**BOSCARD Matrix: Transformation of Community Services (Multi Disciplinary Team Working)** Appendix 3 c **Theme : Out of Hospital Services**

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| 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.<br>• 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<br>• 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.<br>• Establish effective multi-disciplinary working arrangements across Bedfordshire. | | | |
| Scope | Within Scope | Adult community services currently provided by SEPT including but not exclusive to:<br>Community nursing, Community matrons, Rapid intervention, Rehab & enablement teams, Community Beds, Discharge team<br>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<br>• Input and cooperation of all involved – BCCG/BBC and CBC | | | |
| Assumptions | • Project is dependant on the formation of GP clusters across primary care.<br>• 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<br>• Work with Health Education East on Workforce Development Programme | |
| Deliverables | • Aligning resources to clusters – September 2016<br>• Agreed integrated model of care for the service - June 2016<br>• cohort of people identified from risk stratification - June 2016<br>• Commencement of integrated care packages for patients in 16/17<br>• Increased number of patients with integrated care packages by 17/18<br>• Detailed service specification and service specification for the MDT service agreed – June 2016<br>• MDTs commence case management for people with LTCs – September 2016 | | | |
| National Conditions | • Investment in Out of Hospital NHS Services<br>• Protecting Social Care<br>• Joint approach to assessments and care planning<br>• 7 day working and reduced unplanned admission and effective discharges | National Metrics<br>• Reduction in unplanned admissions<br>• Reduction in admissions to care homes<br>• Patients feeling supported with LTCs | | |