in Control

NHS South West London
Integrated Care Board

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Evaluation of Discharge Personal Health Budgets project at Epsom and St Helier University Hospitals NHS Trust (2023-24)

February 2024

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1 | Introduction and summary

1.1 Reducing delayed discharge from hospital – a national challenge

The delayed discharge of medically fit patients remains a significant challenge in English hospitals, with the number of patients remaining in hospital overnight who no longer meet the criteria to remain averaging just under 13,000 per day in December 2023.[1] As well as preventing the admission and treatment of other patients by reducing 'flow' through and out of hospital, delayed discharge can also harm those unable to leave hospital, undermining recovery and recuperation, increasing their need for care or support and the chance of hospital readmission. Expediting discharge of patients who no longer meet the criteria to remain is a central objective of government and health system policy.

1.2 Exploring the potential of Personal Health Budgets

In response to NHSE Discharge Personal Health Budgets (PHBs) guidance (September 2022) South West London Integrated Care Board (ICB) and Epsom and St Helier University Hospitals NHS Trust (ESHT) agreed to pilot the use of one-off PHB's as Discharge Grants for a 12-month period during 2023/24 at St Helier hospital, Sutton.

Frontline NHS staff with responsibility for hospital discharge were empowered to spend small individualised grants (of up £400 per patient) to flexibly and creatively address factors that might otherwise prevent individual medically fit patients from returning to and recuperating in their homes.

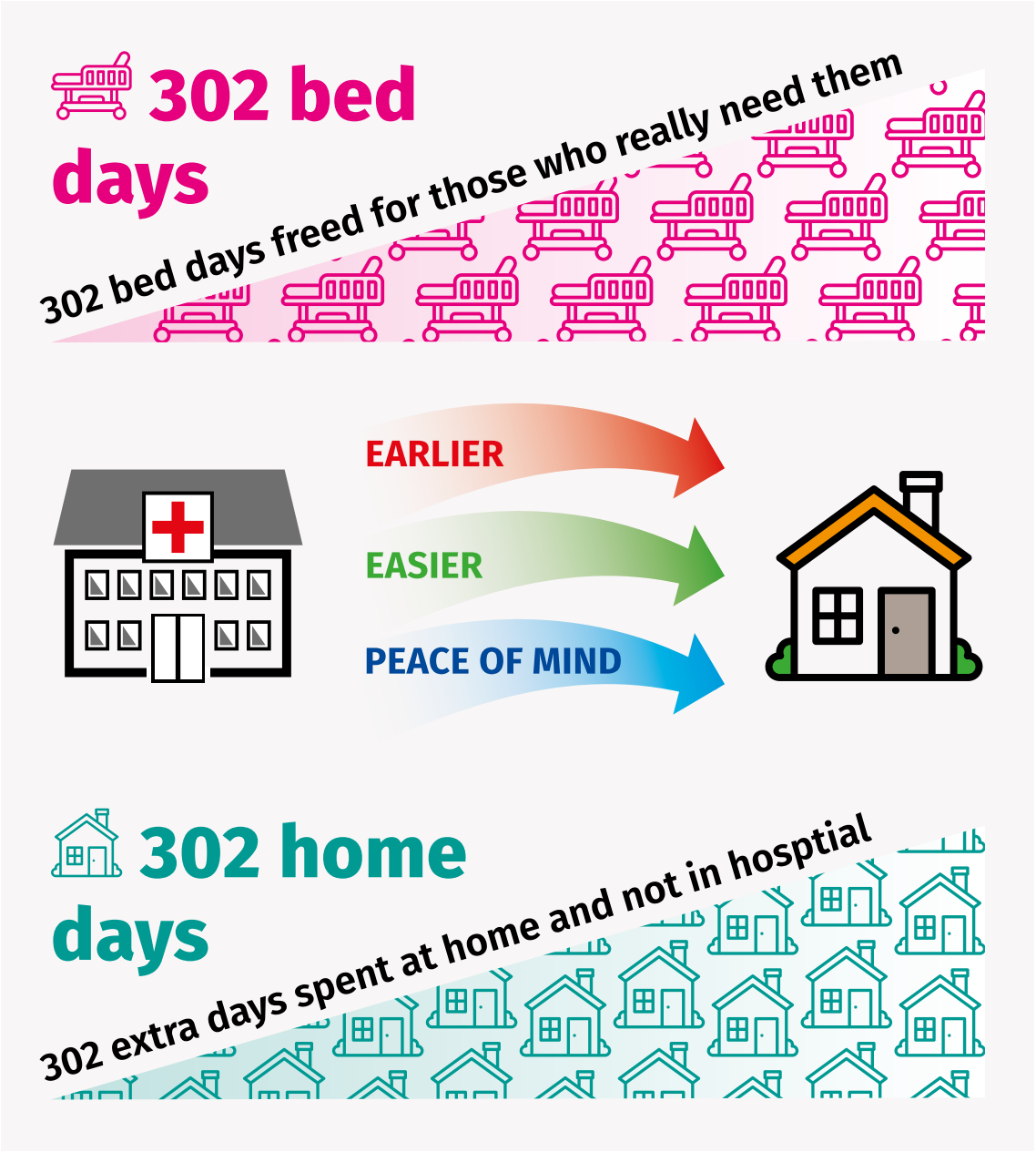
It was agreed that an evaluation would be undertaken to consider the impact of the pilot comprising the following;

