# OUTLINE BUSINESS CASE – 1.0.3

# ADULT SOCIAL CARE & HEALTH

## INTEGRATING TARGETED HEALTH & SOCIAL CARE SERVICES FOR OLDER PEOPLE

## Purpose

To demonstrate how through integrating targeted health and social care services for older people with external support opportunities to improve outcomes for citizens and the delivery of efficiencies can be maximised.

**Project Information and Approval**

| Name | Project/Organization Role | Signed | Date |
|---|---|---|---|
| Mark Lobban | Programme Director | | |
| Graeme Betts | Senior Responsible Officer | | |
| Margaret Ashton-Gray | Finance Representative | | |

**Outline Business Case - Version Control**

| Version | Date | Author | Change Description |
|---|---|---|---|
| 1.0.1 | 24/04/18 | Mark Lobban | In progress draft amended following Birmingham OP Partnership Group |
| 1.0.2 | 01/05/18 | Mark Lobban | In progress draft amended following Birmingham OP Partnership Group |
| 1.0.3 | 15/05/18 | Mark Lobban | Update draft for sign off at Birmingham OP Partnership Group |
| | | | |

## Contents

# 1. Management summary

Our current health and care services are organised in a complex and fragmented way hampered by organisational boundaries which is contributing to poor outcomes for the people of Birmingham. 'Sticking plasters' have been put in place to respond to operational pressures and there is an over reliance upon beds within the system. In addition we know that if demand continues to increase in line with projections, the health and care system will need a combined £712m to manage the increase in activity by 2020/21. This is the equivalent of an additional 430 hospital beds.

The Government's target date for health and social care to be integrated is 2020. This has been identified as a priority by Partners in Birmingham and a shared vision for how health and social care can be delivered at a locality level through a place based approach has been agreed.

In October 2017 Newton Europe were commissioned through the Better Care Fund to undertake a diagnostic evaluation of intermediate care services (a range of targeted interventions to promote faster recovery from illness or injury, prevent unnecessary hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living). This was the first time agreement by all Partners to a collective piece of work had been reached.

The diagnostic forms the basis of a compelling narrative of opportunity to deliver improved outcomes for the people of Birmingham and deliver system wide efficiencies. Currently:

- We admit too many people into an acute hospital bed who do not need acute hospital care and in the future between 2,900 to 3,500 more people will avoid such an admission by having a quickly responding multi-disciplinary approach.
- Some people remain in a hospital bed for longer than is necessary contributing to a loss of independence. In the future people will spend between 28,000 to 40,000 fewer days in hospital by improving assessments and promptly providing the right support.
- Some people have their long term needs assessed in hospital without the option of an assessment at home where they are more settled. In the future between 600 to 1,000 more people will live more independently by discharging them from hospital to assess their longer term needs in the community and providing the right support
- Some people remain in an enablement bed for longer than is necessary and in the future between 300 to 600 more people will live more independently or go home after a shorter stay from an enablement bed
- Some people do not have the opportunity to improve their independence at home and in the future between 2,300 to 4,000 more people will live more independently by receiving therapy led enablement in their own homes

Our vision is to provide an integrated approach to intermediate care services which is person and carer centred and encompasses physical, mental health and social care needs. An Older Person's Advice and Liaison Service (OPAL) will cover the following two areas:

- Crisis response to avoid unnecessary hospital admissions and include the delivery of traditionally acute clinical interventions for older people that can be safely delivered at home.

- enablement – home and/or community bed based interventions which aim to allow the person to remain at home and live as independently as possible. i.e. promote recovery, rehabilitation and re-ablement.

As far as possible individuals will remain at home, in most cases older people are more comfortable in their own homes and therefore recover and regain their independence more quickly if good quality therapeutic support can be provided – 'your own bed is best'. They will tell their story only once and have a single co-ordinated plan tailored to their needs and desired outcomes. They will know who to talk to for help during this time and will know who will be supporting them if they need ongoing support. They will be assessed by an appropriate clinician prior to any hospital admission and will not have to wait for the next stage of their enablement to be put into place.

Enablement will be designed to support people with complex needs including those with moving and handling issues and importantly people living with dementia. The approaches will link with paramedic and general practice services, both of whom have a key role to play.

The Partners believe that by making the above improvements through integrating intermediate care services at a locality level savings of between **£27.1m - £37.5m** per year are achievable. BCC and partner NHS organisations do not have readily available capacity of appropriate capability to manage such a large and complex programme and external support is needed. The expertise of the consultancy used during the review, and the way they worked with staff across the system, was a positive and successful experience; an experience which should be reproduced in any implementation.

If a transformation partner is not appointed then resource will need to be recruited externally with no guarantee that this is possible or that they would be able to maximise the savings opportunity in terms of both outcomes for citizens and savings. Each month of delay 'costs' approximately £3m of savings not achieved in 18/19 and 19/20.

In addition to delivering up to £37.5m savings per year the successful implementation of the early intervention transformation programme would result in thousands of older people avoiding hospital and living more independently.

# 2. Overview

## 2.1 Introduction

The experience of older people using our health and social care services has been reviewed through a number of different approaches and whilst there are positive examples for many people the experience for many others has not been positive. This has been demonstrated through the 'Phyllis' production which was attended by hundreds of staff, based upon the shared experience of real people and their families and staff themselves.

In addition, the diagnostic outlined within this business case identified examples of poor outcomes and experience for individuals an example of which is outlined below:

> Freda is 87. She lives independently at home, and despite having poor hearing and deteriorating eye sight, she lives without support. After a fall at home she was admitted to a hospital bed for treatment.
>
> After her treatment was complete, she was assessed for her ongoing care needs. The ward staff advised Freda and her family that an interim bed was needed, however the OT and social worker felt that she was coping well enough on the ward – she was up and about, taking herself to the toilet – that she could return to live in her own home.
>
> Freda's family could not be convinced by the OT and social worker that she could go home. As she had now been in for a while waiting for an EAB bed she was moved to another ward.
>
> Here, Freda lost confidence due to a change in setting, lost mobility due to a lengthy hospital stay and became upset as she wanted to go home but didn't want to disagree with her family. The OT team recognised this and tried again to get her home but once again the family refused.
>
> Freda now lives in a residential home.
>
> 'The moment 'residential care home' was mentioned, was the moment the family decided that's where she's going. I tried as hard as I could to get her home, it's where she wanted to be'.
>
> Occupational Therapist

The independent CQC review of the Birmingham system conducted in January 2018 confirmed our own diagnosis of fragmentation and 'sticking plasters'. They pulled out a series of key issues:

- Lack of a number of key foundations for effective partnership working in both commissioning and delivery including a comprehensive Joint Strategic Needs Assessment, a

framework for interagency collaboration and a system wide vision with accountabilities for delivery, a systematic approach for feedback from diverse populations and groups

- Fragmentation of services with individual organisational focus and priorities and as a consequence limited systematic focus on implementing such things as the Nationally recommended 8 High Impact Changes for improving delayed transfers of care.

