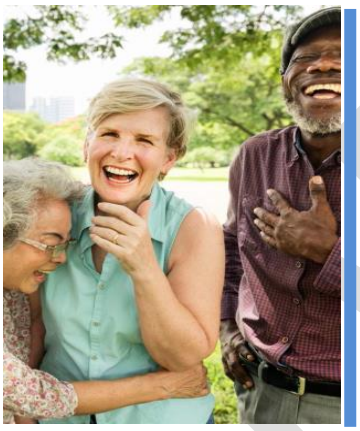
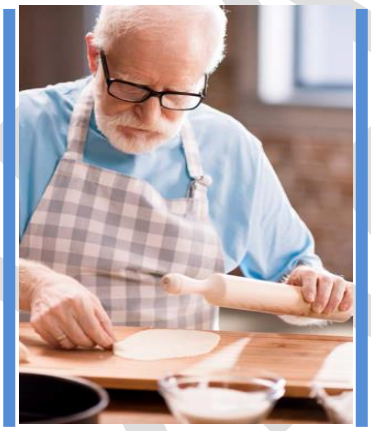
Making Birmingham

a great place to grow old in.

The Early Intervention Programme (Intermediate Care Community Pathways)

Part of the Birmingham Older People's Programme.

Forward Plan - July 2020

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Introduction

This document summarises the progress to date and sets the direction for the next phase of work to be undertaken by health and social care partners within the Birmingham Older People's Partnership (BOPP) in relation to the on-going improvement of Early Intervention (EI) services (Intermediate Care Community Pathways). It builds upon the overarching framework agreed for the integrated improvement of services for older people, and those with similar needs, by system partners in July 2018 – 'Making Birmingham a great place to grow old In'. The workstream sits alongside the two other BOPP workstreams: Care Homes and Integrated Neighbourhoods.

This document set outs the following aspects of the next phase of the EI workstream:

- The relevant background and results to date
- The project structure that will be used to run the workstream
- The nominal leads at a workstream and project level
- The governance that will be used to run the workstream
- The short term, priority deliverables and associated measurable outcomes
- The expected timelines for these deliverables
- The longer term deliverables for the EI workstream and associated measurable outcomes

This document has been pulled together through collaboration involving the following individuals from health and social care providers and commissioners in Birmingham:

- **Birmingham and Solihull CCG**: Paul Athey, Karen Helliwell, Helen Kelly
- **Birmingham City Council**: Louise Collet, Mike Walsh, Balwinder Kaur, Andrew Marsh
- **Birmingham Community Healthcare Foundation Trust**: Chris Holt, Ben Richards, Liza Walsh
- **University Hospital Birmingham Trust**: Andrew McKirgan, Zoe Wyrko, Judith Davis
- **St Mary's Hospice and John Taylor Hospice**: Penny Venables
- **Birmingham and Solihull Mental Health Foundation Trust**: Derek Tobin
- **Sandwell and West Birmingham CCG**: Pip Mayo

It's acknowledged that West Midlands Ambulance Service will need to be engaged through this work and the group is comfortable this can be done at an operational level.

Early Intervention

The Early Intervention programme commenced in October 2018 and was the first integrated programme of work in Birmingham that was supported by an external partner, Newton Europe. The programme has had active involvement from all the partners listed on the previous page, except for the hospice trusts.

The programme set out 5 components of a future Early Intervention Service, through engagement with senior health and social care practitioners in the Birmingham system:

- **OPAL**: A geriatrician lead multi-disciplinary team that ensures individuals presenting at the front door of the acute hospital get the most appropriate onward care
- **Hubs**: A multi-disciplinary team that work at the point of discharge from acute hospitals to ensure timely discharge on the most appropriate discharge pathway
- **EI Beds**: A single bedded intermediate care provision to support people to recover as much independence following a crisis as possible, ideally returning home
- **EI Community Team**: A single at home intermediate care offer that supports people to recover in their own homes and minimise the ongoing level of need an individual has and therefore the support they require
- **Mental Health Wards**: Specialist mental health provision to care for people experiencing an acute mental health episode

Health and social care professionals worked together to identify several **principles** that would underpin a future model:

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

Working this way would mean:

- Organisational boundaries should not have a detrimental impact on an older person's care.
- No wrong door for someone that needs help.
- Clearly defined roles to maximise skills and capacity.
- Efficient distribution of resources within a locality.
- Overall consistency accepting local variation where it makes sense.

The EI Programme sought to measurably deliver the following outcomes:

- Increasing the proportion of people remaining home after a crisis by 8%
- The reduction of non-elective admissions by 4,000 each year
- The reduction of length of stay in acute beds for 7,000 people going through complex discharges each year, by 4 days per person
- A reduced level of ongoing need for people after a crisis 9,000 people per year

COVID19

In January 2020 the world was made aware of the beginnings of a global viral pandemic, subsequently named COVID-19. A national response to the pandemic was instigated giving little flexibility in locally designed responses, the most relevant document for the EI programme and associated discharge functions throughout the system was published on 19th March 2020. It was entitled the *'COVID-19 Hospital Discharge Service Requirements'* and flexibilities identified were enacted through the COVID Act in parliament in March 2020.

Significantly for this programme it required the establishment of the following:

- A language and reporting mechanism around 4 pathways out of hospital (0-3)
- The suspension of key requirements around Continuing Heath Care with safeguards put in place to ensure any requirements were completed at a later date
- The ability of Local Authorities to suspend key Care Act requirements with safeguards put in place to ensure any requirements were completed at a later date
- Health community service organisations placed in a leadership role with regards to hospital discharge with the role of other organisations, and a nominated lead within each organisation defined.
- A redeployment of community-based staff to support critical services

All the components of the EI programme were identified as critical and all had significant changes to adopt. The redesign and improvement work of the previous 15 months placed the service in a positive place to respond and make the most of the changes presented. Each part of the service has worked exceptionally hard in challenging circumstances and the benefits are clear in the outcomes identified above.

An assessment of the changes to the components because of Covid-19 specifics are given in the 'Detailed Briefs' at the end of this document.

A new Birmingham and Solihull governance structure was identified during the peak of the wave of the pandemic between February/March and June 2020. However, BOPP has recently reconvened and has agreed the next phase of 'Making Birmingham a Great Place to Grow Old In' which builds on:

- The successful work of the EI programme (and other two programmes – On-going personalised Support and Prevention)
- The positives of the COVID experience and changes around primary care networks in the last 12 months

The on-going improvement of integrated intermediate care has been agreed as a key priority and will continue with the name 'Early Intervention'.

The largest impacts on system outcomes due to COVID have been:

- The current acute length of stay for complex discharges is 4.5 days lower than the targeted levels
- The current EI Bed length of stay is 17 days lower than the targeted levels
- There is an opportunity to reduce 2,800 people ongoing social care needs per year as the referrals from Community Social Work Teams to the EICT were consciously delayed (to preserve acute step down capacity) and are in the process of being activated
- There is an opportunity to reduce NELs by a further 3,000 per year as the OPAL teams at BHH and GHH have been impacted by the COVID response.

At the end of August, further national guidance has emerged for managing Winter 20/21 and this is being incorporated into planning.

