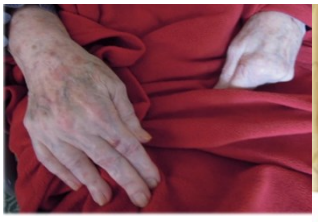
FEASIBILITY STUDY:

for a Teaching/Research-based Care Home

Centre of Excellence





THE UNIVERSITY of EDINBURGH

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The Vision:

The Vision is for a Teaching/Research-based Care Home Centre of excellence in the care of frail older people and their families. It will be developed and sustained through a cohesive multi-partnership model, embracing residents and families, local communities with health and social care professionals, local educational establishments, local care homes, local and central government.

The goal of the Teaching/Research-based Care Home Centre is to enable a change in the perception of the care of frail older people in care homes – both publicly and professionally. The core objectives are: care and compassion; knowledge & skills development; research and quality improvement; and community involvement. This will be underpinned by a philosophy of person-centred care.

Innovative design, staffing and management will enable the Centre to become both a showcase for best practice alongside a rich source for research, skills development and community involvement in the delivery of care for frail older people.

The outcome of some preliminary research (theoretical and field-based) has shown the need for such an establishment and the potential for its success. Enthusiastic encouragement and support for the concept was expressed during a facilitated discussion event held in 2015 and attended by over 60 experts and interested stakeholders in the field. The group described and clarified the vision which was then published.

In 2016, a Vision Steering Group and a smaller Working Group were established. Both groups have helped to formulate this detailed feasibility study exploring aspects required to move the Vision forward. The Vision promotes a career development in care home work for students in a number of fields e.g. medicine, nursing, social care, social work. The Vision embraces the importance of health and social care integration – looking at innovative care for frail older people. This document makes a case for a Teaching/Research based Care Home Centre that is timely and innovative, and which has the potential to address a number of issues together.

In this document the Teaching/Research-based Care Home is henceforth described as 'the Centre'.

'The significant problems we face cannot be solved at the same level of thinking we were at when we created them'[1]

Steering group for feasibility study:

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Professor Scott Murray	Professor of Primary Palliative Care, University of Edinburgh
Dr Jenni Harrison	Clinical Research Fellow, Medicine for the Elderly, University of Edinburgh
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Marion Randall	Edinburgh Health and Social Care Partnership, Lead for Care Homes (until December 2016)
Dr Julie Watson	Research Fellow, Nursing Studies, University of Edinburgh
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Dr Sarah Rhynas	Teaching Fellow, Nursing Studies, University of Edinburgh
Dr Susan Shenkin	Clinical Senior Lecturer/Honorary Consultant Geriatrician, University of Edinburgh
Anne Vokes	Lay member

Acknowledgements:

We are particularly grateful for the time that care home managers, care staff, residents and families gave in completing questionnaires and interviews across Lothian and for Marie Curran who helped to set up, undertake interviews and help with analysing data. Further afield, we would like to thank all here in the UK and in Norway, the Netherlands, Belgium, Australia who have caught the Vision and helped inform this project. Finally, thank you to all the Steering Group members.

Our thanks to to Marilyn Boggust who since 2010 has been instrumental in encouraging Jo Hockley to keep the Vision alive. Both Marilyn and John Smith helped frame the original Vision Document and played major parts in outlining this feasibility study.

The feasibility study was supported by a medical educational grant from Astellas Pharma Ltd.

OVERVIEW:

This report establishes the feasibility of a Teaching/Research-based Care Home Centre of Excellence within Lothian. A partnership is essential to realise the benefits outlined in the Vision.

Chapter 1 sets out the Vision for the Centre with its tri-partite model with the resident and family central to the ethos of care. The core aims for the Centre are highlighted in relation to: providing excellence in care; knowledge and skills development of staff; training of undergraduate and postgraduates; research and quality improvement; and community engagement.

Chapter 2 documents that care home residents now have high levels of both social and medical needs and ensuring they receive optimal care is of paramount important to us all. Other issues of concern include the difficulty of recruitment and retention of staff. Care homes are an important untapped training area for undergraduate and postgraduate students from a variety of disciplines.

Chapter 3 discusses the philosophy of care for the Centre. Person-centred care will inform the design principles, its staffing and the attitude of care. Co-production will be an important aspect in building the Centre and its ongoing training and research initiatives. The proposed design has been informed by visits to models in the UK, Norway, The Netherlands and Australia. The plan is for a 'care village' where extra-care/sheltered housing APARTMENTS can off-set costs of care for people requiring 24-hour care within six 12-bedded HOUSEHOLDS. Other components such as volunteers, student accommodation and student placements would enhance the quality of life of residents at the Centre. Crucially, the Centre will not be an ivory tower but will reach out to promote high quality care, training and evidence-based practice across the region.

Chapter 4 summarises the learning from other successful care homes and local short-term care home projects. It also proposes markers of success for the Centre.

Chapter 5 addresses the regulatory environment which would influence the Centre. .

Chapter 6 describes the proposed site and facility requirements for the Centre. A new build is favoured to deliver the preferred model of care.

Chapter 7 models ideal operating assumptions.

Chapter 8 outlines indicative costs extrapolating information from other care providers. Specific operating assumptions will depend on the partnership model agreed, the specifics of which have not yet been negotiated at this stage.

Chapter 9 describes the risks and their mitigation. The greatest of which is sustaining the financial viability of the Centre.

Chapter 10 concludes that, especially at a time of financial austerity, a partnership model is essential. We have been encouraged by the level of engagement from potential partners during this feasibility study.

CONTENTS:

The Approach

The vision for a teaching/research-based care home was originally conceived in 2006 following research into death and dying in care homes.[2] After a number of quality improvement initiatives, the problems associated with short-term funding of projects and sustainability in care homes were identified and confirmed the need for a more radical vision – one that would make a sea-change, not only to the quality of care in care homes, but also to public and professional perceptions of care homes. There have been three phases of investigation: a scoping review, a visioning workshop and document, and then the final work on the overall feasibility

Scoping Review (2015/16):

A scoping review using a framework by Arskey & O'Malley[3] on the concept of a teaching/research-based care home was undertaken. This included a review of the literature, supplemented by discussions with health and social care professionals.

The international literature highlighted the importance of:

- An *affiliation between nursing homes* and academic institutions
- Establishing a positive profile, thereby bringing a *positive attitude to the care of frail older people*
- Creating a positive environment for *training students and other health professionals*
- Creating a positive environment in *research with frail older people* to reduce the gap between theory and practice, and increase evidence-based practice
- *Improving competency of care home staff* at all levels thereby meeting the needs of frail older people and improving quality of care
- Creating *a hub* for outreach services both to other care homes and home care

Discussions on the concept with over 30 health and social care professionals mostly within Lothian but also Inverness, Glasgow and Dundee (including GPs, Medicine for the Elderly, Old Age Psychiatry, Care Inspectorate, Scottish Care, palliative care practitioners, independent care home organisations/nurses, academics and community nurses) revealed a considerable groundswell of interest and enthusiasm for the concept.

The Visioning Workshop (June 2015):

The scoping review culminated in a visioning afternoon on the concept of a teaching/research-based care home attended by over 60 experts. Attendees took part in a world café style workshop addressing the question 'what is ideal?' across a variety of topics ascribed to different tables. Analysis of data from this event highlighted the importance of the following themes, which have underpinned the feasibility study:

- connection to community;
- aspects of architecture and design;

- relationship with residents;
- staffing the teaching/research-based care home;
- potential of technology to contribute to residents' quality of life, to care, teaching and research;
- connection to research and teaching;
- finance;
- the wider context of policy, culture and education.

A fuller exploration of this workshop can be found in the visioning document (http://www.ed.ac.uk/files/atoms/files/the_vision_for_a_teachingresearch-based_care_home_0.pdf)

By 2015/16, there was also increasing media coverage on care homes. Typical of this were articles by Janice Turner in *The Times*. A commentary on this theme underpinned by the scoping review was published in *Age and Ageing* in 2016.[4]

The Feasibility Study (2016/17):

It was important that the Vision became grounded in reality. A feasibility study was therefore started in February 2016. It comprised ten tasks – ranging from sharpening the concept and considering the populations to be served, to researching potential sites and investigating the financial feasibility along with the risks. The structure of the document explores these tasks in turn.

A day-to-day project group was established and recruited specific expertise when required to inform the feasbility tasks. This was led by Jo Hockley who met with stakeholders and experts (see Appendix 1). Relevant literature was reviewed. A Lothian-wide questionnaire was sent to all 107 care homes operating at the time of the survey (June 2016)(See Appendix 2). The response rate was 42% (45/107). We also undertook 'snap-shot chats' with care home residents, their families and staff from across the NW locality in the City of Edinburgh health and social care partnership. All were asked three questions: What is good about this care home? What would you improve? What would your dream care home look like? Responses have been summarised in a diagram (see page 50). Ethical approval was obtained.

A steering group was formed comprising health and social care professionals, researchers, regulators of care, enriched by lay experience. The steering group had an independent chair and met six times over a 15-month period. Their role was to provide advice and governance to the feasibility study. Other interested parties were identified and agreed to receive updates on the progress of the work.

In this Feasbility Study, for the sake of clarity, the word 'care homes' is used for all care homes (both with on-site nursing and without) for frail older people over the age of 65 years. Where data were only collected from care homes with on-site nurse, these are termed as 'nursing care homes'.

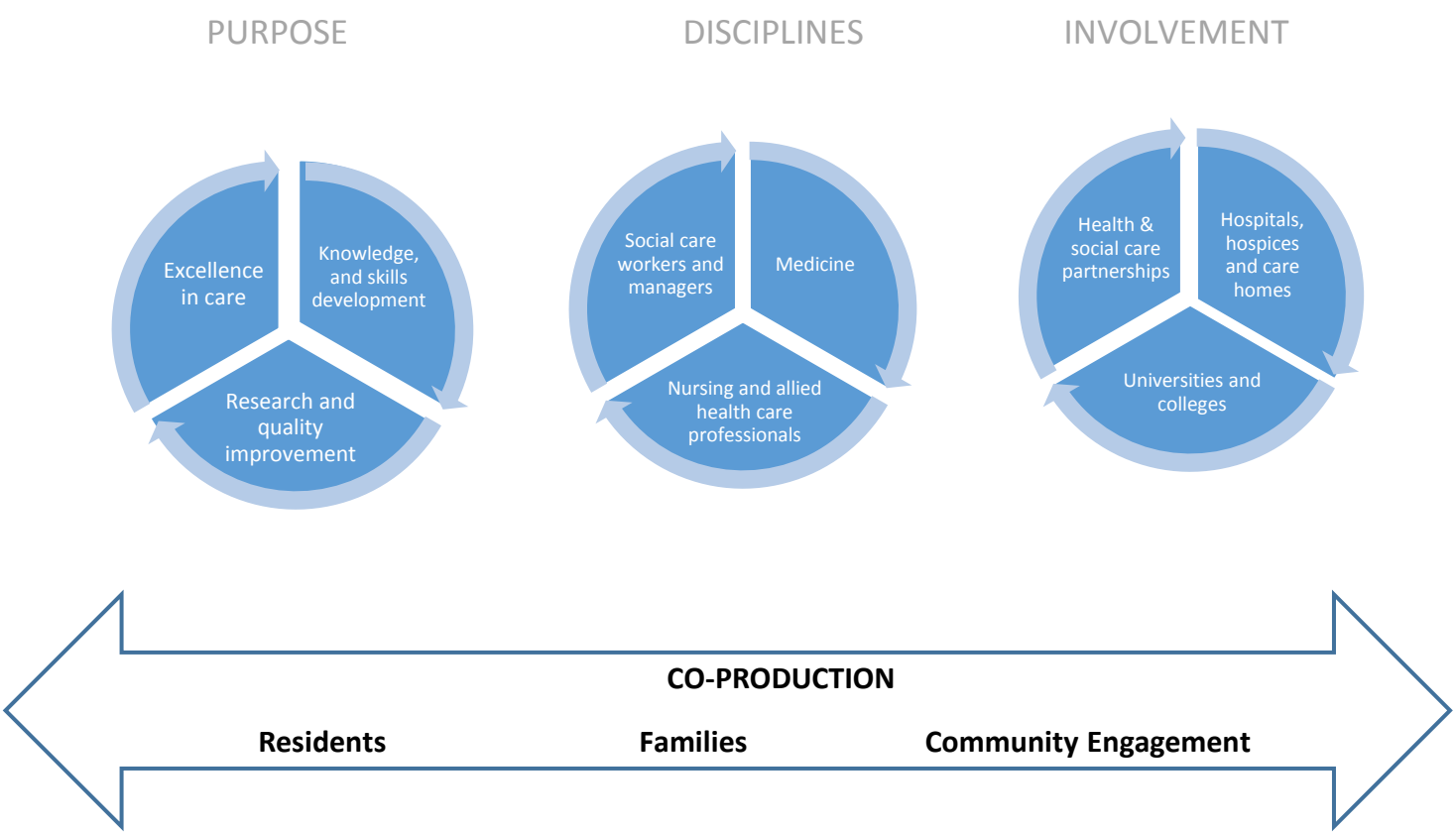
CHAPTER 1

THE VISION FOR A TEACHING/RESEARCH-BASED CARE HOME: 'THE CENTRE'

1.1 The tri-partite model for the Centre

The Centre will be based on a tri-partite concept of care across its purpose, disciplines and involvement being underpinned by a strong resident, family and community focus and involvement (see Figure 1.1). This model has been developed through discussions and stakeholder engagement.

Figure 1.1: The tri-partite model for the Centre



Co-production is whereby '*citizens, decision makers and people who use the services, family, carers and service providers, work together to reach a decision or create a service which works for them all. The approach is built on the principle that those who use a service are best placed to help design it'.*[5]

1.2 The goal of the Centre and its five core aims

The goal of the Centre is to enable a change in the perception of the care of frail older people in care homes – both publicly and professionally.

The core objectives for the Centre are:

- *Service Provision:* To provide high-quality, innovative care for frail older people requiring 24-hour care, including care for people with dementia and those at the end of life, in order to showcase expert holistic care.
- *Knowledge and skills development:* To develop greater knowledge, skills and expertise for staff in care homes through innovative training approaches in order to transform the care home culture. Such a focus would be extended to health and social care workers supporting frail older people in their own homes.
- *Training of undergraduate and postgraduate students:* To provide, in collaboration with local universities, a typical setting for multi-disciplinary training in chronic illnesses and multimorbidity for medical, nursing, social work students and those of other healthcare professions, including pharmacy, dietetics, speech & language therapy, dentistry, physiotherapy and occupational therapy.
- *Research:* To be a centre for multi-disciplinary research, practice development and quality improvement programmes working in partnership with local universities and other sponsors, in collaboration with care homes across the region.
- *Community engagement:* To be part of a local community, engaging with and enabling people to volunteer in care home work. the Centre will also promote individual and carer resilience and offer support to families caring for frail older people living at home, including innovative respite care.

The Centre will be underpinned by McCormack & McCance's model of person-centred approach to care[6] that takes as its core the importance of building relationships not just with people living at the Centre but with families, staff and those professionals who support the care at the Centre (see Chapter 3).

CHAPTER 2

THE CASE FOR CHANGE

2.1 Issues of Concern

There are several issues of concern in relation to the care of frail older people that appear to be connected and require a whole system approach for change.

Context:

- People aged 85 years and over are the fastest growing segment of the UK population (see Figure 2.1) and this group is projected to more than double by 2039[7] and is associated with increasing incidence of dementia.
- The number of centenarians is projected to rise by nearly 6-fold increase in the next 25 years, from 14,000 at mid-2014 to 83,000 in 2039.[7]
- People over the age of 80 years who are likely to require 24-hour care is projected to increase by 82% with a demand for 630,000 care home places across the UK by 2030.[8]
- Most frail older people with complex needs requiring 24-hour care are cared for in care homes. Across the UK, there are over 19,000 care homes – the majority of which are in the independent sector.
- There are 437,669 care home beds for frail older people which is 3 times the number of care home beds compared with all NHS beds.[9, 10]. In March 2016, there were 873 older people's care homes in Scotland;[11] the number fluctuates.

Figure 2.1 Projected population by age, United Kingdom, mid-2014 to mid-2039[7]

millions

Ages	2014	2019	2024	2029	2034	2039
0-14	11.4	12.0	12.3	12.3	12.3	12.4
15-29	12.6	12.4	12.3	12.6	13.2	13.5
30-44	12.7	12.9	13.6	13.7	13.3	13.2
45-59	13.0	13.4	12.9	12.6	12.7	13.4
60-74	9.7	10.4	11.1	12.0	12.4	12.0
75 & over	5.2	5.8	7.0	7.8	8.7	9.9
75-84	3.7	4.1	4.9	5.4	5.6	6.3
85 & over	1.5	1.7	2.0	2.4	3.2	3.6
All ages	64.6	66.9	69.0	71.0	72.7	74.3
Children	12.2	12.7	13.1	13.1	13.2	13.2
Working age	40.0	42.0	43.0	44.2	44.3	44.6
Pensionable age	12.4	12.2	13.0	13.6	15.2	16.5
Old Age Dependency Ratio (people of pensionable age per thousand people of working age)	310.4	290.4	301.3	308.1	344.1	369.6

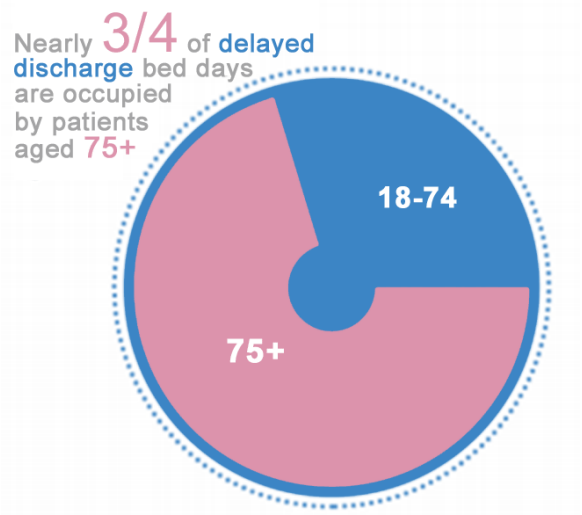
Source: Office for National Statistics

2.1.1 Acute Hospital Context and Delayed Discharges

The Scottish Government's 2020 Vision is: 'that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting'.[12] To realise this there is to be a greater emphasis on integrated care and bringing services out of hospitals and into the community with swift transfer of older people from hospital.

- Delayed discharges occur when inpatients are considered 'medically fit' to leave hospital, but other factors delay their discharge from hospital.
- The consequences of delayed discharges are increased waiting times in A&E and cancellation of planned surgery due to lack of beds.
- In Scotland, three quarters of all delayed discharges (425,880) were of people 75 years or older.[13]
- NHS Lothian has the highest percentage of delayed discharge in Scotland.[13]
- Delayed discharges from hospital respond to the availability of care home beds. However, increasing the number of care home beds makes only minimal impact.[14] There are other factors within the system that support delayed discharge:
    - an increase in care home beds of 10% (250 additional beds per Local Authority would reduce social care delayed discharges by only 6–9%.
    - higher prices in care homes contribute to increasing delayed discharges.
- Reductions in delayed discharge also rely on good coordination for community care, home care and adaptations at home.
- Care home residents represent one group who have been identified as benefitting from targeted efforts to reduce the need for acute hospital care by working with care homes themselves.[15]
- Keeping frail older people at home without having discussed plans for admission to a care home in the event of a crisis increases the risk of emergency hospital admission.