- A review of **performance activity**
- Sampling **patient experience** of the service
- Inviting **staff feedback** on the service

The ICB commissioned In Control (a national charity) to support undertaking the evaluation between October – December 2023. This report summarises the key messages from the evaluation. It will inform future development of the use of discharge PHBs across the SWL Integrated Care System.

1. Source: NHS England Acute Daily Discharge Report 1 December – 31 December 2023 published 11 January 2024

1.3 Key learning from the evaluation



- The grants brought about earlier discharge for patients, estimated at 2.7 days per grant
- A total of 70 grants had been implemented by the end of December 2023. The average spend per patient of 70 grants was £190
- The projected full-year impact of the pilot is an estimated 302 bed days released
- The projected full-year value of estimated bed days released (at £484 per bed day) is £146,168
- The annual budget invested in the project in 2023/24 is £100,000

- Grants were typically spent on home layout, beds and furniture, key safes to facilitate access for care and support staff or volunteers, microwaves to prepare food , cleaning and de-cluttering.
- Staff perceived the grants to have achieved the results they did because they facilitated earlier, easier discharge, reducing bureaucracy, creating flexibility, offering peace of mind among patients and families and speeding up their ability to help ensure patient's homes are fit for them to return to
- Patients perceived the grants permitted them to return home earlier than anticipated, having offered peace of mind about the move and to have helped them to avoid re-admission
- These findings point to a clear opportunity to extend the scheme in support of other efforts to redirect healthcare from hospitals into the community, such as virtual wards
- Staff believed that the scheme could be made more effective and efficient through improved internal communications and data sharing, via more personalised engagement with patients and their families and through a broader number of staff being able to access and deploy the grants.
- Staff also raised questions about institutional and professional boundaries and responsibilities. Investing in community organisations and neighbourhood-level teams to lead this work (and permitting similar small grant spend) could free up hospital/acute staff, although questions of oversight and data sharing would need to be addressed.

1.4 Recommendations

On the basis of the experience and evaluation of the Discharge Grants pilot project it is recommended that;

1. The service at St Helier hospital is maintained for 2024/25 and extended to include the Rehabilitation ward and Virtual Ward cohort within the hospital.
2. The learning from the pilot project should be shared across NHS SWL and opportunities explored during 2024/25 for implementing similar one-off discharge grants to support discharge pathways within other SWL hospital Trusts.
3. Extending grant-making authority to other appropriate staff and/or ensuring continuity when lead staff are unavailable should be explored
4. Effort is made to deepen the involvement of patients and/or their families (as appropriate) in making decisions about the use of discharge grants to the ends of facilitating safe and sustainable discharge from hospital

2 | Background

NHSE published *One-off PHBs within the Hospital Discharge Pathway* guidance (September 2022). The aim of the initiative is to use small, one-off rapidly deployed budgets to facilitate timely discharge for groups of medically fit patients (typically those on discharge pathways 0 or 1) where barriers exist that prevent their discharge home. The budgets are designed to enable patients to access personalised care and support when their needs cannot be met through existing commissioned services.

