helpforce

Funded by:
NHS England and NHS Improvement

A volunteering service designed and tested by:

NHS

Norfolk and Norwich University Hospitals
NHS Foundation Trust

Volunteering Service Guide: Discharge Support

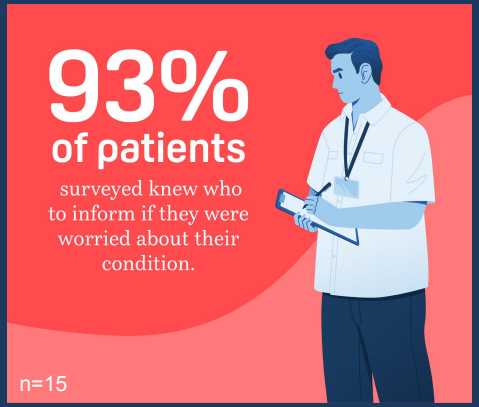
From the ward through to 72 hours post discharge in the home

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 at home on the day of their discharge from hospital in order to reduce readmissions up to 72 hours post discharge. Volunteers meet patients and ensure that they have food and drink, and a safe environment at home (e.g. the lighting, water and heating are all fully functional).

The volunteer service provides:

- Support & companionship to patients in their homes, helping with day to day tasks they might not otherwise be able to manage e.g. essential food shopping, unpacking luggage, making a light meal.
- Ensuring that patients are comfortable and integrated back into their homes and communities following a stay in hospital.
- A second volunteer visit or phone call on the next day or within 48 hours.
- Support and advice for patients and referrals to other relevant organisations where appropriate.



N.B. Norfolk and Norwich University Hospitals NHS Foundation Trust have named their 'Home from Hospital Service 'Settle in Service' 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 a service will work in a new location.

This ‘Volunteer Service Guide’ uses learning from the ‘Settle in Service’ being delivered by the Norfolk & Norwich University Hospitals. 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

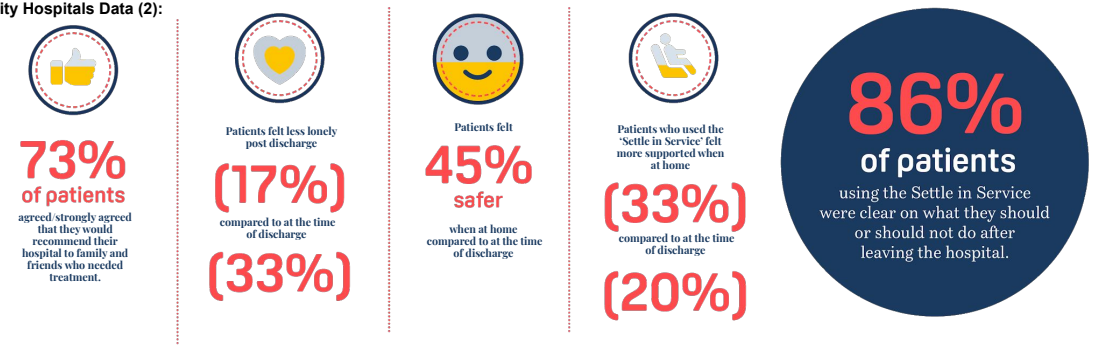
Contents:

How to:

“Walked around with her with her walking frame, moved a rug and table to make it easier for her to manoeuvre around the house, emptied the fridge and bins, unpacked bags, arranged medication and offered companionship and a listening ear.”

Volunteer - Settle in Service Norfolk and Norwich University Hospitals

Norfolk & Norwich University Hospitals Data (2):



(1). Adopter, person looking to take on (adopt and adapt) an existing and tested volunteer service model, 2. Data collected as part of the Helpforce Volunteers Innovators Programme (VIP), Patients at Norfolk & Norwich completed the VIP Patient Discharge Survey (n=15) and Volunteers at Norfolk & Norwich completed the VIP Volunteer Survey (n=100)

The results

The project started with 10 volunteers and increased over a period of 12 months to 15 volunteers. Across a typical 1 month period it is estimated that the active volunteers deliver an average of 9 hours of support to 6 patients.

