Healthcare framework for adults living in care homes My Health - My Care - My Home

Summary Document

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Scottish Government
Riaghaltas na h-Alba
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Contents

Ministerial Foreword

As the Cabinet Secretary for Health and Social Care and Minister for Mental Wellbeing and Social Care, we are proud to announce this new healthcare framework, which seeks to strengthen the continuity and increase access to healthcare for people living in care homes.

This framework is a bold and ambitious document which aims to provide information, assurance and direction to all those involved in and affected by the provision of health and care in care homes. This includes people living in care homes and their family and friends, health and social care teams, care home providers and sector leaders across Scotland.

The framework is important for those living in care homes, as well as the wider health and social care system. However, it also plays a critical part as we recover and rebuild from COVID-19. As the sector emerges from the pandemic, it is essential that we learn from these experiences. We must expand the excellent advances in transformational change, integrated working, and relationship-building which have arisen over the last few years. We are also aware of the many good practices and innovation that the care home sector has exhibited and continued to show over the last couple of years against a very difficult background. The number of good practice examples that were collected as part of the development of the framework is testimony to that. We would like to take this opportunity to thank the workforce and wider social care sector for the commitment and hard work it has shown over the course of the pandemic. The professionalism and dedication of staff has been exceptional and we thank you on behalf of the Government and people of Scotland.

The recent Independent Review of Adult Social Care (2021) re-emphasised the importance of professionals working together across the traditional boundaries of health and social care to ensure that people living in care homes receive the same access to healthcare as people living in their own homes. As part of the Care Home Clinical and Professional Advisory Group pandemic response (CPAG), a Clinical Models of Care sub-group of stakeholders from across Health and Social care was established. The ask of the group was to review the current model of healthcare for care homes in Scotland and to set out recommendations for enhanced ways of working in order to fully meet the holistic needs of people living in care homes. As a result, in 2020, the Scottish Government tasked CPAG with developing a healthcare framework for adults living in care homes in Scotland. This was part of the delivery phase for the Adult social care - winter preparedness plan: 2021-22.

It is also part of a wider approach to improving the national healthcare model by seeking to fully integrate the Health and Social care system in Scotland. It is a pivotal building block in improving outcomes as we move towards the establishment of the National Care Service (NCS). Importantly, it also strongly aligns with other key Government policies, including; our development of a Health and Social Care Strategy for Older People; the framework for community health and social care integrated services; the health and social care standards; Promoting Excellence 2021 (Dementia framework); the Preventative and Proactive Programme Charter; the Rehabilitation Framework; A Fairer Scotland for Older People framework; the transformation of Primary Care; and, our commitment and approach to a new national strategy for palliative and end of life care.

Following a period of extensive engagement, this framework has been produced in collaboration with those living and working in the health and social care sector. From this

engagement, responses included; there is a strong need for everyone in the sector to work together in a supportive way to enable better health outcomes for individuals living in care homes; the importance of informed decision-making; good communication; that healthcare should be more than medicine.

We wish to take this opportunity to express our gratitude to those who took part in the engagement events. Your frank, open and honest views have been invaluable, and helped to develop this framework. Some examples of your feedback can be read in quotes throughout this document.

To address the comments reflected, this new and transformative framework sets out a series of recommendations to improve the outcomes for people living in care homes. It has a strong focus on multidisciplinary team (MDT) working, with a need to place the person living in the care home at the centre of the MDT. It is important that the individual is integral to this and they should be able to make an informed decision on their own care, which should be supported by a MDT. To enable this, there should be regular meetings and good communication between those professionals providing constant and regular input and the person living in the care home. It aims to meet the needs of all people living in care homes by enhancing not only their health, but also their wellbeing. By working in a collaborative and coordinated way, we can enhance the health and wellbeing of those living in care homes, and therefore, improve outcomes.

As we move forward to implement these recommendations, we will continue to be committed to supporting this work and expect the same commitment from all partners. We must be ambitious and bold in our aspirations to transform the healthcare that people living in care homes receive. True multi-disciplinary and multi-agency working must commence now, with people living in care homes, their families and carers firmly at the centre of what we do.

Humza Yousaf
Cabinet Secretary for Health and Social Care

Kevin Stewart
Minister for Mental Wellbeing and Social Care

About This Framework

People who live in care homes have a right to have their health and healthcare needs met in a person-centred, holistic, consistent and co-ordinated way. Their requirements go beyond physical health, and include social, psychological and spiritual care. People need consistent and timely access to good health and social care support to enable them to have joyful purposeful, fulfilled lives. However, healthcare services are not always configured with care homes in mind.

Through active engagement and participation, this framework and its recommendations has been developed in collaboration with various key stakeholders from across the sector. This includes people who live in care homes and their families, care home providers, representatives and staff, Health and Social Care Partnerships (HSCPs), our health and social care workforce, academics, and policymakers.

The recommendations draw on the diverse experience and feedback shared during the engagement and consultation process aiming to ensure consistent high-level healthcare for everyone who is living in a care home.

The wider determinants of health and wellbeing have also been examined and explored. This, coupled with our extensive programme of engagement, has helped to centre the framework around the following six core elements:

1. Nurturing environment
2. The multi-disciplinary team
3. Prevention
4. Anticipatory care, supporting self-management and early intervention
5. Urgent and emergency care
6. Palliative and end of life care

Importantly, the core elements are underpinned by both ‘a sustainable and skilled workforce’ and effective use of ‘data, digital and technology’. These areas are seen as key enablers that will help the sector to implement the recommendations within this framework.

Other enablers are realistic medicine and ethical commissioning.

Practising and applying the six principles of Realistic Medicine will ensure decisions about healthcare are made in partnership with people and their families and will deliver care of greatest value to them. These six principles are:

- shared decision making
- personalised approach to care
- managing risk better
- reducing harm and waste
- reducing unwarranted variation
- innovating and improving

In March 2021, the Scottish Government and Convention of Scottish Local Authorities (COSLA) issued a joint statement of intent outlining how they would work together to deliver the key foundation pillars set out in the Independent Review of Adult Social Care in Scotland. This will lead to shared ethical commissioning principles and establishment of core

requirements for ethical commissioning which will ensure that going forward, fair work requirements and principles are met and delivered consistently across Scotland.

Introduction

Scotland's population is now at its highest level and is also growing steadily older. This is true of both people living in care homes and the workforce that provides healthcare. It is undoubtedly positive that people are living longer, however, some are living with increasingly complex health and care needs which may necessitate residing within a care home.

The care home sector in Scotland provides care for adults and older people, individuals with learning and physical disabilities, neurological illness, mental health conditions and brain injury. Some care homes also provide intermediate care and respite services for people on a temporary basis. Across each of these groups the healthcare needs of those living in care homes is becoming more complex and requires more specialist interventions.

