NHS
Lancashire and South Cumbria
Integrated Care Board

Local Enhanced Service Specification:

Enhanced Care Home Service

Service Specification No.	
Service	Local Enhanced Care Home Service
Commissioner Lead	Lancashire and South Cumbria ICB
Provider Lead	GP Practices in Lancashire and South Cumbria
Period	1st May 2025 - 31st March 2026
Date of Review	To be reviewed annually

1. Population Needs and Background

NHS Lancashire and South Cumbria ICB covers 196 GP Practices and has a total registered population of 1,853,016 (as of January 2024) patients.

The scope of this specification will cover all 196 practices and registered patients, along with temporary residents (where appropriate) that live within the geographical area of Lancashire and South Cumbria.

1.1 National/local context and evidence base

One in seven people aged 85 or over permanently live in a care home. People living in care homes account for 185,000 emergency admissions each year and 1.46 million emergency bed days, with 35-40% of emergency admissions being potentially avoidable. Evidence suggests that many people living in care homes are not having their needs assessed and addressed as well as they could be, often resulting in unnecessary, unplanned, and avoidable admissions to hospital and sub-optimal medication regimes.

People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through collaborative working between health, social care, the voluntary sector, and care home partners.

The NHS is committed to supporting people who live and work in and around care homes. People living in care homes should expect the same level of support as if they were living in their own home – but this can only be achieved through collaborative working between health, social care, voluntary, community, and social enterprise (VCSE) sector and care home partners.

The NHS Long Term Plan committed to rolling out the Enhanced health in care homes (EHCH) model across England by 2024. This was achieved ahead of schedule in 2020. This model moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff. Such care can only be achieved through a whole-system, collaborative approach.

Requirements for the delivery of EHCHs by primary care networks (PCNs) are included in the 2023/24 Network DES with corresponding requirements for community health services and other NHS providers in the NHS Standard Contract.

Every care home:

- is aligned to a primary care network (PCN)
- has a named clinical lead (who is responsible for overseeing implementation of the framework)
- has a weekly 'home round' supported by the care home multidisciplinary team (MDT)
- has established protocols between the PCN, care home and system partners for information sharing, shared care planning, use of shared care records and clear clinical governance.

Every person living in a care home, within 7 working days of admission or re-admission:

- has participated in a comprehensive personalised assessment of need undertaken by the MDT
- has participated in the development of their personalised care and support plan (PCSP) with a member of the MDT
- care home residents should be identified and prioritised by their PCN as people who would benefit from a structured medication review (SMR)

The Enhanced health in care homes framework has been updated to support the delivery of the standards described in these contracts. It sets out practical guidance and best practice for integrated care boards (ICBs), primary care networks (PCNs) and health and social care providers, as they work collaboratively to go further in enhancing the care for people who live in care homes.

The framework reflects new ways of partnership working since the COVID-19 pandemic including the use of digital technology to improve integrated working and information sharing across health and social care teams such as NHS mail.

Evidence shows that a coordinated focus on the primary care services available to care home residents leads to better care and reduces unplanned admissions to hospital. This local Enhanced Care Home (EHCH) service specification has been informed by the national EHCH Framework (November 2023) and the Network Contract DES 2024/2025. The service has been designed to complement the primary care service requirements in the Network Contract DES and wider efforts across the Integrated Care System to integrate primary care and community services and reduce unplanned admissions to secondary care.

1.2 Local context

In recognition of the increase in patient demand within our vulnerable populations and the unique position of General Practice and PCNs in delivering enhanced care

services to our care home population, NHS Lancashire and South Cumbria Integrated Care Board will continue to commission an Enhanced Care Home Services across the system, to support the ongoing implementation of the national requirements in the Network Contract DES, to continue to improve the quality of care in line with current evidence. The aim is to improve the quality of life through improved care in community settings with fewer and shorter stays in acute hospital settings.

We expect our local population (in line with national trends) to live longer and this increase in life expectancy is forecast to continue, impacting on population size particularly in the over 65 population. Over the period of the five-year plan, it is forecast to increase 1.9% year on year, in comparison with a 0.5% growth year on year in the under 18 and a 0.1% growth in adults of a working age.

