

Grant L. Duncan
Deputy Director; Dirprwy Gyfarwyddwr
Primary Care Division; Yr Is-adran Gofal Sylfaenol
Directorate of Health Policy; Cyfarwyddiaeth Polisi Iechyd
Health and Social Service Group, Iechyd a Grwp Gwasanaethau



Llywodraeth Cymru
Welsh Government

12 April 2017

Dear Colleagues

Directed Enhanced Service for Care Homes

Please find attached the new Directed Enhanced Service (DES) for Care Homes together with the supporting Directions, which come into force on 12 April 2017.

The DES, which applies to residential care homes and nursing homes, should be offered to all GMS contractors.

The Specification and Directions will be placed on our GMS contract website at <http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=6064>

A Welsh language version of the DES Directions will also be placed on the GMS contract website in due course.

Yours sincerely

Dr. Grant L. Duncan
Dirprwy Gyfarwyddwr, yr Is-adran Gofal Sylfaenol
Deputy Director, Primary Care Division

Directed Enhanced Service: Care Homes 2017/18

Strategic context

1. The Welsh Government's plan¹ for a primary care service for Wales up to March 2018 sets out the intention to develop a more social model of health, promoting physical, mental and social wellbeing, rather than just the absence of ill health, ensuring the root causes of poor health are addressed and to meet individuals needs at home. The primary care plan is underpinned by prudent health care principles where the clinical skills and abilities of all members of the primary care team are maximised.

2. The GP's role increasingly will be to collaborate with other local health services through the primary care clusters to provide overarching leadership of multi-professional teams. These teams will be made up of general practice nurses, community and district nurses, health visitors, healthcare support workers, pharmacists, physiotherapists, occupational therapists, podiatrists, dentists, optometrists, other specialist staff, social services staff and staff working in care homes and third sector services. **Annex E** sets out the role of health boards in supporting the coordination of community primary care services and ensuring the availability of GP led multi disciplinary teams.

3. The review undertaken by the Older Persons Commissioner for Wales (OPC) *A review into the quality of life and care of older people living in care homes* and the review undertaken by Dr Margaret Flynn *A review into the quality of life and care for older people living in care homes investigated as Operation Jasmine* demands better care planning for residents living in the nursing homes and residential care homes and to become a sector of primary national strategic importance for Wales. These reports, broadly, raise concerns about:

- Variations in how older people living in care homes are able to access GP services ; concerns about access to preventative healthcare services, such as physiotherapy, occupational therapy, speech and language therapy and podiatry; oral health; falls prevention, mental health support, including dementia, physiotherapy.
- The need for stronger compatibility between person-centred care, relationship centred care and palliative care.
- The need for stronger support for residents who suffer from dementia and oral health.
- The need for specialist staff to treat pressure ulcers to be available for care homes.

Medical needs of residents in care homes

4. The medical needs of residents in care homes are complex and changeable with increasing dependency levels. While growing older does not necessarily equate with increased morbidity and dependency, ageing is often associated with increased needs for care and support. Recent evidence indicates the resident population in care homes is

¹ Plan for a primary care service for Wales up to March 2018:
<http://gov.wales/topics/health/nhswales/plans/care/?lang=en>

ageing.² These residents are also usually unable to attend a primary care centre and therefore require home visits together with frequent and multiple prescribing interventions and have a higher than average use of Out of Hours Service.

Application of the Directed Enhanced Service (DES)

5. The definition of a care home, which is outlined at **Annex A**, does not distinguish between a nursing home and a residential home. For the purposes of clarity, the DES applies to nursing homes and residential homes.

The aims of the DES

6. The aim³ of the DES, which builds on the benefits of the previous enhanced services provision, is to enhance the care provided for residents in care homes through a proactive, holistic coordinated model of care. There is a strong emphasis on prudent healthcare principles where the clinical skills and abilities of all members of the primary care team are maximised. In particular, the DES seeks to (a) deliver best-evidenced treatment and services to the most appropriate level based on individual need; maximise the continuity of care; (b) minimise unplanned transitions of care; (c) minimise the risk of poly pharmacy and (d) ensure the most appropriate professional is available to deliver care.

7. Central to the delivery of the DES is clear clinical leadership in relation to the development and coordination of care and the facilitation and encouragement of closer multi-disciplinary working between community professionals (for example, community nurses, community pharmacists, dieticians, mental health professionals, social services) and the integration of practice teams for maximum effect and the identification and management of risks ensuring safe high quality services. This requires a change in emphasis for GP practices and clusters to a role of coordination and oversight to ensure quality care.

