healthwatch
Havering

Community Engagement

Care Homes in Havering

Understanding and use of Designated Enhanced GP contracts

September 2022

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care in the London Borough of Havering. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Community Interest Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff, and by volunteers, both from professional health and social care backgrounds and lay people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your voice, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups, NHS Services and contractors, and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

Community engagement

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has a statutory duty to ascertain the views of health and social care services and to make them known to the commissioners and providers of those services so that they can be taken into account in the development, commissioning and delivery of services.

We do this in a variety of ways, such as surveys, interviews and focus groups.

We also participate, with other Healthwatch organisations across North East London, in the Community Insights System, which gathers views and comments on health and social care from people across the area. Intelligence gained from Community Insights is used directly in, or to inform, many of the surveys and other public engagement events that we carry out.

The results of our community engagement are shared with Havering Council, NHS North East London, NHS and other provider organisations and Healthwatch England.

The project

In May 2022, NHS North East London commissioned the eight local Healthwatch in North East London to find out the views of the managements of residential care and nursing homes in their respective boroughs about the designated enhanced service (DES) provided to them by local GP practices.

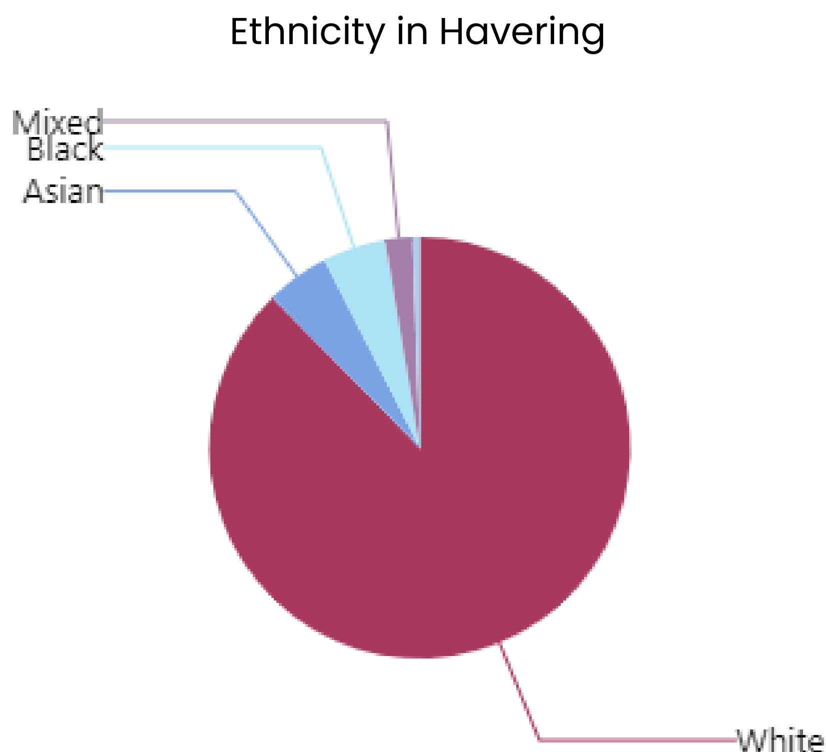
This report sets out the views expressed by the managements of homes in Havering that we were able to contact (50% of the total of such homes).

The report should be read in conjunction with the report of the collective data across the whole of North East London.

Introduction

Havering is one of the least ethnically diverse of London's boroughs (in the 2011 census[1], over 80% of residents had a white background), and also has the largest population of people aged 60 and over; latest population projections suggest that by 2041 the number of people in the borough aged over 70 will have risen by 24% and those over 80 by 45% to over 20,000 while the number of under 20s will have fallen slightly. The demographics of the borough are different in many respects from the other boroughs of North East London.

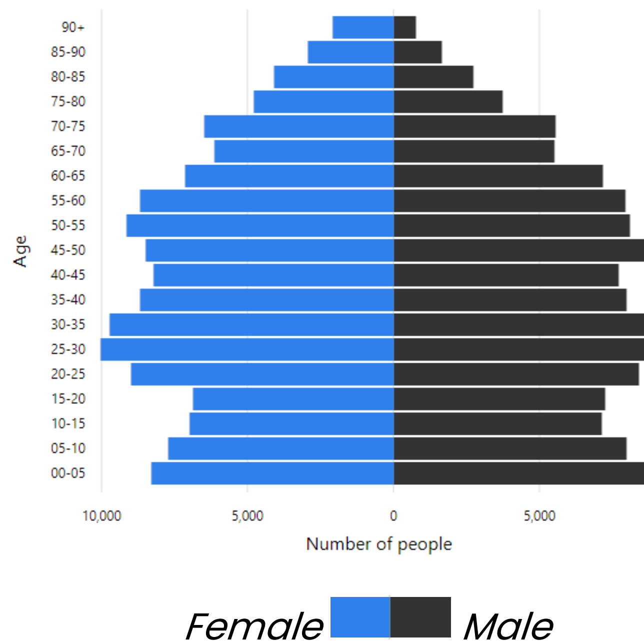
Ethnicity in Havering



Source: https://www.varbes.com/demographics/havering-demographics, from 2011 census, © Crown Copyright

[1] At the time of writing, the data from the 2021 census had not yet been released

Age profile of Havering



Havering has the second highest number (56) of residential and nursing homes in North East London but, because many of those homes are quite large, it has by far the largest number of beds (around 1400).

For this survey, volunteers from Healthwatch Havering attempted to contact all of the borough's homes – but with mixed results: with some care homes, volunteers were able to have long conversations with the manager or a senior representative of the home and to fully complete the survey; with others, volunteers were unable to make contact at all.

For the purposes of the survey, each volunteer was assigned a group of homes to contact and instructed to attempt to make contact no more than twice. This met with mixed success: some

homes were contacted on the first call; others on the second call; but many could not be contacted at all. In all, contact was made with 26 homes (46%). Several others declined to complete the survey when called but undertook to complete it online, which resulted in responses from two further homes. In all, 50% of the care homes in the borough responded to the survey.

In this report, the generic term "care home" is used to describe the homes surveyed but it is important to bear in mind that the term covers a very wide range of provision and that no two "care homes" will offer the same range of services or accommodation or be organised in the same way.

The data

Of the care homes that completed the survey, all were aware of the contact details for the GP practice assigned to them under the DES system. Most reported a good working relationship with their assigned GP although, as might be expected, the level of response received varied considerably. In some cases, the home was unaware of the formal DES contract basis for their contact with their assigned GP.

Most of the data in the report is derived from the responses received during the survey; some qualitative data is also derived from the Community Insights System operated by

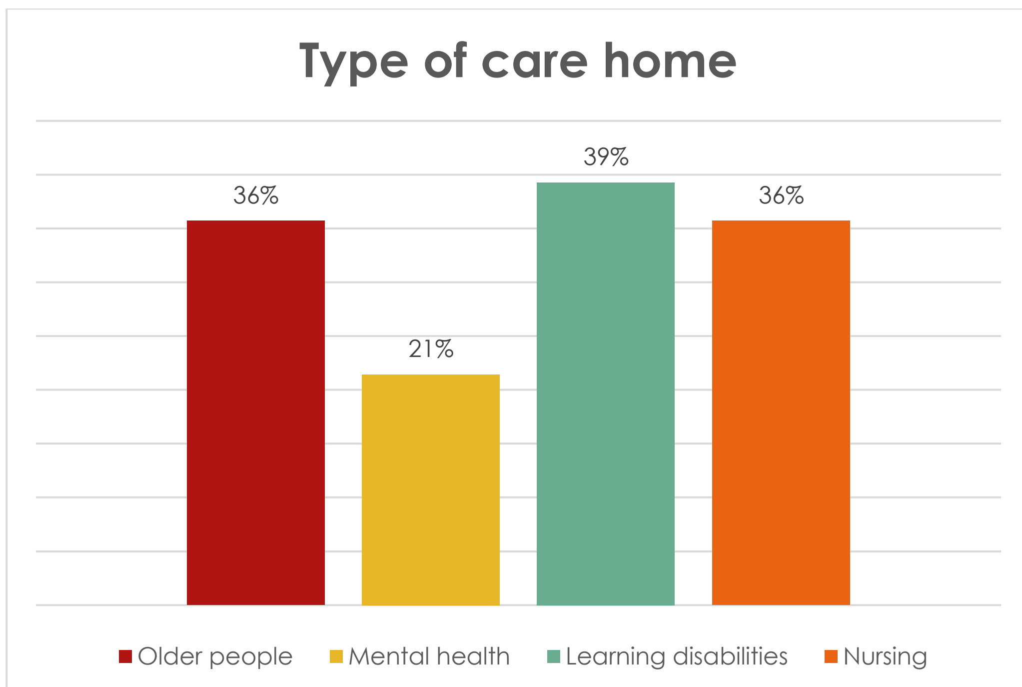
Healthwatch across North East London. It should be borne in mind that some care homes offer both residential care and nursing care and some provide services for more than one client group – for example, most care homes now have at least some residents who have mental health needs because of dementia, and some care homes cater for both people with learning disabilities and those who have mental health needs. Because of these overlaps, some data presented here will add up to more than 100%.

The quotations

Various quotations appear in italics in the text, taken from remarks made by the care home managers responding to the survey.

