Making Birmingham

a great place to grow old in.

The Early Intervention Programme

Part of the Birmingham Integrated Care Partnership (BICP)

Project Completion Report

June 2022

EARLY INTERVENTION PARTNERS

John Taylor Hospice · Birmingham St Mary's Hospice · Marie Curie · St Giles Hospice · HoBS (Hospices of Birmingham and Solihull) · NHS · Birmingham and Solihull Mental Health NHS Foundation Trust · Sandwell and West Birmingham Clinical Commissioning Group · Birmingham and Solihull Clinical Commissioning Group · Birmingham Community Healthcare NHS Foundation Trust · University Hospitals Birmingham NHS Foundation Trust · Birmingham City Council

Birmingham and Solihull Integrated Care System
Caring about healthier lives

Birmingham City Council

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1. Welcome by Graeme Betts, Chair of BICP Board

Welcome to this report which celebrates the success of the Early Intervention (EI) programme, reports on its progress to date and outlines how future work will build on its legacy.

EI has been delivered as one of three workstreams in the Birmingham Integrated Care Partnership (BICP), the remaining two being Care Homes and Neighbourhood Integration (NI). In many respects, EI has been our flagship programme and was our first integrated programme of work in Birmingham.

EI is remarkable in so many ways. It has transformed how partners work together to put the person at the centre, promoting "home first" as the default outcome for citizens who experience, or who are at risk of, the need for acute care.

I would like to acknowledge the effort, determination and commitment of our 1000+ colleagues who took those first steps in not only introducing a new way of working across the city's health and social care teams, but doing so during a global pandemic, the path, duration and outcome of which was unknown to global health leaders, let alone us here in Birmingham.

On behalf of the BICP Board, I would also like to pay tribute to colleagues in the wider health and social care system who are not directly involved in EI, but who have also stepped up to the plate to support those who are.

Perhaps the most notable aspect of EI has been the creation of the new Early Intervention Community Teams which are playing the pivotal part of enabling people to live more independently, reduce the length of stay in hospital and deliver financial benefits for the system.

The BICP collaboration demonstrates that transformational change can be delivered when we all collaborate and commit to a shared purpose.

I would like to take this opportunity to thank each and every one of my colleagues for their ongoing collaboration and commitment, and their perseverance in helping to deliver the right care at the right time in the right place.

BICP and all who work within our programme have achieved some amazing results: simply outstanding given the backdrop and demand on our services. I sincerely look forward to the next stage in our journey.

EI VISION

'For older people to be as happy and healthy as possible, living self-sufficient, independent lives, able to have choice and control over what they do and what happens to them."

Professor Graeme Betts

2. Overview by Chris Holt, SRO for Early Intervention

Chris Holt

Can I begin by saying what a privilege it has been to work on this programme with so many fantastic colleagues across our health and social care services, and for part of the journey at least, to help provide some leadership.

Overall, our EI and our collective determination to create a Home First care approach to ensure that people remain as independent as possible in their own home, for as long as possible, has delivered some fantastic results. Not least that our achievements, measured against our performance before the programme started, took place in the midst of an unprecedented global pandemic.

EI has helped put Birmingham on the health and social care map, evidenced by the fact that the programme is showcased by NHS England as a best practice model in delivering Home First integrated health and social care across Birmingham; the programme has also been shortlisted for four national awards for the same reason.

This has also been a collaborative effort not really seen before across Birmingham's health and care system. As a city, we have successfully taken multiple, separate teams and services and brought them together to deliver a coherent service model to the benefit of the 1.3m+ citizens we serve.

We have also learnt many lessons. We know that it is essential that each partner organisation needed to commit to deliver the shared vision and maintain that conviction throughout. Our colleagues embraced the opportunity to work outside their traditional organisational boundaries to the benefit of Birmingham's citizens but needed this regular endorsement that it is okay to do that.

We have learnt that it is important to make decisions based on data and evidence and not anecdotal information, involve front line staff in redesign and decision making and embed this into operational management frameworks and standard operating procedures.

And possibly most importantly, we have also learnt that equipped with the right tools, our front-line colleagues are highly effective in continuing to improve the way we work to meet our goals and delver enhanced care to our service users. We provided a structured approach to help them do this with the support of our dedicated improvement team. The delivery of the Early Intervention is a success, and the model is now firmly embedded across our services and considered ***business as usual***.

Our EI efforts have always been about intervening early to enhance the independence of citizens whilst adopting a Home First ethos in all that we do. This will not change. Early Intervention has delivered as a programme and this approach is here to stay. I look forward to working with you all in the next chapter of Birmingham's Home First journey.

Chris Holt
Senior Responsible Officer for Early Intervention
Chief Operating Officer for Birmingham Community Healthcare Community Foundation Trust

3. Background

In October 2018, more than 1000 staff from health and social care partner organisations across Birmingham joined forces for the first time in the city's history, to deliver EI programme.

This was one of the largest integrated programmes of work in Birmingham, and was supported by an external partner, Newton Europe.

EI marks a new integrated approach for Birmingham – targeting the interface between health and social care, particularly at the point of crisis. It aims to support people, who have experienced an illness or injury, to avoid hospital admission, prevent premature admission to long term residential care, recover faster and live healthier and more independent lives, ideally at home. It is driven by a fresh approach to data-led decision-making, front-line staff design, personalised care, testing and iterating programme changes.

The purpose of this project completion report is to assess the project's impact, ensure completion, and derive lessons learned and best practices to be applied to future projects.

3.1 Development of Early Intervention

The EI programme was designed in response to the findings of a 2017 Care Quality Commission (CQC) review which identified a fragmented intermediate care system with poor relationships and variations between providers, inconsistent capacity, an overreliance on hospitals beds and tactical 'sticking plaster' responses to pressure only set to get worse without direct action. This was impacting negatively on patient outcomes. The conclusion was that the system was failing Birmingham's older and frail citizens.

Birmingham City Council also held citizen forums to gain further feedback and a number of 'I' statements were agreed at these sessions (Figure 2) which have been used to structure the BICP programmes.

Figure 2 – The 'I' statements

'I' Statements

"I want to tell my story only once"

"I only want to be assessed once if possible"

"I want to be in control and plan my care together with professional people who understand my culture and are non- judgmental"

"If I'm receiving my support at home I want as few strangers as possible entering my home"

"I want help, not barriers put in place for me to get the support I need"

"I don't want to go into hospital unless I need to"

3.2 Response

In response the Birmingham and Solihull Sustainability and Transformation Partnership (STP) and Birmingham City Council's Health and Wellbeing Board set the independence of older people as a top priority for Birmingham

The two organisations established the Birmingham Older People's Programme (now known as the Birmingham Integrated Care Partnership (BICP) in October 2018 to deliver three key areas of work to meet the city's goals: Early Intervention, Neighbourhood Integration and Care Homes. ***Early Intervention would be the first of the three to be launched across five localities (Figure 3)and be the flagship of the BICP strategy.***

BICP partners are Birmingham City Council, Birmingham Community Healthcare NHS Foundation Trust, University Hospitals Birmingham, Birmingham & Solihull Mental Health Foundation Trust, Birmingham and Solihull CCG and Sandwell and West Birmingham CCG, Sandwell and West Birmingham NHS Trust, Birmingham Voluntary Services Council and Healthwatch Birmingham.

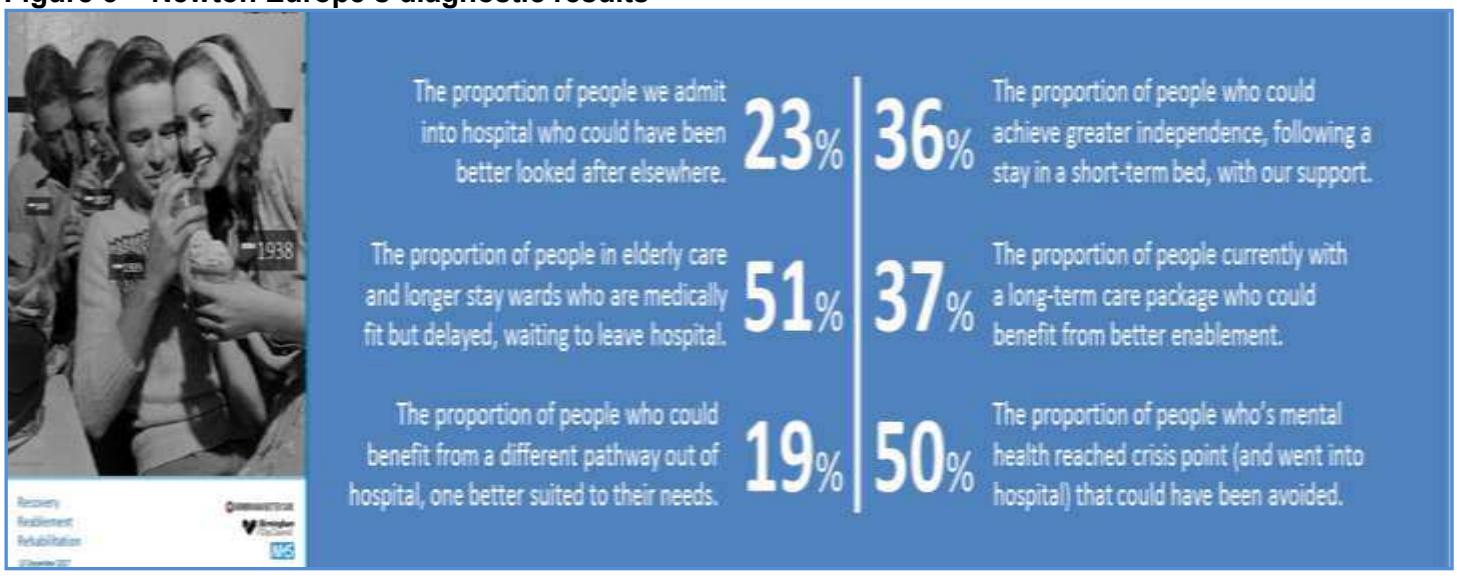
3.3 Approach

BICP identified it needed specialist external capacity and capability to support the city to deliver a common evidence-based approach to change with three criteria for success:

- Have we delivered intended outcomes?
- Have we made required savings?
- Have we created a solid platform for the next phase?

