Better Care Fund Bristol

- Capital investment for improving housing conditions
- Improve Wellaware and digital information and signposting and reducing digital exclusion
- Greater education of general public about what interventions are available
- Clothing and social inclusion
  - Able to go out regularly and meet people
- Professionals in health and social care must be made more aware of what’s available in the community. But currently there’s no single resource that provides this, local knowledge is
- Career assessments being standard
- Calling information BK displays in Doctors surgeries re: Voluntary help available
- Befriending resources
- Some kind of assistance in reconnecting with old friends and interests and building up new ones
- Professinals in health and social care must be made more aware of what’s available in the community. But currently there’s no single resource that provides this, local knowledge is
- Close links between community groups, community health and social care to enable isolated older people/people in residential provision to accommod community
- Central pool of accessible community provision
- Care co-ordinators to work across health and social care C+vol sector services
Better Care Fund Bristol

Involving Irene in community groups outside of dementia community – will maintain links beyond Bobs life

Provide clubs, home visiting systems where the elderly support each other and enabling learning classes. Further education can possible bring back classes which

Better education and information to guide older people

Thinking differently about what the outcome of a services intervention achieves

1 x care plan with access for professionals involved

More information/services available to people about what is available in their community

Knowlegable links within the community who can signpost people to support services available

Community link worker

More multi-purpose health centres with accessible social prescribing

More low cost accessible arts/exercise/social and wellbeing activities and groups based in the heart of the communities

Communication is an important issue plus information how will people know what help they can get? It could be doctors surgeries notice boards

Get the signposting right, but make sure that services people are signposted to are sustainable. Don’t cut

Better transport links for elderly isolated people who are lonely or care for somebody etc

Better

Communication

Transport

Links

Connect

Health

Centres

Multi-purpose

Social prescribing

Low cost

Activities

Groups

Art

Exercise

Wellbeing

Signposting

Sustainable

Funding
**Better Care Fund Bristol**

<table>
<thead>
<tr>
<th>Person not service approach</th>
<th>Joint funding tool – to assess contribution from the two streams</th>
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<tr>
<td>Integrated services</td>
<td>Better links between landlords and health and social care</td>
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<tr>
<td>Care plans patient/carers</td>
<td>Access to information improved. Communication between professionals</td>
</tr>
<tr>
<td>Care plans that are:</td>
<td>More preventative community support for social</td>
</tr>
<tr>
<td>Focused on prevention</td>
<td>Respite is very important for carers</td>
</tr>
<tr>
<td>Client driven</td>
<td>7 Day working</td>
</tr>
<tr>
<td>Regularly reviewed</td>
<td>Care co-ordination/information sharing</td>
</tr>
<tr>
<td>Acted upon</td>
<td>Prevention – moderate to be included on legibility criteria</td>
</tr>
<tr>
<td>A single health/care ‘navigator’ who helps the individual with info and directions</td>
<td>O.T access adjustments to home to enable ongoing life</td>
</tr>
<tr>
<td>The individual having a central point to all decisions – real say</td>
<td>Work to make Arts on prescription &amp; other social prescribing more accessible and friendly through Bristol Lift (potentially a barrier to access)</td>
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<td></td>
<td>People with multiple health conditions need support to be able to have all their needs met locally</td>
</tr>
<tr>
<td></td>
<td>Carers – essential to have assessment and then services to meet there needs to prevent escalation to crisis point</td>
</tr>
<tr>
<td></td>
<td>24hrs seven day per week service in health and social care</td>
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<tr>
<td></td>
<td>More flexible purchasing policies to allow Bob and Irene to buy services for their daughter to involve their daughter to be more included in their care (potentially providing respite)</td>
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<td></td>
<td>Better education, communication and pooled reviews</td>
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<tr>
<td></td>
<td>Better dementia training across H&amp;SC start early –eg. In college/uni as people are starting their core training. Make it compulsory</td>
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<tr>
<td></td>
<td>Older people will include older carers who may be also caring for an older person as well and also mutual caring and we need to</td>
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**Health Services & Social Care**