- Staff who are demoralised and risk burn out

Birmingham has a complex and diverse health and social care economy. The city sits across two STP areas with c.80% of the population within the Birmingham and Solihull system and c.20% within the Black Country and West Birmingham footprint.

Of the approximately 146,000 older people in Birmingham, 142,000 live in the community and 4000 live in care homes. An estimated 14,000 older people receive a care package each year (short and long-term).

The specific focus of this business case is to outline the proposed approach to transformation of Birmingham's intermediate care services – those services supporting the recovery, rehabilitation and reablement of older people addressing their physical, mental health and social care needs. In the new framework for joint working between health and social care and the supporting locality model this is described as **'early intervention' (appendix a and b)**.

This proposal is a component of a strategy that supports the aspirations of Partners to improve care and support for older people. This strategic approach consists of:

- The assessment of 'gaps' identified in health and wellbeing, care and quality and finance as part of the NHS STP process **(appendix c).**

- The establishment of an Aging and Later Life priority and portfolio as part of the refresh of the Birmingham and Solihull STP – One Care Partnership **(appendix d).**

The business case includes a description of the current and proposed model in the specific area of intermediate care, but also specifically outlines the need for external support to facilitate timely delivery and maximise savings.

The evidence within this business case formed the basis of the information provided to the CQC prior to their review of the degree of integration of the Birmingham health and social care system for older people in January 2018. Their report was published on 14th May and has validated and further informed this evidence base.

## 2.2 Scope

The areas within scope are as follows:

- Intermediate care services (crisis response and home and bed based enabalement)
- How decisions are made and by whom within the intermediate care pathway e.g. in a hospital setting by clinicians and social workers etc.
- The systems, processes and procedures supporting these services to minimise delays in movement through the intermediate care pathway and deliver system flow.

## 2.3 Stakeholders

Staff who work in current services, their managers, union representatives

Organisations employing these staff and currently delivering services from their estate

People who need these services, their families and carers

Independent sector providers who currently provide beds

Independent sector providers who are exit pathways from these services

Community and voluntary sector groups who provide services supporting these approaches or as exit pathways

Voluntary sector organisations with a specific interest linked to this area

Academic institutions with an interest in research in this area

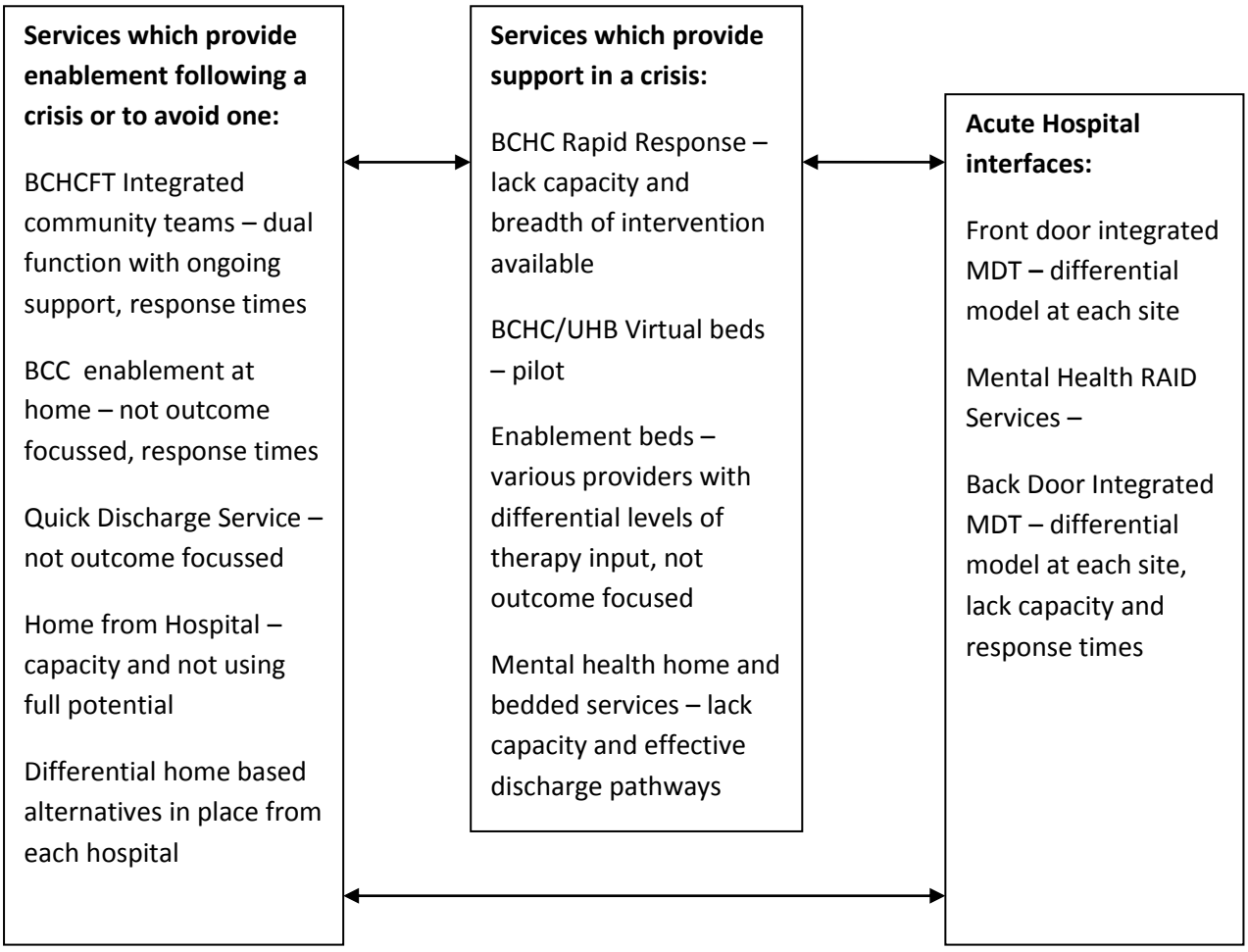
## 3. Current situation

The previous organisation of CCGs within the City had been a barrier to a single system approach. Positively, in November 2017 the two Birmingham CCGs (CrossCity and South Central) had their merger plans with Solihull CCG agreed with effect from 1st April 2018. The BSol CCG now has in place a new Chief Executive and Executive team.

West Birmingham forms part of the SWB CCG, which is part of the Black Country and West Birmingham STP. This CCG has associate membership of the BSol STP and has agreed a new co-ordinated approach for West Birmingham with the BSol CCG. This means that we now have a single system within the Birmingham City Council area.

