NHS
Bath and
North East Somerset
Clinical Commissioning Group

Primary Care Commissioning Committee

Purpose	Approval	X	Discussion		Information		Assurance	
Title	Care Home LCS Review				**Agenda Item**		3.3	

Meeting	Primary Care Commissioning Committee		
Date	11 April 2019		
Title of Paper	**Care Home LCS Review**		
Executive Lead	Catherine Phillips – Acting Director for Acute Commissioning	**Executive Lead Sign off**	X
Clinical Lead	Dr Liz Hersch – GP lead for Urgent Care	**Clinical Lead Sign off**	X
Authors	Louise Sturgess – Commissioning Manager for Urgent Care		
Appendices	Appendix 1 – Enhancements to the existing Nursing Home LCS		

Executive Summary	An enhanced service for nursing homes was commissioned from GP practices in December 2012. The service provided an enhanced quality of medical cover for nursing home residents, providing high quality care in partnership with the care home and other professionals to prevent inappropriate admissions to acute care services. Following the introduction of the LCS, admissions from nursing homes substantially reduced and this reduction has been sustained. The LCS also standardised practice across BaNES, improved communication between the Care Home and GP practice and improved continuity of care for nursing home residents. A review of the LCS showed it is still yielding benefits but that the LCS could be enhanced by aligning it with local initiatives that support a move from a reactive to a proactive approach and from a medical model to a multi-professional/integrated model. The majority of the additional requirements relate to more structured assessments of new patients and their care planning. In recognition of the additional work required on admission and the throughput of residents, an additional payment of £100 for each new permanent resident into a nursing home is recommended, on top of the current annual payment of £244 per bed. Enhanced medical cover is currently not provided to residential home residents. A residential home LCS was commissioned from April 2016 as part of the transitional arrangements arising from the PMS review process. The purpose of the LCS was to confirm bed allocations across all practices and collect raw data on the number of visits GPs made to the homes. The LCS is currently paid on a fair share basis based on raw list size with the annual total cost being £99,000. A review of the data collected showed that practices visited residential homes on 2,518 separate occasions in 2017/18. This averages 6.4 visits per bed per year. The number of non-elective admissions from residential homes in BANES from April – November 2018 exceeded the number of admissions from nursing homes even though the acuity and complexity of patients in residential homes is lower than those in nursing homes. The commissioned Frailty Advanced Nurse Practitioner has talked to the top ten

	admitting residential homes and he highlighted the reactive nature of the care currently provided and a lack of continuity of care resulting from multiple GPs visiting the home. It is believed that the introduction of an LCS in residential homes would yield similar benefits in improved quality of care for residents and a reduction in non- elective admissions as was seen in nursing homes. An 18% reduction in admission from residential homes in year 1 would save approximately £200,000 in admission avoidance. Based on the findings of the review there is a recommendation to expand the LCS to include residential homes with the same annual payment of £244 per bed per year.					
Recommendation	PCCC is asked to approve the following recommendations: • To continue with an enhanced nursing home LCS from April 2019 • To pay practices an additional £100 per new permanent resident to a nursing home at an additional annual cost of approximately £92,300 to top up the current funding of £185,000. • To expand the LCS to include residential homes with the same annual payment of £244 per bed but with no additional payment for new residents. Expansion of the LCS to residential homes will cost approximately £109,800 each year.					
Risk	**High**		**Medium**		**Low**	**X**
Key Risks	The key risks are: • Practices will not sign up to the enhanced Care Home LCS. • The practices will not organise themselves to coordinate cover of the homes for a minimum of 20 beds per practice per home. • There is a risk that residents will not wish to change GP. • There is a risk that forecasted reduced admissions will not be realised. These risks are mitigated against and further details shared under 6.1.					
Impact on Quality	The service within the current Nursing Home LCS enhances patient care by providing regular clinical input into the care plans and medication review of residents. Enhancing the existing LCS as suggested will support a move toward a more multi-professional proactive approach as outlined in the Long Term Plan and in the proposed national service specifications arising from the emerging guidance on Primary Care Networks. Expanding the LCS to cover residential homes will deliver improved quality of care for residential home residents through the standardisation of practice, improved communication and improved continuity of care.					
Impact on Finance	The Care Homes LCS budget has reduced over previous financial years, with the potential for mitigating actions noted should cost pressures arise. PCCC is now asked to recommend approval of an additional total investment of £103,100. The additional payment of £100 per new permanent resident to nursing homes will cost approximately £92,300. This tops up the current annual recurrent funding of £185,000. This additional funding would be transferred from underspends in the winter pressures budget for 19/20. The residential home LCS will cost a total of £109,800 but £99,000 is already recurrently allocated as part of the PMS review. This funding reflected a transitional	**Finance Lead Sign off Name Lead:** **Gigi El-Shourbagy**	**X**			

