

# The Framework for Enhanced Health in Care Homes

Version 2

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# The framework for Enhanced Health in Care Homes 2020/21 - Version 2

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## 1. Introduction

- 1.1 People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through collaborative working between health, social care, Voluntary, Community, and Social Enterprise (VCSE) sector and care home partners.
- 1.2 The Enhanced Health in Care Homes (EHCH) model moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff. Such care can only be achieved through a whole-system, collaborative approach.
- 1.3 The [NHS Long Term Plan](#) (2019) contained a commitment as part of the Ageing Well Programme to roll out EHCH across England by 2024, commencing in 2020. This reflects an ambition for the NHS to strengthen its support for the people who live and work in and around care homes. This includes how Urgent Community Response is accessible to people living in a care home, increased support for nurses working in care homes through a national network, and the appointment of a chief advisor on care home nursing. Information will also be shared more easily and securely between the NHS and care homes, with NHSMail now available to all care homes.
- 1.4 Requirements for the delivery of Enhanced Health in Care Homes by Primary Care Networks (PCNs) are included in the [Network Contract Directed Enhanced Service \(DES\)](#) for 2020/21. Complementary EHCH requirements for relevant providers of community physical and mental health services have been included in the [NHS Standard Contract](#)<sup>1</sup>. This supports the NHS Long Term Plan goal of "dissolving the historic divide" between primary care and community healthcare services and sets a minimum standard for NHS support to people living in care homes.
- 1.5 This implementation framework supports the delivery of the minimum standard described in the contracts above, and should be read alongside the contractual requirements. Clinical Commissioning Groups (CCGs) should continue to develop and separately commission, as required, services that go further than the minimum national requirements in order to implement a mature EHCH service and must consider maintaining such enhanced services where they already exist. This framework also, therefore, sets out practical guidance and best practice for CCGs, PCNs and other providers and stakeholders as they work collaboratively to develop a mature EHCH service. The implementation framework is a refresh of the original EHCH framework, published in 2016, and has been developed with a range of experts and partners. Care has been taken to expand EHCH without disrupting the elements of the original framework most likely to result in benefits for people living in care homes, such as continuity of care.
- 1.6 The first framework for EHCH was co-developed with the six EHCH vanguards and partners in social care. It was based on a suite of evidence-

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<sup>1</sup> <https://www.england.nhs.uk/nhs-standard-contract/20-21/>

based interventions, designed to be delivered within and around a care home in a coordinated manner to improve services and outcomes for all people living in care homes and those who require support to live independently in the community.

- 1.7 This implementation framework builds on experiences of those who have implemented the EHCH model since 2016 and describes best practice in doing so. Implementing the good practice EHCH model described in the framework, will help to ensure that:
- a. People living in care homes have access to enhanced primary care and to specialist services and maintain their independence as far as possible by reducing, delaying or preventing the need for additional health and social care services;
  - b. Staff working in care homes 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;
  - c. Budgets and incentives are aligned so that all parts of the system work together to improve people's health and wellbeing;
  - d. 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 For the purposes of the EHCH implementation framework a 'care home' is defined as a CQC-registered care home service, with or without nursing. Whether each home is included in the scope of the service will be determined by its registration with CQC. The CQC website contains a spreadsheet which can be filtered to show CQC registered care homes. This spreadsheet can be found [here](#)<sup>2</sup> and is titled "CQC care directory – with filters" followed by the date of the latest update. Column C can be filtered to show CQC-registered care homes. All care homes in this directory are in the scope of the EHCH service.
- 1.9 The EHCH service 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. It is equally applicable to homes for people with learning disabilities and/or mental health needs and should not be interpreted as only pertaining to care homes for older people. However, secure mental health units are not in scope.
- 1.10 Personalised care and support are at the heart of EHCH model. This implementation framework draws on both the 'I statements' (published by National Voices ([Think Local Act Personal](#) and [Making It Real](#)), as well as the comprehensive model of personalised care set out in the Long-Term Plan and [Universal Personalised Care](#).

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<sup>2</sup> <https://www.cqc.org.uk/about-us/transparency/using-cqc-data>

## 2. Principles of a successful EHCH model

### 2.1 Fit with whole population care models

- 2.1.1. Since the first publication of the EHCH framework, the vast majority of GP practices have joined PCNs. PCNs are networks of practices, working closely with other community healthcare providers to improve the health and wellbeing of patients living within their practices' geographic boundaries. Based on GP practice lists and generally serving populations of 30,000-50,000, they are small enough to provide the personal care valued by both patients and practice staff but large enough to have economies of scale through better collaboration between practices and others in the local health and social care system.
- 2.1.2. While many people living in care homes will be living with complex needs, including severe frailty, some may not. To commission and deliver an effective EHCH model, the needs of the care home population should be understood at the local level. Understanding the typical case mix of local care homes and the length of stay of people living in them will determine the enhanced services and support needed. For example, homes with a resident average length of stay of seven years will not have the same need for palliative care services as those with an average length of stay of under two years.
- 2.1.3. Conditions critical for success:
  - a. Personalised care
    - i. Putting the needs of the person at the centre through “what matters to you” conversations and personalised care and support planning processes.
    - ii. Supporting people to talk about the outcomes that matter most to them; and encouraging and enabling them to take on as much responsibility as they want to manage their own care, health and wellbeing.
    - iii. Supporting carers and families and recognising their needs, as well as those of the individual care home resident, and acknowledging them all as experts in their own care and lives.
  - b. Co-production
    - i. Working and integrating with local government, the community and the VCSE and independent care homes sectors to co-design and co-deliver the model of care as equal partners.
    - ii. Acknowledging the value of the care home sector in working alongside the NHS and the significant level of healthcare that is delivered in care homes by social care staff.
    - iii. Adopting a whole-system approach, breaking down the organisational barriers between health, social care, and the VCSE sector.
  - c. Quality
    - i. A focus on quality as the driving factor for change.
    - ii. Using clinical evidence to drive and sustain change.

