Birmingham BCF narrative plan 2022-23

Responsible to the Birmingham Health and Wellbeing Board

This Better Care Fund Plan and programmes contained within it were developed in partnership by:

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

Executive summary

Our 22/23 BCF plan has been developed to support the delivery of ICS and Birmingham Integrated Care Partnership priorities. In particular the plan builds upon our well-established, place-based collaboration in respect of urgent and emergency care pathways in order to reduce admissions, improve flow and improve outcomes for citizens through a “home-first” focus and approach. As a partnership we also recognise the need to invest in community services to maintain well-being and independence. This is reflected in our plan in terms of investment in, for example, multi-disciplinary team working, support to carers, housing pathways and community equipment.

Our continuing response to and recovery from COVID remains a key priority. The plan supports investment to continue vital services set up in during the pandemic that have demonstrated benefits. This includes a commitment to 7-day working and enhanced therapy input for our Early Intervention Community Teams and support for a hospital homeless pathway.

The plan exceeds the national requirement in terms of the minimum required spend on NHS Commissioned Out of Hospital services and meets the minimum ICB contribution for Adult Social Care services.

In terms of developing our collaborative working in the current and future years we have also committed resources in the plan to invest in transformation capacity in respect of joint commissioning, learning disabilities and autism and neighbourhood integration.

Governance

Birmingham City Council (BCC) Cabinet and the Birmingham and Solihull Integrated Care Board (ICB) have a statutory responsibility for the delivery of services and are accountable for the proper use of BCF resources. BCC's Cabinet is made up of elected representatives and is accountable for making decisions on behalf of the local authority. The Integrated Care Board is responsible developing a plan for meeting the health needs of the Birmingham and Solihull population, managing the NHS budget and arranging for the provision of health services in the Integrated Care System (ICS) area. The ICB is led by a Chair and a Chief Executive. In addition, representatives from the local authorities, provider trusts, and, in progress, primary care attend bi-monthly board meetings. This ensures good governance and is intended to promote a culture of strong engagement with citizens, their carers, primary care, staff and other stakeholders.

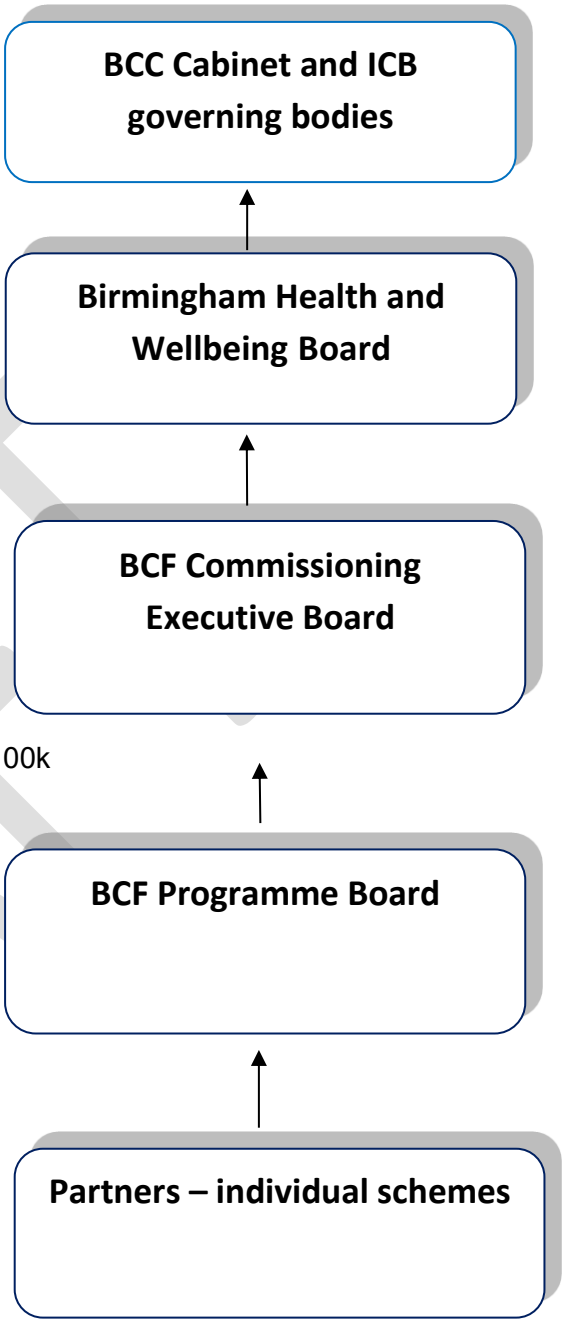
The Birmingham Health and Wellbeing Board has overall responsibility for ensuring the integration of health and social care functions within the city. The Board is the accountable body for the approval and implementation of the BCF plan for the whole of Birmingham and across the current ICB footprints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

The BCF Commissioning Executive acts as a collective vehicle for integrated commissioning on behalf of the ICB and the LA. It has been established to develop and operate the BCF pooled budget arrangement (section 75) and to provide strategic oversight and decision making relating to the delivery of BCF plan. The group oversees the operational and financial delivery of BCF and monitors its performance through bi-monthly meetings. Furthermore, the role of the group is to undertake commissioning through the BCF in support of the priorities of the Birmingham Integrated Care Partnership – whose membership comprises representatives from the local authority, ICB, NHS provider trusts and the Voluntary and Community Sector – including Healthwatch, Birmingham Voluntary and Community Services Council and Hospices in Birmingham.

