Making Birmingham

a great place to grow old in.

The Early Intervention Programme.

Part of the Birmingham Older People's Programme.

Health & Wellbeing Board

Status as at 11 July 2019

Live healthy
Live happy
Birmingham and Solihull

Birmingham City Council

NHS

This is not about Health
and it's not about Social Care.

This is about people's lives.

Together with partners from across health and social care, we have committed to 'Making Birmingham a great place to grow old in'.

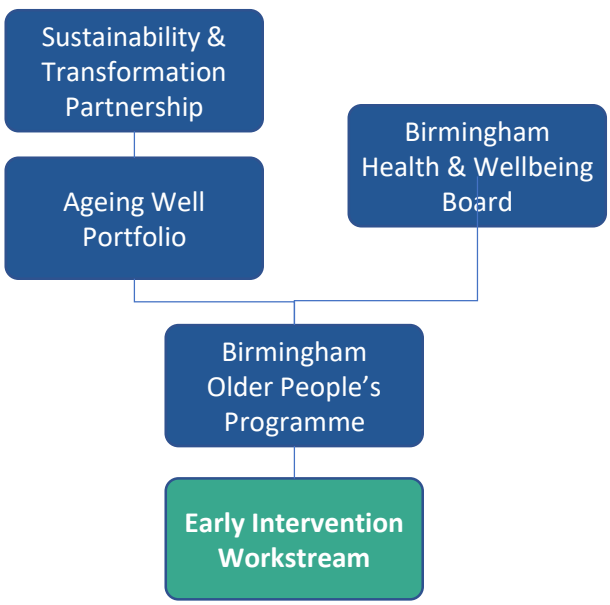
In doing so, we can help older people be happy and healthy, live self-sufficient, independent lives, with choice and control over what they do and what happens to them.

To deliver this we believe we need to design an integrated model of care that will deliver the right support, in the right place, at the right time. And once it's designed, make sure it delivers better outcomes for older people.

As part of this work, a team has been working on the delivery of a new early intervention model, that provides urgent assessment, treatment and care to older people; as well as a range of integrated services that promote recovery and independence.

This report provides an update on progress on how we designed the new integrated model of care, as well as how we tested the new model on the front-line and the results we achieved.

Andrew McKirgan
Senior Responsible Officer
Early Intervention Workstream
Birmingham Older People's Programme



You may be wondering how this work fits into other things that you might have heard of, like the Birmingham and Solihull Sustainability and Transformation Partnership (STP), and the Birmingham Health and Wellbeing board.

The Ageing Well Portfolio is one of the key priorities of the STP. Within the Ageing Well Portfolio, the Birmingham Older People's Programme is taking the lead in Birmingham.

The Birmingham Older People's Programme reports into both the STP and the Birmingham Health and Wellbeing Board.

Finally, the Early Intervention Workstream is one part of the Birmingham Older People's Programme.

MAKING BIRMINGHAM
A GREAT PLACE TO GROW OLD IN

You may have seen 'Phyllis', a production by the Women in Theatre group commissioned by the STP. The play focused on the experiences of Phyllis and her family when she was admitted to hospital. The production has been seen by hundreds of people across Birmingham and graphically underlined what needs to change to improve older people's experiences of health and social care. These are the issues we want to address.

We also knew in order to move forward we had to take on board the findings of the CQC system-wide report and an independent, detailed analysis of the root cause of our challenges completed by Newton.

Phyllis Photo credit: Stephen P. Burke

As a result of the findings, it became apparent that a **single system vision**, linked to the wider STP vision and strategy, was absent and we were letting down our older citizens like Phyllis. Both executive and operational leads agreed a joint vision was essential for all organisations to start moving forward together.

During 2018, we agreed an overarching vision for where we wanted to be in the future.

The vision of the Birmingham Older People's Programme is:

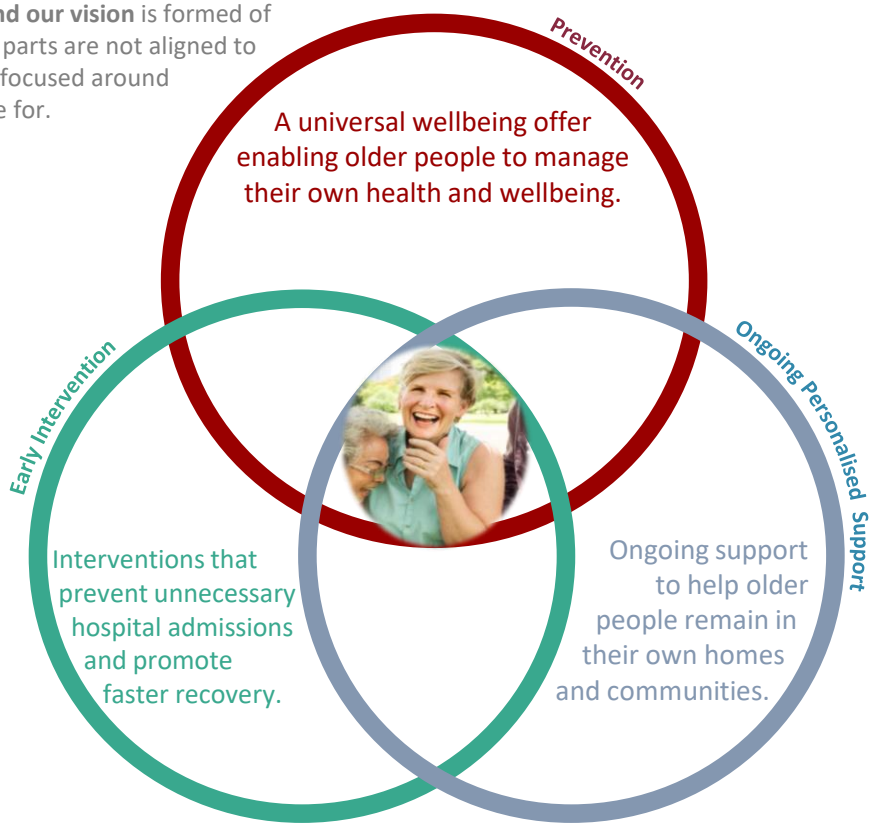
for older people to be as happy and healthy as possible, living self-sufficient, independent lives, able to have choice and control over what they do and what happens to them.