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

### 3. About this implementation framework

- 3.1. The original framework (published in 2016) identified seven care elements that describe the EHCH model. All of these elements are still recognised and remain as existing good practice. Version 2 (this framework) has augmented those care elements with additional sub-elements which reflect the continued learning of stakeholders working in this area and which will further improve the offer to people living in a care home. The EHCH model is about implementing these care elements and sub-elements together in a coordinated, sustainable way, at scale, to deliver person-centred care that promotes independence.
- 3.2. This framework will be of interest to all stakeholders who will need to work collaboratively across organisational boundaries to commission or deliver high quality, cost-effective care for individuals in care homes. It will be of particular interest to the following audiences:
  - a. PCNs and providers of community physical and mental health services delivering the EHCH requirements in their respective contracts;
  - b. care home providers and managers (nursing, residential, learning disability, and mental health);
  - c. local authority and STP/ICS leaders who are responsible for commissioning care home services;
  - d. partner organisations in the community, mental health, and acute sectors of the NHS, and in the community and VCSE sector; and
  - e. individuals with care needs, carers, and families.
- 3.3. The nationally commissioned EHCH service – included in the Network Contract DES and NHS Standard Contract – represents a minimum standard of delivery for the EHCH service. This framework is intended to provide context, best practice guidance and methods of delivery to support implementation of this model, and describes additional actions that commissioners and care home providers can take to provide high-quality care for people living in care homes. This includes the ‘enabling’ elements of the EHCH model, which are not included in national contracts.
- 3.4. The EHCH model has three principal aims:
  - a. **delivering high-quality personalised care** within care homes;
  - b. providing, wherever possible, for individuals who (temporarily or permanently), live in a care home **access to the right care and the right health services** in the place of their choosing; and
  - c. enabling effective use of resources by reducing unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for people living in care homes.



- 3.5. In the EHCH model, care providers work in partnership with local GPs, PCNs, community healthcare providers, hospitals, social care, individuals and their families, and wider public services to deliver care 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.
- 3.6. Table 1 sets out the care elements and sub-elements which comprise the refreshed EHCH model.

<b>Table 1</b>	
<b>Care element</b>	<b>Sub-element</b>
1. Enhanced primary care support	Each care home aligned to a named PCN, which leads a weekly multidisciplinary ‘home round’
	Medicine reviews
	Hydration and nutrition support
	Oral health care
2. Multi-disciplinary team (MDT) support including coordinated health and social care	Access to out-of-hours/urgent care when needed
	Expert advice and care for those with the most complex needs
	Continence promotion and management
	Flu prevention and management
	Wound care – leg and foot ulcers
3. Falls prevention, Reablement, and rehabilitation including strength and balance	Helping professionals, carers, and individuals with needs navigate the health and care system
	Rehabilitation/reablement services
	Falls, strength, and balance
	Developing community assets to support resilience and independence
4. High quality palliative and end-of-life care, Mental health, and dementia care	Palliative and end-of-life care
	Mental health 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

- 3.7. Appendix 1 contains a table showing the contractual requirements for EHCH that fall to PCNs through the Network Contract DES and providers of community physical and mental health services through the NHS Standard Contract, together with the corresponding care elements in the framework.

- 3.8. This framework will reference these contractual requirements under relevant care elements, and describe good practice in implementing and enhancing the core EHCH service.

## 4. Care Element One: Enhanced primary and community care support

### 4.1 Aligning care homes with PCNs

- 4.1.1. The contractual requirements for aligning care homes with PCNs and community services providers are covered in Appendix 1.
- 4.1.2. Under the Network Contract DES, each care home will be aligned to a single PCN (and its MDT), which will deliver the EHCH service for that home. This will enable consistency of care for people living in that home, and help care homes, PCNs and providers of community services to build the strong working relationships and integrated care arrangements that are crucial to the success of the model.
- 4.1.3. Commissioners have overall responsibility for aligning each care home to a single PCN. Where possible, this alignment should be defined and agreed jointly with the care home and the PCN. In aligning homes to practices, PCNs and CCGs are expected to consider:
- a. where the home is located in relation to practices/PCNs;
  - b. the existing GP registration of people living in the home;
  - c. what contracts are already held between CCG and practices to provide support to the home, or directly between the home and practices; and
  - d. existing relationships between care homes and practices.
- 4.1.4. In supporting patients to re-register with a practice in the aligned PCN, care homes, PCNs and CCGs should describe the benefits offered under the enhanced service, and consider the use of advocacy services to support this transition.
- 4.1.5. Commissioners should seek to reach agreement with care homes and PCNs on which PCN will be aligned to which home. In instances where agreeing alignment proves difficult, CCGs should try to broker an agreement with the home, PCN, and other interested groups (such as LMCs) before allocating alignment.

### 4.2 The “home round”

- 4.2.1. The contractual requirements for delivery of the home round for PCN and providers of community physical and mental health services are covered in Appendix 1.
- 4.2.2. It is best practice:
- a. for the home round to be led by a clinician with advanced assessment and clinical decision-making skills;

- b. to agree in advance of the home round the individuals who will be discussed and reviewed. Identification could be through use of validated tools, clinical judgement and feedback from care home staff;
- c. to collate relevant information pertaining to those individuals from a number of sources/records of care (e.g. GP, community services, care homes, the individual and their family) to be ready for review within the home round;
- d. for the MDT to individually appraise their home round patients to determine if they need to physically review the person(s), or can make a clinical judgement based on the information provided within the meeting; and
- e. to set review dates for each person for follow up.