The latest Public Health Scotland Care Home Census for Adults in Scotland (published December 2021) reports that there are 33,000 people living in 1,069 care homes for adults in Scotland. Of these, 91% are living in a care home for older people, where 64% will be living with dementia (either medically or non-medically diagnosed) and the mean age at admission is 82 years.

The COVID-19 pandemic has undoubtedly had a significant impact on people who live and work in care homes and their friends and families. However, there have also been historical factors pre-pandemic which have challenged the sector. These issues are well documented in the Independent Review of Adult Social Care in Scotland report (2021).

People have a range of health and wellbeing needs that extend across relationships with family and friends. These include psychological and social needs, in addition to environmental needs and basic biological needs. The wheel of wellbeing diagram (below) helps us to visualise the range of needs, that when fulfilled, contribute to good experiences of wellbeing. All five of the segments within the wheel must be in place to enable optimal health. If one or more of the segments are missing, it can result in a decline in physical or mental health.

Care homes are where people live and call home. They should expect the same level of involvement, choice and support for their health and wellbeing as if they were living elsewhere in the community. This can only be achieved through a whole-system, collaborative approach. This new framework specifically seeks to strengthen the continuity and access to healthcare, both from within and from outwith the care home.

Figure 1 The biopsychosocial components within the 'wheel of wellbeing'

What We've Heard

Our programme of engagement, most of which took place online between November 2021 and April 2022, involved the following:

- 29 engagement events
- With 674 stakeholders invited to participate, including 44 residents and families
- 6 focus groups
- An online survey which generated 508 responses, and
- 73 good practice returns from Health Boards across the country

Whilst the opportunity for face-to-face engagement was limited by the Omicron wave of the COVID-19 pandemic, it was possible to engage directly with 25 people living in care homes. People were encouraged to share their views on living in the care home, and their experiences of accessing healthcare.

We also engaged directly with 19 family members. However, many stakeholders attending other engagement sessions in a professional capacity also gave views on their personal experiences of family members living in care homes.

We have also used social media, surveys and focus groups to hear from a wide range of stakeholders. These included care home providers and staff, the Care Inspectorate, Healthcare Improvement Scotland (HIS), the 'third' and independent sector and numerous other professionals from across the system who plan, provide and deliver care.

All the various comments, stories, experiences, opinions and suggestions from our engagement activities have been used to shape the framework and inform its recommendations. Engagement is not a one-off exercise and must continue as we start implementing the various recommendations within this report. More information on implementation can be found in the 'Making This Happen' section.

1. Nurturing Environment

The health and wellbeing of someone is greatly influenced by the immediate environment, activities, and those providing day to day care.

Health and healthcare is much more than medicines and clinical diagnoses. Provision of a safe, homely and stimulating environment with meaningful activities, good nutrition and social connection are essential and fundamental components of good healthcare that also support positive wellbeing. Health and wellbeing is represented by the largest section of the diagram below (figure 2) as it is greatly influenced by families and friends, the local environment, the community living in the care home, and professional carers. It is often through routine daily contacts that families and social care staff are able to detect that 'something is not quite right'. This comes from knowing the person in the care home well, recognising different patterns of behaviour and spotting changes that are indicative of illness.

It is essential that the important role of care home staff in improving health and wellbeing is both recognised and valued in our society. The care home team should continue to play the leading role in the healthcare of people living in care homes, with a keyworker who co-ordinates the day-to-day care of the individual

Contact and engagement with families and friends greatly enhances health and wellbeing. Based on feedback from stakeholders and families, the Scottish Government considers that Anne's Law should provide people who live in adult care homes with the right to see and spend time with a named visitor or visitors at all times.

Other healthcare provision can be categorised as general, complex and specialist; and it is important to ensure that people are able to access the help they need from the right person at the right time.

The requirement for someone to be living in a care home indicates a level of complexity in their care. However, some people have very specific and highly complex healthcare needs which may have previously required inpatient hospital care, or specialist input within a community hospital or a complex care ward. These individuals must be able to access appropriate specialist assessment and regular specialist review when living in a care home where that is required.

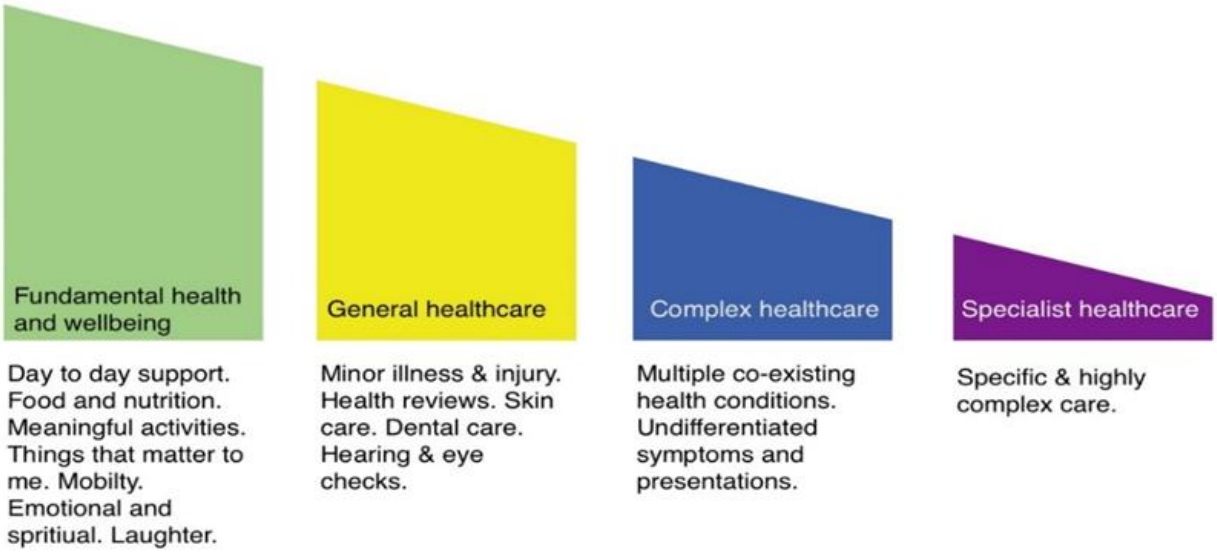

Figure 2 The healthcare needs of people living in care homes

Recommendations

1.1 We must recognise and value the important role of all staff working in the care home in improving health and wellbeing of people living in care homes.

1.2 The care home team should continue to play a leading role in the healthcare of people living in care homes, alongside a keyworker who co-ordinates the day-to-day care of the individual.