Newton Europe was appointed to support this work following a competitive tender process. The Newton team undertook a diagnostic of the city's recovery, reablement and rehabilitation (early intervention) system in November and December 2017. The diagnostic findings are highlighted in Figure 3.

Figure 3 – Newton Europe's diagnostic results



Combined, these reviews and insights into Birmingham's system highlighted fragmented services, inconsistent capacity, an overreliance on hospital beds, tactical 'sticking plaster' responses to pressures and an increasingly difficult financial situation only set to get worse without direct action.

3.4 Vision

In a first for Birmingham, its health and care system set out to solve the issues together. Using the Birmingham Older People's Programme, it began with a vision "***for older people to be as happy and healthy as possible, living self—sufficient, independent lives, able to have choice and control over what they do and what happens to them."***

3.5 Strategy

Behind the vision were three strategic areas: prevention, early intervention and personalised ongoing support. All of these centred around people receiving services.

The EI programme was tasked with creating an integrated approach to urgent and intermediate care services that it person and care centred and encompasses physical, mental health and social care needs that support older people, before, during and following a crisis. This is defined as:

- Recovery, ensuring people recover from illness or injury as quickly as possible.
- Rehabilitation – preventing unnecessary hospital admission and premature admission to long-term residential care
- Reablement – supporting timely discharge from hospital, maximising independent living.

Ultimately this programme was going to be about achieving consistent, safe, high-quality services and outcomes for older people across the city. This would ensure that thousands more citizens emerge from a health or social crisis as independent from care as possible – and ideally in their own home. And at the same time, delivering financial benefits for the system.

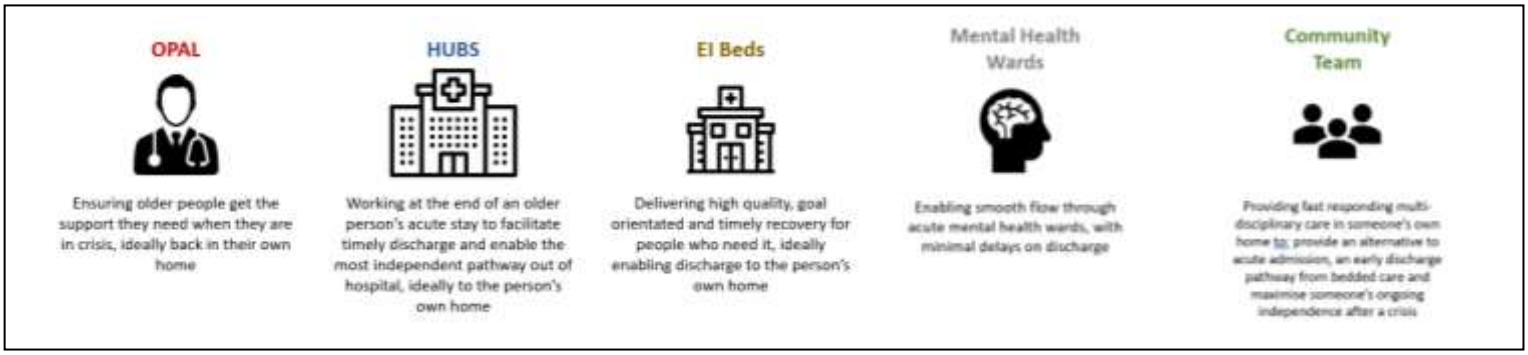
3.6 Goals

Newton's assessment (Figure 3) identified some significant opportunities which became the Early Intervention programme's broad goals:

- Improving support for people in their own home would result in 6,000 people living more independently
- Reducing avoidable acute hospital admissions whilst helping get people out of hospital more quickly would result in 40,000 fewer beds spend in acute beds per year.
- Reducing avoidable admissions to intermediate care beds would result in 20,000 more days spent at home living independently
- Annual financial benefit for the system of between £27m and £37m as a result of improving outcomes for people.

The process also identified the five "component" parts of our EI model that provided the basis for the programme (**Figure 4**).

Figure 4 – Early Intervention programme components.



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3.7 Method

To achieve this, teams from across the system worked with Newton Europe to help co-design new ways of working and established an evidence-based frontline-led plan to help realise the city's vision. This involved interviews with hundreds of frontline staff. 28 practitioners from all partners then spent time developing a set of recommendations about what needed to change and where these changes needed to happen. This was the first-time teams from across the system had come together in this way and so breaking down cultural and organisational barriers, myth busting and building trust formed an important part of these sessions.

They came up with a guiding set of principles:

To have one integrated model across our entire system

- The person must be at the centre of everything we do (with family and carer input also valued).
- Our aim is to support an older person's life not simply deliver a service.
- We need to make sure each person receives the right care, at the right time, in the right place, by the right professional, at the right cost.
- People should have to tell their story as few times as possible.
- Staff across organisations work together (co-locating where appropriate) to champion 'home first'.

Working this way would mean:

- Organisational boundaries should not have a detrimental impact on an older person's care.
- No wrong door for someone that needs help.
- Clearly defined roles to maximise skills and capacity.
- Efficient distribution of resources within a locality.
- Overall consistency accepting local variation where it makes sense.

3.8 Pilot Testing

The decision was taken to trial new ways of working before implementing them on a wider scale. The 28 strong team of practitioners helped to identify five sites in the south of the city, where testing the new model through design and iteration of the component parts (3.3) would take place. This meant setting up multidisciplinary teams of practitioners from all partners and a wide variety of disciplines including therapy, nursing, medicine and social work.

Eight newly trained 'Improvement Managers' were also recruited from across the partners to work with Newton to support the programme and to help establish the whole-system approach. The approach of the Improvement Team adopted four fundamental underlying principles:

- The identification of need for change is data driven
- The change is co-designed with front line staff
- The change will be delivered through the following approach – changes to process designed, tools designed to help process change and identifying impact, people coached to use tools
- The latter is delivered through a series of improvement cycles

To provide the necessary senior and corporate support, appropriate forums were also put in place with senior representation from all partners, operational and financial sponsors at director level, finance mangers, informatics and data teams, estates and services and primary care engagement through three representative GP's.

Finally, direct links were created with Healthwatch, the independent body focussed on incorporating citizen insight, experience and involvement into health and social services.

Full details of the test sites and the results are outlined in Appendix D**.** They included the following areas:

3.8.1 Hospital front door (OPAL) – Queen Elizabeth Hospital

The OPAL team provides a timely, multidisciplinary, patient-centred, comprehensive assessment to those who have an urgent need. The team provides patients with early access to expert advice, regardless of whether they are referred by a GP, community services or arrive at the front door.

3.8.2 Hospital back door (COMPLEX DISCHARGE HUB) – Queen Elizabeth Hospital

The Complex Discharge Hub at the QE assesses and sources support for people that require further care after a stay in an acute hospital bed. The team provides health and social work expertise as well as liaises with therapy teams in order to provide timely discharge into the most appropriate care.

3.8.3 EARLY INTERVENTION COMMUNITY TEAM - Norman Power Centre, Birmingham

A new service providing urgent assessment, treatment and care for people in their own home or usual surroundings was introduced and tested. The team delivered a range of integrated services provided by multiple professionals who promoted recovery and independence.

3.8.4 Test site 4: Early Intervention beds – Norman Power Centre, Birmingham

EI Beds provide an inpatient rehabilitation and recovery service for older adults who no longer need the acute medical care of a hospital, but are not yet ready to return home

3.8.5 Acute Mental Health – Juniper Centre and Reservoir Court, Moseley

The Juniper Centre and Reservoir Court provide inpatient services for older adults with a functional or organic acute mental health issue. This includes comprehensive assessment by a multidisciplinary team, diagnosis and treatment, responding to a wide range of needs of the service user in a person-centred approach.

