Enhanced Health in Care Homes

A guide for staff working in care homes in Hull and East Riding

This leaflet explains what the Enhanced Health in Care Homes (EHCH) programme is, how to make it work in the best way possible for people living in your care home and the people who care for them, and what everyone involved can expect from it.

We hope it reassures you that being actively involved in the EHCH programme should not require a significant change to the way you work, and you should see increased support into the home from local health and care services.

"People who happen to live in care homes have the same right to access to healthcare as any other citizen. Many of them will have significant healthcare needs which require support beyond that delivered by the care home. The Enhanced Health in Care Homes service provides a clear framework for delivering healthcare through the support of a multi-disciplinary team including primary care, specialists, community-based care services and care home staff." Kathy Roberts, Former Chair, Care Provider Alliance

1. Linking GP Primary Care Networks (PCNs) with care homes in Hull and East Riding

Linking each care home in Hull and East Riding with their local Primary Care Networks (PCNs) is the first step to delivering enhanced health care.

We recognise that some people living in your care home may not be registered with a GP practice in the aligned PCN and may wish to consider changing their GP practice to be able to receive the enhanced level of services.

This is the resident's choice, and they should be fully involved and supported with the decision they make. Residents who decide to remain with a GP who is not in their aligned PCN will still be entitled to receive primary care services but may not benefit from the full Enhanced Health for Care Homes service. Working across organisations in a co-ordinated way people will receive better and more proactive care - delivered where they live.

We know this can support:

- primary (GP) care and specialist services to help maintain independence as far as possible by reducing, delaying or preventing the need for additional health and social care services; and
- staff working in care homes feeling at the heart of an integrated team that spans primary, community, mental health and specialist care, as well as social care services and the voluntary sector

2. What can my residents expect?

The minimum standards for EHCH involve PCNs and community providers (locally City Health Care Partnership (CHCP CIC), Humber Teaching NHS Foundation Trust), Yorkshire Ambulance Service and Hull City Council/ East Riding of Yorkshire Council working together to support:

- **A named clinical lead who will provide leadership to staff delivering the service.** The clinical lead is not medically responsible and accountable for the day-to-day care of individual care home residents. Medical responsibility and

accountability for the care of individual care home residents remains with their registered GP – and there may be residents with different registered GPs within a care home.

- **A weekly 'home round' or 'check in' with permanent residents prioritised for a review based on care home advice and the Multi-Disciplinary Team clinical judgement** (this is not intended to be a weekly review for all residents). People who work in a care home know their residents better than a visiting health professional, and the EHCH framework fully recognises this expertise and care home staff are a key foundation and critical part of the MDT. Some MDT members might be co-opted in, such as dietitians or speech and language therapists.
- **Within 7 days of re/admission to a care home, a permanent resident should have a person-centred holistic health assessment of need** (which will include physical, psychological, functional, social and environmental needs, which can draw on existing assessments outside of the home, as long as they reflect their goals).
- **Within 7 days of re/admission to a care home, a permanent resident should have personalised care** and support plan(s), based upon their holistic assessment.
- **Structured medication reviews**

3. Personalised care planning

Once a decision is made that a new resident will be staying permanently in the care home, the frailty team from the Jean Bishop Integrated Care Centre will come and review the resident, supporting a holistic assessment, personalised care plan and medication review.

4. Making the most of the MDT and Home Care round

The MDT provides a proactive and preventative approach to support people living in a care home. The way your home round will happen will be locally determined, based on the needs of the residents you care for. The make-up of the MDT will also be determined by the type of home, the needs of the residents living there, and the availability of locally commissioned health and care services. It is worth noting that the MDT might meet virtually prior to the home round so all team members can input to the conversation and agree which residents need a review as part of the home round. Not every member of the MDT needs to be present at every home round. As a minimum, an identified and consistent person(s) from the home should be routinely part of the MDT and home round.

A suggested checklist to discuss in the weekly check ins / MDTs includes:

- New permanent residents
- Permanent residents returned from hospital in the past week
- Permanent residents who have had more than 2 paramedics calls in the past week or ED attendances
- New Covid positive residents
- New concerns that someone is unwell, eg has "soft signs" or you are worried about
- Anyone who is gradually deteriorating and has not been reviewed recently

You may wish to have a rolling programme to ensure everyone has an annual medication review, and review of their advance care plan (ReSPECT form).

Please work with your PCN to agree protocols for information sharing, shared care planning, use of shared care records and clear clinical governance. To support this, you should check that you are using NHS Mail.

What do I need to do now?

- **Ensure you know which Primary Care Network your care home is aligned to.**
- **Check if your residents are registered with a GP within the PCN aligned to your care home.** If some residents are not, you should discuss the benefits of re-registering to a GP within the PCN with them. You may wish to discuss these benefits with the PCN and involve an advocacy service to support the resident in this transition.
- **Check if your PCN is providing at least the minimum EHCH services to your care home** (see above). These include a weekly 'home round' or 'check in' with residents prioritised for a review; and a person-centred holistic health assessment of need and a personalised care and support plan(s), based upon their holistic assessment within seven days of admission/readmission to a care home.
- **Ensure that you are actively involved as a member of the care home MDT and the MDT has input into the weekly home round.** Each care home should be actively involved in agreeing how the MDT will be organised and work. It is important that this is not seen as your administrative responsibility, and you should agree locally how this will work well for the home you lead.
- **Work with your PCN to agree protocols for information sharing, shared care planning, use of shared care records and clear clinical governance.** To support this you should check that you are using NHS Mail. This is available free to all care homes and is a secure email system which can be used for sending and receiving patient information.
- **Community Nursing.** All Care Homes will have an allocated named case manager. If you do not currently have any intervention from a district nursing team but need to make a new referral, you can do so by contacting 01482 247111.

If you have any further questions or queries relating this leaflet, please contact your PCN Clinical Lead (if known), or the Hull/ East Riding Health and Care Partnership (formerly NHS Hull/ East Riding CCG) on hnyicb-hull.contactus@nhs.net or hnyicb-ery.contractmailbox@nhs.net.