Primary Care Service for Care Homes and Extra Care Housing (Bromley Borough)

Background

This service covers the London Borough of Bromley and is a dedicated primary care service for older residents living in residential and nursing care homes, and extra care housing.

Residential and nursing care home residents are amongst the most frail and vulnerable, with significant clinical complexity. Residents are three times more likely to fall in a care home than in their own home. Falls prevention is a core part of the early training for care homes and an essential component of mitigating against avoidable hospital admissions.

At least one-third of over-75s take six or more medications on a regular basis. Problematic polypharmacy is common amongst older people for this reason, and early medication reviews are essential to mitigate against deterioration (for example, falls, delirium, dehydration or more significant harm) associated with incorrect medication. These reviews are complex and require specialist clinical pharmacist input.

To meet national best practice recommendations for individuals in their last year of life, personalised care planning is required. This supports the improved quality of life for the individual, reduce emergency admissions at end of life and to assist with meeting their wishes for their place of death. The personalised care plans are produced through careful, sensitive discussions between the individual, their family, the care home team and the healthcare professionals involved.

As many individuals moving into care home settings do so with multiple chronic conditions, including advanced diseases, where rapid deterioration can occur, it is expected that advanced care plans are organised and planned in a timely manner.

This innovative primary care service was designed to build a highly specialist expertise, a dedicated service and a tailored offer to improve the quality of life and experience of care for these residents.

Details

<u>Outline</u>

The service will operate under an APMS primary care contract to provide core General Medical Services, the Network Contract Direct Enhanced Services (DES) and an enhanced service specification for primary medical care for nursing home residents, residential care home residents and extra care housing tenants.

The enhanced service is designed to take a multi-disciplinary approach to proactive case management, support prescribing priorities and deliver both routine and urgent care ‘in-hours’.

<u>Workforce</u>

It is anticipated that this service will be be GP-led, supported by nurses,community pharmacists and wider PCN ARRS roles in line with NHS England expectations for primary care workforce.

The intended staffing mix should be determined through detailed workforce capacity modelling, however indicatively, it expects it will be made up of around 40% of GPs and nursing, pharmacy, ARRS roles and other clinical roles making up the other 60% This

would equate to 1.0 WTE GP for every 230 registered patients. The workforce capacity modelling will also need to account for service requirement regarding care provided to Temporary Residents, who make up a proportion of the patient cohort for this service.

GP services would be provided to care homes and extra care housing through a combination of visiting sites and appropriate arrangements for providing care remotely.

Aims

The aims of the service are to:

- Deliver a proactive, multidisciplinary and patient-centred model of case management and primary care 'at scale' for this patient cohort
- Improve patient outcomes for this cohort
- Provide a responsive service that adapts over time to patient feedback and to changes in evidence concerning medical care for care home residents
- Provide clinical leadership and learning to improve the quality of care for patients in care homes
- Develop effective working relationships with care homes, acute hospitals, community based providers, social care and other stakeholders that will allow the contractor to effectively deliver against the objectives of this service
- Improve the quality of medical support to the patient
- Improve consistency and remove variation across the borough in quality of care
- Improve patient experience and satisfaction
- Improve end of life care
- Improve management of long-term conditions, frailty and dementia
- Improve the wider wellbeing of care home residents

The service currently has a list size of 1253 (December 2022) under the APMS contract and provides support to 35 care homes and 6 extra care housing locations. The service is part of one PCN in Bromley, operating from one base for the whole of the borough.

The latest census information from 2021 demonstrates a 12% growth in over 65s in the 10 years since the last census, compared to a growth in the full population of 7% over the same period. In addition, whilst this contract is currently to cover 41 locations, there are ongoing planning applications and approvals in progress for new additional provision. It is expected that new locations will be opened over the coming years accordingly, and its residents will be served by this contract in the future.

All the areas under the Network DES relevant to this cohort should be covered by this service including:

Enhanced Health in Care Homes

The Enhanced Health in Care Homes (EHCH) model moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff. Such care can only be achieved through a whole-system, collaborative approach. This approach covers:

- Every care home having a named clinical lead.
- A weekly 'home round' or 'check in' with residents prioritised for review based on MDT clinical judgement and care home advice (this is not intended to be a weekly review for *all* residents)
- Within 7 days of re/admission to a care home, a resident will have a person-centred holistic health assessment of need (will include physical, psychological, functional,

social and environmental needs of the person and can draw on existing assessments that have taken place outside of the home, if it reflects their goals)
- Within 7 days of re/admission to a care home, a resident will have in place personalised care and support plan(s), based upon their holistic assessment.

