Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG Primary Care Commissioning Committee (PCCC)

Date: 26th May 2020
Time: 9.00am – 11:00am
Location: Virtual meeting to be held via Microsoft Teams. Details to be included in the calendar invite.

Agenda Number :	13
Title:	Primary Care and Community Support to Care Homes
Purpose: For Information	
Key Points for Discussion:	
The purpose of this paper is to update the Committee on the status of the covid-19 care home support model and the emerging work to support the enhanced health in care home DES.	
Recommendations:	The Committee are asked to note the contents of this report and the ongoing work to provide a comprehensive primary and community Covid 19 response to supporting care homes in BNSSG.
Previously Considered By and feedback :	PCOG, discussed and agreed approach with support from Area Teams and the LMC
Management of Declared Interest:	Not Applicable
Risk and Assurance:	Risks are highlighted in body of this paper.
Financial / Resource Implications:	Financial implications are highlighted in the body of this paper
Legal, Policy and Regulatory Requirements:	There are no specific legal implications highlighted within this paper. Any contractual change requests will be considered via separate papers and will include any relevant legal implications.
How does this reduce Health Inequalities:	The care home support service will ensure complete coverage of all care homes registered with the CQC. This will reduce health inequalities given that there isn't currently 100% coverage.
How does this impact on Equality & diversity	Monitoring of practice demographic information will help to highlight areas of variation of services, which will then be addressed accordingly.

Patient and Public Involvement:	Whilst there has not been consultation and communication with the public in the production of this paper, patient experience and public involvement is recognised as an important factor in reviewing and gaining assurance regarding primary care services.
Communications and Engagement:	We will work with the communications team to support proactive communication to the public to highlight practice support care to homes during the covid-19 crisis.
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Sponsoring Director / Clinical Lead / Lay Member:	Martin Jones, Medical Director, Primary Care and Commissioning

Agenda item: 13

Report title: Primary Care and Community Support to Care Homes

1. Background

In light of Covid-19 general practice has received several communications from NHS England to support them to deliver their contractual requirements during this time. On 29 April 2020 Sir Simon Stephens formally announced that the NHS is now entering phase two of its response to the COVID-19 emergency. Dr Niki Kanani, on behalf of NHS England, wrote out on 1 May 2020 to outline the specific role that primary care will need to take in response to this new phase. The letter outlined several commitments in relation to primary and community health support to care home residents and the proactive action that needs to be taken by the end of May 2020.

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/COVID-19-response-primary-care-and-community-health-support-care-home-residents.pdf

The letter presented the expected care home support model to be implemented across all care homes. It acknowledged that, in many areas, the model is already established. Where there are local arrangements that go beyond the service model presented, these should continue without disruption. Where the model does not exist the letter emphasised the urgent need to establish support working with CCGs, general practice, community service providers, care homes, LMCs (GP and Pharmacy) and wider partners in the area.

In particular it was highlighted that practices and community providers will want to ensure:

- timely access to clinical advice for care home staff and residents
- proactive support for people living in care homes, including through personalised care and support planning as appropriate
- care home residents with suspected or confirmed COVID-19 are supported through remote monitoring – and face-to-face assessment where clinically appropriate – by a multidisciplinary team (MDT) where practically possible (including those for whom monitoring is needed following discharge from either an acute or step-down bed) and
- sensitive and collaborative decisions around hospital admissions for care home residents if they are likely to benefit

Primary Care Networks have been identified as the level for which primary care delivery should be organised. The letter confirmed the intention that from 1 October 2020, the model will be adapted to support the service specification already set out in the Network Contract DES.
In order to implement the clinical service model presented in the letter, the following steps will need to implemented

- Delivery of a consistent, weekly 'check in', to review patients identified as a clinical priority for assessment and care (to be delivered remotely where appropriate)
- Development and delivery of personalised care and support plans for care home residents
- Provision of pharmacy and medication support to care homes

To deliver this support it is requested that CCGs take immediate steps to:

- Support individual practices and community health services teams to organise themselves according to their local areas or networks.
- Ensure that clear and consistent out of hours provision is in place for each care home
- Work with secondary care providers to ensure they will accept referrals and admissions from care home residents where clinically appropriate (considering individual care and support plans)

In regards to scope and timescales, the letter confirmed that:

- Support should be delivered for all care homes (CQC registered with or without nursing)
- Model to be established as soon as possible within a fortnight at the least in order to support residents as quickly as possible (15 May 2020)
- Additional costs for general practices and community health services providers, which cannot be met from their existing resources may be eligible for reimbursement.

