Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Care Homes LCS – Proposal from PCS

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Primary Care Commissioning Committee meeting

22 March 2018

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Purpose of Paper

To seek PCCC approval to the proposed change of contracting arrangements with a number of practices in relation to the current Care Home Locally Commissioned Service

Key Issues

Mixed views within practices in regard to the Care Home LCS. Some homes remain uncovered for non-core services. Practices have approached PCS for a solution. This will entail one practices taking full contractual responsibility for patients in the affected Care Homes

Is your report for Approval / Consideration / Noting

Approval

Recommendations / Action Required by the Primary Care Commissioning Committee

The Primary Care Commissioning Committee is asked to:

- discuss the content of this paper
- and approve the inter-practice transfer of patients under the current processes for care home patients to Heeley Green Surgery, subject to sufficient scale to enable PCS to provide a dedicated resource

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?

2. To improve the quality and equality of healthcare in Sheffield
4. To ensure there is a sustainable, affordable healthcare system in Sheffield.

Are there any Resource Implications (including Financial, Staffing etc)?

No additional resources required from the CCG

Have you carried out an Equality Impact Assessment and is it attached?

Please attach if completed. Please explain if not, why not

See relevant section in the paper

Have you involved patients, carers and the public in the preparation of the report?

See relevant section in the paper

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1. Introduction / Background

The Care Homes Locally Commissioned Service has been in place for a number of years in Sheffield. It was initially designed to resource practices to provide, as far as possible, full cover to individual homes and to develop care plans for each patient which would support them avoiding unnecessary hospital admissions.

There is a range of opinions within practices in regard to this LCS: Some practices are supportive of the approach and can see the overall benefit; others express concern around the opportunity cost of providing this service and have looked to serve notice on the LCS. When this happens neighbouring practices worry that they will be asked to take on responsibility for the effected patients. A small number of homes remain uncovered.

The attached proposal from Primary Care Sheffield (PCS) has been produced in response to approaches from a number of practices asking PCS to consider an alternative service model. The paper sets out the PCS proposed approach which has been shared and consulted upon with CCG colleagues. It seeks Committee's approval for the approach outlined therein.

2. Contractual Implications

Having one Primary Care provider assuming responsibility for patients within a Nursing Home is in line with that which the CCG has looked to support through the lifespan of the LCS, and colleagues in contracting have experience in facilitating lead practice arrangements.

The proposal from PCS entails the Heeley Green practice – for which PCS is the main contractor – taking full core and non-core GMS responsibility for the effected Care Home patients. We are advised by NHSE colleagues that, subject to patients being able to exercise choice, this is permissible. The proposal sets out how PCS intends to engage with patients, carers and the Nursing Homes once practices have finally confirmed their agreement to the approach (see attached appendices).

3. Action for Primary Care Commissioning Committee / Recommendations

The Primary Care Commissioning Committee is asked to:

- discuss the content of this paper;
- and approve the inter-practice transfer of patients under the current processes for care home patients to Heeley Green Surgery, subject to sufficient scale to enable PCS to provide a dedicated resource.

Paper prepared by: Katrina Cleary, Programme Director Primary Care

Date: 13/03/2018

1	**Executive Lead: Chris Kearton** **Lead Clinician (s): Dr Amin Goodarzi** **Lead Manager(s) : Nicola Simpson**
2	**Title of proposed service: PCS Care Home Service**
3	**Introduction and context**

This paper details a proposal received from Primary Care Sheffield, based on expressions of interest from 26 practices regarding the delivery of core, additional and extended General Medical Services, to up to 1248 of the city's care/nursing home patients (living in 34 homes). These practices are interested in transferring the patient registrations and the associated LCS, to PCS.
The proposal which is seeking Committee's approval is in response to increasing workload pressures in general practice and the potential opportunity to provide an 'at-scale' service to this cohort of frail elderly patients.
This proposal has the potential to include the 6 Care homes (212 patients) which are not currently receiving the LCS services.

