ITEM No …7……..

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 12 FEBRUARY 2019**

REPORT ON: **FALLS PERFORMANCE AND ACTION PLAN**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC6-2019**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide assurance that issues in relation to falls related hospital admissions in Dundee have been identified and that an associated action plan has been developed to address the identified issues.

2.0 RECOMMENDATIONS

It is recommended that the Performance and Audit Committee (PAC):

2.1 Notes the contents of this report.

2.2 Notes the current activity to reduce falls related hospital admissions, prevent incidences of falls and support people who have fallen or who are at risk of a fall.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 BACKGROUND INFORMATION

4.1 Falls data was presented to the PAC on 29 May 2018 (Article IX of the minute of the meeting refers) with the PAC requesting further detailed identification of issues and an associated action plan to address these issues.

4.2 National Health and Wellbeing Indicator 16 is “Falls rate per 1,000 of >65 population”. The focus of this indicator is the number of falls that occur in the population (aged 65 plus). The indicator is measured using data gathered by Information Services Division (ISD). .

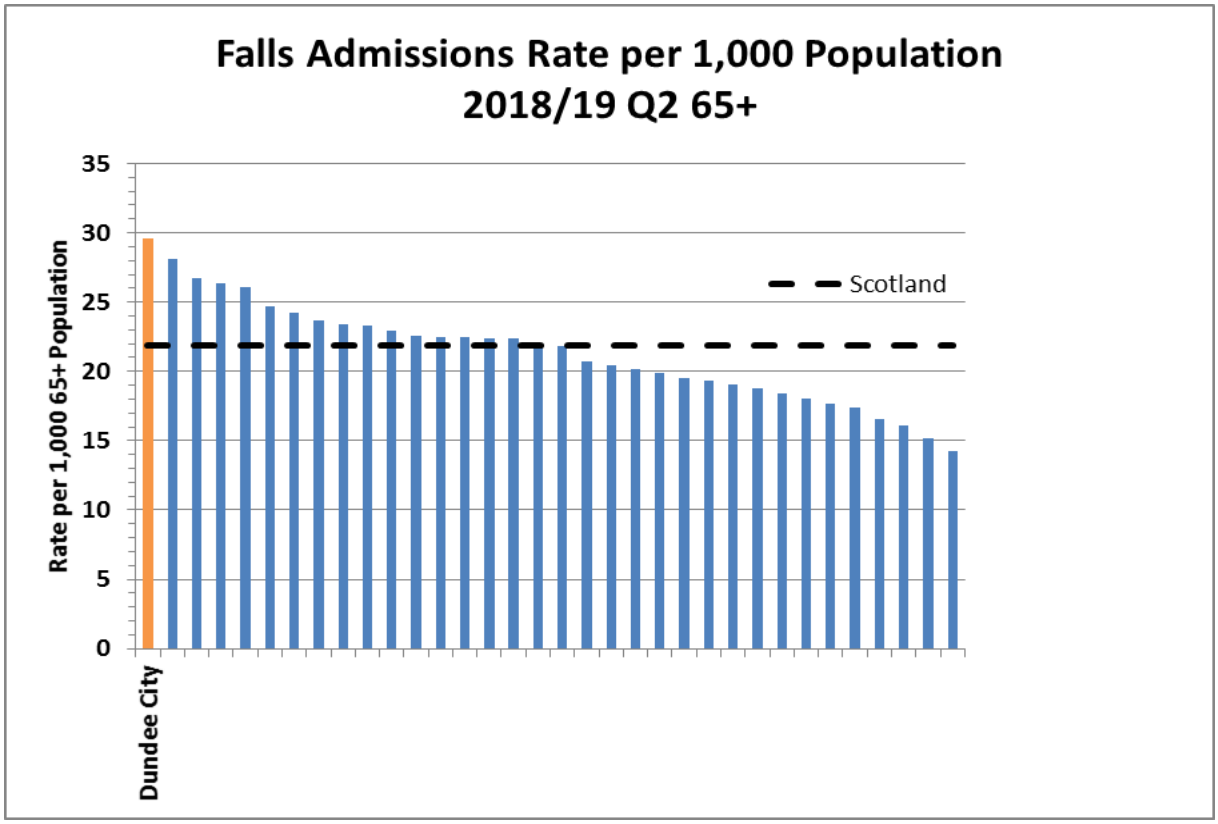
4.3 This indicator is monitored in the Quarterly Performance Report and was included in the Q3 report (presented to the PAC meeting on 19 July 2017, Article VIII of the minute refers) and the Annual Performance Report (presented to the IJB held on 29 August 2017, Article V of minute refers). Both reports highlighted the particularly high rate of hospital admissions within the Dundee population of people aged 65+ as a result of a fall.