1.3 Health and social care professionals must work together to address any healthcare needs within the nurturing environment of the care home and ensure that people living in care homes are not over-medicalised.

1.4 Everyone living in a care home should have access to nursing care. These nurses may either be employed by the care home, or, if employed externally, should have expertise in care homes.

2. The Multi-Disciplinary Team

A multi-disciplinary approach allows people to benefit from the combined skills and expertise of health and social care professionals who are working together to optimise health and care outcomes.

A constant desire emanating from our programme of engagement is the need to adopt a multi-disciplinary team (MDT) approach to healthcare. This approach is the foundation on which we have built the framework.

There are many different individuals and professionals who support the health and wellbeing of an individual living in a care home and provide constant, regular and timely intervention.

This is represented in the concentric wheel at figures 3. An example showing an individual with swallowing problems can be found at figure 4.

The framework recommends regular MDT meetings and good communication between the professionals involved in an individual's care. For practical reasons MDT meetings may take place virtually, and should happen as frequently as is necessary. This will differ depending on the person and/or the care home; smaller care homes may wish meetings to take place monthly whereas larger care homes may need to meet more frequently.

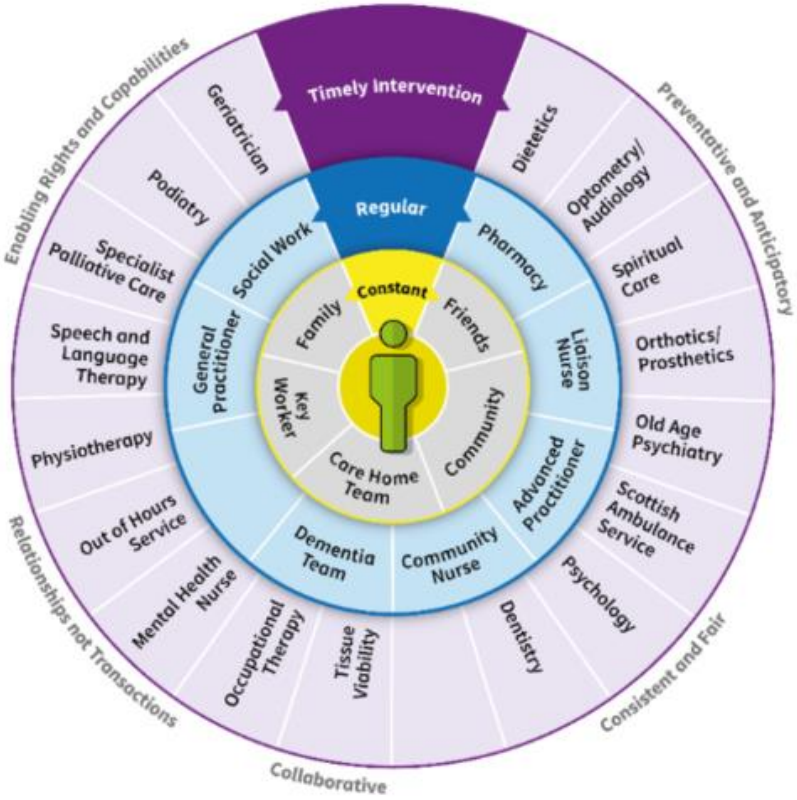

Figure 3 The multidisciplinary team around the person living in a care home

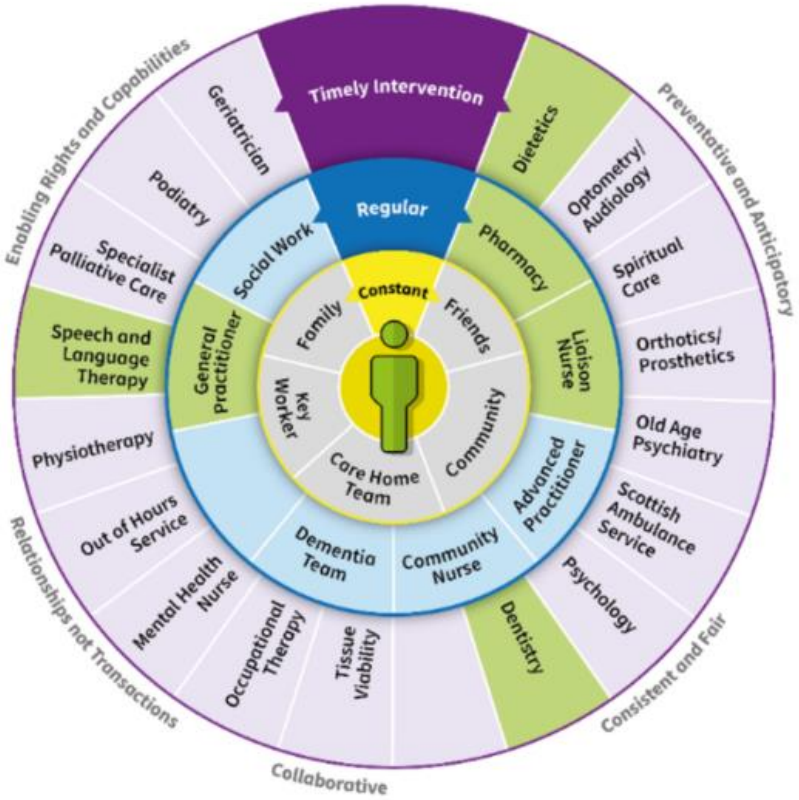

Figure 4 An example showing an individual with swallowing problems

Care home staff and community MDTs report difficulties when dealing with several GP practices who each have different ways for requesting advice, visits and prescriptions. It is also inefficient for staff in the same GP practice to visit multiple care homes on the same day. Therefore, the framework recommends that each care home should be linked with a named GP practice that will play a lead role with that home. However there may be someone living in the care home who chooses to remain registered with a GP practice which is not the lead practice for that home, and this request should be accommodated whenever possible.

Recommendations

2.1 Regular MDT meetings (face to face, virtual or hybrid) should take place involving the care home team, the GP practice and relevant other professionals to co-ordinate and plan healthcare.

2.2 The administration and support of MDT meetings should be co-ordinated between the HSCP and the care home.

2.3 People living in care homes should have the opportunity to involve a family member or any legally appointed welfare guardian or attorney during consultations with members of the MDT.

2.4 As MDTs form and develop, opportunities for shared learning should be explored, to develop the knowledge, skills and experience required to provide the best possible care.

2.5 Wherever possible, each care home should be linked with a named GP practice that will play a lead role with that home. Where this is not possible, HSCPs should work with the local care homes and GP practices to establish safe and reliable alternative arrangements that enable effective MDT working.

2.6 People living in care homes should be made aware of the benefits of being registered with the GP practice that is linked to the care home that they live in, however they should not be forced to change GP practice.

