New care models

Enhanced Health in Care Homes

Vanguard learning guide

EHCH Element 1.1

Access to named GP and wider primary care

This is a live document:
Version 1.0
27/06/2017

Our values: clinical engagement, patient involvement, local ownership, national support

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**Our values:** clinical engagement, patient involvement, local ownership, national support

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What do the ‘vanguard learning guides’ do?

- Focus on a key element or sub-element of the Enhanced Health in Care Homes (EHCH) care model.
- Identify interventions put in place by the enhanced health in care home vanguards that have worked particularly well, and which could be readily replicated at clinical commissioning group (CCG), local authority, Sustainability and Transformation Partnership (STP) and/or regional level.
- Reference learning from relevant good work going on outside of the vanguards, where it is improving the lives of care home residents (includes residential, nursing and other settings).
- Describe a step-by-step approach to support implementation in non-vanguard areas, including first steps, roles and responsibilities, things to consider and the resourcing and benefits associated with these interventions.
- Support a consistent implementation of the core elements of the EHCH care model.
- Include practical materials such as job descriptions, referral criteria and operating models that can be easily adapted and adopted by other areas.
- Set out the key practical challenges arising from implementation of the care model, together with learning from the vanguards to help you overcome them.
- Link to national guidance and NHS England’s series of ‘Quick Guides’ where relevant.
About aligned GP and care homes and access to primary care

**Name of Intervention**

- Access to named GP and wider primary care.

**Description of intervention**

- Facilitated support for GPs to work in a multi disciplinary team and take a proactive approach for people living in all care homes, with care that is centred on the needs of residents, their families and care home staff.
- Formalised practice relationships with care homes. Care home residents have a named GP, but the option of remaining with their existing GP. This preserves patient choice - but majority choose link GP over time.
- A safe and steady transfer of residents to link GP from existing arrangements.
- Work towards systematic use of holistic assessment and regular review of the mental and physical health of the care home population, aiming to benefit from use of comprehensive geriatric assessment (CGA). Work towards incorporating frailty in assessment and care planning.
- Supported development on strong professional relationships between home and GP practices.
How does access to named GP and wider primary care support the EHCH care model?

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- Access to named GP and wider primary care is key to successful implementation of the EHCH care model.
- Enhanced primary care support forms one of the seven elements of the EHCH framework, and has four sub-elements:
  - Access to named GP and wider primary care
  - Medicines reviews
  - Hydration and Nutrition support
  - Access to out-of-hours / urgent care
- This vanguard learning guide focuses on sub-element 1.1: Access to named GP and wider primary care services.
- Mapping of GP practices to care homes within an EHCH care model simplifies care delivery, and enables pro-active, consistent, personalised care and multi-disciplinary team (MDT) working. This is supported by regular ward rounds and holistic, personalised assessment and care planning.

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What does Enhanced Primary Care need to provide?

A service that works for your area

- There is no single model which fits all. Every care market is different, and pressures on primary and secondary care vary around the country. However, the EHCH vanguards have identified the following as key aims and components of good enhanced primary care services:

Aims of the service

- Coordinated and proactive care, with GPs working as part of a multi-disciplinary team (MDT), that serves people living in care homes.
- Single practice relationships with care homes and each care home resident has a named GP.
- A programme of assessment and regular review of the mental and physical health of the care home population.
- To build strong professional relationships between care homes, community health teams, and GP practices.
- To foster a continuous improvement approach.

Components of the service

- Wherever possible, there should be one-to-one mapping of GP practices to care homes.
- A regular ‘home round’ should be held in each care home. Scheduled time should be protected time to allow clinicians to support this (approximately three hours including prep time). This can also support medicines review, end of life care planning and dialogue with families / carers. The ‘home’ or ‘ward’ round can also help with root cause analysis of avoidable admissions and associated action planning as part of a MDT approach.
- When a resident moves into a care home, a holistic approach to assessment, should be undertaken as part of care planning. This should recognise frailty and include an assessment of functional needs and physical / mental health.
- Assessment and care planning is an iterative process, with review at six months.
- When a resident moves between a care home and hospital, a prompt and efficient transfer of clinical care is required.
Vanguard service models – Nottingham City

Population
- Up to four GPs involved in each home.
- 70% coverage in Nottingham City.
- Being delivered in 60 of the 92 homes.
- Both nursing and residential homes.

