Think Home - Think Community:

Addressing the Challenges in Unscheduled Care

Top Tips and Case Studies across Scotland, England and Wales

Community Led Support

an NDTi Programme

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Healthcare Improvement Scotland | ihub

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Disclaimer

Acknowledgements

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(ihub is part of Healthcare Improvement Scotland).

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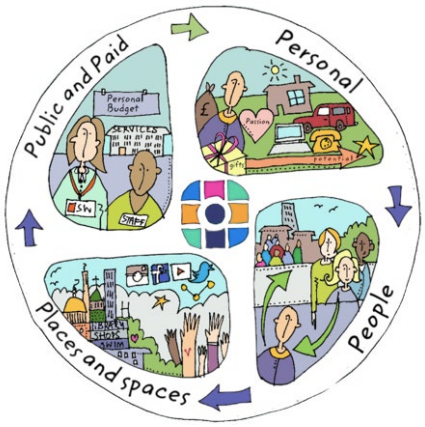
10 Top Tips for Leaders to Manage Hospital Demand



A ‘whole system’ culture change is needed across the health and social care, both in communities and in hospitals, to reduce avoidable admissions and speed up the process for people to return home. Leaders can assist by promoting a number of simple key messages to drive this culture change.

1. Think people first – not hospital beds first

This should always be the first consideration when contemplating an admission to hospital or discharge home. Often hospitals can seem to be the easiest solution to resolve a health concern but moving people from their own home can present significant challenges for people themselves – especially so for people with dementia- so we all need ask and to listen to the person’s/ family wishes and what is their preferred solution.

2. Always ask “Why not home? Why not now?

This should be the question that all professionals across the system need to answer– from GP’s making a home call, ambulance staff when called to a home visit, staff in Accident and Emergency departments and by ward staff when arranging a discharge home.

3. Encourage Proportionate risk taking

All situations and decisions involve risk taking and when admitting a person to hospital, or to return home from hospital, we need to consider the views of the person and take a proportionate approach to risk. Remember the risks associated with being in hospital include the risk of infection, loss or confidence and independence and these may outweigh the risks of returning home with appropriate follow up support.

4. Listen to people/patients and act on their wishes - identify and build on their strengths

Building the skills of all staff to have an asset based, strength based conversation is key focusing on what matters to the person rather than what is the matter. By doing so we can identify the strengths people have themselves and in their community and build up confidence and independence.

5. Focus on the outcomes for people and results rather than processes

Checking out what matters to people and how well they feel supported to live their own life means we focus on what needs to happen to achieve that outcome. People often feel safer at home and more able to adapt to their own surroundings so gathering and using quantitative and qualitative data when a person returns home is important to inform decision making and streamline our processes.

6. Be adaptable and flexible – go with 'good enough' solutions to get people home

It is difficult to assess people's needs fully in a hospital setting so we need to put in place enough support to return people home - this doesn't always have to be traditional statutory solutions such as transport by ambulance or local authority care at home. Think about SMART technology solutions and there are a range of third sector resources to support people home in a timely way including community transport schemes and home from hospital visiting services.

7. Know and trust local community resources including the voluntary sector and use these community solutions

There are a range of great local resources available to support people at home but staff need to know what they are and how to access them quickly and easily. Local information directories are useful and local community navigators can provide this information and ensure links are made.

