

# Enhanced health in care homes

Learning from experiences so far

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# 1 Introduction

Caring for older people in care homes is one of the most important priorities for the health and care system in England. The ‘average’ care home resident is an 85-year-old woman, with a life expectancy of 12–30 months. Her care needs are likely to be extremely complex, with six or more diagnosed conditions, seven or more prescribed medicines, and a combination of physical frailty, disability and mental health conditions. Older people are the fastest-growing section of the community: the number of people over 85 is expected to double within two decades. The number of older people living in care homes in England (currently 329,000) is already more than three times the number of hospital beds, and is set to increase further ([Care Quality Commission 2017](#); [National Institute for Health Research 2017](#); [Wittenberg and Hu 2015](#)).

A string of studies and reports have consistently shown that care home residents – most of whom are already in vulnerable circumstances and have complex needs – often have poor access to health services and especially a full range of quality services that meet their needs (*see*, for example, [Healthwatch 2017](#); [Smith \*et al\* 2015](#); [Care Quality Commission 2012](#); [British Geriatrics Society 2011](#)). This is one of the most striking inequalities of the English health and care system.

Historically, care home residents have been under-represented in dementia and other research, and care home services have often been considered separately to health care. But this is now starting to change ([National Institute for Health Research 2017](#)). NHS England’s programme to develop new care models is a practical embodiment of the recognition that good health, health care and social care are mutually dependent and need to be approached together ([NHS England, undated b](#)). One of the new care models specifically promotes enhanced health in care homes, while others that are focused on urgent care or community services include care homes as key partners.

Hospitals, GPs, community health and social care services working together as one local care system, rather than fragmented or competing services, is also increasingly deemed essential if levels of quality and access to health and care services are to be sustained ([Ham and Alderwick 2015](#); [NHS England \*et al\* 2014](#)). The NHS and local



authorities face significant pressures around capacity and demand ([Robertson et al 2017](#); [Baird et al 2016](#); [Maybin et al 2016](#)). The environment for care homes is also extremely challenging, with concerns about the fundamental viability of the way the market operates, and day-to-day difficulties such as a 28 per cent staff turnover rate across social care services ([Care Quality Commission 2017](#); [Competition and Markets Authority 2017](#)).

Working together more closely will involve practical changes, such as more integrated care processes and better communication. It will also involve changing cultures, mindsets and power relationships – not least the relationships between large health organisations with highly professionalised staff, and care homes, which are usually small enterprises with staff who often do not have formal qualifications.

For several years, The King's Fund has helped to develop and promote improvements in practice, understanding and leadership skills to support these changes ([The King's Fund 2016](#)). In partnership with My Home Life, we have also run a learning network for housing, health and social care services working with care homes (see [The King's Fund, undated](#)). This report builds on that experience and is part of a growing focus within The King's Fund on care homes and social care.

The report will be of interest to people working in care homes, health services, local authorities and clinical commissioning groups (CCGs). Its purpose is to share learning from diverse areas about how staff in these organisations experienced the process of working together more closely. It focuses on what they have actually done to put the high-level aim of closer partnership working into practice.

In some areas, teams of health staff have provided intensive support to care homes facing challenges such as high rates of hospital admission or regulatory concerns. In others, health staff have started working routinely with care homes to ensure regular 'ward rounds' so that all residents' care is reviewed regularly. Other areas used an approach of continuous quality improvement, with providers supporting each other to develop a series of projects to improve care processes. Our interviewees said that common threads running through these different approaches included regular assessment and close working together on care processes, training staff from different organisations together, and a cultural change leading to shared ownership of responsibility for care and greater mutual understanding.



Various studies and reports have shown that when care homes and health services work closely together in these ways, they can achieve impressive results, such as reductions of 30 per cent or more in urgent admissions to hospital (Baker *et al* 2016). However, for every study showing achievements, there are others showing limited results, or that an approach that was effective in one area did not replicate the results when introduced in another. This is because the types of partnerships that are needed are highly dependent on relationships and on the local context of services, organisations and practices.

When developing projects to enhance health in care homes, a set of partner organisations is identified to define the area that the projects will cover. They then work out for themselves how to adapt and tailor NHS England's framework guidance (NHS England 2016b) and approaches such as those described in this report to their unique circumstances. The improvements that this enables can be significant, but there are no shortcuts: simply importing approaches developed elsewhere, without adaptation and without involving all stakeholders, is likely to fail. By synthesising and sharing experiences, and reflecting on their implications, this report should help local areas going through the process of developing partnerships and practices that will enable them to maximise the health, quality of care and quality of life for older people living in care homes.



## 2 Background

### Context

Older people living in care homes increasingly have complex health and care needs ([British Geriatrics Society 2016b](#)) including progressive frailty and end-of-life care ([Public Health England 2017](#); Bowman and Meyer 2014). Meeting those needs involves accessing a range of services and, when those health and care services are able to co-ordinate and work closely together, they can actively promote and enhance residents' health and wellbeing rather than only responding to crises. These two characteristics – co-ordinated services working together, and promoting good health rather than only reacting to ill health – are at the heart of promoting enhanced health in care homes. When put into practice, this involves regular comprehensive assessment and continuity of working together, multidisciplinary team (MDT) approaches, and health and care home staff learning together to develop their roles and skills in managing residents' health.

There is no single set of actions or processes that can be guaranteed to enhance the health of people living in care homes; instead, approaches need to be tailored to the unique context of each care home and its residents' needs. However, NHS England ([2016b](#)) has set out an overall framework for enhanced health care (see box). It has seven core elements within which local services can develop their own detailed approaches.



## NHS England's framework for enhanced health in care homes

Seven elements can enable care home and health care services to work together effectively to enhance residents' health. Progress is needed on all seven elements, rather than just some:

- enhanced primary care support into the care home (eg, regular visits and assessment, rather than reactive intervention only)
- multidisciplinary team support, including co-ordination of a range of health and social care services
- a focus on reablement and rehabilitation
- high-quality end-of-life care and dementia care
- joined-up commissioning of health and social care, and collaboration across the health and social care system (as well as between individual care homes, GP practices and community teams)
- workforce development, including consideration of training needs and new roles working across organisational boundaries
- development of data, information-sharing and use of information, with IT and technology enablers as appropriate.

NHS England has issued tools for self-assessment against these seven elements and is collating and sharing evidence, guidance and case studies to support local development.

Source: [NHS England 2016b](#)

This approach has received national prominence by its inclusion in six of NHS England's 'vanguard' services (*see box*). Vanguard sites act as demonstrator sites for new care models that have the potential to help meet three strategic goals for the NHS in England, as set out in the *NHS five year forward view* ([NHS England et al 2014](#)): closing current gaps in care quality, funding and efficiency, and health and wellbeing. However, many other areas of the country have also developed approaches to enhanced health in care homes and, in some cases, have been working together for many years.



### Vanguards for enhanced health in care homes

- Airedale and Partners
- Connecting Care – Wakefield District
- East and North Hertfordshire CCG
- Newcastle and Gateshead CCG
- Nottingham City CCG
- Sutton Homes of Care

Source: [NHS England, undated a](#)

The qualitative and relational nature of many of the changes involved in developing enhanced health in care homes, and the relatively small size of care homes compared to NHS trusts, may help explain why these vanguards have had a lower profile than some others, which involve major service redesigns and reconfigurations. However, their smaller scale does not mean that the changes involved are easy to achieve. A raft of studies and guidance have highlighted the difficulties and sensitivities of developing and sustaining the relationships, culture and leadership necessary for the range of services involved to work together effectively (see, for example, [Goodman et al 2017b, 2016](#); [Gordon et al 2017](#); [National Institute for Health Research 2017](#); [National Care Homes Research and Development Forum 2007](#)). At the same time, evidence on the number of hospital admissions that could be avoided through better co-ordination of services ([Smith et al 2015](#)) indicates that, where it is implemented effectively, enhanced health in care homes has the potential to achieve significant gains.

The development of enhanced health in care homes is taking place in a complex and challenging environment. In addition to the current capacity and financial pressures facing the NHS, it must also take account of pressures on local authorities and instability in the care home market.

There are 16,262 registered care homes in England. Almost all are in the independent sector and most are for-profit. The average size care home has 20 beds; only 10 per cent have more than 50 beds. Although 15 per cent of the



market is provided by four companies, the rest is made up of small organisations, each of which has less than 0.4 per cent market share (Jarrett 2017).

There is significant regional variation in the proportion of self-pay places compared to local authority-funded places, but overall about 65 per cent of people in care homes have some public funding support (Jarrett 2017). However, public funding is under pressure: since 1990, entitlement to NHS-funded continuing health care has progressively reduced, and there has been a 38 per cent reduction in local authority budgets since 2009/10 (Sutaria *et al* 2017).

Stability of the care home market has become a cause of concern, to the extent that arrangements were put in place in 2014 at both national and local levels to monitor and respond quickly if providers cease to be financially viable. The Competition and Markets Authority is currently carrying out a study into the care home market. The state of the local care home market may have an effect on relationships between care homes and health services. For example, care homes in challenging circumstances may have less capacity to engage with other services but, equally, those other services may be willing to act to avoid knock-on effects to the wider system of an unplanned and unmanaged market exit by a care home.

## About this report

This report draws on published literature about joining up and co-ordinating care homes and health services. It also draws on interviews with a range of providers, local authorities and CCGs. It aims to help care homes and NHS providers (including GPs), local authorities and CCGs who are thinking through how to join up and co-ordinate services locally and how to manage the complexities involved. Accordingly, our focus is primarily on the leadership, management and practice implications rather than the experience of care home residents.

We interviewed 30 individuals working in 15 local authority areas (*see box*). They included care home managers, proprietors and care assistants, GPs, community nursing and therapy team leaders, social care commissioners and designated leads for enhanced health in care home programmes in community trusts, GP federations, CCGs and local authorities. We selected these areas by seeking volunteers from a learning network set up by The King's Fund in partnership with My Home Life. Some areas contacted us on their own initiative to volunteer to share their experience.



We selected the areas to ensure diversity and to include different regions, urban and rural settings, different levels and geographical size of local government, different types of care home (number of beds, from single home to national group, for-profit and not-for-profit, different proportions of self-funded residents) and different types of GP practice (federated or not).

We identified relevant literature through a ‘snowballing’ approach of following up references in NHS England’s framework for enhanced health in care homes and any publications suggested by our advisers and interviewees, and then using those references to identify other relevant literature.

