

Integration of health and social care:
Rising to the challenge

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- Dr Melanie Chalder of the University of Bristol who facilitated the working group meetings, collated the information generated from those meetings and compiled the information which formed the basis of this report, whilst conducting the work funded by her Medical Research Council 'Proximity to Discovery' award.
- Rob Benington, Health Improvement Manager, Public Health (Bristol)
- Rachael Dyson, Social Worker, Maximising Independence (Bristol City Council, Bristol South)
- Nick Miles, Social Worker (Bristol Royal Infirmary)
- Jonathan Little, Social Worker, Maximising Independence (Bristol City Council, Bristol North)
- Dr Andrew Taylor, Stockwood Medical Centre, Bristol

Executive summary

In February 2017 a cross-functional working group within the charity and housing association Brunelcare was established to compile a report evidencing how Brunelcare contributes to the integration of Health and Social Care within the region in which the charity's services are provided.

Group Purpose

'How does the work of Brunelcare support and evidence the integration of health and social care?'

To focus on two specific elements of Brunelcare's performance:

- (1) Reducing hospital admissions
- (2) Reducing the delay to transfer of care from hospital to other settings

The group also established at the outset that they would endeavour to:

- Share evidence of best practice working to share with practitioners and agencies within the health and care sector.
- Evidence how Brunelcare teams make a positive difference to health and social care integration.

Background

Media reports in early 2017 stated that the integration of health and social care was not achieving the results intended and that hospital admissions and delayed transfers ("bed blockers") were actually increasing. In addition, the National Audit Office (NAO) published a report dated 8th February 2017, entitled 'Health and social care integration.'

Integration within the health and social care system is defined in many ways but in this report we intend it to mean the coordination of care provision for Brunelcare's service users; involving how we work efficiently with the NHS, care commissioners and other care providers within our operating region in the South West.

Establishing the working group

Kevin Fairman, CEO Brunelcare, 2017:

"Our aim is to respond to the NAO report on the Integration of Health & Social Care. We will also involve other healthcare agencies, and Bristol University, to add independent credibility to the report."

Key Findings:

- Brunelcare is recognised as being at the forefront of new, innovative initiatives and the work detailed in this report highlights those that have been particularly successful.
- There are many best practice initiatives described in this report that have led to improved outcomes for the people accessing services from Brunelcare. Examples from the Falls Project, End of Life Care work, Pathway 2 and Reablement and the Health & Wellbeing Officer pilot all provide a picture of best practice that is to be commended.
- With Brunelcare's falls management expertise, we can evidence an innovative and outcome-focused falls management system within our own care homes. Our Council funded Falls Management project, led by Brunelcare, was also successful in improving the management of falls in many homes in Bristol; with evidence generated from this project enabling further funding to be secured from NHS England for further work on Falls Management in Care Homes.
- The Falls Management Project also highlighted to us that sharing work and best practice initiatives with other providers and colleagues from health and social care has been a valuable way to stimulate integrated working.
- Working in line with the Gold Standard Framework (GSF) Guidelines for End of Life Care encourages us to continue working in partnership with our partner GP practices across the homes. A fundamental requirement of meeting the GSF accreditation standards is to demonstrate a multi-disciplinary approach. Working in this way, we follow best practice guidelines and work collaboratively with our fellow professionals. This, in turn, impacts upon our colleagues in the NHS as we manage expected deaths effectively in the Care Homes thus reducing costly hospital based care.
- Providing person-centred care: Putting the people using Brunelcare's variety of care and support services at the centre enables a person-focused and evidence based framework of excellence to exist. The challenge, moving forward, will be to maintain and develop this framework so that more people can benefit.
- We evidence the innovation and impact delivered by the role of Brunelcare's new Health & Wellbeing Officers, initially funded by Bristol City Council's 'Supporting People' pilot scheme. This helps our 1,000 sheltered housing tenants to gain better access to the range of health and social care services available to them from Brunelcare, the NHS and their local community.
- Management challenges for Brunelcare charity to progress integration are significant in terms of the resources required – in terms of people, time and money. In this respect we also acknowledge that high levels of collaboration are currently limited by the care sector's funding crisis.

- Continued integrated working is key to the maintenance of excellence and the provision of seamless health and social care. Challenges and solutions can be overcome by all to ensure that people's changing health needs are met if partnership working across the sectors is encouraged and adopted as the norm.
- Brunelcare is seen to be reducing the financial burden on the NHS, particularly the expense of hospital bed care, by avoiding hospital admissions and helping reduce delay of transfers of care. This also means more acute hospital beds are available to those most in need. For example, our Health & Wellbeing Officers evidenced a notional saving to the NHS of approximately £179,600 in hospital bed care due to the reduced hospital stays enabled for our housing tenants in a six month period, comparing 2016 and 2017.
- In 2014 Brunelcare worked with Clinical Commissioning Groups to develop Brunelcare's Orchard Grove Reablement Centre where patients who no longer need a hospital bed but are unsafe to return home, stay and receive care and support before returning home safely. As the first 'Reablement Centre' created by an independent provider (and registered charity) in Bristol in 2014, Brunelcare's Orchard Grove Reablement Centre evidences how it continues to make a difference. To get patients out of hospital in a timely manner we ensure our beds are turned around quickly and liaise with the hospital discharge teams; our average length of stay is 41 days. We monitor delays of transfer of care, sending this information to the commissioners.
- Inadequate provision of social care. This appears to be a major issue for all the different care sectors and its impact is substantial, both on the services and their service users.
- Brunelcare acknowledges and agrees with the key findings in the National Audit Office's report dated 8th February 2017, entitled 'Health and social care integration'. In particular, acknowledging that we operate in a sector with a rising demand for services, and that as a care provider we are coping with ever increasing numbers of clients waiting for a care package in their own home or waiting for a nursing home placement. We also support the NAO's finding that expectations of the rate of progress of integration are over-optimistic. We agree that embedding new ways of working, developing trust and understanding between organisations that work together to provide care is vital to successful integration. Finally, and this also defines Brunelcare's approach to care, we agree that integrated care should be entirely focused on the patient's wishes and needs.

1: Introduction / context

This report contains examples of good practice from the charity, care and housing provider Brunelcare, as a means of publicising the beneficial outcomes experienced by those who use its services. It also contains examples of the challenges facing Brunelcare as it strives to deliver excellence.

It is not intended to be a comprehensive report but to give insight into what Brunelcare is doing and how. It is an in-progress document and, with the appropriate resource, can be continuously updated to reflect current practice and the prevailing social, economic and political landscape.

Report Aim and Purpose

This is a report produced to publicise how the work of Brunelcare supports and evidences the integration of health and social care, focusing on two specific elements of Brunelcare's work and performance:

- (a) reducing hospital admissions and
- (b) reducing the delay to transfer of care from hospital to other settings

Background

Originally, the drive to convene a Working Group stemmed from the publication of a National Audit Office report dated 8th February 2017, entitled 'Health and social care integration.'

The Better Care Fund has not achieved the expected value for money, in terms of savings, outcomes for patients or hospital activity.

See: <https://www.nao.org.uk/report/health-and-social-care-integration/>

Key extracts from the NAO report's summary and findings:

- Summary, 1: "Integration is about placing patients at the centre of the design and delivery of care with the aim of improving patient outcomes, satisfaction and value for money."
- Summary, 2: "Integration aims to overcome organisational, professional, legal and regulatory boundaries within the health and social care sectors, to ensure that patients receive the most cost-effective care, when and where they need it."

- Key finding, 8: “The two main reported reasons for this increase [rising demand for services] were patients waiting for a care package in their own home and patients waiting for a nursing home placement. These trends indicate that an ageing population is putting pressure on hospitals and social services.”
- Key finding, 12: “The Departments’ (i.e. Department of Health and the Department for Communities) expectations of the rate of progress of integration are over-optimistic. Embedding new ways of working and developing trust and understanding between organisations and their leaders are vital to successful integration.”
- Key finding, 18: “The Departments and their partners are still developing their understanding of how to measure progress in integrating health and social care. They plan to agree a definition of integrated care focused on patient experience.”

Since the NAO published their report, the integration of health and social care has steadfastly remained a key discussion point and area of focus within the UK’s health and care sector.

Report Scope

With specific reference to two areas of focus, i.e. (1) reducing unscheduled hospital admissions and (2) reducing the delay to transfer of care, the report demonstrates how the following care services within Brunelcare evidence and support the integration of health and care within Brunelcare’s geographic region of operation:

- Health & Wellbeing Service to Brunelcare’s sheltered housing tenants
- Falls management
- End of Life care
- Homecare and community reablement services
- ‘Pathway 2’ reablement services

Report Audience

Groups that we work in partnership with on a daily basis, with whom we seek to share best practice and to advise of our progress providing health, care and housing solutions.

Namely:

- National Care Forum
- NHS agencies and groups, such Clinical Commissioning Groups
- Care and Support West
- Brunelcare's partner GP Practices
- Brunelcare's adult social care delivery partners, including: social workers, occupational therapists and physiotherapists
- Dementia Wellbeing Service
- Age UK
- Sirona Care & Health
- Bristol Community Health
- Other interested organisations, including: National Audit Office and health, care and housing sector media titles

2: Approach

This report is the output of a cross-functional Working Group formed from within the charity Brunelcare, convened at the request of Kevin Fairman, CEO of Brunelcare in February 2017.

