Birmingham Integrated Care Partnership (BICP)

Annual Report

December 2021

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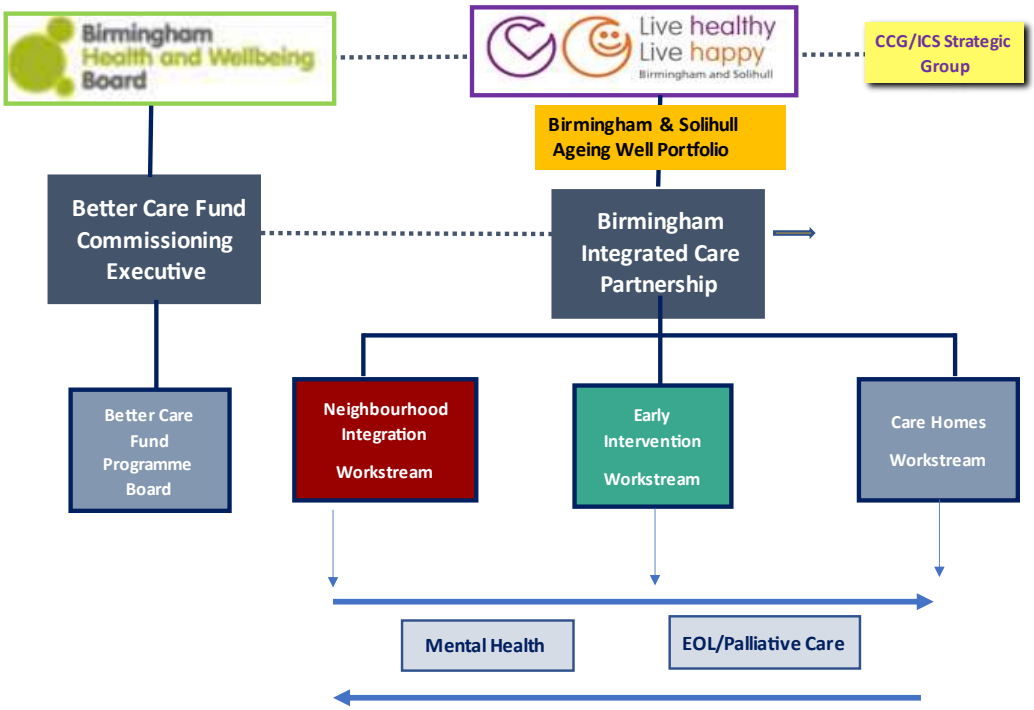
1. Introduction

In 2018 Birmingham partners within the local health and social care system came together to form the Birmingham Integrated Care Partnership (BICP) (formerly known as Birmingham Older People Programme (BOPP)) to tackle challenges in the system that were acknowledged as letting down the people of Birmingham.

These challenges included fragmented services, inconsistent decision making, over reliance on providing intermediate care from bedded units rather than in people's own homes and poor value for money. All of which resulted in citizens of Birmingham not getting the best outcomes for them.

The purpose of our partnership (Figure 1) is to work together so that we deliver better care for the people in Birmingham. BICP has come a long way as a partnership. We consistently review what we are achieving and what we need to achieve to ensure that we remain focussed on the critical areas where we need to work together for positive change.

Figure 1: **How BICP fits in with Birmingham's health and social care system.**



In line with this continuous improvement approach, we have refreshed our priorities based on our learning as a partnership and to reflect changes that have happened since we formed as the BOPP. We have recognised the need to broaden our scope to work for better health and care outcomes for **all adults** in Birmingham and that some of our work will also impact upon children and young people.

BICP has set the independence of all Birmingham's 1.3m+ citizens as a goal for Birmingham's health and social care system. Our goal will be achieved by:

- Improving the health and well-being of our 1.3m population
- Reducing inequalities
- Maintaining and improving the quality of care we provide
- Supporting the NHS Long Term Plan focus to ensure patients get the care they need.

We will achieve this by focussing on three priority programmes:

- ✓ Early Intervention
- ✓ Care Homes
- ✓ Neighbourhood Integration.

The unifying operational theme across these priority programmes is that they bring together professionals from different services and organisations to keep people in their homes and if they do require a hospital stay, they are safely discharged back to their home as soon as possible.

The two themes that run across these priority programmes are Mental Health and End of Life (EOL)/Palliative Care.

The three BICP programmes have been developed using feedback from citizen forums from which a number of "I" statement were agreed (Figure 2).

Figure 2: The 'I' statements

'I' Statements

"I want to tell my story only once"

"I want to be assessed only once, as far as possible"

"I want to be in control and plan my care together with professional people who understand my culture and are non- judgmental"

"If I'm receiving my support at home I want as few strangers as possible entering my home"

"I want help, not barriers put in place for me to get the support I need"

"I don't want to go into hospital unless I need to"

BICP Partners

Birmingham Community Healthcare NHS Foundation Trust (BCHC)

University Hospitals Birmingham NHS Foundation Trust (UHB)

Birmingham & Solihull Mental Health Foundation Trust (BSMHFT)

Birmingham & Solihull Clinical Commissioning Group (BSOLCCG)

Birmingham City Council (BCC)

Hospices of Birmingham & Solihull (HoBS)

Birmingham Voluntary Services Council

Black Country & West Birmingham Clinical Commissioning Group (CCG)

Healthwatch Birmingham

2. Welcome by Graeme Betts, Chair of BICP Board

Welcome to the first annual report of the Birmingham Integrated Care Partnership (BICP).