4.4 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; eyesight, footwear, foot condition, bone health, nutrition, continence, 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 recently published economic evaluation provided an estimate of the cost to health and social care services in Scotland of managing the consequences of falls is in excess of £470 million and without intervention is set to rise over the next decade as our population ages and the proportion with multi-morbidity and polypharmacy (service users in receipt of multiple drugs to treat conditions) grows.

5.0 WHAT THE DATA IS TELLING US

Falls Admissions Rate 65+ Benchmarking 2018/19 Q2



Source: Core Suite of Integration Indicators December 18 (ISD)

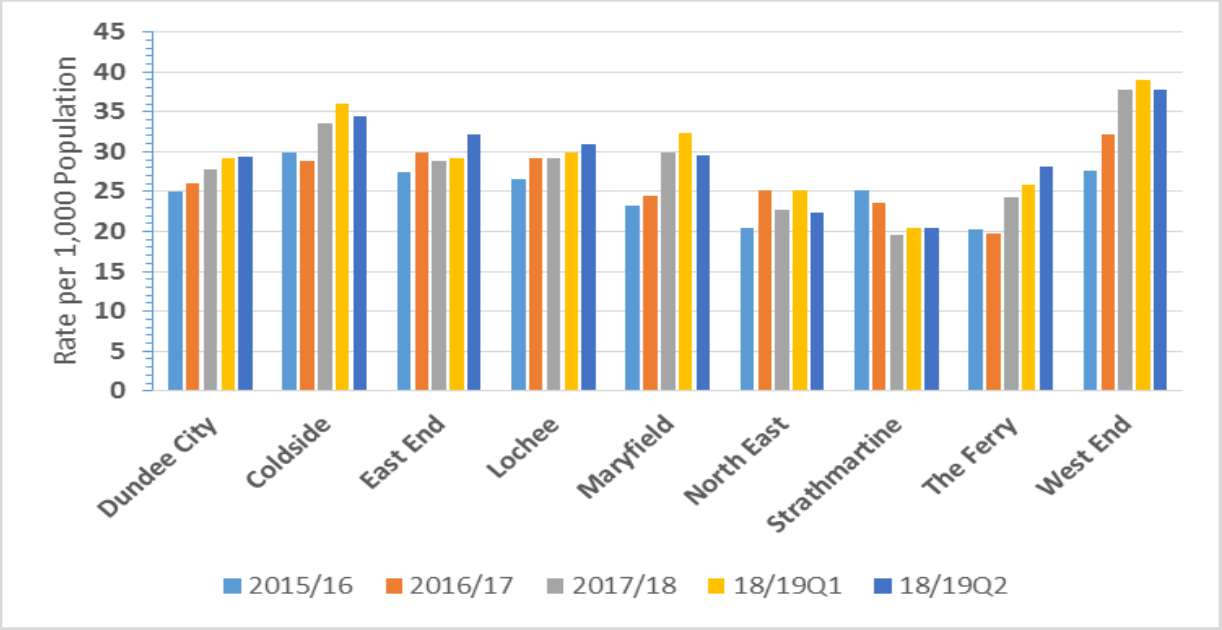
- The rate of hospital admissions due to a fall in Dundee was higher than the Scottish rate.
- Dundee is the poorest performing partnership in Scotland.

Rate of Falls Admissions per 1,000 Population– 18/19 Q2 65+ by Locality

	2015/16	2016/17	2017/18	18/19Q1	18/19Q2	18/19Q3	2018/19
Dundee City	24.9	26.0	27.8	29.2	29.3		
Coldside	29.9	28.9	33.6	36.0	34.4		
East End	27.4	29.8	28.8	29.1	32.2		
Lochee	26.6	29.2	29.2	29.8	30.9		
Maryfield	23.2	24.4	29.9	32.4	29.4		
North East	20.5	25.1	22.7	25.1	22.3		
Strathmartine	25.2	23.5	19.5	20.4	20.4		
The Ferry	20.3	19.7	24.2	25.9	28.1		
West End	27.6	32.1	37.7	38.9	37.7		

Source: NHS TAYSIDE BSU

Rate of Falls Admissions per 1,000 Population– 18/19 Q2 65+ by Locality



Source: NHS TAYSIDE BSU

Difference from 2015/16 Baseline to 2018/19 Q2

- 17.67% increase in Dundee rate.
- The Dundee rate has shown an increase year on year since the 2015/16 baseline.
- Increases were shown in all Localities except Strathmartine.

