Health and Wellbeing Board

8 May 2019

Falls Prevention Strategy 2018-2021

Report of Denise Elliott, Interim Head of Commissioning, Durham County Council and Joanne Todd, Associate Director of Nursing, Patient Safety and Governance, County Durham and Darlington NHS Foundation Trust

Electoral division(s) affected:

None

Purpose of the Report

1 To update Health and Wellbeing Board (HWB) on work undertaken as set out in the Community Action Plan element of the Falls Prevention Strategy 2018-2021.

Executive summary

2 Falls are common in older people and can have serious consequences, including loss of independence. Economic costs of falls increases with fall frequency and falls can be a predictor for admission to long-term care.

3 A joint Falls Strategy is in place for 2018-2021 which includes actions from both a community and acute perspective to reduce the number of falls and improve on performance.

4 Performance on two falls related indicators are reported to the Health and Wellbeing Board via the Performance Report: Falls and injuries in the over 65's and hip fractures in the over 65's.

5 Following a dip in performance of these indicators in 2017, a sub-group of the Joint Commissioning Group (Falls Task Group), led by the Head of Commissioning, was established to identify and address any issues.

6 There is significant work underway within the acute hospital sites to reduce the incidents of inpatient falls. However this report focusses on the community element of the strategy. The current Community Action Plan of the Falls Strategy maps initiatives and progress and is attached to this report at Appendix 2.

Recommendation(s)

7 Members of the Health and Wellbeing Board are requested to:

a) Note the contents of this report and recognise the work being undertaken across the county led by the Joint Commissioning Group via the Falls Strategy Task Group.

b) Receive updates on the Falls Strategy Community Action Plan as required.

Background

8 Falls are common in people aged 65 years and older and are the leading cause of injury in this age group. They can have serious consequences, including trauma, pain, impaired function, loss of confidence in carrying out everyday activities, loss of independence and autonomy and even death.

9 The economic costs of falls increase with fall frequency and falls are an independent predictor for admission to long-term care.

10 Strength, flexibility, balance and reaction time are considered the most readily modifiable risk factors for falls. People, even in their 90s, can improve their strength and balance to achieve stability and avoid falls.

11 The 2016-19 Performance Report, tabled at the Health and Wellbeing Board meeting on 26 July 2017, highlighted a dip in performance in County Durham relating to falls and injuries in the over 65's and hip fractures in the over 65's. Following that meeting the Joint Commissioning Group were tasked with addressing these issues and with providing a report to the Board in 2018. (NB: updated performance information will be available at the end of quarter 1, 2019-20).

12 A report tabled at the Health and Wellbeing Board meeting on 4 July 2018 concluded that work undertaken throughout the county to improve rates of falls and the injuries most common to falls should impact on outcomes positively in the medium term and that the Joint Falls Strategy 2018-21 would provide a strategic direction upon which all partner agencies could focus and work together to achieve common goals.

a) The Falls Task Group (a sub-group of the Joint Commissioning Group), chaired by the Interim Head of Commissioning, facilitates development, planning and implementation of the community element of the Joint Falls Strategy Action Plan. Key priorities for the community are:

b) Education, awareness and training around falls prevention amongst the workforce and wider community;

c) Improved partnership working between community and acute services to streamline services;
d) Increased accuracy of identifying those at risk of falls; and to
e) Map out and develop a clear pathway for falls and fragility services in acute and community settings.

13 Members of the Health and Wellbeing Board requested an update on progress in early 2019.

Update on progress

14 In addition to the ongoing work set out in the report to the Board on 4 July 2018 the following progress is continuing:

- The Falls Task Group is established and meeting on a monthly basis.

- A Community Action Plan (see Appendix 2) is in place and agreed by all partners. The action plan is updated at each Falls Task Group meeting and will be cross-referenced with the acute action plan.

- Agreement has been received from the Adult Care Transformation and Innovation Fund (ACTIF) that £6,000 from the DCC Commissioning Supporting the Provider Market (STPM) project contributes to the funding of two additional Raizers (with additional funding from Care Connect). Raizers enable a service user who has fallen to be safely lifted off the floor with only one member of Care Connect staff in attendance. The two additional Raizers will enable a faster response and free up time to deal with other calls, while reducing inappropriate interventions from domiciliary care services.

- A Falls Policy checklist is being developed led by the STPM project team, in consultation with relevant stakeholders and will be signed off by the Falls Task Group. Care home policies will be requested, targeting those homes with the highest number of 999 calls (linked to high incidence of falls), and reviewed against the Falls Policy Checklist. Care Home policies that do not meet an agreed standard will be provided with written feedback indicating recommended changes, which will be followed up by DCC Commissioning.

- A report to the Clinical Commissioning Groups Executive in Common in December 2018 recommended that £252,000 of iBCF funding be approved to expedite actions set out in the Falls Strategy Community Action Plan. It also recommended delegation of authority to the Director of Community Integrated Services to be flexible in the use of the iBCF

funding for enhanced falls service and to allow the flexibility to utilise monies to provide additional OTAGO[1] programmes.

Medication reviews were prioritised by the Falls Task Group and this is being delivered through the use of dedicated pharmacy resource to complete medications reviews and to expand the scope of this work into Care Homes

Following procurement and award to County Durham and Darlington Foundation Trust (CDDFT) of the community services contract, falls will be considered within the first phase of review of transferred services. The requirement of the contract is that services are developed to be equitable across the county. Whilst CDDFT are working towards this the funding above will be used to expedite the enhancement of the current services.
CDDFT executive has indicated a direction to shift falls services from secondary care and a willingness to pull a falls offer together which will put all falls services into the community.

- Falls training in care homes is continuing and "mop up" sessions took place in January 2019. The training has been positively received by care home staff and DCC staff will track impact of the training through 999 data for care homes. Data for training carried out from September 2018 to date is set out in the table below:

	Completed Training		**Planned Training**
No of Courses held	36	No of Courses planned	8
No of Homes received training	34	No of new homes to be trained (if some homes are in the January mop up that haven't been trained pre- Christmas)	3
No of staff trained	291	No of staff booked on	73 - 75

- Meetings have taken place between representatives from Care Connect and CDDFT to explore the potential of a pilot scheme in Chester-le-Street to improve communications between Care Connect and Health where Care Connect can refer directly into the Falls Service. Information from the pilot will be used to inform and support a more

[1] The OTAGO exercise programme is a set of leg muscle strengthening and balance retraining exercises designed specifically to prevent falls.

preventative approach in the medium to longer-term. Funding may be available through the STPM project for data enabled phones to allow staff access to an App for electronic referrals.

- The take up of the Care Connect pilot with NEAS for attendance at non-injury falls, as outlined in the July 2018 report, is picking up with 131 calls since the start of the pilot in June 2018.

- Colleagues from Commissioning and the STPM project met with the Falls Project Manager from Middlesbrough Borough Council whose role it is to develop and implement an integrated falls prevention strategy across South Tees.

  An overall tiered system is being implemented in Middlesbrough in relation to the training and education model and falls systems pathways. The aim of the project, through a multi-agency partnership approach, is to reduce falls and to improve access to services for older people at risk of falling. Learning from Middlesbrough will inform ongoing work plans in Durham.

- The Falls Task Group are collating a list of key performance indicators that are currently collected by both health and social care to be provided to HWB in addition to the two reported through the performance report. (Number of hip fractures in people aged 65 and over per 100,000 population and emergency hospital admissions due to falls in people aged 65 and over per 100,000 population).

15 In addition to the above, regional work, including a Regional Falls Task Group, is ongoing led by the Clinical Director of Community Services. On a national level the recently published NHS 10 Year Plan sets out the aim to “work on falls and fracture prevention” and acknowledges that “fall prevention schemes, including exercise classes and strength and balance training, can significantly reduce the likelihood of falls and are cost effective in reducing admissions to hospital.”

Conclusion

16 Extensive work, as set out in the Falls Strategy Community Action Plan, is being undertaken throughout the county to improve rates of falls and the injuries most common to falls. A positive impact on outcomes should be seen in the medium-term.

Appendix 1: Implications

Legal Implications

No issues

Finance

Funds from the iBCF are in place to support the falls initiatives

Consultation

Clinical consultation carried out as part of the enhanced falls work

Equality and Diversity / Public Sector Equality Duty

N/A

Human Rights

N/A

Crime and Disorder

N/A

Staffing

No issues

Accommodation

N/A

Risk

Risk to CCG and LA finances if falls initiatives do not improve performance on falls and fractures.

Procurement

N/A

Appendix 2: Joint Falls Strategy Community Action Plan

To do
In progress
Complete/ ongoing
Future start

Milestone/ Task Ref	Action/Task	Lead	Start	Finish	Status (RAG)	Comments
Part 1 - Prevention (Primary and Secondary)						
P1	**Prevention: Identify universal provision to improve the physical wellbeing of older people in order to reduce their risk of falling**					
P1.1	Map the current opportunities for older people including physical activity, healthy diet and reducing alcohol	MM/KW	01/12/2018	28/02/2019	Green	Public Health cardio vascular disease prevention audit. OP to be mapped as a sub-set of this work. Community exercise classes and activities that are suitable for people with complex mental health problems including dementia to be mapped as part of the above. DDHF carry out falls assessments without the community as part of their full assessment. Any one found to be high risk are referred to the Falls Team. Information is available via GIS (wellbeing activities, not falls specific). Information shared with community staff.

P1.2	Identify gaps, geographic and activity and make recommendation for future provision	MM/KW	28/02/2019		Amber	Depending on the outcome of the housebound patient pilot, implement a programme of medication reviews for people living in Care Homes. Additional 1000 pharmacy sessions £140,000. This is in addition to the IBCF funding which was identified to deliver a programme of medication reviews for housebound patients. Ensure that all patients regardless of locality have an equitable access to group exercise programmes within the community. Additional 100 places £66,000 Gap = Care Connect cannot refer directly to Community Services (of which the Falls Service is a part) and they are lifting 7,000 per annum. Chester le street pilot will address this issue as a representation of the county
P1.3	Review and utilise the existing evidence base (i.e. NICE Guidance) in relation to falls prevention and use this evidence base to guide implementation and commissioning in the future	MM/KW			Amber	
P1.4	Make links with new strategic manager for sport/culture/public health	MM/KW	05/12/2018	16/01/2019	Green	Close working relationships developed

P1.5	Establish links with HWBB re social isolation	MMac	05/12/2018	16/01/2019	Amber	
P1.6	Develop/source communication materials on key messages i.e. strength, falls prevention, aids and adaptations	JT/HR	01/10/2018		Green	Acute and community falls services have reviewed their information leaflets and are using "Get Up and Go: a guide to staying steady". This leaflet will be utilised as the main offer for all service areas /partners to ensure consistency of message. Booklet can be downloaded or printed. Logos can be added if required.
P1.7	Source costs for identified materials from P1.6 and identify budgets to be used	JT/HR	01/10/2018	05/12/2018	Amber	Cost identified as £679.00 for 2.5k copies of a 32 page booklet.
P1.8	Agree communication and roll out of materials identified at P1.6 to partners/stakeholders/front line staff	All	16/01/2019		Amber	LO will include in welcome packs
P1.9	Explore work at South Tees re prevention/triage service and education package delivered (link to P2.5 and P4.2)	MMac/SD	05/12/2018		Green	Meeting held 15 January 2019. South Tees willing to share their documents
P1.10	Work to disseminate information to rehabilitation teams	MM	16/01/2019		Green	
P2	**Technology: Identify technology currently being utilised in the community in County Durham, its availability, usage and impact**					
P2.1	Map technology (equipment) currently being utilised in the community in County Durham, its availability and usage	LO/NJ	05/12/2018		Green	e.g. Bed sensors, falls detectors, home hubs (e.g. Amazon Alexa, Google Home), chair sensors. People can also purchase equipment privately

						where no eligibility through social care
P2.2	Identify new sources of information/reports from usage of equipment	LO/CH	05/12/2018		Amber	CH has been working closely with ID and BM (care connect) to find ways of capturing information on falls. The information captured on "Tunstall" (IT system used by Care connect) will be relayed back to the Health Care Coordinator team. Triggers for referral would be anyone who has had 3 or more falls, to be assessed or referred directly to the Falls team. LO, CH and ID met to look at reports which can be ran and shared. SD looking at information sharing agreement. HAS ARMED (identified through market testing exercise for IC+ service) would enable the Council to be able to record health metrics associated with frailty and falls. Case study shows successful outcomes. Chester le street may be able to assist in addressing issues.

