CARE HOME NEEDS ASSESSMENT IN WANDSWORTH

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1 EXECUTIVE SUMMARY

i. England's population is ageing. The number of people aged 85 and over increased from 0.7 million in 1985 to 1.4 million in 2010 and is projected to reach 3.5 million in 2035. As people live longer, more will be living with significant morbidity. Older people are high users of both health and social services and costs of care for this group will increase. Although Wandsworth has a young population, a significant growth in the numbers of older people is expected. It is estimated that between 2014 and 2019 there will be a 14.3% increase in people aged 85 to 89 years, and a 19.5% increase in those aged over 90 years. With nearly 20% of over 85's in England living in care homes, we can expect an increase in the number of Wandsworth residents requiring care in these settings. The increasing health costs for care of the elderly are already evident in rises in continuing care funding and non-elective admissions that have been seen in Wandsworth.

ii. As older people are increasingly supported to remain in their homes for as long as possible, the care home population has become older and frailer. With reductions in NHS long term care beds, the care home sector is now an important source of care provision for older people living with complex clinical needs. Despite this it's widely acknowledged that they sometimes have less access to health services than older people who live in the community and that there is wide variation in how health care is delivered to care home residents. In this needs assessment we found that this was also the case in Wandsworth, with some reports of difficulty accessing primary care and also limited specialist medical support provided to care home residents. Only half of care homes stated that a geriatrician service was available. Use of specialist nursing and other healthcare services was also variable, and co-ordination between specialist teams was reported to be poor. Improvements in how care homes are kept informed of available services and how to access these were felt to be needed. The lack of availability of a multidisciplinary team to provide care to care home residents was felt to be a major equity issue, as this is available to older people living in the community. Exploring how these services can be made available to address the particular healthcare needs of care home residents is essential.

iii. Nationally health care service provision to care homes has been reported to be fragmented and reactive. Variations in the use of acute services among care homes in Wandsworth suggests that some care homes are better able to manage the health needs of residents. Suggested factors that contribute to this include how proactively primary care and care home managers are at managing health needs, and the access to and responsiveness of specialist and community health services. The responsibility for the care of this population lies with GP's. GPs report that care home residents can require an intensive level of primary care support. Each care home negotiates its own relationship with a GP practice, the details of which may not be made public, and it was found that there was no uniformity in the services delivered across the borough. Retainer fees are sometimes paid to a practice to provide additional services. In our survey most care homes reported paying a retainer fee to a GP practice, but other sources of information suggested that approximately 30% of homes paid a retainer. Recently announced changes to the 2014/15 GP contract are likely to impact on many care home residents. These include the introduction of an enhanced service from GPs aimed at improving services to patients with complex health and care needs, and having

a named GP for all patients aged 75 and over. The literature suggests that improving communication with the GP, having more consistent care i.e. a single GP visiting rather than anyone from a practice, are ways in which care could be improved. In addition recording of care home residence and flagging care home residents on a patient register is a potential tool for improving monitoring and outcomes.

iv. The data analysis in this needs assessment was based on a dataset that was an approximation of the care home population. All data were extracted while public health was part of the then Wandsworth Primary Care Trust. Public Health was not allowed access to patient-identifiable data from primary care that would have enabled us to identify patients who were actually resident within a care home. We therefore estimated this population by selecting patients aged 64 and over, registered with a Wandsworth GP, who were resident at a care home postcode. There is a high likelihood that the dataset includes patients aged >64 who lived at the same postcode but were not necessarily resident in that care home, as two care homes share postcodes with extra care housing schemes. We conducted limited analyses due to difficulties with data quality and interpretation and view the findings as indicators of areas of concern that need further investigation. As it is possible to identify residents of care homes from GP patient lists, a more accurate analysis is possible. This would provide better information on the health needs of the care home population and allow more accurate targeting of resources.

v. The data analysis suggested that there is variation in the use of hospital services by care home, which is supported by the findings of the literature review. The high rate of admissions for diseases of the genitourinary system ties in with input from the stakeholder interviews that problems with continence care and catheterisation are a frequent reason for referral to hospital. The variations in the use of accident and emergency services and the London Ambulance Service suggests that there are some care homes that need greater enhanced clinical support than others. It may be that residents of these homes are more clinically complex and greater specialist care is required, or that primary care support to these homes is insufficient, or that more training of staff on specific aspects of care is required. Further investigation for the reasons for high use of emergency services is needed.

vi. Care home support teams have been established in several places across the UK to address the reactive nature of care and have been reported to improve the quality of care and result in cost savings. In the literature review we found that there were no comparative studies of the different models of providing enhanced clinical support to care homes. There are a few factors related to the format of the support services that appear repeatedly in the literature including, senior or specialist nursing staff as the key contact or provider of the service, the use of an advisory or facilitative approach where ongoing training and support is provided, a focus on improving communication particularly between primary care and the care home but also with other specialist therapy teams and with family, and access to a multidisciplinary team and to specialist support. To inform what the best format of such a team might be in Wandsworth, further local analysis of health service utilisation data by care homes and individuals within care homes is needed, as well as a closer analysis of the precipitating factors for the use of emergency services, and the findings of recent projects delivered within care homes in Wandsworth.

vii. In stakeholder interviews further issues were raised concerning general nursing procedures in care homes. Nursing homes are paid a flat rate NHS funded nursing care contribution for the registered nursing services that they provide to residents. Occasionally care home nurses were not able to perform tasks that were felt to be expected nursing competencies, resulting in residents being admitted to hospital (for catheterisation as an example). However, it was noted that some tasks occurred too infrequently in the home for nurses to maintain their competency to perform these. This raised issues of how support could be provided to nursing staff in the event that a nursing task could not be performed. A means of supporting nurses to maintain their competency as well as promoting consistent and up to date practice across the homes though the availability of a care home matron or specialist nurse that had a training role, as described above, could be considered. Alternate suggestions include nursing support being provided at a cost to the home in the event a task was deemed to fall into an expected nursing competency.

viii. With an estimated 80% of care home residents having dementia or significant memory problems, managing the care and support needs of people living with dementia is a key area of clinical practice in care homes. Specialist support and training on dementia was the most frequently requested area of support by care home staff. There have been recent pilot services developed in Wandsworth in response to this need. It was also evident from the interviews that in some care homes there was a need to improve skills and knowledge of staff on aspects of caring for people with dementia, which echoes recently published national findings. In addition, it has been found nationally that people with dementia are 30% more likely to have an avoidable admission and multiple avoidable admissions to hospital. Supporting care home staff to better manage dementia patients would therefore likely result in cost savings from avoidable admissions, one-to-one care costs and reductions in anti-psychotic prescribing, as well as improving the quality of life and quality of care for residents.

ix. Published literature suggests that diagnosis and management of long term conditions tends to be less among the care home population compared to older people living in the community. We were unable to assess in this needs assessment the prevalence of long term conditions in the Wandsworth care home population, or to make an assessment of the quality of care for chronic conditions, or whether chronic conditions are being under-diagnosed as has been suggested in the literature.

x. In recognition of a variety of service gaps for care home residents, a number of pilot interventions have recently developed in Wandsworth. The findings from these have provided important insight into some of the health and service gaps in care homes. However there is currently no oversight group, for example a clinical reference or strategy group, where the findings of these pilots or any other issues relating to care of older people in care homes can be presented to ensure that action is taken and to inform future commissioning. A group with clinical input is needed to oversee the co-ordination of health related activities in care homes, like the pilot studies referred to above, to ensure that these are coherent and the best use of available resources; and to support the co-ordination of health and social care activities. Improved communication with and engagement of providers in the development and running of services is also necessary. The development of a separate

forum that included care home providers and was aimed at fostering positive engagement and early involvement in service development by providers is needed.

xi. The complexity of the commissioning process by both health and social care requires a greater level of communication for both placement and monitoring and evaluation of the care provided by care homes. This is necessary not only for safety and clinical governance reasons but to support joint market engagement in order to ensure the delivery of highest quality care for care home residents in Wandsworth.

xii. Taking the above into consideration, recommendations have been drafted that centre around improving and standardising care among care home residents in Wandsworth. There are real opportunities for health and adult social care to continue to work together to improve outcomes for our ageing population. This needs assessment highlights that, as has been found nationally there is unacceptable variation in the accessibility and quality of health care provided to care home residents who are the most vulnerable elderly in our population and whose care requirements are costly and complex. There is significant scope to improve the quality of care provided, to improve the health and quality of life of care home residents, and to potentially realise cost savings from avoiding the use of acute services.

RECOMMENDATIONS:

1) All care home residents should be flagged on the GP database to support regular monitoring of health outcomes and use of health services by this patient group.
2) An in-depth analysis of the health status of care home residents using a dataset comprised of an accurate list of the care home population should be undertaken. In addition an analysis of hospital admissions (and A&E attendances) by care home, to identify causes of hospital admission and to provide a baseline for monitoring the effectiveness of interventions.
3) To improve our understanding of the precipitating factors for use of acute services and in order to determine what the most appropriate format of an intervention to improve care to care homes in Wandsworth would be, it is suggested that for a short period a sample of admissions and ambulance callouts to care homes is reviewed by an clinician to determine what the precipitating factors for the event were and what supportive interventions are required to prevent further occurrences.
4) Where potentially avoidable attendances and/or admissions are identified, establish clear protocols for management of these common conditions and review admissions on a quarterly basis to improve quality of care and avoid unnecessary hospital admissions (and A&E attendances).
5) Consider the establishment of a consistent multi-disciplinary team to provide enhanced clinical support to care homes. Findings from the admissions and call out review described above, and from existing projects in care homes will inform the key elements of support that are required.
6) Identify or establish a clinical or strategic group with representation from both health and social care, to provide oversight of the health care needs of the care home population and how health care services to care homes are organised. Clinical input from a GP lead and geriatric specialist would be required.

7) Develop a joint health, social care and care home providers forum aimed at improving communication and involvement of all partners in the development and implementation of services.
8) Analyse the levels of primary care input provided by GPs to care home residents and use the results to set a minimum local level of primary care provision to care home residents.
9) Define the levels of nursing competency required across care homes. This should involve training required by national regulators as well as locally defined training needs, e.g. dementia.
10) Specialist support and training on dementia should be made available. This was a major area of need and was the most frequently requested area of support from care home staff and health workers working in care homes.
11) Ensure that care homes have easy access to up to date information regarding available specialist services to care homes, including methods of referral as well as service contact details.
12) Define protocols for the following procedures for health and social care funded placements in partnership with care homes;
    a. **Preadmission process** for residents entering a care home: this will involve screening for physical and mental health needs as well as social care needs.
    b. **Care planning documentation**: ensure that all care homes have person-centred, holistic care plans that consider the individual and their carer and how they are involved in care planning.
13) Consideration should be given to implementing individual placement plans for continuing care patients.
14) Establish an information sharing protocol between health and social care commissioners to improve information sharing on initial placements, reviews, and monitoring and evaluation of placements. A large share of the care home market is commissioned by the health and social care sectors and information sharing is critical to ensuring that high quality care that meets patients needs is delivered.

2 INTRODUCTION

England is an ageing society. Between 1995 and 2025 the number of people over the age of 80 is set to increase by almost a half and the number of people over 90 will double (Department of Health, 2001). The number of people aged 85 and over increased from 0.7 million in 1985 to 1.4 million in 2010 and is projected to reach 3.5 million in 2035 (Office for National Statistics, 2012). More than 400, 000 older people in England live in care homes, comprising nearly 20% of over 85's (British Geriatrics Society, 2013). Recent changes in the provision of health care have reduced the numbers of hospital beds available to provide long term care for the elderly and more care is being delivered in the community. The care home sector has become an increasingly important source of long-term care provision for older people who are often living with complex clinical and care needs (Szcezepura, et al., 2008a). Despite this it's widely acknowledged that they sometimes have less access to health services than older people who live in the community and that there is wide variation in how health care is delivered to care home residents. An ageing population and increasing numbers of frail older people with complex needs are likely to result in a significant growth in health and social care costs.

In Wandsworth, we have had little specific information about the health needs of this vulnerable group. The care home health needs assessment (CHNA) aims to provide an evidence-based resource to support commissioners and providers to provide optimum care for older care home residents in Wandsworth. The HNA aimed to explore quality of care indicators for chronic diseases among older people in care homes, the accessibility and use of health services, and the evidence base on ways of providing clinical support to care homes.

2.1 The population of Wandsworth

According to the 2011 Census, in April 2011 the population in Wandsworth was 307,710. Based on these data population projections estimated that in 2013 the total population in Wandsworth was 315,171, (Males 48.2%; Females 51.8%), and was predicted to increase by 1.2% in 2014 to 318,996. The population pyramid in Figure 1 illustrates the estimated population in 2014 by age group and gender and shows that Wandsworth has a predominantly young population, with those aged between 25 and 39 making up 39.1% of the total borough population (Public Health Wandsworth, 2013).

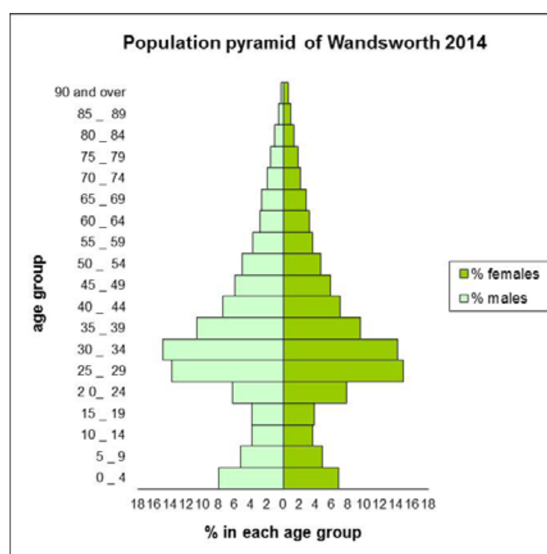
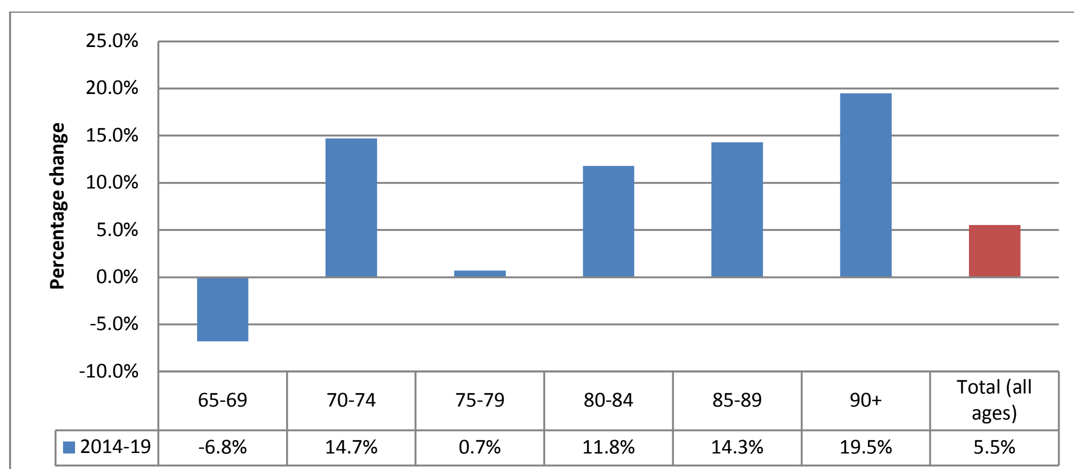


Figure 1: Population pyramid by age and gender. Source: ONS sub-national 2011-based population projections

Figure 2 shows that between 2014 and 2019, the population in Wandsworth is expected to age as it is predicted that there will be substantial relative increases in the over 80 age group in the borough.



