

**To all practices Surrey & Sussex LMCs**

5<sup>th</sup> May 2020

Dear Colleagues

**NHS Response to Covid19; recommended clinical service model for Care Homes**

I am writing to highlight two important letters sent recently from NHS England, both enclosed. The first was from the NHS Chief Executive, Simon Stevens, and described the 'second phase' in NHS England's response to the Covid19 emergency. Within this letter are many positive steps which will support General Practice, if implemented, but the widest publicity (at least in General Practice) was given to the statement that, in order to support Care Homes, the national roll out of key elements of the Enhanced Health in Care Homes specification within the DES was to be brought forward from October 2020.

That this was not in fact happening was stated by Nikki Kanani (NHS Director for Primary Care) several times during her national webinars on Thursday 30<sup>th</sup> April; she was thereby given the unenviable task of writing a letter which purported to implement what Simon Stevens was saying whilst also including the statement that the model of working being proposed could be adapted from 1<sup>st</sup> October 2020 to support the Enhanced Health in Care Homes service specification already agreed as part of the PCN DES.

Clearly, this ambiguity has provided an opportunity for GP colleagues to review their approach to the PCN DES, accompanied by a reinforced scepticism about NHS England.

Indeed, this may be the opportunity to recycle an old saying about NHS England:

Q: Why does NHS England invest so much in bioengineering?

A: Because they wish to grow a stick that looks like a carrot

The contractual position remains as outlined in my letter of 6<sup>th</sup> April which is that practices have until 31<sup>st</sup> May 2020 to opt out of participation in the 2020/21 DES; however, not actively opting-out (by informing the CCG) means GP practices will be included within the 2020/21 DES by default, and so unless practices have done so they will have already received April's Network Participation Payment. This (and May's payment if made) will need to be repaid if a practice does opt out. If practices do not opt out by 31<sup>st</sup> May, they will next be able to opt-out in April 2021, and not before then unless the CCG agrees.

The LMC recommends any practice considering opting-out should discuss this with their PCN CD and other practices within their network, as opting-out may have implications for their PCN configuration and participation of other practices.

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Nikki Kanani's letter describes a Covid19 care home support model of working and it is likely that most practices will already be undertaking elements of this, although it also requires the support of community and pharmacy services (amongst others) to be delivered in full. Although the letter is aimed at engaging GP practices, it implies PCNs will be active participants.

CCGs have been asked to support practices to implement this model and as a first step are seeking to define the service model in terms of what Community Trusts are currently undertaking, and whether any Locally Commissioned services, currently in abeyance, do include elements of this model. Colleagues will be aware such LCSs would have in any event needed to be 'repurposed' to complement the PCN DES specification from 1<sup>st</sup> October 2020 if they duplicated it, but with a commitment to retain this investment in General Practice. There is considerable variation across current historic CCGs in terms of LCSs and their detailed specifications. and the same variability is the case in terms of Community Service support for Care Homes.

The LMC believes the first steps for all CCGs should therefore be:

- 1) Establish a simple description of the service that is outlined in NHS England's letter of 1<sup>st</sup> May.
- 2) Establish what elements of current Locally Commissioned Service(s) specifications would contribute to delivering this service: this is likely to vary across different CCGs and no one LCS is likely to cover all elements of the clinical service model.
- 3) Establish the level of support from Community Services that is currently available and would contribute to such a service model.

The model outlined in Nikki Kanani's letter describes using 'existing PCN arrangements (as) the default' but clearly this is not a PCN DES specification, and so until 1<sup>st</sup> October this service must be commissioned from practices, even if it is delivered by practices working collaboratively within their PCN.

One real challenge is the patient registration arrangements within Care Homes as in many areas the proposed alignment of Care Homes between GP practices, so that residents in each home are only registered with one practice, or within one PCN, is either at an early stage of discussion or not implemented at all. In some areas this issue is more advanced. Neither Nikki Kanani's letter nor the guidance around this element of the PCN DES addressed the challenge this creates in terms of an individual patient's right to register with a GP practice of their choice if the home is within the practice boundary.

Many practices may wish to participate in a CCG contractual model that supports the delivery of this service, and this will be required since the weekly 'check in' to review Care Home residents does not form part of the delivery of GMS essential services; nor is creating arrangements for an MDT meeting. GP practices are likely to find the remote monitoring of Covid19 patients using pulse oximetry helpful, but any equipment provision will require reimbursement.

Preparation of personalised care and support plans for care home residents (including end-of-life care plans) was a key element of the PCN DES Enhanced Health in Care Homes and if this process is now to be brought forward it will need to be resourced. If such arrangements are developed in advance of 1<sup>st</sup> October this will clearly align what practices are doing with the introduction of the PCN DES. Unfortunately, one expected element of this was the recruitment of staff under the PCN ARR Scheme, and without such staff it is unlikely many practices will have the resources to undertake this work, which is according to Nikki Kanani's letter, expected for all Care Home residents.

The LMC is uncertain if PCNs, as currently constituted, will have the managerial infrastructure to support:

- 1) the creation of MDT meetings, which will require considerable co-ordination and commitment
- 2) the coordination of pharmacy teams to provide pharmacy and medication support to care homes and believes this is more properly the role of the CCG. Current Pharmacy support within practices and PCNs should be prioritising the delivery of practice services and practice workload

Obviously, PCN CDs should consult their member practices before committing any individual practice or PCN resources to these processes. The LMC believes CCGs or PCN CDs cannot seek to rely on participation in the DES to support the delivery of the Care Home clinical service model before 1<sup>st</sup> October 2020.

Self-evidently GP colleagues will wish to support patients living within Care Homes and also Care Home staff, given the extremely challenging circumstances created by the Covid19 pandemic. In terms of delivering primary medical services, this is already the responsibility of GP practices for their registered patients. Participating in virtual weekly 'check-ins' often delivers that care in a more co-ordinated and time-efficient way for GPs, although it is not a requirement of the GMS contract.

The additional elements of the clinical service model in Nikki Kanani's letter are:

- creation and organisation of an MDT focused on care homes
- development and delivery of personalised care and support plans for care home residents, although her letter notes that the time and resources necessary to undertake this may be limited
- Provision of pharmacy and medication support to care homes.

These are not the contracted responsibility of GP practices and are likely to require additional resourcing if GP practices are to support these; they do align closely with the PCN DES Enhanced Health in Care Home specification which commences on 1<sup>st</sup> October, but this relied on Community Service Support, which will be necessary if this model is to be introduced over the next few weeks, and ARRS staff, which are unlikely to have been recruited.

The LMCs advice on participation in the PCN DES for 2020/21 outlined in my letter of 6<sup>th</sup> April is unchanged and is a pragmatic approach to the current exceptional circumstances. Anyone who concludes this letter is a panegyric for PCNs should reread it. Colleagues are welcome to contact the LMC with any queries..

A handwritten signature in blue ink, appearing to read 'Julius', written in a cursive style.

Dr Julius Parker  
**Chief Executive**