Derby and Derbyshire
Clinical Commissioning Group

Addendum for the Care Homes Enhanced Service

(Derbyshire Legacy Enhanced Services w/e 31/10/19 – 31/03/20)

Introduction

This document sets out more information to support the addendum to the Enhanced Care Home Service Specification, which will be implemented from October 2019 by participating practices within Derby and Derbyshire CCG. It sets out:

- The ask of practices and PCNs
- The offer to practices and PCNs

The Frailty at Home Service in Erewash will be subject to a separate but equivalent change.

Why are we changing the service?

From 1st April 2020 the new NHS England Enhanced Health in Care Home Framework service (based on Care Home Vanguard sites) will be commissioned via PCNs. The detail of this service specification is currently unknown, but it will be based on the delivery model tested in the six care home vanguards between 2014 and 2018. This comprises a structured set of evidence based interventions that have reduced ambulance conveyances, over-medication and improved the quality of care for residents. The new specification will ensure that all care homes are supported by a consistent team of multi-disciplinary health and social care professionals delivering proactive and reactive care, led by named GPs and nurse practitioners, organised by the Primary Care Network.

In Derbyshire we have a range of different models, reflecting the legacy of four CCGs and local variation. Practices have carried out a great deal of positive work as part of the care home service and improved support to residents and care home staff. However, there are inconsistencies in service delivery across the patch and it is not clear that the monitoring arrangements demonstrate the tangible benefits for both patient care and reducing costs to the system.

In addition the CCG and the health system as a whole is under significant financial pressure with the CCG is facing a savings requirement of £69.5m for 2019/20. We feel that developing the care homes service in line with national evidence will reduce avoidable cost in the system and help towards this target.

By asking practices to develop and implement a PCN plan we aim to ensure a consistent and evidence based approach, provide extra focus on care homes over the coming winter, and get ahead of the curve to prepare for the new service specification coming in April 2020.

The ask of practices and PCNs (October 2019 to March 31st 2020)

The current service specifications issued by the former Derbyshire CCGs, with the accompanying update, will continue to be commissioned until 31st March 2020. The additional requirement of practices is as follows:

- From 31st October 2019 (at the latest) practices are expected to work together with other practices in their Primary Care Network to develop and implement a PCN approach to delivering this service at scale for their patient population for care homes within the PCN boundary.
- PCNs will be supported to develop and implement plans that will allow for a smooth transition into the service required under the national Network Service Specification (Enhanced Health in Care Homes) from 1st April 2020, with further detail provided on this as soon as it is available
- Plans to follow best practice as detailed in the Enhanced Health Care Homes Framework to show how the PCN will work with partners to:
    - Focus on pro-active care planning in line with a Comprehensive Geriatric Assessment (CGA) style approach)
    - Develop a lead practice or lead clinician for each care home
    - Support Multi-Disciplinary Team working and ensure regular visits to care homes
    - Focus on supporting care homes with their educational needs wherever possible and in implementing local pathways as a way of avoiding urgent care episodes
- PCNs, and their constituent practices, are asked to report on the progress of this work and to monitor activity linked to the care homes within their geography and take action to improve quality and reduce unwarranted activity wherever possible

The attached appendix provides detail on the elements expected within the plan, the evidence behind them, and examples of good practice.

Place Alliances are well placed to support this work and have 'care homes' as a priority area of focus and can be pro-active in supporting collaboration, improving demand management and promoting integrated approaches.

As part of the MDT approach it is expected that PCNs will link in with their Place Alliance members to:

- Work together to identify potential areas for more joined up and closer working relationships that will benefit people living in care homes.
- Agree the areas where joined up working would be possible and add value to the care of residents.
- Develop a shared service model to include ways of communicating, sharing information, escalating issues etc. This does not need to be anything too formal but a description of how partners will work together.
- Build in opportunities to meet on a regular basis to review working practice and make changes as appropriate.

