NHS
Oxfordshire
Clinical Commissioning Group

SUPPLEMENTARY NETWORK SERVICE
Specification for Proactive GP Support to Care Homes

1 Background

This supplementary network service (SNS) aims to address the specific additional primary healthcare needs of patients in CQC registered care homes, recognising the benefits of working in partnership with the home and noting the additional input required from GP practices to ensure the highest quality of care and to avoid unnecessary hospital admissions.

All patients in nursing and residential care homes are entitled to register with a GP on arrival at a home and it is the responsibility of the care home to ensure that patients (and their relatives / carers if appropriate) are informed about the options in choosing a GP practice. The model of care recommends that each residential or nursing home should become the responsibility of one specific GP practice, with as many patients as possible registered within that practice, thus enabling the GP to deliver care to the patients in the home in the most coordinated and efficient way. The rationale for this is that the best opportunity for individualised care planning and patient management derives from a level of trust, mutual understanding and familiarity between care home staff, patient and GP.

The SNS will work alongside the Primary Care Network DES and the Care Home Support Service (CHSS). CHSS work in partnership with care home staff in all care homes with the main focus of supporting care homes to improve the care of their residents and reduce the need for emergency medical intervention and the use of the urgent care pathway.

No part of this specification by commission, omission or implication defines or redefines essential or additional services.

2 Eligibility

It is a requirement of the SNS that the practice responsible for the home will register all patients who wish to do so, potentially up to 100% of residents / patients. A practice will only be eligible to provide this service if more than 50% (where the number of beds is greater than 20) of residents of the home are registered with the practice taking on responsibility for the home as permanent patients within the time periods specified below:

Current percentage of patients registered with practice at start date	**Time available from start date to achieve 50% (phase in period)**
0 – 25%	6 months
26 – 50%	12 months

Where a practice has signed up under this scheme, it will be eligible to receive payment on a per patient basis during the phase-in period even if it is not yet providing care for the majority of patients. However, if the practice failed to reach the 50% target within the phase in period the practice would be subject to a review and would need to submit an action plan to assure the CCG that the target would be met within a reasonable timeframe or risk losing its eligibility under this scheme. If a patient should choose to register with another practice, this will not affect eligibility as long as a minimum of 50% is maintained.

Once the phase in period is successfully completed, practices will be expected to maintain the percentage of patients register with them at or above 50%. Should the number of patients in

the home who are registered with the responsible practice fall below 50% for two successive quarters, the practice may lose its eligibility to participate in the scheme.

Practices who do not meet the eligibility criteria for providing this service, or who choose not to participate, will be expected to continue to provide usual GMS services to their patients in care homes and will not receive any additional funding.

Practices will not be eligible for this service if they are already receiving a retainer, other payment or PMS premium that covers any element contained in the service specification unless this payment ceases by the time the practice signs up for the scheme. It is a requirement of the scheme that both the practice and the care home confirm that, as from the start date, there is no private arrangement for any retainer or other payment by the care home to the practice or to any GP partner / employee of the practice for services that duplicate any element of this service.

We encourage PCNs to work together to achieve complete coverage and to maintain a good quality service across the network, with a reduction in urgent care pathway activity per home and within the PCN as a whole.

3 Service Outline

The practice taking on responsibility for the home (the providing practice) will be expected to permanently register any resident of the home who is willing to transfer to them. Temporary residents who are willing should also be registered, but will not be included for the purposes of this scheme unless they subsequently become permanently registered (see section 3.1 below).

The single practice model is the preference, however there may be circumstances where two practices could share responsibility for a home, e.g. if the home is exceptionally large and if the organisation of the home leads to a natural separation based e.g. on type of service provided or level of dependency of the patients. In determining whether responsibility for the home can be shared, the views of the Care Home Manager will be taken into account.

The key feature of this service is for the practice to provide a usual GP from the practice providing the service to carry out a weekly scheduled visit at a dedicated time to review issues, queries, patients causing concern and all proactive care in conjunction with a fully-briefed senior member of staff from the care home. The visiting GP may be supported by other members of the practice team appropriate to meeting the needs of the patients e.g. a pharmacist. This will ensure that the weekly GP visiting time can be used as effectively as possible to minimise time away from the practice.

Practices could also provide the service under a collaborative model whereby a GP is employed by a single practice, PCN or Federation to deliver the regular visiting and care planning elements of the service for a number of practices. The GP could also be supported by other clinical staff employed under collaborative arrangements.