Getting to this point was itself an achievement given that historically we only ever worked inside our own organisations fixing things we could control, as opposed to working together across the system. It was clear that to achieve our ambitions would require us to think differently – **less about what our individual organisations do today that doesn't work and more about what older people need now and in the future.**

We have therefore committed to provide support that is **'joined-up'** across organisations so that older people do not experience duplication of services or delays in accessing support or fall between the gaps. We are open to new ways of doing things and we will make the most of the strengths of all our partner organisations from the public, private, voluntary and community sectors. There will be **no wrong door** throughout the system, avoiding people struggling and often failing to get the support, care and advice they need.

In order to give older people across Birmingham choice and control over what they do and what happens to them, we need to think of them as being at the **centre of everything we do**.

The strategy behind our vision is formed of three parts. These parts are not aligned to organisations, but focused around the people we care for.



PREVENTION

A universal wellbeing offer enabling older people to manage their own health and wellbeing, based in local communities and utilising local resources. It will address the issues that lead to older people entering into formal health and care systems, such as social isolation, falls and carer breakdown. Access to good quality information and advice will be the cornerstone of our wellbeing offer, enabling people to identify and access the support that they need in order to maintain living fulfilled lives.

EARLY INTERVENTION

A range of targeted interventions to promote faster recovery from illness or injury, prevent unnecessary hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. We will respond quickly, minimise delays and not make decisions about long term care in a hospital setting.

PERSONALISED ONGOING SUPPORT

Some older people will need ongoing support to remain living in their own homes and communities. These services aim to maintain individual wellbeing and self-sufficiency, keep older people safe and enable them to be treated with dignity, stay connected to their communities and avoid unnecessary admissions to hospitals or care homes. We will change the way our services are commissioned and delivered to be more focused on achieving better outcomes for older people.

EARLY INTERVENTION **EXPLAINED**

Early Intervention is described in the green box on the previous page. The ultimate aim is to help people remain in their homes whenever possible. In most cases, this means older people are more comfortable and regain their independence more quickly if good quality therapeutic support is provided.

In 2017 Newton were commissioned to independently assess the health and social care services provided to older people before, during and following a crisis. Results highlighted areas going well and what could be done differently in order to:

- **Improve outcomes for those in need**
- **Improve the effectiveness of some services**
- **Improve the efficiency of service delivery**
- **Improve how organisations work together**
- **Deliver financial benefits**

In response, health and social care professionals worked together to identify a number of **principles**. These principles form a useful guide for understanding what it is and what it isn't:

- Our aim is to have one integrated model across our entire system.
- The person must be at the centre of everything we do (with family and carer input also valued).
- Our aim is to support their life not simply deliver a service.
- We need to make sure each person receives the right care, at the right time, in the right place, by the right professional, at the right cost.
- People should only have to tell their story as few times as possible.
- Staff across organisations work together to champion the 'home first' ethos.
- And the result of all these points - more people will live more independently in later life.

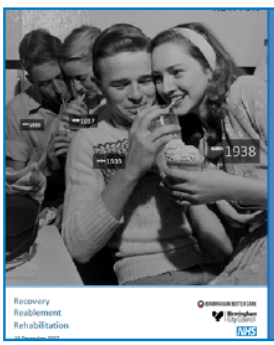
Working this way will mean:

- New relationships across the system.
- Removal of organisational boundaries.
- No wrong door for someone that needs help.
- Clearly defined roles to maximise skills and capacity.
- Efficient distribution of resources within a locality.
- Overall consistency accepting local variation where it makes sense.

The Early Intervention Programme will help us turn our vision into reality and ultimately achieve better outcomes for thousands of older people and at the same time deliver financial benefits for our system.

Early intervention will draw on the skills of a number of people working together. These are represented today in roles such as:

Consultant Geriatrician | CPN
Enablement Worker | Nurse
Occupational Therapist | Paramedic
Physiotherapist | Social Worker
GP | Specialist Nurse



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.

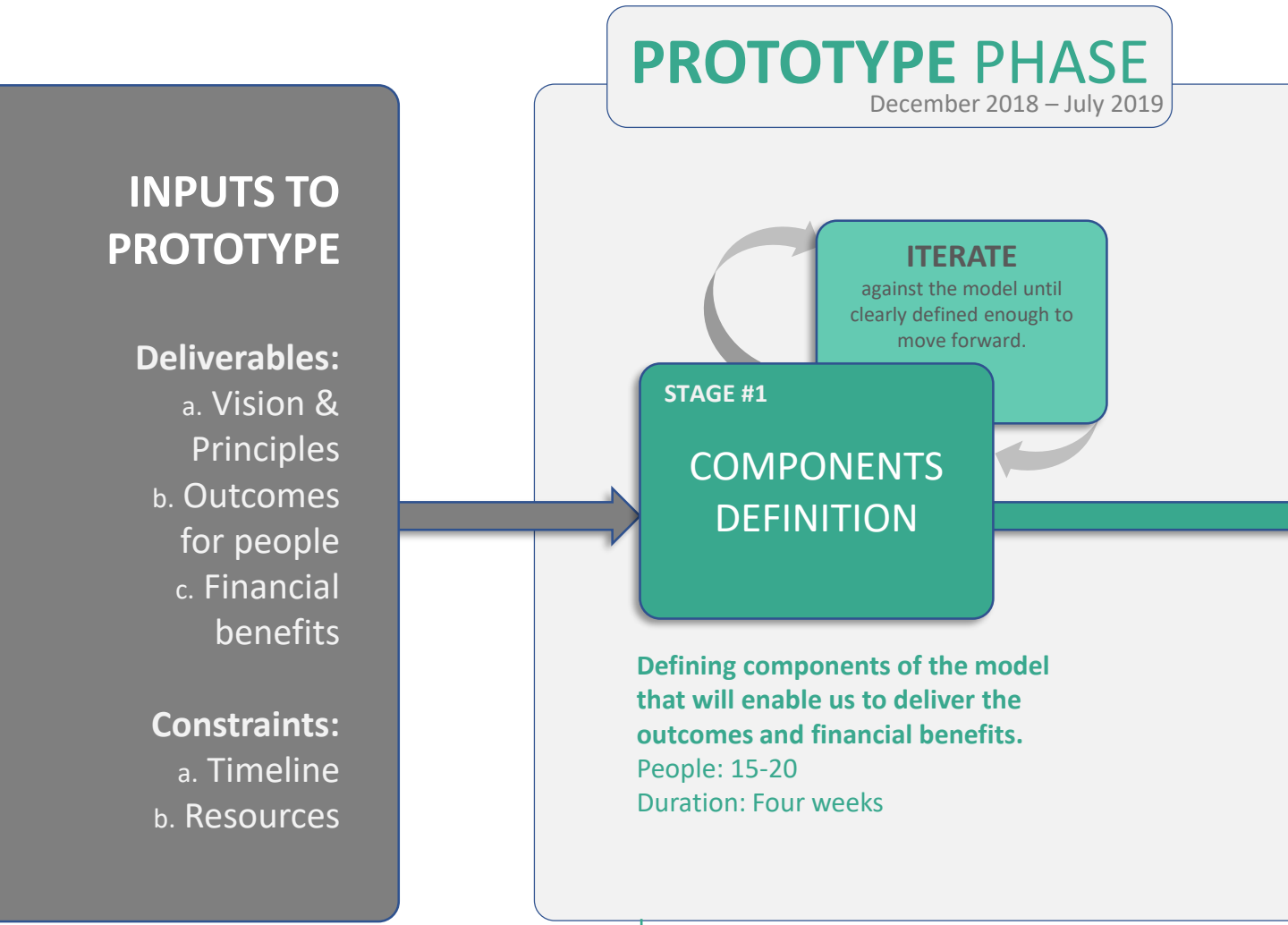
Six high-level headlines from the Newton work against which detailed analysis of root cause was provided.