8. The DES is designed to:

- Increase continuity, familiarity and enable holistic care through multi disciplinary team working, cluster network support and health board support.
- Increase pre-emptive proactive and anticipatory care; decrease unplanned admissions; decrease unplanned intervention, particularly Out of Hours.
- Enable ready access to primary care advice for care home staff, ambulance service staff and Emergency Departments when an unscheduled care need is identified.
- 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.
- Address the variability and pricing of existing enhanced services provision and promote a good quality more standardised approach across health boards.
- Deliver full flexibility for a team based approach in keeping with prudent health care principles.

Delivery

² ONS: Changes in the Older Resident Care Home Population between 2001 and 2011: the resident care home population is ageing: in 2011, people aged 85 and over represented 59.2% of the older care home population compared to 56.5% in 2001.

³ *General Practice – Prescription for Healthy Future*

9. Delivery of the DES can be through the residents' current GP practice (which would ensure continuity of care); or through a single GP practice as lead on behalf of a group / cluster of GP practices ; or another service delivery model (such as salaried GPs) if GP practices are unable to deliver the service.

Service specification

10. The DES remunerates a programme of assessment and regular review of the mental and physical health of the nursing home population which will include, where appropriate, end of life care planning.

11. The specification of this service 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.

12. During a financial year the GMS contractor will undertake for each resident either an Initial Resident Review or an Annual Resident Review and a minimum of one clinical review, with more as clinically appropriate , for residents who have resided in the care home for the full financial year.

Initial Resident Review

13. Each resident must have a comprehensive review of their mental and physical health provided within 28 days of moving into the care home. This review will include the discharge medicines review to reconcile medicines prescribed and to update the record of prescribed medicines maintained by the GMS contractor. The medicines review will include, but not be limited to, polypharmacy, antipsychotic prescribing and other high risk medicines. A pro-forma template outlining the areas for review is at **Annex B**. The care home will hold a copy of the completed Initial Resident Review. Where an Initial Resident Review has been undertaken during the financial year, an Annual Resident Review is not required.

14. A multi-professional team approach to the health assessment will be necessary, 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 the GP will personally deliver all aspects of the holistic assessment, but will be responsible for recommending the assessment and appropriate referral. Recommended READ codes will be provided to facilitate audit, where this audit has been commissioned by health boards.

Monitoring the Provision of Care

15. Monitoring the provision of care will be through a range of modalities, including nursing home visits or a virtual ward approach and integration with existing crisis response team arrangements between provider and senior staff of the care home

Clinical Review

16. Where appropriate, healthcare professionals such as a practice nurse or a pharmacist will support the GP to undertake the review. Each patient who resides in the care home for the full financial year must have a minimum of one clinical review undertaken by the GMS contractor. Further clinical reviews will be undertaken as clinically appropriate. For those residents who have not resided in the care home for a full financial year, the GMS contractor will need to determine the necessity for a clinical review. Where a pharmacist undertakes a medication review, with particular reference to polypharmacy, antipsychotic prescribing and other high risk medicines, the GMS contractor will take this into account in the clinical review.

Medication Review

17. A GP employed pharmacists, or cluster based health board employed pharmacist, or community pharmacist providing services to the relevant care homes will undertake at least one medication review, with particular reference to polypharmacy, antipsychotic prescribing and other high risk medicines, for each resident in the care home. Further medication reviews will be undertaken by pharmacists as clinically appropriate.

18. The GP, as the lead clinician in the multi disciplinary team, may commission a medication review to be undertaken by a pharmacist

Annual Resident review

19. Each resident must have a comprehensive annual review undertaken within 4 weeks of the anniversary of the day the resident moved into the care home

Post Unscheduled Care Review

20. A post unscheduled care review must be undertaken within 4 weeks of receipt of the discharge summary following attendance at the emergency department or emergency hospital admission. The purpose of the review is to establish if unscheduled care could have been avoided and if so what actions should be taken to reduce the possibility of further unscheduled care. The post unscheduled care review will be undertaken either face to face or via phone as appropriate as determined by the GP on receipt of the discharge summary.

Anticipatory / Advance Care Planning

21. Special Patient Notes (which will depend on the OOH service and may be paperless) about vulnerable residents and palliative care residents must be completed and provided to the OOH service. The care home will receive a copy of the Special Patient Notes. Appropriate end of life care and where appropriate Do not Attempt Cardiopulmonary Resuscitation (DNACPR) notification will be included with an emphasis on good communication.

Annual Report

22. Each GP practice / lead practice acting on behalf of the GP cluster / or other service provider must complete an annual report of outcomes by 31 March each year, appropriate for service development and needs. A pro-forma template outlining the format of the annual report is at **Annex C**

Accreditation

23. The GP practice or single GP 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 take responsibility for ensuring all staff delivering the enhanced service are appropriately trained, qualified, competent and supervised.