A key focus of the commissioning executive role is to take a whole system approach to maximise investment of any schemes funded under BCF. The board report regularly to HWB and make recommendations for the strategic direction and management of the BCF. The Commissioning Executive is supported by the BCF Programme Board. Workstreams within the BCF programme report back to the Programme Board and are led by a range of statutory and voluntary and community sector organisations.

It is recognised that the governance arrangements are likely to be reviewed and iterated over the year as ICB/ICS arrangements develop and are embedded.

BCF Governance – reporting structure overview



Overall BCF plan and approach to integration

Our BCF Plan for 2022/23 continues to build upon the work we have undertaken as a system to embed integrated health, social care and housing services. Key developments and issues that have shaped this year's plan include:

- Creation of BSOL ICS – launched on 1 July 2022
- 100 Day Discharge Challenge and responding to the pressure on Urgent and Emergency Care
- Completion of the Early Intervention Programme
- Approval of a Staying Independent at Home Policy

The formation of BSOL ICS marks a further stage of system integration. In respect of the Better Care Fund, the move to ensure that all ICS boundaries are co-terminus with local authorities provides a streamlining of funding and governance arrangements for the Birmingham BCF programme. Whereas NHS contributions previously came via 2 CCGs there is now just a single relationship with BSOL ICS for the whole of the city. Since 2018, integration of health and social care has been driven through the Birmingham Integrated Care Partnership (BICP) – formed as a response to the system issues that were acknowledged as contributing to poor outcomes for our citizens. In developing the governance of the new ICB we have been careful to ensure that effective, existing arrangements are maintained whilst taking the opportunities for further integration. To this end BICP has been retained to provide oversight and will report into the new ICS Place Committee for Birmingham – a sub-committee of the statutory ICB.

Ongoing pressure on Urgent and Emergency Care remains the context for integration of health and social care. The system is experiencing unprecedented levels of pressure including hospital front-door activity levels, the elective recovery programme, demand for community discharge pathways, and a 15% increase in GP demand for same day access. A symptom of the overall pressure is ambulance handover delays and management of calls waiting for ambulance conveyancing, which increases the level of risk to patients. We recognise that the solution in addressing these challenges lies in the system working together to integrate, a shared understanding of issues and embedding good practice. In responding to these pressures, we further recognise the importance of investing in demand management, earlier intervention and prevention alongside more immediate responses to facilitating discharge. This is reflected in the two key priorities for BICP:

- Intermediate Care – collaboration across ICS partners in respect of Urgent Community Response (UCR), Discharge2Assess (D2A), virtual wards, single point of access and enhanced support to care homes.

- Neighbourhood Integration – multi-disciplinary team working to better manage long-term conditions in the community and intervene earlier for those at risk of admission to acute.

Delivery arrangements for these programmes are currently being developed in the context of emerging ICS responsibilities and delegations to place and provider collaboratives. However, we fully recognise the need for continuity and continued collaboration whilst the system works through the implications of the new ICS arrangements. Our work to ensure that resources for intermediate care are aligned within the BCF ensures that we have an effective joint mechanism across social care and health to manage resources across the system to respond to pressures and invest in transformation.

The Early Intervention Programme was launched in 2019 as the first large-scale, integrated transformation programme across health and social care partners in Birmingham. Supported

through the Better Care Fund, system partners came together to design a programme to address the identified issues relating to the experience and outcomes experienced by citizens at the interface of acute care and social care. Central to the programme was a commitment to promoting an ethos of "home first" – with the objective that we would co-ordinate our efforts to enable citizens to return to or remain in their own homes and that unnecessary and harmful delays associated with necessary or overlong stays in hospital were designed out of our processes. Following a design and testing phase, the programme was fully rolled out in early 2020. A review of impact between the start date and March 2022 identified the following key benefits:

- 120k acute bed days saved on an annual basis as a result of more rapid discharge
- Citizens were 45% more likely to go home following a stay in a non-acute bed
- A reduction from 12 to 4 days in the time taken for complex discharges from acute hospital
- 20k+ reduction in unnecessary admissions to acute hospital
- A reduction in ongoing care needs equivalent to an average of 6.5hrs of care per week for citizens going home following an early intervention service
- 18k+ referrals to the new Early Intervention Community Teams

The programme has now largely achieved the original ambitions. Consequently, Birmingham Integrated Care Partnership have taken to decision to bring this programme to an end and to now focus on a refreshed intermediate care transformation programme.