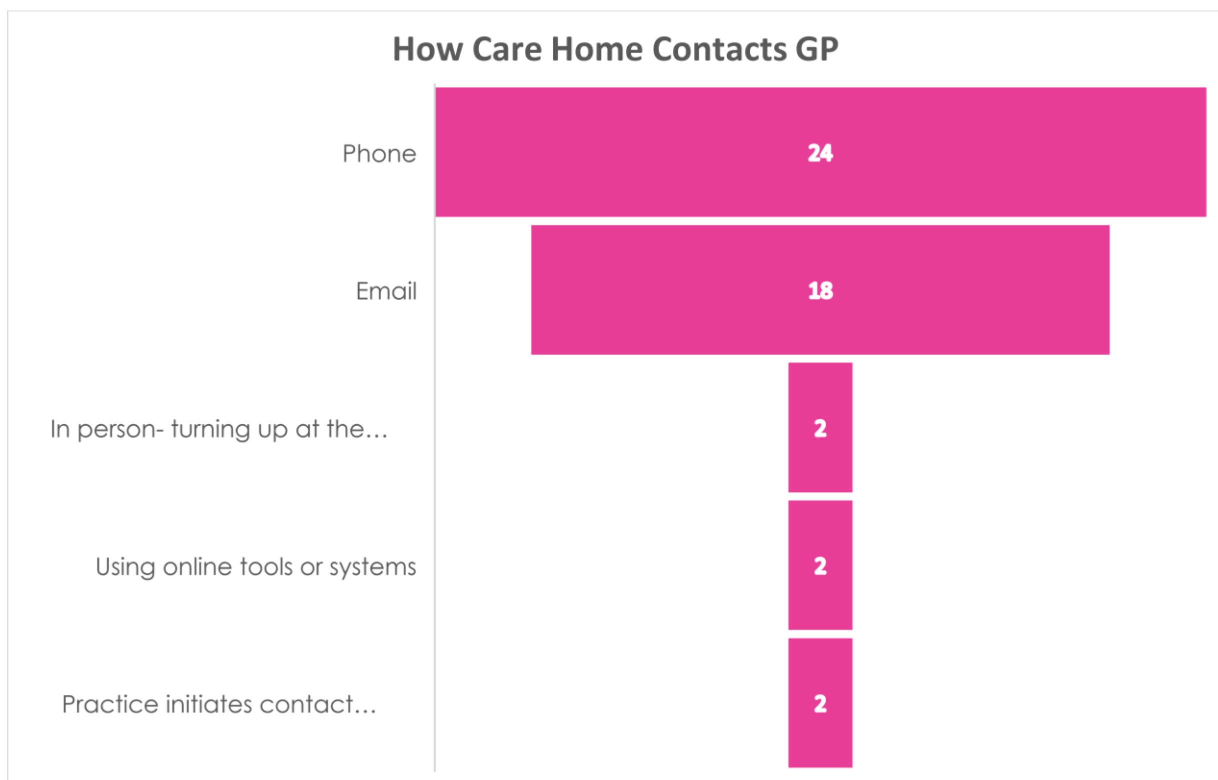
Types of care home

Although care homes are generally seen by the public as inhabited mainly by older people, in Havering there is a very mixed economy within the care home sector. It should be borne in mind that, although for example a home may be primarily designated as providing care of the elderly, that does not preclude it from accommodating other people in need of care.



Contact with the assigned GP and other healthcare professionals

Nearly all of the care homes contacted their assigned GP by telephone, although email contact was nearly as important. Other forms of contact were used by a few respondents:

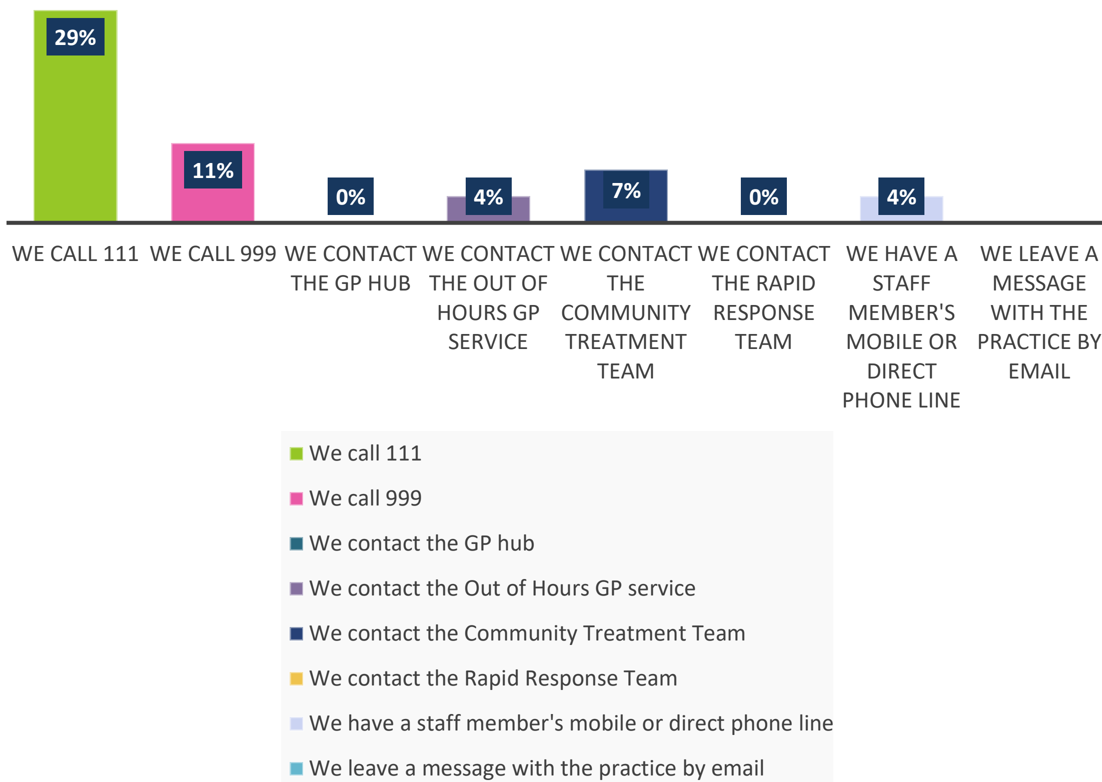


Telephone GP - who always rings back or telephone NHS 111 or in emergency 999

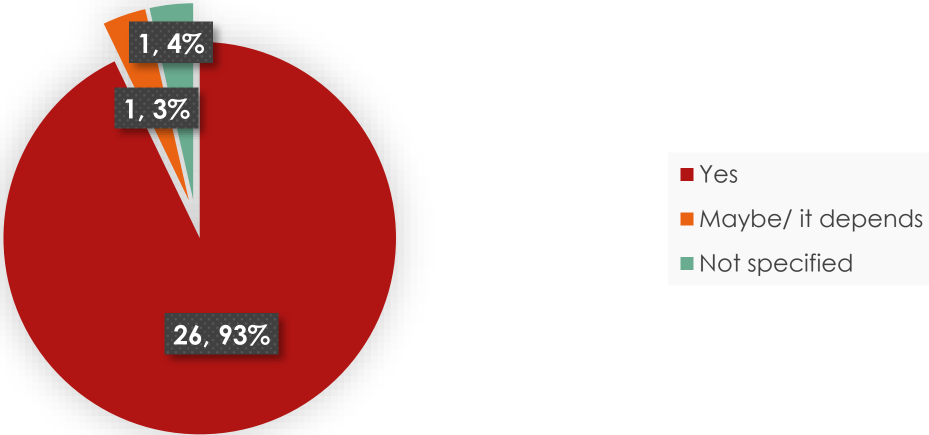
Telephone, What's App, Face time: Dr … is very approachable

Email, What's app - between GP and nursing staff; 111 when necessary

Outside normal business hours, a range of contact methods was used by homes, not all involving contact with the assigned GP:



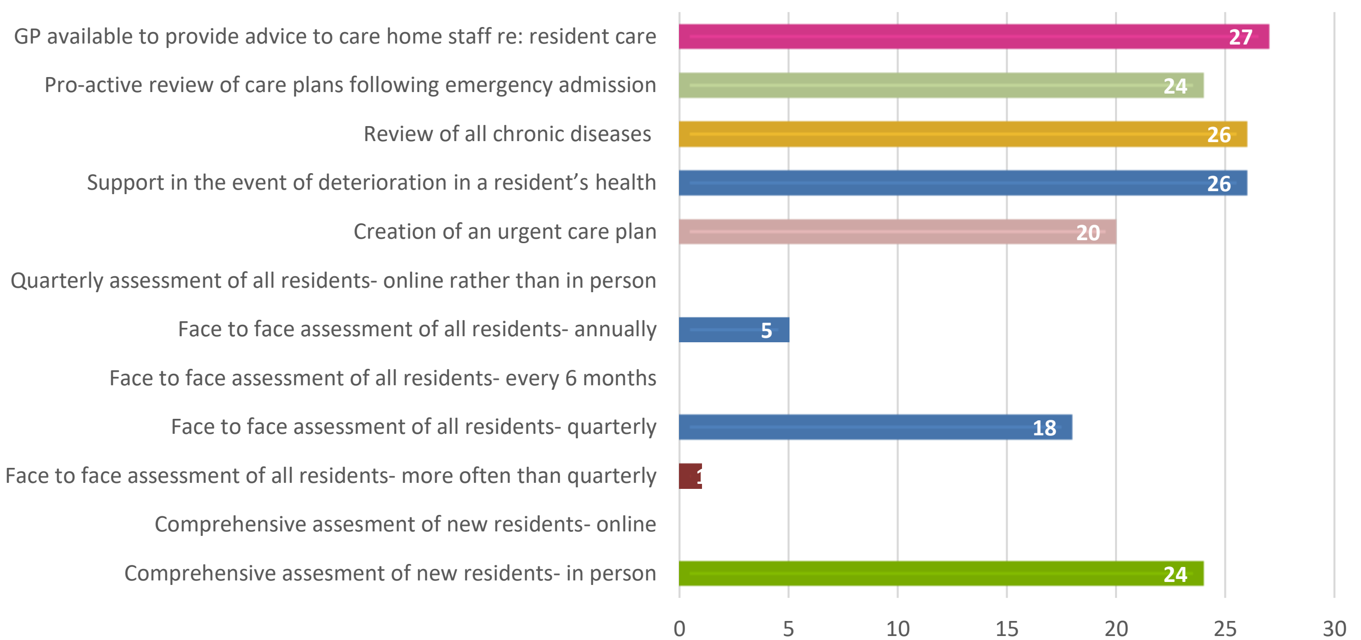
Nearly all care homes were felt comfortable contacting their assigned GP outside rounds:



Overall, 71% of respondents reported that they received all services provided under the DES but not all homes appeared aware of the range of services available to them under the DES system; a few did not appear to be offered at all:

Services provided by the DES

- Comprehensive assesment of new residents- in person
- Comprehensive assesment of new residents- online
- Face to face assessment of all residents- more often than quarterly
- Face to face assessment of all residents- quarterly
- Face to face assessment of all residents- every 6 months
- Face to face assessment of all residents- annually
- Quarterly assessment of all residents- online rather than in person
- Creation of an urgent care plan
- Support in the event of deterioration in a resident's health
- Review of all chronic diseases
- Pro-active review of care plans following emergency admission
- GP available to provide advice to care home staff re: resident care

