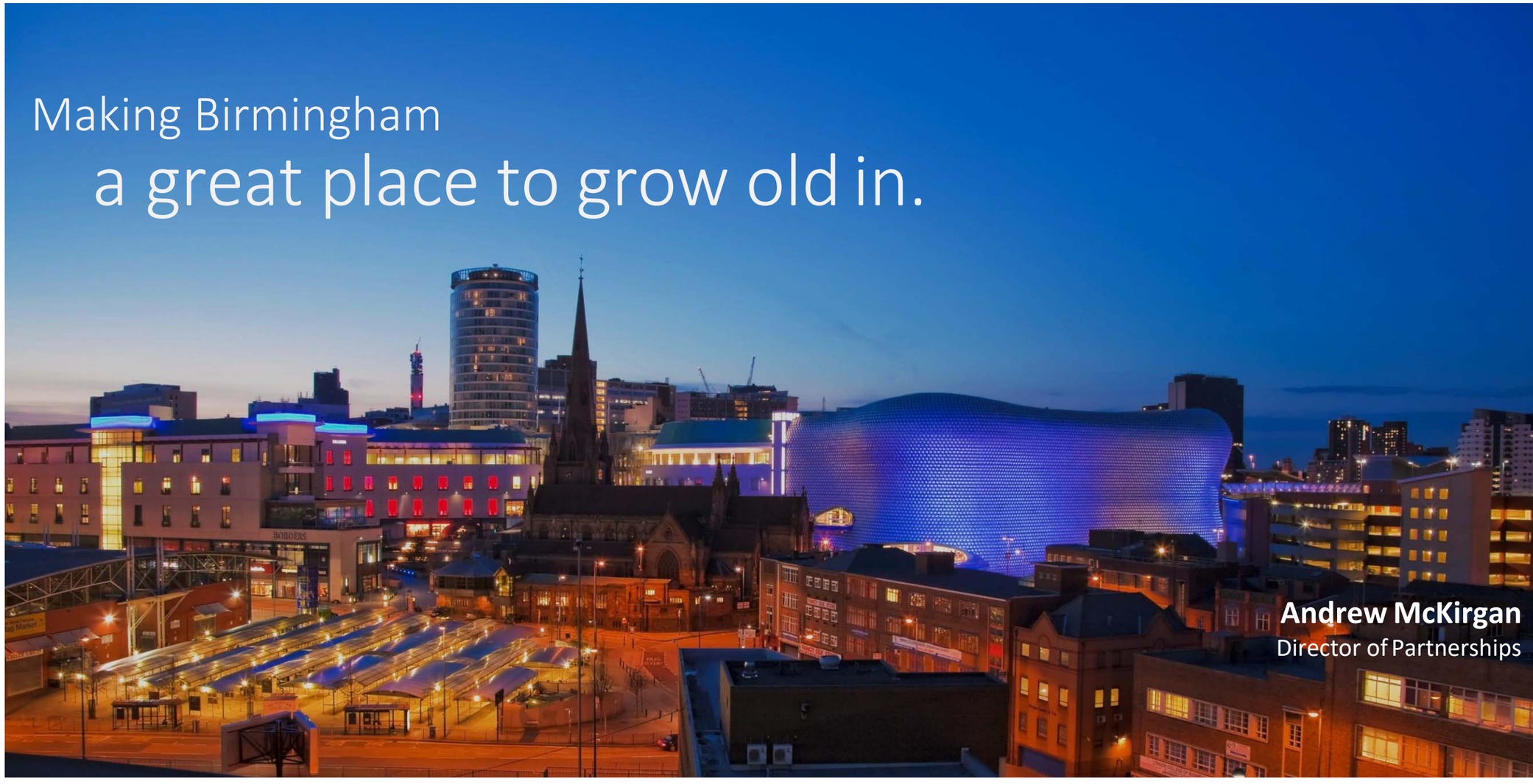

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The proportion of people we admit into hospital who could have been better looked after elsewhere. **23%**

The proportion of people in elderly care and longer stay wards who are medically fit but delayed, waiting to leave hospital. **51%**

The proportion of people who could benefit from a different pathway out of hospital, one better suited to their needs. **19%**

36% The proportion of people who could achieve greater independence, following a stay in a short-term bed, with our support.

37% The proportion of people currently with a long-term care package who could benefit from better enablement.

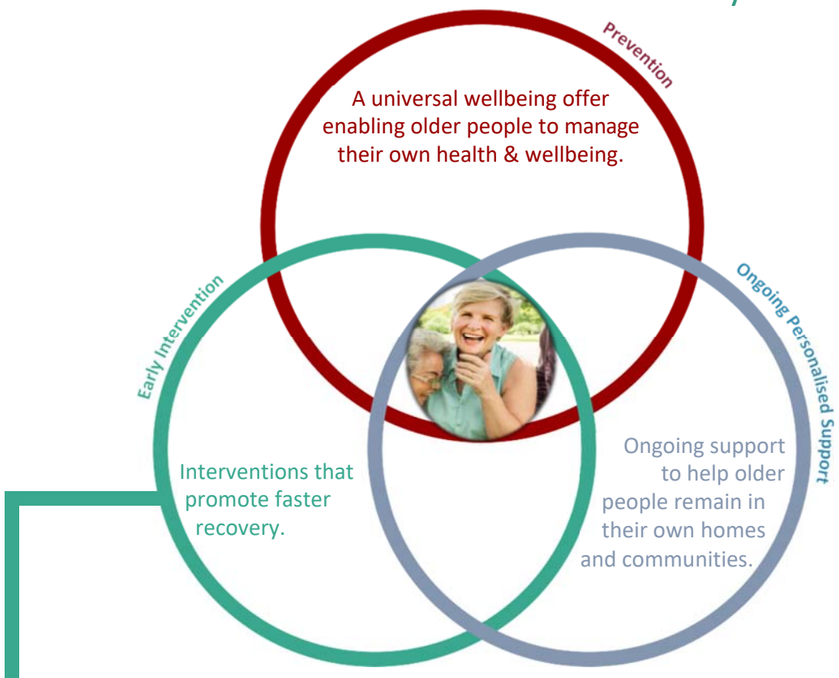
50% The proportion of people who's mental health reached crisis point (and went into hospital) that could have been avoided.

"The people of Birmingham have been let down."

Regulated by CareQuality Commission

Whole-system **vision & strategy**…

…for older people to be as happy and healthy as possible, living self-sufficient, independent lives, able to have choice and control over what they do and what happens to them.



To provide an integrated approach to intermediate care services that is person and carer centred and encompasses physical, mental health and social care needs.