Service model and scope
- MDT model with GP input:
  - Planned Visits to care homes
  - Comprehensive Reviews
  - Advanced Care Planning
  - Medication Reviews
  - Education and Support

Evolving the service:
- Getting the model right.
- Redesigning services that deliver into care homes.
- Ensuring systems are in place for effective performance management.

What has worked well?
- Increased accessibility and continuity of health care.
- Improved integration and partnership working.
- More proactive care, less reactive care.

Challenges:
- Homes having more than one practice.
- Difficulty performance managing the local enhanced service (LES) contract.
- Underestimation of the needs of care home residents.
- Establishing and evolving fair and affordable payment mechanisms.

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Vanguard service models – East and North Hertfordshire

Service model and resourcing

- A locally enhanced service (LES) with GPs aligned to a care home. The scheme covers care homes where patients are unable to travel to the practice or need above GMS support. The LES covers all beds but intermediate care beds, which is subject to a separate contract.
- In some localities, district nurses are aligned to residential care homes.
- In some localities, the alignment is linked with the GP alignment i.e. A district nurse is aligned to a GP practice and therefore is aligned to the residential care home.
- There is an agreement on expectations and what is offered.
- Case management within the homes by Home First (a MDT-led team) if referred by GP.
- District nurses are not aligned to nursing homes. There is some support nursing homes in some circumstances, if this is required.

Evolving the service:

- Review of the primary care support into care homes to look at alternative commissioning models and to develop a place based approach.
- Developing service specifications.
- Linking the support into care homes with the wider service that are on offer to the community.

Lessons learnt:

- Building the care model is an iterative process.
- Design back-ups and flexibility – GPs and care homes won’t always have full care records straight away.
- You need buy-in from the GPs and care homes to make the relationships work.
- Begin by developing a clear specification, including what the expected outcomes are.
- It is important to think about the make-up of the homes, such as turnover, quality and the work involved.

What has worked well?

- Relationship building with practices and care homes.
- Proactive care for residents in the care home.
- Avoiding preventable hospital admissions.
- Improving end of life care.
Vanguard service models – Wakefield

Service model and resourcing

• GP/Aligned Nurse service:
  – Five Federations.
  – 40 GP practices.
  – 26 of these practices are part of the local enhanced service (LES) and look after 27 homes (68 care homes for over 65`s residential and nursing in Wakefield).

• Set KPIs:
  – One GP one Care Home.
  – Read code alignment.
  – Weekly GP / Advanced Nurse Practitioner (ANP) visits.
  – A named GP for each care home resident.

Learning

• Do not underestimate the time it takes time to build the relationships with the practices and the care homes.
• Regular monitoring and verification should be built into the progress.
• Securing and justifying funding - costs of the service should be readily recouped not only by fewer and shorter admissions but also fewer ambulance call outs, fewer non-routine GP visits, better medicines management and improved end of life planning.

Challenges:

• Convincing the local medical council (LMC) of the merits of the approach
• Ensuring that a full healthcare plan is in place within eight weeks of admission
• Limited time allocated to visits from GP practice
• GPs listening to the care home manager and understanding that they are needed at that time

What has worked well?

• Relationship building with practices and care homes
• Avoiding preventable hospital admissions
• Reducing medicines errors
• Improving end of life care
• Responded to medical needs at the request of staff
• Practices realising it doesn’t have to be a GP who attend the weekly visits
• Identification of residents through read codes
Vanguard service models – Newcastle Gateshead

Service model and resourcing

- 32 homes, 31 have a link GP.
- 30 practices (some link to more than one care home).
- 85% of patients with link practice.
- 8 community nurse specialists, linked to 19 homes.
- One practice frailty nurse linked to one home.

Elements of care delivery:

- Comprehensive Geriatric Assessment (CGA) and care planning.
- Weekly ward round.
- MDT shared decision making.
- Virtual ward round; complex decision making, referrals, home visits.
- Workforce development around nutrition & hydration, dementia, end of life care.
- Linked in with a wider programme of IT development - laptops, TECs, EMIS solutions.

Lessons learnt:

- Value staff across the system; care home staff equal MDT members
- Case load size, consistency of care delivery, continuity of nurse impacts on outcomes, quality and experience
- Most virtual ward referrals come from care home ward rounds; shared decision making from case based discussions
- Transfer of care can be improved through communication between hospital teams and care home teams
- Proactive, coordinated approach means clinicians really get to know their patients well
- See our MDT guide for more detail on Newcastle’s virtual ward approach

Evolving the service:

- Working on service specifications.
- GP and nurse specialist alignment.
- Community service reconfiguration.
- Developing the virtual ward approach.
- Continuous improvement and development.
Vanguard service models – Sutton

Service model and resourcing:

• Nursing Home: Health and Wellbeing Reviews (HWBRs)
  – Weekly review of resident needs.
  – Named Care coordinator and link GP.
  – Acute reviews identified by care coordinators.
  – Planned and proactive reviews at six and 12 months.
  – Standard documents.
  – Supports integration of wider initiatives e.g. dementia pathway.

