Clinical Senate Forum

Enhancing health in care homes- leading a whole system response

Summary report

25 May 2017 at The King's Fund, London.

Enhancing health in care homes

Meeting the needs of a growing and ageing population is one of the key challenges for our health and care system. Whilst overall London has a younger population than other parts of the country, the number of Londoners aged over 80 is rising and is predicted to increase by 40% over the next 15 years. As the greatest users of health and care services we need to consider how to best meet the needs of older people, particularly the frail elderly, supporting them to have the best possible quality of life and care. The *Next Steps on the NHS Five Year Forward View (March 2017)* describes the task clearly; "*As people live longer lives the NHS needs to adapt to their needs, helping frail and older people stay healthy and independent, avoiding hospital stays where possible. To improve prevention and care for patients, as well as to place the NHS on a more sustainable footing, the NHS Five Year Forward View called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes*".

Enhancing and expanding care out of hospital is a core, and critical, part of London's five sustainability and transformation partnerships' (STPs) plans and was the topic for the Senate Forum in January 2017. We continued this theme in May 2017, with a focus **on improving health in care homes.** This is a key part of STPs' approach to meet older people's needs and one that **requires an integrated, whole system response**.

Many people living in care homes have complex needs e.g. limited mobility, falls risks, dementia, incontinence, cardiovascular and cardiorespiratory disease, often with multiple prescribed medications. There is significant evidence that a more proactive approach and more responsive support can improve health and quality of life, breaking the cycle of emergency admission, delayed discharge, reduced independence and re-admission that many frail older people experience. Early results from parts of the country that have started doing this – the health in care home vanguards, including **Sutton Homes of Care** - are seeing slower growth in emergency hospitalisations and less time spent in hospital compared to the rest of the country, with the difference particularly noticeable for people over 75, and meaningful savings from reducing unnecessary prescribing costs[1].

Around 29,000[2] people live in nursing or residential homes in London. Provision varies across boroughs and we know many challenges exist within the care home market. The framework for enhanced health in care homes**,** developed with the six care home vanguards, describes the care and quality, financial and organisational barriers that are, in many parts of the country, holding back the care for people living in care homes or who are at risk of losing their independence. London is no exception. **The framework provides an approach to tackling these issues with a suite of evidence-based interventions, designed to be delivered within and around a care home in a coordinated manner to improve the quality of life, healthcare and planning for residents**.

Enhanced health in care homes, **offering people joined up, coordinated health and care services**, has been identified as **one of eight high impact changes for managing transfers of care[3]**. It is a **measure of progress in improving urgent and emergency care systems** and now a **core part of the assurance process for STPs**.

> **This Forum**:
> 1. **Considered the needs of ageing and frail elderly Londoners living in care homes** and opportunities to improve their health and well-being as a key part of wider health and care transformation plans
> 2. Helped participants to gain a **better understanding of London's care home market** and the issues faced by providers of care and commissioners;
> 3. **Shared examples of innovation and good practice** in enhancing health in care homes, **their impact** and **considered how these initiatives could be progressed at greater scale** across London.

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[1] Next Steps on the NHS Five Year Forward View

[2] Based on CQC registration data from 4 April 2017

[3] High Impact Change Model Managing Transfers of Care

Almost 150 people attended this Forum and contributed to the discussions with real passion and the aspiration to deliver positive, lasting change that makes a real difference to people. We would like to thank everyone who participated and particularly those who shared experiences and learning. **We would especially like to thank Suzanne Peppitt**, who started the meeting by sharing her, and her mother's, experiences of moving to and living in a care home. Suzanne's candid reflections, perspectives and advice on what can make a difference perfectly set the context for the meeting and also provided real optimism about what could be achieved.

The enhancing heath in care homes framework sets out a care model which has seven main elements (four clinical and three enabling elements) **and eighteen sub-elements** (ten clinical and eight enabling), defined as core or enhanced. All but one of the clinical elements are core. **Learning indicates that most can be implemented in less than 12 months.** Examples of innovation and good practice shared at the Forum illustrated how different elements can be delivered and the impact and learning from experience of doing so.

This report highlights key points from the Forum, including views from participants on the opportunities to enhance health in care homes in their respective STP geographies and what support would help them most to do this. It also aims to promote examples shared, the learning, resources and includes contact details of colleagues involved in developing and delivering them. We know that other initiatives are taking place in London as well as those we considered and that other resources and sources of support are available to support improvement, for example through national programmes. Additional information and links to resources are included at the end of the report.

Reflections and recommendations

1. There is **significant evidence that supporting older people who live in care homes to maintain and improve their health and well-being will enhance their quality of life and independence and bring benefits to the health and care system**, in particular reducing hospitalisation.

2. There is **also increasing evidence about models of care that will deliver these benefits**, including many examples in London. **The focus now should be spreading and adopting initiatives that have been proven to work**, adapted to a local context as necessary. **Using the self-assessment tool** developed through the care home vanguards' programme **to benchmark against the enhancing health in care homes framework** and inform priorities for action is encouraged.

3. The Forum encountered **real enthusiasm amongst health and care professionals to work together** to develop and implement changes. We need to **listen to people who live in care homes and their families** about what makes a difference (for example, how can we respond to the challenges set on page 4?). The **importance of clear leadership**, and seeing **care homes as part of the overall care system**, were also highlighted. **Good examples of engagement that bring the health, social care and care home sectors together exist.**

4. **STPs offer a significant opportunity** through collaborative place based approaches **to embed care homes into local systems and communities as a lever to respond to some of the opportunities and challenges** that were **highlighted at this meeting** e.g. training and education, recruitment and retention, developing community assets, increasing respect between generations.

