Community Care Collaborative

Right care, right time, right place
for the people of Birmingham and Solihull

Birmingham and Solihull Community Care Collaborative

Implementation Plan 2024/5 - 2026/7

June 2024

	Date	Changes
Version 0.1	30/05/24	First draft
Version 0.2	04/06/24	Additional sections included
Version 0.3	10/06/24	Edits and amendments for SG
Version 0.4	17/06/24	Amendments following Steering Group
Version 0.5	18/06/24	Further amendments following Steering Group
Version 0.6	26/06/24	Feedback from partners
Version 0.7		

Partners

- NHS Organisations
    - Birmingham Community Healthcare NHS Foundation Trust
    - University Hospitals Birmingham NHS Foundation Trust
    - Sandwell and West Birmingham NHS Trust
    - Birmingham Women's and Children's NHS Foundation Trust
    - Birmingham and Solihull Mental Health NHS Foundation Trust
    - Royal Orthopaedic Hospital NHS Foundation Trust
- General Practice
- Local Authorities
    - Birmingham City Council
    - Solihull Metropolitan Borough Council
- Birmingham Children's Trust
- Voluntary, Community, Faith and Social Enterprise (VCFSE) sector
    - Birmingham Voluntary Service Council
    - Community and Voluntary Action Solihull

Consultation and Approval Process

Community Care Collaborative Steering Group	13th June 2024
Birmingham and Solihull Place Committees	21st June 2024
GP Partnership Board	26th June 2024
BCHC Community Care Collaborative Committee	27th June 2024
BSol Integrated Care Board	8th July 2024
BCHC Trust Board	1st August 2024

Partner Consultation

ICB executive team	24th June 2024
BCHC Trust Leadership Team	25th June 2024
Solihull Metropolitan Borough Council – Corporate Leadership Team	25th June 2024
University Hospitals Birmingham Executive Team Trust Board	25th June July
ROH Executive Meeting ROH Trust Board	25th June 2024 1st July 2024
Birmingham City Council – Adult Social Care Management Team Children's Transformation Leadership Team	26th June 2024 Via email
SWBH Integration Committee	27th June 2024
BSMHFT Senior Leadership Meeting	1st July 2024
BVSC and CAVA - BSol VCFSE Leadership Alliance	Via email
BWCH – Chief Officers Meeting	w/c 25th June 2024
Birmingham Children's Trust Leadership Team	June 2024

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Foreword from Richard Kirby, Senior Responsible Officer

Community Care Collaborative

Welcome to the Birmingham and Solihull Community Care Collaborative's Implementation Plan.

The Collaborative is the system-wide partnership of primary care, community services, mental health services, social care and the community and voluntary sector. We exist to deliver integrated care in neighbourhoods and localities that helps people to stay as healthy as possible in their own homes. This Plan sets out how we intend to deliver this mission over the next three years.

"A Bolder Healthier Future for the People of Birmingham & Solihull", the 10-year strategy for our Integrated Care System, sets out an ambition to increase healthy life expectancy for our citizens. Our "Joint Forward Plan" describes how we will work together based on two Place Committees and three Provider Collaboratives. The Community Care Collaborative is one of those collaboratives.

Our Strategic Outline Case, approved in 2023, outlined our purpose. This Implementation Plan describes how we will approach this task. It sets out our model of care based on integrated primary and community care services, early intervention and prevention and partnerships with the community and voluntary sector. We will bring this to life through five work programmes:

- integrated care in neighbourhoods and localities;
- intermediate care transformation;
- long-term condition pathways;
- supporting primary care development;
- community children's services.

These will be supported by three enabling programmes – estates, digital and workforce – to build the infrastructure that we need to support integrated care.

We are not starting from scratch and as we take forward our work programmes, we will learn from the work that we have already done with our partners. We have already established five Integrated Neighbourhood Teams, one in each of Birmingham's localities with well-advanced

plans to launch a sixth in Solihull, and each of our six localities have the core elements of a Locality Hub in place.

We recognise that we work within a diverse and complex system in which one size will definitely not fit all. It is for this reason that we have committed to support six Locality Delivery Partnerships. This will enable us to bring together local services to deliver the Collaborative's model of care in a way that makes sense to the communities they serve and to build the local relationships between clinical and professional teams that will be at the heart of a more integrated approach to care.

The Locality Delivery Partnerships will also be central to the contribution that we can make to reducing inequalities in health outcomes within Birmingham and Solihull. We will aim to understand the issues that most effect health outcomes for citizens in each locality and tailor our approach to reflect these through local partnerships. The work of the "Flourish" voluntary and community sector collaboration in West Birmingham is a good example of this approach already in action.

Developing integrated care in neighbourhoods and localities is not a "quick fix" and the approach that we set out in this plan is designed to build sustainable foundations for the future. We are committed to learning as we go and have described our approach to evaluation and outlined the measures that we will use to track our impact. I trust that, in this Implementation Plan, you will see how as a Collaborative we intend to approach integrated care in neighbourhoods and localities for the people of Birmingham and Solihull.

Richard Kirby

Senior Responsible Officer – Birmingham & Solihull Community Care Collaborative

Chief Executive Officer – Birmingham Community Healthcare NHS Foundation Trust

June 2024

1. Introduction and Context

The Birmingham and Solihull Community Care Collaborative (the Collaborative) provides a historic opportunity for our Integrated Care System to ensure that everyone has the chance to live a longer, healthier and happier life. To tackle the long-standing inequalities in health and care provision, in terms of access, experience and outcomes, it is essential that local services are better integrated and coordinated within local places.

The Collaborative is a key vehicle for the delivery of more holistic, integrated care, at place, locality and neighbourhood level. At the heart of the Collaborative is the drive to make it easier for citizens to access the care and support they need when they need it, to support more people to live well in their homes and communities, and to create space and time for clinicians and professionals to provide better care and to have a greater focus on prevention and addressing inequalities.

The Collaborative will address the holistic needs of local people in neighbourhoods, localities and places, through our C.A.R.E. approach (Appendix 1 – C.A.R.E Approach. By working together we will be more:-

- Connected – removing barriers, working together in local places;
- Accessible – making it easier for people to access the care they need, when and where they need it;
- Responsive – providing proactive, personalised care;
- Empowering – supporting everyone to live a happy, healthy life.

The Collaborative will enable us to create clarity and visibility about shared needs and responses, to act as an influential voice on behalf of community care within the system and to foster strong connections and a climate of trust between a wide range of service providers.

In November 2023 the Integrated Care Board approved the Strategic Outline Case (SOC) for the Collaborative[1]. The SOC set out a vision for the Collaborative as an all-age partnership focused on the development of integrated care in neighbourhoods and localities that enables people to live well in their homes and local communities. The Collaborative will develop models of care that promote early intervention and prevention with more timely access to the right care and support as local to where people live as possible, and reduce health inequalities.

The Collaborative brings together a wide range of health and care providers from primary medical care, community physical and mental health services, social care, acute care and the voluntary, faith, community and social enterprise sector. Hosted by BCHC, we are developing the Collaborative as an inclusive partnership of all providers, with community involvement and participation running through everything we do. A summary of our purpose and approach is included in the infographic below.

[1] Strategic Outline Case (2023) available at https://www.bhamcommunity.nhs.uk/download.cfm?doc=docm93jijm4n6339

Community Care Collaborative

Providing the **right care** at the **right time** in the **right place** for the people of Birmingham & Solihull

The Vision

To deliver integrated care in localities and neighbourhoods to support people to live well for longer in their own homes

C **CONNECTED** removing barriers and working together in local places

A **ACCESSIBLE** making it easier for people to access the care they need when they need it

R **RESPONSIVE** providing proactive and personalised care

E **EMPOWERING** supporting everyone to live a happy and healthy life

Integrated teams in localities and neighbourhoods	Intermediate care transformation	Long term condition pathways	Supporting primary care development	Community children's services

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Caring about healthier lives

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The national and local context was set out in the SOC as well in the ICP's Ten Year Strategy so is not repeated in any detail in this Implementation Plan. However, it is important to reference the diverse communities and population within Birmingham and Solihull, noting that these include areas of high deprivation, where people have significantly lower life expectancy and lower healthy life expectancy than the national average, and experience significant health inequalities. As we develop the Collaborative, focusing our support on the areas that need us most, to address and reduce the inequalities that exist, is a core aim.

The infographic above also shows the five key work programmes, agreed through the SOC, that the Collaborative will deliver over the next three years.

1. Integrated Teams in Localities and Neighbourhoods
2. Intermediate Care Transformation
3. Long Term Conditions Pathways
4. Supporting Primary Care
5. Community Children's Services

This Implementation Plan will build on the SOC, to set out

- **Why the Collaborative exists** - the expected and desired outcomes and benefits of the Collaborative, and how we will demonstrate impact and effectiveness
- **What the Collaborative will do** - the scope of the Collaborative, and what existing and new services will be in its remit
- **How and when** –
    - Plans, where known, for each of the five work programmes for the next three years, along with current and developing models of care
    - The role of Locality Delivery Partnerships in the Collaborative and the System including the developing Locality Operating Model
    - How resources and responsibility will be transferred to the Collaborative to enable the agreed work programmes.

1.1 National Context

As we develop the Collaborative further, it is worth recognising that a number of national organisations have recently published reports on integrated care. These reports help build the evidence-base for our approach and identify some of the key issues that we will need to address in order to ensure that we succeed. Additionally the publication Next Steps for Integrating Primary Care (2022) has helped to shape our work over the past year.

In 2023, the NHS Confederation published Unlocking the Power of Health Beyond the Hospital which showed that systems with well-developed primary and community services experience reduced pressure on acute care. More recently, the King's Fund published Making Care Closer to Home a Reality setting out key changes to support the NHS to become more primary and community care based and in 2024 the Nuffield Trust published Integrated Neighbourhood Teams: Lessons from a Decade of Integration All of these reports provide useful insights into the evidence-base for

effective primary and community care that we care building into the development of integrated care through the Collaborative.

1.2 Establishing the Collaborative

The development of the Collaborative will happen largely in three broad phases:-

- **Phase 1 (Design)** – concluded December 2023. This phase concentrated on establishing a system-wide Steering Group, developing the Collaborative SOC, launching the first two work programmes, and determining and agreeing our approach for locality Delivery Partnerships.
- **Phase 2 (Build)** – this phase is expected to run through to March 2025 and includes approval of this Implementation Plan, establishing Locality Delivery Partnerships and strengthening our primary care partnership through work with the GP Provider Support Unit;
- **Phase 3 (Operate)** – this phase will run from April 2025 and will see the Collaborative progress our work programmes and support locally integrated care through Locality Delivery Partnerships and a Locality Operating Model.

2. Benefits and Outcomes of the Community Care Collaborative

Through our work so far, we believe that benefits will be delivered across a range of areas:

- Addressing historic inequities in service provision by improving access, experience and care outcomes
- Positive impact on demand to services, through the focus on prevention and early invention
- Addressing workforce challenges, through building new roles and skills and developing new careers, increasing flexibility and opportunities for our staff, and widening participation
- Improved productivity and efficiency, through reducing duplication of services and joining up care

The Birmingham and Solihull Integrated Care Board (BSol ICB) Clinical Outcomes Framework[2] described the priority areas for improvement over the next 10 years. We have mapped the five key work programmes for the Collaborative against this outcome framework. Table 1 below shows how the work of the Collaborative will contribute to and influence all of the system level ambitions.

[2] Birmingham_and_Solihull_Joint_Forward_Plan.pdf (icb.nhs.uk)

		Work programme				
System level ambition		1	2	3	4	5
Prevention	*Reduced prevalence of Smoking*	•	•	•	•	
	Increased prevalence of Physical activity	•	•	•	•	
	Reduced prevalence of Obesity	•	•	•	•	
Cancer, Frailty End of Life	*Reduced Under 75yrs mortality rate from cancer*	•	•		•	
	Increased healthy life expectancy at 65yrs	•	•	•	•	
	Increase the number of patients with End of Life Personalised Care Plans	•	•	•	•	
Mental Health	*Reduced prevalence of depression and anxiety in adults*	•			•	
	Reduced excess under 75 mortality rates in adults with serious mental illness	•			•	
	Substance misuse	•			•	
Early Years	*Reduced Infant Mortality Rate*	•			•	•
	Reduced Child / early years Mortality Rate	•			•	•
	Substance misuse	•			•	•
Respiratory Health	*Reduced prevalence of COPD*	•			•	•
	Reduced prevalence of Asthma (6yrs+)	•			•	•
Cardiovascular Health	*Cardiovascular Health (e.g. stroke, heart failure, atrial fibrillation, hypertension)*	•		•	•	
	Reduced under 75yrs mortality from acute myocardial infarction, stroke	•		•	•	
	Reduced prevalence of Diabetes	•		•	•	
Other	*Improved Patient experience*	•	•	•		

Table 1 – ICB Outcomes Framework

Table 2 below builds on the expected impact of the Community Care Collaborative work programmes as set out in our Strategic Outline Case and proposes a set of initial measures of impact for the Collaborative over the period 2024/5 to 2026/7.

- Our measures of impact will continue to evolve as the Collaborative itself develops. We will commission specific further work on our approach to outcomes and impact for citizens across our partnership.
- The initial measures aim to take account of the outcome framework in the ICS 10-year strategy and relevant existing metrics such as those associated with the Better Care Fund (BCF) and the Primary Care Right Access First Time (RAFT) metrics. The framework also seeks to take account of the priorities and outcomes frameworks of our Place Committees in Birmingham and Solihull where these are relevant to the work of the Collaborative. Finally, It reflects existing system-wide priorities relevant to the Collaborative including a commitment to improve end of life care pathways, wound care pathways and the detection and management of hypertension as our circulatory disease priority.

In developing this initial set of impact measures for the Collaborative, we recognise that there are more measures that could be included over time as the work of the Collaborative develops. These could include, for example, uptake of annual healthchecks by those eligible for these, vaccination coverage in adults and children, an expanded range of long-term condition measures, measures of oral health or measures of the effectiveness of stroke and neurological rehabilitation pathways. Whilst we have had to be selective and concentrate on measures relating to our current “live” priorities, we expect that this will continue to develop in the period covered by this Implementation Plan.

MEASURES OF IMPACT 2024/5 – 2026/7

WORK PROGRAMME	EXPECTED IMPACT (FROM OUR STRATEGIC OUTLINE CASE)	INITIAL MEASURES OF IMPACT 2024/5 – 2026/7
1. Integrated Teams in Neighbourhoods & Localities	• Improved support for high users of health and care – reducing reliance on Emergency Departments (ED) and acute admission. • Improved early intervention and prevention reducing the chances of people becoming high users. • More people supported safely and effectively in their own homes at the end of their lives.	1. People on the caseload for Integrated Neighbourhood Teams (i.e. existing high users of health and care services). 2. Emergency admissions to acute hospital for people on the caseload of the Integrated Neighbourhood Team. 3. GP consultations for people on the caseload of the Integrated Neighbourhood Team. 4. Rate of admission to residential or nursing care homes (BCF metric).
2. Intermediate Care Transformation	• Increased admission avoidance – more patients cared for at home instead of ED or admission. • Improved discharge – patients discharged home earlier with improved rehabilitation support. • Improved healthcare support for people living in care homes reducing the need for ED / acute admission for this group.	5. Urgent Community Response referrals, response time and percentage of people managed at home. 6. Time from “discharge ready” to discharge from acute hospital for Pathway 1 and Pathway 2 referrals. 7. Emergency admissions to acute care for people resident in nursing care homes. 8. Older people still at home 91 days after discharge from hospital into reablement or rehabilitation services (BCF metric). 9. Emergency admission to acute hospital following a fall for older people (BCF metric).
3. Long Term Conditions	• More people living with long-term conditions are well-supported in their community.	10. Patients with registered smoking status and proportion referred to Stop Smoking Services

WORK PROGRAMME	EXPECTED IMPACT (FROM OUR STRATEGIC OUTLINE CASE)	INITIAL MEASURES OF IMPACT 2024/5 – 2026/7
	• Reduced use of ED and acute admission by people with long-term conditions. • More people supported safely and effectively in their own homes at the end of their lives.	11. Number of people on primary care hypertension registers compared to expected incidence. 12. Proportion of people with hypertension with blood pressure and cholesterol within clinically appropriate ranges. 13. [As part of our next steps, we will develop indicators of the identification and community management of diabetes similar to those included for hypertension] 14. Percentage of deaths that occur at home or in a care home (i.e. outside of acute hospital). 15. [As part of our next steps, we will develop a measure of the quality of end of life care as well as its location]. 16. Unplanned admissions to acute hospital for ambulatory sensitive chronic conditions (BCF metric).
4. Supporting Primary Care Development	• Improving access to primary care in line with the system's Primary Care strategy. • Improved resilience in primary care workforce, estate and digital systems. • Improved interface between general practice and other providers	17. Improved wound care pathway: Urgent Treatment Centre consultations for wound care and GP prescribing of wound care related products. 18. GP appointments per 1,000 patients. (RAFT metric) 19. GP appointments: percentage offered on same day and within 14 days (RAFT metric). 20. [A measure of the sustainability of the primary care workforce to be developed]
5. Community Children's Services	• To be scoped as the programme is developed but expected to include long-term conditions and intermediate care impact for children.	21. [To be scoped as part of the future development of the Collaborative.]

