NHS North Staffordshire & Stoke-on-Trent Clinical Commissioning Groups Care Homes Strategy 2015 – 2017

Quality care, best value, better outcomes

NHS North Staffordshire Clinical Commissioning Group

Putting patients first

NHS Stoke-on-Trent Clinical Commissioning Group

Contents

Version Number	Reviewed by	Comments
10	Nicola Bucknall, Commissioning Manager	Changes made following comments from Quality committee and frail complex steering group
11	Nicola Bucknall, Commissioning Manager	Changes made following comments from Council
12	Nicola Bucknall, Commissioning Manager	Engagement feedback included
13	Nicola Bucknall, Commissioning Manager	Exec summary included

Executive Summary

Due to an aging population requiring increasing levels of support in the community, care homes are an important part of the overall structure of the Northern Staffordshire Health Economy. People living in care homes tend to be the most vulnerable in our society with complex physical and mental health needs and a significantly higher risk of harm, hospital admission and death. The issues are varied and complicated due to:

- Multiple care home provider organisations
- Variable support for homes from health and social care organisations
- Regulatory and quality monitoring input from various bodies within healthcare, social services and the local authorities
- A number of separate funding streams to cover the cost of care

Despite these complexities it is essential that the Clinical Commissioning Groups of Northern Staffordshire work with care homes and resident GPs to ensure that the population receive equitable access to services and high quality care.

Examples of good practice exist within Northern Staffordshire yet it is evident that a number of care home residents do not receive equitable access to NHS services or receive regular assessments to ensure that health needs are being met. It is also apparent that fragmentation exists between the traditional domains of the health, social services, Local Authority and the Care Home sector. This fragmentation is a key concern expressed by those accessing and navigating the care home sector as it leads to confusion, duplication and inefficiencies.

Supporting improvements in care homes with an increasing emphasis on anticipatory care including 'step up' interventions such as augmented community beds is likely to reduce the number of emergency admissions into hospital by up to a third as well as increase the quality of life for residents and save more than the cost of the intervention. Such changes need to be considered and delivered in an integrated manner in order to better meet the needs of the population by improving communication, reducing duplication and providing greater efficiencies.

This care home strategy document provides an overview of the current issues and key priority areas for improvement. The document is written in collaboration with Stoke on Trent and Northern Staffordshire CCGs following engagement with the primary care team, care home providers and the Local Authorities. It is anticipated that adherence to the key principles described within this document will drive the required changes.

James Rushton, Clinical Associate Nurse

David Sanzeri, Head of Commissioning

Nicola Bucknall, Commissioning Manager

Amanda Locke, Commissioning Manager

1. Introduction

1.1 The strategy details the vision for the next three years and sets out the priorities for action to achieve high quality care provided by a local care home sector that is sustainable and committed to continuous improvement. In addition the strategy sets out how securing equity for all care home residents in accessing primary care and wider community-based health services will be achieved.

1.2 This strategy sits within the overarching Staffordshire Frail Elderly Care Programme and has been developed by local health economy commissioners. Engagement and involvement has included; GPs, care home providers, social care commissioners, Quality Committees and the Frail Elderly steering group. Both CCGs have identified that a collaborative health and social care strategy is required to ensure high quality services that meet the needs of care home residents are available and being delivered consistently across the local economy.

1.3 This strategy refers to care homes as an umbrella term for residential care settings which can be with qualified nursing care (nursing homes) or without (residential homes). The national definition set out by the Care Quality Commission (CQC) states that:

"A care home is a place where personal care and accommodation are provided together. People may live in the service for short or long periods. For many people, it is their sole place of residence and so it becomes their home, although they do not legally own or rent it. Both the care that people receive and the premises are regulated"

1.4 Both CCGs have an expectation of quality embedded as key guiding principles to drive commissioning intentions, therefore issues related to the quality of care provided are at the forefront of this strategy.

Stoke-on-Trent Clinical Commissioning Group guiding principle:

"Our local population has the right to an affordable, sustainable, improved quality of life whereby every individual is treated with compassion, dignity and respect"

North Staffordshire Clinical Commissioning Group guiding principle:

"Quality care, best value, better outcomes;

1.5 For the purposes of clarity, quality within this document is defined as that set out by NHS England within Vision and Purpose '*High Quality Care for All*[1]'

Diagram 1: High Quality Care for All

1.6 This single common definition of quality encompasses three equally important parts, and recognises that high quality care is only being achieved when all three dimensions are present:

1. Care that is **clinically effective**- not just in the eyes of clinicians but in the eyes of patients themselves;
2. Care that is **safe**; and,
3. Care that provides as positive an **experience** for patients as possible

1.7 This Strategy identifies a number of priorities which will be addressed by a number of high level actions. Local Health Economy (LHE) commissioners will work collaboratively with stakeholders to deliver the actions detailed within this strategy

2. Our Vision

2.1 This Strategy sets out the vision for an agreed approach to commission continuous improvements and compliance in the quality of care homes services for the residents of Northern Staffordshire.

2.2 Our vision is to ensure that:

"Care Home residents within Northern Staffordshire have equitable access to high quality healthcare services, a good experience of care within the care home setting and the respective commissioning groups have a suitable framework to provide assurance that this is the case".

2.3 The strategy outlines a number of high level actions which address a set of key priorities. Our priorities are:

Priority 1:

Develop, support and improve quality of care within care home settings ensuring that the care home sector is able to manage the increasing complexity of residents needs in the future

Priority 2:

Ensure equitable access to healthcare services that are responsive and can meet the holistic needs of this vulnerable group of patients

Priority 3:

Ensure robust quality monitoring and assurance framework for all nursing homes

Priority 4:

Reduce avoidable admissions to hospital and ensure that care home residents have access to safe, high quality care in an environment that is most appropriate

3. National Context

3.1 Nationally, nearly 400,000 people reside in care homes in the UK, almost 20% of those are aged 85 years or over. Their health and social care needs are complex; the majority have some sort of disability, many have dementia, and collectively they have high rates of both necessary and avoidable admissions to hospital[23].