2. Proposed CCG approach to taking forward this work

In order to take this forward a small working group has been established to meet twice weekly which reports to the Care Provider Cell and make the required links to the Primary Care Cell. Membership includes:

- Kate Rush, Medical Director and Mary Lewis, Director of Nursing – Sirona
- Miriam Ainsworth, Chair of the LMC
- Carol Watson, Head of Adult Care Commissioning, Bristol City Council
- Greg Penlington and Lindsay Gee, Heads of Locality Development BNSSG CCG
- Harriet Soderberg and Eliot Waters, Service Improvement Facilitators BNSSG CCG
- David Moss, Jenny Bowker, and Louisa Darlison, CCG Primary Contracting and Primary Care Development
- Mike Jenkins and Geeta Iyer CCG Clinical Leads
- CCG BI
- Rob Ayerst – Head of Finance Primary and Community Care BNSSG CCG
- Debbie Campbell, Deputy Director Medicines Optimisation BNSSG CCG
- Anne Whitehouse, Deputy Medical Director, Brisdoc Healthcare Services

3. Mapping of our local offer against the national requirements

We have a strong foundation to build on in BNSSG as we have a Local Enhanced Service which encompasses the key aspects of this clinical model and the Care Provider Cell has worked hard to develop a WrapAround support offer to care homes providing access to a 24/7 SPA operated by Sirona. The Wraparound Support Team provides proactive, pre-emptive and reactive non-emergency healthcare advice and general support to providers.

During Covid-19 the team make weekly contact with each care home to discuss any issues the home may have, not just those relating to Covid. The purpose of this contact is to:

- Provide support and advice to care providers in caring for residents
- Develop strong working relationships with care providers
- Early identification of issues and /or homes requiring targeted support
- Identification of training requirements
- Signposting homes to resources available including mental health and wellbeing support
- Provision of clinical support and advice regarding individual residents

The WrapAround Support service is a joint health and care service connecting Care Homes to support within the Local Authorities as well as to health support. Furthermore, Sirona has mobilised named clinical leads to support all our care homes as part of the covid response in addition to their contract requirements which includes proactive support to care homes from community teams.

A comparison of the national requirements against the corresponding indicators within the BNSSG GP Practice Support to Care Homes LES is attached at Appendix 1. Out of Hours primary medical support to care homes is available through the SevernSide Integrated Urgent Care service. In addition, nursing homes have access to support from the professional line run by BrisDoc.

4. Primary Care Support to Care Homes as at April 2020

BNSSG CCG has had a local enhanced service in place for GP Support to care Homes for several years. The specification was reviewed and re-launched for 19/20. Following the announcement of the Enhanced Health in Care Home Support Direct Enhanced Service, it was agreed that the current LES would roll forward at least until the anticipated start date of the national specification from 1 October 2020. During this time the CCG had committed to a full review across the two schemes and develop a transition plan.

Under the existing local enhanced service there are approximately 246 homes covered with support to 5,346 beds.

It is likely less than 246 homes are covered in reality given that there are some duplicate homes in the source data, reflecting current arrangements where multiple practices can support a single home in a few exceptional circumstances.

5. Work required to Establish Full Coverage to Care Homes May 2020

Before the release of the letter Primary care contract / development teams were already in the process of establishing a process to support alignment of care homes with a single PCN.
As set out in the network contract specification 2020-21 PCNs are required to agree with the commissioner the care homes for which the PCN will have responsibility (PCN's aligned care homes). The CCG holds the ongoing responsibility for ensuring that care homes within our geographical area are aligned to a single PCN and therefore may, acting reasonably, allocate a care home to a PCN if agreement cannot be reached. It should be stressed, however, that the preferred approach is for the CCG to reach mutual agreement with PCNs.

For the purposes of this enhanced service a care home is defined as a 'CQC-registered care home service, with or without nursing. Whether each home is included in the scope of the service will be determined by its registration with CQC'.