3.9 Covid 19

Following the completion of the test phase in the South of the city; EI was rolled out citywide in March 2020 as the pressure on Birmingham's health and social care system intensified due to Covid-19. The success of the test phase demonstrated that embedding the approach citywide would be critical to Birmingham's response to the pandemic, in particular, the creation of new EICT teams for all parts of the city would be essential in order to respond to the need to rapidly and safely return people to their homes following a stay in hospital. However, there was a need to do some redesign work (**Figure 5**) to respond to the new nationally mandated hospital discharge requirements - *COVID-19 Hospital Discharge Service Requirements (March 2020)*. This created a resilient and sustainable Early Intervention programme and put its services in a positive place to respond.

Additional information on the impact of Covid-19 on Early Intervention is outlined in 4.2.

Figure 5 - Changes made within each Early Intervention component in response to Covid-19.

Changes made within EI components to meet national discharge to assess guidelines 2020
OPAL
The service created "OPAL+" – a functionality for ambulance teams to call in for advice from OPAL remotely, before making the decision to convey, which operates out of the QE.
EICT
The service was a focal point for redeployment of over 150 practitioners from across the system in order to provide the capacity needed. This enabled the service to: • utilise Advanced Clinical Practitioners to enhance the clinical oversight of patients within EICT • utilise additional therapists to provide a 7-day therapy service
iHub
The iHub was created to act as a focal point for referrals to EI Beds and manage flow and discharge through these beds too. This was done by co-locating BCHC's bed management and BCC's EAB management team at Moseley Hall Hospital. The remit of the iHub is being widened to become a single point of access for Discharge to Assess in Birmingham.
EI Beds (P2)
The changes to EI Beds, over and above those introduced by the iHub work and the cessation of certain assessment frameworks, mainly centred around taking steps towards making the staff at all sites more uniform so that there is greater flexibility in the demand that each site can receive.

4. Programme structure & resource

4.1 Improvement Managers and PMO support

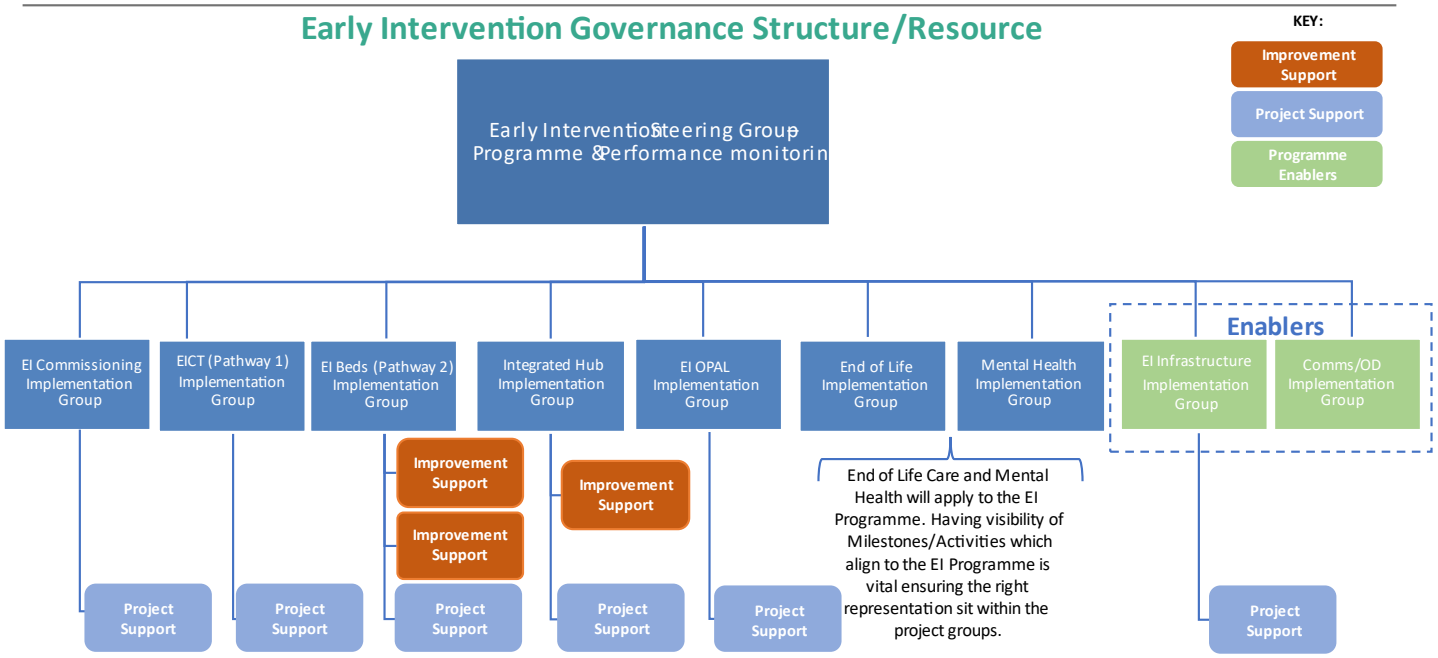
The system commissioned an improvement approach, capacity and expertise from Newton Europe. The approach also included recruiting and developing staff from within the system to lead the change. They were known as the Improvement Managers. Alongside this, project management support was also sourced which allowed for overseeing the programme and component level for delivery and reporting.

4.2 Steering Group & Governance

A weekly EI steering group under-pinned the programme structure (**Figure 6**) and discussed the progress of deliverables outlined in the brief for each project as well as the operational performance of the EI components. For the duration of the project, all risks and issues were reported to the Early Intervention Steering Group and escalated as appropriate. All issues and risks are now being reported via business as usual (BAU) meetings.

The progress of the programme was regularly reported to the Birmingham Integrated Care Partnership (BICP) Board where high-level risks are reported.

Figure 6 – Resource and governance aligned to the EI project programme



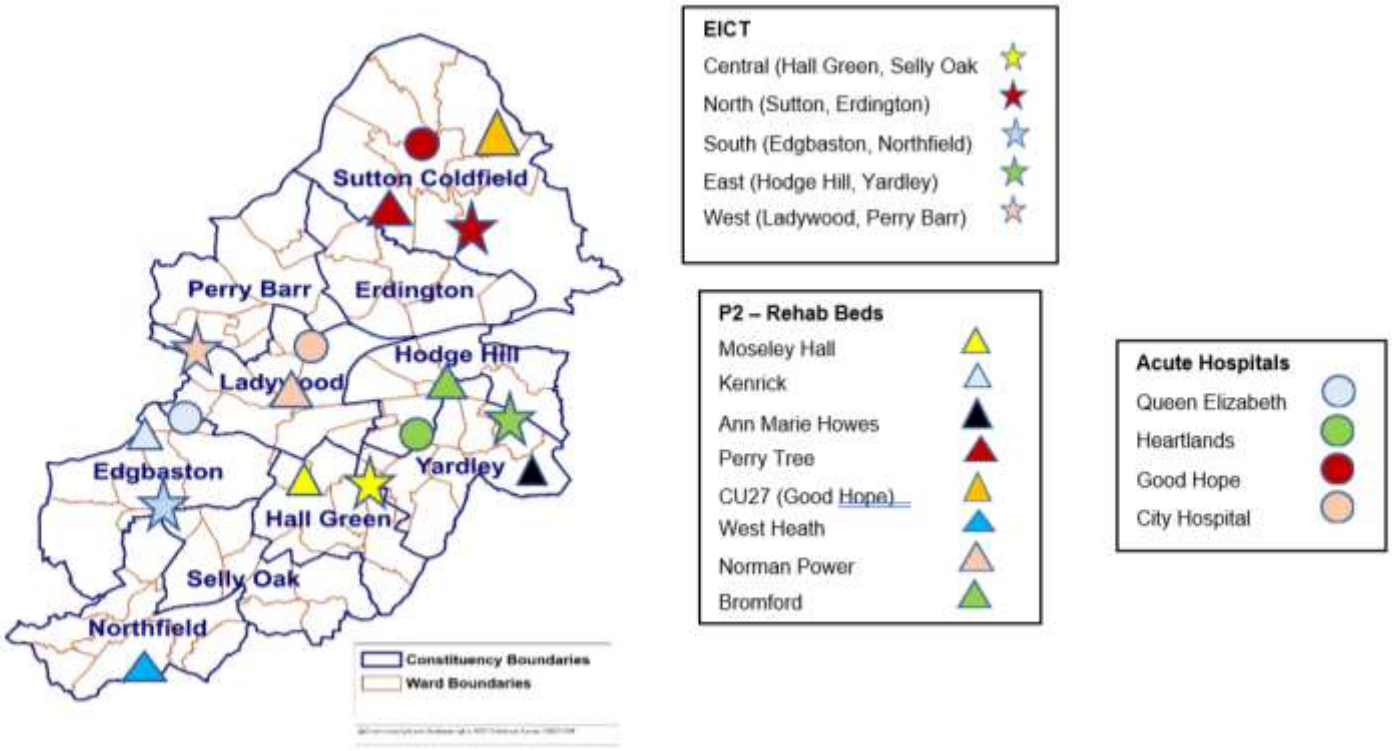
4.3 Baseline objectives for each EI component

Key baseline objectives were agreed for each component, signed off by all key stakeholders and used to measure progress as the EI developed. **Appendix A** outlines all the key baseline objectives outlined in the project plan.

