Local Enhanced Service for Older Patients in Care Homes

Service Level Agreement

PRACTICE -

Contents:

1. Financial Details

All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

This agreement is to cover the period from *1st April 2014 to 31st March 2015*

Payment

Payment per patient per year	£120
Number of patients registered with the practice in a Care Home (Nursing & Residential Home) as at 1st Jan 2014	
Total Number of Care Home Patients registered in a Highland Practice as at 1st Jan 2014	
Practice % of Care Home Population	0
Practice Notional available budget (as % share of Care Home Budget £260,000)	£

Practice budgets have been set notionally based on the number of Care Home patients as at 1st January 2014 (see above). Any budget underspends will be vired to reimburse those practices within the Operational Unit who have reported activity higher than their notional budget. Notional budgets may be reviewed under exceptional circumstances with the agreement of the GP Sub-committee e.g. the opening of a new Care Home.

At the year end the practice is to provide a list of all patients in a Care Home including CHI numbers (including deceased patients) for whom they have completed an up to date ACPA/ ePCS and Polypharmacy Assessment as clinically appropriate.

Payment will be calculated based on the number of patients reported (via ESCRO) who have had the appropriate assessments during the year, as detailed in the Service Outline (point 1, 2 and 3).

- If number of patients with an appropriate assessment x £120 <= Notional Budget then actual activity is paid
- If number of patients with an appropriate assessment x £120 > Notional Budget then budget is paid plus share of any underspend.
- Maximum payment = number of patients with an appropriate assessment x £120.

At the year end, practices will provide a list of all patients who have had the appropriate Assessments during the year (including deceased patients). Practices may have only one payment per patient per year, but may have several appropriate assessments over the period of the SLA (or under previous SLAs) where the GP identifies this as clinically appropriate.

Payment will be calculated based on the number of patients identified via the ESCRO reporting tool who meet the criteria and have had the appropriate assessments during that financial year,

Payment Verification

Practices entering into this contract must participate fully in the verification process determined by NHS Highland and LMC. Practices should ensure that they keep proper records to ensure a full and proper audit trail, and be able to evidence service delivery if requested by NHS Highland.

2. Signature Sheet

This document constitutes the agreement between the practice and the PCO in regards to this local enhanced service.

PRACTICE

Signature on behalf of the Practice:

Signature	Name	Date

Signature on behalf of the PCO:

Signature	Name	Date

PAYMENT WILL ONLY BE MADE UPON RECEIPT OF THIS SIGNED CONTRACT

Name of Care Home (Nursing & Residential)	Name of Lead GP

Please add more row's as necessary.

3. Introduction

The Royal Pharmaceutical Society (Scotland) report *'Improving Pharmaceutical Care in Care Homes'* http://www.rpharms.com/promoting-pharmacy-pdfs/rpscarehomereportfinalmarch2012.pdf

states *'As the proportion of older people in Scotland continues to grow, alongside the increasing frailty of those living longer, we need to address the health and social needs of this population in a way that is accessible, appropriate to their care needs and also financially sustainable'*

'With increasing numbers of frail older people living with long term conditions and increasingly complex requirements, many with palliative care needs, some care homes are now providing aspects of care which historically would have been provided in hospital.' 'We need to ensure that people in care homes receive the same standards of health care as those living in their own home and that evidence based clinical guidelines and practice are applied to the frail older care home population'

The report made several recommendations including:

- Safety could be improved through sharing hospital discharge information, clinical information, including diagnosis, monitoring, test results, adverse drug reactions and allergies between the GP practices, Pharmacist and Care Home Provider
- National guidance on efficient working in managing repeat medicines including the use of nationally agreed documentation wherever possible, including the Medicines Administration Record
- National Guidance on medication/ polypharmacy review
- Alignment of one GP practice and one community pharmacy to each care home

This enhanced service has been developed to build on the principles of the *NHS Scotland Healthcare Quality Strategy 2010* of quality, safety, effectiveness and person-centred Care, by reducing harm, waste and variation.

The *NHS Scotland Delivering Quality in Primary Care – A National Action Plan* prioritises people with dementia and older people (both at home and in care homes) who are frail and have multiple longer term conditions which combine to reduce their ability to function independently. Finally *Reshaping Care for Older People – a programme for change* is currently reshaping care and support for older people in Scotland. In Highland work is also ongoing on the Dementia Strategy and Fall's strategy and this work will be linked to the pathway work within QOF in 2012/13.

