ITEM No …7……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 21 FEBRUARY 2024**

REPORT ON: **FALLS SERVICE**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB3-2024**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide analysis of falls-related hospital admissions and assurance regarding the preventative and proactive work being undertaken.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board:

2.1 Notes the contents of this report and the analysis of falls-related hospital admissions (section 5.0 of this report).

2.2 Notes the current model for prevention and rehabilitation and how this links with the wider socio-economic situation.

2.3 Notes the development of the Tayside Falls Prevention and Falls Management Framework

3.0 FINANCIAL IMPLICATIONS

None.

4.0 BACKGROUND INFORMATION

4.1 National Health and Wellbeing Indicator 16 is “falls rate per 1,000 population in over 65s”. The focus of this indicator is the number of falls that occur in the population aged 65 plus where the person is admitted to hospital. The indicator is measured using data gathered by Public Health Scotland.

4.2 Local NHS Tayside data for this indicator is monitored in the Quarterly Performance Report and validated, published data is reported in the Annual Performance Report. Both reports highlighted the particularly high rate of hospital admissions within the Dundee population of people aged 65+ as a result of a fall.

4.3 In 2021, Dundee had a high rate of hospital admissions as a result of a fall per 1,000 people aged 65+. Benchmarking with other Partnerships shows that Dundee had the highest falls rate (31.8) in Scotland and was significantly higher than the Scottish rate of 23.0 admissions as a result of a fall per 1,000 people aged 65+. Analysis of falls admissions was presented to the PAC held on 12 September 2017 Article X of the minute of meeting refers (PAC26-2017), with further analysis provided to the PAC held on 29 May 2018 Article IX of the minute of meeting refers (PAC32-2018) and 26 November 2019 Article VI of the minute of meeting refers (PAC41-2019) and 28 September 2022 Article V of the minute of meeting refers (PAC21-2022).

4.4 Falls can have a significant impact on an older person's independence and quality of life, impeding a person’s mobility and confidence. However, falls are not an inevitable consequence of old age. Well-organised services, delivering recommended and evidence-

based practices can prevent many falls and fractures in older people in a community setting. Rehabilitation services are key to preventing repeat falls. In addition, the safety of a person's immediate environment as well as a review of their prescribed medicines are important alongside a multifactorial assessment including; falls history, muscle strength and balance, eyesight, footwear, foot condition, bone health, nutrition, continence, medication, daily activities and cognition. For every £1 invested in physiotherapy rehabilitation into falls services, £4 is saved across health and social care services (Chartered Society of Physiotherapy).

4.5 A published economic evaluation provided an estimate of the cost to health and social care services in Scotland of managing the consequences of falls in excess of £470 million, and without intervention this is set to rise over the next decade as our population ages and the proportion with multimorbidity and polypharmacy (service users in receipt of multiple drugs to treat conditions) grows.

4.6 The national falls and fracture prevention strategy was under development until the COVID-19 Pandemic, however is currently paused. NHS Tayside and the three health and social care partnerships have developed a Tayside Falls Prevention and Falls Management Strategic Framework (Appendix 1).

4.7 The framework sets out 12 commitments for Tayside to achieve in the next three years. The Tayside commitments are listed below, demonstrating how these align to the requirements of the National Up and About Framework:

Tayside Commitments		Up and About Framework			
		Stage One	Stage Two	Stage Three	Stage Four
Activity and Awareness	Understand the views of the public and service providers to help develop our future offer	✓	✓	✓	✓
	Offer of a range of lifelong opportunities to enable people to improve and maintain their strength, balance, and mobility	✓	✓		✓
	Provide easy to access signposting to the information and resources	✓	✓	✓	✓
Sharing and Communication	Develop and share clear and consistent pathways across Tayside		✓	✓	✓
	Build our multi-professional networks across Tayside	✓	✓	✓	✓
	Use consistent, high-quality documentation across the system		✓		✓
Education and Training	Provide accessible evidence-based information and reference material	✓	✓		✓
	Support all staff in Tayside to complete the training relevant to their role	✓	✓	✓	✓
	Provide multi agency training for shared learning	✓	✓	✓	✓
Data	Understand currently available data and develop processes for sharing, analysis, understanding and learning		✓	✓	✓
	Develop a single fall and falls prevention data and measurement framework for the Tayside pathway		✓	✓	✓
	Share and communicate our learning from data to offer assurance and drive improvement	✓	✓	✓	✓