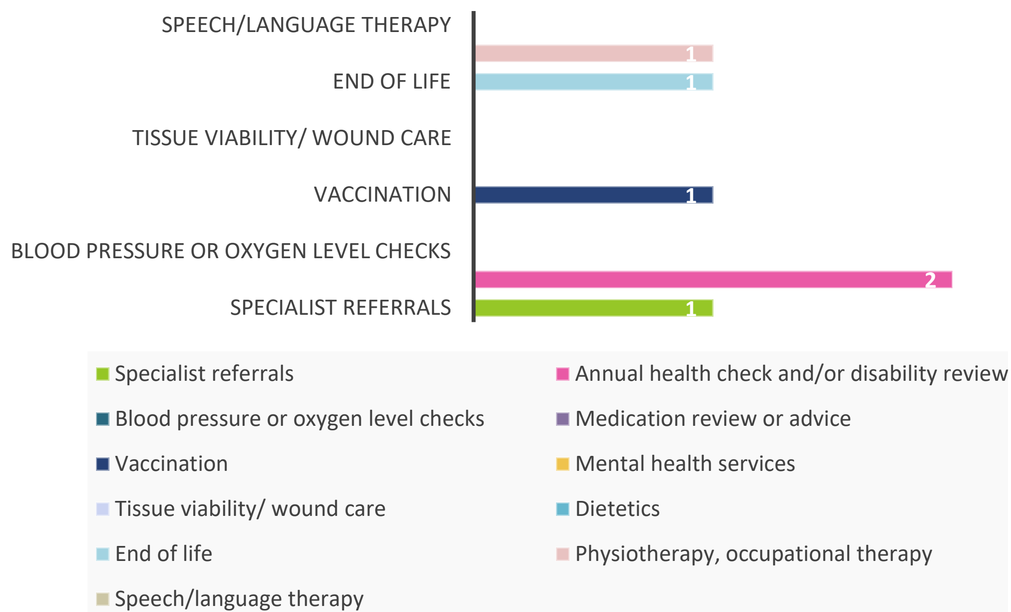


A pro-active review of care plans etc - No emergency admissions

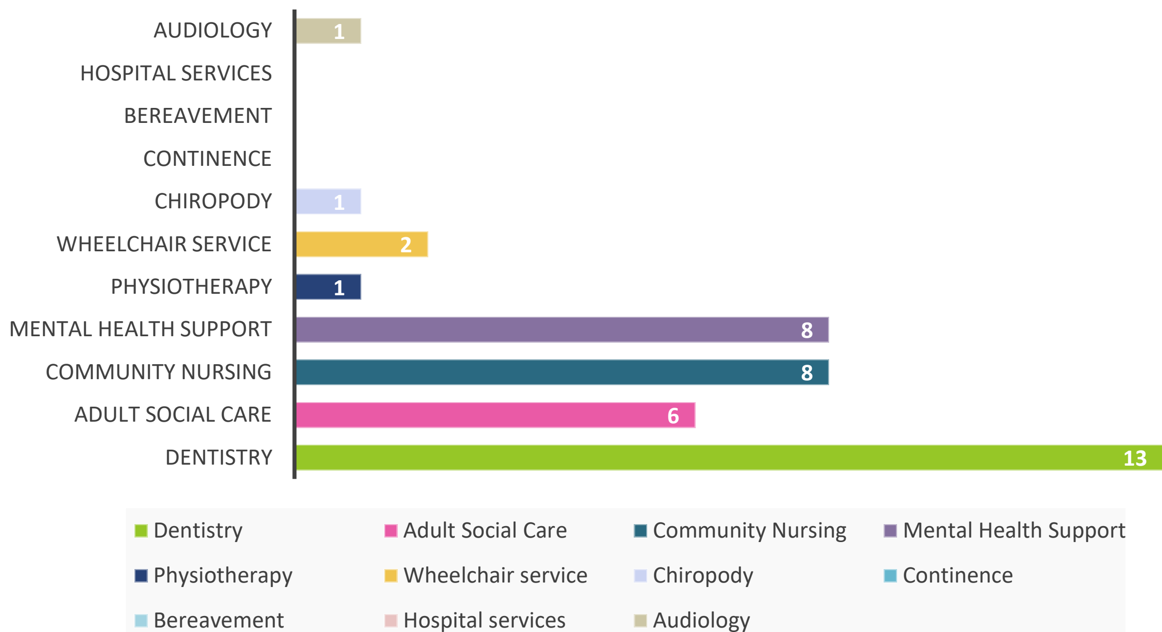
Creation of an urgent care plan - No need for one at the moment. Very small residential home and has not been applicable for some time

Did not know what a DES was

Equally, there was no great awareness of other services available:



Care homes reported problems accessing other health services: unsurprisingly, the list was headed by dentistry, nearly half of those contacted reporting that they had difficulties with that service:

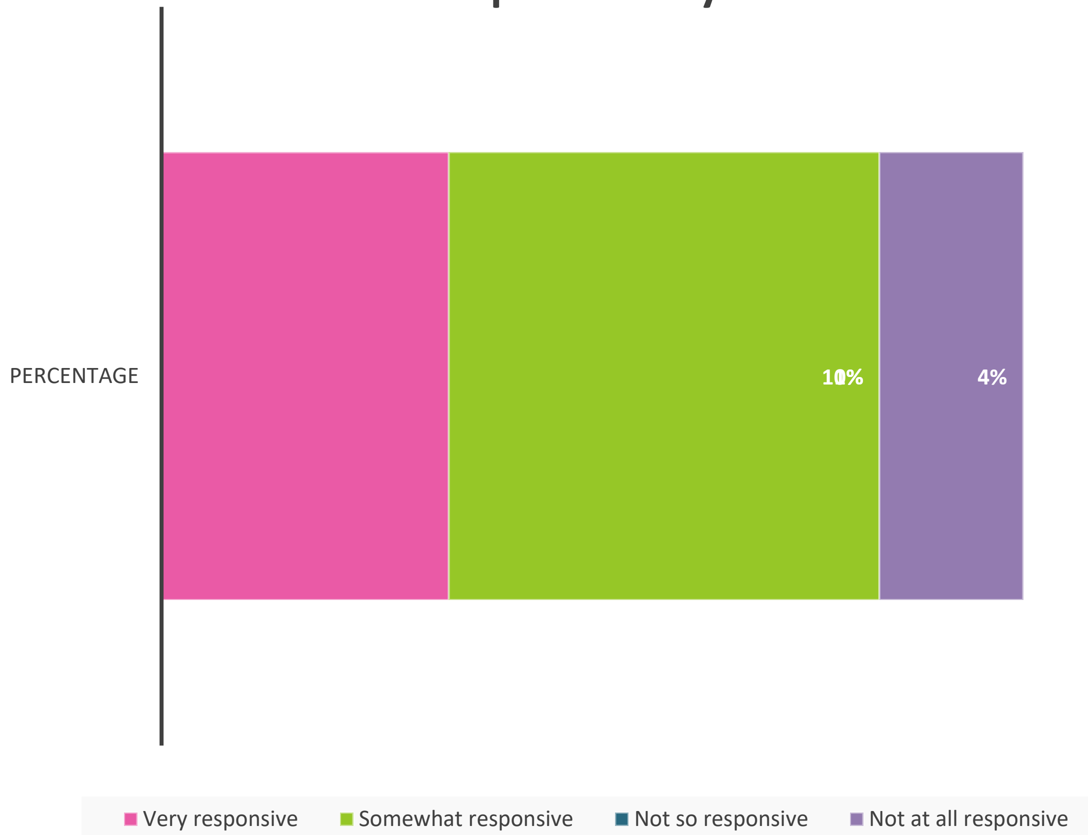


Hairdresser and chiropodist - ok. Adult Social Care - meetings to be set up. Community Nursing - TVN nurses are ok, currently 4 residents need this. One sent home from hospital with no dressings on (Grade 3). Mental Health Support - Meetings to be set up. There is lack of co-operation from hospital.

Adult Social Care - Long waits - private residents. Community Nursing - Sometimes delays. Mental Health Support - Long waits. Dementia service required.

78% of respondents found the DES valuable – 71% described it as “very valuable” and 7% found it “valuable”. None described it as having no value.

82% found the GP very responsive; only 1 respondent told us that the GP was not responsive:



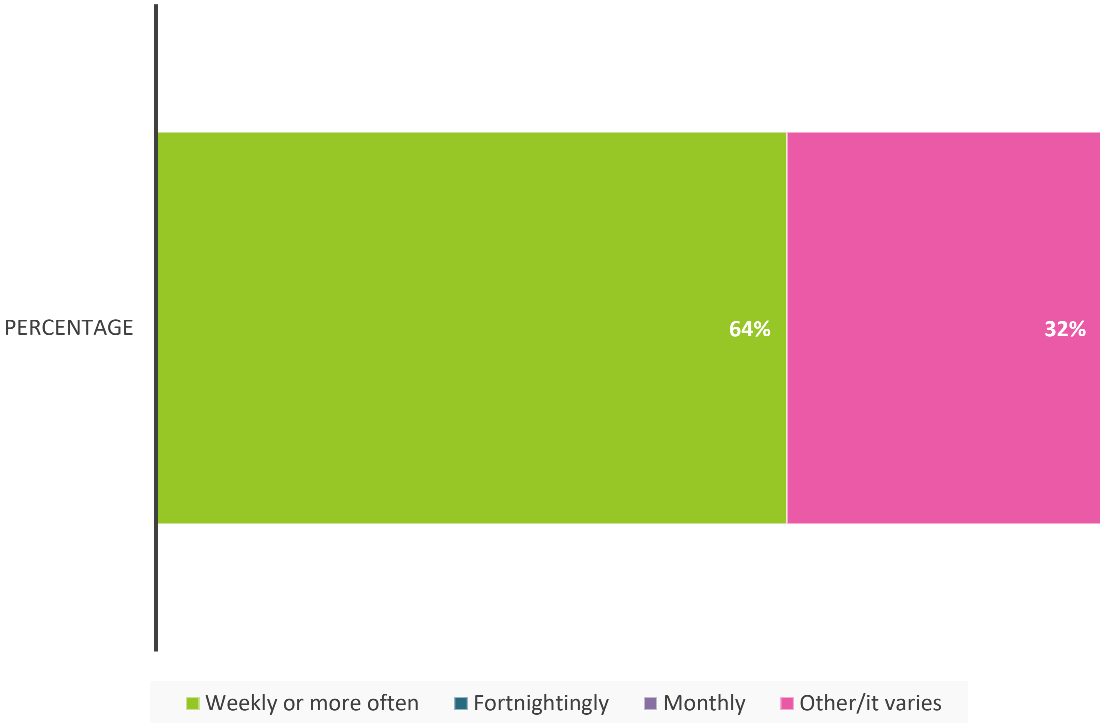
Very responsive, almost immediate. GP was in contact in responsible timeframe and in covid - zoom call first then came into home if necessary. Surgery went over and beyond because GPs contacted family members etc. Face to face at home.

