QUEST FOR QUALITY

2011

**British Geriatrics Society
Joint Working Party Inquiry into
the Quality of Healthcare Support
for Older People in Care Homes:
A Call for Leadership, Partnership and
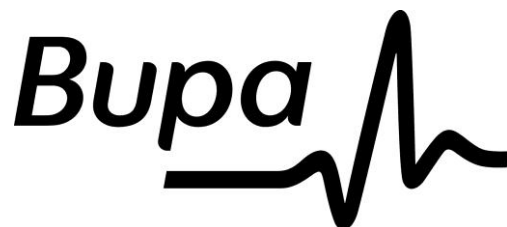Quality Improvement**

Quest for Quality

An Inquiry into the Quality of Healthcare Support for Older People in Care Homes: A Call for Leadership, Partnership and Improvement

June 2011

Contents

1. Executive summary and recommendations

This report describes current NHS support for care homes. It tells a story of unmet need, unacceptable variation and often poor quality of care provided by the NHS to the estimated 400,000 older people resident in UK care homes.

It describes what should and could be done and calls for national action by government and local action by NHS commissioners, planners and clinical services to improve the quality of NHS support to care homes.

It highlights the need to build joint professional leadership from the health, social, and care home sectors, statutory regulators and patient advocacy groups to find the solutions that none of these can achieve alone.

The problems
1. Residents of Care homes have complex healthcare needs, reflecting multiple long-term conditions, significant disability and frailty.
2. The social care model is central but insufficient to meet residents' health needs.
3. As the independent sector grew to take on this area of care over the last three decades, the NHS gradually withdrew its expertise and support. Most geriatricians and old age psychiatrists now play no part.
4. Regulation can highlight problems and promote improvement but care home providers cannot achieve this without necessary support.
5. No model of co-ordinated healthcare has been developed to meet the needs of care home residents. 'Traditional' general practice in many areas does not appear equipped or supported to fill this void.
6. Our report shows that many care home residents are denied equitable access to suitable NHS primary and secondary healthcare. While NHS policy makers, commissioners or managers acknowledge that there are problems, they have little consensus on their obligations to address this. Ensuring effective healthcare for individual residents and effective support for care homes seems to be a low priority. As a result, residents are denied the necessary healthcare resources, support and expertise they need and many are inappropriately admitted to hospital.
7. Care homes will continue to be an important component of care provision for frail older people. But healthcare for residents remains a "Cinderella" service in the NHS. This is a betrayal of older people, an infringement of their human rights and is unacceptable in a civilised society.

What is needed?
1. **A health service suitable for the specific needs of this population.** This means a structured and pro-active approach to care, with coordinated teams working together built on primary care and supported by a range of specialists (for instance geriatric medicine, mental health and rehabilitation medicine).
2. **The residents and their relatives must be at the centre of decisions about care**. Their voices and those of their advocates must be heard, and their choices and priorities known and respected.
3. **A multi-disciplinary approach.** This should include nationally consistent access to specialist community nursing and the full range of allied health professionals which would be available to older people living at home.
4. **A partnership approach with care homes and social care professionals.** This means shared information, assessments, policies, training and learning to support quality improvement and clinical governance to tackle key challenges that affect the quality of life of residents.

Recommendations

1. Local NHS planners/commissioners should ensure that clear and specific service specifications are agreed with their local NHS providers**.** These need to link with quality standards based on patient experience and appropriate clinical outcomes.
2. Care home residents should be at the centre of decisions about their care. An integrated social and clinical approach should support anticipatory care planning, encompassing preferred place of care and end of life plans.
3. Service specification for providing healthcare support to care homes should guarantee a holistic review for any individual within a set period from their move into a care home, leading to healthcare plans with clear goals. This will guide medication reviews and modifications, and clinical interventions both in and "out of hours".
4. Healthcare services to support the achievement of these goals (see Recommendation 3) should be integrated. This should combine enhanced primary medical and nursing care with dedicated input from departments of old age medicine, mental health services, and other specialisms such as palliative care and rehabilitation medicine according to local needs.
5. The UK nations' health departments should clarify NHS obligations for NHS care to care home residents.
6. Statutory regulators should include in their scope of scrutiny, the provision of NHS support to care homes and the achievement of quality standards.
7. Multi-agency and multi-professional national leadership should be promoted to support development and dissemination of good healthcare practice in care homes, supported by clinical guidance and quality standards.

This report marks the start of a process of partnership to develop impetus, resources and clinical guidance that will support the NHS to play part in improving the experience and the quality of life of residents in care homes.

The report and its recommendations were developed through collaborative inquiry of stakeholders drawn from care homes, social care, NHS (including primary care) and academia.

2. Introduction

Defining exactly what is meant by a care home can be a complex task given that all four nations of the UK use different terms. A care home has been defined as a 'residential setting where…older people live, usually in single rooms, and have access to on-site care services'[1] and where residents do not legally own or rent their home.[2] Care homes for older people are often categorised by the type of care they provide rather than the type of ownership.[3] In England, the Care Quality Commission defines both as residential social care, referring to them as 'care homes with nursing services' or those 'without'.[4] In Northern Ireland, the terms 'nursing homes' and 'residential homes' are used.[5] In Scotland and Wales the term care home is used to include those with nursing care.[6]

In practice, however, the distinction is vital to those providing the accommodation as this regulated activity brings with it specific responsibilities. Furthermore, the provision of nursing care for an individual can affect the individual resident's entitlement to NHS services, specifically to general district nursing. Also, there can be differences in the personal and health needs of residents, with nursing homes often caring for older people with higher levels of morbidity and disability, requiring nursing support.

In this report, the term 'care home' will be used to apply to both care homes providing residential services only and to those providing nursing care also. There is considerable overlap in the case mix and clinical needs of the populations, regardless of registration status. Also, the majority of the issues outlined in this report affect both types of care homes.

In 2000 the British Geriatrics Society (BGS), Royal College of Physicians London (RCP) and the Royal College of Nursing (RCN) produced guidance and recommendations for the health and care of people in care homes.[7] It highlighted that 'care-home residents have often become the medically dispossessed in spite of their complex health care needs, which may contribute to avoidable ill-health and acute hospital admissions'.[8] Recommendations were made which set out how the NHS could do better, promoting the idea of an older persons' specialist nurse working with primary care and specialist services to support care homes. The report concluded that 'it is a paradox that older people with the greatest needs for consistent, creative and effective care now live in care homes denied the traditional essence of inter-disciplinary geriatric care'.[9]

In 2000, there was limited evidence upon which to base these recommendations. They represented a consensus view of concerned professionals. At that stage, there had been little practical engagement by these multi-professional groups with the care homes sector itself. Since then, there has been increasing engagement between the NHS and care homes, partly to satisfy the statutory requirement for assessment and funding of nursing care.

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[1] http://www.firststopcareadvice.org.uk/jargon-care-home.aspx Accessed 7 June 2011.
[2] Essential Standards of Quality and Safety, Care Quality Commission, March 2010, 26.
[3] My Home Life, Quality of life in care homes, A review of the literature, prepared for Help the Aged by The National Care Homes Research and Development Forum, Help the Aged, 2007, 11.
[4] Essential standards of quality and safety, Care Quality Commission, March 2010, 26.
[5] http://www.rqia.org.uk/what_we_do/registration__inspection_and_reviews/who_we_regulate.cfm Accessed 12 June 2011.
[6] British Geriatrics Society Scotland and Royal College of General Practitioners Scotland, Frailty, Older People and Care Homes, Can we do better?: Improving What we do? October 2009, 7. http://www.scswis.com/index.php?option=com_content&task=view&id=7671&Itemid=522 Accessed 8 June 2011. Care and Social Services Inspectorate Wales, Annual Report 2009-2010, January 2011, 7.
7 Royal College of Physicians, Royal College of Nursing, British Geriatrics Society. The Health and Care of Older People in Care Homes. A comprehensive interdisciplinary approach. A report of a joint working party. Royal College of Physicians. London 2000.
8 *Ibid*, Para 2.9.
9 *Ibid*, Para 2.4.

We produced this 2011 report with recommendations for action because far too little has been done to meet these obligations. We believe that many in the NHS with responsibilities for local services are unclear about what these obligations mean in practice and how best to meet them for care home residents. Thus, in some localities, the NHS has done little or nothing to improve support for care homes despite record increases in health spending over the past decade. Meanwhile, others have funded specialist teams, education and training partnerships and GP services (PMS) solely for care home residents. The economic climate has now changed but this cannot be an excuse for inaction. In fact, we suggest that not acting now is not only a breach of the NHS's duty, but would also constitute an expensive folly. It would perpetuate the unnecessary and inappropriate patterns of healthcare use which inevitably result from an inadequately coordinated service. It also risks isolating care homes from the wider systems of healthcare and reduces their accountability to colleagues in the NHS. In this document we present a rationale for action and offer some suggestions on how it should be carried out. This matters for residents of care homes and their families, but it also matters to those charged with planning or providing an efficient and effective health and social care system. It should also matter to the rest of us, as the way we care for the most vulnerable people in our population is a barometer of a civilised society.

It is unclear whether the previous lack of progress in this area is due to ignorance or ageism or the lack of appropriate incentives and sanctions to redress the situation. The *Equality Act* (2010) may force some of these issues to be addressed, but this report also considers other more complex contributing factors including:

- Financial pressures have been a dominant force in the relationship between local authorities and social care commissioners.
- The regulatory frameworks in which care homes have existed have created conflicting pressures, often discouraging providers from innovations such as in end of life care (e.g. Liverpool Pathway, Gold Standards Framework), for which there has been no additional resource provided. The care homes and their staff are invariably regarded by the NHS as central to the solution of providing long-term care to the oldest old but often fail to provide the requisite corresponding support.
- Fragmentation in service organisation and delivery within the NHS and between health and social care is another obstacle, and has impeded the development of a collaborative model of care in which the NHS could provide consistent support.
- Finally, there has been lack of clarity amongst clinicians about what should be done. Evidence-based clinical practice guidance may help in the treatment of long term conditions in the average older person, but may not help the non-specialist clinician providing long-term care to the resident with complex co-morbidity and relatively short life expectancy.

a) This report
The primary focus of this report is older people in care homes, but the report also covers some specific needs of younger people and adults of all ages with complex neurological disabilities in long-term care. (The British Society of Rehabilitation Medicine is currently drawing up a parallel set of guidance specifically for the needs of this group titled *Specialist Nursing Home Care for People with Complex Neurological Disability*.)

This report was produced by a broader alliance than our previous report created in 2000. The working party liased more closely with the care homes sector. The collaboration was initiated and led by the BGS in partnership with many professional organisations, clinicians experienced in care homes work,

academic researchers, organisations representing care home providers and providers themselves.[10] These stakeholders comprised an overarching steering group for the work. The BGS Secretariat coordinated the project and was responsible for its publication.

b) Aim and objectives

The aim of this report is to improve the quality of health care services for people living (and dying) in care homes.

The objective of this report was to:
- Take a strategic perspective in understanding the challenges and potential solutions for the healthcare needs of care home residents.
- Draw upon evidence which reflects the voice of the older resident based on their receipt of healthcare support, particularly medical support, their views on the problems and potential solutions.
- Learn about the key clinical challenges in providing high quality, safe care for residents from the experience of care homes providers and healthcare professionals.
- Draw upon the perspectives of local authorities in their commissioning and that of practitioners with responsibilities for assessing care planning and arranging publicly funded care.
- Learn from residents, care homes providers and experienced healthcare professionals about successful clinical practice for improving the quality of life (and of dying) in care homes.
- Evaluate the published evidence on innovations and models of healthcare provision used to support care homes and their residents. Incorporate the characteristics of useful models in our recommendations about service specification and commissioning.
- Identify any policy or regulatory changes that would support the implementation of these recommendations.

The range of healthcare issues which face care homes is enormous. In this context we have restricted the focus of our report to those issues which we consider to be within our areas of expertise and experience. This is a report about healthcare provision by the NHS. To be effective, there must be a partnership between the care home providers, social care commissioners and practitioners. Our conclusions and recommendations are intended as a resource and benchmark for the policy and regulatory frameworks, and to aid workforce development and planning to provide high quality safe personal and nursing care.

c) Methods

We used several approaches to assess the current situation, to understand what is needed and learn to from the research and experience.

We commissioned research and held in-depth interviews and focus group discussions to arrive at a greater understanding of care homes, the health and healthcare needs of their residents, the current arrangements in the NHS to support meeting these needs, and the research evidence on specific clinical practice innovations and models of service provision. These strands of work were funded through a £67K unrestricted educational grant from Bupa.

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[10] Appendix 1 for list of organisations that were collaborators and/or endorsed this report.

i) Working with stakeholders

- We arranged for provider organisation from the care homes sector to be represented on our steering group to give knowledge and insight and to facilitate access to front line sources.
- We undertook an integrative review of all current reviews of the published research literature.
- We collaborated with the *My Home Life* project (MHL, www.myhomelife.org.uk), a UK-wide initiative aimed at promoting quality of life for those who are living, dying, visiting or working in care homes for older people. MHL is led by Age UK (Age Concern and Help the Aged) in partnership with City University London and Joseph Rowntree Foundation, and is supported by the Relatives and Residents Association and all the national provider organisations that represent care homes across the UK.[11]
- We arranged interviews and focus group discussions with a representative sample of senior and experienced clinicians working in care homes. During these interview we canvassed their:
    - Perspective on the important health issues and healthcare challenges of the residents they cared for.
    - Opinions on the support residents currently receive from the NHS.
    - Experience of what support from GPs and other external health professionals works best.

ii) Obtaining health professionals' perspectives

- We arranged professional organisation representation on our steering group to agree the scope of this report and to provide knowledge and ongoing commitment to the findings.
- We undertook in-depth interviews with 21 health professionals who work predominantly with older people in care homes around Britain (18 in England, two in Scotland and one in Wales). They included:
    - Six geriatricians.
    - Five GPs (two providing regular but not enhanced input as part of their general practice, two working within a locally enhanced service and who were GPs with special interest in older people (GPSIs), one working in nursing home medical practices).
    - Two Older People Specialist Nurses (OPSNs) working as part of the NHS PCT provider service, predominantly in care homes.
    - Two OPSNs specialising in mental health.
    - Two community matrons.
    - Two other qualified nurses (care home manager and researcher).

