**Higher prevalence of older people in care homes in Sutton**

6% of people aged 75 years old and above in Sutton live in care homes, compared with a national average of 4%. Institute of Public Care (IPC), “POPPI: Projecting Older People Population Information”, accessed July 2015, Available at http://www.poppi.org.uk/.

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### VANGUARD: Sutton Homes of Care

<table>
<thead>
<tr>
<th>Case study:</th>
<th>Enhanced nursing role: Building competence and confidence in nursing home staff to improve the quality of care for nursing home residents</th>
</tr>
</thead>
</table>

### Purpose:

The purpose of this element of our work was to improve further the quality of care given to nursing home residents.

Residents of nursing homes have a wide range of complex health needs, which can place significant pressure on the health and care sectors, particularly in areas like Sutton where the population of care home residents aged 75 years and older is higher than the national average. It is crucial that new models of care are developed to support care homes to manage these pressures themselves as far as they can and to improve the quality of care provided to their residents.

As part of the Sutton Homes of Care programme, we have been piloting Health and Wellbeing Reviews (HWBRs) of residents by linked GPs in six nursing homes across the borough. Through HWBRs, every resident in the pilot sites will have an individual care plan developed in partnership with them, their family, their GP and the home’s Care Coordinator (a new enhanced nursing role as part of this pilot).
care plan aims to ensure the provision of preventative and proactive holistic healthcare, which we anticipate will bring about a reduction in the number of emergency calls made to the ambulance service, unnecessary admissions to hospital and shorter lengths of stay for those residents whose admission to hospital was unavoidable.

The HWBR model was developed by our local partners in the vanguard programme at a work shop in 2015, and the GP element is based on a similar model introduced in Newcastle Gateshead CCG in 2009. The key difference in our model is the role of the Care Coordinator; a vital element of the pilot, facilitating an effective working relationship between the GP and the care home. This in turn creates an environment where shared, resident-centred decision-making is developed and maintained within the care team.

The Care Coordinator makes sure that the care plan is delivered and reviewed, either after six months or when things change. The role also enables a permanent member of care home staff to provide clinical leadership in respect of meeting the complex needs of residents. Their experience from within the Care Home draws on their knowledge of residents and their individual health needs.

The HWBR process works by the Care Coordinator assessing their residents to determine urgency of health need. Residents classified as having an urgent need are seen first, then those who require a follow-up. Time is also allocated to review residents who are due a HWBR. The ‘link GP’ visits the care home at the same time each week to undertake these reviews. Following the visit, the Care Coordinator will update the residents’ notes and nursing care plans and begin any required referrals to other services or other actions agreed with the GP. The GP will update the residents’ primary care notes and make any referrals that only he/she has authority to do.

During the previous weeks’ visit, certain residents will have been identified for a HWBR. This includes a review of a resident’s physical and psychological health needs based on a full geriatric assessment. The HWBR ensures the adoption of a proactive approach to care, including consideration of advanced care planning for potential health crisis management and for end of life care needs. A template for the HWBR was developed by one of the linked GPs to ensure consistency.

Our approach recognises the unique knowledge that care home staff have regarding their residents’ and by valuing and investing in these staff, they are empowered to achieve higher standards of care... This enables them to evidence the 6 C’s (compassion, care, communication, courage, commitment, and competence) in practice, which is the essence of our programme. Funding is provided to enable the Care Coordinators to be supernumary for the GP visit to ensure the
Prior to commencing the pilot, a facilitated study day was held where Care Coordinators received leadership training, in addition to clinical training in assessing the older person to identify health and social care needs. Care Coordinators initially met monthly to network and share their experiences and learning from the HWBR. However as the pilot has progressed, the network has started to meet quarterly to enable peer learning and provide ongoing support.

Phase One of the pilot ran from November 2015 until March 2016 (22 weeks), with Phase Two running from April through to the end of July 2016. In Phase One, there were a total of 1460 episodes of care across all six care homes. About half (715) were for an acute need, 525 (36 per cent) for a follow-up to a previous concern and 230 (15 per cent) were for the HWBR.

