Building bridges,
breaking barriers

How care is integrated across health
and social care and the impact on older
people who use services, and their
families and carers

JULY 2016

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation.

Caring – treating everyone with dignity and respect.

Integrity – doing the right thing.

Teamwork – learning from each other to be the best we can.

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Foreword

People deserve consistently good care regardless of where they are treated and how complex their needs are.

People with complex needs, and who need care from a range of different services, often say they are very satisfied with the care they receive from each individual care provider. However, given that many of them move between services or care professionals, their care often becomes fragmented. This can have an impact on their experience and their overall care.

When staff from different services talk to each other and share information effectively, people experience better, safer care. When they don't, care can become disjointed and it is ultimately the person receiving care who suffers.

As our older population is growing, it is more important than ever that care systems work together. Older people typically have the most complex care needs and consequently receive care from more than one provider and in multiple settings.

Effective integrated care has been a widespread, national policy ambition and commitment for many years. The Government, in its 2015 Comprehensive Spending Review, re-confirmed this ambition for integration between health and social care services by 2020. While there are many examples of local leaders improving the quality and efficiency of care for people through integration, we still see too much of a gap between the national ambition and the

experience of people using services in their local area.

The NHS Five Year Forward View, through its new care models vanguard programme and other national initiatives, provides a significant opportunity to make this ambition a reality.

As one of the few national bodies with an explicit remit across health and adult social care services, CQC has an ability and duty to support this opportunity and use it to develop the way we carry out our own work.

CQC has therefore strengthened its programme of work to look at how well services work together, and started a programme to look at how the way we regulate could respond to new ways of providing care, and how we could assess the overall quality of care in an area.

We have an important contribution to make as the lead agency responsible for the independent assessment of the quality of care across health and social care, and encourage the improvement, innovation and transformation of how care is provided.

We hope this report will help the professionals who are responsible for improving processes and systems for the benefit of people using their services.

David Behan
Chief Executive

Carer's story

"As a family, we experienced first hand just how difficult and stressful it can be to get the right care for a loved one.

When my mother-in-law had a stroke, the initial care she received in a specialist unit was excellent. But when she left hospital and then suffered another stroke, moving my in-laws closer to my husband and I proved to be a mammoth task.

The GP she was under took forever to send her notes, even though it was just a matter of emailing a file. I had to chase and, in the end, beg for information about her medication.

Then the trust she was under refused to give her medication to cover the period in which she was relocating. Her new GP wouldn't prescribe anything for her until she had visited the surgery – madness. We agreed that my mother-in-law would visit the surgery the day after she arrived (very tricky as she finds it extremely hard to move around). As soon as we saw the doctor he said he would have visited her in the home if he had realised how immobile she was!

We have also had problems with information not being passed on. On two occasions when my mother-in-law was taken to hospital by ambulance, the GP was not informed of the incidents or that her medication had changed. I had to call the GP, explain what had happened and discuss the new prescription.

It also fell to me to organise the referral letters from the GP for physiotherapy, speech therapy and her prescriptions. I am not medically minded and I found it very difficult to keep having to ask what I needed to do next. The ringing around took forever and often all I could do was leave messages on answerphones.

I really feel that if my mother-in-law had one person helping us to organise the care that she needed it would have been a much smoother transition.

We are a year on and I feel I have learned so much about the care for elderly people. The help is there, it just needs to be accessed. This is where the difficulty lies.

My mother-in-law is very lucky to have a caring, loving family around her. If she was alone I doubt very much that she would have got the care that she needed."

Daughter-in-law
Older person's carer

Summary

We conducted this thematic review to improve our understanding of how well health and social care and support services work together to meet the needs of older people, and how this affects people's experiences of care.

The review also enabled us to independently assess the current state of integrated care within fieldwork sites, to develop and pilot tools and methods to support future reviews of coordinated care and to inform CQC's approach to the new models of care that are emerging.

We gathered evidence from a range of sources, undertook site visits and spoke with older people and their carers to understand how integration across services affected their experiences of care.

To support providers and commissioners in improving the quality of care for older people, we looked for examples of where care was effectively coordinated and identified barriers that prevent it from working well.

We found many initiatives that aimed to deliver integrated care. We saw some good practice, and in many cases considerable drive from providers and commissioners to improve the way services work together. Yet we did not find many examples of it working really well. There was considerable variation in the care provided and in the experiences and outcomes for older people.

It is challenging to define exactly which integrated care systems are most effective.

There seems to be no 'best way' of integrating care – improvements are often focused at multiple levels in the health and social care system and are developed locally rather than nationally.

Across the eight sites we reviewed, our findings related to both how services were working together and the impact this has on older people's experiences. Looking at how services were working together for older people, we found that:

- Reflecting the challenge that delivering integrated care represents, there were still many organisational barriers that made it difficult for services to identify older people who were at risk of deterioration or unplanned admission to hospital in a timely manner. This included a lack of consistency in the use of assessments and in the sharing of information.

- There were examples of joint working in the delivery of health and social care. Successful initiatives were set up by local practitioners to encourage and enable joint working. While some were more substantial (as set out in the good practice examples in this report), many were often short-term or reliant on partial or temporary funding and goodwill between different providers. They were not a mainstream part of the way in which services were planned or delivered around older people.

- Monitoring and evaluation of many of the initiatives in place to improve integration within areas was not carried out locally or was insufficient. The methods used were varied and typically measured the effectiveness of initiatives or interventions rather than the overall system of care in an area.

- There was widespread commitment to delivering integrated care and a belief that it is improving. However, local leaders still struggle to translate this commitment into an understanding for staff about how services work for older people across a local area, and within organisations, and how they can collectively provide integrated care.

- Older people often had multiple care plans as a result of professionals not routinely linking together and sharing information. There was also a widespread lack of knowledge among professionals of how care plans should be written and reviewed.

- The lack of connection between services often resulted in older people and their families or carers needing to take responsibility for navigating complex local services. This could result in people 'falling through the gaps' and only being identified in response to a crisis.

- Older people and their families or carers were not routinely provided with clear information about how their health and social care would be coordinated, in particular in the event of unplanned or emergency admission to hospital or changes in their circumstances.

Substantial progress is still needed to achieve our collective ambition for integrated care across England.

We found that where integrated, person-centred care succeeded, local leaders worked closely across health and social care services to share information, reduce duplicated efforts and use resources more effectively.

