BOSCARD Matrix: Prevention and Early Intervention 2017/19 **Appendix 1a**

<table>
<tr><td>Background</td><td colspan="3">There are important opportunities to shift the focus of health and care services in Central Bedfordshire towards prevention and early intervention, reshaping residents' expectations and experiences of care -- enabling them to stay healthier for longer and empowering them to take more control of their care. The need for a system wide approach to prevention and early intervention in response to system pressures was recognised in earlier iterations of the BCF plan and continues to be a key focus in our 2017-19 plans.
There needs to be an integrated approach to primary, secondary, and tertiary prevention to stop or reduce deterioration in health.
Via the delivery of our Integration and BCF programme of work, by 2019, residents will have :
• Access to a wider range of support to prevent ill-health, with increased emphasis on early interventions supported by voluntary, community and long-term condition groups, enabling them to stay healthier for longer;
• Be supported to remain independent with integrated GP and community multidisciplinary teams delivering care directly within their own home wherever it is possible to do so;
• Have access to a wider range of health and care services in the community that will help to avoid unnecessary hospital admission and, following any necessary admission, will enable discharge to home care as soon as it is safe to do so
This work stream mirrors the objective of Priority One of the BLMK STP which is to "encourage healthy living and self care, supporting people to stay well and take more control of their own health and wellbeing".</td></tr>
<tr><td>Objectives</td><td colspan="3">• To prevent or reduce deterioration in health.
• To help people to manage their own conditions in the community.
• To build capacity and resilience in our communities to be self sustaining.
• To expand the use of assistive technology.
• To improve quality of life by supporting people to live independently in their own homes for as long as possible.</td></tr>
<tr><td rowspan="2">Scope</td><td>Within Scope</td><td colspan="2">All Central Bedfordshire residents
Residential and Nursing Homes
Reablement and domiciliary care services</td></tr>
<tr><td>Outside Scope</td><td colspan="2">None</td></tr>
<tr><td>Constraints</td><td colspan="3">• Workforce and delays to recruitment
• Timelines associated with development of IT infrastructure for assistive technology into Care Homes</td></tr>
<tr><td>Assumptions</td><td colspan="3">• Development of PID for CBC strength and balance and falls group will require new investment; it is assumed that this funding will be secured.
• That Central Bedfordshire residents will be willing to take on greater responsibility for their own health and wellbeing</td></tr>
<tr><td>Risks</td><td>• FLS service for south Bedfordshire requires joint working with LCCG; if they do not wish to pursue this model it will cause inequity of access for residents</td><td>Mitigation</td><td>• Continued engagement with colleagues at LCCG by BCCG commissioners.</td></tr>
<tr><td>Deliverables</td><td colspan="3">• Expansion of telehealth/telecare services will promote independence and self management
• Implementation of Social Prescribing so that Central Bedfordshire residents with practical, emotional and social issues are empowered to access support from community and voluntary services through an enhanced network of Village Care Schemes supported by community navigators
• Care home residents are supported to stay active and well through the pilot and subsequent roll-out of the OOMPH physical activity programme
• Implementation of a falls pathway will ensure that secondary falls and fractures are prevented
• Falls Prevention training for Extra Care Homes to ensure preventative measures are in place for all residents</td></tr>
<tr><td>National Conditions And Metrics</td><td colspan="2">National Conditions
• Investment in out of hospital NHS Services
• Protection of social care</td><td>National Metrics
• Reduction in non elective admissions
• Permanent admissions to care homes
• Delayed transfers of care</td></tr>
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