GM VCSE Home from Hospital Best Practice Model

10GM

A joint venture to support the local VCSE sector in Greater Manchester

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Background

The Home from Hospital Best Practice Model aims to demonstrate the value of the VCSE sector in delivering home-from-hospital provision and offers a set of practical recommendations for VCSE organisations and the Greater Manchester Integrated Care Partnership to establish a best practice model.

In collaboration with the GM VCSE Hospital Discharge Alliance, we identified important key factors (internal and systemic) that should be in place to ensure a successful delivery of each of the twelve recommendations.

Through this analysis and a mapping exercise carried out earlier this year, we have also identified the main gaps in VCSE home from hospital provision across Greater Manchester, and the improvements needed within the wider system to ensure that these services are fully integrated and function effectively. The ultimate goal is to ensure that patients have access to the care and support they need to successfully transition from hospital to home.

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This Best Practice Model is based on the British Red Cross outline of a full home from hospital service, which focuses on helping people to develop 5 independences:

About The GM Home From Hospital Programme

In Greater Manchester, the VCSE sector plays an important role in helping people to get home from hospital, helping them recover at home, and preventing hospital readmission. However, not everyone has equal access to the same types and levels of support.

With funding from NHS GM Integrated Care, 10GM delivered the Home from Hospital Programme, which aimed at upscaling and enhancing the existing response to discharge pressures, by increasing collaborative working between the VCSE sector and hospital systems.

We supported the GM VCSE Hospital Discharge Alliance, a group of 30+ providers who work together to increase the role of the VCSE sector in providing home-from-hospital services, support and influence commissioning in this space, and create opportunities for more joined-up working. This infrastructure was essential to facilitate VCSE participation in the development of a costed business case for VCSE discharge funding for year 2023/24.

We implemented a short-term Targeted Investment Fund, which aimed at upscaling and enhancing the existing response to known discharge pressures by investing more into VCSE-led home from hospital and readmission avoidance support. This resulted in 594 people supported to being discharged from hospital during Winter 2022/23, of which 32 were readmitted to hospital within 7 days of being discharged.

In collaboration with GM Homelessness Action Network, we designed and implemented a pilot project around supporting the discharge of people experiencing homelessness.

Throughout the delivery of this programme, 10GM gathered learning and evidence that demonstrate the value of the VCSE sector in delivering home from hospital provisions, such as case studies, a mapping exercise, and a Home from Hospital Best Practice Model.

To learn more about the GM VCSE Home from Hospital Programme, visit www.10gm.org.uk/Home-from-hospital.html.

Benefits of a VCSE-led delivery of home from hospital provision

The VCSE sector's person-centred approach empowers individuals to maintain their independence and develop resilience, reducing their reliance on services and, ultimately, lowering the potential of readmission. A can-do approach within VCSE organisations enables the delivery of bespoke services that may be overlooked in traditional statutory services. This approach also bolsters the confidence of patients in their own recovery plans and in the VCSE services available to them.

VCSE organisations have in-depth knowledge of the various services, providers, and community groups available, thereby providing patients with a wider array of support options. Furthermore, long-standing and successful partnerships with relevant agencies and services help ensure the best possible outcomes for patients. VCSE providers are highly trusted by the communities they are a part of, promoting a sense of trust and reliability.

One of the significant advantages of VCSE services is their immediacy, as patients do not have to endure lengthy waiting lists. Additionally, VCSE services are characterised by their flexibility and responsiveness, allowing them to adapt quickly to the unique needs of each patient, further enhancing the overall quality of care provided.

Voicing the feedback of service users

Families' testimonials regarding VCSE hospital discharge support services are overwhelmingly positive. Without these services, they would have encountered significant difficulties in securing placements. The families were thankful for the extensive support received, and the clarity demonstrated throughout the processes. One family was so content with the assistance they received that they expressed their gratitude by sending flowers to the support worker involved.

"The service is very helpful and we are very grateful. The service is very person-centred. We have moved forward at a tremendous pace."

"Thank you so much to Paul who came this morning and fixed a cover over the loft aperture for me. Quality job and a nicer man you could not meet. Keep up the good work for those less fortunate to do these things for themselves and know you are hugely appreciated."