5.0 DATA SUMMARY

5.1 During 2022, Dundee had the highest rate of hospital admissions due to a fall in Scotland. The Dundee rate was 33.1 (869 falls), compared with a rate of 22.2 for Scotland (23,862 falls). Dundee also had the highest rate across Tayside as the rate in Perth and Kinross was 25.5 (943 falls) and 5th highest in Scotland and 25.1 in Angus (715 falls) which was 8th highest in Scotland. Note calendar year 2022 is the most recent benchmarking data that can be used for

public reporting as agreed by Public Health Scotland. Financial year 22/23 data will be published by Public Health Scotland in Q4 2024.

5.2 The rate in Perth and Kinross was lower than in Dundee, although the number of hospital admissions due to a fall was higher than Dundee (the rate was lower due to the higher age 65+ population in Perth and Kinross).

5.3 The number of hospital admissions due to a fall has increased for all three Tayside Partnerships, particularly over the last five years.

5.4 A large proportion of admissions due to a fall had no recorded operation/procedure (67.5%). Of these admissions, the most common primary diagnosis was 'open wound of head' (13%) followed by 'superficial head injury' (13%) and 'other unspecified injury of head) (11%).

5.5 30.2% of admissions due to a fall had a length of stay of less than one day and 23% were discharged the following day, making a total of 53.2% of admissions discharges either the same or the following day.

5.6 In order to achieve the same rate as for Scotland, Dundee would need to reduce the number of falls related hospital admissions from 869 to 580, a reduction of 289 falls (33% less than the number of falls-related hospital admissions in Dundee during 2022).

6.0 CONTEXT

6.1 While we may not be anticipating the very large increases in the 65+ age group that will affect some other parts of Scotland, we still expect to see an increase of 38% in the population aged over 75 by 2043. The 75+ and 90+ age groups, where there will be the largest increase in numbers, are groups who increasingly rely on unpaid family care, and health and social care services, as they become more frail.

6.2 Dundee has high levels of deprivation with a wide gap between the richest and poorest communities. Overall Dundee is the fifth most deprived local authority area in Scotland. Seven out of eight Dundee LCPP areas contain postcodes which are of the most deprived in Scotland. More than half of those living in Lochee, East End and Coldside live in the 20% most deprived areas of Scotland.

6.3 A higher percentage of people in Dundee live with one or more health condition than in Scotland as a whole. East End, Coldside and Lochee are the LCPP areas with the highest levels of deprivation and they also have the highest rates of people experiencing multiple health conditions compared with the more affluent parts of Dundee and Scotland. People in Dundee experience age associated ill health earlier in life than many other areas due to lifestyles associated with deprivation.