We are now in the process of ensuring continuous improvement for Early Intervention Teams. This includes working with Emergency Care Improvement Support Team (ECIST) across the system to identify key areas for further improvements. The improvements include reviewing our position against the adoption of the 100 day Discharge Challenge and the High Impact Change Model. A priority has been the establishment of a D2A dashboard which is a 'single version of the truth'. Digital opportunities are key and there is a proposal for the current Discharge Hub Management System (DHMS) in already in use within the UHB to further develop DHMS and unlock wider benefits such as a complete view of the patient journey, optimise flow and productivity, provide a system view of the key performance measures and improve the focus on demand and capacity.

<u>Headline changes within the BCF Plan</u>
The Council has adopted a new Staying Independent at Home policy to broaden the assistance that is available to support people to remain in their own homes or to return home following a stay in acute or intermediate care. More information is provided in the Disabled Facilities Grant Section of this plan.

As part of supporting the health and social care system exit from the pandemic the Better Care Fund has taken on the funding of additional elements of the Early Intervention programme providing long term sustainability. There has also been a range of short-term funding offered to ensure that services delivered through the pandemic can be exited from in a planned way, such as the reduction in Pathway 2 beds and continued funding for the homeless pathways.

Financial Summary

In recognition of the integrated approach and the local system agreement to utilise the Better Care Fund to align our budgets for activity delivered as part of the Birmingham Integrated Care Partnership, there continues to be an increase in the level of additional contributions into the plan for this financial year.

Funding Area	Income	Planned Expenditure
DFG	£12,943,092	£12,943,092
Minimum NHS Contribution	£97,901,719	£97,901,719
iBCF	£67,918,344	£67,918,344
Additional LA Contribution	£30,608,926	£30,608,926
Additional NHS Contribution	£3,174,348	£3,174,348
Total	**£212,546,429**	**£212,546,429**

Required Spend

	Minimum Required	Planned Spend
NHS Commissioned out of Hospital spend from the minimum ICB allocation	£27,843,716	£48,335,844
Adult Social Care services spend from the minimum ICB allocations	£38,830,118	£38,830,119

Transformation Fund

In Birmingham the Better Care Fund is increasingly being used as a mechanism to support integration transformation. It is recognised that transformation in a complex system can take time and needs to be phased. To this end we have developed a system-wide Transformation Fund to support the system work and development under the Birmingham Integrated Care Partnership. This resource is critical to enable change, making up-front investment to realise future benefits. For 2022-23 commitments have been prioritised to stabilise the system recovering from the pandemic. The priority areas for years 2 and 3 include:

- Further development of the Early Intervention model, including development of the care centre model for Pathway 2
- Further development of the Neighbourhood Integration model
- Further development of the Care Homes model
- Technology enabled care
- Falls prevention
- BICP programme development
- Enablers including the Birmingham Community Loan Equipment Service

Implementing the BCF Policy Objectives (national condition four)

Birmingham Integrated Care Partnership priorities reflect the BCF Policy Objectives. Our Neighbourhood Integration theme is aligned to the objective of enabling people to stay well, safe and independent at home for longer whilst our Intermediate Care theme is our approach to delivering the right care, in the place, at the right time in respect of a home first, discharge process.

<u>Supporting People to Remain Independent at Home for Longer</u>
During 2022 – following a period when the focus of system working has, of necessity, been on responding to the pandemic – we have taken the opportunity to reset our ambitions in respect of neighbourhood integration. We have come together as a system around this theme and agreed:

- To get new integrated working within neighbourhoods up and operational by Autumn, ahead of Winter pressures
- To work with a cohort of frail citizens/service-users, with the aim of maintaining safe, independent living and avoiding crisis
- To accept the geographic constructs in Birmingham and work with them, not allowing them to become barriers
- A phased approach to implementation, starting in one area within each locality (pairs of constituencies c200k population) and then rolling out further, based on what we learn
- We will empower our teams to prioritise the building of relationships and new ways of working in their areas

A system design group has been established with active participation from primary care, NHS provider trusts, local authority and the voluntary and community sector. This group has progressed the development of:

- Communication and engagement plan
- Programme plan and governance
- An overarching model - articulated and tested with the design group and other groups
- Engagement with primary care via GP locality meetings and the multiagency partnership meetings
- Organisational Development work commissioned from an external organisation. Initial dates for the first phase have been set for September (one team in each locality).
- Surveys have been produced and distributed amongst frontline staff to provide a baseline for team working.
- An initial developmental evaluation tool
- Mapping to existing programmes (e.g., Mental health transformation and Neighbourhood Network Schemes)

As the recently designated Community Service Integrator, accountable to the Place Committee, responsibility for further development and implementation now rests with Birmingham Community Healthcare Trust.

Anticipatory care helps people to live well and independently for longer through proactive care for those at high risk of unwarranted health outcomes. We are working with our PCNs as part of the Neighbourhood Integration theme to focus on groups of patients who will be offered proactive care interventions to improve or sustain their health. This aims to benefit patients with complex needs and their carers, to reduce their need for reactive health care and to deliver better interconnectedness between all parts of the health and care systems. Anticipatory care should, potentially, encompass many different types of intervention which may include broad approaches to assessing needs and planning and

delivering the interventions required to meet them, or more specific interventions which target particular risks or health problems, singly or in combination. This approach will be reviewed when the anticipatory care national guidelines are issued in Q3 22/23.