"I cannot tell you how grateful I am for your support - lightening the load. I did not realise the impact of what I have been carrying for so long. A breath of fresh air, and the simple yet practical support, is life changing."

"Thank you for offering me the service and the warm and friendly environment you have created for me."

Our Recommendations for a Best Practice Model

We have used the findings from our work on the Targeted Investment Fund to offer a set of practical recommendations for VCSE organisations and the Greater Manchester Integrated Care Partnership to establish a best practice model. Our recommendations for action are as follows:

1. **Designate a VCSE lead agency responsible for coordinating discharge support activities within the locality**
2. **Integrate VCSE services within discharge hubs**
3. **Conduct regular checks on patient via telephone or in-person visits**
4. **Arrange for transportation services**
5. **Ease the transition from hospital to home through 'settling in' support**
6. **Ensure the safety of patient's home environment with adaptations and improvements to housing**
7. **Supply minor equipment**
8. **Work collaboratively with other organisations and agencies to provide essential information, advice and support**
9. **Help reduce social isolation**
10. **Signpost patients to culturally appropriate support**
11. **Assist with prescription collection and medication plans**
12. **Establish an organised referral process**

Elements of a Best Practice Model

Designate a VCSE lead agency responsible for coordinating discharge support activities within the locality

Key Internal Factors

To facilitate effective collaboration among VCSE providers, we recommend implementing the following internal processes:

- Shared Referral Form: Utilising a standardised referral form for collecting essential information on clients streamlines the referral process, saving time and effort for the providers involved. A data sharing agreement is essential to ensure compliance with data privacy regulations and maintain client confidentiality when sharing sensitive information. The agreement should be comprehensive and outline the terms and conditions for secure data sharing.
- Joint-Referral System: Simplify administrative processes and ensure clients' privacy preferences are consistently respected by implementing a join-referral system, where patients provide consent once, applicable to all services and providers.
- Lived Experience Panel: Involving a lived experience panel in the decision-making and service-design processes promotes inclusivity and ensures that providers consider the perspectives and insights of those with direct experience with their services.
- Database of Local and Pan-GM Organisations: Maintaining a comprehensive database of local and pan-GM VCSE providers of home from hospital services is essential for effective service coordination and informed referrals. This database should include information on the organisation's key contacts, service offer, referral routes, operating hours, and mission, vision, and values.
- Clear Roles: Clearly defined roles and responsibilities within the organisations ensures employees understand their tasks, reduces confusion and improves overall operational efficiency. This clarity is essential for effective collaborative working.
- Seven-Day Provision: To provide timely support and assistance, offering home from hospital services seven days a week enhances accessibility and responsiveness to patients' needs.

Key Systemic Factors

In order to meet the escalating demand for Voluntary, Community, and Social Enterprise (VCSE) home from hospital provision and sustain it in the long term, several key factors must be considered:

- Dedicated Funding: Adequate funding is crucial to ensure the team or organisation responsible for this provision can operate effectively.
- Access to NHS Care Records: Access to the NHS electronic health record system containing comprehensive and up-to-date patient information can significantly enhance patient care, coordination, and decision-making. By providing VCSE providers with a patient's medical history and information, access to the NHS Care Record can result in improved healthcare outcomes.
- Clear Agreements and Protocols: Well-defined agreements and protocols for collaborating with wider-system partners are essential. These protocols should outline the roles, responsibilities, expectations, and communication processes between different organisations. Having clear agreements streamlines operations and ensures that everyone involved is informed, ultimately benefiting patients.

Elements of a Best Practice Model

Integrate VCSE services within discharge hubs

The involvement of physical VCSE home services in hospitals enables streamlined referrals by establishing direct communication with hospital systems and participating in discharge planning processes.

Key Internal Factors
Maintaining a physical presence within the hospital enables direct communication and collaboration between VCSE staff and hospital systems, streamlining discharge planning processes.

- It's essential that VCSE providers are easily identifiable and visible to hospital staff, particularly discharge teams. This ensures that hospital staff are aware of the VCSE role and can readily engage when needed.
- Access to hospital wards and patients enables VCSE providers to interact with patients, understand their needs, and provide appropriate support or resources.
- Practical arrangements such as having an office space located on hospital grounds and access to parking permits are examples of ways to facilitate the implementation of this element.

