Hampshire County Council -

Social Work Line

Kirsty Ayakwah: Hello, and welcome to Season Two of *The Social Work Community* podcast, where we aim to connect you directly with the social workers and the issues affecting the sector.

My name is Kirsty Ayakwah, the senior careers editor at Community Care, and in this episode we explore how Hampshire County Council works to ensure that older adults avoid unnecessary journeys to the hospital, thanks to a collaboration they've formed with the South Central Ambulance Service (or SCAS). Through the collaboration, the Social Work Line was created, a dedicated phone number that crew can use to contact a social worker directly who is based with SCAS.

Let's start with some introductions. [0:00:45.7]

Matt Hutchinson: My name's Matt Hutchinson. I'm head of service for older adults, South Hampshire County Council.

Kirsty Ayakwah: Thank you. And Maria? [0:00:54.5]

Maria Kneller: Yep. So my name's Maria Kneller. I'm a senior social worker working for Hampshire County Council but based in the South Central Ambulance Service control centre.

Kirsty Ayakwah: Well, it's great to have you both here today. I wanted to find out a bit more about the Social Work Line and how it has been constructed with SCAS. [0:01:12.1]

Matt Hutchinson: So, the Social Work Line developed in about 2018. At that particular point I was managing the hospital discharge teams across the country and I was discussing some of the issues that SCAS (South Central Ambulance Service) were having when they were attending individuals when they were called out with a colleague, senior colleague in SCAS called Neil, who's the area manager. And their hospital systems were under particular pressure and he invited me up to the Osbourne HQ to see how they were organised.

It occurred to me when I was there that there was a lot more that we could do to support preventing conveyances to hospital. One of the things that Neil described to me was the lack of information they had when they attended individuals, particularly social care information, and some of the difficulties they had in assessing whether somebody needed to be conveyed or not who might not necessarily need to be conveyed. So if somebody had a fall and they didn't have anybody to be with them, quite naturally they would be concerned about that individual falling again, and they are often conveyed to hospital

because they were so concerned about the risk of an adverse outcome by a repeated fall and an injury.

So we arranged for a number of team managers to go and sit with the call staff over a number of evenings, and one team manager actually went out with crews to see their experience when managing individuals, and the Social Work Line was developed from there, really.

Kirsty Ayakwah: I think there was a pilot initially. So how long's it been running for? [0:02:57.8]

Matt Hutchinson: Yes. It ran for two years, two successful years. And then Covid hit. We had to pause it for another couple of years, actually, and then we recruited Maria at the back end of last year and she started in September this year. So it's been running now for another three months since we restarted the project.

Kirsty Ayakwah: Brilliant. Maria, tell us more about how it works on a day-to-day basis. [0:03:23.5]

Maria Kneller: So, the good thing about being based in the control centre is I've got access to the ambulance service system. So I can look at jobs that are coming in. So if there's jobs that I feel that I could just action, I'm able to allocate that job to myself and work on it and update the system. Or it might be that I can see a job that actually I know the crews need to go out on, but I can gather information and message the crew and say, 'If you need any further information I could help you out with X, Y and Z.'

I can also share information with…'cause being based in the control centre it's not just your call-takers. You've also got the dispatchers. So we can talk about, you know, services that might be better to go out. We've also got the clinical decision-makers. So they're paramedics and nurses. So we can go and have a chat with them and say, 'Look, I know this information about an individual.' For example, somebody recently was end-of-life palliative care. They'd had a fall, they were on the floor. There were no injuries reported. We were able to say, 'Look, we can't leave her waiting several hours for an ambulance. You know, if she's non-injury would it be suitable for one of the community first responders to go out?' And it's being able to have those conversations with the people within a timely manner to actually achieve the best outcomes for those patients. Just being able to share the information we've got enables us to do that, and just being housed together is amazing 'cause they can happen quickly.

Kirsty Ayakwah: How long is a critical amount of time for somebody to be, say, on the floor? [0:05:00.3]

Maria Kneller: I believe that they class a long lie, most ambulance services, anything over half an hour. That puts somebody at risk of developing various health complications such as a condition called rhabdomyolysis. But they generally talk about a four-hour window. But what they will do is they will triage calls, and if they haven't got the resources to send out within a timely manner they will re-triage as appropriate, depending on the length of time that call's been on there.