Professor Graeme Betts, CBE

The last two years have been remarkable in so many ways with our health and social care services rising to the pandemic challenges with strength and unity.

I'm proud to work alongside my system partners who remain passionate about the service they provide and committed to improving outcomes for the people of Birmingham in spite of the tremendous pressures generated by the pandemic.

COVID 19 and the BICP ongoing response to the pandemic has underlined and reinforced our existing learning. As a partnership we have learnt the value of strong relationships that allow for challenge, openness and transparency, the benefit of allocating dedicated staff for our programme and project support, as well as the importance of staff and citizens being at the heart of change. We know that to help achieve our goals we need to focus on our capacity and place greater emphasis on addressing inequalities in citizen outcomes.

BICP has three workstreams within our portfolio: Early Intervention (EI), Care Homes and Neighbourhood Integration. EI has been our flagship programme and you can read more detail about its approach and success in this report. Commencing in October 2018, this has been our first integrated programme of work in Birmingham.

EI has transformed how partners work together to put the person at the centre, promoting "home first" as the default outcome for citizens who experience, or who are at risk of, the need for acute care.

Perhaps the most notable aspect of EI has been the creation of the new Early Intervention Community Teams which are playing the pivotal part of a programme to enable people to live more independently, reduce the length of stay in hospital and deliver financial benefits for the system.

Good progress has been made against the two remaining workstreams and these are gaining momentum. Neighbourhood Networks are established across all parts of the city, helping to build community capacity and to enhance the resilience of citizens. Similarly, we have improved the consistency of our response to the management of long-term conditions and have commenced restructuring of service delivery towards neighbourhood working.

Care homes have been particularly hard hit by the pandemic. As a system we have come together to provide practical support to the independent care sector – fully recognising the commitment and dedication to keeping citizens safe that has been demonstrated by care providers. We have also maintained a focus on our long-term goals of consistent access to clinical support and quality of care.

Underpinning the BICP vision is an ongoing commitment to personalised care. This means that whoever is in contact with a person or their carers will work in partnership with them to find out what they want and need to achieve and understand what motivates them. We will focus on a person's own strengths and help them realise their potential to be healthy and happy, regain independence and remain independent for as long as possible.

This means collaborating with partners to take a holistic approach to care planning and delivery through the integration of physical health, mental health and personal well-being interventions.

The BICP collaboration demonstrates that transformational change can be delivered when we all collaborate and commit to a shared purpose.

I would like to take this opportunity to thank each and every one of my colleagues for their ongoing collaboration and commitment, and their perseverance in helping to deliver the right care at the right time in the right place.

BICP and all who work within our programme have achieved some amazing results: simply outstanding given the backdrop and demand on our services. I sincerely look forward to the next stage in our journey.

Professor Graeme Betts

3. EARLY INTERVENTION

3.1 Introduction

The Early Intervention programme (Figure 3) provides short-term, intensive support for frail people who have experienced an illness or injury with the aim of helping them to recover faster and live healthier and more independent lives, ideally at home.

Figure 3: How the Early Intervention programme works

In 2018, more than 1000 staff from health and social care partner organisations across Birmingham joined forces for the first time in the city's history, to deliver the EI programme.

Spanning five localities, covering the whole city, the programme has delivered a transformation in how partners work together to provide a seamless care service for citizens. This means putting the person at the centre and to promote "home first" as the default outcome for citizens who experience, or who are at risk of, the need for acute care.

3.2 Early Intervention Approach

EI was developed using an evidence-based, data and frontline-led plan that engaged staff at all levels and across all partner organisations.

To provide key governance and oversight, forums were put in place with representatives from all partners and areas including finance, informatics, data, estates and services and primary care. Its 2020/2021 goals were set:

- Prevent 3,650 unnecessary hospital admissions
- Enable 26% of patients to go home rather than be admitted into long term care
- Reduce the average length of stay of complex patients who no longer need to be in an acute hospital from 12 to three days, a saving of 77,000 days a year
- Support people to be more independent in their own home more quickly and on average requiring six hours less care per week

3.3 Progress to date

3.3.1 Covid 19

EI was fully rolled out in March 2020 as the pressure on Birmingham's health and social care system intensified due to Covid-19. Its model was quickly adapted in response to the pandemic, creating a resilient and sustainable service.

