Planned interventions 14/15

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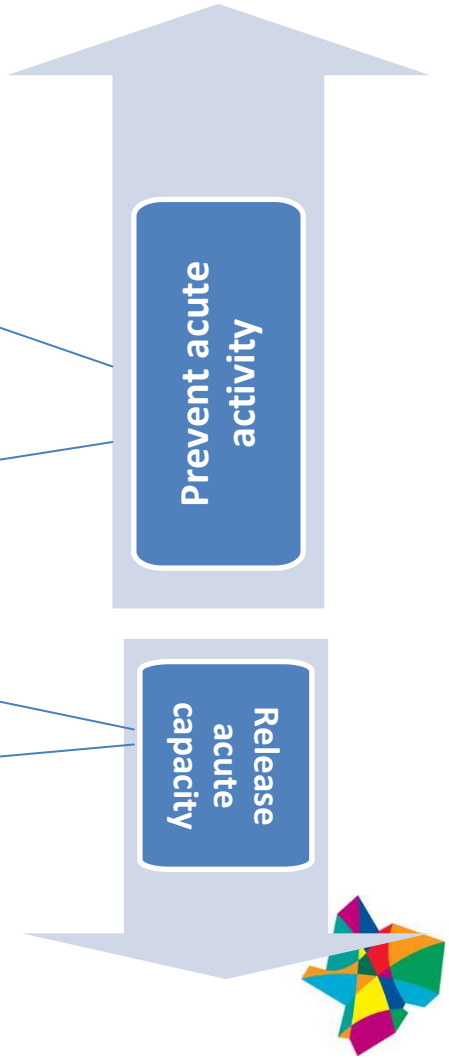
Ref no.	Scheme
Priority 1: Prevention, early detection and improvement of health-related quality of life	
1	Risk stratification
2	Lifestyle Hub
3	General Practice scheme (3-10%)
Priority 2: Reducing the time spent in hospital avoidably	
4	Clinical Response Team
5	Unscheduled Care Team
6	Mental health community crisis team
7	System Integration Coordinator
8	Intensive Community Support service
9	IT integration
Priority 3: Enabling independence following hospital care	
10	Planned Care Team
11	Mental health discharge team



Impact of BCF schemes - highlights

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Planned Care Team

•As at January 2015, **200 plus** patients each month who are over 75 are being supported by Care Navigators each month
•**6,500** care plans have been but in place for those at highest risk of unplanned admission and **618** EOLC care plans have been put in place
•Referrals to the Planned Care Team have increased by **44.3%**

Unscheduled Care Team

•**Over 2000 ICRS referrals with 621 potential saved admissions**
•**36 Intensive Community Beds now available with occupancy rates averaging 96%**
•**Doubling the night capacity and co-located with social care**
•**Hospital at Home service commenced September 2014 based at LRI expected 300 referrals for city patients over winter**

Clinical Response Team – Phase One

•**418 patients have been treated at home instead of being admitted to hospital as an emergency**
•**85% of patients seen remained at home**
•**Service now live for GP referrals and care homes with patients at risk of hospital admission – January has seen an increase in activity of nearly 40%**

BCF national metrics (1)

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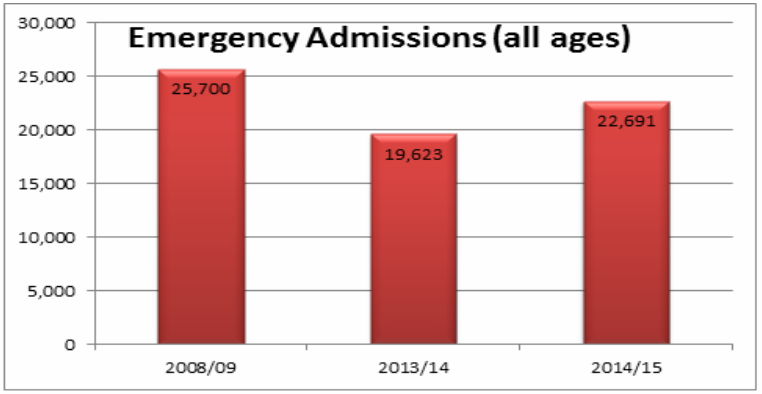
Emergency admissions have not decreased through 14/15.

