Enhanced Health in Care Homes

A guide for care homes

1st Edition – 18 January 2021

Introduction

The NHS Long Term Plan contained a commitment to roll out the Framework for Enhanced Health in Care Homes (V2) across England between 2020 and 2024.

This document explains what the Enhanced Health in Care Homes (EHCH) programme is, how to make it work in the best way possible for people living in care homes and the people who care for them, and what everyone involved can expect from it. We hope it reassures you that being actively involved in the EHCH programme should not require a significant change to the way you work, instead, you should see increased support into the home from health and care services

This guide is intended for Registered Managers of care homes and care home staff in England but may be of interest to a wider group, including health care professionals.

With thanks to the Enhanced Health in Care Homes policy team at NHS England and Improvement for their advice on the content.

Foreword

“People who happen to live in care homes have the same right to access to healthcare as any other citizen. Many of them will have significant healthcare needs which require support beyond that delivered by the care home. The Enhanced Health in Care Homes service provides a clear framework for delivering healthcare through the support of a multi-disciplinary team including primary care, specialists, community-based care services and care home staff. The Care Provider Alliance looks forward to continuing to work with our members and our health colleagues to ensure all care homes have access to this support.”

Kathy Roberts, Chair, Care Provider Alliance

“The Enhanced Health in Care Homes service addresses some of the health inequalities of care that exist for many of those living with dementia and with a learning disability but also for many of the half a million residents living in care homes in England. It takes into account some of the wider issues of health which are important to our residents such as nutrition, oral health as well as addressing areas such as medication and coordinated support at the end of life. The service is designed to help local teams of professionals work together to deliver seamless care and this comes together in a multidisciplinary meeting. We hope that by bringing teams of professionals together to focus on the needs of individual residents that we can support a much more personalised approach to care which shall help support better outcomes in the future.”

Dr Adrian Hayter, GP Partner and National Clinical Director for Older People and Integrated Person Centred Care

“Almost 30,000 adults with learning disability live in residential social care. People with learning disability have higher rates of physical and mental health problems and they also die at a much younger age than the general population. The COVID pandemic has highlighted the vulnerability of this group and the even higher death rates not just from COVID but from other health conditions. The Enhanced Health in Care Homes service provides a significant opportunity to address these inequalities and to provide the support and facilitation for timely and appropriately adjusted healthcare.”

Dr Roger Banks, National Clinical Director for Learning Disability and Autism, NHS England and Improvement)

“The majority of care home residents (about 70%) have dementia and the condition is often unrecognised. The EHCH service presents a unique opportunity to raise awareness of the importance of dementia and to ensure a person centred approach to care. Improved understanding of dementia can also enhance job satisfaction for caring staff. The COVID pandemic has underscored the need for high quality dementia care, to communicate with residents who may have difficulties in expressing symptoms and may not appreciate the need for isolation from family and friends.”

Professor Alistair Burns, National Clinical Director for Dementia and Older People’s Mental Health, NHS England and Improvement

Contents

Background

People living in care homes should expect the same level of health care support and treatment as if they were living in their own home. We know there are some great examples of how this happens across the country, but we now have a national policy to support everyone living in a care home to access the healthcare they need, with a new way of working developing in primary care. Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.

This level of support can only be achieved through collaborative working between health, social care, Voluntary, Community and Social Enterprise (VCSE) sector and care home providers.

Through working across organisations in a co-ordinated way the individual will receive better, more co-ordinated and proactive care, delivered where they live. We know this can support:

- better outcomes for people through better management of their long-term condition(s)
- a reduction in unplanned hospital admissions
- a reduction in hospital as the place of death.

For the care home and other Multi-Disciplinary Team (MDT) members the benefits of building trusted working relationships will allow the whole system to work more effectively and efficiently, and to deliver care and support that matters to people in their home environment.

Aligning care homes to Primary Care Networks (PCNs)

For the purposes of the EHCH programme a 'care home' is defined as a Care Quality Commission (CQC)-registered care home service, with or without nursing. Whether an individual home is included in the scope of the EHCH service will be determined by its registration with CQC.