	65-69	70-74	75-79	80-84	85-89	90+	Total (all ages)
2014-19	-6.8%	14.7%	0.7%	11.8%	14.3%	19.5%	5.5%

Figure 2: Estimated percentage population change between 2014 and 2019 in Wandsworth older population. Source: ONS sub-national 2011-based population projections

From the 2011 Census data, there were 15,140 people (6.2% of people aged 16 to 74) who were classified as retired. Of all households in the borough, 10,385 (8%) were one person households of someone aged 65 or over. In 299 (0.2%) of households, all inhabitants were over the age of 65.

There are some wards in the borough that have larger proportions of older people including West Putney, Roehampton and Putney and Nightingale (Figure 3).

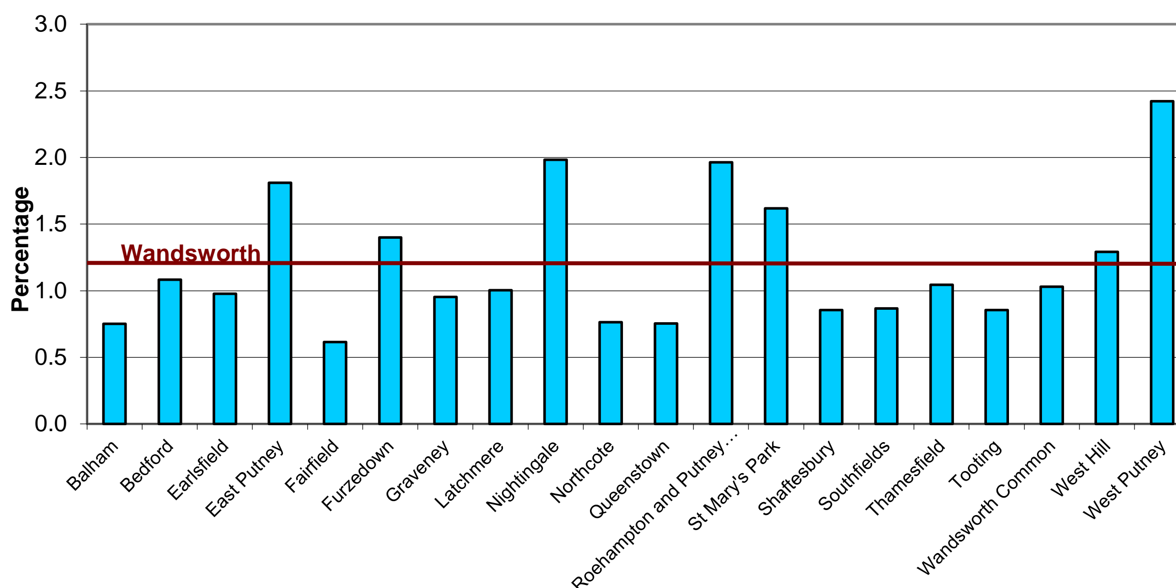


Figure 3: Proportion of 85+ population by borough in Wandsworth. Source: 2011 Census data, Office for National Statistics

Wandsworth has a smaller percentage of BAME population than both Inner and Outer London with 29.9% of the Wandsworth population being in a BAME group. While the majority of the BAME population in Wandsworth is young there is an above average proportion of BAME population in the 45 to 64 year and 75 to 79 year age groups.

Wandsworth has the highest levels of older people living in deprivation (Calculated as adults aged 60 or over living in pension credit (guarantee) households as a percentage of all adults aged 60 or over) of all the South West London CCGs (Wandsworth CCG, 2013). 26.4% of older people live in deprivation compared to a low of 12.4% in Richmond and a high of 18.1% in Croydon. The map below (Figure 4) illustrates the indices of deprivation for older people scores, by lower super output areas in Wandsworth. The areas with the highest deprivation are in the North East and North West parts of the borough, primarily within Queenstown, Latchmere and Roehampton wards. However, there are also large pockets of deprivation in Tooting and Graveney wards.

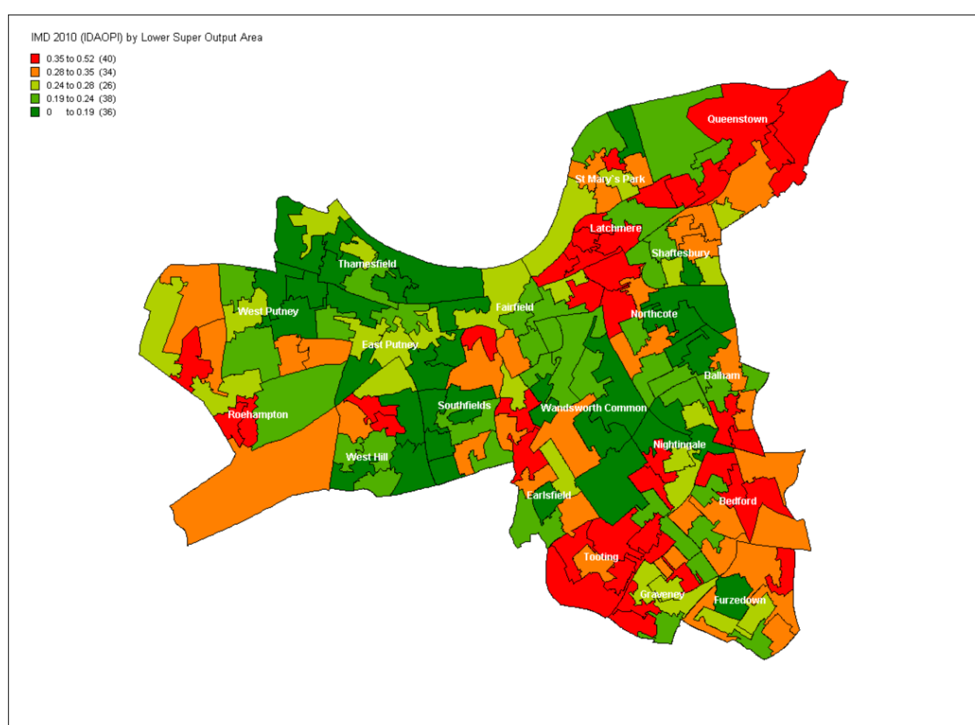


Figure 4: Index of deprivation affecting older people score, IMD 2010, Department of Communities and Local Government

2.2 Health spending

Spending on continuing care for older people in Wandsworth has been increasing rapidly over recent years. Wandsworths' 2013-14 planned spend on Continuing Care (per population of those aged 70 and above) is approximately 20% more than the SWL average (Wandsworth CCG, 2013).

In 2012-13 Wandsworth spent £23m on non-elective care for over 70-year-olds, which is equivalent to a spend of £1,197 per head of over 70 population; 33% more than Richmond spent per head. Admissions for the over 70 age group are also growing faster than overall non-elective activity. Wandsworth has the highest levels of non-elective admissions for over 70's in the South West London CCGs, with 16% more admissions per head than the South West London average for the over

70 population. Non-elective admissions associated with long term conditions are also higher for over 70s than the South West London average.

3 METHODOLOGY

The care home needs assessment consists of the following parts:

- a policy analysis and literature review,
- analysis of questionnaires completed by care homes in Wandsworth,
- key stakeholder interviews, and
- data analysis of hospital admissions and mortality among older people aged >64 who are registered with a Wandsworth GP and resident in the postcode of a care home in Wandsworth.

This HNA deals specifically with care homes for the older population of Wandsworth (>65 years) and will not cover care homes for younger residents with learning or other disabilities. A distinction should also be made between care homes that are residential i.e. there is generally no nursing staff available, residents are more mobile and have fewer or less serious health problems; and care homes that have nursing services available. Many care homes, particularly those that are larger will have a combination of these types of beds available. Residential care homes are reliant on GPs and district nurses to provide medical care to their residents, while nursing homes have their own nursing staff and do not currently receive generic district nursing services, although they are also reliant on GPs and other specialist nurses and specialist services from community teams.

4 POLICY ANALYSIS

This section of the needs assessment sets out the national policy context surrounding the health needs of people who live in care homes. National research, policy and guidance documents have formed the basis of this section.

4.1 Older people

In the UK there are approximately 400,000 people living in over 18,000 care homes (Commission on Dignity in Care for Older People , 2012) which equates to 4% of the over 65 population and nearly 20% of those aged over 85 years (British Geriatrics Soicety, 2011). It is well documented that Britain is an ageing society (Department of Health, 2001) and between 2012 to 2020 there will be a 17% increase in the proportion of people aged 65 years and over in England (POPPI, 2012). Older people are the largest user group of health and social care services, therefore, an increase in the number of older people is likely to result in an increase in the number of people requiring these services.

A Nuffield Trust report (2012) looked at the projected expenditure to 2022 on social care and continuing health care for Englands older population. The key findings of that report were

- The number of older people with moderate or severe disabilities is projected to increase by 32%, and public expenditure on social care and continuing health care for older people is expected to rise by 37% in real terms between 2010 and 2022.
- Depending on whether a low life expectancy projection or a high life expectancy projection is used, the number of older people with moderate or severe disabilities is projected to rise by 30 - 34%, with public expenditure on social care and continuing health care rising by 35 - 40% in real terms between 2010 and 2022.

- In addition, if rates of chronic disease continue to rise in line with recent trends, the number of older people with moderate or severe disabilities is projected to increase by 54%, and public expenditure on social care and continuing health care to increase by 56% between 2010 and 2022, to £14.4 billion in real terms.

As older people are increasingly being supported to remain in their own homes for as long as possible, the number of residential care services has been falling and decreased by 10% between 2004 and 2010 whilst the number of domiciliary care providers increased by over a third (Care Quality Commission, 2011), illustrating the general preference for care to be provided at home. Despite this recent decline it has been estimated that overall there may be a rise in care home places of 150% over the next 50 years (British Geriatrics Soicety, 2011).

4.2 Social care and the older population

Social care is personal and practical support to help people carry out the activities of day-to-day living; keeping well, safe and independent; enjoying a good quality of life; and playing an active role in their communities (Audit Commission, 2013). Social care is crucial to the care of older people and some 80% will need care in the later years of their lives (Nuffield Trust, 2012).

Legal responsibilities for adult social care lie with single tier and county councils and each council decides who is eligible for social care, based on the government's guidance on eligibility criteria for adult social care. This guidance allows councils to decide whether to offer support to people who are assessed as having low, moderate, substantial or critical needs according to the Fair Access to Care Services (FACS) criteria. In 2011 18% of local authorities provided care to individuals who are assessed as 'moderate' with the remaining only providing care services to those who meet the 'substantial' or 'critical' criteria (Age UK, 2012). People may need to pay a financial contribution towards the cost of their social care, or pay the full cost if their income or savings are above certain agreed and specified levels. More than half of the adult social care budget is spent on support for older people. Councils are continuing to have to find ways of reducing costs and improving efficiency in response to substantial budget reductions (Audit Commission, 2013).

Providing good quality social care can help reduce the need for NHS services and Government is encouraging increased health and social care integration in order to improve outcomes for people and to reduce costs.

4.3 Health needs of the care home population

In 2006 a census of 32,301 care home residents found that

- 72% of residents were immobile or reliant on assistance to mobilise
- 62% were confused or forgetful
- 86% had one or more diagnoses clearly driving the need for personal care
- 54% of care related to dementia, stroke or Parkinsonism
- 24% had the 'unholy trinity' of confusion, immobility and incontinence (Gladman, 2007).

In Scotland there is an annual census of care home residents, and on 31st March 2012 there were 32,555 long stay residents in care homes for older people in Scotland accounting for 97 per cent of

the total residents of care homes (Information Services Division Scotland, 2012). The largest proportion of residents were admitted to care homes from hospital. From care homes, 78% were 'discharged' at death, a further 18% were discharged to either another care home or hospital, and very few long stay residents (4%) returned to their own home or supported housing. Since March 2005, the numbers of long stay residents in the 75-84 age group had been steadily falling; a decrease of 7 per cent, and the numbers of residents in the 85-94 age group has increased by 8 per cent. One in two long stay residents in care homes for older people had a formal diagnosis of dementia.

This shows that the care home population is becoming increasingly older and frailer, that for the vast majority the care home will be their place of death, and that majority of residents will have some form of dementia. This is likely to also be the case in the care home population in England.

The most recent CQC report on the state of health and social care in England (Care Quality Commission, 2013) found that more older people are being admitted to hospital in an emergency with conditions that are avoidable and that, if you live in a care home, an avoidable hospital admission was 30% more likely if you also had dementia. The likelihood of an avoidable admission also appears to increase with age. One of the most important contributing factors to this was the interactions between primary health care (GP services), secondary health care (hospitals) and social care (care homes and care provided in people's own homes).

A health needs assessment on care home residents in Tyneside similarly found that 63% of residents had dementia and that other mental health conditions were common. Problems with swallowing, weight loss, malnutrition and dehydration were also common. Importantly they found that many residents had combinations of long-term conditions with 77% having 3 or more co-morbid conditions (Lingard, 2011).

Compared to older people living at home residents in care homes were three times more likely to fall, with the result of a fall often being more serious (Social Care and Social Work Improvement Scotland, 2011). The factors that contribute to this heightened risk of falls include physical frailty and inactivity, the presence of long-term conditions, use of multiple medication and unfamiliar surroundings (Social Care and Social Work Improvement Scotland, 2011).

Older people in care homes have high levels of morbidity, often with multiple health problems and can be on multiple prescribed medicines. In addition the presence of frailty, altered pharmacodynamics, changes in drug distribution and susceptibility to renal and hepatic impairment in old age all mean that these patients are more susceptible to adverse drug events (ADEs). There is a wealth of research that indicates inappropriate prescribing in care homes in the UK and the USA and it is accepted that medication management in care homes needs to be improved (Alldred, et al., 2009). As many residents have some degree of cognitive impairment they are unable to act as detector of medication errors. The Commission for Social Care Inspection (2006b) reports that nearly half of homes (caring for an estimated 200,000 residents) are failing to meet national minimum standards for how they give people medication prescribed by their doctors to treat serious and other illnesses.

These findings indicate not only a high level of health care need but also that the dependency of care home residents is increasing. It is medical morbidity and associated disability rather than general frailty and social need that is precipitating the move to a care home for most residents and it is therefore less likely that the needs of these people can be met in the community (National Care Homes Research and Development Forum, 2007).

4.4 Access to health services

Historically, the NHS was the main provider of long term care for older people, often within a hospital setting through the use of 'geriatric' beds. Over a number of decades as the numbers of beds for older people have reduced, the proportion of long-term care that has been provided in care homes and other community settings has risen (Care Quality Commission, 2011). This has moved the responsibility for the long term health care of older people from specialist hospitals into that of community GPs who have principal responsibility for the medical care of care home residents. Less than 40% of GPs have had any specialist training in the care of the elderly, but are now responsible for the care of people who would previously have been managed by hospital specialists (Steves, et al., 2009). The transfer of care has not been accompanied by a transfer of medical resources to the community to support GPs. Less than 1 per cent of total UK consultant geriatrician time is contractually allocated to care homes (Hockney, 2013). Government policy on healthcare provision to care homes has not been particularly clear and local arrangements for allocating clinical input are variable. There is a growing body of evidence that there is limited medical, multi-professional and specialist gerontological input into care homes (National Care Homes Research and Development Forum, 2007). There is little involvement of geriatricians in pre-assessment of admissions to care homes, particularly those being admitted from the community which limits the input specialists can provide to improving care or assessing the rehabilitation needs of these patients. There has been increased participation of geriatricians in multidisciplinary initiatives to support the ongoing care of residents of care homes however this is predominantly to care homes with nursing rather than residential care homes (Steves, et al., 2009).