There are over 17,270 care home beds across Lancashire and South Cumbria. Not all these beds are occupied all at the same time and some are occupied with temporary residents in 'hospital avoidance beds' or in intermediate care. While many people living in care homes will be living with complex needs, including severe frailty, some may not. This local enhanced service covers all residents who are required to enter a bed-based service within Lancashire and South Cumbria either as a permanent or temporary resident including for hospital avoidance.

1.3 Evidence Base

The principal rationale for developing the new service is outlined below:

Inequity in clinical outcomes

- High variability in the quality of care delivered, resulting in inequities in outcomes for patients.
- National concern over the sustainability of the Care Home sector.
- Current and ongoing local quality issues in the Care Home sector.

Inequity in patient registrations/workload

- Current inequity in nursing home allocations and ongoing disputes over closed lists, placing a disproportionate burden on a number of practices.
- Inequity in allocations persists as practices deemed to deliver good care build relationships with Care Homes and thus attract more patients.

Inequity in finance

- Acknowledged, historic under-resourcing of Care Home patients through the Carr-Hill formula.
- Evidence from other health economies suggests that investments deliver real savings in the longer term e.g., Salford, Sheffield, and Airedale.

Momentum for change

- Included in ICB primary care strategy and endorsed with strong support from the ICB membership and other health economy stakeholders.

- Linked to the Care Home Collaborative work with good support and engagement with Acute and Community providers.

1.3 Outcomes

NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	✓
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

1.5 Locally Defined Outcomes

- reduction in acute admissions from care homes
- reduction in the length of stay in acute care for residents admitted from care homes
- reduction in the number of delayed transfers of care following admission.
- reduction in prescribing costs.
- reduction in the number of medication errors.
- reduction in the number of care home residents dying in hospital, and
- improvement in care home experiences of care.
- development of an integrated multi-disciplinary team to support all patients.

2. Scope & Service Standards

2.1 A primary goal of health and social care services is to support people in their own home for as long as possible. If this is no longer possible, we need to ensure that the best possible care is provided to those in a care home setting. The evidence however suggests that people in Care Homes are not always having their needs properly assessed and met. As a result, they often experience unnecessary, unplanned, and avoidable admissions to hospital, and sub-optimal medication management.

2.2 The principal aim of the Local Enhanced Care Home Service (the Service) is to provide an additional level of care over and above that of a) the General, Personal Medical Services Contract or Alternative Provider Medical Services Contract provided by the Provider; and b) to support the delivery of the requirements of the nationally commissioned Enhanced Health in Care Home service and the Framework for Enhanced Health in Care Homes set out in the Network Contract DES. This is a proactive, preventative service aimed at improving the quality of care to people in Care Homes.

2.3 For the purposes of this specification a "Care Home" is defined as a CQC-registered care home with or without nursing in line with the Network Contract DES definition of Care Homes.

2.4 Service Requirements:

- To improve care for patients who live in Care Homes, which is based on person-centered care planning and coordinated input from primary healthcare teams, nursing, and residential care staff
- To ensure that all residents receive dedicated medical services
- To reduce inappropriate visits to A&E and avoidable admissions by, for instance, reducing the risk of falls or implementing the NICE guidelines for nutritional care
- To improve healthcare support that reduces or prevents potential ill health through improved coverage of influenza and pneumococcal vaccination
- To reduce the risk from polypharmacy through proactive medication management
- Reducing costs associated with medicines waste, errors in administration of medicines, and admissions to hospital
- To provide proactive care in managing chronic disease and medicines including care planning especially around discharge and end of life care
- To improve end of life care, allowing people to die where they choose, and respecting their wishes
- To minimise the risk and complications for vulnerable groups, which includes patients with highly complex needs care
- To build more effective communication and improve professional relationships between primary healthcare teams, nursing, and residential care staff in order to meet the needs of residents
- To promote the wellbeing of all people who may have difficulty in protecting themselves from harm and abuse and in promoting their own interests
- To utilise technology (where it is clinically appropriate to do so) to improve ways of working; facilitate medical input; support joint decision making about the care of individuals and reduce unnecessary admissions and callouts

2.5 Service Description/Care Pathway

The Provider is required to work to the following service specification for all Care Homes in scope of the Service.

The delivery of this service description will be dependent on the model established within each Practice or PCN - i.e. responsibility for delivery may vary based on the types of roles e.g. GP, ANP, Paramedic, Pharmacist, Care Coordinator, Care Homes Nurse, Practice staff.

