NHS Greater Glasgow and Clyde	**Paper No. 24/15**
Meeting:	**Clinical and Care Governance Committee**
Meeting Date:	**4th June 2024**
Title:	**NHSGGC Care Home Support Annual Report 2023-2024**
Sponsoring Director/Manager	**Professor Angela Wallace, Executive Nurse Director**
Report Author:	**Jennifer Rodgers, Deputy Nurse Director**

1. Purpose

The purpose of the attached paper is to:
Provide an annual update to the NHS Greater Glasgow and Clyde (NHSGGC) Clinical Care Governance Committee on the progress pertaining to the support of Care Homes, the review of the Care Home Support Model, and work of the Care Home Collaborative (CHC).

2. Executive Summary

The paper can be summarised as follows:
This paper provides detail of progress made over the last 12 months in relation to NHSGGC support for Care Homes. The report updates on the processes and functions that provide governance, assurance, improvement and achievements across the care home sector.

The paper notes the responsibilities of Executive Nurse Directors (END) since the Cabinet Secretary's initial request in May 2020 for ENDs to provide professional leadership, support and guidance within the Care Home Sector. The report updates on the changing local and national context with the publication of the *My Health, My Care, My Home* Healthcare Framework for adults living in care homes leading to a review and refresh of the governance structures, ensuring strategic alignment to national recommendations.

Care assurance is a key component of the support model. In the last 12 months 97% of NHSGGC care homes received at least one assurance visit, with additional follow-up visits as required. This paper demonstrates the positive impact of these visits,

including opportunities for shared learning and demonstrated improvement across reporting areas such as Infection Prevention and Control (IPC), Residents Health and Care needs, Workforce, and Leadership.

This report details the achievements of the Care Home Collaborative (CHC), which is driven by the overarching aim to support care home communities, in partnership with HSCPs, to co-create the conditions to enable all residents to live their best lives aligned to what matters to them. To that end, systems and processes are in place to ensure that all care homes have direct and equitable access to support. For example, the development of an online CHC contact process; the expansion of training and education resources, which has resulted in 2,223 care home staff undertaking training and education activities provided by the CHC; and a further 572 visits to care homes, building relationships, raising awareness of the services offered, and supporting quality improvement (QI) projects.

Improvement workstreams are well-established and utilise quality improvement methodology, working collegiately with care homes and HSCP teams on QI projects. This approach has enhanced local ownership, building agency for change and generating improvement stories and data to upscale. These include:

- Improved early recognition and escalation of resident deterioration, resulting in positive outcomes for residents

- Implementation of a *Call Before Convey* model aimed to reduce the number of care home residents attending the emergency department unnecessarily

- Work to achieve a reduction in care home resident falls risk by implementing strength and balance exercise classes

- Improving nutrition for residents by expanding access to fortified milkshakes with all-round health benefits

Successful improvement work is based on a collaborative approach, working together with care home teams and HSCP local Care Home Support Teams (CCHST), and utilising quality improvement methodology.

3. Recommendations

The NHSGGC Clinical and Care Governance Committee is asked to accept the following recommendations:

- Note the reviewed and refreshed governance arrangements to support care homes to support strategic alignment with the *My Health, My Care, My Home* Healthcare Framework for adults living in care homes
- Note the positive impact of care home assurance visits with stability and improvement noted across the three defined reporting areas of reporting

- Note the achievements of the CCHSTs, the CHC and the improvement work streams

4. Response Required

This paper is presented for assurance.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows: *(Provide a high-level assessment of whether the paper increases the likelihood of these being achieved.)*

- **Better Health** **Positive**
- **Better Care** **Positive**
- **Better Value** **Positive**
- **Better Workplace** **Positive**
- **Equality & Diversity** **Positive**
- **Environment** **Positive**

6. Engagement and Communications

Communication and engagement with key stakeholders, residents, families and the public is a key strategic objective for the CCHSTs and the CHC. Ongoing feedback through the various care home forums and wider stakeholder groups continue to inform the development and progress of the care home support model.

7. Governance Route

The content of this paper (within the subject area) has been subject to comment/approval through the appropriate forums as follows:

Care Home Governance Groups

HSCP Chief Nurses Group

8. Date Prepared and Issued

Paper was written: 9th May 2024

Paper was issued:

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1. Introduction

The purpose of this report is to provide an annual update on the progress of NHS Greater Glasgow and Clyde (NHSGGC) Care Home Support Model and the Care Home Collaborative (CHC) which spans the six Health and Social Care Partnerships (HSCPs). The 2023 annual report detailed the development of the CHC, the priorities and progress within each improvement workstream and professional assurance and support arrangements within care homes. This report details progress and impact made during the reporting period of April 2023 to March 2024 and describes the next phase of support for care homes.

The report provides an overview of the:

- Review and refresh of governance arrangements to support care homes to support the strategic alignment with the changing national context – *My Health, My Care, My Home* Healthcare Framework for adults living in care homes
- Positive impact of care home assurance visits across the care homes and the extensive work undertaken to review and revise the care home assurance visit template
- Achievements and impact of the work carried out by the Collaborative Care Home Support Teams (CCHSTs), the CHC and improvement work streams

2. Background

As of April 2023, there were 182 registered care homes across NHSGGC, providing specialist care for adults and older people, people with learning and physical disability, neurological illness, mental health conditions and brain injury.

In 2020, Executive Nurse Directors (END) were delegated accountability from Scottish Government to lead on aspects of professional and infection control nursing care quality within the care home context. This delegated accountability provided clarity on roles, noting that HSCP Chief Officers' extant accountabilities would remain, and Chief Social Work Officers remit would continue unchanged to ensure that commissioned services deliver effective care, as well as advising elected members and council chief executives of the quality of social provision. In light of these arrangements, specific funding was allocated to enable the ENDs to undertake this additional role. Whilst this accountability remains, the local and national context have changed, with documents such as the *My Health, My Care, My Home - healthcare framework for adults living in care homes* published (Appendix 1).

Each HSCP has a local multi-disciplinary Collaborative Care Home Support Team (CCHST). Each team has staff from health, social work and commissioning to ensure commissioned services deliver effective quality care. The teams meet regularly to review local care home information including Infection Prevention and Control (IPC), quality of care, safe staffing, adult support and protection and emerging risks.

The Care Home Collaborative model was developed in NHSGGC to enhance the support to care homes and carry out the END's accountabilities. As health and care services emerge from the pandemic, a period of review and consultation was undertaken to ensure that the model of support for care homes continues to deliver on the changing local and national strategy.

3. Care Home Collaborative (CHC)

The aim of the CHC is to support care home communities in partnership with the HSCPs to create the conditions to enable all residents to live their best lives aligned to what matters to them.

