October 2016

PSNC Briefing 055/16: The Enhanced Health in Care Homes care model

In January 2015, the NHS invited individual organisations and partnerships, including those with the voluntary sector to apply to become vanguard sites for the New Models of Care Programme, one of the first steps towards delivering the NHS Five Year Forward View (5YFV) and supporting improvement and integration of services.

One of the vanguard types is the enhanced health in care homes (EHCH) care model which offers older people better, joined up health, care and rehabilitation services.

This PSNC Briefing summarises NHS England's document, *The framework for enhanced health in care homes*, which outlines various evidence-based interventions designed to be delivered within and around a care home in a coordinated manner in order to make the biggest difference to its residents. It will be of particular interest to LPC members who have EHCH models being developed in their area.

Introduction

At the time of writing (October 2016), six vanguards are working to improve the quality of life, healthcare and planning for people living in care homes.

One in seven people aged 85 or over is living permanently in a care home. The evidence suggests that many of these people are not having their needs properly assessed and addressed. As a result, they often experience unnecessary, unplanned and avoidable admissions to hospital, and sub-optimal use of medication.

Within these six vanguard areas, care homes are working closely with the NHS, local authorities, the voluntary sector, carers and families to optimise the health of their residents. The EHCH care model is an adjunct to the other new care models that are delivering whole population healthcare. It will become a core element of the multispecialty community provider (MCP) and primary and acute care system (PACS) models.

The EHCH model has three principal aims:

- To ensure the provision of high-quality care within care homes;
- To ensure that, wherever possible, individuals who require support to live independently have access to the right care and the right health services in the place of their choosing; and
- To ensure that the best use of resources is made by reducing unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for residents.

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The wider context

A primary goal of health and social care services is to support people in their own home for as long as possible. If this is no longer possible, the health and care system must ensure that the best possible care is provided to those individuals in residential and care settings.

In many parts of the country, the care for people who are living in care homes or who are at risk of losing their independence is being held back by a series of care barriers, financial barriers, and organisational barriers:

- Care barriers
  - a narrow focus on medical rather than holistic needs;
  - lack of integrated care planning that focuses on prevention and pro-active care;
  - variable access for care home residents to NHS services; and
  - lack of continuity of care and the difficulties faced by current workforce crisis.

- Financial barriers
  - few system-wide incentives around preventative care across health and social care providers;
  - a financially distressed care provider market which will impact on quality in some care homes;
  - the financial challenges that the national living wage and other centrally imposed cost increases put on the finances of the providers and local authority/clinical commissioning group commissioners;
  - recruitment and retention (including training) within the care sector; and
  - contractual mechanisms for provision of preventative health care for those in care homes and those at risk of losing their independence.

- Organisational barriers:
  - barriers between organisations in different parts of the health service and between the NHS and other sectors, in particular social care;
  - a lack of financial and clinical accountability for the health of the defined population; and
  - variations in policy, process and supporting systems (such as Information Technology) across organisations.

This new care model seeks to overcome as many of these challenges as possible by ensuring that:

- people have access to enhanced primary care and to specialist services;
- budgets and incentives are aligned so that all parts of the system as unequivocally focused on improving people's health and wellbeing;
- the working environment is optimised for staff employed by social care providers so that they feel 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;
- people maintain their independence as far as possible by reducing, delaying or preventing the need for formal social care services; and
- health and social care services are commissioned in a coordinated manner, and the role of the social care provider market is properly understood by commissioners and providers across health and social care.

The 'footprint' of an EHCH is all of the care homes (residential and nursing) that are situated in the planning footprint that chooses to implement the EHCH model.

Care elements and sub-elements

NHS England has identified seven core elements that describe the EHCH care model. All of these elements are recognised as existing good practice; therefore, the care model is about implementing them together in a

coordinated, sustainable way, at a scale to deliver person-centred care that promotes independence. Optimising the use of medicines applies across a number of the core elements and it can therefore be seen how community pharmacists and their teams might be able to participate in this work.

Care element	Sub-element
1. Enhanced primary care support	Access to consistent, named GP and wider primary care service
	Medicines reviews
	Hydration and nutrition support
	Access to out-of-hours/urgent care when needed
2. Multi-disciplinary team (MDT) support including coordinated health and social care	Expert advice and care for those with the most complex needs
	Helping professionals, carers and individuals with needs navigate the health and care system
3. Reablement and rehabilitation	Rehabilitation/reablement services
	Developing community assets to support resilience and independence
4. High quality end-of-life care and dementia care	End-of-life care
	Dementia care
5. Joined-up commissioning and collaboration between health and social care	Co-production with providers and networked care homes
	Shared contractual mechanisms to promote integration (including Continuing Healthcare)
	Access to appropriate housing options
6. Workforce development	Training and development for social care provider staff
	Joint workforce planning across all sectors
7. Data, IT and technology	Linked health and social care data sets
	Access to the care record and secure email
	Better use of technology in care homes