Performance Trend between 18/19 Q1 and 18/19 Q2

- Improved rates in Coldside (4.44%), Maryfield (9.26%), North East (11.16%) and West End (3.08%)
- No change in Strathmartine
- Increased rates in East End (10.65%), Lochee (3.69%) and
- The Ferry (8.49%)

Variation across Localities in 2018/19 Q2

- West End had the highest rate of falls in Dundee with 37.7 falls related hospital admissions per 1,000 population.
- Strathmartine had the lowest rate with 20.4 falls related hospital admissions per 1,000 population.

5.1 The number of monthly fall admissions in Dundee, where a fall occurred in the home, has not seen any significant changes. The number of monthly fall admissions in Dundee, where a fall occurred outside the home or place of work, saw a significant increase in December 2017 which may be attributable to weather conditions.

5.2 The gap between fall admission rates of people who live in the most deprived (quintile 1) and the least deprived (quintile 5) has increased since 2014/15 Q4. In 2014/15 Q4, the fall admission rate for the people who live in the most deprived areas was 25% higher than the least deprived and this increased to 37% in 2017/18 Q3.

5.3 In 2016/17 there were 330 people who experienced a single fall admission, 45 people who experienced two fall admissions and 17 people who experience three or more falls admissions.

5.4 Of the people who experienced three or more fall admissions in 2016/17, nearly half had a home care package. This fell to around 30% for people who had experienced 1 or 2 falls.

5.5 Arthritis was the most common long term condition for people who experienced a fall admission in 2016/17. For those who experienced 3+ falls, around half had arthritis. Chronic heart disease and dementia were also prevalent with over a third of people who experienced multiple falls having one of these conditions.

5.6 The average cost to the health service of providing treatment to people who had a single fall admission in 2016/17 was £18,000 per person. This increased to £25,000 for people who had 2 fall admissions and £27,000 for those who had three or more fall admissions.

5.7 Analysis of people who had multiple falls has shown that all people with three or more falls were known to the AHP Services, and 60% were also known to the Psychiatry of Old Age Out Patient Service. Of those that fell twice 90% were known to AHP Services. Services were provided across care homes a d in people's own homes too.

6.0 CURRENT SERVICE MODEL

6.1 **Falls Classes**

There are currently six falls prevention classes held each week in three locations – Mackinnon Centre, Kings Cross Hospital and Royal Victoria Hospital and these classes accept both self, carer and professional referrals. These classes are organised and run by the community rehabilitation and falls team. It is intended that the location of falls classes will be reviewed in line with locality plans and neighbourhood level data about falls. These classes are supported by physiotherapists and support workers and are aimed at people who have fallen or who have a fear of falling. The classes improve strength, balance, confidence and function. Education is also provided to participants on reducing the risk of falls in the future. The evidence base behind providing classes to prevent falling states that balance and strength must be challenged in order for improvements to be seen. For this reason there are three levels which are aimed at different levels of ability and frailty. There is also an Otago based maintenance class within the community, to prevent re-referrals and recurrent falls. The current waiting list is approximately 15 weeks from referral, however following an initial assessment people are offered advice and basic exercises to prevent falls while they await their place at the class.

6.2 **Education**

Education and falls prevention roadshows are being rolled out to established groups in the community in collaboration with other services within the Dundee Health and Social Care Partnership. In addition to this, training has been provided to physiotherapy community staff, ambulance crews, social care response workers, medical students and care home workers.

6.3 **Community Equipment Loan Service**

Dundee and Angus Health and Social Care Partnerships launched a new shared community equipment loan service for people with disabilities living in Dundee and Angus. The new venture is based at the Dundee Independent Living and Community Equipment Centre in Dundee and provides, delivers, installs, repairs, maintains and recycles a range of equipment to help people of all ages living in Dundee to live independently. It also provides a technical advice service and carries out risk assessments with medical and care professionals, both in-store and in people's homes.

