The care home clinical lead

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PCN Network

Leadership through COVID-19 and beyond

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Background

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

Good practice features of the clinical lead role

Service feature	Description
Clinical leadership to the local MDT	

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

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

Good practice features of the clinical lead role…continued

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

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Good practice features of the clinical lead role…continued

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