BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Oxfordshire Improvement Programme System HOSC up date

November 2022

PML Principal Med Cal

NHS South Central Ambulance Service NHS Foundation Trust

NHS Oxford Health NHS Foundation Trust

Oxfordshire County Council

NHS Oxfordshire Clinical Commissioning Group

NHS Oxford University Hospitals NHS Foundation Trust

Oxfordshire Integrated Improvement Programme: Winter 22-23

	Urgent & Same-Day Care Programme	OHFT + OUHFT Provider Collaborative	Oxfordshire Community Services Strategy
Project support provided by	*Oxfordshire ICB*	*Collaboration of Oxford Health NHS FT & Oxford University Hospitals NHS FT*	*Oxford Health NHS Foundation Trust*
Exec Sponsors	*Sam Foster (Chair, Oxfordshire Integrated Leadership Board)* *Dan Leveson (Managing Director for Place, BOB ICB* *Karen Fuller (Interim Director of Adult Social Care, OCC)*	*Prof Meghana Pandit & Dr Nick Broughton (CEOs)* *Sam Foster & Dr Ben Riley (Trust Exec Leads)*	*Dr Nick Broughton (CEO, OHFT)* *Dr Ben Riley (Managing Director for Primary, Community & Dental Care, OHFT)*
Programme Leads (Point of Contact)	*Lily O'Connor (Director of Urgent Care Oxfordshire, BOB ICB)*	*Hannah Iqbal (Director of Strategy & Partnerships, OUHFT)* *Helen Shute (Comm. Services Prog. Director, OHFT)*	*Helen Shute (Comm. Services Prog. Director, OHFT)*
Prevention & Planned Care	Providing better support for those who live at home: Social Prescribing & Oxfordshire Way Anticipatory care Primary Care virtual care	Review and update of joint podiatry and diabetes foot care pathway	Community Hospital Outpatients Pilot (Wantage CH), focusing on improving eye health, ENT, hearing and mental health & wellbeing (children & adults)
			Community Vaccination Service for school-aged children, the immobile and vulnerable groups
			Sustainable 7-day Community Nursing and Therapy services (adults)
Care close to home at the time of need	Further development of Urgent Care Centre in Banbury	Joined-up care from coordinated Urgent Community Response, CARe and Hospice@Home teams, reducing duplication	Integrated 24-hour community urgent care service (strengthening GP out-of-hours and minor injuries services)
	Urgent Community response	Developing Hospital-at-Home teams into enhanced North, Central & South Oxfordshire virtual ward teams (with PML)	
	Acute virtual wards (adults & children)	Sustainable and consistent same-day ambulatory care capability to support the acute virtual wards	
Patient flow, discharge & recovery	Multi-partner Transfer of Care Team		Modernising Community Hospital inpatient care and resolving the future of Wantage CH inpatient unit
	Better Care Fund plan		Developing the community Single Point of Access into a care coordination centre

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Oxfordshire system integrated improvement programme funding and PMO support

Funding bid for	Regional funding
Transfer of Care team	£500,000
Development of Acute virtual wards (Hospital @Home)	1.6 million – £628,000 released to date
Development of Primary care virtual wards	1.2 million

Project Management support	
BOB ICB	Virtual ward PMO and governance
Oxon UEC team	Oxon adult acute/Primary Care and children's virtual wards
Recovery and Patient flow	Price Waterhouse Cooper (PWC)

Oxfordshire system integrated improvement programme

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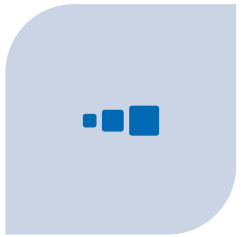
LIVING WELL: PROVIDING BETTER SUPPORT FOR THOSE WHO LIVE AT HOME

RIGHT CARE IN THE RIGHT PLACE AT THE RIGHT TIME: PRIMARY CARE AND ACUTE VIRTUAL WARDS

PROVIDING CARE AND TREATMENT TO REDUCE THE NEED FOR THE PERSON TO BE ADMITTED TO HOSPITAL ADULTS AND CHILDREN.

FURTHER DEVELOPMENT OF URGENT CARE CENTRE ON THE HORTON GENERAL HOSPITAL SITE



ALIGNING DEMAND AND CAPACITY- RECOVERY AND FLOW

Achievement highlights Oxfordshire April 2022 – October 2022

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Bicester PCN
Primary Care enhanced service (Primary Care virtual ward

Bicester PCN virtual ward have

- Recruited a virtual ward coordinator
- Contracted Age UK to see all those in the VW,
- Developed a strong working relationship with PML visiting service
- Working with discharge team in OUHFT on the follow up required for Bicester patients due to be discharged from the acute
- Working with H@H services to step up and down patients to and from the acute virtual ward
- Developed pathways to maintain people in their own home.

Oxford City PCN Primary Care Virtual ward
Oxford City PCN's have started the enhanced service as described above for Bicester but at an earlier stage in the programme.

Improving peoples lives and wellbeing

Age UK working with health and social care to help establish what matters to individuals
Focussing on reducing loneliness and getting people more active to improve their mobility

.

People who fall at home

People, families , 999, NHS 111 and Health Care Professional s can refer to Urgent Community Response for an assessment within 2hrs or two days.

Urgent Community Response

Urgent Community Response (UCR) supported patients to have their initial assessment and treatment in their own home – avoiding a hospital admission. If the person requires ongoing care they refer to H@H acute Virtual ward.

Acute Virtual ward (Hospital @ Home)
Take referrals from 999, NHS 111, ED's EMU's GP's and health Care Professionals
Delivering care that can be delivered in secondary care in the patients own home
Achieved above trajectory assessing and treating an additional 33% of people in their own home.

Ambulance handovers
OUHFT have worked in partnership with SCAS to minimise ambulance handover delays. There is a renewed focus in working with ambulance providers to ensure they are able to respond to those who are waiting for an ambulance.

Transfer of Care team

- Set up an Oxfordshire transfer of Care team to focus on the individual person and valuing time i.e., changing the culture from days away from home instead of length of stay in hospital
- Monitoring the length of time on each pathway and how we can reduce the time waiting.
- Working with Age UK, county council teams and home first to support who require support to return home

Communications campaign activity and materials

The following campaigns and activity will run throughout the winter months using national materials where available and appropriate to our system requirements as well as tailored campaigns for place as required.

111 online
111.nhs.uk

A Communications Resource is being set up on a website with resources for the public and health care professionals containing resources to encourage sharing via social media channels and websites.
Information for the public on health matters relating to maintaining independence, heating and resources to maintain peoples safety in their own home.

