WELCOME!

Delivering The National Delivery Plan for the AHPs
The Prevention of Falls

Falls Leads WebEx

29 May 2014

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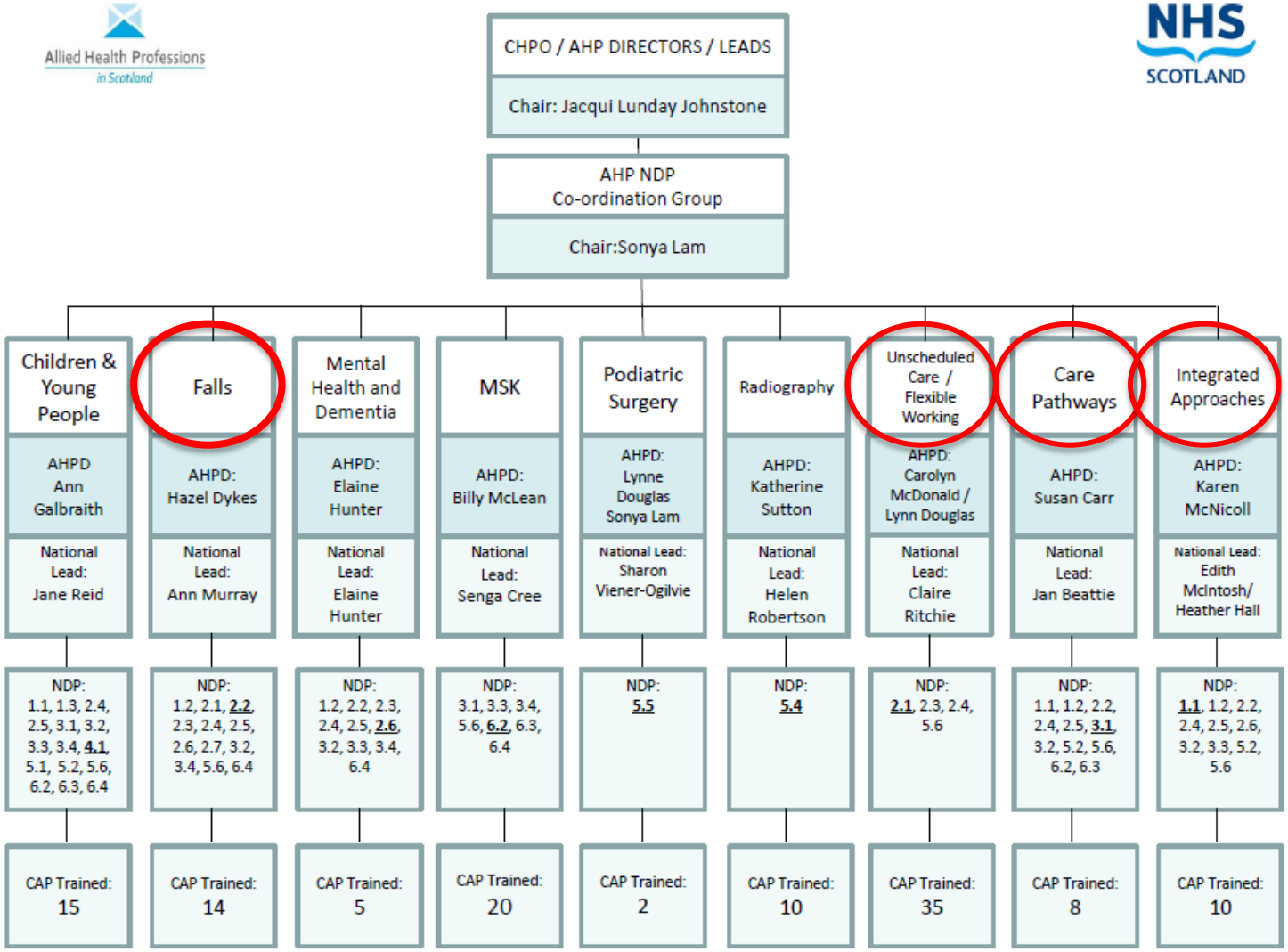
Outline of this session

- **NDP Governance**
  - NDP Co-ordinating Group
  - Reporting, charters and flash reports
  - Monitoring progress: the RAG status
- **Brief review of NDP actions relating to falls prevention and management.**
- **How does this fit with the bigger picture?**
- **Resources to inform NDP implementation plans and support their delivery:**
  - Driver Diagram
  - Point of Care Change Package
  - Spread self-assessment
- **Measurement for improvement**
  - Outcome measures
  - Process measures
- **Project proposal**
- **Questions and discussion**

NDP Governance

NDP Co-ordinating Group



NDP Governance

Project Charter

Allied Health Professions in Scotland

Project Charter
Falls Prevention and Management in the Community (NDP)