- Membership of Multidisciplinary Teams: VCSE staff should be active members of the hospital's multidisciplinary teams (MDTs), contributing their VCSE sector expertise to improve patient outcomes. This involves actively participating in discharge planning, case discussions, and decision-making processes.

- Clear mandate: VCSE providers must operate with a well-defined and clearly understood mandate that aligns with the hospital's goals and patient care objectives. Hospital staff should be aware of the specific services and support the organisation offers.

- Information exchange: The VCSE provider should actively engage in information sharing with hospital staff, and vice versa. This includes sharing relevant patient data, updates on patient progress, and insights from their interactions with patients. Effective information sharing ensures that everyone involved in a patient's care has the necessary information for informed decision-making.

Key Systemic Factors
Centralised referral system: This method functions as a hub that manages referrals from healthcare providers, both within and outside the locality, in an efficient and effective manner. It serves as a centralised system for all referral-related activities.

- A standardised setup, uniformly applied across all hospitals, guarantees that the referral process is transparent and consistent for all concerned parties.
- This system serves as the primary point of communication between VCSE and Health & Social Care teams, which facilitates collaboration, promotes communication, and guarantees a coordinated approach to patient care.
- This mechanism allows authorised users with access to shared patient records to make informed decisions based on a patient's medical history and previous care interactions.

The Age UK Stockport Hospital Discharge Service is based at Stepping Hill Hospital, as part of the Integrated Transfer Team. This service is provided 7 days per week, 9am-8pm. Age UK staff are visible and included in the discharge planning processes, as they attend multidisciplinary team meetings as key members of the group, and have their own desks in the hospital.

Elements of a Best Practice Model

Conduct regular checks on patient via telephone or in-person visits

Regular physical and mental health check-ups, coupled with evaluations of one's home environment, are crucial in identifying necessary support needs.

Key Internal Factors:

- Holistic patient care: A comprehensive approach to addressing a person's physical, mental, and social wellbeing.
- Home visits: Conducting home visits is essential to evaluate the patient's living conditions, potential safety hazards and gain valuable insights into their overall wellbeing.
- Communication methods: While phone calls may be convenient, it's important to recognise that not everyone can answer the phone or may experience anxiety related to phone calls. VCSE providers should be flexible and adapt their communication methods to meet individual preferences and needs.
- Contact preference form: Implementing a contact preference form at the point of referral enables patients to specify their preferred means of communication, thus minimizing anxiety and improving engagement.
- Risk assessments: Risk assessments are vital in identifying potential risks to the patient's health and safety, and developing appropriate interventions to address factors that may impact their wellbeing.
- Lone worker policy and process: VCSE staff conducting home visits should have a clear lone worker policy and process, outlining safety measures and protocols to protect them when working alone in patients' homes.
- Regular review points: Regularly scheduled review points enable VCSE staff to monitor the patient's progress, adjust care plans as needed, and address emerging concerns, ensuring care remains tailored to the patient's evolving needs.

Key Systemic Factors:

- Patient consent: It is essential to obtain patient consent before sharing any information or conducting assessments. This is not only an ethical requirement but also a legal one. Patients must provide informed and voluntary consent, understanding the purpose, scope, and potential outcomes of these actions.
- Information sharing: With patient consent, relevant VCSE and healthcare providers can securely access and exchange necessary patient information. This information may include medical history, care plans, medication records, and more, all of which contribute to better-informed decisions and improved patient outcomes.
- Automatic home assessments: Automatic home assessments can be particularly beneficial for individuals living alone, with poor mobility, and a history of falls. These assessments can help identify potential hazards and risks within the patient's living environment.

The Age UK Stockport Hospital Discharge Service includes telephone/visit assessments. This service is provided 7 days per week, 9am-8pm.
When a referral is received, a telephone call is made within 12 hours. This initial assessment is followed by the delivery of other elements, in response to the patient’s need identified through the initial phone call.

Elements of a Best Practice Model

Arrange for transportation services

This can include transport home from hospital, transport to appointments, or any other type of transport, as required by the patient.