The current situation of service configuration (this section 3) and case for change (section 4) are linked and overlap. This section outlines the way current services are organised and the consequences in terms of system 'characteristics.

Our current intermediate care services which are mainly but not exclusively used by older people are organised in a complex and fragmented way. Pathways through services are too often constrained by organisational boundaries and have been put in place as unilateral unco-ordinated 'sticking plasters' in response to a number of years of operational pressures within individual organisations. This has primarily resulted in an over reliance upon beds within the system.



Arguably we have many of the components of the system we propose to put in place but they each have reasons why they are not functioning optimally. In overall summary we have a system which is characterised in two ways:

- Poor experience and outcomes for people and their families
- Inefficiencies demonstrated by 'waits' within the current pathways of care

The challenges within each service were highlighted through the diagnostic review conducted by Newton Europe in November / December 2017 (see section 4 below).

A good example of these two issues being linked is that there are currently up to 13 assessments required for an older person in hospital who requires ongoing care before they are discharged. The average number of assessments each person receives is 10.

The key national indicators of an inefficient system are:

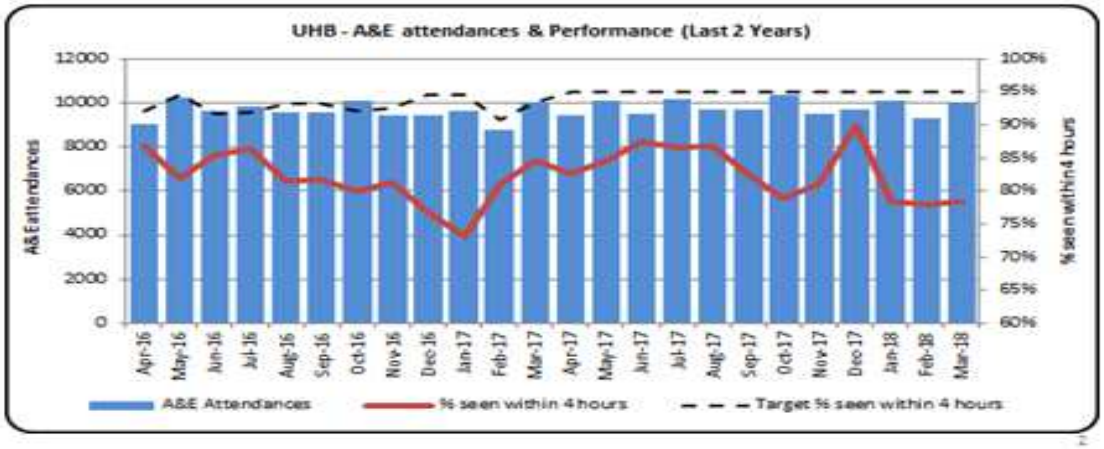
- A&E waiting times against a four hour target
- Health and social care delayed transfers of care

**Current Performance in A&E waiting times (to March 2018)**

## A&E Performance UHB

**UHB**

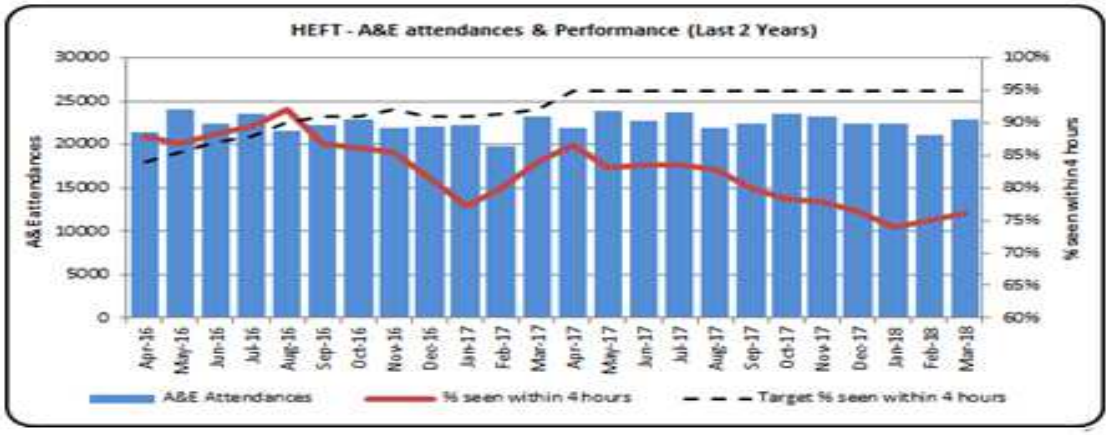
March 2018 4hr performance = 78.3 % compared to 84.6% March 2017
Attendances slightly lower than March 2017
**17/18 attendances 2% higher than 16/17**
February Admission rate from ED remains high at 33.5%, higher than March 2017 (29.2%)



## A&E Performance HEFT

**HEFT**

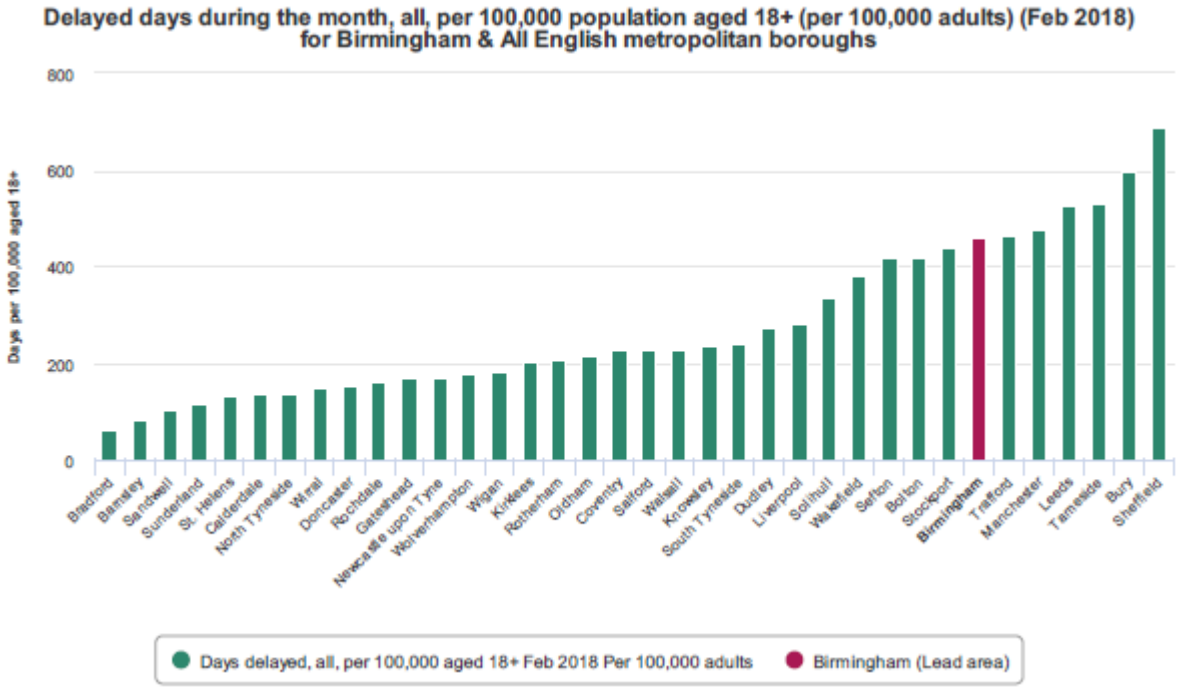
March 4hr performance = 76.1 % compared to 84.0% March 2017
Attendances slightly lower than March 2017
**17/18 attendances 2% higher than 16/17**
Latest admission rate from ED remains high at 32% Jan 2018




It is clear that our acute hospitals have been unable to deliver the national target since 2016.

