Evaluation of the Enhanced Universal Support Offer to Care Homes across the North East and Yorkshire Region

October 2020

NHS England and NHS Improvement

Background

‘There are over 2300 care homes in the North East and Yorkshire Region, caring for some of the most vulnerable people in our communities.

With rising rates of COVID-19 infection in April 2020 it was clear that we needed to work with partners across health and social care to combine our collective efforts and expertise to support the sector.

A set of universal principles were agreed in May and rolled out at speed, building on existing good practice to offer additional support in the context of the unparalleled challenges we were facing.

This evaluation has allowed us to start to reflect on what has worked, what is needed and most valued by the sector and to inform future planning’.

Margaret Kitching – Regional Chief Nurse NEY, NHSE/I

Principles to Deliver an Enhanced Universal Support Offer to Care Homes in the North East and Yorkshire Region

- Implemented in May 2020 the overall aim to deliver an enhanced healthcare support offer to all care homes in the region by adopting a core set of principles in response to COVID-19
- Multi-agency collaborative approach to deliver the enhanced offer in 4 areas:
  - Leadership
  - Prevention
  - Additional clinical support
  - Workforce
- Self assessment against the principles undertaken by each CCG in May and July 2020, demonstrating improvement and progress
- *The self-assessment tool is a measure of inputs rather than impact, experience or effectiveness. Therefore, a qualitative evaluation was commissioned to begin to understand the impact of the interventions*

Qualitative Evaluation

Aim

- To undertake a co-designed appreciative enquiry into the benefits arising from the enhanced support offer, in order to understand which elements are perceived to have had a positive impact and are wanted and needed. To decide collectively what should be retained or to inform the strategic planning for further care sector support

Objectives

- To co-design a data collection process using an appreciative enquiry approach, and based on the stakeholder engagement in the delivery of the enhanced support offer
- To interview and undertake focus groups based on purposive sampling of leaders and clinicians with direct experience of the enhanced support offer across the region.
- To undertake a systematic (framework) analysis of the qualitative data – identifying themes related to benefits and any challenges within the implementation
- To compare the findings with the existing data associated with care home sector quality and outcomes at regional level including any analysis of resident and care feedback and experience
- To co-produce (with the evaluation steering group) a shared understanding and set of recommendations from the data, related to future planning for care home support
- To report on learning, limitations and recommendations from the evaluation process
- To share recommendations and identify what has worked well and what should be retained, how we should harness innovation and collaborative working going forward

Data Collection

- The sample was purposeful and a list of key stakeholders to be interviewed agreed
- The methodology was ‘Appreciative Enquiry’
- Interviews were conducted by NHS Graduate Trainees and Public Health Trainees
- 14 Semi-structured interviews and 8 focus groups were undertaken in August and early September, with 55 stakeholders from the following groups:
    - **Independent Care Sector Groups**
    - **Care Home Managers forums**
    - **Community Nurses**
    - **Chief Nurses in CCG’s**
    - **Directors of Adult Social Services via ADASS**
    - **Local Authority Commissioners**
    - **Local Resilience Forum members**
    - **Pharmacists in CCGs**
    - **Pharmacists in Primary Care multi-disciplinary teams**
    - **General Practitioners**