Table 2 – Collaborative measures of impact

Health Inequalities

Addressing the significant health inequalities that exist across our System is a core aim of the ICS. The Collaborative's work programmes reflect the importance of reducing inequalities in health outcomes set out in the ICS 10-year strategy, the Birmingham and Solihull Joint Strategic Needs Assessments (JSNAs) and Public Health priorities and the national "Core20Plus5" approach.

The measures set out above in Table 2 will be reviewed through different lenses, and we will view access, outcomes and experience across a range of factors including

- socio-economic factors,
- geography, within and between Locality and Place. The 'system-designed, locality-delivery' model will ensure equity of offer across the System, whilst allowing for localisation to take account of local health needs.
- specific characteristics including those protected in law, such as sex, ethnicity or disability
- socially excluded groups, for example, people experiencing homelessness.

In tracking our impact we will keep a focus on our impact on inequalities. Our approach will strengthen as the Collaborative develops but in the first instance we would expect:

- to understand the characteristics of the people who make up the caseloads for our Integrated Neighbourhood Teams, ensuring that these include people for whom access to and outcomes from health and care are worst in our current model of care;
- to use a targeted approach to specific at-risk groups through our neighbourhood-level integrated teams as part of a wider population health management approach
- in developing working on smoking and the detection and management of hypertension, to concentrate on showing greatest improvement for people who the worst outcomes currently;
- in supporting improved access to primary care, to seek to ensure that access is improving for all communities and that we can show improved access to appropriate care for those communities with the poorest health outcomes.

2.1 Evidence

There is a significant body of evidence regarding the impact of integrated care models to support the expectations above. Whilst the results are mixed, there is a general trend towards positive outcomes[3; 4] (see also National Context). Measures include both performance outputs (emergency department attendances, length of stay etc.) and more specific clinical outcomes (patient experience, hypertension and diabetes control, mortality etc.).

[3] Evelien S. van Hoorn et al. Value-Based Integrated Care: A Systematic Literature Review *Int J Health Policy Manag* 2024; 13: 8038
[4] Dorling G et al (for McKinsey). The evidence for integrated care. *Healthcare Practice*. March 2015

It is important to note that evaluation of UK integrated care models[5; 6] have suggested that changes to unscheduled care activity may take between two to six years to become apparent. However, more local data has demonstrated that focused effort may produce much more rapid benefit, although these may be more resource dependant.

A summary of the available evidence is included at Appendix 2 – Collaborative Outcomes – Evidence Base.

The pilot phase of the work to date on Integrated Neighbourhood Teams has been evaluated and the early impact of the initial INTs along with more integrated working across the locality in East Birmingham is set out in the box below. Although small scale, these interventions have shown a positive impact and the Collaborative will build on our 'test and learn' approach and to scale up these successful initiatives.

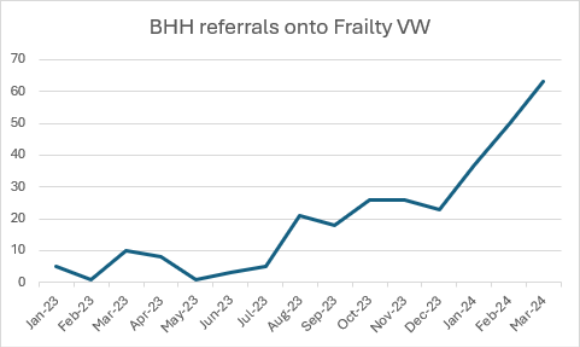
[5] The long-term impacts of new care models on hospital use. An evaluation of the Integrated Care Transformation Programme in Mid-Nottinghamshire. *Health Foundation.* September 2020
[6] Evaluation of the Dudley Multidisciplinary Teams (MDTs). *The Strategy Unit*. May 2017

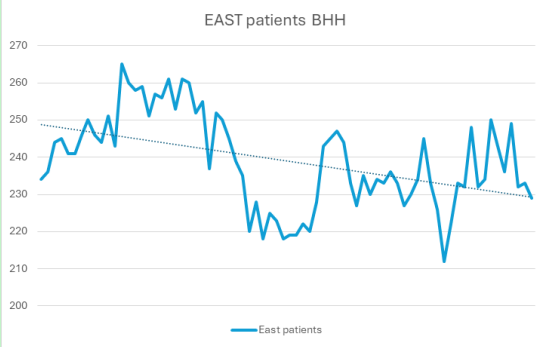
Early Impact - Birmingham

- The Case for Change for Integrated Neighbourhood Teams[1] identified that a small group (10%) of citizens are receiving up to 71% of the total system care provision across specific services, and that 45% of these individuals could benefit from support from an Integrated Neighbourhood Team.
- An initial diagnostic of our INT pilot teams[1] supported this, and further found that 80% of interventions required were medication reviews, social and mental health support, and social prescribing services, and thus demonstrating the importance of a multidisciplinary approach.
- Very early analysis is beginning to demonstrate that for those individuals supported by the INT, the number of service interventions needed has begun to significantly reduce compared with equivalent periods pre-involvement of the INT. Whilst further analysis is underway, these initial findings are very encouraging..

		GP APPOINTMENTS	A&E ATTENDANCES	INPATIENT SPELLS	OUTPATIENTS & COMMUNITY CONTACTS	CARE PACKAGES
EAST INT	PRE-INT INTERVENTION	2110	370	87	3262	8
	POST INT INTERVENTION	1372	56	31	2257	3
	VARIANCE	-738	-314	-56	-1005	-5
WEST INT	PRE-INT INTERVENTION	2951	783	145	4855	17
	POST INT INTERVENTION	2108	188	58	3597	5
	VARIANCE	-843	-595	-87	-1258	-12
TOTAL	PRE-INT INTERVENTION	5061	1153	232	8117	25
	POST INT INTERVENTION	3480	244	89	5854	8
	VARIANCE	-1581	-909	-143	-2263	-17

- During winter 2023, the system undertook a “perfect week” initiative in the East locality, which provided the locality team with far greater visibility on where and how their locality citizens were accessing urgent and emergency care, and therefore how to join teams and services up to better support this demand.
- The results saw improvement across a number of settings including those frequently attending the Emergency Department, the number waiting in acute assessment facilities as well as the number of patients staying in hospital for over seven days.
- Coordinating teams and services better also saw a substantial increase in referrals to the frailty Virtual Ward and therefore allowing more people to be receiving their care at home
- Underpinning the initiatives above was therefore a reduction in the overall number of citizens from the East locality residing in a hospital bed, by providing integrated care closer, or at home





3. Community Care Collaborative Model of Care

The Birmingham & Solihull Community Care Collaborative is the system-wide, all-age partnership of primary care, social care, mental health services, community health services and the community and voluntary sector. It exists to deliver integrated care in localities and neighbourhoods to support people to live well for longer in their own homes.

In developing our plans for the Collaborative, we have worked with partners and stakeholders on the principles that will guide our model of care. These are set out in our C.A.R.E. approach.

- **C**onnected – removing barriers and working together in local places;
- **A**ccessible – making it easier for people to access the care they need when they need it;
- **R**esponsive – providing proactive and personalised care;
- **E**mpowering – supporting everyone to live a happy and healthy life.

As we have developed the Collaborative we have designed a "model of care" based on these principles to support us to deliver our ambition. This section of the plan sets out that model of care. The Collaborative model of care is based on the following elements.

1. Focusing on a "whole person" approach that brings together the physical and mental health needs of our citizens and seeks to design services that bring a bio-psycho-social approach to the understanding of people's strengths and needs for support. (**Empowering**)

2. Developing easy access to appropriate care and advice from primary care and community services when people need it. This will build on existing work to improve access to multi-disciplinary teams in primary and community care including appropriate access to same-day and urgent care and support for those who need it. (**Accessible**)

3. Developing pro-active, personalised care from multi-disciplinary and multi-organisational teams for people with complex needs including long-term conditions. Our model of care aims to identify those with the most complex needs making greatest use of health and social care services and use our integrated neighbourhood teams to provide care that better supports them to live well in their communities. (**Responsive**)

4. Strengthening our approach to community-based prevention and early intervention in ways that support people to stay well at home. This approach will build on local partnerships to understand the needs of the neighbourhoods and localities that we serve and design local approaches to prevention and early intervention. It will include work to develop models of self-care empowering people to look after their own health (learning from the experience of the BCHC supported self-care team in community nursing) (**Empowering**).

5. Bringing together intermediate care services to avoid emergency admissions to hospital, support early discharge and promote rehabilitation and recovery. We will build a co-ordinated, locality-based approach to intermediate care based on a “home first” approach and a focus on maintaining independence, rehabilitation and recovery (**Responsive**).

6. Building partnerships with the community, voluntary, faith and social enterprise sector to deliver support in ways that work with local groups who know and understand the people who live in their community (**Connected**).

7. Focussing on those citizens and communities who most need support as we play our part in the wider work of the Integrated Care System to reduce inequalities in health outcomes in Birmingham and Solihull. As the Collaborative develops we will aim to focus our efforts on those communities that most need our support (**Empowering**).

3.1 Locality Operating Model

To enable us to deliver this model of care in practice we have developed a “Locality Operating Model” (LOM) for our system. It is based on the following levels of provision.

- **General Practice**. The GP practice is the core unit for primary and community care services working together to meet the needs of our patients and citizens. Through the GP Provider Support Unit and our Primary Care work programme we will work to support the sustainability and effectiveness of practices.

- **Neighbourhood**. Neighbourhoods of 30,000 – 50,000 people form the next level of our model. We will increasingly align neighbourhoods and Primary Care Networks and each neighbourhood will be supported by an Integrated Neighbourhood Team approach. Voluntary and community organisations and services providers will be linked to our neighbourhood teams. Whilst we will develop neighbourhoods with some flexibility to local circumstances, we expect that there will be c. 35 neighbourhoods across Birmingham and Solihull.

- **Locality**. Localities of c. 250,000 – 300,000 people are the third level of our model. Localities will support neighbourhoods to operate effectively (there will be 5-6 neighbourhoods in each locality) and will be the level at which we deliver more specialist services including intermediate care services working closely with the local acute hospital. Our system will have six localities each of which will be supported by the development of a locality hub. Each locality will also develop a dedicated local voluntary and community sector partnership.

Our LOM builds upon the principles within the Fuller Stocktake to deliver an offer for episodic or same day urgent care built around our neighbourhoods and localities as well as increasing our capacity for continuity of care and prevention. It will include all system partners across primary, secondary and community care, mental health, local

authorities and the voluntary sector (VCFSE), to provide care closer to the neighbourhoods and communities we serve and support the move towards more localised coordination and decision making. An emerging LOM has been developed with system partners (Figure 3) and it is anticipated that there will be further iterations of the model, with various elements being refined or added as the work programme progresses.

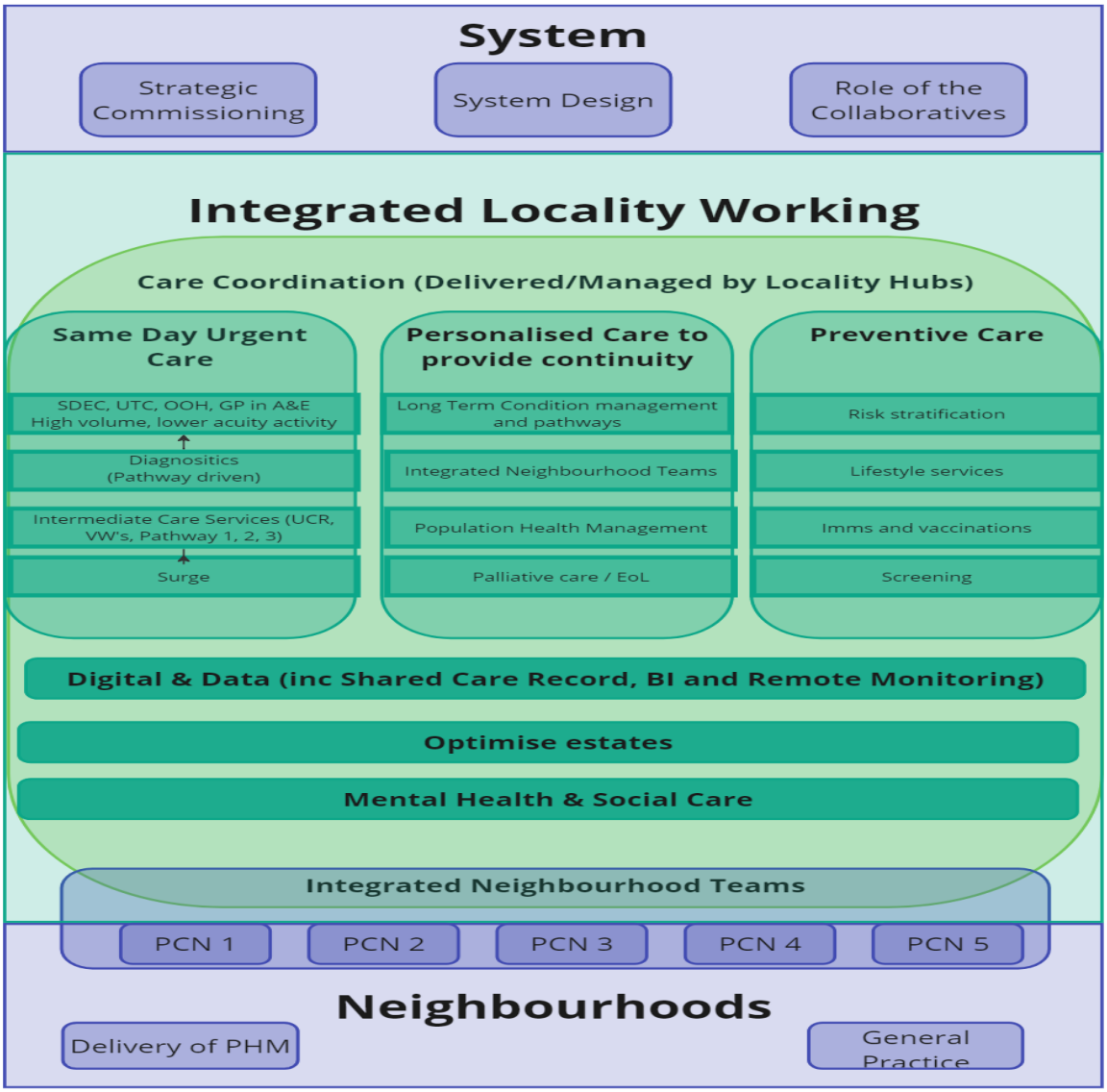


Figure 3 – Locality Operating Model April 2024

The Locality Operating Model will also be key to tackling health inequalities, with our Integrated Neighbourhood Teams evolving to be the 'delivery arm for targeted Population Health Management (PHM)'.

Locality Hubs

An important feature of the Locality Operating Model is the **locality hub**, with one planned for each of the six localities across Birmingham Solihull. A locality hub system design group is working to develop and oversee a standardised approach to the hubs including how the hubs can better co-ordinate care across each locality

taking account of existing provision locally, e.g. in general practice. It is envisaged that, as a core offer, they will deliver:

- A care coordination function across the locality (including the provision of an interface for general practice and acute hospital sites).
- A physical location for locality based long term condition management, whilst also providing oversight from supporting satellite sites.
- Same-day urgent treatment capacity for the Locality.
- The ability to mobilise surge capacity for the locality based on increases in hospital and primary care demand.
- A potential base to act as the locality 'HQ'.

The locality hub infrastructure will enable neighbourhood-level integrated teams to target specific at-risk groups as part of a wider population health management approach, which is a fundamental enabler for the Collaborative's role in addressing health inequalities.

3.2 Locality Delivery Partnerships

The vision for integrated working at a population level of 250,000 – 300,000 was set out by NHS England back in 2019[7] and has been part of the Birmingham and Solihull system operating model since the inception of the Integrated Care System (see figure 4 below; note – the term 'integrator' has been superseded by 'Collaborative'.)

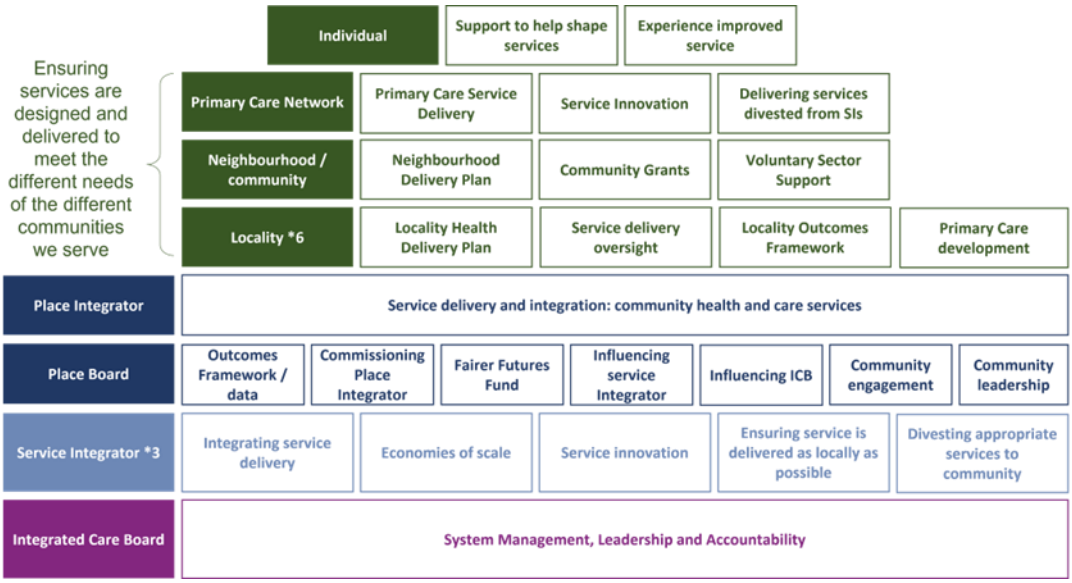


Figure 4 – ICS Operating Model

The Birmingham and Solihull Integrated Care Board Joint Forward Plan (2023)[8] set out the role of the Community Care Collaborative in 'bringing together services run by multiple organisations to work together as one team to support the delivery of services' working at this 250,000 – 300,000 population level.

