SCHEDULE 2 – THE SERVICES

Enhanced Health in Care Homes: Additional Services Scheme
LOCAL ENHANCED SERVICE

Service Specification No.	
Service	**Enhanced Health in Care Homes: Additional Services scheme**
Clinical Lead	Dr Avanthi Gunasekera, Strategic Clinical Executive
RCCG Officer Lead	Rachel Garrison, Senior Contracting and Service Improvement Manager (Primary Care)
Provider Lead	
Period	~~1 June 2020 – 31 March 2021~~ 1 April 2021 – 31 March 2022
Date of Review	January 202~~1~~21

1. Population Needs

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 build on the Enhanced Health in Care Homes DES and provide additional services beyond the scope of the national scheme.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

- The maintenance and improvement of quality care
- 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
- Improved safeguarding for care home patients

3. Scope

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 services described within this scheme are designed to provide care beyond that of the national DES. For clarity, the requirements of the DES are:

1. 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;

2. 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;

3. 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

4. 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.

5. 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

6. 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. 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.

8. 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;

9. Using the MDT arrangements, 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 Assessment10 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;

10. Identify and/or engage in locally organised shared learning opportunities as appropriate and as capacity allows; and

11. Support with a patient's discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 2711.

The additional services commissioned by this scheme are:

1. Agree to have a practice Lead GP for each Care home provided to the CCG. The named GP is to have the practice responsibility for the implementation of enhanced care in care home DES contract (7.3 of DES contract) in that individual care home only but not have any further responsibility. The named GP lead will act as the Communications lead where there are shared responsibilities in care homes, at present there are 4 homes where there is shared responsibility:

   Laydon Court - Manor Field and Queens
   Ashton Court - Manor Field and Blyth Road
   ~~Broadacres - Greasbrough and The Gate (to be confirmed)~~
   Silverwood - Morthen Road and Wickersley

   Each PCN shall determine how the payment will be distributed in relation to the shared homes.

2. The practice will make arrangements for ALL patients to be discussed with the care home manager/team every second month. This is in addition to the patients in the DES picked weekly for clinical need. It will be for the care home and MDT team to share responsibility in this arrangement. These meeting can be arranged via video link.

3. All patients to have a care plan written and updated every 6 months.

4. The practice will offer to meet the care home manager and MDT every 3 months to discuss admissions to hospital and deaths to discuss learning points. It will be for the care home and MDT team to share responsibility in this arrangement. Records of these meetings /SEA to be kept. These meetings can be arranged via video link.

5. Care home residents to have a medication review every 6 months by an appropriate clinician in addition to the annual structured medication review.

6. Care home residents will have medicine reconciliation within 7 days of admission from home or hospital to a care home by the appropriate clinician.

7. GP practices will be responsible for providing palliative care to care home residents in conjunction with the palliative care services in Rotherham including:

   - ensuring the palliative care register is updated

- completing the palliative care template (found as part of the case management template)

3.3 Recording

Practices will need to ensure that the appropriate read codes are used (see minimum dataset).

3.4 Population covered

The service will cover all patients in a CQC registered care home in Rotherham.

Patients not residing in a care home will be exempt from this service.

3.5 Any acceptance and exclusion criteria and thresholds

New or reopening CQC registered care homes, and additional floors within existing care homes that are brought into operation but have not previously been funded under this scheme, will only be included at 100% once their utilisation achieves 75%. Until that point, payment will be based on occupied bed.

Respite homes - due to the nature of service provision within respite homes, these homes will be excluded from this LES. Practices aligned with respite homes will remain eligible for reimbursement in line with the national Enhanced Health in Care Homes DES.

Intermediate care beds are also subject to a separate arrangement for care and are excluded from this LES

In the last few years, there has been a requirement for a higher level of input into 'winter beds' in procured beds in care homes in Rotherham. As the DES and this LES is for 100% of beds, if this arrangement is required in Rotherham this winter, the beds would be reviewed and excluded for this period and the relevant winter bed scheme applied.