5. Impact

By October 2020, all EI components were fully launched across Birmingham (**Figure 7)** and real time data was being gathered to enable all decisions to be made on clear data and evidence.

Figure 7 – the current spread of Early Intervention across the city



The data, summarised in **Figure 8,** shows that since the Early Intervention (EI) model was rolled out in early 2020. **Appendix B** outlines the key milestones that the project has achieved to date.

Figure 8 – EI programme results

Results overview March 2020-March 2022

120,000+
acute bed **days saved** annually

20,000+
unnecessary admissions avoided

45% more **likely to go home** when leaving non-acute beds than before EI started

6.5 hours/ week
Ongoing **care needs reduced** on average

12 to 4 days
Reduction in average time to be **discharged** from acute hospital

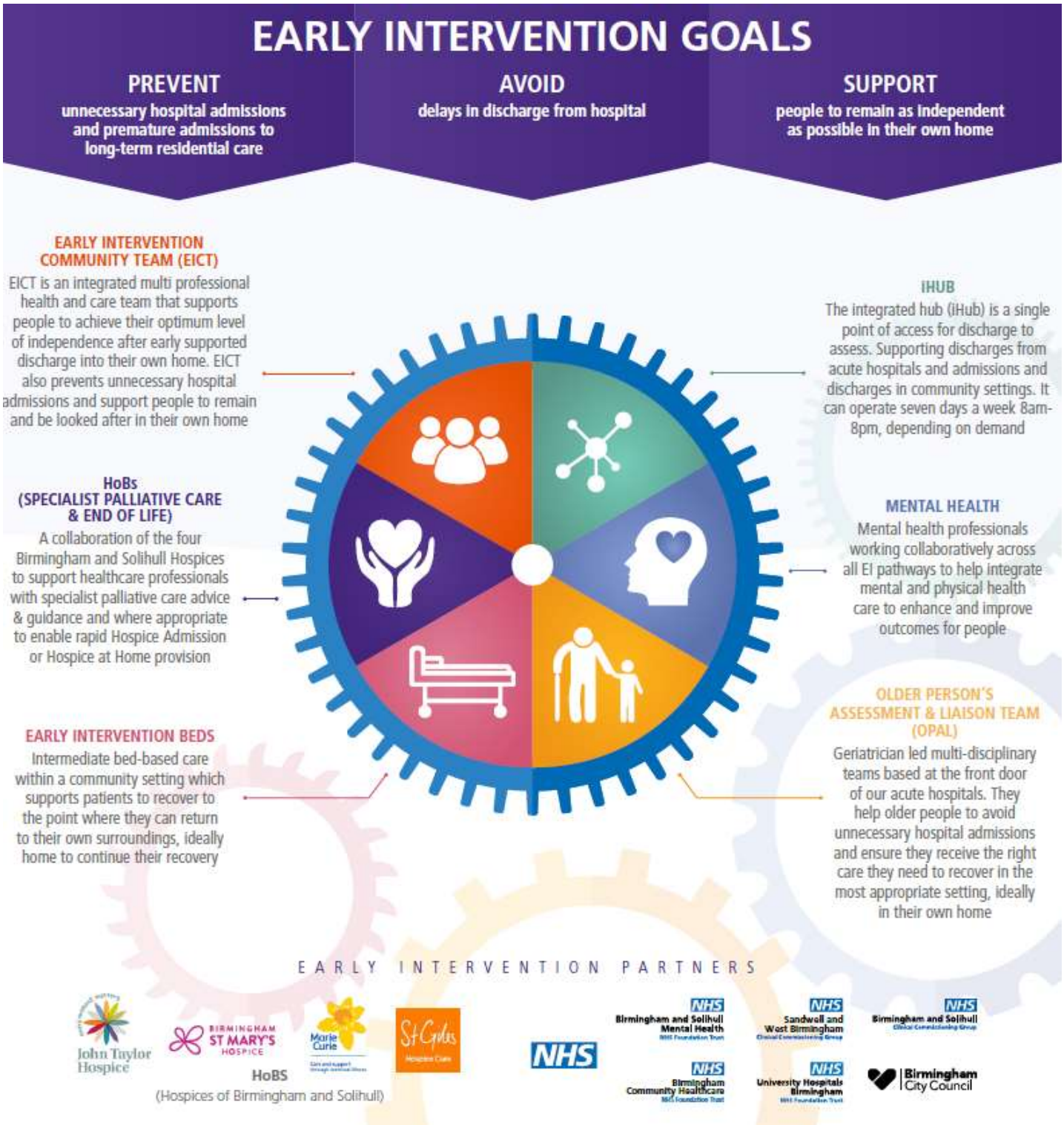
18,000+ referrals into **new EICT** service

There has been a financial benefit equivalent to £26.7m to Birmingham's health and social care system. This has enabled the programme to do more with the resources that it has available to it.

The programme's performance has been achieved throughout Covid-19 and against the backdrop of new Discharge to Assess guidance (D2A), issued by the government in March 2020 and updated in August 2020. These factors have skewed the original rationale of the objectives. What is clear is that citizen outcomes have measurably improved from this innovative whole system approach.

Each component has continued to test and develop new ways of working to evolve its approach. The current Early Intervention model is shown in **Figure 8**.

Figure 8 – EI across Birmingham



5.1 Key Areas of Success

Innovative Collaboration: 1000+ staff from seven health and social care organisations spanning five localities across Birmingham joined forces for the first time in the city's history to launch the EI programme. There is clear evidence of comradery across Birmingham and historical barriers between organisations were quickly addressed.

Data Led: Decisions were made on data &evidence, not anecdote and front-line staff were involved in redesign and decision making. Tools were developed to support staff to make the right decisions and focus on operational management framework and sustainability of standard operating procedures was maintained throughout.

Impact on citizen outcomes: The EI programme rolled out in March 2020. In response to Covid-19 its model was quickly adapted, creating a resilient and sustainable service that has helped to prevent more than 20,000 unnecessary hospital admission and reduced ongoing care hours by 6.5/week. There was huge support across all EI partner organisations in redeploying staff during Covid.

Continuous Improvement: A continuous improvement cycle was introduced and maintained.

Adaptability of the EI model: EI is an integrated care system already in action. Its process has been mapped out to enable others to adapt their services and embed the same approach to help improve system, staff, patient and citizen outcomes with their own organisations.

5.2 Lessons learned for future programmes

In a complex system like Birmingham, whole-system, integrated working is a long-term commitment. Key lessons are outlined below. **Appendix C** outlines further details of what has worked well and which areas require improvement.

- Jointly agree a vision and purpose for the programme at the start and ensure regular and consistent communication of the key messages to all staff and stakeholders throughout the programme.
- Have a greater focus on culture change and multi-disciplinary working as part of one team; consider integrated management structures as an enabler and invest in OD to support/reinforce/embed this change
- Properly resource additional improvement capacity to support operational teams to deliver transformation.
- Have a dedicated finance lead from the system to maintain oversight of the programme.
- Put robust programme governance in place – supported by a dedicated PMO function.
- Create a single enabling workstream to work across the programme and support components.
- Ensure that Mental Health and End of Life are integrated from the start and engaged throughout.
- Ensure all professional groups working in the programme have access to the same sources of information – ideally a single source.
- Set a clear methodology for benefits realisation before the programme starts

6. The Future

6.1 A journey of integration

The delivery of the Early Intervention project is complete and its workstreams are now fully integrated across Birmingham's health and social care system. As a result, the Early Intervention Steering Group meetings have been stood down and all Component Groups have all finalised their respective completion reports. The project team has been disbanded. **Appendix E** outlines key deliverables transferred to Business as Usual and adopted into the workstream groups.

EI continues to be a journey of integration and colleagues continue in their ambition to become the largest integrated health and social care 'home-first' teams in the country. This is in addition to

- enabling innovative workforce opportunities (qualified/non-qualified)
- attracting and retaining staff,
- provide a simple offer for the population - I statement (Figure 2)
- to do what is required in supporting 1.3m+ Birmingham citizens to improve their outcomes.

6.2 Next steps

All core components continue to evolve to meet the ongoing needs of the changing landscape of integrated care and the introduction of the Integrated Care System (ICS). These are outlined below:

6.2.1 EICT

<u>System Wide Requirements</u>

- Continue to develop EICT response to Urgent Community Response (UCR) to ensure EICT teams can respond within 2 hours. Ensure EICT teams have the right skills and knowledge to provide a confident and robust approach to this new requirement.
- Enable locality-based health and social care working across all services
- Enable a Discharge to Assess pathway across community bedded units to community teams across the health and social care sector

<u>Infrastructure to support</u>

- Single IT system to track patient journey
- Roll out supporting technology initiatives
- Standardise sustainability & continuous improvement process across five EICT localities
- Ensure teams are located in the right place, providing the right care to meet the needs of the population
- Ensure EICT staff have the right tools, space and equipment to meet those needs

<u>Quality Assurance</u>

- Operational & Quality service review. Gap analysis to ensure competence, training & development
- Revision of KPI and targets

6.2.2 EI Beds

There is a strategy to deliver the next steps of the EI Beds. There is an ambition to roll out the EI approach into a locality-based model that maximises outcomes for citizens – ideally returning home and maintaining their independence.

