

Publications approval reference: 001559

To:

GP practices and primary care networks
CEOs of community health providers
Regional directors of primary care
CCG accountable officers

NHS England and NHS Improvement
Skipton House
London Road
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1 May 2020

Dear Colleagues,

COVID-19 response: Primary care and community health support care home residents

Thank you for all your continued extraordinary efforts to transform your services and ways of working to support the effective NHS management of the COVID-19 pandemic.

As you may know, care homes are reporting that the COVID-19 pandemic is posing a significant challenge. This calls for continued and further immediate assistance through Local Resilience Forums, and as highlighted in Simon Stevens' and Amanda Pritchard's 29 April letter to NHS leaders about the [Second Phase of NHS Response to COVID-19](#).

So, alongside (i) continued NHS testing of all patients prior to discharge to care homes, (ii) clinical commissioning groups (CCG) directors of nursing assisting local authorities with training in infection prevention and control, (iii) supporting different staff groups to take up opportunities in care homes, we are (iv) **requesting primary care and community health services help, building on what practices are already doing, to support care homes.**

The model described in this letter has already been established – and is in the process of being implemented – in much of England. Where local arrangements go beyond the service model set out, and are working well for care homes, these should not be disrupted. The healthcare needs of care home residents – combined with the impact of the COVID-19 pandemic – means that the task of completing the job of implementation across the country is more urgent than before. Where this service does not exist, it therefore needs to be established as part of the COVID-19 response by CCGs, working with general practice, community services providers,

care homes, local medical and pharmacy committees and wider partners in their area.

The guidance set out below draws on key elements of [existing evidence-based guidance and good practice](#), and updates this in order to bring it in line with the needs of care home residents during the current COVID-19 situation.

Practices and community providers will want to ensure:

- timely access to clinical advice for care home staff and residents
- proactive support for people living in care homes, including through personalised care and support planning as appropriate
- care home residents with suspected or confirmed COVID-19 are supported through remote monitoring – and face-to-face assessment where clinically appropriate – by a multidisciplinary team (MDT) where practically possible (including those for whom monitoring is needed following discharge from either an acute or step-down bed) and
- sensitive and collaborative decisions around hospital admissions for care home residents if they are likely to benefit.

We are looking for all practices to take part, not just Primary Care Networks (PCNs). However, it will be less burdensome for general practice, easier for community partners and better for care homes for this to be delivered at a PCN level as the default. The intention is that from 1st October, the model will be adapted to support the service specification already set out in the Network Contract Directed Enhanced Service.

COVID-19 care home support

Clinical service model

1. CCGs – working with general practices, community health services providers and engaging LMCs – should take immediate steps to implement the following support for care home residents:
 - a) **Delivery of a consistent, weekly ‘check in’, to review patients identified as a clinical priority for assessment and care.** The weekly check in should:
 - i. be delivered – primarily remotely wherever appropriate – by an MDT where practically possible, drawing on general practice and community services staff and expertise, including advanced nurse practitioners, clinical pharmacy, social prescribing link workers, dental care, and wider specialist services (eg geriatrician and dementia services) where appropriate

- ii. review patients identified as a clinical priority for assessment, including but not limited to those with suspected or confirmed COVID-19 symptoms, in line with the protocols established in [the primary care](#) standard operating procedures and [the community services](#) standard operating procedures
- iii. support the provision of care for those patients identified as a clinical priority
- iv. include appropriate and consistent medical oversight and input from a GP and/or geriatrician (with the frequency and form of that input determined by clinical judgement)
- v. support the introduction and use of remote monitoring of COVID-19 patients using pulse oximeters and other equipment (which may be supplied directly to care homes or eligible for practice reimbursement), and prescription and supply of oxygen to care homes for treatment, where clinically indicated and
- vi. be supplemented by more frequent contact with the care home where further needs are identified.

b) Development and delivery of personalised care and support plans for care home residents. A process needs to be established to:

- i. Support development of personalised and individually agreed treatment escalation plans for care home residents with care home teams, including end of life care plans and preferences where appropriate and drawing on available guidance and [templates](#) (including from the [Royal College of General Practitioners](#) and the [joint statement from the British Medical Association, Care Provider Alliance, Care Quality Commission, and Royal College of General Practitioners](#)). Where time and resources are limited the advance care planning process should not be rushed and appropriate time found as soon as reasonable to complete the task with care and compassion.

c) Provision of pharmacy and medication support to care homes. CCGs, PCNs and practices should co-ordinate pharmacy teams (including CCG employed pharmacists and pharmacists working as part of the Medicines Optimisation in Care Homes (MOCH) programme) to provide support to care home residents and staff. This support should include:

- i. facilitating medication supply to care homes, including end of life medication
- ii. delivering structured medication reviews – via video or telephone consultation where appropriate - to care home residents
- iii. supporting reviews of new residents or those recently discharged from hospital
- iv. supporting care homes with medication queries, and facilitating their medicines needs with the wider healthcare system (eg through medicines ordering).

Service enablers

2. **To deliver this support, CCGs should take immediate steps to support individual practices and community health services teams to organise themselves according to their local areas or networks.** Existing PCN arrangements should be the default. A network approach to delivery – backed by appropriate information sharing arrangements – will ensure that individual care homes have a single point of access for the majority of their residents and should reduce the infection control risks associated with multiple teams visiting individual care homes. As part of this process, networks should identify a named clinical lead for each care home.
3. **CCGs must ensure that clear and consistent out of hours provision is in place for each care home.** Out of hours provision to care homes may be provided via out of hours providers and community health services and should include arrangements for the supply and availability of medication through community pharmacy or other routes. This support must be clearly signposted to care homes.
4. **Secondary care providers should accept referrals and admissions from care home residents where clinically appropriate,** considering individuals' care and support plans and the benefits and risks of escalation to hospital-based care.
5. [Wider guidance to support care homes](#) and the [Government's action plan for adult social care](#) provide wider information for care homes (including on management of COVID-19 cases within care homes, testing for care home staff and residents, the provision of remote consultation support to care homes, and personal protective equipment) and should be read alongside this document.

Scope and timescales

6. **This support should be delivered for all care homes.** A 'care home' is defined as a [CQC-registered care home service, with or without nursing](#).
7. **This model should be established as soon as possible, and within a fortnight at the latest in order to support residents as quickly as possible.**
8. **NHS England and NHS Improvement will collect regular 'sitrep' data from CCGs, starting next week, to understand the support being provided to care homes and the coverage achieved across the country.** This will provide information on whether there are local issues which need to be addressed and whether regulatory provisions are required. We will also look to collect information from care homes on the impact this service is having.
9. **We will also run dedicated webinars, to share examples of good practice and practical implementation challenges and offer regional and system level support where needed.**
10. **Additional costs for general practices and community health services providers – which cannot be met from their existing resources – may be eligible for reimbursement.** A reimbursement mechanism for general practice will be established to help practices meet the additional costs of COVID-19 related activity which cannot be met from existing practice resources. Reimbursement will be managed through CCGs, on the basis of national guidance. Community services providers should consult the [letter of 17 March](#).

Further queries

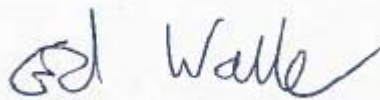
11. Those seeking further information should contact their NHS England and NHS Improvement Regional Team in the first instance. Contact details are available [here](#).
12. **Thank you again for your responsiveness and renewed commitment to supporting care homes, their staff and their residents, during the COVID incident,** in the context of a very fast-moving and difficult situation for everyone in the NHS and social care. We will do our best to provide as much support as we can nationally, regionally and locally to facilitate this.

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Dr Nikki Kanani
Medical Director for Primary Care
NHS England and NHS Improvement

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Matthew Winn
Director of Community Health
NHS England and NHS Improvement

A handwritten signature in black ink, with the letters 'Ed' followed by 'Waller' and a checkmark-like flourish.

Ed Waller
Director for Primary Care Strategy
and NHS Contracts
NHS England and NHS Improvement