New care models

NHS

The framework for enhanced health in care homes

Our values:
clinical engagement, patient involvement,
local ownership, national support

September 2016

Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.
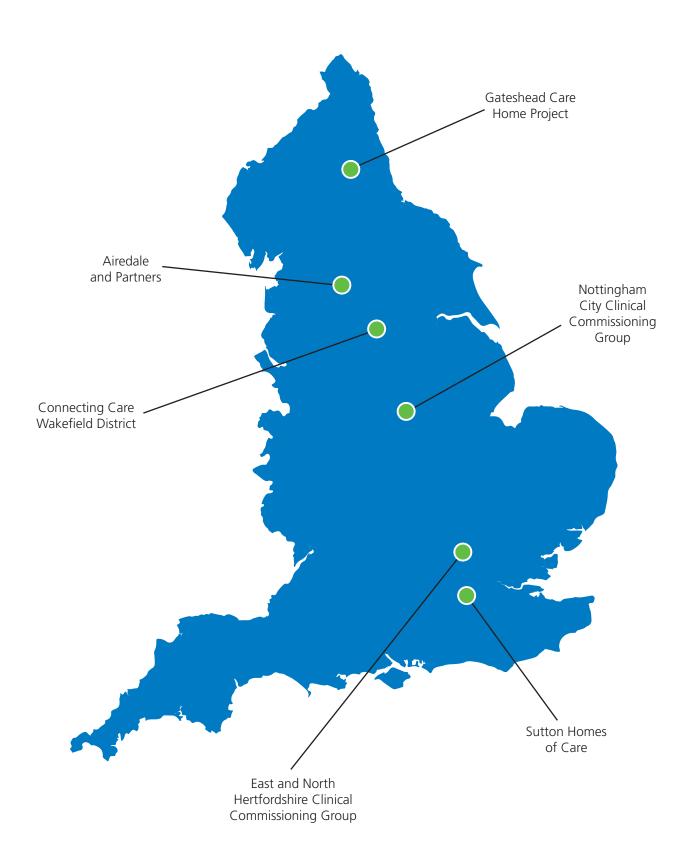
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1 Introduction and summary

Introduction

1.1   Across England, 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 medication.

1.2   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 enhanced health in care homes (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.

1.3   We have co-developed this document with the six EHCH vanguards and our partners in social care. The EHCH model is based on a suite of evidence-based interventions, which are designed to be delivered within and around a care home in a coordinated manner in order to make the biggest difference to its residents.

1.4   Many of these interventions are well known. Some areas of the country will either have established some of these interventions already or will have been working towards them for a number of years. The work within the EHCH vanguards is therefore the culmination of many years' worth of work to improve the wellbeing and care of care home residents. By bringing a range of commissioners and providers together, solutions have been developed in a coordinated way, which has meant that vanguards can implement changes which would not be possible if done in isolation.

Figure 1 -
The six enhanced health in care homes (EHCH) vanguards

Gateshead Care
Home Project

Airedale
and Partners

Nottingham
City Clinical
Commissioning
Group

Connecting Care
Wakefield District

Sutton Homes
of Care

East and North
Hertfordshire Clinical
Commissioning Group

The wider context

1.5   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, we must ensure that the best possible care is provided to those in residential settings.

1.6   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
  - **Lack of continuity of care** and the difficulties faced by the 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
  - **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
  - Variations in policy, process and supporting systems (such as information technology (IT)) across organisations.

1.7   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 are unequivocally focussed 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;

- 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.

1.8   This EHCH framework applies equally to people who self-fund their care and to people whose care is funded by the NHS or their local authority: everyone has the right to high quality NHS services. 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, be it a sustainability and transformation plan (STP) area, a clinical commissioning group (CCG), a local authority or an MCP or PACS. Its scope may therefore include certain reablement and rehabilitation services that are provided in the community and which are aimed at avoiding unnecessary admission to hospital or into a care home; however, all aspects of the care described in this framework will need to be tailored to local circumstances and to each individual person's care needs.

1.9   In order to help deliver a person-centred approach to care and support, the emerging EHCH framework draws on both the 'I statements' (published by the 'Think Local, Act Personal' (TLAP) partnership that spans the health and social care sector) and the 'My Home Life' initiative (that promotes quality of life and delivers positive change in care homes for older people).

1.10 Through the process of developing the EHCH care model, we have also become aware of a range of 'small, big ideas'. These are defined as simple ideas that - if done well and replicated elsewhere - will not by themselves solve the significant issues being faced but may improve the quality and outcomes of care for care home residents. What all of these frugal innovations have in common is that they are simple, and replicable.

Figure 2 - Principles of a successful enhanced health in care homes care model

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Principles of a successful enhanced health in care homes care model

The EHCH vanguards have identified the following conditions which are critical for success:

- Person-centred change
  - Putting the needs of the resident or person with care needs at the centre of any changes
  - Supporting carers and families as well as those with care needs

- Co-production
  - Working and integrating with local government, the community and the voluntary and care homes sectors to co-design and co-deliver the model of care
  - Acknowledging the value of the care home sector in supporting the NHS and the significant level of healthcare that is delivered in care homes by social care staff
  - Adopting a whole-system approach, breaking down organisational barriers between health, social care and the voluntary sector

- Quality
  - A focus on quality as the driving factor for change
  - Using clinical evidence to support as well as drive change

- Leadership
  - Strong leadership and a joint shared vision for better care
  - Recognising the cultural differences between organisations and different types of commissioner and provider and focussing on the shared care aims despite differences in language and process.

The principles of establishing a successful EHCH care model apply equally to all people living in care homes and those who require support to live independently in the community or who are at risk of losing their independence.

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Purpose of this framework

1.11   This document describes:

- the seven core elements of the EHCH model and how they can be commissioned to deliver joined-up services, and

- the fully mature EHCH model

1.12   We seek to inform four principal audiences:

- care home providers and managers (nursing, residential and supported living);

- local authority and CCG leaders who are responsible for commissioning care home services;

- partner organisations in community, mental health, and acute sectors of the NHS, and in the community and voluntary sector; and

- individuals with care needs, carers and families.

1.13   We hope that this framework will be of interest to all stakeholders who are interested in working collaboratively across organisational boundaries to commission or deliver high quality, cost-effective care for individuals in the place of their choice. We make clear the challenges facing each of the six EHCH vanguards as they navigate the many fragmented health and care services available to care homes and present the opportunities they have seized through collaboration and integrated working. We describe their journey towards delivering the fully mature EHCH model.

1.14   Working collaboratively with the six Care Home vanguards, we have identified seven core elements that describe the EHCH care model. All of these elements are recognised as existing good practice; therefore, the EHCH care model is about implementing them together in a coordinated, sustainable way, at scale to deliver person-centred care that promotes independence. Table 1 sets out the care element and sub-elements which comprise the care model.

1.15   The EHCH framework forms part of a suite of frameworks that also cover other models within the new care models programme: multispecialty community providers (MCPs), primary and acute care systems (PACSs) and acute care collaboratives (ACCs). This document should be read alongside these other frameworks.

Table 1 - Care elements and sub-elements

Care element	Sub-element
1. Enhanced primary care support	Access to consistent, named GP and wider primary care service
	Medicine 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

An enhanced care model

1.16 In recent years, much work has been undertaken to identify and offer **preventive care and support** to people living in the community who are **at risk of losing their independence** or of having an **unplanned admission to hospital**. In contrast, people already living in care homes or in 'supported living' settings have tended to miss out on this type of **coordinated, preventive care**. Although there are multiple services available to residents of care homes and supported living environments, these services are often fragmented, uncoordinated and variable, and they are divided between different statutory and voluntary providers.

1.17 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 we make the best use of resources by reducing unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for residents.

1.18 In the EHCH model, care providers work in partnership with local GPs, community healthcare providers, hospitals, social care, individuals and their families, and wider public services to deliver care in people's homes as well as in care homes. Services are 'wrapped around' the individual and their family, who are connected to and supported by their local community. Proactive, personalised care and support becomes the norm.

Fit with whole population care models

1.19 Both the MCPs and PACSs are place-based population health models (i.e. they are responsible for the health and wellbeing of everyone living within their geographic boundaries). An MCP integrates core primary care with out-of-hospital services, social care, and some secondary care services where this is appropriate; PACS expands on this arrangement to include acute and tertiary services where it is wanted and feasible.

1.20 The EHCH model provides care for a segment of an MCP's or a PACS's population: namely those people who are living in care homes or supported living environments or who are at high risk of losing their independence. The EHCH segment of the MCP or PACS population is likely to include those people at highest risk of unplanned hospital admission and those people with the highest needs, such as frail older people. In the same way that the MCP and PACS care model includes 'extensivist' roles (i.e. GPs, geriatricians and other specialists who work solely with people that are most at risk to deliver personalised, specialist care), so the EHCH model ensures that people living in care homes and supported living environments have enhanced access to services via multidisciplinary teams.