Current Performance Position

The following tables summarise the system performance levels as of 22nd July

EARLY INTERVENTION SYSTEM IMPACT (22/07/20)

Getting more people home	In the old world, if someone interacted with an EI component, there was a 65% likelihood of going home **Now, there's a 63% likelihood of going home** *To get more people home, we should look first at OPAL as that's where most people aren't going home at the moment* *If we want to improve further, we should then look at Hubs*
Using fewer acute bed days	EI components today mean we need to use 77000 fewer acute bed days than we used to This is better than the diagnostic predicted! Our biggest area of success has been with the Hub teams! *To use fewer acute bed days, we should first look to make further improvements with the OPAL teams* *To make even more improvements, we should work with Juniper teams*
Using fewer non-acute bed days	Compared to the old world, the Birmingham system is using 19000 fewer non-acute bed days Reduced admissions means 1300 fewer days are needed Shorter length of stay means 17300 fewer days are needed *To reduce our use of non-acute bed days, we need to focus on reducing admissions to EI Beds from our Hubs*
Reducing system length of stay	Across all EI components, people spend 11.5 fewer days in the system This is better than the diagnostic predicted! Our biggest area of success has been with the EI Community teams, taking 20.7 days off the baseline length of stay! *To help people move through the system quicker, we should first look to the EI Bed teams* *To make even more of an impact, we should look at the Hub teams*
Making a positive financial impact	Our new EI services are having a impact of £25.8million saved for Birmingham The diagnostic indicates we could achieve further financial benefits of £7.8million Our biggest area of success has been with the Hub teams, with a £14.3m run rate financial benefit! *To have a bigger financial impact, we should look at the our EICT volumes, as this has a value of £9.1million* *The next area of priority would be our OPAL teams, as this has a value of £3.6million*

Staff Perspectives

The most recent engagement with staff across all the EI service was an event held in December 2019, inviting contributions from front line management across all 5 components. Supporting this event, a video was produced to showcase staff perceptions of the EI Programme. The video can be found here and some quotes and stats from the event are listed below.

"This is great for the older population of Birmingham and feels like patients are being given a voice"

"There is a level of MDT and cross organisational working that wasn't there before"

"What we've got to work on now is sustainability… and keeping everyone motivated"

More recently, following the mobilisation of the EICT across the city in March 2020, an OD report was produced focussing specifically on the staff within this component. Whilst it is only one of the 5 components of EI, the conclusions could we have thematic relevance for the whole service:

Headlines

Summary

- People are generally feeling engaged with the concept and potential benefits of EICT, although some practical and process challenges are impacting on overall engagement levels
- Team cohesion is improving and people feel they are starting to work together well, but still need greater understanding of different roles & disciplines
- There are some practical skill and knowledge gaps (systems and processes in particular) and people feel a more robust induction would be beneficial

Skills & knowledge	• There are still some gaps for the teams in their understanding of key processes and systems but some work is happening to address these areas (e.g. Rio training) • There are some mindset / behavioural gaps which may also need some focus • People have found practical training and peer and manager support have been most useful for them so far
Engagement	• The large majority of people are engaged with the potential benefits of the EICT, but some practical challenges are impacting on overall engagement levels (e.g. people working in different places) • Generally people feel part of the team and positive about the possibilities of EICT • However, a number of people feel unclear on their own roles and responsibilities as well as those of others which is impacting on their engagement and motivation; and volume and duplication of paperwork is also impacting on this quite consistently
Team cohesion & ways of working	• Overall people feel the teams are starting to work in a well integrated way despite the challenges of COVID • There is more work to do to make sure people get to know each other, and really understand each others' roles and expertise • Most of the key ways of working are starting to be at least partly demonstrated across the teams but more work is needed to fully embed these

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Further staff engagement is planned in the coming months – in the very short term, a 'thank you' card and small gift has been sent to staff to acknowledge the efforts that have gone in to the COVID response. Looking slightly further ahead, an event is planned in September to align with the Health and Wellbeing Board to more holistically feed back to staff about the achievements of the Programme and gather views from front line staff on what changes should happen next.

Stories of Difference

The Early Intervention service interacts with hundreds of new people that live in Birmingham every single week. Gathering stories of difference and patient feedback has been at the core of the approach throughout the programme.

We've received some excellent feedback on the EICT:

And some incredible stories collected that show how valuable the changes across all the components are when they are brought together:

"Sam pulled her pendant alarm after a fall. The ambulance crew came to see her and immediately phoned "Ask OPAL" for a remote consultation as they believed Sam needed to be admitted. After speaking with the OPAL team at QE, Sam actually stayed at home and was referred to the EICT instead. Sam was seen by a nurse from the EICT and had an initial assessment that outlined some care requirements and a recovery plan. This included realising that Sam had not been taking her medication – an important part of keeping her safe and well at home. The nurse noticed that Sam had mobility issues, particularly with one shoulder. Through the daily MDT in the EICT, the nurse was able to bring in a physio to work with Sam as well to help her recover her mobility and her ongoing independence. After two weeks of intensive support, Sam was discharged from the EICT fully independent and taking her medication meaning she's much more stable on an ongoing basis."

Project Structure, Leads and Governance

The EI programme sits as part of the wider BOPP governance and will have relationships with other BOPP level groups. A strategic group is being proposed at a BOPP level to look across all programme so there is no need for an EI specific strategic group.

To deliver the EI programme, it has been agreed to create 5 project implementation groups that will deliver the programme, in addition to a coordinating group that will work at a programme level (the EI Steering Group'). The 4 provision groups align to 4 of the operational components established through the previous work

The 5 project groups are:

- 4 provision groups:
  - OPAL
  - Integrated Hub (including acute and co-ordination hubs and their underpinning processes)
  - Pathway 1
  - Pathway 2
- A commissioning group

The leads for each group is shown on page 10.

There is an acknowledgement that there will be a lot of crossover in the people that need to review the performance of these operational teams (established through the EI Programme – part 1) against their established KPIs. Therefore, the project delivery governance needs to intertwine with system operational performance governance.

The proposed approach is to convene the EI Steering Group **fortnightly** with the remit of discussing either of the following as required:

- Progress of deliverables outlined in the brief for each project group
- The operational performance of components