Phase 1: Exit from COVID-19 pandemic response and planning

- Return to a 'steady state' in a managed way
- De-escalate surge beds that were mobilised as a pandemic response

Phase 2: Consolidation and interim planning

- Monitor capacity, demand, and length of stay in a more 'steady state'
- Adjust model as required for all bed types to inform bed/site requirements for phase 3
- Engagement and consultation with service users to inform phase 3

Phase 3: Locality-based model

- Move to a locality-based model with consistency across all sites – a generic model
- Optimised outcomes – maximising citizens returning home
- Optimised length of stay
- Adjust overall beds (based on modelling in phases 1 and 2) and retain the appropriate number of sites
- Implementation of other bedded pathways as appropriate

6.2.3 OPAL

OPAL will continue to support the OPAL and OPAD operational teams at the Heartland site to help them to function at their optimum level. Remaining vacancies will be filled through the cross-site recruitment strategy and development of the DHMS system will continue including the training of staff and final go-live. OPAL will develop links with the Birmingham and Solihull Mental Health Trust to monitor the impact on patient outcomes. Continue to expand OPAL+. The OPAL+/BT pilot is in the process of being evaluated – next steps for development of OPAL+ and future collaborations will be worked through following the evaluation.

6.2.4 iHub

The iHub has progressed despite the challenges of the pandemic but there is significant work ahead.

There is now a joint BCHC and BCC bed management team and the work for the short to medium term is to have a seamless operating process that links to the EI beds strategy and means the bed management team manage across provider boundaries.

An MDT approach has been put in place to support flow. The work ahead is to improve the robustness of the approach. Within the discharge pathways this means ensuring a clear focus on the principles of setting an expected date of discharge with the right MDT engagement based on the needs of citizens, progress tracking and escalation process to ensure timely discharges.

Significant improvements have been made in the complex discharge hubs and the work ahead is aimed at moving to a single iHub. The needs of the citizen being described in the acute with the iHub then determining the optimal discharge pathway and coordinating admission into the discharge pathway.

This will see social work capacity currently in acute hospitals working across D2A therefore creating better flow. A draft SOP and core team structure was developed during the pandemic and will now be revisited to account for the changes described above.
The review of the SOP and team structure will seek to reaffirm organisational and team commitment to developing the model further. A key enabler will be an IT solution that gives practitioners access to necessary records and allows flow to be tracked and reported on across D2A.

The focus for the iHub over the longer term includes a full BSol approach and progressing the opportunities of a single point of access for discharge to assess.

6.2.5 Commissioning

Commissioning and funding to support discharge has been pooled across health and social care under the Better Care Fund section 75 to support the services at the interface of health and social care system to deliver EI. This will continue to develop to ensure that we jointly plan, commission and deliver appropriate care and support that meets population needs and is affordable within existing budgets available to NHS commissioners and local authorities.

The COVID-19 pandemic has shown the benefit of NHS providers working together to address challenges. Although collaboration existed prior to COVID-19, the experiences during the pandemic and the formation of an ICS helps us build on collaboration and partnership working

An EI commissioning road map has been set out as to the steps to bring this to life and to potentially commission a single EI service for Birmingham.

Key elements of the EI road map are:

- Health inequalities – understanding the profiles of who is using EI services to support decisions and plans to improve local people's health and reduce health inequalities.
- Strategic planning – assessing needs, reviewing provision and deciding priorities
- Procuring services – designing services, shaping structure of supply, planning capacity and managing demand
- Monitoring and evaluation – supporting patient choice, managing performance, seeking public and patient views

Significant work has already taken place to expand EI beds provision (now referred to as pathway 2 beds and aligned to national Discharge to Assess guidance); moving us closer to a locality model that provides an integrated, standardised, therapy and assessment response to support citizens' home

6.2.6 Infrastructure

The infrastructure group consisted of key stakeholders from across the System with the aim of delivering against five key workstreams:

- P1 - Identify what we have now, new KPIS and data streams. align with other component groups to enable list for sharing.
- Collection of data and processes in place to extract clinical activity from our systems to enable reporting of Urgent Community Response to CSDS.
- Effective governance arrangements for access and sharing of data and information.
- A single performance, finance and outcome dashboard created and in use across the programme - complete for EICT available on One Vision.
- Estates Strategy - short and long term estates plan in place to support pathways 1, 2 & 3

The five key deliverables broadly covered both the digital infrastructure developments that were required to deliver the EI programme, as well as, to develop an estates strategy which would underpin the revised clinical and operational models which had been developed as part of EI.

Key achievements include -

- Significant work was undertaken which consolidated the myriad of data collection and reporting providing a suite of metrics which could be adopted and embedded as part of the continued operational delivery of EICT.
- UCR data now submitted via CSDS templates
- DSA reviewed and informing longer term commissioning arrangements
- EICT dashboards reconfigured and presented in Finance, Operational and Outcome sections
- Review of current estates and gap analysis completed identifying a number of short term actions required to ensure sites are fit for purpose
- Options appraisal of all potential sites to support P1 and P2 clinical operational delivery model

6.2.7 Mental Health

The pathways between all Mental Health and other EI components, including End of Life, have made significant progress and will continue to be strengthened to enhance the flow through mental health wards and reduce waiting times for transfer of patients from the acute hospitals, ensuring that a person receives the right care at the right time in the right place, ideally in their own surroundings.

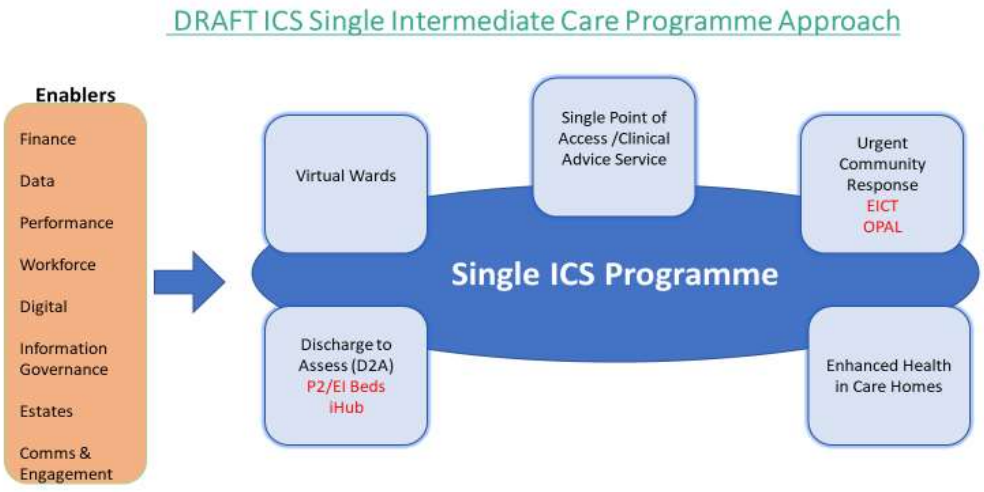
Continuing with the ethos of Home First, work will continue to develop across the mental health community teams, memory assessment units, rare dementia service, care home liaison and community enablement and rehabilitation service. This will ensure that specific issues related to mental health across partner services are picked up and addressed at the earliest opportunity, in the interest of those who experience mental health problems.

6.3 Future Transformation Programme

Much has been achieved and much has changed since the EI programme was launched. The programme as designed has delivered lasting transformation but there is still further work to do. Improvement in the health and care sector is a continuous process and as we finalise the completion of this programme we are developing and configuring our next transformation programme – building on the foundations, successes and lessons from EI to date. Our new programme will enable the ongoing actions for EI components identified above to be progressed within a new programme structure that is fit for purpose for the current and future challenges that we face.

A draft outline of our new “Intermediate Care” programme is shown below in Figure 11:

Figure 11 – a draft model of the new Intermediate Care programme.



It is proposed that this programme operates across BSol ICS with delivery at Place.

7. Case Studies

7.1 Mary

OPAL, West Midlands Ambulance Service (WMAS) & EICT partnership working

OPAL at Good Hope hospital received a call from West Midlands Ambulance Service (WMAS) crew at 7.30am. Mary, a 94-year-old lady had called an ambulance as she had tripped and fallen and had difficulty in mobilising. She had also fallen the week before and had a swollen hand which the crew were concerned about. There were no family members, Mary lived alone and there was no package of care or any assistance at all.

WMAS felt that Mary needed to attend ED for an x-ray and that a package of care needed to be arranged as she could no longer manage her personal needs; she was sleeping on the sofa and struggling to climb the stairs to use the bathroom, as well as get out to do food shopping for herself However, Mary flatly refused to attend hospital as well as accept any support on offer. After they had been with Mary for an hour, the crew called OPAL+ for advice and assistance and to see if the team could persuade Mary to attend ED just for an x-ray.

Mary finally agreed, but only to go for an x-ray then she was **"definitely going home!"** The x-ray showed no broken bones, just soft tissue injury. Mary's main objective was once again "**to return home**."

Following Mary's discharge from ED, OPAL GHH gave her a full assessment and once again tried to persuade her that a package of care would be great support for her at home.