Channels of Communications

As outlined previously we have bespoke designed materials to support all localised winter messaging. This covers leaflets, social media posts, large design and hard copy materials. Our communications channels include:

- All ICB Facebook, Twitter, Nextdoor and Place Instagram advertising
- Health provider websites and social media
- Community and third sector networks
- Faith groups networks
- Local authority outreach teams
- Local authority websites and social media
- Local media (incl advertising)
- Social media (incl paid Facebook advertising)
- Digital and online channels
- GP websites
- GP text messaging to patients
- E-newsletters / place e-magazines
- Websites and social media of charities and partner organisations such as Healthwatch
- Libraries
- Schools, nurseries and children's centres
- Town & Parish Councils website and social media
- Bus & bus stop advertising
- Paid advertising on specific websites as indicated
- Community / parish noticeboard

Live well- Improving people's health and wellbeing

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People's health and wellbeing are determined mostly by a range of social, economic, and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health.

In Oxfordshire, the development of Social Prescribing is a priority in the Joint Health & Wellbeing Strategy as a means of *Improving Health by Tackling Wider Issues.* Specifically, it was one of the areas of focus for the Health Improvement Board to meet its aim to

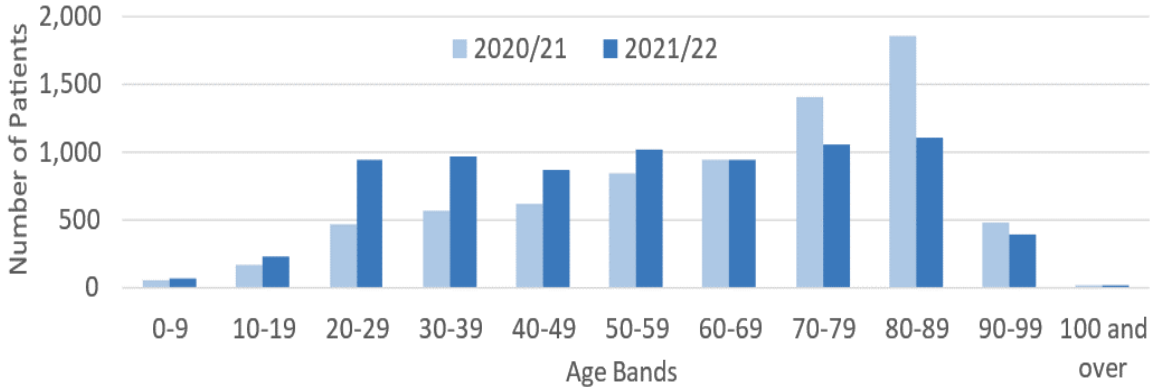
- *Create healthy communities where people of all ages can maintain and improve their health as they live, learn, work, and socialise.*

Outcomes

19 out of 20 Primary Care Networks now employ Social Prescribing Link Workers either directly or via voluntary and community sector organizations. Overall referrals are increasing from 2020/21 to 2021/22 and a change in the age profile:

a. In 2021/22 there was a total of 7,552 patients referred to Social Prescribing in Oxfordshire. Almost two thirds (62%) of patients referred were female and 38% were male.

b. Between 2020/21 and 2021/22 there was an increase in the number of younger people and a decrease in the number of older people referred.



Further initiatives

a. Improving our response to Carers, to people with mental health problems, to people living with learning disability and/or autism; helping with practical issues as well as building up that individual resilience to deliver 16b above.
b. Developing our information and advice offer Live Well Oxfordshire to increase the options and resources available to the public and to social prescribers
c. Increasing community capacity, social capital and capability and the ability of our communities to "grow their own" in terms of the things that will help keep the local population connected and well. This forms a key part of the Oxfordshire Better Care Fund 2022/23 plan

Themes from social prescribing

The common themes across these different Social Prescribing approaches are a focus on addressing key risks to long-term health and wellbeing outcomes

- Combating isolation and increasing the sense of connectedness
- Mental wellbeing
- Physical wellbeing, especially physical activity
- Practical resources that can address specific risk factors (e.g., debt advice, housing issues, fuel and other forms of poverty) which contribute to the wider determinants of ill-health

The range of different models for Social Prescribing in Oxfordshire are built around key inputs

- Need for good quality, accessible, information and advice that can support self-help and act as a touch point for professionals and other referrers
- Co-produced, person-centred approaches to planning: what is important to the individual and how do they meet their individual challenges
- Practical support and navigation to enable people to access community resources when they cannot do so themselves
- Community resources and social capital that people can use to help them develop and achieve their personal plans

Social prescribing - stories of difference

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- **Mrs Chan** has a long term health condition
- Referred by GP because she was isolated and lonely. She is Cambodian, and her first language is not English.
- Several *'what matters to you'* conversations helped establish a goal for Mrs Chan.

Goal: meeting people & establishing friendships

Making connections

- Introduced to a Health Walk - she was chatty and enjoyed it
- Introduced to two welcoming social groups, which she liked
- The University's Cambodian Society helped us identify a volunteer to make regular weekly phone calls to Mrs Chan.

- Mrs Chan has made some friends, feels less lonely and is happier.
- She is ready for her next goal of using volunteer transport to increase her independence.

Outcomes: increased social connections & independence

- **Mrs Stokes** is in her 80s & lives alone. Fear of falling meant she lost confidence to go out alone and she struggled at home and was unable to use the bath.
- She feels very isolated.
- Mrs Stokes is waiting for a physio appointment.

Goal: getting out and about safely

Making connections

- Introduced to *Move Together* and home based gentle exercise has increased her confidence and mobility. She now walks confidently into town.
- Referred for home equipment & is now able to use the bath
- Referred for benefits advice and to Home Library Service.

- Mrs S is able to get out and about safely and to cope more confidently at home.
- She is ready for her next goal of being introduced to local groups to make new friendships.

Outcomes: increased mobility, confidence & independence

Right Care, Right Place Right time

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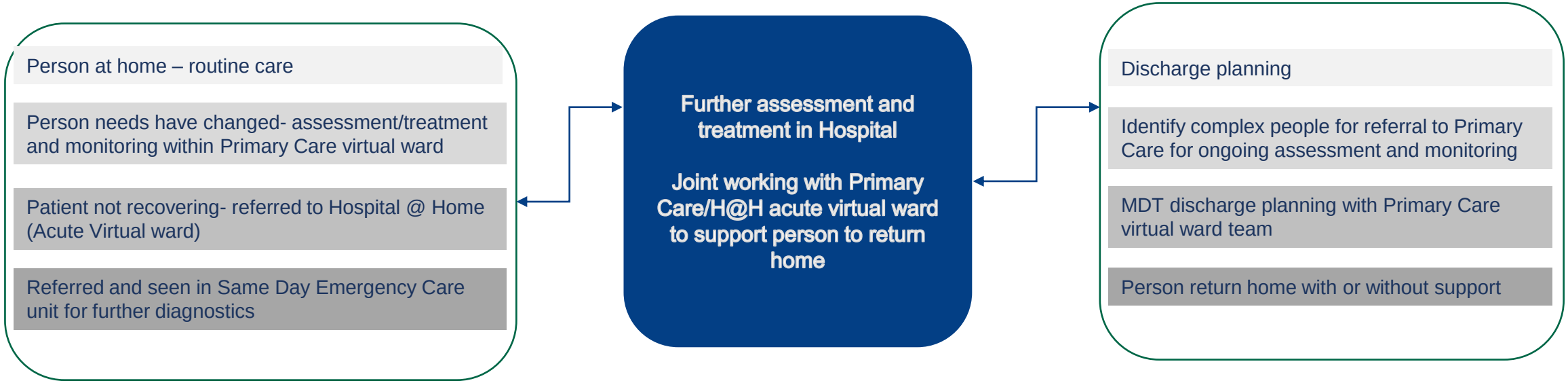
- Delivery of key system initiatives that assure “right care, right place, right time” as set out in the Better Care Fund plan and the system urgent care Integrated Improvement Plan. This will help manage demand on our health and care services.

