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# **Early implementation of Enhanced Health in Care Homes due to COVID-19: A service review**

Sharon L Riverol and Rosie McCarthy

## **Abstract**

A priority for the NHS Long Term Plan (NHS 2019) includes improved service for care homes which will lower the volume of unnecessary hospital admissions, enhance residents' care and encourage inter-professional working. During the COVID-19 pandemic, the enhanced service was introduced earlier than planned. This project reflects on and discusses one nurse's experience of setting up the service to be provided by a general practice to care homes and the challenges which were overcome, and suggests some improvements, along with areas of expansion.

## **Background**

The author is employed by a general practice on the Wirral, working as nurse practitioner.

During the current COVID-19 crisis, the second phase of the National Health Service (NHS) (2020a) response required practices to roll out the Enhanced Health in Care Homes (EHCH) as soon as possible. An enhanced service is provided by general practice in addition to the core General Medical Service (GMS) contract, to provide extra services for patients and generate further income for general practice (GP One 2020). The EHCH (NHS 2020b) ensures that people who live in care homes can expect the same level of care as those in their own homes. This is to be achieved using a collaborative approach between the care home partners, healthcare, social care, social enterprise and the voluntary sector. The aim to step away from reactive care and pursue proactive care while providing support for people who live and work in care homes (NHS 2020b). This ensures that the residents have their needs met, avoidable hospital admissions are reduced, medications are appropriate and early intervention during illness is achieved. The EHCH is also included in the Network Contract Directed Enhanced Service (NHS 2020c) which aims to address health inequalities, promote equal opportunities and collaborative working across all sectors. This has enabled the local practices to form Primary Care Networks (PCNs). I currently work for a practice which is part of a PCN of seven practices overseeing care of 63,330 patients; the British Medical Association (BMA) (2020) states the average PCN covers 48,020 patients.

The EHCH is driven by the NHS Long Term Plan (2019) for redesign of services to improve quality of life and reduce the financial burden of an aging population. The aim is to enhance the integration of community teams, care institutions and funding streams to support people in the community with long-term health conditions. This service has been rolled out nationwide following a three-year trial where the service took less than 1% of the NHS budget, but made a positive impact on emergency admission using proactive care (NHS 2019). Care home residents account for 185,000 emergency admissions, 1.46 million emergency bed days, of which 35-40% is avoidable (NHS 2019). EHCH has proven to meet residents' needs and reduce admissions to hospital; sicker patients are being cared for at home and community services have not seen expenditure grow as much as acute sectors despite this extra care (NHS 2019).

During the COVID outbreak, care homes were significantly affected with outbreaks, causing increasing death toll (Department of Health 2020). This was highlighted in a letter received by general practice from the NHS, along with a request to commence support for the care homes early. The scheme was planned to start in October 2020. Practices were advised to start by 31<sup>st</sup> July 2020 at the latest; we were able to start this as a PCN in early June 2020. The home which we support has not had a COVID outbreak and has placed stringent restrictions on access to the home. Prior to the service implementation, care was reactionary, only responding to events or illness taking place when contacted by the care givers.

Personalised care is at the centre of the EHCH (NHS 2020b), in line with the NHS Long Term Plan (NHS 2019), understanding the local area and the care home needs will support successful outcomes for the EHCH (NHS 2020b). The four conditions set out by the EHCH (NHS 2020b) are: personalised care, co-production, quality and leadership. These four conditions have seven care elements with several sub-elements to be completed to guarantee support for the patient and care home, see below.

**Table 1: Elements which comprise the ECHC model (NHS 2020b)**

Care element	Sub-element
1. Enhanced primary care support	<ul style="list-style-type: none"> <li>▪ Each care home aligned to a named PCN, which leads a weekly multidisciplinary 'home round'</li> <li>▪ Medicine reviews</li> <li>▪ Hydration and nutrition support</li> <li>▪ Oral healthcare</li> <li>▪ Access to out of hours/ urgent care when needed</li> </ul>
2. Multi-disciplinary team (MDT) support including	<ul style="list-style-type: none"> <li>▪ Expert advice and care for those with the most complex needs</li> <li>▪ Continence promotion and management</li> <li>▪ Flu prevention and management</li> <li>▪ Wound care: leg and foot ulcers</li> <li>▪ Helping professionals, carers, and individuals with needs navigate the health and care system</li> </ul>
3. Falls prevention, reablement, and	<ul style="list-style-type: none"> <li>▪ Rehabilitation/reablement services</li> <li>▪ Falls, strength, and balance</li> </ul>

