# **SCHEDULE 2 A** Service Specifications

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| **Service Specification No.** | 01 |
| **Service** | Local Commissioned Service for Care Homes |
| **Commissioner Lead** | Sarah Burt – Head of Commissioning<br>Dr Andrew McGinty, GP and Clinical Lead |
| **Provider Lead** | This service is provided by individual GP practices |
| **Period** | 1st April 2019 -31st March 2020 |
| **Date of Review** | 15th December 2016 – ongoing |

## 1. Population Needs

1.1 The scheme is designed so that residents in residential and nursing homes are given extra primary care to meet their needs. Most of this care is already provided under the GMS/PMS contract, including QOF.

1.2 20% of residents in homes will die very soon after admission to the home but thereafter life expectancy rates improve before falling again. For people aged 85 and over, the average length of stay is 717 days for women and 452 days for men. Age, sex, condition and bed-type significantly affect LOS. For every year residents are older than 85 on admission to the home, their estimated LOS is around 35 days less than the average. Men are estimated to live for about half the average LOS of women. People with dementia live on average 127 days less. People in nursing beds lived around 200 days less than people in residential beds.[1]

1.3 There were 1,894 hospital admissions from Sheffield homes in 2011/12, involving 1,365 people, and accounting for just **3.5%** of emergency admissions that year. While residents in homes are not over-represented in those experiencing emergency admission, analysis of the causes of admission offers insight into aspects of care quality. Over half of admissions were accounted for by three broad primary or secondary causes:

- Respiratory problems (23%)
- Signs & symptoms, for example faints, pains etc (17%)
- Falls (13%)[2]
- Dementia was also found to be a contributory factor in likelihood of admission

1.4 Of the people admitted, 9 in 10 also had a chronic '*ambulatory care sensitive'* (ACS) condition as either a primary or contributory cause of admission. Chronic ACS conditions are a particular set of long term conditions that are amenable to interventions that can significantly reduce the risk of emergency hospital admission.[2] Whilst not a predominant primary cause of admission, ACS are substantially contributory to admission. Dementia is by far the predominant condition in this cohort, accounting a quarter of recorded instances of chronic conditions, although heart disease as a group (CHD + heart failure + arrhythmias) accounted for a third of recorded chronic conditions; then comes diabetes (11%) followed by COPD (9%). The remaining chronic conditions were minor contributors to admission from care homes.[3]

[1] Julien Forder and Jose-Luis Fernandez, Length of Stay In Care Homes, PSSRU Discussion Paper 2769, Jan 2011. www.pssru.ac.uk

[2] There were no admissions with 'fall' as a primary cause. The recorded primary cause would reflect the outcome of assessment on admission and, for example, would be recorded as an injury or fracture (under injury & poisoning) or pain, dizziness etc. (under signs & symptoms).

## 2. Outcomes

**2.1 NHS Outcomes Framework Domains & Indicators**

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|---|---|---|
| **Domain 1** | **Preventing people from dying prematurely** | **X** |
| **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** | **X** |
| **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** | **X** |

**2.2 Reduced inappropriate hospital admission.**

**2.3 Improved GMS/PMS care for resident in care homes**

**2.4 Improved end of life care and a higher proportion of residents dying in their preferred place.**

## 3. Scope

**3.1 Aims and objectives of service**

The aim is to improve access to NHS services by funding additional general medical services to residential and nursing homes in Sheffield where populations of the most vulnerable and medically complex housebound residents are concentrated.

The objectives are:-

- to provide a 1 GP: 1 home care model as the best way to provide high quality care. Larger homes of more than 40 beds can be shared by, for example, providing 1 GP: 1 floor or wing. Pro-active management of residents is essential.

- to ensure that robust and personalised care plans are developed for every resident and that home staff and other NHS staff work to these.

Details of individual care homes bed numbers and GP Practices can be found at:

http://www.sheffieldccgportal.co.uk/pressv2/index.php/information-for-clinicians/item/surgeries-providing-care-homes-lcs-cover

**3.2 Service description/care pathway**

Requirements for the LCS are as follows.

**Computer entries**

All residents under the LCS should have a Read code entry that identifies them as such. This includes Temporary Residents.

**Weekly visits**

It is reasonable for the practice to provide GMS/PMS care while the GP is on leave, providing that the named LCS GP consistently covers at least 46/52 weeks a year.

The GP should visit the home weekly at a pre-arranged day and time agreed with the home, to routinely review the residents. The GP should also arrange for specialists to periodically join these visits to review care across the home population as clinically appropriate, e.g. Community Psychogeriatricians.