The Working Group comprised employees drawn from across the charity, for their specialist expertise in aspects of care provision and caring, namely:

- Kinlay Burns, Reablement Centre Manager, Orchard Grove Reablement Centre
- Janice Clements, Health & Wellbeing Officer, Housing
- Sophie Hill, Health & Wellbeing Officer, Housing
- Maggie Hehir, Trustee, Brunelcare's Board of Trustees
- Ceara McDermott, Operations Manager, Reablement South Gloucestershire
- Carolyn Mills, Operations Manager, North Somerset Community Services
- Sandra Payne, Head of Clinical Excellence
- Anne Whaley, Operations Manager, Somerset Community Services
- Helen Chick, Marketing Coordinator, Business Development (report editor)

The majority of information contained in this report was generated as a result of three workshops in early to mid-2017. The meetings were facilitated by an independent Chair: Dr Melanie Chalder of the University of Bristol. The key discussion and action points for each meeting were recorded, reviewed and shared amongst the group for further discussion and future reference.

The group was asked to consider how health and social care integration might impact upon two specific outcomes of interest:

- a) Reducing hospital admissions
- b) Reducing the delay to transfer of care.

To ensure a balanced discussion of the issues, members of the Working Group were asked to answer three questions for each of the two outcomes of interest:

1. What solutions have you tried or found successful in your area of care / business?
2. Are there any advantages or rewards for trying to work in an integrated way? What 'evidence' do you have to show how your work brings benefits or has impact?
3. What difficulties/barriers have you come across or overcome? Are there any disadvantages to trying to work in an integrated way?

Members of the group were encouraged to think broadly and creatively – and to offer whatever insight they felt best represented their particular expertise and experience. The group agreed they would endeavour to share evidence of best practice working that they would want to share with practitioners and agencies within the health and care industry, along with evidencing how Brunelcare teams make a positive difference to health and social care integration.

3: Findings and evidence

This section of the report presents the 'evidence' provided by the following areas of the charity, on both outcomes of interest:



- **Health and Wellbeing Service, for sheltered housing tenants:** Brunelcare has two full time Health and Wellbeing Officers who provide a health and wellbeing service to Brunelcare's Sheltered Housing tenants. Sheltered Housing is rented accommodation for the over 60's, to live independently with access to housing support if needed. Brunelcare owns and manages 31 Sheltered Housing sites within Bristol providing 1,000 homes.
- **Falls Management:** The falls management system within Brunelcare care homes, and associated project work.
- **End of Life Care:** End of life, and palliative care provision, within Brunelcare care homes
- **Homecare and Community Reablement services:** Community Services, providing home care and support to enable people to stay in their own homes, remaining independent. Brunelcare's Reablement service is usually for elderly people who have had a long stay in hospital and want to regain their independence and confidence. This is provided within South Gloucestershire and Brunelcare's Orchard Grove Reablement Centre, taking referrals from local hospitals, rather than direct or private patient referrals.

- **'Pathway 2' Reablement services:** There are three pathways for people coming out of hospital that are medically fit but still need further input: 'Pathway 1' – people go home with a new package of care as they are safe between the visits of the carers. 'Pathway 2' – people intending to go home but need more therapy input to do this safely as they would not be safe between carer visits. 'Pathway 3' – people who are not safe to go home and are at their physical baseline and are therefore going to long term placement. **Brunelcare's Orchard Grove Reablement Centre** provides a 'Pathway 2' support service, providing the physiotherapy, occupational therapy and social services input required, facilitating a safe discharge home.

In developing ideas for this report, the group preferred to take an expansive and practical approach to what constituted 'evidence'.

Two different types of 'evidence' were found:

- Quantitative, numeric or 'hard' data – often presented as tables, graphs or charts – originating from Brunelcare's own systems
- Qualitative, descriptive or 'soft' data e.g. case studies, peer / partner feedback or testimonials from Brunelcare's employees/residents/families.

Evidence has been presented by taking each of the two specific outcomes of interest in turn, answering the questions listed in our Approach.

3.1: Avoiding unnecessary hospital admission

3.1.1 What solutions have you tried or found successful in your area of care / business?

Health and Wellbeing Service, for sheltered housing tenants:

- Using a 'traffic light system' for site staff to flag any concerns there may be regarding a tenant to Health & Wellbeing before they go in to crisis. This could be a change in behaviour or routine, mental health issues, medication issues, referrals also made by family/friends, concerns about 'coping' alone.
- Use of monthly reports from Centra (24 hour telephone support service) to measure the number of times an ambulance is called to site, reasons for calls such as falls, monitor and follow up frequent use of pull-cords or pendants.
- We are trusted assessors and can carry out aids & adaptation assessments to install grab-rails, key safe etc.
- Support to address hoarding, hazard assessment.
- Regular liaison with other support and health & care professionals, such as District Nurses, GP's.
- We carry out safeguarding referrals in an appropriate manner.
- Community development projects to address loneliness and social isolation.
- Making contact with hospital teams to be part of any discharge planning enabling tenants to return home with the correct support.
- Work with Social Workers and other care practitioners to assess housing and housing-related support needs.
- Provide or signpost to support, in response to needs such as medication prompts.
- We have established a working partnership with the Red Cross and as part of their Hospital to Home (First Call) Service they have changed their assessment paperwork to include asking patients in hospital if they live in a Brunelcare Sheltered Housing property, the Red Cross then notify us. Apart from our own hospital checks, this is another safeguard in ensuring we are fully aware of any tenant's admission to hospital.

Falls management:

The Falls Project: Public Health has a ring-fenced grant made to Bristol City Council (BCC) by the Department of Health. Brunelcare was selected by Bristol City Council, following a competitive tender process, to lead on this project supported by this funding. The charity was successful in the tender process due to our ability to evidence an innovative and outcome-focused falls management system within our own care homes.

- The aim of the project - focus upon Care Homes in Bristol with a list supplied by BCC of homes to work with to reduce falls and improve the overall falls management processes they had in place. This included homes where there were already elements of good practice but also homes that were experiencing high levels of falls or had no effective falls management process in place. The project ran from April 2015 to February 2016 and aimed to raise awareness and improve practice in falls management in care homes ultimately to reduce the number of falls but also to reduce the incidence of injurious falls which would result in a hospital admission.
- The specific objectives set by BCC were to coach Falls Champions in each of the participating homes, verifying falls management protocols and systems were in place and obtaining audit data from the homes each month.
- The plotting and mapping of falls to detail the who/why/when/where of a fall underpins a holistic approach to falls management and was demonstrated and adopted by each home that fully engaged in the project. Using this approach, employees were able to adopt a proactive strategy rather than reactive approach to falls management. Plotting and mapping involved the use of a monthly clock face to detail the initials of the person, date and time of a fall and the mapping involved plotting the fall by location on a site map of the home. These very easy, visual tools were then clearly displayed in the homes so that staff could be involved in falls management. The clock face and map quickly identifies trends in time or place, particularly where 'clusters' of falls may have occurred in particular areas at particular times.
- The safety cross principle was also adopted and this identifies numbers of 'falls free' days in green within a month and any falls taking place in red. This gives staff a very visual, easy to understand overview of how many falls are occurring. The greener the cross, the better.
- The project was successful in improving the management of falls in many homes, and was associated with reductions in falls in some, although the numbers of falls were also affected as residents' level of dependency and support needs naturally changed over time. The work and evidence generated from this project enabled further funding to be secured from NHS England for further Falls Management in Care Homes work.

Feedback from one of the homes working on the project, an extract from the Falls Project Newsletter, Autumn 2015, circulated to all care homes in Bristol –



Meadowcare Home,
Redland, Bristol – proud
to be plotting falls!

Feedback from Meadowcare Home, Bristol (non-Brunelcare):

- Since working on the project, Meadowcare Home reduced their falls by a massive 57%. This is a fantastic achievement which the home is really proud of.
- Meadowcare home Manager Evelyn and Deputy Juliet have been working on the Falls Project since the very beginning. They have been enthusiastic from the outset and quickly grasped the concept of plotting and mapping falls and evidencing the incidence of falls using the safety cross.
- Evelyn and Juliet say that the general staff awareness of who is 'at risk' has increased enormously. Staff found all of the tools helpful, easy to use and a clear source of evidence. CQC visited to inspect the home whilst the Falls Project was in place and were very impressed with the visual impact of the mapping and plotting. **They were also pleased to see that the home was working in partnership with external professionals in order to achieve best practice in falls management.**

Quote about the Falls Project from Public Health (Bristol) :

"The project was particularly successful in engaging staff, and gave them an easy-to-use tool to keep track of the patterns of falling. Identification of patterns invites enquiry about causes and a gives sense that control may be possible. This helps challenge the erroneous view that falls are an inevitable part of ageing. Brunelcare were an ideal partner in this work; their experience with the safety cross approach and other aspects of falls management, combined with their experience of running homes, made them a credible and authoritative champion in the eyes of the participating providers and their staff".

