helpforce

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A volunteering Service designed and tested by:

NHS
North Tees and Hartlepool
NHS Foundation Trust

Volunteering Service Guide: Discharge Support

From the ward through to 28 days post discharge in the home

Understand how this service works, the impact it will make and considerations for adopting and adapting it locally

A volunteer service that supports vulnerable patients throughout their discharge from hospital after an extended stay. The service aim is to get patients 'home for lunch' so that identified settling in issues and patient adjustment to being home can happen during the daytime. This is also to help acute wards with their flow of available beds and to reduce readmissions.

The volunteer service provides:

- A Discharge Support Volunteer (DSV) to help/ coordinate:
  - Patients getting ready to leave hospital e.g. packing their belongings, providing emergency food parcels and clothing if needed, waiting with them in the discharge lounge.
  - Transport home, accompanying the patient if needed.
  - Settling-in support for a patient in their home for up to 28 days: checking in on the patient, confirming that the heating is working/on and that food is available.
  - On-going support, for example taking patients to attend outpatient appointments.

N.B. North Tees and Hartlepool NHS Foundation Trust have named their 'Home from Hospital Service 'Home but not Alone' which is referenced throughout this guide

Adopting and adapting a ‘home from hospital’ service

Adopting an existing model provides great value in terms of knowing that it is tried and tested, however understanding how to make it fit into a new environment can be a challenge. Adapting an existing volunteer service is an essential step in making sure that a service will work in a new location.

This ‘Volunteer Service Guide’ uses learning from the Home from Hospital Service being delivered by North Tees & Hartlepool NHS Foundation Trust. The purpose of the guide is to provide a potential service adopter (1) with the information needed to be able to:

a) Decide whether the service would be of benefit to their organisation
b) Understand what considerations are needed to adapt the service to their environment

Contents:

How to:

“Really enjoyed getting involved in some of the complex issues involved in getting patients home. Loved the problem solving. Got great satisfaction in just helping people get home sooner than they might have otherwise.”

Volunteer - ‘Home but not Alone service’ - North Tees

North Tees Survey Data (2):

1.Adopter, person looking to take on (adopt and then adapt) an existing and tested volunteer service model, 2. Helpforce Volunteers Innovators Programme (VIP) Patient Discharge Survey, Staff Survey and Volunteer Survey. Patients at North Tees completed the VIP Patient Discharge Survey (n=10), Staff at North Tees completed the VIP Staff Survey (n=11) and Volunteers at North Tees completed the VIP Volunteer Survey (n=35).

The results

The project started with 12 volunteers providing support in the driver role and 3 volunteers providing support in the discharge role. Over a period of 7 months the service was scaled up to 23 volunteer drivers and 8 discharge support volunteers. In a typical 1 month period the active volunteers delivered an average of 541 hours of support to 102 patients.

Insight and impact project questions: **Does a 'Home but not Alone' volunteer innovation at North Tees improve efficiency and productivity in the hospital?**

Volunteer drivers at North Tees undertook 2,625 patient journeys during the programme, covering over 60,000 miles (April 2019 to March 2020). It is estimated that the volunteer drivers have saved c £40K through a reduction in expenditure on private taxis previously paid for by the Trust.

Does the 'Home but not Alone' volunteer service improve patient experience?

'Home but not Alone' volunteers ensure that patients are well-informed at the time of discharge. 100% of patients felt clear on what they should or should not do after leaving the hospital (n=10).

Do volunteers contribute to improving staff wellbeing and morale?

90% of staff agreed/strongly agreed that when the wards are busy or short-handed, the volunteer support helped them to feel less stressed (n=11).

Does volunteering have an impact on volunteer wellbeing ?

100% of volunteers felt that volunteering gives them a sense of purpose (n=35).

> *"I really enjoyed getting involved in some of the complex issues involved in getting patients home. I loved the problem solving and got great satisfaction in just helping people get home sooner than they might have otherwise. Being able to help those really in need was very satisfying."*
>
> VOLUNTEER

> *"Can't thank you enough for helping me with some food to get me through the first few days, until I can arrange to get to the shops. Its lovely to know, there are some nice people about. Thanks so much for helping."*
>
> PATIENT

> *"My experience with volunteers has been more positive than expected. As a result of the difference they make with their positive attitude to making a difference to the patient experience. The time has allowed me extra time to support unwell patients. Our volunteers help patients who are anxious, supporting them through the discharge lounge."*
>
> STAFF

Patients who used the 'Home but not Alone' service felt safer, more reassured and more supported when at home compared to at the time of discharge

Figure 1.

