Good Governance Institute

CARE ENGLAND
Representing independent care providers

System transformation and care homes: a discussion document

The Good Governance Institute and Care England

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System transformation and care homes: a discussion document

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Date:	October 2017
Authors:	Chris Smith, Consultant, GGI Laura Tantum, Programme Delivery Quality Officer, GGI
Reviewed by:	Andrew Corbett-Nolan, Chief Executive, GGI Professor Martin Green, Chief Executive, Care England Rachel Cashman, Associate, GGI
Designed by:	Emiliano Rattin, Communications Team Leader, GGI

This report is part of a growing series of reports developed by the Good Governance Institute (GGI) that consider issues contributing to the better governance of healthcare organisations. GGI is an independent organisation working to improve governance through both direct work with individual boards and governing bodies, and by promoting better practice through broader, national programmes and studies. We run board development programmes, undertake governance reviews and support organisations develop towards authorisation.

Other recent GGI reports and board development tools have considered board assurance, patient safety, clinical audit, quality and safety of telehealth services for people with long-term conditions, diabetes services, better practice in treatment decision-making, productive diversity, the board assurance framework, integrated governance, governance between organisations and of course good governance.

GGI is committed to develop and promote the Good Governance Body of Knowledge

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info@good-governance.org.uk

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Introduction

Despite being recognised by the US-based Commonwealth Fund as the most equitable and efficient healthcare system in the world[1], the NHS is currently in the midst of the most serious financial crisis since its inception, the implications of which, and especially in regards to quality, are increasingly visible.

As part of a concerted effort from policy makers and system leaders to arrest any decline, 44 Sustainability and Transformation Partnerships (STPs), plans that bring together local hospital, primary care and social care bodies to reform services and restore financial balance in a given area, are being developed and implemented. Still in their relative infancy, it is hoped that these will drive new and innovative ways of working that span sectors and deliver improved efficiencies and savings.

Within this broader context, the care sector itself is in the grip of its own particular crisis. An aging population and one living with an increasing number of long-term conditions, a significant funding gap which is estimated to reach at least £2.8 billion by the end of the decade,[2] and rising costs associated with care driven by the implementation of a national living wage are just some of the challenges which have led to what Dr. Chai Patel, Chair of HC-One (a large care home provider), has deemed "a perfect storm building in the…social care system."[3]

STPs present an opportunity to address some of these challenges through investment and development of the care sector. However, increasingly academics and social care professionals are explicit in warning that plans are not inclusive, and are becoming unworkable, revealing a system in dire need of greater investment, culture change and reform.[4] Certainly, from this review, it is clear that the STPs are at varying stages of maturity.

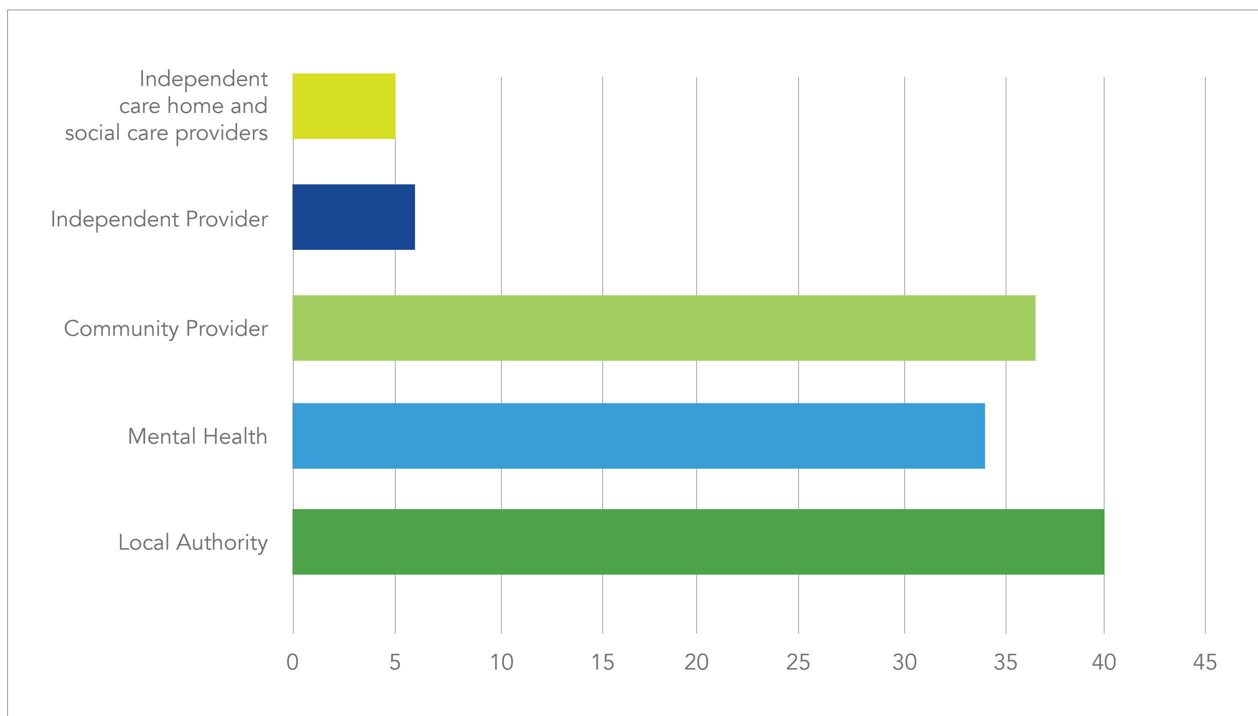
Reflecting on this, this paper will explore in what circumstance STPs make reference to social care, focusing particularly on care homes, before presenting some case studies which demonstrate the impact that an effective care home sector can have on the performance of the health system as a whole.