Rob Benington, Health Improvement Manager, Public Health (Bristol)

End of Life care:

- Brunelcare care homes have worked to reduce the number of unnecessary admissions and deaths in hospital from the homes in line with the Gold Standards Framework (GSF) End Of Life Care (EOLC) in Care Homes initiatives aiming to address the following:
 - High numbers of residents transferred from Care Homes to acute hospitals in the last stages of life.
 - Some hospital admissions may not necessarily be the residents wish or in their best interests.
 - Emphasis on the need to focus upon strategic planning and training in end of life care in care homes.
 - The necessity to ensure there is a high quality of care for people in their final years.
- The EOLC work identified the need to have the following in place:
 - Focus on quality of life.
 - Whole person approach.
 - Care for both the person and their loved ones.
 - Respect for choice.
 - Open and sensitive communication.
 - Planning future care whilst well enough to do so.
 - Where do they want to spend their last days and who with.
- In 2010, Brunelcare formulated two key documents whilst working with St Peters Hospice: the 'Do Not Admit to Hospital Form' and the 'End of Life Care Pathway'. Both documents are still in use and are recognised by our partner GP's as robust evidence of advance planning and recording of wish.
- The main aims of the 'Do Not Admit to Hospital' document are:
 - To ensure that as far as is practically possible, unnecessary and potentially distressing hospital admissions which are not in the best interests of the resident are avoided and care is delivered in the home.
 - To ensure that relatives/representatives are fully informed and supported by the multi-disciplinary team in relation to understanding the illness, prognosis and on-going care needs.
 - To facilitate open and honest discussion regarding future care options where a resident's illness has progressed and invasive treatments are not viewed to be in their best interests.
 - To establish a proactive approach to care.

- Collaborative working with a key partner GP at the outset has resulted in the 'Do not admit to hospital' form being placed on to the GP computer system 'ADASTRA' which will alert any out of hours GP of the person's wishes and the decisions made regarding an admission to hospital. The 'End of Life Care Pathway' was also introduced to enable staff to evidence care given in the very last few days of life. Again, in conjunction with the GP, anticipatory end of life medications are prescribed and EOL care wishes discussed and care explained to the family members.

Homecare and Community Reablement services:

- **Somerset Community Services:**

Case Study 1: We have been a carer for a client for 6 years. The client is 64 and had been diagnosed with MS 10 years ago and now totally immobile and non-verbal. Two weeks ago she appeared to have a further relapse which affected her well-being significantly. It was witnessed by a member of the team that while she was being fed by her live-in carer, she was choking and unable to swallow her liquidised food. It was also noted that she had lost muscle tone in her neck and it was now starting to fuse to the right-hand side. This was handed over to the team leader on the Monday morning. She made arrangements to visit the client and her carer to clarify the information she had been given. The live-in carer appeared to be upset and wasn't sure what he could do. The team leader explained that the first step was to speak to the GP, which she did on her return to the office. The client has always expressed a wish to be cared for at home and it was important to her to avoid Hospital admission. The team leader then contacted the following people to enable a Multi-Disciplinary Team approach.

- GP was asked to visit to assess her needs.
- District Nurse - contacted and asked if they would check on her pressure sores and advise of anything we could do to prevent further sores.
- Duty Team - contacted
- Speech and Language Therapist – contacted to visit her and assess her fluid/food intake.
- Occupational Therapist – contacted to source sling with head support, to prevent damage to her neck.

Once all visits had taken place the feeling was that she needed to be admitted to hospital to avoid malnutrition. **We were aware of her wish to remain at home and so had long discussions how this could be achieved with minimum risk. Client remains at home with the input of all professionals.**

Care increased and visit times changed to allow her to be rested and turned on her bed in the afternoon. New feeding regime was given to live-in carer. New manual handling equipment was in place within 36 hours.

We all believe with the joint working between agencies we have prevented an hospital admission which would have been inappropriate.

- **Somerset Community Services:**

Case Study 2: Team leader was with client for his tea time visit. The District Nurse arrived to check client's blood glucose and to administer his insulin. The nurse checked his blood glucose and informed client that she was going to admit him to hospital because his blood glucose was so high that there was no reading, the team leader politely advised the nurse to check client's blood glucose again and suggested that client washed his hands first, as the reading could be inaccurate with not so clean hands. The nurse did this and this time had an accurate result. **The nurse then said to the client that he was to thank the team leader, as she had saved him from going into hospital.**

- **North Somerset Community Services:**

- Detailed and individually tailored Care/Support Plans for every client to ensure that the support provided best suits them, one size does not fit all.
- Staff build a rapport with the client and their loved ones to ensure personal outcomes are met.
- Staff are trained to contact GPs, District Nurses, OTs etc. from the client's home so that the client where able, can be involved in the phone call.
- We have introduced a monitoring form for each client to log when any healthcare intervention is required. This will help us to identify individual patterns and take any necessary action.
- We work in localised teams so we can build our knowledge of local groups, coffee mornings, day trips, professional groups etc. that we can signpost clients to and support to attend if needed.
- We are responsive. We have trusted assessors on site who can assess a client's need for lower level equipment such as grab rails or toilet raisers. This is a quick service and assists the client to remain at home whilst reducing the risk of harm.
- We raise safeguarding concerns and work with the client, their loved ones, social workers and other healthcare professionals to prevent further risk of harm.
- We assist or manage client medication.
- We can offer a flexible service to be able to move client's times of calls or add in extra calls. This supports the client to attend a day trip or go to a doctor's appointment, maybe to attend a local group or to do some shopping. All of these 'little' things aid the client to live as fulfilling a life as possible.

North Somerset Community Services, domiciliary care case study:

We have a client who has diabetes and his main carer, his wife, administered his insulin. Client was admitted to hospital after having a fall. The team leader was made aware of this during the evening and she recalled how the client's wife always administered the client's insulin. **The team leader rang the emergency duty team and explained the situation and our restrictions for administering insulin so the District Nurses visited the client as an emergency and then ongoing so that he could remain at home. The team all monitored his condition to make sure that he was managing his diabetes without his wife at home. The wife did return home to then continue with administering the client's medication.**

North Somerset Community Services, End of Life Care case study:

We have cared for a female client, who has dementia, for over six years and she had deteriorated over the last 12 months. The team worked very closely with the client, her family, Social Workers, District Nurses and Occupational Therapists to ensure that her wish to remain at home was met. There were numerous reviews at the client's home to ensure that she had all necessary equipment at home and that her care was meeting her needs. **Her care package was changed numerous times to ensure that she could remain at home. Our client remained at home where she passes away comfortably in her own surroundings.**

- **South Gloucestershire Community Services:**

- Working closely with Occupational Therapists (OTs) to get appropriate assessments and equipment or aids in place to assist with successful independent living. By having a dedicated team of social workers, senior practitioners and OTs promoting independence, this helps to get things done in a more appropriate and timely manner. We assist and work together to help adapt the home environment and identify risks and hazards and look for solutions to overcome initial barriers. We look at aids such as telecare, grab rails, micro environments, stair lifts and perching stools to make daily tasks more manageable and safe.

- **'Pathway 2' Reablement services:**

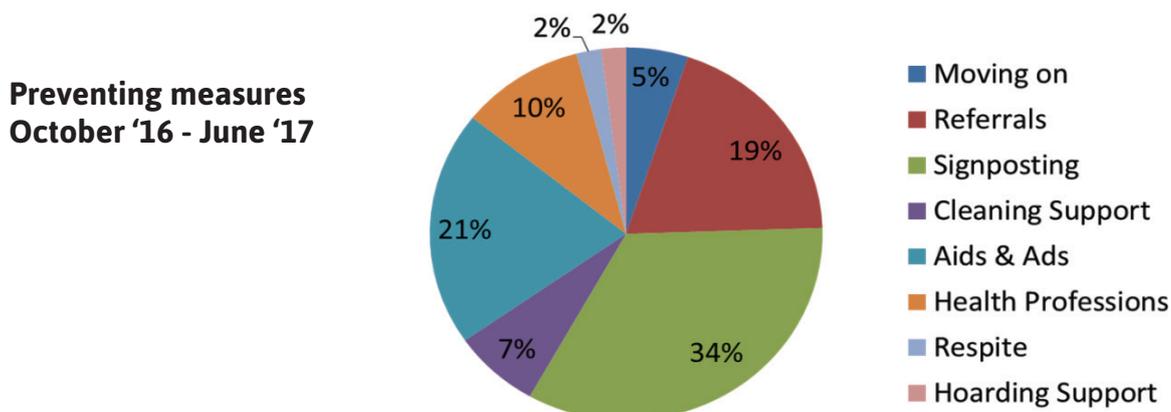
- As an innovative organisation Brunelcare could see that there was a need to help the NHS to get people out of hospital to reduce the delay to transfer of care. In 2014 we worked with Clinical Commissioning Groups to develop our reablement centre in Bristol, Orchard Grove Reablement Centre, where patients who no longer need a hospital bed, but are unsafe to return home, stay and receive care and support for up to six weeks before returning home safely.
- The Centre works closely with Social Services to ensure appropriate 'Pathway 2' support is in place when someone is discharged home from hospital.
- When people are staying with us we use the National Early Warning Score (NEWS) to monitor people and catch early any deterioration in someone's health and get our partner GP involved early.
- We work with Physiotherapists and Occupational Therapists to get people fitter, more confident and independent.
- We provide health education to improve people's diet and nutrition.
- We teach best practice at home, flag up hazards and adapt people's home environment.
- We link with local support networks such as Community Reablement Teams, Age UK, Red Cross and volunteer services.

1.1.2 Are there any advantages or rewards for trying to work in an integrated way? What 'evidence' do you have to show how your work brings benefits or has impact?

