NHS
Lancashire and South Cumbria
Integrated Care Board

FAQs for Local Enhanced Care Home Service

Q: Will it be paid as a block contract or tariff?
A: 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. Whilst the funding will be paid to practices, the service can be delivered flexibly at PCN or other level that makes sense to the practices.
Q: Can consideration be given to those care homes with a high turnover of beds - high level of care that is needed?
A: We recognise that some Care Homes will have a higher turnover of beds and higher levels of clinical complexity will differ for each Care home. However, we have taken a standardised approach to the costing to pay per bed which may vary from one home to another in terms of bed turnover and at times may be vacant, the Provider will receive payment regardless of whether beds are occupied.
Q: Can a LES be delivered as a PCN model or Practice level?
A: This LES can be delivered as a PCN Model, or any level that makes sense, or at individual Practice Level. The delivery of this service will be dependent on the model established within each Practice or PCN and complements the PCN DES specification. PCN's and Practices will be advised that it will up to them to decide which model makes sense to your practices/PCNs to deliver the Care home LES. This will be dependent on your practice/PCN/INT/ICC footprint.
Q: How will the LES delivery be monitored?
A: This is to be confirmed. In terms of monitoring this hasn't been confirmed yet, however it is currently under review by the ICB.
Q: How does the Care Home LES differ from the Enhanced Health in Care Homes Network DES requirements?
A: 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 **Local Enhanced Care Home Service- LES- Contract 24/25 – Summary Service Requirements** **Patient Group: -** 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.

Service Specification for all Care Homes in scope of the Service: -

- Initial Review of the patient undertaken to collect key information for all patients upon admission to a Care Home within 7 working days of being informed.

-an initial review to include a mental health assessment and a frailty screen.
-medication review.
-information gathering to develop a personalised care and support plan.

- Identify a Care Co-ordinator with the necessary skills and knowledge to co-ordinate the PCN MDT including collating the information required prior to the meeting, take notes at the meeting, and ensure actions are completed.
- Routine Management of Care Home Patients- (Management of Patients Care Plan, Issue repeat prescriptions, carry out medication reviews on a 6 monthly basis)
- Dementia Care- Where a patient is showing early signs of dementia, the service provider will follow the ICB Dementia Referral Pathway.
- 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), 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.

Enhanced Health in Care Homes National DES Summary requirements

The DES specification states that a "PCN must deliver an Enhanced Health in Care Homes service in accordance with the framework and guidance, including:

Every care home:
• is aligned to a 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 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).*

Q: Have beds been appropriately identified as being intermediate care, and what should practices do if they have intermediate care beds that are not identified as such?

A: This spec doesn't cover intermediate care beds. Where practices think they have intermediate care beds they should confirm this with the Urgent & Emergency Care team

Q: Do the initial reviews need to be F2F or can they be undertaken as a telephone review?

A: The initial review could be carried out remotely, but only where it is deemed clinically appropriate to do so. F2F or video reviews may allow for more meaningful discussions around priorities and planning.

Q: Will SMR's have a de-prescribing focus using a tool such as Medstopper, PresQipp or Stoppstart? Can there be a focus on social prescribing for these patients as often medication is used when activity or access to nature would be more beneficial.
A: SMRs should address the needs of the patient and focus on what is important to the individual. Deprescribing may be appropriate to reduce the risk of harm to the patient, the SMR element of the medicines optimisation specification can be used here for guidance. Social prescribing and other activity may well be helpful to reduce the need for medication, and where these services are available then practices are encouraged to use them.
Q: Concern regarding the fair share and allocation of patients across the PCN. Currently lack of consistent support from the Care Home Support team. We are a small surgery competing with the demand for community resource with two much larger surgeries. How can workload and support be allocated fairly?
A: This is being reviewed & will be picked up as part of the delivery plan, where similar specifications have been in place across the ICB, there is learning that we share to support practices to manage the resource they have available.
Q: I notice that this LES mentions that Primary Care must provide adequate staffing at all times. What does this mean?
A: Practices should ensure adequate staffing to provide services. Periods of leave and any sickness/absence should be managed as per your Business Continuity Plan. There must be a reasonable attempt to ensure cover and plan for upcoming leave.
Q: Will meeting the QOF Standards in care home patients be linked to a "what Matters to you" approach?
A: Clinical decision making is paramount in ensuring that patients have the care and support needed to meet their needs. It is recognised that QOF standards may not always be appropriate e.g. palliative patients and practices are encouraged to take a personalised approach to patient care.
Q: Where do we find the ICB dementia referral pathway?
A: Where a patient is showing early signs of dementia, the service provider should use their local referral pathway and guidance to refer patients appropriately.
Q. Consent for EPACCS etc - please be aware that some patients and families do decline consent for information sharing for various reasons. The LES needs to take account of that please.
A: Care Home LES updated to incorporate if patients and families decline, and that consent is required for the Palliative Care Records to be shared. Patients and families can also withdraw consent at any time the Care records will be updated, and access will be restricted.
Q: What is our obligation to temporary residents?
A: Where a patient is admitted to a care home on a temporary basis, the provisions of this DES do not apply, and the patient may remain registered with their usual practice. The standard GMS guidance on temporary resident care will continue to apply
Q: Does the SMR need to have been completed since the start of April, or is it annually? I.e. as long as the patient has had an SMR in the last 12 months?
A: No, the SMR doesn't have to have been completed from April, as long as the patient has had an SMR in the last 12 months.

In line with the Care Home service specification it advises *"Carry out a medication review or structured medication review for all patients on a six- monthly basis by a Clinician or Pharmacist"*. SMRs should address the needs of the patient and focus on what is important to the individual.
Q: Is there a way of seeing the baseline searches?
A: Yes the baseline searches, will be extracted with a date of 1 Apr 25 and then this baseline data will be added to the BI spreadsheet.
Q: It says to be completed within 7 days of going into a care home, but sometimes it takes time to get registered, so this is not always possible.
A: You need to work within the Service Specification as much as possible if there are exceptions were this is not feasible to undertake the review within 7 days then could there be an option to record the reason why it was not completed within 7 days? I understand this could be that the resident has had to register with a new GP aligned to the Care Home
Q: Is it two structured medication reviews or one meds review and one structured?
A: The specification states carry out a medication review or structured medication review for all patients on a six- monthly basis by a Clinician or Pharmacist. It is flexible depending on what the Clinician or Pharmacist want to do in terms of meeting the service spec and the patient's needs. I would advise one meds review and one structured which captures both. SMRs should address the needs of the patient and focus on what is important to the individual.
Q: What do you consider to be psychosocial assessments?
A: The assessment which make up the term psychosocial assessment in terms of care home patients is a full holistic assessment which includes and assessment for depression and dementia. By using the ML DQ ICB Enhanced Care Home LES template, will ensure you are capturing all of the information required. There is a box on the dementia screening page that you car tick to say a psychosocial assessment has been completed.
Q: Can you adapt the search for patients who are no longer living in care home ? We have used no longer living in care home SNoMed code and it doesn't take them off the care home list?
A: To remove a patient from the care home resident list, the patient's residential status should be changed in EMIS, to reflect their living status, such as lives in own home, lives in sheltered accommodation, lives with relative etc. This was how it was specified in the rules of the DES.