healthier scotland

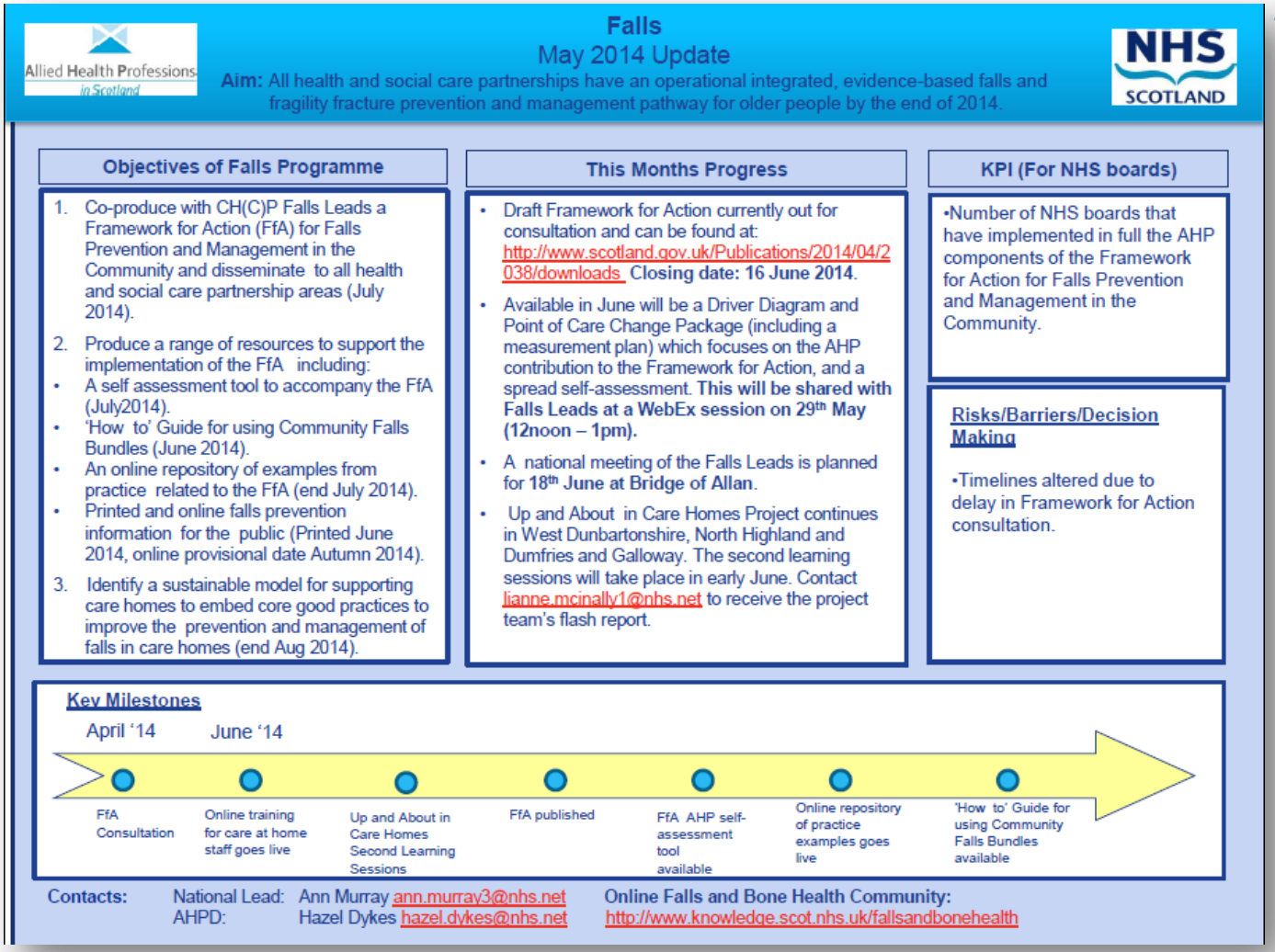
Business Case	Scope	
Service User Benefit	**In**	**Out**
In many cases, early and/or timely action or intervention to prevent a cycle of recurrent falls will avoid the harm and distress associated with falls, and supports older people to retain and restore function, independence and quality of life.	•Older people living in the community, including care homes. •Actions and interventions delivered by AHPs. •Pathway development, such as referral routes, that AHPs can influence.	•Younger population. •Hospital inpatients (acute and community) •Interventions delivered by other professions.
Org. Benefit & Cost	**Start Point**	**Stop Point**
The estimated annual cost to health and social care for managing the consequences of falls in Scotland is £444 million (rising to £666million by 2020). Implementation of the falls bundles (evidence based practice) is estimated to deliver net 'savings' of about £100,000 (2%) . Benefits to the older person, carers and family have not been quantified. Taking no action will place huge strains on services seeking to deliver effective, compassionate and sustainable services.	Primary prevention.	Co-ordinated management including supporting self management.

Problem Statement and SMART Goal	Team and Timeline	
Problem, Observation, Measures, Impact (What's your problem, How do you know, So What ?!)	**Team Members: Project Role**	**Team Members: Name/Title**
The 2012 report, Up and About or Falling Short, suggests there is considerable variation in the provision, quality and uptake of services to manage and prevent falls and fractures across Scotland. Local integrated pathways do not exist in every partnership area. As a result older people do not receive the timely support they require to prevent falls and recurrent falls and avoid the serious physical and psychological consequences. **KPI:** Number of NHS boards that have implemented in full the AHP components of the Framework for Action.	Sponsor Advocate Programme Owner Change Agents Partnership	Jacqui Lunday-Johnstone, SG Sarah Mitchell, Rehab. Programme Manager Ann Murray, Falls Programme Manager CH(C)P Falls Leads Hazel Dykes, AHPD, NHS D&G

SMART Goal	Milestones	
To reduce the rate of emergency admission related to falls in people 65 years and older by 20% by the end of 2014.	Framework for Action published. Self assessment tool available. Falls Bundles 'How to' Guide published. Good practice repository goes live. Public information materials available. Complete Phase 1 Care Homes Project.	End June 2014 End June 2014 End June 2014 End July 2014 Autumn 2014 End Aug 2014

NDP Governance

Monthly Flash Reports



Allied Health Professions in Scotland

Falls

May 2014 Update

Aim: All health and social care partnerships have an operational integrated, evidence-based falls and fragility fracture prevention and management pathway for older people by the end of 2014.

NHS SCOTLAND

Objectives of Falls Programme

1. Co-produce with CH(C)P Falls Leads a Framework for Action (FfA) for Falls Prevention and Management in the Community and disseminate to all health and social care partnership areas (July 2014).
2. Produce a range of resources to support the implementation of the FfA including:
   - A self assessment tool to accompany the FfA (July2014).
   - 'How to' Guide for using Community Falls Bundles (June 2014).
   - An online repository of examples from practice related to the FfA (end July 2014).
   - Printed and online falls prevention information for the public (Printed June 2014, online provisional date Autumn 2014).
3. Identify a sustainable model for supporting care homes to embed core good practices to improve the prevention and management of falls in care homes (end Aug 2014).