Health and Wellbeing Service, for sheltered housing tenants:

- One of the two Health & Wellbeing posts within Brunelcare has now been made permanent. The second post has been extended until March 2018 and, subject to the Supporting People funding outcome, may also be made permanent.
- Based on the hospital admissions data collected for our Brunelcare sheltered housing tenants, although there is only a difference of 8 more tenants being admitted to hospital in 2016 compared to 2017, when comparing the duration tenants stayed in hospital there was a substantial difference. In 2016, tenants who were admitted between Jan-Jun 2016 stayed a total of 1,309 days. For the same period in 2017 our tenants stayed in hospital for a total of 860 days, that's a 449 day difference. Based on the average cost per day of £400 for a hospital stay this presents a saving to the NHS of £179,600.00. This figure excludes any treatment or theatre costs.
- We have taken preventative measures, organising respite and reablement placements for our housing tenants. The impact this has on the wider community results in there being more bed availability within our hospitals for people to receive the health care they need. This work includes:
 - Providing support to enable a tenant to be discharged from hospital as a suitable care provider could not be found to meet his overall needs. Brunelcare were able to fill this gap until the care provider had the capacity.
 - Cleaning support: we arranged for tenants to have cleaning services and deep cleans set up in order to improve their living environment and health; reducing the risk of falls and potential hospital admission.
 - Health Professions: We've liaised with GP's and District Nurses to address concerns or to let them know of any changes in health and wellbeing. We've requested medication reviews, organised dosset boxes, set up appointments in order to help reduce the likelihood of tenants going in to hospital and made referrals to falls clinics.
 - Referrals have also been made to Care Direct regarding Safeguarding, Self-Neglect, moving on to Extra Care Housing. We've also used Care Direct as a source of advice and knowledge.
 - Promoting our service to health professionals and hospitals via our own Service Information leaflet providing details of all our sheltered sites. We've built effective working relationships with hospital teams such as REACT, Social Workers, ward staff and Occupational Therapists. This has enabled us to work with them in order to meet their needs.
 - By making Aids & Adaptation assessments for our tenants before occupational therapists (OTs) need to be involved it not only reduces the risk of falls and hospital admissions but also frees up the time of OTs.

- Signposting to other agencies – for example substance abuse, mental health concerns, befriending, loneliness and isolation, community involvement and activities. We promote and refer to the Red Cross 'First Call Service'; they can provide light support when a tenants health declines. This can help prevent them going into crisis which can result in hospital admission.



Janice Clements, Brunelcare Health & Wellbeing Officer, case study:

Tenant Z was admitted to hospital after being found collapsed in his flat. He has a history of mental health issues and was known to the Mental Health Teams having previously been sectioned. However, he was reluctant to engage with anyone and suffered regular episodes of psychotic behaviour and delusion. After a long stay in hospital he was transferred to Callington Road Hospital where his mental health was controlled with injections.

It was his wish to return to his flat and one of the conditions for his return was to accept a daily care package. He agreed to allow us to arrange for his flat to be deep cleaned and engaged with us and other health professionals to enable him to return home. However, at the time of discharge there were no care providers in the area that had the capacity for the complete care package. We facilitated one of our own support staff to visit daily for 4 weeks to check on welfare and prompt breakfast. This support continued until the care provider was able to provide the full care package.

Although the tenant's mental health continues to fluctuate, with the assistance in place that he needs, he continues to live in Sheltered accommodation.

Testimonial about 'Tenant Z' received from Rachael Dyson, Social Worker, Maximising Independence SE (Bristol City Council, Bristol South):

"It was useful to have a contact from Brunelcare that knew Tenant Z, his history and what the issues were when he was living at home. **Janice and Sophie have been invaluable in liaising with other professionals including GP, District Nurses, the Mental Health Team, Agincare and Occupational Therapists in regards to the tenant's care.** The Wellbeing Officer role supported him on his discharge from hospital, and has been really valuable since he has returned home. I believe this has been really positive for his physical and mental health. They have been able to raise concerns and follow up on these **to try and prevent him from being readmitted to hospital.** They have supported his wish to retain his independence and remain at home, despite the risks present."

Testimonial from a tenant's daughter:

“Dad was starting to not engage with me and I tried to explain that he should go to hospital. He wouldn't listen to me but he did engage with Janice [Clements]... **Janice organised the GP and Dad went into hospital which saved his life.**”

Testimonial from Nick Miles, Social Worker (Bristol Royal Infirmary):

“Working in partnership with Sophie [Hill] **helped facilitate a speedy, safe and appropriate discharge from hospital** and I'm sure that without her support my task would have been a more arduous one.”

Testimonial from Jonathan Little, Social Worker, Maximising Independence (Bristol City Council, Bristol North):

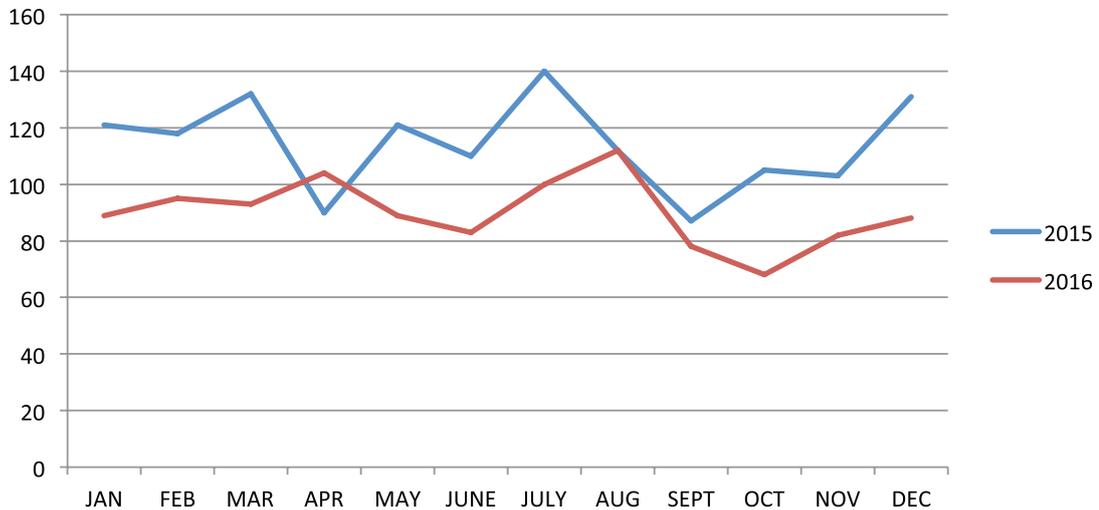
“From having recently worked with Janice [Clements] on two quite differing cases, it has **highlighted the immense benefit and pragmatism of a joint approach.**”

Falls management:

- All care homes who participated in the project (17 in total) demonstrated a reduction in the number of falls in the home and the data to evidence this is available. Care Homes that fully engaged with Brunelcare have continued to have a very positive working relationship with us. Networking with our colleagues in the sector is an important aspect of integration and this will continue.
- Brunelcare homes evidence a 32% reduction in falls across all four care homes from 2015 to 2016. Brunelcare homes use the plotting and mapping and safety cross falls management system as the falls audit tool.
- This obviously has a positive impact upon the people living in our care homes and staying at our Reablement Centre. Injurious falls have been reduced to a minimum thus impacting upon a reduction in the need for hospitalisation for our client group. This helps to reduce the strain on NHS resources as clients are not requiring treatment in a secondary care setting. Falls are effectively managed across the care homes resulting in better outcomes for the people using these services.

Data collated from Brunelcare care homes demonstrates the impact that the plotting and mapping of falls in the homes has had in relation to the reduction of falls:

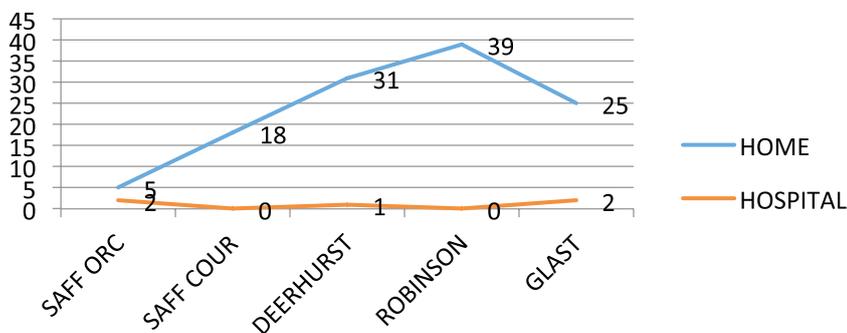
Falls in Brunelcare care homes 2015 and 2016



End of Life care:

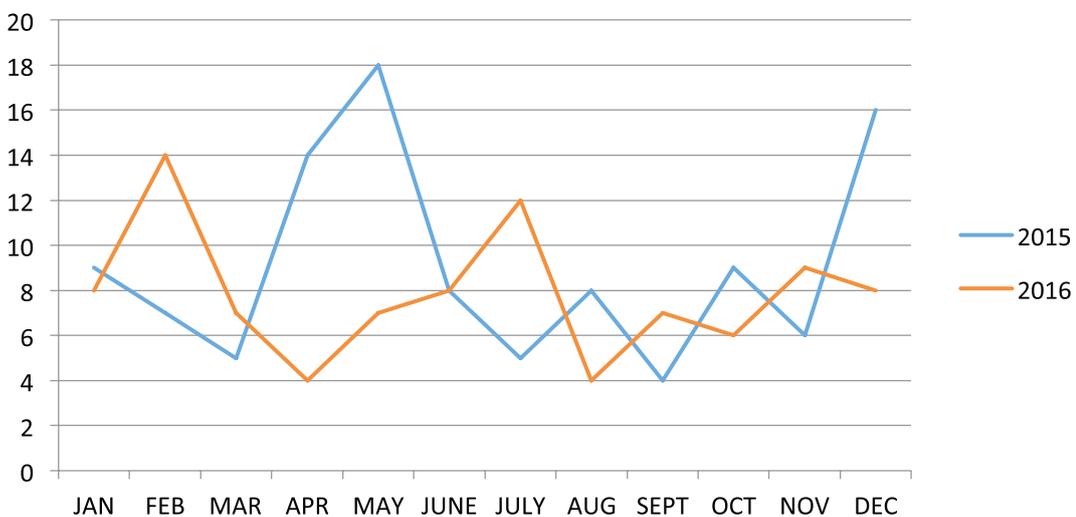
- There is evidence available to demonstrate the benefits of the advance care planning and end of life care that is provided to people living in Brunelcare care homes.
- Our data demonstrate a 62% reduction in deaths in hospital from 2014 to 2016 (see also 2014 and 2015 data in appendix 3). This obviously impacts positively upon NHS resources where we have been able to facilitate a total of 339 good deaths in our care homes in a three-year period. We define a good death as a person dying with all of their preferred priorities of care planned for and in place:

Deaths in Home v Hospital 2016



- Three out of our four care homes have now achieved Gold Standard Framework accreditation for End of Life Care, a nationally recognised quality mark for excellence in end of life care. Saffron Gardens will be accredited at the end of 2017.
- As evidenced on the Gold Standards Framework accredited care homes list, Brunelcare’s Robinson House is the only care home in the Bristol authority to have achieved Gold Standards Framework accreditation and Deerhurst is the only care home in South Gloucestershire to achieve the accreditation. Brunelcare’s Glastonbury Care Home is one of five homes in the South West Region who have been awarded the highest Platinum status out of a total of 97 accredited homes.
- Working in line with the Gold Standards Framework Guidelines for End of Life Care encourages us to continue working in partnership with our partner GP practices across the homes. A fundamental requirement of meeting the accreditation standards is to demonstrate a multi-disciplinary approach. By continuing to work in this way, we can ensure that we adhere to best practice guidelines by working collaboratively with our fellow professionals. This, in turn, impacts upon our colleagues in the NHS as we manage expected deaths effectively in the care homes thus reducing costly hospital based care.
- The importance of planning to reduce hospital admissions is recognised not only as a benefit to relieve the stresses and strains on NHS resources but also doing the right thing at the right time for the person concerned. This falls in line with our advance planning initiatives and involves inclusive and informed discussions and decision making with all parties.
- Brunelcare care homes work to identify recognised signs and symptoms of deterioration and also to take appropriate and timely action when acute situations occur.

Unplanned hospital admissions from Brunelcare care homes 2015 & 2016 comparative data, evidencing a 14% reduction year to year



Quotes from the Gold Standards Framework Accreditation Reports

Gold Standards Framework (GSF) Accreditation feedback August 2017 – Brunelcare’s Glastonbury Care Home:-

“We are delighted to inform you that you have successfully completed the GSF Care Homes Re Accreditation Assessment Round 13, 2017, and have been awarded the Quality Hallmark Award at Platinum status, which recognises the sustained practice to maintain GSF in your home.

Integrated Cross Boundary care: There is an effective communication process to reduce avoidable crises, and inappropriate hospital admissions towards the end of life. Particular focus on enabling the person with dementia, and other cognitive difficulties, to remain in the home. There is an active and effective process in place to reduce length of hospital stay.

Hospital admission is kept to a minimum and admissions are followed up. Changes in coding or condition are faxed to the GPs who are then responsible for informing out of hours.

Good relationships with Multi-Disciplinary Team and the local hospice.”



Pictured: Brunelcare’s Glastonbury Care Home team, 2017

Gold Standards Framework Accreditation feedback December 2016 – Brunelcare’s Robinson House:-

“Areas of Strength -

- Good leadership
- Proactive work with GPs to avoid hospital admission
- Good working relationship with hospice including receiving training
- Allocated beds for emergency admissions for fast track end of life care and short term stay for those with dementia
- Takes student nurses and paramedics
- Person centred care
- Range of activities”



Pictured: Brunelcare’s Robinson House Care Home employees receiving GSF Quality Hallmark Award, 2017

Gold Standards Framework Accreditation feedback December 2016 – Brunelcare’s Deerhurst care home:-

“Evidence of closely working with the wider team including the hospice, mental health team, physio and reablement team.

Staff can administer intravenous (IV) anti-biotics so **avoiding hospital admissions.”**



Pictured: Brunelcare’s Deerhurst Care Home employees and residents, 2017

Homecare and Community Reablement services:**• North Somerset Community Services:**

- Person Centred.
- Utilisation of joint resources.
- Broader range of knowledge, skills and specialisms.
- Reducing the repetition of information for the client.
- Monthly reablement monitoring data including the reduction of care hours required by a client.
- Data around the healthcare intervention form to evidence the proactive work of the care staff for each client.
- Service delivery data that the Council require to evidence the work that staff do to enable clients who have chosen outcomes that they want to achieve.

• Somerset Community Services:

- Work going on at the moment in Somerset, called the HomeFirst service, very new but hopefully will be able to evidence that working together more benefits all.

• South Gloucestershire Community Services:

- We work towards weekly goals and assess with the client on a regular basis. We update and develop these as appropriate for each individual. Our goal is to keep people in their own home environment where possible. The reduction in planned hours from start to finish is monitored by us and by South Gloucestershire Council.

'Pathway 2' Reablement services:

- We monitor outcomes of our patients and compare their dependency score on arrival and discharge.
- We set goals on arrival and ensure they have been met.
- We discharge to home address wherever possible.

1.1.3 What difficulties/barriers have you come across or overcome? Are there any disadvantages to trying to work in an integrated way?

Health and Wellbeing Service, for sheltered housing tenants:

- Building relationships with professional teams has been a challenge.
- No disadvantages to working in an integrated way – this would encourage a ‘joined up’ way of working
- Barriers identified so far have been with GPs – difficult to engage. We continue to establish links with GP Surgeries. The success of this varies from surgery to surgery. We try to attend as many Health & Wellbeing activities organised by surgeries or in the local area to further promote the service. However, it is clear that our roles work better with the Hospitals.
- We are facing increasing pressures due to the changing funding framework and continue to be aware of restrictions whilst looking to sustain the service.

Falls management:

- There were some difficulties and reluctance from care homes of other providers in accessing and gaining ‘sign up’ for the project. In the Care Home sector, there can be a reticence to share best practice initiatives and this was the case with some organisations during the project. Some of the larger providers already had a corporate approach to falls management and so did not want to adopt or look in to a new way of working. It was also difficult to encourage some of the other care home providers to spend time on the initiative as they were not able to visualise the longer term benefits that this falls management process could offer them.

End of Life care:

- We come across very few problems due to our proactive End Of Life / Advance Planning with all involved.
- Working in partnership with GPs, local hospices and Secondary Healthcare colleagues has only served to strengthen our reputation in the local communities and maintain our excellent standard of end of life care.

Homecare and Community Reablement services:**• North Somerset Community Services:**

- There can sometimes be a lack of communication or participation from some people in the partnership group (care provider, social worker, occupational therapists, GP, client and their loved ones).
- There may be a difference of opinion over what is right for the client.
- Time delays due to individual workloads.
- Lack of resource.

• Somerset Community Services:

- Difficulties in communication between health and social care. Lack of understanding of our limitations. Lack of funding.

• South Gloucestershire Community Services:

- Barriers for getting people home from hospital, such as communication within hospital departments, transport not being arranged, the wrong type of transport, wrong transport time or medication not being ready.

‘Pathway 2’ Reablement services:

- Social care availability.
- People’s receptiveness to change their habits and home environment.

3.2: Reducing the delay to transfer of care from hospital to other settings

3.2.1 What solutions have you tried or found successful in your area of care / business?

Health and Wellbeing Service, for sheltered housing tenants:

- Building relationships with occupational therapists, hospital social workers, and discharge liaison teams.
- Being part of the discharge plan.
- We have established a good working relationship with REACT (Rapid Emergency Assessment Care Team), particularly at Southmead Hospital and now have NHS passes which allow us staff access to medical areas. This also means we are able to work (when necessary) from the REACT Office at Southmead which is used by the Hospital Social Workers team. This is helping to build good relationships with the Social Workers that are assigned to our tenants. We will be having a meeting with REACT at the BRI mid-October (2017) and hope to have the same arrangement there as we have at Southmead. The CAL's (Complex Assessment Leads) also have our contact details and have called us for our input in to some complex assessments.
- Having a joint approach has shown good results.

Falls management:

- Reductions in post fall fractures in Brunelcare's care homes since using the plotting and mapping process enables us to manage falls effectively. There is a more positive experience for the people living in the homes who experience falls and less reliance upon the Secondary Health Sector to provide input or treatments as a result of falls.
- External agencies are able to see that we are working in a proactive rather than a reactive manner. We are able to evidence an efficient and person centred approach to falls management that puts the person at risk at the centre.
- Sharing our work and best practice initiatives with other providers and colleagues from health and social care has been a valuable way of trying to work in an integrated way. This has been rewarding for us as a charity as we are able to showcase our good work and make a positive difference.