Insight and impact project questions:

Does the 'Settle in Service' improve the patient experience post-discharge?When patients were asked to think about their discharge experience and say if they would recommend their hospital to family and friends who needed treatment, 73% of patients surveyed agreed or strongly agreed. The majority of patients using the Settle in Service were clear on what they should or should not do after leaving the hospital (86%) (n=15).

Is the 'Settle in Service' effective in signposting discharged patients to community resources?
Food support was a common reason for signposting throughout the duration of the programme. Welfare calls formed an important part of the signposting community support available from volunteers.

Additional insights:

Volunteers supported patient wellbeing post-discharge
Patients using the service generally felt:
Safer when at home (57%) compared to at the time of discharge (12%), and
Less lonely post discharge (17% feeling lonely) compared to at the point of discharge (33% feeling lonely),
Less frightened (0% feeling frightened soon after discharge, 20% at time of discharge),
More reassured when at home (38%) compared to at the time of discharge (28%),
More supported at home (33%) compared to at the time of discharge (20%) (n=15).

> *"I like the Settle in Service for many reasons. Patients are very grateful for your support when arriving home. I love being able to reassure patients and reduce their anxiety. This gives me great pleasure in knowing I've made a difference."*
>
> VOLUNTEER FOR THE 'SETTLE IN SERVICE'

> *"The patient asked if we could get her some bread so one of the volunteers popped out with little change she had and bought her some bread from the local shop. They then tested her pendant alarm to see it was still working. We then asked her how she was feeling about being back home and she was very happy and thanked us for our help. They followed up with a call the next day, no concerns raised. Patient reports she was comfortable at home with her package of care from Norfolk First Support."*
>
> FEEDBACK FROM THE VOLUNTARY SERVICES TEAM AT NORFOLK & NORWICH

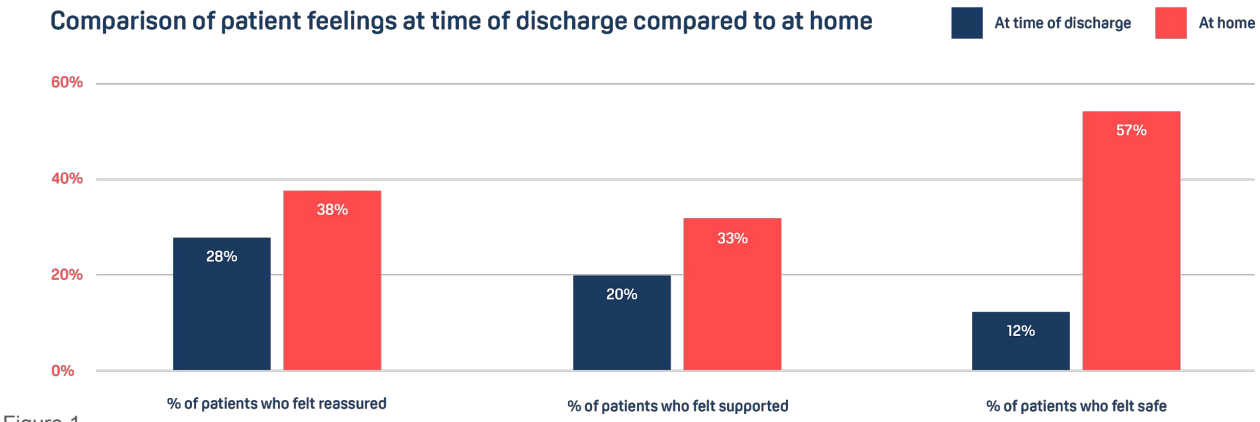


Figure 1.

Figure 1. Data collected using the VIP Patient Discharge Survey. n-15.

Service Principles

Norfolk & Norwich Settle in Service 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.

Enabling patients to return home confidently

Many patients are anxious about being discharged home, particularly if they live alone.This service arranges for a volunteer to meet patients at home after discharge to help them settle in and to address any concerns that patients might have. This is followed up the next day with a call or visit.