[7] https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf

[8] Birmingham_and_Solihull_Joint_Forward_Plan.pdf (icb.nhs.uk) https://www.birminghamsolihull.icb.nhs.uk/application/files/9516/9176/8128/Birmingham_and_Solihull_Joint_Forward_Plan.pdf

The Community Care Collaborative has established six Locality Delivery Partnerships that are accountable to the Collaborative Steering Group. The Locality Delivery Partnerships (LDPs) also have a strong link to the Birmingham and Solihull Place Committees and to the GP Partnership Board.

Whilst the LDPs are at different stages of maturity across the BSol system, they are bringing together providers of primary care, social care, community physical and mental healthcare, the voluntary, community, faith & social enterprise sector, and secondary care where care coordination across providers is key for patients, service users, their families and wider citizens.

The purpose of the LDP as per their terms of reference is to:

- Focus on delivery and be a “unit of action”; with each LDP developing an annual delivery plan linked to the Collaborative key Delivery Priorities and taking into account local population demographics.
- Have an outcome focus and encourage a preventative and proactive approach.
- Drive integration and quality improvement.

Establishing the Collaborative model of care across Birmingham and Solihull to improve the care we provide to support people to stay well at home, is a significant task that we expect will take the full three-year period of this Implementation Plan.

The LDPs will also be a place where the different system Collaboratives (Mental Health Provider Collaborative and Acute Provider Collaborative) can come together. As key members from each will be included in the LDPs this will be an opportunity for coordination with out-of-scope programmes of work, and visibility of the work of other collaboratives.

Starting from our C.A.R.E. approach designed with partners, building on the principles for our model of care described in this section and developing the Locality Operating Model and Locality Delivery Partnerships will, we believe, enable us to deliver the ambitious shift in the way we deliver care in our system that is the ambition of the Collaborative.

4. What the Collaborative Will Do

4.1 Scope

The Collaborative’s five programmes of work were agreed in the Strategic Outline Case, and are described in greater detail in section 5. We expect this to continue to evolve as the Collaborative develops through the period covered by this Plan.

This section therefore describes what current services are in and out of scope for the Collaborative, for delegation of commissioning responsibilities from the ICB, and what roles we anticipate the Collaborative and BCHC will play in each case over the next three years as the Collaborative continues to mature and system confidence grows in the Collaborative’s ability to deliver benefits for citizens, patients and service users. It should be recognised that a wider range of services than those that

"in scope" for delegation are covered by the partnership and transformation work of the Collaborative. Community mental heath services, for example, will not be directly commissioned by the Collaborative but are a vital part of our integrated neighbourhood and locality teams.

In Scope	Out of Scope
• Integrated Teams in Neighbourhoods and Localities • Intermediate Care (NHS-funded) • Intermediate Care (council-funded) • Urgent care* • Primary Medical Care development (GPPSU) • Adult Community Services • Long Term Conditions • Children's Community Services	• Children's Community Services where jointly commissioned with LA • Mental Health Services • Primary Care Contracting & Performance • Continuing Healthcare (CHC) Packages of care • Learning Disability and Autism Services (these will sit in the MH Collaborative) • Services outside of BSol footprint

See table 7

Figure 5 - Scope of Collaborative

*subject to UEC review

Where services are included in 'out of scope' above – the Collaborative will not be responsible for the delivery or coordination of these services. However, Collaborative partners and services will still be working closely with other services (for example mental health practitioners are a key part of the INT).

It should be noted that there are naturally interdependencies with the other provider collaboratives in the system (Acute Provider Collaborative and Mental Health Provider Collaborative) and with other programmes of work in the system. As the governance around LDPs and the Collaboratives develops it will be important to consider how these are managed in a pragmatic and effective way.

4.2 Role of the Collaborative

As described in the Strategic Outline Case, the Collaborative may take a variety of roles, dependent on factors such as where and how existing services are commissioned, the number of providers involved, and the benefits that a single provider might bring. Of the four potential models described in the SOC, we have identified that two of these will be applicable for the Collaborative over the next three years.

The role of the Collaborative will evolve over time as the Collaborative matures. The Collaborative will play two key roles as **Lead Provider** (taking responsibility for the budget and tactical commissioning and contracts of a portfolio) and **Programme**

Enabler (coordinating operational integration across system-partners at a local level).

The intentions are depicted in Table 6; with dates subject to confirmation.

Table 6 – proposed role of Collaborative

Portfolio Area	24/25	25/26 (TBC)	26/27 (TBC)
Localities and INTs			
Intermediate care: NHS services	100 Day Challenge, UEC Review (ICB led)		
Intermediate care: council-commissioned services			
Urgent care	100 Day Challenge, UEC Review (ICB led)		
Primary Medical care development	Pending separate case for change	April 25	
Adult community services (Bham)*		April 2025	
Adult community services (Solihull)*		April 2025	
LTC programme			
Children's community services**		To be decided	

Key	Position	Descriptor
	Lead provider – responsible for services	Receiving transferred responsibility from the ICB for the tactical commissioning, contracting, quality assurance and financial management of a specified portfolio.
	Programme Enabler – oversight and coordination	The Collaborative plays a convening role that better enables stakeholders to align their own decision making and delivery activities. Budgets, resources, accountability remains with individual organisations
	Status quo	Providers to work as active partners in commissioner-led programmes

*The ICB is leading a review of Community services, including future arrangements for commissioning and provision. The Collaborative will work with the ICB to determine the most effective and appropriate models of commissioning and delivery of services and to include the outcome of this review in our future development.

**As shown above (and detailed in section 5.5), the long-term vision is that Children and Young People's (CYP) community services will, ultimately, be in scope for the Collaborative. However, the ICB's Children and Young People Partnership Board is currently being established and will provide a strategic view on CYP services and the role of the Collaborative. CYP services are therefore not being brought into the Collaborative at this point; plans will be developed and approved through the Collaborative Steering Group.

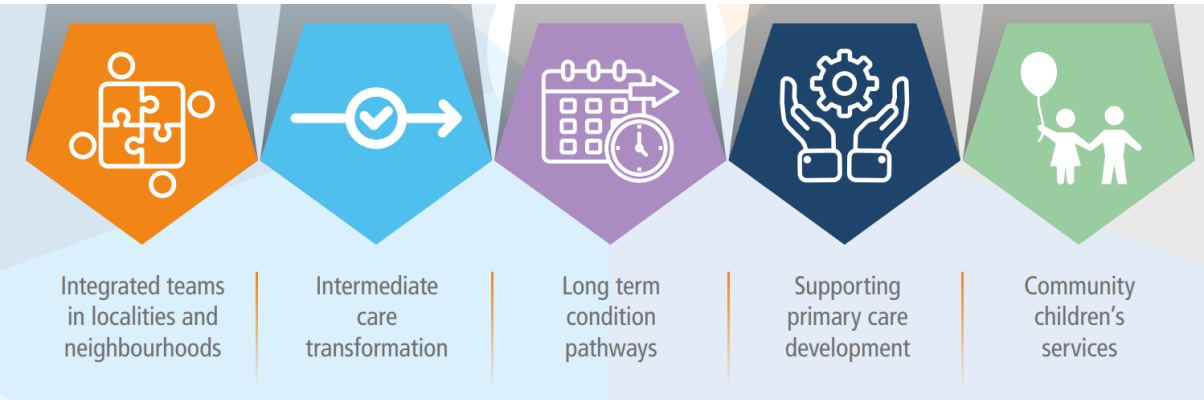
Table 7 shows in more detail which services are included under the high-level headings in Figure 5, and where commissioning and provision responsibilities for these services currently sit.

	Localities and INT	Intermediate Care	Urgent Care	Supporting Primary Care Development	Adult Community Services		Long Term Conditions	Children's Community Services
					Birmingham	Solihull		
Services included	• Non-recurrent INT • Non-recurrent Locality Hubs • Place Support Teams	• P1 Home Care (NHS/council-commissioned) • P2 Intermediate Care Beds • Care Home Support (Solihull) • Discharge Outside Pathway • Virtual wards • UCR • Care Coordination Centre	• UTCs • GP OOH • GP streaming at EDs	• GP Provider Support Unit • ARRS coordination	• Community Nursing • Specialist Nursing • Therapies • Community In-patient • Early Intervention Team • Long Covid	• Community Nursing • Specialist Nursing • Therapies • Community Inpatient	• CVD / Stroke • Diabetes • Respiratory • End of Life	• *Detail of portfolio TBC*
	Aligned VCFSE Contracts							
Commissioners	ICB BCF	ICB Local Authorities BCF	ICB	ICB	ICB	ICB	ICB	ICB Joint commissioning Local Authorities
Providers	BCHC General Practice VCFSE	BCHC UHB VCFSE	BCHC Various Independent	ICB (currently)	BCHC VCFSE	 UHB VCFSE	BCHC General Practice UHB VCFSE	BCHC UHB VCFSE

Table 7 – Portfolio overview

5. Work Programmes

As agreed through the SOC, there are five work programmes currently in the Collaborative as shown below. The aim of each work programme, intended models of care, and current stage of development are set out in this section. The detail of the work programmes over the next three years is laid out in detail in section 7.



As shown in the Introduction, overall the Collaborative is in the 'build' phase. However, our work programmes are at different stages of development, as is shown in this section, with a summary below.

Work Programmes		Design	Build	Operate
Integrated Teams in Neighbourhoods and Localities			✓	
Intermediate Care			✓	
Long Term conditions		✓		
Supporting Primary care Development			✓	
Children's Community Services		✓		
Enabling Programmes	**Estates**	✓		
	Digital	✓		
	Workforce	✓		

Table 8 – Stages of the Collaborative Work Programmes

5.1 Integrated Teams in Neighbourhoods and Localities - Work Programme 1

5.1.1 Delivering the Locality Operating Model

The Locality Operating Model (Section 3.1) will bring health and care services together at neighbourhood and locality level, across all sectors, to better meet the needs and preferences of the diverse communities within Birmingham and Solihull.

Work Programme One will build Integrated Neighbourhood Teams and Locality Hubs along with their supporting infrastructure, coordinating health and care services to provide care more effectively and efficiently, supporting better access, experience and outcomes for citizens.

The initial phase will focus on bringing together services for adults, based on the concept that existing services and importantly the people working in them will be better connected and will feel like one locality team. Core to this model will be the design, development and delivery of Locality Hubs and Integrated Neighbourhood Teams.

Work Programme One will also co-ordinate better utilisation, and flexible use of, public estate, with a focus on primary care centres and community care bases. This will include the re-development of Sutton Cottage Hospital as a hub for services for older people (in the North Birmingham locality) and the planned 'Kingshurst Integrated Community, Health and Wellness Hub' in north Solihull (See Section 8.3.6).

5.1.2 Integrated Neighbourhood Teams

Fundamental to delivery of the LOM will be the development and mobilisation of our Integrated Neighbourhood Teams (INTs).

With support from Newton Europe and extensive engagement from clinical colleagues we have developed a model for Integrated Neighbourhood Teams. Our INTs are broadly aligned to Primary Care Networks and bring together GPs, community health services, community mental health services, social care and links to the community and voluntary sector. Our prototype teams have started by reviewing the care we provide for those people who make the greatest use of health and social care in each neighbourhood currently. Our design work has demonstrated the potential to make an impact by better integrated care including more joined up work with community and voluntary sector partners,

There is currently one INT across each of the five Localities in Birmingham and work is underway to mobilise an INT in Solihull (expected mobilisation Summer 2024). The INT model works on the basis that there will be aligned resource within an INT which will deliver expertise and intervention(s) at a Neighbourhood/PCN level.

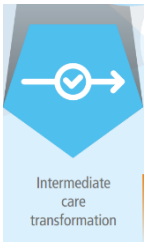
- For the future roll out of the model, system partners are in agreement that realigning existing resource for social care, mental health, GP and community health services will deliver the core roles of an INT. Neighbourhood experts

and neighbourhood coordinators could be delivered through locality-wide arrangements with the voluntary sector or hosted by a partner organisation within the community care collaborative.

- There are two crucial roles within the model which will require recurrent investment to support further roll-out; the Neighbourhood Expert and Neighbourhood Co-Ordinator roles. A summary of all the roles within the INT (including the new roles referenced above) is included in Appendix 3.

As detailed in Section 2, the development of integrated teams must be aligned to improving outcomes for patients and citizens, and the initial focus will be on supporting those High Intensity Service Users with complex care needs who are making the greatest current use of health and social care services.

5.2 Intermediate Care - Work Programme 2



As part of the system-wide Urgent and Emergency Care (UEC) programme, overseen by the UEC Board, the Collaborative will deliver Intermediate Care across BSol. System partners have developed a vision for Intermediate Care across BSol, as below:

To offer a consistent Intermediate Care service across Birmingham and Solihull, which is locality led in its delivery and supported by Place and System infrastructure.

Services will be designed to ensure that they reflect the needs of their local community and support people to receive the appropriate care and rehabilitation they need, in a seamless way, that will deliver the best possible outcomes and help people return to or remain in their own home.

It will have the following features:

- A single, integrated Intermediate Care model across Birmingham and Solihull, which is locality-led in its delivery, supported by Place and System infrastructure.
- A single point of access and referral into the service, which is responsive and simple to navigate.
- A workforce that can work flexibly across intermediate care, following the person from hospital to community bed and/or directly home, with a locality focus, and independent of organisational setting.
- An inclusive model which does not exclude individuals based on whether they have a particular condition, are a certain age or live in a particular environment.
- A service based upon professional trusted principles between teams to minimise assessment and duplication and ensure information.
- A service that drives a reduction in health inequalities by ensuring equity of access and provision across a locality footprint.

- A service that sets, agrees and delivers consistent standards, performance and objectives across the BSol System.

5.2.1 Model of Delivery

The vision of a system-wide Intermediate Care service that is locality delivered, is something that system partners have been working towards since 2023/24. As shown in section 4.2, to deliver the Intermediate Care programme, it is proposed that BCHC (on behalf of the Community Care Collaborative) will become the Lead Provider for all NHS-funded elements of Intermediate Care services.

The future model will be intrinsically linked to locality hubs and Integrated Neighbourhood Teams (INTs), as outlined under work programme 1. It will ensure alignment with other models of care e.g. community nursing, primary care, community mental health, by delivering a cohesive set of services across the locality geographical footprint.

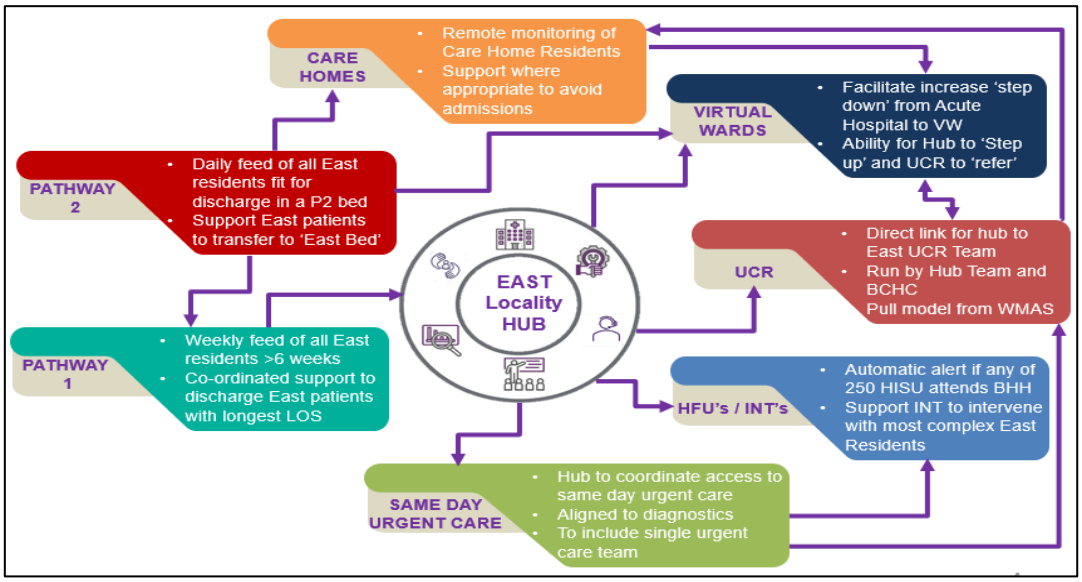


Figure 9 – Intermediate Care Services

Figure 9 provides a representation of the range of intermediate care services that will come together to form the Intermediate Care Team within each locality. Our intermediate care vision includes improved care and support for people living in care homes to reduce their need for emergency admission to acute care.

5.2.2 Focus in 2024/25

The aim is to have Intermediate Care services which are system-designed and locality-delivered. As part of the development of the Locality Operating Model, the Collaborative will pilot a locality-based Intermediate Care Team in one area, working in partnership with the local acute hospital, with the aim of improving patient outcomes and locality-level patient flow over winter 2024/25.