• Residential home: Link Nurse-led HWBRs: Weekly Health and Wellbeing Round
  – Dedicated link nurse liaising with senior carer.
  – Review of residents with acute needs (may not require GP) identified previous week. Six month (health and well being) review.
  – Identification of any equipment required or referrals to be completed.
  – Identification of training needs amongst care home staff.

• Residential home: Falls and End of Life Care Champions
  – Two care staff being up skilled and empowered to become competent in agreed areas.

Enabling supportive processes:

• Care home pharmacist
• Signposting tools for staff
• Enhanced training opportunities
• Care Home support team
• Link nurses, EOLC, challenging behaviour
• Care coordinators network
• Shared learning
• Leadership development
• Clinical supervision/action learning (2016)

Tips for sustainability:

• Pilot and learn from the outcomes
• Support private contracts – specify role of primary care
• Upskill local care co-ordinators and champions – effective working with primary care
• Using the Link staff: intermediary with primary care

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Vanguard service models – East Lancashire CCG / Airedale and Partners

Population

- 104 Nursing and Residential Homes across CCG.
- 95 have Telemedicine installed.
- 21 have access to GP Triage.
- GPs spread across Care Homes.

Service model and scope

- Telemedicine.
- GP Triage.
- Advanced Nurse Practitioners in Care Homes.
- Integrated Neighbourhood Teams (INTs) provide support services for patients with complex needs who may benefit from a multi-agency approach, in care homes and wider community, including dedicated over-75 Nurses.
- Extended Appointments in Primary Care for Over 75 patients.
- Home Visit Scheme to Housebound and Care Home Residents.

Challenges:

- Equitable access and geography – seeking to form a core offer from different models across localities
- Sharing best practice amongst operational teams
- Improved use and gathering of ‘soft’ intelligence to better understand the impact of the services on quality
- Growing complexity of needs amongst over-75s

Evolving the service:

- Revising the local quality framework and developing service specifications.
- Developing systems to link performance to GP practice.
- Considering how to introduce Primary Care Specialist Nurse Forum.
- Strengthening intelligence systems with Care Homes to understand impacts.
- Improving use of technology to support the model.
Potential benefits for residents, families and carers

- Improved quality of health care for residents, through patient-centred care that involves families.

- Supports continuity of care – informed staff and no need for residents to retell their ‘story’ again and again to different health and social care caregivers.

- Improved safety and consistency of care.

- Improved, pro-active care for residents with frailty and support for falls prevention.

- Supports anticipatory/advanced care planning and end of life care planning – to allow residents to die with dignity and compassion and choose their place of death.

- A regular GP or aligned nurse visiting the home can facilitate discussions regarding current and future health needs with the individual and/or their family and carers, ensuring personalised decision-making.

- An opportunity for a more coherent and planned approach to End of Life Care. See our End of Life Care learning guide for more details.
Potential benefits for care provider staff

- Closer relationships between health and care home staff.
- Protected time, developed organisational skills and a proactive approach.
- Increased professional respect.
- Greater confidence for care home staff in communication with families and healthcare professionals.
- Increased opportunities for networking.
- Proactive, coordinated approach means clinicians really get to know their patients well.
- Enhanced training opportunities.
- Opportunities for sharing knowledge and skills.
Potential benefits for primary care and community nursing staff

- Proactive rather than reactive care to vulnerable group of patients. This can be a more structured way to manage caseload and contribute to a more sustainable primary care workforce.
- Protected time to be able to plan for visits.
- Working with named, trusted and responsible contacts within each home, often with improved co-ordination/communication with care home via care co-ordinator.
- Better supported care planning. More time to discuss patients plans and wishes.
- More time to be available for families and carers, and improved communication.
- Continuity of care in turn can reduce demand on primary care staff time, as clinicians know individuals’ situations and are often able to respond to queries more easily – e.g. by telephone or video link rather than callout).
- Improved chronic disease management, dementia diagnosis, support for systematic medication reviews, and a possible reduction in prescribing costs.
- Enhanced primary care can also offer an opportunity to improve management of influenza, shingles and pneumococcal immunisations.
- A favourable service to over 75s and vulnerable groups helping to fulfil CQC aims.

