Ambitions for change:
Improving healthcare in care homes

Contents

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1 Introduction

The COVID-19 pandemic hit the whole of society in an unprecedented way, resulting in the deaths of more than 130,000 people in the UK.[1] Care home residents were particularly affected by the pandemic, accounting for 35.6% of these deaths.[†] The pandemic exposed both the diversity of the social care and care home sector and how little governments and the public understand about provision of care in care homes. Care homes and those who live and work in them were initially neglected by governments and many have paid the ultimate price for this. While experts predicted that care homes would be particularly badly affected by the pandemic, these warnings were not initially heeded.

Many members of the British Geriatrics Society (BGS) work in or with care homes, either as their primary place of employment or, more commonly, as geriatricians, GPs, nurses and allied health professionals (AHPs) working in the community. Healthcare for older people living in care homes has been a priority for the BGS for some time. Since the publication of *Quest for Quality*[1] in 2011, the BGS has campaigned for policy-makers, commissioners, trainers, providers and professionals to recognise the clinical complexity of healthcare delivery in care homes and to develop approaches to competencies, training, health service design and delivery that meet the needs of older people living in care homes. During the first stages of the pandemic, it became apparent

that there was limited guidance for managing COVID-19 in care homes. The BGS filled this gap with the publication of guidance on care for COVID-19 in a care home environment.[2] We now aim to expand on this guidance, by moving beyond the specific example of the pandemic and focussing on the future of healthcare in care homes.

This document describes the care home sector across the UK as it currently stands and recent initiatives taken to improve healthcare for care home residents, including specific initiatives during the COVID-19 pandemic. It describes how health and wellbeing has traditionally been supported in care homes and sets out what good healthcare provision in a care home environment should look like.

While aspects of this document will be applicable for everyone involved in the provision of care in care homes, our primary focus is on the provision of healthcare in care homes by nurses employed by care homes and other members of the multidisciplinary team supporting staff and residents. As such, the primary audience for this document will be members of this multidisciplinary team.

[†]*We have estimated this figure from official data published by the four nations.*
In England and Wales, there have been 41,552 COVID deaths among care home residents aged over 65: https://tinyurl.com/ONSCOVID19.
In Scotland, there have been 3761 COVID deaths among people living in care homes for older people (with no age specified): https://tinyurl.com/CIScotCareHomes.
In Northern Ireland, there have been 1014 COVID deaths among care home residents (with no age specified): https://tinyurl.com/NISRACareHomes.

2 Summary of recommendations

This document sets out how healthcare delivered in care homes can be improved. Throughout the text we make the following 11 recommendations for local and national Governments and decision-makers to consider:

1. The NHS across the UK should work with care homes to **roll out and fund programmes to enable enhanced healthcare services to be provided in all care homes**. This support should include investment in IT infrastructure that enables relevant data to be accessed by all professionals involved in care delivery. Additional support should be provided to care homes which are struggling to implement the changes.

2. Governments across the UK should dedicate **appropriate funding for the development of care home staff** to ensure that they have the knowledge, skills and competencies to support residents with frailty and complex needs.

3. **Comprehensive Geriatric Assessment (CGA) should be routine for older people entering care homes** to ensure that their needs are met. This enables proactive assessment with a focus on quality of life rather than depending on reactive crisis-driven care. Care plans produced as part of CGA should be recorded in residents' care home and primary care records.

4. A **definition of a care home multidisciplinary team (MDT) should be developed and standardised across the UK**, as part of **Enhanced Health in Care Homes** (EHCH) in England and through similar initiatives in the other nations, with the overall aim of allowing CGA to be conducted as described.

5. All members of a care home MDT, including those employed by both the NHS and care homes, should undergo **specific training in the care of older people**. This should include nurses employed by care homes, so that they are enabled to play an active role in the care home MDT.

6. Regardless of where they live, care home residents should be able to access **NHS-funded rehabilitation, equipment and other services** according to their needs, in the same way that an individual living in their own home would.

7. Education providers should develop and define **specific core competencies** for each of the professional groups regularly participating in the care home MDT and consider the development of accreditation for these individuals.

