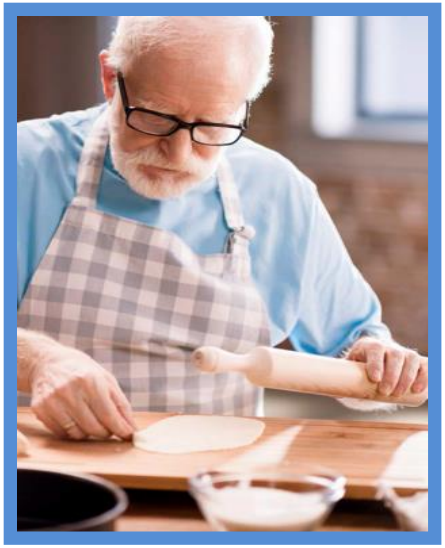
Appendix ii

Birmingham Older Peoples Programme

Making Birmingham a great place to grow old in



Framework Summary

Live healthy Live happy
Birmingham and Solihull

Birmingham City Council

NHS

OVERVIEW

Why we need to change

How we will manage change

Our joint vision for the future

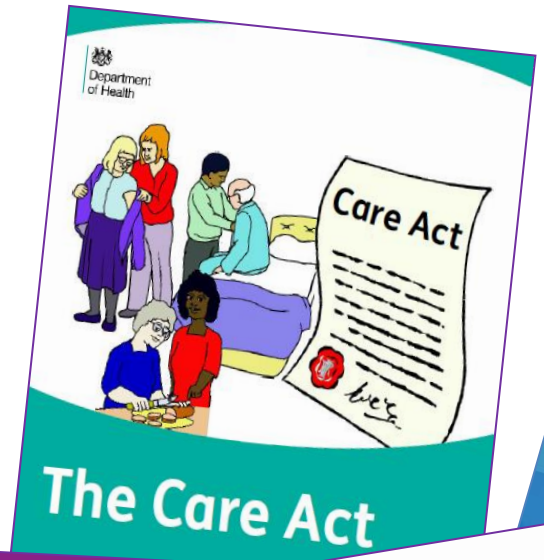
Prevention

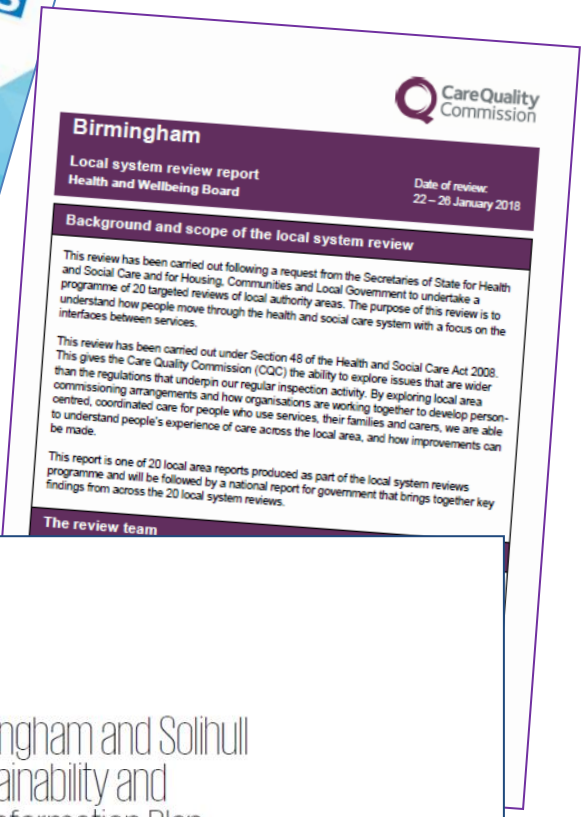
Early Intervention

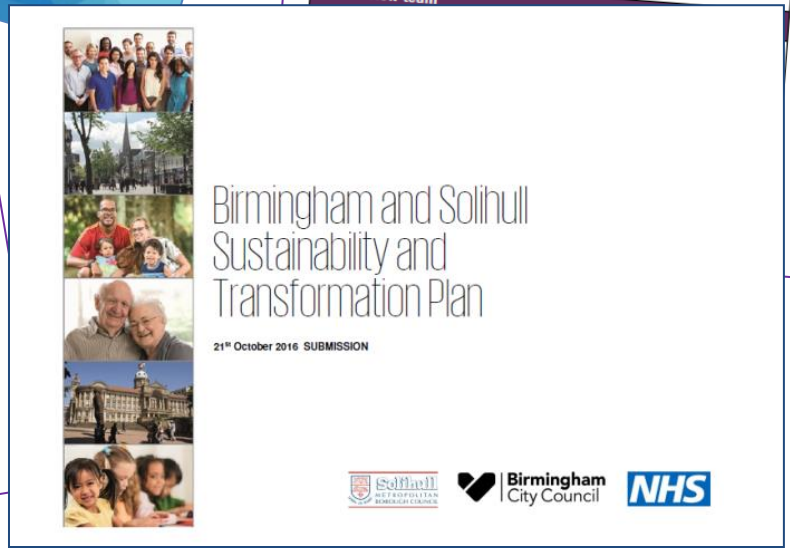
Personalised Ongoing Support

A place based approach

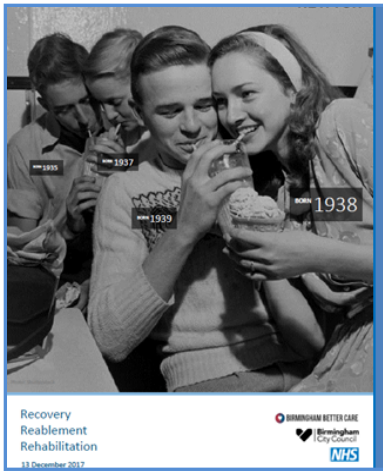
Why we need to change







Why we need to change



The proportion of people we admit into hospital who could have been better looked after elsewhere. **23%**

The proportion of people in elderly care and longer stay wards who are medically fit but delayed, waiting to leave hospital. **51%**

The proportion of people who could benefit from a different pathway out of hospital, one better suited to their needs. **19%**

36% The proportion of people who could achieve greater independence, following a stay in a short-term bed, with our support.

37% The proportion of people currently with a long-term care package who could benefit from better enablement.

50% The proportion of people who's mental health reached crisis point (and went into hospital) that could have been avoided.

- **Fragmented services, inconsistent capacity and an overreliance on beds**
- **Phyllis production – true stories of working that isn't joined up**
- **Sticking plasters as tactical responses to pressures**
- **Financial situation – must inject pace**

