

Agenda

Introduction to the session	Andy Cave CEO, Healthwatch Birmingham
Overview of the Birmingham Integrated Care Partnership	Prof. Graeme Betts
	Interim Chief Executive — Birmingham City Council Chair — Birmingham Integrated Care Partnership
Neighbourhood Integration	Dr. Will Taylor
	Clinical Chair – Birmingham and Solihull CCG
Q&A	
Interactive Session	Andy Cave and Mark McKinley Healthwatch Birmingham





Birmingham Integrated Care Partnership

Making Birmingham a great place to grow old in

Birmingham Integrated Care Partnership

Prof. Graeme Betts

Interim Chief Executive – Birmingham City Council Chair – Birmingham Integrated Care Partnership





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

The Birmingham Integrated Care Partners are:

- Birmingham and Solihull CCG
- Black Country 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 Trust
- Birmingham Community Healthcare NHS
- Foundation Trust
- Hospices of Birmingham and Solihull
- Birmingham Voluntary Services Council
- Healthwatch Birmingham





Background

- Partners came together in 2018 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
- We have come along way as a partnership. Effective collaboration has been vital during Covid-19 and our ongoing response to the pandemic
- Now is the time to reflect on our achievements and refresh our approach to ensure that
 we remain focussed on the critical areas where we need to work together for positive
 change.





What we have learnt

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.





Our Delivery Priorities

- We have recognised the need to broaden our scope to work for better health and care outcomes for all adults in Birmingham.
- Our work will also impact upon children and young people.
- Our three priority programmes are:
 - Early Intervention (Phase 2)
 - Neighbourhood Integration
 - Care Homes





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





The Importance of Citizen Involvement

The Birmingham Integrated Care Partnership has citizens at the heart. Only through involving and listening to our citizens can we truly make a difference in the City.













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Neighbourhood Integration

Dr. Will Taylor Clinical Chair – Birmingham and Solihull CCG



Why is this work important?

- A diagnostic was commissioned in 2018 to identify the potential issues and opportunities available in the development of an integrated approach to care delivery
- The following issues were identified
 - 38% of citizens were <u>not receiving the right care</u> for their needs & <u>could be more independent</u>
 - 24% of citizens <u>needed multiple services</u> to meet their needs
 - 40% of non-ideal outcomes were driven by not having the right professional input.
- Largely driven by:
 - Professionals not talking together often enough
 - Process for contacting and discussing with each other is difficult
 - Professionals not sure what other services are on offer or how to contact them
- It was concluded one of the most important aspects is having the right impact from other professionals
- By bringing professionals together, we could support*:
 - 1,050 citizens to be more independent & requiring less support at home
 - 750 more citizens being supported by multiple services
 - 100 citizens to receive care in their home and not in a care home





What do we mean by "Integrated Neighbourhood Team"?

What is a "Neighbourhood"?

- A neighbourhood should be a population of c. 30,000 50,000 people.
- Neighbourhoods should align to Primary Care Networks. Within Birmingham & Solihull CCG there are 30 Birmingham PCNs and 6 Solihull PCNs. In addition there are 5 PCNs in West Birmingham who are part of Sandwell & West Birmingham CCG.

What is an "Integrated Team"?

- 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.

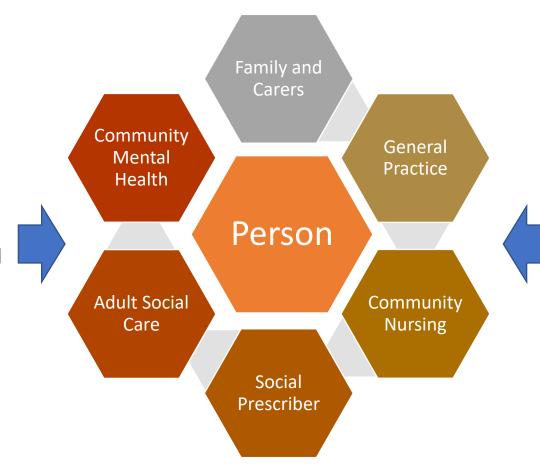




An Integrated Neighbourhood Team

Community resources and organisations:

- Community assets
- Neighbourhood networks
- Third sector services



Specialist support:

- Palliative care
- Specialist LTC Teams /MDTs
- Locality geriatricians
- Care home teams
- Physiotherapy
- Consultant Psychiatrists
- Early Intervention Community Team





Purpose and Scope: Ongoing Personalised Support

- Establishing integrated health and social care teams in neighbourhoods to support older people to live well at home thereby reducing our reliance on institutional care and the need for emergency admissions to hospital is a key priority for the STP's Ageing Well programme.
- Having committed significant capacity in 2019 to designing and starting to deliver the Early Intervention model for intermediate care, the Portfolio Board agreed at our January meeting to focus on neighbourhood team development as our 2020 priority.
- We do not start from scratch. Work commenced in September 2018 to identify neighbourhoods and develop principles for the service model. Necessarily this work was delayed by the need to establish PCNs in Birmingham & Solihull in 2019.





Our shared vision and common principles:

These were developed in September 2018

Patients

- I am empowered to care for myself
- I am connected to the resources of my community
- I am listened to about what works for me, in my life.
- The professionals involved with my care talk to each other. We all work as a team
- When I move between services or settings it is seamless and I don't have to repeat my story.

Professionals

- Team Birmingham working together:
- My team is based on the community I serve not the organisation I work for;
- We always say yes even if it isn't my 'job' we work together
- Data sharing is in place and I have access to local data to enable me to plan for my community;
- I have strong relationships with other professionals and communities in my neighbourhood
- I enjoy working both as team member and being able to deliver the best care possible
- I work with professionals with a wide range of skills who support each other in a neighbourhood team

Organisation

- We work in true partnership across the health and care sector to:
- Simplify care and reduce duplication
- Improve communication
- Solve problems together
- Empower our staff to work at a local level together
- We never say it is not my organisations problem
- Shared responsibility



Making it happen

Objectives

- Focus has been 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
- Neighbourhood teams are connected to their local communities, with their priorities developed with local people.





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Interactive Session

Your chance to help shape the Neighbourhood Integration

