Birmingham BCF narrative plan 2023-25

Responsible to the Birmingham Health and Wellbeing Board

This Better Care Fund Plan has been developed in partnership by:

- Birmingham City Council
  - Adult Social Care
  - Housing
  - Public Health
- Birmingham and Solihull Integrated Care Board
- Birmingham Community Healthcare NHS Foundation Trust
- Birmingham and Solihull Mental Health NHS Foundation Trust
- Birmingham Voluntary Sector Council
- University Hospitals Birmingham NHS Foundation Trust

All of these stakeholders are closely involved in the delivery of the programme and have input into the development of the plan through the BCF Programme Board, BCF Commissioning Executive as well as the other Place based arrangements. As a consequence of the move to ICS arrangements we have reviewed BCF governance to ensure that Birmingham Community Healthcare can play an enhanced role in the development of the plan and associated commissioning arrangements for delivery.

Governance
Birmingham City Council (BCC) Cabinet and the Birmingham and Solihull Integrated Care Board (ICB) have a statutory responsibility for the delivery of services and are accountable for the proper use of the Better Care Fund (BCF) resources. The BCC Cabinet is made up of elected representatives and is accountable for making decisions on behalf of the local authority. The Integrated Care Board is responsible for developing a plan for meeting the health needs of the Birmingham and Solihull population, managing the NHS budget and arranging for the provision of health services in the Integrated Care System (ICS) area.

The ICB is led by a Chair and a Chief Executive. In additional, representatives from the local authorities, provider trusts and primary care attend bi-monthly board meetings. This ensures good governance and is intended to promote a culture of strong engagement with citizens, their carers, primary care, staff and stakeholders.

The Birmingham Health and Wellbeing Board has overall responsibility for ensuring the integration of health and social care functions within the city. The Board is the accountable body for the approval and implementation of the BCF plan for the whole of Birmingham. Membership of the board includes representatives from the local authority, ICB, NHS providers trusts and the Voluntary and Community Sector.

The BCF Commissioning Executive acts as a collective vehicle for integrated commissioning on behalf of the ICB and the LA. It has been established to develop and operate the BCF pooled budget arrangement (Section 75) and to provide strategic oversight and decision making in relation to the delivery of the BCF Plan. The group oversees the operational and financial delivery of the BCF and monitors its performance through bi-monthly meetings. A key focus of the commissioning executive role is to take a whole system approach to maximise investment of any schemes funded under the BCF. The Board report regularly to the Birmingham Health and Wellbeing Board (HWB). The Commissioning Executive is supported by the BCF Programme Board. Workstreams within the BCF programme report back to the Programme Board and are led by a range of statutory and voluntary community sector organisations.

Governance arrangements have been reviewed since the creation of Integrated Care Systems in July 2022. We recognise the importance of the BCF programme in respect of delivering key outcomes at Place in respect of the Community Service Integrator role; tasked with leading improvements to outcomes for people remaining healthy in the community alongside leading our collaborative work to enhance delivery at the interface of community, acute and social care. The Community Service Integrator is commissioned through and accountable to the Birmingham Place Committee. Place Committee has an assurance role in respect of the BCF Plan in advance of submission and final approval at Health and Well-being Board.

BCF Governance – reporting and accountability structure overview

Birmingham City Council Cabinet and ICB governing bodies

- Determine financial contributions from the respective organisations to the pooled budget
- Section 75 decision making

Birmingham Health and Wellbeing Board

- Overall accountability for the BCF programme
- Accountability for delivery of Section 75 agreement
- To identify opportunities for further integration of health and social care services
- Strategic direction and decision making

Birmingham Better Care Fund Commissioning Executive Board

- Key programme commissioning and de-commissioning decisions
- Finance and performance overview
- Development of the BCF plan
- Review of Section 75 agreement and recommend ratification to governing bodies
- To determine the use of unallocated financial resources >£100k

Birmingham Better Care Fund Programme Board

- Delivery of BCF plan
- To deliver the BCF plan on behalf of the HWB
- Operational oversight of BCF schemes
- Monitoring of performance
- To determine the use of unallocated financial resources <£100k
- Sign off quarterly BCF returns

Partners – individual schemes

- Oversee the schemes implementation
- Report progress against performance targets and outcomes to the BCF Programme Board
- Track and report financial spend, key issues and risks to the BCF programme Board
- Engagement and co-production with stakeholders

Executive Summary
Overall BCF Plan and approach to integration

We value the ability to use the Better Care Fund (BCF) to embed integrated, person-centred health, social care and housing services within our local system. Our priorities for integration are reflected throughout the plan.

The plan has been developed in the context of the evolving Integrated Care System (ICS). In respect of our Better Care Fund planning, we see this as an exciting opportunity to further strengthen focus and leadership and to increasingly align resources and integrate delivery to meet BCF policy objectives. In particular we see the creation of a Community Service Integrator as an excellent opportunity for more effective joint commissioning, planning and delivery of health and social care.

For 23/25 our key objectives as a delivery partnership in respect of BCF are:

Intermediate Care Programme – launched in March 2023 across Birmingham and Solihull. Primarily focused on BCF objective 2: "Provide the right care in the right place at the right time"; but also impacting on BCF objective 1 in respect of reducing admissions into acute care from the community. The aim is to drive improvement and capacity in the functions that sit between acute hospital services and core community services. This will ensure:

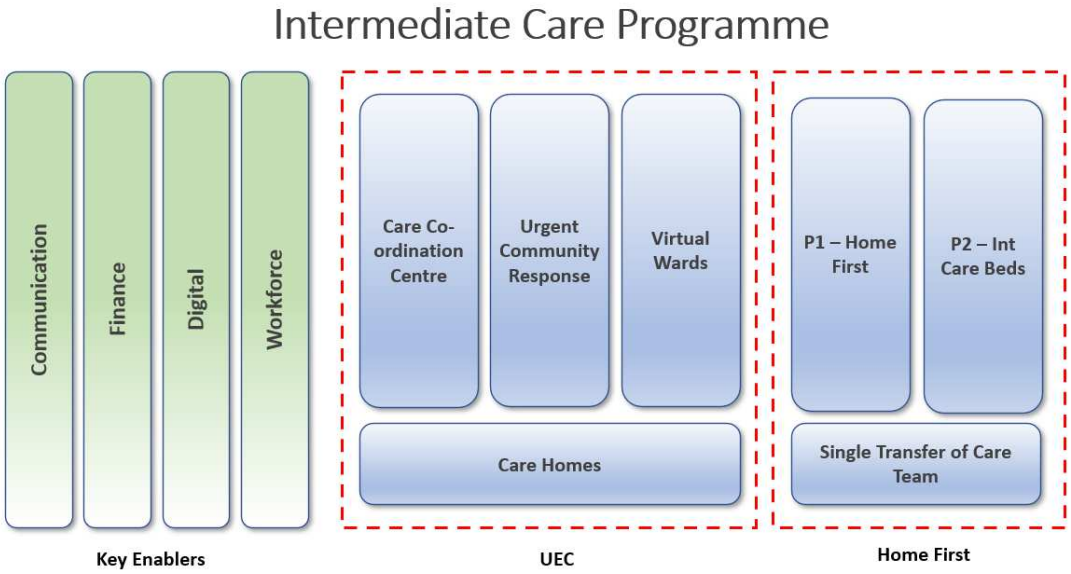
- Expansion of out of hospital services
- Support citizens to avoid hospital attendance or admission
- Support citizens to leave in a timely way
- Reduce length of stay

The programme consists of the following workstreams:

- Unscheduled care -coordination
- Urgent Community Response
- Pathway 1 – Home First
- Pathway 2 beds
- Virtual Wards
- Enhanced Health in Care Homes
- Single Transfer of Care Team

Each of the priority areas in the Intermediate Care Programme detailed in diagram 1 (below) is being progressed jointly between the community integrator, commissioners, clinical leaders and care professionals in the first half of 2023 and delivered locally to test the impact they have. Investment will respond to the success we are able to demonstrate in making an impact on improving citizen's outcomes and we will scale up services over 2023-25 as evidence of efficacy is achieved. This will affect BCF spending priorities during the life of this plan. The schemes of spending in the 2023-25 BCF submission have been aligned to the intermediate care programme workstreams where appropriate, to evidence how the BCF funding is being used to deliver clear thematic priorities, that ultimately support the BCF national conditions and metrics.

Diagram 1: Intermediate Care Programme



Integrated Neighbourhood Teams – This primarily delivers against BCF Objective 1: "Enabling people to stay well, safe and independent at home for longer." This leads our Place response to the Fuller Stocktake through the creation of integrated, multi-disciplinary teams at a neighbourhood level. We are jointly committing operational resources to support this programme and have commissioned external transformation capacity to design and develop an operating model.

Care Act – Supporting citizens with eligible care needs is a core element of the BCF plan. Within this, our vision and strategy is to promote independence, focus on preventative actions and support unpaid carers.

Independent at Home – Embedding new delivery arrangements for Disabled Facilities Grants following the implementation of a Regulatory Reform Order policy that makes use of the flexibilities to deliver discretionary forms of assistance to support people to remain living at home and to be discharged more rapidly from hospital. Driving further integration through our jointly commissioned Community Equipment Loan service.

Key Changes in the 2023/25 Plan

Key changes for the 23/25 Plan reflect the progress we have made over the past 12 months. New elements for this two-year plan include:

- Additional resource for Community Equipment – demand is increasing; in part due to the success of Home First discharge pathways and enabling people to remain independent at home for longer
- Making use of the Discharge Fund to address pressure on P2 capacity with a planned approach to decommissioning P2 beds over the plan period
- Investment from our Transformation Fund in our Integrated Neighbourhood Teams programme to support our ambition to establish teams in each Primary Care Neighbourhood
- Improvements to Homeless Discharge Pathways
- Recommissioning P0 out of hospital support
- Investing ASC Discharge Fund to support workforce recruitment and retention in the independent care sector

Enabling people to stay well, safe and independent at home for longer.

Integrated Neighbourhood Teams
One of the primary objectives of the BCF includes enabling people to stay well, safe and independent at home for longer through investment in prevention and de-escalation. To do this, we are taking a collaborative, cross-sector approach to support the proactive prevention of crises for our citizens and driving early interventions outside of hospital settings.

BSOL ICB plans to integrate its service provision at every level of its operating framework, including at the locality level (c.200-300k population) and at the neighbourhood level beneath that (c.30-50k population). This will involve developing multi-disciplinary teams and integrated service offerings at each of these footprints.

We are anchoring our integration work and our care services by using locality 'hubs' to support at the locality level, and by using emerging Integrated Neighbourhood Teams (INTs) to deliver at the neighbourhood level.

These locality 'hubs' will provide greater system resilience by offering face-to-face and virtual assessments, point-of-care diagnostics, and therapeutic interventions for citizens with complex conditions who cannot receive the specialist care they need at the GP practice or neighbourhood level. Some hub pilots have also hosted voluntary and social care alliances, signposting citizens to social services and providing advice and support in the same place.

These hub models will therefore improve citizens' access to health and care services and information in the community and can be used to support future integration with social care and mental health services. They can also add extra same-day urgent care capacity by offering more appointments to people when the wider system comes under operational pressure (e.g., during seasonal spikes in demand).

Further to the establishment of the Locality Hubs, it is a clear priority to progress the development and mobilisation of Integrated Neighbourhood Teams (INT) as per *The Fuller Stocktake report (May'22): "Next steps for integrating primary care"*.