HOW WE **GOT STARTED**

HOW DID WE **GET STARTED?**

During December 2018, 28 front-line staff and managers came together from all the organisations over three dates to work out the very first steps needed to move us closer to our ambition.

Working with Newton - specialists in large scale, front-line-led transformation - we started with a 'prototype' phase that splits our longer-term vision and ambition into more manageable chunks (or components – see stage 1 below), and in doing so allows us to thoroughly test and improve each bit separately (stage 2 below) before we then bring all the individual components together in one locality and test and improve how they work together until they are achieving everything we hoped they would. We knew if we could get this right it would make the roll-out of the changes much easier and more successful. We are currently at the very end of this prototype phase, with only a few weeks still to go.

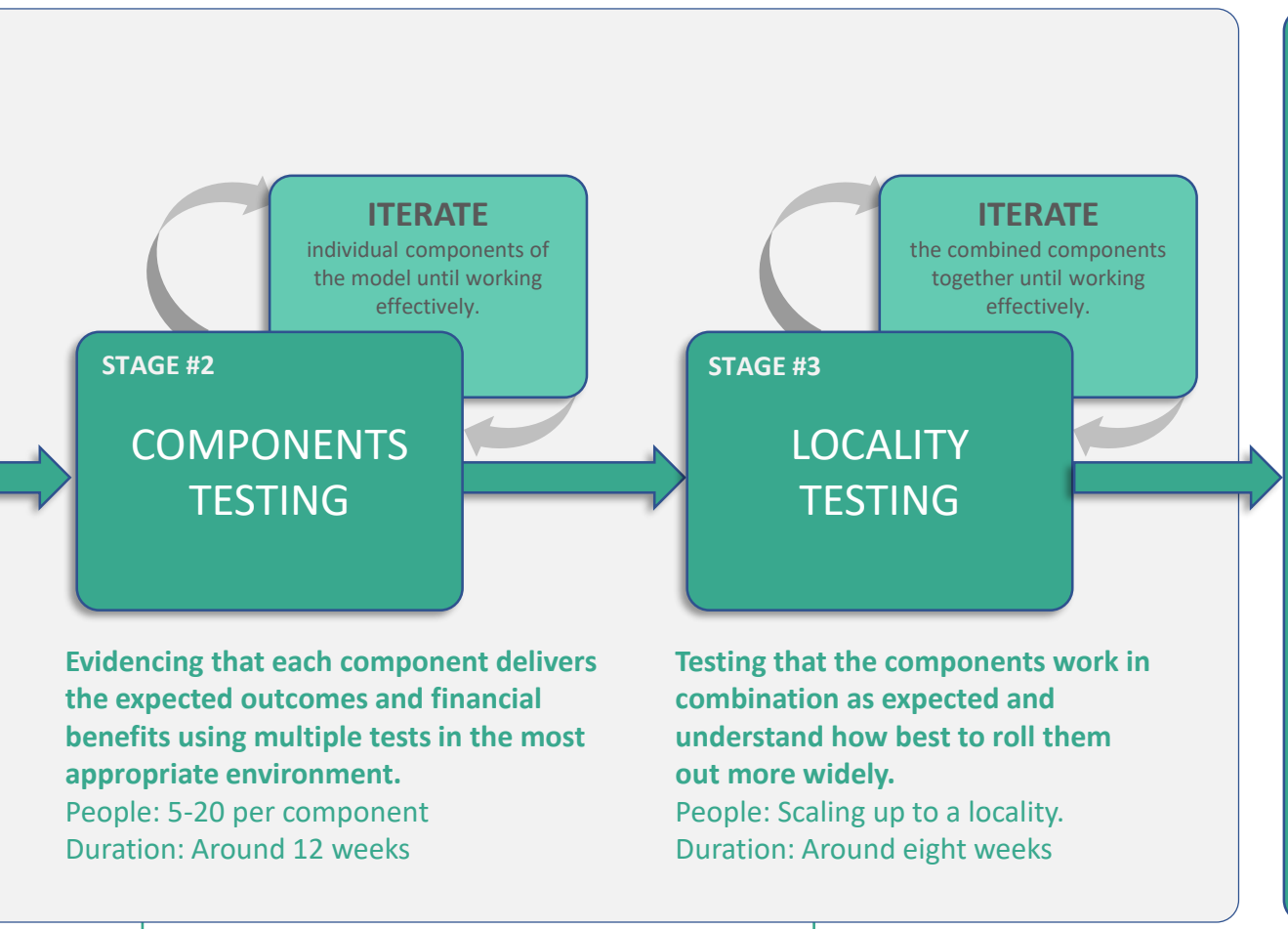


THE **COMPONENTS DEFINITION** STAGE

We've dropped into this document two outputs from this first stage. Firstly, a sample output from the group workshop agreeing what the experience needs to be like for the older person and the member of staff; and secondly, the output from the group discussion on which services should be included in the next stage – testing – along with who should participate and where each test site should be.

