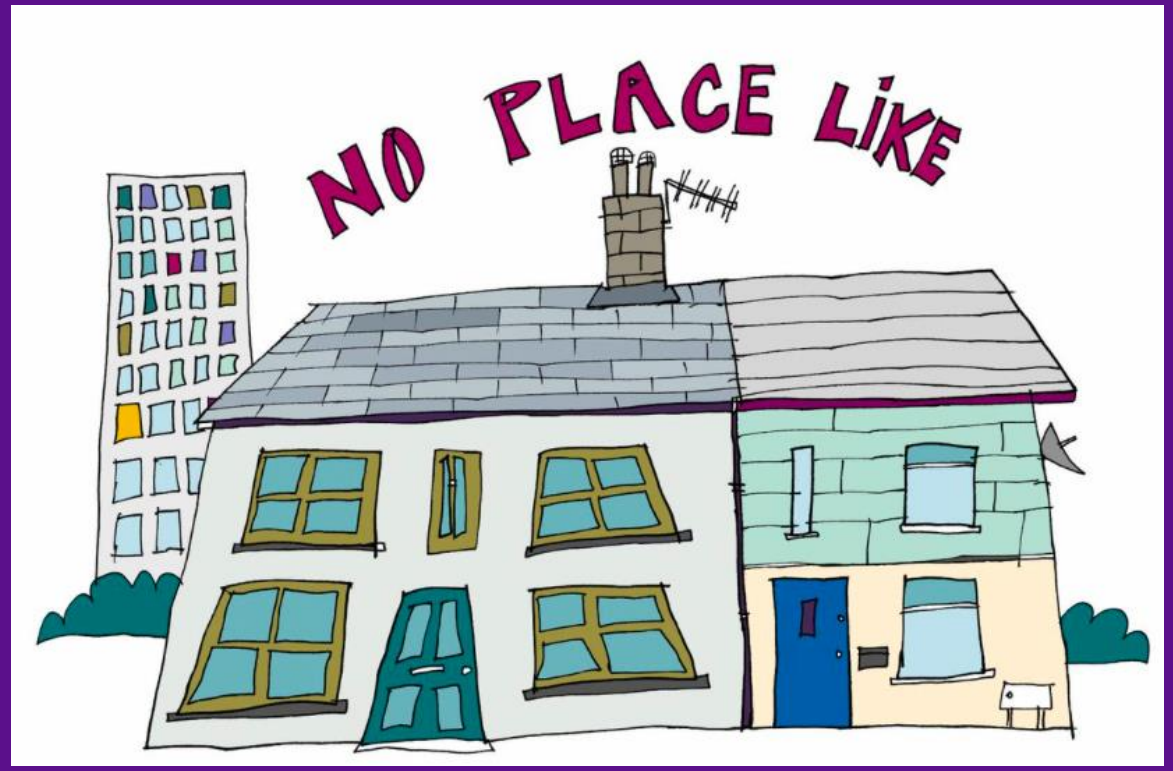
Think Home- Think Community

18th May

National Development Team for Inclusion

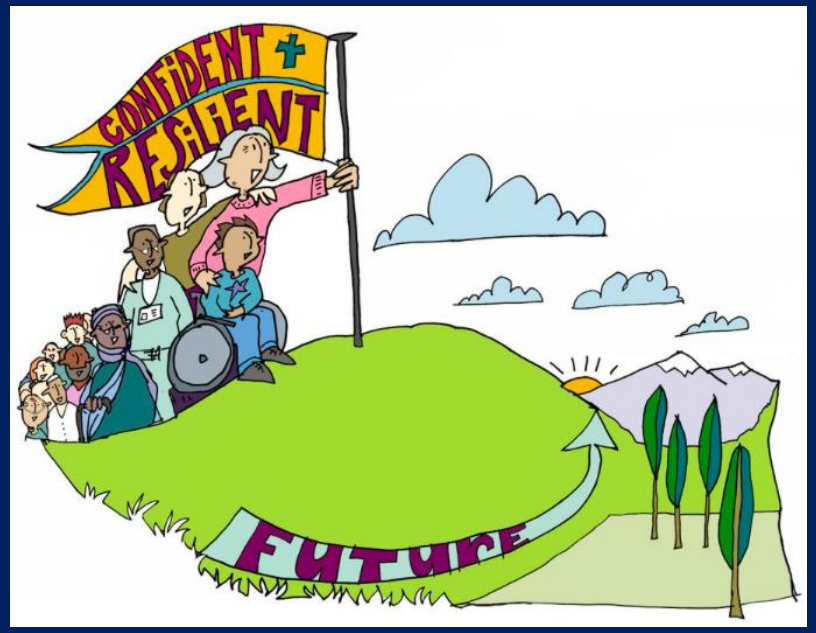
Community Led Support

an NDTi Programme



Healthcare Improvement Scotland | ihub

How we'll use the time



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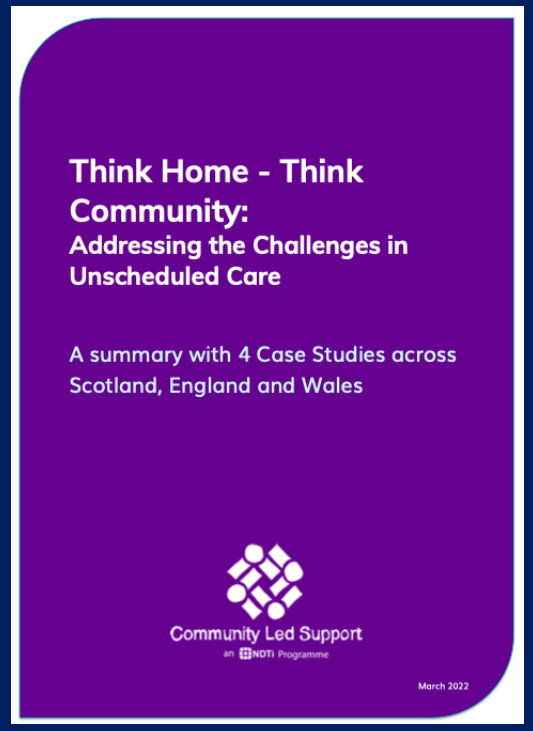
NDTI/ HIS –Think Home, Think Community Report headlines

Introducing the Tools, Case Studies and Resources

Forth Valley Collaborative – Case Study

Discussion and Using the Materials

‘Think Home- Think Community



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Report Commissioned by Health Improvement Scotland – Feb 22