Providing volunteer support to avoid unnecessary re-admission

Many things precipitate hospital readmission. By addressing these often easily remedied issues patients have more confidence to remain at home. These issues can be anything from not having any food in the house to the house being too cold.

Improving patient experience of the discharge process

By linking the Settle in Service with the Volunteer Driver service the patient discharge can be better coordinated, saving time and reducing anxiety.

Providing a rewarding service people can volunteer for

Volunteers want to give something back to their community and local hospital. This is an ideal role for those who wish to contribute without the commitment of regular volunteering.

Measuring Service Impact

Measuring the impact of the volunteer support is crucial to ensure that the desired outcome of reducing/ preventing readmission of patients within the first 72hrs is being achieved.

Case Study

Volunteers feel that volunteering has had a positive impact on their wellbeing:

95% of volunteers felt that volunteering gives them a sense of purpose

The patient was admitted after a fall and had broken her wrist. She had no family who were local as they all lived in other countries. She was extremely nervous about going home and living there after her fall. She had a friend who was able to do her shopping for her but could not be there otherwise as she worked full time. As soon as she stepped through the front door she burst into tears and was overwhelmed at being home.

We walked around with her with her walking frame, practised getting on and off the commode, moved a rug and table to make it easier for her to manoeuvre around the house, emptied the fridge and bins, unpacked bags, arranged medication and offered companionship and a listening ear."

Patient pathway

The service is aimed at patients that have a risk of readmission up to 72 hours post discharge due to lack of confidence in returning home,no immediate provision of community services (the service can bridge a gap or help the patient re engage with previous services) or they may also have a history of unnecessary frequent admissions. Not all support needs are known or understood until back in the home and so having a volunteer trained to proactively identify and resolve any risks/ or ssues will reduce stress for the patient and in turn possible readmissions.

Patient Pathway

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 8) shows how the roles interact to ensure sensitive and timely support is provided across the patient pathway.
- **Support process** (Page 8) highlights the infrastructure that supports the staff and volunteers to consistently deliver and develop the service.

Core components

1. **Multiple and simple ways** for the patient to be identified as requiring the service, including self referral.
2. **Detailed discharge discussions** to proactively identify immediate needs for discharge and inform the approach needed e.g. 1,2 or 3 people required if history of mental health issues, accessibility issues on arrival home.
3. **Volunteer driver support** to provide patient transport home, timed with the arrival of the settle in volunteer(s).
4. **Trained volunteers** that are able to provide both emotional and practical support to the patient.
5. **Regular contact for 72 hours** the volunteer coordinator completes the service by providing an additional call to the patient at 72 hours post discharge to check how they are settling back in and to gain feedback on the support provided.
6. **Community partnership working** with a range of community services e.g. British Red Cross (BRC) Home from Hospital services who provide a once a week visit for up to 6 weeks post discharge. Where further support is needed, the volunteer makes a referral to BRC.

Figure 2.

The patient is reviewed for discharge by Occupational Therapy, Nurse and the Discharge coordinator who may refer the patient or they might request the service for themselves. The volunteer coordinator can assess the patient on the ward to double check that they meet the criteria and identify any other potential support needs .

The patient's arrival home is coordinated to meet the settle in service volunteer(s) who help the patient into their home and provide the initial settling in support such as making a cup of tea, essentials shopping and cleaning. They also complete some basic checks around accessibility, heating, sorting post etc. They provide a follow up call/visit at 48 hrs.

At 72 hours, the volunteer coordinator calls the patient to find out how they are getting on and to get feedback on the service. They will make sure a referral to BRC is made if needed.

Clinical staff and volunteers journey

The Settle in Service is very reactive in the way it is coordinated. For the volunteer coordinator some days may be filled with seeing patients on the ward, organising settle ins and even providing a settle in if no volunteer is available. Other days are filled with admin, promoting and organising training. The coordinator always carries a phone so they can receive a referral when not in the office.