3.2 The care home population is increasing due to the growing number of older people needing care and support, as well as improving survival rates from trauma and other severe physical conditions and disabilities.

3.3 The impact on the future need for care home places is difficult to predict due to uncertain trends in morbidity and disability and the availability of informal carers and preferences for care home use. However in 2011 the British Geriatric Society forecast an increase of up to 150% over the next 50 years[2].

3.4 The increasing population requiring long term care is occurring during a decline in the number of hospital beds for older people leading to increasing medicalisation of care home care with greater levels of dependency amongst residents [4].

3.5 Care for this patient group is variable; nationally there is a clear gap between suggested standards of best practice and actual care delivery. Figures from the British Geriatrics Society show that nationally 68% of care home residents have no regular medical review, 44% have no regular review of medications and just 3% have occupational therapy[2].

3.6 4% of the population aged 65 and over live in care homes, rising to 20% of over 85 year olds in the UK[5].

3.7 Dependency is rising so that the population in residential homes now resembles that only found in nursing homes a few years ago[6]. Considerable overlap in dependency between residential and nursing care was observed in the BGS Quest for Quality report; fewer than half of those in residential care could walk and half were incontinent[2].

3.8 The complex mix of healthcare needs in care home residents is unique to this population. Dementia, stroke, degenerative neurological conditions, advanced cardio-respiratory disease, cancer and painful arthritis are the most common conditions. These are often accompanied by underlying issues concerning loss of appetite or difficulty with eating and drinking, resulting in or exacerbating malnutrition and dehydration.

3.9 Recent data from the Alzheimer's Society also suggests that up to 80% of care home residents have some form of dementia or severe memory problems[7].

3.10 Often residents are admitted to hospital as unplanned emergencies some of which are avoidable. For example, national studies also demonstrate that 50% of residents admitted to hospital who died could have been cared for in their care home with better proactive management[8].

3.11 Admissions into hospital often leads to physiological and cognitive decline for care home residents, reduced quality of life and are costly to the LHE. Poor quality care often results in a higher number of unplanned admissions for patients in care homes. Therefore there is an increasing requirement both nationally and locally to account for the quality and equity of care received in care homes, which is currently of a significant varying degree.

3.12 Care homes contain a proportionally high number of individuals who may be classified as vulnerable as they may be at risk of harm or exploitation due to underlying illness and disease. Therefore it is imperative that care homes are closely monitored and appropriate mechanisms exist to ensure prevention of harm and neglect to residents in order to avoid unnecessary suffering and costly avoidable treatments.

3.13 The British Geriatrics Society, Quest for Quality[2] report summarises the issues as:

- Residents of Care homes have complex healthcare needs, reflecting multiple long-term conditions, significant disability and frailty.
- The social care model is central but insufficient to meet residents' health needs.
- As the independent sector grew to take on this area of care over the last three decades, the NHS gradually withdrew its expertise and support. Most geriatricians and old age psychiatrists now play no part.
- Regulation can highlight problems and promote improvement but care home providers cannot achieve this without necessary support.
- No model of co-ordinated healthcare has been developed to meet the needs of care home residents.
- Traditional general practice in many areas does not appear equipped or supported to fill this void.
- The report shows that many care home residents are denied equitable access to suitable NHS primary and secondary healthcare.

- Care homes will continue to be an important component of care provision for frail older people, but healthcare for residents remains a "Cinderella" service in the NHS. This is a betrayal of older people, an infringement of their human rights and is unacceptable in a civilised society

3.14 Overall national policy is guided by the NHS Outcomes Framework[9], which defines five outcomes that the NHS should be delivering:

1. Prevent people from dying prematurely
2. Enhancing quality of life for people with Long Term Conditions
3. Helping people recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

3.15 In the development of this strategy both CCGs have considered the findings of the Francis, Berwick, Cavendish, Clwyd and Hart and Winterbourne reports in relation to patient safety and failings. This information and learning supports the strategy and its priorities for action. Primarily, these findings are used to develop the quality monitoring of care homes to ensure that the CCGs are able to robustly monitor the quality of care and intervene where necessary within homes contracted to the CCGs.

3.16 This strategy has taken the following national documents into account:

- British Geriatrics Society Commissioning guidance for high quality care for older care home residents
- British Geriatrics Society, Quest for Quality An Inquiry into the Quality of Healthcare Support for Older People in Care Homes: A Call for Leadership, Partnership and Improvement, June 2011
- The Kings Fund 2012/13 Making our healthcare systems fit for an ageing population,
- Social Care Institute for Excellence 2012. Safeguarding and quality in commissioning care homes
- NICE Quality Standard, Mental wellbeing of older people in care homes, December 2013
- Health and Social Care Act 2014
- Care Quality Commission 2013. The State of Health Care and Adult Social Care in England
- National Advisory Group on the Safety of Patients in England 2013. A promise to Learn – A Commitment to Act.
- Department of Health NHS Outcomes Framework 2015-2016

4. Local Context

4.1 North Staffordshire Health Economy comprises of two Clinical Commissioning Groups (CCGs), NHS Stoke on Trent CCG and North Staffordshire CCG with a combined population of 500,000 people. The Health Economy has 86 GP Practices (53 Stoke-on-Trent and 33 North Staffordshire).

4.2 To present the scale of the issues facing the Local Health Economy for the next 20-30 years it is important to understand the demography of the local health economy both now, and in the future.

4.3 Overall, there will be an increase in the entire population of approximately 6%, however the difference in population breakdown between now and 2037 will include a 58% increase in over 65's. Currently, over 65s make up 18% of the population, while in 2037 over 65s will make up 26% of the population[10].

4.4 Currently in Northern Staffordshire there are 111 care homes for older age adults (over 65), of which 33 are with nursing. In total there are 3,894 care home beds, of which 2,008 are with nursing (52%) and 1886 beds are without (48% residential). Some care homes have a dual registration, meaning that the same beds can be registered for use as either nursing or residential depending on demand.