  i. Supporting primary care with at risk populations, especially in terms of physical activity and mental wellbeing
  ii. Providing person-centred alternative forms of support for people who are at risk of hospital admission, or who have recently been discharged from hospital and are being supported by health and care in “virtual wards”. A strengths-based assessment has been shown to reduce the demand for care by identifying the things that are important to the person, and which may be provided outside of formal NHS or Council care



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Peoples stories

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"Thank you for keeping my mum at home and avoiding her going to A&E"

FR in hospital for 28 days- discharged home son main carer

Picked up by Bicester primary care virtual care ward

Hospital bed organised, visited daily by H@H, Reviewed by GP at home

Treatment escalation plan agreed with patient and son.

Patient died with dignity, peacefully at home

80yr old widower Called 999 with shortness of breath

999 advised hospital admission, declined admission

Supported at home with H@H but deteriorated and admitted to hospital

17 days in hospital discharged to Primary care virtual care ward

Follow up with H@H Follow up investigations in the home

Person happy to be at home with follow up support

Patient story
I turned too quick, fell over, ended up in the shower

Pressed the buzzer and the ambulance arrived.
They wanted me to go t hospital but I did not want to go. They called a nurse to see me at home

Two nurses arrived, gave me a full assessment, made an appointment for the next day with my GP, referred me to AGE UK and the falls service

I was really happy to stay at home and I got such a good service

Oxford Virtual Ward Data by Provider

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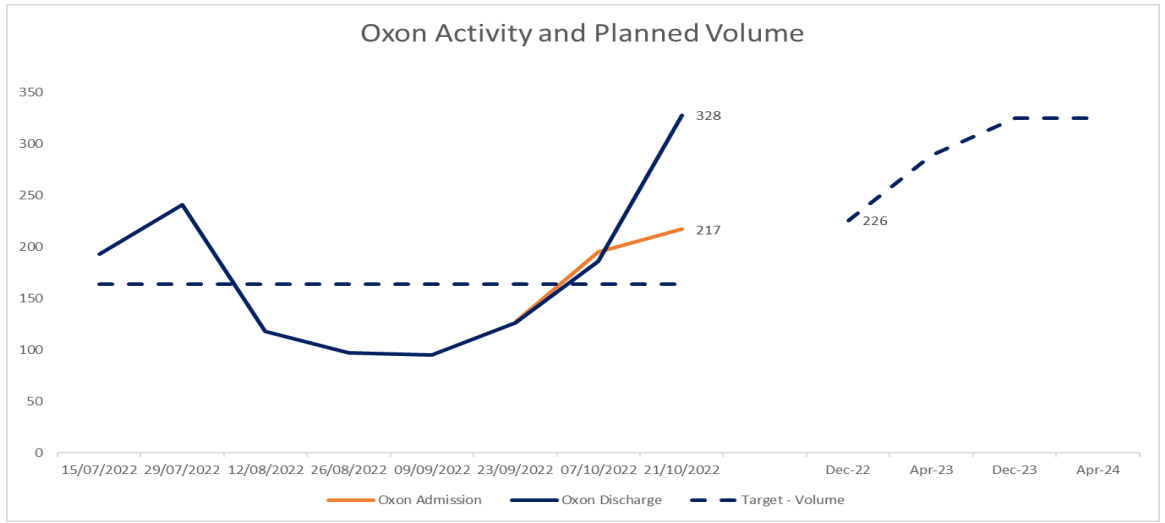
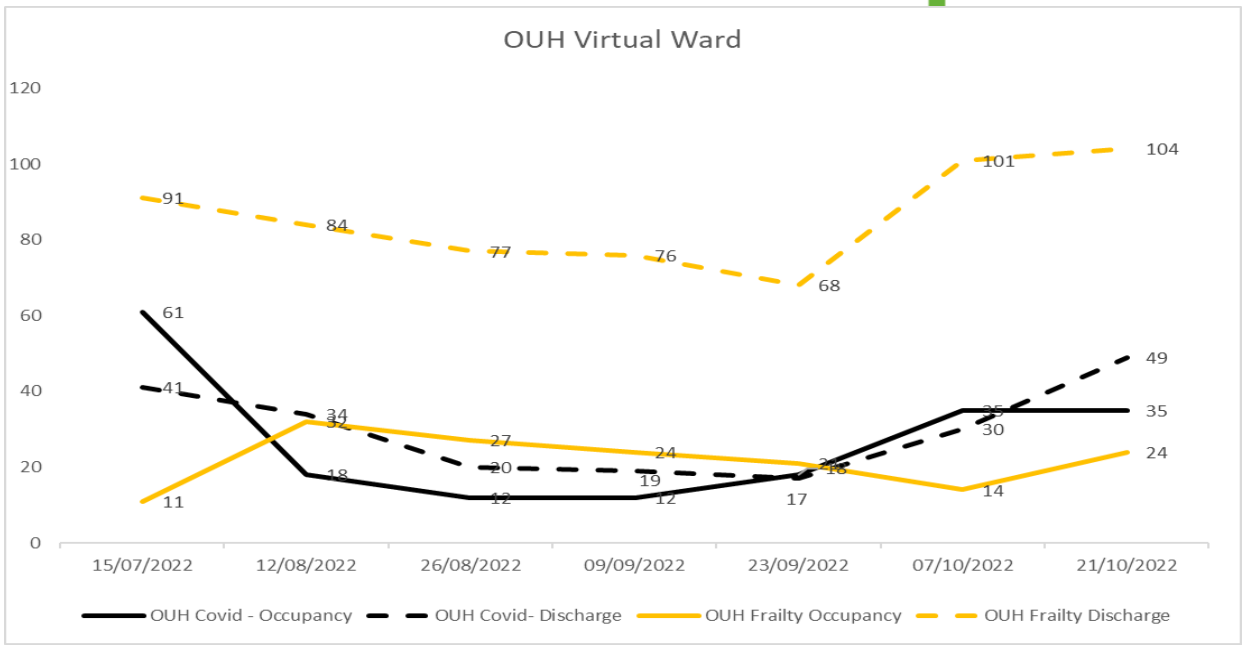
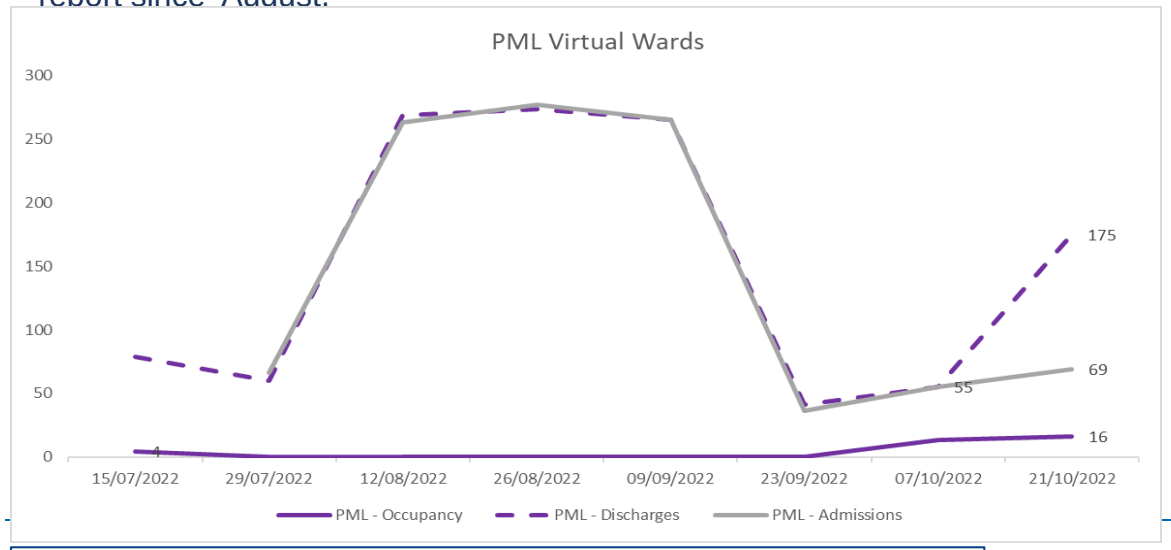
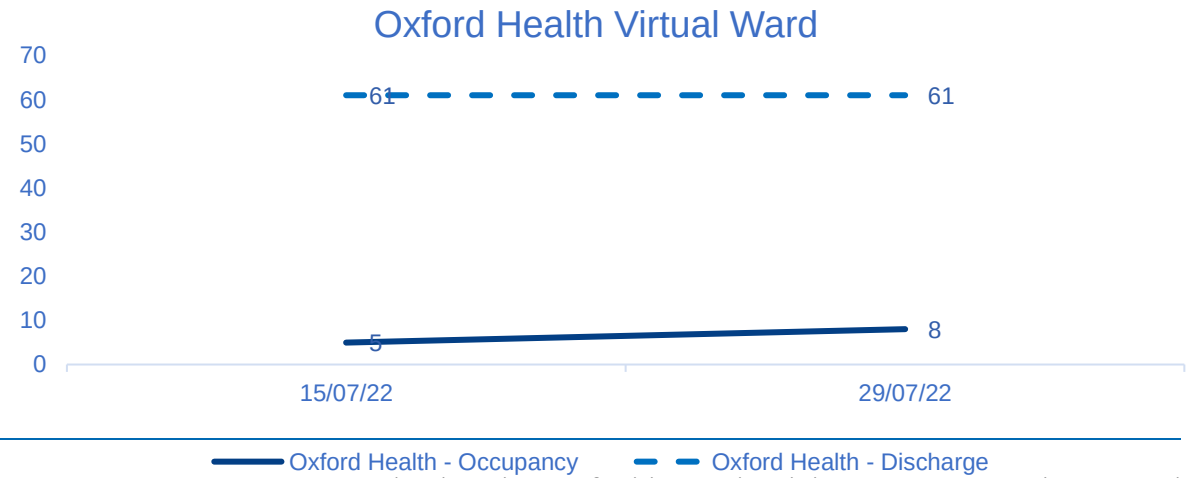