Planning

To inform this discussion paper, we have conducted a desk-top review of each of the 44 STPs. In particular, we have looked at four elements that form the discussion in this paper:

- the organisations that appear to have been involved in the drafting of the documents or on the leadership teams as detailed in plans or statements[5],
- the number of times care homes are mentioned in STPs,
- the number of times mental health or learning disability strategies are mentioned in STPs,
- and, in addition to the quantitative data, the depth and quality of discussion around the inclusion of care homes in STP documents

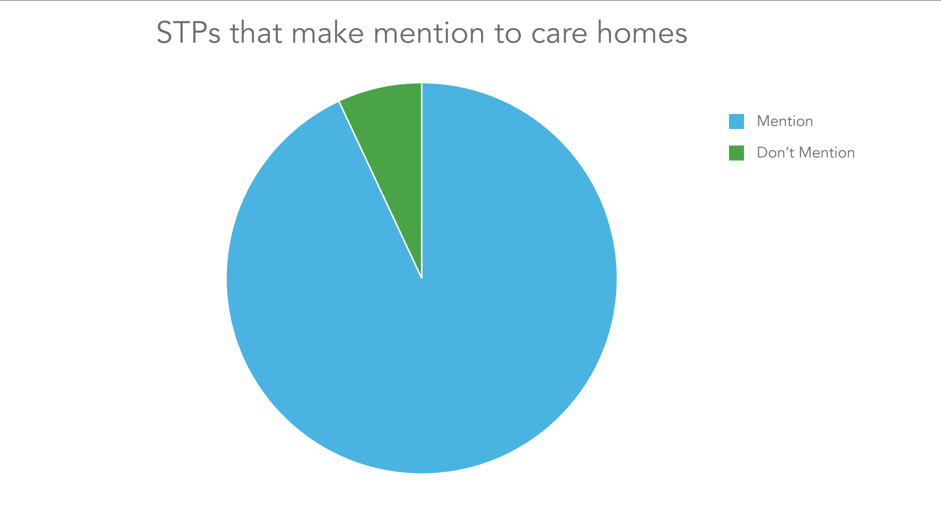
Organisations involved in the development of STPs				
Local authority	Mental health	Community provider	Independent provider	Independent care home and social care providers
40 (out of 44 STPs)	29	37	7	5