	approach, so an additional £10,800 is required which was approved by the Savings Decision Panel in Jan 19.		
Report reviewed by	Catherine Phillips – Acting Director for Acute Commissioning Liz Hersch – GP lead for Urgent Care Val Janson - Deputy Director of Nursing and Quality Karen E Green - Commissioning Lead, Older People Care Homes Caroline Holmes - Acting Director, Integrated Health and Care Commissioning		
Potential Conflicts of Interest	Dr Ian Orpen, Clinical Chair Dr Ruth Grabham, Medical Director		

Care Home Review

1. Executive Summary

1.1 An enhanced service for nursing homes was commissioned from GP practices in December 2012. This service was developed with a number of GPs and all practices in BANES were offered the opportunity to provide the enhanced service, which is over and above core services and attracts a separate payment.

1.2 The service provides an enhanced quality of medical cover for the nursing home residents, providing high quality care in partnership with the care home and other professionals to prevent inappropriate admissions to acute care services.

1.3 Following the introduction of the LCS, admissions from nursing homes substantially reduced and this reduction has been sustained. The LCS also standardised practice across BaNES, improved communication between the Care Home and GP practice and improved continuity of care for nursing home residents.

1.4 A review of the LCS showed it is still yielding benefits but that the LCS could be enhanced by aligning it with local initiatives that support a move from a reactive to a proactive approach and from a medical model to a multi-professional/integrated model. The majority of the additional requirements relate to more structured assessments of new patients and their care planning. In recognition of the additional work required on admission and the throughput of residents, an additional payment of £100 for each new permanent resident into a nursing home is recommended, on top of the current annual payment of £244 per bed.

1.5 Enhanced medical cover is currently not provided to residential home residents. A residential home LCS was commissioned from April 2016 as part of the transitional arrangements arising from the PMS review process. The purpose of the LCS was to confirm bed allocations across all practices and collect raw data on the number of visits GPs made to the homes. The LCS is currently paid on a fair share basis based on raw list size with the annual total cost being £99,000.

1.6 A review of the data collected showed that practices visited residential homes on 2518 separate occasions in 2017/18. This averages 6.4 visits per bed per year.

1.7 The number of non-elective admissions from residential homes in BANES from April – November 2018 exceeded the number of admissions from nursing homes even though the acuity and complexity of patients in residential homes is lower than those in nursing homes.

1.8 Our Frailty ANP has talked to the top ten admitting residential homes and they highlighted the reactive nature of the care currently provided and a lack of continuity of care resulting from multiple GPs visiting the home.

1.9 It is believed that the introduction of an LCS in residential homes would yield similar benefits in improved quality of care for residents and a reduction in non- elective admissions as was seen in nursing homes. An 18% reduction in admission from residential homes in year 1 would save approximately £200,000 in admission avoidance.

1.10 Based on the findings of the review there is a recommendation to expand the LCS to include residential homes with the same annual payment of £244 per bed per year.

2. Recommendation / Rationale

2.1 PCCC is asked to approve the recommendation:

- To continue with an enhanced nursing home LCS from April 2019
- To pay practices an additional £100 per new resident to a nursing home at an additional annual cost of approximately £92,300. This is on top of the current annual budget which was £185,000 for 18/19.
- To expand the LCS to include residential homes with the same annual payment of £244 per bed but with no additional payment for new residents. Expansion of the LCS to residential homes will cost approximately £109,800 each year. £99,000 is already

allocated for the residential home LCS as part of the PMS review so an additional £10,800 is required which was approved by the Savings Decision Panel in Jan 19.