    The interviews explored:
    - Their opinions on what the important health issues and healthcare challenges are for the residents.
    - Their experiences of working together with care homes and other health professionals, and whether there are already proven effective ways of working.
    - What local factors contribute to success or failure of joint working.
    - Opinions on what might be the best overall model of NHS provision.
    - Judgment on how, in clinical terms, they can make the most impact.

- Contemporary surveys (not commissioned as part of this work) also illustrated prevailing beliefs, aspirations and opinions of relevant clinicians and NHS managers, including:
    - October 2010 *Pulse* survey of GPs on care homes, including their current involvement.[12]
    - February 2010 *Pulse* General Election Survey: a study of 876 GPs.[13]

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[11] National Care Forum, English Community Care Association, National Care Association, Registered Nursing Home Association, Care Forum Wales, Independent Health and Care Providers, Scottish Care.
12 Care Home Survey, *Pulse*, 5 October 2010.

- February 2011 British Geriatrics Society membership survey, focusing on their work and/or opinions about care homes involvement and their relationships with GPs relevant to this.[14]
- 2008 Survey of Geriatrician and England primary care trusts, examining the current healthcare arrangements for care homes based on the 2000 recommendations.[15]

iii) Collating and evaluating the published evidence

Professor Julienne Meyer of City University and her *My Home Life* project team were commissioned to conduct a literature review of published research evidence (in peer-reviewed journals and grey literature). She involved research teams from the Universities of Hertfordshire (Professor Claire Goodman) and Nottingham (Professor John Gladman), both of whom were involved in National Institute for Health Research (NIHR) funded work on healthcare interventions in care homes.

The objectives of the review were to compile:
- A review of existing models of care, taking into account both clinical and financial aspects of services delivered within care homes.
- A review of clinical interventions or programmes of care that have been evaluated in the care home setting.
- A comprehensive collection of available guidance on the management of long-term conditions where this has been adapted for use in care home settings.

Although the focus of this report is based on what the NHS needs to do in the UK, evidence was sought from literature describing the international experience. The literature review embraced care delivered by care home staff along with care provided as an "add-on" by external suppliers. This analysis presents evidence from four distinct pieces of work:
(i)   Three previous reviews of healthcare innovations in care homes.
(ii)   Emerging findings from two literature reviews currently underway.
(iii)   Other relevant current material known to the research teams.
(iv)   Gold Standards Framework (GSF) literature review and other studies of end of life care.

The previous reviews were:
1. NHS Trent Policy and Practice R&D Department (2003) which carried out a systematic review and meta-analysis of models of care applied in care homes, including those directly involving care home staff practice. Fifty-eight papers from 37 randomised and non-randomised studies were reviewed as a whole and classified into categories: the philosophy of care, enhanced assessment, staff education, specialist nursing, medication review, physical therapy and alternative therapy.[16] An unpublished report undertaken for the National Institute for Health Research Service Delivery and Organisation (NIHR SDO) by the University of Hertfordshire.[17] This aimed to evaluate interventions designed to promote integrated working between care homes and healthcare

13 Pulse General Election Survey. February 2010. http://www.pulsetoday.co.uk/story.asp?storyCode=4125106&sectioncode=19 Accessed on 12 August 2010.
[14] http://www.bgsnet.org.uk/index.php?option=com_content&view=article&id=163&Itemid=87
[15] C Steves, R Schiff, FC Martin,Geriatricians and care homes: perspectives from geriatric medicine departments and primary care trusts. Clinical Medicine 2009, 9 (6): 528–33.
[16] Peet et al (2004) Models of delivery of health care to older people in long term care: A systematic review. A summary is available online: http://www2.le.ac.uk/departments/health-sciences/archive/extranet/research-groups/nuffield/project_profiles/040.html. The full review was obtained from the authors. This research was supported by the National Institute for Health Research Service Delivery and Organisation programme (project number 08/1809/231). Disclaimer: The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NIHR SDO programme or the Department of Health.
[17] The Approach study (2010). A systematic review of integrated working between care homes and the health care services. Unpublished report undertaken for NIHR SDO, CRIPPAC, Centre for Research in Primary and Community Care, University of Hertfordshire. Obtained from the author.

practitioners, identify barriers to such working, and the contextual factors that affect the effectiveness and sustainability of such interventions. The review only considered studies that had involved the existing workforce and drew on resources already available within the participating organisations. The rationale for this was that interventions that do not engage with the staff of care homes may make a difference but cannot be sustained without the creation of new services and resources. The review considered interventions to support integrated working at different levels (organisational, service and individual patient care). Seventeen studies (ten in the UK) met these criteria - ten quantitative, one mixed methods, two process evaluations and four qualitative.

2. A literature review conducted for the Joseph Rowntree Foundation.[18]
The two literature reviews in progress were those undertaken for unpublished PhD studies.[19] We also drew on the literature review for the *My Home Life* programme for this section of the report, the findings of an associated European study[20] to develop benchmarks or quality standards for care homes (European Centre for Social Welfare Policy and Research, 2010), and papers in a recent supplement published by the International Psychogeriatric Association.[21]

We looked at the reviews of end of life studies. This included a critical review of the literature undertaken to determine what impact the GSF has had on end of life care within primary care.[22] We also reviewed other sources looking at end of life care, specifically in care homes, for instance, the study by East Lancashire PCT on three end of life care initiatives (the GSF, the Liverpool Care Pathway and the Preferred Priorities for Care) and their implementation and use in care homes on the Flyde Coast in Lancashire.[23]

In addition to this report, full documents produced from the research and interviews are available on the BGS website. These online resources include:
1. An evidence review. This brings together the several academic reviews undertaken and incorporates a BGS Commentary from which our recommendations are drawn.
2. A list of current national and international guidance for the management of health conditions in care homes. This document summarises up to date guidance[24] on clinical conditions in the specific environments of care homes.
3. Results from the qualitative interviews. This document summarises in detail the interviews which were held with 21 health and social care professionals on their input into care homes.

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[18] A Szczepura, S Nelson, D Wild, (2008) 'Improving care in residential care homes: A literature review', JFF, October 2008.

19 J Dudman (2010) in progress – PhD review, presented at BGS 2010 (contact Jennifer.Dudman.1@city.ac.uk); A Gordon (2010) in progress. PhD review (contact Adam.Gordon@nottingham.ac.uk).

[20] European Centre for Social Welfare Policy and Research (Coordinator) (2010). Measuring Progress: Indicators for Care Homes. Vienna/Bad Schallerbach/Utrecht/London/Dortmund/Essen/Düsseldorf: European Centre/E-Qalin/Vilans/City University/Uni Dortund/MDS/MGEPA NRW.

21 International Psychogeriatrics 2010.

[22] KL Shaw, C. Clifford, K. Thomas and H. Meehan, Review: Improving end-of-life care: a critical review of the Gold Standards Framework in primary care, *Palliat Med* 2010 24: 317-331.

[23] M Turner and K Froggatt, Evaluation of end of life care initiatives in care homes on the Fylde Coast, Project report for North Lancashire Primary Care Trust March 2009.

[24] At time of writing in February 2011.

3. Care homes and their residents

From the interviews and research, we amassed a wealth of information and new insight.

a) Care homes residents

Around 400,000 older people[25] live in care homes in the UK and are distributed as follows:

- England: 376,250 older people in 10,331 care homes.[26]
- Northern Ireland: 9,485 older people[27] in around 464 residential and nursing homes.[28]
- Scotland: 39,150 residents in 943 care homes.[29]
- Wales: Around 27,700 places[30] in 1,164 care homes.[31]

The proportion of the 65-plus population varies considerably from a low of 26.4 per 1,000 in Northern Ireland[32] to an England regional high of 54.9 per 1,000 in the north east.[33] Overall, while numbers rose dramatically over the last 25 years, recently they have fallen. For instance, in England, the number of care homes and care home places have fallen slightly each year between 2004 and 2008. This has also been the trend in Scotland, with a reduction of 1.4% in the total number of registered places from March 2000 to March 2010.[34] In England across all ownership sectors, the average size is 18.5 places for residential care homes and 46.6 places for nursing homes.[35]

There is a mixed economy of provision. In England, for example, ownership of care homes in 2010 was described as 73% independent, 14% voluntary sector, 11% local council and 1% each for NHS and 'other'.[36] The total value of the market in England is estimated at £22 billion[37], comprising approximately £16 billion[38] of state funding and at least six billion of self-funded spend.[39]

It is only in the last two decades that the independent sector has predominated, rising from 20,300 nursing home places in 1970 to almost 200,000 in 2010. Prior to this, the majority provider was local councils, using the enabling provisions under Part 3 of the National Assistance Act which set out the duties of local authorities to do so.[40] In 1948, the NHS was the major provider for the more frail older people, in long-stay "geriatric" wards in old hospitals that typically were remnants of the poor law infirmaries. Policy changes from 1981 onwards enabled a massive increase of publicly funded provision in the independent sector. Initially, this was made possible by enabling widespread use of

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[25] At the end of March 2010, there were 18,255 registered care homes, with a total of 459,448 registered places in England alone. The Adult Social Care Market and the Quality of Services, Care Quality Commission, November 2010, 4.

[26] The Adult Social Care Market and the Quality of Services, Care Quality Commission, November 2010, Figure 7: Places in homes for older people by population aged 65 and over, 7.

[27] Your Health Matters, The Annual Report of the Chief Medical Officer for Northern Ireland 2009, Department of Health, Social Services and Public Safety, 2010, 32.

[28] http://www.carehome.co.uk/care_search_results.cfm/searchcountry/Northern%20Ireland Accessed 2 June 2011.

[29] ISD Scotland, Care Home Census 2010, Scotland, Table 1 – Care Homes, Places, Residents by Sector / Places per 1,000 Population, 2000 – 2010, October 2010 3.

[30] Figures for 2004. Care homes for older people in the UK - a market study, Office of Fair Trading, Annexe K, consumer behaviour and care homes - a literature assessment, May 2005, 7.

[31] http://www.carehome.co.uk/care_search_results.cfm/searchcountry/Wales. Accessed 7 February 2011.

[32] 9,485 people in Northern Ireland aged 65 and over are cared for in residential and nursing homes. Your Health Matters, The Annual Report of the Chief Medical Officer for Northern Ireland 2009, Department of Health, Social Services and Public Safety, 2010, 32.

[33] Office for National Statistics, Government Office Regions of England, Table 1.3, number for men aged 65 and over and women aged 60 and over. www.statistics.gov.uk/downloads/theme_health/Pop-subnational13.xls Accessed 3 February 2011.

[34] ISD Scotland, Care Home Census 2010, Scotland, Table 1 – Care Homes, Places, Residents by Sector/Places per 1,000 Population, 2000 – 2010, October 2010 3.

[35] Care Quality Commission, The adult social care market and the quality of services – technical report, November 2010, 5.

[36] The Adult Social Care Market and the Quality of Services, Care Quality Commission, November 2010, 12.

[37] Practical approaches to market and provider development, Department of Health (England), 2010, 8.

[38] *Ibid*

[39] *Ibid*

[40] See National Assistance Act 1948, http://www.legislation.gov.uk/ukpga/Geo6/11-12/29. Accessed 2 June 2011.

supplementary benefit funded by central government through its locally based social security offices. Arrangements for funding and for regulation have gone through numerous iterations since then. Simultaneously, there has been a cut in NHS inpatient resources (for instance, from 75,000 long stay beds in 1970 to around 15,000 in 2010.[41] Also, from 297,364 beds of all types in 1987-88 in England have been reduced to 139,733 in February 2011[42]). Since the 1990s, there has been closure or privatisation of care homes, with some local authorities ceasing to invest in publically operated care homes, and the majority of provision being taken on by the independent and voluntary sectors. These changes were most marked in England, but have gradually spread throughout the UK and had a significant impact on a large number of care home residents and the nature of their needs.

b) The workforce

In 2009, there were 1.75 million jobs in adult social care in England, in upwards of 40,000 organisations across the independent and voluntary sectors.[43] Staffing in care homes remains a key issue though. The workforce is 80% female[44], many are overseas migrants (19% of all workers were born overseas[45]) and a large number receive low rates of pay.[46] In terms of employment length analysis, in 2009, one third of all adult social care workers had been in their current job for less than three years, one third between three and seven years, and the majority of the rest for more than seven years.[47]

The number of people working in care homes is estimated at 507,060.[48] Although there are several large private providers, most of the workforce is widely dispersed, as is typical of the social care sector generally. As this reports highlights, this huge workforce is caring for residents with complex care needs as a result of their clinical co-morbidities. Successful community care has led to the care home resident populations being on average older and with more disabilities. Only in homes providing nursing care, as previously defined, is there an obligation that these carers are supported or supervised by nurses.

c) Developments in care homes

Care homes and the residents they support have changed. They are no longer housing options for frail and financially insecure older people, as might be inferred from reading the *National Assistance Act* (1948) which set out in Part III the duty of local authorities to provide accommodation. They are now a major component of the welfare system's provision of care for vulnerable and clinically unstable older people. Many are now providing highly specialised services, for instance for older people with dementia.