The CHC team works alongside the CCHSTs to undertake assurance, improvement, education, reporting and infection control activities. Through local intelligence and assurance visits, five core workstreams were established:

- Right Care Right Place
- Food Fluid and Nutrition
- Tissue Viability
- Infection Prevention and Control
- Person-Centred Care

3.1 CHC Teams

The CHC Hub model encompasses three teams (hubs) of health professionals supporting care homes. There are two nursing teams who work in partnership with local CCHSTs to undertake assurance visits and provide tailored input to homes with a red and amber rating as well as large-scale investigations. In addition, they offer training opportunities to care home staff and support homes to undertake projects to improve care quality. The Glasgow City Care Home Nursing Team covers the 95 care homes within Glasgow City HSCP. The Hub 5 Nursing Team work with Renfrewshire, East Renfrewshire, East Dunbartonshire, West Dunbartonshire and Inverclyde CCHST teams and 87 care homes. The central CHC Multidisciplinary Team has shared resources and expertise and spans both hubs and can be accessed directly by any of the 6 CCHSTs and 182 care homes.

4. Governance Review and Strategic Alignment

4.1 Governance structures

NHSGGC Care Home governance groups continue to provide assurance and have evolved to reflect the changing context within care homes. Established structures provided the framework for whole system support for care homes during 2023/24.

Each local CCHST met regularly to review care home information, including IPC, quality of care, safe staffing, adult support and protection and emerging risks. The output from local meetings informed the classification of care homes using the CCHST agreed RAG rating which continues to be collated for the Board weekly and until March 2024 was returned monthly to Scottish Government.

The Care Home Assurance and Governance (CHAG) Group met monthly and provided operational and clinical support to oversee the implementation of national policy and guidance within the care home context. This included, but was not limited to, IPC issues, matters covered by the Care Homes TURAS Report and the CCHST Report. Progress with ongoing assurance visits, and other reports were tabled on an ad hoc basis at the request of the group.

The CHC Steering Group met every eight weeks and was the reporting mechanism for the outputs of the work undertaken across the CHC. This group facilitated delivery of the five core workstreams of Right Care Right Place, Food Fluid and Nutrition, Tissue Viability Infection Prevention and Control and Person-Centred Care. This improvement focused group received formal updates from each individual workstream twice a year, demonstrating progress to date and next period actions. Each workstream developed project plans to achieve measurable outcomes.

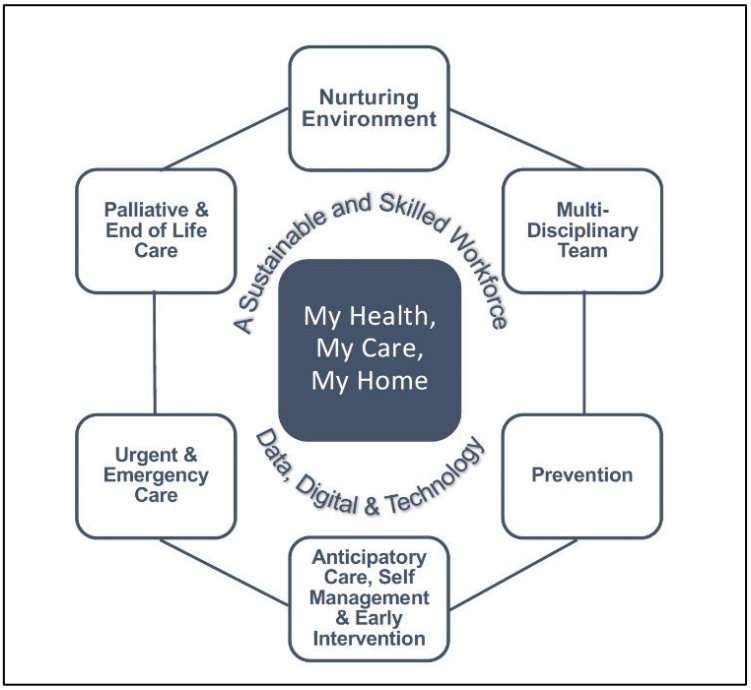
The overarching END Care Home Group provided specialist oversight, professional nursing leadership, support, and governance regarding quality of care within care homes. This group's remit also included scrutiny of the CHC's development to ensure workstreams were strategically aligned to the national framework.

4.2 Strategic Alignment

The publication of the *My Health, My Care, My Home* Framework, set out the Scottish Government's vision that all care home residents are provided with high-quality, personalised care that is consistent, safe, and meaningful. This was confirmed in letters to Boards from the Chief Nursing Directorate (CNOD) as the national direction of travel.

The framework aims to examine how the health and healthcare of people living in care homes should be optimised, supported, and delivered. It sets out a vision to enhance the assessment, monitoring and response to the ever-changing health and healthcare needs of people who live in care homes, centred on the six core elements of nurturing environment; the Multidisciplinary Team; prevention; anticipatory care, supporting self-management and early intervention; urgent and emergency care; and palliative and end of life care (Figure 1). In addition, it highlights the importance of a sustainable and skilled workforce and effective use of data, digital and technology as key enablers to implement the recommendations within the framework.

Figure 1: Health Care Framework



4.3 Care Home Support Model Review

As health and care services emerge from the pandemic, a period of review and consultation was undertaken to ensure that the model of support for care homes continued to deliver in light of the changing local and national strategy. Following engagement with stakeholders, a development session was held in September 2023 regarding the model of support for care homes. This session involved stakeholders who hold formal responsibility within the care home context across the board. The

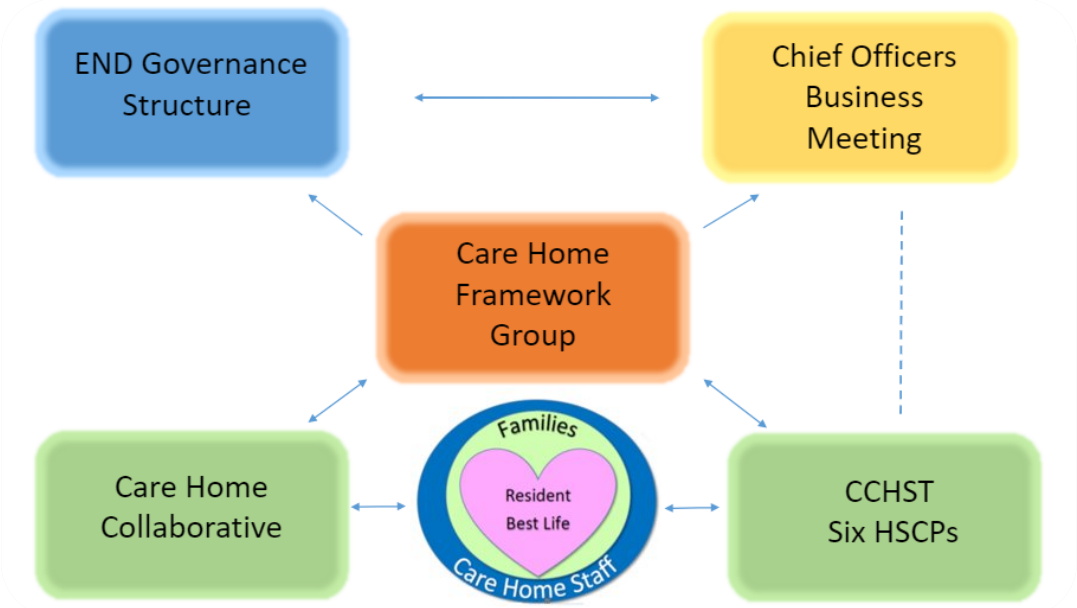
aim was to envisage the best way for the board to deliver its accountabilities in terms of long-term sustainable care home support aligned to local and national strategy. The session used the 3 Horizon Methodology to explore delegates' views of what a new and ambitious model would look like, and what would be required to achieve it.