3. Background

3.1 In 2017 BANES had a resident population of 187,751 (BANES, JSNA 2016). 38,361 were aged 65 and over, of whom approximately 13% (5,022) have a diagnosis of moderate or severe frailty.

3.2 Older people are the fastest-growing section of the community with the number of people over 85 expected to double by 2040. One in seven people aged over 85 permanently live in a care home. Caring for older people in care homes is therefore one of the most important priorities for the health and care system in England. The number of older people living in care homes in England (approx. 329,000) is already more than three times the number of hospital beds, and is set to increase further.

3.3 The overall population of BANES is expected to increase to nearly 200,000 by 2024, an increase of 11% from 2014. Population projections suggest that there will be large increases in the number of older people in BANES. For example, by 2024 the number of over 75s in the population is projected to increase by 18% (approximately 5,600 people) compared with 2014 and the number of over 90s is projected to increase by 53%, compared with 2014.

3.4 Responding to the challenges of an ageing population is a key strategic priority for the CCG. In response, the CCG introduced a Nursing Home Local Commissioned Service (LCS) in 2012 which requires practices to deliver pro-active health care based on a minimum of a weekly routine visit to the nursing home.

3.5 There is considerable overlap in health status and need for care and support amongst residents in all care homes. Many residents of care homes have multiple health and care needs on admission, and others may experience declining health as part of the aging process. They are often unable to attend a GP Practice requiring visits to the care home, frequent and multiple prescribing interventions and a higher than average use of Out of Hours Services.

3.7 Currently within BANES, according to the Council records, there are 17 Nursing Homes with 790 beds and 16 Residential Homes with 506 Beds. There are two homes that have both nursing and residential beds providing an additional 46 of each between them. There are also two homes on the BANES/Somerset border which the Council class as out of area but are covered by BANES GPs. The total number of nursing beds is therefore 923 and residential is 552.

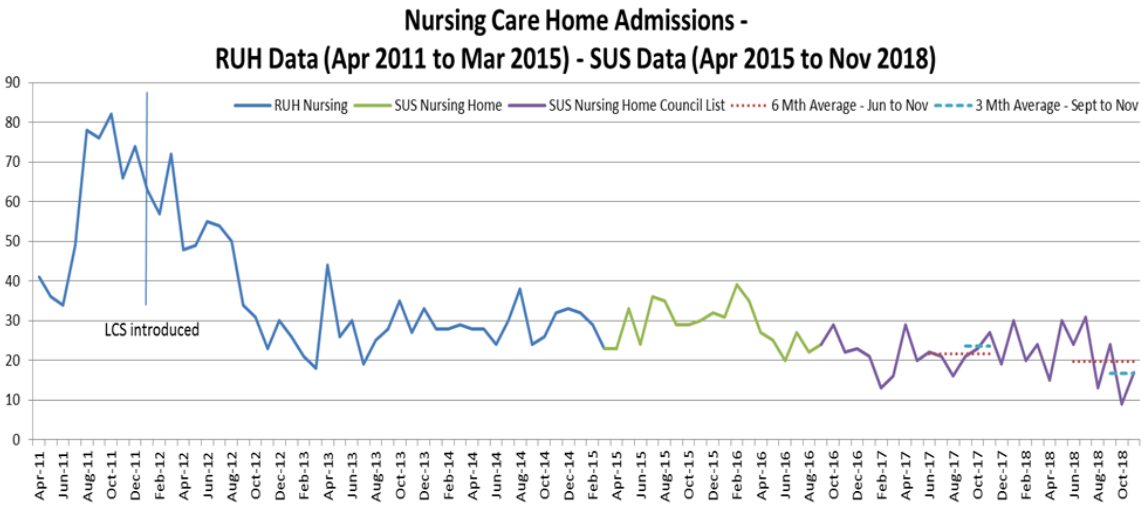
4. Nursing Home LCS review

4.1 The nursing home LCS was introduced in 2012 with the aim of enhancing the quality of medical cover for nursing home residents, providing high quality care in partnership with the care home and other professionals to prevent inappropriate admissions to acute care services. The LCS has been relatively unchanged since its introduction.

