ROTHERHAM
INTEGRATED CARE PARTNERSHIP | HEALTH AND SOCIAL CARE

Rotherham Health & Well Being Board

Voluntary and Community Sector Support for right care, right time, right place

NHS
South Yorkshire
Integrated Care Board

Rotherham, Doncaster and South Humber
NHS Foundation Trust

The Rotherham
NHS Foundation Trust

Rotherham
Metropolitan
Borough Council

VoluntaryAction Rotherham

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Context

- Base on Rotherham's commitment to supporting people to remain independent at home for as long as possible and home first ethos
- Building on strong tradition of partnership working & Voluntary Action Rotherham's early pioneering of social prescribing
- Highlighting 3 services which support admission avoidance and discharge, ensuring people receive the right level of care according to their needs

Supported by Better Care Fund/discharge monies

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Urgent and Emergency Care Social Prescribing Pilot

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Clinical Commissioning Group

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Rotherham Urgent & Emergency Care Social Prescribing Service

The role

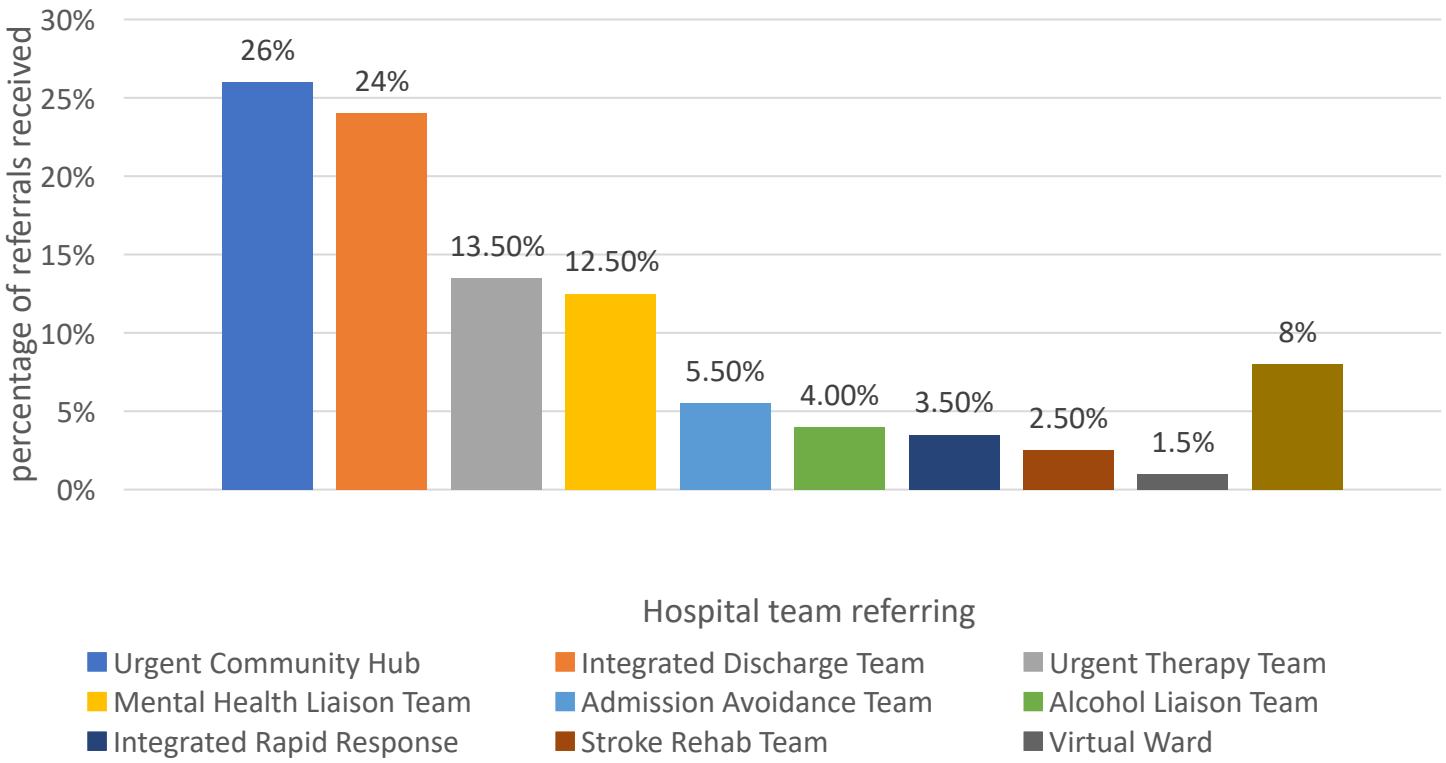
- To work with health and social care professionals to support patients experiencing social, emotional and /or practical barriers to better health and wellbeing
- For admission avoidance & discharge
- Provides holistic, wrap-around support for patients
- Utilising wider voluntary and community sector services
- Helping to ensure a safe home environment & build independence, confidence and resilience