4.5 Funding for care home residents comes from a variety of sources including health, social care and individual private funding.

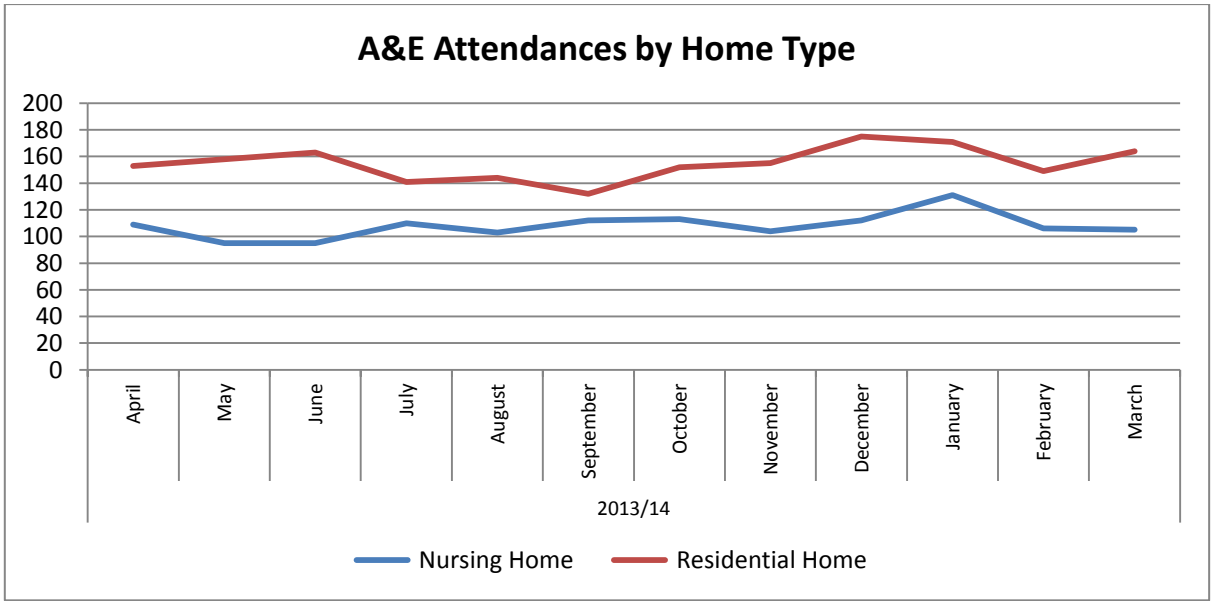
4.6 **Table 1: Local Health Economy Care Homes Breakdown**

Older People	Nursing Homes		Residential Homes		Total	
	Total Homes	Total Beds	Total Homes	Total Beds	Total Homes	Total Beds
North Staffordshire CCG	18	1,059	41	946	**59**	**2,005**
Stoke-on-Trent CCG	15	949	37	940	**52**	**1,889**
Local Health Economy	33	2,008	78	1,886	**111**	**3,894**

Source: Active locations for providers registered under the Health and Social Care Act: CQC database at 1st October 2014. Data Requests Team/Strategy & Intelligence Directorate

4.7 On average 230 (Northern Staffordshire) care home residents are admitted to hospital each month. In 2013/14 there were a total of 2804 admissions at a cost of £6.73million with an average length of stay of 6.94 days. Analysis of the diagnostic codes demonstrates that 29% of admissions are for ambulatory care sensitive conditions[1] and therefore potentially avoidable.

4.8 The graph below shows the admission trend for both residential and nursing homes within Northern Staffordshire during 2013/14.



[1] Ambulatory care sensitive (ACS) conditions are chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions. Examples include congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension

4.9 Evidence from the Nursing Homes Local Enhanced Service (LES) implemented during 2013 in North Staffordshire, and more recently rolled out across Stoke-on-Trent suggests that providing nursing homes with access to enhanced and proactive primary care services improves the quality of care as evidenced by reduced non-elective hospital admissions (↓19%).

4.10 Currently 21 GPs receive additional payment via a Local Incentive Scheme (LIS) to provide additional care, over and above core GMS, to nursing home beds within 24 homes. However it is understood locally that care homes often receive primary care services from multiple GPs, therefore residents within the same home may receive variation in the level of care provided. Additionally the LES does not cover residential homes which are responsible for the majority of admissions (57%).

4.11 **Table 2: Local Health Economy Nursing Homes LIS**

CCG	Number of GPs	Total Number of Homes	Total Number of Beds covered by enhanced scheme	Proportion of Nursing Home Beds covered by the LES
North Staffs CCG	12	14	714	67%
Stoke on Trent CCG	9	10	320	33%
Local Health Economy	21	24	1034	51%

4.12 Both CCGs additionally commission beds directly from a number of Care Homes, to increase capacity and improve rate of discharge from the acute hospital including:

- Assessment and rehabilitation, 43 in Stoke-on-Trent. These are contracted and have a clear specification and admission criteria in place.
- Historically the CCGs have also spot purchased beds at times of high demand (winter). Local review reports have highlighted a number of quality issues when commissioning in this way:

    - **Resource strain within care homes** - Transferring large numbers of frail patients to individual care homes in a short space of time puts considerable strain on resources within the care homes. This has the potential to increase the risks within the care homes
    - **Lack of continuity of medical care** - There is a complete loss of continuity of medical care. Many patients transferred to spot purchased beds will receive their primary care on a temporary resident basis from a GP local to the care home, rather than from their usual GP.
    - **Reduced access to care homes for other patients** - Spot purchasing reduces the capacity in care homes for other patients requiring long term care placements.
    - **Operational strain on Social Care** - The spot purchase process puts Social Care Assessors and Social workers under increasing pressure due to the fact that they are required to hold responsibility for patients in a number of spot purchase beds as well as for patients on wards.
    - **Difficulties with co-ordination and follow up**

4.13 Indirectly on behalf of the CCG, beds are spot purchased from various care homes by the Continuing Health Care (CHC) Team following assessment for NHS continuing healthcare where the individual has a primary health need. The number of these beds varies, with a current estimate of 530, resulting in a total cost to the CCG's of £13.7m for North Staffordshire CCG and £14.5m for Stoke CCG. Each care

home has a standard NHS contract and is required to report on a considerable number of performance and quality metrics. This contract is new and was only introduced to the care home sector in 2013/14. Stafford and Surrounds CCG is the lead commissioner for Staffordshire with regards to the development of the contract requirements and specification for CHC patients. There is currently no dashboard within the CCG to monitor quality and performance for those care homes with an NHS contract.