In 2010, the CQC conducted a survey of PCT's to determine how care was provided to residents of care homes. These data were analysed by the British Geriatric Society. They found that there was no consensus across PCTs as commissioners about what services older people in care homes needed, how care should be provided and what services can do. Just 51% of PCTs had enhanced service agreements with GPs for work in care homes and only 12% of specialist community services involved a care home specific provider (British Geriatric Society, 2012).

In providing services to meet the health needs of the care home population there is wide variation in both the quality and availability of services. The Care Quality Commission undertook a review of 81 care homes between January and February 2011. The review examined resident's access to NHS services to meet their health needs. In 35% of the homes it was found that there was sometimes a problem getting medication to the resident. There was also variability between care homes in the services provided by GPs and payment for these services. GPs did not provide a post-admission assessment for residents in 33% of care homes, 53% of homes said assessments were provided and paid for by the Primary Care Trust (PCT) however 7% said that whilst the assessments were provided by GPs the care home paid for these themselves (Care Quality Commission, 2011). Although these

findings should be treated with caution due to the low sample size (0.45% of the total care home market) it highlights possible problems in obtaining health services for care home residents.

GP's are predominantly responsible for the care of care home residents and a recent evidence review found that studies had reported an increased workload associated with care homes as a result of the complexity of care needs, travel requirements and being called out inappropriately (Goldman, 2013). The report highlighted the importance of effective communication and information sharing to promote joint working between GPs and care homes. Consistency and availability of medical records at the care home was reported to be a problem, and poor information sharing contributed to medication errors and inappropriate prescribing by GPs. Several studies had reported the importance of leadership and proactivity from care home managers and from GPs, and the positive impact of a close working relationship between the GP and the care home.

Recent announcements by the Department of Health stated that changes to the GP contract for 2014/15 had been agreed, and that these would focus on improving care for the frail elderly. They include providing a named accountable GP for all patients aged 75 and over. The changes also include the introduction of a new enhanced service for patients with complex health and care needs aimed at proactively case managing these patients through integrated care plans, providing timely support to providers via telephone to reduce avoidable hospital admissions or A&E attendance, improve access to appointments for these vulnerable patients, and undertaking internal reviews of unplanned admissions (Department of Health, 2013b) (Department of Health, 2013c).

The variability in access to health services found by the Care Quality Commission's review have also been echoed by the *Quest for Quality, 2011* report by the British Geriatrics Society who state that many care home residents receive fragmented access to NHS services (British Geriatrics Soicety, 2011). A survey of PCTs by the Care Quality Commission found that only 60% of PCTs provided a specialist geriatrician service to all older people and only 43% of PCTs provided all the services considered appropriate to older people (British Geriatric Society, 2012).

Two of the key principles of the NHS Constitution clearly state that it provides a comprehensive service, available to all and secondly that, access to NHS services is based on clinical need, not an individual's ability to pay (Department of Health, 2013a). The difference in health services provided to care homes demonstrates that there is not necessarily clear and standard implementation and interpretation of the NHS Constitution at present.

4.5 Standards and Guidelines

This gradual move to providing health care in more community settings has not been accompanied by any new NHS or government explicit, comprehensive or clear obligations for the delivering of local health services to care homes (British Geriatrics Soicety, 2011). This may explain some of the inequity of health care provision across care homes.

A number of standards and guidelines have been developed to ensure quality health and social care is provided to older people. The *National Service Framework for Older People, 2001* was created to improve the quality and variation in care. The National Service Framework was the first comprehensive strategy that looked specifically at providing fair, high quality health and social care

to older people. It recognised that there had been improvements to the standards of care in care homes, particularly after the *Care Standards Act, 2000* through the creation of the National Care Standards Commission to ensure National Minimum Standards were met (Department of Health, 2001).

Since 2001 there have been a number of national standards for the provision of health and social care within care homes such as the *National Minimum Standards, Care Home Regulations, 2003* published by the Department of Health.

At present, the Care Quality Commission is the regulator of health and adult social care in England and has the responsibility to ensure that the essential standards of quality and safety are met. The essential standards have been produced to comply with the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2010* and the *Care Quality Commission (Registration) Regulations 2009* (Care Quality Commission, 2010). For the last 4 years the CQC has published a State of Care Report on the state of health and social care services. The most recent report found that 1 in 5 nursing home inspections revealed safety concerns such as failing to give out medicines safely or not carrying out risk assessments when starting to care for someone, and ongoing staffing pressures. In residential homes a link was found with notifications of deaths and high staff turnover rates, suggesting that too many changes in staff may result in gaps in care. More than 10% of inspections uncovered problems with either safeguarding and safety, staffing or care and support received by residents (Care Quality Commission, 2013).

In December 2013, NICE (National Institute for Health and Clinical Excellence) published six quality standards for the *Mental wellbeing of older people in care homes* (QS50) (NICE, 2013a). These were published as it was found that many older people in care homes are living with low levels of life satisfaction and wellbeing. Many care homes are still not providing person centered care for older people, residents do not have enough access to activities or ways to occupy their time and may have problems accessing NHS primary and secondary healthcare services. NICE has also set out 14 Quality Statements designed to improve quality of patient experience within adult NHS services. In particular *Quality Statement 12: Coordinated care through the exchange of patient information* sets out to ensure that patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals (NICE, 2012). The report *Delivering Dignity, 2012* has recommended the use of these NICE quality standards for commissioners, providers and regulators to provide a standard to both define and measure performance for adult health services (Commission on Dignity in Care for Older People , 2012).

4.6 Legislation

In the last few years there have been significant changes to health and social care as a result of new legislation. The *Health and Social Care Act 2012* set out the requirement for more effective coordinated working across the NHS, local government and other sectors in order to improve outcomes for people. A number of organisations and groups have been developed in order to promote and enable integration this includes the NHS Commissioning Board, Clinical Commissioning Groups, Monitor, and Health and Wellbeing Boards (Department of Health, 2012). The draft Care

and Support Bill has also set out duties for local authorities to further promote integration of services (HM Government, 2012).

Integrated services are expected to be more person-centred, improve people's outcomes and reduce health inequalities (HM Government, 2012), particularly in the way people can access different services. Integrated services between health and social care was further endorsed by the Commission on Funding of Care and Support in their report *Fairer Care Funding: The Report of the Commission on Funding of Care and Support (2011).*

5 LITERATURE REVIEW

A literature review has been completed to examine the quality of care for chronic diseases among older people in care homes, identify the clinical characteristics of older people living in care homes and examine the level of access to health services for people living in care homes, and ways of providing clinical support to care homes to improve health outcomes for residents.

A search was completed in May 2013 on MEDLINE, EMBASE, CINAHL and the Cochrane database to identify relevant studies. The main search terms were "care home residents", or "homes for the aged", "residential or care or nursing" with "chronic or long term diseases(conditions)", "chronic disease" and "access to care, healthcare or service" and "quality of health care". The search was limited to English language and papers published from 2003 – current. In addition, an extensive search was completed for grey literature, legal and strategic documents and reports and evaluations elsewhere. Titles and abstracts were reviewed and assessed against the following inclusion criteria:

Study design	Systematic reviews, meta-analyses and RCTs were eligible for inclusion. Where these studies were not available, case studies were eligible for inclusion.
Study population	Adult population aged >64 living in care homes.
Outcome measures	**Studies with one or more of the following outcome measures were included:** • Prevalence of long term conditions *(acc to LTC compendium, see Telehealth review)* • Clinical outcomes (including mortality) • Access to primary care services • Access to preventative programmes (health promotion, secondary prevention programmes, falls prevention etc.) • Admission or readmission to hospital • Duration of hospital stay • Does the article identify factors that improve the care of residents in care homes?

A total of 40 papers were identified to review. The majority of studies identified were observational and therefore the results reported must be interpreted with some caution as they do not necessarily report statistically significant findings that can be applied to the local population. Nevertheless, the papers add value to this needs assessment as they identify key themes and issues to consider in light of the findings from the data and stakeholder analysis.

The following section summarises the studies reviewed by theme.

5.1 Management of long-term conditions

Most of the relevant articles related to the management of long-term conditions among care home residents. A UK study assessed 16 process quality indicators for chronic disease management appropriate for vulnerable older people for conditions included in the UK Quality and Outcomes Framework (Shah, et al., 2011). Results shows that attainment of quality indicators was significantly lower for residents of care homes than for those in the community in 14 out of 16 indicators, the largest differences were for prescribing in heart disease and monitoring of diabetes; smaller differences were seen for monitoring hypothyroidism, blood pressure in people with stroke and electrolytes for those receiving loop diuretics. A second UK study assessed the quality of care given to elderly people in Bristol UK and compared the care given to residents in nursing homes with those living in their own homes against quality indicators derived from national sources (Fahey, et al., 2003). The study concluded that the quality of medical care that elderly patients, particularly those in one UK city, and those in nursing homes received, was inadequate. The study reported underuse of beneficial drugs, poor monitoring of chronic disease and overuse of inappropriate or unnecessary drugs. Disease-specific papers were also assessed. A recent UK study used the *Good Clinical Practice Guidelines for Care Home Residents with Diabetes* (Diabetes UK, 2010) and discussed the shortfalls in delivery of care (Kirkland & Sinclair, 2008). Recommendations were made which, included screening for diabetes and related complications on admission to a care home, development of a management plan, and specialist support for care home staff.

5.2 Diagnosis of disease

Underdiagnoses of chronic disease was identified as an issue in the reviewed literature. In one UK study, an established primary care database (THIN) was used to examine recorded chronic disease prevalence in nursing and residential homes compared to the community using QOF disease definitions from the UK general practice contract (Shah, et al., 2010). Results showed that recording of care home residence is limited in primary care and this is a barrier to routine monitoring of this group. Lower prevalence of some chronic diseases suggests incomplete recording or case findings. The study suggests that routine flagging of care home residents in health care systems is a potential tool for improving monitoring and outcomes. An observational study of older subjects (>69) resident in care homes in east Kent also reported that chronic kidney disease was prevalent but unrecognised in the study population (Carter, et al., 2008). This was consistent with findings from an American study that reviewed charts of residents in a nursing home aged 60 and over and concluded that CKD may be substantially underdiagnosed in the elderly nursing home population (Cohen, et al., 2009).

5.3 Models of care

A systematic review identified models of comprehensive health care that have been shown to improve the quality, efficiency, or health-related outcomes of care for chronically ill older persons (Boult, et al., 2009). The review identified several models that had been developed to improve the care of nursing home residents, most of which relied on primary care provided by an advance practice nurse or physician assistant who evaluated the patient every few weeks, trained the nursing home staff to recognise and respond to early signs of deterioration, assessed changes in the patient's status, communicated with family and treated medical conditions in the nursing home. Such programmes, like the US-based EverCare model have shown the capacity to improve quality of care, reduce mortality and patients' use of hospitals and emergency departments. The transfer of

the EverCare model to the UK has however produced less favourable effects (Joseph Rowntree Foundation). Introducing a geriatric nurse practitioner into a nursing home has been reported to lead to a reduction in hospital admissions, improvements in pressure ulcers, incontinence, depression, and aggressive behaviour, but little difference in residents' functional status, physical condition, or satisfaction (Szczepura, et al., 2008).

A peer reviewed descriptive article by Burns and Hurman outlined the use of a community matron for care homes (Burns & Hurman, 2013). They found that it was care homes rather than individual residents that were high users of acute services. The matrons used an advisory, supportive and facilitative approach to assist care home staff in developing their competence and confidence in managing their residents care. The service was found to significantly reduce avoidable attendance or admissions at hospital.

Szczepura et al describe a nursing and physiotherapy in reach team to four residential care homes which was shown to be at least cost neutral but was probably cost saving. Additional non-financial benefits included new and improved skills in care home staff, enhanced quality of care for residents, better access to other specialist services and improved quality of life of residents (Szcezepura, et al., 2008a).

Briggs et al reviewed the impact of a GP Locally Enhanced Service (LES) aimed at improving service delivery to care homes, and found that it appeared to have enhanced the method by which residents were monitored for health problems and improved continuity of care, as well as enhanced the prescribing systems. It also appeared to have significantly reduced hospital referrals and the authors suggest that the service was therefore cost saving, however this was based on figures from one care home. The improvements were suggested to be due to having fixed regular visits to care homes by a specific GP, which provided consistency and allowed improved communication and allowed positive working relationships to develop (Briggs & Bright, 2011).

A search of the grey literature identified a number of other examples of care home support teams in, amongst others, Croydon, Southwark, Manchester, Derbyshire, Sheffield and Gloucestershire. The collaborative model was considered to be key to the success of the intervention. The interventions were mainly multi-disciplinary teams who provided training, education, support and hands on care. A qualitative evaluation of the Croydon care home support team found that there was improved communication between staff, improved staff development and confidence, and improved quality of care (Lawrence & Banerjee, 2010).

In Southwark the Care Homes Support Team was described as a multidisciplinary, inter agency service for 38 independent sector care homes with nursing (CHN) in Lambeth, Southwark and Lewisham (LSL). The clinical team comprised Older People's Specialist Nurses (OPSNs), a Consultant Old Age Psychiatrist, and Pharmacists, and had input from Consultant Geriatricians and a Consultant Nurse. The two primary functions were:

- Systematic determination and review of the nursing care needs of all LSL CHN residents, and where required, review of their Continuing Care needs, to inform commissioning and care planning processes

- Continuous development of knowledge, skills, confidence and practice of the LSL CHN staff to improve the residents' experience of care and quality of life (Bell, 2007).

In Derbyshire, a care home support team pilot was aimed at providing a simplified referral system to intermediate care, individual treatment to residents and supporting staff through training and education (Pessoll, 2011).

In Manchester the care home support team was made up of 2 advanced nurse practitioners who provided support and education to patients and carers proactively managing any health deterioration, carrying out medication reviews, following patients across boundaries with the aim of reducing length of stay in acute trusts. They also liaised and co-ordinated other services for the best interests of the patient (Nursing Home Support Team Central District, 2014).

The Gloucestershire Care Home Support Team was a team of therapists, general nurses, mental health nurses and pharmacists providing support and training to care home staff and primarily focusing on the topic of dementia and person centred care in care homes (Gloucestershire Care Services NHS Trust, 2014).

In Stockton upon Tees and Hartlepool, a quality improvement methodology was used by health and social care services to develop an intervention that was piloted in 3 care homes in the area (North Tees Dementia Collaborative, 2013). It was aimed at improving outcomes and services for patients with dementia and involved the implementation of a number of process improvements including:

- Development of a standard transfer document pack including North East ambulance Service documentation and 'All about me' document.
- Set up reduction by completing and holding these documents in care home records in readiness for any 999 call
- Using yellow folders to provide Visual control of the transfer document pack ensuring the paperwork follows the patient into and out of acute hospital with updating of record by acute staff if required.
- Introduction of regular health observations by residential homes, training provided by Acute Clinical educators.
- Introduction of SBARD tool for communications between care home and health staff for any concerns about resident's health deterioration.
- Agreed procedure for promoting 'Deciding right' within care homes.
- Communication plan and tools to ensure all other parties e.g. GPs, Acute community staff and relatives are informed of the changes.

They found that the introduction of the regular physical health monitoring and improved communication with GPs and health professionals had resulted in a 33% reduction in the number of 999 calls made by the three care homes since the start of the pilot. It was estimated that annual savings to the health economy from these three care homes alone in reduced 999 calls, A&E attendances and admissions were in excess of £33, 000. It has been agreed to roll out this quality improvement process to the remaining 54 care homes in the Stockton on Tees and Hartlepool area.

Although a qualitative evaluation of one of the models described above was found, there were no comparative studies of these models or of any of the elements of the models of care. They were all locally initiated and the structure of the team and intervention appeared to be determined by available resources and local champions. A recent evidence review on the way care homes and GP work together also found little robust UK evidence on outcomes from studies comparing various practice models to usual GP care (Goldman, 2013). The review also discussed examples of nurses and nurse-led teams mediating the relationship between care homes and GPs; taking on some of GPs' work; and having a lead medical role in individual care homes, but again there was no robust evaluation found in the literature on outcomes.

