Our Health Partnership

OHP A healthy future for patients and practices

Report on processes for weekly check-in and care home support In Birmingham OHP supported GP Practice and Primary Care Networks

Introduction:

Our Health Partnership (OHP) will be overseeing the delivery of the interim care home service contract across their 8 supported Primary Care Networks (PCN) in Birmingham until the end of September 2020. From October 2020 this will be replaced by the Enhanced Health in Care Homes Framework which is part of the Primary Care Directed Enhanced Service (DES).

This is the start of a transformation project which will involve developing Multi-Disciplinary Teams (MDTs) operating at both PCN and cluster level. These MDTs will incorporate PCN level additional reimbursable roles (ARRs) in addition to existing GP Practice and cluster level provider staff as appropriate.

We are specifically developing our PCN MDT model for delivering the Enhanced Health in Care Home DES with the care coordinator role being a pivotal contact to ensure the resident and their carers gets the right input from the right MDT member(s) at the right time. This is described in Figure 1 below:

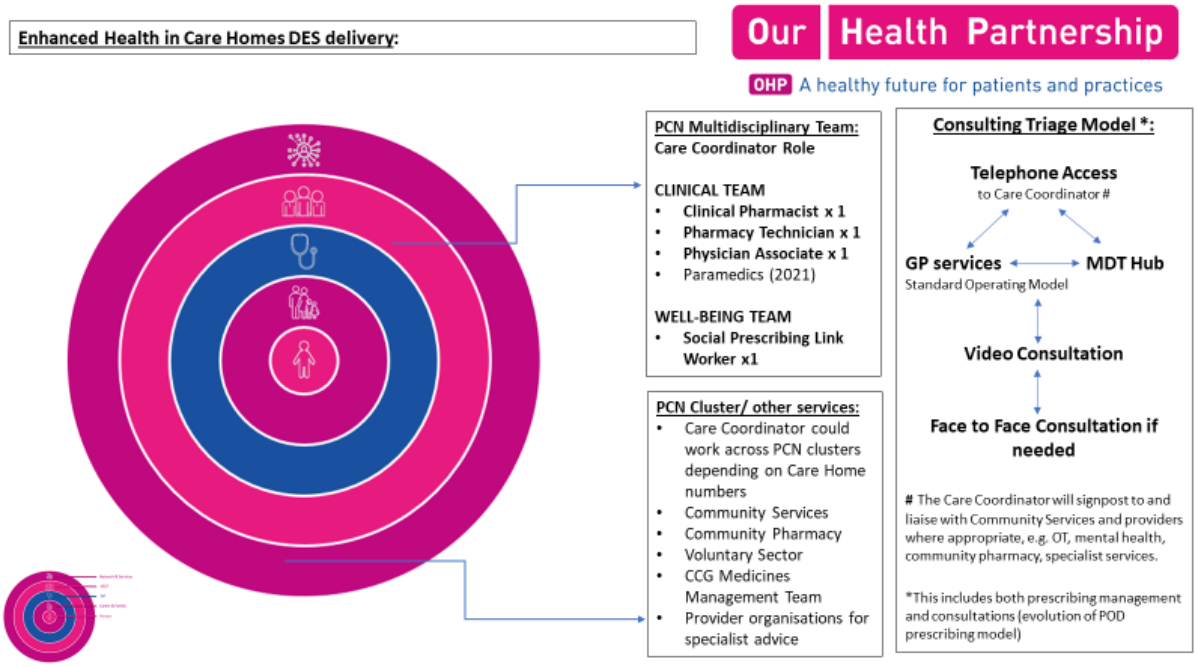
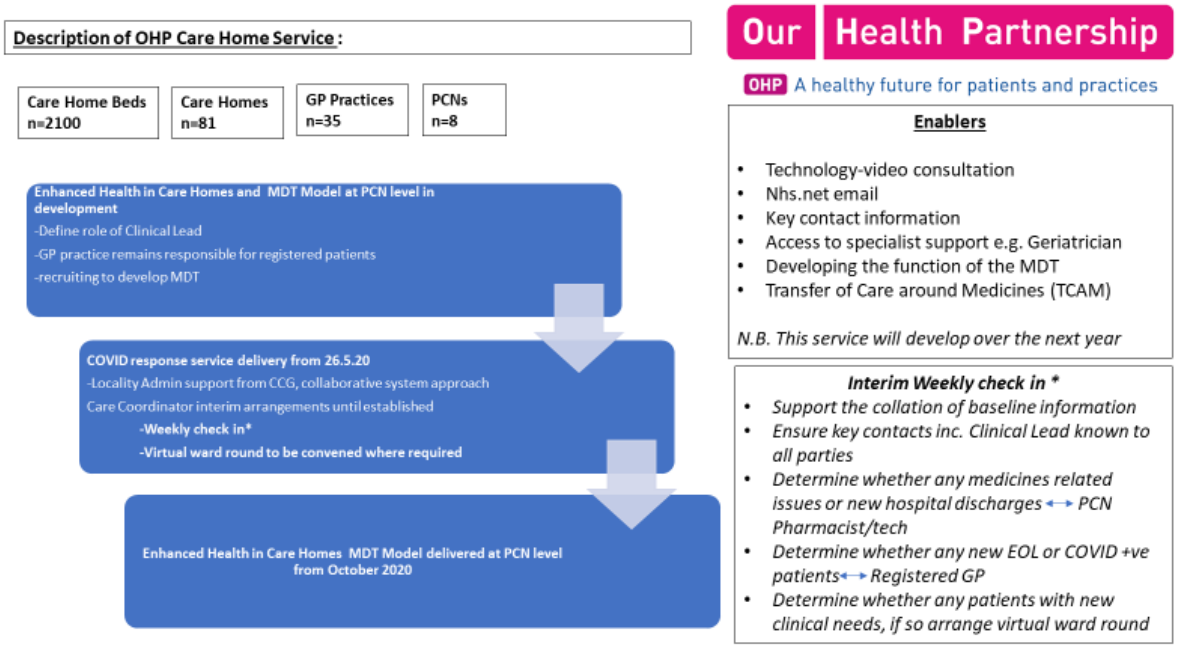