But also it's about looking at what other services we can use. So if it is a non-injury fall we can look at sending a community first responder. You've also got the urgent care response teams that they could look at. Some areas have got frailty teams. So it's just about knowing what services are out there and available that might be suitable for those people as alternatives to sending out an ambulance.

Kirsty Ayakwah: Which is very costly and time-consuming.

Maria Kneller: Yes.

Kirsty Ayakwah: I think there was an example that was mentioned about a service user that was very overweight? [0:06:02.0]

Maria Kneller: We did have a call-out recently for a larger person. So, all the ambulance crews and the community first responders and some of the falls teams do carry lifting equipment. I think the weight limit on them is generally 25-30 stone. But most ambulance staff are not trained in how to use manual handling equipment such as hoists, stand aids. They don't receive training. So if somebody is non-weight-bearing and their normal mode of transfer is using a mechanical aid, they're not able to do that.

So as much as they can lift people up off the floor, they then have the struggle of getting that person from the piece of equipment that they use, that could be a mango or a camel or an elk or a raiser chair, but they would struggle to get them from that piece of equipment into their wheelchair or back into bed.

So I was able to recently ask our occupational therapist to go out, who know how to use hoists, and they were able to safely hoist that person up off the floor and get them back into their wheelchair, and then assess any other needs that they might have. They were able to look at the environment. You know, it was a really good piece of work that meant that that person was assisted off the floor in a timely manner but in a manner that was dignified and appropriate for him.

Kirsty Ayakwah: It sounds like it's really positive. And it does also sound like there are strengths-based approaches that are integrated into supporting service users? [0:07:27.3]

Maria Kneller: Yeah. So ever since I've worked in health and social care I've worked in rehab settings. I started working on a stoke unit. So people would come into hospital acutely unwell, having had an event, and we would then support them through the rehab process back hopefully to going back out to living independently. So I've always worked within a rehab setting. So you know, my focus is to promote people to be as independent as possible when we look at services.

So certainly when I'm having conversations with people, you know, I will do a telephone assessment and try and get a clear view of how they are managing day-to-day. And I will use sentences like, 'You sound like you've got some really good support around you. What can we do to build on that?' rather than saying, 'You sound like you're in a bit of a pickle or things aren't going very well.' You know, and then it's looking at, 'Right, so what is it you want to change? What is

achievable? And how can we do that and work together to make that plan?' You know, it might be that we refer them through to the [unclear – 0:08:26.5] team, to either have occupational therapy or a short-term care package to get them back to being independent. It could be that actually they just need advice and information, so we can signpost them to the social prescribers. I had somebody the other day who was struggling financially so referred him through to companies that can support with paying for his bills, looking for the best tariffs, things like that, so that he can manage his finances better.

So it's just saying, 'Okay, what can we do? How can we work things out to be better for you in the longer-term?' but also enabling them to take that lead and hopefully want to engage in the process and improve themselves.

Kirsty Ayakwah: Absolutely. And Matt, I remember when we did the previous podcast, which was about the PEC approach that was used in Hampshire, I think some of those learning have been able to be used in this setting as well? [0:09:22.7]

The Proactive Enhanced Care (or PEC) approach was devised by Matt, and is a preventative social work intervention for people over 85 years old, to ensure that early help is available to promote wellbeing and prevent deterioration. [0:09:40.6]

Matt Hutchinson: Yeah. I'm interested in falls. One of the really interesting bits of data that we had right at the very beginning of this was trying to understand more about falls. The SCAS data suggested that the first thing in the mornings are a high-risk time of falls. So we continued with that work. We built into the PEC work in terms of trying to understand that more and more. And it's just one part of it. It's not the whole part of it.

But what it does is it spills into other questions that we want to ask or want to understand as part of that. So for example, we've looked at dependents' call data. So when people push a dependent, is there a pattern around that, bearing in mind the SCAS data showed a high level of activity between 7 and 10am in the mornings, in terms of call-outs, much to do with falls.

So we looked at the data, and what it's suggesting is that people are at higher risk of falls around mealtimes. So we seem to have a peak between 7 and 10, 12 and 2, and 5 and 6. So that would suggest to me, my hypothesis, is that people are more likely to be sedentary in between those times when people need to get up, and potentially have a fall.

