system. This should have the following key characteristics:

- **It should be built with and for people and the local community.** Services should be co-designed with the people who will use them.

- **It should be a consciously planned and managed system,** built on ambition. Working closely together, all partners will need to refocus their activities around those people receiving care and ensure existing barriers to integrated working and delivery are eliminated.

- **It should involve all partners,** including local authorities, health, housing, the third and independent sectors.

Whilst professionals and service providers have specific knowledge, skills and experience, there must be a strong commitment to increase the voice of people who use the services. They need to be placed at the heart of service design, planning, delivery, review and evaluation. It is the people (and their carers) who use services and receive care and support who know best what their individual needs, preferences and circumstances are. Planners and service providers need to build on this potential to ‘co-produce’ to ensure the best services and best outcomes for individuals.

The same principle of co-production can apply in developing healthier communities and reducing dependency, loneliness and isolation. 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) and developing new models such as social enterprises, co-operatives, mutual and community interest companies.

Developing co-produced services will ensure:

- people who use services, including their carers, take an active role in developing their plan of care to achieve the outcomes that are important to
them. This will include a named single point of contact, an assessment of their support needs and having access to relevant, up to date information.

- an increased focus on preventative community based interventions to reduce or delay dependency upon support services.
- financial benefits by reducing demand and levels of support for statutory services and reducing costly failures in care.
- a smooth and seamless transition between different parts of the system, ensuring the right care, at the right time, in the right place, by the right person.
- services are developed to meet local circumstances whether in urban or rural areas.
- capturing information once and ensuring it is accessible to those who need it (including across sectors).
- ensuring appropriate and proportionate needs assessment, with a plan of care and respond to respond accordingly.
- services that operate across sectors, ensuring access to 24/7 care.
- early intervention and support for independent living including rehabilitation and reablement and intermediate care, with pathways into secondary care, residential care or specialist services when required.
- consideration is given to language and communication needs.

In relation to communication and the provision of information, this needs to take account of people’s specific requirements e.g. language needs or other needs such as sensory loss. It is essential the All Wales Standards for communication and information for people with sensory loss are met.

Good multi-disciplinary assessment to capture the needs of people will become standard practice and the new integrated assessment, planning and review arrangements for older people, published in December 2013, will ensure this is achieved.

The new assessment guidance explicitly includes language requirements. It recognises that many people can only communicate their care needs effectively through the medium of Welsh. For many Welsh speakers, being able to use their language of choice has to be seen as a core component of care and not an optional extra. The new arrangements include a requirement to record people’s language need and preference.

Service providers will also need to ensure compliance with More than just words – the Strategic Framework for Welsh Language Services in Health, Social Services and Social Care.
Chapter 4: Making it Happen

Whilst there is a range of evidence relating to the best ways of integrating care, the key principles remain consistent. These have been helpfully summarised by the King’s Fund and, based on their work, sixteen key planning issues have been identified. These can be grouped into three main strands:

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<tr>
<th>Creating the environment</th>
<th>Working together</th>
<th>Making it happen</th>
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<tbody>
<tr>
<td>A shared narrative</td>
<td>A common cause (aligned goals, levers and incentives)</td>
<td>Build into a strategy</td>
</tr>
<tr>
<td>A persuasive vision</td>
<td>Building true partnerships (at all levels – with partnership agreements)</td>
<td>Focus on services and user groups that offer the biggest benefits</td>
</tr>
<tr>
<td>Shared leadership</td>
<td>Build from bottom up and top down</td>
<td>Using the workforce effectively</td>
</tr>
<tr>
<td>Supported and empowered users</td>
<td>Pooled resources</td>
<td>Avoiding the wrong sort of integration</td>
</tr>
<tr>
<td>Avoid being unrealistic about costs (need to ensure resource models can operate across all sectors)</td>
<td>Sharing information safely (across sectors)</td>
<td>Set objectives and measure progress</td>
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<tr>
<td>Use commissioning, contracting and money to create integration</td>
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To deliver high quality, effective, integrated services, care and support will be challenging. It will require strong leadership at all levels. The ability to influence and collaborate effectively with other sectors to deliver person centred services and outcomes is essential to the implementation of sustainable models of integrated care.

It is also essential that we explore and exploit the use of technology to improve service delivery and access to information, advice and support. This includes ensuring work is progressed to develop the IT infrastructure to support integration between health and social care, as well as technology such as telemedicine, telehealth and telecare.
Key actions

1. **All partners** must **by end of January 2014** develop an initial draft Statement of Intent on Integrated Care. A final Statement of Intent must be provided by **end March 2014**. This Statement of Intent will be published. It must include:
   - a baseline assessment of their current situation and action required in relation to the key planning principles identified by the King’s Fund (in broad terms not each individual area).
   - and set out clearly how partners intend to address the areas in **Annex A**.

2. The **Welsh Government** will work with partners to identify what work or support is required at a national level to enable delivery and remove existing barriers to integration. This will be undertaken **by April 2014**.

3. The **Welsh Government** is currently developing a national outcomes framework for both social services and the NHS that will set out the most important well-being outcomes for people. These will be developed in a phased approach, with a publication in **April 2014**. Partners should then ensure they have local systems for monitoring progress against these outcomes and specified measures and also develop any additional measures required to reflect local circumstances.

4. The **Welsh Government** will **during 2014/15** use the baseline assessments in the Statement of Intent as a means of reviewing progress in delivering the requirements in this document.

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 ensure that integrated services for older people with complex needs are embedded within mainstream delivery and are designed in line with this Framework.

