GRAY HEALTHCARE

Health and Wellbeing Strategy

Bringing Healthcare Home

Introduction

It is well researched, and evidenced, that people who are identified as having a life-long or long-term condition experience poor health and wellbeing outcomes (Health and Care White Paper, 2021). And, although the Learning from Lives and Deaths (LeDeR) Report 2022 identifies that things are improving for people with a learning disability and/ or autism, the number of deaths due to avoidable causes remains higher than the general population. This figure has decreased from 49% in 2021 to 42% in 2022.

Although the LeDeR report focuses on individuals with a learning disability and/or autism, it is widely recognised that people who experience long-term mental health conditions face similar challenges with their health and wellbeing.

At Gray Healthcare, the people we support face significant challenges in maintaining good health and wellbeing due to several factors:

- Psychotropic medication
- Communication deficits
- Previous trauma
- Physical health
- Mental health
- Comorbidities/ Co-occurring mental health conditions

This Health and Wellbeing strategy demonstrates what we do to mitigate the risk associated with these identified challenges and provides evidence in relation to how we engage those we support and our approach to health and wellbeing throughout the company.

This strategy is underpinned by the Care Quality Commission (CQC) guidance 'Right support, right care, right culture' and enables us to evidence that what we do at Gray Healthcare does in fact deliver a model of support that maximises people's choice, is person-centred and that we have a culture within our company that encourages people to feel confident and empowered. Our strategy towards Health and Wellbeing aims to deliver on the following statement extracted from the LeDeR report 2022:

> 'For the first time, we demonstrate that care packages that meet a person's needs and appropriate use of Deprivation of Liberty Safeguards to deliver care are associated with a reduced risk of premature death.'

Trauma Informed Approaches (TIA) to Health and Wellbeing

Trauma can affect individuals, groups, and communities

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being. (SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, 2014)

Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development (UK Government, Working Definition of Trauma-Informed Practice, 2022).

Society is increasingly understanding that exposure to trauma and adverse experiences, particularly in childhood but in adulthood as well, can increase the risk of serious mental, physical and behavioural health problems throughout life. There is now emerging evidence that providers of services can help to address these traumatic experiences and health effects by implementing trauma-informed approaches to care (SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach,2014). We can all experience these life experiences so, securing time and resources for staff wellness is one essential element to trauma-informed care, not just because supporting staff well-being helps the individual but also supports them in their role of providing high quality support with consistent and predicable environments.

Understanding the effects of trauma and adversity is an important part of providing effective care and support. This is especially true when supporting those with complex health conditions and social needs. Although many TI approaches directly relate to the supported person's experience, they also apply to the organisation as a whole. Not only is it recognised that staff may have experienced challenges in their own lives but there is much evidence to suggest that staff can also experience secondary or vicarious trauma when supporting people who have been exposed to traumatic life events. Staff welfare, with a focus on self-care and well-being is then vital to organisation's ability to provide high quality, consistent and compassionate care.

Impact on supporting staff

We know that without support strategies to help staff, anyone working with people who have experienced trauma and adversity are more likely to be subject to chronic emotional stress; that can negatively affect physical and psychological health.

Impact on providers

Obviously, staff experiencing these conditions may have personal difficulties and as such, are more likely to struggle to provide high-quality care necessary for providing a secure base for positive outcomes. The 'dis-stress' and feelings of not being valued or supported, amongst other things, leads to staff turnover, which can amplify similar feelings in remaining staff teams. With more resources needed for recruitment and training, fewer resources are there for staff and organisational development.

Encouraging staff wellness

Implementing strategies to raise awareness of the importance of self and colleague care help with staff resilience, increase staff morale, job satisfaction, and drive up the quality of care and understanding. In turn, this has the potential to reduce harm and associated costs of turnover. At the time of this strategy being published, 98% of our staff had attended our Trauma-Informed Training programme (December 2024). Staff wellness is a focus priority for our organisation. In addition to an annual appraisal, all staff have regular one-to-one meetings with their line manager (as a minimum every 8 weeks), team meetings every two months and access to incident debriefs if required. These each provide opportunities for discussing staff wellness.

Strategies to prevent secondary traumatic stress, vicarious traumatisation, burn out, should include:

General wellness

Encouraging/promoting activities like yoga, meditation, exercise, nature, expressive arts, etc

Organisational

Nurturing a culture that encourages staff to seek support; keeping caseloads manageable; and providing sufficient health benefits.
Active organisational awareness to new concepts and health and wellbeing innovations.

