Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Review of Integrated Care: Focus on Falls

September 2019

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:
Provide an independent view on the quality of care

Promote improvement:
Encourage improvement through reporting and sharing of good practice

Influence policy and standards:
Use what we find to influence policy, standards and practice

We have created five short animated videos that accompany this report and highlight some of its key messages. These are available on our website and YouTube Channel.

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Integrated care – where health and social care and any other services that contribute to the wellbeing of individuals merge seamlessly with one another – is the nationally-held vision of current policy makers in Wales.

We can promote healthier, happier lives for the people of Wales by making care person-centred, and not creating or encouraging artificial barriers between interdependent systems that should work together.

The Parliamentary Review challenged inspectorates to consider our approach to inspecting complex, integrated systems of care, and so we have conducted a review of such an example of integration in community falls pathways for older citizens.

This review is concerned with the significant themes that arose from fieldwork that we conducted in three health board areas. We looked along the pathway of care from prevention of falls to reablement following the event, and how these identified themes relate to the promotion of good quality, seamless care. We have made recommendations that will help steer integrated care in general and specifically in the case of falls in older people.

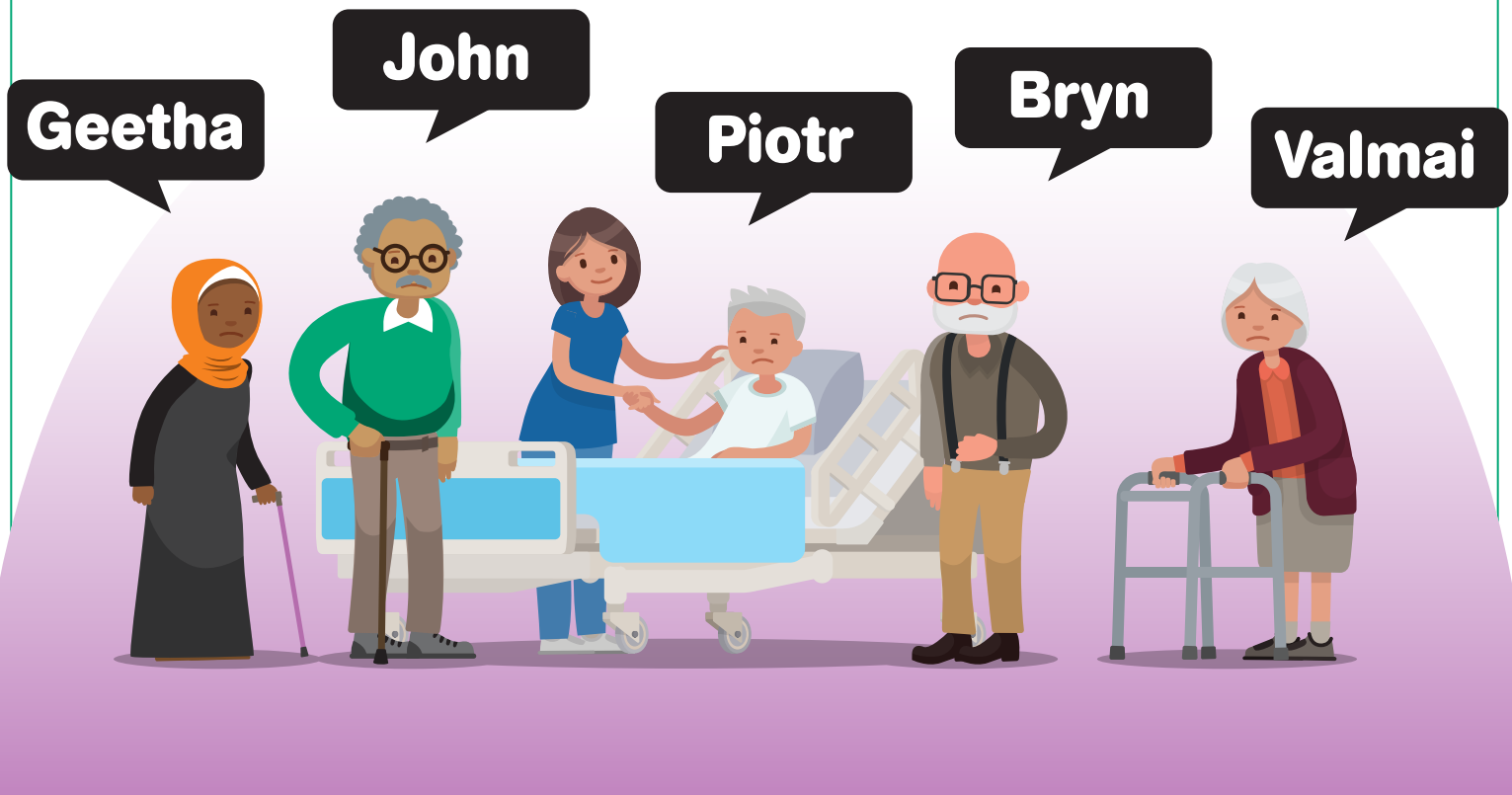
Themes

1. Conventional measures/metrics used to evaluate services or guide care are not adequate to reflect good quality integrated care
2. Meaningful engagement with the public is paramount
3. Information exchange and communication between social care, health and housing workers is key to quality care
4. Governance/strategic oversight is sometimes lacking or insufficient
5. There is unnecessary variation in services and supporting activities
6. Sources of funding for services can be an important enabler or barrier to integration
7. The importance of the voluntary and independent sector in providing a good integrated pathway
8. The social care workforce need to feel – and be – valued
9. Investment in person-centred, community-based, preventative resources is money well spent
10. An overly risk-averse culture is counter-productive to integration
11. Care should be person-centred and not service-convenient
12. The contribution of outstanding individuals makes a huge impact on services such as falls
13. There is a place for in-reaching to acute care settings and extracting suitable people for active reablement
14. New technology should be used to enhance care and enable practitioners to do the best job they are capable of doing, and not to replace interactions that should only be done by people
15. Falls are everyone's business.

Executive Summary

Recommendations

1. Falls in people aged over 65 years should be a priority in its own right.
2. A large-scale public engagement campaign is due for falls in older people.
3. Communication between health and its partners in the integrated care arena – especially social care – needs to be improved.
4. Funding needs to be focussed on preventative, community-based resources to support integration for the benefit of the public.
5. A high-level standardised framework of best practice for falls should be deployed nationally.
6. Below this, local operational multi-agency falls pathways should be clearly described to ensure delivery of high quality care in the specific context of each area.
7. Everyday behaviours of providers should lead the way for the culture shift towards person-centred care that puts 'what matters' to the individual first.
8. Organisations need to ensure that sufficient people are trained and empowered to deliver tiered falls assessment and management.



1. Introduction

Why did we do this review?

In 2018, Welsh Government set out its 10 year plan for health and social care systems in 'A Healthier Wales'[1]. The plan champions a whole system approach to the delivery of health and social care, making use of integrated pathways of care involving health, social care, housing and other statutory and independent/voluntary sector organisations. Although these pathways may offer great benefits for people in terms of outcome and experience, they can also involve complex interactions between different organisations. The primary aim of this review was to identify and explore one of these complex pathways as a means of providing a view on the challenges, successes and benefits of such an approach. Our expectation is that these findings are considered by a range of organisations across Wales and that our report stimulates dialogue and action which leads to the benefits of integrated pathways being fully realised.

Healthcare Inspectorate Wales (HIW) acknowledges the changing nature of care provision across Wales and is keen to consider how new models of care may be inspected in the future[2], compared with the traditional approach of separate, settings-based inspections (e.g. inspecting a GP surgery or a ward).

What will health and care systems look like in the future[3]?

Welsh Government's plan, 'A Healthier Wales', sets out four key ambitions:

- Person-centred care – care based on what matters to the individual
- Prudent care – the right person getting the right care from the right services at the right time
- Shift from hospital to community based care wherever possible – this includes an emphasis on prevention and health promotion

"A whole system approach to health and social care…It will be a 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health."

The overall aim is that people receive better quality care that gives them a better experience, and the system ultimately benefits from better use of its resources and improved population health and satisfaction outcomes.

Why is this review looking at falls?

