Hospital Discharge embedding the VCSE

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VS6

Cheshire & Warrington Infrastructure Partnership

Voluntary Sector North West

Introduction

The Voluntary, Community & Social Enterprise (VCSE) Sector has a key role to play in supporting hospital discharge pathways. VCSE organisations are uniquely placed to support people and communities and are vitally important to reducing hospital readmissions, recovery planning, supporting population health and reducing health inequalities.

The NHS Long Term Plan sets out a clear vision for shifting support for health away from acute settings and into the community. Moving away from treating people as a collection of diagnoses towards person-centred support. The VCSE has a critical role to play in this vision, through more collaborative, cross-sector working, and channelling resources towards preventative approaches, as well as supporting more coordinated work across acute settings getting alongside people and enabling them to access the support that they need, at the right time.

The diversity of the VCSE is a strength to be recognised and celebrated and creates a real opportunity to help address NHS pressures and some of the gaps in support that can lead people to be admitted to hospital.

Across Cheshire & Merseyside there are over 15,000 VCSE organisations, ranging from national charities and social enterprises employing a large workforce to informal grassroots and volunteer-led groups supporting people in their local community.

NHS bodies and local government already commission VCSE organisations and work with them at different scales, and the COVID-19 response has, in many cases, accelerated collaboration and deepened relationships, providing good foundations to build on.

Evidence highlights that multi-agency work and multi-disciplinary teams are much improved with a combined sense of purpose. This approach ensures better communications, relationships and trust, sharing of information and data, as well as a more pro-active response to benefit patients and services.

The VCSE plays a pivotal role in using asset or strengths based approaches to develop people's skills and networks. By encouraging community connections, creating greater independence and supporting to build self-resilience.

At a place level, VCSE infrastructure organisations (often called CVS's or Voluntary Action) exist and provide a coordinating function for the wider VCSE sector. The VCSE Infrastructure network provides an invaluable link to VCSE services and community assets.

Analysis by NHS England demonstrated a strong relationship between the rate of emergency admissions and socio-economic deprivation. In areas where the most deprived 10 per cent of the population live, the rate of emergency admissions is more than twice that in areas where the most affluent 10 per cent of the population of England live. The VCSE infrastructure network provides access to specialist services working within the most deprived areas of Cheshire and Merseyside, supporting the most vulnerable in our communities. Working with the VCSE will better enable the ICS to prioritise the voices of those who are otherwise seldom heard, enabling inclusivity and helping to address health inequalities.

Many acute hospitals offer VCSE services based from within hospital settings. These services provide support with non-clinical factors like patient physical, social, psychological, financial and practical needs, including home adaptations and equipment. This model of delivery meets patient needs and supports early discharge and helps towards reduced re-admissions. Examples of services across Cheshire and Merseyside are:

- British Red Cross
- Carer's Services
- Snow Angels - hospital volunteers
- Sefton CVS discharge services.

In these models almost all interventions are carried out via the host organisation, based within the hospital.

However, there is the opportunity to further enhance this offer to fully embed the VCSE in the discharge process, accelerating collaboration and creating a more effective pathway flow, ensuring people's non-clinical needs have parity of esteem with their clinical needs. Most clinical staff are not aware of services offered by the VCSE, and most certainly don't have the time to research the local offer.

The optimum model of delivery is to enable effective navigation of wider VCSE services to maximise community-based support and local connections. A model providing a locality neighbourhood approach with the VCSE that offer a wide range of flexible specialist support and community connections. This will result in better patient choice, better patient outcomes, smoother pathways, reduced hospital stays (and associated decline), and lower overall costs.

Connecting with a wider VCSE network increases opportunities for collaboration for NHS services such as 'Virtual Wards', by offering wrap-around support to people in their homes alongside community led strengths-based care and support.

VCSE services integrated within hospital discharge provides extra capacity to:

Support with preparation leaving hospital, enabling effective and quick mobilisation of a support package focusing on safety and positive experiences for patients.

Provide a range of practical support to facilitate rapid discharge, including transport home and access to mobility equipment.

Support discharged patients with home settling services to maintain wellbeing in the community, such as safety checks, essential food shopping & prescription collection, heating and addressing food and fuel poverty issues.

Utilise VCSE organisations based within the hospital setting within discharge pathways and enhance with input from wider specialised VCSE organisations

Coordinate specialist support from VCSE providers to support with housing, welfare, debt and benefits advice.

Provide ongoing community-based support to support emotional wellbeing, such as befriending, linking into community volunteers.

Coordinate follow-up calls or visits and assessment at home after discharge from hospital.

