Public Health Devon

Devon County Council

Care Home Residents in Devon, Plymouth and Torbay – A Health Needs Assessment
Part 1

April 2014

PLYMOUTH CITY COUNCIL

TORBAY COUNCIL

Contents

Foreword

Care home residents are some of the most vulnerable individuals in Devon although many just require supported residential accommodation. They can appear hidden and there is little information about the health needs of the population group that are in the main elderly but living in accommodation provided by others.

The health needs assessment for care home residents has been produced to support work with local care homes through understanding the health needs of local care home residents, understanding what the evidence on care home interventions is telling us and considering the local interventions that have been undertaken in the area.

The needs assessment covers Devon, Torbay and Plymouth local authority areas and South Devon and Torbay Clinical Commissioning Group and NEW Devon Clinical Commissioning Group.

The needs assessment overlaps with other Health Needs Assessments and planned Health Needs Assessments in particular end of life care, dementia, mental health and substance misuse.

There is a lack of local data about the care home population as the residents are part of the population as a whole and the datasets do not directly distinguish this group. There is a paucity of evidence of care home interventions and many studies are observational in nature and the evidence base is not strong. A literature review was undertaken rather than evidence synthesis and the search was quite broad to consider health needs in the widest sense to identify what a good quality of life may look like for care home residents.

The Health Needs Assessment covers all care home residents but due to the demographic nature of Devon residents the focus is on elder care. The Health Needs Assessment excludes shared lives and supported living and community based care.

The data used for analysis was the best available at the time of writing and the one of the findings of the work is that there is a need for accurate data sets to inform commissioning. The data provides a snap shot of health needs to allow consideration of future information and intelligence needs but seeks to identify themes for further consideration.

1. Introduction

1.1 The Care Home Quality Collaborative in Devon was set up to consider the quality assurance and improvement arrangements for care homes. It was set up as a collaborative to ensure a vision and improvements could be agreed collectively with providers, commissioners in the local authority and Clinical Commissioning Group (CCG). One of the first steps in setting a vision and assurance and governance framework is to understand the needs of the population under consideration so a health needs assessment has been produced at the request of the Care Home Quality Collaborative.

2. Background/Context

2.1 Care homes offer accommodation and personal care for people who may not be able to live independently. Some homes also offer care from qualified nurses or specialise in caring for particular groups such as younger adults with learning disabilities. Care home places can be funded publicly but many people pay for their own care. A care home is a place where personal care and accommodation are provided together. People may live in the service for short or long periods. For many people, it is their sole place of residence and so it becomes their home.

2.2 Care homes can be residential or nursing or a combination, nursing homes include nursing homes, convalescent home with nursing, respite care with nursing, mental health crisis house with nursing and care home services without nursing. Residential homes include: residential home, rest home, convalescent home, respite care, mental health crisis house and therapeutic communities.

National Drivers

2.3 A number of serious cases have been identified nationally including reports of abuse and neglect exposed in the Winterbourne View review. The Frances report published on 24th February 2010 reviewed the failings of the Mid Staffordshire NHS Foundation Trust between the periods of 2005–09. The Francis report highlights 'a systematic failure of the provisions of good care'. To support all organisations to learn from and respond to the recommendations of the report, three further reports have been published to help embed effective governance and detect and prevent such serious failures occurring again. The themes of these are identifying early warning signs, assuring quality and providing governance to present such failings occurring.

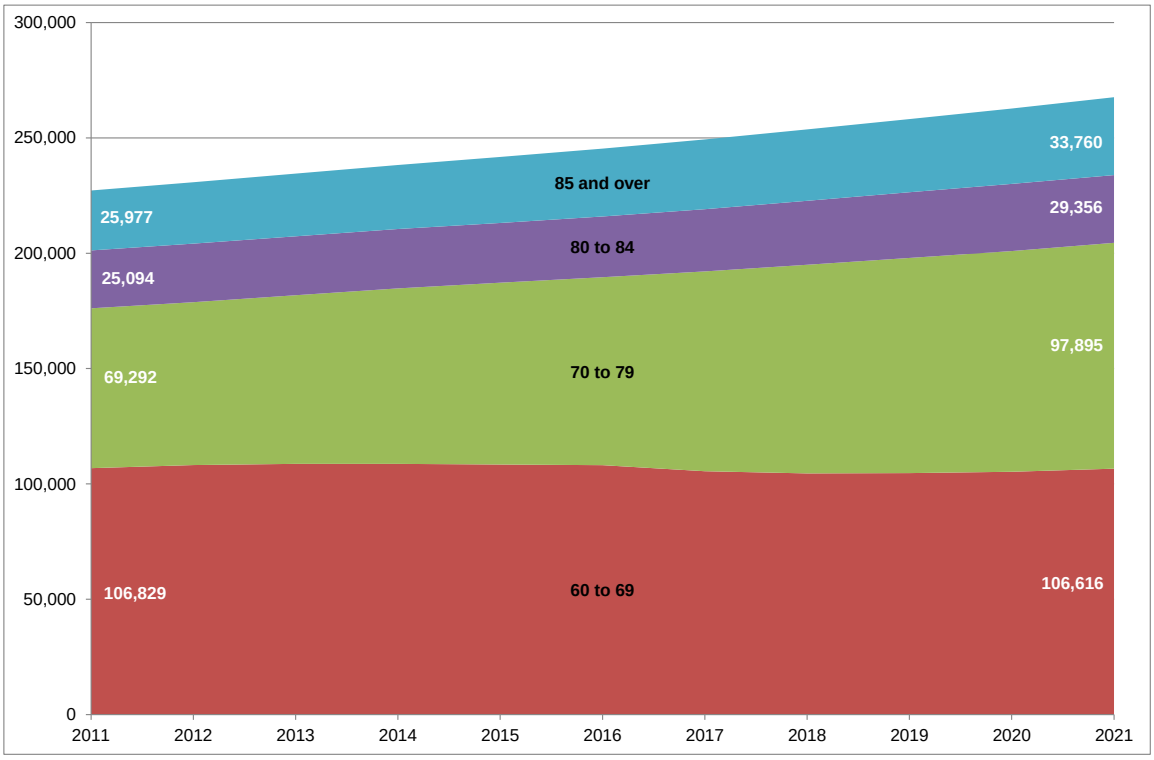
2.4 Care homes need the same quality assurance and governance as the wider health and social care sector but the sector is large and variable so this provides a challenge to local commissioners.

Local Drivers

2.5 The governance framework for care homes is complex and involves a number of statutory agencies which are considered in more detail in section 5. Locally the commissioners within the local authority and Clinical Commissioning Groups are responsible for health and social care of the population including the care home population and are also responsible for funding some care home and nursing home placements depending on eligibility. This is against a backdrop of increasing financial pressures for both the care home and statutory sector. Figure 1 shows the increasing

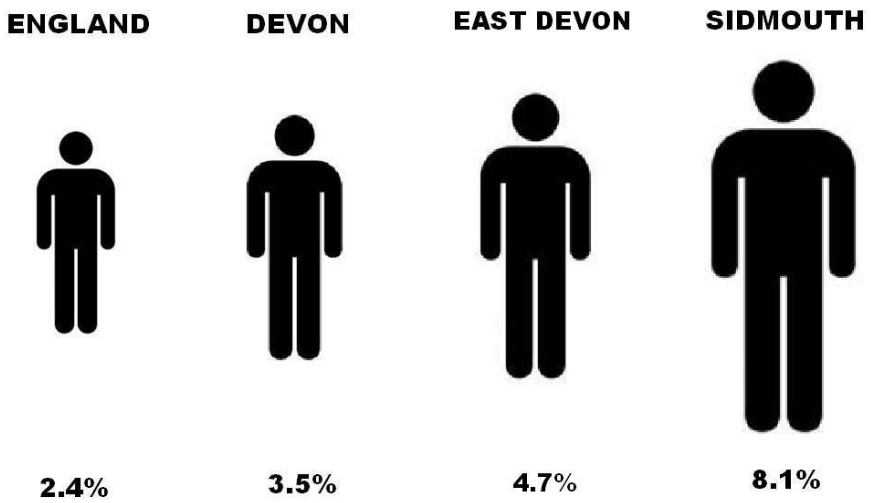
trend of older people in Devon in future years. This will have resource implications whether residents are cared for at home or in care home settings.

Figure 1: The Projected Demographic Change in the Population Structure of Devon, Persons Aged 60 and Over By Age Group 2011-21



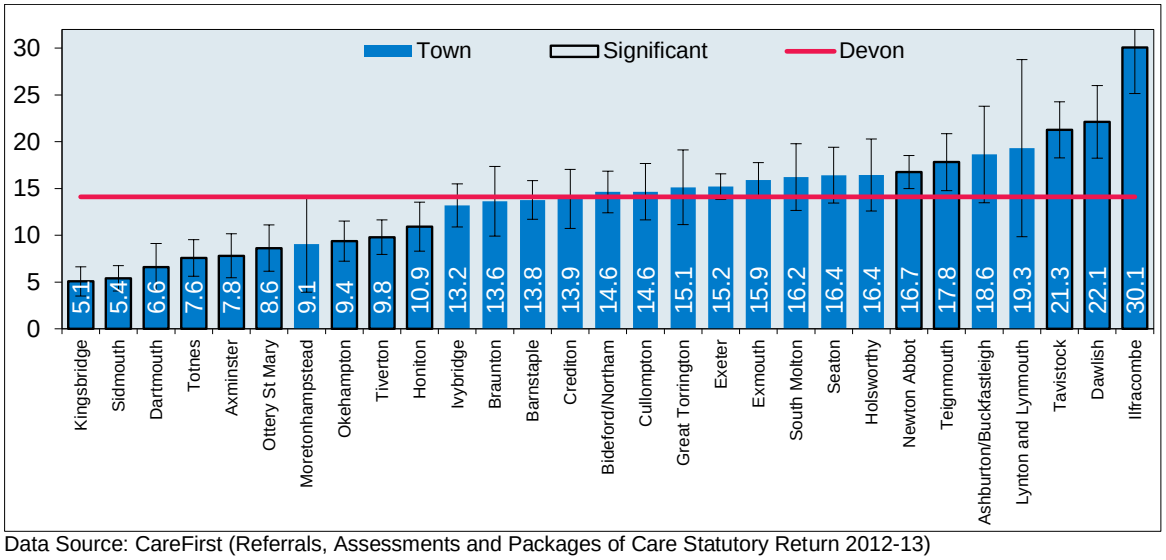
2.6 Devon will experience 28% increase in people aged 60-69, 58% increase in 70-79, 92% increase in 80-89 and 233% increase in people over 90. (Devon Joint Strategic Needs Assessment 2013) Figure 2 compares the Devon proportion of 85+ population with England and it will take until 2076 for England to have the same proportion of 85+ as Sidmouth today.

Figure 2: Devon 85+ Population



2.7 Figure 3 shows the direct age standardised rate of the 65+ population receiving adult community services provided –commissioned residential care and all areas of Devon are funding placements with some areas such as Ilfracombe, Dawlish and Tavistock funding significantly higher rates of the population.

Figure 3: Direct Age Standardised Rate of the population aged 65+ receiving ACS provided-commissioned residential-nursing care (2012- 2013)



Data Source: CareFirst (Referrals, Assessments and Packages of Care Statutory Return 2012-13)

2.8 There are many cost pressures in the health and social care system. From a local authority perspective permanent admissions to care homes are a significant cost pressure and for Clinical Commissioning groups emergency hospital admissions from care homes are seen to be a significant issue. Supporting individuals to remain independent in their own homes will prevent permanent admissions to care homes but once there residents must be cared for to reduce preventable hospital admissions.

Limitations of the Health Needs Assessment

2.9 There is no national data on the health needs of care home residents. The health needs assessment was based on the intelligence available and used current data sources available. Care home admission data is post code matched to care home addresses provided by the Care Quality Commission and could include non-resident admissions if matching postcodes. Demographic information was obtained from a snapshot of Care Quality Commission data in October 2013. This data will change over time so caution is needed when drawing conclusions or using for future decision making.

2.10 The Health Needs Assessment has not considered the views of care home residents or their carers and this is a separate workstream of the care home quality collaborative so it is proposed that the health needs assessment is used as part of the engagement with care homes to explore their expressed and felt needs and to update the Health Needs Assessment in light of the feedback.

3. Care Home Residents

Demographics

3.1 In Devon, Plymouth and Torbay there are 686 care homes (Care Quality Commission 31st October 2013) with 11,907 residents. 9,558 are 65+, 6,096 85+ and 207 were over 100 and the oldest resident was 108. The care home population across the area is predominantly female, particularly in the 70+ population; this pattern is replicated for both Clinical Commissioning Group areas as shown in Figure 4 and Figure 5. The care home population only represents approximately 1% of the total population. The population pyramids have been produced for locality areas and the population is predominantly female 85+ in all areas but the percentage in certain areas does vary with an indication that homes in more deprived areas have a smaller percentage of 85+ residents.

3.2 There were 406 care homes in Devon (Care Quality Commission August 2013) with a varied number of beds up to 77, ownership varies with Devon County Council owning the largest number of homes (n=23), one provider having 15 and most owning one to four, there were 72 homes owned by named individuals rather than company names demonstrating that the provider landscape is varied.

3.3 Of the total older population in Devon only 1.41% of the 65-74 age population are from ethnic groups other than white, 0.76 of the 75-84 age population and 0.45 of the 85 + population. (Projecting older peoples population intelligence (POPPI 2014). ONS mid 2009). This will be reflected in the care home population which will have a very low percentage of individuals from black, Asian and ethnic minority groups.

Figure 4: The Population Pyramid for Care Home Residents in NEW Devon Clinical Commissioning Group Area (Care Quality Commission October 2013)

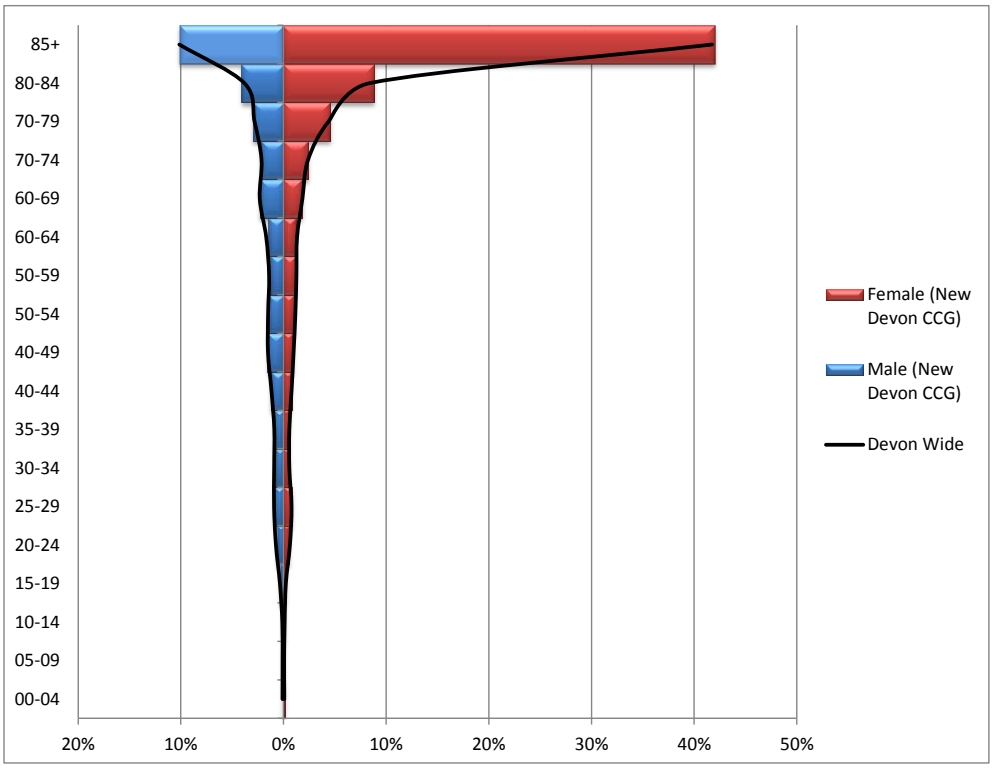
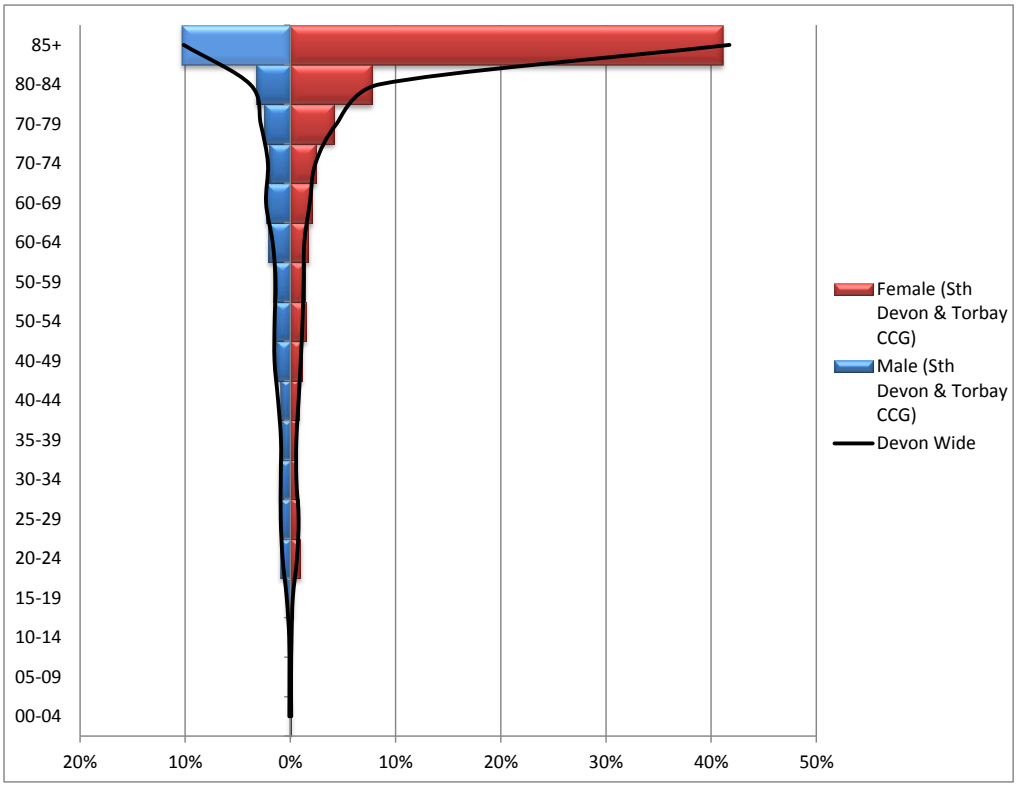


Figure 5: The Population Pyramid for Care Home Residents in South Devon and Torbay Clinical Commissioning Group Area (Care Quality Commission 2013)



3.4 Care homes are located across Devon and the number of residents is scattered across the whole area as shown in Figures 6 and 7. The population is shown as a number and the crude population rate per 100,000 by postcode district. Higher numbers are seen in Buckfastleigh and Seaton and higher crude rates in Torquay, Exmouth and Newton Abbot which will be reflected by a larger concentration of homes or larger homes. The care home population makes up approximately 1% of the Devon population.

Figure 6: Care Home Population by Postcode District (Care Quality Commission October 2013)

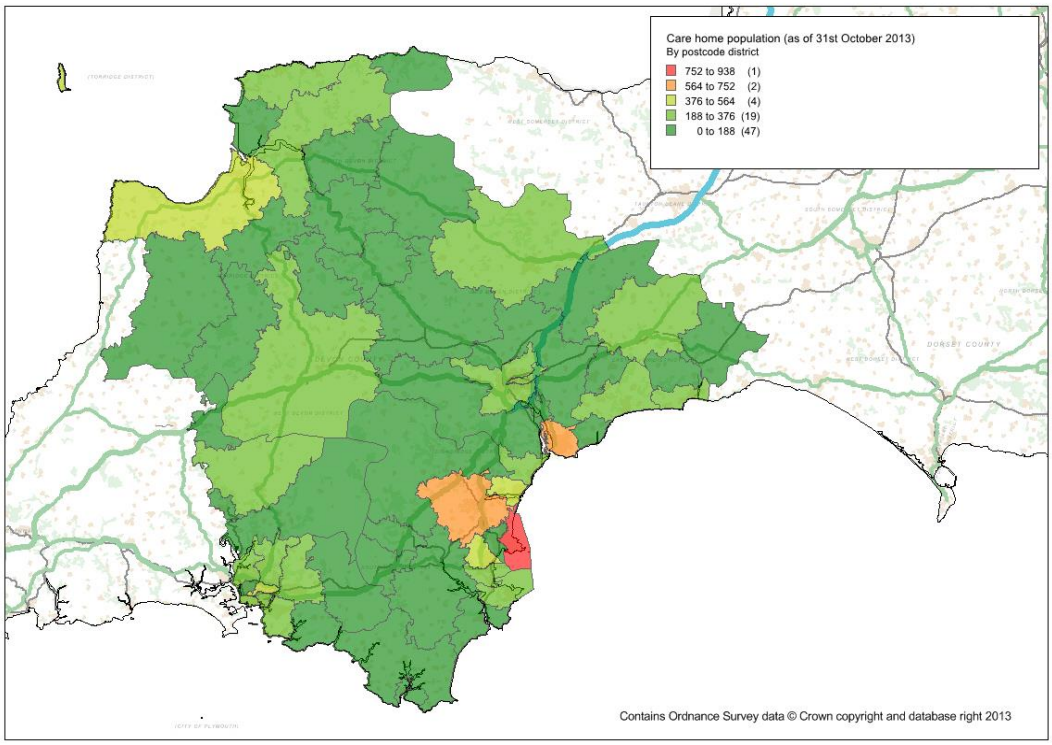
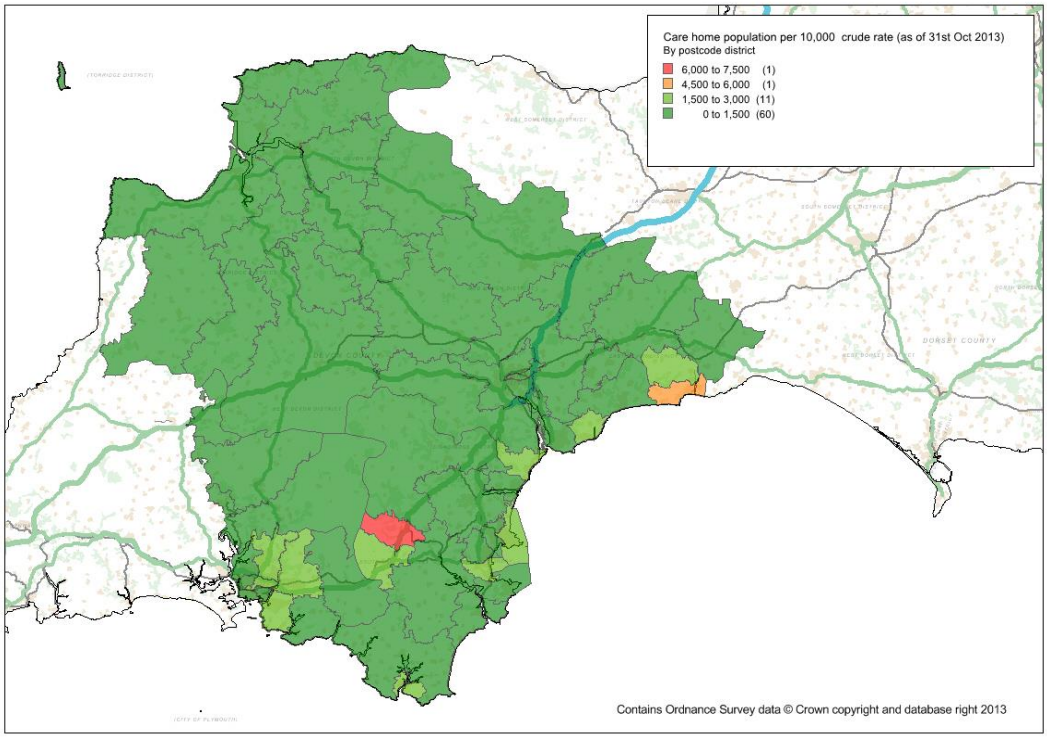


Figure 7: Care Home Population per 100,000 Crude Rate by Postcode District (Care Quality Commission 2013)



Number and Location of Care Homes

3.5 Figures 8 to 10 breakdown the number and type of home by town area for Devon, and localities in Plymouth and Torbay it does not show the numbers of residents but demonstrates that the care homes vary in number and location but the location does not necessarily reflect the age of the local indigenous population. Homes are no longer registered for a number of beds by category but register for a type of provision and can choose to utilise bed capacity this makes determining the need in homes more challenging.