### **The 15 areas selected to participate in this research**

We carried out semi-structured interviews in the following local authority areas:

- Bolton
- Derby
- Derbyshire
- Dorset
- Essex
- Gateshead
- Herefordshire
- Lancashire
- Leeds
- Lincolnshire
- London Borough of Hammersmith and Fulham
- Norfolk
- Rotherham
- Warwickshire
- Worcestershire



## 3 What is the case for enhanced health in care homes?

### What sort of impacts can be achieved?

The box below gives examples of the kinds of achievements described by interviewees in areas with longer-standing enhanced health care arrangements.

#### What have enhanced health care arrangements achieved in care homes for older people?

- Significantly reduced hospital admissions for ambulatory care conditions, accident and emergency (A&E) attendances and ambulance journeys.
- Reductions in delayed transfers of care from hospitals, and more early discharges.
- Better continuity of care and involvement of residents and their families in care planning and review.
- Better prescribing practice (eg, anti-psychotic medication), including reductions in inappropriate prescriptions and in prescription costs.
- Reductions in falls, including through reviewing medication and physiotherapy assessments.
- Improvements in wound care.
- Reductions in depression among care home residents.
- Improvements in documenting and recognising symptoms, eg, in end-of-life care.
- Improvements in end-of-life care practice generally.
- Improvements in residents' quality of life.
- Increased confidence among care home staff, a greater sense of empowerment and feelings of connectedness to other services.



Many of these areas were able to demonstrate reductions in hospital admissions of between 30 per cent and even 50 per cent. The level of reductions varied, depending on the design and coverage of different approaches, the baseline in each area, the approach to measurement, and early versus ongoing reductions. However, guidance and studies of effective approaches also indicate that this significant scale of impact can be achieved in other areas. Of course, it should be emphasised that this level of impact is not automatic and cannot be achieved simply by importing processes developed elsewhere; the impact of any intervention will depend on it being tailored to fit the local context and on the culture, leadership and governance of the services involved ([Goodman et al 2017b](#); [Petch 2014](#); [Davies et al 2011](#)).

### How do projects to enhance health in care homes measure their impact?

Although a number of studies have assessed impacts on care home residents' quality of life, there is limited agreement on how best to define and measure quality of care and quality of life in care homes ([Goodman et al 2017b](#)).

Most interviewees in the 15 areas covered by our study had monitored the impact of enhanced health in care homes through a combination of:

- measures of potentially avoidable NHS activity (eg, hospital attendances and admissions, ambulance transport)
- measures related to quality of care, eg, Care Quality Commission (CQC) ratings, rates of incidents, falls and pressure ulcers, and number of complaints
- quality monitoring visits, including seeking the views of residents and relatives.

Some also monitored certain care processes (eg, percentage of residents reviewed within 72 hours of hospital discharge, or percentage with an anticipatory care plan in case of deterioration in their condition).

Only one area had a specific focus on monitoring the impact of its enhanced health activities on quality of life for care home residents. Its approach was to invite care home providers to come up with ways of promoting and monitoring quality of life, and then to further develop the approaches, which turned out to be useful.



*We said to care homes, 'if you come up with ideas about how to improve quality of life, we'll help fund them'. There's lots of evidence that getting people [in care homes] more active can help improve their health and wellbeing and mental stimulation. We're thinking very much about preventative approaches, like getting people more active. And they need to fit with the fact that these are people's homes. But what we're hearing from care homes is that they just don't have the resources. The grants are £4,000 but there's more in some cases.*

*We ran a small workshop to help them think about what they could do. What we recognised was that care homes do know their residents really well and have good ideas; they know what they are doing. Rather than us telling them what to do, we invited them to come up with the solutions themselves. We want to see what they come up with and what works, and then next year we may push the approaches that have most impact with other homes.*

(Local authority)

### **How are residents involved in identifying what 'good' co-ordination of care looks like?**

In two areas care home residents or their relatives were involved in steering groups or specific projects but, in general, service users had only a limited role in defining the approach to developing enhanced health services in their area. This was disappointing, especially given the emphasis that all areas placed on involving care home residents in decisions about their own care.

We heard that involving residents and relatives in comprehensive assessment, care planning and escalation care planning was helping to empower them to make decisions. However, we also heard that this empowerment was limited if community nurses and health care assistants did not then delegate procedures to care home staff where appropriate, or co-ordinate their visits. In these cases, health care was provided at whatever time the NHS staff were able to visit (rather than when was suitable for the resident) and could involve a significant number of unco-ordinated visits.



*When they [district nurses or NHS health care assistants] come in they might be having lunch, they might be in an activity. I don't think it's right that someone can say, 'right it's 2pm I'm coming in, can you just take Mrs So-and-so to her bedroom so we can check their skin', when we know that's already been done because we've trained up our staff and they do it.*

(Care provider)

In one area a potentially interesting approach was being developed to collect staff views on the quality of care – knowledge that was not usually accessed systematically. With a high turnover of care assistants locally, the hypothesis was that they would be able to comment on quality of care in comparison to other homes that they had worked in, and the ease with which they could move jobs would mean they would not feel pressured to give positive reports.

### Learning points

- **Co-ordination of health services and care homes can achieve significant impacts on quality of care for older people living in care homes.** These impacts are not automatic and can be difficult to measure, but indications from our interviews are that, where approaches are implemented effectively, the cumulative effect of individual small-scale changes may be disproportionately beneficial, providing grounds both for optimism and for aiming high.
- **Measures of impact should be broader in focus.** Although quantitative data, such as hospital admissions, is easier to measure, the overall aim is to improve the health and quality of life of older people with complex needs, and so monitoring impact should not focus only on quantitative measures. It should also measure benefits to care home residents as well as reductions in avoidable activity or costs. The areas covered by our research were all adopting a broader approach to measuring impact than just hospital episodes data, by including indicators of quality of care; but the way they measured impact varied, and only one area was starting to measure quality of life, which is perhaps the most important issue of all. This is undoubtedly a complex issue and one for which further national guidance or research may be needed. Even though some studies have used validated tools for measuring quality of life, those had not been put into practice in the 15 areas in which our interviewees worked.



- **Care home residents and their relatives should have a voice in defining the overall approach taken by their local system and defining what good-quality care involves.** This principle was well-established at the level of individuals' care, but was less visible in shaping the overall approach. For example, as relationships matured (ie, only at the later rather than the initial stages of the approach), some areas were considering how to involve residents and relatives in their leadership groups, but not all had started to consider ways of involving them.



## 4 Why develop enhanced health in care homes?

### Research and guidance

Joining up health and care home services is not an end in itself; it should be for a purpose. Oliver *et al* (2014) identified its purpose as enabling high-quality health and care services for older people to be co-ordinated around the individual's needs and preferences (rather than organised around single diseases), and to promote good health and maintain independence (rather than just reacting to ill health). This requires new thinking and a transformation of services.

Progress on this transformation has been uneven and slow, despite a wealth of guidance that is generally consistent and clear on what sorts of change are needed. Progress has been hindered by the complexity of the fundamentally different systems for funding and accountability between care homes and the NHS (social care funding is means-tested and a high proportion of care home residents are self-funded), and the absence of a detailed specification of what services care home residents can expect from the NHS.

In addition, guidance has usually been targeted at individual parts of the care system, such as clinical professionals (see, for example, [British Geriatrics Society 2011](#); Baker *et al* 2016), care home managers ([National Care Homes Research and Development Forum 2007](#)) or commissioners ([British Geriatrics Society 2016a](#)). The array of separate guidance documents mirrors the complex and fragmented arrangements for commissioning and providing primary care, community health services and specialist health care, the uncertain boundaries between commissioning social care and continuing health care, and the nature of the care home market itself, which has a multiplicity of providers, models of care homes and funding arrangements ([Humphries \*et al\* 2016](#)).

By contrast, *The framework for enhanced health in care homes* ([NHS England 2016b](#)) provides guidance that targets four constituencies simultaneously: care homes, commissioners (both NHS and local authority), health service providers, and people



who use care services and their families. It is part of a system-wide approach, which aims to co-ordinate and join up services into integrated, whole population care models. Explicit warnings from NHS leaders that the NHS will not be sustainable unless there is system-wide change of this type – including greater roles for care homes in health services, and the highly visible challenges facing acute hospitals in ensuring access to services and timely transfers of care – have created a sense of urgency. This change of approach is necessary rather than just desirable.

*In the last 18 months, all the talk about STPs [sustainability and transformation plans], no money and the increases in these people with complex needs, it's forcing people to open that box and say, 'we've got to do this'.*

(NHS provider)

## Findings from our interviews

The pattern illustrated in national guidance – of motivation by individual parts of the system but, increasingly, system-wide approaches too – was replicated in our sample of geographical areas.

- In some cases, care home owners or managers had worked directly with individual GP practices to enable regular ward rounds and comprehensive assessment in their care home. These arrangements were specific to the care home rather than system-wide. In our sample, these care homes and the GPs they worked with generally had a natural geographical fit (in some cases, located very close to each other).

*I don't really have a scheme or this [NHS England] framework, I don't really know what it is. We just do what we need to do, to provide good-quality care. I've been a registered manager for 14 years, and over that time I got all the residents registered with one surgery so we really built up the relationship.*

(Care provider)

- In other cases, highly motivated professionals (usually nurses, therapists or social workers) had coincided with a commissioner who also recognised the importance of bringing services together and was prepared to advocate for its funding across their area of responsibility. These examples were usually focused on providing hands-on support to local care homes with the highest rates of hospital admissions, or they accepted referrals where care homes



needed advice on meeting an individual's needs. They involved bottom-up quality improvement, often working back from an individual's care to a review of that care home's wider management systems.

*We came together from working in care homes but from a different perspective: I was an OT [occupational therapist] and she was a community matron. We were very lucky to have a commissioner at the time with a very proactive interest in care homes and we got into discussion with him about how things could be done.*

(NHS provider)

- In the third group, system leaders identified the importance of bringing care homes and health services closer together, and created arrangements for engaging and empowering care homes, GPs, and sometimes other services, in planning how to do this. By 'system leaders' we mean those individuals with key responsibility in local authorities or CCGs, as these organisations' roles and responsibilities invariably involve them in working across the local health and care system, and complement the leadership of individual services, care homes and projects. Although local authorities and CCGs are both commissioning organisations, it was usually not the person responsible for commissioning who led the approach; indeed, our interviewees emphasised that the role needed to be distinct to that of the commissioning role. The motivations behind these approaches varied, with different areas placing different emphasis on: following national guidance from NHS England, a broad agenda of improving quality of care in care homes (of which health care was one part), or trying to reduce hospital attendances, admissions and length of stay. In our sample of areas, these were the most strategic approaches, in some cases explicitly seeking to change cultures and develop a movement for joined-up care. They tended to cover a whole area rather than a targeted approach.

