

Enhanced Care Home Support (ECHS) Harrow - Community Support to Care Homes

An initial discussion for consideration

Enhanced Health in Care Homes (EHCH) - Community Support to Care Homes (Harrow)

1. Background

For the purposes of the implementation framework a 'care home' is defined as a CQC-registered care home service, with or without nursing. Whether each home is included in the scope of the service will be determined by its registration with CQC. (See appendix 1 for care homes currently registered with the CQC)

The Harrow care home model has four principal aims:

1. Providing residents living in care home the access to the right social care and health services in the place and time of their choosing;
2. Delivering high-quality personalised care within care homes;
3. Enabling effective use of resources for both proactive and reactive care and support required in care homes
4. Reducing unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for people living in care homes.

2. Core elements of the Enhanced Support to Harrow

In line with 'The framework for Enhanced Health in Care Homes 2020/21 - Version 2', Harrow Health and Care Partnership are committed to providing care in line with the national framework, as outlined below:

1. Enhanced primary care support	Each care home aligned to a named PCN, which leads a weekly multidisciplinary 'home round'
	Medicine reviews
	Hydration and nutrition support
	Oral health care
	Access to out-of-hours/urgent care when needed
2. Multi-disciplinary team (MDT) support including coordinated health and social care	Expert advice and care for those with the most complex needs
	Continence promotion and management
	Flu prevention and management
	Wound care – leg and foot ulcers
	Helping professionals, carers, and individuals with needs navigate the health and care system
3. Falls prevention, Reablement, and rehabilitation including strength and balance	Rehabilitation/reablement services
	Falls, strength, and balance
	Developing community assets to support resilience and independence
4. High quality palliative and end-of-life care, Mental health, and dementia care	Palliative and end-of-life care
	Mental health care
	Dementia care
5. Joined-up commissioning and collaboration between health and social care	Co-production with providers and networked care homes
	Shared contractual mechanisms to promote integration (including Continuing Healthcare)
	Access to appropriate housing options
6. Workforce development	Training and development for social care provider staff
	Joint workforce planning across all sectors
7. Data, IT and technology	Linked health and social care data sets
	Access to the care record and secure email
	Better use of technology in care homes

3. Current provision in Harrow - gap analysis:

1. Enhanced primary care support (EPCS)

Discussions have commenced with PCN regarding the establishment of EPCS to care homes. At present there is a named clinical lead for the 57 residential and care home in Harrow (appendix 1). In addition to this and in response to COVID the following local pathways/support have been established in addition to core general practice input and review of residents on a weekly basis: 1) Enhanced in-hour support to general practices for homes/residents requiring additional support via a central co-ordination function and access to geriatric consultant support 2) Enhanced out-of-hour support to general practices for homes/residents requiring additional, including proactive calls to high risk homes, 3) rapid and co-ordinated testing for homes with outbreaks, 4) provision of some guidance, education and advice on ordering, management and administration of medicines in care homes, access to anticipatory care medicines and structured medication reviews, 5) additional support and resource for the completion of care plans – CMCs, prioritising those at highest risk (see appendix 2).

2. Multi-disciplinary team (MDT) support including coordinated health and social care

Since the beginning of COVID Harrow has come together in a truly collaborative approach to ensure a joined up response to provide support for the residences of Harrow. This has included daily calls between the CCG, Harrow Local Authority and CLCH to discuss and agree the pathways and approaches. In addition to this there is an existing level of established risk stratification undertaken by EPNs to identify high risk patient cohorts, although this is not consistently done through the borough.

3. Falls prevention, Re-ablement, and rehabilitation including strength and balance

Harrow has a range of community services including specialist falls and rehab services. Work is on-going to ensure all services are integrated and we reduce variation. At present there is a range of support provided via social care, care homes staff, rapid response teams and community nurses, however this is not consistent and aligned to PCN supported risk management. Although there is always room for improvement, the current community response is based on need and urgent consultations are generally dealt with in 1 day. This reactive clinical response has been enhanced by the locally agreed COVID pathway providing geriatric consultations on-call support as required.

4. High quality palliative and end-of-life care, Mental health, and dementia care

In response to COVID we have had additional support offered and provided via palliative support consultants from LNWHT. This support has involved in-hours access to on call advice between 8am – 8pm Monday – Friday and informal support to general practice, particularly where there are large homes with a number of end of life patients. Mental health and dementia support to care homes needs to be strengthened as a consistent part of the ECHS and MDT based approach.