8. UK Governments should commit funding to ensure that all care homes have access to support allowing **care home residents to receive care in situ that would otherwise have been provided in a hospital setting**. This includes extensivist care provided by registered nurses employed by care homes as well as that provided by visiting healthcare professionals. Care home staff should be involved in the design of all new initiatives to support healthcare in care homes.
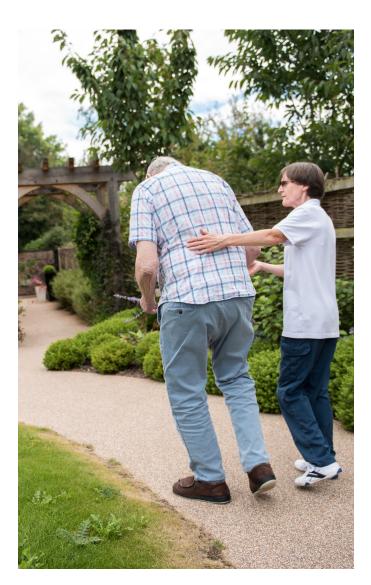

9. Healthcare systems should be set up to ensure that providing **healthcare within a care home environment is the default option** if at all possible, unless the resident prefers other alternatives. We know that there will be exceptions to this and in some cases, hospital treatment will be the best option for a resident. **Care home residents should never be denied hospital treatment where there is a clear health benefit to be achieved that outweighs the burden and risk of harm associated with hospitalisation.**

10. UK Governments should commit to ensuring that linkable **datasets for long-term care are developed with the aim of improving the quality of care received by residents**. This may include implementing the recommendations of the DACHA (Developing resources And minimum dataset for Care Homes' Adoption) study if shown to be relevant to all four nations. We acknowledge that data collection has implications in terms of resource and staff time; the benefit of collecting the data must justify the burden placed on staff.

11. Governments in the UK should set out plans to **support care homes to harness digital technology** to help them improve the care they provide to their residents. This support should include financial assistance to enable care homes to purchase the equipment they need as well as training for care home staff to ensure that they have the skills to use the technology to its potential.

3 Context

3.1 The care home sector

Care homes are home to some 400,000 older people in the UK[3] with the care home population projected to rise by 127% over the next 20 years.[4] The care home sector provides a particular challenge when trying to generalise because there is no 'standard' care home – they can range in size from fewer than 10 residents to more than 100 residents. The sector is also diverse in terms of business models, with some care homes owned by independent 'for-profit' companies or individuals, some operated by local authorities and others owned by charitable organisations, particularly for specific faith groups. The sector has a large number of small operators - the National Audit Office reported that in England 75% of care home providers own just one home and that these homes account for 38% of care home beds.[5] This statistic is similar in Scotland with the Care Inspectorate estimating 36% of care home beds are provided by small operators.[6] Care homes are also diverse in the care provided – some are nursing homes and have registered nursing staff available 24 hours a day, while others are residential homes, staffed by people with a range of job titles and qualifications. Some care homes also provide a combination of nursing and residential care. Across the UK, 42% of care homes provide nursing care. Registration of professionals working in care homes varies depending on nation. In Scotland, care home staff are all required to be registered whereas this is not the case in England.

Care homes also have a role to play in providing temporary care such as step-up and step-down intermediate care and respite care. While such temporary care arrangements do not constitute a care home's primary business, these models of care are important to the ways that care homes operate and how healthcare is provided in care homes.

Funding of care in care homes is also variable with some residents funding their own care, some having their care funded by local authorities and some funded by a combination of local authority and self-funding (known as 'top-ups').

In England and Wales some care home residents will have been assessed as being eligible for NHS Continuing Health Care and as such will have their care fully funded by Clinical Commissioning Groups. These residents are often receiving end of life or palliative care. In Scotland, the concept of NHS continuing care has been replaced by Hospital Based Complex Clinical Care[7] but free personal and nursing care is funded in care homes, although care home residents will usually need to make a financial contribution towards the accommodation element of their care. In Northern Ireland, care home funding is based on financial assessment; some will have to make a full or partial contribution to their care costs, but others are fully funded by the integrated health and social care trust. Health and social care trusts also pay a contribution towards the care costs for nursing home residents with recognised nursing needs.

Care homes are also physically different places. Some are purpose-built modern buildings with all the facilities needed to care for a population living with frailty. Others will have originally been purpose-built as care homes. However, if they were built in the 1970s or 1980s, they are now 40 or 50 years old and may no longer be fit for purpose. Some smaller homes will be adapted houses which will have been re-fitted and re-purposed as care homes.

The care home sector consists of many independent businesses, and is characterised by its heterogeneity. It is therefore difficult to generalise about what should be implemented within care homes as advice will vary in its relevance and practicality, depending on the business model, the size, the funding, the workforce, and the facilities.

