NHS Rotherham Clinical Commissioning Governing Body

Primary Care Sub-Group- 28/1/16

Operational Executive – 8/2/16

Strategic Clinical Executive – 10/2/16

GP Members Committee (GPMC) –

LMC Officers- 22 Feb 2016

Primary Care Committee - **9/3/16**

Improving the Care for Older People in Care Homes Enhanced Service- Building on Proactive Case Management

Lead Executive:	**Sue Cassin,** *Chief Nurse*
Lead Officer:	**Dawn Anderson**, *Head of Primary Care Quality* **Wendy Allott**, *Deputy Chief Finance Officer*
Lead GP:	**Jason Page,** *SCE GP- Primary Care*

For Information ☐	**For Approval** ☒	**For Feedback** ☒

Purpose:

This enhanced service is designed to build on the alignment process (whereby practices and care homes have been assisted to move towards 1 practice per care home) for care homes and GP practices.

This proposal has been through the current Local Enhanced Services Development process and is now presented to the Primary Care Committee for approval. *The current specification can be seen in Appendix 1.*

Background:

National evidence has shown that a co-ordinated, proactive approach to primary care services in care homes improves care and reduces unplanned admissions to hospital. Residents of care homes often have complex health care needs, reflecting multiple long term conditions, significant disability and frailty. This group has more needs than those of elderly who reside in their own homes. With such a vulnerable patient group, any increase in clinical input can make a big difference.

Recent evidence from the Commissioning Value pack has also highlighted that the greatest percentage of patients with complex needs (of which 15% of the CCGs budget is spent) is in the 70+ age group.

It is commonplace in several CCGs to have a Care Home Enhanced Service. The LES presented here for consideration has been tailored to suit Rotherham, but is based upon several successful enhanced services already established in other areas. This enhanced service is targeted at elderly and elderly mentally impaired only. The key adaptations for Rotherham are that the service can be delivered by a GP or a suitably qualified clinician and that clinical pharmacists can also be involved. Practices can choose how to deliver this, but need to be mindful of putting in the correct staffing model to achieve the objectives of this enhanced service.

In Rotherham, admissions from Care Homes have been consistently high. There are approximately 1500 patients living in **36** elderly and EMI (elderly mentally impaired) homes.

There are 34 GP practices. At the start of alignment over half of the homes had between 6 and 12 practices visiting them (SEE APPENDIX 2). It is easy to see how the home that had **12** practices will have a bigger job to do to maintain relations with the practices, than the one which has just **1** practice. Conversely, there are practices which had patients in up to **24** homes, which is not very efficient for the practice in terms of visits or continuity of care. Alignment is currently underway (SEE APPENDIX 3 for list of aligned practices).

What are the objectives of this enhanced service?

- To improve overall care for Rotherham patients in residential and nursing homes
- To make it easier for GPs to look after this cohort by encouraging more proactive care and reducing unscheduled visits
- To reduce <u>avoidable</u> unplanned admissions to hospital
- To improve communication with other health professionals involved in the care of this cohort of patients and avoid unnecessary duplication
- To reduce the risk that any incidences of safeguarding may be missed
- To improve end of life care so that patients are more likely to be able to die in their place of choice
- To complement the wider effort taking place in other parts of the NHS to target resources towards communities, to integrate health and social care efficiently.

Since the scheme has been developed it has also become clear that other improvements can be put in place as a result of this such as medicines management and also communication via SystemOne.

How will this be achieved?

The detail about how this will be delivered is included in the service overview (SEE APPENDIX 4). Nb. As part of the alignment process, practices will have to produce a schedule of visits and meetings with the care home and will have agreed a memorandum of understanding about how they will work with the home.

<u>This service covers the work to be done to deliver a proactive service to care home patients and exceeds that currently included in the contract</u>. (Further details can be found in the service overview - APPENDIX 4)

The service will consist of the following elements:

- **Regular planned clinics** (minimum fortnightly) with a GP or 'suitably qualified clinician.
- All residents should be reviewed with the carer (and physically 'seen' if needed) **every two months**. *The aim is that the care plan is kept up to date by these regular visits*.
- Every resident must be seen 6 monthly by the Lead GP or a GP who is familiar with them and their care (physical review and review of care plan).
- **Bi-monthly meetings** with the care home manager and Lead GP to look at unplanned admissions.
- A practice register for all care home patients
- Production and maintenance of a care plan for each resident
- 6-monthly medication reviews
- Assessment of the resident within two weeks of admission to the care home by the Lead GP.