- **Joint funding tool** – to assess contribution from the two streams
- **Better links** between landlords and health and social care
- **Access to information improved. Communication between professionals**
- **More preventative community support for social**
- **Respite is very important for carers**
- **7 Day working**
- **Care co-ordination/information sharing**
- **Prevention – moderate to be included on legibility criteria**
- **O.T access adjustments to home to enable ongoing life**
- **Work to make Arts on prescription & other social prescribing more accessible and friendly through Bristol Lift (potentially a barrier to access)**
- **A planned systematic involvement of the voluntary sector support so that it is integrated into a care plan**
- **Complete and informal assessment of exactly what Bob & Irene want with that single assessment being used for access to all services and help**
- **Carers need respite/breaks to enable them to continue to care. This could be residential or in house but there needs to be a real choice**
- **Irene needs home care**
- **Reassessment for her regular health & social care needs**
- **Bereavement counselling**

- **Knowledge of services, organisations etc**
- **Developing Wellaware making it part of GPs, carers, social services etc life**
- **More acknowledgement with funding of the problems of social isolation e.g befriending services that visit the home, not just on the phone, and more transport to groups or other social opportunities**
- **More flexible purchasing policies to allow Bob and Irene to buy services for their daughter to involve their daughter to be more included in their care (potentially providing respite)**
- **Better education, communication and pooled reviews**
- **Better dementia training across H&SC start early –eg. In college/uni as people are starting their core training. Make it compulsory**

- **Older people will include people with Learning Difficulties – we need to have services that meet their needs**
- **Better links between landlords and health and social care**
- **Accessible arts on prescription**
- **Resolving the challenges of data sharing reduce duplication and inaccuracy**
- **Prevention – moderate to be included on legibility criteria**
- **O.T access adjustments to home to enable ongoing life**
- **Work to make Arts on prescription & other social prescribing more accessible and friendly through Bristol Lift (potentially a barrier to access)**
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Better Care Fund Bristol

- Carer identification in primary care (Gp surgeries) increased signposting and referral to support services
- Info shaped by all professions but co-ordinated by one
- More resources in re-enablement for everyone
- Communication of processes for all involved
- 7 day working for all services (but define carefully what this means)
- Integrated care coordination for people with long term conditions to cover social and health care (inc CHC funded needs)
- A care/support co-ordinator based in each GP practice who can care plan the wider needs of patients with complex medical/social problems
- Continuation of funding for breaks/support for carers post 2014 – through better care fund as this has achieved many positive outcomes for carers
- Integrated health & social care plan leads to a personal budget and access to a pooled budget to meet needs flexibly
- Connecting care is an opportunity
- There is a high need to share information to create the shared health & social care plan, between health, social care and VCS staff and housing
- Many people with learning difficulties are now getting older
- Better holistic assessment and care co-ordination in care
- 3 priorities
  - One stop shop for self-assessments
  - One funding stream for H&SC
  - More flexibility in services
- Making care professionals aware of all available interventions
- Information at doctors surgery of what is available if someone needs care or support
- More streamlined assessment
- Waiting times shortened to access services
- Care co-ordinators - very important to try to ensure it’s the same person all through the process so often with care packages a different person every week
- Joint care management and commissioning for CHC
- Care plan facilitator who can address the mental/social/personal aspects of the person’s life
- Better joining up of health for care resources where patient needs both
- Co-ordinator in the community/Gp to give a more holistic approach and person centered care plan
- Culture change for both hospitals and councils
- What resources ie staffing will there be within BCC to implement these changes and communicate them to staff? Back office staff are currently being reduced
- Questions about who will fund what hold things up – streamline – make processes clearer
- Individual risk assessment and appropriate preventative care package
- Keyworking/care co-ordinator role essential
- Ability to track a patient journey in real time
- Early provision/introduction of support for dementia
- Better future planning with people for when health deteriorates
- Not over rely on IT have a friendly voice at the end of the phone
- Culture change for both hospitals and councils
- Integrated care coordination for people with long term conditions to cover social and health care (inc CHC funded needs)
- What resources ie staffing will there be within BCC to implement these changes and communicate them to staff? Back office staff are currently being reduced
- Questions about who will fund what hold things up – streamline – make processes clearer
- Individual risk assessment and appropriate preventative care package
Greater consistency in involving carers as expert partners in care and discharge planning, to avoid unnecessary re-admissions and caring situations from breaking down.

Pooled budgets for hospital discharge and services up to 6 weeks.

Hospital consultants need to be on board and read only health support plan and not do things already discussed as.

Information sharing – hospitals maintain info about Irene so when she is admitted again they know her needs. Look at Cardiff university hospital for medicine passport/message in.

Better communication from hospital to community services to prevent readmissions.

Common discharge hub, cross health and social care (third sector) Cross local authorities (north Somerset, Bristol, South Glos.