2.6 Initial Review of the patient

Ensure that an initial review is undertaken to collect key information for patients upon admission to a Care Home within 7 working days of the practice being informed. The initial review shall collect, but is not limited to the following:

- an initial review to include a mental health assessment and a frailty screen. Based upon their holistic assessment.
- medication review.
- information gathering.

2.6.1 The initial review could be carried out remotely, only where it is deemed clinically appropriate to do so. The required timescale is over and above the DES requirement for a personalised care and support plan based on the principles and domains of a Comprehensive Geriatric Assessment to be developed and agreed with each new patient within 7 working days of admission or re-admission following a hospital episode.

2.6.2 Where appropriate, discuss with the care home the findings of a personalised care and support plan (which has been developed / refreshed by the PCN MDT under the Network Contract DES) to ensure the important aspects of shared care are co-ordinated for the benefit of improved patient care. These discussions should be documented in the patient's medical records.

2.7 Routine Management of Care Home Patients

- Identify a Care Co-ordinator with the necessary skills and knowledge to co-ordinate the Practice or PCN MDT including collating the information required prior to the meeting, take notes at the meeting, and ensure actions are completed.
- Issue repeat prescriptions within 48-72 hours of the request.
- Meet relevant QOF standards for long term condition reviews, ensuring residents have appropriate access to review within their home (if appropriate, avoid unnecessary tests in very elderly or frail patients).
- Carry out a medication review or structured medication review for all patients on a six- monthly basis by a Clinician or Pharmacist. This requirement is in addition to the twelve-monthly medication review stipulated in the Network Contract DES. The review could be carried out remotely, only where it is deemed clinically appropriate to do so.
- Conduct medicines reconciliation each time a patient moves between different care settings, with appropriate clinical input from a Clinical Pharmacist, Pharmacy Technician, or other appropriate Clinician. (Medicines reconciliation is the process of identifying the most accurate list of a patient's current medication and comparing it with the list currently in use, recognising any discrepancies, and documenting any changes, thus resulting in a complete list of medications accurately communicated).
- Where a patient has an emergency admission or elective admission to hospital, experiences an exacerbation of a long-term condition or requires a follow-up review for any other reason as clinically appropriate. The Provider will conduct a medical review, a review of the patients care plan and carry out medicines' reconciliation. This could be carried out remotely, only where it is deemed clinically appropriate to do so.

- The lead Clinician to oversee that all changes are updated in the patients care plan and that the appropriate care home staff are notified to make any necessary changes to future prescription orders.

2.8 Advanced Care Plans (ACP)

- Ensure where appropriate that a personalised Advanced Care Plan (ACP) has been completed and should be documented in the resident's electronic record by way of **Electronic Palliative Care Coordination Systems** **(EPaCCS)**, which should avoid a resident in having to repeat relevant information to the healthcare professionals involved in their care. ACPs can be adapted at any time following further discussions.
- To ensure the completed Advanced Care Plan (ACP), and patient's preferences and what matters to them, are visible across Lancashire & South Cumbria via the Shared Care Record (ShCR formally LPRES) practices ***MUST tick the 'consent to share box'*** within EMIS with patient consent or in the best interests of the patient where appropriate. If this box is **NOT** ticked the completed ACP will not be visible outside of EMIS/practice, and available to other health care professionals involved in the persons PEoLC care. Currently all LSC Acute Trusts, Hospices, NWAS and Community Teams have access to the LSC ShCR, and if consent is provided will be able to see elements of the patients EPaCCS/ACP pulled through from the EMIS record – for example preferred place of care/death. If a patient declines to share the record this should be documented in the EMIS record.
- Participating Practices and PCN's in this LES specification are encouraged to also review the ***Palliative and End of Life Care (PEoLC) Service Spec 2025/26*** ensuring ACP conversations are documented in the resident's electronic record, which should avoid a resident in having to repeat relevant information to the healthcare professionals involved in their care. This is part of home rounds under EHCH framework. Residents ACP wishes such as preferred place of care/death will need to be updated within Primary Care EMIS ACP template with the consent to share button ticked for this information to be visible via the LSC ShCR.
- It will be the responsibility, of the MDT lead clinician to update the Advanced Care Plan (ACP) on EMIS as required to ensure the version on EMIS is the most update and accurate version.
- The consent of the patients or families is required for the **EPaCCS** to be accessible to the GP, District Nurses, Hospital, NWAS and Out of hours Services. Patients and families can also withdraw consent at any time the Care records will need to be updated, and access will need to then be restricted.

