Framework to embed VCFSE within Hospital Discharge: Step Down

Context

Voluntary, community, faith and social enterprise (VCFSE) organisations play a **critical role in reducing hospital readmissions**, supporting recovery, population health and addressing health inequalities. Their community presence and flexibility make them **ideal partners** in delivering holistic, personalised care closer to home.

Framework aims

Drawing on VCFSE delivery of step-down patient support across Cheshire and Merseyside, the North West and the best models across England, this framework provides a roadmap for collaborative, community-centred care using the untapped potential of local VCFSE organisations. This framework also supports real choices for patients to maximise their independence and remain in their own home and reduce readmission rates. Based on the model in Chester and West Cheshire, 12-month readmission rates are just 12%.

While the framework developed here is focused on step-down, it is compatible with admission reduction programmes (e.g. **Lancashire and South Cumbria**) and can build VCFSE Neighbourhood Health capacity (see Appendix).

The framework provides health partners and commissioners with a template to develop a service specification to create an effective VCFSE embedded hospital discharge service. Based on good practice, the framework model delivers:

- Embedded VCFSE in discharge planning and delivery
- Ensures non-clinical needs are addressed alongside clinical care
- Single point of access for all referrals to VCFSE support
- Timely discharge for pathway 0 to 3 patients
- Reduced hospital stays and re-admissions
- Improved patient outcomes, supporting patients to regain or maximise their independence
- Reduced system pressures and system costs
- Build system capacity to redress wider determinants of health inequality

The framework includes specialist services for housing, welfare and benefits, for people experiencing homelessness and substance abuse issues, and support for people with long term conditions and carers, as well as capacity to provide wellbeing support in the community. The framework is the building block for early intervention.

Service specification template	
VCFSE embedded in discharge planning and delivery	Establish the provision of VCFSE Link Workers, integrated within the hospital's discharge team, providing a triage service to VCFSE connections and volunteer support.
	Establish a VCFSE Hospital Discharge Alliance to provide a wide range of services to support timely discharge, short-term practical and emotional support and specialist VCFSE services.
	Regular attendance of appropriate meetings e.g. NRTR, MDT, ward walks.
	Establish an agreed protocol with VCFSE Hospital Discharge Alliance to ensure that the process from assessment to discharge is effective to quickly mobilise the required services.
	Establish relationships within the trust. For example, falls, dementia, physio, Social Care, mental health and care homes.
Assisted discharge	Provide a range of practical support to facilitate rapid discharge, including transport home and access to mobility equipment.
	Support to safely transport frail older people and vulnerable patients from hospital, identifying initial support to help them settle back in at home before discharge.
	Utilise VCFSE organisations based within the hospital and enhance with input from wider VCFSE Alliance.
	Maintain databases of local transport providers which will include taxis, volunteer schemes and community transport.
	Coordinate a comprehensive home support package that includes key safe fitting, small repairs, maintenance, aids and adaptations to property (such as walk-in showers, grab rails, and banister rails), furniture moving, assessing and securing trip hazards, energy efficiency assessment, and hoarding support.
	Maintain databases of local contractors to provide home clearing and cleaning, handyman services, telecare support etc.
	Support patients on discharge with any immediate issues such as essential food shopping & prescription collection, heating and addressing food and fuel poverty issues.
	Manage a practical support fund, a flexible discretionary fund to resolve discharge barriers quickly.

Patients have access to the care and support they need to successfully transition from hospital to home	Provision of support with preparation for leaving hospital, enabling effective and quick mobilisation of a support package focusing on safety and positive experiences for patients.
	Provide access to assistive technology, and digital solutions to support rehabilitation and reablement
	Produce and disseminate VCFSE service information packs for patients and families to highlight service and community support available.
Support for patients to recover, build resilience and stay independent at home	Coordinate patient connections to VCFSE services via hospital discharge alliance and wider.
	Coordinate specialist support from VCFSE providers to include homelessness, substance abuse, and chronic condition.
	Provide support to help maximise income through benefits, grants and access to information regarding debt management where needed.
	Coordinate specialist support from VCFSE providers to support with housing, welfare, debt and benefits advice.
	Provide ongoing community-based support to support emotional wellbeing, such as befriending, linking into community volunteers and home settling services to maintain wellbeing in the community.
	Coordinate follow-up welfare calls
	Provide home visits as appropriate to evaluate the patient's living conditions, potential safety hazards and gain valuable insights into their overall wellbeing