Clinical staff and volunteer interaction

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

Core components

7 **Clinical staff have clear referral criteria** and simply phone through to make a referral,explaining the requirements for settling in. The overall referral process is kept very open and simple so that anyone can request settle in support for a patient

8 **Volunteers visit in pairs** for safeguarding and practical reasons. One volunteer can be settling the patient in and the other can be carrying out safety checks and practical tasks. Support needs and visits are then agreed with the patient. As a minimum the volunteer will call 48 hours later to check to see how the patient is managing.

9 **The volunteer coordinator** works to bring together all the learning and service improvements by working closely and collaborating with ward staff and the discharge team.

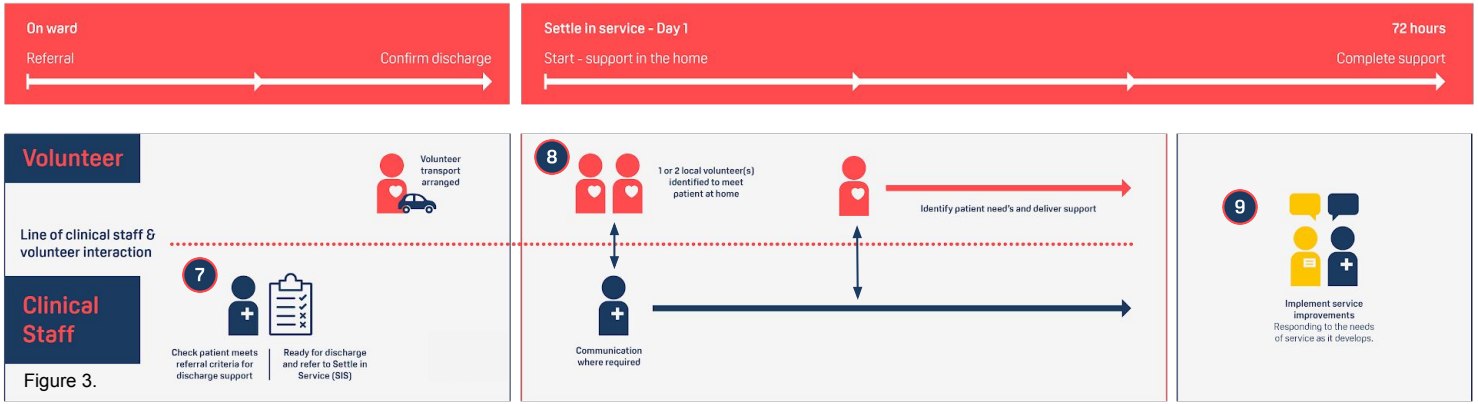


Figure 3.

Generally, ward staff (discharge coordinators and occupational therapists) identify patients suitable for the service and make a referral. However this is a very open process and anyone including the patient and members of their community can request settle in support for the patient. Where needed the the volunteer coordinator will make contact with volunteer transport to provide the patient with transport home alongside the 'Settle in Service' volunteers.

Volunteers will attend the home of the discharged patient on arrival and at 48 hours unless more frequent support needs are identified at the initial settle in session. The coordinator checks again at 72 hrs and then the volunteer will hand refer the patient to the British Red Cross where support post 72 hrs is required.

The volunteer coordinator takes on board feedback and more formal adjustments to the service from the steering group.

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.