4. History of the Nursing Home LCS

a. The LCS has been in place since 2008. It provides funding to practices (£220/200 per patient) to establish care plans for Care home residents, which should include how their medical and other needs are met, when to involve family/carers, and where appropriate, the patient's wishes in respect of End of Life Care.
b. The LCS is based on a business case which predicts the care planning process and ongoing monitoring will reduce unnecessary hospital admissions, improve prescribing and also enable patients to choose where they die – all key issues in relation to quality of care. Evidence to date is not specific, but Sheffield is not an outlier in terms of admissions from Homes, and feedback from patients and homes is generally favourable. There is also a service improvement element in terms of support to care home staff.
c. Currently, whilst patients retain choice in terms of GP registration, in almost all cases they are agreeing to transfer of care in order to receive the GP service linked to that residential unit – ie the scheme is supported in practice by patients and their families.
d. However, it has become more difficult to persuade practices to take on the LCS contract - and indeed to accept care home patients on their list – because of rising demand on practice resources. Many Practices are struggling to manage the demand from this cohort of generally frail and ill patients. There are now 6 homes without an LCS service and a significant number of practices are considering giving notice on their existing LCS contracts.
e. PCS currently provides the LCS to its GMS/APMS patients at Care Homes registered with Clover and Heeley Green practices, as well as LCS care to patients at Broomcroft, Glen and Chatsworth Grange – we thus have extensive relevant experience.
f. Through its position as a provider of GMS services at Heeley Green Surgery, PCS could develop a larger scale approach to this service. By taking on a number of Care Home contracts, PCS could support primary care in ensuring equity of service and relieve some of the demand pressures on practices.

5. The Proposed Approach

PCS is the contractor responsible for GMS services at Heeley Green Surgery (included within the remit of the Collaboration agreement with SHSCFT). The practice has a Good CQC rating (2017), a list size of 5700 patients and a workforce of 18, led by 5 GP's. It is also a training practice. This proposal is being made by PCS from its position as an independent contractor, a holder of a GMS contract – ie in its capacity as one of 80 GP providers in the city.

a. Practices wishing to do so would, subject to patient consent, transfer the registrations of current Care/Nursing home patients to Heeley Green for the provision of GMS and LCS care.
b. PCS would meet the needs of these patients by creating a dedicated multi-disciplinary team

which would provide all GMS and LCS care. The resources to do so would require a minimum of 1000 patients and the proposal could only proceed if this number were agreed.

c. The team would comprise;

2 x 0.5 GP's as clinical leads. Acute and routine visits, CDM management, care plan leads, team oversight/support
2 x 0.5 Nurse Practitioner (prescriber). Acute visits, care planning, CDM.
1 x Advanced Nurse Practitioner. As above.
0.6 x Clinical Pharmacist; would cover the patients' TTO's and medication reviews.
0.6 x Healthcare Assistant; obtain samples, observations and tests. Assist with care plans.
Other clinical and support staff would be incorporated through partnership working with other providers.
Management & Admin – to assist in the smooth running of the LCS, making sure that all objectives & deadlines are met. In addition they will ensure MDT meetings are supported and ensure quarterly meetings between the clinicians and the care home staff/managers.

d. PCS would also aim to establish telephone response and acute visit capacity at our GPAF hubs outside core hours, in order to reduce demand on A/E and to reduce avoidable admissions.
e. We will also look to incorporate digital innovations currently being piloted in care homes under the Test Bed programme.

The evidence base from Rushcliffe http://www.rushcliffeccg.nhs.uk/principia-mcp-vanguard/ and elsewhere strongly supports the business case for a robust enhanced primary care service for patients in residential care, linked to freeing up resources by reducing non-elective admissions.

6. The Remit of this Proposal

This proposal seeks approval for practices to enter into discussions with PCS (Heeley Green Surgery) regarding the potential transfer of their Care Home patients. Where both practices agree, a transfer plan will be agreed with NHS Sheffield.
NHS Sheffield will agree a process for the registration of patients living at Care Homes which are not currently receiving LCS services to be transferred to Heeley Green Surgery.
Heeley Green will accept transfers on the same basis as any other practice in terms of processes of re-allocation should the LCS be discontinued or if the terms and conditions of the LCS are altered to the extent PCS feels delivery is no longer sustainable.

