Birmingham Older Peoples Programme - Progress Update & Planned Activity

1. Purpose

To provide the Health and Wellbeing Board with an update on progress and planned activity for each workstream of the Birmingham Older Peoples Programme.

2. Background

The Birmingham Health and Wellbeing Board on 27th March 2018 supported a Framework for how health and social care can be delivered at a locality level through a place based approach. The Framework breaks our approach down into three interrelated themes which cover the whole range of support provided for older people and their carers: Prevention; Early Intervention; and Ongoing Personalised support.

2.1 Prevention

A universal wellbeing offer enabling older people to manage their own health & wellbeing, based in local communities and utilising local resources. It will address the issues that lead to older people entering into formal health & care systems, such as social isolation, falls and carer breakdown. Access to good quality information & advice will be the cornerstone of our wellbeing offer, enabling people to identify and access the support that they need in order to maintain living fulfilled lives.

2.2 Early Intervention

A range of targeted interventions to promote faster recovery from illness or injury, prevent unnecessary hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. We will respond quickly, minimise delays and not make decisions about long term care in a hospital setting.

2.3 Ongoing Personalised Support

Some older people will need ongoing support to remain living in their own homes and communities. These services aim to maintain individual wellbeing and self-sufficiency, keep older people safe and enable them to be treated with dignity, stay connected to their communities and avoid unnecessary admissions to hospitals or care homes. We will change the way our services are commissioned and delivered to be more focused on achieving better outcomes for older people.

All of the work will be done with these key principles in mind:

- The person who is receiving care is at the centre - the person comes first, with family and carer input also valued.
- More people will live independently in later life.
- Each person receives the right care, at the right time, in the right place, by the right professional, at the right cost.
- We aim to support people's lives, not just deliver a service.
- The person will have to tell their story as few times as possible.
- All staff are working together to champion the "home first" ethos.
- We will have one integrated model across the system.

Working this way will mean:

- New relationships across the system.
- Removal of organisational boundaries.
- No wrong door for someone that needs help.
- Clearly defined roles to maximise individual and collective skills and capacity.
- Efficient distribution of resources within a locality.
- Overall consistency accepting local variation where it makes sense.

From a citizen perspective we 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 joint, health or social care personalised budgets or direct payments

3. Progress update and planned activity

3.1 Prevention

3.1.1 <u>Carers</u>

Supporting citizens who provide unpaid care for family and friends is an exemplar area for health and social care integration. A system-wide Carers Board has been established, the first joint Carers Strategy has been drafted and pooled funding for 3 years identified to deliver a single approach to supporting carers across the life-course. Formal consultation on the strategy has taken place and has identified that

additional engagement work with carers from BME and newly arrived communities is required.

Current contracts and grant funding arrangements with community sector providers for support to carers have been extended for 3 months to allow appropriate levels of market engagement on the new model of delivery. Feedback from a market event held on 23rd November 2018 has been useful in developing and refining the specification for services. Key areas of focus include the transition phase for young carers and ensuring that we retain a clear pathway and carer focus through the different elements of the tender.

During the process it was identified that commissioning activity regarding support for mental health carers was also underway in the system. Commissioning teams are now working together to align this proposed tender activity into the wider commissioning strategy for carers.

3.1.2 Neighbourhood Network Scheme (NNS)

Neighbourhood Network Schemes are locality and constituency based networks which enable engagement with and investment in community assets. Community assets include local organizations, people, partnerships, facilities, funding and a community's collective experience. Any positive aspect of the community is an asset that can be leveraged to develop effective solutions.The intended outcome is that NNS's will support older people to connect to community assets in their neighbourhoods in order to improve their health and well-being. This approach is integral to the new community social work model and the overall investment by Adult Social Care & Health in "Prevention First". They will also work alongside and support other neighbourhood and place based activity in social care and health, such as the Three Conversations approach to social work practice, NHS social prescribing, Community Catalysts and Local Area Coordination.

NNS is now operating in 2 constituencies; Perry Barr and Selly Oak. A Steering Group brings partners together to direct, coordinate and advise on the development of NNS in each area. The local commissioning process will start in January to fund new activity; make existing activity more accessible to older people and to develop support for community groups and organisations (e.g. fundraising, marketing, volunteer recruitment etc.)

In October 2018 the first citywide community asset register was compiled with 559 listings. It is expected that this will grow to c1,500 by January 2019 and will be kept up to date on a monthly basis and widely shared. At a city and neighbourhood level this mapping will help us to identify gaps in our community asset-base. For example, the first compilation has highlighted clear gaps around support to enable older people to "maximise income". This presents an opportunity to work with the Financial Inclusion Partnership to address this issue.

