South West Region Care Home Clinical Leads Network
What did we learn?

A clinically led learning and development forum for Clinical Leads from across the South West, to provide the space to think and share, be solution focused, and support leadership.

The Clinical Lead role was established during an pandemic, and it is recognised that there was little time to focus on what is needed for the role to succeed. This network is the first in a series to be run regularly, with the intention of being open and safe space to support the roles and ways of working to grow.

24th June 2021

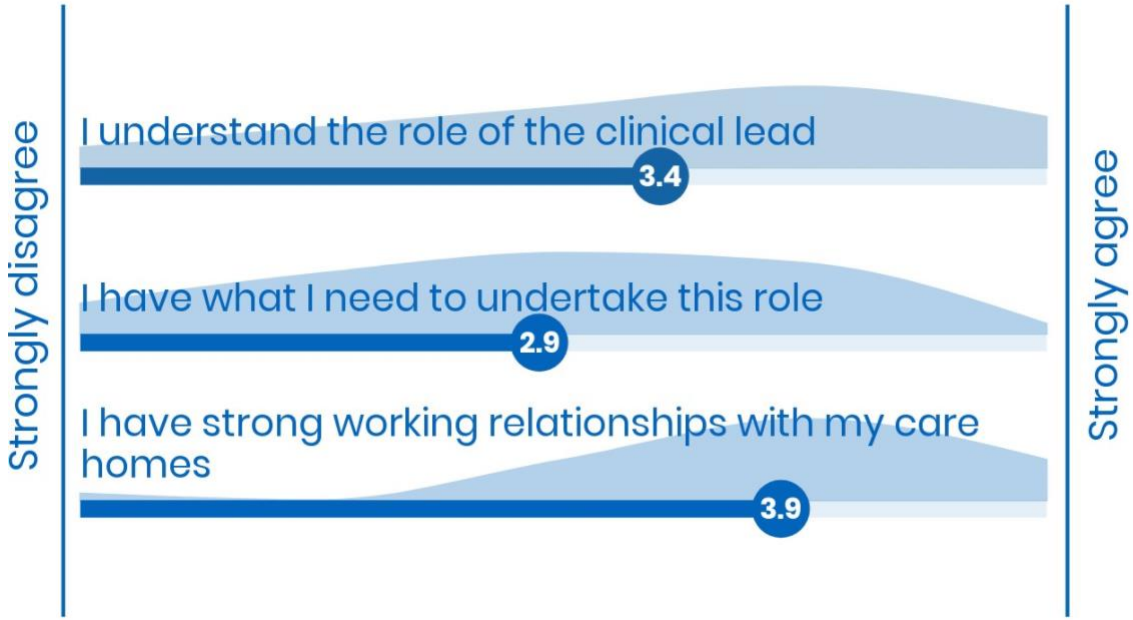
NHS England and NHS Improvement

Care Home Clinical Leads are very varied….

The variation in homes/ residents supported was significant:

- Range of 3 homes and 30 residents to 21 Homes and 800 residents.
- Many have homes for people with LD&A; requires a different approach, ie higher number of homes with fewer residents
- (Mean: 7 homes per lead, with 300 residents)

Two thirds are GPs by background, one third are nurses or AHPs. A number were unclear if they are a clinical lead or not.



MDTs;
36% of leads had a dedicated MDT to support them,
34% are in the process of establishing this,
30% did not have a team to support them

The role….

Many commented this role was “given” to them;

- Issues with time being released to undertake this properly, alongside competing clinical work
- Majority are focused on getting home rounds and MDT established rather than the leadership – many didn’t feel they ‘signed up’ to this aspect of the role
- General agreement that there is a lack of clarity about the role expectations – no consistency emerging yet across neighbourhoods. A job description or work plan might help with some quick wins / good practice examples. How do you know if you are getting it right? Currently doing what they feel is the right thing
- Positive feedback on the skill set that non-GP clinical leads can offer; de-medicalising and empowering of care homes
- Areas that had a historic Local Enhanced Service in place seem to be further ahead given relationships often already established,
- There needs to be a balance between the rush to implement new processes / deadlines and the time it takes to codesign and get it right

Positives already being seen;

- Outcomes of a pilot shared: A large Home with the highest admission rates identified, a weekly ward round MDT set up, reduced admissions by 60%. Staff, residents, and primary care all reported increased confidence, ability to know patients and develop relationships with care staff enabled this is happen.
- Weekly Care Home learning – builds trust, hybrid approach beneficial for this re: face to face and virtual
- Has helped to foster better relationships not only wider health partners but within PCN’s and primary care
- One named GP per home has improved communications, trust and understanding what makes each other ’tick’
- Having a clinical lead really supports care home managers
- Not having to attend to many meetings!