This Months Progress

- Draft Framework for Action currently out for consultation and can be found at: http://www.scotland.gov.uk/Publications/2014/04/2038/downloads **Closing date: 16 June 2014.**
- Available in June will be a Driver Diagram and Point of Care Change Package (including a measurement plan) which focuses on the AHP contribution to the Framework for Action, and a spread self-assessment. **This will be shared with Falls Leads at a WebEx session on 29th May (12noon – 1pm).**
- A national meeting of the Falls Leads is planned for **18th June at Bridge of Allan.**
- Up and About in Care Homes Project continues in West Dunbartonshire, North Highland and Dumfries and Galloway. The second learning sessions will take place in early June. Contact lianne.mcinally1@nhs.net to receive the project team's flash report.

KPI (For NHS boards)

•Number of NHS boards that have implemented in full the AHP components of the Framework for Action for Falls Prevention and Management in the Community.

Risks/Barriers/Decision Making

•Timelines altered due to delay in Framework for Action consultation.

Key Milestones

April '14 – June '14

- FfA Consultation
- Online training for care at home staff goes live
- Up and About in Care Homes Second Learning Sessions
- FfA published
- FfA AHP self-assessment tool available
- Online repository of practice examples goes live
- 'How to' Guide for using Community Falls Bundles available

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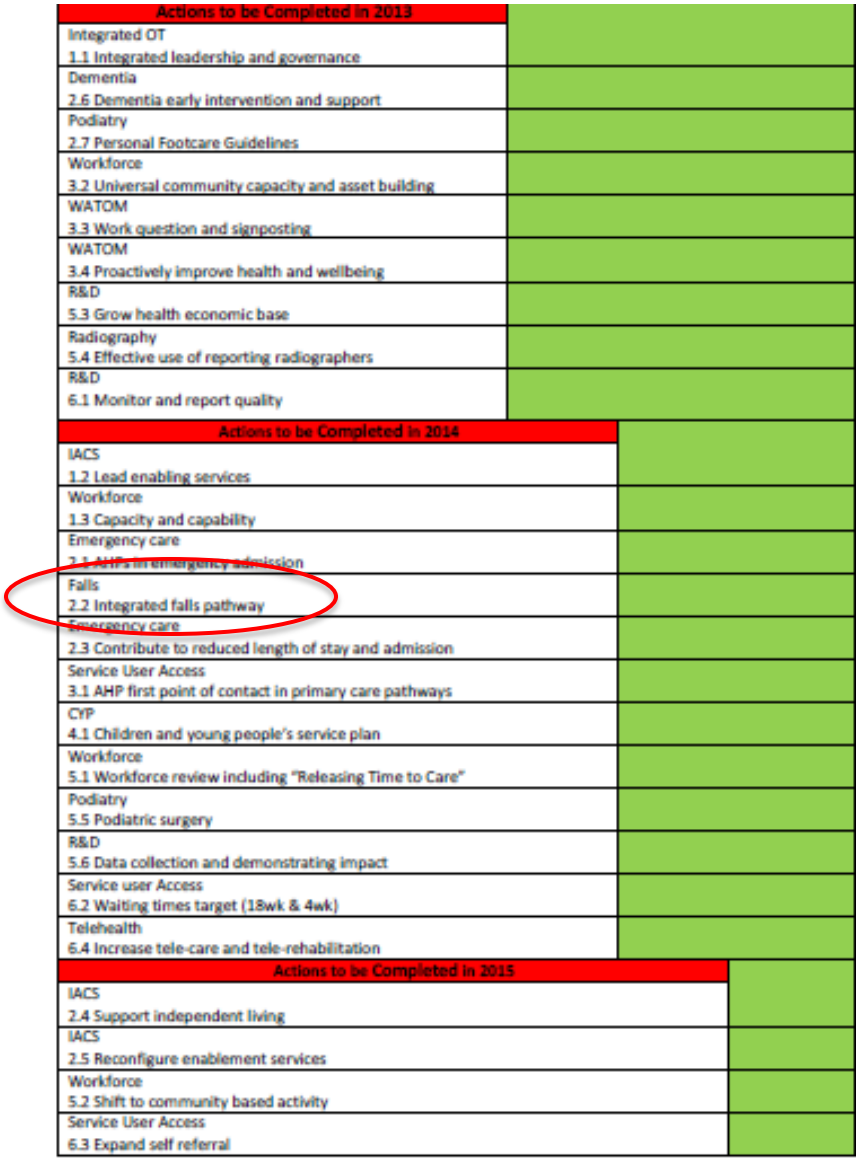
AHPD: Hazel Dykes hazel.dykes@nhs.net

Online Falls and Bone Health Community: http://www.knowledge.scot.nhs.uk/fallsandbonehealth