In order to bring the EHCH service in to being, Clinical Commissioning Groups (CCGs) have a key role in aligning/linking all eligible care homes to an individual Primary Care Network (PCN). It is the CCG's responsibility to make sure that each eligible care home in its area is aligned to a PCN, and initial alignment of homes to PCNs took place in July 2020. It is important that this alignment is defined and agreed jointly between the care home, the CCG and the relevant PCN.

If you don't know which PCN your care home is aligned to, please contact your PCN Clinical Lead (if known), or your CCG.

In aligning care homes to the PCN, PCNs and CCGs are expected to consider:

- where the home is located in relation to GP practices/PCNs
- the existing GP registration of people living in the home
- what contracts are already held between CCG and GP practices to provide support to the home, or directly between the home and practices
- existing relationships between care homes and GP practices.

Some people living in the home may not be registered with a practice in the aligned PCN. In order to receive the EHCH service, the resident might wish to consider changing their registered GP to one who is in their aligned PCN.

This is the resident's choice, and they should be fully involved and supported with the decision they make. In supporting residents to re-register with a GP practice in the aligned PCN area, care homes, PCNs and CCGs should describe the benefits offered under the EHCH service, and consider the use of advocacy services to support this transition.

You should check out with the CCG/PCN what work they have done to help describe the benefits, but it will be important you are able to describe them to your team and each resident and their family. You might need to read through the rest of this document to help you understand more about the benefits, so you feel confident in explaining them.

For an explanation of these benefits, see information below on the EHCH service. Residents who decide to remain with their GP who is not in their aligned PCN will still

be entitled to receive primary care services, but may not benefit from the full EHCH service.

About Primary Care Networks (PCNs)

Since the NHS was created in 1948, the population has grown and people are living longer. Many people are living with long term conditions such as diabetes and heart disease, or suffer with mental health issues and may need to access their local health services more often.

To meet these needs, GP practices have begun working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in primary care networks.

Primary care networks build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. Clinicians describe this as a change from reactively providing appointments to proactively caring for the people and communities they serve.

Primary care networks are based on GP registered lists of patients, typically serving communities of around 30,000 to 50,000 people. They are small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between GP practices and others in the local health and social care system.

The Enhanced Health in Care Homes (EHCH) service

The EHCH service moves towards proactive care that is centred on the needs of individual residents, their families and care home staff. Such care can only be achieved through the whole system working together.

The minimum standards for this service are outlined in the Network Contract Directed Enhanced Service (DES) - which describes the responsibilities of PCNs, and the NHS Standard Contract - which describes the responsibilities of providers of community services. These are:

- Every care home aligned to a named PCN
- Every care home has a named clinical lead
- A weekly ‘home round’ or ‘check in’ with residents prioritised for a review based on care home advice and the MDT clinical judgement (this is not intended to be a weekly review for all residents)

- Within 7 days of re/admission to a care home, a resident should have a person-centred holistic health assessment of need (will include physical, psychological, functional, social and environmental needs of the person and can draw on existing assessments that have taken place outside of the home, as long as it reflects their goals)

- Within 7 days of re/admission to a care home, a resident should have in place personalised care and support plan(s), based upon their holistic assessment

- The Network Contract DES: Structured medication reviews also has a contractual requirement to prioritise care home residents who would benefit from a Structured Medication Review (SMR)

Elements of this service were stood up quickly in May 2020 to support care home residents through the first wave of the COVID-19 pandemic. This interim service transitioned to the more comprehensive service described in the Network Contract DES and NHS Standard Contract from 1 October 2020. All elements of the Network Contract DES and NHS Standard Contract service are now live and should already be in place.

If you feel that any of the above elements are not in place for your care home or have any questions about elements of the service for your care home you should contact your PCN Clinical Lead in the first instance. If you do not know who your PCN Clinical Lead is, then please contact your CCG to find out.