The INT programme will see the establishment of INTs across each Primary Care Network in Birmingham, with a vision to ''*support people to live healthier, happier and more independent lives in the neighbourhood and communities they call home".*

The INT's will be the delivery arm of population health management for their respective PCN footprints (circa 30k – 50k population). Each INT will have access to, and utilise, more specialist health and social care intervention which will be provided on a Locality footprint

Partners across the Health and Social Care system in Birmingham have come together through our Integrated Neighbourhood Teams programme to design, test and iterate new ways of working within neighbourhoods to improve outcomes for citizens. The programme is being led by Birmingham Community Healthcare NHS Foundation Trust (BCHC) in their capacity as the commissioned Community Service Integrator. 5 test sites have now been established – one in each of the 5 localities in the City. Test teams are based around Primary Care Networks (PCN) and comprise representatives from primary care, community health care, community mental health, social care and the voluntary and community sectors.

External transformation capacity has been commissioned through the BCF to support the programme. This has enabled us to accelerate data sharing and to identify high frequency service users at a neighbourhood level across all test sites. Using this data has enabled teams to review cases, to explore opportunities to better integrate care and to improve

outcomes for citizens. Appropriate data sharing and information governance protocols are in place.

Whilst we are working with teams across the city, we are particularly focusing resource within the East and West localities - areas that experience high levels of health inequalities associated with multiple deprivation factors. Here the test teams we are using the external capacity to go further; through undertaking structured case reviews at scale in order to identify trends in respect of cohorts who are disproportionately accessing services and through undertaking design sprints with front-line staff to develop a sustainable operating model for INT. Our intention is to embed and test the operating model in these 2 locations during a 3-month period in late 2023 before rolling out to the 3 fast-follower sites and then across the remaining 26 PCNs. This will require additional capacity both in terms of the partner organisations and external transformation resource. Resources from our BCF Transformation Fund have been allocated in the plan to support delivery of this key priority.

In respect of BCF metrics this activity is intended to have an impact on unplanned admissions to hospital for chronic ambulatory care sensitive conditions; emergency hospital admissions following a fall for people over the age of 65 and the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes.

Falls

A multi-agency Birmingham Falls Group meets monthly to make links between stakeholders, to support each other to work more effectively and to collaborate. The group maintains a falls dashboard to gain intelligence on themes and trends and to inform practice and activity. Birmingham Community Healthcare NHS Foundation Trust (BCHC) operates a Falls Prevention Service for citizens living in North, East, Central and West Birmingham. This is a Therapy led team assessing and providing interventions for high-risk fallers within community settings. It is a multidisciplinary team made up of Physiotherapists, Occupational Therapists, Rehab Technicians, and a Specialist Nurse. The team complete a holistic initial assessment of each citizen in their own home, (includes care, residential and nursing homes) and analyses the risk factors for each citizen and implements change to reduce their risk of falling. The BCHC Falls Prevention Team, work alongside many other teams such as the Early Intervention Community Teams, Speech and Language, District Nurses, Care/Nursing Homes, Neurotherapy teams, Continence teams, Dieticians and GP's from across the city, to ensure that citizens care, and wellbeing are of high standard.

There were 26 care and residential homes in Birmingham were selected by BCHC and BSOL CCG to take part in a falls pilot scheme for 12 months beginning August 2021. This proof-of-concept pilot provided support to participating care homes for early hospital discharge, supporting hospital admissions, personalised care planning, and care home staff training and education. Support was delivered by a team of Advanced Nurse Practitioners, including a clinical educator/trainer, working closely with other organisations and specialist services across primary, secondary and community care settings. The pilot demonstrated a 32.6% reduction in falls admissions to hospital from participating care homes. This is now being mainstreamed through the Care Homes workstream of the Intermediate Care Programme. Other initiatives to reduce falls include the provision of lifting cushions and training on the IStumble App for care homes; a falls pathway as part of UCR provision and use of discretionary assistance utilising Disabled Facilities Grant to more rapidly respond to citizens at risk.

Activity to enable people to remain living independently for longer at home in respect of housing adaptions and support for carers is included later in this plan (sections Disabled Facilities Grant and Supporting Unpaid Carers respectively).

Provide the right care in the right place at the right time.

Addressing this policy objective has been, and remains, a core driver for integration in our local health and social care system. We have worked hard to structure our BCF plan so that we have clarity on the use of system resources to support timely and safe discharges, to promote a home first approach and to maximise the impact of post-discharge rehabilitation in respect of ongoing independence.

As a partnership we have been keen to build on the success of our Early Intervention programme which has transformed the way in which we work together and has improved outcomes for citizens. Our Intermediate Care Programme is the next step on the journey – reflecting the post-pandemic environment and new duties – particularly in respect of 2-hour urgent care response. The key workstreams that deliver against this BCF policy objective are:

- Unscheduled care co-ordination
- Urgent Community Response (UCR)
- Pathway 1 – Home First
- Pathway 2 beds
- Virtual Wards
- Enhanced Health in Care Homes
- Single Transfer of Care Team

Unscheduled Care Co-ordination
BCHC currently provides call handling for referrals into their UCR and community provision **to enable people to stay at home longer**. Since mid-January 2023, there has been a significant increase in West Midlands Ambulance Service referrals daily for UHB citizens that require a community pathway. Current changes to the 111 service provider will also need to be addressed to ensure no duplication is created. This aspect of the programme will deliver against 6 key priorities:

1) Coverage & Conditions
    - Ensure a 'minimum coverage offer' for Primary Care, WMAS and Care Homes to address immediate demand
    - Map out all "Single Points of Access" and define scope and plan for Care Coordination Centre (CCC)
    - Develop operating model for usual and out of hours ability to provide a 24/7 model
2) Increasing Calls
    - Increase referrals from the 3 main sources: Primary Care, Care Homes and WMAS
    - Review current 3-way MDT calls process (with WMAS, OPAL+ and CCC) to allow crews to contact CCC directly if not an OPAL+ patient to build on current call-before-convey principle • Develop communication plan for Primary Care and Care homes to encompass all key services i.e., 2hr UCR.
3) Workforce
    - Development of a workforce model • Recruitment to additional roles i.e., paramedics to support teams located within CCC • Recruitment and training plan for increasing the capacity within the team

