Health and Social Care Board

NORTHERN IRELAND LOCAL ENHANCED SERVICE:

PROACTIVE GP CARE FOR NURSING AND RESIDENTIAL HOMES

2020-2021

INTRODUCTION

All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. This enhanced service specification outlines the more specialised service to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

BACKGROUND

Covid-19 has highlighted the need for clear care pathways and medical care planning for care home residents with clear communication across the health and social care system.

This NILES will combine and replace a number of current enhanced services to include the nursing and residential care element of NILES medical care planning, Key information summaries and a number of proactive care home local enhanced services. This will allow a regional NILES incorporating the core elements of these services for care home patients. Patients who are suitable for medical care planning but not resident in a nursing or residential home will be reviewed as previously, through NILES medical care planning. Going forward all nursing and residential home residents will have medical care plans completed through this service.

HSC Trusts are planning to develop Trust Multidisciplinary Support Teams (TST) who will go into care homes and be available to support GPs in accessing appropriate services for their patients.

AIMS

1. To identify care home resident wishes to allow planning of future care.
2. To proactively review new care home residents medical needs as soon as possible after arrival in the home.
3. To proactively review care home residents ongoing medical needs on a regular basis.
4. To develop or update an individual medical care plan to improve the patient's quality of life, aid decision making when managing deterioration in health and identify and address any palliative care needs.
5. To use Key Information Summaries to improve communication of patient wishes from primary to secondary care.
6. To use local services and Trust Multidisciplinary Support Teams (TST) as available to help manage care home residents' health needs within the care home setting when possible. With the aim of avoiding hospital admission unless necessary.
7. When hospital admission is required to use local pathways as alternatives to ED when possible.
8. To improve team working and communication within the care home, community, primary care and HSC Trust services.
9. To allow standardisation of organisational aspects of providing primary care services for care home patients (to include GP registration processes, home visits, repeat medications, care planning and communication across interfaces between primary and secondary care)

ELIGIBILITY CRITERIA

All Northern Ireland GP practices are eligible for this NILES with the exception of 15 Practices within the East Antrim Area GP Federation who contract to provide East Antrim Nursing Home Inreach. These contracted practices will continue to provide the Nursing Home inreach Local Enhanced service and will continue to care for their care home residents through the provision of this existing LES for the remainder of the financial year.

SERVICE OUTLINE

Please note: For the purposes of this NILES only patients in permanent/temporary nursing/residential beds are included. Patients residing in sheltered housing and short term respite bed etc should be reviewed through the NILES medical care planning as appropriate.

Proactive GP Care

The GP practice to provide a weekly review to all nursing and residential homes it has patients residing in. Arrangements for the review (day or time) should be agreed with the home at sign up to the service. The review should be completed by a GP working regularly within the GP practice, which could include an ST3 GP trainee as part of their training.

Given the ongoing change in General Practice workforce, please be aware that if you have members of the MDT completing work for any enhanced service which specifies a GP must complete the work, then you will **not** be able to claim payment for this work.

A list of both temporary residents and permanently registered patients requiring review should be compiled in advance by the care home. A review should be done to address any concerns on request of staff, the patient or the patient's relative. All new patients registering permanently or temporarily to a care home should also have a formal review at the next proactive weekly review. This should include any patients who are discharged back to the home following a hospital admission.

This NILES does not negate the responsibility for appropriate planning for patient care prior to admission to a care home. Prior to transfer to a nursing or residential home plans for GP registration should be considered and a management plan should be in place. On discharge from hospital up to 28 days supply of medication should be supplied as per Regional Policy http://primarycare.hscni.net/?s=28+day+discharge with all relevant medical details and any follow up investigations or onward referral to other services in place. This will aid the GP in their formal review which for the purposes of the NILES should include establishing current medical conditions, a review of medication and updating of the patients medical records. Community pharmacy should be informed of any medication changes as appropriate.

If no patients require a GP review from the care home on a particular week this should be communicated to the practice. The care home and practice should agree at commencement of the service how this will be communicated. Patients identified for review should be assessed either remotely or face to face depending on clinical need.

Patients who are acutely unwell between the planned weekly review will still be assessed by the GP under normal GMS contract arrangements.

Patients who have medical needs beyond usual GMS requirements (eg those in intermediate care beds), will continue to have their medical care through established HSC trust arrangements and will not be included in the reviews for the purposes of this NILES.

