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The Enhanced Health in Care Home Vanguards and Dementia

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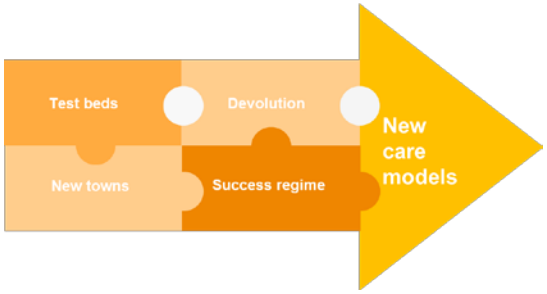
The context

1	Health and wellbeing gap	Radical upgrade in prevention
2	Care and quality gap	New care models
3	Funding gap	Efficiency and investment

The approach

Not the only show in town



50 vanguards selected

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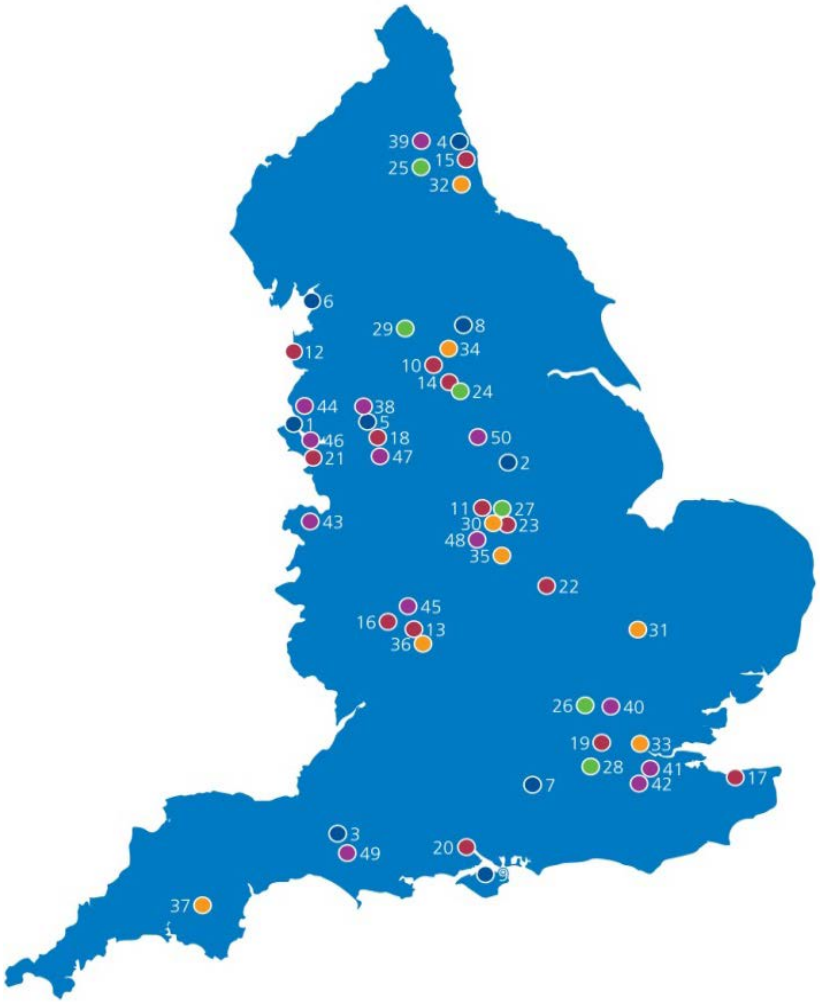
5 new models of care with a total of **50 vanguards**:



9	Integrated primary and acute care systems
14	Multispecialty community providers
6	Enhanced health in care homes
8	Urgent and emergency care
13	Acute care collaboration