The has plan been pro rated from Monthly to Fortnightly to allow for monitoring next to Foundry submissions. Oxford Health has been unable to report since August.





Increase in PML discharges, but admissions were lower

Children's Virtual Ward

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Actions & Progress

- GP Webinar to present new wheeze pathway 29.10.22
- OPAT processes review
- Networking with key teams to improve processes and increase referral rates
- Bid submitted via CHA re funding for pilot -tech enabled virtual wards, remote monitoring and Multi system platform (will apply to respiratory pathways)
- PGD review and planning
- Work with comms -Review of OH CC H@H website and resources
- Progression to enable OPAT Medication dispensing process to move to CCN Localities
- Stakeholder meetings and planning underway for Porting and Delivery of EPNS Ma Module (Enhanced Paediatric Nursing Skills)

Planned Actions

- Progression of new pathways- Wheeze (Non Continuous Remote monitoring and With Continuous Remote monitoring), Jaundice
- Leaflets and pathways to be Trust approved and uploaded to Website
- Setup daily virtual ward rounds as volumes increase.
- Further Exploration/scoping of remote monitoring models
- Teaching for new staff/ update of EPR processes with OUH Teams
- Medications for OPAT to be available in CCN Localities
- Staff to commence eLearning for EPNS for surge (respiratory enhanced skills)
- SOP and Governance document to be agreed

	Los - Hrs on CAOAH Ward	LOS - days on CAOAH Ward (Acute Bed Days Saved)	Value of Bed Days Saved (based on £350 per bed day)
Sep-21	52	2	£700.00
Oct-21	2145	89	£31,150.00
Nov-21	1100	46	£16,100.00
Dec-21	2386	99	£34,650.00
Jan-22	2371	99	£34,650.00
Feb-22	919	38	£13,300.00
Mar-22	2515	105	£36,750.00
Apr-22	1481	62	£21,700.00
May-22	1950	81	£28,437.50
Jun-22	1464	61	£21,350.00
Jul-22	1838	77	£26,804.17
Aug-22	1309	55	£19,089.58
Sep-22	1321	55	£19,264.58
Total	**20851**	869	£304,164.58

