Ayrshire Home from Hospital – Summary Report

01 January to 31 October 2021

November 2021

Contents

Introduction

The British Red Cross provide an Assisted Discharge service on behalf of the 3 Ayrshire Health and Social Care Partnerships.

The service operates from University Hospitals Ayr and Crosshouse, 7 days a week, from 14:00 to 21:00. The service supports discharges from the Emergency Departments (ED), Combined Assessment Units (CAU), Discharge Lounges and from the hospital Wards.

A short summary of the history of the service is provided in the appendix.

The core service provides:

- Monday, Tuesday, and Friday: 2 vehicles each with a double crew
- Wednesday, Thursday, Saturday, and Sunday: 1 double crewed vehicle

Additional COVID response funding is being used to provide an extra vehicle and double crew on Wednesday, Thursday, and the weekend.

Service purpose

The service is designed to:

- Help prevent unnecessary hospital admissions
- Help reduce delayed discharges and boarding
- Help prevent failed discharges and readmissions
- Help promote independence
- Help reduce isolation and loneliness

Service design

The service is comprised of 4 elements:

1. Transport home in a wheelchair accessible vehicle
2. Resettlement at the service user's home / place of residence
3. Safe and well phone call (within 48 hours)
4. Follow on support

Period covered by the report

This report covers the 10 months from the **01st January to 31st October 2021**

Service Data Summary

From the 01st January 2021 to the 31st October 2021 the service has accepted **2,037 referrals,** this equates to 1,777 people receiving support (some people were supported more than once).

We have included in the appendix information about the service user profile for the service.

Accepted referrals by Hospital and Department

During the reporting period, 936 referrals were received from University Hospital Ayr and 1,098 from University Hospital Crosshouse.

	ED	**CAU**	**Ward**	**Total**
University Hospital Ayr	64	59	813	936
University Hospital Crosshouse	130	69	899	1,098
Woodland View	N/A	N/A	3	3
Totals	**194**	**128**	**1715**	**2,037**

Table 1 – accepted referrals by hospital and department

Accepted referrals by H&SC Partnership

During the report period, 650 service users had a home address in East Ayrshire (32%), 632 in North Ayrshire (31%) and 754 in South Ayrshire (37%).

	Accepted New Referrals	**%**
East Ayrshire	650	32%
North Ayrshire	632	31%
South Ayrshire	754	37%
Out of Area	1	<0%
Total	**2037**	100%

Table 2 – accepted referrals by H&SC Partnership area

Referral Objectives

Each referral is allocated a referral objective or objectives based on information given by the referrer, the department / ward the patient is coming from and the destination the patient is going to[1].

Referral Objective	Number	Referral Objective	Number
Preventing a hospital admission	180	Preventing breach of 4 hour standard in A&E	158
Ensuring a quicker discharge	283	Reducing the length of a hospital stay	1,315
Ensuring a safer discharge	1,157	Preventing the delayed transfer of care	378

Table 3 – Referral objectives

Safe and Well calls

As part of the service, and where the service user consents, the service will make a safe and well phone call to service users within 48 hours of supporting them home (this excludes Care / Nursing homes and hospitals). This call is designed to ensure that the service user is safe and settled back into their home. It is also an opportunity to discuss with the service user any additional support they may need.

During the reporting period the service made **852 safe and well calls** to service users.

Follow on support

Where it is appropriate the Red Cross also provide follow up support to service users post discharge. This support is designed to help people achieve goals that they determine with the aim of helping them live more independently and to help reduce the likelihood of readmission to hospital.

Follow on cases

	Follow on Cases
East Ayrshire	99
North Ayrshire	107
South Ayrshire	86

[1] See the appendix for the rules on how a referral objective is allocated.

Total	**292**

Table 4 – Follow on cases by H&SC Partnership area

Top 3 Goals

For each service user, we apply a Top 3 Goal methodology. Service Users are supported to identify up to 3 Goals (personal outcomes) – in most cases this can be done over the phone but for more complex cases, or where it would not be appropriate to do it over the phone, a Coordinator will visit the service users at home. We then provide support, information and / or resources to help individuals achieve their goals.