4) Productivity & Performance
    - Define and deliver against a minimum response standard for “call response time” and “call pick-up” rates
    - Continue demand and capacity planning to manage increased demand pressures
5) Data
    - Ensure alignment between Solihull & Birmingham triage models to ensure consistent recording of CCC activity • Coordinate all ‘unplanned / unscheduled’ call activity and capture in a simple dashboard and sit-rep return • Provide remote, live access of call activity, response times and performance to support system coordination • Revise reporting to show source of referrals i.e. WMAS, Care Homes, Primary Care, Other
6) Infrastructure (Digital and Estates)
    - Identify appropriate estate for CCC team and alignment with other services
    - Align digital requirements with wider IC programme – virtual ward digital monitoring etc.
    - Scope requirements for single CCC across BSOL and deliver integrated telephony services.

Urgent Community Response (UCR)
To address this challenge, Community Service UCR teams are implementing several strategies, to increase the availability and accessibility of community-based services that provide alternatives to hospital admission, through home-based care. This helps to provide citizens with more convenient and appropriate options for their care needs whilst reducing pressure on acute services.

Urgent Community Response allows the provision of timely and appropriate care in the community for citizens with urgent or worsening health needs, including services such as rapid assessment, treatment, monitoring, and support by multidisciplinary teams of health professionals.

Urgent community response aims to reduce unplanned admissions to hospital by focussing on the following 9 clinical conditions:

1) Falls (with no apparent serious injury)
2) Decompensation of frailty
3) Reduced function/deconditioning/reduced mobility
4) Palliative/End of life crisis support
5) Urgent Equipment provision to support a person experiencing a crisis / at risk of hospital admission
6) Confusion / delirium
7) Urgent Catheter care
8) Urgent support for diabetes
9) Unpaid carer breakdown, which if unresolved, will result in a healthcare crisis for cared for person

This focus allows UCR to:

- Prevent further deterioration through early identification and intervention
- Provide an alternative to an emergency department visit and potential of hospitalisation for citizens who can be safely treated and supported within the community in their usual place of residence.

- Onward referral from UCR team will also enhance coordination and communication among primary care providers, community services, and acutes.
- Improve citizen satisfaction and quality of life by reducing unnecessary hospital visits and stays

By reducing unplanned admissions to hospital, urgent community response can also benefit the health system by:

- Saving resources and costs associated with hospital care
- Reducing pressure and overcrowding in emergency departments and wards
- Improving efficiency and effectiveness of care delivery
- Promoting integration and collaboration across different levels and sectors of care

UCR teams are continuing to increase awareness of the service to Care Homes across Birmingham, via communication and educational materials to ensure that Care Home staff consistently turn to UCR for appropriate referrals that can be diverted away from a previously made 999 call.

In response to the escalation to address category 3 & 4 West Midlands Ambulance Service (WMAS) calls for non-harm falls, BSol UEC system has a community-based falls response service for people who have fallen at home, including in care homes. The incidence of falls is slowly reducing, to continue this trend BSOL system priorities are:

- Continue to Implement a post-fall decision-support tool (istumble) for assessing injury and response, and safe patient lifting cushions to aid the post-fall management of care home residents, plus ensure the right care at the right time. 74 lifting cushions have been distributed to urgent crisis response teams and care homes highlighted as frequent callers by WMAS for category 3 and 4 calls across BSol ICS.
- The outstanding 120 care homes to have received the lifting device and post-fall management training in time to support 2023/24 winter pressures.

Further advancement of the team, such as current integration of paramedics, allows for a multidisciplinary team approach that provides coordinated care for citizens with complex needs and multiple long-term conditions, and working alongside BCHC care coordination team ensures onward referral if required can be swiftly enacted, involving health and social care professionals, voluntary sector organisations, and carers when and where needed.

This onward referral and wraparound of further community services allows UCR team to be an initial start point for ongoing patient provision to avoid hospital admission via use of community-based services that deliver intermediate care, rehabilitation, and reablement for citizens who need support to avoid admission, or after a hospital stay. This allows us to improve the integration and coordination of care across different providers and settings and can help to ensure that citizens with complex needs receive timely and appropriate care, avoid duplication of services, and reduce fragmentation of care.

In conclusion, urgent community response can reduce unplanned admissions to hospital by providing timely and appropriate care in the community for patients with urgent or worsening health needs. This can improve outcomes for patients and the health system by preventing patient deterioration, providing alternatives to hospitalisation, enhancing coordination and communication, and improving citizen satisfaction and quality of life.

Pathway 1 – Home First

Pathway 1 (P1) is a route to a citizen's own home to; assess, recover and rehabilitate with support from social care and / or health support.

With the changes in the ICS and the move to a single community integrator, we are in a position to move forward at pace with the Intermediate Care plan; looking to provide truly integrated and responsive services across BSOL, with a care centre focused. As part of this we must provide a consistent 7-day model at both Places which acts as a 'one-stop-shop' for P1 care in the community.

The model in Birmingham is delivered via the Early Intervention in the Community Team (EICT) and was rolled out in 2020 after a comprehensive system redesign. The team is a combination of resources aligned from Birmingham Community Healthcare NHS Foundation Trust (BCHC), Birmingham City Council (BCC), and the private sector offering support to anybody 17 years old or above across Birmingham.