4.2 The LCS specifically requires Practices to:

- Deliver pro-active health care based on a minimum of weekly routine visits to the nursing home
- Provide high quality, appropriate end of life care for residents.
- Review the residents medication at least six monthly if the resident is stable and at every clinical review if the resident is unstable.
- Build effective communication links between Primary and Community based health care teams and nursing home staff.
- Promote the GP practice as the first point of contact when there are medical concerns for a resident.

4.3 SUS data shows an 18% reduction in non-elective admission admissions from nursing home to the RUH in the 12 months following the introduction of the LCS.



4.4 In addition to the reduction in admissions, the review in 2014/15 identified the following additional benefits which are still applicable today.

- Standardisation of practice across BaNES
- Improved communication between the Care Home and GP practice
- Residents benefit from consistent and reliable access to medical support
- Improved consistency resulting from the same GP visiting each week
- Reduced confusion for residents and relatives feel reassured by regular contact with a familiar doctor.
- Residents having better access to services such as occupational therapy and speech and language therapy.
- Care homes like knowing when the GP will visit

4.5 The Long Term Plan (NHS England), The Five Year Forward View (NHS England) and Fit for Frailty (BGS) support a move from a reactive to a proactive approach and from a medical model to a multi-professional/integrated model. A number of local initiatives that support GPs to make this shift have been introduced in recent years and the nursing home LCS can be enhanced by setting out requirements that align and support these initiatives for the benefit of Primary Care and the wider healthcare system. The detail of the suggested enhancements can be seen in Appendix 1.

4.6 Practices are currently paid £244 per bed per year on a pro-rata basis based on average quarterly bed occupancy. Recognising that the payment is not intended to fully cover all care for nursing home patients, practices still feel that the £244 payment does not reflect workload especially considering the high throughput of nursing home residents.

4.7 It has been difficult to source information on the average length of stay in nursing homes but one report from 2011 which is quoted frequently in other reports gives an average length of stay of 11.9 months (Length of Stay in Care Homes by Julien Forder and Jose-Luis Fernandez). Seven years on, the average stay of nursing home residents is likely to be even shorter, especially as the acuity of patients in nursing homes has increased and nursing home beds are used for end of life care.

4.8 In order to ensure that any further payment is linked to the additional workload related to new admissions, a £100 payment for new permanent residents is suggested instead of a blanket uplift to the payment per bed. This also takes into account that the majority of the additional requirements relate to more structured assessments of new patients and their care planning. The payment relates to approximately two hours of GP time. This payment would not apply to temporary residents such as those admitted for respite care or residents admitted into winter pressure beds or fracture pathway beds as these residents only stay 4 – 6 weeks.

5. Residential Homes

5.1 The Residential Home LCS was commissioned from April 2016 as part of the transitional arrangements arising from the PMS review process. The LCS is currently paid on a fair share basis based on raw list size with the annual total cost being £99,000.

5.2 The purpose of the current Residential Home LCS is to confirm the allocation of residential home beds across all practices and collect data on the number of GP visits to each home. The data shows that in 2017/18, 20 practices covered 392 beds in 19 residential homes.

5.3 The practices visited the homes on 2518 separate occasions in 2017/18. This equates to an average of 42 visits a week in Q1 and Q2 and 54 visits a week in Q3 and Q4. It also averages 6.4 visits per bed per year.

5.4 As part of other commissioned work on frailty, we have commissioned the support of a Frailty Advanced Nurse Practitioner (ANP) who has talked to the top ten admitting residential homes. They highlighted a number of issues relating to;

- Multiple GPs visiting the home and the lack of continuity of care, the reactive nature of the care currently provided,
- Their frustration that GPs will not generally discuss the care of another residents when called out for a visit even it that resident is registered with the same practice
- How following an acute admission it can sometimes be weeks before the home are aware of changes made by the hospital due to a lack of communication with both the RUH and the GP.