Using the opportunities now available through the NHS Five Year Forward View new care models vanguard programme, the Sustainability and Transformation Plans, and other initiatives, we believe other leaders can achieve this ambition too. Based on our findings, we recommend:

	Locally, **health and social care leaders** build on the opportunities offered by initiatives such as the NHS Five Year Forward View vanguards and the development of Sustainability and Transformation Plans to develop and agree a shared understanding and definition of what integrated care means for their population in their local area, and then work towards delivering this shared aim.
	NHS England and ADASS lead on developing an agreed methodology at a national and local level across health and social care for identifying people who are at risk of admission to secondary care or deterioration, underpinned by a clear data set.
	Commissioners and providers meaningfully involve older people in making informed decisions about their care needs and care planning – in particular about the outcomes that are important to them – based on the existing national and local guidance.
	Commissioners and providers in an area ensure that information and support for older people and their families or carers is available and that this sets out what details of what services are available, connections between different services, and how the people's accessibility requirements will be met.
	The **National Quality Board**, in partnership with the **National Information Board**, develop and share a set of validated data metrics and outcomes measures for integrated care. These should have person-centred outcomes at the heart of decision making about service provision and be based on a consistent, shared view and definition of integration.

Introduction

> "Integration across the NHS, public health and social care is a key means to achieving improvement in the quality of services and people's experience of them. An integrated system of leadership is required in order to implement an integrated system of care."
>
> **Hard Truths: The Journey to Putting Patients First**, Department of Health, January 2014

People in England are living longer, and the number of people aged 65 and over in the UK is projected to rise by over 40% in the next 17 years to nearly 17 million.[1]

Many older people live with multiple long-term health conditions and need to access care from a range of providers (for example, hospitals and care homes).[2] And many have medical conditions that can mean after a hospital stay, different care providers need to be involved in the person's discharge, so that they can return home with support or move to a care home setting.[3]

The Nuffield Trust's latest estimate (for 2015/16) was that two fifths (£46.56 billion) of the NHS budget was spent on people over the age of 65.[4] Local authorities' expenditure on social care for people over the age of 65 was £7.2 billion (2014/15 figures).[5] It is estimated that, by 2018, an additional £5 billion may be required to support the ageing population and increased number of people living with long-term conditions.[6]

As our older population grows and the health and social care system needs to find more efficient ways of delivering care and reduce costs, it is more important than ever to make better use of resources, reduce duplication of effort, and work with people to empower them in their health and social care services.

The Government and health and social care organisations have identified integrated care as a key step in responding to this changing environment.

Numerous organisations, including The King's Fund, have produced reports that demonstrate how integrated care can improve people's experience and outcomes and deliver efficiencies in care.[7]

In addition, integrated care can empower individuals and communities to manage their own health and wellbeing and is central to delivering effective services for people with long-term conditions.[8] However, when it goes wrong, particularly when people are discharged from hospital, the impact can be significant.[9]

Older people are particularly vulnerable when transitioning between different points of care. Addressing the national variation in delayed transitions could help reduce unnecessarily prolonged hospital stays and avoid inappropriate admission to acute inpatient care, long-term

residential care or continuing NHS inpatient care.[10]

There is a need for metrics to be established to monitor and evaluate the performance of integrated care to help identify where things are going well and where improvements are needed. While NHS Five Year Forward View vanguard sites are to publish a suite of data metrics to monitor and assess performance, these metrics are yet to be finalised.[11]
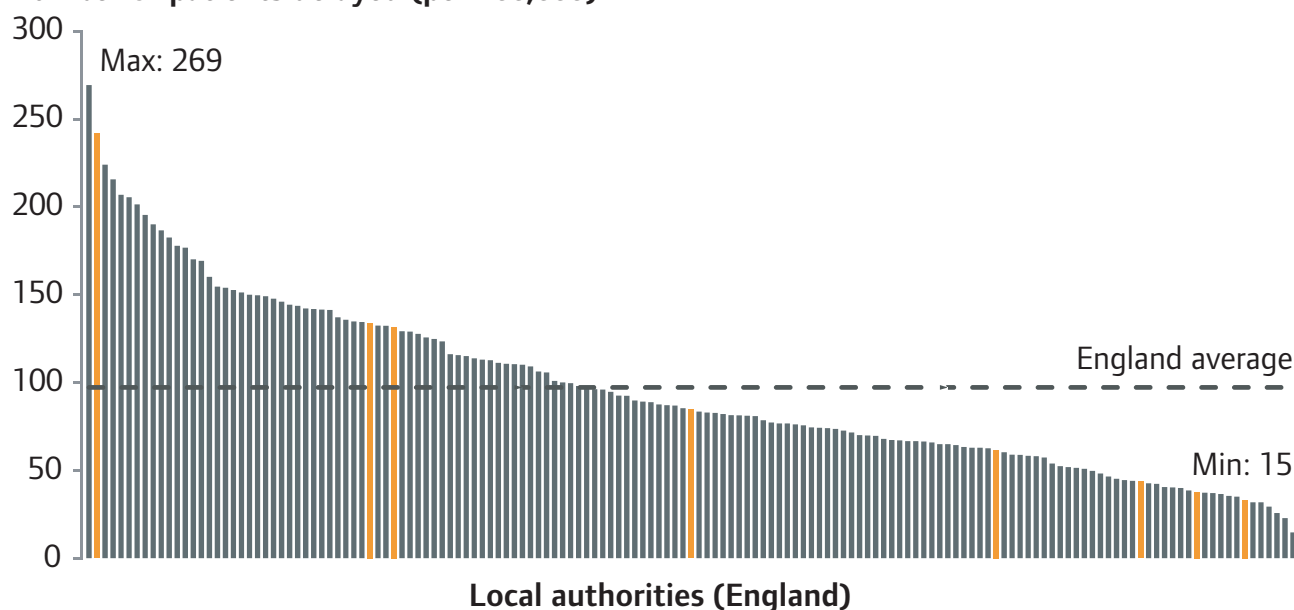
The Better Care Fund[12], which incentivises the NHS and local government to work more closely together, has begun publishing collected metric results that address elements of integrated care, such as delayed transfers of care (DToC). A delayed transfer occurs when a patient is ready and safe to leave hospital care, but is unable to do so. **FIGURE 1** highlights the national variation around DToC. Variation in care, particularly for older people, can mean losing muscle condition, and potentially losing the confidence to remain living independently.[13]

Defining integrated care metrics can support benchmarking against peers and monitoring against national trends, improve care coordination and inform regulators, other national agencies and researchers.[14] An example of a currently available metric specific to older people is 'the percentage of people aged 65+ who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation'. In 2014/15 this varied from 65% to 100% across England **(FIGURE 2)**.[15]