8. Empower all staff to make decisions

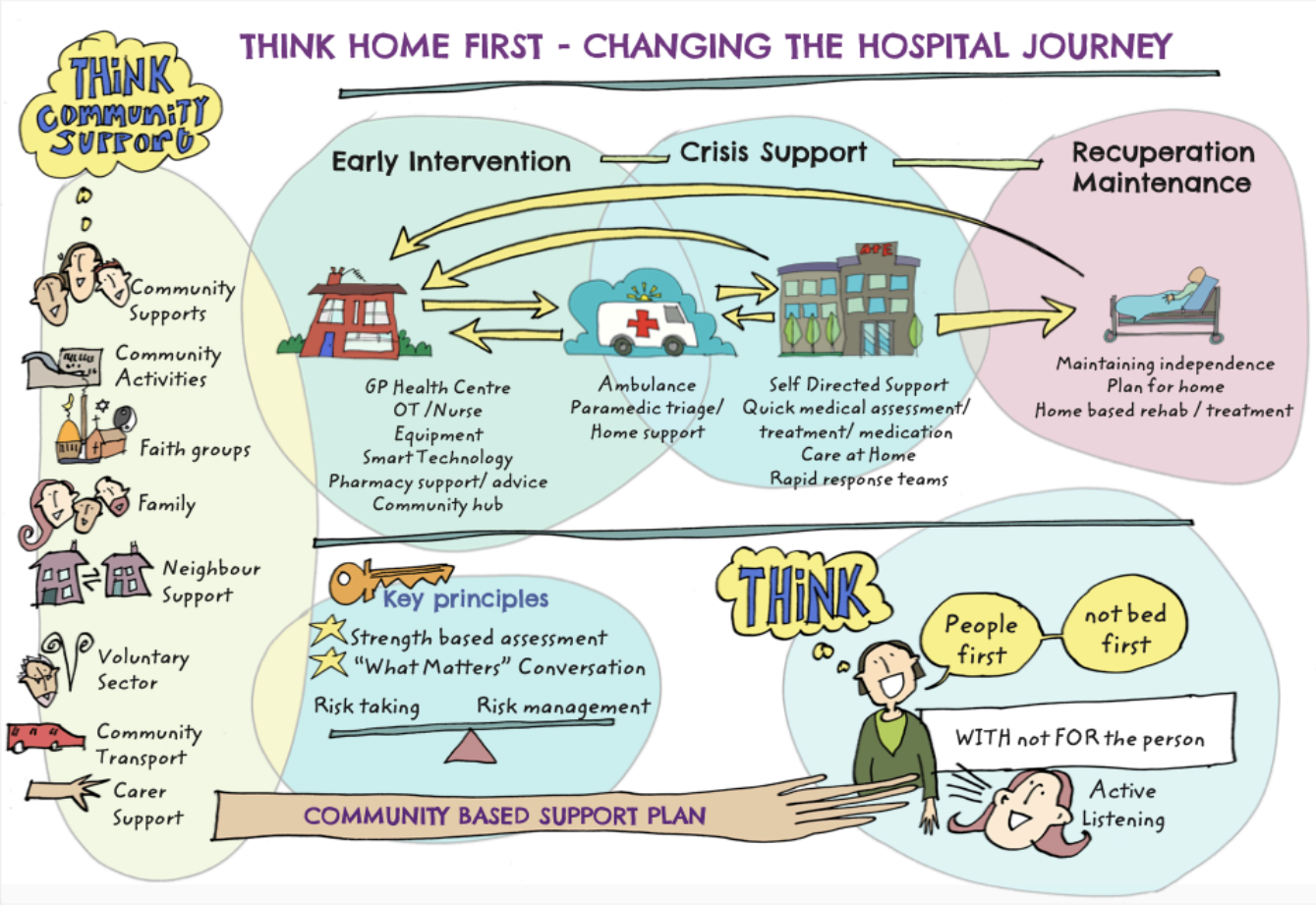
Delegation of decision making avoids unnecessary delays and speeds up planning. Leaders can support this by creating a culture of trust, reducing bureaucracy and delegating resources to staff at the front line.

9. Encourage a no blame culture – work in a non-adversarial manner and work in partnership

Health and social care working together with the voluntary sector and local communities means that there is a much wider range of resources available to access and support people to remain at home or return home from hospital. We need to trust our partners and work together. If things do go wrong, we need to review and learn together.

10. Make the best way the easiest way!

Sharing information, having good, up to date information about community supports and involving those people who do have that information in the decision making will mean that community solutions can be found and put in place easily and quickly. Working together across disciplines and organisations, reducing bureaucratic hurdles and supporting a culture of creative, honest and solution focused exploration with the person, will all contribute to the likelihood of people being supported with their wellbeing sustained in their home environment.



This graphic can be customised with your own local information and contact points. This is available on the [NDTi website.]

Who Cares for the Carer: South Ayrshire

What is the project?

In response to recognised increased pressures on carers during the pandemic, along with ongoing pressures on the hospital system, there was a growing understanding of the importance of supporting carers; to prevent the need for either increased formal support and to prevent hospital admissions. It was noted that when attending Accident and Emergency people who were clearly supporting people with significant needs were not identifying themselves as a carer and thereby not receiving support that was available. The project aimed to work with pharmacies to assist in identifying carers who would benefit from support at an early stage and to then encourage them to contact their local carers centre.