The *My Home Life (*http://myhomelifemovement.org/) project has worked with care homes to support them in improving the daily care they provide. These developments have demonstrated the appetite in care homes to gain recognition as an integral and specialist resource for the future health and social care of older people. The experience of the *Gold Standards Framework (*http://www.goldstandardsframework.org.uk/), along with other end of life initiatives have shown

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[41] Laing & Buisson (2010), Care of Elderly People: UK market survey 2010–11. London: Laing and Buisson.

[42] Hospital bed numbers set to fall by 20,000 in a year, Daily Telegraph, 25 February 2011. http://www.telegraph.co.uk/health/healthnews/8345065/Hospital-bed-numbers-set-to-fall-by-20000-in-a-year.html Accessed 13 June 2011.

[43] State of the Adult Social Care Workforce 2010, Skills for Care, May 2010, 9.

[44] *Ibid*, 10.

[45] *Ibid*, May 2010, 10.

[46] In 2009, care workers' estimated median gross hourly pay was £6.00 in the private sector, £7.03 in the voluntary sector and £7.73 in councils. State of the Adult Social Care Workforce 2010, Skills for Care, May 2010, 11.

[47] State of the Adult Social Care Workforce 2010, Skills for Care, May 2010, 11.

[48] *Ibid*, Table - Estimated total number of workforce jobs in independent sector social care services in England, 2009, by type of service, provision and sector (source: estimates based on NMDS-SC at end September 2009), 39.

what a proactive planned care approach can achieve. With NHS generalists, specialists and care homes' staff and management working collaboratively, dramatic improvements can be made to the experiences of residents and their families, alongside increased satisfaction in working together.

On quality indicators, the standards of care provided appear to have improved consistently over the last few years. For instance, in England, 23% more care homes met National Minimum Standards in 2008 than in 2003[49] and the latest report (for 2009-2010, published in March 2011) shows that 93% met or exceeded those standards.[50] The percentage of older people supported in care homes rated "good" or "excellent" rose from 75% to 86%.[51] Also, the proportion of care homes for older people that met or exceeded the standards for safe working practices has doubled since 2003 to 80%.[52]

Whilst this is encouraging, problems remain. Some poor standards of care persist and examples continue to attract media attention. Our view however, is that while registered providers must carry legal obligations for care, the responsibility for maintaining and promoting these improvements must be seen as a challenge across the sectors, with the NHS and its healthcare professionals being important elements.

d) Current use and future needs

Care home residents comprise about 4% of the UK population aged 65 and over, but nearly 20% of those are aged 85 and over.[53] This is slightly less than the European average. Current projections are for an increase in life expectancy - three years for women to 88 and four years for men to 86 by 2025.[54] By 2031, this improvement in life span will result in a 131% increase in those aged 85-plus and a total of 15.8 million people aged 65-plus. That is 22% of the UK population.[55] The impact on the future need of care home places is difficult to predict due to uncertain trends in morbidity and disability, the availability of informal carers and preferences for care home use. But they have been forecast to rise by perhaps 150% over the next 50 years.[56] In Scotland, if age specific rates of care home provision do not alter significantly, their requirement for placements is estimated to increase from a current 33,000 to over 57,000 residents by 2028 (a 72% rise). The increase of the oldest old is thus predicted to increase the percentage of people aged 65-plus entering care homes from 3.9% currently to 4.8% by 2028.[57]

A key factor in determining whether a person should enter a care home is the nature of their needs. For example, new treatments and systems of community support are unlikely to prevent the increasing prevalence of dementia and therefore an increased need for the provisions of specialised care home places.

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

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[49] State of Social Care, 2007-08, Commission for Social Care Inspection, February 2009, 8.

[50] The state of health care and adult social care in England, Care Quality Commission, 28 March 2011, 20.

[51] *ibid*, 7.

[52] *ibid*, 19.

[53] Care homes for older people in the UK - a market study, Office of Fair Trading, Annexe K, consumer behaviour and care homes - a literature assessment, May 2005, 7.

[54] GAD Period expectations of life (years) 2006-based projections, www.gad.gov.uk. Accessed 3 June 2011.

[55] James Bayliss and Frances Sly, Ageing across the UK, Office for National Statistics, 14 June 2010, http://www.statistics.gov.uk/articles/RegionalTrends/rt42-article1.pdf.

[56] Wittenberg R, Comas-Herrera A, Pickard L and Hancock R, Future demand for long-term care in the UK. A summary of projections of long-termcare finance for older people to 2051. York. Joseph Rowntree Foundation 2004.

[57] British Geriatrics Society Scotland and Royal College of General Practitioners Scotland, Frailty, Older People and Care Homes, Can we do better?: Improving What we do? October 2009, 8.

involvement in decision-making. This means keeping up with the population as it becomes more diverse and anticipating requirements for interpretation, advocacy and other appropriate resources.

e) Care home residents

The average care home resident is in their mid-80s or older. Around 75% are women.[58] The journey for individuals entering care homes is changing. Department of Health policy in England discourages direct admissions from hospital. Nevertheless, over half are still admitted from acute hospitals and about a quarter from home.[59] Official figures have been published outlining the causes of admission[60], but this is inevitably arbitrary as the decisions are complex, and no specific medical or mental health condition in itself is ever the sole cause. It is more useful to look at the range of conditions and clinical issues which residents experience.

The average length of stay in care homes differs by gender: one to two years for men and two to three years for women.[61] Nursing home residents survive shorter periods than more physically robust individuals entering residential care, many of whom have dementia.

f) The health and healthcare needs of the residents

Many older people who live in care homes have high levels of healthcare needs. Some reports have suggested that three quarters of people in care homes have a disability.[62] Others have found that 57% of women and 48% of men needed help with one or more 'self care' tasks.[63] A survey by Bupa in 2003 of 16,043 people resident in 244 Bupa care homes (25% residential and 75% nursing) across the UK identified that[64]:

- 78% had at least one form of cognitive impairment. Only 22% were said to have a 'normal' mental state.
- 64% were 'confused' or 'forgetful'.
- 20% exhibited challenging behaviour.
- 19% were described as 'depressed' or 'agitated'.
- 71% were incontinent.
- 27% were immobile, confused and incontinent.
- 76% required assistance with their mobility or were immobile.

Considerable overlap in dependency between residential and nursing care was observed, where fewer than half of those in residential care could walk and half were incontinent.[65]

Depression is also common[66], as is malnutrition at the time of admission.[67] Many report pain[68] particularly associated with arthritis, limb stiffness or immobility.

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[58] Care homes for older people in the UK - a market study, Office of Fair Trading, Annexe K, consumer behaviour and care homes - a literature assessment, May 2005, 8.
[59] Personal Social Services Research Unit, Care Homes for Older People: Volume 2 - Admissions, Needs and Outcomes. The 1995/96 National Longitudinal Survey of Publicly-Funded Admissions, A Bebbington, R Darton and A Netten. Quoted in Care homes for older people in the UK - a market study, Office of Fair Trading, May 2005, 23.
[60] Care homes for older people in the UK - a market study, Office of Fair Trading, May 2005, Table 3.1 - Reasons for admission into care, 23.
[61] Office of Fair Trading, *op. cit.*, Annexe K, consumer behaviour and care homes - a literature assessment, May 2005, 11.
[62] *Ibid*, 21.
[63] *Ibid* , 22.
[64] Help the Aged, Quality of life in care homes, A review of the literature, 2007, 96-97.
[65] C Bowman, J Whistler, M Ellerby, A national census of care home residents, Age and Ageing 2004; 33: 561–566.
[66] Depression and Older People: Towards securing well-being in later life, Help the Aged, 2004.
[67] Malnutrition Matters Meeting Quality Standards in Nutritional Care, A Toolkit for Commissioners and Providers in England, BAPEN, May 2010, 4.
[68] My Home Life Quality of life in care homes, A review of the literature prepared for Help the Aged by The National Care Homes Research and Development Forum, Help the Aged, 2007, 106.

A survey conducted by the Commission for Social Care Inspection (CSCI) of 657 care homes in England found that 40% of residents had particular needs as a result of dementia, and over 84% of homes in the survey had at least one resident with dementia.[69] In England, around 208,000 people with dementia live in care homes, with 91,000 of those in dedicated dementia care beds.[70] In Scotland it is estimated that 40% of all those with dementia live in care homes.[71]

The British Association for Parenteral and Enteral Nutrition's (BAPEN) Nutrition Screening Week surveys have also consistently established that 30 - 40% of those recently admitted into care homes are at risk of malnutrition, and the majority are at high risk.[72] Additionally, BAPEN's British Artificial Nutrition Survey (BANS) data for 2009 recorded that at the end of the year there were almost 9,000 care home residents receiving Home Enteral Tube Feeding with most receiving nutritional support via a PEG tube feed (percutaneous endoscopic gastrostomy).[73]

Unsurprisingly, many care home residents are on multiple medications. The recent Department of Health in England survey (Care Homes Use of Medicines Study - CHUMS) found that residents were prescribed an average of 7.2 medicines.[74] It noted that seven out of ten care home residents were exposed to at least one medication error, although most were likely not to be harmful.[75] Other studies of prescribing in UK care homes suggest inappropriate prescribing occurs in 50 - 90% of patients.[76] Medication errors are also common in other care settings such as acute hospitals. In both settings the most frail older people are the most vulnerable to drug related adverse events. This highlights the need for an inter-professional and partnership approach to reducing avoidable harm.

Increasingly, residents die in their care home, not in hospital. This can be through choice or circumstance. Thus, end of life care is also an important consideration.

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[69] The state of social care in England 2007-08, Commission for Social Care Inspection, February 2009, 45.
[70] National Audit Office, Improving Dementia Services in England – an Interim Report Part One, 2010, 18.
[71] Alzheimer Scotland, http://www.alzscot.org/pages/policy/dementiaepidemic.htm, accessed 3 June 2011.
[72] BAPEN's NSW07. NSW08, NSW10 www.bapen.org.uk/nsw.html Accessed 2 June 2010.
[73] www.bapen.org.uk/pdfs/bans_reports/bans_report_10.pdf Accessed 2 June 2011.
[74] Care Home Use of Medicines Study (CHUMS), Patient Safety Research Portfolio, Dept of Health, 2009, iv.
[75] *Ibid*, iv.
[76] *Ibid*, 3.

4. Current policy and practice

a) What is current policy?

None of the four countries in the UK have an explicit comprehensive statement describing current NHS obligations or government expectations of its local NHS services for care home residents. Policies in the four UK nations have been largely focused on funding and regulatory issues. The UK government recognised the inconsistency and lack of clarity in the application of funding policy when it set up a Royal Commission on long-term care.[77] Its main recommendations concerned the funding of personal (including nursing) care. There were no specific recommendations on the clinical aspects of the NHS responsibilities for healthcare.

The fundamental legal obligations of the NHS have not altered since 1948, but interpretation in practice has been modified by various regulations and government directives. For instance, in England, the most recent example of this is the NHS Constitution. This has identified two key principles which can be said to apply across the UK:

> **1. The NHS provides a comprehensive service, available to all** irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.[78]

> **2. Access to NHS services is based on clinical need, not an individual's ability to pay.**[79]

The National Assistance Act (1948) set out duties to be provided by visiting medical officers (VMOs) to support local authority councils with advice in carrying out certain functions in residential care homes, such as illness prevention and medication administration. The law did not enable local authorities to provide nursing home care, though increasingly this is what residential home residents actually needed. This VMO service was never provided uniformly. The district medical officer of health service, which oversaw VMOs, has itself been radically altered and/or transferred to new structures, most recently to primary care organisations (such as primary care trusts or health and social care boards). Responsibilities of VMOs never included direct medical care for individual residents, but care homes often secured the input of a local GP by appointing them as a VMO.

With the closure of NHS long-term care facilities, which were variously provided in large and deteriorating Victorian hospitals or in unsuitable wards, the care homes sector expanded. It was enabled to do so by the provision of means-tested supplementary benefit (later income support) to individuals. A consequence of this major transformation was a dislocation from the NHS healthcare professionals with the most experience of supporting long term care (notably geriatricians). The residents became entitled to primary medical care by virtue of no longer being NHS inpatients. Care homes sometimes found that to secure the commitment of general practitioners for their residents (a pre-requisite for registration) retainer fees were necessary.[80] Such arrangements were and continue to

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[77] Department of Health. With Respect to Old Age. The Royal Commission on Long-term care. London: Department of Health, 1999.
http://collections.europarchive.org/tna/20081023125241/http://www.royal-commission-elderly.gov.uk (last accessed April 25th 2011)
[78] The Handbook to the NHS Constitution, Department of Health, March 2010, 7.
[79] *ibid*
[80] Can We Afford the Doctor? GP Retainers and Care Homes, ECCA, September 2008.

be contentious. Paid in principle to provide advice to the home and its management on matters such as infection control, these fees are widely seen as a means to secure willingness to provide medical care for individual residents. The legality of this is dubious as the GPs are already paid for the medical care of care home residents as NHS patients (even though such reimbursement may not adequately recognise their needs). These payments can be significant.[81] Whilst in many cases GPs who levy such retainer fees provide a good service, overall there is a lack of evidence that the payment of such fees do improve access to healthcare or the quality of medical input for residents.

Our interpretation of the current policy, legal obligations and entitlements of individual residents is as follows:

1. All residents are entitled to the free provision of **general medical services,** the content of which is set out in agreements with primary care providers.

2. All residents are entitled to fair access, according to need, to other **community health services**, including generic district nursing and various specialist provisions such as physiotherapy. Access is subject to local variation, depending on resources and interpretation of responsibilities by the local NHS. Those responsible for local decisions are the commissioning organisations in England (currently primary care trusts) and equivalent bodies in Wales, Northern Ireland and Scotland where the distinction between commissioning and provider roles may not apply. Throughout the UK from 2012 onwards the allocation of services may no longer legally be allocated directly on the basis of age or any basis which indirectly but systematically discriminates against older people.