2.7 Health Boards should review Local Enhanced Services (LES) that relate to care homes and revise them in line with the aspirations of the 2018 GP contract and the ambitions of this framework.

2.8 HSCPs must ensure that there is access to appropriate specialist provision when commissioning with the care home sector to provide specific services for people with highly complex care needs.

2.9 Care home teams must be provided with contact details and referral routes for all members of the MDT. Where these are not clear, the HSCP should work with the care home to obtain these.

3. Prevention

Preventing deterioration in health and wellbeing through good nutrition, hydration, continence, movement and activity, cognitive stimulation and social connections

Prevention can stop the onset of illness through early positive interventions. It can also reverse, stop or delay the progression and impact of a pre-existing condition. Put simply, it involves proactively keeping people well, and maximising their independence to thrive in the most appropriate care setting for their needs. This involves an asset based approach, focusing on what a person can and likes to do, rather than where their difficulties are.

People living in care homes must be supported to access any relevant age-specific public health programmes, for example, screening for bowel cancer or immunisations against flu, COVID-19, pneumococcal and shingles infections. They should have the opportunity to make an informed decision about whether to take part in these programmes with appropriate information that is tailored to their needs.

Preventing the spread of infections has always been important within care homes, and has been even more apparent during the COVID-19 pandemic. Care homes are not and should not become sterile ‘clinical’ settings, but they must remain safe environments for people to live in.

The Healthcare Improvement Scotland (HIS) Infection Prevention and Control (IPC) standards are a requisite for safe, high-quality care in all settings. They must be supported by access to relevant IPC guidance, advice, education/training and guidance.

People living in care homes have increasingly complex needs, so preventing deterioration in health through good nutrition, hydration, continence, movement and activity, cognitive stimulation and social connections is imperative. A key aspect for a person with multiple

needs (physical, mental health and other social needs) is a personal plan detailing how care and support will be provided.

Effective prevention of deterioration or of harm must also include proactive management of all long-term health conditions as well as regular, structured pharmacist led polypharmacy reviews. Moreover, prevention places importance on a number of other issues including: oral health, hearing and eye care, nutrition and hydration, continence promotion and bowel care, tissue viability and wound care, mobility and meaningful activity, and psychological wellbeing and spiritual support.

Recommendations

3.1 People living in care homes must be supported to access any relevant age-specific public health programmes with appropriate information to allow an informed decision.

3.2 Application of IPC standards in care homes should be supported by access to relevant IPC advice, education and guidance.

3.3 Everyone living in a care home will have a regularly reviewed personal plan.

3.4 Ensure there are effective systems in place to deliver a consistent approach to the development and implementation of proactive, personal plans.

3.5 A person centred medication review, using the 7-step approach should be initiated by a pharmacist when someone first moves into a care home, and then at least annually thereafter. Certain high risk drugs, such as antipsychotics, will require more frequent monitoring and review.

3.6 Routine dental, sight, and hearing reviews should continue to be part of an individual's personal care plan when they move to live in a care home.

3.7 There should be a named dentist / dental practitioner for each care home and contracts with local optometry and hearing services.

3.8 There should be a proactive approach to hydration, nutrition, continence promotion, meaningful activity and mobility using appropriate resources and should be considered with the same degree of importance as reactive healthcare.

3.9 Religious and philosophical beliefs in relation to food and diet should be enquired about and catered for.

3.10 Psychological and spiritual aspects of healthcare should be assessed and regularly reviewed within care plans.

3.11 Individuals should be supported to maintain links in their local community which enables cognitive stimulation, mobility, independence and communication.

4. Anticipatory Care, Self-Management and Early Intervention

Helping people to think and plan ahead according to their wishes, helping people to be involved in their own health and wellbeing, and managing any existing health conditions at an early stage to reduce deterioration.

Anticipatory care planning is an approach where people living in care homes are supported to have meaningful discussions about '*What Matters to Me'* in the context of their health and care. This can then progress to a conversation about '*Let's Think and Plan Ahead'.*

The MDT meetings should be used to check that every person living in the care home has had the opportunity to develop an anticipatory care plan (ACP), and that it is up to date. ACPs must be visible to all who need to see them.

Supporting self-management describes a way of working which aims to support, empower and enable people living in care homes to manage aspects of their health and wellbeing so that they can live as well as possible. For example, some people living with learning disabilities may need to stay in a care home because they cannot live independently in the community. However, with support and supervision from families and social care staff, they are able to manage many aspects of their care. By promoting a shift from 'doing to' to 'doing with', people can greatly enhance their confidence, self-esteem and feelings of self-worth.

'Supporting self-management' can also be used to enable people to play an active role in the planned management of their existing health conditions. People living in a care home should not be denied regular 'chronic disease management' reviews that other people receive from their GP and Primary healthcare teams. However, there is a significant risk of over-medicalisation if standard tests, such as cholesterol checks, are taken without considering personalised goals. This is an important opportunity to consider Realistic Medicine principles, by agreeing the goals for management of long term health conditions, and reducing unnecessary investigations and treatment.

Another area where care home staff make a significant contribution is early intervention to maintain health and reduce deterioration. For example, through the early detection of hearing loss and access to appropriate hearing aids, someone living in a care home will be supported to remain engaged and involved in the life of the care home. This reduces the risk of withdrawal, isolation and depression. Early identification of cognitive changes is important to ensure that care home residents access the same standard of dementia care as those living in the community, from pre-diagnostic to post diagnostic support.

Recommendations

4.1 'What Matters to Me' and 'Thinking Ahead' ACP conversations should take place at the earliest opportunity, ideally prior to entering the care home, and at regular intervals throughout the individual's stay.

4.2 Where someone has a complex health condition, or there are a variety of different treatment options, a senior clinician, such as GP should be involved in discussions.

4.3 All health and social care staff must be provided with support and training in communication to improve confidence and skills in conducting these meaningful conversations.

4.4 Everyone living in a care home should have the opportunity to develop an Anticipatory Care Plan.

4.5 All health boards should seek to agree and adopt a robust approach (such as the HIS ACP Toolkit, Lothian 7 Steps, ReSPECT) to conducting ACP discussions.

4.6 Anticipatory Care Plans should be shared with everyone involved in providing the individual's care, and a summary should be included in the Key Information Summary (KIS).

4.7 Establish community-based supporting self-management programmes to consider how best to support care home teams to adopt self-management approaches.

4.8 People living in a care home should continue to have regular assessments of their long term conditions, as appropriate, from their Primary Healthcare Teams.

4.9 Realistic Medicine principles should be adopted to reduce unnecessary or inappropriate investigations and treatment.

4.10 Where possible, people with complex medical conditions should be supported to attend hospital-based clinics. Where this is not possible, specialist input into the care of the person living in a care home should be adapted to the situation. This may be by telephone, video consultation or by visiting the care home.