The CCG Business Intelligence team has mapped each care home (CQC registered with / without nursing) to a single PCN. The mapping has been done based on straight line distance between the home and nearest practice (including branch), then assigned to the relevant PCN.

Based on the scope defined above there are 291 care homes and 8,046 beds that will require support under this model. Based on the coverage established through the LES there is therefore a gap to address.

An initial comparison between the two data sources (CQC / CCG LES) has identified potentially 110 homes that require cover under this scheme. This list will be further refined and is expected that this number will decrease.

It is important to note that there may be some differences in the homes supported through the LES and the CQC list provided to support the DES and these may need to be worked through on a case by case basis. Examples include a small number of homes at the border with other CCGs where pragmatic decisions may need to be made in relation to Local Authority boundary and predominant GP practice registration of the residents.

Given the context set out work is now progressing at considerable pace to align PCN and practice support to care homes.

It should be noted that the Covid Wraparound team model extends to all Care Providers including Extra Care Housing. These may not be included in the CQC list required to support the PCN DES scope and Extra Care Housing is out of scope for the LES.

6. Enablers to Support Moving to Full Coverage at Pace

We recognise that practices will require financial support to establish this model at pace, have the managerial time to broker and negotiate coverage as well as support the additional clinical delivery required.

As part of COVID-19 PCNs are in receipt of a PCN Support payment. This is recycled from the investment and impact fund and is paid monthly until the end of September 2020.

The GP contract has also introduced a Care home Premium payment, paid monthly from August. The introduction of this payment was to recognise the variation of distribution of care homes across PCNs, noting that the full resourcing was to come from the Additional Roles Scheme. To illustrate distribution across PCNs is widely varied across BNSSG:

PCN Name	Number of Care Homes	Number of Beds	PCN actual list size (1 Jan 2020)	Heads of population per bed
4PCC PCN	15	389	53,355	137.16
Affinity PCN	21	728	50,414	69
Bridge View PCN	2	224	37,520	168
Network 4 PCN	31	646	69,212	107
Connexus PCN	13	307	53,945	176
FABB PCN	13	317	37,962	120
FOSS PCN	13	150	46,532	310
Gordano & Mendip PCN	22	800	96,261	120
Healthwest PCN	5	174	71,114	409
Bristol Inner City PCN	9	255	84,906	333
Northern Arc PCN	17	417	43,173	104
Phoenix PCN	10	252	38,233	152
Severnvale PCN	8	299	31,879	107
The Stokes PCN	7	211	59,758	283
Swift PCN	9	277	76,692	277
Tyntesfield PCN	6	240	32,757	136
Pier Health PCN	72	1799	94,455	53
Yate & Frampton PCN	17	473	57,601	122
Total	**290**	**7958**	**1,035,769**	**130**

7. Communication With PCNs and Practices

Communications about the NHSE primary and community support to Care Homes has been shared within the daily shared CCG/One Care/LMC bulletin. In addition, the proposed approach has been discussed at the Covid 19 Primary Care Cell, the Covid 19 Locality Cell including PCN Clinical Directors and at each of the CCG practice membership meetings in May. The LMC is an active partner in the primary and community care homes working group and a separate CCG and LMC clinical leads meeting was held to agree principles about the approach.

All practices and PCNs received a letter on Friday 15 May that presented the output of the mapping exercise. The letter requested that PCNs submit a return by close of play Friday 22 May 2020 that confirms if they accept the homes that have been 'allocated' to them. The contracts team will review the initial returns in order to establish those that remain uncovered. Further work will then begin to negotiate with practices and PCNs and progress through any identified issues as we work towards achieving full coverage. A clear commitment was made to giving PCN Clinical Directors and leadership teams support to negotiate and agree coverage from the CCG Area Directorate teams and also from the LMC.

8. Reporting to NHS England

NHS England has instigated a SitRep to report progress on the roll out of the Covid-19 care home support model. The first return was submitted on Wednesday 13 May, with subsequent returns due each Friday on a weekly basis.

Care Homes

3. What percentage of practices have implemented (directly or through arrangements with other providers) for their registered care home population the following elements of the COVID-19 care home support model?