### 4.3 Personalised Care and Support Plans (PCSPs)

- 4.3.1 The contractual requirements for delivery of the personalised care and support plan for PCN and community services providers are covered in Appendix 1.
- 4.3.2 The plan will be delivered based on the principles and domains of a Comprehensive Geriatric Assessment (CGA). A structured medication review (SMR) will form part of this assessment.
- 4.3.3 The plan will also be developed with the person and/or their carer(s). 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 to give a holistic picture of a person's preferences and goals, rather than simply their medical needs.
- 4.3.4 In developing the personalised care and support plan, it is good practice to follow the standard model of personalised care and support planning set out in [Universal Personalised Care](#).
- 4.3.5 Where people living in care homes are identified as likely to die within the next twelve months, it is good practice to ensure that the personalised care and support plan includes information on the person's priorities and preferences for end of life care, advance care planning and treatment escalation plans or emergency care and treatment plans and that arrangements are in place to coordinate across multiple providers (see also section 7.1).
- 4.3.6 Where people living in care homes are likely to die within the next few days or hours, it is good practice to ensure that appropriate communication with the family is taking place, that food and fluid support and anticipatory prescribing have been considered, and that the personalised care and support plan has been checked so that, where possible:
  - a. the person dies in their preferred place; and
  - b. arrangements for timely verification and certification of death and signposting to bereavement support are in place.

- 4.3.7 Providers of primary care and community services are also required to make all reasonable efforts to support delivery of relevant clinical activity described in the personalised care and support plans. In establishing the EHCH service, providers should work with commissioners to understand likely divisions of responsibility for this delivery, and should use the MDT to allocate and monitor the delivery of tasks. CCGs should support PCNs and providers of community services to agree their responsibilities in delivering the EHCH service, with reference to existing contracts and arrangements, when it is established from April 2020.

## 4.4 Structured Medication Reviews (SMR)

- 4.4.1 A structured medication review forms part of the CGA-based holistic assessment 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 SMRs, with safety being the most important factor. SMR should be no longer than one year apart and are best tied into regular care and support planning reviews. It is good practice for every person admitted to a care home to receive a SMR alongside their CGA-based assessment.

- 4.4.2 Best practice includes:

- a. In a structured medicine review, each medication should be reviewed according to national care homes, SMR guidance, and any relevant local prescribing guidance issued by the area prescribing committee.
- b. 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.
- c. Agreeing what medicines the person will take after the SMR and making sure they can use the medicines as prescribed.

## 4.5 Hydration and nutrition support

- 4.5.1 Poor hydration and poor nutrition can often lead to confusion, falls, and poor health; therefore, good practice in primary care support to a care home is to enable effective management of each resident's hydration and nutrition.

- 4.4.3 Best practice includes:

- a. Every person's hydration and nutrition should be reviewed regularly and included in their care plan. Where clinically appropriate, 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 hydration and nutrition.
- 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. Staff employed by social care providers should undertake clinical training and professional development, which is critical in promoting good nutrition for older people. Technology can also provide innovative solutions. Several areas have connected clinicians 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. This could include, for example, administering subcutaneous and intravenous fluids to maintain optimum hydration status.

## 4.6. Oral health

4.6.1 Good oral health is important for general health and wellbeing and an essential part of active ageing. Older people living in care homes are more likely to have experienced tooth decay and the majority of residents with one or more natural teeth will have untreated tooth decay<sup>3</sup>.

4.6.2 Evidence shows that poor oral health can lead to pain and discomfort, leading to mood and behaviour changes, particularly in those who cannot communicate their experience. There can also be problems with chewing and swallowing, which limit food choices and can lead to impaired nutritional status. Care staff can find it difficult at times to provide good mouth care, particularly when there are challenges such as advanced dementia or complex dental conditions.

4.6.3 The Care Quality Commission (CQC) 2019<sup>4</sup> report indicated that too many people living in care homes are not being supported to maintain and improve their oral health.

4.6.4 Best practice includes:

- a. Every person's oral health should be assessed as part of the holistic assessment of needs and personalised care and support planning process.
- b. Care homes should have an oral health policy in place with one staff member taking responsibility for this policy within the home. This should be clearly aligned to [NICE guidance 48](#) Oral Health for adults in care homes.
- c. Every person's oral health should be enquired after and/or observed regularly by care home staff as part of their usual hygiene routine, and they should have access to routine dental checks and specialist dental professionals as appropriate. Local systems should work collaboratively to provide access to appropriate clinical dental services for people living in care homes.
- d. Staff employed by care home providers should undertake training in oral healthcare to support delivery of oral health assessments and daily mouthcare for individuals, and maintain this knowledge and skill through ongoing professional development.

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<sup>3</sup> Public Health England, (2015) What is Known About the Oral Health of Older People in England and Wales

<sup>4</sup> CQC (2019) Smiling Matters: oral healthcare in care homes

<https://www.cqc.org.uk/publications/major-report/smiling-matters-oral-health-care-care-homes>

## **4.7. Access to “out of hours”/urgent care when needed**

- 4.7.1 People living in care homes should have equity of access to the urgent and emergency care system with people living in their own homes. Every care home should be linked to these teams through single points of access and through sharing care plans and protocols with these teams, including: GP in-hours services; GP extended access services; GP out-of-hours services: NHS 111; Urgent Community Response, and the local ambulance service. When hospital admission is indicated, this should be facilitated promptly.
- 4.7.2 Urgent Community Response teams will respond to people with complex health needs who have a very urgent care need, including the risk of being hospitalised, and will be able to access a response from a skilled team of professionals within two hours to provide the care they need to remain independent.
- 4.7.3 A two-day standard will also apply for teams to put in place reablement support for individuals in their own homes, with the aim of restoring independence and confidence after a hospital stay.
- 4.7.4 Both the two hour and two-day standards will be in place across England by April 2023, and seven accelerator sites will be working at pace towards delivery of these targets in 2020/21.