https://www.ndti.org.uk/projects/scottish-reports-may-2022-cls-in-scotland

A Practical Resource for use by Health and Social Care Partnerships

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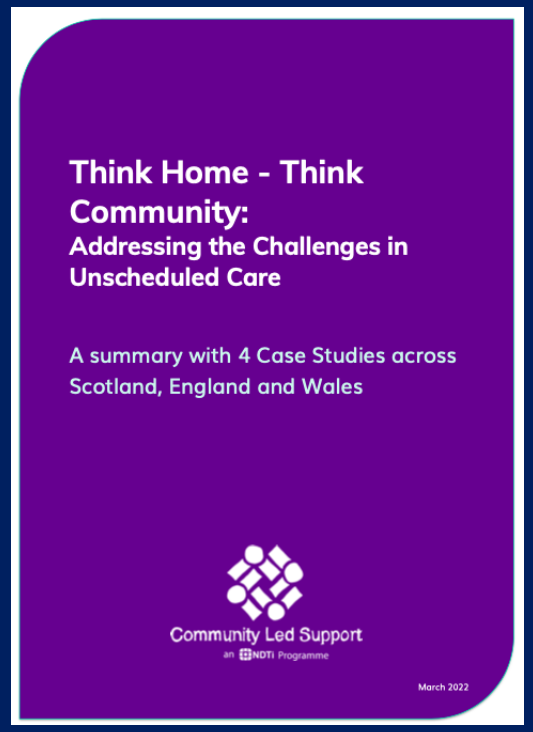
‘Top Tips



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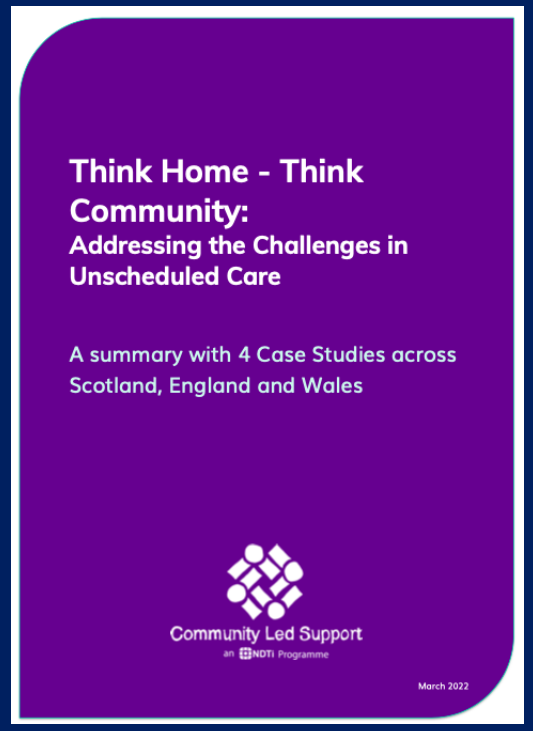
1. Think people first – not hospital beds first
2. Always ask “why not home, why not now?”
3. Encourage proportionate risk taking
4. Listen to people and act on their wishes – identify and build on their strengths
5. Focus on the outcomes for people and results rather than process

‘Top tips’



