Scottish Government

Healthcare framework for adults living in care homes

My Health – My Care – My Home

June 2022

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Contents

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Ministerial Foreword

As the Cabinet Secretary for Health and Social Care and the 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 population 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: that 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 multi-disciplinary 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

This framework will examine how the health and healthcare of people living in care homes should be optimised, supported, and delivered. It will also enhance the assessment, monitoring and response to the forever-changing health and healthcare needs of people who live in care homes.

It is clear, however, that a person's health is enabled by both our 'social care' and our 'healthcare' workforce. Therefore, throughout this document, the term healthcare refers to the health needs of the individual in their broadest sense. It will be made clear where there is an intention to specifically refer to the healthcare or social care workforce.

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.

Aims

The majority of people in care homes are living with more than one significant long term medical condition which may not improve and will often be progressive. Provision of a consistent and enhanced approach to care will enable people to remain as healthy as possible, therefore encouraging them to live their best life. It challenges professionals, services and systems to work effectively to support this, and therefore provide seamless, personalised care at all times.

With this in mind, a key element of this framework is to ensure a proactive focus on the fundamental components of what we need to live well. For example, by ensuring that our fundamental needs of fluid, nutrition and movement are met, we can reduce or delay the need for wound care. Similarly, by ensuring a person has the opportunity and support to connect, engage and express their needs, we can alleviate distress and anxiety.

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

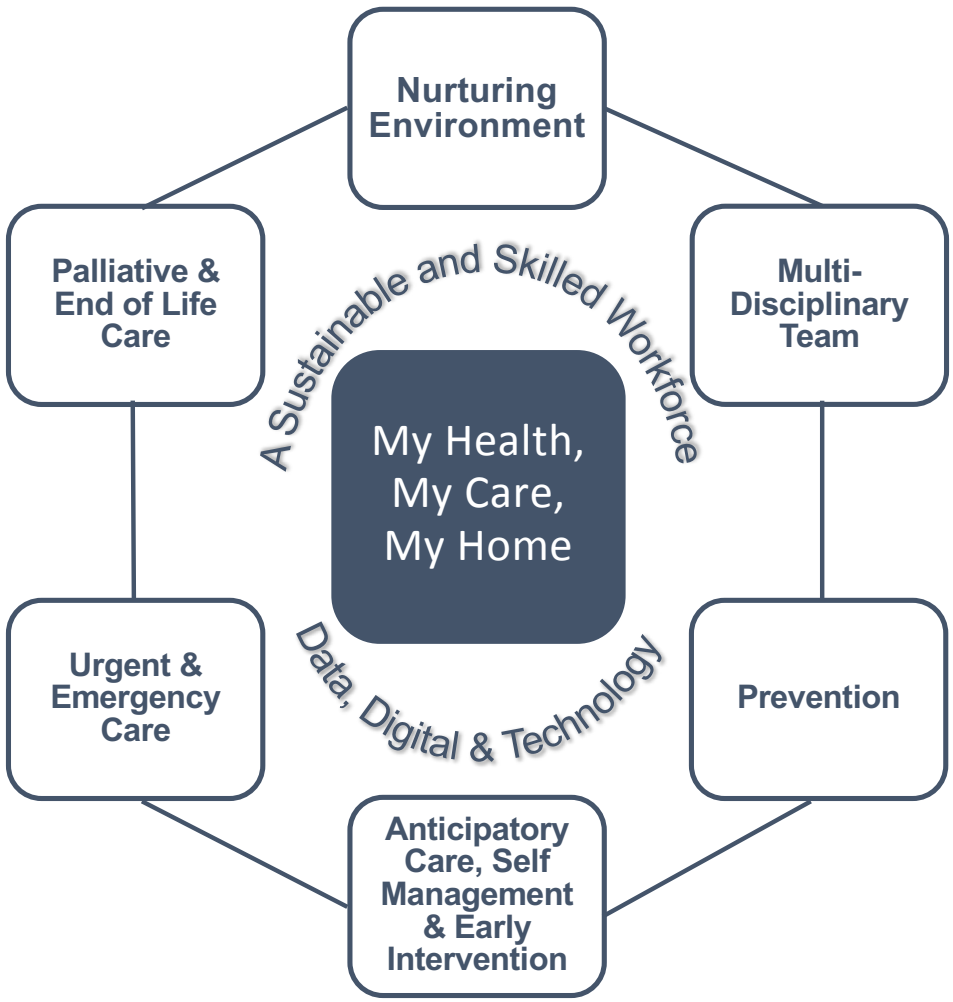
Importantly, the core elements are underpinned by both 'a sustainable and skilled workforce' and effective use of 'data, digital and technology'. These areas are seen as key enablers that will help the sector to implement the recommendations within this framework. Other enablers are realistic medicine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

These take account of an individual's approach to risk and their decisions about the care they feel is right for them. In addition, when practising Realistic Medicine, we strive to reduce waste, harm and unwarranted variation in pathways of care, enabling optimal use of our precious health and social care resources. We call this value-based healthcare. Value-based healthcare is not focused on saving money or delivering efficiencies. It is about working with people to consider whether a treatment or an investigation is going to be of value, based on what matters to them.

In March 2021, the Scottish Government and 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. Ethical commissioning and procurement standards will allow the Scottish Government to focus on those important issues that will affect how care is planned, designed, sourced, delivered, and monitored. Components in the commissioning cycle that are important to achieving the vision in this framework. It will also allow the Scottish Government to spotlight critical areas were we have limited legislative levers to take action through NCS accountability and governance structures. By taking action now to embed ethical commissioning and procurement principles, the Scottish Government can help public bodies and providers to fully engage in the new and changing responsibilities for a NCS.



The remaining chapters of the framework will describe what we have heard from those living and working in the sector, and our recommendations for the future. This is a pivotal building block in improving outcomes as we move towards the establishment of the National Care Service.

Introduction

Providing high-quality, personalised care that is consistent, safe, and meaningful, is the top priority for our health and social care services in Scotland today. This framework aims to provide direction and vision that will maximise the health and wellbeing of people living in care homes. It aims to ensure that people living in care homes experience this wherever they are living in Scotland. Therefore, the framework, and its recommendations, are aligned to the Health and Social Care Standards and takes a human rights based approach. In order to fully implement this framework, it will be necessary to ensure that workforce and other resources are in place to address local needs and circumstances.

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, and 64% are living with dementia (either medically or non-medically diagnosed). The mean age at admission into a care home for older people is 82 years.

The 2021 census also reports there are 157 care homes for people with learning disabilities, 52 for people with mental health conditions, and 36 for people with physical and sensory impairment. The remaining 15 care homes for adults in Scotland included those for acquired brain injury, alcohol and drug misuse, and blood-borne virus.

The requirements of those living in care homes go beyond physical health, and include social, psychological and spiritual care needs.

> **"Importance of retaining community links, relationships, family and friendships. The importance of this in helping to maintain good health cannot be understated."**

The COVID-19 pandemic has undoubtedly had a significant impact on people who live and work in care homes, and their friends and families. Older people, individuals with a weakened immune system, and those living with long term medical conditions were all more vulnerable to severe illness from the infection.

There have also been historical factors pre-pandemic which have challenged the care home sector. These issues are well documented in the Independent review of adult social care in Scotland report (2021). It is essential that we learn from these experiences and build on some of the excellent innovative practice, integrated working and relationship-building which have arisen in parts of the country during the course of the pandemic.

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 they would if they were living elsewhere in the community. This can only be achieved through a whole-system, collaborative approach.

> **All parts of the system working together to review the true cause of the presenting issue.**

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.

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

The deliberate focus on people, and their health and care, is in recognition of the increasing number and complexity of long term conditions that individuals in a care home are living with. It is also in recognition of the fragmented or reactive healthcare that is often experienced, rather than preventative and planned healthcare.

This new framework specifically seeks to strengthen the continuity and access to healthcare, both from within and outwith the care home. It is about ensuring that people living in care homes have all of their needs met, and are supported to live their best life possible. The first step to achieve this was to have a diverse programme of engagement that encouraged active participation with various stakeholders including those living and working in care homes and their families.

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	**674 Stakeholders invited**	**44 Residents and families**
6 Focus groups	**508 Online survey responses**	**73 Good practice returns**

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 wanted to know what was important to them. Some of this feedback was collected using postcards (see page 11).

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. We are extremely grateful to everyone who provided their thoughts, insights and suggestions.

A consistent comment emanating from our engagement was the need to do work 'with' the care home community rather than doing things 'to' them. There was a strong desire for everyone to work together in a supportive way to enable better health outcomes for people living in care homes.

An online survey was developed and sent to all care homes across Scotland. There was an overwhelming view from respondents (93%) that healthcare for people living in care homes could be improved.

All the various comments, stories, experiences, opinions and suggestions from our engagement activities have been used to shape the framework and inform the 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.

Resident Engagement Sessions – Fife

In 2021, Abbotsford Care, the Care Home Hub from Fife Health and Social Care Partnership collaborated to develop the 'Hear My Voice and Return to Sender' initiative as a means of exploring new methods of engagement with people living in care homes. The immediate aim was to influence this framework but the group has longer-term aims to develop methodology utilising an activities-based approach to supporting and prioritising the voices of people living in care homes throughout Scotland.

The focus of this initiative centred around a creative approach, using fun and activities in focus group sessions to begin conversations and support the generation of feedback in a comfortable environment. Using person-centred activities, participants engaged in a number of activities; for example, they were asked to assign a colour scale to a set of emotive questions, create a shape to reflect their feelings representing their experiences, discuss and sharing a mind map of all the support services who have helped them, and detail their personal experiences on a postcard which centres around a performative moment for residents and staff to engage in.

The importance of being well-cared-for was emphasised, as was the sense of living and enjoying life. While some residents expressed a preference to be able to live independently at home, others highlighted that they felt safe in the care home. Individual preferences for company and solace were shared. Some spoke of their enjoyment of activities within the home, shared with staff and other residents. The negative impact of restrictions on access to family, opportunities for leaving the home and going outside were noted, with residents looking forward to greater opportunities now restrictions have eased. Connectedness and relationships with families and care staff were shared.

What was noted as one of the most positive outcomes from this initiative was the direct opportunities for Care Home Liaison nurses from the Health and Social Care Partnership to spend time with those living in Care Homes and to learn more about their experiences. A further 1,000 postcards have been distributed to people living in care homes across Scotland which will be used to inform the roll-out and implementation of the framework.

1. Nurturing Environment

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

During the COVID-19 pandemic, restrictions were imposed on many of the activities that people living in care homes were allowed to participate in. This had a significant and detrimental impact on their health and wellbeing, and also that of their friends and families.

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.

There should be daily opportunities to do things that are important or meaningful to the individual; such as connecting with families and friends, music, art, exercise, gardening, animal therapy and spiritual time.

As such, health and wellbeing is represented by the largest section of the diagram below (figure 2) as it is greatly influenced by the local environment, the community living in the care home, professional carers, families and friends.