ICS partners in Birmingham recognise the importance of a co-ordinated approach to supporting care homes in order to both improve personalised care and to reduce pressure on acute services. A pilot programme – supported through the BCF – to provide enhanced care into 26 care homes in the city was launched in 2021. An evaluation has been undertaken by the University of Birmingham which has demonstrated significant benefits in terms of reducing admission to acute across a range of conditions including UTIs and as a result of falls. We are now working to develop plans for implementation across the care home sector. A key consideration in terms of roll-out is how the offer can be integrated with the existing intermediate care components (virtual wards, UCR, discharge to assess) that are in place in the system.

Originally supported through the Better Care Fund, Neighbourhood Network Schemes are now funded through mainstream Adult Social Care funding. Each constituency in the city now has a NNS lead provider in place to connect citizens with local community assets as part of our preventative approach to improving outcomes. The new approaches to neighbourhood and locality working that are being introduced through the developing ICS arrangements provide further opportunities to build on the considerable impact of this programme through increasing integration with primary care and neighbourhood MDTs.

The section of this plan concerning Disabled Facilities Grants details the new forms of assistance that will be provided as a result of the development and adoption of a new Staying Independent at Home policy. Our approach has been designed with the objectives of enabling citizens with care and support needs to remain living in their own homes and removing housing-related barriers to discharge.

<u>Providing the right care in the right place at the right time</u>
Providing the right care in the right place at the right time in respect of intermediate care and discharge has been the key focus for integration and collaboration in the system. The legacy of our Early Intervention programme is an integrated system with the following components:

- Early Intervention Community Team (P1)
- Early Intervention Beds (P2)
- Integrated Referral Hub (IHub)
- (OPAL/OPAL+ at acute sites; not funded via BCF plan)

The components of EI and alignment of pathways are described in more detail below in terms of how they support effective discharge outcomes.

<u>Pathway 0</u>
The system approach to supporting Pathway 0 – for example the Home from Hospital service that is supported via the BCF will be reviewed during 2022/23 with the intention of reconfiguring resources into an integrated offer focused on enabling independence and resilience.

<u>Pathway 1 - Early Intervention Community Team (EICT)</u>
The Early Intervention Community Team (EICT) is an integrated offer across Birmingham. The service comprises of staff from Birmingham Community Healthcare NHS Foundation Trust (BCHC), University Hospitals Birmingham NHS Foundation Trust (UHB) and Birmingham City Council (BCC). In addition, the teams work alongside colleagues from Birmingham and Solihull NHS Mental Health Foundation Trust (BSMHFT).

The service provides a range of support from intermediate care to personal care within someone's own home. The care and support the service will provide will typically involve an assessment of health and social care needs and a level of therapy. The combination of these elements ensures that this service meets the goals of the citizens in a seamless way, where citizens should only have to tell their story once.

The whole ethos of the service is ensuring that there are clear and seamless routes for supporting discharge with the home first principle, in a timely way, with a same day response. The service brought together various other community services to ensure a single route out of hospital for pathway 1 eligible citizens. The intensive multi-agency, and multi-disciplinary nature of the team ensures that discharges are supported effectively in the community.

The EICT service was rapidly rolled out across the city through the height of the pandemic in 2020 and was integral to the community response to assist with discharge of citizens back home in a timely manner and to alleviate the pressures on acute hospitals.

Bringing three organisations together to work in an integrated way has provided the system with challenges – for example, we have had to address issues relating to organisation and professional line management; appointing a single lead officer for all partners at a locality level to provide a clear line of management and escalation. Ultimately the ethos of keeping the citizen at the centre drove the cultural change that was needed for Birmingham.

Pathway 2 - Early Intervention – Pathway 2 (P2) Beds

Our strategy to consolidate the number and location of P2 beds has been disrupted by successive waves of COVID. We have been unable to reduce the number of P2 beds due to the requirements to rapidly move patients from acute sites during the pandemic. However, we have continued to work with P2 sites to introduce new ways of working and reduce length of stay (see Ongoing Transformation Plan section).

Pathway 3

A range of pathway 3 beds are commissioned from the independent sector for patients who are unable to return home and are known to have complex needs that could not be met in pathway 1 or 2.

Commissioners are currently in the process of implementing a programme of work to ensure a single approach to managing the regulated care market. This will refine our system approach to market shaping of the care sector in the long term. During 2022/23 our ambition is to:

- Develop a joint Commissioning & Procurement Strategy for Domiciliary Care – Adults and Children
- Develop and implement joint Commissioning & Procurement Strategies for Pathway 2 and Pathway 3 Beds

Taking account of existing contractual arrangements, it is proposed to develop and implement joint strategies for care home and supported living commissioning in 2024/25.

Integrated Hub Team (IHub)

The Integrated Hub Team is in place to ensure effective discharge. The IHub has representation from BCHC, Birmingham City Council, UHB, the ICB, BSMHFT and Hospices. The aims of the hub are:

- To ensure consistent decision making in relation to pathway and service allocation
- To oversee system flow in and out of pathways

- To ensure that the pathways are appropriately managed and that citizens have a high-quality experience of the pathway

IHub delivery is a focus of continuous improvement from the ECIST team to ensure optimisation of the D2A pathway.