We chose falls in the community as the pathway of care to look at as it is complex, and involves services from both health and social care, as well as the private/independent/voluntary sectors. We decided not to look at inpatient falls in hospitals, as risk factors for falling in a hospital setting can be very different from people's own homes.

Falls are:

- **Common:** One in three people aged over 65 and one in two people aged over 80 have at least one fall per year[4], and the fact that many falls are unreported means that the number is likely to be much higher. Older people who have fallen are also the most common reason for a 999 call in the UK[5]

1 *https://gov.wales/healthier-wales-long-term-plan-health-and-social-care*

2 *http://bit.ly/ParliamentaryReviewHSCareWales*

3 *https://www.kingsfund.org.uk/topics/integrated-care*

4 *http://bit.ly/NICE_CG_161*

5 *WAST Integrated Medium Term Plan 2018/19-2020/21 http://bit.ly/2WTQrEb*

1. Introduction

- **Important to the individual:** Having a fall can have serious physical and psychological consequences for the older person[6]
  - Physical: Apart from the increased risk of death, there is the serious consequence of loss of quality of life with people who fall experiencing pain, injury, distress, loss of independence and requirement for long-term care. Currently, only one in three older people who fall regain their former independence[7]. Falls are the third highest cause for morbidity in people aged over 70 years in England[8] (exact data not available but can be extrapolated for Wales)
  - Psychological: A first fall can trigger a downward spiral of fear of falling, leading to more inactivity, loss of strength and further falls
- **Costly:** The financial cost of falls was estimated at £2.3 billion UK-wide in 2013. This equates to approximately £110 million in Wales, even before taking account of the higher proportion of older people in our population[9]
- **Improvable:** There are risk factors that can be addressed that may reduce the incidence of avoidable falls, and reduce the harm from unavoidable falls[10].

What we did:

We chose three areas of Wales in which to study the entire community-based falls pathway, from primary prevention in people who haven't yet had a fall, through to discharge back into the community from hospital following admission for a fall with serious consequences.

The areas we selected were:

- **Betsi Cadwaladr University Health Board area.**
- **Powys Teaching Health Board area.**
- **Aneurin Bevan University Health Board area.**

We chose these areas in order to represent a diverse spread of services and population demographics, across different geographical areas.

To inform this review, we gathered evidence from:

- six individual falls services in all their different configurations (see Appendix B)
- a wide range of employees from community resource teams
- outpatient teams
- community hospitals
- hospital therapy teams
- discharge liaison teams
- five care homes
- domiciliary care staff
- primary care teams, including GPs, and
- five older persons' focus groups comprising a total of approximately 50 people aged 65 years and over.

Some of the focus groups were arranged through Age Cymru's[11] public engagement team who gave invaluable assistance with the logistics of focus group organisation.

The health board areas that this review focused on contributed significantly to the gathering of information for this review and are also active partners in the national programmes outlined in Appendix C.

6 *http://bit.ly/PHE_TheHumanCostofFalls*

7 *'Care and Support in Wales: National Population Assessment Report' p53 - Social Care Wales http://bit.ly/2NeC4en*

8 *http://bit.ly/HealthProfileforEngland2017*

9 *http://bit.ly/ONSPopulationEstimates*

10 *http://bit.ly/NICECG161_*

11 *https://www.ageuk.org.uk/cymru*

1. Introduction

Why should I read this review?

» **Public / Service Users:**
To see what is meant by integrated care, and to gain an insight into what you should experience and expect over the years to come in relation to how services are provided to you.

» **Service Providers:**
To consider, in a new light, some of the issues currently faced in delivering effective falls prevention and management in a way that is person/community-centred care.

» **Service Commissioners:**
To consider the extent to which falls services demonstrate integration and to identify some of the common themes that enable seamless, person-centred care. Conversely, to understand what may act as a barrier to achieving this aim.

In this review we do not offer a comprehensive list of each and every programme of work that is currently underway to address the prevention and management of falls in Wales. We do aim to show a snapshot of the current situation through the voices of people using and working in the services, and to give a broad overview of the issues experienced. We tested the approach and also the review findings with a panel of stakeholders from Welsh Government, health, social care and voluntary/independent organisations[12].

The review answers the question of whether falls services across the country are delivering integrated care, and what could be done to move falls services even closer to the ideal model. We hope that the learning from this approach could be applied to other integrated, complex care pathways.

12 *Membership of stakeholder group: Welsh Government, Care Inspectorate Wales, Social Care Wales, Age Cymru, 1000 Lives National Falls Taskforce, NHS Delivery Unit, WAST, Older Peoples Commissioner for Wales, Community Health Council*

2. Pitstop!

Before you go any further, here is everything you need to know about the National Guidance, and what should be expected, in relation to falls…

In order to get the most out of reading this review and understanding what is good and what has some way to go yet, here is a summary of what the National Institute for Health and Clinical Excellence (NICE) says on the subject[13].

This is the **nationally accepted 'gold standard'** that should theoretically be expected by any citizen over the age of 65 years in Wales.

- You should be routinely asked about falls by the healthcare professionals (e.g. doctors, nurses, pharmacists, therapists, etc.) that you see day to day.
- If you have had a fall or have trouble with your walking or balance, you should be offered an in-depth assessment, often called a multi-factorial risk assessment (MRA), of your risk of falling or harm from falling, normally from a specialist falls service (see MRA below).
- If this assessment says you are at risk of harm from falling, you should be offered to have something done about it, potentially anything and everything you need in fact, based on agreement between yourself and the person assessing you. See multi-factorial intervention, below.
- If you end up in hospital after a fall, you should be offered an MRA and a multi-factorial intervention based on your individualised assessment. As well as these you should **always** be offered a home hazard check to try and reduce the chance of you falling over for some avoidable reason e.g. an obstacle or down stairs after you return home.
- You may be offered a programme of exercises based on whether you have had a fall already, and whether you live in your own home or in a care home/ sheltered accommodation. The exercises aim to improve your fitness, strength and balance. The exercise programmes should be tailored to you and effort should be made to be flexible and check what would best suit you personally and fit in with your lifestyle. You should expect to enjoy this opportunity and be able to use the opportunity to socialise as well!
- All healthcare professionals should be able to offer you, orally and in writing, information about:
  - what measures you can take to prevent further falls
  - how to stay motivated if referred for exercise programmes
  - the preventable nature of some falls
  - the physical and psychological benefits of lowering your risk of falls
  - where you can seek further advice and assistance
  - how to cope if you have a fall, including how to summon help and how to avoid a long lie on the floor.

Falls are also highlighted as an important cause of cold-weather morbidity and mortality in the 2015 NICE guidance on the health impact of cold homes[14].

13 *https://www.nice.org.uk/guidance/cg161*

14 *https://www.nice.org.uk/guidance/ng6*

3. Pathways

In the following section we outline some example illustrations of desirable and undesirable pathways through the health and care system in the context of falls.

These are high-level, broadly generic pathways, and the examples of good and bad experiences are drawn from all of the sources consulted in this review. The pathways do not describe one model that currently exists, nor do the 'aspirational' pathways suggest one 'correct' way of doing falls prevention and management.

The individuals' stories are fictional but again drawn from the many real experiences of service users and staff that have informed this review.

We have split the whole falls journey down to three main parts:

- Prevention of falls and promotion of independence
- Response to falls when they happen in the community
- What happens if you attend hospital due to a fall.

"What matters to you" – When we talk about the individual being engaged with their own care, it is important to remember that an individual with 'capacity' (that is, the ability to make an informed decision for themselves about something), may choose **not** to participate in some or all of the assessment or intervention that providers recommend are in their best interests. **That is their prerogative** – we, as human beings, have the right to make 'bad' choices – as long as we understand all the ways this might affect us, and we also have the right to change our minds along the way.