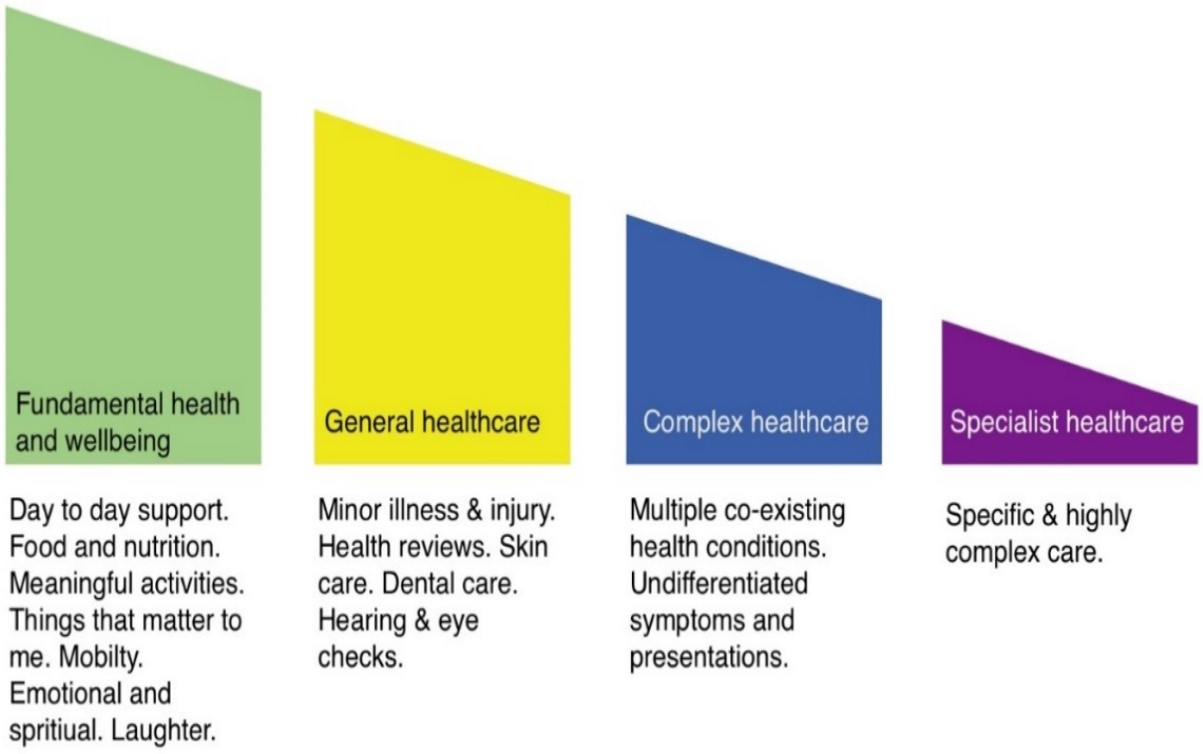


Figure 2 The healthcare needs of people living in care homes

As we come through the pandemic, the importance of day-to-day activities and social interactions has never been clearer and we rely on our skilled and dedicated care home staff to enable this to happen. It is often through these routine daily contacts that 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. They will have the same access rights to care homes as staff, while following infection, prevention and control procedures. Anne's Law will be incorporated into primary legislation in the National Care Service Bill, due to be introduced by the end of this parliamentary year.

The Health and Social Care Standards set out what people should expect when receiving health and social care in Scotland. Two new standards were introduced in March 2022 to ensure that people living in care homes have their right to maintain contact with people important to them in their care and support upheld.

Other healthcare provision (as outlined in figure 2) can be categorised as general, complex and specialist. However, health and wellbeing must not become over-medicalised as care homes are where people live and call home, they are not, and should not become clinical wards. Health and social care professionals must work together to address these healthcare needs within the nurturing environment of the care home.

Nurses working in care homes play a leading role in supporting people living in care homes to live the best life possible. They also lead many aspects of 'general healthcare' such as managing minor illness and infections supporting the more complex care needs that people have.

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. It is important that there is also responsive access to wider community and specialist nursing, allied health professionals and advanced practitioners for healthcare.

The General Practitioner, as the 'expert medical generalist', has a particularly important role within the multi-disciplinary community team in managing people with complex and multiple medical problems and making sense of 'undifferentiated presentations'. This is illustrated in the 'complex healthcare' section of figure 2.

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.

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 is where a group of healthcare and social care professionals, who are members of different disciplines, with different skills and expertise (e.g. care workers, social workers, podiatrists, dentists, nurses and doctors), work together to enable the best outcome for the person living in the care home.

The MDT

There are many different individuals and professionals who support the health and wellbeing of an individual living in a care home, and these can be represented by concentric wheels around the person (figure 3).

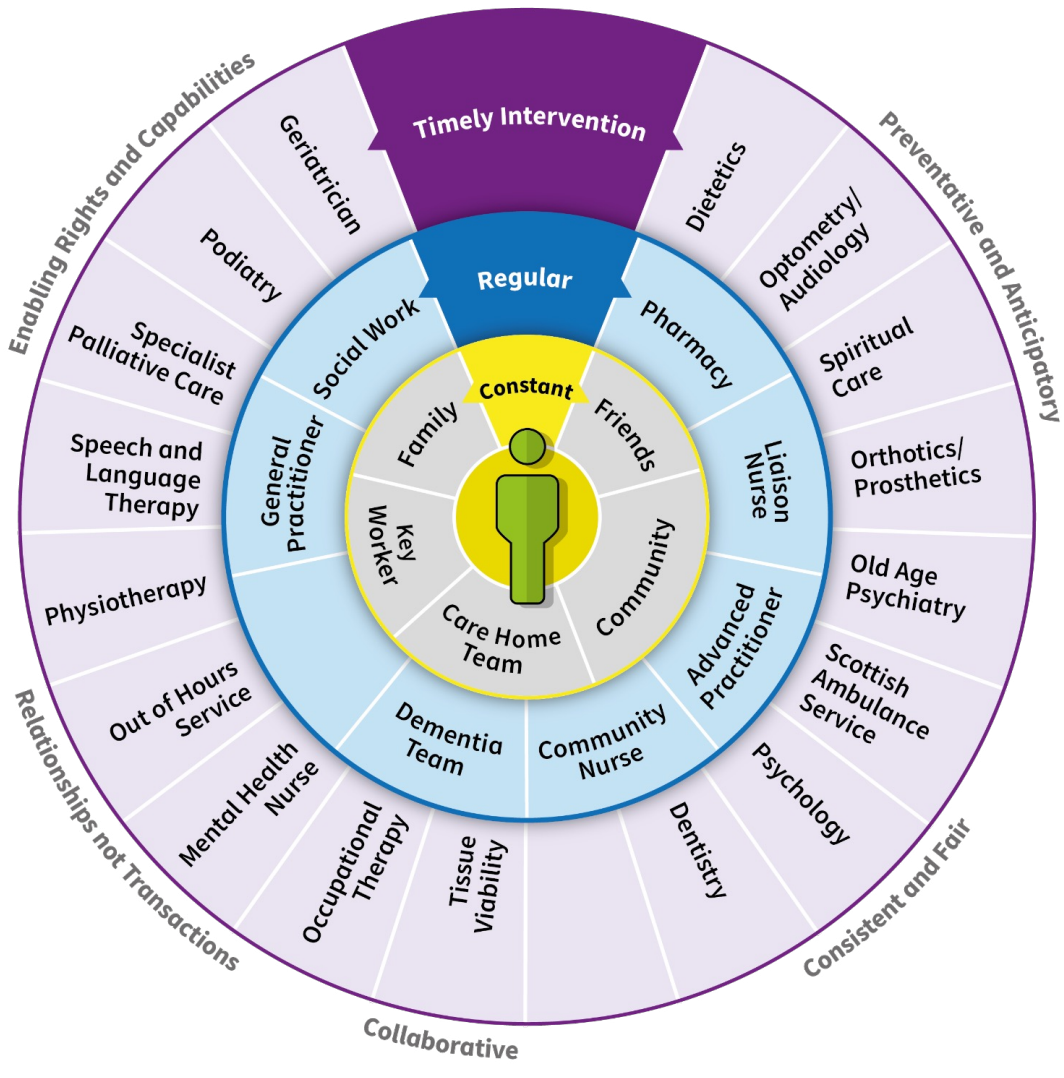


Figure 3 The multi-disciplinary team around the person living in a care home

The people that will normally have the largest impact on health and wellbeing, and who are likely to be a constant presence in the life of the individual in a care home, are listed in the inner wheel. These include friends and family, the community and the care home team. All members of the care home team have an important role in promoting a person's health and wellbeing; for example, catering staff supporting nutritional care, domestic staff engaging in day-to-day conversation and promoting mental wellbeing, and gardening staff who can promote outdoor physical activity by creating a safe and stimulating outdoor environment. There is a particularly important role for the registered nurse within this team. They possess an in-depth knowledge of long term health conditions associated with ageing and skills in the management of complex multiple morbidities and frailty.

Nurses working in care homes require leadership skills and will often have management responsibilities for others within the care team. They are also a key link with the professionals working within the middle and outer wheels.

The people listed in the middle wheel may not be involved on a daily basis, but will often be providing regular healthcare advice and reviews over many weeks, months and sometimes years. They will work closely with those in the inner wheel. Those in this wheel may change depending on the needs of the individual. For example, someone recovering from an illness or injury may require a proactive rehabilitative or enablement approach led by a physiotherapist or an occupational therapist. The role of advanced practitioners within the middle wheel, providing regular professional input is increasing. These advanced practitioners may be specialist nurses or Allied Health Professionals. Social workers hold legal duties under the Social Work (Scotland) Act 1968 to assess needs and make arrangements for care and support. They have an important role in 'protection and monitoring', and also provide assessment of needs and finance when making arrangements for people to go into care homes. Approaches based on human-rights enabling and person-centred strengths should drive the support delivered, but also challenge it where it is not. Social workers have a statutory duty to ensure this happens.

The outer wheel represents a range of other health and care professionals who will provide proactive timely interventions to support the individual. This may be through offering advice and guidance to those in the inner or middle wheel.

It is likely that the individual will not require input from everyone within these concentric wheels, and for some people there will be more focused involvement than for others.

The blank boxes within the diagram signify that other professionals who are not listed, may become part of the MDT for an individual, and that professionals may move between the outer and inner wheels.

Someone living in a care home may need the time-limited and focused support from specific members of the MDT. For example, someone with swallowing problems may require increased input from those professionals highlighted in green within figure 4.

It should be clear to the key worker and care home team how to access all members of the MDT, with a clear understanding of how and when to obtain help. Professional to professional support should be available without having to go through the GP, whenever it is clinically appropriate to do so.

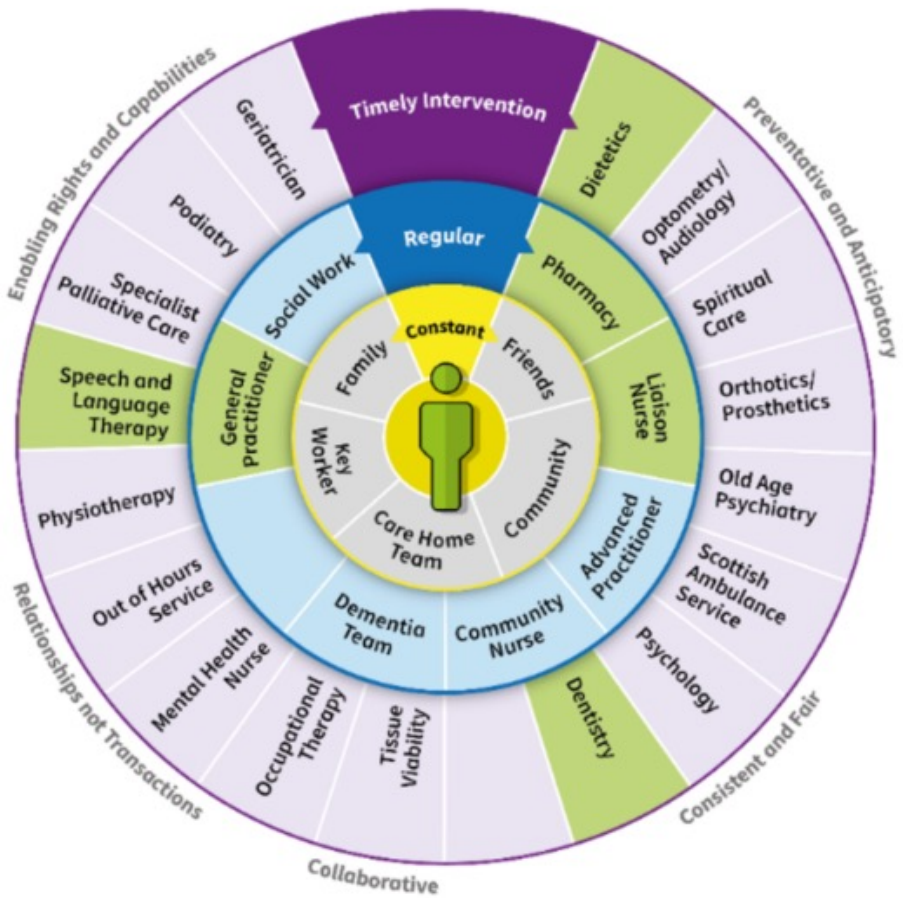


Figure 4 An example showing an individual with swallowing problems

MDT meetings

The MDT must take a proactive and anticipatory approach to the care of those living within the care home. To enable this to happen there should be regular meetings and good communication between those professionals providing constant and regular input (the inner two wheels in figures 3 and 4) and the person living in the care home. Other professionals highlighted as part of a person's care team (for example those in green in figure 4) should be invited to contribute to MDT meetings as and when required. This could be in person, or by providing a report or update ahead of the MDT meeting. Allied Health Professionals can make a significant contribution to discussions by shifting the focus onto prevention, rehabilitation and reablement. These MDT meetings will allow professionals to share information, discuss and plan care for the individual. All members of the team (including families and the person) will have the opportunity to highlight people that should be discussed at the MDT meeting.

