carr gomm
Supporting People & Communities
25 YEARS

Carr Gomm: Demonstrating successful discharge outcomes and reducing unnecessary hospital admissions

October 2023

Introduction

For 25 years, Carr Gomm has been supporting people in communities across Scotland. Our services both support people after hospital stays as well as working with them to reduce their likelihood of being hospitalised. They demonstrate that the best outcomes for people happen when they are supported to live safely and independently in their own homes. In this report you'll see examples of good outcomes for people:

Glasgow Delayed Discharge Project
76% of recorded people were successfully discharged from an acute mental health hospital.

Argyll and Bute Mobile Homecare and Responder Services
Our services made 27,858 visits from April to August 2023, to people in the community; including 5406 visits which facilitated hospital discharge and promoted short term homecare support.

Edinburgh Community Link Working
10% of the 886 referrals made last year were to Edinburgh Leisure, giving people access to classes and specialist programmes including mental health support, falls rehab and Ageing Well walks.

Argyll and Bute/Highlands Community Contacts
Between October 2018 and April 2023, intensive support was offered to 739 people to help them access the social care they need to live safely at home and to achieve their personal outcomes.

Our support is person-centred which means that we work with each person to identify how they can best recover from hospital stays or to develop lasting support networks at home in their community. For Carr Gomm, the National Care Service would be a success only if it ensures that everyone can experience such person-centred support which enables them to live their best possible lives.

We are experts in supporting people in communities. Therefore we would like to explore with the Scottish Government ways to expand and replicate these services and how services can be strengthened by a National Care Service. Contact bethjohnstone@carrgomm.org for more information or to visit our services.

Glasgow Integrated Services and Delayed Discharge Project

Our Glasgow Integrated Services provide social care support as an integrated part of the mental health teams across Glasgow's Community Health and Social Care Partnerships (CHCP). This service supports people in the community with mental health challenges, building confidence and increasing independence. Our Integrated Services are based in health and resource centres in the North East, North West and South of Glasgow.

Our Integrated Services established a Delayed Discharge Pilot during the COVID pandemic. Historically, people in acute mental health wards could leave the hospital for increasing periods of time on a pass system, as part of a phased return into the community.

When this was not possible during COVID, Carr Gomm was approached by services within the CHCP North East to see how their Integrated Service could help people safely return to living in the community and promote independence.

A Delayed Discharge Project was then established to be operated from all three Integrated Services. The project works in partnership with the local hospital, clinical staff, homelessness prevention teams, community mental health teams and discharge co-ordinators to ensure people can access the right support at the right time. As a partnership we work with people before they are discharged from hospital to assess their needs; from assessing what services they need to connect with to establishing if their accommodation is safe enough for them to return to.

We then support them for several weeks in the community, working with people to achieve their day to day and long-term goals as set out in their support plan. Glasgow City Council commissioned Carr Gomm in summer 2023 to deliver the Glasgow Mental Health Discharge Support Service – progressing from the work of the Delayed Discharge Service.

Figures - October 2021 to August 2022

- 76% of recorded individuals were successfully discharged.
- 2354.5 hours of was support delivered. This is an average of 29 hours per person.
- Supports begins 47 days prior to discharge to build up relationships.
- The average time that support was delivered within the community was 66 days, which was spread over a range of 0 – 177 days. Length of support was based on the needs and aspirations outlined by the person in their support plan.

Successful discharge with further temporary supports	**42 (53.2%)**
Successful discharge with no ongoing supports	**9 (11.4%)**
Successful discharge with ongoing supports	**9 (11.4%)**
Unsuccessful discharge	**5 (6.3%)**
Other	**14 (17.7%)**

100% of planned discharges happen earlier then they would otherwise, and some proportion of unplanned discharges managed to get back on track with a plan around their discharge.

This service has meant that people are more likely to be successfully discharged than they would have otherwise, and go on to sustain their life in the community and live well.

Why these services work

Our services work in partnership.
We work with teams including Social Work, Crisis Team and Community Mental Health Teams. Being co-located with these teams means that there is excellent on-going communication with the other professionals involved in their lives. The partnership between the third sector and the statutory services means that people have wrap-around support which can respond to people's needs.