The team consists of:

- BCHC nurses, physiotherapists and occupational therapists
- BCC Social Workers
- Home care – private sector domiciliary care agency providing home support

The aims of the service are to:

- Proactively prevent delays in hospital
- Ensure citizens remain in an acute hospital as short a time as possible
- Prevent citizens from requiring an acute admission (admission avoidance)
- Support citizens to return home wherever possible

The P1 approach is a key part of the Intermediate Care Programme and BSOL approach to improving services and pathways for patients. Birmingham and Solihull P1 offers are currently very different, creating challenges when attempting to integrate and align with concurrent workstreams.

Key aims of this workstream:

- To support a Home First approach
- To deliver a consistent approach to P1 across BSOL
- The service must have consistent and meaningful reporting frameworks with a single set of metrics.
- The level of demand for the domiciliary service is exceeding commissioned capacity and contract is due to end next year. Therefore, a procurement exercise will need to be undertaken to secure the domiciliary care provider.

Pathway 2 Beds

The key priorities in the pathway 2 bed intermediate care workstream are to:

- To de-escalate independent sector surge capacity and prepare for winter
- Focus on optimising length of stay across all sites
- Commission an independent rehabilitation acuity and complexity audit to evidence citizen care needs and how these can be provided by nursing, therapy, and medical workforce
- Establish a system baseline that is sustainable for the longer-term model
- Develop a BSOL operational model and outcomes framework
- Confirm the overall number of sites required for a long term P2 bed model and underlying principles – e.g., locality based and citizen flow.
- Within this agree the capacity required for complex citizens, agree and commission the future delivery model
- Link in with single discharge team workstream regarding the development of a single information system and the development of a streamlined D2A process for placement into P2 beds

- As part of to be established overarching BSOL D2A governance have oversight of overall place based P2 metrics and outcomes
- Prepare the resilience plan for next winter; ensure that a more sustainable approach to capacity is delivered in line with the longer term aims toward locality / place-based pathway 2 bed model, that maximises statutory provision
- Prepare the business case for a long-term pathway 2 provision, including:
    - Clearly define what subacute care is and what provision is required to meet that.
    - Undertake the detailed planning work on the final locality-based model to be implemented on longer term, factoring in what the new steady state demand and patient flows materialise after de-escalation and draw down on surge/ winter demand.
- Rationalise independent sector provision across BSol Footprint.

Virtual Wards

The 23/24 virtual ward plan maintains the 22/23 ambition to deliver a virtual ward capacity of 135 beds across respiratory, frailty and surgical pathways by end of April 2023.

This is dependent on recruitment as well as expanding the surgery virtual ward to additional citizen cohorts. Detailed delivery plans are in place to achieve this. A workforce plan is also in place and aligned with the 23/24 virtual ward trajectory.

Average length of stay across all virtual ward pathways was 6 days in 22/23. This was less than the pre go-live assumption that average length of stay would be 10 days. However, the 22/23 plan to admit a total of 1,400 citizens has been achieved. This meant that fewer beds were occupied by the planned number of citizens. This presents an opportunity in 23/24 to increase utilisation of the 135 beds and increase the number of admissions beyond that in the original plan. At 80% utilisation it is anticipated that up to 500 admissions per month can be achieved and this would equate to 3,000 virtual ward occupied bed days each month. The virtual ward delivery plan has a particular focus on improving utilisation of capacity. For example, a communication and engagement plan is aimed at raising awareness and increasing confidence levels amongst referring clinicians. Another key priority for virtual wards in 23/24 is to complete the roll out of remote monitoring technology. This will improve clinical oversight of virtual ward citizens as well as facilitate the automatic capture of Patient Reported Outcome Measures (PROMs) and (PREMs).

Single Transfer of Care Team

Development of the Single Transfer of Care Team will be pivotal to providing the right care, and the right place at the right time. During 23/24, we are looking to establish a single BSOL Transfer of Care approach. This will have the following objectives:

1. To establish a single Birmingham & Solihull Transfer of Care approach via multi-disciplinary working, to deliver the 'pull' **from the acute and community bedded settings into people's homes** to ensure people are in the right place, at the right time to meet their needs.
2. To establish consistent professional decision making across discharge pathways underpinned by necessary agreements between organisations including data and risk sharing, and trusted assessments as required.
3. To develop and deliver the single IT system and operational processes required to support the transfer of care and managerial oversight, including ongoing improvement.

4. To confirm the discharge ‘offers’ across Birmingham & Solihull including voluntary and community service support for settling in post discharge, 48hour short term support, offers for homeless and extremely vulnerable people.

Packages outside of existing Pathways - A panel is to be established and chaired by the ICB with health and social care system representation to oversee the spend of BCF allocated funds on bespoke packages for citizens who do not fit in to existing or traditional pathway.

Housing and Homeless Pathways - The impact of poor housing conditions or homelessness had already been identified as an area of improvement prior to the pandemic and has continued to remain a priority. Although the numbers being delayed due to housing issues remain relatively small, the length of stay within acute per citizen was often significant.

In response, we continue to commission independent living, temporary accommodation to enable discharge from acute/enablement beds whilst long-term housing solutions are explored. This has been developed in collaboration with housing colleagues and the provision also includes dedicated Birmingham City Council Housing Officers who are able to prioritise and review those citizens who present as homeless at point of discharge with ongoing care and support needs. This has reduced admissions into short and long-term residential care for this cohort.

Birmingham was also successful in bidding for Out of Hospital Care Model funding from the Department for Health and Social Care, to improve the support and pathways for citizens who present homeless at the point of discharge. The funding has allowed Birmingham to have dedicated staff based within the 4 Birmingham acutes to provide support, assessments, advice and move on for those citizens referred into the service. The service has identified really benefits to the wider health and social care system by supporting citizens as early as possible within their hospital or enablement bed journey. Funding has now been allocated to continue the service, with this going out to procurement in 2024.

