The Care Home Strategy For Doncaster
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1 Introduction

Care Homes are an essential part of the Health and Social Care landscape providing care to some of the most vulnerable people in society, it is essential that the provision of care within Care Homes is high quality and meets the needs of the people who live there. Currently Doncaster has 54 Care Homes for older people and these are registered with the Care Quality Commission.

This strategy is a 5 year approach to this sector of care, providing a direction of travel for existing care providers and a clear indication to new providers wishing to become part of the Doncaster Care Home market. Essential to the success of this strategy is strong leadership at all levels and across all agencies. Success will revolve around a commitment to supporting and delivering quality care and the development of trusting committed partnerships.

The current Care Home Market in Doncaster is uncoordinated in terms of development or direction. Currently new Care Homes are being built within the Borough with little discussion regarding the provision being offered or whether this provision falls within the commissioning direction of both health and social care.

The aim of the strategy is to develop and communicate the long term commissioning intentions of Doncaster Metropolitan Borough Council (DMBC) and the Doncaster Clinical Commissioning Group (DCCG).

The strategy’s key aim is to look at how a model of care provision can be developed that leads to the individual remaining in their own home for longer. This will require a fundamental improvement in the availability of home support services and other community provision that supports people to live at home.

2 Older People’s Mental Health and Physical Health and the Care Home Setting

The prevalence of mental health issues within the Care Home setting is extremely common with estimates varying from 70% (Dementia 2014, Alzheimer’s Society) to 90% (Cracks in the Pathway, Care Quality Commission (2014) of residents having mental health needs. These needs can be divided into 2 elements:

- Functional mental health needs such as depression and anxiety disorders
- Organic mental health needs such as dementia and Parkinson’s disease.

Many care home residents, like the elderly population in general may have more than 1 condition often increasing significantly the complexity of care. Delirium is also a frequent presentation with residents often becoming confused or more confused and unwell as a result of physical health problems. This high prevalence of mental health issues in the care home population requires a specific and coordinated response.
One in six people aged 85 or over are living permanently in a care home yet data suggest that had more active health and health and rehabilitation support been available some people discharged from hospital from could have avoided permanent admission. Similarly, the Care Quality Commission and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital.

3 Executive Summary

Care homes are an essential part of health and social care provision they provide care to some of the most vulnerable people in society, it is therefore essential that the provision of care is both of high quality and meets the needs of the individual and that of the commissioners. Currently Doncaster has 54 older peoples Care Homes, each is registered with the Care Quality Commission. Despite this number of Homes many Doncaster Residents are placed out of area in surrounding boroughs as a result of the market being unable to meet the needs of the more complex group of people.

3.1 What do DMBC and DCCG want Doncaster Care Home Care to look like in the future?

The Care Home Market is an essential partner in health and social care, the market cares for some of Doncaster's most frail, most vulnerable people. The CCG and DMBC want these people to receive the highest level of care possible; we want to see Care Homes in Doncaster reaching 'Exceptional' Status when it comes to CQC Inspections. We want to move away from the current variations that are seen in the standard of care in the Care Home market.

The CCG's and DMBC intention is that we see less people being placed in Care Homes. We will look to support the person for longer period of time at home. We will look to develop services that will enable this to happen. This will impact on the current number of Care Home Beds commissioned from the CCG and DMBC; we will see a rise in the demand for Care Home Beds that provide higher level/complex care. This could be seen as a threat to the Care Home Market, it could also be seen as an opportunity, as it is envisaged that Domiciliary Care will increase and improve to meet the individual needs of the person in their own home. We intend on supporting Care Homes to diversify into this Market.

We want Care Homes to deliver Care that is individualised to the person, which allows the person to maintain their individuality and to encourage Care Homes to move away from the current one size fits all delivery of care model. We will look to Care Homes to adopt the ‘My Home Life’ model of care which looks to support the individual needs of the Care Home Resident.

We are currently concerned at the number of people that have to be placed outside of Doncaster away from their family and places of contact. In order to address this we will support the opportunity to Care Homes in identifying a ‘Complex’ Tier of Care Homes that will develop the capability to meet the demands of this group of
Residents. The market will therefore become two tiered. Trained Nurses will become instrumental in meeting this challenge.

We will look to build on the work currently being undertaken that brings together ‘One GP per Care Home’. This will be supported by the development of a Community Geriatrician that will support the GP in the care of both people both at home and in Care Homes. This will be further supported by the development of clear quicker referral pathways of care.

We want Care Homes to become a central pivotal part of their local communities by developing services and events that can be utilised by the whole community. We want Care Homes to open their doors and engage with voluntary agencies, charities and churches. This will improve the well-being of all involved. We want Care Home Residents to become active in the running of their Care Home, we want to see them have a voice in how the home is run.

We want to move away from society’s view that Care Homes are negative places where according to the media abuse is rife. We want Doncaster’s Care Homes to be vibrant places, we want them to move away from the place where people go to die, move away from ‘end of the road’ to make Care Home living a positive choice.

We will enable Care Homes to take responsibility for the management of its own incidents by supporting the development of Incident Reporting Systems. This will supported by robust contract management and monitoring.

The issue of recruitment and retaining staff is a major concern to the CCG and DMBC. We do not see a significant change in the current issues of attracting staff changing in the coming years. Furthermore we want to support Care Homes in addressing the current challenges that you have in the excessive use of Agency Nurses.

We will support the development of the Care Supervisor Role, this role will develop to NVQ Level 3/4 and will look to plug some of the gaps created by the staffing crisis Care Homes are facing. Similar to the extended roles currently in place in hospitals and in community care, we feel the climate requires this level of radical thinking. We will look to support the development of a new role by developing training programmes that will meet the current needs and requirements of the Care Home Market.

3.2 Older People’s Mental and Physical Health Care

We want a partnership working approach that assists the delivery of best practice to ensure that older people in care homes receive high quality person centred care and that staff are able to recognise and promote mental and emotional wellbeing. We will promote good physical and mental health as this assists the prevention of deterioration and exacerbation of need.

We want residents to expect to be helped to remain physically well and pain free. Staff must be able to recognise the increased risk of delirium. This is achieved
through staff understanding of the changes in behaviour and joint working with older people’s mental health services and primary care.

The identification of Dementia, Depression and Delirium is paramount to ensure a timely response to resident’s needs. Through training and education we want staff to be aware of residents with Dementia and other Mental Health problems and how this affects their care. This includes communication skills to ensure that staff are able to communicate and respond effectively to behaviours that they may find challenging.

Through the partnership working staff should recognise that behaviours are a method of communication and understand distressed behaviour.

We want Care Homes to be aware what should be expected to ensure the safety of older people with mental health problems and be aware of how to escalate risks and raise concerns.