Programme Approach

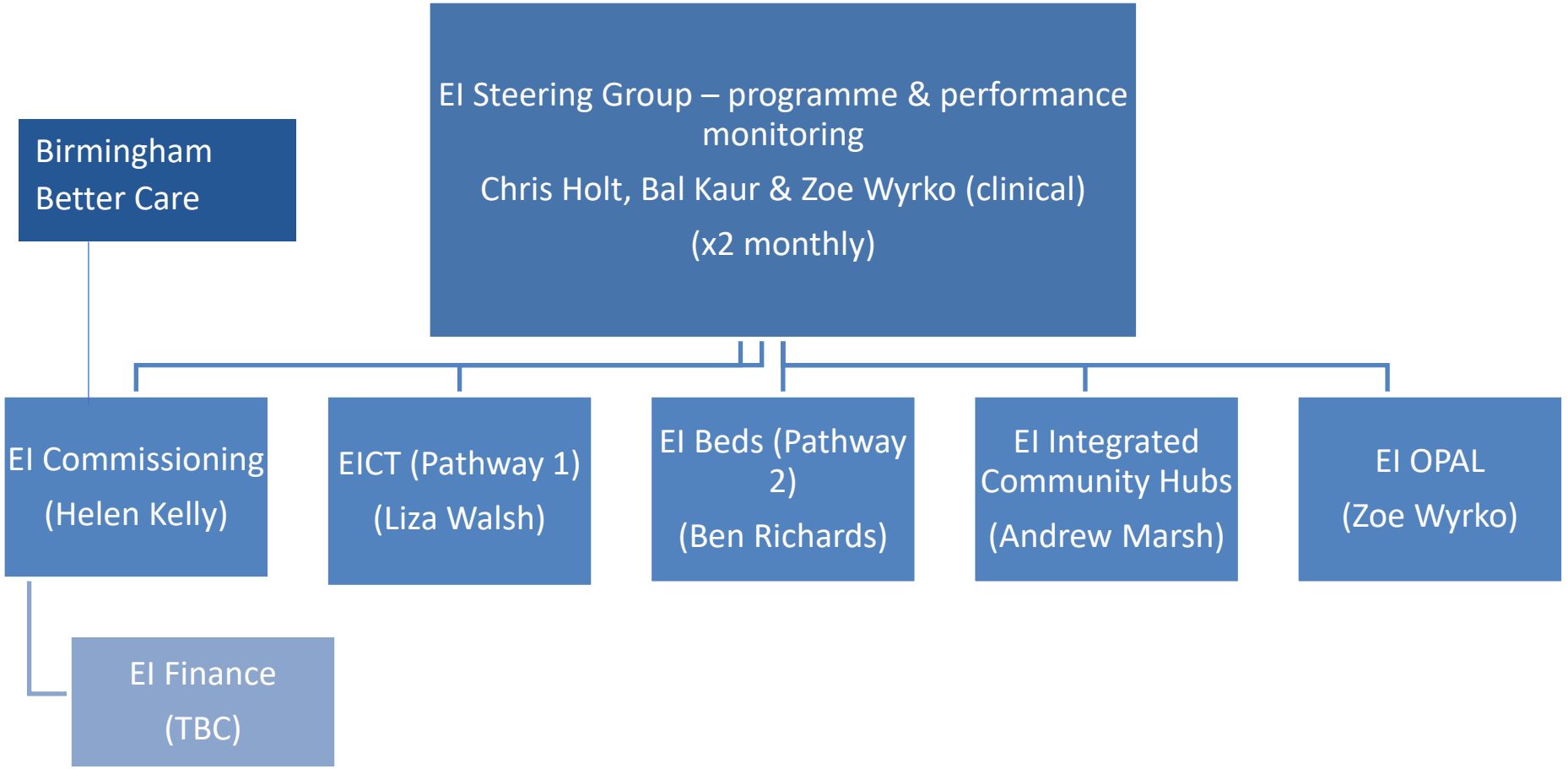
The EI programme to date has followed a methodology commissioned and contracted from Newton Europe, this has included the development of the role of Improvement Manager. Currently there are 2 individuals who have worked in the programme for 18 months and have an advanced set of improvement skills, as opposed to project management skills. A further 4 individuals have a more limited set of improvement skills, but none the less are significant.

The approach taken has had four fundamental underlying principles:

- The identification of need for change is data driven
- The change is co-designed with front line staff
- The change will be delivered through the following approach – changes to process designed, tools designed to help process change and identifying impact, people coached to use tools
- The later is delivered through a series of improvement cycles

The improvement managers have skill sets across the breadth of these principles to a greater or lesser degree, and as far as possible these principles will be maintained moving forwards.

Programme Governance



End of Life Care and Mental Health Service Involvement

End of Life Care and Mental Health services apply to the whole of BOPP and therefore will need to have representation in the right project groups of the EI programme moving forward. The schematics below show how End of Life Care and Mental Health services interface with the three BOPP workstreams.

End of Life Care

The End of Life Care Oversight Group has worked alongside partners for the last two years to improve and integrate end of life and specialist palliative care across the health and social care economy. Before the outbreak of the Covid-19 pandemic the End of Life Care Delivery Group had been established and work completed on a shared vision for the future of services agreed. Evidence for Birmingham and Solihull indicating higher numbers of people than the national average ending their lives in an acute hospital has driven the vision to deliver urgent and rapid response to these patients needs on a 24/7 basis across the economy.

End of life services cross all health services including acute, primary care and community and those provided by not for profit providers and it is therefore important that in the next stages of the Early Intervention programme this work is integrated into all the new work streams. Phase two of this work will help to deliver change and integration of services to allow specialist input and education where required in the system and new pathways to open up access to specialist health professionals.

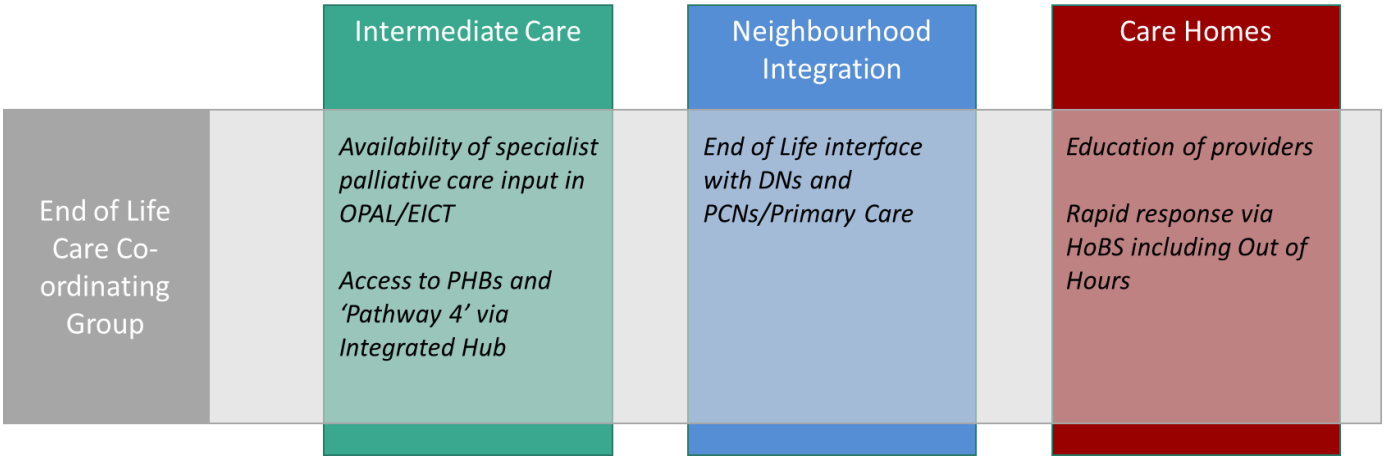
As part of the end of life care programme, partners have agreed the following set of priorities for focus:

- Development of a sustainable model of HoBS (EOLC CO-Ordination Hub and rapid response service)with wider involvement of more partners
- A Review, streamlining and simplification of community services across all providers
- CHC fast-track redesign to include use of Personal Health Budgets at end of life
- Care homes work on support and education
- Wider communication around changes to EOLC

To progress these end of life care colleagues will work within the following new groups:

- OPAL Project
- EICT Project
- Integrated Hubs Project
- EI Beds project

In addition colleagues will link into the Neighbourhood Integration and Care Homes work streams of the Birmingham Older Peoples Board. This will allow the development of pathways between providers and the integration of both the elective and urgent provision of specialist palliative care to be achieved with other health and social care services.