The following recommendations were agreed:

1. The work of the Care Home Collaborative will be aligned to reflect the principles and priorities of the *My Health, My Care, My Home* Framework for adults living in care homes
2. Governance Groups will be reviewed and refreshed within the above context.
3. Work will be undertaken to build a dual/ blended model of local CCHST teams providing care home support and working closely with the central specialist function, with clear function and role.
4. Continue to support an assurance and improvement model and further develop an evaluation of the framework delivery in line with the national approach.
5. A time critical action to undertake focussed work within care homes aligned to the unscheduled care actions.

Following additional consultation with stakeholders, these recommendations were endorsed by the HSCP Chief Officers and the Executive Nurse Director's Nursing and Midwifery Steering Council in 2024. Governance structures have been refreshed and revised (Figure 2). Work is underway to align CHC priorities with the six core elements of the Healthcare Framework.

Figure 2: Revised Governance Arrangements



5. Care Home Assurance

5.1 CCHST Returns

Local CCHSTs continue to meet regularly and monitor, review and escalate any concerns regarding quality and safety within care homes. The CCHST Report is completed weekly, reported through governance structures, concerns escalated as appropriate and until March 2024 these were returned monthly to Scottish Government. The CCHST Report provides a robust local record of outbreaks, events, inspections, and details mitigations in place. This report provides assurance of issues being identified early and that appropriate, timely and relevant support is provided. During the reporting period of April 23 to March 24, inclusive of 182 care homes, a total of 17 were rated red and 28 amber due to quality and safety concerns. Each red and amber rated home has an associated SBAR document which details the chronology of the concerns, and the actions taken to mitigate risk. In addition, a nursing focused summary is completed monthly, detailing assurance, actions and outputs.

5.2 Care Home Assurance Visits

Care home assurance visits (CHAV) commenced in May 2020 in response to the impact of the pandemic. Each HSCP, in partnership with local care homes, plans a schedule of visits annually. Schedules are adapted in response to locally evolving situations and activity. During 2023, the obligation to undertake two visits per year was reduced to one, with local intelligence driving the need for further visits as indicated. In total, across all 6 HSCPs, 277 visits took place with 97% of care homes visited at least once. These visits continue to identify and highlight areas of good practice. Where areas for improvement are identified, care home teams are supported to have ownership of the actions required, working in collaboration with local HSCP teams and the CHC to achieve improvements. In addition to Care Home Assurance Visits and education sessions, the CHC Teams have carried out a further 388 visits to care homes to raise awareness of the offer of the CHC, provide support and undertake quality improvement projects.

All care home assurance visits are reported using the Care Home Assurance Tool (CHAT). The CHAT has defined areas of reporting which cover IPC, Resident Health and Care Needs and Workforce, Leadership and Culture. The key themes remain consistent across all reporting periods and continue to drive the improvement agenda. Evidence is shown in charts below respectively.

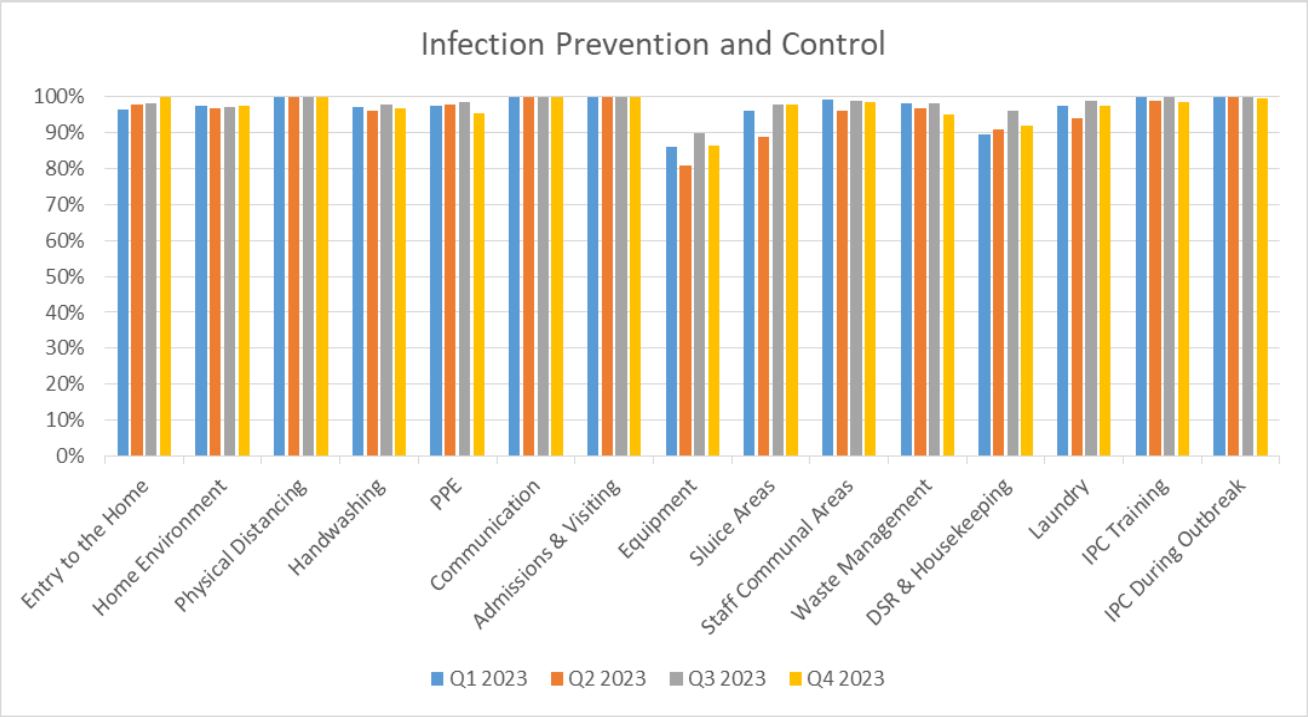
Outputs of visits are discussed with the care home teams, they are shared locally and collated centrally. A Care Home Assurance Report and Infograph (Appendix 2) detailing the collective outputs from HSCP visits is compiled quarterly and reported through governance routes. Different care homes are visited each reporting period therefore findings in each quarter should be interpreted with this in mind.

