PCN DES Enhanced Health in Care Homes (EHCH)

By 31 July 2020, a PCN is required to:

* have agreed with the commissioner the care homes (defined as a CQC registered care home service, with or without nursing) for which the PCN will have responsibility. The commissioner will hold ongoing responsibility for ensuring that care homes within their geographical area are aligned to a single PCN and may, acting reasonably, allocate a care home to a PCN if agreement cannot be reached. Where the commissioner allocates a care home to a PCN, that PCN must deliver the EHCH service requirements in respect of that care home in accordance with this Specification;
* have in place with local partners (including community services providers) a simple plan about how the EHCH service requirements set out in this Specification will operate;
* support people entering, or already resident in the PCN’s Aligned Care Home, to register with a practice in the aligned PCN if this is not already the case; and
* ensure a lead GP (or GPs) with responsibility for these EHCH service requirements is agreed for each of the PCN’s Aligned Care Homes.

By 30 September 2020, a PCN must:

* work with community service providers (whose contracts will describe their responsibility in this respect) and other relevant partners to establish and coordinate a multidisciplinary team (“MDT”) to deliver these EHCH service requirements; and
* have established arrangements for the MDT to enable the development of personalised care and support plans with people living in the PCN’s Aligned Care Homes.

As soon as is practicable, and by no later than 31 March 2021, a PCN must:

* establish protocols between the care home and with system partners for information sharing, shared care planning, use of shared care records, and clear clinical governance.

From 1 October 2020 (amended to May in Simon Stevens letter dated 29/04/2020), a PCN must:

* deliver a weekly ‘home round’ for the PCN’s Patients who are living in the PCN’s Aligned Care Home(s). In providing the weekly home round a PCN:
  + must prioritise residents for review according to need based on MDT clinical judgement and care home advice (a PCN is not required to deliver a weekly review for all residents);
  + must have consistency of staff in the MDT, save in exceptional circumstances;
  + must include appropriate and consistent medical input from a GP or geriatrician, with the frequency and form of this input determined on the basis of clinical judgement; and
  + may use digital technology to support the weekly home round and facilitate the medical input;
* using the MDT arrangements referred to above develop and refresh as required a personalised care and support plan with the PCN’s Patients who are resident in the PCN’s Aligned Care Home(s). A PCN must:
  + aim for the plan to be developed and agreed with each new patient within seven working days of admission to the home and within seven working days of readmission following a hospital episode (unless there is good reason for a different timescale);
  + develop plans with the patient and/or their carer;
  + base plans on the principles and domains of a Comprehensive Geriatric Assessment including assessment of the physical, psychological, functional, social and environmental needs of the patient including end of life care needs where appropriate;
  + draw, where practicable, on existing assessments that have taken place outside of the home and reflecting their goals; and
  + make all reasonable efforts to support delivery of the plan;
  + identify and/or engage in locally organised shared learning opportunities as appropriate and as capacity allows; and
  + support with a patient’s discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 2750.

For the purposes of this section 7.3, a ‘care home’