4.14 **Infection Prevention and Control (IPC)**

Recent review undertaken by Public Health England highlighted key themes in relation to IPC provision across Staffordshire. These include:

- Availability and quality of education and training,
- The reactive nature of IPC advice and support and
- A lack of proactive intervention,
- A lack of IPC standards in care homes,
- Varying levels of skill of both substantively employed and agency staff
- High turnover of staff
- Communication issues
- Lack of funding to provide extra support to care homes.

IPC staff from commissioning and provider organisations are working closely with Public health England and the Area Team to enable and sustain the close relationship and partnership working required to develop and sustain a whole health economy approach to IPC support for care.

In response, all Nursing Homes across Staffordshire have received an IPC audit for completion and the IPC team have offered additional support and education to assist homes to meet the requisite standard. Once care homes have demonstrated the ability to self audit they will be required to undertake these audits independently and to submit the completed audit to the Infection Prevention and Control Team at SSOTP. Following a review of the returned audits, the Infection Prevention and Control Team will visit a selection of homes to ensure that the returned audit reflects practice and environmental cleanliness within the home.

Infection Prevention and Control in Care Homes has been identified as a high priority work stream by the Shropshire and Staffordshire Health Economy Infection Prevention and Control Forum. Currently, Public Health England are leading on a work programme to scope and review infection prevention and control practises and support in care homes. Following this, recommendations will be made on how to improve infection prevention and control in care homes.

4.15 **Safeguarding**

The Staffordshire and Stoke on Trent Adult Safeguarding Partnership Interagency Procedures www.stopabuse.info underpin the infra-structure for raising safeguarding concerns including Section 42 enquiries (Care Act 2014). In terms of care establishments this commonly occurs when care homes are failing to maintain compliance with the regulators (Care Quality Commission) standards and/or multiple safeguarding concerns are raised.

It is important that the Registered Managers of the homes have a good understanding of the Procedures, have safeguarding policies in place and ensure that their employees receive adult safeguarding training to include Mental Capacity Act 2005 (MCA) / Deprivation of Liberty Safeguards (DoLS). It is also important that information relating to on-going and completed multiagency Section

42 enquiries when completed are shared within the CCG's and ideally aligned against all other metrics relating to areas of concern and quality within individual care homes.

5. Drivers for change

5.1 **Equality Act 2012**

In April 2012, the Act came into force making discrimination based on age in health and social care services illegal. Concerns have been expressed that the apparent lack of care home residents to access some NHS services could be breaching their human rights.

5.2 **General Medical Services (GMS) GP Contract**

In April 2014 the changes to the General Medical Services (GMS) contract were implemented that see patients benefiting from:

- A named GP who is accountable for ensuring proactive care is provided for people aged 75 and older as well as patients who are at high risk of hospital admission or have complex health needs.
- GPs ensuring integrated and personalised care for vulnerable patients, working with health providers such as A&E, the ambulance service and care homes to ensure joined up care. There will be a particular focus on reducing unnecessary hospital admissions and supporting appropriate admission and follow-up care

5.3 **Avoiding Unplanned Admissions Direct Enhanced Service**

The Avoiding Unplanned Admissions Enhanced Service for 2014/15 is available for uptake by GPs across Northern Staffordshire and includes the following specific requirements for care homes:

- Timely telephone access for care homes, encouraging homes to contact the resident's GP Practice to discuss care options before calling an ambulance.
- Where Practices have a large percentage of their patients in care homes, they should focus their reviews for case managed patients on any emergency themes from a sample of patients and on any patients who have regular avoidable admissions or A&E attendances.

5.4 **Reducing unplanned admissions and A&E attendances overall**

Local data analysis demonstrates that approximately 30% of unplanned admissions from care homes could be avoided with improved care planning and proactive management or timely access to specialist services. Discussions with geriatricians within Northern Staffordshire revealed that once residents are admitted into acute care they tend to have an elongated length of stay and often need reassessment for long term care placement. Unfortunately there is no facility to support discharge back to the original care home to then carry out reassessment. Additionally, unplanned admissions to hospital and attendance at A&E have a disproportionate impact on older people, studies suggest;

- 48% of people over 85 die within one year of hospital admission[11]
- There is a 43% increase in mortality at 10 days after admission through a crowded A&E department[12].

A&E attendances

In 2013/14 there were 3152 attendances from care homes to A&E at the University Hospital North Midlands (Royal Stoke) resulting in a total cost of £388,658, 57% of which are from residential homes. 93% were brought in by ambulance, the most common reasons for attendance were for respiratory and urological conditions. 73% of patients were admitted to hospital following attendance to A&E.

5.5 Nursing and Midwifery Council Revalidation Requirements

Revalidation will replace the Post Registration Education and Practice(Prep) standards from 31 December 2015. Revalidation will require all registered nurses to meet new higher standards to maintain professional registration. Specifically, under revalidation, nurses and midwives will be required to declare they have:

- Met the requirements for practice hours and continuing professional development (CPD)
- Reflected on their practice, based on the requirements of the Code, using feedback from service users, patients, relatives, colleagues and others

Specific guidance relating to the new assessment standards are awaited. Yet these changes are likely to place strain upon Care Homes, especially those with small bed bases because the process is likely to require organisational support and sign off for individual nurses working within Care Homes.