The minimum service requirements described in the Network Contract DES and NHS Standard Contract are the building blocks on which the rest of the framework can be built. Implementing the good practice EHCH model as it is described in the framework, will help support some important principles such as that:

- ✓ People living in care homes have access to enhanced primary care and to specialist services and maintain their independence as far as possible by reducing, delaying or preventing the need for additional health and social care services.

- ✓ Staff working in care homes feel at the heart of an integrated team that spans primary, community, mental health and specialist care, as well as social care services and the voluntary sector.

- ✓ Budgets and incentives are aligned so that all parts of the system work together to improve people's health and wellbeing.

- ✓ Health and social care services are commissioned in a coordinated manner, and the role of the social care provider market is properly understood by commissioners and providers across health and social care.

The PCN clinical lead role

The PCN clinical lead has responsibility for oversight of the service provided to care home residents, in line with the contractual requirements in the Directly Enhanced Services (DES) contract. The clinical lead also has responsibility to ensure the service is delivered in line with best practice as set out in 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 EHCH 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. More detailed information on the Clinical Lead role can be found here.

The Multi-Disciplinary Team (MDT)

Each care home will be supported by a multidisciplinary team (MDT) in its aligned PCN.

People who might be part of the MDT include (but are not limited to): care home staff; PCN staff; community service provider staff; social care staff; VCSE workers.

People who work in a care home know the people who live in the care home far better than a visiting health professional, and the EHCH framework fully recognises this expertise to create the foundations for a truly collaborative way of working together across health and social care. Care home staff are a key foundation and critical part of the MDT.

The care home's MDT should focus on developing a full picture of each resident/person being discussed, not just their apparent health issues but inclusive too of the things that makes that person an individual. There are already some great examples of care plans operating in care homes based around the person, with a focus on the individual. The MDT will need to build on this, rather than duplicate.

The exact make up of each MDT will be determined by a number of local factors including the type and size of the home. For example, a small learning disabilities home where residents are often out at work will have very different needs to a larger nursing home caring for older people with different complex needs and long term health conditions including dementia. This will mean their MDT needs to reflect the local circumstance, to best meet the needs of those residents.

Some MDT members will be co-opted in, for example those whose professions exist in smaller numbers and serve larger populations, such as dietitians or speech and language therapists (see Annexe C for suggestions of who might participate in the MDT meeting).

The MDT should have input into the weekly home round, the function and format of this also determined locally by the needs of those resident in each particular care home, and those in need of MDT review. Each care home should be actively involved in agreeing how the MDT will be organised and work. It is important that this is not seen as your administrative responsibility and you should agree locally how this will work well for the home you lead.

The MDT should review the information available to them prior to the meeting taking place, and work together to determine the appropriate response to needs identified (e.g. clinical input from the MDT; onward referral to a co-opted MDT member or other; maintenance of current personalised care and support plan).

This list is not intended to be exhaustive, and other responses will also be appropriate. The information available to them may include: clinical history, care history, current concerns, latest assessments, the person's personalised care and support plan, if they have one. MDTs should determine locally what information they require and agree who will provide which part.

The MDT provides a proactive and preventative approach to support people living in a care home. The MDT uses a partnership approach to clinical governance and decision making with social care staff being core team members. Membership of the MDT will vary depending on the local expertise and resources available and the needs of the care home population.

MDTs and dementia care

Given the high percentage of people living in a care home with dementia (whether diagnosed or not), the MDT approach will provide individuals with dementia and mental health conditions access to the right care when they need it. It will improve the care of people with dementia by taking a holistic view of their mental and physical health and enables input from team members from multiple disciplines and service providers. The expertise of care homes working with people with dementia will make an important contribution.

It is crucial for all members of the MDT to understand dementia and mental health conditions due to prevalence amongst care home residents. Expertise from within the MDT can be shared across the team by making use of shared learning opportunities and resources.

For people who do not have formal diagnosis confirmed on their GP medical record and recorded through the CCG , this will be a great opportunity to ensure people have an equal opportunity to have diagnosis confirmed and to provide them and their family access to expert support.

The weekly home round

The home round usually follows the MDT meeting, with all MDT members agreeing the most appropriate clinician to assess the person on each occasion (this will be determined by clinical need and the skills within the MDT, noting that skills are likely to be enhanced and change over time).