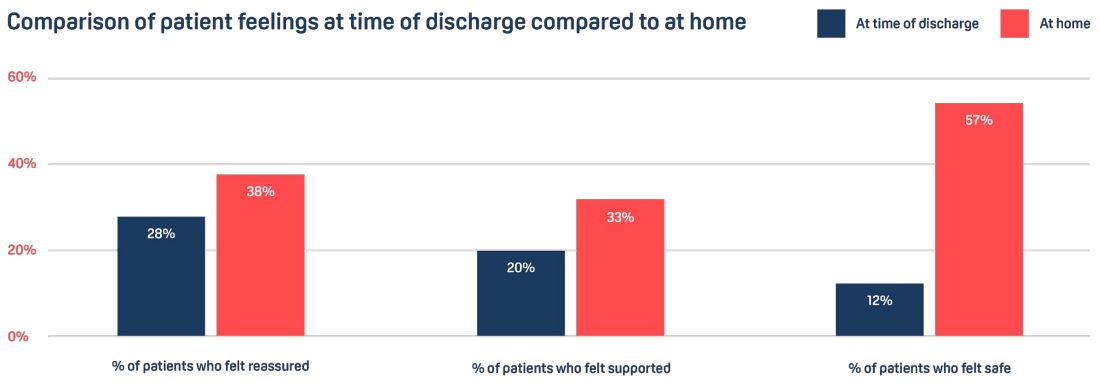

Figure 1. Data collected using the VIP Patient Discharge Survey. n=10.

Service Principles

The North Tees Home from Hospital Service principles depict the essence of this service and provide guidance to ensure that the service remains true to its original intent across both development and management activities and decisions.

Service design based on patient need
The service identifies what patients need in order to be discharged safely, for example emergency food parcels and clothes that can be taken home with them. Volunteers can also support a patient in their home for up to 28 days from the day of discharge.

Ongoing support for patients
Home support includes making sure the house is ready for the patient to go home, checking in on patients either by phone or in person, providing help with shopping and transport for outpatient appointments.

Stakeholder engagement
This project has been developed following ongoing dialogue with members of the Integrated discharge team, ward managers and patient feedback. Involvement of the local community has ensured that the project complements existing community services.

Obtaining feedback
Feedback is obtained through staff and patient engagement. In addition the service is closely monitored through feedback from members of the Integrated Discharge Team, Senior Clinical Managers and Ward Managers. Feedback is used to refine and develop the service.

Meeting service demand
The team plans for future discharge needs to make sure that volunteer capacity is available to meet demand.

Active promotion of the service
The team actively ensures that staff know that the service is available and when and how they can access it in order to increase the number of referrals.

Using simple systems
To keep the service as efficient and effective as possible referrals are made by phoning individual volunteers. The service has developed links with local volunteer services and volunteers are encouraged to develop their own local networks that can enhance the service.

Embedding impact measurement in the service
Collecting data on patient discharge time and the number of patients discharged before 2pm helps to identify potential improvements in the discharge process. The service is also identifying links between improved discharge processes, reduced re-admissions and improved attendance at outpatient appointments.

Case Study

Staff feel that volunteers help them to have extra time to support their patients

82% of staff agreed/strongly agreed that volunteer support is helpful in allowing them to have enough time to deliver good care to patients

"My experience with volunteers has been more positive than expected. As a result of the difference they make with their positive attitude to making a difference to the patient experience. The time has allowed me extra time to support unwell patients. Our volunteers help patients who are anxious, supporting them through the discharge lounge."

Clinical Staff Member North Tees and Hartlepool NHS Foundation Trust

Patient pathway

The Home from Hospital volunteer service provides the patient with support from the point of knowing that they are going to be discharged through to 28 days post-discharge. From the patient's perspective this helps to reduce stress and anxiety around coming home. Supporting the person to settle in after a long hospital stay aims to reduce the likelihood of re-admission.

Patient Pathway

The patient pathway (below, figure 2.) is at the heart of the service and has been designed to provide high quality support that adds value to not only the patients and the family and friends, but to the clinical staff and volunteers delivering it.