5.4 Prescribing

Prescribing for older people in nursing homes is known to be problematic and it has been accepted that medication management in care homes needs to be improved (Alldred, et al., 2009) Commission for Social Care Inspection, 2006b). Altered pharmacodynamics and hepatic and renal impairment in the elderly, especially in those with co-morbidities who typically need multiple medications, means that prescribing in this group is particularly complicated. A review of studies on prescribing in nursing homes found six key issues that arose consistently and were identified as being particularly problematic. These were: polypharmacy, inappropriate use of medicines (both overuse and under-use), medication-related adverse events, compliance/adherence with medication, medication issues for nursing home staff, and communication across boundaries of care (Parsons, et al., 2011).

A UK study of the prevalence of medication errors in residential and nursing care homes found that residents were on a mean of 7.2 medicines and seven out of 10 residents were exposed to at least one medication error ((Alldred, et al., 2009). Polypharmacy may be associated with falls, hospital admissions, increased length of hospital stay, an increased risk of readmission soon after discharge, and increased mortality. It may also contribute to poor medication adherence, inappropriate prescribing, geriatric syndromes such as urinary incontinence and cognitive impairment, and functional decline in activities of daily living.

The over-use of psychotropic drugs has been a particular concern in the literature on prescribing and use of medicines in nursing homes. It has been suggested that psychotropic drugs may be used as 'chemical restraints' to sedate and subdue residents (Parsons, et al., 2011). There is further information on this in the section reviewing the literature on dementia.

Multiple papers discussed prescribing among nursing home residents; with one concluding that adherence to hypertension guidelines (specifically proportion of people on a thiazide diuretic) among nursing home patients is low (Drawz, et al., 2009) (Roberts & Stokes, 2003).

A project to develop a medication review process in Northumbria Healthcare NHS Foundation Trust used a clinical pharmacist to review the medication of patients in care homes, and a multidisciplinary team comprising of the pharmacist, care home nurse, general practitioner and the patient (or family) to discuss the review and amend treatment as appropriate. After reviewing 105 patients, they had made 364 interventions (the majority of which were to stop medicines), and stopped 195 of 825

medicines (23.6%) that the patients were originally taking. The net cost savings were £21,705 or £206 per patient reviewed (Baqir, 2013).

A review by Burns et al (2011) found that the evidence for a comprehensive geriatric assessment in care home prescribing suggests that it reduces potentially inappropriate medication use and improves sub-optimal prescribing (Burns & McQuillan, 2011). They also found that a medication review as part of a comprehensive assessment rather than in isolation may also be of benefit. Reviews by clinical pharmacists have been suggested to significantly reduce the risk of falls but not to have any impact on overall hospital admission or mortality. There is also evidence of variability in the extent to which GPs follow the suggestions of pharmacists. A single review of repeat prescription lists by a GP for patients in care homes was found to significantly reduce the number of drugs prescribed, the prescribed dose or enabled a switch to a suitable less expensive alternative. This may have financial benefit but there is no evidence yet of impact on quality of life, hospital admissions or adverse drug reactions.

There are a number of interventions that have been recommended to help improve medicines management including

- medication reviews, usually in general practice, that seek to ensure prescribing standards are being met
- pharmacist- and nurse-led interventions that provide educational information and outreach services to reduce prescribing and monitoring errors among high-risk patients
- improved systems to support safe transfer of information on patient medication at admission and discharge
- use of pharmacy technicians to support practices to improve their prescribing practice by conducting systematic audits, evaluating patients and recommending changes to medication (Kings Fund, effective medicines management)

5.5 Palliative and End of life care

Nursing homes are an increasingly common site of death. In England, 16% of all deaths take place in the long-term care sector, with most occurring in nursing homes among over 85 year olds. Older people admitted to nursing homes have been estimated to have a life expectancy of 9–12 months, with those who have dementia having the shortest life expectancy. There is evidence that older people residing in care homes receive variable quality of end-of-life care because of clinical and organisational factors (Seymour, et al., 2010).

Factors identified in the literature as posing problems for the provision of palliative care in the nursing home setting include: the nature of the residents receiving care, the changing profile of individuals admitted to nursing homes and the primary diagnoses, symptoms and disease trajectories of the illnesses experienced by residents living in such homes (Wowchuk, et al., 2006).

Seymour et al (2010) conducted a postal survey of 180 care homes and found that survey respondents alluded to the following difficulties in getting support from GPs: problems of communication, 'out of hours' coverage and variability in interest, skills and willing attendance to residents' needs among the GPs they came into contact with. The survey also showed that nursing homes which implement an end-of-life care tool, such as the GSF or LCP, were more likely to describe their end-of-life care as 'excellent' and 'good'. Providing some insight into how crucial the

implementation of pathways was perceived to be among care home staff and their stakeholders. The role of clinical leadership in care homes was identified as critical to care quality. Regular and proactive input from a multidisciplinary group was a major contributor to the ability of the home to cope with the residents' needs.

This study demonstrated how the delivery of good quality end-of-life care in care homes required an effective balance of external support, such as systems to access medication and syringe drivers, with internal resources, such as staff who are well trained and who work in a supportive culture in which they are able to make residents' and their relatives' needs and concerns their first priority.

5.6 Falls in care homes

Injury caused by falls is the leading cause of accidental death for people over the age of 65 years, and is a significant cause of suffering, disability, loss of independence and decline in quality of life. The incidence of falls in nursing care facilities are reported to be three times that in the community and rates of hip fractures as a result of falls in nursing care facilities have been estimated to be 10 times higher than in the community, accounting for 42% of all hip fractures (Cameron, et al., 2012). Fourty percent of moves to a care home are due to previous falls. Care home residents are likely to be physically frail and have medical conditions that increase the risk of falling, and they may be on medication or combinations of medications that increase the risk of falling (Help the Aged, 2006).

A review by Help the Aged (2006) found that homes that regularly audit falls increase staff awareness of the reasons for falls and actions needed to reduce falls. Raising awareness amongst residents of what can cause falls and their risks of falling and helping them to reduce their risk can also help prevent falls. The majority of falls are caused by complex combinations of factors operating at the time of each event. Experience suggests that falls can be reduced by 50% when an individual's risk of falling is assessed and action taken to reduce the risk (Help the Aged, 2006). Interventions may target risk factors in the individuals or target staff and clinicians with the aim of improving clinical practice or the organisation of care.

Standard 6 of the National Service Framework (NSF) for older people states that the NHS, working in partnership with councils, should take action to prevent falls and reduce resultant fractures or other injuries in their populations of older people. Older people who have fallen should receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialised falls service. The NSF recommends that critical incident analysis following a fall will develop an awareness and learning culture amongst staff and will ensure that action taken will minimise future incidents (Department of Health, 2001).

In 2013 an updated Cochrane review of interventions for preventing falls in older people in nursing care facilities and hospitals included 60 studies with 60, 345 participants of which 43 studies were in nursing care facilities. Their findings included the following:

- Currently, there is no evidence overall that exercise reduces falls in care facilities, but may be more effective in less frail residents. Of the exercise types tested, only balance training using mechanical apparatus in intermediate level care facilities was effective, but the adoption of these interventions may be problematic. These interventions were supervised perturbed gait exercises on a treadmill and balance training using computerised visual feedback.

- Results relating to medication review by pharmacists are equivocal, and no conclusions for clinical practice could be drawn from the review.
- The prescription of vitamin D in care facilities is effective in reducing falls.
- There is currently no evidence of effect from interventions targeting staff and the organisation of care.
- Some falls prevention programmes that target multiple individual risk factors (classified as multifactorial interventions) may be effective (Cameron, et al., 2012).

Recent NICE guidance on falls prevention (2013) made the following recommendations for older people in extended care settings who are at risk of falling:

- Multifactorial interventions with an exercise component are recommended for older people in extended care settings who are at risk of falling.
- Older people on psychotropic medications should have their medication reviewed, with specialist input if appropriate, and discontinued if possible to reduce their risk of falling
- Although the use of combined calcium and vitamin D3 supplementation has been found to reduce fracture rates in older people in residential/nursing homes and sheltered accommodation, no firm recommendation can be made on its use for this indication.
- Reported trials that have used individual patient randomisation have provided no evidence for the effectiveness of hip protectors to prevent fractures when offered to older people living in extended care settings or in their own homes. Data from cluster-randomised trials provide some evidence that hip protectors are effective in the prevention of hip fractures in older people living in extended care settings who are considered at high risk (NICE, 2013b).

An older systematic review and meta-analysis of 43 papers found that the evidence was inconclusive for multifaceted interventions in care homes and single interventions (except hip protectors) in reducing fall rates, risk of falling, or fracture rates. Use of hip protectors in care homes was associated with a small reduction in rates of hip fracture, which despite borderline significance on meta-analysis was inconclusive because of clustering effects (Oliver, et al., 2006).

5.7 Dementia

Recent studies have indicated that at least 80% of people in care homes have dementia or significant memory problems. Providing good care and quality of life to people with dementia is therefore a primary concern of the care home sector. Several reports have drawn attention to issues such as lack of training and support for staff, need for occupation for residents and use of antipsychotic drugs in care homes. Broader challenges also remain around identification of abuse, and sufficient funding for care, which remains a central challenge to provision of appropriate support and care. Furthermore, confidence that people with dementia can enjoy a good quality of life in care homes is lacking. More needs to be done to raise expectations and aspirations for life in care homes, support people to make choices in care, promote care homes as part of the community, and improve public faith in the care home sector (Alzheimers Society, 2013). The Alzheimers Society Home from Home report also found that staff in care homes placed a considerable importance on training and support.

The CQC recently reported that in their inspections of care homes providing care to older people they found that in homes caring for people with dementia, including those with a dedicated dementia unit:

- Not all staff caring for people with dementia had the appropriate skills, knowledge and experience.
- Not all staff understood the Mental Capacity Act (which protects people who lack the capacity to make decisions about their own care) or the implications for people they care for (Care Quality Commission, 2013).

In addition they found that In 2012/13 admissions to hospital for potentially avoidable conditions from care home postcodes were 30% higher among those with dementia than similar people without dementia. A similar pattern was evident for homes providing specialist dementia services and homes without dementia services. However care homes providing nursing care were associated with 39% more avoidable admissions to hospital for those with dementia than those without, while homes without nursing care were associated with 25% more avoidable admissions to hospital for those with dementia than those without. The number of multiple emergency admissions to hospital from care home postcodes was 10% higher among people with dementia than matched people without dementia (Care Quality Commission, 2013).

A 5 country study, which included England, Scotland and Wales, looking at where people with dementia died found that majority (67.5%) died in a long term care facility (Houttekier, et al., 2010), highlighting a need for a palliative approach in dementia (Hughes, et al., 2011).

The development of behavioural and psychological difficulties (BPSD) which may include agitation, aggression, wandering, shouting, repeated questioning and sleep disturbance is common in dementia (Banerjee, 2009). BPSD is often triggered by a physical cause, in particular pain and infections, and a medical review is essential to detect treatable conditions that will improve symptoms (Alzheimers Society, 2011). Behavioural symptoms in dementia patients have traditionally been treated with anti-psychotics, however their use has been associated with 1, 800 excess deaths annually (Child, et al., 2012). NICE guidance recommends that psychosocial and behavioural interventions are used as first line treatments of BPSD and recently the National Dementia Strategy has targeted a two-thirds reduction in the use of antipsychotics for this condition. A study in Medway PCT found that 15.3% of patients on the GP dementia register in the PCT were being treated with anti-psychotics, and that people with dementia living in care homes were 3.5 times more likely to receive an anti-psychotic than people living in their own homes ($p<0.0001$). Of the patients who were not receiving care from local secondary care or learning disability services, a pharmacy led medication review resulted in the withdrawal or a reduction in dosage of 61.4% of these cases (Child, et al., 2012).

A recent analysis by the Public Health Department in Wandsworth estimated the prevalence and incidence of dementia in Wandsworths GP registered population (Public Health Wandsworth, 2012). It was found that most dementia is late-onset and affects people aged 65 and over, with about one in 40 cases being early-onset and occurring before that age. Late onset dementia accounts for 97.8% of the total burden of dementia amounting to an estimated 2,031 cases in Wandsworth. Overall it is estimated that 718 men and 1,314 women have late onset dementia in Wandsworth. The burden of dementia is two times higher in the Wandle locality compared to Battersea and West Wandsworth due to the higher number of older registered patients.

It is estimated that 62% of all people with dementia in Wandsworth have Alzheimer's disease (AD), the most common form of dementia. This equates to around 1,314 people. The next most common subtypes are vascular dementia (VaD) and mixed (vascular dementia and Alzheimer's disease) dementia, together accounting for an estimated 27% of cases (569) in Wandsworth. In order of relative frequency, dementia with lewy bodies, frontotemporal dementia and Parkinson's dementia together account for an estimated 8% (150) of all cases in Wandsworth.

For those with late onset dementia, it is estimated that 1,121 (55%) have mild dementia, 653 (32%) have moderate dementia and 257 (13%) have severe dementia. The proportion considered to have severe dementia increases with age, from an estimated 128 cases (6%) for those aged 65 to 69 to 467 cases (23%) for those aged 95+. The data on dementia prevalence should be used with caution; in particular numbers should not be treated as exact but as an indication of the burden of dementia in the registered population.

6 CARE HOMES IN WANDSWORTH

There were 15 care homes providing care to older people that were included in this needs assessment (Table 1). There were three purely residential care homes included in this review. The remainder are nursing homes or dual registered i.e. providing a combination of nursing and residential beds within units in the home. Five care homes were not meeting all CQC standards as per the latest published CQC reports for each care home (Table 2).

Table 1: Care home types and bed numbers

Care Home	Number of beds	Type of service
Nightingale House	215	Care home service with nursing Care home service without nursing
Meadbank Nursing Centre	176	Care home service with nursing
Ashmead Care Centre	110	Care home service with nursing
Heritage Care Centre	72	Care home service with nursing
George Potter House	69	Care home service with nursing
Rosedene Nursing home	67	Care home service with nursing
Park Lodge Care Home	60	Care home service with nursing Care home service without nursing
Ronald Gibson House	56	Care home service with nursing
Trinity Court	50	Care home service with nursing
The Pines Nursing home	50	Care home service with nursing
Lyle House	45	Care home service without nursing
Wood House	34	Care home service without nursing
Sir Jules Thorn Court	30	Care home service with nursing
Hazel Court Nursing Home	24	Care home service with nursing
Redclyffe Residential Home	21	Care home service without nursing

6.1 Commissioning in Wandsworth care homes

Care homes for older people in Wandsworth have residents that are either self-funded, or have their place commissioned by CCG's, social care or a combination of health and social care services. Other boroughs and CCG's also commission health and social care placements in care homes in Wandsworth, and a care home may therefore have contracts with a number of different commissioners.

Health and social care departments commission places based on different criteria, pay different amounts for placements, and have different lists of approved providers. A health or NHS continuing healthcare placement can be arranged for an individual registered with a Wandsworth GP where that individual has been found to have a 'primary health need' following a health need assessment as set out in the National Framework Guidance (Department of Health, 2012).

Commissioning Support Unit (CSU), currently are responsible for the commissioning of NHS continuing healthcare care packages / placements for the 5 Southwest London CCGs. The CSU, in discussion with the individual and family, select a place that is able to meet the individual's assessed health and associated social care needs and that reflects the individual's preferences, as far as

possible taking into account the risks of different types of provision and fairness of access to resources.

