Our Primary Care Network, Our Care Home, Our Resident:

A summary of Direct Enhanced Services (DES) contract requirements and support agreement between Primary Care and Adult Social Care services.

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

Central Bedfordshire Council

Direct Enhanced Services (DES) contracts were developed for the Primary Care Networks (PCNs) by NHS England in 2020. They have continued to develop to include Enhanced Health in Care Homes (EHCH) services to ensure that every care home is:

- **Aligned to a Primary Care Network (PCN)**
- **Has a named clinical lead who is responsible for overseeing the implementation of the "Enhanced Health in Care Homes (EHCH) framework" as part of the DES Contract.**
- **Has a weekly home round (virtual or face to face) supported by a member of the Primary care multidisciplinary Team (MDT)**
- **Has systems in place for information sharing, use of shared care records and clear clinical governance.**

What does this mean for the care home, the practice, and the resident?

Residents/Family Responsibilities

The resident or the family may highlight a particular health query or concern that they would like to discuss with the healthcare professional on the weekly home round and the care home can ensure that this is actioned on behalf of the resident or the family.

Primary Care Responsibilities

- The named clinical lead is responsible for overseeing the implementation of the "Enhanced Health in Care Homes framework" in relation to the needs of the care home. They must allocate the most appropriate professional from the team to carry out the ward round at the home each week. This may be any member of the Multidisciplinary Team (MDT) from the practice such as a Pharmacist, Paramedic, Physician Associate, GP or Designated Nurse.
- Information regarding the ward round for any given week should be provided in advance by the designated person in the care home and reviewed by the professional who is responsible for the weekly home round in the care home.
- Once an assessment has been made by the visiting professional from the practice, they may be able to plan care immediately or they may involve others from the team to assist in ensuring that a personalised plan of care is in place. This may involve advice from or referral to other healthcare professionals. There should be an agreed process of how this additional information is fed back to the designated person within the care home so that the care plans can be modified appropriately.
- Sometimes, in complex cases, it may be necessary for all involved in the residents' care to meet together to decide personalised care planning. A Multidisciplinary Team (MDT) meeting may be held with the resident, family, care staff and other professionals and advocates. Meeting together to discuss ongoing care can provide a better understanding of how to support the resident with their personalised care so positive outcomes can be achieved. For further guidance, please refer to the "Resources" section.

Care Home Responsibilities

- The care home has a designated person who identifies the residents in the care home who require a review by the practice. This could be a review for a MCA, ongoing health need, medication changes, injury/rehabilitation advice or any other health concerns identified.
- Once the resident has been identified the designated person for the care home should prepare some background information of the problem for the practice in readiness for their weekly home round. The care home and practice may have agreed a process to send this information securely to the practice 24 or 48 hours in advance to a designated NHS.net email. The process needs to be agreed by the care home and the practice to ensure seamless communication and ensure the practice and care home are prepared for the weekly home round.

Urgent clinical concerns or queries should be escalated through the appropriate channels without unnecessary delay/waiting for the weekly home round.

Resources

- NHS England—EHCH Framework
- Developing Effective EHCH MDT Meetings Resource Pack and Toolkit
- NHS England—Providing Proactive Care for People Living in Care Homes
- Acute Hospital Trusts—Contact details for discharge queries or concerns
- Enhanced Health in Care Homes: A guide for care homes
- Services to Support Central Bedfordshire Care Homes

Our Primary Care Network, Our Care Home, Our Resident:

Practice / Care Home Agreement Template

(A copy should be retained by the care home and practice)

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

Central Bedfordshire Council

Care Home Details

Care Home Name……

Type of Service (Residential / Nursing / LD)……

Care Home Manager / Designated Person within the Care Home……

Contact Details (Tel. / NHS.net email)……...

GP Practice Details

Practice Name……..……..

Designated Point of Contact……

Contact Details (Tel. / NHS.net email)……...

Clinical Lead

Named Clinical Lead……..

Contact Details (Tel. / NHS.net email)……

Profession / Role……

Information Sharing & Coding

Practice and care home has systems in place for information sharing (e.g. NHS.net email), use of shared care records and clear clinical governance - Y / N

Weekly Care Home Round

Day……

Time……

Virtual / Face-to-Face / Other (please specify)……

……..

Seamless Processes

Each service has a responsibility for ensuring:

- Secure communication processes are in place (NHS emails, proxy access, consent for record sharing).
- An agreed process for contacting the care home/practice and dissemination of changes in personalised care planning for the resident, which may include SystmOne proxy access.
- A designated person at the care home and practice for seamless communication.
- The resident(s) to be seen in the home round should be identified in advance, through discussion with care home staff and through MDT meeting. Any relevant information about the resident(s) should be made available to the healthcare professional in a timely manner.