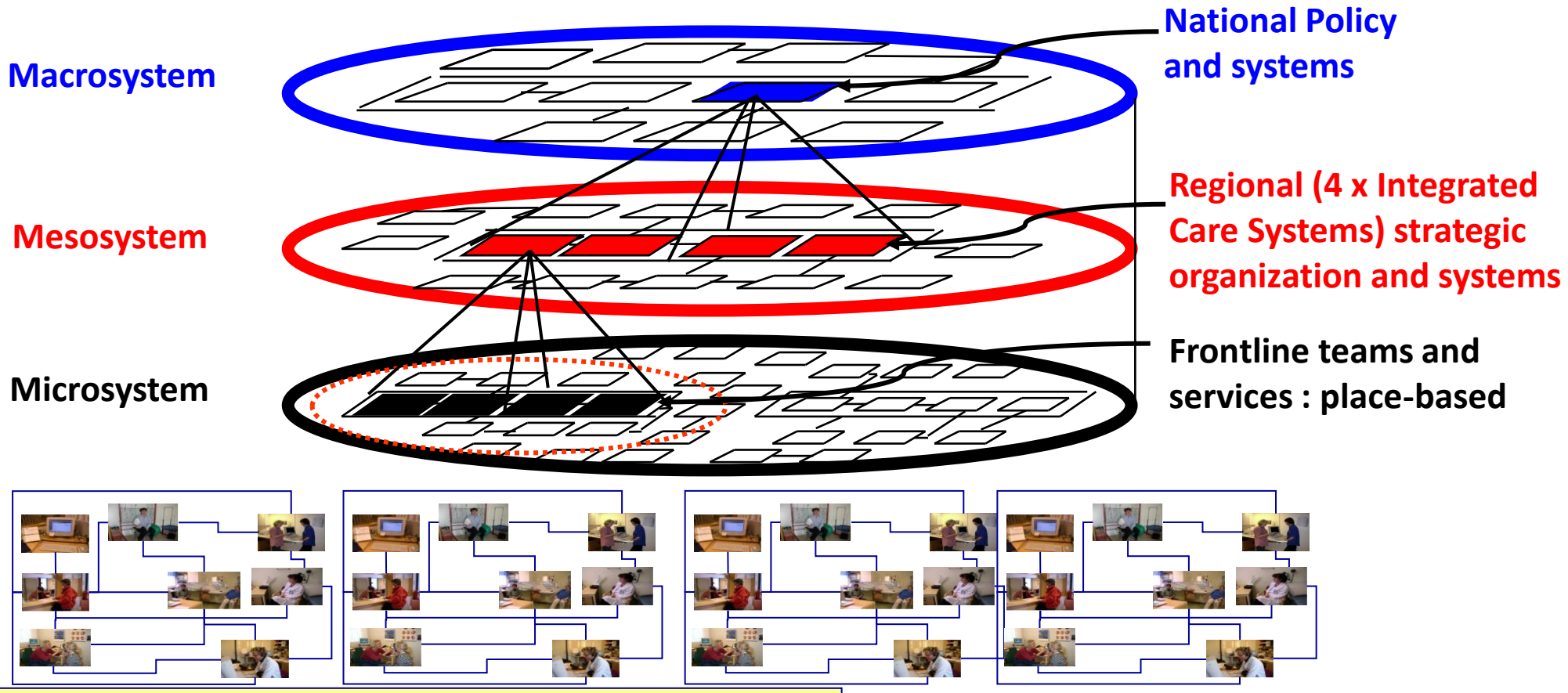
Data Analysis

- Data analysis has been undertaken at Sheffield Hallam University within academic guidance and support from the evaluation steering group
- Thematic analysis using NVivo 11 has been shared with the evaluation group who have met to review learning and insights
- Additional quantitative findings were presented to showcase achievements across the four ICS's and used as context for the qualitative evaluation

Synthesis:

- The findings was discussed with the steering group
- A shared understanding of the way that the enhanced support offer has been experienced; what has worked well (*i.e. benefitted safety and wellbeing of residents and staff*) and what learning needs to be identified for further planning (*i.e. where the enhanced offer was perceived to be unhelpful or ineffective*).
- The focus will remain on quality improvement and organisational learning with additional recognition of leadership and activity at three levels
- A formal report will be disseminated
- A publication will be produced

A framework for understanding the findings at 3 organisational levels



Source: Hendriks & Bojestig, Jonkoping City Council Sweden

Staines, A., Thor, J., & Robert, G. (2015). Sustaining improvement? The 20-year Jönköping quality improvement program revisited. *Quality Management in Healthcare*, *24*(1), 21-37.

Summary of impacts identified within the evaluation- high level overview

An increased appreciation of the policy and principles within the enhanced offer and value of the investment and focus on care homes

National Policy and systems

Joint working (health, local authority and care homes) commitment to build structures, systems and process for improvement related to health and care. Investment in medication optimisation and technology use

Within and across the 4 ICS's - strategic organisation and systems

Access to named GP with named community nurse working as a part of a wider multidisciplinary team, with the local authority and partners maintaining regular contact; delivering services that supported care home residents and staff

Frontline teams and services: place based

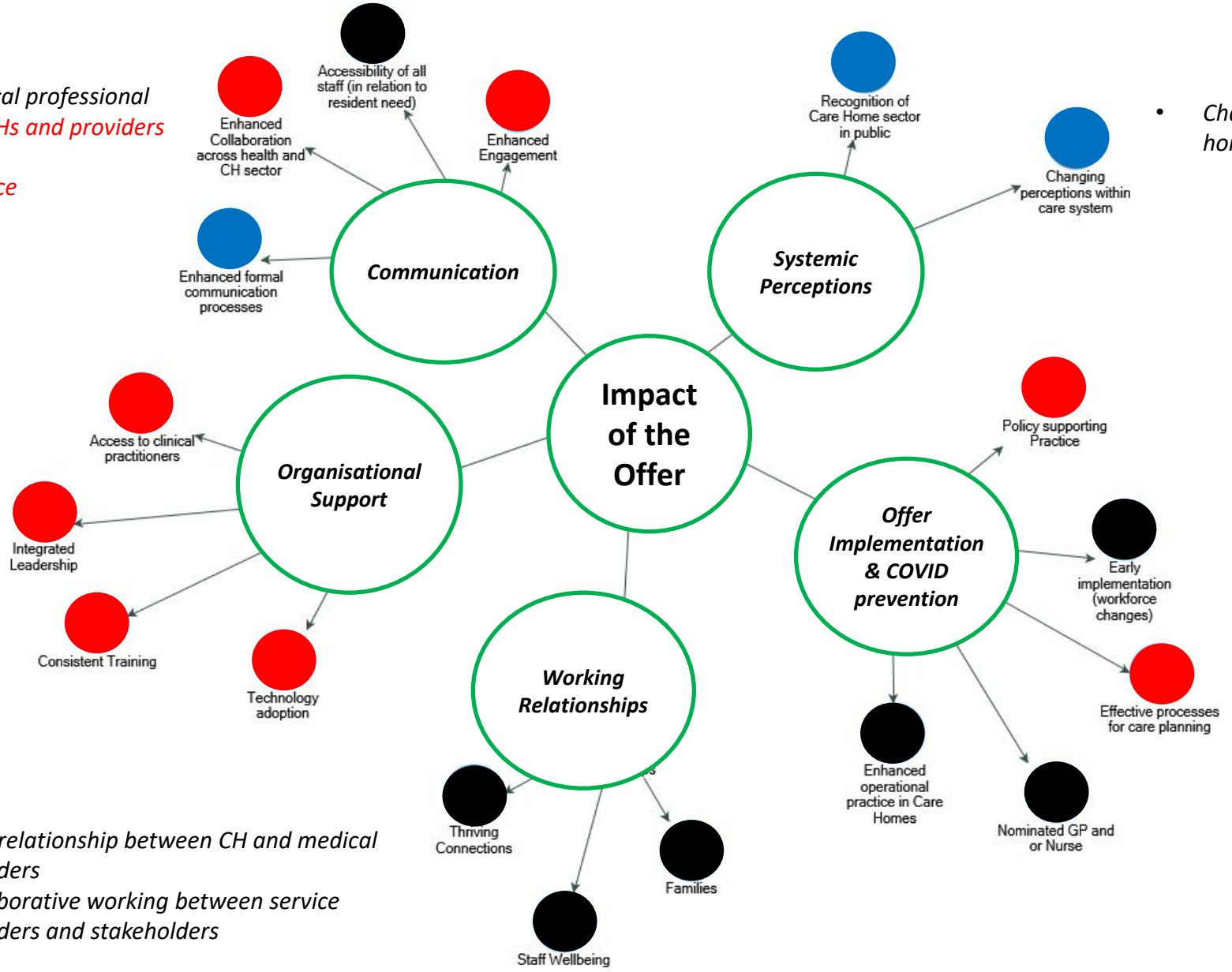
Key themes from the interviews and focus groups