Older Person's Assessment and Liaison (OPAL) Team

OPAL is a recognised term used to describe front-door acute hospital services for older people and those with complex needs. The Birmingham services are available to any citizen aged over 18 who would benefit from the input of the team, there are no age or frailty-score related limits.

The service was first established at Queen Elizabeth Hospital in 2012 and is one of the interlinked components in the Early Intervention Programme and is therefore built on a strong evidence base and integration across health and social care.

The OPAL teams are based at the 'front door' of the hospitals, but face outwards to interface with all aspects of community care and services including statutory, private and third sector providers. The more integrated our care and health services are, the bigger role OPAL can play in the 'Home First' model, and the more successful the overall system model will be.

Core principles are a multi-disciplinary team including consultants, nursing, therapy and social work working in emergency departments and acute assessment areas to assess and treat older people and those with complex needs as soon as possible after they reach acute care. OPAL also supports community Advance Nurse Practitioners (ANPs) across the ICS, and West Midlands Ambulance Service (WMAS) to avoid citizens being unnecessarily conveyed to acute care.

The input of OPAL expertise involvement makes a person more likely to receive the care and support they need in their own home, or if they do need admitting their length of stay is reduced. In line with the Early Intervention strategy the future of OPAL will ensure a consultant workforce that will not just operate at the front door, but which will also be linked into the other EI services to maximise the home first approach.

OPAL+ is an extension of the OPAL service. In 2019 OPAL began a collaboration with the West Midlands Ambulance Service (WMAS) to take the approach one step further by introducing the use of technology to enable virtual consultations in the home. During 2021 OPAL+ received 2,490 calls, of which 1,815 remained in their own surroundings. The service has now been extended to include community and mental health teams as well as the community palliative care team to help reduce hospital admissions of palliative patients and ensure they are managed in the community.

Housing and Homeless Pathways

The impact of poor housing conditions or homelessness had already been identified as an area of improvement prior to the pandemic. Although the numbers being delayed due to housing issues were relatively small, the length of stay within acute per citizen was often significant.

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

Birmingham was also successful in bidding for Out of Hospital Care Model funding from the Department for Health and Social Care, to improve the support and pathways for citizens who present homeless at the point of discharge. This aims to reduce the number of citizens presenting as homeless and rough sleeping within Birmingham. The funding has allowed Birmingham to have dedicated staff based within the 4 Birmingham acutes to provide support, assessments, advice and move on for those citizens referred into the service.

Each quarter has seen an increase in the number of citizens being referred as the service develops and expands the variety of support that it is able to offer, to date since 1st November 2021 there have been 655 referrals made. The service completes a bespoke Homeless Assessment that is a holistic view of the citizen, working alongside professionals within the hospital to decide the best pathway for the citizen which can be home, into independent living or alternative accommodation as a temporary measure to ensure we give the citizen the best opportunity of returning to community living or their usual place of residence. The model is being managed through the BCF programme.

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

Birmingham Community Equipment Loan Service

Community equipment loans are critical in ensuring safe, timely and effective discharges. The service source, deliver, collect and decontaminate clinically prescribed rehabilitation equipment to individuals to support discharge to their usual place of residence. This service was commissioned through a joint collaborative approach between health and social care, to bring together funding, service provision and improve the outcomes for citizens which was extremely successful.

Provision of quality, clinically recommended equipment via clinical prescription from hospital discharge teams, who are supported by expert BCF funded Clinical Leads based within the service who:

- ensure appropriateness and availability of the standard stock catalogue items,
- ensure stocks at the peripheral stores are stocked,
- advise on the best options for order on special/bespoke orders.

As the 'Home First' approach has moved forward in Birmingham and more packages of care are delivered in citizens own homes we have seen an increase in demand, this has needed an increase in capacity within the teams who now also provide a service to continuing healthcare teams, as the timely service is aiding the pace of discharge of this cohort of citizens from a bedded setting. Increase demand is reflected in the BCF plan with an increased budget for community equipment.

Recent service developments include aligning Continuing Health Care equipment provision with BCELS provision to deliver efficiency benefits for the CHC service and a better experience for citizens. The service has also tested the use of lateral turners to reduce overnight care calls and double-handed care. Further service developments planned for 2022/23 include bringing dynamic pressure care within scope for BCELS.

Ongoing Transformation Plans

As BSOL ICS we recognise that by focussing on intermediate care as a specific area, and setting clear priorities, we have an opportunity to harness the resources and energy in the system to achieve the National Institute for Health and Care Excellence (NICE) aims of intermediate care:

- Remain at home

- Recover after acute illness or an operation
- Avoiding going into hospital unnecessarily
- Returning home more quickly after a hospital stay

We have collaborated across BSOL ICS to develop a proposed set of priority areas for intermediate care as an immediate focus within an overarching programme of work. The priority areas are all at different stages of development, with some that are brand new. All priority areas will require further detailed planning, with short, medium and long-term deliverables, and some will require decision making at place level.

