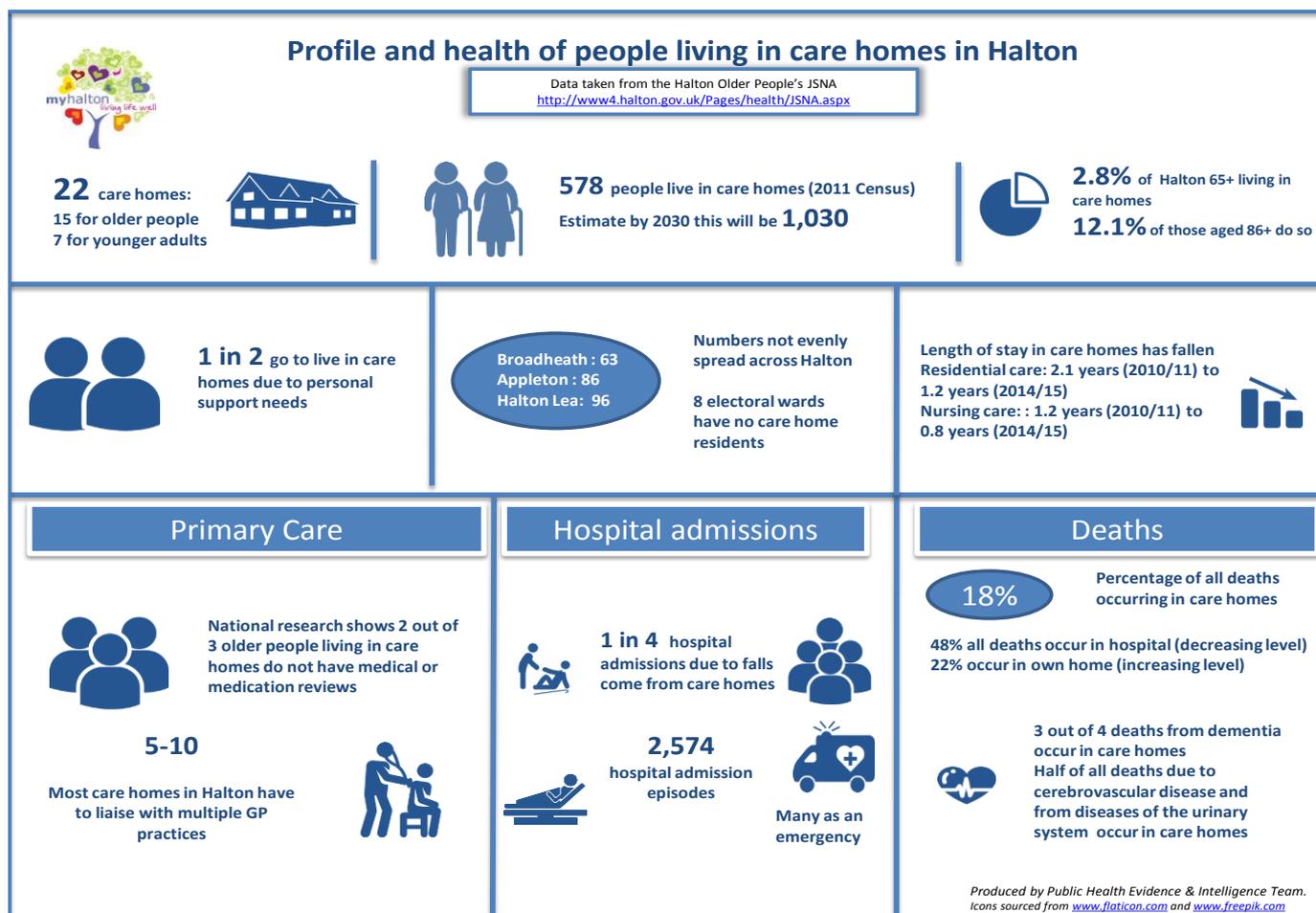


**GP Alignment/Care Home – Options Appraisal Paper**



Care homes now provide more beds than NHS hospitals, for a predominately older population, with increasingly complex needs.<sup>1</sup>

Under the terms of NHS Constitution, Equality Act and current GP contract **care home residents have the same rights to NHS services as the rest of the population.**

NHS England guidance (2014) states 'Healthcare for care home residents should be an actively commissioned service, with clear specifications linked to quality, outcomes and contractual obligations'.<sup>2</sup>