THE **ROLL-OUT** PHASE

This starts with planning a roll-out approach. What resources are required, what timelines are we working to, what is in and out of roll-out scope, and what does each organisation need to do separately, as well as collectively, to turn the results from the tests into results the whole city can benefit from.



Evidencing that each component delivers the expected outcomes and financial benefits using multiple tests in the most appropriate environment.
People: 5-20 per component
Duration: Around 12 weeks

Testing that the components work in combination as expected and understand how best to roll them out more widely.
People: Scaling up to a locality.
Duration: Around eight weeks

THE **COMPONENTS TESTING** STAGE

This stage helped us demonstrate exactly what operational changes impacted positively on outcomes, performance and cost for each component. By understanding this, we have been able to prioritise the ones with the biggest and best impact for citizens.

THE **LOCALITY TESTING** STAGE

Since May 2019 we have been testing how the separate components work together. For example: how OPAL or CDH can refer to the new community team; and how the intermediate beds are affected by different cohorts of older people moving through our system. **This is where we are today, with only a few weeks remaining before this work is completed.**

STAGE #1

COMPONENTS DEFINITION

This is a sample output from the group workshop agreeing what the experience needs to be like for the older person and the member of staff

How did teams from across Birmingham describe what services for older people should be like in the future?

The older **person in need** of some extra help should be able to say…

I'm in control and I feel safe.
I have my own plan, it's up-to-date, I know what's in it, it makes sense, I know what I need to do and how much I need to pay.
I can get the help I need - with things important to me - when I need it.
I feel listened to.
I know who to contact, they know me too - and we are honest with one another.
When I need some extra help, I am not overwhelmed by lots of different people coming and going.
The help I get fits around me - regardless of where I live - not the other way around.
It feels like my local community is there for me and there are things going on that can help me.
I am the one who's responsible for planning ahead for my own future.

The **member of staff** providing the help should be able to say…

There's one plan, it tells the person's story, it works for everyone and it's continuous.
I'm using my training and professional judgement, I'm capable and competent.
When I make decisions I feel confident and supported and I get feedback.
I know what options are available, they are relatively simple to follow and when new options become available I am effectively informed.
It's straightforward to join up with peers from different services when we need to and when I work with them we are honest with each other, we listen to each other, we trust one another.
The way I am measured is meaningful - aligned to outcomes.
I have access to forward-thinking services. The way we're set up means it's easy to work with local services.
I feel safe - through joint working or through feeling connected to the rest of my team.

STAGE #1

COMPONENTS DEFINITION

This is a summary of the output from the group, agreeing which services should be included in testing, along with who should participate and where each test site should be.

- 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?

Early Intervention 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.	• 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 and financial sponsors for each programme at director level
			• Finance managers
			• Informatics and data teams
			• Estates and services
			• Primary care engagement through three recently appointed GPs
			• Healthwatch for a public perspective

Acute 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.	
Acute Back Door	QEH – Complex Discharge Hub for Edgbaston	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 person, prioritising active recovery and getting people home.	
Early Intervention Beds	Norman Power Care Centre	A therapy-led trial to standardise and 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.	

WHO'S **INVOLVED?**

Various groups of people have been carefully selected to get involved so that all organisations are represented, but the way we make progress is always together:

The **Chief Executives** of our organisations, who signed off the programme, are actively involved in helping to unblock some of the thorny challenges that make it difficult for us to work effectively across the system.

The **Citizen Representatives** who will be working throughout the programme to ensure service user experience is improved through co-production.

Three **GPs** applied to get involved in the programme and are provided support, challenge and feedback to the group.

The **Early Intervention Steering Group**, where we have executive leads for each organisation. The Early Intervention Steering Group are the ones who have been shaping the vision and setting up the programme so far:

- Birmingham City Council – Louise Collett, Pauline Mugridge, Mike Walsh
- Birmingham Community Healthcare NHS Foundation Trust- Chris Holt & Angie Wallace
- Birmingham & Solihull Mental Health Foundation Trust- Derek Tobin
- Birmingham & Solihull Clinical Commissioning Group - Karen Helliwell/Helen Kelly
- University Hospitals Birmingham NHS Foundation Trust - Andrew McKirgan
- University Hospitals Birmingham NHS Foundation Trust, Heartlands & Good Hope sites - Andrew Clements
- Programme lead - Judith Davis
- STP Special Adviser Older People - Professor Zoe Wyrko