1.21 In both the MCP and PACS models, we move away from payment-for-activity towards a whole population budget (WPB), coupled with payment-for-quality. Accordingly, both of these new care models will be financially incentivised to provide proactive, preventive care. Moreover, the MCP and the PACS will work in partnership with their local authorities to

improve people's independence and wellbeing by supporting prevention, thereby reducing the need for ongoing care and support. Many of these duties are also enshrined within the Care Act 2014. The EHCH model ensures that integrated services, which focus on maintaining health and wellbeing, are at the forefront of the services being delivered.

1.22   Unlike with MCPs and PACSs, however, implementing the EHCH care model does not involve the creation of a single lead provider; nor are we expecting care home providers to merge with an MCP or a PACS in a new organisational form. Rather, care home providers may, if they wish, enter into a formal agreement with an MCP or PACS, or existing commissioners and providers, to formalise their commitment to whole-system, partnership working.

2 Illustrating the care model

2.1 This section unpacks the core elements of the care model illustrated in section 1 (Table 1) and enhances the theory with practical examples from the EHCH vanguards. The fully mature EHCH model will deliver the seven care elements of the care model.

Enhanced primary care support

2.2 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 **continuity of care for residents, timely medicines reviews, access to hydration and nutrition support, and streamlined referral to out-of-hours services and urgent care**.

"I have care and support that is directed by me and responsive to my needs"

Case studies - how it has been achieved

Enhanced primary care support

Nottingham City CCG

There is an enhanced agreement in place with a number of GP practices to deliver all elements of the enhanced primary care service. The resident still has the choice to retain their own GP as long as they are within the catchment area.

Sutton Homes of Care

Linked GPs carry out health and wellbeing reviews of residents in six nursing homes across the borough. Through these reviews, every resident will have an individual care plan developed in partnership with them, their family, their GP and the home's care co-ordinator. The care plan aims to ensure provision of preventive and proactive holistic healthcare.

Nutrition and hydration reference cards have been developed for care home staff

Key messages

- A shared and coordinated approach to care delivery ensures residents have access to the best care possible.
- Comprehensive Geriatric Assessment (CGA) is a vital part of personalised care planning.
- Building strong personal relationships between care home providers and GP practices is critical in developing local enhanced primary care support.
- Continuity of care matters to the individual and their carers/families.
- Carers and families should be supported in making care decisions.

Gateshead Care Home Project

Each care home has a link GP practice and each practice has a lead GP via a LES agreement. Each nursing home has a link nurse specialist for older people who works in partnership with the GP and has a shared approach to CGA and care planning, including the weekly 'home round'.

The CCG has also funded a pharmacist and pharmacy technician to support all care homes with medicine optimisation.

A dietician and dietetic support assistants are in post, working alongside the care home teams, attending virtual rounds and taking referrals from clinicians.

East and North Hertfordshire CCG

There is a dedicated care homes medicines management team which covers 60 care homes within the area.

Through the Better Care Fund, the CCG and Hertfordshire County Council have agreed to invest in acute focussed rapid response care for older people in East & North Hertfordshire. The aims are to provide support as an appropriate alternative to 999; respond to 999 calls for residents aged 65 years and over without a red flag presentation or where a predefined pathway is appropriate (e.g. chest pain or stroke); provide safe appropriate admission avoidance solutions which promote independent living and person-centred goals; facilitate an immediate CGA assessment approach to older people at risk of admission.

2.3 The EHCH vanguards stress the importance to residents of having access to a consistent, named GP, who is linked to a wider primary care team. Their work has demonstrated how 'enhanced primary care' can add further value to the services provided by a local enhanced service (LES) through the GP. Indeed, many CCGs have a LES in place to deliver this type of service for individuals who have complex needs.

a. Wherever possible, there should be one-to-one mapping of GP practices to care homes within an EHCH as this arrangement simplifies care delivery (e.g. through multidisciplinary and interagency working between primary care and care home teams). This arrangement needs to respect patient choice. Each resident should have a named GP to ensure comprehensive assessment, problem identification and care planning. However, care planning will be a shared role with staff employed by social care providers (including registered nurses), social care staff, and nurse specialists. The specific arrangements should be decided in partnership with the individual resident and their family.

b. A weekly 'home round' should be held in each care home. This proactive round is a cross between a hospital ward round and a home visit, and it is crucial for reviewing and planning a resident's care. Members of the team who participate in the 'home round' are the resident's GP, the care home team and other members of the local MDT such as nurse specialists and pharmacists. If appropriate, this can form part of a virtual ward round, should this be in place locally.

c. When a resident moves into a care home, a 'comprehensive geriatric assessment' (CGA) process should be carried out on admission as part of their personalised holistic care planning. This assessment should be reviewed at least twice a year and undertaken by appropriate members of the MDT. It is good practice to include family members in the assessment when this is appropriate, taking into consideration issues such as mental capacity, vulnerability or coercion. Including family members helps where there may be cognitive impairment and also helps give a holistic picture of a person's preferences and goals, rather than simply their medical needs. It also recognises the caring role the family member may have held before the person was admitted to the home or hospital, or before domiciliary care started.

d. When a resident moves between a care home and hospital, a prompt and efficient transfer of clinical care is required. One example of how this transfer may be achieved is the 'Sutton hospital discharge pathway'. When a resident becomes unwell and is assessed as needing hospital care, care home staff pack a dedicated red bag that includes the resident's standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items (e.g. toiletries, spectacles, dentures). The pathway includes an assessment of the functional level of the resident when they are well. This information allows the hospital team to understand the functional level they should be aiming for to support discharge. The ambition is for this pathway documentation to be made available digitally in due course.

2.4 Medicine reviews

A medicine review forms part of the CGA process and, as with CGA, the resident and/or their family or carers should be involved in the review. Thereafter, the MDT should agree the frequency of medication reviews, with safety being the most important factor. Medicine reviews should be no longer than one year apart and are best tied into regular CGA reviews and care planning.

In a structured medicine review, each medication should be reviewed according to national care homes guidance and any relevant local prescribing guidance issued by the area prescribing committee. Care home providers should be supported to have an effective 'care home medicines policy' that aims to avoid unnecessary harm, reduce medication errors, optimise the choice and use of medicines with care home residents, and reduce medication waste.

In East and North Hertfordshire, introducing the medicines reviews led to 665 medicines being stopped in the 20 care homes visited between December 2015 and July 2016. This included stopping 111 medicines that are linked to an increased risk of falls, with a direct reduction in ongoing drug costs of £74,093 per annum.

2.5 Hydration and nutrition support

Poor hydration and poor nutrition can often lead to confusion, falls, and poor health; therefore, an important role of primary care support to a care home is to ensure that each resident's hydration and nutrition is well managed.

a. Every resident's hydration, nutrition and oral health should be reviewed regularly and included in their care plan. They should have access to specialist dietetic and speech and language professionals, who should form part of the extended MDT in line with best practice for oral health. The Gateshead Care Home Project vanguard is implementing a plan for improving a 'food first' approach to nutrition and hydration, which is reducing spend on unnecessary supplements.

b. The care home should have a nutritional screening policy in place with one staff member taking responsibility for this policy within the home.

c. Ensuring staff employed by social care providers undertake clinical training and professional development is critical in promoting good nutrition for older people. In Sutton they have developed a simple set of cards with their care homes to support staff to identify dehydration early. Technology can also provide innovative solutions. Fylde Coast Local Health Economy (an MCP vanguard) has connected GPs with care homes using high-definition cameras. The system enables clinicians to observe an individual's ability to feed themselves unaided, without requiring a call-out. They can then work with the home and person involved to ensure they are supported to eat and drink well.

d. When appropriate, and in line with local policy, community nursing teams should provide supporting services for staff employed by social care providers. For example, administering subcutaneous and intravenous fluids to maintain optimum hydration status.

2.6 Access to out of hours/urgent care when needed

Out-of-hospital services form a vital part of the urgent and emergency care system at all times of day and night. The EHCH sits within a streamlined system of health and social care teams that provide advice and care both in hours and out-of-hours. The EHCH is linked to these teams through single points of access and through sharing care plans and protocols with these teams. These teams include GP in-hours services, GP extended-access services, GP out-of-hours services, NHS 111, rapid-response health and care teams, and the local ambulance service. When hospital admission is indicated, this should be facilitated promptly. For example, the Airedale telehealth hub enables local care homes to directly interact with the multidisciplinary team at the hub. In a single month, the centre received over 1,500 calls, more than half of which occurred out of hours. Of the calls received, more than 1,300 resulted in the patients being able to remain in their place of residence.

Some EHCH vanguards will provide enhanced services both for those at risk of admission to hospital from care homes and for vulnerable people in community settings. These enhanced services provide a rapid response alternative to ambulance or GP callouts in emergencies. In East and North Herts, this component of the care model includes an acute focussed rapid response vehicle which allows access to acute assessment, interpretation and bed-side testing.

Multidisciplinary team support including coordinated health and social care

2.7 A multidisciplinary team (MDT) approach provides individuals with care and support needs with access to the right care when they need it (Figure 2). 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**.