7. How will this be achieved?

PCS would agree with practices and NHS Sheffield a phased implementation, on a geographical basis, for care home patients to be registered at Heeley Green Surgery, and PCS would agree the LCS contract for the homes in which they live – this would require practices to relinquish registrations if they wish to also cease providing the LCS contracts.

PCS would provide advocacy support from a 3rd party for any patient who wished to consider retaining their current practice registration (and foregoing LCS provision). NB current practice is automatic notice to change GP where the unit is not in the catchment of their current practice, so this would be an enhancement of patient choice. If a patient refuses to re-register, the current practice would have to retain GMS duties, but PCS could provide the LCS service). Carers, patients and homes affected will be consulted through meetings and a range of other communications with PCS.

A cohort of at least 1000 registered patients will enable the economies of scale to be realised, including the creation of a dedicated multi-disciplinary team (staff including GP, Nurse, ECP, pharmacist, HCA) which is able to respond across core hours in order to manage both the LCS and core contract demand. PCS believes it is not in the interests of the patient to have the LCS provided separately from core primary care. By combining the funding for both the LCS and practice registration, a dedicated team can be recruited.

By registering all the patients at one site, access to the clinical record and management of prescribing and QOF etc will be simplified.

The LCS requires;

1. A dedicated team, led by a GP.
2. Post-admission review by a GP to assess and plan medical care and treatment.
3. Agree a Care Plan with the patient and/or their family/carers. (clinician not specified)
4. Weekly visits to each home to provide routine monitoring of the Care Plan.
5. Support the care home staff in using the care plan, avoiding
6. Review medication every 6 months. – NB CCG Meds mgt current capacity (do the sums re hours per 100 pts)
7. Review post-hospital admission.
8. NB – payment is per bed, not per patient, but input is per patient. Estimated 20-25% annual turnover in care home beds.

PCS Model

1. Minimum 1000 care/nursing home patients registered with PCS practice. This will enable a dedicated team to provide routine, acute and LCS primary care across core hours.
2. The team will be led by GP's and will include Nurses, Pharmacists, HCA's, and admin/management support.
3. The Care Plan process will be comprehensive and inclusive of care staff and family. The document will be a live point of reference, jointly owned and accessible to all parties (including out of hours services). Great emphasis will be placed upon admission avoidance and End of Life Care as appropriate, but other key areas include medication review, BP, bladder & bowel function, dementia assessment, any social needs, DOLS assessment and DNACPR.
4. Care Home staff will be supported in becoming more confident in managing those conditions which an independent person would be able to deal with, and in supporting families if they become anxious about their loved one.
5. IT will be a key element of the model, eg, PCS will also look to establish Digital health services to enable Care Home staff to relay health readings to the clinical team.
6. Close working with community services, based on the assessed needs and outcomes identified in the Care Plan, will maximize the effectiveness of these resources. NB – this includes palliative care services.
7. Acute care will always be given priority. Triage by staff who know the patients involved will enable surges in demand to be managed – our experience predicts a maximum of 100 visit requests in a single day, and we will ensure we are able to visit 30% on the day, in the belief that the majority of requests can be managed by other means (this equates to 10 visits per GP/ANP).
8. LCS provision will be weighted over the summer months in order to reserve capacity for increased acute demand over winter.

5. Equality impact assessment

- This proposal concerns the care of a highly vulnerable patient cohort, often with no or marginal capacity to make their own decisions.
- PCS will ensure capacity is carefully assessed and recorded in order to ensure advocacy is in place where needed. This will usually involve active engagement with family members in order to ensure patients' wishes are respected.
- PCS will work with CCG Patient Engagement services to ensure communications regarding the service are accessible and effectively targeted.
- there is compelling evidence that clinical practice benefits from a degree of specialisation (eg specialist nurse services) and the creation of a dedicated MDT to provide the service will, we believe, enhance service quality.
- our team will also focus on supporting quality within the care homes, producing and maintaining care plans which are patient-led and developing efficient and effective systems for meeting acute need.

6. Risk assessment

- The funding level for the LCS is seen as barely sustainable by many practices and the service can only be provided by the efficient use of an MDT approach which focusses medical resources to maximum effect.