3.6 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

This LES arrangement is with the Primary Care Network to reflect the DES arrangement. As such, the payments will be made to the Primary Care Network and responsibility for distribution of the funding will lie with the relevant Primary Care Network not the CCG.

Each network will be required to submit outcomes on a template report around **Emergency admissions data** in September 202~~0~~1 and March 202~~1~~2. The report should include:

- Numbers of emergency admissions
- Any relevant actions taken
- Number of unplanned visits made to the homes
- Any changes in practice as a result of discussions

On an ad-hoc basis (not routine) evidence will be required showing that the Lead GP has met with the Care Home Manager to review all patients every ~~2~~3 months to discuss unplanned admissions. Evidence to be supplied when requested will include;

- A signed attendance sheet
- Relevant details made in the patient record (please only submit anonymised information).

We are also expecting specific DES reporting requirements which will have to be adhered to but are not currently available.

4.2 Remunerations

A total sum of **£215.38** per bed per annum is available (this is maximum funding, if the number of beds increase the value will be reviewed as there are no additional available funds) this will be paid in quarterly payments via the Primary Care Network. ~~The following schedule details the funding arrangements for this financial year.~~

As practices are unable to fulfil the requirements of the LES within respite homes, due to the nature of the service provided by these facilities, respite homes will be reimbursed in line with the national Enhanced Health in Care Homes DES.

	~~April - June~~	~~June - March~~	~~July - March~~	~~Total~~
~~Current RCCG LES~~	~~£91,442.75~~			~~£ 91,442.75~~
~~New LES - existing 1822 beds~~			~~£294,316.77~~	~~£294,316.77~~
~~New LES – new 522 beds~~		~~£93,690.30~~		~~£ 93,690.30~~
~~Flexible funding~~				~~£ 25,402~~
~~**Total**~~				~~**£504,851.82**~~

~~The flexible funding will be distributed by the Primary Care Networks to practices with the highest turnover care homes (excluding respite beds)~~

Consequences for late submission of activity data:

- 1 – 7 days: 5% of payment
- 8 – 14 days: 10% of payment and payment won't be released until the next payment run
- 15 – 21 days: 50% of payment and payment won't be released until the next payment run
- Submissions received after 21 days (3 weeks) will receive no payment

A reminder by email will be sent out at least one week prior to submission date. It is the responsibility of the PCN to ensure that any changes to contact details for the PCN are notified to the GP Commissioning team.

In the event of unforeseen exceptional circumstances e.g. unplanned admission to hospital, there is scope for the CCG to process a payment without precedent. It is however a PCN responsibility to put in place sufficient contingency arrangements to ensure activity is submitted by the date specified.

If the CCG makes a payment to a PCN under the LES and :

a) The practice was not entitled to receive all or part thereof, whether because it did not meet the entitlement conditions for the payment **or because the payment**

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was calculated incorrectly (including where a payment on account overestimates the amount that is to fall due);or

b) the CCG was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money is already been paid,

then the CCG is entitled to repayment of all or part of the money paid.

Any suspicions of fraud will be referred to the CCGs Counter Fraud Specialist for further investigation. It is important to recognise that claiming for procedures that do not fall within the service specification may constitute fraud and will be referred to the CCGs Counter Fraud Specialist for further investigation.

4.3 Audit – Compliance with the Scheme

PCNs and care homes will be selected at random for audit (and also if the GP for Primary Care identifies any potential irregularities). PCNs selected for audit are required to work with the auditors to demonstrate to them that all parts of the scheme have been complied with.

4.4 Termination of agreement

Following the recent publication of the 'Investment and Evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan' the CCG acknowledges that further guidance may influence the future delivery of Local Enhanced Services.

All Local Enhanced Services will be subject to regular review in line with the development of Primary Care Networks (PCNs). Three months' notice will be given to Providers if services are to transfer to PCN delivery and/or payment