The Service

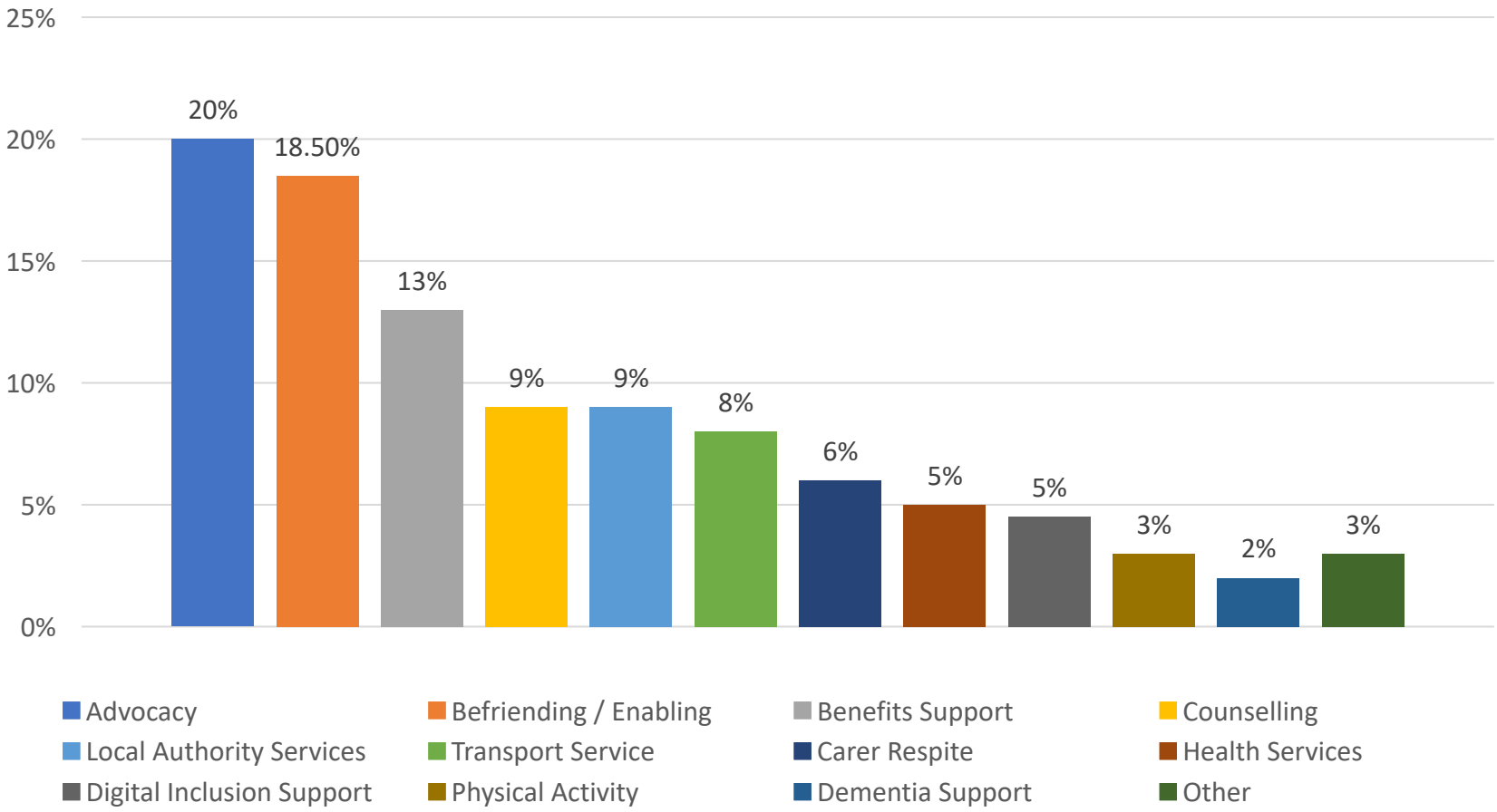
- Monday – Friday, 18+
- Receive referrals & assess discharged patients
- Develop a support plan
- Onward referrals
- Ongoing, short-term support
- Follow-up and closure of case

Hospital teams referring to Social Prescribing

Based on 293 referrals Nov 22 – Oct 23



Onward referrals to voluntary and community services



UEC social prescribing in practice

About Paul:

- Admitted with Critical Pneumonia
- Unable to walk or mobilise
- Poor mental and physical health following 9 months in hospital and a huge life change
- Lost job and home

I am delighted with Paul's progress, socially and psychologically. He told me he cannot thank us enough for helping him recover from being bedbound to living independently' – Social Prescriber

All the services I received from Social Prescribing helped me mentally and physically. Combined, they helped me get to where I am now – looking forward, not back

Paul's experience:

- Spent 9 months in hospital and step-down beds
- Referred to: Befriending/enabling, Advocacy, benefits support
- Since discharge, Paul has progressed from a bed space to independent living within supported housing
- Now feeling positive, and is aiming to walk independently and return to work in the future

Impact

For Paul

- Improved wellbeing (outcomes measures)
- Improved mental health and physical health
- Improved social connections
- Maximised finances
- Greater independence / resilience

For the System

- Bridging gap from acute back into the community
- Linking in with ED high intensity user group
- Improved co-ordination of care between health, social care and voluntary sectors
- Reduction in likelihood of readmissions

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You Asked We Responded (YAWR) Personal Health Budget Pilot

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YAWR Services
Personal Health Budget (PHB)

The Need

- To remove barriers to allow early and safe discharge to reduce delayed discharges
- Assessment and award of PHB (up to £500, with escalation process for exceptions) used to buy a service or goods for discharge home from the acute or community bed base

YAWR Services Offer

- **Visit patients on the ward prior to discharge** to discuss and assess their needs to facilitate discharge from hospital.
- **Pre discharge** – initial assessment to discuss support needs and action plan.
- **Post discharge** – Visit the patient to address additional needs including benefits support.