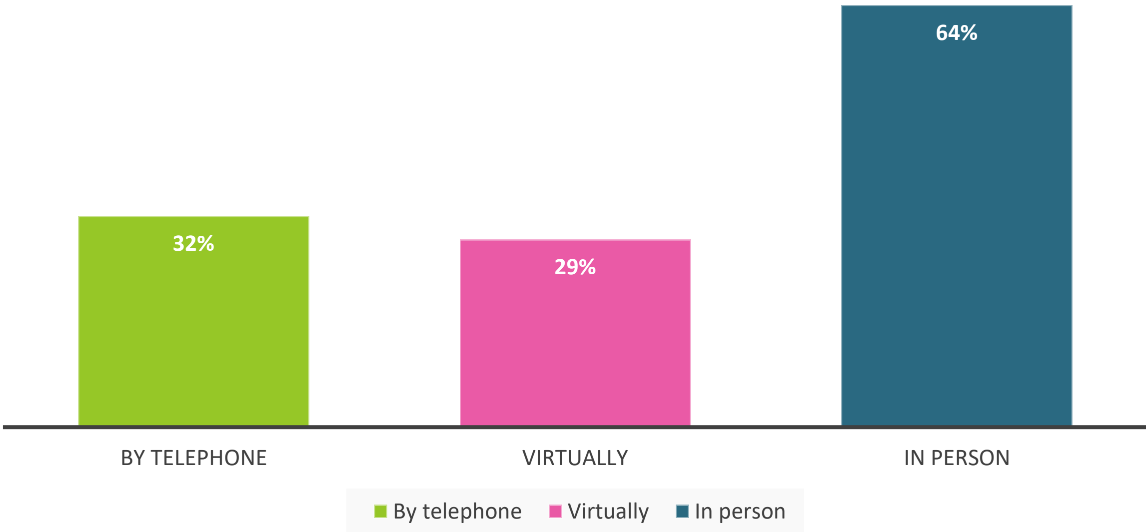
Not very responsive. Repeat scripts are not forthcoming. Residents' reviews take a long time.

Fairly good, better than some I've heard of.

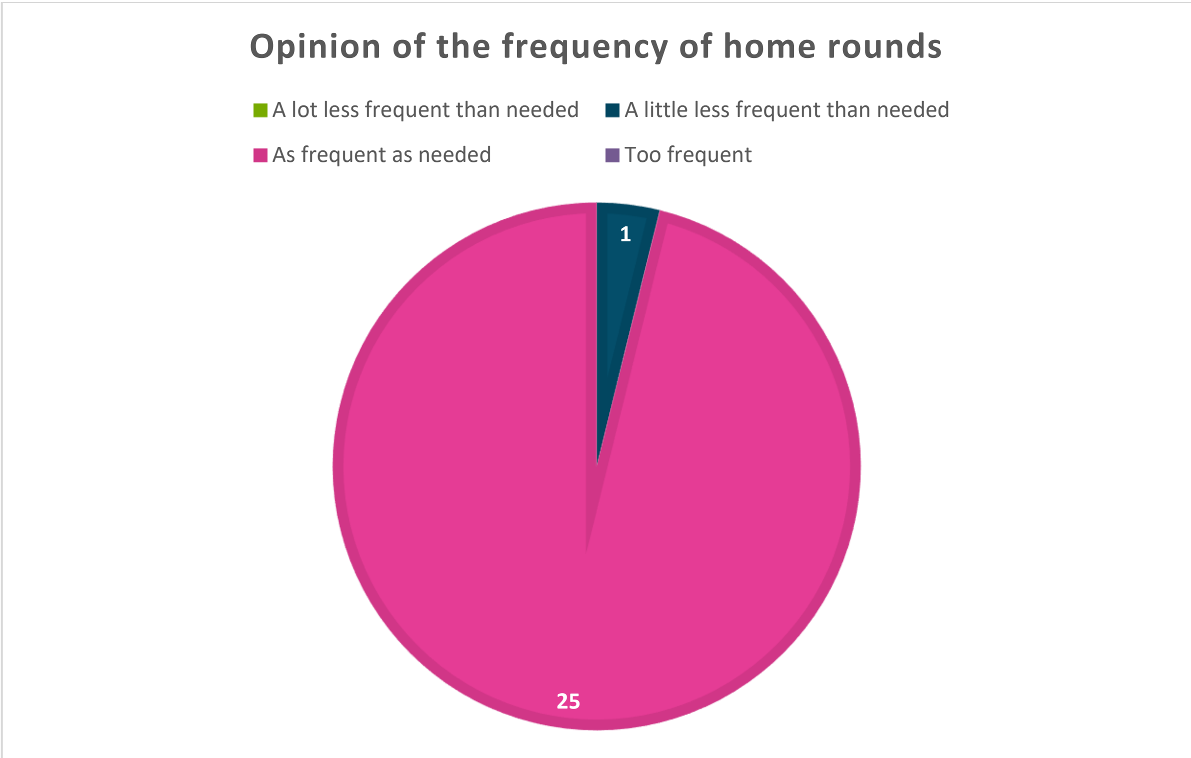
Services within the care home

The main contact between the GP and residents is the "home round". Most – 64% - of respondents reported that rounds were at least weekly, in person; roughly equal numbers reported rounds were carried out either virtually (29%) or by telephone (32%):





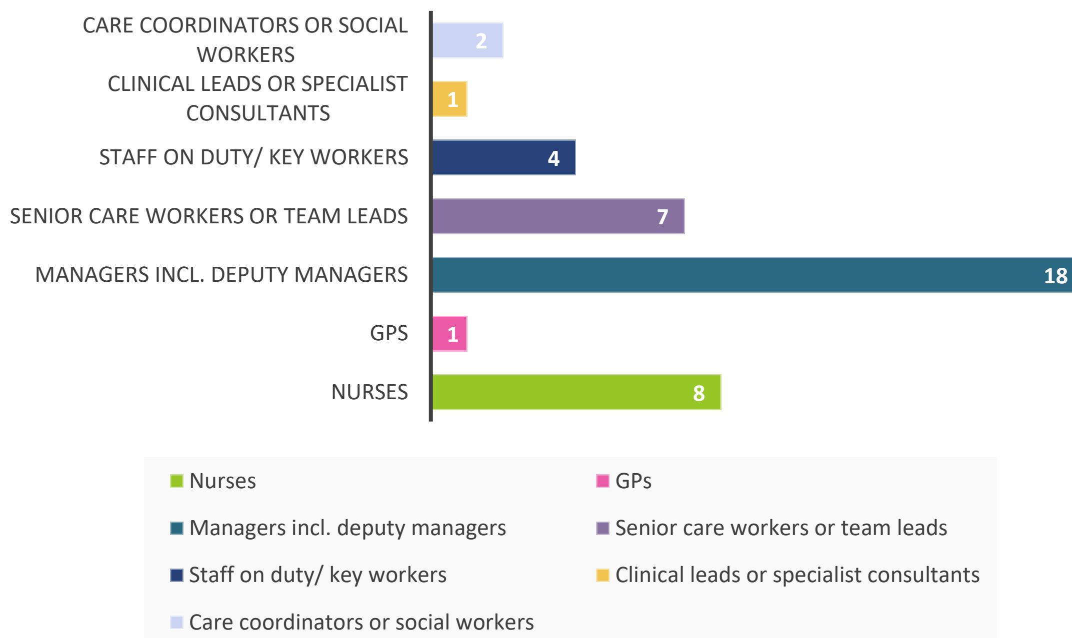
Most (25 = 89%) respondents considered that rounds were held as frequently as needed; only 1 (4%) respondent felt that rounds were less frequent than needed and none reported that they were either too frequent or not at all frequent:



Home rounds carried out every Monday. GPs always supportive. The manager is most impressed and feels they have had maximum support from surgery at all times and in all ways. Covid highlighted this support.

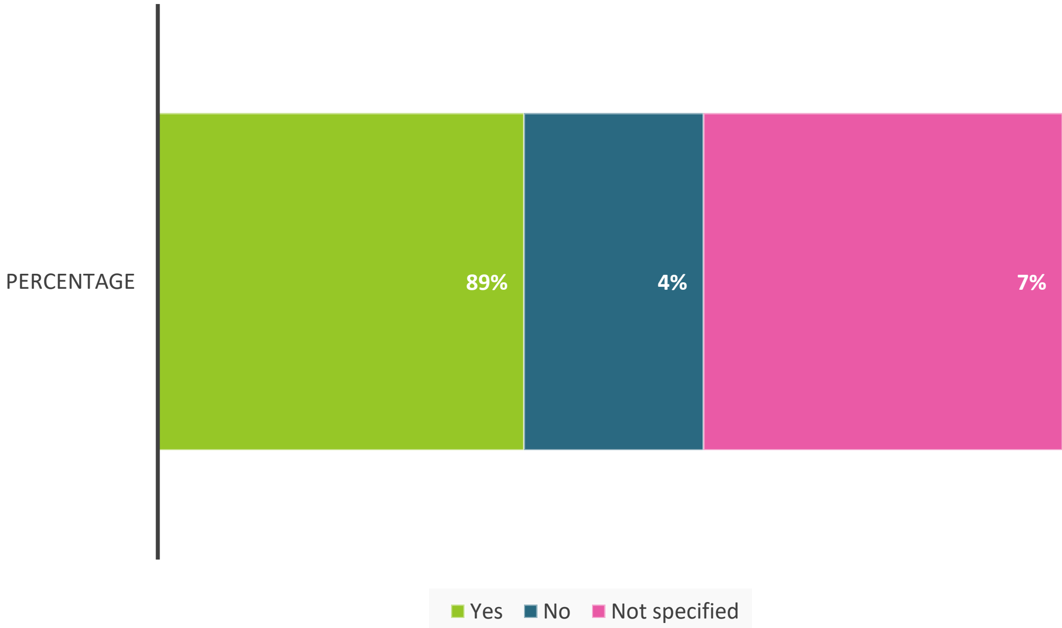
Manager wants her residents to receive care from him and get a nice rapport but this is not happening. Video calls seem to be more acceptable to him.