Definition of Pathways 0 and 1

Pathway 0: Simple discharge / no formal input from health or social care needed once home – A patient may have barriers outside of accessed clinical need, with wider health and social needs which are preventing discharge.

Pathway 1: Support to recover at home required/ able to return home with support from health and/or social care – A patient may have barriers which are not met by existing commissioned services to support their discharge home. Barriers preventing timely discharge can be unlocked through use of a one-off PHB.

Source: Pathways for the Discharge to Assess Model, Hospital Discharge and Community Support, DHSS Guidance Published 31 March 2022.

Individual patients do not receive the budgets directly themselves. Instead, the budgets are accessed by the hospital Discharge team using a pre-paid payment card or a dedicated account. The Discharge team members use the card/account to pay for the goods or services expected to be agreed with the patient to address the reason(s) preventing their discharge. This enables them to return home avoiding unnecessary stays in hospital.

The payment cards/accounts are linked to a digital e-wallet providing transparency, audits, accounting, and reporting on card usage. The ICB transfers funds into the e-wallet. Discharge team members can then draw funds from this budget for the purchase made for patients. The amount of the budget is capped at £400 per patient and amounts spent rarely exceed £200. The funding is not means-tested.

The anticipated outcomes of the initiative are:

- Reduced delayed discharges,
- Saved bed days,
- Reduced demand for formal support,
- Patient safely discharged to recuperate at home,
- Improved patient, family and staff experience

3 | Implementation of NHS South West London Discharge Grants pilot project

In November 2022 the SWL ICB and ESHT agreed to pilot the use of one-off discharge budgets at St Helier hospital for a period of 12 months. The pilot is referred to as the *SWL Discharge Grants pilot.*

The project commenced with a set-up and mobilisation phase; to arrange project funding, procure an e-wallet system (to facilitate and manage secure card payments), recruit a Discharge Grants Project Coordinator for employment within the Trust, introduce operational and reporting arrangements, and raise awareness of the initiative with Trust discharge staff. This phase was completed in March 23.

Pilot set-up costs

The set-up costs for the pilot project totalled £100,000. This comprised,

- the procurement of an e-wallet system,
- staffing (appointment of Project Coordinator on a fixed term contract),
- a fund for the purchase of the goods and services required by patients.

Following an NHS procurement exercise a 12-month contract was awarded to My Care Banking to provide the virtual e-wallet system to support the operation of the project.

The virtual wallet integrates linked cards and BACS payments to a dedicated virtual account set up specifically for the SWL ICB pilot project. The arrangement ensures secure transactions, complete with approval limits and transaction restrictions, providing robust financial management and control over project finances.

Once My Care Banking had established the dedicated bank account for the pilot, the ICB transferred an agreed level of funding into the account to be used for the purchase of goods and services with the discharge grants.

ESHT identified three members of the St Helier hospital Home First Discharge team who would be able to make the agreed purchases on behalf of the patients. The staff could access the dedicated account using bespoke account cards or BACs to arrange the purchases. It was agreed that expenditure on goods and services should not exceed £400 for each grant. ICB authorisation is required in those exceptional circumstances where expenditure may exceed this amount.

A project Working group was established with membership from the ICB Personalisation team, ESHT Discharge leads and Service Improvement team, and My Care Banking. The group meets monthly to oversee the implementation

and operation of the pilot project. A key role of the group has been to maintain communications with Trust discharge staff regarding the project. A promotional poster was produced, and staff meetings attended to raise the project profile.