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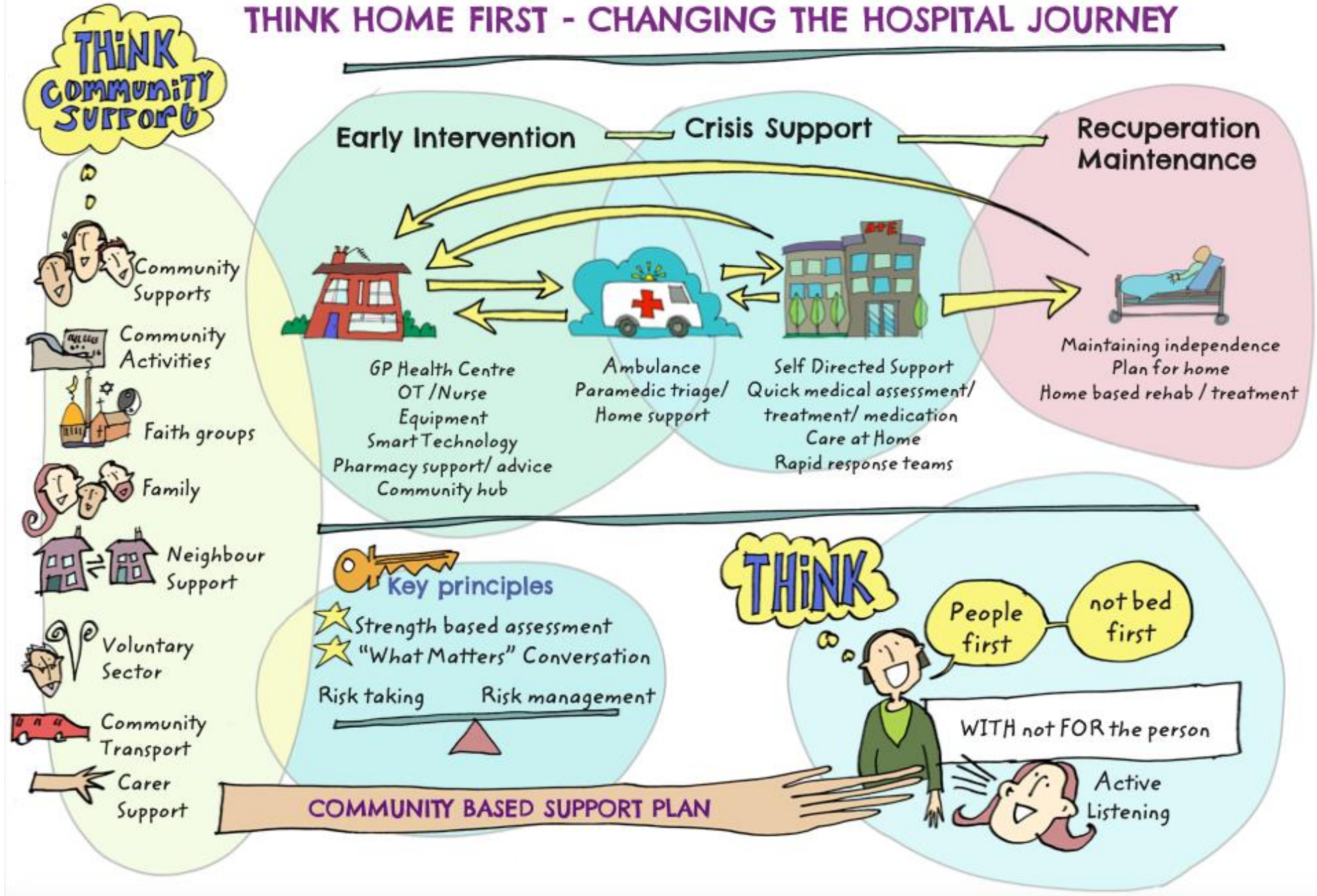
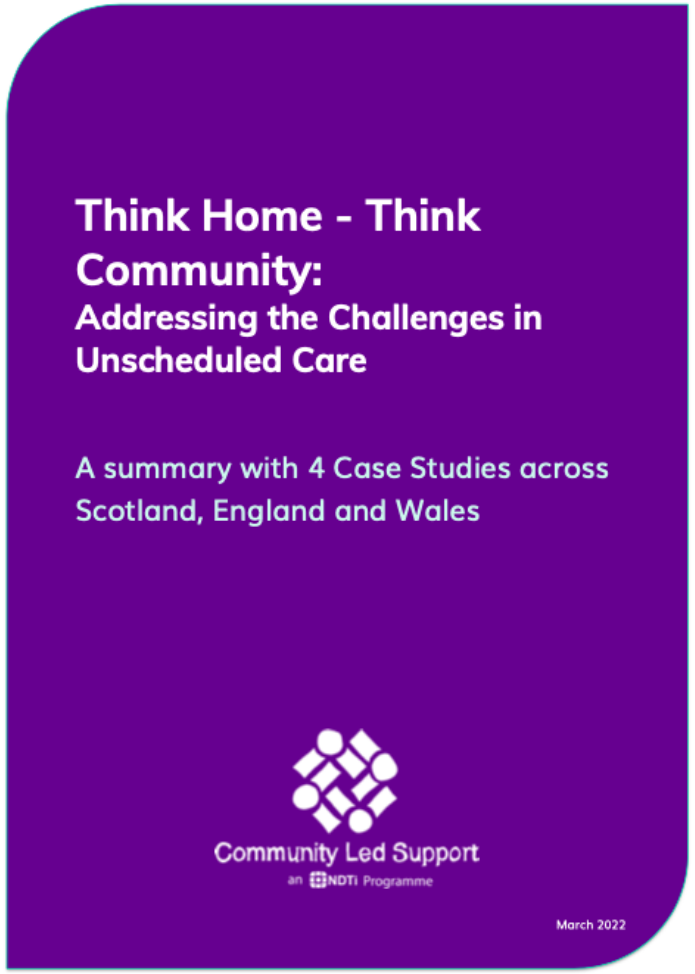
6. Be adaptable and flexible – go with ‘good enough’ solutions to get people home
7. Know and trust local, community resources including the voluntary sector
8. Empower all staff to make decisions
9. Encourage a no-blame, non-adversarial culture and work in partnership
10. Make the best way the easiest way.