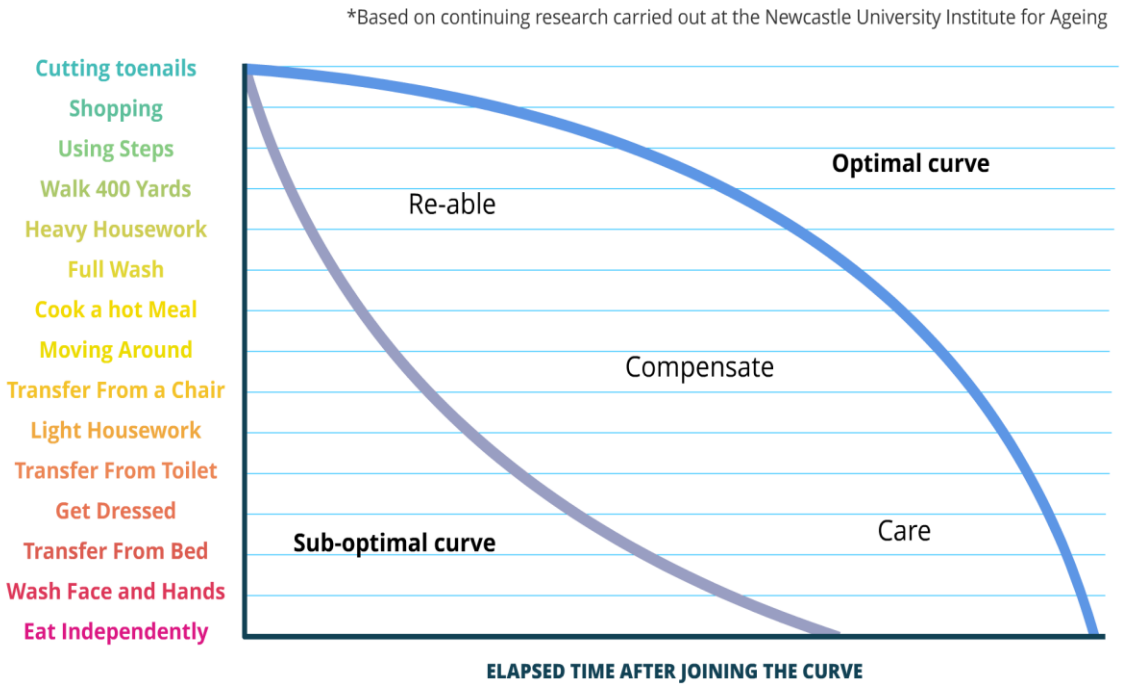
6.4 Evidence across a range of issues such as attainment, health, mental health and substance misuse highlights a strong correlation between poverty and poorer life outcomes and this association is clearly visible in Dundee. In addition to the frailty and ill health which is prevalent in the ageing population, many younger people are experiencing health conditions earlier in life as a result of lifestyles associated with deprivation. Looking after their own health may be more difficult for people with long term conditions including mental illness and disabilities.

6.5 In Dundee, the model of care takes into account the increased frailty of some older people and instead of sending those people who have had no procedures and are medically well back home, they are admitted to a ward in order to assess, monitor, hydrate and ensure adequate care and support is available on their return home.

6.6 The responsibility to reduce the rate of hospital admissions as a result of a fall is extremely wide ranging and is not solely the responsibility of the Falls Service. The deprivation and associated multi-morbidities and health inequalities in Dundee means that the risk of falling for some people is higher than elsewhere in Scotland and the model of care is enhanced as a response to the high levels of frailty, co-morbidities and deprivation in the population.

6.7 It is widely accepted that around 25% of how we age is genetic, and around 75% is about the choices we can and do make. At least some of the difference in health span between areas of different socio-economic status seem to be explained by less good choices being available to people from more deprived communities, and lower educational attainment.

6.8 The falls work across Dundee has used the lifecurve model to support professionals and individuals have conversations about lifestyle decisions. (See below)



7.0 PREVENTATIVE AND PROACTIVE APPROACH

7.1 Dundee Falls Group

The Dundee Falls Group is a multi-agency group which meets every 2 months. The group is co-chaired by the Dundee HSCP Operational and Strategic Leads for Falls. The key aims for the Dundee Falls Group are to:

- Reduce the number of falls of individuals, harm from falls and consequential costs attached including emergency admissions, extended length of stay in hospital, additional invasive hospital interventions, increased health and social care costs and care home admissions.
- Monitor and continuously improve services to target people for whom a serious fall is more likely, and take effective action to reduce the risks of falling.
- Work in partnership to improve safety within the general environment including where people live, community settings, care homes, hospitals and other service buildings.
- Work in partnership to provide services and interventions which improve strength and balance and maintain bone strength so falls and fractures are less likely to occur.
- Ensure that where falls occur of individuals in the community, hospital admission is avoided wherever possible, effective support to prevent further falls is provided and that where falls occur in hospitals and care homes, there is a safe and effective response.
- Following a fall, ensure a seamless transition for individuals across primary, secondary and tertiary care.
- Heighten awareness about measures to prevent falls through health promotion and self management.

- Promote early and effective identification of people at risk with clear actions to reduce risk of falls.
- Ensure appropriate evidence based services are in place to meet the needs of people at risk of experiencing falls including robust falls assessment and effective intervention programmes for people who fall.
- Utilise emerging technologies aimed at reducing risk of falls and early detection of falls.
- Embed effective communication structures and pathways through a whole system cross organisational collaborative approach and coordinated interventions and strengthened partnerships.