Through input from the steering group and further inductive analysis, five main themes relating to both the impact and learnings of the offer were formed:

- **Communication –** defined as the factors relating to system-wide communication between service providers, ICS groups and national bodies.
- **Working Relationships –** defined as the factors involved in relationship maintenance and development across all organisational levels (front line, ICS, national).
- **Systemic Perceptions –** defined as the wider perceptions of the health and social care system and societal care roles.
- **Offer Implementation & COVID prevention –** defined as the processes involved in the Enhanced Offer being implemented and preventative measures relating to COVID infection prevention.
- **Organisational Support –** defined as the factors related to positive/negative support from frontline staff, ICS groups and national bodies.

Themes arising from the interviews and focus groups: *Impacts colour code*

- *Constant contact with homes*
- *Direct contact with GP or medical professional*
- *Establishing feedback loop to CHs and providers*
- *MDT positive collaboration*
- *Sharing of skills and best practice*



- *Changing outside perception of care homes*

- *Clear delegation of leadership across organisations*
- *Positive support in training for CH staff*
- *Integration of IT clinical systems*
- *Introduction of tablets into CHs*
- *Remote consultations*
- *Video calling software for MDTs*

- *Pre-implemented support before lockdown*
- *Streamlined CH processes*
- *Adapting policy to suit individual CH*
- *Regular patient reviews or assessments*

- *Built relationship between CH and medical providers*
- *Collaborative working between service providers and stakeholders*

Key:

- Macrosystem (National policy/systems)
- Mesosystem (Regional/ ICS level)
- Microsystem (Frontline teams/services)

Quotes – Impact of offer

That triangle of communication which I think has really improved now, that we have said, this is your point of contact in practice for any medication problems. *(Medicines Optimisation Pharmacist)*

Any questions we had were answered quickly and good support from CQC as well. Supported us with queries. ... We had queries around testing and capacity and working around people who didn't want to be tested. *(Senior CH Managers, focus group)*

They have regular meetings which allow conversations and support to be in place which will "help share some of the difficulties". *(GP)*

We moved mountains on those Friday evening meetings (Chief Nurses, Focus Group)

Residents had more access to a GP than normal in some instances which made them feel safer and more cared for from a health perspective *(Chair of Registered Managers Forum Group)*

[The] sudden realisation that we could do more remotely without anything changing *(Clinical Leads, focus group)*

Themes arising from the interviews and focus groups: *Learnings*

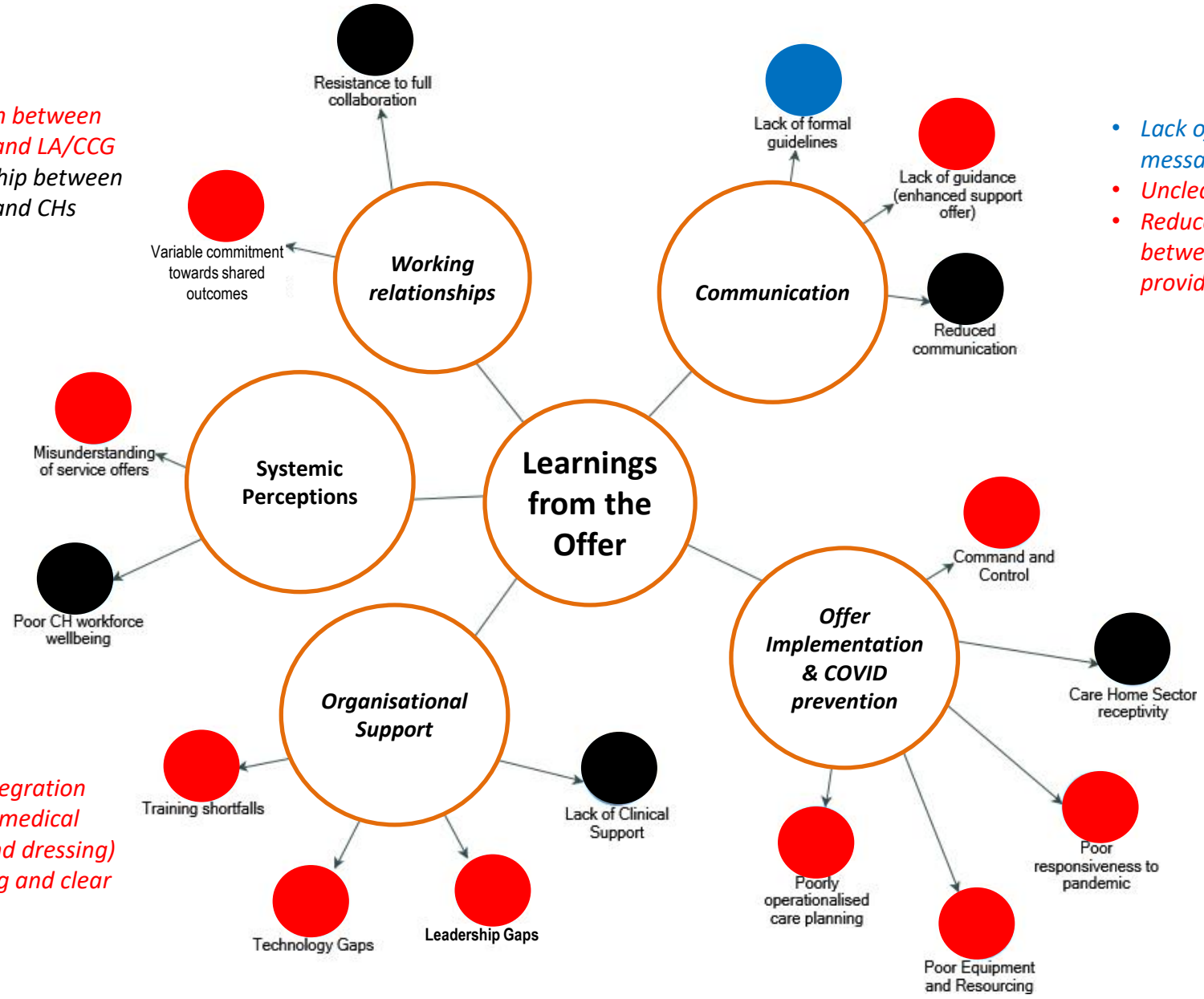
- *Lack of integration between service providers and LA/CCG*
- *Strained relationship between service providers and CHs*