NDP Governance

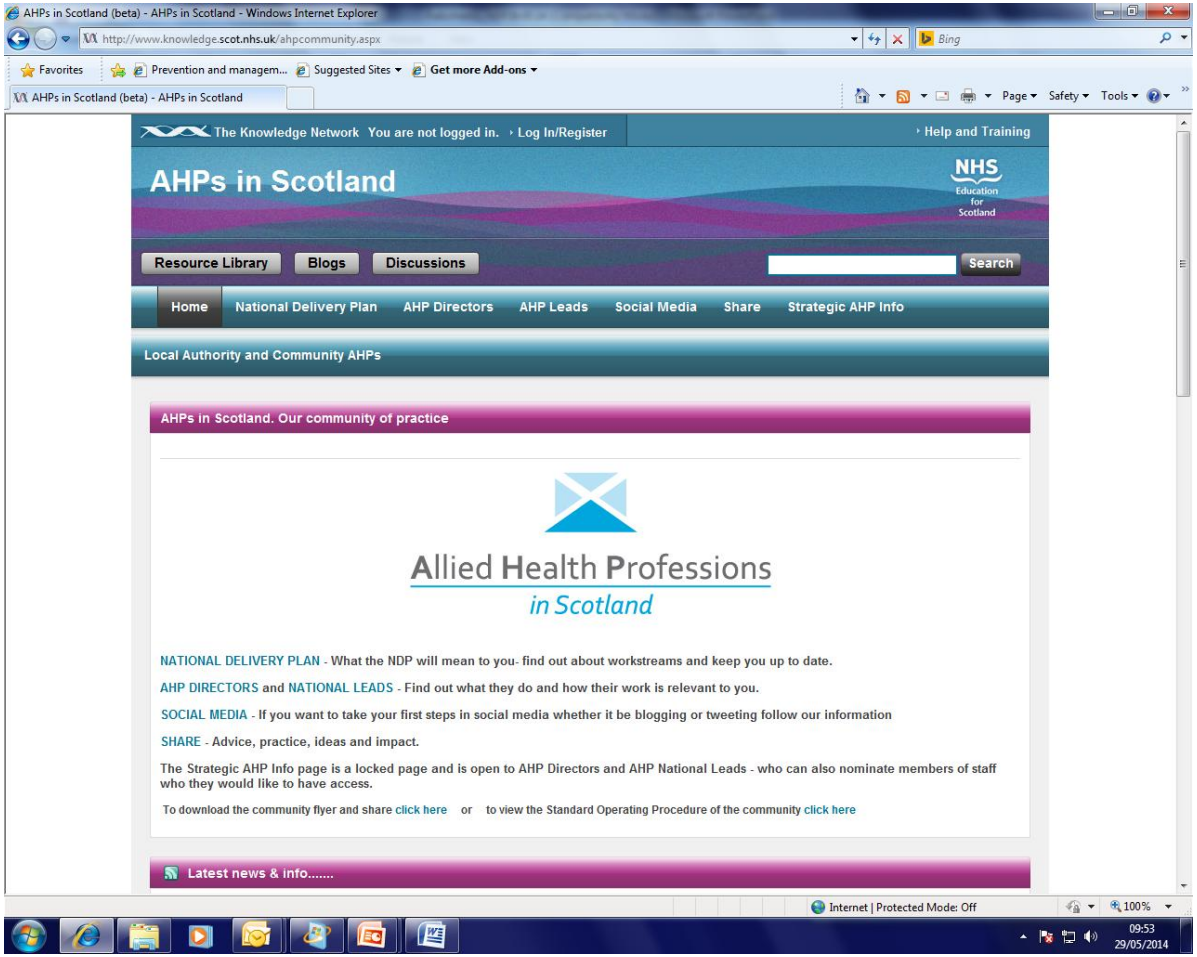
Monitoring progress: the RAG Status



Actions to be Completed in 2013	
Integrated OT 1.1 Integrated leadership and governance	
Dementia 2.6 Dementia early intervention and support	
Podiatry 2.7 Personal Footcare Guidelines	
Workforce 3.2 Universal community capacity and asset building	
WATOM 3.3 Work question and signposting	
WATOM 3.4 Proactively improve health and wellbeing	
R&D 5.3 Grow health economic base	
Radiography 5.4 Effective use of reporting radiographers	
R&D 6.1 Monitor and report quality	
Actions to be Completed in 2014	
IACS 1.2 Lead enabling services	
Workforce 1.3 Capacity and capability	
Emergency care 2.1 AHPs in emergency admission	
Falls 2.2 Integrated falls pathway	
Emergency care 2.3 Contribute to reduced length of stay and admission	
Service User Access 3.1 AHP first point of contact in primary care pathways	
CYP 4.1 Children and young people's service plan	
Workforce 5.1 Workforce review including "Releasing Time to Care"	
Podiatry 5.5 Podiatric surgery	
R&D 5.6 Data collection and demonstrating impact	
Service user Access 6.2 Waiting times target (18wk & 4wk)	
Telehealth 6.4 Increase tele-care and tele-rehabilitation	
Actions to be Completed in 2015	
IACS 2.4 Support independent living	
IACS 2.5 Reconfigure enablement services	
Workforce 5.2 Shift to community based activity	
Service User Access 6.3 Expand self referral	

Progress (ie the RAG status) for Action Area 2.2 is being monitored in two ways:

- The development, agreement and delivery of a local plan for implementing the 'minimum standard for falls prevention and management'.
- The rate per 1,000 population of falls-related emergency admissions to hospital in the over 65s.



NHS SCOTLAND

http://www.knowledge.scot.nhs.uk/ahpcommunity.aspx

What does the NDP say about falls prevention?

2.2	AHP directors will work within their NHS boards to support falls leads within CHCPs (and HSCPs as they emerge) to implement integrated falls and fracture care pathways to reduce falls-related admissions to hospital in the over 65s by 20%.	2014

What does the NDP say about falls prevention?

2.1	AHP directors will work within their NHS boards to ensure dedicated AHP support is established within emergency admission services, in line with best practice for emergency care (RCP, 2007), to prevent unnecessary admissions to hospital.	2014

Links with:
Unscheduled Care/Flexible Working work stream (NHS board lead?)

What does the NDP say about falls prevention?

3.1	AHP directors will work with primary care leads, general practitioners and across their NHS board to support enhanced pathways in primary care which maximise AHP expertise as first-point-of-contact practitioners to improve the care experience and reduce unnecessary referrals to secondary and unscheduled care.	2014

Links with:
Integrated Approaches and Care Pathways work streams (incl SPOA/Open Access)

What does the NDP say about falls prevention?

3.4	AHPs from health and social care will use each consultation as an opportunity to improve overall health and well-being with people who use their services, focusing on issues such as physical activity, nutrition and mental well-being, and including signposting to relevant resources.	2014

How does this fit with the bigger picture?

