Covid-19
Guidance for practices

Date: 16.11.2020

Please be aware that this is a rapidly evolving situation.

Covid-19 and care homes

Introduction

It is helpful to outline why care homes and the services that are provided by them and in them are so important before considering the affects of the Covid-19 pandemic. It is well known that the UK has an ageing population (ONS, 2018k). There are now nearly 15.5 million people aged 60 and above in the UK of which:

- 5.4 million people are aged 75+
- 1.6 million are aged 85+
- Over 600,000 people are 90+ (579,776)
- 4,430 are centenarians (ONS, 2018f, 2018e)

Of the 11 thousand care homes for older people, there are 4,632 registered nursing homes (Laing Buisson survey 2018) with approximately 416,000 people live in care homes (Laing and Buisson survey 2016), a significant number of whom are living with frailty. This is 6.5% of the population aged 60-69 years and over, rising to 65% of those aged 90+ or more, and people aged 85+ are represented as 59.2% of the older care home population. Note: there are no definite statistics on the number of people living in retirement housing.

It is estimated that four million older adults in the UK, 36% of people aged 65-74 and 47% of those aged 75+, have a limiting long-standing illness (Horsfield 2017). Dementia is a key cause of disability in later life, a more common cause than cancer, cardiovascular disease and stroke (Alzheimer's Society 2019) and of the 850 thousand over the age of 50 living with dementia, approximately 288,000 are in residential care settings (Care UK /ONS 2019), while 70% of people in care homes have dementia or severe memory problems (Alzheimer's Society 2019)

Care home beds represents a bed base of three times that of the acute hospital sector in England (Kings Fund NHS hospital bed numbers publication). It is to be expected that most care home residents have cognitive impairment, multiple health conditions and physical dependency (Gordon, Franklin, Bradshaw, Health Status of UK care home residents Age Ageing 2014), and many are in the last year of their life (Shah, Carey, Harris et al, Mortality in older care home residents in England and Wales Age Ageing 2013).

Covid-19
- - - - - -
Guidance for practices

Care home provision models

Some CCGs have commissioned a Care Home LCS and/or support programmes/in-reach services. A unifying characteristic of such support programmes and in-reach models is the multidisciplinary team (MDT) approach to care; close working and collaboration with community services, the importance and organisation of which cannot be underestimated.

Key principles of existing models:

- Holistic assessment (including remote assessment)
- Scheduled and unscheduled care
- Rapid response at the time of crisis
- Treatment and symptom management acute conditions
- Management of long-term conditions
- Palliative and end of life care
- Assessment treatment and advice for common mental health conditions, including dementia, depression and anxiety
- Polypharmacy and medicines management
- Falls prevention
- Continence issues
- Tissue viability
- Health education and health promotion
- Education and training for care home staff.

The Multiple Disciplinary Team can include:

- Community matron/lead nurses
- Consultant geriatrician
- GP with special interest (extensivist role)
- Consultant psychiatrist
- Mental health nurses
- Specialist physiotherapists
- Occupational therapists
- Pharmacists
- Dietetics
- SALT
- Phlebotomists

PCN DES: Enhanced Health in Care Homes

The introduction of the Framework for Enhanced Health in Care Homes (EHCH) 2020/21 vs2 opens with *'People living in care homes should expect the same level of support as if they were living in their own home.'* The introduction further states that the [Enhanced Health in Care Homes] EHCH model '*moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents*.'

For the purpose of the EHCH service requirements in the PCN DES specification, a care home is defined as a CQC-registered care home service, with or without nursing. For the purpose of the DES therefore, whether a care home is included in the scope of the service will be determined by its registration with CQC

Under the DES, PCNs will be entitled to a care home premium of £120 per bed, based on CQC data on registered care home beds and is a recurrent per annum premium. As this has not been implemented until 30th September, the funding is based on a half-year rate of £60 per bed for 2020/21. PCNs have been required to confirm their participation in the Network DES and following that, under the Enhanced Health in Care Homes part of the DES.

Response to Covid-19

In Simon Stevens and Amanda Pritchards' letter: Important for action second phase of NHS Response to Covid-19, dated 29 April 2020, it was outlined that "*the NHS will bring forward from October to May 2020 the national elements of the primary and community health service-led Enhanced Health in Care Homes service".*

There was a further letter from Nikki Kanani and Matthew Winn, title Covid-19 response: Primary care and community health support care home residents and published on 1 May 2020, which stated that they were *'requesting primary care and community health services help, building on what practices are already doing, to support care homes'.* Although refuting that this was bringing forward the EHCH part of the PCN DES, '*the impact of Covid-19 pandemic has made the task of completing the job of implementation of support to care homes more urgent.'*

The letter outlined that where services did not already exist, they need to be established as part of the Covid-19 response by CCGs, working with general practice, community service providers, care homes, local medical and community pharmacy committees and wider partners in the area.

Services to be provided include

1. A weekly check in to review patents as identified as a clinical priority for assessment and care (delivered by an MDT where practically possible).