For practical reasons meetings may take place virtually using video technology, and should happen as frequently as is necessary. However, this is likely to be dependent 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. The 2018 General Medical Services (GMS) contract describes how GPs should provide senior clinical leadership to the MDT, and so with the implementation of Primary Care Improvement Plans, it is a strong recommendation that there is GP representation at these meetings.

MDT meetings will require some administrative support to ensure that they take place and that the appropriate people are invited. This role should be co-ordinated between the HSCP and the care home. Discussions during these meetings should be led by the most appropriate members of the MDT. During any subsequent planned review, people living in care homes should have the opportunity to involve a family member or any legally appointed welfare guardian or attorney. If required, Chief Social

Work Officers can act as legal welfare guardians, making decisions (Adults with Incapacity (Scotland) Act 2000) if there are no other suitable people in a person's life to undertake this role.

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.

Some health boards are already looking at this multi-disciplinary way of working. NHS Tayside have developed a set of principles for developing the MDT and for how General Practice should work with care homes.

Communication between different agencies needs to be improved for a co-ordinated and enhanced MDT approach to work. There must be better access to relevant care and clinical information, with sharing of relevant assessments, care plans and treatment decisions. This theme is explored more in the Data, Digital and Technology section.

Alignment of GP practices with care homes

Some care homes look after people who are registered across multiple GP practices, and similarly some GP practices look after people residing in multiple different care homes. This can be challenging for all involved.

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. There is evidence of better outcomes (better satisfaction amongst all professionals, fewer medication-related problems, reduced inappropriate admissions to hospital, agreement over the optimal healthcare management plan) when care homes are either aligned or work more closely with specific GP practices. Optimal NHS service delivery to care homes

It is a strong recommendation that each care home should be linked with a named GP practice that will play a lead role with that home. This will allow closer and stronger working relationships to develop between the GP practice team and the care home. It will also provide clarity over which GP practice should be supporting the MDT.

> **We are lucky as our district nursing teams and GP practice work excellently alongside us to benefit the resident.**

HSCPs should work within localities to have, wherever possible, a single lead GP practice, working in close partnership within an extended MDT for each care home. Very large care homes may require input from more than one GP practice. Where there are exceptional circumstances making linkage of care home and GP practice impossible, HSCPs should work with the local care homes and GP practices to establish safe and reliable alternative arrangements that enable effective MDT working.

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, but is still within the practice boundary. This request should be accommodated whenever possible, but the individual should be aware of the advantages of being registered with the lead GP practice for their care home and that they are able to make a decision that best suits their needs.

Most health boards in Scotland offer GP practices 'local enhanced services' (LES) in relation to care homes. These provide additional funding to supplement services already offered within the core GP contract. GP practices can decide whether or not to participate in a LES. Many of the LES relating to care homes have not been revised since the introduction of the GP contract in 2018. Health Boards should review their existing 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.

Specialist provision for those with the most complex care needs

Care home staff have a wealth of experience and expertise in caring for frail older people, people living with dementia and within palliative and end of life care. However, there should still be clear pathways to access and obtain support from specialist services. There should be a proactive system in place for reviewing people living with the most complex of healthcare needs.

Some care homes have established dedicated facilities for people living with very specific and complex health conditions (e.g. homes for people with advanced Huntington's disease or severe brain injury). The healthcare needs of these people go beyond the scope of General Practice, and so HSCPs have a responsibility to ensure that there is the appropriate specialist provision available when commissioning such services from the care home sector. These specialist services must maintain close links with the care home and be responsive to the specialist needs of the unit, as well as with the GP practice and MDT. This includes having clear contact details, referral routes and communication channels for when specialist advice and support is required.

Getting It Right For Everyone (GIRFE)

The Scottish Government's National Care Service consultation consulted on a National Practice Model: Getting It Right For Everyone. A proposed multi-agency approach of support and services from young adulthood to end of life care.

GIRFE will help define the adult's journey through individualised support and services, and will respect the role that everyone involved has in providing support planning and support. Too often, adults and their families are excluded from assessment and support processes by complex bureaucracy.

GIRFE is about providing an easier way to access help and support when it is needed – placing the person at the centre of the decision-making process to achieve the best outcomes, with a joined-up, coherent and consistent multi-agency approach regardless of the support needed at any stage of life.

Principles:

- **Focused on individual care needs**
  ensures that every person is at the centre of informed multi-disciplinary decision making and the support available to them.
- **People treated as equal partners**
  share decisions about treatment options so people are supported to make an informed choice about what's right for them.
- **Based on an understanding of the wellbeing of individuals**
  adopts a person centred approach to ensure that a person's needs are taken into account while acknowledging that their needs will vary over time.
- **Based on early intervention**
  aims to ensure individual needs are identified through meaningful and ongoing conversation, and appropriate support provided, as early as possible.
- **Requires joined-up working/information sharing**
  is about people and their care teams working together in a co-ordinated way to meet specific needs, provide care they really value and improve their wellbeing.
- **Requires an evidence-based approach**,
  where professional judgment, the best available evidence and people's preferences converge to ensure we provide better value care for the people we care for and for the system, and in turn help to reduce waste and potential harm.
- **Based on a human rights approach**
  about ensuring that both the standards and the principles of human rights are integrated into policymaking as well as the day-to-day running of organisations. Everyone has the right to be involved in decisions about their treatment and care.

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. By applying best practice, infections such as respiratory tract, gastrointestinal or wound infections, may be prevented. It is essential that this is part of routine compassionate care in a homely environment. IPC plays a part but so does hydration, mobility and medicines management.

A regularly reviewed personal plan can support a preventative approach to care, and is therefore essential that everyone living in a care home has one. The health and social care standards define a personal plan as:

> *'A plan of how care and support will be provided, as agreed in writing between an individual and the service provider. The plan will set out how an individual's assessed needs will be met, as well as their wishes and choices.'*

Personal plans are currently being produced, often at a very good standard, across the country. However, there is a variation in how they are being written and utilised, particularly in respect to the development and use of online resources. There should be consistency in the approach taken when developing these personal plans, as recommended within the Care Inspectorate's Guide for providers on personal planning.

> **The views and wishes of the resident should be sought, considered and implemented to support them to live their lives to the fulfilment.**

Preventative care involves a collaborative approach where professionals focus on their knowledge and understanding of the individual to do what is right for them. MyHomeLife Scotland is an initiative to promote quality of life for those living, dying, visiting and working in care homes for older people through relationship-centred and evidence based practice. Together in Dementia Everyday (TIDE) acknowledges and values the experience and skills of carers, and gives them a voice across many aspects of care, including prevention.

Restoring Relationships: The Recovery of Love, Connection and Family

As the COVID-19 pandemic took hold families felt a physical and emotional separation from their relatives living in care homes. Care home staff and managers have also experienced a huge range of emotions, loss and change whilst ensuring the safety of the people they care for.

In response TIDE (Together In Dementia Everyday) have created two Recovering Relationships toolkits, one for families and friends and one for care home staff and managers. These toolkits are for anyone who knows someone living in a care home in Scotland or for anyone who works with care providers in Scotland. Relationships initiative

These toolkits focus on different areas of communication and relationships with lots of practical hints and tips designed to support you to take the first steps to improve and renew your relationships.

Prevention also covers many other aspects of healthcare, including:

Medicines management

Prevention of deterioration or of harm also involves the proactive management of long term health conditions and regular, structured polypharmacy reviews. It has been estimated that 25% to 40% of hospital admissions of older people are related to harm caused by medication errors. In residential care facilities, falls occur at a much higher rate and progress to more severe complications in the presence of polypharmacy and/or inappropriate prescriptions.

The person centred medication review, using the 7-step approach should be initiated by a pharmacist and take place 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. The aim should be to optimise benefits from medication, and minimise medication related harm.

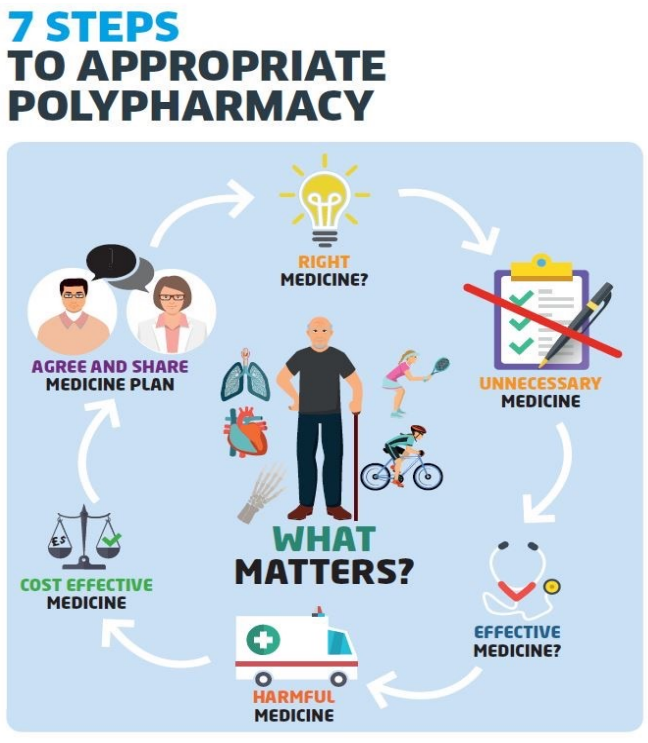


Figure 5 The 7 steps to appropriate polypharmacy

A suite of prescribing safety indicators are available to help address unwarranted variation and support improvement. In addition, several tools are available to ensure that people and their families are involved in shared decision making at the point of prescribing.

Oral health

Good oral health is crucial to overall wellbeing and helps to promote adequate nutrition and hydration. People living in care homes are at greater risk of oral conditions because of a variety of factors including high levels of dependency, the effects of medication, physical disabilities and cognitive impairment. However, many people are now keeping their natural teeth for much longer than before and so, it is essential that they receive good oral care.

The national Caring for Smiles programme offers training to care staff in oral health. Whilst it is a national programme, there have been some local adaptations. Further useful information can also be found in the Care Inspectorate's 'Supporting better oral care in care homes' quality illustration. This includes details of the oral health programme Open Wide for younger adults with additional care needs who may need support with daily oral care.

Routine and regular dental reviews should continue to be part of an individual's personal care plan when they move to live in a care home. There should be a named dentist / dental practitioner for each care home.

Hearing and eye care

The monitoring and maintenance and proper use of hearing aids, glasses and low vision aids are an important part of preventative care. Uncorrected poor eyesight or poor hearing can significantly impact a person's ability to engage. Low vision or poor hearing impacts on holistic wellbeing and on undertaking the functions of daily living such as eating, dressing, or basic hygiene.