rehabilitation including strength and balance	<ul style="list-style-type: none"> <li>▪ Developing community assets to support resilience and independence</li> </ul>
4. High quality palliative and end-of-life care, mental health, and dementia care	<ul style="list-style-type: none"> <li>▪ Palliative and end-of-life care</li> <li>▪ Mental healthcare</li> <li>▪ Dementia care</li> </ul>
5. Joined-up commissioning and collaboration between health and social care	<ul style="list-style-type: none"> <li>▪ Co-production with providers and networked care homes</li> <li>▪ Shared contractual mechanisms to promote integration (including Continuing Healthcare)</li> <li>▪ Access to appropriate housing options</li> </ul>
6. Workforce development	<ul style="list-style-type: none"> <li>▪ Training and development for social care provider staff</li> <li>▪ Joint workforce planning across all sectors</li> </ul>
7. Data, IT and technology	<ul style="list-style-type: none"> <li>▪ Linked health and social care data sets</li> <li>▪ Access to the care record and secure email</li> <li>▪ Better use of technology in care homes</li> </ul>

### **Implementing Service**

**Table 2: A step-by-step implementation of service**

Step One (Day 1)	I was advised I would be the lead nurse for the scheme and of the lead GP. From then, the set-up was my responsibility.
Step Two (week 1)	Contacted the homes and advised of service to be commenced, discussed concerns/issues.
Step Three (week 1)	Once the single home we were to cover was identified, I contacted the PCN pharmacy and requested medication reviews on all residents.
Step Four (week 2)	Contacted District Nurses (DNs) to find out who our lead DN would be and obtain contact details and times when available to attend MDT.
Step Five (week 2)	Weekly rounds organised with the care home once technology in place; this became a virtual round.

Step Six (within 1 <sup>st</sup> month)	Organised MDT including myself, the home, district nurse, GP and pharmacist. Geriatrician declined to attend as did dietician.
Step Seven (on going practice)	Weekly rounds including discussion for long-term care plans resus status and 'My COVID Plan' in lieu of full long-term care plan - which is to be completed once able to be back in practice.
Step Eight (bimonthly activity)	Continue to attend PCN meetings and reviews of the Standard Operating Procedure (SOP)
Step Nine (on going from week 1)	Continue with weekly meetings and ensure that the care and sub elements are completed.

Meetings with the care home were set up as well as Multi-Disciplinary Team (MDT) meetings. Time being taken out of clinics was a concern. This in part was due to the current COVID-19 situation which has changed the way in which practices work (British Medical Journal 2020). Currently, the partners have agreed one hour a week to complete the EHCH contact obligations.

Despite the planning for this service being in place, some organisations were not prepared. It was surprising to find that some of the care homes were unaware and were in some cases unwilling to engage in the reviews. At this point, each practice was contacting several care homes and starting the review process on any patients who were residents within these homes. This method was not productive to the practices or the homes, being very time consuming. During the next PCN meeting, it was decided that each practice would take whole homes and we could cover each other's patients. It was agreed that a letter from the PCN would be sent to the care homes advising of the early implementation of the EHCH (NHS 2020b) and that practices would be in touch in the hope that the care homes would then engage. For my practice, the home was aware of the support now being implemented and was willing to engage in all meetings.

Typically, there is limited time for MDT meetings due to staff rotas and workload. Consequently, the practice has been as flexible as possible with meeting dates and times to encourage increased attendance via Microsoft Teams. Despite having access to records for all practices within the PCN, the nursing home has chosen to gain consent to register all patients to the practice. The home felt this would be easier for them and ensure continuity of care but

was aware consent from the residents was essential. One, however, is unwilling to move and is registered outside the PCN, so impossible to safely review. On discussion with the PCN, it has been decided this resident will need to opt out of the service.

### **Technology**

Each care home has been supplied with up-to-date smart technology and an NHS email account to allow for the safe use of virtual platforms to complete patient reviews. The NHS Long Term Plan (NHS 2019) discusses at length the benefits of virtual health and interorganisational clinics but gives minimal information on the training needed to use this technology. The Queen's Nursing Institute (2018) advised that several different virtual systems are currently in place across the UK. Also, 20.8% of community nurses have had little or no training to use these systems. From personal experience, the virtual platforms were being introduced as a 'big bang' (NHS 2020d) where this was the only way to request review or report illness. Introduction and training of this technology to the practice team was rushed. Tech UK (2020) advised that 1.3million people in the UK are without online access. Baird (2019) goes further stating all virtual access risks a two-tier healthcare system with those who have and can use technology experiencing a better health service. This is echoed by Kozłowska (2018) and NHS (2020e) stating that digital health has the potential to reduce health inequalities but only if everyone has access and can use. The author has observed that, with the EHCH, the care home has increased the use of technology and virtual patient reviews. As the care home was having some difficulty using the new technology issued, it was helpful to arrange some training from the local NHS information technology support services, although this was distance training due to COVID-19.

