HELPING THEM HOME
SUPPORTING HOSPITAL DISCHARGE IN SCOTLAND
Scotland’s population is ageing. We are living longer and whilst this may be a cause for celebration it presents major challenges to our health and social care system. From 2003-13, the number of people over 75 has increased by 16% and the number of over 75 year olds is predicted to grow by 86% by 2037.¹

Across Scotland, NHS boards are under unprecedented pressure. Delays to discharge exacerbate this. Waiting to go home is a major cause of delayed discharge in Scotland, with 90 patients recorded as having remained in hospital for over 4 weeks for this reason in October 2014.

As people age, they are more likely to need a stay in hospital. Successful timely discharge is critical to the patient’s wellbeing as well as reducing pressure on the NHS. We know that support in the 72 hours after discharge also reduces the chance of unplanned future readmission.

- Delayed discharge is becoming more of a serious problem with 215 patients delayed for more than 6 weeks in October 2014, up from 175 in July 2014 and 100 in October 2013.²

- Over the next 10 years the proportion of over 75s in Scotland’s population – who tend to be the highest users of healthcare services – will increase by over 25%³

- In 2012/13 the equivalent of over 837 hospital beds were occupied for a year by patients aged 75 or over who are clinically ready to leave hospital⁴

- People aged 75 and over are three and a half times more likely to be admitted to hospital as an emergency⁵

- Readmissions for people aged 75 and over have risen 88% in ten years⁶

CURRENT PRIORITIES

Since 2011, Scottish Government has focussed on prevention through integration of health and social care services. This also underpinned the creation of the Change Fund to shift the balance of care. In January 2015 Scottish Government committed £100m over 3 years to reducing delayed discharge. This funding forms part of a wider commitment to integrating health and social care services.

This funding is to support good quality care and support for people at home. The aim is to strengthen community care and prevent unnecessary hospital admissions, while ensuring that people are not delayed unnecessarily in hospital and that they are adequately supported on their return home.

HOW WE CAN HELP

ROYAL VOLUNTARY SERVICE, SUPPORTING HOSPITAL DISCHARGE

Our Home from Hospital Service places a caring volunteer at the centre of an older person’s recovery plan dramatically improving their experience at discharge, their confidence and their wellbeing and helping them regain independence and resilience.

Our volunteers are there at the start of the patient journey, supporting them whilst in hospital in a number of non-clinical ways, complementing the work of hospital staff, encouraging wellbeing to aid a speedy discharge. By liaising with the discharge team, gaining understanding of the patient’s needs and possible discharge date our volunteer can support the discharge process. Help may include bringing in clothes and personal belongings, accompanying the older person home (or in the case where hospital transport is required – be there at home to greet on arrival), help to settle in, ensuring the home is warm and safe with the necessary food items in the fridge. Over the next few weeks, our volunteers can provide transport to follow-up medical appointments, help with shopping, run errands, pick up prescriptions, and offer regular, much-needed companionship.

We aim to prevent unnecessary acute hospital admission or premature admission to long-term care. As well as making a difference to the lives of older people, the service eases pressure on NHS resources. It supports well-managed discharge from hospital wards and helps keep emergency readmission rates low.

THE SERVICE AIMS TO

- Support and engage with patients on ward during the recovery phase to identify personalised outcomes for discharge.
- Provide practical help and support following a discharge from hospital.
- Help users regain confidence and reduce anxiety.
- Reduce social isolation.
- Promote independent living and choice.
- Help users maintain day to day activities.
- Provide information/signpost to other organisations.
- Help prevent readmissions to hospital.

The service is designed to be short-term, friendly and confidential.
Case Study 1: Older Person

Alex (78), from Glasgow was admitted to hospital after he was found lying on the floor of his home for four days. Alex has no family nearby - only a brother in England with whom he keeps in contact with by telephone.

Royal Voluntary Service (RVS) stepped in when Alex was referred to the Home from Hospital service by social services. RVS went to Alex’s home to collect his night clothes and toiletries. Alex’s regular visits have helped Alex get back on his feet and rebuild his confidence, and he no longer feels isolated or lonely.

“I’m so grateful for what RVS have done for me – changing my life and improving it in so many ways. It’s a comfort having Alex as a good friend and I look forward to seeing him every day.”

WHAT DOES THE SERVICE OFFER?

- Support older people whilst in hospital by assisting in recovery plans through practical support such as preparation for mealtimes, encouragement to eat and drink, as well as time to chat.

- Opportunity to identify personal outcomes and liaise with family, carers and health professionals to support timely discharge, for example by collecting clothes, personal belongings and transport.

- Practical preparation on the day of returning home by ensuring there is a basic supply of food, such as bread and milk, and the heating is on ready for arrival.

