Birmingham and Solihull Mental Health, Learning Disabilities and Autism Provider Collaborative

# 2026-2029 Learning Disability and Autism Delivery Plan

Part of the Five Year Strategy for Mental Health 2026-2031

# Contents

# Introduction

**The 2026–29 Learning Disability and Autism Delivery Plan sets out the Mental Health, Learning Disabilities and Autism Provider Collaborative's commitment to continuing to improve the lives of autistic people and people with a learning disability across Birmingham and Solihull. The plan aims to reduce the significant health inequalities experienced by these communities and to create opportunities for people to lead fulfilling and meaningful lives.**

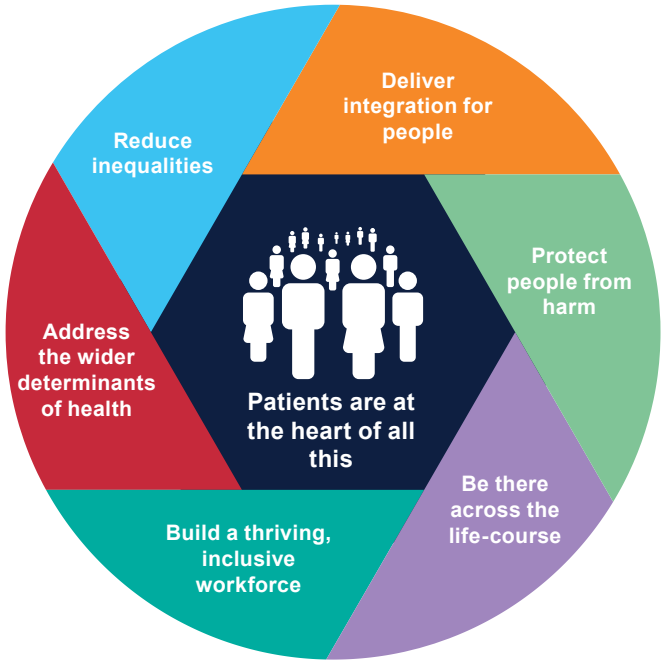
While there is much work to be done, meaningful and lasting change can be achieved through strong collaboration between the NHS, the local Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, partner organisations, and, importantly, people with lived experience.

Over the next three years, we want people to be able to tell us that their health and wellbeing has improved. And when they can't, we want to use this as an opportunity to learn and act on how we can do better.

## Scope and language

Whilst this a 'Learning Disability and Autism' delivery plan it includes references to services, care and support for neurodivergent people and people with mental ill-health. The terms used throughout this document are 'autistic people', 'neurodivergent people', 'people with a learning disability', and 'people with mental ill-health'. It is recognised that this is not the preference of everyone with lived experience.

The delivery plan is 'all age'. This means it considers the lives, needs and intended outcomes for children and adults.




Commitments of the Birmingham and Solihull Strategy for Health and Care 2023-33 and Five Year Strategy for Mental Health 2026-31. This plan is about delivering those commitments for autistic people and people with a learning disability.

# Foreword

"Through the Mental Health, Learning Disabilities and Autism Provider Collaborative, teams across the NHS, the Voluntary, Community, Faith and Social Enterprise sector and social care have been working together to make progress towards our shared vision that autistic people and people with a learning disability can access the right support at the right time, to enable them to live a good and fulfilling life as part of our diverse local communities in Birmingham and Solihull.

Whilst we have made progress in developing services to support people to live well in local communities we know from working with people with lived experience that there is a more we can do. There is a long way to go before we have done our part to enable autistic people and people with a learning disability to have healthy, happy lives. In our system: there is more we can do to ensure that GP registers are up to date and that we provide meaningful Annual Health Checks; we still rely on inpatient care to keep people safe and cared for more than other parts of England; and reviews still highlight the impact of inequalities on outcomes for autistic people and people with a learning disability.

It is in our gift to work together to make meaningful and sustainable improvements in the support that people can get from the NHS and the Voluntary, Community, Faith and Social Enterprise sector. The delivery plan tells you how we intend to do this.  It won't always be easy; we may have to adapt to overcome changing local and national circumstances. We will at all times seek to work closely with people with lived experience.

The work of the Collaborative so far and the objectives set out in this plan give us the foundations from which we can deliver the improvement that is needed."

**Richard Kirby, Chief Executive Birmingham Community Healthcare NHS Foundation Trust and Birmingham and Solihull's Senior Responsible Officer for learning disabilities and autism.**

"Autism West Midlands wholeheartedly welcomes and supports this Learning Disability and Autism Delivery Plan.

As an autism specialist provider we have been working closely with the NHS through our Autism Key Worker Service and involvement with the Autism Enhanced Support Team to improve treatment and care for autistic people with mental ill-health. The plan for the next three years sets out some exciting and ambitious objectives, helping services to look through an 'autism lens' - therefore promoting better access and understanding.

The involvement of the Voluntary, Community, Faith and Social Enterprise sector in Provider Collaborative governance arrangements and the commitment to hear the voices of autistic people are strong features of a delivery plan that seeks to seriously tackle health inequalities and build a portfolio of sustainable preventative services."

**Tom Harrison – Chief Executive Officer at Autism West Midlands.**

"By the end of the delivery plan, I would hope to see measurable improvements in outcomes, experience and equity for people with a learning disability and autistic people across the system. This should include improved access to timely, reasonable and person-centred care, a reduction in health inequalities and avoidable early deaths, stronger multi-agency working, and more effective transitions between services. Success would also mean increased opportunities for people to live healthy, independent and fulfilling lives within their communities, with co-production embedded throughout. Most importantly, individuals and their families should feel listened to, empowered and confident that services are responsive to their individual needs."