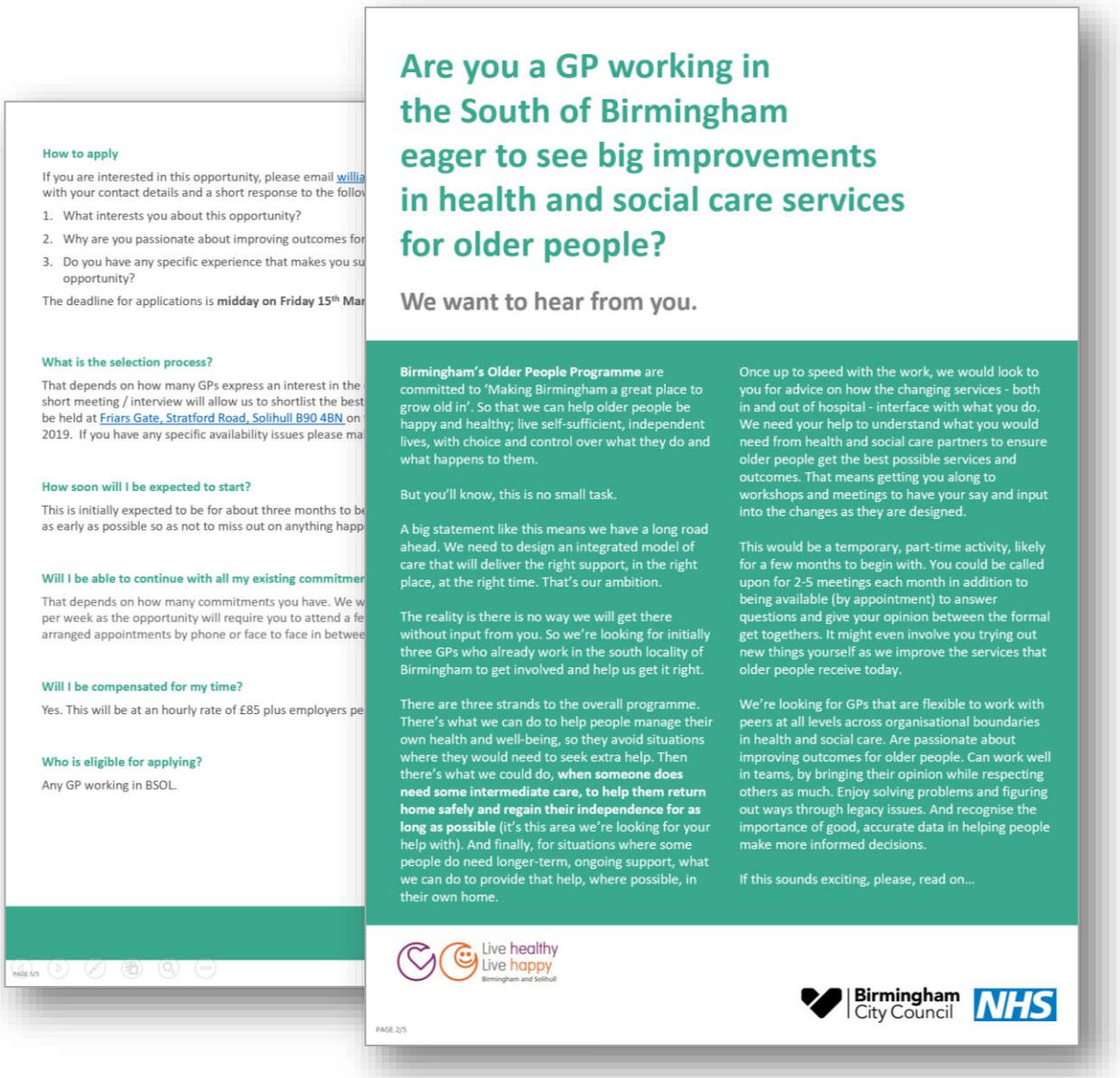
The **Finance Group**, who will help ensure the programme measures the right things and keeps on top of its performance and financial measures is chaired by Phil Johns, Deputy CEO, BSol CCG and has participants from every organisation.

The **Improvement Managers**
Eight dedicated 'Improvement Managers' have been recruited from across the system to support this programme. These eight individuals have been selected for their passion for improving outcomes for older people, their ability to work across the organisational boundaries, and their ability to solve problems and embrace change. They will be working full time as part of the Early Intervention team for the next year.

PROGRAMME SUPPORT FROM **PRIMARY CARE**

An invitation to participate in the programme was advertised and – following a selection process – three GP's were appointed to act in an advisory capacity to the programme:

Roger Gent – Coutts & Partners
Layla Eagles – Lordswood House Group Medical Practice
Rory Meade – Harborne Medical Practice



How to apply

If you are interested in this opportunity, please email willia
with your contact details and a short response to the follo

1. What interests you about this opportunity?
2. Why are you passionate about improving outcomes for
3. Do you have any specific experience that makes you su
opportunity?

The deadline for applications is **midday on Friday 15th Mar**

What is the selection process?

That depends on how many GPs express an interest in the
short meeting / interview will allow us to shortlist the best
be held at Friars Gate, Stratford Road, Solihull B90 4BN on
2019. If you have any specific availability issues please ma

How soon will I be expected to start?

This is initially expected to be for about three months to b
as early as possible so as not to miss out on anything happ

Will I be able to continue with all my existing commitmer

That depends on how many commitments you have. We w
per week as the opportunity will require you to attend a fe
arranged appointments by phone or face to face in betwee

Will I be compensated for my time?

Yes. This will be at an hourly rate of £85 plus employers pe

Who is eligible for applying?

Any GP working in BSOL.

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Are you a GP working in the South of Birmingham eager to see big improvements in health and social care services for older people?

We want to hear from you.

Birmingham's Older People Programme are committed to 'Making Birmingham a great place to grow old in'. So that we can help older people be happy and healthy; live self-sufficient, independent lives, with choice and control over what they do and what happens to them.

But you'll know, this is no small task.

A big statement like this means we have a long road ahead. We need to design an integrated model of care that will deliver the right support, in the right place, at the right time. That's our ambition.

The reality is there is no way we will get there without input from you. So we're looking for initially three GPs who already work in the south locality of Birmingham to get involved and help us get it right.

There are three strands to the overall programme. There's what we can do to help people manage their own health and well-being, so they avoid situations where they would need to seek extra help. Then there's what we could do, **when someone does need some intermediate care, to help them return home safely and regain their independence for as long as possible** (it's this area we're looking for your help with). And finally, for situations where some people do need longer-term, ongoing support, what we can do to provide that help, where possible, in their own home.

Once up to speed with the work, we would look to you for advice on how the changing services - both in and out of hospital - interface with what you do. We need your help to understand what you would need from health and social care partners to ensure older people get the best possible services and outcomes. That means getting you along to workshops and meetings to have your say and input into the changes as they are designed.

This would be a temporary, part-time activity, likely for a few months to begin with. You could be called upon for 2-5 meetings each month in addition to being available (by appointment) to answer questions and give your opinion between the formal get togethers. It might even involve you trying out new things yourself as we improve the services that older people receive today.