Near the end of Phase One, we asked the Care Coordinators, care home managers and linked GPs about their experiences of running the HWBR rounds. Everyone involved agreed or strongly agreed that the HWBRs had enabled them to be more proactive and reduce unnecessary admissions. They explained their reasons for these positive outcomes as:

- the adoption of a more systematic and holistic approach to residents’ care and disease management resulting in fewer crises;
- earlier use of appropriate medications to support good end of life care; and
- more proactive medicines management.

One of the most notable impacts has been the increased confidence of the Care Coordinators, which we reviewed before the pilot began and again near the end of Phase One. The results showed that HWBRs have enabled more effective working relationships between all parties. The confidence of Care Coordinators’ when communicating with GPs and emergency services increased by 23 per cent, and their confidence in communicating with relatives in critical situations increased by 44 per cent.

Anecdotal feedback from the linked GPs at the workshop showed that they felt more confident in the Care Coordinators and care staff in general.

Care home managers reported that the HWBR rounds had created a much more open and supportive culture.

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**Success so far (i.e. what has been the outcome and impact for residents?)**

- time is utilised efficiently and effectively.
Further analyses of the pilot will be carried out on completion.

<table>
<thead>
<tr>
<th>What has been the financial impact of this innovative idea, compared to before implementation? I.e. Is this cost effective?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The total cost over a six month period was £60,100 (an average of about £10,000 to cover each home). Of this, £14,000 went to the nursing homes to enable the Care Coordinators to be supernumerary for the weekly HWBR rounds and for one day each month to attend training and meetings. About £46,000 was paid to the six linked GP’s practices to enable weekly GP locum cover of a morning or afternoon session to provide for regular, pro-active care and for each HWBR, up to a limit of two per resident per year. Full details are provided in the attached contract document.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lessons learnt:</th>
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</thead>
<tbody>
<tr>
<td>We have learnt the following lessons:</td>
</tr>
<tr>
<td>- The role of the Care Coordinator is key to making sure that the HWBR rounds work effectively and efficiently.</td>
</tr>
<tr>
<td>- It is important to recognise the context and the individuality of each care home, each GP, and each Care Coordinator.</td>
</tr>
<tr>
<td>- Protected time for the linked GPs and the Care Coordinators is essential to allow them to proactively agree each resident’s health needs together, to plan ahead, to document and deliver the plan and to involve the families. It benefits the individual residents and their families too, as there is an agreed time each week for families to be involved.</td>
</tr>
<tr>
<td>- Protected time for the Care Coordinators enabled them to take the initiative and support the most effective use of the GPs’ time in the homes.</td>
</tr>
<tr>
<td>- The regular presence of the GPs contributed to an increased level of confidence amongst the Care Coordinators, which enabled them to better manage the care needs of residents.</td>
</tr>
<tr>
<td>One example of this was the management of residents who were approaching the end of their lives. Collaborative working with the GP led to the delivery of improved care, and care home staff reported an increased level of confidence when communicating with both the residents and their families at this difficult time.</td>
</tr>
<tr>
<td>- Some positive outcomes were unexpected, for example, improved team working across organisations and increased confidence of individual staff.</td>
</tr>
<tr>
<td>- It takes time to carry out a full HWBR or even an acute assessment of nursing home residents, as typically they are very frail, have complex health needs and are taking a number of medications.</td>
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</tbody>
</table>
We will be carrying out a full evaluation of the pilot once it has completed and will include an examination of the outcomes for residents. If you would like to know more, please get in touch:
suttccg.carehomevanguard@nhs.net

Additional documents included below:

- Care coordinator role outline
- Care coordinator data collection
- Primary care specification for pilot
- Template for HWBR
ROLE OUTLINE

Position: Care Co-ordinator

Responsible to: Home Manager

Accountable to: Home Manager

ROLE SUMMARY

- To provide leadership within the care home to continuously improve the standards of care and quality of life for all residents within the home.
- To be actively involved in the Vanguard programme new models of care, including attendance and participation in any training and evaluation relevant to the role (internal or external providers).