3. Pathways

3.1 What Does 'Good' Look Like?

Prevention of harm from falls and promotion of independence for a person living in their own home

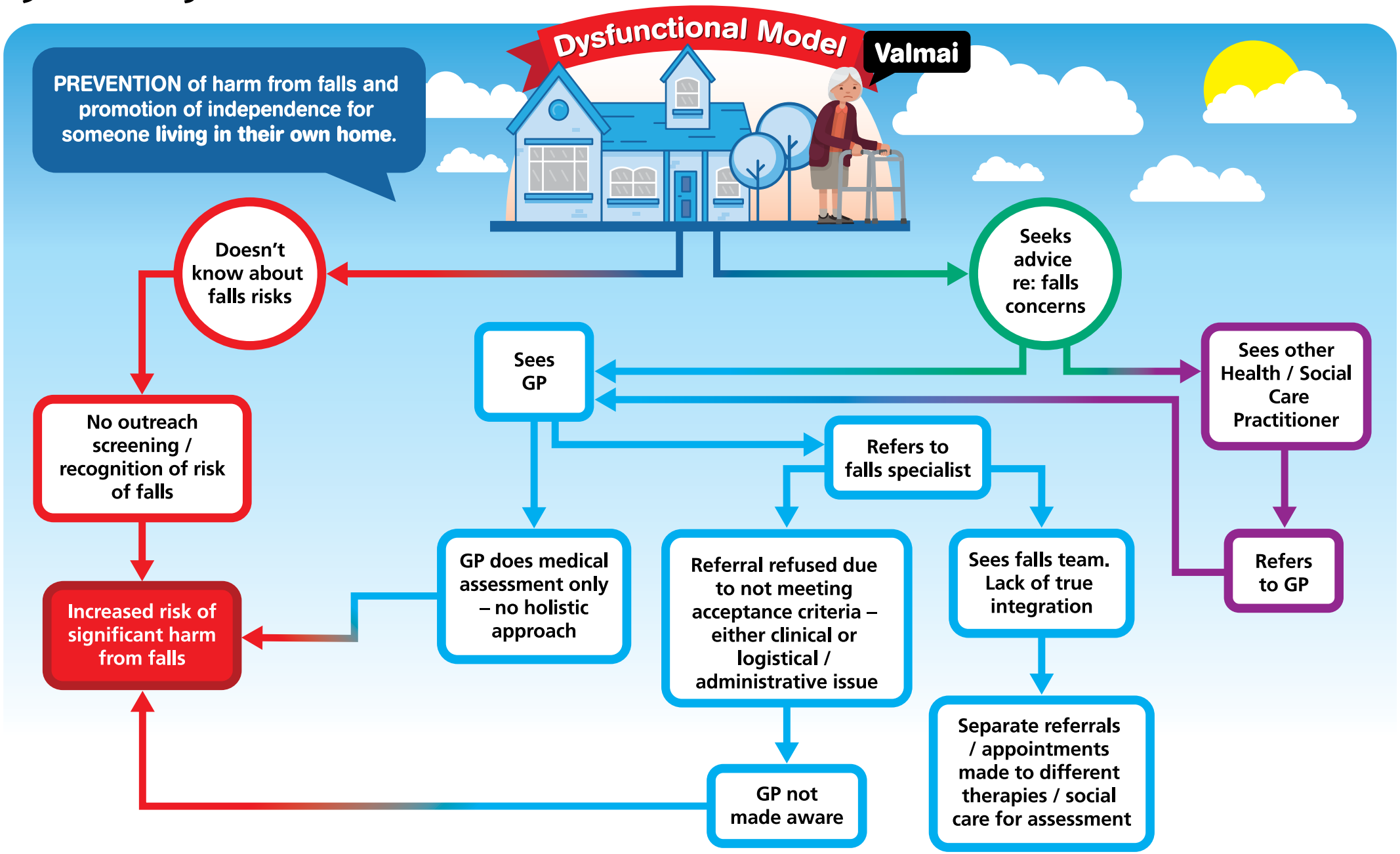
Valmai is a 70 year old woman who lives in her own home. "I was aware in my 50s that as we age we can 'decondition'. I started attending a weekly resistance weights class at my local gym as well as walking twice a week with my friends - we always stopped for a cuppa along the way so it didn't feel too much like 'exercise'!

After I was 65 my pharmacist asked me one day when I was picking up my repeat prescription if I wouldn't mind answering a few simple questions aimed at assessing whether I was at risk of falls. I had heard that falls were a significant concern in my age group - I had seen the leaflet in the GP's surgery, and so I said yes. To my surprise the pharmacist swiftly identified that I may indeed benefit from some risk-reduction interventions, and referred me to a specialist who saw me that week.

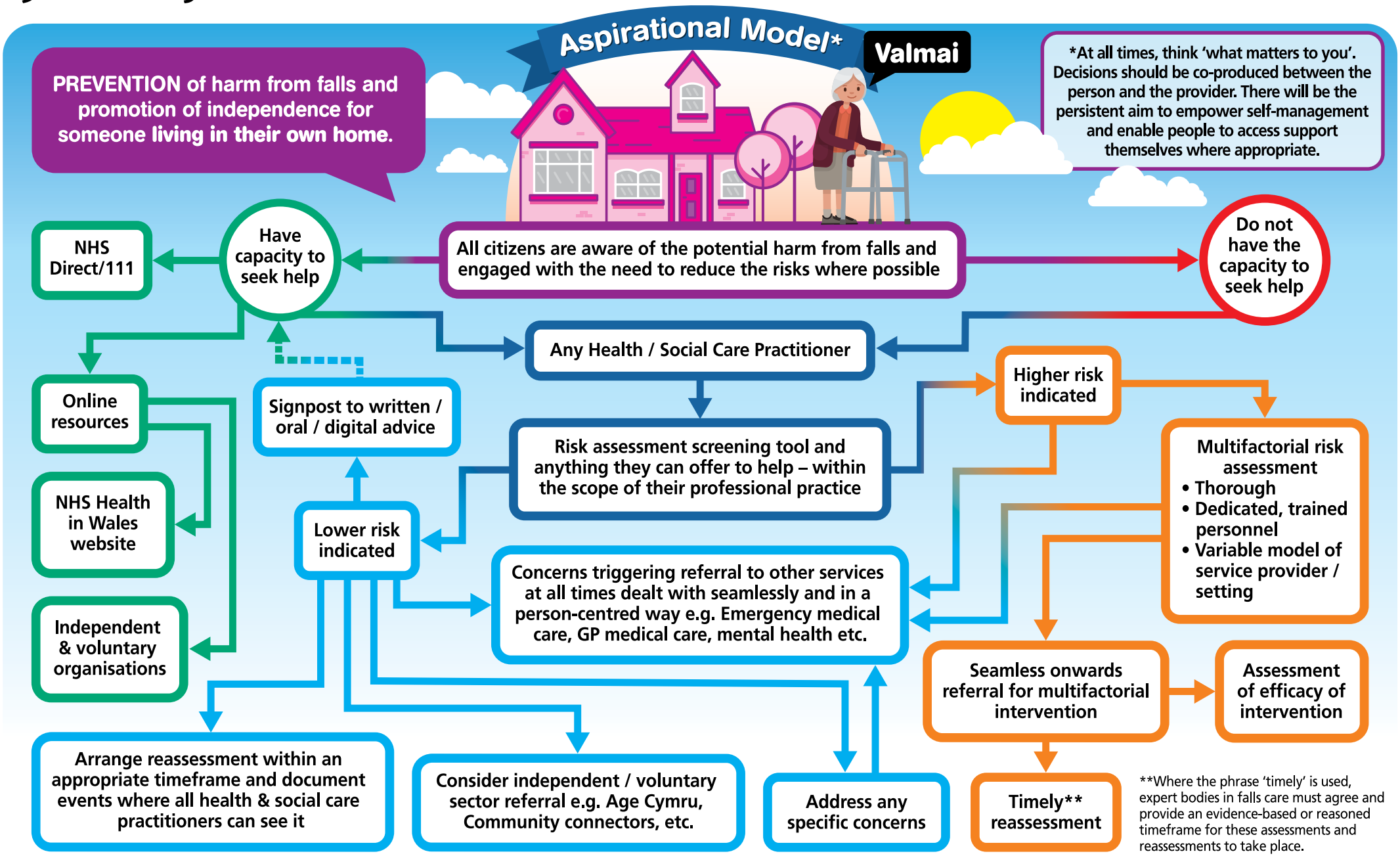
We had a really in-depth talk about absolutely everything - it felt really good to have all aspects considered in one sitting, without having to go back and fore to several different specialists. I did find it a little daunting - especially as I love my independence and the last thing I wanted was to be identified as needing to go into a 'home'. But we decided together that all I needed was an eye test and a home hazard check - both of which were arranged there and then, and I was able to have them done within the following week.