3. Other specialist medical and related services, such as **acute hospital care**, depending upon need, should be provided on an identical basis to other citizens.

4. **Nursing care to meet day-to-day health needs**. The Scottish Parliament extended this legal entitlement to personal care, albeit subject to assessment and funding limitations. In England, the Funded Nursing Care (previously Registered Nurse Care Contribution RNCC) is operated. The NHS's obligation to fund (though not provide) nursing care has now been simplified and is dependent on a formal assessment to confirm the presence of nursing care needs. The payment therefore applies to individuals deemed by this assessment to be receiving nursing care (and who are resident in a care home registered to provide nursing care). The standard and universal entitlement is £108.70p per week (at the time of writing, frozen from April 2010) although those on the higher band of the pre-2007 RNCC receive £149.60 a week.[82] Many care home managers would suggest that the amounts allocated do not meet the real cost of this provision, and that the real costs of personal care are in many cases just as high.

5. **NHS continuing healthcare**. This is fully funded health and personal care provided on the basis of a detailed needs assessment, the conduct of which is also an NHS responsibility, in partnership with local councils. Since the Royal Commission, there have been several clarifications and central directives aimed at reducing variation between local NHS services on their interpretation of eligibility for this NHS funding. Approximately 10% of older care home residents receive this funding at present. Decisions on individuals are reviewed, initially at three months and then yearly.

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[81] English Community Care Association, Post Code Tariff, PCTs and GP Retainers in Care Homes, July 2009.
[82] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_106230 (accessed June 5 2011)

6. **Intermediate services.** These are usually NHS-funded step up or step down services which are provided on a short-term basis and designed to minimise inappropriate hospital usage. Medical cover is often not by the GP, but by a contracted GP dedicated to the service.

These various assessment systems were developed to enable funding decisions to be made, but they also provide an opportunity to plan ongoing healthcare based on detailed assessment of need.

b) Current NHS healthcare provision for care home residents

As there are no national specific standards or models for either primary, medical care or community health (e.g. allied health professionals); the provision of care for residents is highly variable. There is no separate specialty of care home physicians, as exists in the Netherlands. Primary medical care is the responsibility of each resident's GP. Some care homes (or their local primary care organisations) have secured an agreement with a single GP practice to register all residents on admission. Clearly this infringes the individual's freedom to choose a GP. In other care homes, residents retain their pre-admission GP. The local arrangements depend somewhat on geography and practicalities.

Maintaining a continuity of medical care for each individual (by retaining their pre-admission GP) results in many GPs attending the care home. Where patients are allocated to a variety of local GPs, not only are the numbers of visiting doctors high, but their knowledge of individual patients is often limited. Situations where many doctors are attending care homes may pose difficulties and barriers to collaborative working (the research conducted for this report heard reports of over 20 doctors attending some care homes). The principle of 'one general practice per home' model may offer better prospects for partnership working, although there is little evidence to confirm or refute this.[83] It is recognised that not all GPs are willing to accept responsibility for the residents of a care home because of the workload (and lack of recognition), and/or lack of interest or expertise.[84]

Whatever pattern of primary care exists, it is unusual for it to be tailored to the specific challenges of the care home context. To address these issues, some primary care organisations have entered in to a "Local Enhanced Service" (LES) agreement with GP practices to pay a practice to provide a specifically higher than usual level of care. This agreement recognises that working with care homes can be labour intensive and also introduces some accountability and monitoring of performance (largely at process levels rather than that of clinical governance). There is some evidence that this may have clinical and resource advantages.[85]

In some areas of urban density, or where there is a lack of GP provision, care home-specific practices have been set up as Personal Medical Services (PMS) sites. The GPs and nurses working in these practices are employed to work solely for care home residents. Examples of this approach can be found in London, Salford, Glasgow and county Durham.

c) Problems with access and quality of health care

Across the UK there are wide variations in access to healthcare services for care home residents. A comprehensive review of the evidence and best practice conducted for the *My Home Life* programme showed evidence of the limited medical, multi-professional and specialist geriatric input into care

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[83] IP Donald, J Gladman, S Conroy, M Vernon, E Kendrick, E Burns, Care home medicine in the UK - in from the cold, Age & Ageing 2008; 37(6): 618-620.
[84] Care Home Survey, Pulse, 5 October 2010.
[85] D Briggs, L Bright, Reducing hospital admissions from care homes: considering the role of a local enhanced service from GPs. Working with Older People 2011; 15(1): 4-12.

homes. This was perceived to result in a lower-than-possible quality of life for residents.[86] Several difficulties and issues were identified:

- Problems obtaining GP services for care home residents, particularly where large or numerous care homes increased the local need.
- Loss of continuity with some care homes operating a policy of registering all residents with one GP who serves the home.
- Passing costs of NHS care onto residents. Many GPs have been found to have a contract with care homes to charge a fee or 'retainer' for their services at the home. These were maintained over and above the 'general medical services' contracted for them by the NHS. When such costs are recouped in charges to residents, the funding council or the NHS, the GPs are in effect being paid twice for the same service. It is unlawful for local authorities or individuals to be charged for general medical services.

The English Community Care Association (ECCA) reported that many of its members were paying retainers to GP practices to provide care - including 12% of homes in one large care home provider, ranging from £897 to £24,000 per year, with £7,000 being the average.[87]

The professional interviews conducted for this report identified additional evidence of problems with access. One GP said that people living in care homes *'get excluded from a lot of things. District nurses won't go into nursing beds. Physiotherapists are reluctant so [people living in care homes] get excluded from things that are available to people in their own homes. Bringing services in can be difficult.''* Many interviewees reported clear inequality in the provision of services commonly available to older people living in their own homes, such as access to specific equipment like syringe drivers (nursing services) or modified seating (occupational therapy or combined equipment stores).

These conclusions were also supported by a survey conducted in 2010 by the multi-professional Older People's Specialists' Forum (OPSF) which is hosted by the BGS. This survey asked care homes across the UK about their experiences of accessing healthcare services for their residents.[88] It found that:

- 68% of care home residents do not get a regular planned medical review by their GP
- 44% were not getting a regular planned review of their medication.
- 41% could not access specialist dementia services such as memory clinics and community mental health teams.

An older survey showed that only 10% of residents could access physiotherapy, mostly through private physiotherapists employed by the care homes, and only 3.3% of residents received occupational therapy.[89]

In discussions with the care home sector it emerged that access to health services was sometimes dependent on whether a home was classed as nursing or residential. It was explained: "*People in residential homes are considered to be in 'the community' and are entitled to all of the services as if they were in their own home.*" This did not happen in nursing homes. We were told that this even applied to disposal of unwanted medicines. A nursing home cannot return these medicines to the

86 My Home Life Quality of life in care homes, A review of the literature prepared for Help the Aged by The National Care Homes Research and Development Forum, Help the Aged, 2007, 97.

87 See Can We Afford the Doctor? GP Retainers and Care Homes, ECCA, September 2008.

88 Survey Suggests Care Home Residents Are Not Getting The Medical Support They Need, Older People's Specialists' Forum press release 5 October 2010. See http://www.bgs.org.uk/index.php?option=com_content&view=article&id=988:opsf-survey-suggest-care-home-residents-are-not-getting-the-medical-support-they-need&catid=6:prindex&Itemid=99 Accessed 8 February 2011.

89 S Barodawala, S Kesavan and J Young, A survey of physiotherapy and occupational therapy provision in UK nursing homes, Clinical Rehabilitation 2001 15: 607-610.

pharmacy but must treat them as 'clinical waste' and dispose of them via a registered waste disposal company. This distinction has led to some patients not getting the care they may need. One manager explained: *"In some parts of the country there are examples of where a District Nurse is asked to replace a male catheter* (something not all nurses are trained to do), *objecting to have to do so and asking why the nursing home can't do it themselves."*

One care home manager interviewed said: *"One of our biggest issues is out of hours cover for continuity of access. We hate having to telephone out of hours services. They don't know patients' needs or the capabilities of the home."* Another reported: *"Our out of hours GPs tend to say 'send to hospital'."* A specialist nurse described difficulty in maintaining an appropriate end of life care approach when the out-of-hours GP either did not have, or did not look at, agreements about resuscitation.

Another problem identified by physiotherapists in our stakeholder engagement was the issue of seating. Many care home residents, because of physical health problems or disabilities, spend much of their time sitting. The right type of chair and cushions can help significantly with posture, and pressure management. For older people who are immobile this can make a positive difference in terms of comfort and reduced pain. One physiotherapist said: *"It is not unusual for physios and OTs to report unnecessary battles with 'Continuing Health Care funding' when we request such specialist seating for a patient. Specialist seating requires a highly skilled individual [OT, Nurse or Physiotherapist] and resources are ring fenced for this work. At present specialist seating is assessed by a range of staff, but would be better delivered by one highly skilled team for a local commissioner."*

d) Why is access to healthcare support so variable and patchy?

Our various sources of evidence include surveys of healthcare professionals and England primary care trusts and discussions with care homes managers. These illustrate a variety of opinions, expectations and aspirations. In the context of having no clear central policy guidance, the diversity of provision is unsurprising. Other possible reasons could be:

- Healthcare support for care homes is rarely commissioned or planned as a specific service. For instance, a survey of old age psychiatrists showed that while 87% worked in care homes, 64% were not specifically commissioned to do so.[90] Work by the BGS suggests that commissioning for care homes by PCTs is a low priority. A survey found that only 18.4% of PCTs report that they funded geriatricians' involvement in care homes.[91] A *Pulse* survey in 2010 of 115 primary care organisations found that they cut funding on medical and nursing services for care-home residents by 11% in the last year. This went from an average of £586million in 2009/10 to a forecast spend of £520million in 2010/11.[92]

- **Confusion over the obligations of NHS healthcare services to provide medical support to care homes**. A recent report by the English Community Care Association (ECCA – a large representative body for care home providers in England) said that there was a '*a real lack of clarity and consistency as to exactly what services GP practices can charge care homes for, and how much these services should cost*'.[93] The responses by government departments such as

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[90] National Audit Office, Improving Dementia Services in England – an Interim Report Part One, 2010, 18.
[91] C Steves, R Schiff and F Martin, Geriatricians and care homes: perspectives from geriatric medicine departments and primary care trusts, Clinical Medicine 2009, Vol 9, No 6: 529.
[92] Care home funding cuts leave GPs 'time bomb', Pulse, 06 Oct 10. http://www.pulsetoday.co.uk/story.asp?storycode=4127275 Accessed on 10 June 2010.
[93] Can We Afford the Doctor? GP Retainers and Care Homes, ECCA, September 2008, 7.

the Department of Health in England to the Health Select Committee's 2004 *Inquiry into Elder Abuse* demonstrates that confusion. It argued: "*Everyone who is eligible to receive NHS care is entitled to be registered with a GP if they so choose… [including those] in care homes…However, where the management of a care home that provides nursing care requires the professional services of a doctor or other health care professional to assist in the management of their business, the Government believes that it is reasonable for the business to bear that cost".[94]*

- **Commissioning arrangements**. Two issues were identified by care home managers in our consultation with stakeholders. Firstly, that: "*Care homes operate within a health and social care model, and care home priorities are set by social care not healthcare.*" This can mean that one area which is overlooked is access to healthcare for those residents. Secondly, there are frequent disputes between health and social care commissioners over who pays for nursing care. One care home manager said: "*So often in the past have L[ocal] A[uthority] commissioners placed people with clear nursing needs in residential care homes, at a lower fee than had they placed them in a nursing home, with the particular intent that the Health Authority will then have to pay for the nursing input because they will have to use district nurses to meet the healthcare needs.*"

- **Ageism in the NHS?** Ever since the American gerontologist and psychiatrist Dr Robert Butler coined the term 'ageism' in 1968[95], surveys of patients[96] and even clinicians, such as geriatricians[97] and GPs[98], have suggested that the NHS often prioritises services based on patients' ages (youth) rather than need.

- **Ambivalence about working with independent sector**. There is a widely held perception that care homes are making large profits at the expense of its residents and want to use NHS services to avoid providing care and equipment they have been paid to provide. In fact, reports repeatedly highlight the low margins of profitability that the majority of care homes work with. However, this myth persists in tainting working relationships and affects residents' access to health care.

e) What's different and difficult about providing healthcare in care homes?
The issues revolve around:
1. The particular healthcare needs of the resident individuals.
2. Working in a care setting where the skills of the care staff (observation, communication, practical action and knowledge of the care homes residents) are vital to help visiting health professionals achieve optimum impact. Thus working collaboratively becomes central to delivering effective healthcare. This is fundamentally different from working with patients as distinct individuals, like in a GP surgery or hospital clinic. It is much more in common with hospital ward work.

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[94] The Government's response to the recommendations and conclusions of The Health Select Committee's Inquiry into Elder Abuse, 2004, 3. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4084520.pdf.
[95] 'Inventor of the phrase 'ageism' dies at 83', Daily Telegraph, 12 July 2010. http://www.telegraph.co.uk/news/worldnews/northamerica/usa/7876259/Inventor-of-the-phrase-ageism-dies-at-83.html
[96] One Voice: Shaping our ageing society, Age Concern and Help the Aged, 2009.
[97] GPs say NHS is ageist, BBC News, 16 May, 2000 http://news.bbc.co.uk/1/hi/health/750494.stm
[98] Ageism and age discrimination in primary and community health care in the United Kingdom. A review from the literature, Centre for Policy on Ageing, 2009, 9.

However, the complex mix of healthcare needs in care home residents is unique to this population. Dementia, stroke, degenerative neurological conditions, advanced cardio-respiratory disease, cancer and painful arthritis are the most common conditions. These are often accompanied by underlying issues concerning loss of appetite or difficulty with eating and drinking, resulting in or exacerbating malnutrition and dehydration. Some general health issues of the older population, such as flu immunisation, are relevant, others are not. For many residents, the optimum approach is that of end of life care, not conventional long-term condition management. In order for a palliative approach to be effective, it is important to understand long-term conditions and how they contribute to immediate and symptomatic problems.