The table below provides an overview of progress towards this approach and identifies that further work is required to support a system-design model for pathway 1 (home discharge services) and pathway 2 (intermediate care beds):

Services	System Designed	Locality Delivered
Pathway 1 – Home discharge	✖	The proposed locality operating model will aim to bring the different services together to deliver a single, locality-based service.
Pathway 2 – Intermediate care beds	✖	
Care Coordination Centre	✖	
Virtual Wards	✓	
Urgent Community Response	✓	
Single Transfer of Care	✓	

Table 10 – Intermediate Care status

For 2024/25, the priorities and scope for the Intermediate Care work programme encompasses four components (Table 11)

Pathway 1 - Home Discharge	Pathway 2 - Intermediate Care Beds*	Locality Operating Model	Remote Monitoring
•To develop a consistent service model for Pathway 1 discharges and 'step up' support for patients across Birmingham & Solihull •To develop an Operational delivery model which is Locality based, across all relevant providers	•To progress P2 bed strategy for circa 480 beds (inc mobilisation of Solihull P2 beds) •Initial focus on Care Centre model and developing a consistent model & approach •Future phases to incorporate Sub-Acute and Specialist step down beds	•Create a single, consolidated 'Unplanned' team across a Locality (UCR, VW's, EICT, P2) •Integrate wider Collaborative components e.g. Locality Hub, INT etc	•Utilise West Mids Regional funding for RM •Roll out Docobo to 80% of Care Homes in E,W &Sol •Develop tech anabled support for P2 bed model

Table 11 – Priorities for Intermediate Care

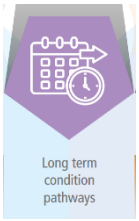
5.2.3 Intermediate Care Beds

A key priority for the work programme is the better organisation and provision of the Intermediate Care beds across BSol. The table below outlines the 3 phases to undertake this work.

	Beds / Units	What	Facilities	No. of beds	Approach
Phase 1	**Rehabilitation & further assessment (via Care Centres)**	Patients / citizens who we aim to get home but require a period of rehabilitation / recovery to maximise independence or require further assessment of care needs	• Anne-Marie Howes • Perry Trees • Norman Power • Kenrick Centre • CU27	156 beds (B)	Initial area of focus for Intermediate Care Programme – P2 Beds Predominantly Care Centre provision, working with BCC
	EAB / Nursing	Assessing longer term care and support for citizens who require nursing	• Abbey Rose • Aran Court • Solihull (Various)	22 beds (B) ~60 beds (Sol)	Short-medium term solution in Solihull at Solihull Hospital
Phase 2	**Generic sub-acute / Specialist**	• Sub-acute care for patients medically stable, but requiring ongoing observation / support • Specialist care e.g. INRU, Stroke • EOL / Palliative care	• Mosely Hall Hospital • West Heath Hospital	171 beds (B)	Focus for 2025/26 in terms of role and use of MHH and WHH Potential to enhance specialist care provision e.g. INRU
Phase 3	**Nursing / Complex Dementia**	Assessment of longer-term care for patients with nursing needs & complex dementia & require a physical setting / layout that can support this.	• Bromford Lane • Anne-Marie Howes	68 beds	Independent-sector provided beds for more complex nursing / dementia care. Potential to work with BSMHFT.
				~ 480 beds	

The alignment of the budgets across the c. 480 community-based beds is considered a key enabler for the Community Care Collaborative to deliver a more consistent, sustainable solution and drive better productivity and efficiency. It is anticipated that oversight of the full suite of intermediate care beds will form part of the lead provider arrangements (as per section 4.2).

5.3 Long Term Conditions - Work Programme 3



Long Term Conditions (LTCs or chronic diseases) are conditions for which there is currently no cure, and which are managed with drugs and other treatments, for example: diabetes, hypertension, cardiovascular disease, chronic kidney disease, cerebrovascular disease, dementia, chronic obstructive pulmonary disease, arthritis. They are managed across service providers as shown in table 7 (section 4) with a large element delivered by general practice.

Inequalities in health outcomes are overwhelming and most of these inequalities are associated with the development and progression of LTCs. Birmingham and Solihull has the highest proportion of citizens within the most deprived sections of the population in England. There are major differences in LTCs between demographic groups; for example, one in three people of South Asian ethnicity over the age of 35 has diabetes or pre-diabetes; hypertension has a very high presence in people of Black ethnicity.

People with Long-Term Conditions comprise most cases of hospital outpatient and primary care appointments, inpatient bed days, acute hospitalisation, re-admissions, and health care costs. People with Long-Term Conditions are those who progress to dementia, frailty, and end-of life care. In BSOL there are over 300,000 people with Cardiovascular disease, 200,000 people with chronic kidney disease and over 140,000 with Type 2 Diabetes.

The Integrated Care Partnership strategy[9] identified five key clinical condition areas which, through sustained improvements in prevention and outcomes, offer the greatest opportunity increase to life expectancy and reduce premature deaths across Birmingham and Solihull. The Long Term Conditions work programme covers two of these (circulatory disease and respiratory disease) as well as other long term conditions, as detailed in section 4.2.

- Respiratory
- Cardiovascular disease / Stroke / Diabetes
- Palliative & End of Life care

Established core principles for LTC care in BSoL comprise:

- Equality of outcomes; clinical and patient reported
- Locality enabled, locality delivered
- Integrated LTC teams (primary, community specialty, secondary care)
- Empowered workforce development
- Based on measurables for interventions with an evidence base
- Maximising partnerships: charity; industry; academic; social care

Key areas of focus within the overarching programme are

1. **The development of an integrated framework to identify those with or at risk of LTCs;** ensuring primary care data is used to identify patients with, or at risk of developing, a LTC; ensuring all health-care professionals can access and enter information on LTC onto the primary care electronic record; linking and using primary and secondary care data to enhance care for admissions for patients with a LTC (section 8.3.7)
2. **Workforce configuration and development;** defining the skill-mix and models for Locality-based teams, understanding the current workforce, and developing a programme of evolution from a specialist to an enhanced generalist model
3. **Delivery of care**; integrated patient information and patient reported experience measurement framework; BSol evidence and implementation hub for LTC (multi-partnership), including a secondary prevention framework; Locality-based models of care
4. **Research, development and innovation**; developing criteria for service pilots, and appropriate generalizable evaluation framework; establishing a framework for clinical trials, research, development and innovation with partners.

Core measurements for circulatory and respiratory disease are being finalised as well as the development of a single core dataset that identifies, for each major long term condition, numbers, demographics, including localities and combinations of conditions. The starting data set will

(i) Identify, by locality, the number of individuals with long-term conditions both singly and in combination, weighted for demography.

(ii) Measure core primary and secondary prevention interventions

[9] A Bolder, Healthier Future for the People of Birmingham and Solihull (icb.nhs.uk)

This will allow the mapping of numbers to system design, workforce skills and distribution, infrastructure, interventions.

5.3.1 Respiratory

In Birmingham and Solihull more than 23,000 mainly older adults suffer from COPD, while over 88,000 people – including children – suffer from asthma. Emergency admissions for COPD, admission rates for children from asthma, and under-75 mortality rates from respiratory disease are both significantly higher than the England average. There is considerable variation in both the availability and quality of care provided within primary medical and community services, including variation in diagnosis rates and waiting times. Respiratory virtual wards are not being utilised effectively and joint working between secondary care at a neighbourhood/locality level with primary medical care and community specialist services is limited. Several providers are commissioned to provide components of the current respiratory pathway however these are often delivered in isolation and there is no overarching system respiratory oversight. More needs to be done to reduce smoking prevalence and increase vaccination rates within high-risk groups.

The Collaborative will bring together providers from across the system to develop an integrated end-to-end respiratory pathway which is evidence-based and outcomes focused, starting from primary prevention right through to end of life care.

5.3.1.1 Focus in 2024/25

Currently led by the ICB, a Respiratory Programme Board was established in May 2024 to take this work forward. The Board includes clinical and operational representatives from all partners and comprises 4 work streams:

1. Integrated community respiratory model
2. Community respiratory diagnostics
3. Pulmonary Rehabilitation
4. Home Oxygen Treatment

The Board will bring together current strands of respiratory activity across providers and work effectively with interdependent work programmes. A significant amount of work in this area was undertaken at a system level pre COVID; although an overarching model was not implemented across BSOL as originally proposed in 2019 there are a number of elements that are in operation (some non-recurrently), but are being managed in separate programmes:

a) Virtual wards
b) Same Day Emergency Care
c) Community Diagnostic Centres

The initial focus for the Respiratory Programme Board is the development of an integrated care model, utilising a multi-disciplinary approach, to improve the management of adults with existing chronic respiratory conditions; mainly Chronic Obstructive Pulmonary Disease (COPD) and asthma. The model aims to provide

four key levels of intervention to support patients that require advanced clinical expertise beyond what is ordinarily provided by Primary Medical Care professionals.

Figure 12 – Respiratory Model

Multi-disciplinary teams will bring together existing clinicians and care professionals from different health and care sectors, working at neighbourhood or locality level. It is envisaged that these teams will support primary medical care practitioners to improve their skills and knowledge through direct involvement in multi-disciplinary working, combined with educational programmes. The teams will work across the community and acute hospitals to identify patients who can safely be cared for at home through Early Supported Discharge and virtual wards, with escalation to specialist intervention where required (Appendix 5).

5.3.2 Circulatory Disease

Circulatory disease includes a range of clinical conditions such as hypertension, diabetes, ischaemic heart disease and stroke. A significant amount of work is already happening across the BSol system to drive a reduction of harm related to circulatory disease. Primary prevention is the root to widespread reduction of cardiovascular disease; although the Collaborative may have limited influence on primary prevention as it relates to “macro” public policy, a priority will be to improve secondary prevention where existing risk factors are treated more effectively, specifically for hypertension and diabetes.

Similar to the respiratory pathway, current activity is often fragmented across different organisations and needs aligning through the development of a single end-to-end, system wide circulatory model. Inclusion in the remit of the Collaborative will ensure that interdependencies with other agreed Collaborative priorities, for example INTs and the LOM, are identified and addressed.

5.3.2.1 Focus in 2024/25

The workstream will be led initially in 2024/25 by the ICB through a Circulatory Board with membership from secondary, community and primary medical care health providers, public health and the VCFSE. The priority for 2024/25 will be the creation of a single, integrated approach to hypertension which is the most common circulatory disease in BSol, affecting over 300,000 people.

The workstream will work to improve outcomes by implementing evidence-based primary prevention, targeted earlier detection within at-risk communities and intervention to treat known risk factors, as well as effective and prompt treatment of acute disease. The workstream will include effective interventions to reduce obesity and smoking, increased uptake of NHS health checks, treatment to guidelines of high blood pressure and cholesterol, structured stroke care (including mechanical thrombectomy) and primary coronary angioplasty for myocardial infarction (heart attack).

Four workstreams will be established:-

1. **Optimising condition management in primary medical care** through the 2024/25 Enhanced Support Offer (ESO) to General Practice through pathway-based management, educational support and a single service directory for healthy lifestyle support services available to citizens.
2. **Tackling Health Inequalities** there is a specific ask to increase hypertension case finding within the Core20PLUS5[10] NHS England Health Inequalities approach and the ICS Health Inequalities Strategy. The programme will include innovative approaches, for example through training community advocates / third sector to screen their neighbourhood population through the use of Blood Pressure Monitors and / or mini health checks. Locations include barbers, hairdressers, libraries and faith settings.
3. **Patient Platform & Engagement** - The co-design and delivery of a single patient information platform for circulatory diseases, including local adaptation for approaches to lifestyle support as well as linkages to clinical management pathways.
4. **Innovation & Improvement Hub** - In partnership with Health Innovation West Midlands (HIWM):
   a) create a single framework for evaluating the value of any intervention for the population that we serve and ensuring we are clear what we are asking for from any stakeholder (see section 2.2).
   b) create a single system framework to identify and maximise all funding opportunities including those from industry. At present engagement with industry is fragmented across the system hindering the ability of BSol to attract at-scale collaborators with significant investment.
   c) Scope the potential for a single team approach to continuous improvement in the circulatory space, in line with the Collaborative's agreed Quality Improvement approach (section 9.4.1).

Whilst the programme will in time be housed within the Community Care Collaborative, both the acute and mental health collaboratives will play an important

[10] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

role in the development and effective implementation of new long term condition models. This includes ensuring there is a multi-disciplinary team framework for those who need specialist care and that identified secondary care specialists are embedded within locality-based teams.

5.3.3 Palliative and End of Life Care

People of all ages who face progressive, life-limiting illnesses, need a variety of health and care support at different points in their lives. In addition, most people are likely to need Palliative and/or End of Life Care (PEoLC), as they approach the last year(s) of their lives.

Currently, many Birmingham and Solihull residents do not die in their preferred place of death, with hospital deaths higher than the national average, and low numbers of care home deaths. Between April 22 and March 23, of the **11,868** recorded deaths, 5,792 of these people died in hospital. On average, each person attended ED 3 times in the 90 days prior to their death.

The Birmingham Joint Service Needs Assessment (JSNA) Deep Dive report[11] (2022) identified areas for service improvement to improve experience for those approaching end of life:

- Services could be more coordinated.
- Care plans are not routinely offered to patients in need of palliative care and their carers.
- People have difficulty discussing what they want when they die.

Similarly, the Solihull report[12] identified that around a half of older people who died in Solihull in 2016 did so in hospital.

Inequalities exist in both access to and experience of all palliative / end of life care services[13]. The current model across Birmingham and Solihull is fragmented with multiple providers commissioned separately to provide elements of palliative / end of life care pathway, including charitable hospices. Without considering the best use of investment, gaps in funded services and inequalities will likely worsen over time. As the population ages and more people die outside hospital, it will be important to consider how to meet projected increased demand and ensure a more sustainable and resilient model.

5.3.3.1 Model of Care

By bringing end of life care within the remit of the Collaborative, we will be able to take a more holistic view, focusing less on specific diseases or conditions, and instead developing an integrated, person-centred and personalised model of care.

We want to

[11] Joint Strategic Needs Assessment (JSNA) | Birmingham City Council
[12] Joint Strategic Needs Assessment: Evidence Summary (solihull.gov.uk)
[13] ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf (england.nhs.uk)

- Improve identification of those nearing the end of their life for better coordinated care, allowing for preferred place of death.
- Improve experience: the Integrated Palliative care Outcome Scale (IPOS) has been used to measure how well a patient's needs are met at this time. This, or similar, should be implemented to allow for quantitative assessment of patient experience.

Over the past three years extensive work has sought to align with the National Ambitions for Palliative & EoL Life Care Framework 2021 – 2026[14]. Underpinning these ambitions are 8 foundation principles, which have been agreed as BSol priorities.

1. **Personalised Care Planning** – more patients having personalised care plans
2. **Shared Records** – centralisation of work relating to 'identification' of patients; agreed community dataset.
3. **Evidence and Information** – improved recording end of life priorities through the shared care record
4. **Those important to the dying person** – increasing Preferred Priorities of Care (PCC) discussions
5. **Education & Training** – increasing workforce knowledge and confidence, through a shared resource web-based platform
6. **24/7 access** – to ensure equality of access across 24/7. A submitted bid to Macmillan (outcome to be determined) proposed that by developing an OOH service could reduce the number of hospital admissions and calls to 999 and increase the number of patients who die in their place of choice
7. **Co–design** – involving patients, carers and citizens in designing services
8. **Leadership** – providing strong and integrated leadership across providers.

5.3.3.2 Focus in 2024/25

The workstream will be led initially in 2024/25 by the ICB as part of the Long Term Conditions programme through an End of Life Board with membership from secondary, community and primary medical care health providers, public health and the VCFSE. The priority for 2024/25 will be to develop a system wide strategy and dashboard around End of Life Care.

5.4 Supporting Primary Care Development - Work Programme 4

This work programme will initially focus on General Practice; it will not initially include a focus on wider primary care services, though these may be included in time.

General Practice is considered the bedrock of the NHS[15]. It provides a large proportion of NHS care and is the anchor for integration across primary care, community and acute physical and mental health and social care at neighbourhood level. It is critical that General Practice are equal partners in the Collaborative and

[14] NHS England » Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026
[15] NHS England » Next steps for integrating primary care: Fuller stocktake report

there is an explicit aspiration that the Collaborative will support the development and resilience of the sector.

General Practice is currently experiencing some of its most challenging times with increased demand, workforce challenges and resilience. Despite these issues, General Practice in BSol has continued to deliver, offering more activity than ever (16% more compared to pre-covid levels) and working to modernise the model of care in line with local and national aspirations.

The work programme will support General Practice development in line with BSol's Enabling Primary Care strategy[16]. There are many inefficient systems, processes and referral pathways between General Practice and other providers that add burden to health and care professionals and add no value to patient care. The work programme will enhance interface working between General Practice, community and acute physical and mental health services, social care and the VCFSE, to build trust and practical working relationships.

The work programme will aim to

- Promote functional working relationships between teams at practice, PCN and locality levels
- Support general practice delivery, in particularly enhancing pathways and processes that add value to the patient journey and reduce bureaucracy for General Practice (e.g. self-referrals)
- Deliver joint working to address health inequalities
- Deliver closer practical interfaces across health and care providers.

A separate Case for Change is being considered to move the hosting of the GP Provider Support Unit (GP PSU) to BCHC, as the lead provider organisation for the Collaborative. This would further enhance the potential benefits of closer and more integrated working between general practice and other providers.