5. Joined-up commissioning and collaboration between health and social care

As part of the Harrow Integrated Care Partnership (ICP), pre-COVID partner organisations had already committed joint funding for two posts, one proactive and one reactive to support residents in a co-ordinated health and care approach (see appendix 3).

6. Workforce development

There has been a range of support provided to care homes and carer in terms of education and training. There has been a range of support provided via in-reach nursing teams, NWL quality visits, CCG webinars and weekly Local Authority led meetings with homes. Topics include: infection control, PPE, social distancing, quality improvement initiatives and local pathways and additional support orientation. All improvement actions are followed up with the homes. There is a diverse workforce including health and social care staff and it is important the workforce development plan addresses the specific issues relating to the various staff groups eg recruitment and retention.

7. Data, IT and technology

There are 4 out of 25 older adult homes that currently regularly utilise digital technology. Harrow is part of the wider NWL programme to expand the use of technology and training to enable virtual MDT reviews and consultations via TEAMS. This is not to say that virtual consultations between homes and general practice are not already a part of standard practice.

4. Recovery Plan – Next Steps

Co-ordinating care around the needs of individuals



1. Enhanced primary care support (EPCS)

By 6 July - A Task and Finish Group will be formed, comprising PCN Clinical Leadership and Community Partners. This group will be tasked with implementing the MDT requirements of the Enhanced Health in Care Homes model (as part of PCN DES 2020/21). By 30 September MDTs will be established and operational in each of the 5 PCNs. These MDT will encompass general practice, social care, pharmacists and community providers.

2. Multi-disciplinary team (MDT) support including coordinated health and social care

Established joint forums and collaborative ways of working will continue. Senior leads have been identified by all ICP providers for each recovery workstream to ensure pace and collective ownership. This stakeholder group will be tasked with implementing a range of training including: bladder and bowel, hydration and nutrient, infection control and falls and pressure ulcer prevention and strategies for specific work force issues including building on Government campaigns eg Proud to Care.

To enhance and consistently progress an understanding of the risk stratification of patients by PCN the CCG is actively reviewing the Effective Resource Management (ERM) KPIs for 2020/21. In the context of COVID alternative incentive options are being reviewed.

3. Falls prevention, Reablement, and rehabilitation including strength and balance

One of the local borough recovery workstreams is Frailty (incorporating care homes). The scope and aim of this workstream will be to ensure reablement and prevention is effective and consistent regardless of the place of residence. This includes a review of a range of services including the virtual ward, falls, rapids and frailty etc.

As part of this review of services to support rising and high risk patients the workstream will ensuring the effective utilisation of voluntary and 3rd sector services.

4. High quality palliative and end-of-life care, Mental health, and dementia care

The frailty and care homes recovery workstream will be looking to enhance the level of mental health and dementia support to care homes. The proposed CNWL model for Harrow due to commence from 1st July is based around a 3 hub model. Further discussions are required to confirm how this community based model will support the PCN (x5) Enhanced Health in Care Homes model.

5. Joined-up commissioning and collaboration between health and social care

The CCG, Local Authority and wider community providers have already commenced and intend to continue to live and work to a set of collectively agreed principles as part Harrow ICP. The collective local response to COVID has only further embedded and engrained this commitment. As such CLCH, public health and the local authority have committed to support with funding for essential roles (see appendix 3).

6. Workforce development

As part of the Harrow local system response to the core nationally specified EHCH standards, CLCH will be working with local stakeholders and the CLCH Training Academy to scope the requirements and provision of a comprehensive training programme to care homes including: bladder and bowel, hydration and nutrition, infection control and falls and pressure ulcer prevention.

7. Data, IT and technology

Harrow providers have effectively utilised digital options during this pandemic period. General practice has continued to support care homes with virtual patient reviews and we

have had high levels of engagement from care homes staff in an on-going series of training and education webinars. Harrow will continue to be a progressive partner in the rollout of the NWL digital programme and will review all lessons learnt in order to make the 'digital first' agenda an effective and enabling resource.

5. Conclusion

The collective stakeholders in Harrow have been able to evidence the ability to implement integrated, enhanced service provision in the face of COVID for a large number of residents in homes (care and residential) at pace. Building on this and the existing ICP work there is a collective impetus to ensure that these strong collaborative relationships continue and that service provision and aims are based on need and enhanced outcomes and experience.

