Birmingham and Solihull
Integrated Care System
Caring about healthier lives

Developing the Birmingham and Solihull Community Care Collaborative

Overview of Implementation Plan for Partners

June 2024

Birmingham and Solihull Integrated Care System
Caring about healthier lives

Community Care Collaborative on a page

Community Care Collaborative

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

The Strategic Outline Case (SOC) was approved by the ICB in November 2023. This laid out the vision, the C.A.R.E. approach and the five work programmes for the Collaborative, which are shown in this infographic.

Birmingham and Solihull Integrated Care System
Caring about healthier lives

www.birminghamsolihullics.org.uk

Benefits and outcomes of the Collaborative

Work Programme	2024/25 Key Metrics
Integrated Teams in Neighbourhoods & Localities	• Reduced GP attendances for HISUs • Reduced GP attendances for non-clinical issues e.g. lifestyle support • Reduced ED attendances and admissions for HISUs
Intermediate Care	• Reduced ED attendance, admissions and length of stay for intermediate care amenable conditions • Increased use of frailty virtual wards • 2h Urgent Community Response performance target • Increased uptake of ‘call before convey’

Long term conditions	• Increased identification of people with hypertension
	• Improved clinical outcomes –
	  ○ Increase in people supported to die in place of choice outside acute settings
	  ○ Reduction in smoking prevalence
	  ○ Treatment optimisation for high blood pressure and cholesterol within general practice
	  ○ Increased immunisation uptake for ‘flu and pneumonia
	• Improved system outcomes –
	  ○ reduced ED attendances, acute admissions and length of stay for COPD, asthma, cardiovascular disease and end of life care; Increased use of respiratory virtual wards

Supporting Primary Care Development	• Reduced attendance at Urgent Treatment Centres for wound care • Reduced follow-up attendances in general practices for wound care • Increase in proportion of self-referrals to other services

Collaborative Model of Care

The Collaborative model of care is based on our C.A.R.E. approach (Connected, Accessible, Responsive, Empowering)

1. Focus 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. (**Accessible**)
3. Developing pro-active, personalised care from multi-disciplinary and multi-organisational teams for people with complex needs including long-term conditions. (**Responsive**)
4. Strengthening our approach to community-based prevention and early intervention in ways that support people to stay well at home. (**Empowering**).
5. Bringing together intermediate care services to 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. (**Empowering**).

The work will be overseen by the Locality delivery Partnerships, through an agreed, system-designed, Locality Operating Model.

Locality Delivery Partnerships

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

The LDPs are bringing together providers of primary care, social care, community physical and mental healthcare, the voluntary, community, faith & social enterprise sector, and secondary care. They are at different stages of maturity across the BSol system.

The purpose of the LDPs 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, taking into account local population demographics.
- Have an outcome focus and encourage a preventative and proactive approach.
- Drive integration and quality improvement

The LDPs will focus first on integrating physical and mental health and care for adults. 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
- .

Locality Operating Model

The shift to more joined up care will be facilitated by the development of an all-age system Locality Operating Model (LOM), based on provision at the following levels:

- General Practice
- Neighbourhood
- Locality

It will include all system partners, to provide care closer to neighbourhoods and communities and support the move towards more localised coordination and decision making. The LOM will