We want best practice guidelines to be followed including the auditing of medication in care homes by Older Peoples Mental Health services to prevent the over use of antipsychotics which has been identified as a particular issue affecting people with dementia. Care homes should ensure that antipsychotic drugs are only prescribed in exceptional circumstances and regular reviews completed. This rigorous review should also apply to the prescribing of antidepressant to ensure safe and effective prescribing.
4 Future Commissioning Intentions of the CCG and DMBC

- The DCCG and DMBC will only contract with the Care Homes delivering the highest quality and care for people in Doncaster.
- The DCCG and DMBC will have a contract with Care Homes that is fit for purpose and promotes high quality care and improvement that is supported by a robust improvement and quality monitoring process.
- The CCG and DMBC will commission fewer beds in the future.
- There will be a spread of Care Homes throughout the Borough to promote choice.
- There will be a range of Care Homes that can accommodate and care for people with a range of complex conditions such as dementia, neurological and degenerative conditions. This will become known as the complex tier.
- People with a high level of need and complex conditions will be cared for and remain living in the Borough.
- The age profile of older people on admission to a Care Home will rise.
- A strong collaborative partnership between the DCCG and DMBC with the care Home market will be embedded.
- A fair fee structure will be in place that recompenses Care Home providers for the high quality care they deliver.
- There will be a supply of high quality intermediate care beds that actively support people to return home to live independently with in the community.
- Care Homes will be a central pivotal part of their local communities offering services and events that can be utilised by the whole community working in collaboration with voluntary agencies, charities and churches.
- Care Home residents will be active in the running of their Care Home, and have a voice in how it is run.
- Care Home living will be seen as a positive choice at the right stage of an individual’s life when they are no longer able to remain living in the community.
- Care Homes will take responsibility for the management of its own incidents by supporting the development of Incident Reporting Systems.
- A Community Geriatrician will be introduced to support the GP’s with the care of people in Care Homes.
- Clear quicker referral pathways of care will be in place.
- Assessments will identify immediate care needs and also potential deterioration of the person, so that Care Home placement can meet both their immediate and potential emerging future needs up to the end of life.
- Care Homes to adopt the ‘My Home Life’ model of care which looks to support the individual needs of the Care Home Resident.
- Ensure clear links are made to the transformational work programmes within the CCG and DMBC and the development of the primary care strategy.
- Develop community based services to support people to remain living independently at home for as long as possible supplemented by responsive Social Care services, responsive Primary and Community Care services that are supported by Secondary Care and Intermediate Health Care Services.
- Reduce the reliance on Care Homes in that this option is not seen as the first port of call when a person starts to deteriorate, has a hospital admission or a significant life change.
• People in Doncaster will be able to remain living in their own homes for as long as possible and will only be admitted to a Care Home when all other community options have been exhausted.
• That the Care Home market will meet their future needs and requirements.
• People in Care Homes will know that Care Homes are regularly assessed and monitored ensuring that they receive high quality care and are kept safe.
• A well trained and educated workforce will operate within Care Homes and Care Sector

5 Proposed Care Home Market of the Future

The current concerns regarding Doncaster are primarily two fold. Firstly the Care Home market lacks flexibility and secondly has limited capacity in terms of meeting the needs of Doncaster’s most complex persons. This results in the high level of people being placed ‘out of area’.

The future plan looks to challenge the current organisation of the Market and establish processes and services that enable people to remain in their own home for as long as possible and to move into formal care settings almost as a last resort. In order to achieve this aspiration future commissioning intentions relating to the Care Home market needs to be brave and radical.

6 Continued Placement at Home

Currently the choice of an individual as they deteriorate at home is to be placed in a Care Home, there is often little availability or flexibility in the Domiciliary Care Market to meet individual needs, this results in individuals being placed in Care Homes earlier than is absolutely necessary.

This approach needs to change, in order to improve the capability and quality of care in the Care Home Market, we need to develop a comprehensive, robust, well-funded and efficient Domiciliary Care Market that is flexible and responsive and supported by an equally responsive health offer that will meet the needs of Doncaster ageing population.

There needs to be greater attention and support given to the Domiciliary Care Market and even prior to face to face support the use of technology should be investigated as enabler for independence. This sector is essential in providing individualised personalised care at home and will become part of the community team that will enable more responsive reactions in terms of providing care. The team also includes responsive Social Care, responsive Primary and Community Care supported by Secondary Care and Intermediate Health Care Services. This is to be supported by the development of DCCG Primary Care strategy, which will be able to co-ordinate service intervention leading to the person remaining at home.

This approach will have a direct impact on the number of people being placed in ‘Residential’ Care Placements by the CCG and DMBC as a greater number of people will stay at home for longer lengths of time. This will result in a reduction in
bed usage as more individuals stay at home. This Commissioning Strategy needs to support Care Homes to diversify their services and to provide some of these facilities, encouraging them to become Domiciliary Care providers for their local population.

The role of ‘Extra Care Housing’ is influential in this choice. Extra Care housing is seen as a positive alternative to residential care. It provides purpose built accessible housing alongside an offer of care and support at different levels to enable people aged 55 years and over to stay independent and look after themselves in their own self-contained home.

Doncaster has 4 extra care schemes with the most recent one opening in April 2015. The schemes provide a total of 208 units; 183 units for rent and 25 units for shared ownership. Occupancy rates suggest that Extra Care is a popular form of accommodation for older people in Doncaster. To be eligible for extra care housing in Doncaster, people need to be aged over 55 years, have a housing support and/or social care need and a local connection to the Doncaster Council area. There is a desire to develop a number of additional schemes over the coming years.

7 **Placement in a Care Home**

When being assessed for future care a change will be required. The assessment needs to identify immediate care needs and also potential deterioration of the person. This identification will enable the individual to be placed in a care placement that will be able to meet their immediate and also future needs up to death.

8 **Development of a Community Based Health Care Team**

Currently health care support for care homes is varied across Doncaster. Many Care Homes are serviced by multiple GPs and indeed multiple GP practices. Some Care homes receive a high level of support while others do not. Those that do not ultimately look to use other care services such as the Emergency Care Practitioners, Community Nurses or ultimately use the local Accident and Emergency Department to enable residents to receive care.

This strategy is advocating the development of Community Based Healthcare Teams; the teams would be ‘virtual’ in nature but led by the GP. The GP should have at his disposal, rapid referral processes to Social Workers, Pharmacists, Community Nurses and the Community Geriatrician. The Community Geriatrician will have links into the Acute Hospital, Intermediate Care, Care Homes and for people at home. By developing this model Doncaster should see a greater number of people continued to be cared for in their own home, and when they do move into a care setting this improved level of care should result in less admissions into the Emergency Department.

In order to support this initiative, individual plans of care should be developed that are accessible to out of hours services such as the Emergency Care Practitioners and Out of Hours GP Services; this should again lead to continuity of services.
9 **Complex Care Homes**

One of the key concerns around the current provision in the Doncaster Market is the limited capability of the market to meet the needs of complex residents. Doncaster does have a small number of homes that can meet these criteria of patients, these homes often receiving residents from other Doncaster homes that have indicated they are incapable of meeting the needs of complex patients, which is not conducive for continuation of patient care. Unfortunately when this limited resource is exhausted the person is transferred out of area, which clearly can be detrimental to both the person and their family and concerning to both the CCG and DMBC.

It is proposed that future commissioning will enable a greater number of care homes within Doncaster area to take ‘complex’ residents. This will require financial support and incentives to continue to drive quality by the use of contractual mechanisms such as CQUINs.

All Care Home provision will be supported by other transformational health projects for example the review of Community Nursing services, including specialist teams, the community geriatrician pilot and the emerging Primary Care strategy.

10 **Recommendations**

**End of Life Care**

1. To link care homes to the new community palliative care model, DBHFT and other providers like FCMS (particularly out of hours) to support homes to care for their residents in their usual place of residence in a planned way rather than in hospital as a result of a crisis.
2. Ensure each home has a robust link with their named community nurse who will act as the care co-ordinator for residents at the end of their lives.
3. All care homes should demonstrate equity for residents regarding the application End of Life care and the Gold Standard Framework (DH, 2015)
4. We will also link care homes to the future to outcomes and ambitions for people at the end of their lives. We will do this by engaging care homes in two pieces of work (i) the care homes skills/education audit with DMBC which will consider the workforce skills, needs and gaps in the currently (ii) the current Stocktake of End of life care in Doncaster, which will help direct our future ambition around End of life care.