We're looking for GPs that are flexible to work with peers at all levels across organisational boundaries in health and social care. Are passionate about improving outcomes for older people. Can work well in teams, by bringing their opinion while respecting others as much. Enjoy solving problems and figuring out ways through legacy issues. And recognise the importance of good, accurate data in helping people make more informed decisions.

If this sounds exciting, please, read on...

Live healthy Live happy
Birmingham and Solihull

Birmingham City Council NHS

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PROTOTYPE PHASE:
TESTING RESULTS

TEST AREA #1
HOSPITAL FRONT DOOR

All figures correct as at 9 July 2019

CONTEXT:
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 in a ward.

The Older Person's Assessment & Liaison service (OPAL) at the QE was chosen as the test site. Before changes were put in place, OPAL were already getting **6.6 people home every day**. That's around 2,400 a year.

RESULTS:
By changing the data captured; improving the quality and access to that new data; improving the actions that are taken by the team using the new data; optimising the mix of skills in the department; and giving the team access to the new community team (test area #3) – **OPAL now get 9.3 people home every day**. That's around 1,000 more people every year.

Right now, the single biggest blocker for OPAL not being able to get even more people straight home is related to IV – both antibiotics and fluids. Having improved access to these would allow OPAL to get an **extra two people home every day** – 730 a year.

However, more could be achieved. OPAL are not seeing everyone they could see right now because there aren't enough people in their team. A study at the QE front door revealed there are between **1,000 and 1,500 more older people** that could benefit from OPAL's input if they had the staff to see them – the shortages are broadly found in Nursing, Therapists and Geriatricians.

To support the case to invest in OPAL another study at QE was conducted to evaluate how 'effective' OPAL is at stopping people being admitted into hospital. The results were clear – as an older person, if you see OPAL **you have a 70% chance of going straight home.** If OPAL don't see you, you have a 52% chance of being admitted onto a ward.

COMING NEXT:
Meetings with teams at Good Hope and Heartlands hospitals are underway / being scheduled to first understand similarities / differences in operating models. Once established, it will be clear to what extent all the hospitals can benefit from the changes and successful results tested in QE.

Queen Elizabeth Hospital OPAL department was chosen as the test site.

TEST AREA #2
HOSPITAL BACK DOOR

All figures correct as at 9 July 2019

CONTEXT:
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.

The QE 'Complex Discharge Hub' was chosen as the test site. Before changes were put in place, the average time it would take to get a person out of hospital once they were declared medically fit was **12 days**.

RESULTS:
By changing the data captured; improving the quality and access to the new data; improving the actions taken by the team using the new data; improving how the social workers and nurses work together; and giving the team access to the new community team (test area #3), the 12 days has reduced down to **nine days**.

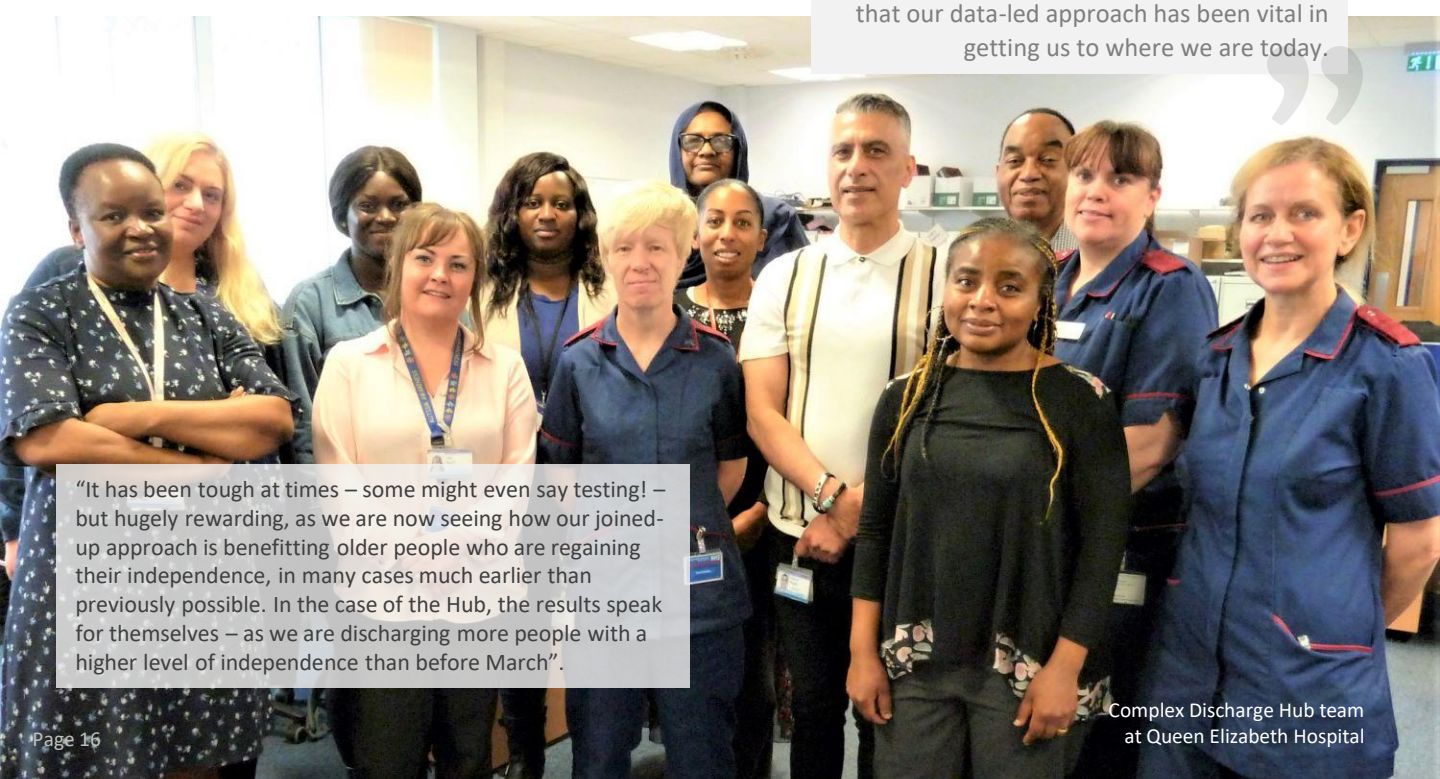
This reduction is benefitting the hospital, the equivalent of **6,500 bed days being freed up** per year that can be put to better use.