Educational

Providing Trauma-Informed training opportunities that raise awareness of chronic emotional stress, teamwork, and the importance of self-care.

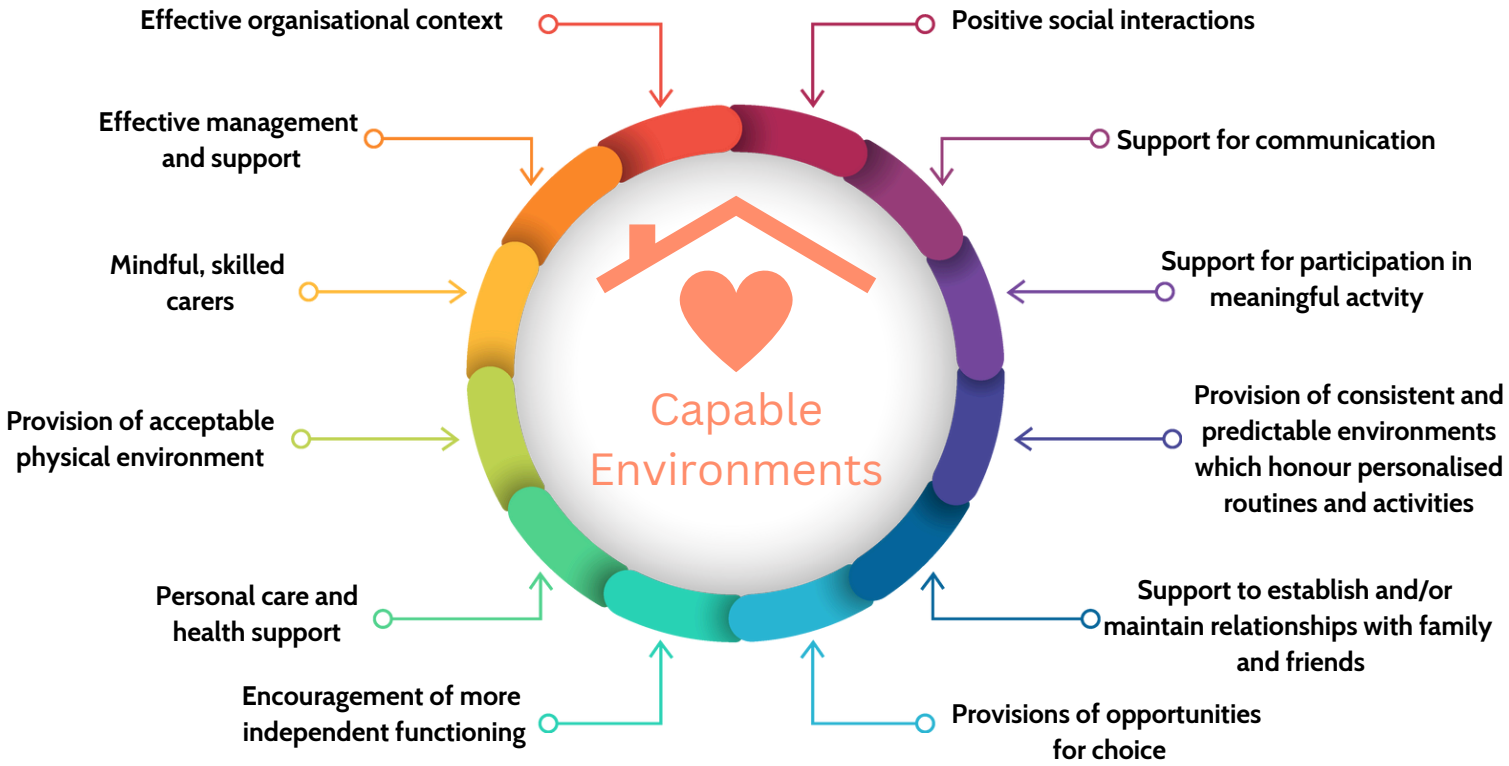
Supervision

Focussing staff wellness through management strategies such as reflective supervision, meaningful 1:1's and appraisals (Trauma-Informed Care Implementation Resource Centre)

Positive Behaviour Support and Environments

The environment in which we live impacts on our physical and mental health and wellbeing, as well as our quality of life. Our Positive Behaviour Support Strategy has identified that the following characteristics are what are required for each of the people we support, and they all have an impact on the overall health and wellbeing of an individual.