- Many Care Homes make very high demands on practice resources, having a low threshold for requesting acute visits. However, many practices have demonstrated that training and support can achieve significant improvement in a unit's ability to manage health needs.
- Acute medical needs will require careful management, using triage and Nurse Practitioner staff unless specific medical input is clearly indicated.
- Recruitment and retention of staff at sustainable rates of pay will require careful planning and management.
- Some patients/carers will be reluctant to change GP, which could disrupt provision.
- Should the LCS be de-commissioned, a significant number of registrations would require re-allocation (this is already the case).

7. Implementation timetable :

- Having secured sufficient interest in principle from practices and the CCG, and subject to in principle approval of PCS Board;
- submit business case to the CCG for approval at PCCC on 22.3.18.
- discuss any other implications for practices and patients with LMC colleagues.
- 19.4.18 confirm viability in terms of firm commitments from practices and patients.
- 20 week phased transfer of contracts and staff recruitment – complete service in place by 1.10.18.

8.Delivery model

Key: GP – GP
N – Nurse
h – Home

Wk1	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**
AM1	Meeting/Paperwork			Meeting/Paperwork	Meeting/Paperwork	Meeting/Paperwork
	Meeting/Paperwork				
AM2	GPh1	Nh16	GPh4	Nh19	GPh7	Nh22	GPh10	Nh25	GPh13	Nh28
PM1	GPh2	Nh17	GPh5	Nh20	GPh8	Nh23	GPh11	Nh26	GPh14	Nh29
PM2	GPh3	Nh18	GPh6	Nh21	GPh9	Nh24	GPh12	Nh27	GPh15	Nh30

WK2	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**
AM1	Meeting/Paperwork			Meeting/Paperwork	Meeting/Paperwork	Meeting/Paperwork
	Meeting/Paperwork				
AM2	GPh16	Nh1	GPh19	Nh4	GPh22	Nh7	GPh25	Nh10	GPh28	Nh13
PM1	GPh17	Nh12	GPh20	Nh5	GPh23	Nh8	GPh26	Nh11	GPh29	Nh14
PM2	GPh18	Nh3	GPh21	Nh6	GPh24	Nh9	GPh27	Nh12	GPh30	Nh15

1000 patients, in 30 homes; 30-35 patients in each home
March-Oct:
Focus on care plans; 30 patients reviewed per week for 34 weeks
2 patients per home, GP visits 3 homes per day.
Reviews take an hour each at most; 1.5-2 hours.
Routine visits 0.5-1 hour; 2-2.5(maximum) hours at each home for the GP (to cover reviews and acute care).
To cover 30 homes per week, 3 to be visited per session; GP/NP visit 2 each per session.
Therefore 20 clinician sessions pw needed, a mix of NP and GP.

Each home has a weekly GP visit to complete reviews and a weekly ANP visit to manage acute need.
The NP also responds to other on the day needs.
10 GP sessions pw; 8-10am, GP and NP triage acute requests.
The GP then attends homes to complete care plan reviews, unless acute medical need identified.
The ANP completes acute visits.
The GP and ANP will continue to triage whilst on visits if needed.

9. Recommendation

The committee is asked to discuss the content of this paper and approve the inter-practice transfer of patients under the current processes for care home patients to Heeley Green Surgery. This is the first step of an approval process that would then require significant practices to provide the scale and the approval of Primary Care Sheffield and Sheffield Health and Social Care Boards under the Clover Partnership.

To confirm Heeley Green Surgery will be subject to the same terms as any other practice in relation to the processes for giving notice on the LCS.

Appendix

1. Original email to practices, to request expressions of interest.

Background

As practices will be aware the Care Homes LCS has been in place since 2010. It provides funding to practices (£220/£200 per patient dependent on the type of home) to establish care plans for Care home residents (residential and nursing often with complex medical needs), which include how their medical and other needs are met, when to involve family/carers, and where appropriate, the patient's wishes in respect of End of Life Care. The LCS is based on a business case which predicts the care planning process and ongoing monitoring will reduce unnecessary hospital admissions and also enable patients to choose where they die.

Influencing factors

PCS is aware that :

- there are a number of Care Homes whose residents are not receiving the LCS service because practices feel it is not possible to meet the contract terms within the contract value.
- due to rising demand on practice resources, many practices report difficulty managing the needs of this cohort of generally frail and ill patients.
- as a result of the above, a significant number of practices may be considering giving notice on their existing LCS contracts.