Mental Health

The development of phase two of the Early Intervention programme provides system partners the opportunity to integrate mental health across all work streams. As well as local drivers outlined in this document there are two key national documents that support this approach. No Health without Mental Health (2011) advocates the integration of mental health and physical health for those who experience mental health difficulties but also the mental health well-being of people who experience physical health problems that can impact on their mental health. The document outlines that one in four people will experience a mental health problem over the course of their lifetime which would suggest that people who experience mental health problems are already presenting to services outlined in this document and demonstrates that mental health is "everybody's business." The integration of mental health is therefore central to addressing the needs of those individuals and to ensuring that they receive the right support at the right time in the right place. More recently the Long Term Plan (LTP) for mental health advocates enhanced access to mental health services across all ages and sets out expectations around partnership working to achieve better outcomes in terms of mental and physical health.

The programme of work set out in this document will enable system partners to be innovative in their approach to the integration of mental health and physical health and to make this explicit across the work streams.

To date the Early Intervention programme has been inclusive of mental health and the mental health acute inpatient facilities at the Juniper Centre/Reservoir Court were one of the five test sites referred to earlier in this document. This work enabled the development of a more integrated approach with the other test sites and focused on enhanced flow through the mental health wards and promoted a home first philosophy which was advocated across the system. As this work developed and through data collection it highlighted that between 20% and 30 % of acute mental health admissions come via the acute hospitals. Enhanced flow through the wards and closer partnerships have helped to reduce length of stay on the mental health wards and reduce waiting times for transfer of patients from the acute hospitals which enhances quality of care through ensuring that appropriate care is provided within the most appropriate environment. An integrated approach is therefore central to the further development of the EI programme.

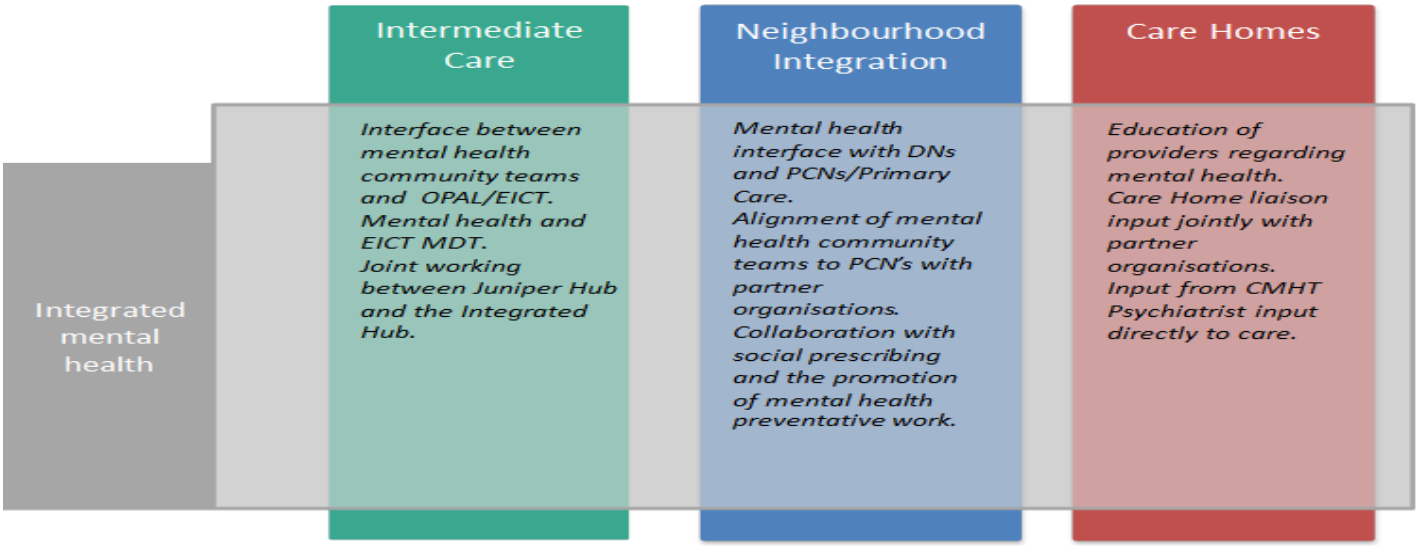
Phase two of the programme will enable work to develop across the mental health community teams, Community Mental Health Teams (CMHT), Memory Assessment Service (MAS) Rare Dementia Service (RDS), Care Home Liaison (CHL), Community Enablement and Rehabilitation Service (CERT).

Mental health services will therefore specifically link into the following EI projects:

- EICT Project
- Beds Project
- OPAL Project
- Integrated Hub Project

This will ensure that specific issues related to mental health across partner services are picked up and addressed at the earliest opportunity in the interest of those people who experience mental health problems. For older people it will also ensure awareness of a broad range of mental health issues ranging from dementia through to functional mental health problems for example, psychosis, anxiety, and depression. The table below provides an outline of how mental health will integrate within the BOPP workstreams.

Integration of mental health within the workstream groups



Deliverables and Timeline – Short Term

In considering the priorities for the programme moving forward, the rationale has been to focus on:

- Sustaining and embedding the improvements made to date through the EI Programme and the COVID response
- Delivering the outstanding improvements from the original EI benefits case

There is a recognition that the aspirations, around the services being considered, go further than the improvements that have been made so far. However, the realities of the current situation mean they will need to be captured here but picked up later (likely to be coming out of winter into 2021).

The detailed deliverables are broken down by project in the subsequent sections. At a high level, the short-term deliverables can be considered as:

- **An interim commissioning framework** to provide a means of ensuring the sustainability of services (and associated funding) throughout the winter period.
- **Operational changes** within each component to sustain or further improve performance
- **Operational resilience** within each component and across the system to ensure performance and services are maintained in the event of a 2nd COVID-19 spike, anticipated difficult winter pressures coupled with increased prevalence of flu and potential BREXIT disruptions

The interim commissioning framework will need to include:

- The outcomes and performance expectations from the services in scope and how they will be measured
- The specification for the services to be delivered and how providers will work together to meet the specification
- The financial envelope for the services to operate within

Given that the commissioning framework will require an iterative collaboration between providers, commissioners and finance colleagues it is anticipated that tis will be completed by mid - September

The operational changes not connected to the interim commissioning framework will be delivered by the relevant project group, with an end of October deadline.

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Citizen Engagement

The EI programme was established on the basis of citizen engagement to develop the Birmingham Better Care Fund and subsequent discussions with citizens forums established by Birmingham City Council. The design principles identified by citizens and EI staff were consistent with each other. The main messages from citizens were:

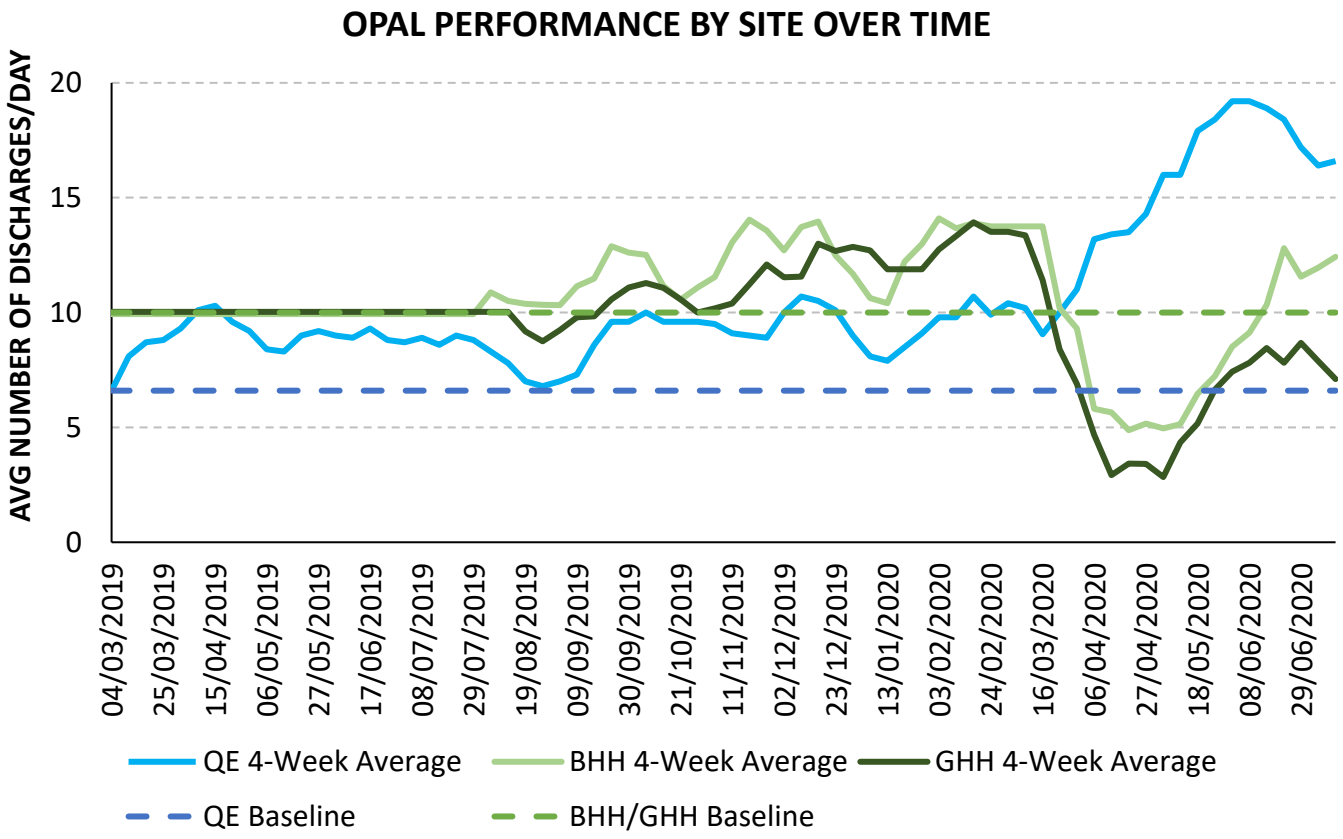
- I want to tell my story only once
- I only want to be assessed once as far as possible
- I want to be in control and plan my care together with professional people who understand my culture and are non-judgemental
- If I'm receiving my support at home I want as few strangers as possible entering my 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

In 2019 Healthwatch Birmingham undertook a review of the EI programme with regards to citizen engagement and use of feedback information. The report identified many positives but also made a series of recommendations and Healthwatch gave a commitment to help deliver the recommendations. The circumstances around Covid – 19 have stopped this work however it will be picked up again if possible, at an appropriate point within the programme. The programme was also visited in 2019 by the national Healthwatch Board following the local report.

Moving forwards, in addition to the Healthwatch work as previously described, the programme will continue to use BCC forums, and those of any other organisation, as has been the case to date.

Detailed Brief: OPAL

The graph below shows how OPAL performance has varied over time since the beginning of the programme.



The ongoing changes delivered through the EI Programme are:

- Confirmed that proactive patient identification, and a co-located multidisciplinary team is the optimal OPAL model
- Used data collection and analysis to drive improvements in OPAL performance and allow challenge between the sites
- On QE site, audit and modelling led to the required uplift in staff to hit target activity levels

The changes introduced during the COVID response are:

- Redeployment of consultant staff at QE site, and introduction of Covid rotas, allowed a trial of 12 hour consultant shifts which has been successful and now forms the basis for senior medical rotas.
- Repurposing of Solihull Hospital resulted in the OPAL Solihull team being dispersed between the three acute sites, with the majority of non-medical staff moving to Heartlands
- OPAL QE offered direct advice to WMAS paramedic crews and BCHC ANPs through #AskOPAL. EICT and non-acute beds have been essential to the success of this work

The following short term operational deliverables have been agreed:

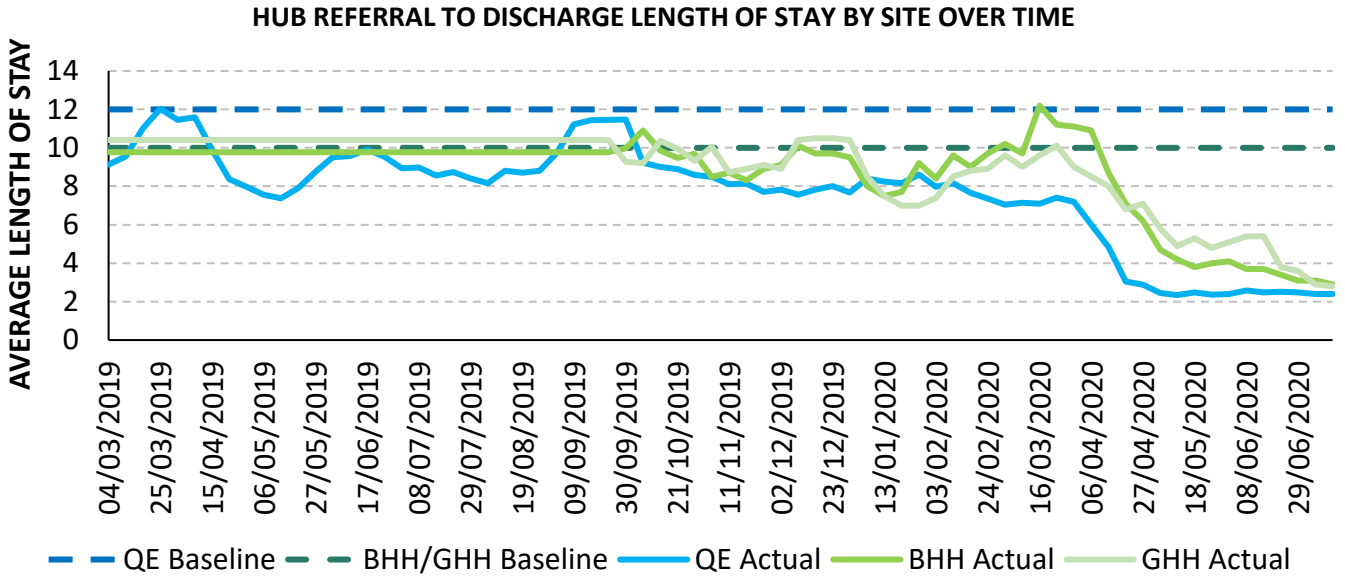
- Supporting the Interim Commissioning Framework
    - OPAL specific items relate to determining any further uplift in demand expected over winter and ensuring the commensurate levels of staffing are in place to meet it.