November 2018

28 front-line staff from all the partners make recommendations on what needs to change and where the changes need to happen. This provides us with five areas to test our new model of care before we roll it out.

TEST AREAS

Testing is a true partnership effort: team members, sponsors and practitioners have come together from across Birmingham

Team	Test Site	What's happening?	Who's involved?

Hospital Front Door	QEH – Older Person's Assessment & Liaison Team	An enhanced and expanded Older Person's clinical team at the Front Door of our hospitals, providing specialist care quickly, reducing hospital admissions, and ensuring we care for Older People in the most ideal setting for their recovery.	• Multidisciplinary teams of practitioners from all agencies
			  • Therapy
			  • Nursing
			  • Social Work
			  • Operations
			  • Clinical
			• A new, specially trained team of cross-system improvement managers
			• Senior representatives from all partners in the Birmingham system
			• Operational & financial sponsors for each programme at director level
			• Finance managers
			• Informatics & data teams
			• Estates & services
			• Primary care engagement through 3 recently appointed GPs
			• Healthwatch for a public perspective

Hospital Back Door	QEH – Complex Discharge Hub	A multidisciplinary team responsible for the appropriate and timely discharge of Older People with ongoing complex care needs. Ensuring we make the best decision for each individual, prioritising active recovery & getting people home.	
New Community Team	Edgbaston	A brand new team providing active health & therapy recovery services at home – supporting Older People to live independently and happily in their own homes.	
Intermediate beds	Norman Power Care Centre	A therapy-led trial to standardise & simplify bed-based recovery for Older People across Birmingham. Bringing together a multidisciplinary team to promote more independent outcomes and minimise the time before an Older Person gets home.	
Acute Mental Health	Juniper Centre	Bringing together clinical, nursing, therapy and social work practitioners in our Acute Mental Health wards, to minimise every Older Person's stay and get them home.	

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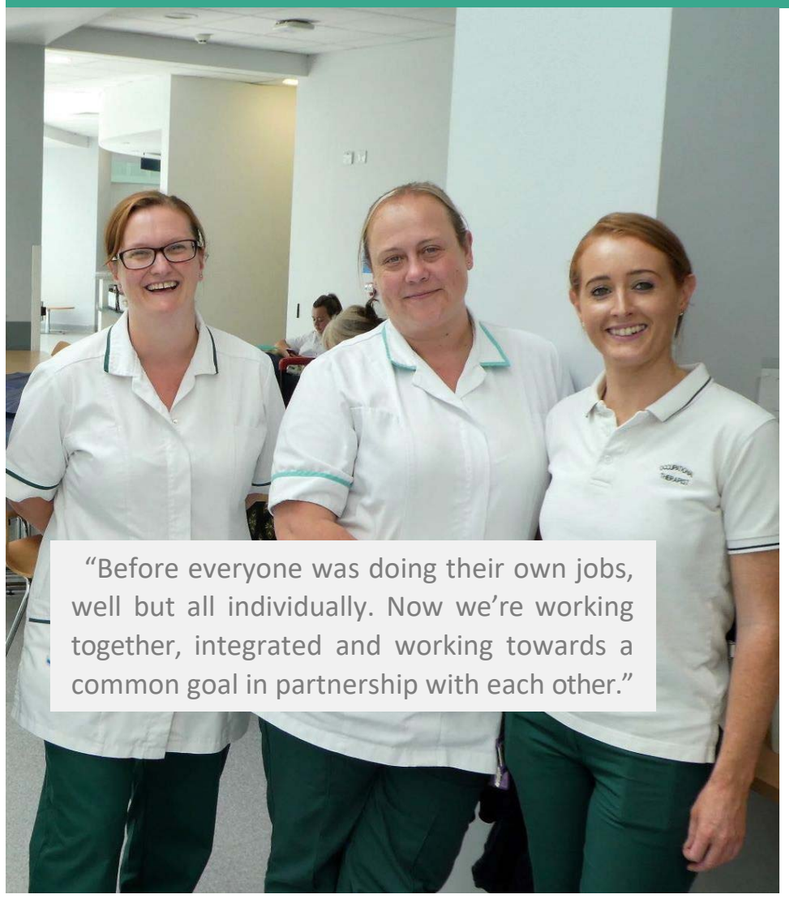
TEST AREA #1

HOSPITAL FRONT DOOR – QUEEN ELIZABETH HOSPITAL

Older People's Assessment & Liaison team at Queen Elizabeth Hospital, Birmingham



"Before everyone was doing their own jobs, well but all individually. Now we're working together, integrated and working towards a common goal in partnership with each other."

"Working together, closer will make the decision making process better and more efficient. It means patients get a better joined up service. "

The work here is all about helping older people as they enter the hospital to get the support they need ideally back in their own home, thereby reducing the number of people that end up unnecessarily in a ward.