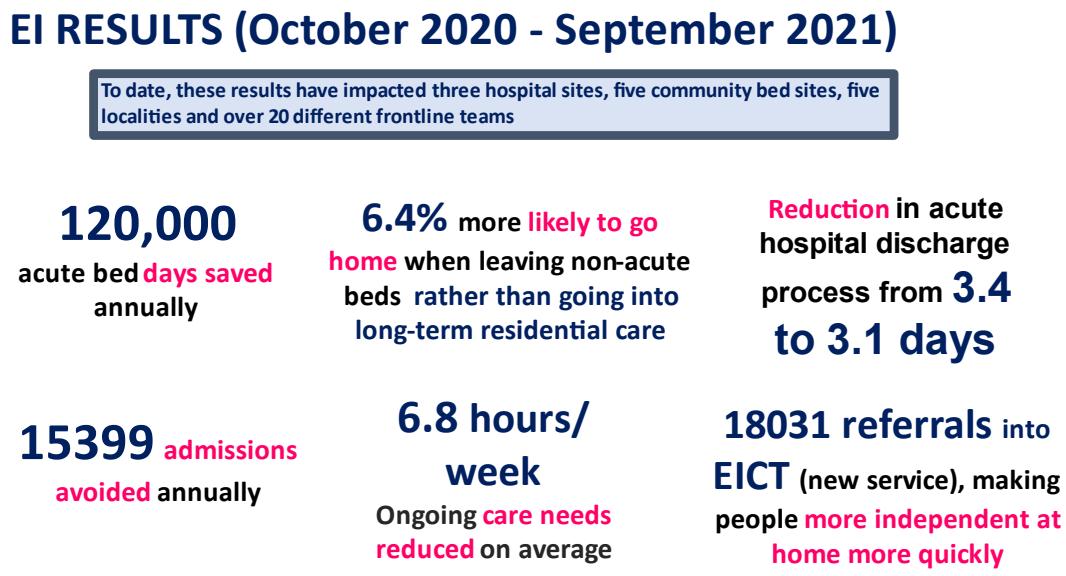
There was cross partnership support in the redeployment of staff during the pandemic and the EI programme has played a crucial role in the city's response to coronavirus.

3.3.2 Performance

By October 2020, all five EI components were fully launched and real time data was being gathered enabling all decisions to be made on clear data & evidence.

The performance in Figure 4 has been achieved throughout Covid-19 and against the backdrop of new Discharge to Assess guidance (D2A), issued by the government in March 2020 and updated in August 2020. These factors have skewed the original rationale of the objectives. What is clear is that citizen outcomes have measurably improved from this innovative whole system approach.

Figure 4: EI programme results



3.3.3 Integrated Care Approach

EI continues to be a journey of integration across the system. No matter who the employer, staff are committed to doing what is required in supporting citizens to meet their outcomes. Teams are now co-located, working relationships and dynamics have been fostered and joint processes and joint standard operating procedures are now in place. Front line staff were involved in the redesign & decision making and provided with tools to support them to make the best decisions for people in their care. Throughout all, focus has been maintained on the operational management framework and the sustainability of standard operating procedures

3.3.4 Culture

EI has created a shift in culture through frontline-led change that is helping to break down the barriers between organisations.

3.3.5 Cross-organisational governance

Under cross-organisational governance, new ways of working have been adopted, using clear, accurate, timely and trustworthy data across the system

3.3.6 EI Beds model development

EI Beds offer an intermediate care provision to support people to recover as much independence following a crisis as possible, ideally returning home. In response to the original CQC findings in 2018 and as we start to emerge from the pandemic to a steadier state, there is a need to develop a new city-wide EI community bed model for Birmingham to provide a consistent offer and citizen experience.

The revised model will respond to new D2A guidance and adopt the city's integrated care approach and Home First ethos. The three proposed phases within the draft strategy include: exit from our pandemic response, a remodelling of bed numbers to meet the needs of a 'steady state' and adoption of the new generic rehabilitation (P2) model.

3.4 Strategy & Sustainability

The focus during Covid-19 has been to sustain and embed the improvements made to date and delivering the COVID response.

A systematic continuous improvement programme has been developed and is in place across each component. In addition, an integrated commissioning strategy and plan is in development to provide a means of ensuring the sustainability of services both now and for the future.

3.5 Case Studies

A new animation showing how Early Intervention works in practice has been launched. This is available to all colleagues here and also on the LiveHealthyLiveHappy.org.uk site which also gives more detail on the progress of EI across the city.

The two case studies of Abdul and Alice describe how the multi-disciplinary team approach of the Early Intervention programme is helping it to achieve its goals.

4. NEIGHBOURHOOD INTEGRATION (NI)

Neighbourhood Integration (NI) is the integration of local health and care providers including voluntary and community groups, to create 'Neighbourhood Teams'.

A typical Integrated Neighbourhood Team (NT) will consist of staff from a number of different teams/professions; social care for adults and children/families, health, mental health, district and borough teams.

NT's take a holistic approach to care planning and delivery through the integration of physical health, mental health, social care and personalised well-being interventions. They put the citizen at the centre of all that they do, working across their respective organisational boundaries to create a seamless service to local people at a local level. Each 'neighbourhood team' will cover 30,000-50,000 people.

