Improvement Fund End of Project Impact Report

We have designed this form to be flexible so that you can evaluate your project in a way that is meaningful to you but that covers our needs as a funder too. We have provided prompts for the information we are looking for, with a particular emphasis on improvement tools and methodology, the impact made, and the role the improvement fund played in you project.

Project Details	
Project Title	Community Support Programme For Early Discharge
Date of Report	01.05.19
Project Start Date	
Project End Date	
Lead Organisation	STRiVE
Partner Organisations	
Funding Amount	

What was the challenge? Guideline word count: 150
• What is the context / background to the need or problem your project addressed? In 2017, 7,296 East Lothian residents were admitted to hospital as an emergency. While most of these admissions would have been appropriate, it is likely that a percentage could have been cared for at home had the services been available. Each month an average of 26 East Lothian patients are medically well but are unable to leave hospital because they required care which could be provided. However, patients identified as having rehab potential only needed some low level support to assist them. By providing community volunteers and third sector additionality to the supported care pathways / home assessment and rehabilitation work programmes, the anticipated outcomes were: • A reduction in unnecessary hospital admissions and readmissions within 28 days • An increase in people self-managing their care • A reduction in unmet need for care • A reduction in the number of people delayed in hospital

- What did you want to achieve, and plan to do, with this funding?
- How will this project contribute to the delivery of the National Health
and Wellbeing Outcomes, local integration priorities and strategies and the reducing inequalities agenda?

To embed the use of volunteers and build social capital into the East Lothian Care Pathways, with particular focus on joint working with the START Team on early supported discharge, for over 65s. Volunteers support will include ensuring utilities are in place, support to engage with meaningful daily activities and assistance with achieving agreed outcomes. If further support is required signposting to relevant agencies was provided.

To offer everyone receiving the Supported Home Assessment and Rehabilitation Service the opportunity to benefit from the additionality of volunteer and community services as an integral element of assessment and support

To have a "real/good" person centred conversation with the patients, so that they could engage in activities that were important to them with the assistance of volunteers and the community. To assist them in regaining control and offering choice (informed)

To enhance the quality of someone's life by providing an opportunity to, with support from a volunteer or nominated contact, reconnect and engage with their community in a safe manner

To improve the experience and quality of being discharged home from hospital for patients

By providing this additional support patients we contributed to the National Health and Wellbeing Outcomes by ensuring that:

Patients were actively encouraged and supported to participate in their communities and participate in activities that could improve their own health and wellbeing and live in good health

Patients were supported and encouraged to look at what they could do rather than what they couldn't do, promoting their independence

Patients commented how they felt supported and how good it was to not be "just left" after a service/task had been provided. This promoted a positive experience where patients felt listened too, were treated with dignity and respect, and we as a team provided a service and support that was responsive to their needs and reliable, which in turn promoted positive

relationships.

Patients supported through this project felt that being given more information about what was available in their communities, services and advice, ensured the opportunities could be accessed safely and with the support of a volunteer if needed to build their confidence.

What was your approach? Guideline word count: 500

- Who were they people / roles / partners involved in the work, and what did they do to deliver the project?
- How did you engage with those actively involved in undertaking, or affected by, this work?
- What were your key activities? Describe the interventions or changes implemented in sufficient detail that others could reproduce it.
- What tools and methodologies did you use and why? (e.g. Lean, Model for Improvement, Appreciative Inquiry)
- What methods were used to test change and monitor progress? (e.g. meetings, data analysis, interviews and surveys)

What was the key data on activities (e.g. numbers of people involved from a service and user perspective, what they did, what happened)?

The project team consisted of STRiVE as the project lead working collaboratively with the Short Term Assessment & Rehabilitation Team (START) Lesley Berry/Victoria Houston and others, but with support from the Health & Social Care Partnership and Improvement Fund funding and support from Christine Owens, Heather (Logic Methodology, Evaluation).