AVOIDED ADMISSIONS PER YEAR

BEFORE: 2,400

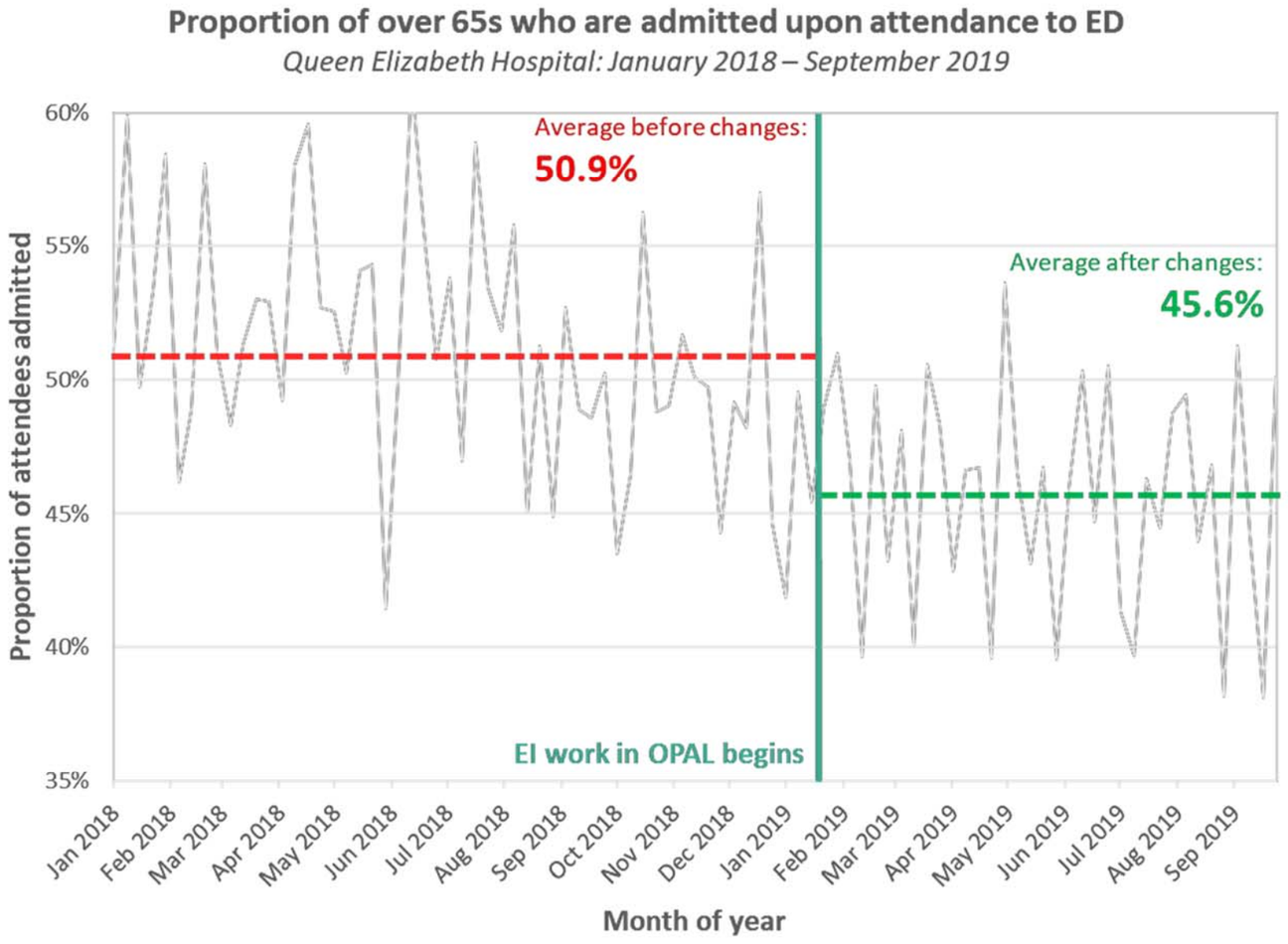
NOW: 3,650

POTENTIAL: 5,500

Numbers correct as at 10 December 2019

OPAL: QUEEN ELIZABETH HOSPITAL

ATTENDANCES & ADMISSIONS



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TEST AREA #2

HOSPITAL BACK DOOR - QUEEN ELIZABETH HOSPITAL

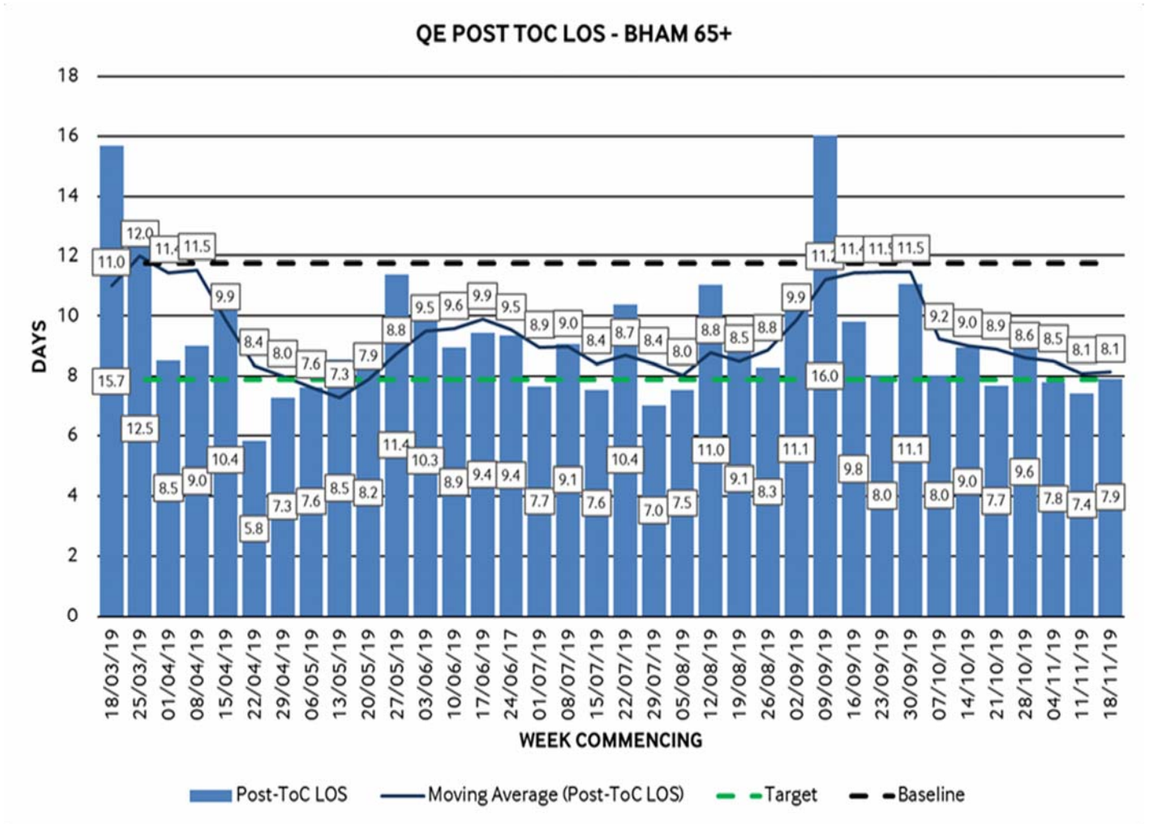
Complex Discharge Hub team at Queen Elizabeth Hospital

The work here is looking to speed up the time it takes to get older people out of the hospital. And, when we get them out, we get them to a place that is best suited to their situation because right now we often provide them with care in excess of their actual needs thereby impacting their ability to recover to their previous levels of independence.