The Importance of Supporting Carers

The project recognised the importance of identifying and acknowledging the role of carers highlighting that carers must look after themselves to be able to continue to provide essential care and support for those relying on this support. The definition of an unpaid carer used in the project was broad and inclusive covering anyone providing help and support without payment to someone who could not manage without them.

Who are the Partners?

NHS Ayrshire and Arran, South Ayrshire Health and Social Care Partnership (HSCP), the three Carers centres and local Pharmacies. An integrated planning team was in place with key representatives and at the heart of the team was an experienced carer who was a key advisor as the project developed. Three community pharmacy advisors employed by the partnership provided good local knowledge, drive, and support for the project.

Setting up the Project

The project set up was designed to be implemented quickly and flexibly. Short weekly meetings – often just for 20 minutes were set up to keep the momentum and drive forward the changes. These focused on implementation and problem solving to enable the roll out to be small, focused and at pace adopting a human learning approach to start, implement and adapt based on learning.

The Role of Pharmacies

To start the project pharmacies who wanted to engage were used and 20 pharmacies initially volunteered with 6 testing out the initial approach.

There were 3 aims to the project for pharmacy staff:

- Identify – to help all pharmacy staff to identify any unpaid carers using personal knowledge – often carers regularly picked up prescriptions from the same local pharmacy
- Engage – pharmacy staff to be encouraged to have a conversation with unpaid carers – posters and leaflets in the pharmacies also assisted with this
- Signpost – once identified carers were encouraged to self-refer to the local carers centre.

Training was provided to the pharmacies initially with staff using a presentation delivered by professionals but as the project rolled out more broadly information sessions were recorded and could therefore be easily accessed by all. This included ways to initiate different conversations and conversation starters with potential carers.

The role of Carers Centres

The Carers Centres continue to be a key partner and when approached by a carer they can offer a range of support and advice to carers including a sympathetic ear, respite opportunities, carers support groups, outreach support, training as well as a range of alternative therapies including relaxation and massage.

Benefits of the Project

- For carers – Pharmacies are accessible, and carers can simply walk in with no appointment needed providing easier access. Emotional and

practical support to enable them to look after themselves was offered at an earlier stage before a crisis occurred.

- For Community Pharmacies – improved job satisfaction for staff, better joint working with the carers centre and an increased customer base.
- For Carers Centres and the HSC partnership – improved joint working and increased knowledge and understanding of the broader role of pharmacies.

Qualitative and Quantitative data was built in the project designed to be provided by the carers centre who are monitoring the number of carers who have contacted from pharmacies and feedback.

Key Learning

- Start small and scale up
- Drive forward small changes and adapt as you to
- Start with pharmacies who are enthusiastic and embrace the change
- Effective communication – share the successes
- Involve people who have direct experience to inform the project

Next Steps

This approach is being considered to roll out to wider health care system and many of the resources have been designed to be used by other professionals including the training package/ posters and flyers.

For further information please contact Phil White phil.white@aapct.scot.nhs.uk

The Role of Volunteers in Denbighshire, North Wales

What is the Project?

In response to the pandemic and the need to support people in their own homes two staff members were redeployed from health and social care to set up a volunteering service to take the pressure of traditional services including hospitals. Key to the new service was providing flexible support to improve the quality of life of citizens. This service has now been mainstreamed given the success of the project.

Who are the Volunteers?

A range of people came forward as volunteers, giving up their free time to support others. The age range of volunteers spanned younger people in their early 20's through to people in their 70's all with different experiences of life. All brought an interest in helping others but with very different skill sets for example craft skills, interests in walking or the environment.

The volunteers had time to listen and engage and very much used their own personal skills to develop relationships.

Volunteers are considered to be a key part of the team with regular check in discussions and having a knowledge of the volunteer's skills, interests. Valuing and supporting them was key.

Understanding your Citizens

The matching process for matching the citizen to the volunteer was found to be key for the co-ordinator who took time to have a strength-based conversation with the citizen understanding their interests, skills, talents and needs.

Networking by the co-ordinator with other departments and services was identified as important, for example linking in with 3rd sector community navigators, voluntary services and other professionals such as occupational therapists.

