SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	Care Homes Advanced Scheme (CHAS)
Commissioner Lead	NHS Shropshire CCG
Provider Lead	GP Practice
Period	1st April 2019 - 31st March 2020
Date of Review	October 2019

1. Population Needs

1.1 National/local context and evidence base

Shropshire Clinical Commissioning Group has a population of approximately 312,000. It consists of 41 GP member practices that are working together to ensure the local population has high quality healthcare services which are sustainable.

Shropshire has one of the highest numbers of care home beds per head of population in the region; this is growing rapidly. Care home beds are occupied largely by people who are 'living with frailty and have complex needs'. Such residents form one cohort of a much larger similarly affected population, most of who live in their own homes.

Adopting pro-active care through active case management, care planning and multidisciplinary review for this group of patients is effective in improving quality and outcomes as well as reducing un-necessary hospital admissions.

2. Outcomes

2.1 <u>NHS Outcomes Framework Domains & Indicators</u>

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**	**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**	

2.2 Local defined outcomes

- Reduced hospitalisation of patients from care homes – A&E attendances, emergency admissions and if a patient is admitted, length-of-stay (LOS)
- Improve quality of prescribing with a personalised approach and reduce harm from unnecessary polypharmacy
- Improve anticipatory care planning for both end of life and avoidable unplanned admissions
- Improved life for care home residents and enhances the quality of life for people with long-term conditions (NHS Outcomes Framework domain - 2)

- Promotes positive working relationships between care home and GP – regular visits allowing communication and consistency

3. Scope

3.1 Aims and objectives of service

Aim

The aim of the Care Homes Advanced Scheme is to support practices to improve the quality of life, health care and planning for people living in care homes.

It is supported by the following objectives;

- Assist practices to comply with GMS contract requirements for patients that are identified as having moderate to severe frailty (eFI Index)
- Develop a process that will ensure practices meet the recommended documentation in 2019/20 Quality domain for end of life care
- Promote consistent documentation and communication between GP and care homes
- Ensure practices have planned regular visits to the care home
- Ensure patients receive a systematic medication review on admission, and at least annually using a recognised tool appropriate to the individual.
- Ensure an admission analysis is undertaken for any resident in the event of an unplanned admission or A& E attendance.

3.2 Service description/care pathway

GP Practice:

- Will meet the requirements laid out in the GMS contract as a prerequisite for signing up to this service. Appendix 1 contains a summary of GMS 2019/20 requirements for both frailty and end of life quality domain. Full details can be found **https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf**

- Shall involve the care home, patients and/or their relatives in discussions of their care to enable joint decision making.

- Shall undertake an assessment of the resident on admission to the care home and at least annually (appendix 2). This will include residents who are on either the learning disability register or are assessed as moderate to severely frail. An individual clinical care plan will be developed jointly with the provider staff, resident and/or family and other community professionals as required.

- GP Practice shall provide planned and regular structured patient medication reviews to the provider as a minimum on admission, then once annually and following an unplanned admission or A&E attendance. Structured medication reviews must be carried out using a validated tool. This would include STOMP principles in learning disability residents (see appendix 3), STOPP/START in residents over 65 years and STOPPFrail in residents judged to be in the last year of life. The CCG has produced guidance and a resource pack to assist clinicians with these medication reviews. Any changes to medication will be communicated to the care home using the template in appendix 4.

- Shall coordinate and undertake an unplanned admission analysis (Appendix 5) for any resident following any unplanned admission to an acute hospital bed or A&E attendance. The review should include structured medication review and anticipatory care planning to reduce avoidable admissions where possible.

- Shall flag each resident with an anticipatory care plan to the Out-of-Hours Service.

Care Home:

- Will work in full collaboration with the GP Practice and provide designated senior member of staff to meet with the GP for the duration of each GP visit.
- Will prepare in advance for the planned GP visits, ensuring up to date information is available regarding the resident's condition and collating the relevant provider documentation.
- Will fully contribute to the development of care plans with the GP, resident and family and other

community professionals as required.