Within the Edgbaston constituency (test site area) every week we used to discharge two or three older people directly into long term care settings such as residential or nursing homes. Since the changes were made, **only one person has gone into long term care** in the last three months. That means in Edgbaston alone, the testing has shown that more than 130 people every year will end up back home as opposed to in a long term placement.

More broadly, people going from the hospital directly into **long term placements have reduced** significantly.

COMING NEXT:
Meetings with colleagues at Good Hope, Heartlands and City hospital are underway / being scheduled to first understand similarities / differences in operating models. Once established, it will be clear to what extent all the hospitals can benefit from the changes and successful results tested in QE.

> We have had to change the way we work since we began testing in March, as we shape services for the future. And I am convinced that our data-led approach has been vital in getting us to where we are today.



"It has been tough at times – some might even say testing! – but hugely rewarding, as we are now seeing how our joined-up approach is benefitting older people who are regaining their independence, in many cases much earlier than previously possible. In the case of the Hub, the results speak for themselves – as we are discharging more people with a higher level of independence than before March".

Complex Discharge Hub team at Queen Elizabeth Hospital

TEST AREA #3
NEW COMMUNITY TEAM

All figures correct as at 9 July 2019

CONTEXT:
The work here was to bring the expertise currently found in services such as BCHC'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.

The test team of around 15 staff pulled together from BCC, BCHC and UHB have now seen over 65 people since it started on 26 March 2019.

RESULTS:
Around half the people that have been referred to the new community team are now discharged from the service. **76% of the people that remained in their own homes are now enjoying full independence** with no reliance on either health or social care services.

There are people on the service that have not been able to remain in their own homes and have been admitted back into a hospital. This is currently **averaging out at 19%** of all referrals. This is being closely examined by the team to understand what can be done that is both inside and outside of their direct control to reduce this number.

Everyone that is discharged from the service is offered a feedback card –**100% of family or carers said they would be happy to recommend** the service.

The KPIs are reporting positive results already, with the combined team achieving an average **reduction of two care calls per day per person** – performance beyond early expectations. Work is underway in the team to continue to achieve these results in less time – currently the average time for a person being with the service is **30 days** and ideally we would like to see this reduced to around 18 days.

These results are also producing some **inspiring stories from citizens** which obviously help to remind the team why we're doing this and one of the few things that we can all definitely agree on.

A story of difference: Sara

After suffering a fall, Sara was referred to the new community team by OPAL to improve her transfer and mobility outside, which was affecting her social life.

Initially Sara received daily personal care visits. After nine days she needed two weekly visits only, to help with her wash.

Now, in addition to the decreased care needed, Sara can independently get the ring-and-ride bus to attend day centres.

A story of difference: Paul

Paul was fully independent before his lengthy hospital stay due to pneumonia. When he was referred from the Complex Discharge Hub, he was anxious, had poor mobility, poor balance and reduced stamina.

Paul started the service on two calls a day, but through hard work we were able to facilitate his complete independence. Now Paul is much more confident, requires no walking aids in his home and is able to walk to the shops to buy his daily newspaper – with one walking stick – and has resumed his previous social life.

Patient names have been changed.

Colleagues from UHB, BCHC and BCC come together to form a new 'community team'.

HOW THE NEW COMMUNITY TEAM IS MAKING A POSITIVE IMPACT ON **PEOPLE'S LIVES**

Initial fall and admission	After suffering **multiple falls** due to a weakness, David was admitted into the QE hospital. After a stay in hospital he was referred into the new community team from the Complex Discharge Hub.
Came out of hospital requiring physio	David already had a pre-existing, private package of care in place, but needed help to regain his confidence and ability mobilising after his most recent fall and hospital admission.
Early Intervention Community Team	David was seen by a physiotherapist from the new community team **four times in nine days**, following a plan of action designed to get him back to his old self.
Increased independence and confidence	David now has **increased independence mobilising**, and has **regained confidence,** returning to his level of independence prior to admission.
Return to pre-admission needs	Even better, this care will help to break David's pattern of falls and is important to enable him to safely complete his weekly trip to dialysis.

Patient names have been changed.

TEST AREA #4
INTERMEDIATE BEDS

All figures correct as at 9 July 2019

CONTEXT:
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.

The test site chosen to participate in the trials was Norman Power where there are 32 beds. Before any changes were tested the team at Norman Power were managing to get 28% of people home, whilst the average length of stay for a person was 36 days.

RESULTS:
Changes have been made in a number of areas: introducing specific, measurable and timely 'therapy goal setting'; a regular team meeting attended by an MDT aimed at tracking and progressing towards the ideal outcome for everyone; ensuring the person and their carer / family, have a say in what's happening and their expectations are managed.

These changes have brought about an increase in the number of **people going home from 28% up to 45%,** against a target of 38%.

During the testing period, the complexity levels of people entering Norman Power has increased which on the one hand makes the increase in people going home all the more significant, however it also means that the length of stay for people in Norman Power has not gone down – it has actually gone **up from 36 days to 49 days**. On the plus side, these are people who would have previously gone into long term care settings such as residential / nursing homes.

COMING NEXT:
Work is underway to further reduce the length of stay. Areas of opportunity include social worker assessments.

The existing team also carry out duties that are not related to completing the assessments – such as 'community reviews' (which it was agreed needed to remain with them); liaising with other colleagues to chase brokerage, housing, care homes; and general administration.

The group is therefore looking into what can be done to address these points and potentially free the social workers up to focus on their critical tasks.

And finally, the group is looking at whether some people need a social work assessment in the first place.

Evidence from this investigation is showing that people who are taken through a 'therapy led' route out of their bed and into the new community team (test area #3) versus a social care assessment and onto a package of care at home route, spend on average **23 fewer days in Norman Power.**

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

TEST AREA #5
ACUTE MENTAL HEALTH

All figures correct for the period March to June 2019.

