



# Enhanced Health in Care Homes benchmarking, planning and resource guide

**Our values:**  
clinical engagement, patient involvement, local ownership, national support

June 2017

## Building on learning from the vanguards

- This guide is intended help clinical commissioning groups (CCGs) and local government commissioners work with care home providers and other local partners to understand how much of the Enhanced Health in Care Homes (EHCH) model your organisations have already implemented, and to prompt thinking on next steps.
- Learning from the vanguards has indicated that bringing together the local system and benchmarking against the framework is useful before you start to implement the EHCH care model. Most areas will have some elements of the care model in place – yet not everybody will know what services these are.
- Using this guide will help you prioritise where to invest, and to begin work with partners as part of a shared approach to design, plan and implement the services that will work best for your area.
- There are a wealth of resources available to support local areas to implement the EHCH care model, both regionally and nationally. We have brought these resources together in one place, aligned to the elements of the framework so it easy to see how these resources can be used to fill the gaps in existing provision, to make it easier to identify how you can implement the framework locally.
- A simple benchmarking tool is also available for recording your current position against each of the elements and sub-elements of the EHCH framework.
- We want to provide the right support to local areas to adopt the framework regardless of their current position, and ensure that there is a shared national and local understanding of potential benefits of implementation in each area.
- Should you wish to share details of your current level of progress, plans and support needs, you can share your completed benchmarking tool, by sending to [england.carehomes@nhs.net](mailto:england.carehomes@nhs.net).

## How might self-assessment be useful for your area?

- This guide will help:
  - Stimulate strategic discussions, internal challenge and a review of existing plans;
  - Map and measure existing services and progress which can contribute to EHCH implementation and identify areas where more work needs to be done;
  - Identify opportunities for sharing learning with other health and care systems;
  - Form the basis for a discussion with senior management, commissioners in other organisations and care homes about the benefits and feasibility of implementing the EHCH care model in your area;
  - Identify areas where partnership working and collaboration can assist with particular common challenges; and
  - Identify areas for review in relation to patient privacy, confidentiality and data sharing.

## Format of the framework

- The guide is **modular**, and covers the majority of the EHCH framework's proposals and key supporting activity.
- Each section focuses on an element of the EHCH framework, sets out the sub-elements and components a local area should have in place to fulfil the care model, and sets out questions for local areas to consider.
- The guide refers to 'care homes' throughout - this term is used to cover residential, nursing and specialist homes.

## How to use the guide

- Activate links and navigation by holding 'Ctrl' and clicking.
- Teams (i.e. CCGs, local authorities and providers) may wish to review the document and use sections as a starting point for discussion with colleagues in the community, acute, social care, voluntary or care provider sectors, depending on the element of the framework.
- A guide to the partners with whom you may wish to work with to complete each section is included. You should consider the document alongside local plans for integration of services such as your Sustainability and Transformation Partnerships (STP), Quality Improvement Plans (QIPP) and Better Care Fund initiatives.
- There is also a [glossary](#) which explains many key terms, which are sometimes used differently across the health and social care system.

This is the first version of the tool, and we will iterate the content in response to your feedback and suggestions. Should you have any questions or comments please email: [england.carehomes@nhs.net](mailto:england.carehomes@nhs.net)



Care model element	Sub-element	Page	Core or enhanced model
Clinical elements			
1. Enhanced primary care support	Access to consistent, named GP and wider primary care services	4	Core
	Medicine reviews	5	Core
	Hydration and nutrition support	5	Core
	Access to out of hours/urgent care	6	Core
2. Multi-disciplinary team (MDT) support including coordinated health and social care	Expert advice and support for those with the most complex needs	7-8	Core
	Helping professionals, carers and those with support needs to navigate	8	Enhanced
3. Reablement and rehabilitation to promote independence	Aligned rehabilitation and reablement services	9	Core
	Developing community assets to support resilience and independence	10	Core
4. High quality end-of-life care and dementia care	End-of-life care	11-12	Core
	Dementia care	13	Core
Enabler elements			
5. Joined-up commissioning and collaboration between health and social care	Co-production with providers and networked care homes	14	Core
	Shared contractual mechanisms	14	Enhanced
	Access to appropriate housing options	15	Enhanced
	Equality and health inequalities	15	Enhanced
6. Workforce development	Training and development for care staff	16	Core
	Joint workforce planning	17	Enhanced
7. Data, IT and technology	Linked health and social care data sets	18	Enhanced
	Access to the care record and secure email	19	Enhanced
	Better use of technology	19	Enhanced

## 1. Enhanced primary care

### What the framework says

- An EHCH moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of residents, their families and care home staff. Such care can only be achieved through a whole-system, collaborative approach. The specific aims are to provide continuity of care for residents, timely medicines reviews, access to hydration and nutrition support, and streamlined referral to out-of-hours services and urgent care.

### Who might be best placed to think this through?

- It may be useful to receive input from the following groups: **CCG and local authority commissioners, GP and primary care teams, care home staff.**

### 'I' statement

- "I have care and support that is directed by me and responsive to my needs."

Sub-element	Component	Implementation prompts	Support available
1.1 Access to a consistent, named GP and wider primary care service	i One-to-one mapping of GP practices to care homes.	<ul style="list-style-type: none"> <li>• How many care homes have an aligned GP or GPs?</li> <li>• If this is not in place are there plans locally to implement this?</li> <li>• What is the local level of ambition around Enhanced Primary Care?</li> <li>• How is this supported financially and contractually?</li> <li>• How do these arrangements respect patient choice and existing relationships?</li> </ul>	<p><b>Vanguard case studies and resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Newcastle and Gateshead CCG – Care home rounds</a></li> <li>• <a href="#">Newcastle and Gateshead CCG – Virtual ward rounds</a></li> </ul> <p><b>Policy and learning</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Making integrated out-of-hospital care a reality</a>, NHS Confederation and Royal College of General Practitioners (2013)</li> <li>• <a href="#">General Practice Forward View</a>, NHS England (2016)</li> </ul> <p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Comprehensive Geriatric Assessment</a>, British Geriatrics Society</li> <li>• <a href="#">GP services for older people: a guide for care home managers</a>, Social Care Institute for Excellence [SCIE] (2013)</li> <li>• <a href="#">Clinical input to care homes</a>, NHS England Quick Guide (2016)</li> <li>• <a href="#">Enhanced services commissioning: Key facts</a>, NHS England (2016)</li> <li>• <a href="#">Primary care commissioning resources</a>, NHS England</li> </ul>
	ii A regular 'home round' in place to review and plan a resident's care.	<ul style="list-style-type: none"> <li>• How are regular in-person or virtual care home rounds (or equivalent service) undertaken?</li> <li>• What is the frequency of these care home rounds?</li> <li>• What is the operational function/model (i.e. is this a dedicated MDT or GP role, shared, pro-active or reactive?)</li> <li>• Who is best placed to undertake the rounds; does it have to be a GP?</li> </ul>	
	iii Comprehensive geriatric assessment (CGA) process carried out on a resident's admission.	<ul style="list-style-type: none"> <li>• Are you aware of the comprehensive geriatric assessment (CGA)? Do clinicians and care staff use this in care homes?</li> <li>• How often are residents' care plans reviewed?</li> <li>• What percentage is this of the total number of care homes in your area?</li> </ul>	
	iv Prompt and efficient transfer of clinical care when a resident moves between a care home and hospital.	<ul style="list-style-type: none"> <li>• Have you established a local process for transfer of care when a resident needs to be admitted to hospital?</li> <li>• Across which services and organisations have standardised protocols for transfer of clinical care been implemented?</li> <li>• Have you implemented the hospital transfer pathway (red bag)?</li> <li>• Have the ambulance trust been engaged?</li> </ul>	



