Schedule 1

Service Specification

Service Specification No.	
Service	Enhanced Primary Care in Care Homes
Commissioner Lead	NHS Wirral Clinical Commissioning Group
Provider Lead	
Period	1st July 2019 – 31st March 2020 (Stage 2)
Date of Review	31th December 2019

1. Population Needs

1.1 National/local context and evidence base

National context and evidence base

With multiple co-morbidities and multiple medication use, residents in care homes are often the most medically complex people in the community. For example, approximately 80% of people living in care homes have a form of dementia or severe memory problems and on average patients take ~9 medications. However, according to figures from the British Geriatrics Society (BGS), 68% of care home residents have no regular medical review, 44% have no regular review of medications and just 3% have occupational therapy - a critical service to promote independence.

Due to their complex needs residents need structured and pro-active approaches to their care, with coordinated teams working together built on primary care. Despite this need the BGS report 'Failing the Frail' (2012) suggested the levels of proactive in reach by primary care providers and specialist community teams are limited – see tables 1 and 2 below.

Table 1 – The frequency of scheduled visits by specialist primary healthcare services to care homes

	Nursing homes		Residential homes		All homes	
At least weekly (1-5 working days)	47	12%	43	11%	90	11%
At least fortnightly (6-10 working days)	31	8%	24	6%	55	7%
At least monthly (11-21 working days)	66	16%	54	14%	120	15%
At least quarterly (22-62 working days)	91	22%	90	23%	181	23%
Less frequently (>62 working days)	45	11%	51	13%	96	12%
Don't know	125	31%	129	33%	254	32%

Table 2 – Specialist primary healthcare services visiting care homes

PCTs	Geriatricians	Psychiatry	Dietetics	Occup therapy	Physio therapy	Podiatry	Continence	Falls	Tissue viability	All services
No. providing service†	97	134	139	139	148	138	147	131	140	1,213
All homes	74%	91%	90%	91%	88%	85%	86%	81%	88%	86%
Nursing care	9%	2%	3%	1%	1%	1%	0%	1%	6%	3%
Residential care	1%	1%	1%	4%	4%	1%	10%	2%	2%	3%
No homes	15%	6%	6%	4%	7%	12%	5%	16%	4%	8%

Recent recommendations from NHS England (New Care Models – The Framework for enhanced health in care homes) suggest that local commissioners should ensure there is enhanced primary care support to care homes including:

a) Access to consistent, named GP and wider primary care services
b) Medicines reviews
c) Hydration and nutrition support
d) Access to out-of-hours/urgent care when needed

Within Wirral this pilot service has been operating since May 2017 and now covers approximately 1,500 of the 2,900 bed capacity of 78 older peoples care homes. GP providers in some areas particularly in Birkenhead (56%) and Wallasey (57% coverage) have found it difficult to mobilise the service 'at scale' leading to reduced population coverage. Fewer homes that have multiple GP providers have been covered by the service as a result. However, coverage in West Wirral is at approximately 75% coverage with greater alignment between Care Homes and GP Providers.

From April 2020, a new national care home service specification will be commissioned as a component of the new Network Contract Directed Enhanced Service. Full details regarding the service model to be deployed are not expected until late 2019/20. Guidance references full roll out of the DES to all Care Homes by a consistent team delivered via Primary Care Networks.

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 Locally defined outcomes

a) Improve patient's experience of primary care services who are resident in a care home
b) Improve the overall quality of life and health outcomes for patients in residential and nursing care homes
c) Reduction in care home acute hospital admissions – 10% from baseline of 1st April 2017
d) Reduction in category green ambulance calls from care homes
e) Reduction in green ambulances conveyances from care homes
f) Reduction in GP care home acute reactive call outs

3. Scope

3.1 Aims and objectives of service

Service Aim

The service primarily aims to reduce unnecessary non-elective acute hospital admissions for all patients in Wirral care homes for older people.

Service Objectives

a) To enhance the level of GP and Nurse Specialist proactive care management available to residents in care homes

b) To improve continuity of care, with regular planned visits to each care home.

c) To provide a proactive approach to developing residents' healthcare goals via comprehensive assessments considering residents' preferences, culture and decisions about end of life care.