Payment

24. All agreements to enter into these arrangements must be in writing. Health Boards must commission this enhanced service from 12 April 2017.

25. A payment will be made at the rate of £270 per resident in respect of each financial year. These payments should be made either monthly or quarterly upon the submission of a claim to the health board by participating medical practices. These claims must be accompanied by a list of residents residing in the care home on the last day of the quarter to which the claim relates and who are registered as patients with the claiming medical practice.

26. For those patients which are registered with the medical practice providing the service or a practice which forms part of a group or cluster the patients receive the service from, the lead practice which provides the service will make the claim for payment.

27. Where the death of a resident occurs during the year, the practice is able to claim the full payment for that year as long as the Initial Resident Review has been completed. If not, the practice will not be able to claim a payment.

28. If a resident resides in a care home up to 6 months of the relevant financial year the practice will receive 50% (£135) of the annual payment.

29. If a resident resides in a care home up to 9 months of the relevant financial year the practice will receive 75% (£202.50) of the annual payment.

30. If a resident resides in a care home for over 9 months of the relevant financial year the practice will receive 100% of the annual payment.

31. No practice will be able to receive more than the annual payment of £270 in any financial year. It may therefore be necessary to undertake a process of financial reconciliation at the end of the financial year.

32. Practices are required to agree they will no longer receive a retainer from the care home if they opt to offer this service provision outlined by the health board.

33. Signed completion of the application form attached serves as confirmation of this agreement.

Monitoring and Payment Arrangements

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

Review of the DES

35. A review the DES will be undertaken six months after implementation of the DES from an operational perspective

Disputes

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

Practice declaration

37. The GP practice or single GP practice acting as lead 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 scheme and is seeking to provide a service on this basis.

38. If commissioned the GP practice or single GP 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 scheme.

Signed: _____

As GP principal representative of the practice

As single GP practice acting as lead on behalf of a group / cluster of GP practices

GP acting as lead for the service delivery

* Please delete as appropriate

Date: _____

Definition of Care Home

The Definition of a Care Home is outlined in the Care Standards Act 2000. This abolished the distinction between nursing and residential homes under the term 'Care Home'. This states:

For the purposes of this Act, an establishment is a care home if it provides accommodation together with nursing or personal care, for any of the following persons. They are:

- (a) persons who are ill or have been ill
- (b) persons who have or have had a mental disorder
- (c) persons who are disabled or infirm
- (d) persons who are or have been dependant on alcohol or drugs

But an establishment is not a care home if it is:

- (a) independent hospital⁴
- (b) an independent clinic
- (c) a children's home

or if it is of a description excepted by regulations.

An establishment is not a care home for the purposes of this Act unless the care, which it provides, includes assistance with bodily functions where such assistance is required.

This includes both short-term and long-term residents

⁴ Care Standards Act 2000: A hospital which is not a health service hospital is an independent hospital. "Hospital" (except in the expression health service hospital) means an establishment the main purpose of which is to provide medical or psychiatric treatment for illness or mental disorder or palliative care; or any of the listed services are provided or any other establishment in which treatment or nursing (or both) are provided for persons liable to be detained under the Mental Health Act 1983.

Initial Resident Review

Residents 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 dxa)	Hx of recent falls: Y / N On calcium & Vit D supplements Y/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 . A proforma template is attached Annex D

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:

GP Practice Annual Report

Year

Practice

1. Number of residents claimed for the year

Full year

Partial year

2. Residents who have an end of life care plan in place at end of year

Number %

3. Themes arising from medication reviews carried out

How many medication reviews, which include polypharmacy, antipsychotic prescribing and other high risk medicines, have been undertaken during the year?

.....

Themes arising from the medication reviews which include polypharmacy, __antipsychotic prescribing and other high risk medicines

.....
.....

4. Themes arising from significant learning events and incidents identified during the year and actions

.....
.....

5. Results of the post unscheduled care review

How many unscheduled admissions were reviewed?

.....

Please provide a brief description of the outcome of the reviews

.....
.....

Please describe any changes to be made as a result of the reviews undertaken

.....
.....

6. Residents dying within 48 hrs of hospital admission

Number of residents reviewed who had been admitted and died within 48 hrs.....

Please provide a brief description of the outcome of the review

.....
.....

Please describe any changes to be made/ implemented as a result of the review undertaken

.....
.....

7. Patient and Care Home feedback

Identify key themes from feedback

Identify ways in which to improve the service after taking into account feedback

.....
.....