**Commissioning**

5. Develop Robust Individualised Domiciliary Care Provision.
6. Commission the development of a complex tier of Care Homes
7. Give clear direction to Care Home Market regarding the future commissioning intentions of reducing Care Home placements.
8. Support the development of GP Led Multi-Disciplinary community Teams,
9. When a placement is being considered by care managers, all opportunities need to be explored that look at placing the person in Doncaster. This may
mean additional support to the care setting from 'core services' or additional staffing.
10. Support care homes to diversify and utilise their services and staffing to meet the needs of the wider community
11. Review Develop Outcome Measures of the Care Homes currently piloting different GP models.
12. All Care Home contracts to DCCG and DMBC to adopt the ‘My Home Life’ initiative
13. Review the current fee schedule to reflect the higher cost of delivering care in the ‘complex tier’
14. Ensure clear links are made to the different strategies being developed across the DCCG and DMBC e.g. Transformational work programmes and the development of the primary care strategy.

**Dementia Care**

15. All care homes should be able to demonstrate the achievement of the Dementia Care standards.
16. All care home staff should have an understanding of Older Peoples Mental Health issues particular dementia, depression, anxiety and delirium and aspects of prevention.
17. All care home staff should achieve Skills for Care level 1 of dementia training
18. All care homes should be recognized as “Dementia Friendly”
19. All care homes should have an identified Dementia Friends Champion/ Dementia Champion
20. Develop a “Dementia Quality Mark” (Nottinghamshire County Council, 2013)
21. All care homes perform/receive a dementia mapping exercise each year producing an improvement plan.
22. All care homes should demonstrate equity for residents with OPMH regarding the application End of Life and the Gold Standard Framework (DH, 2015)

**Quality Monitoring, Safeguarding**

23. Monitoring of Homes to be undertaken through the Care Home Executive Group
24. Include 6C’s as part of the Quality Monitoring Process
25. Develop and introduce an Operational Policy for review and escalation of concerns related to Care Home Providers
26. Undertake review and consultation of QIF involving all key agencies and partners
27. Commence ‘Completion Visits’ as soon as possible
28. Review current arrangements of quality monitoring for out of area placements.
29. Utilising data reflecting the impact of the Care Home on other partners, namely GP Services, Attendances at the local Emergency Department, Use of Community Nursing Services.
Engagement

30. Develop a Quarterly Care Home Commissioning Forum supported by the development of a ‘Newsletter’.
31. Develop and hold a yearly ‘Care Home’ conference

Workforce Recommendations

32. Workforce Group to investigate facilitation of relationships between key partners to enable learning and development. Opportunities to be maximised.
33. Incorporate workforce issues into care home executive group
34. All new members of Care Home Staff either undertake the Care Certificate or be assessed against it with any identified gaps are addressed through individual training plans.
35. Multi-Agency Strategic Health and Social Care Workforce Group to develop an active role in the support of Trained Nurses
36. The CCG and DMBC commit to supporting the Care Home Market by building a relationship with both the local Higher Education Provider and the Local Universities in order that the position of Care Homes in terms of employment changes
37. Develop an enhanced role of carer within the Care Home Market meeting the education requirement of NVQ Level 3 along with locally assigned training. Commence this role initially in the ‘Complex Tier’ Care Homes.
38. Multi-Agency Strategic Health and Social Care Workforce Group to become active with representation across appropriate agencies. Developing a role of monitoring and activating education streams as identified by national drivers and local intelligence.
39. Support the further development of the Training Matrix, support piloting, evaluation and implementation of the tool through the Strategic Workforce Group.
40. Adopt the recommendations of the Care Home Education Project.
11 National Picture

11.1 Review of Literature

In order to enable this strategy to be up to date with current thinking and reports, several reports were identified as being significant and influential in the development of a care home market of the future.

The first report reviewed was John Kennedy’s Care Home inquiry on behalf of the Joseph Rowntree Foundation. The report gives an innovative view of the care home market and that of the people that work in this sector, advocating that it is vital that the care home market should be seen as an instrumental part of the healthcare system, recognising that the whole system should share responsibility when a failing home is identified. The report claims that by under investing in this market the costs are expensive, and have a direct impact on other parts of the healthcare system, suggesting we adopt regulation processes using a whole system approach. Advocating that regulation should encompass pay and working conditions, staffing levels, commissioning practices, and transparent tariffs. In essence regulate for success not failure.

In terms of the workforce, Kennedy is very clear that in order for care homes to care for our most vulnerable we should ensure our systems and processes are set up to support them as opposed to criticize them. The report recognizes that in order for people to care well, they need to be appropriately paid supported properly and allowed to provide direct care, letting their natural qualities shine through.

In terms of leadership, Kennedy identifies the crucial role the care home manager plays in delivering quality care. Reflecting, without good managers the care home and market as a whole will fail.

The report recognises that care homes have become isolated from communities meaning that residents are therefore excluded, advocating that homes must reengage and becomes part of their community, recognises that care homes have a social and community responsibility

The issue of risk is also discussed in the report, recognising that modern lives are risky and that there is a difference between an evil act and one which is a mistake. This lack of clarity has almost developed an approach where everyone is guilty and under suspicion, this once again gets in the way of developing good relationships of which good care can prosper.

The report identifies that a partnership supportive role involving all the key agencies is the only way to ensure continued success, but notes that the more bureaucracy that is put into homes, this removes key staff from providing good quality care, promote people time not office time.

The second piece of work that is reference is The Commission on Residential Care- A vision for care fit for the twenty first century’ (2014).
This key document makes a bold statement from the outset, Care Homes, be it Nursing, Residential or EMI, and indeed all the ‘specialist’ housing that has begun to emerge, are referred to in the document as ‘Homes with Care’, this absolutely changes the context and emphasis of homes. Reflecting the view that the term ‘Care Homes’ suffer from extreme negative publicity and so it is vital to refocus the market.

The other key indication in this report is the suggestion that long term focus should be on personalization by suggesting question should be raised as ‘What is required (care)’ as opposed ‘Where it is delivered’

The report gives clear recognition that despite all the negativity around Care Homes and the widely held view that this should be the last stage of someone’s life, a move into a formal care setting can be an enriching positive action. This could lead to a situation where choice is exercised and true personalized care is delivered that is less restrictive and more fulfilling. Where personal cares are required a move into a formal care setting can be truly transformational.

The report follows an extensive consultation process that looked at what people want in later life. The outcome unsurprisingly are the same things the majority of the population want, these are opportunity to explore, a sense of belonging, good relationships, not feeling isolated, plenty of opportunities to enjoy the things that give them pleasure. The report identified two key criteria that affected individuals as they aged; these are the desire for dignity when this is no longer in their own hands, and help with daily activities.

Acknowledging these ‘wants’, the report is stark in its reflection that a housing market built on current demands will be outdated within one generation, in order to avoid this the market has to be flexible and responsive, the report is clear that the market should not adopt a one size fits all.

One other key finding of the consultation process is the view that to move into care is a major step and that action should be taken that enables the step to be far narrower, incrementalising this situation.

The report identifies the key challenges facing the market. These are funding pressures, challenges in staff recruitment, negative perceptions of housing with care, extreme confusion of the terminology used and the options on offer, the demographic challenges along with extensive multi-morbidities, limited support from primary and other health services.