This service is funded flexibly and efficiently.
This means our services can be ready to support people when they need it, and so is not dependent on recruitment or other processes.

Our services our person centred.
We understand that a sustained return to the community is more likely when people have choice and control over what their support looks and what their goals are.

Grant's story

Grant* had been through the criminal justice system and so needed strict measures in place to facilitate his discharge, including two male workers at all times and reporting protocols if he attempted to visit certain mosques highlighted by Prevent.

Grant was discharged directly from the Intensive Psychiatric Care Unit due to COVID with several Multi-Agency Public Protection Arrangement (MAPPA) meetings needed to manage this transition. When Grant started receiving support at home, he engaged very little.

As staff continued to speak to him and suggested opportunities to make his home more comfortable, Grant began sharing his opinion about repairs he wanted completed. This gave staff an opportunity to engage with him further. After the repairs were reported and carried out, they supported Grant to tidy his home and make it more liveable.

Grant had the same two male support practitioners each week which gave him the consistency to develop trust and explore opportunities to engage safely in his community. He tried Tai Chi, visited the nearby Men's Shed and fulfilled his desire to build his own bike by being supported to travel north of the city to attend a workshop.

When Grant was in hospital, it was thought that if he managed to remain in the community that he would require long-term support. Yet through close partnership working with social work and health colleagues, Carr Gomm provided consistent support which offered Grant greater choice and control in choosing how to reintegrate within his community.

Grant no longer requires support and is no longer subject to MAPPA; he manages his medication well, and has re-built relationships with his family, who struggled to understand and comprehend his behaviour when he was unwell.

Grant's life has turned out to be far better than anyone thought when he was discharged.

*Grant's name and all other names in this publication have been changed to protect people's identity.

Argyll & Bute Mobile Homecare and Responder Teams

Responder Services

The Responder services operate 24/7 across Argyll and Bute. These are reactive services that keep people safe and well in their own home, increase the uptake of Telecare, reduce calls to emergency services, reduce hospital admission, delayed discharge timescales and improve carer wellbeing.

Mobile Home Care teams

The Mobile Home Care Teams facilitate hospital discharges and community escalation to prevent hospital or care home admission. The Teams also provide short-term care at home service to determine any longer-term requirements.

Without these services over 18,000 people had an increased likelihood of unnecessarily remaining in or being admitted to a hospital setting

Homecare & Responder Visits - April 2023 – August 2023

Reason for visit	Outcome	No. of visits
Short-term homecare support.	To maintain independence and remain safely at home.	4550
	To provide assessment of support needs in advance of commissioned support package.	
	To maintain independence and remain at home until commissioned support package is arranged.	
	To provide reablement support to promote independence and remain at home until injury is manageable.	
Facilitating hospital discharge and promoting short term homecare support. (Mobile Homecare).	To maintain independence and remain safely at home.	5406
	To provide assessment of support needs in advance of commissioned support package.	
Responding to community alarm for fall.	Rapid response to assess for injuries and avoid unnecessary use of emergency services.	844

Reason for visit	Outcome	No. of visits
Emergency support to prevent hospital or care home admission.	To maintain independence and remain safely at home.	211
	To maintain dignity at home while commissioned support package is arranged.	
Responding to Auxiliary and GPS alarms.	To ensure supported people can remain safely at home in the community.	1252
Responding to community alarm for personal care.	To maintain dignity at home outside of commissioned support times.	3831
	To avoid skin breakdown overnight.	
Responding to community alarm for no response.	Rapid response to assess and ensure the health and safety of supported person is maintained.	3105
Planned delivery of items.	To ensure supported people can access essential items and medicines to promote and maintain independence at home.	874
Planned personal care support.	To maintain dignity at home while commissioned support package is arranged.	6187
	To maintain dignity at home outside of commissioned support times.	
	To avoid skin breakdown overnight.	
Supporting discharge from hospital.	To provide safe transport home from hospital and avoid unnecessary use of emergency services.	90
Planned welfare check.	To assess and ensure the Health and Safety of a supported person is maintained.	1508
	Total no. of visits	27858

Why these services work

Staff are highly trained.
Our services provide specific support to allow a hospital to safely discharge people and to prevent unnecessary readmission. This includes providing catheter care and supporting a person to administer their own medication.