## **5. Care Element Two: MDT support including coordinated health and social care**

- 5.1. Under the requirements in the Network Contract DES, each care home will be supported by a multidisciplinary team in its aligned PCN. Members of this MDT will deliver the weekly home round, as described in section 2.2, will be responsible for the development and maintenance of personalised care and support plans for care home residents, and will make every reasonable effort to support delivery of these plans.
- 5.2. The MDT approach provides individuals living in care homes with care and support needs with access to the right care when they need it. It improves the care of people with complex conditions by making full use of the knowledge and skills of team members from multiple disciplines and service providers. Good practice in establishing and managing the MDT is described below.
- 5.3. Best practice includes:
  - a. The MDT should use risk stratification tools and clinical judgement to ensure it focuses attention on those individuals with the greatest potential to benefit, in particular when identifying people who should be seen during the home round. This could involve, for example, using a risk stratification tool to identify those people who are at high risk of unplanned hospital admission, and the insight of the care home staff who are experts in knowing the individual’s usual presentation(s) and any deviations from this.



- b. The MDT should meet weekly. The function and format of this meeting should be locally determined dependent upon the needs of those people resident in the care home, and those individuals identified as requiring MDT input.
- c. People who might be part of the MDT include (but are not limited) to;
  - i. PCN staff
  - ii. community services provider staff
  - iii. local authority staff
  - iv. care home staff
  - v. VCSE representatives/workers
- d. The MDT should review the information available to them prior to the meeting taking place, and work together to determine the appropriate response to needs identified e.g. clinical input from the MDT; onward referral to a co-opted MDT member or other; maintenance of current personalised care and support plan. (This list is not intended to be exhaustive, and other responses will also be appropriate).
- e. The home round usually follows the MDT meeting, with all MDT members agreeing the most appropriate clinician to assess the person on each occasion (this will be determined by clinical need and the skills within the MDT, noting that skills are likely to be enhanced and change over time).
- f. The MDT provides a proactive and preventative approach to support people living in a care home. The MDT uses a partnership approach to clinical governance and decision making with social care staff being core team members. Membership of the MDT outside of the core team will vary depending on the local expertise and resources available and the needs of the care home population.
- g. All members of the MDT should have access to shared care planning and shared care records through information sharing protocols established across all system partners (see Appendix 1).

## 5.4. Continence promotion and management

- 5.4.1. Urinary and/or faecal incontinence is often embarrassing and is likely to be under-reported. Urinary incontinence is estimated to affect up to a third of women. The figure for men is largely unknown. Prevalence rises with age and is higher in people with dementia ([NICE quality standard 77](#)). Faecal incontinence prevalence is between one per cent and 10 per cent of the population ([NICE Clinical Guidance 49](#)).
- 5.4.2. Best practice includes:
  - a. Every person should have an assessment of their continence completed as part of their holistic assessment of needs on admission to the care home, and as part of a regular re-assessment of needs.
  - b. All relevant staff employed by health or social care providers should undertake training and development relevant to their role on the promotion and management of incontinence in adults, which should include adults with dementia, and also address the functional causes of incontinence.

- c. Every person should have access to community nursing teams who can support bladder and bowel management, and to specialist bladder and/or bowel care within community or acute services as appropriate.

## 5.5. Flu prevention and management

- 5.5.1. Flu can be a serious illness, particularly for older people or those with other health conditions. Care workers look after some of the most vulnerable people in our communities, so it is important that they help protect themselves and those receiving care against flu. The flu vaccine is safe and effective and, as it is inactivated, it cannot cause flu.
- 5.5.2. Every year there are flu outbreaks in care homes despite high flu vaccination rates for residents. This is partly because, as people age, they do not produce as good an immune response to vaccination. This makes vaccination of staff caring for these people even more important.
- 5.5.3. Vaccination has shown to be effective in reducing disease spread and person mortality in the residential care setting<sup>5</sup>. It can also help to ensure business continuity by reducing staff flu related illness, and the need to provide agency cover.
- 5.5.4. Best practice includes:
  - a. Each care home should identify a member of staff with the responsibility for running the flu immunisation campaign. The campaign should not only focus on staff and residents but on family members and visitors too (who may not routinely be vaccinated but could carry the virus unknowingly).
  - b. Record the number of staff with direct resident contact and the number receiving the flu vaccine so uptake can be measured.
  - c. Use resources such as posters, leaflets, and digital tools, which can be downloaded from the Public Health England [Campaign Resource Centre](#).

## 5.6. Leg and foot ulcers

- 5.6.1. Effective wound care can support people to live in good health for longer. Leg and foot ulcers are wounds that fail to heal within a few weeks and are common in older, less mobile people<sup>6</sup>. They can have a profound negative impact on quality of life in terms of pain, malodour and leakage, impaired mobility, anxiety, sleep disturbance, and social isolation<sup>7</sup>.

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[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/824680/PHE\\_flu\\_immunisation\\_social\\_care\\_staff\\_leaflet.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/824680/PHE_flu_immunisation_social_care_staff_leaflet.pdf)

<sup>6</sup> Guest JF, Fuller GW, Vowden P. Venous leg ulcer management in clinical practice in the UK: costs and outcomes. *International Wound Journal*. 2018 Feb;15(1):29-37

<sup>7</sup> Briggs, M. & Closs, J. 2006. Patients' perceptions of the impact of treatments and products on their experience of leg ulcer pain. *Journal of Wound Care*, 15, 333-337.



5.6.2. Most leg ulcers are due to poor venous return and can be healed if people receive an accurate diagnosis and appropriate treatment. Therefore, it is important that anyone who has a wound on their leg or foot that is not healing or not likely to heal should receive an assessment from a clinician with expertise in leg and foot ulcer management.