Practices providing care under this scheme are required to agree to the Oxfordshire Care Summary (OCS) so that OOH GPs and other colleagues can gain access to the key features of a patient's medical record when needed. Information will be fed directly into the OCS via the Digital Proactive Care Plan (dPCP). Practices are expected to liaise with out of hours services and other services being developed as part of the frailty pathway to ensure that patients residing in care homes have the same equal access to medical care as the rest of the population living within the community.

It is not a requirement of this scheme that all patients are reviewed weekly but only if clinically indicated. The details of the expected service under this scheme are detailed below.

3.1 Registration of Patients

All patients newly arrived at the home will be invited to register with the GP practice responsible for the home as soon as possible. Such patients should be coded as resident in a care home. It is a fundamental principle that registration with the practice caring for the home will be the choice of the patient or, if the patient is not competent to make a choice on their own behalf, of their relatives, carers or advocate, in line with the Mental Capacity Act 2005. The Care Home Manager will be responsible for ensuring that the patient, relative, carer or advocate is able to make an informed choice on the options available by providing a suitable patient information leaflet / letter.

Where possible, residents who are anticipated to be in the home on a temporary basis should remain under the care of their own GP, if local. If this is not an option, the patient should be invited to register as a temporary patient with the providing practice, transferring to permanent registration if they are still in the home after one month. The new practice taking responsibility for the patient may register them as permanent if it is expected that their stay will be over one month. NHS England recognise that sometimes this is very difficult to predict and would like to reassure practices that no action will be taken against practices who register patients as permanent in the best interest of patient care. Patients who are having short term respite admissions should only be registered as temporary residents.

The practice should ensure they have efficient arrangements to chase up medical records that have not arrived within the expected time frame and to request records urgently when indicated. Practices are also advised to carry out regular checks to ensure patients who have been temporarily registered are flagged after one month and queries raised at regular intervals with the care home to see if it would be more appropriate for them to be registered permanently.

Practices and the usual visiting GP are advised to note the key requirements in situations where patients may lack capacity. A useful summary is provided from CQC.

3.2 Initial Assessment of New Care Home Residents

It is the responsibility of the care home to provide a medical summary from the patient's previous GP including prescribed medication and, in the case of hospital discharge (including community hospital), a copy of the medical discharge summary. Other supplementary information should also be provided. It is also the responsibility of care home staff to provide baseline data on each patient – see Appendix 1. All newly arrived patients in the home will be assessed by the GP within 10 working days of arrival. An initial assessment may be performed by another competent clinician, but it is expected that face-to-face GP review will follow within this time frame. In all instances clinicians need to ensure that the medical notes are written within the patients GP records. The assessment will include the following:

Initial Care Review

- Current concerns of the care home, staff, patient and / or relatives
- Face to face assessment of patient
- Ensuring medication correct (see below)
- Baseline information captured – care home staff should already have documented on admission and recorded on Appendix 1
- Arrangements for chronic disease review, including inclusion on QOF registers, appropriate monitoring and any exception coding indicated
- Mental health review, including evidence of depression and dementia. A GPCOG is recommended if dementia is suspected which may be carried out by trained care home staff. Dementia should be diagnosed and coded on the patient record where appropriate and this should be communicated to the next of kin if not already aware of the diagnosis.

A depression questionnaire may also be useful if depression is suspected which can also be carried out by trained care home staff

- Risk of falls and to consider fracture prevention where appropriate
- Nutritional status including any problems with chewing / swallowing – care home should have already documented weight on admission and recorded on Appendix 1 and monthly thereafter
- Continence – care home staff should have already documented on admission and recorded on Appendix 1
- Visual or hearing impairments – care home staff should have already documented on admission and recorded on Appendix 1
- Status of skin and management of any skin problems and wounds – also documented on Appendix 1
- Any specific needs including palliative care and end of life care
- Ensuring preparation for Proactive Care Plans are underway (see below)

A summary of the key issues and patient's general status should be made as a consultation note.

Flu Immunisations
Practices are expected to ensure that flu immunisations are offered to all patients and provided to those who wish to take it up, either at the initial review or as part of ongoing care. The CCG may ask for a report on the number of patients offered the vaccine and the number of patients vaccinated. The practice agrees to provide this list to the CCG when requested.