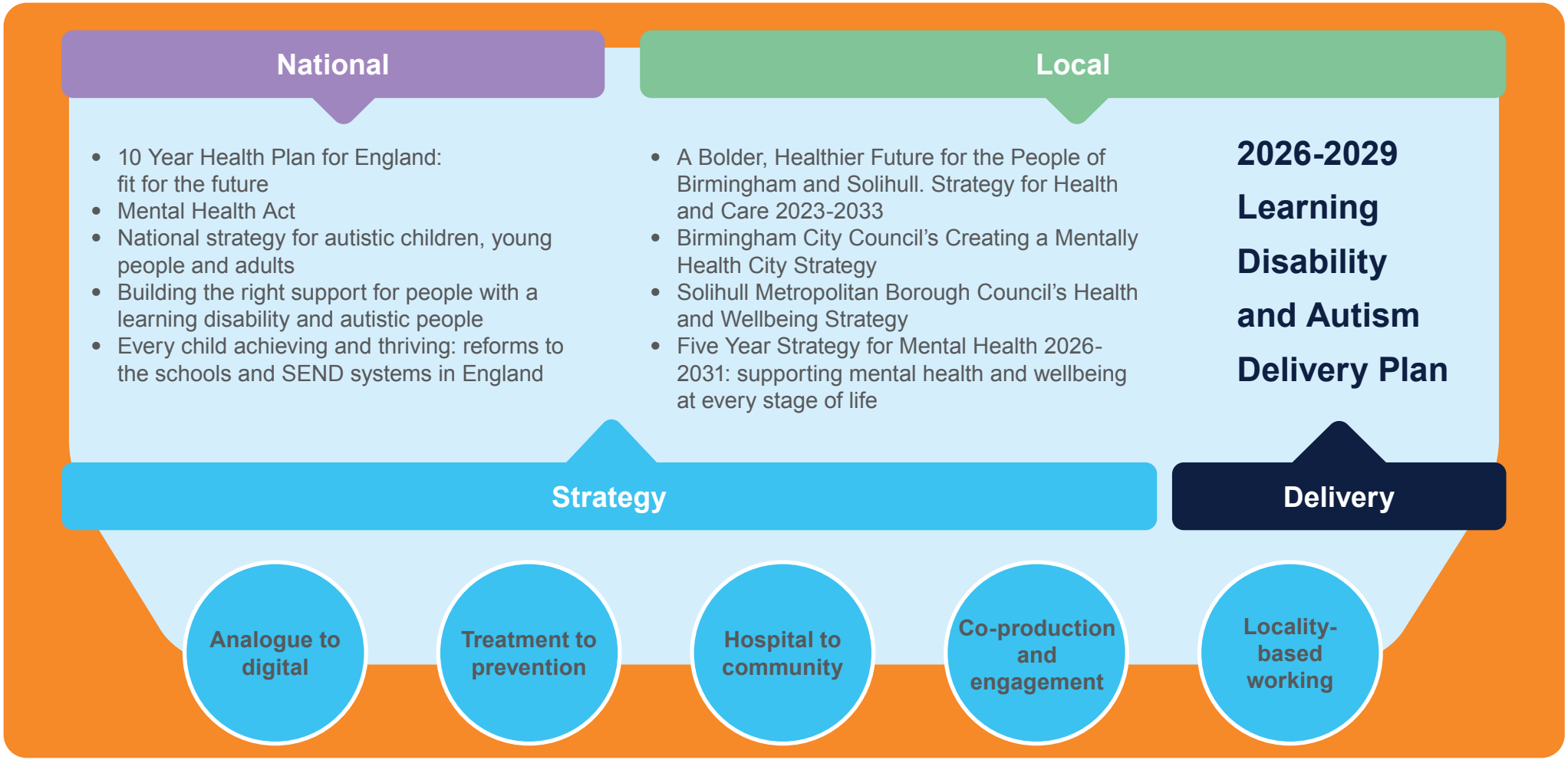
**Dave Rogers – Chief Executive Officer at Midland Mencap.**

# Part A:
# Overview of the delivery plan

# 3.1 What is the delivery plan?

Simply put, the delivery plan is how the Provider Collaborative intends to improve the lives of autistic people and people with a learning disability over the next three years. It is how national and local priorities – whether in legislation and policy or learned through co-production and stakeholder engagement – will be delivered through an achievable programme of work.

Not everything can be done at once, and not everything of importance will be for the Provider Collaborative to lead.



# 3.2 How was the delivery plan brought together?

**People working across health and social care in Birmingham and Solihull have already committed a lot of time to understanding how care and support can be improved for local neurodivergent people and people with a learning disability.**

Sometimes this has been led by the local Integrated Care System, sometimes by organisations such as the Local Government Association or Ofsted. Regardless these have involved learning from the lives of local people and the experience of the professionals, volunteers and informal carers who support them. Some notable examples are:

**2022**

Strategic Vision for Autism 2022-2027

**2022**

Strategic Vision for Learning Disabilities 2022-2027

**2023**

Learning Disability and Autism Framework for Change 2023-2033

**2024**

Learning Disabilities in Birmingham Joint Strategic Needs Assessment Deep Dive

**2024**

Building the Right Support Local Government Association Peer Review 2024

**2025**

Birmingham Special Educational Needs and Disabilities Inspection Report 2025

**2025**

Birmingham Autism and ADHD Partnership Board Delivery Plan 2025

**2025**

Learning Disability and Autism Remedial Action Plan 2025

Delivery plan engagement with the Birmingham Community Healthcare NHS Foundation Trust Service User Group.

Each identified a range of recommendations as to how the NHS and partners can improve the lives of local people. Many of these recommendations have been completed but some remain outstanding. They are the strategic priorities, areas of action and objectives to be delivered which are the heart of the delivery plan.

The Provider Collaborative will continue to work with partners to update the delivery plan to ensure it remains fit and relevant to Birmingham and Solihull. This includes in response to other equivalent plans and emerging evidence bases. Examples include: Neurodivergence in Birmingham Joint Strategic Needs Assessment Deep Dive; Learning Disabilities Housing Needs and Solutions Joint Strategic Needs Assessment; and Birmingham City and Solihull Metropolitan Borough Council's Special Educational Needs and Disabilities Plans. It is expected that these will be published in 2026 but after the launch of the delivery plan.

## A continuous programme of co-production and engagement

Part of this delivery plan is a commitment to an ongoing conversation about what the Provider Collaborative and partners can do to improve local people's lives. In the months leading up to the delivery plan's launch the Provider Collaborative has spoken to nearly 100 people with lived experience and over 60 professionals, volunteers and other interested parties. Meetings, workshops and presentations have taken place with (amongst others):

List of organisations and groups who have been engaged with so far:

- Birmingham Autism and ADHD Partnership Board
- Birmingham City Council Quality Champions
- Birmingham Community Healthcare Service User Group
- Communicate 2 U
- Solihull Learning Disability Partnership Board
- Crafting Conversations
- Balsall Health Children Action Support Team
- Solihull Action through Advocacy.

Birmingham and Solihull is made of diverse communities and neighbourhoods. Some the Provider Collaborative will have strong connections with already, others less so. Over the next three years proactive efforts will be made to build trusting and open relationships with anyone across Birmingham and Solihull with lived experience of learning disabilities and autism. For example in May 2026 the Provider Collaborative took part in the first of what is intended to be a series of appearances on Unity FM, the United Kingdom's largest Muslim community radio station.

Delivery plan engagement with Communicate 2 U.


An introductory conversation about learning disabilities and autism on Unity FM.