Not every resident reviewed by the MDT will need to be seen during the weekly home round. The MDT may agree another course of action is more appropriate. In cases of small care homes with a stable resident population, the care home and MDT may agree that there is no resident requiring clinical review that week, in which case the home round may consist of a 'check in' to the care home in order to confirm that.

It is best practice for the home round to be led by a clinician with advanced assessment and clinical decision-making skills, and must include appropriate and consistent medical input from a GP or geriatrician, with the frequency and form of this input determined on the basis of clinical judgement.

Review dates should be set for each clinician to follow up. The individuals personalised care and support plan may be updated in line with any jointly agreed decisions made during the home round.

What to expect

By now your aligned PCN should have made contact to discuss forming your care home MDT and your weekly home round, and they should be taking place regularly.

If this hasn't happened, please contact your named PCN clinical lead to discuss arrangements for your home. If you don't know who your named PCN clinical lead is, please contact your local CCG.

The way the home round will happen will be locally determined, based on the needs of the residents you care for. The make-up of the MDT will also be determined by the type of home, the needs of the residents living there, and the availability of locally

commissioned health and care services. It is worth noting that the MDT might meet virtually prior to the home round so all team members can input to the conversation and agree which residents need a review as part of the home round. Not every member of the MDT needs to be present at every home round.

As a member of the care homes MDT, you must be involved in the discussion of the setting up and running of the home round. As a minimum, an identified and consistent person(s) from the home should be routinely part of the MDT and home round. You can decide who might best fill this role for your own home. This could be staff who take the clinical lead within the care home, the manager or deputy, a registered nurse or team leader, or a unit manager or clinical lead in larger Care Homes. This may vary in individual situations where the person leading is the person most closely involved with their care.

How to prepare for the MDT

There is no set minimum standard of information or health measurements that you will need to take with you about each resident. This will be developed together as you begin to work together and shape your weekly home rounds. Ideally, the staff member joining the MDT will have in-depth knowledge of each of the residents and access to all information held about the individuals within the home.

Capturing and sharing information

The Network Contract DES states that as soon as is practicable, and by no later than 31 March 2021, the PCN must "…establish protocols between the care home and with system partners for information sharing, shared care planning, used of shared care records and clear clinical governance"

NHS Mail is available free to all care homes, and is a secure email system which can be used for sending/receiving patient information.

CQC requirements for records and care plans will remain unchanged, and the information in these records should be used to inform the personalised care and support plans.

The comprehensive holistic assessment

For the purpose of the care home round, and in line with the EHCH framework, this assessment will include the physical, psychological, functional, social and environmental needs of the person and should include existing assessments which reflect the goals of the individual. This will include assessments you will have done with the person on (and subsequent to) admission to the home, and you will be pivotal to the completion of the comprehensive holistic assessment. How this

happens locally will depend on the dynamics and expertise of the MDT, and is likely to change and grow over time as your MDT become familiar with each other's skill sets and the MDT's expertise grows.

Personalised care and support planning (PCSP)

Personalised care is a partnership approach that helps people make informed decisions and choices about their health and wellbeing, working alongside clinical information. The new ECHC approach will support this and members of the MDT may be learning about the approach you already take.

A one-size-fits-all health and care system simply cannot meet the increasing complexity of people's needs and expectations, and personalised care gives people the same choice and control over their mental and physical health that they have come to expect in every other aspect of their life. About 40% of patients say they weren't as involved as they wanted to be in decisions about the management of their health care. The NHS Long Term Plan also committed to enabling 2.5 million people to have access to personalised care by 2024 and the training of health and care staff is an important step to realising this.

Launched recently, the Personalised Care Institute offers free, online learning which the MDT could undertake individually or as a group, dependent on their learning needs. Nationally, work is being done to explore how we undertake personalised care and support planning across different workstreams, (including EHCH) to ensure we are all sharing the same understanding of what this is and how to do it.