This approach ensures that a person's health and wellbeing is supported and they receive ongoing personalised support and care, both prevention and pro-active.

Health and care partners in the Birmingham NI programme include GP's, Primary Clinical Networks (PCN's), NHS Trusts, Birmingham City Council and voluntary and third sector organisations.

As part of its Ageing Well portfolio, BICP formed the Birmingham Neighbourhood Integration (NI) Programme Board Group in 2020. It provides steering and oversight and reports to the monthly BICP Board.

4.1 Neighbourhood Integration Objectives

NI objectives complement the BICP, Early Intervention and Care Homes outcomes:

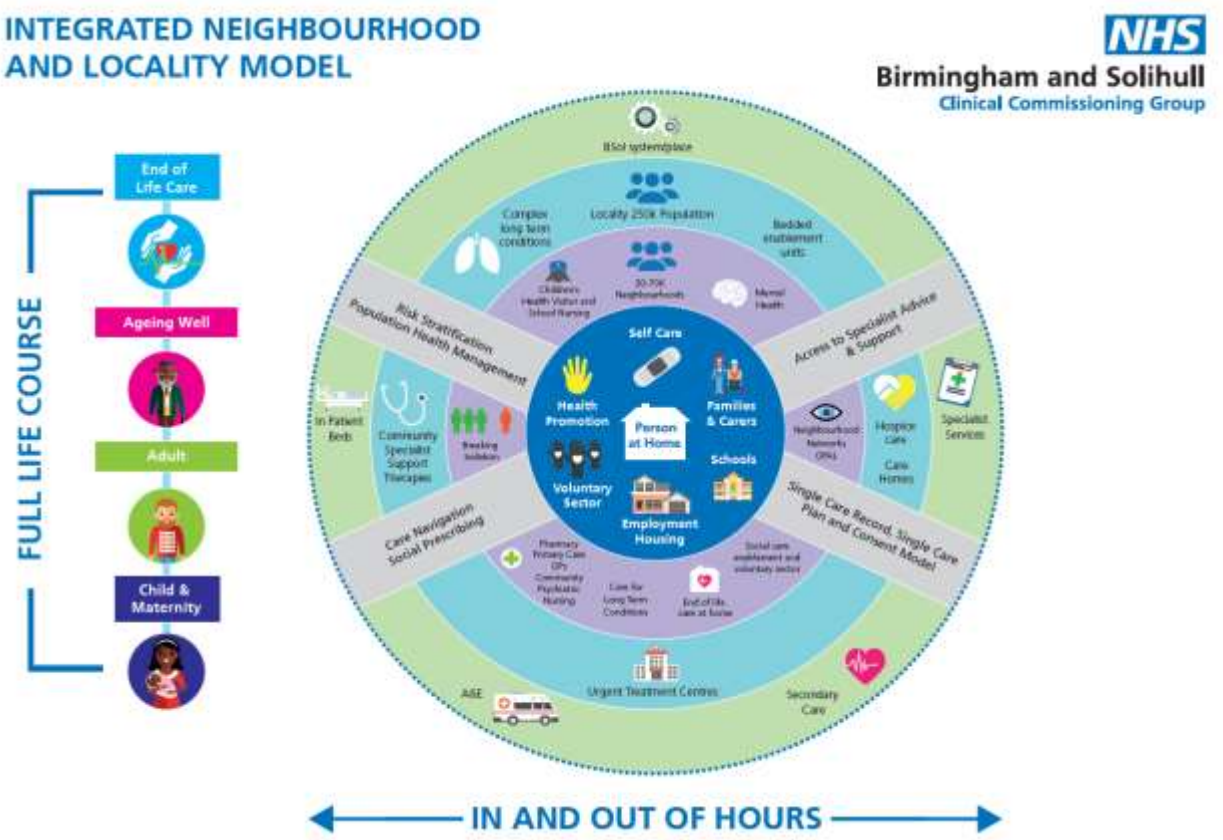
- Support our most vulnerable citizens and improve health outcomes. Enable people to live healthy, active and independent lives in their community
- Reduce Health inequalities across Birmingham
- Aim to address the health and social care needs of citizens whilst helping to build community capacity and enhance citizen resilience
- Remove organisational boundaries to work collaboratively and deliver integrated and joined up care and services for the local community
- Aim for Neighbourhood teams to be connected to their local communities, with priorities developed with local people
- Further develop and support our health and social care staff to work as a team to deliver quality care and effective utilisation of resources

This will be done by:

- Strengthening local relationships and collaborative working of system partners and building and improving on current work progress
- Continue supporting the city's Covid-19 response to focus on the needs of the most vulnerable, regardless of age
- Clinically-led approach with improved communication flows and record sharing
- Primary Care Networks, mental health providers; BSMHFT and Forward Thinking Birmingham (FTB), Birmingham City Council and BCHC will be at the heart of this
- Creating a system where the person is at the centre of all that we do
- Ensuring the 'voice of the service user' is heard