- **Clinical staff and volunteers journey** (Page 6) shows how the roles interact to ensure sensitive and timely support is provided across the patient pathway.
- **Support process** (Page 7) highlights the infrastructure that supports the staff and volunteers to consistently deliver and develop the service.

Core components

1. **Clinical Volunteer (CV) pre discharge support** - If a patient is Identified as needing discharge support the CV visits the patient on the ward and discusses the support that is available. If required the identified patient is then referred to the Discharge Support Volunteer (DSV).
2. **Discharge Support Volunteer (DSV, sometime known as 'buddy')** visits the patients that have agreed to discharge support and discusses in detail what sort of support they may need. This may include options for a food/clothes parcel provided by the local food bank, being accompanied home by the DSV and/ or receiving support at home.This continuity is important as it helps the patient build a trusting relationship with the volunteer. Volunteers work in pairs in order to offer peer support and to satisfy safeguarding requirements, in addition a second DSV will also attend any home visits.
3. **Arriving home,** the DSV spends time helping the patient to settle in.If the home has been unoccupied for a while the DSV will carry out checks to ensure that the home is safe and warm. Working in pairs means that one volunteer can be carrying out these checks whilst the other can be helping the patient to feel settled.
4. **Needing more support** is common and is generally identified during in the arrival home.For the next 28 days post discharge the patient will receive visits/calls monitor their wellbeing and to identify ongoing need.
5. **Local services -** the DSV will signpost the patient to relevant local services and support networks where needed.

Figure 2.

Ward nurse introduces the Clinical Volunteer (CV) to the patient following identifying the need for some on ward support. The CV is trained to identify if the patient would benefit from support during discharge and on arrival home.

If discharge support is needed then the Discharge Support Volunteer (DSV), chats with the patient to understand in more detail about the support that they will need and organises/ facilitates the different elements of support. On arrival home the DSV will help the patient to settle back in.

The DSV remains in contact with the patient for the 28 day period if needed and will signpost to local service where needed.

Clinical staff and volunteers journey

The team of volunteers will have a wide range of skills to ensure that the programme is a success. Interpersonal skills are important in developing effective and trusting relationships with patients, helping to reduce re-admissions and enhancing the patient experience. The DSV will have access to appropriate links within the wider community/third sector through existing volunteering networks and local knowledge to support any on-going needs that the patients may have. As an acute hospital the aim is to facilitate discharge of patients as early as possible. This is to ensure patients are returning home in daylight hours and are able to settle in safely. This will improve the patient experience and as a result will also improve patient flow ensuring acute hospital beds are available for those that need them most.

Clinical staff and volunteer interaction

Figure 3 below demonstrates the importance of the relationship between the clinical staff and the volunteers.

Core components

6 **Link to Clinical Volunteer (CV)** role plays an essential part in identifying patients that are most likely to need support when they are home and will introduce the idea of the discharge support and will refer that patient over to the DSV.

7 The DSV provides practical assistance to patients on the wards, helping to pack belongings and prepare mentally for going home. The DSV liaises with the ward team, discharge lounge and volunteer drivers and coordinates any support and services needed for the patient's successful transfer home. This may include emergency food parcels or clothing if required. The DSV may travel with the patient or arrive to support the patient as the volunteer driver returns the patient to their home.

8 The DSV will ensure patients are taken home safely and as soon as possible. Once reaching home tasks might include checking that household amenities are in working order, helping the patient to unpack and ensuring that food and refreshments are available. The DSV will explain the next steps and the support that is available to them.