Referrals into the support remain high with the variety of support that it is able to offer, to date since 1st November 2021 there have been 1318 referrals made. The service completes a bespoke Homeless Assessment that is a holistic view of the citizen, working alongside professionals within the hospital to decide the best pathway for the citizen which can be home, into independent living or alternative accommodation as a temporary measure to ensure we give the citizen the best opportunity of returning to community living or their usual place of residence.

There has been considerable impact in the reduction of citizens remaining in hospital for housing needs and the pathways as they embed within the acute settings are offering an alternative for fast-track support for housing and homelessness.

Support Home from Hospital - Spending time in hospital or in an enablement bed (EAB) can be a challenging and stressful experience for citizens. The priority is to get citizens home as quickly as possible with the right support in the community in order to minimize the risks of loss of condition and independence that are associated with spending too long in bed-based care. The Support Home from Hospital Service is part of the community services offered to citizens providing bespoke support around befriending, benefit maximisation, access to primary care, food provision, home safety and social reintegration. The service is focused on supporting citizens from the day of discharge for up to 6 weeks post discharge with the aim of enabling the citizen to remain within the community and to avoid unnecessary readmission to hospital.

Capacity and Demand

Key features of the 2023/2024 capacity and demand submission in relation to both discharge from acute and demand from community settings:

- **Hospital Discharge Capacity and Demand**
  - Capacity either equates to or exceeds demand for all lines, with the exception of the P2 activity (see narrative below)
- **Community Capacity and Demand –**
  - Capacity either equates to or exceeds demand for all lines ***as a year-end total***
  - Demand exceeds capacity ***for some individual months*** for both UCR activity and rehabilitation at home
- The **key context** to the above is that:
  - The **forecasts** are based on historic demand.
  - **Support at home (pathway 1) - The** emphasis, as reflected in the capacity and demand forecast, is on pathway 1 in this financial year, in supporting as many citizens at home as possible, and is entirely in line with the Home First approach at the core of the Intermediate Care Programme described in earlier sections of this document. There is sufficient capacity for discharge 'step down' all year, and a forecast deficit in some months for 'step up' community demand. However, the pathway 1 caseload is managed in its entirety by EICT, giving flexibility to manage across discharge and step up community pathways.
  - **Bed based intermediate care (pathway 2)**- The emphasis on maintaining a 'steady state' in terms of bed-based pathway 2 intermediate care and avoiding a cycle of surging and then de-escalating bed capacity – as we know as a system that this can a) perpetuate a culture of reliance on bed based care and b) lead to significant issues in de-escalating beds as the system comes out of winter. The expectation is that the actual demand for pathway 2 will reduce compared to historic demand levels and the forecast submitted, with the introduction of the intermediate care programme. To mitigate against any unmet demand, a framework call-off agreement is being put in place ahead of winter so some beds can be stepped up if required.
  - **UCR** – UCR activity or opening hours can be stepped up very easily to expand capacity, and therefore in the any individual months where actual demand is being seen to exceed capacity, this can be done with 24hrs notice. The intention would not be to significantly increase UCR capacity at present in light of a marginal amount of seasonal demand that can be met at short notice.

Learning from 22-23

- Overall, the data available for 23/24 is more intelligent and nuances compared to last year's submission, allowing for more accurate forecast capacity and demand in the relevant format.
- Pathway 2 beds forecast for capacity and demand is higher for 23/24 than 22/23. This year more intelligent data is available from our joined-up Bed Management Hub.
- Pathway 0 – Not all pathway 0 data is included that year and has been refined to include only those with social support.

As a more general theme, learning from last year; discharges have been increasingly complex, with more younger adult mental health demand than in previous years and increased distressed behaviours relating to dementia and mental health, which have been

challenging to support in existing provision. Work is being done across the system to find better support options for this cohort to reduce the demands for one-to-one care.

Care Act Duty Delivery

Funding for Care Act duties remains a core element of our BCF Plan in terms of the utilisation of NHS minimum contributions for social care, iBCF and ASC Discharge Fund.

The Plan supports £66.4m of expenditure on long-term nursing, residential and supported living packages alongside £22.2m for domiciliary care. A further £1.2m in the plan is allocated for safeguarding, advocacy and occupational therapy.

In addition, our plans for the use of ASC Discharge Fund will ensure that Care Act duties are being delivered. Planned expenditure includes support for the independent care sector to retain and recruit workforce by directly increasing the take-home pay of care staff. This is critical if we are to maintain capacity in the sector in order to both meet Care Act duties towards citizens and also to maintain flow in the system. Similarly, the fund is being used to support retention and overtime payments for qualified social work staff. This has been targeted at teams undertaking care act assessments as part of the discharge process. Other elements of the fund include provision for increasing demand for community equipment in support of Care Act duties.

Residential admissions metric

Historically this metric was recorded and reported incorrectly, below is the data extracted. There was an increase of the number of citizens going into residential care during Covid-19, but this has reduced since. This supports the continued priority locally of the Home First principle and additional investment in services to support citizens to return to the community with services and support as required.

		Apr-19 to Mar-20	Apr-20 to Mar-21	Apr-21 to Mar-22	Apr-22 to Mar-23
65+	Admissions*	1072	1076	1138	1051
	per 100,000	710.4	713.1	754.2	696.5
Target				417.6	710