The placement and residents needs are then reviewed at regular intervals to determine if the resident is still eligible for NHS continuing healthcare funding and that the care package is meeting the individuals assessed needs. If the resident following review is determined to no longer be eligible to NHS continuing healthcare funding may be withdrawn. Residents who are no longer eligible for NHS continuing healthcare funding may be eligible to funding from social care, this will be subject to review and decision at that time.

Eligibility for social care funded placements are based on FACS criteria (see section 4.2) and are means tested. An individual will be placed in a home after discussion with the family and the provider, and the placement is then reviewed at regular intervals to determine if the home is meeting the holistic needs of the resident. The local authority has an overarching framework agreement with each home that it commissions beds from which details the care the home is required to provide.

Together health and social care services in Wandsworth commission 51% of beds in care homes for the elderly in the borough, ranging from 18% to 74% of beds in individual homes (J. Chalmers, personal communication). Monitoring of homes and reviewing of the quality of care provided to residents is done separately by health and social care commissioners.

Table 2: Care Home CQC assessment as per latest published CQC report; accessed 28 February 2014

	Standards of treating people with respect and involving them in their care	Standards of providing care treatment and support that meets people's needs	Standards of caring for people safely and protecting them from harm	Standards of staffing	Standards of quality and suitability of management	Date of inspection report publication
Nightingale House	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	February 2014
Rosedene Nursing Home	Meeting the standard	Improvements required	Improvements required	Improvements required	Improvements required	January 2014
George Potter House	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	January 2014
Trinity Court	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	August 2013
Ashmead Care Centre	Improvements required	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	October 2013
Heritage Care centre	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	February 2014
Hazel Court Nursing Home	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	Improvements required	January 2014
Lyle House	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	May 2013
Wood House	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	October 2013
Park Lodge Care Home	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	January 2014
The Pines Nursing Home	Meeting the standard	Meeting the standard	Improvements required	Meeting the standard	Meeting the standard	December 2013
Ronald Gibson House	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	May 2013
Redclyffe Residential Home	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	May 2013
Sir Jules Thorne Court	Meeting the standard	Meeting the standard	Improvements required	Improvements required	Meeting the standard	January 2014
Meadbank Nursing Centre	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	Meeting the standard	October 2013

Source: www.cqc.org.uk

7 DATA ANALYSIS

The aim of the analysis was to assess the current health status of the residents of care homes and their use of secondary healthcare services. However, Public Health were not allowed access to patient-identifiable data from primary care that would have enabled us to identify patients who were actually resident within a care home. Therefore, 'care home residents' refers to patients aged 64 and over, registered with a Wandsworth GP, who were resident at a care home postcode. The dataset may include patients aged >64 who lived at the same postcode but were not necessarily resident in that care home. As a result the findings need to be viewed with caution as we cannot be certain that we had purely the care home population in the dataset (see section 7.1 below). We intended to conduct more extensive analyses but with the limitations of the data, these would have had limited value as they would have been too difficult to interpret. We view the findings from the data analysis as indicators of areas of concern that need further investigation.

Data collection and analysis were conducted prior to 1st April 2013.

Data from Secondary Uses Service (SUS)[1] and the primary care mortality database have been extracted and used for this analysis.

[1] **Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.**

7.1 Demographics

In total there were 789 people registered with a Wandsworth GP, aged >64 and resident in the same postcode as a care home. We assessed the likelihood of non-care home residents being included in the dataset by looking at the numbers and types of additional addresses at each care home postcode (Table 3), and found that two care homes shared a postcode with extra care housing schemes which have a high likelihood of including older residents. The 789 individuals do not include the residents of Meadbank care home as these residents were registered with GP practices outside of Wandsworth.

Table 3: Number of additional addresses at care home postcodes in Wandsworth, October 2013

Care Home	Postcode	Number of additional addresses at the postcode	Comment
Nightingale House	**SW12 8NB**	**0**	
Ashmead Care Centre	**SW15 3AX**	**12**	
Lyle House	**SW15 5LH**	**43**	**Includes 42 flats in an extra care housing scheme**
Heritage Centre	**SW17 6DJ**	**29**	
George Potter House	**SW11 3JR**	**10**	
Wood House	**SW17 0HA**	**84**	**Includes 30 flats in a retirement or sheltered housing scheme only accepting residents >60 years**
Park Lodge	**SW19 6AB**	**3**	
Trinity Court	**SW17 7HL**	**13**	
Rosedene	**SW17 7HJ**	**18**	
The Pines	**SW15 2UQ**	**0**	
Ronald Gibson House	**SW17 0AN**	**3**	**Care home includes a 16 bed intermediate care centre**
Redclyffe	**SW16 1TH**	**16**	
Sir Jules Thorn Court	**SW11 4SL**	**0**	
Hazel Court	**SW11 1YF**	**20**	

Source: Royal Mail Postcode finder, http://www.royalmail.com/postcode-finder , accessed October 2013

In Figure ***5*** we see that as expected there were more females in the care home population (69%) than males (31%), which differs from the Wandsworth over 65 population where males and females make up 44% and 56% of the population respectively. This graph also shows us that the care home population is made up mainly of those aged 85 and over, i.e. the oldest and frailest in the population.

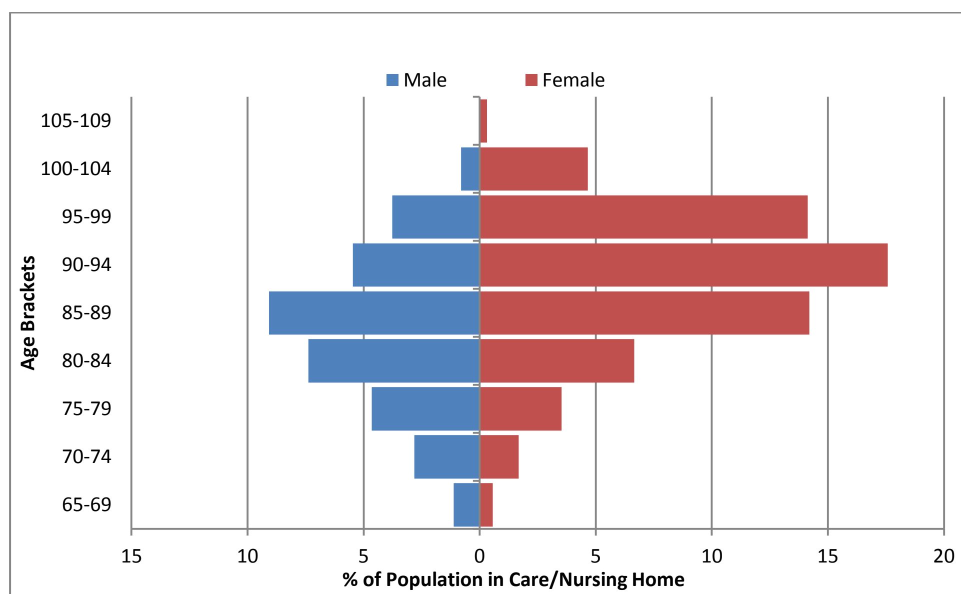


Figure 5: Age and gender breakdown of population of over 64's registered at a care home postcode, April 2013.

Source: Primary Care Support Service, April 2013

7.2 Inpatient admissions

During the three-year period 2009/10 – 2011/12, diseases of the genitourinary system were the most common diagnoses for care home patients admitted to hospital (Table 4). The second most common set of diagnoses are used for conditions that are ill-defined and that cannot be classified elsewhere, commonly used when the diagnosis is not clear. The third most common reasons for admission were related to injuries. Falls are likely to come into this category.

Table 4: Primary diagnosis ICD10 chapter heading for inpatient admissions from care home residents in Wandsworth, 2009 - 2012

Inpatient Admission Primary Diagnosis ICD10 Chapter Heading		2009/10	2010/11	2011/12	Total
N00-N99	Diseases of the genitourinary system	118	106	129	353
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	75	108	101	284
S00-T98	Injury, poisoning and certain other consequences of external causes	58	106	120	284
J00-J99	Diseases of the respiratory system	40	71	111	222
I00-I99	Diseases of the circulatory system	43	86	89	218
K00-K93	Diseases of the digestive system	33	52	70	155
F00-F99	Mental and behavioural disorders	30	44	67	141
M00-M99	Diseases of the musculoskeletal system and connective tissue	19	41	52	112
E00-E90	Endocrine, nutritional and metabolic diseases	23	40	26	89
G00-G99	Diseases of the nervous system	19	22	27	68
H00-H59	Diseases of the eye and adnexa	18	29	12	59
L00-L99	Diseases of the skin and subcutaneous tissue	13	20	12	45
C00-D48	Neoplasms	8	5	26	39
A00-B99	Certain infectious and parasitic diseases	7	8	12	27
D50-D89	Diseases of the blood and blood-forming organs	5	12	10	27
Z00-Z99	Factors influencing health status and contact with health services	9	6	<5	19
	Not recorded	<5	6	<5	10
H60-H95	Diseases of the ear and mastoid process	<5	<5	<5	<5
Total		524	764	868	2156

Source: SUS, 2013

There was variation in the specialty for inpatient admissions across care homes. For all the care homes except one, most admissions were broadly classified as general or geriatric medicine. In one care home accident and emergency medicine was the most common cause for admission.

7.3 Accident and emergency department attendances

There were 1,376 accident and emergency (A&E) attendances between 1 April 2010 – 31 March 2012 from 13 care homes (Table 5). Data from Hazel Court were excluded due to small numbers. There is a wide variation between care homes in the numbers of attendances at A&E, and there is no correlation between the size of the care home and the number of A&E visits. Again at some care homes, the small numbers of registered patients in the dataset make the data difficult to interpret. Due to the nature of the dataset and the lack of other health data on the individual residents, it was not possible to determine what factors might have contributed to the numbers of A&E attendances.

Table 5: Count of accident and emergency attendances by care home, 2010/11 - 2011/12

Care Home	No. of attendances 2010/11	No. of attendances 2011/12	Total
Ashmead Care Centre	80	155	235
Lyle House	99	98	197
Heritage Centre	61	92	153
Wood House	59	84	143
Park Lodge	63	46	109
George Potter House	51	50	101
Trinity Court	42	51	93
Nightingale House	38	54	92
Rosedene	31	37	68
Ronald Gibson House	30	27	57
Redclyffe	26	23	49
Sir Jules Thorne Court	24	24	48
The Pines	20	11	31
Total	**624**	**752**	**1376**

Source: SUS, 2013

7.4 Mortality

Mortality data were analysed for the five year period 2007 – 2012 to account for the small numbers of deaths. The numbers of deaths by cause are presented in Figure 7.

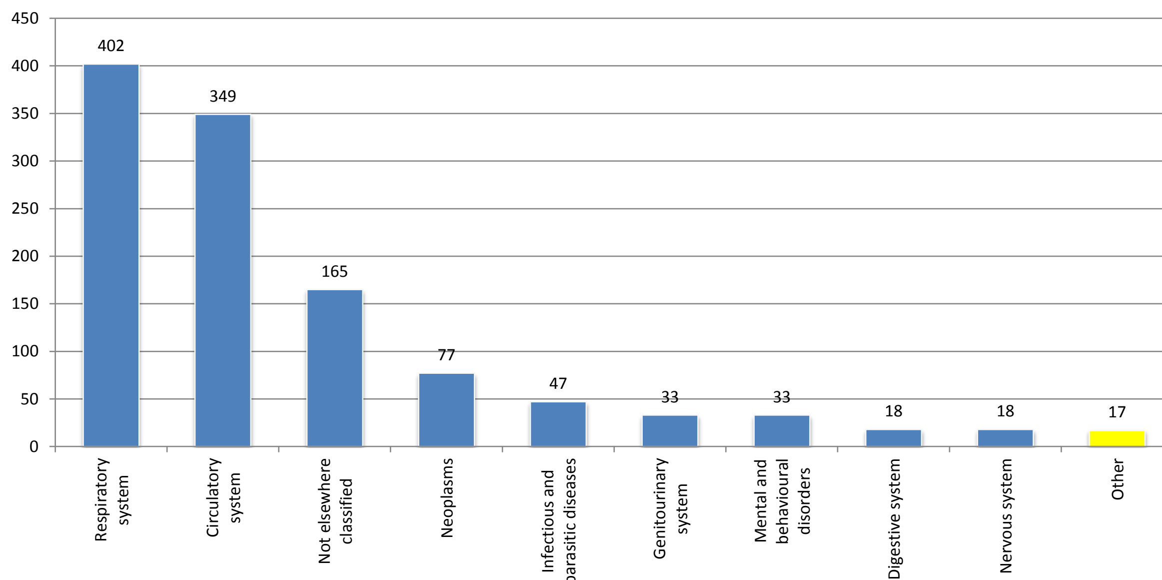


Figure 6: Number of deaths among care home residents by primary cause of death, 2007 – 2012.

Source: Primary Care Mortality Database

The top 5 causes of death among care home residents during the period 2007-2012 were causes related to the respiratory system (441/1246), the cardiovascular system (359/1246), causes that are not elsewhere classified (183/1246), neoplasms (87/1246), and infectious and parasitic diseases (49/1246). Deaths from causes related to the respiratory and cardiovascular system accounted for the highest proportion of deaths in all the care homes except for one.

The London Ambulance Service (LAS) also collect data on the incidents that they are called to at care homes. We are not able to publish these data, however they do show that the proportion of incidents that the LAS are called to where there is no conveyance varies from 0 to 26% by care home. It also shows that the second most common reason for ambulance callouts to care homes is for falls.

8 SURVEY OF CARE HOMES THAT CATER FOR OLDER PEOPLE IN WANDSWORTH

In this part of the needs assessment we undertook a questionnaire survey of all of the 15 care homes in Wandsworth that provide care for people aged 65 and over. This was aimed at enhancing our understanding of the characteristics of the care home sector in Wandsworth, the range of services provided and how they organise and manage their services and care provision. Although we had responses from all the care homes included in the needs assessment, not all questionnaires were fully completed. The answers reflect the views and experiences of care home staff.

Characteristics of care homes

Four out of the 15 care homes categorised themselves as 'charities' compared to 10 that stated that they were 'corporate', while one stated that the care home was 'independent'.

The age distribution of residents in care homes varied, the majority of residents were aged between 60 to 90 years. Nightingale house had the largest number of residents aged over 100 years.

Three of the care homes surveyed did not offer any nursing services, i.e. they were residential homes, and four of the care homes did not offer residential beds. The remainder had a mixture of nursing and residential beds available. Approximately half (7/15) of the care homes stated that they would offer respite care if they had the beds available.

Staffing

The staffing structures in the care homes varied considerably. The largest group of staff members were health care assistants, with smaller numbers of registered nurses and managers. Only two care homes reported that they employed their own physiotherapists, one care home had an in-house occupational therapist, with the remaining homes reliant on referrals to these services. Seven out of 10 care homes who provided this information stated that they only employed permanent staff and made no use of agency staff.

Patient funding

The proportion of residents who were self funded varied between 2% and 66% at different care homes. Care homes reported receiving funding from the local authority for between 15 to 98% of their residents. Most (60%) of care homes did not provide information regarding the proportion of their residents funded by continuing care, those who did answer reported between 4% and 30% of their residents receiving this funding.

Pre-admission process

Patients are assessed prior to admission to the care home by a range of different processes. This included assessment at the patients' home, hospital, or another nursing home or service. The assessment was conducted by either a care home manager, Clinical Nurse Manager, Dementia Champions or Unit manager, Director of Care Services, social worker, GP or CPN. Referrals to the care home come from a range of sources including social services, hospitals, GPs, CPN or self referrals.