4.11 Changes to mood or cognition should be identified at an early stage and discussed with members of the MDT to determine whether referral is indicated for specialist mental health services for assessment and intervention

5. Urgent and Emergency Care

Accessing appropriate urgent and emergency care in a safe and timely way is extremely important. This is particularly so at weekends and during the out of hours period.

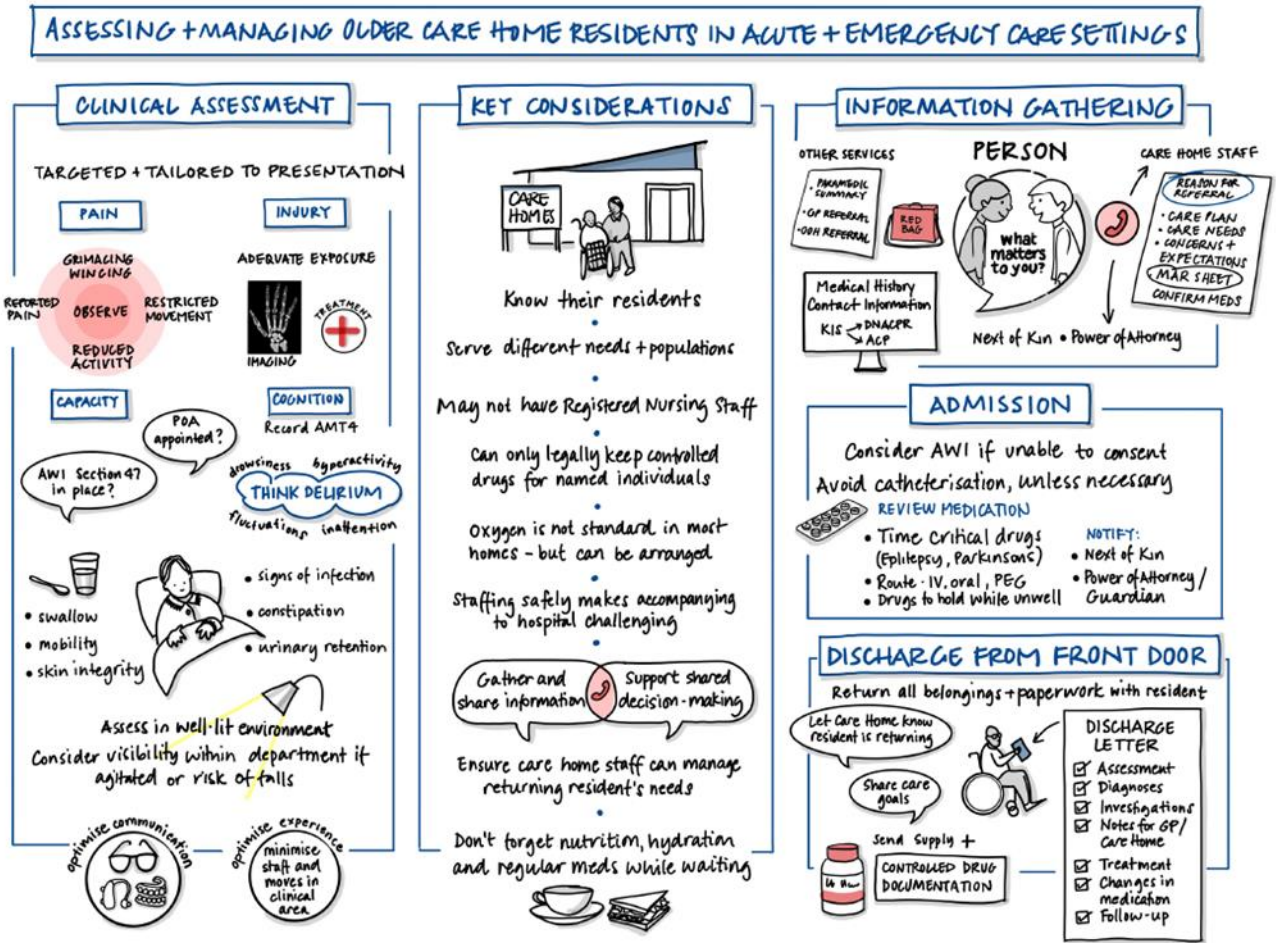

Figure 5 Looking after people from a care home infographic

People living in care homes can become unexpectedly unwell, requiring urgent care and attention. At times it can prove difficult to establish the cause of sudden deterioration due to complex issues, for example cognitive decline or reduced physical function. It is also more difficult for people living in care homes to access services that have been set up for urgent care (e.g. an urgent optometry or dental appointment, a community pharmacy or a hospital minor injuries unit). Many of the urgent care services developed as part of the General Practice (GP) contract, such as advanced practitioners, will only see people who are able to attend the GP surgery.

Access to services out of hours can be challenging for care home staff and response times may be lengthy. There are many different ways to obtain urgent and emergency care across Scotland outwith normal working hours (out of hours services, professional lines, NHS 24/ 111, or 999), many of which do not provide an immediate service for vulnerable people living in care homes. A consistent approach is needed. As is a multidisciplianry approach for professionals working together. The sector has made clear their desire for direct professional to professional communication channels, such as dedicated phone lines, to ensure staff in care homes have 24/7 support in making decisions for a person who has become unwell. Having direct access to help during the out of hours period will aid seamless and timely access to health and care support and response 24/7. This is particularly important in managing symptom control for people approaching the end of life.

However, people living in care homes are at risk of developing delirium and deconditioning from an admission to hospital. A shared decision should be made about whether transfer to hospital is appropriate, taking into account the individual's care plan, carer and relatives' wishes and clinical assessment.

Alternatives to hospital admission including community-facing specialty teams (e.g. hospital@home) should be considered to allow individuals to receive hospital-level care within the care home when appropriate.

Recommendations

5.1 Support and empower care home staff by providing and encouraging participation in training opportunities and enabling all staff to have the tools to assess and communicate in acute and emergency situations using the SBAR format.

5.2 People living in care homes should have timely access to members of their MDT, 24/7 when urgent or unscheduled care is required.

5.3 HSCPs should consider developing dedicated community healthcare teams comprising advanced practitioners who can respond quickly and visit people in care homes requiring urgent unscheduled assessments, with support and advice being easily available from the GP by phone. These services should cover both weekdays and weekends.

5.4 Both care home staff and healthcare staff should be familiar with the SBAR format when discussing urgent or emergency care, and consider using a structured proforma for these conversations.

5.5 Care home staff should be able to contact healthcare professionals during an urgent or emergency situation in a consistent and timely manner - this includes exploring possibilities for dedicated professional to professional communication channels.