Numbers correct as at 18 November 2019

TEST AREA #2

HOSPITAL BACK DOOR - QUEEN ELIZABETH HOSPITAL

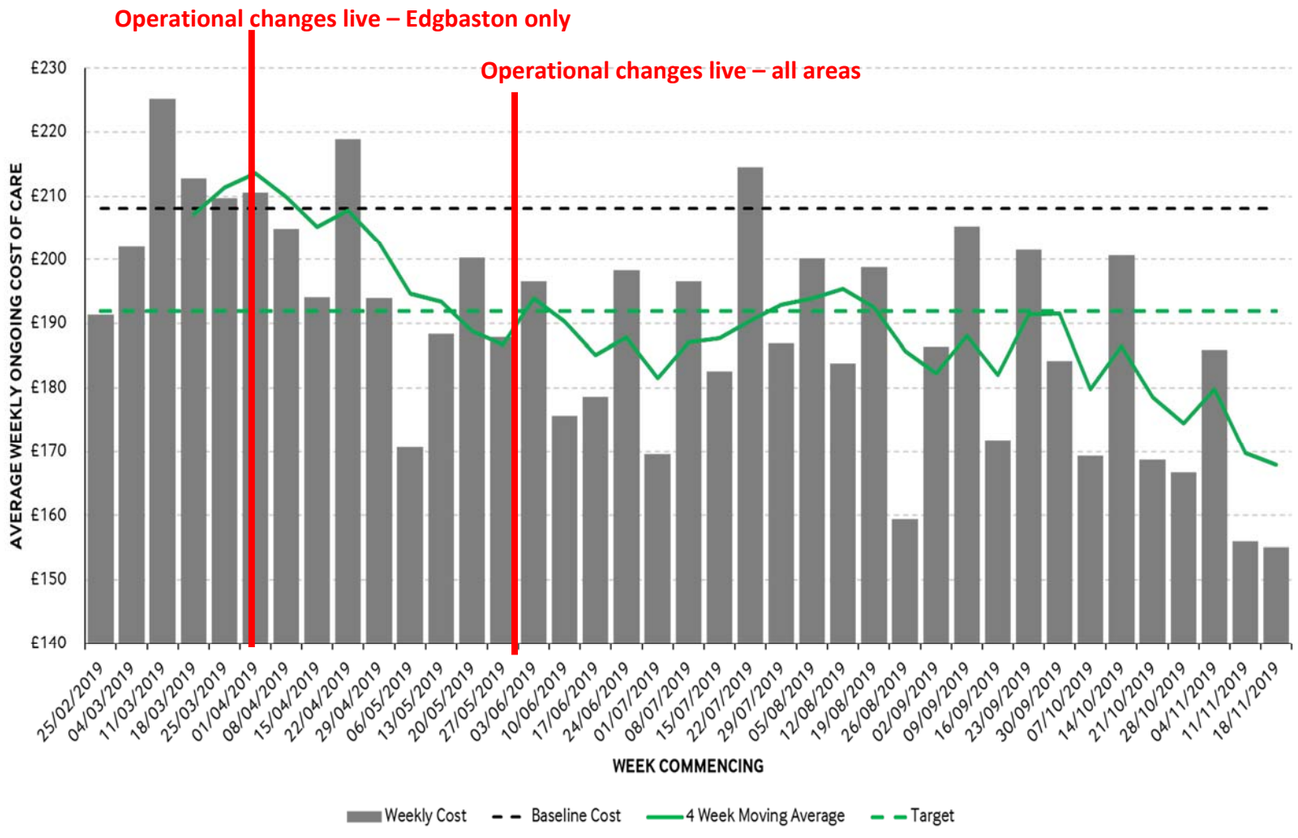


QE Complex Discharge Hub has a length of stay target of 7.9 days and despite the new community teams not being available city wide they have achieved 8.1 days.

Since the intense support from Newton finished, performance levels have not just sustained but continued to improve despite a dip in September caused by flow issues in the private EAB provision.

TEST AREA #2

HOSPITAL BACK DOOR - QUEEN ELIZABETH HOSPITAL



QE AVERAGE ONGOING COST OF CARE ALL 65+ BIRMINGHAM DISCHARGES

A consistent reduction in the cost of ongoing care following discharge from QE can be seen, including the two key milestone points where major changes were made having an impact. These changes have sustained and continued to improve well past the dotted green line target since the intense support from Newton finished.

£5m saved as at 18 November 2019

TEST AREA #3

NEW COMMUNITY TEAM – SOUTH BIRMINGHAM

"EICT is great because it is professionals working together in partnership, empowering service users and giving them a streamlined service".

"It's a wonderful service. It needs time to really get off the ground but I've seen lots of progress already".

Colleagues from the acute trust, community trust and council come together to form a new 'community team'.

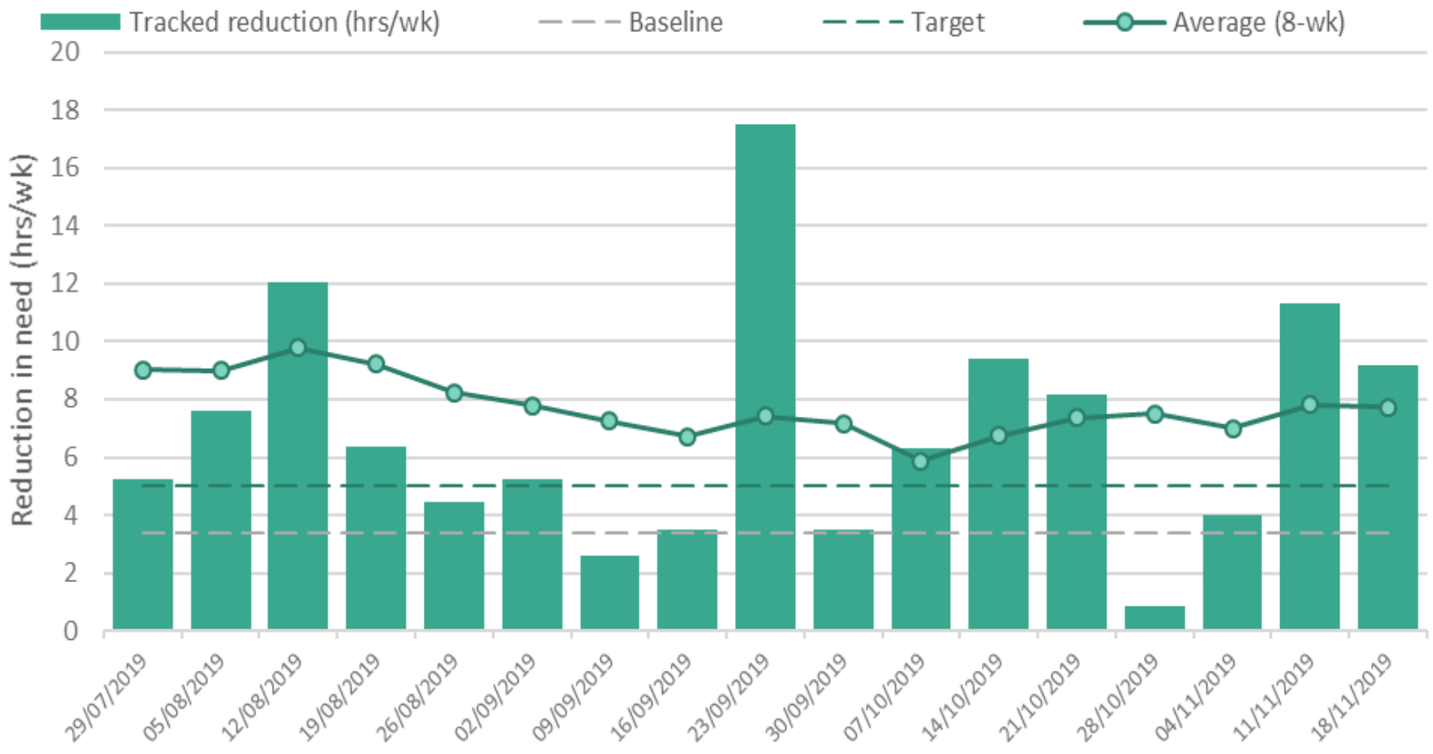
The work here was to bring the expertise currently found in services such as the Community Trust's 'Rapid Response' alongside other services that, together, would provide the right care in people's homes that helps them regain their independence and stay at home for longer.