"My support is coordinated, co-operative and works well together and I know who to contact to get things changed"

Case studies - how it has been achieved

Multidisciplinary team support including coordinated health and social care

Connecting Care - Wakefield District

The community MDT uses a screening process to identify care needs which, if not met, may lead to residents needing inappropriate secondary care. The MDTs can then raise any issues with the care home, support them to meet those individual needs and improve the resident's quality of life - at the same time reducing unnecessary pressure on secondary care services.

Sutton Homes of Care

The care co-ordinator role has been developed to provide nursing leadership within care homes and continuity of nursing input into GP health and wellbeing reviews for care home residents. This builds on the professional-to-professional relationship between the GP and nursing staff and helps to develop shared expectations of each other and give nurses the confidence to have an equal input in decision-making.

Key messages

- The resident, their family and their carers are at the centre of the MDT's decision-making process.
- Don't underestimate the time needed to get the relationships and partnerships in the MDT going.
- Explore innovative approaches in the design and implementation of new ways of working.
- Real time sharing of care records is crucial.
- Wider community services and mental health services are part of the MDT.
- The MDT is crucial in ensuring that individuals are appropriately admitted to the acute hospital when necessary.

Gateshead Care Home Project

The Gateshead care home initiative service provides responsive community services to older people with complex needs through joint case management between the GP and nurse specialists for older people through a MDT approach.

The virtual ward model allows the MDT to meet weekly in a local care home to discuss care home residents. Most residents enter the virtual ward for shared complex decision making and are identified on the weekly 'home rounds'.
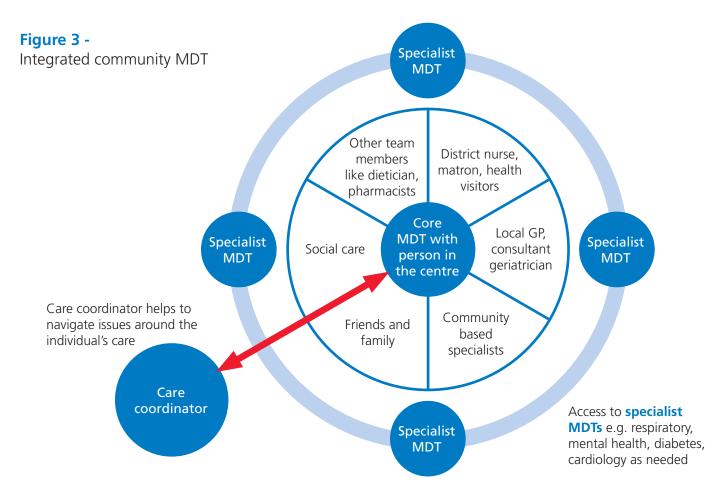
East and North Hertfordshire CCG

The 'Homefirst' MDTs are made up of social care, community health and mental health staff, which operate virtual wards of approximately 250 residents (in and outside of care homes), targeting support for those who are at most risk of a hospital admission, based on risk stratification. Homefirst teams also deliver rapid response within 60 minutes of referral to avoid hospital admissions where possible. Named matrons in the team work with high-risk care homes in each area.

Interface geriatricians deliver rapid access frailty clinics based on a 'comprehensive geriatric assessment' approach complemented by a telephone advice line used by health staff and specialist reviews.

2.8   Expert advice and care for those with the most complex needs

a. Within an EHCH, the MDT could use risk stratification tools to ensure it focuses its attention on those individuals with the greatest potential to benefit, in care homes and in the community. For example, it may use a risk stratification tool to identify care home residents who are at high risk of unplanned hospital admission. Similarly, it may use risk stratification to identify people living in the community who are at high risk of losing their independence.

b. The MDT provides both preventive care and reactive support to the people on its caseload. The team uses a partnership approach to clinical governance and decision-making, with social care provider staff being core members of the team.

c. 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).

d. The resident, their family and their carers are kept at the centre of the MDT's decision-making process at all times, by following the principles set out in the NHS' personalised care and support planning handbook, and where applicable, the Care Act 2014's statutory guidance.

e. Where an EHCH is operating as an adjunct to an MCP, the MCP's MDT could provide care for people living in care homes who are at high risk of unplanned hospital admission and for people living independently who are at high risk of losing their independence.

Figure 3 -
Integrated community MDT

Core MDT with person in the centre
- Other team members like dietician, pharmacists
- District nurse, matron, health visitors
- Local GP, consultant geriatrician
- Community based specialists
- Friends and family
- Social care

Specialist MDT

Care coordinator helps to navigate issues around the individual's care

Care coordinator

Access to **specialist MDTs** e.g. respiratory, mental health, diabetes, cardiology as needed

2.9 Helping professionals, carers and individuals with needs navigate the health and care system

The EHCH care model is designed to ensure that care and support is co-ordinated and consistent, and that interventions are offered as early as possible to meet each individual's needs. Too often, the feedback from people living and working in care homes is that when they access health and care services, the care is disjointed and insufficiently tailored to the individual's needs. The Care Act (2014) introduces rights for carers to get the support they need and the EHCH care model also aspires to emulate this parity of esteem and support.

a. To address these issues, several of the EHCH vanguards have incorporated a care co-ordinator as part of their MDT, building on services already provided in the community through social care provision, or creating these afresh. Care coordinators provide dedicated support to residents and their carers for residents who are having multiple simultaneous interactions with different health, care and voluntary services.

b. Feedback from social care provider staff is that they often find it difficult to know which service to contact when they need advice and input from colleagues in the NHS or social work sectors. This lack of clarity can lead to residents being referred inappropriately to services that do not meet their needs. In contrast, under the EHCH care model, care provider staff have easy access to reliable and trusted advice and triage.

c. The MDT facilitates and supports 'discharge to assess', which aims to help individuals who are ready to be discharged from the acute hospital but who may need further support at home or in an alternative community setting. Individuals would be given the appropriate support at home until a full assessment could take place and a longer term care package initiated if necessary. Close working between care homes and the local NHS system to implement the EHCH care model also draws on learning from programmes to reduce delayed transfers of care such as the emergency care improvement programme (ECIP) to deliver real improvements in quality, safety and patient flow.

Reablement and rehabilitation to promote independence

2.10 The aims of reablement and rehabilitation are fourfold: (i) to promote independence at home, (ii) to decrease the length of hospital stays, (iii) to reduce the chance of readmission to hospital, and (iv) to reduce the risk of admission to a care home.

"I feel safe. I can live the life I want and I am supported to manage any risks"

Case studies - how it has been achieved

Reablement and rehabilitation to promote independence

Connecting Care - Wakefield District

Community anchors have been commissioned to interact with care home residents. Community anchors are independent multi-purpose organisations, based in geographically defined neighbourhoods and accessed and used by the whole community. They provide a place for local people to access social and economic opportunities but also a focus for health and social care to engage with communities to understand their needs and to extend pathways of care and support. They can contribute to social change by providing a vehicle for local voices to be heard and a platform for community cohesion and development.

Nottingham City CCG

'Worry catcher' volunteers have made positive changes through their regular visits by spending one-on-one time with residents in care homes, identifying any concerns or worries and passing them on to the care home manager for action. This has helped to improve the quality of life for residents within these homes and make positive changes which enhance their health and wellbeing.

Key messages

- Residents, their families and care home staff are at the heart of the care model.

- Work together with all partners and test the model with the individuals who will deliver and receive the care, incorporating their skills, experience and expertise.

- Working with communities in innovative and small scale ways such as knitting groups or lunch clubs can lead to significant changes for individuals.

- Rapid response services help and support people to stay well and remain at home rather than going into care.

East and North Hertfordshire CCG

In April 2016, a new specialist care at home contract began, jointly procured via the Better Care Fund. It will pull together and enhance all reablement homecare services in a single framework which will focus on:

(a) more intensive and time limited interventions (up to six weeks, with seven days live-in care to manage crises)

(b) more flexible levels of care according to a service user's need

(c) enabling care, which will encourage people to re-learn skills and manage their own lives in their own homes

(d) rapid deployment, to prevent avoidable hospital admissions and facilitate seamless hospital discharge.

2.11 Reablement and rehabilitation services

Reablement and rehabilitation provide specialist assessment and treatment. Their purpose is to restore independent functioning, thereby improving health and wellbeing.

a. Under the EHCH model, both local authorities and the NHS make continued investment in reablement and rehabilitation a shared priority. The investments made in East and North Hertfordshire to establish integrated rapid response teams enable the MDT to physically assess a patient within one hour of referral in the community (including care homes). The type of response will depend on the nature of the patient's issue, but could include nursing, therapy, social work, or domiciliary care.

b. CCGs should work with local authorities to ensure that rehabilitation and reablement is provided in the right setting, including in-home care and bed-based rehabilitation for individuals who are not suitable for rehabilitation at home. Sometimes, bed-based reablement services may be commissioned from care home providers. In Sutton Nursing Home beds are commissioned by the CCG to provide an alternative to hospital care for those who need support to return home. In mature EHCH care systems the individual who is receiving reablement is given greater choice and control by offering them a range of different living options.

c. Activity coordinators can form an important part of a reablement team. They help facilitate and support exercise and other activities for the individual.

d. By conducting personalised care planning, members of the reablement team ensure that the support offered is proportionate to the individual's circumstances and needs. In Nottingham the reablement service has a risk stratified and personalised approach focussing on prevention and frailty ensuring those with the greatest need receive support, covering both those who need support in the community and those in care homes.