[3] Chronic ACS: CHD, Heart failure, Cardiac arrhythmias (such as atrial fibrillation), Asthma, COPD, Dementia, Diabetes, Hypertension, Anaemia, Seizures, Hepatitis

**Initial and Annual Reviews**

All residents should be initially assessed by the GP as soon as possible following admission to the home, and an initial care plan developed within two weeks. It is accepted that a full care plan may take longer as it will require discussion with the patient / carers / staff over time. A full care plan must be in place as soon as possible given the need to talk to the resident, family and care staff and definitely within 8 weeks of admission. If a patient is very ill and frail the full care plan must be in place within 2 weeks of admission.

For the initial and the annual review, the GP should ask care staff to undertake a review beforehand to provide the GP with an initial assessment of need and highlight matters they want to draw to the GP's attention.

The GP review should, in partnership with care home staff, include:

- Medication – are all medications still needed, are any blood tests needed to monitor medications, are medications contributing to falls, does the resident have disabling postural hypotension, is the dosage appropriate bearing in mind age and renal function
- Nutrition and hydration status including initial weight
- A check that a pressure area risk assessment has been done
- A check of bladder and bowel function
- Falls risk and appropriate actions to reduce risk
- Mental health assessment e.g. depression, anxiety, dementia.
- Assessment to assure optimum function, with particular attention to case-finding and management of respiratory problems and heart disease.
- Assessment of social needs
- Implications for DOLS (Deprivation of Liberty Safeguards)
- DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) if in place should be reviewed and if not in place should be considered

**Care Plans**

**The initial care plan** should include the diagnosis and what to do when a resident is unwell. This should be a clear plan that allows staff to decide whether or not to call a GP and enables an Out of Hours GP to make a decision about whether to admit the patient or not.

**The full care plan** should include consideration of all points as in the care planning template (to be provided) and completion of all the sections which are relevant.

For practices using Emis (or for SystmOne practices not using the Care Homes Template) a paper copy of all relevant plans should be kept in the home at the front of the resident's care home plan, In addition an electronic copy of the medical/EOLC plan should be scanned into the clinical record.

The plan should be developed after discussion with the resident, if they have capacity, the key worker and if the patient gives permission or if the patient is not able to discuss the plan with any family or carer. The plan should be discussed with all relevant care staff.

The plans should be reviewed annually or more frequently if the resident's condition changes. Special notes should be forwarded to the OOH provider.

**Acute admission reviews**

After each admission the GP must review the care plan in partnership with staff at the home to assess what changes need to be made, and must record the review and any agreed action plan on the care plan.

**Medication review meetings**

The GP should review the medication when the resident is admitted and at least every six months, and should bring in other health professionals as needed.

**Palliative Care**

An End of Life Care Plan and DNACPR should be discussed with each resident, unless the resident is unwilling to do so, or is unable to do so. Where there is cognitive impairment, the EOLC plan and DNACPR should be discussed with the family.

The plan should take into account the wishes of the resident regarding the place of death and physical care, social, cultural and spiritual needs and should be reviewed at least on a six monthly basis. Special notes should be sent to OOH. Advice should be sought from specialist palliative care staff or other relevant staff if appropriate and consideration should be given to pre-emptive prescribing and the practical implementation of the resident's wishes when the time comes.

In accordance with One Chance to get it Right [4]When it is thought that a resident may die within the next few days or hours the GP should work with care home staff, district nurses and specialist palliative care staff where necessary to ensure the following standards are met as far as possible:

1. this possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
3. the dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. the needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
5. an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.

### 3.3 Population covered

All residents in care homes for frail elderly including temporary residents.

Please note: The LCS provider should make no distinction in the care provided to Temporary Residents. However it is expected that at 3 months it is reasonable for the Temporary Resident to be registered permanently with the LCS provider, even if plans are still on-going to transfer the resident to another home.

There may be circumstances when it is appropriate for the GP to liaise with the residents own practice.

### 3.4 Any acceptance and exclusion criteria and thresholds

Residents may choose not to register with the LCS provider.

### 3.5 Interdependence with other services/providers

The GP will engage as appropriate with other health and social care providers and will refer on to other healthcare services as needed.

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### 3.6 Arrangements if Providers wish to withdraw from provision of the service

Providers will need to give six months' notice if they wish to withdraw from the service to give sufficient time for the commissioner to negotiate an alternative service, since this will impact on primary care in the local area. Providers wishing to withdraw from continuing to provide the LCS care homes service will still have a duty to provide GMS/PMS to all residents registered with their practice.

## 4. Applicable Service Standards

### 4.1 Applicable national standards (eg NICE)

[4] Leadership Alliance for the Care of Dying People June 2014 Gateway reference 01509

**4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**

**4.3 Applicable local standards**

All long term condition management should be consistent with local pathways and policies.