*Initially it was all about developing a work plan with care homes to take things we picked up from the [NHS England] vanguards but it's become more than that and we've linked the programme to the fees that we pay. We're incentivising care homes to be part of the programme; if they sign up and commit to excellence then we're giving those homes a bit of extra money and they're part of this care home excellence network where we offer things exclusively to those care homes – for example, we're launching My Home Life locally, available to those in the network. It's both the council and the NHS who are putting in extra resource for these care homes.*

(Local authority)



We spoke with people in other areas beyond the 15 covered by our study, which were not yet ready to begin joining up services, or were at a very early stage of doing so. We found widespread interest and appetite for care homes and health services working together more closely. For example, people from several areas wanted to join The King's Fund/My Home Life learning network, but did not know who to involve in other local organisations. Individuals from some areas with key system-wide roles for health care in care homes had met each other for the first time through our learning network.

*We are not a vanguard area and we had a number of initiatives in care homes but it was all a bit of a scatter-gun approach. The King's Fund learning network was an opportunity to bring the different agencies together. The irony was, we were putting an application to join the learning network together as people who had never actually been in the same room together.*

(NHS provider)

## Learning points

- **Enhanced health in care homes is entirely achievable.** It is not just something to be achieved by the nationally selected vanguard areas. It is about drawing activity together and co-ordinating it, rather than inventing new types of service, and there is guidance available for how to approach this.
- **There is no single way to develop enhanced health in care homes.** Our interviewees all reported that their areas were making progress, having started in different ways and with different drivers. However, there was variation in the extent to which organisations and local health and care systems (as opposed to highly motivated individuals) were committed to achieving change.
- **Areas should build on the work that is already under way.** Most areas were already undertaking some activities to join up health services and care homes, and/or had a foundation of support from leaders within local authorities and CCGs. They were all building on these factors, which represent strengths and assets.



## 5 How to begin implementing enhanced health in care homes?

### Research and guidance

Some studies and guidance have focused on care homes with the highest rates of hospital admission or attendance, or urgent conveyance to hospital (NHS England 2016a). Others recruited volunteers from care homes and GP practices who were willing to adopt a particular quality improvement method or model (Gordon *et al* 2017). In other cases, an approach was rolled out to all care homes across a local authority area simultaneously (Marshall *et al* 2016). NHS England has produced a self-assessment tool to identify elements of the enhanced health framework that have the greatest need for development, which can also help local areas identify where to start and what to focus on (NHS England 2016b). In all cases, research and guidance emphasise that there is no single 'recipe' which can be followed: approaches need to be sensitive to context at the organisational level, service level and hands-on care delivery level.

From the research literature and a consensus workshop, Goodman *et al* (2017a) identified several tests of care home readiness to support health care innovation or change for residents (*see box*). They noted that there is no equivalent literature on health services' readiness to work more closely with care homes. They emphasised the need to engage with care homes *before* introducing enhanced health processes and to involve them in making decisions about the approach, rather than presenting them with an action plan they were not involved in creating, as this is unlikely to gain sufficient buy-in. In a separate paper, Goodman *et al* (2016) also noted a range of characteristics of care homes – including the size of the care home, its ownership, staff turnover, length of stay, and length of tenure of its manager – that could influence how readily they were able to take part in arrangements for co-ordinating with health services.



### Ten key questions to assess organisational context before commencing a health initiative in a care home

1. Does this intervention align with care home priorities? Or are there other potential interventions that care homes identify as more pressing?
2. What evidence is there of senior management interest and enthusiasm for this intervention at the organisation and unit levels? Are they willing and able on a daily basis to take a leadership role in supporting the proposed change?
3. Do care home staff have enough 'slack and flexibility' to accommodate the change into their current workload? Is this recognised as core to their work?
4. How is change discussed (formally and informally) in the care home setting? Who needs to be involved in decision-making about what is being proposed and how it is implemented?
5. What are the recent changes or health-related projects this care home has been involved with?
6. Is there a champion in both the care home and in the linked NHS service with protected time to help facilitate change?
7. What are the pre-existing working relationships between NHS services and care home staff and networks of care and support around the care home (eg, GPs, visiting specialists, links with local hospital)?
8. Could the intervention appear judgemental by signalling in a negative way that the care home needs to change?
9. How well do existing care home training programmes and work schedules fit with what is proposed?
10. Will care home staff have to collect and enter new data or is it held in existing systems?

Source: [Goodman et al 2017a](#)

Many studies (such as [Goodman et al 2016](#)) found that a history of organisations already having worked together was a significant aid to developing enhanced health in care homes. However, there were differing views on how long this working relationship needed to have been in place for, and whether too long a relationship could become institutionalised and inhibit new thinking.



In a literature review by Petch (2014), studies suggested that achieving a culture change to support closer co-ordination across a health and care system was likely to take a minimum of three years, including two for development and testing and one for rolling out and embedding. However, it often required much longer: Petch noted that one high-profile integrated care programme took more than 10 years to embed cultural change, and that unrealistic expectations for rapid progress could be unhelpful if they conflicted with the need to continue evolving and adapting approaches over time.

## Findings from our interviews

### Developing a targeted approach with selected care homes

Around half of the 15 areas had started by focusing on the five or so care homes with the highest rates of hospital admissions, or a similar number of care homes which represented all those in one specific neighbourhood of the local authority or CCG area.

It was often difficult to identify the care homes with high rates of hospital admissions because of poor-quality data, for example, data based on postcodes rather than full address. NHS England has since developed guidance to help support analysis of information across care home and NHS datasets. Areas that developed ways of collecting information across different systems at the outset did so by engaging particularly with those inputting the data (eg, in A&E departments) as well as informatics departments. In all cases, data needed to be combined with insights – for example, from quality monitoring visits or the CQC. Interviewees noted that it was particularly important to discuss both data and insights openly with care homes and capture their views too. This was partly because they could help in understanding the whole picture, and partly because it helped set up a relationship on the basis of listening and partnership.

*The CCG put in capital expenditure at first so the team have an office and IT to make sure they could talk to all the GP systems. One really important factor is that we're on EMIS [software for care records and managing activity], we're employed by the community trust but we actually write in the GP practices' notes. So they see everything on their EMIS. Whereas the community trust system is much harder to use, and anything that's clinically coded in community, it doesn't map across to primary care so it's not very effective if you want to audit, for example.*

(NHS provider)



*We started off by looking at the data and unpicking who had what and where it was – the care homes had some, the GPs had some, the hospital, the ambulance, the commissioners, and it wasn't getting shared. We've made a start on addressing that and out of it we've taken forward a number of 'small wins' which make a difference. For example, when someone goes into hospital, the care home can phone the discharge team as a single point of contact, to make sure they have the details of what they need, their preferences, issues to look out for and so on, and the discharge team make sure the information gets to the right staff and that there's feedback and discussion when it's time to go back home.*

(NHS provider)

### **Developing a system-wide approach across an entire area**

The other areas started in a more organic way, either bringing the relevant health services into care homes in response to referrals about individual residents' needs, or in response to proposals made by provider forums (especially care homes). These areas usually described their approach as including both a responsive element (enabling referrals and requests for support, or responding to safeguarding or regulatory concerns) and a prospective one, such as offering training to all care homes. However, the relative proportions were not always defined, and they could be at risk of being overwhelmed by requests and concerns or develop a tension between enabling care homes to propose work or doing work 'to' them.

*We wanted something quite informal and organic because the care homes are not homogenous, they've all got their different issues, ways of working and support systems, so we didn't want too rigid a structure, we let the care homes come up with ideas and work on them in small working groups.*

(Local authority)

*We've had a number of events where the whole system is represented in the room and the frontline staff identify where it isn't great and we could improve care, and share good practice. As leaders, we need to listen, take what they tell us on board, and give them the opportunity. Once you do that, they'll pretty much redesign it for you!*

(Local authority)



In two cases, local authorities were supporting enhanced health in care homes as part of a much broader strategic approach that redefined their system for developing quality of care for older people in their area. In one case, establishing enhanced health was part of a fundamental review of the commissioning strategy for quality in social care. In the other, it was part of an overall programme that the local authority had developed to support and incentivise continuous quality improvement in care homes towards a broad definition of excellence, including quality of life rather than just quantitative performance indicators such as rates of hospital attendance. One of them had well-established arrangements for working with the NHS, whereas for the other, this was a new approach. Both were working with every care home in their locality and had high levels of senior and corporate support. The approach they brought to leadership across the health and care system was, in our view, as important in getting this established as the content of their plans.

*It has been quite brave to say 'they are equal partners, we're going to look at this slightly differently, those traditional ways of working with providers won't lead to the outcomes we want', moving to a much more inclusive approach. The power dynamic has shifted; obviously, we still hold the purse strings and have contracts with them but it's much more inclusive and we work much more closely with care homes and they feel part of something now that will hopefully make a difference for people.*

(Local authority)

### **Initial engagement with care homes to secure buy-in**

Most areas started off with an inclusive workshop to begin defining priorities and getting providers on board as partners. In some cases, these initial workshops had been seminal moments. They needed very careful preparation and pre-engagement, modelling the intended style of partnership in order to reduce what could otherwise be a lengthy process of building trust.

*We knew we hadn't really engaged care homes properly for years, so we held a workshop and asked them 'what are the things that prevent you providing an outstanding quality service to people?' And they came up with a lot of things and*



*then we added in things from the [NHS England] enhanced health framework. Having that workshop was a key moment, it's really, really important to define the problem and to get care homes involved. We got various volunteers to sit on working groups so it was a really useful starting point.*

(Local authority)

*To start with, we tried to get all the local care homes into a room and talk to them about our plans. But there were more of us than there were of them when we tried this! It just took a lot of going round knocking on doors, over five months of reaching out to them, to get beyond their apprehensiveness and all the reasons for why 'we can't share information with you', 'we're too busy to be involved', and so on.*

(NHS provider)

### **Establishing a leadership or steering group**

Other than in the few cases where individual care homes and GP practices started working together on their own initiative (not as part of a broader plan), we heard that it was essential to regularly and collectively engage not just care homes but also other providers too, such as GP practices. This engagement usually took the form of a steering committee or leadership group, which could directly engage services as partners in projects and enable their ideas and suggestions to be taken on board. Many areas found it useful to include perspectives from people one step removed from delivering or receiving health and care home services (such as residents' relatives, care home owners or hospice representatives). This helped to counterbalance engrained relationships of power between care homes, health professionals and commissioners, and – particularly in the case of hospices – was felt to provide useful insights from a different perspective. However, interviewees in all 15 areas told us that they still had some care homes, and some GP practices, who were not yet engaged at all and, overall, few had involved care home residents and relatives in deciding their approaches, aims and priorities.