5.4.1 Model of Delivery

The ethos and purpose of the Collaborative is to drive integration and improve interfaces between providers, and to provide integrated services which promote early intervention and prevention. General Practice will be an essential part of each work programme, and is referenced throughout this Plan.

Interfaces

This work programme will support specific deliverables around redesign of processes between general practice and other providers, to reduce bureaucracy and improve pathways of care for patients. These will include

[16] Birmingham and Solihull ICB (2023). *Enabling Primary Care - A strategy for enabling primary care across BSOL ICB*

- Developing an integrated practical model of preventive care, which includes targeting those people who do not ordinarily present at primary care e.g. links to immunisations and vaccinations
- Initiating a systematic joint communication programme (see section 8.3.4) to describe offers of care/support, how they can be accessed and where they are delivered
- Co-producing and developing a workforce model which designs and implements solutions to attract and retain staff to help deliver general practice and community care. This will be part of the overall workforce plan for the Collaborative (section 8.3.5).
- Reviewing and redesigning interface processes to reduce bureaucracy on GPs and other providers, and improve pathways of care for patients. As per the NHS England Delivery Plan for Recovering Access to Primary Care this will include a focus initially on the main recommendations from the Academy of Medical Royal Collages and the RCGP[17] to streamline and agree an approach to
    - onward referrals
    - complete care (fit notes and discharge letters)
    - call and recall
    - a point of contact for clinicians.

Infrastructure - GP Provider Support Unit

The GP PSU is the delivery arm of the GP Partnership Board which provides essential leadership on behalf of General Practice across BSol. The PSU was set up in 2022 to provide dedicated infrastructure to support General Practice, with the three main aims to

- support **sustainability** of general practice;
- increase **standardisation** to meet and exceed quality service standards;
- achieve overall **improvement** of general practice service delivery.

5.4.2 Focus in 2024/25

The work programme will be led initially in 2024/25 by the ICB which currently hosts the GP PSU.

The priority for 2024/25 will be to

- Support the transition of the GP PSU to the lead organisation for the Collaborative (BCHC), if agreed through the separate Case for Change.
- To work with partners to identify specific objectives and deliverables to begin to deliver the aims outlined in 5.4.1, focusing on wound care and community nursing.

[17] Policy areas (rcgp.org.uk); GPSC_Working_better_together_0323.pdf (aomrc.org.uk)

5.5 Children's Community Services - Work Programme 5

The Collaborative remains committed to being 'all age' and to cover the full life course. Since the Strategic Outline Case was approved by the ICB in November 2023, there has been limited progress in determining which NHS-commissioned community services for babies, children, young people and their families might be included within the remit of the Collaborative.

We recognise that the place-based partnership arrangements for services for children and young people are different from those for adults and that there are well-established programmes of work in both Birmingham and Solihull seeking to improve services for children with Special Education Needs and Disabilities (SEND) and to develop integrated local care for children and young people through Family Hubs and 0 – 19 years pathways. The Collaborative does not want to disrupt this existing work.

The ICB is looking to establish a Children and Young People's Health Partnership Board. The terms of reference have been drafted and, whilst not yet ratified, it is expected that the Partnership Board will provide a strategic view across the numerous programmes of work in relationship to Children and Young People which meet the following criteria:

- The programme involves clinical care
- The programme exists within the ICS
- The programme requires both horizontal and vertical integration.

Through involvement in this new Health Partnership Board, the role of the Community Care Collaborative in relation to NHS-commissioned community services for babies, children, young people and their families will become clear.

As our understanding of the how the Collaborative can best support the delivery of local integrated care for children and young people, it is possible that the following services could form part of this work programme:

- Intermediate care services for children and young people;
- managing long-term conditions for children and young people;
- supporting the delivery of locally integrated care working closely with the place-based partnerships in Birmingham and Solihull.

In 2024/25 the above will be taken forward to identify what is in scope for the Collaborative in this work programme, and what the delivery plan will be for 2025/26 and beyond.

6. Locality Delivery Partnerships

The Locality Delivery Partnerships described in Section 3.2 will focus first on integrating physical and mental health and care for adults. In time, the emerging Family Hub networks within Birmingham and Solihull will connect into the developing Locality Operating Model and membership of the Locality Delivery Partnerships will evolve accordingly.

The functions of the Locality Delivery Partnerships to deliver the vision set out in section 3.2 are set out below:-

- To bring local partners together to build and continue to develop an inclusive and active Locality Delivery Partnership
- To understand locality demographics, population health needs and key performance / delivery pressures linked to the Community Care collaborative's Outcomes Framework
- Initial operational focus in 2024/25 will be on the development and delivery within the locality of:
    - Integrated Neighbourhood Teams and establishing a 'Locality Operating Model'
    - Local Intermediate Care pathway
    - Development and operation of physical Locality Hubs for same day urgent community care
    - Oversight of the allocation of Fairer Futures Locality Funds targeted to local health needs and monitoring delivery of schemes / projects.

During quarter two of 2024/25, each LDP will develop a delivery plan and align delivery capacity to agreed system/place priorities.

Each LDP is chaired by a Locality GP who is a representative on the GP Partnership Board who will work closely with a named senior system leader, working on behalf of the Community Care Collaborative to deliver the Collaboratives objectives. The system leader will act as the Senior Responsible Officer (SRO) and is a member of the Community Care Collaborative Steering Group; the chair and the SRO are accountable to the Steering Group for the performance of the Locality Delivery Partnership. They will also play a key role in representing the views and priorities of the Locality Delivery Partnership within the Collaborative

The Locality Delivery Partnerships will be supported by a Locality Manager employed by the Community Care Collaborative. Core membership is set out in Box 13 below. As the Community Care Collaborative takes on additional responsibilities in future, the functions and membership of LDPs will be reviewed.

- **NHS Community Healthcare Provider**
- **General Practice** (in addition to GP Chair)
- **Local Authority Adult Social Care**
- **Local Authority Children's Social Care / Birmingham Children's Trust**
- **Voluntary, Faith, Community & Social Enterprise Sector**
- **Local Authority Public Health**
- **NHS Community Mental Health Provider**
- **NHS Acute Provider**
- **Neighbourhood Network Scheme lead** (Birmingham)
- **Experts by experience / citizen reps** (To be developed)
- **Family Hub Network lead provider** (in time)

Box 13 – Core Membership of Locality Delivery Partnerships

7. Phasing of Delivery

	2024/25	2025/26	2026/27
Development of the Collaborative	• Develop, agree and implement Quality Improvement approach • Models for VCFSE, citizens and Experts by Experience (EbE) involvement designed and implemented • Establish LDPs in all localities • Develop workforce, digital and estates delivery plans • Develop Locality Operating Model dashboard • Appraisal and procurement of system data extraction tool • Embed robust governance and risk management approaches across the Collaborative	• Quality Improvement approach embedded across all work programmes • Locality-level VCFSE collaboratives established and working in partnership with the LDPs • Citizens and EbE involved in decision making at all levels • LDPs take on responsibility for locality-level delivery and performance • Collaborative governance and risk management systems fully matured	• Quality Improvement used routinely in all change programmes • LDPs take on increased delegated responsibility from the Collaborative and Place Committees • Sustainability of Locality Fairer Futures Fund schemes post-evaluation addressed • Audit of Collaborative governance and risk systems and processes to ensure fit for purpose
Overarching deliverables	• Initiate a joint communications plan for staff and the public • Produce and implement a combined community and general practice winter plan	•	•
Integrated Teams in Neighbourhoods and Localities	• Sustainable, integrated digital solution in place for ongoing identification of INT caseload(s). • Locality hub 'case for change' agreed.	• Integrated Neighbourhood Team coverage across all 35 Neighbourhoods/PCN's in BSOL	• Population Health Management approach mobilised within all INT's across BSol (funding dependent)

	• Integrated locality operating model tested and evaluated in one locality. • Digital and Estates enabling strategies agreed	• Locality hubs mobilised and operational across all five Birmingham localities and Solihull (subject to agreed funding). • Locality operating model mobilisation underway. • Sutton Cottage refurbishment completed.	• Kingshurst Health & Wellness Hub completed
Intermediate Care	• Locality-based Intermediate Care service tested and evaluated in one Locality • Recommissioning of P1 Pathway (Birmingham) agreed. • Full Business Case on provision of Phase 2 of Pathway 2 beds agreed (Birmingham & Solihull). • Process for transfer of commissioning responsibilities for NHS services	• Roll-out of locality-based Intermediate Care teams. • Implementation of Pathway 2 provision (Phase 1) across BSol underway to plan. • Full Business Case for Phase 2 of Pathway 2 beds. • Collaborative lead Provider for Intermediate Care. • Locality operating model mobilisation underway (re. Intermediate Care)	• Implementation of Pathway 2 provision (Phase 2) across BSol underway to plan. • Locality operating model mobilisation completed (re. Intermediate Care)
Long Term Conditions	• Establish BSOL Respiratory Board • Appoint BSOL clinical lead for respiratory. • Bring together existing programmes comprising respiratory elements. • Refine and test integrated community team model aligned to an acute hospital and its localities during winter 24/25.	• Develop and roll out (subject to approval) an integrated community respiratory model. • Develop and roll out (subject to approval) a future community diagnostic model. • Bring forward proposals for Pulmonary Rehabilitation & Home Oxygen	•

	• Develop future community diagnostic model for BSOL. • Establish single respiratory clinical dashboard for BSOL. • Complete review of Pulmonary Rehabilitation and Home Oxygen services • Establish single BSOL circulatory board with underlying workstreams • Create a single set of system hypertension metrics to form part of system circulatory dashboard • Embed hypertension measures in the ESO 24/25 with appropriate support offer to primary care • Map current activity focusing on detection and primary prevention across partners and agree system priority work programme. Work with HIWM/Aston University on evaluation methodology • Scope opportunity to develop a single patient platform across all circulatory conditions • Scope potential for launch of integrated PEoLC life OOH service across Bsol • Delivery on improved identification metrics • Develop Bsol PEoLC Dashboard	• Focus on develop PEoLC strategic (focusing on future commissioning) • Integrated PEoLC and LTC workstreams	• Deliver Bsol PEoLC strategy

	• Set planning for Bsol system PEoLC Strategy • Web based platform launch	• Post identification support pathways • 24/7 PEoLC service review	
Supporting Primary Care Development	• Design and implement wound care model • Redesign process for joint working between general practice and community nursing • Launch ICBs *transfer of commissioning responsibilities* (September) to move the PSU to BCHC	• Mobilisation of the transfer of GP PSU to BCHC • Include alignment to community teams in a target operating model for general practice • First year of PSU within BCHC – stabilisation phase • Improve the community mental health and general practice interface • Promote social care and general practice interface • Identify further ambulatory pathway design and implementation based on PHM • Develop robust general practice and community workforce plans • Design a joint preventative approach	• Develop and implement a comprehensive community and general practice strategy • Flexible employment models in place for nursing staff • Implementation of further pathways of care • Fully implement the preventative approach
Children's Community Services	• Define scope of the work programme and prioritise areas for inclusion • Develop delivery plan for 2025/26 and beyond	SUBJECT TO WORK IN 2024/25	

8. What is Needed to Achieve this?

8.1 Resources

Appropriate resourcing of the Collaborative, and the risk to delivery if this is not adequate, is recognised as a significant risk (rating 15) on the Collaborative's risk register. In view of the current financial situation, it is understood by partners that in large part improvement and transformation will need to come from a realignment of existing resources, rather than the ability to expand the workforce. However, there are significant requirements in some areas, which are summarised below and in table 14.

- **Delivery Team**

There has been some investment in the overarching architecture of the Collaborative, in recognition of the need to invest in resource to drive forward change and transformation. £1.2m of funding has been agreed to support this work as per Table 14. This provides sufficient capacity to make the progress that we aim to make in 2024/5.

- **Collaborative Infrastructure**

Additional capacity in some key corporate areas is crucial if we are to realise the potential benefits of the Collaborative. These include

- **Business Intelligence** – to develop the tools to integrate data from partners, and display this in a useful way for those providing care directly, and for those designing and managing pathways of care. To analyse the data in a way that informs and drives change in an evidence-based way. If appropriate technology is invested in, this may be largely a pump priming investment rather than ongoing.
- **Information Governance** – to ensure information governance and information security across the system, to manage and streamline the current situation of multiple agreements and assessments, and to negotiate the reduction and integration of patient records and administration systems.
- **Digital** – to support the development of digital interoperability and integration interoperability between partners; investment in equipment and technology.
- **Communications** – as resource is non recurrently funded
- **Experts by Experience** - to realise our ambition to include meaningful participation and coproduction with citizens and experts be experience (as per section 8.3.1).

As the delegation process is worked through, identification of existing resource in the ICB may support these corporate areas and the shift in resource.

- **Work Programmes**

Individual work programmes will be subject to business cases where appropriate if changes are being made to services, or investment sought.

- **Locality Hubs.** The current Locality Hubs in Birmingham are being funded non-recurrently from the Birmingham Better Care Fund. The future funding

arrangements for the locality hubs will be, in some part, linked to the BSOL ICS 'UEC Reform' programme, with opportunities to potentially better co-ordinate existing funding arrangements on a locality footprint. It is important to note therefore that the existing current funding arrangements for locality hubs are non-recurrent only cover 2024/25.

- Solihull Locality Hub – We have identified non-recurrent funding to get the Solihull locality hub and running; the recently submitted Solihull Better Care Fund plan includes a budget of £365k towards the cost of a Locality Hub in Solihull from the ICB's element of the Social Care Discharge Fund. Access to this funding is contingent on the delivery of a clear business case setting out the proposed operating model, costs & benefits etc for the Locality Hub.
- We recognise that we need to agree a sustainable approach to funding for Solihull and the Collaborative and ICB are working with Solihull Council to identify how this can be done from within the resources available to us.
- **Work programme 1: Integrated Neighbourhood Teams**. The Business case for INTs is being written - whilst the majority of the Integrated Neighbourhood Teams model is based upon re-organisation, focus and co-ordination of existing services and teams, there are two crucial roles within the model which will require recurrent investment to support further roll-out; the Neighbourhood Expert and Neighbourhood Co-Ordinator roles, as per table 14. A summary of all the roles within the INT (including the new roles referenced above) is included in Appendix 3.
- In Birmingham, there is c£1m ringfenced within the 24/25 Better Care Fund plan to fund core roles in the existing INT, whilst the business case is being written and assessed.

Programme	Value (£)	BSOL Agreed (Y/N)	Rec / Non Rec	Source of Funding
Community Integrator - Project Team to deliver the CCC Pla	1,186,089	Y	Rec	BSOL
INT - Five existing Teams	984,612	Y	Non Rec	Better Care Fund (BCF)
INT - Roll Out - 20 Teams	2,079,840	N	Rec	BSOL
Hubs - For East and West	3,119,000	Y	Non Rec	Better Care Fund (BCF)
Hub - Solihull	1,043,208	Part	Non Rec	Social Care Discharge Fund (BCF)

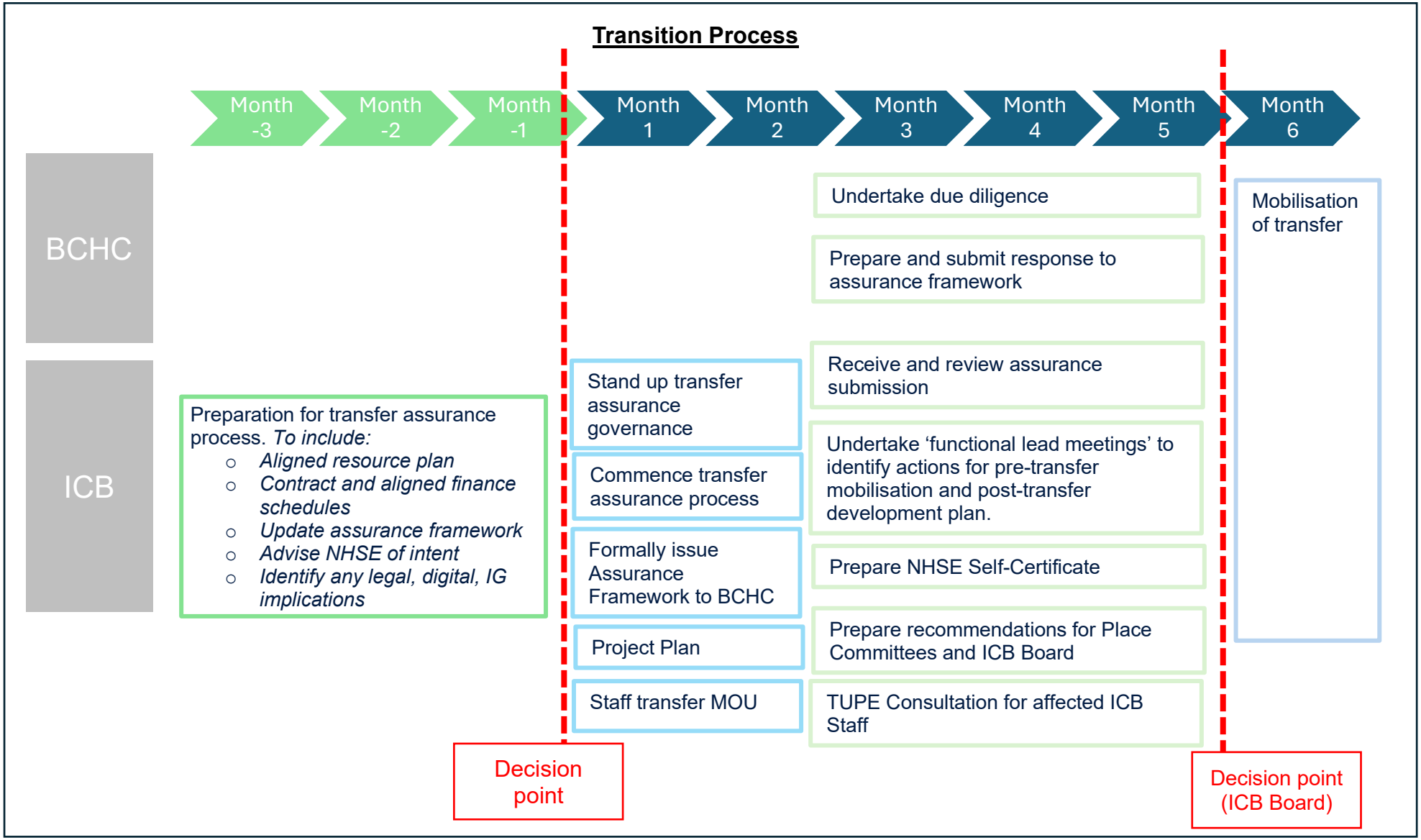
Table 14 – Collaborative funding streams

As noted above historic differences mean that we are fortunate to have more flexibility to use the Better Care Fund to support integrated neighbourhood teams and locality hubs in Birmingham than we do in Solihull. The ICB and the Collaborative are committed to working with Solihull Council to agree how we can resource these developments in Solihull in 2024/5 so that we have a shared agreed approach by September 2024. We recognise that this approach will have to work within the resources already available to each of the partners.