We add value to commissioned support.
Our Move to Improve pilot works with people to increase their activity and movement so they can regain confidence and independence after falls or stretches in hospital.

We work with other care providers.
All the Mobile Homecare and Responder teams regularly assist other care providers, covering support visits due to staff shortages. This ensures all people in the community receive continuity of care.

We work closely with the Argyll & Bute Health and Social Care Partnership.
We are commissioned and funded to provide a flexible, reactive and person-centred service.

Mary, 92 years - Story

When Mary came out of the hospital, the Campbeltown Mobile Homecare team came to assess her chronic back pain.

Over the three weeks of assessment, Mary's confidence grew each day as she became more familiar with daily tasks knowing that she had support when she required it. On each visit, Carr Gomm supported Mary to walk from her chair to the hallway and back, and this helped increased her strength and confidence after being more sedentary in hospital.

The team never rushed her recovery, but gave her the time she needed to build up her independence.

After those three weeks, our Homecare team began supporting her with everyday activities. She is happy to have regained her independence and looks forwards to getting back to her gardening.

Mary now only requires a welfare check and medication prompt.

Community Link Workers

Community Link Working offers non-clinical one-to-one support to people in contact with GP practices. We have 3 full-time Community Link Workers in 5 practices working with over 500 people.

Many of our referrals are about keeping people well within their communities, both mentally and physically.

We have prevented people from becoming unwell, returning to their GP, or being hospitalised; achieved by addressing the root causes of their stress or distress, whether poor housing, debt, unemployment, or feelings of isolation.

Craig's story

Craig was referred to our Community Link Workers by his doctor, who advised that he was suffering from anxiety and depression. Craig did not know where to find help with his lack of mobility, caused by a stroke 5 months previous.

He returned to work after 3 months but he could not cope with the demands. He was put on a leave of absence which left him feeling dejected. Craig wanted specialist support to work with him on a plan to improve his cognition and mobility issues, and to see that there was a possibility for progression.

His Community Link Worker put him in touch with the Edinburgh Community Stroke Service. As a result, the next time he spoke to his GP he told them how much the service had supported him and how better he was feeling. His GP then asked the Community Link Worker about the Stroke Service and how she could refer patients directly.

Craig's referral by the Community Link Worker reduced the likelihood that his condition will deteriorate, reduce chances of rehospitalisation and increase the likelihood of returning to work. It also means more stroke survivors will get the right support, reducing visits to primary and secondary healthcare settings.

Why this project works

Community Link Workers know their community.
They understand the best groups and activities for the person, often going along with the person to support them on their first visit.

Community Link Workers get to know people.
They are positively persistent; building relationships and understanding their aspirations to help people access the right support at the right time.

Community Link Workers work in partnership.
They are a link between the NHS and third sector, increasing the support offered by GP services and strengthening support networks in the community.

From April 22 to March 23 we made 886 referral to 224 different destinations

Referral Destination	Referrals	Referral Destination	Referrals
Community Groups	168	General Wellbeing Support	13
Sports and Leisure	132	Weight Management	11
Hardship Support	95	Illness Recovery	10
Social Care Support	86	Addiction Support	9
Advice & Advocacy	74	Religious Group	8
Mental Health Support	65	Healthcare	4
Housing Support	61	Befriending	3
Illness/Disability Support	52	Financial Advice	3
Employability Support	23	Grief Support	3
Energy Support	16	Survivor Support	3
Education	15	Transport Support	3
Carer Support	15	Family Support	14

Community Contacts - Argyll & Bute/Highlands

Our Community Contacts project is the Scottish Government funded Support in The Right Direction (SiRD) project working in Argyll & Bute since 2013 and Highland since 2018.

Working with individuals and families, it offers impartial support, information, and advice on Self-Directed Support (SDS) at any point in the process. This ranges from providing light-touch information to more intensive casework.

- 770 people are currently accessing direct payments in Highland and 360 in Argyll & Bute; and this is increasing.
- From October 2018 - April 2023, 739 people were offered intensive support.
- 75% of casework is to support people with SDS Option 1 (direct payments). This high number is due to the lack of registered support options in these geographies.

Without the work of Community Contacts, the people we supported would have struggled to access the right support at the right time; increasing their likelihood of remaining in or being readmitted to hospital.