5.6.3. Best practice includes:

- a. The care home should have an up to date leg and foot ulcer policy, either as a stand-alone document or as part of another policy such as wound care. Such policies should reflect national guidance where it exists.
- b. Care home staff should be offered training and support to ensure the appropriate care of a resident with a leg or foot ulcer by undertaking initial wound care, and referring to the local service that undertakes leg and foot ulcer assessment and care planning.
- c. Care home staff should be supported to continue to ensure that the resident receives appropriate individualised care while awaiting the outcome of the leg and foot ulcer service recommendations.
- d. Care home staff should be supported to implement the recommended care plan of the leg and foot ulcer service in partnership with local NHS services.
- e. The care plan should focus on enabling and empowering the resident to keep active and undertake activities and interventions that promote wound healing.

## **5.7. Helping professionals, carers, and individuals with needs navigate the health and care system**

5.7.1. The EHCH framework is designed to ensure that care and support is coordinated and consistent, and that interventions are offered as early as possible to meet each individual's needs. The Care Act (2014)<sup>8</sup> 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.

5.7.2. Best practice includes:

- a. Care coordinators can build 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 who are having multiple simultaneous interactions with different health, care, and voluntary sector services.

## **6. Care Element Three: Falls prevention, reablement and rehabilitation including strength and balance**

6.1 The aims of reablement and rehabilitation are fourfold to:

- a. promote independence at home;

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<sup>8</sup> <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

- b. decrease the length of hospital stays;
- c. reduce the chance of readmission to hospital; and
- d. reduce the risk of admission to a care home.

## **6.2. Reablement and rehabilitation services**

- 6.2.1. Reablement and rehabilitation provide specialist assessment and treatment. Their purpose is to restore independent functioning, thereby improving health and wellbeing. These services should be available to people living in care homes in the same way as they could expect within their own home. Access to these services will be available as part of the Ageing Well model and delivered under the remit of Urgent Community Response (UCR) 2-day response as clinically appropriate. It is best practice for activity coordinators to form an important part of a reablement team. They help facilitate and support exercise and other activities for the individual.

## **6.3. Falls, strength and balance**

- 6.3.1. Each year around one third of people aged over 65 experiences one or more falls, this figure rises to 50 per cent for those over 80 years old. Falls rates among care home residents are much higher than among older people living in their own homes. A fall can result in suffering, disability, loss of independence, and decline in quality of life.
- 6.3.2. Falls and fracture prevention and management is not the preserve of one profession, service or organisation, and everyone can help with falls prevention. The consequences of a fall or fracture cuts across all agencies working with older people, and with support to understand their contribution all agencies can be part of the solution.
- 6.3.3. Physical activity is a primary determinant of bone, muscle and joint strength, as well as functionality. NICE guidance identifies low muscle strength and poor balance in later life as the most common preventable risk factors for falls. Regular physical activity is associated with up to 40 per cent risk reduction of fall-related injuries and up to 66 per cent risk reduction of bone fractures. However less than 1 in 3 of men (31 per cent) and 1 in 4 (24 per cent) of women meet the guidelines for muscle-strengthening exercises; with even lower proportions in those aged over 65 years.
- 6.3.4. Many falls and fractures can be prevented and managed by well organised services and organisations working in partnership with the individual residents and their carers. Effective falls prevention and management can make a significant contribution to improving quality and outcomes and supporting people to live in good health for longer.
- 6.3.5. Best practice includes:
  - a. Falls risk assessments should, where relevant, form part of the CGA-based holistic assessment process which is included in the nationally commissioned EHCH model.
  - b. Care homes should have a policy in place to determine how falls risks will be assessed and managed. This should include how to get the

- resident from the floor when they have fallen, and when to call for additional support/advice e.g. via 111/999.
- c. Care home staff should be offered training and support on how to undertake a physical activity assessment with an individual and develop a personalised physical activity plan on admission to the home.
  - d. Care home staff should be offered training on falls prevention and management and physical activities (including advice on muscle strengthening and balance activities) and be supported to use this knowledge by the MDT.
  - e. Care home staff should be supported to ensure the safety of the individual by providing an appropriate individualised falls prevention plan which is linked to their personalised care and support plan.
  - f. People living in a care home should have access to local falls specialist services as clinically necessary.

## **6.4. Developing community assets to support resilience and independence**

- 6.4.1. In aspiring to best practice, care homes, with their MDTs, should work collaboratively with local community groups and other VCSE organisations to develop existing and new community assets to support local people to improve their health and wellbeing. This includes people living in care homes, their families and carers, as well as people in the wider community, through for example, volunteering opportunities.
- a. The EHCH framework 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.
  - b. People are supported to be involved with, and feel 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. Volunteers can help address social isolation by providing a 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. Professionals in care homes, health services and the community can embrace tools which help to ensure that 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 and care needs in a personalised way.

## 7. Care element four: High quality palliative and end-of-life, mental health, and dementia care

### 1.1. Palliative and end-of-life care

- 7.1.1 Individuals who are approaching the end of their life often experience profound physical and emotional changes. Palliative care and end-of-life care is therefore seen as a priority for every care home, and this should address the needs not only of the individual themselves but also of their family, their carers, and their community.
- 7.1.2 The Mental Capacity Act 2005<sup>9</sup> provides formalised outcomes of advance care planning, which may include the individual appointing somebody to make decisions for them as Lasting Power of Attorney.
- 7.1.3 Where possible, the use of integrated IT systems and digital tools such as the electronic palliative care coordination system (EPaCCS) or equivalent to enhance the coordination and quality of end-of-life care should be prioritised to share information e.g. personalised care and support planning.
- 7.1.4 The person's family and those important to them should be kept informed of what is going on and involved in decisions to the extent that the person wishes.
- 7.1.5 Best practice includes:
- Each care home working in partnership with their MDT and using a systematic, proactive approach to identify individuals who are likely to be in the last 12 months of their life.
  - Effective end-of-life care being provided in a variety of settings including care homes, ensuring everyone identified on the GPs palliative care register has the opportunity to develop a personalised care and support plan (including advance care planning, treatment and escalation plans etc).
  - The MDT providing access to adequate and timely medication and equipment that may be required to enable palliative and end-of-life care to be effective. When appropriate, the care home should seek support in delivering end-of-life care from its MDT and partner organisations, including secondary care, hospice, and specialist palliative care services.
  - Supporting care home staff with education and training on palliative care knowledge and skills, delivered in partnership and collaboration between health and care providers and the VCSE sector.