8.2 Transfer of Responsibilities

As shown in section 4.2, there will be a move to bring some services under the umbrella of the Collaborative – i.e. when status moves to Collaborative as **Programme Enabler**. There will be a decision point here; this decision will be taken by the Collaborative Steering Group, and where applicable, by associated partner governance.

In order for the lead organisation for the Collaborative (BCHC) to assume **Lead Provider** status there will be a formal process as shown below. This will take a minimum of six months (based on learning from the MHPC).



The Transition will be informed by the Approach taken with the MHPC, and the assurance framework developed, proportionally and thematically adjusted:

- **Shared Vision, Collaboration** and **Leadership**
- **Governance**
- **Financial management, commissioning and contracting**
- **Quality monitoring and assurance**

8.3 Enabling Functions

8.3.1 Participation and Co-production

The Birmingham and Solihull Integrated Care System is committed to ensuring citizens have a real voice in shaping the way services are planned and delivered.

"We are ambitious to ensure that there is not only effective participation of residents, patients, service users, carers and partners in the design, delivery and evaluation of our ICS ambition but also that future participation enables true power-sharing with our communities and encompasses all ICS activity, including governance arrangements, the development of strategy and informing decision making and prioritisation."

Taken from the Birmingham and Solihull Integrated Care System Operating Framework (2022)

"Birmingham and Solihull ICS will seize the opportunity to reshape citizen engagement…. We want to ensure that citizen and patient voices are at the heart of future service development and delivery, and that we are engaging our communities in a coherent and coordinated way…. In doing so, we will seek to systematically drive improvement in health outcomes and tackle health inequalities."

Taken from the Birmingham and Solihull Integrated Care Board 'Working with People and Communities Strategy' (2022)

In the Community Care Collaborative C.A.R.E. approach, set out in Section 1, the 'E' stands for Empowering:-

Empowering - helping everyone to live a healthy, happy life, with better and easier-to-find information about healthy choices and local activities that support a healthy lifestyle.

Being **Empowering** also includes our commitment to engage and involve people and communities.

'We will engage and involve citizen representatives and Experts by Experience in every decision-making group, at all levels of our Collaborative. Through our VCFSE partners, we will actively engage with all local communities, with a particular focus on the marginalised, minoritized and so-called 'seldom heard', to ensure we are working on the issues that matter most to local people. We will work together with our super-diverse communities across Birmingham and Solihull to co-produce services that most effectively meet local needs**.'**

Taken from the Birmingham and Solihull Community Care Collaborative Strategic Outline Case, approved by BSol Integrated Care Board November 2023

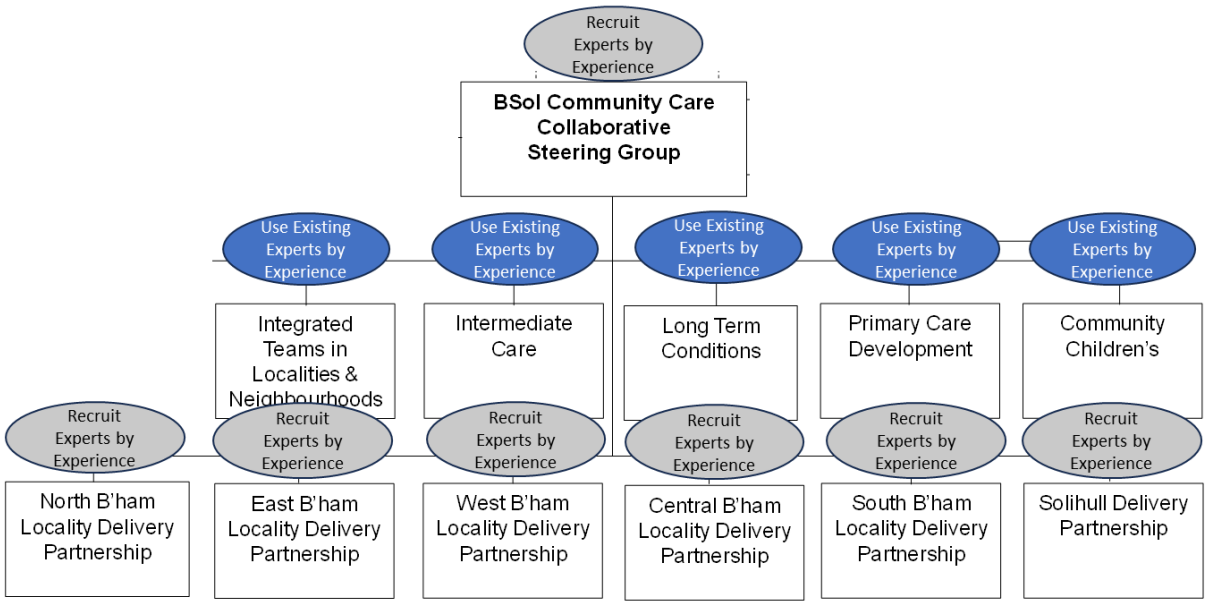
The Community Care Collaborative has developed and agreed the following principles for engaging citizens and 'experts by experience'[18] in the work of the Collaborative based on a review of national best practice models

- Experts by Experience and citizens should be involved in decision making at every level of the Community Care Collaborative
- These roles should be recognised as having equal voice and value
- People should be given the support they need to feel fully included and to be able to actively participate
- People should be recognised for the expertise they bring and paid for their time. This creates greater equity with employed staff who also attend these meetings

The Collaborative recognises that an approach with varied and wide-ranging engagement with citizens and service users will provide the richest input, and will be looking to utilise a range of methods of engaging with our communities and experts by experience.

8.3.2 Proposed Engagement Model

The proposed model is to have citizens and 'experts by experience' involved in all levels of decision-making within the Collaborative:-



Where these already exist, we will ensure that we engage with patient, service user and carer forums and networks across Birmingham and Solihull. The Collaborative will look to recruit Experts by Experience for each of the five work programmes and ensure that they have appropriate ongoing support.

The involvement of citizens in the six Locality Delivery Partnership and the wider Collaborative decision-making groups will require a different approach. These citizen representatives (who may also be Experts by Experience) will be recruited through

[18] Experts by Experience are people who have lived experience of using or caring for someone who has used health and / or social care services recently.

an open process, receive some basic training on how the health and care system operates and be provided with ongoing support to undertake their roles on the various groups. These individuals will be well connected within their local community to represent the views of the wider community, rather than simply their own views.

The Collaborative will need to identify resources, in particular funding, to enable our ambition for inclusion through participation and coproduction to be realised in a range of ways. Preferred options being explored include increasing existing capacity and capability in one of the Collaborative partner organisations or to commission this as a discrete service. This could include utilising and build on the existing expertise of Community Connexions [19], funded by the Clinical Research Network West Midlands and led by BCHC and Black Country Healthcare NHS Foundation Trust with Aston University. Community Connexions collaborate with a broad spectrum of community and voluntary organisations from faith organisations, local charities groups, mutual aid groups and community forums to better understand the needs and priorities of local communities, Health behaviours and barriers that lead to poor engagement with health services and/or research. This helps to adapt our services to better meet local needs, inform future health research and develop understanding for prevailing health inequalities and how these can be addressed.

8.3.3 VCFSE Collaboration

BCHC as the lead for the Collaborative has an established relationship with the VCFSE. We have worked closely with BVSC in Birmingham for a number of years and are building links with CAVA in Solihull.

Supported by funding from the former Black Country and West Birmingham Clinical Commissioning Group, we enabled the development of Flourish, the West Birmingham Community Health Collaborative[20] as an open group of third sector organisations working in partnership with the NHS and other care providers to reduce health inequalities across West Birmingham.

This partnership between the NHS, Local Authority and VCFSE sector has already shown impact, winning the Health Service Journal NHS Race Equality Award in 2023[21]. Flourish are already part of the Locality Delivery Partnership for West Birmingham and we want to replicate this model across Birmingham and Solihull.

In Birmingham, we have supported BVSC to develop a proposal to establish similar collaboratives across the VCFSE sector in each of the five localities. These

[19] https://www.bhamcommunity.nhs.uk/community-connexions/
[20] https://flourish-health.net/
[21] https://flourish-health.net/winner-flourish-and-the-ladywood-perry-barr-locality-partnership-walk-away-the-nhs-race-equality-award-at-the-hsj-awards/

collaboratives will play a key role in working with statutory sector partners to develop proposals for the Locality element of the Birmingham Fairer Futures Fund.
We will look to work in a similar way with CAVA and the VCFSE sector within Solihull.

8.3.4 Communications

A communications strategy was developed in December 2023. It includes the development of a Collaborative brand identity which, launched in March 2024. With multiple system stakeholders, and a large workforce involved both directly and indirectly in the work of the Collaborative, it is important to ensure that communications are well managed to ensure a consistent 'single story' approach. This will help to avoid any confusion or speculation as the Collaborative continues to develop.

As a first step we have established "Connect" as our monthly newsletter for partners and stakeholders.

The Collaborative will continue to develop effective tools and assets for stakeholders and disseminate via established neighbourhood, locality, place and system-level communication and engagement channels.

It will be important to communicate with citizens and patients around the offers of care and support, what these means and how to access them.

8.3.5 Workforce

Having enough people, with the right skills and values, in the right place is clearly fundamental to the realisation of the Collaborative's aims. In addition to the resources referred to in 5.1, we will also be looking to work differently across our collective workforce, to promote integrated teams and leadership, and support new ways of working.

The opportunities offered by integrated working to address the many workforce challenges faced by the members of the Collaborative – including high vacancy rates and turnover and low levels of staff satisfaction – were identified in the Strategic Outline Case[22]. They include building new capabilities, developing fulfilling careers, widening participation, sharing good practice, and supporting development.

The Collaborative will develop a workforce model which attracts and retains staff to primary and community services, to improve the delivery of care and services.

BSol Workforce Programme

This workforce plan should be seen in the system context, and the Collaborative is connected to the wider system workforce programme. In 2023 a 'workforce diagnostic' was carried out across the ICS, which highlighted that BSOL was

[22] Strategic Outline Case 2023 - https://www.bhamcommunity.nhs.uk/download.cfm?doc=docm93jijm4n6339

struggling to achieve net growth in some professions, more people were leaving than joining, increasingly any growth was coming from International Recruitment (163% increase since 17/18) and agency, and that 93% of our workforce was still within the acute sector.

It was recognised that unless trend-breaking actions were taken, in the short term, BSOL would not achieve in-year operational plans in terms of activity and finance, and in the medium term, were likely to lose more staff with an impact on the quality of care, and in the longer term, fail to achieve JFP objectives of improved quality and reduced inequalities.

In response a system wide action plan was agreed under a '4 R's' Workforce Programme, which member organisations are involved in.

- Reconnecting with our staff
- Recovering net growth through recruitment and retention
- Resilience - Reducing reliance on contingent actions (agency and IR)
- Redistributing growth and new skills to redesigned future (community/NHTs)

Reform

Under the 4th priority a Reform Workstream was established to understand the workforce requirements of the new models of care and develop resources to support them. The workstream is of particular importance to the Collaborative as it will support the delivery of local plans and strategies[23] through redesigning the model of care and ensuring we have enough people with the right skills and values in the right place to deliver it.

The Community Care Collaborative has been actively involved in the initial work of the Reform workstream in developing and testing a range of tools and resources to support workforce planning and development, and identify initial workforce risks and challenges.

The vision of the Reform approach is to see a redistribution of skills and people to support the longer-term model of care; key enablers of that will be to influence a shift in education placements and training and enhance the experience of staff working within primary care and community settings.

Collaborative workforce leads will not work in isolation but will work with other collaboratives to share and learn in terms of workforce transformation good practice.

Wellbeing

We should also recognize the significance of some of the shifts and changes on our workforce, and the need to support our colleagues through HR and OD offers, to understand, embed, and make the most of the opportunities from the Collaborative.

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8.3.6 Estates

To deliver on our commitment to integration, reducing duplication, and providing connected, accessible services, we will need to ensure that we have the right Estate. We recognise, collectively, that our current estate is not always fit for purpose, or in the best place for our service users and for delivery of efficient services, and that there is a limit to suitable estate in the system. Our estates needs will be affected by the new ways that we are and will be working together: teams will be working across organisational and professional boundaries, and our services will be increasingly organised around Neighbourhoods and Localities.

Working together with our partners, through the Collaborative, gives us huge opportunity to

- Connect our services better, through co-location of teams, e.g. our Primary Care Centres to co-locate teams from across health and care organisations and ensure the development of new models of care utilise this space e.g. integrated locality hubs.
- Understand what estate we have available to us as a Collaborative, and how that might be better used, to minimise waste and duplication including for travel of our workforce.
- Use community-based assets in delivery of our services.
- Review where services are best provided across the System, and flex how partners' estate might be used.
- Challenging cultures and actively pursuing and investing in agile working.
- Utilising digital technologies to avoid over reliance on the estate and create flexibility

Estate is an area which challenges all Collaborative partner organisations, and is a prime example of how working together in the Collaborative will allow us to address longstanding issues. A holistic approach to department budgets will be required to facilitate implementation of shared estate use. As in so many areas of collaboration, trust and openness will be key to realising potential benefits.

8.3.7 Digital, Information and Information Governance

As with our ambitions around estates, the same is true of how we use and embrace digital technology and information as a critical enabler in the delivery of our overall agenda.

Having the right systems, information and data will be an important part in realising the potential benefits of the Collaborative, to support direct patient care, population health management and the reduction in health inequalities. Learning from other Collaboratives such as Leeds Health and Care Partnership[24] has shown that being able to input and access information and data, in real time, is a key enabler of change.

[24] Innovation is key: early learnings from NHS England's discharge frontrunner sites (nhsproviders.org)
Breakfast session - How enhanced system visibility is enabling transformation and improved in Leeds (youtube.com)

The Collaborative will work towards minimising duplication and ensuring secure and appropriate access to systems and information. Our commitment to improving the availability and use of information will be at differing levels:

A. unhindered confidential patient information (CPI) data flow to individual professionals, and integrated teams (to deliver direct patient care),
B. pseudonymised data flow at locality and system level (population health management, reducing health inequality),
C. anonymised data flow to levels system and national level (reporting requirements, service and resource planning), and
D. citizen / patient autonomy through national NHS App – appointments, prescriptions, medical records

Confidential patient information – if we are to deliver the promise of being **CONNECTED**, and people only telling their story once, we will need to ensure all those who are providing support across the care pathway can see the relevant information to support care and improve outcomes.

Pseudonymised and Anonymised data
Being able to see information, in real time, at individual, team, neighbourhood, locality, place and system level, will enable us to be **CONNECTED** and **RESPONSIVE**; to effect changes and respond to demand, to see the impact on outcomes, to understand system performance, and identify people most at risk and identify health and service inequalities.

Citizen/patient autonomy
We will share information with citizens, **EMPOWERING** and enabling people to join in conversations about their health and well-being and shape their care and support. People will be able to access care more easily, using the full potential of the NHS App to book appointments online, check test results and access information on their own care

Digital and technology

The Collaborative will identify opportunities for Digital, Data and Technological innovation, and play an active role in driving integration and development through the ICS-wide digital programme of change.

This will be done through building upon progress being made in critical areas and developing opportunities, this will include:

- Delivering upon the ambition to present a single care record which will allow our health and social care professionals to easily and accurately establish a holistic picture of an citizens care needs and the various interactions they are having with our collective services. We will do this through the increasing expansion of the Digital eco system of which the Shared Care Record sits centrally to ensure this is available and accessible to all of our teams.
- Ensuing that the right equipment and networking is in place so all professionals working across BSol are able to connect with an appropriate, fit for purpose device, no matter what facility they are working from.
- Joining up our data across all providers to allow us to release the potential of a data-driven approach to care. The advantages of such an approach have already been identified in the work undertaken with the integrated

neighbourhood teams. The development of sustainable data streams, which are continually refreshed and supporting teams to identify and support the right citizens, through a more detailed population-health management approach is critical
  - Expanding the use of home-based remote monitoring technologies to support people to better manage their condition from the comfort of their own home
  - Developing digitally enabled integrated care pathways that offer clearer advice and guidance for how to access online health promotion, self-management support materials, e-therapeutic platforms, community service signposting, self-assessment services, self-referral options and wellbeing apps.
  - Giving greater choice to empower service users and carers to make better decisions and make it easier to interact with our services and access information about them.

