# Support at Home Service – Bracknell and Ascot, Frimley Park Hospital
# July 2015 to March 2016 Report

## Outline of Service

The Support at Home service aims to help patients regain their independence after a stay in hospital by supporting with low level practical and emotional needs, visiting once a week for approximately an hour at a time for a six week period. We work closely with the Adult Social Care Team and take an integrative approach with the wider discharge team within the hospital. The service aims to:

- Support patients registered to a Bracknell and Ascot Clinical Commissioning Group GP
- Prevent hospital readmission
- Reduce hospital length of stay
- Integrate with other British Red Cross Independent Living services including Mobility Aids
- Signpost patients to other local services
- Reach on average 30 beneficiaries per month
- Improve quality of life and independence
- Provide 6 weeks face to face or telephone support as needed.

This service is provided by 4 British Red Cross staff members, working 7 days per week from 10am to 6pm (not including Bank Holidays). The staff members consist of one full time Service Coordinator (currently shared with Surrey and North Hampshire services) , two dedicated full time Service Assistants and one part time weekend Service Assistant (14 hours per week).

## Top 3 Goals

The service takes a person centred approach with patients, working collaboratively with them to enable them to achieve their Top 3 Goals. The first home visit is completed by a member of staff who will discuss with the patient what they would like to achieve and how the service can enable them to do so. From this conversation the Top 3 Goals are set and a support plan is put in place so that both the patient and member of staff/volunteer know how best to work together. The British Red Cross Top 3 Goals outcome domains are mapped against the Health and Social Care National Outcomes framework and include:

- Feeling more safe and secure
- Improved ability to manage day-to-day activities
- Improved awareness and access to other services
- Improved social networks and friendships
- Increased satisfaction with the home environment
- Making more meaningful use of time

During the final visit or at the end of telephone support the member of staff/volunteer discusses with the patient whether they have achieved the goals they set out at the beginning of the service, and if not, the reasons why this was not achieved.

## Performance

We had some initial recruitment issues and unfortunately it took longer than planned to recruit to full staffing, with both the Service Co-ordinator and weekend worker not being fully operational until September 2015.

The delay in recruitment resulted in us having lower capacity than expected and referrals were slow to build. **See Appendix 1**

As you will see in Appendix one the referrals have grown steadily over the 8 months and are heading in the direction we would expect but are still below the expected 30 a month.

We have capacity with current staffing to do more than 30 referrals per month but the question is there solid evidence of demand for an increase in referrals to this service and will the professional bodies refer to us to help us meet the target?

The team have tried to increase referrals rates and the Bracknell and Ascot service assistants have done several presentations to Bracknell council staff, made links with GP's and stepped up our promotion within Frimley Park Hospital.

We are also aware of a new ward that opened at the end of November in Farnham hospital which provides support and rehab to Frimley Park Patients. Therefore, these patients were not being referred to our service.

## Gender spilts

There has been a fairly equal split between male and female referrals that the service has supported athough January to March has shown an increase in female users. These statistics are in line with our other services across Thames Valley. **See Appendix 2**

## Age groups

Most of the patients seen are between 65 and 85 years old with an increase in number of 85+ in January to March 2016. **See Appendix 3**

This highlights the need in this area for programmes that encourage individuals aged above state pension age to live independently and receive support on discharge from hospital.

## Referral source – GP's/Surgeries

The service has predominantly received referrals for individuals living in the Bracknell area with only a few referred in Ascot or out of area. **Appendix 4** A (two pages) highlights the GP's who have referred to us.

As you can see in July through to December 2015 the Gainsborough Practice and the Waterfield Practice provided most of the referrals closely followed by Heath Hill Surgery.

The upward trend in referrals from other surgeries is encouraging; in the period January to March 2016 other surgeries have increased the referrals as word spreads about the service. For example Boundary House and Sandhurst have upped the referrals rates from between 5% to 11%.

## Referral source – professionals

**Appendix 5** - (apologies for differing format of information) details the professional referral source for our service users. The majority of the referrals received were by the Adult Social Care Team. This number may be influenced by the Support at Home Team being based in the same office which allows for increased partnership working and improved communication between the services. The referrals show that the service has been utilised by other professionals within Frimley Park Hospital as the next largest amount of referrals were received from the Therapy staff and nurses. We have also received referrals from community teams and we are also looking to strengthen the links with our own Red Cross Admissions Avoidance Service in A&E at the Royal Berkshire Hospital.

We will actively signpost any patients we take home from RBH to our Bracknell and Ascot service if they are discharged into the area. This process currently works very well with our Care and Support service covering Reading residents.

## Activities

**Appendix6 and 6a** shows the range of activities completed by our staff and volunteers. There is high demand for shopping both for and with the service user, providing companionship and confidence building.

The period July to September showed the greatest demand for shopping. As the service has become embedded and the conversations around the service users top 3 Goals /wishes have developed we have seen a growth in the demand for home visits/check and chat visits and support to appointments.

## Visits/care hours and phone contacts

**Appendix 7** – Visits/ care hours / phone calls

This bar graph shows the total number of visits, care hours delivered and telephone calls.

The graph shows an encouraging upwards trend. The telephone calls include first contact with service user and follow up calls over 4 to 6 week period.