**Delayed Transfers of Care**

National assessments have linked performance at the front door with challenges in discharging people from hospitals. The performance data below demonstrates that whilst on an improvement trajectory meeting targets is still a significant challenge and Birmingham remains within the worst performing quartile nationally.



# 4. Need for change

This section provides more detail of the issues within the intermediate care services and identifies the areas for improvement. These findings are then directly linked to the outcomes outlined within section 5 - the proposed strategic direction.

**Diagnostic of Intermediate Care Services**

In October 2017 through the agreement of all Partners Newton Europe were commissioned to undertake a diagnostic evaluation of the current health and social care services within Birmingham supporting an individual's recovery, rehabilitation and re-ablement from illness, injury or aging (intermediate care services). The commission was undertaken by BCC under the auspices of the Better Care Fund on behalf of all Birmingham partners. This was the first time agreement by all to a collective piece of work had been reached.

The associated diagnostic findings are included as **appendix e** and are summarised as follows:

**23%** - Total proportion of people we inappropriately admit into acute hospitals
**51%** - Total proportion of people delayed in hospital waiting to leave
**19%** - Total proportion of people we discharge out of hospitals onto an inappropriate pathway
**36%** - Total proportion of people we could provide better short-term bed enablement for
**37%** - Total proportion of people we could provide better home based enablement for

The identified opportunities to improve outcomes for people receiving the services and efficiency within the services were significant.

Newton proposed a set of projects which would improve current services.

Subsequent to receiving the report and following wider development of 'place based' thinking the executive group steering the review recognised that system transformation was required rather than improving what currently exists.

This thinking does not change the scale of the opportunity but changes the approach to realising the opportunity. The review of intermediate care has most significantly identified an over reliance upon out-of-hospital beds which were commissioned in response to winter system pressures over the last 5 years.

Key areas identified for improvement from the intermediate care review are:

• Reducing the proportion of people we inappropriately admit into acute hospitals;

• Reducing the proportion of people delayed in hospital, waiting to leave;

• Reducing the proportion of people we discharge out of hospitals on inappropriate pathways;

• Increasing the proportion of people for whom we could provide better short-term bed enablement; and

• Increasing the proportion of people for whom we could provide better home based enablement.

# 5. Strategic direction

## 5.1 Vision

**Your Own Bed is Best**

The definition of intermediate care provided by the Department of Health (Intermediate Care - Halfway Home, DH 2009) is "a range of *integrated* services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living".

Our vision is to provide an integrated approach to intermediate care services which is person and carer centred and encompasses physical, mental health and social care needs. An Older Person's Advice and Liaison Service (OPAL) will cover the following two areas:

- Crisis response to avoid unnecessary hospital admissions and include the delivery of traditionally acute clinical interventions for older people that can be safely delivered at home.
- enablement – home and/or community bed based interventions which aim to allow the person to remain at home and live as independently as possible. i.e. promote recovery, rehabilitation and re-ablement.

As far as possible individuals will remain at home, in most cases older people are more comfortable in their own homes and therefore recover and regain their independence more quickly if good quality therapeutic support can be provided – 'your own bed is best'. They will tell their story only once and have a single co-ordinated plan tailored to their needs and desired outcomes. They will know who to talk to for help during this time and will know who will be supporting them if they need ongoing support. They will be assessed by an appropriate clinician prior to any hospital admission and will not have to wait for the next stage of their enablement to be put into place.

Enablement will be designed to support people with complex needs including those with moving and handling issues and importantly people living with dementia. The approaches will link with paramedic and general practice services, both of whom have a key role to play.

*Crisis Response*

To avoid older people being unnecessarily admitted to hospital we will have a multidisciplinary approach at the front door 7 days a week. The team will specialise in treating and supporting older people at home only admitting to an acute bed if needed for safe treatment. They will be supported to do this by a multidisciplinary quick response that will be linked to their GP and other professionals.

We will ensure that a response can be started within 2 hours when necessary, identifying a person's ongoing support and make arrangements for these needs to be met. We will ensure that older people can be seen by expert clinicians, have appropriate tests and investigations if required, and an

accurate diagnosis made as a prompt diagnosis and treatment improves likelihood of a good recovery.

Although based at the front door of the hospital the multidisciplinary approach supported by a quick response will be an important component of wider joined-up community support.

The patient was around 85 years old and an ambulance was called out in the morning when she had pain in her lower back and also pain while urinating.

She was admitted into hospital following an ECG and her bloods being taken. Whilst in hospital more tests were ran and she was given IV antibiotics.

"**You get so many of these, where we could easily treat this in their own home**".

The group in the workshop identified this patient could have had an assessment by an Advanced Nurse Practitioner and the Rapid Response team to treat her with IV antibiotics while she recovers.

This patient spent 2 days in hospital.

*Enablement – home based*

Some older people do not need to be in hospital but are not ready to benefit from a therapeutic intervention. For these people we will provide appropriate short term (possibly up to 5 days) support to allow people to recover in their own homes wherever practical. Many older people after a short period of recovery will have no ongoing support needs but for those that need further support to return to their optimal level of health and ability we will provide an integrated response through therapists and support staff (normally up to but not restricted to 6 weeks).

Integrated enablement will be therapy led. We will join-up occupational and physiotherapy services to improve access, optimise services, and remove the risk of duplication and variation in assessment and provision.

In addition, we will make any adjustments, for example equipment or adaptations, needed to make this vision happen. We will offer enablement as a first option to older people being considered for home support, if it has been assessed that enablement could improve their independence.

Olivia is in her late 70s and was recently admitted to hospital following a fall at home. After her fall and her stay in hospital she had lost a lot of mobility and needed assistance to get out of and into bed.

Olivia was not referred to enablement as she was deemed to need a large package of two carers and four calls a day and the worker was convinced they would not be accepted.