3.2 Service Description/care pathway

The service should be delivered by providers according to the following mandatory operational requirements.

A. Consistent Clinical Team: A consistent clinical team from the PCN should be deployed to each individual care home within the PCN. The team should include a nominated lead clinician and deputy who will provide an enhanced level of proactive care to patients on a weekly basis. Minimum clinical time spent per week both in and outside the ward round should be:

Number of beds	*Minimum* Clinical Time (Pro rata </> for 25 beds
25	2 hours per week

B. Full initial assessment: Each patient should have their needs assessed following admission and a multi-disciplinary management plan developed. The management plan must include the criteria for admission/non-admission to hospital, agreed with the patient/their family. Both an Emergency Health Care Plan (EHCP) and DNAcpr should be considered and if not deemed necessary clinical justification written in the patient's clinical notes.

C. Regular ward round: A GP (minimum attendance once monthly) or a Nurse Specialist from the PCN will attend the home on a weekly basis to review the care of the patients. They should also be contactable by phone during in-hours to answer queries as required. Technology such as video consultations maybe used with express permission of the commissioner. A summary record of the consultations should be recorded during the ward round at the home ideally using the EMIS Anywhere IT platform and laptops.

The weekly ward round should be provided according to the following criteria:

I. From 1st July 2019 – 31st March 2020 the service will be required to be delivered via Primary Care Networks (PCN) and not individual GP practices.
II. GP Practices will be expected in the first instance to mutually agree which care home is linked to which PCN on a 1:1 basis. Assistance may be sought from Wirral Local Medical Committee as necessary. If agreement cannot be reached the CCGs Primary Care Co-Commissioning Committee will make the final adjudication.
III. A consistent clinical team must be in place to deliver the service to each individual Care Home within the PCN.
IV. The service will cover proactive 'enhanced' care for this year, but with the recognition that from April 2020 this will also include reactive care and therefore PCNs should start to consider how they will achieve this.
V. Re-registration of patients is NOT a requirement of the scheme and patients must NOT be put under any pressure either from GP Practice or care home staff to re-register.
VI. Providers will be expected to work in a multidisciplinary team manner with other relevant health and care providers as necessary.
VII. Agreed visit timetable (not during meal times) with the home, so that a mechanism can be established for concerns and issues raised by staff and relatives to be addressed.
VIII. Give reasonable notice of any planned changes in visit times to allow Home staff to inform relatives who may have made an appointment
IX. Physical and Mental Health assessment, where relevant;
X. Liaise with other Health and Social Care Professionals where relevant, including acute medical services, primary care services and social care;
XI. Liaise with senior qualified nurses for nursing homes or the senior carer in residential homes;
XII. Liaise and or meet with relatives (unless otherwise indicated)

XIII. Subject to Community Geriatrician advice, the lead clinician or deputy from the provider will be required, where appropriate, to:

- be available to attend Community Geriatrician reviews and case conferences; and liaise with the appropriate Consultant for advice as applicable.

D. Regular care plan review: Each registered patient will have their condition reviewed on a regular basis as deemed appropriate by the practice and the Home, following the initial assessment and no less than once in six months.

E. Medication usage and review: Each registered patient will receive full and regular review of their medication including a review upon discharge from hospital of all medications prescribed. The practice will have access to a named Pharmacist in their PCN footprint who will undertake this work on their behalf. The practice is to ensure all changes in medication are communicated to the relevant community pharmacy.

F. ICCT MDT Referrals: It is expected that the provider will refer patients with the most complex health and social care needs to their ICCT MDT locality meeting. The referral must be made using the agreed referral template in advance of the planned MDT.

G. Liaison/professional links: To work together with other health and social care professionals as appropriate to ensure the management plan is reviewed and updated. This will include care home patients having 1 week referral response times for community services including SALT, OT/Physio and dietetics. To meet with the care home staff on a regular basis to discuss any problems/concerns experienced with the provision of the locally commissioned service.