Figure 1 MDT Model for delivery of Enhanced Health in Care Homes (developed by Clair Huckerby in consultation with OHP PCN CDs)

Method for service delivery:

We have co-produced a system in consultation with our Clinical Directors and Board Members:



Preparatory work:

1. Initially we engaged interim care coordinators to provide support to the care homes in our 8 PCNs, the plan was that they would start the work detailed below whilst we were recruiting permanent Care Coordinators (for which we had immediately started the recruitment process).
2. OHP wrote to each care homes, introducing ourselves, providing key contact details (including a direct office telephone line)and information on the services we would be providing.
3. OHP arranged a dedicated mailbox for care homes to use (which is checked daily), this opened up critical dialogue with the Care Home, providing reassurance and support where required.
4. In addition to this we have developed a dedicated section of our OHP website to Care Homes: https://ourhealthpartnership.com/care-homes/ here, there are a number of resources which are publicly available including a frequently asked questions section, which remains a work in progress.
5. OHP host an intranet site which is utilised by all of our member practices and supported PCNs and PCN staff. We have developed a Care Homes topic page which contains a more detailed suite of resources in addition toa directory of contact details of MDT members and other service providers.

Contract Delivery

6. Each Care Home has a named Care Coordinator(s) (see the model above) who is the first point of contact, they conduct the weekly check in, arrange virtual ward rounds , MDTs or direct to

specific members of the MDT for particular issues in relation to the interim care homes contract and the DES (once in place) as they arise.

7. Where a specific need is identified, the Care Coordinator will refer directly to an MDT member e.g. if this is a medicines issue then they may go directly to the PCN pharmacist in the first instance; if there is a requirement for a clinical assessment it may be that the patient is initially referred to a Paramedic or Physicians Associate or directly to the registered GP or the general practice team (this will depend on the PCN level MDT and it's evolutionary position).

8. Where there are a number of reviews required either on a one off or regular basis either a MDT meeting or a ward round will be convened which could be done virtually (we have guidance to describe how this will work). This ward round may involve the GP and or pharmacist or be broader and include the wider MDT, all of which will be tailored to the needs of that Care Home and their residents.

9. Initially, the care coordinators made a first contact call. The purpose of this first contact call to the Care Home was to identify the person in-charge and a key contact in addition to a suitable time for the weekly check in. Where care homes did not have an nhs.net email, they were guided as to how to set one up, this was reinforced as a priority for the care home. Additional 'soft information' was collected such as clarity on current arrangements in place including whether there was already a weekly ward round/ contact and if so, what it looked like

The weekly check in call:

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1. Admin/ Care Coordinator to arrange weekly check in call at a mutually convenient time

2. The weekly check in call will be a weekly call between the care coordinator or other named person and the named Care Home contact to discuss any residents for priority assessment that week, this will include those residents:
   - I. Who have clinical need for review, including those who have recently been diagnosed as COVID +ve
   - II. Who are End Of Life and require clinical input
   - III. Have issues with medicines (e.g. administration, access) which require pharmacy input
   - IV. Are newly discharged from hospital
   - V. Who do not have a Personalised Care Plan in place

3. The weekly check in should match the size and need of the care home

4. If there are no new patients to discuss then this concludes the call, the Care Coordinator will maintain a record of all weekly check in calls within their PCN.

5. If there are new patients to discuss then the Care Coordinator will convene a Ward Round.

10. After this initial check in, a routine weekly call followed. OHP has developed a series of standard questions to prompt and support the Care Coordinators to deliver a structured weekly

check in. The Care Coordinator will decide on next steps based on the responses to the standardised weekly check in questions with respect to navigation of care for the relevant resident(s).

11. OHP identified Clinical leads for all the aligned care homes, we have worked with the CCG to define the role of the Clinical Lead. The Clinical Lead (if not the same person as the Clinical Director) works alongside the Clinical Director. They obtain weekly updates from the Care Coordinators to ensure that the required plans are in place to provide the care home residents with the specified level of care and support, to ensure that ward rounds and or MDTs are convened where necessary. The full specification for the Clinical Lead role is available on request.

12. OHP hosts weekly review calls for all Care Coordinators to discuss and monitor progress, contract and service delivery and identify areas for improvement and change. Where necessary outcomes and learning are shared with the CCG and relevant providers.

13. OHP supported PCNs will continue to engage with Birmingham Community Healthcare Trust and other organisations to enable a comprehensive delivery of the services.

Conclusion and next steps:

OHP will continue to engage with the CCG and relevant networks to review, refine and develop the service in preparation for the delivery of the EHCH DES from October 1st 2020.

We are working with potential training providers, Health Education England, NHSE and the Personalised Care Institute to develop a training programme for our new care coordinators for training as required by DES.