5.6 Scoping work should take place to explore the use of near patient and point of care testing within care homes, taking into account Realistic Medicine principles.

5.7 Health boards should develop Hospital@Home services that support people living in care homes to receive hospital-level care within the care home.

5.8 Further work is required across Scotland to improve the accessibility and provision of medicines during an urgent situation. This includes exploring mechanisms to enable care homes to hold a stock of certain drugs within the home.

5.9 People living in care homes should never be denied admission to hospital solely on the basis of living in a care home, and at point of admission older people should be assessed by a senior clinical decision maker with experience in caring for frail older adults.

5.10 Timely and safe transfers to and from hospital for older people in care homes should be optimised.

5.11 Digital access to an individual's health records, and clinical outcomes should be timely and accessible to all parts of the system.

6. Palliative and End of Life Care

Enabling a person-centred and holistic approach to health and care when curative treatments are no longer possible and length of remaining life is reducing.

Palliative care supports people to have a good quality of life even when faced with serious, irreversible and progressive health conditions. 'End of life care' is also an important part of palliative care which addresses the physical, social, emotional, spiritual and accommodation needs of people who are approaching death.

Many adults and most older people living in care homes will benefit from a palliative approach to their care, which can be enabled and provided by members of the individual's family and community, and all the health and social professionals who have responsibilities for the person's care.

Social care staff working within care homes have a wealth of experience and expertise in adopting a palliative approach to care, and supporting someone who is nearing the end of their life. However, there may still be occasions when advice and support is required from Primary Care and specialist palliative care services. Health and Social Care Partnerships have responsibility to ensure that these specialist services are in place and easily available.

Figure 6 The 4 domains of care (image Hazel White Design)

It is important to be able to identify individuals whose health is at risk of deterioration at an early stage to allow early and proactive assessment and delivery of the most appropriate care. Assessing symptoms can be particularly difficult where there is associated cognitive impairment, and there is a risk of diagnostic overshadowing, whereby physical symptoms such as pain are not recognised, and instead incorrectly attributed to dementia.

There is wide variation in access to specialist palliative care across Scotland. NHS boards should ensure that specialist palliative care services are available for the care homes in their area, as set out in the advice note on Strategic Commissioning of Palliative and End of Life Care by Integration Authorities. It is particularly important that families and friends are kept informed, involved and supported as their loved one approaches the end of their life.

Scotland's first bereavement charter was published in April 2020. This describes what good bereavement support and care looks like. This bereavement charter is particularly pertinent to people who live and work within care homes and should be used to guide the support that is offered to those who are bereaved.

Recommendations

6.1 Care homes should consider how they can incorporate identification tools and assessments within normal practice to help identify people who may require a palliative approach to their care, and support the individual as their health needs change.

6.2 Provide training in the use of appropriate symptom assessment tools, and enable early involvement of dementia link workers to ensure that those living with dementia receive the care and treatment they require.

6.3 Anticipatory Care Plans should be reviewed as people are nearing the end of life to ensure they are firmly rooted in a clear understanding of the values, beliefs and preferences of the individual.

6.4 Care home providers should use the 'enriching and improving experience' framework to identify need and plan the learning and development of their employed staff in relation to palliative and end of life care.

6.5 HSCPs and NHS boards should ensure that there is a specialist palliative care service available and easily accessible to the MDT, and these services should foster close "co-working" and "shared learning" relationships.

6.6 Care home providers and specialist palliative care teams should work together to explore shared learning and peer support opportunities, through initiatives such as Project Echo.

6.7 GPs and other members of the MDT should be available to support the care home staff with end of life care, and speak with relatives when required.

6.8 Dedicated out of hours palliative care lines, allowing direct and fast access to community nursing and medical staff for people who are nearing the end of life, should be available in all HSCPs.

6.9 There should be prompt access to appropriate medication (including anticipatory 'just in case medication' and oxygen) and equipment, such as syringe pumps and pressure relieving mattresses.

6.10 Scotland's bereavement charter should be adopted by all those working in and with care homes and used to guide the support that is offered to those who are bereaved.

7. A Sustainable and Skilled Workforce

The vision of this framework - that the health and wellbeing needs of people living in care homes are met so that they can live their best life - will only be fully achieved by a sustainable and skilled workforce.

The care home workforce demonstrate care, compassion, professionalism, and a broad range of skills in working with people living in care homes, their families, and the multi-disciplinary team to deliver personalised, relationship-based services which not only keep people safe, but also preserve their identity and promote their independence.

There is a need to look at recruitment of workforce and career opportunities around it, including the implementation of training. Placing a focus more on values than experience

when recruiting may assist to grow, nurture and sustain the workforce. Exploring opportunities for people leaving school and ways we can link in with schools and the school curriculum, as well as advertising such opportunities, also need to be considered.

The health and wellbeing of those working in care homes is of equal importance to that of those living in care homes. The needs of staff should be addressed and they should feel supported as they deal with difficult and traumatic experiences. There is also the need to strengthen the healthcare workforce. GPs, Community Nurses and Primary Care teams are under considerable pressure to meet the increasing demand that is associated with the ageing Scottish population.

The Health and Social Care: National Workforce Strategy makes clear the need to grow the workforce. The Five Pillars of Workforce: Plan, Attract, Train, Employ and Nurture, are key to the Strategy, and to how the vision of a 'sustainable and skilled workforce with attractive career choices where all are respected and valued for the work they do can be achieved'.

The SSSC' s Workforce Skills report (2021) highlights that over 90% of care home managers felt existing qualifications are fit for purpose. But, 72% believed new skills needs will develop over the next five years that existing qualifications won't address.

Good induction training is essential to prepare all members of the care home team for their duties and help them to immediately feel valued and supported in their role, which in turn may lead to better staff retention. The SSSC and NES have worked in partnership with Scottish Government and employers to deliver an National Induction Framework for adult social care.

Currently, much of the training takes place online and there is a desire from those we spoke to whilst developing the framework to introduce more practical support tools, with education and training that is meaningful, consistent, and fit for purpose, to better equip staff and empower them to feel confident in doing their job.

Many areas have successfully developed a HSCP based 'Care Home Liaison Service'. This is a multi-disciplinary team who work alongside the care home team to build competence and confidence in meeting the needs of the people living in the home. Evidence from the OPTIMAL study shows that when training includes all members of the care home team (e.g. catering, care and domiciliary team members) there is more likely to be organisational engagement and sustained improvements. This may not always be appropriate as there will be different levels of training required for different roles, where possible this should be encouraged.