H. Make referrals and inquiries as clinically indicated: To work with the care home staff to ensure that patients are referred to secondary care or for assessment by other agencies as clinically appropriate, such that clinical intervention is tailored to the needs of the individual. To ensure that referrals are only made when appropriate and that those necessary are made in good time to reduce the rate of emergency admissions, through Wirral's Integrated Referral Gateway.

I. Record-keeping: Each patient's management should be recorded in both the care home and the practice record (EMIS – Remote Consultation if necessary), to ensure access to appropriate and timely information. A printed summary of the patient's record, with full details from their last review/contact should be provided for the home. The record must include criteria for admission/non-admission to hospital agreed with the patient/their family, this information should also be communicated to the OOH service. The provider must work with the CCG to ensure that all acute patient activity is recorded for patients managed under the service including the collation of a baseline data set (admissions in previous 12 months).

J. Patient Consent: Patients should be asked to consent before receiving the enhanced service level and prior to any changes in patient GP Registration. Those without capacity to consent should be treated according following a 'Best Interest' assessment.

Minimum reporting and data collection requirements

- The provider must adhere to the audit arrangements put in place for the service by the commissioner which includes:

Step 1: Upon commencement of the service all patients cared for under the service should have the following Read Code added to their medical notes: 9kw (Care Home Enhanced Services administration). Read Codes should also be used to differentiate between those patients living in residential homes and nursing homes - 13F61 – Lives in a nursing home13FK – Lives in a residential home.

Step 2: Once the initial assessment is completed for patients upon admission to the Care Home this code should be added to the patient's medical record: EMISNQCA980 (Care Home Assessment Completed) and once every 6 months thereafter.

Step 3: Should a patient have an Emergency Health Care Plan issued for them then Read Code 8CMd should be used.

Step 4: Upon receipt of hospital discharge documentation the following Read Codes should be used to identify if a patient has an A&E attendance or Emergency Hospital Admission.

Emergency hospital admission: 8H2
Seen in accident and emergency dept: 9N19-1

Step 5: Should the patient be no longer under care of enhanced primary care service (if patient leaves the practice/care home or is deceased) then this code should be used: EMISNQNO171

Note: EMIS codes may need to be turned on within your system to allow your practice staff to use them. This may be undertaken by within your system going to: Organisation Configuration>Open Organisations>Select your GP practice name>Organisation Details>Display EMIS/Egton codes in the code picker.

- It is expected that the contract holder works with the CCGs Business Intelligence Team to source the above data when possible via the EMIS Search and Reporting tool.

Payment and Service Suspension

- In 2019/20, each provider contracted to provide this service will receive £360 per patient per annum pro rata.
- The CCG should be invoiced on a quarterly basis for patients managed under the service. For example, if a patient is only managed under the scheme for half of the quarter then only 50% of the fee should be claimed = £360/4*50% = £45
- Claims must be countersigned by Care Homes confirming the ward rounds have been undertaken.
- A Post Payment Verification (PPV) visit auditing up to 10% of claims made by providers may be undertaken by the CCG. Payments will only be made where GP practices also meet both of the following two quality standards.

  a) 100% of patients claimed for to have a care review and plan developed upon admission to the home and no less than once every 6 months thereafter using Read Code: EMISNQCA980
  b) No fewer than 20% of patients to have an Emergency Health Care Plan in Place who are resident in a Nursing Home (expected norm is typically between 30-50%).

- The above standards will be assessed by the CCG using Read Code information extracted from GP Practice systems using EMIS Search and Reporting. It is therefore important GP practices use the correct Read Codes and also remove patients who are no longer receiving the service - Read Code EMISNQNO171.
- Payments under the scheme will be suspended if at any time the practice is unable to provide services in line with the service specification. Before any suspension the provider and Wirral CCG will meet discuss the reason for the suspension identifying any possible resolution. If the matter is not resolved the CCG will issue a suspension notice to the practice within seven days.
- The provider agrees to give Wirral CCG a minimum of six months' notice in order to terminate their agreement to provide care under this LCS.
- Either party can appeal against a suspension or termination notice to the CCG's Primary Care Co-Commissioning Committee.