One of the Hospital OTs reviewing the case identified this service user was independent before coming to hospital, and had potential to regain independence, especially as two carers were potentially only needed for morning and evening calls.

'Why not enablement? Surely that is the crux of the service'.

Occupational Therapist

*Enablement – bed based*

We will also provide bed-based enablement within 4 or 5 specialist centres across the City for people who are in a sub- acute but stable condition, but not fit for safe transfer home. Wherever the beds are there will be consistent criteria, objectives, and clinical / therapy input. We are aware that if the move to bed-based enablement takes longer than 2 days after a person is ready to move it is likely to be less successful.

*Integrated Personalised Approach*

Multidisciplinary practitioners will:

- work in partnership with the older person and their carers to find out what they want and need to achieve and understand what motivates them
- focus on a person's own strengths and help them realise their potential to regain independence
- build the person's knowledge, skills, resilience and confidence
- learn to observe and guide and not automatically intervene, even when the person is struggling to perform an activity, such as dressing themselves or preparing a snack
- support positive risk taking

## 5.2 Outcomes

This proposal if accepted will impact upon the two characteristics of the system previously identified, namely:

- Poor experience and outcomes for people and their families
- Inefficiencies demonstrated by 'waits' within the current pathways of care. Therefore it will contribute to improved A&E and DTOC performance.

More specifically the Newton diagnostic has identified the following measurable opportunities which are translated into outcomes:

- We admit too many people into an acute hospital bed who do not need acute hospital care and in the future between 2,900 to 3,500 more people will avoid such an admission by having a quickly responding multi-disciplinary approach.

- Some people remain in a hospital bed for longer than is necessary contributing to a loss of independence. In the future people will spend between 28,000 to 40,000 fewer days in hospital by improving assessments and promptly providing the right support.

- Some people have their long term needs assessed in hospital without the option of an assessment at home where they are more settled. In the future between 600 to 1,000 more people will live more independently by discharging them from hospital to assess their longer term needs in the community and providing the right support

- Some people remain in an intermediate care bed for longer than is necessary and in the future between 300 to 600 more people will live more independently or go home after a shorter stay from an enablement bed

- Some people do not have the opportunity to improve their independence at home and in the future between 2,300 to 4,000 more people will live more independently by receiving therapy led enablement in their own homes.

As a consequence of delivering these outcomes it is expected that people and their families will report a better experience of care and support in this area.

## 5.3 Future Operating Model

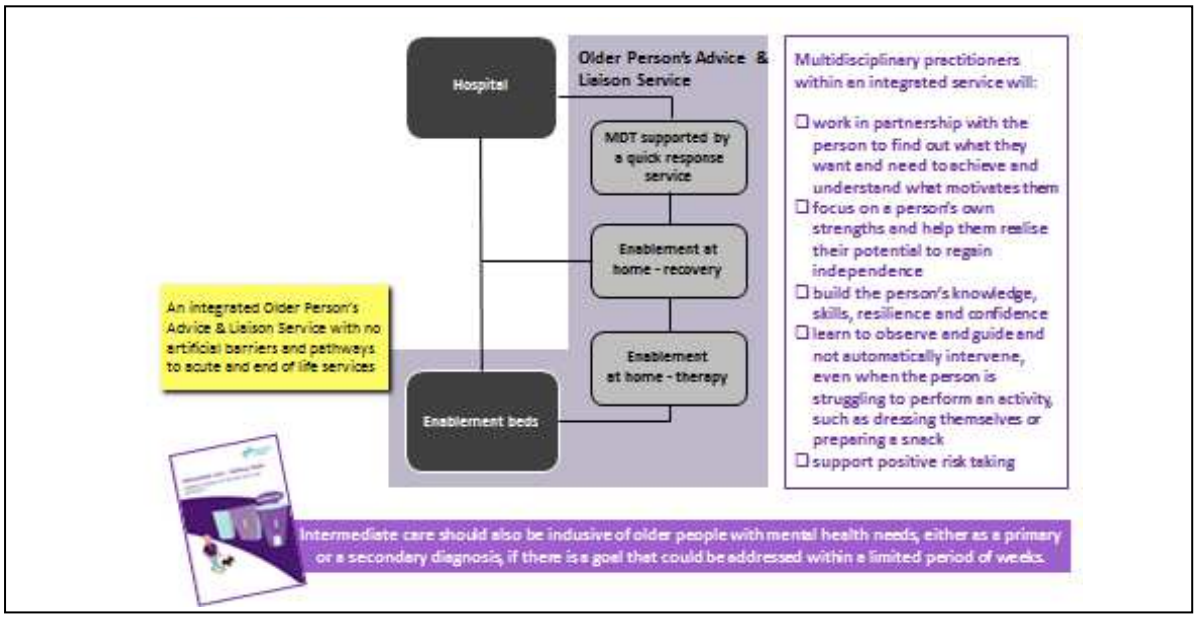
The high level integrated pathway model is outlined below and designed to ensure that people get the 'right support at the right time by the right professional'.

Entry into the Older Person's Advice and Liaison (OPAL) Service will be through two routes:

1. Clinicians and registered professionals will have direct access to the OPAL team for triage, diagnosis and intervention

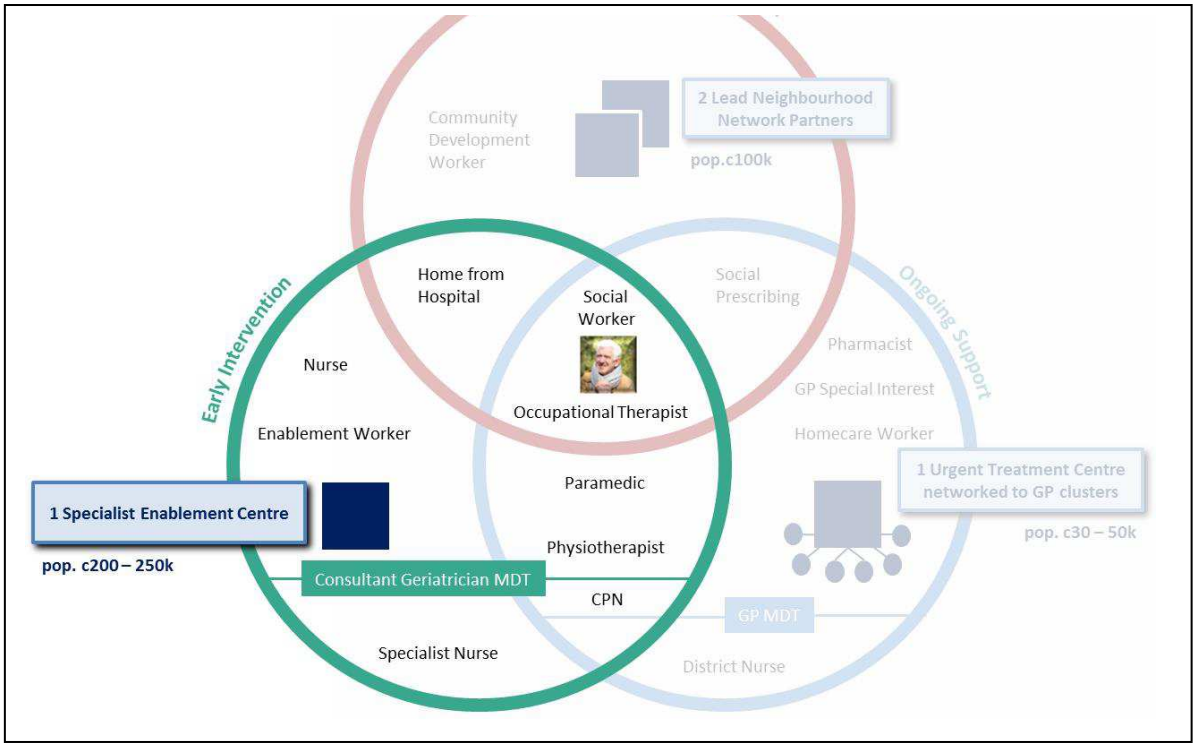
2. Police and fire services, housing, community and voluntary and independent sectors will be able to access advice and guidance or an intervention via a 'gateway' function when they are concerned about an individual.