Infection, Prevention and Control

Performance across all aspects of IPC remains strong. Care homes were found to be welcoming to visitors and demonstrated informative and robust entry procedures. They were clean, tidy, and homely, with comfortable and personalised resident

spaces. Communication remained a consistent area of strength with numerous communication methods used to promote information sharing and gathering feedback. Where refurbishments were needed, these were planned or already underway. In 2023, the management and cleaning of shared equipment, safe handling of contaminated linen, and the inclusion of large-scale items on cleaning schedules, remained areas for improvement.

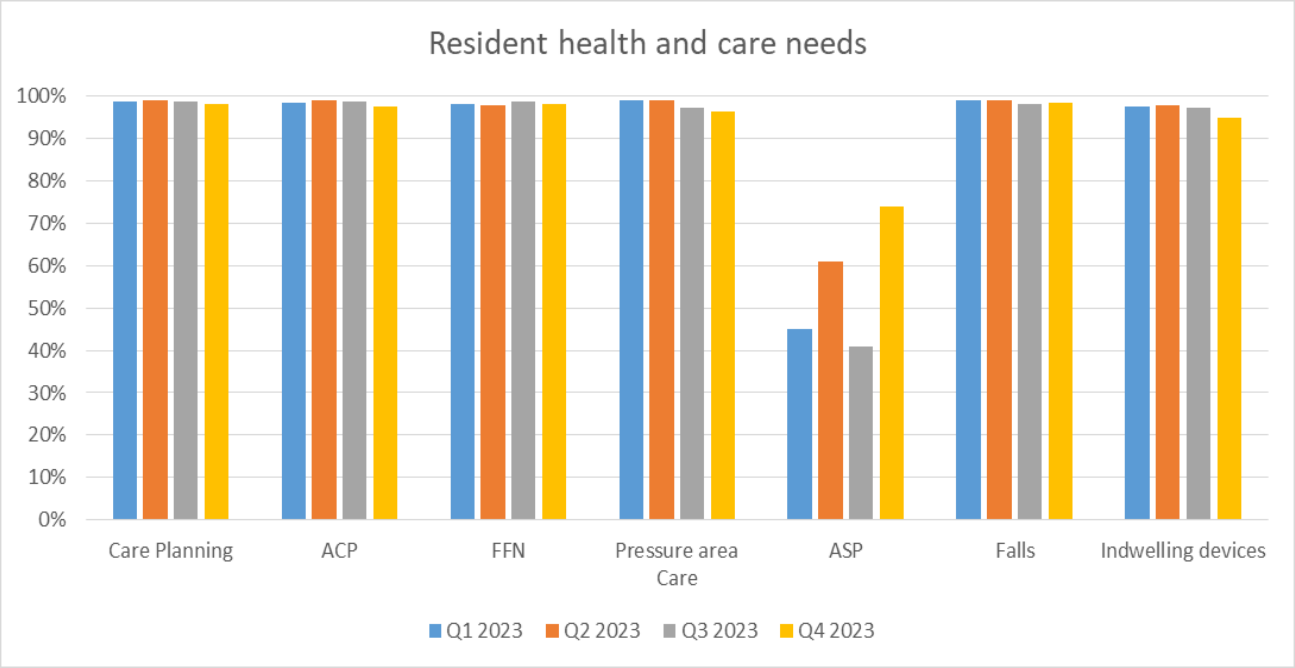
Chart 1: 2023 IPC Themes from Care Home Assurance Visits



Resident Health and Care Needs

Care planning and practices relating to residents' health and care needs continue to be of a high standard, there were examples of person-centred approaches to planning care with residents and their families. Care plans captured residents' histories, preferences, abilities, and goals. The Adult Support and Protection (ASP) data in Chart 2 is broadly similar to 2022 and indicates the number of homes that had active ASP referrals at the time of the care assurance visit. Common themes identified included medication errors, unwitnessed falls and altercations between residents. These incidents are actioned through the adult support and protection teams. Record-keeping practices remained an area for improvement, in response to this recurring theme the CHC teams have delivered record keeping sessions to over 250 staff in the last year.

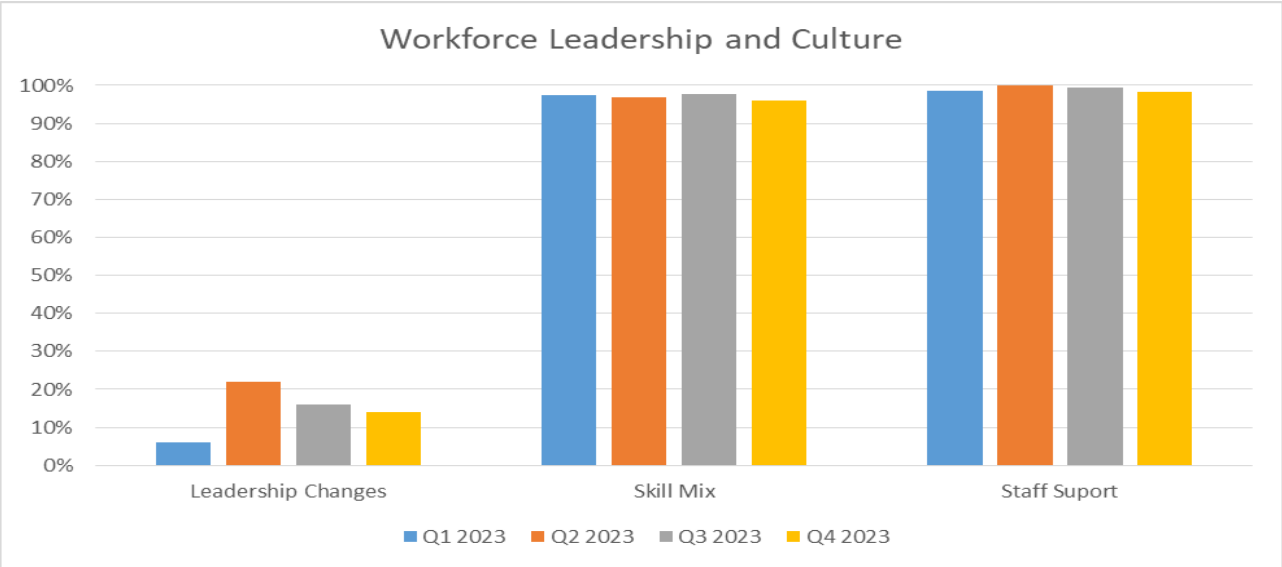
Chart 2: 2023 Resident Health and Care Needs themes from CHAV



Workforce Leadership and Culture

Across workforce, leadership and culture, homes continue to perform well. In line with the national picture across health and social care, the care home sector continues to face recruitment and retention challenges; however, care home teams continue to work flexibly to support their residents and services. The commitment of care home leaders was noted with several long-standing care home managers, and one who had been nominated for the RCN Nurse of the Year Award.