> *"Initially a referral is made by social service or a GP or CPN who send in a written report. The patient then visits for a few hours, their family may come as well. At the visit there is a*

> *written assessment, and we watch patients mobility and their response to the home. They can have a second visit if they're not sure. A manager may visit patients in their homes or hospital but it's preferred to have the patient visit. We get information from the hospital and a social services report. There are yearly reviews with the social workers. If mobility begins to be impaired or their condition deteriorates then a GP or psychogeriatrician review is done, firstly to assess if there is anything that can be done to reverse the decline e.g. altering medication. If nothing then we will refer to a nursing unit." (Care home manager)*

Provision of health related care

Health promotion

Most care homes (11/15) stated that health promotion was provided to residents. The information provided was dependent on the needs of residents, requests by family members, information and leaflets available, existing activities in the care home, or if identified as a need by care home nursing staff.

> *"Depending on the residents needs or relatives preferences. Leaflets are available in reception." (Deputy care home manager)*

Health Promotion was provided to residents from a range of different sources including Home Front, 'in-house' i.e. from care home multi-disciplinary staff, St Georges Hospital, specialist local staff, GPs, external training providers and through NHS Leaflets and training.

The care homes that responded stated that the following areas of health promotion had been provided; Healthy Living (including Nutrition, Weight management and Physical activity), Stop smoking, information about access to services, information on funding and information on emergencies.

Three care homes stated that no information was provided to residents or noted 'not applicable' as a response.

Primary care

> *'We would like to see the PCT directly fund GPs who look after care homes. The nursing home has residents from other boroughs as well. There's always been close contact with Wandsworth, and assistance and support is always there, although the owner feels that the payment received for Wandsworth residents is not enough." (Care home manager and owner)*

- **GP practice on retainer:** Most care homes (13/15) stated that they paid a GP or a practice a retainer. GPs attend the care home on a weekly basis at 12 of the 15 care homes. One care home has a GP attend daily, and one care home stated that they attended quarterly. One care home left this question blank.

- **Residents allowed to retain their own GP:** Most care homes (11/15) stated that residents were allowed to retain their own GP. Two care homes stated that residents could keep their own GP if they were local, however patients were encouraged to register with the care home GP as it was often found to be difficult to get other GPs to visit.

- **Annual review by GP**: Six (6/15) care homes stated that residents have an annual review by the GP, while two care homes did not have an annual review for residents. At a further two care homes residents were reported to have an annual general health review by a multi disciplinary team.

- **Annual medication reviews** were reported to be conducted for residents at 12 of the 15 care homes. One care home stated that a 6 monthly review is conducted, while another reported monthly ward rounds that included medication reviews.

- **Enhanced GP services provided for care home residents:** the responses received for this question were variable. Care homes gave details of the specialist services (psychogeriatric, dietician, palliative care, dementia, infection prevention and end of life care) that a GP may refer a resident to, rather than specific details of enhanced primary care services that are provided to care home residents.

- **Protocols for the management of common conditions e.g. UTI's, LRTI's or falls:** Six care homes indicated that protocols were in place compared to four who stated that they were not. Four care homes stated that the management of common conditions was covered within wider policies or through the GP or other clinical staff.

  "There are protocols for the management of clinical areas, also for safeguarding and for falls e.g. triggering a medication review." (Care home manager)

Community based services

- **Contract between the home and community pharmacy**: One care home stated that they have an in-house pharmacy and the remaining care homes stated that a contract with a pharmacy was in place.

- **Medication use reviews for residents**: 11 of the care homes indicated that reviews were completed. Three care homes indicated 'no' or not directly because patients do not self medicate or that the pharmacy checks equipment not medication.

  "Patients do not self medicate. The medication is held by the staff and dispensed to the patient by trained staff. There is annual training done with staff on medication use, or at another time if there are any concerns". (Care home manager)

Care homes were asked about access to a range of other services including occupational therapy, physiotherapy, old age psychiatry, dietetics, podiatry, falls, tissue viability nurses and continence services. The majority of care homes indicated that they had access to these services, either through direct contact or referrals from a GP or district nursing team. There were variable responses regarding how accessible care homes found individual services to be.

Secondary care
Over half (8 out of 15) care homes stated that a geriatrician service was available either through a GP, Mental Health Community Team and St Georges Hospital referral. Five out of 15 care homes stated that a geriatrician service was only available to residents by referral.

End of life care

- **Staff in the care home trained in the Gold Standards Framework for end of life care:** In half of care homes (7/15) it was reported that staff had been trained in end of life care. Three care homes stated that they had received GSF accreditation. One care home stated that 'All senior staff have done palliative care training'. In one care home staff had completed Basic End of Life training and some staff were currently undertaking Level 3 End of life training. In six homes staff were undertaking the GSF training and going for accreditation. A further six care homes stated 'no' or 'not working on this yet' or 'Not in Gold Standard Framework'.

Infection control

Most care homes (13/15) indicated that support was available via an infection control champion, an internal infection control group, the Health Protection Agency, training or general information from the Department of Health and from South West London Health Protection Unit. One care home stated that 'no' advice or support was available, while one other home stated that the care home had inspections from the council on infection control.

Transport to and from hospital for non-urgent appointments.

Most (14/15) indicated that hospital transport was used to transport residents to and from hospital for non-urgent appointments or visits if the residents were eligible. One care home stated that non emergency transport ambulance or private transport was used. If there was a cost involved, half (7/15) of care homes indicated that the family or patient paid for this. In eight care homes the cost was reported to be covered by the company and not passed onto the patient or family. One home stated that the 'GP I suppose' paid for the transport.

Improving care to residents

Care homes were invited to comment on whether they would like to see the access or relationship with health care providers change. Four of care homes stated that 'accessibility' to services would improve care to residents, two care homes identified that 'training' for some 'common medical conditions e.g. diabetes, pressure sores, tissue viability' would be beneficial. Two care homes wanted 'general communication' to improve while one other care home felt that communication with the CCG should be changed.

> *'Training in managing dementia is needed.'(Care home manager)*

Additional primary care services

All care homes stated that residents had access to the dental and optician service. Six out of 15 stated that the services were provided by domiciliary services who visited regularly or on referral and a further six stated that the dentist or optician visited either monthly, 6 monthly or annually, four care homes used a domiciliary team to provide and one reported that residents access dental and optician services by a 'private provider', 'NHS services', 'vision call optical services' or 'health all'.

Rapid response

Care homes were asked to list the top three reasons when a rapid response from community services or primary care could prevent A&E attendance and/or admission to hospital for a resident.

The following reasons were given:

1. Catheterisation (5/15): either a replacement catheter or insertion of a Supra Pubic.
2. Management of acute infections or exacerbations of long term or chronic conditions (4/15) e.g. COPD, diabetes and residents who have sudden onset of symptoms.
3. Residents becoming ill out of working hours (3/15) when GP practices are closed, during the weekends, or bank holidays.

Other reasons listed included; tracheotomy support, treatment of residents with intravenous antibiotics following chest or urinary tract infections, epileptic fits, diabetic coma and increased confusion. Daily visits by the GP to assess the risk of falls were suggested by one care home as one way to prevent A&E attendances and/or hospital admissions.

> *"Rapid response makes very little difference to our client group. Our main reason for calling emergency services would be respiratory or possible fractures. Neither is managed effectively by rapid response because an x-ray or further monitoring is usually required"*

(Care home manager)

9 STAKEHOLDER INTERVIEWS

Eighteen interviews have been completed with 'key stakeholder's identified to have an interest in the care home needs assessment. A complete list of stakeholders can be found in appendix C. The majority of interviews were completed in person, with a small number completed over the telephone, or electronically. Transcripts were sent to interviewees with an opportunity to make amendments. All interviewees were asked 5 questions (see appendix B), key themes have been documented below.

What are the key health and social care issues within care homes in Wandsworth?

Dementia and issues related to dementia, for example, feeding and nutrition, along with speech and language therapy needs were the most commonly identified health care issues among care homes in Wandsworth. Health care staff interviewed noted that even in homes that had dementia units, there was a limited understanding of dementia and evidence based ways of making the home more dementia friendly. The lack of knowledge particularly on how to manage behaviour difficulties in dementia patients had led to the establishment of a pilot Behaviour and Communication Service (BACS) delivered by South West London and St Georges Mental Health Trust to support homes in managing behaviour in dementia residents.

Issues were raised regarding the support required by nursing homes to deliver basic health care. Interviewees noted a tension between nursing homes not having access to community nursing services as they are staffed by registered nurses but not necessarily having the competencies to deal with expected nursing issues, such as catheterisation. The opportunities to perform certain procedures, for example male catheterisation, may not occur regularly enough for nursing staff in the care home to feel competent to perform them when they are needed. There is however the expectation that as staff are registered nurses they should be able to perform a certain range of tasks related to taking samples, catheterisation, feeding, nutrition and continence care.

The commissioning of placements in care homes by health and social care was also raised as an issue. There is little joint commissioning, and health and social care commission based on different criteria. Places in Wandsworth care homes are commissioned by a number of different commissioners and there is little sharing of information particularly on results of reviews of care provided at homes. It was felt that there needed to be better communication between health and social care commissioners and commissioners from other boroughs; greater sharing of information particularly around reviewing placements and monitoring the quality of care provided and how well it is meeting residents' needs. There also needs to be a better process of feeding in results of reviews of individual care into strategic reviews and the overall commissioning process. More commissioning at the individual level is required, and it was suggested that having individual placement plans for continuing care patients may be helpful. Having commissioners work together can strengthen the oversight function and capacity to influence the care provision at the care home.

The communication with and involvement of care home providers in the development and running of services was also felt to be area where improvements were needed. As care homes across the borough are so different, incorporating the views and needs of providers and involving providers as partners in the development of services was felt to be critical. Building on the WBC care home

providers forum, a regular joint forum with health, social care and care home providers would help develop greater partnership working in developing and implementing services.

In addition questions were raised of whether or not there was a proper assessment of the suitability of residents for the care home. The care homes were sometimes felt to be under pressure to accept all residents in order to fill their beds even if they were not always best suited to providing the type of care required.

Equity of access to health care was felt to be a problem in that the older people who live in the community and have complex medical problems are able to access a multidisciplinary team via the community wards, community matrons and the day hospital services, however this is not available for care home residents. Those living in care homes are believed to have all the care they need as nursing staff are available, however the care provided is general and many of the older people need some specialist nursing and medical input. Although facilities like the multidisciplinary team at the Day Hospitals at St John and Queen Mary's, which includes a geriatrician, are available to care home residents these were rarely used. Suggested reasons for this included that several visits to the Day Hospital may be required and this caused significant disruption for staff and residents and could result in increased confusion and agitation in the resident. A 'one-stop shop' where a resident could be sent for a day to be seen and have all needed investigations done in a single visit would be better tolerated.

In addition it was thought that some care homes needed better infrastructure and co-ordination between health care professionals providing in-reach care in the care homes. For example, if the GP holds patient notes on a practice system which is physically separate from the care home those notes are not available for other specialty teams to access within the home. This can result in fragmented care of a resident. Communication of care needs within the care home was also raised as an issue. For example, decisions that were made regarding the care of an individual patient were reported to not be appropriately communicated between shifts, particularly for those who were ill and at risk of an admission.

Pressure area management (tissue viability) was identified as an issue among care homes and the link with neglect and safeguarding raised by more than one interviewee. There is a greater level of support and training required to help primary care and care homes meet the expectations of reporting serious incidents and requirements regarding safeguarding.

End of Life Care in nursing homes, particularly symptom management and ensuring that a resident is able to die in their preferred place of death was identified as a key health issue. More skills were thought to be needed in communication around dying, advance care planning and advance directives, and around what the residents preference for care around death should be. These are sensitive discussions that need to be handled carefully with the resident and family. Also in some instances there was not adequate understanding of what an end-of-life care plan meant, and it was taken to mean that the person was literally at the end of life and needed minimal intervention, where this was not necessarily the case.

Some homes are very risk averse and this can be a barrier to getting residents active and mobile. If there were not enough staff to accompany residents, they were kept sedentary and discouraged from being active and doing things for themselves as they could not be monitored. There wasn't a re-abling attitude in some care homes and acute episodes of illness weren't managed early enough to enable residents to become active again. It was felt that activity needed to be viewed as everybody's business and integrated into every part of every residents day.

Not all of the issues raised above applied to all care homes. Although some care issues were raised consistently as problems, others varied from home to home. Some care homes experienced particular difficulty with certain areas of care that other homes did not, and with high staff turnover this was subject to change over time. The care homes in Wandsworth were not felt to be at all homogenous. They differed considerably in the types of residents, the management structures, the payment for services and the availability of resources. As such it was felt that these differences should be taken into account in developing approaches to supporting care homes, and in particular, that care homes also needed to be part of the process.

Is there variation in levels of access to care within the care homes you work with?

It was acknowledged that there is variation in how care homes across the borough access care for residents. Some homes are very engaged with local services and use specialist community services more proactively, compared to other homes who work in a more isolated manner. Some care homes have specialty teams visiting the care home regularly to provide care for a resident, they are more likely to be utilised by the care home for other residents. As there is high staff turnover in care homes, staff may not have knowledge of the full range of services available and it was felt that providers could do a better job of keeping care homes informed of available services and how to access them. One interviewee noted that there can be inequity within the care home themselves; depending on the organisation and delivery of care (e.g. one ward or floor may access services that are not provided to residents on another floor in the same care home).

Referrals to specialist therapy teams were reported to be one-dimensional as opposed to holistic. There is not a multidisciplinary assessment of residents as may happen in the community and the care provided is often fragmented.

> *"The GP can only act on what is reported to them, so if care homes do not have good communication with a GP, they may not receive services that are available". (Care home manager)*

It was felt that GPs were key to the accessibility of health services. Interviewees felt that a care home with a good relationship with a proactive and accessible GP, who felt comfortable with the level of primary care support were less likely to use the acute services. However when staff did not feel supported, out of fear they were more likely to call emergency services. Although care home staff were largely positive about the relationship with and responsiveness of GPs, one interviewee did report that they had difficulty getting a GP to see patients, and another reported experiencing similar problems in the past. Commissioners have recently had the situation where it has not been possible to register new residents at a care home with a local GP. The matter has been referred to

NHS England but in the interim there are residents in a care home in the borough who are not registered with a GP.

It was also raised that care homes had concentrations of patients with high needs who need a lot of primary care input and that this could take up a lot of a GP practice resources. Particularly those patients with nursing needs and a dementia diagnosis tended to require significant GP input. This can add significantly to the workload of a GP practice.

The management culture of the care home was noted by several interviewees as influencing the level of access to care. The culture of the care home as well as high turnover of staff can mean new teams may not necessarily know what services they can access. It was noted that the manager can influence the attitude of staff – *"if a care home has a forward thinking, enthusiastic manager, this rubs off on staff" (Nurse).* Care homes that are part of larger corporates can have access to more resources for training and support than the smaller independent homes, and there may also be more senior managerial support to the care home manager.

Activity coordinators were cited as an example of a role that varied across care homes. They were felt to be important roles that can improve activity levels in residents and potentially reduce boredom, which is particularly important for those with dementia as it can result in reduced agitation. How well activity programmes are implemented differs from home to home. One interviewee noted that although an activity schedule was in place few of the activities actually occurred. If residents did not express interest or if there wasn't enough staff available, activities would be cancelled. Also, having activities only provided in the home means that residents never get to leave the home and the opportunities for social interaction were therefore limited. It was suggested that social activities in the community like lunch clubs or day groups would be beneficial for the health and well-being of residents. The impact of boredom or a lack of activity on health and the overall well-being of residents was not felt to be fully appreciated.

There is currently no forum where issues relating to care of the frail older person with co-morbidities is overseen. The older peoples Clinical Reference Group which previously provided this function is not active at the moment and although some issues will be discussed in a number of different Clinical Reference Groups, there are gaps and no one group has an overview of all the ongoing work and issues related to health services provided to care home residents. One of the ongoing pilot studies in care homes found that were a number of projects running in care homes in isolation and with conflicting messages, and there was no clear evidence that care homes were implementing recommendations in the long term.