5. **STP Leads should consider how the issues that participants identified as the most important to address** to support development of out of hospital care **could be tackled in their STP areas.** The **need to develop strategies alongside those for domiciliary care** is strongly emphasised. **STP Leads should look at barriers to adoption of good practice and consider options for responding** to these.

6. The **Care Closer to Home programme should consider participants' feedback** about opportunities and enablers, promoting and adopting innovation and support that would add most value **in shaping the programme's content.**

Enhancing health in London's care homes

This meeting was chaired Professor Oliver Shanley OBE, Regional Chief Nurse, NHS England and NHS Improvement (London Region) who opened the meeting by setting out the aims of this Forum and how it will support improvement across London.

We would like to start this report, however, by setting out key themes from Suzanne Peppitt's talk to the Forum.

Making care homes a new beginning: a relative's perspective

Suzanne talked about her mother's journey from living in her own home to living in a care home, sharing their experiences and her own perspective. Suzanne noted that care homes are often invisible within communities, out of sight and out of mind for many people unless something goes wrong. Yet care homes provide a vital service. Whilst many of us may not want to live in a care home (confirmed by few hands showing when Suzanne asked the question of the Forum) it is likely that many of us will.

Suzanne reflected on the difficulties, and emotions involved in finding and choosing a care home – what information is available? How do you know what is right for your family member? How will they adapt to the change? Will they be well looked after and safe? Will all of their needs be recognised and met? Will they be happy? Does going into a care home mean we have failed them?

Moving into a care home means saying goodbye to many things, including independence and being in a familiar environment. However, Suzanne reflected it can also be a new start for people and for their relatives, involving many "hellos" as well as "goodbyes" and shared some examples of positive experiences – on hand care and attention reducing pressure ulcers within a few months; reassurance from a safer environment with needs better met, including mental health; reduced calls to the ambulance service; reduced need for hospitalisation.

Suzanne talked about caring staff in care homes, the skills they have and can develop with support – which are often overlooked; she reflected on the need to make caring roles more valued as a career option, the need to tackle negative perceptions that may exist within communities, including perceptions that young people often have of older people and the benefits that can accrue to both when they spend time together.

Suzanne spoke positively about her experience of working with the Sutton Homes of Care Vanguard, including the development of "the red bag" (hospital transfer pathway) and the assurance this gives in knowing that all necessary information and support (e.g. including glasses) will be readily available in the event that her mother needs to go to hospital.

Suzanne **challenged us all to do five things as we develop plans to enhance health in care homes**:

- Acknowledge the skills of staff in nursing and residential homes, build on these and raise their profile e.g. upskill to administer intravenous medicines to reduce the need for hospital admissions;
- Develop peer support and value diversity, for example ensuring people with dementia are part of same community as those without, as an inclusive community benefits both groups;
- Give people living in care homes access to open air, which provides important health benefits. Some residents can spend weeks and months without going out. Suzanne recommended a goal of accompanied access to the outdoors for 20 minutes every fortnight (noting that prison inmates should expect to spend at least 30 minutes in the open air each day) – surely we can do better than that?
- Meet residents' spiritual needs - some care homes do not have access to, or work with, all faith groups;
- Provide the same level of dental care and access to people living in care homes as people who live in their own home.

Enhancing health in London's care homes

Key points from **Professor Oliver Shanley's** introduction are:

- We have an increasing older population. Helping people to stay at home longer and get home quicker following admission to hospital is a high priority for us all. In London in 2016 around one third of delayed discharges were attributed to waiting for nursing and residential care. The London Ambulance Service can respond to up to 4,000 incidents in care homes per month.

- People who live in nursing and residential homes should receive the same high quality health care as everyone else. Outcomes for individuals, and health and care systems, improve when the right care and support is put in place. The National Vanguards have a series of tools to support us and we have a number of examples of good practice in London, including the Sutton Vanguards model.

- **The Association of Directors of Adult Social Services (ADASS), NHS England (London) and the Healthy London Partnership have launched a Care Closer to Home programme**. Building on work already underway, it is working across the health and social care system to achieve the outcomes set out in the *Next Steps for the NHS Five Year Forward View*, particularly in the key areas of Hospital to Home (**including enhancing health in care homes**). It has three work streams:

  1. Once for London: doing things at a pan London level that support all areas
  2. Bespoke local support: working with local areas – in the way that works best for them – to support their progress and activities
  3. Bringing together the range of national improvement resources so that local systems and local EHCH leaders can identify and use the "offers" that fit their needs most effectively

For further information contact: carecloser2home@nhs.net

London's Care Home Market: an overview

Aileen Buckton, Executive Director for Community Services, Community Services Directorate, London Borough of Lewisham & London ADASS Branch Chair, gave an overview of London's care home market (click here for presentation slides). Key points that Aileen made include:

Commissioning is a demanding role, requiring skill, understanding and compassion. It can be extremely challenging. Over the years, the Local Authority role has developed from provider of care and support to more of a shaper of the market, increasingly in partnership with Clinical Commissioning Groups (noting greater evidence of good joint working) and where many people organise and purchase their own care and support.

Being a provider in the care home market is also a difficult job in a challenging environment. Provision varies across London with more care homes in outer than inner London. We need to take a London-wide view when considering costs and availability. CQC ratings show there is some very good practice in London's nursing and residential homes. More nursing homes are rated "requires improvement" indicating where we need to focus.