The Team…..

Inconsistency and variation in the wrap around support available:

- Despite the Pandemic many have continued to do care home visits, and report that they are delivering all element of the Enhanced Service. However, most report that they have not really established effective links with Community providers or established MDT meetings.
- Some of the community support structure around practices are more helpful than others; few were confident about what support and role they should be expecting from community care
- Many were finding it challenging to access the right skill sets for the MDT and consistency in the team
- Common challenges in accessing secondary care support especially geriatricians, but, where this is in place it has been hugely beneficial not only in care of the residents but team working, and relationships
- Clinical Pharmacist participation in MDT has been beneficial
- Care Coordinators have proved beneficial in being a single point of contact for care homes
- Access to Physician Associate has been good, working on improving ways of working together
- Some leads are hosted / employed through different organisations on behalf of the PCN, which has supported improved engagement with community and acute health care teams

Communicating…..

Use of technology was a common barrier and facilitator;

- Use of a single phone line or email dedicated to direct communication works well and saves time for both.
- Many adopting a blended approach of digital and face to face; telephone calls quicker than video consultations.
- Use of photography has been more expedient at times
- Recognise that Care Homes need support to make use of technology; reports that staff often have to use their own phones, some homes have no internet or devices etc. However, its not just infrastructure – its training and support
- No replacement for face to face conversations with the residents at times – visiting has been reintroduced in many locations
- Investment in time and inefficiencies; MDT work better thanks to MSTeams as members can all be in different places, but takes a while to get it set up, tweaked, and going well to make this efficiency and get best effectiveness

The variety in Care Homes was a factor in leadership;

- In larger Homes, it can be a challenge for all the staff to be aware and prepared ahead of an MDT or Home Round; works well with specific Home staff who have become familiar and confident with the role
- Common theme that homes that are proactive in triage with collating concerns and identifying residents for discussion before a meeting saves time for the home and the GP and gives a more positive experience
- Several comments on needing to understand more the complexities of the Care Home market, and what can be expected from Care Staff in terms of skills (complex care / physiological observations).
- Support for older peoples residential care homes, nursing homes and homes for people with LD is different. One leadership role for the whole PCN is therefore challenging depending not just on numbers but needs of residents

What is needed….