PML Urgent Care Centre Horton General Hospital

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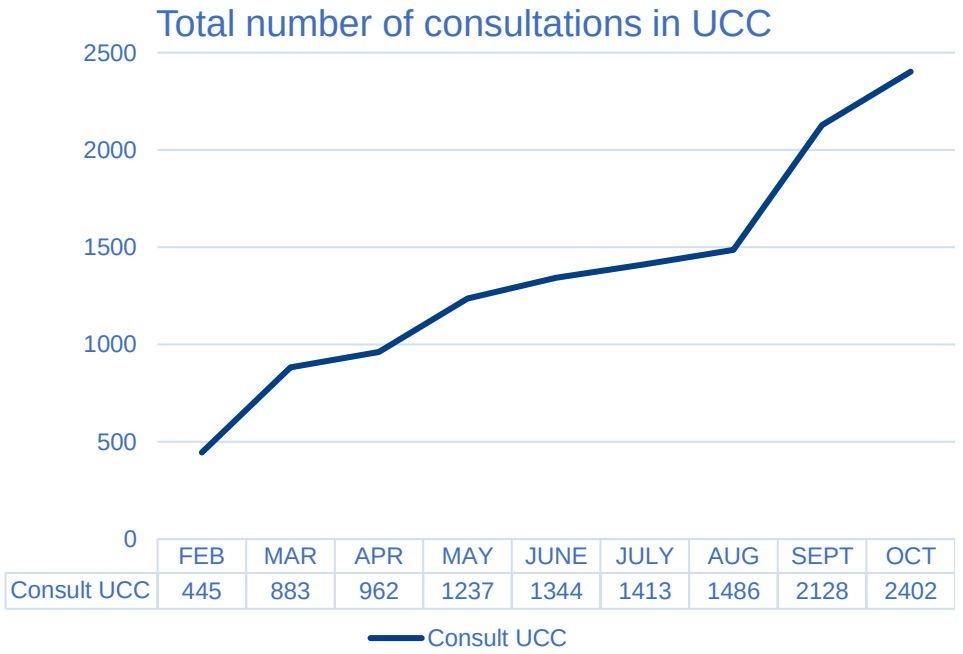
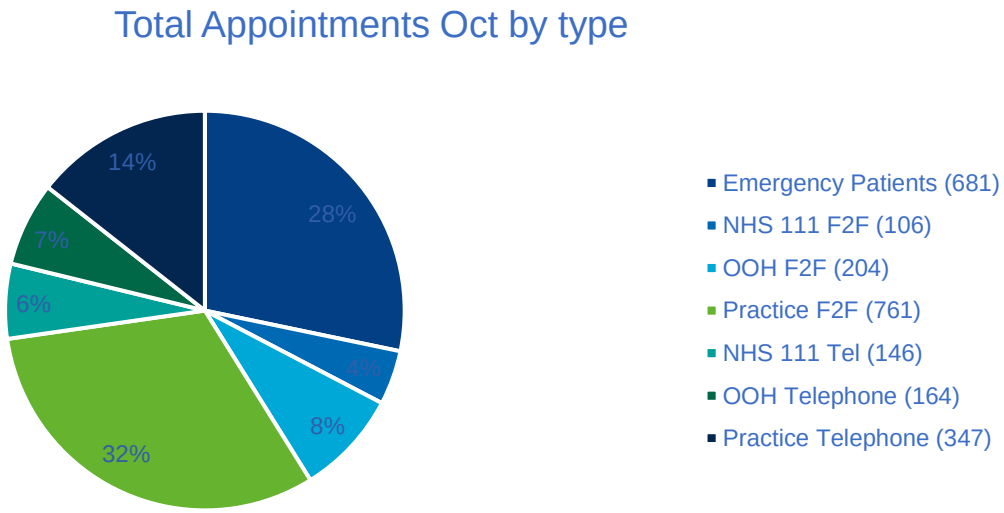
- Number of people triaged/seen to date

	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Total
ED	279	380	393	483	411	462	450	478	681	4017
111	68	114	172	126	111	98	129	428	252	1489
OOH				172	317	138	201	299	368	1495
GP Practice	107	391	397	447	525	715	723	923	1107	4228
								Grand	Total	11238





Ambulance Handover Delays

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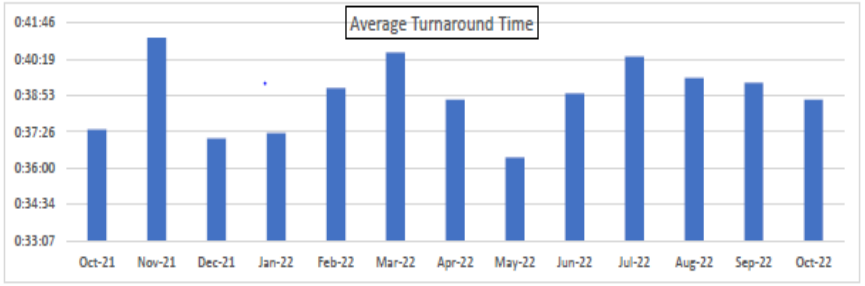
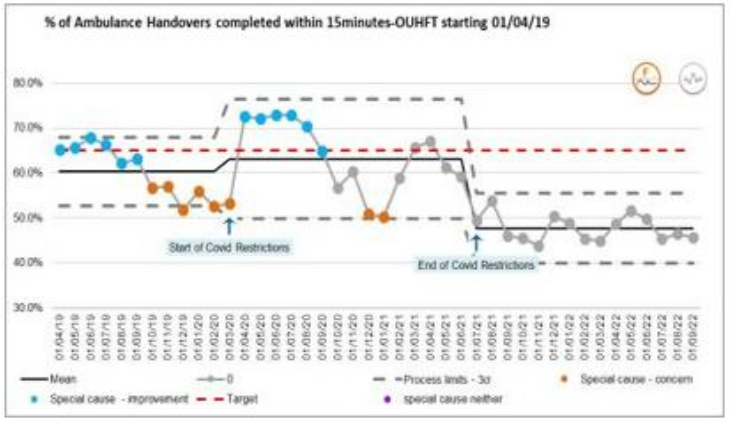
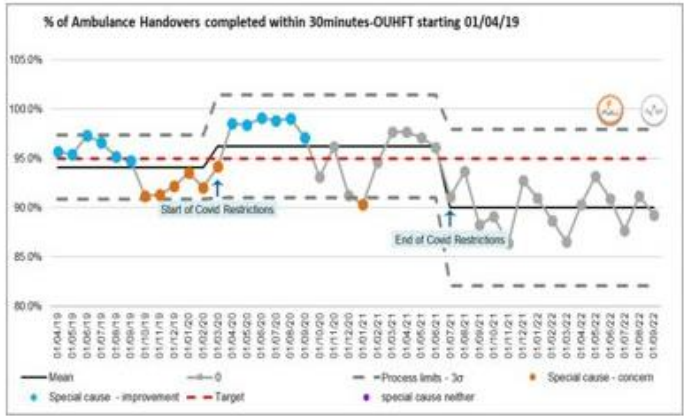
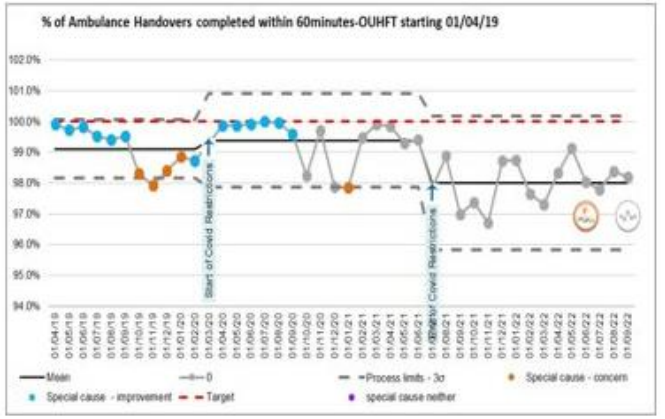
Arrivals, Handovers & Turnarounds	Aug-22	Sep-22	Oct-22
Number of Arrivals	3,462	3,456	3,640
Number of Handovers	2,415	2,411	2,520
Average Handover Time	0:19:40	0:19:52	0:20:07
Average Turnaround Time	0:39:34	0:39:23	0:38:42