- Make these plans available to relevant healthcare professionals appropriately and in a timely manner.
- Will liaise with residents and their relatives regarding the scheme as required**.**
- Following each GP visit, will ensure relevant actions for the provider are actioned in a timely way.
- Will notify the GP practice if a resident has an unplanned admission to Acute hospital or A&E attendance as soon as possible.
- Will contribute to a GP led admission analysis (Appendix 5) for any resident identified within this scheme following an unplanned admission they have to an acute hospital bed or A&E attendance. This will include providing information on reasons and circumstances for the admission, who made the decision to admit, discussion regarding any previous similar admissions for the resident and consideration of any appropriate local resources or interventions that may have prevented the need for the admission. The responsibility to ensure provider staff are suitably trained to meet the needs of their residents

3.3 Population covered

The aim of the Care Home Advanced Scheme (CHAS) is to provide pro-active care to patients living in care homes. It applies to all Personal Care and Nursing Care home residents that are assessed as moderate to severe under frail and complex (eFI Index) and to all care home residents who are on the learning disability register. This care is additional to that covered in the standard GMS contract

This will be led by the GP but using a multi-disciplinary team (MDT) approach that fully includes the staff of the provider, the resident and their relatives, as well as other primary and community care professionals and services as appropriate.

The population covered is permanent residents of all care homes which include residential, nurse and learning disabilities. A single fee will be paid per step up or step down bed where these are used on a short term basis. CHAS reviews should only be done in temporary residents where this adds value to their clinical care.

This will provide additional support to the providers to assist them to continue to meet the needs of their highest risk residents and reduce unnecessary admissions to Acute Hospitals and the inappropriate use of West Midlands Ambulance Services and Out-of-Hours services.

3.4 Any acceptance and exclusion criteria and thresholds

- If the GP has a financial agreement in place with the provider to support care home patients. The GP shall notify Shropshire CCG about what the arrangement includes and how they plan to deliver those services differently to CHAS.
- Interdependence with other services/providers on behalf of the practice supported by the clinical lead, to work in partnership with the provider, OOH and emergency services.
- Co-ordinate and support the development of networks for individuals with long term conditions within the community.
- Enable these networks to access advice and education from experts.
- Link with existing initiatives and facilitate broader networks.
- Learning disability schools where residents are not permanent will not be included.

3.5 Annual Review

All practices providing this service shall conduct an annual review of the management of CHAS patients to include:

- register of patients
- clinical outcomes
- complications

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

- NHS Outcomes Framework

https://www.gov.uk/government/statistics/nhs-outcomes-framework-indicators-may-

2017-release

- Enhanced Health Service

https://www.kingsfund.org.uk/sites/default/files/2017-11/Enhanced-health-care-homes-summary-Kings_Fund_December-2017.pdf

- GMS – frailty guidance

https://www.england.nhs.uk/wp-content/uploads/2017/04/supporting-guidance-on-frailty-update-sept-2017.pdf

- GMS 2019 contract

https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

- STOMP

https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

4.3 Practices will submit a short quarterly declaration see appendix 6

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 4D)

None identified.

6. Location of Provider Premises

The Provider's Premises are located at: GP Practice

7. Individual Service User Placement

N/A

Appendix 1

Summary of 2019/20 GMS Contract

Full details available from:

https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

GMS contract - Frailty

Practices will use an appropriate evidenced based tool, e.g. Electronic Frailty Index (eFI)4 5 to identify patients aged 65 and over who may be living with moderate or severe frailty. For those patients confirmed through clinical judgement as living with severe frailty, the practice will:

- deliver a clinical review providing an annual medication review and;
- where clinically appropriate discuss whether the patient has fallen in the last 12 months;
- provide any other clinically relevant interventions;
- where a patient does not already have an enriched Summary Care Record (SCR) the practice will promote this by seeking informed patient consent to activate the enriched SCR6.

Overview of the GMS Quality Improvement Domain – End of Life Care

The overarching aim of these QI indicators is to lead to improvements in relation to the following aspects of care:

1. Early identification and support for people with advanced progressive illness who might die within the next twelve months.

2. Well-planned and coordinated care that is responsive to the patient's changing needs with the aim of improving the experience of care.