7.2 A wide array of representatives attends the falls meetings. These include representatives from:

- Social Care Response Team
- Physiotherapy
- Occupational Therapy
- Podiatry
- Nutrition and Dietetics
- In-Patient Reps
- Care Homes
- Independent Living Team
- Scottish Ambulance Service
- Scottish Fire and Rescue Service
- DHSCP Strategic Planning
- Data Analysts
- Community Nursing
- Royal Voluntary Service
- Dundee Volunteer and Voluntary Action
- Social Isolation Team
- Dundee Falls Service
- Independent Sector Lead.

The work of the falls group links across the 4 stages listed below from the Up and About Framework:

Stage 1: Supporting active ageing, health improvement and self-management to reduce the risk of falls and fragility fractures

Stage 2: Identifying individuals at high risk of falls and/or fragility fractures

Stage 3: Responding to an individual who has just fallen and requires immediate assistance

Stage 4: Co-ordinated management including specialist assessment

7.3 **Stage 1:** This stage emphasises the importance of supporting individuals to take responsibility for their own health, wellbeing and safety and having a central role in reducing their risk of falls and fractures e.g. by taking opportunities to improve their strength and balance and address other causative factors in falls. The emphasis is on self-care, supported self-management, health education and promotion to enable active ageing and minimise the risk of falls and fragility fractures.

Specifically, people:

- Have an opportunity to engage in health promotion and lifelong learning around health improvement and minimising falls and fracture risk
- Have an opportunity to access appropriate services and organisations which aim to support the maintenance of health and wellbeing, a safe home environment and a safer community environment.

Many activities and interventions at this stage contribute to healthy and active ageing; some are more specific to falls and fracture prevention. The role of physical activity warrants a

special mention. Specific balance and strength exercise programmes have been proven to reduce further risk of falling. Active older adults are less likely to fall and suffer less serious consequences if they do. Physical inactivity is detrimental to physical and mental health and can adversely affect an individual's resilience and ability to adapt.

7.4 **Stage 2:**

- A person at high risk of falls and fragility fractures is identified and this triggers appropriate intervention or referral for appropriate intervention.
- A person is identified *either* (a) when they report a fall, present with a fall or with an injury due to a fall, *or* (b) opportunistically when a health or social care practitioner, or partner (Scottish Fire and Rescue, for example) asks about falls.
- A level 1 conversation aims to identify individuals at high risk of falling; it is not intended to determine all contributory factors or specific interventions required.

7.5 **Stage 3:**

- A person has fallen and has requested or requires immediate assistance.
- The person may have sustained an injury and/or be unwell or is asymptomatic, appears uninjured, but is unable to get up from the floor/ground independently.
- Appropriate response, onward referral and intervention at this stage may prevent further falls, unnecessary hospital admission, functional decline (frailty) and unwanted consequences of falls.

This stage is when an individual has just fallen and requires immediate assistance and access to services that provide an effective, safe and timely response and is relevant to those:

- who have fallen, but are not conveyed to hospital following the fall but are considered for further assessment of falls and fracture risk and offered this where indicated.
- who have received treatment for any injury due to a fall, or treatment for any acute medical condition related to a fall and are offered further assessment of falls and fracture risk.

7.6 **Stage 4:**

- An individual has been identified as being at high risk of falling and/or sustaining a fracture.
- Falls risk and fracture risk management are considered in combination with services for falls and osteoporosis operationally linked or dovetailed.
- Interventions aim to identify, then minimise, an individual’s risk factors for falling and sustaining a fracture as well as restoring function following a fall(s).
- Timely, appropriate and co-ordinated management may lead to reduced ED attendances and hospital admissions including admission with a fragility fracture.

7.7 **Assessment:** Older people identified as having a high risk of falling should be offered a multi-factorial assessment /screening to identify contributory risk factors, this should include a comprehensive falls history, medication review and assessments of their fracture risk, gait and balance, home environment, risk factors for postural hypotension, cognition, feet/footwear and diagnostic tests. This may be in the form of:

- **Level 2 Screening –** A multifactorial falls risk screening process aims to (a) identify risk factors for falling and for sustaining a fragility fracture, and (b) guide tailored intervention. Following this an individualised multifactorial action plan, agreed with the person (and carers, if appropriate), which addresses risk factors and issues identified in the level 2 screen should be provided. The plan should reflect the person’s needs, goals and choices.
- **Level 3 Specialist Assessment and intervention** aims to further assess the risk factors identified, with a view to providing tailored interventions to reduce the risk of falls and/or

fractures. Evidence-based specialised multi-disciplinary falls assessment services should be available for all older adults who fall or are at risk of falling across Tayside.