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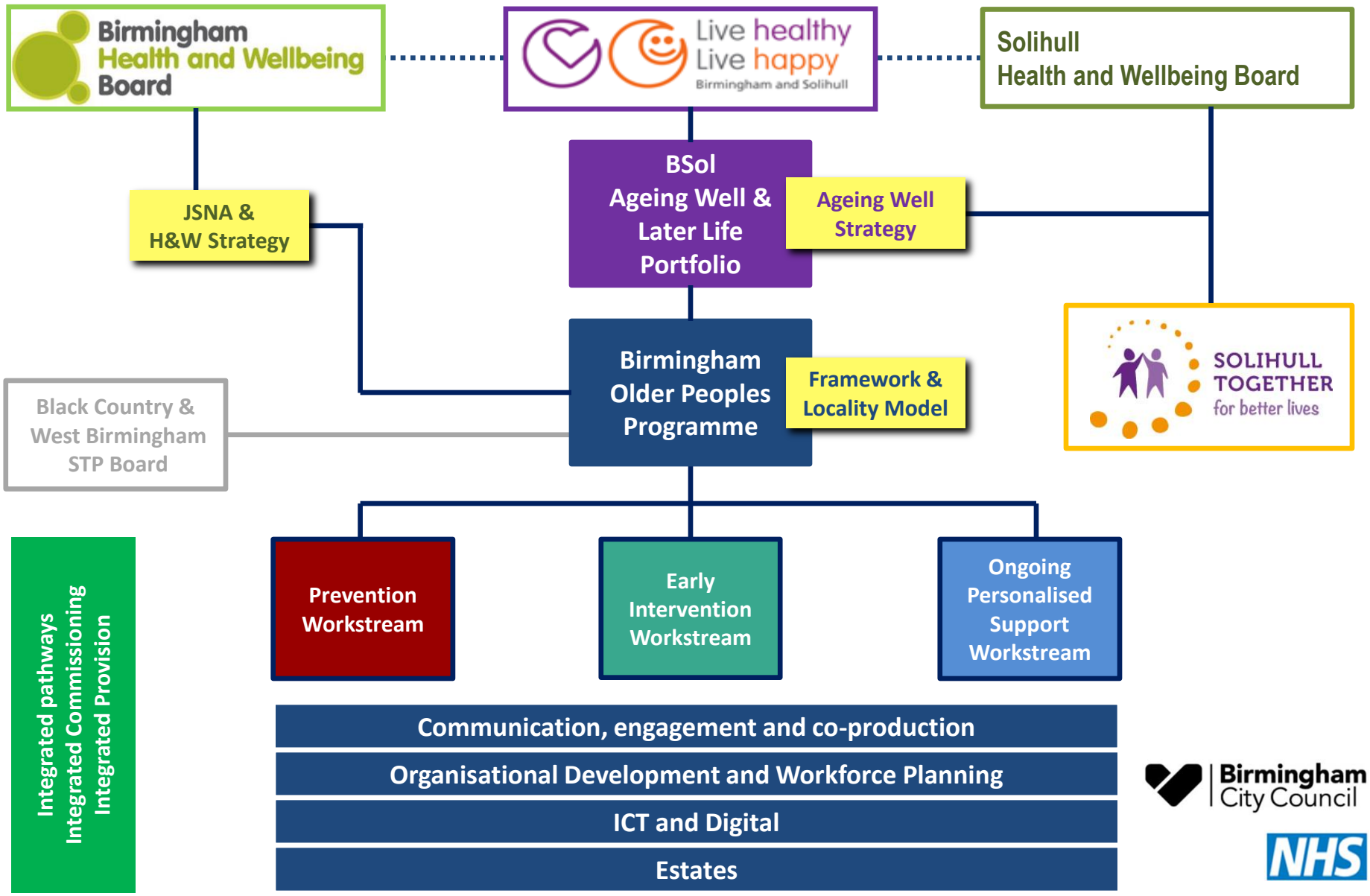
The people of Birmingham have been let down (CQC)

NHS

How we will manage change



Our joint vision for the future

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.

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.

Personalised Ongoing 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.

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The right care at the right time in the right place

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Our joint vision for the future

Whoever is in contact with an older person or their carers will:

- **Work in partnership with them to find out what they want and need to achieve and understand what motivates them**
- **Focus on a person's own strengths and help them realise their potential to be healthy and happy, regain independence and remain independent for as long as possible**
- **Build the person's knowledge, skills, resilience and confidence**
- **Learn to observe and guide and not automatically intervene**
- **Support positive risk taking**
- **Promote the use of joint, health or social care personalised budgets or direct payments**

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Prevention

- Some older people will need support to feel safe to enjoy the wide range of community assets available
- Provide the best advice and guidance on what people might need, when and where they need it
- Help local groups to develop new services and activities, where people have told us they are needed
- Keeping people connected keeps them well physically and mentally
- Explore how social prescribing models supported by 'guided conversation' techniques help older people think about their needs and get the support they require
- Support older people to manage their own care and support needs including long term conditions. Talking therapies for those with anxiety issues or depression should be as accessible for older people as they are for younger adults
- Work in partnership to improve the lives of carers focusing equally upon their health and happiness

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Early Intervention

Enablement – home based

- Short term support to allow people to recover in their own homes
- Therapy led support for all those that would benefit
- Adjustments for equipment or adaptations
- Enablement as a first option for people being considered for homecare

Quick response

- Multidisciplinary team at the front door of hospitals 7 days a week specialising in treating & supporting older people at home
- Supported by a quick response team that will be linked to their GP and other professionals
- Prompt diagnosis and treatment improving the likelihood of a good recovery

Enablement – bed based

- Bed-based enablement within 4 or 5 specialist centres for people who are in a sub-acute but stable condition, but not fit for safe transfer home
- Consistent criteria, objectives, and clinical / therapy input
- The specialist centres will provide physical space to allow the components of the pathway to come together

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Ongoing Personalised Support

- Bring together home support workers and community physical and mental health nurses to provide outcome focussed, flexible and responsive support to older people living at home
- Work together to improve the links between physical and mental health and provide a timely appropriate response
- Wrap around holistic support for older people with more complex needs identifying these individuals as early as possible. This will support specific high risk individuals including those with dementia or very unstable long term conditions and will ensure effective later and end of life planning
- Integrated community teams will provide peripatetic support to care homes in the local area to provide specialist support for residents and to help staff develop skills and confidence
- A common approach to personalisation which puts the person at the centre, wherever possible older people will be encouraged to have as much control as they wish of their care and support needs through such approaches as personal budgets and direct payments

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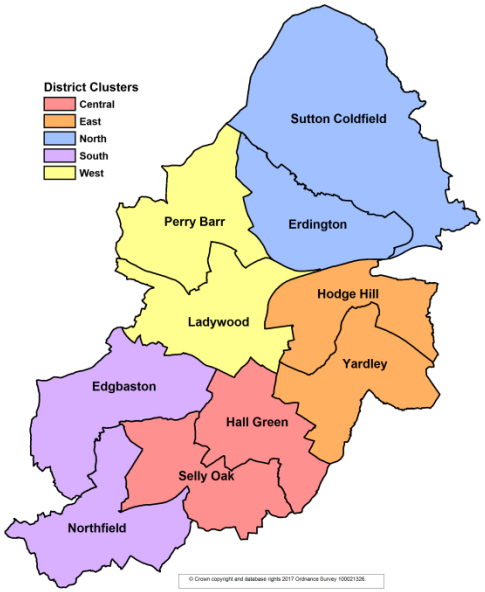
A place based approach



- The 10 Districts have been formed into 5 co-terminus health and social care Localities of circa 250K pop.
- Efficient distribution of resources within a locality
  - 2 Lead Partners networking Voluntary & Community Sector
  - 1 Specialist Enablement Centre
  - 1 Urgent Treatment Centre
  - Primary Care neighbourhoods of 30k – 50k pop.
- GPs and consultant geriatricians working together to champion the 'home first' ethos
- Organisational boundaries removed with staff roles clearly defined to maximise individual and collective skills and capacity
- A wide network of integrated community support connected to the more local neighbourhood networks as well as community hospitals, care homes and housing
- A digital catalogue of care, support and activities so that everyone knows what is available locally to keep people as active and well as possible with no wrong door
- People co-ordinating or providing direct support will have timely access to shared electronic records

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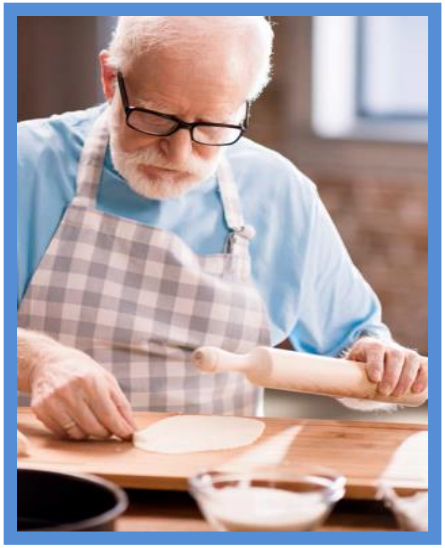
A network of joined-up care and support to communities with no wrong door

NHS

Birmingham Older Peoples Programme

Making Birmingham a great place to grow old in



QUESTIONS

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