This enhanced service also builds on previous Anticipatory Care and Polypharmacy enhanced services which included Care Home patients. This revised SLA is an interim arrangement whilst an NHS Highland review takes place to consider clinical care standards for Care Homes which aims to establish the roles of healthcare staff including GPs.

4. Service Outline

The provision of General Medical Services (GMS) to residents in Care Homes (formerly Nursing and Residential Homes) will be via the normal GMS funding arrangements (Global Sum).

This enhanced service is for the provision of the following for all patients registered with the practice in a Care Home:

1. An initial assessment of patients on admission to care homes. A standard template has been developed to support this (Appendix 1). The assessment will include:
    - Determining whether an Anticipatory Care Patient Alert is required.
    - Medication review focusing on medicines reconciliation, high risk drugs and drugs that are poorly tolerated in frail populations (covered by template).
    - Determining whether a Polypharmacy review is required.

2. If clinically appropriate, Anticipatory Care or Palliative Care Plans/KIS should be provided. An ACPA/KIS or ePCS should be created or reviewed on the patient's admission to the care home, and reviewed as clinically appropriate thereafter. (ePCS as per Palliative Care DES).

3. If clinically appropriate, a Polypharmacy review should be conducted as per current NHS Highland Polypharmacy guidance..

4. In addition, the following are recommended as good practice, as per the Royal Pharmaceutical Society (Scotland) report:

    - Medicines reconciliation at each change of circumstances/treatment. This involves:
        i. Ensuring all medicines are updated on Vision after every change in circumstances/treatment (eg, after discharge from hospital or a change in drug treatment).
        ii. Sending a copy of the updated repeat to the care home and the community pharmacy dispensing the patient's medicines, to ensure all involved are informed of the patient's current treatment.

    - Aligning medicines and identifying over-ordering. This involves:
        i. Aligning care home patients' medicines so that prescriptions of regular medicines are issued together and limited to 28 days' supply at a time.
        ii. Setting minimum repeat intervals for all medicines so any over-ordering is identified. This includes "when required" medicines, which should be prescribed as a reasonable quantity to last for 28 days.

5. Each practice to identify Lead GP for each Care Home in which they have patients registered. Name of Lead GP to be notified to Primary Care Manager with signed SLA.

6. A primary role of the Lead GP for the Care Home should be ensuring the initial and regular medicine reviews, as above.

7. Where NHS-employed pharmacists working in primary care provide detailed medication reviews to patients in care homes, (both on admission to the care home and at regular intervals thereafter) this exceeds the requirement of the medication part of the initial assessment in Appendix 1. Therefore, instead of repeating a medication review, GPs should work with the primary care pharmacist to address any medication issues the pharmacist review has identified.

8. The Lead GP should take cognisance of any areas of concern within the Care Home and ensure these are fed back to the Unit Clinical Director, demonstrating their commitment to working with colleagues in ways that best serve the patients' interests.

9. Liaise with Consultant Geriatrician/ Psycho – geriatrician and other health and social care staff as required.also other GPs who may have patients in the home.

10. To inform relatives about the progress and health of patients when requested.

11. Agree with Care Home suitable time for regular visits.

5. Training and Support

Support will be available as required.

6. Accreditation

Those doctors who have previously provided services similar to the proposed enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.

7. Dispute Resolution

Every attempt will be made to resolve any dispute informally between the Practice and the PCO. Failing that, the Dispute Procedure contained within the sections 464 to 474 of the Scottish General Medical Services Contract 2004 will apply.

9. Variation and Termination of Contract

Any variation to the terms and conditions contained herein requires to be agreed between the Practice and the PCO. Any termination of services, or any part of the services covered by this contract, requires to be agreed between the Practice and the PCO before any termination takes place.

APPENDIX 1

Local Enhanced Service for Older People in Care Homes

This is a template for the assessment of frail adults in care homes:
- On initial admission to a care home
- Then every 6 months

All sections (1-3) should be completed for each patient.

Please print out a copy of the patient's GP Home Visit Summary Information" from the GP Practice system and use it for this assessment. Any changes to the patient's management/medication as a result of this assessment should be recorded on the "GP Home Visit Summary Information" sheet and transferred onto the patient's electronic record on return to the practice.