2.12 Developing community assets to support resilience and independence

The EHCH care model works with the voluntary sector and develops existing and new community assets to support local people to improve their health and wellbeing.

a. The EHCH model encourages self-management and the provision of informal care. It does so by supporting networks such as friends and families to ensure families and carers are involved, and that volunteers are provided with ongoing support. Where the EHCH is an adjunct to an MCP or a PACS, the broader community involvement of that organisation will complement the community involvement of the EHCH.

b. People are supported to ensure that they can be involved with, and feel a part of, the wider community, particularly through 'community anchor' organisations. This helps build people's confidence and independence, and can reduce social isolation and loneliness. Community involvement has also been shown to improve adherence to national screening programmes and can help with primary prevention, such as encouraging people to stop smoking, reduce excessive alcohol consumption, and tackle obesity.

c. In Wakefield, volunteers addressed social isolation by providing a more person-centred approach to activities such as 1-1 befriending services and exercise, thereby facilitating the development of friendships and social interaction. These schemes can build on the network of care homes they serve to extend the offer to also help address loneliness and isolation amongst those at risk of loss of independence in the wider community.

d. In the EHCH care model, professionals in care homes, health services and the community embrace the use of tools such as LEAF, Portrait of a Life, which help ensure the care planning process identifies the outcomes that are important to individuals, and then supports them to have as fulfilling a life as possible, whilst also meeting their health needs in a personalised way.

High quality end-of-life care and dementia care

2.13 High quality end-of-life care ensures that people die in the place of their choosing with dignity and in comfort. High quality dementia care ensures that people with dementia have equal access to the services and support that they require. Care home residents have the same entitlement to these types of high-quality care as everyone else.

"I am in control of planning my care and support"

"I have access to a range of support that helps me live the life I want and remain a contributing member of my community"

Case studies - how it has been achieved

High quality end-of-life care and dementia care

Airedale and Partners

Airedale and partners have established a dedicated 'gold line' telephone service across Airedale, Wharfedale and Craven, aiming to provide one point of contact for residents and their carers for help and advice, 24 hours a day, seven days a week, to support them in their preferred place of care wherever possible. One of the aims of the service is to prevent the gold line residents having to go into hospital by providing support at home. However, hospital admissions will be arranged when required. Calls are answered by a team of experienced nurses in the telehealth hub at Airedale Hospital. The nurses are linked up to community-based teams, who can visit residents if necessary.

By working collaboratively with their local cricket clubs, a dementia-focused social movement has been established. Intended outcomes are: increased community involvement into care homes to reduce residents' feelings of loneliness and isolation; improved care planning (physical, mental, emotional and social needs) with a focus on keeping residents in their normal place of residence; greater opportunity for residents to be involved in decisions about their health and care.

Key messages

- People living with dementia and cognitive impairment are 'core business' in homes of all kinds and not just specialist dementia units.

- Supporting people with dementia in non-specialist homes can enable them to stay there.

- The use of digital tools can enhance the quality of end-of-life care.

- Many areas have existing high quality dementia and end-of-life care services - these should be made available to care home residents in that area.

Nottingham City CCG

A dedicated 'dementia outreach team' is in place, delivering specialist dementia care training to care homes. This is a dedicated multidisciplinary service that consistently improves the wellbeing of people living with dementia in care homes. As well as providing training, the team offers a range of specialist skills to those with very complex mental health needs. Complex patients with primary health needs are supported and reviewed.

Sutton Homes of Care

A rolling training programme has been established for end of life care and other high risk conditions identified through quality surveillance conducted by their joint intelligence group.

2.14 End-of-life care

Individuals who are approaching the end of their life often experience profound physical and emotional changes. Palliative care and end-of-life care should therefore be a priority for any EHCH, and the EHCH should ensure that it is addressing the needs not only of the individual themselves but also of their family, their carers, and their community.

a. An EHCH uses a systematic, proactive approach to identify residents who may require end-of-life care.

b. Individuals should be supported to die in their place of choice. Their preference can be reinforced through 'advance care planning', personalised care plans, and treatment escalation plans. The Mental Capacity Act 2005 provides formalised outcomes of advance care planning, which may include the individual appointing somebody to make decisions for them using a Lasting Power of Attorney.

Where possible, an EHCH should use digital tools such as the electronic palliative care coordination system (EpaCCS) to enhance the quality of end-of-life care. Airedale and Partner's 'goldline' provides one point of contact for residents and their carers for help and advice, 24 hours a day, seven days a week, to support them whether in care homes or in the community.

c. When appropriate, the EHCH should seek support in delivering end-of-life care from its partner organisations, including acute hospital, hospices and community nursing teams.

d. Care home staff are supported with education and training on palliative care knowledge and skills. This is incentivised through both contracts and partnership working and delivered in collaboration between social care providers, NHS, local government and the voluntary and community sectors.

2.15 Dementia care

Dementia and cognitive impairment is estimated to affect around 80 per cent 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.

a. A timely diagnosis of dementia is important, as is the support required following a diagnosis.

b. Shared care planning is of paramount importance in delivering high-quality, personalised care planning and life planning, and for ensuring timely access to secondary care and to specialised mental health services.

c. Education, training and professional development help ensure that carers, families, and staff employed by social care providers feel supported. The voluntary sector plays an important role in providing dementia services in the community and in offering ongoing support for individuals and their carers and families. These organisations provide invaluable information advice and support, ranging from advocacy services and support groups, through to activity clubs and respite days.

d. 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.

e. The leadership of the care homes and EHCH should pay close attention to the physical environment for residents. Well-designed facilities, such as sensory environments and home environments, have been shown to improve the quality of life for persons living with dementia, as have activities and therapies such as animal assisted therapy.

f. EHCHs make use of the 'This is Me' tool, which helps NHS services ensure that all care home residents' needs are met, both when NHS staff attend the care home and when residents attend NHS services as outpatients, day patients, or in-patients.

Joined-up commissioning and collaboration between health and social care

2.16 In order to ensure that an EHCH transforms the quality of care, its commissioners will need to work closely with its providers to promote the use of **networked care homes, shared contracts** and **access to a full range of housing options**. Commissioning the model is achieved through collaboration, building on and improving existing contractual arrangements.

Case studies - how it has been achieved

Collaborative commissioning between health and social care

Connecting Care - Wakefield District

In Wakefield, the EHCH offer extends beyond care homes and includes independent living schemes where different elements of the care model are implemented.

By working with local community anchors, boundaries between community and care settings are blurred and this increases the involvement of residents or tenants in the community.

One element of the EHCH model is the offer of 'holistic assessments', where listening exercises and engagement tools are used to identify tenants' needs. This has had a positive impact on improving wellbeing and quality of life as well as addressing social isolation.

Key messages

- Engage with partners and develop relationships and trust. It may be necessary to work on a goodwill basis between partners initially. Changes can be achieved through engagement.

- Don't underestimate the time needed to talk to providers to discuss this new approach and the benefits for them and yourself as a commissioner.

- As a commissioner, be prepared to compromise on the agreement so that all parties are comfortable with it and can see their suggestions have been acted upon.

- Don't underestimate the strength of your partner relationships; if you have trust in each other as a system you can overcome any concerns.

Nottingham City CCG

Nottingham CCG has a joint CHC and local authority (LA) contract and has successfully developed the same service specifications and quality assurance for all care homes. This work started in 2011 and it has taken a while to successfully develop the relationship with their LA.

Shared contractual arrangements have now been established with all care homes. The vanguard also has a successful care home forum that is used to channel information and concerns. The challenge is that membership is solely with the registered managers and hence there has been little attendance from care home owners. As a result, the care home forum engages with home owners on an ad hoc basis.

2.17 Co-production with providers and networked care homes

By working closely with the providers of social care and, in particular, with networks of care homes, the commissioners of an EHCH can improve the ways in which organisations work together and share information.

a. Commissioners work together with providers of care home services either through a local care home forum or through online networks. Doing so supports commissioners and providers to co-develop and co-produce solutions to problems that they have in common. For example, the EHCH vanguards have used such forums to help understand the local issues faced and to explore what specific support and training is needed.

b. An active, well-attended care provider forum helps strengthen relationships between CCG and local authority commissioners, providers, care home owners and managers. Likewise, online communications or regular engagement between commissioners and a care home association can achieve the same goals. Online engagement is particularly helpful for providers who are not members of a forum and for regional managers who work across large areas and may therefore be unable to attend meetings in person.

c. In the EHCH model, CCG and local authority commissioners, service users, and the owners and staff of care homes work together to co-produce service specifications and to set quality expectations as encouraged by the Care Act 2014 and subsequent guidance.