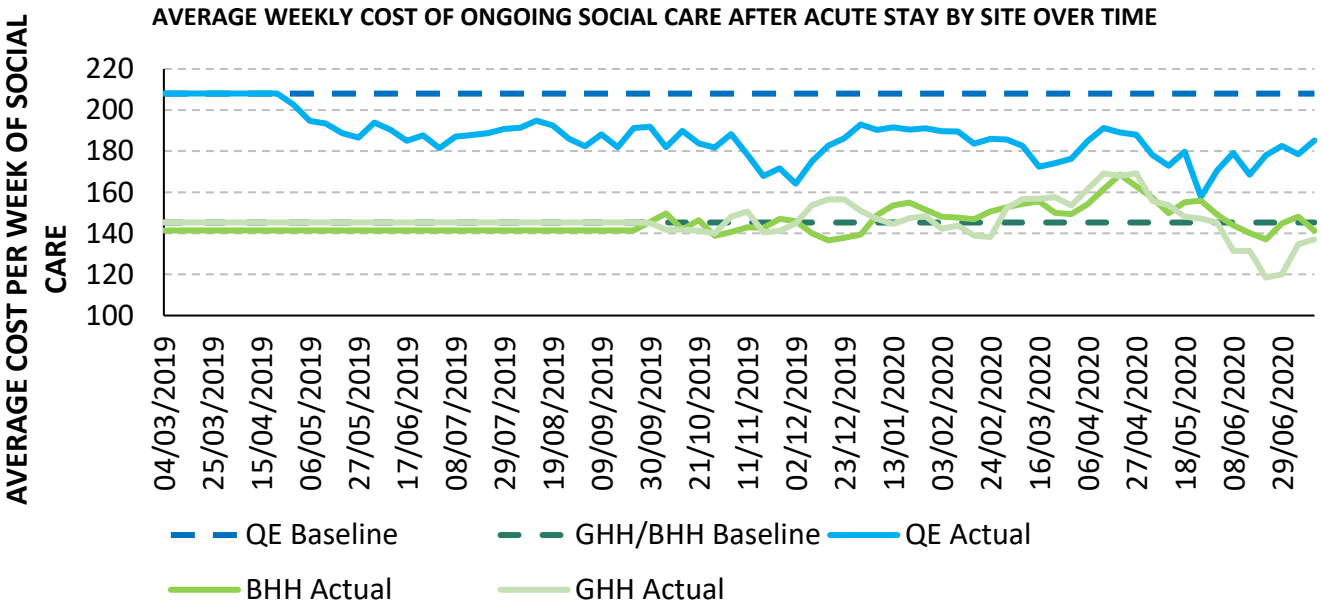
- To establish the OPAL teams at BHH and GHH given the impact COVID has had here and ensure the design ways of working are being adhered to
- Ensure that all OPAL teams have staff rotas and proper allocated staff (where necessary incorporating REACT, REACT +, FAEC and others), covering the required OPAL working hours (8am – 8pm Monday to Friday, minimum 8am – 6pm weekends and bank holidays).
- Unsure all staff are familiar with referral routes, including (but not limited to) EICT, Solihull Community Services, HoBS, non-acute beds
- In conjunction with the 'beds/P2' work stream, agree a medical workforce model across UHB and BCHC to support OPAL, EIB and other appropriate community teams

Detailed Brief: Integrated Hubs

The graphs below show the performance of QE, GHH and BHH discharge hubs since the beginning of the programme. The hubs have had 2 operational KPIs:

The performance against the two metrics is shown below, with the length of stay performance particularly enhanced by the COVID response.





The ongoing changes delivered through the EI Programme were:

- Combining previously separate complex discharge nurse, acute social worker and ward-based therapy teams into single discharge hubs
- Setting up daily patient level tracking to highlight patients not heading home or those blocked in their discharge pathway
- Forming MDT 'clusters' and a redesigned discharge assessment process to ensure the optimal discharge pathway is targeted for an individual

- Using the patient tracking and cluster structure to challenge sub-optimal discharge pathways and discharge blockages
- Creating a multi-organisational escalation structure across all three acute sites to monitor performance and receive escalations

The COVID response made some key changes to discharge operations that have drastically improved length of stay performance. These include:

- Changes to CHC, long term placement, housing and budget approval process that reduce the overall workload for practitioners progressing discharge (data captured through the EI model shows these processes accounted for the biggest delays in beds)
- The changes above also increased the flow through Pathway 2 beds. In combination with changing Pathway 2 bed provision across the city to accept all Pathway 2 referrals, this led to a massive improvement in flow through EI Beds and therefore a reduction in delays in the acute.
- The point above was augmented with the creation of a 'Co-ordination Hub' overseeing flow from acute beds, through pathway 2 beds and into long term settings. This became the primary escalation structure to enable system flow, with clear patient by patient actions.

The short term deliverables for the Integrated Hub workstream focus on sustaining the gains achieved over COVID. The following short term deliverables have been agreed:

- Supporting the Interim Commissioning Framework:
    - The co-ordination hub is currently staffed by temporary/redeployed staff. Using the Interim Commissioning Framework to stabilise this staffing base over the winter period will be critical to its continuation.
- Continue to embed front line operational processes to support acute flow during winter i.e. how the Acute Interface Team interface with the acute setting and how acute based staff interact with the co-ordination hub and the Pathway 1/Pathway 2/Pathway 3 placements. This will include access to hospice beds and access to personal health budgets.
- Continue to embed the processes that have changed through COVID (CHC, placements, budget approvals, housing) so that they can sustain the improved flow as much as possible. This is whilst acknowledging the discharge guidance is likely to change and some constraints are likely to be reintroduced that were lifted in the original discharge guidance
- Agree resource commitments from partner organisations to maintain new roles and integrated working (particularly BCHC, BCC, CCG)
- Provide oversight on pathway delays, Medically Fit For Discharge (MFFD) metrics, bed capacity and occupancy and overall system flow
- Map current resources across the system from across all Partners and outline proposals on potential options on future configuration