Due to the complex health and social needs of individuals in care homes, standardised health care meets the needs of care home residents poorly, but well-tailored services can make a significant difference.<sup>3</sup>

In the recent Quality Watch (2015) report, a number of key findings were recorded<sup>4</sup>:

- Care home patients were much older (86.3 compared to 82.1) and were 40-50% more likely to have emergency admissions. There were also significantly fewer

<sup>1</sup> CQC The state of health care and adult social care in England 2013/14

<sup>2</sup> NHS England (2014) Safe, compassionate care for frail older people using an integrated pathway

<sup>3</sup> British Geriatrics Society (2013) Commissioning Guidance High Quality Health Care for Older Care Home Residents

<sup>4</sup> Quality Watch (2015) 'Focus on: Hospital admissions from care homes'

elective admissions and outpatient appointments compared to the general population aged 75 and over.

- Care home patients admitted to hospital tended to be at the end of their lives. Around 40% of care home residents admitted as an emergency died within 6 months of admission.
- The health problems recorded on admission to hospital were different for patients living in a care home. Pneumonia, dementia and epilepsy were 3 times more common compared to the general population aged 75 years and over. Other more common reasons for admission from care home residents included sepsis, head injury and hip fracture.
- In areas containing care homes where hospital admissions were high, there was a greater proportion of instances where patients had 3 or more admissions in a year (as opposed to the higher rates being because more patients had single admissions)

It is widely accepted that good quality preventative care can reduce the frequency of health crises in the population that require hospital admission<sup>5</sup>, and according to British Geriatrics Society, (2015)<sup>6</sup> there is no reason why this concept is not applicable in care homes.

Despite the complex and high level of need of people living in care homes, there is wide variation in their access to necessary health services. In the British Geriatric Society (2012a)<sup>7</sup> report the following findings were noted:

- 68% of care home residents do not get a regular planned medical review by their GP
- 44% were not getting a regular planned review of their medication
- 41% could not access specialist dementia services

'It is anticipated that alignment, will reduce the workload in general practice whilst supporting improvements in patient care. Thus, care home alignment fulfils a key requirement of the 5 Year Forward View<sup>8</sup>. – *Dr David Lyon, GP Clinical Lead and Governing Body Member.*

On 27<sup>th</sup> January 2016, a CCG/HBC Care Home Summit was held with support from the Director of Adult Services for HBC and the CCG Chief Nurse.

The event had a wide representation from care homes, Health Watch, the NHS and HBC. An item on the agenda for discussion was a 'Primary Care/Care Home Model' which was led by Dr David Lyon.

Key recommendations from the Summit for future action included:

- ***GP Care Home Model development***

Further to the Summit, a 'Care Home Conversations' Forum was established by Damian Nolan, Divisional Manager HBC, to enable discussions across a wide range of stakeholders including care home providers. In these discussions the alignment of GPs to Care Homes has been extremely well received.

On 21<sup>st</sup> April 2016 a PMS Review meeting was held with GPs across Halton and the alignment of GPs to Care Homes ***was supported by a majority of Members.***

The CCG is proposing initially to align GP services across all care homes in the Borough of which there are currently 22.

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<sup>5</sup> [D.Oliver et al \(2014\) Making our health and care systems fit for an ageing population](#)

<sup>6</sup> [According to British Geriatrics Society.' Hospital admissions from care homes' \(2015\)](#)

<sup>7</sup> [British Geriatrics Society \(2012a\) Failing the frail](#)

<sup>8</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf>

With agreement of Practices and with the understanding from the care homes, this will be managed in a ***phased approach***.

As part of the Engagement Plan, initial discussions have taken place with care homes, via the HBC Care Home Provider Forum, Care Home Conversations Forum and through direct visits to care homes. The purpose of these discussions was to:

- Establish with care homes the current state of play
- Explore opportunities for improvement
- To gauge whether there was an appetite locally for alignment

Discussions so far have been very positive, and care homes wish to be involved in this work.

Of note, Managers who had worked with the single GP/single care home alignment were very positive about this approach, and reported an unfavourable comparison with the current model in Halton.