Handover Breakdown	Aug-22	Sep-22	Oct-22
Handovers >30 <60 Mins	251	271	292
Handovers >60 Mins	49	52	57
% Handovers >30 <60 Mins	10.39%	11.24%	11.59%
% Handovers >60 Mins	2.03%	2.16%	2.26%









- Handover delays at the JR have stabilised. Arrivals and handovers were on a par to the previous month and the number of >30 mins and <60 mins delays increased slightly.
- Communication between South Central Ambulance Service (SCAS), OUHFT and Urgent Community Response (UCR) has been excellent and referrals to alternative clinical pathways have increased.
- OUHFT continues to provide an ambulance handover nurse; in addition to this, a second ambulance nurse has been provided at peak times to reduce the reliance on a Hospital Ambulance Liaison Officer (HALO). This has had a direct positive impact on releasing resources within SCAS to be back out in the community.
- Patient safety and experience for patients delayed remains a focus of high priority across the Trust.
- Geography and infrastructure on the JR site, with the multiple areas receiving patients directly from SCAS, is a continuing challenge.
- Work continues within the Ambulance Handovers Task & Finish group to minimise delays. High volume of conveyances in the evenings continues to be the most challenging time.

4 and 12-hour ED Performance

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ED 4-hr performance has deteriorated over several months despite steady attendance figures. 'Wait to be seen' is the most significant breach reason. Despite attendance figures remaining steady, there is a peak in activity in the evening and into the night.

ED 12-hr total length of stay performance has remained above the national target despite an improved position earlier in the year. Long waits to be seen and flow out of the ED are the main factors contributing to this position.

High occupancy within the wards on the John Radcliffe site and delayed discharges for medically optimised patients have significantly impacted flow within the Hospital.

Children's and General Surgery have also been challenged.

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Attendances (total)	12,123	11,501	13,556	12,377	13,807	13,303	13,373	12,397	12,569
Attendances over 12 hrs	611	761	990	710	591	639	988	793	874
% of attendances over 12 hrs	5.0%	6.6%	7.3%	5.7%	4.3%	4.8%	7.4%	6.4%	7.0%
Target	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

Patients Medically Optimised For Discharge OUHFT

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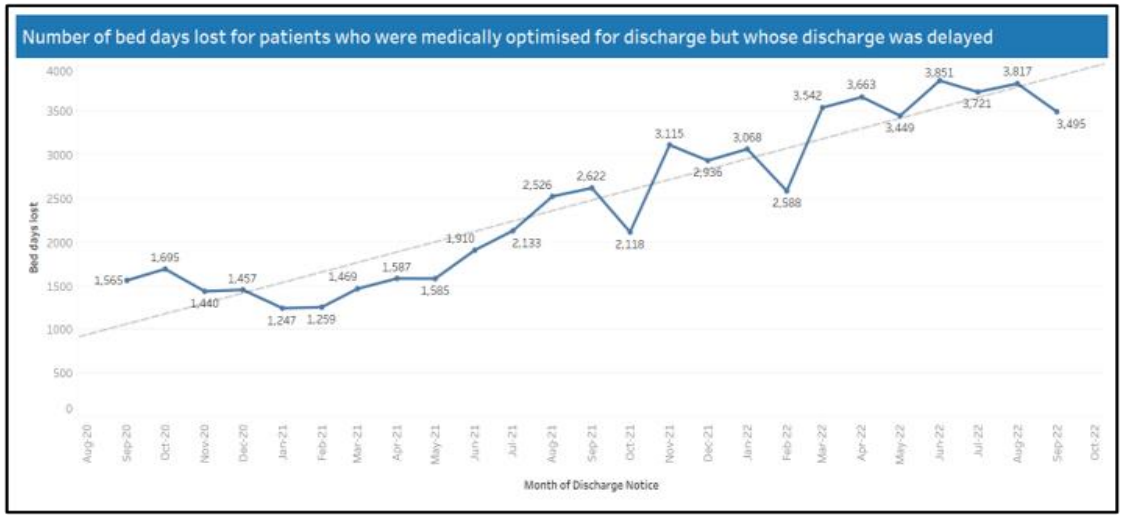

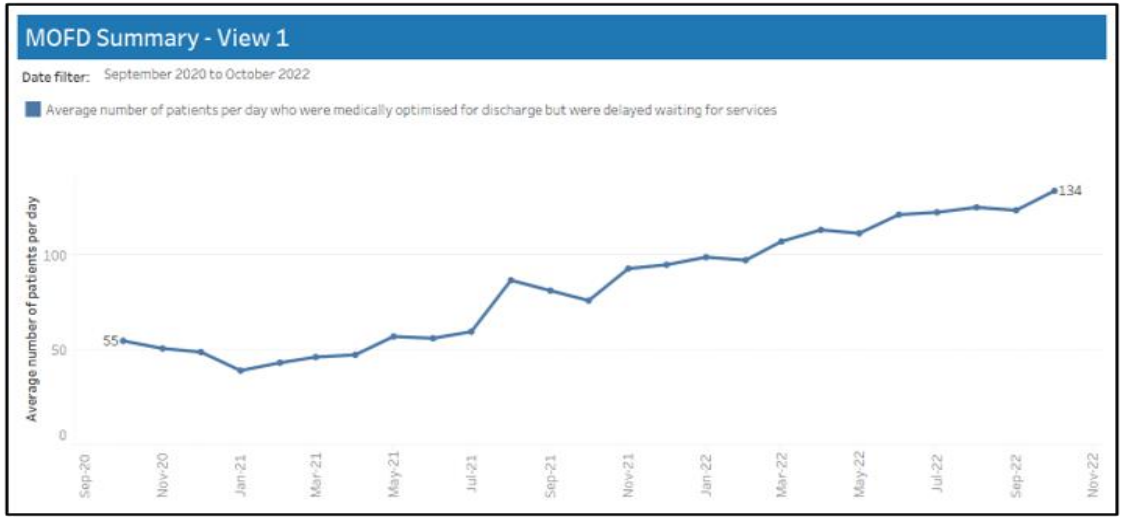

There has been a steady increase in the number of patients who do not meet the criteria to reside that are delayed waiting for services to support discharge (Pathways 1-3) over the past 2 years.