*all admissions both supported by the council and self-directed

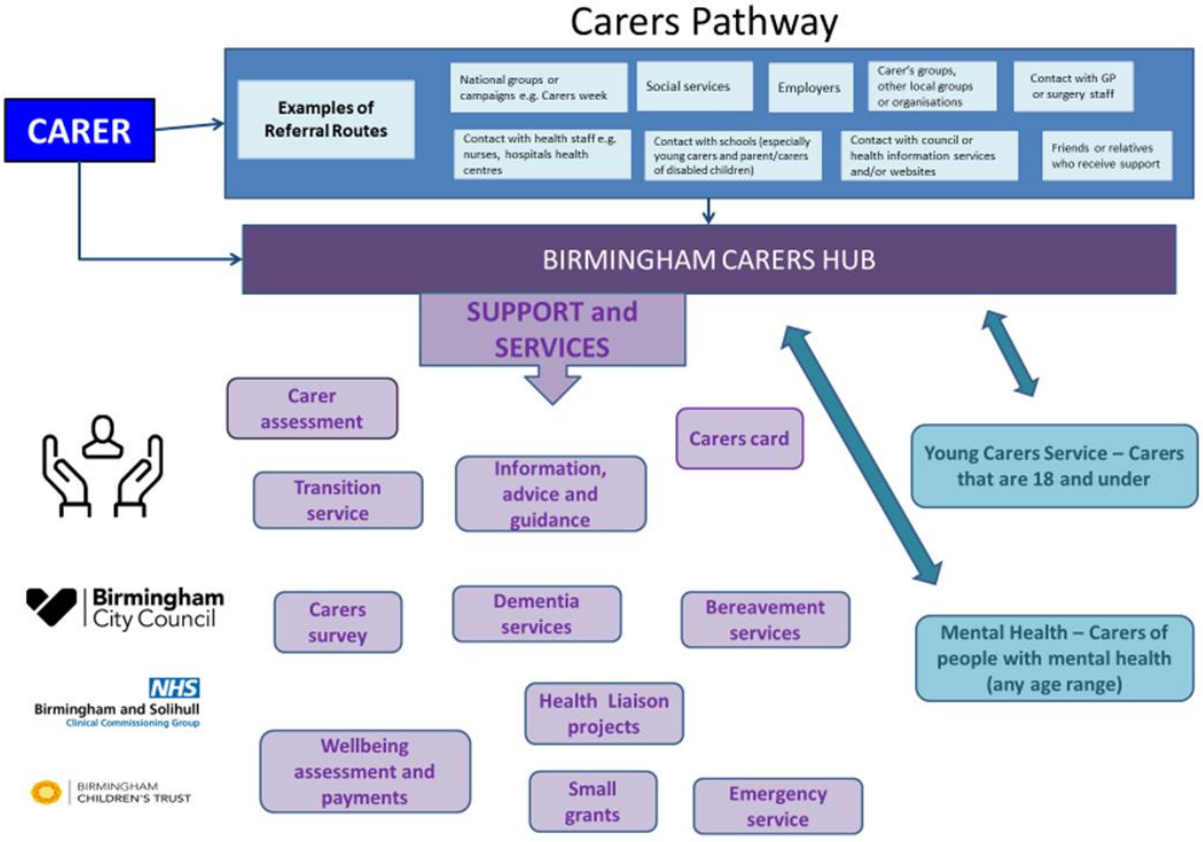
The plan for 2022/23 was 710 per 100,000 which the end of year achievement being 696.5. This highlights the continued improvement in supporting citizens to remain in the community rather than going into residential care. As well the improved outcomes as a result of the Early Intervention Community Team providing support at the right time to ensure services and support are in place to reduce the need or delay the requirement for residential care.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Birmingham Carers Hub (Hub) was commissioned in 2023 and jointly procured with Birmingham Children's Trust and Birmingham and Solihull Integrated Care Board (ICB) embedding a cohesive carers pathway for Birmingham across all carer services. The Hub is jointly funded by Adult Social Care, Birmingham City Council and the Better Care Fund. The Care Act 2014 gives carers the legal right to receive support from their local authority if they have eligible needs. This support can be accessed through a carer's assessment and should look at all the carers needs.

The Hub was commissioned as part of the carer's pathway model with Young Carer and Mental Health carer services enabling a whole life course approach. There are clear links and pathways between the services to simplify a carers journey across their life course. Referrals and introductions are made between services ensuring the carer receives the right support at the right time.



The new Hub service will provide a range of services including; statutory carer assessments, Carers Cards in a Community and Hospital setting, advice, information and guidance, practical emotional and peer support including 1:1 support and carers groups, advocacy, navigator role, awareness raising and engagement, training in relation to the caring role to include practical and manhandling particularly at home, bereavement support, carers

emergency and planned response, working with Children's Trust disabled child register to help identify parent carers and to manage the Children's Trust Disabled Children's Register, annual carers survey, transition service for young carers transitioning to adulthood, carers wellbeing payments and breaks, small grants for specialist services, health liaison project and specialist support dementia carers. The Hub will also be expected to develop a Carer Friendly Employer service and address digital inclusion and poverty.

Over the past two years services have adapted to the changing circumstances and it is expected that services will continue to develop taking on board lessons learnt. In particular, a focus on locality-based work to address isolation and improve satisfaction levels, working closely with the community and technology with training, including support for digital equipment.

The outcomes for the Hub are linked to the Care Act requirements in supporting Carers and include:

Payment by outcomes:

1. 85% of Carer assessments completed in timescale of 28 days
2. Working across the Carers Pathway
3. Working in partnership.

Number of Carers working or participating in training or education

Carers report improved health and wellbeing in carer scores from assessment to review

Number GP surgeries accessed

Number sessions held in hospital setting

Number carers assessments started and completed including parent, young and dementia Carers and % completed in 28 days

Number dementia friendly plans

Number social prescribers based at GP practices

Number of referrals from health professionals showing breakdown of source

Number groups delivered to dementia Carers

Number of Partners in Care and in the Community Cards issued

Currently Carers Breaks are not commissioned but there is a local Carers Emergency Response Service (CERS) which provides a sitting service for up to 48 hours. Carers breaks are part of the refreshing of the Carers Strategy work which will begin consultation during Carers Week on the 7th June.

Disabled Facilities Grant (DFG)

In March 2022 the Staying Independent at Home Policy was approved by Birmingham Cabinet that brings together the responsibilities and duties under:

- The Housing Grants, Construction and Regeneration Act 1996
- Care Act 2014
- The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO 2002).