## Day of week referrals received.

**Appendix 8 –** Days of week referrals received.

Apologies it appears there are no stats available for the period July to September. October to December shows Thursday as the busiest day with low referrals at weekends.

January to March shows an encouraging increase and little difference between the referral rates Monday to Friday. Saturday and Sunday have decreased from an already low rate. We are not sure of the reasons behind the low referrals rates at weekend; we can assume that family and friends may be more available to help relatives at weekends.

## Testimonials

## Case Studies/ professional testimonies

**Sabeel Ali, Social Worker Hospital In-reach team, Bracknell Forest Council Adult Services,** "I referred a Mrs G to your Support at Home service. She is a very elderly anxious and lonely rather deaf lady who lives in warden assisted flats in Bracknell. She has no family to speak of and only sees one lady, a voluntary befriender, every Tuesday. We were initially involved as she was frightened of the noise her fridge was making when it switched on and off which had resulted in admittance to FPH. I understand that [one of our service assistants] saw her and that it took her about 5 weeks to arrange her initial visit as Mrs G kept saying she was busy so [the] initial visit was actually the Red Cross's last week of service. [The Red Cross] talked to me after that visit and was pleased that she had been able to make a lot of progress in only 1 week. After chatting to Mrs G during the visit it became apparent to [the Red Cross] that one of Mrs G's major anxieties was that her medication would run out and she telephoned the doctors most days. [The Red Cross] apparently telephoned Mrs G's doctor and chemist during the visit and organised that the chemist would automatically request repeat prescriptions on her behalf and then deliver the medication to her flat. She then asked that I refer Mrs G again in order that she could monitor that the system was working... It all did work fine and Mrs G has said that she 'really looks forward to seeing the Red Cross Lady every Friday and she is a lovely kind lady'… The Red Cross service has been great, thank you."

**Ngaire Walker – Occupational Therapist, Frimley Park Hospital** "I was working in A&E on a weekend in November (29/11/2015), I saw a patient who had come in after a fall and fractured her wrist. She was usually able to independently get to town to get her shopping in and had no local friends or family who would be support her to get in shopping when she was discharged. I contacted your hospital Red Cross service (on the Sunday) – expecting it to just be a voicemail on a weekend or someone to just take the referral, however the man I spoke to was very helpful.
He took the referral from me over the phone and said he would go to meet the patient in A&E and would follow her up at home either that afternoon or during the week – whenever needed.
I found the service to be very useful and supported in facilitating the discharge of the patient from A&E on a Sunday."

**Mel Leighton – Occupational Therapist at Frimley Park Hospital** "A really useful service, in particular with the companionship element due to the increasing number of older people that live alone and are socially isolated. The Support at Home Service is able to respond to the referral in an

efficient time to see the patients at home. It's great to have a central contact to take the referrals and even better that it covers the large catchment area. ."

**Joanne Bishop, Adult social care, Bracknell forest council, Support co coordinator.** "The [Red Cross] have been a great help to one of my individuals that I have been supporting in the community. [The Service Assistant] has made this person more confident and has increased his mobility and allowed him to get back to being more independent. The person has enjoyed regular contact/visits from [Red Cross], and this has made his self-confidence and personality grow over the past 6 weeks. I have found [the Service Assistant] very helpful and supportive to myself and to the person involved. Wonderful job done."

**Alice Coles, Intake Social Worker, Bracknell Forest Council**. "Well done [Red Cross] you are doing a tremendous job. I have seen you in action with some of the people we support, you are patient and professional. Thank you"

**Mercy, Social Worker, Social Services.** "All the clients I have referred to the service have given positive feedback, the staff are very helpful, always easy to approach and very quick to respond. I always recommend the service to families/clients. Very good service, keep up the good work."

## Lessons Learnt

The biggest challenge with setting up this service was caused by staff recruitment taking longer than expected and in particular the service co-ordinator role, which was pivotal to the service. This led to a possible reduction in capacity to receive referrals while the Frimley Park support at home team were still establishing themselves.

There were also a few minor issues in Bracknell council offices with office space, hot desking and IT. These have since been resolved and we are now focused on establishing ourselves as an integral part of the Bracknell Forest Council.

## Challenges

The biggest challenge is to increase the number of referrals so we can achieve at least 30 a month. Many of our other similar services across Thames valley have higher rates of referrals albeit that is achieved after the service has been fully operational for 12 to 18 months.
Recruitment is still a challenge as Thames Valley has a low rate on unemployment.

## Conclusion

The service is invaluable to both patients being discharged from Frimley Park Hospital and the Bracknell Social Services and community teams to ensure that patients have a safe and timely discharge home. The evidence demonstrates that the service enabled users to achieve their goals and improve their confidence and independence on return home, resulting in a smooth discharge experience for the patient and confidence from the hospital staff team in the British Red Cross service.

This service has helped those living within the Bracknell and Ascot areas, and it is envisaged that the longer this service runs the larger its reach will become to help support those living in the community to prevent an admission to hospital and improve their health and wellbeing at home.

Points to consider – does the service require 7 day working? Could the referrals be higher and how can this be achieved? Would there be a benefit in carrying out 31 day follow up call to each service user to log if the patient has been re admitted to hospital and use this data to support the importance of our service to support independence post discharge?

Julie Weston Senior Services Manager Thames Valley 09/05/2016

**01296 739313**

**jweston@redcross.org.uk**