Unscheduled Care Co-Ordination

We know there is a system opportunity in unscheduled care. As an illustration, a diagnostic of the BSol urgent community response (UCR) opportunity was undertaken by external consultants Newton Europe (Newton) and initial findings reported in July 2022. From the diagnostic sample of cases reviewed, Newton identified that if the urgent community response was enhanced, up to 31% of patients could have avoided conveyance to hospital, and up to 28% of patients who called an ambulance but were not conveyed could have been seen by a UCR response instead of an ambulance crew. In the context of this opportunity, we are proposing to explore the following areas for transformation:

- Single approach to access – address current fragmentation of urgent care pathways; emphasis on managing the needs of sub-acute people, who are not seriously ill, but who are at risk of attending hospital. Responding to calls from West Midlands Ambulance Service/111/999, primary care and care homes.
- Hospital Ambulance Reception Improvement System (HARIS) - HARIS or a similar approach, could form a pivotal element of the overall unscheduled care response. It is an approach that has been rolled out in other systems including Hertfordshire and West Essex and provides a range of initiatives for physical and virtual solutions to ensure patients' needs are met in the most appropriate setting, a reduction in the impact of handover delays, relieved pressure on ED, and migrating unscheduled care into a scheduled care environment. Discussions and workshops session are being held with the NHSE/I Emergency Care Improve Support Team (ECIST) to determine how the HARIS approach could be developed in BSol ICS as a lever for change. System workshop planned for September 2022 to set up a series of test of change over a 4-month cycle outcome will be a compelling case of change. Once complete will moved into the 'embed and sustain' process.

Discharge to Assess

The following priorities/opportunities have been identified:

- Standardising approach to discharge - There is an ambition to have a standardised transfer of care approach across the ICS as part of the implementation of the Hospital Discharge and Community Support Guidance (April 2022) and subsequent Integration and Better Care Fund implementation guide (May 2022). There is an opportunity to build on the current position across BSol by integrating hubs, processes and IT systems where it can be evidenced to have a positive impact on flow, patient outcomes and will meet local need at place level. Scoping work will identify the size and feasibility of the BSol and place level opportunities. Regardless of the specific delivery model for this priority, a single dataset and dashboard will be critical in enabling a common view of effective flow. The standardised approach to discharge will need to extend to involve the voluntary sector, housing, CHC, end of life pathways and any relevant providers.

- 7-day working for discharge teams – Linked to the standard approach to discharge above, hospital discharge and community support guidance (March 2022) is clear

that discharges from hospital should operate over seven days, and crucially, that a high proportion of people should achieve a same day discharge. Whilst statutory partners in Birmingham do operate across 7 days, at present discharges are predominantly over the five weekdays, with a large reduction in flow at weekends. We need to co-ordinate the approach to seven day working across all services that impact on discharge, to maximise the opportunity to optimise flow (e.g.care homes, transport, equipment, pharmacy).

- Home First Model (Discharge to assess pathway 1) **–** We want to build upon the progress that has been made against this theme through our Early Intervention programme. Further development work in Birmingham includes an ambition to further integrate operational teams and developing a sustainable approach to the personal care element of the workforce (currently provided by the independent sector). Across BSol ICS there is an ambition to maximise the number of patients discharged home via pathway 1, who may have historically being discharged to a pathway 2 bed-based setting. Achieving this will require a focus not only on the specific pathway 1 services, but also innovative approaches to technology enabled care and equipment and adaptations. Ensuring that patients are given the chance to continue their lives at home is vital for their long-term wellbeing outcomes.

- Pathway 2 bed-based care **–** Our focus will be on standardising the P2 offer, promoting recovery and assessment supported by an integrated health and care pathway. A more resilient, consistent medical workforce model and structure with integrated UHB/ BCHC medical roles and joint recruitment will be pivotal to providing a firm foundation for this work, alongside using technology to link in with the Older Peoples Assessment and Liaison Service (OPAL). A Birmingham business case is in development to specify this approach in the form of locality-based care centres, with the principle that there should be co-location with pathway 1 (EICT) where practical, to ensure patients can return home as soon as appropriate in a seamless transition. In the short-term there is a BSol wide need to improve bed utilisation through reducing length of stay. The use of BCF to support this immediate issue has been agreed.

- Agreed next steps – during Q3 22/23 dedicated enhanced system wide discharge team focused on system wide improvements to drive flow, timely and effective discharge over 7 days. All improvement work will focus on data and measures of improvement.

Virtual Wards

Virtual wards allow patients to get the care they need at home safely and conveniently rather than being in hospital. This supports discharge from hospital settings, but crucially, also avoidance of inappropriate admissions supported by a community response. For BSol the specific plan is:

- UHB sites up to 340 adult virtual ward beds by April 2024 (including those already within the baseline), with a commitment to undertaking an assessment of the evidence base in Q4 2022/23 to determine the case for further expansion.
- Sandwell and West Birmingham Hospitals (SWBH) have provided current assumptions of 78 virtual ward beds by April 2024 (further work to take place during Q2 to test assumptions).
- By April 2024 the overall ambition for BSol is to create 418 virtual ward beds (national planning guidance minimum of 423 virtual ward beds)
- Build in the use of technology, and remote monitoring, and links with the overall evolving approach/ framework for unscheduled care so if a patient deteriorates or feels unwell, a co-ordinated response can be provided.