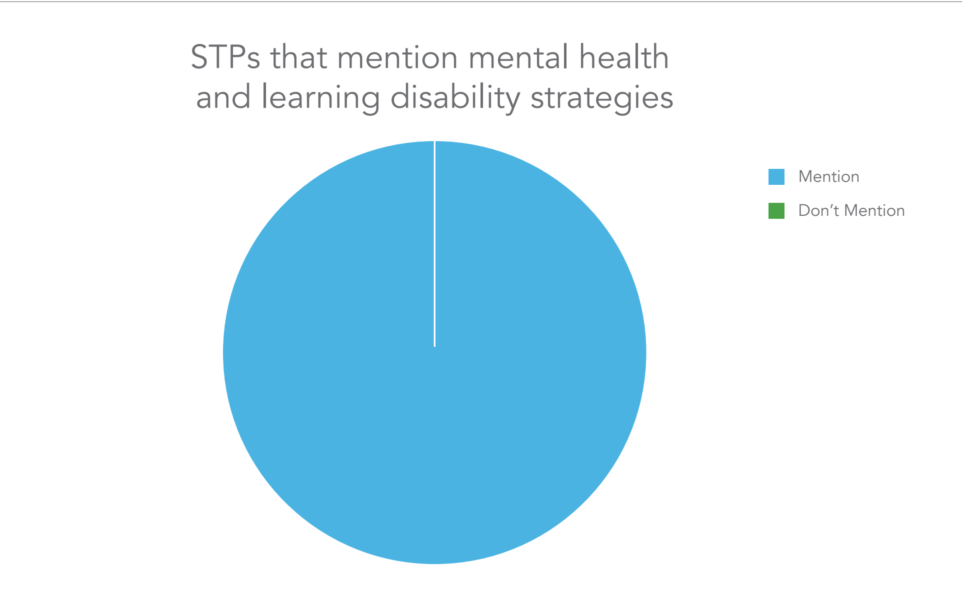


The availability of information detailing the extent of organisations' involvement in STPs is limited, however the challenges in involving all parts of the health and care system in their formation has been widely reported.[6] This is also borne out in our research.

Each footprint is statutorily obliged to involve all NHS organisations as well as local government in the design of the STP, however no organisational framework exists for STPs and they have been granted significant freedoms for agreeing what area and leadership model would work best locally. Importantly, the development and operationalising of STPs is taking place in addition to the current activities of partner organisations. This, to some extent, accounts for the varied involvement of social care and mental health organisations in the development of plans, and therefore the extent to which the plans appropriately and adequately engage with the issues we discuss in this paper.

Mentioned in how many of the STPs	
Care homes	Mental health and learning disability strategies
41 (out of 44 STPs)	44





Although our desktop review suggests that the majority of STPs are at least making references to care homes, in many cases this does not amount to in-depth discussion about the problems facing the sector and how these can be solved, in order to ensure a sustainable sector playing a significant role in integrated care. Furthermore, our review suggests that only 11 per cent of STPs include independent social care or care home providers as partner organisations in the formulation of plans. A particular pertinent issue is that of dementia and mental health in care homes, and although we found that STPs are, with one or two exceptions, referencing these linked issues, again the quality of discussion was extremely variable. For example, many STPs describe the need to integrate community and mental health teams as outlined in the Five Year Forward View without providing suitable detail as to how this might be achieved.

We explore these issues further in our discussion below. Where relevant, we have aligned headings with those found in the Next Steps on the Five Year Forward View document which lays out steps for the delivery of more integrated health system in England.[7]

Funding and efficiency

A recent report by the Local Government Information Unit described the UK's home care industry as "on the brink of collapse."[8] It is hard to disagree, with the number of UK care home places falling and an estimated half of care homes facing closure at a time when demand is rising; there are now more people in the UK aged 60 and above than there are under the age of 18 and the number of people aged 65 and over is projected to rise by over 40 per cent by 2035 to over 16 million.[9] Although the recent council tax precept is welcome, the Local Government Association has warned that "extra council tax income will not bring in anywhere near enough money to alleviate the growing pressure on social care both now and in the future," and that, "without genuinely new additional government funding for social care, vulnerable people face an ever-uncertain future where they might no longer receive the dignified care and support they deserve."[10]

All this has serious implications for the wider health system. For example, Delayed Transfers of Care (DTOC) are a growing issue. In February 2017, there were 184,900 total delayed days, of which 124,200 were acute, compared to February 2016 where there were 158,000, of which 104,300 were acute. Of the total delayed days in February 2017, 559, or 15%, were because patients were awaiting placement or availability in a residential and nursing home.[11] The National Audit Office (NAO) has estimated that the gross cost to the NHS of older patients in hospital beds who are no longer in need of acute treatment is some £820 million,[12] while the Carter Review argued that hospitals could make savings of £900 million if they were able to tackle issues of DTOC across all age groups.[13]

Most of the STPs we reviewed acknowledge a funding gap in social care and that the system, as is, is increasingly unsustainable. However, not all plans are explicit in stating the specific gap for social care and the actions that will be taken to address this. Research by the Health Foundation has shown that of the 44 STP footprints, 25 have quantified a social care gap, based on local analysis of social care needs and the social care market. The social care funding gap in these 25 STPs amounts to £1.2bn for 2017/18, rising to £2.5bn by 2020/21.[14] Similarly, the King's Fund have argued that, "the most urgent priority is to recognise the claims of social care, which is already in crisis and is adding to the significant pressures on the NHS."[15]

The Government has acknowledged the requirement for a new, longer-term solution for social care and has announced that a Green Paper will be published in 2017, following the extra funding allocated in the most recent budget. The Government should make the most of this opportunity to address the funding and workforce pressures that have consistently affected the social care and care homes sector in recent years, and allow care homes to play a significant role in achieving the STP vision.