Figure 8: Number of Devon Nursing Care and Care Only Homes by Town Area

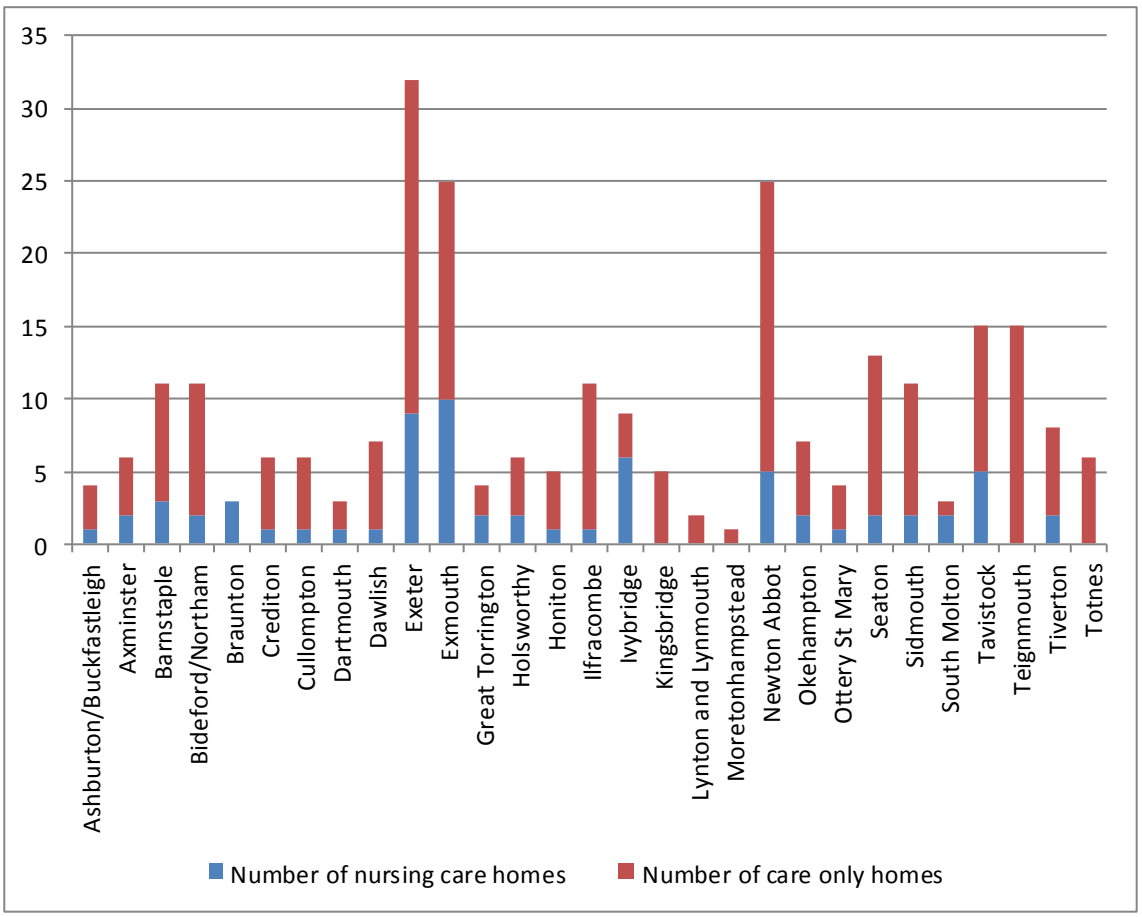


Figure 9: Number of Plymouth Nursing Care and Care Only Homes by Locality

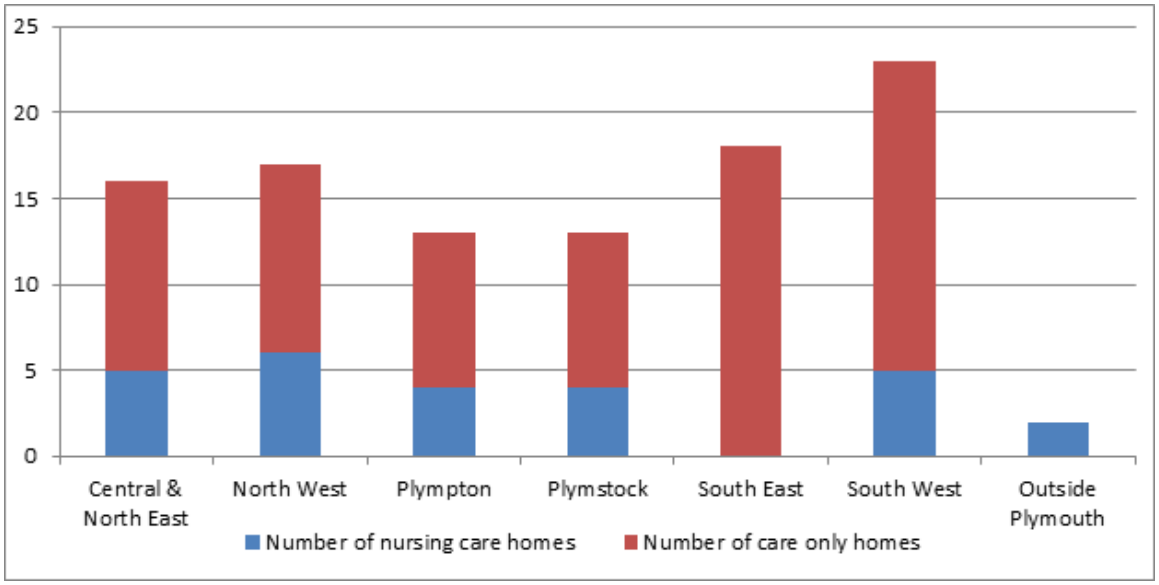
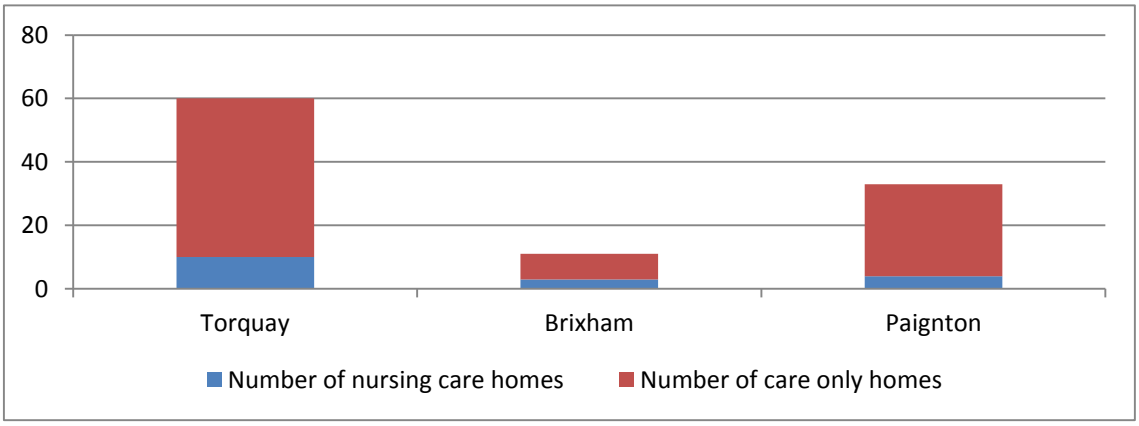


Figure 10: Number of Torbay Nursing Care and Care Only Homes by Locality



Length of Stay in Care Homes

3.6 Just under half of residents are in the home for two years and 17/18% less than six months. The reason for ending the stay is not recorded and will include move to other home, relocated to own home and deceased. It does show that the time within the home can be short. The rate is similar in each locality so charts for the Clinical Commissioning Group areas are shown (Figures 11 and 12). The Bupa census 2009 compared length of stay to date in its homes and in all countries (UK, Australia, New Zealand and Spain the mean length of stay was around 2.4 years). The UK census found that nearly one quarter had been resident for less than six months. (Lievesley 2011).

3.7 The increasing age of care home residents will bring increased vulnerability and increased frailty, the data does not reflect this and the movement between homes is not possible to track so it is not clear if residents leave the care home to move to another with increasing care needs, whether they return home or pass away.

Figure 11: Length of Stay in Care Homes NEW Devon Clinical Commissioning Group (Care Quality Commission 2013)

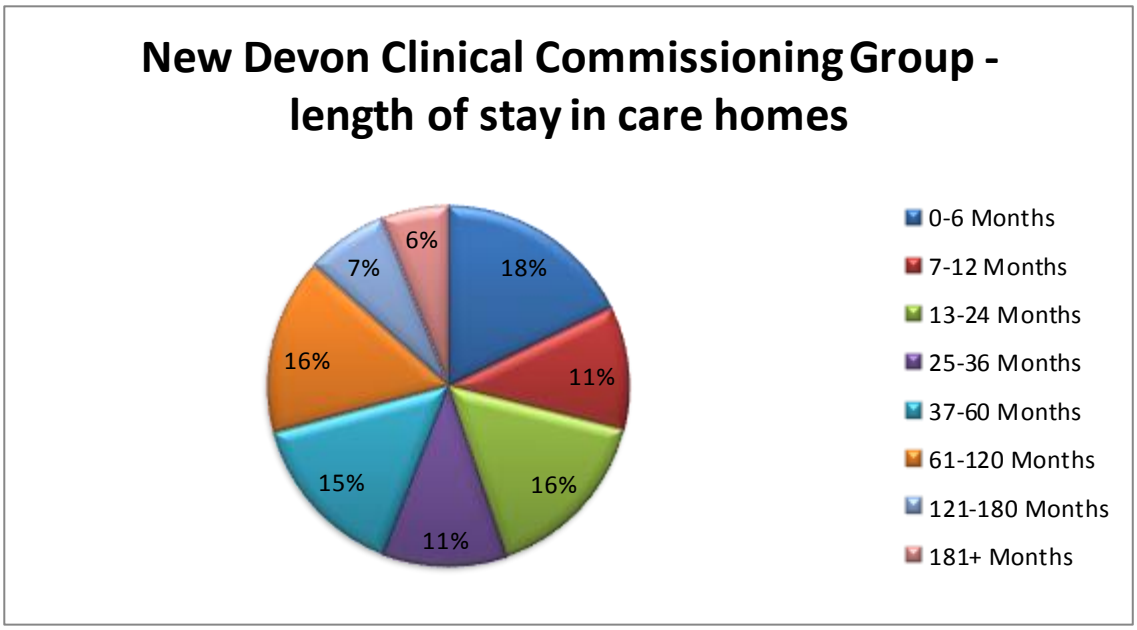
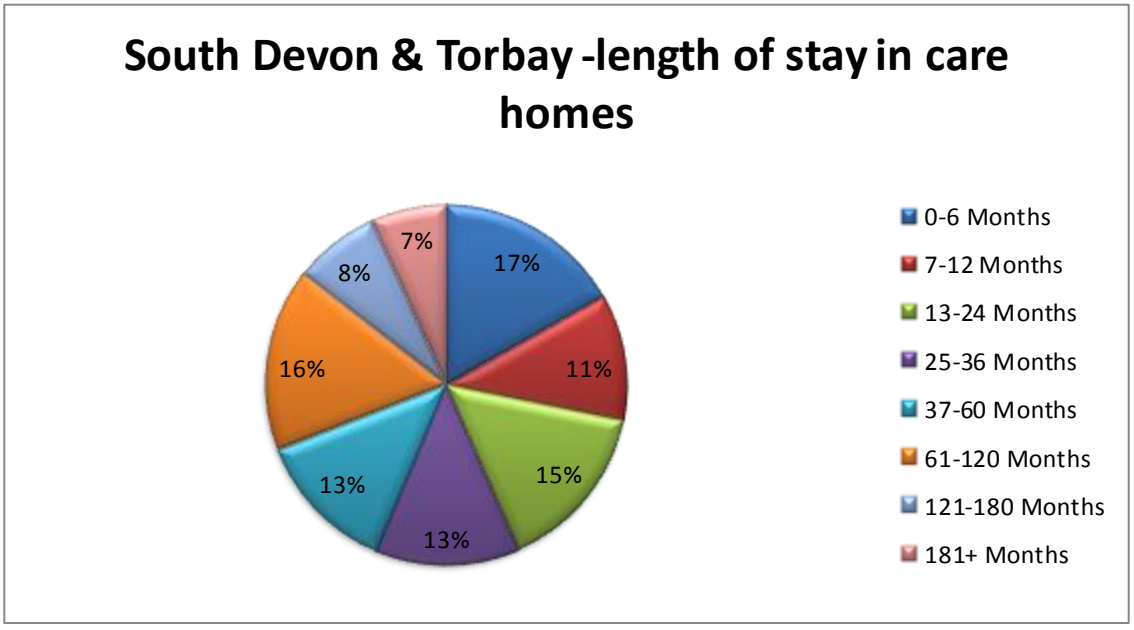
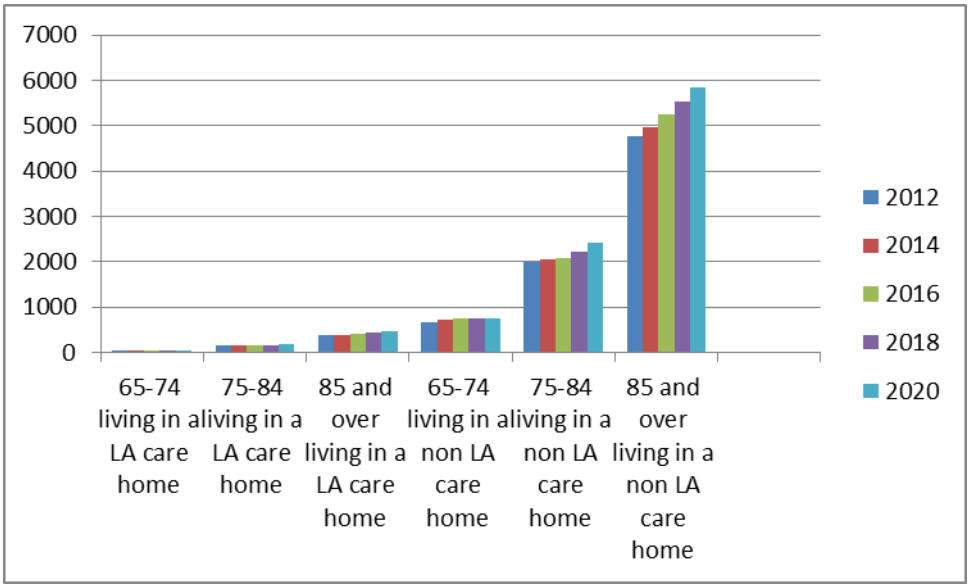


Figure 12: Length of Stay in Care Homes South Devon and Torbay Clinical Commissioning Groups (Care Quality Commission 2013)



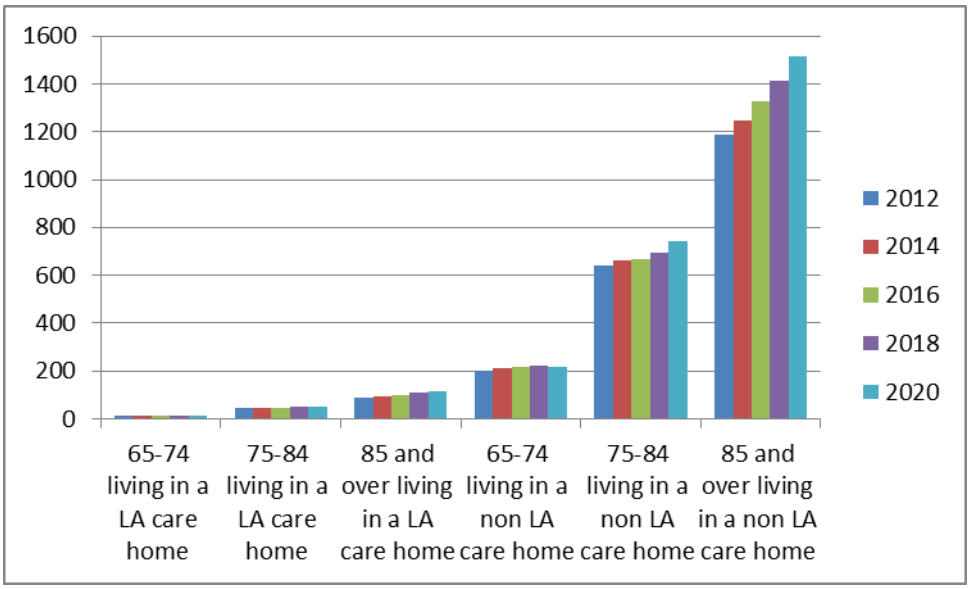
3.8 It is anticipated that an increase in the older population in Devon will result in an increased demand for care home places. Projecting Older Peoples Population Information (POPPI) data estimates an increase in demand in Devon, Plymouth and Torbay. (Figures 13-15) This increase in provision will need to be met through an increase in bed capacity unless alternative models of care are developed. This is presented based on Census data from 2001 and will need updating.

Figure 13: Projected Increase in Residents in Devon Living in Care Homes With or Without Nursing



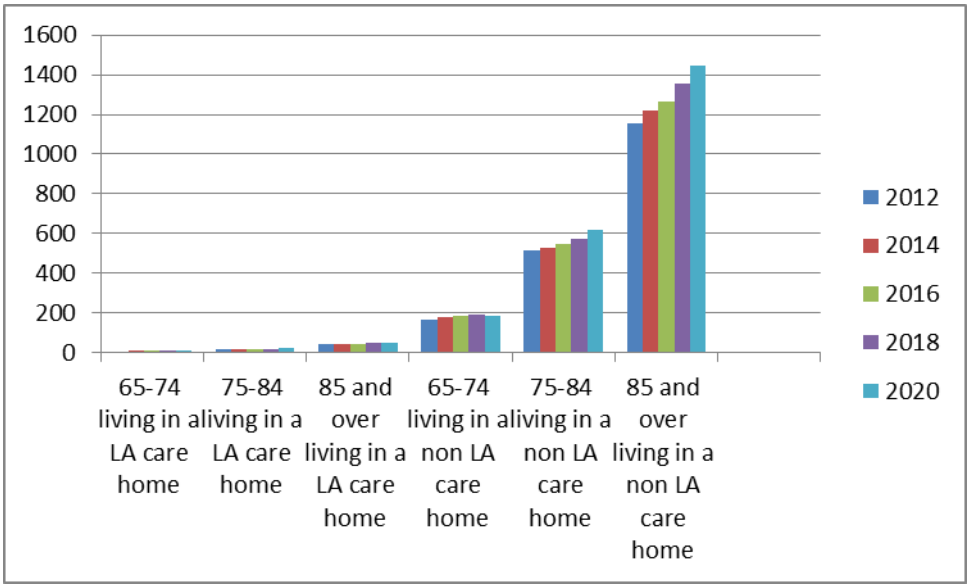
Source: POPPI 2013. ONS Census 2001

Figure 14: Projected Increase in Residents in Plymouth Living in Care Homes With or Without Nursing



Source: POPPI 2013. ONS Census 2001

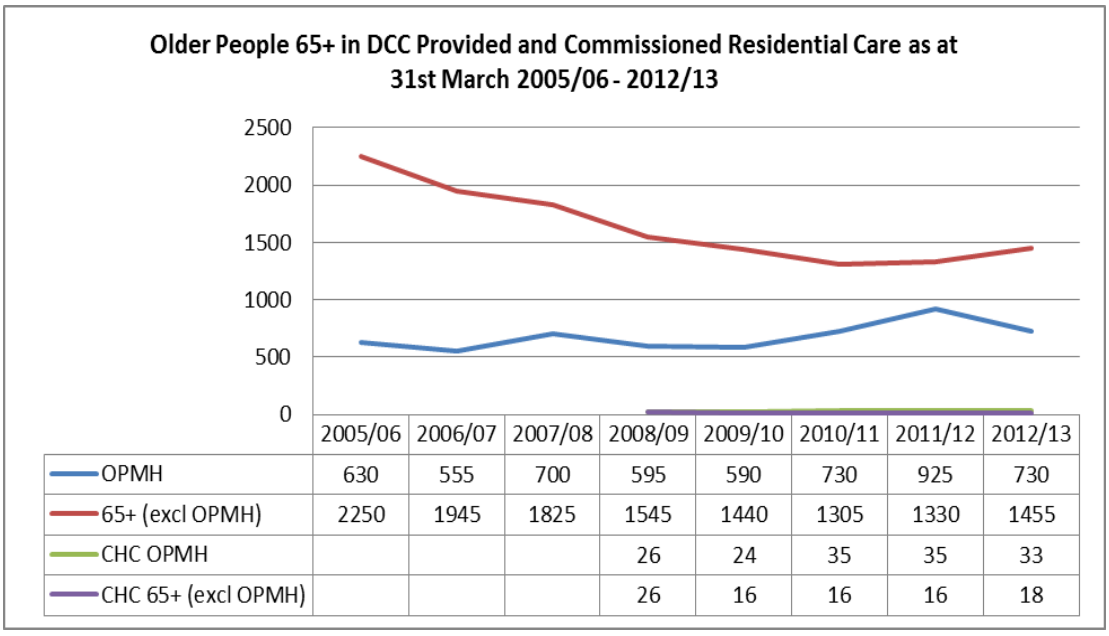
Figure 15: Projected Increase in Residents in Torbay Living in Care Homes With or Without Nursing



Source: POPPI 2013. ONS Census 2001

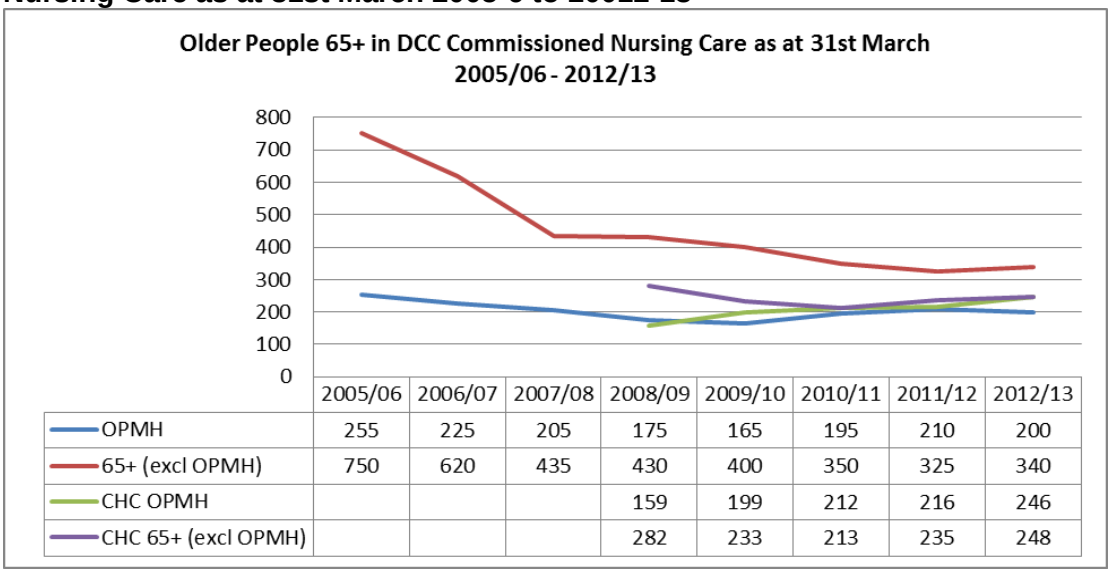
3.9 Figure 16 shows a decrease in Devon County Council provided and commissioned residential care but increase in older people's mental health (OPMH) provided and commissioned care. Figure 17 shows that commissioned residential care for 65+ (excluding OMPH) has decreased since 2005-6, with a more static position for older people's mental health. In 2005 the arrangements for care home funding changed due to legislative and benefit changes.

Figure 16: Trend in Older People 65+ in Devon County Council Provided and Commissioned Residential Care as at 31st March 2005-6 to 20012-13



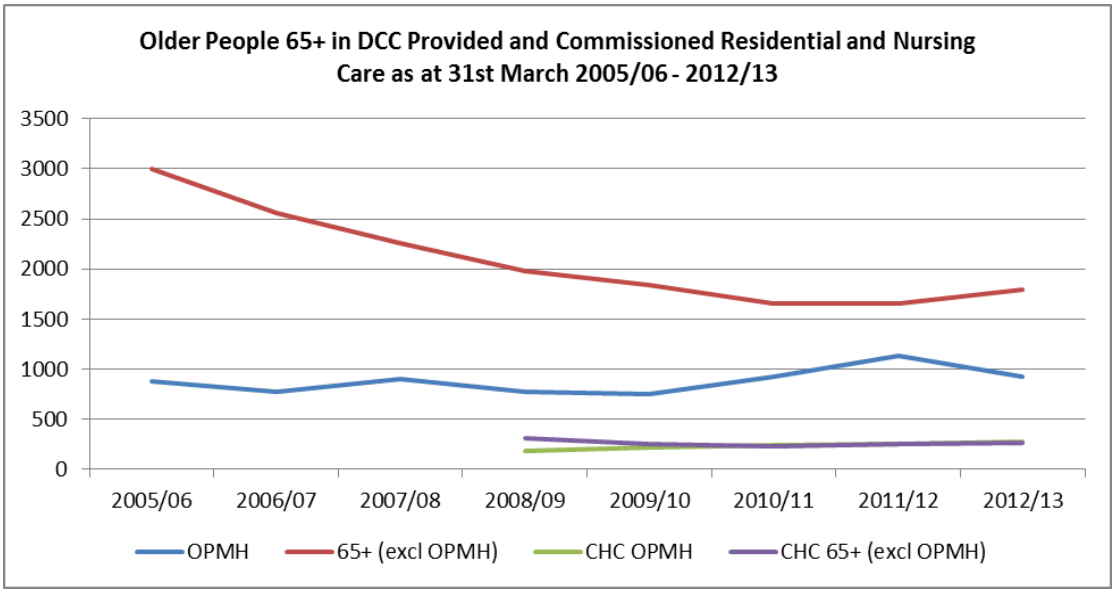
	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
OPMH	630	555	700	595	590	730	925	730
65+ (excl OPMH)	2250	1945	1825	1545	1440	1305	1330	1455
CHC OPMH				26	24	35	35	33
CHC 65+ (excl OPMH)				26	16	16	16	18

Figure 17: Trend in older people 65+ in Devon County Council Commissioned Nursing Care as at 31st March 2005-6 to 20012-13



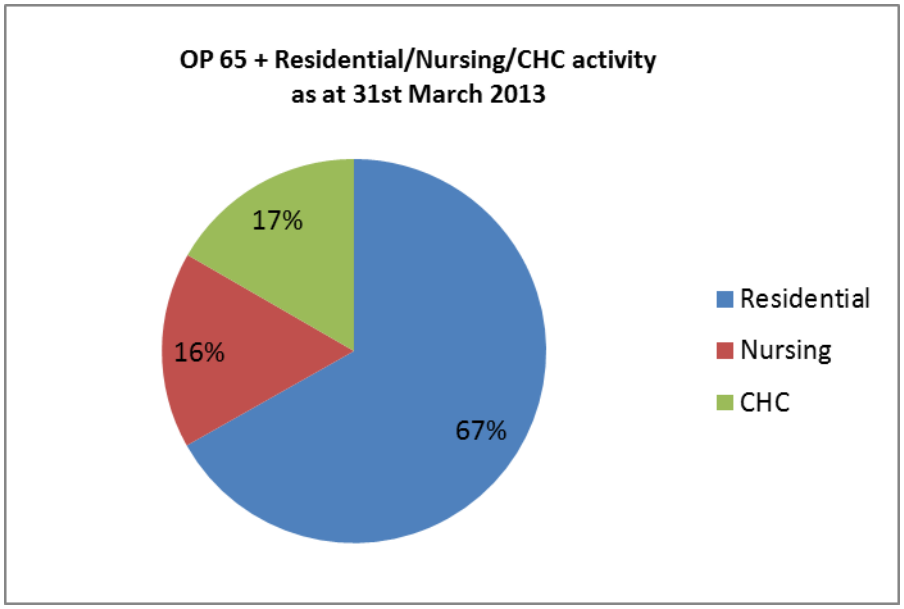
	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
OPMH	255	225	205	175	165	195	210	200
65+ (excl OPMH)	750	620	435	430	400	350	325	340
CHC OPMH				159	199	212	216	246
CHC 65+ (excl OPMH)				282	233	213	235	248

Figure 18: Trend in Older People 65+ in Devon County Council Provided and Commissioned Residential and Nursing Care as at 31st March 2005-6 to 20012-13



3.10 The statutory sector fund 40% of provision through continuing health care (CHC) and the adult social care budget with the remaining provision being self-funded and charitable provision. A snapshot of funding at March 2013 (Figure 19) shows residential and social care funding in nursing care account for the majority of spend with 17% receiving continuing health care funding.

Figure 19: Older People 65+ Residential, Nursing and Continuing Healthcare Activity as at 31st March 2013

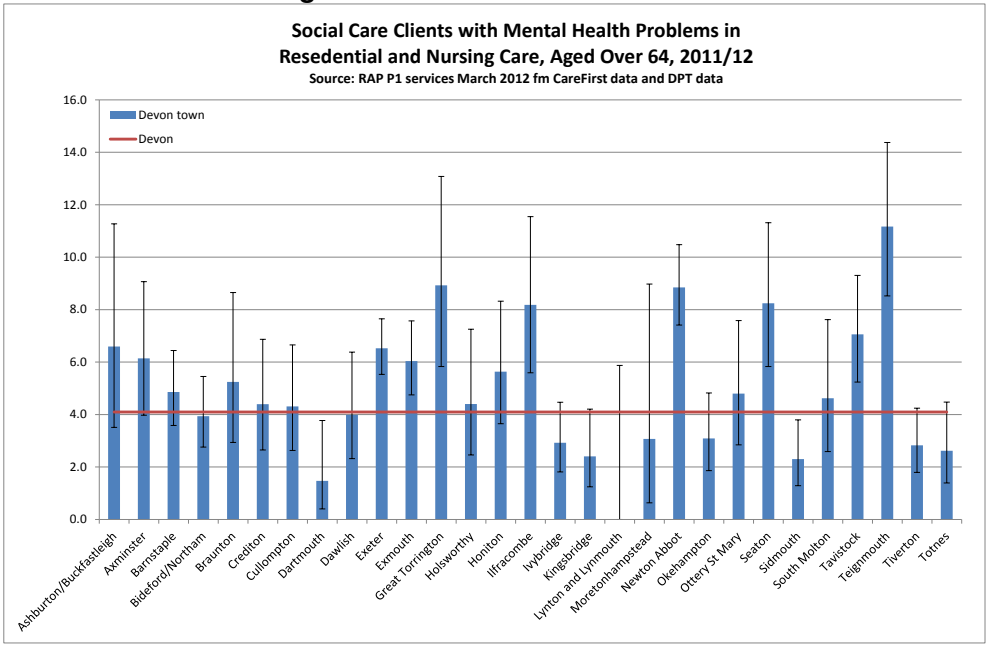


3.11 There were 625.0 permanent admissions to care homes per 100,000 persons aged 65 and over in Devon in 2012-13. This is below the South West (680.8), local authority comparator group (685.9), and England (697.2) rates. Care home admission rates have been gradually falling in Devon over recent years. Within Devon, rates were highest in North Devon District (802.2) and lowest in the South Hams (426.4) and Mid Devon (485.6). There were 697 permanent admissions to care homes per 100,000 persons aged 65 and over in Plymouth and 718.4 in Torbay which is close to the South West and England rate. The trend in Devon has been marginally downwards. (People counted as a permanent admission include residents where the local authority makes any contribution to the costs of care, no matter how trivial the amount and irrespective of how the balance of these costs are met, and supported residents in local authority staffed care homes for residential care, independent sector care homes for residential care; and registered care homes for nursing care. It also includes residential or nursing care which is of a permanent nature and where the intention is that the spell of care should not be ended by a set date). (Adult Social Care Outcomes Framework Indicator 3A Part 2)

Social Care Clients with a mental health condition receiving residential or nursing care.