Have you identified any training needs/gaps in the care homes you work with?

The main area identified by key stakeholders was training on dementia. Training that had previously been provided by social services was mentioned several times by different stakeholders as a gap that now exists across the borough. It was noted by one stakeholder that the need for dementia training was not unique to only care home staff, but that this need existed across other health and social care professionals.

> *"Encouraging staff to think outside the box when caring for people with dementia. There is an issue regarding the amount of time spent with patients. Staff in care homes are overworked and often concerned with blame". (Nurse)*

Care home staff were reported to often be asking for training on 'distressed reactions' (formerly referred to as challenging behaviour). Care homes were not necessarily aware of the impact of dementia and memory issues. At times, it was noted that there can be a lack of clinical/health reasoning skills among care home staff to consider behaviour of dementia patients as a result of a clinical (rather than behavioural) issue, for example medication or other clinical influences like an acute infection or an exacerbation of an underlying condition. It was noted that abuse may sometimes happen in this type of setting because of a lack of understanding of dementia and associated behaviours. In response to this a pilot behaviour and communication service was developed to help provide support to homes managing these behaviours.

Care planning was noted across the group of stakeholders as a training need, ranging from advanced care planning, appropriate documentation and person-centred care planning. Better care planning was felt to be needed so that staff know what is normal for a particular resident and are better able to identify problems when they occur. This needed to be associated with protocols for management of certain conditions so that staff know when to call.

Training or education on Deprivation of Liberty and Mental Capacity Act was also noted as a need.
A range of other training needs were identified including continence, diabetes and caring for unstable diabetics, UTI symptom awareness and management as well as 'End of Life care' and syringe driver training.

There was a query among several stakeholders that training may be attended by care home staff, but there is not a clear sense of following up and support for staff after the training. One interviewee felt that training needs to be relevant to the patients you are dealing with at the time and therefore off-site training may be of limited value.

> *"Most care homes are generally good at ensuring mandatory training to staff as this is looked at by Care Quality Commission. The question is whether staff implement what they have learnt when they go back to the care home". (Nurse)*

It was raised that there may not be sufficient support for nursing staff to attend training sessions. Some nurses have been known to attend on their days off.

Some training can be done in the home, but resources are limited and this is done if a particular need is identified. Some of the homes will pay for additional training but more creative ways of organising training need to be found.

Do you provide any training to staff within care homes?

Adult social services previously provided dementia training, but this has since stopped. The Adult Community Mental Health Team can potentially provide training where needed (dependent on capacity).

Specialist community nursing teams run regular sessions that are open to all health care professionals (including care homes). Generally there is a low uptake from care homes. Providing the cover so that care home staff can attend the training is cited as a common reason for low attendance. There is no co-ordination of the training provided by different teams.

Comment on the top 3-5 reasons identified by care homes where a rapid response function is needed to prevent A&E attendance and/or hospital admission.

Stakeholders were presented with the list of reasons that care homes had identified where a rapid response function was needed to prevent A&E attendance or hospital admission(s).

Generally, it was felt that the reasons identified by care homes felt right and were what people would have expected.

One interviewee noted that acute exacerbations were sometimes linked to the speech and language therapy need. A lot of residents are at the end stage of their life. There is a need to support patients to continue feeding as part of end of life care and speech and language therapy services are needed to support that. Another stakeholder queried whether exacerbations would highlight how well a resident is being managed in the care home.

One interviewee observed that they would have expected falls to feature in this list, and that the reasons care homes identified generally related to crisis management.

> *"Falling is an equal crisis, however the types of falls that residents have do not necessarily result in injury and may not be reported as a fall so underreporting is an issue". (Therapist)*

Additional areas where it was felt that a rapid response function would prevent A&E attendances or hospital admissions among care home residents include challenging behaviour, symptom management at end of life, UTIs (particularly among dementia patients) as this can be difficult to pick up as UTI can lead to increased confusion and patients cannot necessarily communicate issues to recognise symptoms. Also care related to incontinence particularly catheterisation.

10 CURRENT WORK AND NEW DEVELOPMENTS IN WANDSWORTH

10.1 Community adult health services (CAHS) redesign

Wandsworths Clinical Commissioning Group has recently agreed a new model for Community Adult Health Services (CAHS). The redesign is aimed at, amongst other things, improving access to community adult health services for patients/service users and all health and social service professionals who need assistance to maintain care for people in the community. In addition it aims to provide a platform where secondary care specialists (such as geriatricians) can integrate with and support community adult health services.

In the proposed new community services structure, it is anticipated that there will be 4 geographically focussed locality teams that will have a range of community services functions including complex case management and specialist input for dementia and mental health and end of life care. As part of this 'in-reach' services will also be available to nursing and residential care homes.

10.2 Behaviour and communication support services (BACS) pilot

Behaviour and Communication Support Service (BACs) to care homes was launched in October 2013. The 6 month pilot is currently being delivered in four Wandsworth care homes and provides training, education and psychology led clinical interventions based on the good practice and evaluation of both the Newcastle and the Sutton and Merton models. BACS works with care home staff to enable them to manage behavioural and psychological difficulties experienced by people living in care homes. The pilot is supporting the reduction of antipsychotic prescribing, unnecessary hospital admissions and improvements in the care and quality of life of people with distressed reactions in care homes. In Wandsworth there are 17 identified care homes that care for older people/people with dementia. Up to 90% of people with dementia (PWD) will have some form of behavioural and psychological symptoms of dementia which cause distress (BSPD) at some point in the course of their condition. It is therefore highly likely that there is substantial need for effective management of this distress in care homes. The pilot findings will inform a business case for funding in 2014-16. Whilst the business case is being developed the pilot has been extended to June 2014 to enable service continuity.

The BACS service functions as part of the Older Adults Community Mental Health Team (OACMHT) and is being provided to people who are resident in pilot site care homes. The BACS will:

- Provide a holistic, person centred assessment of needs consistent with delivering effective intensive interventions for distressed reactions
- Offer support and advice to care home staff and family members / friends
- Share skills and knowledge with other services including the OACMHT/MASW
- Develop personalised care plans in collaboration with person, care home staff and next of kin
- Model good dementia care practices and communication skills in order to enhance quality of care and quality of life with in the care homes.

From referral to discharge the duration of intervention will normally be 12 weeks.

10.3 Access to wellbeing project

The Integrated Falls and Bone Health service conducted a pilot of the Access to Wellbeing project in one care home in Wandsworth in 2013. Access to Wellbeing had previously been implemented in 2 day centres in Wandsworth and had resulted in significant improvements in mobility and activity in patients, as well as a reduction in acute admissions.

In the care home pilot, an occupational therapist spent a 3-week period observing staff and residents in the care home to identify the barriers and facilitators to activity in the home, staff needs, what was appropriate in terms of activities for residents needs and interests. An in-depth sample assessment of residents was done to identify residents needs with respect to mobility, sleep, medication, meal times etc. The overall aim was to identify all the opportunities for greater activity in the home. This was done by looking at the physical environment and opportunities for making this more activity friendly for dementia residents, as well as looking at the interactions of staff and residents for opportunities to introduce small amounts of physical activity in to the daily routines. After observation, feedback was made to the manager of the care home and recommendations were made on changes that could be made to improve activity levels for residents, including changes to the environment. Modules of training were then developed and staff were trained in the home so that they were able to integrate the training into their working.

10.4 Speech and Language Therapy Dementia pilot

The Speech and Language Therapy (SLT) pilot examining the swallowing, nutrition and communication needs of patients with dementia and the support needs of staff at two nursing homes in the Wandsworth borough, was run from mid-January 2013 to 31st March 2013. The pilot was extended to two further homes from July to December 2013. The pilot focused on the swallowing, nutrition and communication needs of patients with dementia and the support needs of the two nursing homes. All patients included in the pilot had some form of dementia or significant cognitive or memory impairment, small vessel disease, cerebrovascular disease which were not specifically from one specific stroke (unless labelled vascular), head injury or developmental issue. Patients generally presented with one or more of the following: noted swallowing difficulty, recurrent chest infections, chocking, persistent coughing following oral intake, poor verbal communication.

The pilot revealed a gap in the service provision of SLT within the community. A number of the patients seen needed multidisciplinary input and onward referrals were made. There was a need for some education in care homes around the risk associated with incorrect feeding. The extended pilot also found that a speech and language therapist working in isolation within a nursing home rather than as part of an MDT approach had limited impact.

In order to address the gap in provision of SLT within the community (including care home residents), WCCG has agreed that as from April 2014 two full time Speech and Language Therapist posts will be delivered as part of the new Community Adult Healthcare service specification, with the expectation that the majority of referrals will be for people diagnosed with dementia.

10.5 A pilot project to optimise prescribing and reduce waste of oral nutritional supplements in nursing & residential homes in Wandsworth CCG.

Wandsworth's spend on Adult Oral Nutritional Supplement (ONS) prescribing is significantly higher than our neighbouring CCGs and Wandsworth is now the 9th highest prescriber in London out of 32 CCG's. London audit data indicates between 57-75% of prescriptions are inappropriate, based on Advisory Committee for Borderline Substances (ACBS) prescribing criteria and dietetic clinical judgement.

In addition to savings associated with reducing inappropriate ONS prescribing, an analysis by NICE suggests that improving the treatment of malnutrition has the third highest potential to deliver cost savings for the NHS (NICE, 2006). A large proportion of sip feed prescribing in Wandsworth CCG is for patients in nursing and care homes. There is considerable opportunity to make savings and optimise prescribing in this area by reviewing patients on sip feeds to assess their dietary needs. There is currently limited dietetic support to care and nursing homes and a pilot project providing dedicated dietetic support in all nursing and care homes in Wandsworth has been agreed.

The provision of adequate quantities of good quality food is essential in care homes if the use of unnecessary nutrition support is to be avoided. ONS should not be used as a substitute for the provision of food. Suitable snacks and food fortification can be used to improve the nutritional intake of those at risk of malnutrition. The "food first" pilot in one care home demonstrated that fortification of care home meals and provision of homemade nourishing drinks can effectively maintain and/or improve the nutritional status of care home residents. The provision of training and a practical framework for identification and treatment of malnutrition in care homes allows nursing and catering staff to effectively manage malnutrition in this setting. Cost analysis demonstrates that significant savings can be made by identifying and treating malnutrition in care homes using a 'food first' approach. There will be residents for whom the 'food first' approach does not meet their nutritional requirements. Prescribed ONS should be considered for such residents and for those who have specific nutritional requirements.

The pilot aims to improve the nutritional intake and status of malnourished older people living in care homes in Wandsworth CCG in a clinical and cost effective manner by employing a registered dietician for one year (working two days per week) who could build upon the findings of the "food first" pilot project at one nursing home.

The dietician aims to ensure the following:

- All patients on ONS will have a dietetic review to ensure that they have a nutritional plan that meets their health needs
- Implementation of the MUST tool and the Wandsworth CCG treatment guidelines into all nursing, and residential registered homes.
- Support and training to care home chefs in the provision of a fortified diet to nutritionally "at risk" residents.
- Re-education of home staff on proper stock management of ONS to reduce wastage of sip feeds

11 DISCUSSION

The care home needs assessment was conducted to provide information on the health needs of the most vulnerable elderly in our population. Although Wandsworths population is predominantly young, local population change predictions suggest that there is going to be a substantial relative increase in the numbers of people aged 80 and over in the next 5 to 10 years. Nationally nearly 20% of those aged 85 and over are resident in care homes. We can therefore expect an increase in the number of people requiring care in these settings. The increasing health costs are already evident in the rises in continuing care funding and non-elective admissions that have been seen in Wandsworth (Wandsworth CCG, 2013). Further analysis of where the increases in costs are occurring i.e. are rising costs due to greater numbers or greater complexity of patient care, would help inform commissioning of appropriate services.

The care home population has in recent years been ageing and has increasing levels of morbidity. The decrease in long term care beds in the NHS means that care homes are having to manage patients with greater levels of frailty and complex morbidity. Other needs assessments of care home populations have found that 77% of residents had 3 or more co-morbid long term conditions (Lingard, 2011). We were unable to assess in this needs assessment the prevalence of long term conditions in the Wandsworth care home population, or to make an assessment of the quality of care for chronic conditions, or whether chronic conditions are being under-diagnosed as has been suggested in the literature as we were unable to access these data. It is however recommended that these analyses are conducted to inform further interventions into care homes and to ensure that relevant services are appropriately targeted.

The data analysis included in this needs assessment was conducted on a dataset that was an approximation of the care home population, as we were not allowed access to data that would have enabled us to identify patients who were actually resident within a care home. We therefore estimated the care home population using patients registered at care home postcodes, and the dataset is very likely to include older people who were resident within the same postcode as a care home but not a resident of the care home itself. The data analysis results are therefore to be interpreted with caution. They are an indicator of possible trends that need to be explored further, and support for these trends have been sought in the literature. As it is possible to identify residents of care homes from GP patient lists, a more accurate analysis is possible. This would provide better information on the health needs of the care home population.

The data analysis suggested that there is huge variation in the use of hospital services by care home, which is supported by the findings of the literature review. The high rate of admissions for diseases of the genitourinary system ties in with input from the stakeholder interviews that problems with continence care and catheterisation are a frequent reason for referral to hospital. The variations in the use of accident and emergency and the London Ambulance Service suggests that there are some care homes that need greater enhanced clinical support than others. It may be that residents of these homes are more clinically complex and greater specialist care is required, or that primary care support to these homes is insufficient, or that more training of staff on specific aspects of care is required. Further investigation for the reasons for high use of emergency services is needed.

As has been found nationally, the health care service provision to care homes is not coherent and care has tended to be fragmented and reactive, although this is not the case for all care homes. The

responsibility for the care of this population lies with GP's and there is little specialist support provided, despite the complexity of the medical needs of this patient population. This was raised as an equity issue by stakeholders as older people in the community with complex medical conditions have access to multidisciplinary teams that either do not appear to be available or are not used for care home residents. The reactive nature of care not only does not allow residents to achieve potential health improvements, but is also costly as it may result in unnecessary use of hospital services. Care home support teams have been established in other places to address the reactive nature of care and have been reported to improve the quality of care and accrue cost savings. This is discussed further below.

The accessibility of health services were reported to be dependent on a number of factors. GPs are key to accessibility as they are primarily responsible for the health care of care home residents. Although most of the care home staff reported good relationships with GPs, other health care workers who go into care homes did raise issues regarding the responsiveness of GPs. Most of the care homes reported paying a retainer fee to a GP or GP practice, however little detail was available on the services that this fee covered and whether these constituted enhanced services. Stakeholders queried the accuracy of the numbers of homes with GPs on retainer as it was felt that the true proportion was much lower, and an alternate source of information found that it was closer to 30%. The literature suggests that improving communication with the GP, having more consistent care i.e. a single GP visiting rather than anyone from a practice, improving information sharing and record keeping, and routinely flagging care home residents on a patient register are all ways in which care could be improved and the use of emergency services reduced (Briggs & Bright, 2011) (Shah, et al., 2010) (Goldman, 2013). Recently announced changes to the GP contact for 2014/15 are focussed on improving care to the frail elderly by improving access to GPs and increasing GP involvement in planning and integrating care for patients with complex health and care needs (Department of Health, 2013b) (Department of Health, 2013c). These positive developments will impact on many care home residents. There is now an opportunity to ensure that as the relationship between GPs and care homes is strengthened, tools such as flagging of care home residents on GP lists are also in place to support the delivery of care.