## 1. Enhanced primary care

Sub-element	Component	Implementation prompts	Support available
1.2 Medicine reviews	i A structured medicine review forms part of the CGA process.	<ul style="list-style-type: none"> <li>• What format does medicines review take in the care homes in your area? Is this part of local GPs' contractual responsibilities?</li> <li>• How many linked GP practices in your area regularly undertake medicines reviews?</li> <li>• If a service exists what is the commissioning and operational model? How are GPs working with the local pharmaceutical team?</li> </ul>	<p><b>NHS Pharmacy Integration Fund</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Pharmacy Integration Fund</a></li> </ul> <p><b>Quality standards</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Managing medicines in care homes [QS85]</a>, NICE, 2015</li> </ul> <p><b>Policy and learning</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Helping patients make the most of their medicines</a>, Royal Pharmaceutical Society (2013)</li> <li>• <a href="#">Polypharmacy and medicines optimisation: making it safe and sound</a>, The King's Fund (2013)</li> </ul> <p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Medication safety in care homes</a>, NCF (2013)</li> <li>• <a href="#">Managing medicines in care homes</a>, NICE guideline [SC1]</li> <li>• <a href="#">Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes</a>, NICE guideline [NG5] (2015)</li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Malnutrition Universal Screening Tool (MUST)</a>, British Association of Parenteral and Enteral Nutrition [BAPEN] (2003)</li> </ul>
	ii Care home providers should be supported to have an effective 'care homes medicines policy'.	<ul style="list-style-type: none"> <li>• On what frequency are medicines reviewed and by whom?</li> <li>• Do any homes require improvement according to CQC or your local authority partners?</li> <li>• How is information around this collected for care and nursing homes in your area?</li> <li>• Are you considering an application to the <a href="#">Pharmacy Integration Fund</a>?</li> </ul>	
1.3 Hydration and nutrition support	i Every resident's hydration, nutrition and oral health should be reviewed regularly and included in their care plan.	<ul style="list-style-type: none"> <li>• What are the local authority and CCG responsibilities and support offer around hydration and nutrition?</li> <li>• Are hydration, nutrition and oral health included in care plans?</li> <li>• How is this monitored? (e.g. information from quality assurance teams)</li> </ul>	<p><b>Quality standards</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition</a>, NICE guideline [CG32]</li> </ul> <p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Commissioning excellent nutrition and hydration</a>, Guidance, NHS England (2015)</li> <li>• <a href="#">Oral health for adults in care homes</a>, NICE guideline [NG48]</li> <li>• <a href="#">Malnutrition Matters: A commitment to act - A three-step guide to improving nutritional care in England</a>, British Association of Parenteral and Enteral Nutrition [BAPEN] (2004)</li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Malnutrition Universal Screening Tool (MUST)</a>, British Association of Parenteral and Enteral Nutrition [BAPEN] (2003)</li> <li>• <a href="#">Hydr8 app case study</a>, November 2016</li> </ul>
	ii A nutritional screening policy should be in place in the care home with one staff member taking responsibility for this policy within the home.	<ul style="list-style-type: none"> <li>• How many care homes have a nutritional screening policy in place?</li> <li>• Is specialist support around swallowing available from the local health and care system?</li> </ul>	
	iii Staff employed by social care providers undertake clinical training and professional development that is critical in promoting good nutrition in older people.	<ul style="list-style-type: none"> <li>• What training is available to care home staff on a consistent basis to ensure basic competency around nutrition?</li> <li>• Are any arrangements in place with the local acute sector? What could be planned for the future?</li> </ul>	



## 1. Enhanced primary care

Sub-element	Component	Implementation prompts	Support available
1.4 Access to out of hours/urgent care	i The EHCH is linked with the urgent and emergency care system through a single point of access and through the sharing of care plans and protocols.	<ul style="list-style-type: none"> <li>• What proactive services are in place to recognise and prevent potential acute illness and quickly react to address urgent care needs?</li> <li>• Is there is a simplified, integrated and coordinated route into unplanned urgent and emergency care?</li> <li>• Is there a joined up rapid response service in place?</li> <li>• Has a shared description of the local urgent and emergency care system been developed and shared with care homes and their staff?</li> </ul>	<p><b>Vanguard learning 'How To' guides and resources:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Hospital Transfer Pathway 'Red Bag'</a></li> <li>• <a href="#">Supporting resources and vanguard material</a></li> </ul> <p><b>Vanguard case studies and resources:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Wakefield CCG – Link falls responder service</a></li> </ul> <p><b>Policy and learning</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Transforming urgent and emergency care services in England. Update on the Urgent and Emergency Care Review</a>, NHS England (2014)</li> <li>• <a href="#">Improving referral pathways between urgent and emergency services in England: Advice for Urgent and Emergency Care Networks</a>, NHS England (2015)</li> </ul> <p><b>Quality standards</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Quality care for older people with urgent and emergency care needs "Silver book"</a>, British Geriatrics Society (2012)</li> <li>• <a href="#">NHS GP practices and GP out-of-hours services: provider handbook</a>, Care Quality Commission (2016)</li> </ul> <p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Transition between inpatient hospital settings and community or care home settings for adults with social care needs [ng27]</a>, Guideline, NICE (2016)</li> <li>• <a href="#">Effective Healthcare for Older People Living in Care Homes</a>, British Geriatrics Society (2016)</li> <li>• <a href="#">The Keogh Urgent Care Review - Quick guides</a>, NHS England</li> <li>• <a href="#">Clinical input to care homes</a>, NHS England Quick Guide (2016)</li> <li>• <a href="#">High Impact Change Model for reducing delayed transfers of care</a>, LGA, ADASS, NHSI, NHSE, DH</li> </ul>
	ii Hospital admissions from care homes, when necessary, should be promptly facilitated.	<ul style="list-style-type: none"> <li>• Have you agreed any joint protocol(s) across care homes, acute and emergency care providers and community services for sharing of care plans in emergency situations?</li> <li>• What arrangements have been agreed with local hospitals to receive residents from care homes?</li> <li>• Does discharge planning begin immediately?</li> <li>• Are you implementing the High Impact Change Model for reducing delayed transfers of care?</li> <li>• How are you planning to work with your regional NHS England Urgent and Emergency Care team, to strengthen support to your care homes and to ensure that care homes have direct access to clinical advice, by implementing *6 as part of NHS 111?</li> </ul>	

## 2. Multidisciplinary team support including coordinated health and social care

### What the framework says

- A multidisciplinary team (MDT) approach provides individuals with care and support needs with access to the right care when they need it. The MDT improves the care of complex conditions by making full use of the knowledge and skills of team members from multiple disciplines and service providers, including primary care, community health services, acute care, social care, and other specialist advice. The MDT approach also ensures that residents with complex needs have access to expert advice.

### Who might be best placed to think this through?

- This section is most relevant to CCG and local authority commissioners. It may be useful to seek input from community teams, GPs, MDTs, the acute sector, and care home providers.

### 'I' statement

- "My support is coordinated, co-operative and works well together and I know who to contact to get things changed."