3.12 Figure 20 shows the proportion of adults aged over 64 with a mental health condition receiving residential or nursing care. There is variation in rates between towns, with Exeter, Exmouth, Great Torrington, Ilfracombe, Newton Abbot, Seaton, Tavistock and Teignmouth all having statistically significantly high rates. Statistically significantly low rates were seen in Dartmouth and Sidmouth.

Figure 20: Social Care Clients with Mental Health Conditions Receiving Residential or Nursing Care



4. Size and Nature of Health Need

4.1 Sources of information on the health of care home residents are limited. Care home residents are aged, many have multiple co-morbidities and low levels of functioning and yet the UK has no routinely available, national data on health in care homes.

4.2 Moore (2013) undertook a study to identify longitudinal or nationally representative cross-sectional sources of information on the health and wellbeing of older adults residing in care homes in the UK and Ireland. The study found that in the UK and Ireland, most longitudinal and nationally representative cross-sectional studies do not include or follow-up older adults in care homes. The study concludes systematic data collection on the health of older adults in care homes should be a priority, to inform policy development and enable monitoring of care delivery and health outcomes.

4.3 BUPA is one of the largest UK providers of care homes and in 2011 reported on an analysis of census data of care homes and care homes with nursing, the census had a 95% response rate and reported:

- 94% of residents over 65 years.
- 90% of residents have high support needs defined as having one or more of dementia, confusion, challenging behaviour, dual incontinence, hearing or visual impairment or total dependence in mobility.
- Just under 70% experience some form of incontinence.
- Just under 50% have severe mobility problems.
- 75% have some form of neurological condition or mental disorder; the most commonly occurring are dementia (44%), stroke (20%), depression (20%), epilepsy (6%) and Parkinson's (5%).
- The most commonly occurring pathologies include: heart disease (21%), arthritis (18%) diabetes (14%) fractures (12%) osteoporosis (9%) lung or chest disease (8%) and cancer (7%).

- The median length of stay are declining and projections showed that by 2015 people with dementia will have a median LOS of just over one year and for frail elderly residents a little under 9 months.
- The census found that older residents (ages 95 and over) have better continence and lower level of the disease stated above than residents 65-94. (Lievesley 2009).

4.4 The length of stay predictions would be supported by the Care Quality Commission data for Devon (Figures 11 and 12). The last point is important to note as lifestyle related diseases and multi-morbidities in future years are predicted to increase resulting in a larger number of residents who could be more dependent.

4.5 The Alzheimers Society (2013) undertook a review of academic evidence and suggested a frequency of dementia and/or significant cognitive impairment in excess of 80% among people in the UK living in residential and nursing homes, they found that 32% of people with dementia had moved home since going into care mostly for increasing health needs.

Hospital Admissions

4.6 One of the purposes of the needs assessment was to identify what could be done to reduce avoidable hospital admissions. The Care Quality Commission 'State of Care Report' (2013) looked at avoidable care home admissions and categorised them as bone fractures, dehydration, pneumonia and respiratory infections. In Devon there has been considerable interest in avoiding admissions from care homes due to the volume and cost of admissions. More older people are being admitted to hospital in an emergency with conditions that are generally avoidable**.** This is increasing faster than the growth in the older population. Among people living in care homes, hospital admissions for avoidable conditions were 30% higher for those who had dementia compared to those without dementia. Areas of the country that have a higher proportion of older people tend to have fewer avoidable admissions per older person.

4.7 The Western locality of NEW Devon Clinical Commissioning Group looked at trends in ambulance call-out data from October 2012 to March 2013 for Plymouth Hospital NHS Trust facing areas and identified that in response to ambulance service calls, 2% were 'hear and treat' 58% see and convey and 40% see and treat. The report looked at conveyance reason which was predominantly GP urgent and bed bureau calls with the listed other predominant causes of: fitting/unconscious, leg injury – blunt and trauma.

4.8 Figures 21 and 22 categorise care home admissions from 2010-11 to 2012-13. Consideration is given to both cost and volume of admissions. The data was extracted by NEW Devon Intelligence Team and cross referenced with a database of care homes. The data is subject to potential inaccuracies as it is a postcode match. The data is presented to identify themes and consideration of areas where potentially avoidable admissions can be identified. The data is presented by locality in Appendix 1 but the causes are quite similar in each locality.

4.9 Table 1 Explains the International Classification of Disease (ICD) chapters used to categorise admission reason. There are likely to be other co-morbidities.

Figure 21: Emergency Admissions from Care Homes in Devon 2010/11- 2012/13 – Volume

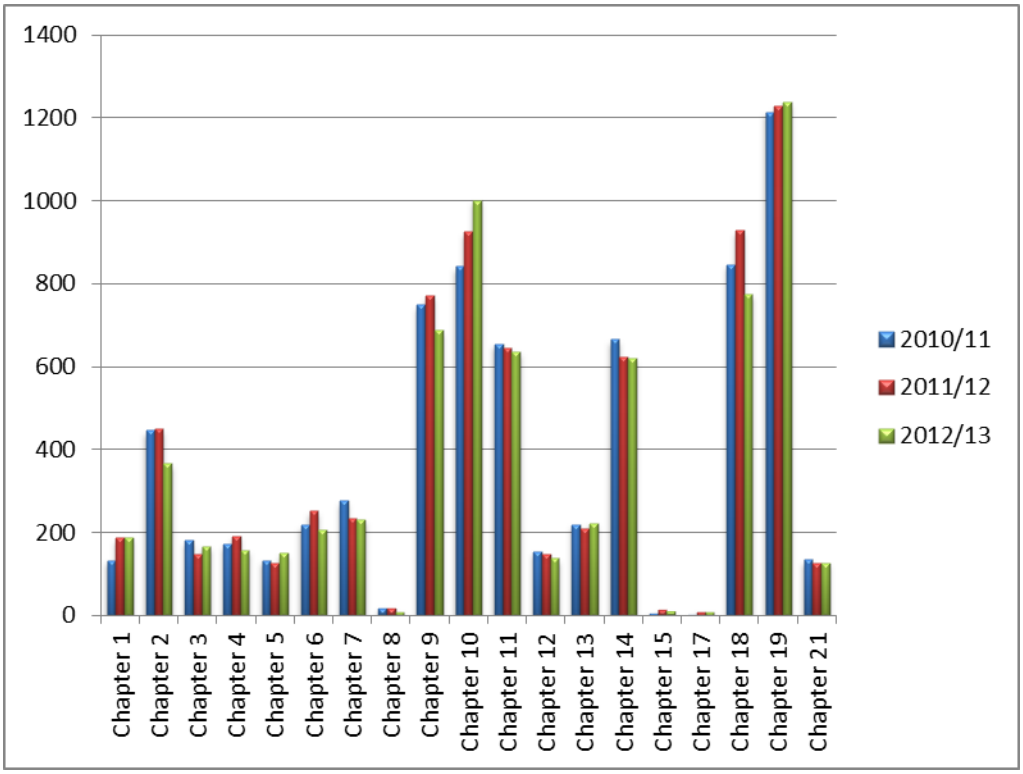
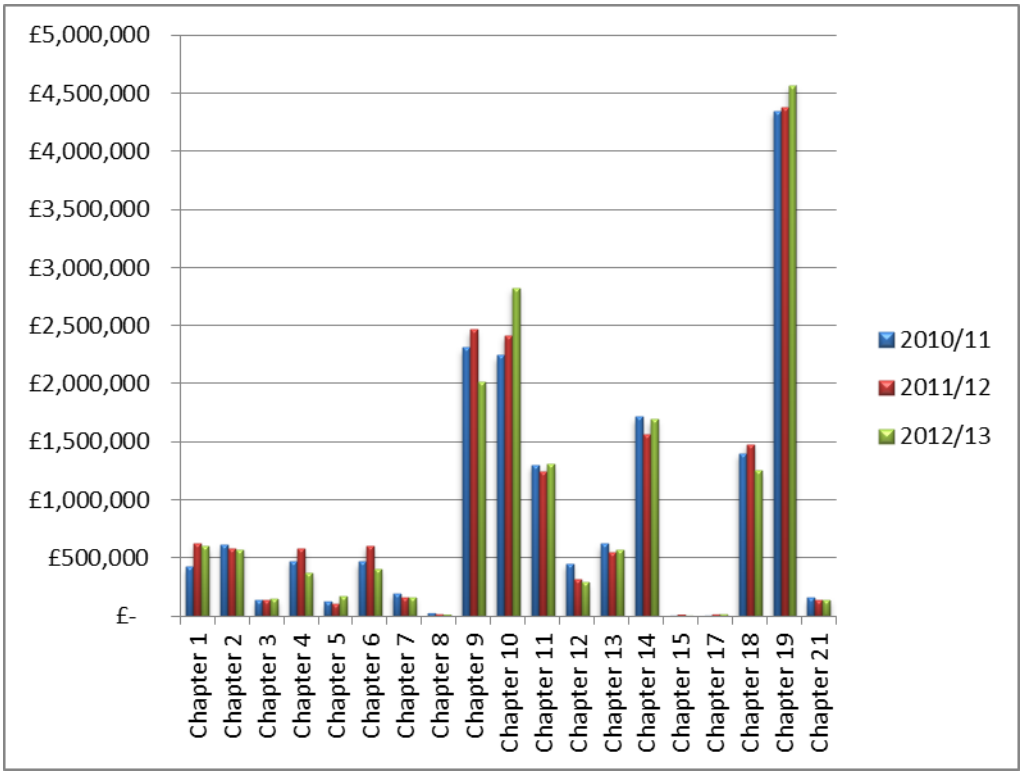


Table 1: International Classification of Disease (ICD)10 Chapters

International Classification of Disease 10 Chapter	
Certain infectious and parasitic diseases	Chapter 1
Neoplasms	Chapter 2
Diseases of the blood and blood-forming organs	Chapter 3
Endocrine, nutritional and metabolic diseases	Chapter 4
Mental and behavioural disorders	Chapter 5
Diseases of the nervous system	Chapter 6
Diseases of the eye and adnexa	Chapter 7
Diseases of the ear and mastoid process	Chapter 8
Diseases of the circulatory system	Chapter 9
Diseases of the respiratory system	Chapter 10
Diseases of the digestive system	Chapter 11
Diseases of the skin and subcutaneous tissue	Chapter 12
Diseases of the musculoskeletal system and connective tissue	Chapter 13
Diseases of the genitourinary system	Chapter 14
Pregnancy Childbirth and Peurperium	Chapter 15
Congenital malformations, deformations and chromosomal abnormalities	Chapter 17
Symptoms, signs and abnormal clinical and laboratory findings	Chapter 18
Injuries, poisoning and certain other consequences of other causes	Chapter 19
Factors Influencing Health Status and Contact with Health Services	Chapter 21

Figure 22: Admissions from Care Homes in Devon 2010-11 to 2012-13 - Costs



4.10 Table 2 provides a breakdown of the sub-categories and shows that the predominant main diagnosis at admission is pneumonia, followed by other disorders of the urinary system. Fracture of femur has a high number of admissions but more importantly the most significant spend. If other fractures are taken into account this is the leading cause of hospital admissions from care homes.

Table 2: Main Diagnosis on Admission to Hospital from Care Homes in Devon January - December 2013

Main Diagnosis ICD10 subsection (January – December 2013)	No. of Admissions	£s Total Cost
Pneumonia, organism unspecified	490	£1,462,431
Fracture of femur	405	£2,555,446
Other disorders of urinary system	399	£1,230,350
Unspecified acute lower respiratory infection	185	£443,003
Open wound of head	128	£167,247
Heart failure	116	£348,750
Cerebral infarction	103	£430,754
Epilepsy	100	£129,239
Syncope and collapse	94	£123,311
Other septicaemia	94	£302,771
Other chronic obstructive pulmonary disease	93	£230,703
Pain in throat and chest	88	£62,869
Other diseases of digestive system	72	£148,291
Superficial injury of head	71	£77,269
Grand Total (ICD10 subsections)	**5151**	**£14,270,061**

4.11 Ambulatory Care Sensitive (ACS) conditions are a group of conditions including angina, Coronary Heart Disease Chronic Obstructive Pulmonary Disease (COPD), asthma and diabetes where admissions to hospital can be avoided through effective case management in primary and community care. The admission rate in Devon (147.8) is below the South West (169.6), local authority comparator group (177.4) and England rates (210.1) and has fallen over time. Within Devon, the highest rates were seen in North Devon and Exeter. (Devon County Council 2013) Ambulatory Care Sensitive conditions are often used as a quality marker.

4.12 There are limitations to using the available data to compare the rate of Ambulatory Care Sensitive admissions from care homes with the population as a whole but it is important to consider this as it is not clear whether the rate of potentially avoidable admissions is better or worse than the population as a whole.

4.13 For Table 3 expected admissions from care homes have been worked out by applying the age and sex specific admission rates for the total population of Devon (age is in five year bands with top age band of 85 and over), to the snapshot care home population for the county, which produces the expected number of admissions if the care home had the same age and sex specific admission rates of the total population. The results are dependent on the accuracy of the care home population which was calculated form a snapshot of Care Quality Commission data in October 2013 and the setting (care home) specified in the SUS data.

Table 3: Admissions for ACS Conditions - Care Homes versus Total Population - Devon, Plymouth and Torbay, 2012-13

Condition	Admissions from Care Homes	Total Admissions	Expected Admissions from Care Homes	SAR	95% CI
Angina	34	1502	33	104.4	(72.3 to 145.8)
Asthma	38	1562	10	385.9	(273.1 to 529.6)
Cellulitis	54	1415	46	116.6	(87.6 to 152.1)
Chronic obstructive pulmonary disease	130	3681	92	140.9	(117.7 to 167.3)
Congestive Heart Failure	123	2526	186	66.1	(54.9 to 78.8)
Convulsions and epilepsy	190	1923	29	656.4	(566.3 to 756.6)
Dehydration and gastroenteritis	72	526	25	290.3	(227.2 to 365.6)
Dental conditions	1	238	1	111.4	(2.8 to 620.9)
Diabetes complications	21	668	6	358.1	(221.6 to 547.3)
Ear, nose and throat infections	15	1050	4	403.0	(225.6 to 664.7)
Gangrene	22	370	15	145.4	(91.1 to 220.1)
Hypertension	3	140	2	129.7	(26.7 to 378.9)
Iron deficiency anaemia	17	343	16	108.0	(62.9 to 172.9)
Nutritional deficiencies	0	8	0	0	-
Other vaccine preventable	0	79	0	0	-
Pelvic inflammatory disease	0	97	0	0	-
Perforated/bleeding ulcer	19	406	16	117.1	(70.5 to 182.8)
Pyelonephritis	11	446	2	681.5	(340.2 to 1219.4)
All ACS Conditions	750	16980	483	155.3	(144.3 to 166.8)

4.14 The age and sex standardised admission rate for ACS conditions is statistically significantly higher in the care home population when compared to the population as a whole. This is not surprising as the population are more vulnerable but does demonstrate that it is valid to consider interventions that assist with management of potentially avoidable admissions. (Figure 23)

4.15 It is particularly interesting to consider dehydration and gastroenteritis and diabetes complications and ear nose and throat infections and these have been discussed in the body of the health needs assessment. Pyelonephritis is an inflammation of the kidney and upper urinary tract that usually results from noncontagious bacterial infection of the bladder (cystitis) the numbers in this case are quite low but the rate higher than expected.

Figure 23: Standardised Admission Rates for Care Home Residents versus the total population (total population = 100) – Devon, Plymouth and Torbay, 2012-13

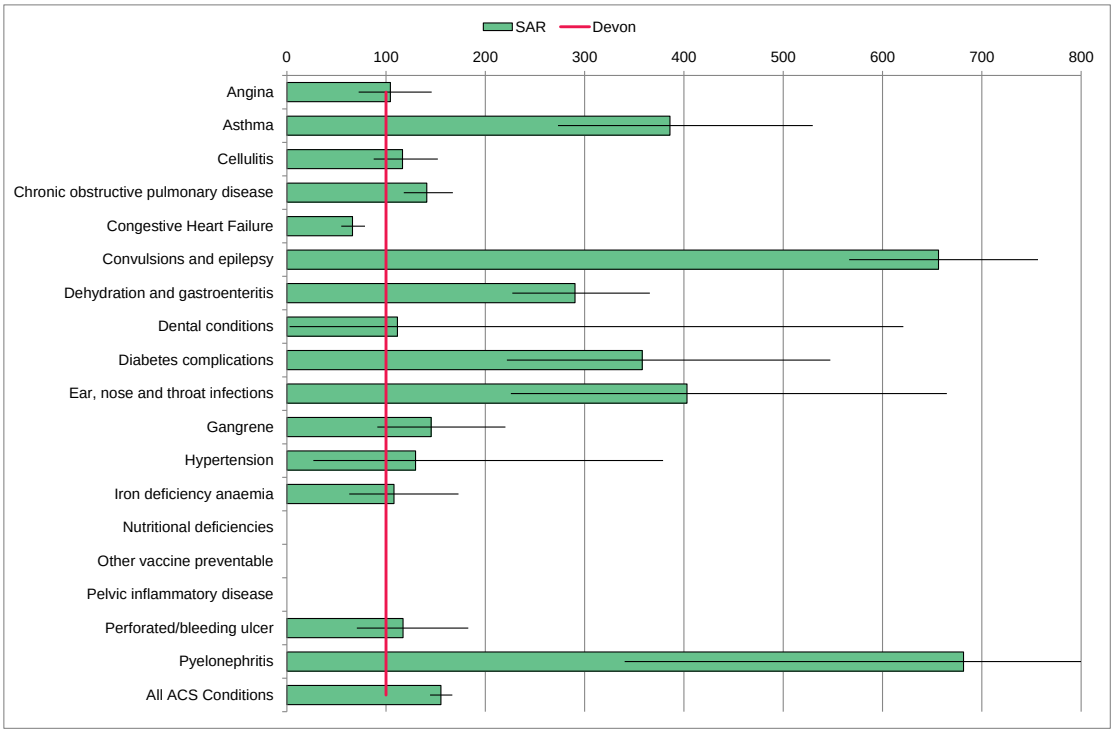
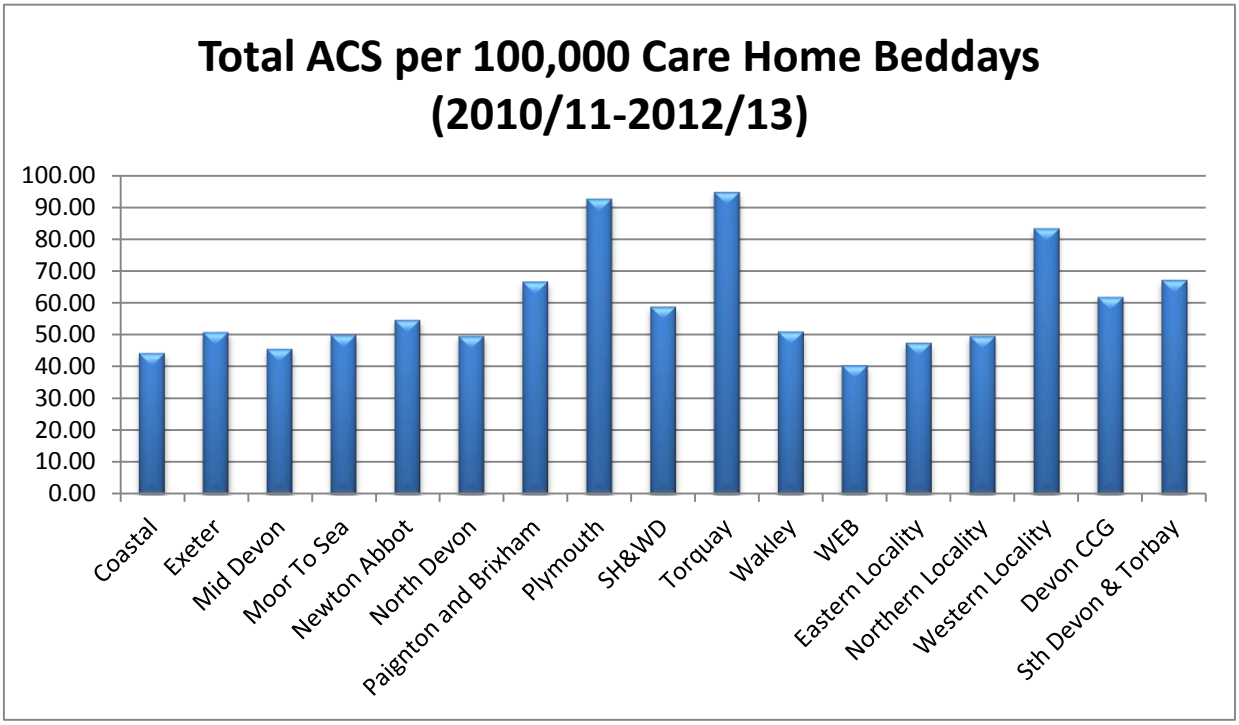


Figure 24 shows the ACS per 100,000 care home bed days and demonstrates the use of hospital beds from care home admissions for potentially avoidable admissions.

Figure 24: Total Ambulatory Care Sensitive Conditions per 100,000 Care Home Beddays. (2010/11 -2012/13)



4.16 Quality watch (2013) published a report entitled: 'Focus on Preventable Admissions – Trends in ambulatory care sensitive conditions 2001-2013' the report found that five conditions account for half of all ambulatory care sensitive admissions. Three of these disproportionately affect older people (urinary tract infection/ pyelonephritis, pneumonia and chronic obstructive pulmonary disease (COPD) and the other two disproportionately affect children and young people (convulsions and epilepsy, and ear, nose and throat infections.

- The level of deprivation in an area is strongly linked to rates of ambulatory care sensitive admission, especially for COPD. However, there are significant differences between areas, even after adjusting for age, sex and deprivation of the population.
- Ambulatory care sensitive admissions increased by 48 per cent over the 12 years from 2001 to 2013, more than the increase in other emergency admissions (34 per cent). Less than half of this increase can be explained by population growth and ageing. The magnitude of change varied by type of ambulatory care sensitive condition, with admission for acute conditions increasing by 49 per cent, but rates for chronic ambulatory care sensitive conditions falling by 3 per cent.
- There have been some successes in reducing ambulatory care sensitive admissions, particularly when initiatives are supported by proven innovations in care (for example, angina and bleeding ulcer). Yet, in other conditions, substantial policy effort has had little or no impact. For example, COPD has been the focus for a range of national and local initiatives since the early 2000s, yet rates of admission have not changed significantly since 2001.

4.17 The report recommends three ways that providers and commissioners can respond to reduce rates of Ambulatory Care Sensitive admissions:

- Develop a local understanding of the rate and trend of admissions for each Ambulatory Care Sensitive condition in their area as markers of local performance. Where admission rates for a particular condition in their area appear atypical (that is, usually higher than expected) when compared with similar areas, undertake further local analysis to explore why this is the case.
- Where proven interventions or quality standards exist for a condition, ensure that these are in place across their own area.
- Consider the extent to which broader strategies for reducing the need for emergency admission are being successful. In particular, focus on changes in key patient groups, especially care for frail older patients. The need is not only to prevent hospital admission, but also to prevent the distress and deterioration of the patient that leads to hospital admission.

4.18 Figures 25 to 28 provide a breakdown by cost and volume of hospital admissions from care homes by clinical commissioning group area. A further breakdown is available by locality in appendix 1.