Asked about which staff were involved in rounds, most (18 = 64%) reported that the home manager was involved, while a range of other staff participated as well although, surprisingly only one reported GP involvement:



The home's qualified nurses and clinical lead and manager involved.

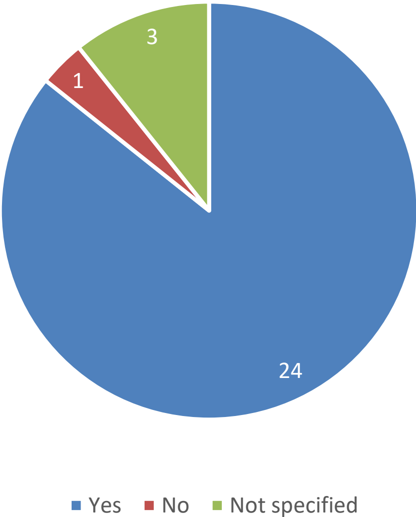
Family members were also allowed to take part if they wished in most cases:



Person involved, family, manager, social worker and GP

Similarly, outcomes were discussed with residents and their families in most cases:

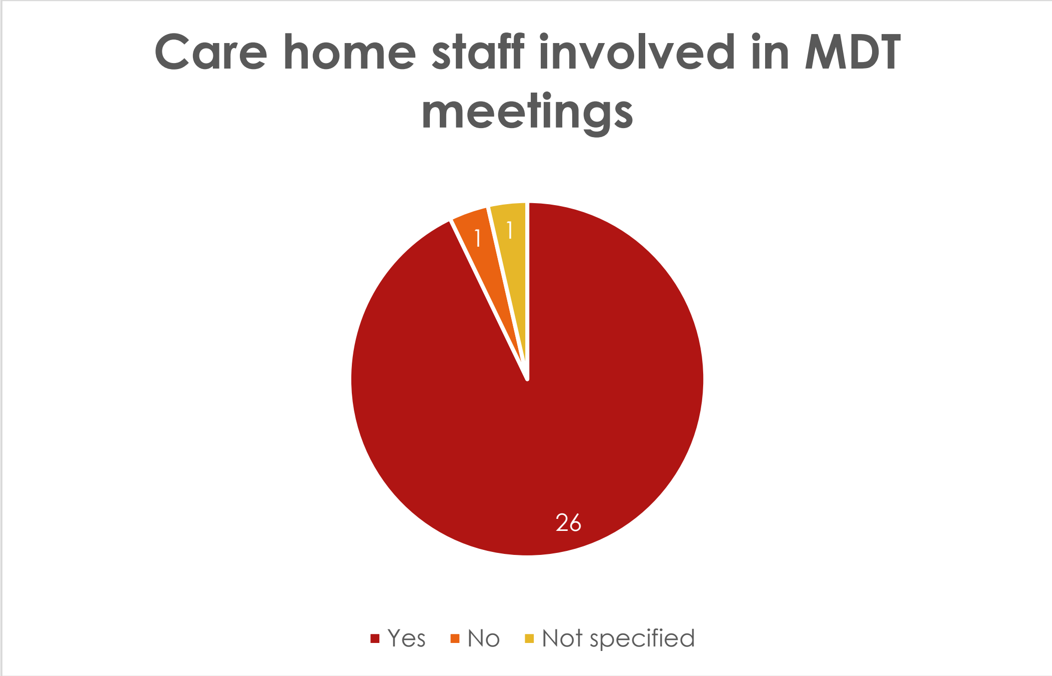
Conversations with residents & family about outcomes



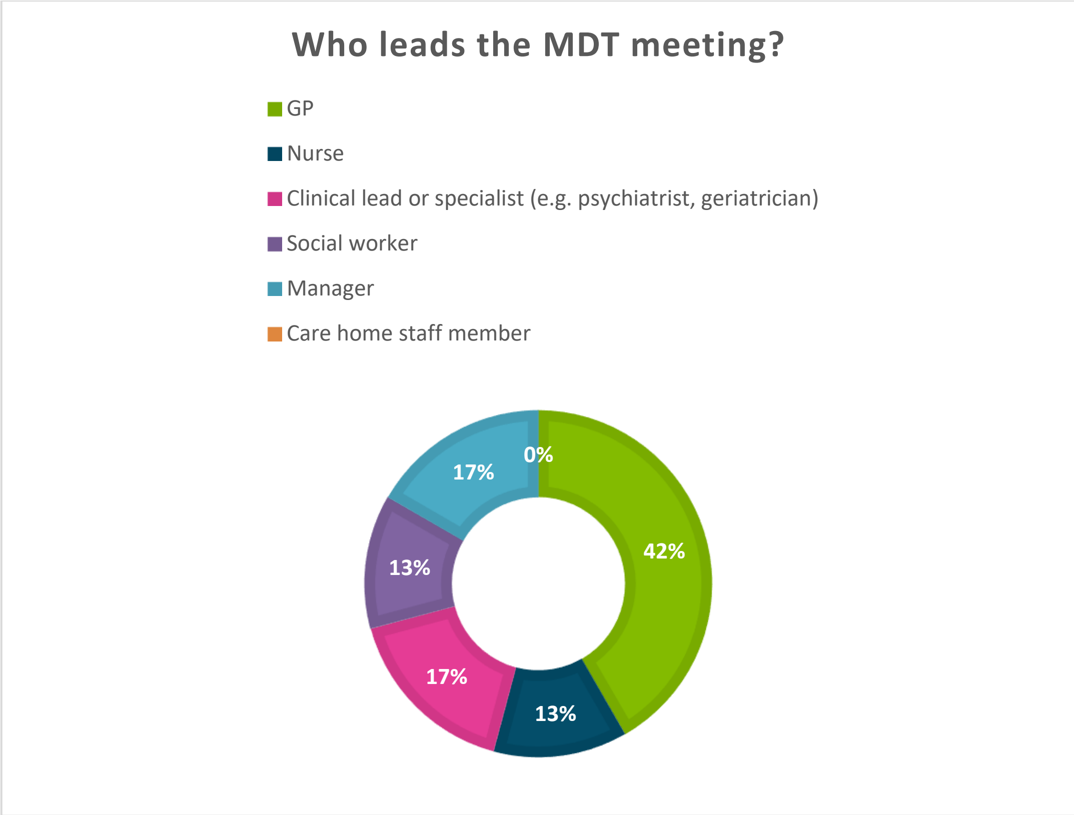
Yes No Not specified

Multi-Disciplinary Team (MDT) working

Most homes involved their staff in multi-disciplinary team (MDT) meetings:



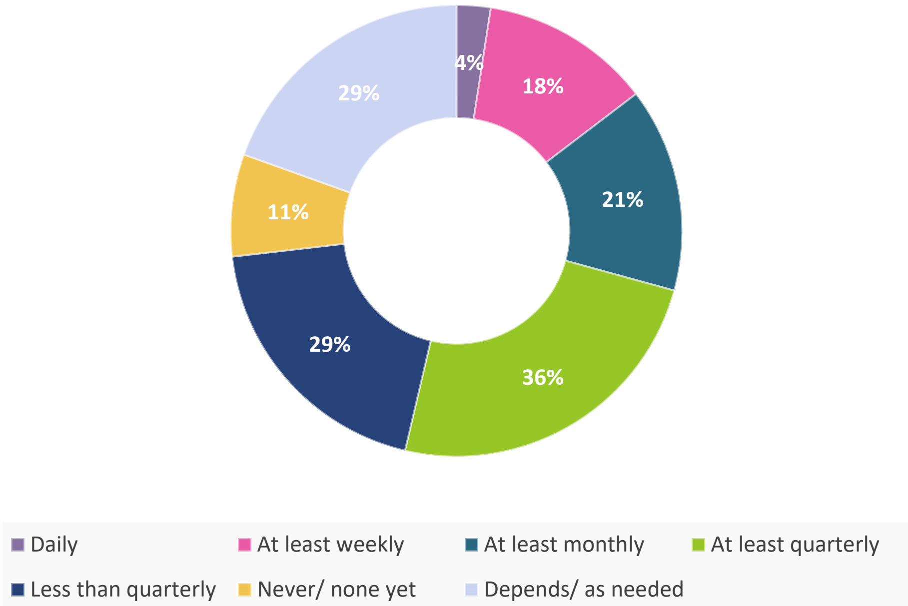
MDT meetings were led by a range of healthcare professionals, including GPs, but none used care home staff (other than the manager) for that role:



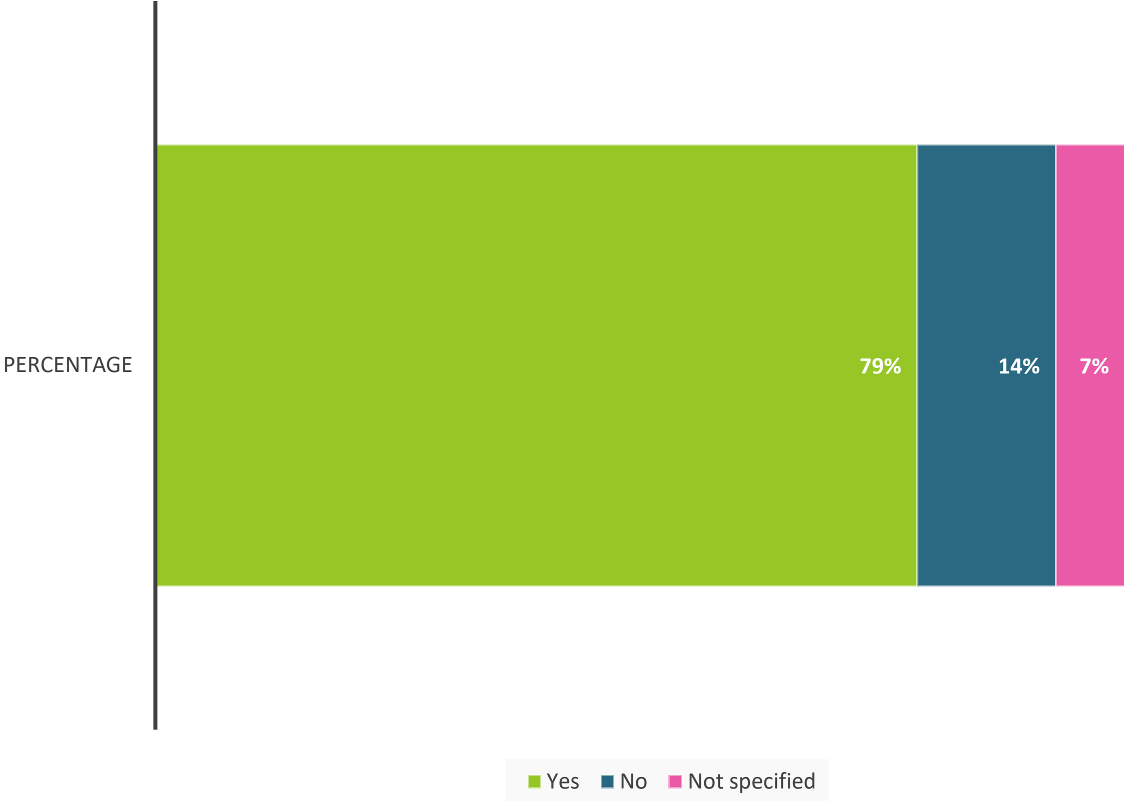
Nurses, manager and clinical lead involved. Any member of staff and family who notice unusual circumstances then flag up to nurses and other staff.