5.5.1 Access To Core Training for Staff Within Care Homes

Discussions with local care home owners reveal that it is becoming increasingly difficult to access training for staff within care homes and it is also apparent that there is no accepted core training matrix for care home staff to complete for annual revalidation.

5.5.2 Recruitment and Retention of Registered Nurses Within Care Homes and Implications of Safe Staffing

Nationally the UK is undergoing a chronic shortage of registered nurses, which has been made more acute recently with the publication of minimal safe staffing numbers (NICE in June 2014). In effect, this new guidance has reduced the available pool of registered nurses available to work in Care homes due to increased demand in hospitals. The minimum ratio is for 8 patients to 1 registered nurse during the day and 10 patients to 1 registered nurse at night time, these ratios apply to hospitals only. Nursing Homes have an average ratio of 18 patients per registered nurse during the day and 26 patients per registered nurse during the night.

The overall effect of the nursing shortage is most heavily experienced in the care home sector and especially in smaller organisations where recruitment of registered nurses is extremely difficult. Locally due to this issue, care home providers experience great difficulty in maintaining operational effectiveness and quality of care and report increasing dependence upon agency nurses.

Due to this on-going and worsening workforce supply/demand mismatch, discussions with care home providers reveal that some may stop accepting patients requiring registered nursing care. Which will in turn add further strain to the LHE given growing demand for these beds.

5.6 **Better Care Fund**

The Better Care Fund provides an opportunity for health and social care commissioners to work more effectively together and co-commission services which deliver better health and social care outcomes. Specifically the Better Care Fund is a mechanism that is intended to:

- Drive forward agendas for the integration of the commissioning and delivery of NHS and Social Care services to better meet the needs of vulnerable people
- Ensure that services (especially those associated with pressures on the acute sector and urgent care)are planned across the whole pathway and operate in an efficient, coordinated and coherent way

In Stoke-on-Trent, commissioning for continuing health care patients has been identified as a key workstream in the BCF plans.

6. Engagement

6.1 Nationally the 2011 British Geriatric Society membership survey found that:

- Over 40% of the 330 respondents felt that medical support to care homes was below average or poor in quality.
- Over 70% believed that depression and dementia affecting residents of care homes were not optimally managed.
- Over half thought that incontinence and end of life care could be better managed.
- 80% of respondents give telephone advice to local GPs on request, but less than 20% make care home visits

6.2 Locally a survey was distributed to all care homes, in total 34 Care Homes responded to the survey; a response rate of 31%. The majority of responses (71%) were from residential homes. Key findings from the survey include:

- **High satisfaction with primary care services for those homes served by only one GP**.71% of care homes with 1 GP Practice report being either satisfied or very satisfied with the service they receive, conversely those homes with 3 or more GPs report low satisfaction.

- **Care Homes report being least satisfied around care planning and regular reviews, and the availability of GPs to speak to relatives and carers about care plans**

- More than 50% of care homes said that the following areas were most important to receive training support:
    - Tissue viability
    - Infection control
    - Falls prevention
    - Nutritional support
    - Safeguarding
    - Identifying signs of early clinical deterioration

6.3 A review of the avoiding unplanned admissions DES audit data showed the following key themes for admissions from care homes:

- Education required for spotting signs of clinical deterioration earlier
- Education on what is appropriate for acute admission
- Direct access to the Hub, local services to help manage crises
- Promotion of dedicated phone line for care homes in GP surgeries
- Earlier review of patients whose needs are increasing
- Better access to FEAU / AMU, OOH and x ray services

6.4 The draft strategy was presented to the following patient/carer representative groups by Commissioners on 2nd June 2015

- Age UK
- Health Watch Stoke-on-Trent
- EngAGE

6.5 The presentation session was also attended by the Chair of the Staffordshire Association of Registered Care Providers (SARCP)

6.6 Following the presentation the groups were asked if they;

- Agreed with the principles of the strategy including the four key priority areas
- Wished for any other priorities to be considered

6.7 The consensus within the meeting was that all were in agreement with the focus of the strategy including the four highlighted priority areas and high level actions.

6.8 The group noted that the strategy did not include anything unexpected and focused upon key issues that they were all aware of and keen to see addressed.

6.9 The group were also clear that they did not think that any key issues related to the strategy had been missed from a patient and carer perspective. They were also in agreement with the implementation plan that has been drafted.

6.10 It was also noted that those present wished to take part in any subsequent steering groups to support and oversee implementation of the strategy.

6.11 Therefore from a patient and public involvement perspective the Clinical and Commissioning Leads for the joint CCG Care Home Strategy were satisfied that the priorities within the strategy represent the needs and issues identified from key user groups related to care homes.

7. Priorities

In determining our priorities we have looked to both national reports, data and intelligence of the local care home sector in North Staffordshire and Stoke-on-Trent and taken into account feedback from care home managers and various stakeholder groups. The strategy on a page can be found in appendix 1.

7.1 **Priority 1: Develop, support and improve quality of care within care home settings ensuring that the sector is able to manage the increasing complexity of residents 'needs in the future**

7.1.1 Within the context of the local population projections and the changing clinical needs of care home residents over recent years, we need to act now to ensure that care homes are supported to have the necessary skills and competencies to safely and proactively manage care home residents with increasingly complex care requirements.

7.1.2 Healthcare services to support the achievement of residents person-centred goals should be integrated and should combine enhanced primary medical and nursing care with dedicated input from departments of old age medicine, mental health services, and other specialisms such as palliative care and rehabilitation medicine.

7.1.3 Care homes will require support regarding the proposed new re-registration requirements for nurses to ensure that individual nurses are compliant.

7.1.4 CCGs need to be appraised of on-going supply / demand mismatch for registered nurses within care homes, given the likely impact on quality of care and the ability of care homes to function as a care home with nursing.