There are more nursing than residential home beds across London (over 20,000 and 16,000 respectively[2]) which differs from the picture across England as a whole. There has been a steady decline in residential homes across London since 2010 and some decline in nursing homes in the last two years; since 2015 residential beds and nursing home beds have decreased by 2% and 4%, with greater changes seen in some boroughs. Reasons are mixed: residents' choice; some had to close, some chose to close. Since 2010, the greatest increase in the provider market has been in the number of domiciliary care agencies (70%) and whilst this Forum has specifically focused on the care home sector, we must acknowledge that provision of care in people's homes is an essential part of care provision that also needs attention – ADASS is leading work in this area.

In terms of staffing, the care market workforce is primarily non health however health always needs to be considered and it is essential we take a holistic view to support people's overall health and wellbeing, to maintain health as far as possible for as long as possible. The workforce is large (170,000) however is also transient (almost 40% started in the last year); vacancies average 10% which can be difficult to manage in small organisations. The sector finds it difficult to attract younger staff – the average age of staff is 44 years.

Key challenges are: variation in primary care provision to homes; variation in the community health offer; understanding and tackling variations in quality that exist; ensuring effective information sharing to lever improvements and tackle poor care.

New Care Models: learning from the care home vanguards

William Roberts, National Lead for Enhanced Care in Care Homes, New Care Models Programme, NHS England, shared learning from the six care home vanguards discussed the Enhanced health in care home framework and resources available to support implementation (click here for presentation slides). Key points that William highlighted are:

The New Care Models programme involving 5 new models of care and 50 vanguards started three years ago to enable delivery of the NHS Five Year Forward View, supporting people to live longer, healthier lives, shifting focus from treatment to prevention, increasing sustainability and effectiveness of health care. The Enhanced Health in Care Homes (EHCH) programme involves six vanguards, including Sutton Homes of Care.

Historically, change programmes have not led to widespread adoption of changes proven to be affective. The real difference with the EHCH vanguards is taking a system wide approach, through locally led change supported by, not led by, the centre i.e. joining up care across a place and population.

This is not about single intervention – it is about doing things in a coordinated manner. Where the model has been implemented most comprehensively vanguards have seen a reduction emergency hospital admissions and ambulance call outs; achieved savings on medicines; reduced oral nutrition support and benefit of people avoiding poor experience. **Benefits can be delivered within 6-18 months**.

The framework for enhanced health in care homes is based on the common coordinated interventions vanguards are delivering. The care model has 7 core elements and 18 sub-elements. The aim is to spread the care model across England over the coming year. Most areas will have some elements in place already. Come together, work together and wrap around care when and where needed; end of life care and dementia care are areas where more support and choice is needed for the care home population

There are three times as many people in care homes beds than hospital beds – we need to see care homes as part of our overall systems. We need to work together with Care Homes; members were encouraged to visit a care home in their area - this will change perceptions, show the capability of staff capability and quality of care that exists, often skewed by media.

Workforce is critical and needs to be planned in a joint way, considering social care and health care together. Elective placements in care homes could help. Supporting people to stay in their own homes will also support the care home sector so it is important to consider domiciliary care too. Learning from the vanguards can be more applied to other areas.

There are a range of resources and support available to help local areas develop the model and apply to a local context including significant opportunities relating to use of data. There are great examples of changes that have had real impact – steal with pride!

Learning from innovation and good practice across London

This session involved sharing examples of innovation and good practice which show how key elements of the enhancing health in care homes framework can be delivered in practice. Through round table discussions participants explore approaches, learning and impact of different initiatives with colleagues involved in developing and delivering them. The aim was to raise awareness of different programmes and services and stimulate thinking about how learning can be applied elsewhere, spreading and adopting innovation. Colleagues who shared their work were asked to summarise key messages that they would like people to take away to share with people who were not able to hear from and speak with them directly.

The Sutton Homes of Care Vanguard

The Vanguard shared the overall programme of work with a focus on 3 elements. Since becoming a Vanguard, partners have seen a **reduction in acute activity, LAS call outs as well an improvement in clinical outcomes** such as achievement of preferred place of death.

Quality and Assurance: Having data to establish the baseline of Care Home activity is vital to measure the success of any interventions. Sutton Vanguard will share options available for gathering data. This includes the Joint Intelligence Group (JIG), set up to enable different agencies working with care homes to quality assure the level of care within each home by sharing information and data on a range of quality indicators, and a Quality Dashboard developed to unify high level data, which is supported by soft intelligence to provide a holistic view and flag concerns and monitor trends. By working together in a collaborative way and sharing data and intelligence, the programme has been able to quality assure the care homes in the borough and maintain a strong focus on quality, performance and safety.

Workforce Education and Training: In order to provide the greatest care for residents, care home staff need to have the right mix of skills and expertise. The Vanguard will share how it has been able to build on earlier work to develop an enhanced package of training opportunities and resources that provide ongoing development for care home staff. This includes resources such as e-learning modules, training courses, posters, films and reference cards as well as co-ordinating care home forums.

The Team will also discuss the Care Home Forum, set up to provide a safe environment for care home managers and staff to discuss any issues and challenges they face. The forum gives care homes the opportunity to network and develop relationships which have continued outside of the meetings. It provides an excellent environment to communicate with our care homes, to share information and provide training on select themes.

Hospital Transfer Pathway aka "the red bag": The Hospital Transfer Pathway is designed to ensure that residents living in Sutton care homes receive safe and effective treatment should they need to go into hospital in an emergency. The pathway supports care homes, the ambulance service and the local hospital to meet the requirements of the forthcoming NICE guidance on transition between inpatient hospital setting and care homes. Discussions with key partners identified gaps in providing the necessary support and care to unwell residents who needed to go into hospital, including access to necessary clinical information for admission and a summary of care on discharge. Poor communication channels made it difficult for care staff to talk to each other, often leading to residents remaining in hospital longer than they needed to.