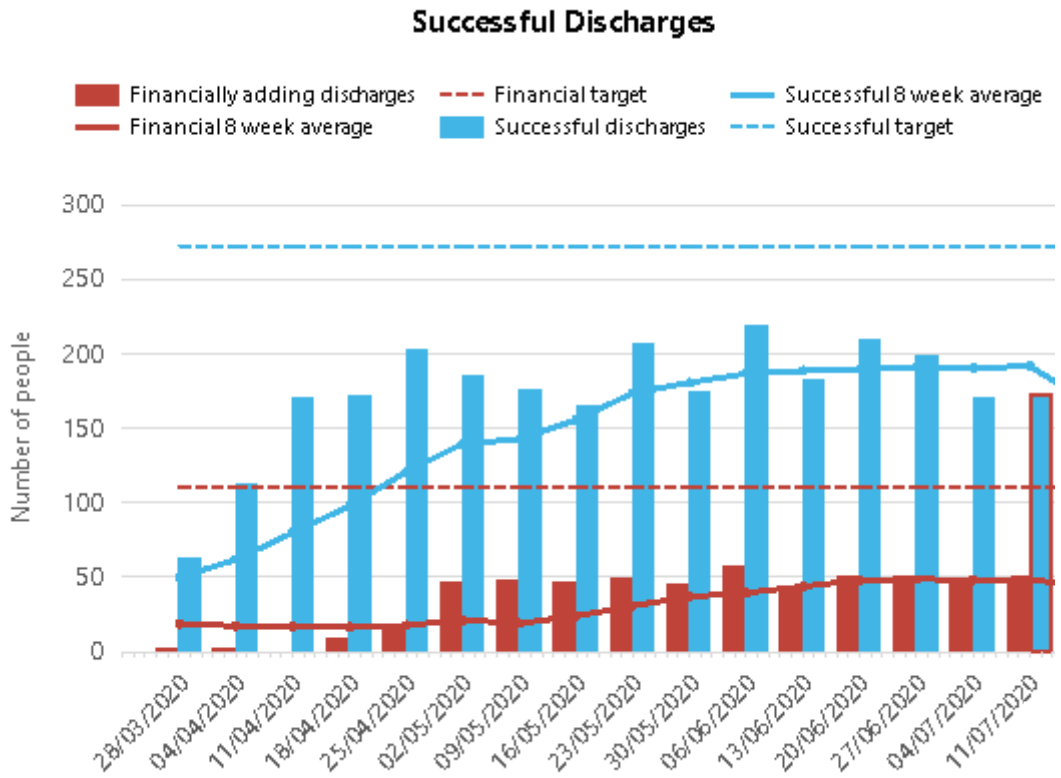
Detailed Brief: Pathway 1

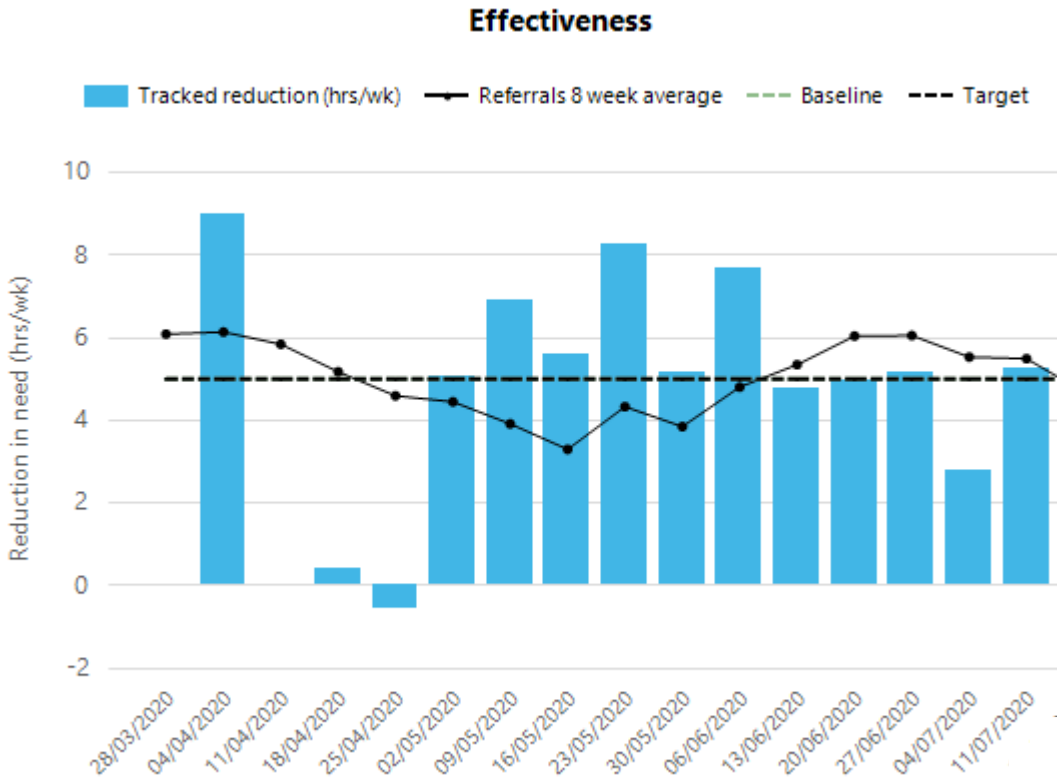
The vision for EI services included a single intermediate care service that would have the capability to deliver the opportunities above in addition to capabilities to intercept people during their escalation of need and avoid acute admission.

To deliver on the vision and the opportunities the Early Intervention Community Team (EICT) was created after a successful pilot and agreement of a city wide business case in September 2019. The EICT was comprised of previous services including:

- BCHC's Rapid Response Team
- BCC's Post Hospital Discharge Social Work Team
- BCC's OT Team (that had previously supported the enablement service)
- Unregistered staff provided by Sevacare through the Quick Discharge Service contract
- BCHC's Home Based Therapy Team
- UHB's Supported Integrated Discharge Service
- SWB's Own Bed Instead (OBI) model

The EICT was mobilised in March 2020 across the city in 5 locality teams. The team is more effective at reducing someone's ongoing need after a crisis than the initial target but the team is not currently seeing the number of people on social care pathways that were originally planned. This is primarily due to referrals from Community Social Work Teams not being 'switched on' after conscious delay to this as part of the COVID response





As well as mobilising the 5 teams, additional work was delivered to ensure the opportunities were delivered:

- Patient level data tracking was set up so that performance can be reported at locality and city levels
- Performance dashboards have intelligent prompting built in to guide the user to clear operational priorities (hosted on BCHC systems)
- Front line governance was established including structured, data-informed MDTs and weekly performance reviews. This has included coaching staff to break down organisational and professional boundaries to enable a more collaborative management team.
- A single integrated assessment and review methodology was bespoke designed and implemented, reducing duplication between professions
- Feedback from unregistered Sevacare staff visits is collated in a structured way and fed back to registered staff

During COVID the EICT was deemed an integral part of the city's response, forming the primary part of Pathway 1. This required additional work primarily involving redeploying 150 staff into the EICT. The result of this was that during the entire COVID response the EICT had only one instance of having to reject a referral due to capacity.

The detailed short-term deliverables for the EICT are:

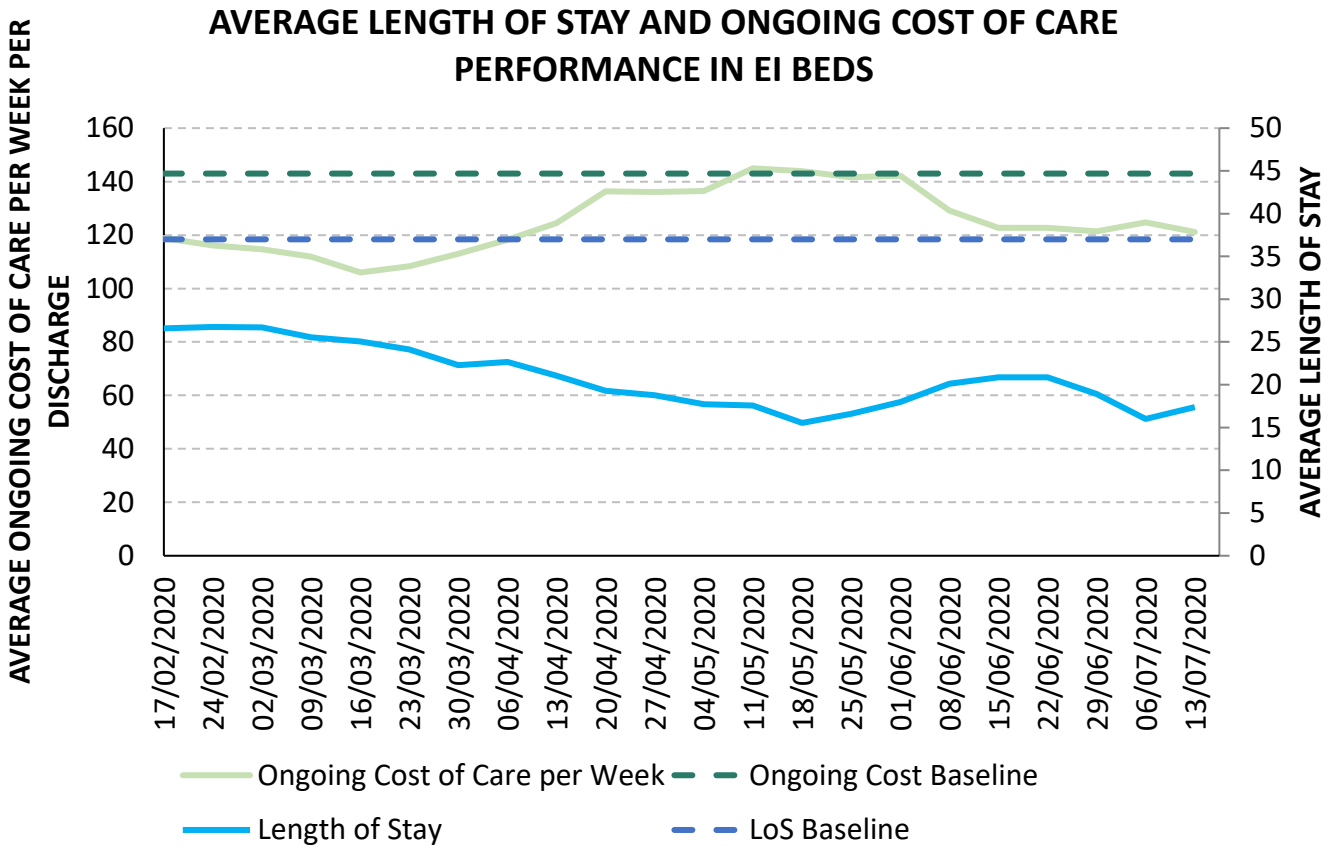
- Work with CSWTs to mobilise and achieve target referral levels
- Support the Interim Commissioning Framework by:
    - Confirm the staffing in EICT split by funding route (recurrent and non-recurrent)
    - Determine any uplift in staffing required for winter/COVID resilience
    - Confirm overall funding requirements
- Ensure funded staffing levels are agreed for EICT Phase 1
- Define, agree and fulfil staffing model for winter (and COVID) resilience and associated impact assessment
- Stabilising the current management team in the EICT localities, specifically Locality Operational Managers
- Ensuring the MDT with BSMHFT sustains over winter
- Review other pathway 1 services and agree alignment with EICT

