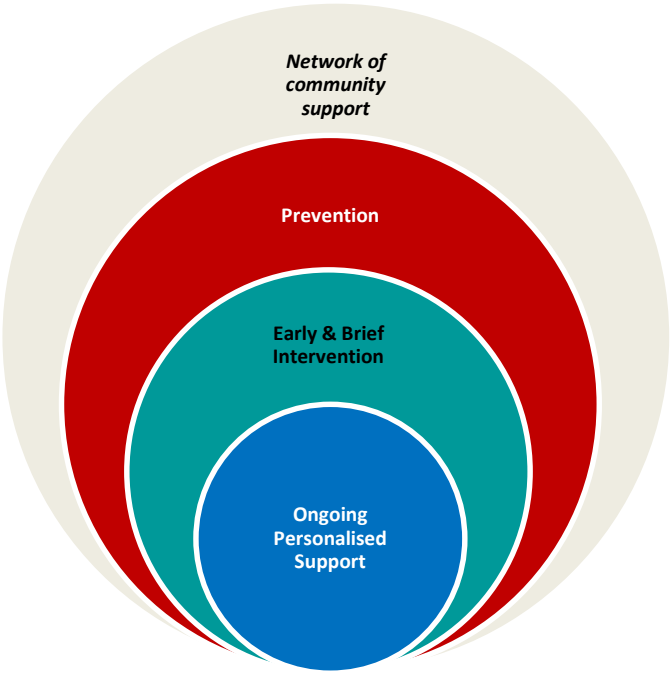
Joined-up Health and Social Care for Older People in Birmingham

Older people and their carers shouldn't need to know where the help comes from, just so long as they get it, quickly and when they need it. Our joint vision is for older people to be as happy and healthy as possible, living self-sufficient, independent lives, able to have choice and control over what they do and what happens to them.

It is essential to recognise that in order to support older people to achieve these goals, there is a broad common responsibility across the range of partner organisations involved to make sure we achieve this together
We will provide support that is 'joined-up' across organisations so that older people do not experience duplication of services or delays in accessing support or fall between the gaps. We are open to new ways of doing things and we will make the most of the strengths of all our partner organisations from the public, private, voluntary and community sectors. There will be **no wrong door** throughout the system, avoiding people struggling and often failing to get the support, care and advice they need.

Our strategy for older people over the next five years breaks our approach down into **themes** with supporting enablers which cover the whole range of support provided for older people and their carers.



Prevention – A universal wellbeing offer enabling older people to manage their own health and wellbeing, based in local communities and utilising local resources. It will address the issues that lead to older people entering into formal physical and mental health and care systems, such as social isolation, falls and carer breakdown. Access to good quality information and 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 & Brief Intervention. Some older people will need treatment and support on occasion for a short period of time; designed to promote faster recovery from physical and mental matters associated with aging, illness or injury. We will prevent hospital admission when it is not necessary for a person and too early 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 which will include both urgent and planned care. These approaches 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.

As the three themes overlap we will ensure that support is fully joined up so older people will be able to access ***the right care at the right time in the right place*** in order to be as independent and well as possible at all times.

Prevention – your health and happiness

Current models of support fit older people into narrow bands of available services; whereas future support needs to be more personalised to enable older people to achieve the outcomes that matter to them

For older people to take part in community activities there needs to be a wide range of community opportunities, also known as community assets, which the Council and other organisations should make sure are in place across the City including community centres, leisure centres, parks and gardens. Older people need to feel safe to come out of their homes to enjoy them.

Most older people can undertake active roles in their local community with help and support from their families, friends, neighbours and social groups. However, for some citizens this is only possible with support from public sector organisations or voluntary and community sector organisations.

There are a lot of services and activities that take place in local areas, that aren't always known to everyone who lives there, and older people are more likely to experience exclusion due to poverty or lack of digital connectivity. We want to provide older people with the best advice and guidance on what they might need, when and where they need it**.** We also want to help local groups to develop new services and activities, where people have told us they are needed.

We believe that keeping people connected keeps them well physically and mentally. Social isolation and loneliness is a huge issue; central to our vision will be developing schemes which help older people connect together and with different generations for mutual support, activity and fun.

We will be exploring how social prescribing models (e.g. GPs prescribing a course of exercise classes rather than, or as well as, medication) supported by 'guided conversation' techniques help older people think about their needs and get the support they require. We will investigate how we can support older people to plan for later life and be more in control of their care and support needs including managing any long term conditions. Talking therapies including psycho-education for those with anxiety issues or depression should be as accessible for older people as they are for younger adults.

The carers of older people with care and support needs (who might be family, friends or neighbours), play an essential role in the wellbeing of the people they care for and we recognise the important contribution that they make to society. We know that carers can

experience significant negative effects on their finances, health (physical, mental and emotional) and employment prospects as a result of their caring role. As part of this strategy we will work in partnership to improve the lives of carers focusing equally upon their health and happiness..

Early Intervention – your own bed is best

As far as possible individuals will remain at home, in most cases older people are more comfortable in their own homes and therefore recover and regain their independence more quickly if good quality therapeutic support can be provided – 'your own bed is best'. They will tell their story only once and have a single co-ordinated plan tailored to their needs and desired outcomes. They will know who to talk to for help during this time and will know who will be supporting them if they need ongoing support. They will be assessed by an appropriate clinician prior to any hospital admission and will not have to wait for the next stage of their enablement to be put into place.