3.3 Medication Reviews

Medication reviews should happen at first encounter with patient after admission, three months after admission and then six monthly thereafter. The medication reviews should be carried out by the GP or an alternative member of the practice who is competent to do so. Practices need to implement a system to ensure that medication reviews take place to the agreed schedule and that reviews are coded in the patient's medical record and review dates are updated. Any medication changes should be clearly explained to the care home staff, patient / relative as appropriate and the rationale documented in the patient medical record.

Initial and Three Month Medication Review
A printed list of medication taken from a GP medical summary plus / minus hospital discharge summary plus / minus a photocopy of a hospital drug chart or up to date FP10 should be provided on admission and the GP is advised not to accept medication that is a handwritten list from anyone else due to the risk of error in drug dose or name.

- Any inappropriate medication should be stopped or changed if no clear indication to continue, in particular 'specials' and red / blacklisted drugs under the OCCG Traffic Light system. Sip feeds should only be continued in exceptional circumstances as the care home should provide a suitable modified diet as required based on OUHFT dietician leaflets and recommendations.
- In most cases a GP will wish to wait for the patient's full medical record to arrive before deciding about stopping some drugs and a further medication review should take place three months after admission in the expectation the medical records will then be available.
- Where life expectancy is limited, medications to reduce longer term risk in chronic disease (e.g. statins; anti-hypertensives) should be reviewed and consideration given to stopping especially if side effects may be outweighing benefits (e.g. postural hypotension / falls in those on anti-hypertensives).
- Analgesics – review of efficacy, step-up or down especially where side effects e.g. constipation, may be outweighing benefits. However, all patients should have adequate analgesia where indicated.

- Drug monitoring requirements.
- Use of the most cost effective alternatives and ensuring all medication is consistent with Oxfordshire Prescribing Guidelines on ClinOx.
- Wound management is consistent with ONPOS formulary unless non-ONPOS items are advised to continue under ongoing monitoring from the local Tissue Viability Service.

Six Monthly Medication Review
These should be carried out along the same principles as above.

3.4 Proactive Care Planning

All patients in the home should have a proactive care plan completed by the GP, supported by appropriate clinical staff from the practice, within four weeks of arrival at the home. A care plan must be agreed in collaboration with the patient and / or their relatives / carers as appropriate. Ideally care planning should be done via a face to face discussion with the patient, but if the patient does not have capacity to participate, the discussion could be with a relative. If it is not possible for the relative to meet to discuss, they could be invited to complete a Thinking Ahead Form. In some circumstances it might also be appropriate for a patient to complete a Thinking Ahead Form e.g. if they find discussion difficult due to deafness. Should either the relative or the patient choose to complete the form, this will be taken into account in completing the care plan and therefore should ideally be available in time for the face to face initial assessment or at the latest within two weeks of admission.

The GP is responsible for ensuring that the care plan is completed and verifying that copies are held in the medical record and in the care home records, the latter to include an easily accessible orange summary sheet clearly outlining action to be taken in the event of exacerbation of the patient's condition (see example at Appendix 2). Patients and / or relatives should be offered a copy and have the opportunity to discuss any concerns or issues with the usual GP if required. Where patients / relatives or carers decline to contribute to a care plan this should be documented / coded but the written care plan should still be completed by the usual GP and coded.

Proactive Care Plans should include resuscitation status and where a patient expresses a preference not to be resuscitated a DNACPR form should be completed and the lilac copy lodged with the nursing home staff. The DNACPR form should also travel with the patient record if the patient moves to another care setting. The GP will ensure that Proactive Care Plans and any DNACPR forms are coded as active problems on the patient's computerised record so that this information is available via the OCS and OOH service if needed.

Practices are required to use the CCGs approved dPCP template for these patients. The dPCP software (which includes the data entry template and document templates) is already installed in all GP surgeries so should be easily accessible for use. This needs to include / document the patient / family wishes and adequate documentation so that it is clear to care home staff when and for whom it would not be appropriate to summon an ambulance for hospitalisation. Instead, the expectation would be to discuss the patient's situation with the GP practice or OOH GP. Care home staff have access to the alternative NHS 111 number to access and OOH GP if necessary. It is recommended that the GP ensures the care home has a system in place to ensure that even unfamiliar staff can access this information readily at any time.

All care plans should be reviewed at regular intervals as clinically appropriate and discussed with patients / their relative as required.

3.5 Hospital Admissions

Care homes will be provided with the NHS 111 clinician line to facilitate consultation and advice from an OOH GP to ensure patients are managed in their best interests and hospital admissions are avoided unless there is no other reasonable course of action. This applies particularly where there is a proactive care plan indicating intention to avoid hospital admission where possible.