Payment of **£282** per patient per annum (see finance section for details) has been proposed.

Analysis of key issues and of risks

1. **Coverage**- This LES will cover all the relevant care homes in Rotherham.

2. **Tiered payments-** There has been some discussion about having different payments for nursing, residential and dementia patients, but at this current time there are mixed opinions about whether this is needed. It is therefore suggested that one payment rate is offered at this time, but that this be reviewed in the future. The flat rate will be offered per patient.

3. This is a development of case management but is a separate scheme for practices which replaces the current case management for this cohort of patients. Practices may draw a comparison with case management, but in reality this scheme is asking for a different model of service and offers a recurrent level of payment, whereas the case management input and level of payment declines in the second year.[1] Practices also need to recognise the benefits of alignment and better communication with the home.

4. **Funding-** The funding for this cohort currently resides within the better care fund and as this is a development of case management it is logical for the scheme itself to be under case management. **It can be seen within the financial section that if 1 admission per month per home could be saved, then this would more than fund this service.**

5. **Patient choice-** Patients and their carers will have been consulted about the service as part of the alignment process. This issue is continually raised, however evidence has shown that when offered the option of a regular visit with a familiar GP, patients and carers choose this option. It is expected that the number of patients who refuse to move will be minimal and will reduce over time. Current evidence is supporting this within Rotherham.

6. **Staffing**- Some GPs have voiced a concern that this is extra work for the GP, however the majority accept that planned visits give the practice the control over workload and aid efficiency. The service is also intended to be flexible to meet the workforce model within the practice so that 'suitably qualified clinician' can be utilised to triage and assist the GP. The CCG and RMBC recognise that assistance may be needed for some practices where issues arise with the home. Firm links have been established with RMBC to facilitate this.

7. **Other Local Enhanced Services and Directed Enhanced Services**- This cohort of patients are also likely to attract funding from the DES for dementia, the locally developed dementia LES and the Avoiding admissions DES. This needs to be highlighted in discussions with GPs. These schemes are complimentary to this one.

8. Some practices have expressed their concerns that this will lead to them managing the homes or that they will be linked to bad practice within the home. It has been re-iterated to them that the role of contract management firmly lies with RMBC. The service overview includes details of where they need to go to get assistance with regard to contracting and other issues.

The Consequences of not doing this

1. Admissions from care homes are likely to remain high, despite increased input from case management
2. The current situation within Rotherham is untenable and needs to be addressed so that patient care can be optimised. Current care is inequitable.
3. These are the most vulnerable patients. When 1 practice is looking after them it is

[1] Case Management is £250 for yr 1 and then £150 per year.

far more likely that any issues with their care will be identified.

4. The CCG would be open to challenge as to why it was not following a national direction of travel.
5. The integration agenda and new models of care will be difficult to implement for this cohort without this.
6. It will be difficult to ensure that End of Life care is undertaken in a consistent way

Patient, Public and Stakeholder Involvement:

Patients and their carers will have been actively involved in the alignment process. All care homes involved in the scheme have been visited and the service has been discussed with them- their enthusiasm is immense. There have been two care home/GP Practice events to share good practice. Further patient consultation will be built into the scheme once established.

This scheme has been discussed individually with practices and also with the LMC.

All supporting services, including RMBC are aware of this proposal and are supportive.

Equality Impact:

This LES will ensure that all patients within care homes are covered by this proactive service. Where a patient chooses not to be looked after by the GP practice aligned to the home, the original practice will still provide reactive medical services but will not be expected to deliver the enhanced service for this patient. *The current practice will have to apply to the CCG to continue case management for this patient.*

Financial Implications:

The recommended level of payment of £282 per patient is based on the calculations shown below:

STAFFING COST BASIS					
	Per hour				
Band 6 (inc on-costs)	£20.36				
Band 7 (inc on costs)	£22.00				
GP- based on SCE rate	£75.00				
Nurse Band 6 mid point	£19.11				
A&C 3 mid point	£9.00				
REQUIREMENTS		**Time per patient (hrs) per annum**			Cost per patient
Each patient seen bi-monthly for 15 mins by GP for treatment and/or review		1.5			£113
Each patient seen monthly for 15 mins by nurse		3			£57
Bi-monthly review of admissions with care home staff- Manager time- **based on 6pts being discussed per hour**					£4
Bi-monthly review of admissions with care home staff- GP time-**based on 10pts being discussed per hour**					£13
Production of care plan within 3 months of admission to the home		45			£38
Medication review 2 @ 20 mins		0.67			£50
Admin- 20 mins per patient					£9
Total per patient					**£282**
Total amount (based on 1500 patients)					**£423,745.00**

This is based on the best estimate of how much time will be involved. This will vary according to the medical needs of the patient. Although the scheme must be GP led, it will be at the discretion of the practice to deliver it in the best way that suits the patient and practice, so requests for clinic appointments may be triaged to a suitably qualified professional.

