COVID-19 Care Homes Scheme Directed Enhanced Service Specification

Strategic Context

1. The onset of the Covid-19 pandemic in March 2020 resulted in a review of all general medical services (GMS) activity. The Care Homes Directed Enhanced Service (DES) was suspended along with other enhanced services to enable practices to plan how to deliver GMS at the peak of pandemic. Whilst the Care Homes DES was suspended, payments to practices have been maintained to ensure financial stability for practices. The suspension of the DES did not detract from the need for practices to continue to support care homes and residents of care homes are entitled to access essential services the same as any other registered patients.

2. The prevalence of Covid-19 and mortality rate within care homes came into sharp focus across the UK during mid-April 2020. In Wales, this led all health and social care organisations to re-examine their roles and delivery of service to the care home sector. Within Welsh Government it prompted establishment of a Task & Finish group to look at what changes were necessary to service delivery to minimise harm and provide safe care in the community.

3. The work of the Task & Finish group provided the foundation for extremely positive discussions with BMA on how general practice can continue to deliver high quality care and support to care homes and their residents during the Covid-19 pandemic. As a result Welsh Government, BMA and Health Boards agreed the Care Home DES should be refocused to address the support needed during the Covid-19 pandemic with a revised service specification. This enhanced service specification will expire on 31 March 2021, and will be replaced with a Care Homes DES negotiated with the BMA.

Application of the Directed Enhanced Service (DES)

4. The legal definition of “care home services” in relation to Wales is set out at **Annex A**. In line with that definition, a “care home” for the purposes of this DES is a place in Wales at which accommodation, together with nursing or care, is provided to persons because of their vulnerability or need. The definition does not distinguish between a nursing home and a residential home. For the avoidance of doubt, the Care Homes DES applies to nursing homes and residential homes.

The Aims of the DES

5. During the period of the Covid-19 pandemic the COVID-19 Care Homes Scheme is designed to:

    - Optimise access to primary medical care for care home residents

- Enable urgent access to primary medical care advice for care home staff
- Continue provision of pre-emptive proactive and anticipatory care
- Promote a high quality consistent approach across health boards whilst at the same time being flexible enough to be adopted by clusters or individual practices

Delivery

6. Delivery of the DES can be through the residents' current GP practice ensuring continuity of care; or through a single GP practice as lead on behalf of a group or cluster of GP practices ("a cluster lead practice"); or another service delivery model such as a health board delivered service where a GP practice is unable to provide and no cluster arrangements are agreed. Whichever model is used, the practice delivering the DES, either for itself or on behalf of a cluster or group of practices, will be the "engaged GMS contractor".

Service Specification

7. The specification of this DES is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential and additional services. No part of the specification by commission, omission or implication defines or redefines essential services or additional services. The General Practitioner Committee guidance for GPs on "Treating patients in private hospitals, nursing and residential homes" states "All UK residents have a right to be registered for primary medical services with an NHS practice… (GPs) would be expected to attend residential and nursing homes as appropriate." Global Sum calculations take account of additional work associated with caring for an older population. In delivering this enhanced service the engaged GMS contractor must:

    a. Regularly and effectively engage with care home staff in the comprehensive management of care home residents on a weekly basis, termed for the purposes of this DES a "weekly ward round", followed up where necessary with structured clinical consultations to care home residents,

    b. Allow General Medical Practitioners to support a multi-disciplinary team to provide comprehensive management of care home residents and ensure appropriate assessments are completed,

    c. Work with the cluster lead practice, local general medical practices and care home managers, to reduce the numbers of clinicians and community staff that need to visit care homes during the Covid-19 pandemic, e.g. by streamlining patient registration policies where it will benefit care to residents whilst preserving and respecting residents' choice.

<u>Initial Resident Review</u>

8. Each care home resident must have a comprehensive review of their mental and physical health completed within 28 days of moving in / being admitted to the care home. A pro-forma template outlining the areas for review is at **Annex B**. The care home will hold a copy of the completed initial patient review. The assessment can be conducted via remote audio-visual means when the home and resident are more comfortable from an infection control point of view. This review will include discharge medicines review to:

- reconcile medicines prescribed,
- address issues of polypharmacy,
- address any antipsychotic prescribing and other high risk medicines, and
- update the record of prescribed medicines, maintained by the GMS contractor.

9. A multi-professional team approach to the health assessment will be necessary and flexible to suit differing GP cluster models / service models. The multi-professional team can include, for example, clinical pharmacists, dieticians, optometrists, physiotherapists, chiropodists, podiatrists. There is no expectation a GP will personally deliver all aspects of the holistic assessment, but will be responsible for recommending the assessment and appropriate referral.