As housing is a key determinant of health the policy sets out how the council will reduce the health inequality brought about by poor living standards, by providing support in the form of grants, loans or services to improve housing conditions. Ensuring that homes are decent, accessible, safe and secure, this is not only important for the health and wellbeing of the citizen but is also vital for the sustainability of communities.

The policy clearly sets out both the assistance that the Council has a duty to provide (mandatory) and assistance that will be provided through the use of discretionary powers. The discretionary assistance through the policy will be to:

- Support disabled citizens to secure necessary adaptations which cost more than the maximum allowed under the Disabled Facilities Grant
- Secure prompt discharge from hospital of citizens who might, due to accommodation difficulties, otherwise remain in hospital longer than necessary
- Address accommodation difficulties which, if not resolves, might lead to an avoidable admission to hospital, or residential care or which impact upon the ability of the citizen to live safely and independently at home.

In order to deliver the new discretionary assistance, the commissioning of a new integrated service to deliver the principles in the new policy and meet the demands of the citizens of Birmingham has commenced. It is expected that a new service model will be implemented from January 2024. In the meantime, services have been adapted and scaled up in order to deliver the new discretionary assistance and this has been in place since October 2022.

As already detailed within the homeless and housing pathways section there has been a considerable amount of work to develop effective pathways for citizens who are not able to return home for various reasons including, not having a home or this not meeting their needs (homeless), hoarding, cleanliness, health and safety and domestic abuse. The pathways have been developed through integration of housing and adult social care teams and recongising for citizens who are being discharged from hospital that a one service approach means better outcomes and the right accommodation offer being made at the right time.

Additional information (not assured)
Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services?
Yes, Birmingham published and implemented a Staying Independent at Home Policy in March 2022.

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding? Funding for discretionary services is part of the overall development of the Staying Independent at Home services and policy roll out. Provision for mandatory services will always be prioritised. There has been no specific value identified for discretionary assistance, but this is included in the procurement currently being undertaken (May-June 2023).

Equality and health inequalities

Birmingham and Solihull ICS (BSol ICS) have the biggest opportunity in a generation for the most radical overhaul in the way health and care services are delivered in Birmingham and Solihull. In shifting to a new way of working, the greatest collective impact we can make on the lives of the citizens we serve is to ensure that improving health outcomes and closing inequality is hard-wired into every plan we make, every investment we agree and every decision we take.

Whilst tackling the determinants of poor health, improving outcomes and closing inequality has always been at the heart of health and care, it hasn't always been core business: that will change under the new operating model being designed for Birmingham and Solihull Integrated Health System.

In BSol ICS Inception Framework published in February 2022, we committed to working with our citizens, health and care providers, and voluntary & community organisations to create a 10-year Master Plan which will not only be ambitious in the long-term aspirations it sets to reduce inequality but will guide our decision-making in the short and medium-term.

We are already broadening our scope to look beyond traditional performance measures and starting to measure the outcomes of decisions: not just 'are we hitting our targets?' but 'are the lives of citizens being improved?'

The National Core20Plus5 framework also sets out the national expectations for tackling health inequalities. It reflects the importance of understanding these gaps and differences better, being clear about priorities and taking evidence-based action at different levels of the ICS.

We have started to do this by focusing our Integrated Care System on six system-wide priorities. Alongside this each part of our system will focus additional activity on what matters most to citizens in their area at Place, locality, and neighbourhood level.

We have identified our six system priorities based on:

- factors that drive poor healthy life expectancy for our citizens;
- priorities of the Health & Wellbeing boards;
- priorities of the Inequalities strategy being developed for BSol ICS;
- citizens waiting longer for diagnostics and surgery;
- opportunities for improvement identified in the Birmingham & Lewisham Black African and Caribbean Health Inequalities Review (BLACHIR) across Birmingham and Solihull
  lessons learnt from the way in which COVID-19 hit hardest those who were already worst off; and
- national "Core20plus5" priorities for reducing inequalities.

We will use the ICS five-year Health Inequalities Strategy's six main priorities focussed around those populations who experience the greatest health inequalities in BSol. The priorities include:

- Better outcomes for people with disabilities, including a learning disability,
- Better prevention and detection of diseases Including respiratory
- Better outcomes for people with mental illness
- Improved outcomes for inclusion groups such as new migrants, refuges or asylum seekers

The six building blocks for delivery are:

1) Insight and impact – using data to identify drivers and consequences of inequality
2) Pathway improvement – support service improvement methods, and working with citizens to deliver change at scale
3) Targeting our prevention programmes – deliver these in a culturally sensitive way
4) Working with communities – recognise our citizens are experts
5) Supporting healthy literacy – Build health literacy
6) Anchor institutions – Use the full potential of our health and care providers

The Core20Plus5 is the national NHS England & Improvement approach to tackling inequalities in health and is the framework utlilised to deliver the BSol ICS Health Inequality Strategy. It is based on three elements.

- **Core20** - A national target population – the 20% most deprived people in the country based on the Index of Multiple Deprivation. Nearly 50% of our population live within the national 20% most deprived communities. Mainly in Birmingham but includes parts of North Solihull.
- **Plus** – focus on a locally-defined target of those experiencing worse than average outcomes needing a tailored approach. PLUS population groups include ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others. Specific consideration should be taken for the inclusion of young carers, looked after children/care leavers and those in contact with the justice system.
- **5** - five areas of focus are part of wider actions for Integrated Care Board and Integrated Care Partnerships to achieve system change and improve care for adults, children and young people. Governance for these focus areas sits with national programmes; national and regional teams coordinate local systems to achieve aims. For adults these five areas are maternity, mental ill health, respiratory, cancer and hypertension). For children and young people, the focus will be on asthma, epilepsy, oral health, mental health and diabetes.