For a person to participate fully within their environment and community, they must be able to see and hear as well as possible. This is particularly important for a person with a cognitive impairment, and can help to reduce distress and prevent falls. With effect from 1st April 2023, a new national low vision service will roll out across Scotland, which will provide support to those who have low vision or are sight impaired. This service will operate in both practice premises and domiciliary locations, which will include care homes.

Routine 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. This is one of the recommendations in the Scottish Government/COSLA See Hear strategy.

Particular attention should be paid to the needs of residents who have both sight and hearing loss (deafblindness). Deafblindness is a unique disability, with prevalence rates increasing sharply from age 70.

Nutrition and hydration

Nutrition and hydration is a part of our everyday life. What and how much we eat and drink has a direct impact on our health and wellbeing. Building nutrition and hydration into everyday practice is important, and should include the proactive identification of anything that might prevent good intake. This includes the ability to see well, ability to hold cutlery and ability to chew food. Dietary choices extend beyond just vegetarianism and veganism. Around 10% of the total UK population may have special dietary requirements because of the beliefs that they hold. These should be respected and supported when someone moves into a care home. An all-party parliamentary group has produced Respect for religious and philosophical beliefs while eating in care with recommendations.

Malnutrition affects every system in the body and results in increased vulnerability to illness and complications, for example, increased risk of chest infections, falls, anxiety and depression or the ability to fight off infection. The Malnutrition universal screening tool (MUST) should be used to identify those at risk. Good hydration is vital for many elements of healthcare for example in the prevention of UTIs; tissue viability and clarity of cognition. A helpful resource about eating and drinking well can be found on the Care Inspectorate website. Further helpful information to support nutrition and hydration can be found on the Royal College of Psychiatrists website and the Scottish palliative care guidelines.

Continence promotion and bowel care

Loss of continence can produce marked reduction of self-esteem and independence. It may be associated with physical problems such as skin breakdown, falls, urine infection and catheter associated urinary tract infection which in turn often causes confusion that in itself can result in injuries that require an acute hospital admission.

Therefore, proactive continence promotion can have multiple benefits for an individual and forms an important part of a person's health and wellbeing. The Care Inspectorate provides a helpful resource for promoting continence for people living with dementia and long term conditions.

Tissue Viability and Wound Care

Tissue viability and wound care is closely connected with hydration, nutrition, continence and mobility. Prevention and early intervention when required are vital as is support from a range of people in a person's care team.

There are a number of resources which can help, for example, the tissue viability toolkit from Health Improvement Scotland. NHS Lothian has a dedicated Care Home Tissue Viability Team who deliver educational packages that build on care home staff's knowledge, skills, and confidence.

Mobility and meaningful activity

Maintaining independence and being engaged in meaningful activity is core to enabling a person to live their best life. Mobility may be how a person moves around. It can be classed as aided (e.g. with a Zimmer frame), or unaided. Being active is how we all help prevent ill health or deterioration. It also has a positive impact on a person's self-esteem, independence, respiratory care, joint pain and tissue viability.

Activity does not have to be a formal exercise or activity programme; it also includes recognising the opportunities to make every moment count throughout a person's day. CAPA Resources | care about physical activity can be used to support physical activity in different ways. Allied Health Professionals may be an important part of a person's care team to help with this area of their wellbeing. For example, a physiotherapist can help an individual maintain their mobility, enabling them to independently engage in their daily activities.

Psychological wellbeing and spiritual support

Upholding people's psychological wellbeing and connections to a spiritual life are fundamental principles of person-centred care. Knowing 'what makes life worth living' and facilitating support for everyone's right to live according to their beliefs and fulfil their emotional, psychological and spiritual needs start from confident conversations with the person and those close to them. Their wishes should be reflected and upheld and regularly reviewed via their plan.

Spiritual care is an integrating aspect of holistic, person-centred care; affirming that fear, anxiety, loss and sadness are all part of the normal range of human experience within health and social care. By supporting individuals to explore challenging questions relating to change, mortality, meaning, purpose and identity we can help individuals to (re)discover core values and

beliefs. When such matters are expressed, identified and addressed, people living in care homes can experience a greater sense of enablement, personal wellbeing and resilience in the context of illness, disease and life-changing or other social issues.

Low mood, anxiety and depression

Admission to a care home can be associated with multiple losses and represents a major life transition. It is important to distinguish between the transitory low mood and sadness that may be related to a change in circumstances, compared with enduring depressive disorders.

Agitation is a physical sign of anxiety and can manifest in shouting or other displays of stress and distress, particularly for people living with dementia. Loneliness is a factor in low mood, which is why it is so important to understand what and who are important to a person, and to plan their care and days collaboratively. Low mood and depressive disorders often precede development of dementia and symptoms can be difficult to tell apart. Management begins with a careful assessment to determine cause, followed by a range of therapies which may include activity based interventions, psychological or pharmacological interventions.

Cognitive stimulation and connections with the wider community

Across the sector there are some great examples of cognitive stimulation and active connections within the community, but these do not consistently happen everywhere. The result of this is that for some people, their experiences are limited to 'traditional' activities that may exclude those with declining cognitive health or may not take into account a person's individual preference. Being mindful of a person's life before they have moved into the care home and what connects them to their community should always be part of their care plan. Understanding what matters to the person, whether that be maintaining a spiritual life, family and intergenerational connections or a passion for music is a vital starting point.

In July 2021, Scotland launched a strategy for promoting brain health and dementia research, with the ambition of translating this into health and social care practice. One of the key aims of the strategy is to develop brain health and dementia boards within each NHS board area that will look at dementia research. In addition the Brain health Scotland initiative was developed in partnership with Alzheimer Scotland and funded by the Scottish Government. This initiative provides advice about brain health research and policy, supports the provision of personalised prevention plans and promotes positive brain health in collaboration with Public Health Scotland and other partners.

Communication equipment and support

People who have difficulty speaking and who can be assisted by communication equipment have the right to get the equipment and support they need to use it, when they need it, whoever they are and wherever they live in Scotland, enabling them to participate in their communities and be fully included in society.

Communication equipment, and support in using it, can make a real difference to people's lives and makes sure they have a voice to be heard. From 19 March 2018, NHS boards in Scotland have a duty to provide communication equipment and support to use that equipment.

This duty applies to children and adults, from all care groups who have lost their voice or have difficulty speaking. Health Boards deliver this duty, in the main, through Speech and Language Therapists.

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

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*'.

Effective conversations should help people (including family members) to understand what living well with their physical and mental health conditions means for them, both now and in the future. People should be supported to 'think ahead' and be as fully involved as they are able to be in the management and planning of their care.

Whenever possible, anticipatory care planning should commence long before the person moves into a care home and should continue at regular intervals with the various people and professionals who are involved in providing care throughout their time in the care home. Social workers provide initial identification of the outcomes that people have expressed as important to them, covering their daily lives and their emotional and spiritual needs. This is the foundation for the personal plan developed by the care staff delivering day-to-day care over many conversations.

People living in care homes should have the opportunity to be supported by their family when thinking and planning ahead, including any registered welfare power of attorney where the person lacks capacity to make these decisions.

Some elements of anticipatory care planning require a more detailed understanding of how the health of an individual is likely to change in the future, and the various treatment options that may be appropriate should that happen. It is often helpful to consider and plan what to do following a sudden deterioration such as a collapse, swallowing difficulty, or a severe infection in the context of existing health conditions. Where someone has a complex health condition or when there are a variety of different treatment options, a senior clinician such as GP should be involved in discussions.

It is not the sole responsibility of any particular professional group to lead these conversations, but those who do must be suitably trained and equipped to do so. 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. The 6-step RED-MAP framework offers a helpful model to guide health and care professionals having care planning conversations.

Once an anticipatory care plan (ACP) has been agreed with the person and any registered welfare power of attorney, it must be available and accessible to the various health and social care professionals involved in providing care.

Although 'What Matters to Me' conversations are taking place within care homes across Scotland, they are often not reviewed as frequently as they should be. Sometimes these discussions are not used to 'Think and Plan Ahead' and to create a proactive ACP. The MDT should be consulted to check that every person living in the care home has had the opportunity to develop an ACP and that it is up to date. Where this has not happened there should be a discussion and agreement about who is the most appropriate person to take a lead.

ACPs must also be visible to all that need to see them. Work must continue to develop a national shared clinical and care record onto which ACPs can be stored, seen and used to inform decisions around treatment and care. Until such an integrated health and care record is developed, the Key Information Summary (KIS) remains the best way to share elements of an ACP between different healthcare providers. It is therefore recommended that everyone living in a care home has the opportunity to have a KIS created incorporating their ACP. It can be helpful for the care home staff to hold a paper copy of the KIS, but as this will not be a 'live' document it will require regular updating. Practical advice and guidance on ways to keep the KIS up to date has been published by Healthcare Improvement Scotland (HIS).

A comprehensive ACP toolkit comprising resources that can be used in different situations (e.g. for people with dementia or neurological conditions) has been developed by Healthcare Improvement Scotland, with the aim of supporting the development of holistic and person-centred ACPs.

We know that a whole systems approach to ACP is possible and leads to better outcomes for individuals. Edinburgh Health and Social Care Partnership has demonstrated through their 7 steps to ACP programme that where there is a shared understanding of an individual's health and care. Care home staff, including social care workers, can be supported to have ACP conversations effectively with appropriate tools and an appropriate process.

There is growing interest in the use of the ReSPECT process for developing person-centred plans around emergency care and treatment. NHS Forth Valley are adopting a digital ReSPECT approach to support the development of ACPs with care homes. Formal evaluation of their pilot is not yet complete, but several other health boards in Scotland are also exploring the use of the ReSPECT process and documentation.

It is recommended that all health boards agree and adopt a robust approach (such as those referenced above) when conducting ACP discussions.

Supporting self-management

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 the best life possible. When people first move into a care home it is particularly important that their lifetime habits and self-management actions continue, building on and maintaining what a person can do for themselves (e.g. brushing their teeth, applying a prosthesis etc.)

Health and social care professionals who adopt self-management approaches are 'facilitators' not 'fixers', who support people to identify their own health and wellbeing outcomes. Supporting self-management should be achieved through a shared agenda that uses a person's motivation to make changes that can improve health and wellbeing.

Some people living with learning disabilities may need to stay in a care home because they are unable to live independently elsewhere in the community. However, with support and supervision from families and social care staff, they should be able to manage many aspects of their care themselves. By promoting a shift from 'doing to' to 'doing with', people can greatly enhance their confidence, self-esteem and feelings of self-worth.

People living with frailty can be supported to manage many aspects of their health and care by allowing them more time to undertake daily tasks (e.g. when washing, dressing, moving around the home). Supporting self-management is more challenging when people lose capacity through cognitive impairment and dementia. However, social care staff can and do achieve this through the encouragement of meaningful activities, regular routines and prompting. Occupational Therapists have specialist knowledge and can help the care home team if this becomes difficult.

It is recommended that community-based supporting self-management programmes are established to consider how best to support care home teams to adopt self-management approaches.

Planned healthcare

'Supporting self-management' can also be used to enable people to play an active role in the planned management of their existing health conditions. Having the opportunity to be involved in the management of known medical conditions in the context of everyday life is empowering and can lead to better health outcomes.

There should be regular proactive review of medical conditions such as hypertension, diabetes and heart disease. People living in a care home should not be denied regular check-ups and '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 priorities. 'Realistic Medicine' principles should be adopted. We must work with people living in care homes and their families to agree the goals for management of long term health conditions, and reduce unnecessary investigations and treatment.

Planned healthcare should be delivered as part of general medical services provided by a General Practice to its registered population, with additional services provided to many care homes through funded Local Enhanced Services. These planned healthcare services include the proactive management of people living with long term medical conditions, regular review of medication, and the development of proactive and person-centred anticipatory care plans.

The OPTIMAL study (2017) looking at Optimal NHS service delivery to care homes demonstrated that regular patterns of GP working (e.g. through regular clinics, or a regular MDT) were associated with higher levels of care home staff satisfaction and fewer medication related problems. This was particularly true when there were opportunities to discuss care provision across the care home and not just individual patient's healthcare.