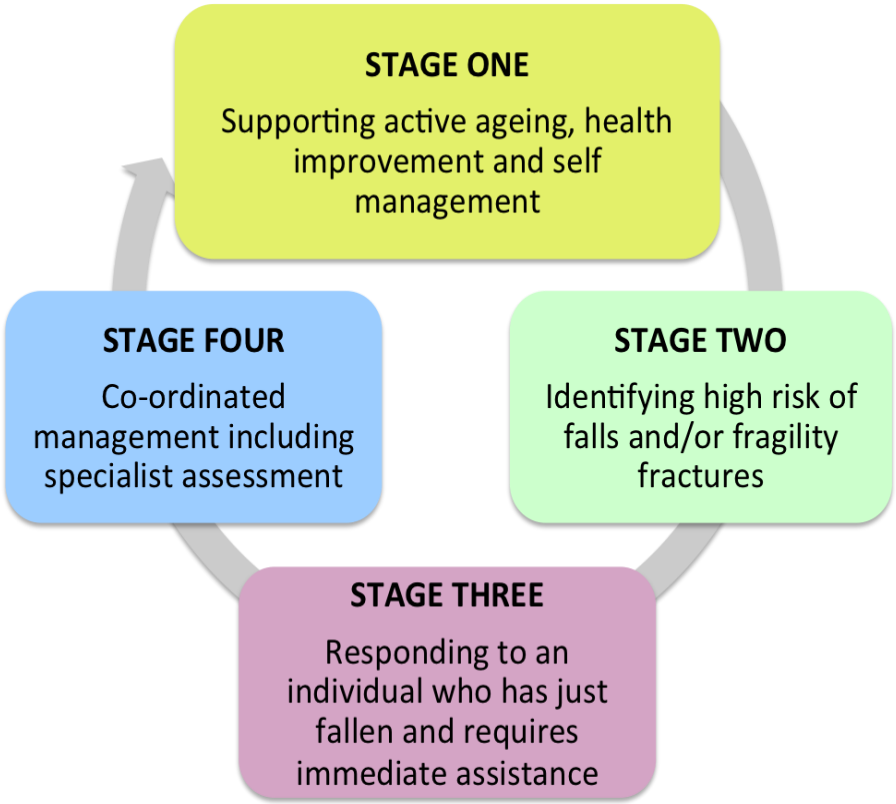
AHP Leadership

2.2	AHP directors will work within their NHS boards to support falls leads within CHCPs (and HSCPs as they emerge) to implement integrated falls and fracture care pathways to reduce falls-related admissions to hospital in the over 65s by 20%.	2014

- **Of the 14 territorial NHS boards, AHP Directors/Associate Directors are the corporate leads for falls in five boards.**
  - Ayrshire & Arran
  - Dumfries and Galloway
  - Highland
  - Tayside
  - Lothian

How does this fit with the bigger picture?

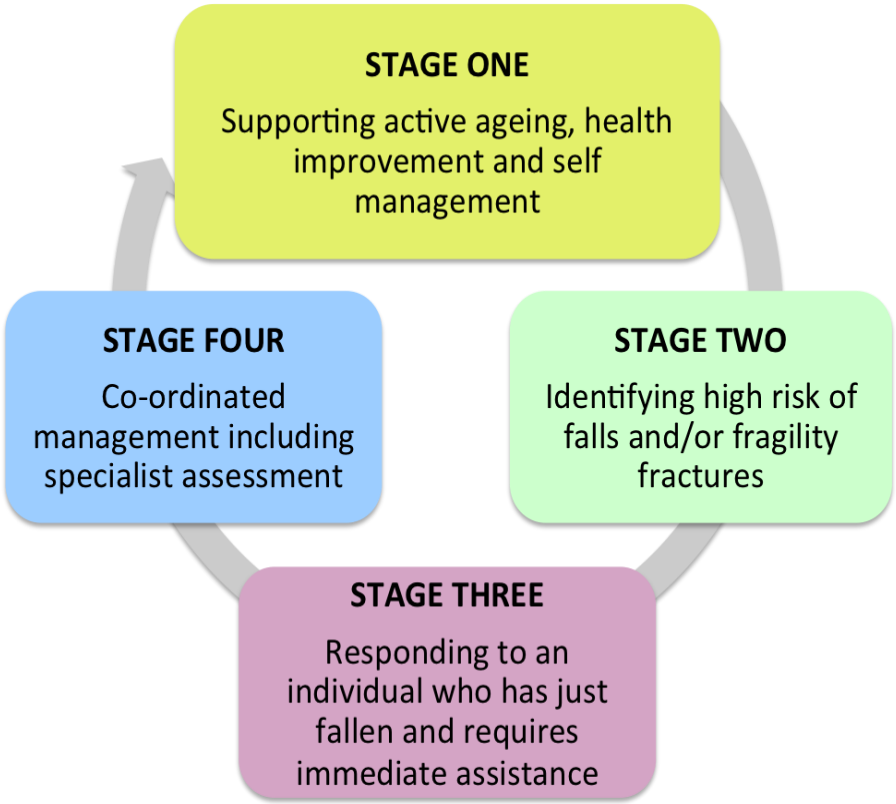
The dual role of AHPs



Up and About (NHSQIS 2010)

- ✓ Delivering key evidence-based assessments and interventions, and
- ✓ Influencing partners to create local pathways to support primary prevention, risk identification, co-ordinated management and self management.