Unplanned hospital admissions and discharges should be coded based on information from the admitting GP, including GPs working in the OOH service. Care home staff must notify the GP practice whenever a patient is admitted by ambulance. As soon as possible on notice of an admission the practice must ensure that a summary of the patients medical record, including the last three consultations and current medication should be sent to the admissions office of the relevant hospital with a cover note indicating the patient has been admitted and that the summary is for information of the attending clinicians. This will enable the quarterly review of unplanned hospital admissions.

Nursing and care home staff should facilitate the timely discharge of their patients from an acute hospital admission by accepting patients back whenever they are ready for discharge from acute care. The usual GP involved with a patient (or GP colleague from the same practice) is expected to be available to support in discharge planning arrangements from a secondary care or community hospital setting.

3.6 Palliative and End of Life Care

It would be expected that the practice should extend all usual palliative care to ensure comfort and symptoms control with regular reviews of patients in this category. It is recommended that the Gold Standards Palliative Care in Nursing Homes is adopted and promoted. Specialist expertise from the local hospices should be sought if further advice on management is required. Patients needing end of life care should be discussed in the regular palliative care practice meetings so that GP colleagues are aware of these patients if the usual GP is not available and also to identify any issues or improvements needed in end of life care.

3.7 Deaths

All deaths should be notified to the practice by the care home and coded on the practice computer system including date and place of death to enable quarterly review. GPs should be aware that deaths occurring in those subject to Deprivation of Liberty orders have to be notified to the coroner and the GP cannot issue a death certificate.

4 Scheduled Weekly Visit by GP

Practices responsible for supporting a care home will be expected to organise a scheduled weekly visit with dedicated time as appropriate to meet the needs of the patients. Consideration should be given to the appropriate use of technology such as Microsoft Teams. For smaller homes there may be some weeks where there is no clinical necessity to attend and in discussion with the care home it may be appropriate to convert this to a telephone discussion between the GP and the nurse in charge. The care home should still send a list of patients to be discussed or any queries and the call should take place at an agreed time.

The usual GP should be a partner, salaried GP or long-term locum and the weekly visit should not be delegated to a short-term locum or training GP / clinician. A GP registrar should have the opportunity to work with the usual GP in a care home when deemed sufficiently experienced and trained and may support or stand in for the usual GP on occasion. The practice should provide a GP mentor to supervise / debrief after the visit.

During the weekly visit, the GP will be expected to see patients who have become unwell, follow up those who have had a recent illness, review those recently discharged from hospital, discuss patient management issues with staff, complete medication reviews and plan the future care of patients. Visit sessions will also provide an opportunity to carry out initial

assessments of new patients and to develop care plans. Other members of the practice staff may support the GP in completing some of the above tasks at the discretion of the visiting GP. This will enable the GP to focus primarily on activities that require medical input so that his / her time is used as efficiently as possible, minimising absence from the practice whilst still maintaining the weekly GP visiting requirement.

These routine visits should be recorded as a consultation in a care home as opposed to a home visit to distinguish the routine scheduled visit from separate urgent calls to a care home. It is also recommended that the GP adopts a system of recording third party consultation if the patient is not actually seen so that it is clear, in the event of death, whether one of the requirements for completing a death certificate are met (patient seen by GP in the previous 14 days).

The visiting GP should be aware of and fulfil the obligations of the Mental Capacity Act 2005, Safeguarding and Deprivation of Liberty Safeguards (DOLS) including reporting all concerns to the appropriate authorities.

Practices may like to consider providing a print out of the consultation and any changes in medication for the home so staff are clear about actions and plans which may also avoid subsequent telephone queries.

Care homes should help make best use of time by the following:

- Complete a patient list of those to be seen / discussed with supporting information (see template in Appendix 3)
- Ensure good liaison with the practice so that patients who need to be examined are ready in a private room for the GP visit
- Ensure all information on new admissions is collected in advance and that follow-up data (e.g. to support advanced care planning) is made available
- Ensure that the GP is not expected to write in the nursing record or other paper record but that staff should make their own notes to ensure plans / actions are noted. The GP will make a written entry in the patient's computer record on return to the practice (practices can choose their own preferred way of achieving this)
- Ensure patients who are declining are reviewed by the GP especially if death is anticipated

The practice will also be expected to respond to requests to visit a patient who needs medical attention outside the scheduled visit times, but it is expected that the number of unplanned visits will reduce as proactive management of patients in partnership with the home becomes routine. It is also expected that both the GP and other clinical staff in the practice who know the care home residents and staff well will be able to manage a broader range of problems with telephone advice. Practices are encouraged to ensure that their reception staff are correctly briefed about how to pass on urgent queries from care homes staff in a timely fashion.