Assessments to be carried out earlier in hospitals to ensure more planning and avoid last minute plans for discharge.

Hospitals working in partnership with VCS, social services to facilitate discharge – education and training for staff working in frontline active services.

Weekend service provision.

Close link between hospital, community care (paid or voluntary) and family.

Re people leaving hospital they should have all the aids and support in place before leaving hospital.

Hospitals need to have a good level of knowledge of services available outside of NHS break down.

Current barriers.

Health, Housing and support co-ordinated by one person.

Break down barriers between organisations/teams one assessment.

Hospitals communicate with family/carer about assessment, diagnosis and discharge. Hospital staff talk to each other.

Better Care Fund Bristol
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<tr>
<th>A system wide approach that puts the needs of the individual before those of the various organisations</th>
<th>A system that functions 24/7</th>
<th>Training for staff, providers, family and professionals</th>
<th>Need to consider how CHC funded are included</th>
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<tr>
<td>Early prevention intervention</td>
<td>Care/support facilitator who can be central point of contact Take lead in delivery of all services to the individual Able to assess, commission and monitor all services</td>
<td>Adaptation to the house and use of assistive technology</td>
<td>More IT services computer training/access</td>
</tr>
<tr>
<td>Overall system management to ensure that changes are tested and reviewed for wider impact</td>
<td>Central, outline comprehensive care and social support plan</td>
<td>Person centred not service led</td>
<td>Single Co-ordinator for individuals</td>
</tr>
<tr>
<td>The patient does know best</td>
<td>Grab the opportunity to change and make it happen ensure Bristol are at the forefront of change and make a difference</td>
<td>Empower people to be involved in decisions about how care provided – people own their care plan (just one)</td>
<td>Making service’s cost effective for all (even people who do not get help from benefits who normally can’t access them because of price</td>
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<tr>
<td>Be absolutely committed to making change – determined to do it</td>
<td>Be clear about knock on consequences of changes – impact on other services</td>
<td>A cohesive, joined up approach to planning and service provision, which is flexible to changing needs at different times</td>
<td>More preventative support. Care plan which is controlled by the individual and supported by professionals</td>
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<tr>
<td>The patient should have support to meet key obligations eg planning for EOL</td>
<td>Mutuality and systematic thinking</td>
<td>If it is unavoidable that someone needs to go into care then the quality of life in the care home is good</td>
<td>One person who is the point of contact (i.e. not 10 different people) fewer assessments, easier to get help. Idea of an event where older people can get information</td>
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I feel that there is an ongoing role which would provide continuity for Irene, in the form of a diabetes nurse service. This could provide support in the home potentially, and could also be the key worker who writes and updates the care plan.
Better Care Fund Bristol

Multi-agency agreement that the care co-ordinator has authority to spend care and direct other professionals to act on behalf of the client.

Use better care fund cash to enable “preventative” assessments for older people to provide interventions that would prevent/defer likely hospital admissions.

At pensionable age invite people to take part in an assessment of what they might need from a range of services and how they make plans for later life.

Linkage and care and repair are very good to help people stay in their own home IE, adaptations. Linkage helps older people to be less lengthy which can help them to their health issues.

Accessible, variable IT structure that can manage one care plan for all health and social care services.

The big picture for individuals

Customer/client/patient choice – based on up to date information empowerment to design support.

Information hub that can be updated by and for link worker/accountable professionals. Sharing data ability – interface systems.

Social prescribing – support and access services and knowledge via GP or social workers or other professionals

Key worker – ensure someone is trusted with making sure things happen and is an advocate for the patient. This can be anyone people to be allocated to resolve issues) and should be a family member.

The helicopter view – overarching view of services

Shared casework/understanding (cultural diversity)

Evaluation of service outcomes

Allocation of monies/resource/joint commission

Includes: health, Social care, housing, patient commitment, voluntary sector

The big picture for individuals

There needs to be a phone number for people to contact if they need help and support. It must be a person at the end of the phone not press 1 press 2 etc. as this puts older people off.

We need to promote individuals writing their care needs down in advance in the way that they would for an advanced direct line ie do I want to remain in my home or go into a care home. Do I want statutory or charitable providers as a preference. Having such aspirations and preferences recorded in advance would be helpful.

Customer/client/patient choice – based on up to date information empowerment to design support.

Develop ECH services out of better care fund as research shows it has clear benefits with NHS.

IT solutions – Shared information/communication

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