Case study: Luton Meet and Greet service

Background

Age Concern Luton delivers a Meet & Greet service for **people returning home after a stay in hospital** or respite care. It helps people to settle back in at home, to smooth the transition between being in hospital and returning to living independently - **reducing the risk of hospital readmission.**

Meet & Greet provides support and assistance to people **over 65** who do not qualify for or do not want personal care services, self funders, and those who do not have access to local support networks.

The service lasts for up to **six weeks** help is focussed on resolving any practical or emotional issues during that time. Age Concern workers make sure that cupboards are full, beds are made, and help with practical tasks such as moving furniture to allow for disability equipment. The service also helps people to keep future appointments and ensure that the care plan is working properly.

The Meet and Greet Service sees nearly 500 patients each year and over 1650 people have been supported since July 2011.

How is it funded?

The project was initially a **small pilot** funded by **Age Concern Luton** and the **local authority.**

Age Concern had always offered support for this group, and wanted to create a dedicated service that would have the capacity to grow and develop. **In 2011, it was commissioned by Luton CCG, who continue to support it.**

	Q1	Q2	Q3	Q4
2011-12	N/A	N/A	£326,839	N/A
2012-13	£123,127	£266,093	£415,518	£643,771
2013-14	£137,145	£278,273	£460,513	£675,072
2014-15	£145,752	£326,837	£476,766*	

The current investment in the project from the CCG is £125k (until March 2015) and the total savings to date are displayed in the table above.

Drivers for the project

There are an estimated 37,000 people currently living in Luton with some form of long term condition ($1/5^{th}$ of the overall population).

Feedback from social workers, healthcare professionals, Age Concern staff and volunteers was that there were low levels of social support for older people, with many having no family living locally. There was a need to identify people who needed help earlier on, by going into wards and working to provide a pathway back into the community.

25% of people were not taking up follow up appointments, and this was often related to a fear of further procedures, being ill, and not wanting their lives to revolve around hospital appointments.

The relationship between Luton CCG and Age Concern

Luton CCG had been looking at how to reduce readmissions, and was interested in how to improve outcomes around increased discharges, overall shift of care to the community, reduction in the length of stay in hospital, and improved patient experience.

A commissioner within the CCG held a **workshop** with different VCS and statutory stakeholders in Luton to start a discussion about how they could all work together to address the challenge.

The CCG listened to what Age Concern could offer, recognising that Age Concern were the experts and could be trusted to deliver. Age Concern were given a certain amount of freedom – provided that the main goal of reducing readmissions could be achieved.

Age Concern Luton was put onto a NHS standard contract and the CCG helped with this, as a lot of the terms were not very relevant for a small organisation. They invested time in meeting face to face to go through the requirements and having seen that they were largely irrelevant the commissioner approached her Director to recommend that a DCLG tool and monitoring framework was used as it more efficiently mapped the benefits of the scheme in a way that was clear and easily benchmarked. This was subsequently scrutinised by the Department for Health during a deep dive and by the Cabinet Office.

What is Luton CCG's vision?

Self management *can improve health outcomes, patient experience and reduce unplanned hospital admissions.*

Our vision is to work ***collaboratively*** *with patients and their carers to empower them with the skills, knowledge and resources to give them the* ***confidence*** *to care for themselves and their condition effectively and confidently.*

In so doing that they are able to ***maintain independence*** *for as long as possible.*

Outcomes

Data has been collected on the number of falls, the number of readmissions, and attendance/referrals.

The interventions of the Meet and Greet Service have led to a **20% reduction in readmissions for over 75s,** and a **32% reduction in falls.**

A monitoring and evaluation framework is now being developed to improve and build on the data. The CCG is interested in seeing which patients are accessing the service and how.

Learning for commissioners

- The CCG **knew the outcomes they wanted to achieve** – and it was a case of finding a solution together of how to get there. This was empowering for those involved.
- There was a **champion within the CCG** who pushed for the project to be funded. She came up against an initial lack of trust of the quality of services provided by the VCS.
- Statutory services still think they know best – this is an engrained mindset that needs to be challenged
- The **evidence that the Age Concern pilot worked** was crucial – there was no counter argument which made it easier to make the case.
- Age Concern in Luton had a **good track record of delivering services** and excellent community connections. They had a real passion for this work which impressed the CCG.
- The **contract was important** – but onerous for a small charity. The CCG had to find the balance between needing to be formal, but not putting them off entirely.
- It was a relatively **low key** approach. Commissioners need bravery – big is not always better.
- Commissioners need to keep abreast of **what is happening in the community**, look at needs, and understand what they are hoping to achieve, before even reaching the commissioning stage.