NHS
Doncaster
Clinical Commissioning Group

Service Specification: **COVID-19 Response - Primary Care Support to Care Home Residents** (Temporary realignment of Proactive Care Service)	
Period:	1st June 2020 – 31st August 2020
Date of Review:	Subject to Ongoing review and adjustment as the situation develops (suggested review point 31.7.20)
Version Control:	V4.0

Introduction:

In March 2020 the proactive care requirements were suspended until at least the end of June 2020 to enable practices to enact their COVID-19 response. The CCG has confirmed that it will continue to fund the practices for proactive care during this period based upon the 2019/20 proactive care specification.

This appropriately resulted in the updated 2020/21 specification, approved at March's Primary Care Commissioning Committee and due to begin on 1st April 2020, not being implemented by practices and PCNs. Despite the suspension of the formal Proactive Care service in this period, proactive care has continued incorporating many of the asks relating to the COVID-19 guidance such as appropriate advanced care planning, proactive support to care homes, identification and support to shielded patients, primarily through telephone and video consultations.

Many practices' Proactive Care registers contain significant care home patient cohorts and there has been significant work carried out by practices over the years and in recent weeks to support these patients. The '**Primary care and community health support care home residents**' letter from NHSE dated the 1st May 2020 advises that 'care homes are reporting that the COVID-19 pandemic is posing a significant challenge' and calls for further immediate assistance through Local Resilience Forums and sets out the clinical service model required.

Through conversations and work including the CCG, LMC, PCD and the PCN Clinical directors it is recognised that much of the service model asked for is above & beyond that of the General Medical Services contract. With the understanding that the funding for the Enhanced Health in Care Homes Service Requirements of the Network Contract DES will not come in to effect until the 1st August 2020 it has been jointly agreed to use the Proactive Care Contract as an emergency vehicle to support the Care Home service model in a direct response to COVID-19 for the next 3 months. This specification sets out the requirements for practices/PCNs for this time period and provides the expectation that the resource funded through the Proactive Care contract should temporarily be prioritised to meeting the needs of this revised specification.

The intention is that when the national DES funding goes live we will phase back to the 19/20 Proactive Care model. Further information will be forthcoming in the coming weeks but it is recognised that this does pose significant challenges and as such the reporting and feedback requirements will be taken into account.

It should be noted that there is a significant caveat to all of this work dependent on the ongoing COVID-19 response/requirement and further

national guidance within this area. **Any changes to national guidance or increased COVID-19 pressures (e.g. second peak) may necessitate a change in process/delivery.** There is also an expectation that delivery of this service model will provide a stepping stone to full delivery of the Enhanced Health in Care Home service in accordance with the Network Contract DES specification for 20/21.

The CCG is working with all care homes to understand their digital/I.T baselines before facilitating the introduction of new equipment/technology rapidly to help facilitate virtual approaches (e.g. virtual ward rounds and video consultations).

This service realignment is mandatory and all practices wishing to continue to participate in and receive funding for proactive care for 20/21 must sign up to deliver this service (see caveats for exceptional circumstances described in the eligibility section). Any practices who choose not to deliver MUST notify the CCG as soon as possible, this would result in payments to the practice ceasing and funding being reinvested to the appropriate practice or PCN to ensure the specification requirements are met for Doncaster care homes.

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**	**x**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	**x**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

Local defined outcomes

Effective delivery of the service is expected to lead to:

- Equitable offer of proactive care and support to all CQC registered and other care homes across Doncaster in relation to the COVID-19 response
- A single point of contact for all care homes across Doncaster and identification of a named clinical lead
- Provide a solid foundation for Practices & care homes before the commencement of the Enhanced Health in Care Homes Service through the Network Contract DES

Scope:

For the purpose of this service specification a care home is defined as a CQC-registered care home service, with or without nursing. This includes:

- Nursing Homes

- Convalescent homes with and without nursing
- Respite Care with and without nursing
- Mental Health Crisis Houses with and without nursing
- Residential care homes
- Therapeutic communities
- Specialist college services

However practices/PCNs should include non CQC registered homes already identified to practices within the scope of this specification.

Aims and objectives of the service

The Primary care and community health support care home residents letter from NHSE dated the 1st May 2020 Sets the key outcomes as:

A. **Delivery of a consistent, weekly 'check in', to review patients identified as a clinical priority for assessment and care**

B. **Development and delivery of personalised care and support plans for care home residents**

C. **Provision of pharmacy and medication support to care homes**

D. **Identification of a named clinical lead for each CQC registered care home in Doncaster.**

Service Description/care pathway

<u>Clinical Leadership</u>
A clinical lead should be identified for each care home. Where more than one practice is providing care to the home they should agree who will provide this role. Ordinarily, but not exclusively, it is envisaged that clinical leadership will be provided by the practice with the most residents in that care home. However it is acceptable that one clinical lead be identified for the whole PCN.