AVERAGE REDUCTION OF **8 HOURS OF CARE PER WEEK** PER PERSON.

100% OF RESIDENTS/CARERS WOULD RECOMMEND THE SERVICE.

TEST AREA #3

NEW COMMUNITY TEAM – SOUTH BIRMINGHAM

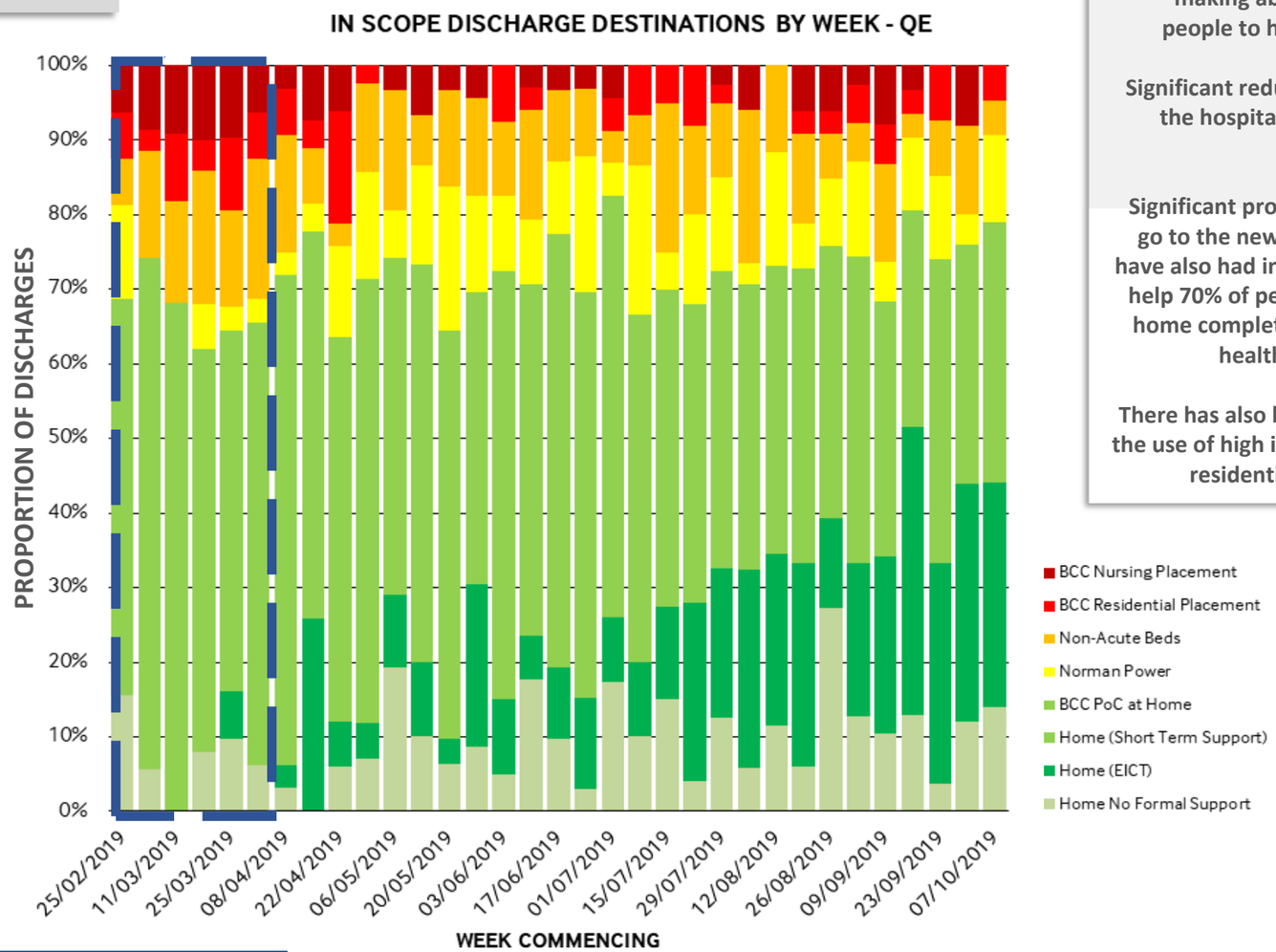


The South Community Team have consistently reduced the amount of care people receive on their service every week by levels beyond the original targets. As at end November 2019 they were reducing the number of hours of care every week per person by an average of 8 hours. This is an excellent result and has proven beyond doubt that the service will benefit citizens across the city once it is fully rolled out in 2020.

"Everyone works together as a team. It's great to have everyone working from the same office. If there's a problem, we always help each other"

Period before any changes were made.

This graph shows where staff in QE's discharge hub send older people after a stay in the hospital.



Acute back door changes start in QE.

Following six months of intense support, the decisions that staff are making about where to discharge people to have completely shifted:

Significant reduction in people leaving the hospital with sometimes costly packages of care.

Significant proportions of people now go to the new community team who, have also had intense support and now help 70% of people they see to stay at home completely independent of any health or social care support.

There has also been a steady decline in the use of high intensity, costly nursing, residential and temporary beds.

TEST AREA #4

INTERMEDIATE BEDS – NORMAN POWER

The team in Norman Power looking after 32 intermediate care beds for older people.

The work here was to increase the number of discharges from the beds to settings more aligned with the needs of the person. And at the same time, decrease the length of time people stay in an intermediate bed.