- *Lack of correct or clear messaging from national bodies*
- *Unclear PPE IPC guidelines*
- *Reduced communication between CCG/LA and service providers*

- *Care Homes feeling abandoned*

- *Enhanced offer reactive rather than proactive*
- *Lack of suitable discharge procedures*
- *Funding too prescriptive and inflexible*
- *Lack of testing*
- *Reduced access to PPE*
- *CH heterogeneity of response*

- *Lack of technology integration*
- *Lack of CH training in medical procedures (e.g. wound dressing)*
- *Need to identify strong and clear leadership*



Key:

- Macrosystem (National policy/systems)
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Quotes – Learnings from offer

There has been no variation for individual needs. There has currently been a lack of provision for mental health and LD facilities, which should be addressed. (*Chief Executive in Care Home)*

A lot of local areas had already initiated approaches to this. And I think it's a challenge when you come at anything with a standardised, top down way it's how do you make those two things join up. And I'm not sure how well that happened in practice at the time. *(Quality and Improvement Manager)*

Having experienced an outbreak and losing residents… due to the infection you couldn't do end of life…very difficult to mentally find positivity within you (Care Home Managers, Focus Group)

I think the main thing that would make a difference would be to somehow put some sort of governance, or leadership in place… we almost need to treat it [health and social care as] as one unit. *(Chief Nurses, focus group)*

"GPs aren't on the same IT system so we can see the same resident but we don't know what has been done. But we're in the same building so I can call the GP directly and need to if I'm worried about someone *(Region wide community nursing FG)*

Key enablers and inhibitors in the approach to implementation*

*The analysis suggests that there are some organisational factors that lead to best and worst outcomes in relation to building and sustaining the improvement in care homes through the the enhanced offer to care homes – these are contrasted above

Enablers (do more)

Early implementation of response – preparedness and anticipation of needs based on evidence and existing networking

Person-centred communication – a commitment to problem-solving and co-production around the resident and the care home population

Commitment to shared strategic planning – collaboration at every level with strategic prioritisation for improvements communicated to all providers.

Recognition of care home sector and collaboration – enabling rapid implementation and outcome and impact assessment and shared evaluation

Inhibitors (try to do less)

Reactive response – slow and poorly operationalised response due to inadequate and sustained team building and structures

'Command and control' – focus on deliverables that meet the health agenda without specific guidance from care homes about the timeliness or need for support

Health orientated planning 'imposed' on care sector - negative view of 'low-skilled' care works perpetuated with training model and resulting dependency and/or resistance.

Misunderstanding of care home services and/or 'forced' collaboration - early relationship or mistrust or reticence in place-based integration associated with care home sector

Discussion

*Based in additional elements for sustaining quality improvement and organisational learning that appear in the literature and other surveys, i.e. Healthwatch reports and AHSN technology evaluation, but were not strongly present in this analysis

- **Workforce issues** – several Healthwatch reports demonstrate the residents' concerns for staff wellbeing and the importance of maintaining and supporting the care home managers and workers. In addition, the level of sickness, absence and ongoing resilience of the care home workforce is lacking, also the risks associated with agency workers in terms of viral transmission and general operations of the care home.

- **Sustainability of the sector -** some care homes and care organisations are openly publishing the increased costs incurred during the pandemic in relation to reduced bed occupancy and increased costs of PPE and agency staff. Little was referenced in terms of the impacts of enhanced health care in relation to the wider care provision and operations.

- **'Seldom Heard Voices'** – some care homes are 'harder to reach' and their residents may also represent more marginalised populations. The equality and diversity of provision is not referenced and this may be an important factor to enhance the care home offer in relation to targeted population health management at place. People with dementia are especially affected.

- **Culture of health and care delivery –** the analysis of assets and deficits is generally understood as a series of strategic and operational commitments and processes. A wider consideration of the cultural challenges faced by the care home sector is warranted. The overarching negative view that society places on care homes is discussed in the literature and could be an important consideration in terms of the shared values associated with enhanced offer, e.g. a 'culture of learning' is suggested as an alternative to existing rhetoric about 'training (*low skilled*) care home workers'

Strengths and limitations of the evaluation method

Strengths

- **The evaluation was co-produced-** The study was devised and co-designed by a group of senior managers across health and local authorities, with direct involvement in the Enhanced Universal Support Offer to Care Homes. Sheffield Hallam University and a number of NHS Graduate Trainees and Public Health Trainees supported the work which was funded by the 'Better Care Fund'. (Steering group members are detailed in the appendices)
- **The evaluation showcases the substantial improvements made at a NE region** in the health care support experienced by some care homes, where the access to clinical expertise and proactive engagement with homes was highly valued by the sector. This includes a step forward in digital methods.