Feedback so far has been hugely positive, and relationships and channels of communication between care home staff and local hospitals have improved significantly. An initial review has shown a reduction in hospital stay for residents using the red bag.

Key messages:

1. Invest time and energy in building relationships - good engagement and great relationships underpin the work that has been successfully achieved in our programme

2. Do with not to - Make sure the care homes are with you every step of the way, involve the residents, families and staff

3. Spend time getting an accurate baseline and way of measuring your impact.

Viccie Nelson, Programme Director
Christine Hanger, Quality Assurance Lead
Jo Carr, Darzi Fellow

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Further information: [Quality and Assurance](#), [Workforce Education and Training](#); [Hospital Transfer Pathway](#)
(the red bag). A wealth of information and resources are available via the Vanguard's [website](#) pages
(including videos shared at the Forum).

Health Innovation Network - Supporting spread and adoption across the south London care home sector

Health Innovation Network (HIN), the Academic Health Science Network for South London, has developed strong links with the care home sector and health and social care professionals that support it. South London has over 350 older people homes with 12,700 beds, spread across 12 boroughs. We share good practice and learning through regular care home forum events, newsletters and care home leads meetings. Strong engagement with the sector encourages successful piloting of interventions such as DeAR-GP, Barbara's Story Dementia Awareness training and the person-centred life story resource Music Mirrors.

Since 2016 the HIN has supported Sutton Homes of Care Vanguard with the spread of the Red Bag Hospital Transfer Pathway across six South London Boroughs, offering tailored facilitation and implementation support to CCGs, hospitals and care homes.

Key messages:

1. Engage with your care homes. Provide a safe space for them to share learning, ideas and challenges and for peer to peer networking at Manager only forums, without representatives from the CCGs or Local Authority. Visit them face to face and pick up the phone to build relationships and trust.

2. If asking for care homes to change the way they work, ensure your intervention is evidence based, reflects their priorities or addresses issues / problems experienced e.g. staff training, delivery of care or working with health and social care providers.   Involve care homes from the beginning to ensure buy-in and give staff the opportunity to contribute to the design and implementation processes of the intervention.

Contact: Rebecca Jarvis, Programme Director (Alcohol, Healthy Ageing and Patient Experience), Health Innovation Network rebecca.jarvis4@nhs.net

Further information: [Overview of the HIN's work in residential and nursing homes](#); [Care Home Network and adoption and spread](#); www.hin-southlondon.org

Health 1000: The Wellness Practice – Is enhanced primary care for nursing homes in Havering effective?

Health 1000: The Wellness Practice provides focused, coordinated care for patients living with multiple long term conditions. It is a primary care practice, providing joined up health and social care services to the 1000 highest end users of services locally ensuring a 'one-stop-practice' for people with complex health needs (defined as having five or more of long-term conditions including: coronary heart disease; high blood pressure; heart failure; stroke or mini stroke; diabetes; COPD; depression; dementia. The model of care is drawn from best practice in the UK, USA and Europe - adapted for the people of North East London. It has a dedicated multidisciplinary team who work with patients/carers to co-design their own care programme. It is being run as a pilot for two years and is being evaluated for clinical effectiveness, patient experience and value for money.

The Practice evolved to support four nursing homes with up to around 180 residents in total. The service includes a named GP for each home who undertakes a weekly review visit supported by monthly visits and specialist support from a consultant geriatrician already embedded in the Practice. Other routine primary care and out of hours is provided by the Practice as for all our other patients (8am to 8pm) seven days a week. Development and support around prescribing, inter-current illness and managing end of life have been particularly valuable. Full evaluation is being undertaken by the Nuffield and preliminary results show significant reductions in acute admissions with qualitative evaluation also underway.

Key messages:

1. Practice infrastructure including remote access to the GP system and an ability to prescribe electronically are essentials enablers
2. An interested workforce with an MDT approach; specialist support needs to be embedded in a practice
3. The out of hours service and support needs to be fully integrated

Contact: Dr Mike Gill, Medical Director: michael.gill1@nhs.net
Further information: Overview; www.health1000practice.nhs.uk

Integrated Urgent Care (IUC) Pilots: Fast access to GP via *lines for health care professionals

The IUC Pilots have been contributing to the care home admission avoidance agenda by providing "fast access to a GP" for LAS crews, Care Homes and Rapid Response Teams to support appropriate management of care to avoid conveyance and reduce 999 calls. On January 23rd 2017 new telephony routing (Dial 111 press *5, *6 & *7) capability went live to enable this.

The team took colleagues through an overview of the *lines looking at the data and demand to date, some case studies to bring to life how the model operates in practice and then considered some of the initial outcome data on the impact these pilots have had.

Key messages:
1. Care home staff now have direct access to a GP through the 111 service by dialling 111 *6
2. This has seen better patient care and experiences as these frail patients do not unnecessarily attend A&E
3. There has been a positive impact on the urgent and emergency care system with higher number of cases are being closed after a discussion between the health care professional/ carer and the GP and lower ambulance and emergency department referral numbers for *line calls to the GP
4. Video conferencing pilots have also complemented this – allowing GPs to avoid home visits whilst being able to interact and observe the patient.