Working with Hospitals

During the pandemic the volunteers had a positive impact on enabling and supporting early discharge from hospital. Volunteers continued to make home visits when needed with appropriate PPE provided and regular COVID checks. They provided support to help people settle back at home, picking up prescriptions, and practical tasks including shopping, paying bills and writing cards.

One volunteer was able to support a citizen's recovery at home providing speech therapy support using computer connectivity. Similarly help was provided to improve mobility by assisting with walking around the garden thereby improving skills and independence.

If a volunteer was involved prior to a hospital admission, although not able to visit during the pandemic ,they kept in touch by phone and provided some ongoing support with tasks such as picking up or dropping of laundry and providing essentials.

A younger person in their 20's became a volunteer and was matched with an older citizen who both shared an interest in knitting and crotchet skills. This was mutually beneficial with both sharing life experiences and shared interests.

An older man with dementia was displaying some cheeky, challenging behaviour which led to his wife cancelling the traditional service. He was matched with a male volunteer of similar age who responded well to and who was not offended by his behaviour and they developed a good relationship which also helped to support his wife as the key carer.

Successes

- Benefits for the citizens - included early support when needed, a better quality of life and a much more flexible approach to support.
- Benefits for the volunteers - volunteers reported developing confidence for example to get into employment, developing their own interests and skills and some volunteers reported a positive impact on their own mental wellbeing.
- Benefits for the system - reducing pressure on traditional, statutory service led to an impact on commissioning – this approach moved away from commissioning by time and task to a more flexible approach.

A lady with dementia was being supported by traditional care at home services but was reluctant to eat during the allocated time slot. She was matched with a volunteer who took her out on picnics where they were not rushed and she enjoyed the picnic food and experience as well as benefitting from being out in the fresh air.

Key Messages/Learning

- The ability of volunteers to provide flexible support and not being restricted to time and tasks worked well and provided better outcomes for citizens.
- Volunteers had time to listen to the person and this led to an improved sense of wellbeing.
- The use of volunteers highlighted the importance of a strength based approach both in terms of identifying the citizen's strengths but also those of the volunteer supporters.
- The project changed the approach to supporting carers and moved away from a respite/breaks approach to a more partnership and flexible response.

For more information contact hazel.wilson@denbighshire.gov.uk

Falkirk and Forth Valley Collaborative

What is the Project?

A collaboration of partners working together to enable people return home from the hospital in a timely manner and to thereby improve the flow of patients through Forth Valley Royal Hospital. Health and Social Care are working together with 5 voluntary organisations to co-ordinate solutions to enable people to return home with appropriate community support and make community connections to improve wellbeing. The project was funded by Winter Pressures money from the Scottish Government.

Who are the Partners?

Falkirk Health and Social Care Partnership (HSCP), Clackmannanshire and Stirling HSCP, Royal Voluntary Service (RVS), Strathcarron Hospice, Carers Centre, Dial- A-Journey, Food Train.

All partners work together to provide a range of support to return people home by addressing their immediate needs and following up with a good conversation to consider any further medium and longer term needs.

Role of Link Workers

Key to the project is the role of the link workers, who are employed by RVS and work directly with teams across the hospital, including front door and discharge teams. The link worker arranges and co-ordinates support from third sector partners to enable people to return home safely. The link worker then conducts a follow up visit and holds a "good conversation" with the individual themselves (including their carer if involved), and using an asset based approach agrees with the individual what would help to support both to continue to maintain the individual at home as well as to maintain their independence and wellbeing. This includes consideration of local community resources and links.

Role of Partners

Dial-A Journey – provide transport from hospital home but also are available to collect medication and equipment, which has reduced delays in hospital for people simply awaiting for prescriptions to be made up.

RVS provide a range of support at home including home checks, practical support and links into community activities.

Strathcarron hospice, as part of their Compassionate Communities approach, provide access to social networks and befriending.

Food Train make up food packs a number of which are stored in the hospital for ready access and also provide follow up support with grocery shopping and support with household tasks.

Successes

- The number of people using the service has exceeded expectation with over 800 referrals since it started in December 2021 (as at end of March 2022).
- The project has been successful in preventing delays in hospital and enabling to people to get home safely – a key outcome for patients.
- This is a great example of partnership working demonstrating innovation and effective collaboration and highlights the importance of linking effectively into community supports.