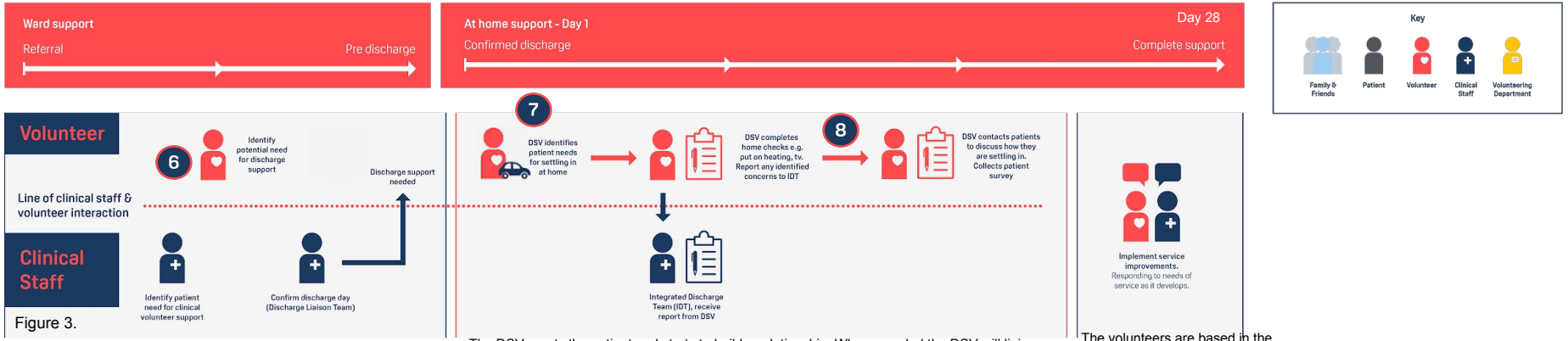

Figure 3.

The clinical team identify those who will benefit from the service and make a referral to the clinical volunteer (CV). Once the discharge day is confirmed the patient is introduced to the DSV.

The DSV meets the patient and starts to build a relationship. Where needed the DSV will liaise with the Integrated Discharge Team for expert advice and will provide them with a report once the patient is settled home and a plan for support agreed.
The DSV continues to support the patient as needed through calls or visits and where appropriate will signpost the patient to other community services.

The volunteers are based in the Integrated Discharge Team, enabling improvements to be discussed and put into practice quickly.

Service blueprint

This service blueprint brings together the patient pathway (figure 2.), the clinical staff and volunteer journey (figure 3.) and the support processes (below figure 4) that enable the service to operate.

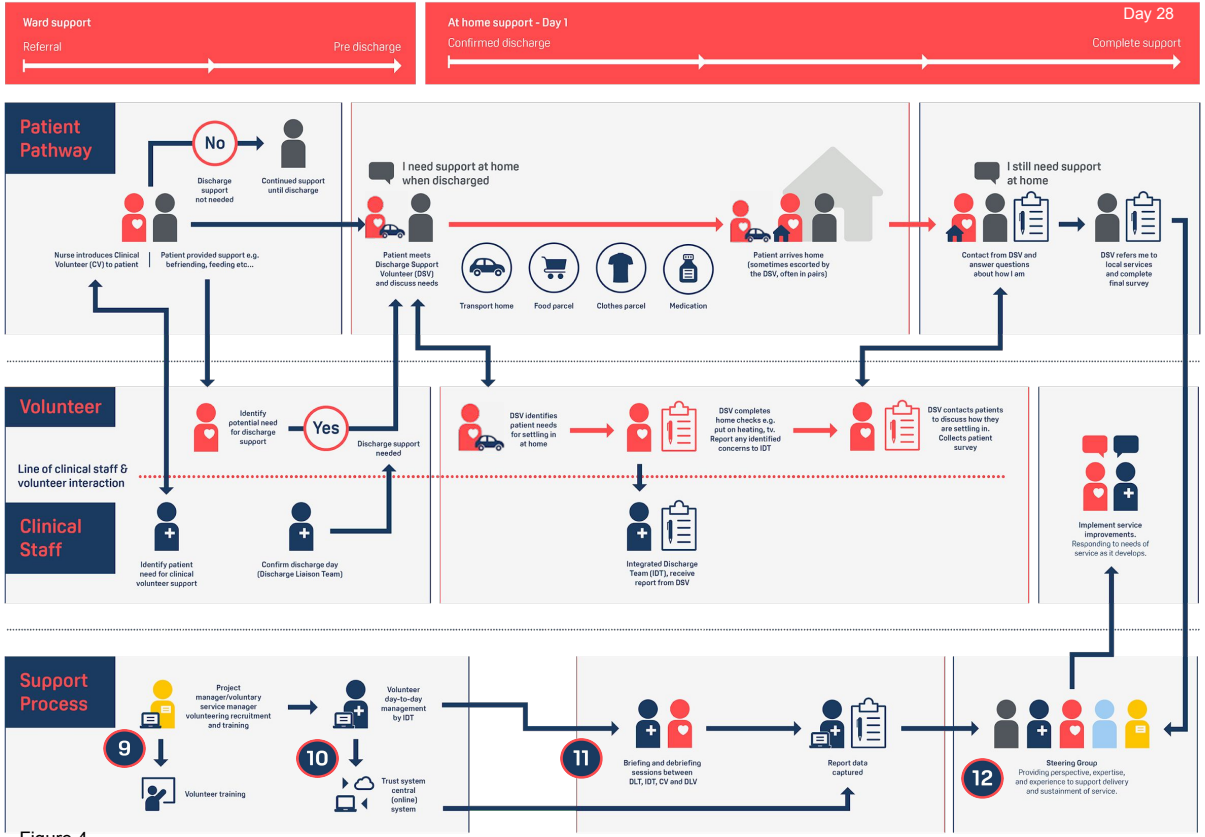

Figure 4.

Support process

The patient pathway (below, figure 2.) is at the heart of the service and has been designed to provide high quality support that adds value to the patients and also to the clinical staff and volunteers delivering the service.

Core components

9 **Dedicated resource/time to manage** - a Volunteer Support Officer was recruited for the length of time of the project to allow the Volunteer Coordinator the time to effectively manage/develop the new service. Support offered from the Resources team to ensure the recruitment period is kept to a minimum. Support also offered from the Trust's Education and Training team ensures that induction training is delivered to an acceptable standards.

10 **Simple systems** - referrals are received as a simple phone call into the service or direct referral to a volunteer. This will become an online system using the Trust's central system. Patients or family and friends can also self refer.

11 **Briefing and debriefing sessions** are an effective way of supporting the volunteers and enable the service to learn and develop. These are held with the Integrated Discharge Team at the beginning and end of each shift. This can be an emotionally difficult role and volunteers benefit from the opportunity to offload as well as share best practice and learn.

12 **Cross Department Steering Group** - this comprises members of staff from all areas of the Trust and at various levels. It includes volunteer representatives and colleagues from external voluntary agencies.

Develop & implement

Developing and implementing a Home from Hospital volunteer service involves taking a strategic view of the different stakeholders that will be impacted by, and benefit from, the service. One way to bring people together and deliver an achievable plan is through a cross-organisational steering group.

Core components

1. **Developing additional patient benefits for those most vulnerable -** the volunteer driver service was initially added to return patients to their home where needed. Further service developments were added, for example emergency food and clothes parcels, supported by local food banks.
2. **Engaging and upskilling volunteers and staff** - by training more people to identify those patients that would most benefit from the service the referral numbers grew and this helped to establish the service quickly. Involving key stakeholders such as senior managers, clinical leads and voluntary sector colleagues to explore the opportunities and identify barriers helped to develop solutions. Face to face contact, group meetings and telephone contact worked particularly well.
3. **Cross department Steering Group** - the group comprised members of staff from all areas of the Trust and at various levels, including senior managers, volunteer representatives and colleagues from external voluntary agencies.
4. **Effective approach to recruitment** - initially recruitment was managed directly with the volunteering team where specific Home from Hospital role descriptions and use of channels such as NHS jobs were used to maximise the effectiveness. Recruitment has now been integrated into the wider volunteer recruitment process.
5. **Embedded marketing and communication plan** - promoting the service internally through the use of banners, leaflets and posters has helped to increase referrals. The service has also been promoted externally through social and local media as well as directly to primary care networks.

Consideration checklist

- ❑ Know your organisation's key strategic and operational priorities.
- ❑ Agree how the service will meet strategic priorities.
- ❑ Agree on the scale and scope of your new service.
- ❑ Confirm the budget and resources needed.
- ❑ Identify key stakeholders/support team for implementation and wider on-going service development and support e.g. co-design.
- ❑ Run workshops to co-design and develop ideas for your new service.
- ❑ Produce an implementation/ project plan and risk log covering:
  - ❑ Systems and infrastructure
  - ❑ Operations (inc. engagement plan)
  - ❑ Volunteer management
  - ❑ Measuring impact
- ❑ Identify and develop new policies you may need.

Key Learning

★ Look at existing volunteer services to see whether linking them with an additional role may make them more impactful.

★ Start slowly, test, review, revise, and plan for growth over time.

★ Start engagement with key stakeholders early to gain their support and buy in.

Stakeholders you could consider:
Volunteer manager, volunteers, senior leadership team representative, eg chief nurse, head of patient experience, director of workforce, data expert/member of business information team, integrated discharge team, ward staff members, voluntary sector representative, PMIO Team, IT.