### 2. Multidisciplinary team support including coordinated health and social care

Sub-element	Component	Implementation prompts	Support available
2.1 Expert advice and care for those with the most complex needs	i Using a partnership approach, people in care homes have access to an MDT which provides both preventative care and reactive support to the people on its caseload.	<ul style="list-style-type: none"> <li>• Do all the care homes (both nursing and residential) in your area have access to a dedicated or wider-focused MDT which regularly discusses care home residents?</li> <li>• What is the operational and commissioning model?</li> <li>• Which health and care professionals make up your MDT(s)?</li> <li>• Do your job descriptions for MDT members support this model of working?</li> <li>• Is structured education and support available for the clinicians and care staff?</li> <li>• How frequently does the MDT meet and jointly discuss cases?</li> </ul>	<p><b>Vanguard case studies and resources:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Wakefield CCG – MDT support in care homes</a></li> <li>• <a href="#">Wakefield CCG – Reviewing 'frailty tools' used in care homes</a></li> </ul> <p><b>Policy and learning</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Quest for Quality - a call for leadership, partnership and quality improvement</a>, British Geriatrics Society (2011)</li> <li>• <a href="#">Integrated care for older people with frailty: Innovative approaches in practice</a>, BGS/RCGP (2016)</li> </ul>
	ii Risk stratification tools could be used by the MDT to ensure it focuses its attention on those individuals with the greatest potential to benefit.	<ul style="list-style-type: none"> <li>• How are cases identified and referrals made?</li> <li>• How does your local health and care system identify cohorts of people (within care homes and in the community) that are most vulnerable and/or will benefit most from tailored care and support?</li> <li>• How are services and resources targeted as a result?</li> </ul>	<p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Older people with social care needs and multiple long-term conditions [ng22]</a>, Guideline, NICE (2015)</li> <li>• <a href="#">Effective Healthcare for Older People Living in Care Homes</a>, British Geriatrics Society (2016)</li> <li>• <a href="#">Quick Guide: Clinical input into care homes</a>, NHS England (2015)</li> <li>• <a href="#">MDT Development – working toward an effective multidisciplinary/multiagency team</a>, NHS England (2015)</li> </ul>
	iii All members of the team have access to sections of the integrated care record that are appropriate to their role.	<ul style="list-style-type: none"> <li>• Do MDT members (including GPs and relevant care home staff) have access to relevant sections of a shared care record (e.g. via locally integrated systems or Patient Online)?</li> </ul>	<p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Delivering care and support planning</a>, Think Local Act Personal (2014)</li> </ul>

## 2. Multidisciplinary team support including coordinated health and social care

Sub-element	Component	Implementation prompts	Support available
2.1 Expert advice and care for those with the most complex needs	iv Person-centred care planning.	<ul style="list-style-type: none"> <li>What percentage of care home placements (continuing healthcare [CHC], self-funded and local authority funded) have access to personalised health and care planning?</li> <li>What mechanisms are in place to understand and improve this?</li> <li>How is communication with residents which is meaningful and enables choice and control over care, built into the design of your local change programme?</li> </ul>	<ul style="list-style-type: none"> <li><a href="#">Personalised care and support planning: a handbook</a>, NHS England (2016)</li> <li><a href="#">Case finding and risk stratification</a>, NHS England (2016)</li> </ul> <p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li><a href="#">Better use of care at home</a>, NHS England Quick guide</li> <li><a href="#">Supporting patients' choices to avoid long hospital stays</a>, NHS England Quick guide</li> <li><a href="#">Toolkit for general practice in supporting older people living with frailty</a>, NHS England</li> </ul>
	v Coverage beyond care homes.	<ul style="list-style-type: none"> <li>Does the MDT model extend to cover other settings in addition to care homes (e.g. learning disability [LD] and supported living settings) and/or those at risk living in their own homes?</li> </ul>	
2.2 Helping professionals, carers and individuals with needs navigate the health and care system	i Care coordinators provide dedicated support to residents and their carers for residents who are having multiple simultaneous interactions with different health, care and voluntary services.	<ul style="list-style-type: none"> <li>Is there a model for care coordination and support and advocacy for care home residents in your area?</li> <li>Are care coordinators, link workers, activity coordinators or equivalent roles around signposting and involvement in care planning available to people in care homes (both nursing and residential) in your area?</li> </ul>	<p><b>Vanguard learning 'How To' guides and resources:</b></p> <ul style="list-style-type: none"> <li><a href="#">Hospital Transfer Pathway 'Red Bag'</a></li> <li><a href="#">Supporting resources and vanguard material</a></li> </ul> <p><b>Vanguard case studies and resources:</b></p> <ul style="list-style-type: none"> <li><a href="#">Sutton CCG – Red Bag scheme</a></li> <li><a href="#">Discharge to assess / Development of trusted assessor role</a></li> <li><a href="#">Newcastle and Gateshead CCG - Delivering Enhanced Care across the Whole System: Transition into a Care Home, Peggy's Story</a></li> <li><a href="#">Sutton – Concerned about a resident</a></li> </ul> <p><b>Policy and learning</b></p> <ul style="list-style-type: none"> <li><a href="#">Care Act 2014</a>, Department of Health (2014)</li> <li><a href="#">Care and support statutory guidance: Issued under the Care Act 2014</a>, Department of Health (2015)</li> </ul> <p><b>Quality standards</b></p> <ul style="list-style-type: none"> <li><a href="#">Transition between inpatient hospital settings and community or care home settings for adults with social care needs [ng27]</a>, Guideline, NICE (2016)</li> </ul> <p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li><a href="#">Discharge to assess</a>, NHS England Quick guide</li> <li><a href="#">Improving hospital discharge into the care sector</a>, NHS England Quick guide</li> <li><a href="#">Identifying local care home placements</a>, NHS England Quick guide</li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li><a href="#">Hospital2Home resource pack</a>, Housing LIN - information to support hospital discharge</li> <li><a href="#">Coordinate my care</a>, Coordinate My Care (CMC)</li> <li><a href="#">High Impact Change Model for reducing delayed transfers of care</a>, LGA, ADASS, NHSI, NHSE, DH</li> </ul>
	ii Care provider staff have easy access to reliable and trusted advice and triage.	<ul style="list-style-type: none"> <li>How can care home staff in your area access advice and guidance relating to a residents' health needs?</li> <li>How are these queries triaged according to perceived level of need?</li> <li>What protocols for responding are in place?</li> </ul>	
	iii The MDT facilitates and support 'discharge to assess' which aims to help individuals who are ready to be discharged from the acute hospital but who may need further support to regain health, wellbeing and capability in the care home, their own home, or in an alternative community setting.	<ul style="list-style-type: none"> <li>What is the discharge to assess process in your area? How integrated is this between health and social care services?</li> <li>Is there a dedicated discharge to assess team in your area?</li> <li>Are you implementing the High Impact Change Model for reducing delayed transfers of care?</li> <li>How are you planning to work with your regional NHS England Urgent and Emergency Care team, to strengthen support to your Care Homes and to ensure that care homes have direct access to clinical advice, by implementing *6 as part of NHS 111?</li> </ul>	

## 3. Reablement and rehabilitation

### What the framework says

- The aims of reablement and rehabilitation are fourfold: (i) to promote independence at home, (ii) to decrease the length of hospital stays, (iii) to reduce the chance of readmission to hospital, and (iv) to reduce the risk of admission to a care home.
- The EHCH care model works with the voluntary sector and develops existing and new community assets to support local people to improve their health and wellbeing.

### Who might be best placed to think this through?

- This section is relevant to CCG and local authority commissioners, with input from community teams, GPs, MDTs, the acute sector, and care home providers.