How will the payments be made?

It is proposed that all payments will be made quarterly in arrears. These will be as follows:

Q1 £102 (to include review of patients upon entry into the home)
Q2 £60
Q3 £60
Q4 £60

Each quarter the practices will submit numbers of patients, new and removals.

Where there are any new patients entering the home they will attract the higher fee on the quarter in which they enter. Any temporary patients during the time period will attract the £60 payment only as it is not expected that they will have a care plan, but it is expected that they will be reviewed (unless the time period is very short) and that they will be included in any of the clinic visits.

This will be funded by the monies within the case management scheme.

How does this compare to other CCGS?

CCG	PAYMENT	Per bed	Notes
A	£200	Residential Bed	* Figures based on 2013
	£300	Nursing home bed	
B	£227	Per bed	
C	£227	Per bed	
D	£220	Per Nursing home bed	* Figures based on 2012
	£200	Per residential bed	
F	£252	Per bed	
G	£650	Per patient	
H	£200	Residential Bed	
	£300	Nursing home bed	

Comparison with other CCGS is difficult as there are various ways in which enhanced services are paid. The suggested payment for Rotherham is within the range of payments offered elsewhere.

What could the potential savings be?

The admissions and potential savings are shown below:

	Total Length of Stay	Total Admissions	Average LoS	5% reduction	Potential savings	Admissions saved per month per home
12/13	9203	1014	9.1			
13/14	10108	1005	10.1			
14/15	12951	1287	10.1	648	£507,679	1
15/16 to date	1873	250	7.5			

These are based on the lowest admission tariff below (£784).

Tariffs

£784	Non Elective Same Day
£845	Non elective short stay i.e. up to 2 days
£102	Average A&E attendance
£2,383	Full blown non-elective admission to hospital

How will the scheme be monitored?

It is intended that the monitoring is light touch, with the focus upon the outcomes rather than the work done. Practices will have the relevant read codes and templates and will be able to generate reports about the number of patients and the number of times that they have been visited. They will also be required to submit a report signed off by themselves and the care home manager.

How will the scheme be evaluated?

Benchmarking data has already been established for:

- The number of non-elective admissions for each care home[2]
- The number of patients within the home allocated to each practice
- The number of 999 calls made by the home (from the ambulance service and the home)

Once the scheme is implemented we will also ask for admissions data from the practice (this can be more readily validated as the practice can see the patient-level details).

Practices will be asked to provide a quarterly summary of their patient numbers and activity and the emergency admissions.

Human Resource Implications:

GP practices will need to look at how they organise their staff to deliver this service and it may result in changes such as practice nurses going out to the homes.

Procurement:

GP practices are already contracted to provide basic primary medical services to patients within care homes. This enhanced service will build upon the service already offered.

References:

Recommendations:

The Primary Care Committee is asked to approve this proposal so that it can be implemented as soon as possible.

[2] Based upon the postcodes so may include some patients who are residing at that postcode but not within the home

APPENDIX 1- Service Spec

SCHEDULE 2 – THE SERVICES

CARE HOME LOCAL ENHANCED SERVICE

Service Specification No.	
Service	**CARE HOME LOCAL ENHANCED SERVICE**
Clinical Lead	Dr Jason Page, Strategic Clinical Executive
Officer Lead	Dawn Anderson, Head of Primary Care Quality
Provider Lead	As signed
Period	1st April 2016- 31st March 2017
Date of Review	

1. Population Needs

1.1 It is nationally accepted that aligning a care home with a GP practice improves care for those patients, and also improves communication with the care home staff. [3]

Evidence shows that a co-ordinated focus on the primary care services available to care home residents leads to better care and reduces unplanned admissions to hospital. This enhanced service is designed to complement the wider effort taking place in other parts of the NHS to target resources towards communities, to integrate health and social care efficiently and to reduce unplanned admissions to secondary care and therefore cost.