Key Internal Factors:

- Database of Local Contractors and Community Transport Providers: The maintenance of an up-to-date and comprehensive database of local contractors and community transport providers is crucial for effective service coordination and informed referrals. This database should contain pertinent information regarding the services offered, availability, contact information, and any specific considerations such as wheelchair accessibility.
- Operational Efficiency: Practical arrangements such as a dedicated vehicle with the organisation's logo, a clearly designated pick-up point at the hospital, and car park passes, can streamline the transportation process and mitigate confusion.
- Ongoing Support: Provision of assistance should extend beyond hospital discharge, including transport to medical appointments, community activities, and other essential destinations. This approach promotes long-term independence and overall well-being.

Key Systemic Factors:

- Patient readiness for discharge: Ensuring a successful hospital discharge entails preparing the patient for their transition home, including meeting their basic needs such as medication plan, feeding, and toileting.
- Information for transportation providers: Providing the transportation provider with detailed instructions regarding the patient's requirements is essential. This includes information about the patient's mobility status, any mobility aids required (e.g. wheelchair, walker), and any specific requirements for assistance during transport, as well as contact information, medical information, and destination details.
- Coordination: Effective coordination between the healthcare team, transportation provider, and the patient is crucial. This includes scheduling transportation in advance, confirming pick-up times, and addressing any concerns or questions the patient may have about the transportation process.

The HMR Circle Home from Hospital Service is designed to help older people leaving hospital in a safe, comfortable and timely manner, supported by HMR Circle staff and volunteers. This transport service has a particular emphasis on supporting those who live alone and/or no access to transport.
This service provides support to Rochdale residents being discharged from Fairfield Hospital, Royal Oldham Hospital, North Manchester General Hospital, and Rochdale Infirmary.

Elements of a Best Practice Model

Ease the transition from hospital to home through ‘settling in’ support

‘Settling in’ support to assist with basic tasks, adapting to the home providing practical and emotional support

Key Internal Factors:
To ensure successful delivery of this element, support must be tailored to the patient's unique needs. Adopting a 'one size fits all' approach is not an effective solution. An initial assessment is a crucial first step in providing quality support that is customised to individual needs.

Other important components that comprise a comprehensive 'settling in’ support offer include but are not restricted to:

- Assistance with grocery shopping
- Prescription collection
- Meal delivery, including culturally appropriate options
- Access to white goods, furniture, and/or crockery
- Provision of heating (emergency credit or radiators)
- House cleaning services
- Gardening services
- Culturally appropriate support
- Pet support (feeding, cleaning, walking)

- Swift response time and consistent welfare checks: Ensuring prompt response time to requests for assistance and scheduling regular welfare checks.
- Onward support and referral to other providers: Providing ongoing support, either internally or through linking up with other providers, to address long-term needs and challenges.
- Occasional follow-up check-ins: Periodic checks to assess the continued well-being of individuals and identify any evolving needs.
- Risk assessments: Conducting risk assessments to evaluate potential hazards to the patient's health and safety, identify factors that may impact their well-being, and develop appropriate interventions.
- Lone worker policy and process: For VCSE staff conducting home visits, having a clear lone worker policy and process is critical. The policy outlines safety measures and protocols to protect individuals when they work alone in patients' homes. It addresses potential risks and ensures that necessary precautions are taken.

Key Systemic Factors:
- One of the key systemic factors is partnership working and referrals to various services, including both the VCSE sector and statutory agencies. This approach is crucial in delivering holistic and comprehensive support to individuals.

Caribbean & African Health Network offers ‘settling in’ support to people being discharged from hospital. This service is provided 7 days a week, 9am - 7pm.

Once a referral is received, an initial assessment is carried out to identify the patient’s wellbeing and support needs, and to confirm contact details.

For example, client J needs a hot meal, support with shopping, and a house and garden cleaning:
·The hot meal is sourced via an online eatery. However, if the client is not comfortable with receiving the order, a volunteer prepares the meal and drops it off.
·A volunteer goes shopping for the client, and deliver the groceries.
·A booking is made for a house and garden cleaning.