While the BGS is obviously concerned with care homes for older people and this is the focus for this document, it is important to acknowledge that older people are not the only people who live in care homes. Care homes are also home to adults of working age with long-term physical and learning disabilities. Policies relating to care homes should be designed with the relevant care group in mind, rather than assuming that older people will always be the people affected.
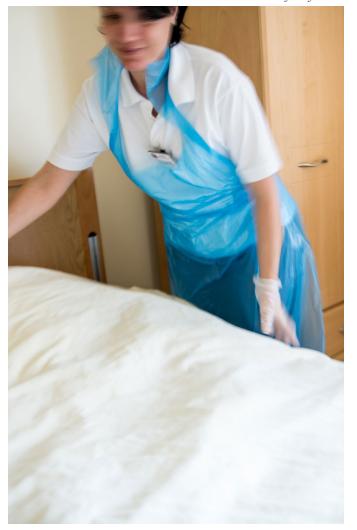
3.2 The wider social care context

Social care encompasses much more than care homes and it is not possible to discuss care homes without also discussing social care more generally. With the devolution of health and social care in the UK, the social care sectors in the four nations of the UK are organised, funded, commissioned and regulated in different ways and therefore face different challenges. Social care in England has been in crisis for decades, with multiple governments promising and failing to reform social care. Accustomed to a National Health Service where most of

the healthcare is provided free at the point of delivery†, many people are surprised when they require ongoing care which is not considered to be healthcare (such as personal care – help with daily tasks of washing, dressing and feeding themselves) and are expected to pay for it. Most people have not planned for this eventuality and while there is some provision of state-funded care, this is means-tested and most people will have to pay for at least some of their social care.

Because promised reforms from governments of all political persuasions have not been delivered, families, care home operators and local authorities are still navigating a confusing and expensive system. Lack of joined-up health and social care is the cause of much heartbreak as different organisations can disagree over where responsibility for funding lies, leaving older people and their families in the lurch. Progress has been made in joining up health and social care commissioning in England through the introduction of Integrated Care Systems (ICSs)[8] but this is variable across the country. There is also no evidence as yet that this has made the system any more straightforward to navigate for people who use services. In Scotland, those deemed eligible can receive free personal or nursing care although other aspects of social care need to be paid for. There is, however, a cap on the amount for personal and nursing care which is covered by the state, and any costs above this need to be funded by the individual. In September 2020, the current First Minister commissioned an independent review to recommend improvements to

adult social care in Scotland.[9] The review reported earlier this year and it will be important for the Scottish Government to carefully consider the recommendations and set out a timetable for how these will be implemented.

In early 2021, the Welsh Government consulted on the future of social care in Wales with the vision of building on people's strengths to support them to achieve wellbeing. For older people this means living longer, healthier and happier lives, being able to remain active and independent, in their own homes, for as long as possible.

In Northern Ireland, health and social care are integrated. Following a health and social care needs assessment, domiciliary care is provided free at the point of delivery. It is also possible for people, based on eligibility, to access direct payments to buy services that meet more individualised needs.

3.3 COVID-19 in care homes

The COVID-19 pandemic has been devastating for care home residents, who make up 35.6% of COVID-related deaths across the country. Life in care homes has been transformed, largely not for the better, by the impositions of the pandemic. It has led to visiting restrictions and consequent social isolation, restrictions on movement within the home, structured testing regimens that require staff and residents to participate in regular swab testing, and widespread introduction of personal protective equipment (PPE) that has acted as a barrier to effective communication to residents, many of whom have sensory and/or cognitive impairment.

The impact of the pandemic on care home staff has also been considerable. Many have lost residents and colleagues with whom they had longstanding relationships. They have seen dramatic reconfiguration of their working environment and conditions, and have been exposed to high levels of clinical risk, which many of them will not have had in mind when they signed up for the role. They have worked extended hours, and have changed workflows to accommodate pandemic-related safety measures, data requests, testing and vaccination programmes, and to provide additional support to their residents. Many people working in care homes will have experienced increased mental and emotional strain as a result of the pandemic including anxiety for their own health and that of their families, and burnout caused by constant vigilance and stress.

The pandemic has also been a challenging time for care home management and staff in terms of their residents' healthcare. Staff have had to manage outbreaks of COVID-19 within care homes, isolating infected residents and controlling transmissions. This is particularly difficult with residents who have cognitive impairment and may 'walk with purpose'. This was all the more challenging in the early stages of the pandemic when guidance was issued regularly from Governments and the NHS, some of it conflicting, and some external healthcare professionals were reluctant to visit. Care home managers were balancing these new and different challenges to the way they worked at a time when they were also experiencing staff shortages due to illness.