Figure 25: Hospital Admissions from care homes in NEW Devon Clinical Commissioning Group –volume

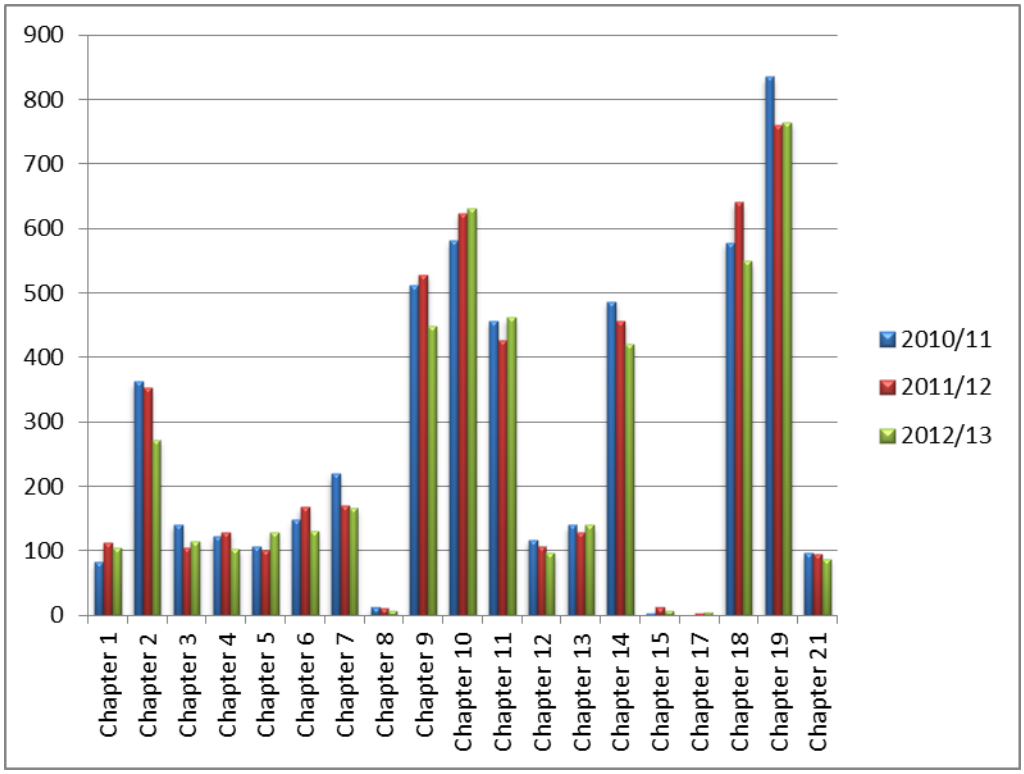


Figure 26: Hospital Admissions from care homes in NEW Devon Clinical Commissioning Group - Costs

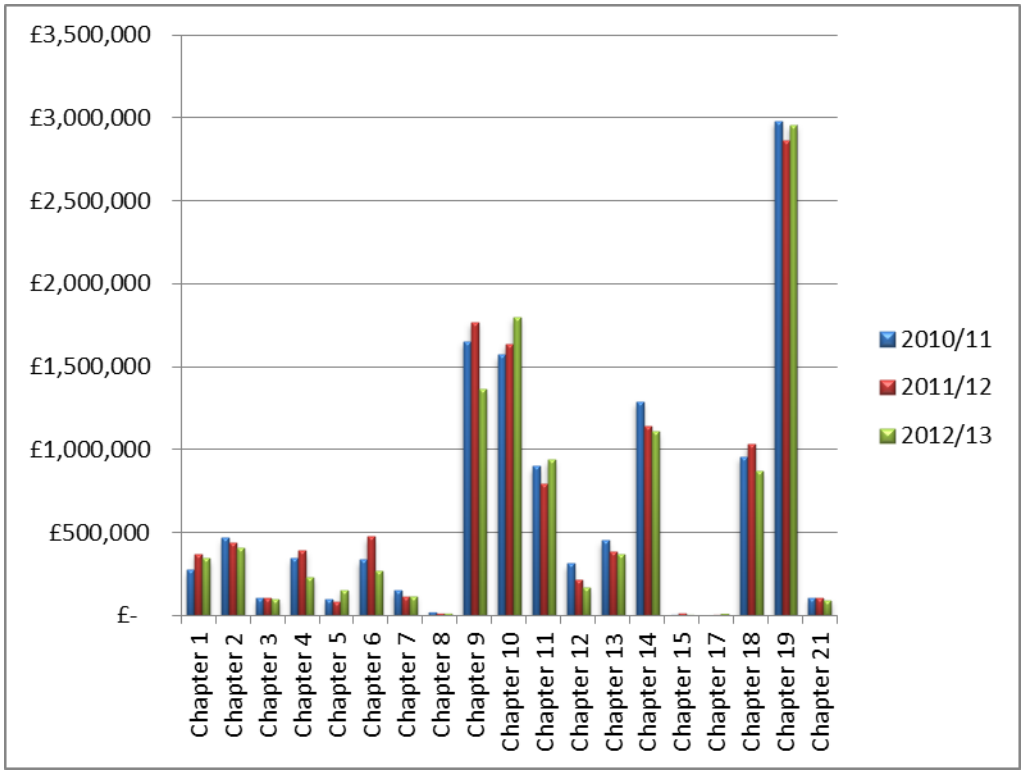


Figure 27: Hospital Admissions from care homes in South Devon and Torbay Clinical Commissioning Group

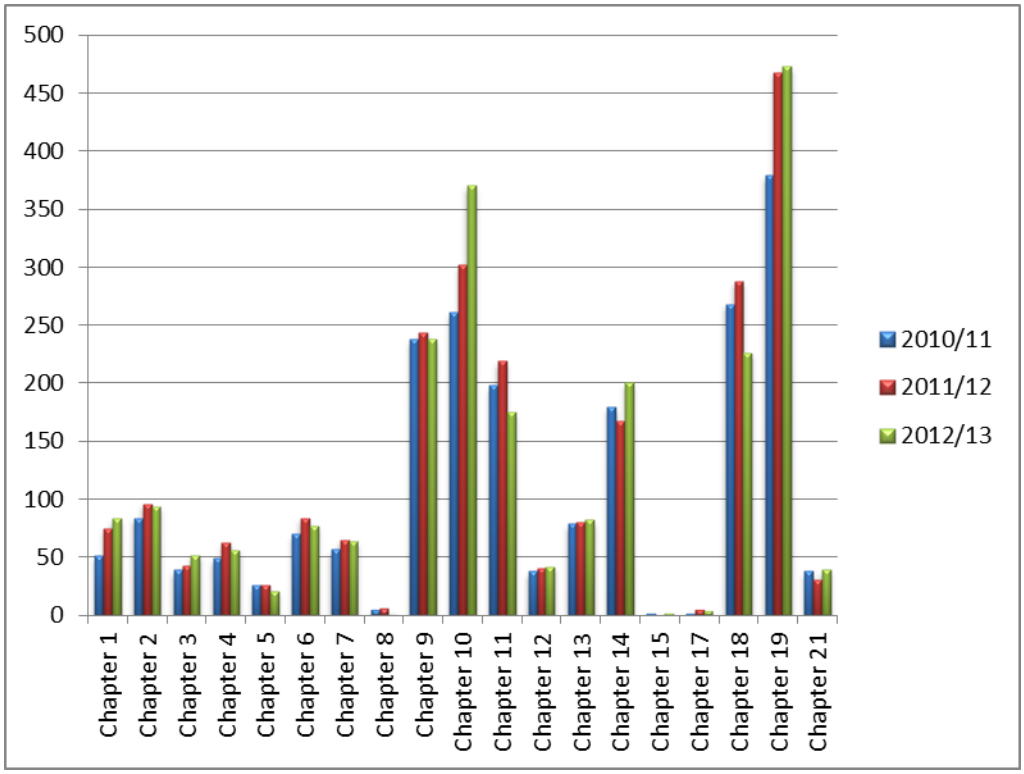
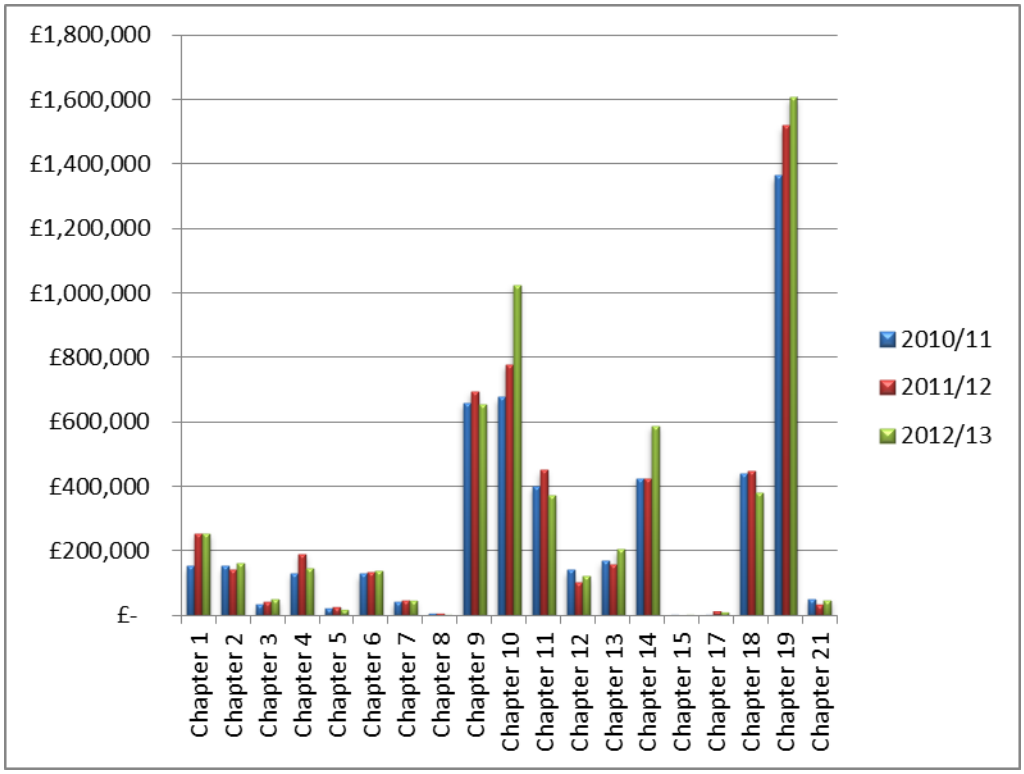


Figure 28: Hospital Admissions from care homes in South Devon and Torbay Clinical Commissioning Group - Costs



4.19 As part of the literature review (Appendix 2) consideration was given to studies seeking to avoid hospital admissions. Brownhill (2013) undertook an observational study looking at training in care homes to reduce avoidable harm. This study investigated the effectiveness of using workshop-based education and service-improvement models in care homes. The models were designed around both threshold and predictive modelling and were intended to raise awareness of the symptoms that may result from a fall, pressure ulcers or urinary tract infections. The project exceeded targets. Preventive assessments, care planning and timely referrals resulted in a reduction in avoidable hospital admissions and district nurse and GP visits.

4.20 Each home was set the following reduction targets:

- Falls-40%
- Recurrent falls - 60%
- Care home-acquired grade 2 pressure ulcers - 75%
- Care home-acquired grade 3 and 4 pressure ulcers - 95%
- Urinary and catheter-acquired infections - 40%
- Hospital admissions - 60%
- District Nurse visits - 40%
- GP visits - 40%

4.21 Once the targets had been reached, the study aimed to sustain the levels through continuing to work with the care homes. Through a robust training package and tailored support, the study reported a reduction the number of avoidable hospital admissions from participating care homes by 51%. By raising awareness of symptoms and encouraging early risk assessment and care planning, the study reported that the level of care delivered to vulnerable patients was raised. It reported a significant link between falls and urinary tract infections. Early assessment by care staff, including recognition of symptoms and urine dip test results, reduced the number of recurrent falls in care homes.

4.22 Many of the studies reviewed were observational studies providing a weak level of evidence of effectiveness.

Dementia Care

4.23 Many residents in care homes in Devon will have a dementia diagnosis. Everyone with dementia is different. For some people with dementia the main problems that they experience will be dementia-related, whereas for other people with dementia their main problems may be caused by a different condition, such as a stroke. The type of home that the person requires will depend on their general health and care needs.

4.24 Many people with dementia move into a care home once their dementia progresses to a certain stage. Some people with dementia have other illnesses or disabilities that make it difficult for them to remain at home. Some people may need to move from one care home into another. Good quality care that preserves dignity, treats people with respect and promotes independence can improve the lives of care home residents with dementia.

4.25 Recent findings from the Care Quality Commission revealed that the current health and social care system is struggling to provide adequate care for people with dementia and their families. This is partly due to dementia not being diagnosed early

enough, with the report highlighting that knowledge and recognition of the signs are the first steps to improving the quality of care that people receive. (NICE 2013)

4.26 Devon has a low dementia diagnosis rate when compared to other areas and early diagnosis will ensure the right services are put in place. In 2011-12, 4,848 people in Devon were on a GP register for dementia, compared with an expected prevalence of 13,075, this is a diagnosis rate of 37.1%. This is the third lowest ratio in the South West, and is below the South West (42.6%) and England (45.0%) rates. Diagnosis rates have improved in recent years, increasing from 28.0% in 2006-07, however national ratios have increased at the same rate. Prevalence rates for dementia increase rapidly with age, with one in 1400 affected under the age of 65, compared with more than one in five in those aged 85 and over. (Devon County Council 2013) Diagnosis in care homes is as important as in the community.

4.27 Commissioning services for dementia is also complex, and a whole systems approach and collaboration between health and social care commissioners and providers is necessary to achieve a good level of personalised care.

4.28 There is limited evidence to support the assumption that the care of people with dementia in special care units is superior to care in traditional nursing units (Lai 2009) and quality standards for dementia should be met regardless of setting.

4.29 Wilson (2013) undertook a study aimed to develop, deliver, and evaluate a training programme in care homes to enhance the quality of care for people living with dementia based on the principles of relationship-centred care expressed through the Senses Framework. Using a biographical approach to care planning structured through the Senses Framework the study helped staff to develop a greater understanding of the person with dementia.

Nutrition and Hydration

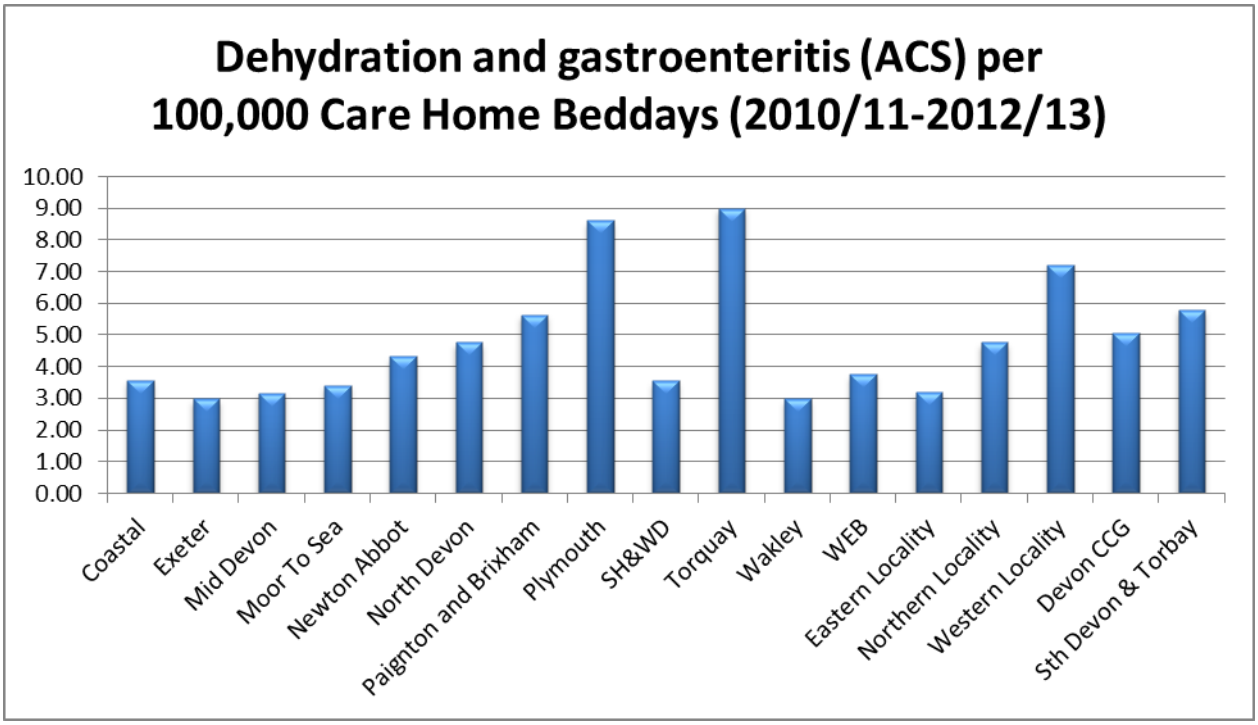
4.30 Under the Health and Social Care Act meeting nutritional and hydration needs is a legal requirement. Specifically the regulations require:

- a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs.
- food and hydration that meet any reasonable requirements arising from a service user's religious or cultural background.
- support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.

4.31 Limited evidence was found regarding interventions to improve hydration and nutritional balance. Care home residents are frail and experience multiple health risks. Kenkmann (2010) undertook a study to improve food and drink provision which was well received by residents, but effects on health indicators (despite the relative reduction in falls rate) were inconclusive, partly due to problems with routine data collection and loss to follow up. The study concluded that further research with more homes is needed to understand which, if any, components of the intervention may be successful. Gleibs (2011) studied the role of water clubs in improving hydration but concluded that it was the social interaction that improved health and wellbeing and not the role of hydration alone.

4.32 The care home hospital admission data (Figure 29) highlights the number of dehydration and gastroenteritis spells per 100,000 care home bed days and suggests that interventions to improve hydration could reduce the number of hospital bed days. This is supported by Table 3 where a higher than expected rate of admissions has been demonstrated across the area.

Figure 29: Number of Cases of Dehydration and Gastroenteritis 100,000 Care Home Bed Days in Hospital



4.33 Choking is caused when a piece of food or other object gets stuck in the upper airway. In older adults, choking most often occurs when food is not chewed properly this may be due to poor dental condition, health status or inappropriate food texture. Prevention of choking is important in care planning.

4.34 Babford (2012) undertook a study on nutritional standards in care homes and concluded older adults should be screened for nutritional issues at diagnosis, on admission to hospitals or care homes and during follow up at outpatient or general practitioner clinics, at regular intervals depending on clinical status. Early identification and treatment of nutrition problems can lead to improved outcomes and better quality of life. The absence of observable benefits to clients confirmed the negative preconceptions of many staff, with limited evidence of reappraisal following implementation. The successful implementation of the nutrition guidelines requires that the fundamental issues relating to their perceived value and fit with other priorities and goals be addressed. Specialist support is needed to equip staff with the technical knowledge and skills required for menu analysis and development and to devise ways of evaluating the outcomes of modified menus.

4.35 Studies by Smith (2008), Dunne (2009), and Merrell (2012) also considered screening tools and a focus on nutrition. Merrell highlights the role of training of staff on nutrition.

Falls and Accident Prevention

4.36 Falls by older people in residential or nursing care facilities and hospitals are common events that may cause loss of independence, injuries, and sometimes death as a result of injury. Effective interventions to prevent falls are important as they will have significant health benefits.

4.37 Residents of care and nursing homes account for about 30% of all patients with hip fractures admitted to hospital. About one-fifth of people with a hip fracture die within one month and one-third within 12 months mostly due to associated conditions (NHS Devon 2011). Falls prevention is an essential intervention to improve the health and wellbeing of care homes residents. In Devon fractures and predominantly fractured neck of femur account for a large number of care homes admissions and the highest cost of any single cause. It is important to prevent falls but the principle of responding to the first fracture and preventing the second is also important.

4.38 Falls prevention involves interventions or packages of interventions intended to reduce falls and fall-related harm. The prevention may be primary (intended to prevent falls and fall-related harm in those who have never fallen) or secondary (intended to prevent further falls and related harm in those who have previously fallen).

4.39 A Cochrane collaboration systematic review on falls prevention in care homes and hospital inpatients included 60 trials (60,345 participants) but did not find robust evidence regarding effective interventions for reducing falls in care homes and studies included in the review varied in quality. (Cameron 2010)

4.40 In contrast to the findings in this review for residents of care facilities and hospital inpatients, the evidence is very clear that falls can be prevented in older people living in the community (Gillespie 2012). The effectiveness of group and home-based exercise programmes and Tai Chi in particular is well established in the community setting. There is the potential for falls to be reduced in care facilities using the same multiple-component exercise programmes, but despite 13 trials in this review testing exercise programmes, the results were inconsistent. Two small studies did show that additional physiotherapy exercises reduced falls in subacute wards in hospital. Vitamin D supplementation may reduce falls in community-living people with lower vitamin D levels (Gillespie 2012). This is consistent with the finding in this review that vitamin D is effective in reducing falls in care facilities as most residents have low vitamin D levels (Pilz 2012).

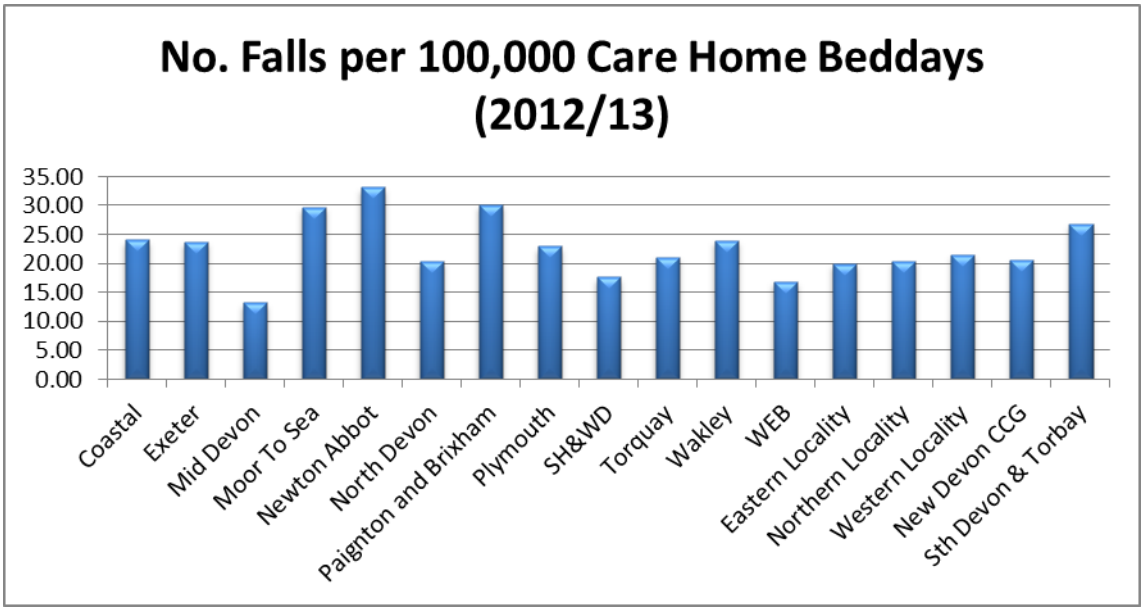
4.41 Multifactorial approaches can be effective in all three settings. In the community setting, assessment and multifactorial interventions reduced rate of falls by 25% but not risk of falling (Gillespie 2012). These interventions reduced risk of falling by 10% in care facilities and 27% in hospital wards. There is some evidence that falls prevention strategies in the community can be cost saving (Gillespie 2012), but there were no economic evaluations conducted within the care facilities or hospital trials to provide information on value for money.

4.42 The lack of robust evidence for specific interventions for care homes to prevent falls does not mean that action should not be taken to reduce falls from care homes. The evidence should be considered as part of the decision making process. The important factor is that the interventions are based on the available evidence and are robustly evaluated. The Cameron review concluded:

- Currently, there is no evidence overall that exercise reduces falls in care facilities, but may be more effective in less frail residents. Of the exercise types tested, only balance training using mechanical apparatus in intermediate level care facilities was effective, but the adoption of these interventions may be problematic. These interventions were supervised perturbed gait exercises on a treadmill and balance training using computerised visual feedback.
- Results relating to medication review by pharmacists are equivocal, and conclusions for clinical practice from this review cannot be made based on the available evidence.
- The prescription of vitamin D in care facilities is effective in reducing falls.
- There is currently no evidence of effect from interventions targeting staff and the organisation of care.
- Some falls prevention programmes that target multiple individual risk factors (classified as multifactorial interventions) may be effective.

4.43 The number of falls per 100,000 care home bed day shows the importance of reducing hospital stays from falls in all areas (Figure 30)

Figure 30: Number of Falls per 100,000 Care Home Bed Days



Healthy Lifestyle Including Activity and Emotional Health and Wellbeing

4.44 Limited evidence of effective interventions to improve the health and wellbeing of residents in care homes was found. No data regarding smoking prevalence, healthy weight or activity levels was found; such data is available on a population basis or from GP practice systems but it is not available locally for care home residents.

4.45 Care home residents should be supported to maintain a healthy lifestyle but there is a paucity of evidence to support development of interventions. There was some evidence supporting emotional health and wellbeing and physical activity.

4.46 Depression is common and is associated with poor outcomes among elderly care-home residents. Exercise is a promising low-risk intervention for depression in this

population. A cluster randomised control trial by Underwood (2013) tested the hypothesis that a moderate intensity exercise programme would reduce the burden of depressive symptoms in residents of care homes. Despite robust methodology, a strong theoretical grounding and good uptake of a moderately intensive exercise intervention, the study found no evidence that the intervention had a positive effect on any of our carefully selected primary or secondary outcomes. This evidence does not support the use of this type of intervention to reduce the burden of depressive symptoms in residents of care homes, and alternative strategies for this common and important problem are needed.

4.47 There is a need to find meaningful and engaging interventions to improve mood and behaviour for residents of care homes. The demand on care staff might diminish opportunities for them to encourage these activities. Staff anecdotal information attests that dancing as an activity improves mood in residents and staff. Hence, the importance of investigating what dancing brings to the care home social environment. A systematic review of the evidence from studies related to dancing interventions for older people with dementia living in care homes was undertaken. (Guzmán-García 2013) Ten studies were identified that satisfied the inclusion criteria: seven qualitative and three quantitative. Studies used different approaches such as therapeutic dance, dance movement therapy, dance therapy, social dancing and psychomotor dance-based exercise. There was evidence that problematic behaviours decreased; social interaction and enjoyment in both residents and care staff improved. A few adverse effects were also acknowledged.

4.48 The evidence on the efficacy of dancing in care homes is limited in part owing to the methodological challenges facing such research. The review aimed to raise awareness of the possibility of implementing dance work as an engaging activity in care homes.

Exercise Programs for People with Dementia

4.49 In future, as the population ages, the number of people in our communities suffering with dementia will rise dramatically. This will not only affect the quality of life of people with dementia but also increase the burden on family caregivers, community care, and residential care services. Exercise is one lifestyle factor identified as a potential means of reducing or delaying progression of the symptoms of dementia.

4.50 A review by Forbes (2013) evaluated the results of 16 trials (search date August 2012), including 937 participants, that tested whether exercise programs could improve cognition, activities of daily living, behaviour, depression, and mortality in older people with dementia or benefit their family caregivers.

4.51 There was promising evidence that exercise programs can significantly improve the cognitive functioning of people with dementia and their ability to perform daily activities, but there was a lot of variation between trial results that we were not able to explain. The studies showed no significant effect of exercise on mood. There was little or no evidence regarding the other outcomes listed above. Further well-designed research is required to examine these outcomes and to determine the best type of exercise program for people with different types and severity of dementia.

Exercise for Improving Balance in Older People

4.52 Balance is staying upright and steady when stationary, such as when standing or sitting, or during movement. The loss of ability to balance may be linked with a higher risk of falling, increased dependency, illness and sometimes early death. However, it

is unclear which types of exercise are best at improving balance in older people (aged 60 years and over) living at home or in residential care.

4.53 A review by Howe (2011) included 94 (62 new to this update) randomised controlled trials involving 9821 participants. Most participants were women living in their own home. Some studies included frail people residing in hospital or residential facilities.

4.54 Many of the trials had flawed or poorly described methods that meant that their findings could be biased. Most studies only reported outcome up to the end of the exercise programme. Thus they did not check to see if there were any lasting effects.

4.55 There were eight categories of exercise programmes together with those measures of balance for which there was some evidence of a positive (statistically significant) effect from the specific type of exercise at the end of the exercise programme.

4.56 Some trials tested more than one type of exercise. It is important to note that the evidence for each outcome was generally from only a few of the trials for each exercise category.

4.57 The review concluded that there was weak evidence that some exercise types are moderately effective, immediately post intervention, in improving balance in older people. However, the missing data and compromised methods of many included trials meant that further high quality research is required.

4.58 Prevention of cardiovascular disease is equally important for care home residents and eligible residents aged 40-74 should be included in the national health check programme to identify individuals undiagnosed or at risk. Figure 31 demonstrates the number of diabetic admissions per 100,000 care home bed days and figure 32 demonstrates the number of COPD admissions. Interventions for long term conditions would need to span community and residential care settings.