High Level Actions

- Develop the care home workforce in partnership with Councils and the Staffordshire Association of Registered Care Home Providers (SARCP). A training needs analysis will be conducted and the CCGs will support the development of a training programme for the care home sector.
- The CCGs will explore ways in which it can support qualified staff in care homes to maintain their clinical competencies and improve clinical skills. This may include a skills exchange with acute and community providers.
- Develop a best practice resource for care homes to encourage a shared and systematic approach to good quality care and joint working between the care home sector, community services and the social care sector.
- Create local forums, mapped to CCG locality areas, for primary care and care home staff. The forums will provide opportunities to share key messages and priorities within the local health economy and will encourage standardisation of practice across the care sector.

7.2 Priority 2: Ensure access to healthcare services that are responsive and can meet the holistic needs of this vulnerable group of patients

7.2.1 Across Northern Staffordshire individual care homes can be served by multiple GPs which can lead to fragmentation and confusion. Therefore ideally care homes should be served by a single practice. However, time constraints of GP practices to provide medical care to individual care homes and patient choice is a current major constraint to achieving this aim, yet is a position which the CCGs will strive to achieve.

7.2.2 One of the key challenges for primary care for patients residing in care homes is the increasing level of complexity and the time taken to support these patients and the homes they reside in. The Nursing Home LIS addresses some of these issues yet only partial coverage is provided across the LHE. Therefore there is a requirement to consider options for an alternative model to the LIS to ensure that residents receive equity of access to high quality care.

7.2.3 Care home residents are vulnerable and can physiologically deteriorate quickly; community services should therefore be commissioned to provide a responsive service thereby enabling the resident to remain in the care home during periods of illness and instability. Conversely it is often reported that many older care home residents deteriorate over a period of time and that with appropriate training, care home staff can be up skilled to recognise signs of clinical deterioration earlier.

7.2.4 Access to community services is variable with regards to both response times and inclusion criteria. Some community services are not available to care homes due to current commissioning arrangements. This is clearly not an equitable position; responsibilities of both clinical staff within nursing homes and community services will therefore need to be reviewed and clarified. Access to services should be based on clinical needs of patients not their place of residence.

7.2.5 The CCGs commission a limited amount of dedicated support for care homes. Both CCGs commission a care home liaison team (2x Community Psychiatric Nurses (CPN)) across Northern Staffordshire. Due to the significant and increasing prevalence of cognitive impairment /dementia within care home settings and the subsequent impact, the CCG's will need to consider reviewing this resource.

7.2.6 In addition to the care home liaison team, North Staffordshire CCG has commissioned a pilot care home physiotherapist role with specialist dementia management skills. A short evaluation has demonstrated that the service is highly valued by care home staff with particularly positive feedback in relation to response times, raising falls awareness, reducing safeguarding concerns, supporting the development of care plans and use of appropriate equipment.

7.2.7 An additional challenge is the increasing diversity of the older population in terms of ethnicity, religion and culture. This affects catering and communication between carers and residents, but more fundamentally it will bring a range of complexities to healthcare and technological approaches, from eating and drinking to death and dying. A resident-centred approach to care is required.

High Level Actions:

To achieve our outcomes we will:

- Put forward a proposal for '1 Practice, 1 Care Home'. GP practices to be aligned to nursing homes and commissioned to provide an enhanced service which will ensure consistency of care delivered. The current enhanced scheme and level of investment will be reviewed to ensure that payments appropriately reflect the resource required to provide clinical leadership and improve quality processes within the home.

- Ensure all community service specifications and admission avoidance schemes explicitly include care home residents and that triage / response of service is based on clinical needs and risks not patients' residence. Clinically led prioritisation tools / triage systems to be put into place.

- Develop pathways to ensure that care home residents have equal and responsive access to specialists (such as palliative care, geriatric medicine, mental health) provided within the care home environment utilising assistive technologies and technology enabled care wherever possible.

- Work collaboratively with social care commissioners to identify commissioning options and potential to utilise the BCF to proactively support residential home residents to stay well and as independent as possible via a range of occupational therapy and social activities.

7.3 **Priority 3: Ensure robust quality monitoring and assurance framework for all nursing homes**

7.3.1 Current Quality Assurance Process - The assessment of quality within care homes is conducted by multiple agencies, which include:

- The Care Quality Commission
- Local Authorities – Staffordshire County Council , Stoke-on-Trent City Council
- Stoke-on-Trent and North Staffordshire Clinical Commissioning Groups via contracting and governance teams as well as 'soft' intelligence
- HealthWatch Stoke-on-Trent and HealthWatch Staffordshire

7.3.2 The above agencies collect a range of metrics related to the quality/standard of care provided within care homes, this data set is not amalgamated into a single interface and each agency utilises differing processes to respond to areas of concern. Actions related to assurance on particular issues are not formally shared across the multiple agencies and there is no overarching body to review these metrics/actions as a whole.

7.3.3 The local authorities regularly visit care homes as part of the organisations quality monitoring process monitor standards and support homes to make improvements where indicated. In particular Stoke on Trent Council are considering the introduction of a Rag rated system to monitor issues and track progress.

7.3.4 There is a nursing home quality assurance meeting - chaired by Staffordshire and Surrounds CCG, this meeting has Staffordshire wide attendance and provides a forum for individual CCGs to discuss specific issues, network and to ensure that practice related to quality assessment is fit for purpose. This forum does not address or solve the current issues/gaps identified within this paper and terms of reference are currently under review.

7.3.5 Of specific concern for LHE CCG's, no formalised co-ordinated mechanism exists within the CCGs for the review and challenge of metrics related to the quality of care delivered within care homes. Therefore the CCG does not currently possess an adequate system to provide assurance that care for which it has directly or indirectly purchased is of an adequate standard.