However, despite the Conservative Party's Manifesto displaying a focus on social care, and the eventual pledge to introduce a cap on the costs of care, as originally recommended in the Dilnot Commission of 2011,[16] there are now concerns that these proposals will not be delivered, with the post-election agreement between the Conservatives and the Democratic Unionist Party meaning that the proposals originally intended to release extra funding for health and social care have been dropped.[17]

Integrating care locally

The Next Steps on the Five Year Forward View makes clear the ambition to introduce new models of care to drive integration across the health system, including by offering older people better, joined up health, care and rehabilitation services. Through our review of STPs we have found examples of significant improvements to care delivery which we explore in a series of care studies later in this document.

Nonetheless, concerns have been raised around the way in which the Better Care Fund (BCF), announced in 2013 as a means of bringing together clinical commissioning groups and local authorities to pool budgets and improve resourcing to social care and community services, has been managed and the impact of this on social care.

The BCF has recently been criticised by both the National Audit Office, which has argued that "the Fund has not achieved the expected value for money, in terms of savings, outcomes for patients or reduced hospital activity,"[18] and the Public Accounts Committee, which has called it "little more than a complicated ruse to cover up funding pressures on adult social care by transferring money from healthcare to Local Government."[19]

In response, the recently published *2017-19 Integration and Better Care Fund Policy Framework*,[20] has announced an additional £2 billion for adult social care paid through a grant to Councils, and a reduction to the number of national conditions that must be achieved to access this money:

- the need to jointly produce plans agreed by the Health and Wellbeing Board
- the need to maintain social care
- the need to invest in NHS commissioned out of hours' services
- the need to manage transfers of care

Future plans will likely be closely aligned with those in the STP, and we would expect to see much more connectivity across the two going forward.

That said, the then likely rolling of BCF monies into overall STP financial control totals means it will be difficult to assess the specific impact of the increased funding on social care, and certainly, there is a danger that this, as before, is used to simply paper over the cracks in social care rather than supporting transformative change.

Strengthening our workforce

Workforce morale and capacity is increasingly stretched in the care sector. Earlier this year Skills for Care reported that there are around 90,000 vacancies for social care jobs in England and that, in 2015-16 alone, some 358,500 adult social care workers left their roles, a staff turnover rate of 27%.[21] Alarmingly, 60 per cent of those leaving their positions left the social care sector altogether. Despite government initiatives to relieve pressures through the provision of an additional £2 billion in funding over the next three years and through the increased recruitment of apprentices, it is unlikely that these gaps can be adequately plugged. Furthermore, although the introduction of the National Living Wage has the potential to do much to improve staff retention and morale in the care home sector, it will add extra financial stress to a sector already facing significant funding issues.

The STPs provide little empirical data with regards to the workforce gap for social care and care homes. Where gaps are recognised, the STPs tend to reference vague promises to 'develop skills' or to 'commission a review to better understand the needs of the sector'. Although some workforce pressures are felt more acutely in certain regions, the alarming increase in workforce pressures in the care sector is a high-profile issue and one that warrants more attention in plans. In those footprints where care home vanguards are already advancing, there is a key focus on 'upskilling' and developing the workforce, for example in the Sutton Homes of Care vanguard, where the education and development of care home staff is one of three key work streams (see case study).

One mechanism for improving capacity within social care and care homes that was highlighted in many of the plans we reviewed is through integrated approaches to care delivery, and, in particular, through the provision of greater support from primary care. Studies have demonstrated that when trained nurses are present in care homes, admissions rates, and medical administration errors are lower than in purely residential homes.[22] More generally, effectively utilising a multi-disciplinary approach to healthcare has been demonstrated to improve outcomes and patient satisfaction, as well as deliver increased efficiencies.[23]

Mental health

Around 80 per cent of all those living in a care home have dementia or significant memory problems, requiring significant focus and attention from care workers. However, as a result of some of the issues outlined previously, Age UK have estimated that 1.2 million people do not receive the social care service they need in England,[24] whilst the CQC have highlighted that less than half of those living in care homes receive the NHS services and supports they require.[25]

Meanwhile, the Five Year Forward View for Mental Health, published by the independent Mental Health Taskforce to the NHS England in February 2016, wrote that 40 per cent of older people living in care homes are affected by depression, however clinicians may not be as effective as they could be in diagnosing and treating depression in older people.