Some people living in care homes may be able to attend their GP practice for such reviews, however for many these will be more appropriately undertaken in the care home. GP practice teams must ensure that adequate arrangements are made for these to happen.

Through 'Primary Care Improvement Plans', pharmacists are integral members of the multi-disciplinary team with expertise and responsibilities for reviewing medication, monitoring high-risk drugs, and considering the impact of polypharmacy. Further investment in pharmacists and pharmacy technicians across Scotland is required to enable provision of level 2 and level 3 pharmacotherapy services.

Everyone living in a care home taking prescribed medication should have an annual medication review using a person centred '7-step approach' as outlined in the Prevention section.

Early intervention

Early intervention to maintain health and reduce deterioration is another important area of focus. For example, through the early detection of hearing loss and access to appropriate assessment and hearing aids, someone living in a care home will be supported to remain engaged and involved in the life of the care home, reducing 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 prediagnostic to post diagnostic support. This may include differential diagnosis of reversible or non progressive causes of cognitive impairment, or multidisciplinary dementia care, including intervention for distress or timely palliative care. Currently access to cognitive assessments and post diagnostic support is very variable, and many people with

dementia will not receive a formal diagnosis once they are living in a care home. Having the right support and understanding can make a huge impact on the quality of life and independence for someone experiencing cognitive challenges.

People with complex medical conditions may require a planned review from specialist services. They should be supported to attend hospital-based clinics where this is possible and will not cause distress. 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.

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.

Equity of access to urgent care services

People living in care homes can become unexpectedly unwell, requiring urgent care and attention. However, it is more difficult for people living in care homes to access some 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 GP contract, such as advanced practitioners, will only see people who are able to attend the GP surgery.

During our programme of engagement, we learned that when urgent and emergency care can be accessed in a responsive way, with consideration of ACPs and using a 'Realistic Medicine' approach, experiences were good. However, inappropriate admissions to hospital were more likely to happen where that preventative planning was not in place or professionals did not have the relevant access to an ACP.

Urgent and emergency care services perform a critical role in keeping the population healthy. People living in care homes should receive the right care, in the right place, at the right time. Care home staff are pivotal in providing this on a day-to-day basis, but there are circumstances when they may need more support to empower them to have confidence in their decisions, and there may be situations where additional services are required to meet the needs of the person.

> **Urgent/emergency care can be very sporadic as residents are deemed to be in a place of safety therefore not a priority for out of hours services.**

People living in care homes should have timely and equitable access to a member of the primary care multi-disciplinary team when this is required. Several HSCPs have already set up dedicated care home teams comprising of Advanced Practitioners (nurses, paramedics and physiotherapists) who can respond quickly and visit people requiring urgent unscheduled assessments, with support and advice being available from the GP by phone. The development of these local care home teams has many potential benefits and should be considered within every HSCP covering weekdays and weekends.

Supporting good communication between professional staff

Social care staff and health care staff must be able to communicate the needs of an individual in a way that is clear and concise. By implementing an SBAR (Situation, Background, Assessment, Recommendation) tool care home staff have described increased confidence in being able to focus on their observations, reflect on the person experiencing care and their care needs. Healthcare staff also found that the use of SBAR aided communication, as it provided them with the appropriate information in a concise way. It is therefore recommended that both care home staff and healthcare staff are familiar with the SBAR format when discussing urgent or emergency care and consider using a structured proforma for these conversations.

RESTORE2 is a physical deterioration and escalation tool for care homes. It is designed to support homes and health professionals to:

- recognise when someone may be deteriorating or at risk of physical deterioration
- act appropriately according to the person's care plan
- obtain a set of physical observations to inform escalation and conversations with health professionals
- speak with the most appropriate health professional in a timely way to get the right support
- provide a concise escalation history to health professionals to support their professional decision making

During the COVID-19 pandemic, the development of a Care Home Assessment Tool (CHAT) was led by Technology Enabled Care, working with care homes and GP practices in Glasgow and Lanarkshire. This digital tool used the components of RESTORE 2 to enable care homes to share assessments of people who had symptoms of COVID-19 or other serious infection quickly with their GP practice.

Access to services out of hours can be challenging for care home staff and response times may be lengthy. This was echoed in the responses to our survey of care homes. 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.

> **"Staff can be on the phone an hour before getting connected.**

A multi-disciplinary approach of professionals working together is required. 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.

Providing urgent and emergency care within the care home

There are advances in near patient and point of care testing that allow medical tests and investigations to be undertaken outwith hospitals or other healthcare facilities. It is important to explore how these could be used to benefit the care of people in care homes and aid decision making regarding treatment. It is felt that simple tests such as the ability to measure oxygen saturations would be useful in the decision relating to need for hospital admission. However, this needs to be balanced with the concern of inappropriate investigations and remembering that care homes should not become clinical settings. Just because it is possible to do an investigation or test remotely, does not mean that the test should be done. Realistic Medicine principles should be considered when determining the best course of action for an individual. As part of the implementation process further exploratory work should be done to investigate this field and also how near patient and point of care testing could link in with Hospital at Home services.

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. All health boards should develop Hospital@Home type services that enable people living in care homes to receive hospital-level care within the care home.

Hospital at Home (H@H)
H@H is a short-term, targeted intervention that provides a level of acute hospital care in an individual's own home which is equivalent to that provided within a hospital. A hospital specialist acts as senior decision maker and responsible medical officer, sometimes with the help of other grades of medical staff. Care is delivered by multi-disciplinary teams of healthcare professionals complying with current acute standards of care. It complements other community-based health and care initiatives which support patients to remain in their own homes. It provides a different level of interventions, such as access to intravenous fluids and oxygen. It has been in existence in a number of countries across the world for 25 years. The first hospital at home service was introduced in Scotland in 2011.

HIS have established a programme to support the implementation of H@H, including work with a mixture of NHS boards and Health and Social Care Partnerships. A total of 20 HSCP areas across the country are supported.

The programme includes a system to share learning and good practice, building on the experience of the established services in NHS Lanarkshire, NHS Fife and NHS Lothian. It tends to work best when it is part of an integrated acute and community-based service model to meet local population need.

The Urgent and Unscheduled Care Team are leading on the development of virtual capacity pathways with a number of stakeholders. Outpatient Parenteral Antimicrobial Therapy (OPAT) and Respiratory pathways are currently in place with others in the development phase.

Treating urgent medical conditions within the care home will often require prompt access to appropriate medication. The relationship between care homes and pharmacy services is varied across the country. One of the main challenges the sector faces is how medicines can be obtained out of hours. Visiting out of hours GPs only carry a limited supply of medicines, and care homes are not permitted to hold stocks of prescription-only drugs unless they are for a specific named individual. It is a constant challenge for staff to access medicine when their local pharmacy is closed. This can sometimes lead to attendances / admission to hospital if medication is not available. During the pandemic, temporary changes in legislation were allowed for care homes to repurpose medicines for another person if they had stocks in the care home. Further work is required within this area.

Hospital transfers and admissions

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. However, people should never be denied admission to hospital solely on account of living in a care home.

There are often delays in transferring people living in care homes to and from hospitals, often as a result of wider system pressures. It is important that ambulance staff and other stakeholders work closely together, optimise safe travel routes and utilise all options of transport available.

Upon arrival at hospital it is vital that people living in care homes have equitable access to specialist care and they should, wherever possible, be assessed by a senior clinical decision maker. We know that older people living in care homes are often frail, and unless clinically inappropriate (e.g. if they have an acute stroke), their care should be in a specialist area for frail, older adults. They should have early access to comprehensive geriatric assessment, with nurses and AHPs trained and experienced in caring for this vulnerable group. This can enable faster recovery and earlier discharge back to the care home.

Acute and Emergency Care

It is recognised that when care home patients are admitted to hospital they are at risk of adverse events. It is important that the hospital team are aware of the wealth of information that would be available from the carers usually looking after them and that there are ways to mitigate the risk of adverse events. The following infographic is available to download from the Scottish Government website, and was developed to assist in assessing and managing older adults being admitted from their care home.

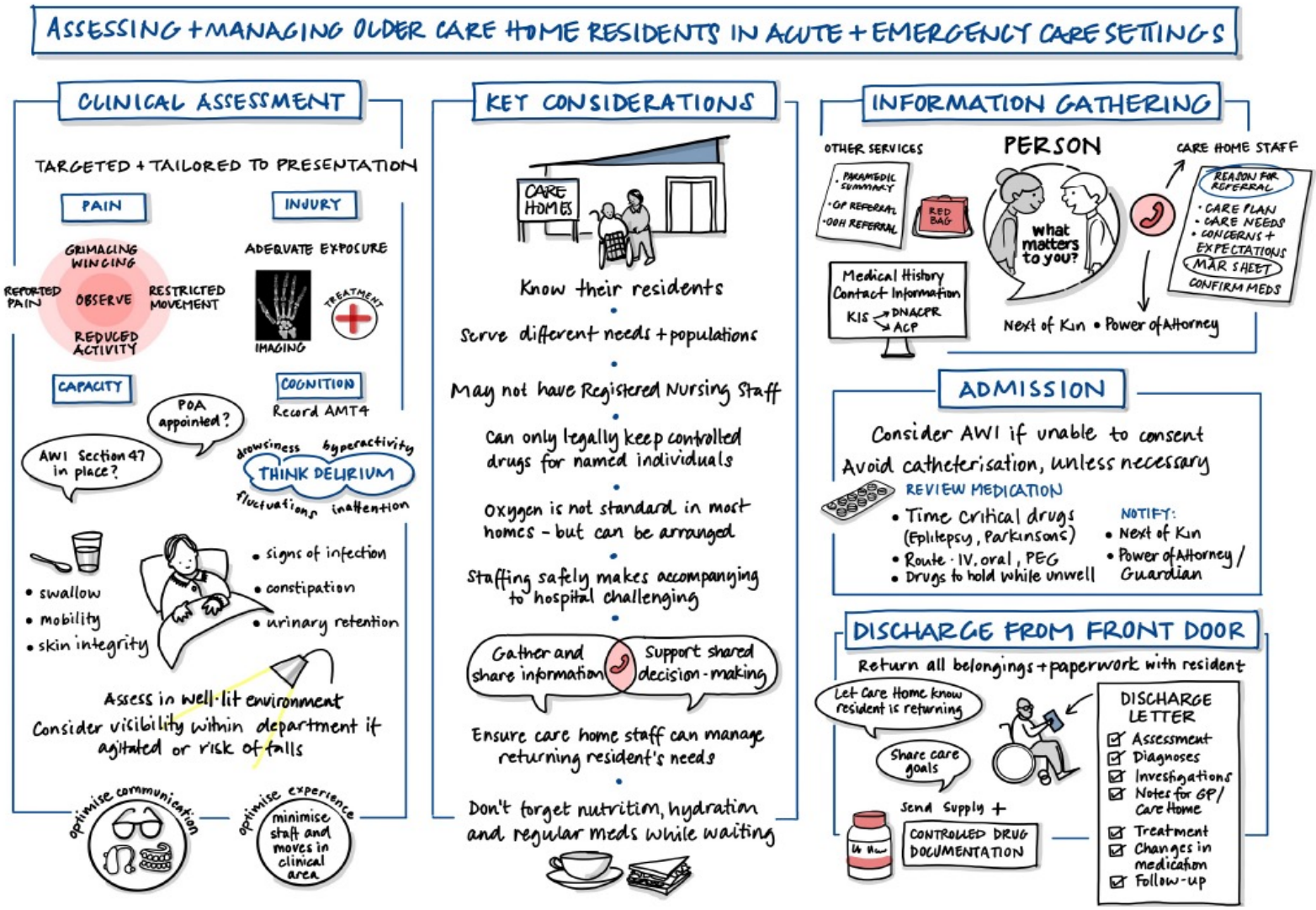


Figure 6 Looking after people from a care home infographic

Timely access to someone's health records is also vital. The Key Information Summary (KIS) and ACP information should be readily available to all parts of the system. On transfer back to the care home, clinical information and outcomes should be shared with the care home to allow the care home records to be updated. Sharing details of any previous discussions and decisions regarding capacity and DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) can be helpful both for people being admitted but also on discharge back to the care home.