Limitations

- **Timely access to resident and family carer views**; the interviews include questions about residents experience but further substantial attempts are needed to reference the resident or family carer experience during the pandemic.
- **Variations in practice quality**; it was apparent that each ICS area has pockets of exceptional practice and also, at place, areas where further integration of strategic planning is urgently needed. The quantitative data does not allow for detailed discrimination at place level.

Thanks to those who contributed via interviews and focus groups and focussed on the impact and outcomes of overall health support during the C19 pandemic since March 2020.

Recommendations

1. **Sustain the support for care homes with named GP and named community practitioners** - The evaluation identified how teams of practitioners with named GPs working in close collaboration with the care homes, enabled the homes to enhance their operational activity, this is supported by the research literature.

2. **Significant effort is needed to incorporate the priorities of residents and acknowledge the skills of care home staff in meeting these needs-** In future planning, delivery and evaluation of the enhanced offer there will be a clear commitment to collaboration and partnership with residents, managers and staff to be clear about 'what matters' in the care home setting.

3. **Develop a culture of learning using remote and technology-based methods -** as the acuity of residents and the demand for health services increases so does the complexity of resident need. Learning methods and outcomes need to be sustainable, quality assured and evaluated for the impact in practice.

4. **Increase clarity and specific national and regional Covid19 policy and testing practice -** Cost, staff satisfaction and resident outcomes need to be closely monitored with effective personal care plans, to maintain and improve the relationships between the care sector and local authorities; with communication as a key variable in success.

5. **Ensure that integrated health, social care and care home leadership achieves a shared vision of population health-** The best operational practices appear to be supported by fully integrated leadership systems across health and local authorities.

6. **People with Dementia (PwD) in care homes may require specialist care following Covid19 or as a result of home-isolating –** rehabilitation and palliative care are specific needs, supported by pharmacy and allied health professional practices that respond to care home resident needs.

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Reports

- Your Healthwatch Leeds (June 2020). What relatives of care home residents in Leeds are saying about their family member's emotional wellbeing
- AHSN - Rapid Insights into Digital and Technology Solutions in Care Homes during the COVID-19 Pandemic North East and Yorkshire July 2020

Appendices

- The quantitative data is presented below
- It reflects the range of practices across the ICS's
- The sitreps reflect the reports from the ICS in relation to local (place) knowledge
- Changes in the elements of the support were reported by the CCG's and ICSs with the data presented on process outcomes between May and July 2020

1. Mortality data

Deaths occurred in England and Wales between 1st January 2020 – 21st August 2020 (all locations)

Total number of deaths 463,760

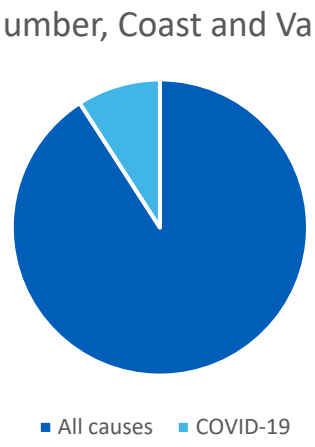
Total number of deaths: All causes 409,053

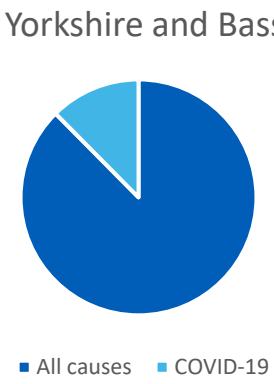
Total number of deaths: COVID-19 54,707

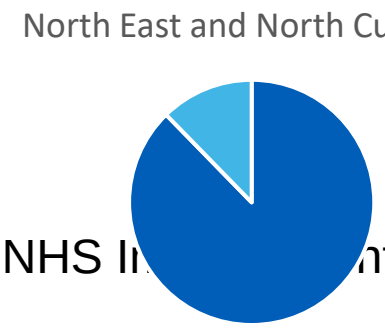
Ref: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard

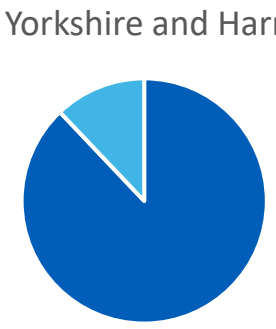
Number of deaths (all causes) by ICS	Total
Humber, Coast and Vale	9590
North East and North Cumbria	22948
South Yorkshire and Bassetlaw	10666
West Yorkshire and Harrogate	13840
	57044

Number of deaths (COVID-19) by ICS	Total
Humber, Coast and Vale	961
North East and North Cumbria	3220
South Yorkshire and Bassetlaw	1513
West Yorkshire and Harrogate	1902
	7596