FIGURE 1: THE NUMBER OF PATIENTS WITH DELAYED TRANSFERS OF CARE, BY LOCAL AUTHORITY IN 2015

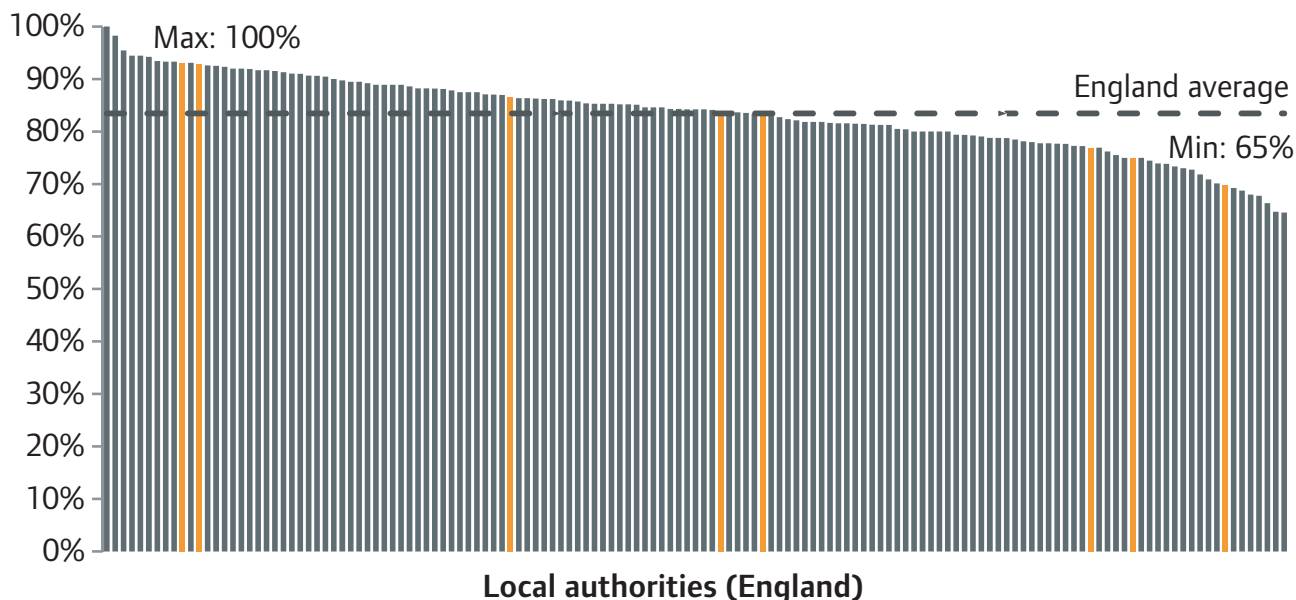**Number of patients delayed (per 100,000)**

Local authorities (England)

Note: Yellow shaded columns represent the fieldwork areas visited

Source: NHS England, Delayed Transfers of Care, January to December 2015; population source: Health & Social Care Information Centre (HSCIC) GP registered population, July 2015.

FIGURE 2: THE PROPORTION OF OLDER PEOPLE (65+) WHO WERE STILL AT HOME 91 DAYS AFTER DISCHARGE FROM HOSPITAL INTO REABLEMENT/REHABILITATION SERVICES BY LOCAL AUTHORITY, 2014/15

Percentage of older people still at home

Local authorities (England)

Note: Yellow shaded columns represent the fieldwork areas visited

Source: Health & Social Care Information Centre (HSCIC) NHS Outcomes framework, 2014/15.

> "Integrated care is not about structures, organisations or pathways, nor about the way services are commissioned or funded. It is about individuals and communities having a better experience of care and support, experiencing less inequality and achieving better outcomes."
>
> **Integrated Care and Support: Our Shared Commitment**, National Collaboration on Integrated Care and Support, May 2013

Despite some improvements, care is still fragmented with unclear lines of referral and communication within and between organisations – a problem that is magnified when people have multiple medical conditions.[16] The NHS Five Year Forward View stresses the need to integrate care: the vanguard programme is developing new models of care, and the Sustainability and Transformation Plans are bringing together local health and social care providers and commissioners. The NHS Five Year Forward View made particular recommendations

that new models of care must pay attention to identified barriers and facilitators, and must drive coordinated care forward.

The aim of this review was to independently assess integrated care within the fieldwork areas, build on existing information to better understand older people's experiences of integrated care and add value by:

● Improving our understanding of how well different health and social care and support services work together across systems and pathways to meet older people's needs, and how this affects the quality of care they receive.

● Making recommendations for providers and commissioners to improve the quality of care for older people through delivering coordinated care that focuses on the needs and requirements of the person, at a local and national level.

● Informing CQC's regulatory approach, including how we measure and assess the quality of care across pathways, population

groups, and new models of care that will emerge over the next few years, in line with CQC's strategy.

This review predominantly covered older people with complex needs or co-morbidity. For the purpose of scoping this review, and in recognition that different definitions exist across healthcare, people aged 65 and over were included in the fieldwork, except for case tracking, where the selection criteria was refined to only include those aged 75 and over.

CQC defines integrated care using the definition produced by National Voices and Think Local Act Personal and adopted by the Department of Health in 2013: "I can plan my care with people who work together to understand me and my carer(s), allowing me control and bringing together services to achieve the outcomes that are important to me."[17]

The supporting 'I statements' were developed further with the needs of older people in mind.[18] We used these publications to inform the development of themes and key lines of enquiry for this thematic review.

> "A key test of whether we have got safe, compassionate care right is the care we provide for older people, who can often be the most vulnerable patients, and those most in need of care that is properly joined up and well managed."
>
> **Hard Truths: The Journey to Putting Patients First**, Department of Health, January 2014

How we carried out the review

We worked with an expert advisory group who provided advice and guidance throughout the review, and with a range of health and social care providers who helped us to understand people's experiences.

We reviewed existing literature, including evidence from our comprehensive inspections, consulted with stakeholders and considered current policy and initiatives relating to integrated care.

We selected eight health and wellbeing board areas to cover different areas and demographic characteristics, as well as a range of providers with differing performance against relevant pathway metrics, such as delayed transfers of care and falls recovery (for example figures 1 and 2). We included some areas that were involved in initiatives to explore new models of care.[19,20]

We developed our approach with external stakeholders and worked with two health and wellbeing board areas during the pilot stage. We used findings from the pilot to refine the draft assessment framework and fieldwork activity.

We carried out the fieldwork for this review between October and December 2015 in the following eight areas:

- Bristol
- Cambridgeshire
- Camden
- Central Bedfordshire
- Hammersmith and Fulham
- Portsmouth
- Stockton-on-Tees
- Wakefield.