- Citizen co-production and regular engagement and dialogue for citizens to shape decisions and be informed of strategy plans
- Ensuring resources are collectively focused on improving health outcomes
- Developing a shared 'one team' culture to deliver a 'one team' service
- Implement a organisational development programme for team development
- Supporting staff to deliver new innovative ways of working
- Acknowledgement that Neighbourhood teams may develop at different pace, in different ways, in different areas. All areas should be working towards this strategy as a continuous development
- Achieving compassionate city status for Birmingham
- Implementing the integrated Neighbourhood and Locality Model (Figure 5)

Figure 5: The Integrated Neighbourhood and Locality



4.2 Progress to date

4.2.1 Development of Integrated Neighbourhood Teams Principles

The system-wide principles for the development of **Neighbourhood Teams** (Figure 6) were agreed by the NI board members in 2021. They complement the goals of the Early Intervention and Care Home BICP workstreams and align with the goals of BICP and the Ageing Well Portfolio.

Work continues with other partners to enable NI to note connections and interdependencies to other work programmes e.g., children's and young people, end of life and palliative care.

PRINCIPLES FOR DEVELOPING INTEGRATED NEIGHBOURHOOD TEAMS

Figure 6: Principles of developing Neighbourhood Teams

4.2.2 Primary Care Network localities established

There are 30 Primary Care Networks within Birmingham. Different elements of a neighbourhood team may have different shared geographies (eg, community nursing teams aligned to PCN's whilst community mental health teams and social work teams cover a larger area); but all will provide named links to the neighbourhood

PCN Locality structures and leads have been agreed with the move to an ICS. Twelve GP representatives have been appointed with a mandate and skills to contribute to the ICS Partnership Board Terms of Reference. Their vision will influence the NI strategy and direction.

The key priorities mandated are to operationally work at the PCN/Neighbourhood Level and to work with System Partners to address local priorities and inequalities.

4.2.3 GP Operating Model and interface with BSOL ICS Strategy & Governance

The strategy interfaces with the BSOL ICS strategy and governance model (Figure 7).

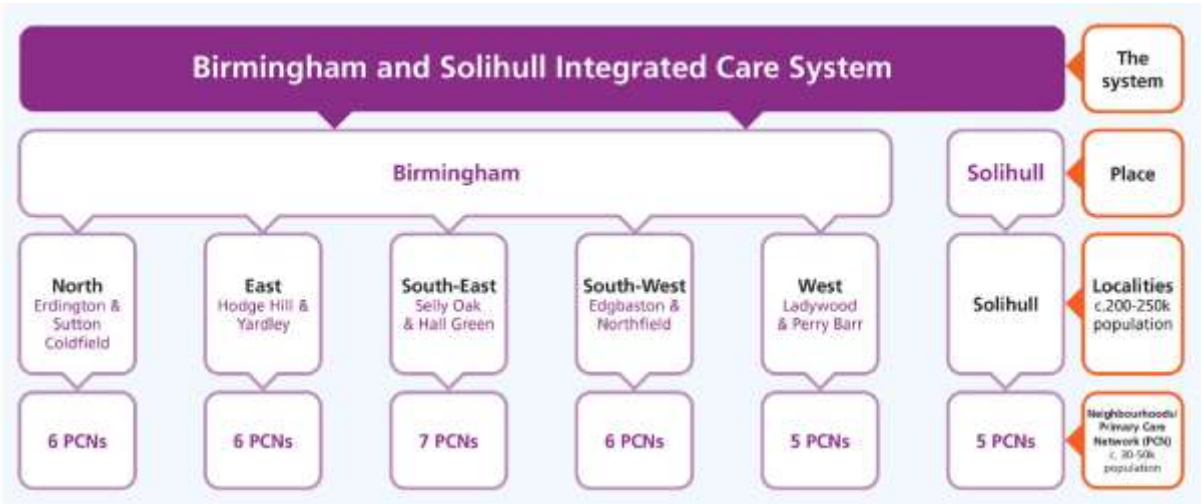


Figure 7: BSOL ICS strategy & governance model

4.2.4 Development of person-centred care model

A person-centred model of care (Figure 8) has been developed which will be adopted by the Neighbourhood Teams.

The model is being piloted within BCHC to align the BCHC Community District Nursing Teams to Neighbourhoods and Locality structures. This model will make it easier for GPs to refer patients for district nursing care and for patients/relatives/carers to contact their local district nursing team through a single community nursing referral hub.

Each PCN will have a dedicated Relationship Manager and Clinical Practitioner who will act as the PCN point of contact.

This model of care moves away from a mindset of 'referral' to a culture of identifying which neighbourhood team professional is best placed to meet the current need of the person.

Figure 8: Neighbourhood Team Care Model – approved by the BICP Board in 2018

This connected system is designed and delivered around local people and located in neighbourhoods.

This will allow better continuity of care, increase the time available for direct patient care, improve team resilience, reduce estate and carbon footprint. It also complements the Ageing well Agenda and Clinical Case Management transformation and redesign within BCHC.

4.2.5 Creation and implementation of Neighbourhood Network Schemes (NNS)

Led by Birmingham City Council in collaboration with BVSC and co-designed with citizens and system partners, NNS is fully operational in all 10 constituencies.

