ANNEX TO MINUTES

BEST VALUE REVIEW OF OLDER PEOPLE'S SERVICES

Recommendations for change-

1. To adopt the vision outlined below for the future joint development of services.

   We will provide integrated community-based health and social care services that are:

   - Person centred and needs led.
   - Easy to understand.
   - Focused on keeping older people at home.
   - Provided without delay, when and where they are needed.
   - Better organised, making the most effective use of resources.
   - Designed to ensure no-one is admitted to acute hospital. unnecessarily or discharged to permanent residential/nursing home care from acute hospital.
   - Organised around functions rather than individual professional activity/service areas.

2. To adopt the model agreed at the stakeholder day for the future joint development of services.

   A description of the model is in section F- Competition.

3. To set up a project steering group to develop and implement detailed project plan for integrated intermediate care, access and assessment service and long term/specialist services.

   - To integrate the Intermediate Care services under a single manager as stage one (over next 9 months).
   - To fund dedicated project development capacity 50/50 from Council and PCT to develop and implement the detailed plan integrating services.
   - To develop integrated locality based access and assessment teams each with single manager as stage 2 (over next 18 months/2 years).
   - To develop an integrated long-term/specialist team over next three years, starting with older people's mental health.
   - To accommodate stroke and falls specialist staff for community services within integrated intermediate care services.

4. To develop a proactive programme to support change and change management.

- Develop and resource a joint training programme to support integration.
- Develop a workforce planning strategy for recruiting and developing/multi-skilling staff based on the National Occupational Standards.
- Continue to develop IT systems that can share information and revise policies on confidentiality/information sharing to enable sharing across organisational and professional boundaries.
- Agree a joint approach to develop information about a wide range of services, making preventative services across both statutory and voluntary sector easier to access.

5. To develop and co-ordinate out of hours services.

    - Priority for investment in community based nurse/therapy led rapid response services.
    - Seek to establish 'hospital at home' service, combining focused short-term nursing, therapy, equipment and home care input.
    - Greater co-ordination needed across community health, emergency social work, home care, community alarm service, NHS direct and primary care out of hours services locally.

6. To develop a culture, criteria, protocols and an agreed approach to support older people in their own homes or sheltered housing as much as possible.

    - Ensure all services are person-centred and focus on rehabilitation.
    - Ensure older people receive recuperation and rehabilitation services (away from acute hospital) before making a decision on long-term care needs.
    - Establish clear criteria and pathways which compliment each other for all intermediate care and rehabilitation resources including Bletchley Community Hospital, Orchard House, step-down beds, CHAT and Intake and Rehab. Home care.
    - The PCT and Council explore development of pooled budget combining continuing care, 'free' nursing care and nursing home placements budget.
    - Develop culturally appropriate community based services for older people from black and minority ethnic groups to support them to remain at home.
    - Council sheltered housing is developed to support older people with high care needs including older people with dementia.