Housing, diet, employment, social status and environmental factors all play a part in the lives of older people when providing health and social care to meet their needs. However, details of how these affect older people's health and lifestyle were beyond the remit of this review.

We used a detailed assessment framework to structure interviews and discussions with people, carers and staff during our fieldwork. Our assessment was built around four key questions.

1. **Identification and prevention**
   How are older people with complex needs, or at high risk of deterioration in their health or social situation, identified?

2. **Person-centred assessment and planning**
   Do older people always have a person-centred, holistic assessment that forms the basis of a care plan which meets their physical, emotional, spiritual, social and practical needs, and is the plan regularly reviewed and updated?

3. **Coordination**
   Is care coordinated effectively to ensure that the older person is at the centre of their care – including when they have multiple or complex needs or vulnerabilities?

4. **Recognition and management of change and wellbeing**
   Do services and professionals recognise when the care required for an older person changes and how do they manage this change in an integrated way?

We have presented our findings by the first three key questions. What we found in relation to question 4 was relevant to the other areas of the review. Therefore we have integrated these findings throughout the report.

Each fieldwork team was led by two CQC inspectors, and for the majority of sites was also supported by an Expert by Experience (person with experience of using a particular service or caring for someone who uses a type of service) and a specialist professional advisor (senior clinician or professional who assists in CQC inspections).

We reviewed care records and spoke with people, their carers and the professionals who provide their care. We worked with a range of voluntary and community organisations to gather further feedback from older people and their families or carers. We held focus groups with a range of staff involved in care for older people.

We received feedback from stakeholders including local Healthwatch organisations, Age UK, overview and scrutiny committees and networks of older people, and carers organisations such as Carers UK.

We attempted to determine whether better coordinated services create better outcomes for people. We did this by using nationally available outcome data to develop questions that we asked during our inspections.

We used our Section 48 powers under the Health and Social Care Act 2008 to request information from clinical commissioning groups and local authorities to comment on commissioning.

We worked with others in the health and social care system to identify recommendations for national and local stakeholders based on our evidence.

We also considered findings from other CQC thematic reviews to increase our understanding of common issues:

- 'Quality of care in a place' found that leaders and partners across an area need to recognise their role in system leadership and the benefits of working closely together to achieve an agreed common goal. It also found that there is an ongoing focus to developing a common language across the area, and that partners should continue to monitor whether initiatives are being implemented successfully.

- 'End of life care' highlighted that a coordinated approach can facilitate early identification of people approaching the end of their life, and that effective sharing of information across services is essential for meeting people's needs and preferences.

- The 'Review of dementia care' found that arrangements to share information between care homes and hospitals were not good enough. Often, relevant information was not shared or acted on when people were moved between care homes and hospitals. As a result, their needs were not being met.

- The thematic study of 'People's involvement in their own care' encouraged providers to focus on personalised care plans – written with people, for people, and reflecting their wishes throughout their care journey; sustained and supported involvement of families and carers, and coordination of people's involvement in their care as they move between services.

Findings

Overall, we found that many of the providers across the fieldwork sites were committed to developing and delivering coordinated care.

We found examples of local health and social care professionals working across organisations and putting arrangements in place to make sure that people moving between services receive coordinated care. This included implementing various coordination systems, using integration tools and providing specific services to older, or at-risk, people. The good practice examples provided throughout this report share some of the initiatives we saw.

Where we found poor integration of health and social care, leaders had not created a culture in which the organisations could work together. We found that standardised assessment tools were not used consistently, there was a lack of understanding of how to use care plans, and information was poorly shared across organisations, which left older people and their carers having to navigate the system themselves at times of stress and crisis.

A number of initiatives, strategies and systems offered real opportunity to begin the process of delivering coordinated care in local areas.[21] These approaches actively involved older people and their families or carers. They also included the collection of comprehensive information and ways to share it across providers in a timely manner.

However, the quality and effectiveness of these initiatives and strategies was assessed through local monitoring and some small scale evaluations. The methods were varied and typically measured the effectiveness of initiatives or interventions rather than the overall system of care in an area. Nationally, this poses a question as to how we can assess whether new service models are effective.

For this review we selected areas based on, among other factors, their performance in selected possible integrated care metrics – particularly those that performed notably better or worse against the average.

Retrospectively, we compared how these areas performed across the metrics against the findings from the fieldwork to examine if we could identify measures of integration. Across the sites and metrics there was a mixed picture, with fieldwork findings not in line with the data, which indicated that the metrics chosen were not able to represent what we saw through our fieldwork. At the time this review was undertaken, we also did not see a noticeable difference between sites where new models of care were being piloted and those where they were not. This outcome is not surprising, as the new models of care were still being implemented at the time of the fieldwork.

1. Identification and prevention

KEY FINDINGS

- Reflecting the challenge that delivering integrated care represents, there were still many organisational barriers that made it difficult for services to identify older people who were at risk of deterioration or unplanned admission to hospital in a timely manner. This included a lack of consistency in the use of assessments and in the sharing of information.

- There were examples of joint working in the delivery of health and social care. Successful initiatives were set up by local practitioners to encourage and enable joint working. While some were more substantial, many were often short-term or reliant on partial or temporary funding and goodwill between different providers. They were not a mainstream part of the way in which services were planned or delivered around older people.

- Monitoring and evaluation of many of the initiatives in place to improve integration within areas was not carried out locally or was insufficient. The methods used were varied and typically measured the effectiveness of initiatives or interventions rather than the overall system of care in an area.

> "I have had lots of falls and fractures and no follow up. I only get treatment for the fracture. There may be other issues for me as I was weak and there was no plan in place to help this."
>
> (Older person)

There was an overall consensus across providers that they had made improvements to identifying and reviewing people with complex needs, or at high risk of deterioration. Providers told us that the improvements had enabled services to identify people at risk and support them to live in accordance with their wishes, and had helped individuals to move from unplanned to planned care.

However, we did not always find strong evidence to support these beliefs. Although there was some indication that local monitoring and small scale evaluations were undertaken, the methods varied and often measured the effectiveness of specific initiatives or interventions rather than the overall system of care in an area.

Identification and review

There was a mixed picture of how older people with complex needs, or at high risk

of deterioration in their health or social care circumstances, were identified. While many providers were proactive in their efforts to identify and review older people at risk, others were more reactive. It is important that professionals and staff in individual services are aware of this when thinking about how they provide care and coordinate services and share information across a local area.

Professionals who took a proactive approach regularly reviewed the needs and wishes of older people. They shared information with each other, and held ongoing discussions in which actions and outcomes were negotiated and agreed between various professionals, older people and their families or carers.