THINK HOME FIRST - CHANGING THE HOSPITAL JOURNEY





4 Case Studies

Who Cares For the Carer – the Role of Pharmacies - South Ayrshire

The Role of the Volunteer – Denbighshire – Wales

Falkirk and Forth Valley Collaborative

Community Led Support – Working with Hospital Teams – Salford

Winter pressures service

Summary of evaluation

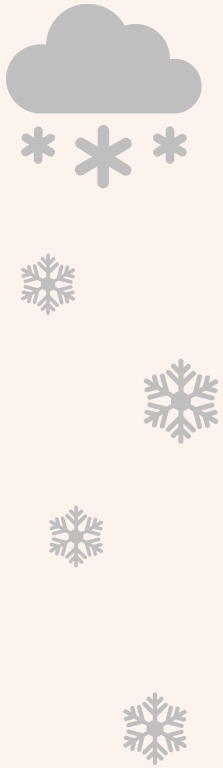
April 2022

Falkirk
Health and Social Care
Partnership

Background

Winter Pressures at Forth Valley Royal Hospital

The service provides support to patients being discharged from Forth Valley Royal Hospital, which, in common with other hospitals, faces challenges in maintaining regular services due to demand over the winter period. Winter 2021/22, as anticipated, has been particularly challenging as the usual cold weather-related illnesses have been compounded by the Omicron Covid-19 variant.



Aims of the service

- Reduction in delays in discharge from hospital and re-admissions to hospital (for non-clinical reasons)
- Avoidance of admission to hospital
- Reduction in the Social Work assessment pending list
- Increased access to, and options for support
- Increased support for carers and families
- Increase in volunteer numbers and opportunities
- Sustainable network of third sector support providing risk reduction and early intervention

Support provided

Immediate

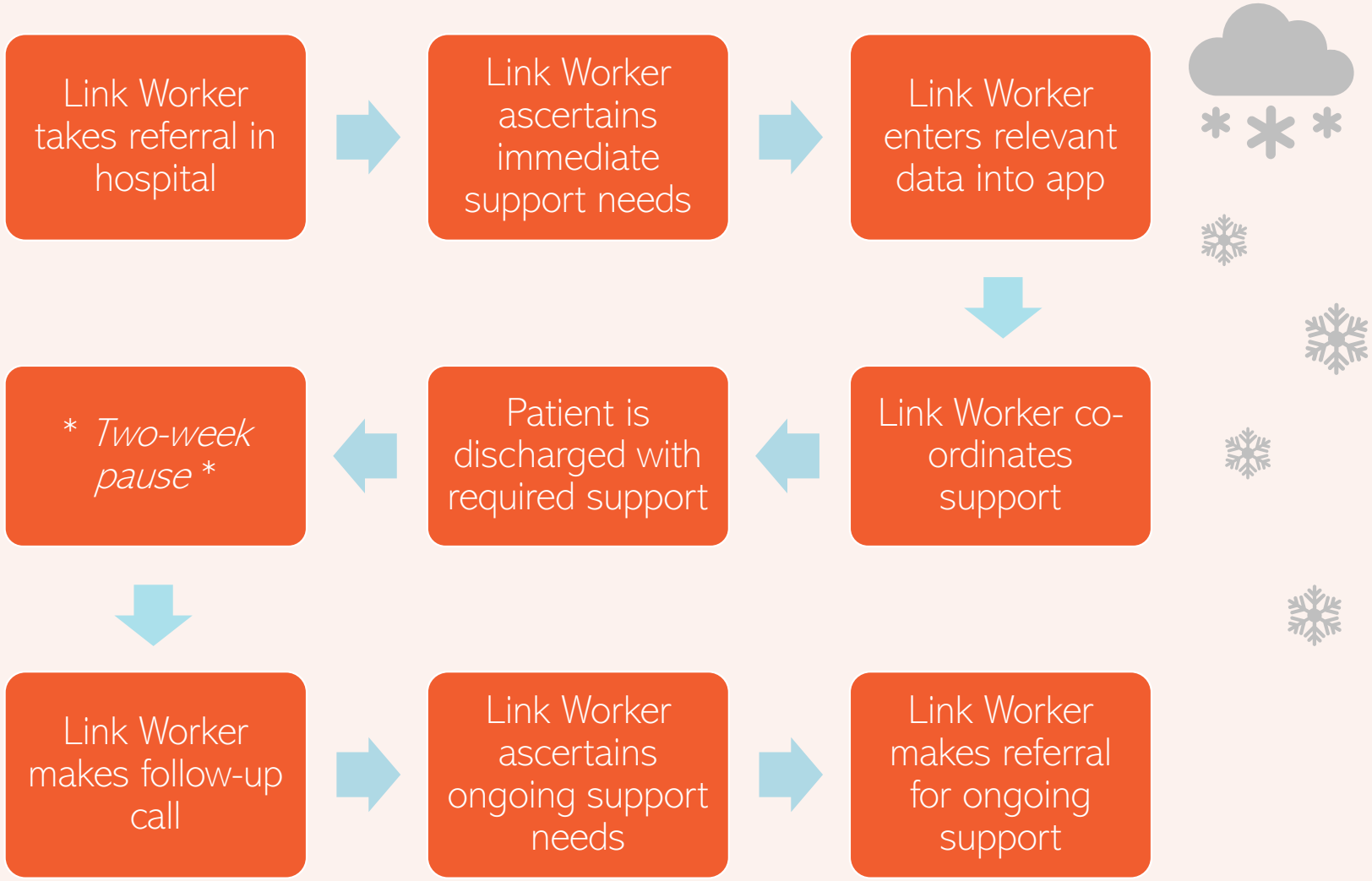
- Transport home
- Delivery of medication
- Food packs
- Wellbeing visits

Ongoing

- Support for carers
- Befriending, social networks
- Grocery shopping
- Support with household tasks

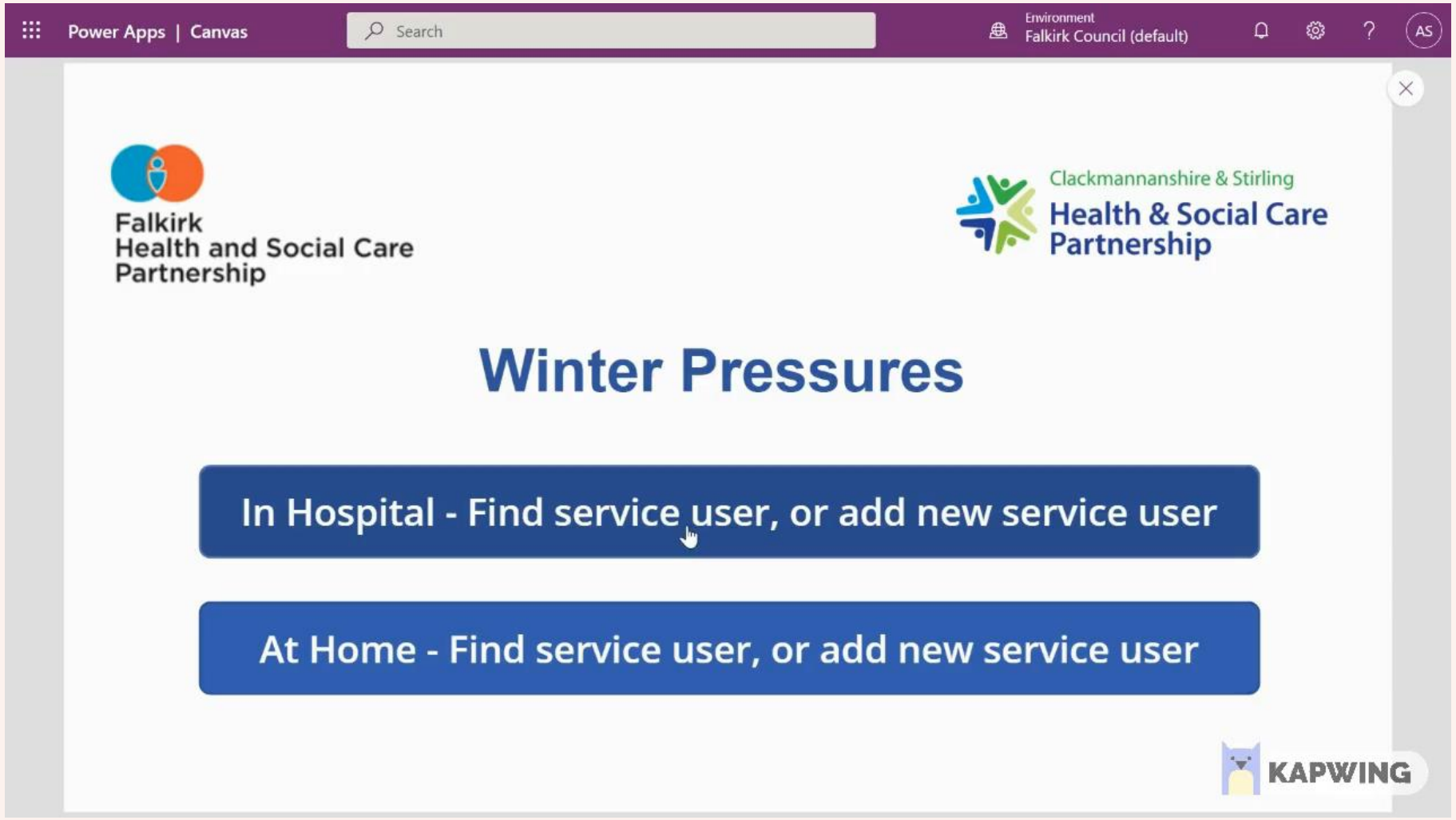
Partners (along with Falkirk HSCP and Clackmannanshire & Stirling HSCP):