Clearly, a lot of detailed information about individual residents is already captured by the home, to inform their existing care plans. The Personalised Care and Support Plan will be informed by this and won't replace CQC requirements for records and care plans.

Summary of actions for care homes

- **Ensure you know which Primary Care Network your care home is aligned to**. If unsure, please contact your PCN Clinical Lead (if known), or your CCG.

- **Check if your residents are registered with a GP within the PCN** aligned to your care home. If some residents are not, you should discuss the benefits of re-registering to a GP within the PCN with them. This would include ensuring they can easily access all of the EHCH services. You may wish to discuss these benefits with the PCN, and involve an advocacy service to support this transition.

- **Check if your PCN is providing at least the minimum EHCH services** to your care home. These include: a weekly 'home round' or 'check in' with residents prioritised for a review; and within 7 days of re/admission to a care home, a resident should have a person-centred holistic health assessment of need and a personalised care and support plan(s), based upon their holistic assessment.

  If you believe these minimum services are not being provided, or have any questions about the EHC, contact your PCN Clinical Lead (if known), or your CCG.

- **Check if your aligned PCN has made contact to discuss forming your care home Multi-Disciplinary Team and your weekly home round**, and if they are happening regularly.

  If this hasn't happened, please contact your named PCN clinical lead or, if not know, contact your local CCG.

- **Ensure that you are actively involved as a member of the Multi-Disciplinary Team**. The MDT should have input into the weekly home round, the function and format of this also determined locally by the needs of those resident in each particular care home, and those in need of MDT review. Each care home should be actively involved in agreeing how the MDT will be organised and work. It is important that this is not seen as your administrative responsibility and you should agree locally how this will work well for the home you lead.

- **Work with your PCN to agree protocols for information sharing,** shared care planning, use of shared care records and clear clinical governance, by March 2021

  To support this you should check that you are using NHS Mail. This is available free to all care homes, and is a secure email system which can be used for sending/receiving patient information.

Glossary

Enhanced Health in Care Homes (EHCH) Framework is an implementation framework which supports the delivery of the minimum standard described in the Network Contract Directed Enhanced Service (DES) for 2020/21 and the NHS Standard Contract, and should be read alongside these contractual requirements.

Network Contract Directed Enhanced Service (DES) for 2020/21 includes the requirements for the delivery of Enhanced Health in Care Homes by Primary Care Networks (PCNs). The DES sets a minimum standard for support to people living in care homes. The Network Contract is an extension of the core GP contract, which must be offered to all general practices.

NHS Standard Contracts include EHCH requirements for relevant providers of community physical and mental health services. As per the DES, it sets a minimum standard for support to people living in care homes.

Primary Care Networks (PCNs) are networks based on GP registered lists, and bring together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas. Primary care networks are based on GP registered lists, typically serving natural communities of around 30,000 to 50,000. The aim is that they are small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system. PCNs are responsible for delivering the Enhanced Health in Care Homes services, in addition to other services.

Multi-disciplinary teams (MDTs) involve a range of health and care professionals, from one or more organisations, working together to deliver comprehensive care care. In the context of the EHCH service, each care home will be supported by a MDT which is aligned with the Primary Care Network. People who might be part of the MDT include (but are not limited to): care home staff; PCN staff; community service provider staff; social care staff; voluntary and community sector workers.

Annexe A: The residents' journey through the EHCH service

The ideal individual journey described here reflects what a resident's journey should look like when EHCH is fully implemented in the care home where they live. For some people this may already happen, the implementation of the EHCH service will support this to happen for everyone.

The journey is set out as an 'I statement' based on their ideal journey and experience

"I move into a care home as a new resident having had an assessment completed by the Registered Manager the week before. Within a week I've had a full holistic assessment of my physical, psychological, functional, social and environmental needs undertaken in a coordinated way by several MDT members. This has been easy to organise for the care home through a process developed jointly with the Primary Care Network (PCN). The long term conditions I'm living with have been discussed with me and my family (if appropriate) in order to identify what's important to me in any future care and treatment in relation to any of these conditions. If I struggle to communicate my wishes I would expect support to help me to do this, or if I am unable to take part in these conversations, then any decisions and plans about me should be made in my best interests.