ROLE DESCRIPTION

- To be available (supernumary) on the day of the GP ward round review.
- To proactively identify residents of concern for GP review, including the completion of any necessary assessments required prior to review, e.g. urinalysis, patient observations, wound assessment.
- To be a key liaison and the named point of contact for the GP and other health and social care professionals (HCP).
- To ensure communications received from the GP and other HCP are documented and shared with the care home manager and other staff as appropriate.
- To ensure the resident is involved in all discussions around their care and treatment and the plan of care is updated following review from the GP or other HCP.
- To ensure the residents’ next of kin is aware of any concerns regarding their relative’s health and is kept informed of the plan of care to address this concern.
- To minimise the need for hospital admission by proactively utilising resources identified in the ‘Concerned about a resident’ poster, e.g. CPAT.
- To ensure that the ‘red bag protocol’ is adhered to if a resident requires admission to hospital.
- To minimise the hospital length of stay by reviewing residents within 48 hours of admission and liaising with the treating team to determine the earliest discharge date. Following this assessment, any changes to the residents needs are taken into consideration and a plan of care is put in place to address these.
- To be able to identify when a HCP referral would be appropriate and initiate the referral process e.g. dietician.
- To undertake the role of Medicines Champion in close liaison with the Care Home pharmacist.
- To be able to identify when a health needs assessment may be appropriate and take responsibility for ensuring this is completed in a timely manner.
- To develop an effective working relationship with all community teams who support the provision of individualised care for residents within the home.
- To demonstrate a comprehensive awareness of services available in the local community to support health and wellbeing and how residents may access these services. This may include voluntary and charitable agencies.
- To be actively involved in the Care Home Network and Care Co-ordinators network across the borough to enable peer support, the sharing of best practice and evaluation of the role.
- To be responsible for initial and ongoing holistic assessments to address the resident’s physical, psychological, spiritual, social, emotional and cultural health and wellbeing needs, ensuring a multidisciplinary approach to their care is initiated, planned and implemented.
- To develop effective working relationships with the care home staff and be involved continuing personal and professional development.
- To supervise care staff to ensure that the care delivered meets the personal care needs of the residents in a way that respects the dignity of the individual and promotes independence.
- To work closely with the care home manager to coordinate the working day effectively, ensuring any identified issues are resolved.
- To optimise the residents and family’s positive experience of care within the home.
- To help and support residents to be able to continue the expression of their cultural and spiritual needs and values, recognising what is important to them as individuals.
- To ensure that residents reaching the end of life have a plan of care that will meet their clinical and personal needs and is aligned with their wishes, underpinned by the 5 core principles of end of life care.
ROLE AND PERSON SPECIFICATION

Essential

- An experienced nurse in the care home.
- Genuine interest in the maximisation of health, wellbeing and independence in the older person and the ability to advocate effectively.
- Evidence of enhanced skills in the following areas of care:
  - Physical assessment
  - Tissue viability and pressure ulcer prevention and management
  - Hydration and nutrition
  - End of Life Care
  - Dementia expertise, specifically managing challenging behaviour
  - Continence and urinary catheter management
  - Bowel care and management
  - Management of home oxygen
- Excellent verbal and written communication skills

Desirable

- A recognised mentorship qualification to support the development of others.
- The ability to critically reflect on situations to identify learning.
- Evidence of enhanced skills in the following areas of care:
  - Administration of intravenous fluids and antibiotics
  - Tracheostomy care and management
- Evidence of previous experience in comprehensive physical assessment and managing long term conditions.
**1. Complete all fields for every Multidisciplinary Health and Wellbeing Review (MHWR)**

**2. Email to sutccg.carehomevanguard@nhs.net at the end of each month**

<table>
<thead>
<tr>
<th>Name of Care Home:</th>
<th>GP Name and Practice:</th>
<th>Month:</th>
<th>Date invoice sent for Nursing time payment:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Number of resident reviews</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5 (if needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute need</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Follow-up</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>6/12 holistic</strong> *</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>What community service referrals were made and how many?</th>
<th>Number of GP callouts</th>
<th>Number of 999 call outs</th>
<th>Hospital admissions</th>
<th>Average time spent on MHWR</th>
<th>Nursing time to complete associated activities</th>
<th>Estimated GP time to complete associated activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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* Holistic 6/12 review must be structured to include review of holistic needs including medicines and consideration of multidisciplinary needs to maintain function and quality of life
SCHEDULE 2 – THE SERVICES