Practices / PCNs will be issued with information regarding the care homes that are in their locality. The CCG would expect PCNs and practices to agree internally which care homes would come under their responsibility as part of the service. It is recognised that this may not be a straightforward process for all care homes and all PCNs due to border issues etc. The general principles of allocating care homes to PCNs should be based on:

- geography
- PCN boundary
- size of home
- type of home (ie. specialist end of life facility)
- fairness / sharing responsibility.

If decisions regarding alignment of care home to PCN cannot be resolved and agreed internally then the CCG GP Commissioning and Development team will facilitate to support a resolution. PCNs will be required to confirm what care homes will be included in their service in line with criteria set out above.

It is recognised that this is a transitional process and represents a new way of working for practices. Therefore, this period from October 2019 – April 2020 gives practices opportunity and lead in time to form relationships and work collaboratively to develop an agreed model of care to support patients in care homes. It is recognised that this will take time to implement but it is expected that practices work towards this and can demonstrate that actions are being undertaken to monitor progress towards a PCN model of care. The monitoring arrangements will also reflect this.

This update does not intend to be overly prescriptive regarding service model / design. It is intended to support practices to move in the right direction of working together to develop better integrated, more joined up services to support those in care homes and ensure that practices are in a prime position to begin the new Enhanced Health in Care Home service from April 2020.

The Monitoring Arrangements

The monitoring will reflect the expectations above. Each PCN will be asked to set its own plan and within that its own targets for the progress they believe they can make. The CCG will take responsibility to ensure that these targets are consistent and reasonable county wide and moderate accordingly.

However, the CCG will be asking PCNs to focus on the activity from care homes which drives cost and resource use in the system as a priority. This means monitoring non-elective and elective activity, and focusing on those homes that are outlying in terms of their activity and cost to the system. We recognise that there may be good reasons behind this, and that much of this is outside the control of practices so would be seeking for PCNs to identify it and work with fellow providers and the CCG to develop interventions to address it.

The CCG will thus expect these plans to include targets for

- Non elective admissions
- A&E attendances
- First and follow up outpatient attendances
- Pharmacy spend

- EMAS Calls & conveyance.

The CCG will collect and provide information on these targets on a monthly basis, as well as providing information on activity by home (see section on information below). PCNs can choose to develop other targets as well, which are indicative of quality. For example:

- Reduction in falls
- More people dying in their preferred choice
- More people having a CGA based style of care assessment
- Medicine reviews undertaken regularly

Measures relating to cost and quality are inter-related and the expectation is that a more pro-active integrated form of care will improve quality and experience of the service but also reduce costs to the system. he quality measures will not be collated centrally as part of the QIPP process but may be monitored at a more local level as evidence of increased quality of care.

PCNs will be asked to provide an in year report on progress in February 2020 ahead of the new DES

The support offer to practices and PCNs

Good quality information

PCNs will be provided with a list of the care homes in their locality. The first task for PCNs / practices will be to validate this list and to confirm the care homes that will be included in their service by 16th August 2019. Information should be sent to Emma Plummer (e.plummer@nhs.net).

Once validated PCNs will be provided with their *Care Home Data Resource Pack* that will include data on the targets detailed above (Non elective admissions; EMAS calls and conveyances; A&E attendance; First and follow up outpatient appointments)

This pack will be developed in consultation with PCNs. Information will be categorised by activity and cost for PCN / practice and also tracked by individual care home (benchmarked and standardised by bed numbers).

There will also be links available to specific RAIDR reports to enable PCNs / practices to understand more specific, patient related information to inform work planning.

The information will be refreshed on a regular basis and PCNs will be expected to use the information to inform their service delivery model and planning. The information will also be pivotal in enabling PCNs to monitor outcomes locally.

Support from the CCG team and expert working group

PCNs will be supported in developing their plans by members of the CCG GP Development and the CCG Place team. If required the CCG will provide a template to help structure this plan as well as facilitation, offering a point of contact for queries, support for service planning and project management. PCNs will also have access to CCG Business Intelligence support (for example, further data analysis to refine service development work) The Care Home Working Group will also be able

to offer any specialist support regarding clinical and quality perspectives / expertise from other organisations.

