VAR and YAWR Services

Adults Discharge Reablement

Evaluation 2023-24

Table of Contents

1. *Preamble* ... 2
2. *Process* ... 2
3. *Outcomes and Outputs* ... 3
4. *Personal Health Budget in Practice* ... 7
5. *Conclusion* ... 9

1. Preamble

You Asked We Responded (YAWR) were invited to engage in a 4 month pilot to enable individuals who had been in hospital for a considerable amount of time to return home. The aim was to ease “bed blocking” and facilitate the patients return to some form of independence. The focus initially was on “Pathways 1”, however following discussions with NHS staff “Pathways 0” was also included in January 2024.

As this was a pilot, it was a case of learning from experience and developing the programme from lessons learned.

The pilot was then extended to the end of the financial year.

2. Process

YAWR appointed a member of staff to lead on the pilot and received referrals from the Voluntary Action Rotherham (VAR) team who were working closely with the Integrated Care Team (ICT). The ICT would identify individuals and would forward them onto YAWR who would then engage with the clients and close family members as appropriate to support the patient and facilitate the transition from hospital to home.

Once a referral had been received, YAWR would then engage with the patient and their family members if appropriate and ascertain what is required to ensure that the patient can return home.

To facilitate this a “Personal Health Budget” (PHB) would be allocated to address barriers that prevented the patient returning home.

Barriers to address included cleaning the house, decluttering, cooking utensils, small items of furniture, bedding, transport, etc.

3. Outcomes and Outputs

The first three months was a case of understanding the process and putting in place a plan of action. This included identifying organisations where their services could be procured through the PHB.

Over the last 12 months we have received 90 referrals, 65 patients have been discharged to their homes, 29 personal health budgets were allocated and a total of 932 hours was allocated to supporting patients.

From the initial pilot 3 tranches of funding has been allocated. Tranche 1 for the initial pilot was allocated £7,500, tranche 2 to extend the project until the end of the financial year received £16,875 and as the funds allocated had been expended by November 2023 a further amount of £5,000 was received in January 2024.

Due to the success of the pilot an additional amount of £15,000 has been allocated in February to the end of the current financial year and any amounts underspent will be carried forward to the next financial year.

To the end of January 2024, the total amount expended is £27,729. Of this amount 65% has been allocated to staffing that includes Project Management, Administration, and patient support. Personal Health Budgets accounted for 31% of the costs for 29 patients and the balance of 4% was allocated to mileage, parking, and equipment. It needs to be noted that additional costs incurred by YAWR where staff have supported the member of staff assigned to this pilot have not been included.

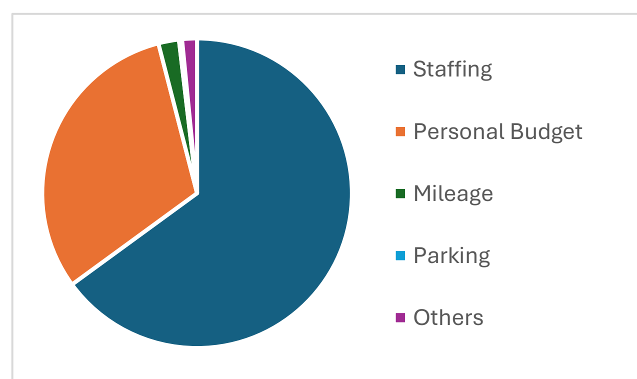
The tables and pie charts below provide additional information.

Referrals

Number of referrals received	90
Withdrawn	1
Discharged	65
Numbers of PHB	29
Total Patient hours	932

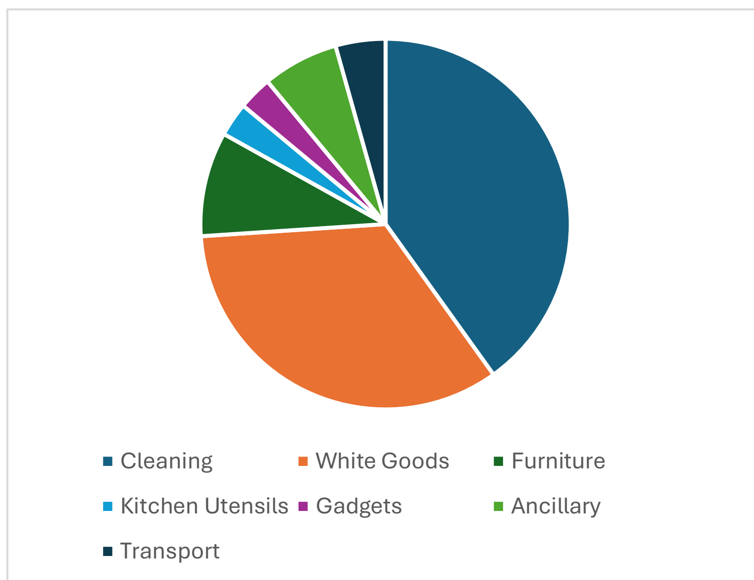
Costs

Staffing	£18,014.80	65%
Personal Budget	£ 8,600.19	31%
Mileage	£ 595.33	2%
Parking	£ 90.20	0%
Others	£ 428.99	2%
	£27,729.51	