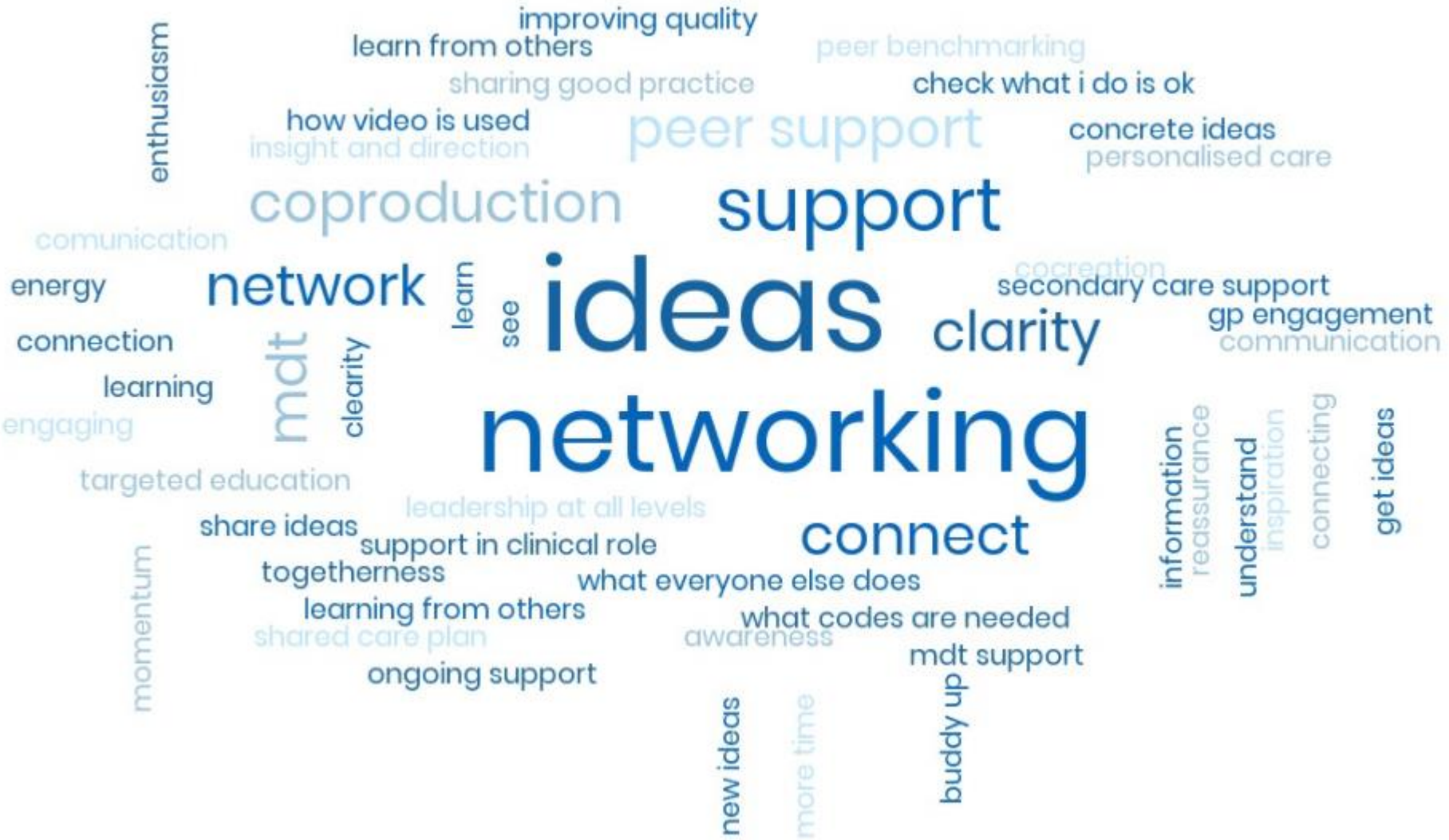
Digital enablers:
- Support for different levels of digitalisation to enable personalisation of care
- RESTORE2 is part of day to day care
- Access to secure email and MSTeams
- Information sharing / shared care records
- EMIS Templates, coding, design bare minimum required for PCN level data

Leadership development:
- Clarity on roles and expectations, across all partners
- Top tips resources ie blended approach to ward rounds, Support of physician associates, enabling access, building trust
- For not all care homes to be lumped together; appreciate unique nature and specialist functions – one size does not fit all
- Personalised approaches and empowerment to try different things / culture that is permissive

Education and training:
- Care Home workforce is diverse, any training/education should reflect that and be pitched at various abilities / competencies / ages as well as recognising difference in specialist functions for many Homes

Time for:
- Relationship building
- Empowering care home managers
- Straight talking
- Trust
- Communication
- Co-designed approach
- Unify the carers not just clinicians
- Coproduction, residents views embedded

What do Leads want from a network?



Summary

3 key take home points:

1. Where the Clinical leads is also the named GP, the current focus is establishing and honing the Home Rounds and MDT to be most effective; the clinical leadership requirements is a secondary activity, and little understood yet.

2. Clinical leads commonly do not have the established dedicated community MDT to be able to facilitate the care planning and implementation of the clinical elements of the Framework

3. Consensus that there is a stronger role for CCGs in their commissioning support for the implementation of the leadership role, and their role in acting as a lever to affect change as needed

Next Steps:

1. Set a date for a second South West Region Care Home Clinical Session to share learning and help create connections across the Region. To have a themed approach to focus session
2. Share this feedback with CCG leads / Ageing Well System leads to enable enhanced local support and development . Invite them to the next session
3. Create and circulate details of a South West Futures site to share resources

Did you know….?

The role description for a Care Home Clinical lead can be found on the following slides

Resources and information, including best practice and evidence for the EHCH Framework can be found here: Enhanced health in care homes - FutureNHS Collaboration Platform

The video recording of the first section of the Network can be found here: Care Home Clinical Lead Network 24 June 2021 - Enhanced Health in Care Homes - FutureNHS Collaboration Platform

All care homes are eligible for NHSmail accounts for secure exchange of information, access to Proxy Access to Online Ordering of Medication etc; 70% already have accounts. Homes have access to MSTeams through this to support collaborative working and videocalls. Further information england.swcommunityhealthandcare@nhs.net