Figure 31: Number of Diabetic Complications per 100,000 Care Home Bed Days

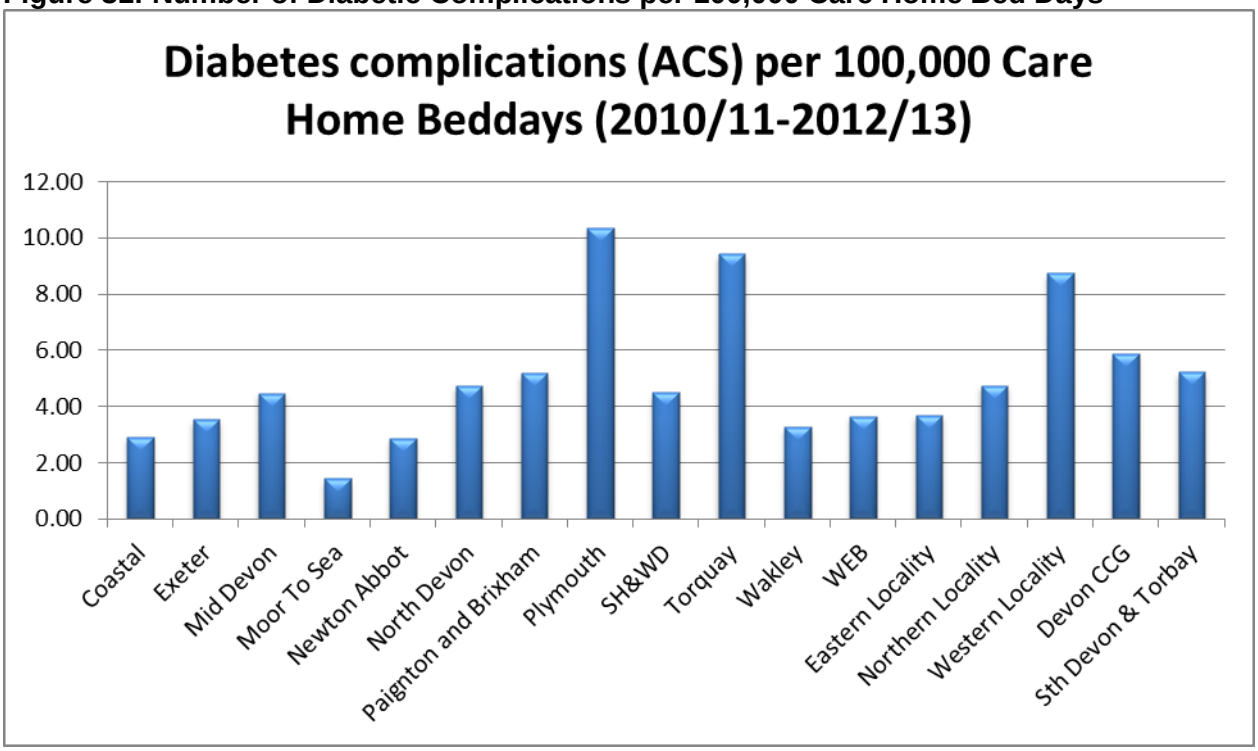
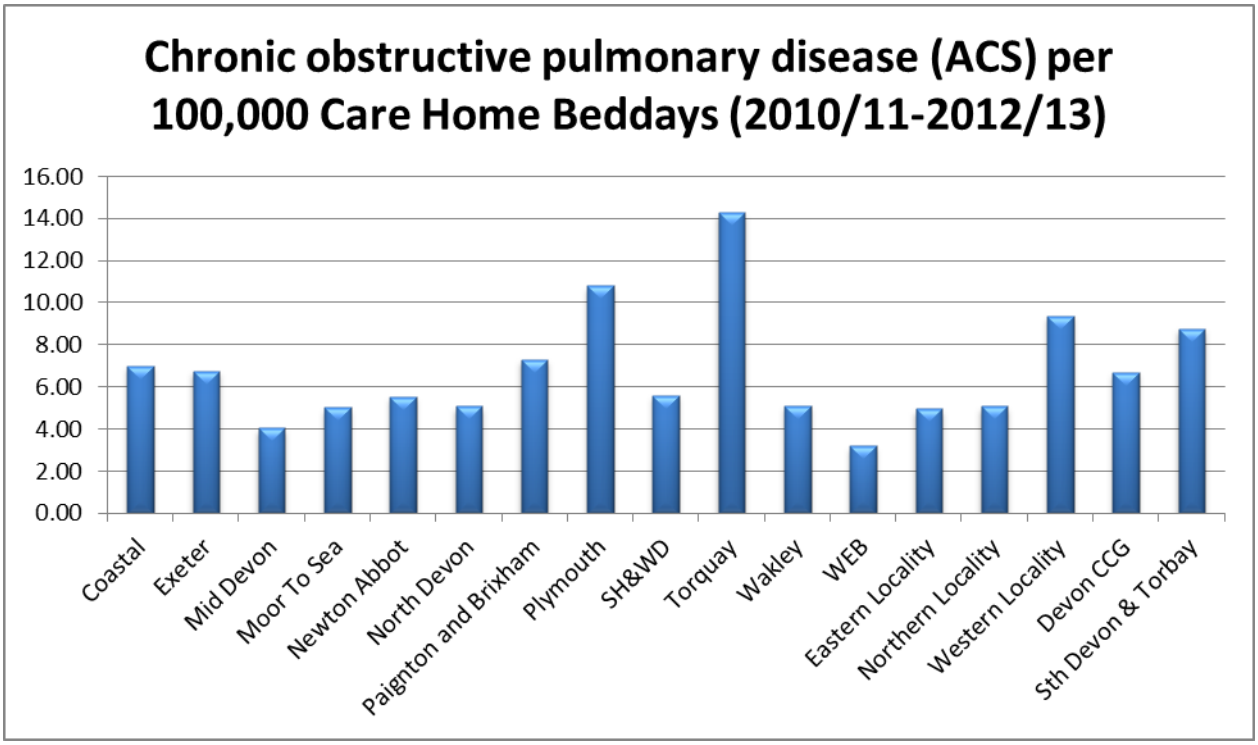


Figure 32: Number of COPD Complications per 100,000 Care Home Bed Days



Social Interaction

4.59 Engaging in meaningful social interaction is central to quality of life and this does not diminish following the move to a care home. However, social interaction in this setting can be difficult and is not always well supported by the environment or by staff.

4.60 An action learning project on social interaction in care homes developed the INTERACT framework, which provides a guide to many of the issues that staff need to consider in promoting social interaction in the care home setting. By careful consideration of each aspect of the framework it is likely that interventions can be identified and planned to support social interaction. Enhancing social interaction in this context forms the foundation for maintaining or developing social relationships.

4.61 The quality of social relationships is a determinant of quality of life in later life (Bowling et al 2002, Haslam e al 2008, Cook and Stanley 2009). Enhancing social interaction between those living, working and visiting care homes has the potential to contribute to improvement of residents' quality of life and their sense of wellbeing.

4.62 Supporting the expression of sexuality, intimate relationships or sex for older people living in care homes can be challenging for staff (Bauer 2007). There is often a tension between supporting human rights and acting within legal frameworks. The Nursing and Midwifery Council (NMC) recognises that decisions are often not straightforward but nurses must always act within the law and within the NMC code and guidance (NMC 2008, 2009a, 2009b). All decisions will depend on the people involved and individual circumstances. Comprehensive assessments of individuals and specific circumstances, including risk, must be undertaken. When appropriate, the views of a range of people should be incorporated into care and specialist advice should be sought. Approaches must be person centered and care provided in ways that are personalised, rather than based on assumptions and stereotypes. Nurses must always strive to promote and support human rights, dignity, privacy and choice.

4.63 Barriers faced by nurses when trying to ensure patients' sexual rights are described, and legal issues are discussed in a paper by Heath (2011). The paper discusses the challenges nurses face and the Royal College of Nursing has developed guidance to help nurses and care staff work effectively with issues of sexuality, intimate relationships and sex, particularly for older people living in care homes.

4.64 There was a lack of information and evidence found on spiritual and cultural matters so they were not explored further but is likely to form an important role in social interaction.

Protected Characteristics

4.65 The protected characteristics are considered in Appendix 3 in the context of living in care homes. Lesbian, gay, bisexual and transgender needs (LGBT) are considered but the LGBT Health Needs Assessment will provide more detail on the care of LGBT individuals.

4.66 The Commission for Social Care Inspection report 'Equality and Diversity Matters' (2008) discusses the needs of black and ethnic minority nursing home residents. The report indicates that many residents feel their needs are unmet and recommendations for care home managers to improve services are highlighted, including better staff training, raised awareness and more positive staff attitudes (Mooney 2008).

4.67 A literature review on issues relating to ethnicity in end-of-life care within care homes for the elderly was undertaken by Badger (2009) and identified the need for research to examine the perspectives and experiences of black and minority ethnic residents, families and staff in order to assist future service provision is highlighted.

Quality of Life

4.68 Evidence from the Institute for Public Policy Research suggests that many older people are dissatisfied, lonely and depressed, and many are living with low levels of life satisfaction and wellbeing. These problems are widespread in older people living in care homes. Research by the Alzheimer's Society has shown that many care homes are still not providing person-centred care for older people. One of the major problems identified was that older people in care homes do not have access to enough activities or ways to occupy their time. It has also been reported that many care home residents have problems accessing NHS primary and secondary healthcare services. A lack of activity and limited access to essential healthcare services can have a detrimental impact on a person's mental wellbeing. (See Quality statements 5.1)

4.69 The Joseph Rowntree Foundation published a report in 2009 seeking to define ‘a good life’ for older people in care homes and surveyed 200 people, 84 who were residents of care homes and concluded that the voices of old people were so quiet as to be practically absent from discussions about their requirements, preferences and priorities. The report found older people in care homes had low self esteem and expectations and no personal identity. A move to a care home is a frightening and difficult time often resulting from sudden illness and disability with a quick move with little advance preparation and often no return home after a hospital stay. The report concludes that whilst important ‘dignity and respect’ are low aspirations for a challenging agenda and further work is needed to define ‘a good life for older people with high support needs’ Some of the commonly identified areas included: people knowing and caring about you, the importance of belonging, relationships and links

with your local or chosen community, being valued, being able to choose how you spend your time getting out and about. This was a small study and more work is needed to understand the needs of Devon care home residents. Part 2 of the health needs assessment will include the views of care home residents

4.70 A survey of family members by the Alzheimer's Society for family members for people with dementia (DEFAM) and staff working in care homes (DEMSTAF) found that only 41% thought the quality of life in care homes was good, 56% said support from GPs was good but other health services less positive. Only 44% thought opportunities in care homes were good. (Alzheimer's Society 2013))

4.71 Engagement in meaningful activity can change mood, behaviour and even cognition for the duration of the activity (Pulsford, 1997). Activities expand knowledge and provide a sense of meaning and accomplishment (Tappen, 1997). They facilitate socialisation and communication and enhance self-esteem (Wald, 1993). Finally, they provide physical, mental and emotional stimulation (Whitcomb, 1993). The provision of training for care home staff facilitates grading of activities to ensure they are appropriate to each resident's ability and interests. It also reduces the risk of discouragement and hostility, experienced when activity breaks down (Pulsford, 1997)

4.72 The Adult Social Care Outcomes Framework ASCOF indicator '1A – Social care-related quality of life' reports quality of life for people using social care services this was calculated for just those in nursing and residential care in 2012-2013. This is calculated from a selection of questions in the Adult Social Care Survey 2013: The overall quality of life measure brings together people's experience of eight outcomes related to social care into a single measure. The eight outcomes have been developed by the Personal Social Services Research Unit at the University of Kent, and comprise: being clean and presentable, getting the right amount of food and drink, having a clean and comfortable home, feeling safe, having control over daily life, having social contact with people, the way people are treated and spending time doing enjoyable things that are valued or enjoyed. (Source: ASCOF 2012-13)

4.73 Calculating this for just people in residential and nursing care in the Devon County Council area the outturn is 20.3 (this consists of 264 of the 1,032 people that took part in the survey). To put this into perspective Devon's overall measure for quality of life was 18.7, our comparator group authorities was 19.0 and the England average was 18.8. This indicates that people's quality of life living in care homes in Devon was rated better than the average of all people surveyed receiving social care services.

End of Life

4.74 The latest available mortality data is for 2012 and during that year there were 8,588 deaths in total in Devon, of which 2,236 were below the age of 75. The commonest causes of death in those aged under 75, with coronary heart disease (CHD) accounting for 280 deaths, followed by lung cancers with 211 deaths and asthma, bronchiectasis, Emphysema and other COPD accounting for 94 deaths.

4.75 Present trends in overall mortality rates between 1993 and 2012; highlight that mortality rates have fallen significantly over recent years. Devon rates have stayed consistently below South West and national rates with only the latest year showing a slight increase.

4.76 End of life care profiles are produced for each local authority. The latest end of life profiles shows of all deaths that occur in care homes cardiovascular disease is the

predominant underlying cause. In care homes Alzheimers/dementia/senility are the predominant causes demanding end of life care.

Table 4: End of Life Care Profiles. Place of Death by Local Authority Area

End of Life Care Profiles 2012			
	Plymouth	**Torbay**	**Devon**
Place of Death			
Care Home	24%	32%	23%
Hospital	45%	42%	49%

Source: ONS Mortality Data 2008-10

4.77 The proportion of deaths in care homes varies across the area with 23% in Devon and 32% in Torbay. A significant number of deaths occur in care homes.

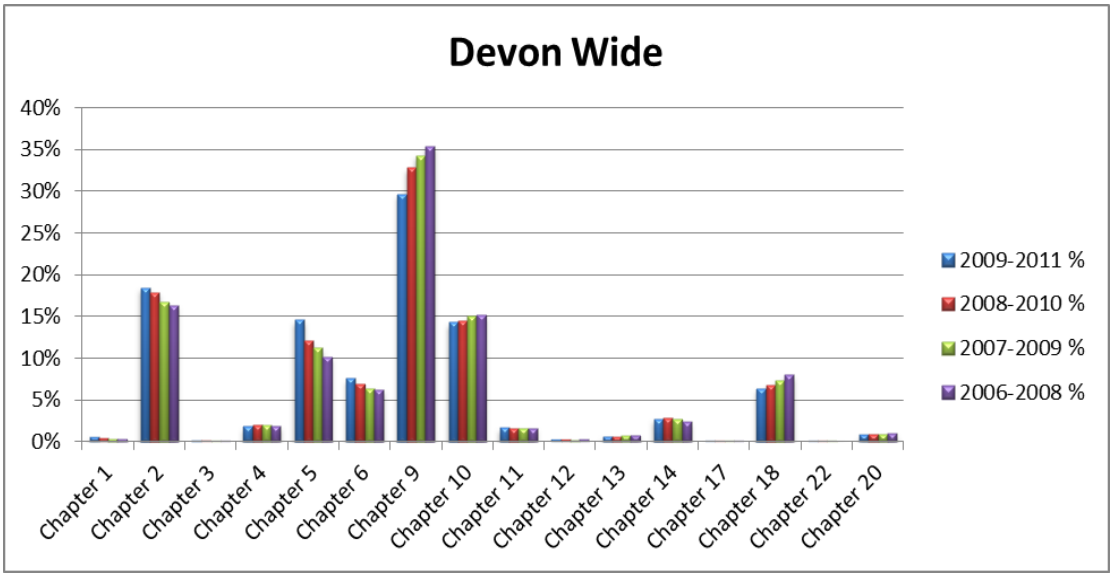
4.78 A systematic review considered how effective palliative care interventions in care homes are. The study identified there is a need for more high quality research, particularly outside the USA (Hall 2011).

4.79 If palliative and end of life care for dementia is to mirror that provided for other terminal illnesses, development of knowledge, confidence and communication skills amongst the workforce is crucial. In order to be successful, multi agency working, flexible and creative ways of delivering palliative and end of life care for this group are essential. (Crowther 2012)

4.80 Stone (2013) undertook a qualitative descriptive study for end of life care using the Gold Service Framework and found that staff, need to develop skills, knowledge and confidence to engage in discussions around end of life.

4.81 Table 1 provides the classification of diseases and Figure 33 the trend in causes of death within care homes across the whole Devon area. Diseases of the circulatory system have been decreasing and neoplasms and mental and behavioural problems have been increasing. Diseases of the respiratory system have remained quite static. The category of home at time of death is predominantly private nursing home and private residential care home with a percentage increase over the past few recorded years in residential homes and decrease in nursing homes. This is important as end of life support is equally important to both sectors.

Figure 33: Cause of Death of Residents within Care Homes in Devon 2006-8 to 2009-11



Health Inequalities

4.82 Care home residents will move into an area and move between local authoirty areas so the pattern of health inequalities will not be clear as the impact through the life course of lifestyle choices and impact from the wider determinants of health will not be known. Many care home residents in Devon are old and have a high life expectancy many of whom will have lived in Devon and experience good health but have care and support needs in later life. In areas of higher deprivation such as Plymouth and Torquay the population of 85+ residents is less than 10% for males and under 40% for females this is very different to Paignton and Brixham where the 85+ populaiton are 12% and over 40% respectively. In Wakely over 50% of the female adult care home population are 85+.

5. Quality and Safeguarding

Quality

5.1 Care homes play an important role in social care, providing services to some of our most vulnerable citizens. By focusing on the quality of life in care homes for older people, providers can play a part in delivering services that people want, in the way that they want them. (Moore 2013)

5.2 To assess the quality of care given to elderly people and compare the care given to residents in nursing homes with those living in their own homes. A controlled observational study of elderly individuals (aged 65 years) registered with three general practices, of whom 172 were residents in nursing homes (cases) and 526 lived at home (matched controls) was undertaken. The study concluded that the quality of medical care that elderly patients receive in one UK city, particularly those in nursing homes, is inadequate. It suggests that better coordinated care for these patients would avoid the problems of overuse of unnecessary or harmful drugs, underuse of beneficial drugs, and poor monitoring of chronic disease. (Fahey 2003)

5.3 NICE guidance on mental wellbeing of older people in care homes provides a list of quality statements which should be developed in homes in Devon:

Statement 1. Older people in care homes are offered opportunities during their day to participate in meaningful activity that promotes their health and mental wellbeing.

Statement 2. Older people in care homes are enabled to maintain and develop their personal identity.

Statement 3. Older people in care homes have the symptoms and signs of mental health conditions recognised and recorded as part of their care plan.

Statement 4. Older people in care homes who have specific needs arising from sensory impairment have these recognised and recorded as part of their care plan.

Statement 5. Older people in care homes have the symptoms and signs of physical problems recognised and recorded as part of their care plan.

Statement 6. Older people in care homes have access to the full range of healthcare services when they need them. (NICE 2013 QS50)

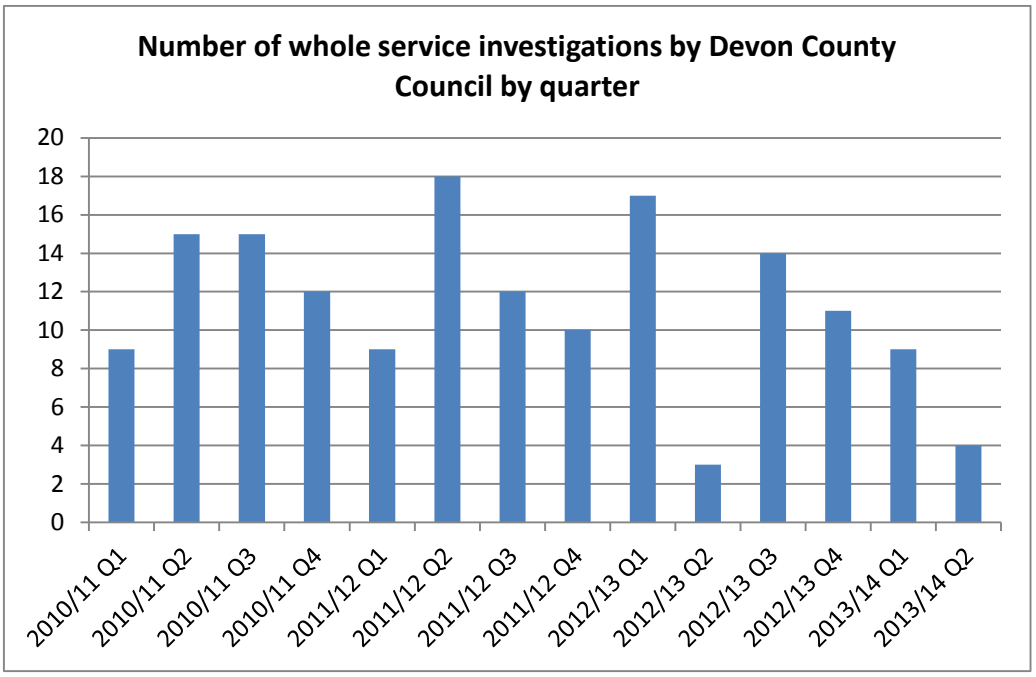
Safeguarding

5.4 There were 49 whole service investigations during 2011-12 compared to 51 in 2010-11. In 2012-13, there have been 45 whole service investigations. (Including a small number of multiple and domiciliary care providers) Over the last four quarters, as shown in Figure 34, the volume of whole service investigations has gradually fallen. Many investigations are not substantiated. Of the 49 whole home reviews in 2011-12 the following themes were identified:

- Skin care
- Medicines management
- Pain management
- Nutrition and hydration - provide food and drink in the right way
- Falls prevention
- Application of MCA
- Variability of skills knowledge in staff

5.5 In 2012-13 the majority of referrals were for alleged neglect, with a smaller number for alleged physical and psychological abuse and only one for sexual abuse. There were none for financial abuse. There have been 52 suspensions from Devon County Council since Q1 2011 with numbers reducing over time.

Figure 34: Whole Home Investigations by Devon County Council Q1 2010-11 to Q2 2013-14



5.6 Nursing care skills, medicines management and documentation are frequently reported safeguarding themes.

Care Home Standards

5.7 Care homes are regulated under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and Care Quality Commission (Registration) Regulations 2009 and the Care Quality Commission have produced outcome based approach guidance entitled “Essential standards of quality and safety” (March 2010).

5.8 There are a range of outcomes for providers to achieve:

- Involvement and information
- Personalised care, treatment and support
- Safeguarding and safety
- Suitability of staffing
- Quality and management
- Suitability of management

5.9 The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by carrying out of an assessment of the needs of the service user; and planning and delivery of care and, where appropriate, treatment in such a way as to:

- Meet the service user’s individual needs.
- Ensure the welfare and safety of the service user.
- Reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment.
- Avoid unlawful discrimination including, where applicable, by providing for the making of reasonable adjustments in service provision to meet the service user’s individual needs.

Health & Safety Executive/Local Authority Enforcement

5.10 Care Homes have to comply with Health and Safety legislation and may have inspections undertaken to seek compliance with the law and investigate breaches of legislation following injuries or fatalities. The Local Authority enforces health and safety in care homes and the Health and Safety Executive in homes offering nursing care. In the Wales and South West region there were three prosecutions in residential care activities, four in residential nursing care activities, none in learning disability, mental health and substance misuse facilities and one for residential care for elderly and disabled. Only one took place in the area which was in Plymouth, this demonstrates that enforcement in care homes is rare and approaches such as education, guidance and support are important in maintaining standards.

5.11 Legislation of relevance includes:

- **Health and Safety at Work Act 1974.** The Act lays down general duties to employees and people affected by work activities. To take reasonably practicable measures to ensure the health and safety
- **Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.** The regulations include a requirement to report fatal accidents and certain non-fatal accidents to non-workers. Accidents to members of the public or others who are not at work must be reported if they result in an injury and the person is taken directly from the scene of the accident to hospital for treatment to that injury. Examinations and diagnostic tests do not constitute 'treatment' in such circumstances.
- **Provision and Use of Work Equipment Regulations 1992 and Lifting Operations and Equipment Regulations 1998.** The regulations cover the maintenance and safety of work equipment and lifting equipment.
- **Management of Health and Safety at Work Regulations 1999.** The regulations relate to management of health and safety and include a requirement to undertake risk assessments and would cover consideration of matters such as the control of water temperatures, risk of falls and falls from windows.

5.12 There is a specific guidance document to support care home managers entitled: Health and Safety in Care Homes (http://www.hse.gov.uk/pubns/priced/hsg220.pdf). The guidance covers a numbers of topic areas in the needs assessment, specifically relating to the care home environment.

5.13 Locally environmental health teams have offered safety and health awareness days for care home owners, which provide guidance on the legislation and themed topics. There is no evaluation of the impact of the sessions, which provide an opportunity to theme awareness messages specifically for the sector. The care home sector is a sector commonly receptive to training.

Public Health England - Outbreaks and Infection Control

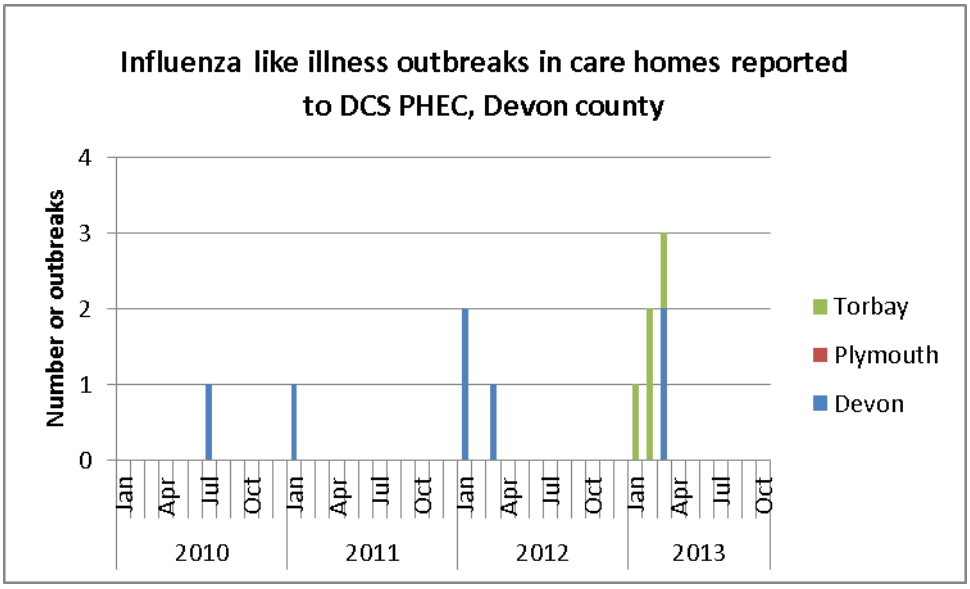
5.14 Cases and outbreaks of communicable diseases are collated by Public Health England (PHE) and are reported to and investigated by Environmental Health Departments. Outbreaks are co-ordinated by Public Health England. Outbreaks are investigated to control further spread of infections and to ensure a foodborne source is not responsible. Many outbreaks are viral.

5.15 Responsibility for infection control advice to care homes is not clear and can be provided by infection control nurses at Public Health England and through EH departments, locally Environmental Health has produced guidance on viral outbreak infection control and historically the Primary Care Trust provided training and support to care homes. The new arrangements for support and advice to care homes on infection control need to be clarified.

5.16 Two outbreaks of Clostridium difficile were reported, both from care homes in the Devon PCT area, during the time period January 2010 to October 2013.

5.17 There is limited evidence of interventions in care homes relating to infection control although guidance exists for care homes. After putting in place measures to reduce C difficile in hospital, (Smith 2013) found that patients in the community were experiencing recurrences of infection, which can lead to readmission. A project was launched in which care homes received a free or part- funded deep clean of residents' rooms, and skilled nurses offer support to care home staff. This led to a reduction in recurrences of C difficile.

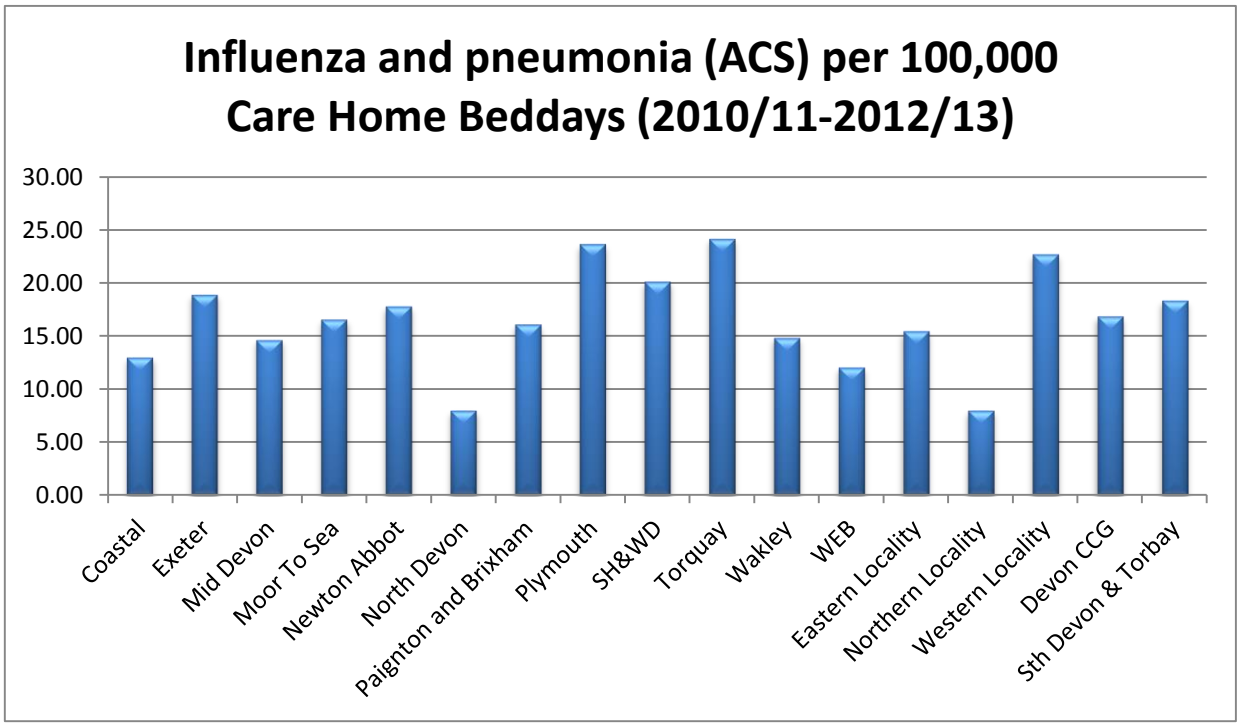
Figure 35: Influenza like Illness Outbreaks in Care Homes in Devon 2010-13. Devon Cornwall and Somerset Public Health England Centre (DCS PHEC)



5.18 There is no local data on flu vaccination coverage in care homes so it is not clear whether care homes are achieving the 75% national target. Many care home residents are vulnerable due to age 65+ and ill-health and action should be taken to ensure at least 75% of vulnerable care homes residents receive vaccination. As care home residents also live in close proximity transmission and spread of flu will be difficult to control, to achieve 'herd immunity' 95% uptake would be required in care homes with the defined vulnerable populations. A methodology for understanding uptake in care homes should be developed working with local providers.