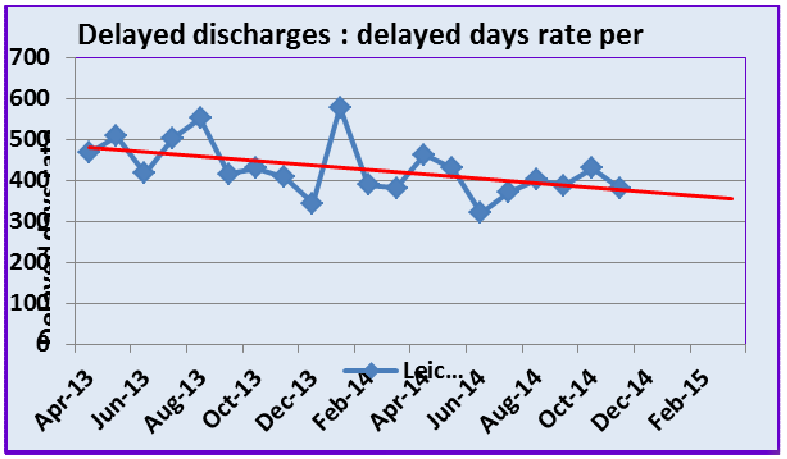
Currently, emergency admissions are +15% compared to 2013/14



Emergency admissions, all ages, Leicester City. GEM CSU

Delayed Transfers of Care have decreased through the year.

These levels have been largely sustained through winter 2014/15 at all providers.



BCF national metrics (2)

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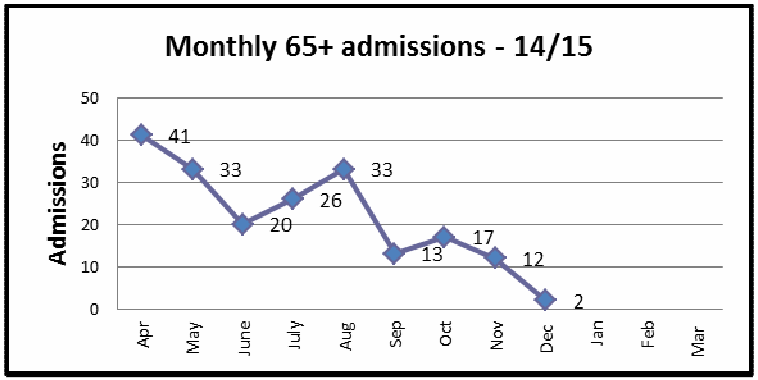
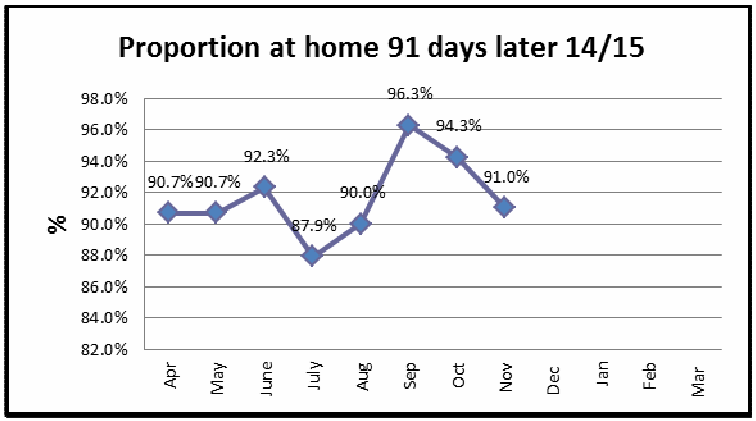
Admissions to residential care:
The BCF target for year-end activity is not to have more than 280 admissions in the year, with current forecasts predicting 276 65+ admissions for 14/15



Proportion of those aged 65+ at home 91 days later following hospital discharge:
The City has largely maintained performance at 90% against a target of 89%.



Real patient experience – November 2014

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Usual patient pathway:

Residential Care Home with 78 yr old faller calls 999 → EMAS responds within 30 mins as G2 call → Transport patient to hospital due to condition, age & time → Pt in ED for ~4 hours, admitted due to age, time and lack of independence

What actually happened via the BCF pathway:

Residential Care Home with 78 yr old faller calls the CRT → CRT ECP responds within 20 mins → Assessed and treated in home. Referred to UCT for holistic assessment → Unscheduled Care Team responded within 2 hours, provided 72 hours of care plus CGA + falls assessment etc → Patient discharged from care with full independence maintained. GP informed for follow up MUR

Plans for 15/16

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- Current interventions being evaluated
- Most schemes likely to continue with improvements based on learning from 14/15. This puts us in a much stronger delivery position
- Opportunity to link BCF interventions to a much wider agenda in 15/16 onwards as outlined in the '5 Year Forward View'