A. Service Specifications

<table>
<thead>
<tr>
<th>Service Specification No.</th>
<th>Service</th>
<th>Commissioner Lead</th>
<th>Provider Lead</th>
<th>Period</th>
<th>Date of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enhanced Care in Care Homes</td>
<td>Sutton Clinical Commissioning Group</td>
<td></td>
<td>1 October 2015 – 31 March 2016 initial phase then 1 April 2016 to 31 March 2017</td>
<td>31 March 2016</td>
</tr>
</tbody>
</table>

1. Population Needs

1.1 National/local context and evidence base

1.1.1 National and local policy documentation and targets promote the aim of keeping older adults well, improving their health and reducing health inequalities as well as improving access, patient experience, staff satisfaction and engagement. Local objectives include supporting people to retain their independence and be in control of their condition as well as supporting carers with advice and information.

1.1.2 The vision of Sutton Clinical Commissioning Group (CCG) is driven by local health challenges and is to:

- Care for people in a seamless way that is not restricted by either organisational or professional boundaries;
- Improve the Quality of health services and ensure the people of Sutton live longer, happier and healthier lives;
- Ensure commissioning is clinically led and driven by patient and carer involvement.

1.1.3 Sutton CCG has identified a range of commissioning ambitions which include moving care closer to home, ensuring patients receive a high quality experience and developing patient defined outcomes; joining health and social care for better outcomes, creating more opportunity for self-care and patient–led services, and reducing disease and premature death by targeting those most at risk. Sutton CCG is also committed to improving people’s opportunities to live independently and with dignity.
1.1.4 Implementing the CCGs vision requires a model of proactive care that adopts an approach to service delivery that ensures needs are met by incorporating the views of stakeholders, supported by intelligent use of information systems, clinical evidence and robust commissioning frameworks.

1.1.5 An increasing frail elderly population in care homes is coupled with an increasing number of acute hospital admissions unless there is a model of preventative and proactive care that improves the quality, safety and experience of patients and families while at the same time reducing the need for unscheduled care, whether that is hospital admissions, calls to 999/111 or requests for unscheduled home visits.

1.1.6 The high level of emergency admissions from care homes is not surprising, given that these are frail elderly patients with multiple medical problems and complex needs. However, the evidence is clear that those patients who have a comprehensive geriatric assessment [CGA] and subsequently have a care plan that is shared with appropriate urgent care services will see a reduction in avoidable hospital admissions.

There are unavoidable reasons for emergency admissions from care homes:-

- Acute major illness or trauma e.g. a heart attack or fall fracture
- Deterioration in chronic disease
- Acute minor illness, e.g. chest infection, dehydration
- End of life issues
- Specific factors in the home – e.g. staff training needs

1.1.7 Active input from GPs can contribute to improvements in the following:

- Inefficient systems and poor communication
- Many residents in the same home registered with different practices
- Lack of proactive care in managing chronic disease and medicines
- Lack of care planning, especially around discharge and end of life care
- Over-reliance on Out of Hours services (OOH) for crisis management

1.1.8 As a first step, at risk care home residents need to be identified correctly. NHS England has introduced an enhanced service specification to promote active case finding and patient review for vulnerable people. The enhanced service specification states explicitly that case finding and review should be part of a whole system commissioning approach if the number of avoidable unplanned admissions is to be reduced. Sutton CCG recognises this and wishes not only to identify vulnerable people in care homes but to ensure their care is properly managed in the community.

1.1.9 Managing frail people in the community, especially in a care home requires ‘team work’, through a collaborative working arrangement across service providers and an integrated approach to management. It is expected that the practice works collaboratively as part of a Multi-disciplinary Team which includes Care Co-ordinator Nurses (named nurses within the nursing home), including Community Prevention of Admission Team, End of Life Care Specialist Nurses, Pharmacy, and other appropriate clinical teams and staff.
1.1.10 The healthcare needs of people in nursing homes are complex and many residents require 24 hour nursing care. Many nursing homes already provide professional healthcare support to their residents but more work needs to be done to understand the complex health needs of this population.