### 1.2. Mental health

- 7.2.1 Mental health conditions are common in people living in care homes. For example, depression is the most common mental health problem in older

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<sup>9</sup> <http://www.legislation.gov.uk/ukpga/2005/9/contents>

people, affecting up to 40 per cent of older individuals in a care home setting. For those living with a learning disability, mental health conditions are almost double that of the general population. However, those conditions are often under-identified, under-diagnosed, and under-treated in residential care. Simple steps can be taken to enhance the identification and management of mental health issues of people living in a care home, reduce their risk of self-harm and suicide, and to support their overall mental wellbeing. Providers of mental health should form part of the MDT described in 2.1.7, and relevant EHCH requirements in the Standard Contract apply equally to providers of community mental health as they do to providers of community physical health services.

#### 7.2.2 Best practice includes:

- a. Daily opportunities for people to maintain their mental wellbeing through a healthy lifestyle, meaningful activities (e.g. music, arts, gardening, animal-assisted therapy, and physical activity) and a welcoming social environment for all individuals and visitors, drawing on community assets and the VCSE sector as appropriate.
- b. The initial holistic assessment and personalised care and support planning undertaken on admission to the care home should include a systematic, proactive approach to identifying and recording mental health needs, in keeping with the principles of a CGA. This should be repeated in a timely manner upon first/new presentation of signs and symptoms. Assessment should include screening for common mental health conditions such as depression and anxiety, as well as severe mental illnesses and delirium. Further support can be accessed through the PCN MDT and community mental health services. For people with significant language or communication difficulties, for example people with sensory impairments or a learning disability, consider using tools such as the Distress Thermometer and/or asking a family member of carer about the person's symptoms to identify a possible common mental health disorder.
- c. The biopsychosocial needs of individuals should be recorded in the person's personalised care plan as part of an integrated care record, accessible to all involved in the person's care.
- d. People should have access to specialist mental health services for assessment and management of complex mental health need, including management of mental health medications and response to complex mental health crisis needs. This can be achieved through regular support from the MDT. In some cases, those services may also provide support for dementia and cognitive needs e.g. older people's mental health services (see dementia section). They can also provide direct support to care home staff, helping to identify and manage their mental health needs as well as upskilling them in mental health care.
- e. People with mental health needs should have access to a wide range of therapies and specialist support services for their psychological needs. This may include psychological therapies through Improving Access to Psychological Therapies (IAPT) services for people with common mental health problems including co-existing long-term physical health conditions and medically unexplained symptoms e.g. group or individual cognitive behavioural therapy and/or community

mental health services which provide NICE recommended therapies for people with severe mental illnesses.

- f. Education, training, and professional development should be made available to help ensure that carers, families, and care home staff feel supported and confident in identifying and managing the mental health needs of individuals and helping them to prevent self-harm and suicide.

### 1.3. Dementia care

7.3.1 Today, around 70 per cent of people living in care homes have dementia, a prevalence which has risen from 56 per cent in 2002. Most care home residents who live with dementia are at the latter stages of the condition and may struggle to communicate on their needs and preferences. This may cause them to act in ways that are seen as challenging, including aggression. They may also experience other physical and mental health conditions, e.g. frailty, diabetes, depression, and delirium. However, despite a growing prevalence, dementia and cognitive impairment remain under-diagnosed in care homes, and too many people living with the condition are admitted to hospital due to a lack of appropriate support in residential care and the community.

7.3.2 A number of steps can be taken to enhance the identification and management of dementia in care homes, and to support the maintenance of cognitive skills.

7.3.3 Best practice includes:

- a. There should be daily opportunities for residents to maintain their brain health and cognitive skills through a healthy lifestyle, meaningful activities (e.g. music, arts, gardening, animal-assisted therapy, and physical activity) and a welcoming, dementia-friendly, social environment for all residents and visitors, drawing on community assets and the VCSE sector as appropriate (See resources on dementia-friendly environments).
- b. There should be a systematic and proactive approach to identifying, diagnosing and recording dementia and cognitive needs in a timely manner, following admission to the care home and upon first presentation of signs and symptoms. This can be achieved through support from the local GP and community dementia/mental health services. Tools such as [DiADeM](#) and [DeAR-GP](#) can help GPs with dementia case finding and diagnosis in residential settings, and confirm whether residents have dementia or delirium or both.
- c. The dementia diagnosis and holistic needs of individuals should be recorded in a single personalised care plan as part of an integrated care record, accessible to all involved in the person's care (primary care, secondary care, social care, VCSE, and relatives, etc), in line with principles outlined in the [Dementia Good Care Planning Guide](#). The care plan should be developed in partnership with the resident where this is possible, with input from the family/carer where appropriate, and include advance care planning/end of life care needs and preferences, as well as timescales for review. **Care home staff should consider using personalised support tools such as the "This is Me" document**



and memory boxes to enable person-centred care and avoid potential distress.