8. Please outline how you have improved communication and handover of care with others including GP OOH, and in particular, how 'special notes' have been used to support this process

.....
.....

9. Any other comments that the practice would like to make including suggestions for how the enhanced service / scheme could be improved or developed and any specific actions that you consider the Health Board should address.

.....
.....
.....

**End of Life Care Plan
(Adapted from the Gold Standards Framework template)**

Aims:

1. Formalise what residents and their family do wish to happen to them
 2. Is useful to clinicians in the planning of patient's individual care
 3. To reduce crisis decisions or unnecessary admissions to hospital
(to be written following discussion with appropriate input including, but not exclusively, the patient, nursing / care home staff, patient's usual GP and relatives)
- This is not a one off statement – it can be amended at any time by the patient and is designed to be a “dynamic” document – it should be completed when there is a likelihood that the patient will pass away within 6 months

THESE PLANS ARE TO BE AVAILABLE TO THE OOH PROVIDER

1. What elements of care are important to you and what would you like to happen in future?

2. Is there anything that you worry about or dread happening? What would you NOT want to happen?

**3. Do you have a Living Will or Legal Advance Decision Document?
If yes, please give details (e.g. who has a copy)?**

4. Who else would you like to be involved if it ever becomes difficult for you to make decisions or if there was an emergency? Do they have official Lasting Power of Attorney?

Name Contact Details

Name Contact Details

5. If your condition deteriorates where would you most like to be cared for?

1st Choice

2nd Choice

Comments

6. Do you have any special requests, preferences or other comments?

The role of health boards in coordinating primary care services to support residents in care homes and coordinating the availability of GP led multi-professional teams to support the delivery of the enhanced service

Strategic context

1. The Welsh Government's plan for a primary care service for Wales up to March 2018 is underpinned by prudent health care principles where the clinical skills and abilities of all members of the primary care team are maximised. The plan also highlights the the GP's role increasingly will be to collaborate with other local health services through the primary care clusters to provide overarching leadership of multi-professional teams. These teams will be made up of general practice nurses, community and district nurses, health visitors, healthcare support workers, pharmacists, physiotherapists, occupational therapists, podiatrists, dentists, optometrists, other specialist staff, social services staff and staff working in care homes and third sector services.
2. The review undertaken by the Older Persons Commissioner for Wales (OPC) '*A review into the quality of life and care of older people living in care homes*' and the review undertaken by Dr Margaret Flynn '*A review into the quality of life and care for older people living in care homes investigated as Operation Jasmine*' demands better care planning for residents living in the nursing homes and residential care homes These reports raised concern about:
 - Variations in how older people living in care homes are able to access GP services ; concerns about access to preventative healthcare services, such as physiotherapy, occupational therapy, speech and language therapy and podiatry; oral health; falls prevention, mental health support, including dementia and physiotherapy.
 - The need for stronger compatibility between person-centred care, relationship centred care and palliative care.
 - The need for stronger support for residents who suffer from dementia and oral health.
 - The need for specialist staff to treat pressure ulcers to be available for care homes.
3. Addressing the issues raised in the Older Persons Commissioner for Wales report and review undertaken by Dr Margaret Flynn will require care home residents to have access to community and primary care, including community and district nurses, pharmacists, physiotherapists, occupational therapists, podiatrists, dentists, social services and other outreach services.

The role of health boards in coordinating primary care services to support residents in care home.

4. Health boards will be expected, through their Integrated Medium Term Strategic Plans , to ensure residents in residential and nursing homes have access to a wide range of primary care services and other health professionals, including where appropriate, specialist nursing care (such as tissue viability nursing care) and community mental health nursing care.
5. In particular, residents for care homes will require access to community primary care services including pharmacists, dentists, optometrists, audiologists, dieticians, podiatrists, mental health care and other health professionals as required.

6. It is expected health boards will take responsibility for ensuring community based health professionals are appropriately trained. Health boards will also be expected to work closely with social services and other agencies to ensure an integrated approach to health and social care.

The role of health boards in coordinating the availability of GP led multi professional teams to support the delivery of the enhanced service

7. As indicated in the primary care plan for Wales, the GP practice is at the heart of primary care. Increasingly, the role of the GP will be to provide overarching leadership of multi-professional teams, through primary care clusters, made up of for example, advanced practice nurses, community and district nurses, clinical pharmacists, physiotherapists, occupational therapists, podiatrists , chiropodist dentists, optometrists, dieticians, and social services.

8. It is expected health boards will liaise closely with GP practices and GP primary care cluster leads to coordinate and plan for the availability of GP led multi-professional teams to support the delivery of the enhanced service.