The care home clinical lead

NHS CONFEDERATION
PCN Network

Leadership through COVID-19 and beyond

September 2020

Background

- **This document provides guidance on the role of the clinical lead for the Enhanced Health in Care Homes (EHCH) service set out in the network contract DES. A PCN must deliver the EHCH service to the care homes it is aligned to. The network contract DES also states that a lead clinician must be identified for each of the PCN's aligned homes. This is the clinical lead.**
- The clinical lead has responsible for oversight of the service provided to care home residents, in line with the contractual requirements in the DES, the NHS Standard Contract and the EHCH Framework. They should provide clinical leadership to staff delivering the service in the multidisciplinary care home team (MDT), and support continuous improvement of the service.
- The clinical lead is not medically responsible and accountable for the day-to-day care of individual care home residents. Medical responsibility and accountability for the care of individual care home residents remains with their registered GP – and there may be residents with different registered GPs within a care home. The relevant community services provider is responsible for appropriate provision of resource to support the MDT requirements set out in the NHS Standard Contract.
- The DES states that the clinical lead should be a GP, but by exception, may be a non-GP clinician, for example a nurse or an allied health professional with appropriate skills and experience of working with care homes.

Good practice features of the clinical lead role

Service feature	Description
Clinical leadership to the local MDT	

The weekly 'home round' for every care home
EHCH Framework section 4.2
	• The clinician leading the home round should have advanced assessment and clinical decisions skills and ensure that there is appropriate and consistent medical input from a GP or geriatrician.
	• Encouraging common approaches and standards across the PCN for the home round, such as:
	  ○ Working with care homes and the MDT to establish best practice of a common process for prioritising which residents should receive a review as part of the home round – through clinical judgement, care home staff feedback and validated tools. The process should ensure that the MDT collates relevant information on these individuals from relevant sources (GP, community services, the individual/their family) in advance of the round.
	  ○ Ensuring appropriate use of digital technology, especially to facilitate medical input or improve care.

Multidisciplinary team working EHCH Framework section 5.3	• Work with primary, community and acute NHS services, and local authorities, to ensure appropriate input into the MDTs working with care homes is secured and consistent (to include dentist, optometrist, social workers as required). • Ensure appropriate pharmacist input into the MDT, in a way that supports regular delivery of structured medication reviews to residents.
Training and development EHCH Framework multiple sections	• Facilitate the identification of training needs for members of the MDT and make recommendations for where additional training should be undertaken across the PCN and community trust. This might include specialist training in complex conditions and encouraging opportunities for staff from the MDT and the care sector to work across different employers to make best use of skills and support development. Responsibility for provision of suitable training remains with the employer. • Identify shared learning needs across health and care providers involved in EHCH service delivery.

Good practice features of the clinical lead role…continued

Service feature	Description
Clinical oversight of the service requirements	
Personalised care and support planning EHCH Framework section 4.3	• Ensure that there is an appropriate process in place for the MDT to develop and refresh personalised care and support plans (PCSPs) for all residents in the care homes aligned to a PCN. Clinical leads should consider establishing common practice across the PCN's care homes, based on these principles.
Advance care plans and end-of-life support EHCH Framework section 7.1	• Ensure that across the PCN's aligned homes, residents and their carers are supported to talk about their preferences and make informed decisions about their treatment wishes ahead of time – particularly if they should enter a crisis – as part of their regularly updated PCSP. Individuals who are likely to be in the last 12 months of life should be proactively identified. • Support cross-organisational partnership work on end-of-life care to provide support in accordance with people's preferences for care. In addition to care homes, PCNs and community providers, this should include secondary care, hospices and specialised palliative care services.
Mental health support, including dementia EHCH Framework section 7.2	• Facilitate links with local mental health trusts to get advice about mental health problems including dementia, and appropriate input into the MDT.
Detecting early deterioration of residents	• Determine how training and support can be delivered in collaboration with the care home to embed the use of an identified early deterioration tool. By building a closer working relationship with the home, carers will feel confident to raise and voice any concerns about their residents in a timely way. This would include strategies such as remote monitoring.
Transfers of care NICE Guideline 27	• Encourage partnership working between hospitals, PCNs and care homes to support successful discharge procedure and safe transfers of care between settings. This should include consistent following of processes and coding of care home residency on primary care records.

Good practice features of the clinical lead role…continued

Service feature	Description
Building relationships with other clinical leads	
Within and across PCNs	• If there are multiple clinical leads within a PCN, they should work together to ensure a consistent approach to service delivery. Both within and across PCNs (particularly neighbouring PCNs), clinical leads should aspire to build constructive relationships for the purpose of peer support and continuous improvement.