The report concludes by identifying what needs to change. The first step is to build on what we have and recognize that housing with care is an asset, it is generally under resourced and often overlooked as a source of specialist support and expertise. The report recognizes that housing with care could be an excellent resource for step up and step down facilities, as a provider of rehab facilities, as short stay or respite facility, or as an outreach service to provide housing with care in the home, in a similar manner to hospice at home.

The report also recommends that when care is commissioned the specific needs of the individual are assessed and care should be assessed from an outcome
standpoint, as opposed to a location standpoint. We should move away from 'commissioning a bed' and move towards a package of support. This thread also extends to review and regulation, indicating that outcomes should be the central assessment criteria.

The second key recommendation is to create a flourishing market of supply. The view of the report is that the current registration criteria limits innovation and prevents flexibility. The report makes a clear association of lack of flexibility is as a result lack of planning.

The third step identified by the report is to build on the terminology, recognising that by using the term ‘housing with care’ it moves the decision of moving from a care decision to an housing decision, dispelling the idea that this is an ‘end’ stage process, introducing the notion that this is simply a further step of a pathway of choices.

The final step in the report relates to funding and makes the link between funding and true implementation of the Care Act. The report identifies that in the housing with care market a lack of quality care is creating instability, it strongly recommends that funding and investment should result in improving quality.

Healthcare in Care Homes
The Forward View into Action
The NHS Forward View into Action Vanguard sites provide an insight into organizations and communities where innovative approaches have been utilized in care homes.

Examples of the sites include

Connecting Care Wakefield District

The development of a proactive assessment and care planning based around wide determinants of health. Integrating care homes with, Voluntary Services, GP’s, Wakefield Council, Yorkshire Ambulance Service and the local NHS Foundation Trust.

Gateshead Care Home Project
The development of co-commissioning across the CCG Gateshead Council, across the community bed and home based care. There is also a Ward Round based service from GP’s and community nursing teams. This has led to reductions in hospital admissions. There is a future pan to extend this to be developed across intermediate care

East and North Hertfordshire CCG
This initiative works across the partnership of Hertfordshire County Council, East and North Hertfordshire Clinical Commissioning Group and Hertfordshire Care Providers Association.

The key work in this area is the development of education and training, whereby participatory homes become accredited. In addition there is also the development of
multi-disciplinary teams including GP’s, MH Nurses, Community Nurses and Geriatricians. The emphasis here is to provide proactive support and the development of a rapid response team.

**Nottingham City Clinical Commissioning Group**
Vanguard includes partnership working involving two NHS Acute Trusts, City Care Partnership, Nottingham City Council, Age UK Nottingham and local primary care providers.

This initiative includes mobile working for GP’s, use of remote video consultation between care home residents and GP, remote access to health data and the increased use of tele-health.

**Sutton Homes of Care**
The partners in this initiative are the London Borough of Sutton, AgeUK Sutton, the Alzheimer’s Society, Epsom and St Hellier NHS Trust, South West London and St George’s Mental Health Trust and Sutton and Merton Community Services.

This initiative is to develop a care home provider network, to support training, tele-health and development of in reach services, enabling care at the care home by a variety of specialists enabling them to stay at home.

**Airedale and Partners**
The partners in this initiative included the CCG and member practices, NHS Providers, Care Home Providers, Social Services and the Third Sector and technology and academic partners.

The initiative is to deliver enhanced care, by use of tele-health and an Intermediate Care Hub enabling care home residents and carers to receive 24/7 remote support via video consultation with A/E Consultant.

Making our Health and Care Systems Fit for an Ageing Population
This document from the Kings Fund provides a sense of direction into the wide use of care services by our elderly population. However for the purpose of this strategy I have focused on the section covering care homes.

The report recognizes the importance of effective assessment, effective treatment and adequate rehabilitation and wherever possible the individual is not moved directly from an acute hospital admission into a long term care placement. The report also identifies that capacity may have a negative effect on threshold, identifying that when capacity is high threshold for admission is often lower.

The report recognizes things that work, these are capacity and availability in age friendly housing, availability and use of tele-care, availability of home care services, and availability of step up and step down intermediate care facilities, investment in good discharge planning and support, systematic use of a comprehensive geriatric assessment, availability of specialist support for dementia and end of life care.

The report makes several recommendations, The key action is that an active relationship with the care home market through effective contracts and specifications should lead to improved quality of care. Particularly when related to the delivery of enhanced primary care services which will in turn lead to improved access to the MDT and specialist consultant led services.
These have to be coordinated and not delivered in an ad hoc fashion as is often the case.

Information sharing is also identified as being crucial to good care delivery. The report particularly looks at the role of the community nurse in a ‘case manager’ role not only in bridging the information gap but acting as clinical and communication bridge to specialists.

The report also recommends that a multi-disciplinary approach to assessment incorporating a Geriatrician, Nurse Specialist and Pharmacist. The impact of this approach is a reduction of hospital admissions of between 16 % and 29%, with a reduction in occupied bed days of 43% and 71%.

Support and training are evidenced as a mechanism for addressing the challenges of staff turnover, insinuating that staff leave as they are unprepared. The report particularly identifies Dementia and End of Life Care, suggesting from evidence that workers who are both registered and non-registered learn best as on site as part of a wider quality initiative.

The report also recognises the role of evidence based quality frameworks as a mechanism to improve quality of care and that of relationship centered care.

11.2 The National Picture around Dementia

According to the CQC report *Cracks in the Pathway* (2014) there are 400,000 people living in care homes with most of them having dementia or similar impairment. The CQC report also highlighted that variable or poor care was found in 90% of the homes surveyed. This often results in residents being admitted to hospital with avoidable conditions such as urinary tract infections, chest infections, dehydration and delirium.
12 The Key Issues in the Doncaster Market

According to local data provided weekly by Doncaster Metropolitan Borough Council, as of January 2016 Doncaster Clinical Commissioning Team and Doncaster Council contracts with 54 Care Homes within the Borough that provide 2,036 beds of these 875 beds are for people with dementia (residential beds 586, nursing beds 289). Of these, 24 Care Homes provide general needs residential care the remaining 30 provide both general needs residential care and nursing care with 1 Care Home in Doncaster that provides nursing care only.

Many of the Care Homes are adapted properties rather than purpose built facilities, many owned by small local or regional providers. There are also three main national providers within the area; Crown Care, Runwood and Four Seasons. Of these, Four Seasons is the largest provider with 9 Care Homes in Doncaster.

Applying the prevalence statistics this would mean that currently 1200 residents will have a dementia condition and as many as 1400 residents will have a mental health condition.

All the Care Homes are subject to local monitoring contract and quality monitoring processes. This is undertaken by the DMBC Contract and Quality Monitoring Team on behalf of both Doncaster Metropolitan Borough Council and Doncaster Clinical Commissioning Group.

13 Current Activity within the Doncaster Market

The market is made up of the majority of independently owned Care Homes, with a small number of homes belonging to ‘small groups’. The biggest provider is Four Seasons who currently have nine homes in the Doncaster Borough.