Resources

- What are Service Principles
- What are Core Components

Systems & infrastructure

The ‘Home but not Alone’ service demonstrates the importance of volunteers being based within the Integrated Discharge Team. This promotes a team environment and a sense of belonging whilst gaining peer support from other volunteers. Gaining support and knowledge from liaising closely with healthcare professionals is a key part of integrating the service.

Core components

1. **Training -** volunteers are trained to enable them to identify the different needs of the people they are working with. This improves the quality of the service as well as increasing referrals.
2. **Co-location** - volunteers are co-located within the Integrated Discharge Team in order to improve the support for volunteers and to improve the volunteer understanding of the discharge process.
3. **Communication** - active engagement with the communications team helps to create materials that reflect how the service has evolved. Powerful marketing materials are key to increasing levels of referrals to the service.
4. **Relationship building** - working with local voluntary sector organisations increases the scope of the service. Volunteers are encouraged to make connections with other organisations and develop local networks.
5. **Data collection** - spreadsheets are a good starting point to establish the range of data that needs to be collected. At the point where the service needs to scale, consideration should be given to integration into wider Trust data systems.

Consideration checklist

- ❑ Decide where your service will be based and how the space will be equipped.
- ❑ Identify data that needs to be collected to support your service (e.g. volunteer activities).
- ❑ Identify other agencies that might be involved in patient care.
- ❑ Design your referral process and communicate this with staff teams.
- ❑ Arrange training for staff and volunteers who will be using the systems and equipment.

Key Learning

★ Putting training in to enable volunteers to identify appropriate referrals has improved the efficiency of the service.

★ Using a Trust wide system simplifies the way data is collected. Once a system is in place it is important to allow time for staff training and data inputting.

Resources

- Home but not alone - referral process

Operations

Understanding the budget, people, systems and associated processes required to manage the service once it is live is essential. In terms of the budget for this service, the primary costs are salaries for the project coordinator/manager(2) with a proportion attributed to supervisory support from the Volunteer Services manager. Other costs are attributed to volunteer recruitment, training, equipment and expenses.

Core components

1. **Staff engagement** - commitment from ward staff is crucial to the success of the service. Prompting for referrals and training new staff in how to refer and listening to ideas & feedback ensures a more supportive environment for the volunteers. Staff see the benefits of the service enabling more patients to benefit from volunteer support.
2. **Dedicated service resource -** having a role such as a coordinator creates visibility of the service and provides an environment where volunteer support, staff engagement and continuous improvement can flourish.
3. **Starting small** - embedding your volunteer service in a department or ward to begin with will enable you to test your processes and address any teething problems before expanding to other areas. Staff involved in the early stages of the service can become clinical champions and promote the benefits of the 'Home but not Alone' service to colleagues in other departments.
4. **Internal and external communications** and marketing resources keeps the service prominent in staff minds and increases the rate of referrals to the service.
5. **Impact Measurement** - Day to day data collection creates a challenge in terms of integrity of data and storage of data. Processes should be integrated into a dedicated data collection system at an early stage to improve quality and simplify impact reporting.

Consideration checklist

- ❑ Define the reporting structure for your service.
- ❑ Produce a comms and marketing plan to raise awareness of your service.
- ❑ Produce a service delivery plan and update it regularly.
- ❑ Identify simple referral pathways.
- ❑ Manage an active Steering Group.
- ❑ Engage clinical champions to promote your volunteer service.
- ❑ Develop your approach to managing the service. You will need to consider:
  - ❑ Stakeholder engagement plan
  - ❑ Volunteer recruitment plan
  - ❑ Volunteer induction and training package delivery
  - ❑ Governance structure
  - ❑ Comms and marketing plan
  - ❑ Reporting structure and frequency
  - ❑ Scheduling of volunteer shifts
  - ❑ Documentation for department /ward staff

Key Learning

★ Being able to access the professional support of the Integrated Discharge Team has had a profound effect on the breadth of support that volunteers can offer and the way they feel about their contribution to each patient's progress.

★ Having the volunteers based within the Integrated Discharge Team creates efficiencies and supports the sustainability of the programme once the service is established.

★ Staff and volunteers have a wealth of knowledge around local service provision which can offer great benefits to patients too.

Resources

- Home from Hospital Coordinator Activities/ Duties

(2). Dedicated resource of a volunteer coordinator/ project manager was funded in this example service as part of the Helpforce VIP programme, the scale/ scope of a service will dictate whether a dedicated resource is required or a commitment of time from existing resource..