2.9 Dementia Care

Where a patient is showing early signs of Dementia, the Service Provider will use their local referral pathway and guidance to refer patients appropriately.

2.10 Consent

The Provider shall comply with the NHS Requirements in relation to obtaining consent from each Patient to the provision of Services (Informed Consent) and in particular:

- Mental Capacity Act 2005
- Department of Health Reference Guide to Consent for Examination or Treatment
- Consent: Patients and Doctors making decisions together (GMC 2008)
- Data Protection Act 2018

The Provider will ensure in each case the patient is fully informed of the treatment options and the treatment proposed. Consent must be recorded in the patient's record held by the Provider. Consideration must be given to any Lasting Power of Attorney for Health. Where the patient lacks capacity and does not have a Lasting Power of Attorney, a Best Interest Assessment and outcome will determine the most appropriate course of treatment.

A chaperone must be available, if required by the patient or family/carer, for any procedure undertaken.

2.11 Care Home Experience Monitoring
Complaints should be documented and acted on according to the Provider's written complaints policy and as agreed by the ICB. The Provider must add any complaints to their complaints register and submit via K014B, which is an annual contractual return.

2.12 Hours of Service
The service will be provided during core hours, as per agreed PCN or practice delivery model.

2.13 Provider Eligibility Criteria
The Provider must be fully compliant with all requirements of core contracts (General Medical Services, Personal Medical Services or Alternative Provider Medical Services) and signed up as a member of a PCN.

All safeguarding training will have been completed and be up to date as per the requirements of core contracts (General Medical Services, Personal Medical Services or Alternative Provider Medical Services).

2.14 Staffing
The Provider will be responsible for ensuring that all staff will be competent and appropriately qualified to provide the specific care home service requirements.

Training and development of the workforce is a key element in the sustainability of the service model.

Providers should attempt where reasonably possible to ensure adequate staffing is available to cover the service at all times. Practices should plan ahead to ensure they have staffing cover for periods of leave and sickness absence.

2.15 Population covered

The service provided shall be for all eligible patients registered permanently with a GP practice; living in a Care Home in Lancashire and South Cumbria. The service applies equally to patients who self-fund their care and whose care is funded by the NHS or their local authority. It is equally applicable to Care Homes for people with learning disabilities and / or mental health needs and for adults both under and over the age of 65. For the avoidance of doubt, this service is for patients in the following settings:

Nursing Homes – a CQC registered home whose premises are used for the reception and the provision of nursing for persons suffering from any illness or infirmity.

Residential Homes – a CQC registered home, providing residential accommodation for any of the following:

- Under 65s
- Old age and infirmity
- Dementia
- S117 patients
- Learning Disability and/or Autism
- Past or present dependence on alcohol or drugs; or
- Past or present mental disorder.

2.16 Any acceptance and exclusion criteria and thresholds

Care Home patients who choose not to register with a practice within the Network their Care Home is aligned to, will be exempt from this service. However, the practice which currently looks after these patients should encourage patients wherever possible to re-register to receive the service.

2.17 Interdependence with other services/providers

This list includes but is not limited to:

- **Network Contract DES Service Specification**, including the following contents:
    - **Enhanced Health in Care Homes Service**
    - **Structured Medication Reviews**
    - **Early Cancer Diagnosis**
- **General Practices.**
- **Lancashire Teaching Hospitals NHS Foundation Trust** – Geriatrician Service, Medical Assessment Unit, Accident and Emergency, Consultants.
- **Blackpool Teaching Hospitals NHS Foundation Trust**
- **East Lancashire Hospitals NHS Trust**
- **University Hospitals of Morecambe Bay NHs Foundation Trust**
- **Lancashire County Council** – Adult Social Care and Some Adult Community Services.
- **Lancashire & South Cumbria NHS Foundation Trust** – CHESS, Adult Community Services, Mental Health Services.
- **St Catherine's Hospice** – End of Life Care.
- **GTD Healthcare** – Out of Hours Care and 111 Services.
- **NWAS**- Northwest Ambulance Service NHS Trust
- **FCMS**- Fylde Coast Medical Services

- **Care Homes** – all those covered under the scope of this specification.
- **Voluntary, Independent and Third Sector**.