Detailed Brief: Pathway 2

The graphs below show the performance of EI Beds (Norman Power, Moseley Hall W4,5,6, Perry Trees and CU27) since the beginning of the programme. The EI Beds have had 2 operational KPIs:

- The length of stay from the point of admission to discharge
- The average ongoing cost of social care support per person

The performance against the two metrics is shown below, with the length of stay performance particularly enhanced by the COVID response.



As part of the EI Programme, the following changes were delivered:

- Patient level outcome and next step tracking was introduced to each site
- A daily MDT between nursing, therapists and social workers was introduced to progress patients to the best possible outcome
- An escalation structure enabling blockages in flow to be raised
- Discharge links with the EICT
- Modelling to determine the long term viability of a 5 care centre bed model including the associated staffing and costs

The COVID-19 response improved length of stay in EI Beds significantly. This was due to:

- Changes to CHC, long term placement, housing and budget approval process that reduce the overall workload for practitioners progressing discharge (data captured through the EI model shows these processes accounted for the biggest delays in beds)
- The creation of a 'Co-ordination Hub' overseeing flow from acute beds, through pathway 2 beds and into long term settings. This became the primary escalation structure to enable system flow, with clear patient by patient actions.
- Redeploying staff (mainly from social care) so that all EI Beds provided the same care and did not have criteria for entry

The short-term deliverables for the Pathway 2 project are:

- Support the Interim Commissioning Framework by:
    - Working with commissioners, delivering demand and capacity modelling to determine winter bed requirement, including estate and workforce. This needs to clearly set out performance and outcome expectations for the beds.
    - Determine the financial envelop for the whole provision to work within, based on available funds/resource and the requirements from the point above
    - Determine the proportion of the beds and the subsequent strategy for EABs
- Continue to embed the performance standards, monitoring and review processes established through EI across all sites to maintain LOS and flow
- Determine the desired medical model to proceed with over winter
- Formalise definition / classification of bed base (generalist / specialist) and how capacity will be provided to meet demand modelling (including use of EAB and flex capacity)
- Define, agree and pilot medical workforce model to operate over winter, optimising workforce across UHB and BCHC and adoption of technology
- Agree appropriate model and timeline for future provision and running of Norman Power beds

Detailed Brief: Commissioning

Birmingham and Solihull CCG (BSol CCG), Sandwell and West Birmingham CCG and Birmingham City Council, as the commissioners, currently commission separate elements of the early intervention clinical model through a number of different contractual and payment mechanisms. The challenges this brings is that there is not a single clear specification and set of outcomes for the service being commissioned through one route. All commissioners had agreed to develop and deliver an integrated commissioning approach for the Early Intervention model. The ambition is to achieve a single commissioner voice, contractual mechanism and payment methodology with the aim of commissioning a single provider model such as an alliance or prime provider model. The intention is for the Integrated Commissioning to be via the Birmingham Better Care Fund (BCF) to ensure the single funding stream, integrated governance and processes for monitoring the service. Detailed work had taken place to understand the existing commissioning/ contractual arrangements alongside the financial framework. In particular work had taken place to develop an Early Intervention Bed Strategy as there were numerous commissioning consideration – such as capacity and demand modelling, the mixed market approach to providers of bedded care, varying access and fragmented support offer, contractual and financial implications.

An integrated commissioning road map had been developed and 2020/21 was going to be a transitional year to the new integrated commissioning and delivery arrangements. The first step was designing service specifications which would also facilitate provider alliance discussions as each specification would form part of that provider's contract.

Prior to the COVID response, the system had draft specifications to review for OPAL, EI Beds and EICT. These had been jointed created by the CCG and BCC and had been initially circulated amongst partners with a view to iterating them ahead of the 20/21 contract year.

It's important to recognise the different time horizons now being considered in the work. There is a need for strategic commissioning piece of work to enable the long-term aspirations of the system and this was the mind set taken to the work on the specifications mentioned above. However, in the short term it has been agreed that the system needs to focus on preparedness for winter and the aspiration is not to move to the 'end state' for winter. Therefore, the commissioning work needs to enable sustaining as much of the positive changes as possible for winter, with a view to the longer term work commencing once that is in place.

The short term deliverables for the Commissioning project are:

- An agreed statement of intent for commissioning EI; setting out an outline framework and approach for the commissioning of services within scope of Pathways 1-3, OPAL and an Integrated Pathway Hub including and assessment of the financial envelope for EI as we move to a sustainable deliver model.
- An Interim Commissioning Framework in recognition of the need to enable EI's winter response by:
    - Setting the expected demand/outcomes/performance by component for winter
        - Specifically for EI beds, to determine winter bed requirement, including estate and workforce. This needs to clearly set out performance and outcome expectations for the beds.
    - Setting the expected financial envelop for each component/service for winter
        - This will be significantly impacted by the ability to make the notional financial benefits of the Early Intervention service cash releasing. This will be worked through specifically by FPDG and fed into this work.
        - There is a recognition that EI inherited a large amount of non-recurrently funded front line staff from the services that existed before that. It's acknowledged that if these non-recurrently funded staff were removed from the 'old system' then front line operations would have broken down. Therefore the ask for this group is to find a pragmatic way to bring assurance to these staff being funded rather than whether these staff should be funded.

- Setting out any additional expected resource to support the EI winter response (i.e. redeployed staff from other services)
- Setting out any further specification of the services that are to be provided for winter