Understanding the challenge

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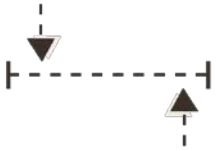
Increasing demand: *Ageing population, Dementia growth, multi morbidity growth, care home care increasingly becoming dementia care*



Huge variation in cost and quality

Money is tight, both in terms of the state and the individual

Greater *expectations, culturally and in terms of society*

Poor outcomes: 10 days in hospital is the equivalent to ten years of ageing in an >75 old, older people often poorly represented in solutions

Push for improvement and innovation but seduction of magic bullet persists

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Enhanced Health in Care Homes

Vanguards

The Care Home Vanguards

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Why

- Care homes residents are a frail, vulnerable population with increasingly complex needs & dependency with variable access to NHS services
- Hospital-based interventions have limited effectiveness for this population

What

- 6 exemplar sites across the country
- These 6 sites are providing joined-up primary, community and secondary, social care to residents of care/ nursing homes and Extra care Living Schemes

How

- Co-production- top-bottom
- With not to
- Whole system, multiple changes, coordinated

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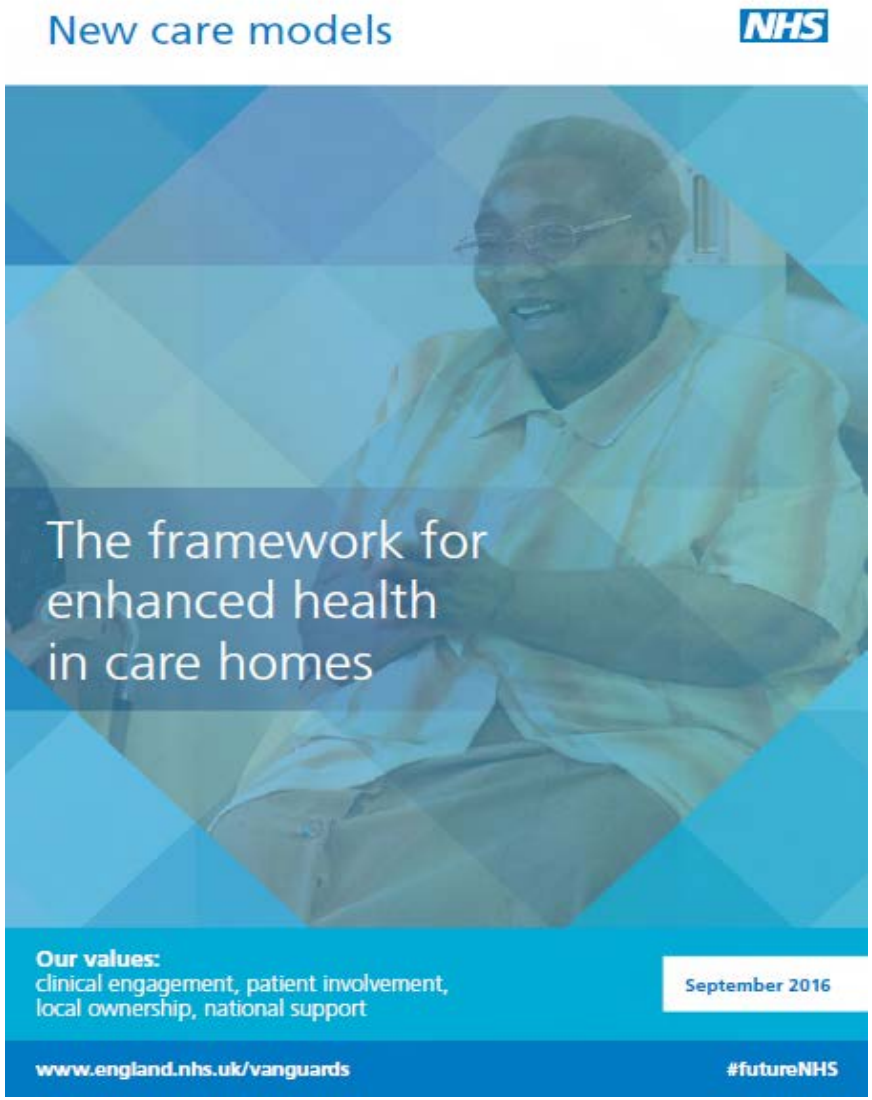