# 3.3 What will be different in three years time?

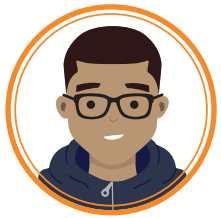
**People will have better physical and mental health, improving life expectancy by reducing health inequalities.**

**There will be less reliance on intensive and restrictive care to keep people safe and well. Instead it will be preventative, and people can access what they need when they need it.**

**To bring this to life we have included stories of people who have experience of local NHS and Voluntary, Community, Faith and Social Enterprise sector services for autistic people and people with a learning disability. These stories showcase some things that have gone well. However, they also give an insight as to what the Provider Collaborative wants to be different for people in the future.**

**Lillian's story:**
Breaking barriers with Key Working Service
**Page 33**

**Daniel's story:**
Personalised care with the Autism Enhanced Support Team
**Page 34**



**Ahmed's story:**
Intensive Support Team's inclusive approach to learning disability care
**Page 35**

Local people including those with lived experience celebrating Learning Disability Week

# 3.4 How will this be achieved?

**Having a three-year delivery plan allows the Provider Collaborative to take a longer-term view at how it can make best use of its resources (workforce, funding etc.) to improve the lives of autistic people and people with a learning disability and their families in Birmingham and Solihull.**

Based on all the work described in 'How was the delivery plan brought together?' an initial three-year overview has been developed.

This is outlined in the table below. It includes:

- Six immediate strategic priorities. Some of these may continue through the delivery plan's three-year life. Some may not, creating the space for others. How these strategic priorities will be delivered are through ten Areas of Action, indicated by () and described on the next page.
- Three enablers to ensure the delivery plan remains on track and relevant to the priorities of local people.

<table>
<tr><th></th><th colspan="4">Year One – 2026/27</th><th colspan="4">Year Two – 2027/28</th><th colspan="4">Year Three – 2028/29</th></tr>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td rowspan="8">Strategic priorities</td><td colspan="8">Resolving short term funding arrangements in the NHS and VCFSE (2 and 5)</td><td colspan="4"></td></tr>
<tr><td colspan="8">Focusing attention onto immediate operational pressures in NHS services (4, 5 and 9)</td><td colspan="4"></td></tr>
<tr><td colspan="12">Preparing and embedding requirements of legislative reform (1, 6, 10)</td></tr>
<tr><td colspan="12">Improving the approach and processes which reduce admissions risk and ensure safe and timely inpatient discharge (1 and 8)</td></tr>
<tr><td colspan="12">Reducing health inequalities and premature mortality including improving quality across all services. (3).</td></tr>
<tr><td colspan="8">Addressing the immediate risks relating to increasing costs of packages of care (8)</td><td colspan="4"></td></tr>
<tr><td colspan="9">Stimulating services which can help keep people safe and well in their local communities (2 and 7).</td><td colspan="3"></td></tr>
<tr><td rowspan="3">Enablers</td><td colspan="12">Aligning the delivery plan with place, locality and neighbourhood-based working, including clustering with the Black Country</td></tr>
<tr><td colspan="12">Continuing process of engagement and co-production to ensure that delivery plan remains focused on where greatest impact can be made on the lives of local people</td></tr>
<tr><td colspan="3">Embedding delivery plan ways of working</td><td colspan="3">Refreshing delivery plan for Year 2</td><td colspan="2"></td><td colspan="2">Refreshing delivery plan for Year 3</td><td colspan="2">Developing next delivery plan</td></tr>
</table>

The delivery plan will need to be flexible to changing national and local circumstances. However, its focus will remain on those improvements which can have the greatest impact on the lives of local people.

There are ten Areas of Action that will help to deliver more preventative care and improve people's health and wellbeing. There has been, and continues to be, consistent feedback that these are where the Provider Collaborative and partners can make a significant impact in improving the lives of local autistic people and people with a learning disability.

1. Care oversight for admission avoidance and discharge delivery
2. Sustainable preventative services
3. Reducing health inequalities / preventing premature mortality
4. Specialist community NHS services for autistic children and children with a learning disability
5. Crisis care for autistic people, people with a learning disability and people with mental ill-health
6. Care and accommodation in the community
7. A thriving, inclusive workforce
8. Commissioning for strengths-based care for individuals
9. The neurodivergent diagnostic pathway
10. Education and special educational needs and disabilities

# Part B
# Objectives to be delivered

**These objectives are the initial overview of what will be delivered under each Area of Action. Some are specific, some broad. It is anticipated that as each Area of Action develops, some objectives will be amended, some new ones created. The Learning Disability and Autism Delivery Group (see 'Governance and Accountability') is accountable for ensuring that any changes do not prevent the Area of Action from delivering the aspired difference to local people. Each Area of Action has an identified lead officer from the Provider Collaborative. This does not mean that that individual is responsible for delivering all the objectives, responsibility is shared across relevant partners.**

# 1. Care oversight for admission avoidance and discharge delivery

## What will the difference be to local people?

All autistic people and people with a learning disability who are at risk of harm to themselves and others – whether as an inpatient or in the community – will have robust, multi-agency oversight of their care.

## Objective

- Review and agree any changes to how inpatient discharges should be co-ordinated, including the potential requirement for specific discharge co-ordinator roles.
- Review and agree any changes to case managers for autistic people and people with a learning disability, including the potential requirement for specific case manager roles.
- Hold monthly discharge review meetings to ensure that plans are in place and are on track. This includes:
  – that everyone is on the Assuring Transformation platform and monitored through the 12-point discharge checklist
  – collaborative working to identify and mitigate potential delays or failures.
- Implement a process for conducting thematic reviews of delayed discharges and sharing findings to inform quality improvement and commissioning intentions.
- Put in place additional oversight and assurance processes for people with the longest lengths of stay.
- Review the long-term need for 'life planning' support for people who most need it (inpatients or in the community) and how it can have sustainable delivery.
- Develop and implement a communications plan to keep all stakeholders, including local people, aware of the services available when experiencing serious mental ill-health or behavioural challenge.
- Raise awareness, understanding and compliance of the dynamic support register, Care (Education) and Treatment Reviews and local area emergency protocol through a communication and training plan.
- Review functionality of online dynamic support register portal for any improvements or changes needed.
- Hold monthly dynamic support register oversight meetings to ensure that it is working effectively, and that findings and learnings are used to inform quality improvement and commissioning intentions.
- Consolidate the dynamic support register into single oversight by the Provider Collaborative.
- Agree who should attend dynamic support register meetings, ensuring appropriate decision-making authority so that risks can be mitigated or escalated to those who can.
- Forecast the anticipated demand for Care (Education) and Treatment Reviews and local area emergency protocol to ensure enough system capacity.
- Review confidence, competence and capability of Care (Education) and Treatment Reviews panel members so they can deliver this expected roles.
- Develop and report against quality and performance measures for dynamic support register, Care (Education) and Treatment Reviews and local area emergency protocol.
- Agree a system escalation process of individual cases where issues and risks cannot be mitigated without additional senior management and leadership decisions or approvals.
- Agree and implement an 'after action' process for when the system has not been complaint with dynamic support register, Care (Education) and Treatment Reviews and local area emergency protocol policies and procedure.

**Provider Collaborative Lead**
Rachael Garvey

# 2. Sustainable Preventative Services

## What will the difference be to local people?

There will be local community-based services to provide care and support for people to prevent worsening health and wellbeing, and these services will be more sustainable through longer term commissioning and contracting arrangements.

## Objective

- Evaluate the effectiveness and capacity of local Key Working services.
- Co-design new approaches and/or community services to support people in developing friendships, peer groups and social networks.
- Evaluate and take appropriate commissioning action as appropriate for services paid for through service development funding.
- Create forums to support providers to work in greater collaboration with each other, including in delivering the sustainable preventative services.
- Ensure the involvement in people with lived experience in the design, evaluation and review of workforce training.
- Explore the greater use of technology in supporting people to:
  – maintain and/or develop their independent living skills
  – identify, manage and address their mental ill-health and/or behaviours that challenge.

**Provider Collaborative Lead**
James Lewis

# 3. Reducing health inequalities / preventing premature mortality

## What will the difference be to local people?

People will have better access and experience of better-quality services, contributing to improved health and wellbeing and less premature mortality.

## Objective

- Create a network of learning disability and autism champions across appropriate Birmingham and Solihull services to help inform and drive quality improvement.
- Carry out appropriate reviews and inspections of local services to ensure they are neurodivergent and learning disability friendly.
- Co-design, agree and rollout a system wide approach to Hospital Passports with standards as appropriate and use available communication channels to promote to the public.
- Audit workforce understanding and compliance with the following, taking corrective action as necessary:
  – Do Not Attempt Cardiopulmonary Resuscitation
  – Mental Capacity.
- Develop a system understanding of a ‘rights-based approach’ and implement policy, process and cultural changes needed to implement it.
- Routinely gather data that includes insights into how different protected characteristics affect the accessibility and quality of care for people with a learning disability.
- Deliver the Fairer Futures Fund bid project to increase the number of people with a learning disability aged 14 and over that are registered with their local General Practice.
- Continue to measure Birmingham and Solihull services against the NHS Learning Disability Improvement Standards.
- Review and identify actions to improve the quality of Annual Health Checks and Health Action Plans, with a particular focus on how they can lead to improving health outcomes for patients.
- Understand and act on the opportunities to improve the provision of reasonable adjustments in primary and acute care.
- Undertake a needs assessment relating to diagnostic assessment for learning disabilities in both children and adults.

**Provider Collaborative Lead**
Rachael Garvey

## 4. Specialist community NHS services for autistic children and children with a learning disability

### What will the difference be to local people?

The NHS and partners will better understand the care pathway needed for autistic children and children with learning disability need, and will have plans as to how this pathway can be delivered.

### Objective

- Review the current care pathway for autistic children and children with a learning disability who need specialist NHS care to meet their health and wellbeing needs.

**Provider Collaborative Lead**
James Lewis

## 5. Crisis care for autistic people, people with learning disabilities and people with mental ill-health

### What will the difference be to local people?

People in 'crisis' get the right help quickly, with more alternatives to hospital admission and services.

### Objective

- Mobilise and monitor the new crisis accommodation and wrap around service.
- Review the Autism Enhanced Support Team to understand the impact it has had and where potential improvements can be made.
- Review the current 'crisis offer' for children and young people who are preparing for adulthood.
- Continue participating in the NHS Confederation Project to improve the experience of neurodivergent people and people with a learning disability in Emergency Departments.
- Review the 24/7 Text Support Service to understand the impact it has had and where potential improvements can be made.

**Provider Collaborative Lead**
Emma Ambler

# 6. Care and accommodation in the community

## What will the difference be to local people?

There will be more care and accommodation (notably supported living) for autistic people and people with a learning disability who have co-occurring health and social care (or forensic) needs.

## Objective

- Mobilise Small Supports provision in Birmingham and Solihull.
- Deliver two NHS England capital funding projects to develop new supported living for people who are inpatients or are at risk of admission.
- Develop and communicate a care and accommodation for autistic people and people with a learning disability needs assessment and plan for delivery which considers the needs of (amongst others):
  - older adults and people with dementia
  - children who are preparing for or who have recently become adults
  - those who live in residential or nursing care who could live with greater independence
  - people who are inpatients or who are at risk of inpatient admission
  - people with low care needs but present at high risk (for example those with forensic presentations, who use substances or who have suicide ideation).
- Make stronger working arrangements with housing developers (private, social landlord, charity, housing associations).
- Develop an understanding of the potential estates opportunities which could benefit services for autistic people and people with a learning disability.
- Raise awareness of the Disabled Facilities Grant which can support adaptations in people's homes.
- Support the HOLD (Home Ownership for People with Long-Term Disabilities) programme.

**Provider Collaborative Lead**
Roger Hazelden

# 7. A thriving, inclusive workforce

## What will the difference be to local people?

People accessing services feel they are receiving high quality care from a happy, engaged and excelling workforce.

## Objective

- Design and implement a ‘workforce plan’ to build capacity and capability needed to meet current and future needs, working alongside partners such as Skills for Care, local universities and the National Learning Disability Consultants Network as beneficial.
- Co-produce the values and culture Birmingham and Solihull wants for its workforce and integrate those into recruitment and management of staff.
- Evaluate opportunities for greater integrated working across health and social care, including consideration of care co-ordination, integrated or co-located teams and pooled budgets.
- Audit competency and confidence in the following areas across the local learning disability and autism workforce (recognition, understanding and appropriate interventions for) the following:
  – pain
  – deterioration in care settings
  – domestic abuse and ‘mate crimes’
  – multiple health co-morbidities
  – mental ill-health
  – behaviours that challenge.

**Provider Collaborative Lead**
Rachael Garvey

# 8. Commissioning for personalised, strengths-based care for individuals

## What will the difference be to local people?

There will be well defined and agreed approaches to how people's care is planned, delivered and funded.

## Objective

- Design and implement systems, processes and approaches which ensure that the following are considered in care and support planning and delivery:
  - people's whole network of support, including wider family and friends
  - people's caring responsibilities, and how these might affect them and what support they might need
  - people's intimate relationships
  - people's sensory profile and needs.
- Review and, as necessary, develop funding pathways to enable the commissioning of personalised, strengths-based care that offers value for money:
  - Section 117
  - Continuing healthcare
  - Direct payments, individual service funds, personal health budgets and equivalent.
- Evaluate opportunities for greater integrated working across health and social care, including consideration of care co-ordination, integrated or co-located teams and pooled budgets.

**Provider Collaborative Lead**

TBC

# 9. The neurodivergent diagnostic pathway

## What will the difference be to local people?

People will have to wait less time for a diagnostic assessment for a neurodivergent condition and that there is the right support available before, during and after it.

## Objective

- Triage people waiting for an assessment for a neurodivergent condition to ensure that risks are identified and mitigated as appropriate.
- Ensure that there is pre, peri and post diagnostic support to meet need.
- Review the effectiveness of the diagnostic assessment pathway for girls and women with personality disorder.
- Rollout an accreditation process for providers as part of Right to Choose, to deliver more consistent quality and experience.
- Reduce the waiting times for assessments for neurodivergent conditions through a pathway that better reflects demand and makes better use of available resources.
- Ensure that there are sufficient and appropriate services available for people who choose to self-diagnose.
- Explore opportunities for diagnostic assessments for neurodivergent conditions to be completed by education, social care and wider health professionals.
- Implement processes and approaches that enable people to be kept up to date throughout their diagnostic assessment (from initial referral to triage and assessment to report and follow up).

**Provider Collaborative Lead**
Clare Yarnall

# 10. Education and Special Education Needs and Disabilities

## What will the difference be to local people?

The Provider Collaborative has been supporting Birmingham City Council and Solihull Metropolitan Borough Council as they develop their Special Educational Needs and Disabilities reform plans. These plans with the objectives below will then form what the difference we want to be for local people.

## Objective

- Whilst the delivery plan was being written, the government published its policy paper 'Every child achieving and thriving', announcing the intention to reform schools and Special Educational Needs and Disabilities. These proposals are still in consultation, but local systems are starting to prepare for their potential implementation. This does not mean that the actions described below are not important. However, they may need to be amended, added to and re-prioritised as necessary to deliver the national agenda.
- Increase awareness and understanding of neurodivergence in schools.
- Co-design support that can help reduce permanent exclusions from school.
- Explore opportunities to use time in schools to help children develop independent living skills, preparing for adulthood and readiness for employment.
- Improve 'out of education' and 'homeschooled' support for children and families.
- Address the gap in provision for educational psychology.
- Develop online resources for education professionals to help with best practice in neurodivergence and learning disabilities.
- Create resources and support for parents that:
  – makes the process to apply for and manage an Education, Health and Care Plan easier to understand,
  – increases transparency around how decisions are made and how families can appeal,
  – prepares parents for their child to transition to adulthood, including the legal changes that will take place around parental responsibilities.
- Improve policies and practice in Education, Health and Care Plans so that they take a 'whole life' approach, reflect the up to date views of children and families, and are more timely.
- Audit practice in preparing children for adulthood in alignment with national guidance, notably that it starts in a timely way and is proportionate to how much preparation is required.
- Review how local practice aligns to the national special educational needs and disabilities and alternative provision improvement plan to reduce waiting times in services.

**Provider Collaborative Lead**
James Lewis

# Part C
# Supporting Information

# 5. About the Provider Collaborative

**The Birmingham and Solihull Mental Health Provider Collaborative was the first provider collaborative to be established in Birmingham and Solihull, in April 2023. In July 2024 the Provider Collaborative was expanded to include learning disabilities and autism services and it became the Birmingham and Solihull Mental Health and Learning Disabilities and Autism Provider Collaborative.**

**'Provider Collaboratives'** bring providers together to work together at scale to benefit their local populations. While providers have worked together for many years, the move to formalise this way of working is part of a fundamental shift in the way the health and care system is organised, moving from organisational autonomy and competition to collaboration and partnership working.

It formally brings together:

- Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT)
- Birmingham Community Healthcare NHS Foundation Trust (BCHC)
- Voluntary, Community, Faith and Social Enterprise organisations

The Provider Collaborative also works closely with wider partners including Coventry and Warwickshire Partnership NHS Foundation Trust (CWPT) who provide NHS learning disability services in Solihull; and Birmingham City Council and Solihull Metropolitan Borough Council who provide social care and education services across the system

- ✔ We have already seen many benefits from us coming together as a provide collaborative:
- ✔ Relationships between partners have evolved and matured, with **increasing trust and confidence**
- ✔ **Making decisions together** as a collaborative about the best way to develop and transform mental health services for our communities
- ✔ **Strengthened voice** for the **Voluntary, Community, Faith and Social Enterprise (VCFSE) sector** through our new Panel and Collective as part of our formal governance
- ✔ **Tackling challenges together,** working collaboratively from a system perspective rather than in organisational silos has led to some real positive changes in the design and delivery of services, for example in helping people who are on the **Dynamic Support Register** to remain safe in their local community rather than requiring an inpatient admission
- ✔ **A shared understanding** of our vision and ambitions for mental health, learning disability and autism services addition of autism

# How the Provider Collaborative works across Birmingham and Solihull

**The Provider Collaborative commissions and delivers services to various geographic areas and/or population sizes. In some areas in order to achieve economies of scale or consistency of care there is single provider or approach; in other areas it is more important to have smaller, more localised provision to meet a community's needs. Regardless of size all need to deliver high quality, good value for money care.**

| Place | Geography | Population | Example of service delivered at this place level |
|---|---|---|---|
| **One system** | Birmingham and Solihull | Around 1.4 million people | Adult Autism Diagnostic Assessment Service |
| **Two places** | The two local authority areas: Birmingham; Solihull | Birmingham around 1.2 million people, Solihull around 200,000 | Community Learning Disability Teams |
| **Six localities** | North, East, South, West and Central Birmingham, and Solihull | Around 300,000 people | Community Counselling Services |
| **Thirty-five neighbourhoods** | Broadly aligned to Primary Care Networks | Around 30,000-50,000 people each | 24/7 Neighbourhood Mental Health Hubs |


## The Future

As part of NHS re-organisation Birmingham and Solihull Integrated Care Board is 'clustering' with Black Country Integrated Care Board. This means that a single NHS Birmingham, Black Country and Solihull Integrated Care Board will be responsible for commissioning services across that geographical area.

Similarly, the Birmingham and Solihull Mental Health, Learning Disabilities and Autism Provider Collaborative will be clustering with the Black Country Healthcare NHS Foundation Trust as Lead Provider of mental health, learning disability and autism services.

The clustering is still at its early stages, however as it develops the delivery plan will be updated as appropriate.

# What else have people told us is important?

**The delivery plan has been developed to ensure that the Provider Collaborative and partners can best deliver the programmes of work needed to improve the lives of autistic people and people with a learning disability.**

This means recognising that not everything can be done at once; that it is more important to deliver some things well, rather than lots of things less well (or not deliver them at all).

Furthermore, NHS and Voluntary, Community, Faith and Social Enterprise sector services are just one part of people's lives. The Provider Collaborative has influence beyond the services it commissions and delivers. However, we also rely on partners such as local government, the police and fire services and the private sector to play their part in improving the lives of autistic people and people with a learning disability.

This means that some of the issues people with lived experience, professionals, volunteers and unpaid carers said were important to them are not included in the delivery plan's Areas of Action.

**These include:**

- Respite, short breaks and day services.
- Intermediate care, reablement and enablement.
- Peer support for friendship, peer groups and social networks.
- Experience of policy, prisons and criminal justice.
- Community safety.
- Helping people to become digitally enabled.
- Ensuring there is suitable and appropriate advocacy for people who need it.
- Making Birmingham and Solihull neurodivergent and learning disability friendly.

The Provider Collaborative will be supporting partners to help deliver improvements in these areas. The Solihull Neurodivergence and Community Safety Project is an example which the Provider Collaborative has and will continue to be a part of.

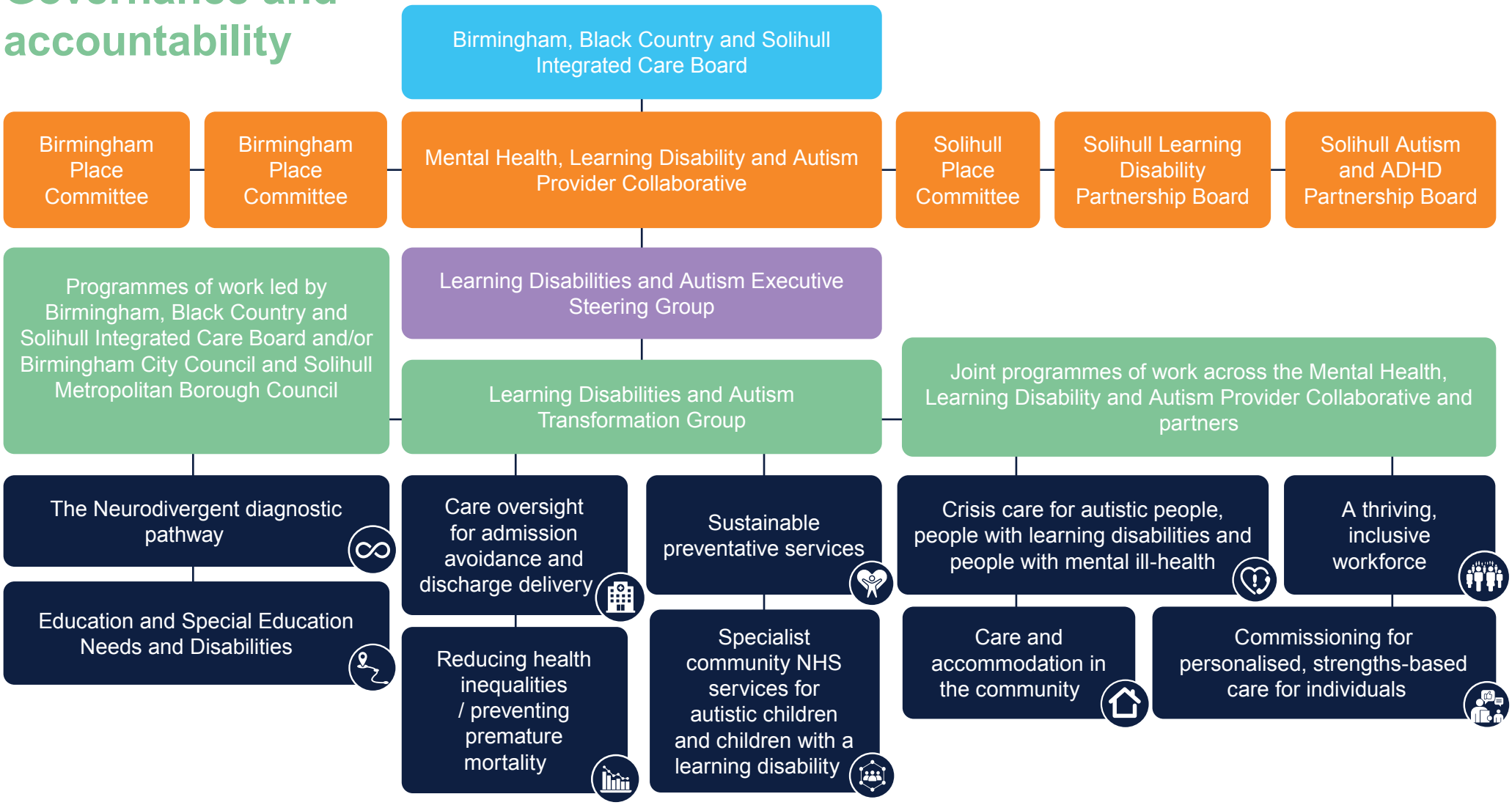
***"You can't be autistic, you have kids"***

Autistic person who is a member of the Solihull Autism and ADHD Partnership Board.

***"I don't feel safe going out"***

Person with a learning disability who is a member of the Birmingham Community Healthcare NHS Foundation Trust Service User Group.

# Governance and accountability




Some of these Areas of Action may look like traditional workstreams or task and finish groups, some less so. What is important is that there is accountability for delivery, and this will be overseen by the learning disability and autism transformation group. A highlight report for each Area of Action will be produced every second month, collectively forming an overall delivery plan progress report. The report will not only track objectives which have been completed or may need to be amended but also identify risks and issues which need to be addressed.

# Measuring success

## Mandated performance improvements

The Department of Health and Social Care have mandated that all Integrated Care Systems improve the quality and availability of care and support for autistic people and people with a learning disability in their local community. There are two key ways in which they are measuring whether that has been achieved:

### Reducing reliance on inpatient care for autistic people and people with a learning disability

This not only includes reducing the total number of autistic inpatients and inpatients with a learning disability, but also the number of people admitted to inpatient care and reducing the number of people who are defined as having the 'longest lengths of stay'. Working with NHS providers and NHS England, the Provider Collaborative has committed to delivering the following over the next three years.

| Required area of improvement | End of year position | | | | % Change from year before | | | |
|---|---|---|---|---|---|---|---|---|
| | 25/26 | 26/27 | 27/28 | 28/29 | 25/26 | 26/27 | 27/28 | 28/29 |
| Total adult inpatients | 68 | 52 | 40 | 32 | | -22% | -25% | -20% |
| Total child inpatients | 9 | 4 | 4 | 4 | | -56% | 0% | 0% |
| Number of adults admitted in the year | | 35 | 32 | 27 | | | -9% | -16% |
| Number of children admitted in the year | | 13 | 11 | 8 | | | -15% | -27% |
| People with the 'longest lengths of stay'* | | 23 | 12 | 8 | | | -48% | -33% |

*** Defined as: greater than 9 months for children, greater than 2 years for adults on 'non restricted' sections, and greater than 5 years for adults on 'restricted' sections.**

Alongside the delivery plan each NHS Provider Trust has developed their own set of actions which will help achieve these areas of improvement. These will be refreshed each year of the delivery plan.

### Increasing the number of people with a learning disability aged 14 and over who have a Health Action Plan as a result of an Annual Health Check

Annual Health Checks and Health Action Plans are an important way that can help people with a learning disability understand their physical and mental health and the ways they can maintain or improve it. The Provider Collaborative alongside commissioning leads for General Practice (who deliver Annual Health Checks) have committed to a 3 per cent increase each year of the delivery plan.

| Total Annual Health Checks with a Health Action Plan delivered per year | | | | % Change from year before | | | |
|---|---|---|---|---|---|---|---|
| 25/26 | 26/27 | 27/28 | 28/29 | 25/26 | 26/27 | 27/28 | 28/29 |
| | 9,641 | 9,925 | 10,229 | | | 3% | 3% |

To continue to increase the number and percentage of people with a learning disability registered with a General Practice receiving their Annual Health Check, the delivery plan also commits to:

- understanding and delivering improvements to the quality of the checks and the resulting Health Action Plans
- increasing the total number of people with a learning disability aged 14 and over that are registered with their local GP, including targeted work in places and communities where registration is less than expected.

## Local performance and quality improvements

In addition to the mandated performance indicators the Provider Collaborative has been developing local measures to understand where impact is being made. Some of these are about pathways and processes (such as how successful Care Education and Treatment Reviews are at helping to keep people safe and well in their community), some about specific services. It is the intention that reporting against these measures will be added to the delivery plan.

## Examples of what has already been achieved between April 2025 and March 2026

- ✔ Completed 230 Safe and Well Checks across 46 hospital wards or units for people who are mental health inpatients from Colchester to Liverpool
- ✔ Developed the Dynamic Support Register to where at least 91% of people added have been kept safe in their local community, regardless of how imminent their potential inpatient admission was
- ✔ Spent an additional near £1,000,000 on services in the community which will provide care for up to 1,500 people across three key areas: preventing people from escalating mental ill-health or behaviours that challenge; children and young people waiting for a diagnostic assessment for a neurodivergent condition; or to reduce inequalities of access or experience of NHS services
- ✔ Increased the number of people with a learning disability over the age of 14 years who received an Annual Health Check from their GP by 395 people (3.6%)
- ✔ 'Understanding Autism' training has been delivered to 80 members of NHS staff, with an 83% growth in the number of staff feeling they have a good understanding of autism following the training and 100% reporting that they gained some useful strategies that will improve their professional practice.

Staff from Birmingham and Solihull Mental Health NHS Foundation Trust completing 'Understanding Autism' training.


To promote Annual Health Checks to parents and carers a video has been produced in partnership with local people and Solihull Healthcare Partnership.

# Making the most of the Provider Collaborative's money

## Overview

**The Provider Collaborative has its budget agreed each year, and a breakdown of how its funding will be spent on services for autistic people and people with a learning disability in the first year of the delivery plan (2026/27) can be found in the table below. There are some additional smaller areas of spend. These are the things the Provider Collaborative needs to deliver the plan (staff, online platforms, costs to deliver Care (Education) and Treatment Reviews as examples).**

| 2026/27 areas of spend | £s | % of total | SDF contribution | SDF contribution of area of spend % |
|---|---|---|---|---|
| NHS provided services | £25,155,797 | 44.2% | £1,511,064 | 6.0% |
| Non-NHS provided services | £3,238,785 | 5.7% | £2,642,909 | 81.6% |
| Packages of care for individuals | £28,534,644 | 50.1% | £0 | 0% |
| **Total** | **£56,929,226** | | **£4,153,974** | **7.7%** |

## What is service development funding?

Between 2021 and 2025 service development funding (SDF) was a non-recurrent allocation of funding by NHS England to Integrated Care Systems to help transform community services. In 2025 this funding was made recurrent, providing greater freedoms for commissioners, in this case the Provider Collaborative, to look at more long term, sustainable investments.

## How have the Provider Collaborative been using it?

In the 2025/26 financial year the Provider Collaborative committed to using its total allocation of SDF for the first time. This included investments in NHS and Voluntary, Community, Faith and Social Enterprise services; some continuations of previous funded services, others new. Of this new provision some were delayed in mobilisation, meaning that there was the potential for an underspend. This was prevented by commissioning additional new services to help deliver identified priorities to: prevent people going into hospital, support children and young people awaiting or following a diagnostic assessment for a neurodivergent condition, or reduce inequalities in access to NHS services.

## What happens when short term funding comes to an end?

It has been agreed that most investments made in 2025/26 will continue until either the end of the 2026/27 financial year or approximately 6-9 months into 2027/28. One of the delivery plan's areas of action is to work in collaboration with partners to review and evaluate these investments to recommend and commission what is needed longer term. This will require a detailed understanding of what has been delivered, the outcomes achieved and what value for money and return on investment they represent.

## Capital funding

The Provider Collaborative has had the opportunity to apply for capital funding to help increase or improve the available estate providing services for autistic people, people with a learning disability and people with mental ill-health. Two significant projects to the delivery plan are:

- Two allocations to develop new bespoke accommodation in the community which can support autistic people and people with a learning disability who have been or are at risk of inpatient admission.
- 24/7 Neighbourhood Mental Health Centres, providing support for people in their local communities.

The former forms part of this delivery plan, the latter a key component of the wider mental health strategy.

# Overview of financial risks

## 1. Rising costs for packages of care

The amount and proportion of Provider Collaborative spend on packages of care for individuals continues to grow. This is both more people receiving NHS funding (for example through Section 117 of the Mental Health Act) and the costs of people's care increasing (whether because they need more care or because of increasing costs to provide that care).

### Area of Action addressing the risk

- Care oversight for admission avoidance and discharge delivery.
- Care and accommodation in the community.
- Commissioning for personalised, strengths-based care for individuals.

## 2. Financial vulnerability of local care providers

The increasing costs to provide care, notably adhering to the National Living Wage and wider 'cost of living' implications, increase the financial vulnerability particularly prevalent in the Voluntary, Community, Faith and Social Enterprise sector (for example in how the Provider Collaborative has used its service development funding).

### Area of Action addressing the risk

- Sustainable preventive services.
- Care and accommodation in the community.
- Commissioning for personalised, strengths-based care for individuals.

## 3. Securing sustainable preventative services

The Provider Collaborative has invested in services which aim to be preventative, to stop people requiring mental health inpatient care or attend Accident and Emergency departments or even need to speak to their GP. Business cases for long term, sustainable preventative services like these can be difficult to develop, the challenge being in identifying the saving that is made to the NHS.

### Area of Action addressing the risk

- Sustainable preventative services.
- Specialist community NHS services for autistic children and children with a learning disability.
- Crisis care for autistic people, people with learning disabilities and people with mental ill-health.
- The neurodivergent diagnostic pathway.

