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

Ipswich and East Suffolk CCG response.

Summary

The service draws on key elements of existing evidence-based guidance and good practice, and has been updated to bring it in line with the needs of care home residents during the current COVID-19 situation.

Guidance relates to all practices individually. However, it will be less burdensome for general practice, easier for community partners and better for care homes for this to be delivered at a PCN level as the default. This 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.

This model should be established as soon as possible, and within a fortnight at the latest in order to support residents as quickly as possible.

NHS England and NHS Improvement will collect regular 'sitrep' data from CCGs, starting next week, to understand the support being provided to care homes and the coverage achieved across the country.

Requirements for practices

Task	Details	Ipswich & East Suffolk GP Practice current position
Delivery of a consistent, weekly 'check in', to review patients identified as a clinical priority.	To be delivered – remotely wherever appropriate – by an MDT where practically possible*	Weekly ward rounds are happening and are established already within I&ESCCG. Ipads are being delivered 7th May 2020 onwards to all care homes, this will mean access to virtual consultations in every care home. There could be practical problems in delivering MDT's therefore it is not required weekly however it is permitted locally and encouraged where needed.
	Review patients identified as a clinical priority for assessment, including but not limited to those with suspected or confirmed COVID-19 symptoms**	This already happens in line with above and it is for both the care home and GP practice and INT's to identify patients.
	Include appropriate and consistent medical oversight and input from a GP and/or geriatrician	This already happens locally in line with the Care Home LES. Geriatrician Support…Practices can call FAB 7 days a week 9-5pm
	Support the introduction and use of remote monitoring of COVID-19 patients using pulse oximeters and other equipment (which may be supplied directly to care homes or eligible for practice reimbursement)	All care homes have equipment as of 4.5.20. Excluding LD care homes (although some may have their own equipment)

	Prescription and supply of oxygen to care homes for treatment, where clinically indicated and be supplemented by more frequent contact with the care home where further needs are identified	GP's are not required to supply and prescribe oxygen. Only in exceptional cases where clinically required.
Development and delivery of personalised care and support plans for care home residents.	A process established to 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	Processes are already established locally in line with the Care Homes LES. I&ESCCG have Yellow Folders to inform personalised care plans although we would encourage a review of the systems in place with your aligned care homes at this time.
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.	Facilitation of medication supply to care homes, including end of life medication	All pharmacies within IES have a basic set of EoL drugs a further 9 pharmacies have been commissioned to stock an extended list
	Deliver structured medication reviews – via video or telephone consultation where appropriate - to care home residents	Reviews are being undertaken as per the IESCCG Care homes LES which covers aspects of the SMR criteria outlined on the DES
	Supporting reviews of new residents or those recently discharged from hospital	LES requires review of new residents but does not state 'on discharge' (for returning residents for example) some practices may do this anyway others may have to communicate with care homes to ensure this can take place as per the new service model.
	Support care homes with medication queries, and facilitation of their medicines needs with the wider healthcare system (eg through medicines ordering)	IES medicines management pharmacist supports care homes around medication queries.
Provide a network approach to delivery – backed by appropriate information sharing arrangements.	Networks should identify a named clinical lead for each care home	LK to action/email all Practice Managers
Registrations of patients: Where a patient moves out of area to an alternative care home permanently, it is expected they would re-register with the aligned GP Practice of that care home.		
Finance resource for this service model is included in the current Care Homes Local Enhanced Service (LES).		
This document excludes LD care homes whilst we await confirmation from NHSE.		

*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.

**To be implemented in line with the protocols established in the primary care standard operating procedures and the community services standard operating procedures