As the HSC trusts develop their Trust Multidisciplinary Support Teams (TSTs) GPs can give direction to them as required to assist the GP in managing patient care. As acute care at home teams are developed with community geriatrician leads, GPs providing this NILES will be able to discuss and refer patients accordingly through this pathway. GPs using the NILES are expected to become familiar with available pathways as they are developed and to work with the Trust Multidisciplinary Support Teams to provide best care for patients.

Medical Care Planning and Key Information Summary (KIS)

All new permanently registered patients should have a medical care plan completed within 4 weeks of admission to the care home.
See **Appendix 1** for Medical Care Plan template.

All other permanently registered patients in the care home should have a medical care plan completed or reviewed on an annual basis.

All registered nursing/residential home patients should have a care plan completed or reviewed before year end. Exceptions will be granted for patients who are resident for less than 4 weeks eg have been discharged or died before GP able to complete care plan, or any new residents in the last 4 weeks of the contracting year.

The medical care plan should be used to complete the KIS template and should be uploaded to NIECR subject to patient consent/patient best wishes.

Medical Care plans can be completed during the planned weekly review. Ideally medical care plans will be completed face to face. However, given the current situation with Covid-19 in some circumstances it may not be appropriate for GPs to attend patients face to face. GPs can use their clinical judgment to decide when it is more appropriate to provide the service via telephone or video call. This should ensure practices can continue to provide this NILES as a priority even in the event of further Covid-19 pressures.

When completing the Medical Care Plan the following should be completed:

- **Identify and record existing record of patient wishes or Advance Care Plan Summary or formal advance decision to refuse treatment**
  NOTE: Advance care plan summaries or other records of patient wishes are non-legal documents which should influence patient care. Advance decision to refuse treatment is a legal document completed by the patient. These are less frequently used but do have legal

standing. https://www.nhs.uk/conditions/end-of-life-care/advance-decision-to-refuse-treatment/

Identify if the patient has a "Record of my Wishes" such as the one provided in "Your Life and Your Choices, plan ahead" booklet or an Advance Care Plan Summary (attached as **Appendix 2**)

If so these should form the basis of discussions and completing the Medical Care Plan.

If they do not have a record of their wishes the patient should be offered the option of completing an Advance Care Planning Summary if they wish to do so (it is not a requirement). Time and support should be offered to complete a record of my wishes or Advance Care Planning Summary. The Advance Care Planning Summary can be completed by a healthcare professional who knows the patient, such as care home nurse, heart failure or respiratory nurse or palliative care key worker before the holistic review or by the GP during the holistic review.

- **Medicines review**
  Medicines review should be carried out either shortly before or during the holistic review. Practice pharmacists or GPs can complete the medicines review. Community pharmacy should be informed of any changes as appropriate.

  In Spring 2020, all Nursing homes in Northern Ireland were offered a pandemic pack which contains medicines for clinically urgent care in covid or non covid situations. This includes antibiotics as well as other medicines eg anti-emetics. The list of homes with a pack in place, details of content and arrangements for replenishment can be found at:
  http://www.hscbusiness.hscni.net/services/3162.htm

- **Face to face (or remote consultation) structured holistic review by GP and completion of medical care plan**
  a. This should be completed annually for all patients identified.
  b. Check Medicines review has been completed and advance care plan has been offered.
  c. The medical care plan should be developed after face to face (or remote consultation) review of the patient and input from other professionals involved with the patient's care and relatives
  d. **For some (but not all) patients** it may be appropriate to consider a Do Not Attempt CPR (DNACPR) decision. A copy

of the plan should be left with the patient/carers/nursing home.

e. A copy of the plan should be included in the patient records.
f. The medical care plan should be used to complete a Key Information Summary (KIS) and (if consented/best interests) uploaded to ECR.
g. The Special notes box on the KIS should be used to record the existence **and location** of any advance care planning summary or advance directive to refuse treatment or DNACPR decision (eg in patients hand held records, with nursing home manager)

- **Completing and Uploading KIS**
  See **Appendix 3 and 4** for information about completing the KIS template and a patient information leaflet. The KIS template should be completed based on the medical care plan. If required practices can request training in KIS completion and upload by emailing: KISinformation@hscni.net

  Patients with capacity should be asked for their consent to upload KIS to ECR. KIS should be uploaded with consent or if not uploaded a note of dissent should be recorded.

