BOSCARD Matrix: Enhanced Care in Care Homes 2017/19 Appendix 1d

Background	Older people living in care homes have some of the most complex health needs, yet successive studies have shown that they have variable access to health care and, as a result, high rates of unscheduled admissions to hospital. Better integration between care homes, primary care, community services and hospitals can improve health outcomes and costs and lead to better experiences for care home residents and for staff. It involves GPs and other health professionals providing services in care homes and developing a partnership with care home staff. Together, they manage residents' care needs prospectively – helping them to keep well, not just reacting to ill-health – and the health professionals support care home staff to develop their confidence and skills in providing health care. There is agreement across the system that care homes could play a key role in preventing NELs and reducing DTOCs. A system wide stakeholder task and finish group has already been established to better understand the needs of the care home populations and identify priorities for change, with the aim of ensuring health and social care services are high quality, coordinated and work together to support need, both on a day to day basis and at times of crisis			
Objectives	• To introduce a range of initiatives which support care homes to deliver an enhanced range of services • To reduce the number of non-elective admissions from care homes • To reduce the number of DTOCs relating to delays in getting customers discharged from hospital to care homes			
Scope	Within Scope	Residential homes , nursing homes and learning disability homes in Central Bedfordshire.		
	Outside Scope	None identified at this stage		
Constraints	• Until the digitisation agenda has been progressed, the limited access to a shared system for timely exchange of patient data across providers will affect the response			
Assumptions	• That care home providers will be willing to participate in these initiatives and potentially take on additional responsibilities			
Risks	• Lack of care home sign up to the initiatives • Digitisation agenda will not progress with sufficient pace • Lack of geriatricians to provide community based support	Mitigation	• Working with Bedfordshire Care Association to extend their membership and develop the initiatives with their core members • Working on local solutions in the first instance, such as Wi-Fi coverage for care homes , as a staged approach to digitisation • Complex care offer to care homes will be multi-disciplinary and therefore not solely dependent on the recruitment of geriatricians	
Deliverables	• Trusted Assessor model in place to advise and support care homes in the admission and discharge of patients to/from acute care settings • Red bag scheme in place to ensure safe transfer of client information, medication etc • Undertake medication reviews to reduce inappropriate polypharmacy • Complex care support (such as geriatricians) available to care homes to reduce ambulance call out , conveyance and hospital admission • Continuation and expansion of training programme to care home staff • Digitisation progressed in care home sector (infrastructure, wifi, SystmOne etc) • Airedale model scoped, including single point of contact (SPOC)			
National Conditions And Metrics	National Conditions • Investment in Out of Hospital NHS Services • Implementation of High Impact Change Model		National Metrics • Reduction in non elective admissions • Delayed transfers of care	