Within the first 3 to 7 days post-discharge, the team carries out daily welfare checks. This can be extended up to 14 days. During the welfare checks, the client is asked about their wellbeing and daily routine. Callers are trained to notice any social cues or any specific support that may be required.

Elements of a Best Practice Model

Ensure the safety of patient’s home environment with adaptations and improvements to housing

A variety of services are needed to ensure the safety, accessibility, and wellbeing of individuals within their homes.

Key Internal Factors:

- Commence with a comprehensive home safety assessment to identify potential safety hazards and areas that require attention.
- Offer a comprehensive home support package that includes key safe fitting, small repairs, maintenance, aids and adaptations to property (such as walk-in showers, grab rails, and bannister rails), furniture moving, assessing and securing trip hazards, energy efficiency assessment, and hoarding support (which typically requires longer timescales).
- Collaborate with trusted contractors and service providers to undertake necessary repairs and adaptations.
- Know when and how to refer individuals to other services that can address specific needs or concerns in a timely and effective manner.

Key Systemic Factors:

- Collaborate with statutory agencies to ensure practical and financial support is available from various departments and organisations, particularly Housing and Adult Social Care services in order to provide a holistic approach to supporting individuals within their homes.
- Utilise discretionary funding and spot-purchasing funds to resource services and equipment that support independent living for individuals.
- Collaborate with trades and contractors to ensure individuals receive high-quality and reliable services for home adaptations, repairs, and maintenance.
- Implement ‘move-in’ places to support younger patients transitioning into independent living arrangements, as different individuals have unique needs.
- Address hoarding environments by providing the necessary support, guidance, and resources to individuals dealing with hoarding issues. Note that hoarding support requires longer timescales and specialised interventions.

The Handyperson team, at Manchester Care & Repair, complete works to aid hospital discharge within 48 hours to help people safely return home from hospital. Referrals are received directly from the hospital.

The team can fit essential aids such as key safes, grab rails and bannister rails, can move furniture to make room for a hospital bed or other equipment, and can secure trip hazards in the home.

Elements of a Best Practice Model

Supply minor equipment

The procurement and delivery of equipment tailored to the specific requirements of the patient and their living conditions is crucial. These equipment types may include minor items such as commodes, walking aids, toilet seats, handrails, kitchen implements, personal alarms, key safes, and similar items.

Key Internal Factors:

- Pre-discharge home visits: The pre-discharge phase begins with comprehensive home visits to assess patients' needs. These visits are crucial for understanding the specific requirements of each patient, including any equipment or adaptations needed to support their safety and wellbeing upon returning home.
- Rapid access to equipment prescription: Following the home assessment, equipment prescriptions are issued based on the patients' identified needs. The goal is to ensure that the necessary equipment is ready for use at home as soon as the patient is discharged.
- Building timeframes into discharge planning: Discharge planning should account for the collection and installation timeframes of equipment. This ensures that patients do not experience unnecessary delays or gaps in care due to equipment availability.
- Use of trusted assessors: Collaboration with trusted assessors, who are knowledgeable about patients' needs and equipment requirements, accelerates the assessment and prescription process. These assessors can expedite decision-making and minimise potential delays.
- High demand for key safe fitting: Key safe fitting is often in high demand, particularly for patients who require secure access to their homes. Proactively addressing this demand ensures that patients can safely and conveniently access their residences upon discharge.

Key Systemic Factors:

- Working alongside healthcare providers: Collaboration between the VCSE sector and healthcare providers, such as Reablement teams and Occupational Health Assessors, is crucial for providing comprehensive and coordinated care to patients. These teams collectively assess patients' needs and abilities to create tailored care plans.
- Spot purchasing funds and fully funded services: Spot purchasing funds are essential for acquiring specific services or equipment quickly, especially when immediate support is required. Additionally, having fully funded services available ensures that patients have access to necessary care and support without financial barriers. This promotes equitable healthcare delivery.
- Easy access to funding sources and eligibility information: To streamline this process, VCSE providers should have easy access to information about available funding sources and eligibility criteria. Simplified and transparent eligibility requirements also help identify which funding sources are appropriate for their organisation.

The Age UK Hospital Discharge Service includes the delivery of minor equipment. This service is provided 7 days per week, 9am-8pm.