Figure 2.2: Delayed discharges[13]



2.2 Residents in long-term care: embracing complex comorbidities, frailty and disability

- It is recognised that the population that now resides in care homes has high levels of medical and physical need.[16]
- Older people living in nursing care homes have an average of four to six diagnoses recorded in their care home record. This lends complexity to their care.[17, 18]
- Care home residents are also more likely to be frail, making them vulnerable to deterioration as a consequence of minor events, such as an infection or a fall.[19]
- 56% of residents are likely to die within a year of admission to a nursing care home.[17]
- Current population projections for the City of Edinburgh forecast significant growth in the proportion with severe disabilities among those aged 85 and over.[20]

Table 2.1: Recorded medical diagnoses reported in the notes of 2,444 deceased residents[17]

Medical diagnosis	Valid % (n)
Other	53.8 (1,235/2,294)
Organic mental health (dementia only)	47.5 (1,123/2,366)
Heart disease	43.8 (1,008/2,304)
Muscular skeletal	34.5 (790/2,292)
Stroke	32.7 (755/2,309)
Cognitive impairment	31.1 (736/2,369)
Cancer	23.7 (546/2,305)
Functional mental disorder	22.8 (522/2,288)
Diabetes	20 (457/2,287)
Urinary and gynaecological	18.7 (428/2,289)
Respiratory disease	16 (367/2,291)
Lower GI problem	10.5 (240/2,287)
Neurological disorders	9.7 (222/2,291)
Upper GI problem	5.3 (121/2,287)
Skin	4.1 (94/2,288)
Elderly/frail	3.8 (86/2,291)

2.2.1 Residents in long-term care: dementia and delirium

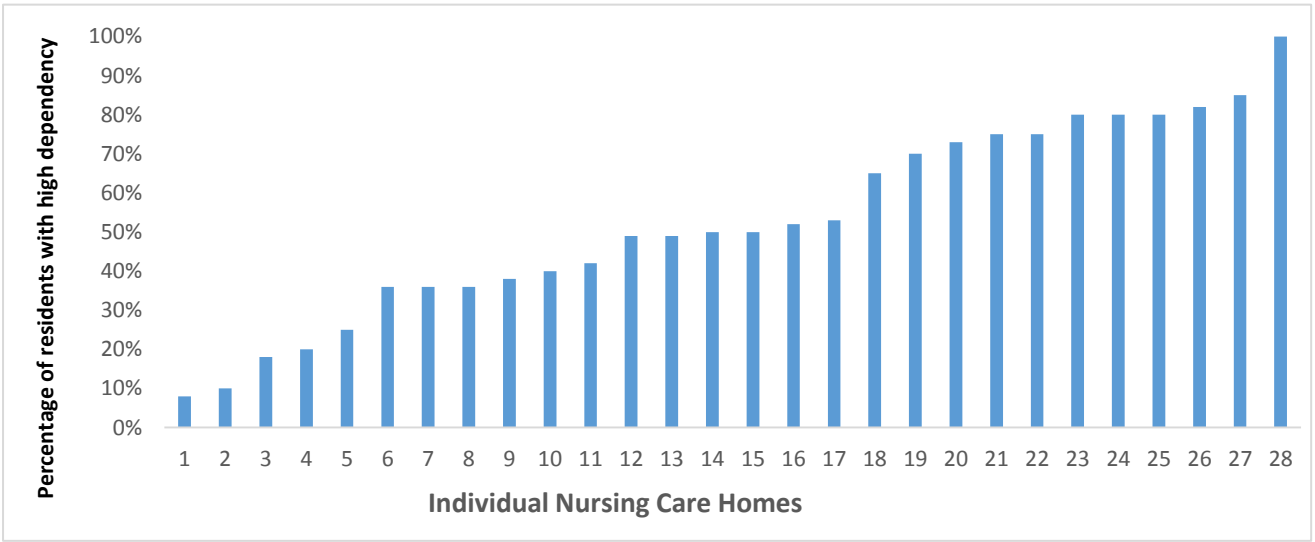
- In Scotland, there has been a 21% increase (from 33% to 54%) over the past 10 years in care home residents living with a diagnosed dementia.[21]
- The above figure is thought to be an underestimate, with others reporting that as many as 80% of residents in care homes have dementia or a serious memory loss.[17]
- There is a lack of provision locally for people with advanced dementia:
    - Between September 2013 and June 2015 an average of 17 people a month in the City of Edinburgh were waiting for a place in a dementia care facility.[13]
- Delirium is a complication of both dementia and Parkinson's disease but often goes unrecognised in care homes. The 'Stop Delirium' project has improved the recognition of delirium.[22, 23]

2.2.2 Residents in long-term care: dependency

Measuring the level of dependency and care needs of older people requires to be undertaken in order to plan the workforce. This is assessed on a monthly basis in care homes.

- Several different dependency tools are being used in care homes across Lothian. Some have not been specifically developed with the cognitive impairment needs of people with dementia in mind. Examples include:
    - IoRN (Indicator of Relative Need); Isaac & Neville; in-house tools; RUM (Resource Use Measure)
- Dependency is high across all care homes because policy in the care of older people is encouraging greater care within their own homes, so when people are admitted to care homes they are much more frail.
- Care Homes are now "a location of last resort for individuals with high support needs near the end of life".[24]
- On the day of the survey:
    - an average of 36.5% residents in care homes, without on-site nursing, required 'high or total care' (10/13 care homes responded) (range from 3.6% to 80%).
    - an average of 52.75% residents in nursing care homes required 'high or total care' (28/32 care homes responded) (see Figure 2.3).

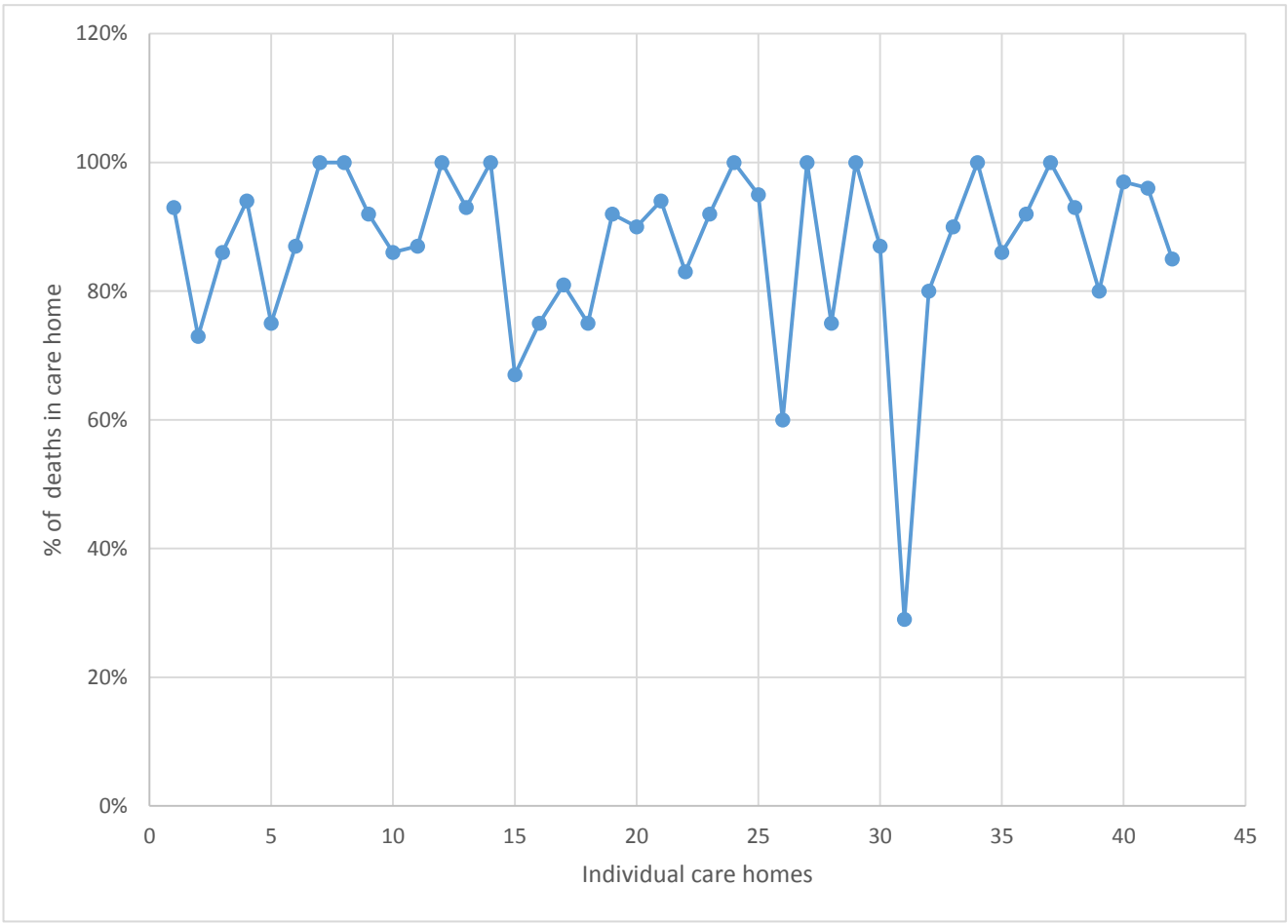
Figure 2.3: Percentage of residents per nursing care homes who had 'high or total care'



2.2.3 Residents in long-term care: deaths

- Care home residents are increasingly more frail on admission to a care home, with 56% of residents admitted to a nursing care home dying within a year of admission.[17]
- Deaths in care homes in England have increased from 80,000 to 111,000 in the last five years.[25] During this period, the number of UK care home places has remained relatively stable with around 437,000 places.[10]
- The percentage of deaths in care homes compared with deaths in hospital is considerably higher in Lothian (86%) than in other parts of the UK – most notably London.[26] It is therefore important to look at the quality of the last month of life as a performance marker rather than only the place of death.
- In our recent survey, the majority of deaths occurred in the care home. There was little variation between type of care home (Figure 2.4). However, considerably more deaths occured in nursing care homes
    - 86% (n=535) of deaths occurred in nursing care homes
    - 91% (n=182) in care homes supported by District Nurses

Figure 2.4 : Percentage of residents dying in all care homes



2.3 Current Care Home provision for frail older people across LOTHIAN (as at June 2016)

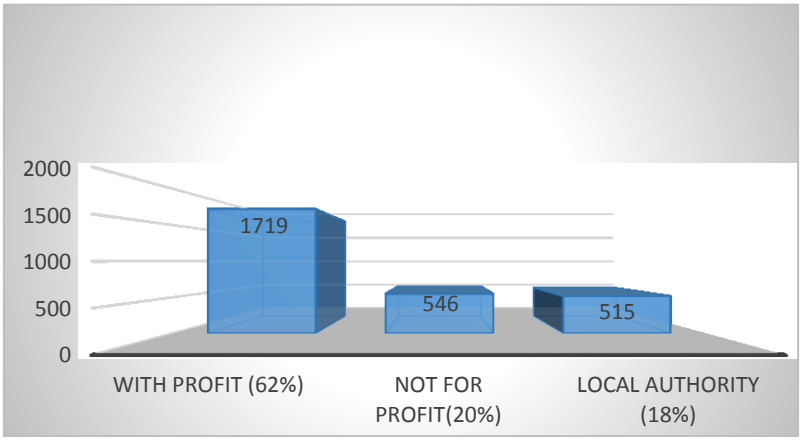
In Lothian, most care homes (86/107 - 80%) are under the Independent Care Home sector – of these, 23% (20/86) are 'not for profit'. Care homes owned by the local authority make up 20% of Lothian care homes (see Table 2.2).

Table 2.2: Number and type of care homes across Lothian

	CHs with on-site nurses		CHs with personal care		Council with personal care	TOTALS: Care Homes	TOTALS: Beds
	For profit	Not for profit	For profit	Not for profit			
East Lothian	11	1	2	-	4	18	597
West Lothian	11	1	-	2	4	18	909
City of Edinburgh	27	6	8	8	11	60	2,780
Midlothian	7	-	-	2	2	11	555
TOTAL:	56	8	10	12	21	107	4,841

Across the City of Edinburgh, there are currently 2,780 care home beds – a reduction in 213 beds since 'Live Well in Later Life' report.[20] (see Figure 2.5)

Figure 2.5: Provision of care home beds across the City of Edinburgh



2.3.1 Unoccupied beds

It was interesting to note there were only 94 empty beds (4.7%) across the Lothian care homes on the day of the survey (total of 2,047 beds). The majority of care homes had small numbers of unoccupied beds (1-3). The greatest number of vacancies were among the independent 'for profit' care homes – this amounted to a total of 58 beds across the 24 'for profit' care homes.

2.3.2 Hospital-Based Complex Clinical Care (HBCCC) provision across the City of Edinburgh

There are five hospital-based complex clinical care units (HBCCC) in Edinburgh. Previously these were known as NHS 'continuing care' units and re-named as HBCCC in 2015.

- HBCC is for individuals who are assessed as having 'complex, specialist, unpredictable, intense' care needs.[27]
- Ongoing eligibility is reviewed every 90 days by a specialist.
- HBCCC are funded by the NHS in contrast to care home beds.

Table 2.3: Capacity of HBCCC Units in Edinburgh

HBCCC Units	Beds for frail older people and mental health (MH)	Respite beds	TOTAL beds
Astley Ainslie	16 (physical frailty)	6	22
Ellen's Glen	60 (physical frailty and MH)	-	60
Ferryfield House	60 (physical frailty and MH)	-	60
Finlay House	60 (physical frailty and MH)	-	60
Royal Edinburgh Hospital	25 (MH)	-	60
TOTAL:			**261 beds**

2.4 External healthcare support for Lothian care homes

Care homes rely on external healthcare support. The threat of undersupply of GPs and District Nurses to care homes within the next five years is significant.[28]

The survey highlighted the following:

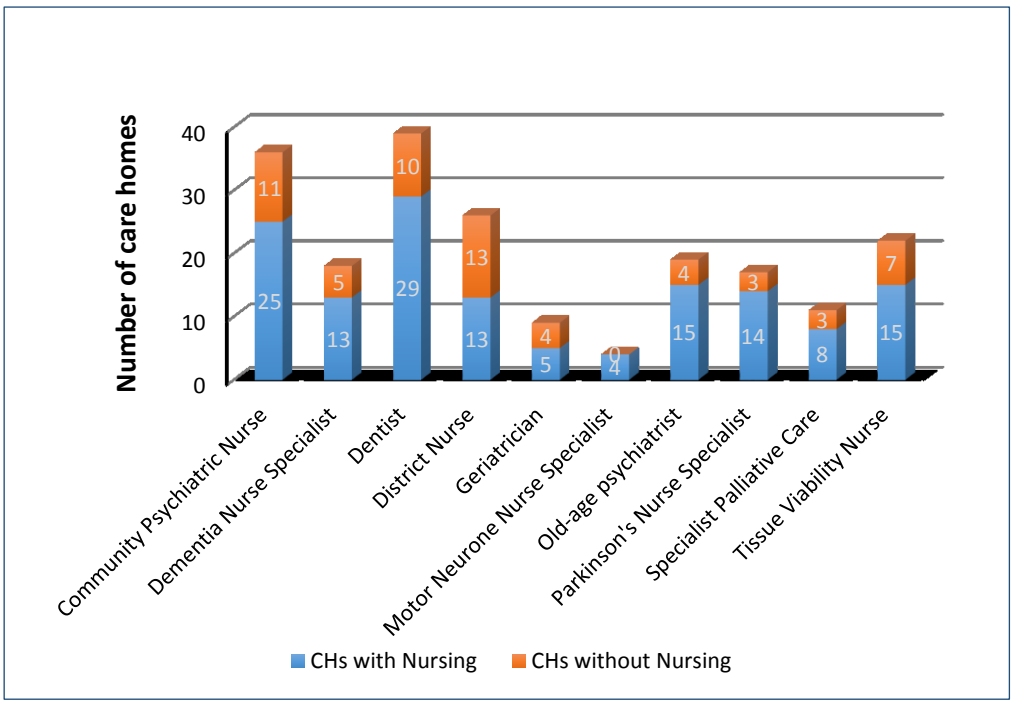
GPs:

- All care homes receive external GP support
  - 18 care homes had a GP visit for 1 session/week
  - 5 care homes had a GP visit for 2 sessions/week
  - 1 care home had a GP visit for 3 sessions/week
  - Only one care home with nursing paid a GP retainer
- 55% of care homes had either one or two GP practices attending.
- A small percentage (14%) had four or more GP practices visiting the home. Several practices visiting a care home makes it difficult to build relationships between staff and GPs.

Other healthcare professionals:

- In the survey we were surprised at the level of external support regularly attending residents in nursing care homes (see Figure 2.7). Some explanation will be that 32/45 care homes responding to the survey had on-site nurses. However, it also highlights the complexity of care of many residents in nursing care homes requiring external healthcare support.

Figure 2.7: Regular attendance of 'non-medical' healthcare professionals to care homes



2.5 Funding for people who require 24-hour care in care homes

- In July 2002, the Scottish Government introduced 'free personal care' for adults aged over 65 who are assessed as requiring it. It is not means-tested and is available to those living in the community or in institutional care, at a rate of up to £171 per week.[29]
- Personal care provision covers: personal hygiene, continence management, food and diet, problems with immobility, counselling and support, 'simple' treatments (assistance with medication/creams and lotions/oxygen) and personal assistance (assistance with dressing, assistance to get up and go to bed and transfers including use of a hoist).[29]
- Nursing care funding is available, without age restriction, at an additional rate of £78 per week (£4,056/year), but needs assessment is more stringent.[29] Funding for care home placements is means tested. Only those who have <£16,000 in savings and property will receive full public funding. Their pension and any other income will be used to pay for the costs of the care home, supplemented by the local authority.[21] They can retain £25.80 per week for personal expenses.
- Self-funded residents (>£26,000 of savings and property) are liable for the entire cost of the placement, excluding the amount received in their free personal care allowance.[21]
- Charges vary widely across Scotland – the average costs in 2015 for a publicly funded resident are £508/week and £590 for nursing care and for self-funded residents £708/week and £775 for nursing care, which puts average annual charges at £26,416 - £40,300.[21]

Most people over 65 years requiring 24-hr care pay for some or all of the care home fees. Table 2.4 shows the average gross weekly charges for 'self-funders' (as from March 2015) in Edinburgh and the Lothians. The weekly fees range from £750 to £1,500.[29]

Table 2.4: Average gross weekly charge for 'self-funders' from March 2015

	Without Nursing Care	With Nursing Care	All Self Funders
East Lothian	£781	£802	£779
West Lothian	£680	£732	£719
Midlothian	£758	£836	£814
City of Edinburgh	£863	£940	£883

2.6 Workforce in care homes

2.6.1 Turnover

A number of factors affect staff turnover in care homes. Good leadership will often promote stable staffing.

- Unsocial hours and increased level of responsibility are being blamed for the difficulty of recruitment into management posts.[30]
- In spite of looking after the frailest older people in our society, social care workers are paid less than staff stacking shelves in supermarkets.[31]
- Different care home providers have different pay scales for staff compared with the NHS which has a universal salary and benefits scheme, making it likely that staff will move to NHS employment when they can. This contributes to the high turnover of staff.
- There are concerns about the quality of care for frail older people in care homes. High turnover of staff inevitably causes disruption in care and has been linked to poor care.[32, 33]
- Although 79% of care homes in Scotland were given 'adequate' or 'good' rating, 193 (21%) care homes were regarded as 'underperforming' by The Care Inspectorate.[34]
- Many young care workers have never experienced a death before working in a care home. With increasing number of deaths in care homes, young care workers who are not supported through this experience often leave.[35]
- When nurses and doctors were employed in care homes in Norway the retention and recruitment of staff improved as care home staff felt more supported.[36]
- Financial legislation regarding wages is increasing pressure on care home providers. Examples are regularly reported in the press.

2.6.2 Need for validation

There are career challenges that face many of those working at all levels in care homes.

- Current policy encourages a minimum of 50% staff/CH to have basic SVQ2 training:
    - In the survey, there was a range between 10%-100% adherence to this policy
    - In total 31.3% staff had no SVQ qualification – probably reflecting the high turnover of staff who had not had the opportunity for training.
- There is little structure for career progression for healthcare assistants/social care workers.
- Many care home staff from outside the UK come as trained nurses and work in care homes as care assistants while waiting for UK nurse registration. They then transfer to the NHS.
- For some nurses who find themselves working in care homes it has not been an active career choice.[4]
- The care home workforce is overlooked compared with its NHS counterpart, with a lack of career structure and training opportunities.[37]

- Care home managers are a professional group whose role often lacks external definition and whose perspectives are often not included in research conducted in the sector.[38]
- There is an increasing case for all care homes to have both social care assistants and nurses on site because of the increasing comorbidities and complexity of care.
- There is a need to make the care sector attractive for nurses. Nurses within the care home sector are seen as 'second-class citizens'.[30]
- The current role of the nurse within the care home setting is not without criticism. Spilsbury highlights the need for nurses to adopt greater leadership and training in relation to social care workers and the healthcare needs of their residents.[37]
- The importance of the changing role of the nurse in care homes and one with advanced nursing skills has been highlighted in order to provide a more effective workforce.[39]

'Scottish Care', the voice for independent care homes across Scotland, recently highlighted the importance of nursing as part of the skills mix within care homes.[31, 40]

It listed the key issues which should be addressed to improve the situation:

1. Identify what are the core skills mix for nursing in social care
2. Develop a career pathway with NHS nursing
3. Develop nursing in social care as a positive career
4. Address the inequalities in 'terms and conditions' of employment
5. Rebalance the level of scrutiny and inspection
6. Resource the development of nursing specialisms in social care nursing, e.g. dementia, neurology, geriatrics, mental health, palliative care etc.
7. Develop and promote a positive image of nursing in care homes
8. Work with Higher Educational Institutes to promote nursing in a care home setting as a positive career choice
9. Positively address workforce issues such as emotional fatigue, mental wellbeing, stress and distress
10. Address the issues of nurse recruitment and use of agencies

2.7 Knowledge and skills development – current opportunities

Table 2.5 outlines current opportunities for knowledge and skills development in care homes for care staff and student nurse [both the degree in adult nursing and to become a registered mental nurse (RMN)]. There appears to be little opportunity for placement in care homes for medical students, student social workers or students of allied health care professions. A considerable number of students who go through Edinburgh College and West Lothian College go on to do nursing.

Table 2.5: Current opportunities for care staff and student nurse experience in care homes

Edinburgh College & Milton Road campus	Napier University	Queen Margaret University (QMU)	University of Edinburgh (UoE)
HNC – higher national certificate ○ for students under 21yrs with some existing formal qualifications ○ courses in nursing, occupational therapy, podiatry, speech and language, social care. ○ One-year course with 350hrs placement in a care home (2days/week/6 months). ○ assessed through: essays, closed book physiology exam; graded unit activity; placement booklet	○ Organises student placements in care homes for all local universities ○ 300 students (Napier); 120 (from other universities) ○ Unfortunately, not all students request care home placement ○ *1st Year students* (community module 4-5 week placement)	○ Potential for 60 adult nurses on placement in CHs – organised by Napier University. However, often less than this go on placement ○	○ No specific care home placement at present. However, students can request if an allocation comes up – commonly in 3rd year. Generally they are requesting hospital-based 'care of the elderly' rather than care home placement.
Endorsed HNC ○ for students already working in care homes who have achieved SVQ2 ○ interested in nursing only (one-year course with 750hr placement in care homes – 2 days college/2 days care home). ○ once finished, students go straight to Year 2 Nursing degree at Napier University	○ *3rd Year students:* ○ 6 weeks – living with long-term conditions module or ○ 12 weeks – final consolidation placement. It is this placement that can influence students – importance of length of placement; teamwork within placement; sense of belonging ○ Students undertaking a RMN will go to care homes.	○ Developing 'apprenticeship' schemes for teenagers finishing 'Highers' ○ Will get a Diploma in Health & Wellbeing – aiding entrance to nurse training	Students go to CHs during: ○ Mental health module: 2-6 weeks ○ Older people module: 2-6 weeks ○ Community module: 2-6 weeks
Access to Nursing Programme (Edinburgh College – two intakes of 24 people/yr; Milton road – one intake) ○ Students over 21yrs who have been out of education for three years ○ No clinical placement – purely academic ○ Once finished student go into Yr1 Nursing degree at Napier University			

2.7.1 Student nurse and student carer placements in care homes

Across Scotland there are 14 'Care Home Education Facilitators' (CHEFs), all of whom are nurses, who support care home mentors to ensure that they can mentor students effectively and provide an effective learning environment.