Enhanced primary care support

An EHCH moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of residents, their families and care home staff. Such care can only be achieved through a whole-system, collaborative approach. The specific aims are to provide:

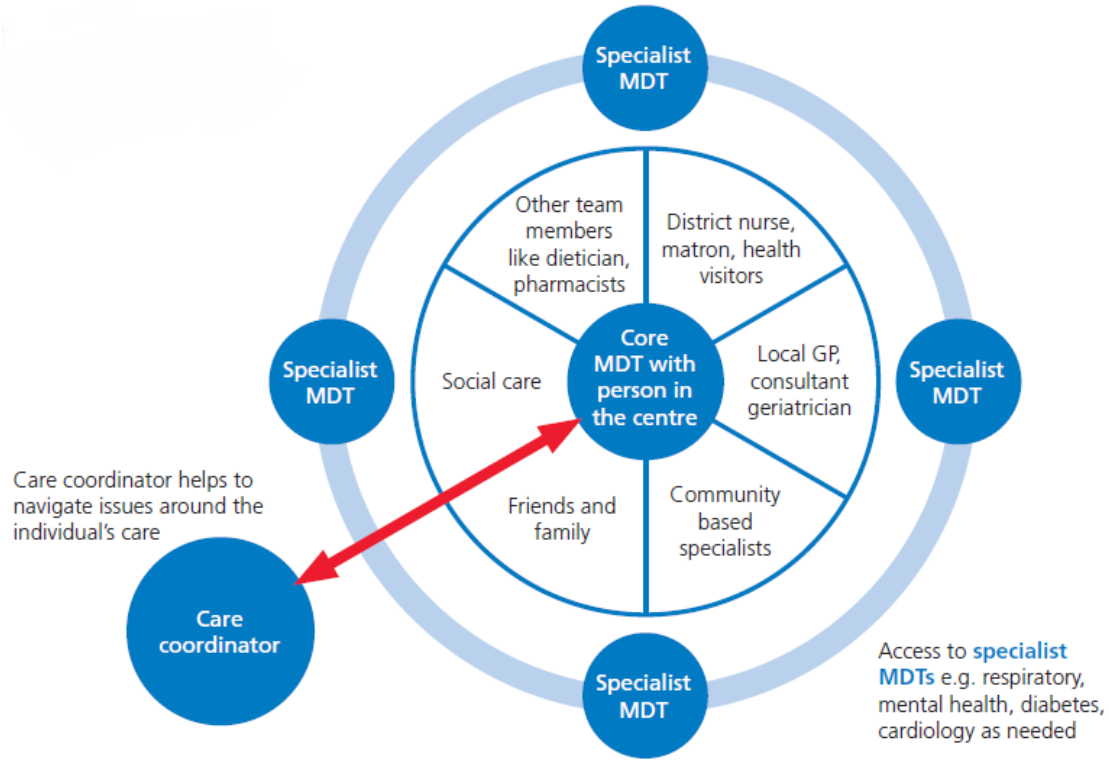
- medicines reviews;
- hydration and nutrition support; and
- access to out of hours/urgent care when needed.

Multidisciplinary team support including coordinated health and social care

A multidisciplinary team (MDT) approach provides individuals with care and support needs with access to the right care when they need it. The MDT improves the care of complex conditions by making full use of the knowledge and skills of team members from multiple disciplines and service providers, including primary care, community health services, acute care, social care, and other specialist advice. The MDT approach also ensures that residents with complex needs have access to expert advice.

The MDT provides both preventive care and reactive support to the people on its caseload. All members of the team have access to sections of the integrated care record that are appropriate to their role. Membership of the MDT will vary depending on the local expertise and resources available, and the needs of the people on the MDT's caseload.

The MDT decides the frequency and nature of its meetings (e.g. face-to-face or virtual ward rounds, via telecare or tele-hub solutions, or through joining up with rapid response teams or hospital-at-home services).



Source: NHS England, The framework for enhanced health in care homes

Dementia care

Dementia and cognitive impairment is estimated to affect around 80% of care home residents. More widely there are 850,000 people living with dementia in the UK today, and this is expected to rise to over one million by 2025. The EHCH models seeks to overcome some of the challenges faced by these people by improving health care support within care homes and by improving access to secondary care and to mental health services in the community.

Medication reviews are particularly important for people with dementia, and should focus on reducing polypharmacy and optimising antipsychotic medication. It is important that these are undertaken by the multidisciplinary team.

Harnessing data and technology

To fully realise the EHCH model, a digital infrastructure is required for staff and commissioners that is fit-for-purpose. It must permit appropriate access to care records, allow data-sharing for planning of provision, and support the use of assistive technology and telemedicine in care homes. The components necessary for such a system are linked health and social care data sets, access to the care record and secure email, and better use of technology in care homes.

If you have queries on this PSNC Briefing or you require more information please contact Zainab Al-Kharsan, Service Development Pharmacist.