The clinical lead will be responsible for the co-ordination of service provision as set out in this specification to care home residents and ensuring service delivery is aligned between primary care and the community service provider.

The clinical lead may be drawn from general practice or from the community services provider and can be a job share arrangement.

The clinical lead will provide clinical leadership for both primary care and community health services support to the care home

The clinical lead does not have to be a GP but must have the skills and competencies to deliver care in a multi-disciplinary setting

A clinical lead may be responsible for delivery of care in more than one care home within a PCN or locality.

Key responsibilities are to ensure that the elements of the service description below are carried out in a consistent and manageable way. Although it is envisaged that the residents usual GP practice will be providing care this needs to be co-ordinated to ensure for example that weekly check ins do not become a burden to care homes where residents are registered with more than one practice. The clinical lead should ensure that practices are supported to work together to deliver care to their registered patients in a care home setting including where practices from more than one PCN are supporting the same care home.

There is an expectation that care homes will be aligned to a single PCN during the three months of this service specification (see Transition to Enhanced Health in Care Homes Service below).

The clinical lead should also check or flag that the care home has access to the universal support offer available as part of the COVID-19 response and that primary care is part of the national offer and meets the care home needs.

The name of the clinical lead for all CQC registered care homes should be notified to the CCG by the commencement of this service on 1 June 2020.

a) **Delivery of a consistent, weekly 'check in', to review patients identified as a clinical priority for assessment and care. The weekly check in should:**

- be delivered – remotely wherever this is appropriate

- Facilitate the input of an MDT drawing on general practice and community services staff and expertise.

- review patients identified as a clinical priority for assessment, including but not limited to those with suspected or confirmed COVID-19 symptoms, in line with the protocols established in the primary care standard operating procedures and the community services standard operating procedures

- support the provision of care for those patients identified as a clinical priority

- Include medical oversight and input from a GP (with the frequency and form of that input determined by clinical judgement) where the clinical lead is not already a GP

- support the introduction and use of remote monitoring of COVID-19 patients where clinically indicated and

- be supplemented by more frequent contact with the care home where further needs are identified and this is indicated

b) **Development and delivery of personalised care and support plans for care home residents.** A process needs to be 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 and drawing on available guidance and templates (including from the Royal College of General Practitioners and the joint statement from the British Medical Association, Care Provider Alliance, Care Quality Commission, and Royal College of General Practitioners).

- Develop a care plan within 14 days of admission or readmission to the care home where this is practical

- Ensure that each resident has a valid care plan in place that meets their needs and the requirements of the COVID-19 response.

    - *Care planning should extend/complement existing health and social care plans already in place and should formulate the use of ReSPECT documentation. Copies should be left in the care homes or shared electronically via teams/NHS mail. The plans should give clear actions so that if the resident deteriorates, all health and social care staff understand the next steps*

c) Provision of pharmacy and medication support to care homes. 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 to care home residents and staff. This support should include:

- facilitating medication supply to care homes, including end of life medication

- delivering remote video or telephone structured medication reviews and telephone consultations to care home residents where this is appropriate

- reviews of new residents or those recently discharged from hospital

- Support to care homes with medication queries, and facilitating medicines needs with the wider healthcare system.

- **Practices are required to discuss their needs with the PCN by 1 June 2020 in order that additional support can be provided by the CCG over and above existing PCN pharmacist provision to support delivery of this service specification.**

d) Reporting requirements. A weekly sitrep must be completed by the CCG based upon the steps put in place by this specification. Assuming all care homes are covered by this specification; reporting would be by exception only and the CCG would confirm that the full requirements are in place/being met. Should there be any instances where elements of the specification are not in place there would be a requirement for practices to inform their nominated PCN Clinical Director to report back to the CCG to amend the weekly return

as appropriate.

Reporting for the proactive element of the specification is covered under the payment section of this specification.

The specific requirement to report the name of the clinical lead and identify medicines management support must be notified by the practice by the commencement of this service specification. Any changes to the clinical lead during the term of this specification must also be notified in a timely manner.

Transition to Enhanced Health in Care Homes Service (Network Contract DES 20/21)

Although the service delivery elements of the DES are delayed until 1 October 2020 payments commence on 1 August 2020 which will mean a one month overlap between the DES and this specification. This is to support practices and PCNs moving towards the requirements outlined by 31 July 2020 namely:

- All care homes aligned to a PCN
- A simple plan in place to describe how the Enhanced Health in Care Homes service requirements will operate in partnership – this should build on the MDT working and locality infrastructure in place to support the COVID-19 response
- Ensure care home residents are supported to register with a practice in the aligned PCN, subject to resident choice
- Identify a lead clinician with responsibility for the Enhanced Health in Care Homes service requirements for each of the PCNs aligned care homes

Eligibility & Signup

This specification is open to all 39 Doncaster GP practices and participation should be notified via the CCG primary care team (donccg.primarycare@nhs.net) no later than the **29th May 2020.** This information will be shared with the identified PCN clinical directors to help co-ordinate care/support as required.