A dedicated Project Coordinator (AFC Band 4) has performed many of the key functions of implementation on behalf of the Working group. These have included;

- Attending hospital ward and discharge hub meetings to remind staff of the initiative and receive referrals.
- Ensuring patient support plans and consent forms are completed to confirm patient choice and that the purchases reflect the patients personalised requirements to enable discharge.
- Sourcing and arranging the purchase of the goods and services required for each patient and ensuring delivery to coincide with the discharge arrangement.
- Maintaining records of those purchases made with each grant.
- Completing a monthly report updating on project performance activity for review by the Working group.
- Liaising with discharged patients regarding their experience of the project

The Working group reports to an Implementation group drawn from senior managers within the ICB and ESHT which steers the project and receives updates on performance. The ICB ensures that project activity is reported within quarterly NHS England PHB reports, and updates provided to NHS London. The ICB have also provided updates to the SWL Integrated Care System Discharge Group

The Implementation Group agreed that a short evaluation of the project should be undertaken to review key performance delivery activity, patient experience of the service and staff feedback. In Control (a national charity) were commissioned to support the evaluation that took place from October to December 2023.

4 | Performance to date

Following initial training and testing, the first grants were arranged from mid-May 23. Activity reports are compiled monthly by ESHT to update on performance. The following is a summary of key activity between May - December 2023 (7.5 months activity).

The key measurement for this pilot is the number of bed days released - indicating the impact on patient flow thorough the hospital discharge arrangement. A financial value of this impact has also been calculated to give a marker against which investment in the scheme can be compared. However this value of the estimated bed days released is not a cash-releasing saving – but simply an indicative saving for the purpose of that comparison.

Headline activity at December 2023	
Number of grants implemented (mid-May – December)	70
Average Number grants per month (based on mid-May– December)	9.3
Average estimated bed days released per grant (1)	2.7
Total number of bed days released (mid-May – December) (1)	189
Total value of bed days released (at £484 per bed day) (2)	£91,476
Average spend on goods and services per grant.	£190
Projected bed days released (full year effect) 23/24	302
Projected value of bed days released 23/24	£146,168
Budget 23/24	£100,000
Projected indicative saving 23/24	£46,168

Note (1) – This figure is based on an estimate made by ESHT Discharge staff. It compares the length of time taken to arrange the one-off grant with the length of time usually taken to deliver a similar service (cleaning, equipment etc).

Note (2) – The figure of £484 reflects the 2023/24 SWL ICB bed bureau cost.

The average estimated bed days released of 2.7 days compares with similar rates of 3 days and 3.6 days released in other London ICBs who have piloted the initiative since 2022.

Goods and services arranged

The main goods and services arranged with the grants have included;

- Furniture move or removal (33 occasions – over 50%)
- Key cutting/Key safe fitting (12)
- Cleaning/de-cluttering (8)
- Bedding/Bed clothes (4)
- Equipment – i.e. microwave (4)
- Food Shopping/supply (4)

In some instances, services were purchased as an alternative to existing commissioned services. This occurred where discharge staff recognised that there was a period of delay to accessing the existing commissioned services. This could be avoided by funding the service or delivery of items directly by using the grant (i.e. fitting of key safes).

Impact on Patient Flow to Discharge

The average estimated bed days released of 2.7 days per patient/grant reflects the estimated time that the patient would have remained in hospital awaiting intervention by either their family/carers or other support to address the barriers or home circumstances preventing discharge. The grant has enabled a timely discharge improving patient flow through the hospital.

Preventing Re-admission

In a small number of cases the grants have also been used to prevent a hospital re-admission. Patients discharged on pathway 1 require some support to recover at home from the Sutton Health and Care Home First Team. There have been occasions where the team have visited a discharged patient and identified an issue preventing their recovery at home. This may then result in hospital re-admission. For instance – one patient required the movement of a bed and furniture to prevent them becoming bed bound and immobile. The use of the grant funded this furniture move and prevented this deterioration.

Several of the grants have been used in this manner.

All the patients accessing the grants are resident of the London Borough of Sutton. The majority have been discharged from St Helier hospital although a small number have been discharged via the Sutton Home First team from neighbouring SWL hospitals.

5 | Patient Feedback

Collecting feed-back from a sample of those patients (or their families/ carers) for who the grants were deployed was identified as a key element of the evaluation. Patients were notified prior to discharge and consented to being contacted by the Project Coordinator after their discharge home. A standard questionnaire was devised to collect their feed-back. The Coordinator contacted a sample of (12) patients within 10 days of their discharge.