LENGTH OF STAY
BEFORE: 44 DAYS
AFTER PILOT: 30 DAYS

% OF PEOPLE GOING HOME
BEFORE: 25%
AFTER PILOT: 55%

TEST AREA #4

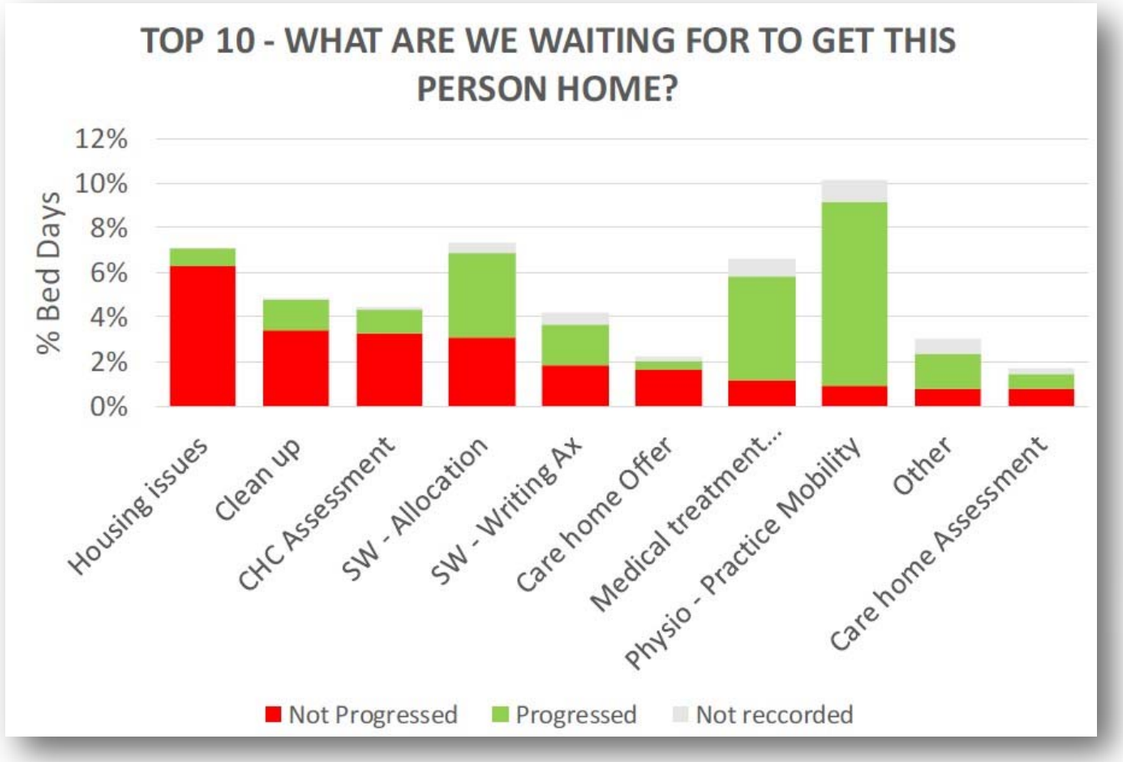
INTERMEDIATE BEDS

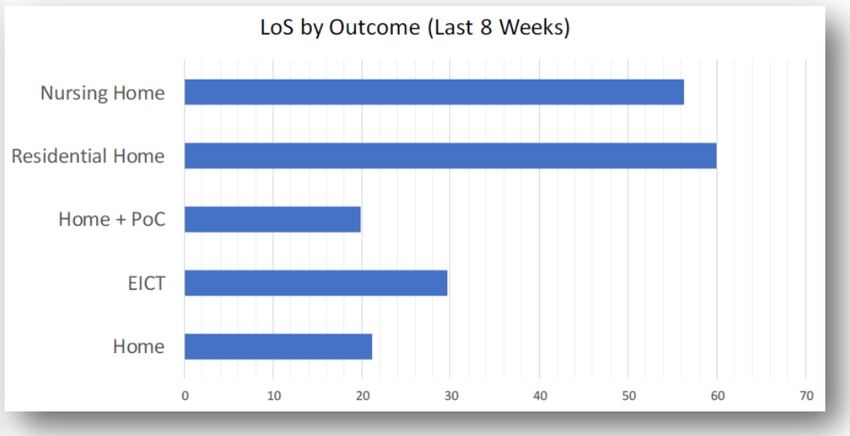
Outcomes (8 Week Average)										
Site	Discharges	% Home		Home (No PoC)	Home + EICT	Home + PoC	Short Term Bed	Residential Care	Nursing Care	Hospital
		Target	Current							
Norman Power Centre	5	33%	31%	8%	17%	6%	0%	31%	17%	8%
Moseley Hall Hospital	22	60%	65%	17%	7%	41%	12%	4%	5%	6%
Community Unit 27	5	33%	24%	18%	3%	3%	0%	3%	26%	34%

Outcomes (8 Week Average)		
Site	Total Cost (£/week/person)	
	Target	Current
Norman Power Centre	£197.68	£ 187.90
Moseley Hall Hospital	£99.24	£ 87.04
Community Unit 27	£197.68	£ 177.55

TEST AREA #4

INTERMEDIATE BEDS





TEST AREA #5

ACUTE MENTAL HEALTH

The work here was to reduce the amount of time people were staying in the hospital as a result of unnecessary delays to getting them healthier or getting them home.