In these discussions with care homes directly, there have been a number of reoccurring themes:

- As a consequence of multiple GPs supporting care homes, there are often competing demands made on nursing resources to accompany visiting GPs, which is very difficult to manage
- Inconsistency of GP wards rounds and frequency
- Variation in quality and method of communication between care homes, GPs, Pharmacy and Hospitals
- Medication issues
- Prescription issues (EPS)

During the GP Practice engagement events, the following outcomes from a GP/Care Home alignment model were identified and agreed:

- Improved quality and access of care
- Reduced unwarranted variation
- Improved quality of life
- Reduced unplanned hospital admissions
- Reduced prescribing wastage
- Improved communication
- Strengthened relationships

There have been discussions with members of the wider care home support teams including; Care Home Liaison Team, Care Home Medicines Team, the Local Authority Safeguarding Lead, and Continuing Healthcare Lead to understand their role within care homes. Universally, a GP/ Care Home alignment type model was received in a very positive manner.

There have also been discussions with Dr David Wilson LMC Representative around patient choice and Information Technology. ***The issue of patient choice is the most important element of this work.*** It has been made ***explicitly clear*** in all discussions with all stakeholders that patient choice is ***paramount and is to be upheld.***

An Equality Analysis has been undertaken, and it is recommended that a further discussion takes place at HBC Overview and Scrutiny Committee.

Dr Wilson is also happy to ensure that any communications that may be developed are presented to General Practitioners Committee (GPC) for comment.

## Current provision in Halton

Currently there are 2 Practices within Halton who undertake proactive ward rounds supported by the 'Over 75s £5 per head' scheme. These are Tower House Practice in Runcorn for Beechcroft and Simonsfield Care Homes and Bevan Group in Widnes for St Patrick's Care Home and prior to closure, Lilycross Care Home.

Whilst there is no formal evaluation available at this time from Bevan Group, anecdotal evidence from the Practice Manager is that a proactive approach creates a better rapport with care homes and has decreased the number of visits.

The remaining Halton Practices implement mainly a reactive care home model.

Tower House Practice has shared positive evaluations of the proactive approach which reported reductions in:

- Home visits
- Hospital admissions
- Out of Hours visits
- Telephone consultations