<u>Data selection and amalgamation</u>

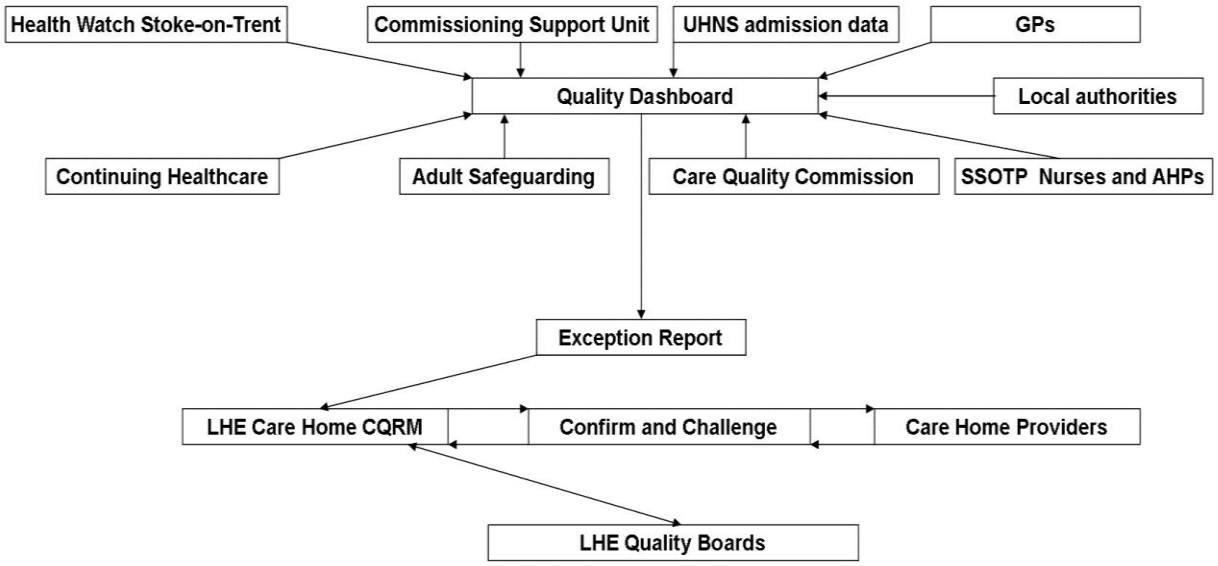
7.3.6 A number of metrics exist related to quality assessment yet this data is not filtered in terms of significance, amalgamated together and then considered as a whole by the CCGs as part of a formal quality assurance mechanism. Creation of a dashboard will provide the CCG with data from multiple sources to enable informed decisions related to the quality of care delivered within care homes. This data set will need to be agreed upon by partners such as the Local Authority and the Safeguarding team etc. to ensure that only pertinent metrics are selected.
The IPC care home audit results should be integrated into the proposed care home quality dashboard, commissioners should also ensure that care homes with an NHS contract within Northern Staffordshire are IPC audit compliant.

<u>Creation of a care home quality review mechanism as part of locally agreed contracts</u>

Once data is selected and amalgamated an LHE Care Home care quality review group will need to be created to consider an agreed exception report dashboard containing a RAG rating for homes where there are concerns. The care home quality review group should then generate tracked actions for homes where concerns are raised to provide an appropriate level of confirm and challenge which can then be fed into the appropriate forums within the CCGs.

Ideally such a group should contain representation from a wide variety of parties including representation from the relevant Local Authorities as well as the traditional health sector in order to make best use of pooled resources and improve the information sharing process.

Proposed Quality Assessment Governance Structure



High Level Actions:

- CCG and local authority develop jointly agreed (or co commissioned) contract for all nursing homes with clear expectations for clinical interventions and competencies.
- Develop quality accreditation framework that Care Homes sign up to
- Nursing home contract to be monitored through a robust quality monitoring framework in conjunction with LA colleagues.
- Quality dashboard to be developed which collates key quality and performance data across the economy so that emerging risks can be quickly and easily identified.

7.4 **Priority 4: Reduce avoidable admissions to hospital, ensuring the care home resident receives safe, high quality care in an environment that is most appropriate**

- Care home residents should be at the centre of decisions about their care. The BGS Quest for Quality report recommends that an integrated social and clinical approach should support anticipatory care planning, encompassing preferred place of care and end of life plans.
- It is important that the LHE supporting infrastructure is in place to enact the care plan particularly at times of crisis. Commissioners will need to ensure that appropriate capacity is in place within relevant community, mental health and palliative services to meet activity demands and that policies are in place to enable more clinical interventions to be provided within the home environment. Out of hours services and ambulance services will need to be engaged so that the care plan is followed and the care home residents preferred wishes are taken into account

High Level Actions:

- For all care home residents to have a care plan clearly indicating ceilings of care, emergency plan actions and advanced plan / preferred wishes - led by and managed within primary care but supported by integrated local care teams. Plans will be accessible to WMAS, OOH services and emergency portals.

- Ensure that all care home residents admitted to the Acute Trust have a comprehensive geriatric assessment. A 'frailty passport' will be developed which will outline the patients main needs and up to date care plan. This will be a 'live'document and will travel with the patient across a number of care settings.

- Joint working with Social care commissioners to ensure that residents changing needs are reviewed appropriately and in a timely way so that residents receive the care they need in the most appropriate environment.

- Ensure that pathways to access rapid community support (e.g. intermediate care, specialist mental health) are in place and communicated to care home staff

8. Assistive Technology and Technology Enables Care Services (TECS)

8.1 There are a wide range of TECS ranging from aids and adaptations, telecare to video links which will support personalised care, promote independence, manage and mitigate risks.

8.2 The use of TECS, such as video consultations between care homes and general practitioners, integrated community teams or acute physicians, can be utilised to negate the necessity for care home residents to travel from homes to clinical settings.

8.3 Transferring frail elderly care home residents to external clinical settings can have a negative impact upon their wellbeing; using such technology can lead to improved experience of high quality essential care that best meets the needs of care home residents in the right place and at the right time.