5 Clinical Governance Meetings

Participating practices will be required to meet on a 6-monthly schedule with the Care Home Manager and relevant staff to discuss a range of clinical governance issues as below and to document key points of note. Notes and action plans are to be shared with OCCG. Where appropriate, the GP or care home staff may invite a member of the Care Home Support Service or OCCG to participate in meetings. A suggested template for these meetings is included as Appendix 4.

- Review unplanned admissions to hospital and agree actions in response including system changes
- Review patient deaths
- Review any safeguarding issues

- Review any serious incidents in the home affecting individual
- Update any relevant local policies or protocols
- Plan for any seasonal initiatives such as flu / pneumococcal vaccinations
- Review the quality of communication between the practice and the home, and with other health or social care providers
- Discuss OCCG provided comparative data for other care homes on prescribing, unplanned admissions, place of death and other comparators and provide any comments or action plans to address any issues of concern
- Discuss any opportunities for innovation to improve the delivery of the scheme

6 Responsibilities of Care Home Manager

The Care Home Manager will be expected to support proactive GP involvement for their homes and provide feedback to relevant bodies of any concerns as follows:

- Arrange for a patient to be registered with the nominated GP practice under this scheme as soon as possible upon arrival in the home unless the patient is choosing to stay with another GP practice
- Ensure that summary patient information from the patient's pervious practice, including list of medications, is available to the GP within three days of the patient's arrival in the home as well as the completed care home admissions form (Appendix 1)
- Seek information from the patient or their relatives on their current situation, preferences and concerns (e.g. using the Thinking Ahead Form) and provide to the GP
- Make sure that the patient's medication record and any hospital provided or community service information is made available to the GP when visiting the patient
- Provide the GP with a list of patients with queries / issues prior to every weekly visit using a secure method of communication (see Appendix 3)
- Arrange for the nurse in charge / on duty to be available to discuss patients on the list with the visiting GP and accompany the GP to see any patients. Drug charts should be to hand
- Ensure that key points arising from these visits are communicated to colleagues or written in nursing notes
- Work with the GP to address medication issues in order to reduce prescribing errors and promote high quality and cost effective prescribing
- Make all reasonable efforts (including stating clearly to reception / other telephone staff when an urgent response is required) to contact the responsible GP practice during core hours, or an out of hours GP outside core hours, before arranging for a patient to be admitted urgently to hospital
- Ensure that any healthcare practitioner attending in the event of an emergency is aware of the existence of a patients proactive care plan including summary and DNACPR form and can access them
- Enable patient's relatives to be present during GP visits (if appropriate and with the consent of the patient) and facilitate communication of concerns or queries from relatives to the GP
- Make all staff familiar with the materials produced by OCCG and the Care Home Support Service for advice to care home staff about management of common conditions and how to relay appropriate information when consulting with a GP
- Provide and train staff in nursing homes to be able to carry out male and female catheterisations, use of an auriscope and check for ear wax and urine testing strips for possible infection. Also ensure suitable staff have the ability to carry out GPCOG assessment, a depression screen using a standard form and assist patients / their relative to complete the Thinking Ahead From where appropriate
- Nursing homes with over 60 residents would be expected to have a syringe driver available to support end of life care and to ensure key nursing staff are trained in its use
- Arrange for the Home Manager or deputy to attend the twice yearly Clinical Governance meetings at the practice providing this service

- Key care home staff should be trained to confirm expected death
- Care home staff are encouraged to report back to the practice and OCCG on any areas of innovation to improve the running of the scheme

7 Audit and Monitoring

Participating practices need to ensure that they are meeting all of the requirements of the specification. Practices do not need to provide a manual data return, however practices will need to be willing to provide the data in the case an audit is undertaken.

8 Payment

Practices participating in this service will be paid £250 per patient in a care home bed per year. This payment is intended to reimburse practices for the additional medical and administrative resource involved in taking responsibility for all (or a majority) of a care home's patients, carrying out the initial assessments of patients on first coming into the home, taking a proactive approach to the ongoing care of patients, including six monthly medication reviews and participating in clinical governance meetings with the care home.