The key headlines from this include:

Feedback %

- 92% (11/12) patients felt the grant has helped them since they came out of hospital
- 100% (12/12) patients felt staff explained the process clearly
- 92% (11/12) patients felt the process was Easy or Very Easy
- 100% (12/12) patients felt that the service or product purchased by the grant will prevent them going back into hospital
- 100% (12/12) patients felt that overall the grant got them home sooner than it would have done without it

The following is a sample of comments received from patients:

Q. has the grant helped you since you came out of hospital? Tell us why?

A. *"I was able to come home after furniture was removed from my home"*

A. "The clean helped make space for my medical furniture"

Q. Was it explained to you whilst you were in hospital?

A. *"It was clear that money could be used to help me get home earlier"*

Q. Did you understand it?

A. *"What would happen was explained and I was happy to give consent for the furniture company to access my property"*

Q. Did you feel you came out of hospital at the right time?

A. *"I was fit to come out of hospital and felt I should go home but knew my house needed to be clean to let the equipment in"*

Q. Do you think this got you home sooner?

A. *"I might have been in hospital for longer if I did not have the deep clean"*

Q. Any thing we could have or should have done differently or better?

A. *"It helped me to get home faster and I was able to get the new bed that I needed" … "Thank you for helping me get home"*

6 | Staff Feedback

6.1 Survey results

ESHT discharge team professionals were invited to attend feed-back sessions held by In Control on 24 and 26 October 2023. This included a range of professionals who had experience of intervention (directly and indirectly) with the discharge grant.

We started with a simple survey exploring whether the opportunity to use the discharge grant made things better or worse across a number of criteria. The full results are in the Annex.

The groups reported that, in contrast with prior arrangements, the grants had permitted both earlier discharge and easier discharge, both for staff and patients. They had also reduced the bureaucracy involved in securing goods or services to facilitate discharge to a patients home, while improving relationships with peer colleagues. Overall they considered it to offer a much better process for discharging patients to their own homes.

The groups were more equivocal about whether the grants had enabled a better relationship with patients, though responses appear less concerned with the grants themselves and more with matters of communication with patients, who they reported may sometimes change their minds about alterations to their homes.

6.2 What worked well?

The groups explored what they considered to have worked well during the pilot to date and highlighted the following areas.

Expedited discharge

The primary benefit identified by staff of being able to use the discharge grant was the opportunity to expedite discharge, through the flexibility offered to get patient's homes ready for their return:

> *It's been really … to sort of think outside the box a little bit with it. So we've sort of had situations where we've not been able to access properties for whatever reasons. We've used it to buy a temporary key safe or get keys cuts. It's been really helpful in trying to sort of expedite some of those outstanding things".*

> *from the orthopaedic unit we are struggling every time with the key safe and furniture move and furniture rising. So the grant really helps with these."*

> *when it comes to request moving _ furniture, you know the simple things that is very beneficial."*

Offering peace of mind to patients and relatives

Staff also noted the particular benefit to patients who did not have relatives or other outside networks, both practically and in offering peace of mind about returning home:

> *in AMU the turnover is quite quick. In situations where moving furniture or like deep clean of property can speed up the discharge process and help both patient and the system at the hospital. I'm from quite a big surgical medical ward. So my colleague has used this service, on at least three occasions. So it's quite a lot. And she's very appreciative that this service has been started. she's used this in a very complex learning disability patient to go home safely.*

And this patient did not have any friends or family that could support her in order to move or pay for the furniture. So basically, this lady was so grateful because I think at the time her bed was in such a state and not having the money or manpower to move or change that bed. So I think__ because of the grant that has been sorted and that gave her like, sense of assurance as well. I think it gave her the assurance because she knows that she's not having to get it organised independently. Because its done through the hospital she feels that she can trust in it rather than sourcing it independently."

"The reality is when you have like a relative in hospital and you're really worried. The last thing that you want on your mind is like oh, well, I'm gonna have to figure out how to move this furniture now, who is going to help me? So it's a great help to ease the worry for families and know a trusted provider will do that job."