The purpose of NNS is to ensure that as many citizens over 50 as possible can access community-based support which can promote well-being and a better quality of life as well as helping to build community capacity and to enhance the resilience of citizens. NNS aims to do this through better co-ordination of community-based prevention & intervention services.

NNS starts with the communities where people live. The focus being on constituencies and wards at the Neighbourhood level. The main purpose of NNS to connect people, local activities & services through NNS Workers in each constituency working closely with social work teams to link residents up with local assets.

4.2.7 Organisational Development

NI has recently (October 2021) secured funding from BICP for organisational development (OD) support. The OD programme will support team development of the locality/neighbourhood team.

5. CARE HOMES

5.1 Introduction

In recent years, much work has been undertaken to identify and offer preventive care and support to people living in the community who are at risk of losing their independence or of having an unnecessary admission to hospital.

In contrast, people already living in care homes or in 'supported living' settings have tended to miss out on this type of coordinated, preventive care.

We know that residents living in our care homes have increasingly complex needs and care provided has often been reactive rather than proactive. Evidence also suggests that many residents are not having their needs properly assessed and addressed. As a result, they often experience unnecessary admission to hospital.

5.2 Mission statement

Birmingham's Care Homes Programme aims to improve the quality of care and experience for care home residents, reduce admissions to hospitals and develop a market that is sustainable

5.3 Strategy

In response to the ongoing Covid-19 pandemic, the short-term priorities are to support, advise and respond to immediate pressures within Birmingham's provider market, maximising take-up and use of financial support that is available, eg, for infection control and co-ordinating vaccination programmes.

5.4 Objectives

We recognise that planning for the longer term is required if we are to make the significant and lasting change that is needed to achieve our ambitions for the care home sector in Birmingham. To meet this need we have developed the following objectives:

- Reduce unplanned admissions into acute care from care homes
- Improve performance against care home quality ratings
- Improve workforce recruitment, well-being and retention
- A care market that is financially sustainable for both provider and commissioners
- Improved experience of care home residents
- Care delivered in the right place at the right time

This will be done by ensuring that we:

- Connect care homes with neighbourhood multi-disciplinary teams to ensure consistent access to primary care, including mental health and other community services.

- Develop better processes to listen to and act on feedback from residents and their families, friends and advocates

- Develop a shared and coordinated approach to care delivery ensures residents have access to the best care possible

- Develop a joined-up system of quality assurance for the care market, led by one organisation on behalf of the system

- Develop a sustainable partnership led methodology for supporting and sustaining the care market including joined up commissioning arrangements and aligning of budgets and incentives.

- Create a city-wide strategy and programme to support the care market to recruit, train and retain quality staff, including the development of career pathways; optimise the working environment for staff employed by social care providers so they feel part of the integrated team.

- Support and drive digital connectivity and data sharing across the health and social care market.

- Build strong personal relationships between care home providers and GP practices to develop local enhanced primary care support

- Develop a shared ‘one team’ culture to deliver a ‘one team’ service

- Support staff to deliver new ways of working including single trusted assessment

5.5 Progress to date

5.5.1 Adoption of NHS England Enhanced Health in Care Homes (EHCH)

During the pandemic the national guidance for ‘Enhanced Health in Care Homes Framework’ was released and we worked as a system to deliver the requirements.

By implementing this framework and ensuring direct clinical leadership from primary care for this sector through the Primary Care Network (PCN) Directed Enhanced Service (DES), Multi-disciplinary Team (MDT) working was put in place.

These significant changes have demonstrated both the prevention of hospital admissions and more timely discharges.

5.5.2 Support through Covid-19

Throughout the pandemic EI teams have provided a support to care homes service across Birmingham, providing both care, support and training to over 250 homes.

5.5.3 Workstream development

Six workstreams have been developed to meet the programme objectives: Digital, Quality Framework and Dashboard, Joint Commissioning, Workforce, Primary Care and Community Support. These workstreams meet on a regular basis to monitor progress against the objectives, using an appropriate evidence base and data to instigate change.

5.5.4 Care Homes Dashboard

A care homes dashboard has been developed to support metrics to measure impact and targeting of care homes that require support.

5.5.5 Proof of Concept

As an output and learning through the pandemic a 'Proof of Concept' project commenced in June 2021 to deliver support to 26 older people's care homes in Birmingham. This consists of Advanced Clinical Practitioners (ACP's) providing proactive care to residents at risk of admission, ensuring care homes can enable swift discharges from hospital and delivering training to support care home staff manage the needs of their residents.

The project will run until March 2022 when a business case will be developed based on the outcomes of the proof of concept, to enable provision of a more proactive service to all Birmingham older people's care homes.

5.5.6 MDT working

MDT working commenced with PCNs, community services and care homes. Work continues to improve the MDT approach by understanding issues and barriers to successful working

5.5.7 Joint Commissioning

An agreement has been reached to develop joint commissioning arrangements between the CCG and the Council.

