Creating a healthier Hull

NHS Hull Clinical Commissioning Group

Item 8.5

Item: 8.5

Report to:	Primary Care Commissioning Committee
Date of Meeting:	26th June 2020
Title of Report:	ENHANCED PRIMARY AND COMMUNITY SUPPORT TO CARE HOMES
Presented by:	Phil Davis, Strategic Lead - Primary Care, Hull CCG
Author:	Phil Davis, Strategic Lead - Primary Care, Hull CCG

STATUS OF THE REPORT:

To approve		To endorse	
To ratify		To discuss	
To consider	x	For information	
To note			

PURPOSE OF REPORT:

The purpose of this report is to provide the Primary Care Commissioning Committee with an update on the enhanced primary and community support to care homes.

RECOMMENDATIONS:

It is recommended that the Primary Care Commissioning Committee consider the contents of this report.

REPORT EXEMPT FROM PUBLIC DISCLOSURE No [x] Yes [ ]

If yes, detail grounds for exemption

CCG STRATEGIC OBJECTIVE *(See guidance notes on page 4)*

Integrated Delivery

The updates contained within this report support the CCG objective of Integrated Delivery through the development of primary care medical services

IMPLICATIONS: (*summary of key implications, including risks, associated with the paper*),

Finance	Financial implications where relevant are covered within the report.
HR	HR implications where relevant are covered in the report.
Quality	Quality implications where relevant are covered within the report
Safety	Safety implications where relevant are covered within the report.

ENGAGEMENT: (*Explain what engagement has taken place e.g. Partners, patients and the public prior to presenting the paper and the outcome of this*)

Engagement undertaken with Primary Care Networks, CHCP, Hull City Council Adult Social Care and North East Commissioning Support.

LEGAL ISSUES: (*Summarise key legal issues / legislation relevant to the report*)

None

EQUALITY AND DIVERSITY ISSUES: (*summary of impact, if any, of CCG's duty to promote equality and diversity based on Equality Impact Analysis (EIA).* ***All*** *reports relating to new services, changes to existing services or CCG strategies / policies* ***must*** *have a valid EIA and will not be received by the Committee if this is not appended to the report*)

	Tick relevant box
An Equality Impact Analysis/Assessment is not required for this report.	√
An Equality Impact Analysis/Assessment has been completed and approved by the lead Director for Equality and Diversity. As a result of performing the analysis/assessment there are no actions arising from the analysis/assessment.	
An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.	

THE NHS CONSTITUTION: (*How the report supports the NHS Constitution*)

The report supports the delivery of the NHS Constitution as the commissioning of primary care services will aid in the delivery of the following principles, rights and NHS pledges:

1) The NHS aspires to the highest standards of excellence and professionalism
2) NHS works across organisational boundaries and in partnership with other organisations in the interests of patients
3) Quality of care
4) You have the right to expect NHS organisations to monitor, and make efforts to improve, the quality of healthcare they commission or provide.

ENHANCED PRIMARY AND COMMUNITY SUPPORT TO CARE HOMES

1 INTRODUCTION

The purpose of this report is to provide the Primary Care Commissioning Committee with an update on the enhanced primary and community support to care homes.

2 BACKGROUND

The 2020/21 Network Contract DES includes the introduction of a national service specification. Guidance published on 31st March 2020 by NHS England & NHS Improvement: *Network Contract Directed Enhanced Service Guidance for 2020/21 in England* and *Network Contract Directed Enhanced Service Contract specification 2020/21 - PCN Requirements and Entitlements)* confirmed the requirements of PCNs in delivering the service.

These documents included guidance in the following areas:

- Definition of a care home: a CQC registered care home service
- Alignment of care homes to PCNs by 31st July
- Development of delivery plans with local partners including community services
- Re-registration of care home residents

The service requirements are attached as Appendix 1.

Specific work to support care homes had commenced in the early stages of the pandemic through the re-orientation of the integrated care centre frailty team to provide a frailty response service which includes support for care homes in conjunction with the range of other health and care services.

3. IMPACT OF COVID-19

3.1 National requirements

On 29th April 2020 the *Second Phase of NHS Response to COVID19* letter was received from the NHS Chief Executive and Chief Operating Officer. This letter referenced further support to care homes and would be brought forward drawing on key components of the Enhanced Health in Care Homes service and delivered as a a collaboration between community and general practice teams. This would also include a virtual ‘care home round’ of residents needing clinical support.

On 1st May 2020 a further letter, *COVID-19 response: Primary care and community health support care home residents* was received setting out more details of what primary and community health services were being requested to do to support care homes as follows:

- timely access to clinical advice for care home staff and residents;

- proactive support for people living in care homes, including through personalised care and support planning as appropriate;
- care home residents with suspected or confirmed COVID-19 are supported through remote monitoring – and face-to-face assessment where clinically appropriate – by a multidisciplinary team (MDT) where practically possible (including those for whom monitoring is needed following discharge from either an acute or step-down bed); and
- sensitive and collaborative decisions around hospital admissions for care home residents if they are likely to benefit.

Specifically three elements to the clinical service model were set out:

a) Delivery of a consistent, weekly 'check in', to review patients identified as a clinical priority for assessment and care;
b) Development and delivery of personalised care and support plans for care home residents;
c) Provision of pharmacy and medication support to care homes.

The letter is attached as Appendix 2.