Tenders have now closed for the other NNS areas with contract awards to follow and preparation for starting services to commence from February/March. Plans are being worked up for areas where we may not be successful in appointing a suitable provider. This may include going back out to tender, direct delivery or grant based work in smaller geographical areas.

BVSC is providing support for capacity building and service planning to align with the vision and provide more evidence based outcomes. Furthermore dialogue is ongoing with the Big Lottery to align with the more localised approach. A £100k Innovation Fund – to help test and trial new activity, is in place to support projects which can benefit the NNS and social prescribing in the long-term, so far three projects have been supported with £70K invested.

3.1.3 Housing Pathway

A project is underway to review the pathways into extra care housing. This recognises that at present we are not making best use of the Council's nomination rights for extra care housing in the city in terms of enabling citizens with long-term care needs to access this form of accommodation. The proposal is to change the referral route from a housing pathway into a social care pathway, so that those with social care needs who are eligible for affordable housing can be placed quickly into vacant homes in extra care schemes. A draft social care pathway has been drawn up and we are now looking at resourcing for the new model. Plans are also being developed to bring extra care providers onto the framework contract for commissioned care services so that there is financial equity with other forms of care providers.

3.1.4 Intergenerational Activities

This project aims to bring young and elderly people together in purposeful, mutually beneficial activities which promote greater understanding and respect between generations and which contribute to building more cohesive communities. Presentations have been made to over 500 students attending Birmingham education sessions to introduce the concept and explain the benefits for participants – both old and young. Good progress has been made, with a positive evaluation from the presentations and significant interest from Birmingham schools wanting to engage with local care homes and housing schemes to implement intergenerational activities. A toolkit developed within Solihull provides a how-to guide of implementing intergenerational activities and will be distributed to a peer network to support facilitation / implementation of activities.

3.1.5 Risk Identification

The Supporting Adults Panels (SAP) take place on a monthly basis across the North, South, East and West of Birmingham and have potential to be expanded into wider

stakeholder groups that would provide review and planned intervention to those identified linking into neighbourhood networks.

3.1.6 Social Prescribing

Mapping of social prescribing across constituencies and how these compliment BCC initiatives has been completed. The social prescribing model has been launched and an implementation plan supports rollout across GP localities and integration into neighbourhood networks. Baseline metrics have been established from the outset to demonstrate impact of the model. Work is taking place with DoH and NHSE to support evaluation and potential of joint assurance meetings.

3.2 Early Intervention

Early Intervention describes what happens after an older person experiences an illness or injury, and how they are supported to make a quick recovery. This support is provided for a short period of time with the aim of helping the older person remain in their home wherever possible. It could be provided by a range of different healthcare professionals.

In terms of Early Intervention, this means looking at:

- The short term care services older people can access from home
- The use of short-term beds e.g. in a hospital or care home
- The team of healthcare professionals who make decisions about care and how decisions are made

3.2.1 Prototype Phase (December 2018 – March 2019)

Getting the approach to change right at this scale is crucial. So we have started with a 'prototype' phase that splits our longer-term vision and ambition into more manageable chunks of activity, and in doing so allows us to thoroughly test and improve each bit separately before we then bring all the individual components together in one locality and test and improve how they work together until they are achieving everything we hoped they would. If we get this right it will make the roll-out of the changes a whole lot easier and more successful.

Three workshops involving 15 – 20 staff, representing all the partner organisations, have taken place since 30th November and have helped us to define the components of the model that will enable us to deliver the outcomes and financial benefits.

From the end of January, for 6 – 12 weeks, we will start multiple tests in the most appropriate environment to demonstrate exactly what impacts on outcomes, performance and cost for each change. By understanding this, we can prioritise the ones with the biggest and best impact for citizens, and keep improving any elements which don't quite have the impact we were expecting.

Starting around March 2019, for 10 – 20 weeks, we will put together all the smaller tests within a locality. This will allow us to understand the combined impact of the changes and make improvements until they are ready to be rolled out across Birmingham.

3.2.2 Improvement Managers

We have appointed 8 Improvement Managers who will drive exciting change across the whole health and social care system for the benefit of older people. These individuals come from each of the provider organisations in health and social care and include physical and mental health therapists, social workers and managers with different backgrounds.

The Improvement Managers have received initial training and will now put this to practice by supporting system flow. The initial priority for the Improvement Managers will be to look at the use of short term beds over winter to understand how they work and see if we can make some immediate changes. They will gain an understanding of how the system works at different sites, the services offered, and where patients come from and go to. Improvement Managers will collect data and carry out case studies to establish the current picture, before working with colleagues to design alternatives which are then tested to see whether they are achieving their purpose.