An Older Person's Advice and Liaison Service (OPAL) will cover the following two areas:

- crisis response to avoid unnecessary hospital admissions and include the delivery of traditionally acute clinical interventions for older people that can be safely delivered at home.

- enablement – home and/or community bed based interventions which aim to allow the person to remain at home and live as independently as possible. i.e. promote recovery, rehabilitation and re-ablement.

Crisis response
To avoid older people being unnecessarily admitted to hospital we will have a multidisciplinary approach at the front door 7 days a week. The team will specialise in the treating and supporting older people at home only admitting to an acute bed if needed for safe treatment. They will be supported to do this by a multidisciplinary quick response that will be linked to the GP and other professionals.

We will ensure that a response can be started within 2 hours when necessary, identifying a person's ongoing support and make arrangements for these needs to be met. We will ensure that older people can be seen by expert clinicians, have appropriate tests and investigations if required, and an accurate diagnosis made as a prompt diagnosis and treatment improves likelihood of a good recovery.

Although based at the front door of the hospital the multidisciplinary approach supported by a quick response service will be an important component of wider joined-up community support.

Mental health needs may cause, or significantly contribute to an older person reaching the point of needing early intervention. The multidisciplinary approach will result in simultaneous support for both mental and physical health issues, and ensure that older people are not disadvantaged by the environment they are being cared for in.

Enablement – Recovery, Rehabilitation and Re-ablement at home or in community based beds
Some older people are not ready to benefit from therapy. For these people we will provide appropriate short term (possibly up to 5 days) support to allow people to recover in their own homes wherever practical. Many older people after a short period of recovery will have no ongoing support needs but for those that need further support to return to their previous level

of health and ability we will provide an integrated rehabilitation and re-ablement approach co-ordinated by therapists (normally up to but not restricted to 6 weeks)

Multidisciplinary practitioners within crisis and enablement care will:

- work in partnership with the older person and their carers 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

Integrated enablement will be therapy led. We will join-up occupational and physiotherapy services to improve access, optimise services, and remove the risk of duplication and variation in assessment and provision.

We will make any practical adjustments to people's homes, for example equipment or adaptations, needed to make this care at home possible. We will offer enablement as a first option to older people being considered for home support, if it has been assessed that enablement could improve their independence.

We will also provide bed-based enablement within 4 or 5 specialist centres across the City for people who are in a sub- acute but stable condition but not fit for safe transfer home with consistent criteria, objectives, and clinical / therapy input. We are aware that if the move to bed-based enablement takes longer than 2 days it is likely to be less successful.

Enablement will be designed to support people with complex needs including those with moving and handling issues and importantly people living with dementia. The service will support people to stay out of hospital and will be aligned to the paramedic service.

Ongoing Personalised Support – Your life not a service

We recognise that some older people in order to remain happy and as healthy as possible require ongoing support. This support may be planned e.g. to manage more than one long term condition, or urgent.

To support people in a planned way we will develop an integrated home support service which brings together home support workers and community physical and mental health nurses to provide an outcome focussed flexible and responsive service to support older people living at home. This will offer a real opportunity to develop a workforce model that is fit for the future, and which explores the opportunities to train and develop home support workers, health care assistants and nurses to deliver holistic care focused on individual need. For example, this may include training home support workers and carers to carry out medical procedures such as insulin injections for insulin dependent older people in receipt of home support, and who would otherwise require daily nursing visits. A partnership approach across health and social support services will allow a better understanding of the complex links that exist between physical and mental health, allowing them to be addressed in a timely way when they occur, or preferably prevented or stabilised.

We will provide wrap around holistic support for older people with more complex needs including using agreed ways of 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 enablement services and integrated home support services will also provide peripatetic support to care homes in the area; the teams will in reach to local care homes to provide specialist support for residents and to help staff develop skills and confidence.

Older people have urgent care needs and their needs are central to the planning for sustainable joined up general practice and urgent treatment centres across the city.

Building upon a common approach to personalisation which puts the person and their wishes at the centre, wherever possible older people will be encouraged to have as much control as they wish of their care and support through such approaches as personal budgets and direct payments.

A network of joined-up community support

The 4 or 5 specialist centres across the City will provide the physical space for the right people to form genuinely integrated teams that have a shared ethos of supporting people in their own homes wrapping appropriate support around them.

The integrated community services operating from the care centres will reach into hospitals to ensure that people can go home at the right time with the right type of support (including end of life care). The centres will be part of a wider network of integrated community support. They will support GP practices and be connected to the more local neighbourhood networks as well as community hospitals, care homes and housing providing either specialist or long term support.

Developing an integrated workforce strategy is an essential element of our plan. We must ensure that there is a genuine career pathway across a joined-up health and social care system with generic roles and that we encourage young people into careers by supporting them to gain qualifications and skills. Links with local higher education colleges and schools will be improved.

We will redefine roles of people working in the community to maximise individual and collective skills. Occupational and physiotherapists will support decision making within enablement approaches. Staff providing intermediate care will work closely with quick response and paramedic services which GP's will be able to access avoiding unnecessary conveyance to hospital and allowing timely discharge home. Occupational and physiotherapists will also work with nurses and home support workers to ensure older people with ongoing needs have them met in an enabling, personalised way. We will connect our social workers to their local communities and ensure that they have the time to manage complex cases and safeguarding.

We will review access arrangements within the wider joined-up network making the best use of information and communication technology. The networks will have a digital catalogue of care, support and activities so that everyone within a local community knows what is available to keep people as active and well as possible. People co-ordinating or providing direct support will have timely access to shared electronic records.

Health & Social Care for Older People Joint Framework