6.4 **Referral Pathway Redesign**

GP referrals into medicine for the elderly services are now screened by the falls service instead of by medical teams. Patients are then signposted to the most appropriate clinic (physiotherapy, occupational therapy, nurse) or medical. This has reduced the time patients wait to be seen by the most appropriate person. Previously there was a waiting time of up to 16 weeks to access the medical clinic and then referred to the multidisciplinary team. This has been reduced to 4-6 weeks for the medical clinic and 1-2 weeks for the multidisciplinary team.

6.5 **Support in Care Homes**

The community rehabilitation team provided support to care home employees, particularly regarding the Otago falls programme. All care homes in Dundee that expressed interest in receiving support have been provided with training to employees. There was a high uptake in training in the care homes located in Broughty Ferry. The care homes are expected to roll out training and the quality of the approach to prevent falling in care homes is expected to vary. Further work is required to ensure a sustainable model is in place across Dundee care homes.

6.6 **In Patients and Out Patients**

On a daily basis (Monday to Friday) physiotherapy services identify from referred patients aged 65+ who have either fallen twice in the last 12 months or who are at risk of a fall. They undertake balance, gait and strength assessments to reduce the risk of future falls. Patients are provided with strength and balance exercises, a falls booklet and referred to either the community rehabilitation team or the falls service.

6.7 **Collaborative Working with Scottish Ambulance Service and Other Stakeholders**

Services worked together to develop a pathway for use by the Scottish Ambulance Service and this has recently been implemented to help avoid the conveyance of service users that have fallen, but are uninjured, to hospital. This involves referring directly to the falls service and the first contact, out of hours and social care response teams. Work is currently being undertaken to further develop cross-sector working and promote the importance of all these services, recognising potential falls risk to the service user and referring for assessment as appropriate. An educational falls pack has been developed for service users. The social care response team is assessing IT systems to identify patients who have increased frequency of falling and refer to the falls service. Scottish Ambulance Service, the social care response team and patients can now refer directly to the falls service. This has improved the identification of people at risk of a fall.

6.8 **Emergency Department (ED)**

On a daily bases the falls team receives a list of people who attended the ED following a fall. The team contacts each person by telephone and then signposts to information and refers to services which can support underlying issues such as balance, substance misuse, polypharmacy and sensory impairment. The musculoskeletal and community rehabilitation physiotherapy teams provides support to people with dischargeable injuries, such as a shoulder rotator cuff tear, or stable fracture. In addition to a telephone call, people receive a pack in the post which includes a cover letter, falls prevention booklet, self / professional / carer referral form for the falls service and also the exercise classes. The pack also includes information about DIAL – OP service which signposts to all services and classes in Dundee. This includes a range of voluntary sector supports including a morning call service to check a person is safe and well.

7.0 THE ENVIRONMENT – STREET LIGHTING AND FOOTWAY CONDITION

7.1 The sole function of street lighting is to light the road to ensure Dundee City Council meets their duty of care to road and footpath users. This has a direct link with falls away from the home as adequate street lighting ensures that obstacles, including uneven surfaces are visible during the hours of darkness. Work has commenced on a two year programme of fitting more than 18,000 new white LED lights across Dundee at a cost of £4.8m.

7.2 In relation to the footways in Dundee there were a total of 9 CAT 1 defects in 2017/18, with the Scottish average being 21. All CAT 1 defects were made safe within expected response times. The cost of all maintenance work on footways in Dundee for 2017/18 is £823,762, against a Scottish average of £718,348.

8.0 PRIORITY AREAS FOR IMPROVEMENT

8.1 The Tayside Falls Prevention and Management Framework 2018-2022 has recently been developed and is currently out for consultation. This provides the 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 Framework is organised under four stages:

Stage 1 – Supporting active ageing, health improvement and self management to reduce the risk of falls.
Stage 2 – Identifying individuals at 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 assessments.

8.2 In addition to the Tayside Framework, there is recognition that more still needs to be achieved at a Dundee and locality level and the following actions have been identified:

The main priorities and focus for the falls work will centre on the following areas:

- Supporting the SAS Falls and Frailty Pathways in developing non-conveyance to hospital options, supporting patients remaining in their own homes.
- Dundee Health and Social Care Partnership will have systems and processes established to enable a broad spectrum of services and partner agencies to identify people at high risk of falls. This may be through a level 1 conversation enquiring about falls and/or completion of a level 1 falls referral tool.
- Opportunities are created for individuals to participate in regular and life-long exercise programmes that include strength and balance to minimise falls risk and prevent further falls and frailty. In developing appropriate programmes, links with local leisure services, volunteer services, walking groups and local exercise groups will be considered as well as training volunteers and staff working with older people including care at home, care homes, day care and sheltered housing.
- Review of data available to support targeted approach of falls prevention work (NHS, Council, SAS, and Fire & Rescue). This will allow us to explore neighbourhood level data to direct resources to areas most in need.