There is currently no national data on the frequency by which people living in care homes use urgent and emergency care. NHS 24 have put measures in place to fulfil the desire for this metric by asking callers if they are calling from a care home.

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. Effective palliative care can prevent and relieve suffering through the early identification, accurate assessment and management of pain and other problems, whether physical, psychosocial or spiritual.

'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.

Provision of palliative care

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

Identification of those who need palliative care

It is important to be able to identify individuals whose health is at risk of deterioration at an early stage. This will allow early and proactive assessment and delivery of the most appropriate care. Healthcare Improvement Scotland (HIS) has published various tools which have enabled earlier identification of those who may benefit from a palliative approach to their care. The SPICT (Supportive and Palliative Care Indicators Tool) and PPS (Palliative Performance Scale v2) have both been adopted successfully within some care homes in Scotland for this purpose. Glasgow City's Riverside Care Home used the PPS along with a Supportive Palliative Action Register to assist staff in identifying any change or decline within people living in their care home. Care home staff should consider how they can incorporate such tools and assessments within normal practice to help identify people that may be at risk of deterioration.

Assessing symptoms/needs and planning

Assessing symptoms can be particularly difficult where there is associated cognitive impairment, such as in the context of delirium or dementia. There is a risk of diagnostic overshadowing, whereby physical symptoms such as pain are not recognised and instead changes in behaviours are incorrectly attributed to dementia. Families, friends and the care home team are key to recognising distress, from their knowledge of the person and their normal patterns of behaviour. Other health and social care staff, who do not know the individual as well, must listen to the concerns of those that are closest to the person. Training in the use of appropriate symptom assessment tools (e.g. Doloplus-2 or the Abbey Pain Scale), and early involvement of dementia link workers can help ensure that those living with dementia receive the care and treatment they require.

Distress and suffering is not just about pain and other physical symptoms. Careful consideration must be given to all 4 domains of palliative care, including any psychological, spiritual and social factors which may be contributing to distress. Adopting a

holistic approach to assessment and care is of prime importance, and can be aided by tools such as the HOPE approach to spiritual assessment.

A co-ordinated MDT approach to care is important at the end of life. Anticipatory Care Plans should be reviewed to ensure they are firmly rooted in a clear understanding of the values, beliefs and preferences of the individual. This may include the discontinuation of unnecessary medication and a review of treatment goals, including sensitive discussion around cardiopulmonary resuscitation (CPR).

Figure 7 The four domains of palliative care (image Hazel White Design)

What skills and knowledge are needed to provide palliative care?

Scottish Social Services Council and NHS Education for Scotland has published 'Enriching and improving experience', a framework to support the learning and development needs of the health and social service workforce in Scotland. They have identified five domains which reflect the core knowledge and skills considered integral to the delivery of high-quality palliative and end of life care. Each domain presents four levels of knowledge, skills and experience that outline what health and care workers need to know and do. People working in care homes and their employers should use this framework to identify learning needs in relation to palliative and end of life care.

The Scottish Palliative Care Guidelines have been developed by a multi-disciplinary group of professionals and provide practical, evidence-based or best-practice guidance on a range of symptoms and other palliative care issues. These include guidance on assessing pain in people living with cognitive impairment.

Accessing specialist palliative care services when required

Most of the care for someone who is approaching the end of their life can be provided with compassion, skill and knowledge by the care home team. However, sometimes symptoms will be more troublesome, or there may be other complex factors involved in providing care. In these circumstances the wider MDT should be involved, including timely intervention from specialists in palliative care as required.

There is wide variation in access to specialist palliative care across Scotland. HSCPs and 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. A named individual, team or service from the specialist palliative care should be easily accessible and provide timely support to the MDT and care home. They should foster close "co-working" and "shared learning" relationships with the care homes in their area.

Some care homes have found it extremely helpful to participate in Project ECHO. These multi-site videoconferencing meetings with an emphasis on shared learning and peer support have often focused on palliative and end of life care issues, with input from the local specialist palliative care team. Project ECHO is described in more detail within the data, digital and technology section of the framework.

Responding promptly to change

There may be times when an unexpected change occurs with an individual's symptoms or condition, and so prompt access to assessments, advice and support from the Primary Care and MDT is essential. Many areas of Scotland have a dedicated out of hours palliative care line, allowing direct and fast access to community nursing staff for people who are nearing the end of life. It is recommended that all HSCPs ensure that there are arrangements to allow prompt access to nursing and medical staff throughout the 24-hour period.

> **Very difficult to get in touch with health care professionals.**

People should also have timely access to appropriate medication, equipment such as pressure relieving mattresses and syringe pumps, and to community nursing (particularly where there are no registered nurses in the care home).

'Just in case medication', as recommended in the Scottish Palliative Care Guidelines should be available for everyone who is assessed to be in their last weeks of life. Further work needs to be undertaken to explore the legislative and contractual barriers to requisitioning and holding a stock supply of medicines in care homes in Scotland.

Families and friends

It is particularly important that families and friends are kept informed, involved and supported as their loved one is approaching the end of their life. Clear compassionate communication and unrestricted visiting are key to achieving this. Care home staff are best placed to lead in this area, as they have established relationships with the people that are close to the individual. However, the GP and other members of the MDT should be available to support the care home staff and speak with family and friends when required.

Dealing with loss

Those who work or live in care homes describe the strong bonds and connections that develop between staff and those living in the care home, and so the death of an individual can have a profound effect on everyone. Care home staff will often have to break the news that someone has died whilst they are still coming to terms with the information themselves.

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.

During the COVID-19 pandemic care home staff have had to take on additional responsibilities in relation to testing and adherence to IPC guidance. They have supported individuals, families, and colleagues through the very particular and emotional challenges of the pandemic. They have had to work through their own experiences of grief and bereavement. This has all been within the context of long-standing pressures within care homes with regards to attracting, recruiting, and retaining staff, exacerbated by the combined impacts of the withdrawal from the EU and the pandemic itself.

In December 2021, the Care Inspectorate and the Scottish Social Services Council (SSSC) published their vacancies report which confirmed that care homes for older people in Scotland had 55% of services reporting staff vacancies and 38% of services reporting nursing vacancies.

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, skilled workforce with attractive career choices where all are respected and valued for the work they do' can be achieved. This section of the framework focuses on this vision and identifies the necessary conditions to sustain and further develop the care home workforce.

The care home workforce

The Multi-Disciplinary Team section uses concentric wheels to describe how the MDT is made up of individuals and professionals and how they work together in the direct provision of care. The effectiveness and impact of the MDT will be influenced by the availability of a skilled and sustainable workforce.

The Adults' services workforce table published by the SSSC informs that as of 2020, 46,340 staff were employed in care homes for older people in Scotland. Additionally SSSC's 2020 report on workforce data (August 2021) informs of 52,920 (41,390 WTE) people working in all adult care homes in Scotland.

Analysis of the latter indicates that 75% of all staff are reported as care staff providing direct care, support or clinical assessment. Data relating to the nursing workforce is limited as they are categorised along with others who are responsible for assessment of care needs, for example Social Workers and Occupational Therapists. However, this group account for only 11% of this direct care and support function in care homes, with care home managers accounting for 2% of the total workforce. The data available, along with the time lag in it becoming available, not only makes robust workforce planning challenging, but adds concern regarding the provision of clinical and professional leadership to support the increasing levels of dependency and complexity that now exist.

Care home workforce skills

As described in the introduction to the framework, Scotland's population is ageing and as people are living longer, some are living with increasingly complex health and care needs. This demographic change is also reflected across the care home population impacting on the current and future skills needs of the care home workforce. The SSSC's Workforce Skills report (2021) highlights that over 90% of care home managers felt existing qualifications are fit for purpose. However, 72% believed new skills needs will develop over the next five years that existing qualifications won't address. Particular areas of skills needs that were highlighted were Infection, Prevention and Control, and Digital skills. Survey respondents to the consultation on this framework also identified the value in developing care home workforce skills in preventative asset based approaches and some basic clinical procedures for example, wound dressing.

Care home managers

The responsibilities of the care home manager are all encompassing. In short, they are responsible for the overall management, development and quality assurance of care and support provided in a care home service, including the supervision of staff and the management of resources.

Care home managers are dedicated and caring, they are motivated to meeting the needs of people. Studies on job satisfaction inform that care home managers cite the provision of good quality care, their use and development of skills in their work, working with capable staff, having a good reputation in the care home sector and opportunity for career development as essential. Investment in the development of care home managers, which should include leadership training is required to enable this.

Challenges to be overcome in dispensing these responsibilities are described throughout this framework. Changes to regulation, legislation, policy, challenging recruitment and retention of workforce, fragmented care and communication systems and not least the impact of the financial climate.

Registered Nurses

The NHS Education for Scotland Post-registration Career Development Framework for Nurses, Midwives and AHPs defines four pillars of practice (clinical practice, facilitation of learning, leadership, evidence, research and development). These are core components of education and development which support the development of Registered Nurses to increase their knowledge and skills to work across levels of practice from Newly Qualified Practitioner, Senior/Specialist to Advanced Nurse Practitioner and Consultant Nurse. These are demonstrated in page 5 of the Chief Nursing Officer Directorate, Transforming Roles, Paper 5: Transforming education and career development in nursing.

Whilst Registered Nurses work across these levels of practice, fundamentally they have the skills, knowledge and experience required to undertake assessment of an individual's needs, ensuring that appropriate response to their findings is taken leading to the best outcomes for the individual. At Level 5 of practice (newly qualified practitioner), some examples of responsibilities and roles defined within the four pillars of practice are provided on page 8 of the CNOD: Transforming Nursing, Midwifery and health Professions (NMaHP) Roles; pushing the boundaries to meet health and social care needs in Scotland.

The CNOD Transforming Roles paper: Advanced Nursing Practice set out the core competencies, education priorities and supervision requirements for ANP roles in Scotland. The paper defines Advanced Nurse Practitioners (ANPs) as *'experienced and highly educated registered nurses who manage the complete clinical care of their patients, not focusing on any sole condition.'*

In working with, and as part of, the care home team, all four pillars of practice will be utilised in meeting the needs of the person. However, the attributes, skills and knowledge as leaders that the Registered Nurse brings to the team is key. They bring leadership and co-ordination to the team – they are critical to managing and overseeing infection, prevention and control practices, food, fluid and nutritional care and safe medicines management. Using mentorship and a coaching ethos they oversee and support the wider care and support team. Provision of registered nurses is required, as there is a well reported correlation between provision of Registered Nurses and high-quality, safe and effective care.

Regulation and registration

The Health and Care (Staffing) (Scotland) Act explicitly states that staffing is to provide safe and high-quality services and to ensure the best health care or care outcomes for people experiencing care. Once enacted, it places a statutory duty on care home providers to ensure that, at all times, suitably qualified and competent individuals are working in such numbers as are appropriate for the health, wellbeing and safety of people using the service, and the provision of high-quality care. Providers are also required to ensure staff are appropriately trained for the work they perform. The Care Inspectorate's Guidance for providers on the assessment of staffing levels has been designed to support care home and other care service providers in assessing and providing staffing levels to best meet the needs of people in their care.

Statutory regulation of the health and social care professions serves to protect the public from the risk of harm associated with the provision of health and social care services. There are 9 regulators of healthcare professionals in the UK, overseen by the Professional Standards Authority (PSA), regulating 34 professions, which all must be registered with their professional regulatory body by law. The regulators maintain and hold the register of those qualified to practise in each regulated profession they oversee; they set the education and training requirements for entering a profession; set the standards of conduct and competence needed to continue to practise and take action where concerns are raised about a registered professional.