Contact: Eileen Sutton, Head of Urgent and Emergency Care Programme (111 and Integrated Urgent Care) Healthy London Partnership, Head of Integrated Urgent Care NHS England London Region
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Further information: IUC Pilot overview and learning; Healthy London Partnership

Argyle Surgery, Ealing – a proactive multidisciplinary team approach to intensive management of nursing home patients - outcomes and learning – four years on

The Argyle Surgery, Ealing has developed a Multi-disciplinary team approach to the management of nursing home care. Based in a single GP surgery, the Argyle Care Hope Service utilises a proactive, regular, timely, GP led, clinical approach. Pharmacists and a full pharmacy team manage medicine review, usage and prescribing. The service was commissioned by Ealing CCG in 2013. The skill mix development and utilisation of different professionals' capacity has been a key factor in our success. Our service operates 8am-8pm / 365 days a year.

We have 900 nursing home beds and have demonstrated outcomes around 20% reduction in admissions, 35% reduction in inappropriate A&E attendances, 40% reductions in end of life admissions, 60% reductions in use of antipsychotics in dementia, 11% reductions in medication prescribed, more recently we have data around reductions in mortality/morbidity resulting from timely anti-viral use in flu outbreaks.

Key messages:

1. Care home residents need regular weekly visits from their named healthcare professionals to ensure continuity of proactive care.
2. A strong multidisciplinary team where all members are empowered to work to the top of their license releases capacity for face to face time with patients and keeps the team motivated
3. Consistency of delivery 8am-8pm/365 days a year builds trust and cooperative working between homes, surgery and pharmacy for the benefit of residents, reducing admissions and improving care

Contact: Dr Graham Stretch, Pharmacist GrahamStretch@NHS.net
Further information: The Argyle Care Home Service; infographic

Reaching out to implement an end-of-life care programme in care homes

The global population is changing and care provision needs to match this. Currently the UK has three times the number of beds in care homes than in the NHS. Amongst the 460,000 people who live in care homes are twenty per-cent of the UK population aged 85yrs and older. Perhaps not surprisingly, then care homes currently provide care for a fifth of the UK population who die each year. This role is highlighted particularly within nursing care homes where 19% die within a month of admission, 34% within 3 months and 56% within a year of admission. With the global population not only increasing in size but age addressing care provision, including care provision at the end of life in care homes is now core. In 2008 the Department of Health highlighted the importance of providing quality end of life care across all settings. However, many care homes are private businesses and are not part of the National Health Service. They have traditionally been seen as insular private companies that are in competition with other local care homes. The literature reports that care home managers feel isolated from the wider social and healthcare system. This means that whilst they are part of a wider system, they may have limited relationships between themselves and the other constituent parts of the system. With ever increasing numbers of residents dying in care homes, which have no requirement for mandatory end of life care training, there is a need for external services to reach out to support them.

The Care Home Project Team was established at St Christopher's Hospice 2008 in response to this. The research based model the team developed to support care homes to implement and then sustain cost effective end of life care/palliative care programmes in practice is shared. You will hear how this has been achieved within the 150 care homes (nursing, residential and learning disability) that the Care Home Project Team currently supports. They have learnt that implementing, and then more importantly sustaining, a formal end of life care/palliative care programme is essential. It empowers the care home staff enabling them to deliver high quality care to those both living and dying in these care homes. Audit data has been collected since 2008 with measurable improvements in outcomes including place of death. An on-going demonstrable improvement in practice has resulted in the commissioners across five CCGs continuing to fund the team and thus the ability to provide a sustainability initiative. Relationship building has been central to the success of implementing and sustaining such a programme. Key learning was shared and recommendations for adoption and wider implementation.

Key messages:

1. Implementing a formal end of life care/palliative care programme is essential. It provides a framework that both structures care delivery and empowers and enables the care home staff to deliver high quality care to those both living and dying in these care homes. Care homes have either implemented the Steps to Success Programme http://www.stchristophers.org.uk/steps or the Gold Standards Programme in Care Homes http://www.stchristophers.org.uk/care-homes/nursing-care-homes The staff in care homes need facilitated support to do this.

2. Regardless of the programme implemented in order for it to remain embedded in practice a sustainability programme is essential http://www.stchristophers.org.uk/care-homes/sustainability-initiative The collection of outcome data has been essential. An on-going demonstrable improvement in practice has resulted in commissioners across five CCGs continuing to fund the team and thus the ability to provide a sustainability initiative for nine years. Such support is cost effective.

3. Relationship building is key. It has been central to the success of implementing and sustaining these programmes. The Care Home Project Team has acted as a bridge between the care home and their supporting commissioners and external health care professionals. The relationship between the GP and the care home is vital and is enabled when one GP practice works closely with a care home

Contact: Julie Kinley, Nurse Consultant for Care Homes, St Christopher's J.Kinley@stchristophers.org.uk
Further information: please see supporting references overleaf:

Kinley J., Stone L., Butt A., Kenyon., Santos Lopes N. (2017) Developing, implementing and sustaining an end-of-life care programme in residential care homes. International Journal of Palliative Nursing 23(4), 186-193.

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Kinley J., Froggatt K. and Bennett M. (2013) The effect of policy on end-of-life care practice within nursing care homes: A systematic review. Palliative Medicine 27(3), 209-220.

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Supporting care home staff to meet the needs of people with behavioural and psychological symptoms of dementia

Around one third of people with dementia in the UK live in care homes. Behavioural and psychological symptoms are almost universal in dementia. The neuropsychiatric/ medical model has been of very limited value in helping carers of people with dementia look after those who have distressed or distressing behaviour such as shouting, verbal and physical aggression, and agitation. Antipsychotic drugs are usually ineffective, and cause stroke and sudden death in people with dementia, and sedatives increase the risk of sedation and falls.