Chart 3: 2023 Workforce Leadership & Culture themes from CHAV



The process of carrying out assurance visits is well received. The visits provide opportunities for health and social care colleagues to learn from each other and

understand the unique challenges of what makes a high quality care experience within a care home context. Outputs from assurance visits demonstrate consistent processes, with good knowledge and understanding of standards of care and have built good relationships to ensure care homes are well supported when needed.

5.3 Care Home Assurance Tool (CHAT) Review

As the sector emerged from the pandemic, the CHAG commissioned a review of care home assurance visits and the template. Feedback was gathered from stakeholder focus groups and an electronic survey. Findings were collated into a consultation paper which recommended care home assurance visits continue, but the CHAT Template is refined in size and avoid duplication with processes in other parts of the system.

A short life working group was commissioned to take forward the review of the CHAT Template. The group included colleagues from health, social work, commissioning, and Care Inspectorate.

The following was agreed:

- Build on the three sub-sections – IPC; resident health and care needs; and workforce, leadership and culture
- Reduce the number of questions relating to IPC, shifting the focus from COVID-19 measures to standard infection control precautions (SICPs)
- Update to the Residents' health and care needs section including the following clinical care elements; personal planning, future care plans, right care right place, food fluid and nutrition, continence promotion, pressure area care, falls prevention, medicines management, palliative and end of life care, dementia and delirium and adult support and protection
- Keep workforce, leadership and culture section broadly the same.
- Provide guidance information to aid consistency of approach

The updated tool was tested during Quarter 4 of 2023 and further refinements will be made based on feedback before it is utilised for all remaining visits.

5.4 Support to Red and Amber rated Care Homes

Robust support is available from local CCHSTs and the CHC when improvements are noted to be required during visits or homes are rated red or amber due to quality and safety concerns. This includes access to specialist expertise, training and bespoke packages designed in partnership with the care homes teams.

Examples of collaborative working and impact are noted in the following:

- Service concerns and opportunities for improvement were noted during a care home assurance visit and the home was rated amber due to quality and safety concerns. The Glasgow City Care Home Nursing Team undertook the Care

Home Support and Review Tool (CHSRT) to review nursing care. The care home liaison nurses increased the frequency of visits to support the staff with wound management. Areas for improvement were identified in relation to falls, record keeping and food, fluid and nutrition (FFN). The CHC Dietetic Team and the Practice Development Nurses worked in partnership with the care home staff and delivered training on pressure ulcer prevention, record-keeping and activities of daily living. Follow up CHSRT highlighted improvements in falls, record-keeping and FFN. Meetings with social work, commissioning and health indicated overall improvements, and the care home returned to green and has sustained these improvements

- Ongoing support was provided by the local CCHST to a home rated red following a Care Inspectorate (CI) Inspection which resulted in reduced CI grades. In partnership with the CCHST and the care home, the Hub 5 team provided bespoke support to improve FFN practices, and create a sociable and homely environment during mealtimes. The Hub 5 Team provided 3 Care Support workers (CSWs), 3 days per week for 10 weeks working intensively with the carers within the home, using observation of practice, real-time feedback, role modelling and reflection on practice. Significant improvements to FFN practices were noted with social work staff commenting on the improved organisation and sociability of mealtimes, even in the out-of-hours period. This intensive support resulted in the care home meeting the CI improvements within the timeframes

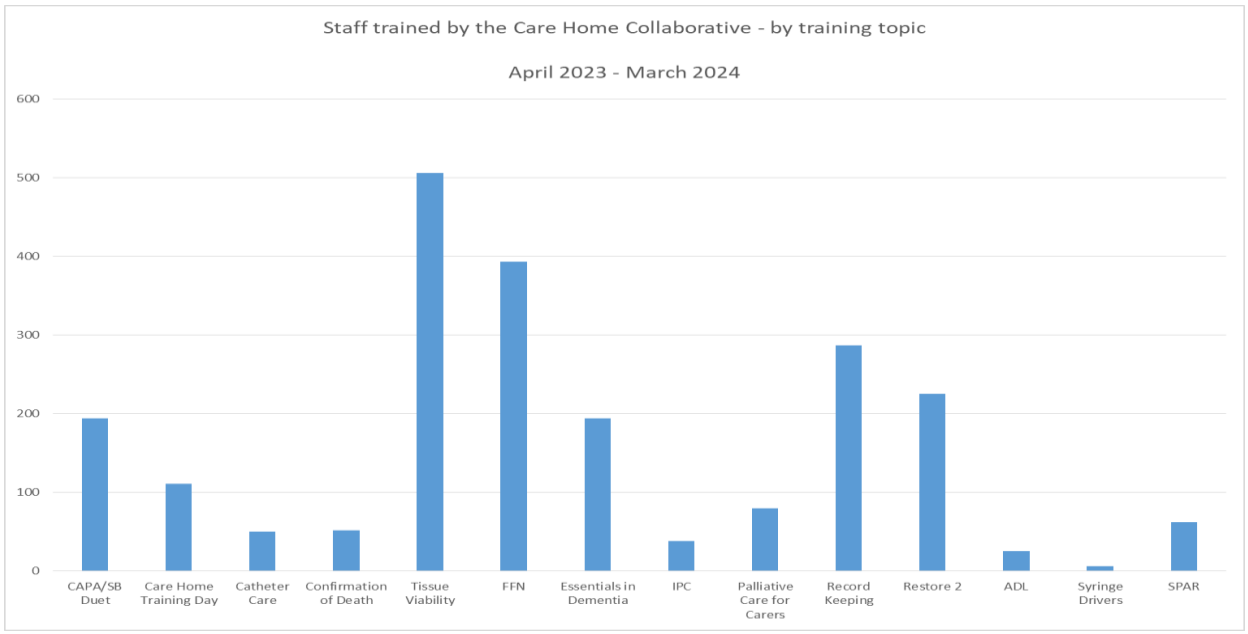
6. Education, Training and Support

6.1 Education and Training

Central to the purpose of the CHC is to support access to specialist clinical expertise and education for care home staff. Shared learning has highlighted examples of exceptional care and innovation within care homes. To build and strengthen what is already good practice, and to further support care home teams, the CHC has developed a suite of bespoke training and education resources. Over the past year, whilst training continued to be delivered within care homes, there has been an increase in the access to in-person full day training covering topics such as Tissue Viability, Dementia, Management of Swallowing Difficulties and multi-specialist days.