"Various services were offered such as therapy assessment and community physio which she initially declined but finally agreed to. She was discharged back home with agreement that the EICT would visit her until her long-term care was arranged.

7.2 Anna

P2 (rehabilitation beds), OPAL+, mental health team partnership working

Anna **is 85-years of age** and was **recuperating at Norman Power (NP**) after being transferred from the **Queen Elizabeth Hospita**l. Anna has **dementia.** As well as supporting her with **rehabilitation**, **NP** was helping her and her family with **long-term residential care planning**.

One morning, Anna became **agitated** and **aggressive**. The NP team (pictured right) contacted OPAL+ who determined Anna's behavioural and psychological symptoms related to the dementia and urgent intervention was essential.

Rather than admit Anna to hospital, OPAL+ contacted the Birmingham & Solihull Community Mental Health Team who visited Anna that same day and prescribed new medication which would support her going forward. It was late in the day at this stage but OPAL+ has the facility to prescribe and deliver medication out of hours. Anna was able to take her first dose of the new medication that evening and her behaviour quickly stabilised.

Prior to EI, Anna would have been taken to the Emergency Department, waited for several hours to be seen & admitted until she had been stabilised and assessed**. Listen to the consultant involved tell the story in his own** words

7.3 Hilda

GP, EICT, End of Life team partnership

Hilda's GP had recently prescribed antibiotics for her to clear up a water infection. Two days later her distressed daughter, Jan, phoned the GP to advise she was calling 999 as her mum was deteriorating and refusing food and fluids.

The GP referred Hilda to the Urgent Community Response service which is delivered by the Early Intervention Community Team. On examination the team found that Hilda had oral thrush which made eating and drinking uncomfortable. Her dementia had been restricting her ability to communicate this.

The UCR prescribed for thrush and to Jan's relief, helped develop a care plan for her mum. Hilda had never wanted to be admitted to hospital and her daughter respected these wishes. UCR and the GP supported Jan with the RESPECT process too and referred Hilda to palliative care at home.

These actions prevented an unnecessary hospital admission, possible admission to long term residential care and respected the wishes of Hilda by keeping her in her own home with the support they both needed.

The UCR team visit included an advanced clinical practitioner (ACP) and a therapist.

Whilst the ACP was talking to the daughter and the GP, the therapist started to play music that Hilda would be familiar with.

Hilda became more lucid and animated to the extent that mother and daughter were able to communicate with each other; plenty of tears of joy were shed.

7.4 Mental health and OPAL+ trial success

A recent trial between Birmingham & Solihull Mental Health Trust (BSMHFT) and OPAL+ has been confirmed a success. It improved pathways between the two services, including how to reduce the time it takes for referrals and the type of patients that can be referred.

Over four-weeks OPAL+ received eight calls from BSMHFT Reservoir Court. Of these, seven people remained at Reservoir Court and received the appropriate care they needed. The next steps are to ensure that this approach is sustainable for BSMHFT and OPAL+ across 50+ sites citywide. BSMHFT now working with OPAL to achieve the same. The trial has helped more patients in the unit to avoid unnecessary hospital admission and recover in their own surroundings.

7.5 Dennis

111, UCR, OPAL+, QE team partnership

Dennis lived alone and was supported by daily carers. His daughter, Mrs B, visited him regularly. When he fell poorly in December, she rang 111 for help and was referred to the Urgent Community Response service.

Dennis was visited the same day by the team who assessed that he had a possible water or chest infection. As per the OPAL+/community service approach, the community team contacted OPAL+ to agree the best course of care.

Following a multi-disciplinary assessment between the OPAL+ consultancy team at the Queen Elizabeth Hospital, the community team, Dennis and his daughter, it was agreed that he did not need to be taken to hospital. Instead, Dennis would be prescribed antibiotics and cared for by the community team over the next few days until he recovered.

Mrs B said: "I am in awe of the way that my dad's care plan seamlessly unfolded. The collaboration between different teams was amazing. Dad and I were fully involved at every step of the way starting with the assessment

and dialogue between the community team and OPAL+ about keeping dad at home through to when the community team were visiting and their thoughts on how he was recovering.

“The fact that he and I were part of all these discussions made a huge difference. We felt that people were properly listening to us, especially my dad who wanted to stay safe, secure and comfortable in his own home. Above all we were shown great humanity.”

Pre-OPAL+, Dennis would have been admitted to hospital where, especially in Covid times, he may have acquired further infections and definite muscle loss.

“I wish I could bottle the seamless care and emotional approach we experienced. It would be priceless.” Mrs B, daughter of Dennis (left)

Pictured: Dennis and his granddaughter Laura and great grandson, Daniel.

“

APPENDIX A

EARLY INTERVENTION PROJECT BASELINE OBJECTIVES & PROGRESS AGAINST THEM

Baseline		
Community Teams		
MDT working not in place	Significant Progress	MDT approach adopted in each locality
Fragmented Services provided by individual partners to enable rapid discharge, supporting people in their homes or prevent admission to acute	Significant Progress	Mostly resolved with scoping plan underway to identify any continuous improvement opportunities, gaps and to include private provider element
Multiple hand offs for some individuals, no co-ordinated approach	Significant Progress	Much improved, but some gaps identified in therapy and social work
Multiple assessments and plans	Significant Progress	One professional now undertakes assessment & develops plan with input from others where required.
P2 (rehabilitation beds)		
Significantly more beds than best performing equivalent systems	Significant Progress	In 2017 there were 409 beds across the system - reduced to 370 prior to Omicron with further right sizing of bed numbers due to be incorporated in phase 3 business case.
Multiple commissioning arrangements and providers including specialist beds with inconsistent access across city	Significant Progress	We have reduced from 19 sites to 14 sites and further reductions planned to nine sites in 2022.
Variable access criteria ,including acuity accepted	Significant Progress	Harmonised access criteria for NHS beds and reducing variability in privately commissioned beds.
Multiple medical management arrangement	Limited Progress	The approach to a single model has been agreed. A detailed implementation plan is underway for governance/ approval.
Inconsistent/poor outcomes	Significant Progress	Consistency of approach has been adopted in NHS beds.
Hospital pre-admission assessment and intervention		
Different "front-door" services in places in places at acute hospitals	Significant Progress	OPAL teams are now in place at all UHB acute hospital sites. Some operational challenges at the BHH site are being worked through systematically.
Limited multi-disciplinary working	Significant Progress	Workforce models agreed, funded and largely recruited to. Remaining vacancies are being filled. Strong multidisciplinary approach taken. Further work is needed around physical space for co-location of social workers at GHH and BHH sites.
Not effectively linked to community teams	Significant Progress	Strong links between OPAL+ and community teams, including mental health . Future BAU work programme aimed at expanding OPAL+ and extending access to OPAL to all BSMHT services
Different operating models and facilities	Significant Progress	OPAL services now in place at all sites. Current SOPs to be reviewed over the next few weeks via BAU. Work is ongoing around consistency of medical input 7 days per week at all sites - this will be improved as additional consultant workforce is recruited at BHH and GHH sites as part of the phased approach to consultant recruitment.
Inconsistent/poor outcomes	Significant Progress	Standardised OPAL service now in place at all acute hospital sites. Work is ongoing to ensure consistent approach and outcomes at all sites

Acute discharge planning		
Different "Hub" services in places in at acute hospitals	Significant Progress	There has been significant progress in getting consistency across the complex discharge hubs. The work ahead will deliver greater consistency through a single iHub.
Limited multi-disciplinary working	Significant Progress	There is much greater MDT working in the complex discharge hubs and similarly within the iHub. The work to develop a single iHub model will improve this further.
Not effectively linked to community teams	Significant Progress	Much greater links with the community teams via the iHub, this includes links with housing, mental health, homelessness. Further work being done to strengthen.
Different operating models & facilities	Significant Progress	iHub now has shared office space & staff have access to shared trackers. The MDT approach is consistent and being further developed. Model is a hybrid of virtual MDT input & physical co-location.
Inconsistent/poor outcomes	Significant Progress	Initial sites were working in different ways, but this has been resolved. Work has continued throughout the year on firming up the D2A processes and improving outcomes for citizens leaving the D2A pathways.
Older People's Mental Health		
Long lengths of stay for those requiring short- or long-term care placements	Fully Completed	Clear process in place to support this work with additional system support for example: **Acute inpatient dashboard** to monitor LOS & reasons for delays. **Joint working** with the iHub to address blockages. **Clearly defined** pathways between mental health & EICT. **Closer links** between mental health and social care which enables assessments to be carried out in a much-reduced timescale.
Limited multi-disciplinary working	Significant Progress	MDT working has been significantly strengthened with an ongoing review to ensure a continuous improvement approach.