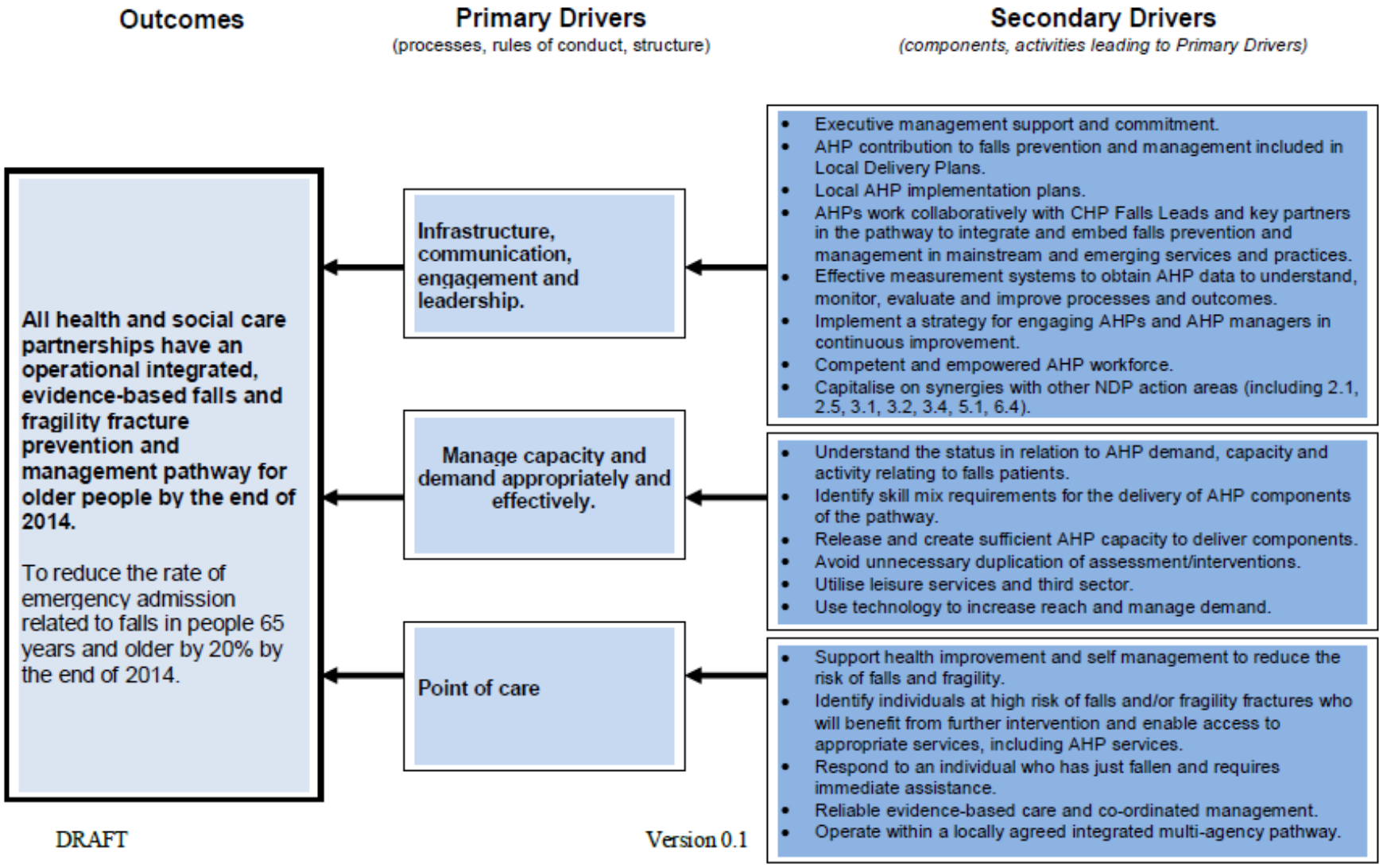
Resources to support planning and delivery of NDP Action Area 2.2



Up and About (NHSQIS 2010)

- ✓ Driver diagram and point of care change package.
- ✓ Falls Care Bundles 'How to' Guide
- ✓ AHP spread self-assessment.
- ✓ Measurement Plan.
- ✓ Project proposal.

NDP Falls Driver Diagram and Change Package



Resources to support planning and delivery

Point of Care Change Package

- Support health improvement and self management to reduce the risk of falls and fragility.
- Identify individuals at high risk of falls and/or fragility fractures who will benefit from further intervention and enable access to appropriate services, including AHP services.
- Respond to an individual who has just fallen and requires immediate assistance.
- Reliable evidence-based care and co-ordinated management.
- Operate within a locally agreed integrated multi-agency pathway.

- **Lifts 'actions' that AHPs can deliver and/or directly influence (14).**

- **The change package includes:**
  - Links to resources
  - Links to improvement tools and guidance
  - **Examples from practice**

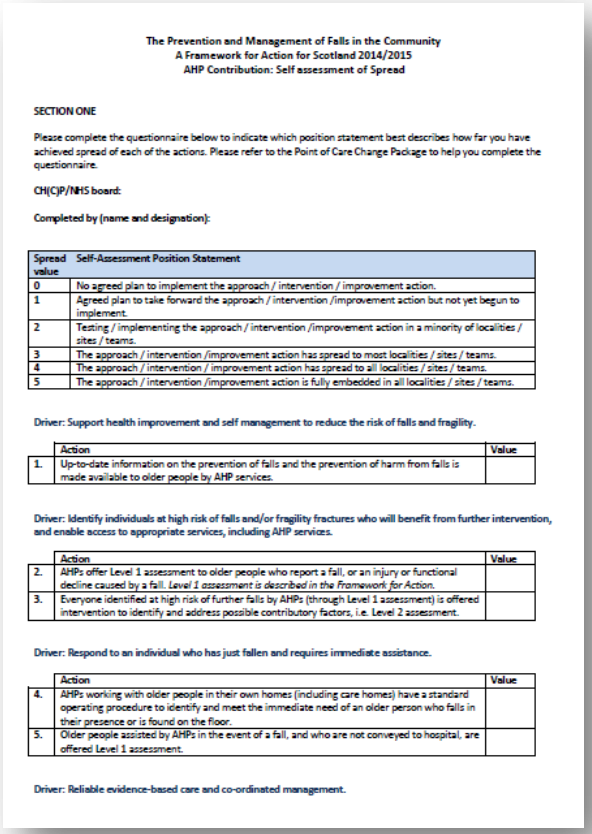
Resources to support planning and delivery

14 Actions

1. Up-to-date information on the prevention of falls and the prevention of harm from falls is made available to older people by AHP services (Action 1.1).
2. AHPs offer Level 1 assessment to older people who report a fall, or an injury or functional decline caused by a fall (Action 2.1).
3. Everyone identified at high risk of further falls by AHPs (through Level 1 assessment) is offered intervention to identify and address possible contributory factors, i.e. Level 2 assessment (Action 2.2).
4. AHPs working with older people in their own homes (including care homes) have a standard operating procedure to identify and meet the immediate need of an older person who falls in their presence or is found on the floor (Action 3.4).
5. Older people assisted by AHPs in the event of a fall, and who are not conveyed to hospital, are offered Level 1 assessment (Action 3.6).
6. Older people referred to AHP services following a fall are offered a Level 2 assessment (if they have not had one already in this episode of care). (Action 4.1),
7. AHP services providing Level 2 assessment have a governance infrastructure to ensure suitable staff undertake Level 2 assessments (Action 4.2).
8. Following Level 2 assessment the AHP service provides the person with a personalised Falls and Fracture Prevention Action Plan (Action 4.3).
9. Level 3 assessment and remedial interventions provided by AHPs are in line with current and emerging evidence. (Action 4.4)
10. Following Level 2 assessment AHPs have referral pathways into services that provide non-AHP delivered evidence based assessment (Level 3) and intervention (Action 4.5)
11. AHP services have a quality assurance process which monitors whether or not Fall and Fracture Prevention Action Plans they develop with older people are implemented (Action 4.7).
12. Direct referral pathways *from* services undertaking screening *to* AHP services providing evidence based assessment and intervention. (Action 2.2)
13. Direct referral pathways *from* responding services *to* AHP services providing evidence based assessment and intervention. (Action 3.5)
14. Non-AHP services providing Level 2 assessment have direct referral pathways in to AHP services providing evidence-based assessment and intervention (Action 4.5)