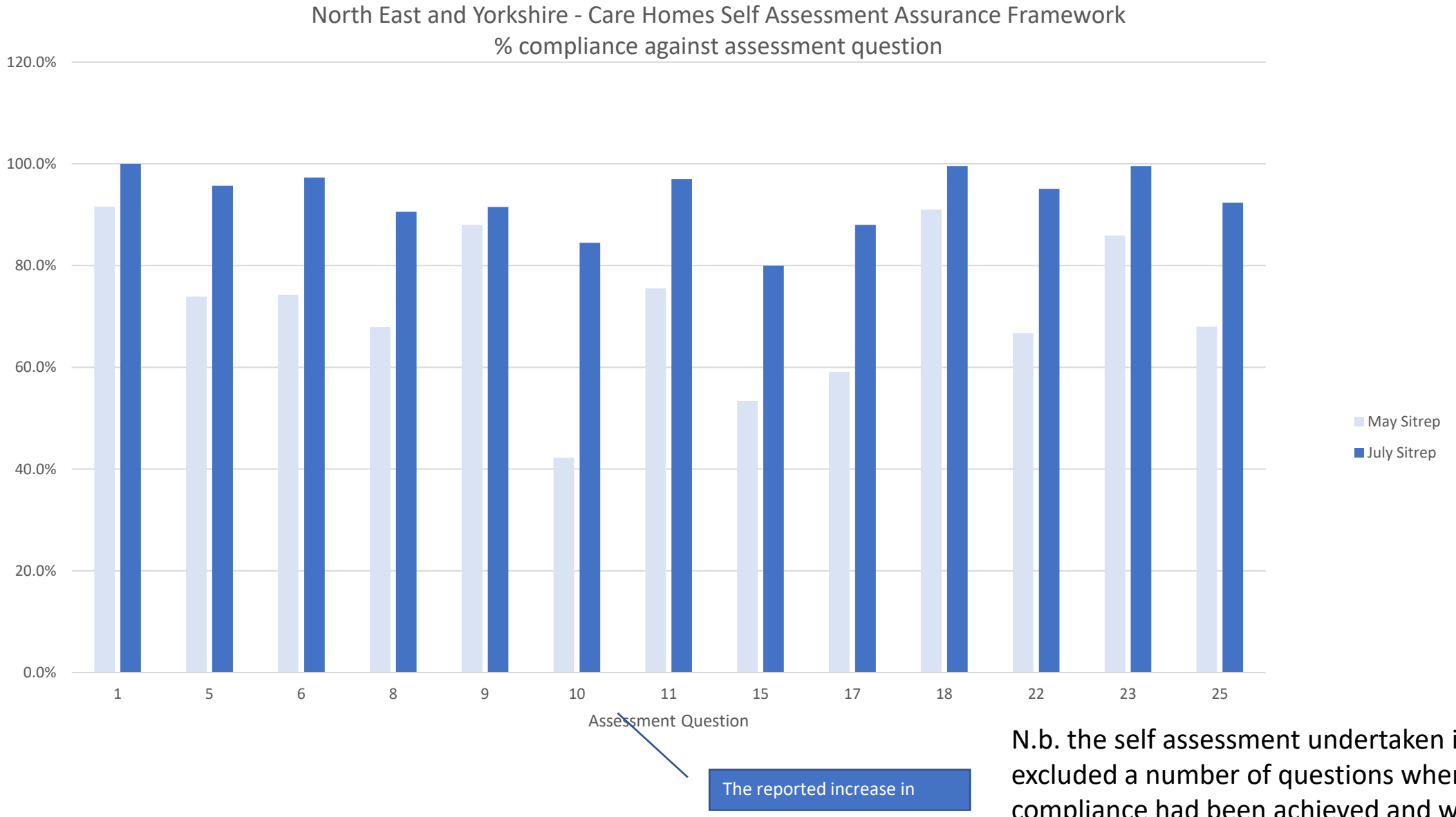






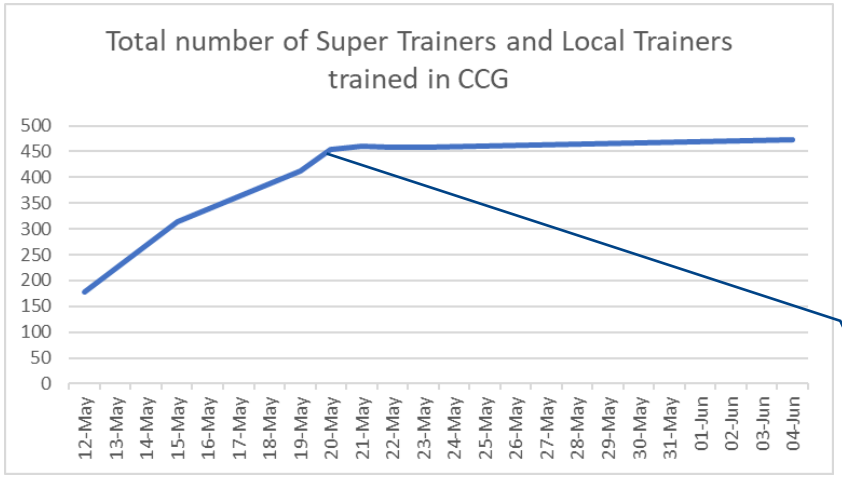
Elements of the enhanced support offer

	Self-assessment Questions
Named Contact/Clinical Lead	
1	Number of care homes with a named, nominated contact ?
2	Number of care homes with a named clinical lead ?
Access to advice/support for care homes	
3	Number of care homes with access to Specialist Infection Prevention and Control (IPC) advice ?
4	Who is providing IPC advice ? (Include answer in additional comments section)
5	Number of care homes offered a visit (including virtual) by a community nurse on a daily basis ?
6	Number of care homes who have been supported to develop preparatory or reactive plans to manage an outbreak ?
7	Number of care homes who have successfully enacted outbreak plans ?
8	Number of care homes who when identifying concerns via the capacity tracker receive a daily call ?
9	Number of care homes who are receiving a daily supportive call (from which partner organisation may vary)?
Support for residents/patients	
10	Number of care homes who have a weekly MDT (including virtual) to support vulnerable patients ?
11	Number of care homes who can access specialist MDT's (including virtual) as needed ?
12	Number of care homes with personalised care plans for 100% of residents ?
13	Number of care homes who can access COVID-19 testing for residents ?
14	Number of care homes who can access pharmacy support for medication supply / review / queries ?
15	Number of care homes where all COVID positive patients discharged from secondary care have a follow up by a face to face visit by a nurse / AHP / community nurse involved in their discharge ?
16	Number of care homes who have access to 24/7 support by telephone /video link /telehealth ?
17	Number of care homes where remote monitoring is available for residents with confirmed or suspected COVID-19 ?
Support/training for staff in care homes	
18	Number of care homes where staff have access to psychological support associated with the COVID-19 response ?
19	Number of care homes with access to IPC training (including a train the trainer approach) ?
20	Number of care homes who have accessed IPC training?
20a*	*Extracted from national IPC care home training sitrep:* Percentage of care homes where IPC/PPE/testing training has been delivered
21	Number of care homes where >80% direct care staff have received Covid-19 IPC training ?
22	Number of care homes with access to End of Life care training (including a train the trainer approach)?
23	Number of care homes who can access educational resources / virtual training ?
24	Number of care homes where staff can access COVID-19 testing ?
25	Number of care homes where support is available for staff in high risk groups ?