"that sense of assurance that they know it's coming from the organisation, from the hospital rather than sourcing independently and the speed of discharge and just like improving the quality of life of that specific person, especially when they wanted to be discharged within their own home."

Permitted patients to move directly home

Another participant noted how the grant had helped to avoid people having to move into 'step down' accommodation before returning home:

"I will echo about the speedy discharge like reducing the admission time and the cost. With complex learning disability patients as well, you know it will improve their quality of life as well enabling safe discharge back to their own homes rather than having to go somewhere else because what needs to be fixed at home can happen and be fixed within their home. Overall the feedback from my team is, it's helping and it's helping really well and patient appreciated it."

The flexibility to offer creative, personalised solutions

Finally, the opportunity to offer personalised, rather than 'off the shelf' solutions was noted as a benefit of the grant:

"The patient wanted to keep their fancy bed not have a hospital bed but it needed raisers for this work and the raiser were provided through the grant."

6.3 Areas for development and improvement

The groups also considered how the approach might be improved upon, highlighting the following areas.

Patient consent and communications

Staff suggested that the consent form might be more user friendly and that it would valuable to not rely solely on the form for communication

"Sometimes if the patient doesn't have the cognition to fill in the form could it be derived from the next of kin or POA?"

"(there could be) More communication face to face or on the phone not just reliant on the form"

"The more complex discharges need more face-to-face communication between teams and families"

Expanding how the grants are used

Staff noted how the grants might have been used for things over and above moving or replacing furniture or decluttering homes and are keen to explore this. But they are also of a view that some things should only be purchased with expert guidance.

> *Better awareness of...what it could be used for. It tends to be used for declutter, furniture removal but could be used for things outside of those?"*

> *At the moment we cannot use the grant for anything that is already commissioned but if the thing commissioned is out of stock it would be useful to use it for that?"*

> *If there is a cap on the amount it needs to be more flexible depending on the needs of the patient and open as to what can and cannot be bought as part of the grant"*

Improving oversight and lines of communication

Staff expressed some frustration that, in the context of the pilot initiative, it could sometimes be hard to keep track of whether grants had led to action, and that in the absence of the discharge grant coordinator, progress couldn't always be made.

> Make it a bit easier to contact the discharge grant team more directly"

> *There is only one person so if she's off for whatever reason it stops"*

> *Communication some things need to be moved before equipment can go on and without that communication it can be a wasted journey if they arrive with the bed but the furniture has not yet been removed. We only get feedback second or third hand"*

Professional boundaries and workload

There was lots of discussion about where institutional and professional boundaries lay depending whether things purchased were classified as a clinical need or social care need.

> *It's adding more for us to do, this used to be social services job but we have to go and do the extra work now. For more complex patients actually it the the kind of the expectation is for us to to kind of coordinate all the things and then it's it's an extra job for us and we don't see it as our role, it's not a therapy issue. we shouldn't be dealing with who is going to cut the keys"*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DISCHARGE
Outpatient
Services
Drop Off
OutPatient
Parking

7 | Summary of Key learning points

Although no specific formal targets were set for the pilot project, this evaluation has been helpful to provide a review of the project implementation and outcomes to date. Aspects of key learning have been captured that are helping to refine some operational processes. In particular, the ICB has produced a suite of documents (Standard Operating Procedure etc) that can support the implementation of similar initiatives in other areas of South West London.

Components of success

- Essential to the success of the one-off discharge grant initiative is the rapid deployment of the grant. Almost 80% of grants were arranged within 1-2 days of referral to the service.
- Staff felt empowered by the pilot with autonomy to intervene and make a difference to patients and their discharge home. The project particularly enabled staff to address persistent barriers preventing discharge home such as furniture removal and de-cluttering
- The value of trust that patients placed in NHS staff to organise and arrange services for delivery to their home environment.
- The importance of on-going communication with hospital staff in discharge hubs and wards to continue to raise staff awareness and ensure staff recall the grants in real time whilst managing patients. This helped build a momentum for the project across discharge teams.
- The opportunity to explore the use of a virtual e-wallet system for service payments. The virtual wallet enabled secure transactions and the ability to monitor payment records from the dedicated account for the project. It also provided the ability to customize transaction approval limits and restrictions on the account - thereby ensuring control over project finances. The virtual wallet can integrate multiple linked cards and BACS payments for a variety of purposes. The robustness and simplicity of the system indicates its transferability to other service areas.
- Discharge leads switched to using BACs to make payments for purchases directly from the dedicated pilot project account. They found that this was preferable to using payment cards. It simplified the process of purchase and payment whilst retaining the facility to monitor/audit purchases in real time.