Helpful Guides and Resources

PCNs will have autonomy to determine how best to deliver enhanced care for people in care homes working within a best practice framework to encourage PCNs to work together with other system providers to develop a more collaborative approach to care, using appropriate data to inform developments with a view to reducing the need for acute hospital visits and urgent care episodes whilst improving quality of care and patient experience.

The appendices below highlight the specific areas of good practice and evidence based work nationally, including learning from the Vanguard sites, that can be used to best support people in care homes and can offer most benefit for improving care for residents. These areas also compliment the priority areas of the Enhanced Health in Care Homes Framework (2016) that will be implemented by NHS England from April 2020.

Finance

The level of funding for the Care Home service specifications will remain the same for the period October 2019 – April 2020 that incorporates the CV. The funding will continue to be allocated to individual practices in line with current arrangements as specified in each of the former CCG agreements. There will not be additional monies available for support relating to service planning or administration. From April 2020 there will be a new funding framework in place as per the new NHS England specification agreement. PCNs will receive information relating to the finances available for individual practices and the total sum available for the PCN. PCNs have the autonomy to allocate these funds as they see fit to deliver the service model agreed locally.

Timetable

Action	**Who**	**By When**
CCG's to add an additional clause into all existing Care Homes Enhanced Service Specifications to require practices to work together within their Primary Care Network (from October) as part of the transition to the new Directed Enhanced Service from April 2020	CCG	End July
CCGs to provide information on what care homes sit within each PCN	CCG	End July
PCNs to check care homes list to confirm which homes are covered by their PCN and to what degree	PCNs	16th August
CCG to provide information on activity linked to those care homes	CCG	16th August
CCG to provide template for plan and support to complete	CCG	16th August
PCNs to agree plan for working together to support care homes	PCN	End Sept.
PCN to implement plan	PCN	Oct - Mar20
CCG to provide monitoring information on activity	CCG	Monthly from August
PCN to provide in year report on progress	PCN	February 20
CCG/PCN to agree plan for 19/20 in line with new national DES	PCN/CCG	TBC

Further information and support

- List of care homes by PCN for checking
- Letter to practices adding an additional clause to existing Care Homes Enhanced Service Specifications requiring them to work together within their Primary Care Network (from 25/10/19) as part of the transition to the new Directed Enhanced Service from April 2020
- Appendices detailing evidence base and best practice
- CCG leads: Clive Newman (clive.newman3@nhs.net) is the Senior Responsible Officer for this work, supported by Emma Plummer (e.plummer@nhs.net) from the CCG Place team. If you have any queries or comments then please get in touch.

Appendices

Appendix One - Inclusions and Exclusions

All care homes including residential and nursing homes will be included in the service. Extra Care facilities and care homes for people with Learning Disabilities will not be included. Where there are care homes (residential and / or nursing) that offer more specialist provision (ie. end of life) they will need to be highlighted to the CCG for consideration of inclusion in this scheme. It is expected that these care homes will be small in number.

Temporary Residents will be considered as being in scope for this work and care should be provided that is in line with the principles and standards highlighted in this document. However, it is recognised that if temporary residents are going to be in a bed for just a number of weeks then it will not be possible for PCNs to offer the full range of support that they may do for permanent residents. It would still be expected that these patients are appropriately assessed and contributions made towards their personalised plan of care and ongoing CGA.

Patients in pathway 2 beds will have their medical care provided via separate contracting arrangements. PCNS should support the flow of patient care via Discharge to Assess and aspire to provide care in line with the principles and standards of integration.

Appendix Two – Lead Clinician and Alignment of Practices

The Enhanced Health in Care Homes Framework (2016) emphasises the importance of care homes having access to a consistent, named GP / lead clinician as a way of enhancing the level of support offered to care homes. It is documented widely that this approach also does much to improve relationships between practices and care homes and support continuity of care for residents. It is expected that this element will be a key feature of the service specification from April 2020.