The professional interviews conducted for this report suggest that the quality of healthcare varies greatly. Two topics were identified in particular:

- **Lack of confidence of care home staff.** One respondent said: "*If staff are not confident, they are not prepared to 'watch and wait'.*" Instead, they seek immediate medical advice or admit the patient to hospital. Likewise, if care staff are not confident or supported to advocate for residents, including to challenge inappropriate medical decisions, then their insight and better knowledge of residents' feelings and priorities is lost. Some respondents identified improved training of staff as necessary, including how best to communicate about healthcare issues. Other healthcare professionals reported that greatly improved communication and confidence of care homes staff (including both nurses and unqualified care staff) was developed through shared decision making about individual residents, where the resident and their advocates were also central to discussions. There were a few examples in the focus groups of where GPs working with community geriatricians and primary health care teams had developed relationships with ongoing opportunities to share knowledge and concerns, most notably when providing end of life care. Greater knowledge itself may not be the most important requirement.

- **Policies operating in care homes.** Several of the interviewees stated that policies in care homes were frustrating good practice, particularly concerning medicines. A community matron explained that, for the management of long-term conditions of people living in their own homes, medications are made available in case of an emergency. For example, for people with chronic obstructive pulmonary disease (COPD), antibiotics and steroids are prescribed and dispensed. Patients can use these when they feel they need them. The matron explained: "*Because the care homes work under different policies, because they are privately run homes, they have set policies…people with COPD understand the signs of when they are exacerbating with COPD or chest infection. In people's [private] homes we have emergency antibiotics and steroids in the house so they can take it if they are unwell. We wanted to do that for residents but could not because of the policies in the homes.*"

  These comments are reported here faithfully but reveal some misunderstanding of the situation. These policies are not the arbitrary judgements of care homes managers or proprietors but reflect the regulatory framework within which they operate. Except for homely remedies, regulation does not allow care homes to have stock drugs.

f) The regulation of healthcare support for care homes

Care homes are regulated by law and monitored and inspected by a range of statutory regulators in each of the four nations across the UK.[99] The regulations which govern care homes in each area are

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[99] These are for at the time of writing (June 2011): England, the Care Quality Commission (http://www.cqc.org.uk/aboutcqc.cfm); Scotland, the Social Care and Social Work Improvement Scotland (http://www.scswis.com/); Wales, the Care and Social Services Inspectorate Wales

based on the National Minimum Standards set out in the *Care Standards Act 2000*. These are interpreted in various areas by specific sets of regulations[100] which determine the responsibilities of the care home providers to maintain and promote the health of their residents. They refer to activities such as record keeping, planning and health monitoring. They also set out requirements for which the fulfillment largely depends on the cooperation of others (mainly NHS health professionals). For instance, in England, Standard 8.10 sets out that care homes 'enables users to register with a GP of their choice (*if the GP is in agreement)'* [italics added].[101]

All regulators have a responsibility to regulate not only the care home provision but the NHS health services providing support to care homes. No regulator to date has identified this as of concern or conducted any research into it.[102]

The Care Quality Commission in England is, at the time of writing, conducting a special review into meeting the healthcare needs of people living in care homes[103]. The review is focused on whether people have equal access to NHS services, choice and control over their healthcare, and receive healthcare that is safe and which respects their dignity[104]. The results are due in the late summer of 2011.

g) Care homes and current policy directions

Improving healthcare support to care homes offers the opportunity to further impact key outcomes for health and other policy objectives pursued by the four administrations across the UK. In all of these areas, the following could help:

- Achieving objectives set out in the national dementia strategies.[105] Improving access of care home residents to healthcare has been a key element of many of them.
- Rectifying possible breaches of the *Equality Act 2010*. In April 2012, the Act articles will come into force making discrimination based on age in health and social care services illegal. Concerns have been expressed that the apparent lack of care home residents to access some NHS services could be breaching their human rights.[106]

(*http://wales.gov.uk/cssiwsubsite/newcssiw/;jsessionid=0Y2WNz1JpvH6qpQJTs9Q7qPs0Cy65C0J51wYx1ck7GnJmTyhFnM7!1324607912?lang=en*);and Northern Ireland, Regulation and Quality Improvement Authority (*http://www.rqia.org.uk/home/index.cfm*).

[100] For instance, in Standard 15 in the National Minimum Standards set out in Wales (*National Minimum Standards For Care Homes For Older People,* Welsh Assembly Government, 31 March 2004, 13-14), Standard 9 in Northern Ireland (*Nursing Homes Minimum Standards*, Department of Health, Social Services and Public Safety, January 2008, 23) and Standard 8 in England (*Care Homes for Older People, National Minimum Standards and The Care Homes Regulations 2001*, Department of Health, 3rd Edition, 2003. 9).

[101] Care Homes for Older People, National Minimum Standards and The Care Homes Regulations 2001, Department of Health, 3rd Edition, 2003. 9.

[102] For instance see Development of RQIA Three Year Review Programme 2012-15, Pre-consultation Guidance Document. http://www.rqia.org.uk/cms_resources/Corporate%20Strategy%20Consultation%20Document_updated.pdf Accessed 12 June 2012.

[103] See Introduction to the review "Meeting the healthcare needs of people living in care homes" 2009/2010, Care Quality Commission. See http://www.cqc.org.uk/aboutcqc/whatwedo/improvinghealthandsocialcare/specialreviewsandstudies/reviewofhealthcareforpeopleincarehomes2009/10.cfm. Standard 8 in England (Care Homes for Older People, National Minimum Standards and The Care Homes Regulations 2001, Department of Health, 3rd Edition, 2003. 9).

[104] Care Homes for Older People, National Minimum Standards and The Care Homes Regulations 2001, Department of Health, 3rd Edition, 2003. 9). http://www.cqc.org.uk/reviewsandstudies/healthcareneedsofpeopleincarehomes.cfm Accessed 12 June 2011.

[105] *Scotland's National Dementia Strategy*, Scottish Government, June 2010. http://www.scotland.gov.uk/Resource/Doc/324377/0104420.pdf; *Improving Dementia Services In Northern Ireland. A Regional Strategy Consultation Paper,* Department of Health, Social Services and Public Safety, May 2010. http://www.dhsspsni.gov.uk/improving-dementia-services-in-northern-ireland-consultation-may-2010.pdf http://www.dh.gov.uk/en/SocialCare/NationalDementiaStrategy/index.htm Accessed 12 June 2011.

[105] *National Dementia Action Plan for Wales*, Welsh Assembly Government, September 2009. http://wales.gov.uk/consultations/healthsocialcare/dementiaactionplan/?lang=en Accessed 12 June 2011. http://www.dh.gov.uk/en/SocialCare/NationalDementiaStrategy/index.htm Accessed 12 June 2011.

[106] See Introduction to the review "Meeting the healthcare needs of people living in care homes" 2009/2010, Care Quality Commission, 3. http://www.cqc.org.uk/aboutcqc/whatwedo/improvinghealthandsocialcare/specialreviewsandstudies/reviewofhealthcareforpeopleincarehomes2009/10.cfm.

- Reducing "inappropriate hospital" admissions for people aged 65 and over. This has been set as a National Indicator in Scotland[107] and inappropriate hospital readmissions may be something for which hospitals may be fined for in England.[108]
- Developing a national programme of deliverable service improvements, based on the "essence of care". This could help allay public and media concerns over the treatment of older people in reaction to reports of poor treatment, such as those from the Health Service Ombudsman[109], Patients Association[110] and the Care Quality Commission.[111]

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[107] http://www.scotland.gov.uk/About/scotPerforms/indicators/hospitalAdmissions Accessed on 12 June 2010.
[108] Hospitals to face financial penalties for readmissions, *BBC*, 8 June 2010 News.http://www.bbc.co.uk/news/10262344.
[109] *Care and Compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people*, February 2011. http://www.ombudsman.org.uk/care-and-compassion/home.
[110] *Patients not Numbers, People not Statistics*, Patients Association, December 2010. http://www.patients-association.com/Research-Publications/297.
[111] http://www.cqc.org.uk/reviewsandstudies/inspectionprogramme-dignityandnutritionforolderpeople.cfm Accessed 12 June 2011.

5. Professional perspectives on healthcare in care homes

There is little published research available on the professional views of GPs, geriatricians and old age psychiatrists about care home medicine and healthcare. Several recent surveys are helpful in providing some perspective from the key professionals involved in the care of older people.

a) What do general practitioners think?

The October 2010 *Pulse* survey of GPs[112] found that:

- 61% believed that current arrangements for the medical care of patients in care homes were not satisfactory.
- Regarding access to local geriatricians and specialist older peoples' nurses: 23% considered such access to be very good/good, 39% acceptable, 35% poor and 4% very poor.
- 68% said that care home work was a major source of stress to the GP.
- 67% did not carry out a medication review on each resident every six months.
- 37% said that new residents would have a medical and nursing care plan within one month, but 26% said no and 37% did not know whether or not it was done.
- 37% said that local healthcare provision for care home residents had been cut in the last year. This affected mental health care (53%), incontinence management (34%) and pharmacist support (21%).

The earlier *Pulse* General Election survey reported that 73% of the 876 GPs felt they lacked sufficient support or resources to manage older patients in care homes safely.[113]

The recent joint BGS Scotland and RCGP Scotland report *Frailty, Older People and Care Homes, Can we do better?*[114] observed that:

- The availability and skills of Comprehensive Geriatric Assessment are not universal in community and/or hospital settings. Those with frailty-related problems may not be accessing appropriate assessment and rehabilitation opportunities.
- The skill mix of staffing in care homes at times fails to meet the changing needs of individual residents.
- Education and training opportunities for care home staff are often inadequate.
- The ability to up-skill nurse staffing to manage inter-current illness and palliative care requirements is identified as a deficit and resulting in some inappropriate hospital admissions.
- Early multi-disciplinary reviews following placement often fail to ask whether a return to the community is possible.
- Key clinical information and summaries regarding individual residents are often not available at the time of admission and often not held within care homes.
- Allied health professional support for assessment and therapy are, as yet, insufficiently available through community or outreach services.
- Pharmacy support is not uniform.
- Involvement through an integrated specialist service to support the practices, residents and care homes is limited, and in some areas non-existent.
- The specialist support of end of life care is lacking in some areas.

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[112] Care Home Survey, Pulse, 5 October 2010.

[113] Pulse General Election Survey. Question 15. February 2010. http://www.pulsetoday.co.uk/story.asp?storyCode=4125106&sectioncode=19. Accessed on 12 August 2010.

[114] British Geriatrics Society Scotland and Royal College of General Practitioners Scotland, Frailty, Older People and Care Homes, Can we do better?: Improving What we do? October 2009, 4-5.

- Consultant community sessions are not routinely available to support practices and care homes or prevent inappropriate use of unscheduled care when appropriate.

b) What do old age psychiatrists think?

Old age psychiatric community mental health teams have always gone into care homes partly because of the considerable number of referrals that come from them. They have long been interested in improving the mental health of residents in the care homes and improving the abilities of the homes to manage residents with mental health issues.

The interim report by the National Audit Office (2009) *Improving Dementia Services in England* included a survey on old age psychiatrists. In this, 87% of respondents said they did work with care homes although 64% were not specifically commissioned to do so.[115] However, old age psychiatrists thought that care homes were important for implementation of the National Dementia Strategy in England.[116]

c) What do geriatricians think?

All departments of geriatric medicine (65% response) and PCTs in England (45% response) were surveyed in late 2006 to assess their attitudes and clinical input to care homes, using the recommendations in the 2000 report by the BGS, RCP and RCN[117] as a template[118]. Findings included:

- In England, only 1% of total consultant geriatrician time in job plans was allocated to care home work, but 73% of departments favoured greater involvement.
- 14% of geriatric medicine departments reported a regular forum where GPs, geriatricians and nurses could discuss challenging or complex patients.
- Thirty-three departments (30%) reported participation in various initiatives to support ongoing care in care homes, of which only half were supported by allocated time in consultant job plans.
- Further evidence of this general commitment showed another 20 departments (18%) had tried to secure PCT funding for an initiative but had been unsuccessful.
- In contrast, 45% of departments reported local PCT initiatives in which their department was not involved. And 128 PCTs (90%) also reported such initiatives, mostly involving community matrons.

These findings reveal a difference between the aspirations of clinicians and PCTs, highlighting the need for further guidance and discussion about the way forward.

The 2011 BGS membership survey found[119] that:

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

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[115] National Audit Office, Improving Dementia Services in England – an Interim Report Part One, 2010, 18.
[116] *ibid.*
[117] Royal College of Physicians, Royal College of Nursing, British Geriatrics Society. The Health and Care of Older People in Care Homes. A comprehensive interdisciplinary approach. A report of a joint working party. Royal College of Physicians. London 2000.
[118] C Steves, R Schiff, F Martin, Geriatricians and care homes: perspectives from geriatric medicine departments and primary care trusts. Clinical Medicine 2009, 9 (6): 528–33.
[119] BGS Membership survey 2011.

- Over half said they were not aware of care pathways or protocols used by GPs and geriatrician teams to support collaborative work in care homes.
- 56% of consultants considered care home medical work important but over 90% spent under 10% of their time on it.
- 72% of geriatric trainees considered care home medicine important, which is encouraging for the future.

d) Tackling the challenge: what can we learn from professional opinion?