3.3 Population covered

- The service may be offered to all patients resident in an Older Persons Care Home in Wirral as listed below.

Name of Care Home	No of Beds
Allandale	6
Ancourage Care Home	40
Brimstage Manor	46
Caldy Manor	34
County Homes	90
Fairfield Nursing Home	30
Grange Nursing Home	32
Hazelwell	41
Heathermount Care Home	16
Hilbre House	20
Hoylake Cottage	62
Lear House	24
Lighthouse Lodge	80
Red Rocks	24
Ridgewood Court Care Home	60
Riversdale	37
Sandtoft	22
The Court	17
Melrose House (Res MH)*	29
The Croft Res Care Home	10
The Dales Care Home	31
The Lodge	19
The Old Garden	40
The Woodlands	15
Trepassey	24
Westhaven	52
Westwood Hall Nursing Home	52
Aynsley Nursing Home	27
Barnston Court	25
Belvidere Nursing Home	40
Homecrest Residential Care Home	29
Kingsley House (Res MH)*	16
Leighton Court Nursing Home	48
Mariners Park Care Home	32
Merseyview Residential Home	12
Mother Red Caps Home	51
Newhaven Sunningdale Rd (LD)*	16
Penket Lodge	27
Ridgewood Court	60

Sandrook Nursing Home	28
Sandstones	35
St George's Care Home	60
Victoria House (Wallasey)	56
Bebington Care Home	87
Birch Tree Manor	61
Charlotte House	60
Daleside Nursing Home	40
Derwent Lodge Nursing Home	46
Elderholme Nursing Home	61
Evergreen Lodge	35
Grovewood Residential Home	32
Safe Harbour Dementia Care Home	47
Summer Fields	50
Acorn House	33
Beechcroft Care Home	43
Birkenhead Court	60
Devonshire Manor	15
Dundoran Nursing and Residential Home	31
Gerald House	18
Grove House	63
Heyberry House	41
Hilbre Manor EMI Residential Home	12
Hillgrove Residential Home	23
Lezayre Nursing Home	32
Mayflower Court - Residenital Home	20
Nazareth House	51
Norway Lodge	29
Oakdene	16
Orton House	39
Oxton Grange Care Home	60
Park House Care Home	111
Salisbury House Residential Home	37
Sylvan House Residential Home	20
The Manor House Nursing Home	58
The Court Nursing Home	31
The Pines Residential Care Home	24
The Roberston Sandle Home	17
Upton Grange	52
Windy Knowe	49
Woodheath / Apple House	61
Total	3080

- *In addition the following Mental Health and Learning Disability Beds may be supported:

  Kingsley House – 16 beds (Residential Mental Health)

Melrose House – 29 beds (Residential Mental Health)
Newhaven Sunningdale Road 14 beds – (Residential Learning Disabilities)

3.4 Service Criteria/Exclusions

- This service may only be provided to patients by a service provider who has direct access to the full primary care medical notes of patient's. This must include medical information relating to any acute 'reactive' visits patients may receive under GMS/PMS/APMS contracts.
- Patients resident in intermediate care, Discharge to Assess or any other beds where separate contracts in place for medical cover.
- All Mental Health and Learning Disability Beds unless prior approval is given.

3.5 Interdependence with other services/providers

- The service provider must work in close partnership with other health and social care providers including local accident and emergency departments, ambulance service and urgent care centres, GP out of hours, NHS 111, as well as social care and community providers.
- Where appropriate and using locally agreed guidelines (where these exist) the provider will refer patients to other health and social care services and to relevant support agencies.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- The Enhanced Health in Care Homes Framework
- Relevant NICE standards

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

- British Geriatrics Society (BGS)

4.3 Applicable local standards

Locally defined, general requirements for providers

The contractor will need to confirm compliance with the standards within this service specification by 30th June 2019.

5. Location of Provider Premises

- The service will be provided in all Wirral Care Homes as specified in section 3 or as otherwise agreed between commissioner and provider.