Health and Care Integration

Stakeholder e-bulletin

September 2016 edition

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Welcome from Dr. Andy Ker

I am delighted to introduce the September edition of our Integration Bulletin and to update you on the wide range of work Leicestershire partners are delivering, to join up health and care for the benefit of local residents.

I have recently been appointed Chair of the Leicestershire Integration Executive and look forward to working with all stakeholders on the next phase of our integration plans.

Looking ahead, across Leicester, Leicestershire and Rutland we are moving into a new era of integrated working which will involve locality based teams working hand in hand to provide more community care.

As GPs we are very often the first point of contact for a whole range of needs - medical, social, health and wellbeing. By working as a strong and co-ordinated, multi-disciplinary team with community nurses, therapists, pharmacists, social services and our voluntary and community sector partners; we can support local people more effectively and holistically.

You might notice we've changed the format of our bulletins to feature bite size features or case studies. In this edition you will find out about latest developments in falls prevention and housing support.

For previous editions of this bulletin–please follow this link:
www.healthandcareleicestershire.co.uk/health-and-care-integration/health-and-care-integration-newsletters/

Preventing falls & the new FRAT app

Every year, the East Midlands Ambulance Service responds to an average of 15,000 calls relating to falls, making it one of the top five reasons for a 999 call.

The ageing population across the LLR region means that the results of a fall are often serious and debilitating, both in terms of serious injury and the lasting effects of fear of falling, resulting in isolation and reduced mobility. Consequently improving the prevention and treatment of falls in older people is an important part of the health and social care integration plan.

In order to better deal with the pressure on local health services and provide a much better service for patients, we are developing more innovative and time-saving ways to be able to help them. We are building an entirely new pathway, starting with prevention, to reduce the likelihood of a fall in older people; improving both the service received if a fall occurs and the access to that service, so that patients receive prompt and appropriate treatment in the community wherever possible as well as support that reduces the risk of a fall occurring again.

Preventing falls

Top 5 tips to prevent falls

1. **Feet** – ensure footwear fits properly
2. **Eyes** – regular eye checks & improved lighting
3. **Health** – eat properly, stay hydrated & take medication
4. **Mobility** – stay active to avoid muscle weakness
5. **Home** – fix worn carpets, uneven steps & trailing wires

One of the ways we have used innovation to improve the service is with the development of the new Falls Risk Assessment Tool (eFRAT)app. Previously a paper based system of risk assessment, eFRAT helps the paramedic once an initial assessment on the patient has been carried out. Some injuries will require an immediate conveyance, but in other cases the decision is much more complex. The app helps the paramedic determine whether follow up support and care could be provided in the patient's home without the need for taking them to hospital.

If immediate treatment is not required, the patient will receive an assessment call within two hours of the app-based referral, followed by a home visit within four hours where necessary. This helps reduce the inconvenience and concern experienced following a fall, and maximises the chance of the individual returning to their previous level of independence. Once assessed, the falls team works together to coordinate any changes needed to the care plan, ensuring access to any therapy required and the outcome of the findings are communicated to their GP, as well as keeping carers and their families involved and updated on the next steps.

The newly developed eFRAT app streamlines and automates parts of the process, allowing paramedics to assess the state of a person (aged 65 and over) that has fallen and input the data, before digitising it, calculating a risk score and then offering the correct referral to community single point of access (SPA). Later versions of the app will allow the data to be integrated and saved into centralised records. This is a faster and more reliable way of progressing each case, ensuring that patients can be treated in their own home or in the community where possible, rather than experiencing long stays in hospital.

Developed by the Hackathon team of DS-Cubed students and developers at De Montfort University, the app is designed for use on the smartphones that are issued to paramedics, and aims to work with other apps or technology currently being used such as Toughbook.

For further information, please contact: andrea.baker@leics.gov.uk

Hospital Housing Enablement Service – pilot a success

Many patients, who would otherwise be delayed from being discharged from hospital, have been able to return home thanks to the support of the Hospital Housing Enablement (HHE) service. The HHE service addresses a range of housing issues, from inadequate facilities, environmental issues and homelessness; to problems with paying bills, debt and any housing related issue that would prevent a patient from returning home once they are well enough.

The HHE service began as a pilot in 2015 and is now part of the Lightbulb initiative with teams based at the Bradgate Unit and University Hospitals Leicester (UHL). The assistance scheme has proven effective in saving money and making bed space available for other patients - in the Bradgate Unit pilot alone, 920 delayed bed days were saved that would have been classed as 'housing delayed transfer of care'. This equates to an approximate saving of £219,000 during the pilot. 40 service users continued to receive support in the community following discharge and of these only one was re-admitted to the Bradgate Unit.

The bespoke bedside service which has now been rolled out on a permanent basis, helps on average 32 patients a month to leave hospital and continue their recovery at home, freeing up hospital beds for those needing more urgent treatment.

The average time taken for the team to resolve a case is eight days and during the pilot period in 2015 there were 362 referrals to the service from Leicester Royal Infirmary and 115 from the Bradgate Unit. Data from January to March 2016 shows the primary reasons for patients needing assistance were homelessness or an unsuitable/unsafe home environment and house clearance and cleaning. However, the HHE team deals with a range of factors that are a barrier to discharge, including assistance with access to the privately rented sector, managing the existing home and even

providing furniture packs if required.

The HHE team works hard to train hospital staff on awareness and benefits of the scheme, in order for it to be as accessible as possible to patients that require it. To facilitate this, new promotional materials are being produced to advertise the service to patients and hospital staff.

Case Study
A patient came into hospital and following an infection, had an unplanned below the knee amputation. As a result he was unable to return to work because his job involved driving. His family and partner were unable to accommodate him and were not able to support him with a house move. He had never lived independently before and had never organised his own tenancy or finances before. In short he had nowhere to go and no income. The Hospital Housing Enabler completed housing applications for the patient whilst in hospital, as well as an Employment and Support Allowance claim over the phone to ensure he had sufficient funds; this supported his housing benefit claim once he was housed. The team also contacted the local authority to start a homeless application whilst in hospital and ensured he had temporary accommodation arranged for a week, with wheelchair access. They contacted the RVS service for a food parcel to ensure he had enough food until his benefit payments commenced.

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Contact us

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Download our Better Care Fund plan on a page: www.healthandcareleicestershire.co.uk/download/unnamed-file.pdf/BCF-strategy-and-progress.pdf

To find out more about Better Care Together – Leicester, Leicestershire and Rutland's five year health and care strategy visit www.bettercareleicester.nhs.uk

For enquiries about this bulletin please email BetterCareFund@leics.gov.uk or call 0116 305 5749