P2.3	From information identified at P2.1 and P2.2 identify impact of technology and gaps/areas of improvement and identify any new technologies	LO	05/12/2018		Green	LO to include technologies available at Innovation Days Gaps in current services Care Connect are not able to refer frequent fallers to the falls services **New Techologies Gociety Solutions**- wearable clip which registers a fall sends text or email with location to emergency contacts **Angel 4 –Sense Care** is a sensor worn on belt connected to a telecare system or mobile phone and sends message indicating a fall and location **Ellcie Health Smart** under development and is connected glasses. Sensors in the glasses and sends data (physical, physiological or environmental) via a smartphone. Provides information on wearers health and safety **Apple** looking to develop fall detection into Apple Watches
P2.4	Review current referral pathways into telecare services from all stakeholders	DE/NJ	05/12/2018		Red	Review widening of scope for potential for partner associations to refer, including associated funding arrangements
P2.5	Review current referral routes/signposting in addition to telecare services	LO	05/12/2018		Amber	Care Connect would make referral to Adult and Health services where appropriate. See

						P1.2 re issue that Care Connect cannot refer directly to Community Services (of which the Falls service is a part)
P2.6	Review communication/ awareness raising materials/ channels for telecare services to all stakeholders	LO	05/12/2018		Amber	On-line referral form with mandatory fields in progress.Care Connect Business Development Manager working with teams to promote telecare.Improve links between Commissioning and Care Connect
P3	**Aids and Adaptations: Identify current services/opportunities for people to access aids and adaptations, review referral pathways and communication/awareness of aids and adaptations**					
P3.1	Map the current services/opportunities for people to access aids and adaptations	NJ/LB	05/12/2018	28/02/2018	Red	
P3.2	Ensure reviews of services are current including: Handyman services Equipment and advice services HIA Community Equipment Service Sensory awareness teams	NJ/LB & CCGs	01/10/2018	31/03/2020	Amber	Handyperson services have been reviewed and are currently being recommissioned. Other service reviews are in the planning stage
P3.3	Review current referral pathways into aids and adaptation services from all stakeholders	NJ/LB & CCGs	01/10/2018	31/03/2020	Amber	Picked up within service reviews
P3.4	Review current referral pathways out of aids and adaptation services	NJ/LB & CCGs	01/10/2018	31/03/2020	Amber	Picked up within service reviews
P3.5	Review communication/ awareness raising materials/ channels for aids and adaptations services to all stakeholders	NJ/LB & CCGs	01/10/2018	31/03/2020	Amber	Picked up within service reviews

P4	**Identification of higher risk individuals to allow targeted interventions**					
P4.1	Map inclusion of falls risk in all stakeholders assessments including: Fire & Rescue safe and wellbeing checks Pharmacy checklists Housing Opticians Social Care TAPs Durham Dales Health federation Care Connect Data (accumulative total of falls throughout the year for any given time period) Handypersons services Six monthly review to keep information up to date	MMac	05/12/2018		Green	**Fire Service** - Safe and Wellbeing form includes questions around falls **Pharmacies** - General information available on Pharmaceutical Services Negotiation Committee website www.psnc.org.uk. **Housing** - referrals for DFG come through social care direct and are referred to OTs for assessment. Livin/CDHG do their own DFGs however they also rely on OT assessments in the same way. **AHS** - Process for dealing with referrals linked to falls (referal to Falls Team, referral for Falls detector) **AHS** - Process for dealing with Annual reviews where a Falls Detector is in place **Handypersons** - Guidance, Signposting and Home Safety Check provides advice on the prevention of accidents in the home in relation to slips/trips/falls **TAPs** - Health, within their contact assessment, have a domain for falls. GPs have EMIS system and identify frailty, risk of falls, social care own assessment.

						Information only gets shared at an MDT. **DDHF** - carry out falls assessments without the community as part of their full assessment. Any one found to be high risk are referred to the Falls Team. (NB: not countywide and what about low/medium risk)
P4.2	Following information sought in P4.1 identify referral pathways (or gaps) once high risk person is identified (link to P1.9)				Red	Falls risk has been mapped across to out of hours (ooh) emergency admissions, established that falls are the highest OOH admission. Training with health care assistants carries out. Further action to follow on pathways
P4.3	Encourage regular targeted case finding on GP systems including bone health to enable preventative prescribing (see BH1.2)	CH	05/12/2018		Amber	HCAs are keen to develop the falls assessments. If do come out as high risk would be referred back to the GP. JT to pass on info re day hospital assessment focusing more on lifestyle. DE asked if they wanted to put some information about a sub pilot putting in here. HD/DH to amend and send on. Frailty assessment - GPs are automatically making a referral if a person hits a trigger on the assessment? Academic Health Services Network have carried out some work (DH to chase) Coding on System1

