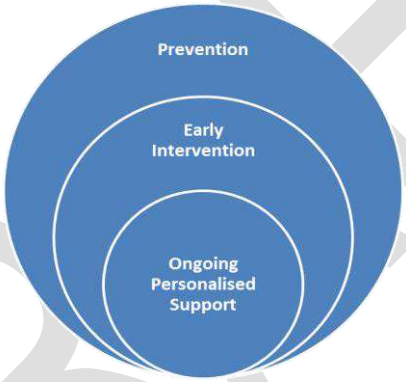
Integrated Health and Social Care Framework for Older People in Birmingham

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 resilient, live independently whenever possible and exercise choice and control so that they can live good quality lives and enjoy good health and wellbeing. This links to the STP vision 'to help everyone in Birmingham and Solihull to live the healthiest and happiest lives possible'.

It is essential to recognise that in order to support older people to achieve these goals, there is a broad responsibility across a range of partner organisations to provide this support and therefore it is a collective responsibility 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.

Our strategy for older people over the next five years breaks our approach down into **three themes** 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 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 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.

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

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 – ***a life not a service***.

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. We want to provide older people with the best advice and guidance on what they might need, when and where they need it with ***no wrong door.*** We also want to help local groups to develop new services and activities, where people have told us they are needed.

Social isolation and loneliness is a huge issue; central to our vision will be developing schemes which help older people connect for mutual support, activity and fun. ***Keeping people connected keeps them well.***

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.

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.

Early Intervention

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 needs of older people only admitting to an acute bed if clinically indicated. and will organise the appropriate care at home when it is safe to do so, following a **home first** approach. They will be supported to do this by a multidisciplinary quick response intervention 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. **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.

Some older people do not need to be in hospital but are not ready to benefit from enablement (support that gives a person the opportunity and confidence to relearn or regain some or all of the skills they may have lost because of poor health). 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 and for those that need further support to return to their previous level of health and ability we will provide an integrated enablement service (**normally up to but not restricted to 6 weeks**)

Multidisciplinary practitioners within an integrated enablement service 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

The integrated enablement intervention 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 provide enablement to older people in their own homes wherever practical, making any adjustments, for example equipment or adaptations, needed to make this happen. 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.

The integrated enablement intervention 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.

The integrated enablement intervention will prevent acute admissions and support timely and effective discharges and will work on the understanding and belief that '***your own bed is best',*** and that 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 in their own homes.

Ongoing Personalised Support

We will develop an integrated home support service which brings together home support workers and community nurses (including CPNs) 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.

We will provide wrap around holistic support for older people with more complex needs. This will support specific high risk individuals including those with dementia or very unstable long term conditions.

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.

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.

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.

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 enablement 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.