More information on the framework can be found here [the-framework-for-enhanced-health-in-care-homes-v2-0.pdf (england.nhs.uk)]

Structured Medical Review

Providing Structured Medicine Reviews (SMRs) to the cohort under the Network DES - these are an evidence-based and comprehensive review of a patient's medication, taking into consideration all aspects of their health. In a structured medication review clinicians and patients work as equal partners to understand the balance between the benefits and risks of and alternatives of taking medicines. The shared decision-making conversation being led by the patient's individual needs, preferences and circumstances. More information can be found here Structured Medication Review (SMR).

Anticipatory Care

Anticipatory care helps people to live well and independently for longer through proactive care for those at high risk of unwarranted health outcomes. Typically, this involves structured proactive care and support from a multidisciplinary team (MDT). It focuses on groups of patients with similar characteristics (for example people living with multimorbidity and/or frailty) identified using validated tools (such as the electronic frailty index) supplemented by professional judgement, refined on the basis of their needs and risks (such as falls or social isolation) to create a dynamic list of patients who will be offered proactive care interventions to improve or sustain their health.

The anticipatory care service has three key aims:

- Benefitting patients with complex needs, and their carers, who are at risk of unwarranted health outcomes by enabling them to stay healthier for longer, with maintained or improved functional ability and enjoy positive experiences of proactive, personalised and self-supported care.
- Reducing need for reactive health care for specific groups of patients and supporting actions to address wider determinants of health.
- Delivering better interconnectedness between all parts of the health system and the voluntary and social care sectors

There is also a need for training or skills development with staff working in Care Settings in line with the EHCHs workforce development element for Training and development for social care provider staff,

Other key priorities are within the EHCH framework for care homes such as falls prevention, hydration management and end of life care. More details on this specification can be found [the-framework-for-enhanced-health-in-care-homes-v2-0.pdf (england.nhs.uk)]

Other services

There are several other services that also need to be covered by this service including the provision of vaccinations within nursing and care home setting and other services expected as part of the APMS contract (as per the APMS contract specification) found B1990v-

standard-alternative-provider-medical-services-contract-november-2022.pdf (england.nhs.uk)

Finance

Funding for this service will be from a number of funding streams including Global Sum (per weighted patient), London Weighting payment (per weighted population) Network DES (in line with the relevant payment base of the element of the DES) and QOF. The financial envelope is between £800k and £1.0 million per year.

The service also receives funding from the Care Homes Premium for the CPC registered beds aligned to the GP practice at a rate of £120. This currently stands at 1371 beds. This is included within the funding envelope above.

The APMS contract would be offered as a 5 year contract with the option to extend for an additional 2 years starting in April 2024.

KPI areas

The service will be expected to demonstrate performance in a number of areas including the following:

End of Life Care

- Percentage of patients who have died and for whom an End of Life Care Plan was used and is recorded in the notes e.g. (GSF)
- Percentage of patients supported to die in their preferred place of death with implemented measures to ensure this happens

Medical Assessments

- Permanent New Patients Assessment: percentage of registered patients that received assessments for new patients within 7 working days of their placement at the care home
- Percentage of registered patients who are followed up within 6 months of their date of registration and every 6 months thereafter
- Permanent Patients - Medical Assessment: percentage of registered patients that are admitted to hospital, mental health inpatient units, and intermediate care will receive a medical review within 7 working days of receipt of notification of discharge back to the care home Electronic Discharge Notification (EDN)

Medicines Management

- Percentage of registered patients that receive a face-to-face medication review at least once annually.
- Percentage of registered patients that receive a face-to-face medication review at least annually that involves patient and or next of kin

Urgent and Emergency Care

- Percentage of requests received by 6.15pm triaged as urgent that receive a visit on the same day as the call is logged

Vaccinations

- Influenza: percentage of patients who receive the flu vaccination before the end of October

- Pneumonia: percentage of patients who have received the pneumonia vaccination, including temporary registered patients
- COVID-19 - percentage of patients who have received a Covid-19 vaccination (excludes temporary patients staying under 14 days)

Hypertension

- Percentage of patients with hypertension with blood pressure recorded at least every 6 months
- Percentage of patients with hypertension not receiving care in line with KPI 8a due to valid clinical reasoning for exclusion

Dementia Care

- Number of Alzheimer's dementia patients prescribed an antipsychotic for behavioural disturbances short term (annually)
- Numbers of Alzheimer's dementia patients prescribed an antipsychotic who have a documented assessment of risks and benefits plus planned regular review (annually)

The service will also agree with the Commissioner an annual audit and quality reporting plan, including but not limited to:

- Medicines management
- Urgent and emergency care, including supporting a reduction in hospital attendance and admissions
- Mental health care
- Management of diabetes
- Drug safety alerts and learning
- Stakeholder satisfaction, including staff, care homes, patients, friends, family and carers
- Safeguarding
- Quality, including clinical governance, complaints, compliments, incidents, alerts, and workforce analysis