### 'I' statement

- "I feel safe. I can live the life I want and I am supported to manage any risks."

3. Reablement and rehabilitation			
Sub-element	Component	Implementation prompts	Support available
3.1 Reablement/rehabilitation services	i Local authorities and the NHS make continued investment in reablement and rehabilitation a shared priority.	<ul style="list-style-type: none"> <li>• What arrangements are in place for rehabilitation and reablement in your locality?</li> <li>• How are these arrangements funded?</li> <li>• To what degree is the rehabilitation and reablement offer for local citizens integrated across health and social care provision?</li> </ul>	<p><b>Vanguard case studies and resources:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Wakefield - Reviewing frailty tools in care homes</a></li> </ul> <p><b>Quality standards</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Intermediate care including reablement (in-development), guideline</a>, NICE (expected 2017)</li> <li>• <a href="#">Homecare: Delivering personal care and practical support to older people living in their own homes</a>, NICE guideline [21]</li> </ul> <p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Commissioning Guidance for Rehabilitation</a>, NHS England (2016). Includes and number of top tips including specific reference to care homes as settings for rehabilitation</li> <li>• <a href="#">The Principles and Expectations for Good Adult Rehabilitation</a>, Wessex Strategic Clinical Networks / NHS England (2015)</li> <li>• <a href="#">Better use of care at home</a>, NHS England Quick Guide (2016)</li> <li>• <a href="#">Allied Health Professionals into Action</a> - the potential and role of AHPs within the health, social and wider care system</li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Reablement: a guide for frontline staff. England. North East Improvement and Efficiency partnership</a>, Office for public management (2010)</li> <li>• <a href="#">Resources for home care providers, GPs, commissioners and families on how to deliver reablement services that promote independence</a>, SCIE</li> </ul>
	ii CCGs work with local authorities to ensure that rehabilitation and reablement is provided in the right setting, including in care homes and bed-based rehabilitation for individuals who are not suitable for rehabilitation in their own homes.	<ul style="list-style-type: none"> <li>• Does the local reablement service extend to those in care homes and nursing homes?</li> </ul>	
	iii Activity coordinators form an important part of the reablement team – they help facilitate and support exercise and other activities for the individual.	<ul style="list-style-type: none"> <li>• Are activity coordinators or similar roles part of your reablement teams?</li> </ul>	
	iv Personalised care planning ensures that the support offered is proportionate to the individual's circumstances and needs.	<ul style="list-style-type: none"> <li>• See 2.1, iv</li> </ul>	

## 3. Reablement and rehabilitation

Sub-element	Component	Implementation prompts	Support available
3.2 Developing community assets to support resilience and independence	i Self-care / care self-management and the provision of informal care are encouraged for those in care homes as well as the community.	<ul style="list-style-type: none"> <li>• How are those in care homes, or at risk of admission supported to manage their own health and care needs?</li> <li>• How far is social prescribing being used across the vanguard?</li> <li>• Is there a pro-active approach to tackling social isolation in care homes in your area?</li> </ul>	<p><b>Vanguard case studies and resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Wakefield CCG – Community solutions</a></li> <li>• <a href="#">Wakefield CCG – Building social capital</a></li> <li>• <a href="#">Wakefield CCG – Pull up a chair (engagement programme)</a></li> </ul> <p><b>Policy and learning</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Head, hands and heart: asset-based approaches in health care</a>, Health Foundation (2015)</li> <li>• <a href="#">VCSE Review: Joint review of partnerships and investment in voluntary, community and social enterprise organisations in the health and care sector</a>, Representatives of the VCSE sector and the Department of Health, NHS England, and Public Health England (2016).</li> <li>• <a href="#">Case study: addressing obesity through community engagement</a>, NICE</li> </ul> <p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Developing Asset Based Approaches to Primary Care: Best Practice Guide</a>, Innovation Unit / Greater Manchester Public Health Network (2016)</li> <li>• <a href="#">A new relationship with people and communities</a>, People and Communities Board (NHSE, National Voices and partners) [2017] outlines a set of 'high impact actions' for accelerating the adoption of person and community-centred approaches to health and care.</li> <li>• <a href="#">Public health working with the voluntary, community and social enterprise sector: new opportunities and sustainable change</a>, LGA (2015)</li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Portrait of a life</a></li> <li>• <a href="#">LEAF-7 tool</a> - a method of measuring a person's quality of life and any changes to that quality of life which occur over time.</li> <li>• <a href="#">Realising the value programme - tools and resources</a>, NHSE / NESTA 2015</li> <li>• <a href="#">People powered health co-production catalogue</a>, NESTA 2014</li> <li>• <a href="#">Route 2 Wellbeing Birmingham</a></li> </ul>
	ii People are supported to ensure that they can be involved with and feel a part of, the wider community, particularly through 'community anchor' organisations.	<ul style="list-style-type: none"> <li>• Are care homes systematically linked with community groups, charities and other organisations offering leisure and wellbeing activities?</li> <li>• What community resources have been mapped and how are you connecting with these?</li> <li>• To what extent are you working in partnership with local communities, local government and voluntary and community organisations?</li> </ul>	
	iii Professionals in care homes, health services and the community ensure the care planning process identifies the outcomes that are important to individuals, as well as meeting their health needs in a personalised way.	<ul style="list-style-type: none"> <li>• Does your CCG or local authority offer support for holistic care planning such as the use of the 'portrait of a life' or LEAF tools?</li> <li>• To what extent is this available in care homes and nursing homes, and for those with health and care needs in the community?</li> <li>• To what extent are carers identified and supported?</li> </ul>	

## 4. High quality end-of-life care and dementia care

### What the framework says

- High quality end-of-life care ensures that people die in the place of their choosing with dignity and in comfort. High quality dementia care ensures that people with dementia have equal access to the services and support that they require. Care home residents have the same entitlement to these types of high-quality care as everyone else.

### Who might be best placed to think this through?

- This section is relevant to CCG and local authority commissioners, with input from community teams, GPs, MDTs, the acute sector, third sector/voluntary sector, and care home providers.

### 'I' statement

- "I am in control of planning my care and support."
- "I have access to a range of support that helps me live the life I want and remain a contributing member of my community."
- "I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)."

### 4. High quality end-of-life care and dementia care

Sub-element	Component	Implementation prompts	Support available
4.1 End-of-life care	i A systematic, proactive approach is used to identify residents who may require end-of-life care.	<ul style="list-style-type: none"> <li>• In what percentage of local homes is there a jointly agreed process between CCG, GP practices, acute trust, care homes and the local authority for identifying those who would benefit from end-of-life care?</li> <li>• How is care provided as a result?</li> </ul>	<p><b>Vanguard case studies and resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Airedale and Partners – Gold Line End of Life Service</a></li> </ul> <p><b>Policy and learning</b></p> <ul style="list-style-type: none"> <li>• <a href="#">The Ambitions for Palliative and EoLC - a national framework for local action</a>, End of Life Care Ambitions</li> <li>• <a href="#">Effective Healthcare for Older People Living in Care Homes</a>, British Geriatrics Society (2016)</li> <li>• <a href="#">Lessons learned: Implementing an Electronic Palliative Care Co-ordination System (EPaCCS)</a></li> <li>• <a href="#">EPaCCS - a case for change</a>, End of Life Care Ambitions</li> <li>• <a href="#">Government's response to the choice review including 6 point EoLC commitment</a></li> <li>• <a href="#">CQC thematic review of inequalities in EoLC</a></li> </ul> <p><b>Quality standards</b></p> <ul style="list-style-type: none"> <li>• <a href="#">End of life care for adults. NICE quality standard [qs13]</a>, Quality Standard, NICE (2011)</li> <li>• <a href="#">National Gold Standards Framework</a> (2012)</li> </ul>
	ii Individuals are supported to die in their place of choice. This is reinforced through 'advance care planning', personalised care plans and treatment escalation plans.	<ul style="list-style-type: none"> <li>• Do any MDTs in your area utilise an Electronic Palliative Care Co-ordination System (EPaCCS) to support care given to those at end of life?</li> <li>• Is advance care planning available to those in care homes?</li> <li>• Are processes in place to measure the percentage of people in your area who die in their preferred place of care?</li> <li>• Is there a robust system in place for identifying this information for those that live in care homes and supported living settings?</li> </ul>	