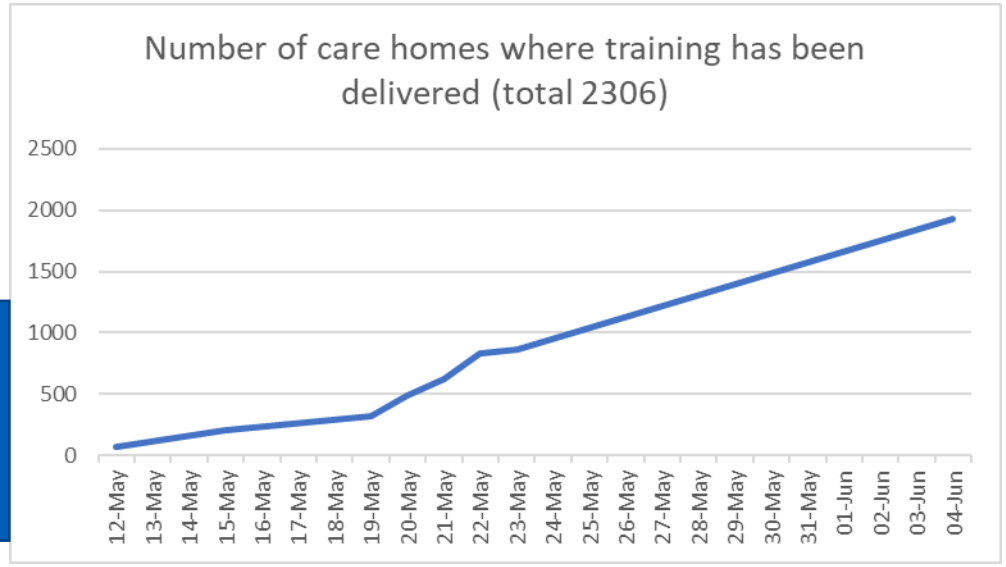


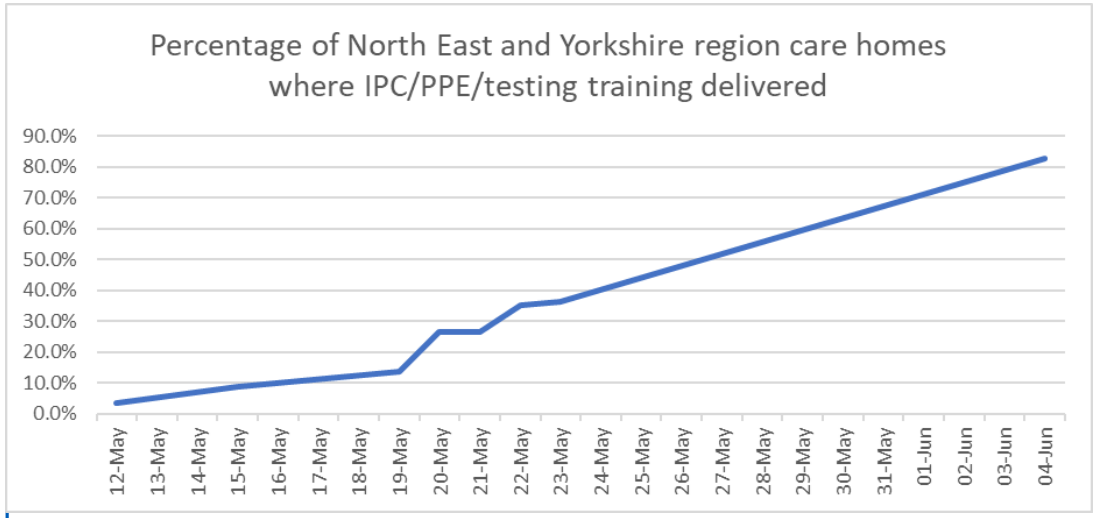
N.b. the self assessment undertaken in July excluded a number of questions where 100% compliance had been achieved and where superseded by the Primary Care and IPC national sitreps returns

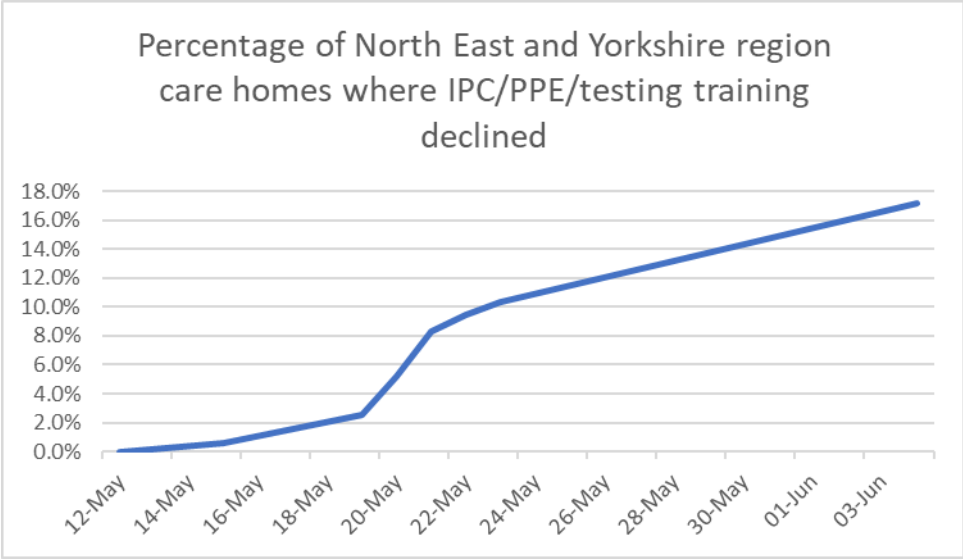
2. Results of super training from SitRep between 12th May- 4th June across all ICS's