NHS Acute Hospitals, Adult Social Care and the VCSE need to work together to deliver a model, making best use of existing resources in the community. In doing so, current investment could be used far more effectively to reshape provision towards more home-based, asset and strengths-based support, with less reliance and expenditure on bed-based provision.

VCSE sector has significant expertise that is invaluable in helping us achieve improvements across the health, social care and public health system'

Department of Health, NHS England and Public Health England".

Patient Outcomes

- Holistic approaches to help reduce delays and better support people through their discharge pathway.
- Increased choice ensuring a more diverse provision, along with good information and advice to empower patients to make choices that are right for them. The delivery of good holistic support to keep people connected to their networks and communities and maximise their independence.
- Access to specialist support on assistive technology services to enable people to live as independently as possible. As well as advice on finance and benefits for patients to address any financial insecurities.
- Improved patient experiences for those being discharged from Acute Hospital Trusts.
- Reduction in the number of unnecessary re-admissions to hospital for people supported by the service.
- An improved and more timely discharge process for the patients supported through the service.

NHS Outcomes

- Support a reduction in delayed discharges due to a wider VCSE support package.
- Help decrease unnecessary emergency in-patient activity.
- Help patients to regain or maximise their independence to enable them to continue to live at home.
- Reduced burden on out-patient services by pro-actively managing conditions.
- Contribute to fewer unnecessary readmissions
- Reduce the length of stay for people in acute care
- Help to improve people's outcomes following a period of rehabilitation and recovery
- Minimise the need for long term care at the end of a person's rehabilitation

Putting it into Practice

VCSE & Warrington and Halton Hospital Foundation Trust

Warrington and Halton's 'Healthy & Home' is one of five community projects across Cheshire and Merseyside to benefit from NHS Charities Together Community Partnership Grant. Healthy & Home led by Warrington Voluntary Action and Halton & St Helens Community & Voluntary Action provides a complementary service to the current discharge pathway and the Emergency Care Intensive Support Team, creating effective and long-lasting links with the VCSE. A key aim of this grant is to demonstrate that cross-sector partnerships between the NHS and the VCSE achieve meaningful health benefits for people adversely affected by COVID-19, especially those from marginalised communities or already experiencing health inequalities

Healthy & Home is delivered through VCSE Link Workers, integrated within the hospital's discharge team, providing a triage to volunteer support and a vast network of specialist VCSE services and community connections, enabling patients to feel supported at home. The service also helps reticent patients feel much more comfortable about being discharged. VCSE engagement with NHS providers, particularly discharge teams helps to provide solutions to operational discharge challenges. The model ensures that the VCSE is fully involved in the discharge process, as a valued and trusted partner, working within a wider multi-disciplinary team to assist in arranged packages of support for patients going home, providing a **'Front Door to the VCSE', with 412 patients supported to access 39 VCSE organisations** during the past 7 months. Healthy & Home has already identified an increase in the contribution to the 'Home First' model, with more patients going home rather than into bed-based care, reducing deterioration, and probability of returning to hospital.

"A big thank you to the 'Healthy and Home' Team for their support in facilitating a complex discharge on A8. This has helped the patient being discharged to their own home in a timely manner and avoid delays"

Taken from Daily metric round up - Warrington & Hospital Trust August

Cost saving to NHS £464,300

Early data estimates a financial saving of £464,300* (due to re-admission prevention & reduced length of stay) in the first 7months.

Case Study:

JE, 45 a frequent patient at WHHFT needed support to stay in her own home and with her self-care. Diagnosed with Elhers Danlos Syndrome and mental health issues, the patient had been known to the system for 10 years, with a habit of self-dislocating to ensure an admission to hospital, which would result in a stay of up to 6 weeks at a time. Despite having a care package and regular support from her sister, JE struggled to move on from NHS care.

Healthy and Home worked through a personalised care plan with JE and identified a number of goals to help break the cycle:

- To lose weight.
- Be more mobile.
- To reduce pain levels and be more resilient.
- To focus on her creative passion.
- To have a wheelchair assessment and move to sheltered accommodation.

Through the Link Worker JE accessed specialist support from 5 local VCSE organistaions. To access 'home settling' in support, friendship to use a meditation app, to learn breathing and anxiety management techniques to better manage self medication and also help with mobility. Regular friendly phone calls have in the short-term reduced the need to move to sheltered accommodation, wishing to stay at home. JE describes the calls as like having a 'guardian angel' watching over me. A referral with support for wheelchair access was followed up by the Link Worker, assessments were carried out, enabling her to access her back garden safely. JE has also been supported to access community arts centre to support with her mental wellbeing.