## 4. High quality end-of-life care and dementia care

Sub-element	Component	Implementation prompts	Support available
4.1 End-of-life care	<p>iii When appropriate, the EHCH should seek support in delivering end-of-life care from its partner organisations, including acute hospital, hospices and community nursing teams.</p>	<ul style="list-style-type: none"> <li>To what degree is the local acute sector and community and voluntary sector involved with the identification of those at the end of life, and in providing support to this group of people?</li> </ul>	<p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>EPACCs - electronic systems that improve end of life care, Marie Curie</li> <li>EPaCCS implementation guidance</li> <li>Summary Care Record additional information - activated where EPaCCS solution is not in place</li> <li>Core educational framework; case studies of good practice and webinars available on NHS Employers website</li> <li>Commissioning toolkit for person centred end of life care</li> <li>NHS England and partners quick guides: transforming urgent and emergency care services out of hospital to support local health and care systems. The guides provide practical tips, case studies and links to useful documents, which can be used to implement solutions to commonly experienced issues.</li> <li>Specialist Palliative Level Care information for commissioners sets out what good SPC looks like from a system perspective</li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li>Case studies and resources available on the 'Knowledge Hub' for palliative and end-of-life care</li> <li>Coordinate my care, Coordinate My Care (CMC)</li> <li>Information and links for professionals who support people and their families at the end of life, SCIE</li> <li>Six Steps to Success Programme, North West Coast Strategic Clinical Networks</li> <li>The Good Death Pilot project, Housing for Health</li> <li>Personalised Care Planning templates and guidance, including templates for advance care plans, emergency care and treatment plans, NHS England</li> <li>Macmillan's Holistic Needs Assessment template</li> <li>Toolkit for general practice in supporting older people living with frailty, NHS England</li> </ul>
	<p>iv Care home staff are supported with education and training on palliative care knowledge and skills.</p>	<ul style="list-style-type: none"> <li>Do you know the level of training staff in the care and nursing homes in your area currently receive on end of life care? (e.g. syringe driver training, holding difficult conversations, medicine management).</li> <li>Is there a reliable method for commissioners to be assured that training is occurring regularly and to a safe quality?</li> </ul>	



## 4. High quality end-of-life care and dementia care

Sub-element	Component	Implementation prompts	Support available
4.2 Dementia care	<b>i</b> A systematic, proactive approach is used to identify residents who may require end-of-life care.	<ul style="list-style-type: none"> <li>Is there an established approach for identifying those with dementia in care homes, who are in hospital and require discharge to care homes, and amongst those in the community who are at risk of admission?</li> </ul>	<p><b>Vanguard case studies and resources</b></p> <ul style="list-style-type: none"> <li>Newcastle and Gateshead CCG – Dementia – ‘Robert’s Story’</li> <li>Nottingham City CCG – Dementia Outreach Team Training</li> </ul> <p><b>Policy and learning</b></p> <ul style="list-style-type: none"> <li>Joint declaration on post-diagnostic dementia care and support, Department of Health and partners (2016)</li> <li>Making a Difference in Dementia - Nursing Vision and Strategy, Department of Health (2016)</li> <li>Prime Minister’s Challenge on Dementia 2020: Implementation Plan, Department of Health (2016)</li> <li>Fix Dementia Care: NHS and care homes report, Alzheimer’s society (2016)</li> </ul> <p><b>Quality standards</b></p> <ul style="list-style-type: none"> <li>Dementia: supporting people with dementia and their carers in health and social care, NICE Clinical guideline [CG42]</li> <li>Hospice services: provider handbook, Care Quality Commission (2015)</li> </ul> <p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>Dementia Core Skills Education and Training Framework, Skills for health, HEE (2015)</li> <li>Shared Lives Plus scheme – supporting older people (including those with dementia) with day support and short breaks to aid living independently longer</li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li>‘This is Me’ tool, Alzheimer’s Society and Royal College of Nursing (2013)</li> <li>Dementia Dog Project, Alzheimer Scotland</li> <li>Music in Mind Project, Manchester Camerata</li> </ul>
	<b>ii</b> Shared care planning delivers high-quality, personalised care, and ensures timely access to secondary care and to specialised mental health services.	<ul style="list-style-type: none"> <li>Does shared care planning (and MDT in-reach if established) ensure timely access to secondary care and mental health services for those in care homes with dementia?</li> <li>What is the operational model and referral route for specialist dementia care for those in care homes?</li> </ul>	
	<b>iii</b> Education, training and professional development ensures that carers, families and staff employed by social care providers feel supported.	<ul style="list-style-type: none"> <li>How is the community and voluntary sector involved in providing dementia care, and support to relatives and carers?</li> </ul>	
	<b>iv</b> Medication reviews focus on reducing polypharmacy and optimising antipsychotic medication.	<ul style="list-style-type: none"> <li>Do medicines reviews include a prompt for optimising anti-psychotic medication?</li> </ul>	
	<b>v</b> The physical environment for residents is considered. This includes sensory and home environments, and therapies such as animal assisted therapy.	<ul style="list-style-type: none"> <li>Are assessments of the physical environment included when considering the best placement for individuals?</li> </ul>	
	<b>vi</b> ‘This is Me’ tool is used to help NHS services ensure that all care home residents’ needs are met.	<ul style="list-style-type: none"> <li>Do community nursing teams and GP use the ‘This is Me’ tool? (See link).</li> </ul>	

## 5. Joined - up commissioning and collaboration between health and social care

### What the framework says

- In order to ensure that an EHCH transforms the quality of care, its commissioners will need to work closely with its providers to promote the use of networked care homes, shared contracts and access to a full range of housing options. Commissioning the model is achieved through collaboration, building on and improving existing contractual arrangements.

### Who might be best placed to think this through?

- This section is most relevant to CCG and local authority commissioners and care home providers.