7. **Welsh Government** to continue working with partners to ensure people are not unnecessarily admitted to hospital and to prevent delayed discharges. This will be supported through the Intermediate Care Fund during 2014-15.

8. **Partners** to enhance opportunities for staff action-learning in co-production and to develop a co-production demonstrator project as part of their integrated care delivery (with the learning to be disseminated nationally).

The maturity matrix included at **Annex B** 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.

**Supporting Implementation**

The Welsh Government, with the improvement agencies (such as the SSIA and the 1,000 Lives team within Public Health Wales) will develop a national programme to support delivery and address some of the significant barriers which have been identified. This will include joint commissioning; effective multidisciplinary assessment and planning; partnership arrangements (including pooled budgets, governance and accountability mechanisms); and key systems architecture requirements such as information exchange.

**Resourcing Integration**

The Welsh Government ‘Invest to Save’ funding already supports frailty service models across much of Wales. This Fund, along with 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.

Additionally, the Intermediate Care Fund, available for 2014-15, provides partners with resources to support both preventative approaches and the transformational change required to deliver integrated services for older people.
Chapter 5: Measuring Success

We want integrated services that enable older people and their carers to achieve the well-being outcomes set out in the Deputy Ministers well-being statement. Some of these include enabling older people and their carers to:

- Be well informed and supported to actively engage in decisions relating to their care and support – with coproduction being the way services are designed and delivered.
- Achieve and maintain good health and well-being.
- To have easy access to services, care and support that is integrated and co-ordinated and easy to use.
- Get the help they need, when they need it and in the way they want it.
- Have access to services, care and support, at home or in the community setting.
- Receive high quality services, care and support, ensuring their rights are respected and individual circumstances considered.
- Only access hospital services when they are required – not because of a lack of other community services.
- Find services are well planned and organised, where they live in Wales.
- Have more options for accessing services, care and support (including face to face and electronic access).

The Welsh Government will be developing national outcome frameworks for both social services and the NHS. This will set out what outcomes people expect, some of these could include:

- Whether people report that appropriate information is available at the right time.
- Satisfaction with care and support received.
- Satisfaction with the people who provide care and support.
- Whether people feel they have been involved in making decisions that affect them (or people they care for).
- Whether people feel they are in control of their daily life and are listened to.
- Whether people say they feel healthy both physical and mentally.
- The level of abuse and neglect.
A performance measurement framework will be developed to underpin the outcomes framework for social services. This will involve defining service specific quality standards and performance measures that will evidence the contribution that organisations make to the well-being outcomes of people. This will be a process that replaces the existing performance measures currently captured from local authority social services. This work will be developed in conjunction with the Regulation and Inspection Bill and is expected to be complete by September 2014.

These measures will all form part of an ‘integrated outcomes framework’, against which we will monitor delivery of the outcome measures for people and performance measures relating to the whole integrated system.
ANNEX A: Statement of Intent

The Statement of Intent must include:

- a baseline assessment of their current situation and action required in relation to the key planning principles identified by the King’s Fund (in broad terms not each individual area).
- and set out clearly how partners intend to address the following areas:
  - Integrated approach to information advice and support
  - Integrated approach to assessment & care planning including acute settings & CHC
  - Integrated approach to targeted preventative services e.g. reablement & intermediate care.
  - Integrated approach to telecare / telehealth, equipment and assistive technology.
  - Integrated approach to the development of community services / resources which promote wellbeing and independence and provide early preventative support. These may also include post reablement services e.g. befriending services, community transport, bereavement support.
  - Integrated approach to long term care – the commissioning of nursing home and residential care including CHC care and where appropriate long term domiciliary care.
  - Integrated approach to commissioning & integrated approach to needs analysis to allow for the aggregation of needs to plan services at the regional and national level where appropriate.
  - Integrated approach to helping older people address their accommodation needs, e.g. through extra care or sheltered housing or adaptations.
  - 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.
  - collaborative resource management will be managed through options such as a financial governance framework; joint commissioning plans, pooled and/or integrated budgets.
## ANNEX B: Maturity Matrix to Support Health and Social Care Integrated Care Partnerships

<table>
<thead>
<tr>
<th>Progress Levels</th>
<th>Key Elements</th>
<th>Purpose and vision</th>
<th>Strategy</th>
<th>Leadership of the local health and social care integration economy</th>
<th>Governance</th>
<th>Information and intelligence</th>
<th>Expertise and skills</th>
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<tr>
<td></td>
<td>0</td>
<td>Basic level</td>
<td>Early progress</td>
<td>Early progress in development</td>
<td>Results</td>
<td>Maturity</td>
<td></td>
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<tr>
<td></td>
<td>No</td>
<td>Principle accepted and commitment to action</td>
<td>Priorities and stretch goals have been agreed with stakeholders.</td>
<td>Strategy development underway. Arrangements in place for areas of joint planning/commissioning and investment opportunities.</td>
<td>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.</td>
<td>Systematically match how purpose dovetails with population needs. Evidence that integrated care is enhancing the quality of services and experience for the citizen</td>
<td>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</td>
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<tr>
<td></td>
<td>1</td>
<td>Early progress</td>
<td>Results</td>
<td>Maturity</td>
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<tr>
<td></td>
<td></td>
<td>Early progress in development</td>
<td>Initial achievements evident</td>
<td>Comprehensive</td>
<td>Assurance in place</td>
<td>Others learning from our consistent achievements</td>
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<td>2</td>
<td>Progress Levels</td>
<td>Maturity</td>
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1*The H&SCIP is a 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