The largest providers in terms of numbers of care placements of the CCG are as follows with these Care Homes providing between 20-30 placements:

- Benfield - 26
- Benton House - 25
- Elm Park - 28
- Dr Andersons Lodge - 27
- Flower Park - 26
- The Old Rectory - 27
- The Richmond - 25
- Wynthorpe Gardens - 29
- The Royal – 27

Despite the significant number of Care Home beds the key challenge in the market currently is the lack of capability to meet highly complex needs of potential residents. Currently there are only a small number of Care Homes that have the capability to meet the needs of this type of residents.
14 Out of Area Activity

One historic response at the lack of flexibility and limitations in the Doncaster Care market has been to utilise an increasing number of ‘out of area’ placements. Using this process has many risks attached to it regarding quality of care, impact on the person’s family and often out of area the placements have a higher cost attached to them.

The other potential reason for an individual to be placed outside of Doncaster is the lack of bed availability, which with a bed vacancy of averaging 105 in Doncaster this probably reflects most the limited capability within the Doncaster Care Home Market. It is recognised there are pockets of increased capability within the market but ultimately bed vacancies in these care homes are limited, resulting in individuals having to be placed ‘out of area’.

Currently the CCG has around 90 ‘Older People’ currently placed outside of the care home sector in Doncaster. This is across 60 different Care Providers.

The placement range from a weekly cost of £112 per week to £4,809

- 31 Placements up to £1000 per week
- 24 Placements between £1000 and £2000 per week
- 26 Placements between £2000 and £3000 per week
- 2 Placements between £3000 and £4000 per week
- 5 Placements above £4000 per week
15 **Reasons for Out of Area Placement**

As part of this work an analysis has been undertaken of where these individuals are placed and the reasons for their placement.

Currently 34% of out of area placements are there as a result of complexity of cases. This is significant in terms of the capability of the care home market in Doncaster to meet individual needs. These are exclusively EMI and Neurological facilities. Interestingly 14% of placements are for reasons and family preference. These are often placements the furthest away from Doncaster.

16 **Impact of Complexity**

The pattern of care appears to be that either the individual is assessed as being too complex from the outset or is deemed to be too complex after being placed or there is clinical deterioration ultimately resulting in individual moving placements from the original Doncaster Placement.

Examples of this are reflected in this ‘snap shot’ of patients movements:
- Hickleton Lodge Care Home to Star Foundation (Rotherham)
- Richmond to Community Places (Barnsley)
- Headingley Court to Star Foundation (Rotherham)
- Walton Grange to Langley Park (Sheffield)
- The Royal to Forest Hill (Worksop)
- Church View to Phoenix Park (Scunthorpe)
17 **Quality Monitoring and Safeguarding of Out of Area Placements**

Placements away from Doncaster raise a concern regarding monitoring the quality of care and of contract monitoring of the placement. This is partly depending on the hosting CCG and Local Authority, plus it is partly the responsibility of the DMBC Contract Monitoring Team who undertakes a ‘desktop’ process of quality monitoring. Currently placements are in the following places:

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of Places</th>
<th>Area</th>
<th>Number of Places</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnsley</td>
<td>17</td>
<td>Northamptonshire</td>
<td>1</td>
</tr>
<tr>
<td>Bridlington</td>
<td>1</td>
<td>Nottinghamshire</td>
<td>6</td>
</tr>
<tr>
<td>Bury</td>
<td>1</td>
<td>Peterborough</td>
<td>1</td>
</tr>
<tr>
<td>Buxton</td>
<td>1</td>
<td>Pontefract</td>
<td>2</td>
</tr>
<tr>
<td>Castleford</td>
<td>1</td>
<td>Sheffield</td>
<td>10</td>
</tr>
<tr>
<td>Chesterfield</td>
<td>1</td>
<td>Scunthorpe</td>
<td>10</td>
</tr>
<tr>
<td>Cleckheaton</td>
<td>1</td>
<td>Rotherham</td>
<td>15</td>
</tr>
<tr>
<td>Coventry</td>
<td>1</td>
<td>Retford</td>
<td>2</td>
</tr>
<tr>
<td>Gainsborough</td>
<td>1</td>
<td>Swindon</td>
<td>1</td>
</tr>
<tr>
<td>Goole</td>
<td>1</td>
<td>Teignmouth</td>
<td>1</td>
</tr>
<tr>
<td>Huddersfield</td>
<td>3</td>
<td>Tyne and Weir</td>
<td>1</td>
</tr>
<tr>
<td>Hyde</td>
<td>1</td>
<td>Workshop</td>
<td>2</td>
</tr>
<tr>
<td>Kent</td>
<td>1</td>
<td>Wrexham</td>
<td>1</td>
</tr>
<tr>
<td>Manchester</td>
<td>1</td>
<td>York</td>
<td>1</td>
</tr>
<tr>
<td>North Lincolnshire</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When analysing the location of these placements the vast majority of them are located in neighbouring CCG’s and Authorities. This does allow closer relationships to be developed particularly in the area of quality monitoring and safeguarding.
18 Healthcare in Care Homes

One of the key areas that require attention is that of the impact of care homes on other health care services. Clearly residents of homes are among the most vulnerable in the Doncaster population and as such are a high user of services.

Accident and Emergency Department Activity in Relation to Care/Nursing Home
Currently when Care Homes struggle to ‘manage’ their residents the ‘fall back’ position is in attendance to the Emergency Department. The period between July 2014 and April 2015 saw 3041 attendances with one home solely being responsible for 125 attendances.

1084 of the 3041 were self-referred, with 865 attended via Emergency Services and the remaining 976 recorded as ‘other’.

The top five reasons for attendance at the Accident and Emergency Department were:

1. Urological Condition
2. Infectious Disease
3. Contusion/Abrasion
4. No Abnormality Detected
5. Dislocation/Fracture/ Joint Injury/Amputation

After being seen 37% were admitted (1122), 28% were discharged (854) with follow up from the GP and 27% (822) discharged with no follow up. In essence this resulted in around 55% attending Accident and Emergency Department unnecessarily.

Emergency Admissions Activity in Relation to Care/Nursing Home
From June 2014 to April 2015 there were a total of 1750 Emergency admissions where the usual place of residence is a care or nursing home establishment. The high number from one care home was 64.

The top five reasons for Emergency Admissions were:

1. Lobar Pneumonia
2. Urinary Tract Infection
3. Lower Respiratory Tract Infection
4. Pneumonitis due to food or vomit
5. Fractured Neck of Femur

In terms of length of stay 17% (295) had a length of stay of one day, while 14% (251) had a zero length of stay. 27% (474) were admitted at weekends. 11% (194) had a discharge method of ‘death’.
Community Nursing Activity (Single Point of Access SPA)

From January 2015 to July 2015 the SPA Teams received 5112 from nursing/care home residencies.

The top five reasons for referral to SPA were:

1. Venepuncture
2. Wound Care
3. Catheter problems
4. Other
5. Medicine Administration

The vast majority of these referrals were during working hours 08:00-20:00. The sources of the referral were:

- General Practice
- Self-Referral
- DBHFT (General Medicine)
- Specialist Nurse
- Out of Hours GP

Emergency Care Practitioner (ECP) Activity in Relation to care/Nursing Homes

From January 2015 to July 2015 the ECP teams have received 3193 referrals from Care/Nursing Home residencies, the highest number being 75 for one home. The top five presenting conditions were:

1. Illness
2. Falls
3. Injury
4. Other

When looking at the data generated from the ECP services it is interesting to view when referrals were made:

- Monday 464
- Tuesday 478
- Wednesday 512
- Thursday 460
- Friday 489
- Saturday 717
- Sunday 691

Clearly we see an increase in activity at the weekend.

The outcomes of the ECP contact are as follows:

- Managed at the Care Home 77%
- 999 Call Made 12%
- Referral into Secondary Care (11%)
The data would appear to support that the ECP service appears to prevent hospital admission.