McGill et al (2020) identify 12 characteristics for creating a capable environment:



Gray Healthcare strive to ensure that these 12 characteristics are met within each of our support provisions; many of these can be met by the very nature of supporting an individual in their own home. By supporting people in their own homes, we can ensure that the people we support are not restricted, either directly or indirectly, by the limitations of a shared/communal environment.

Effective strength-based and person-centred care planning with a focus on enhancing quality of life aims to ensure that these 12 characteristics are facilitated. Practice Leadership, in conjunction with effective learning and development strategies for staff teams also support the provision of the points noted above. Please refer to our annual clinical outcomes report for our most up-to-date Quality of Life data.

Health and Wellbeing - Physical Health (NEWS2 and STOMP)

National Early Warning Score (NEWS2)

All our support staff, as part of their induction, are trained in the use of the National Early Warning Score (NEWS2). Developed by the Royal College of Physicians, NEWS2 is a system for scoring physiological measurements and improves the detection of any clinical deterioration in adult patients.

All our packages of support are provided with the equipment required for monitoring physical health. Some of our staff teams may only use this equipment for monitoring a person who is displaying symptoms of being unwell so this information can be relayed to a GP, or calls to 111 or 999 as required. Our staff teams use it more proactively to monitor any physical health conditions so that medical intervention can be requested in a timely manner to prevent any further deterioration which may then require a hospital admission.

STOMP

STOMP is a project supported by NHS England and was launched in 2016 following on from the review into Winterbourne View which highlighted concerns amongst others about the use of psychotropic medication for the use of management of behaviours when there was no documented mental health diagnosis.

In accordance with NICE guidelines (Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes, 2015), our electronic medication system enables us to share accurate and current information on prescribed medications with other professionals to ensure that no contraindications exist with current medication when considering prescribing a new medication.

All the people we support are encouraged to attend regular reviews with their GP or consultant accompanied by either a member of their team or family member. This ensures that relevant information is shared, and that changes in medication are added to our Electronic Medication Administration Record (eMAR) in a safe and timely manner.

Should a medication error arise, this is reported through our internal incident reporting systems and if deemed to reach the threshold of Safeguarding then a concern will be raised with the relevant Local Authority Safeguarding Team. Robust measures are in place for medication training for all staff and competency assessments are completed annually to evidence that staff know what medication they are administering, and why. As per the legal requirements of the Duty of Candour, we are open, honest and transparent with the people we support and their families if things do go wrong.

Meeting Physical Health Needs

Gray Healthcare provide a clinically-informed service, and we support a number of people with comorbidities/ co-occurring conditions alongside a primary mental health or learning disability diagnosis. Our staff are provided with training to support people with their physical health needs, this may be through Click Learning or face-to-face training. In addition to this, our care plans are written in accordance with NICE Guidelines and we will liaise with external professionals to ensure that people have access to the correct pathways for the management of their condition.

Examples of the physical health conditions that people we support have are: Chronic Obstructive Pulmonary Disease, Diabetes, Asthma and Heart Disease.

Within our nursing team, we have a Registered Mental Health Nurse (RMN) who is trained in venepuncture. This enables us to offer desensitisation therapies if required, and we have worked closely with GPs to make reasonable adjustments to meet the needs of some of the people we support.

We have introduced a nursing assessment based on the Moulster and Griffiths Learning Disability Nursing Model, 2019. This model is person-centred, outcome-focussed and reflective. This will enable us to monitor changes in the needs of the people we support and this data can be further supported by our Quality of Life measure.

Chronic Obstructive Pulmonary Disease

Approximately 1.2 million people are living with chronic obstructive pulmonary disease (COPD), which is over 30% more than the previous estimations made by the Department of health 2011: British Lung Foundation 2022. The number of people diagnosed has increased sharply by 27% over the last decade from 1600, to almost 2000 per 100 000 people in the UK, and many cases remain undiagnosed (Digital Service to manage high-risk chronic obstructive pulmonary disease (COPD) patients).

We engage with the people we support with COPD by:

- Encouraging them to be active as this can improve breathing and quality of life
- Accompanying them to regular appointments, for example, with the respiratory nurse
- Either collecting their inhalers on their behalf from the pharmacy or supporting them to collect these themselves
- If needed, supporting them to use their inhaler and spacer following EMAR guidelines
- Using NEWS2 to record and detect any deterioration such as a chest infection to enable early intervention. The correct use of NEWS2 can reduce the need for extended hospital admissions/ intensive interventions. In the future, we hope to be able to evidence that this is being used to reduce pressure on 111 and 999 services
- Offering advice surrounding the effects of smoking alongside their COPD and encourage and support smoking cessation

Asthma

According to NHS England Asthma results in about 2-3% of primary care consultations and leads to 60,000 hospital admissions every year in the UK. About 1,200 people are recorded as dying from asthma and many of these deaths could be avoided by taking simple measures to improve care.