- Across Lothian, there are two CHEFS across Lothian. Support includes:
  - 'trainee mentors' – through the NMC-approved Mentorship Preparation Programme,
  - 'novice mentors'
  - 'experienced mentors'
- Support from within and outwith the care home varies:
  - Some care homes with on-site nurses do not take student nurses because they lack enough trained mentors
  - The need for annual re-validation of mentors acts as a disincentive.
- Some care homes offer student nurse placements with more than one university/college.
- The survey during this feasibility study identified that placements of >6 weeks encourage students to learn – two-week placements or less were not thought to be meaningful enough.
- The survey highlighted that 12/45 care homes offered no placement (see Table 2.6).

Table 2.6: Care home placement opportunities in Central Scotland – results of survey

Educational/training establishment	**Number of CHs: *student nurse placements***	**Number of CHs: *social care student placements***	**Length of placements**
Napier University	24	0	Generally 4-6 weeks
Stirling University	1		6 weeks
Forth Valley College		1	5 months
West Lothian College		7	5-6 months
Edinburgh College		6	Between 2 and 6 months
Queen Margaret University	5		Ranged from 1-2 weeks to 5-6 weeks
University of Edinburgh	1		2 weeks
Did not offer placement	12CHs		

- Although Allied Healthcare Professionals (AHPs) have student placements in some care homes, they are in the minority.
- There are no placements for social work students, dental hygiene students, medical students or trainees in: medicine for the elderly/palliative care/GP.
- The survey highlighted that one Edinburgh school organised 'work experience' for its pupils in care homes, but we know of a number of schools whose pupils go into care homes as part of their Duke of Edinburgh award. The potential for the Centre/care homes to collaborate more with local schools will be an important aspect of future work.

2.7.2 Priorities for professional development of nurses in care homes

Cooper et al's study reveals that *without* well-trained, motivated staff, a high-quality care sector will remain merely an aspiration.[41] The feasibility study also reveals that nursing degree programmes were perceived as inadequately preparing nurses for work in a nursing care home role – the consequences for the wider health and social-care system are significant. The British Geriatrics Society (BGS) is calling for mandatory training in end of life care for care home staff.[42]

Table 2.7 summarises responses to a Delphi survey on professional development priorities for nurses in care homes.

Table 2.7: Professional Development Priorities for Nurses in Care Homes[41]

Care home nurses	Highest ranked priority	Most frequently ranked priority	Overall top three priorities
Responsibilities of the role	Ensuring resident safety	Promoting dignity, personhood and wellbeing	1. Promoting dignity, personhood and wellbeing 2. Resident safety 3. Enhancing quality of life
CPD priorities	Personal care (e.g. nutrition, bowel care, skin care, hydration)	Dementia care	1. Dementia care 2. Personal care 3. Managing LTCs
Barriers to accessing CPD activities	Staff shortages/lack of cover	Staff shortages/lack of cover	1. Staff shortages 2. No access to NHS courses 3. Need to train in own time
Types of education and training	On the job/opportunistic training *Joint first with* Formal courses/qualifications	Formal courses/qualifications	1. Formal courses 2. On the job training 3. External specialist support
How to ensure nursing profession attracts best people in to care home nursing	Care home nurses deserve the same learning and development opportunities offered to NHS nurses	Care home nurses deserve the same learning and development opportunities offered to NHS nurses	1. Offer similar development opportunities as those for NHS staff 2. Increase understanding and valuing of role by NHS staff 3. Specialist gerontological education for care home nurses

Currently, statutory training for all care home staff does not include end-of-life care, despite the importance of allowing people to die in their place of choice.

2.8 Research and quality improvement initiatives in care homes across Lothian and the UK

2.8.1 Applied research/quality improvement initiatives in care homes currently being undertaken in care homes across Lothian

- Anticipatory Care Planning (involving 2 care homes)
    - Gill Highet et al 2016
- Developing person-centred care in care homes
    - Professor Brendan McCormack, QMU
- Dementia and distressed behaviour
    - Dr Belinda Hacking et al (involving a number of care homes)
- ReConnect – live music for people with dementia
    - Sheila Rodgers, University of Edinburgh (pilot care home x 1 but planning to do larger study
- Scottish Government has funded the expansion of the Lifesmile programme to all care homes across Lothian for frail older people[43]

2.8.2 Exemplars of published applied research/evaluated quality improvement initiatives in care homes across the UK

- Dementia
    - Improving the quality of life for people with advanced dementia – Namaste[44]
    - Developing the Conceptual Underpinning of Relationship-Centred Palliative Dementia Care in Care Homes[45]
    - Quality of life[46]
- Person-centred care[6]
- Palliative Care/end of life care:
    - Gold Standards Framework[47, 48]
    - Integrated Care Plan for the last days of life[49, 50]
    - Sustainability of a palliative care intervention in care homes[51]
    - PACE project (7 European countries including England) (www.eupace.eu)
- Structure of care homes – SENSES framework
    - The SENSES in practice: enhancing the quality of care for residents with dementia in care homes[52]
- Comprehensive Geriatric Assessment[53]
- Inter-professional working[54]
- Integrated health and social care model[54]
- Care culture[55]

2.8.3 Proposed applied research

- Measuring quality of last month of life of residents in care homes through family perception of care (potential base-line for Centre – accepted Annals of Palliative Medicine, January 2017)
- RCN Foundation – student placements in care homes (University of Edinburgh – submitted December 2016)

2.8.4 Research priorities in care homes

Currently there is little evidence base for care in care homes. Shepherd et al. have identified what are believed to be the UK priorities.[56]

Table 2.8: Current UK priorities for research in care homes[56]

Rank	Research question
1	How can person-centred care be provided in care homes appropriate to the person's individualised needs?
2	How can dignity be enhanced for residents in care home settings?
3	What are appropriate staffing levels in relation to the number of residents in care homes and their relative care needs?
4	What are the attitudes of inexperienced care home staff towards providing person-centred care and can training and support improve awareness of the need for person-centred care?
5	What are the essential elements required when training carers working with older people in care homes?
6	How can early and appropriate discussion with older people in care homes about end-of-life care be supported?
7	How can recruitment of carers with essential qualities, such as compassion and empathy, be improved by care homes?
8	How can best-interest decisions made for care home residents with dementia be properly documented in care plans?
9	How can care homes be made to feel more like a home?
10	What are the public and media perceptions of care homes compared with other care settings and what is the impact on care home staff attitudes?
11	What is the impact of levels of oral hygiene on the nutritional status of older people living in care homes?
12	How can families and healthcare professionals contribute to improving end-of-life care for older people in care homes?
13	What activities can improve the quality of life for care home residents with impaired vision or hearing?
14	How can the provision of visual aids enhance the quality of life of people with end-stage dementia?
15	Can education strategies improve care home staff attitudes towards the use of power and authority in their relationship with older people with cognitive impairments?

CHAPTER 3

THE CENTRE

Chapter 2 has highlighted the need for a vision that is not just about the quality of care in care homes but one that links to other systems in order to develop greater knowledge and skills for a wider workforce in the future. Quality work in care homes stems from evidence-based practice through quality improvement initiatives and research. Chapter 3 outlines the philosophy and the practical set-up for the Centre.

3.1 The philosophy that will underpin the Centre

The philosophy of care will be underpinned by the Senses Framework for all – staff, residents and families/friends:

- A sense of security
- A sense of continuity
- A sense of belonging
- A sense of purpose
- A sense of achievement
- A sense of significance

3.1.1 Strengthened by a 'person-centred' care philosophy[6]

"Person-centredness is an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development".[6]

Table 3.1: Person-centred practice framework[6]

Prerequisites	Care Environment	Person-centred Processes	Outcomes
Professionally Competent	Supportive Organisational Systems	Providing Holistic Care	Good Care Experience
Developed Interpersonal Skills	Power Sharing	Working with the Patient's Beliefs & Values	Feeling of Well-Being
Commitment to the Job	Potential for Innovation and Risk Taking	Engaging Authentically	Involvement in Care
Clarity of Beliefs and Values	The Physical Environment	Sharing Decision Making	Existence of a Healthful Culture
Knowing 'self'	Appropriate Skill Mix	Being Sympathetically Present	
	Shared Decision Making Systems		
	Staff Relationships		

3.2 The principles of co-production

The principles of co-production will be integral to the organisation of the Centre in order to build relationships between people using the Centre and those who work at it. It will also be used as a basis for quality improvement initiatives and the research priorities.

The Centre will also use co-production within the community in which it is to be built. To achieve this the co-production framework below (see Table 3.2) will be used alongside specific actions in how we anticipate to achieve this.[57]

Table 3.2: The principles of co-production

	Principle
1	Build on people's existing capabilities: altering the delivery model of public services from a deficit approach to one that provides opportunities to recognise and grow people's capabilities and actively support them to put them to use at an individual and community level.
2	Reciprocity and mutuality: offering people a range of incentives to engage which enable us to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations.
3	Peer support networks: engaging peer and personal networks alongside professionals as the best way of transferring knowledge.
4	Blurring distinctions: removing the distinction between professionals and recipients, and between producers and consumers of services, by reconfiguring the way services are developed and delivered.
5	Facilitating rather than delivering: enabling public service agencies to become catalysts and facilitators rather than central providers themselves.
6	Assets: transforming the perception of people from passive recipients of services and burdens on the system into one where they are equal partners in designing and delivering services.

3.3 Care provision by the Centre

There are many different care home models both nationally and internationally. The care provison for the Centre has been developed from visits to a number of centres of excellence (see Chapter 4) here in the UK, Norway, The Netherlands and Australia alongside reading relevant literature. It is proposed that the Centre will primarily provide a home for long-stay residents aged over 65 years living within its locality.

Our Vision is that the Centre will sit within a care village, incorporating additional housing and facilities that can be accessed by all residents and the community. The Centre would comprise 72 beds (divided into six 'HOUSEHOLDS' of 12 beds) for dependency levels 3 and 4 where all residents will be frail with a number of comorbidities such as dementia, Parkinson's, heart failure, stroke. We anticipate one of the HOUSEHOLDS could be used as for people with severely distressed behaviour and one HOUSEHOLD as a Step Up/Step Down facility with planned 'active' respite. Additional housing would provide 58 beds in 'APARTMENT style' living for dependency levels 1 and 2 (see Chapter 6).

Planned 'active' respite care will be an important aspect of the work of the Centre. The optimal model to provide this requires further exploration.

The Centre will provide beds for emergency respite and/or palliative care, provision:

- An 'empty' bed would be available as far as possible for a local emergency for example,
    - If an elderly carer becomes ill/admitted to hospital;
    - If someone who was dying at home suddenly became distressed, an opportunity would be made for them to be admitted to the Centre following discussion with the GP.

3.3.1 Organisational culture:

- Holistic care will be underpinned by the importance of personhood and will include:
    - Compassionate care
    - Expert symptom control for long-term conditions including the last days of life
    - Psycho-social care for all people including those with advanced dementia
    - On-going support of both emotional and spiritual care

3.3.2 Palliative and end-of-life care

Palliative and end-of-life care will play an important part in the care at the Centre with an emphasis on anticipatory care planning. Many frail older people admitted to care homes have 'advanced, progressive, incurable diseases' – and by definition are in need of palliative care.[58]

Many older people are very aware that their life is coming to an end when they are admitted to a care home for long-term care. Palliative care neither prolongs nor hastens the end. Instead it is built upon[42]:

- Honest open communication between everyone involved including the resident, family and staff to promote control of symptoms of the various comorbidities, appropriate treatment decisions and ongoing care in light of impending death.
- Honest prognostication.
- Expert symptom control – however, staff in care homes need to have adequate training and the ability to access specialist palliative care advice when necessary. The BGS highlights that common symptoms of people in care homes are: pain, breathlessness, nausea and vomiting, anorexia, constipation, depression, cough, delirium, dysphagia, insomnia, incontinence and anxiety.[42]

3.3.3 Principles of a 'good death'

In addition to palliative care, the Centre will subscribe to the principles of a good death which have been identified by Age Concern and are[59]:

1. To know when death is coming, and to understand what can be expected
2. To be able to retain control of what happens
3. To be afforded dignity and privacy
4. To have control over pain relief and other symptom control
5. To have choice and control over where death occurs
6. To have access to information and expertise of whatever kind is necessary
7. To have access to any spiritual or emotional support required
8. To have access to hospice care in any location, not only in hospital
9. To have control over who is present and who shares the end
10. To be able to issue advance directives which ensure wishes are respected
11. To have time to say goodbye, and control over other aspects of timing
12. To be able to leave when it is time to go, and not have life prolonged pointlessly

3.4 Staffing at the Centre

- The 'on-site' care team will comprise the following: (see Figure 7.1, page 71, for potential organisational structure)
    - Director of Operations
    - Director of Care (nurse)
    - Advanced nurse practitioner/Admiral Nurse
    - Nurses
    - Social care workers and practitioners
    - Allied healthcare professionals (Physiotherapist, Occupational Therapist/activities coordinator)
- Medical Cover
    - One lead GP practice – at least weekly
    - Old age Psychiatry – regular multidisciplinary meetings and as necessary
    - Medicine for the elderly – regular multidisciplinary meetings and as necessary
- Support staff
    - Receptionist; Bistro staff/cooks; Ancilliary staff; Volunteers
- Day support staff
    - The manager & social care workers; Volunteers
- Additional external support
    - Pharmacy; Dentistry; Specialist nurses; Dietitians; Opticians
- Education and skills development
    - Social Care Mentor
    - Knowledge and Skills Development/Research Lead

3.4.1 Staffing levels

- Research shows that 12-hr shifts in care homes are not cost effective. They lead to increases in sickness/absence, use of agency and are detrimental to quality of care.[60, 61] Most staff in teaching/research-based care homes in Norway and Australia no longer do 12-hr day shifts routinely.
- Ratios will be the same as for well-reviewed care homes with nursing in the locality (minimum 1:4): complemented by including students on placements and volunteers in the day-to-day routine.
- The Centre will have the following shift patterns but with some flexibility for long 12-hr shifts as requested:
    - two 7.5-hr day shifts (07.30 - 15.00 and 14.30 - 22.00)
    - one 10.5-hr night shift (21.30 - 08.00)

3.5 Transformational leadership in the Centre

- The Centre management structure will incorporate a mix of current health and social care management and innovative models of management from the charity sector (see Chapter 4).
- The Centre will be a demonstration site for integration between health and social care. Lead roles at the Centre will be undertaken by those best qualified for the job. There will be lead roles in social care, nursing and AHPs – all will be expected to be involved with the clinical work.

3.5.1 Different leadership styles:

There are many different leadership styles. Most are transactional leadership but the Centre will be underpinned by transformational leadership.[62]

Table 3.1: Transactional leadership *versus* Transformational leadership

Transactional leadership	Transformational leadership
○ Builds on the need to get a job done and make a living ○ Is preoccupied with power and position, politics and perks ○ Is mired in daily affairs ○ Is short-term and hard data orientated ○ Focuses on tactical issues ○ Relies on human relations to lubricate human interactions ○ Follows and fulfils role expectations by striving to work effectively within current systems ○ Support structures and systems that reinforce the bottom line, maximise efficiency, and guarantee short-term profits	○ Builds on a the need for meaning ○ Is preoccupied with purposes and values, morals and ethics ○ Transcends daily affairs ○ Is orientated toward long-term goals without compromising human values and principles ○ Focuses more on missions and strategies ○ Releases human potential – identifying and developing new talent ○ Designs and redesigns jobs to make them meaningful and challenging ○ Aligns internal structures and systems to reinforce overarching values and goals

In short, *transformational leadership*:

- sets clear goals; has high expectations; encourages others; provides support and recognition; encourages people to look beyond self-interest; and inspires people to reach for the improbable.[63]

Management will be seen 'on the floor'. Overall management, leadership and clinical care will be undertaken collectively ensuring staff take responsibility for developing a high-quality care culture.[64]

3.6 Volunteers - enhancing the quality of life of frail older people and their families

The use of volunteers in health and social care is not new. Despite the development of the Welfare State 1940s, which some thought would undermine the need for volunteering, volunteers have continued to be used both within the hospice movement.[65]

3.6.1 Volunteers

- Volunteering will be for all ages. There will be opportunities for students and children from local schools as well as those people who have retired from full-time work to be involved.
- With current demographics of over 18% UK population being over 65 years and still relatively fit, there are opportunities to tap this resource in the care of frail older people.
- Volunteers will be trained to work in the Centre (see Appendix 3 Table A2.1, for oppoprtunites of volunteers to enhanching care). Once established, however, the Centre will offer volunteer training to other care homes in the region; these care homes would pay for training.
    - Care home managers sending volunteers for training will commit to sending at least four volunteers as well as understand what is important about setting up a sustainable supported volunteer service.
    - There will be many and varied opportunities for volunteers to support the Centre and its residents.
- People retiring in their '60's are fitter now than those who retired at that age 30 years ago.
- Volunteers will be asked to commit to working 4 hours fortnightly, a reasonable compromise as a monthly minimum is too long and weekly too short, ensuring that all shifts will be covered.
- A full-time Volunteer Organiser (eventually with administration support) will provide good leadership and support to the volunteers.
- Centre volunteers will be regarded as an 'enhancement' – they will not replace Centre staff.
- Most volunteers (72%), become involved because of 'local knowledge' about the organisation, rather than because of any personal connection (personal communication).[66]

3.6.2 Volunteer Organiser duties

A full-time Volunteer Organiser will be required once the Centre is up and running. The person will be responsible for the wide range of activities involved in the management and support of volunteers, as well as organising the training of both the Centre staff and any care home organisation that would like help in establishing a volunteer programme. See Appendix 3 (Table A3.2) for outline of duties.

3.7 Students at the Centre - Enhancing quality of life for frail older people and their families

3.7.1 Student placements

Student placements will be encouraged at the Centre. In Adelaide, Australia, a 'not for profit care home organisation called Helping Hand receives over 3000 requests/year and offers placements for around 900 students across their eight care home sites following a two-year Government initiative which funded an educational lead attached to the University of Adelaide. Students of nursing, medicine, speech/language, dietitics, podiatry, physiotherapy, pharmacy, occupational therapy and dental hygiene are accommodated.

BY CAREY REED *April 5, 2015 at 1:19 PM EDT*

Student Onno Selbach interacts with two nursing home residents at Humanitas in the Netherlands. Selbach helped create an intergenerational program there that offers students rent-free housing. Photo courtesy of Humanitas

Students on placement in the Centre will be expected to be part of the team to develop an understanding of frailty and build relationships with the residents through caring for and engaging them in activities.

Requirements for how students will be mentored and assessed will need to be drawn up for each category of student. The University of Edinburgh is interested in discussing the opportunity for medical students to follow a resident with advanced dementia and their family over the span of a year during Year 3. This would form part of learning about the extended health and social care team.

3.7.2 Student accommodation

It is anticipated that there will be student accommodation on site. The University of Edinburgh is keen to provide student accommodation as part of the Centre's care village. Offering a reduced rent for students in return for a certain number of hours/week volunteering in the Centre would be one way of incentivising the participation of younger student volunteers. In the Netherlands, students give 30 hrs/month in return for accomodation.[67] Students, whatever their interests, would be encouraged to take part in the life of the Centre – whether through sharing their musical talent, their art, or undertaking caring duties such as helping people with meals. Such involvement will bring life to the Centre.

3.8 Other components of the Centre

3.8.1 Outside space:

- Of our 'snap shot' interviews with residents, a majority interviewed wanted to be outside more – as well as relatives telling us of other residents who were trying to push the door to get outside. Many times it is thought they are 'trying to escape' – whereas it might be the residents want some fresh air.
- The importance for people with advanced dementia being outside in the fresh air and light with all the important health benefits such as Vitamin D, is now established[68, 69]
- In The Netherlands the 'green care homes' are situated on/alongside a working farm where residents spend 70% of their day outside. Most residents in UK care homes rarely get out. The Centre would promote 'outside space' innovatively:
  - 'Men's sheds'; Gazebos; Greenhouse; Vegetables gardens; Chickens
  - Pitch & Putt course; Sensory gardens; Woodland walk.
- The gardens would be 'dementia friendly' in common with the rest of the 'dementia friendly' design

3.8.2 Communtity Hub:

- A community 'hub' at the Centre would provide an opportunity for the outside world to be more of a part of the Centre and the care of frail older people, through the use of the space for local events.
- A café within the 'hub' will enable residents to feel that they are going out while remaining within the safety of the Centre – many frail older people, especially those with advanced dementia, are frightened to go out.
- A shop within the 'hub' would enable people within the Centre to buy their own personal things rather than always relying on family or friends to bring them in.
- A communal space for performance – art, music, theatre, film, concerts etc.
- Children would be welcomed to the 'hub' and a special play area would be provided for them.

3.8.3 Quiet /reflective area within the Centre:

- The Centre would provide a quiet area for reflection where church services or other faith-based meetings could take place.