The Five Year Forward View made clear that many of those with mental health problems living within care homes are not getting their health needs regularly assessed and met and that this is contributing to avoidable admissions to hospital.[26] With the increased emphasis on preventative care in the NHS, increasing resourcing to the care sector, and introducing integrated workforces would appear a logical step.

This is reflected in a number of the STPs which make clear aspirations to reduce the number of people admitted to hospital from care homes. As before, there are clearly lessons to be learned from care home vanguards. For example, Sunderland's "All together programme", which covers 283,000 patients and brings together local health and social care professionals to create an integrated model of care has already achieved a reduction in admissions to residential and care homes by 4% against the 2015/16 baseline, and has highlighted mental health as a key focus area for the STP with costed plans being developed to increase support for those in care homes.[27]

However, our review of STPs found that despite the increasing incidence of dementia and mental health problems among elderly people living in care homes, only two of the plans have a specific strategy or workstream for addressing these issues in care homes, despite the system wide benefits this would bring in reducing unnecessary hospital admissions and DTOC figures. A further nine plans discuss the prevalence of dementia and mental health in care homes and how this can be addressed in some level of detail. The remainder of the plans mention these either very briefly, or not at all.

Harnessing technology and innovation

Delivering the Five Year Forward View and ensuring a sustainable health and care system is contingent on rapidly improving the implementation and use of new technologies. These include the use of video consultation, and telehealth and telecare services to ensure that interventions are made effectively and at the earliest point.

The use of these technologies can improve the quality of care a patient receives and encourage patients to take greater ownership of their conditions. However, they also require the NHS and its staff to work differently, which will require cultural change and will take time.

The STPs we reviewed made varying mention to the implementation of technology in care homes, and often when mentioned the details of such technology are sketchy, with terms such as 'improve care pathways' and 'transform services' utilised frequently. There is also little information contained by way of the training and development needs of staff.

Plans from areas that had previously implemented a care home vanguard appear more informed in this area. For example, Norfolk and Waveney STP makes mention to telemedicine as a priority project "using technology to remote-link care homes directly to healthcare professionals and local community-based services that can visit patients if necessary, increasing the confidence of care home staff and residents,"[28] whilst Northumberland, Tyne and Wear, and North Durham STP references the Newcastle Gateshead care home vanguard's approach to medicines management and "enhanced care delivery through a telehealth app."[29]

Going forward, plans will need to set out more concretely the steps they will take to improve the use of technology across their services. Although the approaches taken for each of the care home vanguards are not necessarily applicable across the totality of the NHS, there is certainly scope for greater dissemination and learning from these, and we would encourage this in future.

Conclusions

There can be no doubt that the social care sector, and care homes in particular, are becoming increasingly strained both in terms of financial and human resource. Although STPs do to some extent engage with these issues, the extent to which they do so is extremely variable and whilst this is the case, we are unlikely to see the level of integration and transformation required to ensure the sustainability of the sector into the future.

Points for discussion:

- what should be the success measures in STPs, beyond delivering financial sustainability?
- will the measures currently described in STPs adequately transform the system and ensure it will be sustainable into the future?
- has there been enough involvement from social care in the development of STPs?
- what will be the role of regulation in performance managing the STP?
- what should be the next steps to address financial and human issues?

Case studies

Sutton Homes of Care Vanguard

Part of the South West London STP, Sutton Homes of Care serves a population of 190,000 and includes partners from a wide range from NHS and other organisations, including Sutton Clinical Commissioning Group, the London Borough of Sutton, Epsom and St Helier Hospitals NHS Trust, St Raphael's Hospice, Sutton and Merton Community Services, Age UK, South West London and St George's Mental Health Trust, The Alzheimer's Society, London Ambulance Service and the Sutton Centre for the Voluntary Sector.[30]

The vision of the vanguard is to have a vibrant, high quality care home market in Sutton, delivering care that embraces the national nursing values of patient care: care, compassion, competence, communication, courage and commitment (the six Cs). This vision is being delivered and implemented through three 'pillars': integrated care, care staff education and development, and quality assurance and safety.[31]