STRiVE as the operational lead, ensured that

- Networking and marketing of the project was managed in a timely manner. (social media, local radio station, community groups, churches etc)
- Clear guidelines and boundaries were identified and agreed for the volunteers and the patients receiving support
- recruitment campaigns were designed and marketed appropriately (social media, local radio station, community groups, churches etc)
- Recruitment and Selection of volunteers progressed and was in line with recognised safer recruitment guidelines (Appendix 1)
- Provided regular supervision, support and training events for volunteers
- Worked in partnership with the START team, local Community Hospital to identify eligible patients
- Registered patients for the programme

- Supported the patient to Identify what was important to them, as a person, as an individual, and assist them to achieve their goals
- Identified and matched suitable volunteers to identified patients
- Assessed and promoted "self-management" to identified patients
- Provided regular "on-going" support, and links to the project and the opportunities within their communities
- Regular reviews of discharged patients
- Regular reports given to Senior management within STRiVE and NHS Lead and Ihub to ensure accountability, transparency and Governance

START Team & Lesley Berry

- Provided patients, discussion, outcomes and objectives for patients in the first instance
- Supported me working towards achieving my goals and the projects aspirations
- Provided support, guidance and governance (meetings etc)
- Regular support and supervision of my practice as well as the projects direction

Ihub – Christine Owen, Heather & others

- Provided funding
- Insight into where improvements could be made
- Evaluation and Monitoring Support
- Logic Model (Appendix 2)
- Governance
- Support and Guidance

Patients

- Visited them in hospital prior to discharge or at home
- Good Conversation – "normal" conversation, not about "goals/outcomes" about what mattered to them.
- Going on a bus to Musselburgh to have a coffee at Costas
- Shopping at Asda at the Jewel
- Walking to meet their grandchild (great) from school
- Making a pot of soup
- Meeting friends for coffee
- Regular Reviews

Volunteers

15 registered volunteers, my initial target being 5.

Age range 30 – 60

Motivation for volunteering within project came down to 2 distinct areas:
- A desire to help others or "give something back" and
- Opportunity to meet new people

Personal Benefits included

- Personal satisfaction through helping others
- Increased sense of worth through making a contribution
- Gave freely of their time and energy
- Attended regular support, supervision and awareness training (Appendix 3)
- Weekly or daily "wellbeing" checks asking patients
- how they were getting on,
- checking on falls,
- if they were managing to get out and about,
- were they experiencing any pain,
- how were they managing on the whole – did they have any concerns or worries
- Were there any family concerns or worries
- Were they still using the equipment provided, if no did they need it picked up
- Were they still waiting for equipment to be provided
- Anything else of note – this often highlighted hospital appointments etc
- Assisting and supporting patients to achieve their outings etc
- Assisting and supporting patients to access local services and community groups (including signposting)
- Assistance given to fill in forms
- Visits to people at home – supporting in areas such as meal preparation, cooking practice
- Transporting people by car -
- Supporting people on trips outside the home – gentle exercise & agreed outcomes, attend community events, shopping
- Helping people find out information about benefits/services or other resources in the area

- Helping people apply for the above (fill out forms)
- Provide a listening ear for people to talk about worries or problems

All 15 successfully completed their induction which covered the topics including:
- Boundaries
- Confidentiality
- Data Protection
- Support for Volunteers & ongoing contact
- Expenses
- Endings
- Protection of Vulnerable Adults
- Equality & Diversity
- Health & Safety
- Protection of Vulnerable Groups

Community
- Allowed us access to their groups and resources
- Social media (see attached appendix 4)
- Local Radio Station (see below)

📄 **Maureen Allan interview 15.6.18.mp3**

By developing a Community Support Programme which has a strong focus on prevention and "low level" support, we assisted in providing a lower dependency or reliance on care services, maintaining people's health and well-being, reducing unnecessary hospital activity.