Heads of Department every day. All concerns are dealt with during handovers etc infection control and safeguarding etc. Urgent concerns are dealt with on the spot.

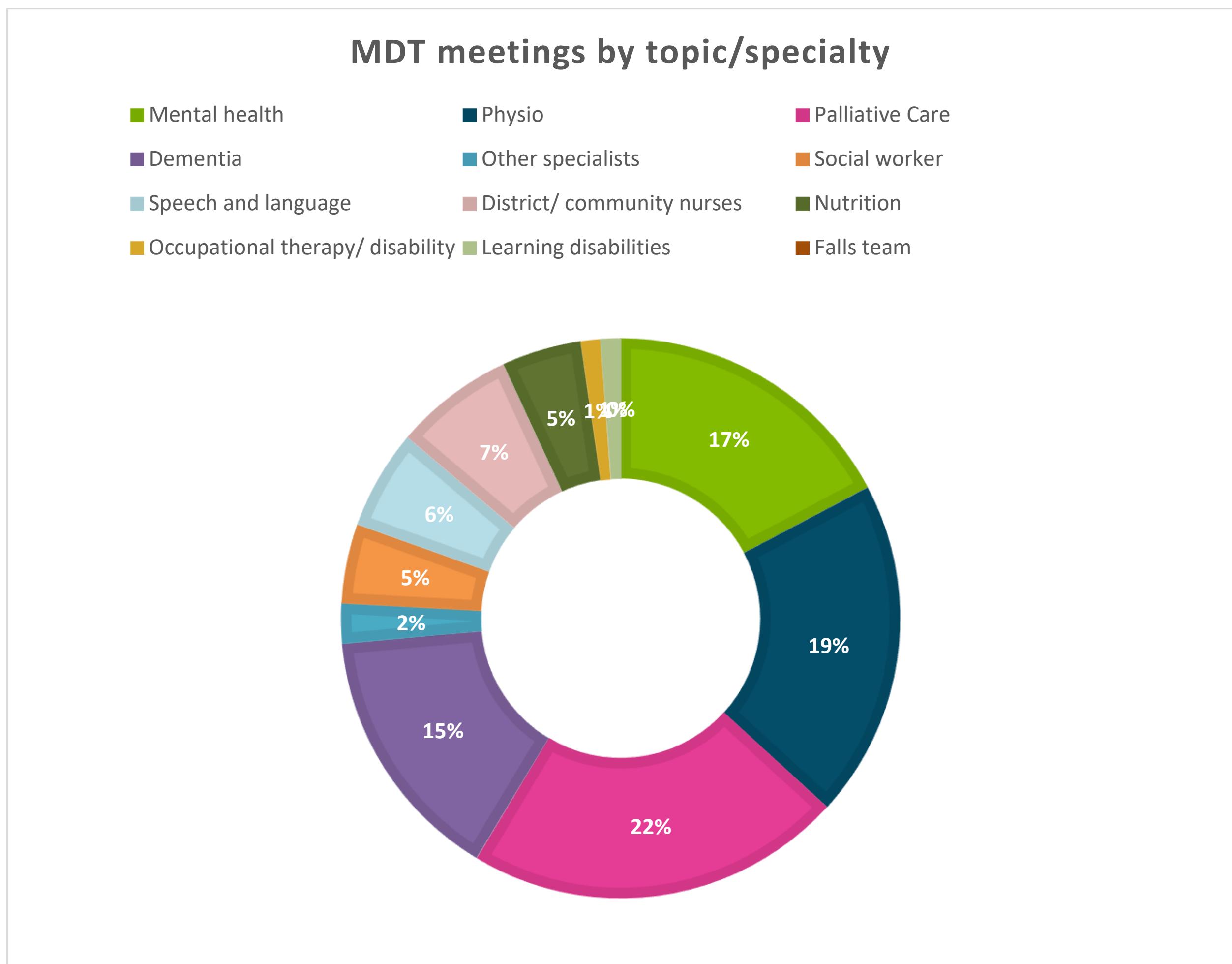
MDT meetings were held at varying frequencies: a few daily but others were held weekly, monthly or at lower frequencies. 11% reported that no MDTs were held, or had yet to be held:



Most MDT meetings included other specialists:



MDTs took place a for a range of topics or specialities:



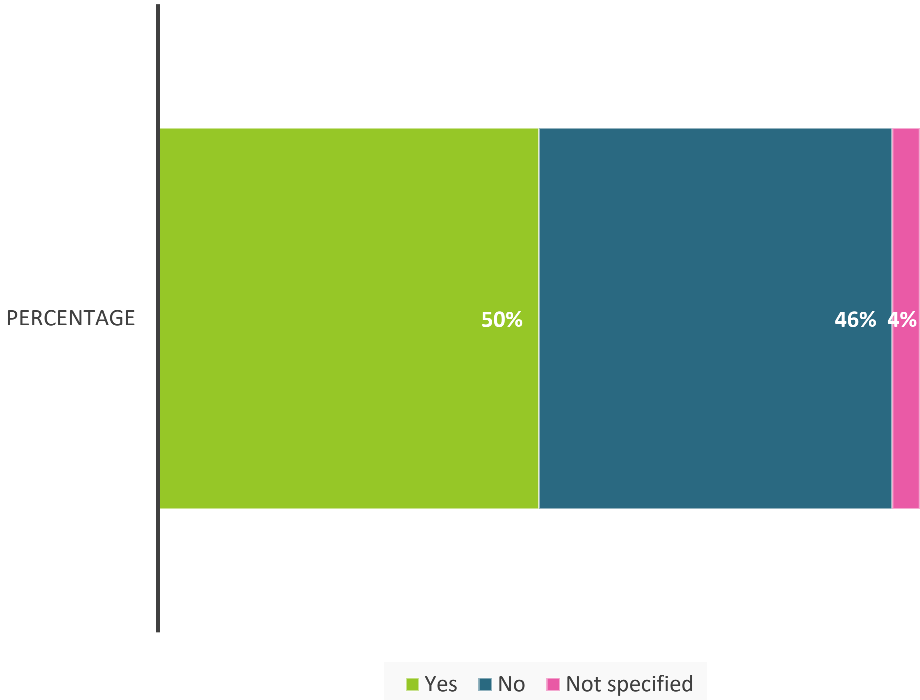
Care plans and medication

All care provided is written in the Care plan and read and signed by the staff who deliver care

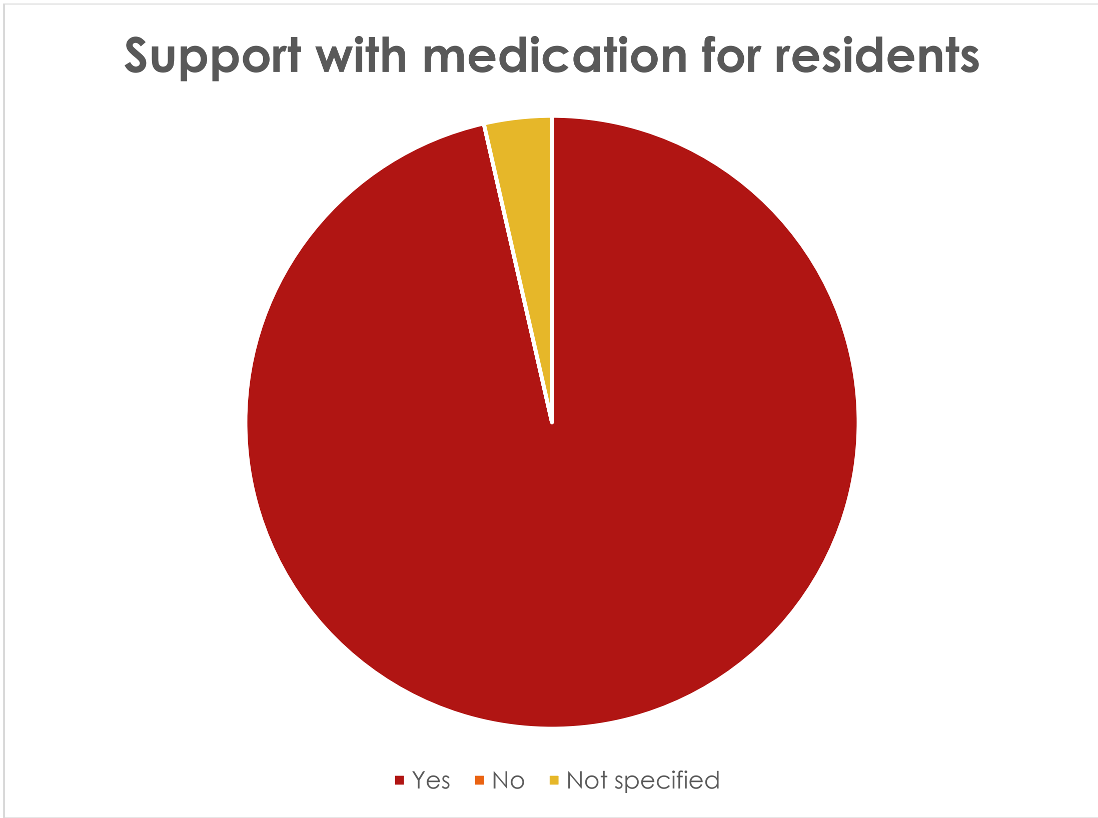
In daily use and accessible to all staff. GP advice/instruction recorded in care plan within professional visits.