<u>Provision of Care</u>

10. The engaged GMS contractor is responsible for establishing weekly contact with care home management to discuss registered patients of concern and where indicated after discussion, to provide structured clinical consultations to care home residents on a weekly basis, termed a “weekly ward round”. Clinicians should aim to provide consultations during a physical visit, but may deliver them using remote video consultation at the request of the care home for the purpose of infection control. When using remote video the clinician must ensure the patient health needs are fully met and where deemed clinically necessary a face-to-face assessment is offered**.**

11. The engaged GMS contractor is responsible for providing urgent clinical advice to care home staff providing care to care home residents. The aim is to ensure care home staff are fully supported in providing care to their residents, the residents receive an optimum level of care and are able to receive care in the place that is their residence for as long as is clinically appropriate, taking account of the needs and wishes of the patient.

12. A structured patient medication review for each care home resident must be undertaken during each year. Where appropriate, healthcare professionals such as a practice nurse or a pharmacist can support a GP to undertake the review. More regular medication reviews will be undertaken as clinically appropriate to reduce the risk to patients, with particular reference to polypharmacy, antipsychotic prescribing and other high risk medicines.

<u>Provision of Advice</u>

13. Under **essential** services, a contractor is already responsible for providing clinical advice to staff providing care to care home residents.

Under this Care Home **Directed Enhanced Service**, the engaged GMS contractor must also have a telephone system in place between 8:00 and 18:30, Monday to Friday, which ensures care home staff receive an appropriate response to a request for urgent clinical advice.

14. **The engaged GMS contractor may choose to receive such requests via either;**

    a. a separate protected telephone number to ensure telephone calls from care homes are answered promptly. This number should not usually be used for routine requests, prescription ordering or general queries. Its use should be protected within the practice for incoming calls only, or

    b. a dedicated mobile phone used only for this purpose.

    The engaged GMS contractor is responsible for notifying the care home of the method of communication and must notify the health board of the telephone number, for audit purposes only.

15. The **response to the request for urgent clinical advice, must in the first instance be a telephone call** from an appropriate clinician, who is competent to deal with the clinical problem, in normal circumstances **within 15 minutes** of the request.

Mortality Review

16. The engaged GMS contractor will engage in and support where appropriate a death review through significant event analysis of the care of a patient who dies within a care home setting or within 7 days of admission to hospital from a care home. However, deaths within care homes are frequent events and so where the death is natural, expected, the death certificate does not include Covid-19 as a cause of death and involved an advance care plan, then these death reviews may simply be undertaken as brief reflections of these circumstances, rather than a full SEA.

Accreditation

17. The engaged GMS contractor itself or as cluster lead practice, or the GP acting as lead for the service delivery model, will take responsibility for ensuring all staff delivering the enhanced service are appropriately trained, qualified, competent and supervised.

Payment

18. Health Boards must commission this enhanced service. All agreements to enter into these arrangements must be in writing.

19. A maximum payment of £270 will be available per registered patient in respect of each financial year. These payments should be made either monthly or quarterly upon the submission of a claim to the relevant health board by an engaged GMS contractor (whether acting for itself or as a cluster

lead practice). These claims must be accompanied by a list of residents residing in care homes within the practice area on the last day of the quarter to which the claim relates and who are registered as patients with the claiming GMS contractor.

20. For those patients which are registered with the medical practice providing the DES, or a practice which forms part of a group or cluster the patients receive the service from, the engaged GMS contractor for itself or as the cluster lead practice will make the claim for payment.

21. Where the death of a registered patient occurs during a financial year, the engaged GMS contractor is able to claim the full payment for that year as long as the initial review has been completed. If the review has not been completed by the date on which the death occurred, no payment may be claimed.

22. If a registered patient resides in a care home for up to 6 months of the relevant financial year, 50% (£135) of the annual payment may be claimed.

23. If a registered patient resides in a care home for up to 9 months of the relevant financial year, 75% (£202.50) of the annual payment may be claimed.

24. If a registered patient resides in a care home for over 9 months of the relevant financial year, 100% of the annual payment may be claimed.

25. Engaged GMS contractors may only claim up to the maximum annual payment of £270 per registered patient in any financial year. It may therefore be necessary to undertake a process of financial reconciliation at the end of the financial year.

26. Engaged GMS contractors are required to agree they will not receive a retainer from a care home if they opt to offer the provision of this DES. Signed completion of the practice declaration below serves as confirmation of the engaged GMS contractor's agreement to this requirement.

Monitoring and Payment Arrangements

27. The health board may make contact with care homes in order to appraise their satisfaction with the provision of this DES throughout the course of the year. Health boards may ask for evidence of resident numbers from the care home and how the engaged GMS contractor undertakes the enhanced service as part of its post payment verification process. Health boards may also review the patient records held by the engaged GMS contractor at the practice as part of the post payment verification process.