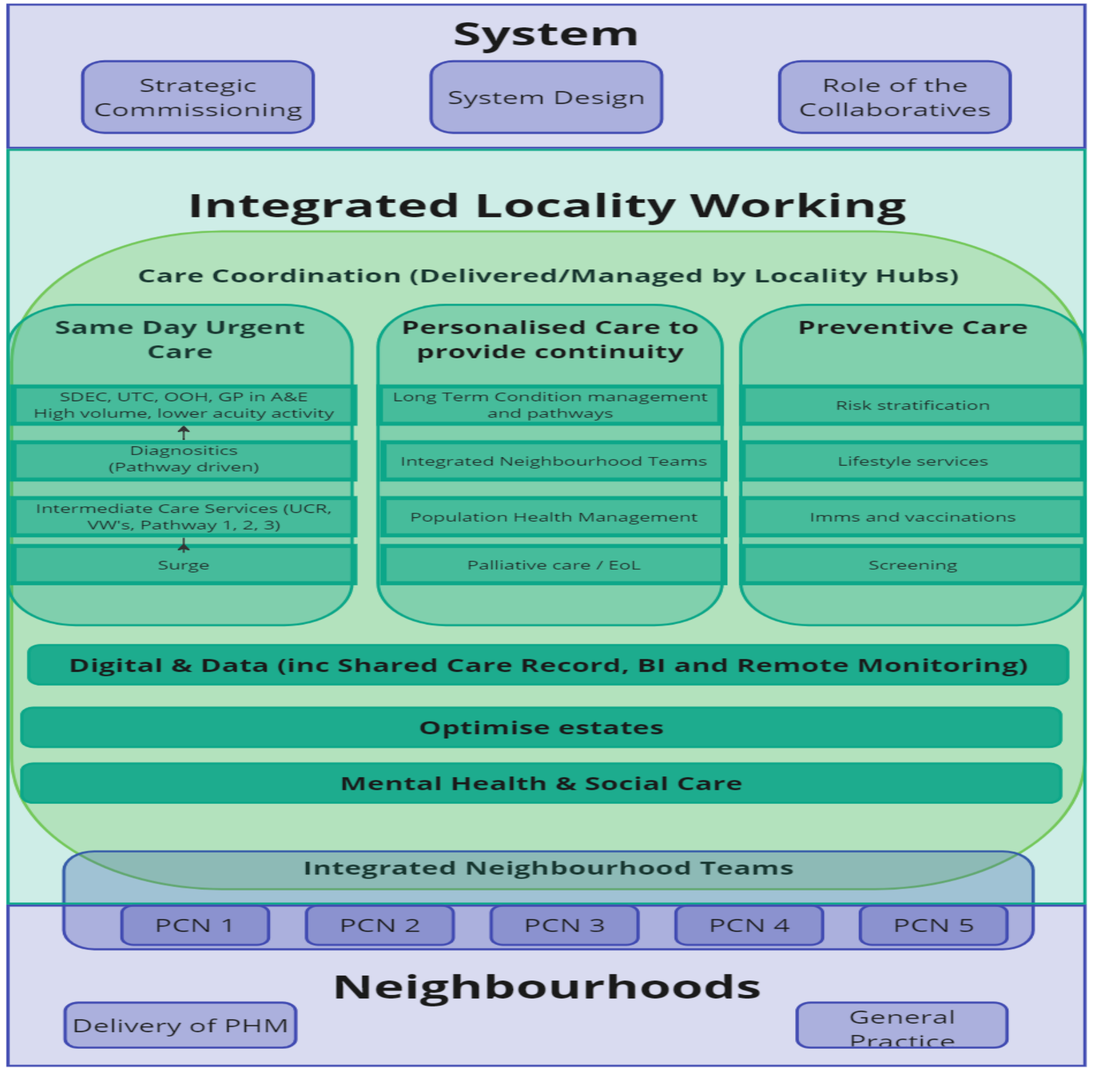
- deliver an offer for episodic or same day urgent care built around our neighbourhoods and localities as well as
- increase our capacity for continuity of care and prevention.

An emerging LOM has been developed with system partners (Figure 3) and it is anticipated that this will continue to develop.

Locality Hubs

A key feature of the Locality Operating Model is the locality hub, with one planned for each of the six localities. These will deliver

- a care coordination function,
- a physical location for locality based long term condition management,
- Same-day urgent treatment capacity for the Locality,
- the ability to mobilise surge capacity for the locality,
- a potential base to act as the locality 'HQ'.