Services that were proactive had a culture of identifying and reviewing people to avoid unplanned emergency admissions and readmissions to hospital.

Similarly, some commissioners told us that they look at the health needs of their local population so that multi-disciplinary teams can identify people at high risk of 'poor outcomes' such as unplanned admission to hospital or moving into long-term care.

> **GOOD PRACTICE EXAMPLE**
>
> The North of England Commissioning Support Unit currently uses a tool known as RAIDR (reporting analysis and intelligence, delivering results) to identify the most vulnerable 2% of people.
>
> It extracts data from secondary and primary care and combines this to determine if someone is at high, medium or low risk of admission to hospital.
>
> RAIDR was developed in collaboration with GPs, integrating previously isolated data sources into a single tool. It is now being used across 40 clinical commissioning groups (a patient population of almost 11 million) to inform decision making.

In contrast, some staff in care homes, and those working in domiciliary care, had a more reactive approach to identifying and responding to risk and complex needs. In these settings, people at risk were generally identified and reviewed when an external health professional (such as a GP or district/community nurse) visited.

Assessment tools

Not all providers routinely used standardised assessment tools for identifying and reviewing older people at risk. However, among those who did, we were concerned by how effective the tools were. The results did not always automatically link to care planning and it was not normal practice for information to always be shared following assessments.

We found a range of practices in place that reflected the different priorities, accountabilities and professional cultures that health and social care professionals in different settings have.

In some cases, providers were aware that a range of assessments were being undertaken in different settings and that they were not compatible with each other or being shared. In others, there was a lack of knowledge as to what additional assessments may have been undertaken in other settings.

It was striking that health and social care professionals reported that information from assessments was not routinely shared and information from other assessments was not always requested. This sometimes resulted in older people having to provide information repeatedly, having multiple tests and assessments and having multiple care plans for different services.

When information was not shared, there was a significant inconvenience to older people and sometimes a cost of duplication. However, most importantly, this also means that there was a risk that decisions about older people's care and support (including medicine and care plans) were sometimes made on the basis of partial or incorrect information.

When older people are identified as being at risk of unplanned hospital admissions or of deterioration in their health, they should be added to GP practice frailty registers. This should trigger information sharing to support coordinated case management and early intervention across the range of relevant health and social care professionals. However, the extent to which this happened varied. In some cases, we were told that this did not always happen or when it did it was not done in a systematic way. Some providers were more connected than others and some tended to rely on more informal means of identification and review.

GPs have a key role in the identification of older people at risk and in the wider healthcare landscape. Therefore, we gathered information from GPs about their views on standardised assessment tools and how they used them. Many GPs reported using the most commonly used standardised assessment tools. However, even among GPs who used these, some had reservations about doing so because they did not know whether they had been formally validated or accredited.

We found that GPs were not using existing standardised assessment tools systematically and that some did not believe the tools were effective or useful and preferred to use their clinical judgement. We also heard that some of the existing tools took too long to implement and were challenging to administer in the time GPs had with patients.

Many GPs in the areas covered by this review had signed up to the Directed Enhanced Services initiative to reduce hospital admissions by identifying the top 2% of the most vulnerable older people. However, where people were identified as being at risk, we found little evidence of meaningful changes for people and none of the people we spoke with knew that they had been identified.

Some GPs commented that the resources they had available to respond to their patients' health issues were insufficient and felt that they did not have enough time to implement tools and undertake care planning in a way that would be meaningful for all of their patients.

GOOD PRACTICE EXAMPLE

North Tees and Hartlepool NHS Trust has assigned 16 beds to a frailty service that takes people from A&E or ambulatory care services.

While people in need of longer-term care go to an elderly care ward, a specialist physician is on call to identify where an alternative to hospital admission could be found. This enhanced assessment makes sure that people are given a diagnosis and their needs are identified, and it enables people to be treated and discharged more quickly.

The aim is for this type of enhanced assessment to eventually be available in the community.

Data sharing

We were concerned that information relating to identifying older people at risk of deterioration or unplanned hospital admission was not routinely shared across local areas.

While funding opportunities significantly improved the way data was collected and shared, staff shortages and lack of effective linkages between staff in different organisations created a considerable barrier. Staff attitudes and a lack of awareness of data sharing tools were also key factors. There were also examples where barriers to sharing information related to information governance, IT incompatibility or concerns over data security and confidentiality.

Where data was not routinely shared between staff and providers, the responsibility for ensuring continuity of care was left to the person or their carer. There is an obvious risk to relying on non-clinical people to relay important information about their medical history, and from the person's perspective it can be very frustrating to be asked the same questions by different clinicians and providers.

> "Telling the same story again and again becomes draining and you end up just wanting to get out ASAP. How can a professional come to an appointment without some information?"
>
> (Older person)

GOOD PRACTICE EXAMPLE

Hammersmith and Fulham Clinical Commissioning Group has been working with local providers to develop a new model of care that initially focuses on older people. Communication has been improved between general practices and community services and steps are being made to move to a single clinical record system.

Organisations within the area have also introduced information sharing agreements to support electronic communication and coordination. A multi-million pound IT investment has allowed GPs to share medical records online with hospitals and community services to improve people's care and clinical safety.

GOOD PRACTICE EXAMPLE

Currently, 75% of primary care records and all community health and mental health care records provided by Solent NHS Trust are recorded on one electronic system.

Access to a shared clinical record means that people can be triaged by phone by a professional who has full access to the patient's notes, regardless of where they are registered.

In the future, it will be able to offer electronic referral and discharge processes for practices on the same system. And it will make it quicker and easier for practices to refer, and make sure that discharge notes are fed back directly into a person's own medical records.

The system has also enabled practices to share the provision of weekend clinics.

Working together

We were told of several examples where local and national initiatives had been put in place over many years to develop coordinated working across health and social care providers.

Some examples included coordinated pathways for people with particular conditions (for example, stroke or hip fracture). We were also told of examples relating to people with dementia, and initiatives to tackle loneliness and isolation, where we saw evidence of joint working between hospitals, GPs, specialist community teams and voluntary sector organisations. Such initiatives were enabling multidisciplinary teams to work together to review and plan people's care across multiple organisations. These often involved organisations from the voluntary sector working in partnership.

Initiatives for coordinated care at a local level, through joint working, were often described as disconnected. They were also driven by temporary funding or incentives and by outputs rather than outcomes. Some initiatives also showed little evidence of having been jointly developed and formally evaluated. The evaluations undertaken were not always done in a robust way and were usually focused on specific initiatives or interventions as opposed to measuring the effectiveness of the overall system of care in an area. It also appeared that lessons were not generally learned and evidence was not shared.