2.18 Shared contractual mechanisms

Over the medium-term, CCGs and local authorities that commission an EHCH may find it helpful to co-ordinate - or indeed integrate - their commissioning and oversight mechanisms.

a. This care model can be commissioned as part of a wider whole systems integration initiative and can go further by implementing a larger whole-population budget, for example as part of an MCP or a PACS care model.

b. The CCGs and local authorities may also wish to develop risk-sharing and gain-sharing mechanisms to ensure that any savings from reductions in hospital admissions or in unplanned GP callouts that are associated with the EHCH model are shared by those health and care providers that were responsible for this improvement. Such arrangements should improve the financial sustainability of the social care providers, thereby leading to further improvement in quality of care.

c. Each EHCH should consider whether to work towards a shared basis for care home contracts across the CCG/s and local authority/ies, and whether to introduce a common set of outcomes. Where a CCG and a local authority are intending to sign the same single contract with a provider, the NHS standard contract must be used. More guidance is provided in the NHS Standard Contract 2016/17 Technical Guidance s14.1-14.2. This can help local commissioners to better benchmark the quality and efficiency of their health and social care providers.

d. The contracting process for dual-registered providers is simplified; it reduces the burden of quality inspection and information requests on care homes; and it enables joint quality monitoring and benchmarking by social care and health commissioners. As a result, local authorities are also better able to fulfil their market-shaping responsibilities under the Care Act because they have a fuller picture of the quality of all providers, whether care is funded by a CCG, the local authority or self-funders.

e. An important lesson from the EHCH vanguards' is that truly collaborative commissioning involves far more than simply transferring budgets or contracting providers jointly. Rather, it involves shared system leadership and the development of a shared culture of working and trust at operational level, regardless of the formal health and local authority commissioning structures that are in place.

2.19 Access to appropriate housing options

An individual's quality of life depends partly on having access to a range of housing options that suit their particular health and care needs. The EHCH vanguards have started to explore the opportunities available through work with local partners within their communities.

a. The EHCH model supports options for care home residents and residents living in extra care housing and in supported living arrangements, but can also extend to those who require support in their own home. Depending on the need identified and personal circumstances, these options might include adaptations to their home, assisted living arrangements, or access to a range of residential or nursing homes.

b. In support of an enhanced EHCH model, NHS commissioners and providers should work with local authorities and housing providers to facilitate a range of supported housing options which enable people to live as independently as possible.

c. Longer term, public and private sector partners could use planning, funding and policy levers to work toward a mix of specialised housing which meets the requirements of those with care and support needs, and general purpose housing which works better for an ageing and diverse population.

Workforce development

2.20 Underpinning the success of the EHCH model is a skilled and confident workforce that is committed to partnership working. Workforce development within an EHCH builds upon the existing learning and training opportunities to ensure that staff who are employed by social care providers receive a wide range of **training and development opportunities**.

2.21 The EHCH also undertakes **joint workforce planning** in order to ensure a sustainable supply of appropriately skilled staff. Together, these two endeavours help ensure that care home residents receive the best available care within the home.

Case studies - how it has been achieved

Workforce development

Sutton Homes of Care

A new role of care coordinator has been developed. The aim is to improve communication between the GP practice and care homes as well as building the professional-to-professional relationship between the GP and nursing staff.

This will help to develop shared expectations of each other and give nurses the confidence to have an equal input in decision making. Care coordinators can also access the enhanced training and education offered to all care home nursing staff through the vanguard.

Victor, a care coordinator, said: "The role represents a really positive change for our residents to improve their health and quality of life. At the same time it gives me the chance to further improve my skills as a nurse and take on additional responsibilities.

"After attending urinary tract infection training I was able to quickly implement changes to catheter care back at the home where I have worked for the last two years. We have had one particular resident suffering with this issue and, since changing the catheter care routine, I have seen their problems significantly decrease."

Improving the skills of care home nursing staff will help avoid unnecessary visits to hospital by managing residents' health issues safely within the home.

Key messages

- Planning across health and social care is critical. Engage with partners and ensure they are involved throughout the journey.

  Many health and social care providers will have excellent training and development programmes in place which can be made available more widely.

- Investing in staff is a priority. By continually upskilling staff, quality of life for care home residents is improved.

- When designing training and support packages consider whether these can be embedded into everyday practice.

- Developing workforce training packages can be beneficial for smaller providers who may otherwise not benefit from comprehensive training.

East and North Hertfordshire CCG

The 'Hertfordshire Care Providers Association' (HCPA) has nearly 700 care providers in the county as members. The vanguard works with the HCPA, Hertfordshire County Councils and district councils, the NHS and care providers to raise quality standards, make budget savings and share practice through training and development of the care sector. HCPA provides up-to-date information to care providers and acts as a collective voice for private, independent and voluntary care providers.

Other benefits include providing information, advice and support around quality assurance as well as providing a strong education offer.

The vanguard also offers a 'complex care premium' which allows care home staff to undertake a new package of training and education, equipping them with enhanced skills to look after patients who have complex needs with increased confidence.

Care homes use this funding to increase training levels across their teams allowing care home staff to identify potential problems earlier and raise them with doctors to prevent residents' conditions worsening.

Pathway champions in areas such as dementia, nutrition, engagement and wellbeing, falls and fragility, and wound management and health (including end of life, continence, neurological and respiratory conditions) have been trained in a number of homes.

2.22 Training and development for social care provider staff

Although many care homes and local NHS services will have training and development programmes in place that reflect good practice, they may not always be delivered consistently across a local area. To ensure consistency, the EHCH should develop a comprehensive training and development plan for all health and social care providers.

a. It is crucial to invest in professional development for care home managers, nurses and care practitioners to maximise the training and professional development opportunities available. Training and development can be achieved through collaborative and contractual arrangements and early indications from vanguards show improvements in the recruitment and retention of staff.

b. An important task for any EHCH is to increase the confidence and proficiency of staff employed by social care providers in caring for care home residents, particularly those with complex needs.

c. Care practitioners should be trained in competencies such as wounds management, nutrition and falls. All staff should be offered training in other complex conditions, such as dementia and end-of-life care.

2.23 Joint workforce planning across all sectors

Within the footprint of an EHCH, and at STP level, NHS and social care commissioners and providers should consider how best to plan for the workforce they will need, given that the pressures faced in social care occur across all types of care home. Common solutions can often be developed to respond to local needs.

a. The EHCH model places a strong emphasis on joint workforce planning and on co-ordination across CCGs, acute and community trusts, local authorities, and independent sector providers. This may include developing and testing new roles within primary care, establishing nursing banks across an area, and making changes to training pathways for nurses to expose nursing trainees to the care setting. In Wakefield, the 'pull up a chair' training tool is used by staff and commissioners in care settings to understand the experiences of older people living in assisted living and the transition to living in care settings.

b. The new 'care coordinator' role helps improve the continuity of care by acting as a point of contact for residents, families and professionals who visit the care home, such as GPs and in-reach specialists. For example, a care coordinator can support the GP with their weekly ward round by proactively identifying residents who need attention and updating the GP on their recent history. Care coordinators might also participate in a MDT meeting and they help residents to navigate community and specialist services. In Sutton, good working relationships between the GP and care coordinators improved team working and the confidence of staff when communicating with residents and their families at difficult times such as around end-of-life care.

c. Working in integrated teams can reduce duplication and improve integration between NHS and staff employed by social care providers. Technology can also improve the safety and efficiency of care, for example through e-triage, which helps ensure that individuals are seen by the most appropriate professional and that all the necessary information is at hand.

d. When undertaking workforce planning in support of the EHCH care model, the NHS needs to take into consideration the local workforce drivers around recruitment and retention of staff (such as registered nurses) in the social care sector.

Harnessing data and technology

2.24 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**.

2.25 We are developing an impact dashboard to measure the impact of vanguards' activities against a set of key metrics which relate to each component of the triple aim. These data are standardised to allow comparison between different areas, including the parts of the country which are not developing new care models. The impact dashboard also allows vanguards to track their progress over the last few years. The impact dashboard for the care home vanguards will be fully operational from Winter 2016.

Case studies - how it has been achieved

Harnessing data and technology

Sutton Homes of Care

Sutton Homes of Care vanguard has been working with the joint intelligence group and key stakeholders to share hard data and soft intelligence. They have also set up all nursing and residential homes in the area with a secure NHS.net email address.

A new quality dashboard has been introduced to measure care home performance and support workforce development. This is complemented by monthly meetings of the joint intelligence group, which bring together all stakeholders including the Care Quality Commission.

The quality dashboard enables the CCG to:

- ensure there is an appropriately skilled and stable workforce within the care home sector,
- accurately monitor the performance of care homes against benchmarks, other local care homes, national standards and best practice,
- accurately monitor falls, UTIs, pressure ulcers, staff turnover, deaths and hospital admissions, and
- analyse trends, identify issues and share learning on areas that are performing well.

Key messages

- Setting up a joint intelligence group enables key stakeholders to take a strategic view and analyse and share intelligence and data between partners.
- Where a summary care record has not yet been developed, CCGs and local authorities can support social care providers to use existing platforms such as 'Patient Online' to give individual residents and their carers access to their care record.
- Working with care providers to understand the equipment and infrastructure within care homes in your area, and the training requirements of staff, is a vital first step to begin to harness technology effectively across organisations.