The CHC teams provide a variety of training opportunities available to care home staff. In total, 2,223 care home staff have undertaken this training between April 2023 and March 2024. Chart 4 indicates the number of care home staff who attended training, by training topic.

Chart 4: CHC training topics delivered in 2023-2024



Care Home Learning Forum

Following discussions with care home staff and Scottish Care, it emerged there was a growing need to enable registered nurses to come together and learn together. The Care Home Learning Forum was developed to provide opportunities to share knowledge and experience, build connections and peer support networks with colleagues across the settings. The online forums are facilitated by the CHC and co-hosted with care home registered nurses. The inaugural learning forum, attended by 50 staff, focused on Palliative Care, and was hosted by East Dunbartonshire. Feedback was positive and a further 5 forums are planned during 2024.

6.2 Communications

Fundamental to achieving success has been establishing and building effective working relationships with care home colleagues, residents and families, HSCPs, and partner organisations, such as Scottish Care and the Care Inspectorate.

The work of the CHC is generated via a number of sources with the majority planned through improvement workstream groups and HSCP requests. Between April 2023 and March 2024, 124 contacts were recorded. The majority of contacts received from HSCPs and care homes result in training being provided and resources being shared.

The CHC Communication Group has successfully developed the following to support communication, collaboration and participation.

1. Care Home Collaborative - NHSGGC.
2. Social Media Presence utilising X (formally Twitter).

3. A monthly newsletter to share information and best practice.

The website is a one-stop repository for bespoke information relating to care homes. Partners utilise the platform to share resources and training opportunities. During the reporting period, the website had 15,000 views, 76% of users were new to the website. Future plans are in place to work with Carers Centres to develop a section for carers, families, and the public.

The CHC utilises X as a social media platform to share information and there has been continued growth in the number of followers, engagement and impressions. On average there are 18 new followers per month and total impressions throughout the year were around 137k.

The CHC launched a monthly newsletter in June 2023 (Appendix 3). The newsletter highlights good practice and celebrates success across care homes. It provides information on training opportunities and resources. The newsletter is available to all on the CHC website, and the link disseminated via email to all care homes and GP Practices across NHSGGC. In addition, the Glasgow City Care Home Nursing Team (GCCHNT) also produce a monthly local care home newsletter which they circulate via email to the GC care homes. Launched in April 2022, the newsletter includes information about upcoming awareness days, highlights good news stories and signposts staff to local training available.

6.3 Operation Koper

Operation Koper is an investigation led by the Crown Office and Procurator Fiscal Service (COPFS) into care home deaths in Scotland attributable or suspected to be attributable to COVID-19. The CHC, in conjunction with the CCHSTs developed a process to support timely responses to information requests received from the Programme Management Office – Public Enquiries. Each response includes centrally held care home assurance visits, information available through the weekly report during specified time periods and any infection prevention and control information pertaining to the home. Between January and March 2024, responses for assurance information from 58 different care homes have been completed.

7. Improvement and Impact

Five priority workstreams were established based on care needs identified by care homes, HSCP teams and through care home assurance visits. The workstreams aim to ensure all residents in care homes across NHSGGC receive:

1. Safe and effective care in the right place at the right time.
2. Food, fluid and nutrition that meets their personal nutritional requirements.
3. Safe, effective skin and wound care that focuses on prevention and early intervention.

4. Safe care aligned with the standards set out in the National Infection Prevention and Control Manual (NICPM).
5. Person-centred quality care.

Each workstream reports on activity, outcomes, impact, and next steps to the CHC Steering Group. The individual groups utilise quality improvement (QI) methodology and work collegiately with care homes and HSCP Teams on small scale QI projects. This approach enhances local ownership and agency of change and generates improvement stories and data to upscale. The aims and associated projects of these workstreams are set out below.

7.1 Safe and effective care in the right place at the right time

This umbrella aim covers a breadth of specialities. Subgroups are established to support improvement work in relation to; RESTORE2, Call Before Convey, Palliative Care, Caring about Physical Activity (CAPA), Dementia and Advanced Practice. The following summarises the key highlights:

- Access to training, resources, and support to Care Homes to utilise the physical deterioration and escalation tool RESTORE 2. This has improved recognition of deterioration in care home residents. Nursing staff feel more confident to escalate residents' needs to other healthcare services, resulting in positive outcomes for residents
- Access to senior decision makers utilising a Call Before Convey model in the out of hours period has resulted in the reduction of care home residents attending the emergency department
- Utilising the Supportive Palliative Action Register (SPAR) for residents with palliative care needs has improved communication with GPs and NHS24 with residents reviewed quicker, supporting right care in the right place at the right time
- Care homes who provide access to strength and balance exercise classes 3 times per week have demonstrated a reduction in the risk of falls and subsequently the number of falls

RESTORE2

RESTORE2 is a physical deterioration and escalation tool for care/nursing homes based on nationally recognised methodologies and recommended within the Healthcare Framework. RESTORE2 empowers care home registered nurses/senior carers to assess and identify when a resident is becoming unwell and supports providing right care in the right place at the right time.

Working in partnership with the local CCHSTs, training has been provided to 174 staff from 31 care homes. A RESTORE2 mini education resource has been developed, 16 staff from 2 residential homes have undertaken training and both homes will be supported to implement the tool and provide feedback.

Example in practice:

> Following feedback from a CI visit, a care home in East Dunbartonshire HSCP, with the support of the CHC, implemented RESTORE2. The deputy manager commented that the tool was simple, self-explanatory and could save residents' lives. Nursing staff highlighted that completing the NEWS score made them more confident to escalate resident's needs to other healthcare services, which in turn led to quicker and more positive outcomes for residents.

Call Before Convey

Following agreement through Care Home governance, from November 2023 each CCHST identified a senior decision maker to support named care homes utilising a Call Before Convey model in the out of hours (OOH) period. HSCP staff accessed the senior decision maker for timely clinical advice, assessment and intervention, to support and maintain residents safely within their care home, avoiding unnecessary conveyance and potential admission to hospital. The model varied to fit staffing and services within HSCPs and utilised, for example a virtual ward round approach in East Dunbartonshire and Inverclyde.

Data across the 6 HSCPs indicated circa 1,000 residents were identified at significant risk of deterioration and conveyance, half of these were deemed highly likely for acute admission. However less than 40 residents from the named care homes were conveyed during the test period. Findings also indicated having access to care home liaison nurses (CHLN) who are non-medical prescribers, specifically within the OOH period aids management of residents and further appropriate escalation to ANP/ GP OOHs as required.

Recognising deterioration using SPAR

Introduction of the Supportive Palliative Action Register (SPAR) improves recognition and documentation of actions when a resident with palliative care needs deteriorates. Improvement work has so far indicated use of the tool supports better and clearer communication and narrative when escalating condition changes, during handovers and in care transitions.

