

# Framework for Community Health and Social Care Integrated Services

**David Rowland**

**Professional Adviser  
Integration Division  
Directorate of Community Health and Social Care  
Scottish Government**

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## **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) and Scotland's Digital Health and Care Strategy (2018).

In order to ensure the framework remains current in this regard, it will be important to reflect new direction and emergent policy in its future development and refinement, as well as in its application at a local level. For instance, in looking to embed the framework within their operational planning arrangements, it will be helpful for Chief Officers and the senior teams to consider how local services can support the work of Public Health Scotland in delivering the Public Health Priorities (2018). Similarly, those teams should consider how they will reflect and apply the guiding principles set out within the Health and Care (Staffing) (Scotland) Act 2019, as well as any associated guidance, as they plan and deliver future improvements.

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 Guide to Emergent Good Practice that sits 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:

<b>Status Quo</b>	→	<b>Future State</b>
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 over time
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:

**C**ome 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;

**A**dopt 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;

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

**E**mpower, 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. community nursing staff, 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 including Care and Protection, particularly in terms of Child Protection and Adult Support and Protection; Mental Health and Adults with Incapacity; and Community Justice, ensuring these are discharged appropriately, in line with robust risk assessment and risk management processes; 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, with appropriate links to local Primary Care Improvement Plans.

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 consistently 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 components 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 **Participation, Accountability, Non-Discrimination and Equality and Legality**;
- 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'<sup>1</sup> 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;

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<sup>1</sup> 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, geographical 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 circumstance, 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**

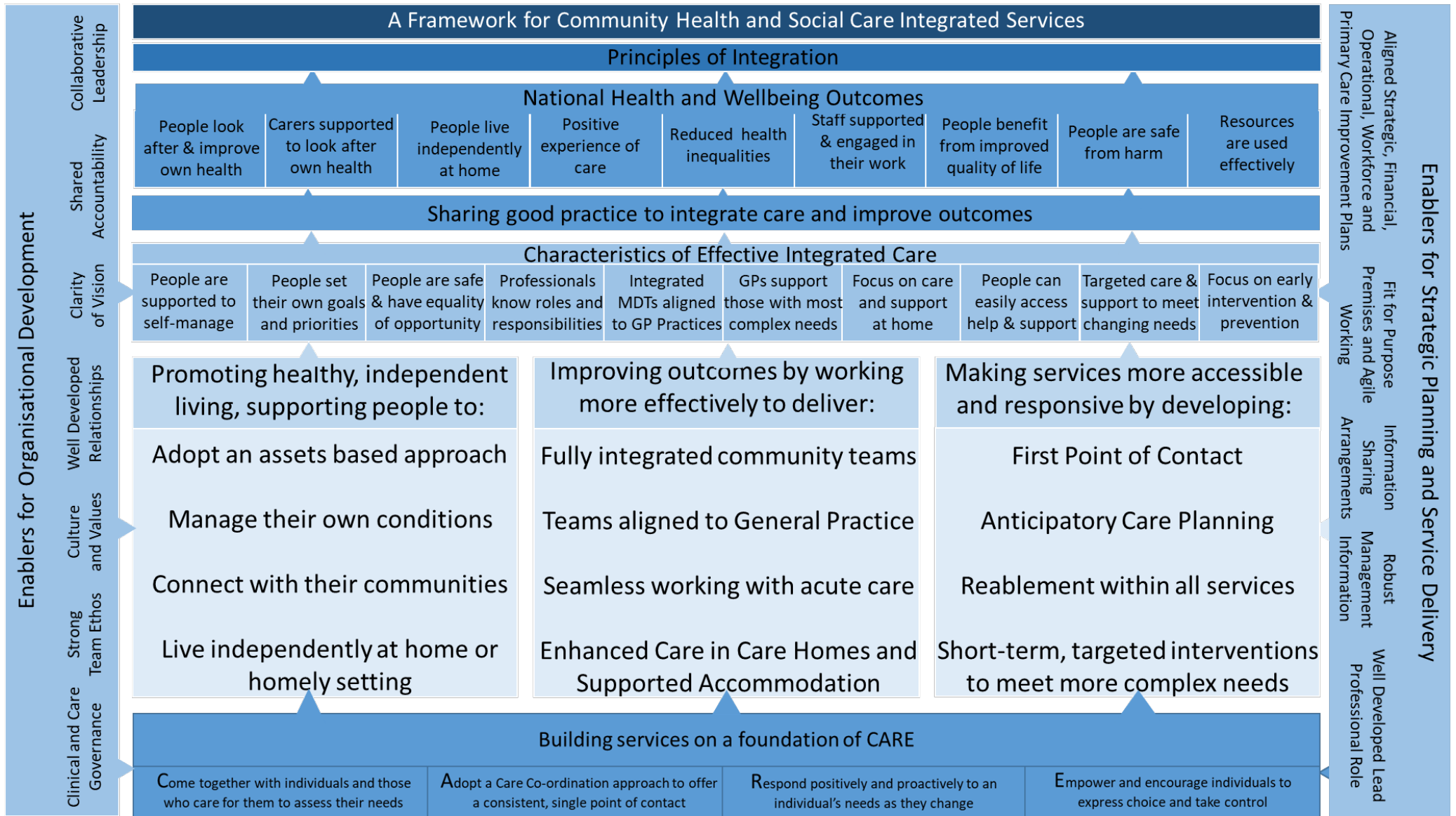
- Streamlined systems and processes to facilitate information sharing and recording, including short-term options to reduce bureaucracy, with robust data aggregation, collection and reporting systems to enable effective service management;
- Appropriate, modern facilities that offer viable alternatives 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:



## 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 that match the support requirements identified by individual Integration Authorities.
Governance Arrangements	That are simple, straightforward and enabling to support 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.