Seamless integrated pathways with ongoing personalised care services including long term health and social care needs assessments will be critical to the success of this model.




The Pathway model will be applied at a population level of between 200 – 250k. GPs and consultant geriatricians will work together to oversee clinical aspects of the pathway and champion the 'home first' ethos.

Organisational barriers will be removed and we will wrap appropriate support around an individual. Roles of people working in the community will be clearly defined to maximise individual and collective skills and capacity.



# 6. Transforming the business

## 6.1 Transformation details

As highlighted previously Health and Social Care Services are currently fragmented with organisational boundaries often preventing us delivering efficient and effective services for older people. We aim to establish a single integrated service with clear decision points and pathways established for leaving the service.

In doing this we will remove artificial organisational boundaries, redefine roles and responsibilities of staff and focus on creating an integrated pathway for older people so that they receive appropriate support 'at the right time, in the right place and by the right professional'. In doing so new assessments, planning documentation, systems and processes will be established removing duplication and waits as far as possible.

The detail of this will be developed during the next design phase of this work with staff who will be delivering these services and their managers, people who use services, their families and carers. This will be a fundamental role of the external partner who will bring a single approach to transformation.

Plans for workforce and shared organisational development (cultural change), information technology and sharing, trusted assessment, new uses of estate will all need to be developed again with the support of an external partner.

This will be a significant task involving hundreds of staff across health and social care agencies. It will need to be underpinned by robust commissioning and contractual arrangements running in tandem with service transformation.

Alongside this an effective communications and engagement strategy with stakeholders will be needed.

**Capability to undertake transformation**

Given the tasks outlined above which are not to be underestimated there are a number of reasons why the current system does not have the capability in isolation to deliver the changes required:

- Whilst relationships under new senior leadership across the system are vastly improved and 'green shoots' of co-operation are showing there is no history of successful joint working to build upon to do something of this scale.
- When challenges emerge a degree of independence will be helpful
- The required level of skill in improvement methodology to efficiently and effectively make the changes does not exist within the system
- The discipline of effective programme management and the focus required does not exist

- The system does not have the necessary numbers of individuals with the required skill sets to deliver at scale and pace
- The concerns of staff and their representatives about change and how it is managed

Therefore, the approach of any external partner will need to be one of hands on with front line staff and their representatives in order to ensure their concerns are understood and considered as far as possible linking back to the point about a degree of independence. In addition they will need to support the expertise of local staff within the enablers identified as key to the successful delivery of this transformation.

**Approach to transformation**

The Partners are committed to a common approach to transformation in order to realise the full benefits for older people, staff, and operational performance. This is essential as the approach to transformation tends to be so influential on programme performance, staff engagement and sustainability.

**One important aspect is that any changes are driven by front-line staff closest to both the people using the services, and all the legislation and guidance that influences why things are done the way they are.**

The common approach to transformation is described below:


Assessment

- Quantify opportunities and prioritise.
- Evidence key levers to improve outcomes and flow.

Strategy & Programme Design

- Refresh strategy and redesign high-level care pathways based on assessment findings.
- Design high level implementation programme and secure resources.

Set Up

- **Begin engagement and communications with front line staff.**
- Begin programme governance.
- Establish live links to performance information.
- Pull together project teams, begin learning and development.

- Establish benefits delivery group.
- Create programme management infrastructure.

Pilot

- Implement, with front line clinicians and practitioners, new care pathways and solutions to biggest problems in one contained part of the city or pathway.
- Measure performance and iterate until delivering required outcomes.
- Develop tools for roll out, including 'product manual', team of SMEs, governance.

Roll Out & Sustain

- Replicate best practice at scale, using tools and SMEs from first phase to accelerate.
- Seek consistency with (warranted) local customisation.
- Develop a sustainability matrix, and support all regions to reach 'Silver' standard, with a clear route to achieve 'Gold' on their own.

An initial plan proposes that a flexible team of 20-30 external people would be required to support us in maximising the opportunity for change within a 60 week period:
5-6 people with a geographical focus – responsible for decision making between local hospitals & care centres, local relationships & roll out success.
4-5 people with a home based enablement focus – own technical approach and central relationships.
2-3 people with a bed based enablement focus – own technical approach and central relationships.
3-4 people with a quick response focus – own technical approach and central relationships.
2-3 people with an improvement cycle focus – to drive short term improvement and sustainability.
3-5 people in enabling roles – including communications, change management, digital support, programme management and governance.
2-3 people in programme leadership roles – providing support to partnership working, delivery oversight and quality assurance. Own relationships with senior steering group team.

The team would need to constantly balance delivery of the pre-defined plan with measuring and following the emerging priorities, to ensure the programme delivers the required outcomes. The team would need to flex in size and skill sets to respond to the challenges presented and ensure delivery.

## 6.2 Benefits

As previously outlined the impact of this proposal is expected to be in two areas:

- Improved outcomes and experience for people and their families
- System efficiency and as a consequence improved performance and financial efficiency.

**Improved Outcomes for Individuals and their families**

Section 5.2 outlines the anticipated improvements in outcomes for people and their families.