- Assisting with practical tasks like shopping, meal preparation, help around the house and collecting prescriptions.

- Transport to follow up medical appointments at hospital or GP, or to go shopping, visit friends and family or attend local lunch or social clubs.

- Provide companionship by visiting and/or having regular chats on the phone.

- Our volunteer will perform a safe, well and warm check to ensure the older person’s wellbeing and will report any concerns.

- Signposting and referral to other agencies or support networks.

- Liaising with other agencies to resolve ongoing or outstanding issues and to raise concerns.

We’ve designed the programme around older people’s wishes, and have built these into the six essentials (see page 4) that we believe should underpin every service.
THE SIX ESSENTIALS
(IN THE WORDS OF THOSE WHO KNOW)

*1 “I want to be kept informed about when I will be going home and my family/carers need to know this too.”

*2 “I want my journey home to be comfortable and with someone who knows me (if only a little) and it would help to have someone to settle me back into my home.”

*3 “It would be reassuring to know that someone is able to pick up my prescriptions for me and help me to my GP and hospital appointments.”

*4 “It would be nice to know that the heating and lighting is on ready for when I return home.”

*5 “I would like to know that there is bread and milk in the fridge when I get home and someone to help me cook a meal and collect shopping.”

*6 “Being home alone, especially if I am less mobile, can be lonely so it would be nice to know someone is coming to visit me.”

Case Study 2: Family

When Sylwestra, 89, came out of hospital after a fairly long spell, Royal Voluntary Service was on hand. Sara, a local volunteer visited Sylwestra daily, helping her get back on her feet with all sorts of tasks, including shopping, laundry and her favourite pastimes; crosswords and drinking tea.

Sylwestra’s son, Andrew, has found the service provided to his mother to be invaluable:

“I try to visit her regularly but in reality it’s only every few weeks due to work commitments, and it’s the day-to-day things that are the problem, such as visits to the GP and odd bits of shopping. It’s a great comfort to know that the little things are being catered for. In fact they’re not really little things at all for a housebound person.”
FROM WARD TO COMMUNITY
HOW OUR SERVICE WORKS

Referrals are generally received from health and social care professionals based in hospitals with smaller numbers self-referred or routed via other means.

Working closely with clinicians, carers and family, our service usually begins on the ward, where we help ward teams to identify older people who could benefit from support at discharge. Volunteers can highlight support needs through conversations and help plan for discharge, working with the service team to ensure a smooth, timely transition from hospital to home. If family or a carer is involved, the volunteer also meets with them at this stage to give them reassurance.

The service is designed to be short-term (approximately 4-6 weeks or more), personalised, friendly and confidential.

At the end of the 6 week period, the older person has the option to move into a local Good Neighbours Service for as long as they need. Again, personal outcomes are identified and the focus is around re-ablement, maintaining independence, reducing loneliness, and helping to improve wellbeing.

OVERVIEW

In Hospitals:
Focus on reducing delayed discharge
Volunteers on wards; supporting patients’ journey and recovery plans.

In Home:
Post Discharge - 6 weeks
Preparing home for return
Hot meal and food hamper on return home
Medication collection
Transport to medical appointment
Assistance shopping - regain confidence
Companionship
Referrals to other services
Planning for longer-term social and practical help: e.g. referrals to community transport, repairs, adaptations, benefits

In Community:
Good Neighbours
Companionship visits
Lunch clubs and Social Centres
Volunteering opportunities
Community and social transport
Health and wellbeing activities
Food and nutrition advice
Memory activities

Transition to be supported through Good Neighbours Service
OUR VOLUNTEERS

Royal Voluntary Service volunteers are compassionate individuals recruited for a wide range of roles including driving, befriending either in person or by telephone, services provided on hospital wards, good neighbours practical support, assisted shopping, social centre help and lunch club support. Volunteers who have regular one to one contact with older people are PVG (Protecting Vulnerable Groups scheme) checked.

WHAT OUR SERVICES CAN ACHIEVE

This is an example of what our services can achieve, based on the Leicestershire Hospital to Home Service evaluation:

- 1201 Referrals
- 915 Signposts to other organisations
- 3649 Hours spent face to face with service users
- 11450 Interactions
- Readmissions rate of 8.35%, nearly half the national average
- 2817 Outcomes

Source: Figures based on Leicestershire Hospital to Home Service 2012-2014
SOME EXAMPLES OF OUR SERVICES

Grampian

With the generous support of NHS Grampian, our services in Aberdeen City, Moray and Aberdeenshire are helping to improve older people’s experience on the ward, where our volunteers identify how we can further support patients when they are ready to be discharged. These On Ward support services operate in ARI, Dr Gray’s and in Aberdeenshire Community Hospitals, with the Home from Hospital service being offered from many wards by more than 76 Volunteers. These volunteers who are trained in falls awareness and prevention, can arrange to be at the person’s home on the day of discharge or can meet them in hospital, help collect prescriptions, GP letters and arrange transport to leave hospital. Volunteers assist with getting the shopping, ensuring that the house is ready and make plans to keep the person company and encourage them to get back into their usual routines.