To be able to complete care for patients registered at other practices, access to patient records was required. Tech UK (2020) changes in the rules for data access and sharing has allowed the PCN to set up shared records although permission from the patients will still be obtained. A local care record has been produced by the local care commissioning group (CCG). This project is not only to improve patient care but to collect local health data and enable access to patient records between health care providers. This is supported by NHSx (2020) which is transforming digital patient care. The BMA (2020a) direct enhanced service enforces a contractual obligation for PCNs to data share, to allow maintenance of contemporaneous health records. Going forward, this was a

collaborative effort by the PCN to deliver the EHCH (NHS 2020b). Although the general practices have access to one another's records, as yet we currently cannot share these with all the members of the MDT. BMA (2020a) and NHS (2020b) patient expressed permission must be obtained for sharing records with other practices or members of the MDT. The care home obtained this permission with the patients, or where required their next of kin as a matter of courtesy. The BMA (2018) clarifies that the next of kin cannot agree or decline permission for sharing records as the next of kin has no legal status.

### **Weekly round/ Monthly MDT**

In 2016 the original EHCH was to be rolled out across the country, including weekly home care face-to-face rounds (currently virtual due to COVID-19). Lind and Price (2016) discussed objections, a major factor being the volume of time away from practice to complete the service and increased workload with a shortage of GP's. Other services have also reported a shortage of staff and time to dedicate to this service, for example the district nurses. The King's Fund (2016) and National Quality Board (2018) acknowledges that the gap between capacity and demand has increased. District nurses have been finding new ways of managing workload including the use of technology and prioritising care. With the current service, the MDT meetings consists of a GP and nurse from the same practice, PCN pharmacist, care home and district nurse. The author has observed that the PCN pharmacist and district nurse comment very infrequently and usually only to advise that care remains ongoing. On discussion with both parties, they advised that this was due to the care home residents not having many issues at present. There have been some occasions where the district nursing team has found it difficult to provide a representative for these meetings so have provided some details of care rather than attend. Although the MDT meetings are part of the ECHC agreement, more research may be needed to reflect on the validity of monthly meetings within the care home environment.

BMA (2020b), Gully et al (2020) and Schwamm et al (2020) all agreed that due to the current COVID-19 pandemic, where possible, all care home rounds should be completed using virtual platforms. A degree of reliance on the home care staff to complete nursing observations and discuss patient symptoms is unavoidable. The care home staff all have yearly training on completing nursing observations, and equipment is calibrated to ensure validity of results. They use National Early Warning Score 2 (NEWS2) to assess results. This ensures



standardisation of identification of the deteriorating patient, resulting in streamlined care between services (Patient Safety Alert, 2018).

The King's Fund (2017) and NHS (2020b) detailed the advantages of the EHCH services. From the author's experience over the last two-three months, only one resident has been admitted to hospital following a fall which caused a fracture. Intravenous antibiotics have been arranged for another resident within the home, avoiding an admission. A long-term urinary catheter has also been placed, again avoiding an admission at the local hospital. All 'My COVID Plans' and two full long-term plans are in place. All residents have decided they do not want to be 'for resuscitation', therefore these forms have been completed or updated by the GP. All residents have had a medication review by a pharmacist and medications no longer needed stopped; this is to happen every six months. Being able to keep residents within the home for treatment has reduced COVID-19 risk to the home as well as expense to the NHS (NHS 2020b).

### **Conclusion**

Support for the EHCH has been widespread across the health service, from the experience so far. The author believes this is a productive service with positive outcomes. There appears to be no reason why, when COVID-19 restrictions are lifted, this service could continue as a virtual platform, reviewing face to face when necessary rather than routinely. Although this service was brought forward and the implementation felt rushed, it has developed into a cooperative, multi professional, dynamic service which benefits the patients and the NHS.

The EHCH patient-centred approach enables our elderly patients' wishes to be acknowledged and respected, while supporting care homes to provide treatment for more complex needs and acute illness. The service allows for end of life care to be discussed with the patient and, where appropriate, family members, ensuring clear documentation of the patient's wishes to promote dignity and respect for the people within our care.

As documented, the benefits to the NHS are largely financial, reducing admissions and attendance to Accident and Emergency departments, alleviating pressure on these departments and tackling the financial burden of an aging population.