It is recognised that such arrangements are already in place across a great deal of the patch. However, where there is not a named, lead clinician for each care home we would expect practices to make arrangements for this to be common practice as part of the CV. The aim is to implement a lead practice or lead clinician for each care home with a view to improving relationships and continuity of care for patients.

It is widely recognised that alignment of practices to care homes improves relationships and outcomes, however, it must be remembered that patient choice is paramount to this and must be respected at all times.

Appendix Three - Principles and Standards for the Integrated Care of People Living in Care Homes in Derbyshire.

It has already been stated in this document that there will not be a prescriptive service model of delivery put forward for practices / PCNs to follow. It is expected that practices will work both individually and collaboratively within their PCNs to support their patients that live in care homes. We expect practices / PCNs to do so according to these principles and standards to facilitate safe, effective, caring, responsive and well led services for people living in care homes.

Providers will:

1. Proactively identify people living as new permanent or temporary residents in care homes.

2. Deliver Comprehensive Geriatric Assessment or an equivalent multidisciplinary, multidimensional and multi-professional process of proactive assessment and iterative case management – started within one week of arrival in a care home. These plans should be reviewed on a regular basis using a PDSA based cycle involving members from appropriate disciplines.

3. Provide integrated proactive and reactive care that is seamless from the perspective of the person receiving services and their family or advocates, avoiding duplication and repetition.

4. Record, document and share with all providers of urgent and routine services a detailed, person centred care plan for every person living in a care home. This must include a comprehensive plan comprising of a Health and Social Care Summary Record to include an escalation plan, an anticipatory care plan, an end of life plan and a DNCPR form.

5. Ensure that if a person living in a care home shows functional decline or suffers a crisis the health and social care response is quick, comprehensive, multidisciplinary and delivered either in or as close to the care home as possible;

    a. At any time of day or night and on any day of the year the community response to a functional decline or crisis suffered by a person living in a care home must have the ability to safely and effectively determine their care needs within 2 hours (in line with the new 2 hour community response detailed in the Long Term Plan). Please note that, whilst the 2 hour response is currently aspirational, that this is considered best practice and something that should be pursued as such. The 2 hour response does not necessarily have to be a face to face contact, a telephone conversation to assess need / triage would be considered acceptable.

    b. A clinical decision maker (a person with clinical diagnostic and care planning skills and competencies) should be able to be involved within that 2 hour window (described above).

    c. The community response together with the responsible clinical decision maker should determine the safest, most effective course of action that best meets the person's wishes and is in their best interests. This must be documented.

6. Ensure that the care and management of people living in care homes promotes autonomy, is

least restrictive, allows choice and personal preference and provides rehabilitation and reablement wherever possible;

a. People living in care homes must be assumed to have the capacity to determine their care. The Mental Capacity Act must be correctly used to support vulnerable people to make decisions and choices and to act in their best interests if they lack capacity.

b. Clinicians, particularly doctors, should recognise that rigid adherence to medical management plans or drug regimens may not be what people want or even in their best interests. Decisions to refuse treatment or decline investigations or escalations of care must be carefully considered and documented.

c. Rehabilitation and reablement are important and effective interventions to help people regain independence, confidence and wellbeing. The multidisciplinary team should assess people living in care homes for the potential to benefit from such services and provide them accordingly.

d. Of equal importance for people living in care homes is equity of access to specialist services either in the community or in hospital. The multidisciplinary team, led by primary care, should work with all providers to enable such access to specialists.

7. Ensure that integrated care for people living in care homes in Derbyshire is safe, effective, caring, responsive and well led. All clinical and non-clinical team members from all organisations should ensure this is done by giving due consideration to the 7 pillars of clinical governance, namely; patient and public involvement, staffing and staff management, clinical effectiveness and research, using information and IT, education and training, risk management and audit.

    a. Agreed performance and outcome measures for integrated teams should be developed using a clinical governance matrix framework approach incorporating these principles and standards.

    b. Employing organisations should agree the composition of place based integrated teams (within Primary Care Networks) to be able to work together to deliver these principles and standards.