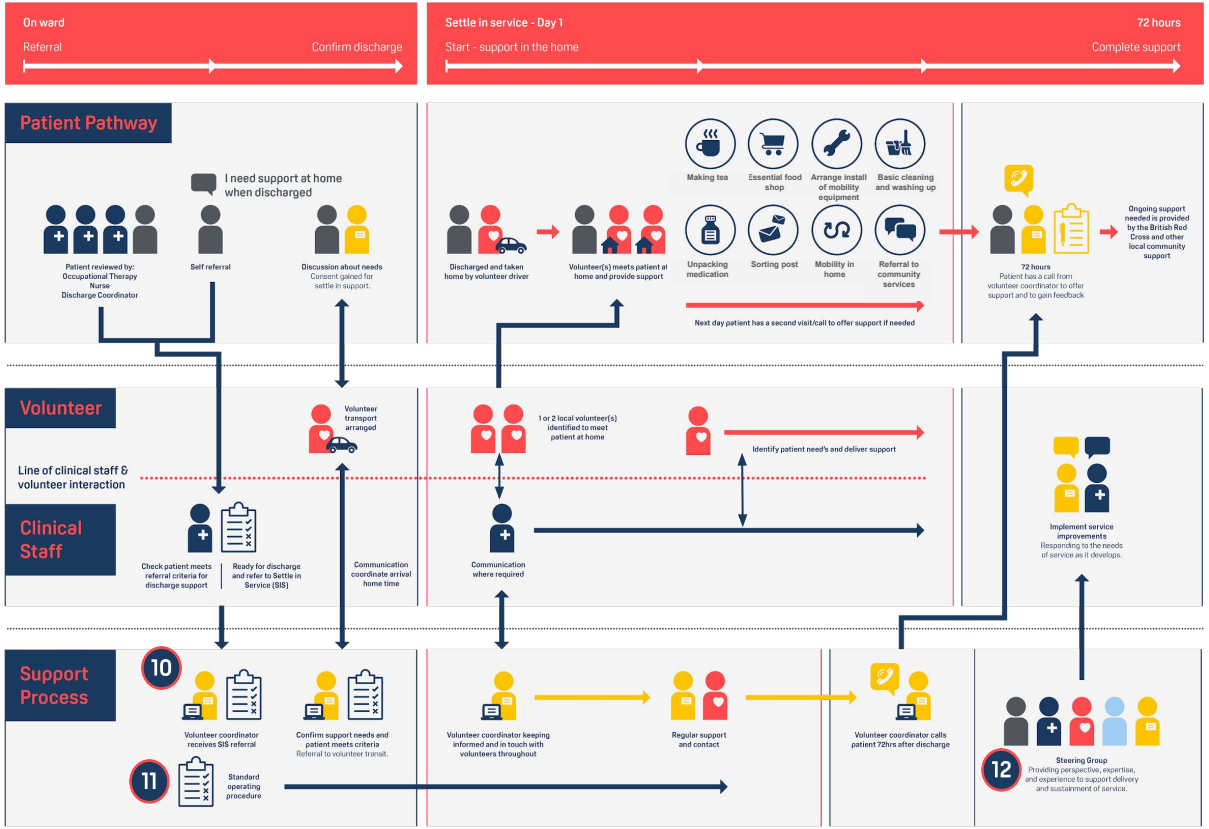


Figure 4.

Support process

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 clinical staff and volunteers delivering it.

Core components

10 **A dedicated volunteer coordinator** is critical for the day to day running of this service. The coordinator receives the referrals, assesses patients and makes decisions about who is suitable for a settle in. The role underpins the service by:

- **a.** promoting the service internally and externally, building relationships and partnerships with local organisations.
- **b.** Managing recruitment and maintaining good volunteer relationships remotely.

11 **The Settle in Service has a standard operating procedure (SOP)** which outlines step-by-step instructions to help volunteers carry out the settle in service and provides guidance on the patients that have been referred. SOPs aim to achieve efficiency, quality output and uniformity of performance.

12 **A steering group** and/or other effective engagement methods include clinical staff, third sector representation, the volunteer team and volunteers themselves, becoming a platform for ensuring continuous improvement and governance.

Develop & implement

Developing and implementing a Settle in Service involves looking at all the considerations and bringing together the right people to help create and deliver a feasible plan for a service in the community. Within this Norfolk and Norwich service model, a partnership has developed with the British Red Cross who already operate a similar service, rather than duplicate and confuse patients through collaboration, it was agreed that the settle in service would hand over to the BRC post 72hrs should the patient still require support.

Core components

1. **Community Integration** - providing an at home and local support for discharged patients has meant developing local relationships with services that the volunteers can refer their patients to if needed.
2. **Service principles & core components -** understanding the existing context and why this service is being set up and how it supports your organisation's strategic and operational priorities are needed to set out a realistic timeline and project plan.
3. **Clinical buy in** - support from ward staff is crucial in delivering the Settle in Service. Ward staff specifically play a key role in identifying patients who could benefit from the service.
4. **Steering group** - active cross department engagement such as a steering group which includes volunteer managers, volunteers, clinical staff and executive level roles ensures a balanced view for future development and improvements to the service.