Care homes were often able to access information on preventative activities such as falls clinics and balance classes through GPs or a 'single point of access'. However, the information was not always used and some providers were unaware that it existed.

GOOD PRACTICE EXAMPLE

NHS Camden Clinical Commissioning Group has an established 'Frail and Elderly Programme' to help older people in Camden receive responsive and coordinated care.

The programme uses a frailty register to support GP practices to improve how vulnerable frail people in the community are identified. In a year, the number of people on the register increased from 854 to over 1,500.

The action taken in response to those on the frailty register has reduced A&E attendances by 58% and avoidable unplanned admissions by 22%.

GOOD PRACTICE EXAMPLE

Cambridgeshire and Peterborough Clinical Commissioning Group has established a 'Joint Emergency Team' (JET) and 'neighbourhood teams' to support older people.

JET provides a rapid response for people over 65 who need support to access urgent care but do not need to go to hospital. The neighbourhood teams have brought together GP services, acute care and mental health services so that people using adult community services, and patients over 65 years old, have their care delivered by teams working together, rather than being seen separately by each service.

2. Person-centred assessment and planning

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KEY FINDINGS

- There was widespread commitment to delivering integrated care and a belief that it is improving. However, local leaders still struggle to translate this commitment into an understanding for staff about how services work for older people across a local area, and within organisations, and how they can collectively provide integrated care.

- Older people often had multiple care plans as a result of professionals not routinely linking together and sharing information. There was also a widespread lack of knowledge among professionals of how care plans should be written and reviewed.

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Care plans

> "My care plan does make a big difference, without it I would not be getting the help and support I need. My care plan helps me to stay at home. To me the care plan makes all the difference in the world."
>
> (Older person)

To support people with complex needs, care plans are expected to be designed with the person – based on their needs, values, preferences and goals.

Despite the many years that care plans have been in use, we found there was a considerable lack of clarity as to what care plans are; what they should include; when they should be produced and reviewed; and what their purpose is.

Care plans were commonly described as being primarily about what actions health and social care professionals were taking, such as number of visits or descriptions of procedures. It was not the case that plans were always focused on setting out how services and support was being provided to ensure people's goals and preferences were being delivered. They also did not routinely include details of how older people had been involved in developing or reviewing their care plan.

It was common for older people to have multiple care plans, with the type and detail

of information varying across plans. In these instances we were concerned that information was not routinely shared with different care providers and in some cases had resulted in conflicting information across the care plans.

Often existing processes or systems in different organisations made it harder for staff to make good use of care plans. Health and social care professionals reported difficulties in producing single coordinated care plans and support. One of the main reasons given for this was the range of IT systems that are used across different providers.

> "Professionals should sit around a table to discuss a patient's care plan and have a key document that is available to everyone. This is about health talking to social care but also about health talking to health."
>
> (Older person)

Providers often made decisions about the care plan according to their own priorities, accountabilities and professional cultures, instead of providing people with a coordinated package of care, designed with the person and their carer(s), and aligned to meaningful outcome measures.

Professionals reported spending a lot of time seeking information about people from across different services, which is an inefficient use of resources. For example, there were differences between domiciliary, residential and other

care settings as to whether they saw hospital discharge sheets or letters. Some said they never saw them but those who did said they were often significantly delayed after discharge.

Different types of health and social care providers often had very different ideas about what care planning was and how it should be put into practice.

For example, urgent care services did not always have appropriate details associated with older

people and patient notes were not always added to their medical records. Where they were added they were often out of date which made it difficult to develop care plans.

GP care plans also had varied levels of detail and were not seen as an effective document in the wider health and social care system. We also found very little evidence that GPs were sharing care plans with other providers.

GOOD PRACTICE EXAMPLE

'Connecting Care' is an IT system designed to share local care records in Bristol, North Somerset and South Gloucestershire. The project provides clinicians and practitioners with a summary of information about a person which includes:

- the GP record (including contact, diagnoses, medications and allergies)
- contacts with out-of-hours, hospital, community and social care support
- notes from community nurse visits and appointments
- information about end of life wishes.

People's involvement in care planning

The attitudes of health and social care staff towards involving people in decision making appeared to have an impact on the ways in which care plans were developed.

Nationally, just 65% of people aged 65 and over with a care plan, who took part in the 2015 GP patient survey, said they helped to put their written care plan together (a decrease from 66%, for 2014).[a,b] Additionally, the 2015 NHS inpatient survey responses revealed that only 59% of patients of the same age group were 'definitely' as involved as they wanted to be

in decisions about their care and treatment, up from 56% in 2014.[c,d]

We found that the delivery of person-centred care and Personal Health Budgets were being promoted in some areas. Personal Health Budgets are funds to support identified health and wellbeing needs, planned and agreed between the person and their local NHS team so that people with long-term conditions and disabilities have greater choice and control over the healthcare and support they receive. However, there was also evidence that some staff were concerned about people being able to make decisions about their care and support, and the associated risks.

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a. Calculated by NHS England, **GP Patient survey 2015**, (based on 15,624 responses from people aged 65+ with care plans)

b. Calculated by Picker Institute Europe, NHS England, **GP Patient survey 2014**, GP Patient survey 2014 (based on 9,110 responses from people aged 65+ with care plans)

c. Calculated by CQC, **NHS inpatient survey 2015**, based on 48,594 responses from patients aged 65+)

d. Calculated by Picker Institute Europe, **NHS inpatient survey 2014**, (based on 19,481 responses from patients aged 65+)

"I've recently been sent a care plan from my GP, however it is not simple to understand and not very informative. I would rather have my own input into my own care plan and flag my vulnerabilities, such as my allergy to penicillin, rather than having something that somebody cannot understand if they find me in an emergency"

(Older person)

GOOD PRACTICE EXAMPLE

Central Bedfordshire has a well-established 'Good Neighbour and Village Care Scheme Network'. The Council funds the Bedfordshire Rural Communities Charity to develop and set up new schemes and support existing schemes.

At the time of the review, there were 40 independent schemes, each of which is self-sustaining, run wholly by local volunteers with running costs being met through donations and local fund raising.

Through these schemes, individuals are supported by their local community to maintain their independence and wellbeing and remain in their own home for as long as possible. Types of support include providing transport to older people for hospital appointments, support with shopping and reducing social isolation.

The schemes currently support over 720 residents, using more than 800 volunteers, and typically carry out 3,100 tasks every quarter. They are seen as a real strength and promoted by people and healthcare professionals in the area.