*Getting stuck in and working together for the common goal – that helps to get to know people. We've been to strategic meetings but for most of the care providers, I can only get them to go to one and then they come away and they say 'what was the point of that?' But if we have a task and finish group to look at, say, advance*



*care planning, they see the benefit in that. I think to start to build relationships, it's much easier if there's some specific outcome you're working towards and a clear task.*

(Care provider)

*We've set up a 'clinical senate' for anyone who works around care homes – GPs, pharmacists, therapists, ambulance, consultants and, of course, the care homes themselves. It doesn't involve residents or families yet but it will in the future. It's where we step back and focus on what do we want to collectively achieve for older people in our area.*

(NHS provider)

### **Doing work 'with' rather than 'to' care homes**

Our interviewees all strongly emphasised the importance, from the outset, of avoiding blame and being supportive (especially where prioritising those care homes with highest hospital use), doing work 'with' care homes rather than 'to' them, and of being very visible. This visibility was also important as a means of raising awareness among other providers as a precursor to rolling out the approach in future.

*They [the five homes initially engaged, due to high hospital admissions] were very defensive at first. The thing that helped really was our approach of being non-threatening, non-inspecting, supportive, and being very present. We were there most days with them. It was quite intensive and I think the rewards came once they saw we'd made a difference to a resident.*

(NHS provider)

*We tried to make it really clear right from the beginning that we weren't another inspection regime, we were there to support care homes. We were open and honest from day one about the purpose of us being there and speaking to the care home staff about everything we do. I think you've got to respect their position in all this because they know the resident better than anyone. There was an assumption that inspection was what we were going to be doing, that we'd be looking for doing things wrong – which was the opposite of what we saw as our purpose.*

(NHS provider)



## Engaging GPs

We also heard that it was important to engage primary care colleagues from the outset, although the extent to which this was happening in practice varied. Where it worked well, GPs had already been engaged with care homes in the past and a defined group was supported to act as champions (for example, by enabling a flexible pot of funding, such as pooling dementia premium payments). The group then developed evidence of impact (both for residents and in terms of their own workloads and roles), which helped bring their peers on board. If GPs were not on board early in a project, and especially if this was combined with payment arrangements that did not incentivise work with care homes, it could cause significant challenges later for scaling up the approach.

*The biggest thing for me is, engage primary care really early. If we had to choose some lessons learnt, the key one is engage primary care early. They don't want to be done to, they don't like being done to. You need to involve at least a few of them with influence right from the get-go.*

(Local authority)

## Engaging hospitals

Engagement with the NHS beyond the services that were already coming into care homes regularly – ie, beyond GPs and community nursing and allied health professionals – was complex. Hospitals in particular were perceived as hard to engage, being focused mainly on their own capacity pressures. None of our interviewees had found a solution to this; in many cases, the relationships were not in place for social care to be able to influence hospitals or the broader NHS agenda. Those working in old-age psychiatry were usually well engaged for routine issues, but with significant difficulties for out-of-hours and weekend cover, and for ensuring rapid responsiveness to very challenging behaviour.

*The relationship with the NHS is working but I would say it's taken a lot longer than the relationship with the local authority. The relationship with the local authority is pretty much a full partnership, we're included right at the beginning of new things, we say what we feel even if it's not what they want to hear, we do work together with local media, national events we go to together. It's taken longer with the NHS*



*because we didn't understand who each person was, it's a very complex set of organisations and sometimes it's difficult to work out who do you need to talk to.*

(Care provider)

*We're now two meetings in to establishing a frailty network but their driver for that is they don't want elderly people on trolleys lining the corridors this winter, that's the extent of their focus.*

(NHS provider)

### **The role of local authorities and CCGs**

The role of local authorities and CCGs varied significantly, from creating a framework of meetings and relationships that enabled partnerships and encouraged innovation, to a more limited role of monitoring detailed performance metrics. The leads for enhanced health were usually alongside rather than within commissioning teams – a distinction of roles that was widely felt to be important. The ways in which local authorities and CCGs worked together were complex, particularly where there were multiple CCGs (eg, different incentive schemes in primary care contracts). Only in a few areas had CCGs and local authorities started working on enhanced health in care homes as full partners from the outset. In most cases, one organisation was clearly the lead partner, resulting in a greater focus on either care homes or NHS priorities. This could lead to disconnected arrangements for training care home staff between the local authority and the NHS, and a perception that one organisation was promoting progress while the other was dragging its heels.

We also found examples from local authorities and CCGs of co-ordinated commissioning, flexibility in funding posts across the organisational divide (particularly through secondments and joint posts so that one individual worked across two or more organisations), and sufficiently good relationships to cope with difficult discussions and still reach agreement. However, these examples were all from the perspective of commissioners: their co-ordination tended to be 'in the background,' with the result that GPs and care home interviewees were not aware of them and able to confirm their benefit. Where local authority and CCG leaders were able to create or exploit flexibilities and made this visible, it could have a significant impact by reducing perceptions of rigid organisational boundaries and giving a signal to providers of a commitment to joined-up approaches.



*We were sat at a joint meeting and the director of social services in the end said, 'do you know what, it probably should be the acute trust that are paying because they're saving money, but they don't have any money, everybody else's money is too tied up in governance, so here's a way of paying' – and for the next three years it's coming out of BCF [Better Care Fund].*

(Care provider)

*When we did the little trial to see how practice-based frailty nurses would work, that was a partnership – the CCG funded the community trust to second a nurse specialist to support it in primary care, to work across the organisations.*

(NHS provider)

### **Are additional resources needed?**

All areas were developing enhanced health within a context of multiple, complex funding systems (various NHS systems, local authority rates, self-pay) and different criteria for public funding. Interviewees in all 15 areas felt that some extra resource was needed to bring care homes and health services together, at least initially. This was mostly about funding (eg, incentive payments, additional staff, funding for dedicated teams) but there were also examples of re-focusing roles or loaning and seconding staff. The level of funding involved appeared to vary considerably, however, including one area that had no specific resource.

*It does need extra resource even if it's just in terms of bodies, attending meetings they wouldn't normally in order to make sure things happen, and so on. In terms of money, the CCG, the county council and regional HEE [Health Education England] have all provided funding for a range of projects, it's not all new money – some of it is re-focused from elsewhere. But any system would struggle to do this without some resource, even if it's just people.*

(Local authority)

*With our 'red bag' project [a scheme developed by vanguards to facilitate effective information-sharing at admission and discharge from hospital], there was a massive impetus behind it eight months ago, but we didn't have the money to fund the actual bags. So people were willing to do it, to implement it and go out there and talk about it. What held us back is the money to actually buy the bags.*

(Clinical commissioning group)



## How long does it take to start work on enhanced health?

There were different experiences about how long it took to establish new ways of working together. Areas with less than a year's experience all said that they still felt at very early stages. Most areas described a set-up time of around six months or a little longer, after which time they were starting to see significant results of between 30 per cent and 50 per cent reductions in hospital use. Where the approach was one of small-scale piloting, there were clear benefits in getting GPs (in particular) on board, but in some cases it meant a time lag of two to three years before approaches were scaled up.

*We went on a journey of working out what good practice looks like and even though we've been doing this for nine months we're only now getting to something that looks like a good model. We started looking at contractual mechanisms but now we're focused on promoting excellence in care homes.*

(NHS provider)

*We've been doing it, probably most of this year [eight months at the time of interview] and we're at a place now where we know anyone in any of the care homes who is high risk has had an assessment and got anticipatory medicines and so on in place.*

(Care provider)

A history of joint working between care homes and health services more generally was clearly beneficial but, in the areas where our interviewees worked, it was not seen as essential. They emphasised that, so long as services were stable (eg, low turnover of key staff, financially viable), progress could start to be made within a matter of months. The role of leaders in the local authority or CCG in providing clear direction and support, and the credibility of individuals working directly with the services, were also emphasised as key factors. Credibility was gained partly by being closely engaged consistently over time, and partly by demonstrating understanding of and respect for care home services.

*It helped that we both had care home experience before. It wouldn't have worked to go in as a fresh pair of eyes hoping to change the world without understanding the pressures and the barriers... but we were realistic from the start. We knew we needed to be needs-led and offer support – a carrot rather than a stick. It helped*



*having a nurse and a therapist angle, because we sometimes have a completely different view when approaching an issue – that made it work. We've had a very stable team, we've been fortunate with the staff we've recruited.*

(NHS provider)

## Learning points

- **Engaging early is essential, before putting decisions into practice.** When asked what they would do differently with hindsight, interviewees in many of the 15 areas told us they wished they had spent longer in getting a greater depth of partnership and shared understanding of approach, especially across the two 'tribes' of NHS and social care stakeholders. Their experiences of involving primary care were that it may not be realistic to put off engaging GPs on the assumption that, when data on achievements became available, that would make it easy; early and continued engagement, with involvement of the CCG, was a more effective strategy.
- **Engagement with care homes needs to treat them as partners from the outset.** Establishing a supportive, appreciative and open approach often amounted to a re-casting of the relationship between social care and the NHS, and was seen as a key objective rather than a byproduct. Establishing forums and communities of practice helped significantly, but they needed to enable providers to work on practical improvement projects as well as developing plans and learning. Approaches targeted at the most challenged care homes required very strong skills of diplomacy and persistence. While leaders in local authorities and CCGs often facilitated engagement with care homes, this role can be taken by leaders in provider organisations (including care homes, care associations, GP practices and GP federations). The role of care homes as partners should not reduce the importance placed on the role of care home leaders within their service and across the local health and care system.
- **There is value in investing time in clarifying aims and objectives, through an inclusive process.** Interviewees in half of the 15 areas started their enhanced health work with what could be interpreted as a negative objective (ie, to avoid hospital admissions), which was expressed in terms of benefiting one of the partners (in this case, the NHS). Research clearly indicates that the aims should relate to all partners' priorities, and the objectives that our interviewees all saw as priorities were around improving residents' health and quality of life.



- **There will need to be a balance between ‘bottom-up’ approaches and ‘top-down’ priorities.** Most areas wanted the innovation that comes from frontline ownership of the approach to enhanced health in care homes but, especially over time, realised that they also needed to fit with the area’s wider strategic priorities. Interviewees were not able to define what the balance should be when they started but, over time, all began to identify the question of how much their ambition was just quality improvement (which may be bottom-up) or also system transformation (which required a system-wide view). In areas starting to develop enhanced health care, those in leadership roles should be aware from the outset that they are likely to need to define this balance, and should be alert to the need to do so, as that is a key leadership responsibility.
- **Areas starting to develop enhanced health in care homes will need to collect their own evaluative information on costs and benefits to build the business case.** We found no clarity about what resources are needed, although there was a strong view that some additional resource is needed, at least initially. Sharing learning about costs and return on investment with other areas, and comparing experiences, may be helpful.
- **Results can be visible within a short time, so it is appropriate to be ambitious.** Research literature emphasises the need to allow time for joined-up approaches and co-ordination to develop, but our interviewees reported that in some cases they were achieving rapid results and deepening relationships, even when they had only recently started working together more closely. Enhanced health in care homes appears to be an area where ambitions for improvement within a short time can be realistic – even if their greater potential may require a longer time period to be realised – and, where successful, results appear to be possible more quickly than in many other types of transformative change programme.