Equipment is sent via a service prescription, depending on the patient's needs, to be able to be discharged home. Age UK staff collect the equipment from various care shops, deliver it to the patient's address and help setting it up (if required).

Elements of a Best Practice Model

Work collaboratively with other organisations and agencies to provide essential information, advice and support

Collaboration and coordination between multiple organisations and agencies to provide essential information, advice, and support to ensure effective and holistic service delivery.

Key Internal Factors:

- Creating a trusting relationship with the patient: Building trust with patients starts with open and empathetic communication. VCSE providers should actively listen to patients, validate their concerns, and involve them in decision-making. Trust is further strengthened by consistently demonstrating respect for patients' autonomy, preferences, and values. This includes respecting their consent and choices regarding their care.
- Person-centred approach starting prior to discharge: A person-centred approach is at the heart of patient care. Prior to discharge, VCSE providers should focus on understanding the patient's individual needs, preferences, and goals for recovery. This approach ensures that the discharge plan plan is tailored to the patient's specific circumstances, optimising their chances of a successful transition from the healthcare facility to their home environment.
- Understanding stressors: A crucial aspect of person-centred care is identifying and addressing the patient's stressors and social determinants of health. These may include financial worries, the cost of living, and feelings of loneliness. By recognising and addressing these stressors, VCSE providers can connect patients to appropriate support services or resources to alleviate these concerns.
- Supporting with scheduling and attending appointments: Assisting patients with scheduling and attending appointments, including follow-up visits, ensures that they receive consistent and necessary care. This support may include helping patients organise transportation, providing reminders, and ensuring that healthcare appointments align with their availability and preferences.
- Home visits and joint assessments: Home visits are invaluable for assessing patients' needs in their own environment. Joint visits alongside other support services, such as social workers or occupational therapists, can provide a comprehensive understanding of the patient's situation.
- Patient consent: Prior to any information sharing or assessments, obtaining patient consent is a fundamental ethical and legal requirement. Patients must provide informed and voluntary consent for their information to be shared with partner organisations. This consent should be obtained in a clear and understandable manner, ensuring that patients fully understand the purpose, scope, and potential outcomes of these actions.

Key Systemic Factors:

- Links to wider Information, Advice & Guidance (IAG) specialists: VCSE providers should establish partnerships or referral pathways with IAG specialists, especially those who have expertise in financial matters. This collaboration ensures that patients receive specialised guidance on matters that may be impacting their health and wellbeing.
- Signposting into other services offering holistic support: Effective signposting involves connecting patients with a wide range of support services that address their holistic needs beyond medical care. This includes services related to housing, social support, mental health, and more

The Resettlement Coach at Groundwork Wigan meets each patient prior to discharge, via an in-reach service at the hospital, and also takes part in the patient's discharge meeting. This allows for an understanding of any further fears or concerns, and how Groundwork can support with it.

The Resettlement Coach creates a 'Home from Hospital Handbook' for each patient, which helps reminding them of everything they had discussed prior to discharge (worries, motivations, priorities etc.), and the support available for them. The Handbook has three key themes: 1) Supporting wellbeing; 2) Practical and financial support; 3) Keeping a routine.

The Resettlement Coach hands the Handbook to the patient on the initial home visit, and starts the discussion with the patient around their priorities, focusing on how Groundwork can support on executing those priorities, which can include linking with other support services.

Elements of a Best Practice Model

Help reduce social isolation

For instance, building relationships with support services and integrating with local peer groups can help sustain the emotional well-being of patients. Such connections with people and the community can positively impact their physical health and reduce or postpone the need for formal support services.

Key Internal Factors:

- A comprehensive support offer includes, but is not limited to:
  - Wellbeing checks
  - Telephone befriending
  - Home visiting
  - Social offer (social calendar)
  - Social groups, exercises, activities (online and in-person)
  - Creative health
- Collaboratively engaging with patients to identify potential peer groups and services that can help alleviate isolation is a key aspect of providing comprehensive support. This involves establishing regular support from a befriender who offers trust, encouragement, and consistent check-ins on both the individual and their home environment.
- In addition, conducting field research to gain a deep understanding of available support options and effectively communicating their benefits to patients is essential. This may include sharing information about relevant programs, community resources, and opportunities for social engagement.
- Moreover, offering to accompany patients to their initial meetings or sessions can help them feel more comfortable and confident in accessing support services.
- The emphasis here is on addressing their needs sooner rather than later, promoting a timely and holistic approach to reducing isolation and enhancing overall wellbeing.