There is some variation in the mechanisms for maintenance of registration across the professions. However, it is the individual responsibility of the registrant to maintain registration, providing and demonstrating evidence of practice, maintenance of skills and knowledge together with evidence of ongoing learning and development. Employers have a duty to regularly check the registration status of their healthcare professional staff, however, it is the individual responsibility of the registrant to maintain registration.

Care home workforce registration

All care staff and managers within care homes for adults require to be registered with the SSSC, if not already registered with another regulatory body. There are four register parts related to working within care homes for adults. To register individuals must satisfy the criteria for registration, this includes gaining employment in a relevant role and holding or agreeing to work towards the appropriate qualifications for their role, usually within a 5-year period. Individuals working in Social Care, who are registered with one of the 9 Healthcare Professional Regulators, are not required to register with the SSSC; for example, Nurses. Social care employers have a legal responsibility to make sure all their staff are correctly registered within six months of their start date.

The SSSC Code of Practice for Social Service Employers sets out the responsibilities of employers in the regulation of social service workers, which states "As a social service employer, you must provide learning and development opportunities to enable social service workers to strengthen and develop their skills and knowledge". The Care Inspectorate take the Codes of Practice into account during inspection of services and may take action to support improvement or require change if providers don't meet the required standards.

Recruitment, retention and wellbeing

There are difficulties with staff recruitment and retention throughout the health and social care workforce which have been present for a number of years, with many care homes experiencing high turnover of staff. The workforce data reported by SSSC informs of a decrease in workforce in care homes between 2011 and 2020 (-2.3%). In addition, many staff move between care homes so they take their skills, knowledge and experience attained through training and education with them. This puts additional pressure on the current workforce and impacts their own personal wellbeing. Recruitment and retention are key to providing adequate care, along with sustaining and improving resilience of the care home team.

The National Workforce Strategy for Health and Social Care in Scotland acknowledges these significant pressures that care home staff, and the wider workforce are facing and emphasises that sustained actions are required from planning for and attracting into the workforce through to support and development of our workforce, and supporting and delivering Recovery, Growth and Transformation of our workforce. Care home staff and wider workforce should experience wellbeing support, meaningful work and attractive terms and conditions, which reflect modern society; all helping to deliver the high-quality care that citizens expect.

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. The range of supports put in place in Lanarkshire are captured in this recent video by the CH Wellbeing Group. NHS Greater Glasgow and Clyde have introduced short care space sessions.

NHS Greater Glasgow and Clyde 20 minute care space sessions

With the increasing pressure on care home staff during the pandemic NHS Greater Glasgow and Clyde developed weekly 20 minute care space sessions to provide a space for self-care through facilitated connection and support. It is an experiential, reflective learning based exercise aimed at providing support to busy healthcare staff. Sessions are hosted by the Senior Principal Clinical Psychologist and have been co-facilitated by previous Trainee Clinical Psychologists and currently, by an Assistant Psychologist.

A number of sessions have been delivered since the programme's inception and staff feedback has been wholly positive in increasing their awareness of self-care and building connections with their colleagues. The programme also has the support from the Care Inspectorate.

Leadership

Effective leadership at all levels is in integral to ensuring that the health and wellbeing outcomes of people living in care are met. As part of our online survey just under half (48%) of respondents highlighted the value in having good leadership but this was counteracted by 41% suggesting that leadership in care homes could be better.

The Scottish Government recognises that having a strong leadership in place within the Health, Social Work and Social Care workforce can improve the culture and the wellbeing of staff and also lead to better care and outcomes for the people who use services. That is why in August 2022, we are launching a National Leadership Development Programme (NLDP), which will build on the work of Project Lift, and complement existing leadership development and support on offer within health, social work and social care workplaces. The Programme will be focused on developing compassionate, collaborative and inclusive leadership at all levels across the health, social work and social care system.

A range of Leadership support programmes and resources across Scotland are available to care home staff and managers via the SSSC's Step into Leadership website.

Pre-employment

There are different open access resources that introduce people to a career in social care, including care homes, and include tools that help people identify their existing skills and knowledge. The SSSC's Right values, right people: recruitment toolkit offers a range of pre-employment tools both for employers and people interested in working in social care. The College Development Network has launched the Introduction to a Career in Care programme and SSSC has created a mechanism for employers, including care home providers to share employment opportunities directly with local colleges and course participants. The SSSC's network of Careers Ambassadors are supported to work with social care staff, schools, colleges and employability providers, to promote life changing careers in social care.

Induction training

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.

Whilst care homes will provide induction training for all new staff, outwith statutory training requirements this can be variable across the sector as it is adapted to the individual requirements of each care home. In addition, previous education and training is not always accepted as being transferable when an employee moves between care homes.

The SSSC and NES have worked in partnership with Scottish Government and employers to deliver a National Induction Framework for adult social care which provides a single point of access to existing NES/SSSC learning materials relevant to adult social care induction as a complement to the induction learning already provided by care home providers. It includes a learning assessment tool and Open Badges that support care home workers work with their managers to plan, record and reflect on their induction. Implementation and widespread consistent use of this induction framework across the sector is recommended.

Education and Career Development Pathway for the integrated community nursing team

The Education and Career Development Pathway for the integrated community nursing team was introduced as part of the Chief Nursing Officer's Transforming roles programme. This supports nurses from care home, district nursing, prison health and general practice nursing teams to develop skills and knowledge to practise confidently and competently from levels 5 to 8 of the NES NMAHP Development Framework and aims to develop a responsive, flexible, community nursing workforce.

Care homes should strive for consistency in providing mandatory training for all staff which addresses the core elements required to deliver safe care, covering a wide range of duties that will increase their knowledge, experience and skill-set. There should also be opportunities for staff to undertake continued professional development and pursue meaningful learning and development and to allow career progression.

Continuous Professional Learning

A requirement of SSSC registration is that individuals either hold or agree to work towards achieving, an approved qualification, usually a SVQ, within a 5-year period. The qualifications are designed from the National Occupation Standards for social care. Both SSSC and registered healthcare professionals are also required to evidence Continuous Professional Development (CPD) to maintain their ongoing registration. It is not unusual for staff to move or change roles during the 5-year period and therefore it can be a challenge to maintain a consistent level of education standards within the workforce. Response to the SSSC's A register for the future consultation have demonstrated an overwhelming support to making qualifications more flexible so people can move more easily to work in different kinds of services.

Although individuals have a professional responsibility to maintain their own training as part of their professional registration, employers have a responsibility to ensure that people living in care homes have suitably trained and qualified staff supporting them. This means that they need to identify relevant general and specialist training and ensure that their care home team delivers safe and effective care in line with all relevant legislation, guidance and best practice.

During our engagement sessions it was evident that there is an abundance of care, compassion, skills and knowledge within the care home team and wider workforce. However, over three quarters (79%) of our online survey responses from care home team members highlighted a lack of protected time for staff to undertake training and practice development. Building on the expertise within the current workforce is essential. Planning protected time, as well as providing opportunities to support the learning and development of the team is required. Everyone in the team should feel supported and valued in their roles, thus, encouraging new people to enter the workforce and experience working in a physical and social environment where they can truthfully say they are satisfied with their role and feel valued.

It is important to support staff and enable them to remain flexible to allow transferability of skills, which will help retain a diverse workforce with different skill sets that all work together to provide the full range of care required.

Availability of training courses, resources and programmes

Lifelong or continuous learning occurs in many different ways. Some high level examples are provided here, but are not exhaustive.

The Scottish Social Services Council have developed digital certificates called 'Open Badges' that help social care staff recognise continuous and informal learning that would otherwise go unrecorded. When applying for an Open Badge, staff need to give evidence of their learning and reflection on practice. Many badges also require endorsement of that evidence by a supervisor or line manager.

The SSSC's Learning Zone and NES TURAS Learn are online platforms where all health and social care staff can access health, wellbeing and social care tools and learning resources. Care home staff can select from a wide range of relevant tools and resources developed specifically to meet the education and training needs of those working in the care home environment. These resources support informal learning, specialist training, induction of new staff and the delivery of learning programmes by employers and critically the formal qualifications required for SSSC registration.

Training and education for Registered Nurses and AHPs is also available online through independent and private education providers, with Health Boards also providing training for their employees. Higher Education Institutes provide pre-degree and postgraduate programmes. Many of these support the recommendations of the Chief Nursing Officers Transforming Roles work, in particular the wider role of nurses working in community settings. Following the pandemic, Transforming Roles is being reviewed, with decisions on what shape this will take in the future awaited.

A training package has been developed for pharmacists, doctors and other healthcare professionals to undertake an in-depth review of prescribed medications. This can be accessed on TURAS and is available for anyone who wishes to complete it.

Much of the training takes place online and there is a desire from those we spoke to whilst developing the framework for the sector 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.

> **"Most training is now done online however not all of our carers feel confident using computers. This is definitely putting some of them off doing it.**

It is recognised that online training solutions can save time, but there needs to be an investment in time to train individuals in digital technology. This is a challenge for an already strained workforce, but it is key that staff have a basic level of digital education to enable access to these resources and opportunities as well as those that are provided face-to-face.

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. This may include focused study sessions on topics such as falls prevention, pressure area care and prevention, use of feeding tubes and palliative care. This should be explored for wider implementation across care homes in Scotland. NHS Lanarkshire for example has developed and built a Care Home Liaison Service over a 20 year period to cover all care homes for older people within the Lanarkshire area.

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.

There are numerous learning and development opportunities offered via various websites, providers and institutions, in various modes. This can make it difficult to keep track of what is available, relevant and what has been completed. There are also examples of good approaches taking place throughout care homes in Scotland that others are not aware of but could benefit from adapting to use within their own areas. It would therefore be beneficial to explore opportunities to develop and introduce a one-stop repository for tools and resources that everyone can access, which includes courses available as well as highlighting these good approaches for others to draw from.

A single record of education and training for all staff would not only assist to evidence statutory and mandatory training undertaken and promote transferability of learning, it would also help identify educational gaps for an individual. Better promotion of the training resources already available would help staff to know what is available to them and would improve take-up.

As we move forward

The Care Inspectorate have developed new approaches to scrutiny, with the Health and Social Care Standards used in conjunction with the Quality Framework for Care Homes for Adults. The importance of and ability for care homes to self-assess and be subject to scrutiny on the quality and experience of care they provide, to take actions required for improvement or maintenance is required to assure the care provided and experiences of people living in the home. However, it can also add to workforce pressures and capacity.

This framework is not intended to replace these standards, rather to support how care home teams and the wider MDT can meet them. Additionally, in its ambition for a sustainable and skilled care home workforce, the framework echoes the Workforce Strategy's vision and outcomes and aligns its recommendations to the five pillars of the workforce journey.

To meet the direct and indirect care requirements, the care home team is critical, in sufficient numbers, with the right skills and knowledge and the right supports to nurture and retain them. For this, the team requires good leadership and oversight. The roles of the care home manager and the registered nurse are key to this leadership provision.

Care home staff and wider workforce should experience wellbeing support, meaningful work and attractive terms and conditions, which reflect modern society; all helping to deliver the high-quality care that citizens expect.

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

For the framework to succeed, we must fully embrace the digital world and use data and technology appropriately to enable people to live well. 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.

Improving the use of data to support people living in care homes

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 – such as the Care home census. During the pandemic, the Safety Huddle Tool was developed to provide real-time data to inform the pandemic response, with respect to outbreaks, staffing and hospital use. It has been necessary to collect this data from care homes directly as it is not possible to identify the whole of the adult care home population using so-called 'routinely collected' health data in Scotland. This challenge limits our ability to use our national data to understand the needs of those living in care homes. This includes having reliable data on vaccination uptake and effectiveness, understanding patterns of hospital use, exploring pathways into care homes and their use to provide temporary care and support (e.g. respite and intermediate care services). Furthermore, there is inconsistency across the health system in what is considered to be a care home, with care home mortality statistics being based on alternative codes and definitions than those used by the Care Inspectorate as care regulator. Such inconsistencies mean we have a poor understanding of vital events and make existing and historical data difficult to compare.