On 8th May 2020 details were received on a Primary care sit-rep that would be required to be submitted on 13th May and weekly thereafter in relation to the care home support provision. Reporting is required as follows:

- For practices:
  i. Delivery of the three elements of the clinical service model
  ii. Delivery of the service through a network or 'at scale' collaboration

- For care homes:
  i. Receipt of the three elements of the clinical service model
  ii. Having a named clinical lead

It should be noted that responsibility for clinical lead will not be medically responsible or accountable for patients that are registered with another GP/practice.

3.2 Progress

3.2.1 Alignment of care homes to PCNs

In support of the CCG's frailty work, and in anticipation of the Network DES requirements, work had commenced pre-COVID-19 to analyse care home resident data to support the alignment of care homes to PCNs. It was recognised that this would be a challenging piece of work as the geographic nature of Hull CCG means that practices have registered patients in multiple care homes and many care homes have their residents registered at multiple practices.

The number of CQC registered care homes in the city and within the scope of the service is 82 which includes a number of small facilities for people with learning disabilities. In addition 2 small care homes for people with learning disabilities in

Wawne within the East Riding of Yorkshire were added, following agreement with East Riding of Yorkshire CCG, given their geographic proximity to Hull.

Data analysis was undertaken to identify current resident registrations and a proposed alignment to PCNs produced which broadly aligned a care to the PCN which had the most residents registered in the home. Discussions took place with the PCN Clinical Directors and an alignment was agreed. The alignment resulted in the proportion of care home residents aligned to each PCN broadly reflecting the overall proportion of all patients registered by PCN.

3.2.2 Implementation of the three elements

Once the alignment of the care homes to each PCN was agreed the PCNs have been developing their own arrangements as to how the service is delivered. In some cases a single team will be supporting all homes whereas in other cases individual practices are aligned to individual care homes. All care homes are receiving the three elements of support.

All care homes have a named clinical lead which has been communicated to the care home through a joint letter from the CCG Chair and Director Adult Social Care. The letter outlined the support that would be available to care homes and the benefits of the model as well as suggesting that discussions be had with new and existing residents and their families/advocates regarding registration.

To support the delivery of the three elements the PCNs have developed a Standard Operating Procedure (SOP). In addition work is on-going with both community services, the frailty team and medicines optimisation services to ensure services are working in a joined-up way to support care homes.

The support and co-operation of the Clinical Directors and wider PCN teams should be recognised in the CCG being able to meet the national requirements.

3.2.3 Other support to care homes

Working with Hull City Council and reflecting requirements of both health and social care in supporting care homes a broader care home support plan for Hull has been developed. The plan covers the following areas:

- Governance and assurance
- Data - including market analysis and capacity in the sector
- Infection prevention and control - including advice, guidance and training
- Testing - including Track, Trace and Isolate
- PPE and clinical equipment - including training and provision of pulse oximetry
- Workforce support - including mutual aid, psychological and well-being support
- Clinical support – as set out above and including follow-up of discharges from hospital into care homes
- Financial support
- Communication

Through pre-existing work across the Humber area all care homes have been provided with a lap-top, wi-fi and an NHS mail account. As part of the COVID-19 response all care homes have also been supplied with a tablet and 4G to support remote check-ins and video consultations. This technology also supports provision of at scale remote training.

Through NHS England and NHS Improvement and CCG resources all care homes will be provided with a pulse oximeter which can be used as part of a remote check-in or consultation. In line with NHS England and NHS Improvement requirements the PCNs and practices will be distributing these and supporting the care homes with training. Provision of further clinical equipment will also be considered.

4 RECOMMENDATION

It is recommended that the Primary Care Commissioning Committee consider the contents of this report.

APPENDIX 1

Enhanced Health in Care Homes service requirements

7.3.1. By 31 July 2020, a PCN is required to:

a) have agreed with the commissioner the care homes for which the PCN will have responsibility (referred to as the "**PCN's Aligned Care Homes**" in this Network Contract DES Specification). 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 Enhanced Health in Care Homes service requirements in respect of that care home in accordance with this Network Contract DES Specification;

b) have in place with local partners (including community services providers) a simple plan about how the Enhanced Health in Care Homes service requirements set out in this Network Contract DES Specification will operate;

c) 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

d) ensure a lead GP (or GPs) with responsibility for these Enhanced Health in Care Homes service requirements is agreed for each of the PCN's Aligned Care Homes.

7.3.2. By 30 September 2020, a PCN must:

a) 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 Enhanced Health in Care Homes service requirements; and

b) 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.

7.3.3. 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.

7.3.4. From 1 October 2020, a PCN must:

a) 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:

   i. 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);
   ii. must have consistency of staff in the MDT, save in exceptional circumstances;
   iii. 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

iv. may use digital technology to support the weekly home round and facilitate the medical input;

b) using the MDT arrangements referred to in section 7.3.2 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:

i. 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);
ii. develop plans with the patient and/or their carer;
iii. base plans on the principles and domains of a Comprehensive Geriatric Assessment49 including assessment of the physical, psychological, functional, social and environmental needs of the patient including end of life care needs where appropriate;
iv. draw, where practicable, on existing assessments that have taken place outside of the home and reflecting their goals; and
v. make all reasonable efforts to support delivery of the plan;

c) identify and/or engage in locally organised shared learning opportunities as appropriate and as capacity allows; and

d) support with a patient's discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 27.

7.3.5. For the purposes of this section 7.3, a 'care home' is defined as a CQC-registered care home service, with or without nursing.