Clearly the data generated from the four different parameters give an interesting insight into the impact of Nursing/care Homes on the different health services in Doncaster. In order to provide some structure and direction to the current organisation of services this strategy is advocating a shift in the way care services are delivered, at the centre of this is the GP.

20 One GP per Care Home

Doncaster has seen several initiatives being developed that has looked at improving the relationships between the GP and the Care Home; several have looked to identify One GP per Care Home. This is in line with several national reports, the latest being ‘Delivering primary care to meet the needs of the population’ (2015), recommending, Care for people in nursing and residential homes should be organised so that all patients in a home are cared for by one GP practice, except where a resident asks to be registered with a different practice. It further advocates within general practices, one or two GPs should take responsibility for their patients in each home, prioritising proactive care over responding to illness, for example with regular ward rounds.

The development of the enhanced GP services is also a repeated phenomenon of the NHS 5 Year Forward View.

This strategy supports these recommendations and also supports the adaptation of a similar model for individuals who remain in their own home.

Doncaster has already seen the early adoption of this type of model, when looking at the development against the involvement of other care agencies, there is no clear pattern or theme in terms of impact.

- **China Cottage**

  China Cottage has a proactive GP that visits on a regular basis, with all the residents of the home being registered to one practice. This approach has seen the use of Community Nursing and Emergency Care Practitioners as being one of the lowest across DONCASTER.

- **St Marys**

  St Marys Care Home has primarily one GP for the Care Home but there are a few residents registered with other GP’s. This home sit at around the middle point of using Community Nursing Services, Out of hours GP visits, use of Emergency Care Practitioners and Emergency Department attendances. The support from the GP comes in the form of regular ‘ward rounds’.

- **Dunniwood**
Half of Dunniwood care home’s residents have the same GP that supports St Mary’s however we see a different view in this care home. This care home has a high use of Community Nursing, Emergency Care Practitioners, Emergency Department attendees and Out of Hours GP contacts.

- **Woodlea and Amphion View**
  As above a good number the majority of the residents at these Care Homes are registered with one GP, but not all. Once again we see the use of the four services of Community Nursing, Emergency Care Practitioners, Emergency Department attendees and Out of Hours GP contacts being as high as Care Homes without specific GP support.

Clearly we are seeing a variation in the impact of the different GP models. In order to evaluate these developments more effectively the strategy advocates that robust outcome measures are placed on the current homes piloting the different GP models. This will enable effective use of resources and identification of the most effective ways of working.

21. **Engagement with the Care Home Market**

A crucial aspect of this Care Home Strategy is to enable the Doncaster Market to be fit for the future, to be able to meet the needs of its residents in the next 5 years. Currently one major obstacle is the lack of engagement the market has with commissioners. Multiple attempts have been made over many years to establish different forums and groups have been initialised, developed and then failed to become established as a result of the lack of engagement.

Currently there are several forums that have a reasonable attendance from Care Home Managers, Senior Staff and in some case owners. These forums work together and cover the work of the Care Home Liaison Teams, End of Life Care, Education and Training and Infection Prevention and Control.

22. **Challenges faced by Providers**

In order to fully understand the Doncaster Care Home Market a full consultation exercise was undertaken by the CCG in July 2015. The consultation targeted the views of the general public and that of Care Home Managers.

The responses have been analysed and ‘themed’ and provide a very clear indication of issues that require action. The themes identified are:

1. Difficulties in the recruitment of staff, in particular qualified nurses
2. Finance – fee rates

Care Home Managers indicated that the support they would like from the CCG and DMBC was with:
1. Retention of staff
2. Agreeing the fee rate and ‘Cost of Care’
3. Developing relationships with GPs

The concerns raised by Care Home Managers are almost identical to those reflected by the public view. These are:

1. Having more staff who are better qualified
2. More emphasis on personalisation
3. Issues around safety
4. The inconsistency of quality in the market

The full report can be found at Appendix D.

In November 2015 Commissioners from the DCCG and DMBC started a programme of individual face to face meetings with Care Home owners or managers within the Doncaster borough. All Care Homes that are under contract will have been visited at the point of the submission of this report. The visits are to discuss a number of specific areas:

- Their relationship with the CCG and DMBC
- How things could be improved
- Their current thoughts and feelings about the Care Home sector/market
- Any plans they have for the future

Key findings from the Care Homes visits are:

- Increasing paperwork and form filling is a challenge.
- Relationships with Quality Monitoring Teams are positive and supportive.
- Difficulty in recruiting staff and qualified nurses.
- Releasing staff to attend training can be problematic.
- Noting an increasing level of care needs for people on admission.
- Frustrated by funding issues and increasing criteria to qualify people for nursing care (i.e. Continuing Health Care funding).
- Welcome a more flexible and ‘needs’ based funding allocation for each individual rather than a static set of four rates.
- A willingness to work collaboratively with the DCCG and DMBC
- A forum specifically for Care Home Owners that will focus on: Quality of Care; Market Management; Commissioning.
- Care Home managers/owners have requested and welcomed the opportunity to have an annual individual one to one visit by Commissioners to their Care Home
- Impact of ‘Panel’ and increased vacancies level means that some Care Homes will be unsustainable within the next year
24 **The Quality Monitoring Process**

Currently all DMBC and majority of NHS Doncaster CCG contracted Care Homes are subjected to quality and contract monitoring undertaken by the contract monitoring team based in DMBC. The quality assurance framework is a full appraisal of all identified risks, intelligence and quality reviews and therefore supports a comprehensive 360° insight into Care Home provision.

25 **The Quality Improvement Framework**

The tool currently used to undertake monitoring is the Quality Improvement Framework (QIF). This development builds on the previous model by the adding of a number of criterions for which the Care Homes are required to produce evidence. The outcome of the QIF process gives the home an overall rating, (A, B, C or standard not met). Currently there is no financial consequence or benefit of the rating.

Currently there are several different levels of monitoring in place.

1. **Basic Level of Quality Monitoring** - Undertaken on an annual basis. In preparation for this type of review, contact is made with a variety of agencies with a request for intelligence of any concerns that relate to their specific service. Information is also sought from providers, service users and representatives.

2. **Responsive Quality Monitoring** - Unannounced monitoring where an immediate concern is identified. These will often be as a result of an overarching quality, safeguarding meeting or a number of concerns being raised.

3. **Enhanced Level of Quality Monitoring** - requiring specialist input following a basic monitoring visit finding levels of concern in a multiple number of areas.

26 **Management of Risk**

In order to support the development of Quality Monitoring Process a weekly risk meetings take place. The purpose of the meeting is to share information and intelligence from a wide range of agencies. The meeting is attended by representation from the Contract Monitoring Team, Safeguarding, Community Nursing, Infection prevention and Control, Contracting, Moving and Handling Therapists and Training.

The quality monitoring processes implemented have led to the identification of poor quality care and unsafe practices that has led to a series of ‘Embargoes’ being placed on a number of Care Homes. In a period of 2 years (November 2013 to 2015) there have been 7 embargoes placed on a number of Care Homes. Of these:

- Imposed by DMBC/CCG: 2
- Self-imposed by the Care Home: 5
Current embargoes: 3 (1 lifted with restriction)

The market also saw one Care Home closed in August 2014 as a result of a series of poor inspections from the Care Quality Commission.