However, as with many aspects of health and care during the pandemic, there have been a number of innovative approaches to the healthcare support of care home residents which, if retained, could represent a significant improvement on what was in place prior to the pandemic. These include:
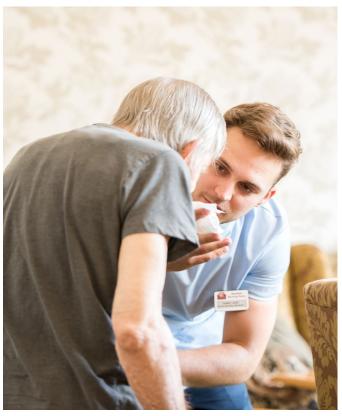
- **Closer alignment of General Practice with care homes** in England, led by Primary Care Networks as part of the Enhanced Health in Care Homes (EHCH) programme.

- Introduction of **Clinical and Professional Oversight Groups** to support care homes in Scotland, although it has been suggested that this provides additional bureaucracy with limited improvement in outcomes.[10]

- **Advances in IT integration**, including access to NHS mail for care homes, increased IT hardware in care homes, and support for broadband installation in care homes. This allowed the use of the NHS Near Me tool for GP consultations in NHS Scotland, although in some places this is limited by the availability of broadband and IT systems.

- Publication of a **digital action plan** for care homes in Scotland to ensure residents in care homes have equal online access to those not in care homes.

- **Remote monitoring** to inform escalation of care through numerous regional roll-outs of the RESTORE-2 model,[11] the national COVID Oximetry at home programme,[12] and the Tameside and Glossop Safe Steps initiative.[13]

- **Point-of-care testing** through the national Lateral Flow Testing programme[14], with further NIHR-funded evaluations of Point of Care Testing technologies including Point-of-Care Polymerase Chain Reaction[15] and Automated Antigen Testing.[16]

- In parts of the country, introduction of **augmented approaches to healthcare delivery** in care homes, including oxygen administration, and use of intravenous fluids.[17] In Northern Ireland, existing Hospital at Home teams developed to provide this enhanced care to care home residents.

- Increased focus on **routine data in care homes**, with collation of mortality data by the Care Quality Commission (CQC), COVID case rates by Public Health England (PHE), care home organisational data through the Capacity Tracker, routine compilation of care home data as part of "the Foundry"[18] and the Turas Care Management Safety Huddle Tool in Scotland.[19]

- Unprecedented levels of **expenditure on care home research**, including the multi-million pound PROTECT-CH study[20], which aims to establish a care home randomised controlled trial (RCT) platform that will inform COVID-prophylaxis initially but extend beyond the pandemic as a national resource.

The corollary of these changes is that care homes are more "healthcare enabled" than ever before. These changes have, however, been introduced without close attention to the implications for workflow and workforce, and with no real consideration about sustainability, or the future state of care. In addition, there are trade-offs. Increased medicalisation of care in care homes means that less time and resource is available for more personalised aspects of care and support for wellbeing in what is the resident's own home. Every

opportunity comes with an opportunity cost. The changes introduced have only been sustainable through the pandemic through serial releases of short-term Infection Control Funds and will not be sustainable following the pandemic if funding returns to pre-pandemic levels.

The increased profile given to care homes during the pandemic has led to renewed interest in the sector amongst policymakers. There are plans in Scotland and England for reconfiguration of the care home sector, with the promise that these will take account of learning during the pandemic. In Northern Ireland, the pandemic has highlighted many areas of good practice and support to care homes but has also demonstrated that much is yet to be done to ensure that care home residents can access care, with the right level of clinical support at the right time. This is in the context of other rebuilding pressures within health and social care including, for example, extensive waiting lists for elective care. The Department of Health 'No More Silos' Urgent and Emergency Care Review extends between primary and secondary care and has elements specific to care home work.[21] The Welsh Government has also identified the opportunity presented by the pandemic to consider how the need for both domiciliary care and residential care is balanced as well as addressing issues around pay for care staff and investment in digital technology.[22]

It is essential that the voices of those working and living in care homes are heard during this process. Too often policies about care homes are written by policymakers and healthcare professionals based on little or no consultation with the people directly affected. The phrase 'nothing about me without me' is used liberally within the NHS and by advocacy groups; it must also apply to social care and people living and working in care homes. At the BGS we are very conscious of this and have sought to include the voices of members who work in care homes as well as care home managers through the development of this document.

3.4 How has care traditionally been perceived in care homes?

As detailed above, the care home sector is very diverse, as are the residents' experiences of living in care homes. There is an almost universal sense of reluctance about entering a care home with very few people choosing this as their ideal dwelling. For many people, moving into a care home represents a loss of independence and an acknowledgement that they can no longer cope in their own home. Older people often move into a care home after a period of crisis and decisions about the future often need to be made quickly, allowing little time for people and their families to come to terms with the new living situation. In addition, people often think of care homes as providing limited stimulation to residents. Despite this, many care homes provide stimulating environments for their residents, enabling older people living in the care home to remain active, connected and to maintain a good quality of life.