**Efficiency savings**

The total benefit range is between £27.1m - £37.5m per year

BCC benefit £11.7m to £16.8m per year
NHS benefit £15.4m to £20.7m per year

The following table shows the rate at which outcome and flow improvements are expected to be delivered, assuming a September 2018 programme start date:

| | Financial year: | 18/19 | 19/20 | 20/21+ |
|---|---|---|---|---|
| **Outcome and flow improvements expected to be delivered in-year** | **BCC** | **7%** of final full year effect | **81%** of final full year effect | **100%** of final full year effect, every year |
| | **NHS** | **5%** of final full year effect | **77%** of final full year effect | **100%** of final full year effect, every year |
| | **System total** | **6%** of final full year effect | **79%** of final full year effect | **100%** of final full year effect, every year |
| | **Comment** | Outcome and flow improvements begin as soon as month 3-4. | Core of transformation work complete part way through the year. Outcome and flow improvements ramp up through the year and are expected to reach target between months 15 and 16. | Outcome and flow improvements running at target levels for the entire year. |

The following table shows the rate at which the resulting financial benefit is expected to be delivered, assuming a September 2018 programme start date:

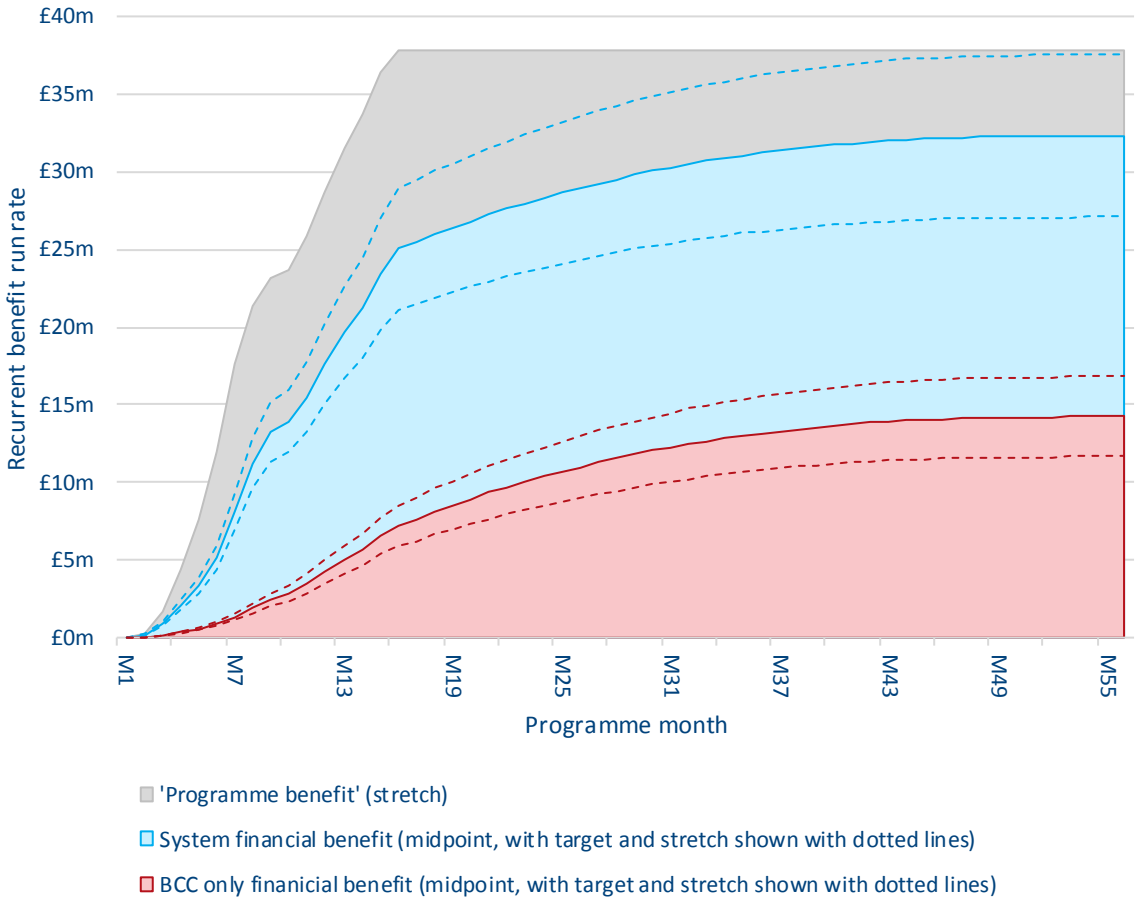
| | | | Financial year: | 18/19 | 19/20 | 20/21 | 21/22 | 22/23+ |
|---|---|---|---|---|---|---|---|---|
| **Financial benefit expected to be delivered in-year** | **BCC*** | Target | | **£0.1m** | **£4m** | **£9m** | **£11m** | **£12m** |
| | | Stretch | | **£0.2m** | **£6m** | **£12m** | **£16m** | **£17m** |
| | | Midpoint | | **£0.2m** | **£5m** | **£10m** | **£13m** | **£14m** |
| | **NHS** | Target | | **£0.7m** | **£12m** | **£15m**, every year | | |
| | | Stretch | | **£0.9m** | **£16m** | **£21m**, every year | | |
| | | Midpoint | | **£0.8m** | **£14m** | **£18m**, every year | | |
| | **System total** | Target | | **£0.8m** | **£16m** | **£24m** | **£26m** | **£27m** |
| | | Stretch | | **£1.1m** | **£21m** | **£33m** | **£36m** | **£38m** |
| | | Midpoint | | **£1.0m** | **£18m** | **£28m** | **£31m** | **£32m** |

* Note that financial benefit from enablement (bed- and home-based) outcome improvement is spread out and continues to climb for 2-3 years beyond the end of the programme as shown. This happens as higher dependency care packages, that were put in place before the programme started, come to an end. The impact of this effect has been modelled into the numbers above. A failure to plan for this effect is a cause of problems for transformation programmes involving enablement services or similar.

Had it not been for this effect the financial benefit for BCC would have been as shown in the table below. This is sometimes referred to as “programme benefit”. It should not be used for accounting purposes, but it is a useful leading indicator to support programme management. It is a measure of the transformation work completed, improved consistency of decision making, improved effectiveness of services and improved outcomes being achieved.

| | | | Financial year: | 18/19 | 19/20 | 20/21+ |
|---|---|---|---|---|---|---|
| **“Programme benefit” (see definition above – <u>not</u> to be used for accounting purposes)** | **BCC** | Target | | £0.8m | £9m | £12m, every year |
| | | Stretch | | £1.2m | £14m | £17m, every year |
| | | Midpoint | | £1.0m | £12m | £14m, every year |
| | **NHS** | Target | | £0.7m | £12m | £15m, every year |
| | | Stretch | | £0.9m | £16m | £21m, every year |
| | | Midpoint | | £0.8m | £14m | £18m, every year |
| | **System total** | Target | | £1.5m | £21m | £27m, every year |
| | | Stretch | | £2.1m | £29m | £38m, every year |
| | | Midpoint | | £1.8m | £25m | £32m, every year |