Review of the DES

28. This DES specification is for delivery during the Covid-19 pandemic and will last until at least 31 March 2021. The effectiveness of this DES in meeting

the needs of care home residents and staff will be considered as part of an overall review of how general medical services are provided to care home residents, the review is expected to be conducted before expiry of this enhanced service.

Disputes

29. Any disputes arising will be dealt with in the prescribed way. Health boards and engaged GMS contractors should make every effort to resolve the dispute locally before formally submitting it through the NHS dispute resolution procedure

Practice declaration

30. The engaged GMS contractor, for itself or as cluster lead practice on behalf of a group / cluster of GP practices or the GP acting as lead for the service delivery model has understood the terms of the COVID-19 Care Homes scheme and is seeking to provide a service on this basis.

31. If commissioned, the engaged GMS contractor for itself or as cluster lead practice acting as lead on behalf of a group / cluster of GP practices or the GP acting as lead for the service delivery model, will adhere to the terms of the COVID-19 Care Homes scheme.

Signed: _____

As GP principal representative of the engaged GMS contractor

As GP principal representative of the engaged GMS contractor acting as cluster lead practice on behalf of a group or cluster of GP practices

GP acting as lead for the service delivery

* Please delete as appropriate

Date: _____

Annex A

Definition of Care Home

The definition of "care home services" in relation to Wales is set out in paragraph 1 of Schedule 1 to the Regulation and Inspection of Social Care (Wales) Act 2016[1]. It states:

1 Care home services

(1) A *"care home service"* is the provision of accommodation, together with nursing or care at a place in Wales, to persons because of their vulnerability or need.

(2) But accommodation together with nursing or care provided at the following places does not constitute a care home service—

(a) a hospital;
(b) a school (but see sub-paragraph (3));
(c) a residential family centre;
(d) a place providing a secure accommodation service;
(e) a place providing accommodation for an adult arranged as part of an adult placement service.

(3) Accommodation together with nursing or care provided at a school does constitute a care home service if, at the time accommodation is provided for children at the school—

(a) accommodation has been provided at the school or under arrangements made by the school's proprietor for at least one child for more than 295 days in any period of 12 months falling within the previous 24 months, or
(b) such accommodation is intended to be provided for at least one child for more than 295 days in any period of 12 months falling within the following 24 months.

(4) The provision of accommodation and care to a child by a parent, relative or foster parent does not constitute a care home service unless paragraph 5A of Schedule 7 to the Children Act 1989 applies (fostering treated as care home service where fostering limit exceeded).

(5) In sub-paragraph (2)(b), "school" has the meaning given by section 4 of the Education Act 1996 (c.56).

(6) In sub-paragraph (4), "parent" means a person who has parental responsibility for a child (within the meaning given by section 3 of the Children Act 1989 (c.41)).

(7) For the purposes of sub-paragraph (4) a person is a foster parent in relation to a child if the person—

(a) is a local authority foster parent, or
(b) fosters the child privately.

[1] http://www.legislation.gov.uk/anaw/2016/2/schedule/1

Annex B

Initial Resident Review (preferable to use coded data here for PPV purposes)

Resident Name: D.O.B.:
Nursing/Residential Home:
Lead GP or Cluster Lead

Date of assessment:

Mental State Assessment ? MMSE

Mini Geriatric Depression Score or 6CIT or similar would be accepted.

Current Medical Problems

Systems Review - problems identified

Examination findings

Specific additional areas

Mobility	Unaided / stick or Zimmer / wheelchair / bed bound	Action required
Falls assessment	Risk assessment undertaken / required - Yes / No	Action required
Podiatry	Podiatry assessment undertaken / required - Yes / No	Action required
Oral health	Oral health assessment undertaken / required – Yes / No If Yes, is there evidence of a care plan being delivered	Action required
Pressure area review	Yes / No	Action required
Diet	Normal / soft / supplements / PEG Yes / No	Action required
Hearing	Normal / hearing aid / Other problem (please Specify):	Action required
Eyesight	Normal / glasses / Other problem (Please specify): Is there evidence of a care plan being delivered	Action required

Osteoporosis Risk Assessment (Using local agreed clinical pathway and please note most in this age group won't need a dexa)	Hx of recent falls: Y / N On calcium & Vit D supplementsY/N On bisphosphonate: Y	Action required

Investigations Recommended by assessor

Medication Review with polypharmacy, antipsychotic prescribing considerations and other high risk medicines Y / N

Any Recommended actions:

End of life plan discussed Y / N

Summary of further actions and person/s responsible: (e.g. hearing test to be arranged by care home manager)

Name of person completing review: Date: