Newton

The right care at the right time in the right place

Designing and delivering an integrated model of urgent and intermediate care for older people in Birmingham

CASE STUDY

SUMMARY

The health and social care organisations of Birmingham recognised that they needed a radical transformation of services for older people, and those with similar needs. Newton was initially brought onboard to carry out an assessment of health and care services provided to older people before, during and following a crisis. The assessment identified significant opportunities to improve, and in August 2018, Newton was commissioned to undertake a large-scale transformation programme – the Early Intervention programme.

The Early Intervention programme was tasked with creating an integrated approach to urgent and intermediate care services that is person and carer-centred and encompasses physical health, mental health and social care needs to support older people before, during and following a crisis. To deliver a truly integrated pathway we needed to look past the constraint of the roles of separate organisations; we needed to think and plan in a radically different – integrated – way, from the very beginning.

THE PROGRAMME HAS ACHIEVED*:

£25M
annualised financial benefit for the health and care system

17%
more people go home following a hospital stay

3,650
more admissions avoided per year

26%
increase in people going home from an intermediate bed

9.4 DAYS
Waiting times reduced by, on average, 9.4 days when ongoing support required

6 HOURS
6-hour average reduction in ongoing care needs per person

*results correct as of July 2021

A whole system 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."**

An evidenced-based approach

The system began by carrying out an assessment of health and care services provided to older people across Birmingham before, during and following a crisis. The purpose of the assessment was to provide a single version of the truth about system performance which would unite all partners across the health and care system.

The assessment identified some significant opportunities for improvement:

23%

The proportion of people admitted into hospital who could have been better looked after elsewhere

51%

The proportion of people on older people's wards and longer stay wards who are medically fit but delayed, waiting to leave hospital

19%

The proportion of people who could benefit from a different pathway out of hospital, one better suited to their needs

36%

The proportion of people who could achieve greater independence, following a stay in a short-term bed, with support

37%

The proportion of people currently with a long-term care package who could benefit from better enablement

50%

The proportion of people whose mental health reached crisis point (and went into hospital) that could have been avoided

> **Having somebody like Newton who were able to work with us, almost as a sort of independent broker… to come up with some very robust, clear opportunities for us to work on and to bring all of those different organisations together in an impartial way was very effective."**

Director of Partnerships, University Hospitals Birmingham NHS Foundation Trust

A whole system strategy

Big challenges like these need bold responses.And so, in a first for Birmingham, the system setout to solve the issues together.

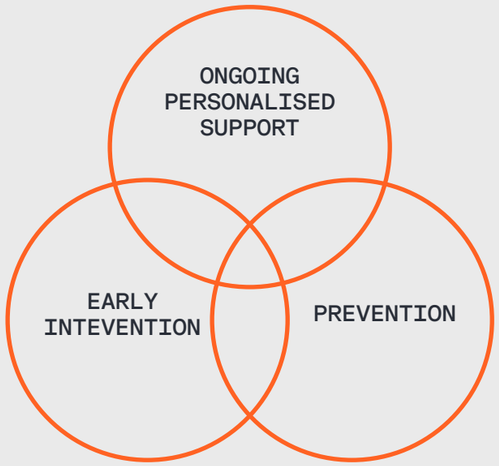
Under the Birmingham Older People's Programme, the whole Birmingham health and social care system, comprising over six different organisations, worked to create a single coherent vision that each of them could stand behind and believe in.

Newton's role was to work with the system to design and implement a programme of work that would help them deliver that vision, navigating the very different practical ramifications for each of the different health and social care partners involved.

Strategy:

To provide an integrated approach to intermediate care services that is person and carer-centred and encompasses physical, mental health and social care needs.

- Early intervention: Interventions that promote faster recovery
- Ongoing personalised support: Ongoing support to help older people remain in their own homes and communities
- Prevention: A universal wellbeing offer enabling older people to manage their own health and wellbeing



A people-centred approach to designing change

A partnership involving teams from across the system came together to establish an evidence-based, frontline-led plan.

During this stage, interviews and patient case reviews were carried out with hundreds of frontline staff. 28 practitioners from all system 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.

Together, the partnership came up with a set of guiding principles.

- To have one integrated model across the entire system.
- The person must be at the centre of everything (with family and carer input also valued).
- Aim to support life not simply deliver a service.
- 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 will work together to champion the 'home first' ethos.
- And the result - more people will be living more independently in later life.

These principles were the foundation of a new model of care which began to take shape within the Early Intervention programme, centred around five core components of the service: system front door; discharge hubs; intermediate bedded care, integrated community teams; and mental health wards.

A model shaped by trial and rapid improvement

The next stage in the process was to trial new ways of working before implementing them on a wider scale. In practise this meant trying something new, understanding what worked, rapidly changing what didn't and continuously making improvements until the right model was in place and working effectively, backed-up by clear evidence.

