Proposed Birmingham Integrated Health and Social Care Model for Older People

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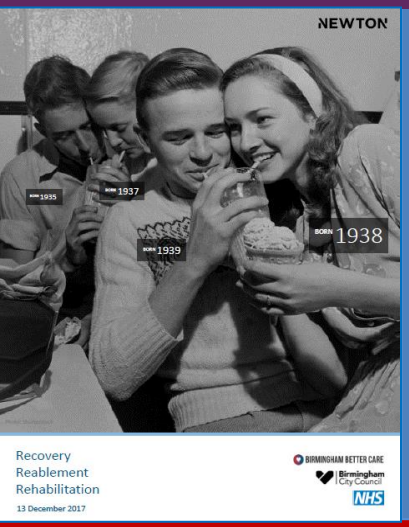
- Need to build a system around the person – would like to see a 5 year forward view of how this will be delivered.
- Lack of a long-term vision. Examples of "sticking plasters" in place as tactical responses to pressures. Stressed the critical role of primary care - opportunity to develop community services and social prescribing.
- No specific system vision for older people. What is the offer for older people? Inconsistent availability of services across the system.



The proportion of people we admit into hospital who could have been better looked after elsewhere.	**23%**	**36%**	The proportion of people who could achieve greater independence, following a stay in a short-term bed, with our support.
The proportion of people in elderly care and longer stay wards who are medically fit but delayed, waiting to leave hospital.	**51%**	**37%**	The proportion of people currently with a long-term care package who could benefit from better enablement.
The proportion of people who could benefit from a different pathway out of hospital, one better suited to their needs.	**19%**	**50%**	The proportion of people who's mental health reached crisis point (and went into hospital) that could have been avoided.

'Phyllis'

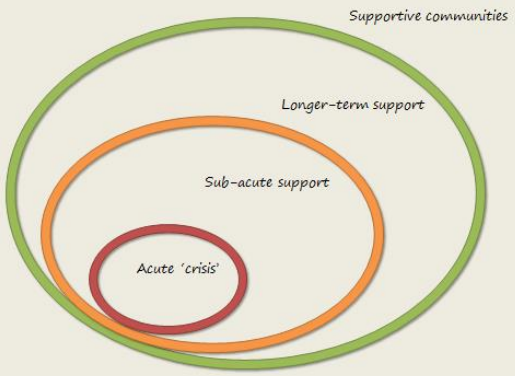
- ❑ Phyllis' really got people talking, across boundaries, about how to make changes >500 people from >25 stakeholders.
- ❑ True stories of working that isn't joined up.
- ❑ 'Ebay for Grannies'.




Our aims are to:

- Create a 'Home First' approach
- Promote health and wellbeing
- End the crisis driven model of care
- Create an outcome focussed culture that nurtures creativity and innovation
- Support access to good quality advice and information enabling people to self-care
- Find solutions that promote wellbeing outside of traditional models
- Encourage community development and increase volunteering
- Support carers in their vital role
- Provide flexible and proactive models of care
- Free up professionals from the rules and bureaucracy to do the right thing
- Bring services (people) together to ensure better communication and use of resources

An equitable offer – regardless of how or where a person presents to the system

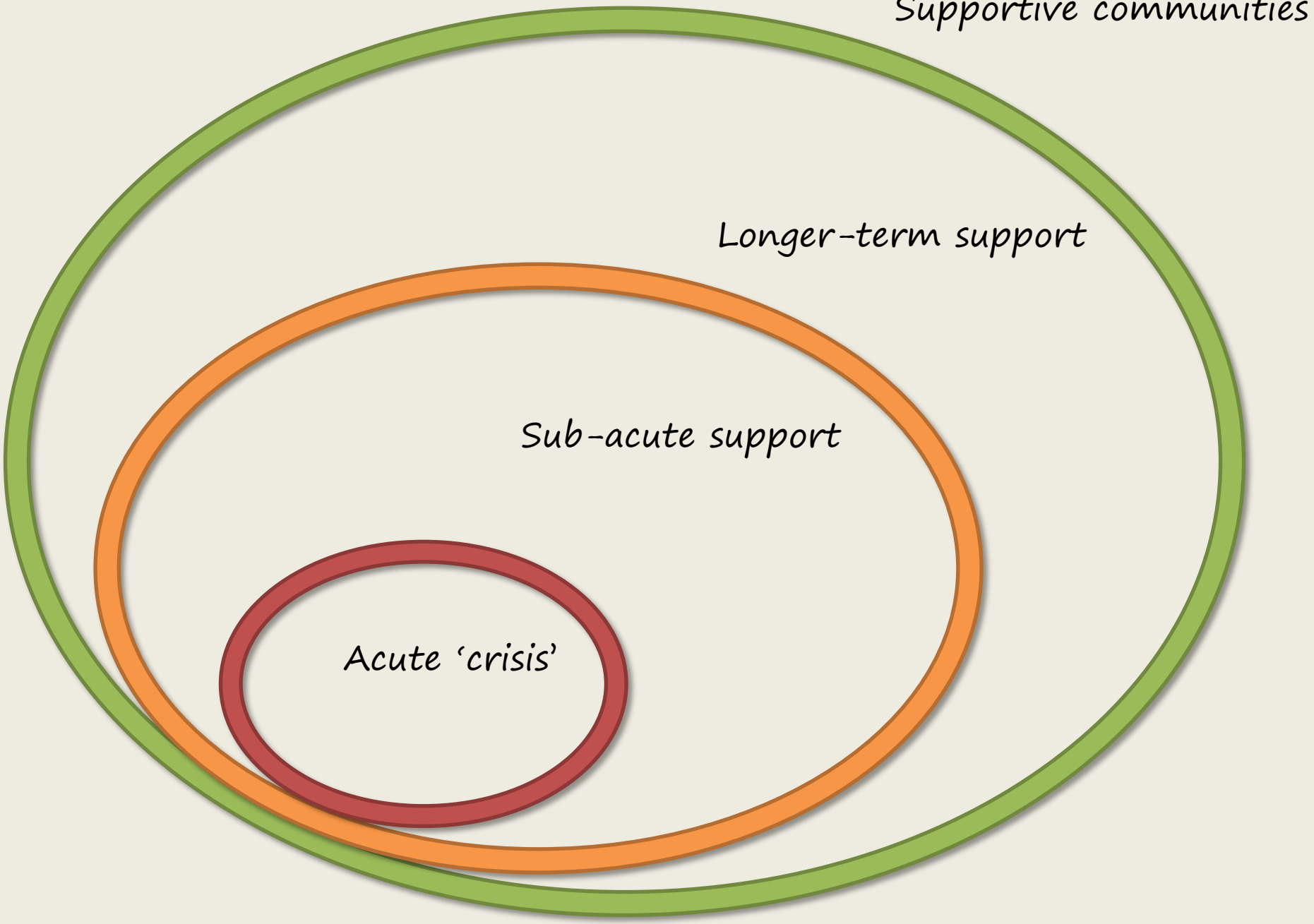


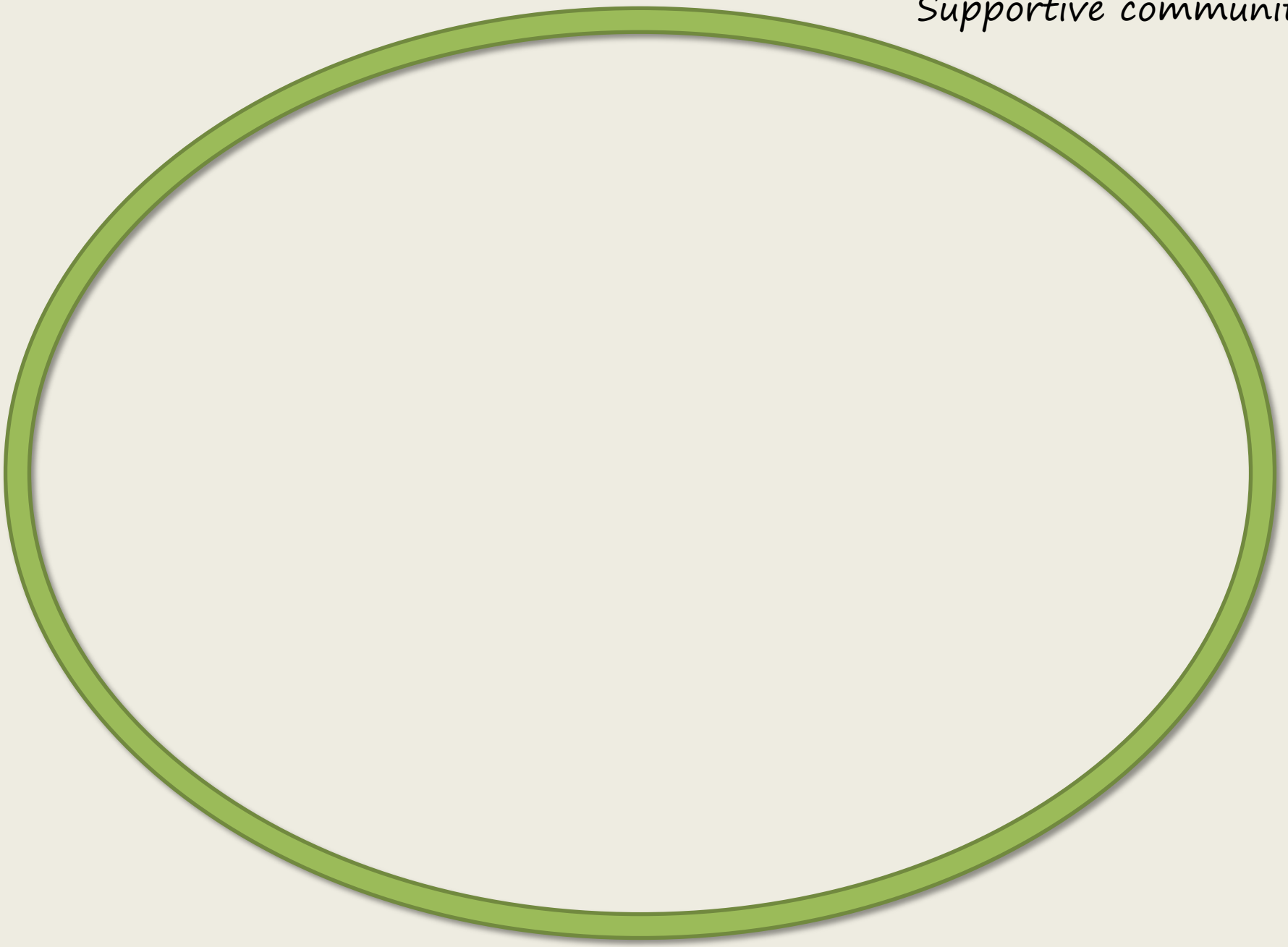
If we work within the system we have to trust each other, and so remove in-built duplication

Prompt, skilled assessment at a time it is needed by a professional who is trained, and has resources to call on

Seamless flow through the system. People receive what they need, in the best place for them to receive it

'We don't say no'


Supportive communities
Longer-term support
Sub-acute support
Acute 'crisis'


Supportive communities

Supportive communities

Schools

Academies

Pre-school

Higher education

Housing

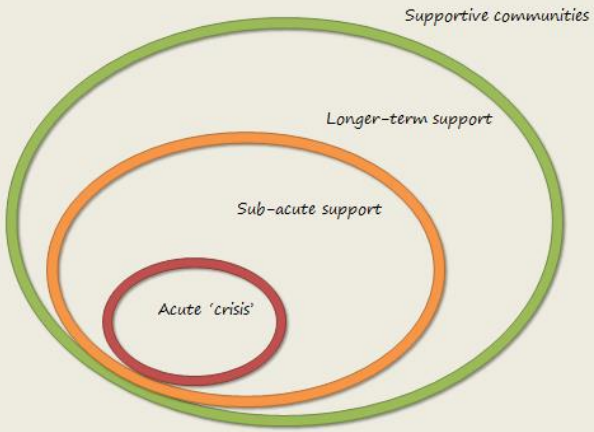
Public sector

Businesses

Religion and faith groups

Parks and the environment

Children's and youth organisations



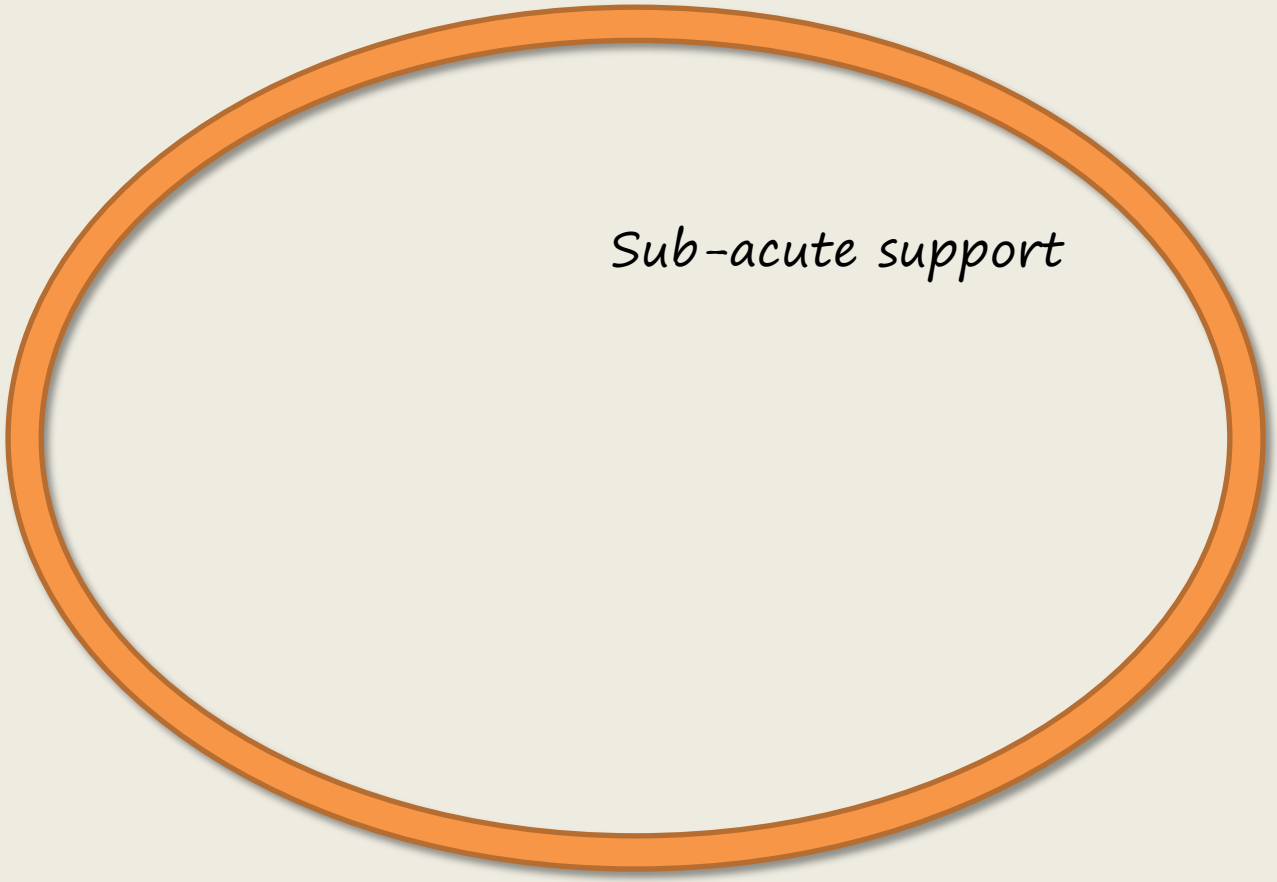
Clubs and community groups

3rd sector

Taking a life-course perspective on ageing

Public health/ prevention are key

Longer-term support



Longer-term support

Sub-acute support

Retirement villages and communities

Day centres and community centres

Local Authority

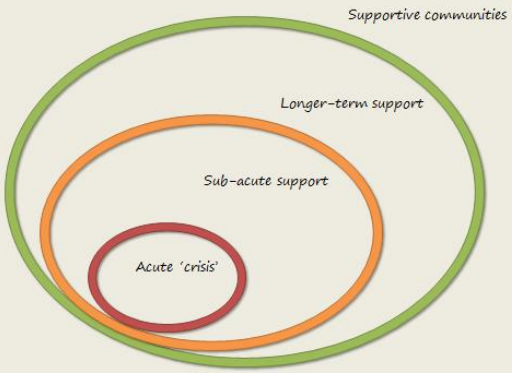
Community Health Services

Primary care

Intermediate care

In own bed

Bedded capacity



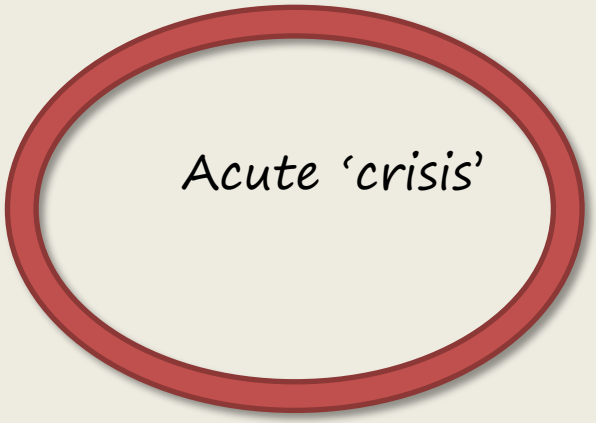
Home carers

Reablement

Short-term

Long-term

Care Homes


Acute ‘crisis’

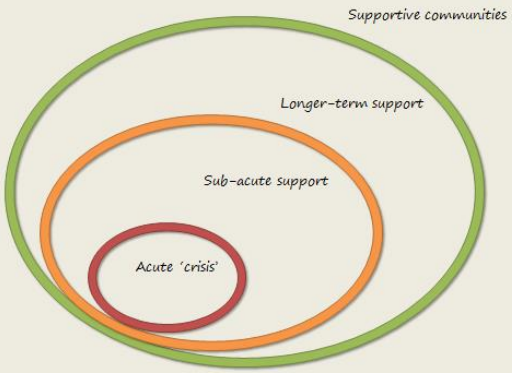
Acute 'crisis'

Acute hospital admission

Rapid Response at home

Acute review

Emergency 'needs' assessment



Primary care review

Equipment, people, support

Multidisciplinary, multi-agency, trust and co-operation

"A system that doesn't say 'no'"

Birmingham Integrated Care Model

Prevention

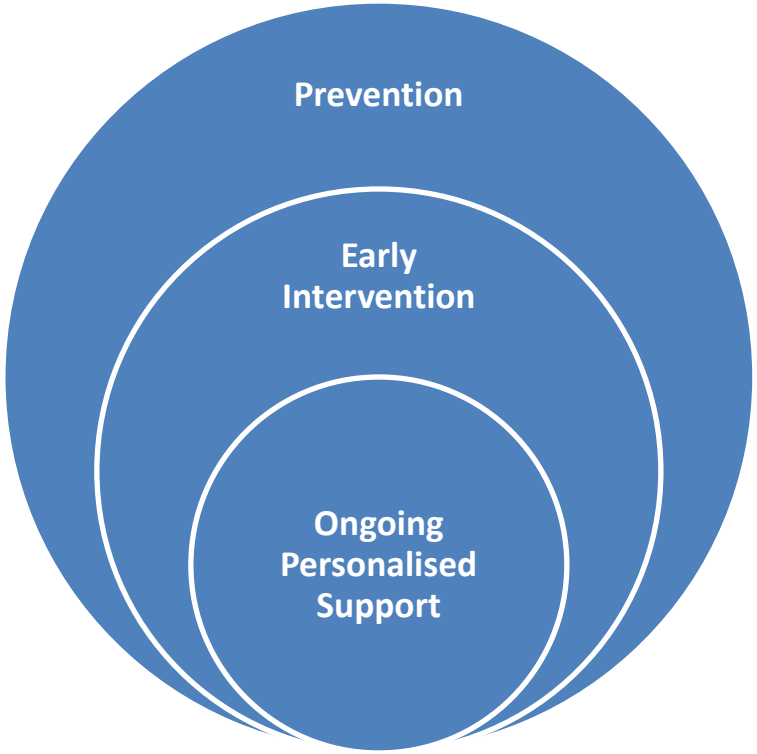
Providing the right response so people can manage their own need for care and support within their communities

Early Intervention

Providing the right short-term action when it is needed and the right environment so people can care for themselves

Ongoing Personalised Support

Providing effective ongoing support to maintain well-being and self-sufficiency to avoid unnecessary stays in hospitals or care homes



Our model is described through three groups of interventions. This is not a linear relationship and the interventions overlap. All support will be fully integrated, silos will be avoided and people will be able to access ***the right care at the right time*** in order to be as independent and well as possible at all times

Birmingham Integrated Care Model

Prevention

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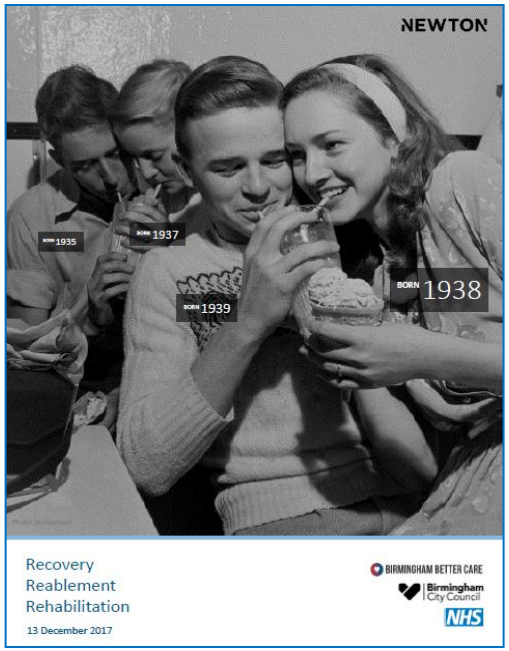
Ongoing Personalised Support

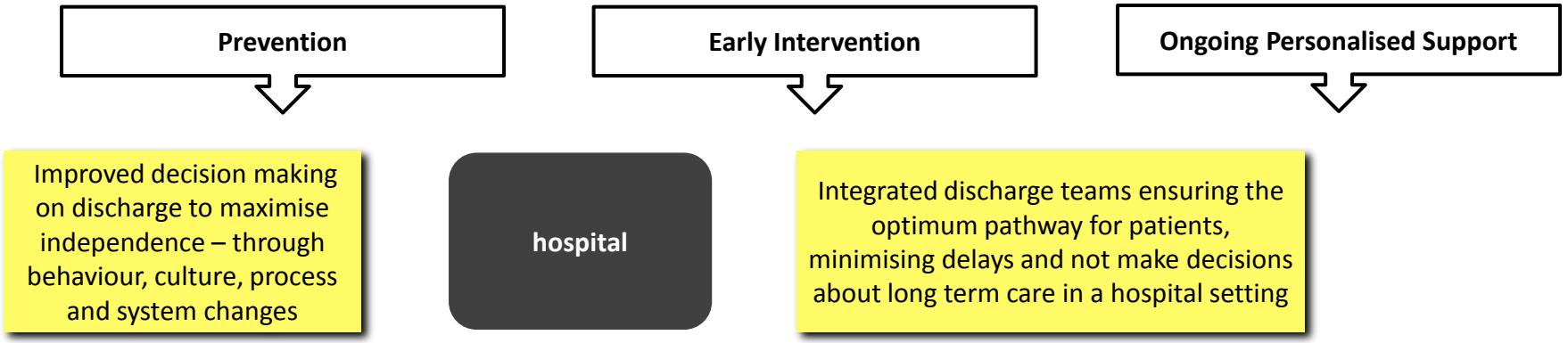
Providing effective ongoing support to maintain well-being and self-sufficiency to avoid unnecessary stays in hospitals or care homes

The 3Rs Programme is established and a Placed Based Strategy is being developed. Needs to be framed within an overall model for local care and interdependencies clearly understood



Interdependencies

Birmingham Integrated Care Model



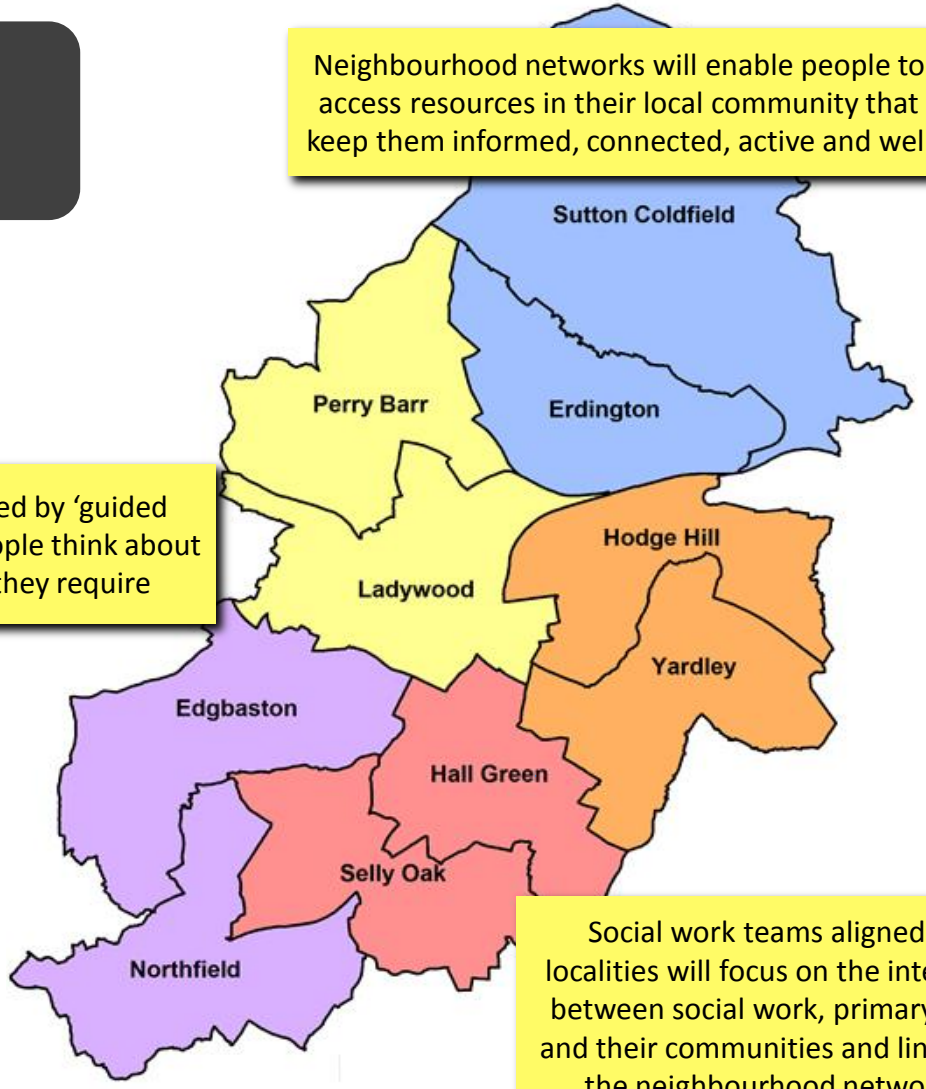
Birmingham Integrated Care Model

Prevention | **Early Intervention** | **Ongoing Personalised Support**

hospital

IAG
voluntary sector
community assets

Neighbourhood networks will enable people to access resources in their local community that keep them informed, connected, active and well



Social prescribing models supported by 'guided conversation' techniques to help people think about their needs and get the support they require

Strategic approach to population health and prevention which anticipates potential needs and intervenes before crisis

Social work teams aligned to localities will focus on the interface between social work, primary care and their communities and link with the neighbourhood networks

Birmingham Integrated Care Model

Prevention

Early Intervention

Ongoing Personalised Support

hospital

IAG
voluntary sector
community assets

MDT supported by a quick response service

Multidisciplinary teams at the front door of hospitals 7 days a week avoiding unnecessary admissions

The quick response service will identify any ongoing support required and ensure that people can be diagnosed quickly if needed

46% of avoidable admissions at UHB could have needs met by a quick response service

Birmingham Integrated Care Model

Prevention

Early Intervention

Ongoing Personalised Support

hospital

IAG
voluntary sector
community assets

MDT supported by a quick response service

recovery at home

Some people do not need to be in hospital but are not ready to benefit from enablement. For these people short term support will be provided in their own homes wherever practical

19% of people discharged on wrong pathway
72% going into short term beds when
2/3rds could have gone home

Birmingham Integrated Care Model

Prevention | **Early Intervention** | **Ongoing Personalised Support**

hospital

IAG
voluntary sector
community assets

MDT supported by a quick response service

recovery at home

enablement at home

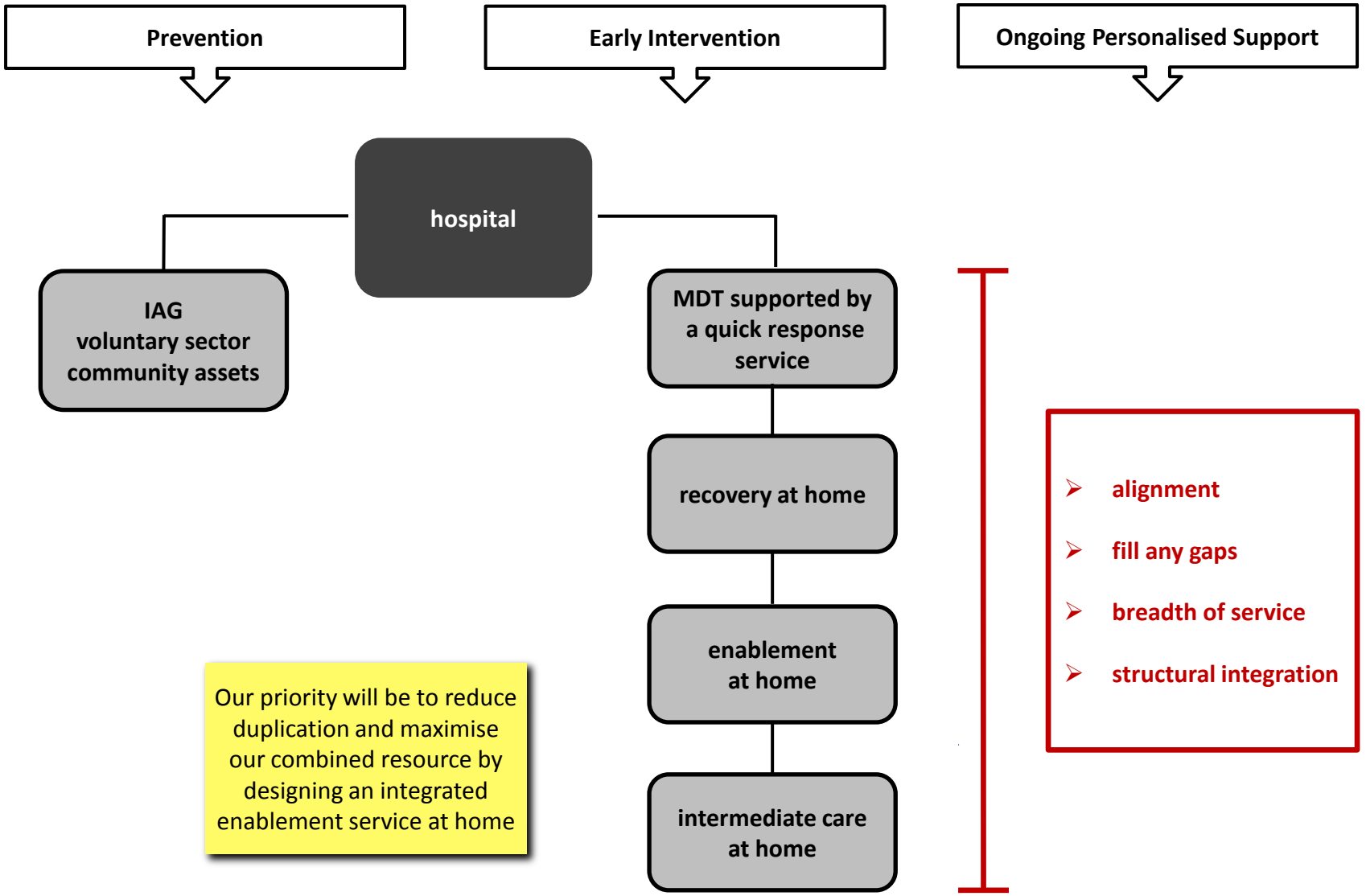
intermediate care at home

Improvements are being made to the BCC's Enablement at Home service

BCHCFT Integrated Multidisciplinary Teams includes nurses, health care assistants, physiotherapists and occupational therapists

36% of people in short term beds and 28% receiving home-based enablement could Be enabled more efficiently

Birmingham Integrated Care Model



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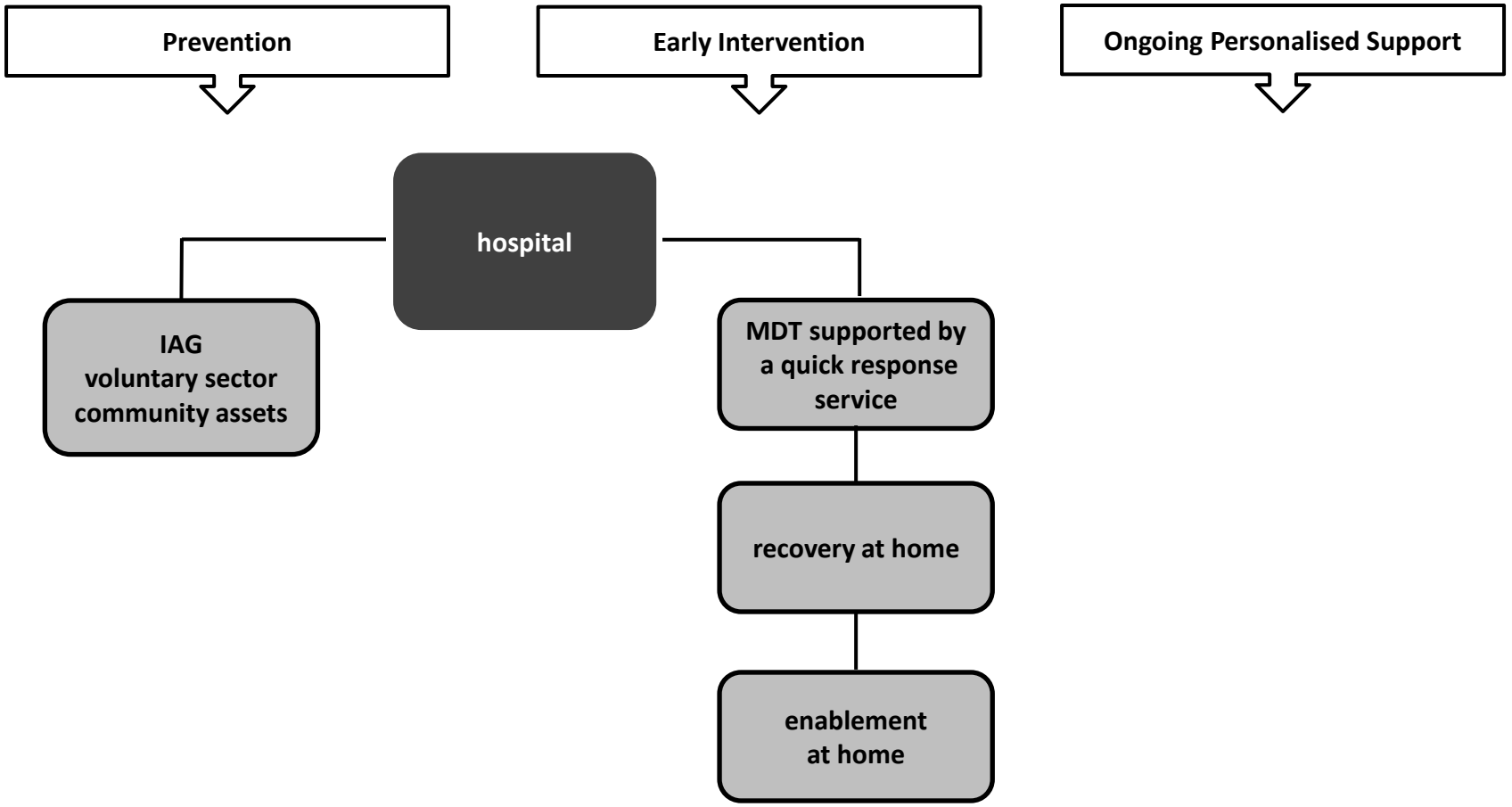

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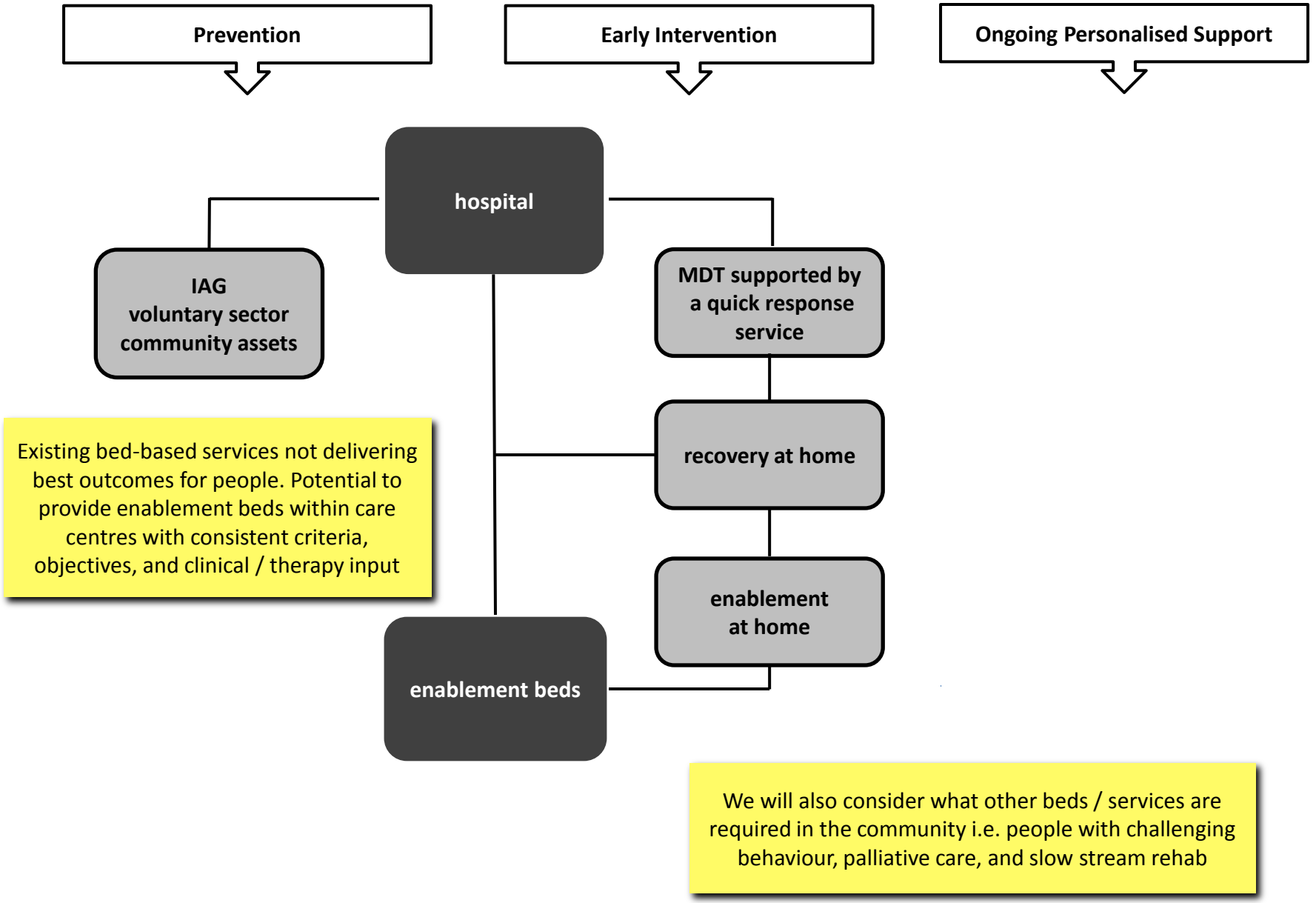


Birmingham Integrated Care Model


Perry Tree Centre Erdington

Norman Power Centre Ladywood

Strategically the centres:

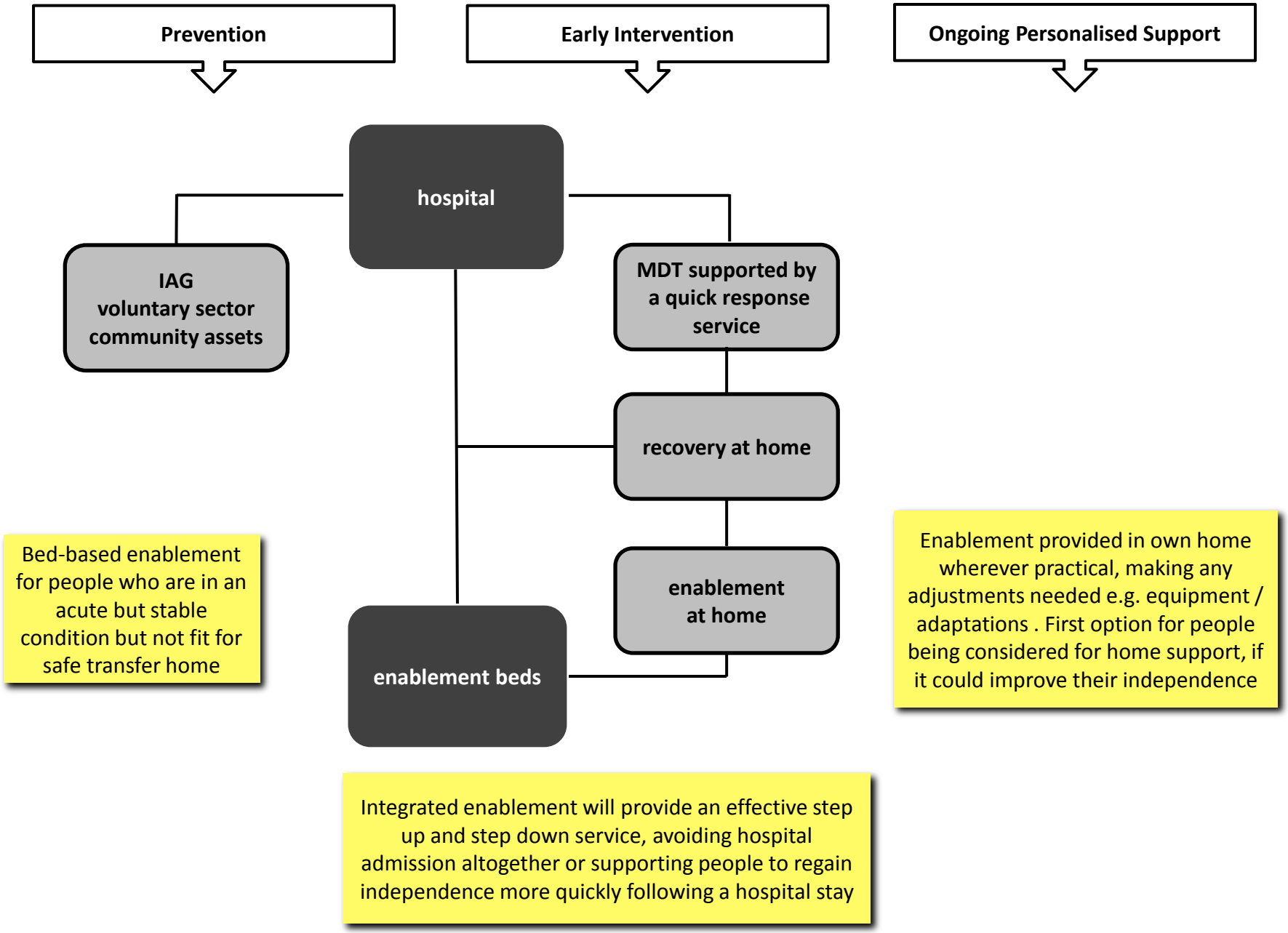
- **are in locations across the City that can support the Birmingham hospitals**
- **are embedded in their communities**
- **offer good quality, purpose built estate for older people with challenging behaviours**
- **already have the supporting estate infrastructure for clinical services**
- **have the infrastructure to be a base for a community support approach**


Ann Marie Howes Centre Yardley

Potential future use would be considered alongside any other potential opportunities e.g. urgent care treatment centre and GP access hub development

The Kenrick Centre Edgbaston

Birmingham Integrated Care Model



Birmingham Integrated Care Model

Prevention | **Early Intervention** | **Ongoing Personalised Support**

hospital

IAG
voluntary sector
community assets

intermediate care

MDT supported by a quick response service

recovery at home

enablement at home

enablement beds

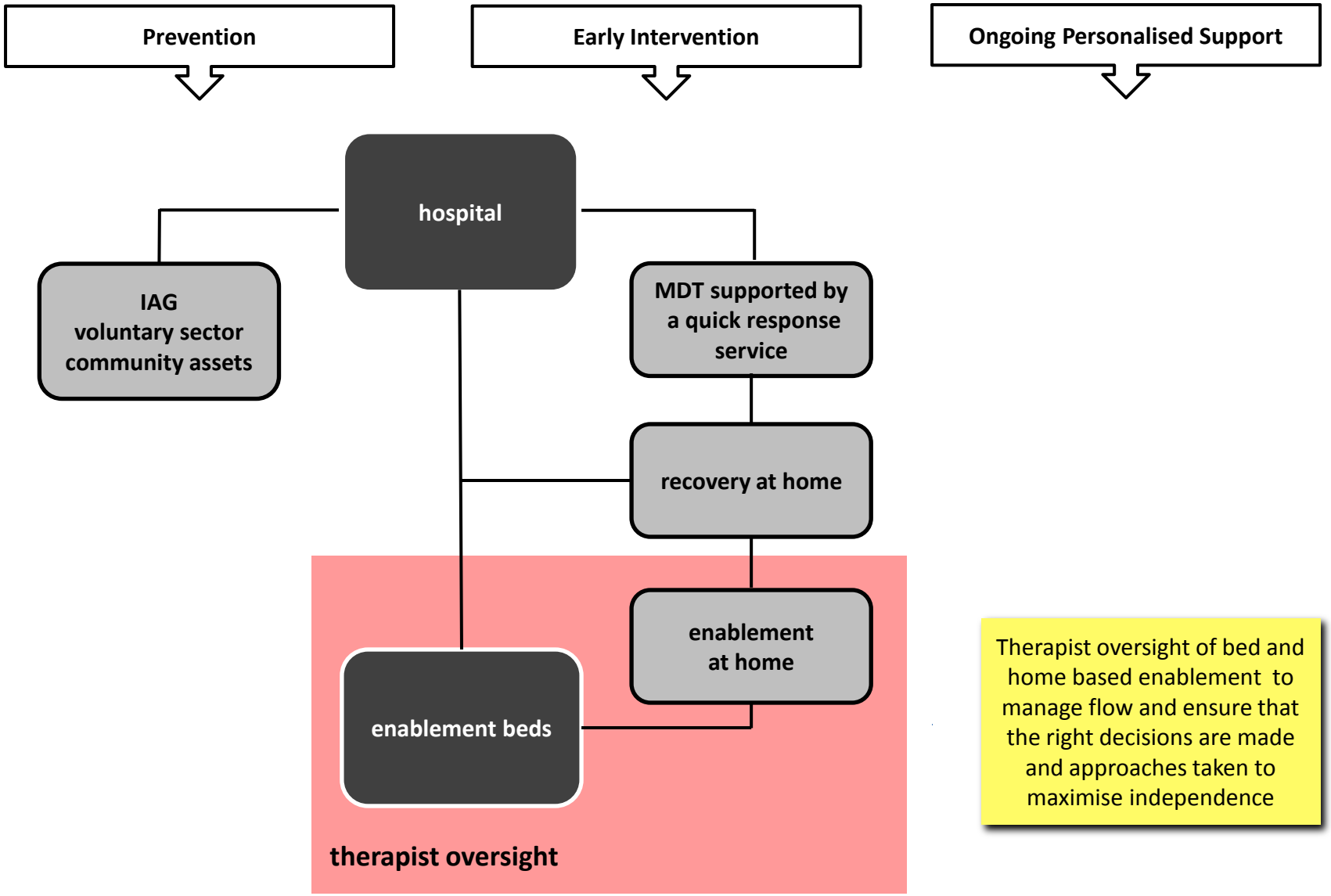
An integrated intermediate care service with no artificial barriers

Multidisciplinary practitioners within an integrated service will:

- ❑ work in partnership with the person 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 regain independence
- ❑ build the person's knowledge, skills, resilience and confidence
- ❑ learn to observe and guide and not automatically intervene, even when the person is struggling to perform an activity, such as dressing themselves or preparing a snack
- ❑ support positive risk taking

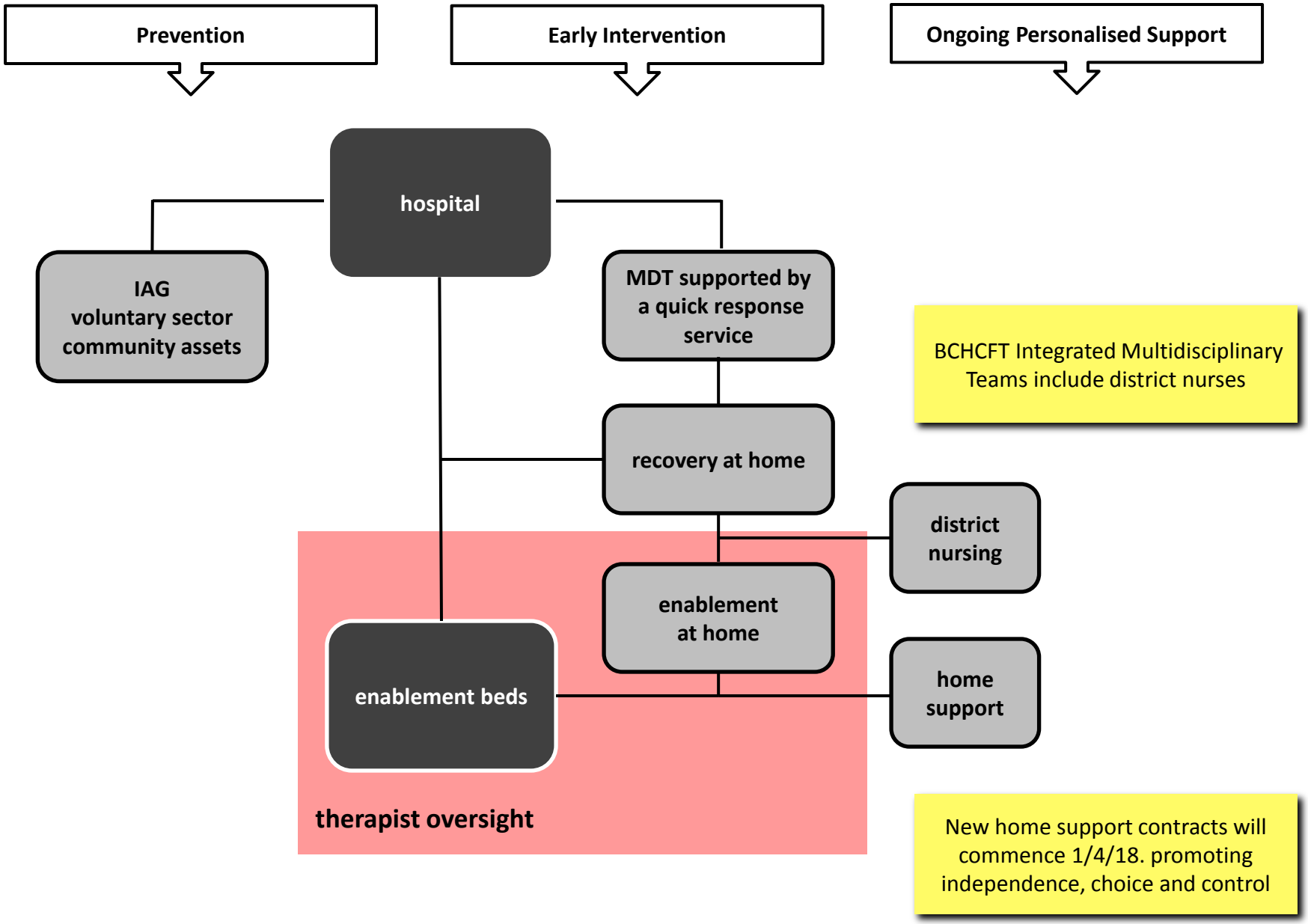
Intermediate care should also be inclusive of older people with mental health needs, either as a primary or a secondary diagnosis, if there is a goal that could be addressed within a limited period of weeks.

Birmingham Integrated Care Model



Therapist oversight of bed and home based enablement to manage flow and ensure that the right decisions are made and approaches taken to maximise independence

Birmingham Integrated Care Model



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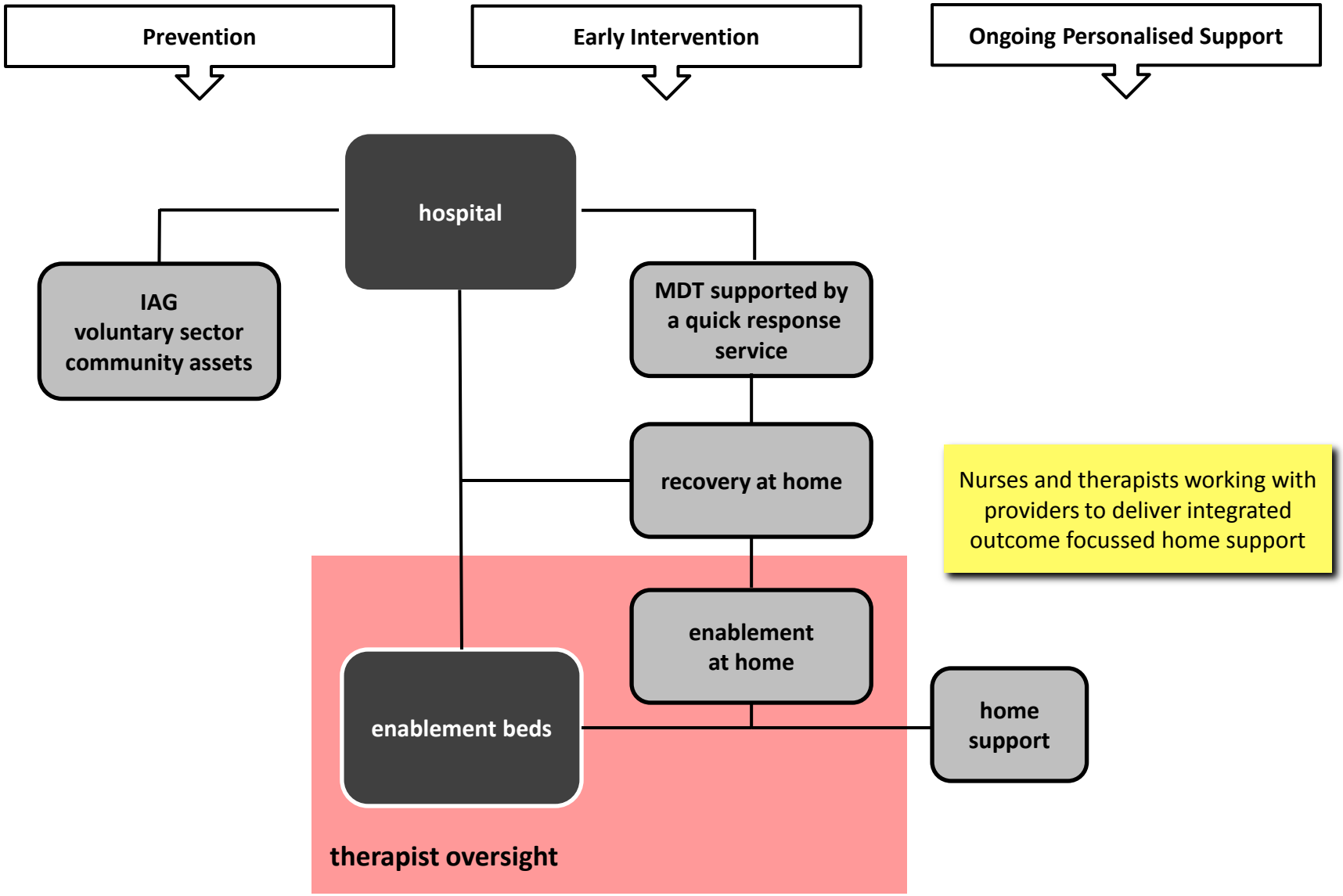


Birmingham Integrated Care Model

Physio

Nurse

OT

Care Worker

Simplification of system with appropriate support wrapped around individuals with no 'hand-offs'

MDT supported by a quick response service

recovery at home

enablement at home

enablement beds

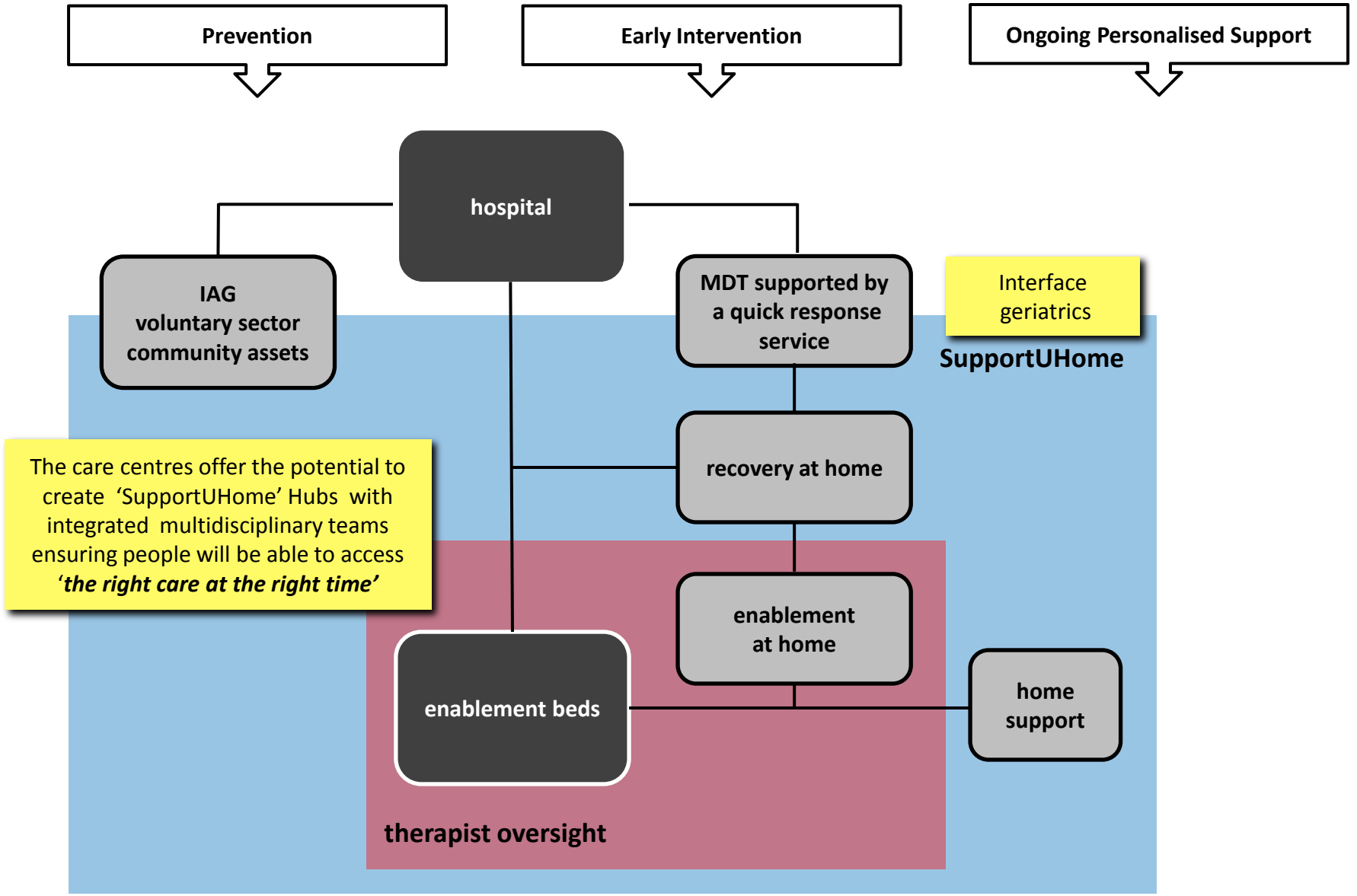
home support

There is no set way to configure services but responsibility and accountability are key requirements

Geriatrician	Social Worker
Pharmacist	GP
Psychiatrist	Psychologist
Housing Officer	Podiatrist
VCS Worker	CPN
Paramedic	Specialist Nurse

clearly define roles of people working in the community to maximise individual and collective skills and capacity

Birmingham Integrated Care Model



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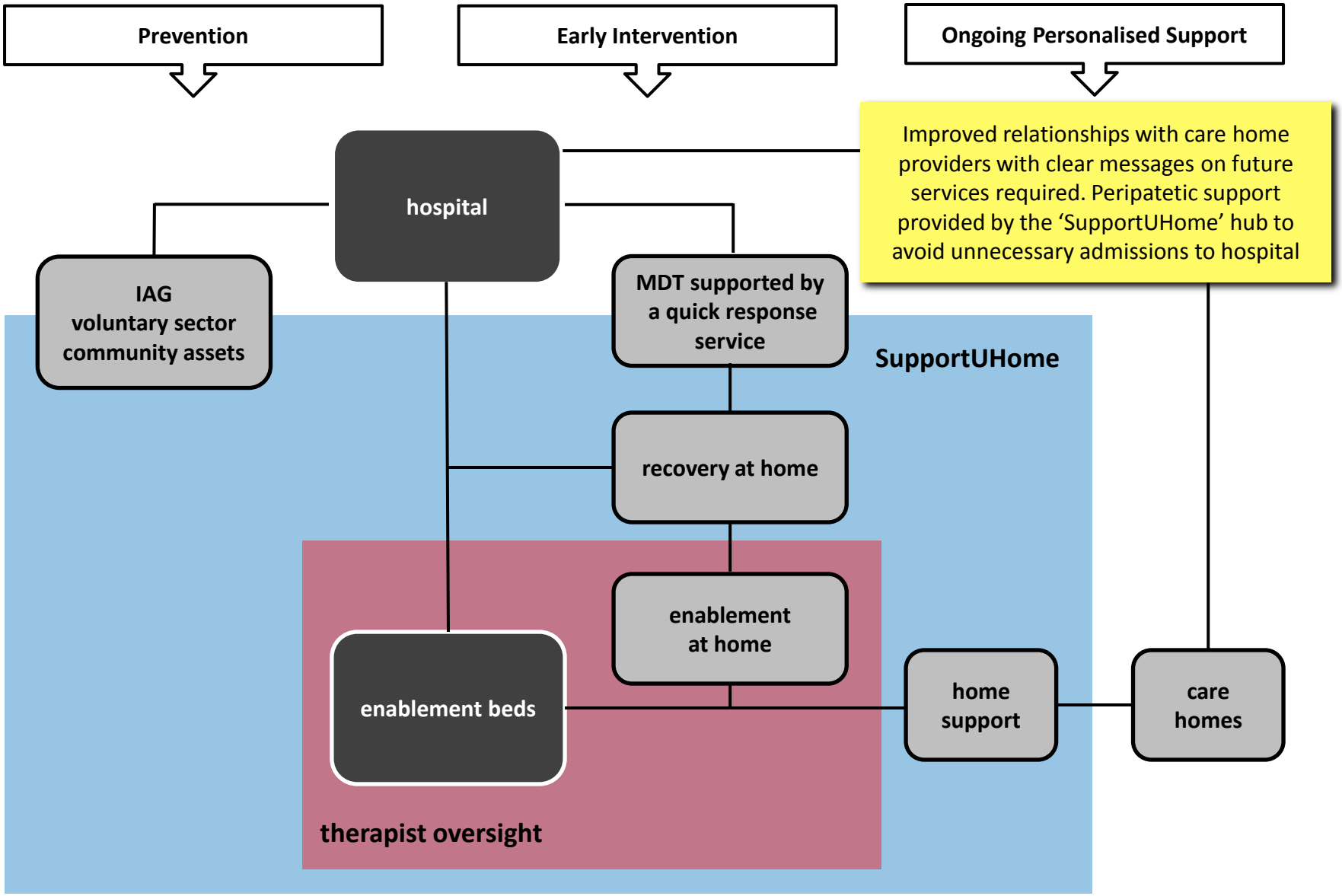

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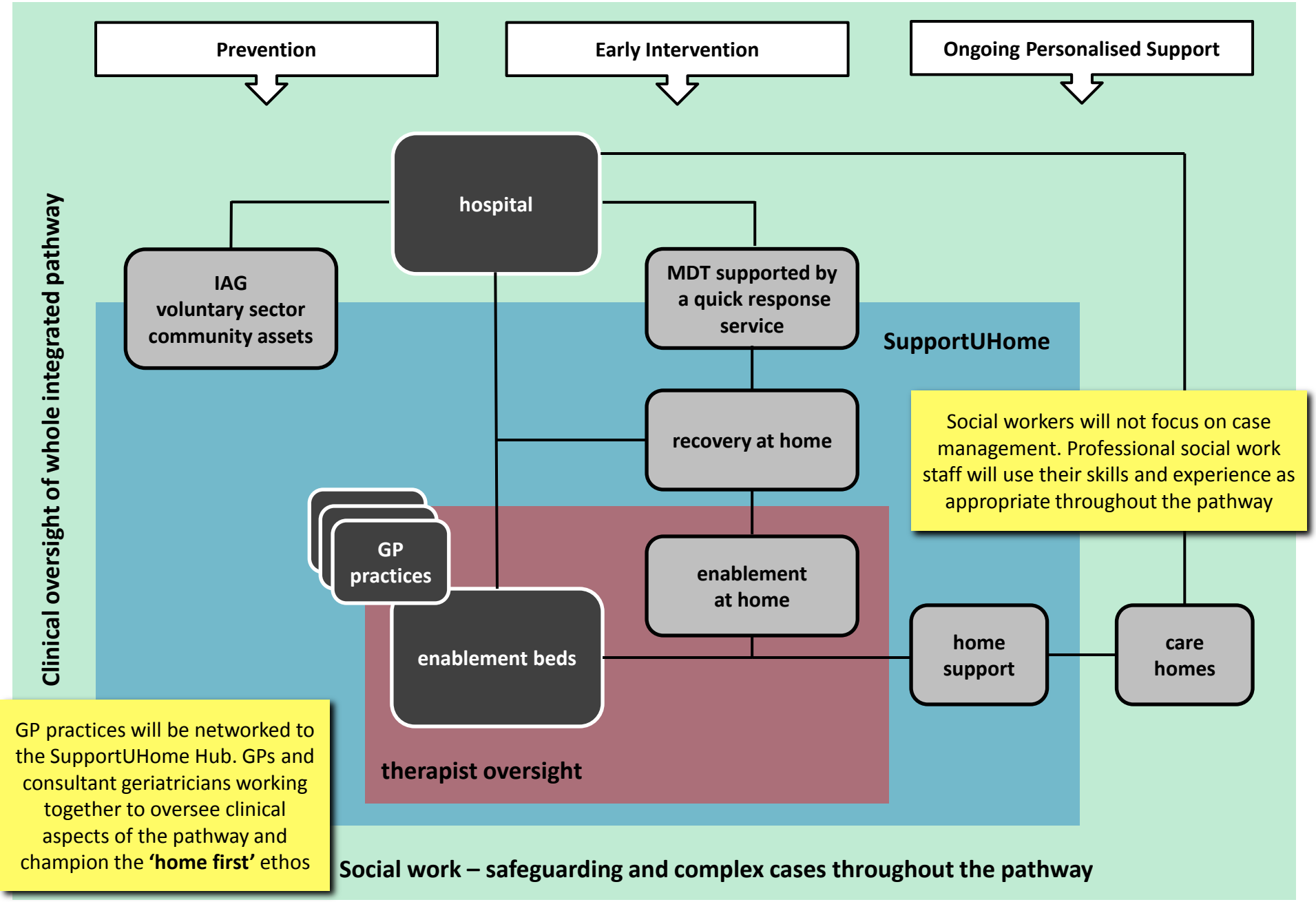

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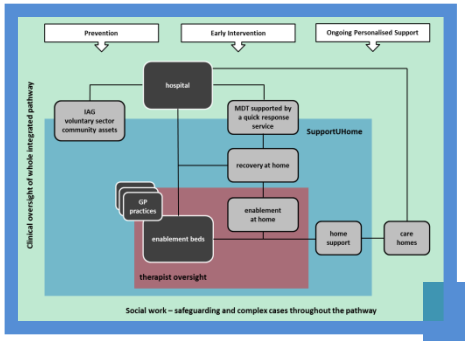
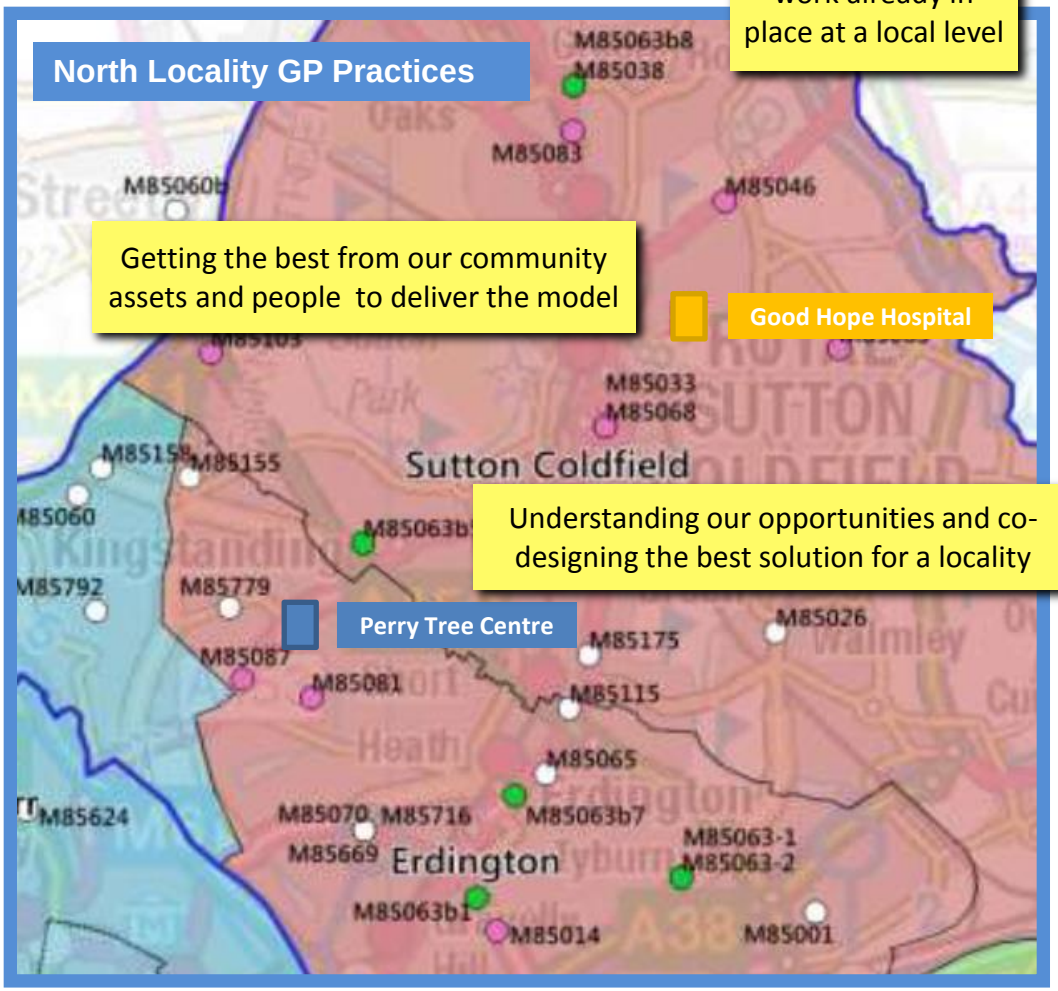


model

assets

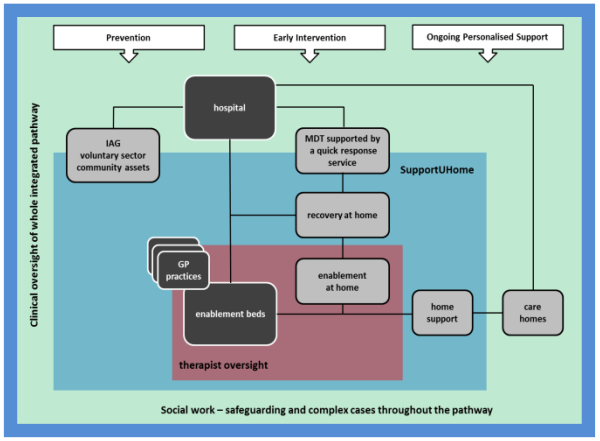
people

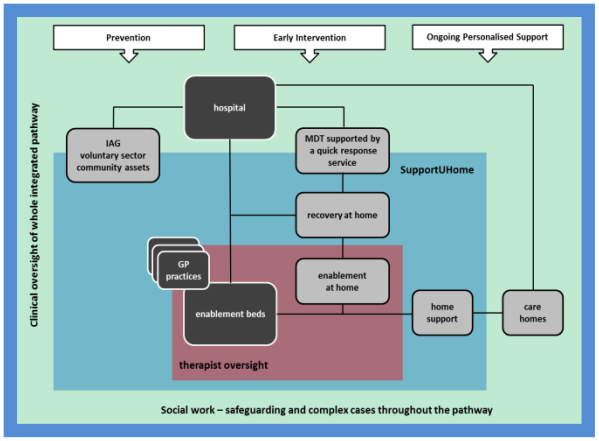
Build upon good work already in place at a local level



Understanding our opportunities and co-designing the best solution for a locality

Birmingham Integrated Care Model





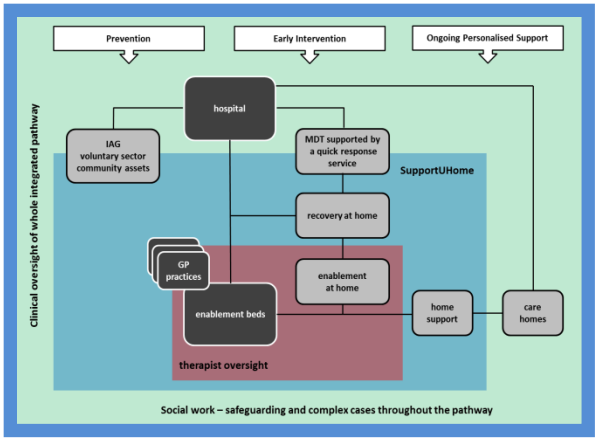
Shared care record

Digital catalogue of support

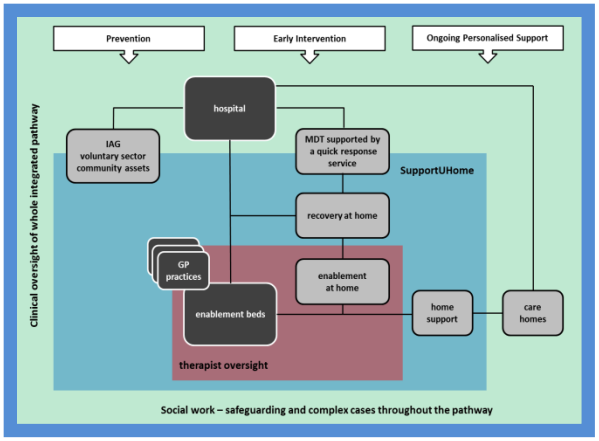
contact support

digital front door

Consistency with local variation



Whole system flow information

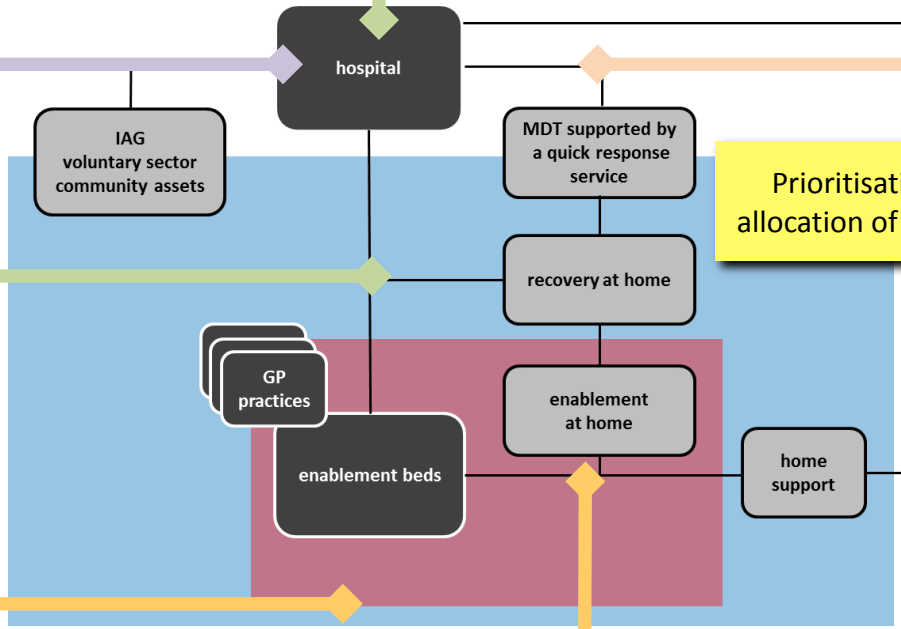


Birmingham Integrated Care Model

Deliver rapid reductions in delayed discharges and increases in best pathway decisions through implementing consistent daily and weekly data collection, analysis and review of top reasons for delayed discharge and discharge pathways chosen.

Part 1. Deliver medium term sustainable reductions in delayed discharges by designing and implementing improved co-ordination of assessments taking place in hospital. Specifically looking at starting assessments as early as possible in patient pathway, and running assessments in parallel rather than in sequence.

This work would achieve reductions in unnecessary admission to acute hospitals. By designing and implementing the processes that would improve links between acute hospitals and rapid response teams with particular attention drawn to staff awareness, referral, range/criteria and capacity of these services across Birmingham .



Prioritisation and allocation of resources

Part 3. Direct more patients onto the best pathway for their needs at discharge from acute or community hospital, through designing and embedding a common 'home first' mindset and approach promoting independence/enablement rather than risk aversion.

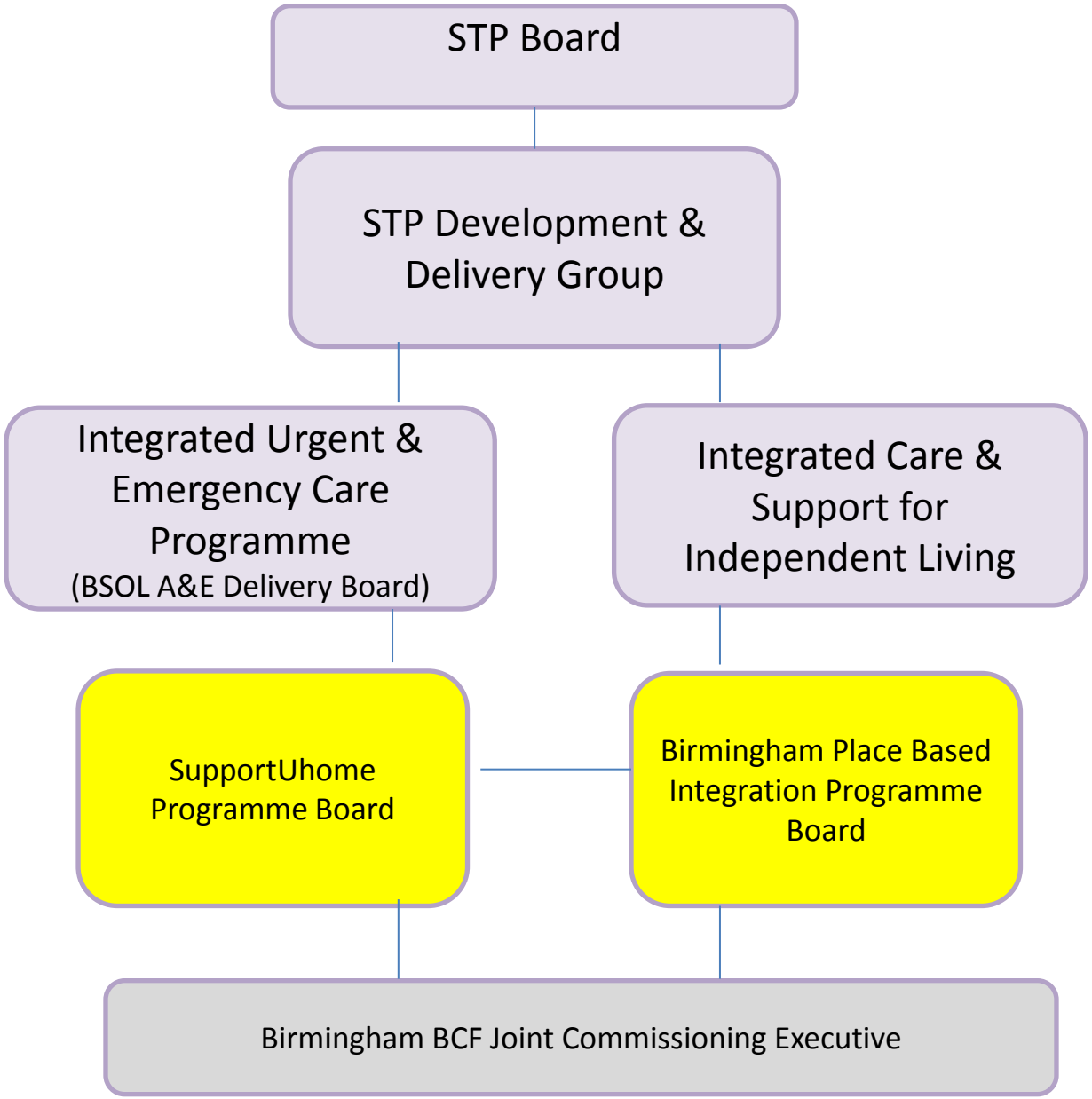
Part 2. Achieve sustainable reductions in delayed discharges by designing and implementing improved ways of sharing accurate, timely information, relationships and co-ordination with permanent nursing placement providers. Specifically working with them to minimise delays in sourcing a placement, provider assessments and the time taken to make a placement available.

Part 2. Deliver further sustainable reductions in delayed discharges by designing and implementing solutions that would see assessments merge and move out of hospital, likely to a community setting.

Part 1. Deliver improved independence for people receiving enablement at home or in short term beds, by designing and implementing a consistent therapy-based model across all settings. This would include a clear definition of the purpose and pathways for each element of the current community urgent care model

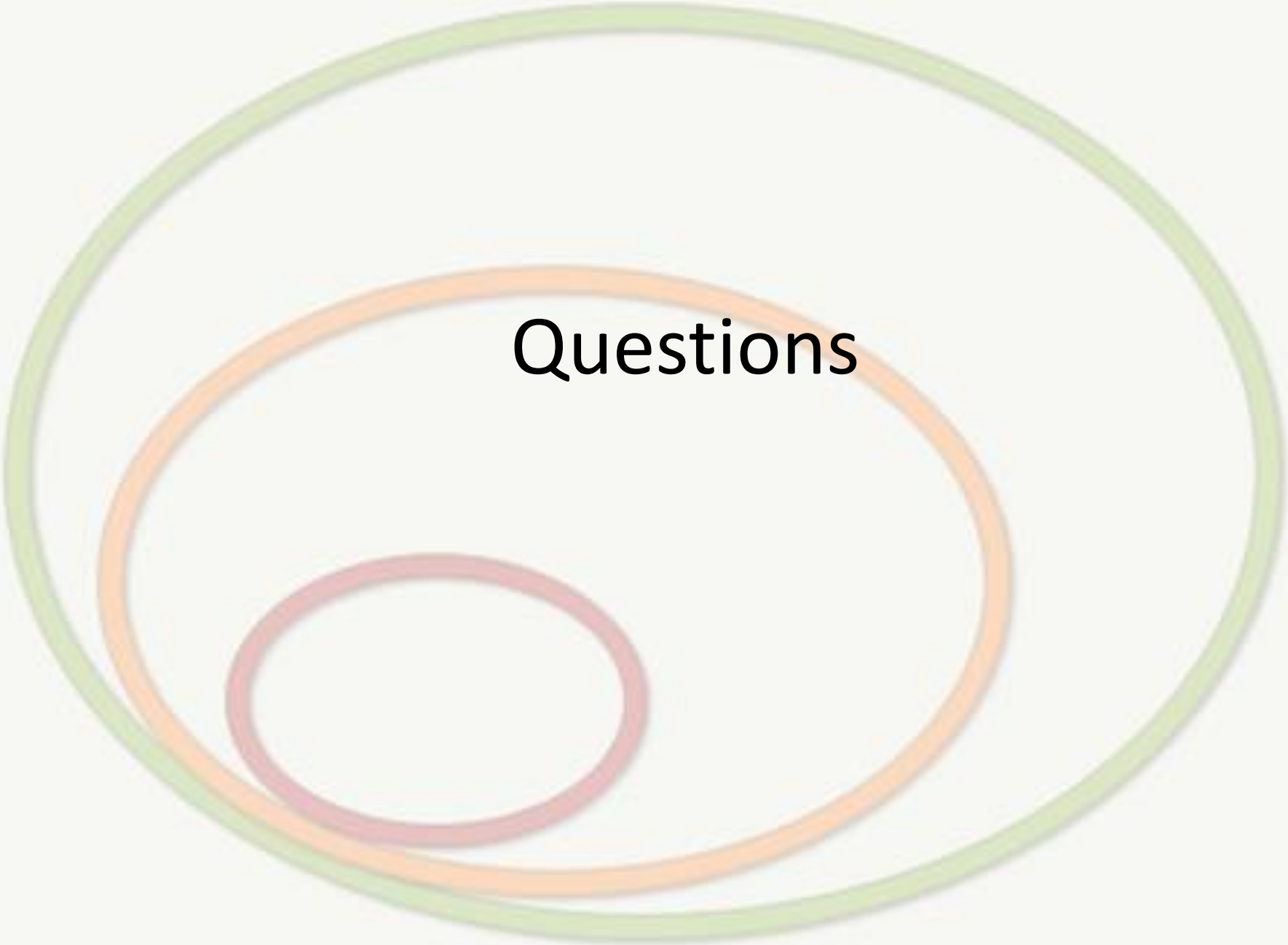
Programme #1	45-50 wks	3.7m-4.6m
Programme #2	55-60 wks	9.5m-13.3m
Programme #3	55-60 wks	9.2m-13.4m
Programme #4	20-25 wks	3.2m-4.4m

Birmingham Integrated Care Model Governance



Next Steps

- Request STP Board support to the proposed model.
- Model to be shared within and across system partners.
- Finalise resource plan proposal for submission to March STP Board (includes Newton offer of support) .
- Confirm system governance process for consideration and approval.


Questions