Example in practice:

> Working in partnership with a West Dunbartonshire care home, 55 staff attended training and the tool was then completed for all residents. Outputs of using SPAR has demonstrated improved communication with comments such as: "I really like the tool, I called NHS 24 and used SPAR to aid communication and I got an answer to my query right away which meant the resident was reviewed much quicker" supporting right care in the right place at the right time.

Increasing Step Count Project

A large proportion of residents in care homes can spend a considerable amount of their time sedentary. Physical inactivity is associated with increased frailty and there is emerging evidence to suggest that physical activity and access to the outdoors and has substantial benefits to the health and wellbeing of residents living in care homes.

Example in practice:

A residential care home within Glasgow City undertook an organised effort to increase the physical activity levels of their residents by introducing personalised, meaningful and purposeful interventions. Activity trackers were worn by residents for 12 weeks to monitor the number of steps per day and personalised interventions were created for each resident. Residents who took part increased their total number of steps. One resident who previously spent most of his time in his room took 4 times the number of steps per week walking to the dining room for meals and the lounge to take part in activity groups.

Strength and Balance

In partnership with 'Paths for All', a charity which aims to support people in Scotland to be active every day, the CHC Team introduced strength and balance training 3 times per week into two care homes in Renfrewshire. Residents and their families were encouraged to participate. Staff measured residents Sit to Stand and Quality of Sit to Stand to indicate improvements in strength and balance. Findings demonstrated improvements in strength and balance and overall mood with powerful stories gathered from resident's families and celebrated in the monthly newsletter.

One resident's daughter commented:

"My mum had a stroke and was in hospital for about six weeks. When she was discharged, she struggled to get up out of a chair and walk. We are so grateful that mums care home partnered with the team. Mum attends classes three times a week, she loves going along as it is quite sociable. At first, she needed help to stand up and she found it difficult to walk and keep her balance. She faithfully did these simple exercises, and she was able to do more each week. Her balance is much better now although she still walks with a zimmer. Sometimes she forgets she needs the zimmer and has been 'caught' walking without it! In the last 4 weeks she has been walking more, she can walk right round the unit at a good pace. In fact, I believe she walks better now than she did before she had her stroke.

Thank you for helping get some of her independence back."

Paths for All and the CHC have invited a further 18 care homes to attend the strength and balance programme and the CHC team will support homes to introduce the programme.

Dementia

Approximately 7 in 10 care home residents have a diagnosis of Dementia, however not all residents with symptoms of Dementia have a formal diagnosis. It is common for those living with Dementia to exhibit stress and distress behaviours when they cannot express their needs. Medications can be used to treat and reduce levels of distress; however, person-centred psychological interventions can be appropriate first line treatments.

The Dementia Nurse Specialist is working with a care home team in East Dunbartonshire to reduce the use of medication as a first line treatment for behaviours related to stress and distress. This project team are currently understanding the system and gathering baseline data. Essentials in Psychological Care training will be delivered as well practical tools and support to implement the theory into practice.

Advancing Practice

Supporting a skilled workforce is essential and recent scoping work has been undertaken to explore views on the educational preparation required for future CHLN roles (with associated appropriate academic credit), providing a clear pathway to progress from Level 6 to 7 within Care Homes. Actions generated included reviewing current CHLN job descriptions and competency frameworks. Anecdotal reports suggest significant variation in the role and remit of CHLNs across the HSCPs. A report is being prepared to describe the workforce resource, competency and scope of practice of CHLNs and provide a consistent approach across all HSCPs.

7.2 Safe care aligned with standards set out in the National Infection Prevention and Control Manual (NIPCM)

Care homes continued to access the CHC IPC Team for advice and support as necessary during outbreaks and a flowchart has been developed to help teams access the correct support during an outbreak.

To highlight safe care aligned to the standards within the NIPCM, the IPC team developed a series of resources accessible on the CHC website.

- PowerPoint video, based on the ten elements of standard infection control precautions (SICPs)
- Two short video clips demonstrating hand washing with soap and water and hand hygiene using alcohol-based hand rub
- Two short power point videos based on transmission-based precautions

In addition, the IPC Team has developed interactive education resources that will be delivered by the CHC care support workers to small groups of staff. The resources are based on four SICPs: hand hygiene, personal protective equipment, safe management of care equipment, and safe management of linen. Feedback from the sessions has been extremely positive. The sessions are available for staff to access on the website.

7.3 Food, fluid and nutrition that meets residents' personal requirements

Development and Testing of the Project Milkshake Resource to Manage Nutritional Risk

In the previous annual report, there were early indications that Project Milkshake had a positive impact on residents within a care home. Over the past 12 months, Project Milkshake has been further developed across additional care homes. The project supports consistent use of fortified milkshakes as part of the food first strategies within the MUST Step 5 pathway.

Building on this the Hub 5 and CHC Dietetic Teams worked in partnership with staff from an East Dunbartonshire care home. Training was delivered, support given to introduce the milkshake recipes and ongoing support to troubleshoot throughout the project. Data gathered indicated an increase in BMI and a reduction in risk of malnutrition (MUST score). In addition, a reduction in the number of referrals to dietetics and reduced need for oral nutritional supplements was noted.

Example in practice:

> The care home manager stated "the whole staff team have embraced the project and have witnessed a marked improvement in one particular resident with a complex clinical condition, noting his wounds heal quicker and he has had less frequent periods of respiratory distress. The only change to his care plan during this time has been the introduction of daily milkshakes."
>
> The care home chef commented about this resident saying, "My goodness, he's come on great, he stood up and gave me a hug this morning."

The CHC teams are currently working in partnership with carers in a Residential care home within West Dunbartonshire. Hand grip strength will also be tracked as an indicator of success. A change package and spread plan is currently being developed to spread the learning across all care homes.

Mealtime Champions

Working in partnership with a home in Inverclyde, the CHC Dietetic Team have developed a package of training and the mealtime champion role. The package of tools developed were tested and 38 mealtimes were observed. Following the test, data collected from residents and staff showed:

- An improved awareness of staff about ensuring a quality mealtime experience even when not carrying out an audit
- A greater understanding of the importance of good mealtimes
- Improved confidence of staff knowledge of nutrition, specialised diets, and the meals to support at-risk patients
- Increased focus on the creation of a positive and calm environment during mealtime

- Appropriate staffing to support mealtimes

The package of tools has now been utilised by 5 further homes within Renfrewshire and Inverclyde.

7.4 Safe, effective skin and wound care that focuses on prevention and early intervention

Reducing Pressure Ulcer Incidence in Residential Care Homes

Work continued to progress towards the reduction of pressure ulcer incidence within residential care homes. Introduction of the Community Pressure Ulcer Risk Assessment (cPURA) documentation along with a number of other tools, a care home had no grade 2 and above pressure ulcers for 243 consecutive days. A change package and spread plan is progressing within residential homes in Glasgow City, Renfrewshire and Inverclyde. The package will continue to be promoted and offered to the remaining residential care homes over the next 12 months.