A number of additional actions have also been identified to support the falls agenda. A number of these actions will support the main priorities as well as developing alternative workstreams:

- Establish a multi-agency falls group to lead on development, implementation and sharing of best practice in relation to falls across Dundee City.
- Explore possibilities of using Celonis software to support enhanced understanding of patient flow through the system.
- Review Dundee Falls Pathway (established 2012) and ensure this remains contemporary practice. Update and enhance as required across multi agency teams.
- Hold a ‘re-launch’ event of the Dundee Falls Pathway with broad range of stakeholders once pathway is agreed across agencies.
- Dundee Health and Social Care Partnership will invest in a mechanism for engaging with local communities and the public to promote the importance of factors relating to falls: examples include: exercise, meaningful activities, nutrition for older people, fluid intake, smoking cessation, alcohol moderation, regular foot care, eyesight and hearing checks. Dundee Falls Prevention Roadshows will be provided on a monthly basis in targeted areas throughout 2019.
- Develop Life Curve Presentation to support enhanced understanding of aging process and options available to remain independent.
- Develop links with the Dundee City Council Road Maintenance and Street Lighting Partnerships to ensure early identification and resolution of areas highlighted as contributing to falls.
- Increased opportunities to heighten public awareness on falls prevention and fracture risks including falls prevention campaigns, media involvement, and presentations to older people groups plus raising awareness about specific websites on falls will be explored.

- Dundee Health and Social Care Partnership explore opportunities for a range of partners to provide 'home safety' visits which encompass falls safety alongside a range of other home safety hazards.
- Education provision to care homes regarding falls prevention will include enabling staff to provide exercise safely for care home residents, with residents having access to mainstream falls exercise classes as ability permits.
- Services providing a level 1 conversation will include GP's, community nursing, allied health professions, Scottish Ambulance Service and social care services including care at home, sheltered housing, community alarm, care homes. Consideration should also be given to the independent, voluntary and other statutory service including community optometrists, community pharmacists.
- All care homes across Dundee are required to ensure a suitable falls risk assessment is completed for all residents on admission to a care home and reviewed throughout their stay which identifies individuals at high risk of falling in accordance with the Care Inspectorate 'Managing falls and fractures in care homes for older people' good practice self assessment resource (Scottish Government, 2011).
- Supporting the SAS Falls and Frailty Pathways to enable referral to a range of community based services, including crisis care, intermediate care, assessment and rehabilitation services.
- Integrated community services (such as rapid response teams, intermediate care teams, assessment and rehabilitation teams), community AHP and nursing services providing specialist interventions following a fall, also provide a level 2 screen if the person has not already received one during the episode of care.
- Opportunities are created to improve skills and knowledge in relation to nutritional wellbeing and this is integrated into falls prevention at all levels.

8.3 Timescale for improvement

- Falls prevention is an ongoing challenge which can only be met by robust interagency working and development of community resources. A fall is the outcome of a complex interaction of risk factors, many of which are modifiable. The introduction of the Dundee Joint Falls Pathway aims to identify people at high risk of falling and intervene to reduce that risk. A successful pathway will deliver benefits to the population by improving quality of life, reducing morbidity and mortality and enabling more people to be independent for longer. Continued investment, mainly in people, is required in prevention services such as Otago and Revitalize before the benefits are realised in the acute and long term care settings. The implementation of this local pathway starts this process in Dundee and builds upon the excellent cooperation between all parties who believe in the importance of this work.
- A number of actions have been implemented. The cultural change to early intervention and prevention is ongoing and will take time to fully embed. The falls work seeks to create the opportunities for citizens to reduce the likelihood of falls, and to reduce the potential for harm following a fall, as well as ensuring that as broad a range of staff are able to identify and support those at risk, or potentially at risk, from falling.
- It is anticipated that changes to the falls data could begin to be noted by the end of 2019.

9.0 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 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.

11.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment and Risk Management. There are no major issues.

12.0 CONSULTATIONS

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

13.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 4 February 2019

Matthew Kendall
Allied Health Professions Lead