3. Identification and support for family / informal care-givers, both as part of the core care team around the patient and as individuals facing impending bereavement.

All practices should start with an assessment of the current quality of care they provide for patients and their families at the end of life. This would usually include the completion of a retrospective baseline audit analysis of deaths unless this has been completed in the previous 3 months. The purpose of this is to understand firstly, the numbers of people who had been identified on the palliative care register and therefore deaths which had been anticipated and secondly, how many patients had care plans in place. If the practice already has well-established end of life care process then this baseline audit analysis could focus upon other aspects of care such as:

- Priority care goals achieved e.g. is preferred place of death recorded and achieved?
- Quality of care plans including treatment escalation and advance care plans e.g. legal status of Power of Attorney and advance Directives, and emergency treatment preferences such as recording of decision on cardiopulmonary resuscitation (note evidence suggests that this should be part of the care planning process and not done in isolation).
- Main carer is identified with offer of assessment and support
- Anticipatory medicines are available in the place of care

Appendix 2

CARE HOMES ADVANCED SCHEME PLAN

A copy of this should be given to the Care Home

Date:	
Name:	
Address:	
Date of birth:	
NHS number:	
eFrailty score:	
☐ Patient is on the Learning Disability Register	

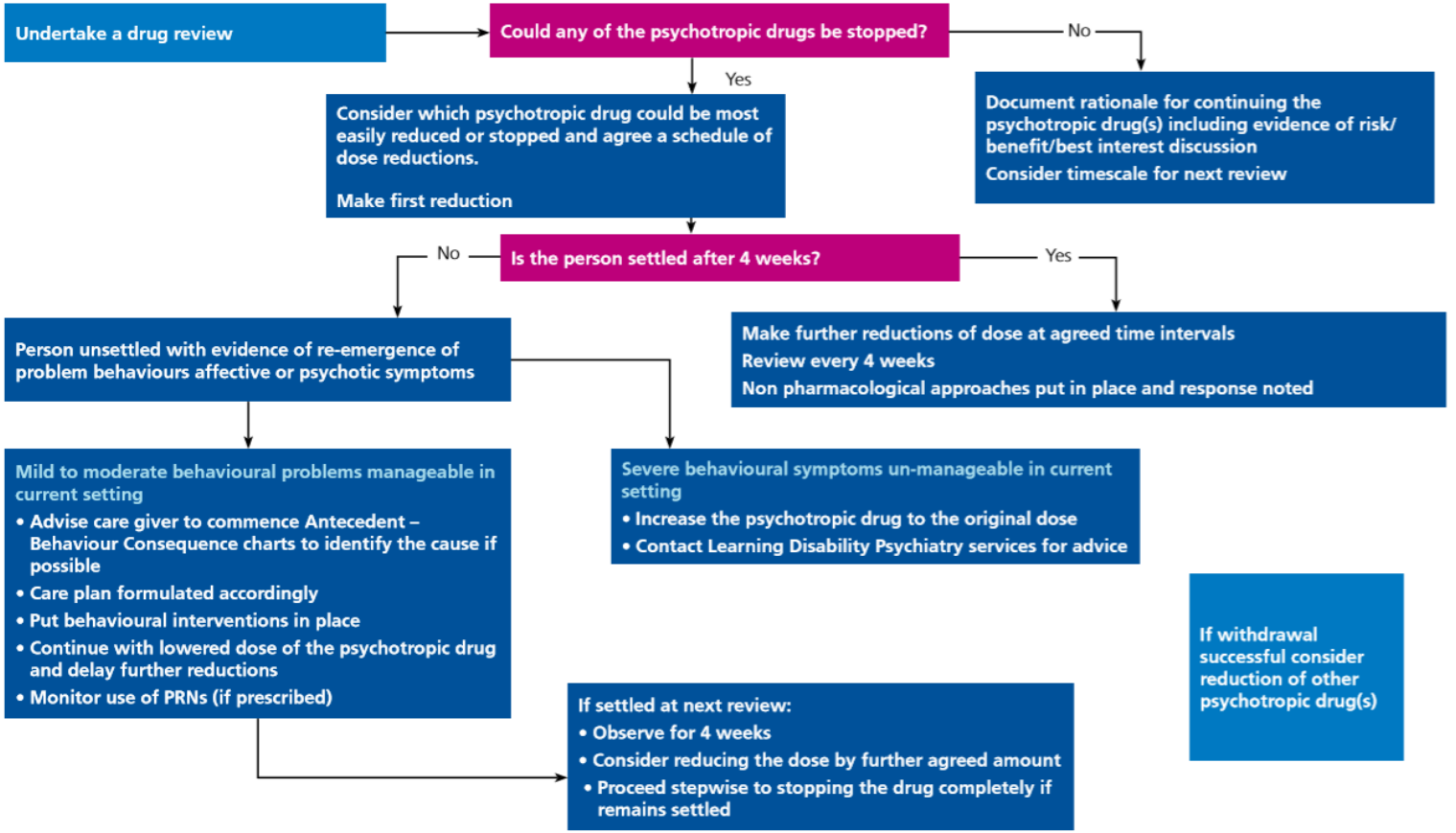
Is the patient for resuscitation? ☐ Yes ☐ No –a DNA CPR form must be completed	
Patient's next of kin:	
Is an 'End of life' care plan in place? ☐ Yes ☐ No	
What are the preferences of the resident and/or family for hospital admission?	
Is there an Advanced Directive in place? ☐ Advanced directive discussed with resident ☐ Advanced directive discussed with relative ☐ Advanced directive signed (copy in notes)	
Is there an LPA in place for? ☐ Health & Wellbeing ☐ Property & Finance	
Has the resident been flagged to Shropdoc? ☐ Yes ☐ No	

