BOSCARD Matrix: Delivering Integrated and Improved Outcomes through Out of Hospital Services Appendix 1b

Background	Robust and appropriate out of Hospital services are essential to providing health and care closer to home. Better Care, locally is key to reducing the financial and activity pressures experienced in secondary care and importantly securing improved experience of care for local people. The population of Central Bedfordshire is predicted to grow significantly over the next five years. In order to ensure the right support is available, there will be investment in community based options including additional community beds focusing on rapid access to intermediate care and assertive in-reach to facilitate timely discharge from hospital. Community support arrangements will be strengthened to minimise the need for re-admission to hospital. The Council is also continuing its investment in alternative forms of accommodation for older people to reduce the need for permanent admissions to residential and nursing homes. O The development of the Primary Care Home model, redesigned community beds and the enhanced intermediate care team will improve patient flow (transitions of care) and support discharge to assess for patients and manage more care outside of hospital.			
Objectives	To improve out of hospital care and support to prevent avoidable admissions to hospital and improve outcomes for people. To shift the balance of care from hospital to intermediate, community and home based care. To enhance development of an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care inclusive of patients and the voluntary sector To implement a place based focus with a person-centred approach and co-ordination of care with improvements in population health outcomes through advanced care planning, risk stratification and multi-disciplinary Team (MDT) working To support delivery of STP priorities.			
Scope	Within Scope	Central Bedfordshire Population		
	Outside Scope	None		
Constraints	Financial pressures Co-dependencies with partner organisations across the system required to support development and implementation Workforce – Rising vacancies in key areas information sharing - The STP is responsible for the development of integrated care records and sharing agreements across the health economy			
Assumptions	Funding available to support the additional workforce to support the model New Community Health Services Provider will adopt this approach			
Risks	Availability and capacity of workforce resource across health and social care Workforce - addressing the issue of capacity to make the required shift	Mitigation	• Application for funding made to CCG • Engagement in procurement process and definition of expectations in service specification.	
Deliverables	Embed Multidisciplinary approach across Central Bedfordshire localities to deliver placed based care including co-location of teams Primary Care Home – joint health and social care planning and management, including Risk Stratification, Comprehensive Geriatric Assessments and frailty tools, Early Discharge Planning, Single Trusted Assessor approach, Single Point of Co-ordination approach and developing Integrated Health and Care Records Community Bed Redesign Integration rehabilitation & reablement Develop integrated care pathways , including End of Life and Stroke			
National Conditions	Protection of social services Out of Hospital Services High Impact Change Model to reduce transfers of Care	National Metrics Non elective admissions Delayed Transfers of Care Rehabilitation and reablement Reducing permanent admission into residential care		