1.1.11 Healthcare for these residents requires input from a multidisciplinary team of NHS healthcare professionals from the Acute Trust, Primary and Community Care working collaboratively with the nursing staff based in the nursing home. Currently in Sutton the CCG is dependent on private sector care homes to meet the complex health needs of these residents and cross-organisational coordination of care is essential.

1.1.12 The findings from several health needs assessments clearly identify the need to plan for the future as well as current healthcare provision for this vulnerable population as it is projected that the Sutton population currently above state pension age rise by 30% by 2030. It follows that there will be a similar increase in the number of residents that will require 24 hour nursing care.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
<th>✔</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1</td>
<td>Preventing people from dying prematurely</td>
<td>✔</td>
</tr>
<tr>
<td>Domain 2</td>
<td>Enhancing quality of life for people with long-term conditions</td>
<td>✔</td>
</tr>
<tr>
<td>Domain 3</td>
<td>Helping people to recover from episodes of ill-health or following injury</td>
<td>✔</td>
</tr>
<tr>
<td>Domain 4</td>
<td>Ensuring people have a positive experience of care</td>
<td>✔</td>
</tr>
<tr>
<td>Domain 5</td>
<td>Treating and caring for people in safe environment and protecting them from avoidable harm</td>
<td>✔</td>
</tr>
</tbody>
</table>

2.2 Local defined outcomes

2.2.1 The number of Care Homes with a linked GP Practice.

2.2.2 The proportion (number and percentage) of patients on the practice register identified as residing in a care home (Residential and Nursing).

2.2.2 Number of patients who reside in a care home who have been assessed/reviewed within each 6 month period.

2.2.3 Number of patients who reside in a care home with an active, individually tailored care plan.
3. **Scope**

3.1 **Aim of service**

The aim of this scheme is to ensure that all Care Home residents are provided with high quality medical care.

The scheme does this by the provision of additional payment to practices who agree to deliver enhanced care, develop care plans that are comprehensive and establish consistent standards of care through an agreed protocol. *This scheme is additional to the NHS England “Enhanced Service Specification Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people 2015/16”. It is expected that any practice, whether aligned to a care home or not, which signs up to this specification will also be delivering the services detailed in the NHS England scheme.*

3.2 **Objectives of Service**

3.2.1 To maintain and enhance the quality of primary health care for all residents of Care Homes (Nursing and Residential) in Sutton provided by General Practice in association with pharmacy and nursing staff, offering consistency, efficiency and a higher quality of service.

3.2.2 To reduce avoidable and admissions to secondary care and inappropriate/unnecessary use of emergency and urgent care services by Care Home staff.

3.2.3 To provide a contractual framework for the provision of enhanced general medical services for all care home residents within Sutton.

3.2.4 To link each Care Home in Sutton to a GP Practice who will forge an effective working relationship with the home as well to provide preventative and proactive healthcare working as part of a multi-disciplinary team.

3.2.5 To ensure that every patient resident in a Care Home in Sutton has an individual care plan which has been co-produced with the patient, the patient’s family, care home staff, Care Co-ordinator and which will be updated according to clinical need and each time any changes to the patient's care or medication occur. The care plan will be formally reviewed and updated every six months.

3.3 **Service description/care pathway**

This section needs to be read in conjunction with:

- **DoH Code of Practice on the prevention and control of infections and related guidance July 2015**
- **NICE Guidance**
- **Managing Medicines in Care Homes – March 2015**
- **Using Quality Standards to Improve Practice in Care Homes for Older People Jan 2015**
**Practices Linked to a Care Home**

3.3.1 This scheme will align (link) a GP practice with a named care home, nursing or residential or both. In the first phase of the vanguard programme, 6 nursing homes will be selected and the model will be tested over an initial 6 month period prior to roll out to all nursing homes, phase 2 will then work with residential care homes to roll out in the same way. It is expected that the link practice will forge a working relationship with the care home to support the long term health needs of residents. To become the link practice, the majority of patients residing at the care home must be registered with the practice.