5.19 Figure 36 demonstrates the impact of influenza and pneumonia on bed days in acute hospital so management of both conditions is important.

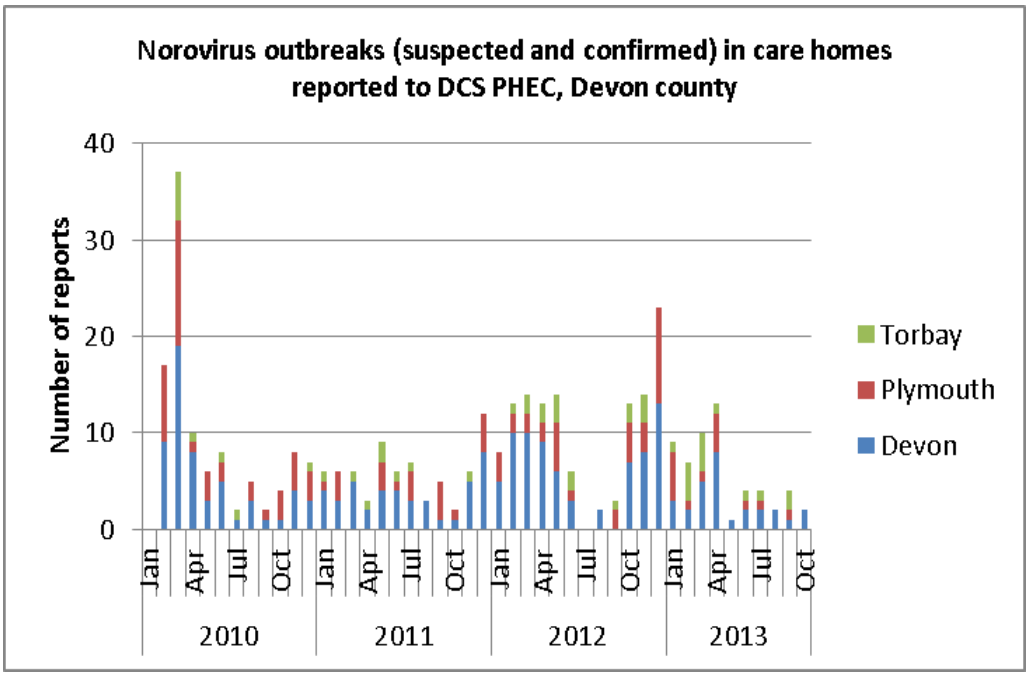
Figure 36: Number of Influenza and Pneumonia Cases per 100,000 Care Home Bed Days



5.20 Non-viral outbreaks in care homes are relatively rare. Two cases of Campylobacter were identified in a care home in South Hams in 2012. Two cases of Group A Streptococcus (non-invasive) were seen in a care home in East Devon in 2012. Staphylococcus aureus was found in cases in five care homes in Plymouth Primary Care Trust area, two in 2010 and three in 2011.

5.21 Environmental Health Departments are responsible for enforcing food hygiene legislation and there is a food hygiene rating system, which allocates ratings for premises.

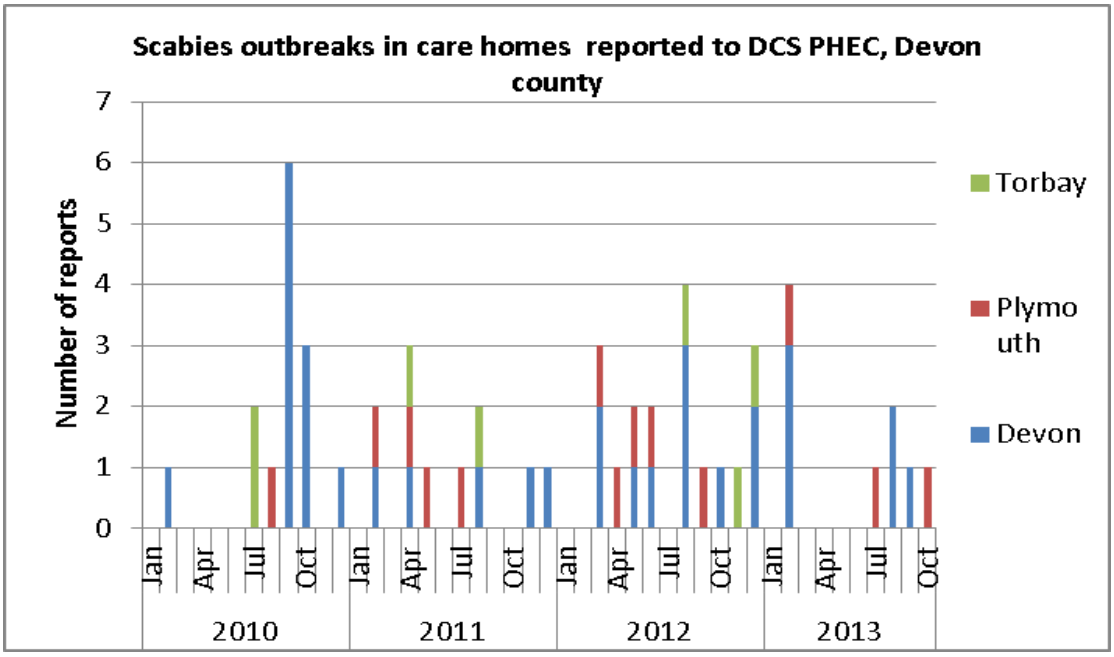
Figure 37: Norovirus Outbreaks in Care Homes in Devon 2010-2013. Devon Cornwall and Somerset Public Health England Centre (DCS PHEC)



5.22 356 suspected or confirmed Norovirus outbreaks were reported in care homes during the time period January 2010 to October 2013. Devon PCT area had 201 outbreaks, Plymouth 108, and Torquay 47. 16 of the outbreaks for Devon PCT area were laboratory confirmed, the remainder were clinically suspected. Seventeen were confirmed for Plymouth and one for Torbay.

5.23 A study assessed the effect of key care quality indicators on viral gastroenteritis outbreaks and control in care homes using mandatory inspection data collected by a non-departmental public body. It found outbreak occurrence was associated with care home size but not with overall quality or individual environmental standards. Care home size, hygiene and infection control standard scores were inversely associated with attack rate in residents, whereas delayed reporting to the local public health agency was associated with higher attack rates (Vivancos 2012)

Figure 38: Scabies Outbreaks in Care Homes in Devon 2010-13. Devon Cornwall and Somerset Public Health England Centre (DCS PHEC)



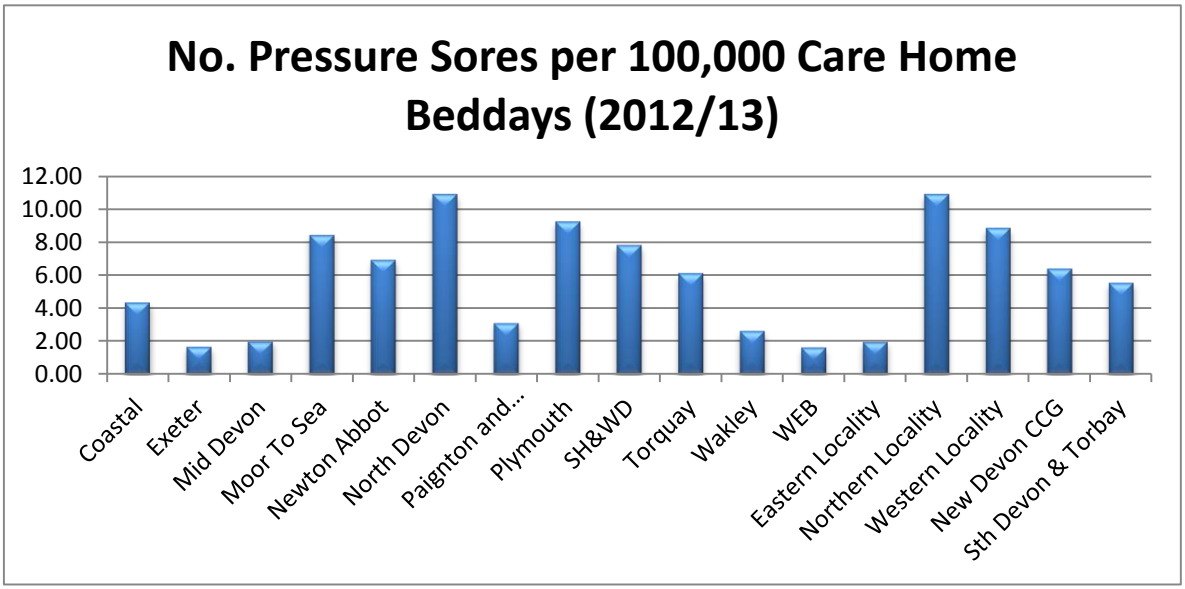
5.24 52 outbreaks of scabies were reported in care homes during the time period from January 2010 to Oct 2013, 32 in Devon PCT area, 13 in Plymouth and seven in Torbay.

Pressure Ulcers (Tissue Viability)

5.25 The literature does not provide information on the prevalence or incidence of pressure ulcers in care homes specifically. In intensive care units the prevalence can be as high as 45% compared to 1 or 2% in the general population. Care home residents vary in their dependency, the incidence is likely to be quite low in residential care but may be higher in nursing care, and it will depend on mobility and the health status. Locally data recording is an issue and discussion with lead professionals raised the importance of training in care homes to identify and grade pressure ulcers. Grade 2 pressure ulcers have to be reported but the true burden of disease is not known if grade 1 ulcers are not identified and recorded. 30-50% of grade 1 pressure ulcers do not progress to grade 2 but better management will lead to improved prevention. North Devon have started collating and reporting prevalence and care home training covered grading and recognition and understanding the difference between diabetic foot ulcers and pressure ulcers. (Section 7)

5.26 Figure 39 provides the main data source of hospital bed days from care home admissions this is presented as a rate and does not provide an accurate measure. Provider's record pressure ulcers and this intelligence needs to be collated to understand prevalence. It is important that pressure ulcers in homes whether residential or nursing become part of the community teams caseload, only Residential care homes would become part of caseload and nursing home support is less clear as homes have their own nursing teams. It is also important to understand if pressure ulcers develop under home care or are inherited on admission.

Figure 39: Number of Bed Sores per 100,000 Care Home Bed Days



Continence

5.27 Roe (2013) undertook a review of descriptive studies that investigated associated factors related to managing urinary incontinence in older people in care homes. Sixteen studies were identified that reported on associated factors related to comorbidities, management preferences, policies, staff views and knowledge or methodological studies. Non-invasive methods involving toileting and use of pads were common management approaches. No studies aimed at maintaining continence were identified. Further study is needed in care home populations to change or inform practice and provide effective care is warranted. Preventive studies that maintain continence are required. Older people and their families should be involved with decisions regarding their preferred care, goals, management and outcomes for managing incontinence, promoting or maintaining continence (Roe 2013).

Medicines Management

5.28 Older people living in care homes have many complex physical and mental health problems. Care home residents are prescribed many medicines compared to people who live in their own homes, with an average of eight medicines being common. International research has shown that these medicines are often not well managed, with some residents prescribed medicines inappropriately. This has the potential to lead to harmful side effects and a loss of benefit. For these reasons, it is important to make sure that care home residents are prescribed the right medicines at the right doses.

5.29 A review (Aldred 2013) found eight studies involving 7653 residents in 262 care homes in six countries that evaluated interventions to optimise prescribing for care home residents. Most of the interventions had several components, often involving a review of medicines with a pharmacist and doctor. Some interventions included a teaching component and one study used Information Technology. There was no evidence of benefit of the interventions with respect to reducing adverse drug events (harmful effects caused by medicines), hospital admissions or death. None of the studies looked at quality of life. Problems relating to medicines were found and

addressed through the interventions used in the studies. Prescribing was improved based on criteria used to assess the appropriateness of prescribing in two studies.

5.30 More high-quality studies need to be done to gather more evidence for these and other types of interventions. Further studies are needed to evaluate new technologies, including computer systems that support prescribing decisions. More work needs to be done to make sure that researchers are consistently measuring outcomes that are important to care home residents.

5.31 A Department of Health Alert issued January 2010 entitled 'The Use of Medicines in Care Homes for Older People' (Gateway number 13238) highlighted a study, which was funded by the Department of Health, that revealed a high prevalence of errors in medications received by older residents of care homes. The main findings of the study were as follows:

- residents (mean age 85 years) were taking an average of 8 medicines each on any one day
- seven out of 10 patients experienced at least one medication error whilst the mean score for potential harm was relatively low, the results did indicate opportunity for more serious harm.

The alert states that there should be a review of the safety of local prescribing, dispensing, administration, and monitoring arrangements in the provision of medication to older people in care homes.

5.32 In response to the alert in NHS Plymouth and NHS Devon a Medicines Management Steering Group comprising: GPs, practice managers, community pharmacists, care home managers, CCG Pharmacists, Local Authority Social Care Commissioners was set up and a range of resources were produced to include: quarterly newsletters distributed to GP Practices, Community Pharmacies and Care Homes, good practice guidance sheets, care home medicines management checklist and accompanying audits. The resources have been shared with Torbay Council Care Homes.

5.33 NICE issued a guideline in March 2014: Managing medicines in care homes. This guideline applies across both health and social care; its purpose is to provide recommendations for good practice on the systems and processes for managing medicines in care homes. It considers prescribing, handling and administering medicines to residents living in care homes and the provision of care or services relating to medicines in care homes. The guidance states that the audience will be people and organisations involved with managing medicines in care homes and that it is anticipated that health and social care providers will need to work together to ensure that care home residents benefit from the good practice recommendations.

NICE are currently developing Quality Standards for managing medicines in care homes which are due to be published in March 2015. This will strengthen work already underway locally in care homes.

5.34 A study entitled 'Psychosocial interventions for Reducing Antipsychotic Medication in Care Home Residents' (Richter 2012) reviewed evidence on psychosocial interventions targeting professionals and found it was consistent with a reduction of antipsychotic medication prescription in care home residents. There is evidence to support the effectiveness of psychosocial interventions for reducing antipsychotic medication in care home residents. However, the review was based on a small number of heterogeneous studies with important methodological shortcomings. The most recent and methodologically most rigorous study showed the most pronounced effect.

5.35 NHS Devon's Director of Public Health Annual Report 2010/11 considered the health and care of older people. The Time for Action Report (2009b) stated that anti-psychotic medications are being prescribed to deal with behavioural and psychological symptoms rather than just for psychosis. The Time for Action Report identified limited benefits and significant harms in treating behavioural symptoms of dementia with anti-psychotics. NHS Devon undertook a survey of dementia within primary care to analyse the practice in the prescribing of anti-psychotic drugs to patients with dementia. The audit found fifty two percent of patients had a care plan – which in eight out of ten cases addressed challenging behaviour. Seventy three percent of patients who were prescribed anti-psychotic drugs had mild to moderate symptoms at initiation. There was a lack of evidence that the effect of co-morbid conditions and cerebrovascular risk factors were considered, although it was stated that such risk factors were considered but it was not recorded in notes. The audit was not specific to care homes but prompted the inclusion of behavioural factors into structured dementia reviews and regular system of recall and review for dementia patients taking anti-psychotic drugs. (NHS Devon 2011) Any medicines optimisation work in care homes should review and update the audit findings.

Integration of Services

5.36 Older people living in care homes in England have complex health needs due to a range of medical conditions, mental health needs and frailty. Despite an increasing policy expectation that professionals should operate in an integrated way across organisational boundaries, there is a lack of understanding between care homes and the National Health Service (NHS) about how the two sectors should work together, meaning that residents can experience a poor "fit" between their needs, and services they can access. Gage (2012) describes a survey to establish the current extent of integrated working that exists between care homes and primary and community health and social services. A survey was sent to a random sample of residential care homes with more than 25 beds (n = 621) in England in 2009. Responses were analysed using quantitative and qualitative methods. The survey achieved an overall response rate of 15.8%. Most care homes (78.7%) worked with more than one general practice. Many (60%) managers considered that they worked with the NHS in an integrated way, including sharing documents, engaging in integrated care planning and joint learning and training. However, some care home managers cited working practices dictated by NHS methods of service delivery and priorities for care, rather than those of the care home or residents, a lack of willingness by NHS professionals to share information, and low levels of respect for the experience and knowledge of care home staff.

5.37 Care homes are a hub for a wide range of NHS activity, but this is ad hoc with no recognised way to support working together. Integration between care homes and local health services is only really evident at the level of individual working relationships and reflects patterns of collaborative working rather than integration. More integrated working between care homes and primary health services has the potential to improve quality of care in a cost-effective manner, but strategic decisions to create more formal arrangements are required to bring this about. Commissioners of services for older people need to capitalise on good working relationships and address idiosyncratic patterns of provision to care homes. The low response rate is indicative of the difficulty of undertaking research in care homes. (Gage 2012)

5.38 Robins (2013) undertook a qualitative interview study to explain the current delivery of healthcare to residents living in UK care homes. The study used a grounded theory approach in 6 UK care homes and primary care professionals serving the homes and concluded that healthcare of care home residents is difficult because their needs are

complex and unpredictable. Robins concluded that neither GPs or care home staff has enough time to meet these needs and many lack the prerequisite skills and training. Anticipatory care is generally held to be preferable to reactive care. Attempts to structure care to make it more anticipatory are dependent on effective relationships between GPs and care home staff and their ability to establish common goals. Roles and responsibilities for many aspects of healthcare are not made explicit and this risks poor outcomes for residents.

5.39 'Transforming our Health and Care System' (Kings Fund 2013) includes ten high impact changes for commissioners including care co-ordination through integrated health and social care teams. The publication identifies that robust evidence on health outcomes is limited other than quality of life and patient experience. Impacts on costs and cost-effectiveness are less easy to predict and are likely to be low in the short term.

5.40 'Co-ordinated Care for People with Complex Needs' (Kings Fund 2013) highlights that programmes should be localised so that they address the priorities of specific communities. This supports the locality approach to integration in Devon. The report raises a number of policy implications including: Greater efforts must be made to measure, evaluate, compare and reflect on the performance of care co-ordination programmes. Care co-ordination innovations can take some years to mature and to build legitimacy and acceptance. Successful approaches are very context-specific; care models cannot be transported 'en bloc' from one setting to another. Models of care co-ordination are likely to be more effective when operating as 'fully-integrated' provider teams with some operational autonomy. The paper raises some principles that are applicable to integrated care for care home residents.

5.41 A systematic review (Davies 2011) on integration between health services and care homes yielded inconclusive results and despite evidence about what inhibits and facilitates integrated working there was limited evidence about what the outcomes of different approaches to integrated care between health service and care homes might be. The review identified a need for more research to understand how integrated working is achieved and to test the effect of different approaches on cost, staff satisfaction and resident outcomes.

5.42 No conclusive research exists to suggest that any nursing model or skill-mix model would be effective at improving patient or staff wellbeing in a residential aged-care facility. The evidence presented for a primary-care model is not sufficient to suggest its use in an aged care facility. (Hodgkinson 2011)

5.43 Evans undertook an evaluation that adopted a mixed methods approach, combining quantitative performance data with semi-structured stakeholder interviews and emergency bed use costings. The evaluation suggested that the project made significant steps towards integrating care homes with the health and social care community and demonstrated cost savings through reduced hospital bed use. Health and social care interventions aimed at upskilling care home staff can increase standards of care and quality of life for residents; they are also likely to highlight unmet needs. The project demonstrated the need for better integration of health and social care services with care homes in order to improve quality of life for residents. (Evans 2013)

5.44 The Care Quality Commission produced a report in 2012 entitled 'Healthcare in Care Homes', which looked at how well the healthcare needs of people living in care homes were met. It looked at services in 81 care homes for 386 residents. It identified variability in provision. 33% had GP visits paid for by the PCT and 7% provided and paid for by the care home. Variability was found between care home and services

provided by GPs and who pays. The report raised suitability of training and variability of offer. 77% of care plans took in views of the person but not all included carers or relatives. 44% had GP surgeries or scheduled visits. The sample size was small.

5.45 The Better Care Fund has been developed to support integration of local health and care services. The integration work needs to demonstrate a reduced demand through a reduction of permanent admissions to care homes and reduce potentially avoidable hospital admissions both rely on integrated effective local services.

6. What Works – Evidence of Effectiveness

6.1 A rapid literature review was undertaken as described in Appendix 2 which covered a broad range of issues relating to the health needs of residents in care homes and sections 4 and 5 have considered the health needs in more detail. In the absence of local intelligence on these issues the national literature and evidence has been used with local information where available. This section summarises the evidence of effectiveness:

Admission Avoidance

6.2 Some conditions are potentially avoidable of particular importance for older people are urinary tract infection/pyelonephritis, pneumonia and COPD. There is a need to develop a local understanding of the rate and trend of admissions and to understand causation.

6.3 Once identified proven interventions and quality standards for those conditions should be followed and consideration should be given to the local success factors in admission avoidance and develop these further.

6.4 Studies identified were observational and provide a low level of evidence a full evidence synthesis may reveal further studies.

Dementia Care

6.5 The quality standards for mental wellbeing of older people in care homes should be implemented. There is limited evidence to support the assumption that care of people with dementia in special care units is superior to care in traditional units so dementia standards of care should be met regardless of setting. (NICE 2013)

Nutrition and Hydration

6.6 Dehydration and gastroenteritis are potentially preventable reasons for hospital admissions. The evidence base for effective interventions is poor but the legislative requirements must be met and local solutions adopted utilising existing frameworks such as care home interventions and provider schemes working with regulators within the Care Quality Commission and Environmental Health Departments.

Falls and Accident Prevention

6.7 The evidence base for prevention of falls in care homes is less clear than the evidence for the wider population. The evidence for exercise is not clear but may be more effective in less frail residents. Evidence for medication reviews to prevent falls is not available but the prescription of vitamin D has been found to be effective. There

is evidence that action to address the first fracture to prevent the second can be effective.

Healthy Lifestyles

6.8 There is limited evidence on interventions to improve the health and wellbeing of care home residents. There is some evidence that dance decreased problematic behaviour, social interaction and enjoyment increased but adverse effects were also reported. Reviews identified the need for well-designed research to determine the best type of exercise for individuals with dementia.

6.9 The evidence for improving balance in older people was unclear.

Social Interaction

6.10 The quality of social relationships is a determinant of quality of life in later life and the evidence supports the need for interventions to facilitate social interaction the type of interaction is less well defined but should form a part of care planning.

Protected Characteristics

6.11 There is some evidence that the needs of protected characteristics may not be understood or met and should be considered as part of care planning.

Quality of Life

6.12 There is national evidence that the quality of life of care home residents is not as good as for older people living in their own home. Quality of life in a care home should be defined and included in care planning.

End of Life

6.13 The evidence on end of life care for care home residents is inconclusive and identifies a need for further research. Research identifies the need for staff training and confidence when dealing with end of life care particularly for dementia. End of life care is equally important for nursing and residential care facilities.

Quality and Safeguarding

6.14 There is limited evidence on effectiveness of quality interventions observational studies were limited and provide a weak level of evidence.

Continence

6.15 Studies revealed the need for further research on continence care including the need to consider maintenance of continence and involvement of residents and their families and carers in decision making regarding personal care and management.

Medicines Management

6.16 Studies identified the need for further research to gather evidence of effective interventions, the need to consider quality of life for residents within studies was also highlighted.

Integration

6.17 The evidence for integration of services with care homes is not clear and it is variable. The national evidence base is not clear as models are developing. The Kings Fund highlights the need to localise integration to meet local care needs. A systematic review identifies the need for further research.

Summary

6.18 The evidence for effective care home interventions is weak, systematic reviews and randomised controlled trials tend to recommend further research. Small scale studies tended to be observational in nature and provide a weak level of evidence. This is not necessarily due to lack of effect but a consequence of poor study design and limited research in this area. Follow up is difficult in care homes as residents move on or pass away so long-term impact is impossible to measure. Comparison is difficult as each intervention is different. Studies tend to follow a small cohort over time.

6.19 In addition the needs of care home residents are complex and multi-faceted so a study to measure the impact of an intervention will have a number of confounding factors such as pre-existing co-morbidities and increasing frailty.

7. Mapping of Current Services and Interventions

7.1 A review of local interventions in care homes was undertaken to consider effectiveness and applicability to other areas.

NEW Devon Clinical Commissioning Group

Northern Devon Care Homes Support Project

7.2 The project provided free training and support from experienced nurses, to care homes (both with nursing and without nursing) across the Illfracombe and South Molton cluster. The project originally focussed on avoiding hospital admissions associated with urinary tract infections (UTIs) and catheter associated urinary tract infections (CAUTIs) and was developed in response to an audit which showed unacceptably high numbers of people admitted to acute hospital from care homes with preventable urinary tract infections and catheter associated urinary tract infections. The success of the initial pilot resulted in an extension to cover other conditions such as pressure damage and diabetes.

7.3 The team consist of two Band 6 Nurses with administrative support, who have developed effective working relationships with care homes and train and support them. The initial investment was £84,683 per annum and with the introduction of the Safeguarding Nurse post, there is now the start of a Care Homes Team for North Devon which is having considerable impact on reducing admissions and also whole home safeguarding, as well as increasing the quality of care provided in care homes.

7.4 The project has covered 19 care homes and the nurses have delivered many training sessions and follow-up support visits. The project has recently won the Guardian Public Sector Award for Excellence in Partnership and recognised by the Chief Executive of NHS England as something that would be welcomed across the NHS as good practice.

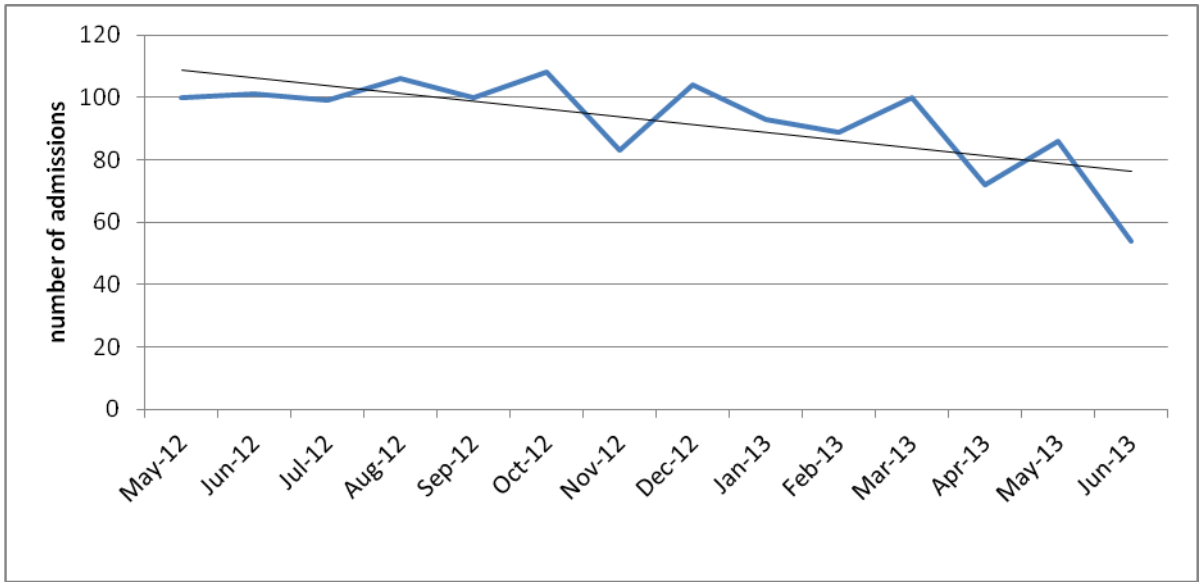
7.5 The Initial project aims were to:

- Reduce the number of people affected by these confections, thus avoiding distress, pain, discomfort and hospital admissions for residents and unnecessary expenditure for the NHS.