To deliver more integrated care, joined up and multi-disciplinary teams of medical, nursing, social care and voluntary sector professionals are working together to improve care for care home residents, with a particular focus on those with long-term conditions or mental health conditions, including dementia. In addition, the vanguard has developed a new role, that of care coordinator, which aims to improve communication and relationships between care homes and GPs.[32] Work is also taking place to improve communication between care homes and acute providers when hospital care is necessary, for example with the 'red bag' initiative. Staff put together a pre-packaged collection of personal belongings, medical supplies and records that accompany every patient to hospital in the case of an emergency admission, with the objectives being to:

- 'improve the efficiency and effectiveness of the conveyancing, admission and discharge process
- reduce the length of stay for residents whilst they are in hospital
- improve communication of the resident's clinical needs whilst in hospital and more inclusive discharge planning with care homes
- ensure residents have their personal belongings, such as, their glasses, dentures, etc. with them at all times during their hospital stay, and their own clothes for discharge
- ensure clearer co-ordination of medications
- improve family's experience whilst their loved one is in hospital'[33]

This innovative pathway, working across organisations to make sure care is as efficient and joined up as possible, is yielding impressive results so far, with it appearing to have reduced average hospital stays by four days.[34] Financially, this initiative will also have a positive impact, with it being anticipated that it will create savings of £183,000 from reduced length of stay for care home residents, in addition to £290,000 saved from reduced loss of residents' belongings. This is against a £3,100 initial investment to produce and provide the bags. Importantly, the care homes in the area have embraced the initiative and the pathway is also being rolled out to learning disability and mental health care homes.[35]

The other two 'pillars' of the vanguard revolve around care home staff education and development, with a focus on training to 'upskill' staff and provide them with the confidence and positive belief to deliver high quality care, and quality assurance and safety. This seeks to increase safety and improve quality 'by enabling the collective sharing monitoring and evaluation of information',[36] for example through a Joint Intelligence Group, quality dashboard, and a policy for medicines management. These workstreams address the issues of staffing and quality that have caused concern in the care home sector across the country.

The Sutton Homes of Care vanguard's work has demonstrated a clear impact across the wider system, including:

- a reduction of 5.80% in London Ambulance Service call outs and conveyances from 2014/15 to 2015/16
- a reduction of 10% in A&E attendance from 2013/4 to 2015/16
- a reduction of 4 days in length of stay since the implementation of the Hospital Transfer Pathway
- an increase of 6% in patients achieving Preferred Place of Death (PPD)
- a reduction of £50,000 in medicines costs from November 2015 to March 2016 through resident medication reviews[37]

To achieve similar results across the wider STP footprint, the South West London STP is now seeking to roll out Sutton Homes of Care's vision across South West London.

Airedale and Partners

Based in the West Yorkshire and Harrogate STP, the Airedale and Partners vanguard is 'harnessing the full potential of modern technology' by using telemedicine in order to improve the quality of life, and end of life care for residents in nursing and care homes. Led by health and social care professionals from a partnership of organisations including acute trusts, clinical commissioning groups, councils, community healthcare providers, IT partners, GP practices and networks, and independent care home providers, the vanguard focuses on the 7,867 residents living in 248 residential and nursing homes in Bradford, Airedale, Wharfedale, Craven and East Lancashire.[38]

The foundation of the vanguard is a telemedicine service that has been running from Airedale General Hospital for a number of years: a 24/7, 365 days a year 'digital hub', providing care homes with immediate video access to a clinical advice service. This is led by senior nursing staff, with support from clinicians from a range of specialties.[39]

Building on this, the Enhanced Health in Care Homes vanguard is using live video links and health monitoring equipment to give care homes direct access to support from healthcare professionals at all hours. Via a secure video link, care home staff and patients are able to have direct access to a 'hub' of senior nurses for advice and support, while health professionals can monitor residents via the video link and make early decisions about treatment that might be needed, avoiding unnecessary emergency admissions to hospital. There is also a dedicated 'goldline' telephone service, which uses technology to provide one point of contact for care home residents and their carers 24/7. These telemedicine initiatives are proving to be particularly useful in residential care homes, where staff are not usually medically trained.[40]

This technology is now in place in 217 care homes across the vanguard and is helping their residents to remain active and independent, including those with complex health conditions and dementia. The area has now seen a 2% reduction in non-elective admissions to hospital.

To further facilitate the integration of care, the information technology partners in the vanguard are also developing a 'real-time' shared patient record so that all health and care professionals working with a particular patient can see see their up-to-date records, supporting quicker, safer care without duplication.