# 6 How to develop and sustain enhanced health in care homes over time?

## Research and guidance

Embedding enhanced health care over time is a key concern: Davies *et al* (2011) found that the average life expectancy of initiatives to improve quality of care in care homes was less than three years. Studies have identified a range of factors that can help health services and care homes work together to meet residents' needs (see box).

### Summary of factors which may facilitate a closer joining-up of care homes and health services

A recent mixed-methods, realist evaluation of effective working for continuing care of older people in care homes identified supportive features and mechanisms, such as:

- education and training of care home staff, especially when based in the care home
- ready access to clinical expertise, especially a clear system for referrals
- and availability of dedicated health services for care homes, and age-appropriate services (such as falls prevention services or dementia care)
- incentives and sanctions to achieve minimum standards of care
- champions and designated staff working in and with care homes
- effective team working
- the use of case management.

*continued on next page*



### Summary of factors which may facilitate a closer joining-up of care homes and health services *continued*

Regular GP clinics in the care homes were associated with fewer difficulties in securing prescriptions and more frequent reviews. The use of shared protocols and guidance, and regular meetings, prompted co-design and alignment of health care provision with the goals of care home staff and a shared view about what needed to be done.

An explicit (funded) commitment to spend time working with care homes was more likely to foster relationships and confidence that residents could access services as needed. Relationships with visiting health professionals had a clear influence on practice and decisions by care home staff. Commissioning a range of NHS services to work with care homes on a regular and ongoing basis was associated with a positive effect on referring residents and reviewing care, leading to improved access to care and lower demand on urgent and emergency care services.

Where there was a narrow focus on care homes as a drain on NHS resources, this was associated with approaches that used short-term interventions and outcomes measured in terms of what had not happened or how resources had not been used.

Source: [Goodman et al 2017b](#)

Evaluations of the English integrated care pilots and integrated care pioneers – the two forerunners of the current vanguard programme for new care models – describe factors which influence the impact and sustainability of joined-up care. These include general issues, which may apply to all change programmes (eg, leadership, information systems, staff engagement, resources), and issues that are specific to joining up health and care services (eg, relationships between leaders of different organisations, complexity of larger-scale change, governance arrangements, support for staff, organisational stability). Both evaluations include sets of questions to consider when leading work to join up and co-ordinate services; several interviewees told us they would have found some structured questions of this sort helpful for checking their own thinking, when designing or scaling up their approach ([Erens et al 2015](#); [Ling et al 2012](#)).

Ham and Walsh (2013) identified 16 principles which can similarly serve as prompts for considering issues likely to affect the impact and longevity of integrated



care projects. Among these is the need to set precise objectives and measure progress towards them. Considering this specifically in a project to reduce hospital admissions from care homes and improve safety, Marshall *et al* (2016) reflected on the importance of flexibility in approaches to monitoring because projects were likely to evolve and change over time, adopting a common-sense theory of change, and avoiding making a summative (ie, conclusive) evaluation too early.

Goodman *et al* (2016) found that effective health care in care homes needs to focus on areas of mutual interest to care home and health staff and to fit with the care home's work flow (rather than, for example, fitting in with the timetables of health service staff). It helped if there was good engagement early on, with care to involve the full range of people involved, before options were discussed and decisions finalised about which approach to use and the planning of activities. Following on from this, and during implementation, shared reflection, learning and development programmes enabled the approach to be adapted as needed. Petch (2014) found particular evidence for the effectiveness of developing dedicated teams, with a clear ethos and governance processes, also suggesting that individuals with roles that spanned organisational boundaries could make important contributions.

However, a survey by Gage *et al* (2012) found that, in practice, care homes experienced interface working as mostly dictated by NHS processes and priorities. A further study by Goodman *et al* (2017a) also found little evidence (beyond adjusting visiting times and improving access) of the NHS organising services to accommodate care home staff or residents' priorities.

Many of the changes that are needed to make joint working effective and sustainable are small in scale and do not involve designing new services or care pathways – although that does not mean they are easy. Examples include standardised paperwork and protocols, and processes for providing information and feedback on admission and discharge from hospital. In fact, these are often significantly more complex than they first appear – for example, because of information governance and IT systems (Owen *et al* 2008). Even small-scale interventions may need committed and sustained effort to change ways of working that are deeply engrained in organisational and professional cultures (Ellins *et al* 2012). There can be difficulties in training staff in new processes when their workload is high and there is high turnover or use of bank and agency staff – in such instances, conducting training in staff workplaces can be a simple solution.



This is not restricted to the care home sector. For example, in one study the turnover rate was much higher among community NHS staff (specifically, district nurses) than in care homes (Goodman *et al* 2009; [Davies \*et al\* 2011](#)).

Although incentives, contractual requirements and alignment of governance processes can help, Goodman *et al* (2015) found that those factors are not sufficient on their own to ensure that enhanced health becomes embedded in care homes. The most important factors are activities which develop the quality of relationships between providers and, by implication, the leadership that supports and promotes these relationships.

## Findings from our interviews

### What sort of leadership establishes the right culture and relationships?

In all 15 areas, interviewees emphasised that, in order to be sustainable, developing enhanced health in care homes needed to build on and fit with a positive culture and values among the providers involved. Care home managers described how working closely with health professionals should just feel like a natural extension of the focus staff already had on quality of care, and GPs told us how working with care homes should mirror how they also worked as partners with other local GPs, social services and community activities. Early and sustained communication about improvements being achieved in care home residents' experiences – even showing benefit for just one person – helped reinforce the fit with values.

However, most people in leadership roles also told us that developing and sustaining joint working involved ongoing hard work, which could feel relentless. This applied to leaders with system-wide roles in local authorities and CCGs, and also to leaders of care homes, provider services, teams and projects. The natural qualities of the leaders that we spoke to clearly included persistence and resilience, as well as skills in partnership working and a depth of understanding of quality of care for older people with frailty and complex needs. They were all aware of their role in advocating for greater involvement of care homes and in changing the historical power imbalance between care homes and the NHS.

*You need to develop fairly good relationships. Having a bit of consistency, having the same person in the role for over a year has helped and a bit of stability across the health and social care sector as a whole. And personal credibility*



*helps. Credibility, persistence and a bit of charm – going around trying to be nice to people!*

(Clinical commissioning group)

*It's really hard work. Every now and then I have to run away to a BGS [British Geriatrics Society] conference and hear people talking about the same things, and come away refreshed and tell myself 'you see, you do know what you're talking about after all'.*

(NHS provider)

Sustaining momentum was seen as important both to make progress over time and to avoid the corrosive effect of not doing so. People who had worked in an area for some time were often able to describe previous attempts and initiatives to reduce hospital admissions from care homes, which had come to nothing or had fizzled out, so it was easy to become cynical. Those in leadership roles told us that they needed to over-communicate the results being achieved and the practical value of meetings in order to counterbalance this.

All areas emphasised the need for effective leadership at both the service and system levels (rather than just at one level), aligned by a common aim and approach. For example, discussions about what constituted health care (NHS-funded) or personal care (local authority-funded) were challenging, while engaging leaders could make the decision-making process easier and more transparent. PEG (percutaneous endoscopic gastrostomy) tube feeding provided a common example of this. The engagement of leaders who worked across the health and care system in addressing such issues and enabling practical solutions gave them visibility in resolving issues that crossed the health and social care sectors or fell into the 'no man's land' between the two; as such, this was perceived as an important enabler for more joined-up approaches to be developed at service level. Those leaders described their role in terms of facilitation, providing space and opportunity, and stepping in to give support; they explicitly avoided describing it in terms of hierarchy (although noting that they could direct where necessary).

*For example, local authority money cannot be used to provide health care, but there is no list of what exactly is health care. PEG feeds, toileting, wound care where his PA [personal assistant] can do it and has done it for a long time? If it's deemed health care, I can't fund it. You have to be as pragmatic as you can and get to*



*know who you can ring and say 'look, this is really stupid, can we just sort it so that person doesn't get caught in the middle and their care suffers'.*

(Local authority)

All areas which extended their approach over time found that they needed to engage with system-wide issues as well as frontline operational ones. For example, they needed to navigate unclear responsibilities about whether the NHS or local authority should provide funding, or ensure a fit with broader strategies such as workforce development or information systems. Sustainability and transformation partnerships (STPs) were perceived as too new or too far removed (ie, covering too large a geographical area) for this, and most leaders were interested in making the connection through groups leading place-based co-ordination and integration at locality or neighbourhood levels.

We noted that frontline staff who were engaged in these projects sometimes described a sense of re-connecting with the values that had originally motivated them to work in this field, which they felt had previously been under threat from the pressure that care homes, district nursing and particularly primary care were facing.

*It [introducing regular ward rounds in care homes] has had a real knock-on effect on quality of care. We had three safeguarding flags in the weeks after we introduced it because now GPs, rather than dashing in and dashing out... when the GPs saw what they perceived to be substandard care, all of a sudden it became 'their' care home and they started escalating concerns.*

(NHS provider)

*It's why I do this job, I have four care homes that I cover, and it's an absolute joy, I love it, the residents and families love it and the staff love it. Because I see all the patients, we're developing a single set of processes and protocols, which makes it easier for me and for the staff, and it's fantastic because you develop relationships and you keep people out of hospital.*

(NHS provider)

The extent to which NHS staff trusted appropriately trained care home staff to carry out delegated procedures (eg, in wound care) or to manage medications (eg, antibiotics) was a noticeable indicator of how well relationships were working at the front line (see box).



## What activities help to build relationships?

According to our interviewees, activities that were helpful in building relationships and trust were:

- workshops that engaged a range of stakeholders in defining and reviewing priorities and demonstrated the commitment of leaders with system-wide roles and responsibilities (ie, local authorities and CCGs)
- training of care home staff by, or alongside, health service staff
- regular, frequent visits, clinics or ward rounds by GPs or nurse practitioners in care homes (eg, weekly or fortnightly)
- involvement of a range of care home staff with clarity of roles (eg, lead responsibilities, and including catering, reception and activity staff)
- dedicated individuals or community health service teams whose roles included supporting care homes with advice, making direct referrals into the NHS, and advocating for care homes and their residents to access health services
- steering groups and provider forums, which included practical 'task and finish' sub-groups to work on solving specific challenges
- newsletters
- reflective practice, including Schwartz rounds (see p 43), multidisciplinary team meetings, and processes for learning from incidents and individual cases.