   3a. Weekly 'check ins'. 100 %

   3b. A process for the development of personalised care and support plans. 73 %

   3c. Clinical pharmacy support, including medication reviews to care home residents. 40 %

4. What percentage of practices are delivering the COVID-19 care home support through a network or other 'at scale' collaboration? 15 %

5. For each care home within the CCG boundary (as set out in accompanying guidance), does the care home have:

   5a. All three elements of the COVID-19 care home support service in place?

   5b. A named clinical lead?

Please upload your completed template with the answers to question 5 here: *

The first update submit required the submission of a spreadsheet that listed each care home for which we had to indicate:

If all three elements of the covid-19 care home support service is in place
If the home has a named clinical lead

For this purpose we reported that 181 homes have all three elements in place, with all 291 homes having a named clinician. This has been supported by the roll out of the wrap around team model.

Rolling out practice coverage will help us to increase our response to support for care planning. A key gap is clinical pharmacy support to care homes. Further national guidance has been established to support pharmacy and medicines support to care homes in recognition of potential supply and workforce challenges. Debbie Campbell, Deputy Director Medicines Optimisation has established a medicines and pharmacy support to care homes working group to deliver this aspect of the requirements. This group is baselining existing provision against

the national guidance and developing plans for increasing pharmacy support to care homes drawing on the system clinical pharmacy workforce in recognition that the PCN clinical pharmacist workforce will need extra support.

9. Financial resource implications

It has been agreed that where a practice now agrees to support a home not currently part of the CCG LES they will be paid for the beds at the current LES rate at least until 1 October 2020. Funding after this point is yet to be agreed and will form part of the wider review of the LES and DES.

The current enhanced service is paid as follows:

£230 per bed per year (nursing Home)
£120 per bed per year (residential Home)

The CQC database presents 85 homes categorised as having nursing (3,934 beds), 196 homes without (3,398 beds) and 9 homes that fall under both categories (626 beds)
Of the estimated 110 homes without cover there are approximately 782 beds with nursing and 1,181 beds without (74 fall into both categories).

Care Home With Nursing £179,860 (per full year)
Care Home without Nursing £141,720 (per full year)

10. Legal implications

There are no specific legal implications highlighted within this paper. Any contractual change requests will be considered via separate papers and will include any relevant legal implications.

11. Risk implications

The timescale to deliver the new model of care is very challenging – the CCG and LMC are offering support to PCNs which need help. Collaborative work sponsored through the Care Provider Cell will ensure a multi-disciplinary approach which will help with making the most of our shared resources.

We may not achieve full coverage despite negotiations with PCNs. The CCG are able to 'allocate' a home to a PCN. However, contractually the terms of the DES do not begin 1 October with the assignment due to be completed originally by 31 July 2020.

This roll out represents a cost pressure to the CCG, however, NHSE guidance is clear that delivery of this model can be reimbursed through national Covid 19 funds where these costs cannot be met locally.
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12. Implications for health inequalities

Proposals to roll out full coverage of practice and PCN support to care homes will reduce inequalities.

13. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

Proposals to roll out full coverage of practice and PCN support to care homes will reduce inequalities.

14. Consultation and Communication including Public Involvement

There is an established communications bulletin with Care Providers that can be used to communicate key messages to Care Homes. Choice of GP registration remains for residents. Communicating the benefits of aligned practice support to care homes will be key. The CCG will work with the communications team to develop proactive communications which can be shared with care homes and residents and support practices in developing relationships.

15. Recommendations

The Committee is asked to note the contents of this report and the ongoing work to provide a comprehensive primary and community Covid 19 response to supporting care homes in BNSSG.

Report Author: **Louisa Darlison, Senior Contract Manager Primary Care and Jenny Bowker, Head of Primary Care Development**
Report Sponsor: **Martin Jones, Medical Director Commissioning and Primary Care**

Glossary of terms and abbreviations

Please explain all initials, technical terms and abbreviations.