6. END OF LIFE (EOL)/PALLIATIVE CARE

6.1 Introduction

Palliative and end of life care is one of the core services provided by Birmingham Community Healthcare (BCHC) Foundation Trust in partnership with University Hospitals Birmingham NHS Foundation Trust; General Practice and the 3 Hospices (John Taylor & St Mary's; St Giles & Marie Curie) with care delivered in people's homes, care homes, hospitals and hospices.

COVID-19 has shone a harsh light on some of the health and wider inequalities that persist in our society. Like nearly every health condition, it has become increasingly clear that COVID-19 has had a disproportionate impact on many who already face disadvantage and discrimination.

The impact of the virus has been particularly detrimental on people living in areas of greatest deprivation, on people from Black, Asian, and Minority Ethnic communities, older people, men, those who are obese and who have other long-term health conditions.

It is also impacting people with a learning disability and other inclusion health groups, those with a severe mental illness and those in certain occupations. COVID-19 risks further compounding inequalities which had already been widening. (Ipsos MORI and the Strategy Unit, 2021)

Whilst hospice care and community-based palliative care services are at the forefront of the local provision of palliative care, patients resident in Birmingham are more likely to die in hospital, rather than in the community.

In September 2021, Birmingham & Solihull health and social care system launched a system-wide collaborative group for End of Life. The group is reviewing the care and support services which are currently available within the system and the services which will be required to ensure a robust, holistic approach to end of life care which support all of our diverse communities across Birmingham and Solihull to access high quality end of life care in the setting of the patient's choice.

EOL partners

BSMHFT, UHB, BCHC, Birmingham City Council, Solihull Metropolitan District Council, Birmingham & Solihull CCG, Hospice Charity Partnership, Marie Curie Hospice West Midlands, St Giles' Hospice.

EOL/Palliative Care Vision

"For people who are approaching the end of life to be able to receive high quality care in the setting of their choice""

6.2 Goals

The goals agreed by the new collaboration have been adopted from the national ambitions framework for local action 2021-2026 (Figure 9). This was issued by the National Palliative and End of Life Care Partnership in May 2021. Further details of the national framework can be found here

Figure 9: The goals of the new collaboration

6.3 Progress to date

- Agreed membership of the EOL steering group
- Established an operational group to resolve pathway issues
- Reviewed the ambitions framework against our current system operational model
- In response to the gap analysis, ten workstreams and their roles within the programme have been developed to help us deliver on these ambitions. Each workstream and its remit to are outlined in Figure 10

Figure 10: EOL programme workstreams

EOL/PALLIATIVE CARE PROGRAMME WORKSTREAMS

Patient Outcomes
Develop a standardised approach to achieve patient optimal outcomes for preferred place of care and the implementation of system wide processes for early identification of those at the end of their lives.

Personalisation Plans
Develop Personalised Care and Support Plans, including a citizen led care plan

Systemwide Dashboard
Review the data currently collated across the system in relation to end of life care and in tandem with the regional and national dashboard development programmes to create a bespoke End of Life Dashboard for the Birmingham & Solihull System

Electronic Palliative Care Co-ordination Systems (EPaCC's)
Develop a Birmingham & Solihull approach to the utilisation of EPaCC in tandem to the West Midlands Shared Care Record (WMShCR) development. The objective for WMShCR is the delivery of the ShCR, sharing defined datasets between health and social care. The project will develop an integrated, single view of a patient's record.

Specialist Palliative Urgent Response (SPUR)
Develop a systemwide approach to urgent palliative care needs, with a focus on the requirement of specialist palliative urgent response for complex palliative care cases.

Education and Training
Undertake a review and training needs analysis of Education and Training for EOL across the system to understand what is currently in place and enable the development of an End of Life education framework.

Personal Health Budgets (PHB)
Through the End-of-Life Personal Health Budget Pilots in Birmingham & Solihull demonstrate the positive outcomes for patients and carers and the impact on the system support needs which are required at End of Life Develop a longer-term sustainable funding stream for PHB across the system.

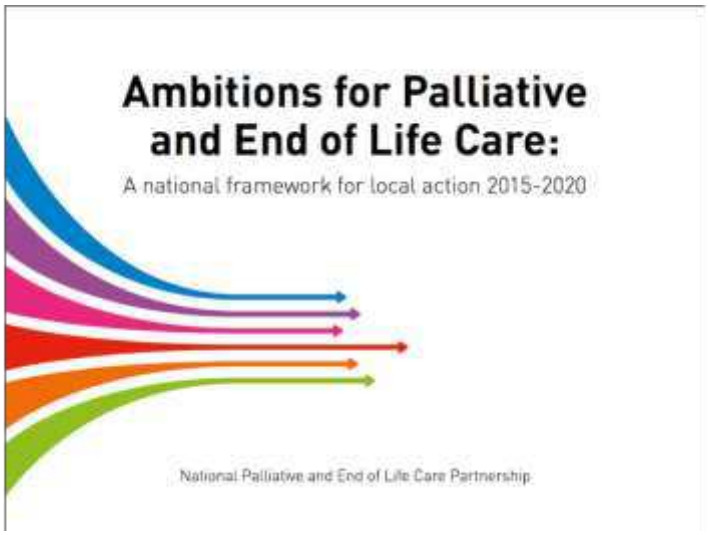
Compassionate Communities
Inform stakeholders on Compassionate City Charter Status. Design and implement a model of care for bereavement support to ensure that communities have access to these services.