The people we support with asthma are more likely to develop serious complications if they contract flu or pneumonia. We engage with the people we support with asthma by:

- Encouraging and supporting them to attend their annual influenza vaccination
- Supporting them to use their inhaler correctly and spacer with the advice from their GP and nurse
- Ensuring our staff are trained in medication administration and know to check information on any new medication to make sure it is suitable for individuals with asthma
- Supporting with peak flow monitoring
- Offering advice and support with healthy eating
- Using NEWS2 to record any concerns or deterioration in physical health, for example, in the event of an asthma attack and contact 111 if necessary

Diabetes

At Gray Healthcare we support people who have a diagnosis of Type 2 Diabetes,. Our staff teams support them to manage their condition with medication and by diet.

All the people we support have a tailored support plan individualised around their Diabetes. They are all supported to collect, or order their medication from their pharmacy and, as they have a diagnosis of Diabetes, they are entitled to a medical exemption certificate. We also support with helping to spot and treat both hypos (low blood sugar) and hypers (high blood sugar).

We engage the people we support with diabetes by:

- Ensuring they attend an annual diabetic review with a doctor or a nurse
- Making sure they have their blood sugar monitored weekly or daily
- Administering medications
- Encouraging changes to diet and activity levels
- Working alongside our Occupational Therapy team
- Making sure they attend regular podiatry appointments.
- Offering emotional support
- Ensuring their staff teams encourage regular brushing of teeth and check for mouth problems associated with diabetes such as gum disease, thrush, and dry mouth.

Case Study - John's Story

Meet John

As a young boy, John's home environment exposed him to multiple adverse childhood experiences, loss and separation. His parents' relationship was described as 'volatile' and ended with John's mother leaving the family home together with his siblings. John was left alone with his father.

At 14, John ran away, leaving his home and father. He spent several chaotic years living on the streets or staying with people that he had met in those early years. During this time, it is reported that he experienced further trauma including physical, sexual and financial abuse. In his late teens, vulnerability, stress and trauma responses combined, and resulted in John becoming unwell. He was admitted to an acute unit and whilst on the ward he was assessed and given a diagnosis of treatment resistant schizophrenia. Due to his symptoms, John was admitted to a secure unit where he remained for over 10 years.

As a result of his experiences, and responses, John's physical health has been affected. John has a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), susceptible to chest infections, and has related heart failure complications. His symptomology, both positive and negative, and his understanding, can affect aspects of his daily living. John is not always aware of signs he is becoming poorly, and those negative responses have an impact on mood, self-care and the ability to act. Understandably, physical health conditions have a direct correlation to mental health outcomes and so, when poorly, this can exacerbate associated symptoms of his diagnosis. John requires medications to optimise his physical and mental health, and these require careful monitoring.

This is the package of support we designed for John...

Clinical Input

Because of his diagnosis of COPD, we included some nursing hours into John's package of support.Our nursing team offer advice on topics such as smoking cessation, good diet choices and the importance of exercise.His nursing team have organised regular appointments with his local COPD nurse and have made sure that he is under the supervision of his local heart failure team.

Our nursing team have trained his support team on the use of NEWS2 to monitor any changes in John's physical health and deliver further training when there is a change to John's prescribed medication. As John has limited capacity, his staff team support him to use his inhaler and listen out for minor changes in his breathing.

Staff monitor John's physical health using NEWS2 daily as per his physical health plan and he must be booked into a GP surgery as an emergency if there is a decline in his mental health as this can be directly related to his physical health.

Shared Interests

John has many interests, so we were able to recruit a team that shared his love of music, films, visiting cafes and going to the seaside.

Accommodation

We worked with John's referring team to find a two-bedroom flat for John in his hometown with easy access to the local amenities. To monitor John's physical health, we equipped his home with a pulse oximeter, blood pressure monitoring machine and a thermometer.

Staff Team

We recruited a new staff team to support John in his own home. Each new team member had prior experience of working with people with mental health conditions.