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Potential benefits for the health and care system

- Potential benefits based on implementation of the whole model (not solely GP intervention) include:
  - Reduction in inequity of healthcare provision.
  - Effective use of the wider workforce (e.g. via telehealth, aligned nurses) rather than reactive GP care.
  - Helping to alleviate pressures on the acute system through reductions in avoidable demand:
    - Reduction in the number of calls made to 111
    - Reduction in the number of calls made to 999
    - Reduction in non-elective admissions
    - Reduction in Ambulance conveyances
    - Improved patient flow (reductions in delayed transfers of care).
  - Clearer safeguarding pathways and responsibilities.
  - Fostering closer relationships between health and care home staff.
  - Improved quality, safety, cost-effectiveness of prescribing.
  - Potential to see improved quality scores for the care home in the next monitoring visit.
  - An opportunity to improve retention and recruitment through better status, support and education for care home staff (may not be applicable to all homes).
## Before you start...

### Improve your data and understanding

- Have you considered how services already provided align with CQC ratings?
- Understand the registration category and total number of beds in the care homes in your area. What is the bed mix (self-funded, local authority contract, continuing healthcare [CHC]-funded)? Do you have a sense of bed turnover/bed occupancy fluctuates?
- Understand how GP practices are currently linked to care homes and whether i.e. is it one practice or do most care homes have multiple practices? Which homes have most practices visiting them on a regular basis? Which could be the best link for aligned services?
- Admissions data can be inaccurate – check and validate the post codes and read codes.
- If you need new read codes – plan ahead – this takes a number of months and can require national consideration.
- Build relationships with the local authority – vital for safeguarding and market intelligence (e.g. when a new care home is opening). Who is the lead commissioner?

### Work to convince GPs of the benefit

- Identify a lead GP who understands the complexity and has knowledge of the local care home landscape.
- Be aware of what GMS contract covers – and of any historic arrangement (e.g. LES) covering similar services to care homes. Work from a shared starting understanding of your starting point.
- Build a relationship with your local GP Federation.
- Consider the impact on the workload of GPs and nurses – particularly where they are working extended hours. Work together to design aligned GP/nurse models which are viable for your area’s workforce.
- Provide education and support. There can be a huge learning curve once there is a realisation of unmet need. What has your area not been doing for years?
- Consider the fit with the GP Forward View and the wider local response being taken forward by your STP.

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### Before you start...

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<th>Understand workforce capacity and capability</th>
<th>Ensure alignment with wider initiatives</th>
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<td>• How can you utilise existing teams?</td>
<td>• What services are already available to your care homes?</td>
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<tr>
<td>• Understanding nursing team roles, responsibilities and clinical governance is key.</td>
<td>• It is essential to think about the system as a whole: bring together all aligned services and plans. Take time to network and find out about various projects underway in your area. Some may even be commissioned by secondary care or other unexpected areas of the system.</td>
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<tr>
<td>• Speak to care homes – what do they want from the service and what are they already receiving? Co-design and buy in from care homes is not optional!</td>
<td>• Understanding how services are currently commissioned. How are community services commissioned?</td>
</tr>
<tr>
<td>• It is essential to consider a dedicated program manager to support the implementation. This role need not necessarily be full time - but you will need a regular steering group and operational group.</td>
<td>• Before doing something specific for care homes, understand what future plans are within the regarding STPs and future regional models where care homes could be a component.</td>
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<td>• Consider evaluation and monitoring – what Data Analyst time will be required?</td>
<td>• Will care homes have access to Out of Hours GP services?</td>
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<tr>
<td>• How can you utilise existing teams?</td>
<td>• How will NHS 111 align and support these services? Is there a role for telecare?</td>
</tr>
<tr>
<td>• Understanding nursing team roles, responsibilities and clinical governance is key.</td>
<td>• Need to ensure aligned service is across both residential and nursing homes as the need is the same, more complex patients in residential homes.</td>
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<tr>
<td>• Speak to care homes – what do they want from the service and what are they already receiving? Co-design and buy in from care homes is not optional!</td>
<td>• Pharmacy team input and expertise is vital.</td>
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Contracting, GMS/PMS and use of locally enhanced services contracts

GP practices are required to provide Primary Care Medical Services. It is for each practice to agree with the management team at the home how they propose to deliver the service e.g.