Harrow's response to COVID in respect of support to care homes has been in general exceptional, with a general will by organisations and a consistency of process and communication. We believe all elements of the above plan will be consistently and substantively in place by the end of September 2020 to ensure on-going support to this vulnerable patient cohort.

It should be noted that in order to meet the national standards, investment will be required. The value of this is currently being finalised.

Appendix 1

CQC Registered Nursing & Residential Homes



Care Homes - GP and
PCN data 04 v7 04062

Appendix 2

Agreed pathways



Care Homes RFT and
swabbing v14.pptx

Appendix 3

Agreed Job Specifications

Pilots funded by Public Health Harrow and The Urgent and Emergency Care Workforce Collaboration Bid (Phase 2) Funds

Vision

An 'Integrated Community Rapid Response' for care homes.

Objectives

- Recruit two clinical practitioners (Reactive Care Practitioner and Proactive Care Facilitator) with funding from Public Health and the Health Education England under the Urgent and Emergency Care (UEC) Workforce Collaboration Bid – Phase Two, working together to enable an integrated community response to care homes
- Link to existing infrastructure and services, aiming to enhance relationships and improve access to this alternative care pathway, rather than the London Ambulance Service

- Learn where the barriers and gaps in the system are (from work done and cases seen), and problem-solve at a system level.

Background and Rationale

Older people are the fastest-growing section of the community: the number of people over 85 is expected to double within two decades. It is estimated that between 2014 and 2024 there will be a ~33% rise in over 85 year olds and a roughly doubling of patients with dementia by 2025¹. The number of older people living in care homes in England (currently 329,000) is already more than three times the number of hospital beds, and is set to increase further².

In Harrow, there are 57 care homes, 40 of which are designed for older people (1,050 beds), and 10 of which are nursing homes (600 beds). The non-elective activity and associated costs for this group of patients in Harrow, in 2017/18 was:

Nursing and residential homes				
	2017/18		2018/19	
	Activity	Cost	Activity	Cost
LAS call outs	739	£184,750	1019	£254,750
LAS conveyances	618	Part of call-out cost	859	Part of call-out cost
Non-elective admissions	696	£2,968,386	618 at Month 9	TBC

Two of Harrow's care homes are amongst the top ten highest LAS callers in North West London, and emergency admissions from care homes are increasing. In the period April 2018 to March 2019 there were 1019 incidents where ambulances were called out across all the care homes. 859 of these were conveyed to hospital. These figures show an increase from 2017/18. At Month 9, 2018/19 (i.e. December 2018), there were already 618 non-elective admissions from care homes – indicating a likely increase also in the NELs on the previous year. The activity data for Months 10-12 and the annual cost data are yet to be confirmed.

In addition to causing distress to residents, their families and staff, hospitalisation is expensive for health and social care systems. Hospital admission increases the risk of decline in functional ability, delirium, adverse events and prolonged stays³

¹ Shifting The Balance Of Care, Great Expectations; Nuffield Trust, March 2017

² Care Quality Commission 2017; National Institute for Health Research 2017; Wittenberg and Hu 2015

³ British Medical Journal Open, *Evidence-based intervention to reduce avoidable hospital admissions in care home residents (the Better Health in Residents in Care Homes (BHiRCH) study): protocol for a pilot cluster randomised trial*, 27 May 2019

Through establishing a different pathway of care when a patient has a health care need in a care home, a proportion of the call-outs and admissions could be avoided. New analysis from the Improvement Analytics Unit, a joint initiative between NHS England and the Health Foundation, has found that more than four in ten (41%) emergency admissions to hospital involving care home residents could be potentially avoided with better provision of preventative primary care, community support or NHS care in care homes⁴. The Harrow Integrated Care (IC) Programme Care Home Improvement Workstream group has been exploring ways to work collaboratively in Harrow to improve the quality of care experienced by residents and staff, and relieve pressure on acute services.

It was proposed by Public Health in Harrow that a specialist paramedic be employed as a one-year pilot to serve the care homes of Harrow. Working with the Care Homes Improvement Workstream and one of the IC clinical leads, it has been proposed that a Band 6 Advanced Care Practitioner role (ACP, focusing on 'Reactive Care') would be more beneficial to care homes and their residents, and to the system. This has been proposed following:

- Engagement with care homes managers
- Engagement with London Ambulance Service (LAS) colleagues
- Reviewing the proposed model with the Rapid Response Team (RRT) and other community nursing leads at CLCH
- Reviewing the proposed model with the Local Authority's Safeguarding, Assurance and Quality Service (SAQS) lead
- Further evaluation of the available data on call-outs and admissions
- Learning about other care homes models in Hertfordshire, Wandsworth and Hackney.