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

★ Identify existing and established community services to be able to complement rather than duplicate them. This will help you decide the detail of the support that you provide. Being able to signpost patients to local services is important when ensuring the patient is supported when your service concludes.

★ Start slow, test, review, revise and approach a plan for growth over time.

★ Start early engagement with key stakeholders 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, discharge team, data expert / member of business information team, quality improvement representative, clinical staff member, eg nurse, occupational therapist, voluntary sector representative

Resources

- What are Service Principles
- What are Core Components

Systems & infrastructure

The volunteer coordinator is the linchpin of this service, linking together the ward based activity needed before home support can be provided by volunteers who are local to the patient. A Standard Operating Procedure (SOP) supports the coordinator in making sure that the service is appropriately governed.

Core components

1. **Standard operating procedure (SOP)** - the Settle in Service has a standard operating procedure which outlines step-by-step instructions to help volunteers carry out their role. It also provides guidance on referrals. The aim of the SOP is to achieve efficiency, quality output and uniformity of performance.

2. **Referral process** - through a defined referral process ward staff are able to refer patients via the telephone or directly to the volunteer coordinator.

3. **Quality Assurance -** the volunteer coordinator ensures that all volunteering activities meet with the Trust's service needs and are carried out in line with policies regarding health and safety, legal requirements, environmental, equal opportunity policies and general duty of care.

4. **Service promotion -** The volunteer coordinator actively promotes the service internally to raise awareness. This ensures that patients requiring support are referred in or know how to access the service.

Consideration checklist

- ❑ Decide where your service will be based and how the space will be equipped.
- ❑ Identify a volunteer management system to support your service.
- ❑ Design your referral process and communicate this with staff teams.
- ❑ Specify the hardware you will need - computer, laptop, bleep, mobile technology etc.
- ❑ Agree on the data capture tools you will use.
- ❑ Arrange training for staff and volunteers who will be using the systems and equipment.

Key Learning

★ The service is provided Monday to Friday before 18:00. The coordinator is on the hospital site for 8 hours a day Monday to Friday to coordinate the service. Some coordination is carried out from home if a volunteer is providing a visit after office hours.

Resources

- Settle in Service Volunteer Coordinator Role Overview
- SOP Standard Operating Procedure
- Referral Criteria
- Referral form
- Visit form

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 volunteer coordinator(2) with a proportion attributed to the Volunteer Services Manager, who leads the service. Other costs are attributed to volunteer recruitment, training and equipment.

Core components

1. **Staff engagement -** committing time to engaging with staff is essential for developing consistent referrals and being able to grow the service. Sharing impact results and case studies, reminding people how to refer, listening and acting on ideas/feedback can all help to achieve this. These activities can also ensure a more supportive environment for the volunteers. Once the staff see the benefits of the service, more patients are able to receive support.
2. **Dedicated Volunteer Coordinator** - this role creates visibility of the service, helps to engage the clinical staff, provides support for the volunteers and facilitates a culture of continuous improvement.
3. **Starting small** - embedding your volunteer service in one department or ward to begin with will enable you to test your processes and address any teething problems before expanding to other areas.
4. **Internal and external communications** and marketing resources keeps the service prominent in staff minds and makes the service visible to family and friends and patients.

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

★ Staff involved in the early stages of the service could become your clinical champions and promote the benefits of volunteer support to their colleagues in other departments.

★ It may help to focus on some key operational questions:

- How will you balance demand for the service with recruitment, training and scheduling of new volunteers?

- How will you build demand for your service to ensure that it is sustainable?

- Who are your main sponsors in the organisation and how can they help you?

★ Remember the steering group is there to guide you and advise on any strategic or operational issues. Together the group can generate ideas, remove blockers and help you to build a business case for continued investment.

Resources

- Referral Criteria
- SOP Standard Operating Procedure

(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. Think about every stage of a volunteer's journey, from their decision to volunteer through to the training, induction, ongoing support and day to day engagement.