Proposal

Following conversations with the CCG, Locality managers and clinicians, PCS has now developed a draft proposal which enables a larger scale model for this service to be delivered within the current financial envelope.

PCS would need a minimum number of units/patients in order to achieve economies of scale - currently estimated at 1000 patients. There are approximately 3,700 Care Home residents in the city.

This would require those practices which wished to do so, to relinquish both the patient registrations (and the associated core funding) and the LCS Care Home contracts. Patients would be registered at a PCS/SHSCFT practice, with a specific multi-disciplinary team created to provide their primary care.

We must stress at the moment this is an outline proposal, based on feedback we have received. PCS would only consider pursuing the model if sufficient practices expressed a wish for us to do so.

We appreciate this would be a new way of working, but PCS are committed to supporting practices and their patients by delivering services in order to ensure investment stays within primary care.

Next steps

We appreciate that there are a number of issues still to be worked through, including patient choice, but our discussions with the CCG suggest there is merit in seeking indicative interest at this point.

We need now to ascertain if there is sufficient interest in this the proposal (ie for practices which no longer wish to provide services for care home residents to transfer their registrations and the associated LCS to PCS) and specifically if your practice would want to consider the proposed PCS model?

If you are prepared to give a clear YES or NO to your practice being interested in the proposal then please confirm this by return of this email

If you would like more information, or would like to discuss this proposal further again please let us know by return of this e-mail.

We must stress that at this point we have not progressed beyond initial discussions with the commissioners, and cannot therefore make a firm offer to practices.

Please be assured a yes/no at this stage is purely indicative and not in any way binding.

Many thanks

Chris Kearton
Director of Primary Care Sheffield
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www.primarycaresheffield.org.uk

2. Proposed email to practices subject to PCCC approval;

Update – Care Homes LCS

Thank you for your expression of interest in a PCS model for services to care home residents, which we have developed at practices' request.
We have continued to discuss this proposal with CCG colleagues and are submitting a proposal for consideration by the Primary Care Commissioning Committee on 22nd March, subject to which we would then seek practices' commitment to the transfers and if there is sufficient demand, the project would proceed.

We are keen to establish what if any assurances you would seek from PCS should you decide to transfer Care Homes patients' registrations.
Some of the issues are;

In terms of patient care, PCS would obviously be bound by the terms of GMS/PMS and any associated LCS/LES service specifications and contractual requirements. We will prepare details of how we will meet these, in order to satisfy practices that patient care is assured.

The issue of patient choice could present issues, with some patients and/or families reluctant to lose established clinical relationships – this could put your practice under pressure, so we anticipate developing written information for patients/carers, and to offer PCS input to address any queries or concerns.

Individual care homes may also have concerns and PCS would again prepare information for this purpose and provide staff to support their engagement in the transfer processes.

Practices would need to be assured they have fully assessed the impact of the transfer, not only in terms of capacity freed up and how that would be used, but also the impact on practice income.
We cannot give you an accurate figure for the income you will lose by giving up the LCS, however you should note that it extends beyond the LCS payment itself and also encompasses:

- The Global Sum is affected by 6 weighting indices; this includes number of patients in nursing homes

so you could see a slight reduction in your weighted list.

- The average income per patient, including QOF and enhanced services, was £151.37 in 2016-17; the loss of patients from your register also affects your disease prevalence which can affect your other QOF sums.
- The Care/Nursing Home LCS pays £200/220 pa per patient
- There are other associated income sources such as varied Enhanced Services which can be affected by the loss of these patients.

Whilst the potential income is not inconsiderable, income is different from profit and many of our shareholders clearly feel they are spending significantly more providing the service than they receive in income.

Your partnerships are best placed to make this decision, but we want you to be fully informed when you do so.

We would be grateful if you could now give the above matters your consideration and let us know if you would like to discuss further or please confirm you remain inclined in principle to transfer Care Homes registrations to PCS, subject to CCG approval.

Please let myself and/or your locality Directors know if you would like to discuss specific issues.

Many thanks

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