8. Care home staff will be enabled to confidently manage residents' needs. Where a training need is identified, the team will support the care home personnel with advice/training or signposting as appropriate. Any identified commissioning gaps, themes for education or additional support required should be reported to the CCG.

Principles and Standards for the Integrated Care of People Living in Care Homes in Derbyshire.

Dr Ben Pearson, Consultant Geriatrician, UHDB (November 2018, updated March 2019).

Appendix Four - Multi-Disciplinary Team Working: Moving Towards an Integrated Approach

People living in care homes have the most complex of needs that can be hugely challenging and the evidence is clear; those with access to MDTs do best. Through regular meetings of a consistent MDT the balance of care for care home residents can shift from being reactive to proactive.

Examples of an MDT may include the following membership / organisations:

- ✓ Primary Care
- ✓ Community Care (DCHS)
- ✓ Specialist Geriatrician / Acute Service Support
- ✓ Mental Health
- ✓ Specialist Care Services (SALT, Dietetics etc)
- ✓ Medicines Management
- ✓ Social Care
- ✓ Voluntary Services.

It is not expected that practices would have completed the process of working with other providers to establish a formal MDT and have implemented that from October.

However, it is good practice to involve other agencies in the care of residents and ensure that there is access to appropriate services and support when necessary. It is expected that practices / PCNs work *towards* developing a more integrated, multi-disciplinary based model of care by engaging with other providers involved in the Place Alliance and working collaboratively with them. Again, this is viewed as a transitional area of development and progress is expected to be made towards a more integrated approach to care in line with expected requirements from April 2020. The monitoring arrangements will reflect this and practices / PCNs will be required to provide evidence of a greater move towards better integration of care for people in care homes.

The Multi-Disciplinary Team (MDT) may work with the individual care home managers and the leadership of the practice / PCN associated with the care home to:

- **Redesign and identify best practice care pathways –** develop safe, non-acute care pathways with the MDT as the first contact for staff in care homes for early intervention. The MDT will triage the issue and support the residents and staff to the most appropriate management plan.
- **Agree protocols with care home staff to facilitate and respond to requests for assistance including emergency care requests.** This should include the way that the care home and MDT will communicate regarding resident related issues.
- **Develop and maintain strong links** and communication channels for effective liaison between all providers involved in a resident's care.
- **Proactively identify residents that may be deteriorating** or at risk of deterioration requiring reactive or proactive care.
- **Develop / monitor/review the delivery of CGA style personalised care plans** A named clinical lead (not necessarily a doctor) will be responsible, in close liaison with the MDT professionals for ensuring every resident has a monthly review of their care plan as a minimum. This must be clearly recorded. Care plans will include aspects on hydration,

nutrition, oral health and end of life care planning

- **Ensure completion of regular medication reviews** of all current residents. Best practice is that this is carried out on a weekly basis but should not be less than monthly.
- **Develop, implement and review education and support** for care home staff and the MDT. This aspect is best applied within in a continuous cycle of review and application.
- **Ensure capacity for ongoing resident, family and carer evaluation** of service and involvement in residents' care.

MDTs function best when:

- There is someone whose role it is to coordinate the MDT meetings and to act as a central contact point.
- There is a system wide approach and engagement for the process. Appropriate recognition for the role and value of MDT involvement is supported by job plans and organisation management teams.
- Members meet on a regular basis with continuity of attendance and input.
- There is effective communication and all members receive and access information in a timely manner that is appropriately documented and shared.
- There is a whole system approach to care delivery.
- MDT members work agnostically of their employing organisation.
- Care is provided in a responsive, timely manner.
- Laptops are used to ensure access to live information and for completing actions during the course of the MDT.