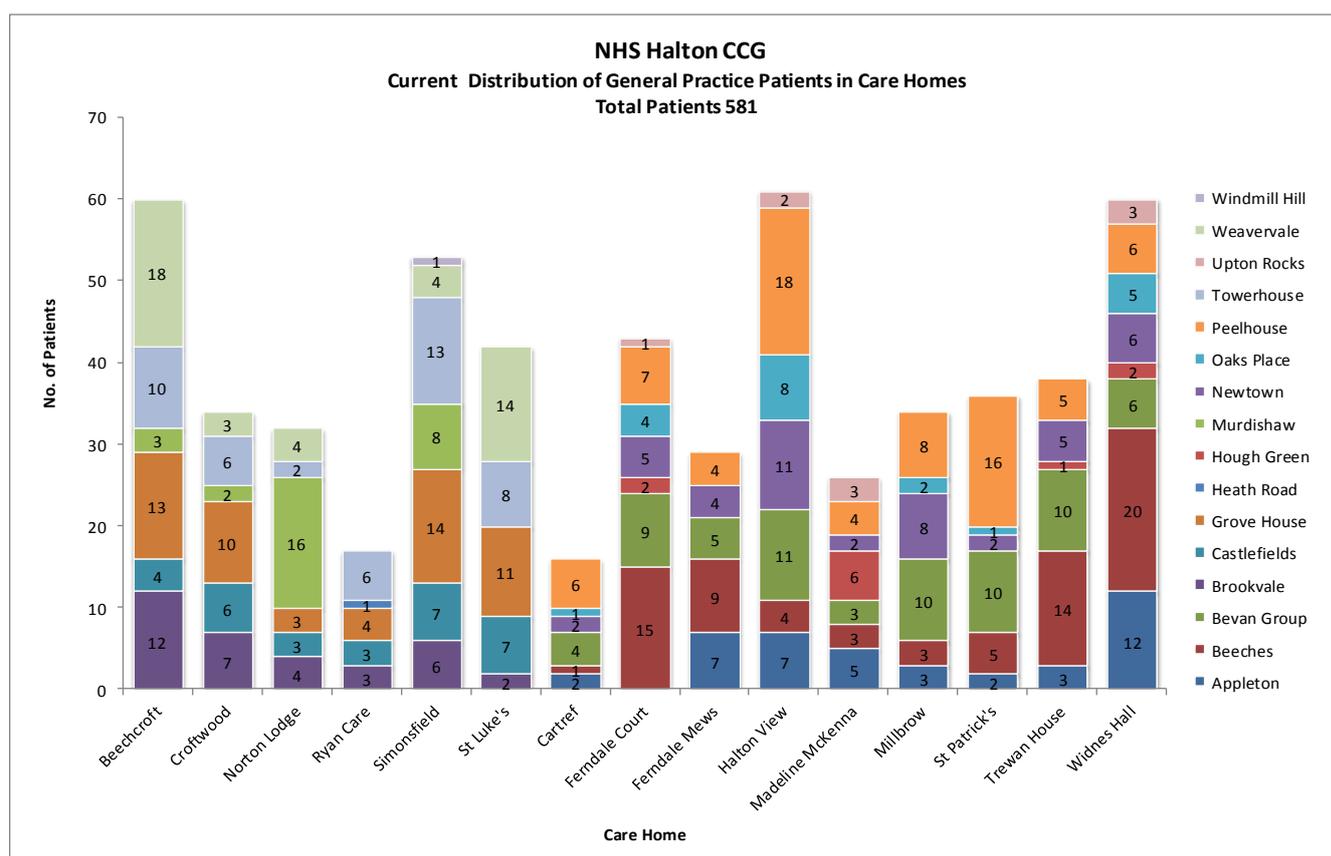
## Model Options

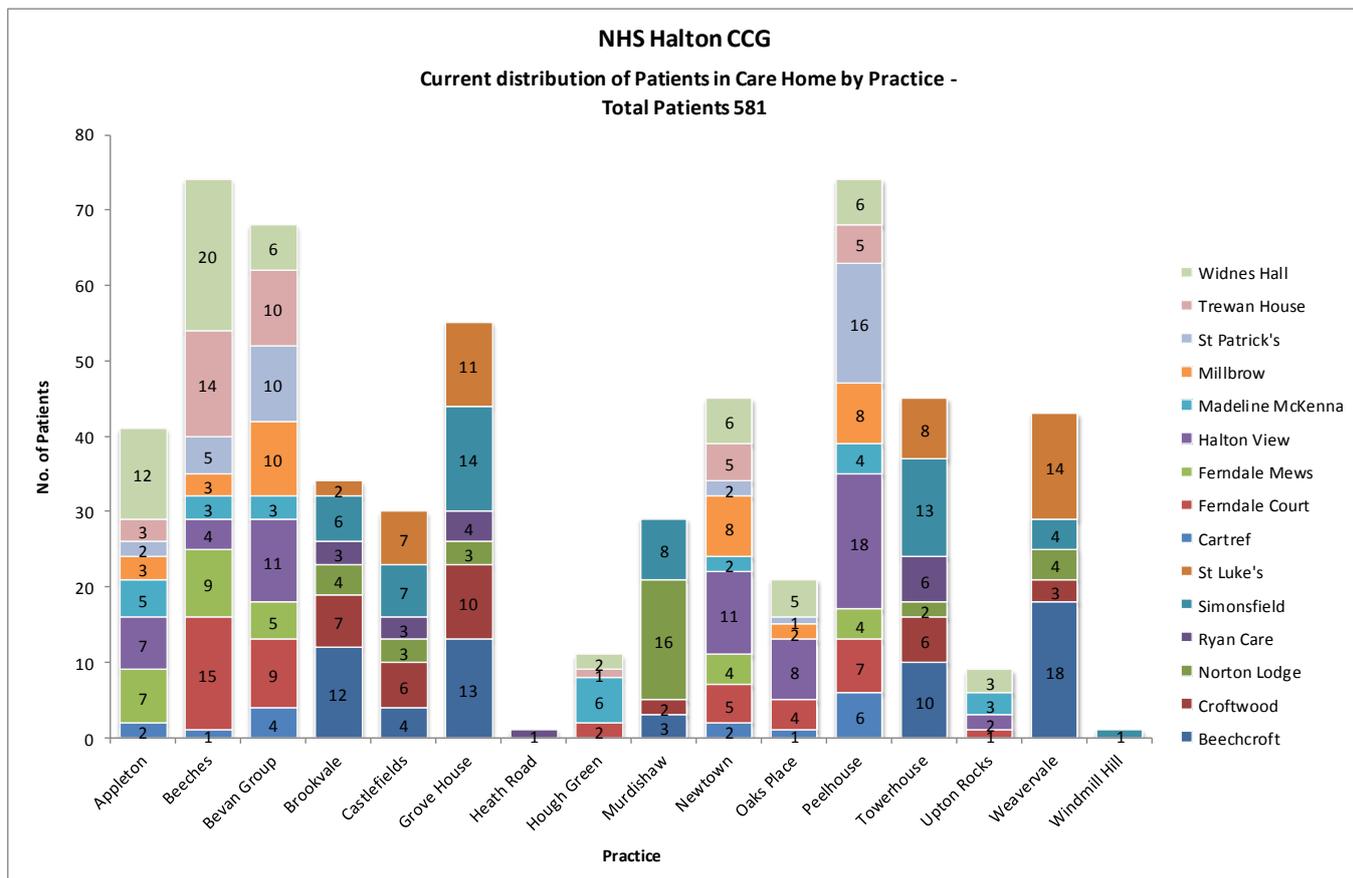
For the purpose of discussion, an outline of 4 potential models has been included.