3.2.3 Citizen Engagement

An initial meeting has taken place with a small group of citizens to agree the approach to co-production. In the past we have sought views from citizens when we already have fully formed ideas and almost completed work. We are now involving citizens at an early stage when we do not have all the answers.

3.3 Ongoing Personalised Support

3.3.1 Neighbourhood Working

The development of integrated neighbourhood teams of health and social care professionals serving populations of c. 50,000 people is the initial main priority of the Ongoing Personalised Support Workstream.

We have committed to developing a single team approach to improve the experience of citizens with long-term care needs in terms of continuity of care and seamless handovers between professionals through establishing integrated neighbourhood teams for the care of older adults bringing together groups of general practices with community health teams linked to mental health and social care services. The aim of these teams is to support older people to live well in their own communities with maximum independence.

There are 3 strands of the work:

1. Agreeing a vision for neighbourhood working;
2. Agreeing a delivery model
3. Agreeing the neighbourhoods

Vision - A draft vision for Neighbourhood Teams has been developed.

Delivery Model – an initial, outline delivery model has been developed and a workshop session held on 2nd January to engage partners in further development to design how care will be delivered in the community for frail older adults.

Agreeing the Neighbourhoods - The neighbourhoods will sit within the 5 Birmingham localities and are an important component of the wider STP development of "place-based" care. Our proposed approach is to recognise that general practices are embedded in their neighbourhoods and are seen by citizens as a primary gateway for health and well-being. Therefore we are proposing to use GP practice populations – within the 5 localities – as the building blocks for neighbourhood teams.

Locality workshops are being held for South, North, Central and East attended by GP providers; GP locality leads; district nurse team leaders/case managers; community mental health team leaders; social care teams; and CCG representatives. The workshops are to discuss/agree neighbourhood footprints of c30-50,000 population within each locality. The workshops are also to identify prototype neighbourhoods in each locality. Further discussion is required with West Birmingham colleagues as to how the model will work in this area.

3.3.2 Support to Care Homes

There is a clear opportunity to improve outcomes through an integrated approach to managing and supporting the care home market. To this end the Ongoing Personalised Support programme has established a care homes workstream to focus on:

1. Integrated approach to quality of care – building on the existing methodology of quality reviews undertaken by BSol CCG and BCC;
2. Primary Care Offer to Care homes – consistent access to primary care is a key challenge in the care home sector

A detailed workplan has also been agreed setting out an integrated approach to support care homes. This is supported by analysis of the system-wide care home market, showing commonalities and differences between the BCC and NHS commissioned market in Birmingham. Additionally, analysis of the impact of care homes on hospital A&E attendance shows the potential for interventions and initiatives in the short and long term to improve outcomes

3.3.3 Long Term Conditions

Workshops have also taken place to determine service models for Respiratory and Diabetes with Stakeholder Delivery Groups set up to progress delivery.

3.3.4 Assistive Technology

A workstream has been established to develop the integrated use of assistive technology for citizens with long term care needs. At present the use of assistive technology is predominantly in terms of fixed and portable mechanical technology such as hoists, stair-lifts, walking sticks etc. There are tremendous opportunities to improve the independence of citizens through greater use of emerging digital technologies and artificial intelligence. We have been successful in securing funding to undertake a pilot to use voice-activated technology to support people with care needs. We are also collaborating with Aston University to explore opportunities presented by emerging technology.

4. Conclusions and Recommendations

4.1 Positive progress has been made across all workstreams aligned to the vision of the programme.

4.2 We are clear that workstreams are inter-related and that we will only deliver the programme outcomes detailed in section 2 of this report through integrating activity across the workstreams.

4.3 We are now at an exciting and critical point of the programme as we roll-out neighbourhood networks through the Prevention workstream, start to test new models of Early Intervention and form locality teams based around GP hubs through Ongoing Personalised Support. In order to achieve a single integrated model of care it is essential that activity is co-ordinated across the programme.

4.4 Whilst we are making good progress and partners are fully committed we recognise that we will only achieve our ambitions if this commitment continues and if the aspiration is embedded throughout all organisations and at all levels within the system.

4.5 The Health and Well-being Board has a crucial role in ensuring delivery of programme. In particular the Board will need to:

- Maintain oversight of the programme
- Provide support and challenge to programme leads to ensure that workstreams are joined up and delivering against the integrated vision and a model of care which places the citizen at the centre
- Act as champions for the programme within the Health and Social Care system in Birmingham to ensure that all partners maintain a focus and commitment to delivering at pace

4.6 Specifically, at the current time, the Board is requested to note the work that is being progressed through the Ongoing Personalised Support workstream to define and agree a model and spatial delivery arrangements for providing integrated care and support to citizens with ongoing care needs. The Board is asked to support this approach to place-based care.