Appendix Five - Team and Working Culture

Several studies point to the fact that it is *how* things are done, *how* care is approached and organised and *how* relationships are built that delivers the most success as opposed to following a prescriptive process / or carrying out a defined list of interventions. In this respect developing a positive team and working culture are paramount to the success of the model. Positive culture and working relationships develop when there is:

- mutual respect and trust between team members
- an equal voice for all members and different opinions valued
- resolution of conflict between members
- encouragement of constructive discussion / debate
- ability to request and provide clarification if anything is unclear
- sharing experiences and learning with the MDT for education purposes.

It is expected that practices / PCNs will work with care homes to build trust, positive working relationship and a culture of openness and respect.

Appendix Six - Education & Training

The Care Home Working Group are keen that there remains a focus on supporting care homes (where possible) with their educational / training needs. This is not to say that practices / PCNs will become formal providers of education / training but will be expected to offer a supportive approach to help care homes identify areas for potential development, learn from any relevant incidents and implement local pathways as a way of avoiding urgent care episodes. It would also be beneficial for practices / PCNs to highlight any commissioning gaps for education training and raise issues / themes / concerns that would offer beneficial intelligence to the wider health and social are system. This element relating to education and support to care homes already features in the majority of specifications.

Appendix Seven – Examples of Best Practice from Vanguard Sites and Resource Guides

These guides have been published by NHS England as part of the Care Home Vanguard work and are intended to serve as a useful resource for supporting other areas to replicate best practice and benefit from learning. The offer useful advice and practical suggestions about how best to move forward to implement an enhanced level of care for people in care homes.

How_to__MDT_v4.6.pdf.pdf

Vanguard_Learning_Guide_1.2_Medicines_

Vanguard_Learning_Guide_4.1_End_of_Li

Vanguard_Learning_Guide_1.1_Primary_C

Appendix Eight - Planning a Comprehensive Geriatric Assessment (CGA) Approach to Care Planning.

The following links and resources from the British Geriatrics Society highlight best practice areas for supporting people living with frailty in community settings. The BGS recommends an holistic, personalised medical review based on the principles of comprehensive geriatric assessment (CGA) for all older people identified with frailty. Developing problem lists related to patients and then having these reviewed and discussed by a multi-disciplinary team is a key component of the care planning, CGA process. The benefit of this approach comes from the quality of the MDT discussions, communication and outcomes as opposed to following any structured template. Templates are available to use but practices are advised against following an overly structured process as this can be counterproductive to developing a truly personalised, holistic approach to care.

British Geriatric Society: Fit for Frailty Part One: Consensus Best Practice Guidance for the Care of Older People Living in Community and Outpatient Settings (2014).

This guidance is intended to support health and social care professionals in the community, in outpatient clinics, in community hospitals and other intermediate care settings and in older people's own homes.
https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-23/fff_full.pdf

British Geriatric Society : Fit for Frailty Part Two: Consensus Best Practice Guidance of Older People Living with Frailty in Community Settings (January 2015).

Developing, commissioning and managing services for people living with frailty in community settings. Guidance for GPs, Geriatricians, Health Service managers, social service managers and commissioners of services

https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-23/fff2_full.pdf

Comprehensive Geriatric Assessment Toolkit for Primary Care Practitioners

The CGA toolkit for General Practitioners and medical and healthcare professionals working in primary care settings explains what comprehensive geriatric assessment is, in what circumstances to use it and how it is done together with planning and involvement of social services. In addition, the series includes guides on specific medical issues that older patients may present with. These CGA guides cover a range of conditions and situations, from bone health to end of life care.

https://www.bgs.org.uk/resources/resource-series/comprehensive-geriatric-assessment-toolkit-for-primary-care-practitioners

Appendix Nine – NHS Right Care Frailty Tool Kit, NICE (June 2019)

Toolkit provides expert, practical guidance on how to commission and provide the best system wide care for people living with frailty.