Scope of the Community Care Collaborative

In Scope	Out of Scope*
• Integrated Teams in Neighbourhoods and Localities • Intermediate Care (NHS-funded) • Intermediate Care (council-funded • Urgent care bundle • Primary Medical Care development (GPPSU) • Adult Community Services • Long Term Conditions • Children's Community NHS 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

*Where services are included in 'out of scope' – 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).

Birmingham and Solihull Integrated Care System
Caring about healthier lives

ICB Community Services Portfolio Overview – Current State

	Localities and INT	Intermediate Care	Urgent Care	Supporting Primary Care	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 • 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 Better Care Fund	ICB Local Authorities Better Care Fund	ICB	ICB	ICB	ICB	ICB	ICB Joint commissioning Local Authorities
Providers	BCHC Primary Medical Care VCFSE	BCHC UHB VCFSE	BCHC Various Independent	ICB (currently)	BCHC VCFSE	 UHB VCFSE	BCHC UHB VCFSE	BCHC UHB VCFSE

Birmingham and Solihull Integrated Care System
Caring about healthier lives

Role of the Community Care Collaborative

The role of the Collaborative will evolve over time as the Collaborative matures and the Collaborative may take different approaches in different scenarios. These roles may vary dependent on where and how existing services are commissioned, the number of providers involved, and the benefits that a system-wide provider might bring.

	24/25	25/26	26/27
Localities and INTs			
Intermediate care: NHS services			
Intermediate care: council-commissioned services			
Urgent care	Subject to UTC review		
Primary Medical care development		(pending separate case for change) from Apr 25	
Adult community services (Bham)*			
Adult community services (Solihull)*			
LTC programme			
Children's community services**			To be decided

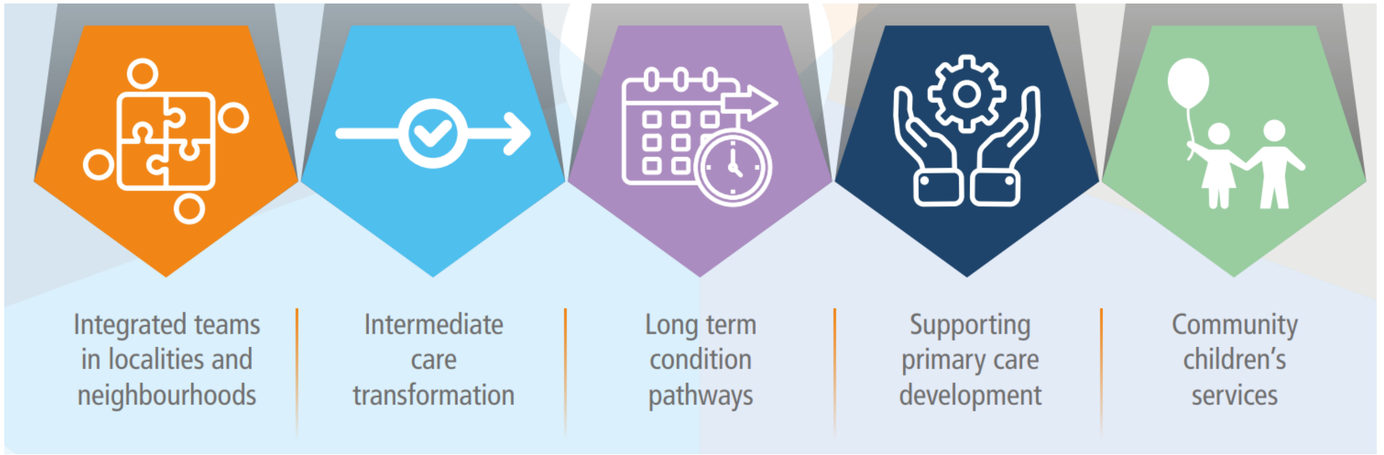
	Lead provider – responsible for services	Some or all functions and resources within scope of the Collaborative transfer to the lead organisation with resource channelled through the Lead or Sole Provider to deliver the functions required.
	Programme Enabler – oversight and coordination	The Collaborative 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

**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 CCC Steering Group.

What will the Community Care Collaborative do?