Key components for success

- Whole system approach and buy-in
- Clear agreements and protocols from the onset
- Physical VCFSE presence in hospitals for real-time collaboration
- VCFSE engaged in multi-disciplinary teams with the hospital, enabling them to actively participate in discharge planning, case discussions, and decision-making processes
- Giving VCFSE access to NHS Care Records and data for informed decision-making
- Address short term funding, minimum of 2-year dedicated funding for all aspects of service delivery
- Access to data to provide effective outcomes measurement and prioritisation
- Appropriate annual cost of living increases

Investment Guidance

Based on delivery across a place with a population c.250,000, with minimum 125 patient discharges per month after initial 6-month set-up phase, with a unit cost per patient of £213.

Service	Description	Investment
VCFSE Link Worker/s	Direct staff cost of link worker @ NJC point 20 (£32,597 pa + on-costs = £39,229) x 2.5 FTE	£98,072.50
	Management and support cost (20%) – contribution to management supervision, governance, HR, finance, compliance	£19,614.50
	Staff travel expenses	£2,100
	IT and back office support (direct project costs)	£2,000
	Information packs	£1,500
Wider VCFSE investment	Up to 10 VCFSE orgs providing specialist support, £12,000 (each VCFSE organisation) x 10 per annum .	£120,000 per annum
Practical Fund	Discretionary fund for patient support	£25,000
Volunteer Programme	Direct staff cost of volunteer coordinator @ NJC point 12 (£28,598 pa + on-costs = £34,350) x 1 FTE. Approx 75 active volunteers will be supported	£34,350
	Office desk (based at VCFSE organisation setting)	£1,000
	Management and support cost (20%) – contribution to management supervision, governance, HR, finance, compliance.	£6,870
	Volunteer DBS checks £15 x 100	£1,500
	Staff travel expenses	£1,000
	IT and back office support (direct project costs)	£1,000
	Information packs	£1,500
	Volunteer expenses – including travel, food, activities & training	£4,000
	Overall total	**£319,507**

How an embedded VCFSE hospital discharge model supports neighbourhood health

Neighbourhood health core component	Contribution of VCFSE hospital discharge model
POPULATION HEALTH MANAGEMENT Using data and technology to understand and meet the needs of the local population, allowing for more targeted and preventative interventions	• Uses shared data systems to provide preventative support and track outcomes • Coordinates specialist services addressing social determinants of health • Supports high intensity users and frequent A&E attendees to reduce admissions and readmissions
MODERN GENERAL PRACTICE Improving and streamlining access to general practice through online, phone, and in-person options to create a better patient experience	• Embeds link workers to support continuity post-discharge • Connects patients to community services aligned with general practice • Facilitates digital rehabilitation and personalised care
STANDARDISING COMMUNITY HEALTH SERVICES Integrating community health services to ensure consistent, high-quality care that addresses both physical and mental health needs across different areas	• Establishes a VCFSE Hospital Discharge Alliance • Delivers consistent practical and emotional support • Provides specialist services for those with complex needs in Pathways 1-3
NEIGHBOURHOOD MULTIDISCIPLINARY TEAMS Establishing teams of various professionals to provide coordinated and proactive care for people with complex needs	• Embeds VCFSE in multi-disciplinary teams, no right to reside and ward rounds • Enables access to NHS care records • Builds cross sector relationships for integrated planning
INTEGRATED INTERMEDIATE CARE Providing a "home first" approach to care, where people can receive support and treatment in their own homes or community settings when possible	• Mobilises rapid discharge support for Pathways 0-3 • Offers transport, home adaptations and volunteer mobilisation • Manages a flexible fund to remove discharge barriers
URGENT NEIGHBOURHOOD SERVICES Offering urgent, community based services for people with escalating or acute health needs, providing an alternative to hospital care	• Central to ensuring the NHS meets its urgent and emergency care priorities • Supports admission avoidance and winter pressures • Coordinates specialist VCFSE input for acute social needs