Any changes or updates. Care plans allocated to individual nurses who review every month and on the day of change/amendment.

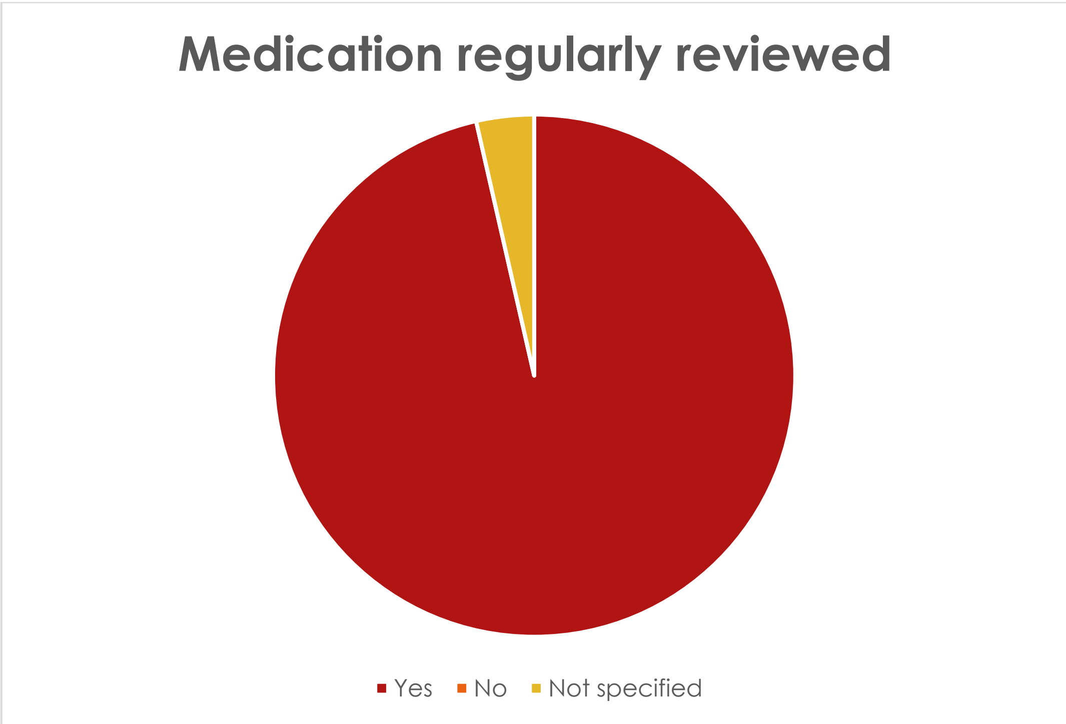
About half of homes reported that their GPs used care plans for their residents:



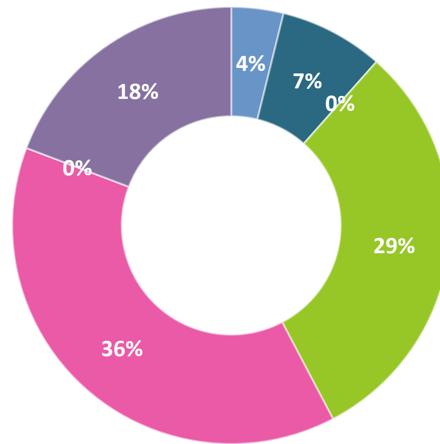
All but one care home told us that they were supported with medication for their residents:

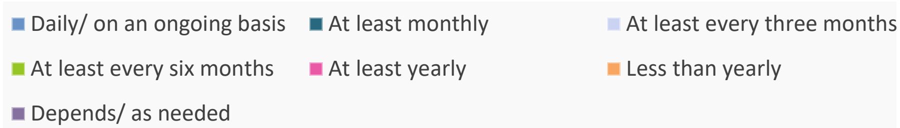


And that medication was reviewed regularly:



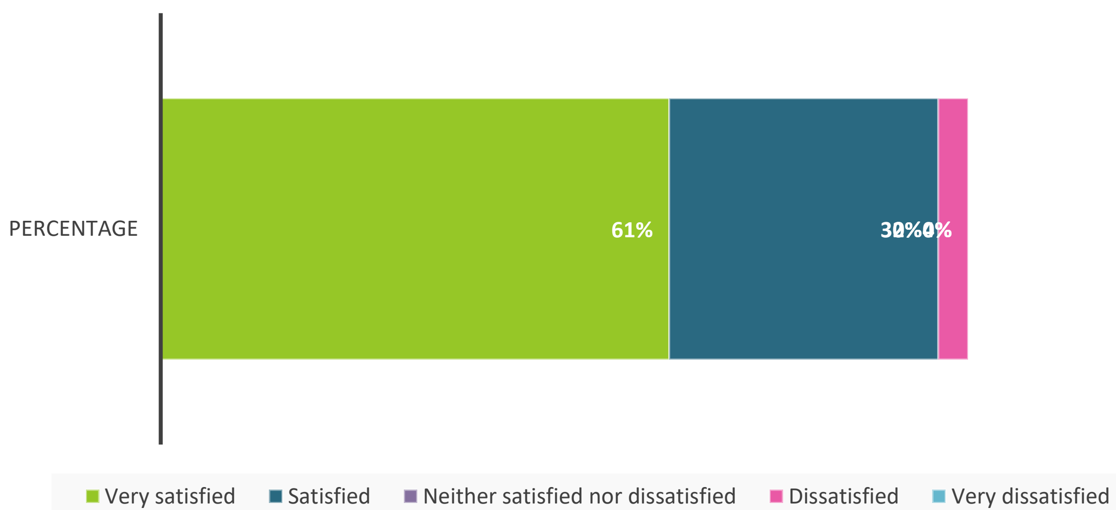
Medication reviewed- how often





Most homes were satisfied with the pharmacy supplier:

Experience of pharmacy supplier



Do not have to wait for medication, they are quick to respond. Pharmacy/GP and staff work together.

Generally very good. Occasionally slow response.

Do have some issues sometimes. Working with them for a year. Improvement is noted

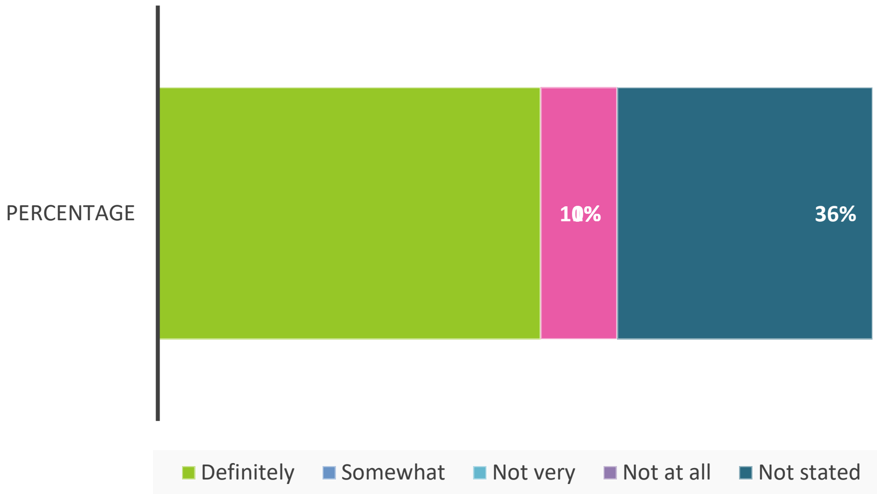
When urgent medication required on Bank Holiday/Sat/Sun the pharmacist will come.

They work closely with the medical professionals. Requesting advice or need emergency prescriptions. Helpful in providing information on storing medication. Work closely with GP Practices.

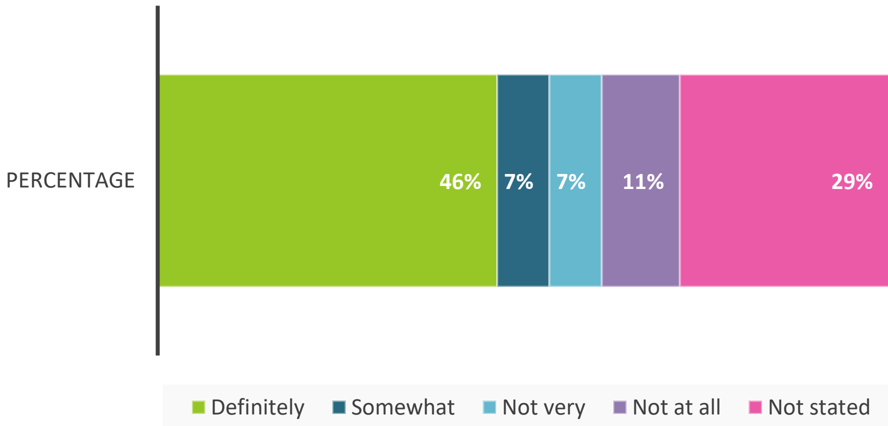
End of life care

Not all homes need to provide end-of-life care and none of those that did felt unsupported with end-of-life care but mixed experiences, especially after the death had occurred, were reported:

Is end of life care supported by DES?



Is after death care supported by DES?



The way it is planned. The nurses are empowered to discuss with GP and end of life care nurse. GP is very responsive

Client group does not include End of Life

End of Life anticipatory medication always prescribed to ensure all is on site when required.