This is borne out by the evaluation data. Figure 1 shows the volume and type of immediate support provided to help people get home from hospital. In many cases the patient will receive more than one type of support, for example transport home and a food pack.

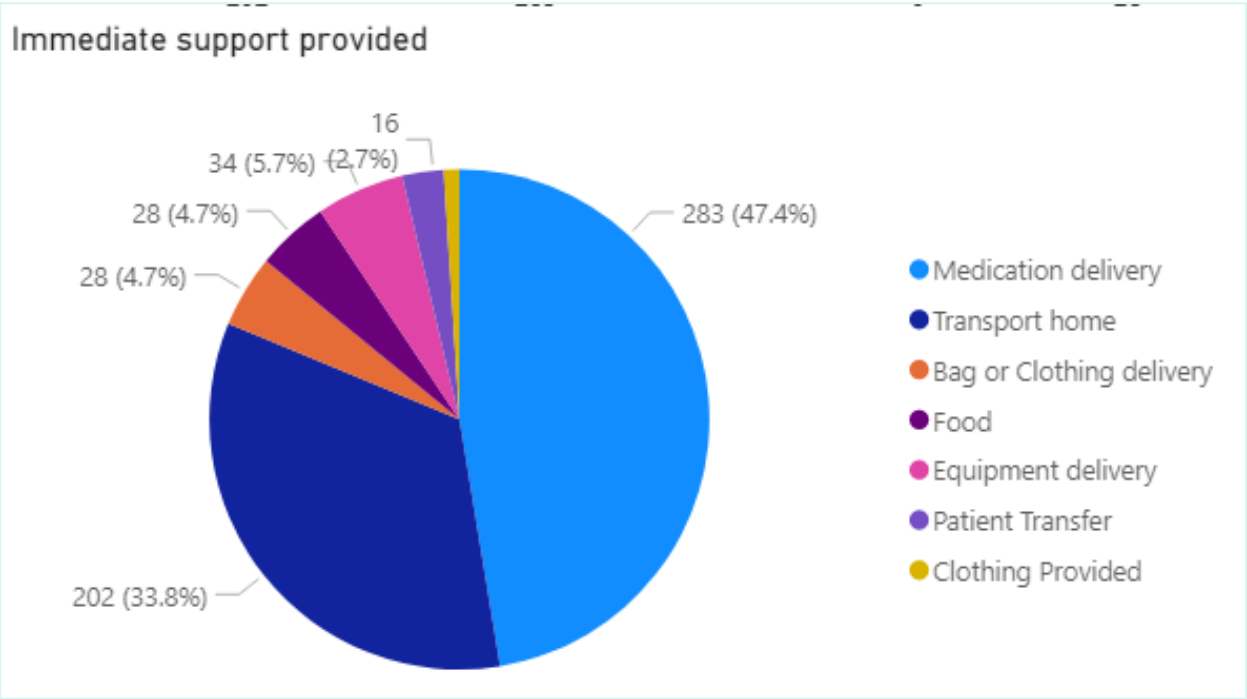


Figure 1

The impact of the ongoing support (identified using the good conversation at the follow-up visit) is more difficult to measure in the short-term. The case study below, however, provides an example of how support from the collaborative is helping a service user to maintain their independence:

Ongoing support – case study:

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.

Use of Technology

The HSCP played an enabling role by developing a bespoke app to help the Link Workers collect the required information, record relevant data sharing consent

from the citizen, share information with partners and process any personal data in accordance with the Data Protection Act.

Next steps – the aim is to build on the successes, consolidate the service and potentially extend it to cover the full year (not just the busy winter period).

For further information please contact Andrew Strickland
andrew.strickland@falkirk.gov.uk

Community Led Support - Working with Hospital Teams in Salford, England

What is the Project?

Salford is an Integrated Care Organisation (ICO) forming part of the Northern Care Alliance. Salford Adult social care have been implementing CLS approaches and principles across integrated neighbourhood teams in Adult Social care and the First Contact team. Like many areas across the Country Salford Royal Hospital faces increasing demand and daily pressures to help people to return home safely and in a timely manner.

In addition to a number of local health focused change programmes, as the CLS programme has progressed in the community there has been interest at a strategic level to consider this approach within acute wards of Salford Royal Hospital.

Who are the Partners?