In Rotherham there are approximately 1500 patients living in 36 Elderly and EMI (Elderly Mentally Impaired) homes. This scheme builds on the alignment of GP practices to Care Homes to improve care to these patients.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	☐
Domain 2	**Enhancing quality of life for people with long-term conditions**	☐
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	☐
Domain 4	**Ensuring people have a positive experience of care**	☐
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	☐

2.2 Local defined outcomes

- The maintenance and improvement of quality
- A reduction in the number (and length of) admissions to acute hospitals from Care Homes
- Prescribing optimisation to reduce potential harm from inappropriate prescribing and associated expenditure.

3. Scope

[3] The Future of Primary Care- Report by the Primary Care Workforce Commission June 2015

3.1 Aims and objectives of service

The objectives of the LES are summarised below:

- To improve overall care for Rotherham patients in residential and nursing homes
- To make it easier for GPs to look after this cohort by encouraging more proactive care and reducing unscheduled visits
- To reduce the unnecessary utilisation of secondary care services and therefore cost
- To facilitate improved quality and co-ordination of care in the community setting
- To reduce the risk that safeguarding incidences may be missed
- To improve end of life care so that more patients are able to die in their place of choice.

3.2 Service description/care pathway

The Care Home LES arrangements will be for the provision of services over and above core services. (Further details can be found in the service overview)

The service will consist of the following elements:

- Regular planned clinics (minimum fortnightly) with a GP or suitably qualified clinician. All residents should be reviewed with the carer(and physically 'seen' if needed) every two months. *The aim is that the care plan is kept up to date by these regular visits*. Every resident must be seen 6 monthly by the Lead GP or a GP familiar with them and their care (physical review and review of care plan).
- Bi-monthly meetings with the care home manager and Lead GP to discuss unplanned admissions
- A practice register for all care home patients
- Production and maintenance of a care plan for each resident
- 6-monthly medication reviews
- Assessment of the resident within two weeks of admission to the care home by the Lead GP.

Recording
Practices will need to ensure that the appropriate read codes are used:

3.3 Population covered

The service will cover all those Rotherham patients in elderly and EMI residential and nursing homes.

Patients not residing in a care home will be exempt from this service. *The service will not cover patients within a care home that are not currently registered with a Rotherham practice.*

3.4 Any acceptance and exclusion criteria and thresholds

Patients who do not choose to register with the practice which is aligned with the home will be exempt from this service. The practice which currently looks after these patients will be required to contact the patient to offer advice, but if the patient chooses not to move <u>then the practice must contact the CCG before case management can be continued for these patients.</u>

Those patients on case management who enter into a care home will then be eligible for this scheme.

Temporary residents will be eligible for the service, but a care plan will not be required.

3.5 Interdependence with other services/providers

The service will provide a vital element of the whole system approach to the management of individuals in care homes by providing the lynchpin for supporting services for these individuals.

The successful delivery will be dependent on the providers' ability to work effectively with community services, care homes, patients and carers.

4. Applicable Service Standards

4.1- Reporting activity and outcomes

Each practice will submit a quarterly numbers report via survey monkey giving

- Patient numbers in each home at the start of the quarter then
- Numbers of new permanent patients (excluding temporary registrations)
- Numbers of temporary patients
- Numbers of patients who have moved from the home
- Number of patients who have died

NB- These figures can be obtained from the home by the practice, but will form the basis upon which payment is made

In addition each practice will be required to submit a 6-monthly outcomes report (August 2016 and end of March 2016) showing:

Emergency admissions data- evidence that the Lead GP has met with the Care Home Manager to discuss unplanned admissions. The report should include : numbers of emergency admissions, any relevant actions taken. Evidence will be a signed attendance sheet and relevant details made in the patient record.

Any changes in practice.

- number of unplanned visits made to the home
- Any changes in practice as a result of discussion

4.2 Remuneration

A total sum of £282 per patient per annum will be payable made in quarterly payments. Due to the turnover rate within care homes due to mortality the first quarter payment that a new patient receives upon entry to the home will be weighted higher. Therefore each patient will get payments as follows:

Q1 £102 (to include review of patients upon entry into the home)

Q2 £60
Q3 £60
Q4 £60

New patients will get £102 for the first quarter in which they enter the home.

Temporary patients will attract the £60 for the quarter in which they are

	resident. This should include an assessment of them upon entry to the home and inclusion in clinics whilst resident, but will not require creation of a care plan. Termination of agreement 3 months written notice is required by either party if they wish to terminate this agreement.