- This will include those with suspected or confirmed Covid-19 symptoms, and in line with Primary Care and Community Services SOPs,
- Support the provision of care for these patients,
- Include appropriate and consistent medical oversight, and
- The introduction of remote monitoring, as well as the prescription and supply of oxygen to care homes for treatment where clinically indicated.

2. Development of personalised care plans.

3. Pharmacy and medication support which should include:

- Facilitating medicine supply to care homes, including EOL medication
- Delivering SMRs
- Reviews of new residents or hospital discharges
- Supporting medication queries

CCGs must also ensure that clear and consistent out of hours provision is in place for each care home.

On 12 May 2020 Dr Nikki Kanani and Ed Waller issued a further letter which was a follow up to the 1 May letter Covid-19 response: Identifying a clinical lead for all care homes. In this letter, the CCG was to identify a named clinical lead for each CQC-registered care home in their area. The role of this clinician is to provide clinical leadership for the primary care and community health services to support the care home, and to be responsible for the co-ordination of the services as mentioned in the 1 May letter. This clinical lead can be either from general practice or community health and may be a joint arrangement.

The overall effect of this these provisions was to bring forward the implementation of the DES as described in The Framework for Enhanced Health in Care Homes. The overall aim of the EHCH model being to:

- Deliver high quality personalised care within care homes
- Providing for individuals who live in care homes, whether temporarily or permanently, access to the right care at the right time in the place of their choosing
- Enabling effective use of resources by reducing unnecessary hospital admissions
- Care providers working in partnership with local GPs PCNs community health providers, hospital, social care the individuals and their families.
- Services to be 'wrapped around' the individual and their family, who are connected to and supported by their local community.

The Framework for Enhanced Health in Care Homes outlines what needs to be in place for residents to benefit from the best model of care and support, working collaboratively and across boundaries. The Framework clearly states that this supports the minimum service required, and that '*CCGs should continue to develop and separately commission, as required, services that go further than the minimum national requirements in order to implement a mature EHCH service and must consider maintaining such enhanced services where they already exist'.*

The Care Elements of the EHCH model as described in the Framework:

Care Element	Sub-element
Enhanced Primary Care Support	Each care home aligned to a named PCN Weekly home round Medicine reviews Hydration and nutrition support Oral health care Access to out of hours/Urgent care when needed
MDT support	Expert advice and care for those with the most complex need Continence management and promotion Flu prevention and management Wound care, including leg and foot ulcers Supporting professionals, carers, and individuals with need navigate the health and care system
Falls Prevention	Fall, strength and balance Rehabilitation and enablement Developing community assets to support resilience and independence
High quality palliative and EOL care, mental health and dementia care	Palliative and end of life care Mental health care Dementia care
Collaboration between health and social care	Co-production with providers and networked care homes Shared contractual mechanisms promoting integration health care
Workforce development	Training and development for social care provider staff Joint workforce planning across sectors
Data, IT and technology	Linked health and social care data sets Access to the care record and secure email Better use of technology on care homes.

Some important points to the Care Elements

Enhanced primary and community care support

Under the PCN DES, each care home is aligned to a PCN, which in turn is aligned to community services and other service provisions, and which will deliver the EHCH for that home. This is to ensure a consistency of care for people living in that home and enable the development of working relationships and integrated care arrangements. Commissioners have the responsibility for aligning each care home to a PCN and supporting residents to re-register with a practice in the aligned PCN if required.

Personalised Care and Support plans are an integral part of the part of the contract, and it is the intention that the plan(s) will be delivered based on the principles of the Comprehensive Geriatric Assessment (CGA). There are various models of care planning that can be used. See Fit for Frailty part 1 and NHS England's Advanced Care Plan guidance and template. Whichever model for personal care plans or advanced care planning is used, it is important that both the resident and the relatives are engaged in these important discussions and resulting decisions.

It is important to note that on 9 November 2020 new GMC guidance on decision making and consent came into force, the seven principles of which sum up well the principles or care planning and engagement. The structured medication review (SMR) is also part of this assessment.

MDT support including coordinated health and social care

Under the PCN DES, members of the MDT will deliver a weekly ward round, currently virtual, which should focus on those individuals with the greatest need (eg highest risk of unplanned admission or unwell). The makeup of the MDT will be influenced by any previous arrangements that may have been in place, such as an LCS or in-reach community services or existing MDT arrangement, e.g. unplanned admissions review. Palliative care and EOLC is a priority for every care home and that every person in this situation has the opportunity to have a personal care plan, that is reviewed as needs arise, including treatment and escalation. All of this links into personalised and advanced care planning, which addresses not only the needs of the individual, but also of their family and carers.

Mental health and dementia

As discussed in the introduction, dementia is a key cause of disability in later life, with 70% of people in care homes living with dementia or poor memory problems. Promotion of the mental wellbeing, through activities and active and welcoming social environment, promoting cognitive skills is key. Access to specialist dementia and mental health services is also part of the essential support provided to residents. Examples of good practice can be found in Evidence Briefing: Behaviour that challenges in dementia and Mental Capacity Act Code of Practice.