The author has noted that the monthly MDT meetings appear to be an area where improvements could be made. At the first MDT meeting, all parties were

able to contribute, however this has been minimal during the continuing monthly MDT meetings. The DES and EHCH service plan is rigid and does not allow for flexibility. This has been discussed within the practice, currently unable to change this aspect but this has been fed back at a higher level. The author recognises that some care homes may have more complex needs and a monthly MDT may be required. An amendment to the current service plan could allow for an agreed MDT meeting schedule between all members rather than a monthly enforced meeting which may not be required.

Future NHS (2020) discussed the need for further research to understand the role of virtual platforms. However, Future NHS (2020) continues to discuss how the current evidence supports virtual health schemes when part of a comprehensive primary care service. The author agrees that the EHCH service has been positive but currently it is in its infancy. Further reflection, research and the addition of others experiences will be needed to enable the full impact of this service to be realised.

### **Expansion of service**

There has been some discussion surrounding expansion of the EHCH to include vulnerable and frail people within their own home. Discussions have been started but currently no plan is in place to implement a service. It has, however, been noted that this would be a significant increase in each practice's workload throughout the PCN. There has been discussion on commissioning a self-contained service by the PCN where a patient could be referred to the frailty service by the GP for review and interventions where required, successes with this model of care can be seen in NHS Kent Community Health (2019).

The NHS Long Term Plan (NHS 2019) discussed supporting the health of an aging population and enabling continued independence. This service would be able to provide pre-emptive care rather than reactionary, being able to aid people to remain within their own home for longer. It would also reduce patient and family stress, pressure on the care home service and again minimise hospital admissions.

## Reference list

Baylis A, Perks-Barker S (2017) Enhanced healthcare in care homes learning from experiences so far.

[https://www.kingsfund.org.uk/sites/default/files/2017-11/Enhanced health care homes Kings Fund December 2017.pdf](https://www.kingsfund.org.uk/sites/default/files/2017-11/Enhanced_health_care_homes_Kings_Fund_December_2017.pdf) (Last accessed: 23<sup>rd</sup> August 2020.)

Baird B. (2019) Digital first primary care: helpful disrupter or unnecessary disruption? <http://www.kingsfund.org.uk/blog/2019/10/digital-first-primary-care> (Last accessed: 22<sup>nd</sup> August 2020.)

British Medical Association (2018) Access to health records updated to reflect the general data protection regulation and data protection act 2018.

<https://www.bma.org.uk/media/1868/bma-access-to-health-records-nov-19.pdf> (Last accessed: 22<sup>nd</sup> August 2020.)

British Medical Association (2020) Primary care networks the year in stats

<https://pcn.bma.org.uk/primary-care-networks-stats/#:~:text=Over%20the%20last%20nine%20months,PCN%20has%2048%2C020%20registered%20patients> (Last Accessed: 29<sup>th</sup> September 2020)

British Medical Association (2020a) Network Contract Direct Enhanced Service 2020/21. <https://www.england.nhs.uk/wp-content/uploads/2020/03/network-contract-des-guidance-2020-21.pdf> (Last accessed: 22<sup>nd</sup> August 2020.)

British Medical Association (2020b) COVID-19 toolkit for GP's and GP practices home visits and care homes. <https://www.bma.org.uk/advice-and-support/covid-19/gp-practices/covid-19-toolkit-for-gps-and-gp-practices/home-visits-care-homes-and-advance-care-planning> (Last accessed: 23<sup>rd</sup> August 2020.)

Department of Health (2020)- Corona Virus (COVID-19): care home support package. <https://www.gov.uk/government/publications/coronavirus-covid-19-support-for-care-homes/coronavirus-covid-19-care-home-support-package> (Last accessed: 28<sup>th</sup> July 2020.)

Future NHS Collaboration Platform (2020) Online consultations. <https://future.nhs.uk/DigitalPC/view?objectId=18388624> (Last accessed: 21<sup>st</sup> August 2020.)

GP One (2020) Enhanced service. <http://www.gpone.wales.nhs.uk/enhanced-services> (Last accessed: 15<sup>th</sup> July 2020.)

Gully K, Karupiah S, Kneale T et al (2020) Supporting care home residents and staff during COVID-19. Royal college of general practitioners. <https://www.rcgp.org.uk/about-us/rcgp-blog/supporting-care-home-residents-and-staff-during-covid-19.aspx> (Last Accessed: 23<sup>rd</sup> August 2020.)

Kozłowska D, Lumb A, Tan DA et al (2018) Barriers and facilitators to integrating primary and specialist healthcare in the United Kingdom: a narrative literature review. Future Healthcare Journal. 5, 1, 64-80.