- d. Residents should have access to specialist dementia/mental health services for assessment and management of complex dementia needs, including management of mental health medications (see section 4.4) and behavioural and psychological symptoms of dementia (BPSD), such as depression, agitation, aggression, distress, and psychosis. This can be achieved through regular support from an integrated MDT. These specialist mental health and dementia staff can help train care home staff in managing BPSD and reducing inappropriate use of antipsychotics, and in ensuring appropriate use of the Mental Capacity Act 2005.
- e. Care home staff should consider following the [Newcastle Support Model](#) and using tools such as 'ABC' (Antecedent, Behaviour, Consequence) charts to understand and manage behaviours that challenge.
- f. Residents living with dementia and cognitive impairment should have access to a wide range of NICE-recommended therapies and post-diagnostic services, including cognitive stimulation therapy, cognitive rehabilitation therapy, reminiscence therapy, and music therapy. Consideration should also be given to therapies that can support the functional mental health needs of residents living with dementia, including depression and anxiety (see section 7.2).
- g. Education, training, and professional development should be made available to help ensure that carers, families, and care home staff feel supported and confident in identifying, assessing, and managing dementia and cognitive needs in care home residents.

## **8. Care element five: Joined-up commissioning and collaboration between health and social care**

- 8.1. The Network Contract DES and Standard Contract place complementary requirements on PCNs and providers of community and mental health to deliver a nationally consistent, core EHCH service. Commissioners should work collaboratively with these providers to agree roles and responsibilities for the service, support the maintenance of these arrangements, and assist in solving the challenges in delivery as they arise. The nationally commissioned EHCH model is detailed in Appendix 1. Good practice in implementing this model, and enhancements to it, are described below.

### **8.2. Co-production with providers of care homes**

- 8.2.1. Working closely and collaboratively with care homes, the EHCH model can improve the way organisations work together and share information. Best practice includes:
  - a. Commissioners work together with care homes and other local health and care service providers, including PCNs, 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 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. National care home associations can also promote better engagement, facilitate discussions, and disseminate messages to the care home sector.

### **8.3. Shared contractual mechanisms**

- 8.3.1. The EHCH model commissioned through the Network Contract DES and Standard Contract represents a minimum national standard, and local commissioners may want to make more progress towards the framework. Commissioners may also want to consider how other contracts/providers, including local authority commissioned services, may need to support the model.
- 8.3.2. In best practice EHCH models:
  - a. CCGs and local authorities may 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.
  - b. 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.
  - c. 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.

### **8.4. Access to appropriate housing options**

- 8.4.1. 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. Whilst the EHCH contract and guidance is aimed at care homes, the wider EHCH framework could be extended to support people living in extra care housing



and in supported living arrangements, or 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.

#### 8.4.2. Best practice includes:

- a. In support of an 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.
- b. 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.

## 9. Care element six: Workforce Development

### 9.1. Workforce development

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

9.1.2. For successful rollout of a good practice EHCH model, joint workforce planning should be undertaken at STP/ICS level with independent adult social care representation in order to ensure a sustainable supply of appropriately skilled staff. Together, these two endeavours help ensure that people living in a care home receive the best available care within the home.

### 9.2. Training and development for social care provider staff

9.2.1. 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. For consistency, STP/ICS workforce planners should collaboratively develop a comprehensive training and development plan for all health and social care providers.

#### 9.2.2. Best practice includes:

- a. Investment 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 delivered through collaborative and contractual arrangements, and indications from EHCH vanguard sites showed improvement in the recruitment and retention of staff.

- b. To increase the confidence and proficiency of staff employed by social care providers in caring for the people who live in care homes, particularly those with complex needs.
- c. Care practitioners should be trained in competencies such as wound management, nutrition, and falls and all of the care elements and sub-elements of this framework. All staff should be offered training in other complex conditions such as dementia and end-of-life care.

### **9.3. Joint workforce planning across all sectors**

9.3.1. Within the footprint of PCNs, and at a STP/ICS 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. This remains an area of rapid development, especially with the investment in out-of-hospital care from the Long-Term Plan.

9.3.2. Best practice includes:

- a. Developing and testing new roles within primary care, establishing nursing banks across an area, making changes to training pathways for pre-registration nursing (both Registered Nurse and Nursing Associate) students to expose them to the care setting.
- b. A 'care coordinator' role in the care home could help improve the continuity of care by acting as a point of contact for residents, families and professionals who visit the care home, such as MDT members and in-reach specialists. They could also support the MDT with the weekly home round through identification of people in need of review, or collation of information on people requiring an MDT review.
- 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 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.

## **10. Care Element seven: Data, IT and Technology**

### **10.1. Harnessing data and technology**

10.1.1. 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.

10.1.2. In this document the following definitions are used:

- a. Telecare - is technology that is used to **support independent living** (e.g. falls monitoring);
- b. 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
- c. Telemedicine - is technology that is used to **exchange decision-making information** between professionals and residents (e.g. video links between homes and clinical hubs).

## 10.2. Linked health and social care data sets

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

10.2.2. Best practice includes:

- a. The care homes' supporting partners from health and social care should begin by conducting a privacy impact assessment and consider what information they require to assess the needs of their diverse care homes population, and to identify opportunities to either reduce unwarranted variation or to improve the quality, equity, and efficiency of the care being delivered.
- b. Business intelligence and population health analytics should be used to identify which people living in a care home are at high risk of unplanned hospital admission, and which people in the wider population are at risk of losing their independence. These 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.

## 10.3. Access to the care record and secure email

10.3.1. It is essential to establish secure information sharing arrangements between care homes, general practice, other community providers, and acute settings (including through NHSMail), as well as the MDTs operating in PCNs. NHSMail has been made available for care homes, and all care homes should be ensuring their staff have access to it or alternatives and are complying with the Data Security and Protection toolkit.

## 10.4. Better use of technology in care homes

10.4.1. 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 individuals. 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.

- 10.4.2. Care homes are able to use the Capacity Tracker to share their live bed state and enable hospital discharge teams and other stakeholders to rapidly find available nursing and residential beds, which significantly improves the speed and efficiency of finding capacity at the time it's needed.
- 10.4.3. 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.
- 10.4.4. Best practice includes:
- 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 for example, 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 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 people's 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.

## Appendix 1

Table showing Network Contract DES and Standard Contract requirements for EHCH relevant to providers of community physical and mental health, mapped to corresponding care elements in the framework.