The monthly profile of the above measures are illustrated by the chart below:



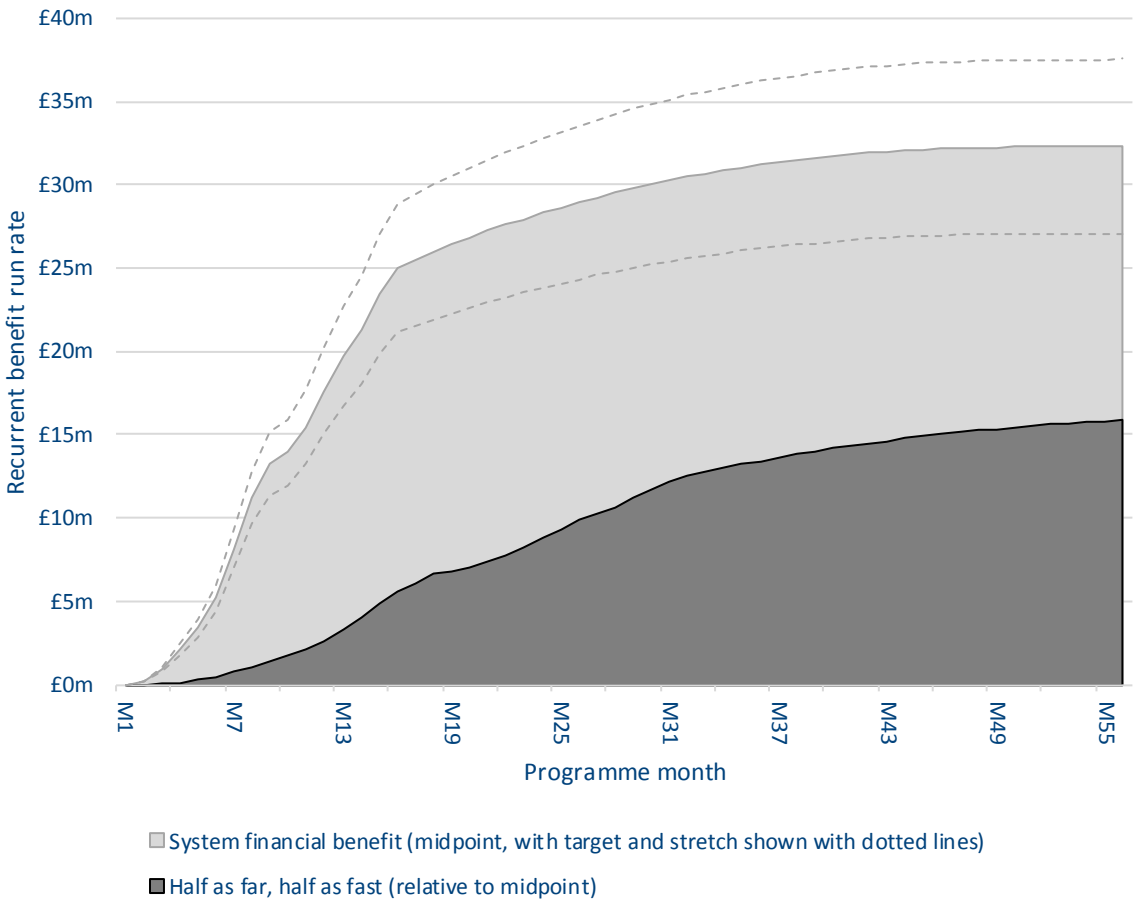

Notes relating to all of the above benefit profiles:

- All profiles assume a September 2018 programme start. In year-benefits would increase if the start date ends up being sooner, or would decrease with a later start date. This is the biggest single driver of in-year benefit changes.
- There is a high degree of confidence in the recurrent benefit range – from a target of £27.1m to a stretch of £37.5m per year. The rate at which this benefit is to be realised, and the balance of which workstreams it comes from, are forecasts based on experience of implementing similar programmes. The accuracy of these forecasts will improve over time as the programme evolves and develops.

It would be impossible to predict exactly how far, and how fast, the programme would go without external support. To illustrate sensitivity to these factors, the table and chart below shows what impact delivering (arbitrarily) half the full potential, and in twice the time, would have on in-year financial impact. Exactly the same logic could be applied to citizen outcomes and staff benefits.

| | Financial year: | 18/19 | 19/20 | 20/21 | 21/22 | 22/23+ |
|---|---|---|---|---|---|---|
| **Financial benefit expected to be delivered in-year** | **System total midpoint** | **£1.0m** | **£18m** | **£28m** | **£31m** | **£32m** |
| | **Half as far, half as fast** | £0.1m | £3m | £9m | £13m | £15m-£16m |

The impact of delivering half the full potential, and in twice the time, would be £15m in 19/20, a further £19m in 20/21, and a combined £53m by the end of 21/22 plus £16m every year thereafter.



## 6.3 Risks

Continuing risk of industrial action

Potential winter pressures diverting staff from transformation activity

A period of recruitment, training and consultation may be required between phases, where new teams are being established, roles and places of work are changing. This risks slowing down the pace of change.

## 6.4 Links with other Initiatives

Our strategy for older people over the next five years breaks our approach down into **three themes** which cover the whole range of support provided for older people and their carers.

- Prevention
- Early Intervention
- Ongoing Personalised Support

As the three themes overlap we will ensure that support is fully joined up so older people will be able to access *the right care at the right time in the right place* in order to be as independent and well as possible at all times. There will always be a focus on 'your life not our services' and making sure that there will be 'no wrong door' when people need help, support or advice.

## 7. Proposal

Integrating health and social care will be a complex and time consuming task taking between 3 – 5 years. This change programme is the first major step towards delivering the vision. It will be resource intensive for the 60 week duration and require BCC and NHS partner organisations to transform their business, whilst simultaneously ensuring that statutory duties are met and operational performance is improved.

The complexity of improving outcomes for older people in Birmingham, building a sustainable health and social care system which is fit for the future, whilst simultaneously working within reduced budgets is a huge challenge.

It is proposed that in order to reduce the risks associated with managing a programme of this size and complexity that BCC and partner NHS organisation procure support from an external partner with: a) enough capacity to support our programme; b) a high level of expertise and experience in implementing similar programmes elsewhere.

Without a transformation and efficiency partner the ability to transform and integrate health and social care services for older people in Birmingham will be severely hindered.

It is proposed that on behalf of the partners that BCC lead a procurement using an appropriate framework via a mini-competition open to organisations that specialise in organisational change and are prepared to enter into a risk share arrangement.

Proposed tender timeline is as follows:

9th July – Advert onto the framework

7th August – Advert closes

W/c 14th August – Scoring, moderation and Award report

3rd September – 10 day stand still finishes

4th September – Award