So I think it's about trying to draw on data from different professional areas to try and form a picture to improve the outcomes for individuals. So we've just done a bit piece of work. We're working with a professor in Southampton University at the moment, the Elder Athletes programme, and trying to build in some of the principles around that. So it's an ever-evolving picture. PEC certainly helped with that. The SCAS data has helped with that. The pendant alarm information is trying to help us build a picture around the patterns of

these things to be able to provide better information to individuals when we're going to speak to them about these sorts of things to try and prevent these things happening. And a bit of knowledge, some good data, will help us achieve that, I think.

Kirsty Ayakwah: You both talked a bit about the impact. Are you able to talk about the financial impact in terms of cost-savings, for example, Matt? [0:11:46.7]

Matt Hutchinson: Well, I can from the Year 1 and Year 2, right at the very beginning. It took a little bit of time to get going, as you'd expect when you introduce a new professional within a system, so to generate referrals from SCAS, which takes a bit of time.

But Year 1 I think we prevented 600 conveyances and Year 2, 700. In terms of system time and an ambulance waiting outside the front door, that's significant, not only for ambulance availability but also triage at the front door as well. So, systems under pressure, one or two less ambulances a day, systems could make a massive difference.

In terms of the cost saving, we saved, we think – based on the See and Treat information – it was about £240 per see treating conveyance, based on 2018 costs. So it's saved for the system about £168,000 on a conservative estimate, based on 609 people. So the outlay for social work time compared to time and cost is a large amount. It's a big return, I think.

Kirsty Ayakwah: Absolutely. Yeah. And positively, in terms of how that impacts the service user. Maria, can you talk about that? [0:13:12.7]

Maria Kneller: We talk about the customer journey, don't we? That's important, how people don't want to be delayed or waiting longer-term. So actually, if we can improve the person's journey through all the services it's going to benefit everybody. But also it's about getting the right people to the right place at the right time. So actually, if I can do a triage assessment at the point of contact to the ambulance service and direct them out to the right service, you're less likely to deteriorate, the physical health will improve quicker 'cause they can access those services. And a lot of that time, actually it's just about sharing that information and they can go off and do it themselves. Or a quick email referral to people. But actually, it means that people aren't having to navigate lots of different systems and we can get that right support in, as appropriate, within a timely manner.

Kirsty Ayakwah: And I can imagine that there'd be some service users that don't want to go to hospital anyway? [0:!4:06.3]

Maria Kneller: Yep, you know. And if we can avoid a hospital admission…hospitals, if you're unwell, are the best place to be. But actually, if you're not acutely unwell, then there are other routes that we can follow. And it is just about doing those triages and those assessments, liaising with the right people to say, 'Actually, is this an appropriate way for that person to go down?' and being able to make those referrals in a timely manner and just know that actually, that is the better option for them than going to ED and going through the systems in the hospitals, which we know are overstretched.

Kirsty Ayakwah: Absolutely. It sounds like there's a lot of co-production in your work. You're working with lots of different experts in trying to facilitate this improved user experience for the service user. Talk to me about how that feels for you as a social worker. [0:14:57.7]

Maria Kneller: Yeah. So I like working within multi-professional teams. I like sharing knowledge and information and learning from each other because ultimately everybody benefits when we share knowledge. We can't all be experts in everything but actually, if we learn and understand each other's roles, then going forward we're going to work better as a system. You know, there's no I in TEAM, is there? You know, we all need to work together to achieve the best and get the best outcomes for people. That works well for the system. I know in this financial climate as organisations, both health and social care, actually if we can do that in a cost-saving way it's only going to benefit everybody in the longer term as well.

Kirsty Ayakwah: Absolutely. I know you mentioned about the bariatric case but I don't know if there's any case that comes to mind or example where you feel like there's been a transformative difference as a result of you working in this way? You may have had a response from the service user about how it made them feel, being able to stay at home, for example. [0:16:00.8]

Maria Kneller: I got some feedback from the occupational therapist that went out, that I can share with you. So, he said, "It was great that we were able to have a social worker who was able to access the case information and tailor a response proportionately. And SCAS and yourself were all able to triage the case to advise that it was likely safe to move the client, and it gave us more confident in going out, assessing the client and hoisting her back into bed with just the occupational therapist. The client was bariatric with advanced dementia and not able to follow instructions or participate in moving and handling, which made it more complex as they did not understand why they could not get up from the floor or why they were on the floor. It was good to know that the OT visit was followed up with a community first responder to review, to ensure that we hadn't missed anything medically." And he said that, "It did have a big impact on the case that was a proportionate view. They were able to look at the state of the property and minimise any future safeguarding."