APMS	Alternative Provider of Medical Services - Type of GP contract
GMS	General Medical Services – Type of GP contract
PMS	Personal Medical Services – Type of GP contract

Appendix 1

COVID-19 response: Primary care and community health support care home residents mapping

NHSE requirement	GP Support to Care Homes LES
Delivery of a consistent, weekly 'check in', to review patients identified as a clinical priority for assessment and care. **i.**The weekly check in should: i. be delivered – primarily remotely wherever appropriate – by an MDT where practically possible, drawing on general practice and community services staff and expertise, including advanced nurse practitioners, clinical pharmacy, social prescribing link workers, dental care, and wider specialist services (eg geriatrician and dementia services) where appropriate — ii. review patients identified as a clinical priority for assessment, including but not limited to those with suspected or confirmed COVID-19 symptoms, in line with the protocols established in the primary care standard operating procedures and the community services standard operating procedures — iii. support the provision of care for those patients identified as a clinical priority — iv. include appropriate and consistent medical oversight and input from a GP and/or geriatrician (with the frequency and form of that input determined by clinical judgement) — v. support the introduction and use of remote monitoring of COVID-	Providing regular routine surgeries (Community Ward Rounds) plus urgent surgeries as needed in the Care Home. The GP practice can support these through a Multidisciplinary approach. It is encouraged that practices invite clinical pharmacists on Community Ward Rounds in order to facilitate medication review and optimisation. To provide pro-active care effectively the frequency of the ward rounds should be at least fortnightly, some larger homes may need more regular visits. The CCG would expect that frequency of Community Ward Rounds will be reviewed on an individual basis. Any home visits made outside of the Community Ward rounds will come under core Primary Medical Service.

19 patients using pulse oximeters and other equipment (which may be supplied directly to care homes or eligible for practice reimbursement), and prescription and supply of oxygen to care homes for treatment, where clinically indicated and — vi. be supplemented by more frequent contact with the care home where further needs are identified.	
— **Development and delivery of personalised care and support plans for care home residents.** A process needs to be established to: i. Support development of personalised and individually agreed treatment escalation plans for care home residents with care home teams, including end of life care plans and preferences where appropriate and drawing on available guidance and templates	Advanced Care Planning including 6 monthly reviews that will be continually updated to measure the patients changes particularly as they approach End of Life (a continuous living document). This will take into account any cross organisational communication form regarding the patient's wishes regarding their treatment, such as the ReSPECT form. Lead GP Practice will be expected to undertake care review within one weeks of patient arriving at the care home.
c) **Provision of pharmacy and medication support to care homes.** CCGs, PCNs and practices should co-ordinate pharmacy teams (including CCG employed pharmacists and pharmacists working as part of the Medicines Optimisation in Care Homes (MOCH) programme) to provide support to care home residents and staff. This support should include: — i. facilitating medication supply to care homes, including end of life	Lead GP Practice will take the lead for clinical review of medicines. Wherever possible, medication review should be undertaken in conjunction with clinical pharmacists. Medication reviews at least annually in line with NICE SC1 Managing medicines in care homes. Reviews should focus on medicines optimisation and polypharmacy. Consider using a screening tool (for example, the STOPP/START tool in older people) to identify medicine-related safety concerns and medicines the person

medication — ii. delivering structured medication reviews – via video or telephone consultation where appropriate - to care home residents — iii. supporting reviews of new residents or those recently discharged from hospital — iv. supporting care homes with medication queries, and facilitating their medicines needs with the wider healthcare system (eg through medicines ordering). — —	might benefit from but is not currently taking. Reviews should focus on safe prescribing, appropriate monitoring, prevention of medicines related adverse events/admissions, reducing medicines waste, and cost effective prescribing. Anticipatory Medicines (Just In Case Medicines, JIC) for end of life should be prescribed as appropriate for care home residents.
To deliver this support, CCGs should take immediate steps to support individual practices and community health services teams to organise themselves according to their local areas or networks. Existing PCN arrangements should be the default. A network approach to delivery – backed by appropriate information sharing arrangements – will ensure that individual care homes have a single point of access for the majority of their residents and should reduce the infection control risks associated with multiple teams visiting individual care homes. As part of this process, networks should identify a named clinical lead for each care home.	LES requires practices to map themselves to one practice per care home or one per unit/floor for larger care homes – note coverage
CCGs must ensure that clear and consistent out of hours provision is in place for each care home. Out of hours provision to care homes may be provided via out of hours providers and	

community health services and should include arrangements for the supply and availability of medication through community pharmacy or other routes. This support must be clearly signposted to care homes.	
Secondary care providers should accept referrals and admissions from care home residents where clinically appropriate, considering individuals' care and support plans and the benefits and risks of escalation to hospital-based care.	