Resources to support planning and delivery

Self assessment of spread (14 Actions)



The Prevention and Management of Falls in the Community
A Framework for Action for Scotland 2014/2015
AHP Contribution: Self assessment of Spread

SECTION ONE

Please complete the questionnaire below to indicate which position statement best describes how far you have achieved spread of each of the actions. Please refer to the Point of Care Change Package to help you complete the questionnaire.

CH(C)P/NHS board:

Completed by (name and designation):

Spread value	Self-Assessment Position Statement
0	No agreed plan to implement the approach / intervention / improvement action.
1	Agreed plan to take forward the approach / intervention /improvement action but not yet begun to implement.
2	Testing / implementing the approach / intervention /improvement action in a minority of localities / sites / teams.
3	The approach / intervention /improvement action has spread to most localities / sites / teams.
4	The approach / intervention / improvement action has spread to all localities / sites / teams.
5	The approach / intervention /improvement action is fully embedded in all localities / sites / teams.

Driver: Support health improvement and self management to reduce the risk of falls and fragility.

	Action	Value
1.	Up-to-date information on the prevention of falls and the prevention of harm from falls is made available to older people by AHP services.	

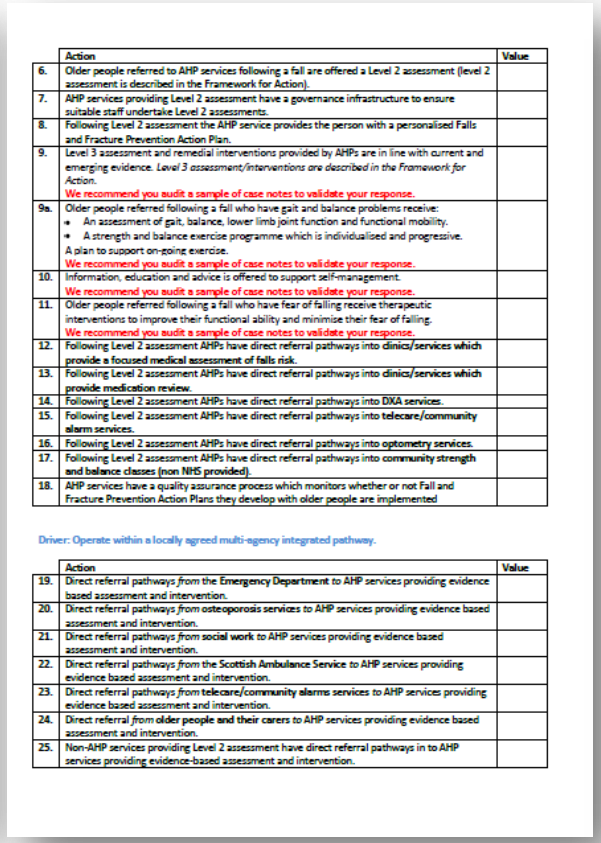
Driver: Identify individuals at high risk of falls and/or fragility fractures who will benefit from further intervention, and enable access to appropriate services, including AHP services.

	Action	Value
2.	AHPs offer Level 1 assessment to older people who report a fall, or an injury or functional decline caused by a fall. *Level 1 assessment is described in the Framework for Action.*	
3.	Everyone identified at high risk of further falls by AHPs (through Level 1 assessment) is offered intervention to identify and address possible contributory factors, i.e. Level 2 assessment.	

Driver: Respond to an individual who has just fallen and requires immediate assistance.

	Action	Value
4.	AHPs working with older people in their own homes (including care homes) have a standard operating procedure to identify and meet the immediate need of an older person who falls in their presence or is found on the floor.	
5.	Older people assisted by AHPs in the event of a fall, and who are not conveyed to hospital, are offered Level 1 assessment.	

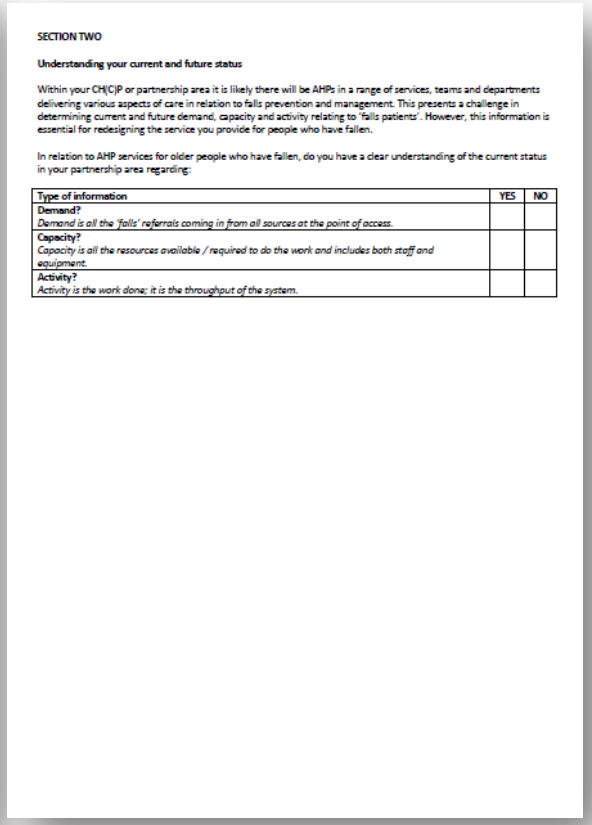
Driver: Reliable evidence-based care and co-ordinated management.