I now feel confident that I have taken positive steps towards protecting my independence and can get on with enjoying my life - I even feel better about the fact that even though falls can happen, I have reduced the risk of them causing harm to me. I am also reassured that in about a year's time I should ask for the assessment to be repeated by any health or care practitioner in case anything has changed. In the meantime if I have any more concerns I can contact my pharmacist, GP, optician or Care and Repair agent."

3. Pathways


Dysfunctional Model
Valmai
PREVENTION of harm from falls and promotion of independence for someone living in their own home.
Doesn't know about falls risks
Seeks advice re: falls concerns
No outreach screening / recognition of risk of falls
Sees GP
Sees other Health / Social Care Practitioner
Refers to falls specialist
Increased risk of significant harm from falls
GP does medical assessment only – no holistic approach
Referral refused due to not meeting acceptance criteria – either clinical or logistical / administrative issue
Sees falls team. Lack of true integration
Refers to GP
GP not made aware
Separate referrals / appointments made to different therapies / social care for assessment

3. Pathways


Aspirational Model*
Valmai
PREVENTION of harm from falls and promotion of independence for someone living in their own home.
*At all times, think 'what matters to you'. Decisions should be co-produced between the person and the provider. There will be the persistent aim to empower self-management and enable people to access support themselves where appropriate.
All citizens are aware of the potential harm from falls and engaged with the need to reduce the risks where possible
Have capacity to seek help
NHS Direct/111
Do not have the capacity to seek help
Any Health / Social Care Practitioner
Online resources
NHS Health in Wales website
Independent & voluntary organisations
Signpost to written / oral / digital advice
Risk assessment screening tool and anything they can offer to help – within the scope of their professional practice
Higher risk indicated
Multifactorial risk assessment
• Thorough
• Dedicated, trained personnel
• Variable model of service provider / setting
Lower risk indicated
Concerns triggering referral to other services at all times dealt with seamlessly and in a person-centred way e.g. Emergency medical care, GP medical care, mental health etc.
Seamless onwards referral for multifactorial intervention
Assessment of efficacy of intervention
Arrange reassessment within an appropriate timeframe and document events where all health & social care practitioners can see it
Consider independent / voluntary sector referral e.g. Age Cymru, Community connectors, etc.
Address any specific concerns
Timely** reassessment
**Where the phrase 'timely' is used, expert bodies in falls care must agree and provide an evidence-based or reasoned timeframe for these assessments and reassessments to take place.

3.2 What Does 'Good' Look Like?

Prevention of harm from falls and promotion of independence in a care home setting

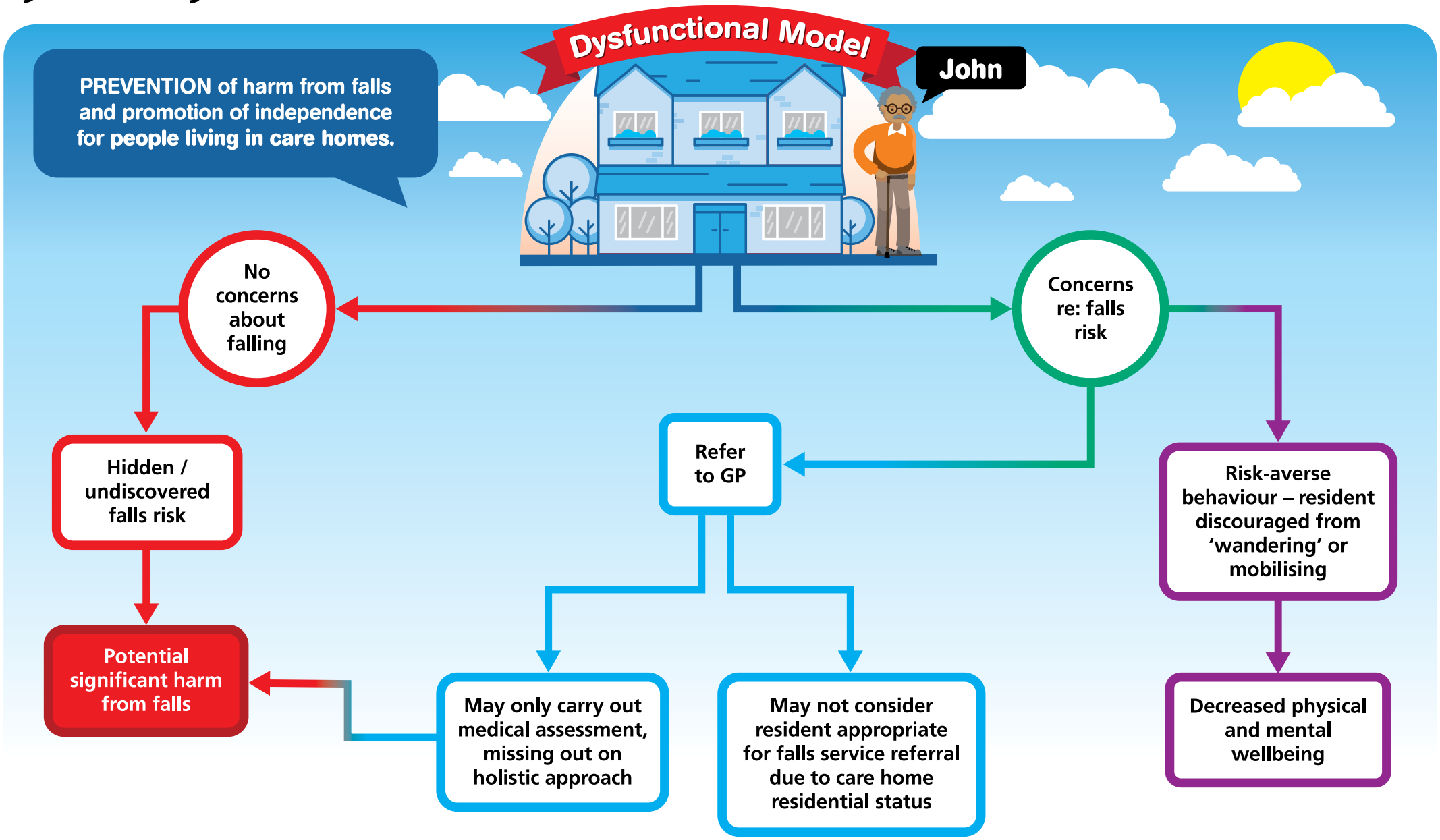
John is going to live in a residential care home for 3 weeks' respite for his daughter's family, who care for him usually at home. On admission the care home manager sits down with John and his daughter and goes through the admission process, including a 'what matters to you' conversation. It transpires that John gets very bored sitting all afternoon and likes to 'wander' about, but is unsteady and so his daughter is very anxious about him falling – he has had several near-misses at home and in fact the daughter has to encourage her father to sit down a lot at home.

They agree a plan that John will be accompanied and supported to walk about as much as he likes whilst he is at the care home, with the understanding that whilst every effort will be made to reduce his risk of harm, this may lead to him falling occasionally. John and his daughter understand this and are happy with the compromise. The care home manager offers John an in-depth falls assessment (MRA) to look at every aspect of his risks of falling and how they may be reduced, and this is accepted. The care home manager also outlines the approach they take to falls – which is an in-house assessment and avoidance of medicalisation as far as possible, which goes down very well with John.