Homecare and Community Reablement services:**• North Somerset Community Services:**

- We work closely with social workers and the Council's Brokerage team to get care started for a client as soon as possible.
- We go and visit clients in hospital to assess them before they come home.
- We ensure we work well with the partnership group to get everything in place for a quick and safe discharge, i.e. equipment, extra care calls, medication, shopping.
- We organise specific training for staff if the client has had a change in condition, such as PEG training.
- We provide end of life care.

• Somerset Community Services:

- We do go into hospitals and work with the staff there and the client to facilitate discharges.
- We have recently started a new Home First Contract in Somerset. This is a frontline reablement service. We have dedicated two team leaders (trusted assessors) to work closely with the hospital and adult social care team. This is a short term reablement service from our two main hospitals, Yeovil and Musgrove, Taunton. The assessments are being done at home with a therapy member of staff and one of our assessors. Some examples, of this are: helping someone gain confidence after being in hospital for quite a while and exercises to enable someone to gain strength. The benefits are there, just not a lot of proof at moment, but initially showing intense reablement is for very short periods, and is working really well.

• South Gloucestershire Community Services:

- We can get people discharged from hospital within 24 hours if suitable. We can conduct a 'meet and greet' within this timeframe. This initial assessment is where the initial goals of the individual is discussed and agreed. From day 1 we look at what, if any, adaptations or aids may be beneficial and have regular contact with the professional key worker. We can usually get most equipment or aids required within 24 hours.

'Pathway 2' Reablement services:

- To get patients out of hospital in a timely manner we ensure our beds are turned around quickly and liaise with the hospital discharge teams.
- We liaise with the patient, their families and social services to plan discharge.
- We start goal setting immediately that someone arrives on the unit.
- The ethos of our unit is such that the whole therapy team work together to ensure a fast turnaround.

3.2.2 Are there any advantages or rewards for trying to work in an integrated way? What 'evidence' do you have to show how your work brings benefits or has impact?

Health and Wellbeing Service, for sheltered housing tenants:

Case Study (North Bristol), from Janice Clements:

Tenant X began his tenancy in 2007, used a mobility scooter, went out daily, and was very friendly and polite although he had a history of drinking. Over the years his alcohol addiction worsened and he became less engaging. He'd previously been hospitalised and was discharged with a care package. He continued to drink but was in denial that there was a problem. Site staff tried to engage with him, however he insisted he was managing as he had carers. After further investigation, we found he had cancelled his care package and had also stopped taking vital medication. He started to isolate himself, only going out to buy alcohol and tobacco. He'd stopped allowing his cleaner to go in to his flat and, despite staff and his daughter pleading with him to accept help, he declined.

Following a desperate plea by his daughter who had a difficult relationship and was medically unfit herself, I became involved with his case in December 2016.

His flat was in a terrible state with empty bottles and piles of unopened dosset boxes. Reluctantly he did agree to have his flat deep cleaned and for us to contact his GP for a medical review.

After the deep clean he continued to drink, not eat, was extremely unwell, resulting in an ambulance being called and admission to hospital.

Discharge planning started and he was still insisting he had carers and was able to manage alone. A hospital Social Worker was assigned and during a best interest meeting we were able to pass on our concerns about his suitability to return to sheltered housing and to continue his existing lifestyle.

A joint best interest decision was made to move him to a care home for a permanent placement.

At that time he was deemed not to have capacity to make decisions regarding his health and accommodation. This presented a problem as he was unable to end the tenancy on his flat and there was no Power Of Attorney. Potentially his case could have been referred to the Court of Protection resulting in long delays before end of tenancy and rent arrears.

I visited him at the care home to discuss ending his tenancy with us. He was coherent and able to have a conversation. His drinking and smoking had also stopped. He agreed to sign his end of tenancy and paid for flat clearance.

Outcome:

Tenant X is now living in more suitable accommodation where his care needs are met. He no longer drinks or smokes and both mentally and medically is in a much better place. His daughter is now able to maintain her relationship with him.

We were able to avoid a lengthy Court of Protection application which could have resulted in large rent arrears for Tenant X.

Case Study (South Bristol), from Sophie Hill:

Tenant Y is 81 years old, has sight and hearing sensory impairments, is prone to falls and gets very lonely. Tenant Y had expressed a desire to move on to housing with more support. Initially Tenant Y wanted to move to Wales to be closer to her son. I visited her and she showed me a letter from her GP stating she is prone to falls and she needed extra support. Site staff said her son claimed to be dealing with it and was looking into residences near his home.

A couple of weeks later Tenant Y had left her flat together with most of her belongings.

We learned her son had taken her to Wales to live with him, we didn't know if this was a permanent or temporary solution. After a couple of weeks Tenant Y returned to her flat in the early hours of the morning with no food, insulin and her property wasn't in its usual manner, with belongings strewn round the flat creating a hazardous situation.

Soon after returning Tenant Y was admitted to hospital after a fall. I regularly contacted the hospital to see how Tenant Y's case progressed and when she was allocated a social worker I introduced myself and my job role. The social worker discussed with me his plans for discharging Tenant Y with a care package. At that point I mentioned to him about Extra Care Housing (ECH) as Tenant Y had indicated she wouldn't feel safe returning to her flat. He also agreed this would be a better option for Tenant Y and discussed this with her. He informed me that from his point of view he has only ever put hospital patients on the waiting list for ECH and then the brokerage team would deal with it once they have been discharged. As I knew there was a place available at ABC (One of Brunelcare's ECH sites) I was able to start the process for an internal transfer. As Tenant Y was medically fit for discharge, the brokerage team continued to obtain a care package for her to fill the period between her being discharged and moving on to ECH. This could have resulted in a delayed discharge as they were struggling to find a care provider.

However, as I was able to offer an internal transfer she was able to move from hospital straight into ECH.

It was a week before Tenant Y was able to be discharged from hospital and move into her property at ECH. During this week Tenant Y's possessions were moved over to the property, medical records were sent to the local GP and district nurses were arranged to administer insulin. The care plan was also put together by the Brokerage team in social services. After that, carers were rotated in place to deliver Tenant Y with support she needed in order to be discharged from hospital.

Conclusion:

I picked Tenant Y up from the hospital and took her to view the property and the son met us there. They were both very happy and signed them up there and then to move into the ECH flat.

Falls management:

- All of the information and data we have been able to evidence in this report underpins the benefits of our falls management process and the impact upon secondary healthcare services.
- Feedback from Public Health England (Bristol) demonstrates the very positive way that our work has been viewed by external professionals, in that Brunelcare is regarded as a credible champion with regards falls management and running care homes.

End of Life care

Testimonial provided by Dr Andrew Taylor, Stockwood Medical Centre, Bristol:

“A few years ago we started performing regular planned visits to [Brunelcare] Robinson House Nursing Home as part of our service to patients there. It quickly became apparent to the manager of the home and I that there were lots of residents being admitted to hospital with little or no clinical benefit for them or their quality of life. Patients with irreversible conditions such as end stage dementia or severe disability from previous massive stroke or cancer were admitted to hospital without any improvement in their long term condition. More important was these visits to hospital were often distressing as modern hospitals are there to treat acute reversible severe illness and are noisy busy places with staff members understandably focused on improving the physical condition as quickly as possible of those under their care.

We have of course had discussions with patients or patient’s relatives or other teams about patients’ futures but this was not formalised or regularly done. We decided this was something that we could do better to make patients comfortable and peaceful at the end of their life, particularly as patients are often going into hospital and dying in an unfamiliar surrounding having been removed from the carers that were looking after them in their home.

We decided we needed to be much more proactive in planning end of life care so that patients could spend their last days in the comfort of familiar surroundings with carers who knew their needs well. This was achieved by writing an informal agreement between doctors and nurses and families for those without mental capacity to make their own decisions should their physical condition suddenly deteriorate. A decision was recorded that it was felt by all involved that continuing care in the nursing home environment would be better for them and avoiding a medical admission where possible would be an improvement in their care. The forms enabled and encouraged this process and meant we had these discussions more openly and more frequently and more effectively. We noticed dramatic reduction in hospital admissions.

Over time this process has evolved so that documentation has generally improved in the nursing records and in the GP records. From an early stage of the patients stay in a nursing home an open and frank discussion about end of life care is had when appropriate. From the GP point of view this has helped improve the care we offer patients and has made us think about end of life care issues for patients early on. This has made decision making easier during an unplanned crisis. I hope this has led to less patient distress at the end of their life and less importantly has saved resources for the health community as a whole.”

Homecare and Community Reablement services:

- **North Somerset Community Services:**

- Review information after a client has been in hospital and the work done to get them home.
- Feedback from Commissioners, Healthcare Professionals, and Clients.
- Ability to get a client home as quickly, smoothly and safely as possible.
- Build good partnership relationships.
- Improve company reputation.
- Enhanced skills and training for staff.