There were also many creative approaches that were unique to each area. For example:

*We did some training for activity co-ordinators. We developed a Facebook page off the back of that where homes can see live feeds and we share information through there, we also use Twitter. We do three to four care home forum events a year, we bring them together, we might have outside speakers, we have a newsletter quarterly. Some homes are agreeable to open their doors up and share with other care homes, sometimes with a little bit of support from us, so we might go into a home that's not doing so well on something just down the road from one that's got it sorted and we'll pair them up. Or if we're doing training with them we'll help them to contact local homes in the area because the more training places get booked, the cheaper it is per person, the more you can share the cost, or if they are in a group we might suggest opening it up to the other homes in their group locally to help us avoid reinventing the*

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### What activities help to build relationships? *continued*

*wheel. This year we're having a version of a hackathon, we call it an ideathon, where we're getting people together to consider the seven elements of the vanguard and then we have a dragon's den at the end of it. It's an ongoing thing to get people working together, you can't ever stop.*

(NHS provider)

### Developing the workforce

Some areas had established dedicated teams of health staff to work with care homes. The teams varied in size significantly. Co-locating them with GPs and including them in MDT meetings helped embed their roles. Getting the right skills and attitudes among team members – especially an understanding of care homes and good relationships within the team – was important. To ensure this, many areas had used secondments and fixed-term placements before making permanent appointments.

Arrangements for providing training to care home staff varied significantly, with a lack of clarity about what the public sector should fund. There was usually a recognition by NHS bodies and local authorities that they should provide free training to care home staff, because it developed skills that were necessary and would otherwise not be available. But there was no clarity about how much funding was appropriate or what the return on investment should be. We found widely differing levels of funding and examples of limited co-ordination of NHS and local authority funding for training care home staff. In some areas, care homes were expected to pay for training. Some areas were unable to commit to continuing to fund free training, given financial pressures, and some interviewees told us that they funded training reluctantly, believing that independent sector providers really ought to pay for training their own staff.

*We got agreement that a nurse is a nurse is a nurse, so our nurses now have the same access to Health Education England-funded education schemes as everybody else's nurses do. That was revolutionary! Learning together has made a major impact. The nursing homes who engage with that see themselves differently and are seen differently: they're not 'just' nursing home nurses.*

(Care provider)



*We've always had a two-pronged approach: education and training for the workforce in care homes, and the clinical evidence base. We underestimated how big the first was and we've increasingly worked with others who could provide training rather than trying to do it all ourselves.*

(NHS provider)

We heard far less emphasis on training NHS staff to work with care homes. But, over time, NHS staff often realised that they had knowledge gaps and were learning from care homes – something that had invariably not been anticipated or planned for. This clearly resulted in a change in the relationship between NHS organisations and care homes: whereas they had initially seen care homes as consumers of learning, they also began to see them as providers of learning, and as positive assets rather than just a draw on resources. We also heard that while most areas placed an emphasis on sharing learning across care homes, many had not done so across the GP practices or across the primary, community and acute health services in their area, and had not anticipated or planned for the value that would come from doing so.

*It's an eye-opener to see what care is like, outside your own sphere of usual practice, for every member of staff – our district nurses went in and out of care homes but they didn't actually recognise the issues that care homes face until they've been working more directly with them and see how specialist palliative care is delivered, to see what good-quality end-of-life care looks like in a care home with a high turnover of staff and bank staff.*

(NHS provider)

*In the 'surge' work we did [to offer intensive support to some challenged care homes], the GP on the team initially thought that in the care homes that she supported, they'd got it all sorted. But it really opened her eyes to see how other care homes, GPs, district nurses and AHPs [allied health professionals] were approaching MDT working and how they made their ward rounds and CGA [comprehensive geriatric assessment] work, and she said she took a lot away from it and came back very motivated.*

(NHS provider)

An emphasis on staff learning, going beyond training in skills, was a notable feature in many of the areas that were making good progress. In these areas, leaders



explicitly promoted reflective practice (including reviewing data) and learning across organisations.

*In the learning networks, we try to get people to walk in each other's shoes. For example, we discussed how hospital staff experience it when someone dies. They clear the bed ready for the next patient within a couple of hours. But when someone dies in a care home, that's their home and the staff don't think it's right if they're pestered and pressured for a fast turnaround like the hospital. We learned that hospitals work to a clock, care homes work to a calendar.*

(NHS provider)

### **Recruitment and retention**

Two areas had carried out in-depth analyses of the social care workforce. These gave them significant insights for developing plans and avoiding unfounded assumptions about staff turnover and training. In one area, which found that the turnover of care assistants tended to be between care homes (rather than them leaving the sector altogether), they had used this insight to get agreement to develop a passport scheme, which ensured that training received in one care home would be recognised as meeting the required standard when moving on to work in another. This was helping to embed a single standard and approach to training care assistants across the system, and had the added benefit of giving NHS staff confidence about being able to delegate. In another area, there was high turnover and use of agency staff and so an online resource pack called *Care home companion* had been developed to support consistent induction, tailored to local processes and facilities.

*We wanted to make the Care Certificate truly transferable and so the NHS and care association training leads agreed a quality threshold and standardisation, so the care homes Care Certificate is recognised by other care homes and the hospital if it's got our combined logos at the bottom.*

(Care provider)

While some care homes faced significant challenges of recruitment and retention, others told us they had a low turnover of staff and that this helped the development of relationships with health staff and ways of embedding practice such as appointing 'champions' and leads for different aspects of care. The leadership of the care home manager was key to enabling this (and, where they



were 'hands-on', the care home owner). In addition to the stability that came from the length of time in post, we heard examples of the manager's role in reinforcing values and culture, facilitating visa processes and supporting staff who were new to the UK, and going out of their way to ensure access to training and to negotiate and advocate for staff with NHS colleagues when changes or innovations were being considered. A number of areas had recognised this and were planning to provide leadership development programmes for care home managers.

One area had started its approach to enhanced health in care homes by focusing on the experience and values of staff, and it was the only area in England to run Schwartz rounds in care homes. (Schwartz rounds enable staff to reflect together on a theme or a real-life event, so as to develop resilience to manage the emotional demands of work and not let them get in the way of focusing on residents' needs.) This approach of working in such a supportive way with care home staff had helped to build trust and confidence to broaden out into developing new roles and practices, and was expected to help improve staff recruitment and retention.

We also heard about care homes facing financial pressures who wanted to develop their services and, in particular, ensure the right staffing and competencies for them, so as to fit with and contribute to plans for developing out-of-hospital NHS services (in particular, through STPs). In some of these cases, the care homes were struggling to make the right connections to get sight of plans and to have their potential offer heard, because the process for developing strategic plans was unclear or processes and roles kept on changing. We observed that, in most areas, the approach to developing the social care workforce predominantly involved training in skills, which was not connected to local strategic plans for the health and care system or market shaping; we saw only a few examples of approaches to understanding and managing the workforce across the local system.

### **How do approaches extend beyond their initial scope and scale?**

As projects matured, they generally expanded in scope or size. Some projects which started in a targeted way went on to target a different set of care homes, but most started broadening out to cover a whole area for at least some issues (such as use of comprehensive assessments, long-term conditions management plans or screening of residents on return from hospital).



### Involving more GPs

Where GPs were not well engaged, data and persuasion were not sufficient to bring them on board without help from CCGs to mobilise peer discussion and include incentives in contracts. The areas that found it easiest to engage GPs were those with a long history of joint working (and, usually, a history of incentive payments by CCGs for working with care homes), or those that started with small pilots. In our sample of areas, rigorous monitoring and feeding back of pilot results were repeatedly advocated as a strategy for building awareness and ownership among GPs. We heard about cases in other areas (not the 15 in our sample) where GPs required payment of a retainer in order to visit care homes, unlike home visits to other patients. This is rare practice nowadays and widely acknowledged to be inappropriate.

*There's one GP practice, they absolutely support what we're doing but they're saying they don't have the resources to provide a regular clinic so they won't come out; they will react but we don't have advance care plans, we don't have DNAR [do not attempt resuscitation] status for some people and the GP does not have a regular clinic in that home. That particular care home is the one that's got the highest number of 999 calls and hospital admissions, and mostly they come from the GPs. We did our own little bit of research, just collating data, we were able to say 'well, across the six homes we can show that we've got between one and two hospital admissions over the last six months in five of the homes', compared to, I think, it was nine or ten in the home that didn't have the GP clinic. And when we compared that to the number of visits to each home, the home with the highest 999 calls had far more visits because they were just reacting. Per month, I think it worked out that the five homes having GP clinics each had between five and eight visits, and the home where they don't have the regular clinics had 24. But we have still not got them on board yet.*

(Care provider)

### Involving more specialists

The importance of access to specialist knowledge and services was emphasised by interviewees in all areas. But no area felt they could get the level of consultant geriatrician involvement that was needed. Some areas were not able to access community dentists and were not confident about improving that. Most felt they were not managing to get the right quality of engagement with acute hospitals



in general (eg, ward staff); where they did, it required time to meet hospital staff repeatedly in their workplace, as well as reasonably stable hospital staffing (eg, low agency use) and hands-on support from senior clinical staff and managers. In these cases, good progress was still being made but was, for the time being, largely weighted towards joining up primary care and community health professionals with the care homes.

*We've got four community geriatricians but whenever the pressure is in secondary care they get sucked back into the hospitals. We've got to be more serious about what these roles should be.*

(NHS provider)

*One of the big challenges we have is our acute trust. They are extremely challenged and they don't talk to us, they don't listen to us, they don't have any understanding of care homes and nursing homes, they don't even know on their registers which are nursing homes and which are residential.*

(NHS provider)

### **Involving more care homes**

Although interviewees in all areas found that it took time and effort at first to engage care homes, once word about the benefits of the approach had spread locally, it was straightforward to get most of the others involved. The depth of engagement also increased: we found many examples where sufficient trust had developed that care homes had been given the authority to propose and take forward approaches to solving challenges. For example, in one area care homes had been distrustful of how the hospital assessed people as ready for discharge to a care home, and so the local authority funded the care association (the local representative group for social care providers) to provide and manage independent 'trusted assessors'. Initially a pilot project, this had subsequently become an ongoing arrangement which had improved both relationships and the assurance of appropriate placements.