In the event that practices currently participating in proactive care do not have care home patient numbers making up 2% of practice total list as of January 2020 they should discuss with their PCN Clinical Director:

- The provision of support for delivery of this specification across the PCN
- Provision of support to other vulnerable or shielded patients as part of the COVID-19 response
- Agree to continue to provide proactive care to the 2% most vulnerable on the registered practice list in accordance with the 2019/20 proactive care specification.

Any deviation from this specification should be discussed with the PCN and agreed with the CCG prior to commencement of the service to ensure payment is not

affected.

Payment:

Payment for this service is a continuation of the ongoing Proactive Care payment. Which is as below:

The first is an "aspiration" payment paid in equal monthly instalments through the year. This is equivalent to £171 per Proactive Care register patient per year, with this payment capped to 2% of January 2020's raw list size for each practice. This is also equivalent to £3.42 per patient on the January 2020 list size.

A second "achievement" payment equivalent to £73.08 per Proactive Care register patient per year (also capped to 2% of January 2020's raw list size, equivalent to £1.46 per patient on the January 2020 list size*)* will be made at the end of the financial year subject to the practice achieving all of the following:

- Participation in this COVID-19 response to supporting care homes and proactive care specifications for the remainder of the 2020/21 financial year (subject to any agreed changes with the LMC, PCN Clinical Directors and the CCG)

- Compliance with the revised proactive care specification requirements when phased back in based upon the revised 2019/20 specification (a full specification will be provided) including:

    a. Confirmation of meeting the gateway criteria (shared in advance of move back to proactive care)

    b. Proactive Care register of at least 2% of the January 2020 list size (assessment through spot checks by Data Quality Team)

    c. Completion of Proactive Care Evaluation (deadline and further details to be determined)

- Compliance with the 2019/20 Proactive Care specification from the 1st September 2020

NOTE: The CCG has agreed to the continuation of the 2019/20 Proactive Care specification from the 1st September 2020 until the 31st March 2021. It is recognised that the current pressures and the switching between specifications will be time consuming and difficult for practices and is not underestimated, therefore the CCG have agreed that ALL reporting for the Proactive Care element will cease with the exception of the below:

a. ALL practices confirm that they are meeting a new gateway criteria for proactive care (as per appendix 1 below) by the 1st October 2020 – A digital version of the form below will be shared with practices.

b. ALL practices must submit a written evaluation by the 26th February 2021 relating to their experiences of proactive care over the last 3 years including

as a minimum:

- What has worked well (patient & practice perspectives)
- What has not worked well
- What have been the barriers
- What changes would you make given the opportunity

c. ALL practices have at least a 2% Proactive care register based upon January 2020 list size when audited by the Data Quality team (based upon the return to the mainstream proactive care specification)

- End of Quarter 3 - 4th January 2021
- End of Quarter 4 - 5th April 2021

NOTE: Practices are reminded that this is a MUST and that the 2% requirement remains an absolute minimum and each practice MUST demonstrate that they have maintained at least 2% at the given dates

Practices who have not taken part in all elements throughout the year (Care Home & Proactive Care) will result in payments being prorated per service actually delivered

Appendix 1 – Gateway Criteria

Proactive Care - Gateway Criteria:

The Primary Care Network/Group are practices are asked to confirm that ALL practices contained within are engaging with the following work areas as part of the gateway criteria for delivering Proactive Care 2020/21. PCNs/Groups of practices will only be required to complete this once at the beginning of the year. The CCG will monitor engagement throughout the year and will discuss with the identified leads where non compliance is evidenced.

PCN/Group of Practices Name: *

	Yes/No
1. The practice are engaging with and using the National Reporting Learning System (NRLS).	*
2. The practice are engaging are using and/or promoting to patients Electronic Prescribing (EPS)	*
3. The practice are actively using Optimise RX	*
4. The practice are engaging are using and/or promoting Patient Online Services	*
5. The practice are engaging are offering the online consultation "doctorlink" to 100% of their registered patients (This can be in either the connected or unconnected state)	*
6. The Practice are Engaging with and referring into the National Diabetes Prevention Programme (NDPP)	*
7. The Practice will co-operate with and give access to PMR systems to the CCG Medicines Management Team	*
8. All practices contained within the PCN/Group of practices have data sharing agreements in place between all participating practices and all partners/stakeholders that are/will be involved in the MDT meetings	*

Failure to comply with the above may result in the practice being in eligible to provide the Proactive Care service. If there are any areas where this is a potential issue practices are encouraged to speak with DCCG Primary Care Team in advance on **01302 566343**

As the identified lead for the practice I confirm that the practice meets the above gateway criteria for the provision of Proactive Care.

	Yes/No
Name:	

* Please complete all the required information below and submit this form to the CCG primary care inbox donccg.primarycare@nhs.net **ALL registrations should be completed and returned by 31/10/2020**