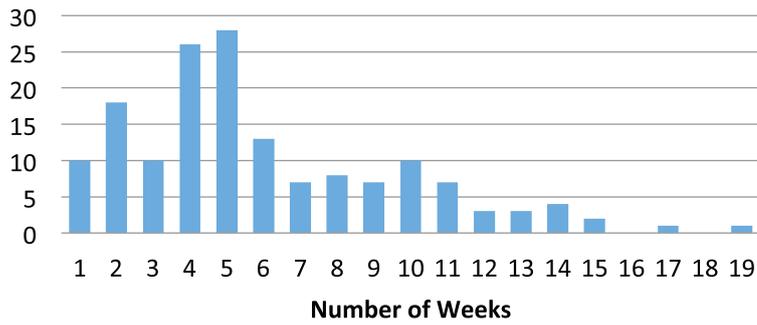
- **South Gloucestershire Community Services:**

- We keep records of the length of stays on our service which flag red after seven weeks. We have records of the reduction in hours from start of service to end.

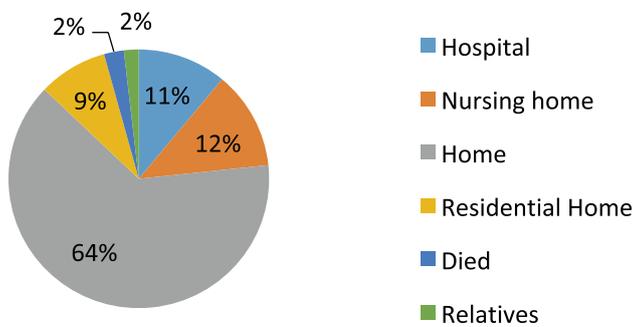
'Pathway 2' Reablement services:

- We monitor delays of transfer of care and send this information to the commissioners.
- We have figures for our average length of stay to show our turnaround times (Average length of stay is 41 days):

Length of stay of Bristol Guests



Destination of Bristol Guests



3.2.3 What difficulties have you come across or overcome? Are there any barriers or disadvantages to trying to work in an integrated way?

Health and Wellbeing Service, for sheltered housing tenants:

- Delays tend to be around social care.
- Obtaining short-term and long-term placements.
- Care package providers not having the capacity to meet demand.
- Social Workers not always want to engage, but this is improving.

Falls management:

- There has been some resistance to listening to what has worked well for us from some providers but on the whole sharing our practice has been positively received.

Homecare and Community Reablement services:

- **North Somerset Community Services:**
 - During hospital assessments, it is clear sometimes that the client is actually not medically fit to be discharged. This wastes time.
 - Time delays in getting equipment at home ready for the client to be discharged.
 - The discharge team don't always understand the limitations that the provider has in regards to manual handling or administering of medication which can cause some disgruntled feelings.
 - Not everyone can work well as a partnership and ego can get in the way.
 - Relatives and loved ones can sometimes have expectations for the client that are not realistic and push for something that can't be achieved or that the actual client doesn't want for themselves. This can become awkward.
 - Joining up everyone's availability can be difficult with workloads and other commitments. This again can cause delays.

- **Somerset Community Services:**
 - Difficulties in liaising with a large team, occupational therapists, physiotherapists not always available. Hospital transport does not always turn up on time. Communication between all members of the team could be better.
- **South Gloucestershire Community Services:**
 - The time it takes for an ongoing package of care from a long term domiciliary care team to take over.
 - Lack of availability within social care.
 - The general understanding of the reablement service from the client and their families.

'Pathway 2' Reablement services:

- Waiting for a package of care to become available.
- Waiting for home adaptations and for deep cleans to be carried out.
- Managing expectations of family.

4: Conclusions and recommendations

A summary of the Working Group's shared conclusions and recommendations, after collaborating to produce this report.

Conclusions

- This report demonstrates that Brunelcare and its partners are working effectively together in many ways, notwithstanding very significant pressures of resources and demand in health and social care. (This supports Summary 2 and Key Finding 8 of the NAO report.)
- This joint working has been better informed by the development of this report, the information gathered for it and the time taken to share lessons and reflect on current practice.
- Brunelcare itself is seen by its partners as a person-centred organisation with good values and committed staff who work hard to provide the best possible service within available resources. (This supports Summary 1 of NAO report.)
- Integration of health and social care is not solely brought about by government policy or reports, but by agencies and individuals working imaginatively at a local level. (This supports Key Finding 12 of NAO report.)
- This local work has produced demonstrable benefits in quality of life for Brunelcare's residents, tenants and patients – as well as a better use of scarce resources.
- However it has been necessary to target existing resources and some project funds in order to help overcome institutional, organisational and process boundaries within a complex system.
- In relation to the NAO Health and Social Care Integration report, Brunelcare can evidence that:
 - Summary 1 - People using our services are continually placed at the centre of the design and delivery of care/support with an outcome focused approach.
 - Summary 2 – Because of our approach to partnership working, people receive the most cost effective care, when and where they need it.
 - Key finding 12 – New ways of working are continually developed across Brunelcare and these have led to successful integration.
 - Key finding 18 – Brunelcare have case studies and hard data available in order to measure the effectiveness of initiatives that promote integrated working with Health and Social Care.

Recommendations

- That the positive initiatives and the key findings described in this report are summarised and shared at senior level in the relevant health and social care organisations
- That Brunelcare considers developing a set of specific investment proposals for health and social care commissioners that build upon the successes evidenced in this report.
- That Brunelcare also considers how best to make available sufficient resource to ensure it is making its maximum contribution to the better integration of local health and social care services.
- That Brunelcare continues to lobby with its partners for improved resources to be made available to support the integration of health and social care in the local area.

5: Report's key findings

- Brunelcare is recognised as being at the forefront of new, innovative initiatives and the work detailed in this report highlights those that have been particularly successful.
- There are many best practice initiatives described in this report that have led to improved outcomes for the people accessing services from Brunelcare. Examples from the Falls Project, End of Life Care work, Pathway 2 and Reablement and the Health & Wellbeing Officer pilot all provide a picture of best practice that is to be commended.
- With Brunelcare's falls management expertise, we can evidence an innovative and outcome-focused falls management system within our own care homes. Our Council funded Falls Management project, led by Brunelcare, was also successful in improving the management of falls in many homes in Bristol; with evidence generated from this project enabling further funding to be secured from NHS England for further work on Falls Management in Care Homes.
- The Falls Management Project also highlighted to us that sharing work and best practice initiatives with other providers and colleagues from health and social care has been a valuable way to stimulate integrated working.
- Working in line with the Gold Standard Framework (GSF) Guidelines for End of Life Care encourages us to continue working in partnership with our partner GP practices across the homes. A fundamental requirement of meeting the GSF accreditation standards is to demonstrate a multi-disciplinary approach. Working in this way, we follow best practice guidelines and work collaboratively with our fellow professionals. This, in turn, impacts upon our colleagues in the NHS as we manage expected deaths effectively in the Care Homes thus reducing costly hospital based care.
- Providing person-centred care: Putting the people using Brunelcare's variety of care and support services at the centre enables a person-focused and evidence based framework of excellence to exist. The challenge, moving forward, will be to maintain and develop this framework so that more people can benefit.
- We evidence the innovation and impact delivered by the role of Brunelcare's new Health & Wellbeing Officers, initially funded by Bristol City Council's 'Supporting People' pilot scheme. This helps our 1,000 sheltered housing tenants to gain better access to the range of health and social care services available to them from Brunelcare, the NHS and their local community.

- Management challenges for Brunelcare charity to progress integration are significant in terms of the resources required – in terms of people, time and money. In this respect we also acknowledge that high levels of collaboration are currently limited by the care sector’s funding crisis.
- Continued integrated working is key to the maintenance of excellence and the provision of seamless health and social care. Challenges and solutions can be overcome by all to ensure that peoples changing health needs are met if partnership working across the sectors is encouraged and adopted as the norm.
- Brunelcare is seen to be reducing the financial burden on the NHS, particularly the expense of hospital bed care, by avoiding hospital admissions and helping reduce delay of transfers of care. This also means more acute hospital beds are available to those most in need. For example, our Health & Wellbeing Officers evidenced a notional saving to the NHS of approx.. £179,600 in hospital bed care due to the reduced hospital stays enabled for our housing tenants in a six month period, comparing 2016 and 2017.
- In 2014 Brunelcare worked with Clinical Commissioning Groups to develop Brunelcare’s Orchard Grove Reablement Centre where patients who no longer need a hospital bed but are unsafe to return home, stay and receive care and support before returning home safely. As the first ‘Reablement Centre’ created by an independent provider (and registered charity) in Bristol in 2014, Brunelcare’s Orchard Grove Reablement Centre evidences how it continues to make a difference. To get patients out of hospital in a timely manner we ensure our beds are turned around quickly and liaise with the hospital discharge teams; our average length of stay is 41 days. We monitor delays of transfer of care, sending this information to the commissioners.
- Inadequate provision of social care. This appears to be a major issue for all the different care sectors and its impact is substantial, both on the services and their service users.
- Brunelcare acknowledges and agrees with the key findings in the National Audit Office’s report dated 8th February 2017, entitled ‘Health and social care integration’. In particular, acknowledging that we operate in a sector with a rising demand for services, and that as a care provider we are coping with ever increasing numbers of clients waiting for a care package in their own home or waiting for a nursing home placement. We also support the NAO’s finding that expectations of the rate of progress of integration are over-optimistic. We agree that embedding new ways of working, developing trust and understanding between organisations that work together to provide care is vital to successful integration. Finally, and this also defines Brunelcare’s approach to care, we agree that integrated care should be entirely focused on the patient’s wishes and needs.