Barriers to Discharge

- Housing - Priority Applications
- Equipment and Adaptations
- Property – Cluttered and Infestation
- Referral Pathways

Personal Health Budgets in Practice

Marcia's story

- Patient is 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

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

Impact of the Personal Health Budget Pilot

For Patients & Families

- Increased independence and quality of life for individuals
- PHB has been utilised for household items, cleaning services enabling individuals to return to a safe and secure environment.
- Reduced carer stress
- Improved financial outcomes for individuals through benefits claimed
- Informed choice through a holistic needs assessment

March – Oct 2023

- 60 Referrals
- 41 Discharged home
- 24 PHBs
- 797.5 Total hours
- 722.5 Patient Support Hours

You Asked We Responded

What our service users say

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.

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

What our practitioners say

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."

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Age UK Hospital After Care Service

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Our offer

- Monday – Friday for 60+
- Transport home from an acute or community bed – within 3 hrs
- Settling in service with safe & well check
- Onward referrals and signposting
- Small aids and adaptations
- Short term non personal enablement support (30 days)
- Service is also for avoidance of unnecessary admissions

Added value

- Over 5200 referrals (including safety netting)
- Over 300 onward referrals/signposts to other agencies
- **Approx £150K** unclaimed monies realised through benefit referrals
- Over 100 people received further enabling support
- Four Trusted Assessor trained staff

After Care Service in Practice – case study

Carol* Referred by frailty nurse due to concern for patient's safety once home

No answer when staff visited following day. Obtained permission from next of kin to enter house

Patient found lying on hall-way floor after falling four hours earlier and couldn't get up

Made patient comfortable and re-assured her, called emergency services

Ambulance arrived 45-60 mins later and checked over.

In consultation with her GP, agreement made to send district nursing team for assessment

Decision reassured ambulance crew that suitable care decision was in place and avoided an ambulance conveyance, attendance at A&E & potential admission

Emergency crew and staff member spent approx. 4 hrs with patient.

Our worker made patient a drink of tea and prepared following day's breakfast and lunch before leaving

* Not patient's real name

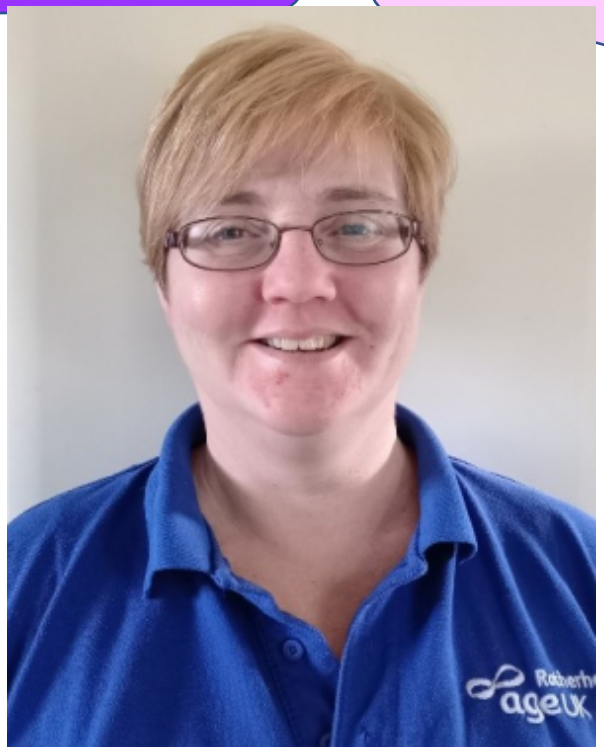
Impact

For patients

"It's been reassuring to know that someone was calling in to see how I was coping after my stay in hospital and have been pleased with the service and support given."

"Getting transport home from hospital was wonderful and very comforting, seeing me settled at home after my hospital stay as my family live a long way away."

"I found this service very helpful, the ladies who looked after me with empathy and complete understanding of my needs were excellent. I cannot thank you enough."



For the system

"The service provides reassurance and confidence to hospital staff, the patient and their families meaning this service fills an important gap by offering flexible, personal short-term support."

"Age UK are seen as an asset both for the range of services services." provided and their ability to signpost to other community/voluntary

"When the service is requested, we arrive on time which causes less stress for patients and families. People are not waiting as long as for hospital transport."

Next steps

- Embed in multi-disciplinary Transfer of Care Hub – right care, time and place
- Evaluate pilots
- Consolidate social prescribing, including investment in wider VCS

Contact Details

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