Key Systemic Factors:

- Collaborative working plays a central role in providing comprehensive support and addressing various aspects of wellbeing. This collaboration extends to social prescribing efforts, with joint visits and assessments enhancing the effectiveness of discharge plans.
- A directory of social activities within the locality serves as a valuable resource, connecting individuals to diverse opportunities for social engagement and community involvement.
- Additionally, collaboration with local transportation services ensures that individuals have reliable and accessible means of getting to these social activities, promoting participation and reducing barriers to engagement.

The Resettlement Coach at Groundwork Wigan has an initial meeting with each patient to understand what support they have around them (family, friends). Some patients feel well supported, whereby others feel isolated and in need of support groups and/or befriending services. The Resettlement Coach finds support groups for all patients which are local to them; even to those who feel very supported at home, as there is no such thing as “too much support”.

Mrs A was an elderly lady who felt isolated since leaving hospital, only had her daughter to talk to. However, she was struggling with calling her daughter because her landline had been disconnected, and her mobile had signal problems. The first priority was to sort out the landline issue, which allowed her to go back to having contact with her daughter as often as she’d like. Second, the Resettlement Coach found her some support groups which aligned with her own hobbies and likes, and a place where she could go to have a brew every morning. Ensuring that this lady remained independent and had links into her community was essential in avoiding readmission.

Mr B felt very supported by his son, but had issues with drugs and alcohol, which required specific support. The Resettlement Coach was able to link him with local groups who were able to support him with his addiction and bereavement issues. These groups gave him an opportunity to socialise with other people without feeling judged, which sometimes needs to be found outside of the immediate support of family and friends.

Elements of a Best Practice Model

Signpost patients to culturally appropriate support

Culturally appropriate support includes services aimed at addressing individuals' unique cultural backgrounds, values, and preferences to provide effective and respectful assistance.

Key Internal Factors:

- A comprehensive culturally appropriate support offer includes, but is not limited to:
  - Culturally appropriate emotional support
  - Identity-specific social groups and befriending
  - Ethnic food delivery
  - Counselling
  - Interpreter (when required)
- Good referral routes and partnerships: Healthcare and VCSE providers should be knowledgeable about the available culturally appropriate referral options and how to initiate them. This includes understanding the criteria for various services and the appropriate contacts for referrals.
- Referral and signposting: Knowing when and how to refer individuals to other services or that can address specific needs or concerns timely and effectively.

In Winter 2021/22 and 2022/23, Wai Yin Society implemented the 'Winter Wonderland Hospital Discharge Project' with the objective of providing culturally sensitive assistance to individuals from the Chinese community who needed support after being discharged from the hospital. The initiative aimed to prevent readmission to hospitals.
The services provided included 'settling in' support, a befriending scheme, advice and information support, and the delivery of ethnic food parcels.
Following participation in the Winter Wonderland program, a service user expressed their gratitude in a letter, stating: "Older adults, especially those living alone, face numerous challenges. I am grateful for the service, which has supported me in reducing my stress levels and increased my confidence in managing my affairs at home."

Key Systemic Factors:

- A culturally competent workforce: Culturally competent professionals possess the knowledge, skills, and attitudes to understand and effectively address the diverse cultural backgrounds and needs of their patients. This competence extends to respecting and valuing cultural differences, fostering trust, and ensuring that services are sensitive and responsive to cultural norms and preferences.
- Diversity in the Workplace: Having a diverse workforce that reflects the communities it serves is crucial. Diversity encompasses a range of backgrounds, including race, ethnicity, gender, age, abilities, and more. A diverse workplace fosters a rich exchange of perspectives, experiences, and ideas, which can enhance the quality of care and decision-making.
- Equality, Diversity & Inclusion (EDI) training: Training in EDI principles equips professionals with the knowledge and tools to actively promote equality, diversity, and inclusion in their work. This training helps individuals recognize and address biases, advocate for equitable care, and create an inclusive environment for both patients and colleagues.
- "By and for community": Engaging individuals with lived experience in the design and delivery of services and programs ensures that these initiatives are truly person-centred and responsive to the needs of the community. This approach acknowledges the expertise that individuals with lived experience bring to the table, creating more effective and relatable services.