There is now an increasing evidence base for non-pharmacological and "whole home" interventions in care homes to support staff who look after residents with dementia. This will be an opportunity to discuss some pragmatic models of dementia service delivery to care homes to support safe prescribing and help staff better understand the causes of residents' distress, thereby informing person centred, individualised care planning.

Key messages:

1. Behavioural and psychological symptoms in dementia are communicating an unmet need

2. Psychiatric drugs are rarely helpful in treating these symptoms

3. Management of these symptoms in care homes involves careful life history work, observation, and talking to person with dementia and care staff, to understand the unmet need(s) being communicated and developing in an individualised care plan to address that need

4. Work with care home staff to develop these approaches in the home -talking about real residents- are likely to be successful than more traditional classroom based "training".

Contact: Dr Dan Harwood, Clinical Director, London Dementia Network and Consultant Psychiatrist and Clinical Director, South London and Maudsley NHS Foundation Trust Daniel.Harwood@slam.nhs.uk

Further information: Supporting care homes to look after people with dementia and behavioural and psychological symptoms; care pathway checklist

Mouth Care Matters – improving the oral health and general health of older adults

Imagine you have just arrived at your summer holiday destination for a fortnight and have forgotten to pack a tooth brush, would you?

1) Not worry about it as you would brush your teeth again when you got back home
2) Find somewhere to buy a tooth brush as soon as possible.

Nearly all of us would choose option two, so why then when people are admitted to a care home can they often spend weeks without having any mouth care or being asked whether they have experiencing any problems with their mouth?

Mouth care is an essential part of personal care but an area of care often neglected in care homes. The aim of Mouth Care Matters is to educate health care professionals about the importance of identifying when people need support with their mouth care and training staff so that they have the skills to provide it. Good oral health allows people to eat, speak, smile and socialise without discomfort or embarrassment. Poor oral health can lead to deterioration in general health, leading to increasing frailty and poor quality of life and dignity. Evidence shows the links between health and general health including diabetes and cardiovascular disease and respiratory infections. Every individual deserves the right to good oral care, it is an essential part of general health and maintains a person's dignity.

Key messages:

1. Every older person deserves the right to good oral health, oral health is an important part of general health, wellbeing and dignity.

2. Care home managers should ensure that every resident has an oral health care plan on admission and is registered with a dentist.

3. All staff looking after older adults must have mouth care training so that they are empowered with the skills and knowledge to provide effective mouthcare

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Further information: Mouth Care Matters - overview
http://www.mouthcarematters.hee.nhs.uk

Why good sensory health improves quality of life and independence of older adults?

Access to good sensory health is key in ensuring a good quality of life. We often overlook the vital role of our senses play in ensuring both good physical and mental health. Vision, hearing and balance, taste, smell and touch are not only part of the bodies warning systems but are what keeps us social beings. As we get older it is common for our senses to become less acute. This can lead to and contribute to social isolation, poor balance, loss of confidence, anxiety and depression, affecting both our physical and mental health. Good sensory health is often forgotten about but is the missing link to ensure good mental and physical health.

Although it can affect anyone at any time, losing our sight becomes increasingly likely as we get older. It is estimated that over half of older residents in care homes are living with some form of undetected sight loss – much of which could be prevented or corrected. Poor vision can have a significant impact on health and quality of life for the individual. As well as potential complications of the eye condition itself, it can increase the risk of falls, contribute to depression and isolation. However, sight loss similar to majority of sensory loss is often a hidden issue. People with sight loss may not recognise it themselves; it is often thought an inevitable part of ageing, but with a little investment many of the issues can potentially be remedied.

Key messages:

1. Ensuring good sensory health is the missing link to ensuring good mental and physical health; early detection of sensory impairment will ensure the impact on care home residents' general health and well-being is identified and addressed, improving quality of life and helping to prevent comorbidities.

2. Raising awareness of sensory impairment issues amongst families, residents and staff is important as need is generally underestimated.

3. A whole systems approach is needed to maintain vision, hearing, balance and other senses and services are ripe for delivering in a more collaborative way; there is an appetite for developing good sensory health as a work stream across all sectors of the system.

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Further information: What Works: Hearing loss and healthy ageing; Commissioning services for people with hearing loss; Eye health needs for older adults;

The Senate Forum identified several issues as important in taking forward and supporting delivery of local plans

Having listened to a relative's perspective, learnt more about London's care home market, heard about progress and impact of the care home vanguards and explored examples of good practice in delivering elements of the enhanced health in care homes framework, in the last session of this Forum we asked participants to come together in their respective STP areas and consider three things:

- The greatest opportunities for enhancing health in care homes
- Key themes of change or innovation that should be adopted more widely
- Support that would help most in developing and implementing local plans and addressing any challenges identified

Every STP area was represented, though there were more participants from some areas than others e.g. more participants from south London than north London geographies. Participants with pan-London roles selected which of the five STP groups to join. Each discussion group had a facilitator and groups were asked to record key points. Detail as recorded for each STP area is included in the appendix. Several common issues emerged. The main themes from the feedback received are noted below (these are not in any order of priority).