Where no link practice exists, the CCG will offer the opportunity to other willing practices to support the care home and become the link practice. Residents who are not already a patient of the link practice will be asked to consider the additional benefits of registering with the link practice. This will be through collaborative working with patients, their families and care home staff whilst maintain choice for the resident.

3.3.2 The link GP practice will deliver a tailored package of support and care centred around care home residents as individuals. An important aspect of the support will be the provision of a named or ‘Lead General Practitioner’ (lead GP) who, along with the Care Coordinator will be the reference point for the resident and their families and carers.

3.3.3 The lead GP and the Care Coordinator will also be the named contact for other care professionals supporting the care home e.g. medicines management and pharmacist support or preventative work carried out by nursing or health care assistants. The Lead GP will therefore ensure that services are co-ordinated in a way that meets the needs of the resident, their families and carers.

3.3.4 The link GP practice will provide a [dedicated weekly session](#) to their linked care home. During this session the Lead GP will meet with the Care Coordinator to discuss current problems and/or healthcare issues. The lead GP will also contribute to the [community multi-disciplinary team](#) meeting with the Care Coordinator to explore care options, review care plans and/or develop new care plans for each resident (where clinically appropriate and/or necessary).

3.3.5 As part of the care planning process, the GP will undertake a comprehensive geriatric assessment upon admission of all new registered patients to the care home. This comprehensive assessment will include:
- A full capacity assessment including a dementia test and best interest review;
- Full review of medication to reduce the number and type of drugs given to residents;
- End of Life discussions, which are to be documented and if appropriate advance care planning and CMC upload (with consent from resident).

3.3.6 An individually tailored care plan will then be developed for each patient registered with the practice. The care plan should be agreed between family members (with consent from resident) and care home staff, with an additional document detailing the agreed actions in nominated care circumstances e.g. Palliative Care, DNAR instructions. The Care Coordinator will support this process.

3.3.7 It is expected that a formal review will take then place at least every six months with the care plan updated.
3.3.8 Clear documentation within the GP records with appropriate Read Codes to assist with communications for any treating Clinicians to provide effective care in keeping with the care plan.

3.3.9 The lead GP will ensure consultations with patients and staff takes place in an area where patients and staff have as much privacy as possible when discussing their concerns or being treated by the lead GP.

3.3.10 For unscheduled support and urgent care enquiries, the GP practice will provide same day telephone access to an appropriate clinician and where required, a visit will be undertaken. Access to a clinician should be within a suitable timeframe recognising that the query may be about a patient in crisis or exacerbation, which may result in an unnecessary admission to hospital if not dealt with appropriately.

3.3.11 The lead GP will work closely with the practice team to review any appropriate policy and procedures.

3.3.12 The GP Practice will ensure that when a registered patient is discharged from hospital, an appropriate clinician will contact the care home in a timely manner to ensure co-ordination and continuity of care as well as to review and where appropriate update the care plan.

3.3.13 The GP practice will be required to regularly review emergency admissions and A&E attendances in order to understand why these presentations or admissions occurred and whether they could have been avoided.

3.3.14 Following these reviews, the link GP Practice will share any emerging themes, pathway issues or points of action with the CCG to inform system reform programmes or future commissioning decisions.

3.3.15 Link GP practices will ensure that their staff providing this enhanced service maintain and develop their knowledge and skills in caring for frail older people and will attend available training around care planning.

3.3.16 The link GP practice will ensure sufficient capacity to deliver the service and make arrangements to cover periods of leave, including sudden and unexpected absence.

Practices who are not Linked

3.3.17 Practices who are not linked to a care home but have registered patients who are resident in a care home will develop an individually tailored care plan for each patient. As part of the care planning process, the GP will undertake a comprehensive geriatric assessment upon admission of all new registered patients to the care home. This comprehensive assessment will include:

- A full capacity assessment including a dementia test and best interest review;
- Full review of medication to reduce the number and type of drugs given to residents;
- End of Life discussions, which are to be documented and if appropriate advance care
planning and CMC upload (with consent from resident).