Elements of a Best Practice Model

Assist with prescription collection and medication plans

Assistance with prescription collection and guidance on medication management, ensuring safe and timely access to prescribed medications.

Key Internal Factors:
- Supporting patients with their medication plan involves several key aspects. This includes prescription collection and assistance with their medication management, ensuring they receive the appropriate medications and understand potential side effects, especially those affecting the patient’s ability to drive safely. Additionally, a VCSE presence in the patient's hospital discharge meetings helps ensure that this information is shared with all providers involved in the patient’s discharge. It's also essential to explore whether the patient's GP or pharmacy provides a delivery service, making it more convenient for them to access their medications.

Key Systemic Factors:
- Collaborative working with hospital pharmacies is a fundamental aspect in delivering the patient’s discharge plan. This partnership involves close coordination and cooperation between healthcare providers and hospital pharmacies to ensure optimal patient care.

Establish an organised referral process

A consistent approach for efficiently sending patient information to service providers.

Key Internal Factors:
- Hospital and ward presence: This factor, alongside active engagement from hospital staff, is key to ensure a smooth referral process and successful discharge process.
- Cross-boundary referral processes between VCSE providers: Equally essential, a consistent and organised referral process between VCSE providers enables seamless transitions for the patient, who will be able to benefit from diverse support services tailored to their needs.
- Awareness raising efforts: VCSE providers should engage in awareness-raising activities within hospital settings, including communication pieces and promotion of service offer, so that hospital staff is aware of the services available and can refer patients to those, and patients can access the support they need. Ideally, these activities should be undertaken throughout Summer and Autumn, in preparation for Winter discharge pressures.

Key Systemic Factors:
- Shared referral form: Having a shared referral form for collecting basic information simplifies the referral process for VCSE providers working alongside hospital systems. It streamlines the intake of new cases by ensuring that essential data is consistently collected and readily available to the relevant teams.
  - A data sharing agreement is crucial to ensure that all partners comply with data privacy regulations and maintain confidentiality when sharing sensitive information about clients. This agreement should outline the terms and conditions for sharing data securely.
  - Implementing a join-referral system where patients provide consent once, applicable to all services and providers, simplifies administrative processes and ensures that patients' privacy preferences are respected consistently across all interactions.

Key areas for further development

Through this analysis and the mapping exercise carried out earlier this year, we have identified the main gaps in VCSE home from hospital across Greater Manchester: hoarding support, cleaning services, furniture move or removal, and access to white goods, furniture and key safes. These gaps stem from a lack of spot purchasing funds and fully funded services, which are essential for acquiring specific services or equipment quickly, and ensure that patients have access to necessary care and support without financial barriers.

Within the wider system, improvements are still needed to ensure that VCSE services are fully integrated and function effectively: hospitals must actively accommodate (hospital presence, physical space for VCSE) and include them within their systems and processes (VCSE access to and use of shared record). Additionally, there is a lack of investment in coordination activity (locality and GM-level) as well as direct provision, alongside the short-term nature of contracts – this is essential for the retention of recruited VCSE staff, the sustainable growth of home from hospital services and, ultimately, to ensure that provision meets the increasing demand.

To address these gaps and improve integration, Greater Manchester must prioritise investment in VCSE home from hospital services. This includes not only funding for spot purchasing and fully funded services, but also support for coordination activities at both locality and GM-levels. Longer-term contracts and investment in staff retention are also necessary to ensure the sustainable growth of these vital services.

Hospitals must also do their part by actively accommodating VCSE services within their systems and processes. This includes providing physical space for VCSE organisations and ensuring that they have access to shared records. By working together and investing in these critical services, we can ensure that patients have access to the care and support they need to successfully transition from hospital to home.

To learn more about the GM VCSE Home from Hospital Programme or to discuss how we can work together, please get in touch - we'd love to hear from you.

10GM

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