Network Contract DES requirement	Standard Contract requirement <b>The Provider must:</b>	EHCH care element
<p>By 31 July 2020, a PCN is required to:</p> <ul style="list-style-type: none"> <li>a. have agreed with the commissioner the care homes for which the PCN will have responsibility (referred to as the <b>“PCN’s Aligned Care Homes”</b> in this Network Contract DES Specification). The commissioner will hold ongoing responsibility for ensuring that care homes within their geographical area are aligned to a single PCN and may, acting reasonably, allocate a care home to a PCN if agreement cannot be reached. Where the commissioner allocates a care home to a PCN, that PCN must deliver the Enhanced Health in Care Homes service requirements in respect of that care home in accordance with this Network Contract DES Specification;</li> <li>b. have in place with local partners (including community services providers) a simple plan about how the Enhanced Health in Care Homes service requirements set out in this Network Contract DES Specification will operate;</li> <li>c. support people entering, or already resident in the PCN’s Aligned Care Home, to register with a practice in the aligned PCN if this is not already the case; and</li> </ul>	<p>By 31 July 2020, agree the care homes for which it has responsibility with the CCG, and have agreed with the PCN and other providers a simple plan about how the service will operate.</p>	<p>1</p>

Network Contract DES requirement	Standard Contract requirement	EHCH care element
d. ensure a lead GP (or GPs) with responsibility for these Enhanced Health in Care Homes service requirements is agreed for each of the PCN's Aligned Care Homes.	The Provider must:	
By 30 September 2020, a PCN must: a. work with community service providers (whose contracts will describe their responsibility in this respect) and other relevant partners to establish and coordinate a multidisciplinary team (“ <b>MDT</b> ”) to deliver these Enhanced Health in Care Homes service requirements; and b. have established arrangements for the MDT to enable the development of personalised care and support plans with people living in the PCN's Aligned Care Homes.	Work with the PCN and other relevant providers to establish, by 30 September 2020, a multidisciplinary team (MDT) to deliver relevant services to the care homes.	1 and 2
As soon as is practicable, and by no later than 31 March 2021, a PCN must establish protocols between the care home and with system partners for information sharing, shared care planning, use of shared care records and clear clinical governance.	Work with the PCN to establish, as soon as is practicable, and by no later than 31 March 2021, protocols between the care home and with system partners for information sharing, shared care planning, use of shared care records, and clear clinical governance.	5 and 7
From 1 October 2020, a PCN must: a. deliver a weekly 'home round' for the PCN's Patients who are living in the PCN's Aligned Care Home(s). In providing the weekly home round a PCN: i. must prioritise residents for review according to need based on MDT clinical judgement and care home	From 30 September 2020, participate in and support 'home rounds' as agreed with the PCN as part of an MDT.  Work with the PCN to establish, by 30 September 2020, arrangements for the MDT to develop and refresh as required a personalised care and support	1, 2 and 6

Network Contract DES requirement	Standard Contract requirement	EHCH care element
<p>advice (a PCN is not required to deliver a weekly review for all residents);</p> <ul style="list-style-type: none"> <li>ii. must have consistency of staff in the MDT, save in exceptional circumstances;</li> <li>iii. must include appropriate and consistent medical input from a GP or geriatrician, with the frequency and form of this input determined on the basis of clinical judgement; and</li> <li>iv. may use digital technology to support the weekly home round and facilitate the medical input;</li> </ul> <p>b. using the MDT arrangements, develop and refresh as required a personalised care and support plan with the PCN's Patients who are resident in the PCN's Aligned Care Home(s). A PCN must:</p> <ul style="list-style-type: none"> <li>i. aim for the plan to be developed and agreed with each new patient within seven working days of admission to the home and within seven working days of readmission following a hospital episode (unless there is good reason for a different timescale);</li> <li>ii. develop plans with the patient and/or their carer;</li> <li>iii. base plans on the principles and domains of a Comprehensive Geriatric Assessment<sup>10</sup> including assessment of the physical, psychological, functional,</li> </ul>	<p><b>The Provider must:</b></p> <p>plan with people living in care homes.</p> <p>Through these arrangements, the MDT will:</p> <ul style="list-style-type: none"> <li>a. aim for the plan to be developed and agreed with each new resident within seven working days of admission to the home and within seven working days of readmission following a hospital episode (unless there is good reason for a different timescale);</li> <li>b. develop plans with the person and/or their carer;</li> <li>c. base plans on the principles and domains of a Comprehensive Geriatric Assessment including assessment of the physical, psychological, functional, social and environmental needs of the person including end of life care needs where appropriate</li> <li>d. draw, where practicable, on existing assessments that have taken place outside of the home and reflecting their goals;</li> <li>e. make all reasonable efforts to support delivery of the plan</li> </ul> <p>From 30 September 2020, work with the PCN to identify and/or engage in locally organised</p>	

<sup>10</sup> [https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-03-12/CGA%20Toolkit%20for%20Primary%20Care%20Practitioners\\_0.pdf](https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-03-12/CGA%20Toolkit%20for%20Primary%20Care%20Practitioners_0.pdf)



Network Contract DES requirement	Standard Contract requirement	EHCH care element
<p>social and environmental needs of the patient including end of life care needs where appropriate;</p> <p>iv. draw, where practicable, on existing assessments that have taken place outside of the home and reflecting their goals; and</p> <p>v. make all reasonable efforts to support delivery of the plan;</p> <p>c. identify and/or engage in locally organised shared learning opportunities as appropriate and as capacity allows; and</p> <p>d. support with a patient's discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 27<sup>11</sup></p>	<p><b>The Provider must:</b></p> <p>shared learning opportunities as appropriate and as capacity allows.</p> <p>From 30 September 2020, work with the PCN to support discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 27.</p>	

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<sup>11</sup> <https://www.nice.org.uk/guidance/ng27>