Reducing Incidence of Harm in the Use of Air Flow Mattresses

There has been identified risk in the incorrect use of mattresses and resulting pressure damage. To that end the CHC have developed staff training and a checklist to support the correct use of airflow mattress equipment. Findings indicated the checklist resulted in the reduction in errors when setting up and caring for residents using an airflow mattress. The initial test care home had no acquired pressure ulcers for residents on airflow mattresses during the testing period. A spread plan is being developed to provide train the trainer and the checklist to other homes.

7.5 Person-Centred Quality Care

This workstream threads through all CHC work and is dedicated to capturing and sharing good practice stories from residents, family members and care home staff, with a specific focus on ‘what matters to you’ conversations. The Person-Centred Care Group includes representation from the Care Inspectorate, Care Home Managers/Leaders, HSCPs and Care Home Relatives Scotland, supporting our aim of collaboration across all stakeholder groups. To date, members have been looking at approaches that enhance person-centred care within care homes.

On the 6th June 2023, as part of What Matters to You day, the team participated in activities and had over 100 conversations with staff, residents and families across all 6 HSCPs. Examples from the day included:

- The Glasgow Care Home Nursing Team secured the use of a vintage double decker bus. The team and the bus visited a care home; residents and staff were invited onto the bus to enjoy some cakes and biscuits and to chat about what matters to them

- The CHC dietetic team visited a home in East Dunbartonshire where they asked residents about the food and fluids that matter to them, and their memories associated with these foods. The chefs listened and organised a comfort food afternoon tea session for them all to enjoy
- The Hub 5 care support worker visited a home in East Renfrewshire and chatted with a resident who used to be an artist and was visited by the Queen when she worked as a designer
- When asked what mattered, the resident said she loved to sketch
- The staff set up a table with her art pencils and crayons; the resident's daughter was pleased to see her mum drawing again
- These stories were shared as examples of good practice within the July CHC newsletter

7.6 Building QI Capacity

Building capacity for improvement is essential to support and maintain quality improvement approaches and models across the NHSGGC care homes. In partnership with the Scottish Social Services Council (SSSC), the CHC have developed and delivered 3 cohorts of the Scottish Improvement foundation Skills (SIFS) course. During the reporting period, 17 staff from HSCPs and the CHC who support care homes have completed the course and undertaking a variety of different projects. Evaluations of the course have been positive, with an increase in knowledge and understanding of QI and the delivery and presentation of a project such as improving hydration, demonstrating learning in practice.

Dates to deliver 3 further cohorts of SIFS, specifically for care home managers and staff in HSCPs, have been agreed and the first cohort of 2024 is underway.

8. Care Home Vaccination Programme

The Care Home Vaccination Group is one arm of a multi-stranded Board-wide COVID Vaccination Programme. The group formed in mid-December 2020 to plan and deliver Covid-19 vaccinations to residents in all adult and older people's care homes across NHSGGC. The group comprised of collaborators across all functions involved in the planning and delivery process, including pharmacy, transport, vaccinator teams, public health, care homes, and HSCP leadership.

The processes and standard operating procedures developed during the first vaccine roll out continue to be adapted, supporting subsequent care home vaccine programmes. The Care Home Vaccination Group continues to meet to oversee delivery of Covid-19 boosters and flu vaccinations to care home residents based on the guidance from the Joint Committee on Vaccination and Immunisations (JCVI). This ensures that all NHSGGC care home residents and staff have been offered a covid-19 booster and flu vaccination well within target completion dates. The uptake

rate for residents in care homes is 84% for both covid-19 and flu vaccine. Anecdotally, the uptake rate for care home staff is considerably lower.

This process has positively contributed to the management of covid-19 and flu within care home residents over the last 3 years.

The roll out of the 2024 spring booster Covid-19 Vaccination Programme commenced in early April and is due to be completed in all care homes by mid-May 2024.

9. Implementation

This report describes progress over the last year regarding the ongoing support for NHSGGC care homes.

The paper reports on the extensive work carried out, in partnership with key stakeholders, to review the model of support for care homes to ensure it continues to deliver in light of the changing local and national strategy. As a result, governance structures have been reviewed and refreshed and work is underway to align CHC priorities with the six core elements of the Healthcare Framework.

The revised governance arrangements will continue to build on existing good practice, improvement and assurance and consider the wider pressures and sustainability of care homes. Further work will be undertaken to build the blended model between the CCHSTs and the CHC, ensuring equitable access to support, training, specialist advice and opportunities for improvements.

NHSGGC assurance processes around clinical and care quality have evolved, and extensive work has been undertaken to review and revise the tools and avoid duplication with processes in other parts of the system. The revised tool will continue to provide data, generating themes and intelligence on what works well and where supported improvement is required. There will continue to be a focus on demonstrating impact through bespoke packages of support for care homes when care concerns have been identified.

Learning opportunities, access to resources and specialist expertise for care home staff will continue to be a central purpose of the CHC. Increased utilisation of the website, monthly newsletters and presence on social media has increased awareness of the service. The Care Home Learning Forum will continue to build momentum and provide opportunities for Registered Nurses who work in or support care homes, to network, share good practice and learn together.

All five cores improvement workstreams are well-established. Each utilise quality improvement methodology and work collegiately with care homes and HSCP Teams on small scale QI projects. This approach has enhanced local ownership and built

agency for change, generating improvement stories and data to upscale. Projects demonstrating impact are being developed to implement at scale.

The CHC Team continues to work in partnership with care homes, supporting them to tell their story of how they enable their residents to live their best lives aligned to what matters to them.

10. Evaluation

Evaluation of impact of the CCHSTs and CHC is essential to illustrate return on investment and demonstrate improvements in quality of care for residents. Developing and enhancing effective relationships, working in partnership with care homes and the CCHST, and utilising QI methodology has been fundamental to demonstrate impact and achieve success. All projects to date have led to improvements in care homes for residents and staff during the duration of the project. Alignment with the Healthcare Framework, monitoring of outputs across the CCHST and the CHC and reporting through the refreshed governance structures will evaluate the framework delivery in line with the national approach.

11. Recommendations

The Board Clinical Governance Committee is asked to note the content of this annual update report for care homes which is presented for information and assurance.

12. Appendices

Appendix 1	*My Health, My Care, My Home* Healthcare Framework for Adults living in care homes healthcare-framework-adults-living-care-h
Appendix 2	Care Home Assurance Quarterly Infograph Q4 Report 2023 Infographic.pdf
Appendix 3	Care Home Collaborative Monthly Newsletter CHC Newsletter Issue 10 March 24.pdf