Lind S, Price, C (2016) GP's to do weekly care home rounds under new NHS England plan. Pulse <http://www.pulsetoday.co.uk/clinical/clinical-specialties/elderly-care/gps-to-do-weekly-care-home-rounds-under-new-nhs-england-plan/20032921.article> (Last accessed: 23<sup>rd</sup> August 2020.)

National Health Service (2019) The NHS Long Term Plan. <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf> (Last accessed: 8<sup>th</sup> July 2020.)

National Health Service (2020a) Important for action- second phase of NHS response to COVID 19. NHS, London.

National Health Service (2020b) The Framework for Enhanced Health in Care Homes. [www.england.nhs.uk/wp-content/uploads/2020/03/the-framework-for-enhanced-health-in-care-homes-v2-0.pdf](http://www.england.nhs.uk/wp-content/uploads/2020/03/the-framework-for-enhanced-health-in-care-homes-v2-0.pdf) (Last accessed: 1<sup>st</sup> July 2020.)

National Health Service (2020c) Network Contract Directed Enhanced Service contract specification 2020/21- PCN. <https://www.england.nhs.uk/wp-content/uploads/2020/03/network-contract-des-specification-pcn-requirements-entitlements-2020-21.pdf> (Last accessed: 3<sup>rd</sup> July 2020.)

National Health Service (2020d) Using online consultations in primary care Implementation toolkit. <https://www.england.nhs.uk/wp-content/uploads/2020/01/online-consultations-implementation-toolkit-v1.1-updated.pdf> (Last accessed: 22<sup>nd</sup> August 2020.)

National Health Service (2020e) Digital inclusion in health care.  
<https://www.england.nhs.uk/itphimenu/digital-inclusion/digital-inclusion-in-health-and-care/> (Last accessed: 22<sup>nd</sup> August 2020.)

Nation Health Service Kent community health (2019) Frailty home treatment service (East Kent). <https://www.kentcht.nhs.uk/service/frailty-home-treatment-service-east-kent> (last accessed: 5<sup>th</sup> October 2020)

National Health Service X (2020) Tech plan for health and care.  
<https://www.nhsx.nhs.uk/key-tools-and-info/tech-plan-health-and-care> (Last accessed: 3<sup>rd</sup> October 2020)

National Quality Board (2018) Safe sustainable and productive staffing An improvement resource for the district nursing service.  
[https://improvement.nhs.uk/documents/816/Safe\\_staffing\\_District\\_Nursing\\_final.pdf](https://improvement.nhs.uk/documents/816/Safe_staffing_District_Nursing_final.pdf) (Last accessed 23<sup>rd</sup> August 2020.)

Patient Safety alert (2018) Resources to support the safe adoption of the revised national early warning score (NEWS2).  
[https://www.england.nhs.uk/wp-content/uploads/2019/12/Patient\\_Safety\\_Alert\\_-\\_adoption\\_of\\_NEWS2.pdf](https://www.england.nhs.uk/wp-content/uploads/2019/12/Patient_Safety_Alert_-_adoption_of_NEWS2.pdf)  
(Last accessed 3<sup>rd</sup> October 2020)

Queens Nursing Institute (2018) Nursing in the digital age Using technology to support patients in the home. <https://www.qni.org.uk/wp-content/uploads/2018/04/Nursing-in-the-Digital-Age-test.pdf> (Last Accessed 3<sup>rd</sup> October 2020)

Tech UK (2020) COVID-19 has primary care had its online banking moment?  
<https://www.techuk.org/insights/opinions/item/18103-covid-19-has-primary-care-had-its-online-banking-moment> (Last accessed: 21<sup>st</sup> August 2020.)

The King's Fund (2016) Understanding quality in district nursing services learning from patients, carers and staff.  
[https://www.kingsfund.org.uk/sites/default/files/field/field\\_publication\\_file/quality\\_district\\_nursing\\_aug\\_2016.pdf](https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/quality_district_nursing_aug_2016.pdf) (Last accessed: 23<sup>rd</sup> August 2020.)

Schwamm L, Estrada J, Erskine J et al (2020) Virtual care: new models of caring for our patients and workforce. The Lancet. 2,6, E282-E285. doi:  
[https://doi.org/10.1016/S2589-7500\(20\)30104-7](https://doi.org/10.1016/S2589-7500(20)30104-7)

Thornton J (2020) Covid-19: how coronavirus will change the face of general practice forever. British Medical Journal. 368.  
doi: <https://doi.org/10.1136/bmj.m1279>