3.8.4 Hairdresser:

- Most care homes have a hairdressing facility. At the Centre, the hairdressing salon will be run commercially (there is already interest from one well respected hairdressing organisation). Besides those living in the HOUSEHOLDS and APARTMENTS, the salon will be available by appointment for staff and relatives visiting the Centre, as well as those in the local community. Student hairdressers at the salon will get work experience that is not normally part of their training especially in relation to their understanding of dementia.

3.8.5 Gym:

- A gym will provide an opportunity for exercise for those within the HOUSEHOLDS as well as those living in the extra-care/sheltered housing APARTMENTS. People aged over 70 years living in the local community will also have access in order to encourage active ageing and to play a part at the Centre, thereby linking the Centre to the community.

3.8.6 Crèche and Nursery:

- A crèche (up to two years) and nursery (from 2 to 5 years) will provide a service for staff at the Centre with young children and also for local community. One of the bonuses of working at the Centre would be reduced crèche prices. This will be commercially led.

3.8.7 Care at Home:

- The Centre will liaise with and support local 'care at home' teams. The Centre could potentially house the 'advanced dementia team'.[70] In Australia, the 'rapid response team' for distressed behaviour is located within the responsibility of the Hammond Care[71] teaching/research-based care home and has been commissioned to provide such a service.

3.9 A 'HUB AND SPOKE' MODEL – to support other care homes across Lothian

- The Centre will reach out to care homes and community teams using a hub and spoke model across the region like the Norwegian model[36]. It will not be an 'isolated ivory tower'.
- Highly rated care homes within the Lothians and south/north Edinburgh will be encouraged to become 'satellite' care homes of excellence to the Centre – to take a leadership role in quality improvement initiatives and research within their own areas, while being well supported by the Centre.
- In the Netherlands, VU University Medical Centre has set up a group of 22 appointed care homes which are closely linked with it and involved in undertaking research. Such a model will be further investigated in-line with local ENRICH networks (http://enrich.nihr.ac.uk/).

Figure 3.1: The 'Hub and Spoke' model for the Centre

3.10 Additional aspects of the Centre

3.10.1 Support and Respite Care

- Support and respite are important issues that, to a greater or lesser extent, have been forgotten in the UK.
- Alzheimer Scotland reported that *support and 'respite' provision* is a key issue for carers of people with dementia.[72] Information received by carers at the point of diagnosis was inadequate and only 28% had access to training in how to cope in their caring role[72]:
    - 37% felt that the services available were sufficient for their needs
    - 27% of carers of people with dementia get a week break in a year
    - 30% said day care was unavailable
    - 50% said that they could not access home support

- Evidence from Maayan et al.'s[73] systematic review highlights the need to define the model in relation to respite care. It is unclear from research as to how beneficial respite is or is not. However, this is because respite is often reactive rather than pro-active. There is a call for further research.
- The model we would adopt would be around planned and active respite – incorporating Geriatric Comprehensive Assessment tool (http://www.bgs.org.uk/index.php/cga-managing). In the early years of the Centre, one aspect of research will be undertaken using a realist evaluation approach, to look at the effect of planned/active respite.
- Respite stays will include a multi-disciplinary team assessment using the Geriatric Comprehensive Assessment tool inclusive of discussions regarding care home placement if home care breaks down. An on-site Social Worker will liaise with the Care at Home team.
- Respite with appropriate on-going assessment and anticipatory planning needs to form part of care in the community for older people.
- Efficient and effective respite care will be offered at the Centre every 4-6 weeks depending on need. In the City of Edinburgh, some frail older people get offered respite 'free' while the carer gets a break – a carers assessment has to be completed.
- Instead of disorientating the person with advanced dementia by bringing them to the Centre for respite, 'purchased respite' could offer support in their own home while families go on holiday. 'Bank staff' would do 12-hr shifts for up to two weeks – paid for by the family.

3.10.2 Day Support

- Day Support will be provided for up to 30 people with moderate dementia (including people under 65 years) still living in the community. Day care supports a number of activities such as dementia cafes, clubs and social events for people with dementia and their relatives/friends.
- The Day Support unit will meet the needs of people with advanced dementia still living at home whose families are at work. The aim would be to keep them at home for as long as possible. One model could be that of the Silviahemmet Centre, Stockholm http://www.silviahemmet.se/en/., which opened in 1996 with strong links to the Karolinska Insititute. Families bring their family member to the Centre on their way to work (at 08.00 hr) and collect them on return (18.00 hr) to spend the night in familiar surroundings.

3.10.3 Step Up/Step Down Facility

- The Centre would also like to offer a Step Up/Step Down facility (as one of the HOUSEHOLDS) **or** work in close collaboration with such a facility, preferably on-site where services can be shared such as an exercise pool, physiotheapists, Occupational Therpists and the 'care at home' team.
- Step Up/Step Down facilities are seen as an important adjunct to care home work and 'care at home'. They take pressure off acute hospitals and help to provide an important service in relation to respite and 'urgent' palliative care of frail older people living in their own homes.
- One audit study (personal communication, Stavanger) reported 60% of patients admitted to the facility from hospital were discharged to their own home within 4-6 weeks. Such facilities are well-staffed by nurses, geriatricians, and physiotherapists with good communication out to 'care at home' services. They relieve pressure on hospital beds as well as the opportunity for focused rehabilitation and assessment.
- Comprehensive Geriatric Assessment would underpin the on-going assessment.
- The introduction of teaching/research-based care homes in Norway alongside Step Up/Step Down facilities, has led to 49% of the Norwegian population dying in nursing homes, and a much lower percentage in acute hospitals, compared with in the UK.[74]
- Effective 'step up/step down' services are multidisciplinary, outcome focused, individualised and characterised by effective team work. In addition, supported self-management approaches combined with nutritional care and, most importantly, physical activity should be elements of services which seek to optimise the functional ability and quality of life of frail older people.
- The Step Up/Step Down facility would need to be fully staffed with the multidisciplinary team working in close co-operation with: care at home, hospitals, care homes.

See Page 51 for an exemplar of Step Up/Step Down facilities in the City of Edinburgh during 2013/14

3.11 A learning organisation for knowledge and skills development

The Centre will have a dedicated 'practice development/educational' lead practitioner to help organise, and foster an ethos of on-going learning across all staff at the Centre as well as across the region. The lead practitioner will support mentorship for all staff.

Table 3.3: Educational Programmes at the Centre

Range of Educational Programmes at the Centre		
In-house	**Other CHs across Lothian**	**In conjunction with higher institutions**
Staff Induction		
Regular training in relation to: • Nutrition • Moving/handling • Advanced dementia • Communication • Pain/symptom control • Palliative and end of life care • Dementia & delirium	Regular training in relation to: • Advanced dementia • Communication • Pain/symptom control • End of life care • Dementia & delirium	SVQ 2-4
Social care workers: • SVQ 2-4	Care Home Leadership training	Mentorship programmes
Nurses • Encouraged to do further higher qualification in older people nursing/palliative care		Masters in older people nursing (QMU) PhD
Namaste Care http://www.namastecare.com/ Relationship-based care		Continuing professional development courses for social workers, GPs etc
Monthly 'reflective debriefing sessions' following a death[75]		
Volunteer training	Volunteer training	
Quality Improvement Initiatives		
Monthly multidisciplinary palliative care meetings		

3.11.1 Ongoing career development – carers and nurses

The Centre would work with SSSC (Scotish Social Care Council) and other organisations to develop the training and development of social care workers within the care home setting.

National Institute for Health and Care Excellence (NICE) Guidance[76] highlights the importance of care homes employing nursing staff with the right knowledge, attitude and approach to ensure staff are competent, appreciate the challenges of working in the sector and understand how to promote quality of care.

The Centre would work with NHS Education for Scotland (NES) in developing the four pillars for career framework (see Figure 3.2) in relation to nurses working in care homes, namely:

- clinical practice
- facilitation of learning
- leadership and evidence
- research & development

Figure 3.2: A career framework for nursing

Taken from: http://www.careerframework.nes.scot.nhs.uk/

Levels are from post registration (Level 5) to a consultancy level and beyond. An opportunity to work with NES to progress on-going learning for nurses within the care home sector is of particular importance and relevance to the vision for the Centre.

3.11.2 Priorities for professional development of nurses and carers in care homes

Competencies for registered nurses working in UK care homes are important – most care home nurses have been trained within the acute hospital setting. The role of the nurse in a care home is underdeveloped and could be usefully used to support and train social care workers in relation to healthcare needs of residents. Stanyon et al.[77] have defined 'core competencies' through their research in this area which would help to formulate further professional development through the Centre for all staff.

Table 3.4: Core competencies for nurses in care homes[77]

No	Competency	E%	D%	I%	FD%
1	Attitudes and relationship-centred care	**83**	**4**	**0**	**12**
2	Enhancing well-being and maintaining ability	**80**	**0**	**0**	**25**
3	Communication	75	0	0	25
4	Knowledge and understanding of old age	80	5	0	15
5	Assessment and care planning	a) **80**	**10**	**0**	**10**
		b) **95**	**0**	**0**	**5**
6	Administrating procedures and interventions	a) 55	30	0	15
		b) 15	60	10	15
7	Hygiene	**92**	**0**	**0**	**8**
8	Urinary continence	**88**	**4**	**0**	**8**
9	Bowel care	**96**	**0**	**0**	**4**
10	Nutrition and hydration	70	10	0	20
11	Pain management	**100**	**0**	**0**	**0**
12	Skin viability	**83**	**4**	**0**	**13**
13	Pharmacology	**85**	**0**	**0**	**15**
14	Dementia care	a) **85**	**0**	**0**	**15**
		b) 60	30	0	10
15	Cultural, spiritual and sexual needs of residents	**85**	**0**	**0**	**15**
16	Sleep	**80**	**5**	**5**	**10**
17	Long-term conditions and comorbidities	70	10	0	20
18	Managing acute ill health	**90**	**5**	**0**	**5**
19	End of life care	**85**	**5**	**0**	**10**
20	Moving and handling	**95**	**0**	**0**	**5**
21	Resident safety	**80**	**5**	**0**	**15**
22	Team working	**92**	**0**	**0**	**8**
23	Management and leadership	75	20	0	5
24	Teaching	55	30	0	15
25	Quality improvement and evidence-based practice	**80**	**15**	**0**	**5**
		75	15	0	10
26	Policy & procedures	a) **80**	**15**	**0**	**5**
		b) **92**	**0**	**0**	**8**
27	Reflective practice	**92**	**0**	**0**	**8**

E, essential; D, desirable; I, irrelevant; FD, further development required; bold, consensus over 80% threshold

3.12 Potential relationships between the Centre and other Academic Institutions

Following discussion with academic institutions across Lothian, the following table represents opportunities that have been highlighted (see Table 3.5).

Table 3.5: Academic Institutions across Lothian

<table>
<tr><th colspan="5">Academic Institutions interested to be involved with the Centre:</th></tr>
<tr><th>University of Edinburgh (RIE, WGH, Royal Ed, St John's</th><th>Queen Margaret University</th><th>Napier University</th><th>Edinburgh College</th><th>West Lothian College</th></tr>
<tr><td>Medical training
• 3rd Yr students would follow a care home resident over a year
• MOE and Yr 5 GP lead.
• clinical psychology students
• social work students

[Potential for student placement in:
• Dental hygiene
• GP trainees
• Medicine – 3rd yr – TEAM / BSc
• Medicine for the elderly and old age psychiatry
• Para-medics
• Pharmacy
• Podiatry
• Social work
• Theology</td><td>Masters in nursing

Also interested in developing nurses to an advanced practitioner level

[Potential for CH student placement in:
• Nursing
• Physiotherapy
• Occupational therapy
• Dietetics
• Podiatry

Currently piloting CH placement for high school pupils interested in health/social care</td><td>BSC in Nursing Studies

Student Nurse Placements in Care Homes & role of CHEFs

[currently places student nurses from all three training universities in care homes but difficult to find places]</td><td rowspan="5">Vocational Level

SSSC Promoting excellence learning resource

[currently places social care workers in care homes]</td><td rowspan="5">Vocational Level

[currently places social care workers in care homes]</td></tr>
<tr><td>Undergraduate nurse training</td><td>Physiotherapy students</td><td rowspan="3">Interested in developing nurses at advanced practitioner level
• i/v qualification
• prescribing
• ear syringing
• s/c fluids</td></tr>
<tr><td>Masters in Clinical Research</td><td>Dietetic students</td></tr>
<tr><td>Edinburgh Centre for the Research in the Experience of Dementia – PhDMasters students</td><td>Courses in art and music</td></tr>
</table>

3.13 Research and Quality improvement – the Centre's role

- The Centre's dedicated 'Research and Quality Improvement Lead will work in conjunction with local university partners, residents and their families
- Ideally the local universities involved would help to fund an academic position to support the research being undertaken in the Centre
- Academic positions suggested:
    - Professorial Chair (possible offer of an endowment)
    - Associate Professor
    - Clinical Lecturer
- The Centre would work with ENRICH (Enabling Research In Care Homes) http://enrich.nihr.ac.uk/offices; and would intend to be involved in its activities, both locally and nationally to develop the evidence-base in care homes.
- Issues for research and current international research being undertaken are highlighted in Table 3.6

Table 3.6: Current research issues, potential international partnerships and funders

Issues for research being highlighted as important	Current applied research internationally	Potential funders of applied research into care homes
• Person-centred care • Behavioural & psychological symptoms of dementia • Depression • Delirium • Polypharmacy • Nutrition • Pain: assessment & management in dementia • Sustainability of quality improvement initiatives • Advance Care Planning/KIS • Leadership • Telemedicine • Falls • Quality of Life • End-of-Life Care • Multi-dimensional assessment • Frailty • Retention and recruitment • Transitions of care for care home residents	• Delirium (The Netherlands; US; Canada) • Falls • Day of care audit / LPZ (The Netherlands, Germany and UK) • Types of care home settings and learning environments (US; Australia; The Netherlands) • Pain assessment/management (Norway; Australia) • Dementia and Depressive Symptoms (US) • Distressed behaviour in people with dementia (Canada & Manchester) • Obesity (US)	• Abbeyfield (grants up to £50,000/year) • Dunhill (large grants) • Alzheimer's Society (large grants) • NIHR (large grants) • Burdett Nursing Trust (small grants generally between £10,000- £45,000) • Lothian Health Foundation (small local grants) • Robertson Trust (Scotland only) • HTA (large grants) • Age UK • Carnegie Trust • Nominet Trust/the Baring Foundation (digital arts & creative ageing) • Life Changes Trust (focussing on dementia in Scotland)

3.13.1 Quality improvement activities

- Quality improvement methodology offers opportunities for the Centre and the satellite care homes to identify and monitor their progress against important national or local standards and identify individual solutions to improve practice and maintain quality in care.
- Use of such methodologies requires support and training for staff different from that for research, but there are exemplars of good practice across Scotland in Frailty, Delirium, and care of the older person in the actue hospital[78] and learning from other projects elsewhere in the UK. Greater extension into care homes is required.

3.13.2 Potential research topics to explore include:

- Approaches to very distressed behaviour in people with dementia
- Incidence of delirium
- Extent of polypharmacy
- Number of Advance Care Plans completed
- Family Perception of Care of last month of life in care home – audit of bereaved relatives' perception of care
- Use of the Individualised Patient Plan for the last days of life for all deaths in care homes
- Continence
- Length of resident's stay
- Pressure ulcer care
- Quality of care, shift patterns, staff well-being
- 'Active' planned respite and 'care at home'
- Educational initiatives to support 'care at home'

3.14 The Strategic Role of the Centre – a summary

- Provide a place of excellence that is 'home for life' for frail older people who require 24-hour care
- Give compassionate care at all times
- Provide transformational leadership that includes expert nursing care and empowers others to succeed
- Develop staff to their full potential making sure they are competent in the care they provide
- Optimise staffing levels through: improved retention of staff, student accommodation, student placements and volunteers
- Engage, listen and promote the views of people living in the care home, their families and the staff who work there
- Work to support the knowledge and skills development of staff in other care homes across the region generally and through 'satellite care homes' supported by the Centre
- Welcome and inspire students from a range of backgrounds to develop an understanding and passion for caring for frail older people
- Champion innovation and evidence-based practice
- Participate in research, audit and quality improvement initiatives in partnership with academic institutions

CHAPTER 4

LEARNING FROM OTHERS TO ENABLE THE CENTRE TO SUCCEED

4.1 What makes a care home 'outstanding'?

An outstanding care home relies on:

- An outstanding leader/manager who is well supported in the role, confident and competent.
- Profit never being the '*raison d'etre'.*
- Sufficient resources.
- Directors who work very hard – and who champion quality.
- Clear organisational values and ethos, known, clear and understood by all those associated with it.
- The care home organisation being generally small with only one or two homes in its portfolio.

'Outstanding care' is care that is 'tailor-made' for the person and their family where patients and family are offered understanding, empathy and choice and where staff truly went the extra mile – Care Quality Commission about St Nicholas's Hospice (August 2016).

4.2 Successful care organisations

Across Scotland, during 2015/2016, eleven care homes across Scotland (11/936 care homes) won an 'outstanding' report across all themes (personal communication, Care Inspectorate (see Table 4.1).

Table 4.1: 'Outstanding' care home organisations in Scotland

Type of care home	Number of beds	Town/City
Residential care home	20	Aberdeen
Nursing care home	*	Arbroath
Nursing care home	30	Ballachulish
Residential care home	27	Bridge of Weir
Residential care home	22	Forfar
Nursing care home	34	Glasgow
Nursing care home	28	Greenock
Nursing care home	20	Haddington
Nursing care home	32	Kelso
Residential care home	22	Leven
Residential care home	44	Perth

* Data censored due to small number of beds

During the feasibility study a number of different care homes were visited because of their good reputation and innovative practice (see Appendix 4) to help inform the Centre's aims and design. One specific area of the care in the Centre will be the palliative and end-of-life care needs of frail older people in the last months of life. Rachel House Children's Hospice in Kinross provided striking similarities between the care provided for children there and the care provided to frail older people with advanced dementia in care homes since both:

- care for people with chronic long-term conditions over many months/years.
- have difficulty in predicting the trajectory associated with advanced progressive illness.
- care for people who are mentally as well as physically vulnerable.
- have a need for 'respite care' to optimise care at home.
- share the importance of true person-centred care.
- need to support the families of those in their care alongside their staff.
- know the importance of engaging people in relevant daytime activities.

4.2.1. What people said their dream care home would look like

What families say and what staff say and what the Care Inspectorate says about an 'outstanding' care home depends on one's expectations.

- The repeated themes in the'snap shot' survey of NW Edinburgh locality care homes in asking what residents, families and staff said their 'dream care home' would look like are shown below in Figure 4.

Figure 4: Themes from 'Our Dream Care Home'

4.3 Key findings from local care home innovations:

A number of short-term initiatives funded by the NHS (generally for 2 years or less) have been set up as 'test of change' exemplars involving care homes to help reduce delayed discharges or prevent inappropriate hospital admission from care homes. These have been:

4.2.1. Step Down Initiative – City of Edinburgh (north and south)[79]
4.2.2. Care Home Liaison Team – City of Edinburgh (north)[80]
4.2.3. Glasgow Care Home Team[81]

East Lothian has a community team specifically supporting care homes. There have also been several funded education programmes mostly in relation to palliative and end-of-life care, , through charities such as Macmillan[82] and the Robertson Trust – but these are not reported here.[83]

4.3.1 Step Down initiative (2012/14) – City of Edinburgh (north and south)[79]

The Step Down initiative in the City of Edinburgh ran from October 2013 to December 2014. A total of 211 people were admitted (see Table 4.3). By the end of the initiative 65% people had either been discharged home or discharged to a suitable care home; 25 people had been readmitted to hospital; seven had died in the Step Down facility; and, of the 31 discharged home, 29 of required a package of care (see Table 4.4).

Table 4.3: Admissions to Step Down Initiatives

	2013			2014												
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Cairdean	12	10	3	12	7	9	11	7	10	9	6	8	5	8	1	118
Silverlea			2	11	3	12	7	9	7	8	5	6	11	7	5	93
Total	12	10	5	23	10	21	18	16	17	17	11	14	16	15	6	211

Table 4.4: Destination on leaving Step Down

	Count			Percentage		
Destination at discharge	**Cairdean**	**Silverlea**	**Total**	**Cairdean**	**Silverlea**	**Total**
Home with package of care	29	24	53	30.5	31.2	30.8
Care home place	32	27	59	33.7	35.1	34.3
Died in Step Down	7	4	11	7.4	5.2	6.4
Readmitted to hospital	25	22	47	26.3	28.6	27.3
Home with no ongoing support	2		2	2.1		1.2
Grand Total	**95**	**77**	**172**			

People admitted to the Step Down facility were at high risk of falls, had low levels of mobility and required high levels of support to undertake daily living activities. The IoRN – 'Indicator of Relative Need ranging from 'A' to 'I' with 'I' being highly dependent' – showed that Silverlea admitted people who had higher levels of need for support, while a greater proportion of those admitted to Cairdean had some level of confusion (see Figure 4.1). For 76 residents, the change in need as measured by the IoRN at discharge shows that just under one-third made some improvement, while just over half remained the same, and for 10% there was deterioration (see Table 4.5).