						and EMIS need to flag up higher risk person and GPs need to be made aware - this is a universal coding issue. CH to speak to AD. LO could provide reports - to meet with CH and ID. Interface with clinical services. Review of GP practices. Portal between portal and system 1 planned by March 2020.
P4.4	Develop a system for identification of "near miss" attendees at emergency departments and urgent care centres	GS	01/11/2018	31/01/2019	Amber	Part of business case at P4.5
P4.5	Scope the development of a potential business case for a follow-up call provision for the emergency department attendees	GS	01/10/2018	01/11/2018	Amber	Fallers are coming through UHND. Business case agreed by CCGs for short-term pilot. Recruitment progressing.
P4.6	Expansion of Falls teams to look at near misses and expand OTAGO therapy	GS	01/01/2019		Red	With ACTIF funding
P4.7	Scope a business case for piloting an ambulance aligned OT provision to reduce conveyances and initiate therapy responses	MW	01/11/2018	31/01/2019	Amber	With ACTIF funding With OT/NEAS pathway.
P4.8	Review community falls workforce and recommend optimum delivery model	MW	01/03/2019	30/09/2019	Amber	
P5	**Pathways**					
P5.1	Link into the review of falls services to ensure streamlining of pathways between acute and community services (include considering the development of one Community Falls Service to ensure an equitable service across County Durham).	JT	01/12/2018	30/04/2019	Red	Dependent on work above. Links to Acute Action Plan

P5.2	Review the access to specialist support/advice available to community and primary care teams to improve outcomes for those who have fallen or are at risk of falling	WL	01/03/2019	31/10/2019	White	This will be addressed as part of the transformation plan within Community Services. Links to 4.8 above.
P5.3	Review referral routes and service eligibility criteria for falls services	WL	01/03/2019	31/10/2019	White	This will be addressed as part of the transformation plan within Community Services
P5.4	To ensure falls service leads review the format and use of individual falls treatment plans to ensure they are NICE compliant and deliver a multiagency approach	WL	01/03/2019	31/10/2019	White	
P5.5	Review the falls community pathways to ensure appropriate exit strategies from specialist services are available with signposting/ facilitation of progression into universal opportunities to reduce the risk of future falls	WL/KW	01/03/2019	31/10/2019	White	This will be addressed as part of the transformation plan within Community Services
Part 2 - Workforce						
W1	**Training: Identify training opportunities/gaps for the wider workforce (i.e. not just those delivering specialist services, e.g. staff in care.**					

W1.1	Identify key workforce cohorts and their "falls awareness" training needs (encompassing prevention and response) including: Care home staff Domiciliary care workers Unpaid carers Care Connect staff Culture and Sport staff	SD/JT/ MM	01/01/2019	31/03/2019	Amber	DDHF associate practitioner and HCA have attended training in falls assessment at the Manor House. Round 3 of Falls Training ongoing in care homes NECS: A focused area of work in year one to support the care homes, to do this a designated person would be required to identify care home staff training requirements for falls prevention and develop packages of care in the first 6 months which can be delivered using a train the trainer model and/or e learning. These packages could then be used to deliver training to the domiciliary care providers. (NB: Must link with STPM project) Care Connect Staff and Culture and Support - Offer of Adult Learning and Skills Service Distance Learning (Falls Prevention Awareness) and SCILS (Social Care Information and Learning Service) Plans to engage with relevant stakeholders are in progress, future paper may be required for Integrated Care Board

W1.2	Develop/source evidence based training materials/ opportunities/channels on key topics, e.g. YouTube, e-learning for promotion to providers (website, newsletter, pocketbook of practice)	SD/JT	01/01/2019	31/03/2019	Amber	Sensory training sent by JT to SD
W1.3	Develop and implement a training delivery plan	SD/JT	01/01/2019	31/07/2019	Amber	
W1.4	Maintain links with regional and national falls networks and departments (e.g. NHSI)	HR	Ongoing		Green	
Part 2 - Bone Health						
BH1	**Bone Health: (NB: DE to establish if this service is included in the community contract)**					
BH1.1	Review Osteoporosis services including referral pathways and availability of DEXA scanning	GF	01/02/2019	31/08/2019	Red	
BH1.2	Develop high risk targeted case finding on GP systems to enable preventative prescribing (see P4.3)	CCGs	01/08/2019	30/11/2019	Red	