Subsequent to this, the IC Programme Team and Harrow CCG have won a £50K bid from the Health Education England under the Urgent and Emergency Care (UEC) Workforce Collaboration Bid – Phase 2. This has offered the opportunity to recruit a 'Proactive Care Facilitator' to work alongside the Reactive Care ACP.

This would mean a change in the pathway for call-outs and consequently, admissions. If a care home has a patient with an urgent healthcare need, the call to 999 would instead go to the 'reactive' ACP. This could be particularly appropriate for issues such as mild sepsis, falls, wound care and fainting. The ACP would visit the care home as part of the Rapid Response Team and provide community-based care if appropriate.

⁴ The Health Foundation, *New analysis finds encouraging results in reducing emergency admissions from care home*, 25 July 2019

This approach could have a number of benefits:

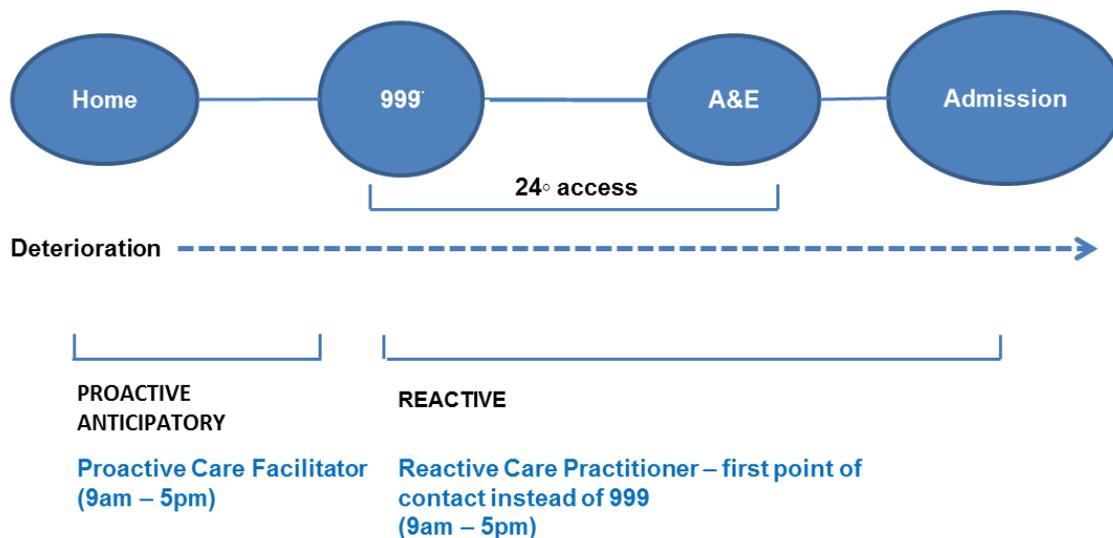
- Reduce the need for hospital care, therefore reducing subsequent lengthy spells in hospital, further healthcare needs and pressure on services
- Reduce the need for adult social care services following hospital discharge, thereby reducing staffing pressures on the service
- Improve patient experience through reducing the likelihood of being admitted to hospital
- Reduce the need for use of the ambulance service, lifting pressure on the service, and allowing ambulances to be used elsewhere
- Reduce costs of hospital stays and treatments, and of adult social care services
- Professional development for the practitioners
- Novel pilots giving an evidence base to further build on.

Similar approaches have been running in Hertfordshire, Wandsworth and Hackney with excellent results for the care homes staff and their residents. In Hertfordshire and Hackney, the teams aimed to reduce hospital admissions by 50% in the top ten homes and achieved their target. The teams have increased in number and have rolled out the improvement to other care homes identified as poor or failing in quality areas.

This proposal seeks to describe the model of care to be piloted for the care homes in Harrow for the next year using the two available funding streams for this work. It is also intended that the learning of this work will be used to inform how to best to utilise the upcoming March 2020 care homes Direct Enhanced Services (DES) contract funds being offered to Harrow's five Primary Care Networks (PCNs).

Proposed Pilots

To recruit two new practitioners will work together to improve and coordinate care in care homes. One role to pro-actively identify need and act as a responsive system informer, and the second role to focus on assessing and treating residents who become unwell.