Payment will be made quarterly in arrears on submission of an invoice.

Practices must submit an invoice at the end of each quarter detailing the number of patients in a care home bed at each care home they are looking after.

The following elements of the service are funded from other sources:

- All medical care provided to the patient falling within the categories of Essential and Additional Services, Directed Enhanced Services and QOF is funded through the GP Contract
- OCCG commissioned services such as Warfarin Monitoring, Near Patient Testing and Leg Ulcer Care are funded through the OCCG contract for primary care services

9 Termination

The service in its current form will be contracted between 1 October 2020 and 31 March 2021.

10 Contact

Contact for queries: occg.primarycarecontracting@nhs.net

Appendix 1: Care Home Admission Data Collection Form

Care Home Admission Form

Please note that this is not mandatory but just for convenience as care home staff can complete and pass to practice for coding for information and QOF requirements. The EMIS web template that can be downloaded and imported and used to record this data.

Name of resident	
Date of birth	
Date of admission	
Next of kin (name)	
Relationship	
Contact telephone numbers	
Can records be discussed	Yes / No
Conversation and mental alertness (please circle)	Able to converse normally
	Able to converse but some confusion evident
	Able to converse but very confused
	Unable to converse
If any apparent confusion and not known to have dementia already, please complete GPCOG if trained to do so	GPCOG score (out of 9)
	GPCOG informant (out of 6)
Smoking status (please circle)	Not known
	Current smoker
	Date ceased smoking
	Never smoked tobacco
	Ex-smoker
Weight	
Systolic blood pressure	
Diastolic blood pressure	
Mobility assessment (please circle)	Independent walking
	Stock for walking
	Uses zimmer frame
	Wheelchair dependent indoors
	Immobile
Hearing (please circle)	O/E – hearing normal
	O/E – slightly deaf
	O/E – significantly deaf
	O/E – completely deaf

	Hearing aid worn
Vision (please circle)	Blind (subjectively)
	Partially sighted (subjectively)
	Vision normal (subjectively)
Bowels (please circle)	Incontinent
	Occasional accident
	Fully continent
	Normal
Bladder (please circle)	Incontinent
	Occasional accident
	Fully continent
Bladder care (please circle)	Indwelling suprapubic catheter
	Indwelling urethral catheter
	Penile sheath provision
Skin status (please state site of any problems	Superficial pressure sore
	Deep pressure sore
	Leg ulcer(s)
	Other problems (specify)

Appendix 2: Anticipatory Care for Hospitalisation Summary sheet (to be printed on orange paper for easy identification)

Anticipatory Care Plan for Hospitalisation

This should be printed on orange paper and, when completed, kept easily visible in patient record

On the basis of the patient's wishes (where patient has capacity to make decisions of this nature), or a best interests decision (where patient does not have capacity) and taking into account the clinical situation as interpreted by the attending / usual GP the following decision has been made to guide other health workers and carers in event that urgent hospitalisation is considered:

	Patient can be admitted if clinically appropriate to do so
	Patient should not be admitted without discussion with GP. If necessary '999' / ambulance can be called for paramedic support until discussion with a GP can occur
	Patient is terminally ill / on end of life care pathway and should not be admitted to hospital

Signed: (Doctor) Print Name: Date

If review occurs, please note date of review and sign below. If status is changed please sign and date any changes against sections above.

Date of review	Signature	Print name

Appendix 3: List of patients to discuss at weekly GP visit template form

GP Visit Patient List		Date		
Rm No	**Residents Name**	**Problems**	**Duration**	**(Temp, BP, Pulse, Urine)**

Appendix 4: Clinical Governance Meeting Agenda Template

NHS
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Clinical Governance Meeting at : Name of Home
Date

Present:
Name and job titles

1 Review of Emergency Hospital Admissions

Patient ID	Date of admission	Admitted by (e.g. OOH, 999)	Reason for admission	Date of Discharge	Could admission have been avoided?	Action / notes
1						
2						
3						
4						

2 Review of Patient Deaths

Patient ID	Date of death	Place of death	Cause of death	Date of discharge	Issues / learning points	Actions
1						
2						
3						
4						

3 Safeguarding Issues / Serious Incidents

4 Local Policies and Protocols Updates

5 Seasonal Initiatives

6 Opportunities for Improvement / Innovation

7 Any Other Business