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| **NHSCT Healthy at Home – Project Information** |
| This project delivers a partnership approach to hospital discharge, supporting patients at the end of their stay in hospital and back at home. Voluntary and Community Sector (VCS) partners have a key role in supporting the hospital discharge pathways, specifically pathways 1 to 3.  ‘Healthy at Home’ will be designed to provide a complementary service to the current discharge pathway and the Emergency Care Intensive Support Team within the hospital. It will enhance the current provision within the hospital and create effective and long-lasting links with the voluntary sector.  The project will be delivered through the provision of two VCSE Link Workers, integrated within the hospital’s discharge team, providing a triage service to volunteer support and VCS connections. The Link Workers will be managed by Warrington Voluntary Action and Halton Voluntary & Community Action respectively.  The model of delivery will ensure that the VCS is fully involved in the discharge process within the hospital system. The VCS will be a valued and trusted partner, working within a wider multi-disciplinary team to assist in arranged packages of support for patients going home or to bed based care.  The project will bring the expertise and knowledge of the VCS to the discharge process across the 2 ‘places’ – Warrington and Halton.  The role of the Link Worker will recognise established hospital discharge services e.g. British Red Cross but will connect patients going home to the wider voluntary sector offer.  The first year of the project will involve developing a VCS Hospital Discharge Alliance bringing together and formalising an Alliance of specialised voluntary sector organisations with the support and capacity to meet demand.  There will be two elements to the Link Worker Role in supporting the discharge process:   1. Linking in with and building on established projects that already exist within the 2 places: the Warrington Good Neighbour Scheme delivered through WVA in Warrington and Street Ambassadors delivered through HVCA in Halton. Both initiatives mobilised thousands of volunteers in response to Covid-19, supporting the shielded/clinically extremely vulnerable and isolated. This project will harness this mass engagement to coordinate volunteers within the NHS and Health and Social Care sector to support those most in need when discharged from hospital - such as the frail and elderly, those with chronic conditions and living in areas of deprivation. WVA and HVCA have identified an increasing interest and empathy in supporting vulnerable residents. This project will provide new opportunities to meet new interest. 2. Coordinate connections with the wider voluntary sector across the 2 places. Warrington and Halton have over 1500 community and voluntary organisations. As the local infrastructure organisations, WVA and HCVA are well connected and trusted partners of the wider voluntary sector, with the ability to coordinate and enable specialised support and social connections within a patient’s locality. Across the 2 places the VCS Link Workers will provide full time cover within the discharge team but also have allocated time to work within the sector, to stay connected with the VCS and develop and support the work of the Alliance.   The Link Worker connection will be key within the Discharge Team, building trusted relationships with the hospital to confidently refer to volunteers for support and the wider voluntary sector, which is currently an ‘unknown’ to the hospital. The project will unlock relationships for support at home or within a bed-based setting.  The VCS Link Workers will allow extra capacity to the Hospital Discharge team to:  • Support with preparation leaving hospital, enabling effective and quick mobilisation of a support package focusing on safety and positive experiences for patients on the discharge process.  • Provide a range of practical support to facilitate rapid discharge, including transport home and mobility equipment  • Support discharged patients with home settling services to maintain wellbeing in the community (e.g. safety checks and essential food shopping)  • Provide ongoing community-based support to support emotional wellbeing, such as befriending  • Offer support in advance of discharge to be at the patient's home to accept equipment delivery of equipment, medication or advice  • Work closely with the discharge team to coordinate follow-up visits and assessment at home after discharge from hospital.  • Enhance and embed input and support from VCS, specifically volunteer led and grassroots groups to help reach out to those living in the deprived areas and within our hidden communities  • Coordinate specialist support from the VCS to provide patients suffering from chronic conditions, including Long Covid, with benefits advice e.g. Carers Allowance and Personal Independence Payment (PIP).  This project will see 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. An integrated delivery with the VCS having a coordination role embedded within the hospital discharge process will support real choices for people to maximize their independence and remain in their own home. |