- Based on the common coordinated interventions being delivered in the vanguards
- Significant research base to support the model
- Framework published 29th September
- Aims to describe the care model and describe plan for spread
- Care model has 7 core elements and 18 sub elements
- Intention to spread the care model across England next year

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Care model element	Sub-element	Core or enhanced EHCH model	Indicative pace of implementation (from standing start)
Clinical elements			
1. Enhanced primary care support	Access to consistent, named GP and wider primary care services	Core	< 1 year
	Medicines reviews	Core	< 1 year
	Hydration and nutrition support	Core	< 1 year
	Out of hours/emergency support	Core	< 1 year
2. MDT in-reach support	Expert advice and support for those with the most complex needs	Core	1 year – 2 years
	Helping professionals, carers and those with support needs to navigate the local system	Enhanced	1 year – 2 years
3. Reablement and rehabilitation to promote independence	Aligned and effective rehabilitation and reablement services	Core	< 1 year
	Developing community assets to support resilience and independence	Core	1 year – 2 years
4. High quality end of life care and dementia care	End of life care	Core	< 1 year
	Dementia care	Core	< 1 year
Enabler elements			
5. Joined-up commissioning and collaboration between health and social care	Co-production with providers and networked care homes	Core	< 1 year
	Shared contractual mechanisms	Enhanced	1 year – 3 years
	Access to appropriate housing options	Enhanced	1-5 years
6. Workforce development	Training and development for care staff	Core	< 1 year
	Joint workforce planning	Enhanced	1 year – 2 years
7. Harnessing data and technology	Linked health and social care data sets	Enhanced	1-3 years
	Access to care record and secure email	Enhanced	< 1 year
	Better use of technology	Enhanced	1-3 years

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What does high-quality dementia care in care homes need to provide?

Person-centred care, supported by:

A. Timely diagnosis of dementia – to get a better understanding of a person's behaviours and help facilitate advanced care planning.

B. Shared advance care planning - of paramount importance in delivering high-quality, personalised care planning, end of life care, and for ensuring timely access to secondary care and to specialised mental health services.

C. Holistic care planning, using personalisation tools such as the 'This is Me' as a foundation. These enable healthcare professionals to understand the person's wishes and values and appreciate an individual's life experiences prior to dementia. This helps both care providers and NHS services ensure that all care home residents' needs are met, both when NHS staff attend the care home and when residents attend NHS services as outpatients, day patients, or in-patients.

D. Education, training and professional development – to help ensure that carers, families, and staff employed by social care providers feel supported. The voluntary sector plays an important role in providing dementia services in the community and in offering ongoing support for individuals and their carers and families. These organisations provide invaluable information advice and support, ranging from advocacy services and support groups, through to activity clubs and respite days.

E. Medication reviews - particularly important for people living with dementia and should focus on reducing polypharmacy and optimising psychotropics and minimising antipsychotic medication. It is important that these are undertaken by the multidisciplinary team.

F. Stimulating and well-designed environment - Care home managers, staff and commissioners and health professionals should pay close attention to the physical environment for residents. Well-designed facilities, such as sensory environments and home environments, have been shown to improve the quality of life for persons living with dementia, as have activities and therapies such as animal assisted therapy.