How the service works



Falkirk Health and Social Care Partnership

Demonstration of the Winter Pressures app (2m 49s)



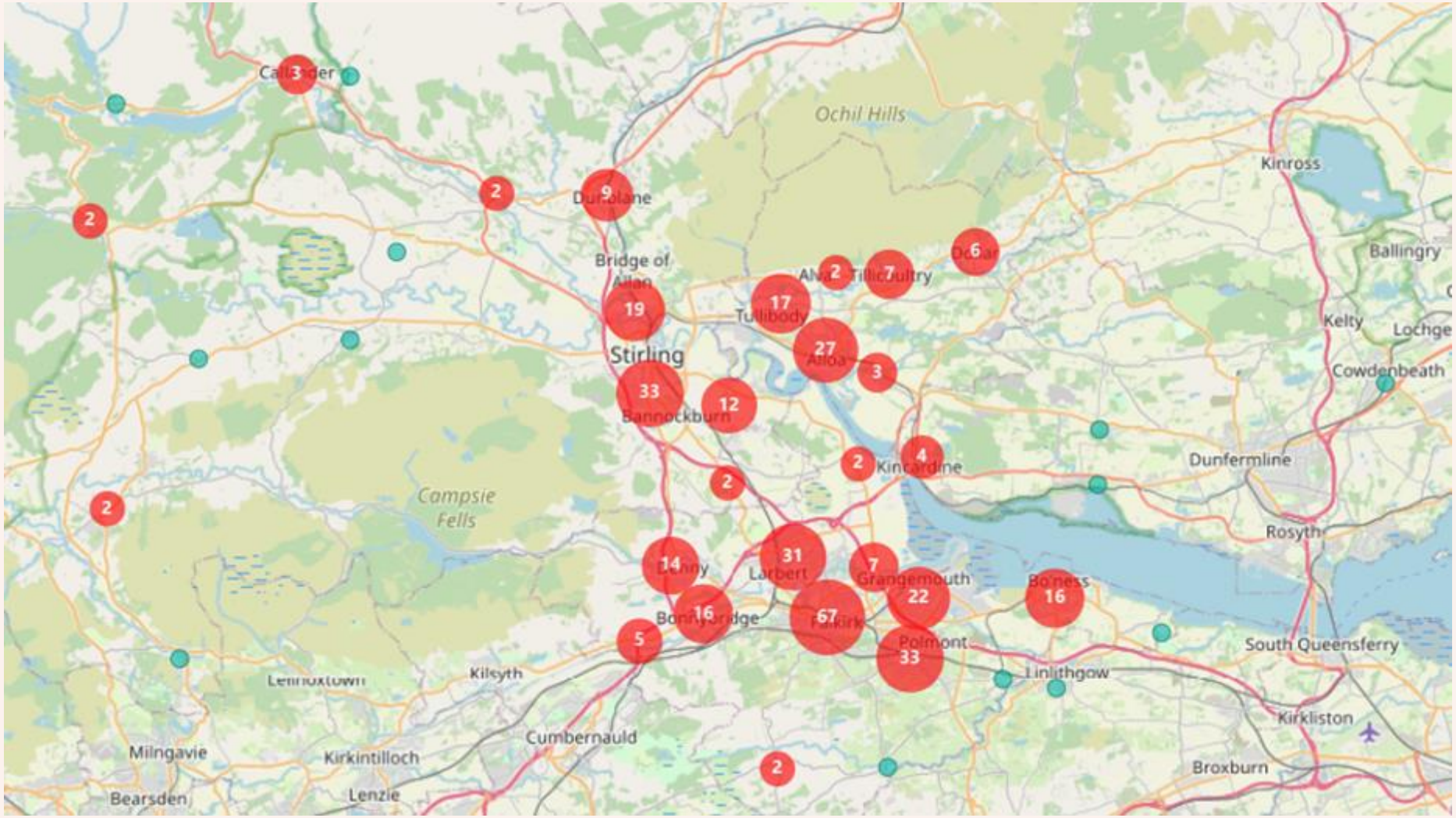
Who uses the service?