When we receive patients requiring palliative care, incomplete medication from the hospital

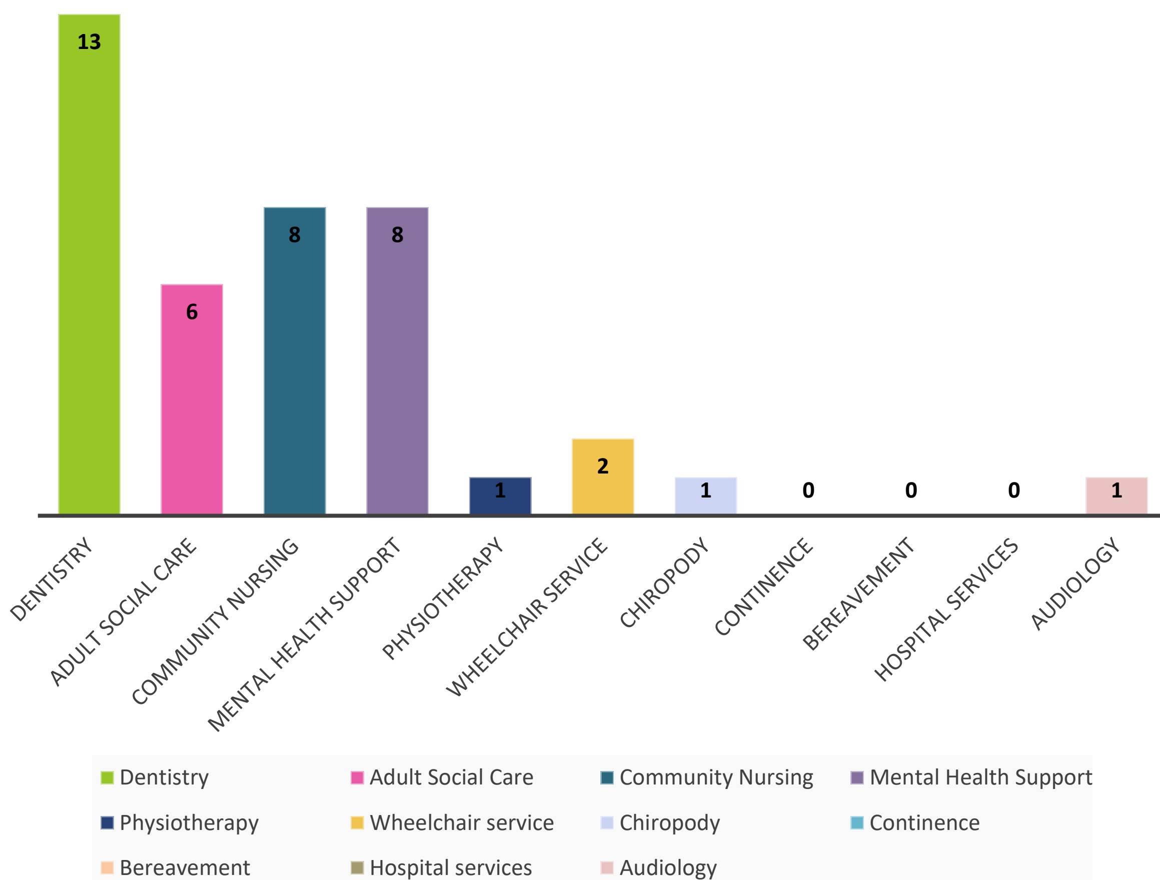
Constantly having to remind GP for death certificates - can take up to 5 days. GPs Policies need reviewing by the practice rather urgently.

Do referrals to St Francis hospice. Long standing patients, staff get effected by death. Right support

Send condolence card to family and more support for staff.

Accessing other healthcare services

Homes experienced varying degrees of difficulty accessing other healthcare services. Unsurprisingly, dentistry was reported as the hardest to access:



Dentistry though the commissioning? based in Kent, not good. Don't respond too quick. Adult Social Care very supportive, Community Nursing good, Mental Health support good.

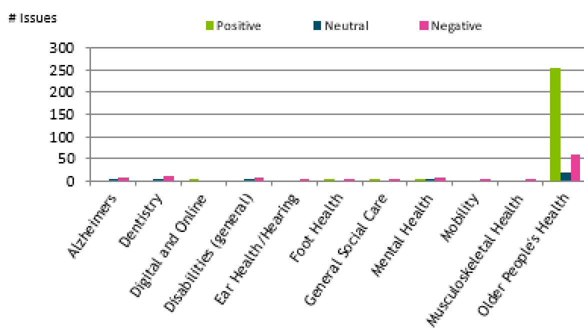
Dentistry - rang 111 but sent to dentist upstairs (wheelchair?) - family very unhappy Community Nursing - No TVN cases

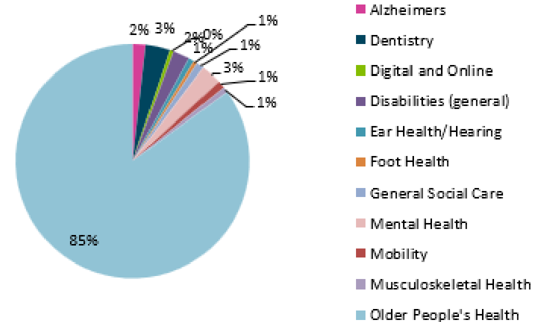
Hairdresser and chiropodist - ok. Adult Social Care - meetings to be set up. Community Nursing - TVN nurses are ok, currently 4 residents need this. One sent home from hospital with no dressings on (Grade 3).

Community Insights

In addition to the quantitative data obtained by the survey, qualitative data provided by the responses to the survey were loaded into the Healthwatch Community Insights system (CIS) to provide insights about the view of the service.

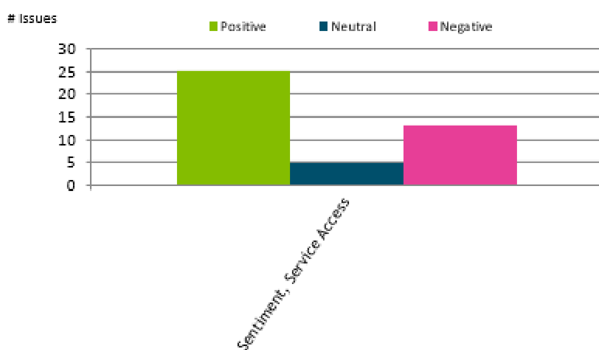
Having analysed comments about health and social care, it is interesting to note that the most commented upon medical condition is Older People's Health:

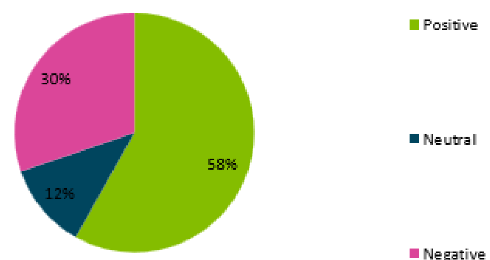




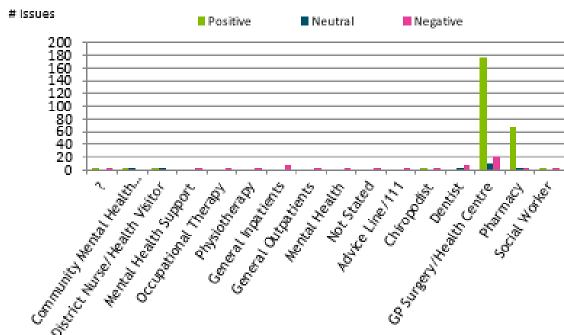
Medical conditions receiving the most comments overall

People were generally positive about services:

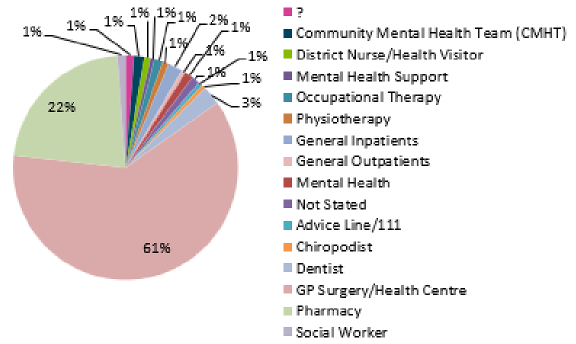




Comments were received about a range of services:



Service type receiving the most comments overall



Conclusions and recommendations

When our volunteers began the survey, they were surprised to find that not all of those contacted were aware of the survey – despite it having been the subject of several prior approaches to them by the then North East London CCG. Some declined to participate because they had not been forewarned. Others were aware of it, or despite not being aware, were happy to participate. Some of the contact details we were supplied with were inaccurate.

Overall, care homes appeared content with the service they received as a result of the DES system, although some expressed surprise that GPs received additional incentives to offer patients in care homes services that patients living in the community would receive in the course of their ordinary dealings with their GP. Not all homes appeared to have realised that the DES constituted a separate contractual arrangement for GPs.

Many care homes reported that, particularly during the periods of Covid disruption, they had had trouble in accessing non-GP healthcare services, especially dentistry. This suggests that thought may need to be given to extending the DES principles to other providers of healthcare services in order to ensure that care home residents receive the levels of care that people living in the community are able to obtain.

The terminology of the questionnaire gave the impression that the general expectation of senior NHS staff is that care homes are organised more along the lines of hospitals than is actually the case.

It became clear that there may be a gap of understanding between social care staff and healthcare professionals, with terms such as "home rounds", "Multi-Disciplinary Team" and "GP care plan" conveying slightly different meanings to people of different professional backgrounds. In the generality of events, that may not be too important, but it is essential that any possibility of misunderstanding is reduced to the minimum – if not eradicated entirely – when dealing with issues that, in the context of care homes, could become a matter of literally life and death.

We therefore recommend that NHS North East London (NHSNEL) work with care home representative organisations, such as Havering Care, to ensure that both care home staff and the healthcare professionals working with them share a common understanding of terminology they use and that healthcare professionals gain greater understanding of the way that homes are actually organised.

While recognising that NHSNEL does not yet have commissioning responsibility for dentistry and pharmacies, we recommend that when the responsibility is devolved to them, they consider some arrangement similar to a DES to ensure that dental practices and pharmacies are assigned to specific care homes.

It became clear in the course of the survey that not all homes were forewarned of the survey, nor that they had been contacted in advance by the CCG., an that the contact details we had been supplied with were inaccurate. We recommend that NHS NEL take prompt action to update and maintain their records of care homes, in liaison with CQC and the local authorities within North East London, to ensure that crucial information that care homes should be receiving from NHS NEL is delivered correctly.

Acknowledgments

We would like to thank all of the care home managers and staff who responded to the survey and provided frank and open comment.

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Healthwatch Havering Friends' Network

Join our Friends' Network for regular updates and other information about health and social care in Havering and North East London. It cost nothing to join and there is no ongoing commitment.

To find out more, visit our website at https://www.healthwatchhavering.co.uk/advice-and-information/2022-06-06/our-friends-network-archive

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