Core components:

1. **Remote management,** some volunteers can go for months without providing a settle in service if there have been no referrals in their local area. This means that it is a priority of the service to keep in touch with volunteers whether it is through a phone call, newsletter or a personal visit to either their home or meet up for a coffee in their village.
2. **Community based volunteers -** volunteers are already based in their community and get on with their day to day lives until they receive a phone call from a coordinator requesting their help. Being local means that follow up calls or support are easier to provide.
3. **Recruitment and Training -** due to the autonomous and remote nature of the role it is important to be confident that the right people are recruited as volunteers. This process starts with awareness days followed by a recruitment process and delivery of a bespoke training package. The volunteers are invited to a training day with speakers from relevant departments which may include health & safety, safeguarding, information governance, infection control, spotting home hazards and occupational health.
4. **Competencies** - as part of training the volunteer attends a settle in visit with a coordinator to complete a series of core competencies e.g. volunteer dress code (wearing gilet, ID on show lanyard), equipment (aprons, gloves, hand gel and leaflets).

Consideration checklist

- ❑ Agree on a set of volunteer tasks, responsibilities and boundaries.
- ❑ Produce a volunteer role description.
- ❑ Lone working policy.
- ❑ Develop your volunteer recruitment plan.
- ❑ Design your volunteer training package.
- ❑ Develop your volunteer supervision, 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.

Key Learning

★ Due to the nature of the Settle in Service we actively look for volunteers who have the appropriate skills, expertise and experience to deal with challenging situations if they arise.

★ We have volunteers who haven't provided a settle in for a couple of months due to various reasons. We make it a priority to keep in touch with volunteers whether it is through a phone call, newsletter or a personal visit to either their home or meet up for a coffee in their village.

★ The Settle in Service volunteers must adhere to the lone working policy and report to the coordinator at the end of a visit.

Resources

- Settle in Service volunteer role description

Norfolk & Norwich Volunteer Documents:

- Volunteer Poster
- Awareness day newsletter
- Volunteer recruitment approach
- Volunteer Newsletter

Measuring impact

Approaching the collation of data and feedback sensitively is important. To understand what data needs to be captured, you also need to understand the key strategic and operational priorities. It is important to identify the measures that will best demonstrate the impact and benefits of the service on these priorities. The approach to collecting data is important to ensure its validity. 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 volunteers' intended impact 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. **Activity capture**:
   - **a.** Number of volunteers
   - **b.** Number of volunteer hours
   - **c.** Number of settle in visits completed by volunteers
   - **d.** Number of other tasks completed
   - **e.** Number of follow up phone calls completed by volunteers
   - **f.** Number of follow up visits to patients completed
   - **g.** Number of referrals
   - **h.** Number of appropriate settle in referrals
   - **i.** Total number of settle ins
   - **j.** Number of cancelled or inappropriate referrals
   - **k.** Total number of interactions by volunteers
   - **l.** Number of referrals which included volunteer driver service
   - **m.** Number of appropriate referrals cancelled (+ whether it was cancelled by the patient/voluntary services/transport/ non-voluntary services team
   - **n.** Number of patients supported

4. **Insight & Impact project questions:**
   1. Does the 'Settle in Service' improve the patient experience post-discharge?
   2. Is the 'Settle in Service' effective in signposting discharged patients to community resources?

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

★ To collect data showing the impact our service had on patients we completed a survey with each patient. The survey came in three parts: how the patient felt in hospital, once home during settle in and 48hrs after discharge. This helped us to measure how we made patients feel after receiving a settle in and how it may have lifted their mood.

★ On occasions some patients were a bit confused and couldn't remember receiving a settle in. This resulted in the questionnaire being incomplete for some.

Resources

- Helpforce Impact & Insight Guidance inc. Theory of Change
- Norfolk & Norwich Volunteer Survey
- Norfolk & Norwich Patient Discharge Survey
- Norfolk and Norwich Theory of Change
- HF Insight and Impact Report - Norfolk and Norwich_29092020