"My personalised care and support plan has been developed with what matters to me at its core. I settle in well and then there is a change in how I'm feeling. One of the care workers notices I'm just not quite myself one day, and as the care home team have been well supported to recognise and understand signs of early deterioration, they suspect that this may be what they are seeing in me. Because the MDT is working well together, the carer feels confident to raise this immediately with the MDT, who swing into action, working alongside the team in the care home, and activate the relevant aspects of my personalised care and support plan. Further deterioration is prevented due to early notification and prompt action, and I recover well in my home.

"Where deterioration indicates that I am approaching the end of my life (within the next 12 months), as my personalised care and support plan includes information on my priorities and preferences for end of life care, advance care planning and treatment escalation plan everyone involved in my care and support is confident about what I want. My family and I are communicated with and supported by the care home MDT so we are kept aware of realistic care and treatment expectations and I am able to die in my place of choice."

Annexe B: Care Homes and Palliative and End of Life Care

Helping residents live well until they die is a core part of what people working in care homes do. Many staff are highly experienced and skilled in this. For others it may feel unfamiliar, and even scary, to care for someone in the last weeks, days or hours of their life.

Support is available in many ways, including within the team; peer support between care homes; primary care networks including district nurses, GPs, pharmacists, allied health professionals and more; hospices and palliative care teams; online. Instant messaging, WhatsApp and similar can help to share **non-confidential** information quickly and enable rapid access to support.

Questions for Care Home Managers and teams to consider:

- What education and support is available, to ensure that we all feel confident to support residents and families at end of life and into bereavement?
- If we need additional advice or support, how would we access this? What would happen if this were in the middle of the night? Or during the weekend?
- How do we support each other – residents, family, people close to them, colleagues - after someone dies? What bereavement support services are available locally?
- How do we link to our local hospice? If you're not sure, Hospice UK have a search facility which could help: https://www.hospiceuk.org/
- How do we learn about what's gone well, and what didn't? Are there any regular meetings locally or communities of practice which could facilitate discussion and learning?
- For the resident who died most recently in your care home, how confident are we that the statements below are true? What makes them harder to achieve? What would make them easier?

Statements for shared reflection

- We recognise when the last months, days and hours of someone's life are approaching.
- We help them to be as comfortable and as cared for (physically and emotionally) as they want to be throughout.
- We help them (and those around them) to understand and anticipate what may happen during the time they have left.
- We understand what really matters to them about this; how they want to live, what they want to achieve and how they want to die.
- We support them to live well in their own way, as part of their community, focusing on what matters to them together.
- We share what matters to them as appropriate, so that they are supported through times of illness in a way that feels right to them, including in the last days of their life.
- We help those close to them to feel supported throughout, including after their death.

Relationships

Relationships are key to ensuring the end of life is as good as it can be.

Attending to connections and relationships – with residents, families, colleagues within and beyond the care home – is fundamental. The wider **Multi-Disciplinary Team** may include GPs, community nurses, pharmacists, community rapid response team, rehabilitation services, mental health teams, medicine for the elderly, frailty teams and more. Depending on the local arrangements, specialist palliative care support may come from the local hospice, community palliative care teams or hospital based teams.

Support from Specialist Palliative Care Services

Each locality will have a range of Palliative and End of Life Care services. Care Home residents should expect the same level of support and access to these services as people living in their own homes. Support may be available in a number of different ways:

Direct care

Specialist palliative care teams may be involved directly in the frontline care of residents, particularly those with the most complex needs and symptom

control concerns. They may lead the clinical care, prescribing medications and reviewing residents face-to-face or via virtual consultation.

Advice and support

More frequently, specialist palliative care teams will offer advice and support to care home staff and the multi-disciplinary team to address palliative care issues and concerns.

Education to improve knowledge, skills and confidence

Many local specialist palliative care teams offer education and training. This may include education and training in having conversations with residents and families / carers about end of life, advance care planning, DNACPR, medication and equipment including the use of syringe drivers, care at the time of death including verification of death, and bereavement. This may take place online through platforms such as Project ECHO or webinars.