The length of time these patients are delayed has also increased, contributing to a significant number of bed days.

Several factors have contributed to this increase:

- A change in reablement provider and the criteria for accessing the service.
- A subsequent increase in referrals to social care - Management and process of referrals (linear).
- Covid outbreaks within the Short Stay Hub Bed providers leading to bed closures.
- Closure of one Short Stay Hub Bed unit.
- Workforce challenges across domiciliary providers.
- The removal of the Hospital Discharge Programme post-Covid.
- Inability to implement a 'Discharge to Assess' at home approach.

UCR (Care team) – cumulative (April to September 2022)

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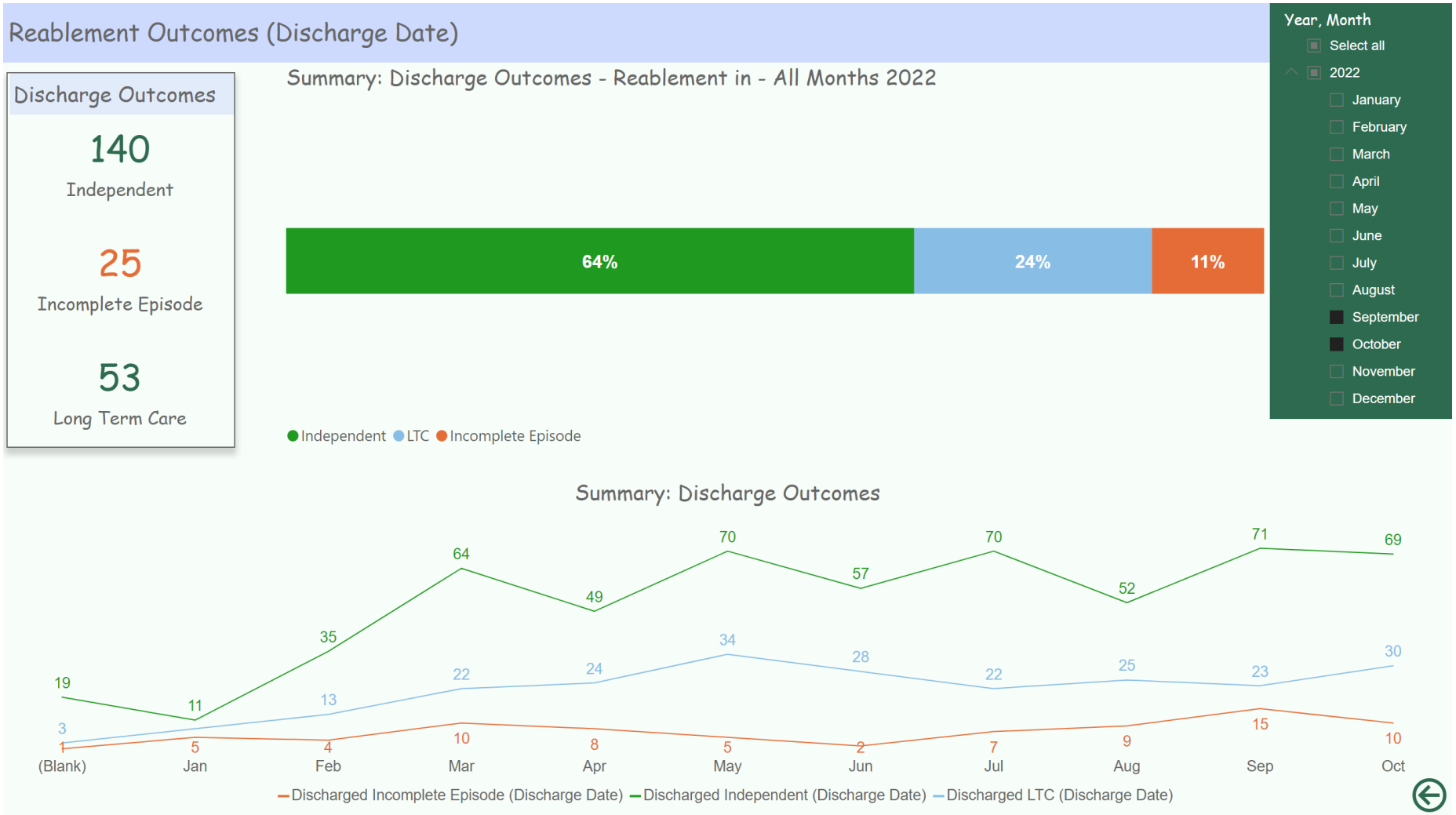
Total patients	**787**
Total discharges	728
Average of LoS (discharged patients only)	11 days
Cumulative Virtual Bed Days	9233 days
Notional Bed Day Savings	£3,231.6K

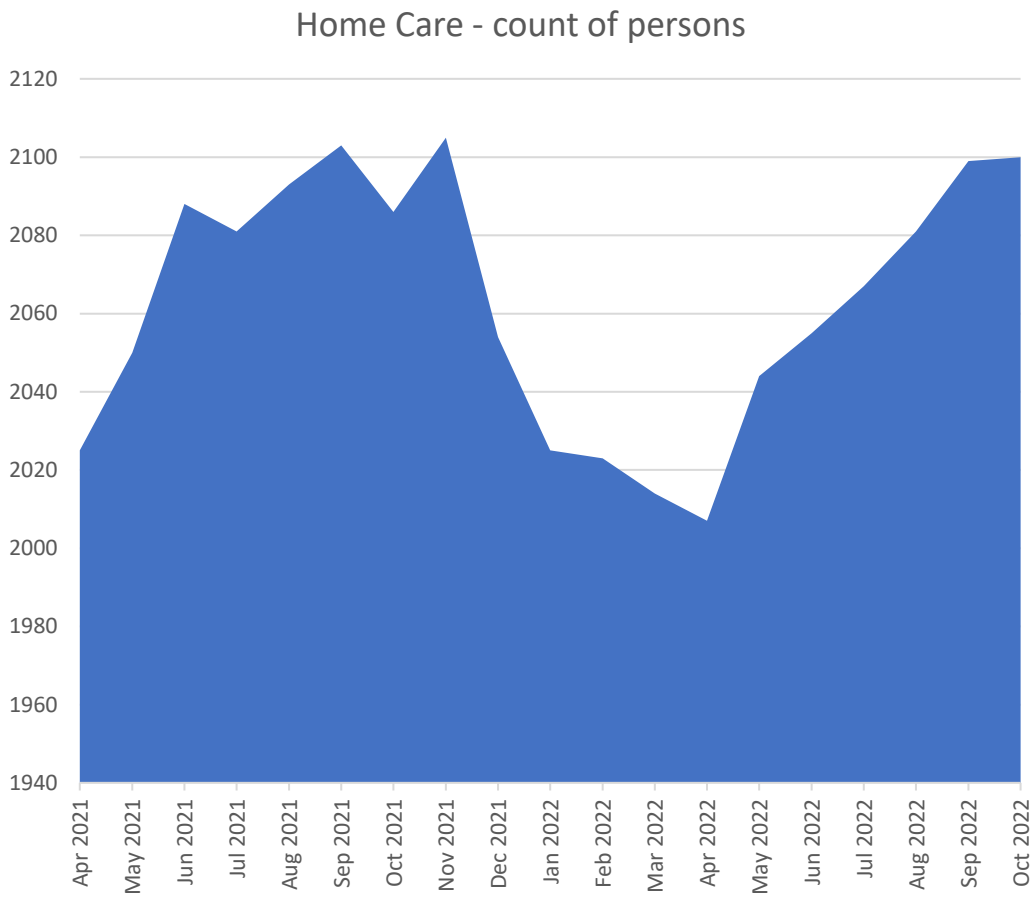
Home Hospice Care (April to September 2022)