NO. DISCHARGES EVERY DAY

BEFORE: 5.9 NOW: 6.6

% PEOPLE WAITING FOR SOCIAL WORK INPUT

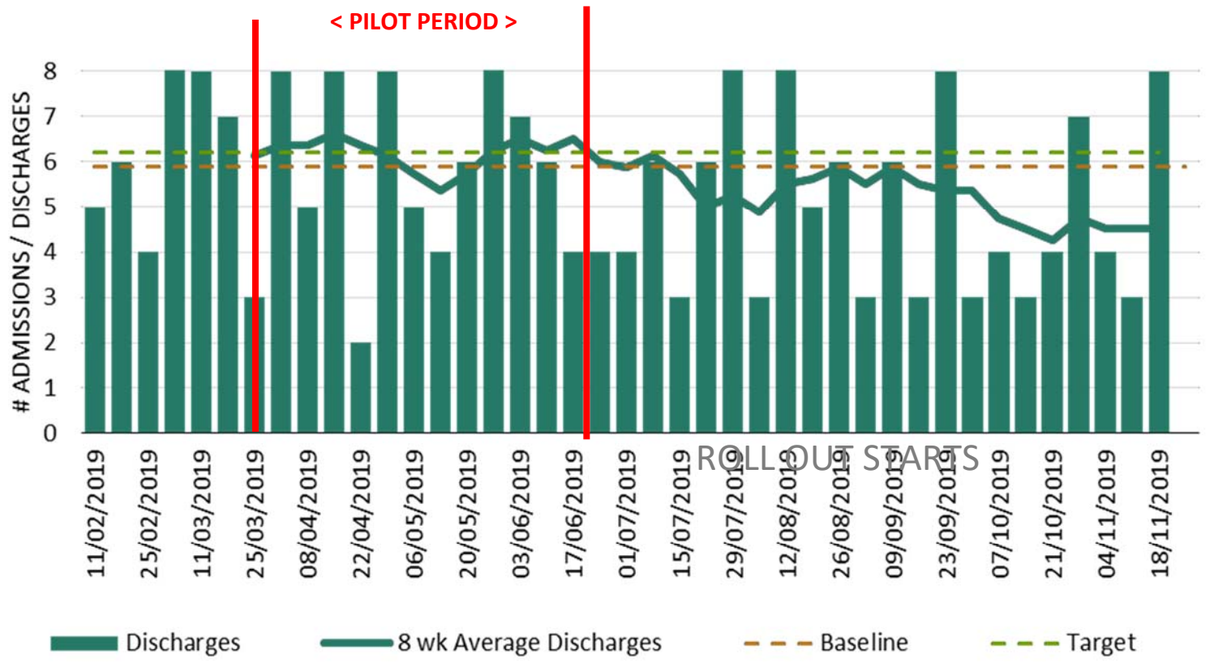
DOWN FROM 14% TO 2%

% OF PEOPLE WAITING FOR ‘ACTIVE’ TREATMENT

UP FROM 30% TO 58%

TEST AREA #5

ACUTE MENTAL HEALTH



Despite spending much of the pilot period above target in the discharge KPI, the most impactful change to social work process and the introduction of a greater amount of dedicated resource was not sustained. The changes made in the pilot were reversed in July and since this point the KPI has dropped below target and baseline.

The system has come a long way…

- **Partnership -** cross-system governance; FPDG; goodwill shared; nominated lead provider of new community team; rise in mental health profile; Council funded health activity; system level business case; agreement for commissioner/ provider alliance…

- **Culture -** front-line designed; front-line trialled; front-line triumph; disparate practice experts working together; performance-led daily management; from gifting care to gifting independence; ownership and accountability…

- **Operationally** - clear, accurate, timely, trustworthy data across the system; processes that help people get what they need, where they need, when they need it; reduced duplication; more efficient use of existing resources; clear, achievable and meaningful KPIs…

- **Improving people's lives** - more people back in their own homes; more people living more independently; more people avoiding hospital admission; more people recovering from a crisis faster….

- **Financially** – the programme is currently reporting £16.2m of annual recurring financial benefit and by spring 2020 this is forecast to rise past £20m.

Numbers correct as at 10 December 2019

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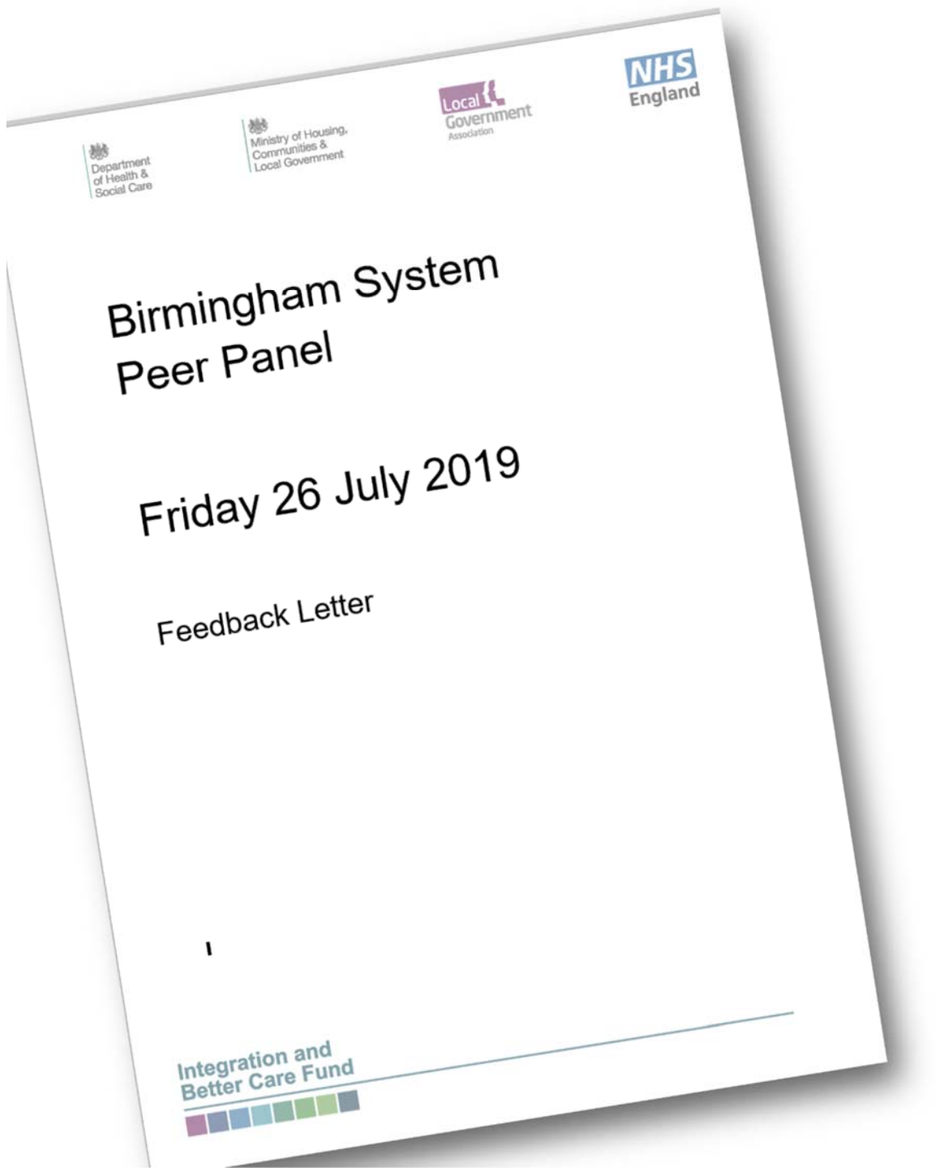

Summer 2019:

"… there is no doubt that Birmingham should be congratulated for grasping simultaneously all of these various elements in order to make a lasting change to the outcomes for older people and to make the best use of the resources that can be deployed to that end. The investment in the programme is clearly very significant in terms of:

- leadership commitment to resource the programmes
- financial investment in the changes through external consultancy
- senior leaders' investment of time and passion
- investment in use of local staff across the system as improvement managers
- use of rigorous programme management techniques and formal gateway reviews to quantify whether outcomes and financials are being delivered."