3.3.18 An individually tailored care plan will then be developed for each patient registered with the practice. The care plan should be agreed between family members and care home staff, with an additional document detailing the agreed actions in nominated care circumstances e.g. Palliative Care, DNAR instructions. The care co-ordinator from each nursing home will support this process.

3.3.19 It is expected that a formal review will take place at least every six months with the care plan updated.

3.3.20 Clear documentation within the GP records with appropriate Read Codes to assist with communications for any treating Clinicians to provide effective care in keeping with the care plan.

3.3.21 GP practices will ensure that their staff providing this service maintain and develop their knowledge and skills in caring for frail older people and will attend available training around care planning.

3.4 Population covered

3.4.1 This service will be available to all patients who are resident in a nursing or care home and who are registered to a GP practice which is in the borough of Sutton.

3.5 Any acceptance and exclusion criteria and thresholds

3.5.1 Patients who do not reside in a care home registered with a GP from Sutton Clinical Commissioning Group are excluded from this service.

3.6 Interdependence with other services/providers

3.6.1 The GP practice will have robust working relationships with the following: (this list is not exhaustive):
- Care Coordinator Nurses within the nursing home or community nurses for residential homes who are aligned to the residential care homes
- Care home staff
- End of Life Care Specialist Nurses
- Occupational Therapy
- Physiotherapy
- Dietician
- Chiropody
- Podiatry
- Pharmacists
- Secondary care
- District nursing
- Community Prevention of Admission Team (CPAT)
- Out of Hours Service
- Acute Trust
## 4. Applicable Service Standards

### 4.1 Applicable national standards (e.g. NICE)

#### 4.1.1 NICE Guidance QS50 – Mental wellbeing of older people in Care Homes (Dec 2013)

This quality standard covers the mental wellbeing of older people (65 years and over) receiving care in all Care Home settings, day care and respite care. The standard uses a broad definition of mental wellbeing, and includes elements that are key to optimum functioning and independence, such as life satisfaction, optimism, self-esteem, feeling in control, having a purpose in life, and a sense of belonging and support.

#### 4.1.2 NICE draft guidance – Managing medicines in Care Homes (March 2015)

The purpose of this guidance is to provide recommendations for good practice on the systems and processes for managing medicines in Care Homes; it looks at prescribing, handling and administering medicines to residents Care Homes and the provision of care or services relating to medicine services in Care Homes.

#### 4.1.3 Using Quality Standards to Improve Practice in Care Homes for Older People Jan 2015

The purpose of this guidance is for care home manager to focus on how to use NICE quality standards to improve the quality of care beyond the standard needed for registration. For example, in its recent themed inspection of the care of people with dementia in care homes and hospitals, the CQC reported that inspectors looked to see who knew about, and was making use of, the 2 NICE quality standards on dementia.

#### 4.1.4 NHS England “Enhanced Service Specification Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people 2015/16”

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

#### 4.2.1 Care Quality Commission (CQC): Guidance about compliance: Essential Standards for Quality and Safety

These provide a common set of requirements applied across all healthcare organisations to ensure that health services that are provided are both safe and of an acceptable quality. They also provide a framework for continuous improvement in the overall quality of care that people receive.


The practice will be expected to work with the CCG to ensure that all core standards and development standards with CQC: Essential standards for Quality and Safety are met.

#### 4.2.2 Social Care Institute for Excellence Guide 52 – GP services for older people: a guide for Care Home managers (Dec 2013).