Allocation of PHB's

Cleaning	40%
White Goods	34%
Furniture	9%
Kitchen Utensils	3%
Gadgets	3%
Ancillary	7%
Transport	4%



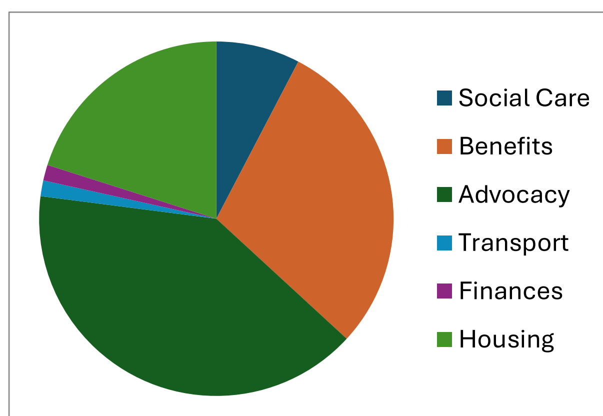
Additional Support

In order to ensure that patients were not at risk of "frequent flyers", YAWR staff also added value as shown in the tables and pie charts below. Multiple support was provided that showed a 29% increase in benefits received, 40% advocacy support, 20% improved housing and the balance was a mixture of additional social care, transport and increase in finance.

YAWR staff successfully enabled 7 patients to apply for attendance allowance, 6 to secure Personal Independence Payment and 9 to secure a mixture of additional benefits.

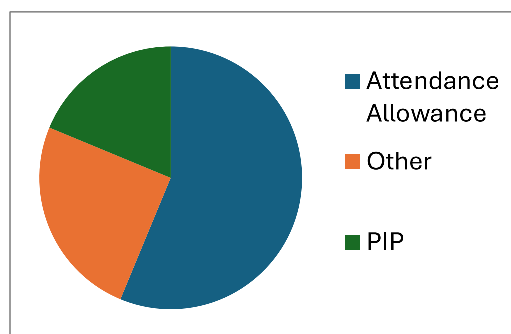
Total Support Provided as some clients had multiple support

Social Care	16	8%
Benefits	61	29%
Advocacy	84	40%
Transport	3	1%
Finances	3	1%
Housing	42	20%
	209	



Benefits Outcome

Attendance Allowance	18	56%
Other	8	25%
PIP	6	19%
	32	



As part of the advocacy support that has been provided, we have discussed with clients the option of applying for additional benefits.

It is important to note that the time taken from initial application to a decision could take up to 6 months, therefore 32 of the clients that have been supported in applying for additional benefits and the positive outcomes are shown below.

Attendance Allowance
High rate: 5 x £101.75 x 52 weeks = £26,455
Standard rate: 3 x £68.10 x 52 weeks = £10,623

PIP
Daily living high rate: 1 x £101.75 x 52 weeks = £5,291
Daily living standard rate: 1 x £68.10 x 52 weeks = £3541.20
Daily living enhanced mobility rate: 1 x £71 x 52 weeks = £3692

Other
Cavell grant: £500

Additional income brought into Rotherham for clients is £50,102.20

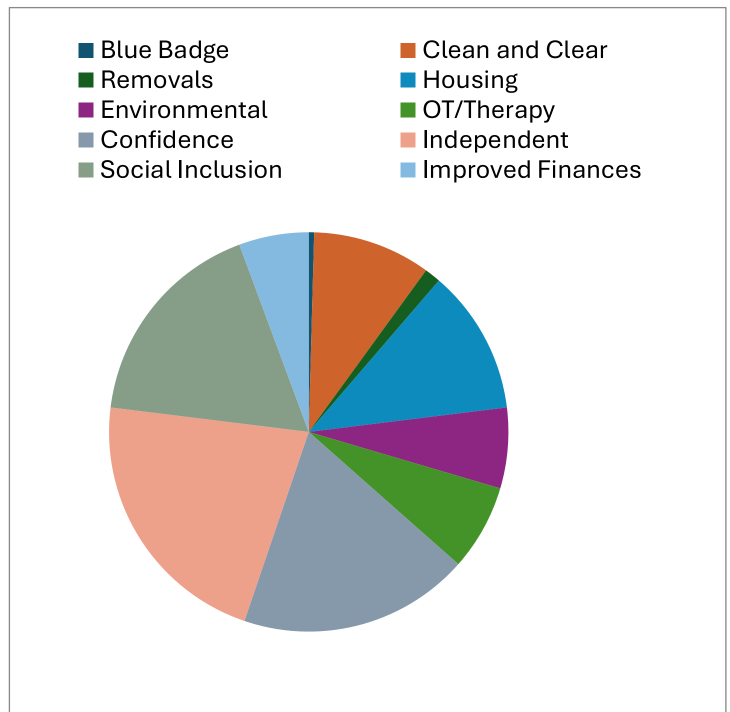
However, we need to highlight that a number of clients that we have supported are still awaiting outcomes of their applications. Some of the clients who were provided with the information did not want to proceed, were referred to other agencies that included Age Concern or sought support from family or friends.