There are an estimated 37,000 GPs[120], just over 1,200 consultant geriatricians[121], and over 600 old age consultant psychiatrists[122] in the UK, many of whom are delivering healthcare to care homes across the UK. In addition there are other specialists such as palliative care physicians and consultants in rehabilitation medicine whose skills are highly relevant to many care home residents. As part of the in-depth interviews carried out, we sought opinions on ways health professionals and care homes could 'do things better.' These themes emerged:

- **Developing proactive working.** All the interviewees advocated proactive working so that residents' health could be monitored, problems anticipated, crisis situations avoided. One GP said: "*Proactive is better in terms of trying to prepare people. Because the reality is that once you get into a nursing home there is a high chance of dying in the next year. People are unwell. We try to prepare families that their loved ones are likely to die.*" Another explained: "*We have a plan for each of our residents to identify what would potentially cause this person to go into hospital so look at what can be done to prevent this happening. I don't want them in casualty and coming out with drugs which I am going to stop again.*"

- **Continuity in care.** One GP explained: "*It's the continuity of care that really counts for the patient. The home knows me and I know them. I can tell if they're not feeling well. And so if I get called by the home it will be something that's relevant. They know I'm coming on a weekly basis so little things that can cause a lot of work for the practice now don't happen because they can talk to me over the telephone. And they know I'm coming so it saves us and them time, and the resident gets a better service.*"

- **Valuing the staff in the home.** Most of the interviewees emphasised that the staff in the care homes are the most important contributors to the health and wellbeing of residents because they are with them all the time. They also emphasised the importance of care staff in supporting healthcare regimes and the decisions of healthcare professionals.

- **Building relationships.** Building relationships between homes and healthcare professionals, and particularly developing trust, is important. An old age psychiatrist said: "*Building relationships and trust are essential. Knowing whom to trust for accurate information. You have to try to get some degree of continuity and some sort of relationship and that's the best way. Also, it is important that you acknowledge you have to understand the culture of the place.*" A GP said: "*It's important to increase the confidence of care home staff...previously the nurses would say a minimum about why they wanted a patient to be seen and wait for the doctor to see them. Now they say 'this is what's going on' and if you could do xyz, this is how we should be dealing with this.*"

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[120] http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1999--2009-overview Accessed 18 May 2011.
[121] Royal College of Physicians of London: annual consultant census, September, 2009. http://old.rcplondon.ac.uk/professional-Issues/workforce/Pages/Consultant-Census.aspx. Accessed 12 June 2011.
[122] Census 2009, Royal College of Psychiatrists, Consultant Specialty Figures for England, Northern Ireland and Wales, 44. http://www.rcpsych.ac.uk/pdf/2009%20Census.pdf.

- **Greater understanding between care homes and secondary care.** An older persons' specialist nurse in mental health said: *"We need to increase awareness of the needs of care homes throughout health and social care and through general hospitals."* One geriatrician commented: *"It's really important that the secondary sector understands much better than it does now what goes on in care homes because we are still having the usual interface wars…We need to have a bit of a campaign…if they can understand the limitations of what can be done in care homes and also opportunities for better healthcare into care homes."*

- **More effective information technology and sharing data.** A geriatrician reported: *"Patients' notes are sometimes difficult to access. For example, patients who have moved into the care home and have changed GP or have been discharged from hospital. Sometimes out of hours GPs have little or no information of that kind, despite the fact that electronic records exist in care homes."* An older person nurse specialist in mental health said: *"Records are really important. There was a patient who had an advanced care plan and DNAR agreement but this was not clearly visible in the records so the paramedics tried to resuscitate him. Not a good situation."*

- **Reviews, protocols, advanced clinical planning and advanced care planning for end of life.** Several of the interviewees described how reviews and advanced clinical planning can help healthcare be more effective and support care home staff in their decision making. A geriatrician explained: *"An advanced clinical plan is made within the first few weeks after admission. We use one which we've developed from a number of different sources and trialed and on which we have now settled on. It has three pages. First page is basic information about the resident and their interested/relevant others and whether there is or is not a living will. The second page regards health [and] what are the things you are particularly concerned about. The third page is really the essence of it, which is similar to other end of life strategies. We have categories of response which are there to guide out of hours doctors who would be called upon to see a resident by a nurse and would never have seen the resident before."*

- **Consistency of clinical practice.** Another geriatrician spoke of the need to have clear protocols '*that care home staff can follow'*. *"Systematic approaches to the management of common conditions. Systems of management for behavioural problems, bowel care, communication, PEG feeding and (the) need to assume ownership of these systems so that people know what to do. CPR forms and advanced wishes forms. And you need information for relatives as well."*

- **Standardised assessment.** A GP recommended: *"Proper assessment forms. Evaluated and standardised with a score…It needs to be a mixture of bringing the individual needs and desires to the forefront but also to be a way of us getting information about that person's health problems and recording that in a standard way [that allows for] easy data entry. The score system is hugely advantageous because it would help us support staffing levels and make arguments."*

Staff feedback. One GP described a method which he had found effective in helping staff to understand how they interacted with patients. *"The idea came out of a cancer professional development review in Scotland Cancer Network, a small group I headed up called RAPPORT. This is to do with trying to care for people better and the need to have therapeutic relationships with the people we serve. Getting people to think about how they like to be treated or not treated in a non-clinical sense. And then thinking about something they have done well and an interaction that has led to a successful encounter with a patient, a time they have felt fulfilled."*

6. Learning from the evidence

Academic interest in care homes and their residents has grown considerably in the last few years. The graph below illustrates the growth of publications available through online searches with a focus on care homes healthcare over the last 30 years or so.
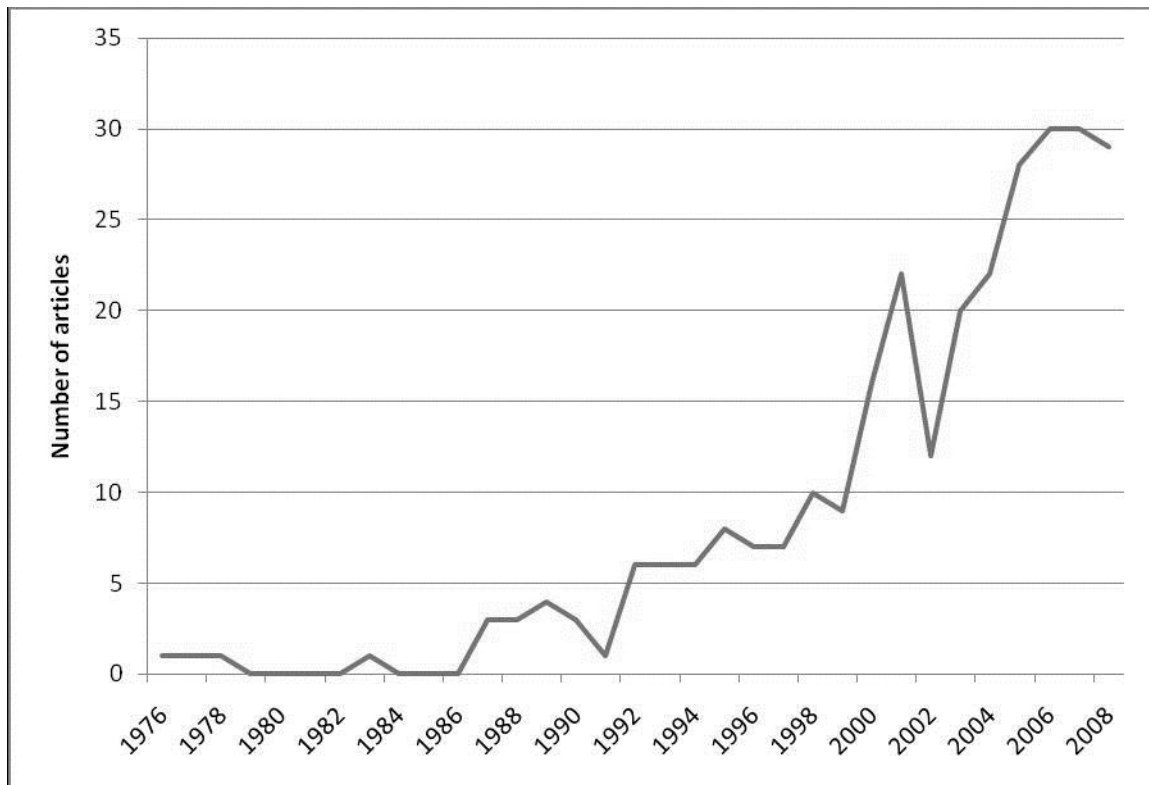
As part of the research for this paper, the BGS commissioned Professor Julienne Meyer of City University and her *My Home Life* project team working with the Universities of Hertfordshire (Professor Claire Goodman) and Nottingham (Professor John Gladman) to review the available evidence. The key points of this evidence are set out below. (More detail on the findings of the literature review is available in the Evidence Review on the BGS website.)

a) Models of care to support healthcare for residents of care homes

No definitive evidence emerges from the literature reviews to favour one model of primary care over another. There is little information available to evaluate whether different configurations of specialists and/or healthcare teams can replace or augment usual primary care. The relative merits of primary care organisation-based, cluster-based or GP-based nurse practitioners, compared to care home specialist teams are not known. One viable approach could be to increase investment in the GP services that have a specialist interest and formal responsibility for care homes and/or developing care home specialist case managers (nurse practitioner community matron, therapist) linked to General Practice. Another approach could be multi-disciplinary in-reach teams as an add-on to existing primary care. Care home-specific practices for areas with a high density of care homes could have the time, expertise and organisation to deliver the interventions referred to in this paper. No evidence exists to indicate if this is so in practice, nor of what the economic effect may be.

It would appear from the reviews however that, regardless of the model developed, service commissioners and planners might start by addressing the following:

- Prompt transfer of clinical information to the care home to enable healthcare staff to build on the wealth of assessment that will have been conducted prior to the transfer of care. The exact format of this varies in the UK, but there is plenty of evidence that detailed multi-disciplinary assessments prior to an individual moving into a care home can identify remedial problems and ongoing healthcare priorities. This will facilitate continuity of care where a change of GP or other healthcare professional occurs.
- Discussion and planning of future care for older people in care homes (including the use of advance directives) to reduce unplanned admission to hospital care services and inappropriate interventions at the end of life.
- Nurses working as case managers could compensate for deficiencies in the scope of usual primary care. This could supplement general medical services and serve as a clinical and communication bridge to specialists and other community health services, thus improving resident outcomes and resource use.
- Involvement of community pharmacy services to support medication reviews and improve prescribing practices.
- Close links with community mental health teams to improve assessment and care of residents with behavioural and mental health problems.
- Close links with community rehabilitation services, such as links with skilled therapists to support day-to-day care which can prevent or minimise complications with disabling conditions such as spasticity, contractures and pain.
- The use of support tools and care frameworks that encourage a shared and systematic approach to joint working between care homes, community nursing and other health professionals. Used in partnership, these tools can provide a basis for continuity and consistency of approach (even where there is rapid turnover in the workforce).

It should be recognised that it is not possible to be prescriptive about exact models of care in an increasingly diverse care market, where the need for care home provision is projected to increase and the organisation of primary care is about to change,. We consider it more important to agree key principles (see Recommendation 1, section b) that can ensure health care interventions are appropriate. We would argue that any service model commissioned or delivered in the UK should be judged on the basis of how well it can implement a proactive and structured approach to care that enables some or all of the above.

b) Innovations and Examples of Good Practice in NHS service provision
Initiatives which have developed at a local level to support medication review (for example, by a primary care trust in England) increase the uptake of flu immunisation, improve end of life care, result in more screens for malnutrition or reduce falls. All these reflect recognition that more should be achieved for this population than is currently done.

The driver for many of these schemes has been concern that the care home residents are being admitted "inappropriately" to hospital. As a result, the schemes may depend on temporary central funding earmarked for this purpose. Sustainability is therefore threatened by this short-term funding, by being focused only on selected and sometimes "failing" homes, and by the schemes not having been integrated into a comprehensive model.

More recently, nurse case managers working as nurse practitioners or community matrons (drawing on US models of working with care homes) have been supported to liaise with GPs and hospital

specialists to coordinate and manage the care that residents receive.[123] These roles are developed locally, sometimes by individual general practices and sometimes by localities, often in response to particular service concerns.

c) Learning from others

Emerging evidence from across the UK suggests that commissioning health related inputs for care homes can improve the quality of care, reduce hospital admissions and save money. Below are six examples:

1. In **Sheffield,** a locally enhanced service (LES) evaluation of the Sheffield PCT scheme demonstrated that the overall care planning process is carried out well and there is widespread evidence of good relationships developing between practices and homes. Feedback from the pilot showed that, of care home residents, 94% agreed that the GP service gave them the help they wanted and needed, and 84% agreed that they felt they received better care with the new GP service. For care home staff, 97% agreed that their relationship with GPs had improved and 86% agreed that the new service helped them understand more about residents' health. Finally, for family members, 97% agreed that the person they care for received better care.

   Although the pilot in Sheffield has only been running for a short time, evidence of the benefits of the scheme is beginning to emerge. In year one of the scheme, there was a reverse in the trend of rising emergency visits from care homes in the area, with a reduction in emergency admissions by six per 100 care home beds (approximately 9%) compared with the previous year. This translated into a gross savings of £145,000 in a single year for the 500 care home beds taking part in this small-scale pilot. The number of A&E attendances fell by three per 100 care home beds (approximately 10%) at a time when A&E attendances were rising in other areas. The use of emergency care practitioners (ECP) following 999 calls also fell by approximately one third.[124]

2. A recent pilot in **Leicester** trialed shared management of patients in residential homes between GP practices and community geriatricians. The pilot offered GP practices access to comprehensive geriatric assessments, care planning, rapid written feedback and a telephone advisory service. After six months, out-of-hours consultations fell by 16% and requests for visits by 37%. Hospital admissions were also reduced by more than half. The total cost of hospital admissions fell by 60%.[125]

3. A recent review of a locally enhanced service (LES) in a **London** borough found it saved money and improved service continuity and good working relationships[126]. The LES had also ensured that preventative measures took place through regular monitoring and 'check up' of care home residents[127], and improving service efficiency.[128] Care home residents and their family members were also very satisfied with the GP service.[129]

[123] J Gladman, G Chikura, Nurse practitioners in UK care homes, Medical Crises in Older People. Discussion paper series. ISSN 2044 4230. Issue 8 February 2011.