East and North Hertfordshire CCG

East and North Hertfordshire's Home First multidisciplinary 'hospital from home' service uses linked data intelligently. Information can be shared and analysed which lead to positive interventions. Joining data to enable risk stratification for residents with different care needs allows Hertfordshire to better support people at the point when interventions can really make a difference to their lives.

All GPs, CCGs, their commissioning support teams and acute service providers now have the ability to directly access a single consistent dataset to support integrated business intelligence, data management and invoice validation activity across individual health economies.

Airedale and Partners

Airedale and partners' dedicated 'goldline' telephone service uses technology to provide one point of contact for residents and their carers for help and advice, 24 hours a day, seven days a week.

Airedale and partners also provide a secure video link to care homes across the country, which connects with a digital care hub. The hub is staffed 24 hours a day, 365 days a year by a multidisciplinary team of doctors, nurses and therapists. Care home residents are assessed by the clinical team, who are able to advise and suggest treatment for a variety of complex health needs.

The telemedicine service is particularly useful in residential homes, where staff are not usually medically trained, and the clinical team are able to provide extra support which benefits the residents. Care home residents are assessed and, if necessary, treatment is arranged without the need for a hospital admission or emergency department attendance.

2.26 In this document, we use the following definitions:

- *Telecare*
  is technology that is used to **support independent living** (e.g. falls monitoring);

- *Telehealth*
  is technology that is used to **exchange information about health and wellbeing** between residents and professionals (e.g. notification of changes to observations such as heart rate or weight); and

- *Telemedicine*
  is technology that is used to **exchange decision-making information** between professionals and residents (e.g. video links between homes and clinical hubs).

2.27 Linked health and social care data sets

The ultimate aim of linking health and social care data is to ensure that individuals receive joined-up care (i.e. to reduce unnecessary duplication and unnecessary gaps in care).

a. The partners within an EHCH should begin by conducting a privacy impact assessment. They should consider what information they require to assess the needs of their diverse population and to identify opportunities to either reduce unwarranted variation or to improve the quality, equity and efficiency of the care being delivered.

b. The EHCH should use business intelligence and population health analytics to identify which care home residents are at high risk of unplanned hospital admission, and which people in the wider population are at risk of losing their independence. Such analyses are necessary to allow commissioners to understand patient flows, to risk-stratify the population, and to understand the impact of different services on admissions.

2.28 Access to the care record and secure email

Care homes need access to the most up-to-date information about their residents from the NHS. The vanguards have sought to tackle this requirement in various ways: through the introduction of the summary care record (SCR) within a care home; by ensuring that care homes can receive information from NHS providers through NHS.net email; and by ensuring that clinical care records are available as part of the enhanced primary care model.

Residents may have access to their own GP records via Patient Online. Care home staff may obtain similar access as a 'proxy' with the patient's valid consent and also the authorisation of the patient's GP practice. Staff who require access must use their own logon credentials which are issued following registration at the practice.

Information on Patient Online proxy access can be found at:
http://elearning.rcgp.org.uk/patientonline

Those EHCH vanguards that do not yet have the technological infrastructure to implement the SCR are instead exploring opportunities to use existing platforms such as 'Patient Online' to give individual residents access to their care record, thereby making the care record available to both the resident and their carer.

a. Many local care and health systems have already started working towards the interoperability of IT systems, including access to shared, integrated care records. Care homes and their staff will be supported to adopt the Information Governance Toolkit and to become compliant with the revised information governance requirements of the most recent Caldicott report.

b. Care providers will also be supported to adopt secure email via NHS Mail 2 or alternatives, in order to support the secure sharing of information. In Sutton, all care homes have now been set up with NHS.net email.

2.29   Better use of technology in care homes

Clinical teams can be supported to make use of technology to improve how they work with staff employed by social care providers to make joint decisions about the care of residents. For example, they may be able to assess some residents remotely, thereby avoiding unnecessary trips to hospitals or call-outs of NHS staff to care homes.

Technology can also help avoid uncoordinated care by ensuring that health and care staff have appropriate access to all of the information they need. Sensors, apps and assistive technology can all help to support independence by identifying problems early. Areas implementing the EHCH model may look to use technology to replace existing systems where this will add value.

a. Telemedicine has the potential to improve the quality and efficiency of care delivered by care homes, community health services, specialist services and local government partners. It can be used to support virtual ward models of care and for triage, assessment, and even direct supervision of treatment. Secure video links can be particularly useful in care homes where a high proportion of the staff are not medically trained. Such systems offer the potential to enhance the quality of care, and to reduce inappropriate GP call outs, ambulance calls and admissions from care homes to hospital. They can also help palliative care residents die in the place of their choosing as has been demonstrated in the Airedale EHCH vanguard and in other vanguard areas.

b. The appropriate use of sensors and monitoring technology can help reduce the incidence of falls and the prevalence of poor nutrition. It can also help alert care home staff and staff working in the wider health system about the deteriorating health of an individual, before a crisis occurs. In Airedale, the digital care hub provides multi-disciplinary support 24 hours a day, throughout the year.

c. Assistive technology can help improve the quality of life for people who are frail or who have dementia or mobility-limiting conditions.

d. To fully realise the EHCH care model, digital infrastructure in a care home should include Wi-Fi connectivity that is sufficient to enable telemedicine systems, sensors and monitors to work; to support mobile working with staff; and to improve residents' leisure and self-care opportunities. Mobile devices such as laptops, tablets and phones should also be made available to provide health and care professionals with mobile read- and write-access to care records, thereby helping to avoid unnecessary repetition of assessments and delays or errors in treatment. These devices, which are often standard consumer devices, also enable telemedicine and telecare for care home residents.

e. Finally, local areas should consider how best to develop the IT skills of the staff employed by social care providers. In particular, they should build confidence around using these IT systems to reduce unnecessary admissions and callouts.

3   Spreading the EHCH care model

3.1 We want areas across England to adopt and adapt the EHCH care model. We know that by implementing the care model we will see benefits to care home residents and those living in other supported housing schemes, and financial savings and improved use of local resources. We also know from the work of the vanguards that the adoption of this care model can support the development of integrated services and commissioning.

3.2 Local areas will not be starting from a standing start - we know that many health and care systems are already delivering elements of the care model. Where this is the case we would expect existing services to continue and to be augmented by the elements of the care model not already in place.

3.3 By publishing a **self-assessment framework** later this year, the new care models programme will help local areas to self-assess against the framework and identify where they have gaps in provision, to determine the priorities for improvement locally.

3.4 In many places the EHCH care model will be developed as part of a local MCP/PACS, however localities need not wait for new forms of provision to be in place to implement this care model. Local action can begin immediately, building from small low/no cost actions to a greater programme of work to progress implementation of all the elements of the care model.

Why do we want to spread the EHCH care model?

3.5 To address growing acuity and complexity of need in an underserved population. Despite a welcome shift towards care provision in community settings, our ageing population means a growing number of people receive residential-based care, and this growing population has an increasing level of acuity and complexity of need.

3.6 However, NHS-led services for this population haven't been able to consistently keep up with these demographic changes. The result has been the development of variation in access to key services and quality of healthcare provision. Data collected by the Care Quality Commission (CQC) and reported by the British Geriatrics Society 'Quest for Quality' (2011) estimates that over half of older people in care homes do not have access to all the services and support they require from the NHS.

3.7 To make best use of scarce local and national resources, contributing to the NHS' triple aim. The NHS Five Year Forward view identified a 'triple aim' for the NHS to address by 2020: improved health and wellbeing, transformed quality of care delivery, and sustainable finances. The care home vanguards show us that getting NHS care right for care home residents, and for those who require support to live independently in the community, offers significant opportunities for every area in England, to positively impact people's care and quality of life and to contribute to a more sustainable health and social care system which responds to the needs arising from our ageing population.

3.8 Local savings will vary according to footprint and the starting point of the local health economy; however, initial analysis by the new care models programme's finance team suggests significant expected reductions in ambulance call outs, A&E attendances and non-elective admissions, along with significant cost savings from reductions in prescriptions.

3.9 The new care models programme's team will continue to work with the six care homes vanguards to understand whether the initial expected savings will be sustained, and how the model works to moderate demand after initial savings are made.

3.10 To implement proven changes, in a systematic and consistent manner across England. Every element of the EHCH care model has already been successfully implemented in part, or in isolation in some areas around the country. However, despite the benefits associated with each element, no area has adopted them all in full, and there is great variation in the quality and extent of provision, as there hasn't been a policy or funding context which drives widespread adoption of these interventions.

3.11 To provide more personalised, coordinated and consistent healthcare. Most importantly the EHCH care model ensures that there is equitable access to high-quality NHS healthcare for those who need it most. It ensures that the multiple services which are already available in theory to care homes and their residents are not fragmented, and that health and care staff are well-informed and well-coordinated. This is being borne out by the experiences of residents within the six vanguards who are beginning to report more personalised, higher quality care.

3.12 Therefore our ambition is for every area of England to have a deliverable, credible and affordable plan for implementation of the EHCH model in 2017/18 - recognising not everything is new, and some areas will already be implementing parts of the model.

