Appendix 4-Health Care Home Support

A comprehensive and integrated Care Home support offer

The most recent request from NHS England to bring forward aspects of Enhanced Care in Care Homes to be implemented in mid-May is an opportunity to improve on current arrangements in Wiltshire to make them both comprehensive and integrated. The approach in Wiltshire is to build upon the existing local support and make this as an offer of support to care home provider partners, rather than providing unwanted support that has been centrally defined. It is proposed that whole offer to support care homes should comprise:

- **Regular contact/monitoring of risks and issues:** The 'Care Home support' team in Wiltshire Council making proactive contact and receiving queries/ request for support from Care Homes. Existing questions that have been developed during the last few weeks about clinical risk factors will also be updated to include proactive prompt to participate/flag up particular issues for a weekly multi-disciplinary 'virtual home round'. This could include the need for clinical review of new residents, or residents of particular concern for clinical review.
- **Streamlined approach to advice and guidance for the care home sector.**
    - A reference group, to be established to support local interpretation of guidance and design of solutions to resolve issues identified.
    - Webinars, offered to all care homes.
    - Education offers, such as infection control where requested
- **Virtual weekly 'check in' meetings** with a multi-disciplinary support team. Using Microsoft Teams as the structure for a 'virtual home round' weekly session offered at PCN level to all care homes in area (in PCN areas with large numbers of homes, this may be subdivided into clusters of care homes). This would be on a common platform allowing both existing activity and a broader team to come together in one process. To include GPs, Clinical Lead from community team, social workers and other colleagues, such as secondary care consultants, Dorothy House and other hospice outreach colleagues. As these are established, further opportunities to use consistent assessment tools etc. can be rolled out over time.

  This can be supported by offering access to the community module of SystmOne to colleagues without SystmOne access (such as geritricians/other consultants) – allowing all clinicians access to notes to support consideration.

  It is proposed that there would be three types of discussion in these 'check in' sessions for care homes:

    - **Weekly escalation point**: Open invitation for each session for all care homes in the area to flag up specific residents for review/discussion to the weekly session. Issues flagged up to care home support team in Wiltshire Council. Care Home given a time slot for the Check In meeting by a local coordinator.
    - **Ongoing review of 'virtual home round':** for residents who have received follow up care/care planning and would benefit from ongoing review at a check in meeting. Agreed through meeting as follow up action.

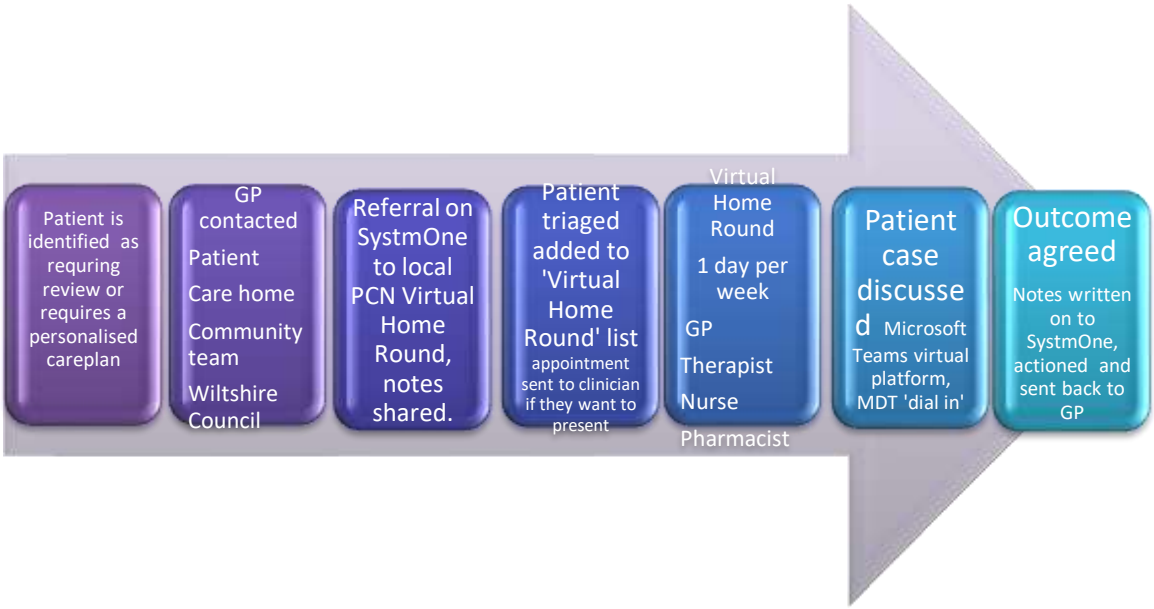
- **Quarterly stocktake**: Each care home invited to attend for an overall stocktake once a quarter (issues to discuss include any issues with accessing clinical advice and support, knowledge and awareness of clinical guidance, assessment tools etc,).