Appendices

Appendix 1: Selected items of media coverage about 'avoiding hospital admission'

National Media:

5th April 2017: Local Government Association: 'LGA responds to new House of Lords Select Committee report on sustainability of NHS', see:

<http://www.local.gov.uk/about/news/lga-responds-new-house-lords-select-committee-report-sustainability-nhs>

March 2017: LGA: '2017-19 Integration and Better Care Fund Policy Framework', for those involved with delivering Better Care Fund at a local level, includes the overall metrics, see:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/605164/Integration_and_BCF_policy_framework_2017-19.pdf

31st March 2017: Major reform of social care funding and provision is needed, say CLG Select Committee, see: <https://www.parliament.uk/pa/cm201617/cmselect/cmcomloc/1103/110302.htm>

Covered 31st March 2017 by: Daily Mail, The Daily Telegraph, The Sun

9th March 2017: The Daily Telegraph: '£2bn to tackle growing crisis in social care for the elderly' see:

<http://www.telegraph.co.uk/news/2017/03/08/philip-hammond-pledges-extra-2-billion-help-tackle-social-care/>

8th March 2017: Spring Budget 2017: Government's announcement to allocate £2 billion to social care over the next three years with £1 billion being made available immediately, as well as the recognition of the need for a long-term plan.

8th February 2017: National Audit Office: 'Health and social care integration. The Better Care Fund has not achieved the expected value for money, in terms of savings, outcomes for patients or hospital activity.' See:

<https://www.nao.org.uk/report/health-and-social-care-integration/>

16th Dec 2010: The Kings Fund: 'Avoiding hospital admissions. What does the research evidence say?' see:

<https://www.kingsfund.org.uk/publications/avoiding-hospital-admissions>

Local Media:

3rd-5th Mar 2017: Bristol Post: 'The fight to save the NHS starts now'

10th-12th Feb 2017: Bristol Post: 'A&E waits 'worst in the Country' – Weston General Hospital

Sector media:

31st March: British Red Cross: 'Home from hospital: simple measures that make the world of difference', see:

<http://blogs.redcross.org.uk/health/2017/03/home-from-hospital-simple-measures/#more-49190>

Appendix 2: Selected items of media coverage about 'reducing delays to transfer of care'

National Media:

1st Feb 2016: The Guardian: 'NHS and social care must not play the blame game on delayed discharges.', see:

<https://www.theguardian.com/social-care-network/2016/feb/01/nhs-social-care-delayed-discharge-hospitals>

Sector Media:

4 April 2017: National care Forum Members Weekly Update: 'Integrated Health and Social Care: 2020'

March 2017: Care Management Matters: 'Slow progress on integration' (page 9)

8th Feb 2017: Nuffield Trust: 'What's behind delayed transfers of care? Nigel Edwards explores what the data tells us about delayed transfers of care and busts some myths about how to prevent them.' See:

<https://www.nuffieldtrust.org.uk/resource/what-s-behind-delayed-transfers-of-care>

1 Nov 2013: NHS England: 'Integrated care pioneers announced. Fourteen areas leading the way in delivering better joined up care', see:

<https://www.england.nhs.uk/2013/11/interg-care-pioneers/>

May 2013: NHS England: 'Integrated care and support. National collaboration for Integrated Care and Support.' See,

<https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/>

13 May 2013: Department of Health: 'Integrated Care: Our Shared Commitment', see:

<https://www.gov.uk/government/publications/integrated-care>

2013: National Voices, commissioned by NHS England 'A Narrative for person-centred Coordinated Care' (National Voices, a national coalition of health and care charities, has developed this 'narrative' on integration (also available as an easy read version) which gives an agreed definition of what we mean by 'integrated' care. It provides a guide to the sort of things that integrated care will achieve, such as better planning, more personal involvement of the person using services, and free access to good information. It also provides some clarity over what local areas should be aiming to achieve practically, in their efforts to integrate services. See also: www.nationalvoices.co.uk and www.thinklocalactpersonal.org.uk (useful case studies)

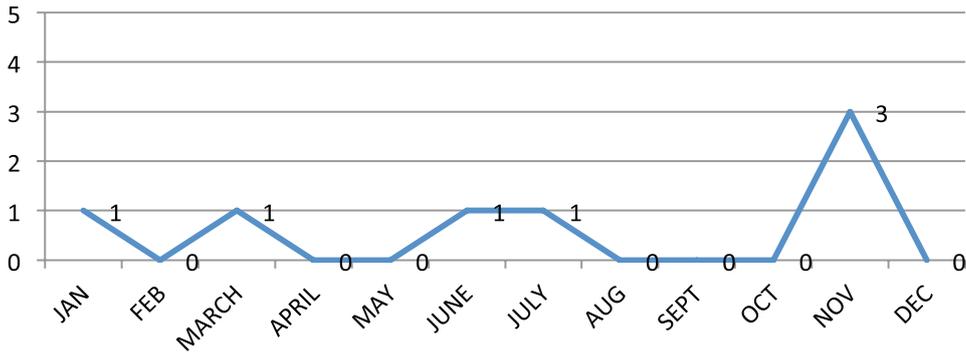
Local Media:

9th Feb 2017: Bristol Post article 'Woman's six-month hospital stay: 'Social care needs more resources'

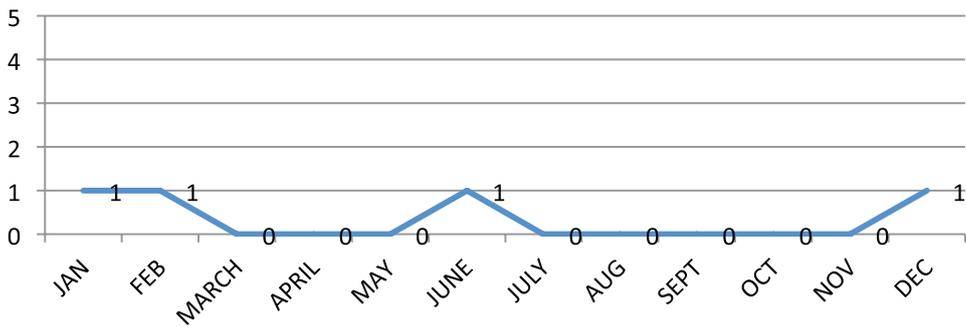
Appendix 3: Falls Management and End of Life Data Charts

Orchard Grove Reablement Centre have fully utilised the plotting, mapping and safety cross tools and evidenced a 43% reduction in post fall fractures from 2015 to 2016 thus reducing the number of hospital admissions.

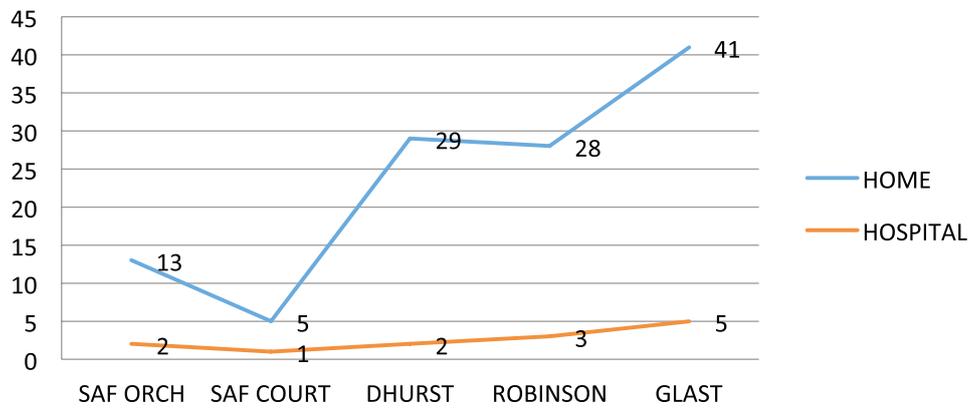
Falls resulting in a fracture, Orchard Grove Reablement Centre, 2015



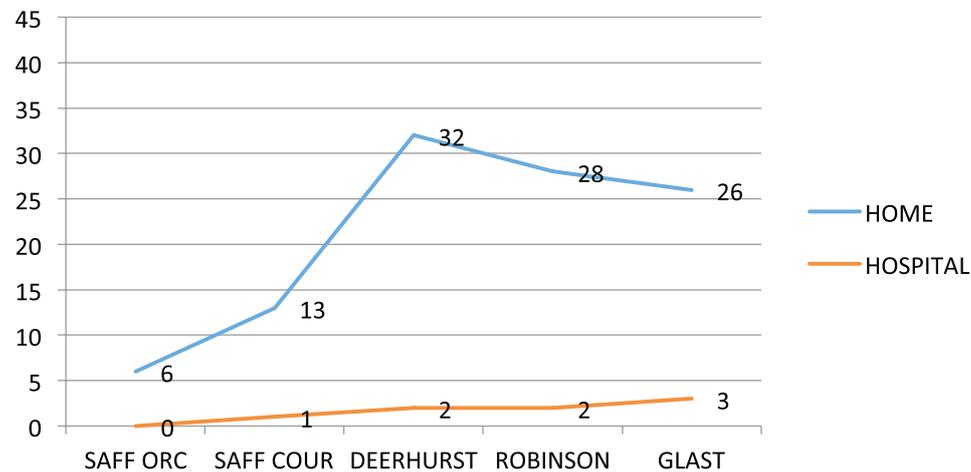
Falls resulting in a fracture, Orchard Grove Reablement Centre, 2016



Deaths in Brunelcare Care Home v Hospital Jan - Dec 2014



Deaths in Brunelcare Care Home v Hospital 2015



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