The health and wellbeing of older people in Care Homes depends on them accessing GP services in a timely way. Effective joint working between GP and Care Home
management, the involvement of residents and their relatives and the engagement of care staff are factors that can affect the outcome and lead to quality improvements. The guide is primarily written for managers and senior staff of Care Homes but it has also been written with GPs in mind.

http://www.scie.org.uk/publications/guides/guide52/

6. Location of Provider Premises

The Provider's Premises are located at:

B. Indicative Activity Plan

Payment Schedule

Practices will receive the following:

<table>
<thead>
<tr>
<th>Practices linked to a Care Home</th>
<th>Audit Criteria / Indicators</th>
<th>Standards / Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Submission of a six monthly audit to include as a minimum the following information:</td>
<td>Submission of audit:</td>
</tr>
<tr>
<td></td>
<td>1. Number of ward rounds undertaken during Quarter 1-2 (April - September) and Quarter 3-4 (October – March) of each financial year (a minimum of 1 per week).</td>
<td>£4000 per ‘link’ Care Home (Payment £2000 per submission)</td>
</tr>
<tr>
<td></td>
<td>2. The proportion (number and percentage) of patients registered as residing in a care home during Quarter 1-2 and Quarter 3-4 of each financial year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Number of patients assessed/reviewed during each quarter of the financial year: - Quarter 1 (April – June) - Quarter 2 (July – September) - Quarter 3 (October – December) - Quarter 4 (January – March)</td>
<td>£100 per patient assessment/review and active care plan every 6 months (£200 per patient, per annum)</td>
</tr>
</tbody>
</table>
4. Number of patients with an active care plan during each quarter of the financial year:
   - Quarter 1 (April – June)
   - Quarter 2 (July – September)
   - Quarter 3 (October – December)
   - Quarter 4 (January – March)

Please note - Claims may only be made twice per financial year, per patient.

<table>
<thead>
<tr>
<th>Practices NOT linked to a Care Home</th>
<th>5. Number of patients assessed/reviewed during each quarter of the financial year:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Quarter 1 (April – June)</td>
</tr>
<tr>
<td></td>
<td>- Quarter 2 (July – September)</td>
</tr>
<tr>
<td></td>
<td>- Quarter 3 (October – December)</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>£100 per patient assessment/review and active care plan every 6 months (£200 per patient, per annum)</td>
</tr>
</tbody>
</table>

6. Number of patients with an active care plan during each quarter of the financial year:
   - Quarter 1 (April – June)
   - Quarter 2 (July – September)
   - Quarter 3 (October – December)
   - Quarter 4 (January – March)

Payment will only be made:
- Upon receipt of a signed standard NHS Contract
- Upon receipt the six monthly audit detailed in the payment schedule above (for link practices)
- Upon receipt of the Care Home Claim Form (for patient assessment/reviews)

Submission of claims information with respect to this service:

Providers will be required to submit information [quarterly] for this service via Sutton CCG. Payment for this service will be generated based on the information.
# HEALTH PROFESSIONAL VISIT – SIX MONTH HEALTH AND WELLBEING REVIEW

**NAME OF SERVICE USER:** __________________________

<table>
<thead>
<tr>
<th>VITAL SIGNS:</th>
<th>URGENT ADMISSIONS IN LAST 6/12:</th>
<th>MEDICATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLOOD PRESSURE –</td>
<td></td>
<td></td>
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<tr>
<td>TEMPERATURE –</td>
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<td>RESPIRATION –</td>
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<td>PULSE –</td>
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<td>O2 SATS –</td>
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<tr>
<td>CBG –</td>
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<table>
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<tr>
<th>PAST MEDICAL HISTORY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise/Mobility (incl. falls)</td>
</tr>
<tr>
<td>Social/Mood (incl. vision and hearing):</td>
</tr>
<tr>
<td>Behaviour/Cognition/Dementia:</td>
</tr>
<tr>
<td>DOLS?</td>
</tr>
</tbody>
</table>

**Chronic Disease Management:**

<table>
<thead>
<tr>
<th>Eating &amp; Drinking (incl. swallow and teeth)</th>
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<tbody>
<tr>
<td>Skin integrity &amp; Continence:</td>
</tr>
</tbody>
</table>

**Advanced care planning/decision-making:**

<table>
<thead>
<tr>
<th>DNAR?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMC?</td>
</tr>
</tbody>
</table>

**MDT’S / DOCTOR’S NAME & SIGNATURE:** __________________________

**NURSE’S NAME & SIGNATURE:** __________________________

**DATE:** __________________________