There is much more to health than healthcare. It is important for care homes to prioritise the overall wellbeing of their residents to ensure that they are happy as well as healthy. This includes coordinating activities and establishing relationships with their residents to enable them to identify their interests and meet those interests, thus improving outcomes. This also includes accommodating visits from relatives and friends within the home – something that has been complicated at many points during the COVID-19 pandemic. For many residents, particularly those with dementia, the absence of family visits has led to a decline in mental and physical health. This has meant that staff have often had to stand in for family carers, something made increasingly difficult by the additional demands on their time during the pandemic.

In England, the Enhanced Health in Care Homes (EHCH) programme aims to ensure that everyone living in a care home has a similar level of care and that this should be the same as the care they should expect to receive if they were still living in their own home. This model relies on increased integration between care homes and primary, community and mental health services. The EHCH model aims to better align GP practices with care homes and provide care home residents with healthcare support delivered by a multidisciplinary team.[23]

Many BGS members working in the community have been involved in the roll-out of the EHCH programme. With adequate funding and effective multidisciplinary support for care home staff, we believe it has potential to ensure that the care and support provided to care home residents is of the same high quality, regardless of where they live.

Recommendation 1: The NHS across the UK should work with care homes to roll out and fund programmes to enable enhanced healthcare services to be provided in all care homes. This support should include investment in IT infrastructure that enables relevant data to be accessed by all professionals involved in care delivery. Additional support should be provided to care homes which are struggling to implement the changes.

4 Specific health concerns for care home residents

Older people in care homes usually have several long-term conditions and are almost universally living with frailty.[24] As such, they have a range of health needs. This section sets out a few of the more common conditions which staff are required to support their residents to manage on a daily basis.

4.1 Cognitive impairment and mental health

Up to three quarters of care home residents have cognitive impairment such as dementia. Caring for those living with such impairment can pose specific challenges for care home staff and visiting clinicians. People living with dementia often appear distressed and struggle to express themselves in ways that are easily understood.

Care home staff who are trained in providing specific care for people with dementia are able to get to know residents well and understand their needs, regardless of how the resident communicates. Care home staff should also be trained in awareness of delirium so that early recognition may support a diagnosis of the underlying trigger and timely treatment.

In addition to dementia and delirium, older people living in care homes may be experiencing other mental health issues, in particular loneliness and isolation, especially if they have been bereaved or have found that they have outlived many of their friends and family members.

4.2 End of life care in care homes

Most older people living in care homes are in their last two years of life.[25, 26] People are entering care homes later than they have in the past, resulting in reduced life expectancy for care home residents allied to increasing levels of clinical acuity.[27] However, it is a complex picture and should not be taken as a given that everyone entering a care home should start preparing for end of life.

Some people will enter a care home with multiple unstable long-term conditions and may die shortly afterwards, while others may live for several years. In addition, moving into a care home is a big step for older people and their families and many may not be ready to have a conversation about advance care planning and end of life care at the point of entry to the care home.[28]

Care home staff must be supported to identify the most appropriate time to have a conversation with residents about their wishes and to carry out these conversations sensitively. In order to ensure that an individual's wishes are adhered to at a time when they might not have the capacity to communicate those wishes, it is important that older people and, where relevant, their families, are involved in the advance care planning process

Care home staff have the opportunity to build relationships with their residents and are therefore ideally placed to have these sensitive conversations with residents and their families. Guidance on how to do this is available in the BGS's *End of Life Care in Frailty* guideline.[29] It is important that a one-size-fits-all approach is not taken to end of life care planning for care home residents.

4.3 Falls

Care home residents are three times more likely to fall than older people living in the community.[30] Care home staff are skilled at reducing the risk of falls among their residents and assessing what needs to happen after a resident has fallen. In most cases, residents who have fallen do not need to be taken to hospital but rather can be managed in the care home by the care home staff and with the support of other local services such as out of hours GP services and non-emergency telephone lines such as 111. Care home staff need to have the knowledge and skills to recognise what the appropriate response is when a resident falls and ensure that the resident's wishes are taken into account as appropriate. Care home staff must be supported to make these decisions, taking advice as needed from paramedics about whether conveyance to hospital would be appropriate and about injuries that the resident may have sustained.