Transition Care for Children and Young People
Enable the development of systemwide pathways for young people with an End of Life illness who are transitioning from Children's & Young People's Services to Adult EOL Services.

Care Homes
Ensure all End-of-Life workstreams are reviewed and inter-connected with care home teams and the system approach to care home support.

Progress already made by these workstreams include

- Mapping out current patient outcome measures for BSol providers - BCHC, UHB (Patient outcomes).
- Engaged with NHSE/I for update on National and Regional Dashboard information. (Dashboard)
- Development of Framework for EOL Education from citizen (Level 1) to palliative care specialist is underway (level 4) (Education and Training)
- Compassionate City Charter Training undertaken and steering group established. (Compassionate Cities)
- Individuals to be involved identified. Urgent palliative response for care homes being scoped with Hospices; BCHC EICT; OPAL, WMAS (Care Home)
- Rapid Mapping of DN service, EICT and OPAL to enable a system wide approach to urgent response completed and needs analysis of specialist palliative intervention required. (SPUR).
- PHB Oversight from BSOL CCG PHB Steering Group to oversee all PHB workstreams. PHB CCG BSol System Audit Undertaken - identified need to increase reach within financial envelope. System communication plan developed.
- System scoping undertaken to identify individuals within the system to be involved within pathway development (Transition Care for Children and Young People).
- Staff focus groups are already underway focussing on BCHC/Hospice Development and BCHC Community Palliative Champions. Quarterly staff focus groups across the system will roll out from spring 2022.



7. MENTAL HEALTH

7.1 Introduction

The Birmingham & Solihull Mental Health Foundation Trust (BSMHFT) provides a wide range of mental healthcare services for the residents of Birmingham and Solihull, as well as some specialist regional and national services to communities in the West Midlands and beyond.

Mental health services complement the BICP workstreams by promoting the integration of mental health and raising awareness that people with co-existing mental health and physical health problems need a joined-up approach to enhance and improve outcomes.

This is key to the BICP workstream development making a difference in terms of looking at the whole person and what their needs are; it is all about enhancing the concept of “no health without mental health”. This means that people’s mental health should be considered as part of the overall offer across the health and social care system.

The key is to look to improve pathways and to support the whole concept around “home first” – to keep people in their own homes with an advanced offer integrating physical and mental health.

7.2 Mental Health & Early Intervention

EI is the most advanced of the three BICP workstreams and mental health services have been involved throughout its development.

BSMHFT provides a number of services within the EI programme. There has been a successful pilot scheme running between OPAL+ and Reservoir Court, an inpatient mental health unit in Erdington, to support decision making on serious physical health problems and the appropriateness of admissions to acute hospitals.

Over a four-week period the OPAL+ team received eight calls from Reservoir Court. Of these, seven people remained at Reservoir Court and received the appropriate care they needed. The pilot will continue to run with a view to rolling out this approach to other units in early 2022.

In a bid to further strengthen ties with the OPAL service, work is underway between BSMHFT and OPAL to improve pathways between the two services, including how to reduce the time it takes for referrals and the type of patients that can be referred. This work is in its infancy having only been launched in October (2020).

BSMHFT is also very much involved in the revised processes around the integrated hub to enhance discharge pathways and are supporting the Early Intervention Community Team with its discharge process and planning.

During Covid, BSMHFT successfully started MDT's with the Early Intervention Community Teams (EICT) to support in managing the impact for mental health and look at people who may have been discharged from hospital sooner due to COVID and whether there was any support that the teams could provide around delirium and challenging behaviours within nursing homes and discharge pathways.

These collaborations are helping to enhance pathways and to establish better joined up working between the various teams and across localities.

7.3 Mental Health & Neighbourhood Integration (NI)

Birmingham & Solihull Mental Health Foundation Trust (BSMHFT) has secured £15m funding to help transform community mental health care. The NI Programme is at the core of this model as these teams will be a part of the Neighbourhood MDT model, which will bring relevant clinicians and organisations working within a PCN to share information, develop an individual plan for each service user ensuring the achievement of enhanced care pathways, making access easier and navigation simpler through pathways and improving and addressing local inequalities for those with Serious Mental Illness (SMI). The redesign model will be rolled out across all the localities from 2021-2023. It is currently being rolled out in the South and it will next be rolled out in the East in April 2022.

7.4 Next steps

The key priority for mental health moving forward is to widen our offer across all BICP workstreams. This will help to enhance a system wide offer of an integrated approach to mental and physical health and enable the BSol system to be innovative in this approach. A lot of our focus has been on older adult services, which has been really positive. However, what we now need to look at is the impact for our adult services and links to the EI programme.