APPENDIX 2 LIST OF HOMES CURRENTLY VISITED BY EACH PRACTICE

Practice	Current homes
Swallownest	Swallownest care home
Dinnington	ATHORPE LODGE
	DAVIES COURT NURSING HOME
	WOODLANDS CARE HOME
	WATERSIDE
Village Surgery	WATERSIDE
St Ann's	DAVIES COURT NURSING HOME
	ACKROYD HOUSE
	ALEXANDRA NURSING HOME
	ATHORPE LODGE
	BROADACRES CLINIC
	BROOM LANE NURSING HOME
	CHERRY TREES NURSING HOME
	CLIFTON MEADOWS
	EASTWOOD HOUSE
	GREASBROUGH NURSING HOME
	LAUREATE COURT NURSING HOME
	LORD HARDY COURT NURSING HOME
	MOORGATE CROFT
	MOORGATE HOLLOW
	MOORGATE LODGE
	ROTHERWOOD
	SILVERWOOD NURSING HOME
	THE ABBEYS
	WHISTON HALL
York Road	ALEXANDRA NURSING HOME
	BROOM LANE NURSING HOME
	CLIFTON MEADOWS
	EASTWOOD HOUSE
	GREASBROUGH NURSING HOME
	LAUREATE COURT NURSING HOME
	MOORGATE CROFT
	MOORGATE HOLLOW
	MOORGATE LODGE
	ROTHERWOOD
	SILVERWOOD NURSING HOME
Kiveton	LADYFIELD HOUSE
	WOODLANDS CARE HOME
Treeton	TREETON GRANGE
Wickersley	SILVERWOOD NURSING HOME
	WHISTON HALL
Morthern Road	BROADACRES CLINIC
	CAMBRON HOUSE
	LAYDON COURT
	SILVERWOOD NURSING HOME
	CLIFTON MEADOWS
Blyth Road	ASHTON COURT CARE CENTRE
	LAYDON COURT

	QUEENS NURSING HOME
Broom Lane	ACKROYD HOUSE
	ATHORPE LODGE
	BROOM LANE NURSING HOME
	CHERRY TREES NURSING HOME
	CLIFTON MEADOWS
	EASTWOOD HOUSE
	GREASBROUGH NURSING HOME
	LAUREATE COURT NURSING HOME
	MOORGATE CROFT
	MOORGATE LODGE
	ROTHERWOOD
	SILVERWOOD NURSING HOME
	WHISTON HALL
Parkgate	BEECHES
	BROADACRES CLINIC
	DAVIES COURT NURSING HOME
	GREASBROUGH NURSING HOME
	LORD HARDY COURT NURSING HOME
	MEADOW VIEW NURSING HOME
	SWALLOWNEST NURSING HOME
	THE ABBEYS
Greenside	
	CHERRY TREES NURSING HOME
	CLIFTON MEADOWS
	GREASBROUGH NURSING HOME
	MOORGATE LODGE
	THE ABBEYS
	WENTWORTH HALL
Greasbrough	CHERRY TREES NURSING HOME
	GREASBROUGH NURSING HOME
	LORD HARDY COURT NURSING HOME
Crown Street	BEECHES
	MEADOW VIEW NURSING HOME
	MULBERRY MANOR
	SANDYGATE RESIDENTIAL HOME
	SILVERWOOD NURSING HOME
	SWINTON GRANGE CARE HOME
	WEST MELTON LODGE
Magna Group	MEADOW VIEW NURSING HOME
	ALEXANDRA NURSING HOME
	Sandygate
	West Melton Lodge
Manorfield	ASHTON COURT CARE CENTRE
	LAUREATE COURT NURSING HOME
	LAYDON COURT
	QUEENS NURSING HOME
Queens	LAYDON COURT
	ASHTON COURT CARE CENTRE
Stag	ACKROYD HOUSE
	BROOM LANE NURSING HOME