2.18 Applicable national standards (e.g. NICE)

- NICE Care and support for people growing older with learning disabilities (April 2018)
- NICE End of life care for adults (Last updated: September 2021)
- NICE Care of dying adults in the last days of life (March 2017)
- NICE Oral Health for adults in care homes (July 2016)
- NICE Transition between inpatient hospital settings and community or care settings for adults with social care needs (December 2015)
- NICE Medicines management in care home (March 2015)
- NICE Urinary incontinence in women (December 2021)
- NICE Nutrition support in adults (November 2012)
- NICE Faecal incontinence in adults (June 2007)
- The comprehensive model of Personalised Care set out in the Long-Term Plan and Universal Personalised Care

2.19 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

As per the NHS Standard Contract.

2.20 Applicable local standards

The Provider is required to maintain evidence of continuing professional development in relation to this service. This may be required to be provided as evidence for re-accreditation. Clinical updates/training could include supervised practice, liaison/clinical audit sessions or attendance at appropriate postgraduate meetings/lectures/events etc.

2.21 IT

The Provider will make use of all available digital and IT equipment including video, tablets, webcams, and screens provided by the ICB during each review, assessment or consultation, the outcome of which must be recorded in the patient's medical records.

3. Applicable quality requirements

3.1 Applicable Quality Requirements

The Provider is required to deliver service provision within the scope of ICB policies and NHS policies, legislation, and terms in relation to:

- Infection Control
- Clinical Audit and Effectiveness
- Health and Safety
- Risk Management
- Complaints
- Medical Devices and Equipment Safety Policies and Maintenance
- Confidentiality, Caldicott Principles and Complaints Procedures
- Medicines Management
- Patient Safety (to include a Resuscitation Policy)

The Provider will have an established clinical governance programme and share key

clinical governance information with the ICB in the form of an annual report, which covers any audits undertaken against the standards set within the policies described in this service specification.

The Provider will ensure that a process is in place to carry out DBS checks on all staff, as legally required, and annual professional registration checks are carried out for all clinical staff. All doctors will be registered licensed practitioners. In addition, the Provider will have systems and processes in place to ensure all clinicians have undergone re-validation as required by their professional body. Evidence of this re-validation may be requested by the Commissioner.

4. Location of Provider Premises

The Service will be provided by PCN Core Network Practices in PCN aligned Care Homes across the Lancashire and South Cumbria

5. Finance

Payment:

The Provider will receive a payment of **£132 per bed**, per year for the beds within their aligned care homes.

The Provider will receive payment regardless of whether beds are occupied. The agreed total will be paid in monthly instalments. The payment will be calculated based on the bed information in the Care Home Alignment document, which the ICB has agreed and shared with each Provider. All costs of the service are included within the payments made.

Fraud Policy

In the event of suspected fraud or other illegality being uncovered at any stage the ICB will implement the ICB Fraud Policy and will investigate.

Information supporting reported activity and monitoring information must be made available to the ICB or its representatives upon request. Failure to provide this information, or the provision of incomplete or inaccurate information, may result in suspension of payments or clawback, as well as further investigation by the ICB and its representatives.

6. Contract and Monitoring Arrangements

Quality, Performance Monitoring and Audit

Each provider shall, as a minimum, provide information on the following:

1. Initial reviews carried out within 7 working days of admission, these reviews must include mental health assessments, frailty screening and a medication review
2. Carry out medication reviews or SMRs on each registered patient on a six monthly basis.
3. Undertake medicines reconciliation for patients each time a patient moves between care settings.
4. Following emergency or elective admissions or exacerbations of a long term

condition, each patient should have a medical review including a review of their care plan
5. Advance care plans must be completed and documented in the patients record and shared with appropriate care providers
6. The practice must refer all patients showing early signs of dementia to the appropriate services

Lancashire and South Cumbria Primary Care Place Based Teams are responsible for obtaining assurance that all the services it commissions are safe and are of good quality.

All activity should be recorded using the appropriate READ/SNOMED codes and an appropriate Data Quality Template will be supplied by the commissioner to support automated extraction, where possible.

All details regarding data quality and submission of data can be found in the supporting Technical Guidance Document.