- NDTi Community Led Support Team
- Salford ICO – Director of Social Care, Managing Director Social Care; Programme manager; Programme Support
- Salford Community and Voluntary Services – Strategic Lead for Wellbeing, Health and Social Care
- Salford City Council – Health Improvement Service and Housing Options Service
- Salford Adult Social Care (ASC) Home First hub team
- Salford Royal Hospital (SRH) – Variety of Acute wards and staff; the patient 'flow facilitators'; Senior Clinicians, Consultants, OT; Performance management

What we've done so far (December 2021)

- Community Led Support Core Good Conversations/Strength based approaches workshop held for Home First Hub staff and Acute ward staff.

- Follow up discussions were held to reflect and share experiences from attendees, looking at how they can embed strength based working into

everyday practice; opportunities and barriers to working in this way. This took place virtually a week after the workshop.

- NDTi then shared a presentation at the strategic leaders regular meeting (Adult Social Care, Executive Directors and Clinical managers) to Introduce the Community Led Support principles; consider system leadership; the need to remove silo working within the acute, community and social care 'system'; We also included feedback from the workshop and follow up session with staff (detailed above) to consider recommendations and plan for next steps.

In January 2022 it was agreed that Salford Health & Social care leaders would identify two acute wards to become Community Led Support 'innovation' wards. The aim is to implement the CLS approach on a 'start small, think big' basis.

What we are doing now (March/April 2022)

There has been a further workshop covering Strength based approaches for the staff in the 'flow facilitation' team. These staff are present on the wards and enable support arranging hospital discharge.
NDTi will join a 'Test of Change' week where direct observations and coaching will take place in situ with ward staff, clinicians conducting daily board 'rounds' and social care staff, health improvement and housing support staff in the Home First hub team. From this we will identify areas that work well, areas for change and opportunities to implement CLS.
It is anticipated that further direct support for hospital and social care staff will be provided, in person and virtual as needed, to implement the approaches.

A critical element of the work will be to identify the links needed with community/3rd sector organisations via Salford Community and Voluntary Service to seek a community connector specifically for the wards involved.

What we will do next (June/July 2022)

Allowing time to test the approach and make any adjustments following practical learning NDTi will host a Pause & Reflect workshop. The aim is to celebrate success and progress; identify areas where change is still needed; consider wider roll out and next steps.

Success so far

There is a real willingness to work differently amongst all partners involved. Involvement of CVS in workshops and meetings to build relationships and impart knowledge of the community sector and it's resources. There is opportunity to link up some of the strands of change programmes.

Challenges so far

With the day to day pressures and demands on Health and Social care it has been difficult to involve higher numbers of staff in the workshops. This has led to delays in getting started. Working across health and social care systems and processes is inevitably a challenge, taking longer to understand these and identify solutions to reduce some of the onerous duplication and bureaucracy.

Contact for further information: Amanda.nally@ndti.org.uk

Home First – some additional useful resources

Hospital Discharge in Scotland – Age Scotland (Oct 21)

A useful resource for patients leaving hospital in Scotland

hwb-11-hospital-discharge-oct-21.pdf (ageuk.org.uk)

Orkney Home First Project

Prior to its implementation, a standard model of delivery based on a traditional assess to discharge model resulted in prolonged hospital stays waiting for assessment and packages of care to be in place. In addition, due to the difficulties of predicting actual need whilst service users were inpatients, this resulted in packages requiring an almost immediate increase or decrease in care hours required.

The Home First initiative was identified as part of the 2020/21 winter bed planning and commenced on 16 February 2021. Funding was secured utilising winter planning funding to support the pilot until 31 March 2022. The pilot costs were 0.6 WTE equivalent Occupational Therapist hours with other elements being provided through re-utilisation of some social care resource.