	CAMBRON HOUSE
	CLIFTON MEADOWS
	EASTWOOD HOUSE
	LAUREATE COURT NURSING HOME
	MOORGATE CROFT
	MOORGATE HOLLOW
	MOORGATE LODGE
	ROTHERWOOD
	SILVERWOOD NURSING HOME
	WHISTON HALL
Clifton	ACKROYD HOUSE
	ALEXANDRA NURSING HOME
	BROOM LANE NURSING HOME
	CAMBRON HOUSE
	CHERRY TREES NURSING HOME
	CLIFTON MEADOWS
	GREASBROUGH NURSING HOME
	LAUREATE COURT NURSING HOME
	MOORGATE CROFT
	MOORGATE HOLLOW
	ROTHERWOOD
	WHISTON HALL
High Street	BROADACRES CLINIC
	CHERRY TREES NURSING HOME
	CLIFTON MEADOWS
	GREASBROUGH NURSING HOME
	LORD HARDY COURT NURSING HOME
	MEADOW VIEW NURSING HOME
	SANDYGATE RESIDENTIAL HOME
	THE ABBEYS
	WENTWORTH HALL
Thorpe Hesley	GREASBROUGH NURSING HOME
	MEADOW VIEW NURSING HOME
	THE ABBEYS
	WENTWORTH HALL
Market	Beeches
	Byron Lodge
	Sandygate
	WEST MELTON LODGE
Shrivastava	ASHTON COURT CARE CENTRE
	LAYDON COURT
	QUEENS NURSING HOME

APPENDIX 3-

Alignment List of Care Homes and GP Practices

Care Home	GP Practice
Queens Care Home	Blyth Road
Broom Lane Care Home	Broom Lane Practice
Laureate Court	Clifton Medical Centre
Clifton Meadows	Clifton Medical Centre
Swinton Grange	Crown Street Practice
Athorpe Lodge	Dinnington Group Practice
Woodlands	Dinnington Group Practice
Davies Court	Dinnington Group Practice
Astrum House	Gateway Primary Care
Lord Hardy Court	Gateway Primary Care
Greasbrough Care Home	Greenside & Greasbrough Medical Centre
The Abbeys	High Street
Ladyfield	Kiveton Practice
Meadowview	Magna Group
Laydon Court	Manorfield & Queens Medical Centre
West Melton Lodge	Market Surgery
Byron Lodge	Market Surgery
Sandygate	Market Surgery
Silverwood Care Home	Morthern Road & Wickersley Group practice
Broadacres	Parkgate Medical Centre & Greasbrough Medical Centre
Ashton Court	Shrivastava
Ackroyd	St Ann's
Eastwood House	St Ann's
Rotherwood	St Ann's
Moorgate Hollow	St Ann's
Moorgate Lodge	St Ann's
Moorgate Croft	St Ann's
Cambron House	Stag Medical Centre
Whiston Hall	Stag Medical Centre
Swallownest Care home	Swallownest Practice
Wentworth Hall	Thorpe Hesley Practice
Treeton Grange	Treeton Practice
Waterside Grange	Village Surgery
Alexandra Care Home	York Road

NHS
Rotherham
Clinical Commissioning Group

Improving Care for Older People in Care Homes Enhanced Service:
Building on Proactive Case Management.

Scheme Overview

Principles of Care

Evidence shows that a co-ordinated focus on the primary care services available to care home residents improves care and reduces avoidable unplanned admissions to hospital. This enhanced service is designed to complement the wider effort taking place in other parts of the NHS to target resources towards communities, to integrate health and social care efficiently and to reduce unplanned admissions to secondary care and therefore cost.

Key Principles

- **Workforce Skill mix-** The current primary care medical provision is entirely reactive and GP-delivered. With the current difficulties in GP workforce, this scheme is designed to deliver a proactive approach to delivering care to care home residents, but be flexible in the way that it is delivered by Practices.

  The enhanced service must be delivered by a GP or other 'suitably qualified clinician' (see appendix 1 for details). *The way in which this is delivered can be flexible to meet the needs of the home and the practice, however the aim is that care home residents are seen for regular proactive care. Examples of delivery models are given in appendix 1.*

- The monitoring of the scheme is intended to be 'light touch'. The emphasis is upon data gathering and interpretation and it is not intended that practice performance will be micromanaged. The practice will need to ensure that they use the relevant 'read codes'. Although an enhanced data set has been provided it will be the responsibility to ensure that the numbers are correct due to the complexity of the templates.

The Key Commissioning outcomes are:

- The maintenance and improvement of quality
- A reduction in the number (and length of) admissions to acute hospitals from Care Homes
- Prescribing optimisation to reduce potential harm from inappropriate prescribing and associated expenditure.