- **Virtual 1:1 'appointments'** to support medicines review and any follow up with individual residents following MDT. While individual GPs and other clinicians may use accuRX for 1:1 consultation for known patients, it is proposed that Care Homes should also be able to access Attend Anywhere as platform for online consultations (this does not require the patient's own mobile number to be known, can support multiple clinicians in a patient consultation and is in use with specialist community teams already) Notes written up on SystmOne, regardless of who has followed up (therapist, nurse, GP, pharmacist, consultant). Further work required to ensure that there is support available to access these systems.

- **Physical follow up** where required; agreed as actions through the virtual home round process, meaning coordinated follow up: notes written up on SystmOne, regardless of who has followed up (therapist, nurse, GP, consultant). All visiting clinicians would provide their own PPE and observe guidelines. If there any broader risks or issues identified during a physical visit, the team member should feed these back to the rest of the virtual team at a weekly meeting and/or through normal escalation arrangements.

Benefits

- **One clear support offer for Care Homes to understand and access**; responds to feedback that, when homes are under pressure, one of the exacerbating factors is the number of contact points and external queries.
- **Does not rely on physical access to the home during COVID.**
- **Brings together** local authority role in overseeing risks in care home sector with the clinical support offer.
- **Feedback loop from 'check in' sessions to Wiltshire Council monitoring of overall risks for providers.**



CARE HOME SUPPORT: MEETING THE REQUIREMENTS OF NHS ENGLAND LETTER

Summary of requirement from letter	What will be in place by 15 May.	What needs to be added over coming weeks	Proposed Action/ Timeline
Delivery of a consistent, weekly check in to review patients identified as a clinical priority for assessment and care. • Delivered remotely wherever appropriate • Include appropriate and consistent medical oversight • Be supplemented by more frequent contact where further needs are identified.	GP involvement and – in some areas – a broader primary care team is in place in most areas as part of a locally commissioned service. Delivering support to care homes across Wiltshire.	Existing arrangements to be broadened to include community health staff (both general or more specialist) or any secondary care expertise where necessary/helpful. Move to fully virtual model on a common virtual platform. A consistent Standard Operating Procedure for these sessions, to allow colleagues who may join multiple sessions across a number of PCN areas to be as effective as possible. Common platform for remote consultations with care home residents Access to SystmOne for colleagues with no access	Community staff identified in each PCN area. Availability of geritrician support identified: WHC – by 31 May 2020. Structure of MS Teams set up for each PCN Further development of high level details in this draft . Attend Anywhere extended to include care home service area. (WHC – by 31 May 2020) WHC – by 31 May 2020, to allow for common noting and sharing platform.
Development and delivery of personalised care and support plans for care home residents	Majority of residents will have care plan in place that reflects their views, family and carers perspectives.	Further structure for support on care planning, recognising holistic picture rather than simply their medical needs. Any need for further support will be identified in the Check In meetings and refer to guidance/best practice.	Ensure is part of focus of local groups; support through guidance.
Provision of pharmacy and medication support to care homes • Facilitating supply • Delivering structured medication review via video or telephone • Review of new residents • Support for care home with medication queries	Medicines Optimisation Care Home (MOCH) team 0.8wte pharmacist and 2wte technicians. 9 community pharmacies commissioned to hold additional stock of EoL medicines. Medicines queries advice line. Monthly newsletter.	Facilitating IT connectivity and secure transfer of info including supporting use of nhs.net and access to TPP clinical system. Nhs.net access in 52% of BSW care homes as of April 2020 Wiltshire has a medicines queries advice line. 92% care home uptake	To work to achieve 100% on areas especially nhs.net access.