Figure 4.1: Level of Need of residents on admission - measured by IoRNS

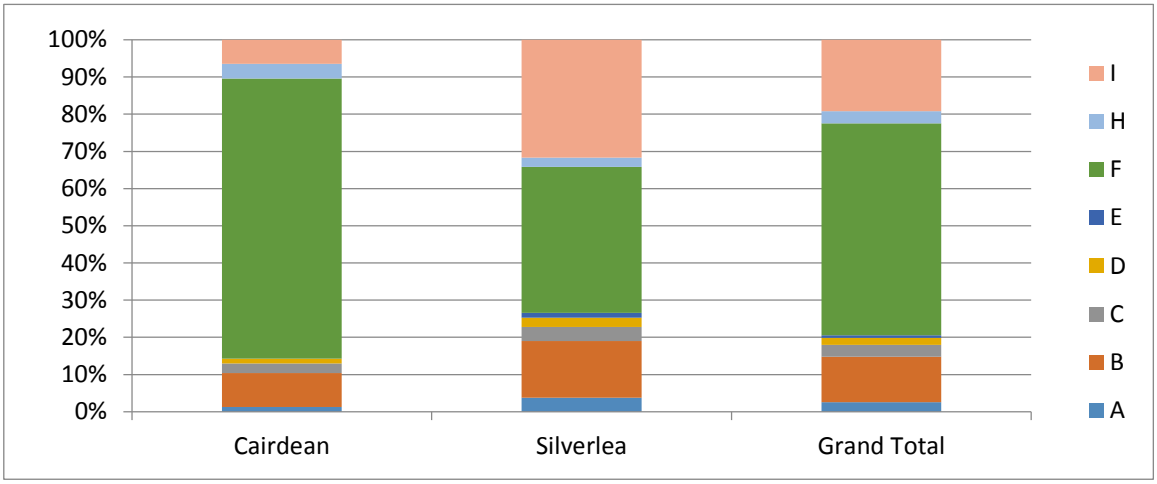


Table 4.5: Change in level of need as measured by IoRN on discharge

Independence	Count	Percentage
Increased	23	30.3%
No change	45	59.2%
Decreased	8	10.5%
Total	76	

Findings suggest that the Step Down service does enable the return home of some people, who would otherwise have moved to a care home.[79] The availability of informal care is a key feature which enables people to return home. Such a facility as a Step Up/Step Down facility working in conjunction with the Centre, and in the future other care homes, could help with delayed discharges and help to maximise quality of life both prior to going home and also prior to admission to a care home.

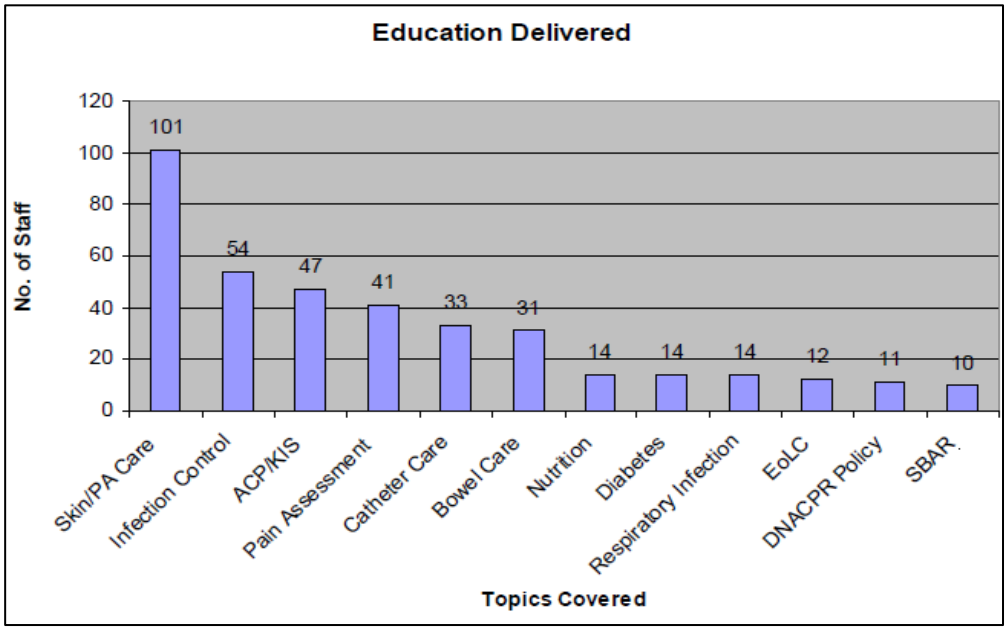
4.3.2 Care Home Liaison Service, Western General Hospital, Edinburgh (2014/15)

The care home liaison service (CHLS) was set up as a result of 'change funding' money in February 2014 and was dismantled in July 2015. It was led by a Consultant in Medicine for the Elderly (0.3WTE) with three band 6 care home liaison nurses (2.5WTE reduced to 1.8 WTE after 9 months).

The main aim of the service was to improve the quality of care delivered to care home residents, by improving access to specialist Medicine for the Elderly advice and providing practical support to GP's and staff within care homes.

Twenty four care homes in north Edinburgh were included. An ambitious service for a team that only had 2.5 WTEs for the majority of the project. During the project, 86 hours of in-house education was delivered to 370 members of staff. Topics of training were requested by managers for their staff (see Figure 4.1)

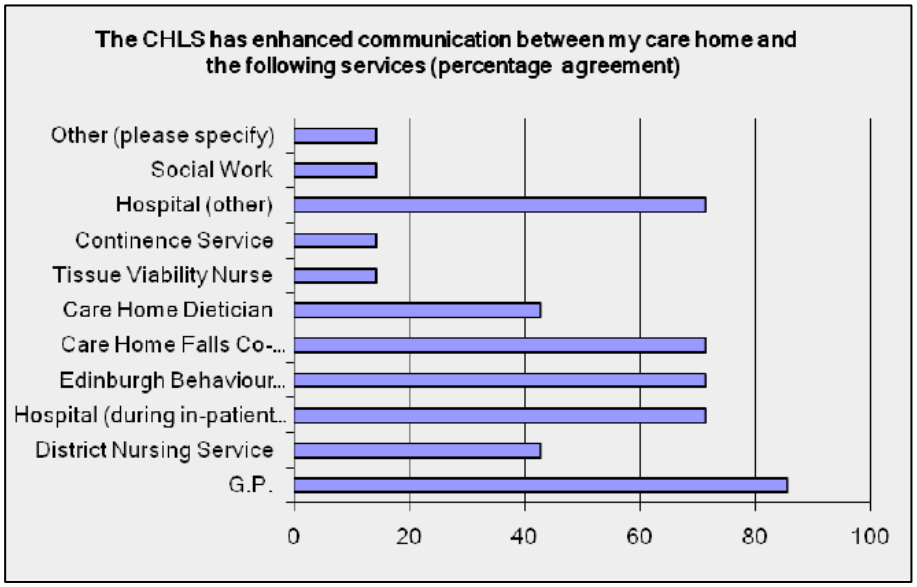
Figure 4.1: Education delivered by Care Home Liaison Service



The evaluation of the CHLS provides a good *'test of change'* and highlighted both the financial savings through the prevention of 20 resident hospital admissions during the project and the support given to care home staff and GPs (see Figure 4.2)

"I would strongly support this valuable service. As a GP I feel very reassured that I have immediate access to telephone advice and possible review by a nurse practitioner or a consultant. This is an excellent initiative as it provides a communication bridge between primary and secondary care in the management of an increasingly frail group of patients." Lead GP for Nursing Home

Figure 4.2: Enhanced communication provided by the Care Home Liaison Service (CHLS)



4.3.3 Glasgow/Clyde – Nursing Home Medical Practice team (2006-2013)[81]

The Nursing Home Medical Practice (NHMP) team was established in 2006 and covered nine assisting Practices and a Central Practice. The NHMP team consisted of GPs, nursing home liaison nurses, a dietitian, a speech and language therapist and a pharmacist with administrative support in each practice. In total, it provided enhanced medical care to approximately 2,672 patients in 59 nursing care homes in the former Greater Glasgow Health Board area. The wider care home s team extend beyond this to offer services and support to approximately 3,400 residents in 70 nursing homes.

In 2013, the service was reviewed and closed as "the current service was found to be disparate with care homes in some areas of Greater Glasgow receiving a dedicated medical and nursing resource from Care Homes Services (CHS) while in other areas of the board care homes received support from individual GP practices and mainstream community teams. Redesign of services should be impact assessed to ensure that the new service does not adversely impact on any of the protected characteristic groups".[84]

All three examples above highlight innovative bottom-up services designed to support quality of care for frail older people in care homes. All three services were stopped due to funding constraints. There is a need for a more sustainable, health and social care partnership model across a region that not only helps to address complex aspects such as delayed discharges, hospital admissions but also concentrates on care home work career development in light of the ageing population and need for care. We believe a teaching/research-based care home is one solution.

4.4 Markers of success and achievements at the Centre

4.3.1 Organisational:

- Stable staffing and a minimum turnover. If staff do leave it is because they want to go into either health or social care professional training and this is seen as a success
- Minimum staff absence as a result of good staff and volunteer well-being[64]
- Minimal use of agency staff
- The general reputation of the Centre within the public sphere will be highly rated
- Involvement with local community and church groups and other faith-based organisations
- Highly rated endorsements from residents and family/friends. Family/friends of the older person who has lived in the Centre will be asked to write a review if they would like. These will be advertised on the Centre website and other websites such as: www.carehome.co.uk

4.3.2 Clinical care and audit:

- The care being given at the Centre will receive 'excellent' or 'outstanding' on the Care Inspectorate regulation reports
- Use of audit to evaluate care
  - Quality of care measures, for example
    - Diagnosing delirium/dementia
    - Continence assessments
    - Care given during the last month of a resident's life through 'Family Perception of Care' audit
  - Quality of life measures
- Reduced attendance at A&E
  - Reduction in inappropriate attendance at A&E
- Specific resident- and family-related outcome measures will be collected, driven by their priorities
- Number of quality improvement initiatives with other care homes in the region
- Number of complaints will be fewer than for an average care home

4.3.3 Knowledge and skills development*:*

- The knowledge, skills and expertise of staff at the Centre will reflect both the Care Inspectorate reports and the reviews from the family/friends. Training will complement the care being given not distract from it.
- Staff will be encouraged to undertake different courses according to their ability and desire e.g. SVQs, courses at the Stirling Dementia Centre. It is hoped that some care workers will decide to go on to train as a nurse. This will be reported every year. At Viewpoint Housing, a 'congratulations ceremony' is held each year for staff who have completed specific training.

- Nurses will be encouraged to develop their skill to an advanced practitioner level (i.e. nurse prescribing) and then encouraged to take a management role in another care home.
- There will be an increasing number of undergraduate and postgraduate placements each year and they will all be asked to formally evaluate their placements. Over the last two years, Viewpoint Housing have had 100 student placements – mostly student nurses – only 2/100 did not enjoy their placement.

4.3.4 Research, quality improvement initiatives and service evaluation*:*

- The Centre will be known for involvement in and coordinating quality improvement initiatvies and research across the region and Scotland.
- Staff will publish and take part in conferences disseminating the work in which they have been involved.
- There will be exchanges with other centres of excellence across the long-term care community e.g. the Netherlands, Norway and Australia.
- The Centre will be involved in ongoing national and international research with particular attention to submission to and attendance at the yearly International Nursing Home Research group.

4.3.5 Community engagement*:*

- The number of volunteers recruited and trained, both within the Centre and those sent from care homes across Lothian, will be reported on every year. Regular evaluations on how supported and equipped to volunteer they feel will be reported.
- Staff working at the Centre will be recruited locally where at all possible.
- Engagement with churches and other places of worship in the local community.
- Good relationships with other businesses/schools/churches and other places of worship in the locality will be evidenced by their generosity and interest in the work of the Centre
- Personal stories – such as: from Helping Hand website: https://vimeo.com/141489169
- The Centre will regularly hold community events e.g. Art, choirs that both residents and families can attend

CHAPTER 5

REGULATORY ENVIRONMENT

5.1 Care Home Standards – and their quality themes

The Centre will be regulated by the Care Inspectorate in the same way as all other care homes in Scotland. There will be different regulatory requirements for the different services provided by the Centre – including the crèche and nursery.The Care Inspectorate currently awards grades on a six-point scale for each of the quality themes it chooses to assess at the yearly inspection (www.careinspectorate.com). The grades range from 1 (Unsatisfactory) to 6 (Excellent).

Out of all the care homes for frail older people in Scotland (more than 900), only 11 care homes achieved 'excellent' for all themes during 2016. Of these the majority were small care homes (generally less than 35 beds) (see Chapter 4).

The four Quality Themes assessed by The Care Inspectorate are shown in the table below.

Table 5.1: The Care Inspectorate - Quality Themes

Four Quality Themes	
Care and support:	How well the service meets the needs of each person who uses it
Environment	Where the service is delivered, for example, how clean, well-maintained, accessible it is; the atmosphere of the service and how welcoming it is.
Staff & Staffing	This includes their qualifications and training
Management & Leadership	How the service is managed and how it develops to meet the needs of the people who use it.

Seven new care standards will be introduced to regulate health and social care settings in Scotland in 2018. They are underpinned by the five following principles: dignity & respect; compassion; being included; responsive care & support; well-being.

There are six new care standards with underlying multiple component themes that are out for consultation with the view of being finalised and implemented in 2018. These will be highly relevant to the governance and organisation of the Centre. The first four of these apply to all who receive care in Scotland.[85]

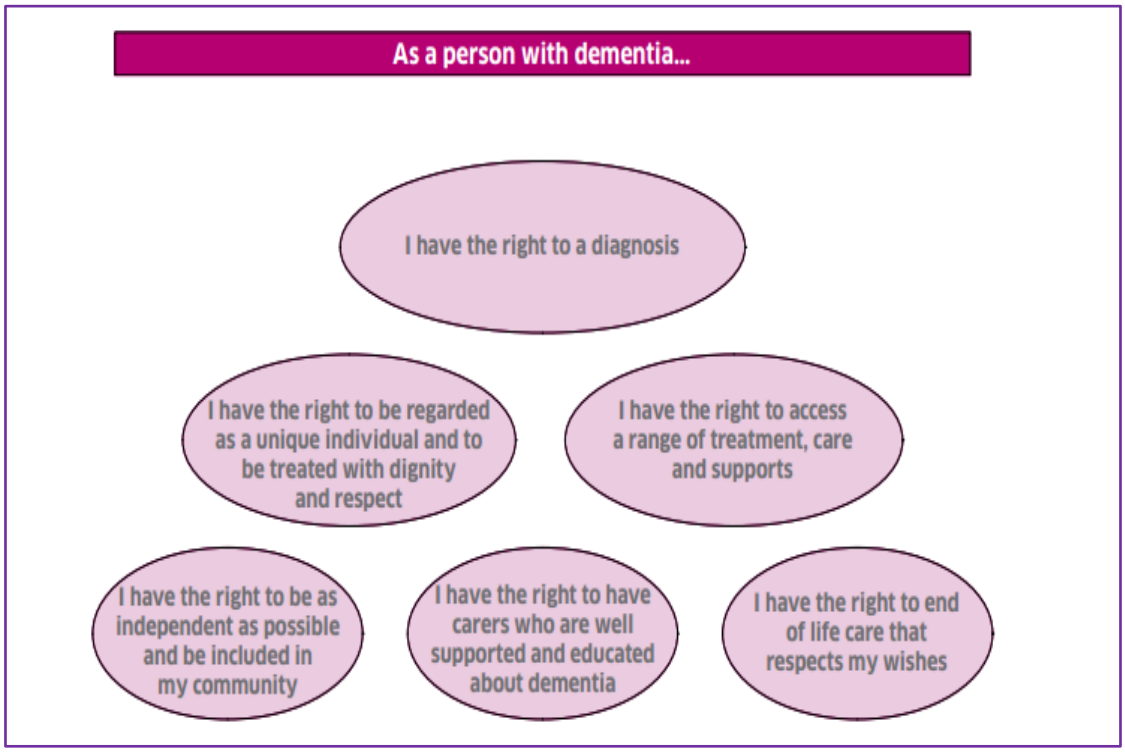
Table 5.2: New 'draft' Care Standards[85]

	CARE STANDARDS
1	I experience high-quality care and support that is right for me
2	I am at the heart of decisions about my care and support
3	I am confident in the people who support and care for me
4	I am confident in the organisation providing my care and support

5.1. Standards of Care – for People with Dementia in Scotland

The following standards developed from the Charter for Rights of People with Dementia and their Carers in Scotland[86] will underpin both the care in the HOUSEHOLDS, those living in the extra-care APARTMENTS and people attending the Day Centre.

Table 5.3: Standards of Care for people with dementia[87]



CHAPTER 6

SITE AND FACILITY REQUIREMENTS

6.1 THE DESIGN

The design for the Centre is that of a care village incorporating people with high and low dependency needs as well as student accommodation and crech/nursery facilities. Buildings will be innovative but fit for purpose and 'dementia friendly', both outside and inside and will consist of:

- **'HOUSEHOLD' accommodation** for 72 residents (mostly dependency 3 & 4) - six HOUSEHOLDS of up to 12 rooms (16km^2 not including ensuite) opening into combined lounge, kitchen and dining area – each HOUSEHOLD has large balcony/garden. The design will promote as much natural light as possible. See Table 6:1 for general design and lifestyle that the HOUSEHOLDS will promote. Within the build will be:
    - 3 spa areas for bathing and massage (one per two HOUSEHOLDS)
    - Bistro – open to public
    - A 'venue' – for films, celebratory occasions – that can be rented by residents' families
    - Shop and library for residents (both HOUSEHOLDS & APARTMENTS)
    - Training area and library
    - Internet café and children's play area
    - Pet friendly – inside and out
    - Hairdresser (franchise)

- **APARTMENT accommodation**, to rent or buy, for up to 58 older people (over the age of 65 years) in one or two-bedded APARTMENTS.

- **Community Hub** that could provide the following:
    - A hub for locality based multidisciplinary teams (i.e. community rehabilitation, hospital at home teams etc)
    - Support groups for early onset dementia/families
    - Care at Home advisory team
    - Gym – used for 'step down' and also for people over 75 years from within the local community
    - Day Centre for people with/without dementia

- **Student accommodation** – would have 'free' or 'reduced rent' in return to giving 30 hrs to the HOUSEHOLDS/month.

- **Education and research area** both both in-house training and to support quality improvement iniatives and research in care homes across the region

- **Creche/Nursery** (franchise) for the children of staff at the Centre (reduced rate) but also for local children (full rate). Children of staff from the Centre would have priority for places.

The 'lifestyle' that the Centre will be trying to portray will be one that promotes 'well-being' despite considerable frailty, especially for those residents living in the HOUSEHOLDS. The BISTRO will provide private family dining areas for residents with the Centre – some people with advanced dementia are too afraid to go out to a restaurant with their family.

The outside will be promoted as much as possible, with heated areas under verandas as well as separate gazebos. Outdoor activity for all residents and visitors (including children) will be promoted e.g. woodland walkway, gazebos, chickens, vegetable gardens, green house/s and men's sheds.

The Centre will have a franchised shop as well as a hairdressing salon that will not just be available to residents, but be open to the public as well as staff and relatives six days/week.

See overleaf (Table 6.1 for a precis of features)

6.2 Important features for the Centre

Table 6.1: Eight features for the teaching/research-based care home centre

(adapted from BELONG Wigan – see Appendix 4)

Care Home beds as 'HOUSEHOLDS' for 72 residents	Bistro & Shop	Apartments	Student Accommodation - bedsits for up to 40 students	Outside Facilities	Creche	Community Hub	Training and Research Area
Six 12-bedded HOUSEHOLDS for frail older people – all with ensuite showers: • Frailty & dementia x 4 • Distressed behaviour X 1 • Step Up/Step Down/Respite & rehabilitation x 1 • Emergency 'end of life'	For residents and families from the HOUSEHOLDS	One or two bedded apartments for 58 older people		'Dementia friendly' garden with a gazebo	For children of staff working in Centre (preferential rates)	Support for families and people in the community with early onset dementia	Simulation & training suite with manikins – especially in relation to death & dying
'The Venue' – bar/entertainment area that can be rented for occasions by families	For those living in the apartments	Rent or buy		Chickens Aviary	For children from local community	Café & Day support for people with moderate dementia	Video-conferencing suite for on-site training and training to other care homes
Namaste Room[44] – sensory room for people with very advanced dementia. One between 2 HOUSEHOLDS	For local community	For people <65 years		Vegetable garden	Children's outside area	Exercise facilitites with a potential pool for people within the community	Lecture/meeting rooms for training staff from other care homes
Spa bathroom – one between 2 HOUSEHOLDS				Men's shed		Place for evening concerts and performances	Training of care staff from 'care at home' agencies
Film room				Greenhouse			
Quiet reflective area				Sensory garden		Care at Home advisory team [this could be an 'advanced dementia care team']	Library and research areas including locked cabinets to store data
Gym				Nature walks			Computer terminals

6.4 Partnership models for the Centre:

Several different partnership models have been considered for the Centre. An early thought was to have a 'for profit' partnership model similar to the John Lewis Partnership. However, during the feasibility study and with the growing interest of working with health and social care under a 'not for profit' umbrella, this has been abandoned. Also, such a model did not suit the Centre's ideal of training staff and encouraging career advancement; there is a risk that staff with a financial incentive will not move on.