This point was when recruitment was completed







3. Primary care SitRep reports 100% of care homes aligned to a PCN, as per the requirements of the Network Contract DES (as reported by the CCG's to reflect place-based improvements)

CCG Primary Care SitRep									
					Q1. Have you employed any returning doctors or other Emergency Registered Practitioners?		Q2. Have you employed any salaried GPs, partners or locums who have volunteered to increase their sessions?	
Region Code	Region Name	Number of CCGs	Number of CCGs not returning	Number of GP practices (May 2020)	Number of Care Homes	Q1a 1a. If yes, how many returning doctors and other Emergency Registered Practitioners have been issued an employment contract? Please provide the cumulative total.	Q1b 1b. Of these, how many have been deployed during the NHS COVID-19 response? Please provide the cumulative total.	Q2a 2a. If yes, how many increasers (salaried GPs, partners or locums who have volunteered to increase their sessions) have been issued an employment contract? Please provide the cumulative total.	Q2b 2b. Of these, how many have been deployed during the COVID-19 response? Please provide a cumulative total.
	National Total	135	2	6,778	15,514	179	140	320	369
Y63	North East and Yorkshire	25	0	1,036	2,373	14	13	79	87
02P	NHS Barnsley CCG			33	73	0	0	0	0
02Q	NHS Bassetlaw CCG			9	42	0	0	0	0
36J	NHS Bradford District and Craven CCG			73	134	1	1	16	16
02T	NHS Calderdale CCG			23	51	0	0	4	4
84H	NHS County Durham CCG			63	149	1	1	0	0
02X	NHS Doncaster CCG			39	80	0	0	0	0
02Y	NHS East Riding of Yorkshire CCG			29	140	0	0	3	3
03A	NHS Greater Huddersfield CCG			37	75	1	1	12	11
03F	NHS Hull CCG			33	86	0	0	2	10
15F	NHS Leeds CCG			94	151	3	3	0	0
13T	NHS Newcastle Gateshead CCG			60	120	0	0	0	0
01H	NHS North Cumbria CCG			39	96	0	0	0	0
03H	NHS North East Lincolnshire CCG			26	53	0	0	0	11
03J	NHS North Kirklees CCG			28	54	0	0	12	2
03K	NHS North Lincolnshire CCG			19	60	0	0	0	0
99C	NHS North Tyneside CCG			26	46	0	0	0	0
42D	NHS North Yorkshire CCG			51	156	2	2	19	19
00L	NHS Northumberland CCG			41	104	1	1	0	0
03L	NHS Rotherham CCG			29	84	3	3	3	3
03N	NHS Sheffield CCG			79	116	0	0	0	0
00N	NHS South Tyneside CCG			21	34	0	0	0	0
00P	NHS Sunderland CCG			39	85	0	0	0	0
16C	NHS Tees Valley CCG			81	210	0	0	0	0
03Q	NHS Vale of York CCG			26	79	2	1	6	6
03R	NHS Wakefield CCG			38	95	0	0	2	2

Steering Group Members

• Gill Hunt,	Senior Clinical Lead NHSE/I North East and Yorkshire Region
• Sally Fowler-Davis,	Associate Professor, Organisation in Health and Care, Sheffield Hallam University
• Heidi Douglas,	Consultant in Public Health, North Tyneside Council
• Kathy Clark,	ADASS Associate
• Jenny Sleight,	Better Care Manager, Yorkshire and the Humber
• Mandy Philbin	Chief Nurse SCCG supporting South Yorkshire and Bassetlaw ICS
• Annie Topping	Executive Director of Nursing, Quality and Patient Safety , Northumberland CCG
• Penny Woodhead	Chief Quality and Nursing Officer, NHS Calderdale, Greater Huddersfield and North Kirklees CCG's
• Jeanette Scott	Director of Nursing, Quality and Patient Safety, South Tyneside CCG
• Jeanette Cookson,	Locality Manager – Skills for Care, Yorkshire and Humber/NE

Data Analysis and Support

• Charlotte Lambert,	Quality Coordinator – Nursing and Quality, NHSE/I North East and Yorkshire Region
• Rachel Cholerton,	Sheffield Hallam University
• Janet Bell,	Project Support Officer Ageing well - Care Sector Team NHS England and NHS Improvement

Interviewers

- Shion Gosrani, Public Health Support Officer
- Yusef Qureshi, Graduate Management Trainee
- Hannah Sharpe, Graduate Management Trainee
- Rebekka Shenfine, Specialty Registrar in Public Health
- Melissa Brown, Specialty Registrar in Public Health
- James Breckwoldt, Graduate Management Trainee
- Christina Cackett, Graduate Management Trainee

Glossary

ADASS	**Association of Directors of Adult Social Services**
AHSN	Academic Health Sciences Networks
CCG	Clinical Commissioning Group
CH	Care Homes
DES	Direct Enhanced Service
FG	Focus Group
GP	General Practitioner
ICS	Integrated Care System
IPC	Infection Prevention and Control
IT	Information Technology
LA	Local Authority
LD	Learning Disability
LRF	Local Resilience Forum
MDT	Multi-Disciplinary Team
Mesosystem	Regional/ ICS level
Microsystem	Frontline teams/services
Macrosystem	National policy/systems
NEY	North East and Yorkshire
NVivo 11	A qualitative data analysis computer software package.
PC MDT	Primary Care Multi-Disciplinary Team
PCN	Primary Care Network
PPE	Personal Protective Equipment
Sitreps	Situation Reports

Thank You