- Equity of provision with patients in the wider community including how they access and receive their care.
- The practice may choose to provide a weekly/fortnightly or monthly clinic session in the home.
- When the home contacts the GP practice for advice and assistance, the practice may choose to undertake clinical telephone triage prior to agreeing or refusing to visit the patient.
- It should be noted that visits are at the clinical discretion of the GP.
- The GP may request another member of the Primary Healthcare Team to undertake the visit e.g. a member of the practice clinical team, community matron, district nurse etc.
- If the GP states the patient does not require a visit the clinical responsibility rests with the GP.
- Repeat prescriptions – On receipt of repeat prescription requests received from the home. The home Manager can expect the prescription requests to be processed and ready for collection – allowing 48 hours for processing (Monday – Friday).
- Hospital referrals – The Home Care Manager can expect the GP practice to refer registered & temporary registered patients to the acute trust and or/other community services as deemed clinically appropriate.
- The care home can expect the visiting GP to update the patient’s clinical records at the practice.
- The GP will be required to record in the patient’s clinical records held by the practice and the home any resident/patient where agreement has been reached that they are not for resuscitation.
- The home can expect the GP practice to provide the Out of Hours service with “Special Patient Notes” for residents that are palliative or the home and/or GP has specific concerns they would like the Out of Hours service to be made aware of.
Contracting, GMS/PMS and use of locally enhanced services contracts

The following are services that GP practices do not have to provide under the terms of their GMS/PMS and APMS contracts:

- Providing a 24/7 service.
- Home visits for patients who are ambulatory.
- Regular ward rounds.
- Anticipatory care - when instigated by the needs of the home rather than the patient.
- Expectation for GPs to see patients' relatives whilst carrying out visits to patients without prior appointments.
- An expectation that all patients will be registered with the same doctor.
- Completion of forms, drug charts and administration beyond that expected for good communication and standard practice.
- Where care is clinically complex and its management may therefore not include any services which may reasonably be included in essential services.
- Care where relevant and adequate secondary care clinical input is required e.g. persistent vegetative state, severe neurological impairment, patients on complex drug regimes and patients on ventilators.
- Providing occupational and management support to homes.
- Holding regular planned patient management visits e.g. surgeries and attending regular clinic type meetings in addition to general medical duties at the community hospital/nursing home.
- Visiting at least once a week if not more frequently to undertake individual assessments and reviews of patients, including carrying out initial assessment of new residents within a specified period after admission, and reviewing at regular intervals.
- Advising on matters of general good health for residents and developing the working practice of the home.
- Providing support and advice to home staff on issues of infection control, prevention and decontamination.
- Provide prescriptions for over the counter medication to residents unless the medication has been identified as necessary following consultation with GP / Nurse Prescriber.
- Supporting nursing home staff in acquiring appropriate competencies.
- Contributing to the developing of clear management and clinical protocols within the home.
Funding options

**Funding considerations:**

- Consider funding from secondary care allocations, where some savings will materialise.
- Also consider the potential savings for acute providers and impact on system-wide targets.
- Understand what can be provided as part of general MDT working – so as to reduce the overall funding challenge.
- Remember to recognise the time commitment needed from not only the GP but other practice staff.
- Include ‘ongoing costs’ e.g. issue support, learning and development, monitoring in your business case.
- Consider structuring contracts around KPIs and payment by results.
Examples of cost

Wakefield
- 17/18 - £226k (27 Care Homes).
- £15 per head for residential and £20 per head for nursing
- Set KPIs such as:
  - One GP one Care Home
  - Read code alignment
  - Weekly GP/ANP visits
  - Named GP.

Newcastle Gateshead
- GP practice £4,000.
- £100 for each care plan and £100 for each review.
- Nurse Specialists, Band 7.
- Pharmacy team (Pharmacist and technician time according to your population and pharmacy model).

East and North Herts
- Locally Enhanced Service - £202/ bed/ year.
- All care homes which have patients unable to travel, are covered under the specification (does not include intermediate care beds).
- Staff time for support and administration.
Things to consider – building essential relationships

- **Build on the enthusiasm of people who want to do this** - find your GP and care home champions. They can be powerful advocates for change.

- It is vitally important that you fully engage with your care homes and build support for Enhanced Primary Care. Develop and utilise your care home managers forum.

- Seek feedback from residents, families and carers on changes they would like to see. Keep them informed.

- Build a strong relationship with your local GP Federation.