The greatest opportunities for enhancing health in care homes

- Improving **end of life care** through a multidisciplinary approach, building relationships, training and supporting staff
- Increasing the focus on **mouth care** (including access to dental services) and **sensory health**
- More **systematic review of medicines** in a multi-disciplinary model
- **Improving the collection, sharing, analysis and use of data and intelligence** to e.g. identify needs, plan and implement change, identify care home residents within the health system and monitor impact of initiatives and interventions (several approaches were identified as good examples)
- Understand where care homes are on their development journey, **establishing a baseline of existing practice** to help identify priorities to focus on and determine where support would help most (recognising starting points will be different within and between boroughs); a stocktake against the enhancing health in care homes framework using the assessment tool developed through by the vanguard programme
- Embed care homes into local strategies – **see care homes more as part of the overall system of care**; though the importance of also focusing on domiciliary care was emphasised
- Several references were made to the **Sutton Homes of Care hospital transfer pathway** (the red bag) and the potential for this to be rolled out more widely given the experience and impact to date (one table advocated rollout across London)
- **Enhancing skills and knowledge of care home staff** through education, training and development programmes; related to this was a general theme and several suggestions to improve recruitment and retention of care home staff **and raise the profile of and support for care homes within communities**, including community engagement and development
- **Engagement with care home providers**, managers and staff e.g. the South London Forum;

Key themes of change or innovation that should be adopted more widely

- **Joint intelligence, information sharing** and **use of technology** to enable a more effective, integrated and unified approach
- **Education and training** (across the system)
- Promoting a **person centred approach** for delivering care and enhancing health
- **Stimulate the ambition of staff** to deliver change and improvements, **facilitate collaboration** and **create collective ownership** and shared responsibility for doing so
- **Engagement and awareness raising within local communities**, including schools, about care homes, ageing, inclusion and supporting older citizens, enabling social prescribing and community involvement
- Improve **consistency of care planning** (inconsistency in care plan formats is a challenge currently); work with larger care home providers and across commissioners to achieve greater standardisation
- Improve **consistency of processes** across STPs (and London) e.g. wide scale adoption of the red bag – evaluate, learn, share and adopt – eliminate the tendency to keep piloting and re-inventing

Support that would help most in developing and implementing local plans and addressing any challenges identified

- **Business case development**/case for change where investment is needed
- **Recruitment and retention** of staff, workforce development
- **Promote opportunities of the care home sector as part of system**, as places to work, as places to support – media campaign, links with schools, education placements, links with professional bodies
- **QI methodology** to support improved care
- Applying and maximising use from technology
- Developing shared resources, **governance and leadership** across STP geographies,
- Promoting **parity of esteem for older people**, parity of esteem for staff
- **Approaches to strengthen relationships** i.e. working with **care home providers**, especially larger ones, on strategies for change and engaging **care home managers and staff** to develop plans and deliver change together

Other programme and resources to support enhancing health in care homes

London Urgent and Emergency Care Improvement Collaborative

The Collaborative was launched on 4 July 2017 – please click here to learn more and access presentations from the launch event. For further information, please contact carecloser2home@nhs.net

Hospital to Home Team - National Directorate of NHS Operations and Delivery

NHS England has published a series of **quick guides to support local health and care systems transform urgent and emergency care services.** The guides provide practical tips, case studies and links to useful documents, which can be used to implement solutions to commonly experienced issues. Click here for the guides.

The **Enhanced Health in Care Homes programme workspace on the FutureNHS platform also provides numerous resources**, aligned to the enhancing health in care homes framework that are free to access. Please contact Zohara Ali, Project Manager – Enhanced Health in Care Homes Programme in the New Care Models team (zohara.ali@nhs.net) for access.

London Clinical Senate
July 2017
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Developing and supporting local plans to enhance health in care homes through STPs: Detail recorded for each STP area.

South West London

The greatest opportunities for enhancing health in care homes
- Baseline data at place based level (IG toolkit) for care homes e.g. CMC and NHS mail blocked – enabled by a pan-London landscape map of basic information about homes   - Take vanguard learning from hospital transfer – pathway across SWL (red bag) (- see below - information transfer timely and effectively)   - Weave in local strategies – actually show these to STP leaders (?stop waiting for STP leadership when local priorities already agreed– opportunity now – STPs stalling things?. perinatal, msk, alcohol, public health – enabled by a standard specification and linking strategies at ? level > identify the workstreams – need a flag for patients in care homes; whenever a practice sees a care home patient they are recorded, agree a common record   - Key early interventions as mentioned in the morning e.g. dental care – try to achieve parity   - Bust myths to access/entitlement   - Identify and respond to equipment failing, a challenge in domiciliary care; outreach from location to delivery   - How do you engage with care homes   - Care home forum into STP including health and social care   - Challenging behaviour team – enabled by framework/models

Key themes of change or innovation that should be adopted more widely
- Information transfer timely and effectively (red bag - see above)   - Multidisciplinary training   - Aspiration – stimulation   - Person centred approach   - Support care home staff in training, reflective practice and supervision and support ??? and commissioned; who is responsible? Create collective responsibility   - Medical model with one service for GP and pharmacy   - Move from pharmacist to assist in medicines; multi-skilled staff e.g. OT/PT role in medicine   - Workforce training and education   - Cumulative effectiveness if people collaborate - model about people, end of life care, dementia

Support that would help most in developing and implementing local plans and addressing any challenges identified
"Debunking" myths – facts and information   - Using local schools – introducing them to care homes; students linking with education; volunteering (link with schools)   - Media campaign   - Professional bodies – PT/OT etc.   - Part of nursing training   - Breaking of silos   - Tackle the "new taboo" – care of the elderly, discrimination of older people   - Mum test; workforce system –shape and influence through commissioning; CQC pretty good overall; reduce care home beds, increase domiciliary care