5.5 The number of admissions from residential homes so far in 2018/19 has been higher than the number from nursing homes (202 vs 163) and in 2017/18 admissions from residential homes was just 7% lower than the number from nursing homes.

5.6 It is believed that the introduction of an LCS in residential homes would yield similar benefits in improved quality and standardisation of care as well as reduced non elective admissions as was seen for nursing homes. An 18% reduction in admission from residential homes in year 1 would save approximately £200,000 in admission avoidance.

5.7 The Urgent Care Commissioner is therefore recommending the nursing home LCS is expanded to also include residential homes. The LCS requirements should be the same for both nursing and residential homes. It is felt that weekly visits to residential homes are appropriate initially, due to the large number of residents that will require review. This should be reviewed in Q4 2019/20 to ascertain whether the frequency of visits to residential homes can reduce to fortnightly and attract a lower payment. The requirement for GP practices to cover a minimum of 20 beds will also apply to residential homes.

5.8 As the cover is the same for both nursing and residential homes the annual payment of £244 will apply. The cost of introducing a Residential Home LCS is therefore approximately £109,800 based on 450 residential home beds being covered.

5.9 The residential home LCS requested information on the number of beds covered and not the number of patients cared for and therefore the turnover of patients in residential beds is unknown. However a report by Laing Buisson entitled Care of Older People: UK Market Report, May 2017, p. xxiii, estimated that the average stay in residential homes is 30 months. Given the average length of stay is much longer for residential home residents, the additional £100 per new permanent resident will not apply.

5. Resource Implications

5.1 The costs to provide this enhanced service can be summarised as follows:

£10,800	The total cost of the residential home LCS is £109,800 based on £244 being paid per year for 450 beds in 2019/20. £99,000 has already been allocated for the residential home LCS as part of the PMS review so an additional £10,800 is needed.
£92,300	£100 per new permanent nursing home resident recognising the additional work required with the high resident turnover. This tops up the current funding of £185,000
£103,100	**Total additional resource required**

5.2 £99,000 has been allocated for the residential home LCS as part of the PMS review for the past 2 years and is part of the Primary Care Budget for 19/20. The additional £10,800 to pay for the residential LCS was approved by the QIPP Savings Decision panel on the 17th January 2019.

5.3 The Senior Commissioning Manager for Primary Care has advised that the £92,300 to fund the £100 for new residents is available within the Primary Care Budget.

6. Risk Management

6.1 The key risks associated with the suggested recommendations are:

Risk	Mitigation
There is a risk that practices will not sign up to the enhanced Care Home LCS.	The Frailty ANP presented to a Care Home Forum during 2018 and strong support was expressed to bring the residential homes in line with the nursing homes
There is a risk that the practices will not organise themselves to coordinate cover of the homes for a minimum of 20 beds per practice per home.	The practices undertake a large number of visits to residential homes and should see the benefit of streamlining their visits.
There is a risk that residents will not wish to change GP	It is accepted that changing GP is the patient's choice and a patient will not be made to change. Overtime the benefits of registering with the home's GP should become apparent to residents.
There is a risk that forecasted reduced admissions will not be realised.	The admissions have been based upon the best information available and experience through the Nursing Home LCS.

7. Next Steps

7.1 If the recommendations are approved by PCCC the Commissioning Manager for Urgent Care will:

- Communicate the changes to the nursing home LCS to GP Practices
- Communicate the extension of the LCS to cover residential homes to GP Practices
- Gain sign up to the enhanced care home LCS and re-issue the charter to be signed by both the GP practices and the care home committing to an agreed way of working
- Develop the new reporting template