What do we want to spread to other areas?

3.13 The EHCH care model framework is modular; it consists of seven main elements and a number of sub-elements. The framework also contains a series of smaller, 'low or no cost' ideas and actions which individually do not make a significant impact but aggregated make a series of marginal gains which can significantly improve quality, sustainability and outcomes.

3.14 Emerging evidence from the vanguards and other similar schemes indicates that the greatest benefit to patients and carers, as well as social care providers, the NHS and local government, is when there is co-ordinated action on all the elements of the model. The policy and funding mechanisms detailed later in this document are aimed at incentivising action on all elements of the framework, whilst recognising that these will be implemented in different ways to fit each community's needs, and take differing lengths of time to implement.

3.15 For this reason, based on the experiences of the six care home vanguards, the new care models programme has developed an indication of the pace of implementing each element (see Table 2), and whether each element is a 'core' or 'enhanced' element of the care model. We want to support immediate action on the 'core' elements of the EHCH framework, and work towards implementation of the 'enhanced' elements as soon as practicable thereafter.

Table 2 - Pace of implementation, care elements and sub-elements

Care model element	Sub-element	Core or enhanced EHCH model	Indicative pace of implementation
Clinical elements			
1. **Enhanced primary care support**	Access to consistent, named GP and wider primary care service	Core	< 1 year
	Medicines reviews	Core	< 1 year
	Hydration and nutrition support	Core	< 1 year
	Out of hours/emergency support	Core	< 1 year
2. **Multi-disciplinary team (MDT) support including coordinated health and social care**	Expert advice and support for those with the most complex needs	Core	1 - 2 years
	Helping professionals, carers and those with support needs to navigate	Enhanced	1 - 2 years
3. **Reablement and rehabilitation to promote independence**	Aligned rehabilitation and reablement services	Core	< 1 year
	Developing community assets to support resilience and independence	Core	1 - 2 years
4. **High quality end of life care and dementia care**	End of life care	Core	< 1 year
	Dementia care	Core	< 1 year
Enabler elements			
5. **Joined-up commissioning and collaboration between health and social care**	Co-production with providers and networked care homes	Core	< 1 year
	Shared contractual mechanisms	Enhanced	1 - 3 years
	Access to appropriate housing options	Enhanced	1 - 5 years
6. **Workforce development**	Training and development for care staff	Core	< 1 year
	Joint workforce planning	Enhanced	1 - 2 years
7. **Harnessing data and technology**	Linked health and social care data sets	Enhanced	1 - 3 years
	Access to care record and secure email	Enhanced	1 - 2 years
	Better use of technology	Enhanced	1 - 3 years

3.16 Spread of the EHCH care model isn't about decommissioning existing services where these work well and fit local circumstance. We want to build upon good practice that is already in place in many areas around England, recognising local areas already have differing levels of existing provision against each element of the model, which reflect local circumstances and historical decisions.

3.17 Other local factors such as clinical variations, the mix of system providers, the digital and physical infrastructure already in place, and the local employment market will also influence the pace at which each area can implement the model. Future guidance will recognise that some areas will have a longer journey than others to fully implement the care model, depending on their starting position.

3.18 Implementation of the EHCH model doesn't necessitate a new organisational form, or a move towards formally integrated commissioning or provision, rather it is about the NHS working in partnership with social care providers, local government and the voluntary, community and social enterprise sector to improve service provision and quality.

3.19 Taking action on both the clinical and enabler elements of the model is equally important. Whilst the initial impetus for action, investment costs and returns all fall to CCGs, both local government and NHS commissioners will need to work together for the EHCH model to be sustainable, and to realise its full potential in terms of rehabilitation and reablement, technology enabled care, collaborative commissioning and support for the social care workforce.

Work with care providers and CQC

3.20 Social care providers are key partners for the NHS in successfully implementing an EHCH care model, and along with the Care Quality Commission (CQC) and local government share ultimate responsibility for the quality of care which individuals and their families and carers receive.

3.21 Recognising this, and the initiatives developed by vanguards and pioneers themselves, we will work with providers and commissioners in a number of ways to help spread elements of the EHCH care model as effectively as possible, particularly where local areas can get on with implementing elements of the model which do not require formal action by commissioners.

Frugal innovations (see Annex 2 for emerging shortlist)

3.22 Through the process of developing the EHCH care model, we have become aware of a range of 'low cost, high impact' interventions. These are simple ideas that - if done well and replicated elsewhere - will not by themselves have the wider system impact of implementing the EHCH model as a whole, but will result in tangible improvements in the quality and outcomes of care for care home residents.

3.23 What all of these interventions have in common is that they are simple, replicable, and inexpensive. We will work with providers and commissioners to help them implement the actions (see Annex A), building on existing engagement with the Social Care Provider Reference Group.

Kitemarking/call to action

3.24 We will work with providers and Department of Health (DH) to consider whether kitemarking or pledge models similar to the DH Responsibility Deal on obesity are feasible, and investigate the potential for a call to action, working with public, private and voluntary sectors.

Quality assurance and quality standards

3.25 Several vanguards are working with NICE to improve individual pathways and interventions, and these will then form the basis for nationally applicable best practice as a quality standard. Examples include work with Sutton Home of Care's 'red bag' transfer of care pathway, and Connecting Care - Wakefield District's work on holistic care planning.

3.26 East and North Hertfordshire CCG has begun to work on the development of a trusted assessor role and accreditation process, at the request of the Hertfordshire Care Home Federation, which offers the potential of a new assessment model which could help reduce delayed transfers of care and potentially provide additional income for social care providers.

3.27 We are also already working with CQC to investigate how inspection can better take into account the access residents have to enhanced health services in care homes, without unfairly penalising providers where they are not the barrier to action.

Collaboration and spread of innovation via care home chains and associations

3.28 Together with care providers the care home vanguards are already generating materials and ways of working which reduce administrative burdens, increase standardisation of process across areas, and help improve quality of care. At the request of care home providers, Wakefield vanguard is working with partners such as NICE to standardise holistic care planning processes and documentation across all homes in their area. This has included participation of national and small and medium providers, and is an example of work which has potential for regional or wider spread via these chains and organically.

3.29 A further example of organic spread of the EHCH is in the Newcastle Gateshead CCG area. Following successfully aligning GP practices to individual care homes in the initial Gateshead care home project, work is expanding the project to cover all care homes in Newcastle.

3.30 We will continue to share learning from such schemes, working with both large and small care providers through appropriate national and local networks to support standardisation of training and recording, reducing burdens on care providers, and ensuring consistency of care.

Assessment of current level of EHCH care model coverage

3.31 Estimates of the total number of people living in care homes range from 250,000 to 480,000. At the mid-point of this range, around four per cent of the population aged 65 and over live in care homes or similar settings, and the number is growing year on year.

3.32 To begin to develop an initial estimate of the current level of coverage of the EHCH care model we have reviewed existing CCG locally commissioned services (LCSs) for indications of GP support to care homes. This has identified that around 40% of CCGs have an existing primary enhanced service for care homes in place. This assessment does not take into account the scope or scale of their service - only that there is one in place, nor does it take into account any local work on other elements of the care model.

3.33 We have also mapped the existing pioneers and vanguards against the seven elements of the EHCH care model and identified that approximately a third of sites have partially adopted the model. Within this there are some areas which have adopted one or two elements of the framework and others where it is four to six.

3.34 Further work is planned to refine central assessments of where enhanced primary care and other elements of the EHCH model are already in place across England. The NCM programme team will also develop a maturity matrix based on the EHCH framework which can offer CCG and local authority commissioners, as well as care home providers, a guide to local maturity against the model, based on self-assessment or assessment by national or regional NHS England teams.

3.35 NHS England is working to develop robust methodologies for the cost, coverage and benefits of each of the main elements of the care model, drawing data from the six care home vanguards and also incorporating other published best practice and studies.

Commissioning the EHCH care model at the right scale

3.36 The primary commissioner for most elements of the EHCH model will be the CCG, or where there is a whole-population model of care in place, part of the responsibility may lie with the PACS or MCP provider. In line with the GP Forward View, and its aspirations for primary care 'at scale', delivery of the enhanced primary care sub-elements of the model is likely to be contracted by the CCG at the level of 30-50,000 population, building on local practice groups, GP federations, and any local initiatives towards service provision from primary care access hubs or locality hubs.

3.37 Across all elements of the model, co-ordination with local government commissioning of social care services is crucial, and there are opportunities to reduce duplication and fragmentation of provision. Commissioners will also need to build and strengthen their understanding of, and relationships with, the care provider and the primary and community care sectors to ensure that social care providers are both safe and sustainable, and supported to deliver person-centred care that promotes independence and engagement with the wider community.

A step towards more integrated and sustainable health and social care provision

3.38 Just as the EHCH framework and work of the six care home vanguards build upon local initiatives already in place and national programmes such as the pioneer programme and the Local Government Association (LGA) / Assoication of Adult Social Service Directors (ADASS) adult social care efficiency programme, implementation of the EHCH care model in a local area forms one base upon which further integration of health and social care provision can be achieved, step-by-step.