7.8 **Treatment**: Following assessment, an older person is considered for an individualised, multi-factorial intervention programme aimed at minimising the identified risks for falling and/or sustaining a fracture, promoting independence, and improving physical and psychological function. Interventions may include; pharmacological management of osteoporosis, strength and balance exercises, medication modification/withdrawal, interventions to mitigate identified home hazards, promotion of the safe performance of daily activities, management of postural hypotension and heart rate or rhythm abnormalities, management of foot problems, vision correction, nutritional requirements, self-management training.

7.9 The combined effort from a wide range of agencies is critical in ensuring the delivery of the stages outlined above. The reach into communities and the range of skills and expertise that the wider team brings is essential in supporting people to minimise falls across Dundee.

8.0 RISK ASSESSMENT

Risk 1 Description	The risk of not reducing the rate of hospital admissions due to a fall could affect outcomes for individuals and their carers and spend associated with unscheduled hospital admissions if the Partnership's performance does not improve.
Risk Category	Financial, Governance, Political
Inherent Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15
Mitigating Actions (including timescales and resources)	- The in depth analysis included in this paper and appendix will be used to inform senior managers. - The Tayside Falls Prevention and Management Framework will provide an infrastructure to monitor progress in the community, hospital and care homes towards preventing the incidence of falls and reducing the negative effect of falling on people who fall and their carers. - The priority areas for improvement (section 8.0) have been developed to reduce the rate of hospital admissions as a result of a fall.
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6
Approval recommendation	The risk level should be accepted with the expectation that the mitigating actions are taken forward.

9.0 POLICY IMPLICATIONS

This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

10.0 CONSULTATIONS

The Chief Officer, Head of Service - Health and Community Care and the Clerk were consulted in the preparation of this report.

11.0 DIRECTIONS

11.1 The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

Direction Required to Dundee City Council, NHS Tayside or Both	**Direction to:**	
	1. No Direction Required	✓
	2. Dundee City Council	
	3. NHS Tayside	
	4. Dundee City Council and NHS Tayside	

12.0 BACKGROUND PAPERS

None.

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Chief Finance Officer

DATE: 25 January 2024

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Local Intelligence Support Team, PHS

Tayside Falls Prevention and Falls Management Strategic Framework

Vision:

Promoting physical and mental health and wellbeing to maximise safe balance, mobility and independence.

Aiming to prevent falls and reduce the consequences of falling but offering high quality support and intervention when required.

ANGUS Health & Social Care Partnership

Dundee Health & Social Care Partnership

NHS Tayside

Perth and Kinross Health and Social Care Partnership

Supporting healthy and independent lives

Contents

Version 1.0
2023 - 2027

Date completed	20/10/23	Planned review	Sept 2027

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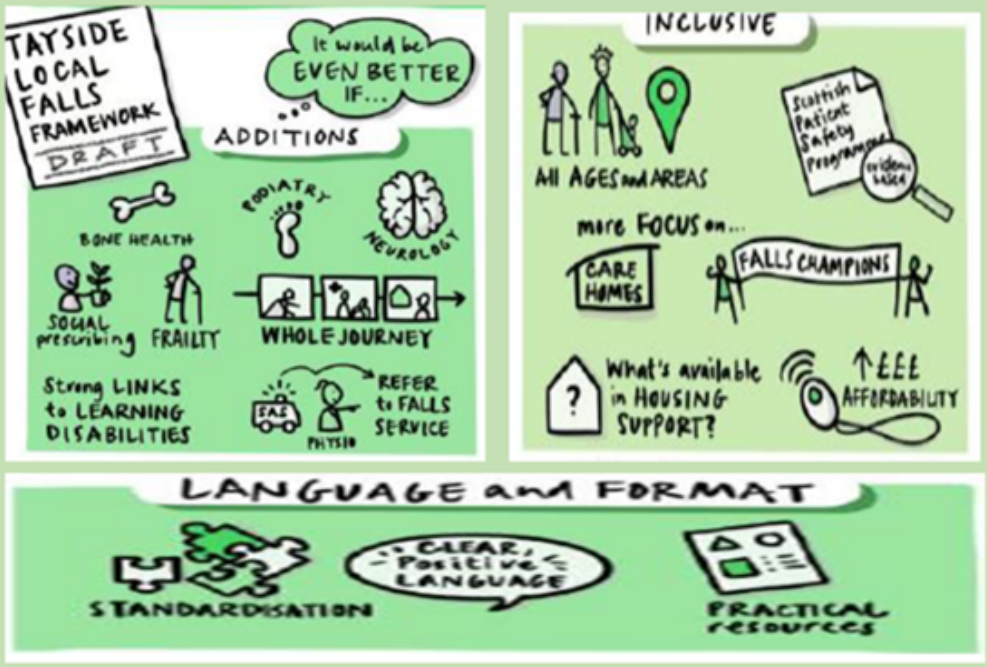