There will be an essential collaborative approach between the two roles and the following partner organisations and on-going improvement projects:

- Medicines Optimisation in Care Homes (MOCH) pharmacists who are undertaking medication reconciliation and can link in with advanced care planning
- CEPN/Harrow Training Hub, including the PIE frailty work and newly appointed Darzi fellow
- The Harrow CCG Integrated Care Delivery Programme, specifically with the Care Homes Improvement Workstream. This is looking to establish a system that is able to respond appropriately and in a timely way when urgent or emergency situations occur, and build resilience to crises in care homes.
- Consistent and seamless access to specialist community nursing and the full range of allied health professionals such as the Falls Service, specialist nurses, district nursing etc.
- North West London Health and Care Partnership Care Homes projects (Telemedicine (111 *6), Data Security and Protection Toolkit (DSPT) Training + nhs.net accounts for care homes, Red Bag Scheme etc.
- Virtual Wards and Harrow Collaborative Care Team
- St Luke's Hospice
- Public Health Team (e.g. Oral Hygiene Project)

The Rapid Response Service Specification is being enhanced to allow for direct referrals from all Harrow care homes into the Rapid Response Team, for the duration of the pilots.

Reactive ACP (Public Health Funding)

Role Details

- Band 6, 1.0WTE
- Integrated within the RRT, focusing specifically on care homes
- Hosted by CLCH via an honorary contract (*employed by CCG or LA, TBC*)
- Service Cover: Monday – Friday 09:00-17:00
- Link between care homes and the RRT
- The care homes will use the RRT number as the point of contact for the ACP. The RRT call handler can then contact the ACP with the relevant details to attend to
- The ACP will assess and treat residents where appropriate and refer on the RRT if a follow-up is required or the case is complex. The ACP could also refer to the other community services such as the Falls Service and the GP Practices
- Link to same day emergencies care work and care homes DES
- Data collection of all care home referrals
- Supportive partnership working with the Proactive Care Facilitator
- Flexibility to learn and continually improve the model

Existing Services and Support Mechanisms

- Rapid Response Team
- Hospital Discharge Team
- Community nursing e.g. District Nurses
- 111*6
- 999
- Harrow Collaborative Care Team (HCCT)

Skillsets Identified

- Clinically skilled
- Prescribing

- Catheterisation
- Phlebotomy

Proactive Care Facilitator (UEC Workforce Collaboration Fund – Phase 2)

Role details

- Band 6, 1.0WTE
- Integrated within the RRT, focusing specifically on care homes
- Hosted by CLCH via an honorary contract (*employed by CCG or LA, TBC*)
- Service Cover: Monday – Friday 09:00-17:00
- Proactive and preventative approach to the management of patients in care homes through supporting front line care home staff with bespoke education and training
- Identify learning needs in care homes
- Co-design and test new ways to improve care using the learning from the care home training models
- Signposting care homes to existing health and social care services
- Identify barriers to accessing appropriate and timely care, to provide vital information to feedback to the system
- Routine assessment of residents after discharge from hospital to avoid readmission
- Root cause analysis of all unscheduled admissions and LAS callouts to seek feedback from the system that can be used as learning to influence change
- Liaise with the named GP when there is a need for an Advanced Care Plan (to be followed up by the CMC record being developed by Enhanced Practice Nurse?)
- Flexibility to learn and continually improve model
- Work with GP practice(s) for care homes with high referrals to RRT
- Supportive partnership working with the Reactive Advanced Care Practitioner

Existing Services and Support Mechanisms

- Primary care
- Enhanced Practice Nurses (EPNs); Advanced Care Planning
- Medicines Optimisation in Care Home (MOCH) Pharmacists
- Communities Services (Falls, specialist nurses, district nursing)
- HCCT

- St Luke's Hospice
- Harrow Training Hub
- Local Authority Safeguarding, Assurance and Quality Service (SAQS)

Skillsets Identified

- Band 6, clinically trained
- Excellent communication and engagement
- Ability to provide training and support to care homes' staff to develop their confidence and competence in managing the needs of their residents
- Role-modelling
- Care co-ordination and signposting

Care Homes Selection for Pilot

Rationale for selecting care homes to undertake pilots:

Reactive ACP

- Attends to care homes where calls coming into RRT are deemed appropriate by RRT call handler
- Attends to care homes when called by the Proactive Care Facilitator

Proactive Care Facilitator

- Cover more than one PCN to ensure equity and also to cover areas that RRT covers (across the borough). This also offers the potential for an ultimate spread across Harrow
- Highest number of LAS call-outs, weighted by number of beds
- Highest number of A&E attendances and admissions, weighted by number of beds
- Care homes willing to engage

