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

April 2014

Executive Summary

1. Foreword

This needs assessment has been produced to support work with care homes across the cluster of Devon, Plymouth and Torbay. Changes brought in to effect from April 2013 through the health and social care act now place the responsibility for local public health with Devon County Council, Torbay Council and Plymouth City Council. The close working relationship with the NHS continues through the provision of public health support and advice to the two clinical commissioning groups covering the area: Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group this is known as the core offer.

This needs assessment is one of many local health needs assessments that are either completed, planned or underway which consider different aspects of health and wellbeing in Devon. Completed needs assessments are published on the Devon Health and Wellbeing website www.devonhealthandwellbeing.org.uk. The findings in this document should be considered alongside other related needs assessments, the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment, to ensure a full picture of need.

2. Introduction

Devon has a growing elderly population and the rate of growth is ahead of other parts of the Country. It will take until 2076 for the 85+ population to reach the same proportion as Sidmouth today. This increase in older people arises due to inward migration and increased life expectancy. The increase in the ageing population leads to a potential increase in demand for residential and nursing care. The health needs assessment was undertaken to support the work of the Care Home Quality Collaborative and further understand the health needs of the care home population locally. The HNA considered the local intelligence (where available), the evidence base following a literature review, consideration of local interventions and discussion with stakeholders as members of the care home quality collaborative and wider contacts. The HNA has been written as part one, as engagement with care home residents is still being developed through the collaborative.

3. The Findings

In Devon, Plymouth and Torbay there are 686 care homes (Care Quality Commission 31st October 2013) with 11,907 residents. 9,558 are 65+, 6,096 85+ and 207 were over 100 and the oldest resident was 108. The care home population across the area is predominantly female, particularly in the 70+ population; this pattern is replicated for both Clinical Commissioning Group areas. The care home population only represents approximately 1% of the total population. The population is predominantly female 85+ in all areas but the percentage in certain areas does vary with an indication that homes in more deprived areas have a smaller percentage of 85+ residents. Many residents spend a short period of time in a care home and may move homes due to increasing dependency or spend the end of life within this setting. Care homes vary in size and type of ownership and offer a varied provider landscape.

Care home resident hospital admissions are significant in terms of cost and volume. Pneumonia, fracture of femur and other disorders of the urinary system are the leading causes. Ambulatory Care Sensitive (ACS) conditions are a group of conditions including angina, Coronary Heart Disease Chronic Obstructive Pulmonary Disease (COPD), asthma and diabetes where admissions to hospital can be avoided through effective case management in primary and community care. The admission rate in Devon (147.8) is below the South West (169.6), local authority comparator group (177.4) and England rates (210.1) and has fallen over time.

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

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

The health needs will vary in complexity and it is important to consider the wider issues impacting on health such as lifestyle factors, social interaction and quality of life as well as the more complex issues of end of life and safeguarding.

The evidence for effective care home interventions is weak, systematic reviews and randomised controlled trials tend to recommend further research. Small scale studies tended to be observational in nature and provide a weak level of evidence. This is not necessarily due to lack of effect but a consequence of poor study design and limited research in this area. Follow up is difficult in care homes as residents move on or pass away so long-term impact is impossible to measure. Comparison is difficult as each intervention is different. Studies tend to follow a small cohort over time. In addition the needs of care home residents are complex and multi-faceted so a study to measure the impact of an intervention will have a number of confounding factors such as pre-existing co-morbidities and increasing frailty.

4. Further Discussion and Observations

A number of initiatives in Devon, Plymouth and Torbay are in place or have been piloted to support care home owners and improve the quality and safety of care in care homes. The Care Home Quality Collaborative was formed in 2013 and is developing a vision for care homes in the area. The local interventions are difficult to

evaluate as the work follows a cohort of residents at a point in time. Some success has been seen in North Devon and other areas but the interventions will be impacted by other work that is being undertaken. Training for care home staff has been cited in many studies in a range of areas such as end of life and nutrition. A collaborative approach to training could be developed with providers reflecting the needs identified in the health needs assessment, locality intelligence and the experience gained by providers and commissioners on interventions to date. The length of stay in care homes can be short and support and interventions need to be timely to ensure they are effective

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

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

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

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

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

The proposal of the Care Home Quality Collaborative to improve engagement with care home residents and families and carers of residents should improve qualitative

understanding of the health needs of the care home population and further define a good quality of life for care home residents.

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