BOSCARD Matrix: Improving the End of Life Service **Theme: Out of Hospital Services**

<table>
<tr><td>Background</td><td colspan="3">Each year many patients die in hospital who would have preferred to have died in their own homes. The 2016/17 year will be used to improve end of life care across health and social care through a number of initiatives including decreasing unnecessary EoL admissions into hospital. These will include additional training to EEAST paramedics Supported by the updated End of Life strategy, providers will work together to offer EOL training programmes to care home staff and paramedics which will include the introduction of a new Advance Care Plan (ACP) document for Bedfordshire.</td></tr>
<tr><td>Objectives</td><td colspan="3">The overall objective is to improve EOL care for our population
• An increase in EOL patients offered an ACP conversation
• An increase in the number of people dying in their preferred place of death
• A decrease in the number of EOL patients having a hospital admission in their final weeks of life
• An increase in the number of care home residents registered to PEPS</td></tr>
<tr><td rowspan="2">Scope</td><td>Within Scope</td><td colspan="2">• Any registered EoL patient
• Paramedics and care home staff</td></tr>
<tr><td>Outside Scope</td><td colspan="2">• Service users not at the end of their life.
• Service users who need to be in an acute facility.</td></tr>
<tr><td>Constraints</td><td colspan="3">Cultural reluctance to talk about death</td></tr>
<tr><td>Assumptions</td><td colspan="3">• There is an assumption that an acute admission is avoidable for EOL patients, however for some this will be completely appropriate.</td></tr>
<tr><td>Risks</td><td>• EoL training for EEAST staff is not currently contractual therefore there is no obligation for EEAST to release staff to attend the training.
• As a result of trained staff not being able to put into practice the full content of the training, there is a risk of inconsistent outcomes which may result in benefits not being realised.</td><td>Mitigation</td><td>• Established relationships is ensuring a continuing participation and engagement in the EoL programme
• Continued learning from reflective practice continues to inform course content..</td></tr>
<tr><td>Deliverables</td><td colspan="3">• EOL strategy reviewed and adopted by BCCG and the EOL Local Implementation Group - October 2016
• 12 Care homes trained and EOL champions established in each home – March 2017
• 80% of EEAST staff trained in EOL – March 2017
• Increased number of people registered with PEPS – Numbers registered – monthly monitoring
• Reduction in conveyancing for ELO care by EEAST – Number of conveyances – monthly monitoring
• Advance Care Plan document for Bedfordshire being issued across all providers – September 2016
• Develop and deliver training around communication for the new Advanced Care Plan – October 2016
• Use of ACP becomes standard – April 2017</td></tr>
<tr><td>National Conditions</td><td colspan="2">• 7 day working and unplanned admissions
• Joint approach to assessments and care planning
• Investment in NHS Out of Hospital Services and Social Care
• Maintenance of Social Services</td><td>National Metrics
• Unplanned admissions for End of life care
• Number of people with advanced care plan</td></tr>
</table>