Components of success

- The value of holding project Working group meetings with a membership of hospital Trust discharge lead/card holders and the e-wallet supplier (Care Banking) to meet regularly to review/resolve operational issues.
- The support and responsiveness of the e-wallet supplier - Care Banking - throughout the process; from initial training through to accessing the Help desk whenever required.
- The experience of the project has led to the refining of operational processes and documentation. Key elements of these – such as Standard Operating Procedures, templates and process mapping are available to share to assist with the spread of learning form the project.
- A dedicated Project Coordinator to arrange and purchase the services required, liaise with patients, and complete the project paperwork/processes was integral to reducing administrative tasks for the discharge leads/staff.

Further issues to consider

The pilot project also identified several issues that may require further review

- Often patient's referred to the service were medically optimised. This can still result in the patient continuing to stay in hospital whilst purchases to support their discharge home are arranged and set-up. If referrals to the service were received earlier in the patient's care pathway – then the service could begin arranging these purchases so that they are ready when the patient is fit to leave. It is proposed that on-going communications are held with discharge hubs/teams to ensure patient requirements for discharge are identified as early as possible in the care pathway.
- Any future development of the project should explore extending the service to include those cohorts of patients on similar car pathways i.e. Virtual Wards project and the newly opened (Dec 23) Rehabilitation ward at St Helier hospital
- Some improvements to streamline paperwork have been made during the project following feed-back from staff (i.e. combining patient support plan and consent form). However, the paperwork and processes should continue to be reviewed to consider further improvements as required.

Further issues to consider

- In the patient experience survey responses– one patient indicated that only a single purchase had been identified for them and they were not asked about further needs or requirements. Although this has only occurred once – it is considered that staff should be reminded to hold conversations with patients in a manner that explores assessing their full needs to facilitate discharge.
- One of the staff feedback sessions identified that there may be the need to ask for clinical specialist advice regarding some purchases. Although no instances have required this to date – this may need to be reviewed and recorded when it occurs.

8 | Recommendations

On the basis of the experience and evaluation of the Discharge Grants pilot project it is recommended that;

1. The service at St Helier hospital is maintained for 2024/25 and extended to include the Rehabilitation ward and Virtual Ward cohort within the hospital.
2. The learning from the pilot project should be shared across NHS SWL and opportunities explored during 2024/25 for implementing similar one-off discharge grants to support discharge pathways within other SWL hospital Trusts.
3. Extending grant-making authority to other appropriate staff and/or ensuring continuity when lead staff are unavailable should be explored
4. Effort is made to deepen the involvement of patients and/or their families (as appropriate) in making decisions about the use of discharge grants to the ends of facilitating safe and sustainable discharge from hospital

9 | Conclusion

This report has evaluated the impact that the one-off hospital Discharge Grants pilot project has made to the discharge pathways at St Helier hospital. The report has reviewed headline performance activity and triangulated this with staff feedback and a sample of patient experience.

It is anticipated that the learning from the project can be shared to inform the future developments of discharge planning across the SWL NHS. A range of documentation is available from the ICB contacts listed below to support the spread of learning. In addition, NHS London have produced a communication toolkit for NHS Trusts who may wish to develop Discharge PHBs. This is also available from the ICB contacts below.

The SWL ICB would like to thank the Epsom and St Helier University Hospitals NHS Trust discharge staff for their participation and support for the pilot project.