5. Joined - up commissioning and collaboration between health and social care			
Sub-element	Component	Implementation prompts	Support available
5.1 Co-production with providers and networked care homes	i Commissioners work together with providers of care home services either through a local care home forum or through online networks.	<ul style="list-style-type: none"> <li>Does a forum exist to bring together care home managers and/or other staff to collectively deal with issues and feedback to the CCG and/or local authority?</li> <li>If so, how often does this meet? Does it include care and nursing homes, and other settings e.g. supported living and learning disabilities (LD)?</li> <li>Is there a forum for more junior staff in care homes to meet and share learning?</li> <li>How often, and how, does the CCG and local authority communicate to care homes in its area?</li> <li>Does the CCG engage with care providers and the local authority on market sustainability issues? How and how often?</li> </ul>	<p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li><a href="#">Commissioning for Excellence in Care Homes</a>, British Geriatrics Society (2013)</li> <li><a href="#">Effective Healthcare for Older People Living in Care Homes</a>, British Geriatrics Society (2016)</li> <li><a href="#">Commissioning for Better Health outcomes</a>, LGA (2016)</li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li><a href="#">Commissioning for Better Outcomes - A route map</a>, LGA/ADASS (2014)</li> <li><a href="#">People not process: a tool for co-production in commissioning</a>, Think Local Act Personal [TLAP], (2015)</li> <li><a href="#">Market shaping toolkit (MaST): supporting local authority and SME care provider innovation and collaboration</a>, Institute of Public Care (2014)</li> </ul>
	ii An active, well-attended care provider forum is in place and there is regular engagement between commissioners and care providers.		
	iii Commissioning with input from those with care and support needs.		
5.2 Shared contractual mechanisms and shared system-wide ambitions	i Implementing the EHCH care model as part of a wider whole systems integration initiative.	<ul style="list-style-type: none"> <li>How would implementation of an EHCH care model in your area fit with the wider Sustainability and Transformation Partnership (STP) and local initiatives in your area? How does it link to QIPP and CQUIN-related plans?</li> <li>Are local health and social care leaders supportive of implementing the EHCH care model in your area?</li> <li>Which elements of the EHCH care model are already funded via a GP-LES/LCS agreement in your area?</li> <li>Is there a forum through which commissioners and care providers can discuss planned transformation work?</li> <li>To what degree is there a shared approach, or ambition, for a common set of outcomes across health and social care to drive local commissioning of residential, nursing and domiciliary care?</li> <li>What formal and informal mechanisms and forums exist locally to support integrated working between CCG and local authority commissioners?</li> </ul>	<p><b>Vanguard case studies and resources:</b></p> <ul style="list-style-type: none"> <li><a href="#">Wakefield Care Home Vanguard – Alliance contract 'How did they achieve it?'</a></li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li><a href="#">NHS Standard Contract 2016/17 Technical Guidance s14.1-14.2</a>, NHS England</li> <li><a href="#">Managing care home closures</a>, NHS England Quick guide (2016)</li> <li><a href="#">Managing care home closures: Management checklist</a>, NHS England and partners (2016)</li> <li><a href="#">Managing care home closures: Stakeholder duties and powers</a>, NHS England and partners (2016)</li> </ul>
	ii Development of risk-sharing and gain-sharing mechanisms.		
	iii Introduction of a common set of outcomes across health and social care commissioning.		
	iv Shared system leadership and the development of a shared culture of working and trust at operational level.		

## 5. Joined - up commissioning and collaboration between health and social care

Sub-element	Component	Implementation prompts	Support available
5.3 Access to appropriate housing options	i The services provided as part of the EHCH care model are extended to those living in the community where beneficial.	<ul style="list-style-type: none"> <li>• What arrangements are in place for provision of housing adaptations? (e.g. equipment such as grab rails).</li> <li>• Are these integrated across NHS, social care and housing providers?</li> <li>• What process is in place to ensure those with health and care needs supported to live in fit for purpose housing?</li> <li>• Are extra care or supportive living arrangements available for those with needs, who do not wish to move to residential care?</li> </ul>	<p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Health and housing</a>, NHS England Quick guide</li> <li>• <a href="#">Supporting patients' choices to avoid long hospital stays</a>, NHS England Quick guide</li> <li>• <a href="#">Template Policy: Supporting patients' choices to avoid long hospital stays</a>, NHS England and partners (2016)</li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Resources from the Housing LIN</a>, Housing Learning and Improvement Network (LIN)</li> <li>• <a href="#">Resources to help staff delivering housing with care and support services</a>, Skills for Care</li> </ul>
	ii Facilitation of a range of support housing options which enable people to live as independently as possible.		
	iii Partnership working to encourage the development of housing which meets the requirements of those with care and support needs.		
5.4 Equality and health inequalities	i Adherence to the Equality Act 2010.	<ul style="list-style-type: none"> <li>• As you implement the EHCH care model have you and your partners given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it?</li> </ul>	<p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Guidance for NHS commissioners on equality and health inequalities legal duties</a>, NHS England (2015)</li> </ul>
	ii Reducing health inequalities	<ul style="list-style-type: none"> <li>• Have you given regard to the need to reduce inequalities between residents in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities?</li> </ul>	

## 6. Workforce development

### What the framework says

- Underpinning the success of the EHCH model is a skilled and confident workforce that is committed to partnership working. Workforce development within an EHCH builds upon the existing learning and training opportunities to ensure that staff who are employed by social care providers receive a wide range of training and development opportunities.
- The EHCH also undertakes joint workforce planning in order to ensure a sustainable supply of appropriately skilled staff. This helps to ensure that care home residents receive the best available care within the home.

### Who might be best placed to think this through?

- This section is most relevant to CCG and local authority commissioners, with input from community teams, GPs, MDTs, the acute sector, and care home providers.

6. Workforce development			
Sub-element	Component	Implementation prompts	Support available
6.1 Training and development for social care provider staff	i Investment in professional development for care home managers, nurses and care practitioners.	<ul style="list-style-type: none"> <li>• How is training and ongoing learning supported for care home staff?</li> <li>• What training programmes with social care providers do health and social care commissioners and acute providers fund, offer or facilitate?</li> <li>• What percentage of care home staff has been offered training in complex conditions (end of life care [EoLC], dementia and falls)?</li> </ul>	<p><b>Vanguard case studies and resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">N&amp;E Herts – Complex Care Premium and pathway champions - focusing on workforce to improve care</a></li> <li>• <a href="#">Sutton CCG - Integration, education and quality</a></li> <li>• <a href="#">Sutton CCG – Upskilling staff in care homes</a></li> </ul> <p><b>Policy and learning</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Teaching Care Home</a>, a ground-breaking, nurse-led pilot to improve the learning environment for staff working in homes, undergraduate nurse apprenticeships and all learning placements in care homes. Care England / Department of Health</li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Skills for Care learning and development pages</a></li> <li>• <a href="#">SCIE care provider pages</a></li> <li>• <a href="#">Royal College of GPs (RCGP) eLearning resources (may require registration or log-in)</a></li> <li>• <a href="#">Accredited Care Navigation Training</a>, West Wakefield Health and Wellbeing</li> <li>• Nursing times / Care England Microsite               <ul style="list-style-type: none"> <li>- <a href="#">resources for Older People Nurses</a></li> <li>- <a href="#">resources for Learning Disability Nurses</a></li> <li>- <a href="#">Care sector resources</a></li> </ul> </li> </ul>
	ii The EHCH increases the confidence and proficiency of staff employed by social care providers in caring for care home residents, particularly those with complex needs.		
	iii Care practitioners are trained in competencies such as wounds management, nutrition and falls.		
	iv All care home staff have access to training on complex conditions.		