Reducing inequalities is a central aim of the Collaborative, and we are committed to addressing inequalities from a digital perspective, moving digital exclusion to digital inclusion and addressing digital poverty

We will develop a digital delivery plan through 2024/25 that will outline our approach and those areas of identified focus.

8.3.8 Research and Evaluation

The principles of research and innovation (R&I) will be embedded within the Collaborative, evaluating the transformational change. This will support us to understand and demonstrate the Collaborative's impact, against the agreed metrics and across a range of balancing and other measures. It will also support our workforce, contributing to job satisfaction, enhancing skills, and recruitment and retention.

We will do this through existing research capacity within the Collaborative's membership, and through collaboration with the University of Birmingham, Aston University, and wider population health analytics in the BSol system.

The Collaborative's research and innovation programme will be:

- **Focused on our communities** – knowing our communities and their needs in relation to research and innovation; ensuring R&I is accessible and meaningful to our communities; supporting support our communities to participate in all aspects of research and innovation.
- **Driven by a confident and capable workforce** – ensuring that R&I is accessible and meaningful to our workforce, embedding R&I in workforce strategies, supporting a culture of continuous improvement
- **Collaborative and coordinated** – working together to facilitate R&I, and ensure collaboration, coordination and communication in R&I
- **Embedded in everything we do** – our work programmes and services will incorporate research and innovation into their design, planning and delivery.

9. Governance and assurance

9.1 Governance

Our governance continues to develop as the Collaborative matures, and since the SOC was approved the structure has responded to need and evolved. As shown in the diagram below, the Collaborative is accountable to the ICB through the BCHC Trust Board and the BCHC Community Care Collaborative Committee (chaired by BCHC Chair Prof David Sallah). The Collaborative Steering Group (chaired by BCHC CEO Richard Kirby) is the governing body for the Community Care Collaborative, and is well-established, with members from all partners in the Collaborative. The Steering Group is supported by the Collaborative Executive Group and the Collaborative Professional Advisory Group.

The Collaborative is represented at both Place Committees to ensure their close alignment and reports regularly to the Place Committees in Birmingham and Solihull as well as the GP Partnership Board.

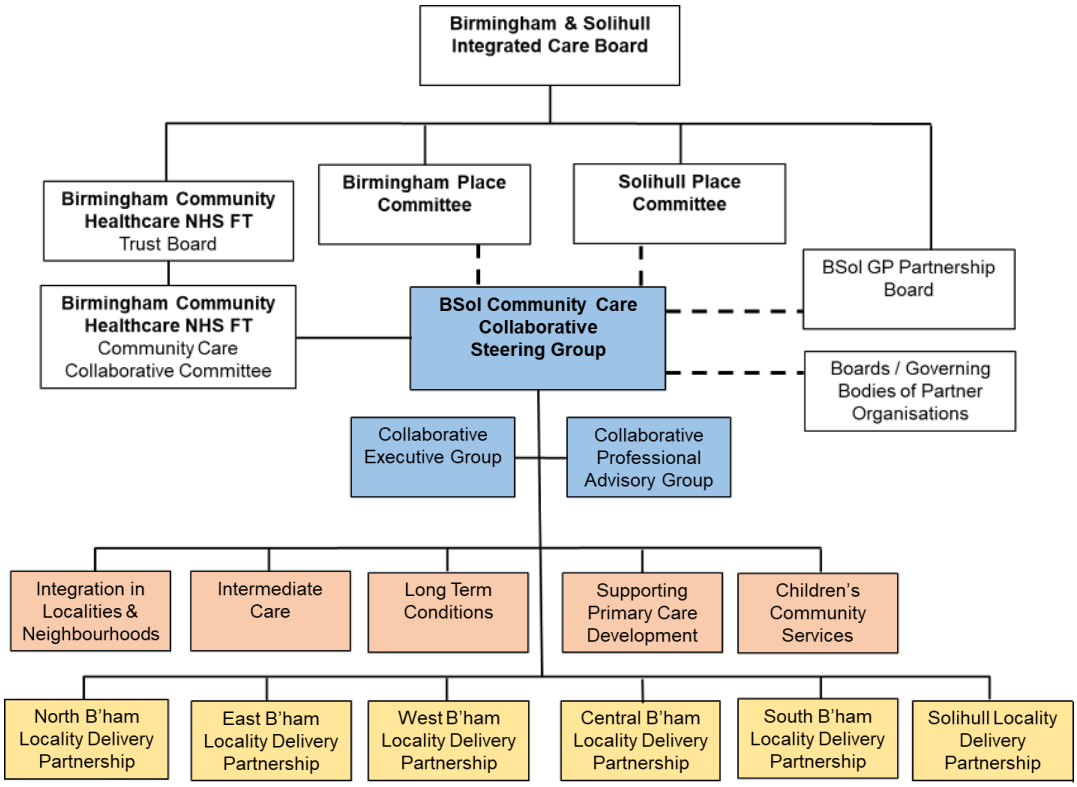


Figure 15 – Collaborative Governance Framework June 2024

The above diagram shows how the Collaborative works through

- **Locality Delivery Partnerships** – to deliver the Collaborative's commitment to integrated care through Localities, taking into account local population demographics (see section 6)
- **System work programmes** – system-wide design groups leading work on new models of integrated care and the redesign of care pathways (see section 5)

- **Collaborative-wide groups** - To agree the priorities and plans for the Collaborative, to hold programmes to account, to provide assurance to the ICB.

The Locality Delivery Partnerships are accountable to the Collaborative Steering Group and responsible to the Birmingham and Solihull Place Committees. The Place Committees may choose to delegate responsibilities to the LDPs and will want to ensure that local priorities are reflected in the LDPs Annual Delivery Plans and are being delivered.

As described earlier in this Plan, not all of the work programmes and not all the LDPs are 'live'; they will report into the Collaborative Steering Group and Place Committees once established.

As detailed in section 5.4, there is a separate Case for Change which proposes that the GP PSU is transferred to BCHC. If this is approved, it is likely that a Joint Committee would be established, with delegated functions of decision-making powers in respect of the ICB and BCHC. This would enable collective decisions in a more streamlined and efficient manner, as there will areas of joint concern given contracting and commissioning functions for primary medical care would remain with the ICB.

As the work programmes develop, there will be appropriate governance implemented to oversee the delivery. Given the interdependencies, it is proposed to have appropriate governance in place which aligns work programmes 1 and 2 around the development of the locality operating model. This is represented in Appendix 4. Further, relationships between the Collaborative and other Collaboratives will need to be considered to promote cross-collaborative working and identify interdependencies.

We also recognise that the Community Care Collaborative has important links to other system-wide work programmes. These include the system-wide Urgent & Emergency Care Board. The Collaborative's intermediate care work programme makes an important contribution to our system-wide urgent and emergency care pathway improvement as well as to the delivery of our Collaborative locality operating model.

9.2 Risk Management

In a complex system, with multiple partners and cross-cutting programmes of work, we need to be clear where and how risks are identified, owned and managed, and how assurance is given to the Steering Group and ultimately to BCHC Trust Board, which is accountable for the delivery of the Collaborative's work. Effective risk management will support the Collaborative and the partners to deliver the plans set out in this document, and to minimise the risk of harm to patients, citizens and our organisations[25].

[25] Provider Collaboration: A practical guide to lawful, well-governed collaboratives (nhsproviders.org)

There are a variety of ‘types’ of risks for the Collaborative. These include service-related risks both regarding transformation (e.g. identification of suitable estate for new services) and once services are up and running (for example the risk of partners moving staff away from INTs to staff other areas). It also includes broader risks such as inadequate resourcing of the Collaborative overall.

The principles of risk management that the Collaborative will work to are

- Any risk to the Collaborative, or to the delivery of programmes of work covered by the Collaborative, should be visible (at the appropriate level) through the governance structures shown above
- The Steering Group and Collaborative Committee will see significant risks and these will be held on BCHC’s risk management tool Datix
- The Steering Group, the Collaborative Committee, and BCHC Board will seek assurance that they are aware of the key risks, and that these are being appropriately managed.
- Lower-level risks will be held on project/LDP risk and issues logs, and/or managed through local organisations’ existing structures and reporting mechanisms
- Individual organisations/services, LDPs, or work programmes will own and manage the risks, as appropriate.

The Collaborative will frequently review the effectiveness of the risk management arrangements during 2024/25. As the arrangements become embedded and established, the frequency of review will reduce.

9.3 Role of Birmingham and Solihull Local Authorities

As shown in section 4.2, council-funded services are not currently in scope for inclusion in the lead provider portfolio for the Collaborative.

There may however be some elements of the Collaborative’s work programmes that are funded through the Better Care Funds in Birmingham and Solihull, which will require approval from Local Authority partners. This is identified in section 8.1 as a potential risk if there are differences in funding arrangements in the two Places within the Birmingham and Solihull Integrated Care System.

Both local Authorities are key partners in the work of the Collaborative, and commit to support the implementation and operation of the Birmingham and Solihull Community Care Collaborative:

- To work in partnership with Collaborative member organisations with the aim of improving services delivered by individual organisations within the partnership, or jointly as organisations working together.
- To provide appropriate representation at the relevant Collaborative forums and participate as per the Terms of Reference of those forums (e.g. Steering Group, Locality Delivery Partnership).

9.4 Quality

As the Collaborative takes on greater responsibility for the delivery of services, ensuring that these services are safe and of high quality will be essential. The Collaborative will establish a quality management system that incorporates quality planning, quality control, quality improvement and quality assurance. These elements are shown in Figure 16 below

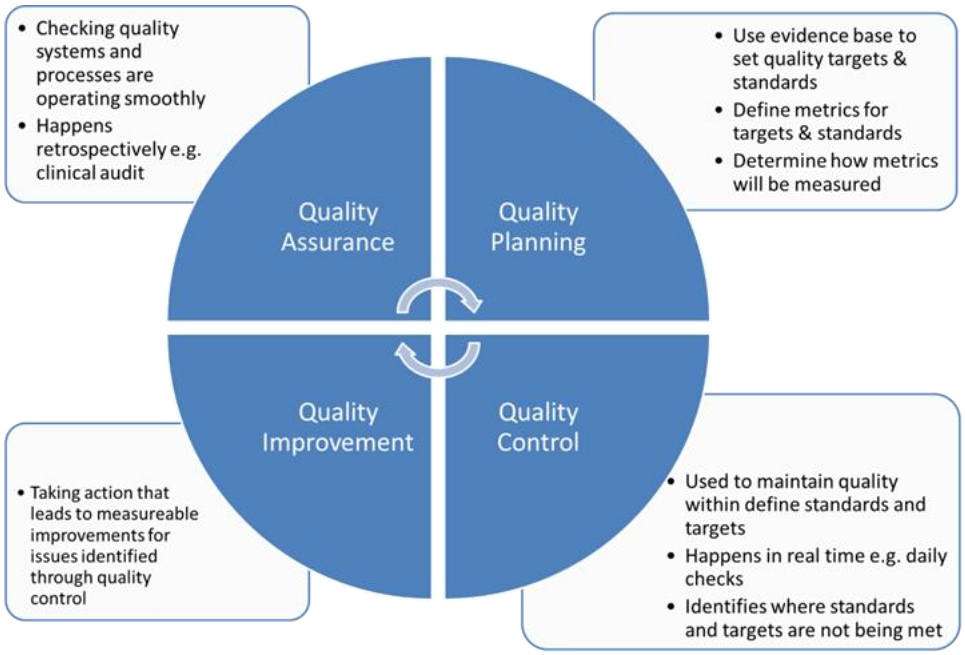


Figure 16: Quality Approach

Initially, the quality management system will be included as part of the existing BCHC governance framework. This will incorporate BCHC's Patient Experience team, and connection of the service-user's voice in the quality system including via the complaints system. The use of BCHC's existing framework is largely for pragmatic reasons and as we anticipate that there will be minimal additional resource transferred to the Collaborative to undertake quality management. As the Collaborative matures and takes on additional responsibilities, it may be necessary to establish management systems for a range of quality and corporate functions for the Collaborative itself.

9.4.1 Quality Improvement

BCHC has established itself as a leader in Quality Improvement (QI) across the local health system so is well placed to embed quality improvement as part of the culture of those whose work is linked to the Collaborative. Literature highlights positive associations between good improvement cultures and the experiences of both people accessing services and those who provide services. The Collaborative will establish systems and processes to ensure information is available to frontline teams (see section 8.3.7) so that they can identify where improvement is needed in quality or productivity, where there are inequalities in care provision and to equip those working within the Collaborative to have the skills and knowledge about improvement

science tools to be able to improve the quality and productivity of service delivery to address the holistic needs of local people in neighbourhoods, localities and places.

Recognising that continuous improvement approaches will vary across sectors and methodologies are similar but not the same, the Collaborative will adopt the key principles of the NHS Impact[26] approach, which are recognised as good evidence-based practice.

1. **Building a shared purpose and vision** which are widely spread and guide all improvement effort.
2. **Investing in people and culture** and building an improvement focused culture.
3. **Developing leadership behaviours** - Leaders at every level who understand improvement and practise it in their daily work.
4. **Building improvement capability and capacity** - The consistent use of an appropriate suite of improvement methods and tools.
5. **Embedding improvement into management systems and processes** so that it becomes the way in which we lead and run our organisations and systems.

As the Collaborative is a diverse and varied group of organisations and sectors, through 2024/25 we will develop and agree our shared approach to quality improvement. This will encompass how we

- Establish and start to embed the agreed improvement model across the Collaborative
- Embed the citizen and service user voice in the quality improvement approach including identification of areas for improvement
- Invest in and support the development of QI capability and capacity (tools and approaches) and how the QI resource is used across organisations and sectors
- Build in local initiatives where teams highlight areas for improvement to resolve local issues (e.g. QI Huddles)
- Apply QI tools and improvement science thinking to the major projects within the five Collaborative work programmes
- Ensure the improvement is data-driven and evidence-based
- Create a community of practice and associates' model that enables us to more successfully share and deploy resources across the system
- Role model the right behaviours whilst sharing and learning from each other the impact of our efforts.

10. Conclusion

The Community Care Collaborative, working together to connect and coordinate services around our citizens and neighbourhoods, gives us a real opportunity to improve outcomes for citizens and patients. We will do this via our five work programmes, and through our six Locality Delivery Partnerships.

[26] NHS England » NHS IMPACT

As noted in section 2, improved integration has been shown elsewhere to reduce the burden of non-elective work in acute trusts, and improve care and outcomes, although sustained changes may not be apparent for several years. Across a number of areas, early evidence of the impact of improved integration can be demonstrated, leading to longer-term fall in mortality and morbidity rates.

As demonstrated throughout this Implementation Plan, realising the potential benefits and changing the way that services are set up and delivered will necessitate a shift in resources and focus. In the main we will transform our services through a realignment of existing resources. However, it should be recognised that there is also a need to fund the Collaborative's infrastructure if we want to make meaningful, lasting, and efficient change. For example, investment in

- Communications resource – to work with our staff and communities so that they understand how and why we are working differently
- Experts by experience – to bring meaningful and inclusive voices to the Collaborative and its programmes of work,
- Digital, information, information governance experts and technology, to enable integration and visibility of data and information at the appropriate level, to inform service design, and delivery of connected direct patient care
- Locality managers, to facilitate the emerging LDPs and see them develop as the delivery arm of the Collaborative.

This Implementation Plan has laid out the intentions for the Collaborative over the next three years, and how we will deliver these plans in a well-managed and planned way. We fully anticipate that the Collaborative and its work programmes will need to change, adapt, and be flexible given the political and economic context in which we are working. The governance processes laid out in section 9 will ensure that any decisions are made openly and according to the principles of the Collaborative laid out in the SOC.

Our partnership is committed to making our services **Connected** and **Accessible**, so that people have access to and can navigate our health and care services; to providing more **Responsive** and proactive care, and to **Empowering** our communities, and helping everyone to live a healthy, happy life. Working as needed at system, Place, Locality and Neighbourhood level, in a 'system-designed, locality-delivered' model, will enable us to localise services and address health inequalities, within a framework set by the Collaborative.

We believe that the Birmingham and Solihull Community Care Collaborative provides a historic opportunity to better meet the diverse needs of all communities across our Integrated Care System and we are all fully committed to ensure that, as the Collaborative, we play our part in realising the vision for the 'people of Birmingham and Solihull to live longer, healthier and happier lives'.

Appendix 1 – C.A.R.E Approach

Our C.A.R.E. approach (see boxes below for more details) includes being better able to identify and take action to address inequalities in the provision of existing services in terms of access, experience and outcomes for the people of Birmingham and Solihull. We will also be able to make better use of our collective resources, both financial and our workforce, by working in more integrated and innovative ways involving all partners in our Community Care Collaborative – the NHS, Local Authorities, Voluntary, Community, Faith and Social Enterprise sectors.