3.39 Initial action to deliver the EHCH care model in new areas will focus on implementing the clinical elements of the model to ensure the right NHS care is provided to care home residents and those at risk of admission to hospital or care homes. However, to fulfil the full vision of the EHCH care model, longer-term joint work will be necessary with local government, the community, the voluntary sector and social care providers around the enabling elements such as workforce, data and IT, and commissioning.

3.40 Vanguards' experiences have shown the potential benefits of the care model not just in terms of higher quality care and reduced pressure on GPs and acute services, but in the potential to spur a different relationship between health and social care (both providers and commissioners), and a new culture of improvement.

3.41 For example, where rehabilitation and reablement services become closely aligned and sustainably funded to enable a spectrum of services from home-based rehab to short stays in care, the local system will be acting in a co-ordinated way to prevent, delay, and reduce care needs, at all levels of acuity of need. This is turn will have implications for both NHS and social care budgets in terms of the cost of provision of reablement and potential for savings and better targeted, preventative provision.

3.42 Close co-operation around commissioning also holds the potential to help change the shape and sustainability of local markets for social care, in terms of the mix of provision (hybrid care homes including rehabilitation facilities; nursing, residential and extra care settings), removing conflicting incentives, and addressing the perverse impacts of cost-differentials.

4 Annexes and supporting material

Annex 1 - Resources and references

Access to a consistent, named GP and wider primary care service

- GP services for older people: a guide for care home managers, Social Care Institute for Excellence [SCIE] (2013)
- Maintaining independence in older people, Reviews in Clinical Gerontology, vol 20, iss 2, pp128-53 (2010)
- Complex interventions to improve physical function and maintain independent living in elderly people; a systematic review and meta-analysis. Lancet. Vol 373, no 9614, pp725-35 (2008)
- Making integrated out-of-hospital care a reality, NHS Confederation and Royal College of General Practitioners (2013)

Medicine reviews

- Managing Medicines in Care Homes, NICE guideline [SC1]
- Medication safety in care homes, National care forum (2013)
- The Right Medicine: Improving Care in Care Homes, Royal Pharmaceutical Society (2016)
- Pharmacists improving care in care homes, Royal Pharmaceutical Society (2014)
- Polypharmacy and medicines optimisation: making it safe and sound, The King's Fund (2013)

Hydration and nutrition support

- Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition, NICE guideline [CG32]
- Oral health for adults in care homes, NICE guideline [NG48]
- Malnutrition Matters: A Commitment to Act - a three-step guide to improving nutritional care in England, British Association of Parenteral and Enteral Nutrition [BAPEN] (2004)
- Malnutrition Universal Screening Tool (MUST), British Association of Parenteral and Enteral Nutrition [BAPEN] (2003)

Out of hours/access to urgent care when needed

- Quality care for older people with urgent and emergency care needs "Silver book", British Geriatrics Society (2012)
- Transforming urgent and emergency care services in England. Update on the Urgent and Emergency Care Review, NHS England (2014)

Expert advice and care for those with the most complex needs

- Quest for Quality - British Geriatrics Society joint working party inquiry into the quality of healthcare support for older people in care homes. A call for leadership, partnership and quality improvement, British Geriatrics Society (2011)
- Quick Guide: Clinical input into care homes, NHS England
- MDT Development - working toward an effective multidisciplinary/multiagency team, NHS England (2015)
- Community services: How they can transform care, Kings Fund (2014)

Helping professionals, carers and individuals with needs navigate the health and care system

- Care Act 2014, Department of Health (2014
- Care and support statutory guidance: Issued under the Care Act 2014, Department of Health (2014)
- Coordinate my care, Coordinate My Care (CMC)
- Accredited Care Navigation Training, West Wakefield Health and Wellbeing

Reablement and rehabilitation services

- Homecare: Delivering personal care and practical support to older people living in their own homes, NICE guideline [21]
- Reablement: a guide for frontline staff. England. North East Improvement and Efficiency partnership, Office for public management (2010)
- LEAF-7 Quality of Life Assessment Tool, Age UK Wakefield District (AUKWD)
- Portrait of a Life, South West Yorkshire Partnership NHS Foundation Trust

Developing community assets to support resilience and independence

- People powered health co-production catalogue, NESTA 2014
- Developing Asset Based Approaches to Primary Care: Best Practice Guide, Innovation Unit / Greater Manchester Public Health Network (2016)
- Head, hands and heart: asset-based approaches in health care, Health Foundation (2015)

End of life care

- National Institute of Health and Clinical Excellence (2011). End of life care for adults. NICE quality standard [qs13]
- National Gold Standards Framework (2012)
- Six Steps to Success Programme, North West Coast Strategic Clinical Networks
- The Good Death Project
- Discharge and End of Life Care at Home, The Good Care Group
- High quality health care for Older Care Home Residents, British Geriatrics Society (2013)
- Lessons learned. Implementing an Electronic Palliative Care Co-ordination System (EPaCCS), NHS Improving Quality (2014)

Dementia care

- Low expectations: Attitudes on choice, care and community for people with dementia in care homes, Alzheimer's Society (2013)
- Mental Capacity Act 2005, Department of Health (2005)
- Mental Capacity Act (MCA) resource, Social Care Institute for Excellence
- 'This is Me' tool, Alzheimer's Society and Royal College of Nursing (2013)
- Dementia: supporting people with dementia and their carers in health and social care, NICE Clinical guideline [CG42]
- Shared Lives Plus scheme - supporting older people (including those with dementia) with day support and short breaks to aid living independently longer.
- Making a Difference in Dementia - Nursing Vision and Strategy, Department of Health (2016)
- Joint declaration on post-diagnostic dementia care and support, Department of Health and partners (2016)
- Prime Minister's Challenge on Dementia 2020: Implementation Plan, Department of Health (2016)
- Dementia Dog Project, Alzheimer Scotland
- Dementia Core Skills Education and Training Framework, Skills for health, HEE (2015)
- Fix Dementia Care: NHS and care homes report, Alzheimer's society (2016)
- DeAR-GP (Dementia Assessment Referral to GP), South London Health Innovation Network

Joined up commissioning and collaboration between health and social care

- People not process: a tool for co-production in commissioning, Think Local Act Personal (TLAP)
- Commissioning for Excellence in Care Homes, British Geriatrics Society (2013)
- NHS Standard Contract 2016/17 Technical Guidance s14.1-14.2, NHS England
- Building our homes, communities and future: preliminary findings from the LGA Housing Commission, Local Government Association (2016)

Workforce development

- www.calderdaleframework.com, The Calderdale Framework - provides a systematic, objective method of reviewing skill, role and service redesign.
- WRaPT Strategic workforce planning tool, Health Education England [North West]

Harnessing data and technology

- Technology Enabled Care Services, NHS England
- Technology Enabled Care Services Resource for Commissioners, NHS England (2015)
- Information on Patient Online proxy access, RCGP Learning
- Joining NHS Mail, NHS Digital
- Information Governance toolkit, NHS Digital

Spreading the EHCH care model in 2017/18 and beyond

- Integrated Care Pioneers Programme, NHS England, Local Government Association and partners
- Adult Social Care Efficiency Programme, LGA/ADASS

Annex 2 - Low cost, high impact ideas

Table 2 - Pace of implementation, care elements and sub-elements

Low/no cost actions for providers and commissioners		Impact vs three 5YFV 'gaps'		
Action	*What this means in practice*	*Improved health and wellbeing*	*Transformed quality of care*	*Funding and efficiency*
NHS secure email	Providers can sign up to receive an NHS.net email account, this enables them to transfer secure emails between providers, reduce the use of fax machines and reduce the cost of transcribing information from paper to an electronic form.		✓	✓
'This is me' pen portraits	Successfully used for residents with cognitive impairment but have proven useful for all residents in supporting the NHS to ensure residents have their needs met, either as inpatients or when NHS staff attend the care home.	✓	✓	
Patient online access	Patient online system is used by residents (and staff with proxy access rights) to access care records, repeat prescriptions and GP appointment bookings. This supports effective liaison between care homes and primary care and enables the care home to better support the resident and ensure access to primary care.	✓	✓	
Networking for care home staff	Networking care home staff within an organisation or area supports the staff to learn and develop. This also offers a means of developing common working practices and sharing of best practice using a community of practice model. Some areas report that this has a positive impact on staff retention.		✓	✓
Description of the UEC system	Care homes consistently state that they call ambulances because they don't know who else to call, in Sutton, they have created a simple poster that tells home staff who to call and in what situation. Staff report that this has increased confidence to make a decision and made them less likely to call an ambulance.	✓	✓	✓
DeAR-GP (Dementia Assessment Referral to GP)	DeAR–GP, developed by the Health Innovation Network and supported by Alzheimer's Society, is a simple paper based case-finding tool which has been designed for use by care workers to identify people who are showing signs of dementia, and improve.	✓	✓	

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England
- Care Quality Commission
- Health Education England
- The National Institute for Health and Care Excellence
- NHS Improvement
- Public Health England

Our values: clinical engagement, patient involvement, local ownership, national support

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