Glasgow

Run in partnership with Glasgow City Council, the Home from Hospital Service offers help to vulnerable people in the first few weeks following their discharge from hospital.

Our volunteers ease the transition from hospital to home by helping with transport, putting on the heating and getting in shopping.

“It’s vital yet very simple that there is someone checking on older people, helping them to get out and about will make a real difference - helping them to recover quicker”

Ann Millar, Social Worker, Glasgow

Case Study 3: Volunteer

Steve Micallef is a police officer who wanted to do something different on his days off. Steve has been volunteering for more than 18 months and finds it very rewarding being able to help settle people back home after being in hospital. At times he can be helping up to three people during the same time:

“I love it, I like meeting different people and enjoy helping people. They are always very appreciative and it feels good to know with a small gesture you are making a real difference to someone’s life”
FIVE STEPS TO SET UP

A simple 5 step process gets a new Royal Voluntary Service Home from Hospital service up and running within 3 months, ready to build and develop over the next few months as we continue to recruit and train more volunteers to meet demand.

Plan (week 1-3)
Setting our goals
Working with the hospital and community teams to see what is required locally, agreeing our funding requirements and setting goals.

Design (week 4-6)
Shaping our service
Designing a tailored service, agreeing impact measurement, setting benchmarks.

Recruit (from week 7)
Building our team
Outreach via marketing and PR to drive recruitment of our people.

Train (from week 10)
Getting ready
Training, PVG checking, integration with hospital and community teams.

Launch (week 15)
Going live...

MEASURING THE DIFFERENCE WE MAKE

At Royal Voluntary Service we track the impact of our services every step of the way. Our aim is to assess how we benefit individuals in their daily lives as well as evaluating the positive impact of our Home from Hospital service on health and social care provision.

As standard we aim to have a positive impact on:

- Patient experience
- Wellbeing
- Achievement of patient goals
- Reductions in delayed discharge
- Reductions in emergency readmissions after 30 days

Case Study 4: Specialist Nurse

Janice Reid works as an Older People’s Liaison Specialist Nurse at Drumchapel Health Centre in Glasgow. On average she refers two people to the service each week but it varies depending on who’s on the ward. She finds it reassuring to know that there is a service on offer that can help to ease the often difficult transition from hospital to home:

“The Home from Hospital service can be a lifeline for people without any family. These people are vulnerable and sometimes a bit of time can make all the difference and help to aid their recovery.”
WHAT DOES A SERVICE COST TO SET UP?

Each service is different, with unique challenges meaning costs for set up will vary due to factors such as size and rurality.

Funding would need to cover the following items to set up a Home from Hospital Service:

- Volunteer Travel
- Welcome Packs
- Staff Costs
- PCs and Office Equipment
- Premises
- Marketing and Materials
- Misc. Office Costs
- Telephones and Costs
- Recruitment Costs (Staff)
- Recruitment Costs (Volunteers)
- Training
- Expenses
- Irrecoverable VAT
- Management Fee

Case Study 5: Commissioner

James Thompson is the Commissioning Manager for Glasgow City Council. With increasing demands placed on the resources the council has available he needs to ensure that the system works as effectively as possible. He says the Home from Hospital service provided by Royal Voluntary Service is critical in ensuring that older people have support put in place to enable them to return home:

“It’s often the very small things in a person’s life that can make the most significant difference and as a commissioner it’s often those services that we struggle most to commission.”
Royal Voluntary Service is expanding its hospital services. Our Scottish team will be happy to help design a supported discharge service which meets the needs in your area. We already work across much of Scotland and are happy to supplement our existing services. We are also keen to work with new partners.

For more information in the following areas:
Aberdeen City, Aberdeenshire, Moray, Orkney, Dundee, Perth and Kinross
Angus, Fife, Falkirk, Clackmannanshire, Stirling, West Lothian, Midlothian,
East Lothian, City of Edinburgh, Scottish Borders, North Lanarkshire, South Lanarkshire.

Please contact: Josephine Mill
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Mobile: 07834 482361

For more information in the following areas:
Highland, Shetland, Na h-Eileanan Siar, Argyll and Bute, Inverclyde, East Dunbartonshire,
West Dunbartonshire, Renfrewshire, East Renfrewshire, North Ayrshire, East Ayrshire,
South Ayrshire, Isle of Arran, Dumfries and Galloway, Glasgow.

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