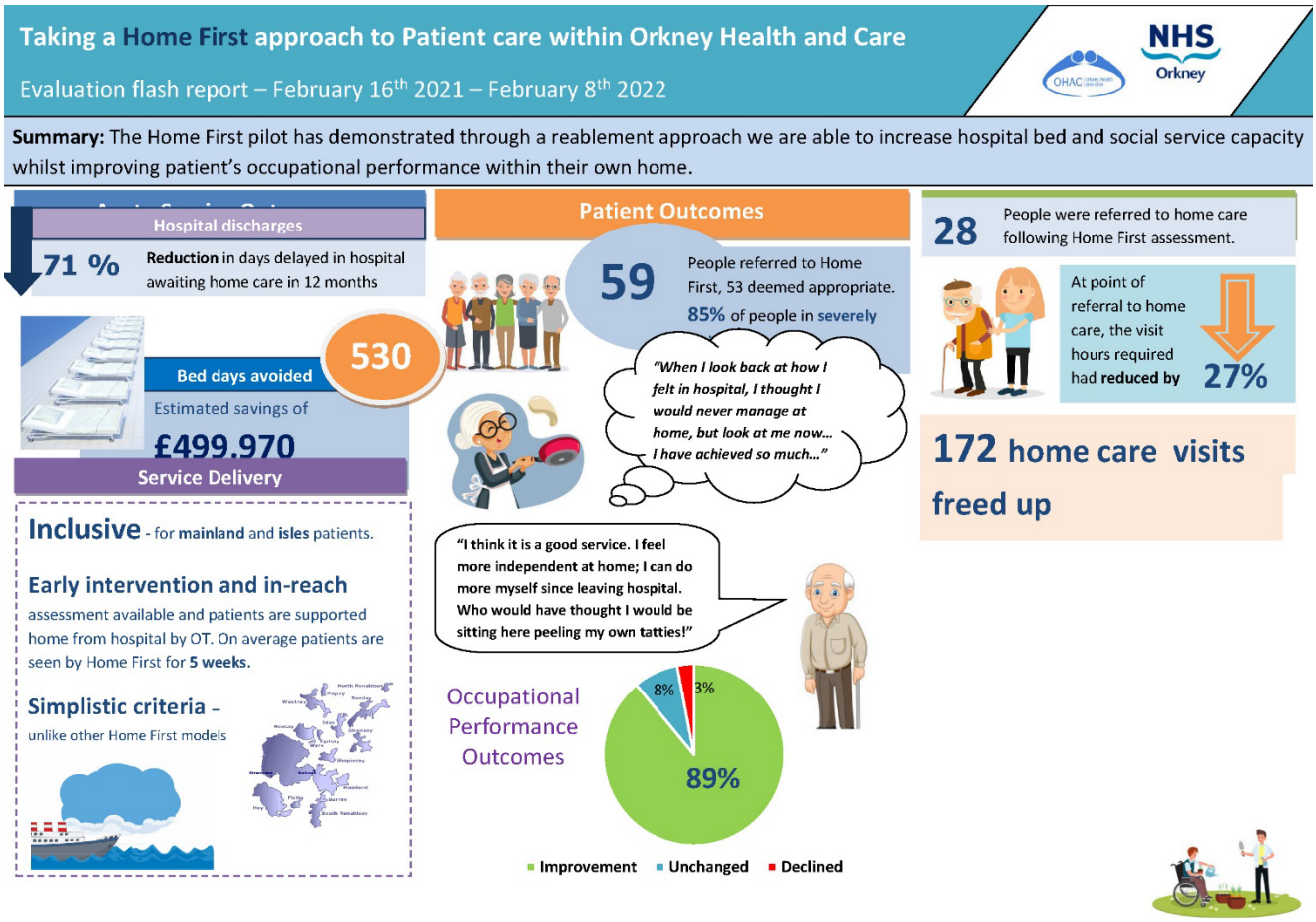
The Home First Service is a discharge to assess model offering up to six weeks of reablement support to enable timely discharge from the hospital and the opportunity to assess patients in their own home. The reablement approach supports people to do things for themselves. It is a 'doing with' model, in contrast to traditional care at home which tends to be a 'doing for' model. Reablement services help people to retain or regain their skills and confidence so they can learn to manage again after a period of illness. An open approach to accepting individuals into the pilot was taken with all new referrals for care at home packages and requests for increases included.

All individuals referred to Care at Home are offered the Home First model to maximise their independence and reduce future demand on Care at Home. The Home First, Intermediate Community Therapy and the Mobile Responder Green Team form an intermediate care hub with a single point of access to request.

The Home First model provides an evidenced based approach to maintaining an individual's independence at home and increases the confidence of the individual and their family members and reduces the expectation and reliance on a long term Care at Home package being required to enable the person to remain at home for longer.