Volunteer management

Identified components around volunteer management are designed to promote high retention of volunteers which in turn will benefit the service through a more experienced, skilled and confident volunteering team. Managing and supporting volunteers effectively is key to the success of this service which was found to be best managed as part of the Integrated Discharge Team.

Core components

1. **Integrated Discharge Team** - the volunteers are predominantly managed from within this team and report at both the start and the finish of their sessions to allow brief and debrief sessions to take place.
2. **Creating a supportive environment for the volunteer** - the wellbeing of volunteers and a supportive environment are essential to ensuring the quality of the delivery of this service. Volunteers are invited to share their challenges and successes, also to actively feed into how the service operates and improves.
3. **Effective training** -Volunteers receive mixed mandatory Trust volunteer training, communication skills training and any additional training that supports them to identify specific needs that patients might have.
4. **Working in pairs** - Volunteers work in pairs to encourage peer support as well as satisfying safeguarding requirements.

Consideration checklist

- ❑ Agree on a set of volunteer tasks, responsibilities and boundaries.
- ❑ Produce a volunteer role description.
- ❑ Develop your volunteer recruitment plan.
- ❑ Design your volunteer training package.
- ❑ Develop your volunteer supervision and communication and engagement plan.
- ❑ Involve clinical staff in training delivery.
- ❑ Meet regularly with clinical staff to grow their support and working relationships with the volunteers.
- ❑ Offer regular one to one support sessions for your volunteers.
- ❑ Encourage reflective practice and sharing of ideas.

Key Learning

★ We initially planned for our recruitment to come from our existing pool of volunteers. This did not happen; quite quickly we understood that once our volunteers had entered an ‘emotional’ contract with the Trust to undertake a particular role, then this is what they wanted to continue to do.

★ Our volunteers need to have enquiring minds, always happy to ask questions and to take responsibility for supporting our patients in terms of the movement back into the wider community.

Resources

- Home from Hospital Volunteer Role Description
- Volunteer Discharge Support Role

Measuring impact

Approaching the collation of data and feedback sensitively is important to ensure its validity. Understanding the key strategic and operational priorities is crucial when identifying the data that needs to be captured in order to demonstrate the impact and benefits of the service. Systems and processes need to be tested for robustness and effective training provided to those involved in collating the data.

Core components

1. **Developing a Theory of Change** - this is an essential tool to outline the intended impact of the volunteer service and to support decision making around what intermediate outcomes and ultimate goals may be measured. This is an upfront activity to complete alongside identifying the service principles and the strategic and operational objectives the service is looking to address.
2. **Capturing patient referrals** - volunteers can be issued with a questionnaire to collect information of any patients to be referred into the programme. These questionnaires should be held within the volunteer services office for use by appropriate staff.
3. **Activity capture**:
    - Number of volunteers
    - Number of volunteer hours
    - Number of referrals
    - Details on follow up
    - Number of patients supported
    - Frequency of volunteer visits per month
4. **Insight and impact project questions**:
    1. Does a new 'Home from Hospital' volunteer innovation at North Tees improve efficiency and productivity in the hospital? (e.g., reduced bed blocking, reduced readmissions at 30 days, reduced transportation costs)
    2. Does the 'Home from Hospital' volunteer service improve patient experience?
    3. Do volunteers contribute to improving staff wellbeing and morale?
    4. Does volunteering have an impact on volunteer wellbeing?

Consideration checklist

- ❑ Agree the service impact measures.
- ❑ Establish a control group or baseline data to demonstrate the impact of your service.
- ❑ Produce a Theory of Change/logic model - this will help you to plan effectively
- ❑ Define the measures that will support continued investment and growth of the service.

Key Learning

★ The transfer of the collection of data to the Trust system was essential as the programme grew and for its sustainability. The collection of questionnaire data is also crucial and we would have benefited from obtaining a 'tablet' type of device to make this part of the process easier.

★ At first all interventions were recorded on an Excel spreadsheet, but as the numbers began to grow this method became difficult to manage. Moving forward, it was agreed that an icon would be used to identify our referrals on the Trust's system. This would allow the capture and analysis of activity across the Trust as this programme developed.

Resources

- Helpforce Impact & Insight Guidance inc. Theory of Change
- North Tees Staff Survey
- North Tees Volunteer Survey
- North Tees Patient Discharge Survey
- North Tees - Theory of Change
- HF Insight and Impact Report - North Tees Hartlepool 29092020