For most service users this can be achieved within 72 hours of the safe and well call, but the service can support service users for longer where needed. Where possible the service looks to make referrals to other organisations, services, community groups / clubs etc in the service user's own community there by increasing their circles of support.

For the reporting period:

- 414 goals have been set by 281 service users
- Of the 238[2] services users that have set at least 1 goal and have had a final progress review, 215 (90%) achieved or made a lot of progress on at least one goal

Each service user's goal is then mapped against the British Red Cross' Independent Living Outcome Framework:

Goals set by outcome

Outcome	Number of Goals	% Goals
Feeling more safe and secure	112	27%
Improved awareness of and access to further services	77	19%
Increased satisfaction with home environment	52	13%
Improved ability to cope in caring role	48	12%
Improved ability to manage day-to-day activities	52	13%
Improved ability to manage paperwork and finances	27	7%
Improved social networks and friendships	26	6%
Making more meaningful use of time	20	5%
Total	**414**	

Table 5 – Goals set by outcome domain

Progress by Outcome

Final Goal Progress	Number of Goals	% Goals

[2] The remaining cases are open cases that have not yet had a final progress review or cases where it was not possible to complete a review

Achieved goal	246	71%
Made a lot of progress	45	13%
Made some progress	39	11%
Made no progress	16	5%

Table 6 – Goals by final goal progress

Financial Summary

Cost of the service

The annual cost of the service is £223,779 – for 10 months this equates to £186,482.50

During the reporting period, there has also been additional COVID funding of £134,187.80

Total funding: **£320,670.30**

Bed days saved

	Referrals	Assumption
Preventing an admission	180	5 bed days
Reducing the length of a hospital stay	1315	1 bed day

- Bed days saved: **2,215**
- Indicative cost saving (assuming £175 per bed day saved): **£387,625**

Case studies

East Ayrshire

Background

The British Red Cross supported a lady in her early 90s with dementia home from hospital in East Ayrshire. Her main support is from her husband, also in his 90s, and a care package 3 times a day. The husband is his wife's main carer and has been struggling to support her and look after himself without becoming exhausted.

The lady was recently placed on a Level 5 diet – (Minced and Moist) her husband, however, was feeling a bit overwhelmed trying to understand exactly what this entailed and felt there was little support as the transfer to a community-based dietician was taking some time to kick in after discharge.

Agreed follow on support

- Obtain information from NHS regarding guidance on Level 5 diet and forward on to gentleman.
- Regular telephone calls for emotion support for a few weeks.
- Referral to the East Ayrshire Carers Centre to open up a range of additional services and support for the husband as an unpaid carer.

Outcomes achieved

- Guidance on Level 5 – minced and moist diet sourced. The summary guidance from the guidance document was read out over the phone so the husband had a starting point and then the full guidance was printed, and hand delivered to the husband.
- Contact details for the community dietician service sourced and passed to husband, this provided a route for the husband to seek assistance if needed before the referral was allocated to a dedicated worker.
- Regular telephone calls were made to ensure that emotional support was provided over the phone to the husband, providing a listening ear and to ensure he could access additional support if needed.
- A referral was made to the East Ayrshire Carer's Centre for support with a Carer's Assessment and the development of a Carer Support Plan to ensure that his needs where being met, and additional support could be obtained to reduce some of his caring responsibilities and pressures.
- As part of the carers assessment a referral was made to "Sight Scotland Veterans" – the husband disclosed to the Carers Centre that he had macular degeneration and cataracts and had also served in the armed forces. Sight Scotland Veterans have been supporting the husband to source aids and equipment.
- The Carer's Centre and Sight Scotland Veterans are also exploring respite opportunities with the husband.
- Sight Scotland Veterans are, as a result of the husband's referral by the Care's Centre, now supporting the husband's younger brother who is also starting to have sight problems and served in the arm forces.