There is evidence that reduction in ongoing support requirement is being maintained after discharge from the service, with some individuals continuing to make progress and care packages continuing to reduce. Given the demographic predications for the Orkney population, with a consequent likely increase in frailty levels, it is important that we maximise independence and maintain this for as long as possible. A reablement model supports this.

Orkney acknowledge the work of the OT service to develop and promote this model.



Home to the Unknown – Getting Hospital Discharge Right – Red Cross Publication

[Getting hospital discharge right | British Red Cross]

Key findings from report based on research

1. There is a substantial opportunity for commissioners and providers to harness the power of non-clinical support, including the voluntary and community sector (VCS), to relieve the pressure on the NHS and to create better outcomes for people and improved patient flow within and between health and social care providers.

2. Every point of hand-off between clinical teams in hospital and from the hospital to the community is a potential point of success or failure for patient recovery. We recommend that there is a clinical responsibility to ensure the

effective management of these transitions, so that there is continuity of care and patients don't fall through the gaps between teams.

3. We recommend that a five part 'independence check' should be completed as part of an improved approach to patient discharge – prior to discharge or within 72 hours of going home. This would help to inform the setting of a realistic discharge date and would include assessing:

- Practical independence (for example, suitable home environment and adaptations)
- Social independence (for example, risk of loneliness and social isolation, if they have meaningful connections and support networks)
- Psychological independence (for example, how they are feeling about going home, dealing with stress associated with injury)
- Physical independence (for example, washing, getting dressed, making tea) and mobility (for example, need for a short-term wheelchair loan)
- Financial independence (for example, ability to cope with financial burdens).

Reducing Avoidable Ambulance Conveyance in England - Interventions and Associated Evidence – E Knowles, J Long, J Turner (University of Sheffield (2020)

https://aace.org.uk/wp-content/uploads/2020/08/ScHARR-report-SRAC-Final-020320-.pdf

A recent study Identifying how the ambulance service can assist in reducing avoidable admissions with a range of examples including working with care homes, managing mental health crisis and specialist transport responses and teams.

Hospital Discharge and Preventing Unnecessary Hospital Admission (COVID 19) – SCIE – Jan 2022

Hospital discharge and preventing unnecessary hospital admissions (COVID-19) (scie.org.uk)

Based on research during pressures on hospital and the impact of COVID 19 the report highlights lessons for commissioners to reduce hospital admissions and shorten the time in hospital including advice for commissioners.

There are some common features where discharge and preventing unnecessary hospital admissions has worked well, and these core principles should become the cornerstone of a positive commissioning approach:

- **Leadership** – strong local decision-making based on good local evidence has saved lives. Good leadership listens to people and creates the conditions to identify solutions.
- **Choice** – people have better outcomes where there is more diverse provision, along with good information and advice so people are empowered to make choices that are right for them. Good holistic support keeps people connected to their networks and communities.
- **Agile and confident** commissioning that develops flexible solutions based on knowing communities and providers well, including local businesses.
- **Co-production** that genuinely shapes decisions and understands the impacts on people who need care and support, and on carers.
- **Communication** and relationships with social care practitioners, support workers, providers and community groups are vital. What issues and barriers are they aware of? What are their ideas for solutions?
- **Integrated and collaborative** working across systems, including with housing partners, using holistic and whole-family approaches, to reduce hand-offs, delays and confusion.

Hospital to Home Evaluation Report – Iriss

Hospital to Home: Evaluation report (iriss.org.uk)

The Iriss *Hospital to Home* project was designed to identify and improve care pathways from hospital to home for older people (over 65), and enable a more positive experience for all. The embedding phase of this project took place between October 2014 and October 2015 when we worked with practitioners in Tayside to establish how the recommended interventions from the project Working Group could be embedded and scaled locally. This report presents an overview of the findings from this last phase of the work and includes: links to the project's theory of change and associated activity; evaluation methods and learning; and reflections about embedding.

Hospital to Home Pathway Map – Iriss

Hospital to home (iriss.org.uk)

A project undertaken by **Iriss** to identify and improve care pathways from **hospital** to home, which includes tools and methods to assist with improving pathways and processes.

Community Solutions - Outside the Box

Community Solutions Blog resource (otbds.org)

This report has a number of case studies in Scotland demonstrating how the community can provide a range of different solutions including hospital discharge and early advice and support in the community.