# Helpforce MAKING MORE TIME FOR CARE

22<sup>nd</sup> June – HelpForce Event Summary of Breakout Table Work

# London Innovation Event – 22<sup>nd</sup> June 2017

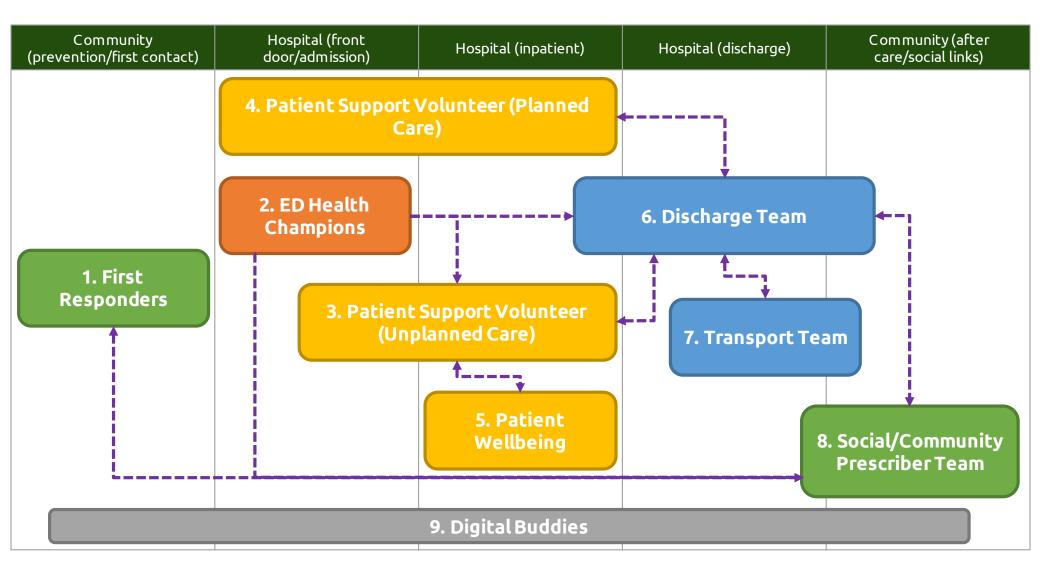
#### Summary of breakout table work - context



- On the 22<sup>nd</sup> June, HelpForce held an innovation event for trusts and VSCE partners across the country to reconvene, connect and share best practice to date.
- Nine patient pathway interventions were identified by the HelpForce team (see next slide) and attendees were given the challenge of trying to develop them in further detail.
- Each group took a slightly different approach either thinking about the role description in further detail, the practicalities of implementation, examples of best practice to share or what the intervention could be used for.
- The outputs of these discussions are presented overleaf.
- Pilot sites will be deciding which volunteering interventions they take forward over the coming months and individual workshops will kick off with each organisation to develop the action plan to implement interventions by the end of the year.

# Headline Interventions – Patient Pathway



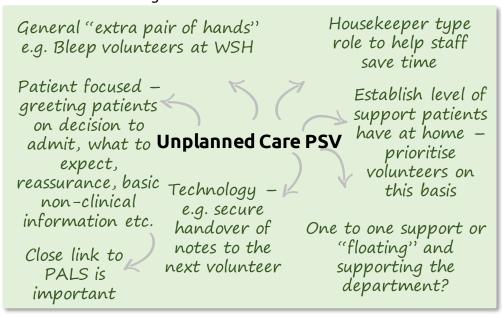


While there is natural overlap between many of these interventions, where there are anticipated to be daily direct links, this is illustrated with a dashed purple arrow (——▶)

**Table 1** looked at the 'First Responder' intervention and thought about the enablers that would be needed to implement it.



**Table 3** looked at the 'Unplanned Care Patient Support Volunteers' intervention and thought about the role and enablers.



**Table 2** looked at the 'ED Health Champion' intervention and thought about how they could help within the department

Supporting communication between staff and patients		Keeping patients calm/reassurance	
Manning alcohol tents	Patient advocate	"check out unanswered	
Arranging transport	ED Health (	Champion	Dementia support
Mental health support - befriending	Care packs/snack packs	Health & wellbeing planning	activities Signposting to services
Emotional support/just "being there"		Offering guidance/support to "frequent flyers"	

**Table 4** looked at the 'Planned Care Patient Support Volunteer' intervention and thought about the role across a planned care pathway.

Make a connection/ build trust	Planned Communicate	Care PSV  Update family	Aftercare support scheme
Call / fetch	with other services	Point of connection text/call update	
Out- patients	"runners"	Ward	Follow up
Culpipoiet	X-Ray		Discharge
Support friends &	Transport /	Handover	Transport
		MDT	ransport
family  Manage expectations	porter when no staff available	MDT Usual residence Daily routine	questions

**Table 5** looked at the 'Patient Wellbeing' intervention and thought about a number of different things

#### Patient Wellbeing

## Critical success factors

- · Training
- Risk assessment
- Ward engagement
- Leadership and management
- · Part of ward skill mix
- Skill matching volunteers to placements
- Understanding impact on patient wellbeing

### Examples to learn from

- Southampton: exercise, nutrition, befriending, F&F test, interpreters
- York: beverage volunteers, dementia champions, breastfeeding, EOLC volunteers
- Other ideas: cognitive stimulation, children & patient transfer

**Table 7** looked at the 'Transport Team' intervention and thought about the examples to learn from and critical success factors.

# Transport Team Critical success

# factors

- Multidisciplinary teams
- Coordinated centralised budgets
- One strategy between all care settings
- Good volunteering management
- · Patient empowerment
- Links to home from hospital services

## Examples to learn from

- RVS & British Red Cross
- Uber & Supercarers partnership
- Sandwell NHS building an app to map patient journeys from home to hospital
- Volunteer cycle drop in service for home visits

**Table 6** looked at the 'Discharge Team' intervention and thought about the activities that a volunteer could do to support the discharge process.

Accompanying the patient home  Assembling discharge bags e.g. fresh clothes, tea, coffee, etc.	Ensuring the patient leaves the hospital with the correct medication  Discharge Team	Creating links with other people in the patient's loca community  Follow up telephone calls
Preventing deconditioning e.g. by assisting with walks	Creating links with voluntary or charity groups in the community	Befriending services at home and in the community

**Table 8** looked at the 'Social /Community Prescriber Team' intervention and thought about the role across a planned care pathway.

Social/Community Prescriber Team Out-						
patients	Ward	Discharge	Home			
-	•	•	<b>→</b>			
Determine the needs & gap	Discuss possible solutions	Agree solutions/ actions	Carry out solutions/ actions			
Assessment	Care Plan	Care Plan	e.g. help them connect them to new groups			