[124] Delivering Health Ambitions: Better for Less, Care homes an enhanced primary medical service, Yorks and the Humber NHS, 5.

[125] GP care home support 'cuts deaths and workload', Pulse, 15 Mar 10, http://www.pulsetoday.co.uk/story.asp?storycode=4125361.

[126] D Briggs & L Bright, Reducing hospital admissions from care homes: considering the role of a local enhanced service from GPs, Working with Older People, March 2011 15:1, 6.

[127] *ibid*, 7.

[128] *ibid*, 8.

[129] *ibid*, 9.

4. A study in care homes in **Peterborough** PCT conducting nutritional screening with 'Malnutrition Universal Screening Tool' showed a 31% reduction in the number of hospital admissions (27% reduction in emergency admissions) and a significant reduction (58%) in the length of hospital stays.[130]

5. A care home specialising in the rehabilitation of severely impaired adults provided evidence of one primary care practice model working proactively. It was agreed that all residents be registered with a designated GP practice where there was one male and one female practitioner who performed a round of the home on most weekdays. Over a six-year period they have documented a ten fold reduction in acute hospital admissions (Roberts 2011 personal communication).

6. A study by the Joseph Rowntree Foundation in **Bath and north east Somerset** looked at a joint NHS and local authority initiative providing a dedicated nursing and physiotherapy team to three residential care homes. The initiative aimed to meet the nursing needs of residents where they live and to train care home staff in basic nursing. The results included reduction in hospital admissions and prevention of nursing home transfers. Cost savings were estimated, ranging from a 'worst case' scenario of £2.70 extra per resident to the more likely scenario of £36.90 savings per week. Savings were mainly through reduced use of NHS services, while the PCT and social services both funded the intervention.[131]

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[130] AL Cawood et al. Effectiveness of implementing 'MUST' into care homes within Peterborough Primary Care Trust Clinical Nutrition, 2009;4, suppl 2:81.
[131] Providing nursing support within residential care homes, Joseph Rowntree Foundation, April 2008. http://www.jrf.org.uk/sites/files/jrf/2202.pdf Accessed 14 June 2011.

7. Conclusions

Below are conclusions we have drawn from our research around the healthcare issues facing care homes, our professional interviews and review of the evidence:

1. There are around 400,00 older people in care homes in the UK with high levels of clinical and personal needs due to their physical and mental health. Many have multiple, complex and enduring conditions which can make them frail, cause considerable disability and put them in a highly vulnerable situation.

2. There are many examples of good practice in care homes which demonstrate care and support can be delivered effectively to improve quality of life and the end of life for residents, however too often these practices are unsustained.

3. Published studies and evaluations do not provide clear support for a specific model of care which best delivers the type of primary care needed, or which gets the best results from the other healthcare professionals, such as specialist nurses, geriatricians or old age psychiatrists.

4. The social care model is central but insufficient in meeting residents' health needs. As social care providers do much commissioning, the health needs of residents are sometimes overlooked as it is assumed that the NHS meets them, and this is not always the case.

5. With little consensus among NHS commissioners, planners or managers on the practical obligations which flow from the legal and policy framework, there is often a failure to see care homes as an integral and necessary part of the healthcare service. Effective healthcare support for care homes, through commissioning or otherwise, seems to be a low priority for primary care organisations.

6. Two possible explanations for the poor access to NHS healthcare for care home residents may include ageism, or ignorance in believing that a social model of care home provision is in itself completely sufficient.

7. Despite having the same legal and human right to NHS healthcare as the general population, the reality shows care home residents receive patchy and fragmented access. Many older people are routinely denied the benefits of primary, secondary and community health services.

8. Reliance on general practices to bridge the medical needs of care home residents does not always work. Surveys of GPs suggest the majority feel they lack sufficient support or resources to safely manage older patients in care homes, and that such work is a significant cause of stress.

9. There is little previously published research available on the professional views of GPs and geriatricians on healthcare support in care homes. We have presented some which suggests that GPs and geriatricians believe the medical care delivered to care homes is perceived as low priority, and the quality is less than optimal.

10. Evidence from the professional interviews suggests that partnership working, and possible integration of services to improve information exchange and learning, is an approach many

believe would improve the current standards of care. Evidence from the surveys of GPs and geriatricians currently suggest considerable solo working.

11. Many healthcare staff who provide support to care homes and their residents have a unique range of skills and expertise. These are used best with a multi-disciplinary and partnership approach to care.

12. Working in partnership with the care homes sector and care homes staff is critical in providing effective healthcare support to older people in care homes. Many care home staff have relationships and knowledge about the people for whom they care, and the care homes sector has developed considerable expertise in managing the care (including end of life care) of frail older people.

13. The literature review, professional interviews and work with the care home sector does provide strong consensus on the likely features and principles of an effective NHS service to care homes. These include:
    o Primary Care Plus - various innovations have shown that GPs working differently (with or without an exclusive focus on care homes) can incorporate the proactive approach needed by working in partnership and applying patient-centred goals. This requires specification over and above the contractual obligations of conventional general practice.
    o Advance care planning optimises management of long-term conditions and prevents unnecessary complications surrounding disability and decisions about end of life care. This includes use of advance directives. It can only be achieved in partnership with residents, their families or other advocates.
    o Partnership working with care homes establishes effective methods of communication and clarifies mutual expectations. This can be facilitated by care homes, community nursing and other health professionals using shared tools for assessments and care planning. It provides a basis for continuity and consistency of approach (even where there is rapid turnover in the workforce).
    o Case managers (usually nurses) broaden the limited and inadequate scope of traditional primary care, and act as a clinical and communication bridge to specialist and other community health services.
    o Community pharmacists support improvements in prescribing practice and medication use.
    o Close links with community mental health teams improves assessment and care of residents with behavioural and mental health problems.
    o Sessional commitment from specialists such as geriatricians, rehabilitation physicians or palliative care teams provides reliable access and a shared approach to meeting the needs of residents without the cumbersome use of clinics and emergency departments.

8. Recommendations: taking action, bringing change, sustaining progress

Our recommendations are intended to galvanise and to guide action, aimed at:
- Clinicians working with care homes - to improve the quality of healthcare and the experience of residents.
- Those responsible for planning or commissioning services - to ensure the right resources and services are provided.
- Government and regulators – to remind them of their policy intentions and legal obligations which should form the basis of both funding decisions and regulatory inspection.
- Older people and their advocates - to provide insight into what they might reasonably expect of their NHS services.

Recommendation 1: Local NHS planners/commissioners should ensure that clear and specific service specifications are agreed with their local NHS providers. These need to link with quality standards based on patient experience and appropriate clinical outcomes.

Commissioners and healthcare planners across the UK have a critical role in shaping services. This section outlines some points to consider when developing services which deliver medical support to care homes and their residents.

a) Why commission or plan to improve healthcare support for care homes?
- To meet human rights considerations and legal obligations under the *Equality Act 2010*.
- To improve this vulnerable groups overall health by providing a more holistic service.
- To reduce inappropriate visits to A&E and avoidable admissions to hospital by, for instance, reducing the risk and subsequent adverse consequences of people falling, or implementing the NICE guidelines for nutritional care. A bed usage survey in Sheffield PCT showed that 25% of admissions from care homes are avoidable and that 40% were due to aggravated long-term conditions.[132]
- To improve healthcare support that reduces or prevents potential ill health proactively through improved coverage of influenza and pneumococcal vaccination, and a reduction in possible adverse reactions from poly-pharmacy.
- To cut costs associated with medicines waste, errors in administration of medicines, and admissions to hospital. Each hospital admission is estimated to cost between £2,000[133] and £3,000.[134]
- To improve end of life care, allowing people to die where they choose, and respecting their wishes.
- To build more effective communication links between primary healthcare teams, nursing and residential care staff.

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[132] Delivering Health Ambitions: Better for Less, Care homes an enhanced primary medical service, Yorks and the Humber NHS, 4.
[133] Complex Care General Practitioner (Enhanced Care of Patients in Nursing and Residential Care Pilot Study. Including Elderly Mental Ill Patients), WyvernHealth.com, Section 7.
[134] D Briggs & L Bright, Reducing hospital admissions from care homes: considering the role of a local enhanced service from GPs, Working with Older People, March 2011 15:1, 6.

- To ensure screening for malnutrition on admission, and regular monitoring according to risk with appropriate nutritional care plans to reduce the risk of 'harm'. For example, where there is increased vulnerability to infections, pressure ulcers and harm from falls.

b) What principles should underpin services to improve healthcare support for care homes?

The principles underlying planning/commissioning services for care homes could include:

- Using a systematic approach where commissioning is for a specific population with complex healthcare needs, ensuring suitable and fair access to NHS services.
- Providing care based on a full bio-psycho-social diagnostic assessment process, such as the Comprehensive Geriatric Assessment, preferably before admission and reviewed soon after admission, and systematically thereafter.
- Promoting autonomy and supporting residents to get the healthcare they need for the life choices they make, and to be partners in their care and treatment plans, including at the end of life.
- Involving significant others, usually family members, in a planned approach to care.
- Using evidence-based approaches focused on individual outcomes.
- Being multi-disciplinary and integrating the services of health, social and community care professionals.
- Taking account of the skills, knowledge and experience of care home staff and their relationships with the people for whom they care.
- Utilising existing expert guidance that has been developed by multi-disciplinary groups such as the BAPEN *Toolkit for Commissioners and Providers: Meeting Quality Standards in Nutritional Care*[135], NICE Guidance for nutrition support in adults[136] and *10 Key Characteristics of Good Nutritional Care*.[137]
- Respecting the diversity of people and views of the different groups to whom services may be delivered, and accounting for those differences (e.g. access to interpreters).

c) What are the clinical activities that need to be ensured through commissioning or planning?

It is recommended that the key areas to consider are:

- Determination of residents' healthcare goals, prior to or soon after admission. This is achieved through a full bio-psycho-social diagnostic assessment taking into account the resident's preferences and culture.
- Creation of advanced clinical plans based on those agreed healthcare goals and incorporating decisions about end of life care.
- Planned regular reviews of residents in light of healthcare goals and clinical changes, including medication and weight loss with nutrition and hydration intake reviews.
- Pro-active and responsive primary medical care. For instance, seeking to identify people at risk of falls or doing preventative work.
- Systems of communication between the care home and primary medical provider (GP), including mutual expectations and language for seeking help.
- Needs-based access to community health services, including district nursing, specialist nursing and allied health professionals to minimise the impact of sensory, cognitive and physical function impairment as part of a continuing care approach.

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[135] Malnutrition Matters – a Toolkit for Commissioners and Providers, BAPEN 2010.

[136] NICE. Nutrition Support in Adults: oral nutrition support, enteral tube feeding and parenteral nutrition, CG32.London, National Institute for Health and Clinical Excellence. 2006

[137] 10 Key Characteristics of Good Nutritional Care. http://www.nrls.npsa.nhs.uk/resources/?entryid45=59865.

- Specialist contributions to medical and multi-disciplinary management of long-term conditions in the context of frailty and malnutrition.
- Establish, review and provide guidance on assessment and management of common clinical challenges, including pain control, eating and drinking, skin integrity, continence, constipation, non-participation, challenging and distressing behaviours etc.
- Specialist contributions to medical and multi-disciplinary management of common clinical challenges.
- Specialist rehabilitation input for homes which provide continuing care or rehabilitation for people with significant disability.
- Support systems to ensure continuity of purpose 24-hours-a-day, with adequate arrangements for out of hours care.
- Clinical governance framework in partnership with care homes staff, and involving clinicians to maintain and improve clinical care of residents.

d) What clinical staff are needed to deliver key services?

The staff needed to deliver comprehensive cover to care homes could include:
- GPs, with explicit additional expectations that may be described in a Local Enhanced Service (LES) or other such arrangement.
- Regular sessional input from secondary care specialists (geriatricians, rehabilitation medicine and old age psychiatrists).
- Older peoples' specialist nurses, including those with expertise in case management and mental health problems.
- Palliative care specialists, such as doctors and nurses.
- Rehabilitation medicine specialists for homes providing care for residents with complex disabilities.
- Community pharmacists.
- Podiatrists and chiropodists.
- Dieticians and enteral nutrition teams.
- Therapists: physiotherapy, speech and language, occupational and other allied health professionals.
- Out of hours services.
- Mental health services such as clinical psychologists.
- Dentists and dental services (e.g. dental hygienists, dental technicians to make, repair and fit dentures).
- Opticians and audiologists.
- Social workers and housing officers.

e) What should a service specification cover?