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Things to consider – diagnosis and transition into care

Diagnosis	Transition into care
• Bust myths! The value of a dementia diagnosis in a care setting is often ignored. A diagnosis can help care home staff understand behaviour and enable the system to support the home via education and training. • Some care home residents have mild or moderate dementia and symptoms which may be drugs or other factors. These diagnoses may be "missed" as they may appear to care home staff as relatively cognitively intact and present no challenges to care. • Staff from the whole system should support a shared understanding of what the diagnosis means by the individual, carers and family. • Some of those coming into residential or nursing home care will already have a diagnosis, your area should consider how to improve recognition and diagnostic process for those who don't, or develop dementia whilst in care. • Understand trends in your area around diagnosis and where there may be an opportunity to improve. Look for variation by GP practice or home. This can identify where there is poor communication of diagnosis between GP and homes (in both directions). • Consider how to make diagnoses via GPs easier – e.g. by utilising tools (e.g. DIADEM), or as part of aligned GP ward rounds or virtual wards. • Remember to keep families and carers involved in the discussions, as proceeding without their involvement can cause unnecessary upset and make care home staff and others nervous about the process. • Take a look at the blogs by Alastair Burns, National Clinical Director for Dementia and Older Peoples' Mental Health, NHS England, highlighting GP's role in diagnosing dementia amongst care home residents.	• It is important to recognise that the move into care is often poorly prepared - for numerous reasons. This could be as a result of an emergency, last-minute move from hospital as a bed becomes available, denial of the condition from the resident or family. Support should be tailored to the individual and their circumstances. • Make sure you commission, contract and monitor as a whole system to avoid services ending upon admission. Existing care shouldn't automatically stop upon admission. There need to be a needs-led transition and handover rather than discharge, including befriender and wellbeing activity as well as health care. • Ensure there is adequate support around transition into care for individual and family. • Work to raise awareness and expectations amongst families and carers on what they and the resident can expect. • Keep people connected with communities – it's the address that changes not the person. • Focus effort of good communication and transfer of information, supported by agreed responsibilities across the system (including the local authority, acute trust and ambulance trust). Do you know whose responsibility it is tell others when a person with dementia moves into a care home? How are families and carers kept updated on progress and wellbeing of their loved one when people are transitioning into care?

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Things to consider – providing excellent care and support

Meaningful activities, interactions and moments

- Not just a 'nice to do' – this is the 'treatment' for dementia in care settings.
- We need concepts of meaningful interactions and meaningful moments especially for those who are less able – can often be excluded by traditional 'activities'.
- Dementia care is as important as hydration, nutrition and medicine management – all are essential.
- Recognise the close parallel to nutrition and hydration – like food and eating/drinking, professionals should be supported to personalise dementia care to a person's situation.
- Build a culture where both care homes and families support cognitive stimulation.
- Involve outside agencies and the community and voluntary sector. Draw upon the energy and expertise of community groups and 'bring the outside world in'.
- Keep care personalised – "meaningful for me".
- **Creative Guide for Staff and Families Communicating with People Living with Dementia – Recipe Cards** - Newcastle Gateshead EHCH Vanguard Programme has worked with Equal Arts and local Care Homes to develop a guide is aimed at care staff to help them use creative methods of engagement to help those living with dementia enjoy meaningful activities. With feedback from staff the communication guide will look like 'Recipe Cards'. It is hoped these cards will also be used by family members and domiciliary care staff in future.

Support for families and carers

- Work with community groups, advocates as well as health and care services to raise public awareness of what outstanding dementia care looks like and build an expectation that it will be available in your area.
- Embed a culture of viewing families and carers as partners in care, through co-production and feedback at a system level, and involvement in holistic care planning at individual level.
- Look at how families and carers can access information - ensure signposting is in place to help people access care and support. Is there a role for local dementia champions in this?
- Put in place support for families and carers throughout their journey.
- Work with families and carers to help maintain relationships between them and their loved ones as dementia worsens (see meaningful interactions across the page).
- John's Campaign – encourage homes to sign up.