4.4 Nutrition and hydration

In addition to addressing someone's healthcare needs, it is also important to ensure that residents are eating and drinking enough. Nutrition and hydration are vital elements of ensuring good health in later life and preventing illness. Many older people find that they experience a loss of appetite as they age, due to a range of reasons including various long-term conditions, loss and bereavement.

It is important for care home staff to identify when residents might be under-eating and support them to eat properly. In order to achieve this, staff need to be able to develop close relationships with residents in order to help them to identify foods that they like to eat which also help them to remain healthy. Support from other professionals such as speech and language therapists to assist with swallowing, and from dental teams can also be beneficial in supporting good nutrition and hydration.

4.5 Continence care and assessment

Many older people struggle with bladder and bowel control. Good quality continence care and assessment is an area which can contribute significantly to quality of life and dignity. If neglected, this can have a substantial impact on an individual. Additional continence care may be provided by community nursing teams, and there may be funding considerations for residents and care home staff to be aware of.

4.6 Medicine optimisation

Many older people have numerous long-term conditions and will be taking a range of medications to address each of their illnesses. These medications can all have side effects and interact with each other, causing additional problems. Care home staff need to carefully manage residents' medications and be trained to be alert to new adverse effects that may be caused by medication in order to discuss this with the residents' doctors and community and clinical pharmacists.

Recommendation 2: Governments across the UK should dedicate appropriate funding for the development of care home staff to ensure that they have the knowledge, skills and competencies to support residents with frailty and complex needs.

5 What does good look like?

Having outlined the diversity in care homes and the specific challenges that care home staff and management face in caring for their residents, we now turn to outlining what good care in care homes looks like and what all older people living in a care home should expect from the staff looking after them, regardless of where in the UK they live. The BGS has a multidisciplinary membership with doctors, nurses and allied health professionals working across a range of acute, primary and community settings in all four countries of the UK. Our members care for care home residents in situ in care homes both as care home staff and as visiting clinicians to care homes and when they are admitted to hospital. They are thus ideally placed to advise on what good practice in providing medical care in care homes looks like.

5.1 Person-centred care for care home residents

This section outlines how provision of healthcare in care homes can be organised to ensure that all care is in the best interests of residents and that the individual is at the centre of all decision-making. Care homes are just that - homes for those who live in them - and this is something that NHS staff must be aware of. It is our intention with this document to make it easier for people living in care homes to receive healthcare in their home. It is not our intention to over-medicalise care homes or to make care homes into mini-hospitals.

Older people living in care homes are almost universally living with frailty. They have multiple diagnoses, and usually more than one long term condition. Many require support for physical disabilities and up to three quarters have cognitive impairment. Many are approaching the end of their lives. They match the profile of people who have been shown in other settings to benefit from Comprehensive Geriatric Assessment (CGA). CGA is an evidence-based approach to care of older people that takes a holistic, multidisciplinary approach to establish a person-centred management plan, with clear management objectives.[31]

Such an approach requires very careful attention as to how community healthcare teams receive referrals from care homes, how they should 'reach into' care homes, how they can cross-refer, how they communicate and share information and how they balance proactive and reactive approaches.[32]

Recommendation 3: Comprehensive Geriatric Assessment (CGA) should be routine for older people entering care homes to ensure that their needs are met. This enables proactive assessment with a focus on quality of life rather than depending on reactive crisis-driven care. Care plans produced as part of CGA should be recorded in residents' care home and primary care records.

The core multidisciplinary team (MDT) for care home CGA has not been specified but most available evidence suggests it should include a nurse, doctor, pharmacist, physiotherapist and occupational therapist, with access to other professionals including a social worker, dietician, speech and language therapist, tissue viability specialist, orthoptist, dentist, optician and audiologist as required.[33] In care homes providing nursing care, the nurse in the MDT should be a care home nurse as this individual will know the residents better than other healthcare professionals involved in their care and will often be responsible for relaying information to the rest of the MDT. Most assessments conducted by these specialists can be undertaken in the care home setting. Given the disruption, discomfort and harm associated with transfer to hospital for assessment, planned care appointments should be conducted in care homes where possible.

MDTs are already starting to come together routinely around care home residents as part of Enhanced Health in Care Homes (EHCH) in England. However, they face difficulties with fragmented clinical systems that can impede multidisciplinary communication.

Recommendation 4: A definition of a care home MDT should be developed and standardised across the UK, as part of EHCH in England and through similar initiatives in the other nations, with the overall aim of allowing CGA to be conducted as described.

Recommendation 5: All members of a care home MDT, including those employed by both the NHS and care homes, should undergo specific training in the care of older people. This should include nurses employed by care homes, so that they are enabled to play an active role in the care home MDT.

