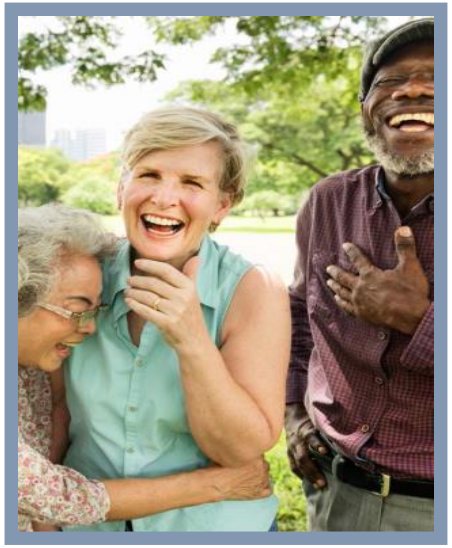
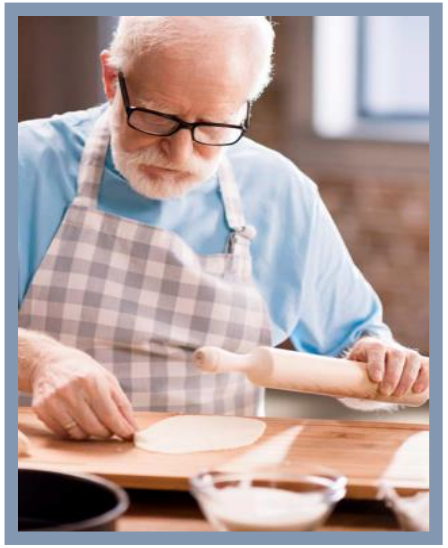
Birmingham Integrated Care Partnership





Live healthy
Live happy
Birmingham and Solihull

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Welcome to our refreshed statement of how we will work together to improve health and well-being outcomes through integration of health, social care and well-being interventions in Birmingham. Much has changed since we first formed our partnership and we recognise that we need to keep challenging ourselves to ensure that we maintain our focus on the things that matter most to citizens. To that end we have looked again at our purpose, vision, objectives and strategies – re-affirming our commitment to move forward, together.

Cabinet Member for Health and Social Care

Birmingham City Council

NHS Birmingham & Solihull Clinical Commissioning Group

NHS Sandwell & West Birmingham Clinical Commissioning Group

Hospices of Birmingham

Brian Carr
Birmingham Voluntary Service Council

Healthwatch Birmingham

Derek Tobin
Birmingham & Solihull Mental Health NHS Foundation Trust

Birmingham Community Healthcare NHS Foundation Trust

Sandwell & West Birmingham Hospitals NHS Trust

University Hospitals Birmingham NHS Foundation Trust

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OVERVIEW

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A Refresh not a Restart

Partners within the local health and social care system came together in 2018 to form the Birmingham Older People Programme to tackle failures in the system that were acknowledged as letting down the people of Birmingham, including:

- Fragmented services, inconsistent capacity and an over-reliance on beds
- Citizen experience of poor outcomes from services that weren't joined up
- Sticking plasters as tactical responses to pressures
- The need to address financial pressures as a system

Since then we have come a long way as a partnership. The time is right to reflect on what we have achieved through working together and on what we still need to do in partnership. But this does not mean that we have to start again. Instead we need to refresh our approach to ensure that we are focussed on the critical areas where we need to work together for positive change.

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What we have achieved

We are proud but not satisfied or complacent with the progress we have made since forming the partnership.

Early Intervention has been our flagship programme. Commencing in October 2018, this has been the first integrated programme of work in Birmingham and was supported by an external change partner. The programme has delivered a transformation in how partners work together to put the person at the centre and to promote “home first” as the default outcome for citizens who experience, or who are at risk of, the need for acute care. Perhaps the most notable aspect of the programme has been the creation of new multi-agency Early Intervention Community Teams as the pivotal part of a programme that has enabled people to live more independently, reduced the length of stay in hospital and delivered financial benefits for the system.

Good progress has been made against the other elements of the original programme vision – Prevention and Ongoing Personalised Support. Neighbourhood Networks are established across all parts of the city, helping to build community capacity and to enhance the resilience of citizens. Similarly we have improved the consistency of our response to the management of long-term conditions and have commenced restructuring of service delivery towards neighbourhood working.

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What we have learnt

COVID 19 and our ongoing response to the pandemic has underlined and reinforced our existing learning as a partnership whilst highlighting the need to challenge our processes and outcomes.

As a partnership we have learnt:

- The value of strong relationships that allow for challenge, openness and transparency;
- To achieve impact we need to focus our capacity;
- The benefit of dedicated staff capacity for programme and project support;
- The importance of staff and citizens being at the heart of change;
- The need for a greater emphasis on addressing inequalities in citizen outcomes;
- That we can deliver transformational change when we commit to a shared purpose.