	Action	Value
6.	Older people referred to AHP services following a fall are offered a Level 2 assessment (level 2 assessment is described in the Framework for Action).	
7.	AHP services providing Level 2 assessment have a governance infrastructure to ensure suitable staff undertake Level 2 assessments.	
8.	Following Level 2 assessment the AHP service provides the person with a personalised Falls and Fracture Prevention Action Plan.	
9.	Level 3 assessment and remedial interventions provided by AHPs are in line with current and emerging evidence. *Level 3 assessment/interventions are described in the Framework for Action.* We recommend you audit a sample of case notes to validate your response.	
9a.	Older people referred following a fall who have gait and balance problems receive: • An assessment of gait, balance, lower limb joint function and functional mobility. • A strength and balance exercise programme which is individualised and progressive. A plan to support on-going exercise. We recommend you audit a sample of case notes to validate your response.	
10.	Information, education and advice is offered to support self-management. We recommend you audit a sample of case notes to validate your response.	
11.	Older people referred following a fall who have fear of falling receive therapeutic interventions to improve their functional ability and minimise their fear of falling. We recommend you audit a sample of case notes to validate your response.	
12.	Following Level 2 assessment AHPs have direct referral pathways into **clinics/services which provide a focused medical assessment of falls risk.**	
13.	Following Level 2 assessment AHPs have direct referral pathways into **clinics/services which provide medication review.**	
14.	Following Level 2 assessment AHPs have direct referral pathways into **DXA services.**	
15.	Following Level 2 assessment AHPs have direct referral pathways into **telecare/community alarm services.**	
16.	Following Level 2 assessment AHPs have direct referral pathways into **optometry services.**	
17.	Following Level 2 assessment AHPs have direct referral pathways into **community strength and balance classes (non NHS provided).**	
18.	AHP services have a quality assurance process which monitors whether or not Fall and Fracture Prevention Action Plans they develop with older people are implemented	

Driver: Operate within a locally agreed multi-agency integrated pathway.

	Action	Value
19.	Direct referral pathways *from* the **Emergency Department** *to* AHP services providing evidence based assessment and intervention.	
20.	Direct referral pathways *from* **osteoporosis services** *to* AHP services providing evidence based assessment and intervention.	
21.	Direct referral pathways *from* **social work** *to* AHP services providing evidence based assessment and intervention.	
22.	Direct referral pathways *from* the **Scottish Ambulance Service** *to* AHP services providing evidence based assessment and intervention.	
23.	Direct referral pathways *from* **telecare/community alarms services** *to* AHP services providing evidence based assessment and intervention.	
24.	Direct referral *from* **older people and their carers** *to* AHP services providing evidence based assessment and intervention.	
25.	Non-AHP services providing Level 2 assessment have direct referral pathways in to AHP services providing evidence-based assessment and intervention.	



SECTION TWO

Understanding your current and future status

Within your CH(C)P or partnership area it is likely there will be AHPs in a range of services, teams and departments delivering various aspects of care in relation to falls prevention and management. This presents a challenge in determining current and future demand, capacity and activity relating to 'falls patients'. However, this information is essential for redesigning the service you provide for people who have fallen.

In relation to AHP services for older people who have fallen, do you have a clear understanding of the current status in your partnership area regarding:

Type of information	YES	NO
Demand? *Demand is all the 'falls' referrals coming in from all sources at the point of access.*		
Capacity? *Capacity is all the resources available / required to do the work and includes both staff and equipment.*		
Activity? *Activity is the work done; it is the throughput of the system.*		

Measurement for improvement

Outcome measures

- SMR01 data from ISD to monitor falls-related emergency admissions at Scotland, NHS board and CHP level (*'Early Access for Management Information'*) .
- The baseline/starting point for measuring the 20% reduction in admissions **is determined by each CH(C)P or board**. This is to ensure improvements in admission rates pre-dating the NDP are taken into account.
- The **default starting point will be 2010**, which saw the publication of *Up and About.*

Measurement for improvement

Process measures

- Level 1 assessments completed
- Referrals made for L2 assessment
- Level 2 assessments completed
- Individualised management plans agreed

Project Proposal

Exercise to prevent falls

- This project aims to co-produce a sustainable model for supporting older people to continue to exercise following a falls prevention intervention. The model will build on the assets of the local community.

  This will include:

  - Mapping the current 'exercise continuum/pathway' in the locality.
  - Engaging with the local community to help co-design the model.
  - Test the model.
  - Produce and promote a 'how-to' guide for other partnerships.

- There will be two test sites, which will be health and social care partnership areas.

- A local lead will be appointed to manage the project. Guidance and support will be provided by the National Falls Programme Manager.

SBAR to NDP Co-ordinating Group

Recommendation

The programme manager and the Falls AHPD Lead requests the NDP Council and AHPDs consider the following recommendations:

- **Measurement of progress:**
  - ISD SMRO1 is the data source for monitoring progress towards the target.
  - The baseline/starting point for measuring the 20% reduction in admissions is determined by each CH(C)P or board. This is to ensure improvements in admission rates pre-dating the NDP are taken into account. The default starting point will be 2010, which saw the publication of **Up and About**.
  - The self assessment is used to identify current state and areas for improvement.
- **Support for developing and delivering implementation plans**
  - The Driver Diagram and Change Package is used for guidance and the measurement plan is implemented.
  - The project proposals are endorsed.
- **Communication**
  - AHPDs discuss the approach outlined above with key staff in their NHS board area including strategic leads for falls, CHP falls leads and social care partners.
  - AHPDs identify a lead for this work in their board area (this might be the existing Falls Lead).

Questions

- How does falls prevention feature in your local NDP implementation plan?
- Have you had the opportunity to provide input?
- Do you have links with unscheduled care, integrated approaches, and pathways work streams?
- How are you measuring progress?

For more information, please contact:

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http://www.knowledge.scot.nhs.uk/fallsandbonehealth