What was the impact? Guideline word count: 800

- What were the differences and improvements made (quantitative and qualitative) and what was the impact or added value for the service and / or users?
- Key findings and data from any testing or evaluation of your project (where possible please attach a graph, table or figures to evidence the improvement made)
- What was / is the short term, medium term and long term impact?
- Who benefitted from the project and in what ways?
- Were there any unexpected outcomes, positive or negative, and what impact did these have?
- If any individuals or groups were unintentionally excluded can you explain why this happened and what was the result?
- Were there differences between observed and anticipated outcomes, including the influence of contextual factors, and what were the reasons for this?
- Please include examples of how individual participants or service users experienced and fed back on
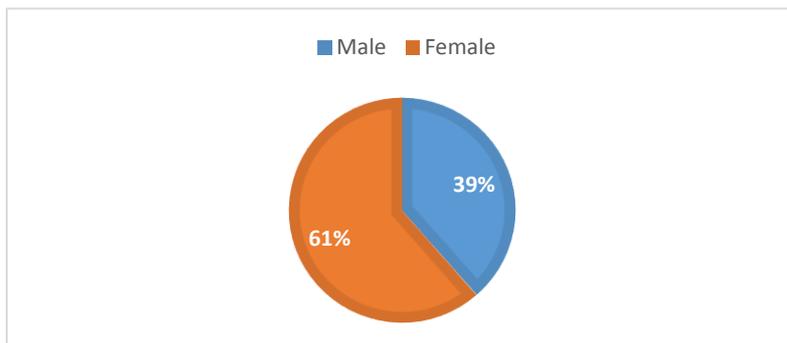
the work (e.g. case studies, interviews, quotes).
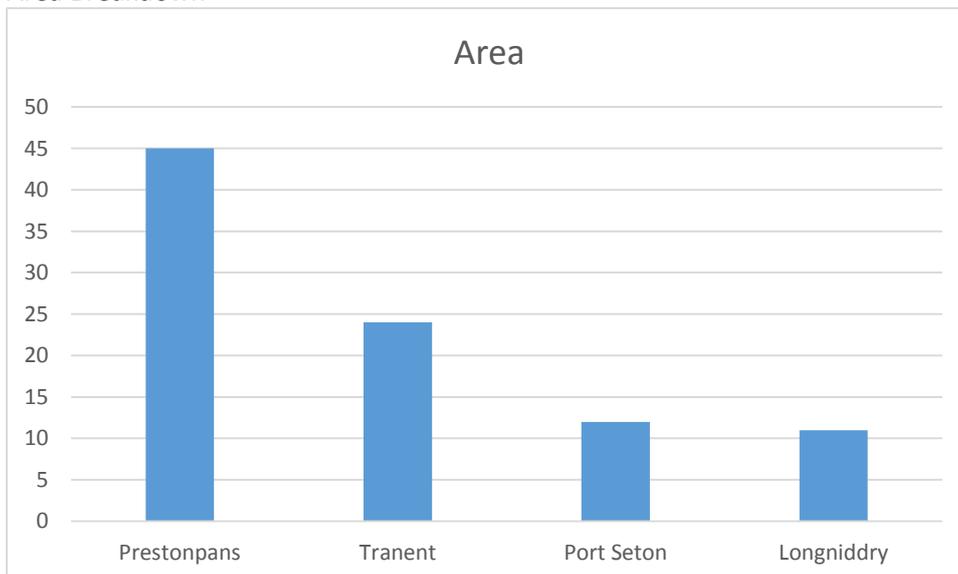- In what ways did partnership working contribute to the success of your project?
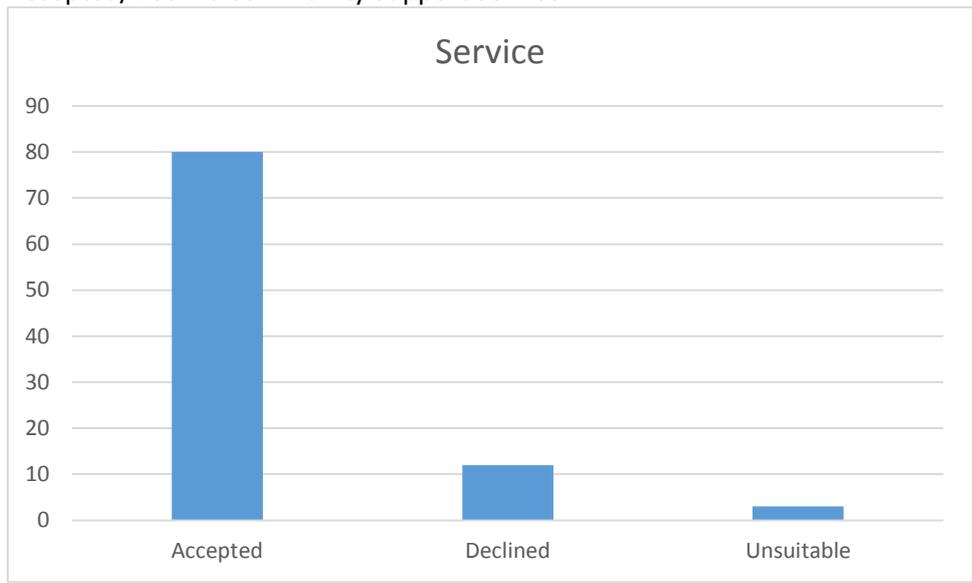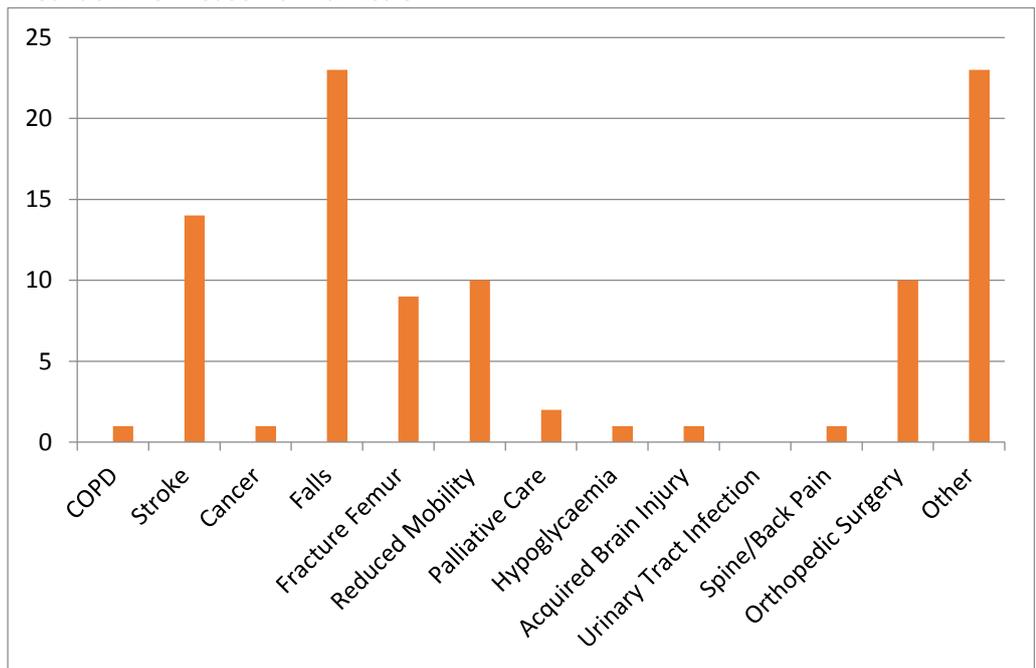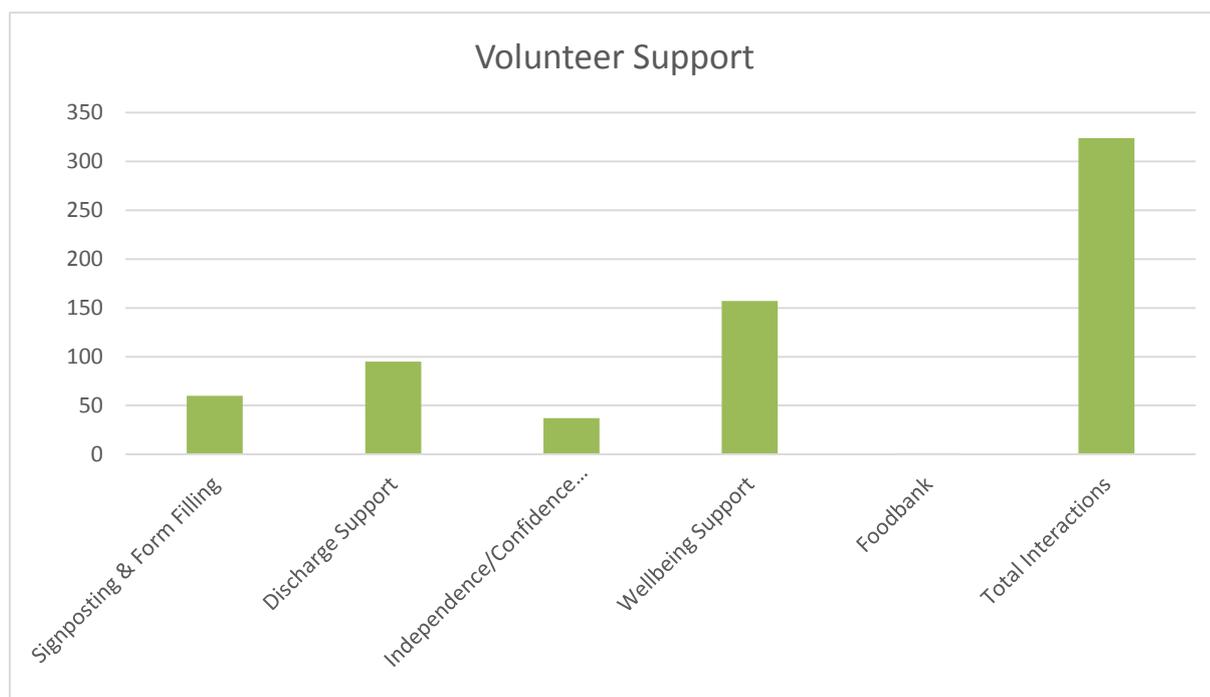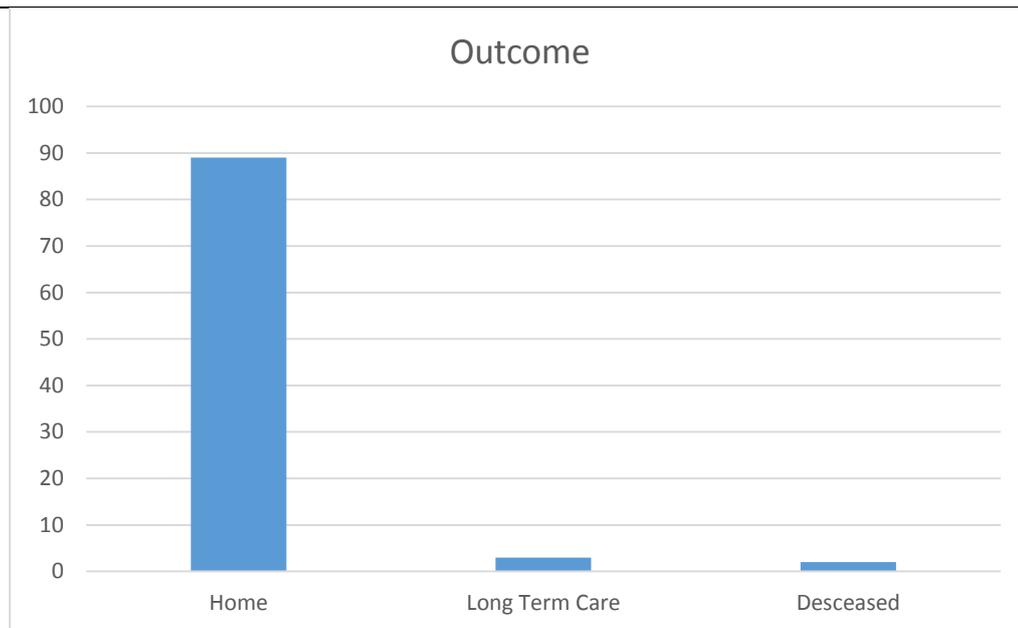
Age Range of Patients
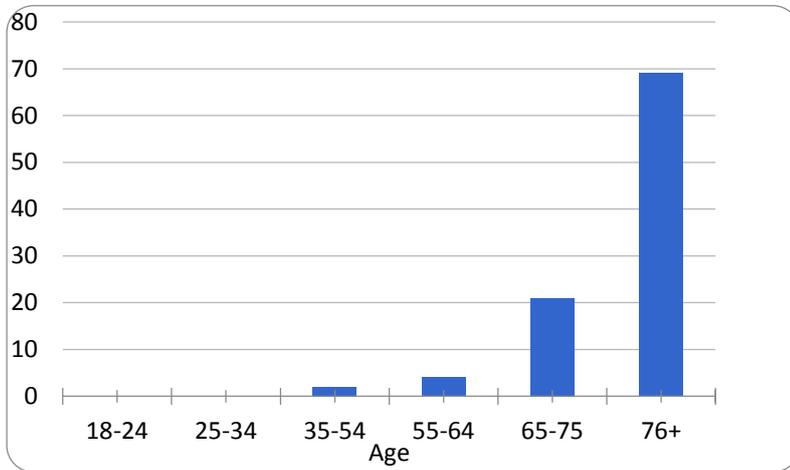
Gender Breakdown