## 6. Workforce development

Sub-element	Component	Implementation prompts	Support available
6.2 Joint workforce planning	<b>i</b> Joint workforce planning across NHS, local government and social care providers.	<ul style="list-style-type: none"> <li>• What mechanisms are in place to allow the local health and care system to jointly plan for staff needed in social care, community and acute settings?</li> <li>• Do these include representatives of social care providers?</li> <li>• To what degree are your workforce and training aspirations embedded in contracts for care homes and health providers?</li> <li>• Is a workforce plan in place for staff across the system?</li> <li>• Is your area considering any of the following?               <ul style="list-style-type: none"> <li>- Care coordinators</li> <li>- Nurse practitioners (including specialists in frailty, older people's care and learning disabilities)</li> <li>- GP practitioners</li> <li>- Pathway champions within care homes e.g. end of life care and falls champions</li> </ul> </li> </ul>	<p><b>Vanguard case studies and resources:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">E&amp;N Herts - Focusing on workforce development to improve care</a></li> <li>• <a href="#">E&amp;N Herts – Discharge to assess / Development of trusted Assessor role</a></li> </ul> <p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Skills for Care - finding and keeping staff</a></li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">The Calderdale Framework</a> - Provides a systematic, objective method of reviewing skill, role and service redesign</li> <li>• <a href="#">WRaPT Strategic workforce planning tool</a>, Health Education England [North West]</li> <li>• <a href="#">Resources on values based recruitment</a>, Health Education England (2016)</li> </ul>
	<b>ii</b> Progress towards integrated health and social care teams, including care provider staff.		
	<b>iii</b> Joint action to address local recruitment and retention issues.		
	<b>iv</b> Work to introduce and test new roles which support the viability of the EHCH care model.		

## 7. Data, IT and technology

### What the framework says

- To fully realise the EHCH model, care homes and health and care partners need fit for purpose digital infrastructure, confident and trained staff, and a system-wide awareness of the opportunities which technology enabled care homes offer for residents, managers, clinicians and commissioners.

### Who might be best placed to think this through?

- This section is relevant to CCG and local authority commissioners, with input from GPs and care home providers. You may wish to draw upon detail from your area's local digital roadmap (LDR).

7. Data, IT and technology			
Sub-element	Component	Implementation prompts	Support available
Privacy impact assessment.	i Privacy impact assessment.	<ul style="list-style-type: none"> <li>When implementing the data, IT and technology elements of the framework, a privacy impact assessment (PIA) should be completed and evidenced to help commissioners understand what information is required and why, including identifying any privacy risks and mitigating these where possible.</li> <li>This in turn will also help query the necessity for any required identifiable information and compliance with the Data Protection Act</li> <li>Have local Information governance considerations been explored for necessary advice and guidance?</li> </ul>	<p><b>Vanguard case studies and resources</b></p> <ul style="list-style-type: none"> <li><a href="#">Sutton CCG – Quality dashboard – ‘what’s been the impact and how does it work?’</a></li> <li><a href="#">E&amp;N Herts – Medeanalytics</a></li> </ul> <p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li><a href="#">Guidance on risk stratification</a>, NHS England</li> <li><a href="#">Nuffield Trust - Choosing a predictive risk model: a guide for commissioners in England</a></li> <li><a href="#">Nuffield Trust - Predicting Social Care Costs</a></li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li><a href="#">NHS England Population Health Analytics network</a> (via FutureNHS platform, requires log-in)</li> </ul>
7.1 Linked health and social care data sets	ii Use of business intelligence and population health analytics.	<ul style="list-style-type: none"> <li>Are integrated data sets available?</li> <li>Can the CCG identify admissions to acute care from care homes?</li> <li>Is a risk-stratification approach in place to guide who MDT and dementia teams draw upon on?</li> <li>If so, which business intelligence systems are you using?</li> <li>Which services have been tailored and therefore changed as a result of your population segmentation and risk stratification?</li> <li>Which preventative services are now delivering as a result of this population segmentation?</li> <li>What is the impact on the residents?</li> </ul>	

## 7. Data, IT and technology

Sub-element	Component	Implementation prompts	Support available
7.2 Access to the shared care record and secure email	i Interoperability of IT systems, including access to shared, integrated care records.	<ul style="list-style-type: none"> <li>• Can clinicians and care home staff access results and reports from community and primary care?</li> <li>• Is your area working towards a shared care record?</li> <li>• How will this be made available to social care providers?</li> </ul>	<p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Sharing patient information</a>, NHSE Quick guide</li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Information Governance toolkit</a>, NHS Digital</li> <li>• <a href="#">Information on Patient Online proxy access</a>, RCGP Learning</li> <li>• <a href="#">Joining NHS Mail</a>, NHS Digital</li> </ul>
	ii Adoption of the Information Governance Toolkit and compliance with Caldicott 3.	<ul style="list-style-type: none"> <li>• Are information governance agreements in place between system partners?</li> </ul>	
	iii All care home providers are supported to adopt secure email via NHS Mail 2 or alternatives.	<ul style="list-style-type: none"> <li>• What percentage of care homes in your area use NHS Mail or other secure email solutions?</li> <li>• Is there an offer from the CCG or local authority to help them adopt these systems?</li> </ul>	
7.3 Better use of technology in care homes	i Telemedicine and secure video links between GPs, community teams, clinical hubs, and care homes.	<ul style="list-style-type: none"> <li>• Do you understand what IT systems are in use in care homes (both nursing and residential) in your area?</li> <li>• Do you know what systems are in use across GP practices?</li> <li>• How are care homes and their staff currently supported to develop their IT capabilities?</li> <li>• How is technology currently used to support service delivery, such as telemedicine, virtual clinics and health apps?</li> <li>• Do the CCG, acute trust, local authority or care homes have any plans or aspirations around Technology Enabled Care?</li> </ul>	<p><b>Vanguard case studies and resources:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Airedale and Partners Telehealth Hub Guide</a></li> <li>• <a href="#">Airedale &amp; Partners - Telehealth opportunities</a></li> </ul> <p><b>Policy and learning</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Technology Enabled Care Services</a>, NHS England</li> <li>• <a href="#">Transforming social care through technology</a>, LGA / Institute of Public Care (2016)</li> </ul> <p><b>Best practice guidance</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Technology in care homes</a>, NHSE Quick Guide</li> </ul> <p><b>Tools and useful resources</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Technology Enabled Care Services Resource for Commissioners</a>, NHS England (2015) - developed by NHS commissioners to help maximise the value of technology enabled care services for patients, carers, commissioners and the whole health economy</li> </ul>
	ii Appropriate use of sensors and monitoring technology.		
	iii Use of assistive technology.		
	iv Enabling digital infrastructure and equipment.		
	v Pro-active and jointly defined programmes of training and familiarisation around technology for care home staff.		

## Glossary

### Asset-based approach

An asset-based approach seeks to mobilise the skills, capacities or resources available to individuals and communities which could enable them to gain more control over their lives and circumstances. Assets could include the practical skills, capacity and knowledge of local residents; the passions and interests of local people that give the energy to change; the networks and connections in a community; the effectiveness of local community and voluntary associations; and the resources of public, private and third sector organisations that are available to support a community.

### Capitated funding approaches

A capitation is the amount of health service funds to be assigned to a person for the service in question, for the time period in question, subject to any national budget constraints. Capitations are usually varied according to an individual's personal and social characteristics, using a process known as risk adjustment. In most nations, the intention is that the risk-adjusted capitation should represent an unbiased estimate of the expected costs of the citizen to the health care plan over the chosen time period (typically one year).

### The Care Act 2014

Sets out a modern legislative framework for social care, creating a strong focus on wellbeing and prevention.

### Care coordination

Involves deliberately organising patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

### Care homes

The guide refers to 'care homes' throughout – this is used as a term covering both residential and nursing homes.