The vanguard is also leading the development of NHS England's Health as a Social Movement initiative, which is working within a selection of new care models and aims to 'develop, test and spread effective ways of mobilising people in social movements that improve health and care outcomes and show a positive return on investment.' As part of this, Airedale and Partners is working with the Alzheimer's Society in order to 'empower dementia friends, connect residents to local communities and support them to be involved in decisions about their health.'[41]

A significant factor contributing to the success of the Airedale and Partners vanguard seems to be the active involvement by a wide range of partners, particularly NHS organisations. Bridget Fletcher, the Chief Executive of Airedale NHS Foundation Trust, has said of the vanguard and the role of the social care sector within the wider system:

'if the care home sector should collapse… it will be the NHS that will have to meet the needs of the care home population. We recognised very early in the life of our vanguard that it provided us with an ideal opportunity to work with partners to consider the future workforce requirements for the sector in the face of these challenges.'[42]

Gateshead Care Home Project

Part of the Northumberland, Tyne and Wear and North Durham STP, the Newcastle Gateshead Enhanced Healthcare in Care Homes vanguard, building upon the Gateshead Care Home Project, aims to 'support the health and wellbeing of older people by speeding up improvements of care for residents in Newcastle and Gateshead.' Partners involved in the vanguard include Newcastle Gateshead Clinical Commissioning Group, local care homes, local authorities from both Newcastle and Gateshead, NHS acute trusts, independent sector care providers and the voluntary and community sector. The project serves the more than 2,500 people who live in residential and nursing care homes in the area.[43]

In the context of an increasingly ageing population, and a rising demand for expensive medical treatment and services, with it being predicted that bed demand will double to 3,000, alongside a 65% increase in continuing healthcare, the vanguard is facilitating new ways of designing, commissioning and providing health and social care for care home residents in the area. This will be facilitated through the creation of a Provider Alliance Network, based on an outcome-based contracting and payment system.[44]

The focus of the vanguard project is on delivering joined-up care designed to meet the needs of individuals, in order to improve the experiences of patients and help to reduce unnecessary admissions to hospital. Whereas in the past, there could have been up to 14 GP practices per care home, now GP practices are linked to a specific care home, enabling further continuity of care and better prevention of ill health through regular care home visits.[45]

Clinically, the redesign of care focuses on 7 key work streams:

- enhanced primary care:
  - case management for all those living with frailty
  - practice aligned multi-disciplinary teams
  - access to specialists via virtual ward approach
- responsive care:
  - rapid response intermediate care nursing and therapy
  - expansion of community intravenous medication administration
- end of life:
  - using prognostic indicators to recognise palliative and end of life
  - best practice guidelines for practice palliative care meetings
  - alignment of Macmillan nurses to care homes as well as GP practices
- technology:
  - improved data sharing including bespoke transfer of care standards for care home residents
  - enhanced care delivery through telehealth apps
- hydration and nutrition care:
  - introduction of technology and facilitation of work based learning through bespoke dietetic support team
- dementia:
  - bespoke pathway for dementia diagnosis
  - crisis response to challenging behaviour
  - improving health and wellbeing through meaningful activities
- medicines management approach
  - pharmacists as core members of general practice and care home teams
  - end of life drug supply service
  - Flu vaccination programme
  - improve discharge pathways

Other key work streams of the Vanguard include ensuring that patient experience is person-centred, a focus on safety and quality, upskilling of the workforce, and integrated provision and commission.[46]

These have been described by the King's Fund as scientifically supported, evidence-based interventions, which robust processes are being built to support.'[47]

The Gateshead Care Home Project has already demonstrated benefits across the wider system, including:

- 14.5% reduction in care home non-elective activity, with average length of stay falling from 13.2 days to 11.8 days
- for those aged 65 and over, the average length of stay has reduced from 7.79 days in 2014/15 to 7.42 days for 2015/16
- trends have suggested a 5.2% reduction from 2014/15 to 2015/16 of the number of patients aged 65 and over dying in hospital
- reduction in oral nutritional supplements prescribed by 17.9% in Gateshead and 13.4% in Newcastle

In the future, the vanguard aims to decrease non-elective admissions for the 65s and over by 27%, which would result in a population wide reduction in non-elective admissions of 8.5%. By 2020/21, it is estimated that the vanguard will lead to £11.2m of savings against a £8.2m investment, accounting for a benefit of £3m.