Contacts for Follow-up

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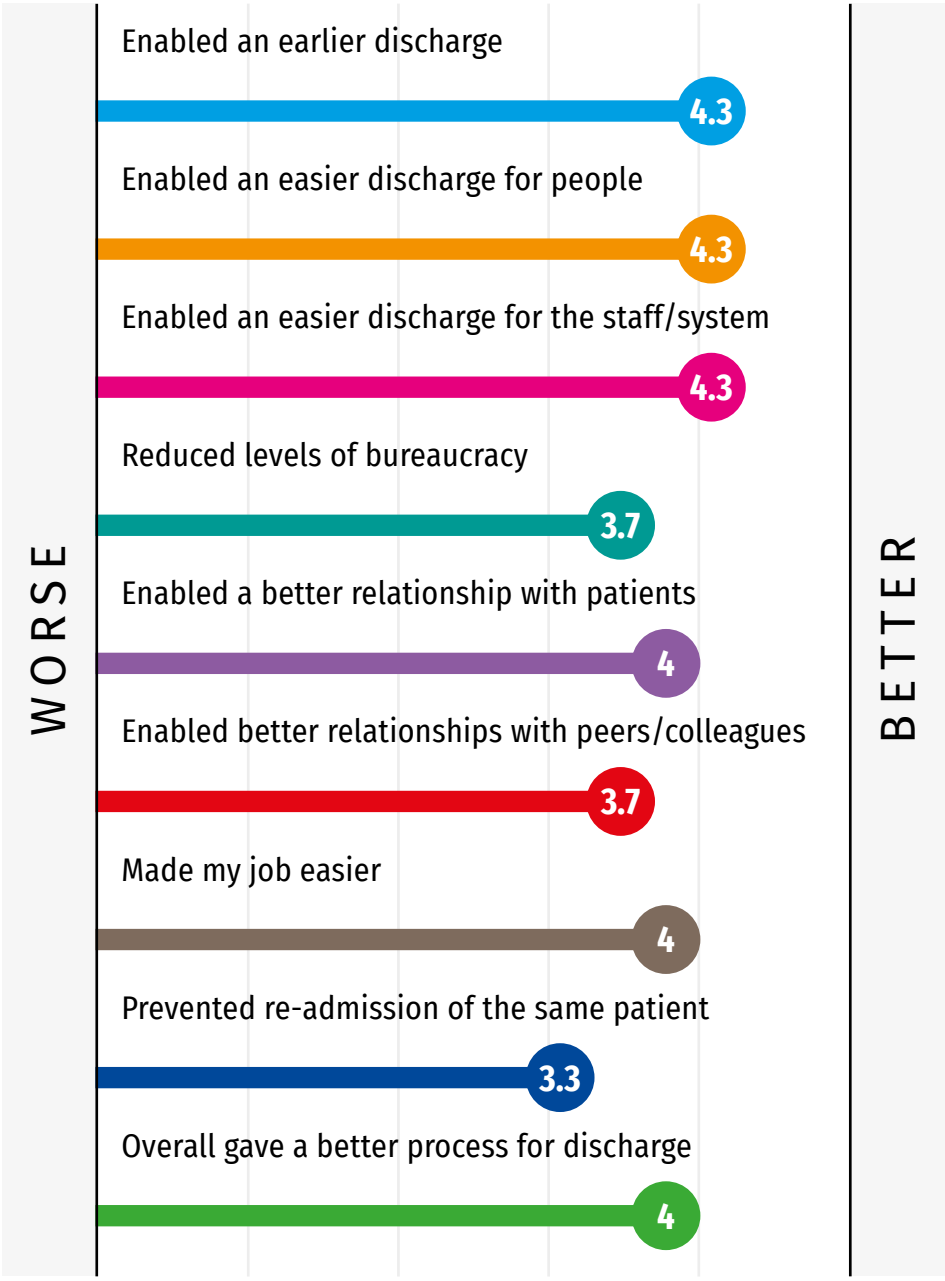
Annex

Polling results from staff focus groups held on October 24th and October 26th 2023

Focus group 24th Oct 2023

What difference has the grants made. Scoring from better to worse, with these statements?



Focus group 26th Oct 2023

What difference has the grants made. Scoring from better to worse, with these statements?