27 Future Contract and Quality Monitoring

The model is now established and provides insight into the Care Homes, its working practices and the culture. Throughout 2015 feedback has been received on the model, with comment often indicating the tool is time consuming and cumbersome for the Care Home Managers who have to collate evidence for submission. As a result of this work has been commenced on reviewing the tool with a view to streamlining this further, but with the action to add other elements of assessment into the tool.

In order to gain a full picture of the Care Home and its position in the market, it is also proposed to begin utilising data reflecting the impact of the Care Home on other partners, namely GP Services, Attendances at the local Emergency Department, Use of Community Nursing Services.

Communication the Outcome of Inspection visits will be undertaken by a ‘completion’ visit by the Contract Monitoring Officer, the Manager of the Contract Monitoring Team and The Lead Nurse for Care Homes. It is also hoped this arrangement will also improve the relationship between the Care Home and Partners and improve engagement.

28 Safeguarding

One of the key sources of identification of care concerns in Care Homes comes from Safeguarding Adults data. This sector is repeatedly the highest sector of indications where potential abuse has taken place. The In 2011/12 - 189 out of 493 (38%) referrals were in Care Homes.

In 2012/13 - 216 out of 584 (37 %) referrals were in Care Homes
In 2013/14 - 164 out of 427 (38 %) referrals were in Care Homes
In 2014/2015 93 out of 311 (44%) referrals were in Care Homes

Clearly this is a concerning feature for the Care Home market but it is important to note that the majority of Care Homes in the market have very little reporting structures of incidents of patient safety and care apart from safeguarding and as a result safeguarding is the system used. This could lead to a distorted picture.

Tables to show referrals by location of alleged abuse 2011 – 2015 see Appendix E
End of Life Care

Care Homes are critical to meeting the needs of their residents at the End of their lives. In fact routine end of life care will be managed by all Care Homes as part of their core offer and forms an important part of their day to day work care with their residents. However sometimes individual needs of situations mean that the care team may need support from other services and education in the future.

Dementia Care

The increasing demand of Dementia in particular has resulted in national drivers referring to Care Homes and dementia care specifically (National Dementia Strategy 2009, Prime Ministers Challenge on Dementia 2012 & 2015).

Dementia is a Doncaster priority and its importance has been captured in the local strategy “Getting There” – A Dementia Strategy for Doncaster 2015-2017 which was launched in March 2015.

Considering our knowledge of where we have been, where we are now and where we need to be regarding good OPMH care in Care Homes the following recommendations have been identified:

- All Care Homes should be able to demonstrate the achievement of the above standards.
- All Care Home staff should have an understanding of OPMH issues particular dementia, depression, anxiety and delirium and aspects of prevention.
- All Care Home staff should achieve Skills for Care level 1 of dementia training
- All Care Homes should be recognized as “Dementia Friendly”
- All Care Homes should have an identified Dementia Friends Champion/ Dementia Champion
- Develop a “Dementia Quality Mark” (Nottinghamshire County Council, 2013)
- All Care Homes perform/receive a dementia mapping exercise each year producing an improvement plan.
- All Care Homes should demonstrate equity for residents with OPMH regarding the application End of Life and the Gold Standard Framework (DH, 2015)
- Care Homes should be able to demonstrate partnership working with statutory core services, voluntary and community services and the wider community in general.

Older People's Mental Health Care

Doncaster has had an OPMH Care Home Liaison service for over 10 years providing timely access and response to mental health support, information, advice, guidance and training to the Care Home sector in Doncaster. Annual evaluation and review of the service demonstrates significant impact on improving the quality of care and preventing avoidable admission to hospital.
This section sets out the required standards for the workforce specifically in relation to Older Peoples Mental Health in Care Homes.

- A Partnership working approach assists the delivery of best practice to ensure that older people in Care Homes receive high quality person centred care and that staff are able to recognise and promote mental and emotional wellbeing. The OPMH liaison service is seen as a partner to work alongside Care Home staff and not as a “regulator” or and “inspector”.
- Promotion of good physical and mental health assists the prevention of deterioration and exacerbation of need.
- Residents should expect to be helped to remain physically well and pain free. Staff must be able to recognise the increased risk of delirium. This is achieved through staff understanding of the changes in behaviour and joint working with older people’s mental health services and primary care.
- The identification of dementia depression and delirium is paramount to ensure a timely response to resident’s needs.
- Through training and education staff sure be aware of residents with dementia and other mental health problems and how this affects their care. This includes communication skills to ensure that staff are able to communicate and respond effectively to behaviours that they may find challenging. Through the partnership working staff should recognise that behaviours are a method of communication and understand distressed behaviour.
- Care Homes are aware what should be expected to ensure the safety of older people with mental health problems and be aware of how to escalate risks and raise concerns.

Best practice guidelines are followed including the auditing of medication in Care Homes by Older Peoples Mental Health services to prevent the over use of antipsychotics which has been identified as a particular issue affecting people with dementia. Care Homes should ensure that antipsychotic drugs are only prescribed in exceptional circumstances and regular reviews completed. This rigorous review should also apply to the prescribing of antidepressant to ensure safe and effective prescribing.

32 **Specialist Nursing Home Role**

The purpose of this role is to develop and sustain the delivery of high quality, safe and effective care for clients within the Care Home sector and to promote a patient safety culture is embedded. This includes the 6c’s as launched by the Chief Nursing Officer;

1. Care
2. Compassion
3. Competence
4. Communication
5. Courage
6. Commitment.
The service will ensure that a nurse within the community nursing team will be identified to be the link between the community practitioners and the individual Care Homes within their geographical area of responsibility. This approach will aim to ensure an improvement in delivery of care.

### 33 Workforce Development

Workforce Development is a key enabler which underpins and drives all aspects of service delivery and the transformation required, in order to ensure that Doncaster achieves its vision for Adult Social Care by ensuring:

- The effective supply, recruitment and retention of our current and future workforce;
- A strong, confident and skilled workforce fit for the future;
- A vibrant and responsive health and social care sector able to meet the changing expectations of people using health and social care support

As local authorities face restrictions in public finances, the most significant challenge will be to further develop efficient, effective and sustainable new ways of working to support the increasing demands on services. Working in partnership with providers, effective workforce planning can facilitate the development of new roles, support the recruitment of staff with the right values and attitudes, and ensure those people have the skills and knowledge to deliver a high quality service.

In addition to working closely with providers and health colleagues, the other key partner working to ensure that the care sector has the right people in the right job with the right skills and knowledge, is Skills for Care. Not only do they provide a whole host of tools and resources to support management and staff development, they also host the National Minimum Data Set for Adult Social Care (NMDS-SC). Using the ‘dashboards’ on the website, care providers can pull off a variety of statistics and information to support workforce planning, but it does require providers to input their workforce data in the first instance. The Care Commitment is another tool they provide which is seen as a workforce quality indicator.

For more information please go to [http://www.skillsforcare.org.uk/Home.aspx](http://www.skillsforcare.org.uk/Home.aspx)

Regular meetings, attended/chaired by both the Adult Social Care Workforce Team (ASCWT) and Skills for Care, are also held regularly to maintain communication with, and disseminate information to care providers:
- Dementia and End of Life Support (DELS) Group – quarterly
- Workforce Forum – 3 times p.a.
- Registered Managers Network (for managers who have attended the Registered Managers Leadership Programme) – at least 4 times p.a.

of training available to the wider workforce across Doncaster can be accessed directly at [http://www.doncaster.gov.uk/services/adult-social-care/training-and-qualifications](http://www.doncaster.gov.uk/services/adult-social-care/training-and-qualifications)

The education and training requirements of Care Home staff and managers are determined predominantly by the Care Quality Commission’s Standards and other National Standards. Routinely training is provided around Safeguarding, Moving and Handling, Infection Prevention and Control, Fire Health and Safety etc., the quality of which is not currently standardised. In recent years as a result of staffing issues Care Homes will use e-learning or will utilise trainers who attend the homes to deliver sessions.

