St Helens Council
Home Improvement Agency

Home From Hospital – The Impact of HIA Interventions

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Lee Norman
Manager Private Sector Housing Services

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Background to St Helens

- St Helens in Merseyside
- Population: 177,188 Unitary
- Large health and well-being inequalities
  - 16 Wards
  - 10 years difference in life expectancy
- Rapidly growing ageing population
- Increase in frailty and dementia
- By 2025, the number of 85yr olds will increase by 69%
- St Helens CCG – 37 GP practices
- 3 main hospitals
  - Whiston Hospital
  - St Helens Hospital
  - Newton Hospital

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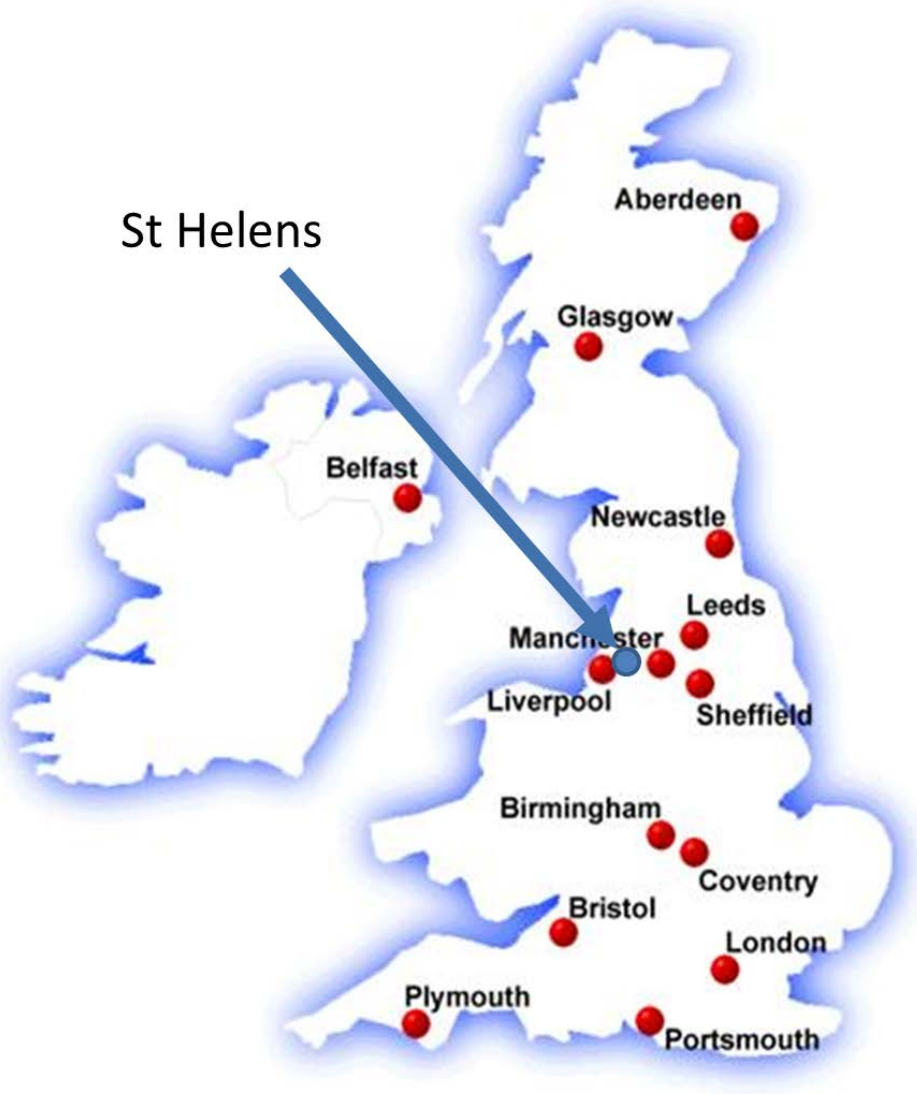

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St Helens HIA

- Integrated within Housing Services along with Occupational Therapy Service
- Strong cross-working with Adult Social Work Team in same Division
- Key drivers:
  - Early, low- level intervention to ‘fill the gap’
  - Maintaining independence
  - Falls prevention
  - Safety at home
  - Preventing hospital admissions/re-admissions and delayed discharges/DTOC
  - Carers
  - Delaying admission to residential care
- Interventions deliver outcomes in all three National Outcomes Frameworks – NHS, Public Health and Adult Social Care