Recommendations

7.1 Seek to improve the timeous availability of workforce data to support robust workforce planning, recruitment and retention in line with requirements of The Health and Care (Staffing) (Scotland) Act 2019,

7.2 Invest in the development of care home managers and consider access to enhanced leadership training, mentoring and leadership networks.

7.3 Plan and ensure clinical and professional leadership through the provision of registered nurses as key members of the care home team.

7.4 Explore opportunities for recruitment within the community, by placing a greater emphasis on values rather than experience.

7.5 Organisations should take steps to ensure the emotional wellbeing of their staff, and provide access to support and signposting to the range of resources currently available to them.

7.6 Ensure workforce plans include dedicated time for staff to undertake recommended and required education and training.

7.7 Explore opportunities for career and development pathways for support workers, ensuring consistency and transferability of skills and knowledge across the sector.

7.8 When complete, implement the Induction Framework, developed by NES, SSSC & Scottish Government, across the sector in a 'Once for Scotland' approach.

7.9 Identify the mandatory and core elements of training for care staff to ensure the essential knowledge and practical skills are readily available for use in the care home.

7.10 Have meaningful and consistent education and training that is fit for purpose, includes more practical support tools, and is supplemented by online training.

7.11 'Care Home Liaison Service' models should be explored, whereby multi-disciplinary teams work alongside the care home team to build competence and confidence in meeting the needs of the people living in the home.

7.12 Explore opportunities to develop and introduce a one-stop repository for tools and resources, that everyone can access and that will highlight and share good practice already happening for others to draw from.

7.13 Encourage interdisciplinary multi-sector learning and development to develop the skills required to support people living in care homes

8. Data, Digital and Technology

The current digital landscape across care homes in Scotland is diverse. Many care homes use digital care planning systems and electronic medication management, and provide Wi-Fi access throughout the home for use by people living in the care home and any families or visitors. Other homes lack both accessible devices and connectivity, with significant implications for all.

Care homes are data-rich environments, collecting and collating detailed records of people's needs, plans and activities. They also provide data to inform the requirements of their regulator, contract monitoring with Partnerships, and intelligence to support national statistics on care home services. However some of the data can be unreliable and challenges limit our ability to use national data to understand the needs of those living in care homes. Improving care home data in Scotland has the potential both to better understand the needs of those living in care homes and the staff who support them, but also to evaluate the implementation of this framework and generate evidence from practice around the most effective models of support.

There is an opportunity to use digital technology when assessing healthcare needs, for consultations and for communicating information between healthcare providers. However, digital technology is not solely for the purpose of evaluating physical needs; it can also support spiritual and emotional needs.

The uptake and use of digital technology across the care home sector is a source of significant variation. Reducing this variation and ensuring people living in care homes can benefit from digital technologies to facilitate and support healthcare is key. This will not be without challenges - it requires investment of resource, addressing governance issues, providing clear established data sharing pathways and supporting the development of a digitally-skilled workforce.

Digital initiatives that support learning, such as Project Echo should be explored. Project ECHO (Extension for Community Healthcare Outcomes) is an internationally recognised collaborative model of health education and care management that empowers health and social care professionals everywhere to provide better care to more people where they live and enhance their skills, confidence and build relationships with other professionals.

Recommendations

8.1 Undertake a review of the existing care home data landscape to ensure it is used to benefit those living in care homes.

8.2 Data standards should be introduced, so that data entries from different organisations are understood to mean the same thing.

8.3 The Information Sharing Toolkit should be used to help organisations sharing or handling NHS Scotland's data to take the necessary steps to confidently share and use health data

8.4 People living in care homes should have opportunities and support to use technology to connect with the world outside the care home, including access to good Wi-Fi and broadband connections.

8.5 There should be access and support for people living in care homes to use NHS Near Me for video-consultations with healthcare professionals.

8.6 There must be appropriate technology within every care home to support virtual MDT meetings.

8.7 The actions listed within Connecting People Connecting Services should be implemented.

8.8 All care home staff should have access to resources that build and strengthen their digital skills, such as those developed by Technology Enabled Care.

8.9 Digital initiatives that support learning, such as Project Echo should be explored.

Table of Recommendations

Framework Chapter	Recommendation	
Nurturing Environment	1.1	We must recognise and value the important role of all staff working in the care home in improving health and wellbeing of people living in care homes.
	1.2	The care home team should continue to play a leading role in the healthcare of people living in care homes, alongside a keyworker who co-ordinates the day-to-day care of the individual.
	1.3	Health and social care professionals must work together to address any healthcare needs within the nurturing environment of the care home and ensure that people living in care homes are not over-medicalised.
	1.4	Everyone living in a care home should have access to nursing care. These nurses may either be employed by the care home, or, if employed externally, should have expertise in care homes.
The Multi-Disciplinary Team	2.1	Regular MDT meetings (face to face, virtual or hybrid) should take place involving the care home team, the GP practice and relevant other professionals to co-ordinate and plan healthcare.
	2.2	The administration and support of MDT meetings should be co-ordinated between the HSCP and the care home.
	2.3	People living in care homes should have the opportunity to involve a family member or any legally appointed welfare guardian or attorney during consultations with members of the MDT.
	2.4	As MDTs form and develop, opportunities for shared learning should be explored, to develop the knowledge, skills and experience required to provide the best possible care.
	2.5	Wherever possible, each care home should be linked with a named GP practice that will play a lead role with that home. Where this is not possible, HSCPs should work with the local care homes and GP practices to establish safe and reliable alternative arrangements that enable effective MDT working
	2.6	People living in care homes should be made aware of the benefits of being registered with the GP practice that is linked to the care home that they live in, however they should not be forced to change GP practice.
	2.7	Health Boards should review Local Enhanced Services (LES) that relate to care homes and revise them in line with the aspirations of the 2018 GP contract and the ambitions of this framework.
	2.8	HSCPs must ensure that there is access to appropriate specialist provision when commissioning with the care home sector to provide specific services for people with highly complex care needs.