APPENDIX B

EARLY INTEVENTION PROJECT HIGHLIGHTS & MILESTONES

The table below outlines key project highlights/milestones that have been achieved to date per EI component:

1. Early Intervention Community Team (EICT)

Mobilised five Early Intervention Community Teams
Patient level data tracking was set up so that performance can be reported at locality and city levels
Performance dashboards have intelligent prompting built in to guide the user to clear operational priorities (hosted on BCHC systems)
Front line governance established including structured, data-informed MDTs and weekly performance reviews. This has included coaching staff to break down organisational and professional boundaries to enable a more collaborative management team.
A single integrated assessment and review methodology was bespoke designed and implemented, reducing duplication between professions
Feedback from unregistered Sevacare staff visits is collated in a structured way and fed back to registered staff
During COVID the EICT was deemed an integral part of the city's response, forming the primary part of Pathway 1. This required additional work primarily involving redeploying 150 staff into the EICT. The result of this was that during the entire COVID response the EICT had only one instance of having to reject a referral due to capacity.
Collaborative agreement and data sharing agreement signed off
Quality process in Localities complete and implementation plan in place
CIF tool in use by appropriate staff in all localities
E - Triage process signed off
Decision to commence consultation with UHB staff and future Therapy funding for BCC agreed
Recommendations for ongoing OD approach agreed
Leadership and management development project completed
Future funding for EICT Agreed and implemented
Clear commissioning plan in place based on outcomes/need
Estates - Review infrastructure and plan for staff moves
Stable staffing structures in place – Staff transferred to BCHC
Recruitment (7 day service) process for all disciplines complete
People and culture plan in place for all localities and service-wide priorities identified
Agree & finalise In-reach model & Finance
Review of Service Specification

2. Beds

Implement performance monitoring framework to all non-acute sites from December 2021
Agree timeline for implementation of Improvement cycle in care centres
Evaluate service improvement trial at PTC and based on the outcomes agreed with P2 bed Implementation group, agree a roll out plan for remaining sites from September 2021
Agree exit from pandemic response plan (covid wave 1)
Confirm needs and demand 'steady state' Apr to Oct 2021
Commence a three-month remote consultation trial at AMH from March 2021
Evaluate the three-month remote consultation trial at AMH and agreed next steps with P2 bed Implementation group by end July 2021
Confirm site scoring evaluation criteria
Business Case for Phase 2 - approved 30 Aug 21
Determine funding available for 9/10 sites for phase P2 (consolidation stage) by end of July 2021
Implement performance monitoring framework to all non-acute sites from December 2021
Agree P2 Consolidation Business Case (phase 2) with BICP Strategic Group by end September 2021
Consolidate number of P2 sites: 14 P2 sites in use compared to baseline of 17 by end of September 2021
Commence consolidating bed base from 14 to 9/10 bed sites in a13 month period starting from October 2021
Evaluate the three-month remote consultation trial at AMH and agreed next steps with P2 bed Implementation group by end July 2021
Agree performance monitoring framework incl KPIs,(LOS, Cost)
Agree timeline for implementation of Improvement cycle at PTC
Evaluate service improvement trial at PTC and based on the outcomes agreed with P2 Bed Implementation group, agree a roll out plan for remaining sites from September 2021.
Confirm needs and demand 'steady state' Apr to Oct 2021
Draft (update) Service Spec for Phase 2
Site desktop assessment for care centres
Confirm bed numbers required

3. OPAL

Heartlands Older Persons Assessment and Diagnosis Unit (OPAD) is now entirely separate from OPAL and is operating 24 hours a day. The bedding in of the OPAL service at Heartlands is now enhanced by the team having their own dedicated space in a separate area. The OPAL and OPAD teams are now meeting regularly to review operational processes and issues as part of business as usual
Single, cross site recruitment process has been very successful, and many posts have been filled despite ongoing challenges, for example fewer candidates than vacancies. The recruitment process will be repeated until remaining gaps are filled as part of business as usual.
There has been progress with the development of DHMS and it is expected to go live towards the end of Q1 2022/23. A set of OPAL performance indicators has been produced for approval and can be found in table 1. An appendix with charts showing daily and weekly contacts and discharges over time is also attached to this document. However, work still needs to be completed on the DHMS dashboard in order for the current manual data collection and reporting processes to be fully automated. This will be picked up via business as usual.

The development of OPAL+ has progressed well. The OPAL+/BT pilot is in the process of being evaluated.
Successful links have been established between OPAL and community mental health services. The number of referrals and the impact they are having is being monitored with a view to assessing the future resources required to provide OPAL access across the whole of BSMHT as part of business as usual.
Completion OPAL Business Case
OPAL+ Project Manager in place
OPAL communications plan being delivered
Agree KPIs and performance measures being reported on

4. Integrated Hub

New 'description of needs form' developed and shared with the system. Several workshops were held throughout the early July. Evaluation of the form took place in July and August and feedback to the IHub component group resulted in sign off of the DoN on 03/09/2021. Following a roll out of communication to all system partners the new form went live on 11th October 2021
Reporting metrics agreed, Metrics reviewed during August 2021 and a full suite agreed and signed of 16/09/2021
Roll out access to DHMS for non UHB staff - A full roll plan was established that commenced in October 2021 and completed February 2022
Completion of DRAFT iHub SOP - The IHub SOP has been compiled, it has been reviewed by the group and operational leads. Go Live with the first iteration of the SOP on the 1st April 2022. The SOP will be reviewed every 3 months during 2022 and changes made accordingly.
P3/CHC, MH, EoL input defined - Workshop held and GAP analysis of SOP in September 2021. Process in place and key individual identified
Homelessness pathway confirmed - Referral processes and pathways in place. Escalation routes identified.
iHub - Discharge Facilitator Recruitment (Round Two)- New starters in post on the 1st September 2021
Work to create a single office complete - One shared office March 2022
Planning for the testing of the early discharge planning in the iHub using an MDT approach

5. Commissioning

Map of BCF Outcomes to programme KPI's
Financial envelope
Plan for commissioning each component
Pathway 1
Establishment of reporting of outcome measures and contractual KPI's in line with national requirements, local need and assurance
DQIP to be put in place to ensure all national mandated reporting requirements are available through CSDS
Commissioning arrangements for non-qualified elements of EICT.
Service specification for EICT to be finalised
Pathway 2
Business Case for phase 2
Confirm P2 needs and demand based on 'first cut' of new 'steady state' data post covid-19 pandemic

Draft service specification for phase 2
IV Therapy Commissioning
Develop winter plan for IV therapy
OPAL
Review OPAL business case 21-22
OPAL Business Case amended based on System Investment Committee comments. To be resubmitted to SIC for consideration
OPAL Financial requirements for 21/22 to be considered by System Investment Committee. Paper to be completed by EQ4 Group.
Clarification of OPAL funding streams for 21/22 & 22/23 onwards
Confirm governance of OPAL+

Infrastructure

A new and refreshed governance structure and clear objectives were developed quickly which helped the group to clearly understand what its remit was, with clear dates and a plan behind each to deliver
We are pleased to say that we developed a single performance dashboard which is now fit for use across the system. EICTs performance data is now available on One Vision and is being used through our GOLD Meetings and daily performance huddles to monitor the performance of the locality based teams

We picked up the requirement to ensure that the data and processes were in place to enable effective data and reporting of our response to UCR, bringing our knowledge and understanding as a system to :
• Gain approval of £12k of additional funding from DITE for a developer role
• Obtained approval for
  ○ Data entry on referral priority
  ○ Future process for clinical triage
  ○ Single data point for collection of referral priority

Implemented RiO config changes necessary to enable data recording
Ensuring that our Community Services Data Set included the 2 hour and 2 day validated dataset
We wanted our patient's journey through the Birmingham system to be as seamless as possible. We have come a long way in our discussions and plans to enable this, through a shared system that enables improved integration and management of the patient's journey.
Our initial work to ensure estates are fit for purpose for the EICT has now been planned and costed out for phase 1. A scoping paper has been produced and signed off. It was agreed to undertake the desktop exercise to identify the preferred EI sites before undertaking any site works

APPENDIX C

LESSONS LEARNT AND AREAS FOR IMPROVEMENT

Culture

What has worked well	Could be improved
Regular communication and consistent drumbeat of embedding the EI approach of "why not home why not today'	Further understanding of Culture Change, as this is a slow process and take several years for systems to behave as an integrated care system
Having a MOU ensured there was a common vision across EI Programme	Operational difficulties were encountered due to different Operational Management Structures. This could have been mitigated through a joint management structure
Great partnership working has enhanced confidence with implementing UCR through EICT	Partners need to work together to agree a shared vision as to what integrated and inclusive care means across the system, specifically around Mental Health
EI approach demonstrates the benefits of an inclusive and integrated system	Limited staff & stakeholder engagement from the offset had implications to staff not understanding the purpose which effected working practises ie OPAL
EI has embedded a collaborative system wide approach with clear pathways and a triage process that enables improvement in patient outcomes and quality of care	

Resource/Capacity

What has worked well	Could be improved
Having a Improvement Team aligned to the programme, ensured any resource requests for Improvement Managers, Project Managers etc. were sourced efficiently	Organisations committing to supplying appropriate resource with the right skills mix ahead of any issues being escalated.
Excellent cross site recruitment process was successful. It was efficient, maximised the use of valuable clinician time and helped to fill vacancies faster than a site specific process.	The use of care programmes within the ICS should be an enabler in terms of having a clearer view of total resources and ability to manage use of resources across the system.
Having BCF resources in one place has provided flexibility and enabled system resources to be used where they are needed to meet pressures and enable transformation	

Planning/Processes

What has worked well	Could be improved
Clear defined processes in place for a persons journey which aims to achieve the least restrictive outcomes	Limited involvement with partners/stakeholders resulted in unrealistic timelines
Having embedded good governance with key stakeholders, kept us up to date on whole system requirements	Consideration in planning of SMART objectives taking into consideration available resources and competing priorities
Having one single enabling work stream to cover IT, Estates and other infrastructure requirements across the whole programme ensured alignment with the component groups	Having a dedicated system finance lead for key transformation projects would bring greater focus and control.
The inclusion of specific groups to be part of the initial scoping of the programme i.e. MH/EOL enhanced a more sustainable and proactive approach that improves service user / carer and staff experience.	Understanding organisational partners governance structures but also being clear on what the structures are for the project
	Planning ahead, ensure funding and resource requirements for large programmes of work are determined and agreed early on
	Having a dedicated PMO function for the programme, would have improved visibility, Top down strategic alignment in the PMO, bottom up, execution driven alignment etc.