BOSCARD Matrix: Transformation of Community Services – Transforming Stroke Care

Theme: Out of Hospital Services/Prevention

Background	Effective treatment of stroke can prevent long-term disability and save lives. Stroke services in Bedfordshire are fragmented with gaps in key elements of an integrated stroke pathway. Currently, placements are spot purchased, which is not cost effective and levels of quality provision and outcomes cannot be effectively monitored The aim is to address this inequalities in stroke care provision for patients who require longer length of rehabilitation or have more complex needs than the current SEPT community bed admission criteria allows. Stroke ESD would alleviate some of the need for spot purchased beds and maximize patients independence by providing intense rehabilitation in their place of residence and improve outcomes for stroke patients. ESD provides an early, intensive rehabilitation service for stroke patients and meets the national best practice stroke rehabilitation guidelines. With the introduction of this service patients will be able to leave hospital more quickly and return to their own homes so that they maximise independence as quickly as possible after their stroke			
Objectives	• Agree principles and implement a stroke early supported discharge service • Reduce length of stay in hospital for stroke patients • Improve outcomes for stoke patients including activities of daily living (ADL) • Increase access to rehab in community • To provide support to family members and carers			
Scope	Within Scope	Discharge home or care home with intensive rehab for those suitable for ESD		
	Outside Scope	Patients not suitable for ESD and require longer in patient rehabilitation Patients who require access to community bed prior to rehab at home		
Constraints	Capacity to deliver full vision of enhanced ESD for more complex patients (slow stream rehabilitation)			
Assumptions	• Acute and community providers will work to deliver this ambition • ESD will be delivered as part of the community transformation in 2016/17 year • Joint working across health and social care in the acute setting • Funding approved for complex patients			
Risks	• National gaps in recruitment of some therapy areas i.e. speech and language therapy mean that we might not be able to recruit the necessary staff • Limited availability of integrated pathways will delay securing the desired outcomes	Mitigation	• Work with Health Education East on workforce development • Multidisciplinary neuro-rehab team established and developing integrated care pathways for stroke care.	
Deliverables	• An agreed criteria for ESD suitable patients – September 2016 • Integrated discharge pathway that facilitates early discharges - September 2016 • Service specification – June 2016 • Recruitment of ESD Team - October 2016 • Access to 7 day rehabilitation for stroke patients - October 2016 • Rehabilitation pathway development - April – October 2016			
National Conditions	• Investment in Out of Hospital NHS Services • Protecting Social Care • Joint approach to assessments in care planning • Reduction in DTOCS • Seven day services	National Metrics • Effectiveness of Reablement 91 days following discharge • Reduction in DTOC • Reduced length of stay for stroke • Number accessing ESD and discharged with joint care plan		

BOSCARD Matrix: Transformation of Community Services (Multi Disciplinary Team Working)

Theme : Out of Hospital Services

Background	• The local vision is for a whole system, person-centred and outcome focused community service which provides care closer to home, reduces reliance on hospital based care and ensures that people have access to good quality, safe, locally delivered health care services including primary care and health and social care across both towns and rural areas. .This requires a realignment of community health services staff to work alongside GP Clusters, providing care within multidisciplinary framework. • The year 2016/17 is a transitional year for delivery of integrated and locality based out of hospital care. The realignment of MDTs to GP Clusters will be the first phase of a new model of community care which is, more efficient, effective and provides comprehensive services which will support the Health and Wellbeing Board vision of care closer to home and reduces the number of unnecessary hospital admissions			
Objectives	• Develop a detailed service specification and key performance indicators for the MDT service • Realign community adult services staff to work alongside the 9 GP clusters. The workforce will be deployed according to the demographics and geography of the clusters. • Establish effective multi-disciplinary working arrangements across Bedfordshire.			
Scope	Within Scope	Adult community services currently provided by SEPT including but not exclusive to: Community nursing, Community matrons, Rapid intervention, Rehab & enablement teams, Community Beds, Discharge team Social care assessment and care management is yet to be agreed (BBC)		
	Outside Scope	The primary care element is not within the scope of this project.		
Constraints	• Challenging implementation timeframe • Input and cooperation of all involved – BCCG/BBC and CBC			
Assumptions	• Project is dependant on the formation of GP clusters across primary care. • Transformation funding available to support community services alignment to the newly proposed model of care.			
Risks	• As a result of the current CHS workforce there is a risk that there is not sufficient workforce capacity to deliver a new model of care which may adversely affect patient care	Mitigation	• Invest in workforce capacity to deliver new agreed model of care • Work with Health Education East on Workforce Development Programme	
Deliverables	• Aligning resources to clusters – September 2016 • Agreed integrated model of care for the service - June 2016 • cohort of people identified from risk stratification - June 2016 • Commencement of integrated care packages for patients in 16/17 • Increased number of patients with integrated care packages by 17/18 • Detailed service specification and service specification for the MDT service agreed – June 2016 • MDTs commence case management for people with LTCs – September 2016			
National Conditions	• Investment in Out of Hospital NHS Services • Protecting Social Care • Joint approach to assessments and care planning • 7 day working and reduced unplanned admission and effective discharges		National Metrics • Reduction in unplanned admissions • Reduction in admissions to care homes • Patients feeling supported with LTCs	