Training

Each member of John's new team attended our induction week and received training on trauma-informed principles, PROACT SCiPR UK UK® and first aid. In addition to this training, his team received specific training on treatment resistant schizophrenia and COPD. The team also received training on diagnostic overshadowing so they could recognise that a decline in John's mental health could be linked to his physical health. John's team are trained to use NEWS2 (National Early Warning Score) to monitor his physical health at home. NEWS2 is a tool developed by the Royal College of Physicians that improves the detection and response to clinical deterioration in adult patients.

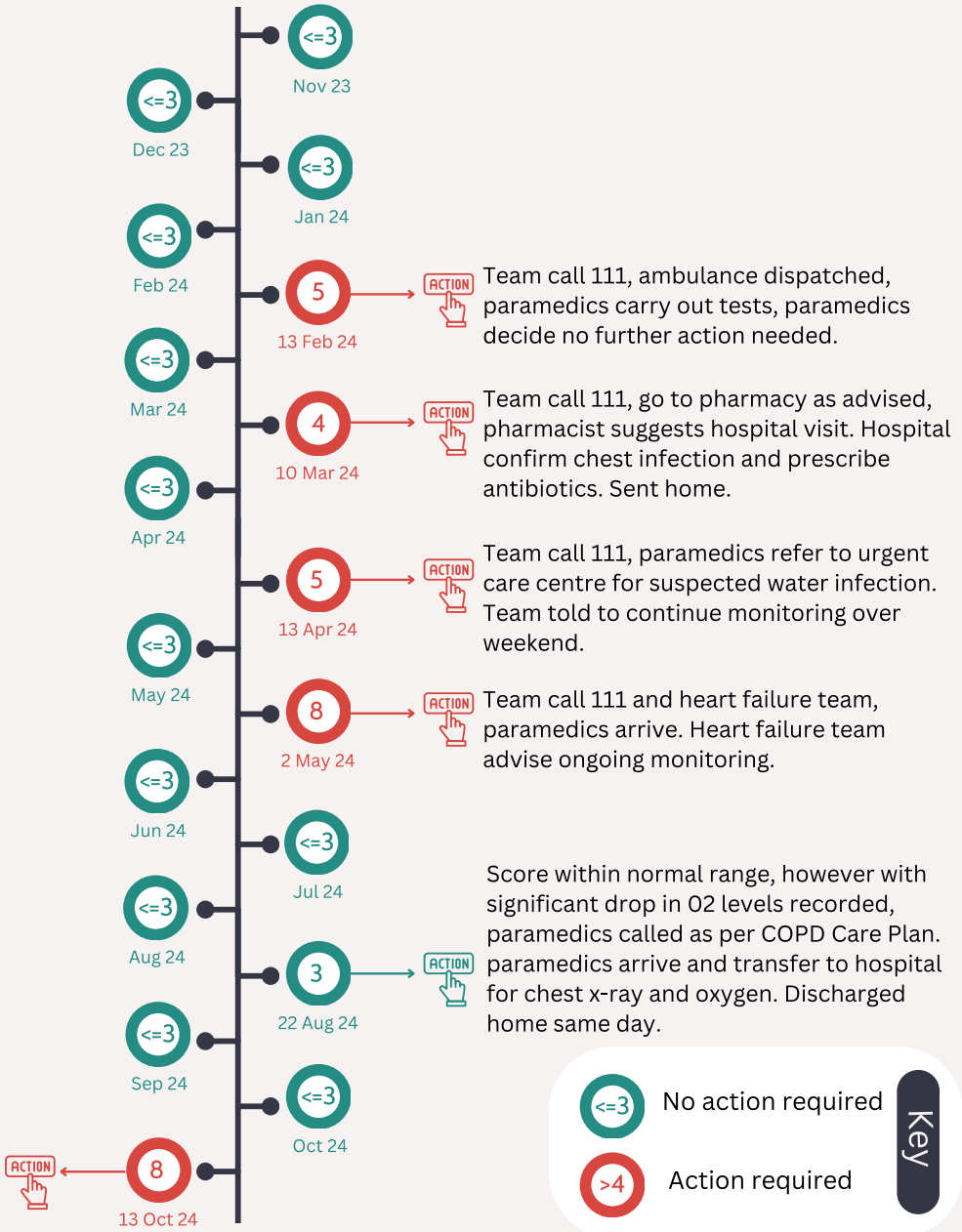
So how is John today?

John still receives support from his team on a 1:1 24/7 basis. However, we reduced his package of support from a waking night to a sleeping night within his first two years with us.

We began supporting John in 2017. John is out in his local community most days. He enjoys going to his local café, to the seaside and keeping his flat nice and tidy. He is now very sociable, and he likes to take an active role in day-to-day routine tasks such as food shopping.