## Schedule 2 B Indicative Activity Plan

Providers are expected to visit the home on a weekly basis with a minimum of 46 visits conducted per year, with a GP service for 52 weeks a year. Every resident is expected to have a full care plan developed within at most 8 weeks of admission and which is reviewed at least every 12 months. Payments will be reduced if providers do not meet these requirements – see Schedule 3 A Non Tariff Prices.

## Schedule 2 K Transfer of and Discharge from care protocols

The Key risk to be managed is that residents in the home are not left without a GP.

The assumption among GP practices will be that residents in homes will receive their care from the LCS provider. If a GP wishes to withdraw from providing the Care Home LCS, they will need to give 6 months' notice, to give sufficient time for the commissioner to negotiate alternative LCS care. The GP practice will still however have an obligation to provide that resident with GMS/PMS care.

Where a GP wants to transfer or discharge (de-register) a resident from their GMS care, they will need to follow the protocols stated within their GMS/PMS contract.

## Schedule 2 L Safeguarding Policies

LCS providers should share concerns early regarding both safeguarding and quality of care Providers are very welcome to seek advice from the Clinical Commissioning Group's Care Home Quality Team:

sheffieldccg.carehometeam@nhs.net

See also Care Home Incident/Concern form (July 2011):

http://nww.sheffield.nhs.uk/referrals/?cat=158

**Sheffield CCG Safeguarding Policy:**


Sheffield Assurance tool for GPs re SG FIN


GUIDANCE ON COMPLETING THE GP


Incident Reporting Form - Care Homes.x

http://www.intranet.sheffieldccg.nhs.uk/corporate-policies.htm

**Sheffield Community Safeguarding Procedures:**

Children:
http://sheffieldscb.proceduresonline.com/index.htm

and

Adults:
https://www.sheffield.gov.uk/caresupport/adult/adult-abuse/professionals/procedures.html

# SCHEDULE 3 PAYMENT

## A. Permitted Variations to Tariff, Non-Tariff Prices and Other Payment Arrangements

**Table 1: Non-Tariff Prices**

| Service Description | Currency | Price |
|---|---|---|
| Scheme payment | Per bed | £200 residential homes<br>(£60 is for the production of a care plan led by the GP)<br><br>£220 for nursing/dual registered home (£66 is for the production of a care plan led by the GP)<br><br>The following amount will be deducted from the quarterly payment for every resident who does not have a full care plan, provided that such a resident has not been admitted to the home in the last 8 weeks.<br><br>£15 – residential<br>£16.50 – nursing/dual registered home<br><br>1/46 of the total quarterly payment will be deducted for every visit missed below the threshold of 10 visits per quarter on a quarterly basis. If less than 46 visits have been made in the year, then following the quarter 4 review further payment will be deducted.<br><br>The following percentages of the total contract value payment will be deducted for failure to achieve each local quality requirement:<br><br>• 10% Acute Admissions Review<br><br>If bed occupancy falls by 25% of your contracted bed number, it is the responsibility of the GP to inform the commissioner and there will be negotiation regarding adjustment of payment to reflect fair recompense for the work carried out, taking into consideration any permanent arrangement the practice has undertaken to increase capacity to deal with the care home work. |

## Schedule 4 Part C Local Quality Requirements

| Quality Requirement | Threshold | Method of Measurement | Consequence of breach | Monthly or annual application of consequence | Applicable Service Specification |
|---|---|---|---|---|---|
| **Service Requirement** | | | | | |
| 3 Acute admissions review to be completed | Submission of templates by 30th November 2017 | Completed template submitted which meets specified requirements | LCS payment reduced by 10% | | 01 |

## SCHEDULE 6 Part C Reporting Requirements

Care Home Specific Activity Information required

| Information required | Reporting Period | **Format of Report** | **Timing and Method for delivery of Report** |
|---|---|---|---|
| No. of visits by registered GP | Monthly | As set out in the database | Via LCS database |
| No. of beds for which the GP is responsible | Monthly | As set out in the database | Via LCS database |
| No. of residents in the beds for which the GP is responsible | Monthly | As set out in the database | Via LCS database |
| No. of residents with full care plan in place | Monthly | As set out in the database | Via LCS database |

Care Home Specific Quality Requirements Information required

| Information required | Reporting Period | **Format of Report** | **Timing and Method for** |
|---|---|---|---|
| 3 Acute admissions review reports | April – Nov 2019 | http://www.sheffieldccgportal.co.uk/pressv2/index.php/forms/item/care-homes-lcs-annual-reporting-templates | By end Nov 2019 submitted electronically |

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