Links with local, regional and national networks for support

There is a range of local, regional and national networks with broad expertise in palliative and end-of-life care. Specialist palliative care services are well placed to link Care Homes with these networks where that might be helpful.

What matters most

Getting to know someone and understanding what matters to each other is key to improving end of life. This may include what the person enjoys doing day to day and who's important to them. A personalised care and support plan helps to document this. The person's preferences for care and support through times of illness, including in the last days of life, are also important. Documenting and sharing this can be through an Advance Care Plan or Treatment Escalation Plan – what's used locally varies from place to place.

Decisions about cardiopulmonary resuscitation and "Allow a natural death"

Decisions about resuscitation are important: "A DNACPR decision is an instruction not to attempt cardiopulmonary resuscitation. DNACPRs are designed to protect people from unnecessary suffering by receiving CPR that they don't want, that won't work or where the harm outweighs the benefits. Every decision about CPR must be made on the basis of a careful assessment of each individual's situation and should never be dictated by 'blanket' policies."

See also CQC report on DNARs during COVID-19.

Further information is available from the Resuscitation Council UK:

Medication in the last days of life

Medications can often be simplified at end of life. When the person is no longer able to swallow reliably, or is vomiting, **subcutaneous injections** of medication may be needed to relieve pain and other symptoms. **Syringe drivers** are a very useful way to give medication if a continuous subcutaneous infusion is needed, reducing the need for repeated injections. It is important for staff to keep skills refreshed. More information is available on the Marie Curie website.

Find out which **local pharmacies** stock End of Life medications locally. It's helpful to check you know the local arrangements for **out of hours** medication provision too.

Verifying that death has occurred

So that verification of death can take place in a timely and way, education is available via Skills for Care or locally (this may be through community nurses or palliative care services). No-one should be made to feel under pressure to verify death if they don't feel confident to do so.

After a death

It is important to acknowledge the person's death and to ensure that the family of a resident who has died, staff and other residents feel supported. This may be through peer support or bereavement services. Some care homes place a framed photo of the person who has died in a communal space, perhaps in the reception area, with a note to say they have died. Others have a memory garden or simple ritual of remembrance.

Reflecting together after a resident has died can be a helpful way to understand what has gone well, and why, and what could make it easier to support someone well at the end of their life in the future. One way to do this is described in this blog by Forest Home Hospice.

Useful resources

End of Life Practitioners Network on NHS Futures – contact Sherree.fagge@nhs.net

National Ambitions for Palliative and End of Life Care

One chance to get it right - The Leadership Alliance for the Care of Dying People

End of Life care - Health Education England

Helping to break unwelcome news - Academic Health Science Networks

End of Life care – Skills for Care resources

Project ECHO – Hospice UK

Six Steps for Care Homes – The End of Life Partnership

The Gold Standards Framework

The Daffodil Standards

Dying Matters

“Dying is not as bad as you think” You Tube BBC video

Bereavement support – The Good Grief Trust

Coping with Bereavement - NHS

Hospice UK

Hospice UK's 'Just B' Counselling and Trauma Helpline: available 7 days a week, from 8am to 8pm, by calling 0300 303 4434. It is for all NHS, care sector staff and emergency service workers.

Annexe C: People who might be involved in your Multi-Disciplinary Team

This will naturally vary from home to home, dependent upon the type of home and the residents living there, and locally commissioned services. The frequency of which the different clinicians are involved should be locally derived by all members of the MDT. This list is not meant to be exhaustive.

- Advanced Clinical Practitioner
- Advanced Nurse Practitioner
- Care home worker(s) who know the residents well
- Community Matron
- Dentist
- Dietitian
- District Nurse
- GP or Geriatrician
- Mental health Nurse/Practitioner
- Occupational Therapist
- Physiotherapist
- Pharmacist
- Practice Nurse
- Social link prescriber
- Specialist therapy teams
- Speech and language therapist
- Support workers
- The person and their family