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Services Provided

- Handyperson
- Assistive Technology – Installation & Care
- Care & Repair
- Benefits Advice
- Disabled Facility Grants
- Affordable Warmth Services

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Handyperson Service

Examples – Simple interventions

- Falls prevention
  - Handrails
  - Changing light bulbs
  - Bed moving
  - Securing carpets
- Minor adaptions
  - External ramps
  - External steps & mild steel rails
- Security and Home Safety
  - Door chains
  - Star locks
- Property repairs

Benefits

- Safe discharge from hospital
- Cost saved of home accidents prevented

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Telecare

Examples

- Falls pendant
- Smoke detector
- Epilepsy sensor
- Bed/chair sensor

The Benefits

- Promotes independence and enables choice – helps individuals to remain in their own homes and communities.
- Local monitoring and rapid response team
- Peace of mind for carer and family who may not live locally
- Reduce risks
- Assist with management of specific conditions
- Enable safe discharge from hospital or care

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The Duffy Project

- Enhanced Integrated Hospital Discharge & Community Care Project
- Trialled over winter and evaluated in March 2012

What was the project looking to achieve?

- Enhanced IDT to break down barriers between health and social care services
- Reduction in number of medically fit patients occupying beds at Whiston Hospital from 40 to 10 (equivalent of a ward)
- Improve capacity to tackle the additional winter pressures
- Fewer delays in patient discharge
- Better integration of Primary, Secondary, and Social Care
- Reduction in direct transfers to long term residential and nursing care

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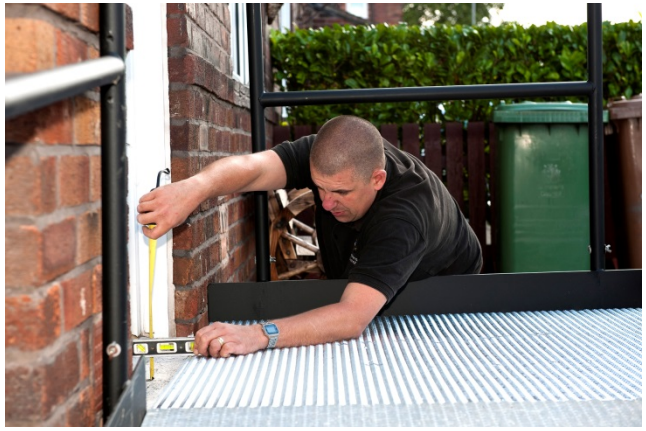
Role of HIA and OT Service in Project

- HIA - 2 man rapid response Handyperson Team
  - Bring bed from upstairs to downstairs
  - Relocation of furniture to avoid trips
  - Fitting of grab rails, stair rails, temporary ramps, drop down rails, key safes
  - Lifeline installations
- Community Occupational Therapist based at Whiston hospital to strengthen links
- Highest priority was given to the hospital referrals with work carried out within 2 days



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Project Achievements

- The number of ‘medically fit’ patients occupying hospitals beds reduced from 40 to 5 beds
- Capacity equivalent to a ward was freed-up at Whiston Hospital
- Those patients who were medically fit for discharge were placed in settings more appropriate to their needs
- 17% Reduction in delayed discharges
- 5 day reduction in the average time between a section 2 notification and actual discharge
- The number of assessments undertaken by the IDT increased by 140%, medically fit patients were assessed and discharged sooner to placements more suited to their needs

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HIA's Contribution to Project

Over 4 month period:

- 142 Discharges involving HIA/Handypersons
- 74 Falls on the Level hazards addressed
- 39 Falls on Stairs hazards addressed
- 1 excess cold prevention
- Savings to NHS in addition to bed days saved
- Evaluation showed HIA work and 2 day intervention target had positive impact on safe and timely discharge

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What Now?