SECTION 1: ANTICIPATORY CARE ALERT STATUS	
1. Does the patient have an anticipatory care alert (ACPA)?	Yes / No
2. Should the patient have an ACPA? Priority groups are those most at risk of an unplanned emergency hospital admission including: • Patients with dementia • Patients over 75 with several long term conditions • Patients with learning difficulties • Frail elderly • Patients at risk of falls •	Yes / No

SECTION 2: GENERAL MEDICATION REVIEW
1. Identify the medicines the patient is currently taking any problems with them. • Refer to patient's GP Home Visit Summary information and current MAR chart (medication administration record which is held in the care home). Compare them to identify any discrepancies and take action to rectify discrepancies by updating Repeat Medication list and/or the MAR chart as appropriate. • Of the medicines prescribed, what is the patient actually taking (ie, check compliance)? • Are there any medicines on the patient's repeat prescription list that are not being ordered/taken that should be i.e. poor compliance with regular medicines?

- Does the patient have any problems with any of the medicines (eg, side effects, ability to take/use, are they getting symptomatic relief)?
- Is the patient taking any other medicines (eg, purchased medicines, herbal supplements, vitamins)?
- Is the patient taking any medicines that require regular monitoring and is this monitoring up-to-date e.g. levothyroxine.
- Care staff need clear directions and specific instructions to be able to administer "when required" medicines or determine how much to administer when medicines are prescribed with a dosing range e.g. 1 to 2 tablets. Do care staff have sufficient guidance for these medicines to avoid any ambiguity? Can any directions be made clearer e.g. avoid "as directed"?

2. Then consider: are these medicines still appropriate?

- Is there a valid indication for continuing each of the medicines?
- Are there any conditions that are not being treated/adequately treated e.g. bone protection in patients at risk of falls?
- Are there any safety issues with any of the medicines, eg, are they in the high risk group or poorly tolerated in frail patients?

High risk drugs:

NSAID plus:	• ACE inhibitor/A2A and diuretic • eGFR below 60 • Heart failure • Warfarin • Age over 75 years and no PPI
Warfarin plus:	• Another antiplatelet • NSAID • Macrolide • Quinolone • Metronidazole • Azole antifungal
Heart failure plas:	• Glitazone • NSAID • Tricyclic antidepressant

Drugs that are poorly tolerated in frail patients:

- Digoxin in higher doses (250microgram or more)
- Antipsychotics (but be cautious: stopping suddenly can result in rapid symptomatic decline)
- Tricyclic antidepressants
- Benzodiazepines (particularly long term)
- Anticholinergics
- Phenothiazines (eg, prochlorperazine)
- Combinations painkillers (eg, co-codamol)

3. Then decide what actions should be taken:

- Which medicines should the patient have on regular repeat prescription?
- If prescribed medicines are not being taken, consider discontinuing them and amend patient's record accordingly.
- If a prescription for a medicine has not been issued in the past 12 months consider inactivating it from the patient's repeat prescription list.
- If the patient has any problems with their medicines, consider the actions needed to tackle these problems.
- Ensure the patient's record in the GP practice system is updated so it contains an accurate list of repeat medicines.
- Ensure the care home and dispensing pharmacy is provided with a copy of the updated repeat prescription list.

In addition:

- Align the quantities of all regular prescribed medicines to 28 days' supply so that all regular medicines are synchronised, prescriptions can be issued simultaneously and that quantities are limited to avoid wastage.
- Decide if any "when required" ("prn") medicines are needed and work out a reasonable quantity for 28 days' supply.
- Re-authorise the repeat prescription list.

SECTION 3: POLYPHARMACY ASSESSMENT	
Section 2 (above) is a general medication review for care home patients and is not intended to be a full polypharmacy review.	
1. Has the patient had an NHS Polypharmacy review?	Yes / No
2. Would the patient benefit from a Polypharmacy review? Groups likely to benefit include: • Patients with several long-term conditions • Patients at risk of a fall • Patients who are frail • Patients who are experiencing adverse drug reactions • Patients with indications of shortened life expectancy.	Yes / No If yes, refer to NHS Highland Guideline for Polypharmacy