A proactive and enthusiastic care home manager can also influence access to care, and influence levels of staff turnover. High staff turnover was a factor in service accessibility in that new teams may not know what services were available, although it was also reported that service providers needed to do a better job of keeping care homes informed of available services and how to access them. It is necessary to ensure that information on available specialist services, referral and access criteria and contact details for the services are easily accessible and are less likely to be lost with the loss of institutional memory.

The lack of availability of a multidisciplinary team to oversee the care of care home residents was felt to be a major issue, particularly as this is available to the elderly living in the community. Co-ordination between specialist teams was reported to be poor, and only half of care homes stated that a geriatrician service was available. As there are multidisciplinary teams available to provide support to the elderly living in the community in Wandsworth, for example at the Day Hospitals based at St Johns Therapy Centre and Queen Mary's hospital and through the community ward, exploring how these services might be made available to support the care of those living in care homes is recommended.

In the literature review a variety of examples of how enhanced clinical services have helped care homes avoid use of acute services and incurred savings for health and social care are described. There are however no comparative studies of these models. The few economic studies published suggest that there are financial savings to be made. The variety of models used suggest that it is local need and available resources that have guided the format of enhanced clinical support teams. There are a few factors related to the format of the support services that appear repeatedly in the literature:

- The use of senior or specialist nursing staff, i.e. a matron or a nurse with additional training in care of the elderly as the key contact or provider of the service.
- The use of an advisory or facilitative approach, where the staff of the home are trained and continuing support is provided to enable care home staff to develop competencies and confidence to manage residents' needs.
- A focus on improving communication particularly between primary care and the care home, but also with other specialist therapy teams and with family.
- Access, possibly virtual, to a multidisciplinary team and to specialist geriatrician support.

To determine what the best format of such a team might be in Wandsworth, further local analysis of health service utilisation data by care homes and individuals within care homes is needed, as well as a closer analysis of the precipitating factors for the use of emergency services, and the findings of recent pilots and projects in care homes.

Nursing homes are paid an additional sum for the nursing services that they provide to residents and a tension was noted in the interviews that care home nurses were occasionally not able to perform tasks that were felt to be expected nursing competencies. However it was also noted that some tasks occurred too infrequently in the home for nurses to maintain their competency to perform these. This raised issues of whether or not appropriate assessments of a care homes ability to provide a residents care needs were being made, and how support could be provided to nursing staff in the event that a nursing task could not be performed. It was suggested that nursing support could be provided at a cost to the home in the event a task was deemed to fall into an expected nursing competency, and that a means of supporting nurses to maintain their competency though the availability of a care home matron or specialist nurse that had a training role could be considered.

The management of dementia is one of the key areas of clinical practice in care homes. With an estimated 80% of care home residents having dementia or significant memory problems (Alzheimers Society, 2013) it was unsurprising that training on dementia was one of the most frequently requested areas of support in the stakeholder interviews. The pilot behaviour and communication support service had developed in response to this need and was launched in October 2013. It was also evident from the interviews that there was a need to ensure that staff in care homes were aware of evidence based ways of making the home more dementia friendly, and of supporting residents with dementia to remain as active and engaged as possible. These findings are echoed by the recent CQC State of Care Report (Care Quality Commission, 2013). In addition, that report found that people with dementia are 30% more likely to have an avoidable admission and multiple avoidable admissions to hospital, supporting homes to better manage dementia patients would likely result in cost savings from avoidable admissions.

Falls are known to be a major factor within care homes and a common reason for admission to a care home. In this needs assessment, we were not able from the available data to determine to contribution of falls to the use of acute services. Care home staff reported high levels of awareness of falls as a health issue and all had protocols in place to manage falls. It did emerge in the stakeholder interviews though that the activity and exercise programmes in care homes were sometimes not implemented as they appeared to be on paper. Also out of fear of litigation and a risk averse approach, residents activity was curtailed and they were encouraged to remain sedentary to avoid them falling. A short term evaluation of ambulance call outs and A&E visits by care home residents would provide some insight and quantification of how much of a problem falls are in Wandsworth care homes.

In recognition of a variety of service gaps for care home residents, a number of pilot interventions have recently developed in Wandsworth. The findings from these have provided important insight into some of the health and service gaps in care homes. However there is currently no single group, for example a clinical reference or strategy group, where the findings of these pilots or any other issues relating to care of older people in care homes can be presented to ensure that action is taken and to inform future commissioning. A group with clinical leadership, that has an overview of all ongoing work and issues related to health services provided to care home residents, is needed to oversee the co-ordination of health related activities in care homes, like the pilot studies referred to above, to ensure that these are coherent and the best use of available resources; and to support the co-ordination of health and social care activities.

Better communication between all health, social care and providers is needed both to ensure that the best quality care possible is being provided and to support the development and implementation of services. The commissioning of placements for care homes by both health and social care appears to be complex. Greater communication is required both for the initial choice of the placement and in the monitoring and evaluation of the care provided by care homes. This is necessary not only for safety and clinical governance reasons but, as such a large share of the local care home market is commissioned by health and social care, it is necessary to support joint market engagement in order to ensure the delivery of highest quality care for care home residents in Wandsworth.

12 RECOMMENDATIONS

1) All care home residents should be flagged on the GP database to support regular monitoring of health outcomes and use of health services by this patient group.
2) An in-depth analysis of the health status of care home residents using a dataset comprised of an accurate list of the care home population should be undertaken. In addition an analysis of hospital admissions (and A&E attendances) by care home, to identify causes of hospital admission and to provide a baseline for monitoring the effectiveness of interventions.
3) To improve our understanding of the precipitating factors for use of acute services and in order to determine what the most appropriate format of an intervention to improve care to care homes in Wandsworth would be, it is suggested that for a short period a sample of admissions and ambulance callouts to care homes is reviewed by an clinician to determine what the precipitating factors for the event were and what supportive interventions are required to prevent further occurrences.
4) Where potentially avoidable attendances and/or admissions are identified, establish clear protocols for management of these common conditions and review admissions on a quarterly basis to improve quality of care and avoid unnecessary hospital admissions (and A&E attendances).
5) Consider the establishment of a consistent multi-disciplinary team to provide enhanced clinical support to care homes. Findings from the admissions and call out review described above, and from existing projects in care homes will inform the key elements of support that are required.
6) Identify or establish a clinical or strategic group with representation from both health and social care, to provide oversight of the health care needs of the care home population and how health care services to care homes are organised. Clinical input from a GP lead and geriatric specialist would be required.
7) Develop a joint health, social care and care home providers forum aimed at improving communication and involvement of all partners in the development and implementation of services.
8) Analyse the levels of primary care input provided by GPs to care home residents and use the results to set a minimum local level of primary care provision to care home residents.
9) Define the levels of nursing competency required across care homes. This should involve training required by national regulators as well as locally defined training needs, e.g. dementia.
10) Specialist support and training on dementia should be made available. This was a major area of need and was the most frequently requested area of support from care home staff and health workers working in care homes.
11) Ensure that care homes have easy access to up to date information regarding available specialist services to care homes, including methods of referral as well as service contact details.
12) Define protocols for the following procedures for health and social care funded placements in partnership with care homes;
    a. **Preadmission process** for residents entering a care home: this will involve screening for physical and mental health needs as well as social care needs.

b. **Care planning documentation**: ensure that all care homes have person-centred, holistic care plans that consider the individual and their carer and how they are involved in care planning.

13) Consideration should be given to implementing individual placement plans for continuing care patients.
14) Establish an information sharing protocol between health and social care commissioners to improve information sharing on initial placements, reviews, and monitoring and evaluation of placements. A large share of the care home market is commissioned by the health and social care sectors and information sharing is critical to ensuring that high quality care that meets patients needs is delivered.

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We would also like to thank the numerous stakeholders who have allowed us to interview them and have contributed significantly to this report.

15 APPENDICES

Appendix A: Care home questionnaire

Wandsworth Care Homes Health Needs Assessment: Care Homes Survey

This survey forms part of the Care Homes Health Needs Assessment of residential and nursing care homes in Wandsworth. For any further information about this questionnaire please contact Chrystal Greenwood, Public Health Department, Wandsworth Borough Council. Tel: 020 8871 5030 (Cgreenwood@wandsworth.gov.uk)

1.	**General Information**		
a.	Name of care home		
b.	Address		
c.	Manager	Name: Telephone: E-mail	
d.	Category of care home	Corporate	
		Charity	
		Housing association	
e.	Name and position of person completing the form		
f.	Name and contact details of person to contact for clarification or further information		

2.	**Overview of care home**		
a.	Number of available beds	Nursing beds	
		Residential beds	
		Respite beds	
b.	Age distribution of residents	Age group	No. of residents in age group
		<50	
		50-60	
		60-70	
		70-80	
		80-90	
		90+	
c.	Staffing	Types of available staff and numbers	
		Nursing	
		Health care assistants	
		Managers	
		How are staff predominantly employed?	

d.	Assessment of patients pre-admission	How and where is this done?	
e.	Funding	Proportion of patients who are: Self funded Funded by local authority Funded by continuing care	

3.	**Provision of health related care**	
a.	**Health promotion**	
i.	Is information provided to care home staff on healthy eating, obesity, physical activity, smoking and cancer screening?	
ii.	Who provides this information?	
iii.	What information is made available to residents?	
b.	**Primary care**	
i.	Does the home have a contracted GP/GP on retainer?	
ii.	If yes, how often do GP's visit the home?	
iii.	If no, how do residents get to see a GP?	
iv.	For visits to the home, what is the average waiting time for a GP visit?	
v.	Are patients allowed to retain their own GP?	
vi.	Does every patient have an annual review by the GP?	
vii.	Does every patient have an annual medication review?	
viii.	Are there other enhanced GP services provided for care home residents? This may include the following: o full health assessment on admission (inc. nutritional status and preventative measures) o specialist assessments o regular visits with face to face contact with patients / carers o support care home nursing staff to develop end-of-life care plans o general support to care home staff inc. advice on NHS services available to patients o liaison with other healthcare	

	professionals working with patient / home		
ix.	Are there protocols in place for the management of common conditions e.g. UTI's, LRTI's or falls?		
c.	**Community based services**		
i.	Does the home have a contract with a community pharmacy?		
ii.	Do care home residents receive medication use reviews?		
iii.	Is access to the following services available for care home residents: Access to these services is mediated through the GP. Any patient with mental health needs all have a CPN attached and will get psychology input as needed.	A psychologist for people with learning disabilities	
		Old age psychiatry	
		Dietetics service	
		Occupational therapy service	
		Physiotherapy service	
		Podiatry	
		Falls service	
		Continence service	
		Tissue viability specialists	
iv.	Is there regular contact with community nurses or matrons?		
v.	What of the above services do care home staff value most or would like access to most?		
d.	**Secondary care**		
	Is there a geriatrician service to care home residents?		

6.	**End of life care**	
a.	Have staff in the care home been trained in the Gold Standards Framework for end of life care?	
b.	Has accreditation been achieved?	

7.	**Infection control**	
	Do you receive advice or support on infection control?	
	If yes, who provides this advice?	
	Is further support needed?	

8.	**Transport**	

	How are patients transported to and from hospital for non-urgent appointments or visits?	
	Is an attendant required?	
	If yes, how is this paid for?	

9.	**Improving the care to residents**	
	How would you like to see the access/relationship with health care providers change?	
	How do you think this will improve the health of the residents in the care home?	

ADDITIONAL QUESTIONS

10.	**Additional primary care services**	
a.	Do residents have access to dental and optician services?	Yes / No
b.	If yes, please briefly state how these are provided.	
c.	What works well/what doesn't work well?) Are the services provided able to meet the needs of all residents?	

11.	**Rapid response**	
	Please list the top 3- 5 reasons when a rapid response from community services or primary care (within 2 – 4 hours) could prevent A&E attendance and/or admission to hospital for a resident? (e.g. Interventions may include male catheterisation, supra pubic catheterisation if problems such as spasm occurred, replacing a PEG tube etc.)?	

ADDITIONAL NOTES (please add any additional comments).

Appendix B: Interview guide

CHNA Stakeholder interview:

Location:

Name and job title:

1. Please describe your role and how this links with care homes in Wandsworth? *(Are the team involved in referrals of patients to care homes, do they hold a regular clinic, or a rapid response function?)*

2. What do you think the key (health and social care) issues are within care homes currently?

3. Is there variation in levels of access to care within the care homes that you work with?

4. Have you identified any training needs/gaps in the care homes you work with? Do you provide any training to staff within care homes? *(uptake of training and education opportunities by care homes)*

5. Comment on the top 3-5 reasons where a rapid response function is needed to prevent A&E attendance and/or hospital admission. *(care homes have identified* **catheterisation** *(PEG Tube or replacement or Supra Pubic),* ***management of acute infections or exacerbations of long term/ chronic conditions*** *e.g. COPD, diabetes and sudden onset of symptoms etc. and* ***residents becoming ill out of working hours*** *(when GP practices are closed, during the weekends, or bank holidays) as the top three reasons where a rapid response would prevent A&E attendance or hospital admission of a resident.*

   Do these feel right to you?

   Are there any other rapid response services that you would expect to be in place to prevent unnecessary A&E attendances and/or hospital admissions?

Appendix C: List of Stakeholders

Name	Job title
Colin Edwards	CCG Safeguarding Adults Lead
Andrew McMylor	Director of CCG Development & Delivery
Dr. Seth Rankin	Lead GP – Older People
Dr. Stephen Deas	Lead GP – EoLC
Dr Rod Ewen	GP and Battersea Locality Clinical Commissioning Lead, WCCG
Sue Tappenden	CCG Commissioning Manager
Jane Hill	Head of Continuing Care
Nicky Parry	Care Home GSF Facilitator
Jessica Barnes-Webb	EoLC Dementia Clinical Nurse Specialist
Claire Ratnayake	Head of Clinical and Service Improvement, WCCG.
Joanna Mcilmurray	Clinical team leader - Primary Care Therapy Team
Fleur Norwood	Head of Community Nursing (including specialist nurses)
Iris Jackson	Acting Team manager, Wandsworth Adult Social Services
Dr Andrew Crombie	Consultant old age psychiatry
Jane Farrell	Interim team manager (Older people's CMHT)
Vicky Damani	Prescribing Advisor, Wandsworth CCG.
Bernadette Kennedy	Head of falls and bone health service, SGH
Liezel Anderson	Occupational Therapist, Falls and bone health service
Sydney Hill	Quality Assurance and Care Home Team [QACH]manager, Adult Social Services
Ambra Caruso	Manager, Health Watch Wandsworth
Clive Simmons	Adult Social Services – Safeguarding Lead
Gill Thompson	Dementia Project Manager
Noyola McNicholls-Washington	Intermediate Care team
Harold Lo	Medical Director, Community Nursing.
Paul Courtman	Clinical team leader, Respiratory and Cardiac Nursing.
Rachel Smithdale	Tissue viability nurse, Community Nursing
Alison Kirby	Commissioning manager for older people, Wandsworth CCG
John Chalmers	Commissioning and service development manager, Wandsworth Borough Council
List of care home contributors	
Nightingale House	Simon Pedzisi, director of care services
Meadbank Nursing Centre	Sonya Fenwick, deputy manager
Ashmead Care Centre	Hugh Wright
Heritage Care Centre	Verna Yap, care home manager
George Potter House	Pauline Hamadi, care home manager
Rosedene Nursing home	Pat Barber, care home manager
Park Lodge Care Home	Ololade Nade, care home manager
Ronald Gibson House	Ann Hinds and Toni Turner, care home managers
Trinity Court	Santa Daly, care home manager
The Pines Nursing home	Sarie Kolbe, care home manager
Lyle House	Sharon Simpson, care home manager

Wood House	Julius Seid, care home manager
Sir Jules Thorn Court	Ann McCormack, manager
Hazel Court Nursing Home	Manny Tagulinao, registered care home manager
Redclyffe Residential Home	Yvonne Wallace, care home manager