# Breaking barriers with Key Working Service:

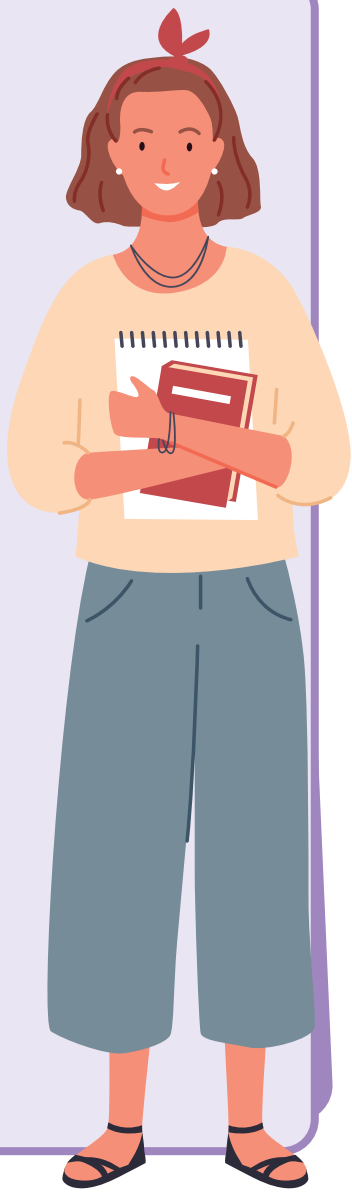
## Lillian's story

32-year-old Lillian received an autism diagnosis less than a year ago. She lives independently and works full-time but was referred to the Autism Key Working Service following several suicide attempts and a voluntary inpatient admission. At referral, she remained at high risk and struggled to engage with unfamiliar professionals. Despite appearing calm, she felt overwhelmed, hopeless, and exhausted, with her ability to mask distress leading to her needs being underestimated. She described her inpatient experience as traumatic, feeling misunderstood by staff.

The Key Working Service aims to reduce health inequalities by addressing barriers autistic adults face in accessing appropriate care. From the outset, adjustments were made: Lillian was offered an introductory video call, and early sessions included her trusted community psychiatric nurse to provide continuity. A personalised health passport, sensory profile, and burnout profile were developed.

When her mental health declined, the Key Worker advocated for support from a familiar home treatment team. By recognising autistic burnout and concealed suicide risk, early intervention prevented further deterioration. Support focused on understanding masking, emotional regulation, and self-advocacy. Lillian built trust with her new community psychiatric nurse, avoided further admission, sought workplace adjustments, and strengthened her identity and support through the Autism Confidence Programme.

| What went well | Opportunities to improve |
|---|---|
| • Person centred-reasonable adjustments.<br>• Partnership working between the Voluntary, Community, Faith and Social Enterprise sector and the NHS.<br>• Advocacy to make sure people get the care they need. | • Earlier autism diagnosis and accompanying post-diagnostic support.<br>• Greater understanding of how to best care for autistic people in mental health inpatient services. |



# Personalised care with the Autism Enhanced Support Team:

## Daniel's story

41-year-old Daniel has autism. He was admitted to the psychiatric intensive care unit following a mental health crisis, but found the environment was overwhelming. Constant noise, bright lights, and frequent staff interactions heightened his anxiety, making it difficult for him to engage in assessments, activities, or communicate his needs. He often became distressed quickly and struggled to regulate his emotions.

The Autism Enhanced Support Team introduced a more personalised approach. Occupational therapy assessments were adapted and delivered in quieter, low-stimulation spaces where Daniel felt safer and more able to focus. Staff also received training on autism-informed communication strategies, including using clear and concise language, allowing additional processing time, recognising early signs of distress and supporting self-regulation techniques.

With these adjustments, Daniel gradually became more engaged in his care. He participated in simple cooking activities during occupational therapy sessions, helping to build routine, confidence and a sense of achievement. Over time, he established a daily routine on the ward, reducing uncertainty and anxiety. Importantly, he began seeking support proactively before reaching crisis point, using learned coping strategies with staff guidance.

As a result, Daniel's wellbeing improved significantly, enabling a successful transition from psychiatric intensive care unit to an acute ward and demonstrating the value of personalised, autism-informed care.

| What went well | Opportunities to improve |
|---|---|
| • Sensory assessment and adaptions to promote better experience of inpatient services.<br>• Training for staff to help improve practice.<br>• Focus on strategies which support better long term health and wellbeing. | • Addressing over reliance on inpatient care to keep people safe.<br>• The need to get it right first time so that people's experience of care is good from the outset. |

# Intensive Support Team's inclusive approach to learning:

## Ahmed's story

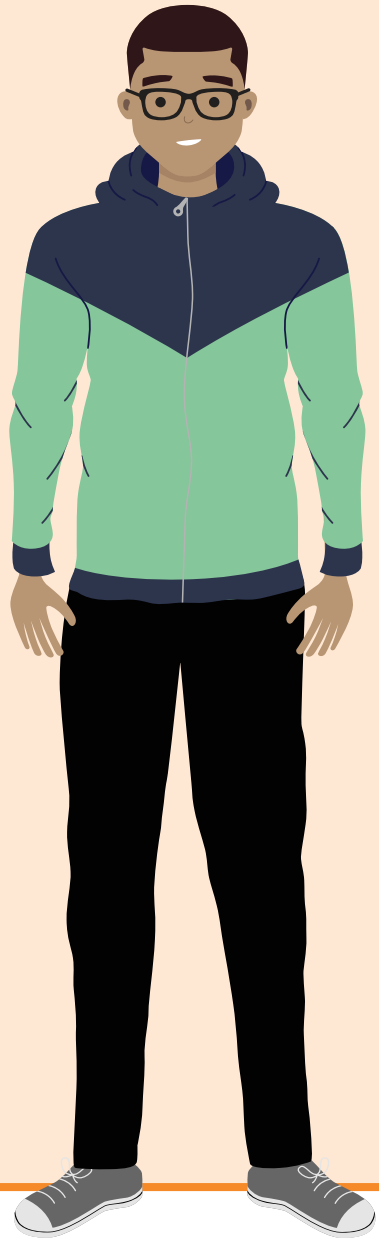
Ahmed is a 28-year-old man with a mild learning disability, autism, and sensory sensitivities. He was referred to the Intensive Support Team after a placement breakdown placed him at risk of hospital admission. At the time, he lived with two carers providing 24/7 support and had a history of multiple placement breakdowns and hospital admissions linked to his mental health.

When Ahmed's anxiety increases, it can escalate into verbal and physical aggression toward staff. This led to the loss of his accommodation and the need to find a new provider and property.

In the short term, Ahmed moved back in with his parents while the Intensive Support Team worked with his family to secure a suitable placement. An initial property proved unsuitable due to limited scope for adaptations, which increased his anxiety and reduced daily functioning.

A second property was identified that better met his sensory needs and was closer to family. This significantly improved his wellbeing and enabled a reduction in support to 1:1, a goal important to Ahmed.

Through joint working, including occupational therapy to develop meaningful activities aligned with his interests, Ahmed's anxiety and behaviours reduced. His care is now stable, and hospital admission has been avoided.



| What went well | Opportunities to improve |
|---|---|
| • Person centred-reasonable adjustments.<br>• Partnership working between the Voluntary, Community, Faith and Social Enterprise sector and the NHS.<br>• Advocacy to make sure people get the care they need. | • Earlier autism diagnosis and accompanying post-diagnostic support.<br>• Greater understanding of how to best care for autistic people in mental health inpatient services. |