Looking at a range of service specifications, key headings could cover:
- Service function. For instance, locally enhanced GP services for care homes or pharmacy advice lines.
- Service aims and description. The nature and scope of the service that should be provided, the care homes covered within the service and to whom the service is provided.
- Staff roles and core competencies.
- Information sharing arrangements. How is patient data shared with partner agencies, for example, between care homes, out of hours services, GP practices and hospital services

- Seamless pathways of care between organisations. For example, nutritional pathways of care that span organisational boundaries and ensure shared information for screening, assessment and care planning.
- Financial and temporal (time) details of the service. How much is being paid over what time?
- Staff accreditation requirements. Ensure that all clinical staff are registered with the relevant regulatory body and have the necessary training to carry out the duties specified.
- Performance management and quality indicators.
- Dispute resolution. How conflicts and problems are resolved in the delivery of services.
- Systems to evaluate service delivery by the commissioner/planner/regulator.
- Clinical governance arrangements.
- Point of contact for the service (service commission/planner or service provider).
- Supporting information. For example, service flow charts and supporting documents (e.g. NICE standards, Liverpool Care pathway), validated relevant forms/proformas (e.g. assessment forms).

f) Key service elements and examples

Examples developed by the NHS across the UK are to be found on the BGS website (www.bgs.org.uk). These include:
- Local enhanced service for nursing home care by Barking and Dagenham PCT, Greater Glasgow and Clyde NHS Care Home Services, South Staffordshire PCT and Adur, and Arun and Worthing PCT.
- Service Level Agreement for Advice which provides pharmaceutical advice to care homes from Warwickshire NHS Trust.
- Medicines Governance Service to Care Homes by NHS Calderdale, Yorkshire.
- General Medical Services Contract in Wales for Enhanced Service for Care Homes Specification and quality improvement toolkit.

The service elements that are commissioned/planned will depend on local conditions but common elements set out in agreements and specifications are outlined below:
- Weekly visits by GPs on a fixed day focusing on clinical attention for people in the care home who may be at highest risk. For example, those who are losing weight, have swallowing problems or who are fallers who might benefit from referral to a falls service.[138]
- Developing policies and procedures to cover contagious or other serious conditions such as outbreaks of gastro-enteritis, management of febrile illnesses and potential critical incidents.[139]
- Training. For instance, helping care homes with medicines management and record keeping.[140]
- Medical record keeping.[141]
- Medication reviews by GPs and local pharmacists.[142]
- Assessment. For instance, on admission to care homes or ongoing routine assessments.[143]
- Falls assessment. Identifying those at most at risk (e.g. postural hypotension, visual impairment).[144] Also, setting up falls registers, recording incidents and analyising why they happen.
- Multi-disciplinary team working.[145]

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[138] Locally Enhanced Service for Nursing Home Care, Barking and Dagenham PCT, 4.
[139] *Ibid.*
[140] See Warwickshire Primary Care Trust, Service Level Agreement for Advice to Care Homes, 2006, 2.
[141] Enhanced Medical Services for Care Home Residents with Nursing Needs, Revised Service Specification 2010, Greater Glasgow and Clyde NHS Care Home Services, See Section 5.
[142] Medicines Governance Service to Care Homes, Locally Enhanced Service, NHS Calderdale, October 2010.
[143] Greater Glasgow and Clyde NHS Care Home Services, *op. cit.*, See Section 2.
[144] Specification for a Locally Enhanced Service (LES) Nursing Homes, Adur, Arun and Worthing PCT, 2005-06, 4.

- Inappropriate emergency admission avoidance.[146]
- Initial assessments of residents admitted to care homes, including temporary residents, to develop appropriate care plans and ensure they are agreed by family members in specified care circumstances (e.g. palliative care, DNR instructions).
- Including care home residents in all relevant audits to support NICE guidance implementation, National Service Frameworks and Quality and Outcomes Frameworks.[147]
- Using root cause analysis for any patient who is admitted into an acute hospital bed from a care home setting to investigate systematically the reasons for the admission.[148]
- Planning and delivery of palliative care.[149]
- Arranging community-focused input from secondary care services such as palliative care, geriatric medicine and old age psychiatry.[150]

g) Measurement and evaluation

A number of resources are available to measure and evaluate a service. Possible measures could be:

- **A register.** A maintained register of patients cared for within the care home for whom the service provider/practice is contracted to provide services.
- **A multi-disciplinary approach.** The service provider/practice to demonstrate that it can and does work across disciplines, and is committed to developing a more integrated approach to health and social care service provision.
- **Evidence of training.** Each clinician to demonstrate attendance at approved training courses, and an ongoing commitment to develop their skills via continuing professional development (CPD).
- **Personal healthcare plans.** Each resident has a personal health plan that reflects their individual needs and ambitions, including advanced health directives such as requests not to be revived or admitted to hospital in the event of a crisis. Personal healthcare plans could also look at whether the admission to a care home is a long-term plan or whether the person is seeking to return to their own home.
- **Referrals and inquiries.** Documented evidence of onward referrals and inquiries about the enhanced level of medical care may be required.
- **Review**. The service provider/practice can provide an annual audit of the care provided to people included in the enhanced care programme.
- **Feedback.** The service provider/practice demonstrates that they have undertaken a survey of patients included in the enhanced care programme, possibly with local primary care commissioner/planner support.

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[145] Commissioning Proposal, Complex Care General Practitioner (Enhanced Care of Patients in Nursing and Residential Care Pilot Study. Including Elderly Mental Ill Patients), Herefordshire Primary Care Trust, 2.
[146] Commissioning Proposal, Complex Care General Practitioner (Enhanced Care of Patients in Nursing and Residential Care Pilot Study. Including Elderly Mental Ill Patients), Herefordshire Primary Care Trust, 2.
[147] Local Enhanced Service for Care of Patients residents in Nursing/Care homes, Service Level Agreement, South Staffordshire PCT, 2.
[148] Local Enhanced Service for Care of Patients residents in Nursing/Care homes, Service Level Agreement, South Staffordshire PCT, 3.
[149] Enhanced Medical Services for Care Home Residents with Nursing Needs, Revised Service Specification 2010, Greater Glasgow and Clyde NHS Care Home Services, See Section 4.
[150] Frailty, Older People And Care Homes, Can We Do Better? Improving What We Do, BGS Scotland and RCGP Scotland, 2009, 11.

Recommendation 2: Care home residents should be at the centre of decisions about their care. An integrated social and clinical approach should support anticipatory care planning, encompassing preferred place of care and end of life plans.

It is important that when working to improve healthcare support in care homes, the views of the people receiving the service should be sought and considered. This includes, but is not restricted to, end of life decisions. Informed participation requires the more knowledge and development of healthcare professionals to help individuals make judgments. This includes using techniques for involving older residents with impaired mental capacity, which have been successfully developed in some innovative schemes.[151] A resident-centered approach should consider diversity of religion, ethnicity and culture, and needs to be facilitated with appropriate supports such as interpreters and advocacy.

Effective planning for possible eventualities in a resident's life needs to be central to their care. Their wishes should be reflected on whether they would want to be resuscitated if they became unconscious, for instance after a stroke, and whether they would want to be admitted to hospital. We believe that no decision about a person should be made without that person or their relatives. Critical to this is planning around end of life care. Ensuring that people die in a dignified, peaceful way, and in compliance with their wishes, is important. As Dame Cicely Saunders said, *"how people die remains in the memory of those who live on"*.

Another important consideration is the need for flexibility in response to a change in a person's circumstances. This can only be done through regular reviews of the objectives of healthcare interventions and the interventions themselves.

Recommendation 3: Service specification for providing healthcare support to care homes should guarantee a holistic review for any individual within a set period from moving to a care home, leading to healthcare plans with clear goals. This will guide medication reviews and modifications, and clinical interventions both in and "out of hours".

To ensure this is achieved it is critical that all residents entering care homes are screened on entry using such assessment tools as the Comprehensive Geriatric Assessment.

It is important that any service specification supports an individualised approach to setting healthcare plans for care home residents. This is consistent with the personalisation agenda and should seek to support what the resident wants to do.

It is also important that residents are monitored on a regular basis. Many care home residents have multiple and complex conditions which require multiple medications to treat and manage. These conditions can change and the medication they receive to treat these conditions needs to be reviewed. This will also reduce medication error.

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[151] See the Short Observational Framework for Inspection (SOFI). http://www.brad.ac.uk/health/dementia/DementiaCareMapping/sofi/ Accessed 6 June 2011.

Recommendation 4: Healthcare services to support the achievement of these goals (see recommendation 3) should be integrated. This should combine enhanced primary medical and nursing care with dedicated input from departments of old age medicine, mental health services, and other specialisms such as palliative care and rehabilitation medicine according to local needs.

Many people in care homes have multiple and complex morbidities, and conditions which require multi-professional and multi-agency responses. Residents in care homes need a health service suitable for their specific needs. This means a structured and pro-active approach to care, with coordinated team working based on primary care and a range of other specialists including geriatric medicine, rehabilitation medicine and mental health. It also requires a partnership approach with care homes and social care professionals. This means shared information, assessments, training and learning to support quality.

Recommendation 5: The UK nations' health departments should clarify NHS obligations for NHS care to care home residents.

We believe that this gives a clear indication of what people in care homes and their advocates can expect from the NHS.

Recommendation 6: Statutory regulators should include in their scope of scrutiny, the provision of NHS support to care homes and the achievement of quality standards.

To sustain change, it is important that metrics are in place to measure progress. We call on all the regulators across the UK to incorporate local NHS support for care homes within their scope of inspection and monitoring.

One set of indicators that could be considered as a basis of regulation and inspection are those featured in the European study 'Quality management by result-oriented indicators: Towards benchmarking in residential care for older people.' This was co-financed by the European Commission, DG Employment, Social Affairs and Equal Opportunities in the framework of the PROGRESS Programme.

Using existing quality management guidelines and frameworks from the countries represented, the project team collected an initial list of performance indicators, taking into account different perspectives, including those of residents, relatives, staff, management and others working in the wider social and political context (for example, regulators and commissioners). These benchmarks or quality standards were set in five domains:
- Quality of care.
- Quality of life.
- Leadership.
- Economic performance.
- Context.

These indicators should be used selectively to drive up quality improvements. Further information can be found by reading "Measuring Progress: Indicators for care homes." Log onto

http://www.euro.centre.org/data/progress/PROGRESS_ENGLISH.pdf to view the set of result-oriented indicators that were developed and agreed by the selected EU member states.

Recommendation 7: Multi-agency and multi-professional national leadership should be promoted to support the development and dissemination of good healthcare practice in care homes, supported by clinical guidance and quality standards.

This leadership needs to come from those engaged in planning, developing and delivering healthcare support to care homes. It needs to be multi-professional, multi-disciplinary and based on an inclusive and partnership approach. The evidence set out in this report suggests that the best solutions to the challenges outlined in Chapters 3 and 4 require the engagement of all primary, secondary and tertiary care, social services, the care home sector and organisations which represent and advocate for residents in care homes. This leadership needs to help statutory and NHS services find solutions, but also hold them to account to ensure that services are commissioned, planned, regulated and inspected.

One possible approach is using the existing Stakeholder Steering Group which helped write this report. A number of future areas of work have been suggested which we believe would help improve the quality of healthcare support given to care homes. These include:

- Development of clinical guidance and recommendations. Our research highlighted that there were a range of areas where clinical recommendations and guidance may be helpful. These covered areas such as dementia, management of falls and nutritional care which included difficulties with eating and drinking and provision of artificial nutritional support. The issues for further consideration include end of life care and also advance care planning. These will seek to fill gaps where they exist and also highlight good practice and guidelines where present.

- Resources for service commissioners and planners. The stakeholder group has identified the importance of developing tools and resources for those who commission or organise services for older people in care homes. The stakeholder group is seeking to develop service specifications and collect case studies of good practice, validated tools and other resources.

- Education and training support for care homes and their staff. This report has identified that care homes staff are vital to the care and health of older people . We shall investigate ways to work with organisations such as Skills for Care to support them in areas such as materials, courses and other resources.

- Engagement with care home residents about the healthcare they receive. An important area for future consideration is to look at how residents and their representatives (for example, in England, the local Healthwatch) are engaged in consultation around the provision of their healthcare services. This may be a role for local statutory and non-statutory patient and public engagement bodies to consider.

Terms and definitions

A&E – Accident and Emergency department.

AHP – Allied Health Professional.

BANS - British Artificial Nutrition Survey.

BAPEN – British Association for Parenteral and Enteral Nutrition (http://www.bapen.org.uk/).

BGS - British Geriatrics Society (http://www.bgs.org.uk).

COPD - Chronic obstructive pulmonary disease.

CPD - Continuing professional development.

CPR – Cardiopulmonary Resuscitation.

CQC – Care Quality Commission (http://www.cqc.org.uk/)

DH – Department of Health (England).

DNAR - Do Not Attempt Resuscitation.

ECCA - English Community Care Association (http://www.ecca.org.uk/).

EoL – End of Life.

GMS - General Medical Services.

GP - General practitioner.

GPs with a special interest (GPSI) - General practitioners (GPs) with a special interest supplement their main GP role by delivering an additional high quality service in a particular area of expertise to meet the needs of patients. For example, a GP with a special interest may specialise in skin conditions, women's health or musculoskeletal problems.

GSF – Gold Standards Framework (http://www.goldstandardsframework.org.uk/).

LES – Locally Enhanced Service.

MHL - My Home Life (www.myhomelife.org.uk).

NCF – National Care Forum (http://www.nationalcareforum.org.uk/).

NHS – National Health Service.

NICE – National Institute for Health and Clinical Effectiveness (http://www.nice.org.uk/).

NIHR SDO - National Institute for Health Research Service Delivery and Organisation (http://www.sdo.nihr.ac.uk/).

OPSN - Older People Specialist Nurses.

OPSN-MH - Older People Specialist Nurse specialising in mental health.

PCT – Primary Care Trust.

PEG - Percutaneous Endoscopic Gastrostomy.

Primary Care Organisation - Known as PCT/GP consortia in England, health boards in Wales and Scotland, and health and social care boards in Northern Ireland.

R&D – Research and Development.

RCN - Royal College of Nursing (http://www.rcn.org.uk/).

RCP – Royal College of Physicians (London - http://www.rcplondon.ac.uk/).

RCPsych – Royal College of Psychiatrists (http://www.rcpsych.ac.uk/).

VMO - Visiting Medical Officers.

Appendix - Members of the Stakeholder Steering Group

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