BOSCARD Matrix: Transformation of Community Services – Maximising Independence through supportive technology (MIST) **Theme: Prevention**

Background	• BCCG, CBC and BBC are in the process of jointly developing a new model of community care. 2016/17 is a transformation year and the MIST service will be the foundation stage of the new integrated community care support service across Bedfordshire targeted at prevention and proactive interventions. • The 2016/17 financial year will deliver the planning and commencement of procurement for the service to go live in April 2017 for a telephonic Centre staffed by clinical staff linked to outreach resources housed within MDTs • Model delivers proactive healthcare coaching and access to interventions through telephone and outreach services. • The model is based around the very high and high risk of admission to hospital patient population (22,500) and would seek to reduce unnecessary admissions into hospital by managing conditions closer to home.			
Objectives	To develop, agree and mobilise the plan to meet the following objectives in 2017/18 • Reduce fragmentation across services for patients • Improved patient experience/satisfaction and independence • Reduce hospital admissions and pressure on primary care • An increase in confidence of patients who become more independent through proactive interventions through coordinated health and social care • A single point of access 24/7 service for the patient cohort			
Scope	Within Scope	• Patients at the very high and high risk of admission to hospital in Bedfordshire • Awaiting agreement as to whether the BBC assistive technology service will be in scope • Awaiting agreement as to whether the BBC lifestyle hub will be in scope		
	Outside Scope	• Patients not in the very high and high risk of admission to hospital.		
Constraints	• Patients not in the very high and high risk of admission to hospital.			
Assumptions	• Investment for the project will be agreed. • Patients will engage with the programme • Information governance will not be a barrier to sharing information			
Risks	• Delay in sign off for the procurement process • Shortage of resources to deliver the objectives for the project • Recruiting a workforce with the right skills • Sign off and funding for the project is yet to be confirmed	Mitigation	• Process monitored and supported by CHS Steering Group • MIST closely aligned to MDTs • Priority within workforce development plan • Project will be part of transformation of CHS	
Deliverables	A developed model of care for the MIST – May 2016 To set up and deliver a successful procurement process for the MIST – Complete by Nov 2016 To have in place a mobilized plan to deliver the following in 2017/18 • Reduced unscheduled admissions to hospital – March 2017 • To have a 24/7 service in place – April 2017			
National Conditions	• Investment in Out of Hospital NHS Services • IT & better data sharing between NHS and Social Care • 7 day working – reducing unplanned admissions	National Metrics • Reduction in unplanned admissions for those receiving MIST support.		

BOSCARD Matrix: Delayed Transfers of Care (DTOC) **Theme: Protecting Social Care Services**