Does the resident have a diagnosis of dementia? ☐ Yes ☐ No	
What additional support does the resident need due to lack of mental capacity?	

Observations	**Comments**
O/E – Blood pressure reading: / mmHg	
Oxygen saturation:	
O/E height:	
O/E weight: ☐ Abnormal weight loss ☐ Increase in weight ☐ MUST Score	

Plans To Reduce Admission Risk
Date of plan:
Assessment of need
Intervention
Review

Algorithm for the review, reduction or stopping of psychotropic drugs in people with a learning disability, autism or both



Reference: https://www.england.nhs.uk/wp-content/uploads/2017/07/stomp-gp-prescribing-v17.pdf

Appendix 4

Care Home medication review

Care Home			
Date review		**Reviewed by**	

Patient demographics

Name		**Address:**
NHS Number		
Date of birth		
Age		
EMIS Number		

EFI Score	
Frailty level	

Review tool used:	
STOPP/START	
STOPPFrail	
STOMP Principles	
Other alternative	

Changes made to current medication and rationale

Advice given to care home/other comments

Current medication

Drug	Dosage	Quantity	Last issued on

Appendix 5

CARE HOMES ADVANCED SCHEME ADMISSION ANALYSIS			
Practice		**Age**	
Care Home		**Care Plan in Place?**	Y/N
Date & Time of Admission		**Female/Male**	

No	Question
1	**What was the reason for the admission?**
2	**Has there been a similar admission for this patient in the previous year?**
3	**Causative factors for admission? (if known)**
4	**Could the admission have been avoided/prevented? YES / NO** **If yes, how?** **Are there any further resources needed to achieve this?**
5	**How long was the patient in hospital for?**
6	**Did the patient receive appropriate/inappropriate investigations whilst in hospital?**
7	**Actions Taken**
	Date of post-discharge medication review been completed
8	**Discussion with Care Homes**
9	**Any other comments**

Appendix 6

CARE HOMES ADVANCED SCHEME (CHAS)
Care Home Delivery Form

Practice name and address:	

Care Homes we will deliver CHAS to:

Name of care home (please list):	Number of residents:

If you already have a financial agreement in place to support patients in care homes, please confirm that this arrangement is to deliver different services than those outlined in the CHAS. Please state what these services are below.

Name: _____ Signature: _____

Date: _____

Please return this form to: Ceri Wright, Medicines Management, Oak Lodge William Farr House, Mytton Oak Road, Shrewsbury SY3 8XL – Email: *ceri.wright@nhs.net*