Required service elements for practices

1. **Regular Planned 'Clinics' (<u>Not ward rounds</u>)**
   - Regular visits/clinics (minimum fortnightly basis) – NB not all patients would be seen on a fortnightly basis, but the home should be visited. The expectation would be that each patients is 'seen' every 2 months; there should be an administrative review of the resident's care needs with care home staff and a physical review as needed. A note should be made in the patient's care record of review. <u>The care plan for each resident should be kept updated . Each patient should be physically seen on a 6 monthly basis by the Lead GP(or a GP who is familiar with them and their care) and the care plan updated (see 6).</u>

2. **Bi-Monthly review of unplanned admissions with care home manager**. The Lead GP and Practice Manager (if required) should meet with the care home manager to discuss unplanned admissions, deaths, OOH contacts and significant events.

3. Practice Register

All new and existing care home patients should have the appropriate codes filled in on their record so that a practice register of patients can be generated. *A read-code has also been provided to shown where a patient has declined to move to the practice that is looking after their home.*

4. Care Planning, including End of Life

- Production of a care plan using the available templates. Practices will be required to use the case management template and identify that this is care home patient using the relevant read-codes. The care plan should be completed within 3 months of admission to the home and then kept up to date.

- When the patient becomes an End of Life patient the relevant EPaCCs template only should be used (this replaces the Long Term Conditions care plan template) and a printout should be placed in the red folder.

5. Assessment of Resident on Admission to Care Home

Within 2 weeks of admission to the home

- Comprehensive and holistic assessment- including MCA (Mental Capacity Assessment)
- Medication review (see section 6)
- Start of care planning process
- Bones protection/falls assessment
- Dementia assessment and diagnosis, if applicable

6. Review of Care Plan for all residents every six months by the Lead GP

It is intended that the proactive service being offered will ensure that the care plan is always up to date, but there may be items that will require planned review such as change in health, mobility or dependency. If the service is GP-led it is expected that the care plan will always be up to date. If the service is not lead by the GP it is mandatory that there is a 6-monthly care review with a GP (Preferably the Lead GP or a GP who is familiar with the patient and their care).

7. Medication Review

- This should be undertaken every 6 months
- Emphasis on reducing polypharmacy using appropriate guidance or systems.
- This can be done by the practice pharmacist or GP.

8. Emergency Hospital Admission Reviews

- Significant event audit type review to be carried out by the clinician working with the care home staff for each unscheduled admission(a template can be provided if required).
- To try to identify common factors leading to admissions and issues that might prevent the need for admission.
- Reflective process suitable for GP revalidation portfolios.
- To be discussed with Care Home Manager at their regular scheduled meeting.

9. Special Notes

- A copy of the care plan with the first 2 pages on yellow paper should be easily accessible at the home and regularly printed to ensure that it is 'current', with any further information added that might help 'out of hours' doctors to make appropriate decisions.
- Care home staff should be encouraged to look at the care plans whenever possible.

10. Safeguarding and Mental Capacity Act Training

- The Lead GP and all other practice GPs should be trained in safeguarding (3-yearly)
- Any concerns about care homes should be raised through the appropriate channels (see contact details)

11. Lead GP Role

At least one GP to be the Lead per care home to aid continuity.

Other service elements for practices

1. **Alignment**
   Alignment reduces the number of care homes visited by each practice and helps to establish strong relationships between practices and care homes. This must be fully in place prior to commencement of the enhanced service.

2. **Engagement with supporting services for care homes (see appendix)**
   The CCG will provide details of how to access the relevant supporting services for care homes including the, Care Home Support team and Nurse Practitioner team

Reporting mechanisms
If practices utilise the templates provided and the appropriate read codes they will be able to produce a quarterly activity report.

Financial Remuneration

A total sum of £282 per patient per annum will be payable made in quarterly payments. Due to the turnover rate within care homes due to mortality the first quarter payment that a new patient receives upon entry to the home will be weighted higher. Therefore each patient will get payments as follows:

Q1 £102 (to include review of patients upon entry into the home)

Q2 £60
Q3 £60
Q4 £60

New patients will get £102 for the first quarter in which they enter the home.

Temporary patients will attract the £60 for the quarter in which they are resident. This should include an assessment of them upon entry to the home and inclusion in clinics whilst resident, but will not require creation of a care plan.

Commissioners' expectations of the Care Homes

In order for the successful delivery of this service, care homes and their staff have a critical role in ensuring success. It is vital that effective working relationships are fostered between the GP practice and the care home staff. It is important that each party understands what is expected of the other. A memorandum of understanding should be in place for all homes and practices.