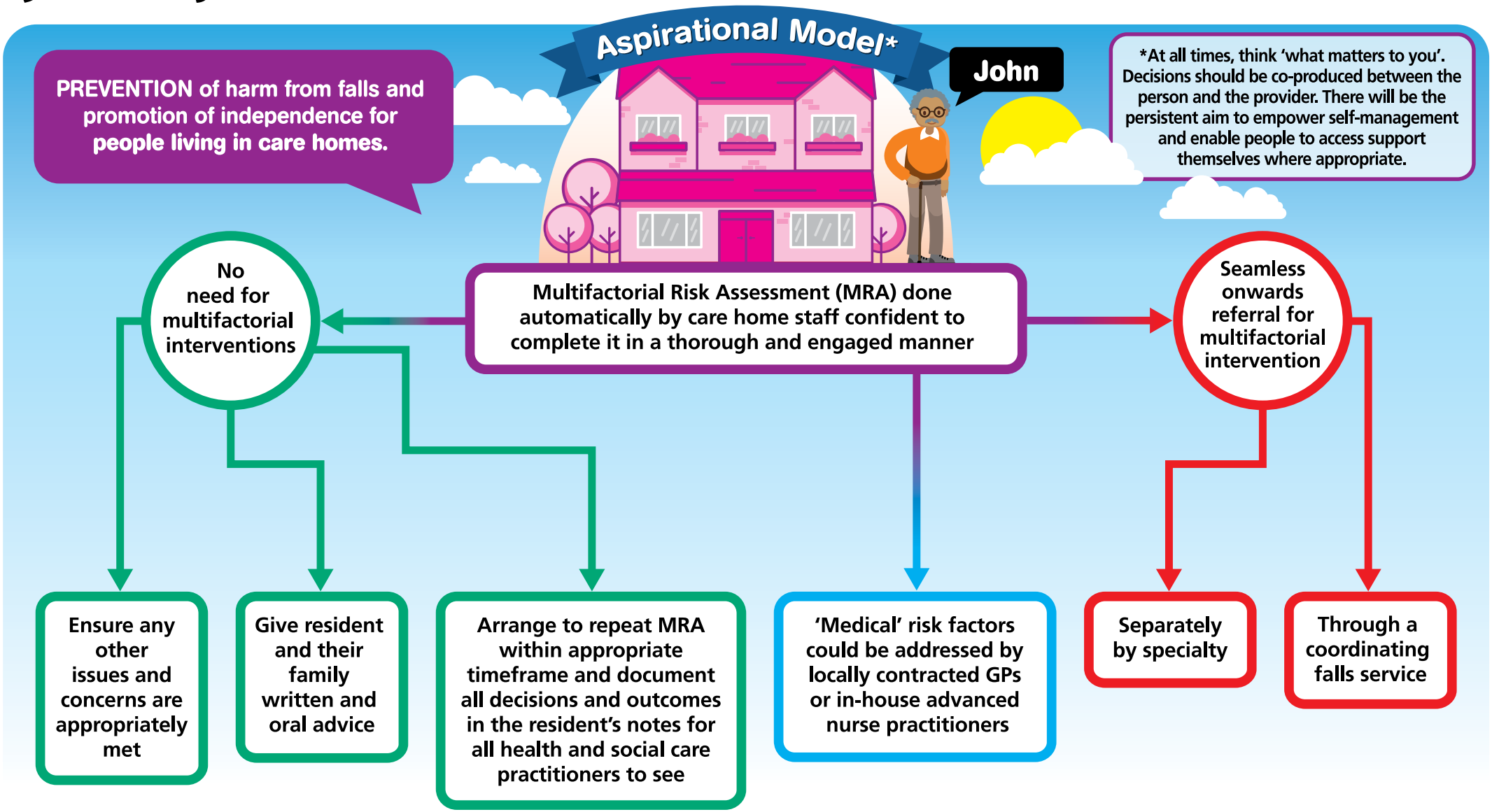
The MRA is done and, to John's surprise, his slippers are deemed to be the biggest risk to him losing his balance and falling! The care home, with John's agreement, offer him a new safe pair of slippers, and also refer to the podiatrist who visits this home to help deal with the problems his poor footwear have been causing him.

At the end of the respite stay, John says to his daughter on return home that actually, he felt he gained a greater degree of independence and freedom whilst at the care home, and that perhaps he might at some point consider a permanent move there, where his family could still come and visit him but where he could enjoy a very good quality of life with companions of his own age around him at all times of the day.

3. Pathways


PREVENTION of harm from falls and promotion of independence for people living in care homes.
Dysfunctional Model
John
No concerns about falling
Concerns re: falls risk
Hidden / undiscovered falls risk
Refer to GP
Risk-averse behaviour – resident discouraged from 'wandering' or mobilising
Potential significant harm from falls
May only carry out medical assessment, missing out on holistic approach
May not consider resident appropriate for falls service referral due to care home residential status
Decreased physical and mental wellbeing

3. Pathways


Aspirational Model*
John
PREVENTION of harm from falls and promotion of independence for people living in care homes.
*At all times, think 'what matters to you'. Decisions should be co-produced between the person and the provider. There will be the persistent aim to empower self-management and enable people to access support themselves where appropriate.
Multifactorial Risk Assessment (MRA) done automatically by care home staff confident to complete it in a thorough and engaged manner
No need for multifactorial interventions
Seamless onwards referral for multifactorial intervention
Ensure any other issues and concerns are appropriately met
Give resident and their family written and oral advice
Arrange to repeat MRA within appropriate timeframe and document all decisions and outcomes in the resident's notes for all health and social care practitioners to see
'Medical' risk factors could be addressed by locally contracted GPs or in-house advanced nurse practitioners
Separately by specialty
Through a coordinating falls service

3. Pathways

3.3 What Does 'Good' Look Like?

Response to a fall for someone living in their own home

Bryn is an 84 year old man who lives in his own home. "I hadn't long celebrated my 84th birthday and was still proud to say that I lived in my own home independently. Unfortunately one evening at 6pm I had a brief episode of light-headedness, which caused me to fall to the floor.

I remembered the techniques taught to me by the falls practitioner at my local falls service, but despite my best efforts I wasn't able to get myself back up off the floor. I didn't panic however – I pressed the button on my emergency pendant and within 20 minutes my son and daughter had arrived. When they started to help me up I felt too dizzy to stand again and so they rang 999.

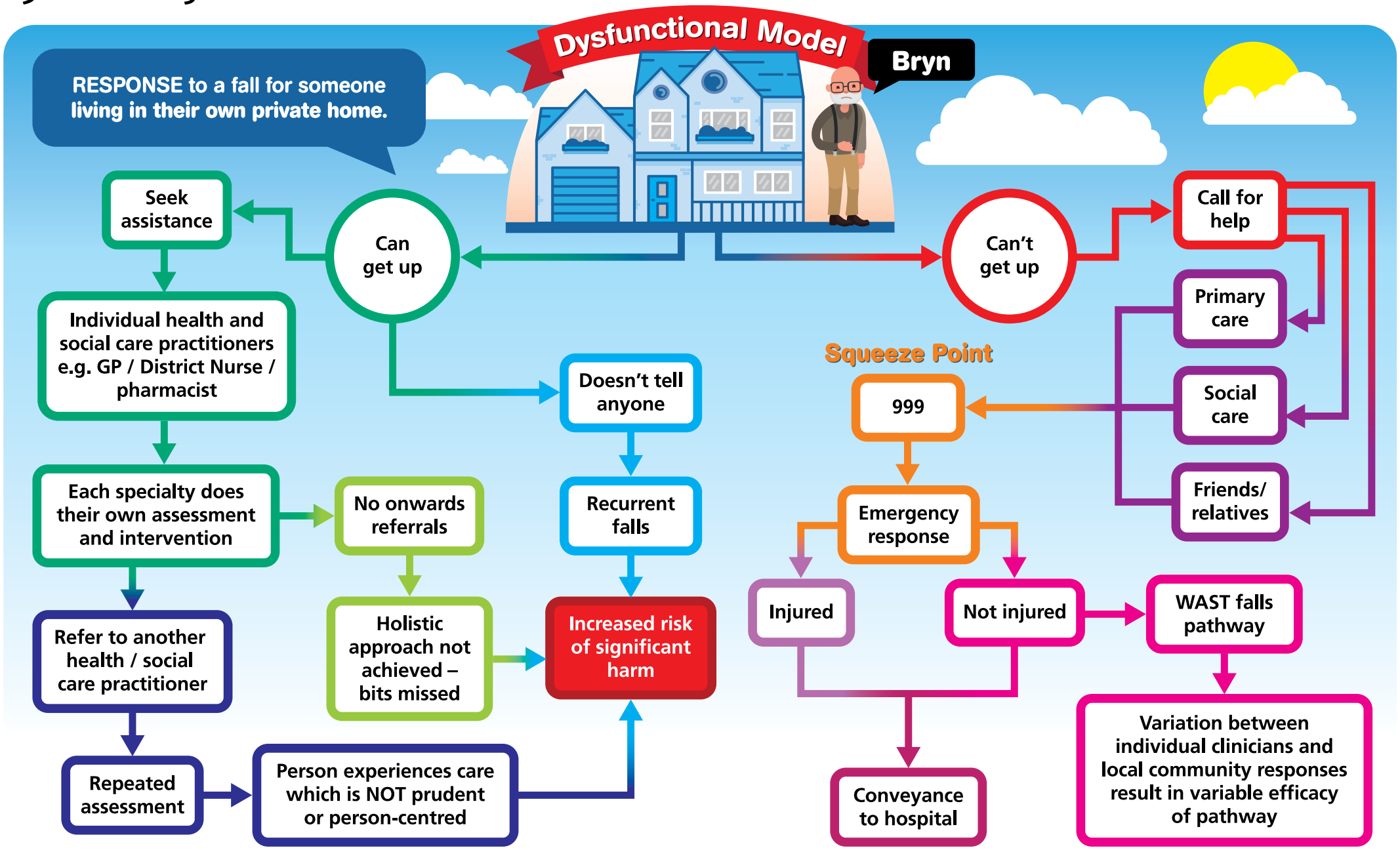
Within another 25 minutes a 'falls assistant' arrived instead of an ambulance. They gave me a quick check-over, including doing my blood pressure and things, and were able to help me up off the floor with a very comfortable cushion device which inflated underneath me – it was much more gradual than the previous effort and so I felt much less dizzy on getting back up.