Option A: University of Edinburgh with NHS Health and Social Care Integrated Board

University of Edinburgh *with* Integrated Joint Board e.g. City of Edinburgh health and social care partnership	
Strengths	***Challenges***
Control over partnership between NHS Lothian and universities because of Government funding	Need to work hard to adopt a proper health and social care partnership like within the hospice movement
Possible site: old RVH building at Comely Bank[1] [1]www.craigleithhill.co.uk/craigleith_house.html	
Comely Bank site in particular • already owned by NHS Lothian • Close to students at WGH • Large site – would accommodate all we would like to do both as a building/s and outdoor space	Currently council care homes do not have on-site nurses
Edinburgh Council had plans to build two care homes as current care homes 'not fit for purpose' • need for beds • a new build would mean no existing culture to change	May not have enough money
Health and social care to lead by example – important for Health becoming more involved in the care of frail older people within care homes and to the care in the other care homes	
Opportunity for flow across care homes/hospital if NHS involved	

Option B: **University of Edinburgh with one/two 'not for profit' CH organisation/s**

University of Edinburgh *with* one/two 'not for profit' organisation/s	
Strengths	*Challenges*
Helping Hand (Australia) is a good example of an organisation partnered with University of Adelaide	Would other Lothian care homes 'buy in' to the Centre as willingly?
The 'not for profit' organisation that is interested to be involved would like to invest financially	Would not be able to influence older people care in hospital
	Management of independent care home organisations and their approach can change

Option C: **University of Edinburgh as a 'social enterprise'**

University of Edinburgh Centre as a social enterprise	
Strengths	*Challenges*
The Gold Standards Framework www.goldstandardsframework.org.uk as a social enterprise has influenced the 'independent' care home sector in England and Wales	Difficult to influence NHS care if outside it
Would be less bureaucratic than doing with NHS health and social care	

Option D: **The multi-partnership model**

The 'multi-partnership model' Health and social care; not-for-profit care home organisations; Lothian Universities	
Strengths	*Challenges*
Extremely innovative – with possibly two 'not for profit' care home organisations keen to partner	The number of partners might make it more difficult to lead
Partnership across so many different organisations could promote greater financial stability at a time of NHS austerity	
Greater number of partners might dissipate specific tensions	
Is still within health and social care partnership	
Increases likelihood of creating career pathway because of university involvement	
Dissipates isolation of the care home industry	
Potential to improve care across all care homes in Lothian	

6.5 Important aspects of a potential site

The Centre needs to be sited in an area with the following criteria:

- Within an established local community and on a bus route
- Near a local medical practice or having one on-site
- Easy access for students
- Close to university activity
- Opportunity within locality to have contact with primary and secondary schools

6.5.1 Three potential sites have been identified:

1 The former Royal Victoria Hospital site, Comely Bank
2 In the Bioquarter near the medical schoole at Royal Infirmary of Edinburgh, Little France
3 A site on Easter Road

Table 6.2: Comparative strengths and challenges of the three sites

SITE	Strengths	Challenges
1	Easy access to local community to encourage community engagement and volunteering Near Western General Hospital (WGH) so easy access for students and potential site for NW locality Hub Near WGH and easy access to consultants in medicine for the elderly and X-ray facilities Big site that would accommodate not only a care home centre of excellence but could also house: - 'step up and step down' facility - day support centre - advanced dementia care team - student accommodation - outdoor space for residents - apartment living for vulnerable adults Site has a history of providing for health and social care for older people – land owned by Scottish Government and currently rented by NHS Lothian Beautiful grounds to encourage outdoor activity Neutral area for involvement with all Lothian universities Local area might provide good volunteers for the 1st teaching/research-based care home in Scotland	Land coming up for tenure in April 2017
2	Have significant 'buy-in' from University of Edinburgh Provide a 'living lab' for students from varied backgrounds Ease of reach across settings Next to 'out of hours' care	Could be perceived as a University of Edinburgh venture Not close to community Residents might be isolated 'on a campus' Potential difficulty in attracting volunteers from local area
3	Site available for sale Near the football club – good for those residents interested GP practice going to be situated at the football ground Neutral area for involvement with all universities	Potential difficulty in attracting volunteers from local area Need to buy land

CHAPTER 7

OPERATING ASSUMPTIONS

7.1 Operating Assumptions – programmes and services to be provided:

The contents of this chapter have been modelled around the preferred components of care extrapolating information from other care providers. The specific operating assumptions will depend on the partnership model agreed, the details of which have not been negotiated at the time of the conclusion of this Feasbility Report.

Programmes and services to be provided:	**HOUSEHOLD – dependency level: 3/4**	**APARTMENTS – dependency level: 1/2**	**Day Care**
CARE	10-12 bedded 'HOUSEHOLDS' (Total of 6) – incorporating residents with: • Physical & mental frailty • Advanced dementia • Distressed behaviour • Emergency respite and/or end-of-life care One HOUSEHOLD will be dedicated to: • Step up/step down • Planned active respite Occupancy: 96% Each HOUSEHOLD will have 3 staff from 08.00hrs to 22.00hrs (1:4): 1 senior social carer; 1 social carer; 1 assistant social carer/host. Nurses will work across the HOUSEHOLDS during the day. At night: one social carer will work on each HOUSEHOLD with 1 nurse and 2 senior social carers working across units.	1-2 bedded APARTMENTS for up to 85 people over the age of 65yrs Occupancy: 96 – 100% Have APARTMENT manager who can call on 'care at home' or the HOUSEHOLD nurse during the day. Apartments have 'buzzers' for night time assistance	Up to 20 people/day Staffing will consist of a Day Care Manager and 3 staff

	The 'distressed behaviour' unit will have 1:3 ratio (i.e. 4 staff) during day + 2 staff/night. Staff will work 7.5hr shift x 2 (07.30 to 15.00hrs shift; 14.30 to 22.00hr shift) + night shift (21.30 to 08.00hrs) Cleaner – 2.5hrs/HOUSEHOLD. The above represents paid positions – we anticipate these numbers will be supplemented by students on placement who will contribute to the delivery of care.		

Programmes & services to be provided for:	**The Centre's STAFF**	**Student placements:**	**Volunteers**	**Staff from other local care homes - secondments**
KNOWLEDGE & SKILLS DEVELOPMENT	• 75% will have SVQ2 • 25% will be working towards SVQ2 • Encouraged to undertake courses in palliative care, dementia, • Practice teacher at the Centre would mentor students • Nurses/AHPs would be encouraged to undertake CPD & Masters modules	• Social care mentor • Assessment of students need to be developed with the different academic units for the following students: social care staff, nursing, medicine, social work, dental hygiene etc	• All volunteers will be given an induction course of 6 weekly evening lectures • Will be asked to work a minimum of 4hrs/2 weeks • Reviews every two years • Volunteers will be allocated to specialising groups	• Secondments will be offered to staff from failing care homes • A development of the Centre could be for Centre staff to help with 'exchanges' from and to other care homes – especially when a specific need is apparent

Programmes & services to be provided for:	Centre's internal quality improvement & research agenda	Centre's quality improvement and research projects across region	Involvement with national and international research programmes
RESEARCH & QUALITY IMPROVEMENT	• PACE-S [developing palliative & end of life care] • Delirium • Polypharmacy and de-prescribing	• PACE-S [developing palliative & end of life care] – www.eupace.eu	• **Newcastle** • **Leeds** • **Bradford** • **Norway** • **The Netherlands** • **Australia**

7.2 Operating Assumptions – equipment

	HOUSEHOLD – dependency level: 3/4	Apartments – dependency level: 1/2	Day Support
EQUIPMENT	• Each bedroom/ensuite – fitted unit and fridge; queen-size bed; bedrails; arm chair (with wheels) • Ensuite – shower, shower seat, basin and lockable cabinet for medication • TV in each lounge • Sofa x 2 • Comfortable armchairs x 6 • Dining table and chairs for 12-16 people • Preferably 'hoist' in casement by bed in each room – otherwise two hoists per HOUSEHOLD (£3,000 /each) • Movement sensors in each bedroom • Wheelchair x 4 for each HOUSEHOLD some of which will be recliners • Commodes x 4 • Fans x 2 for each HOUSEHOLD • Oxygen concentrators • Mixture of laminate and carpeted flooring	• Fitted as 'dementia friendly' flats – light/airy • Lifts	• 20 Loungers for rest after lunch • Tables & chairs • Computer

7.3 Operating assumptions – staff salaries/benefits

During this study, we have appreciated that there are considerable differences between staff working in private care home organisations ('for profit' and 'not for profit') and council care home organisation. All care home organisations have different salary scales and benefits and these in turn differ significantly from the NHS.

Salaries are discussed further in Chapter 8 and are modelled based on the independent sector rather than the NHS. This would encourage people to work at the Centre in order to learn and develop skills in order to move on to more responsible positions in other care homes.

Within the private sector there has been no assured pension, unlike working within the NHS or local authority. However, any future assured pension on the current scale of the NHS and local authority is unlikely. Work-place pensions are now more commonplace. Oncosts have been included in the modelling – these account for full sick pay (not statutory), pension contributions of 6% and variation in annual leave based on length of service.

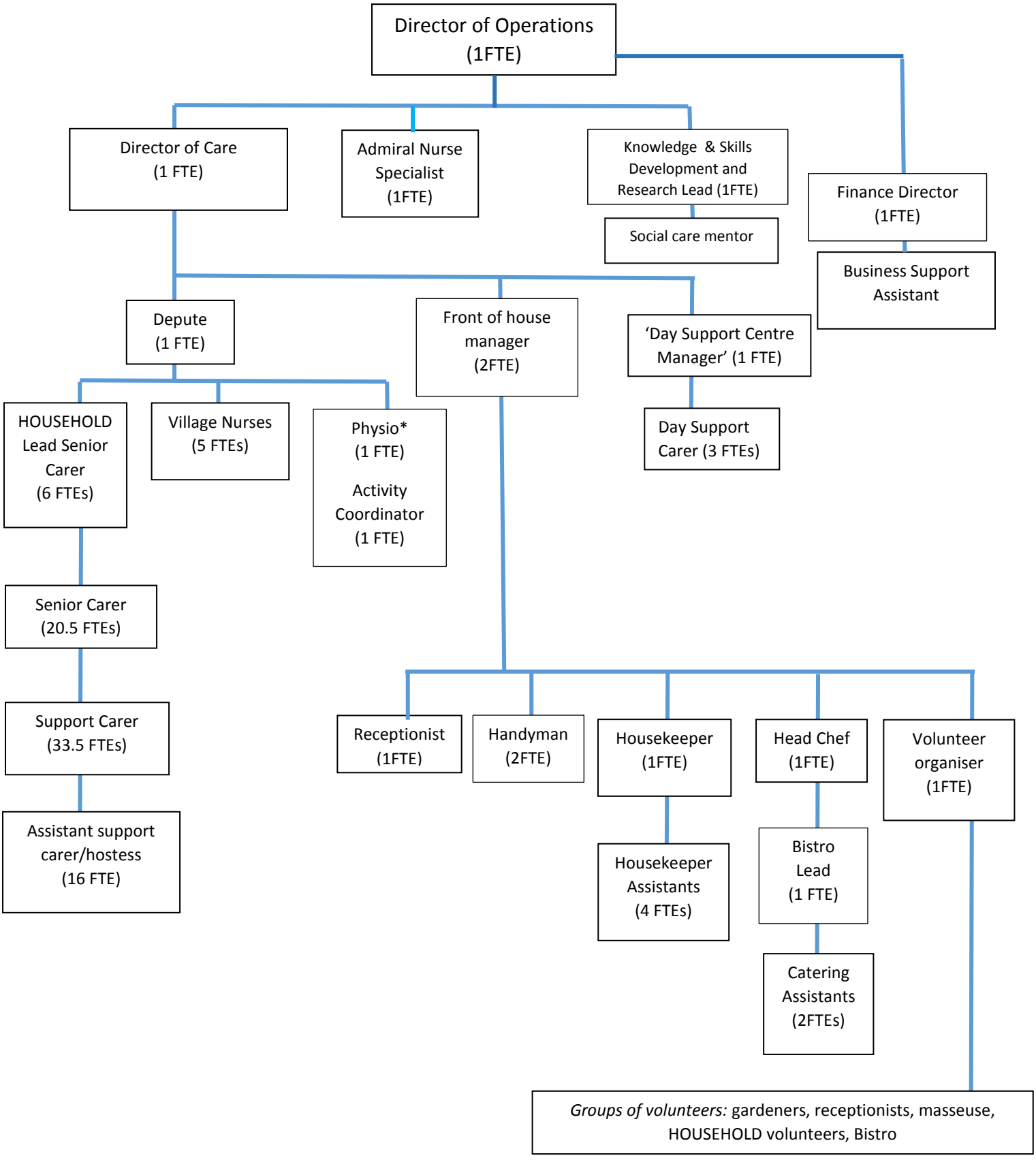
7.4 Organisational structure

This study has taken into account numerous organisational structures both within the NHS/Local Authority as well as in the independent sector such as hospices and different care home organisations (see Appendix 4).

Out of all the models visited which have helped us to formulate the Vision for the Centre, it has been the BELONG Care Village that has been specifically interesting. It has taken on the concept of greater autonomy in the design of HOUSEHOLDS. Such a design has been highlighted within The Hogewey Dementia Village, Amsterdam but instead of 6 people to a villa as in The Hogewey, it is thought that a 12-bedded HOUSEHOLD is more appropriate for the purposes of the Centre.

Figure 7.1 overleaf outlines the potential organisational structure for the whole Centre and includes not only the structure for the HOUSEHOLDS but also for the APARTMENTS and the care at home.

Figure 7.1 Potential organisational structure for Centre: HOUSEHOLDS, APARTMENTS, AND Day Support Unit [* pharmacists, GPs and other medical specialists will come in from outside the Centre]



CHAPTER 8

FINANCIAL FEASIBILITY

The contents of this chapter have been modelled around the preferred components of care, extrapolating information from other care providers that have included a 'not for profit' care village organisation, a 'not for profit' care home organisation with housing, and the local authority. It has been adapted for the Edinburgh and Lothians care home market recognising variation in regional provision. The financial feasibility will be driven by the operating assumptions which depend on the partnership model agreed. If this report is approved then a fully costed financial report would be prepared in collaboration with the agreed partners.

All tables need to be interpreted with caution and will depend on an in-depth financial costing.

8.1 Capital Costs:

- **Acquiring and developing the site:**
  At present this is unknown until further discussions have taken place and available locations earmarked for consideration and their acquisition cost understood.

  The steering group has a Vision for the Centre being part of a care village rather than a traditional stand-alone care home. The Centre would be at the heart of the village surrounded by APARTMENT housing with care, student accommodation and community facilities.

- **New build:**
  It is the steering group's Vision that the Centre (teaching/research-based care home) will require to be a new build to achieve its aims.

  As this study has developed, the Vision has grown from that of a traditional corridor care home model to that of a Care Village where rent/cost for APARTMENTS for older people over the age of 65 years help to off-set other costs of the Centre – in particular care within the HOUSEHOLDS. Some care home organisations are finding it difficult to survive the current financial climate of intense care – many of which have not diversified to take on 'sheltered housing' or apartments within a care village design.

  It is very difficult to compare a 'HOUSEHOLD' and 'APARTMENT' Care Village model with a traditional care home, as the communal areas are an integral part of this innovative model. Data from a recent 'care village' build that we have been given, and one that we would cost (including land, financing costs and professional fees) at around £1,936/m^2.

Table 8:1: Capital costs for 73-bedded HOUSEHOLDs only

Capital Costs			
Land, Financing, Professional fees	£	1,986,840.00	Appartments, Student Accommodation not included
Construction Build	£	6,509,160.00	Carpets and fitted wardrobes included
Fixtures & Fittings	£	748,800.00	Including all communal rooms
Contingency	£	650,916.00	10%
	£	9,895,716.00	

NB – costs are estimates to be revised once partnership model determined

8.2 Operating costs:

- The Centre wants to attract and retain staff because it is a Centre of Excellence.
- Salaries therefore are based on those from the independent sector and applied to a 72-bedded HOUSEHOLD, a Day Community Centre and extra-care APARTMENT costs (see Table 8.2 overleaf).
- On-costs of 20% have been added and accounts for full sick pay (not statutory), pension contributions at 6%, and 7-weeks' paid annual leave with variation based on length of service. This is a higher percentage than many independent care home organisations who often only contribute 1% towards staffs' pension.
- The operating costs overleaf include only salaries and do not include any other operating costs at present such as property management costs (e.g. routine maintenance, insurance, rates) and service costs (e.g. gas and electricity, equipment, catering).
- There will be costs to enable social care staff who are new to care work to undertake SVQs which is likely to be in the region of £900/per person.

Table 8.2: Salary costs for Care Village Centre*

Management	FTEs	Salary	Annual Cost	Total Annual Cost	
Director of Operations	1	£ 53,818.00	£ 64,581.60	£ 64,581.60	
Skills and Knowledge Developmer	1	£ 43,038.00	£ 51,645.60	£ 51,645.60	
Socila Care Mentor	1	£ 36,250.00	£ 43,500.00	£ 43,500.00	
Director of Care - Village Manager	1	£ 43,038.00	£ 51,645.60	£ 51,645.60	
Deputy	1	£ 39,539.00	£ 47,446.80	£ 47,446.80	
Front of House Manager	1	£ 32,904.00	£ 39,484.80	£ 39,484.80	
Admiral Nurse	1	£ 39,539.00	£ 47,446.80	£ 47,446.80	
Business Support Assistant	1	£ 28,000.00	£ 33,600.00	£ 33,600.00	
Total				£ 379,351.20	
Care Staff					
Village Nurses	5	£ 229,958.00	£ 275,949.60	£ 275,949.60	*
Household leads (Team Leaders 7.	6	£ 27,500.00	£ 33,000.00	£ 198,000.00	
Senior Carer Day (7.5hrs)	18	£ 25,298.00	£ 30,357.60	£ 546,436.80	
Senior Carer Night (10hrs)	2.5	£ 94,868.00	£ 113,841.60	£ 113,841.60	*
Support Carers Day (7.5hrs)	20	£ 22,726.00	£ 27,271.20	£ 545,424.00	
Support Carers Night (10hrs)	13.5	£ 460,202.00	£ 552,242.40	£ 552,242.40	*
Host	16	£ 19,768.00	£ 23,721.60	£ 379,545.60	
Activity Organiser	1.5	£ 28,551.00	£ 34,261.20	£ 51,391.80	
Physio	1	£ 30,661.00	£ 36,793.20	£ 36,793.20	
Total		£ 939,532.00		£ 2,699,625.00	
Operational Staff					
Receptionist	1	£ 17,425.00	£ 20,910.00	£ 20,910.00	
Volunteer Organiser	1	£ 17,425.00	£ 20,910.00	£ 20,910.00	
Head Chef	1	£ 22,726.00	£ 27,271.20	£ 27,271.20	
Bistro Lead	1	£ 19,768.00	£ 23,721.60	£ 23,721.60	
Catering Assistants	2	£ 17,425.00	£ 20,910.00	£ 41,820.00	
Handyman	2	£ 17,425.00	£ 20,910.00	£ 41,820.00	
Housekeeper	1	£ 19,768.00	£ 23,721.60	£ 23,721.60	
Housekeeper Assistants	4	£ 17,425.00	£ 20,910.00	£ 83,640.00	
Daycare Hub Team Manager	1	£ 32,904.00	£ 39,484.80	£ 39,484.80	
Day Community Support Carers	3	£ 22,726.00	£ 27,271.20	£ 81,813.60	
Total		£ 205,017.00		£ 405,112.80	
		£ 1,144,549.00		£ 3,484,089.00	£ 696,817.80
					£ 2,787,271.20

*FTEs have been worked out using: Seven Day Ward Professional Judgement Staffing Formula.[88] Time-and-a-half has been given for equivalent night-duty hours.

NB – costs are estimates to be revised once partnership model determined

8.2.1 Regulation costs:

Regulation costs will vary as to the different aspects of the care eventually provided by the Centre. At present regulation costs for the HOUSEHOLD Centre, Community Hub for people with dementia, Community Hub for frail older people, and the service given to people in the APARTMENTS and 'respite at home' have been estimated (see Table 8.3)

Table 8.3: Care Home Regulation Costs

	Initial Regulation Costs	Ongoing Yearly Cost of Regulation
Care Home organisations (i.e. HOUSEHOLD)	£3,849	£11,304
Community hub – day care for early onset dementia and day care for frail older people	£3,422	£1,711
Care at Home (agencies)	£1,261 (under 3FTEs) £2,050 (under 15 FTEs)	£676 £1,476

8.4 OPERATING REVENUE (sources and amounts):

The Centre will have extra-care APARTMENTS for people aged >65 years that can be rented or bought (see Table 8.4). This will help to off-set the costs from the HOUSEHOLDS – but will need further financial analysis. Care required by people in the APARTMENTS would be provided by the HOUSEHOLD team and charged at £20/hour.

Table 8.4: Revenue from extra-care APARTMENTS

APARTMENTS	RENTAL		PURCHASE		COMMUNITY FEE		Additional person
	1 bed	2 bed	1 bed	2 bed	1 bed	2 bed	
	£124.20	£148.55	£134,000	£159,000	£87.86	£94.94	£15.61

Revenue from the HOUSEHOLDS, has been calculated on both a 30/70 (percentage of Local Authority funded places/self-funders) and a 40/60 ratio (See Tables 8.5 and 8.6). Incomes are estimates to be revised once the final partnership model is determined.

Table 8.5: Income from admission of residents to the Centre (30/70)

Income	
No of Beds	72
Local Authority funded (%)	30%
Self-Funded (%)	70%
Average Weekly Council Fee	£600.00
Average Weekly Self Funder Fee	£1,200.00
Average Vacancies (%)	5%
Calculated Weekly Fees (Base)	£73,440.00
Calculated Weekly Vacancies (Base)	£3,672.00
Net Weekly Fees	£69,768.00
Annual Turnover	**£3,627,936.00**

Table 8.6: Income from admission of residents to the Centre (40/60)

Income	
No of Beds	72
Local Authority funded (%)	40%
Self-Funded (%)	60%
Average Weekly Council Fee	£600.00
Average Weekly Self Funder Fee	£1,200.00
Average Vacancies (%)	5%
Calculated Weekly Fees (Base)	£69,120.00
Calculated Weekly Vacancies (Base)	£3,456.00
Net Weekly Fees	£65,664.00
Annual Turnover	**£3,414,528.00**

When considering income from admissions of residents to the HOUSEHOLDS at the Centre and the cost of staff salaries (see Table 8.2), there is a slight profit with 30/70 Local Authority funded/self-funders ratio. There is a slight deficit if a 40/60 ratio is used.