South East London

The greatest opportunities for enhancing health in care homes
- Better end of life care in care homes – training and support enabled by commissioning training packages and different approaches – personalise to care of individual patients/residents   - Share different approaches and intelligence across a wider area /between organisations/sectors – enabled by implementing Sutton information governance approach   - SEL leadership and better communication about work being done to make a difference for people living in care homes across SEL   - Making care homes a more attractive/appealing place to work and what they offer   - Single data set/performance to drive joint working – Sutton approaches to data and dashboards; outcome board – Croydon and Richmond approaches also highlighted   - Pharmacy and GP input – there is an opportunity to spread the model across boroughs   - Different baseline situation in different boroughs needs to be recognised e.g. what exists/practice in place; number of care homes/beds/prioritising actions; resources available   - Working differently with what we have already, given the limited resource e.g. more strategic, joined up work to develop more coherent pathways and a sustainable model across CCGs/boroughs to manage resources effectively   - Key worker housing to support the workforce. Public and voluntary engagement, tapping into wider community resources and increasing co-production   - There is a hidden community of self-funders, of differing sizes in differing boroughs e.g. Approx. 80% Bromley and 20% Lewisham. There is felt to be an unmet need for social care advice and support for this group. Use the health lens to join interventions together, while recognising that there will be different contexts in different boroughs.   - Even out support to care homes and domiciliary care providers. Work across the STP footprint   - Look into supported carers as an option enabled by co-production
Key themes of change or innovation that should be adopted more widely
- Enhancing health in care homes   - Being clear what we are measuring and reporting   - Reduce variation (reduce data collection)   - Red bag schemes should be used everywhere - opportunity for pharmacy to get to understand needs beyond medication through personalisation of the red bags and what is in them   - Care plans – opportunity to work with care homes – could be a national piece of work with the big providers – as well as an opportunity to do something across South East London. Enables consistency of care – a current challenge is that some care providers have standardised care plans in different formats
Support that would help most in developing and implementing local plans and addressing any challenges identified
What is the South East London Strategy?   - Work across South East London to agree actions and establish a plan   - Tackle parent companies of care home changes care to tailor plans on a SE level   - Needs a coordinated piece of work and provider forums and all 6 CCGs   - Develop networks   - Training and quality – join up better   - Co-produce a series of patient led workshops   - Join up better and work across the patch to manage   - There is a workforce development opportunity – Sutton have evidenced reduced turnover with improved career progression and opportunities   - Principles – it's not just about training, it's about thinking differently   - Consistency of approach e.g. Regionally led red bag scheme   - IT – shared access, including out of hours

North West London

The greatest opportunities for enhancing health in care homes
- Education and training   - Health and local authority working together with joint agenda e.g. social workers   - De-stigmatise institutional care - broader than joint commissioning – more integrated society enabled by engagement and interaction with local authority, citizens etc.   - Undergraduate dentist in care homes (sharing opportunities earlier e.g. Brighton model   - More in-reach for care homes – enabled by contracting   - Good sensory health – hearing/sight/oral – better quality of life   - Culture – well-being, how care homes can be part of the local community   - Pathways – end of life, falls, dementia – proactive care   - Think through how we support residents in care homes around primary care (GPs are busy)
Key themes of change or innovation that should be adopted more widely
- Everybody spending time in care homes to broaden understanding – so that everyone in the system has a first-hand experience   - Technology (unified approach) – higher quality care; better time management; shared care record; more joined up and end to end   - Societal change about care and experience of older people – social inclusion
Support that would help most in developing and implementing local plans and addressing any challenges identified
- Financial   - Contractual   - Champions/leaders   - Being clear on "what's in it for me?"   - Concentrated effort on tech with nursing homes   - Training and education   - Leadership   - Make sure we engage care homes in this – managers and staff

North Central London

The greatest opportunities for enhancing health in care homes
- Good oral care – enabled by cross-borough collaboration on commissioning   - Education – FE colleges and apprenticeships – enabled by contractual mechanisms   - Measure – flag care residents with NHS number enabled by education of care workers   - Developing links with a dental practice   - Preventing unnecessary admission to hospital – urine testing as a predictor of hospital admission   - Formal end of life care programme
Key themes of change or innovation that should be adopted more widely
- Joint intelligence   - Link commissioning and share governance – single commissioning manager, "real joint working"   - Awareness in schools – primary and secondary – about ageing as a normal part of life   - Community development and linking up with the voluntary sector   - Social prescribing and community service ideas
Support that would help most in developing and implementing local plans and addressing any challenges identified
- Cultural awareness and sensitivity for diverse populations   - Technology – N3 network/NHS net access   - Shared resource and governance across the STP   - Recognise the hard work of care home staff – parity of esteem for older people; parity of esteem for care home staff

North East London

The greatest opportunities for enhancing health in care homes
- Improving end of life care – enabled by enhanced GP support, hospice/Macmillan relationship building   - Symptomatic prescribing – enabled by time, pharmacist, discussion with relatives   - Use of quality improvement (QI) methodology   - Release time to care, documentation and workload associated is inhibiting time to care – enabled by inspection regime being lighter touch   - Stock take of nursing homes and their stage of development to establish a baseline
Key themes of change or innovation that should be adopted more widely
No specific themes recorded
Support that would help most in developing and implementing local plans and addressing any challenges identified
- Business case for investment in enhancing primary care as this may need pump priming   - Recruitment and retention of staff who are interested and committed   - Identify and focus on homes most in need of support   - Use QI methodology to improve care   - Integrated joint health and social care including quality surveillance groups   - Good engagement - who are the stakeholders   - Sustainability/consistent – no more pilots   - Needs to be meaningful/owned at a local level   - Quality assurance of borough placements appears to be inefficient at every level