8.4 Video consultations can be used to meet a variety of older people's health and care needs. Furthermore, there is evidence to suggest, from Airedale Hospital in West Yorkshire that use of this model has led to reductions in emergency admissions of 35% and A&E attendances of 53%.

8.5 The care home environment needs to be appropriate and essential equipment available to support the needs of the residents. This will include design for dementia care, aids and suitable furniture for frail people. Telecare systems can support people at risk of falls and other devices can support the management of continence, epilepsy and challenging behaviour.

9. Outcomes and key deliverables

9.1 The priorities identified aim to achieve the following high level outcomes:

- Clearly defined service specifications for nursing homes to ensure that there is a consistently high quality clinical service available
- Clinically competent and supported care home workforce
- Responsive and equitable services for care home residents; enabling residents to receive care in the most appropriate setting at the right time
- Improved patient experience with more residents receiving treatments and interventions in their care home residence
- Reduction in avoidable admissions
- Integrated working between health and social care providers and other agencies to achieve a whole systems approach

9.2 The following key deliverables will be achieved within the next 3 years:

- Specific pathways which ensure access to holistic assessment and where needed, comprehensive geriatric assessment.
- All care home residents will have a holistic medical review based on the principles of CGA and an individualised support plan
- The care plan for each nursing home resident will be available for any health and social care professional who needs to see them at the time they are needed.
- Local pathways will be established to ensure that there is timely and regular assessment and review, of people living in residential homes who are developing more complex primary health needs
- Education programme for care home staff
- Local forums for primary care and care home staff based around CCG localities
- Quality dashboard

10. Conclusion

It is important to highlight that this is not an overnight solution but requires all partners to commit and invest in working together into the longer term to achieve sustainable improvements. Therefore, while some aims of the strategy can be put in place in the shorter term, others will require a longer period of time to implement and embed. For this reason, the strategy will need to be refreshed annually to consider what progress has been made, the impact of these changes, and what areas need further work and development.

For this reason, a steering group should retain oversight of the strategy and its delivery, meeting quarterly to review the progress and more importantly, what impact the work is having on quality of care for care home residents and reducing avoidable admissions to long term care.

An update of progress will be provided to both the Executive Forum (Stoke) and Commissioning, Finance & Performance Committee (North Staffs) and to each of the Governing Bodies.

References

1. Department of Health 2008. *High Quality Care for All: NHS Next Stage Review*. Department of Health, London, Gateway Reference 10106
2. British Geriatrics Society 2011. *Quest for Quality.* British Geriatrics Society, London
3. British Geriatrics Society 2013. *British Geriatrics Society Commissioning Guidance: High Quality Health Care for Older Care Home Residents.* http://www.bgs.org.uk/campaigns/2013commissioning/Commissioning_2013.pdf
4. BUPA 2011. *The Changing Role of Care Homes.* BUPA and Centre for Policy on Aging, London
5. Tom Rutherford 2012. *Population Aging Statistics.* House of Commons Library, London
6. Bebbington A, Darton R and Netten A 2001. *Care Homes for Older People: Volume 2, Admissions, Needs and Outcomes*. Personal Social Services Unit, University of Kent, Canterbury.
7. Alzheimer's Society Statistics. Accessed 01/2015. http://www.alzheimers.org.uk/statistics
8. National Audit Department 2008. *End of Life Care.* National Audit Office, London
9. Department of Health 2014. *NHS Outcomes Framework, 2015-2016.* Department of Health, London.
10. Age UK 2015. *Later Life in the United Kingdom – January 2015.* Accessed 01/2015 *http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true*
11. Clarke D, Armstrong M, Allan A, Graham F, Carnon A and Isles C 2014. *Imminence of death among hospital inpatients: Prevalence cohort study.* Palliative Medicine *http://www.goldstandardsframework.org.uk/cd-content/uploads/files/Library,%20Tools%20%26%20resources/Imminence%20of%20death%20amongst%20hospital%20patients.pdf*
12. Richardson D 2006. *Increase in Patient Mortality at 10 days associated with emergency department overcrowding*. The Medical Journal of Australia: 184 (5), 213-216

Reporting to North Staffordshire and Stoke-on-Trent CCG Executive Committees

NS and SoT CCG Care Home Commissioning Strategy 2015 - 2017

Priority 1	Priority 2	Priority 3	Priority 4
Develop, support and improve quality of care within care home settings ensuring that the care home sector is able to manage the increasing complexity of residents needs	**Ensure equitable access to healthcare services that are responsive and can meet the holistic needs of this vulnerable group of residents**	**Ensure robust quality monitoring and assurance framework for all nursing homes**	**Reduce avoidable admissions to hospital by ensuring that residents have access to safe, high quality care in an environment that is most appropriate**
HIGH LEVEL ACTIONS			
Develop care home workforce in partnership with Councils and Staffordshire association of Registered Care Providers. Improve clinical competencies of nursing home staff Develop best practice resources for care homes Create local forums for primary care and care home staff	Ensure all nursing homes have access to enhanced primary care services Put forward a proposal for '1 Practice, 1 Care Home'. Identify commissioning options to proactively support residential home residents to remain active and well Ensure all community service specifications explicitly include care home residents Develop pathways for specialist services	CCG and local authority develop jointly agreed (or co commissioned) contract for all nursing homes Develop quality accreditation framework for Care Homes Nursing home contract to be monitored through a robust quality monitoring framework Quality dashboard to be developed	For all care home residents to have a care plan clearly indicating ceilings of care, emergency plan actions and advanced plan / preferred wishes Joint working with Social care commissioners to ensure that residents changing needs are reviewed appropriately and in a timely way Ensure that pathways to access rapid community support are in place Development of a frailty passport

Outcomes

Consistently high quality clinical services available within care homes; improved patient experience with more residents receiving treatments and interventions in their care home residence; Clinically competent and supported care home workforce; Responsive healthcare services for care home residents all of which lead to a reduction in avoidable admissions.