- Engage the teams who are going to be delivering to co-design the service. They have got to want to be part of this, as anything you design likely won’t deliver successfully otherwise.

- Local authorities can be an important conduit for information sharing with home managers/providers.

- Remember that this service is for all residents – not just those funded via the local authority or CHC placements.

- Acute and secondary care colleagues need to understand what initiatives around care planning are underway and the practicalities e.g. if discharging a patient on Monday, do acute staff know that a GP is coming into the home to assess the patient on Wednesday – don’t presume that everyone will be aware of new initiatives without dedicated engagement.

**System-wide engagement:**

- Clinical leads from CCGs
- GP federations
- Local medical council
- Care provider association
- Care homes forum
- Community / district nurses
- Specialist MDT members e.g. geriatrician, therapists, and old age psychiatrists
- Mental health and dementia teams
- Local pharmacists
- Advanced nurse practitioners
- Care co-ordinators
- Community groups
- STP Leaders

**Our values:** clinical engagement, patient involvement, local ownership, national support

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Things to consider – pace of implementation and model of support

1. Vanguard experience has shown that implementation works better if everyone ‘is in it together for benefit of all practices’. Engage the local LMC and any GP Federation(s), to co-develop your plans. Foster a sense of this being a system-wide priority.

2. Work towards a safe and steady transfer of residents to the new link arrangements. Not all at once. Do not disrupt ongoing care with existing GP. Also ensure that there are named contacts for formal handover, and clear sharing on information e.g. a fax summary.

3. Having a support nurse working across a locality can make enhanced primary care much easier to manage for single-handed GPs or practices who are struggling. A regular link clinician (e.g. GP, Advanced Nurse Practitioner and/or nurse) provides a stable backbone. Nurses can help also help with data gathering and meeting with families etc.

4. Be prepared to adjust case load size to ensure consistency of care delivery. What time needs to be protected per care home per GP? Continuity of nurse/GP impacts on outcomes, quality and experience. Most virtual ward referrals come from care home ward rounds; shared decision making from case based discussions.

5. Once the service is in place vanguard learning suggests that you will need to keep a continuous improvement approach in place. Don't assume just because your are has contracted for or implemented this it doesn't require ongoing adjustment and refinement in response to changing pressures on primary care and changing mixes of needs in care homes.

6. Agree whether it is preferable to implement across all types of beds. Consider a staged approach to include intermediate care beds and/or Learning Disability care homes at a later date.

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Things to consider - Comprehensive Geriatric Assessment [CGA]

What is a Comprehensive Geriatric Assessment (CGA)?

- CGA is a multidimensional holistic assessment of an older person that leads to the formulation of a plan to address issues which are of concern to the individual (and their family and carers when relevant). Interventions are then arranged in support of the plan. Progress is reviewed and the original plan reassessed at appropriate intervals with the interventions reconsidered accordingly.

  THINK: Assess Identify Plan

Why do a CGA?

- CGA has a sound evidence base that shows it is effective in reducing mortality and improving independence for older people admitted to hospital as an emergency compared to those receiving usual medical care.
- In community settings, the evidence shows that complex interventions in people with frailty can reduce hospital admission and can reduce the risk of readmission in those recently discharged.

  SYSTEM BENEFITS: reduced use of unscheduled care

- CGA is a vital part of the management strategy for older people suspected of having frailty in order to identify areas for improvement and support so as to reduce the impact of frailty.
- There is emerging evidence to demonstrate that CGA and individualised care planning can reverse the progression of frailty.

  PERSONAL BENEFITS: maximised independence improved health and wellbeing

Top Tips

- CGA has five domains and all parts are equal [physical, socioeconomic, functional, mental/psychological, environmental]
- CGA can be time consuming but can be iterative and completed over a 2-3 week period
- A lead clinician can coordinate CGA contributions from a wider multidisciplinary team [MDT]
- There is substantial evidence confirming that older people living with frailty who have access to MDTs do best
- Clinicians working in effective MDTS learn from one another
- There are good tools to support assessment but making your own is a fine option
- CGA is the best evidence base we have for the care of older people with complex needs with over 30 years of research
- A good CGA assessment establishes baselines from which to set goals and use as a measure for [good practice] reviews
- Reviews can be planned and unplanned with a planned review six monthly for those most frail and unplanned reviews occurring post crisis

Contents and introduction  What is Enhanced Primary Care?  Vanguard service models  Benefits  Before you start  GMS / PMS  Resourcing and funding  Things to consider  Challenges and solutions  Materials to support you  To do list and thanks

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Things to consider – workforce development

- It's the process of GP involvement in holistic assessment and review, combined with MDT working which makes the biggest difference. Introduction of, and systematic use of Comprehensive Geriatric Assessment, is a journey rather than a single step, for all involved.