	2.9	Care home teams must be provided with contact details and referral routes for all members of the MDT. Where these are not clear, the HSCP should work with the care home to obtain these.
Prevention	3.1	People living in care homes must be supported to access any relevant age-specific public health programmes with appropriate information to allow an informed decision.
	3.2	Application of IPC standards in care homes should be supported by access to relevant IPC advice, education and guidance.
	3.3	Everyone living in a care home will have a regularly reviewed personal plan.
	3.4	Ensure there are effective systems in place to deliver a consistent approach to the development and implementation of proactive, personal plans.
	3.5	A person centred medication review, using the 7-step approach should be initiated by a pharmacist when someone first moves into a care home, and then at least annually thereafter. Certain high risk drugs, such as antipsychotics, will require more frequent monitoring and review
	3.6	Routine dental, sight, and hearing reviews should continue to be part of an individual's personal care plan when they move to live in a care home.
	3.7	There should be a named dentist / dental practitioner for each care home and contracts with local optometry and hearing services.
	3.8	There should be a proactive approach to hydration, nutrition, continence promotion, meaningful activity and mobility using appropriate resources and should be considered with the same degree of importance as reactive healthcare.
	3.9	Religious and philosophical beliefs in relation to food and diet should be enquired about and catered for.
	3.10	Psychological and spiritual aspects of healthcare should be assessed and regularly reviewed within care plans.
	3.11	Individuals should be supported to maintain links in their local community which enables cognitive stimulation, mobility, independence and communication.
	4.1	'What Matters to Me' and 'Thinking Ahead' ACP conversations should take place at the earliest opportunity, ideally prior to entering the care home, and at regular intervals throughout the individual's stay.
	4.2	Where someone has a complex health condition, or there are a variety of different treatment options, a senior clinician, such as GP should be involved in discussions.
	4.3	All health and social care staff must be provided with support and training in communication to improve confidence and skills in conducting these meaningful conversations.
	4.4	Everyone living in a care home should have the opportunity to develop an Anticipatory Care Plan.

Anticipatory care, self-management and early intervention	4.5	All health boards should seek to agree and adopt a robust approach (such as the HIS ACP Toolkit, Lothian 7 Steps, ReSPECT) to conducting ACP discussions.
	4.6	Anticipatory Care Plans should be shared with everyone involved in providing the individual's care, and a summary should be included in the Key Information Summary (KIS).
	4.7	Establish community-based supporting self-management programmes to consider how best to support care home teams to adopt self-management approaches.
	4.8	People living in a care home should continue to have regular assessments of their long term conditions, as appropriate, from their Primary Healthcare Teams.
	4.9	Realistic Medicine principles should be adopted to reduce unnecessary or inappropriate investigations and treatment.
	4.10	Where possible, people with complex medical conditions should be supported to attend hospital-based clinics. Where this is not possible, specialist input into the care of the person living in a care home should be adapted to the situation. This may be by telephone, video consultation or by visiting the care home.
Urgent / Emergency Care	5.1	Support and empower care home staff by providing and encouraging participation in training opportunities and enabling all staff to have the tools to assess and communicate in acute and emergency situations using the SBAR format.
	5.2	People living in care homes should have timely access to members of their MDT, 24/7 when urgent or unscheduled care is required.
	5.3	HSCPs should develop dedicated community healthcare teams comprising advanced practitioners who can respond quickly and visit people in care homes requiring urgent unscheduled assessments, with support and advice being easily available from the GP by phone. These services should cover both weekdays and weekends.
	5.4	Both care home staff and healthcare staff should be familiar with the SBAR format when discussing urgent or emergency care, and consider using a structured proforma for these conversations.
	5.5	Care home staff should be able to contact healthcare professionals during an urgent or emergency situation in a consistent and timely manner - this includes exploring possibilities for dedicated professional to professional communication channels.
	5.6	Scoping work should take place to explore the use of near patient and point of care testing within care homes, taking into account Realistic Medicine principles.
	5.7	Health boards should develop Hospital@Home services that support people living in care homes to receive hospital-level care within the care home.
	5.8	Further work is required across Scotland to improve the accessibility and provision of medicines during an urgent

		situation. This includes exploring mechanisms to enable care homes to hold a stock of certain drugs within the home.
	5.9	People living in care homes should never be denied admission to hospital solely on the basis of living in a care home, and at point of admission older people should be assessed by a senior clinical decision maker with experience in caring for frail older adults.
	5.10	Timely and safe transfers to and from hospital for older people in care homes should be optimised.
	5.11	Digital access to an individual's health records, and clinical outcomes should be timely and accessible to all parts of the system.
Palliative and End of Life Care	6.1	Care homes should consider how they can incorporate identification tools and assessments within normal practice to help identify people who may require a palliative approach to their care, and support the individual as their health needs change.
	6.2	Provide training in the use of appropriate symptom assessment tools, and enable early involvement of dementia link workers to ensure that those living with dementia receive the care and treatment they require.
	6.3	Anticipatory Care Plans should be reviewed as people are nearing the end of life to ensure they are firmly rooted in a clear understanding of the values, beliefs and preferences of the individual.
	6.4	Care home providers should use the 'enriching and improving experience' framework to identify need and plan the learning and development of their employed staff in relation to palliative and end of life care.
	6.5	HSCPs and NHS boards should ensure that there is a specialist palliative care service available and easily accessible to the MDT, and these services should foster close "co-working" and "shared learning" relationships.
	6.6	Care home providers and specialist palliative care teams should work together to explore shared learning and peer support opportunities, through initiatives such as Project Echo.
	6.7	GPs and other members of the MDT should be available to support the care home staff with end of life care, and speak with relatives when required.
	6.8	Dedicated out of hours palliative care lines, allowing direct and fast access to community nursing and medical staff for people who are nearing the end of life, should be available in all HSCPs.
	6.9	There should be prompt access to appropriate medication (including anticipatory 'just in case medication' and oxygen) and equipment, such as syringe pumps and pressure relieving mattresses.
	6.10	Scotland's bereavement charter should be adopted by all those working in and with care homes and used to guide the support that is offered to those who are bereaved.

A sustainable and skilled workforce	7.1	Seek to improve the timeous availability of workforce data to support robust workforce planning, recruitment and retention in line with requirements of The Health and Care (Staffing) (Scotland) Act 2019
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Making This Happen

Following publication of this framework we will embark on a period engagement and collaboration with key stakeholders from across the sector to effectively implement and deliver the recommendations outlined in the framework.

Moving forward it is essential that we ensure we are aligned with individual policies across the health and social care system so we can build on the many good practices that are already in place and are able to influence the levers that will allow the recommendations to happen. We recognise this will not transpire immediately and implementation will be ongoing and require a collaborative approach across the system.

To enable us to do this we will:

- establish an ‘implementation oversight group’ with members from all areas of health and social care as well as people living in care homes and their families
- consider at a Directorate Health and Care level the most effective means on achieving the recommendations by ensuring we are aligned to broader programmes and priorities such as the care and wellbeing portfolio and urgent and emergency care collaborative, and in doing so, ensure we can adequately resource the recommendations.
- work with the Care Inspectorate, Health Improvement Scotland, Public Health Scotland and academic and policy colleagues to develop a set of metrics to monitor and evaluate success and provide a robust platform for quality improvement.
- work with the sector on a number of improvement projects to understand how we can embed the vision and in doing so ensure we understand the opportunities and challenges to achieve the recommendations at scale across the sector.
- Produce an annual review of progress against the frameworks recommendations.

This publication is available at **www.gov.scot**

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