Appendix 1: Enhancements to the current nursing home LCS

Current LCS	Opportunities for improvement	Rationale
Practices to undertake a face to face assessment of new residents within 5 working days of admission this should include a medication review (particularly use of analgesia, laxatives and hypnotics), an assessment of functional status and general health and all major diagnoses should be noted and considered.	A full assessment of all new residents within 10 working days of admission. Details of the areas to be covered in the assessment can be found in appendix 2. Residents returning from a hospital admission should be reviewed within 5 days of their return.	GPs advised that if the assessment is undertaken too soon after the patient's arrival, the care home staff will not have had time to get to know the resident and all the information needed for medical clerking and assessment are not always available. To standardise the assessment and encourage a more pro-active approach towards patient care.
No requirement to screen for dementia	All new residents should be screened for dementia using the DIADEM tool.	Some care home residents with advanced dementia have never had a formal diagnosis. In these cases a referral to memory services is rarely desirable. It is likely to be distressing for the individual and is usually unnecessary. People with advanced dementia, their families and staff caring for them, still benefit from a formal diagnosis. It enables access to appropriate care to meet individual needs and prompts staff to consider MCA and DOLs issues where appropriate.
Advance Care Planning (ACP) should be considered for all residents entering the care home with nursing.	The assessment should include advanced care planning and end of life conversations and completion of the ReSPECT/ TEP form for all residents within 10 working days of admission. The ReSPECT/TEP form should be updated as necessary following a change in the patient's condition or wishes (A separate ReSPECT LCS will be in place for 19/20).	All residents in care homes should have the opportunity to discuss their wishes. An audit by the Frailty ANP showed that a large number of our current TEP forms were not fully completed for care home residents.
All residents covered by the LCS should receive a full review including a medicine review and LTCs at least every 12 months. The GP and pharmacist often visit the home at different times of the week with the GP being tasked to make the suggested changes via TPP.	All patients covered by the LCS should receive a full review including LTCs at least every 6 months. Medicine reviews should be targeted based on patient need The GP and the pharmacist should try to co-ordinate their visits to the care home	An annual medical review was not felt to be regular enough for this complex group of patients. Evidence from other areas suggests that a more targeted medicine review approach is more effective focusing on new admissions and discharges from hospital. To facilitate discussions between the GP and the pharmacists so that medication changes can be enacted within one week.

Nominate a lead GP and promote the GP Practice as the first point of contact when there are medical concerns for a resident. Practice should give nursing homes a clear protocol on how to contact the lead GP and undertake to respond positively and appropriately to any emergency request for visiting a resident and be willing to provide a telephone opinion or triage in urgent circumstances. To support continuity, practice staff should undertake to direct all urgent calls from staff in charge of the home straight to the lead GP.	Practices should have an agreed process for repeat and urgent prescriptions. Homes should be encouraged to request medications monthly, 7 – 10 days in advance with the Practice processing requests for repeat prescriptions within 48 hours. Practices pro-actively contact homes each week to check on any patients whose condition is worsening and repeat medication requests.	The IUC CAS takes just over 200 calls a month from Care Homes. Referrals largely fall into: • Unpredictable acute clinical presentation requiring urgent assessment • Falls • Acute clinical presentation that requires urgent clinical assessment but could have been supported proactively in hours • Medication issues including; repeat medication required that has not been arranged in time, medication missed or medication given in error.
This is a new requirement	Practices should support Care homes to adopt and complete NEWS2 as it is introduced to the homes they visit. Practices should also encourage care home staff to provide a NEWS2 score when they call the Practice with an urgent request for a visit.	Use of NEWS2 helps care homes • Recognise when a resident may be deteriorating or at risk of physical deterioration • Act appropriately according to the residents care plan to protect and manage the resident • Obtain a complete set of physical observations to inform escalation and conversations with health professionals • Speak with the most appropriate health professional in a timely way to get the right support • Provide a concise escalation history to health professionals to support their professional decision making
This is a new requirement	Practices should support the frailty agenda and data sharing by completing the medical section of the CGA when required and attend MDTs held in the Nursing home (attendance at MDTs will attract a separate payment).	An MDT model can facilitate a proactive care approach improving efficiency, making care plans more resident centred and improving outcomes.
The latest version of the ACP should be linked with the GP record as well as in the nursing notes. The GP practice must also ensure that any special instructions are provided to the Out of Hours provider via the Adastra End of Life Care register or Adastra special notes alert screen and updated where appropriate.	Practices should appropriately code the patient's record and seek permission from the patient to share their record.	This ensures other providers in the system can access essential information through the summary care record with additional information or view the patients record in TPP