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. However, this will require specific work to improve the reliability of the data which NHS services collect on those living in care homes and routine systems to identify who lives in a care home, even on a temporary basis, so data are inclusive of the whole care home population. Joint working must take place between national bodies such as Public Health Scotland, National Records of Scotland and the Care Inspectorate, with improvements to NHS digital systems in Scotland. The National Care Service identifies the need for improved data about those receiving any social care, including those living in care homes. It is essential that there is both a review of the existing care home data landscape and work with key stakeholders which establishes the core data which should be collected and the specific purposes for collection, to ensure it is used to benefit those living in care homes.

Scottish Government analysts will shortly commence a review of care home data. The aims of the review are to ensure a coherent suite of data collections, reduce requests on data providers and more comprehensively understand and meet the existing and emerging needs of data users.

This Care Home data review will form one strand of a wider review of the entire social care data landscape. It will provide an important stock-take as we move towards the National Care Service. It will also support us to meet the recommendations set out in the Independent Review of Adult Social Care and reports from the Office for Statistics Regulation. It is envisaged that this will enable the monitoring of future approaches to the delivery of care, such as this healthcare framework.

Sharing information electronically

The importance of being able to share confidential information about the health of an individual, between the healthcare and social care workforce, was a common theme arising through the engagement sessions. We heard from healthcare professionals working in hospitals who did not have access to personal plans or ACPs when treating someone from a care home. Care home staff told us that they would often not receive adequate information at the time of hospital discharge to enable them to provide appropriate care.

It is important that when different professionals or organisations become involved in the provision of care to an individual, that relevant and appropriate personal information is shared between them and that data entries are understood to mean the same thing. The latter could be achieved by introducing and adhering to data standards and should enable professionals and organisations to deliver co-ordinated, effective and seamless services to the person living in a care home.

The Scottish Information Sharing Toolkit enables service-providing organisations directly concerned with the safeguarding, welfare and protection of the wider public to share personal information between them in a lawful and intelligent way. The 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.

Digital technology for the individual

Being mindful of a person's life before they have moved into the care home and maintaining connections with the wider community is important and can be aided through the use of technology. This can enable the continued participation in faith or wider community activities.

During the COVID-19 pandemic there were strict restrictions on what people living in care homes were allowed to do, and who were allowed to visit them. Video calls allowed continued connection with family and friends who were not able to visit. They also enabled people to join church services, weddings and funerals in a virtual manner from the care home. Opportunities to use technology in this way must continue whenever it benefits the individual living in a care home.

However, this depends upon good Wi-Fi or broadband connectivity, access to appropriate phones, tablets, or laptops and staff with the time to help those who need it. It is therefore essential that this is available in all care homes in Scotland.

Digital technology to support the MDT approach to care

Increasingly videoconferencing technology has been used by healthcare teams to assess and review people rather than bringing them to hospital. This was particularly important during the COVID-19 pandemic as it allowed people to have healthcare interventions without the risks associated with attending a clinical environment such as a clinic or hospital.

As we move through the COVID-19 pandemic, the use of videoconferencing technology for consultations will continue to be important. Whilst face-to-face assessments must still take place when they are necessary and clinically appropriate, the use of photos and video-consultations can allow quicker access to advice and treatment for some health conditions (e.g. an unusual rash, or advice on wound-care) and can reduce the need for unnecessary travel. This is particularly important for people with mobility issues, or for people with cognitive decline. NHS Near Me is the platform that is currently used for video-consultations with healthcare professionals, and so staff working in care homes must be familiar with this, and be able to support people living in care homes to use it.

Videoconferencing technology must also be available to health and social care teams to enable the MDT to function. All care homes must have access to appropriate laptops or tablets to support videoconferences and have Wi-Fi and broadband connectivity that is sufficient to host these systems.

Near Me

Near Me is a secure form of video consulting that is widely used across NHS Scotland for health and care appointments. In 2021, a case study examined the use of Near Me to reduce the backlog of health reviews in Glasgow. Conducting the care home reviews via Near Me allowed staff and professionals to come together in a single call. Further benefits of Near Me include:

- Reduced travel to appointments: time, cost, convenience
- Reduced time away from home
- Easier to attend if you usually need someone to take you to appointments
- Enables you to have someone with you for support at your appointment (either with you or joining the consultation by video from another location, even from abroad)
- Better for the environment
- Reduces spread of infectious diseases

Digital approaches in care homes

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 as we move forwards. This will not be without challenges – it requires investment of resource, addressing governance issues, establishing clear data sharing pathways and supporting the development of a digitally-skilled workforce.

The Connecting People Connecting Services Action Plan responds to the current and emerging needs of people living in care homes to realise the benefits of digital technologies. It provides a wider view on the scope of the digital issues and how to address them. The plan sets out key aspirations for enhancing Scotland's care homes' digital capacity to be able to fully embrace the potential for supporting people living in care homes and enabling new care management processes through the use of digital technology. Initial work took place during the COVID-19 pandemic, when the programme that supports the action plan equipped all interested care homes with tablets and dongles for connectivity. This saw people living in care homes being able to connect with outside services and loved ones during the periods of lockdown. Crucially, since November 2020 a number of digital training opportunities have been made available for care home staff with the goal of helping staff gain confidence and key skills to navigate day-to-day digital tasks to support those that they care for. The digital action plan for care homes will continue to be delivered and evolve through engagement with care home staff and managers. Information about current work and opportunities to participate in training and programme development sessions can be found on the Technology Enabled Care website.

Technology Enabled Care (TEC)

Technology Enabled Care (TEC) is a programme within Scottish Government which focuses on citizen facing digital solutions. It has a number of online digital resources that are designed for care homes, and include resources on device security, training resources and information on digital champions. All care home staff can potentially play the role of a digital champion, and can help colleagues and those living in the home to build their confidence and skills to get online.

Technology to support learning and development: Project ECHO

Project ECHO enables collaborative learning and the development of 'communities of practice' via multi-site videoconferencing. These meetings have often focused on palliative and end of life care issues, with input from the local specialist palliative care team. Highland Hospice is a super-hub and has helped establish and train eight other hubs across Scotland.

It is a recommendation that more care homes across Scotland have the opportunity to take part in Project ECHO.

Project ECHO

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.

The ECHO model is guided by four main principles:

1. Amplification – using technology to leverage scarce resources
2. Best practice – to reduce disparity
3. Case based learning – to master complexity
4. Capturing data – Monitoring outcomes

There are a series of 'hubs' established across the UK, which have their own knowledge networks based on needs identified by the community itself.

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.

Framework Chapter	Recommendation	
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.

Framework Chapter	Recommendation	
Anticipatory Care, Self-Management And Early Intervention	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.

Framework Chapter	Recommendation	
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 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.

Framework Chapter	Recommendation	
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.

Framework Chapter	Recommendation	
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.
	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.

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

Making This Happen

Following publication of this framework we will embark on a period of 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 framework's recommendations.

Glossary

Advanced Practitioner	A healthcare professional with developed skills and knowledge allowing them to take on expanded roles and scope of practice caring for patients. These come from a range of professional backgrounds such as nursing, pharmacy, paramedics, physiotherapists and occupational therapy.
Allied Health Professional (AHP)	Someone other than a physician, registered nurse, or dentist, trained to provide system-wide care to assess, treat, diagnose and discharge patients. Includes, chiropodists/podiatrists, dietitians, occupational therapists, paramedics, physiotherapists, and speech and language therapists.
Anticipatory Care Planning	An approach where people are supported to have meaningful discussions about 'What Matters to Me' in the context of their health and care, providing person-centred, co-ordinated care, focusing on goals and preferences, whilst offering opportunities to consider realistic treatment and care options.
Care homes	Care homes providing care for adults in Scotland including care homes for older people (aged 65+), adults with learning disabilities, mental health problems, physical and sensory impairment, acquired brain injury, alcohol and drug misuse, and blood-borne virus.
Care Home Liaison Nurse	A registered nurse working alongside the care home to provide specialist support, advice, education and support interventions to the Care Home staff.
Care Home Liaison Service	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.
Community nursing	Nursing care provided outside of a hospital to people in their own homes, care homes, or close to where they live, in clinics and GP practices across every village, town and city in the country.
COSLA	A councillor-led, cross-party organisation who champions councils' vital work to secure the resources and powers they need. They also work on councils' behalf to focus on the challenges and opportunities they face, and to engage positively with governments and others on policy, funding and legislation.
Early Intervention	Identifying and providing effective early support to people who are at risk of poor outcomes, to prevent problems occurring, or to tackle them head-on when they do, before problems get worse.
Health and Social Care Partnership (HSCP)	A compact of health and social care providers responsible for adult social care, adult primary health care and unscheduled adult hospital care working towards a set of national health and wellbeing outcomes.
Health Board	NHS Scotland consists of 14 regional NHS Boards responsible for the protection and the improvement of their population's health and for the delivery of frontline healthcare services. There are also 7 Special NHS Boards and 1 public health body who support the regional NHS Boards by providing a range of important specialist and national services.
Health and Social Care Standards	Standards applicable to the NHS and services registered with the Care Inspectorate and Healthcare Improvement Scotland, setting out what people should expect when using health, social care or social work services in Scotland.

Health care	Health care or healthcare is the maintenance or improvement of health via the prevention, diagnosis, and treatment of disease, illness, injury, and other physical and mental impairments in people. Health care is delivered by health professionals in allied health fields.
Healthcare Improvement Scotland (HIS)	The purpose of Healthcare Improvement Scotland is to enable the people of Scotland to experience the best quality of health and social care. Their broad work programme supports health and social care services to improve.
Local Enhanced Services (LES)	Services that provide additional funding to supplement services already offered within the core GMS (General Medical Services) contract.
Multi-disciplinary Team (MDT)	A group of healthcare and social care professionals, who are members of different disciplines with different skills and expertise (e.g. care workers, podiatrists, dentists, nurses and doctors) that work together to enable the best outcome for the person living in a care home.
National Care Service	The establishment of a National Care Service (NCS), accountable to Scottish Ministers, to create comprehensive community health and social care service that supports people of all ages which is rights-based and people powered.
Near patient/point of care testing	An investigation taken at the time of consultation with instant availability of results to make immediate and informed decisions about patient care.
Out Of Hours (OOH) service	A fundamental part of the healthcare service in Scotland providing support to those who require medical assistance outwith normal GP surgery hours. The out-of-hours period is from 6:30pm to 8am on weekdays and 24 hours at weekends and on bank holidays.
Personal plan	A plan of how care and support will be provided, as agreed in writing between an individual and the service provider. The plan will set out how an individual's assessed needs will be met, as well as their wishes and choices.
Prevention	Preventing deterioration in health and wellbeing through good nutrition, hydration continence, movement and activity, cognitive stimulation and social connections.
Primary care	The first point of contact with the NHS. This includes community based services provided by general practitioners (GPs), community nurses, dentists, dental nurses, optometrists, dispensing opticians, pharmacists and pharmacy technicians. It can also be with allied health professionals such as physiotherapists and occupational therapists, midwives and pharmacists.
Realistic medicine	An approach that puts the person at the centre of decisions made about their care, with shared decision making and a personalised approach to care. It also aims to reduce harm, waste and unwarranted variation, whilst acknowledging and managing the inherent risks associated with all healthcare, and championing innovation and improvement.
Scottish Social Services Council (SSSC)	The regulator for the social service workforce in Scotland.
Social care	A wide range of non-medical services provided by local authorities and independent bodies, including from the voluntary sector, to support the social needs of individuals, especially older adults, the vulnerable or those with special needs, to improve their quality of life.

Social worker	Social worker is a statutory role which involves assessing need, managing risk and promoting the wellbeing of individuals and communities.
Stakeholders	Stakeholders are individuals, groups or organisations that are affected by the work or activity of an organisation or service.
Tissue viability	A speciality that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and leg ulceration.

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