JE has not returned to hospital with her ongoing medical concerns. Her carers had to have her admitted in July due to a water infection, following her daily catheter care and she was only in hospital for a week before being discharged. Feedback highlights how her mood has improved greatly, she has lost weight, she has reduced her pain relief and her resolve to continue to be more positive, active and avoid hospitalisation is clearly in her mind set. JEs physio has stated that this is the best he has seen her since she was 17 years of age.

Prior to accessing VCSE support JE spent 11.5 weeks in hospital from 4 A&E admissions over a 12 month period and taken to intermediate bed via ambulance on each occasion.
Since accessing support via Healthy &Home Link Worker early 2022, there has been just one A&E admission for 1 week (this was for a UTI) and taken home via ambulance, this time the discharge was a quicker process directly to home.

This equates to a saving of £72,000 (equal to the cost of 2 VCSE Link Workers for 12 months)

On 11th February 2021, the Government published '**Integration and Innovation; working together to improve health & social care for all',** a landmark White Paper setting the clear strategic direction of requiring 'our health and care system to work together to provide high quality health and care, so that we live longer, healthier, active and more independent lives'

A fully integrated discharge service that truly embeds the VCSE is rooted in a one system, one purpose philosophy in supporting people to live well and independently at home and providing a graduated care and support offer when people's needs escalate

Case Studies:

Cath was recovering from surgery and walks with a stick. Cath, made contact with Healthy & Home a few weeks after her discharge and was linked to a VCSE 'walk to wellness' project. Cath's family have commented that she seems much more energetic and able bodied and that her confidence outside had really improved. Cath had recently been to see her Orthopaedic Surgeon and the first thing he said to her was that he'd noticed how well she was walking as soon as she came into the room.

John was referred to Healthy and Home due to his mental health and loneliness. After an initial chat on the ward John advised he was having issues with housing, the landlord was trying to increase the rent on his home and this would mean he would no longer be able to afford to live there, making him homeless. Healthy and Home liaised with the Mental Health Outreach Team and moved him up the waiting list for direct contact from a support worker. He was supported to access a community arts and crafts project and through a direct referral pathway John accessed support from Citizens Advice enabling him to negotiate a lower rent increase once discharged, as well as other benefits advice, as a result john has been able to remain in his home.

Recommendations

The ICS needs to build on what already exists across the VCSE, at place and neighbourhood level rather than creating new programmes or merely displacing funds. Data from across the VCSE and place-based communities should be drawn upon, to help understand where there is a need for investment. Identifying successful, evidence based models of delivery which can then by fully embedded, long term within the hospital discharge process.

Across Cheshire & Merseyside the ICS and VCSE need to work together to make best use of existing resources at both a regional and place-based level. In doing so, current investment could be used far more effectively to reshape service provision and be transformational in reducing reliance and expenditure on bed-based provision. Ensuring that people's needs are assessed holistically, which includes the provision of non-clinical support in line with the Department of Health and Social Care's hospital discharge policy.

Acknowledge that there is a need for ongoing investment in wider VCSE prevention services, to help address health inequalities. This includes services through which people are able to make social connections, as well as specialist services for people experiencing homelessness, mental health issues and support for people with particular conditions. Increasingly, and additional investment is needed for VCSE support for those most affected by the increasing cost of living. In the most deprived communities, the need for investment is greatest and investing in community infrastructure and community development to build capacity is critical. The Healthy and Home model, provides capacity building funds to VCSE organisations identified having an increased demand from referrals.

Value the VCSE, adopting an agreed plan to identify how the sector can be supported to demonstrate how their involvement achieves greater impact and value, which then builds an evidence base for future investment. In turn, this should be championed by the ICS, providing a platform to recognise the important contribution that the VCSE make towards addressing the social determinants of health.

Understand that short-term, non-recurrent funding, and longer contracts with no uplift, as well as competitive tendering can act as a barrier to sustainability, scaling up or adapting services, and collaboration.

Work with the VCSE sector from the outset as equitable partners, following an agreed approach to co-production and co-design of services.

Resources

Resources:
https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-of-health-and-social-care-2021/ the costs from this are short stay NEL £827, long stay £3627. Short stay is an 0-1 day stay and long stay is 2 days onwards. Elective is £4754 and outpatients £137.
*calculation based on costs utilising average rule of the £900 mark.

Hospital discharge and community support guidance - GOV.UK (www.gov.uk)
hospital-discharge-during-covid-19-18-01-2022.pdf (scie.org.uk)
Coronavirus » COVID-19 hospital discharge service requirements (england.nhs.uk)

CVS Cheshire East
Cheshire West Voluntary Action
Community Action Wirral
Halton & St Helens VCA
Liverpool CVS
One Knowsley
Sefton CVS
Warrington Voluntary Action
VSNW