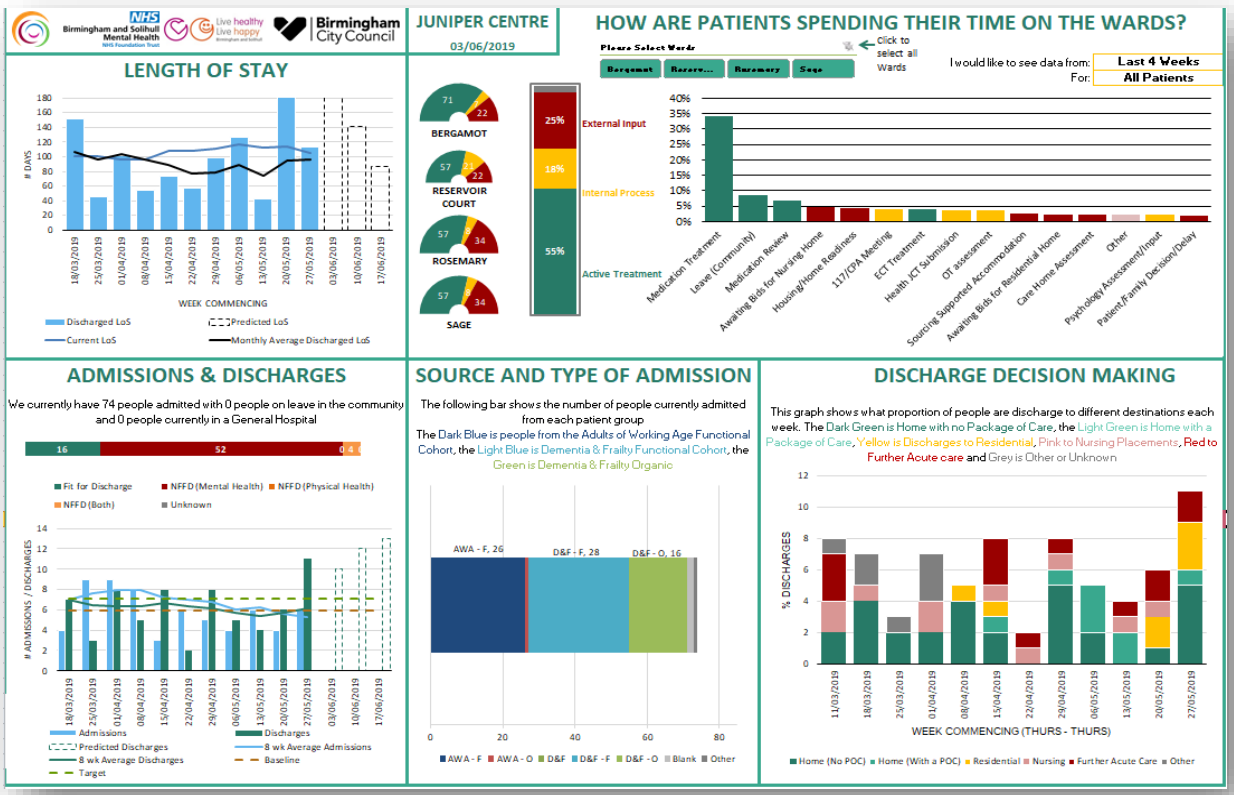
CONTEXT:
The work here was to reduce the amount of time people were staying in the hospital as a result of unnecessary delays to getting them healthier or getting them home. To do this, the team were looking to increase the number of people discharged every day which, before the changes were introduced, averaged at six people per day.

The test team were in the Juniper Centre, Moseley Hall Hospital.

RESULTS:
Changes were introduced including: a new social worker process which reduced the number of people delayed, waiting for social worker input, **from 14% to just 2%**; new data, tracking and reporting on referrals, allocations, timescales and activities – with a focus on having a clear next step for every person on the wards (increasing the proportion of people waiting for 'active treatment' **from 30% up to 58%**); and capacity of the team increased by 0.8 FTE.

These changes combined to increase the number of people being discharged every day **from six up to six point five.** The equivalent to **every person spending nine fewer days in hospital**. These performance figures are above what was anticipated.

COMING NEXT:
The team at Juniper remain above target and continue to work together to keep the new ways of working and reporting in place and running effectively.



A screengrab of the new data, reporting, tracking tool at Juniper that was instrumental in driving up active treatment and daily discharges.

PERFORMANCE MEASURES **& BENEFITS**

PROGRAMME PERFORMANCE & BENEFITS

Figures correct as at 17.May.2019

The programme aims to make significant, measurable improvements to the care older people receive. To achieve this our system needs to make changes to existing services as well as set up new services, such that:

Approximately 5,000 more older people receive a more 'ideal service' than hospital admission per year (such as care in the community).

The 5,500 older people discharged per year in Birmingham with complex needs receive a measurably more independent package of ongoing care.

By improving discharge pathways and focusing on reducing delays, these complex patients also stay in hospital for, on average, ~four fewer days.

By ensuring more independent outcomes and reducing delays in transfer of care, the need for non-acute bed-based care in Birmingham is reduced by ~25%.

The length of stay for our Mental Health patients is reduced by ~10%.

We create a city-wide, joint health and social community service capable of seeing ~6,000 people per year and supporting them towards independence. We develop this joint health and social care service such that it has measurably improved outcomes relative to existing services.

Birmingham City Council, partner NHS organisations and Newton – supported by the Finance and Performance Delivery Group (FPDG) have calculated that by making the above improvements, financial benefits of between **£27.5m - £37.5m** per year are achievable – as a result of improved and more independent outcomes for thousands of older people across Birmingham every year.

The FPDG, chaired by Phil Johns, Deputy CEO at BSol CGG with carefully selected representatives from all partner agencies are responsible for helping guide system partners through challenging financial decisions on the programme as well as ultimately how the system benefits are calculated and released.

Enhancing the future of health and social care services for older people in Birmingham.

For more information:
Contact the EI Steering Group Lead for your organisation.
Visit the STP website: https://www.livehealthylivehappy.org.uk/
Look for Early Intervention newsletters and information in your organisation's communications channels.

Let's get you **healthier**.
Let's get you **home**.

Version: HWB Final

Early Intervention Workstream, part of the Birmingham Older People's Programme.

Live healthy
Live happy
Birmingham and Solihull

Birmingham City Council

NHS