8.5 OTHER REVENUE

The various educational courses held at the Centre for local care home staff will also bring a revenue. One of these courses will be the volunteer programme for care home organisations across Lothian – and further afield following demand. Revenue is also likely to be gained from some undergraduate/postgraduate placements.

The Centre will also promote the opportunity for a service to support carers with a 'respite at home' service. For example, instead of a frail older person being admitted for respite care when their family go on holiday, the Centre would develop a 'respite at home' service where it would provide 24-hr care for 1-2 weeks in the person's home. This enables the person to remain in their own environment, reducing any confusion/anxiety while the family are on holiday.

We have been approached by two 'not for profit' care home organisations which would be interested in working with the Centre – one of which may also be interested in helping with building costs.

Other revenue, especially within the wider practice development of local care homes, will be sought through various research bodies and funders of quality improvement initiatives for the outreach to other care homes in the region. There would be an expectation that care homes would pay to take part in the quality improvement initiatives. Already, grants have been successfully achieved for previous research from:

- Robertson Trust
- Burdett Foundation
- Chief Scientist Office for Scotland

As the Centre will be a not-for-profit organisation, any profit created from conferences, respite at home or revenue from other care homes will be invested in the Centre

Other sources of revenue, such as sponsorship, can be explored once the partnership model is determined.

8.6 Income and expenditure statements for the next five years:

Detailed income and expenditure statements would be produced once initial assurance has been given for the Centre.

8.7 Identify operating surplus and opportunity for on-going growth

Detailed statements for income and expenditure, together with means of identifying any operating surpluses and opportunities for on-going growth, will be produced once initial assurances have been obtained for the Centre.

CHAPTER 9

RISKS

9.1 Risks & Risk Mitigation

There are risks with any project, and this is a large and expensive one and therefore risks must be identified and assessed as to their impact, likely probability and the level of need for review and mitigation.

Table 9.1 (overleaf) provides a summary of the risks identified and how they may be mitigated

Table 9.1: Risks

No	Category of risk	Description of risk	Cause of risk	Mitigation of risk	Impact	Probability	Gross	Review frequency
1	Policy	Loss of momentum between articulating the vision and the final build.	Decision making for a capital build takes time	Ensure continued engagement of key players. Work in partnership with players beyond health and social care. Active engagement of satellite care homes prior to completion of the Centre.	5	2	10	Regular review of communications and engagement strategy by governance group.
2	Policy	Vision is too ambitious.	Failure to supply the resource required to challenge current perceptions of old age and of the caring roles	In depth feasibility study which includes financial feasibility. A new build could allow for development of a fresh culture. Work to challenge the current perceptions of the caring roles eg through career development. Strong engagement and links with other areas where there is a similar challenge to a prevailing culture.	5	2	10	Clear articulation of the vision as the second stage progresses and regular review of the communication of this.
3	Policy	Failure to achieve cohesion between the partner organisations operating the Centre.	Diffuse partners with different priorities, budgets, and approaches.	Regular facilitated opportunities to ensure cohesion as part of the agreed governance structure. Communication channels to ensure escalation of concerns and mechanisms to address these.	5	3	15	A characteristic of the Centre will be regular review of its ethos and purpose. This risk will be on the Centre's operational risk register.

				Regular reporting against agreed contributions.				
4	Policy and reputation	Vision cannot be sustained over time – either loses momentum or becomes an 'ivory tower'.	Loss of momentum due to staff turnover, rising expenses, and failure to continue to engage with key groups who support the centre. Failure to sustain a culture that is open to challenge. Failure to address the potential for care homes to become isolated from other centres. Failure to maintain a flow of expert and trained staff to other care homes.	Regular review of key aims, objectives and policies. Strong governance structure with a structured system of accountability. Regular review of quality improvement initiatives and research in a shifting environment. Systems to ensure circulation of trained staff and mechanisms to connect with other areas of practice. Strong family and volunteer focus to minimise isolation of care home.	5	3	15	This is a high net risk and requires to be regularly reviewed.
5	Policy and Reputation	Failure to place the resident and the family at the centre of the care.	Focus on research, training of students and staff, and compliance with the regulations.	Resident and family engagement from the outset - included in the visioning afternoon and subsequent feasibility study. Clear articulation of the approach to care that is person centred/relationship-based. Use of volunteers and student placements to promote resident/family quality of life. Location of Centre near an existing established community. Clear roles and lines of accountability to ensure clarity of purpose and approach.	2	2	4	This requires regular monitoring and will be on the operational risk register of the Centre.

				A collaborative approach to research using co-production with families, residetns and staff.				
6	Operational	Dependence on key project lead.	Limited funds to share responsibilities	Lessons learned from Oxford experience 1999/2003. A feasibility study following a known process ensures practical viability and explores sustainability. Project lead supported by team at University of Edinburgh. Strong governance mechanism for feasibility study.	4	2	8	Establishing of governance structure for the work following the feasibility study.
7	Financial	Failure to secure start-up capital.	Failure to communicate vision and secure engagement of sponsors. Reliance on only one source of funds.	Approach a variety of sources of funds	5	1	5	This risk will be closed on completion of the build.
8	Financial	Failure to maintain the Centre financially.	An imbalance between self funders and other residents. High staff costs. Unforeseen costs not anticipated in the feasibility study.	Feasibility study has identified 70% self funders is required. Apartment accommodation for frail older people with a low dependency level of 1 or 2 to bring in rent. Use of volunteers. Use of student placements. Robust interrogation of feasibility study by financial and care home experts.	5	4	20	This is a high net risk and requires to be regularly reviewed.
9	Legal, Regulatory and Reputation	Failure to secure 'excellent' regulatory rating after setting up the Centre.	Complexity of different regulatory requirements for different aspects of the centre and failure to	Care Inspectorate representation on the steering group overseeing the feasibility study.	5	4	20	This requires regular monitoring and will be on the operational risk register of the Centre.

			organise a response to these requirements.	Maintain access to professional advice. Identify key requirements and monitor and report on these within a robust governance structure.				
10	Engagement and Reputation	Failure to attract inspirational leadership.	Failure to articulate the Vision in the appropriate channels. Salary perceptions and expectations.	Vocational ethos in the whole Centre. The Centre will initially be a visionary project which should attract inspirational leaders. The time taken to build should allow time to source and involve leaders.	5	1	5	A Governance mechanism will ensure staff appraisal, recruitment, retention and movement to other centres are regularly reviewed.
11	Engagement	Failure to secure right staff for Centre.	Current difficulty of attracting high calibre staff in care homes.	Wide and sustained promotion of the vision to attract staff. A new build to help establish a new culture. Vocational ethos in the whole Centre.	5	2	10	This requires regular monitoring and will be on the operational risk register of the Centre.
12	Engagement	High staff turnover.	Reflects current situation of care home staff due to fatigue and financial constraints and lack of external healthcare support.	Strong supportive leadership using a transformational leadership model. Plan for student placements to be part of the team. Buy-in and active support from Medicine for the Elderly and GPs has been secured. Vocational ethos and support for development and career progression for staff.				
13	Engagement	Failure to engage local community to secure support eg for the services on offer at	Poor perception of care homes by society Inappropriate site for the Centre.	Centre location assessed for suitability for community engagement.	3	3	9	This requires regular monitoring and will be on the operational risk register of the Centre.

		the centre and in volunteering.		Strong local community engagement prior to build of Centre. Allocation of staff resource to support and encourage volunteering.				
14	Engagement	Lack of university and Royal College engagement.	The Centre challenges aspects of current and traditional practice.	Key contacts at Napier, Queen Margaret and Edinburgh Universities established. Governance structure will include a subgroup for the University and research contribution.	3	3	9	This requires regular monitoring and will be on the operational risk register of the Centre.

CHAPTER 10

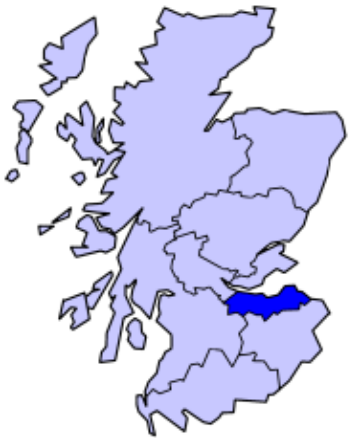
CONCLUSIONS

10.1 Drawing Conclusions:

This Feasibility Report highlights an urgent need for action in relation to the care of frail older people living in care homes. Innovative care home initiatives have been tested locally; but unfortunately none have been established and sustained due to lack of long-term funding.

The World Health Organisation's global strategy and action plan on ageing and health (2016-2020) includes the specific objective of "developing sustainable and equitable systems of providing long-term care".[89]

Care homes are now an integral part of providing the 24-hour care for frail older people in our society. Care home beds in the UK now number three times those of ALL the beds within the NHS. Our Vision for a teaching/research-based care home centre of excellence helps to address the difficulties currently being faced: high turnover of staff, lack of support, lack of a career pathway for all care home staff including nurses, and the need for greater evidenced-based practice. The Centre has the opportunity to set a standard of excellence in care, knowledge and skills development, and research. Furthermore, its benefits have the opportunity to reach beyond the immediate community it would serve by reaching out to other care homes across the region, taking inspiration from various care home initatives and supporting local staff education and quality improvement initiatives.



We draw parallels with the experiences in Norway which established five teaching nursing homes in 1995. These were developed down the 'spine' of the country with each reaching out across the region. Such facilities have helped with recruitment and retention of staff. All care homes in Norway have a dynamic professional workforce that includes physicians and on-site nurses. Now 49% of the Norwegian population die in care homes and 35% die in hospital.[74]

Such a vision of a teaching/research-based care home for each region could be a reality here in Scotland, led by Lothian's example.

10.2 Partnership vision:

At a time of financial austerity, a partnership model is preferable. We have been encouraged by the level of engagement from potential partners.

During the feasibility study there has been engagement with:

- The universities across Lothian
    - University of Edinburgh
    - Queen Margaret University
    - Edinburgh Napier University
- The four Lothian Health and Social Care Partnerships
- 'Not-for-profit' care home organisations within Lothian

In the next stage, these partnerships should be formalised. A key component will be engagement with the health and social care professionals, the community, and other regional care homes. Also, increased engagement with Alzheimer's Scotland and Scottish Care.

10.3 Satellite Care Homes across Lothian:

As part of the Vision, the steering group suggests we start developing the work in potential 'satellite care homes' across Lothian. A 'satellite care home' will be one of high quality reflected, in quality scores from the Care Inspectorate. Three care homes (two 'for profit' – one 'not for profit') have already come forward with an eagerness to be a 'satellite care home' – one in Midlothian and two in south Edinburgh. All have very high ratings from the Care Inspectorate and are already involved in student nurse placements. We believe discussion and development of a wider range of students is a possiblity. These three care homes will be used as 'test sites for change' in order to inform the practicalities for the new Centre.

10.4 Next Steps

The next phase must be well led and coordinated. This will require employed personell dedicated to working on the project, supported by professional stakeholders. The specific governance will depend on the agreed partnership model.

10.4.1 The following sub-groups are anticipated; all will involve lay membership:

- Architecture Group
- Care Facilities Group
- Community Engagement Group
- Education and Career Pathway Group
- Research and Quality Improvement Group
- Finance Group
- Fundraising Group

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APPENDICES

Appendix 1

Table A1: List of people who have informed both the Vision document and this feasibility study

People visited	Position	Area of work
Policy & Government		
Monica Boyle	Accountant	Social Care, City of Edinburgh Council
Jim Crombie Simon Watson Alex McMahon	CEO Head of Quality across Lothian Head of research/innovation	NHS Lothian NHS Lothian NHS Lothian
Graham Cumming	Innovation Team	NHS Lothian & Scottish Government
Colette Ferguson	Director of Nursing, Midwifery and Allied Health Professions	NHS Education for Scotland
David Fotheringham	Housing sustainability and innovative funding division	Scottish Government
Alison Jarvis	Project Liaison, Waverley House	Community and District Nursing, NHS Lothian Waverley Gate, Edinburgh
Niall Kieron	Service Design Manager, Scotland	Marie Curie
Donald McAskell Renee Rigby Katherine Ross	CEO Integration Lead, Independent Sector, City of Edinburgh National Workforce Development Lead	Scottish Care Scottish Care Scottish Care
Rob McCulloch-Graham Katie McWilliam Maria Wilson	Chief Officer Strategic Planning & Quality Manager, Older People, Chief Nurse	Edinburgh Health and Social Care Partnership Edinburgh Health and Social Care Partnership Edinburgh Health and Social Care Partnership
Peter McLaughlin	Strategic Program Manager - Cancer	NHS Lothian
Hazel Marsden Elaine McLean Heather Edwards Donna Gilmour	Team Manager, Registration Team Healthcare Improvement Adviser Dementia Nurse Consultant Older people and care homes – East District	Care Inspectorate, Scotland Care Inspectorate, Scotland Care Inspectorate, Scotland Care Inspectorate, Scotland
Caroline Myles Dawn Barrett	Chief Nurse Service Manager, Older People	Midlothian Health and Social Care Partnership Midlothian Health and Social Care Partnership
Christina Naismith	National Lead for Strategic Commissioning Joint Improvement Team	Scottish Government
David Small	Chief Officer	Health/Social Care Partnership – East Lothian

Jim Forrest Eibhlin McHugh	Chief Officer Chief Officer	Health/Social Care Partnership – West Lothian Health/Social Care Partnership – Midlothian
Robert Skey	Project Manager	COSLA/Scottish Government
Tim Warren	Policy Lead, Scottish Strategic Framework for Palliative and End-of-Life Care	Scottish Government
International Projects Visited		
Kate Barnett	Senior Research Fellow	Unviersity of Adelaide – evaluated care home initiatives set up by Australian Govenerment
Cess Hertogh	Academic Geriatrician at VUU Medical Center, Amsterdam, the Nethelands	Interested in palliative care for frail older people
Colm Cunningham	Hammond Care, Australia	Setting up and evaluating innovative care at Hammond Care
Susan Emerson Helen Loffler Megan Corlis	Director of Care Student Placement Head of Research	Helping Hand – not for profit care home organisation – Adelaide, Australia
Jeff Fiebig	Director	VITA Step Down facility, Adelaide
Marit Kirkevold Susan Saga Kari Sunnervag Bettina Husebo Elizabeth Flo Brian Swann	Professor of Nursing, Norway Director of Care Lead Department of Global Public Health and Primary Care Director of Finance	Developed 'teaching nursing homes' (TNH) across Norway Teaching Nursing Home, Trondheium, Norway Development Centre for Care Homes and Home Care, Bergen, Norway Unviersity of Bergen, Norway University of Bergen, Norway TASTA, Stavanger, Norway
Rod McLeod	Senior Staff Specialist in Palliative Care and Conjoint Professor of the University of Sydney	Hammond Care, Sydney, Australia University of Sydney, Australia
Vivium	The Manager	The Hogeweyk Dementia Village on outskirts of Amsterdam, The Netherlands
Academic		
Helen Cameron Olayinka Ogundipe	Director of the Centre for Medical Education, Medicine of the Elderly,	The University of Edinburgh Royal Infirmery Edinburgh/Liberton Hospital
Tracy Humphrey Angela Kydd Gil McCrossan Ken Dick	Dean of Health Sciences Ass Professor Older People's Nursing CHEF (Care Home Education Facilitator) Lothian	Edinburgh Napier University Edinburgh Napier University Edinburgh Napier University Edinburgh Napier University
Brendan McCormack Fiona Kelly	Director of Nursing Research Fellow	Queen Margaret University Undertaking applied research in care homes Queen Margaret University
Mary Marshall	Honorary Professor	ECRED, University of Edinburgh 'Dementia friendly' environments. Hammond Care, Sydney, Australia
Gillian Mead	Academic and clinical lead for medicine of the elderly	Royal Infirmary Edinburgh + University of Edinburgh
James Cox	Practice Learning Fellow	School of Social and Political Science University of Edinburgh
Sarah Rhynas	Post-doctoral Fellow	Unviersity of Edinburgh

Tonks Fawcett Charlotte Clark	Director of Student Learning Head of the School of Health in Social Science	Unviersity of Edinburgh Unviersity of Edinburgh
Heather Wilkinson Julie Watson	Director, ECRED Post-doctoral Fellow	Edinburgh Centre for Research in the Experience of Dementia University of Edinburgh
Clinical		
Kath Anderson Hilary Gardner Audrey Pringle	Geriatrician, WGH Advanced Nurse Practitioner WGH Advanced Nurse Practitioner	Set up the Care Home Liaison Team at WGH(north Edinburgh)
Tricia Cantley	Consultant in Medicine for the Elderly	Community Team – MERIT Midlothian
Alison Cavinue	Senior Nurse	Care Home Liaison Team, Aidrie, Lanarkshire
Andrew Coull	Consultant in Medicine for the Elderly	COMPASS
Jane Ferguson	Director	Edinburgh and Lothians Health Foundation
Shirley Fife	Director of Nursing	Specialist palliative care/cancer – Lothian (community)
Jean Hannah	GP	Set up Glasgow enhanced service to nursing care homes
Shirley Law	Co-Director	Dementia Care Centre, Stirling
Juliet MacArthur	Chief Nurse, Research and Development	NHS Lothian
Sarah McConachie	GP	Undertaking MSc in CHs (Craigmillar Practice)
Catriona Morton	Lead	Lothian Medical Council
Val Reid Jan Dobbins	Senior Nurse Senior Nurse	East Lothian
Emma Reynish	Consultant	Older People's Medicine RIE and Dementia Care Centre, Stirling
Maggie Scrugham	Social Care	Edinburgh Health and Social Care Partnership
Andy Shanks	Lead – frail older people at home + training of carers	Edinburgh Health and Social Care Partnership
Gillian Taylor	Senior Nurse	Hospital-based Complex Care Units
Care Homes		
Ann Frees Cheryl Henderson	Director of Care Development Educator	Cluny Lodge Nursing Home, Edinburgh Cluny Lodge Nursing Home, Edinburgh
Mandy Cooper	Director of Care	Murrayfield Nursing Care Home, Edinburgh
Tracy Payne Tracey Stakes	Director of Operations Finance Director	BELONG Wigan Care Village, Wigan BELONG Wigan Care Village, Wigan
David Miranda Jackie Stone Andrew McBain	GP Head Nurse Social Care	Guilemuir Care Home Guilemuir Care Home Guilemuir Care Home
Anne Woods Jeannie Garving	Consultant Nurse Head of CAre	The Tor Nursing Care Home
Dorry McLochlan Donna McLeod	CEO Director of Care	Viewpoint Housing
May McCondichie	Director of Care	Archview Nursing Home, Dalkeith
Sian Donkin	Manager	Drumbrae Care Home New style Council of Edinburgh Care Home

Hospices		
Anne Finucane Libby Milton	Head of Research Head of Community Care	Marie Curie Edinburgh (Fairmile)
Libby Gold	Director of Care	Rachel House, CHAS, Kinross
Gill Hamilton	Former Volunteer Organiser	St Columba's Hospice
Emma Hodges	Director of Care	St Giles Hospice
Jackie Husband Ian Adams Erna Haraldsdottir	CEO Finance Director Director of Education	St Columba's Hospice St Columba's Hospice St Columba's Hospice
Kenny Steele Jeremy Keen Kathryn Hamling Jackie Hodges	CEO Medical Director, Director of Care Head of health and social care (care homes)	Highland Hospice Highland Hospice Highland Hospice The Highlands
Others		
Maire Curran	HMC Improvement Consultancy Ltd	Kirkcaldy
Fiona Selkirk	Communications consultant	Paisley

Appendix 2 – questionnaire to care homes

The context of care homes in Lothian: dependency, workforce and education

Description of Care Home:

1. Name of care home (optional):

2. Please tick the box to describe your care home:

   a) Part of a large 'for profit' organisation ☐

   b) A family-run 'for profit' organisation ☐

   c) Part of a small 'voluntary/charitable organisation' ☐

   d) Part of a large 'not-for-profit' organisation ☐

   e) Local Authority care home ☐

3. **Bed occupancy:**

   a. How many beds does the care home have? ☐

   b. To-day – how many beds are unoccupied? ☐

   c. Do you accept residents funded through the Council? (circle as appropriate)
   Yes No

4. What categories of resident care is provided by your care home (please circle as relevant):

   a) Frail older people Yes No
   b) Specialist dementia Yes No
   c) Challenging/distressed behaviour Yes No
   d) Palliative Care Yes No
   e) Respite care Yes No
   f) Rehabilitation Yes No
   g) Day care Yes No
   h) Other – please specify:

Frailty of current residents:

5. Today, how many of your residents are 85 years or over?

6. Do you use a 'dependency' tool? (please indicate)

   Yes ☐ No ☐

   If 'yes' what tool do you use and how often is dependency collected?