Area Breakdown

Accepted/Decline Community Support Service

Service

	Accepted	Declined	Unsuitable

Breakdown of Reason of Admission

Destination

Outcome

A bar chart titled "Outcome" with a vertical axis from 0 to 100. Categories: Home (approximately 89), Long Term Care (approximately 3), Desceased (approximately 2).

Volunteer Support

A bar chart titled "Volunteer Support" with a vertical axis from 0 to 350. Categories: Signposting & Form Filling (approximately 60), Discharge Support (approximately 95), Independence/Confidence... (approximately 37), Wellbeing Support (approximately 157), Foodbank (0), Total Interactions (approximately 324).

Since October 2018 I have visited ALL patients identified with potential for rehabilitation, and gave them the choice to receive support from the service or volunteers. Only 3 patients declined out of the 95 referrals received, the reason given that they were well supported by family.

3 patients were deemed as unsuitable through either not being within the catchment area or becoming unwell again.

The remaining 89 received 324 hours of additional support provided by the

Community Support Volunteers.

15 Pre and post service questionnaires were completed then the format was changed (see pros and cons)

80 further shorter pre-questionnaires were completed but when the post service questionnaires were sent out we only had a 35% return rate (28).

The identified outcomes for patients were:

72% Returned home from hospital sooner
97% felt they had more access to support and advice at home
92% Felt safe, secure and supported
79% Felt wanted and less isolated on discharge
84% had an increased sense of self worth
74% felt they had an increased sense of purpose in life
89% felt they had more confidence to manage daily tasks

Patients and their families have valued the Volunteers input and certainly had positive interactions whether it be so that they the family feel supported or just that they know someone cares it can be hard to define.

Comments from patients include
"Its grand this aftercare, you don't feel like you've just been left"

"Amanda, has done some running about for me, she's great"

"I hope that other folk don't end up like me but knowing Rose is at the end of a phone makes a difference"

"I wanted to go to Musselburgh for coffee and I did on the bus with Roseann, great to be out and about"

Breakdown of Patient Contact Hours:
(1st October 2018 onwards)

Total Hours: 245 hours

54 hours of 1:1 (signposting, form filling)
95 hours of Initial Discharge Support (Meeting and agreeing outcomes & Community Re-engagement)
84 hours of Independence, Confidence Building & Supporting Mobility
160 hours of Wellbeing Checks

Total Patients supported from October 2018 **95 = 15 patients per month average potential to support/assist 180 patients per annum**

Patients often don't know what is on in their own community and the "What's On" guide has been a great "tool" to encourage people to talk about their interests and what they would like to do.

It has been highlighted throughout this project about the need for patients to know what they don't know. People do not know what they are entitled to or services available to them because the statutory authorities don't tell them, aren't as proactive as they should be or are simply unaware of the services in East Lothian.

What went were the pros and cons? Guideline word count: 300

There have been many positives

- Sharing of information and learning is essential
- Working as a Team out with our usual "comfort zones"
- Building Trust and understanding of each other's roles within the person's journey and the additionality that we can bring enhancing the person's experience of services
- Using appropriate language "plain English"
- Community Volunteers eager to engage with people less fortunate than themselves
- The need to adapt and change quickly is essential when dealing with individuals in a person centred manner
- The initial Criteria was too restrictive and changed from 65 to 50 month 5
- Encouraging patients to "self-manage" is the right thing to do, people are proud they don't want to be "beholding" to others, independence and confidence is a priority
- Signposting to community assets and information services are as equally important to individuals as is 1:1 support
- My capacity – 25 hours was not enough, recruiting, retaining and training volunteers is one full time job, assessing/speaking to patients is another

- no admin support, recruitment campaign takes a week of follow up, visiting patients and following up requests, introducing volunteers etc., newsletters "hot picks fb campaigns etc.
- Working with OTs/PTs instead of Nurses gave a better insight into the "can do" rather than you "can't do" approach for patients although they are still psychical goal orientated (learning now)
- Not to give a 51 page pre service questionnaire or a 57 page post questionnaire
- Patients don't want to have to rely on someone else, they appreciate the support but they want to be independent
- Flexibility, adaptability to change processes systems is a must
- Flexibility in your work day and work load is essential. Many families' can't see you in the normal working day, out of hours
- Flexibility – as above but for volunteers, meetings, training etc, these are normal people who work and want to give up their free time, you have to work around their schedules
- Volunteers like Awareness sessions not training sessions and they like to choose what they learn about
- Families would benefit from a one-stop-shop from an independent organisation to talk about their concerns, worries and how to claim what they or their loved ones are entitled to, again has to be flexible most are of working age
- People are lonely and isolated, once "services" stop what happens then, they like the "aftercare" our project provides

Patients often don't know what is on in their own community and the "What's On" guide has been a great "tool" to encourage people to talk about their interests and what they would like to do. Having a "good conversation"

It has been highlighted throughout this project about the need for patients to know what they don't know.