Minimum requirements:

1. The care home seeks consent from residents/relatives for their details to be kept in a care plan folder within the home.
2. The relevant paperwork will be ready prior to the GP/Clinician attending the home.
3. The GP attending should be greeted promptly by a member of staff who is familiar with all of the residents to be seen at that time. In order to ensure continuity of care the nurse/person in charge should attend all the regular planned visits, the admission assessments and 6-monthly reviews, and be an active partner in the care planning process.

Accessing Unscheduled Care

- Before a call is made to the GP Practice/OOH service (including a request for the GP to visit the Care Home), the nurse/person-in-charge should approve the need for the call

- Before a call is made to the ambulance service (unless it is clearly a medical emergency), an attempt should be made to discuss the request with the GP Practice/OOH service. *The nurse/ person-in-charge should make both calls*

Appendix 1

1. **Suitably qualified clinician**- as per the case management scheme. The lead for the LES must be a suitably qualified and experienced GP. The lead for the operational delivery of the scheme should be a suitably qualified and experienced GP or a nurse with one of the following qualifications:

- *Specialist Practitioner General Practice Nursing recorded on NMC register*
- *Primary Health Care Diploma*
- *Cardiovascular and Respiratory Diploma*
- *PGDip Community Specialist Practitioner Qualification – District Nurse (recorded on the NMC register)*

If a practice experiences difficulties in delivering the LES, such as staffing shortages they should contact the Project Lead as soon as possible to discuss and agree a solution such as temporary withdrawal from the LES.

Acceptable Examples of models of delivery

1. **Fully GP delivered model**-

   A named GP visits the home on a regular day and time to deliver a 'clinic'- this should happen at least fortnightly (for practices that have large numbers of patients it is likely to be weekly). There is no requirement here to have a ward-round ie to see all of the patients on every visit, however this is likely to be a mixture of acute problems and reviews. A list of patients must be submitted to the practice beforehand.

2. **GP/ Nurse delivered model**

   The GP and Practice Nurse can deliver a 'joint clinic'.

3. **Other Suitably Qualified Clinician Clinic**

   This is likely to be an advanced nurse practitioner/ suitably qualified nurse. There will need to be close liaison with the Lead GP at the practice. The 'clinics' will still need to happen as a minimum fortnightly and the GP should visit the home fortnightly but would not be expected to see all of the patients. The need for acute visits should be reduced. A GP would have to see the patients on a 6- monthly basis.

   Other models may be applicable. Practices are advised to contact the CCG GP lead if they have any queries.

What to do…

If you're worried about an Adult that is being abused…

A FLOWCHART FOR REFERRAL

PRACTITIONER HAS CONCERNS ABOUT AN ADULTS WELFARE

↓

DO NOT IGNORE YOUR CONCERN
Gather available information that would support your suspicion….
BEWARE NOT TO ALERT ANY POTENTIAL ABUSER
DISCUSS WITH YOUR COLLEAGUES/MANAGER & SAFEGUARDING LEAD

↓

THE MAIN PRIORITY FOR EVERY PRACTITIONER
IS THAT THE ADULT AT RISK IS SAFE

↓

CONCERN REMAINS
This may be even when others do not feel that your worries are safeguarding
DO NOT IGNORE YOUR

CONCERNS RESOLVED
Consider possible referral to other agencies for

↓

IF YOU FEEL THERE IS AN IMMEDIATE RISK CALL
101 or 999

RMBC SAFEGUARDING ADVICE LINE
01709 822330

A CONFIDENTIAL REFERRAL CAN BE COMPLETED ONLINE
REFERRAL FORM LINK
https://www.rotherham.gov.uk/forms/form/58/en/safeguarding_adults_eform

CONTACTS

NHS Rotherham CCG

Catherine Hall
Head of Safeguarding
01709 302172

Kirsty Leahy
Designated Professional for Safeguarding Adults
01709 428724

Dr Lee Oughton
Named GP Safeguarding
01709 302020

The Rotherham NHS Foundation Trust

Jean Summerfield
Named Nurse Adult Safeguarding
01709 427144

Allison Newsum
Nurse Advisor Adult Safeguarding
01709 424659

Rotherham Doncaster and South Humber NHS Foundation Trust

Sue Bower
Safeguarding Adults Lead
01302 796769

REMEMBER

YOU HAVE A DUTY TO PROTECT ADULTS AT RISK

SAFEGUARDING IS EVERYONE'S BUSINESS