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Our Purpose and Vision

The purpose of the Partnership is:

To work together so that we deliver better care for people in Birmingham

Our vision is that through working better together citizens will receive:

The right care, at the right time, at the right place

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Commitment to Personalised Care

Underpinning our vision is an ongoing commitment to personalised care. This means that whoever is in contact with a person or their carers will:

- Work in partnership with them 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 be healthy and happy, regain independence and remain independent for as long as possible
- Build the person's knowledge, skills, resilience and confidence
- Learn to observe and guide and not automatically intervene
- Support positive risk taking
- Promote the use of personalised care plans that are informed by the preferences of people and their carers
- Collaborate with partners to take a holistic approach to care planning and delivery through the integration of physical health, mental health and personal well-being interventions

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Our Delivery Priorities

We have refreshed our priorities based on our learning as a partnership and to reflect changes that have happened since we formed as the Birmingham Older People Partnership. We have recognised the need to broaden our scope to work for better health and care outcomes for all adults in Birmingham and that some of our work will also impact upon children and young people.

Our three priority programmes are:

- Early Intervention (Phase 2)
- Neighbourhood Integration
- Care Homes

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Early Intervention (Phase 2)

Objectives

The success of the programme is measured by monitoring performance against these aims:

- Increase the percentage of people going home from acute care and bed-based intermediate care
- Decrease the number of acute bed days used
- Decrease the number of non-acute bed days used
- Decrease the overall length of time that people experience in the intermediate care system
- Reduce the financial impact on long term care across the system (as a proxy for improved outcomes)

These measures are underpinned by a series of key performance indicators

Strategy

A systematic improvement programme is in place across four components of intermediate care:

- Older Persons Assessment and Liaison (OPAL) - based at acute hospital sites to reduce unnecessary admissions
- Integrated discharge hubs to ensure consistent decision-making to get people home first
- Community-based rehabilitation and assessment beds with a consistent care offer
- Early Intervention Community Team to enable safe return to home and to maximise recovery and independence

In addition, an integrated commissioning strategy and plan is in development

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Neighbourhood Integration

Objectives

- Immediate focus will be to support COVID-19 response, enabling Primary Care Network neighbourhood multi-disciplinary team's to focus on the needs of the most vulnerable, regardless of age
- Build on, and make improvements to what we are already doing
- Practical, flexible, clinically led with an agreed approach for communication and record sharing
- Primary Care Networks, BSMHFT and BCHC will be at the heart of this
- Linked to system strategy - keep partners informed
- Aspire to develop a shared culture with team members having a close working relationship and viewing themselves as a team
- Move away from mindset of 'referral' to culture of the team member best placed to meet current need for patient, supported by trusted assessor model
- All areas are covered by a neighbourhood team – accepting that teams may develop at a different pace in different areas

Strategy

- An integrated team is a local, multi-disciplinary team way of working that supports primary care, community services, community mental health services and adult social care to work together to support people to live well at home.
- Some elements of the team may share a local geography (e.g. community nursing teams aligned to PCNs); others will operate from a larger geography but will provide named links to the neighbourhood (e.g. community mental health teams, adult social care teams).
- The multi-disciplinary team will also link to local community and voluntary sector organisations e.g. through the social prescribing role.

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Care Homes

Objectives

The objectives of the programme are:

- COVID – reduce transmission within care homes
- Reduce infection rates (across a range of conditions) in residential and nursing care settings
- Reduce unplanned admissions into acute care from care homes
- Improve quality of citizen experience
- Improve workforce recruitment, well-being and retention
- Improve performance against care home quality ratings
- A care market that is financially sustainable for both provider and commissioners

Strategy

In response to the ongoing COVID-19 pandemic, short-term priorities are to support, advise and respond to immediate pressures within Birmingham's provider market, maximising take-up and use of financial support that is available – eg. for infection control - and co-ordinating vaccination programmes.

However, we recognise that planning for the longer term is required if we are to make the significant and lasting change this is needed to achieve our ambitions for the sector in Birmingham. To this end our strategy is to deliver on our objectives by:

- Connecting Care Homes with Neighbourhood Multi-Disciplinary Teams to ensure consistent access to primary care including mental health.
- Develop better processes to listen to and act on feedback from residents and their families, friends and advocates.
- Develop a joined-up system of quality assurance for the care market, led by one organisation on behalf of the system.
- Develop a sustainable, partnership led methodology for supporting and sustaining the care market including joined up commissioning arrangements.
- Create city-wide strategy and programme to support the care market to recruit, train and retain quality staff, including development of career pathways.
- Supporting and driving digital connectivity and data sharing across the health and social care market.

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Partners

The Birmingham Integrated Care Partners are:

- NHS Birmingham and Solihull CCG
- NHS Sandwell and West Birmingham CCG
- Birmingham City Council
- Birmingham and Solihull Mental Health NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- Sandwell & West Birmingham NHS Foundation Trust
- Birmingham Community Healthcare NHS Foundation Trust
- Hospices of Birmingham and Solihull
- Birmingham Voluntary Services Council
- Healthwatch Birmingham

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