The 28-stong team of practitioners helped to identify five areas in the south of the city – centred around Birmingham's Queen Elizabeth Hospital - where the testing would take place.

Getting the right people involved was crucial. This meant setting up multidisciplinary teams of practitioners from all agencies and a wide variety of disciplines including therapy, nursing, medicine and social work.

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

Change designed to last

Every element of the programme was designed in partnership with system partners to ensure leaders on the ground drove the transformation and could do so in a sustainable way.

As part of this, Newton recruited eight specially trained 'Improvement Managers' from across the partners to work to support the programme and to help establish the whole-system approach. Representing different parts of the system and including practitioners, commissioners, clinicians, and managers, they were selected for their passion for improving outcomes for older people, their ability to work across organisational boundaries, to solve problems and embrace change. They were dedicated full-time to the programme and were trained in data analysis, short-interval improvement and change management, before undertaking on-the-job learning while working within the new integrated teams.

In 20 years in the NHS, I've never had such a positive experience of working alongside consultants nor on something delivering at this scale."

Deputy Director of Finance, Birmingham and Solihull Mental Health NHS Foundation Trust

The result: an integrated, intermediate care service for the population of Birmingham

Once the new ways of working had been iterated and proven at the test sites, they were gradually expanded across other sites and services in the city. To date, the changes established through the Early Intervention programme have impacted three hospital sites, five community bed sites, five localities and over 20 different frontline teams.

OPAL (hospital front door)	Early intevention beds	Acute Discharge Hubs	Early Intervention Community Teams (EICT)	Mental Health Wards
Aim: reduce the number of hospital admissions by ensuring that older people presenting at the front door of the acute hospital get the most appropriate ongoing care.	Aim: increase the number of discharges from beds to settings better aligned with a person's needs, whilst decreasing the length of stay in an intermediate bed.	Aim: decrease the time it takes for older people to leave hospital when medically fit, and ensure they are discharged to a place that is best suited to their needs.	Aim: help older people to regain their independence by recovering in their own homes (and if possible avoiding a trip to hospital in the first place) and minimise the level of ongoing support that they require.	Aim: reduce the amount of time people stay in hospital following an acute mental health episode.
OPAL is an MDT comprising geriatricians, therapists, nurses, and social workers. The team's combined skillset provides early, comprehensive assessments to older people and those with complex needs.	EI beds involve a single intermediate bedded care provision, delivered by an MDT. This integrated team introduced "therapy goal setting" to track progress towards an ideal outcome, promoting independence and the home first ethos that is so central to the Early Intervention programme.	The hubs introduced an MDT that works at the point of discharge from acute hospitals to ensure timely discharge on the appropriate pathway.	EICT is a brand new MDT-led service delivered by around 500 staff from acute, community health and adult social care. They provide intermediate care in a person's own home.	These two acute mental health wards provide a comprehensive assessment by an MDT, diagnosis and treatment. New ways of working were introduced to reduce unnecessary delays to getting inpatients healthier or getting them home.

The Early Intervention story continues

Early Intervention in Birmingham continues to make brilliant progress, demonstrating the success of the system change capability that was embedded.

The roll out of the programme was particularly timely as it played a key role in the city's response to COVID-19, with many aspects of the programme helping to ease the intense pressure this put on the health and care system. Patient flow through the four Discharge Hubs at University Hospitals Birmingham NHS Foundation Trust reached a decade-high thanks to the new operational and service measures introduced by the Early Intervention team in response to the pandemic. The EICT played a particularly important role in easing pressure on hospital and care home beds by ensuring that those who were able to return home could do so with the right level of support or avoid a hospital stay in the first place.

Aspects of the programme were also advanced during the pandemic, such as the extension of the OPAL service to include the West Midlands Ambulance Service. "AskOPAL" enables paramedics to connect via video link from a patient's home to the OPAL team at the hospital front door, to assess whether they could be supported at home rather than being conveyed to a UHB hospital. Through this service, 70% of people avoided transfer to the acute and were able to be supported at home, either receiving advice or prescriptions services, or being referred to the EICT for the appropriate support in their own home.

There is much more of a collaborative working environment and more trust between organisations and that in itself gives us an ability to do things that we would have never done before."

Director of Partnerships, University Hospitals Birmingham NHS Foundation Trust

This service is absolutely exemplary. It's a national leader and it delivers on the ambition that those of us that have been involved in older people's services set: to enable people to live in their own homes independently for as long as possible, which is what we all want. It's a fantastic piece of work."

Chief Executive, Birmingham and Solihull CCG

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CONTACT US

Andy Lumb
Partner

E: andy.lumb@newtonimpact.com