However, we also found examples where care homes had not been involved in this way; even in areas where enhanced health care was relatively longstanding, NHS and social care staff alike could quite easily fall back into solving their challenges in isolation when they were under pressure. Even when there were no specific



pressures, we heard examples of individuals who reverted to old ways of working (eg, not involving care homes in decisions). There was a constant need to reinforce the principles of working in partnership and to understand this in terms of how organisational cultures needed to change.

*You can't possibly do this unless you really engage with the care homes. People make this mistake the whole time... Even today one of the nurses at the acute trust was telling us about a meeting where they haven't got a single care home round the table – even after we've been on this six-, seven-year journey.*

(NHS provider)

*One of the areas got a bit of money and they were looking at setting up a hit squad although I don't think they used that term, made up of a community matron, pharmacist, dietitian, OT [occupational therapist] and GP that could go in and intensively work with the care home, not to work with specific patients but to look for examples of good practice, training needs and so on, in one area as a pilot and see if it reduced GP call-outs, hospital admissions, and the usual measures of quality. They said, 'This is what we're thinking about doing' and I said, 'Well, have you spoken to any care homes about this? Do you know if they need this?' 'Oh no,' they said, 'we haven't, we just know it's what they need'. And that really sat uncomfortably with me.*

(Clinical commissioning group)

Where approaches had started in an organic way – responding to whatever came up as requests and referrals, or to suggestions and ideas – they were very likely to need to evolve over time in order to strike a balance between responsive and system-wide approaches. The requests and ideas could become overwhelming in number and, when these projects became recognised as a work stream, the governance requirements of both local authorities and CCGs demanded forward plans. In general, those that started off with a system-wide approach across an area were able to describe a clearer view of how they had a planned approach to scaling it up, sometimes developing it as a social movement that would grow.

*We took a lot of learning from organic approaches where no idea is a bad idea, start very small and try things out, if it doesn't work it's still good learning, and so on. But the machinery of the local authority and the CCG works in completely the opposite*



*way to that. It is very structured and they want programme plans, highlight reports, accountability for what's going on. The two had to come together. As long as you are still able to innovate and to think differently, then [the balance] can still work and it's up to the leader to manage the balance between more organic creative stuff and the hierarchy and governance of the organisations we work in.*

(Local authority)

### Use of information

Scaling up usually required prioritising the development of information systems and how information was used. For hospitals, the emphasis was usually on manual systems to share paper-based information at admission and discharge, but for primary and community health care the emphasis was on electronic systems. Where electronic systems were in place, they were felt to provide a significant additional benefit, but areas were also making progress without them. Electronic systems invariably required significant inputs from NHS trusts or commissioners. Use of NHS.net to securely share information about individual patients by email had, in most cases, proved impossible to achieve without CCG support as part of a broader information strategy, including covering the local commissioning support unit's charges for hosting and supporting the service. NHS Digital is now developing guidance on information governance, which may make it easier to access NHS.net.

*If we could get NHS.net emails for care homes, that would be a game-changer because it makes life so much easier when you can exchange confidential information. It's so difficult to get NHS.net [that] we've almost given up. There are issues about who sponsors the care home, then you have to navigate the information governance rules and then finally there's who will provide support if somebody's locked out and forgotten their password and all the rest of it.*

(Care provider)

Staff often resented having to write duplicate records in different systems, or experiencing repeated gaps in record-keeping, to the extent that this could damage relationships. The areas which managed to avoid this resentment building up only did so at an unsatisfactory cost to efficiency – by adopting a policy of documenting activity twice in two different systems.



*If you were to ask what causes fractiousness in our relationship, it is the recording of notes. We hold the care plan, on paper. Sometimes NHS staff refuse to write in it, they say they've got their own records, so our staff have to write in it about care that someone else has provided rather than them.*

(Care provider)

Regular and formative evaluation to support continuous improvement was seen as useful, rather than one-off and summative evaluation. There was significant caution about the risk of over-stating benefits and reaching conclusions too early, with some examples of projects which had lost credibility and support by over-claiming successes. There was also concern that simplistic evaluations might lead to importing approaches used elsewhere without properly taking account of the local context.

*Our big worry is that especially with the pressure for quick results, we'll get STPs or other programmes that say, let's get a red bag scheme, let's do discharge to assess or some other approach that's been evaluated and promoted nationally. They often say let's put in a digital solution – and the care homes laugh because half of them haven't got Wi-Fi. The issue is they're identifying a solution and trying to do it to the care homes.*

(NHS provider)

Some areas were focused broadly on learning, through reflective practice and reviewing data, and were active in interrogating data. Examples include: daily reviews of data such as A&E attendances or discharges from hospital (case-finding to enable assessments within 72 hours of return to care home); weekly ward rounds; monthly Gold Standard Framework (advance end-of-life care) meetings, MDT review meetings and/or informal catch-ups for key leaders; monthly meetings to review performance information and reflect on incidents and events; and quarterly meetings to review emerging formative evaluation findings. Most places will not want all of these meetings, but a defined structure of regular use of data and discussions across organisations focused on learning and reflection helped many areas to build and maintain momentum, and helped address the lack of appreciation that many NHS services had initially of the range and scope of work undertaken by care home staff.



## What helps areas to scale up their approach?

Those areas that had a smoother path to expanding their enhanced health activities tended to:

- have clarity about their balance of responsive and planned work – keeping a clear direction while allowing for day-to-day flexibility and innovations
- have leaders who were conscious of their role in constantly nudging changes in behaviour and power dynamics, promoting values such as co-production and reinforcing achievements
- use information rigorously for regular formative evaluation and performance monitoring, and to demonstrate proof of concept in pilot projects
- engage constantly with staff as the approach expanded.

They adopted imaginative approaches to building capability in care homes without taking ownership of the challenges or of individual patients' needs away from care home staff. Examples included: benchmarking information so that care homes could see their hospital admissions or incidents relative to others; developing the leadership skills of care home managers as well as skills for hands-on care; creating ways for care homes to showcase innovations to each other locally; or supporting small-scale pilots of good practice that care homes could then build into their mainstream approach.

*Falls were identified as a major problem. We did falls training, we did individual falls assessments – the multifactorial NICE [National Institute for Health and Care Excellence] guidance ones – and supported getting individual management plans in place. But one of the things that was still coming out was that because there are a lot of people who are going to walk no matter what and are going to fall no matter what, one of the common themes was we just can't prevent all of these falls. So, we identified assistive technology or falls sensors, got some quotes, we approached commissioners, they gave us some temporary money, we bought a set of different falls sensors and we loaned them out to care homes like a library when they were trying to manage people who were likely to fall. And then, over time, they started to buy them when they saw how effective they were. Now we don't loan them, because the care homes have all put them in place for themselves.*

(NHS provider)



## Learning points

- **National guidance is in place to cover all of the main types of activities being developed in the 15 areas: there is no need to reinvent the wheel.** Organisations can draw on existing guidance, particularly NHS England's framework for enhanced health in care homes, the resources available via NHS England's website or the Social Care Institute for Excellence (SCIE). Creativity, innovation and sharing learning with others will also help, especially in terms of adapting approaches and activities to the local context.
- **There is a need to 'stick with it'.** Interviewees in the 15 areas reported some early 'quick wins' but also that much of the benefit of enhanced health in care homes emerged over time, and sometimes significant amounts of time (especially to embed culture change). There is value in keeping a long-term view. Furthermore, in some areas where previous approaches had not been sustained and had fizzled out, the resulting cynicism and disinclination to work together was still evident several years later.
- **Sustained leadership is needed and should be recognised and supported.** The essential role played by leaders does not reduce over time. Support through networks and communities of practice can help leaders at all levels to maintain constant engagement.
- **Enhanced health in care homes should be part of the local approach to place-based systems of care.** Over time, it is inevitable that developing enhanced health in care homes will involve system-wide issues, such as working out policy when responsibilities are unclear or overlap between local authorities and the NHS. Many of the principles of the approach in care homes could also apply for older people living in other settings, or even to other services, and so having connections to these – for example, by reporting into a broader locality or neighbourhood strategic planning group – could help.
- **Confidence in delegating responsibility is an indicator of effective relationships for enhanced health in care homes.** Where areas had developed sufficient trust that providers, especially care homes, could both propose and take forward solutions to challenges, this was more rewarding for the providers and could take pressure off system leaders. Where NHS staff felt able to delegate care tasks to the care home, it indicated trust and understanding of how each other's roles fitted together.



- **An ongoing role for leaders at all levels is to manage the historical power imbalance between social care and the NHS.** Even when attention was paid from the outset to developing mutual understanding, old patterns of behaviour were likely to reappear and issues which had been assumed (such as that no additional training was needed for NHS staff) would become apparent. Leaders at all levels need to keep alert to these kinds of issues, and reinforce the values of partnership and co-production.
- **Evaluation is essential but it should be formative.** Developing information about impact can help maintain commitment, bring more services on board, support business cases and enable learning and reflective practice. Areas making most progress used information rigorously and frequently, across the organisations involved. Evaluation should be for the purpose of learning, however, rather than for proving that a project has been completed; drawing premature conclusions could be damaging to credibility and to the ongoing, long-term task of embedding change.
- **As approaches mature, a focus will be needed on developing ‘enablers’ as well as hands-on care processes and relationships.** We have not presented experiences of how areas were working on the underlying processes that can support the long-term capability to develop enhanced health care, because most areas had not considered these, being still at quite early stages and therefore focused on establishing hands-on care processes and relationships. From a longer-term perspective, numerous other factors have significant potential to support the development and embedding of enhanced health care: co-ordinated commissioning; alignment of governance, performance indicators, funding and incentives; area-wide strategies for developing information systems across health and social care; area-wide strategies for workforce planning and workforce development; and market-shaping for adult social care. Leaders working at system level, across a local authority or CCG, should consider the need for longer-term enablers as well as the more immediate issue of operational processes.



## 7 Reflections and recommendations

In this section we draw out reflections on the broader policy issues that arise from our findings on enhanced health in care homes. They fall into four themes: the relationship between health and social care; the position of social care in place-based systems of care; the impact of enhanced health in care homes; and support for the leadership that it requires. To conclude, we offer a number of recommendations which may help with extending and embedding enhanced health in care homes.