Quotes from service user

"I am very impressed with how quick the support was accessed. I assumed these types of services would take months. The coordinator started the wheels turning by making a referral to the carers centre and the wheels have continued to turn ever since."

North Ayrshire

Background

J is a 58 year old woman who lives on her own in North Ayrshire.

J has osteoporosis and collapsed at home after sustaining a spinal fracture whilst bending over in her living room. She lay for 48 hours until the fire service accessed her home by breaking down the door. When J came home from hospital, she was unable to use her stairs at all and was sleeping on her couch and was unable to access her bathroom. She had no access to get support for food and could not get out to the pharmacy for medication.

Agreed follow on support

It was agreed with J that we would help her with:

- Contacting the social work team to request assessment for homecare.
- To contact the occupational therapist to assess for adaptations
- Help her with her food shopping
- Support with a housing application for accessible housing

Outcomes achieved

With our help J has:

- Secured homecare support x3 daily where the homecare team help with medication, personal care, and meals. She has begun to put weight back on and has gained 10lbs.
- Has aids and adaptations that help her move upstairs safely and which have reduced the risk for her regarding future falls.
- Made a housing application, we supported J with sourcing medical information in order to expedite her move.

Quotes from service user

“Thank you so much for your kindness. You have went above and beyond what I expected. Who would have imagined that a chance lift home with the Red Cross would result in my getting help with my situation. Aside you doing my shopping, I imagine I’d still be sitting here, desperately unhappy.”

South Ayrshire

Background

The Ayrshire Home from Hospital Service supported home a lady in her 90s from the Emergency Department, University Hospital Ayr. The lady had been admitted because of multiple falls and a deep cut to her leg.

The lady also suffers from rheumatoid arthritis which contributes to her poor mobility. On resettling this lady within her home, the Red Cross crew spoke with her about her mobility and follow-on support and offered a safe and well call.

During the safe and well call the lady explained that she had been taken to the ED after falling and laying for 2 hours on the floor, managing to get up and then falling a second time and laying on the ground for another 2 hours.

Identifying that the lady sometimes relies on furniture walking rather than her tripod

Agreed follow on support

- Referral for a community alarm so that she could summon help if it was needed.
- Referral to Intermediate Care and Enablement Service (ICES) to conduct a falls assessment and to offer advice and support to reduce her risk of falling.
- Regular calls from a volunteer to provide emotional support during recovery and ensure needs where being met (the lady had refused a care package as she likes to be as independent as she can).

Outcomes achieved

- A community alarm has been installed along with a key safe as the lady was unable to provide a local next of kin / emergency contact. The lady reports that she now feels safer knowing that if another fall where to occur she would not have to lay on the floor for hours.
- A physiotherapist from the ICES team has been out to see her and made contact again via telephone to create a plan of action to help address some of her mobility issues and reduce her risk of falling (once her leg wound heals).
- The regular phone calls from a Red Cross volunteer have meant that she feels supported and helped reduce her loneliness whilst her leg wound heals.
- The lady is, whilst remaining strongly independent, now more open to accepting help and support from services.

Quotes from service user

- “The service kept to their word by following through with what they said they would do. I now feel a lot safer knowing the British Red Cross have helped me obtain a community alarm and seek help from a physiotherapist.”
- “I can’t thank the service enough for supporting myself with regular calls and checking on the progress of my recovery.”

Safeguarding

In accordance with the British Red Cross Adults at Risk of Abuse Policy, all Red Cross staff have received Safeguarding training and are aware of the procedures in place to raise causes of concern about individuals that we have supported (at all stages of the service).

Appendices

Appendix 1 - History

The service started on 11 of December 2014 in University Hospital Crosshouse A&E, by mid-April 2015 it had expanded to include both University Hospitals Ayr and Crosshouse and Ward based referrals. As the new CAUs were opened the service was further expanded to include referrals from these. The service operated 7 days a week with 2 crews[3] on shift each day.