Additional Outcomes

Subsequently with advocacy support provided, quality of life of the client has improved as can be seen by the table below. Additional non tangible soft outcomes that included confidence, social inclusion and independence have significantly assisted the clients.

The table below shows additional outcomes that were achieved through discussions with various NHS and local council departments.

Blue Badge	1	0%
Clean and Clear	22	10%
Removals	3	1%
Housing	27	12%
Environmental	15	7%
OT/Therapy	16	7%
Confidence	43	19%
Independent	50	22%
Social Inclusion	40	17%
Improved Finances	13	6%
	230	



4. Personal Health Budget in Practice

The pilot has proved a success as collaborative working between the VCF sector and NHS has resulted in patients have been unable to return home following medical discharge, due to several barriers. Through the Personal Budget payments and support provided by YAWR staff, patients have had the barriers removed and their quality of life has improved.

A case study was illustrated at a recent seminar in Leeds and it was highlighted that the patients wellbeing was addressed as well as the savings in terms of the patient having returned home.

- Patient aged 59 years and admitted to RGDH in June 22 following a stroke, loss of sight, property no longer suitable
- Support with priority housing application, bidding, liaison with eye clinic & Rotherham Sight & Sound, referral for wheelchair access, review of care package for double handling
- PHB used to pay for a removal company, purchased microwave and fridge freezer
- Successful discharge into the community, improved independence, confidence, and quality of life

Comments from Patient

“I was not mentally prepared to lose my independence and go into a care home.
My MH went downhill which impacted my recovery with therapy.
Support from Sophia improved my MH, I felt I was finally listened to and overwhelmed when I finally had a home to go to”.

“Wow I’ve come this far with the support from Sophia, who made sure all my needs were fully met. I have gained some independence and have regular contact with family and friends. I am no longer in a prison and love my home environment”.

Savings Impact

- Client discharged to step down bed 22 Nov 2022
- Clinically ready for discharge in Jan 2023, actual discharge July 2023 – 26 weeks delay
- Referred to YAWR March 21st 2023
- Assume 15 weeks saved @ £850 per week = £12,750
- Personal Health Budget incurred £390 to assist discharge
- 31 hours Patient support - £465
- Estimated amount saved on clients cost of care;
  £12,750 - £390 (PHB) - £465 (staff time) = £11,895

Service users' comments

"My chair was delivered on my birthday, which made it extra special ..... The gentleman who delivered it was very kind and patient. He also removed the old chair"

"Without the support provided my parents would have no quality of life and would never have been able to return home"

"I would never have coped with adjustments made since my husband was discharged if you had not been such a helpful and reliable source. You gave me confidence to cope at a very traumatic time in my life".

"Thanks for your support during transition at a difficult time in my life. You have been kind and helpful throughout".

"Additional finance has reduced further impact on my parent's mental health".

Practitioners Comments

"YAWR's commitment to patient care is an asset to our hospital discharge team and I highly recommend YAWR for their exceptional service".

"The service has improved access to services, benefits and support for Adults in Rotherham".

"YAWR Hospital discharge service helps to reduce length of time an adult will either spend in hospital or in a care home because of social issues that would have otherwise taken a considerable amount of time to resolve."

5. Conclusion

The pilot has been relatively successful, and a number of lessons have been learned. The key is that in addressing barriers to discharge, the personal health budget has bridged a gap in service provision. YAWR Services have mainly been addressing "Pathway 1" and majority of the PHB's utilised have been for Clean, declutter and clear. Discussions have been held that the focus moving forward will on "Pathway 0", therefore PHB required could be minimised.

A clear process for Referrals is key. This is to ensure that no patient is missed and by having a clear referral pathway will ensure that practitioners are clear in whom to refer to and this will ensure that patients' needs are met and impact is on a timely discharge.

In the current climate resources need to be maximised effectively and efficiently. Majority of the costs incurred was for PHB's and staffing both for VAR and YAWR Services. In order to ensure that there is continuity a longer term approach in investment to increase capacity is required. YAWR will dedicate 1.5FTE's and in collaboration with partners a meaningful impact can be made. In order to maximise scarce resources additional sources of external finances could be sought for PHB's.

Partnership work, sharing knowledge and the role of Voluntary and Community Sector has been key to ensuring that this pilot has been successful. It is crucial that moving forward this partnership working is mainstreamed to ensure that knowledge is shared and resources maximised wherever possible.

Partnership working has also highlighted that the pilot has allowed NHS staff to do what they do best in meeting individuals clinical needs. Whilst, YAWR have been able to meet the individuals wider social and environmental needs to facilitate a safe and early discharge home.