There are five programmes of work, which are at differing stages of development.



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	√		

Collaborative Delivery Plan for 2024/25

Development of the Collaborative	Integrated Teams in Neighbourhoods and Localities	Intermediate Care	Long Term Conditions	Supporting Primary Care Development	Children's Community Services
• Develop, agree and implement Quality Improvement approach • Models for VCFSE, citizens and Experts by Experience (EbE) involvement designed and implemented • Develop workforce, digital and estates delivery plans • Develop Locality Operating Model dashboard • Establish LDPs in all localities • Embed robust governance and risk management approaches across the Collaborative	• Sustainable, integrated digital solution in place for ongoing identification of INT caseload(s). • Locality hub 'case for change' agreed. • Integrated locality operating model tested and evaluated in one locality. • Digital and Estates enabling strategies agreed	• 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	• Establish BSOL Respiratory Board • Appoint BSOL clinical lead for respiratory. • Bring together existing respiratory programmes. Refine and test integrated community team model aligned to an acute hospital and its localities during winter 24/25. • Develop future community diagnostic model for BSOL. • Establish single respiratory clinical dashboard for BSOL. • Complete review of Pulmonary Rehabilitation and Home Oxygen services • Map currently commissioned and provided circulatory activity • Create a single set of system hypertension metrics to form part of system circulatory dashboard • Launch integrated EoL life OOH service across Bsol • Delivery on improved identification metrics • Develop Bsol EoL Dashboard • Set planning for Bsol system EoL Strategy • Web based platform launch	• 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	**SUBJECT TO FURTHER WORK ACROSS THE SYSTEM TO DETERMINE THE ROLE OF THE COMMUNITY CARE COLLABORATIVE**
Overarching Deliverables					
• Initiate a joint communications plan for staff and the public • Produce and implement a combined community and general practice winter plan					

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:

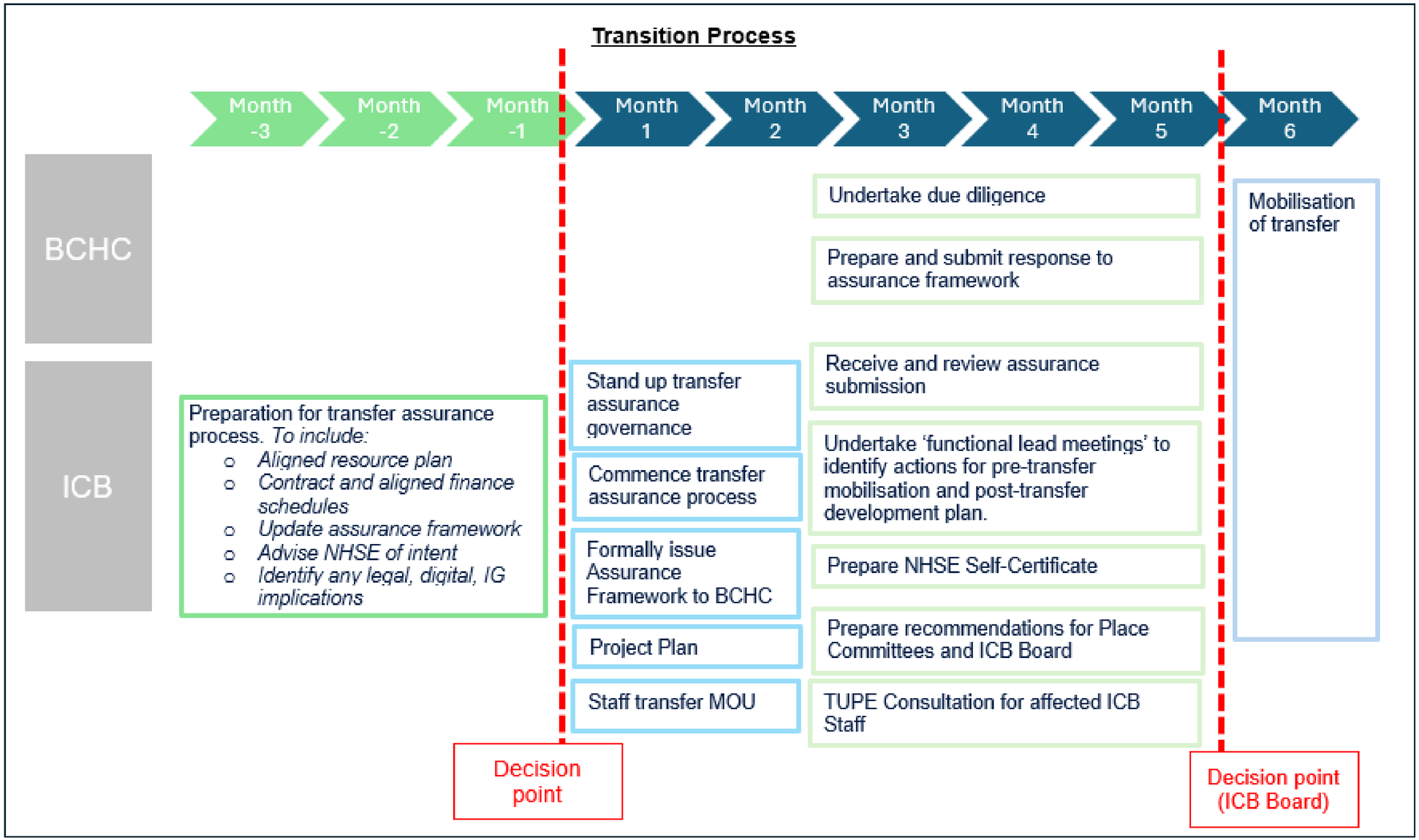
- **Delivery Team** - There has been some investment in the overarching architecture of the Collaborative, in recognition of the need to invest in resource to drive forward change and transformation. This provides sufficient capacity to make the progress that we aim to make in 2024/25.

- **Collaborative Infrastructure** – additional capacity in some key corporate areas will be crucial if we are to realise the potential benefits of the Collaborative. These include
  - Business Intelligence
  - Information Governance
  - Digital
  - Communications
  - Experts by Experience

- **Work Programmes** – though individual work programmes will be subject to business cases where appropriate, investment will be sought for
  - Locality Hubs – to recurrently fund the hubs
  - Integrated Neighbourhood Teams – to support new roles in rolling out the programme

Standard Process for Transfer of Commissioning Responsibilities from the ICB to Provider Collaboratives

In order for the lead organisation for the Collaborative (BCHC) to assume Lead Provider status, there will be a formal process followed as shown, led by the ICB. This will take a minimum of six months.