Completing the Programme

We have come a long way since the start of the programme – both as a partnership and in terms of programme impact - but have not yet fully achieved our vision for Early Intervention. Next stages include:

- City-wide roll-out of Early Intervention Community Teams from Mid-March. Ambition for the teams to be sustainably embedded by end of July 2020. Seeking approval to extend Newton support for this work;

- Transition plan to move to a model of 5 Early Intervention Bed hubs within a 12/18 month timescale – with a consistent offer of bed-based care;

- Put in place commissioning and contracting arrangements that reflect the new delivery model that has been designed and tested through the programme.

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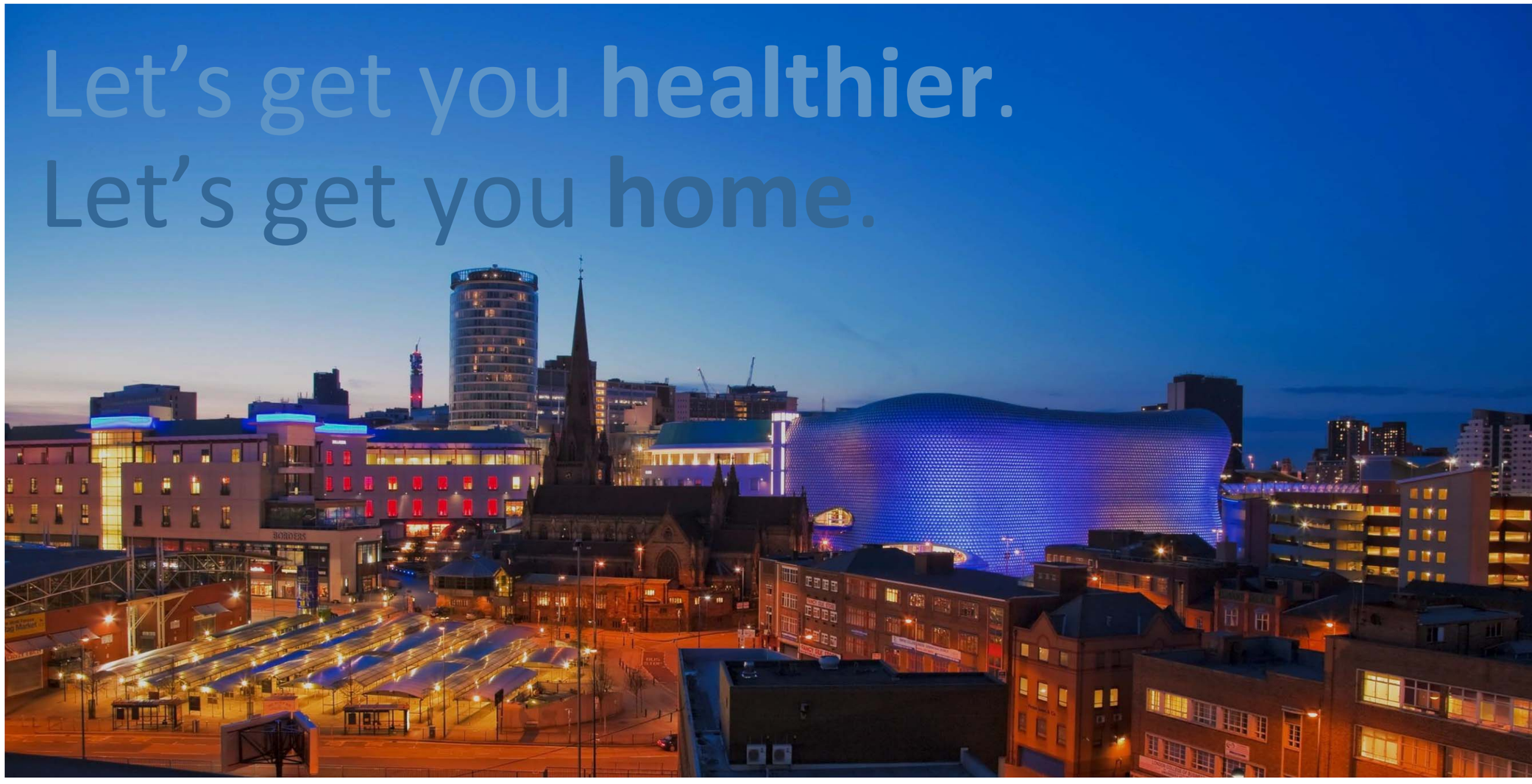
Programme Status Report - 8/1/2020

Component (Lead)	Operational KPI*						Financial Benefit (£m)			
	Description	Actual	Glidepath	Target	Baseline	Change	Live Sites	Live Benefit	Glidepath Target	System Target
OPAL (D Byrne)	No. of discharges/ day	34	38	41	27	↓ 5%	3/3	£4.5m	£7.5m	£9.1m
Hubs (N McFall)	Length of stay (days)	9.2	8.0	7.6	10.6	↓ 2%	3/3	£2.0m	£3.7m	£4.2m
	Average ongoing cost of care (£/week)	£ 160	£ 154	£ 153	£ 165	↑ 0%	3/3	£1.0m	£4.2m	£4.5m
EIBs (B Richards)	Length of stay (days)	33.3	32.2	32.2	34.4	↓ 8%	2/5	£1.0m	£0.5m	£0.6m
	Average Ongoing Cost of Care (£/week)	£ 140	£ 145	£ 145	£ 149	↓ 1%	2/5	£0.5m	£0.2m	£0.4m
EICT (L Walsh)	Non-readmission discharges/week	9.3	8.9	8.9	4.6	↓ 8%	1/5	£0.6m	£0.6m	£7.5m
	Need reduction (hrs/wk/pers.)	8.8	5.0	5.0	3.4	↑ 4%	1/5	£2.1m	£0.6m	£6.4m
MH Wards (D Tobin)	Discharges/week	6.1	6.3	6.3	5.9	-	1/1	£0.3m	£0.4m	£0.4m
EI PROGRAMME						TOTAL:	10/17	£12.1m	£17.7m	£33.1m

*Ops actuals, glidepath, target, baseline and sustainability status is only shown for sites with measures live



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