Kirsty Ayakwah: Exactly. Because it's not just about what's happening at that point. It's also about maybe futureproofing, isn't it? [0:17:05.1]

Maria Kneller: Exactly. And we want to make every contact with our service users or clients, people, as effective as possible. Like Matt's saying, it is about giving that low-level health advice about eating, not smoking, not consuming alcohol in large volumes. 'Cause actually, those are the things that do have an impact on people's overall health and social care longer-term. It is about making sure that the environment's free of clutter so that we reduce the risk of further falls, making sure that we're looking after the carers as well. You know, we can put contingency plans in around pets and things like that.

I mean, another example is we had the carer of somebody was really unwell and needed to go to hospital. She was the main carer for her

husband, who had quite advanced dementia. Because she was so unwell, we agreed that they would convey the cared-for person but actually, because they were already registered with our emergency carer service at the Princess Trust in Hampshire, I was able to activate the emergency plan and by the time the crew got to the hospital I was able to phone the crew and say, 'I've activated the emergency plan. The carer will come and collected the cared-for person from hospital and convey them home,' so that at least then they knew that there was a plan in place. The carer herself could then concentrate on her health and get herself well, knowing that her husband was safe and being looked after. So it worked really, really well, and I had some really, really good feedback from the crew at scene. I think they actually felt there was a plan for him to be looked after. He will be collected. So they felt like they'd achieved as well. And actually, I've been able to share information with the crews about the Princess Trust and say, 'Look, you know, it does work well. You know, if you can share this information as well, longer-term it will just be one phone call that we can activate those emergency care plans.'

But if people aren't registered with those services then it limits what we can do. We're not going to get that help in as quickly as we could do. So they've taken on board that information and they are sharing it amongst themselves now because they know it works. We've done it a few times now with a few crews. You know, and I'm being invited to talk at some of their learning days, done a presentation that they can share with them, so that we're sharing key information with them about what my role is and what we can do together to improve the home environment and situations for people longer-term.

Matt Hutchinson: We've been working with the Princess Royal Trust for a number of years now and very successfully, I might add. Having Maria in place facilitates a quick response. But it's such a good outcome for everybody, really…

Maria Kneller: Definitely

Matt Hutchinson: …that scenario, and it was quite a common scenario in the pilot phase as well, those first two years. And the relief for the individual themselves who's being conveyed, but also the family, the crews, everybody, to make sure that person's being looked after 'cause it's important for that person to remain in their home environment. It's a fantastic outcome. It could be as simple as putting a bed lever in place, for example.

I can think of an example where somebody was falling repeatedly in the bedroom. A bed lever was ordered and put in place, and that person didn't call back into the ambulance service thereafter because they had that piece of equipment, simple piece of equipment, that prevented falls. So it can be simple but have a bit impact or it can be more complex, a la the bariatric example that Maria gave. It's got lots of different benefits.

Kirsty Ayakwah: One thing that I get from speaking to you both is there's a lot of room for creativity and to be innovative, which Hampshire is known for being. [0:20:39.4]

Maria Kneller: Yeah. I was going to say, so one of the things that I've noticed through doing my role and the Careline activations, is that there is actually more work that we could be doing around that. So I've got a meeting with the person who leads on the telecare within Hampshire County Council to look at how we can built on that. So if the Careline's activated and they don't get a response for the person, all those calls go to the ambulance service. But what I'm finding is that the carers will go into the property, I've had social workers go into the property, and people don't know those alarms have been activated. So we've got a live ambulance call, people going in knowing that that person's safe and well. So it's looking at how we can improve that, you know, even if it is as simple as the alarm beeping or something so that we are reducing the time that we've got open cases. And actually, if people are able to say that that person is safe and well then we can stand down that ambulance. 'Cause actually, you know, an ambulance crew will only see a snapshot of a situation. Actually, if somebody knows that person well, if they're normally confused and that's normal for them, great. But actually, if somebody who doesn't know that person and doesn't know that they're normally confused, they might then convey them to hospital. So again, it goes back to that right person, right time, right place.