- The IDT approach continues
- Focus on reducing bed-blocking
- Rapid response HIA service embedded
- Enhanced handyperson service has continued funded via BCF
- Qualified Trusted Assessors – assess further needs in the home
- Strong integration between social care, health and housing
- Simple but effective housing-lead interventions
- IASH satellite based at Whiston A&E (integrated assessment team)
- Emergency Careline Initiative
- Proposals for a Rapid Response Falls Car with Paramedic and OT/Physio 08:00-20:00hrs M-F

Hospital Discharge – Pathways to HIA

- Receive referrals from IASH/IDT
- Direct referrals from other parts of hospital to OT Service
- Referrals from multi-disciplinary Falls Prevention Service
- Same day or next day response (most same day)
- HIA/Handyperson not currently 7 day

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HIA Outcomes in 2015/16

- Simple low-level, low-cost preventative interventions
- 634 rapid response hospital discharges for older people – 345 Handyperson, 289 Telecare/Assistive Technology
- 8639 handyperson interventions across 4900 properties
- 4234 of telecare/assistive technology installations
- 536 heating advice visits including 165 following an unplanned hospital admission in proceeding 12 months
- 29 heating & 52 insulation measures and 21 emergency heating repairs
- 20 emergency adaptations (larger items of equipment) to aid hospital discharge
- 550 major adaptations (DFGs) that keep people from returning to hospital

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Causes and Cost of Falls at Home

Research by BRE for St Helens Council in 2013 identified:

- Almost 10,000 serious hazards in homes of older people
- Most are falls hazards
- 364 instances annually where medical attention needed
- £1.25M annual cost to NHS in 2013

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Older People to Hospital

- Almost 50,000 A&E attendances for St Helens CCG in 2014/15 (Source: NW CSU SUS Data)
- Emergency Admissions Falls Rate 2,899 per 100,000 for over 65s
- 1,054 urgent care falls admissions for 65yrs+ in 2015/16. Average cost £2,750, total cost £2.9M
- St Helens CCG non-elective readmission rates for 65 yrs+ are 18.8% at 30 days and 29.7% at 90 days in 2014 (JSNA 2015)

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Value of a prompt Handyperson and Assistive Technology Intervention

- Win win
- Interventions have a positive impact on the individual – get home quicker to a place the want to be, restores confidence, assists carers and family members, prevents accidents
- Trusted Assessors: Additional measures to prevent repeat admissions
- Cost savings to hospital and social care:
  - Safe & sustainable discharge
  - Hospital bed days saved
  - Accident & treatment costs prevented
  - Prevent/delay admission to residential care

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Case Study 1 - Handyperson Request

9/06/2016

- Referral received from Whiston Hospital discharge team to OT team - (Female 65yr old)
- Requests: stair and banister rails, relocate beds
- Referral checked and signed off by OT and brought to the Handyperson team
- Referral logged on system and daughter contacted to arrange access. Daughter requested Monday 13th June

13/06/2016

- Job given to 2-man handyperson team to visit
- Stair rail and banister fitted, beds swapped between rooms
- Job completed before 11am 13/06/2016
- Clients daughter met the team at the property, and the client arrived home with the OTs upon completion of the works

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Case Study 2 - Assistive Technology Request

25/05/2016

- Referral from Hospital Discharge team through IAS to Assistive Technology Care Installation Team (Male 74yr old)
- Request: Lifeline installation with Wrist falls detector, bed sensor and chair sensor to a care assist
- Client's family contacted and installation date established and booked

27/05/2016

- Installation works carried out. Met client and family at home as client was discharged 1 hour previous
- Works all completed as agreed with family. Installations team met the client at the home 1 hour after he was discharged

Looking Forward

- Maximise HIA involvement in preventing DTOC & repeat admissions
- On-going engagement with the Hospital Teams, Integrated Discharge Team, IASH, Assessment & Review Social Services
- Constant re-enforcement of the value of safe & sustainable hospital discharge – not just treatment and care packages
- Work with health & social care practitioners to take active & holistic approach in prevention
- Promotion of emerging Telecare/Assistive Technology equipment

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Conclusion

- Unsafe & unhealthy home environments undermine safe and sustainable hospital discharge
- HIAs provide simple but timely preventative interventions that can reduce or prevent costs to health services
- Enables people, especially older people, to leave hospital sooner by making their homes safe, accessible and warm
- Requires a holistic approach between Health, Social Care & Housing to remedy ‘home’ issues
- Little things that make a big difference

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Thank You
For Listening

Lee Norman

leenorman@sthelens.gov.uk

01744 676230

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