Our Health Partnership

OHP A healthy future for patients and practices

Care Home Support from General Practice

NHS England have requested several services are put in place to support the care home sector. Primarily this is in response to the COVID pandemic but also longer term to ensure there is joined up care for your residents.

Our Health Partnership is leading on this piece of work on behalf of the Practices that are part of the partnership.

A summary of the services that are currently being introduced to your home are:

1. **Weekly check in with care homes-**
   - Each care home registered with each practice will receive a weekly check in call starting next week.
   - The purpose of this initially is to establish if there are any issues (including those relating to medicines and End of Life care (EoL)), new diagnoses of COVID and to identify patients requiring urgent clinical input.
   - Where issues are identified these are will be dealt with through the existing systems and processes.

2. **Medications issues and queries-** it is important to note that there should already be systems in place for managing medicines related queries and issues. We have summarised these along with ongoing work on improvements below:

   - We now have clinical pharmacists in every PCN (group of practices) who can support existing practice teams with medicines and prescribing related queries, this is already happening to some extent, we are working with the CCG to formalise communication channels.
   - The PCN Lead pharmacists will work with their clinical colleagues in the Practices to ensure these systems to support medicines access and good medicines practice are in place.
   - The Local Pharmaceutical Committee has shared details of each PCN Lead Community Pharmacist who can support us with relevant prescribing and medicines issues (including access).
   - There is national ask for all prescribing where possible to be completed electronically and where appropriate to be converted to Repeat Dispensing.
   - Implementation of guidance on medicines reuse in care homes provided where appropriate.

3. **Personalised Care Planning:** it is important to note that there should already be systems in place for personalised care planning and this remains the responsibility of the individual patients GP.

At Our Health Partnership we have developed a joint system and part of this is employing 'Care Coordinators', who will be the first point of contact and who will be undertaking the

weekly check in (see point 1 above), where it is necessary to convene a ward round, which will initially be virtual they will also arrange this and signpost you where needed to any other relevant member of our multi-disciplinary support team.

See the 'resources section' below for more details

If you have any questions email ***carehomes@ourhealthpartnership.com***

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