Source of referral, by hospital ward

Ward	%	% bar
A11, A21, A22, A32, B21 & B22 Ageing & health	24.3%	
Clinical Assessment Unit	10.4%	
AAU Acute assessment unit	10.0%	
B32 Gastroenterology	6.9%	
A&E	6.7%	
B11 General surgery	5.3%	
B12 Sugical assessment	4.6%	
B31 Respiratory	4.4%	
Cardiology	4.4%	
Other	3.9%	
A12 Endocinology and haematology	3.5%	
Day Surgery	3.0%	
Urgent Care	2.8%	
A31 Infectious diseases	2.1%	
Outpatients	1.9%	
B23 Orthopaedics	1.6%	
Discharge lounge	1.6%	
Ward 8 Antinatal / postnatal	1.6%	
Transport hub	0.9%	

- Median age of 74
- Breakdown similar to each area's population share
- Tend to be from slightly more deprived areas, although differences between Councils
- Vast majority from urban areas clustered around Falkirk and Stirling, but some from as far afield as Killin (45 miles from Forth Valley Royal Hospital)

Service users, by location:



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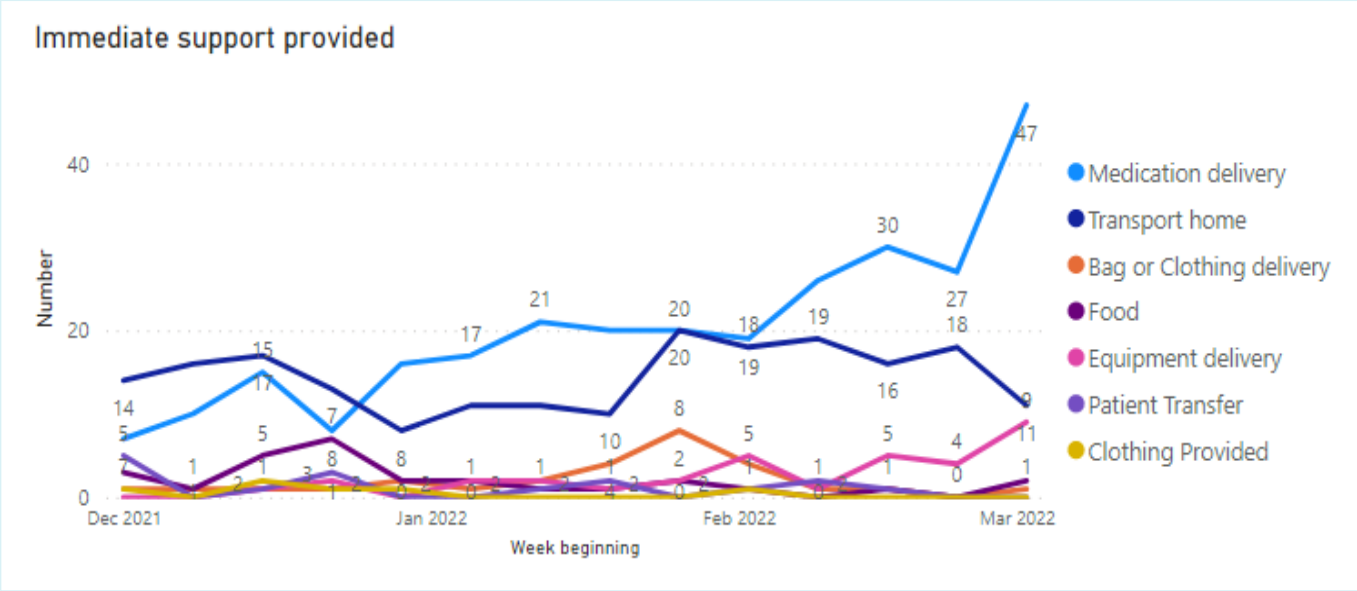
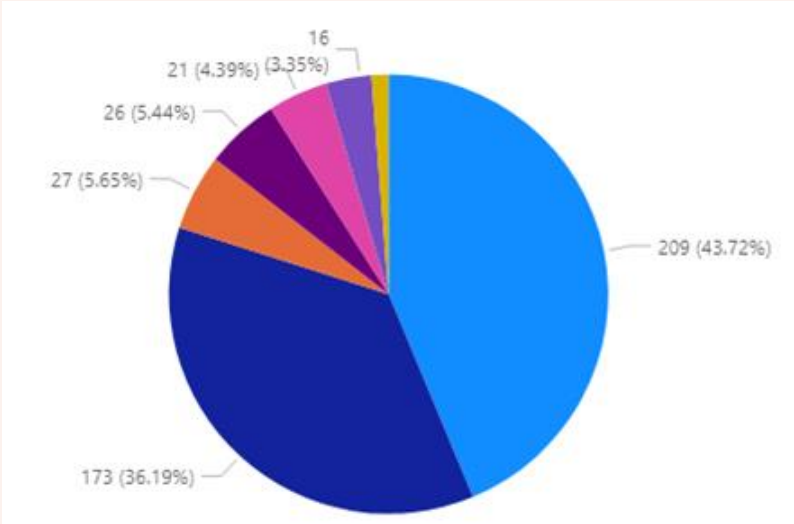
Immediate support