I informed them that I was aware of my risk of falling as I had had a falls assessment previously. They suggested that I might get back in touch to have it revisited in case anything had changed. I agreed, and they made the referral on my behalf so that I didn't even have to remember to ring them the following day when the community hospital where the service is based reopened.

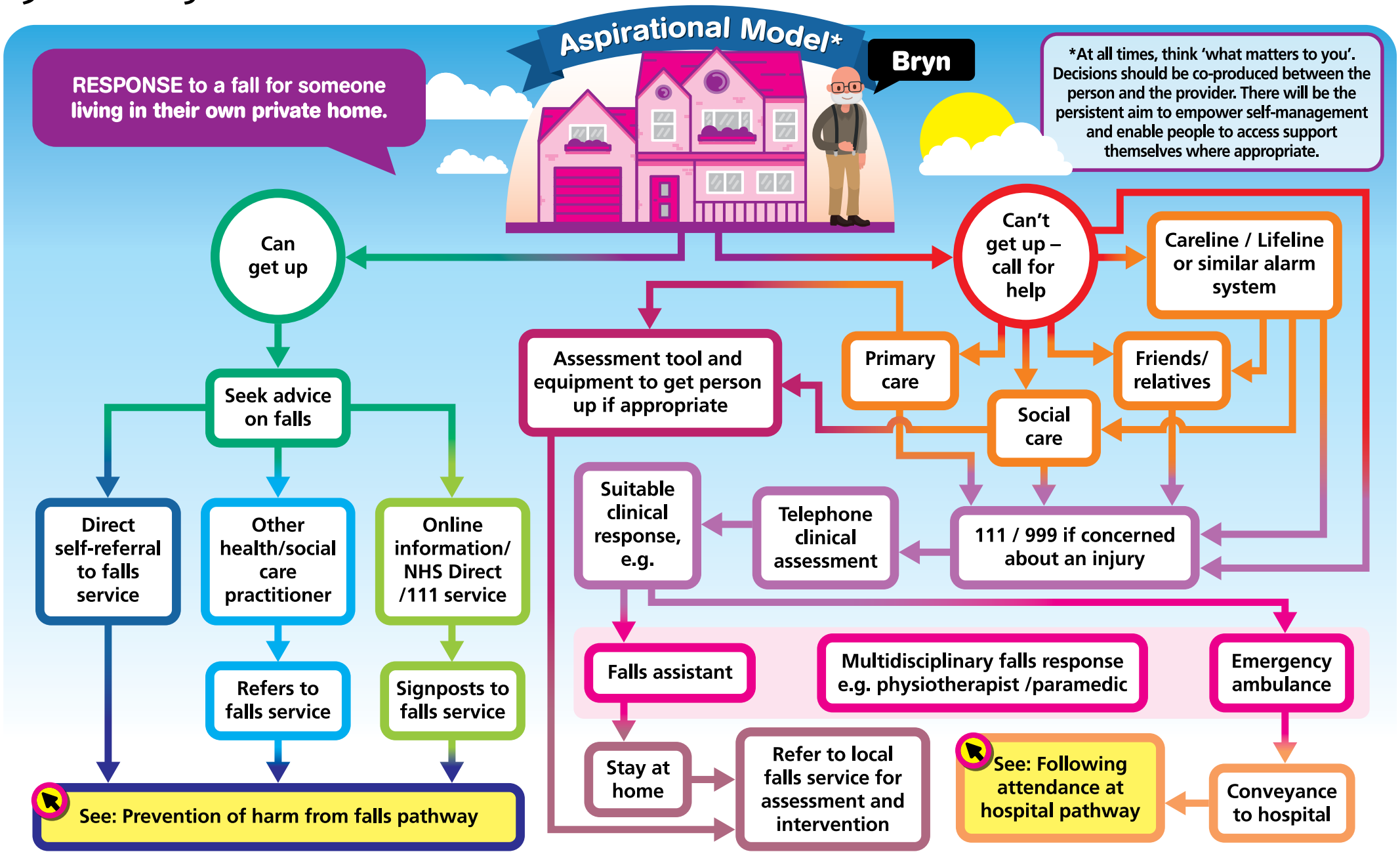
I was called for an appointment for an assessment before the end of the week, and it turned out that my blood pressure was lower than it had been last time, and so one of my blood pressure medications was probably no longer needed. I chatted through the risks and benefits of this with the on-site pharmacist whilst I was there and decided this sounded like a good idea. They also thought that I might benefit from a hearing test as I hadn't had one for some years. I got the appointment for that the following Monday.

I feel happier and safer in my own home than ever before – still living the life I want to live but with the level of health and social care input and support that I have chosen.

3. Pathways


Dysfunctional Model
Bryn
RESPONSE to a fall for someone living in their own private home.
Seek assistance
Can get up
Can't get up
Call for help
Individual health and social care practitioners e.g. GP / District Nurse / pharmacist
Doesn't tell anyone
Primary care
Squeeze Point
999
Social care
Each specialty does their own assessment and intervention
No onwards referrals
Recurrent falls
Friends/ relatives
Emergency response
Refer to another health / social care practitioner
Holistic approach not achieved – bits missed
Increased risk of significant harm
Injured
Not injured
WAST falls pathway
Repeated assessment
Person experiences care which is NOT prudent or person-centred
Conveyance to hospital
Variation between individual clinicians and local community responses result in variable efficacy of pathway

3. Pathways


Aspirational Model*
Bryn
RESPONSE to a fall for someone living in their own private home.
*At all times, think 'what matters to you'. Decisions should be co-produced between the person and the provider. There will be the persistent aim to empower self-management and enable people to access support themselves where appropriate.
Can get up
Can't get up – call for help
Careline / Lifeline or similar alarm system
Seek advice on falls
Assessment tool and equipment to get person up if appropriate
Primary care
Friends/ relatives
Social care
Direct self-referral to falls service
Other health/social care practitioner
Online information/ NHS Direct /111 service
Suitable clinical response, e.g.
Telephone clinical assessment
111 / 999 if concerned about an injury
Refers to falls service
Signposts to falls service
Falls assistant
Multidisciplinary falls response e.g. physiotherapist /paramedic
Emergency ambulance
Stay at home
Refer to local falls service for assessment and intervention
See: Following attendance at hospital pathway
Conveyance to hospital
See: Prevention of harm from falls pathway

3.4 What Does 'Good' Look Like?

Response to a fall for someone living in a care home

Geetha was assessed as being high risk for falls on her admission to the residential care home 2 months earlier. One of the pastimes she gets the most pleasure from is gardening, and on consideration of her enjoyment and wellbeing, and following discussion with her and her family about the risks and benefits, she continued to perform her gardening activities with support from the care home staff and modification of the environment to minimise her risk of getting injured.

Unfortunately despite all of this one afternoon she loses her balance and falls outside in the garden. She isn't able to get up under her own steam, and so the care home staff use the post-fall assessment tool they have been trained with. Using this they identify that she has a graze to her arm but no signs of significant injury, and they are safely able to help her up with the inflating cushion lifting device that they have for this purpose.