- Strengthen ties between the NHS and the care home sector, which have not, historically, been strong.

7.6 The pattern to emergency admissions to hospital from care homes showed a marked decline over the course of the project (Figure 40)

Figure 40: Northern Locality Care Home hospital admissions May 2012-June 2013



7.7 Since the start of the project, the team have made some improvements to how they work:

- The team are now notified of care home admissions to identify themes and trends.
- Undertaking retrospective review of admissions to the acute trust to identify which were preventable and what actions / training could be provided to help target further in future, using a Root Cause Analysis process and working with the care homes.
- On-going training support from the team features in Care Quality Commission action plans as part of a supportive programme.
- Roll out of training to cover wider conditions.
- Consider roll out of service across Devon.
- Consider support to Domiciliary Care Providers.
- Discuss the future of Locality Care Homes Teams, to include nursing, Occupational Therapy and Safeguarding Nurse.

Eastern - Exeter Nursing Homes Pilot

7.8 The pilot involved offering care home residents and their families the opportunity to take part in planning for potential health crisis, and to ensure plans are available to all partner organisations who may be involved in their healthcare.

7.9 Currently some residents are admitted to hospital as emergencies when they either not able to benefit from the admission or would have preferred not to have been admitted had they been consulted in advance of a crisis. This is most likely to happen out of hours when urgent care providers do not have either knowledge of the resident or access to their records.

7.10 The aims of the Exeter pilot were to undertake a targeted piece of work around identifying groups of patients living in care homes who could be managed in the community and subsequently avoid admission through identification, registration, education and advance care directives. The pilot ran for a period of six months from September 2012 to March 2013 involving three nursing homes.
Documentation produced on behalf of residents was held by Devon Doctors who agreed to lead the process of co-ordinating the transfer of information. This documentation was shared with appropriate partners such as Devon Doctors, ambulance and acute hospital staff.

7.11 There are some key areas that can be drawn out from the pilot, particularly from the qualitative interviews:

- The treatment escalation plans (TEP) process is empowering to patients, nursing home staff and reduces distress to patients, relatives and their carers when at the end of life.
- Treatment escalation plans need to travel with the patient but this doesn't happen consistently for patients being discharged from the acute hospital.
- General Practitioners found it easier to have end of life conversations when the patients were deteriorating. Is there a training opportunity?
- General practitioners found end of life work in nursing homes is not a matter of "tick box" exercise. Giving financial incentives for completing the treatment escalation plans doesn't work. What is important in providing quality and appropriate care to residents is having the time and space to build relationships with patients and carers to enable end of life conversations.
- Using collated data i.e. admissions and place of death, to infer impact of pilot was not effective.

7.12 A qualitative evaluation was undertaken and the intervention was well received and deemed of value. The next steps identified by the project included:

- Further work needs to be undertaken to understand how the medical and nursing needs of care home residents can be met. This pilot shows that time is essential and necessary to look at improving the quality of care provided at the home, supporting patients and their families concerning advanced care and end of life issues. Even when GPs have been funded for this additional work, capacity in general practice is limited.

- Projects to encourage general practitioners to work more closely with nursing homes to enable better relationships with families and nursing home staff are necessary. A specific medication review as part of any future project would be useful in improving quality of care.

Eastern Locality - Local Enhanced Service (LES)

7.13 The Local Enhanced Service defined Advance Care Planning as the description for the process of discussing and planning ahead for example in anticipation of some

deterioration in a patient's condition. There are two specific but overlapping areas within Advance Care Planning:

a) Advance Statement - discussion of people's preferences, wishes and likely plans i.e. what they wish might happen to them. These are generally called Advance Statement/Statement of wishes. These are not legally binding, but are invaluable in determining planned provision of care. The process of discussing this can be seen as part of the solution in that it enables emotional 'catch up' and adaptation to the new reality and normalisation of life. Sensitive discussion of advance care planning can strengthen coping mechanisms and enable realistic planning.

b) Advance Decision - these clarify refusal of treatment or what patients do NOT wish to happen, involves assessment of mental competency to make that decision at the time and when accurately formulated, can be legally binding. See Mental Capacity Act 2005. It also strengthens the role of the Lasting Power of Attorney to enable a nominated proxy person to make decisions about medical as well as social welfare.

Western Locality and Plymouth

7.14 Plymouth has a programme of work to support and improve quality in care homes. They established a Quality Assurance & Improvement Team in July 2012 to work within the Joint Commissioning Team. It was developed to have a structured and proactive approach to monitoring and supporting the improvement of the quality of care in the care home sector. The team includes care home practitioners who undertake quality reviews based on a risk assessment framework. The quality reviews take place in the care home, in collaboration with the registered manager, over a period of 2 days. The care home practitioners review documentation within the home, including various audits, staff files and care plans. The review also involves speaking to various staff members and, where possible, residents, to gain their feedback on the running of the home. During the period of July 2012 – December 2013, a total of 57 full Quality Reviews were undertaken, which represents 53% of the Plymouth care homes.

7.15 Plymouth established a Dignity in Care Forum in February 2009. The purpose of the forum is to look at operational issues around training, help and advice with improving quality of commissioned services. It also aims to improve dignity standards in care home settings and raise awareness of current local and national initiatives in the sector. The Forum is focused around the 8 key themes of the My Home Life programme and the Older Persons Charter.
The Forum is a multi-agency approach and is attended by colleagues in Plymouth Hospitals NHS Trust, the Medicines Optimisation Team, NEW Devon CCG and the voluntary sector. There are guest speakers at each event, including representatives from St Luke's, Infection Control and Tissue Viability.

7.16 The Dementia Quality Mark model was created in 2010 by David Francis and was established in Plymouth in 2011. 30 care homes have been awarded the Dementia Quality Mark (March 2014) and further applications are in progress. Plymouth has also established a lleadership programme for registered care home managers.

7.17 The Western Locality have commenced a care home project which will ensure care home residents are flagged on the clinical system and is looking at advanced care planning.

South Devon and Torbay Clinical Commissioning Group

Medical Admissions Team (MAT) Care Homes Intervention

7.18 There are 222 care homes in South Devon and Torbay, home to 3,892 older people.

7.19 Care home residents make up 1% of our population, but 6% of the emergency admissions. There are around 1500 emergency admission a year from care homes, and around 400 ambulance 999 calls a month. One in six is discharged the same day and one in five has a one day length of stay. In 2011-12 there were 1,783 emergency admissions from care homes. 74% of these admissions came from 39% of the care homes. These admissions cost around £4 million a year. Two nursing posts were employed in the MAT team.

7.20 The aims of the project were to:

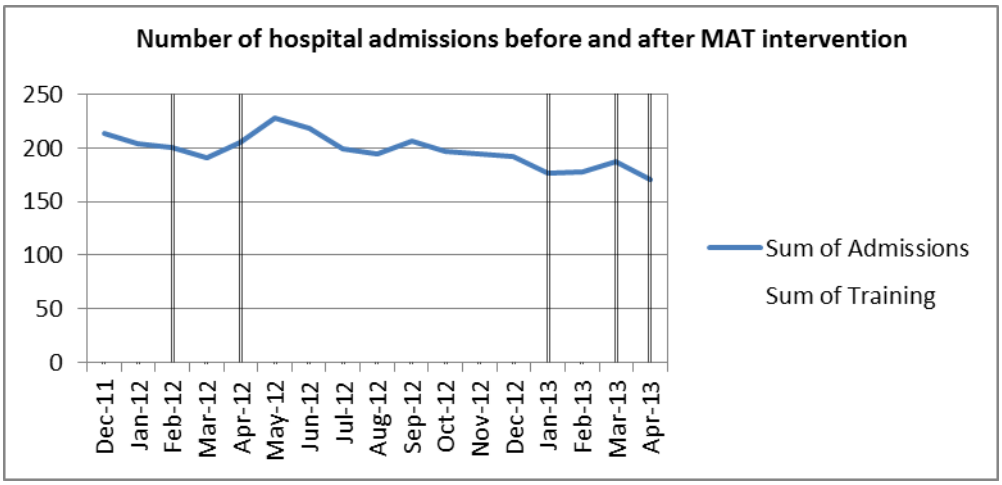
- Provide information/advice/training to residential and nursing homes to prevent admissions, combining visits with other professionals where possible. Delivered in each locality in one venue with care home staff invited to attend.
- Deliver acute nursing treatments in care homes to avoid a hospital admission.
- Initial plans were for the team to target the top 20 highest-cost admitting care homes calculated on a ratio per bed.
- Training events joined with other healthcare professionals, e.g. GSF care home facilitators for end of life care, falls education.
- To ensure resilience, the two nurses allocated to work with the care homes are rotated around the medical admissions team (MAT team).

Figure 41 shows the preliminary findings.

7.21 The project achieved:

- 8 training sessions
- 71 homes attended training sessions (total of 152 staff)
- 45 homes received clinical input from the team (68 episodes of care)
- 34 homes received observation and sepsis training

Figure 41: Trend in hospital admissions from care homes in South Devon and Torbay CCG December 2011 – April 2013



7.22 Evaluation feedback showed that this was a useful tool for building on engagement with care homes, as well as helping to improve quality of care and reduce unplanned admissions to hospital. When comparing the number of admissions for the same period the previous year, the total number of admissions fell by 18% for the top 20 homes, by 11.3% for all homes that have received training, by 18% for those who have received focussed support, and by 15.5% for all care homes in that period.

7.23 The number of people in care homes in the area has fallen, which is likely to account for some of the reduction in admissions. This doesn't account for complexity of patients as it will be the less complex people who have been supported in their own homes, those less likely to have contributed to the admissions Figures. A similar reduction in care home admissions was seen in the wider care home population so the intervention was not funded for 2014-15.

7.24 The Brixham and Paignton locality of South Devon and Torbay Clinical Commissioning Group commenced a care home pilot in 2014 working with local health and social care teams and primary care supporting care homes on long term condition management.

7.25 The area also has a Quest tool for care homes which the community provider uses to identify issues in care homes and provides support to improve quality. A CQUIN has been used to incentivise training but was evaluated and had no measurable impact on outcomes for residents.

7.26 Evaluation of care home interventions are challenging as there are likely to be many confounding variables.

General

Recuperative Care and Short Term Care in Care Homes

7.27 As part of the health and social care integration fund (section 256 funding) recuperative care placements were funded to provide an alternative to hospital based care and in some cases to avoid a hospital admission.

7.28 In September 2013 South Devon and Torbay Clinical Commissioning Group made 20 placements, 10 of which were to avoid a hospital admission. The cost of a recuperative care bed is £60-80 per day compared to £350-400 for an acute bed. The use of care homes for recuperative care is a cost effective measure to reduce hospital admissions. Northern Devon Healthcare NHS Trust covering Northern and Eastern Devon also used 256 funding to utilise recuperative care placements in care homes and made 61 placements with significant cost savings, the average length of stay was 4.4 weeks but this provides a more comfortable and suitable location than an acute or community hospital bed. It also allows a stay potentially closer to home and support networks.

The Sector

7.29 In the Devon a dementia quality kite mark has been developed and ccommenced as part of the work of the local 'Dementia Task and Finish Group' in July 2012. An initial working group (becoming steering group) of 6 care providers representing 13 care and nursing homes addressed residential care developing a plan and priorities through a series of workshops. The work seeks to:

- Developing a means to raise the profile for the best standards of care for people in residential care with dementia.
- 'Driving up quality' as a core principle. This is a term often used and was agreed as a theme underpinning the process.
- Construction of the QKM was to use the best evidence available.
- Developing and implementing a peer review and support process.
- Working on producing a consensus statement to offer a consistent approach in reputation enhancement and common values for providers of care to people with dementia needing residential support.
- Ensuring that the core group are open and transparent in the work through regular updates to the DT&F group, and open inclusive range of meetings and having guest / observers involved in the progress.
- Providing commissioners with a 'commissioning tool' to assist in the purchasing of compliant, progressive and high quality care for people with dementia needing residential care.
- developing a 'phased approach' to implementation with initial scoping, engagement through skills based workshops, peer review, training and wider sharing and roll out

7.30 The Introduction of 'Peer Review' in April 2013 brought a credible supportive 'sharing to learn' focus on homes having a commitment to improvement. Regular presentations and progress updates to a variety of conferences, meetings and national events have been undertaken to share the learning.

7.31 In May 2013 the group ran the first of the bi-annual 'Owner / Manager Dementia Quality Kite Mark Masterclass and three programmes have run to date and a further is planned for October 2014.

7.32 Features of the kite mark programme include:

- It is provider led – thus offering 'real time' credible support to fellow care providers based on an 'appreciative inquiry' non-judgmental approach
- Reputation enhancement and a visible declaration of aspiring to be better through using best evidence, consensus and shared learning are central
- Like mindedness based on open and transparent value based quality principles linked to humanist theory

7.33 The peer reviews scheduled for 2014 include safeguarding, fall prevention, activities, end of life care, long term condition management and provide a full programme to cover issues raised in the HNA.

7.34 The group is also in discussion with several local bodies regarding independent validation of the work these include Age UK Devon, Skills for Health and Skills for Care.

Provider Engagement Network (PEN)

7.35 Devon has a provider engagement network, which provides a forum to meet and discuss emerging issues relating to the care home and wider sector. Plymouth has a dignity forum and such forum provide an opportunity to drive improvements collectively.

Voluntary and Community Sector

7.36 Care homes may engage with their local communities and supporting voluntary and community sector organisations some support services are commissioned or provided by Council activities.

7.37 Funded through the Prevention Strategy a falls prevention strength and balance programme is being piloted in a number of care homes across the Devon area. The hope is that the programme will raise awareness of falls prevention and provide opportunities for move on exercise programmes such as walk and talk and use of leisure services.

7.38 Devon County Council funded a volunteering programme in its own homes (FFAVA), which supported friends, family and volunteer activities and included opportunities such as reading projects.

7.39 There is also a women's royal voluntary service (WRVS) reader project in care homes providing a local library service for care home residents.

7.40 The programmes have not yet been fully evaluated and it is clear links with the sector will support opportunities to reduce social isolation and a parity of access to such services should be available for care home residents.

Primary Care Input in Care Homes

7.41 NHS England commission primary care contracts and practices have a contract which is supplemented by locally enhanced services (LES) which are agreed with CCG's and directly enhanced services (DES) which are set nationally. For 2014/15 there is an 'unplanned admissions enhanced service: proactive case finding and care review for vulnerable people' DES which will have implications for the relationship between care home residents and general practice.

7.42 Contractual arrangements with providers vary across Devon with some having contracts with local practices, some using national contracts with doctors and others utilising local arrangements. A better understanding of the landscape in Devon is necessary to allow developing models with primary care to secure improvements in care homes.

7.43 The regulations require that the care home must make suitable arrangements to protect the health, welfare and safety of service users in circumstances where responsibility for the care and treatment of service users is shared with, or transferred to, others, by means of:

- Working in cooperation with others to ensure that appropriate care planning takes place.
- The sharing of appropriate information in relation to:
  (i) the admission, discharge and transfer of service users, and
  (ii) the co-ordination of emergency procedures; and
- Supporting service users, or persons acting on their behalf, to obtain appropriate health and social care support.

8. Discussion and Observations

8.1 A small percentage (about 1%) of residents in Devon live in care homes but they are some of the area's oldest and most vulnerable individuals. Many residents spend a short period of time in a care home and may move homes due to increasing dependency or spend the end of life within this setting. Care homes vary in size and type of ownership and offer a varied provider landscape of around 686 homes. Some care home residents have complex needs but many other residents live in residential care through choice or due to care and support needs but they may be are otherwise in good health. Some younger residents live in care homes but the vast majority are over 75 years.

8.2 Limited work has been undertaken to understand the health needs of care home residents but there has been some national work by BUPA and the Alzheimer's Society. The health needs assessment has considered the evidence base, local and national intelligence and local initiatives and interventions to date to try to understand the needs of the care home population. The health needs will vary in complexity and it is important to consider the wider issues impacting on health such as lifestyle factors, social interaction and quality of life as well as the more complex issues of end of life and safeguarding.

8.3 A number of initiatives in Devon, Plymouth and Torbay are in place or have been piloted to support care home owners and improve the quality and safety of care in care homes. The Care Home Quality Collaborative was formed in 2013 and is developing a vision for care homes in the area. The collaborative has shared learning to date as illustrated by the range of activities in section 7. The local interventions are difficult to evaluate as the work follows a cohort of residents at a point in time. Some success has been seen in North Devon and other areas but the interventions will be impacted by other work that is being undertaken. The literature review found that many studies were observational and called for further research; there is a lack of randomised control trials so there is not a strong evidence base to work from. Training for care home staff has been cited in many studies in a range of areas such as end of life and nutrition. A collaborative approach to training could be developed with providers reflecting the needs identified in the health needs assessment, locality intelligence and the experience gained by providers and commissioners on interventions to date. The length of stay in care homes can be short and support and interventions need to be timely to ensure they are effective.

8.4 A review of emergency admissions data revealed that there are a significant number of emergency admissions from care homes and the costs of admissions from care homes and number of bed days from hospital admissions from care homes are significant but this is not surprising based on the demographic of the care home population. The admission rate from care homes for ACS conditions is statistically significantly higher than the wider population of that age for certain conditions including asthma, diabetes complications, convulsions and epilepsy, dehydration and gastroenteritis and ear nose and throat infections (figure 23). As discussed in the body of the report caution is needed interpreting the data but consideration of locality intelligence on admission rates is worthwhile and supported by national guidance (Quality watch 2013) consideration of where admission rates are higher than expected may be useful.

8.5 Falls prevention and post fracture support in care homes should remain a priority due to the volume of fractures, particularly fractured neck of femur but also because of the impact on the resident's future outcomes and quality of life.

8.6 A focus on quality in care homes is important and the collaborative is seeking to further define quality standards, Plymouth has already put a quality improvement team in place and Torbay and Southern Devon Health and Care NHS Trust are using a QUEST tool to assess quality. It is important to ensure that quality is considered in the widest sense and account is taken of the NICE Quality Standards, particularly QS50 'Mental Wellbeing of Older People in Care Homes.' Quality of life should include access to physical activity opportunities commensurate with ability, social interaction and support for personal relationships and needs and also ensure consideration of protected characteristics. Equity of access to lifestyle support services such as smoking cessation should also be in place. Involvement of residents and their carers in decisions about their care is important. A good quality of life for residents of care homes should be defined and agreed with care home residents through local engagement. Medicines management and optimisation is an important part of the work of the care home quality collaborative.

8.7 The evidence review has demonstrated the lack of evidence of effective care home interventions so the local approach to collaborative learning is good practice and this should be coupled with consideration of the national evidence base as it emerges. Any interventions should also consider the context of the locality environment as many projects may not be portable to a local setting with a different configuration of services. A consistent approach to evaluation of local schemes is essential to allow comparison and evaluation of cost effectiveness.

8.8 Locally models of care closer to home are being developed and this should include support for residents to maintain independence and reduce the need for permanent admissions to care homes, in dementia care this will be become increasingly important.

8.9 The needs assessment has highlighted the need to understand the respective roles of organisations working with care homes and an example where further clarification is needed relates to infection control and understanding and ensuring flu vaccination coverage for care home residents. Another area is the role of primary care and community services working with care homes as there is some variation across the area and potentially this may lead to gaps in services.

8.10 The health needs assessment has described the range of agencies working with care homes including primary care, community services and acute services in addition there are services enforcing standards including the Care Quality Commission, Health and Safety Executive and Environmental Health and Public Health England who may be investigating outbreaks or providing advice. This is in addition to Commissioners contracting with care homes. The agencies need to work collaboratively to avoid duplication of effort and lack of clarity for home owners which could impact on the resident health, safety and wellbeing.

8.11 The proposal of the Care Home Quality Collaborative to improve engagement with care home residents and families and carers of residents should improve qualitative understanding of the health needs of the care home population and further define a good quality of life for care home residents.

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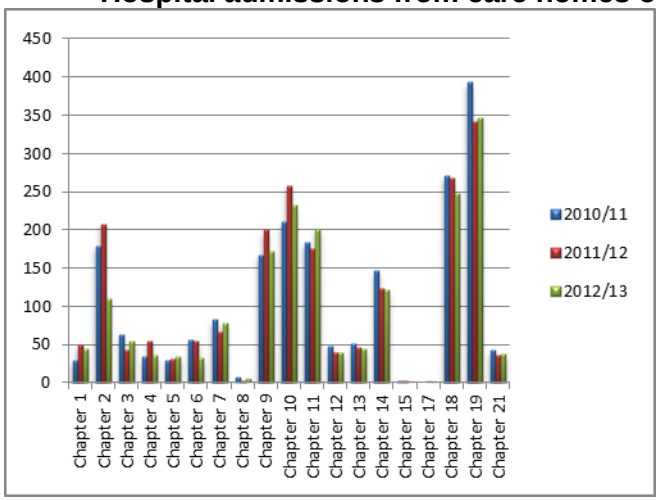
APPENDIX 1

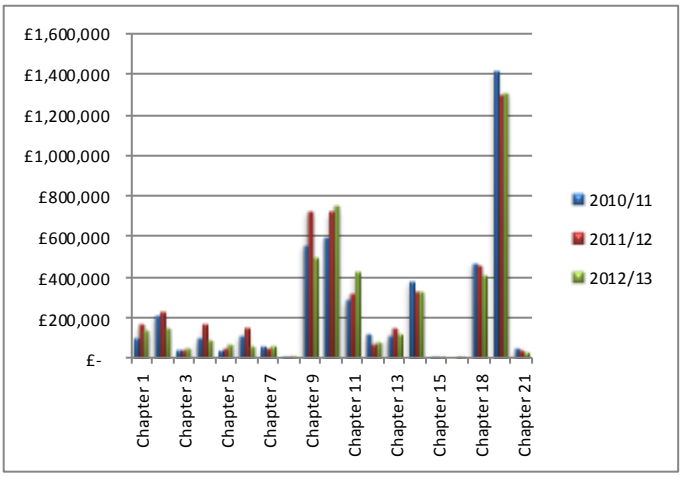
Emergency Admissions by Locality

International Classification of Disease 10 Chapter	
Certain infectious and parasitic diseases	Chapter 1
Neoplasms	Chapter 2
Diseases of the blood and blood-forming organs	Chapter 3
Endocrine, nutritional and metabolic diseases	Chapter 4
Mental and behavioural disorders	Chapter 5
Diseases of the nervous system	Chapter 6
Diseases of the eye and adnexa	Chapter 7
Diseases of the ear and mastoid process	Chapter 8
Diseases of the circulatory system	Chapter 9
Diseases of the respiratory system	Chapter 10
Diseases of the digestive system	Chapter 11
Diseases of the skin and subcutaneous tissue	Chapter 12
Diseases of the musculoskeletal system and connective tissue	Chapter 13
Diseases of the genitourinary system	Chapter 14
Pregnancy Childbirth and Peurperium	Chapter 15
Congenital malformations, deformations and chromosomal abnormalities	Chapter 17
Symptoms, signs and abnormal clinical and laboratory findings	Chapter 18
Injuries, poisoning and certain other consequences of other causes	Chapter 19
Factors Influencing Health Status and Contact with Health Services	Chapter 21

Eastern

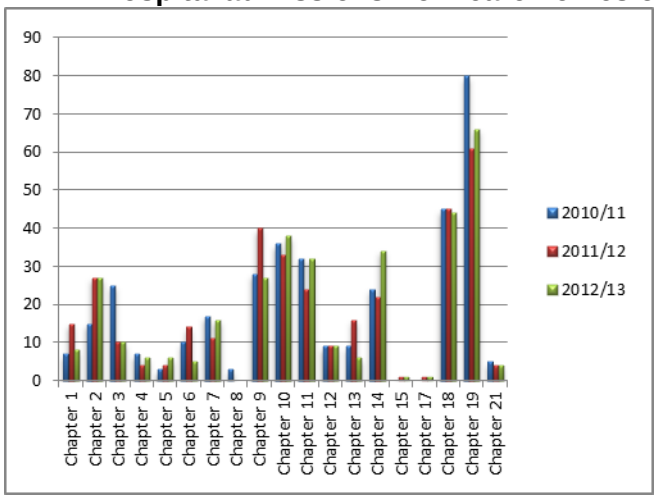
Hospital admissions from care homes over three years by volume and cost

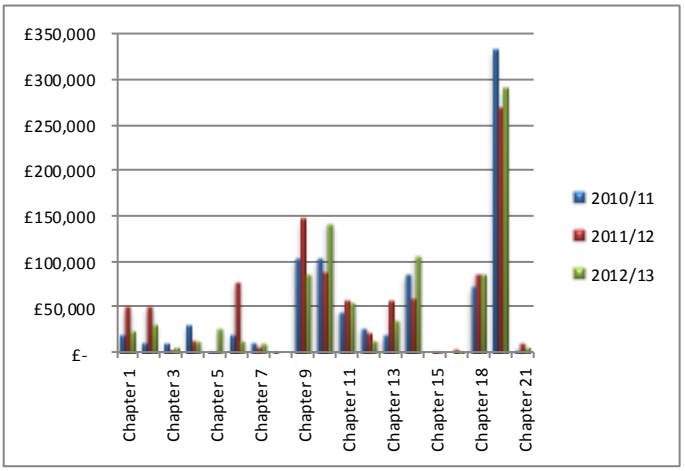




Web

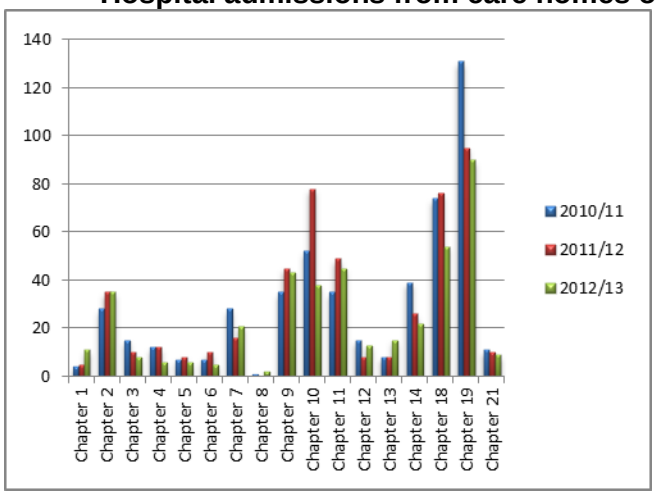
Hospital admissions from care homes over three years by volume and cost

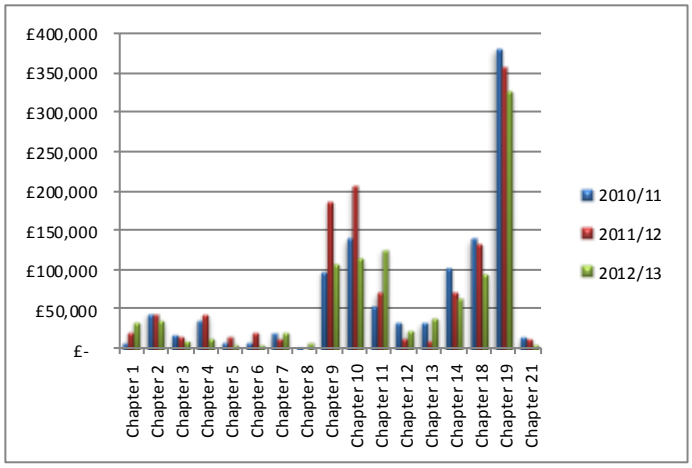




Wakely

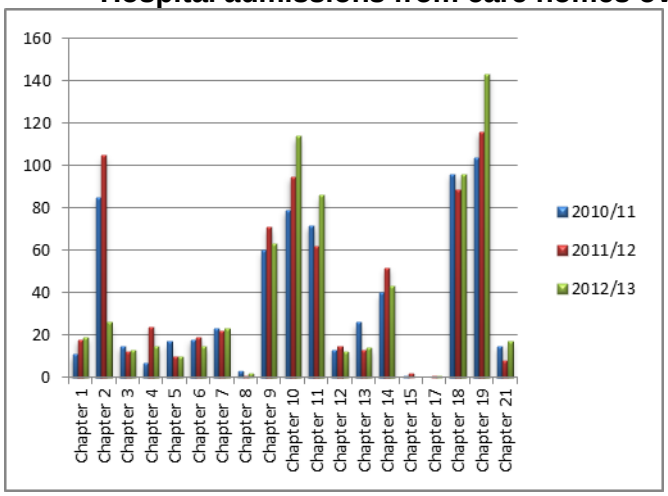
Hospital admissions from care homes over three years by volume and cost