7. If 'yes', please can you give last month's dependency score percentages for 'low and medium' and 'high and total care' below:

Type of dependency	*Percentage of residents*
'low and medium'	
'high and total care'	

Levels of care staff training:

8. How many care staff are on duty today? ☐

9. How many of <u>these</u> care staff are working as 'registered nurses' ☐

10. What percentage of care staff in your care home have SVQ level 2 training or above?

    ☐

11. What percentage of care staff in your care home have no care-specific qualification yet?

    ☐

Level of medical input to care home:

12. Do you have a lead GP practice giving medical support to residents in the care home? [Please circle as appropriate]: Yes No

    a) If **'yes':** do you pay a retainer? Yes No

    b) If **'yes':** how many sessions (morning = 1 session) each week does GP visit ☐

    c) If **'no'** to Q.12 do you have a 'lead' GP practice visiting majority of residents? Yes No

    d) ….and how many different GP practices support the care home? ☐

13. Which healthcare professionals regularly visit residents – circle as appropriate:

a)	Community Psychiatric Nurse		Yes	No
b)	Dementia Nurse Specialist	Yes	No	
c)	Dentist	Yes	No	
d)	District Nurse	Yes	No	
e)	Geriatrician	Yes	No	
f)	Motor Neurone Nurse Specialist		Yes	No
g)	Old-age psychiatrist	Yes	No	
h)	Parkinson's nurse specialist	Yes	No	
i)	Specialist Palliative Care		Yes	No
j)	Tissue Viability Nurse		Yes	No
k)	Other:			

14. Between 1st April 2015 - 31st March 2016 :

a) How many residents died in the care home? ☐

b) How many residents died in hospital? ☐

Links with universities, training colleges and other institutions

15. Do you have 'student placements' in your care home? ☐ Yes ☐ No

If 'yes' please state:

a) Which institution/university do students come from?

b) How long are their placements generally?

c) How many mentors do you have for the care home?

d) What support do mentors get from care home organisation?

16. Please use the box 'on the other side of this page' to add anything else you would like to say…….

THANK YOU SO VERY MUCH FOR YOUR TIME – please return questionnaire in the stamped addressed envelope provided <u>by 30th June</u>

Date completed:

Manager's email:
[please add email address if you would like to receive 'vision document' for teaching/research-based CH]

Further comments:

Appendix 3 – Volunteers

Table A3.1: Examples of where volunteers can enhance care

Gardening	Library
Driving people to clinic or day support unit	Cafe
Day Support Unit	Reception
Wards – giving out water jugs, engaging with project such as baking	Fund raising
Special Events – such as a Garden Party	Helping with Namaste Care programme

Table A3.2: Volunteer Organiser's role

1	Recruit (and dismiss when necessary) volunteers.
2	Produce and provide for all volunteers a **policy document** which covers Centre policies on such topics as 'loss' and 'dementia'.
3	Organise **PVG checks** for all volunteers before they start in the Centre.
4	Provide each volunteer with a **contract,** which covers their duties and responsibilities (including requirement for resident confidentiality), line management, complaints procedures, training &etc.
5	Keep good records of all volunteers and take a genuine interest in their health, their families (including being aware of any changes in family circumstances which might affect their 'work') and also when they return from approved 'holiday'.
6	Deliver an initial familiarisation induction for new volunteers before they start or on their first day.
7	A comprehensive induction programme for all volunteers every six months: One evening/week for six weeks: covering such topics as the organisation, volunteers, students, dementia, loss & grief, finances and student training.
8	Hold a one-to-one support meeting with each volunteer every two years
9	Organise the production of a 6-monthly newsletter for volunteers
10	Organise an annual social event for volunteers
11	Organise an annual award ceremony – to mark length of service to the Centre.

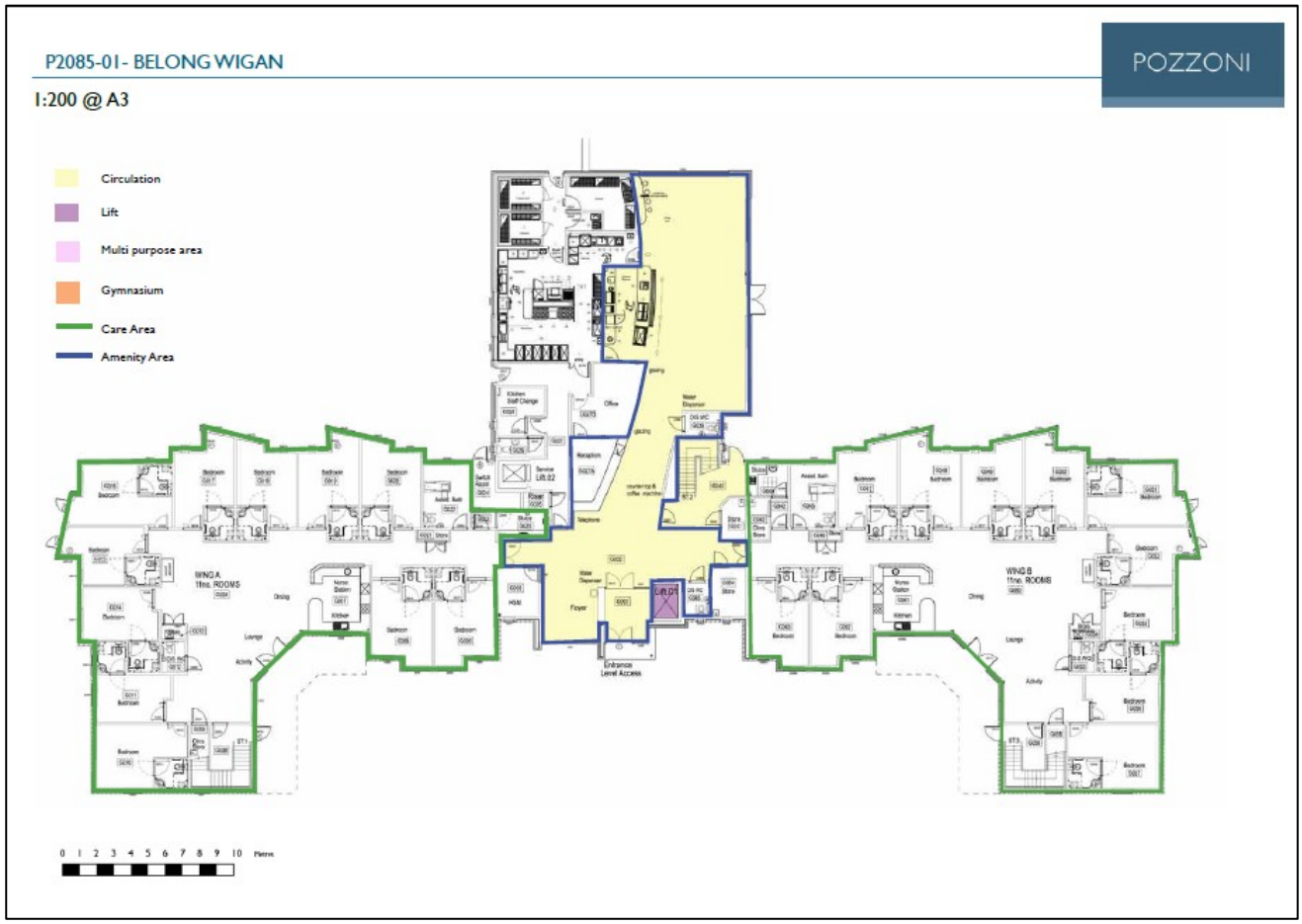
Appendix 4 – Successful 'not for profit' organisations

Table A4: BELONG Care Villages, NW England, UK

Best of BELONG
Not for profit organisation – very reasonable prices for both residential and nursing care residents
Non-institutional
Innovative Care – In HOUSEHOLDS ○ Homely design of 11-12 beds to a 'HOUSEHOLD' ○ The lounge/dining area can be seen from most bedrooms ○ A ratio of 1:4 for each HOUSEHOLD – host, senior support worker, and support care worker ○ Insist on 7.5hr shifts except for night duty ○ Insist that all mobile phones are not used while on duty in the HOUSEHOLD HOUSEHOLD staff eat meals with the residents All HOUSEHOLD have either garden or large veranda
Agree re importance of nurses on-site in HOUSEHOLDS
○ Has residential apartments as part of the scheme – that can be bought as well as rented
Commercial hairdresser salon open to relatives and people from outside – not just residents, so more like a high street salon
Innovative Activities ○ Children's play area ○ Bistro for people within the care home as well as outside ○ Beautiful gardens and barbecue area ○ Venue Room that can be used as a cinema or rented out to family for special occasions. Also has a Bar.
Innovative Training ○ Has a competency document for all nurses ○ RCN agrees to train all their nurses for competency
Has a domiciliary team working with people in their own homes

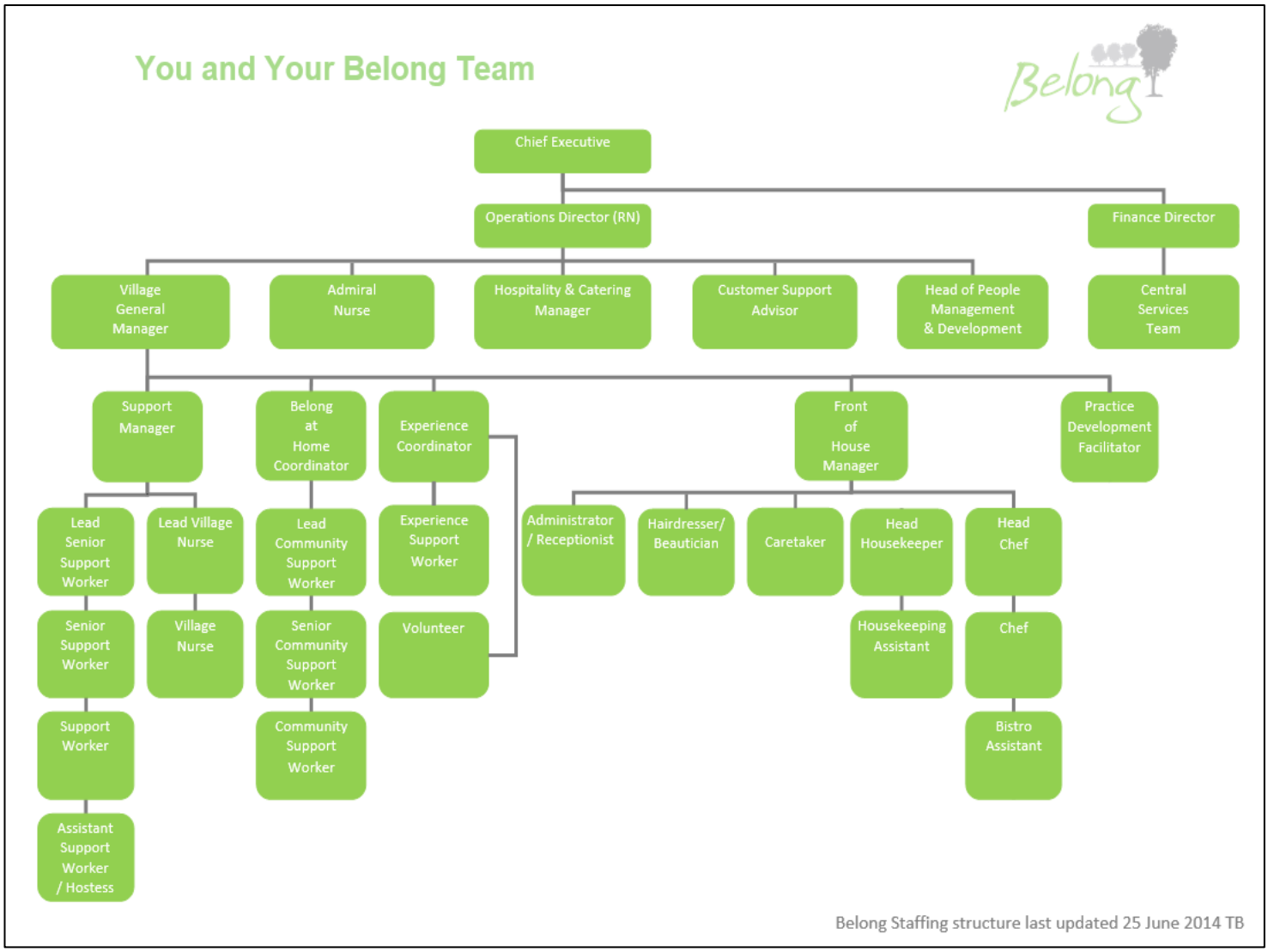
Figure A4: BELONG CARE VILLAGE – design

www.belong.org.uk



BELONG Awards:
2013: Winner of Laing & Buisson Care Home provider award - Independent Specialist Care Awards
2013: Winner of Best Home Care Co-ordinator at the Great British Care Awards
2014: Winner of the Extra Care Provider category at Laing Buisson Independent Healthcare Awards
2015: Frontline Leaders Award at Great British Care Awards
2015: Best Inclusive Building Award at LABC Awards
2016: Belong wins 'Investors In People' Gold Standard

Figure A4.1: Management Structure at BELONG



- Care Villages (Wigan):
  - Apartments
    - 54 apartments – 18 two-bedded apartments; the rest are one bedroom apartments
      - Rented or bought
  - HOUSEHOLDS
    - For more frail people requiring 24-hour care
    - 11-12 bedded HOUSEHOLDS – all bedrooms (16sq.feet – excluding ensuite) in very close proximity to lounge/dining/kitchen area

Table A4.2: Drumbrae Care Home, Edinburgh

Best of Drumbrae Care Home
Pleasant design – verandas and outside space
Residents and their families are happy there, although current manager had been posted to another care home for some months
Have Allied Healthcare Professionals
Have good wi-fi for residents
Close to local community and bus routes
Built by Grahams Construction – who work with University of Edinburgh and NHS Lothian & Council

Table A4.3: Rachel House Children's Hospice, Kinross

Best of Rachel House
Charitable organisation
Very effective volunteer scheme
Full multidisciplinary team
Innovative Care • Good 'respite' care • Used to working with young people who have both physical and mental problems • One to one
Innovative Activities • Two different activity rooms • Individual person-centred activities
Work well with NHS • Have student nurse placements • Hold joint medical posts
Strong home care team

Table A4.4: St Giles Hospice, Walsall

Best of St Giles Hospice
Own social care agency – outcomes of effectiveness measured by staff turnover, engagement in training and patient experience
Number of research grants attained with completed studies – impact of research on practice
Use preferred place of care and death and numbers of advance care plans completed as factors that influence both experience and patient flow
Collect data on number of supporters/donors, active friend groups, human resources data, overall patient experience data from Patient Reported Outcome Measures (PROMS) and Family Reported Outcome Measures (FROMS)
Considerable amount of knowledge and skills development in local care homes

Table A4.5: Viewpoint Housing, Edinburgh

Best of Viewpoint
Not for profit organisation
Very interested in joint vision of a teaching/research-based care home – supported by finance
Recently increased number of nurses due to complexity of care
Innovative Care • Created a Mental Health unit and works with NHS Lothian (Royal Edinburgh Hospital)
Innovative Activities • Tea Dances • Artist in residence • Converted old chapel as an art café – recently selling scarves to John Lewis
Innovative Training • Hold yearly celebration for staff who have achieved a new qualification • In 2015 one-third of staff achieved a new qualification • 100 student nurse placements/two years
Works with outside agencies ○ Glasgow College of Art

Table A4.6: Northgate, Adelaide, Australia

Best of Northgate
Not for profit organisation
Large student placement numbers (100/per care home) Excellent links with University of Adelaide but students from both Flinders and Univversity of Adelaide go to Northgate
Have nurses as well as social care workers and senior care assistants and full AHP team
Innovative Care ○ Student placements are part of the care team ○ Have good technology in relation to room sensors and wi-fi
Innovative Activities ○ Men's shed; Children's area in Reception; Computer area in Reception
Innovative Training ○ Get over 3,000 student requests each year for a placement in one of their care homes ○ Accept 900 student placements across their seven care homes
Design ○ Very light and bright Extra restaurants that relatives and residents can visit

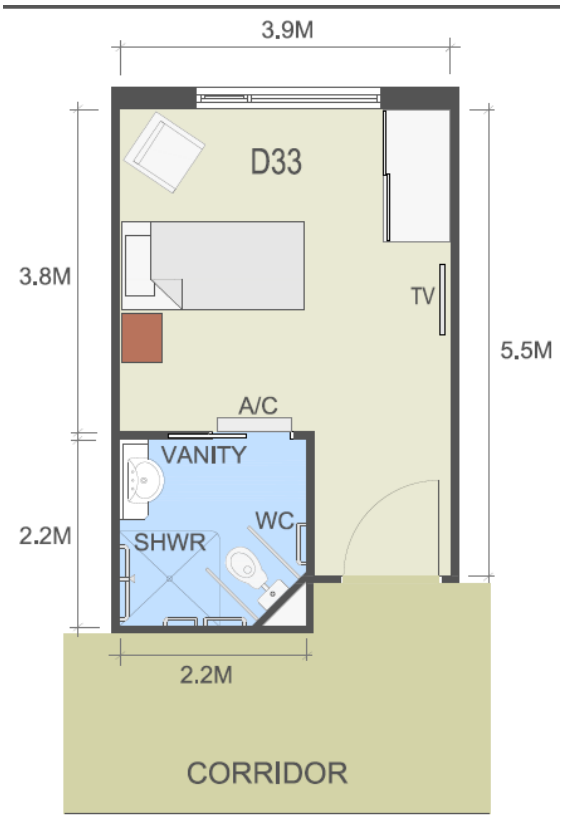
- The care home has won many awards: www.helpinghand.org.au/services/residential-care-homes/northgate/

  - Winner of the '2013 Design Award' in the South Australian Aged and Community Service Awards

  - Winner of the '2013 SA Master Builders Association' award for Excellence in Retirement Living/Aged Care.

Figure A4.2: NORTHGATE, Adelaide – floor design

- There are 110 rooms on 1.1 hectres of land.
- Residents have a choice of two bedroom sizes (17.5sq metres or 23sq metres – excluding ensuite facilities of 4.6sq metres).
- Every room has a large window some of which open to ground floor or balcony.



Smaller-sized ensuite bedrooms at Northgate

Larger sized bedrooms at Northgate

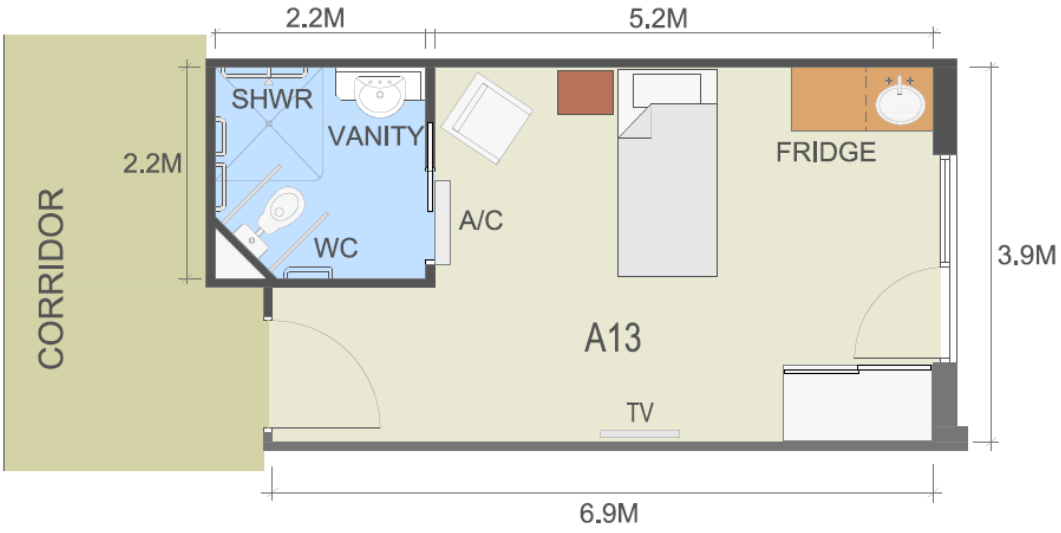
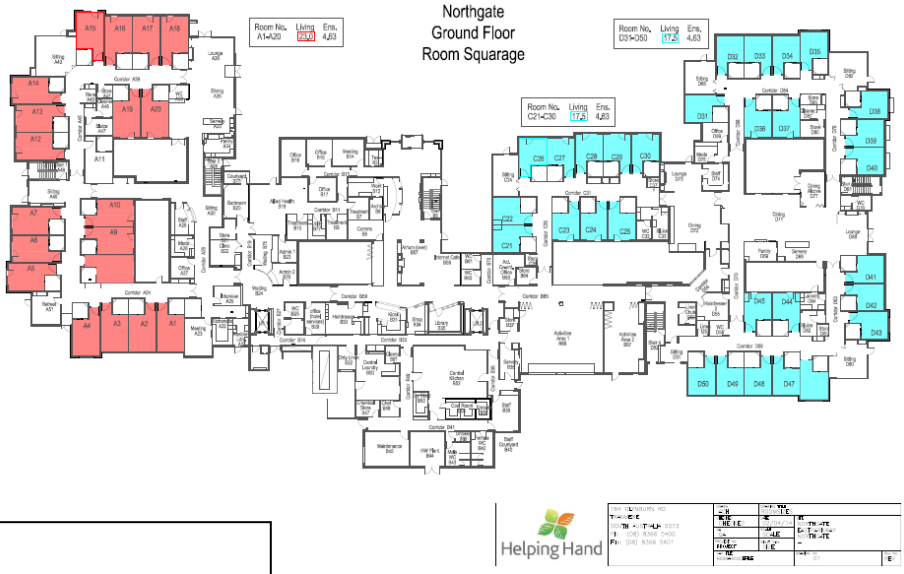


Figure A4.3: NORTHGATE, Adelaide – floor design



Residential Accommodation Prices

Depending on the Government means test a resident may be asked to contribute towards their accommodation or be charged an accommodation payment/deposit. Residents can choose how they wish to pay for their accommodation in the form of either a Refundable