Enhanced Health in Care Homes

During 22/23 the system has agreed to test/ deliver UCR, Virtual Wards and discharge to assess in care homes as part of an overall enhanced health in care homes offer to improve outcomes, reduce hospital admissions, and release capacity. A support to care homes team has been prototyped across 26 homes in Birmingham. However, given the rapid developments, overall strategic direction and financial investment in UCR, discharge to assess and Virtual Wards, it has been agreed to test how these system pathways impact on care home patients and how this compares to the return on investment from the prototype. Delivering this requires a systematic, structured approach to mobilisation and communication, including training and education for the care home workforce so they know when to call for support. The roll out of technology will be key to maximise efficiency.

Supporting unpaid carers

Birmingham Carers Hub (Hub) Service provided by Forward Carers is jointly commissioned by Birmingham City Council Adult Social Care and Birmingham and Solihull Integrated Care Board and funded by Adult Social Care budget and Better Care Fund. The service follows a pathway approach linking to young carer and mental health carers services and their commissioners building on the collaborative approach as an integrated care system. In addition, the service will work in partnership with other organisations bringing additionality and added value throughout the service delivered.

The Hub delivers a range of services to enable carers to continue in their role, feel supported and manage and prevent the likelihood of crisis with early interventions which include; statutory assessments as required by the Care Act, wellbeing assessments and payments, an emergency service, a health liaison project, Partners in Care cards issued in hospitals so that the carer is recognised and actively involved in the person they care for plans and discharge process, group sessions and one to one support. There are over 17,500 carers registered with the service. The Hub will be expected to take a place-based approach having locations across the city to deliver support on a locality basis and link and work with Neighbourhood Networks Services.

The current contract for the Hub ends on 31st March 2023 and recommissioning is currently taking place. Additional funding has been secured to develop a wellbeing break/sitting service for carers to provide much needed breaks to support their mental and physical wellbeing and to expand the health liaison project to support the carer when the person cared for returns home following discharge from hospital.

Co-production will commence on the refresh and review of Birmingham Carers Strategy with the consultation opened at a launch event for the new contract in May 2023. The strategy will seek Cabinet approval and be launched in 2024 allowing time for full consultation and co-production with carers, providers, partners and key stakeholders.

Disabled Facilities Grant (DFG) and wider services

It is widely acknowledged that home is best for most citizens, their families and carers, it is where they are happiest and thrive with the right support. We know that poor quality housing is thought to cost the NHS an estimated 1.4 billion pounds per year, over half of which is attributed to poor housing among older adults.

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

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

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

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

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

In order to deliver the new discretionary assistance, the commissioning of a new integrated service to deliver the principles in the new policy and meet the demands of the citizens of Birmingham has commenced. It is expected that a new service model will be implemented from July 2023. In the meantime, services have been adapted and scaled up in order to deliver the new discretionary assistance from October 2022.

As already detailed within the homeless and housing pathways section (page 11) there has been a considerable amount of work to develop effective pathways for citizens who are not able to return home for various reasons including, not having a home or this not meeting their needs (homeless), hoarding, cleanliness, health and safety and domestic abuse. The pathways have been developed through integration of housing and adult social care teams and recongising for citizens who are being discharged from hospital that a one service approach means better outcomes and the right accommodation offer being made at the right time. During this year a detailed outcomes and provision document will be developed in partnership with the National BCF Team to share the learning and good practice from the pilot and widen homelessness work.

Equality and health inequalities

Addressing health inequality has been, and remains, central to our approaches to delivering integrated health and care services. As a system the BSol ICS has a larger proportion of citizens living in deprivation compared to any other health and care system in England. Within Birmingham four in 10 people live in the 10% most deprived areas of England. Birmingham residents are more likely to die of diabetes, cancer or respiratory disease than in most other parts of England. Stark spatial variations exist within the city; for example, there is a ten-year gap in the estimated life expectancy of a boy born in Castle Vale compared to one born in Sutton Mere Green Not only are people living in the poorest neighbourhoods in Birmingham and Solihull dying a decade earlier than those living in the most well-off neighbourhoods, but they are spending almost 2 decades (17 years on average) of their shorter lives in ill health.

Inequalities exist between communities of place, often reflecting poverty and deprivation as the headline but this sits on top of inequalities between communities of identity e.g. different ethnic groups, LGBTQ+ communities, and communities of experience e.g. homeless populations, veterans, migrants and carers. Birmingham's Public Health team have developed a series of community health profiles to explore in detail the specific health inequalities faced by different communities of identity and experience.

A range of connected factors drive inequality in health outcomes in Birmingham.