### Reflections for policy

#### Relationship between health services and care homes

Most of the 15 areas in our study were at an early stage of joining up and co-ordinating health services and care homes. Many other areas will still have 'unenhanced' health in care homes, in which care homes are often seen as an add-on to health care and in a supporting rather than equal role. That view of care homes can lead to insufficient engagement and thus problems with basic access to health care for residents. We found that those problems still exist, and we heard that some GPs still charge for home visits; these issues generally do not arise for people living in their own homes. As one interviewee told us:

*Calling this 'enhanced health in care homes' is ridiculous, isn't it? We're just talking about care home residents not being disadvantaged.*

The situation is further complicated by most care homes being in the independent sector, rather than part of the public sector. This is especially an issue in areas with high proportions of self-funders. Local authorities and NHS bodies are not clear or consistent about the extent to which they accept it as an appropriate use of public funds, to invest in training the staff of independent sector homes, or to include independent sector homes in investment plans for integrated IT systems.



In policy terms, the need for equality of access to good-quality health care is the theme that runs through these observations. Achieving this should determine how services work together, and how they develop systems and processes. We are re-stating an issue that others have highlighted in the past (see, for example, [British Geriatrics Society 2011](#)), because these well-known inequalities still need to be addressed in many areas of the country.

### Care homes in place-based systems of care

Enhanced health in care homes is one of a number of local approaches to providing care that meets the needs of older people living with frailty and complex conditions. We found that even where approaches start off as practical, hands-on quality improvement, as they mature, they need to fit with broader strategies for meeting this population group's needs.

As such, enhanced health in care homes is part of the wider move towards integrated and co-ordinated systems of care. We have focused on care homes, but the same observations may also be made about home care, extra care housing and other forms of social care. Much of the debate and analysis of place-based systems of care focuses on the NHS, but social care needs to have prominence too as a key partner.

There is no road map for developing social care in placed-based systems of care: there is no equivalent, for example, of the Forward View, which signalled the future direction for care models in the English NHS, or its sector-specific companion reports such as the *General practice forward view*. At the same time, concern about the care home market makes it even more important to understand how the wider health and care system can support the quality and stability of social care. Where care homes are at risk of becoming financially unviable, could closer working with local health services and place-based systems of care reduce the risk of unmanaged market exit? For example, this might mean that care homes were able to plan ahead on the basis of being able to work in partnership and be part of implementing STPs. The NHS could also benefit from care home involvement in providing a greater range of out-of-hospital services, as envisaged in the Forward View. This makes it all the more important that local systems of integrated and co-ordinated care, especially at locality or neighbourhood level, explore how to fully engage the social care sector in both planning and implementing these approaches.



Our sample of 15 areas suggests that involvement is sometimes limited to social care commissioners, and not the providers of care. Interviewees in all 15 areas were mainly focused on developing operational processes to deliver care, and on developing closer working relationships. Closer involvement of care homes in local plans for place-based systems of care may help them to develop the underpinning capability needed for enhanced health (eg, by being included in broader workforce strategies) and may create new opportunities for ways of thinking about future out-of-hospital services (eg, future roles of care homes in reablement services). However, care homes' willingness to engage in this way is not a given, and they will need to see both the value and the feasibility of contributing to place-based care plans.

### **Impact of enhanced health in care homes**

Enhanced health in care homes can achieve significant results within a short period of time. Its achievements should not be overshadowed by larger and more complex new care models, and should not be seen as limited to the six areas designated as vanguards.

Indirect measures of impact (such as the number of hospital admissions), from which we can make inferences, are second best to direct measures of improvement in the experience of care and, in particular, quality of life for care home residents. For example, a high rate of hospital admissions may be as much an indicator of poor availability and responsiveness of community health services (which were therefore unable to provide appropriate care in the home without the need for admission), as of quality of care in care homes. Measures of the quality of care which span services, rather than looking at each service separately, would help – as The King's Fund has proposed in the past (for example, [Ham et al 2016](#)), and the CQC has recently consulted on.

The prominence given to involving care home residents and their families in developing the approach to joining up health services and care homes, and in evaluating their impact, was lower than we had expected to find, given the history of involving people and personalising care in the social care sector. Services need to challenge themselves on whether they have the right level of involvement for residents and relatives, including social care services challenging NHS ones and vice versa. In particular, research literature is clear that evaluations framed primarily in



terms of fewer hospital admissions and lower NHS costs are not associated with the relationships needed for progress to be sustained; the outcomes of working together more closely need to resonate with all the partner organisations' priorities (Goodman *et al* 2017b). In the 15 areas of our study, achieving positive benefit to residents' health and quality of life were the priorities that staff in different organisations consistently cited as the purpose of working more closely together, and presented – often passionately – as their first priority.

Some studies have measured the impact of enhanced health care on quality of life for care home residents (*see, for example, literature summary in Goodman et al 2017a*), but their findings had not translated into practical approaches in any of the 15 areas we looked at. More research and practical guidance are needed.

Even so, measuring quality of life and understanding causality are both so complex that local areas and policy-makers may just have to tolerate this being perceived by some as 'woolly'. One provider told us:

*It's really difficult to pin down one particular intervention which has made that saving or that improvement in quality of care. It's the blend, and the relationship with the home, and embedding all the little things that add up to the whole.*

### **Leadership for enhanced health in care homes**

Leadership – both of services and of local health and care systems – plays a crucial role in supporting the relationships and approaches that are necessary for enhanced health in care homes. NHS England has provided leadership at national level, and interviewees in the 15 areas of our sample had welcomed this and found it to be of real practical help. However, there is a need to avoid a vacuum being created when NHS England's vanguard programme comes to an end in April 2018.

Our experience of leading a learning network together with My Home Life, and our findings in this report, underline the importance of networks and communities of practice for leaders at all levels locally to share learning and support each other. In conducting the research for this report, we found that, as approaches to enhanced health matured, new challenges were inevitably identified. The need for networks is therefore likely to continue for some time.



The recently published framework for leadership development across both the NHS and – in planned future iterations – the social care sector ([Department of Health et al 2016](#)) may create an opportunity in the future for leaders from across the system (including care home managers and, where they are hands-on, care home owners) to participate in common leadership development activities and to increase understanding of each other's roles.

At present, however, we observed an inconsistency in the messages that care home leaders receive. In particular, although we often saw a developmental style of leadership in the 15 areas, we also heard how a fear of regulators, commissioners and safeguarding processes could cause care home leaders to avoid taking on the uncertain task of developing care processes in partnership, or generally make them reluctant to raise their heads above the parapet. It is not clear how much that fear is justified or not, but it was very evident in interviews in all 15 areas, and has the potential to act as a brake on development of the leadership that is needed for enhanced health in care homes.

## Recommendations

Our recommendations aim to build on progress and realise the potential that we identified in the 15 areas in our study.

- We found that many areas were making progress with enhanced health in care homes, not just those designated as vanguards. All areas of England should develop enhanced health in care homes because doing so can bring significant benefits within a short time both to care home residents and to the wider local health and care system. In doing so they should draw on a wealth of learning that is available from many areas of the country. STPs and other locality planning arrangements can provide support and an overall strategic direction by involving social care providers in the development and implementation of local strategic plans.
- We found that leaders of projects to join up health care and care homes have an essential role. They should reflect on the experiences described in this report, not only to learn from what has been achieved but also to consider addressing the 'gaps' in current work, such as:



- developing local approaches to ‘enablers’ such as commissioning, information technology and workforce strategies, beyond the current focus on ‘hands-on’ care processes and relationships
  - focusing on the broad overall purpose of enhanced health in care homes (ie, maximising health and quality of life for older people with complex needs), ensuring that quality of life is monitored, and engaging social care providers in broader local strategies for place-based systems of care
  - involving care home residents and their families in developing overall approaches to enhanced health in care homes and the ways in which quality is monitored, building on the high levels of residents’ involvement in decisions about their own care.
- NHS England has played an important role in supporting enhanced health in care homes. It should seek to ensure that momentum is maintained after the vanguard programme ends in April 2018, and that the learning derived is used to support further rollout and scaling up of enhanced health for older people. For example, it should:
    - encourage national bodies and membership organisations to build on what has been achieved so far by disseminating good practice and facilitating learning networks (especially to provide support for local projects and leaders to keep working on enhanced health, and to engage effectively with regulators, commissioners and safeguarding processes)
    - stimulate a national conversation about what an expected standard of NHS provision for care homes should look like, and what responsibilities public sector organisations should take for investing in the training of care home staff, as well as including care homes in IT strategies.
  - We found continuing concern about care home residents’ access to an appropriate range of NHS services. CCGs must ensure that arrangements are in place to remove inequalities of access to an appropriate range of services, including community dentistry, community geriatricians and free home visits by GPs.
  - We identified that more research is needed into enhanced health in care homes, particularly on:
    - practical approaches to measuring the impact of enhanced health on quality of care and quality of life for care home residents
    - modelling and analysis of returns on investment, to test the assumption that the cost of enhanced health in care homes will be offset by savings from reductions in hospital and ambulance use.



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**Alex Baylis** joined The King's Fund in March 2016, and is assistant director in the policy team, overseeing and leading policy projects on a range of health care, care quality and NHS system topics.

Before joining The King's Fund, he worked at the Care Quality Commission (CQC), where he led development of the framework and approach for inspecting and rating hospitals, and at the Healthcare Commission, where he introduced risk-based regulation in the independent sector. Alex also led the CQC's work with the Department of Health on the policy and legal framework for quality regulation, and with the Department and other national bodies to agree roles and responsibilities for responding to serious concerns.

Before working in quality regulation, Alex worked in management in two NHS trusts. He has also worked for the Department of Health and the World Health Organization Regional Office for Europe in Copenhagen.

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She holds a first-class degree in education for health care professionals, an MSc in clinical research and a PhD in medical anthropology. She is also a qualified executive coach.



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Caring for older people in care homes is one of the most important priorities for the health and care system in England, but studies have shown that care home residents often have poor access to the full range of health services they need. In some areas of England, hospitals, GPs, community health and social care services are working together to deliver enhanced health in care homes, but what can other areas learn from these projects?

*Enhanced health in care homes* looks at the experience of vanguards and other areas where services are working together to actively promote good health for care home residents rather than just reacting to ill health. The report is based on interviews with people working in 15 areas in England and seeks to share learning from their experiences that will be of benefit to those embarking on enhanced health in care homes projects.

The report finds that:

- although approaches varied, all areas reported positive results, including those with unexceptional histories of joint working and funding arrangements
- early positive results often started to show up within a few months, while organisations continued to develop new ways of working together (rather than only after these new approaches had become embedded)
- better ways of measuring impact, including effects on care quality and quality of life, are needed and more attention should be paid to behind-the-scenes 'enablers' such as aligning commissioning, governance and workforce plans
- enhanced health in care homes requires skilled leadership, not least to constantly reinforce equal partnerships: networks and communities of practice are essential to support leaders at all levels and share learning.

More national guidance is needed on expectations for access to health care for care home residents; how enhanced health in care homes is resourced; and the appropriate use of public funds to support training and information systems in independent care homes.

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