### Care pathway

Leads the healthcare commissioner, provider or clinician through the entire care process and patient experience for a given clinical condition – one that displays the clinical steps linked together along a timeline that structures the entire care process. Care pathways have locally agreed standards, based on evidence, where available to help a person with a specific condition or diagnosis move progressively through the clinical experience.

### Care plan

There are many different terms for care plans used across different care settings and for different conditions and purposes. A few examples are given below:

- Advance care plan, which makes clear a person's wishes in anticipation of a deterioration in their condition in the future and their preferences for end of life care
- Discharge plans for people being discharged from hospitals or other care settings
- Education, health and care plan for children and young people with special educational needs and disabilities
- Emergency health care plans or crisis care plans
- Health action plans for people with learning disabilities
- Mental health recovery plans
- Person-centred care plan – often used in social care.

This guide refers to 'care plans'. Whatever the plan is called, the aim should be for a single plan to be developed that includes all aspects of an individual's health, wellbeing and life.

### Care package

Refers to an organised schedule of support (including direct care) that an individual has agreed with their GP, specialist and/or social worker.

### Carer

Anyone who cares, unpaid, for a friend or family member who due to illness, disability, mental health problem or an addiction cannot cope without their support.

### Case management

The process of planning, coordinating, managing and reviewing the care of an individual. There are different models of case management in chronic care. However, the broad principle is to assign each person a 'case manager' to assess resident's needs; to develop a care plan arrange suitable care; monitor the quality of care; and maintain contact with the person and their family.

### Comprehensive Geriatric Assessment (CGA)

The gold standard for the management of frailty in older people is the process of care known as Comprehensive Geriatric Assessment (CGA). It involves a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health and has been demonstrated to be associated with improved outcomes in a variety of settings.

## Glossary

### Co-commissioning

Different commissioning bodies aligning strategies whilst retaining direct responsibility for resources.

### Commissioning

Refers to the commissioning of whole services, organisations and clinical pathways.

### Commissioning for Quality and Innovation (CQUIN)

The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

### Commissioners

Refers to the organisations, agencies and/or departments who have provided the majority of financial resources to any programme, pilot or services.

### Continuity of care

Arrangements in place that ensure any health, care and support arrangement/intervention is carried out to ensure the least disruption to the service user/patient.

### Direct payments

One way of managing a personal health budget is a direct payment where money is given directly to an individual or their representative for the management of their NHS care. This option became legal on 1 August 2013 and is in addition to the pre-existing legal options for managing a personal health budget - by the NHS, or through a third party.

### EPaCCS electronic palliative care coordination systems

Previously known as locality registers, electronic palliative care coordination systems (EPaCCS or KIS for short) allow GPs and other healthcare professionals to share information about those patients who have been identified as likely to be in the last year of their lives. EPaCCS enable the recording and sharing of people's care preferences and key details about their care with those delivering care. The systems support coordination of care and the delivery of the right care in the right place, by the right person, at the right time.

### Holistic needs assessment

A process of gathering information from an individual in order to inform discussion, which focusses on the whole person. Their entire wellbeing is discussed – physical, emotional, spiritual, mental, social and environmental needs.

### Integration

Integration involves joined up, coordinated health and social care that is planned and organised around the needs and preferences of the individual, their carer and family. This may also involve integration with other services, for example education or housing.

### Intervention

In the context of this document, both medical and non-medical interventions are considered. This includes activities, programmes, or offers of support which enable people to have a more active role in their own care, or to experience improved outcomes, such as education programmes, information to support decision making, or peer support, as well as medical interventions which might include drugs or treatments to improve, maintain or assess a person's health.

### Lack of capacity

As defined in the Mental Capacity Act 2005 "...a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain" .

### Link workers

Provide a signposting or facilitator role and act as a bridge between healthcare services and community services. They help people to understand what options are available to them in their local area.

### Medicines review

Many care home residents have multiple and complex conditions. These conditions can change, and the medicines that residents receive to treat these conditions need to be reviewed regularly to ensure that they remain safe and effective. A definition of medication review is "a structured, critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication related problems and reducing waste".

### Multidisciplinary and Multiagency team working

Involves appropriately utilising knowledge, skills and best practice from multiple disciplines and across service provider boundaries, e.g. health, social care or voluntary and private sector providers to redefine, re-scope and reframe health and social care delivery issues and reach solutions based on an improved collective understanding of complex patient need(s).

### NHS Continuing Health Care (NHS CHC)

A package of care that is arranged and funded solely by the NHS for individuals who are not in hospital but who have complex ongoing healthcare needs.

## Glossary

### Partners

Refers to everyone who has a professional interest and is directly involved in the design, development and delivery of a service.

### Peer support

Where people with shared experiences come together to offer empathy, understanding and mutual help. It can range from informal, social support, to more formalised programmes where individuals might be referred to a peer support worker who is trained to help people plan how to manage their health and wellbeing.

### Personal health budgets

An amount of money to support an individual's identified healthcare and wellbeing needs, planned and agreed between them, or their representative, and their local NHS team. At the centre of a personal health budget is a care plan. The plan sets out the individual's personal health and wellbeing needs, the health outcomes they want to achieve, the amount of money in the budget and how they are going to spend it. Personal health budgets can be used to pay for a wide range of items and services, including therapies, personal care and equipment, allowing individuals to have more choice and control over the health services and care they receive.

### Personalisation

Recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support. Personalised approaches involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives.

### Person-centred care

To an individual it means: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me." (National Voices, A narrative for person-centred coordinated care). Residents and their carers are equal partners with health professionals in planning, developing and assessing care to ensure it is most appropriate to their needs. It involves putting individuals and their families at the heart of all decisions and requires a different kind of interaction between residents and healthcare professionals.

### Pooled budgets

Combine funds from different organisations to purchase integrated support to achieve shared outcomes. This will enable organisations to build on previous joint working experience in order to purchase truly integrated care services.

### Quality Improvement Plans (QIPP)

QIPP stands for Quality, Innovation, Productivity and Prevention. It is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver, while making efficiency savings that can be reinvested into the NHS.

### Reablement

A short term service which involves, typically, six weeks of intensive home-based support to help people recover independence following crisis or hospital discharge. It involves the use of focused support and therapy to help people regain daily living skills and become able to do things for themselves again after an illness or accident. It can also include the provision of equipment and aids to help people live more independently in their own homes.

### Rehabilitation

A multidisciplinary process which supports the individual to achieve their maximum potential to function physically, socially and psychologically through support and intervention.

**Risk stratification** is a systematic process that can be used for commissioning as it identifies a population at higher risk of a specified outcome, e.g. unscheduled admission to hospital, from people with a lower risk. **Case finding** is a systematic or opportunistic process that identifies individuals (e.g. people with COPD) from a larger population for a specific purpose, for example, 'flu vaccination. These concepts combine in **risk stratification for case finding**, which is a systematic process to identify sectors of the population that may benefit from additional clinical intervention, as directed by a lead clinician such as the patient's GP.

### Self-care

Includes the actions people take for themselves, their children and their families to stay fit and healthy, from knowing when and how to take medicines and treating minor ailments, to seeking help when you need it.

### Unmet needs

Where care and support needs have been identified but cannot be addressed due to treatments or services being unavailable, inadequate or unsuitable.

### Voluntary and community sector (VCS)

Sometimes referred to as the third sector, VCS is a common umbrella term for organisations such as charities, third sector organisations, not-for-profit organisations, community groups, social enterprises, civil society organisations and non-governmental organisations.



Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

**This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.**

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**Our values:**  
clinical engagement, patient involvement, local ownership, national support