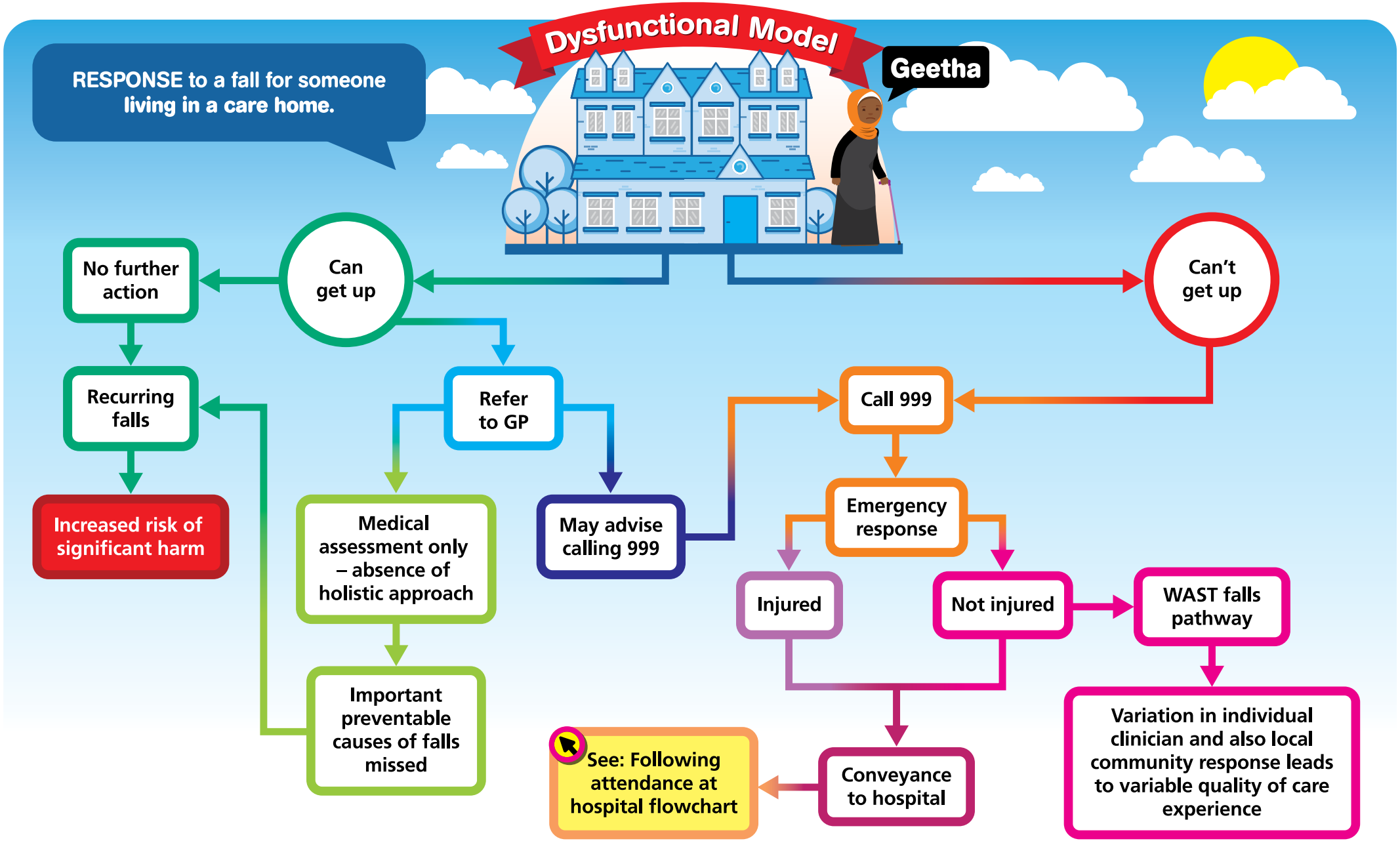
Geetha spends less than 20 minutes on the floor as a result of this approach, and the care home staff are happy that they have conducted a thorough assessment, kept her safe, preserved her dignity and comfort and have not had to contact the ambulance service unnecessarily.

They contact the district nurse from the primary care cluster with whom this care home has a contract for regular visits, to ask for advice about the graze on the arm which has been cleaned and a basic dressing applied by a first aider. She says someone from the community team will call later that day to look at it, which they do, and some more dressing supplies are given to the carers so that the basic care (which is all that is needed) can be continued. They will keep an eye on it during their weekly ward rounds at the home.

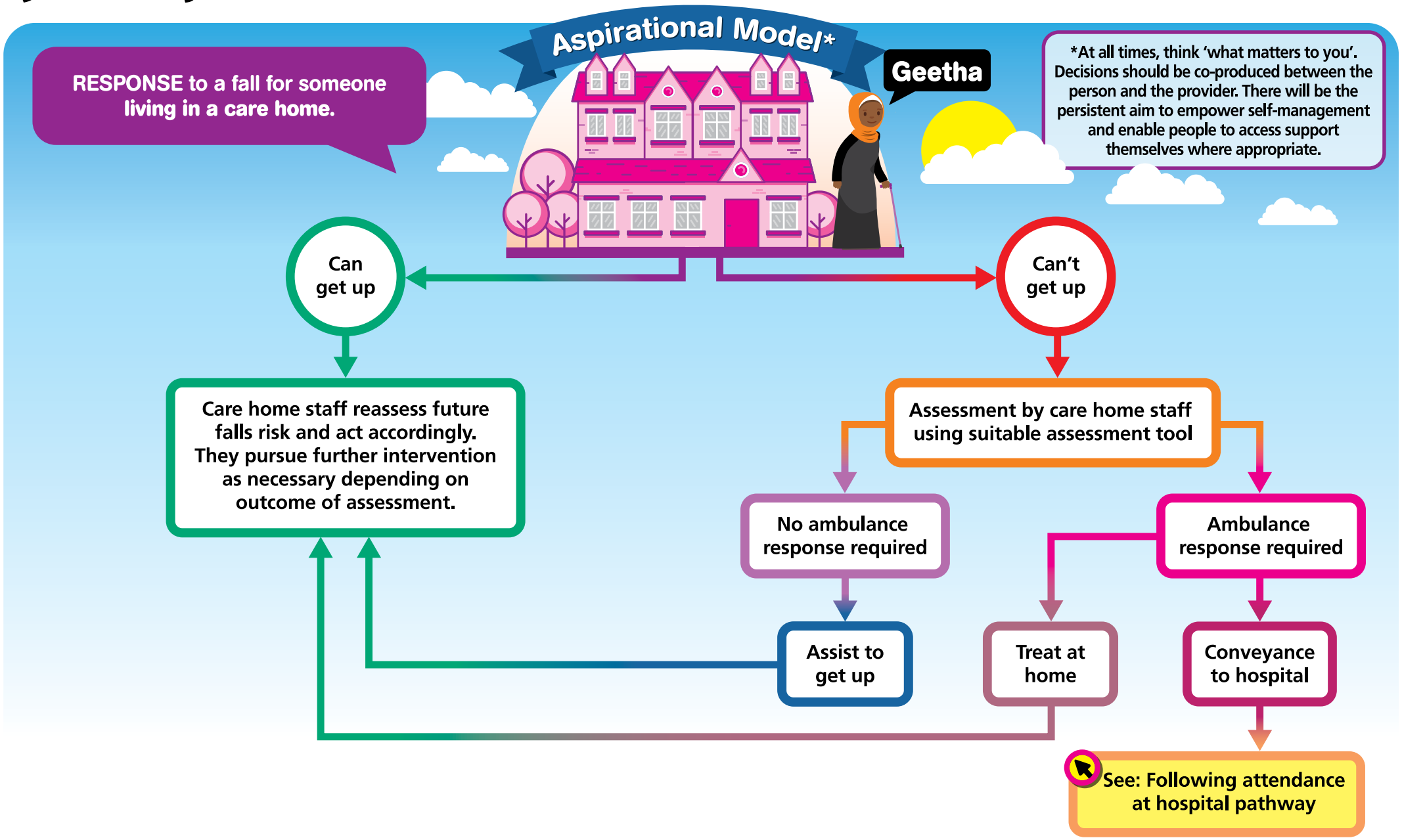
All of this is documented and, with her assent, Geetha's family are told about the whole episode. They are satisfied because it was an eventuality that was discussed with them fully on Geetha's moving into the home, and everything has happened as they understood it would.