The Community Care Collaborative will be CONNECTED – working better together in local places

As a Community Care Collaborative, we will work together to ensure the NHS, Local Authorities and voluntary, community, faith and social enterprise (VCFSE) organisations understand and are better able to meet the needs of local people.

We will work together to make it easier for all people to understand and navigate health and care services, removing barriers between different services and service providers to make care person-centred and as connected as possible.

We will make greater use of digital technology to share information, including enhancing Personalised Care and Support Planning, enabling people to join in conversations about their health and well-being and shape their care and support. With appropriate safeguards and consent, everyone involved in providing care will know what people need and want and involve people in making decisions about their care. This will prevent people having to repeat information about themselves and remove duplication – and potential gaps – between care providers. We will adopt the Shared Care Record as the digital tool to provide better joined-up visibility of digital care plans.

We will work together to co-locate services where possible and appropriate, to provide the best connected care. We will adopt a 'think prevention' approach and will work together effectively to enable this.

The Community Care Collaborative will be ACCESSIBLE - helping everyone to more easily access the care they need, when and where they need it

As a Community Care Collaborative, we will make it simpler for everyone to access the information and services they need, when they need it and where they need it.

Prevention

Our 'think prevention' approach will mean that information and advice is accessible in a co-ordinated and joined up way.

When people need care quickly but don't need to go to hospital – we will make it easier for people to get the care they need by developing an integrated urgent community care model across primary care, community care and social care. This could include a same day appointment at an Integrated Care Hub , a visit to a person's home from our Urgent Community Response service, a short stay in one of our community intermediate care centres or additional monitoring and support on a 'virtual ward'.

When people have longer-term or more complex needs – we will provide more proactive, responsive and personalised care with support from interdisciplinary teams of care professionals (see Responsive)

When people have been in hospital and need additional support – we will work with each person, based on their individual needs and circumstances, to better support them to go home through a service like our virtual wards and our Early Intervention Community Teams, or to have further treatment in one of our community intermediate care centres

The Community Care Collaborative will be RESPONSIVE - providing more proactive, personalised care

As a Community Care Collaborative, we will provide more **proactive**, personalised care with support from multi-disciplinary and multi-organisational teams of care professionals. Our Integrated Teams and multi-organisational teams working within Neighbourhoods / Localities / Places will be able to make better use of information, through shared care records and by working closely together, to identify those people most at risk of deteriorating health and wellbeing, enabling teams to take earlier, preventative action to support people with the appropriate help and care

Where possible, the health and care professionals working in these teams will be physically based together, making it as easy as possible for them to work together, across professional disciplines and organisations to feel like one team – a 'team of teams'

We will expand the use of home-based technologies to support people to better manage their condition(s) from the comfort of their own home. While this won't suit everyone, where people want to be trained to use technology to support their care we will make it accessible to them.

The Community Care Collaborative will be EMPOWERING - helping everyone to live a healthy, happy life

As a Community Care Collaborative, we will work together in local communities to develop and make it easier to find, and get access to better information about living a healthy, happy life, including how to get advice on other important services like employment, housing and benefits. We will focus on the 'Big 5' causes of the gap in life expectancy between those living in the least deprived areas and the most deprived areas:

- Circulatory Disease, including heart disease and diabetes

- Infant Mortality
- Respiratory Disease, including asthma
- Cancer
- Mental Health, including addressing social isolation and loneliness

We will prioritise prevention, and make it easier for people to find out what activities are available in their local area and how to access these. This may be through a physical building also known as a ‘hub’ and also information available online. We will also provide support to help people work out what you need through the Neighbourhood Networks Scheme in Birmingham and similar in Solihull, Social Prescribers, Care Connectors, Early Help and other existing mechanisms to connect people and their families to the support they want.

We will expand the 'Healthy Schools' programme, including the 'health hack' model developed in Ladywood & Perry Barr to provide children, young people and their families with information about specific topics. We will also look to expand the 'community researchers' programme giving young people opportunities and experience.

We will engage and involve citizen representatives and Experts by Experience in every decision-making group, at all levels of our Collaborative. Through our VCFSE partners, we will actively engage with all local communities, with a particular focus on the marginalised, minoritized and so-called ‘seldom heard’, to ensure we are working on the issues that matter most to local people. We will work together with our super-diverse communities across Birmingham and Solihull to co-produce services that most effectively meet local needs.

Appendix 2 – Collaborative Outcomes – Evidence Base

High-intensity service users

Several programmes have been implemented and evaluated elsewhere to work with this population[27]. These service users often have a range of complaints including social issues, mental health, loneliness, addiction, complex medical presentations, or a combination of any of these factors. Through the multi-agency support programmes, a reduction in ED attendances of up to 59% and up to 67% reduction in admissions has been demonstrated, with associated financial savings.

Virtual wards

The current virtual ward (VW) provision across Birmingham provides predominantly step-down care for respiratory and frailty and is relatively new in its implementation. The service is under review, but with a recognition that the occupancy for the respiratory ward is low. However, despite Birmingham having not yet seen a significant impact, a recently published evaluation of more mature services across the South-East of England[28] analysing data from 22,000 admissions suggest that VWs can achieve a 1:1 association between the 'avoided' non-elective admissions and VW activity, with a strong return on investment. Providing a stronger virtual ward model will particularly support those with long-term conditions (LTCs); we would expect to see impact on improved patient experience, and overall reduction in overall healthcare use, including acute hospital care.

Long Terms Conditions

Cardiovascular disease (CVD) secondary prevention

The prevalence of hypertension in Bsol is much lower than the national average (c12.5% v 15%) which, given the demographics suggests under-reporting - 86% of GP-registered patients over the age of 45 have had a blood pressure reading in the last five years. This is why we expect to see increased identification of disease through the Collaborative's work. In terms of outcomes, only 65% of under 80's have a lower blood pressure than recommended. Diabetes prevalence is higher than the national average, only two-thirds are receiving optimal therapy with acceptable control achieved in only one-third of Type 1 diabetics.

Measurable improvement in blood pressure and diabetes will be through a combination of identification, and then optimal management. Much of this will be GP-led and through contractual mechanisms, however the evidence does suggest that the wider input from integrated care systems will also provide benefit by reducing blood pressure, HbA1C levels and subsequently hospital admission**Error! Bookmark not defined.**. With improved care, diabetic ketoacidosis (DKA) and hypoglycaemia should reduce. Whilst it will be outside the scope of the Collaborative in the short-term, such secondary prevention should correlate with longer-term reduction in CVD and its associated mortality and morbidity.

Respiratory disease

[27] Sillero-Rejon C et al. Supporting High impact useRs in Emergency Departments (SHarED) quality improvement: a mixed method evaluation. *BMJ Open Qual.* 2023 Dec 19;12(4); Teams working with high intensity users of health services in BSW report positive results - BSW Together

[28] Summary of South East region virtual wards evaluation. NHS England. 16th May 2024

The NHS Right Care pathway for COPD sets out the necessary components for early identification, diagnosis and optimal management. QOF data suggests our population has a relatively low rate of COPD, which may represent under-recognition. With increased access to place-based diagnostics (spirometry etc.) there should be an initial increase in recorded prevalence. Improving access to pulmonary rehabilitation, in addition to broader measures such as medicines optimisation, discharge bundles, improved self-management and personalised reviews would be anticipated to reduce system performance metrics, but equally important will be to identify patient related experience measures that are not widely captured at present.

Smoking cessation
An important risk factor for both CVD and respiratory disease is smoking. Whilst recent legislation seeks to prevent people form starting, this will not impact on long-term outcomes for many years. Approximately 15% of the BSol population smokes. Dedicated smoking cessation programmes have been demonstrated to reduce hospital admission and 1-year mortality rates compared to controls[29]. Whilst the evidence is primarily related to programmes commenced in hospital, there is no reason these pathways cannot be extended to the community. With the data available we should be able to measure an overall reduction in smoking prevalence, and (together with other Collaborative measures) early reduction in admission/readmission for respiratory related diseases.

Wound care
The National Wound Care Strategy Programme (NWCSP) has been commissioned by NHS England to improve the care of pressure ulcers, lower limb wounds and surgical wounds. In England, there is considerable variation in leg ulcer practice and outcomes which increases care costs and extends healing times. This unwarranted variation offers major opportunities to improve healing rates and reduce recurrence rates and thus reduce individual suffering, spend on inappropriate and ineffective treatments and the amount of clinical time spent on care.

There are an estimated 739,000 leg ulcers in England with estimated associated healthcare costs of £3.1 billion per year, placing a significant burden on NHS services. There is robust evidence that demonstrates that ensuring equitable and accessible services for people with leg ulcers would reduce unwarranted variation of care, increase the use of evidence-based care and discourage the over-use of therapies for which there is insufficient evidence, resulting in higher healing rates and lower recurrence rates.

Locality based specialist lower limb clinic would provide centres of expert clinical assessment and treatment with better use of prescribing resources and efficient use of clinical time. It is anticipated that a standardised approach would improve healing rates and this could be readily demonstrated through measurable outcomes.

Health inequalities and wider impacts

[29] Mullen KA, et al. Effectiveness of a hospital-initiated smoking cessation programme: 2-year health and healthcare outcomes. *Tob Control*. 2017 May; 26(3): 293-299

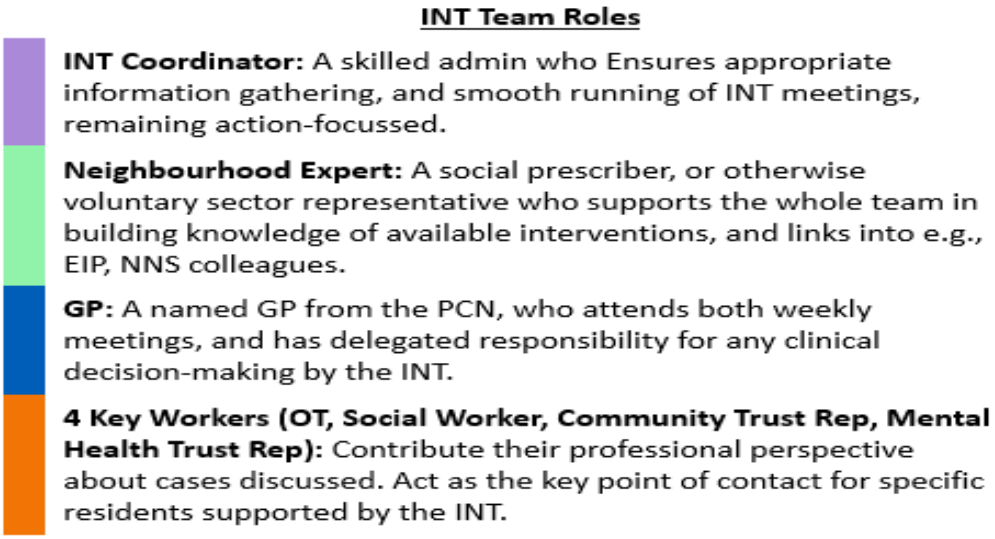
It will be vital that the Collaborative acts to reduce health inequalities, addressing the Core20PLUS5 principles. In terms of the five programmes for accelerated work, the Collaborative will be vital as part of the hypertension and chronic respiratory disease pathway improvement (previously described), but also for increased cancer screening uptake. BSol has some of the lowest screening coverage within England:

Indicator	Period	Birmingham and Solihull ICB - QHL			NHS regions (since ICB setup) England	England		England	
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Proportion of GP registered populations by age group (65+ yrs)	2023	→	217,557	13.6%	18.5%	17.7%	9.3%		25.0%
Deprivation score (IMD 2019)	2019	–	-	-	-	21.7	-	*Insufficient number of values for a spine chart*	-
New cancer cases (Crude incidence rate)	2021/22	–	-	418	-	540	320		716
Breast screening coverage: aged 53 to 70 years old	2022/23	–	81,025	59.4%	67.2%*	66.6%	51.0%		75.7%
Cervical screening coverage: aged 25 to 49 years old	2022/23	↓	167,529	60.8%	67.6%*	67.0%	55.3%		73.5%
Cervical screening coverage, aged 50 to 64 years old	2022/23	↓	85,989	72.2%	75.4%*	74.9%	68.7%		78.1%
Bowel cancer screening coverage: aged 60 to 74 years old	2022/23	↑	123,285	64.8%	71.8%*	72.0%	61.0%		76.5%

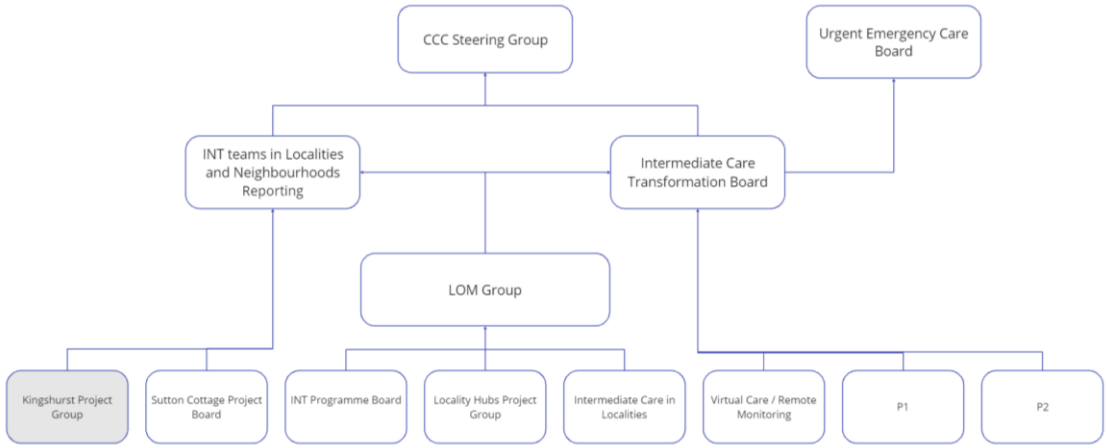
Following recent pilots using “Community Health and Well-being Workers” in London**Error! Bookmark not defined.** cancer screening and NHS Health Checks was 82% higher than previously matched time period. Without necessarily replicating this exact model, it is a proof of concept for better in-reach to underserved communities, using local population understanding and data. In addition to measuring cancer screening coverage, immunisation uptake was also increased by 47%. It is through these surrogate measures that one could assess the impact of the work at integrated and primary care level.

Using a data-driven approach, and targeted action, neighbourhood and Locality teams will identify and address health inequalities. Working well with our communities should identify underserved populations and reduce health inequalities measured through surrogate markers.

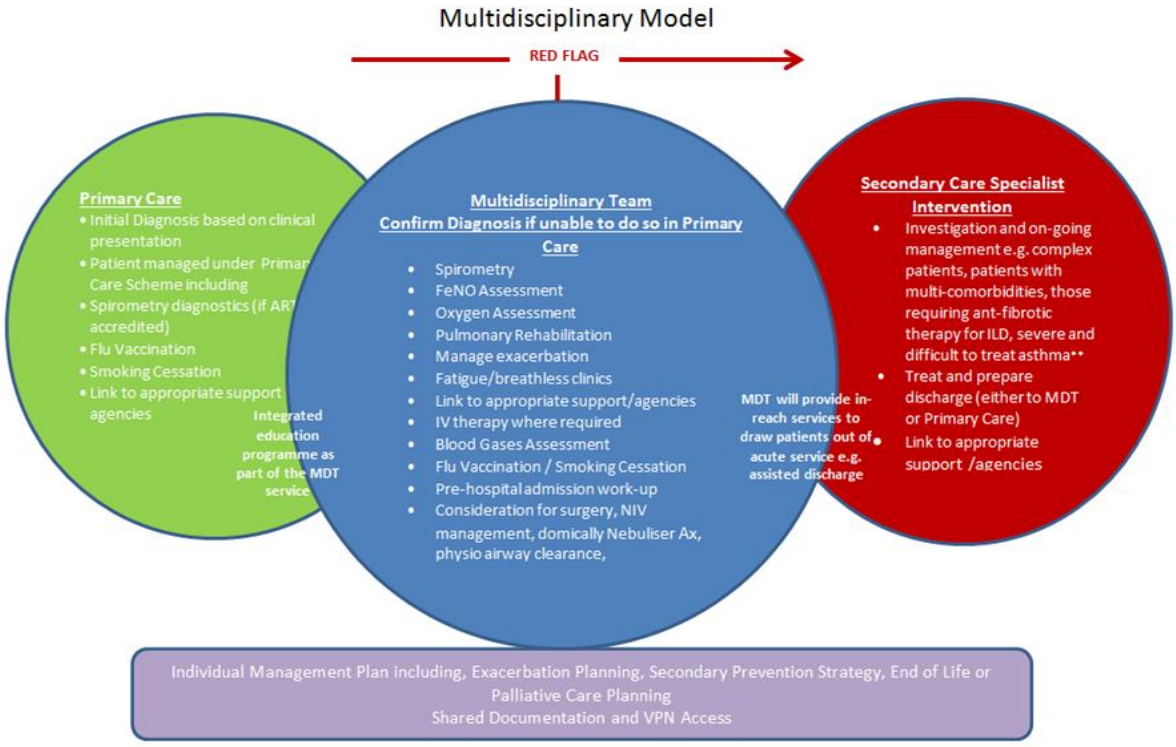
Appendix 3 – Integrated Neighbourhood Team Roles



Appendix 4 – Governance for Locality Operating Model



Appendix 5 –Respiratory Multidisciplinary Model



**https://www.brit-thoracic.org.uk/document-library/clinical-information/specialist-referral/bts-statement-on-criteria-for-specialist-referral/