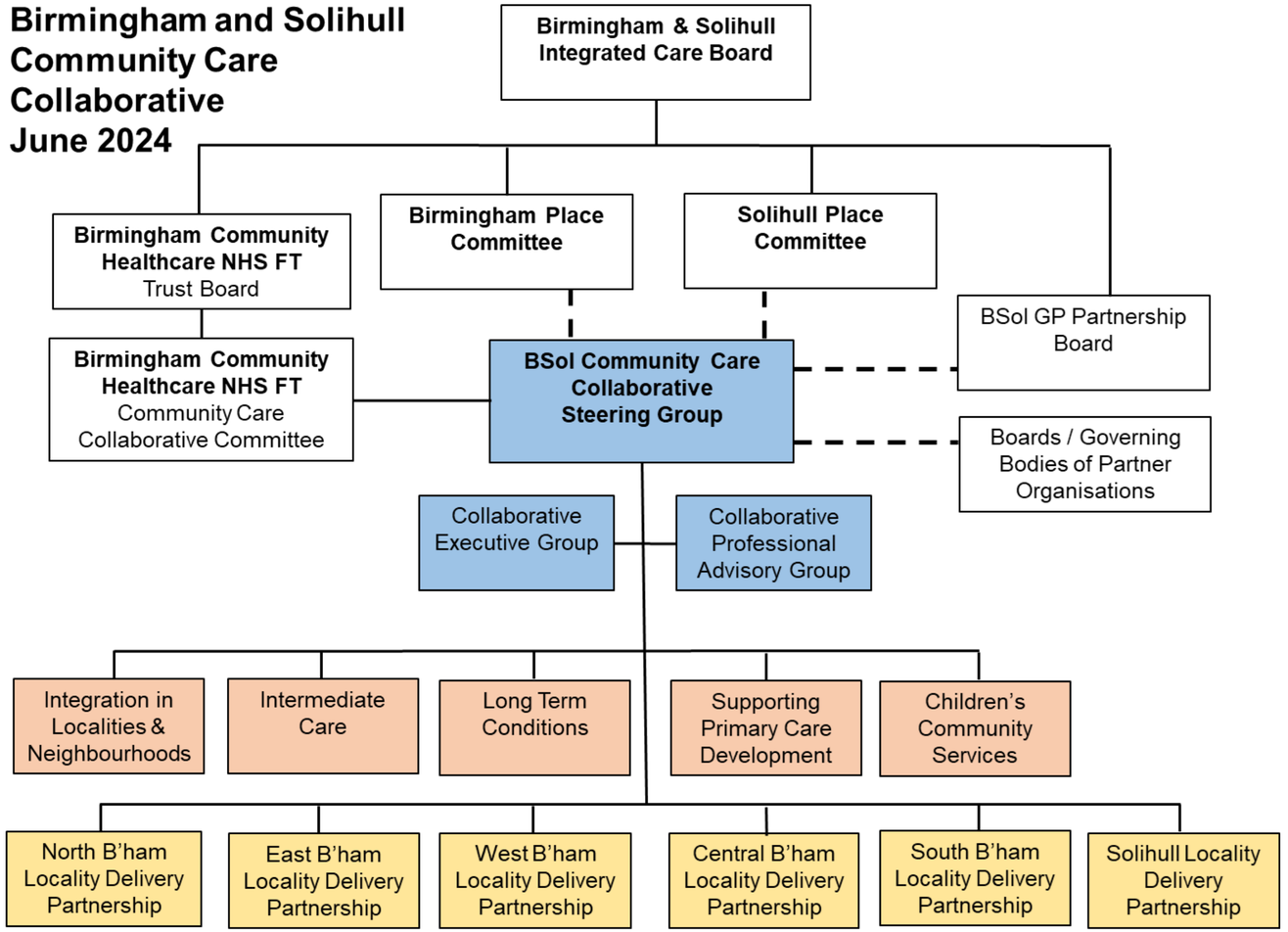
Governance of the Collaborative

The Collaborative Steering Group is the governing body for the Collaborative and provides assurance to the Integrated Care Board via the BCHC Community Care Collaborative Committee and BCHC Trust Board.

The Collaborative works in two ways:

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

The Collaborative reports regularly to the Place Committees in Birmingham and Solihull as well as the GP Partnership Board. The Collaborative is represented at both Place Committees
Locality Delivery Partnerships are accountable to the Collaborative and have a responsibility to the local Place Committee to have due regard for Place priorities



Next Steps

This Implementation Plan has been developed for submission to the ICB Board in July 2024 for approval.

All partners are asked to consider the Implementation Plan in June/July and to confirm endorsement by end July 2024.

For comments and feedback please email Suzanne.cleary@nhs.net or Pippa.Pollard@nhs.net