What do we aim to achieve?

This is a resource primarily for staff working across Health and Social Care services but also links to our partner agencies across local authority, third sector and other agencies.
This framework focuses on supporting people of all ages and abilities to live lives that are as healthy, independent and active as possible. This includes the general population and those who have been identified as being at increased risk of falling.
If people fall, the services that respond to their needs and support them to recover will be optimised to support their return to active mobility.

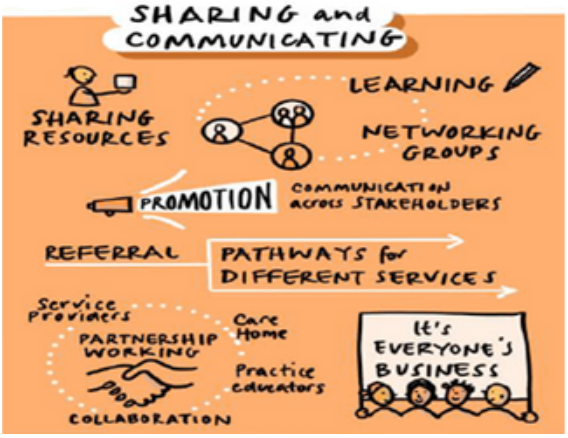
This document describes a three-year improvement plan for Tayside which utilises what we know about preventing falls and falls with harm, how to reduce their impact, and how health and social care, working with individuals and our partners can support people.

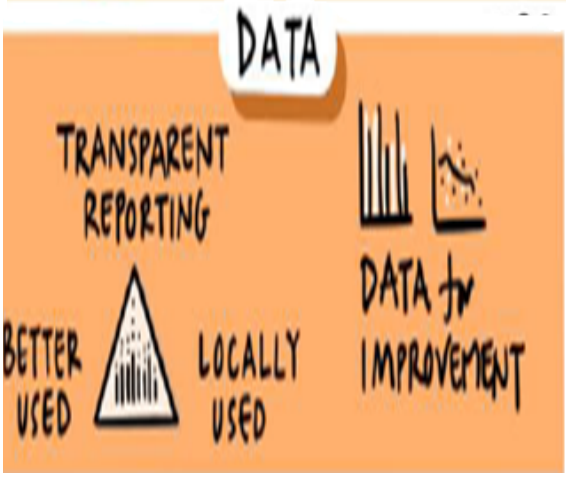
Through developing and providing services in the most beneficial and effective way we aim to reduce the personal and financial impact of emergency admissions, extended lengths of stay in hospital, invasive treatments, increased costs of health and social care in the community and improve quality of life.

This document describes the Tayside strategic commitments and is underpinned by the best available, explicit evidence drawn from a number of national programmes, guidelines and publications

Our Commitments:

The aim of reducing the occurrence of falls and falls with harm and optimising the experiences for those who access services will be achieved between 2023 and 2027 across Tayside through work to achieve the following commitments:





Activity & Awareness

1. Understand the views of the public and service providers to help develop our future offer

2. Offer of a range of lifelong opportunities to enable people to improve and maintain their strength, balance and mobility

3. Provide easy to access signposting to the information and resources

Sharing & Communicating

4. Develop and share clear and consistent pathways across Tayside

5. Build our multi-professional networks across Tayside

6. Use consistent, high quality documentation across the system

Education and Training

7. Provide accessible evidence based information and reference material

8. Support all staff in Tayside to complete the training relevant to their role

9. Provide multi agency training for shared learning

Data

10. Understand currently available data and develop processes for sharing, analysis, understanding and learning across the Tayside Group

11. Develop a single falls and falls prevention data and measurement framework for the Tayside pathway

12. Share and communicate our learning from data to offer assurance and drive improvement

How we defined our Commitments:

Tayside hosted a Falls and Falls Prevention spotlight event in November 2022 to learn from all stakeholders of work that is ongoing and to identify and agree priorities for the next 3 years. This event informed the development of the 12 commitments listed on page 3.