Why this project works

Community Contacts is independent.
This means that it can explore the best outcomes for people based on their needs and choices, rather than the interests of one organisation or agency.

It works in partnership with the Health and Social Care Partnership.
This means that we can find the right, available support and act swiftly to ensure that people can get the support they need at home in their community.

It is a flexible service.
This means that we can work with the geographical challenges that come with SDS implementation to find the support people need.

Yemi's story

Yemi lives with autism spectrum condition and MS (Multiple Sclerosis). He was recently admitted to hospital with a decline in his health. Whilst planning for his discharge home, he highlighted that he would like to employ his own personal assistants; people of his culture, who spoke the same language as him. Community Contacts got to know Yemi and worked with him, through an interpreter, to establish what matters to him. Using this information, Community Contacts developed a recruitment plan and by supporting Yemi to remain in control, helped him employ personal assistants from his own community to enable his successful discharge from hospital.

Lauren's story

Lauren has a learning disability. She does not communicate with words and sometimes her behaviours make it difficult to support her well. Her only support was her parents who became exhausted from meeting Lauren's 24-hour support needs.

A crisis arose as her parents could no longer cope, and Lauren was admitted to hospital. The family approached Community Contacts as they felt a family member, Mark was best placed to support Lauren. Mark had grown up with Lauren and they had a good relationship - the family expressed that Mark 'got' Lauren.

They wanted to employ him, and Mark agreed to this. Community Contacts helped the family to put a case forward to the HSCP to request permission for them to employ Mark under exceptional circumstances. This was agreed; Lauren was discharged from hospital back into her family's care, with the support of Mark. The family fed back that the arrangement is working; Lauren is enjoying Mark's company, and her family can enjoy breaks due to their employment of Mark to support Lauren.

Niamh, 10 years old - Story

Niamh lives with a life limiting, complex health condition which requires frequent admissions to hospital. During an extended admission period, her family moved to Ronald MacDonald House at the Queen Mother's Hospital in Glasgow.

Her health and social work team reached out to Community Contacts to see how SDS might contribute to her being able to leave hospital and have her needs supported at home. This required careful collaboration with Niamh and her family, her health and social work professionals.

It was agreed with the family that personal assistants, employed by them, as part of their multi-disciplinary community-based team, would give Niamh the best chance of living the life she wanted. Community Contacts helped the family to develop a job description, based on the advice and support from the health and social work team. Suitable personal assistants were recruited, and Community Contacts helped to coordinate training to enable them to support Niamh safely.

Niamh returned to her community and today remains at home supported by her family and professional team. She is back at school and has remained in the best health possible for her, for the longest time.

Summary

Carr Gomm's support in communities is successful in expediting safe hospital discharge and helping people live safely and independently in their community because we are:

Highly trained

Our staff are highly trained, qualified to or working towards a minimum of SVQ Level 2 Award. Carr Gomm is committed to continually investing in the professional development of all our staff, recognising the value and expertise needed for their roles.

Person-centred

All our support is based around people's choices, supporting them to achieve their day-to-goals and achieve long-term aspirations. This means their recovery is more likely to be sustainable and they are more likely to lead good lives.

Passionate about partnership-working

We know that each community, each family and each individual is different. From Health and Social Care Partnerships, other social care providers, local community groups and people's families; we always seek to work in partnership to ensure people can access the right support for them, in their own community.

Innovative

Because our services respond to the needs of each individual, we are experienced in finding new ways of supporting people. We share our learning across our organisation and with our partners to increase good practise across our services and across social care. We are indefatigable in ensuring our services aren't just 'good enough', but excellent, adding value to commissioned support.

With over 25 years of experience, Carr Gomm is an expert in supporting people to live safely and well in their community. We would be delighted to share our knowledge and expertise so more people can receive excellent person-centred support. Contact bethjohnstone@carrgomm.org for more information or to visit our services.

carr gomm
Supporting People & Communities

25 YEARS

A Company limited by guarantee in Scotland:
SC 236436 Scottish charity: SC 033491

National and Registered Office:
Space, 11 Harewood Road, Edinburgh
EH16 4NT

www.carrgomm.org
info@carrgomm.org