Access to rehabilitation support in a care home varies depending on where in the UK the care home is located. While care home residents in England may have access to a therapist to assess their needs, any equipment or support such as balance exercises that they may require are unlikely to be funded by the NHS in the way they would be for an individual living in their own home.[34] These services are essential in enabling older people to remain healthy and prevent ill health. There is an expectation that equipment for care home residents will be funded by the home or by the resident's family. This creates an inequality of access to equipment that would otherwise help individuals to be independent. In Northern Ireland, rehabilitation support is

provided through the NHS and is accessible in a care home setting, the same way it would be if an individual still lived in their own home. In Scotland, availability of this support will depend on the type of home and the residents' entitlement to free nursing care in addition to free personal care.

Recommendation 6: Regardless of where they live, care home residents should be able to access NHS-funded rehabilitation, equipment and other services according to their needs, in the same way that an individual living in their own home would.

5.2 Development of a skilled care home clinical workforce

In order to deliver the personalised care outlined previously, it is essential that our healthcare workforce have relevant skills and specific training across all disciplines. Here we will discuss where progress has been made in ensuring that clinicians have the appropriate skills to care for the care home population, and set out where we believe work is still needed. This section does not address ensuring that non-clinical staff working in care homes have appropriate skills. The BGS's expertise is limited to clinical colleagues and this is where we have focused our attention. Other organisations are better placed to comment on how the wider care home workforce should be developed.

The beginnings of core competencies for nurses working in care homes have been published.[35] Similar core competencies have not yet been developed for doctors or other professionals making up the core MDT. For doctors, it is likely that none of the existing training programmes in primary care, geriatric medicine, old age psychiatry, internal medicine or rehabilitation fully cover the range of competencies required of a care home doctor. Other countries have developed core competencies, accreditation and certification for doctors providing long-term care in care homes,[36] and training providers and regulators, including Royal Colleges, the Joint Royal College of Physicians Training Board (JRCPTB) and the General Medical Council (GMC) in the UK should consider emulating these.

The EHCH programme in England requires Primary Care Networks (PCNs) and GPs to provide healthcare to care

home residents with each care home aligned to a named PCN and weekly multidisciplinary 'ward rounds' in care homes. Given the difficulty that both geriatric medicine and general practice face with recruitment in the midst of wider workforce shortages across medicine, it is unlikely that establishing a specific discipline of care home medicine, as is seen in other countries, would produce a sufficiently large cadre of doctors to meet the needs of the care home population. Rather this is likely to be best met by enabling accreditation of doctors from multiple specialty backgrounds and other clinicians such as advanced clinical practitioners (ACPs), who have interest and enthusiasm in providing healthcare to care homes, to train and accredit in the relevant competencies. The focus must be on ensuring that the clinical lead is sufficiently interested and committed, rather than insisting on this role being fulfilled by a specific doctor. Nurses employed by care homes should be supported and developed to take up ACP roles, enabling them to play an active role in delivering the EHCH programme. ACPs employed by care homes with nursing could then offer out-reach services to residential care homes and could support more effective transitions of care from hospitals to care homes. Other professional organisations, such as those representing Allied Health Professionals (AHPs), should consider how expertise in care home practice can be developed and accredited and how career pathways can be modified to attract AHPs into care home practice.

Recommendation 7: Education providers should develop and specify specific core competencies for each of the professional groups regularly participating in the care home MDT and consider the development of accreditation for these individuals.

5.3 Providing hospital-style care in care homes

As we focus more on ensuring that people receive the right care in the right place, where possible acute care needs should be delivered in the care home, minimising the need for the resident to attend hospital unless in their best interests. This section explores the development of 'extensivist' approaches to healthcare in care homes – providing holistic care to residents and bridging the gap that has traditionally existed between primary and secondary care.[37] These approaches have developed in geographical pockets during the pandemic and could have long-lasting impact on the quality of care delivered in care homes in the future. For example:

• Intravenous or subcutaneous fluids could be used to provide hydration support whilst residents receive treatment to reverse reduced intake associated with hypoactive delirium. While some care homes already provide subcutaneous fluids, it is much less common to have intravenous fluids administered in care homes.

• Oxygen therapy could be used in situ, or to facilitate early discharge from hospital, in the context of acute respiratory tract infections.

• Remote monitoring could be used as an adjunct to soft clinical signs to enable care home staff to seek earlier advice for residents at risk of deterioration, or even to trigger proactive assessment by care home MDTs.

• Point-of-care testing could be used in the context of winter respiratory or gastrointestinal infection outbreaks to identify causative pathogens and guide treatment prophylaxis in a timely way.