Work to achieve each of these commitments will consider their relevance across all stages of a person's journey of care, this has been influenced by the Scottish Government's 'Up and About framework' (2014) and Healthcare Improvement Scotland's Scottish Patient Safety Programme Acute Adult Programme (2021)

Stage 1: Supporting active ageing, health improvement and self management to reduce the risk of falls and fragility fractures

Perth and Kinross HSCP shared innovative examples of mobility stations installed at local Care homes to support residents to follow simple activity programmes and maintain their strength, balance and active mobility

Stage 2: Identifying individuals at high risk of falls and/or fragility fractures

Ninewells Neurology ward shared how they were able to identify factors which increased patient's risk of falling. Through this they were able to restructure their working routines to significantly reduce falls on the ward whilst also improving MDT and patient communication

Stage 3: Responding to an individual who has just fallen and requires immediate assistance

Dundee HSCP shared a project carried out with Scottish ambulance service to offer an immediate response from a Paramedic and a Physiotherapist to someone seeking assistance. This reduced unscheduled admissions to hospital and offered a home first approach.

Stage 4: Co-ordinated management including specialist assessment

Angus HSCP shared how utilising level 1, level 2 and level 3 assessments had helped an individual in Angus. A coordinated MDT assessment and action plan supported someone who had fallen and was fearful of falling again so had limited their social activities.

These are only some of the examples shared. Others can be read in the report of the spotlight event by clicking here: Falls Spotlight Event Feedback Report.
(Thank you to Hazel White Design for these images produced from the event.)
The work to maintain or improve care and experience across all 12 commitments will consider all stages of the journey to support prevention, offer early intervention and rehabilitation where this is required across community and acute settings.