3. Coordination

KEY FINDINGS

- The lack of connection between services often resulted in older people and their families or carers needing to take responsibility for navigating complex local services. This could result in people 'falling through the gaps' and only being identified in response to a crisis.
- Older people and their families or carers were not routinely provided with clear information about how their health and social care would be coordinated, in particular in the event of unplanned or emergency admission to hospital or changes in their circumstances.

Care coordination

We saw examples of coordinated working and were told about clear pathways, referral methods between services, and systems to communicate and share data. However, these were not always perceived to be effective. There was a clear feeling of disconnect between local strategy documents and the reality of what it felt like for people using the services.

We were told that it was often the case that several different teams within an area delivered services with seemingly similar remits (for example re-enablement, falls prevention, rehabilitation and enablement, and rapid intervention). Without coordination and communication, this situation could result in a lack of understanding of how care and support is delivered and who is responsible.

A system that becomes difficult to navigate is likely to result in inefficient use of resources and relies on people or their family or carers, to coordinate care themselves.

In some areas, older people and their carers did not always know about relevant services that were available. It appeared that a lack of information sharing among health and social care professionals often left some older people 'lost in the system' between services.

"A patient had come into hospital as an emergency admission after fracturing their hip. They were known to mental health services because of their dementia but information on their fall/fracture was not passed on. A falls prevention care plan was put in place but not included as part of the discharge record. There was no evidence that information was shared with the community falls team to help identify them as at risk and minimise further falls. They also had a pressure area care plan completed in hospital which was not communicated to their GP on discharge and the pressure area care plan was not shared."

(Provider)

The explanations we were given for poor coordination and integration were often specific to each sector. Staff lacked understanding of other providers and did not appreciate their differing priorities, pressures and accountabilities. People working in primary and social care expressed strong views about the way in which staff in hospitals focused on what they needed to do and did not pay sufficient attention to others. Hospital staff said the same about primary and social care providers.

Leaving hospital

Although we were made aware of initiatives to improve older people's transfer of care from hospital, in practice we saw delays in discharge from hospital, poor information for the receiving provider, and a lack of clarity of who was responsible for facilitating older people's hospital discharge.

Nationally, the NHS acute inpatient survey 2015 found that of respondents aged 65 and over, only 61% felt they 'definitely' received enough support from health or social care professionals to help them recover and manage their condition after leaving hospital.[e]

> "I didn't even know he was going to be going home so I hadn't brought his clothes for him to go home in."
>
> (Carer)

As an example, when people's care transferred from hospital to community services (and vice-versa) we were told about a lack of coordination and of different services acknowledging each other's pressures.

A key issue was communication around discharge planning. Some staff felt there was a degree of inconsistency in communication between hospital wards and discharge teams and between hospital teams and social care and community based teams.

Care home and domiciliary care staff told us that they were often not given information that they considered important when a person returned home from hospital. This was sometimes relatively basic, such as a person's weight, but sometimes more critical, such as changes to medication. Some staff reported that they did not automatically receive the information they needed and always had to request it. Others reported that it could be delayed by a significant period. This would result in staff having to make decisions about medication and care without being in possession of up-to-date and comprehensive information about the person, their care needs and their preferences.

Domiciliary care agencies told us that when a person's medication was changed by the GP or hospital, they were often not made aware. GPs said that they had no system in place that would tell them if medication was being administered by a domiciliary care agency, which can pose a serious risk to a person's treatment.

There was a lack of notice and planning around discharge and delayed transfers of care, which could have a significant physical and emotional impact on a person's care, as well as on their family and friends.[22]

Hospital transport was a specific area of concern. People who were ready to go home were often waiting for extended periods to leave hospital and agencies were not always on hand to support the person on discharge, particularly when this had been delayed but not communicated.

This was a particular issue in care homes and domiciliary care during 'out of hours' periods and at weekends when they needed notice and particular information to receive an older person into their care safely. Hospital staff were not always aware of this and did not appear to take responsibility for ensuring that the discharge process extended beyond leaving hospital and returning home or to another care setting.

People's experience of coordination

> "Once your care plan is established, care is coordinated because everyone knows what is going on. Occasionally there is a blip, but a phone call remedies the problem."
>
> (Older person)

While we found that particular aspects of a person's care may have a named coordinator – such as a stay in an acute hospital or during the first week or month following a social care placement – the experience of moving between services or using multiple services, as is the case

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e.   Calculated by CQC, **NHS inpatient survey 2015**, (based on 27,049 responses from patients aged 65+)

for many older people, was generally much more diverse, patchy and confusing.

> **"I have a lot of health problems and everything has been explained to me, but how do I know that the health professionals communicate with each other about my health problems?"**
>
> (Older person)

This often left older people and their family, or carers, to navigate within and across services. It was not uncommon to find examples where people reported that there was no single named person in hospital or in the community who took the lead on their care or transition to other settings. This resulted in people having to repeat themselves or have multiple assessments.

> **"Every doctor or other person who came to see me asked the same questions."**
>
> (Older person)

This was not only inconvenient for people and their carers, but could be dangerous as there is a reliance on people to accurately report their medical history and understand changes to their medication – this could potentially result in life threatening implications and is clearly not a good use of limited resources.

GOOD PRACTICE EXAMPLE

The Integrated Commissioning Unit (ICU) is a joint initiative between Portsmouth City Council and NHS Portsmouth Clinical Commissioning Group.

It aims to deliver efficiencies across departments and improve outcomes for vulnerable adults, children and families in the local area. They commission whole life pathways by joining up services and looking at a wide range of factors that affect health and wellbeing.

Improved outcomes include people being assessed in the right environment at the right time, a significant reduction in complaints and challenges from patients and families, increased efficiency in managing the market across residential, nursing and complex end of life provision and embedding a recovery focused approach across health and social care for people with mental health problems.

GOOD PRACTICE EXAMPLE

NHS Wakefield Clinical Commissioning Group and Wakefield Council, along with other NHS providers and voluntary organisations, are bringing care closer to home in a programme called 'Connecting Care'.

Groups of GP practices are working with a team of community nurses, social care staff, therapists and voluntary organisations to organise services around the needs of the people registered with their practices.

Connecting Care hubs provide a coordinated service for people who are most at risk of becoming ill, such as those with long-term conditions, complex health needs and people who have been in hospital following an emergency or operation.

Early evaluation suggests 'Connecting Care' is proving popular with staff and patients within the system.

GOOD PRACTICE EXAMPLE

Imperial College Healthcare NHS Trust is working in partnership with other health and social care providers in Hammersmith and Fulham to provide the Community Independence Service (CIS).

