Theme 2: Integration

Direction of travel

There is a positive direction of travel for the development of an integrated governance structure. This is beginning to support the system approach model with an early focus on re-shaping commissioning to create place-based partnerships, improving alignment and tackling health inequalities. Risks to progression include needing to align organisational priorities and enhancing approaches to population health.

Summary of strengths

- There are many examples of teams working well together and improving people's outcomes.
- There is a focus on developing collaborative relationships to improve wider population health and reduce health and social inequalities.
- The shared care record supports service integration and information sharing.

Areas for development and next steps

- There is scope to align organisational strategies and priorities to ensure these do not limit integration, particularly at place level. This will support using population health management approaches more effectively to provide joined-up care to reduce health inequalities.

- There is significant challenge around transitions of care, both between sectors and particularly for children transitioning to adult care.
- There are continuing challenges and risks within special educational needs provision (SEND). There are pressures in the system, due to insufficient capacity for diagnosis and provision of services in areas such as occupational therapy and speech and language.
- Collaboratives, which will help to integrate within sectors, are still in early stages and only one, for mental health, has formed.

Summary findings for the quality statements under the Integration theme

This theme includes these quality statements:

- Safe systems, pathways and transitions
- Care provision, integration and continuity
- How staff, teams and services work together

Quality statement: Safe systems, pathways and transitions

The ICS has a system approach model for safe, reliable and effective improvement, in early evolution and embedding. Wherein many areas this is working well, demonstrating positive outcomes for people, system maturity is evolving, and medium and longer-term ambitions are yet to be realised.

System approach alignment and collaboration

Collaborative working relationships have evolved since the ICBs inception. Social care and health care are well-integrated, and they are equal partners in areas such as safeguarding, primary care, and mental health, with initiatives to improve 'flow' through the system and ensure care pathways are designed to meet the diverse needs of the local population.

Services have been organised and integrated to ensure the safety of people and communities across their care journeys. In primary care, GP practices have come together to form primary care networks to deliver safe systems of care and clear transitions as people moved between primary and acute hospital services.

We were told about the development of a General Practice Provider Support Unit, bringing together multiple support functions into a single structure to offer support defined by, and for, general practice with the aim to improve transition infrastructure and collaboration. A steering group had been developed by members with the ambition to see progress from their transition model by March 2024.

An area of focus for the mental health collaborative is a system-wide approach to support the flow of patients out of acute hospital care for those experiencing poor mental health who do not require acute treatment. This approach has seen significant improvement in the reduced length of hospital stay for people and has ensured people receive the appropriate mental health support needed.

There were concerns about how the work would be delivered, the timeframes and capacity within the system for the acute care and community care collaboratives, which were to commence in the coming months. These were recorded on the ICS risk register and monitored through system quality meetings and place committees.

There is alignment, collaboration and an inclusive approach to tackling waiting lists. These include the use of mutual aid, using extra capacity in areas such as orthopaedic elective and dental procedures. Waiting lists and trajectories are monitored at weekly system oversight groups. Within the System Elective Hub, there is a clear focus on admissions pathways and addressing waiting list challenges.

Design and safety

There is commitment from system leaders to work in partnership with people and we saw many examples. Some services had been co-designed with people who used them, but where there was co-design, some parents and representatives from voluntary groups told us they could have been involved earlier to fully collaborate.

Using feedback from people's lived experience, the ICS had identified the need to improve the provision of care for older people. As a result, a care facility has been built in the north of Solihull and other new supported living arrangements are developed for people needing support to live independently in the community.

While there is an increase in integration within the system, we also found a lack of joined-up care pathways for people using hospice services who are moving from children and young people's services into adulthood.

Some groups, for example a service for people who are homeless, didn't feel that their organisation or the people who used their services are engaged with as an equal partner to tackle inequalities.

Quality statement: Care provision, integration and continuity

The ambition of the system is to design care pathways to meet the diverse needs of the local population, and there are some joined-up pathways through partnerships and alliances. Services included several pathways including urgent community response and virtual wards.

Leaders in the system acknowledge that the ICS is in the early stages of using population health management approaches to provide joined-up care and reduce health inequalities. The ICS is taking time to embed these processes and assess the impact on an ongoing basis.

The system is developing integrated neighbourhood teams (INTs) to improve collaboration at a local level. This is being piloted in 2 neighbourhoods in the system where leaders felt there is the greatest need and benefit.

Care for autistic people and people with a learning disability is an area of focus for system leaders and partners, with the chief nurse taking a lead on this. Partners are aware of the need for improvements and identified 20 key priorities. System leaders told us about work to ensure suitable, safe accommodation for people with a learning disability. Through collaboration between partners across the system and close working with the local authority and housing colleagues, a property had been purchased and is currently being renovated to provide crisis care support and prevent admissions to an acute hospital.

Quality statement: How staff, teams and services work together

There is commitment to ensuring people only told their story to health and care providers once by using data, information and technology effectively. This commitment is yet to be fully realised, embedded or holistically evaluated.

Approaches to provide joined-up care and reduce health inequalities

To track progress against the 10-year strategy, the ICS used a dashboard that aligns with the national ICS outcomes framework and measures for its health and wellbeing strategy.

There is a system-wide focus on teams working together, to ensure that people received the right care, in the right place at the right time.

There was a focus on collaborative working to support people in areas of prevention and early intervention. Health and wellbeing community hubs included housing, health and police services and the domestic abuse charities. There was a diversion and development plan to support vulnerable women at risk of going to prison, to holistically support them around not re-offending and to lead healthier lives. We heard about the police crime commissioner's priorities and plans to support these are being discussed by the ICB.

Leaders representing emergency services told us they are made aware of the risks and challenges of health and societal inequalities for people living in Birmingham and Solihull, and that they are committed to resolving these as a system.

Effective use of data, information and technology

System partners felt there is increased collaboration across different sectors including: health, local authority, police, and particularly the voluntary and community sectors. There are more shared cared records across partners, including health and social care, local councils, prison, and emergency services to support integrated services.

The ICS and partners recognise the need to use data, metrics and clinical indicators to support equity in access. There is a structure to develop this further, but this is in early stages.

The system has begun using available data and information to address health inequalities and is developing programmes around access to care that may benefit multiple sectors. However, system-wide challenges meant improving access to care has not always been achieved in certain sectors. For example, experience of carers in making a GP appointment is generally worse than national and regional averages.

Shared care records were being used, but not across the whole system. There were challenges as not all organisations had connected electronic records. Information showed active and ongoing enrolling services including GP surgeries, nursing homes and hospices to the shared care record. We saw that usage information showed an increase in total access (service user/employee) from January to September 2023. At the time of our assessment, 209 services were actively using the shared care record.