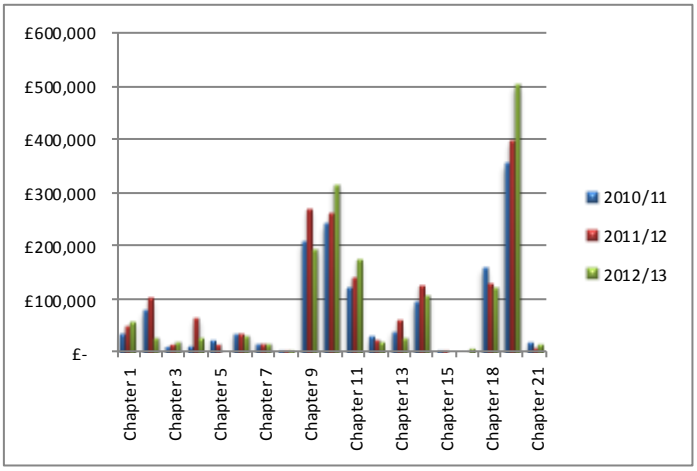




Exeter

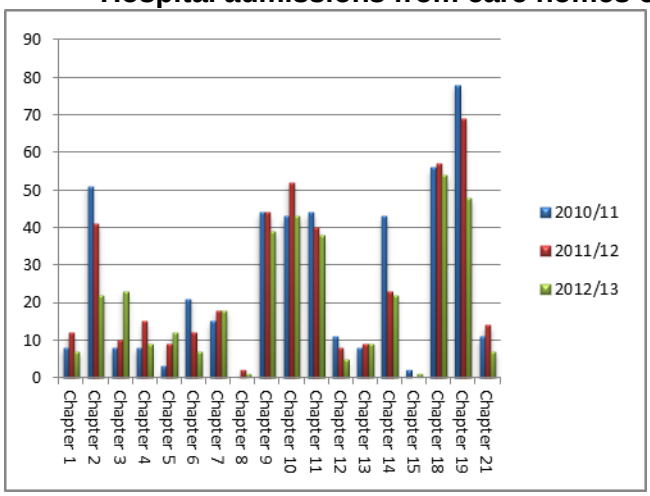
Hospital admissions from care homes over three years by volume and cost

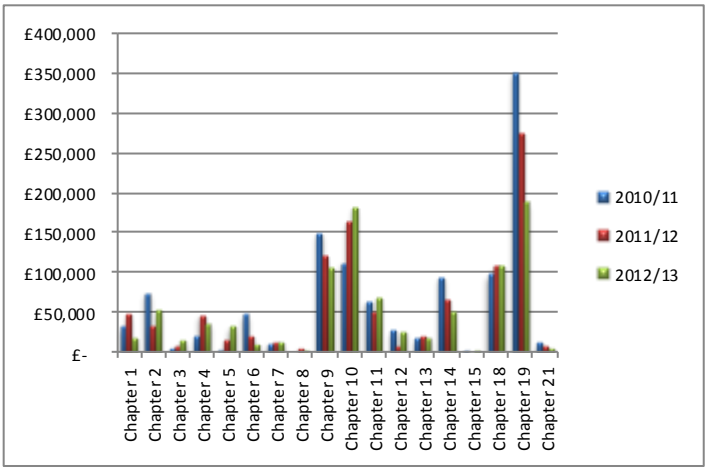




Mid Devon

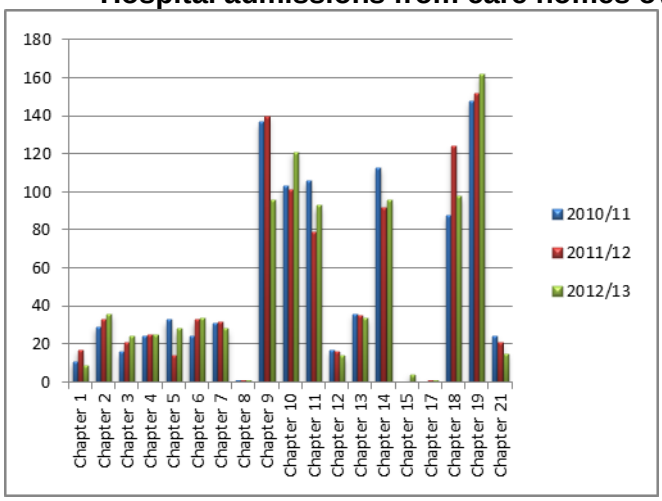
Hospital admissions from care homes over three years by volume and cost

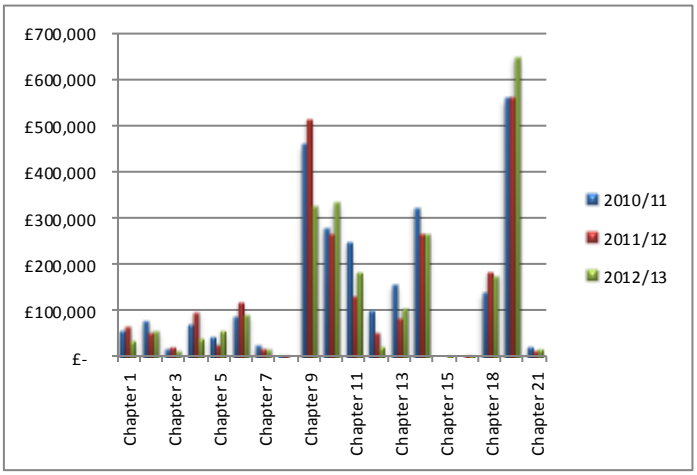




Northern

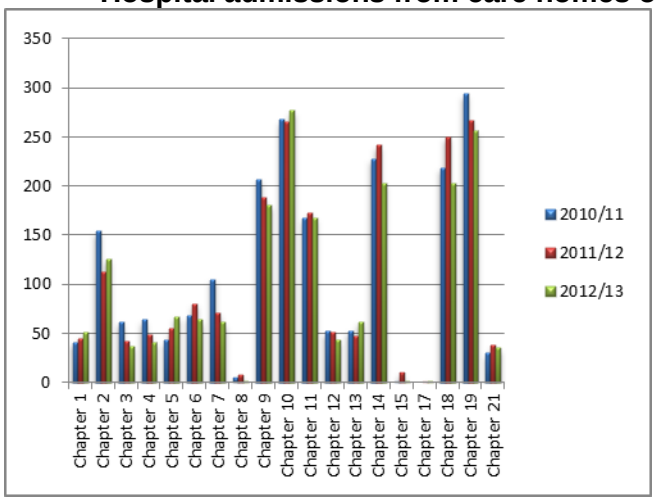
Hospital admissions from care homes over three years by volume and cost

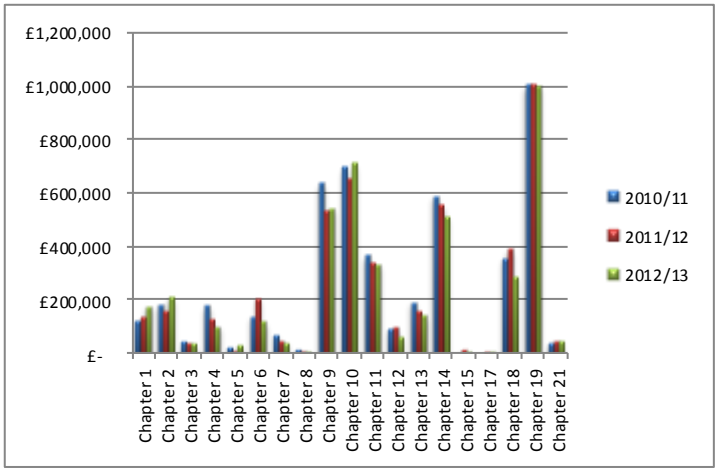




Western

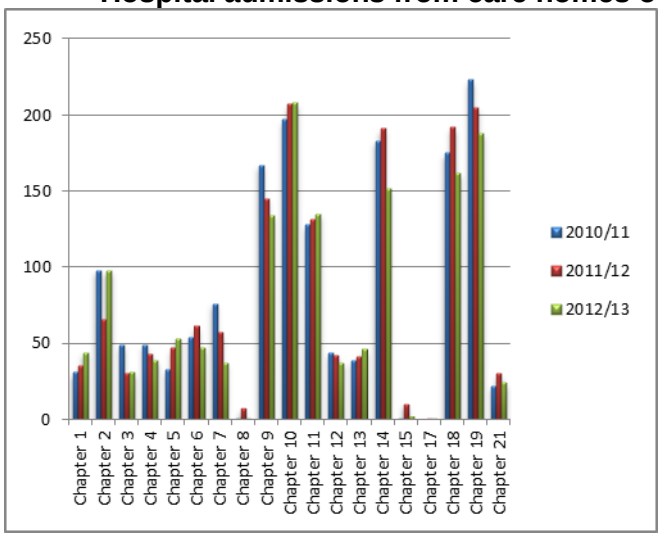
Hospital admissions from care homes over three years by volume and cost

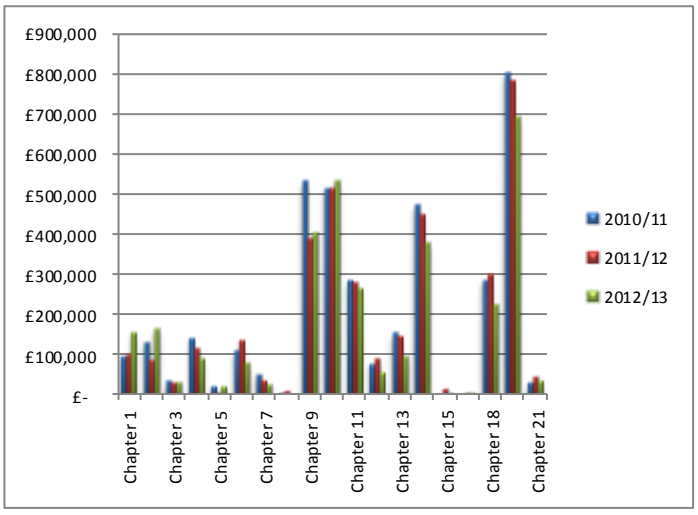




Plymouth

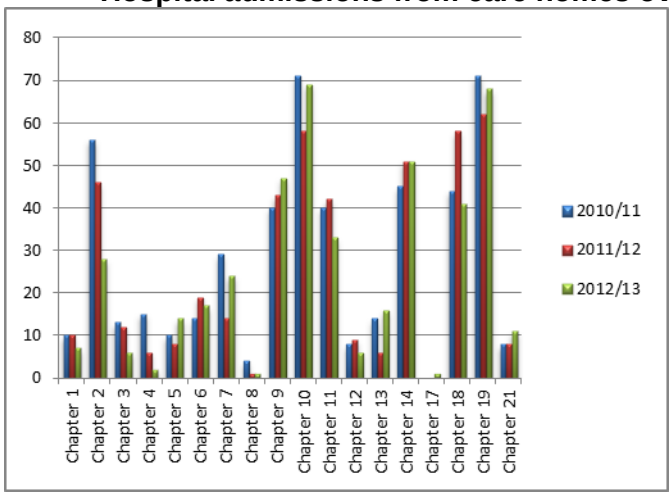
Hospital admissions from care homes over three years by volume and cost

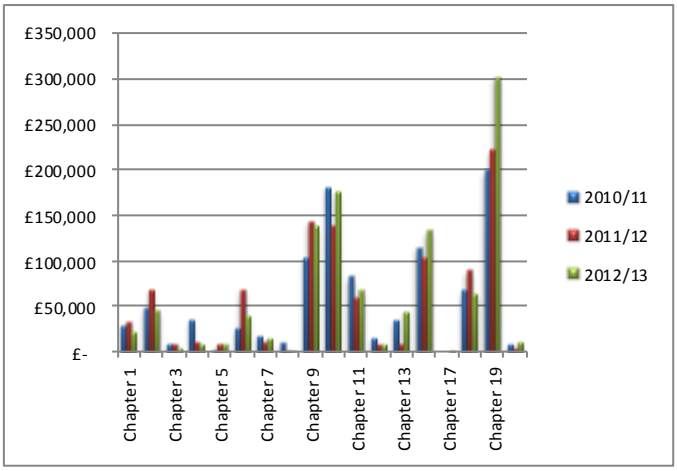




South and West Devon

Hospital admissions from care homes over three years by volume and cost

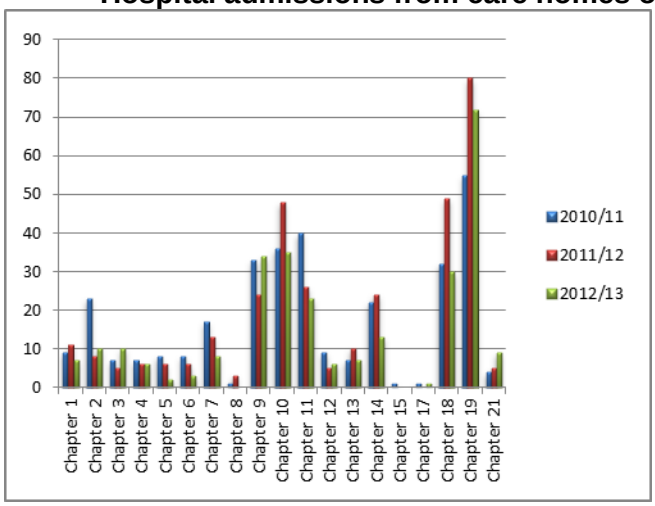


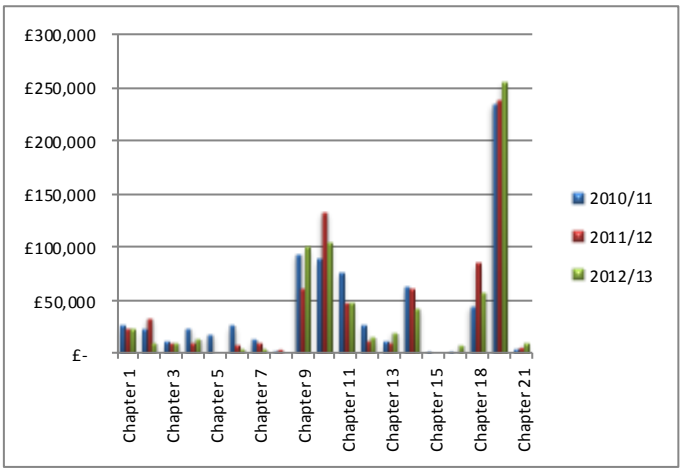


SOUTH DEVON AND TORBAY CLINICAL COMMISSIONING GROUP

Coastal

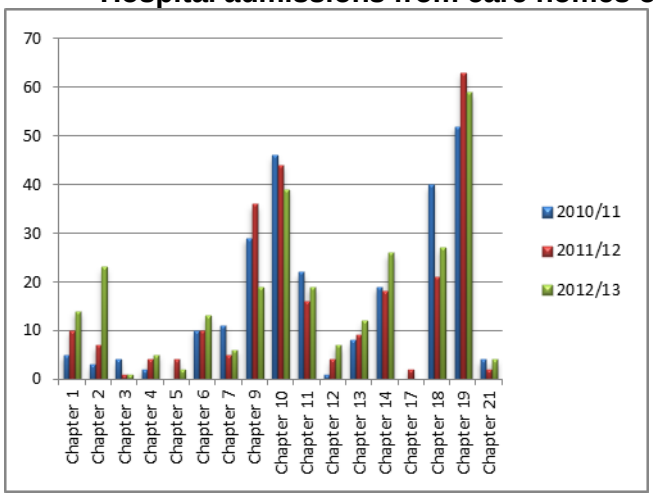
Hospital admissions from care homes over three years by volume and cost

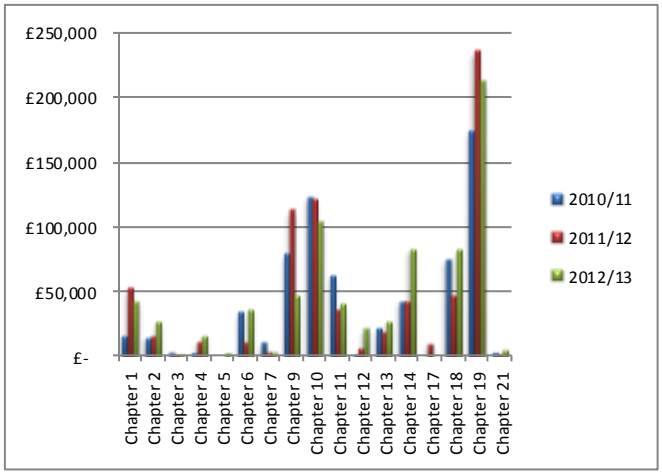




Moor to Sea

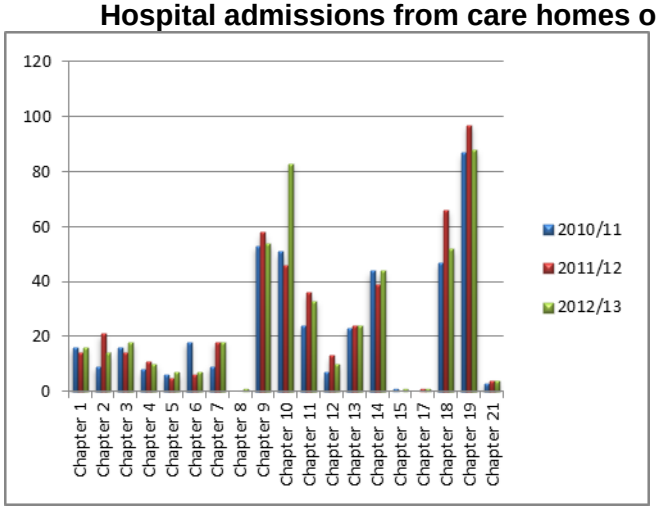
Hospital admissions from care homes over three years by volume and cost

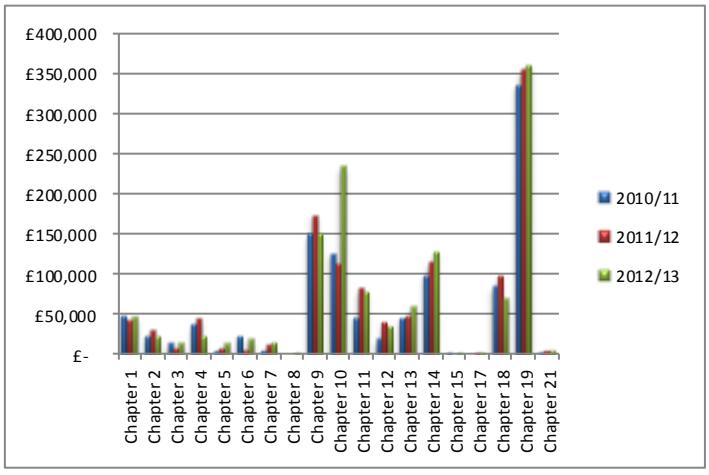




Newton Abbot

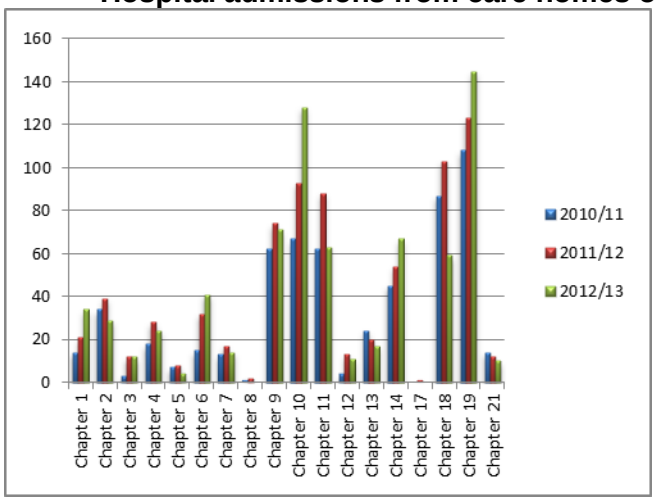
Hospital admissions from care homes over three years by volume and cost

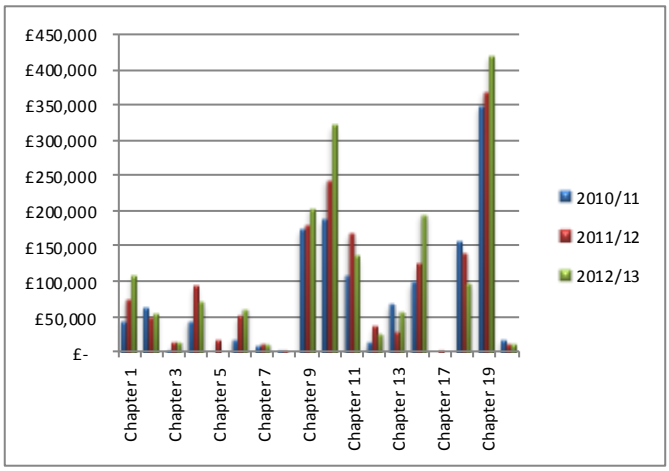




Torquay

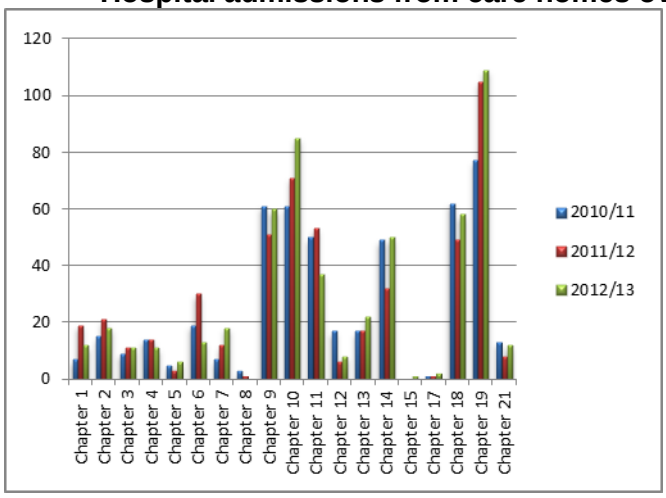
Hospital admissions from care homes over three years by volume and cost

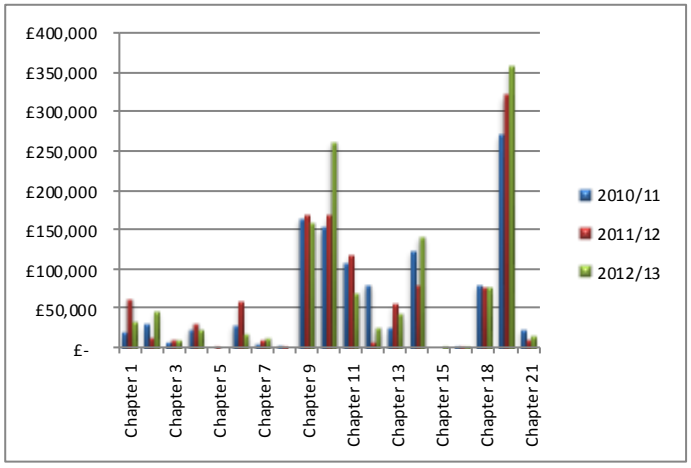




Paignton and Brixham

Hospital admissions from care homes over three years by volume and cost





APPENDIX 2

A Literature Review of Care Home Residents Health Needs

Introduction

This literature review on the health needs of care home residents was conducted to inform a health needs assessment of care home residents. The review has drawn together headline findings from relevant secondary literature sources to summarise published health needs.

Search strategy

As part of the Care Home Residents Needs Assessment a literature review was undertaken to consider interventions in care homes the search yielded 5629 results so was refined to include studies from 2008 to December 2013 which yielded 2235 results. The search included MEDLINE, EMBASE, CINAHL, PsychINFO and BNI, the Cochrane Collaboration Library; was also searched using the terms 'care homes' with refined searches for 'falls' AND 'vitamin D falls' AND 'dementia'. A search for 'care of older people' was also undertaken.

Evidence reviewed

The Health Needs Assessment gives an overview of the Cochrane Systematic Reviews identified and an overview of the other references identified. Abstracts were reviewed to discern relevance to this needs assessment and health and healthcare needs that would be relevant to the local population. Studies concerning more generalised topics such as dementia and care for older people in communities have not been considered in this review which has tried to focus on relevance to care homes. Consideration was made of the relevance of studies to the UK and Devon context.

The Care Quality Commission Kings Fund and NICE websites were considered to identify other relevant publications and documents for the literature review.

Summary

A review of the literature highlights the paucity of robust medical studies that consider the health and wellbeing needs of care home residents. Many of the studies have been observational and of poor evidential value and many systematic reviews were inconclusive. This made local needs assessment challenging for two reasons: 1) the lack of local data and 2) lack of relevant studies.

A summary of the literature reviewed has been produced but not appended to this document.

APPENDIX 3

Equality Act Protected Characteristics

The table below summarises issues for care home residents for the nine protected characteristics from the Equality Act 2010.	**Overview**	**Devon Population**
Protected Characteristic		
Age	By their nature care homes support predominantly older people. High in-migration in Devon at retirement age influences local patterns.	
Disability	People with a learning disability are more likely to experience ill-health and die prematurely and use of screening and health services in this population are known to be low. People with disabilities are more likely to smoke, have a poor diet and limited physical activity, and a higher prevalence of diabetes and heart disease.	PANSI/POPPI estimate for any learning disability is 7,900. 2011 Census figure for persons with a long-term health problem or disability that limits activities a lot is 27,500.
Gender	The majority of care home residents are female so the needs of male residents need to be considered to avoid social isolation. Behavioural risk factors and resultant health problems are usually more common in males.	
Marriage & Civil Partnership	To ensure dignity and respect the status of residents remains relevant as are future life choices within the home.	
Pregnancy & Maternity	Access to services for care home residents should be equitable. The numbers of pregnancies in care homes is not known.	
Race	The pattern of risk factors and the likelihood of developing health conditions vary by ethnic group. Smoking rates are particularly high in Black Caribbean and Bangladeshi men. Heart disease risk is highest in Bangladeshi and Pakistani groups, stroke risk is higher in Black Caribbean groups and type 2 diabetes is highest in Black Caribbean and Indian men. The number within care homes as the percentage in the population as a whole will be very low and will be an important issue for care home residents	**White British** 341,200 **White Other** 7,500 **Mixed** 1,400 **Asian** 2,000 **Black 500** **Other 500**
Religion & Belief	No definitive evidence around the distribution of risk factors and resultant health problems associated with religion and belief. Limited evidence found, important for care planning.	
Sexual Orientation	LGB people may be apprehensive about homophobia or heterosexual assumptions in care homes, whether or not this is borne out by experience. Stonewall's Working with older lesbian, gay and bisexual people recommends that care providers avoid assumptions around sexuality, use open and respectful questions when asking about family and partners. Ensure the same-sex partners are treated with the same respect as opposite sex partners. Ensure that carers are trained and committed to	**LGB Population Estimate** 3,800 over the age of 55

	equality and diversity and know their duty under the Equality Act 2010. Create an open and welcoming environment that reassures LGB people that they are safe to come out. Be aware that LGB people may be at risk of homophobia and exclusion by other residents, as well as staff. While there is a lack of evidence in relation to older trans people, it is reasonable to expect similar patterns of increased isolation and vulnerability. 65% of participants in the *Trans Mental Health Study* (McNeil 2012) say they have worried about growing old alone because of being trans.	
Gender Reassignment	No definitive evidence around the distribution of individuals is known.	**Estimate < 100 total in Devon as a whole**