Background	• Delays in transfer of care remains a challenge and a national imperative. Extended lengths of stay in hospital has a significant impact on outcomes for individuals and their continuing levels of independence, particularly in relation to frail older people. To date the overall performance against the 2015/16 BCF target is green however, seasonal variation can affect this metric. • An operational SRG sub group has been established to self-assess Bedfordshire against current 7 day services and ECIST 8 high impact interventions to address DTOCs across the health and social care system, in relation to demand, capacity and quality. This will inform the plan for future provision with the aim of developing 7 day services across Bedfordshire to meet the needs of the population and to ensure that work is undertaken jointly across organisations.			
Objectives	To have whole system sign up to robust integrated systems and processes as follows to support effective and early discharge planning:- • Systems to Monitor Patient Flow • Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector • Home First/Discharge to Assess • Seven -Day Services • Trusted Assessors • Focus On choice • Enhancing Health in Care Homes			
Scope	Within Scope	Development of improved pathways across Bedfordshire with the two main acute providers, BHT, L&D, ELFT and SEPT		
	Outside Scope	Other acute providers outside of BHT and L&D		
Constraints	• Organisational governance boundaries • BAU Workload			
Assumptions	• Stakeholder support and engagement			
Risks	• Delay in agreement and sign off of the localised DTOC Policy • Delay in agreement and sign off to recognised priority areas of work	Mitigation	• Draft policy produced and system partners aligned to sign up to the policy. • DTOC and 7 day services SRG with clear focus on improving self assessment as per ECIP recommendations	
Deliverables	• Establish direct links with DTOC programmes in neighbouring systems and incorporate into local policy and plan – May 2016 • Joint Commitment and DTOC Policy signed off – September 2016 • Increased discharges from hospital at weekends to be 80% of those during the week – March 2017 • Increased discharges from community settings at weekends – March 2017 • Increased discharges from hospital settings before 1pm to be at 35% of whole daily discharge numbers – March 2017 • Agree localised stretch target of not less than 2% - May 2016 • Better integration of patient centred urgent care services through integrated and interoperable pathways of care regardless of organisational boundaries – September 2016			
National Conditions	• Local action to reduce DTOCs • 7 day services and effective discharges • Joint assessment and care planning • Protecting Social Care Services	National Metrics • Delayed Transfers of Care.		

BOSCARD Matrix: Improving the Falls Service **Theme: Prevention**

Background	• Falls and fall-related injuries represent a major system wide health and social care challenge. Approximately 30% of people aged 65 years and over living in the community are likely to fall at least once a year and this increases to 50% of people older than 80 years (DoH, 2009, NICE, 2013). Half of fallers are likely to have a further fall within the next 12 months. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling therefore has an impact on quality of life, health, and health and social care costs (NICE, 2013). • Over a third of women and one in five men in the UK have one or more bone fractures because of osteoporosis in their lifetime (NOS, 2013). A hip fracture remains the most common cause of accident related death, with a 20% mortality rate within 4 months and a 30% mortality rate within a year (DoH, 2009). Approximately half of those people who were previously independent become partly dependent following a hip fracture, with one third becoming totally dependent. An estimated 10% of older people that suffer a hip fracture are likely to require admission to a care home as a result of their injury (DoH, 2009). • In excess of 95% of hip fractures are fall related and over 90% of hip fractures occur in older people with osteoporosis. Falls and osteoporosis are inextricably linked, both in their consequences and in the patient group who most suffer these outcomes, therefore approaches to fracture prevention must address both the force of the fall, the incidence of falling and bone fragility. • BCCG is seeing an increase both in admissions for injuries due to falls and admission for hip fractures, rates that were once below the national average are now similar to national rates and showing an increasing trend. • Service gaps in the current BCCG falls and fracture prevention pathway need to be addressed with evidence based services to reduce this upward trend in the harm caused to individuals from falls and the cost to the health and social care system.			
Objectives	• To commission a fracture liaison service (FLS) for the BCCG population – A FLS is a multidisciplinary service responsible for the secondary prevention of osteoporotic fractures through case finding. The role of the FLS is to systematically identify, treat and refer to appropriate services all eligible patients over 50 years of age who have suffered fragility fractures with the aim of reducing their risk pf subsequent or secondary fractures. • To commission expansion of the physiotherapy led falls group to cover central Bedfordshire and commission strength and balance classes across BCCG. The strongest evidence for preventing and managing falls is for participation in an exercise programme as part of a multi- factorial assessment and intervention plan. • Fewer falls, to see a reduced recovery time for people who have fallen, reduction in hospital length of stay			
Scope	Within Scope	• Development of FLS at two main acute providers, BHT, L&D • Expansion of physiotherapy led falls group to CBC population. • Commission strength and balance classes across BCCG		
	Outside Scope	• Development of FLS at other BCCG commissioned acute providers • Other acute providers outside of BHT and L&D		
Constraints	There will be 9 month lead in time to commission FLS. A new service is being commissioned and will require significant work up, however stakeholders are supportive, National Osteoporotic Society FLS Implementation Toolkit being used to inform business case development and financial modelling.			
Assumptions	• Stakeholder support and business case approval • Additional funding approved.			
Risks	• FLS development at L&D may not be supported by LCCG (lead commissioner). • Difficulty in demonstrating impact to project due to coding and data recording	Mitigation	• Achieve aligned approach across the two CCGs and via the SRG's established governance • Discussion with provider to address coding and recording issues.	
Deliverables	• Project Initiation Document (PID) and business case approval for FLS - July 2016. • Expansion of physiotherapy led falls group and strength and balance classes - October 2016 • Service specifications for above – August 2016 • Implementation plan for above – October 2016 • CBC expansion of Urgent Homes and Falls Response Service into care homes – April 2016 • Identification of falls champions in care homes – April 2016			
National Conditions	• Investment in Out of Hospital NHS Services • Reduction in unplanned admissions	National Metrics • Reduction in unplanned admissions • Emergency admissions due to falls (local)		