In order to progress these system-wide benefits, the focus for 2017/18 and 2018/19 will be to complete the proof of concept testing around the vanguard to enable the model to be spread around Newcastle Gateshead, and the wider STP footprint, in addition to contributing to national learning.[48]

Outside of the vanguard sites, where care homes are, as expected, more advanced in playing a key role in their local STP, the STPs are variable as to the extent that care homes are presented as an integral part of the system, with clear evidence that work is being undertaken, or at least being planned, to ensure the vitality and centrality of the care home market. However, some STPs are clear in understanding the fragility of the care home market, with plans underway to address this. Although not exhaustive, below is a selection of STPs and how they have included care home services.

North West London STP

The North West London STP clearly states the challenges facing the care home sector in the footprint. In the central London boroughs, there are currently very few care homes, while in the wider footprint, although there are many care homes, these are often in disparate locations. The care home sector in the area is struggling to deal with financial and quality challenges, and there is a genuine risk that the sector will collapse, therefore increasing the existing pressure on health and social care services.

There is, therefore, a strong case for revitalising the care home sector, and of the five key delivery areas of the STP, Delivery Area 3 is focusing on a better model of care for older people. As part of a push to keep older people out of hospital and enable them to die in their place of choice, care homes will be offered training and support to manage people in their last phase of life. A current issue is that it is not being recognised often enough when older people are at the last stage of life and therefore 'medicalisation of care' is occurring, meaning that elderly people are dying in hospital when this is not their wish (4 out of 5 people are wishing to die at their home, whereas only 1 out of 5 are actually achieving this). Therefore, the STP is aiming to reduce the number of non-elective admissions to hospitals from care homes and for every eligible person to have a Last Phase of Life care plan.

To address the quality and financial challenges in the footprint's care home market, as well as the wider sustainability of the sector, the STP will carry out a market analysis of older people's care to understand where there are issues with under supply and quality, and also develop a market management and development strategy, involving a £2 million investment. The aim is that by 2020/21, this should have ensured a sustainable care home sector, with most homes rated at least 'good' by the CQC.

The STP is also aiming to develop joint commissioning of older people's out of hospital care between health and local government by 2020/21, to realise better care and financial savings. Older people's care will also be commissioned as a part of Accountable Care Partnerships in the footprint, which should facilitate integrated and consistent transfer of care, again helping to reduce issues of DTOC from acute services.

The Black Country STP

The Black Country STP is looking at commissioning for quality in care homes, building on work already initiated by the West Midlands Association of Directors of Adult Social Services, which is undertaking a region-wide analysis of residential and nursing home provision. A number of opportunities for improvement have already been identified, and local authorities, in their role as lead commissioner and working with CCGs, will explore how commissioning, such as the enhancement of primary care, can improve the quality of services. A workstream is already underway, with councils acting as market-shapers, and it is planned that understanding the impact of commissioning on the market place will help to moderate the cost of care. Instead of each commissioner paying differential rates, they will procure together for better value. The STP is also seeking to standardise models of care for patients aged 65+, which could save around £7 million per year.

The STP is also exploring opportunities to reduce DTOCs from acute services, through improvement in the provision of care home services, facilitated through the re-design and enhancement of the provision of community based services: 'effective commissioning of community-based services is a first principle which needs to underpin the approach to use of care homes.' In addition, addressing the workforce issues facing the care home sector, the STP will be promoting the education, training, and support of care home staff.
The role of care homes in mental healthcare is also being explored, through joint work between care homes, social care, voluntary services, mental health, and physical health.

Frimley Health STP

A key workstream of the Frimley Health STP is to 'transform the "social care support" market including a comprehensive capacity and demand analysis and market management.' An objective of this workstream is that people who live in care homes are well supported, and are only admitted into hospital when it is necessary. When they are admitted, they will be supported to return home as quickly as possible, utilising digital technology where appropriate.

The STP is seeking to deliver care home services that:

- reduce the number of urgent care admissions (by 20%)
- ensure that people return to care homes from hospital in a timely manner
- make a difference to the experience of those in care homes
- better support people with dementia to remain in familiar surroundings
- have implemented the learning from the 'enhanced health in care home' vanguards

To help deliver these and ensure that care home providers are engaged in the process, there will be early joint planning with provider representatives. Care homes will also be further integrated into the system through the development of integrated care decision making hubs, to provide single points of access to services.

Finally, technology will facilitate the integration of care homes within the wider system and the consistency of care, as projects are underway to go paper free, including an Electronic Document Management System and E-referrals. With the necessary information readily available to care professionals, this should result in a reduction of length of stay in hospital or transfer to a care home. The STP is also looking at opportunities for stronger collaboration between primary care and are homes, including a 24/7 health hub supported by video conferencing.

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