For the financial year 2018/19 it was agreed that the service delivery model would be altered in lieu of a funding increase to reduce the service to 1 crew on a Sunday supporting both hospitals.

For the financial year 2019/20 it was agreed that the service delivery model would be further altered to allow it to be delivered within the existing funding envelope. The service was reduced to single crews on Wednesdays, Thursdays, and the weekends. To allow for consultation with the hospitals and affected Red Cross staff this new model came into effect on the 15 July 19.

Between the 06th January 2020 and the 31st March 2020 we received additional winter pressure funding and from 01St April 2020 additional COVID funding to increase the service's capacity to support the increased demand on the hospitals. This money was used to increase the service to two crews on those days where we had to reduce to 1 crew working across both hospitals (Wednesday, Thursday, Saturday and Sunday).

From 26th February 2020 the service also scaled up to facilitate morning shifts at UHC in support of the winter plans (until 30th March 2020) and COVID response (from the 01st April 2020).

From the 04th January 2021 additional morning shifts were also provided to UHA as part of the COVID response.

On 14 May 2021, the UHA and UHC morning shifts ended.

The additional core shifts on Wednesday, Thursday and the weekend are continuing.

Appendix 2 - Service criteria

For a referral to be made to the service, the service user must:

- consent to receive the service and for their personal information to be shared with the British Red Cross and for the British Red Cross to store and process that data
- be discharged for University Hospitals Ayr or Crosshouse or Wards 1 and 2 at Woodland View
- be considered medically fit for discharge
- be aged 65 or over (under 65s can be included where there are additional vulnerability factors*)
- require help to get home between 14:30 and 20:30

[3] A crew comprises two trained Red Cross personnel

- have access to their home/place of residence
- not be under the influence of alcohol or drugs
- not be known to be violent or aggressive
- not require to be transported on a stretcher
- not require to be transported on oxygen
- live (or be transported to an address) within mainland Ayrshire

* Vulnerability may relate to issues such as multi-morbidity, additional support needs, learning disabilities, mental health, geographical isolation and risk factors in the home situation.

Appendix 3 - Referral Objectives

The following rules are applied when allocating referral objectives to accepted referrals:

- **Preventing a hospital admission** - allocated to all referrals from the ED and CAU where the referrer has stated that an admission has been avoided.
- **Preventing breach of 4 hour standard in A&E** - allocated to all referrals from the ED where the referrer has stated that the referral has prevented a breach of the 4 hour standard.
- **Ensuring a quicker discharge** – allocated to all referrals from the ED and CAU (accept hospital to hospital transfers).
- **Reducing the length of a hospital stay** – allocated to all referrals from the Discharge Lounges or direct from Wards / Stations (accept hospital to hospital transfers).
- **Preventing the delayed transfer of care** – allocated to all referrals where the patient is transported to another hospital.
- **Ensuring a safer discharge** – allocated to all referrals where the crew are able to undertake a home risk assessment or where a safe and well phone call is agreed (this would exclude journeys to hospitals and care / nursing homes).

Appendix 4 - Service user profile

Gender	No. of New Referrals	% of New Referrals
Female	1,148	56%
Male	870	43%
No Data	19	1%

Living Arrangement	No. of New Referrals	% of New Referrals
Living Alone	722	35%
Living with Spouse / Partner	435	21%
Other	288	14%

Nursing / Care home	227	11%
Living with Family / Friends	166	8%
No Data	112[4]	5%
Sheltered Accommodation	84	4%
No Fixed Abode	3	0%

Age	No. of New Referrals	% of New Referrals
0-29	14	1%
30-39	11	1%
40-49	32	2%
50-59	91	4%
60-69	237	12%
70-79	575	28%
80-89	770	38%
90-99	290	14%
100+	11	1%
No Data	6	0%

[4] The majority of these will be for hospital-to-hospital transfers where we do not know the service users' living arrangements