- Don’t burden too much change, for a care home, at once.

- Value staff across the system; care home staff are equal to other MDT members, and this should extend to co-design of the service and access to learning and development support.

- Consider your safeguarding pathways and responsibilities. It may be that you need to put in place training and support for GPs, pharmacists, ANPs and other allied health professionals.

- Opportunity to improve GP involvement in medicines management (see Medicines management guide).

- Evaluate the burden on GP workloads at agreed intervals.

- Consider how you may improve the skill-mix of nursing staff.

- Utilise clinical leads effectively to advocate for change and professional development.

- Recognise how transfer of care can be improved through better informed GPs and care home teams, together with more effective communication between hospital teams and care home teams.

- Whatever model is chosen, make sure to involve community / district nursing teams in the roll out.
Things to consider - evaluation and metrics

Potential metrics to consider:

**KPIs or metrics for aligned GP/nurse service:**
- Number of planned visits to the care home.
- Number of reactive visits to the care home.
- Number of patients who have died in their preferred place of care.
- Reduction in prescribing / inappropriate polypharmacy.
- Nutritional supplements.
- Increase in number of residents with a personalised care plan, comprehensive or holistic care record.
- Number of Comprehensive Geriatric Assessments or similar holistic assessment reviewed.

**System-wide metrics:**
- Non elective admission reductions.
- Outpatient appointments reductions.
- Reduction in A&E attendances.
- Reduction in Ambulance call outs and conveyances.
- Practices developing a full healthcare plan within eight weeks of admission.
- A review for each unplanned admission to the hospital of the care offered and whether the admission could be avoided.
### Challenges and solutions (1/2)

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Solutions / Mitigations</th>
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<tbody>
<tr>
<td>How do you measure the success of the contract?</td>
<td>Consider process KPIs, patient reported improvement in quality of care, impact on admissions and callouts. Be flexible in how you seek information and be prepared to evolve the service, and monitoring of impact over time.</td>
</tr>
<tr>
<td>Securing and maintaining GP interest and support.</td>
<td>Start small and get some demonstrable wins and GP supporters. Highlight potential in terms of pro-active, planned care, reduced time, improved quality. Explain that GPs will inherit patients in the link home and lose patients in other homes to their new link GP. Share and co-develop your strategic vision - how does this support the aims of your STP and local UEC system?</td>
</tr>
<tr>
<td>High care staff turnover.</td>
<td>Positive impact on care staff roles – greater empowerment and work satisfaction, which in turn should lead to greater retention. Learning and development / champion opportunities can foster a sense of a career and aspirations for paid carers.</td>
</tr>
<tr>
<td>Risk of implementation being limited to ‘keen’ practices.</td>
<td>Engage the local LMC and any GP Federation(s), to co-develop your plans. Foster a sense of this being a system-wide priority.</td>
</tr>
<tr>
<td>Building trust and mutual respect between care home staff and visiting clinicians.</td>
<td>Facilitate relationship building between practices and care homes through care home forums. Consider embedding a requirement for clinical staff in community and acute trusts to spend a day working as a carer in the care homes they work with. Consider joint training for staff and joint leadership development initiatives.</td>
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### Challenges and solutions (2/2)

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<th>Solutions / Mitigations</th>
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<tr>
<td>Cost to the GP of providing the service to care homes / Limited time allocated to visits from GP practice.</td>
<td>Look at alternative delivery models involving nurse physicians, AHPs and district nurses. Consider if you can reduce duplication between professionals and how to embed enhanced primary care support as part of your MDT. Make the time to explain the potential benefits in time reduction for GPs as a result of fewer reactive callouts and managed, planned care.</td>
</tr>
<tr>
<td>Responding to different resident turnover, quality of home, type of residents.</td>
<td>Consider offering localities an opportunity to change the payment structure based on their geography, demographics and number of residents, within your current financial envelope and standard expectations.</td>
</tr>
<tr>
<td>Duplication of effort (real or assumed).</td>
<td>This is about GPs, other primary care professionals, care home staff and district nurses working together, to improve care and reduce duplication. Consider how you could introduce joint ward rounds and improve communication between professionals to make lives easier.</td>
</tr>
<tr>
<td>Workforce may not be ready which results in variation in the quality of the delivery of the contract from GPs and impact in care homes.</td>
<td>An enhanced service specification on its own will struggle to succeed. Combine your support for aligned GPs and ward rounds with an MDT approach, and cross-organisational support around education, reflection, and peer review, responding to the needs of GPs and homes.</td>
</tr>
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Material to support your implementation