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Things to consider – providing excellent care and support

Dementia and hydration and nutrition

- It is important never to assume that the patient/resident does not want to eat even if they appear to be refusing.
- Always wait then offer food/drink a second time.
- Environment and social setting is crucial. Ensure that the dining room reflects what your dementia resident needs (e.g. is it quiet and free from clashing colours and patterns?)
- Be creative and think about people's previous life experience – e.g. some people may not be used to sit down meals at lunch due to experiences during their working life – could you consider using a lunchbox to help them feel relaxed.
- Do not worry about the resident's possible preference for strange combinations of foods. Reassure family about this. As long as they're eating, it doesn't matter.
- Some dementia patients do better with a series of finger foods instead of a traditional meal. Try to adapt and provide this if possible.
- The Alzheimer's Society UK website has a detailed 'eating and drinking' section useful for care home staff, families, commissioners and carers.
- A dietician may need to be involved – vanguard experience has been that this is often beneficial.
- See our hydration and nutrition learning guide for further information.

Culture and leadership

- High-quality dementia care requires education at a manager, leader and home owner level.
- Consider using both care home managers and owners forums to share and value best practice.
- Dementia champions have a big role and can be hugely influential in changing cultures.
- Ensure shared values and coordinated action across the wider system. This means from the STP lead, councillors and commissioners to the MDT and registered managers.
- Recognise that there are many levers to raise the profile and importance of high quality dementia care. Raise public awareness of what outstanding dementia care looks like and build an expectation that it will be available in your area.
- Involve your community and voluntary organisations – they have expertise, assets and can assist with this too.
- Consider how you can work with homes and community groups to 'open up' care homes to community and cultural activities, and help staff and residents to feel more part of the community.

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Things to consider – providing excellent care and support

Dementia and end of life care

- Advanced care planning for those living with dementia, or recently diagnosed can support better quality of life and more personalised care over the last year of a person's life.
- For people living with dementia a change of location or admission to hospital can be an unwittingly hostile clinical environment in their dying hours and days. Well-intentioned but often futile intervention is common and profoundly distressing for residents, their families and carers, who rarely have the benefit of previous discussion about health, prognosis and treatment preferences.
- Preferred place of death (PPOD) for people living with dementia - PPOD can be proxy for quality of life.
- Recognise that dementia is a terminal life limiting illness. Many people die with dementia from other causes but others die from dementia.
- Advanced care planning and EOL planning are a dynamic process, not just a one-off.
- See our End of Life Care learning guide for further information.

Medicine and prescribing

- The Enhanced Health in Care Homes care model calls for assessment when a resident moves into a care home as part of their personalised holistic care planning, including an aspiration for areas to use 'Comprehensive Geriatric Assessment' (CGA).
- Any medicines review should be done as part of an MDT approach to ensure that the right overall decision is taken – with input from family and carers, as a diagnosis of dementia may trigger a general review of a resident's medication – and the stopping of drugs which may affect cognition adversely.
- Each medication should be reviewed according to national care homes guidance and any relevant local prescribing guidance issued by the area prescribing committee.
- Care home providers should be supported to have an effective 'care home medicines policy' that aims to avoid unnecessary harm, reduce medication errors, optimise the choice and use of medicines with care home residents, and reduce medication waste.
- Care homes and GPs covering the homes could work together to set up a process whereby all new residents being admitted to care homes have a review to establish whether they have a diagnosis of dementia, ensure a anticipatory planning review of medication is carried out, and arrange baseline blood tests etc. If a diagnosis of dementia is made this can be recorded in the care home records and GP QOF Register.
- Occasionally, covert medication may be considered. Steps can be taken prior to moving to covert medication which may remove the need.
- See our Medicines Review and Optimisation learning guide for further information.