Three suggested care homes as a starting point (**TBC**), within a one-mile radius – 20 mins walk, reducing the need for the facilitator's own transport:

- *Sairam Villa, Kings Road – Harrow Collaborative*
- *Rowanweald, Enderley Road – Healthsense*
- *Sancroft, Belmont – Health Alliance, Stanmore / Harrow Collaborative, Belmont*

Measuring Success

The following indicators are proposed to measure the success of the pilots:

- ↓ LAS call-outs
- ↓ A&E attendances
- ↓ Hospital admissions
- ↑ Deaths in the preferred place (usually in patients' care homes)
- ↑ Hospital bed days saved
- ↑ Patient and carer experience (surveys, TBD)
- ↑ Staff experience (surveys, TBD)

The above are initial indicators to meet the 4 key IC outcome themes of improved patient experience, improved quality of care, financial sustainability and staff satisfaction with services and in delivering care.

Attribution of benefits may be difficult if other pilots or change ideas are being tested or implemented in the care homes selected.

In order to strengthen the evidence base of the data, the evaluation will use data weighted on number of beds in the relevant care homes (to measure A&E attendances and admissions).

Constraints and Risks

Some of the data collection has been rudimentary, based on available hospital data which can only be narrowed down to the postcodes that the care homes are in and could therefore contain additional patient activity data. Also, the bed capacity has been based on information received via telephone calls to care homes, increasing the risk of human error.

It may be difficult to recruit Band 6 level nurses with the required skills. There is no funding to extend the roles to higher bands. The required skill set may need to be reviewed if this is the case.

In order to allow for prescribing by the practitioners, the funding source for any medicines prescribed needs to be agreed and signed-off, after which a prescribing code linked to that funding can be used.

Experiential data collation and recording (of residents, carers and staff experience) will be based on surveys which are subject to misinterpretation.

There is a risk that the recruitment of the Reactive ACP and Proactive Care facilitator could take longer than anticipated (February 2020 at the earliest) and there is a possibility of staff and skill-mix shortages in the Harrow locality.

The length of the pilots is too short to recruit and induct practitioners, as well evidence benefits, if not extended post-March 2020. Currently there is just 4 months to recruit and start to show benefits. The UEC Phase 2 bid funding is available to March 2020 and the one-year Public Health funding was offered in March 2019. The opportunity to run the pilots for one year from the recruitment into the identified roles would offer a more realistic timeframe for meeting the proposed objectives. Harrow CCG is seeking a means of extending the use of the UEC Bid funding for a full year from the Proactive Care Facilitator recruitment.

Potential costs

The cost of recruitment of 1.0WTE band 6 Reactive ACP and Proactive Care Facilitator would be approximately £50,000 each.

It is aimed that the pilots would reduce hospital costs. The pilots would be evaluated for costs and benefits to determine if cost saving or cost neutral.

Next Steps

	Activity	Lead TBC	End Date TBC
1.	Finalise first set of care homes for Proactive Care Facilitator	AA	06.12.19
2.	Communication and engagement with practices linked to care homes (named lead GP)	EW	06.12.19
3.	Develop and finalise job descriptions	TBC, CLCH	December 2019
4.	Recruitment process	TBC, CLCH	January 2020
5.	Determine sources for on-going measurement and start process and baseline data collection with care homes. External support required	ICHP?	February 2020
6.	Implement pilot with a Quality Improvement (incl. Plan Do Study Act 'PDSA') approach to ensure services can be responsive to needs and continuously improve. Book Quality Improvement (QSIR) Training.	Practitioners	March 2019

Future considerations:

The panel for the practitioner interviews to include:

- Rapid Response Lead
- Care Home Manager
- Integrated Care GP Clinical Lead

There will be a need for strong leadership/coaching to enable the 2 practitioners and care homes to be able to work in an iteratively learning way, to share principles of change methodology and system integration. External support could be sought to help the 2 practitioners with this at the start of the work and to help them ask the right questions as well as collect the right data. This support could be funded by the UEC Workforce Collaboration bid - **Phase 1** (won by the IC programme in 2018) dependent on the cost – TBC.

Wider system and health partners could help meet the bespoke training needs of the practitioners and care homes as these become apparent E.g. St Luke's, CPEN frailty work.

True and fully proactive care will require an enhanced model with linked GPs and EPNs – the pilot work could provide the feedback to the system to inform what would be required.