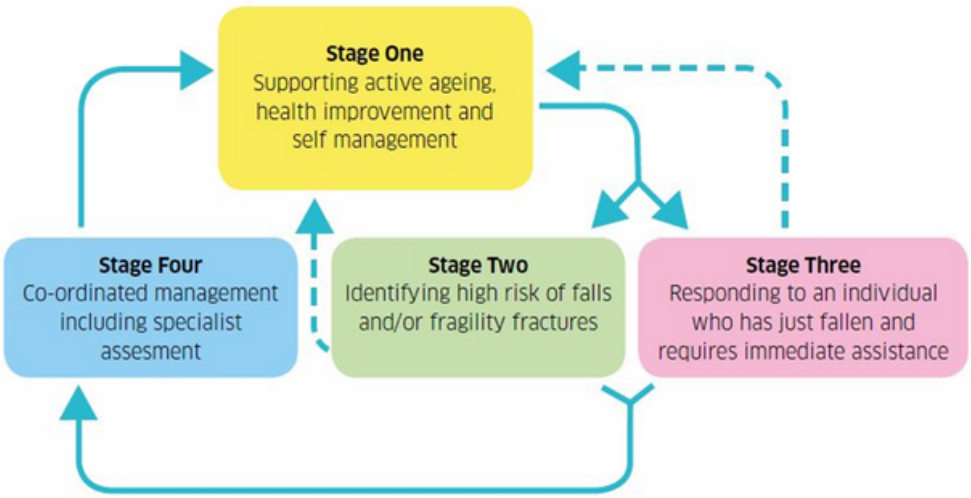


Figure 1 Up and About Pathway, QIS 2010

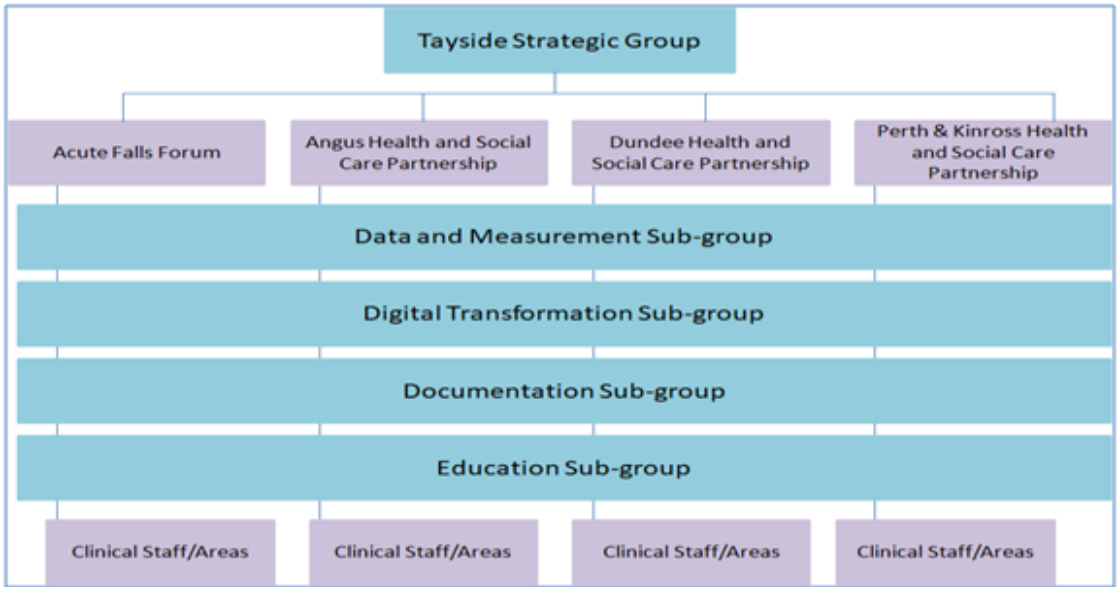
The Scottish Patient Safety Programme Acute Adult Programme is a national quality improvement programme that aims to improve the safety and reliability of care and reduce harm. A Falls Prevention Driver Diagram and Change Package has been co-designed and co-produced with clinical and quality improvement experts. This package is a resource to support NHS (National Health Service) Boards with falls improvement work. The aim of the change package is to provide evidence-based guidance to support falls prevention and patients in hospital settings. It brings together what is known about best practices and processes based on evidence from literature, research, and the experiences of others.

The 12 Tayside commitments include improvement ambitions across all 4 stages of the 'UP and About' Framework model. This is represented by this Matrix diagram below:

	Tayside Commitments	Up and About Framework Stages			
		1	2	3	4
Activity and Awareness	Understand the views of the public and service providers to help develop our future offer	✓	✓	✓	✓
	Offer of a range of lifelong opportunities to enable people to improve and maintain their strength, balance, and mobility	✓	✓		✓
	Provide easy to access signposting to the information and resources	✓	✓	✓	✓
Sharing and Communication	Develop and share clear and consistent pathways across Tayside		✓	✓	✓
	Build our multi-professional networks across Tayside	✓	✓	✓	✓
	Use consistent, high-quality documentation across the system		✓		✓
Education and Training	Provide accessible evidence-based information and reference material	✓	✓		✓
	Support all staff in Tayside to complete the training relevant to their role	✓	✓	✓	✓
	Provide multi agency training for shared learning	✓	✓	✓	✓
Data	Understand currently available data and develop processes for sharing, analysis, understanding and learning		✓	✓	✓
	Develop a single fall and falls prevention data and measurement framework for the Tayside pathway		✓	✓	✓
	Share and communicate our learning from data to offer assurance and drive improvement	✓	✓	✓	✓

How we aim to achieve this:

We will work collectively to ensure a consistent approach whilst enabling and sharing local activity to meet the needs of local populations.



Through enabling local groups and Tayside strategic groups we will drive activity for improvement and assurance.

- Improvement activity will be supported by four Tayside wide groups and Pan-Tayside subgroups focusing on data and measurement, education, digital transformation, and documentation
- Shared learning will occur with linked group sessions biannually
- An annual development event will enable learning and sharing.
- Progress will be monitored and measured by the strategic group
- Biannual reports of progress will be shared with Tayside Care Governance group to provide organisational assurance.

Click here to access the Tayside Falls Prevention and Management Framework Action Plan

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