



# Heathlands

Governing Body

May 2022



# Heathlands summary

The Heathlands project has been ongoing for nearly 5 years.

- 2017 – initial partnership proposal (Bracknell Forest Council, East Berkshire CCG, Frimley STP and Frimley Health FT) of joint development of a care home in Bracknell. This proposal was intended to help address the rising number of people staying longer in hospital and pressures on acute hospital beds, insufficient care facilities for people living with dementia and rising costs of care locally.
- 2017 - Successful ICS bid for NHSE STP Wave 2 capital funding to part fund the facility with the build led by Bracknell Forest Council.
- 2019/20 - Final Business Case Business case submission. Development of the 66 bedded care facility with 20 intermediate care beds and 46 dementia nursing beds.
- 2021 - Final Business case approved.
- 2019/22 - design of the facility in partnership with provider and commissioners to meet complex requirements of the building , with building complete in March 2022
- Heathlands Intermediate Care Unit beds successfully opened on the 28<sup>th</sup> March 2022.

# Heathlands summary

Heathlands is an Intermediate Care facility built on strong collaborative working between partners in Bracknell and across the ICS.

- This new facility is a bed based intermediate care service that helps people receive well-coordinated and joined up care promoting independence for as long as possible. It offers local rehabilitation to people at risk of hospital admission or who have been in hospital, and aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals or residential care.
- This new offer in Bracknell is provided by Frimley Health Foundation Trust and forms part of the Bracknell Place based vision as part of our Ageing Well programme. The Heathlands beds are complemented by community based services provided by Berkshire Healthcare FT, Bracknell Forest council and the Voluntary and community sectors.
- Following a soft launch, the unit has been operating at full capacity since 25<sup>th</sup> April providing step down care for patients following a stay in an Acute hospital setting, and step up admissions for people who require short term intensive support in the community.

# An early case study: Mrs M

## Aims and objective of Heathlands IC

These are underpinned by a collaborative, partnership approach to patient care.

Heathlands works closely with existing community services in Bracknell Forest to provide a coordinated, integrated and multi-disciplinary team approach across the patients inpatient and community rehab journey.

The new service is therapy-led. The Heathlands team and the Community Enhanced Intermediate Care Team have daily contact, working together with the patient and carers, blurring the boundaries between Heathlands and Community rehabilitation.

For our patients, it's one seamless intermediate care service going further on collaborative working to drive better outcomes and better experiences for our residents.

## Case study abstract

This case presentation is a 90 year old lady who sustained an injury to her prosthetic hip following a fall at home.

The case study follows her progress following her discharge home from hospital and subsequent admission to bed-based intermediate care.

The focus of the study is from the initial home visit by a member of the Community Intermediate Care Team and highlights the main problems encountered by the patient, her goals, the rehabilitation programme and the outcome.

This case study demonstrates how bed-based intermediate care improves outcomes whilst avoiding hospital admission or readmission in this case.

## Client characteristics

- Mrs M is a 90 year old Bracknell Forest resident.
- She lives alone in sheltered accommodation.
- She has good support from her family.
- She has type II diabetes and dementia.
- She has a history of falls.
- She is usually fairly independent and able to walk with a frame.
- She doesn't have to cope with stairs as her accommodation has lift access
- After her latest fall she was admitted to hospital where she stayed for 17 days.
- She fractured her prosthetic hip.
- Her management was non surgical.
- On discharge her family declined home support as they thought they would be able to cope.
- The family agreed to ongoing therapy support at home.

## Step Up admission to Heathlands

- A community intermediate care physiotherapist visited Mrs M in the evening, 4 days post discharge.
- She had deteriorated becoming unwell and her family was struggling to care for her.
- Mrs M didn't need acute care but could not safely stay at home.
- The physio and family agreed to 'step up' her care to Heathlands as she was identified as needing rehabilitation and medical assessment.
- She was admitted to Heathlands the next morning.
- On admission she was confused with very poor mobility and diagnosed with a chest infection.

## Personalised Care Planning

- Antibiotics were prescribed for the chest infection.
- Therapy assessment: Mrs M was extremely fragile and could not carry out basic movement without the support of two people.
- She had a low level of confidence and her exercise tolerance was poor.
- The aim was to improve her:
  - ✓ Chest infection
  - ✓ Confusion
  - ✓ Confidence
  - ✓ Exercise tolerance
  - ✓ Achieve her goals
- As her chest infection improved, so did her confusion.
- Her therapy plan improved her confidence, balance and tolerance to exercise.
- She was introduced to new equipment to support her.
- Heathlands and community teams communicated on a daily basis with a wider face to face intermediate care MDT each week where the transition home was coordinated.
- Her home was prepared ahead of discharge with equipment she was supported to use e.g. bed lever, shower chair, kitchen trolley.

## What's important to me? Personalised goal setting

Mrs M wanted to be able to walk to the communal areas in her sheltered accommodation.

- She liked to watch TV
- Sit in the sitting room to do word searches and read magazines
- Have meals in the shared dining room
- Move around her room by herself; go to the loo, help dress herself and move from her bed to chair.

## Outcomes on discharge

Mrs M could walk with her frame, from her room to the unit reception area, about 20m.

She was more confident in moving around.

Her strength and balance had improved.