Implementing BCF Policy Objectives

Scheme and key milestones	Key features	Desired outcomes	Overall impact	Challenges	Mitigations
Unscheduled Care Hub **Pilot phase Oct 22** **Business case development Dec 22** **Continuation of pilot into BAU Dec 22 - Apr 22**	• All patients referred or reviewed will receive a multiple disciplinary team evaluation. • This model aims to deliver an asset-based approach to care within a person's community by pathways including access to: - Same day Urgent Community Response (UCR) service - Remote consultations with advanced practitioners - Urgent Treatment Centres (UTC) - Hot clinics - Same Day Emergency Care (SDEC) - Community mental health - Local authority • In the future this will also include: - Outpatient diagnostics - Virtual wards - Community step up beds - Consultant geriatrician/GPs	• Increase the utilisation of UCR as the first point of call and reduce reliance on 999. Supporting Right Care, Right Time, Right Place • Improve patient outcomes by implementing contingency planning and care plans as part of their "crisis" episode to avoid future crisis from occurring or reoccurring • Opportunity and time to look at future alignment of our UCR offer to host the unscheduled care hub instead of it being a separate operating model • Improve outcomes (with 85% remaining at home) for an increased	• Review our multiple access points with the intent to reduce these significantly across LLR • Identify gaps in our service provision and redesign how our model of care operates in the future • Develop a wider clinical understanding of inappropriate 999 call outs and hospital admissions and those who can be managed appropriately in UCR, over time this will support education and a culture change towards more home-based response	• Maintaining resource and focus on diverting away from A and E • Longer-term costs and sustainability for the function • Not impacting on overall ambulance handover times sufficiently.	• Robust performance reporting on outcomes that decrease pressure on the system • Complete cost-benefit analysis to show benefits of reducing pressure elsewhere in the LLR system • Measure impact against handover times via regular monitoring

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	• Referring clinicians will have trusted assessor status with no secondary triage or referral process • We will aim for the transfer of care to be complete within 15 minutes. The	number of patients across 7 days • Initial outcomes and return on investment show that over the initial 10 week period, the hub diverted 418 cases from the EMAS stack with the outcome of the intervention enabling 252 of these cases to remain at home and avoided 340 EMAS attendances.			
Integrated Discharge Hub **ASC staff part of triage Apr 22 onwards** **HART staff recruitment June – July 22** **HART workers form part of triage Aug 22 onwards**	• We have developed an electronic LLR Discharge Tracker that serves to provide system-wide assurance of acute and community hospital inpatient beds • Multi-agency staff have access to all Systm1 health records and can update and track patient activity in real-time • Adult social care staff are supported to return to triaging patients alongside	• Timely discharge for all patients to their usual place of residence • Maximising recovery, rehabilitation and reablement potential • Right-sizing pathway 1 • Correct level of care on discharge, reducing over-prescription • Increasing flow through hospitals • One data set to enable real-time information	• To meet the national D2A guidance for discharging patients within 24 hours of medical optimisation and meet the local target of 75% • To increase the number of residents discharged to their usual place of residence • Reduce length of stay	• Increased overall admissions has been observed nationally due to many people not seeking healthcare support during the covid pandemic. • Greater healthcare needs overall and has created higher demand for services both within health and social care.	• Ensure that pathways and processes are designed effectively to intake any increases and ensure ongoing care is right-sized • Work to increase community therapy capacity for more complex needs

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	clinical and ward staff to establish appropriate level of care needs with approx 10 staff members available on a daily basis to support ward rounds at 3 UHL sites • 8 HART reablement workers to begin triaging cases to maximise potential reablement referrals. 5 out of 6 referrals on the first day were re-directed to HART instead of home care or pathway 2 beds.	• Increase description of care needs not prescription			including health needs
Re-Commissioning of step-down D2A beds **Commissioning business case developed Apr – July 22** **Agreement for Lot 1 commissioning to begin Aug 22**	• The LLR system is aiming to secure up to 25 beds on a block contract in residential care home/s. • Primary function and purpose of these beds to provide effective reablement opportunities • people who would benefit from a period of rehabilitation, reablement and recovery before moving on to the place they call home.	• Enhancing quality of life for people with care and support needs • Delaying and reducing the need for care and support • Ensuring that people have a positive experience of care and support • Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.	• People are citizens first and foremost and are at the centre -this ensures people are given choice and control over the support they receive. • Conversations with people are based on what matters to them and support is built around their strengths. • People are treated fairly and with dignity	• Unclear and lengthy processes for continuation of funding • No decrease in reablement • Ongoing costs to care and people not returning to their usual place of residence • Insufficient therapy resource to support the model	• Phased approach to implementation • Health funding model for reablement beds • MDT arrangements and process reviewed to ensure timely assessments

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Additional system discussions on commissioning Lot 2 – Sept – Oct 22 **Further commissioning activity to begin Oct 22 – Apr 23**		• Preventing people from dying prematurely • Enhancing the quality of Life for people with long term conditions • Helping people to recover from episodes of ill health or following injury • Ensuring that people have a positive experience of care • Treating and caring for people in a safe environment and protecting them from avoidable harm.	and their feedback is sought and used to bring about improvements in the way these Services are delivered. • Avoiding readmission • Maximising independence by timely provision of RRR principles		