Care homes in the Covid-19 pandemic

Staff in care homes play a key role in the response to Covid-19. They care for their residents in challenging circumstances, sometimes having to learn new competencies and skills and in many cases undergoing the trauma of losing a significant number of residents who may have been known for a number of years, and regarded as part of the family.

As care homes suffered from Covid-19 infection, part of the Infection Protection Control (IPC) procedures included the cessation of visiting by family of their relative in the care home, and in some circumstances resulted in both mental and physical deterioration of the resident(s). Some died in the absence of any family members and this has been one of the most upsetting consequences of the pandemic, for relatives, for staff and all of those including GPs, who cared for these patients.

Covid-19
- - - - - -
Guidance for practices

Adam Gordon and Claire Goodman published a blog in the Kings Fund newsletter (30 April 2020) describing the research that they had undertaken to get a sense from staff working in care homes what they felt they needed to support the health and wellbeing of their residents. This included:

- Rapid access to PPE. Numbers of residents with Covid-19 symptoms can rapidly increase.
- Rapid access to medical advice from GPs and other professional such as advanced care practitioners or nurse prescribers.
- Rapid access to medicines and support from palliative care teams where residents are unwell and may not survive.
- Clear and consistent guidance that is for assistance and can be easily utilised.
- Parity of recognition with acute NHS carers and priority for residents that they deserve.

The British Geriatric Society has also published a good practice guide on Managing the Covid-19 pandemic in care homes for older people (published 25 March 2020, updated 2 June 2020).

This includes a list of 15 key recommendations, some of which replicate previous recommendations regarding advanced care plans, supportive treatments such as care home based oxygen therapy, and importantly multi-professional working, but also describes identifying Covid-19, where there may be differing presentations in the elderly, isolating residents and decisions about escalation of care to hospitals.

There is now a better understanding and more preparedness around IPC, and NHS England have issued guidance Coronavirus (Covid-19) Admission and Care of People in Care Homes last updated on 4 November. There is also guidance on Visiting arrangements in care homes for the period of national restrictions, which covers the period of restrictions which commenced on 5 November.

The first priority remains to prevent infections in care homes and protect staff and residents, but also recognises the importance of allowing care home residents to meet their loved one, particularly at the end of life.

Each STP area should also have 'stepdown' arrangements for a Covid positive pathway in order to protect residents of care homes and other bedded units, including extra care and supported housing, from Covid-19 outbreaks. Where this is particularly relevant is for P2 designated beds (local authority care home with additional care staff and health input to support rehabilitation) in a 'bridging pathway' that will ensure that Covid positive patients still considered to be infectious are not discharged from hospital directly back into care homes' beds.

The response to Covid-19 and the EHCH requires continued investment in general practice and community resources, and which should include its most vital and important resource: its workforce. Training hubs undoubtedly have a role to play, both in the immediate support of the workforce during this challenging time, including its wellbeing, but also in future skills and expertise development. It is only by developing a system that promotes multidisciplinary team working, with a skill set tailored to the needs of the residents within care homes, that we can best service those needs, and this in turn requires investment and sustainable funding.

Covid-19 - - - - - - Guidance for practices

Data, IT and technology

Digital enablement wthin Care homes is necessary to ensure that Practices/PCNs can fully deliver the EHCH part of the DES, and best patient care is achieved. Part of this is to establish secure information sharing between general practice, community providers, including pharmacies, and acute settings. This will include the obvious such as NHSmail and DPST signup, but also care record access, remote consultations/video links enabling virtual MDTs and consultations, as well as proxy access to the care record. (see further resources). Support in these areas can include training and support for care homes staff to embed routine remote monitoring which will support proactive care, and support effective use of the MDT.

Further resources

- Fit for Frailty part 1, British Geriatric Society (BGS)
- Fit for Frailty part 2, BGS & RCGP Developing, managing and commissioning services for people living with frailty in community settings. Guidance for GP, Geriatricians, health service managers, social service managers and commissioners.
- Care Home Resource Pack, NHS England London, updated 20 October 2020
- Adult social care: our Covid-19 winter plan, DHSC, September 2020
- Managing the Covid 19 pandemic in care homes for older people, BGS, updated 2 June 2020
- Admission and Care of Residents in a Care Home during Covid-19, NHS England, updated 16 September 2020
- Coronavirus (Covid-19): admission and care of people in care homes, NHS England, updated 4 November 2020
- Visiting arrangements in care homes for the period of national restrictions, DHSC, 5 November 2020
- Comprehensive Geriatric Assessment Toolkit for Primary Care Practitioners, BGS, February 2019
- Mental Capacity Act Code of Practice, Office of the Public Guardian, updated 14 October 2020
- My Covid-19 Advance Care Plan (including template), NHS England, updated 11 May 2020
- Managing medicines in care homes overview, NICE,2020
- Running a medicine reuse scheme in a care home or hospice setting, NHS England, 23 April 2020
- Ordering medication using proxy access: Guidance for care homes, GP practices and community pharmacies, NHS England
- Covid-19 SOP Community Health Services, NHS England, 15 April 2020
- Covid-19 How to work safely in care homes, Public Health England, updated 2 November 2020