  GPs may make a best interests decision to upload KIS to ECR for patients who do not have capacity to make that decision themselves.

Team working and communication

Practices participating in the NILES should participate in 2 meetings throughout the year with representatives from GP practices and the nursing and residential homes. The homes and practices should determine how this is best delivered. It may be more convenient to arrange a single meeting for groups of care homes or groups of practices to avoid duplication of work, or for a practice with the majority of patients within a care home to meet with that particular care home and then feedback to other practices participating in the NILES with patients resident in the home. Only practices who participate in a meeting can claim payment.

Once the meeting is arranged the practice may wish to invite other attendees for example; the Trust Multidisciplinary Support team (TST), consultant geriatrician and palliative care team and community pharmacy.

The meetings can be arranged remotely as required. They should last a minimum of 1 hour. These meetings can be used as opportunity for;

- Review of any relevant governance issues within the care home
- Review of any GP organisational issues such as prescribing arrangements, GP registration.
- HSC Trusts to present any new development of pathways, or reiterate current pathways. Opportunity for discussion about any difficulties accessing these pathways or ways of improving them.
- Update from consultant geriatrician/ Trust Multidisciplinary Support team (TST) as appropriate.
- The attending GP will be expected to disseminate a written summary from the meetings back to their GP practice and any other GP practices they have agreed to represent.

TRAINING AND ACCREDITATION

Practices must ensure that any General Medical Practitioner who provides this service can satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to provide this enhanced service.

Practices must assure themselves that appropriate governance arrangements are in place to provide this service.

VERIFICATION

The service will be subject to post payment verification checks and practices should be sure before submitting the claim that they fulfil the criteria and the session meets the requirements stated in the specification. Failure to provide this information may result in the recovery of fees.

FEE LEVELS

The fees below include the submission of monthly and year end data returns.

1. **For patients permanently registered with the contracting Practice who reside in a nursing/residential home**

- Fee of £16.67 per patient per month (equates to up to £200 per patient per year)
- Fee of £110 per medical care plan and KIS completed

2. **For temporary residents with the contracting practice who reside in a nursing/residential home**

- Fee of £16.67 per patient per month for a period of up to 3 months.

- Fee of £110 per patient for temporary residents who receive a formal review on admission to a nursing/residential home

3. **For preparation, attendance and feedback at practice/care home meeting**

4. **Fee of £200 (Up to a maximum of one meeting every 6 months)**

Please Note:
Although the medical care plan may be reviewed when clinical situation or place of care changes, only one review/medical careplan per patient per year can be counted/claimed.) Medical careplans already completed under the previous 2020/21 NILES Medical Care Planning cannot be claimed for again in the same financial year under NILES Proactive GP care for nursing and residential homes.

PAYMENT PROCESS

Practices which have contracted to provide this service should make claims using the data return/claim form and return to their Practice Support Manager.

Given the ongoing change in General Practice workforce, please be aware that if you have members of the MDT completing work for any enhanced service which specifies a GP must complete the work, then you will **not** be able to claim payment for this work.

REPORTING REQUIREMENTS

1. Name of all nursing home and residential homes covered by the contracting GP Practice (Worksheet 1)
2. Number of patients permanently registered with the Practice who reside in residential/nursing home at the commencement of the service and on a monthly basis. (Practice Information & Worksheet 1)

3. Number of temporary residents residing in a nursing/residential home at the commencement of the service and on a monthly basis. (Practice Information & Worksheet 1)
4. Number of temporary residents who have had received formal review at admission to nursing/residential home (Worksheet 1)
5. Number of Medical Care plans, advance care planning summaries and KIS templates uploaded to NIECR for permanently registered patients in a nursing/residential home (Worksheet 2)
6. Confirmation of attendance at the Practice/Care home meeting (Worksheet 2)
7. Confirmation that **Appendix 5** has been shared with Nursing and Residential homes covered by contracting Practices. (Practice Information)

RECOMMENDED DATA ENTRY TEMPLATE & READ CODES

Seen in nursing home
Read Code **9N1G**

When KIS completed code:
Electronic record notes summary verified
EMIS / Vision Read Code **93440**
Merlok Read Code **XaR5K**

If not uploading KIS to ECR due to patient dissent code:
Dissent for KIS upload
Read Code **9Nds**