People do not know what they are entitled to or services available to them because the statutory authorities don't tell them, aren't as proactive as they should be or are simply unaware of the services in East Lothian.

This project highlighted how a Community Link Practitioner could be utilised within a hospital and Community setting with the additionality of Volunteers.

When staff don't know about a service and the potential benefits it can have for patients it can be quite difficult for them to describe the additionality that a volunteer can bring, that a person's community can bring.

Staffs from the NHS are used to "fixing" people when really the person needs to "fix" themselves. Staffs from the Local Authority are "task orientated" being person centred when you have budget constraints can be hard and it can be demoralising for staff and patients.

- at were the key things that went well in your project and why?
- What were the barriers and challenges to your project and what did you do to overcome them?
- What were the particular strengths / weaknesses of the project?

- What were the key learning points?
- What are the outputs from your project?
- What would you do differently in the future and why?
- What learning from the project has already been shared so far, using what methods and why?
- In what ways will you share learning from the project going forward? (e.g. events, workshops, posters, presentations, publications)
- What advice would you offer others with similar projects and why?

Key Learning Points:

- Trust yourself and your partners
- Have a good conversation, a real conversation and really listen to the patient
- Speak up, your knowledge and experience is just as important as the "authorities"
- Learn from each other, look outside the box for solutions – no one person, organisation has all the answers
- Keep it simple
- Good reporting is essential
- It's okay to ask for advice, support and assistance
- People, communities want to help those in need but you have to ask
- You must be able to adapt and change your approaches to the situations very quickly

Throughout this project our "goal" was to make a difference to the patients and their lives. Out the "test of change" only 3 patients became unwell and were re-admitted into hospital, all patients reported that they "felt better" –

improved health and wellbeing, most 89% regained their confidence, in regained or maintained an appropriate level of independence.

What would I do differently, I would believe more in myself and the project more, I would speak up and be more confident in what our intended outcomes were. I wouldn't just have "good conversations" with patients I would have them with the team. I would keep it simple, not over complicate literature, language – not "pitch" it to the commissioner but to the people better.

Since this project started, my own learning curve has been enormous. Logic models, project plans, reporting skills (I hope I have improved), I have already taken the learning from this project and applied it to another project that I now manage. I am part now of a review group and I use this knowledge and methodology regularly. My new learning skills have also allowed me to participate in shaping my workplace.

What are the next steps? Guideline word count: 200

- What is your plan for sustaining the project post funding?
- What are your plans for spreading / scaling-up these improvements on a local, regional or national level?

Is this project suitable for potential use in other contexts, why would it work and would there be limitations?

We have secured a small amount of funding from the Health & Social Care Partnership and I am hopeful that they will see the merits of this service. I am also looking for funding from other sources/charities.

If we are successful in gaining more funding I would like this project to cover all of East Lothian with the START team

I believe that the learning and synergy of this project in relation to the Community Links service would benefit many patients in a hospital and community setting in other areas.

Encouraging and supporting patients in "self-management", and supporting them through the community will not only improve the quality of their lives but will allow them to integrate back into the community safely.

What did the Improvement Fund support you with? Guideline word count: 200

- What did you use the funding for and what difference did it make to your project?
- What support did the Improvement Fund team offer and what difference did it make to your project? (e.g. improvement, evaluation, health economics, measurement)

Funding was used to cover staff, volunteer, marketing, training and researching the project.

The improvement team have been essential in the learning and providing advice to this project. I especially appreciate the help that I received from Heather and Christine who were very patient and understanding when it came to statistics, outcomes and supporting my doubts

Other Guideline word count: 200

- Is there anything else you would like to add not covered in the other sections?

Please attach any supporting information as an appendix.

If you have any questions contact hcis.improvementfund@nhs.net