- Deprivation - Around 50% of the population of the ICS are amongst the 20% worst off people nationally (the "Core20"); 94 percent of the most deprived areas of the ICS are in Birmingham.
- Ethnicity - Around 40% of the people of Birmingham are from Black, Asian and minority ethnic groups. Many (though not all) of these communities live in the most deprived neighbourhoods, and additionally suffer the impact of structural racism, worsening already poor outcomes related to poverty. We recognise the variation in access and outcomes between different ethnicities. Pakistani communities are largest ethnic minority group in the ICS, but experience some of the worst health outcomes. Black and African Caribbean communities are the second largest ethnic grouping. People from Gypsy and Traveller Groups are a small minority but have very poor health outcomes. White groups also include a range of ethnicities such as English, Irish, Polish, with their own unique experiences. Evidence shows they are more likely to be impacted by issues related to alcohol and tobacco, and white men have a disproportionately high suicide rate.
- Children - We have the largest population of children and young people in the country. Having the youngest population should mean fewer health challenges. However, one in three children in our system – over 130,000 children in Birmingham - live in poverty and we have some of the highest rates of infant mortality in the country. Studies have shown that adverse experiences in early years have life-long impacts which can entrench generational inequality. Conversely, intervening positively in early years has the biggest impact in improving life chances including healthy outcomes.
- Long Term Conditions - Our system has high numbers of people living with long term conditions and outcomes that vary significantly. We perform worse than the England average on many of the factors that drive good health. The biggest 'killer' in our system is circulatory disease (CVD), followed by respiratory disease (COPD) and cancer. High prevalence of preventable diabetes in our system contributes to these diseases and their impact.
- Mental Health & Learning Disabilities - Outcomes for people with mental illness and learning disabilities are worse than outcomes for the population as a whole. On average people with serious mental illness or a learning disability die 15-20 years earlier than

those without. Not because these conditions are killers, but due to treatable physical conditions not being diagnosed or treated appropriately.

These are deep-seated issues that will not be easily turned around. The Health Inequality Strategy sets an ambition over the next ten years to visibly and meaningfully reduce the gap in healthy life expectancy for citizens. The strategy set out system priorities based on:

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

The priorities are:

1. Maternity Care & Infant Mortality - Improve the experience and outcomes for mothers, parents, and babies and reduce the number of infants who die before their first birthday

2. Better Start for our Children - Improve the health of children from our most deprived communities by supporting them to get the best start in life, focusing first on increasing uptake of vaccination and improving school readiness.

3. Better Prevention, Detection & Treatment of Major Diseases - Improve the prevention, early detection and treatment of the diseases that drive early mortality for people, focusing first on reducing waiting lists for diagnosis and surgery, cardiovascular disease, respiratory disease, cancer screening, diabetes and addressing the backlog of elective treatment.

4. Better Outcomes for People with Mental Illness - Improve the experience and outcomes for people living with serious mental illness and improve their health and wellbeing to achieve their potential in life.

5. Better Outcomes for People with Disabilities including Learning Disability - Improve the experience and outcomes for people living with a disability across the life course, starting with a focus on learning disability and autism.

6. Improved Outcomes for Inclusion Health Groups - Improve health and care outcomes for our most vulnerable citizens in inclusion health groups including new migrants, refugees and asylum seekers, homeless people, people with substance misuse difficulties, women, people experiencing racial disparity and LGBTQIAplus.

In tackling these six priorities and in taking forward our work on inequalities, we have also made a commitment to the principle of subsidiarity which is being enacted in the HWB area through the creation of an ICS place committee and locality forums for pairs of constituencies in Birmingham. This will provide the infrastructure for approaches that are more responsive to local needs and communities. The work of locality forums has already commenced with an initial aim of developing delivery plans that address both ICS outcomes

and local priorities. Our shared experience through the pandemic has shown the value of reflecting local diversity in the delivery of system-wide objectives.

The Better Care Fund programme is an opportunity for health and social care partners to work together to address these priorities – with a particular focus on priorities relating to prevention, early intervention, mental illness and disability and outcomes for inclusion health groups. The origins and development of the programme means that it is predominantly focused on older residents and specifically to address the poor outcomes experienced by older citizens and the opportunities to make improvements through the implementation of consistent and equitable pathways.

Of necessity, our focus to date has been on improving services across the city in a consistent way to ensure that there is equality of access irrespective of where citizens live - particularly in regard to reducing delayed transfers of care, reducing the use and length of stay in P2 beds and increasing the independence of people being discharged from reablement services. This work has been supported by the BCF both in terms of investment in a system transformation programme – Early Intervention – and through the use of BCF to invest in capacity in P1 to facilitate a home-first approach and in P2 capacity to enable discharge for those who are unable to immediately return to their usual place of residence. Notwithstanding the need to focus BCF resource on these key challenges, our BCF programme includes a number of schemes that address specific inequalities and challenges such as investment in jointly commissioned support to carers, dementia, development of out of hospital homeless and bariatric pathways and funding capacity to develop a joint approach to improving outcomes for citizens living with learning disabilities and/or neurodiversity.

All new proposals for Better Care Fund support are subject to an Equality Impact Assessment so that decisions are made with the benefit of a consideration the impact on people with protected characteristics.