AGENDA ITEM 8

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

CQC Feedback - Integrated Care for Older People February 2016	
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Accountable Officers	**Mike Hennessey**
Date of meeting	**17th February 2016**
Report for: Assurance and Information	

Purpose:

To inform the Commissioning Board of the key outcomes of the Integrated Care for Older People thematic review undertaken by the Care Quality Commission (CQC).

Background:

As part of CQC's programme of thematic work, they are undertaking a project to explore how well care is organised and coordinated for older people, and how this affects their experience of care. The review involves a number of different systems across England, with Bristol being one of these systems.

The review ultimately aims to improve older people's experience of integrated care and support. It will add value by:

- Making recommendations for providers and commissioners about improving the delivery of high quality integrated care for older people, at a local and national level.
- Improving CQC's understanding of how well different care services work together across systems, pathways and sectors with a view to improving our 'business as usual' regulatory approach.

The Bristol review started at the beginning of October 2015 with requests for documentation. The onsite review took place 30th November, 1st, 2nd, 3rd and 4th December 2015. They undertook:

- Care tracking of 5-pateints
- Looked at care plans in primary care
- Telephone interviews
- Focus Groups
- Visits to hospitals and rehabilitation centres
- Audit of Delayed Transfers of Care's
- Watched a video of the stroke group meeting
- Listened to the daily alamac teleconference

The draft high-level feedback was Thursday 10th December. The review team were clear that the review was very different to an inspection as they only gained a flavour of what is happening in Bristol.

Good Practice:

- Good practice of staff working together at strategic and operational level
- Every group of staff spoken to committed to integration and ensuring that the patient/ service user is at the centre of what they do

- Many examples of joint working between health, social care and voluntary organisation. e.g.. British Heart Foundation
- Very impressed with the Bristol Ageing Better (BAB) is doing but also the relationship between BAB and Better Care Bristol
- The Community Discharge Coordination Centre (CDCC) was making a positive impact on the coordination of care between hospital and community services.
- The potential of Connecting Care was raised as a future impact
- Dementia navigators were highlighted as an area of good practice that patients had raised with the CQC team.

What could we do better?

- Identification of patients at risk, primarily relating to approach to frailty and in-particular falls across CCG and LA.
- Need to ensure that Discharge to Assessment model is not limited by capacity.
- Rationalise Care Plans by ensuring that the same person does not have multiple care plans and they are in-date and do not conflict each other. It is really important that we move to person centred planning across health and social care.
- Reduce delayed transfers of care across all providers.
- Make is easier for GPs and other clinicians and professionals to navigate the system, GP's reported there was no single point of access for services such as podiatry, dietician, IT, physiotherapist, consultant reviews, pharmacy advice and reviews, community mental health
- Make it easier for patients to navigate mental health services in Bristol

Summary and Recommendations:

- Commissioning Board has delegated the key points / issues of concern to the Transformation Board to give assurances that that all points are covered within current schemes and projects.
- Where issues are not addressed the Transformation Board will make recommendations to Commissioning Board how to take forward.
- To provide assurances to HWB how the points raised will be taken forward within Better Care in next performance report (April 2016).

Thematic Review:

Integrated Care For Older People

Bristol

How we did this

- As part of our programme of thematic work, CQC is undertaking a project to explore how well care is organised and coordinated for older people, and how this affects their experience of care.

- The review ultimately aims to improve older people's experience of integrated care and support. It will add value by:

    - Making recommendations for providers and commissioners about improving the delivery of high quality integrated care for older people, at a local and national level.

    - Improving CQC's understanding of how well different care services work together across systems, pathways and sectors with a view to improving our 'business as usual' regulatory approach.

How we did this

- Examined how effectively health and social care providers are coordinating care for older people and whether providers are communicating and sharing information effectively to support good integration.

- Requested information from commissioners to help us to understand the wider context to older people's experience of health and social care at the local level.

- Looked for examples of good and outstanding care, identifying barriers which prevent older people receiving integrated care. Based on these findings CQC will propose actions that national and local providers can take to address poor integrated care for older people.

Field work activity

- Carried out 30th November, 1st ,2nd ,3rd and 4th December 2015

The team included:

- Ruth Bryant (Inspector, Hospitals division)
- Susan Taylor (Inspector, Primary Medical Services)
- Madeleine Symons (Inspector, Primary Medical Services)
- Mandy Haywards (Specialist Advisor, Social Care)