The Impact

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Better relationships between commissioners and providers

Provider staff more engaged and enthused

Improved access to NHS services for care home residents

Financial savings

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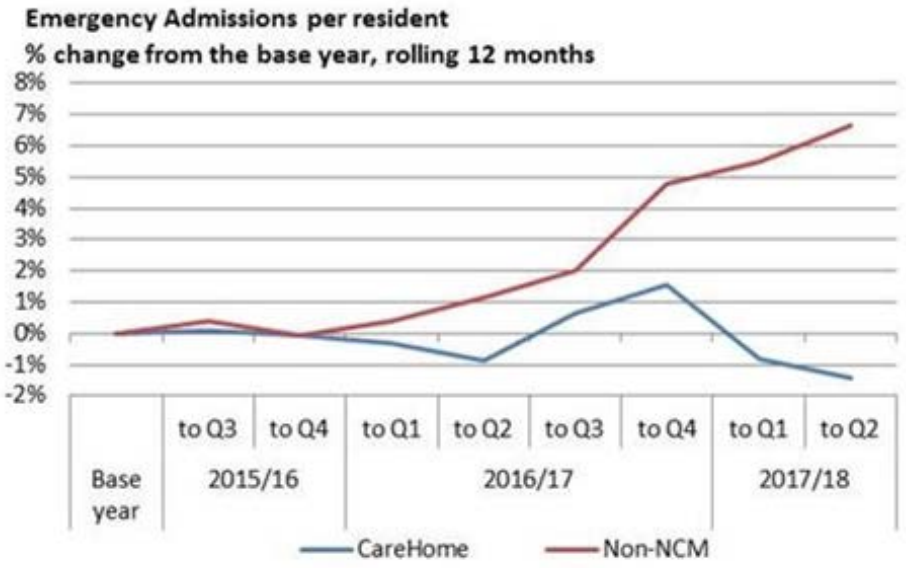
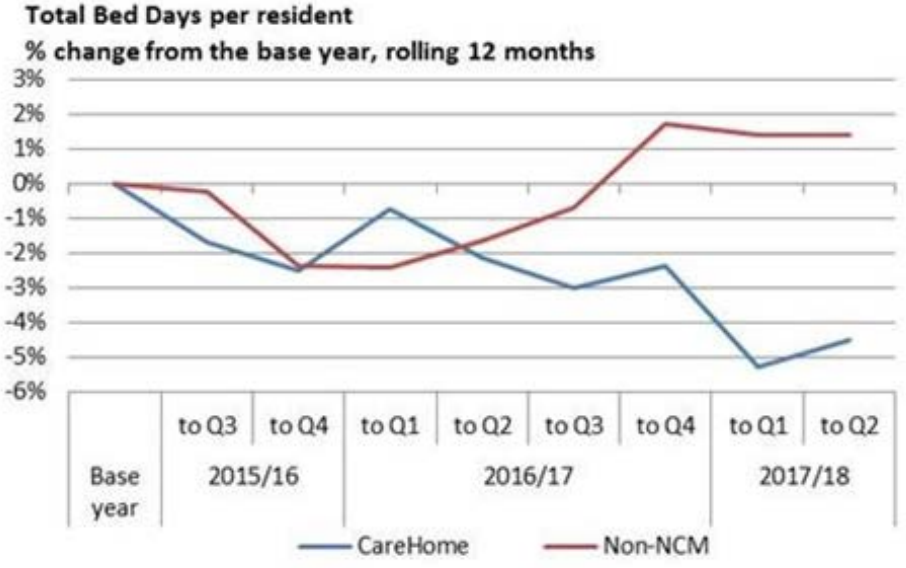
Performance from baseline





There has been a consistent and sustained trend in the performance of care home vanguards

		Care Home Vanguards	Non-NCM
Change from baseline	Emergency Admissions	**-1.4%**	**6.7%**
	Bed Days	**-4.5%**	**1.4%**

Average ROI- 52%

NHS ENGLAND ORE team

What have we learned

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- **Person centred approach essential and focus on the populations health**
- **Care homes critical partner in the work at all stages**
- **Not one change that makes a difference, requires a coordinated approach to improvement as isolated initiatives may create unwanted consequences**
- **Great work goes on all over the country, but it needs building upon and coordinating**

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Thanks

Any questions?