Kirsty Ayakwah: So just to clarify, if it was me and it was my home and I had pulled the cord by accident, what happens next? What's triggered? [0:21:57.7]

Maria Kneller: So they have a base alarm, a base unit. So the contact centre would talk to you through the base unit. They are very loud but we do work with a lot of hearing-impaired or, you know, you might be upstairs, the base unit's downstairs. They will try and contact them by phone but again, if they can't hear the phone ringing, like they haven't put their hearing aids in or they are hard of hearing…we've certainly recently worked with some people that are actually registered deaf and actually use a text service. So I've been able to use my work mobile to text people and say, 'Hello. I work with the ambulance service. Are you okay?' You know, so it's about again communicating with people in the right way.

But if they don't get a response through that base unit or through the telephone their responders will be contacted to say the alarm's gone off. But if that responder's on holiday or can't get there, it will sit waiting for an ambulance until we know that that person's safe. So we'll communicate with the Careline people if, say, like I managed to get hold of the carers, I know they're going in in twenty minutes. I'll say, 'Can you activate the care alarm, let us know whether an ambulance is required or not?' But again, it's working with the services that are already going into those people, know those people well, and if the ambulance isn't needed we can step it down quite quickly. But it's knowing who's going into that property to alert them that that alarm has been activated.

Kirsty Ayakwah: Well, it seems like this is an essential service and I can imagine that if maybe your neighbouring local authorities aren't using it, they should be. Do you know if you're the only one in the area? [0:23:26.5]

Matt Hutchinson: We are. In the pilot phase Portsmouth adults services were part of it. They're not currently. I believe that other local authorities have come

down to look at what we're doing in Hampshire, been in the pilot phase and looked at the model. And I don't know if they actually use it or not but certainly there was a lot of interest. So it does save time, from a system perspective. It's certainly better for the individual. It's better for the crews, in terms of knowing that the person is safe when they leave them. And it certainly will help at the front door. And of course, for the social care system, we will have less people coming through the hospital system potentially as well so it will save time and resource in terms of re-ablement and perhaps even recommissioning a service with a different provider as well, who might not know them.

So, in terms of efficiency it's a much better and efficient way of supporting individuals, and far more proactive.

Kirsty Ayakwah: It definitely sounds it. And also just from a role perspective, Maria, it sounds like your day is never the same day every day? [0:24:25.7]

Maria Kneller: No. No, and I like working in jobs where you have got a variety of different things. I'm really fortunate in my career that I've managed to work in various different settings, and I think that that's given me a really good underpinning knowledge of how different systems work, which I'm able to use in this role and be able to think outside of the box and say, 'Right, we need to do this. Who's best to do that?' and ask the question. The worst somebody's ever going to say to you is no. But generally, in health and social care, we want the best outcome for the people we're working with. So actually, if we can work in a different way that meets that person's needs, then great. And people like challenges and different ways of working. So it does work really well. But it's about having the confidence to say, 'Right, this is the situation. What can we do?' and just talking to different people and saying, 'This is what I want to achieve. How can we do it?' And again, you know, going back to the telecast staff, looking at saying, 'Yes, we've got a really great system but we can build on this,' and working with the right people to achieve those outcomes so that going forward we're working in a smarter way as well that's going to ultimately be better for the people we're working with too.

Matt Hutchinson: I think the real point about this is that when you're working across systems, everything takes more time because you're transferring information all the time and the likelihood of somebody getting stuck in part of the system becomes greater and greater the longer that you're in it. And the longer you're in a system, the more likely you are to decompensate if you're not doing the normal, routine things in your life. And of course, that's going to cost everybody more money, more time, more resources. The whole piece around this is you get better outcomes for people but also, equally important, is you're not putting more pressure into the system, you're not spending more money, you're not doing those sorts of things. So you're just…you've got a pressure valve in the system that you can speak to somebody like Maria, change your trajectory, and then you've got a better chance of staying more independent, doing your normal things, getting the support that you need wrapped around you to be able to continue with your life without interrupting it. And I think that's massive for an older person. And those are the sorts of things that we're trying to strive for, to do those basics really, really well. Because if we don't, then they will cause other things to happen that no one wants.

Kirsty Ayakwah: Thanks for listening to this podcast. If you'd like to find out more about working in Hampshire County Council and you missed our episode on the Proactive Enhanced Care approach, we've left a link in the show notes.

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