- Immediate support enabled people to leave hospital within 1 hour of referral to Dial-a-Journey
- Discharge Lounge has not needed to close during the period in which the service has been running



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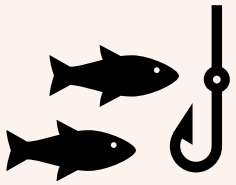
Ongoing support

Example 1

- The Link Worker made a follow up call to Mr X a few weeks after discharge. Things were going reasonably well, but he admitted he was really missing his fishing. Last year his wife would take him in their own car to a loch where they have accessible fishing boats but following discharge his wife had become too frail to lift his wheelchair into the car. This meant he didn't get fishing, and she didn't get a break. The Link Worker connected them to Dial-a-Journey who now take him to the loch every week. He connects with friends, enjoys an outdoor activity, and his wife meets up with friends for a chat and informal support.



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Ongoing support

Example 2

- LM cares for his wife who was recently discharged from hospital. The carer support worker (CSW) contacted LM to discuss his caring role with him. As a result of her hospital admission, the care needs of LM's wife had changed meaning he now had a larger caring role. LM stated he wished to continue being the sole carer but recognised he might need a break at times. The CSW suggested an adult carer support plan as this would enable LM to access support from the social work department, particularly respite.
- During the completion of LM's support plan it was identified that his caring role was impacting on his finances, so the CSW helped him apply for benefits for his wife. It was also identified that LM felt isolated due to his caring role and had concerns about the future and his wife's deteriorating cognition. The CSW arranged from LM to attend care with confidence carer training sessions at the carers centre as well as attend peer support groups ran by the centre.

Impact

Ongoing support

Example 3

- CD was referred to the Food Train for the shopping service after returning home from hospital. CD has mobility and hearing difficulties and is also the main carer for her husband. CD was finding it difficult to get out for food shopping.
- When signing up for shopping delivery with Food Train, staff identified that CD and/or her husband may benefit from befriending, to allow a break from caring, as they are quite socially isolated and have no family support. CD also mentioned that she might be interested in using the Food Train At Home service, where volunteers visit regularly to help with tasks around the home such as hoovering and changing bedding plus also providing some social contact and generally checking on members wellbeing.
- Being referred through the Winter Pressures pilot meant that CD did not have to wait for a Social Work assessment to access services and could also be highlighted to other partners such as the Carers Centre at the same time.

Future plans

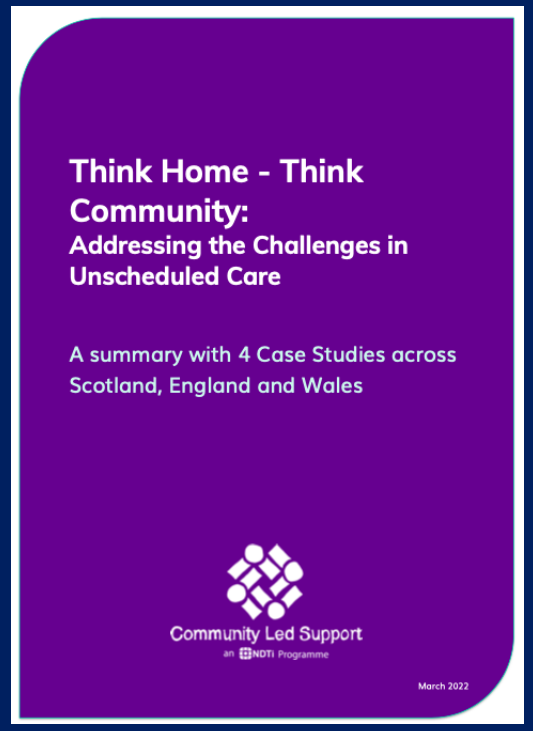
- Options for the continuation of the service throughout the year to be presented for decision
- Potential to introduce more services
- Potential to expand the number of access points beyond the acute hospital
- Greater information sharing and co-ordination with District Nurses, reablement teams etc.
- Link with social work and health records to gain a greater understanding of impact

Contacts

Andrew Strickland
Policy & Research Officer
Andrew.Strickland@falkirk.gov.uk

Lesley MacArthur
Partnership Funding Co-ordinator
Lesley.macarthur@falkirk.gov.uk

‘Additional Resources



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Some additional resources with links including:

Orkney – Home First Project

Outside the Box – Community Case Studies

Hospital Discharge - Red Cross Research

Iriss Materials

For more information do have a look at NDTi website.
www.ndti.org.uk

Follow us on Twitter too
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#communityledsupport

To join the CLS on line forum [Sharepoint & MS Teams] email
Karen.dawkins@ndti.org.uk

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