Each of these extended roles, however, comes with resource implications for care homes and healthcare providers. During the pandemic, they have been supported by a combination of extra care home staffing funding through Infection Control Funding (ICF) grants,[†] and additional in-reach work from NHS staff. For both staff groups, this meant reallocation from other tasks to which they will return once the pandemic is over. If such approaches are to be implemented in the future, they must be adequately funded and resourced – with attention to the harm caused by diverting staff away from routine activities.

Recommendation 8: UK Governments should commit funding to ensure that all care homes have access to support allowing care home residents to receive care in situ that would otherwise have been provided in a hospital setting. This includes extensivist care provided by registered nurses employed by care homes as well as that provided by visiting healthcare professionals. Care home staff should be involved in the design of all new initiatives to support healthcare in care homes.

Recommendation 9: Healthcare systems should be set up to ensure that providing healthcare within a care home environment is the default option if at all possible, unless the resident prefers other alternatives. We know that there will be exceptions to this and in some cases, hospital treatment will be the best option for a resident. Care home residents should never be denied hospital treatment where there is a clear health benefit to be achieved that outweighs the burden and risk of harm associated with hospitalisation.

5.4 Joined-up approach to data collection and sharing

Many of the barriers regarding collaboration between health and social care come down to availability of data and the ability to share that data. This section addresses past failings of care home data collection and outlines how this could be improved.

It became clear early in the COVID-19 pandemic that the routine data available about care home residents were woefully inadequate[38] – to the extent that it was impossible to be confident even of the number of deaths from COVID-19 in the care home sector. This has been a longstanding problem in UK care homes. Data are routinely collected by care home staff, and by health and social care providers but are not collated in such a way that they can be used as source

data to inform clinical decision-making, healthcare provision and commissioning, or public health and healthcare policy.[39] This is in stark contrast to long-term care sectors in countries such as Canada or the USA, where routinely collated real-time minimum datasets are used to inform decisions at all of these levels.[40]

Considerable progress has been made towards a collation of routine data during the COVID-19 pandemic, using data collected by the CQC, Public Health England and the Capacity Tracker[16] and data collected by the TURAS safety huddle data[17] and the Care Inspectorate in Scotland. However, these data are still some way from a routine minimum dataset. The DACHA study[41] will develop specific recommendations around a national dataset for long-term care. Implementing these recommendations nationally should be a priority. Doing so will enable clinical and public health practitioners along with service leaders and policy makers to better understand the sector. They could also provide the basis of a future early-warning system that would detect epidemic or pandemic outbreaks in the care home sector in a more timely manner than was possible during 2020. The Care Inspectorate is also working on a Scotland-specific dataset.

Recommendation 10: UK Governments should commit to ensuring that linkable datasets for long-term care are developed with the long-term aim of improving the quality of care received by care home residents. This may include implementing the recommendations of the DACHA study if shown to be relevant to all four nations. We acknowledge that data collection has implications in terms of resource and staff time – the benefit of collecting the data must justify the burden placed on staff.

5.5 Embracing digital technology

As detailed earlier, the COVID-19 pandemic has brought about advances in the way that digital technology is used in care homes and to support the delivery of healthcare in care homes. While the introduction of these technologies has not been without its challenges, digital technology has the potential to improve care for care home residents and help to bridge the gap between health and social care. However, many care homes are not currently digitally enabled and need support, both financial and practical, to implement digital solutions for the benefit of their residents.

Recommendation 11: Governments in the UK should set out plans to support care homes to harness digital technology to ensure that they are using digital technology to its full potential to continue to improve the care they provide to their residents. This support should include financial assistance to enable care homes to purchase the equipment that they need as well as training for care home staff to ensure that they have the skills to use the technology to its potential.

6 Conclusion

As more people make care homes their home in later life, it will be important for healthcare professionals and systems to adapt to providing healthcare within care homes rather than requiring care home residents to go to hospital or other locations to receive healthcare. While the COVID-19 pandemic has been devastating for care homes, innovations have emerged that must not be lost and an opportunity exists now to build back better for care home residents and staff. The BGS is a strong advocate of the provision of more personalised and integrated care for older people, including the growing number who will be living in care homes. Older people must have access to the same high-quality care, regardless of their living situation.

We implore governments and health and care systems across the country to implement our recommendations to ensure that older people living in care homes are supported to live well for longer. As noted throughout this document, the care home sector is diverse and our recommendations aim to elevate all care provided in care homes to a similar high standard. However, care homes do not exist in a vacuum and the recommendations made in this document must go hand in hand with reform to the wider social care system.

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