Total patients	**209**
Total discharges	200
Average of LOS (discharged patients only)	11 days
Cumulative Virtual Bed Days	2364 days
Notional Bed Day Saving	£827.4k

Reablement Outcomes



Home Care by number of people and hours paid



Actions to increase capacity and reduce the number of people in bed based care to return home

- The New Starter Grant will be available from November. This is being promoted and the effectiveness of this should be realised in the coming weeks in terms of increase in new care staff
- Efforts are ongoing to promote “Care Friends” recruitment app. Provider take up rate will be reported in the near future.
- Continued efforts in reaching out to the provider market to attract new providers onto the framework
- Ongoing engagement with providers of Assistive Technology (AT) and effective solutions have been identified.
- 3 pilots are planned on the homefirst pathway: medication management in the community; Just Checking and Geniecare to promote independence in the home through AT monitoring
- Encourage providers to adopt successful practice such as international recruitment
- Ongoing contract monitoring and management of providers
- Actively working with voluntary / community groups to support service delivery
- MDT are working pro-actively with shadow and zonal providers to improve the business processes to reduce referral and pick-up times. Contact list, reablement training strengthening relationshaip

Oxon HWBB BCF funding and plan 2022-23

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OXFORDSHIRE
COUNTY COUNCIL

Approach to BCF 2022/23

NHS
Oxfordshire
Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

Increasing prevention capacity within BCF

Expansion of community capacity and capability programme focussed on independence, isolation and physical activity:

- mapping, identifying gaps for communities at risk of health inequalities, targeting grants and community development approaches

Developing Oxfordshire's approach to social prescribing: building on and out from the NHS model and integrating what is already there *jointly with PCN and the VCSE*

Improving prevention around falls *jointly with Public Health and the VCSE*

Expanding our offer to Carers, especially around practical support

Developing data collection and evaluation that evidences impact on key BCF metrics

NHS
Oxfordshire
Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

Better Care Fund Metrics: proposed trajectories for ratification by Oxfordshire Improvement Leadership Board

		19/20	20/21	21/22	22/23									Notes
		Actual	Actual	Actual	**Annual Plan**	Q1		Q2		Q3		Q4		
						Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	
1	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	745.1	622	734.4	**720**	175	185	350		535		720		Plan assumes 2% improvement; 6% weighting to last 6 months for winter. M4 performance showed a significant reduction in NEL and this is under review: a more stretching target may be indicated in line with the impact of UCR and virtual ward activity.
3	% of people who are discharged from acute hospital to their normal place of residence	91.3	90.3	91.5	**93%**	93%	90.5%	93%		93%		93%		Proposed trajectory is carried forward from 2021/22. Actions in place to improve allocation to discharge pathways; diversion from P1 to P0; and from P2 to P1 within a Home First ethos and practice.
4	Long term support needs of older people met by admission to residential and nursing care homes per 100,000 population	597	442	370	**352**	85	67	170		261		352		370 admissions per 100,000 population - 481 admissions. A 5% decrease would be 457 admissions in the year (a rate of 352). 7% weighting to last 6 months for winter. Performance already in top quartile nationally
5	% of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	67.2%	62.0%	81.0%	**84%**	n/a						84%		Measure is only of people discharged Oct-Dec each year. Significant improvement last year. National average 79%. 84% top quartile performance

NHS Oxfordshire Clinical Commissioning Group

Oxfordshire County Council

BCF 2022-23 schemes for OLIB ratification

Area	Schemes	Funding (draft)
Additional beds and medical support	Designated beds extension to 20 WW (OCC) [winter] Medical cover to interim beds (ICB) [winter]	250,000
Admission avoidance	Extended UCR capacity (OHFT) [long-term] Additional EMU capacity (OHFT) [winter] SALT input into care homes (OHFT) [pilot] Increased MS capacity (OUH) [pilot] Step up capacity for homeless people in ED (Oxford City) [pilot]	407,000
ED capacity	Extended mental health capacity (OHFT) [winter-?needs to move to BAU] Additional patient transport 0600-1200 7 days (SCAS) [winter-?needs to move to BAU]	108,000
Discharge capacity	Additional discharge liaison capacity (CYP and out of area) [winter] Additional discharge co-ordination in surgical wards [winter] 7 day brokerage support for discharge [winter] Trusted assessor [winter initiative leading to long-term commitment] Extra Care Housing deployment to support P1 discharges [pilot] Investment in P2: assistive technology, 7 day therapy, NH staffing [long-term, new model]	318,000
Health inequalities	Mapping and gap analysis of complex needs pathways to support homeless people [pilot]	30,000
Prevention and support to carers	Extended dementia support service and improved dementia education for carers [long-term] Improved respite and support for carers to support admission avoidance and discharge flow [long-term]	156,000
	Sub-total	**£1.269m**
	Surge provision (beds if not funded by NHSEI) and to be allocated	**£1.2m**

Integrated Care Improvement Programme and winter surge plan -Next steps

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Further development of pathways to maintain people in their own home

- There is confusion as to the best place for a health care professional should refer a person
- We continue to have multiple entry points which leads to some of the ambiguity.
  - **Action**
    - Webinar with Healthcare professionals and GP's being set up to capture all the issues and solution focussed.
    - Continue to recruit to increase capacity 7 days a weeks
    - Planning to increase hours covered from 20:00hrs to 02:00hrs

Further development of the Transfer of care HUB to reduce the time people are away from home

- Realtime feedback from people and their families and providers to continue to learn and change to improve processes.
- Development and implementation of discharge to assess i.e., assessing people in their own home.

New programme of work with care Homes

Single access point with clinical support initially 08:00-20:00hrs seven days a week
Deployment of UCR/H@H team to the care home to provide assessment and additional support to avoid transferring the person to hospital