John does have significant physical health challenges. Using NEWS2 his team track his physical health on a once daily basis and more regularly if required. We can see from the diagram that staff take the appropriate action when NEWS2 scores are above 4.

NEWS2 Scores - John



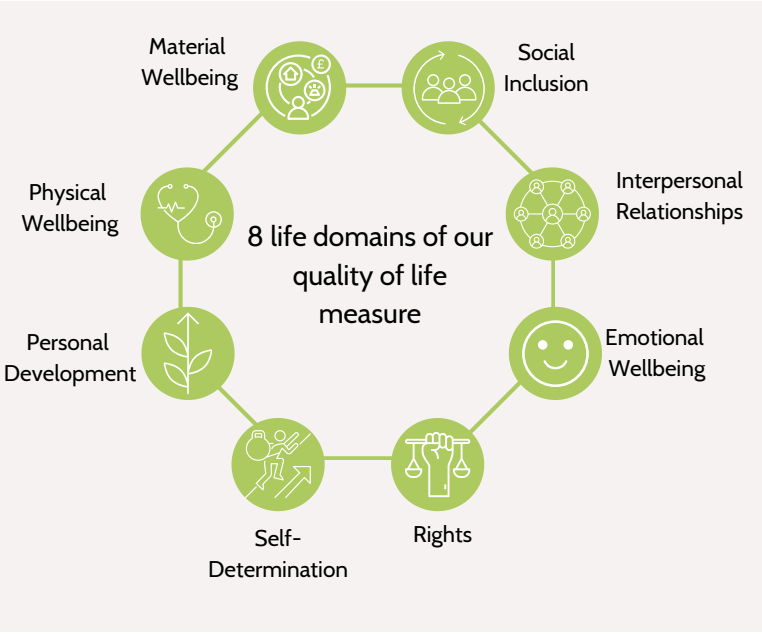
Outcomes

At Gray Healthcare, we have introduced different tools to enable us to measure outcomes that are evidence-based and of value to the person we support, and commissioners to our services. These include:

Quality of life measure

This evidence-based tool was devised for use within Gray Healthcare, to be used by the operational team in collaboration with the person we support and it identifies areas within each life domain where quality of life could be improved. This has been developed with a scoring system to ensure that this can be re-measured following interventions to evaluate and review improved quality of life. This process also allows for SMART goal setting to be used to support success.

We complete this assessment six monthly, and it provides us with the evidence of the effectiveness of targeted areas of work, and helps to identify areas where the person needs additional support to achieve future goals.



Nursing Assessment

This assessment has been underpinned by the Moulster and Griffiths Learning Disability Nursing Model which seeks to improve the health and wellbeing for people with learning disabilities against national frameworks. As it is recognised that people who have a long and enduring mental health diagnosis experience the same diagnostic overshadowing and health inequalities as people with learning disabilities, we use this assessment across the company. This assessment, in collaboration with tools such as the Health Action Plan, can be reviewed to ensure that reasonable adjustments and creative approaches are utilised to ensure that the people we support are experiencing fair and equitable treatment opportunities for their physical health.

Gray Healthcare Screening Tool

This assessment seeks to identify specific areas where function is impacted upon and where there is a potential for functional skills development. This tool allows for SMART goal setting to inform focussed intervention planning and evaluation. This tool can then be re-scored to ascertain the outcome of these interventions and demonstrate progress and support for the person we support. This tool measures ability in the following areas:

- Self-care skills
- Domestic skills
- Activities and Leisure
- Communication and Interactions
- Cognitive skills
- Community
- Clinical

Incident Reviews/ Data Analysis

The review and analysis of incident data allows for patterns and trends to be identified and support the evaluation of support and intervention plans. It is suggested that as positive indicators begin to be seen in the areas noted above, that there would also be an evident reduction in incidents; the research states that as people's quality of life increases, the presentation of behaviours of concern should decrease. It is important, however, to ensure that this data analysis is not taken in isolation; a decrease in incidents is not necessarily indicative of a positive outcome, it may be as a result of increased restrictions and limited opportunity for positive risk taking and therefore should be used to form part of the 'bigger picture' alongside tools such as those noted above.

GRAY HEALTHCARE

Gray Healthcare Limited
2000 Vortex Court
Enterprise Way
Liverpool
L13 1FB

Get in touch!

For more information or to make a referral, contact us now on:

0151 255 2830

info@grayhealthcare.com

www.grayhealthcare.com

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