What we did

- We tracked the stories of five patients. We interviewed these patients and looked closely at their care records in primary care, in the hospital and in rehabilitation settings. We spoke to some of the people who had provided the care to those individuals.
- We looked at care plans in the GP surgery, in the hospital, in the rehabilitation setting, in residential care.
- We interviewed people who are responsible for leading services for older people in the Bristol area including GPs, representatives from the clinical commissioning group, Bristol Ageing Better, the acute trusts, Bristol Community Health, residential care manager plus many others
- Telephone interviews with a dementia navigator, a domiciillary care provider, the British Stroke Foundation and Clinical lead for system leadership at Avon and Wiltshire Partnership
- Held a focus group that looked at the care for a person following a fractured neck of femur. Attended by 16 health and social care staff
- Held a focus group that looked at the care of people who have had a stroke. Attended by 25 health and social care staff
- Visited Bristol Royal Infirmary, Southmead hospital, South Bristol Community Rehabilitation Centre, the CDDC, three GP practices and spoke with several staff at these locations
- Looked at data regarding delayed transfers of care from the older peoples wards at Southmead, the Bristol Royal Infirmary, and at Callington Road.
- Watched a video of the stroke group meeting
- Listened to the daily alamac teleconference

Key lines of enquiry

- Identification and communication: How are older people with complex needs and/or high risk of deterioration in their health or social situation identified?
- Person centred assessment and planning: Do older people always have a person centred, holistic assessment which forms the basis of a plan of care which meets their physical, emotional, spiritual, social and practical needs, and is the plan regularly reviewed and updated?
- Coordination: Is care co-ordinated effectively to ensure that the older person is at the centre of their care, including when they have multiple or complex needs or vulnerabilities?
- Recognition and management of change and well being: 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?

Identification of patients at risk

- Community matrons
- Frailty approach
- Mental health approach to self management of conditions, patients identifying triggers
- Discharge to assess model
- Identification of patients through involvement of the voluntary sector: Bristol Ageing Better – GP case finding, social prescribing, community navigators and first contact checklist
- TIA clinics offered by both trusts

Identification of patients at risk

- Opportunity to reduce falls risk in patients at risk was limited by the lack of provision of therapy and delays to falls assessment service
- There was no standardised ‘coding’ of patients at risk of falls that would trigger multidisciplinary involvement
- Discharge to assess currently limited by capacity
- GP identification after hospital admission only

Person centred care planning

- Assessments in the community rehabilitation teams were holistic and treatment approaches were adaptable. Social care plans we viewed were less holistic
- Incentive for domicillary care to reduce dependency
- Later life mental health liaison teams in acute hospitals were able to look after a persons mental health needs including ECT at BRI

Person centred care planning

- There is no shared written care plan. There was a mixed picture from five people's stories about their involvement in the production of care plans. One patient told us the information was inaccurate and did not describe what was important to her.
- *"I've recently been sent a care plan from my GP however I find 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 asthma, my broken hip , my gallstones, my achy shoulder , my allergies to penicillin rather than having something that somebody cannot understand if they find me in an emergency"*

Person centred care planning

- There is no shared written care plan. There was a mixed picture from five people's stories about their involvement in the production of care plans. One patient told us the information was inaccurate and did not describe what was important to her.
- Care for people who had falls was not well managed. Action to resolve or manage the cause of falls was not prioritised in the acute setting.
- Communication with social care providers was not always thorough or reliable. Training for dementia care

Coordination of care

- Key stakeholders working together to improve flow. Daily alamac call taking a proactive approach to partnership working
- Many examples of joint working between health, social care and voluntary organisation. Eg. British Heart Foundation
- Bristol Ageing Better- looking toward a directory of resources. Some teams not aware of the opportunities available for older people
- The CDDC was making a positive impact on the coordination of care between hospital and community services. But lack of weekend/out of hours cover. Assessments not always up to date
- Connecting Care

Coordination of care

- IT systems: connecting care and the current picture
- There was sometimes a disconnect in communication between therapy in hospital and post discharge.
- Complexity of care provision in the north of the city
- Complexity of mental health care provision in the community
- Delayed transfers of care significant across all providers
- Non-standardised pathway for management of acute pain when admitted to hospital with a fracture.
- Lack of ortho-geriatrician at UHB

Recognition and management of change

- Active choice scheme
- Patient who presented to the acute hospital with a fractured neck of femur was found to have undiagnosed breast cancer. The hospital teams brought the cancer care to her bedside
- Dementia navigators allocated for duration of illness
- NBT highlighting changes in care plans to GPs on discharge e.g. medications

Recognition and management of change

- GPs reported there was no single point of access for services such as podiatry, dietician, IT, physiotherapist, consultant reviews, pharmacy advice and reviews, community mental health.
- Involvement of domicillary care in discharge planning; unrealistic expectations around falls management
- Availability of medication and communication regarding changes to medication following discharge from services. Management of dosette boxes and medication reviews on discharge
- Community therapy teams unable to access weighing equipment to monitor peoples weight

We welcome feedback about your experience of this thematic review and ask that this is shared by either emailing the ICOP Thematic Review or our team

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Thank You

- We wish to acknowledge and thank those people that agreed for us to case track their experience and allowing us into their homes to talk with us.

- Bevleigh Evans, Amy Carr and Daniel Knight worked extremely hard in the planning and coordination of this review and supported the team throughout the field work activity.

- We also wish to acknowledge the commitment, enthusiasm and support we received from all the individuals, teams, organisations and stakeholders we had contact with.