Data/Intelligence

What has worked well	Could be improved
Having access to reliable data can support objective assessment of service improvement	Having a dedicated data control group early in the project would help support flow of information across the different systems
Benefits achieved for the people of Birmingham which is regularly monitored through an effective performance management framework	Limited access to joined system. Having one system to follow patient journey

APPENDIX D

TEST SITES DETAILS AND RESULTS

Test Area 1: Hospital Front Door

The OPAL team at the front door of the Queen Elizabeth Hospital provides a timely, multidisciplinary, patient-centred, comprehensive assessment to those who have an urgent need. The team provides patients with early access to expert advice, regardless of whether they are referred by a GP, community services or arrive at the front door.

The testing work focused on improving how the team could help as many older people as possible as they enter the hospital to get the support they need, ideally back in their own home, thereby reducing the number of people that end up in a ward. The key focuses within the team to achieve this were:

- Enhancing leadership within the team
- Visibility of activity and performance
- Improving efficiency and productivity within the team
- Quantifying un-met demand and modelling what is required to meet this.

Test site results

Before changes were put in place, OPAL were already getting 6.6 people home every day; around 2,400 a year.

By December 2019, this had increased to between 9.5 and 10 people going home each day, with the support of the team. That's around 1,000 more people every year.

Additionally, testing found that if an older person was seen by the OPAL team, they had a 70% chance of going straight home compared to a 52% chance of being admitted onto a ward when they weren't seen by the team.

These results were achieved by changing the data captured on a daily basis; improving the quality and access to that new data; optimising the mix of skills in the department and giving those that needed it, access to the new community team.

Test site 2: Hospital Back Door

The Complex Discharge Hub at the Queen Elizabeth Hospital assesses and sources support for people that require further care after a stay in an acute hospital bed. The team provides health and social work expertise as well as liaises with therapy teams in order to provide timely discharge into the most appropriate care.

The work as part of the Early Intervention Programme has focused on maximising the independence of outcomes for patients and minimising the time spent in a hospital bed whilst medically fit. This has been done with a focus on multidisciplinary working and empowering frontline staff through the collaborative and patient-focussed discussion. Specifically, this involved:

- Enhanced insight on both current caseloads and broader themes
- Empowering the front line through collaborative decision making
- Collaborative working across discharge teams and post-acute services
- A focus on multidisciplinary working an cross-discipline discharge planning.

Test site results

Before the changes were put in place, the average time it would take to get a person out of hospital once they were declared medically fit was 12 days.

Since the end of testing this has reduced to 8.7 days. This has major benefits for the hospital with the equivalent of approximately 6,500 bed days per year being freed up and which can be put to better use.

People going from the hospital directly into long term placements also reduced significantly. Within the Edgbaston constituency (test site area), every week, two or three older people would be discharged into long term care settings such as residential or nursing homes. In a three-month period after the testing, only one person went into long term care. That means in Edgbaston alone, the testing showed that more than 130 people every year could return home as opposed to going into a long-term placement.

This has been achieved by changing the data captured; improving the quality and access to the new data; improving the actions taken by the team using the new data; improving how the social workers and nurses work together and giving people who need it, access to the new community team (Early Intervention Community Team).

Test site 3: New Community Team

A new team providing urgent assessment, treatment and care for people was introduced and tested. The team was delivering a range of integrated services provided by multiple professionals who promote recovery and independence.

Through the Early Intervention programme, the aims of this new approach have been to prevent unnecessary hospital admission and premature admission to long-term residential care, support timely discharge from hospital, promote faster recovery from illness or injury and champion independent living wherever possible. This included

- Breaking down barriers and setting up a brand new multi-disciplinary teams
- Driving citizen-centred plans which aim to promote independence
- Creating a strong and productive relationship between all system partners
- Driving operational performance and caseload visibility

Test site results

As a new team there is no direct comparison to ‘before’ the changes. However, of those supported by the test site, 76% of the people that remained in their own homes are now enjoying full independence with no reliance on either health or social services.

Everyone that was discharged from the service was offered a feedback card; 100% of family or carers said they would be happy to recommend the service.

For the full duration of testing, people being supported by the service have consistently became more independent. This was measured through a reduction in the number of hours of support someone needs, which has reduced by an average of 7.8 hours per person, per week.

Test site 4: Early Intervention Beds

Early Intervention Beds provide an inpatient rehabilitation and recovery service for older adults who no longer need the acute medical care of a hospital. The team sets out to help people identify what is important to them in their ongoing care and treatment, maximising independence and working with families and communities to give as many people as possible the opportunity to return to their own homes.

Early Intervention work showed that multi-disciplinary goal-setting and improved communication between health and social care professionals enabled better outcomes for patients. It iasl identied some key areas for continued work in making sure that the right people are being referred to these beds and moving on to go home or to other appropriate care at the right time. This involved:

- Creating a clear leadership in a multi-disciplinary, multi-organisational setting
- Reinforcing a 'home first' principle with daily patient reviews and performance measurement
- Creating a common goal setting approach, across organisations and professions, with patients and families
- Improving the key processes that enable people to progress towards being discharged.

Test site results

Testing took place at the Norman Power Centre in Edgbaston. During testing, approximately 50% of people were going home rather than onto other care settings, against a starting point of 25%. In addition, the length of time that people were staying in these beds reduced to 30 days from a starting point of 44.

This was achieved through changes in a number of areas: introducing specific, measurable and timely 'therapy goal setting', a regular team meeting attended by a multidisciplinary team aimed at tracking an progressing towards the ideal outcome for everyone, ensuring the person and their carer/family have a say in what's happening and that their expectations are managed.

During the testing period, the complexity levels of people staying in the beds increased. On one hand this makes the increase in people going home all the more significant. However, it also means that the length of stay started to increase, at one point rising from 36 to 49 days. However, these are people who would have previously gone into long term care settings such as residential/nursing homes.

Test site 5: Acute Mental Health

Acute mental health wards at the Juniper Centre and Reservoir Court provide inpatient services for older adults with a functional or organic acute mental health issue. This includes comprehensive assessment by a multidisciplinary team, diagnosis and treatment, responding to a wide range of needs of the service user in a person-centred approach.

The work as part of EI focussed on reducing the amount of time people were staying in hospital as a result of unnecessary delays to getting them healthier or getting them home. This allows people to spend less time in an acute setting and enables others to access the service who otherwise might have had to wait. The work included:

- Visibility of live and accurate information
- Bringing the multidisciplinary team together more frequently
- Re-thinking the way that long term care needs are assessed
- Improving the key processes that enable people to progress towards being discharged

Test site results

Before the changes the number of people being discharged averaged at six per day. Changes were introduced including a new social worker process, which reduced the number of people delayed waiting for social worker input from 14% to 2%, new data, tracking and reporting on referrals, allocations, timescales and activities – with a focus on having a clear next step for every person on the wards. This increased the proportion of people waiting for 'active treatment' from 30% up to 58%. These changes combined to increase the number of people being discharged every day from 6 up to 6.5 – the equivalent to every person spending nine few days in hospital. These performance figures are above what was anticipated.

APPENDIX E

KEY outstanding DELIVERABLES TRANSFERRED TO BUSINESS AS USUAL (BAU)

Component	Description
OPAL	Implementation of DHMS
OPAL	KPI development and performance monitoring
OPAL	OPAL Service Development/Business Development
Commissioning	Health Inequalities (Understanding who is using EI services, what is it telling us about the provision and design of the service)
Integrated Hub	iHub SOP Completion
Integrated Hub	iHub - Training for Changes to services that sit outside the iHub
Integrated Hub	Early Discharge MDT roll out
Integrated Hub	Document baseline service specification for the iHub
Integrated Hub	Stabilise teams with significant vacancies or reliance on Bank/Agency staff
EICT	Revisit and refine referrals diagnostic undertaken by Newton
EICT	All staff will be utilising iPads and Total Mobile
EICT	KPI reviewed and rolled out
EICT	Quarterly review of People and Culture plans
EICT	Implement Demand and capacity modelling for BAU and 2 UR
EICT	Final Service Specification for the Year after