As well as ‘mandatory’ training the majority of Care Homes will recruit staff with minimal educational qualifications with the intention of providing staff with NVQ Qualifications of Level 2 for Care Assistants and Level 3 for Senior Carers.

Currently DMBC assist the Care Home Market in meeting these demands through its Workforce Development Team. This team developed the Workforce Strategy, with support from the Health and Well-being Group.

The strategy provides the following vision for the workforce:

- Be treated with dignity and respect
- Be supported to live independently wherever possible and desired
- Have maximum control of their lives
- Be part of families and social networks that are safe and supportive
- Be included as equal citizens
- Enjoy good quality of life

This has the following priorities of the strategy group:

- Person centred approach
- Involving service users and carers
- Equalities and diversity
- Safeguarding

In order to support the range of objectives covered by the strategy DMBC offer training opportunities on a wide range of subjects. This is predominantly determined by the strategic objectives and also by direct consultation with recipients, who indicate what training they would like DMBC to provide.

Currently in both the CCG and DMBC Contract/Specification there is no clear determinant that indicates where Care Homes should source their training from. As a result many Care Homes seek training from sources other than DMBC. This may be sourced independently or if a home is part of a bigger organisation it may be provided by the organisation itself.

This approach leads to a variation in the quality of training received in terms of the effectiveness of training as there is no actual validation of the training by either DMBC or the CCG.
Work has begun by members of the DMBC Contract Monitoring Team to develop a standard of what training should be undertaken by particular groups of Care Home staff. This work is in its infancy but would enable some consistency across the market, which would give a sound basis from which developments can then be added to. Currently the only measures in place are that of measuring the outcome or learning gained from the training. This is an aspect of the current Quality Improvement Framework undertaken by the DMBC Contract and Quality Monitoring Team on behalf of both the CCG and DMBC.

This current lack of structure remains a concern particularly when there is currently no partnership group established that looks at the provision of training and more importantly provides direction to the Care Home Market in Doncaster.

34 **Education and Workforce Development**

Many of the key policy drivers designed to improve the Care Home sector and in particular the care provided in Care Homes refer to the 16 essential standards (CQC, 2013) summarized effectively from a resident’s perspective by the recent RAND Europe report *Regulating Quality and Safety of Health and Social Care* (p10, 2015):

- You should be respected, involved in your care and support and told what is happening at every stage.
- You should expect care, treatment and support that meets your needs.
- You should expect to be safe.
- You should expect to be cared for by staff with the right skills to do their jobs properly
- You should expect your care provider to routinely check the quality of their services

It is proposed these elements are met by the recommendation that all care staff either undergo the Skills for Care ‘Care Certificate’ or are assessed against the standards set and individual training plans are developed. The standards cover

- Understanding your role
- Your Personal development
- Duty of care
- Equality and diversity
- Work in a person centered way
- Communication
- Privacy and Dignity
- Fluids and Nutrition
- Awareness of Mental Health, Dementia and Learning Disabilities
- End of Life care
- Safeguarding Adults
- Safeguarding Children
- Basic Life Support
- Health and Safety
- Handling Information
- Infection Prevention and Control

The issue of recruitment and retaining staff is a major concern to us. We do not see a significant change in the current issues of attracting staff changing in the coming years. Furthermore we want to support you in addressing the current challenges that you have in the excessive use of Agency Nurses. This needs to be addressed.

We plan to look at the development of the Care Supervisor Role, this role will develop to NVQ Level 3/4 and will look to plug some of the gaps created by the staffing crisis you are facing. Similar to the extended roles currently in place in hospitals and in community care, we feel the climate requires this level of radical thinking. We will look to support the development of a new role by developing training programmes that will meet the current needs and requirements of the Care Home Market.

We need a change of view from all parties, we need improved communications with Care Home Managers and Owners and the development of trust.

35 **Role of Education in Support of the Complex Tier Homes**

This strategy recommends a change that should ultimately lead to the development of a Higher Tier of Care Home. As this occurs the mechanism for determining training and delivering training needs to be fundamentally reassessed as training may be required from different sources currently available as there will be a future demand for more clinically based training delivery. This may need to be delivered in a supported constructed manner by local specialists in Doncaster or by other commissioned services.

36 **Role of Trained Nurses**

The challenges faced by trained Nurses in the Care Home Sector are different particularly in light of the NMC requirements around Nurse Revalidation. The CCG have a role to play in terms of support to Nurses by facilitating relationships with other Nursing Groups that will enable skills and competence to be maintained. This aspect should once again be a key role of the Multi-Agency Strategic Health and Social Care Workforce Group.

37 **Education and Training in Care Homes Project**

Ultimately, Care Homes that are established and have good relationships with healthcare professionals are able to engineer and organise a whole raft of training with little examination of wider consideration. There is no doubt the subjects covered by this training are valid but currently there is no scrutiny or overview of this.

A key piece of work supported by the Better Care Fund is in progress to fully consult with Care Homes regarding education and training that Care Homes currently access. The scope of the project will focus on the following:
• What education and training is going on within Care Homes and to what standard
• Do the Care Homes have an awareness and understanding of the standard required by DMBC/CCG with regard to the education and training of their workforce
• Details of the education and training providers that Care Homes are using to train their workforce
• The level and type of training required by Care Homes
• What are the ‘gaps’ in the provision of education and training, particularly to meet new ways of working under the Care Act and new market demands
• What barriers do Care Homes and their staff encounter in accessing education and training
• What are their preferred education and training delivery methods
• How do Care Homes keep up to date with new learning and development needs and resources

38 Best Practice Support Team

In November 2014 SSAFA were commissioned to develop a Best Practice Support Team for Care Homes on a 12 month pilot basis. The model comprised of three key areas; direct education and access to information, Supportive interventions and Emergency Health Care Plans.

The pilot demonstrated some significant success in reducing emergency admissions to hospital and attendance at A and E from people living in one particular Care Home. Following the education and training there appears to be a sharp and significant reduction in the numbers of patients attending Accident and Emergency from within Care Homes.

One Care Home taking part in the demonstrated that average monthly activity from the Care Home to Doncaster Royal Infirmary had reduced from 2.41 per month to 0.57 following the delivery of education and training to care workers. This equates to a reduction in secondary care activity from this Care Home of 76% with an annual reduction in spend of approximately £25,000 (or £715 per resident).

39 Recruitment and Retention of the Care Home Workforce

The local feedback is very clear the issues of recruitment and retention of staff are central to improving care in the Care Home Market. As things currently stand, working in the Care Home Market is often not seen as the most attractive option.

One of the key issues in retaining staff is the tendency of some staff to move from Care Home to Care Home. It is reported that the majority of the Care Home Workforce are paid the entry level of the National Living Wage. In terms of qualified staff, attracting staff into positions is very challenging, with staff preferring to pursue positions in traditional NHS Organisations, often taking up positions in those organisations at a later point when opportunities arise. The reason often quoted is around professional development and security.
Clearly funding and the rates paid to Care Homes has a direct impact on the salaries of staff and should be reviewed in line with previous agreement. As well as assurance be sought that any increase in rates leads to improved working conditions of staff employed.