The CIS provides a single point of referral for older people, preventing them from having to go into hospital, with a rapid response service. It also supports people recovering after a hospital stay, helping them to regain their independence and get better in their own homes.

The service is provided by a team that includes GPs, a social worker, hospital consultant, community matron, nurses and therapists, a health and social care coordinator and a person's case manager.

GOOD PRACTICE EXAMPLE

In April 2015, NHS Camden CCG launched the 'Care Navigation Service'. It is provided by Age UK Camden to support patients in accessing voluntary and community services that help them to self-manage their conditions. It also supports vulnerable people to get the right health and social care to meet their needs.

The service is aimed at patients over the age of 60 who are either frail or identified as being at high risk of becoming frail. Patients may have long-term conditions, had an emergency admission to hospital in the last year, or are not engaging with health and social care services.

Six care navigators offer support with case management, multi-disciplinary team meetings and complex referrals.

In less than a year, the service has received referrals from over 30 practices and has seen almost 600 patients.

The service is highly rated - 83% would recommend the Care Navigation Service to others in their situation. Sixty-six percent of patients felt strongly that the service had helped their carer too.

Recommendations

Integration and coordination is essential to providing safe, effective care. People's experiences and outcomes can be improved through coordinated involvement of multiple professionals across local organisations.

As people become older, they should continue to have meaningful opportunities to participate in decisions about their care. As care typically becomes more complex due to multiple long-term health conditions and the use of multiple providers, it is essential that care is coordinated, structured and delivered to meet people's needs.

We found that integrated, person-centred care works best where local leaders worked closely across health and social care services to share information, reduce duplicated efforts and use resources more effectively. We found that in the areas where we conducted in-depth fieldwork, there was an over reliance on the commitment and enthusiasm of those delivering care rather than looking for ways to support sustainable change at system level.

Using the opportunities now available through the NHS Five Year Forward View new care models vanguard programme, the Sustainability and Transformation Plans and other initiatives, we believe other leaders can achieve this ambition too. Based on our findings, we believe they are most likely to be successful if they follow and implement the recommendations set out in this report.

RECOMMENDATION 1

Locally, **health and social care leaders** build on the opportunities offered by initiatives such as the NHS Five Year Forward View vanguards and the development of Sustainability and Transformation Plans to develop and agree a shared understanding and definition of what integrated care means for their population in their local area, and then work towards delivering this shared aim.

In practice, this means that:

- All health, social care and community based organisations within an area agree and implement a shared language and definition for integrated care.
- Collective and individual leadership in all organisations demonstrates clear ownership and responsibility for integrated care within their area.
- Commissioners and providers address duplication of care plans within the system.
- Commissioners take the lead in supporting emerging new models of care and ensure services in the future are based on a clear understanding of the current and projected population needs and services available.
- Commissioners and providers ensure that innovations are properly evaluated and learning from validated models is shared and, where appropriate, adopted across the system. They will also consider how to evaluate innovations at a national level.
- Information governance policies and procedures for sharing information across local areas are developed and adopted, and all staff understand their responsibilities. Commissioners and providers should give consideration to how information can be shared electronically, particularly about the most vulnerable people.

RECOMMENDATION 2

NHS England and Association of Directors of Adult Social Services (ADASS) lead on developing an agreed methodology at a national and local level across health and social care for identifying people who are at risk of admission to secondary care or deterioration, underpinned by a clear data set.

In practice, this means that:

- NHS England, ADASS, and commissioners and providers across the health and social care sector should develop a consensus to identify people at high risk of admission to secondary care or deterioration. People should be identified by the whole system, rather than by individual providers. Information is shared across organisations and with the person and their carer(s).
- NHS England, ADASS, commissioners and providers make sure that meaningful outcomes are set for people who are identified as being 'high-risk'.

RECOMMENDATION 3

Commissioners and providers meaningfully involve older people in making informed decisions about their care needs and care planning - in particular about the outcomes that are important to them – based on the existing national and local guidance.

In practice, this means that:

- Commissioners and providers develop a shared consensus on the use of person-centred care plans. This should be based on the guidance in the Care Act 2014. Ideally a care plan should be recognised and used by all providers of health and social care, it should aid transition through the system, reduce duplication, inform everyone of emergency action to be taken and be owned by the person and their carers.
- Commissioners and providers make sure that people and their carers are meaningfully involved in, and are able to influence local changes to the system in a measurable way.
- Care plans involve input with the older person (or their family or carer if they do not have capacity). Otherwise they should be described as treatment or management plans.
- CQC will adapt its methodology so that we assess whether national and local guidance is being followed.

RECOMMENDATION 4

Commissioners and providers in an area ensure that information and support for older people and their families or carers is available and that this sets out what details of what services are available, connections between different services, and how the people's accessibility requirements will be met.

In practice, this means that:

- Commissioners ensure that access to services is effective and aids transition through the system, rather than creates delays.
- Commissioners and providers ensure that older people receive appropriate and accessible information and support to allow them to navigate a complex system safely.
- CQC supports innovation to improve coordinated care and the development of new models of care.
- CQC explores transitions of care, including medicines management, in more detail to improve our understanding of its impact on safety.

RECOMMENDATION 5

The **National Quality Board**, in partnership with the **National Information Board**, develop and share a set of validated data metrics and outcomes measures for integrated care. These should have person-centred outcomes at the heart of decision making about service provision and be based on a consistent, shared view and definition of integration.

In practice, this means that:

- Specific performance and outcome measures, to assess the quality and effectiveness of integrated care across an area, are developed and embedded into local processes. These will measure and monitor the impact of integrated care on health and wellbeing outcomes for people. Although integrated care is difficult to measure and evaluate, steps must be taken towards achieving this and learning from national integrated care initiatives must be taken into account.

- The National Information Board data development programme, as part of its strategy for 2020, gives regard to promoting integrated care measurement by:
    - Linking a greater number of datasets to improve our understanding of how integrated care is, and the outcomes that are achieved.
    - Exploring an integrated care survey. This should take into account work being undertaken by CQC in 2016/17 to understand how to survey people's experiences of integrated care.

- CQC, working with NHS Digital, NHS England and vanguard sites, will develop metrics and outcome measures in line with the development and testing of our regulatory and inspection frameworks for providers, local areas and new models of care.

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- Dementia UK
- Disability Rights UK
- Healthwatch England
- The King's Fund
- The Lesbian and Gay Foundation (LGF)
- Local Government Association
- Marie Curie Cancer Care
- Mind
- Monitor
- National Voices
- NHS England
- NHS Benchmarking Network
- Nuffield Trust
- NW London CCGs (Pioneer Program)
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