### Model 1 - Current GP/Care Home Model – NHS Halton CCG

The current model is a mixture of reactive and proactive service delivery. There is no agreed service model that drives quality, promotes equity in access and delivers favourable outcomes.

An absence of GP alignment results in a distribution of GP Practices providing healthcare in each Care Home as described in the following charts.





There is a level of funding currently available to Practices within the 'Over 75s, £5 per head' allocation, to support nursing home ward rounds. As described earlier, this allocation is being utilised by Tower House Practice and Bevan Group. Other 'Over 75s' schemes are also in place and funded but do not directly relate to care homes. The list of schemes is due to be reviewed shortly in line with 2017/18 planning and no formal agreement has yet been established as a paper for approval will be presented to the November Primary Care Commissioning Committee.

### Model 2 – Single Practice to Care Home Model – NHS Ipswich and East Suffolk CCG

There are numerous models available nationally that focus on the delivery of proactive care model within the care home setting; these contain commonalities such as strong joint vision/purpose between stakeholders, a multi-disciplinary approach to working, defined and measurable outcomes.

Many also describe the alignment of a single GP Practice to a single care home as the enabler to improved care for patients through consistency of approach and greater care planning and a pivotal in the development of strong and effective communication.

This type of model is in use at NHS Sheffield CCG which has reported a 9% reduction in admissions and also at NHS Sutton CCG which is host to a Care Home Vanguard.

In our discussions with multiple stakeholders (GP's, care homes, Medicines Management Team, Care Home Support Team, Safeguarding, Continuing Healthcare) there was universal support for this model. In analysing national evidence the Authors of this report have concluded that his model would best meet the needs of the care home population in Halton.

It is worth noting that the initial alignment of General Practice to care homes would be cost neutral, however further development of a GP/Care Home Model such as the one in place at NHS Ipswich and East Suffolk, may require additional funding.

[NHS Ipswich and East Suffolk CCG Service Specification](#)

### **Model 3 – Virtual Triage – NHS Warrington CCG**

NHS Warrington CCG has commissioned a virtual care model approach for any nursing or residential home patient over 18 years of age. There is a dedicated phone line for referrals in which are then triaged and dealt with by a member of the Team which includes GPs. More details can be seen here; <http://www.bridgewater.nhs.uk/warrington/carehomesupport/>

### **Model 4 – Single Provider – NHS Salford CCG and NHS Southend CCG**

The Salford model is based on an agreement that a single Practice in a geographical area has responsibility for the entirety of primary care services exclusively for care home patients.

Anecdotally, some local care home residents elect to remain with their existing GP but most do register with this Practice. This arrangement is made with the full cooperation of the local GPs and LMC.

In January 2016 there were over 1000 patients registered with the Salford Care Homes Medical Practice. There is little in the way of documentation available on this service or its outcomes but contact has been made to try and understand this model better. An overview can be seen within the Kings Fund report:

<http://www.kingsfund.org.uk/publications/new-care-models>

NHS Southend CCG are also exploring the use of a similar single provider type model which is within the first 12 months pilot phase, having been agreed at their CCG Board in late 2015. A summarising article within Pulse can be seen here: [www.pulsetoday.co.uk](http://www.pulsetoday.co.uk) **7th October 2015**

Financially a model of this type would suggest that a movement of existing funding from General Practice is reviewed in line with the transfer of patients.

Dependent on the agreed service model and outcomes, there may also be a requirement for additional funding to support improved patient outcomes in the delivery of services over and above that of the existing GP contract.

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