BOSCARD Matrix: Enhanced Care in Care Homes **Theme: Protecting Social Care Services**

Background	• The Care Home population represent some of the most vulnerable patients/residents with complex health and social care needs; the majority are frail older people and a significant number will have dementia or significant memory problems. • The number of people residing in care homes in Bedfordshire is 3022; the residential and nursing home population (2470), represents 7% of the total Beds CCG population aged 75+ • The Central Bedfordshire Care Homes scheme was initiated during 15/16 as a key mobilisation area in response to rising non-elective admissions; this year it will be expanded and strengthened • There is agreement across the system that care homes could play a key role in preventing NELs and reducing DTOCs • Anticipate improved outcomes by introducing a framework of support that provides enhanced care to reduce conveyance to hospital			
Objectives	• Understand the profile of emergency admissions from care homes in terms of patient and spell volume, distribution across care homes, cost, clinical condition, day and time profile • Investigate current health and social care services configuration and support to care homes • Identify factors contributing to avoidable admissions and determine what changes are needed to reduce this • Identify what role care homes could play in reducing DTOCs and work to implement this • Explore the ability of general practice to provide extended support to care home • Encourage care homes to accept hospital discharges seven days a week • Provision of enhanced care in care homes • Improve patient outcomes by reducing length of stay in hospital and the frequency of admissions into hospital			
Scope	Within Scope	Residential homes (21), nursing homes (12) and learning disability homes (28) in Central Bedfordshire.		
	Outside Scope			
Constraints	• Limited access to shared system for timely exchange of patient data across providers will affect the response			
Assumptions	• That general practice will be willing to take on extended responsibility for care home residents/patients subject to sufficient remuneration • That there will be sufficient intent (and contractual level) within care home providers to promote the acceptance of weekend discharges from hospital			
Risks	• Ability of care homes to recruit and retain appropriately qualified staff	Mitigation	• On-going work with Beds & Herts Workforce development partnership on transformation programme, focusing on recruitment and retention, training, support for existing staff and news ways of working. Including generic work and Super Carer roles. • Ongoing work to making Caring profession a career of choice	
Deliverables	• Produce profile of emergency admissions from Care Homes – May 2017 • Delivery of falls prevention training in care homes to reduce non elective admissions – April 2016 • Completion of recommendations from 15/16 programme of care homes visits – ongoing monitoring and review • Review of GP and Clinical Pharmacy support to care homes - September 2016 • Production of a plan to support enhanced care in care homes – September 2016 • Implement pro-active approach to admissions avoidance within care home contracts – April 2017			
National Conditions	• Joint assessment and care planning • 7 day working and unplanned admissions • Reduced delays of transfer of care	National Metrics • Reduction in unplanned admissions • Emergency admissions due to falls (local)		