Appendix i

We are delighted to share our thoughts with you about how we will work together to 'Get it right for Phyllis'. This is the first time that all NHS and social care statutory partners in Birmingham have signed up to a joint vision and agreed steps to work together.

The description covers the five localities which have been agreed by the Birmingham Health and Wellbeing Board and Live Healthy, Live Happy Partnership, based around the constituencies that people live in. It describes our thoughts for the older people within each locality.

Cllr Paulette Hamilton
Chair, Birmingham Health & Wellbeing Board

Professor Graeme Betts
Director of Health and Social Care
Birmingham City Council

Dame Julie Moore
STP Lead & Chief Executive
University Hospitals Birmingham FT

Paul Jennings
Chief Executive
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Richard Kirby
Chief Executive
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John Short
Chief Executive
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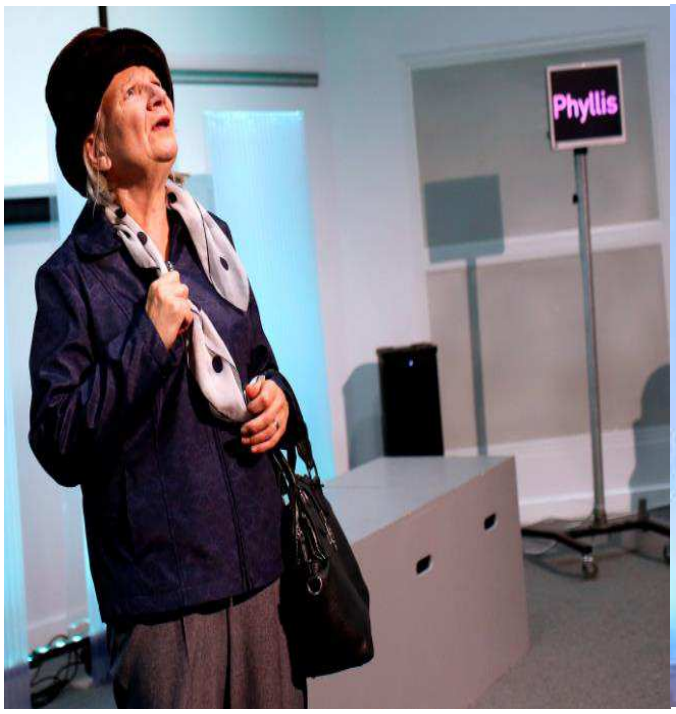
Live healthy Live happy
Birmingham and Solihull

Birmingham City Council

NHS

Appendix i

Getting it Right for Phyllis



'Phyllis' is a production by the Women in Theatre group that was commissioned by the Live Healthy, Live Happy Partnership in Birmingham and Solihull. It is a play focussing on the experiences of Phyllis and her family when she is admitted to hospital after becoming unwell in a supermarket. It is based upon the real experiences of people and their families and staff working within the system in Birmingham and Solihull. The production has been seen by hundreds of staff and makes for difficult viewing. It graphically underlines the findings of other work that has been undertaken in the city to identify the real matters that need to be changed to improve the experiences that older people have of health and social care including their long term health and happiness.

In the past the problems faced by older people using services and the staff working within them have been responded to by individual organisations rather than by working together. This has resulted in a series of 'sticking plasters' rather than a single plan.

This document is the beginning of our journey together. It describes our collective thoughts about the way forwards and is intended as the start of a conversation with you. It is based upon:

- The views of people both locally and nationally that have been shared in recent years including service users , staff and wider stakeholders,
- The available evidence base of things that have been successful elsewhere considered in our context,
- National policy must do's;
- Commitments made by system leaders and their organisations.

Live healthy Live happy Birmingham and Solihull

Birmingham City Council

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Appendix i

Health and Social Care for Older People in Birmingham

Older people and their carers need to get help from health and social care quickly and whenever they need it. Our joint vision is for older people in Birmingham to be as happy and healthy as possible, living self-sufficient, independent lives and having choice and control over what they do and what happens to them.

As demonstrated by 'Phyllis' many older people are coming into hospital or residential social care when other options to support them in their own homes may have been possible. Current models of support fit older people into narrow bands of available services but future support needs to be more personalised to enable older people to live the life they choose.

What we aim to do

Our strategy to provide a range of support for older people and their carer's in Birmingham over the next five years centres on three themes:

1. Prevention
2. Early Intervention
3. Personalised ongoing support

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 as well as possible at all times.

These approaches will be in turn be supported by joint planning around workforce, estates (buildings) and information sharing and use of technology. We are calling this a *'network of community support'* and we are working with the relevant specialists to identify the best ways to work together.

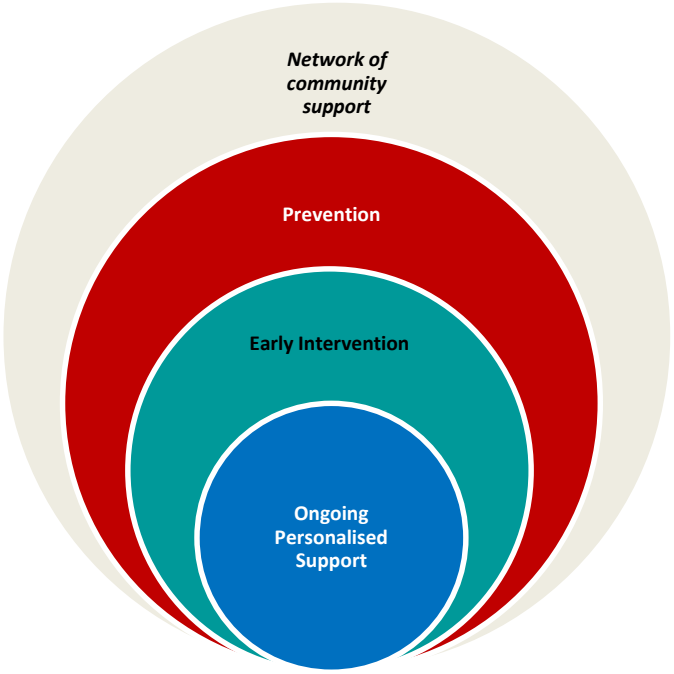
Personalisation as opposed to 'one size fits all' is at the centre of our thinking and in all three themes we aim to put the person at the centre of advice, assessment and planning approaches. Whoever is in contact with an older person or their carers will:

- 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

We will provide 'joined up' support across organisations so that older people do not experience duplication of services, gaps in provision or delays in accessing support. We are open to new ways of delivering services and we will make the most of the strengths of our partner organisations from the public, private, voluntary and community sectors so there will be no 'wrong door' throughout the system.

In order to properly support older people, there must be recognition across the city's wide range of partner organisations of a shared responsibility to make this strategy a reality.



Prevention – your health and happiness

We will organise services in local communities to help older people to manage their own health and wellbeing. Good quality information and advice will help people to identify and access the support that they need in order to continue living good lives and help to prevent issues such as social isolation.

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 ways which help older people connect both with each other and with different generations for mutual support, activities and fun.

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 people 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 identify and develop new services and activities.

Older people need to feel safe to come out of their homes to enjoy being part of their community. In order for them to do this, Birmingham City Council and other organisations need to provide a wide range of opportunities (also known as community assets), such as community centres, leisure centres, parks and gardens.

We will explore how 'social prescribing' models, for example, GPs prescribing a course of exercise classes rather than medication, supported by 'guided conversation' techniques can help older people think about their needs in order to get the support they require. We will also 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 those for use with anxiety issues or depression should be made just as accessible for older people as they are for any other age group.

We will work in partnership to improve the health and happiness of carers of older people, who might be family, friends or neighbours. We know that carers can experience significant negative effects on their physical, mental and emotional health, their finances and on their careers. We recognise that carers play an essential role in the lives of the people they care for and make an essential contribution both to society and to our health and social care system.

We will build upon the Carer's Offer that has already been made and improvements such as establishing the Carer's Hub that is already building links with greater numbers of carers to ensure they receive the assessments and support available to them.

Early Intervention – your own bed is best

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 issues associated with ageing, illness or injury. However, we aim to prevent hospital admission when it is not necessary, support appropriate discharge from hospital and maximise people's ability to lead independent lives outside of the system. We will try to prevent premature admission for people into long-term residential care, minimise delays and not take decisions about long term care in a hospital setting.

We aim to ensure people will remain in their homes whenever possible. In most cases, older people are more comfortable in their own homes and recover and regain their independence more quickly if good quality therapeutic support can be provided. People will have to tell their story only once and will have a single coordinated plan tailored to their needs and desired outcomes. They will know who to talk to for help during this time and who will be supporting them if they need ongoing support. They will be assessed by an appropriate clinician prior to any hospital admission and not have to wait for the next stage of their enablement to be put into place.

OPAL

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

- Enablement – recovery, rehabilitation and re-ablement at home or in community based beds that aim to allow the person to remain at home and live as independently as possible
- Quick response - avoiding unnecessary hospital admissions, including the delivery of traditionally acute clinical interventions for older people that can be safely delivered at home

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 their care environment.

Enablement

Integrated enablement will be therapy-led. We will join up occupational therapists and physiotherapists and short term care workers to improve access, optimise services, and remove the risk of duplication and variation in assessment and provision. Practitioners within quick response and enablement care will apply the approach to personalisation already outlined.

Some older people will not be ready to benefit from therapy and may not need it. We will provide appropriate short term support (possibly up to five days) to allow people to recover in their own homes wherever practical. Following a short period of recovery, many older people will have no ongoing support needs. However, we will provide an integrated

enablement approach co-ordinated by therapists (normally up to but not restricted to six weeks) for those people who need further support to return to their previous level of health and ability.

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

We will make any practical adjustments to people's homes, for example, equipment or adaptations, needed to make 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 four or five specialist centres across Birmingham for people who are in a sub- acute but stable condition but not fit for safe transfer home. We will use consistent criteria, objectives, and clinical or therapeutic input. We are aware that if the move to bed-based enablement takes longer than two days it is likely to be less successful.

Quick response

To avoid older people being unnecessarily admitted to hospital, we will have a multidisciplinary approach at the 'front door' of the hospital seven days a week. Although hospital-based, this multidisciplinary approach supported by a quick response service will be an important component of wider joined up community support.

The team will specialise in treating and supporting older people at home and only admitting people to an acute bed if needed for safe treatment. They will be supported to do this by a fast multidisciplinary response that will be linked to the person's GP and other professionals.

A prompt diagnosis and treatment improves the likelihood of a good recovery. We will ensure that a response can be started within two hours when necessary, identifying a person's ongoing support needs and making arrangements for these 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.

Personalised Ongoing Support – Your life, not a service

We recognise that in order to remain happy and as healthy as possible, some older people require ongoing support to remain living in their own homes and communities and this will include both planned and urgent 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.

Co-ordinated with general practice, this support may be planned, for example, in order to manage more than one long term condition or general frailty, 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 a flexible and responsive service to support older people living at home.

We will provide comprehensive and holistic support for older people with more complex needs, including using consistent methods of identifying those 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 personalised support services will also provide peripatetic support to care homes in the area; the teams will reach out to local care homes to provide specialist support for residents and to help staff develop skills and confidence.

Building upon the 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 which are joined together when appropriate.

Older people also 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.