Specifications and KPIs

- Wakefield – Service specifications
- Wakefield - Enhanced Primary Care KPIs
- E+N Herts - Enhanced Primary Care Support to Patients in Nursing & Residential Homes service specification
- Modality – Enhanced primary care service profile

Preparing to implement

- E+N Herts – targeted support questionnaire for care homes
- Wakefield – service mapping example
- Wakefield – lessons learned so far

Newcastle Gateshead – resources for Comprehensive Geriatric Assessment (CGA)

- Baseline Comprehensive Assessment and Personalised Care Plan
- Root Cause Analysis (RCA) of Avoidable Admissions and Associated Action Plan

Vanguard presentations and briefing

- East & North East & North & North
- Newcastle Gateshead Aligned GP Service
- Wakefield Aligned GP Service
- Airedale and Partners – aligned GP
- Nottingham City – aligned GP
- Sutton Care Homes CoP

Contracts and job descriptions

- Newcastle Gateshead - Primary Care GMS Sub Contract
- Newcastle Gateshead - GP Compact Agreement
- Nottingham City - GP LES Contract Variation 2017-18
- Job Description – Band 7 Link nurses

Newcastle Gateshead – resources for Comprehensive Geriatric Assessment (CGA)

- Resident Review Assessment Form
- GP registration letter (move / existing resident)
- Newcastle Gateshead – Community Geriatrician Service – taking CGA into Primary Care
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Material to support your implementation

Newcastle Gateshead’s Enhanced Primary Care Suite

- **Enhanced Primary Care Suite**
  - Service Specification
  - Costs for 15/16
  - Delivering Enhanced Care
    - How it works
  - Care Home Care-Planning Guide
  - GP Ward Round Audit Presentation
  - GP Ward Round – Case Study
  - Virtual Ward Round – Case Study
  - Virtual Ward Round Guide
  - Virtual Ward Round Presentation

- **Newcastle Gateshead - Providing Enhanced Healthcare in Care Homes: a guide to replicating our model**

Impact of enhanced support for care home residents in Rushcliffe

- **NHS England / Impact Analytics Unit evaluation**

National guidance NHS England

- **Primary care commissioning, NHS England**
- **Policy book for primary medical services**
- **Commissioning development: Key facts**
- **Enhanced services commissioning: Key facts**
- **Securing excellence in commissioning primary care**
- **Securing excellence in commissioning primary care: Annex 2 tasks and functions**
- **Individual GP metrics**

Impact of enhanced support for care home residents in Rushcliffe

- **NHS England / Impact Analytics Unit evaluation**

National work on frailty

- **National work developing on Electronic frailty index- Frailty and GP Contract**
- **Rockwood Clinical Frailty Scale**
## Implementing enhanced primary care – to do list

1. **Respond to the starting point of local relationships** - speak to GPs and care homes to understand their needs and the quality of enhanced primary care residents already receive.

2. **Understand and map any local initiatives**, the local starting point in terms of GP callouts, A&E attendances and levels of assessment and care planning.

3. **Co-develop new service specifications and KPIs with care homes and primary care.** Agree a set of common metrics to monitor at the beginning of implementation and revisit these as needed.

4. **Consider what absolutely must be done by a GP and what can be done by other roles (including Advanced Nurse Practitioners) as part of an MDT approach?**

5. **Ensure that the aligned GP and ward round model is not implemented in isolation from other local work on the EHCH care model and other community and social services.**

6. **Consider how your chosen model of Enhanced Primary Care addresses inequity of access to services?** How will you serve different localities?

7. **Implement and roll-out the intervention in a measured and staged fashion – seeking feedback from care home staff, GPs, aligned nurses and residents to improve and develop it as your area proceeds.**

8. **Build over time to a position where you can implement Comprehensive Geriatric Assessment or a similarly robust holistic assessment and care planning model, including a focus on frailty.**

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- East Lancashire CCG / Airedale and Partners Enhanced Health in Care Home Vanguards
- Nottingham City Enhanced Health in Care Homes Vanguard
- Connecting Care Wakefield Enhanced Health in Care Homes Vanguard
- NHS England Primary Care Commissioning, Medical Directorate