Geetha's multi-factorial risk assessment (MRA) for falls is repeated in case of any change following the fall, but there is none. She will continue as before, including continuing to garden, and the MRA will be repeated in one month's time routinely.

3. Pathways


RESPONSE to a fall for someone living in a care home.
Dysfunctional Model
Geetha
Can get up
Can't get up
No further action
Recurring falls
Increased risk of significant harm
Refer to GP
Medical assessment only – absence of holistic approach
Important preventable causes of falls missed
May advise calling 999
Call 999
Emergency response
Injured
Not injured
WAST falls pathway
Variation in individual clinician and also local community response leads to variable quality of care experience
Conveyance to hospital
See: Following attendance at hospital flowchart

3. Pathways


RESPONSE to a fall for someone living in a care home.
Aspirational Model*
Geetha
*At all times, think 'what matters to you'. Decisions should be co-produced between the person and the provider. There will be the persistent aim to empower self-management and enable people to access support themselves where appropriate.
Can get up
Can't get up
Care home staff reassess future falls risk and act accordingly. They pursue further intervention as necessary depending on outcome of assessment.
Assessment by care home staff using suitable assessment tool
No ambulance response required
Ambulance response required
Assist to get up
Treat at home
Conveyance to hospital
See: Following attendance at hospital pathway

3. Pathways

3.5 What Does 'Good' Look Like?

Following attendance at hospital due to a fall at home

Phyllis, 79 years old, is brought to the emergency department by her son following a fall at home on Saturday morning which resulted in her grazing her face badly, and so they wanted to get her checked out.

Happily there is no medical or surgical reason to admit Phyllis to hospital. However, it does appear that she has been 'struggling' at home for some time since the death of her husband, and there are several issues with her returning home – she can't prepare full meals for herself in her current condition, and she has been living out of one single room downstairs due to the lack of suitability of her home environment for her needs due to trouble managing stairs. Her bathroom and bedroom are upstairs.

The physiotherapist in the emergency department is able to assess the extent of these needs, and also ascertains that Phyllis very much wants to remain living in her own home, but she agrees with staff that it is not very safe for her to do so at present.

The emergency department physiotherapist is able to get a room at a residential home for a short-term placement whilst a full multi-factorial assessment of Phyllis, her falls risk and her holistic needs are made.

As a result the house is adapted (with her agreement) to include a stair lift. A hot meal service is arranged to provide her with adequate food. She is also linked in with a community strength and balance group to improve her functionally, and an eye test to update her glasses prescription – all of which were found to be contributing factors to her fall in the first place.

Not only does Phyllis spend no more than a couple of hours in the hospital, but she spends only a couple of weeks in temporary residential care accommodation. Two months after returning home, through engagement with her interventions and community primary care team and falls service, she is able to discontinue the meals service and return to preparing her own food. She also now has a new social activity in the weekly exercise class and feels confident that she can continue to lead a happy life in her own home for the foreseeable future.

3. Pathways

3.6 What Does 'Good' Look Like?

Following attendance at hospital due to a fall in a care home

Piotr, 84 years old, is a long term resident in a residential care home. He falls whilst walking one day and suffers a broken hip. He is taken to hospital and has an operation to fix this.

On admission to hospital the care home and the hospital team meet with Piotr and his family to ascertain what is important to him. It emerges that he loves living at this care home, where he has been for the last 2 years, as they have a vegetable garden which he is avidly interested in, and many friends there where they hold regular social events such as dances and cocktail parties!

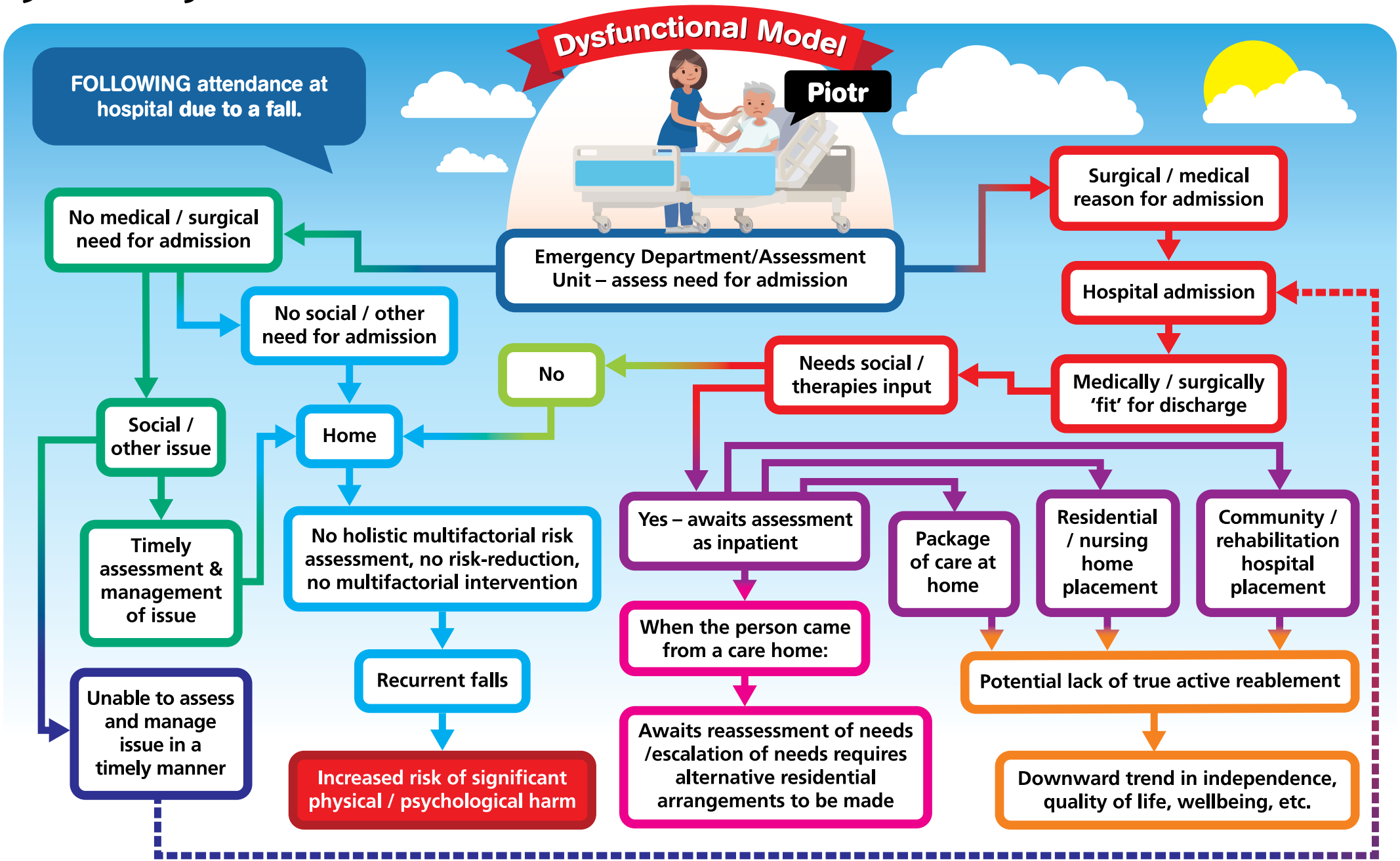
Two days after his operation, Piotr is able to get to the bathroom with the assistance of one other person, although he is still quite weak and under confident. There is another meeting between the hospital team, the community team, the care home, Piotr and his family, and everyone agrees that the best thing would be for Piotr to spend as little time in hospital as possible, but that the barriers to him getting home are the increased need for support in his mobility at present.

The community team agree to provide one-to-one physiotherapy input in order to continue improving Piotr's functional ability, strength and balance in the setting of his own home. They will also monitor his recovery following the surgery by putting him on the Virtual Ward list, where he can be assessed by nurses and discussed at daily meetings at the community hospital to ensure wound healing and absence of infection. The care home has to organise some extra carers temporarily to ensure adequate supervision for safe mobilisation around the home.

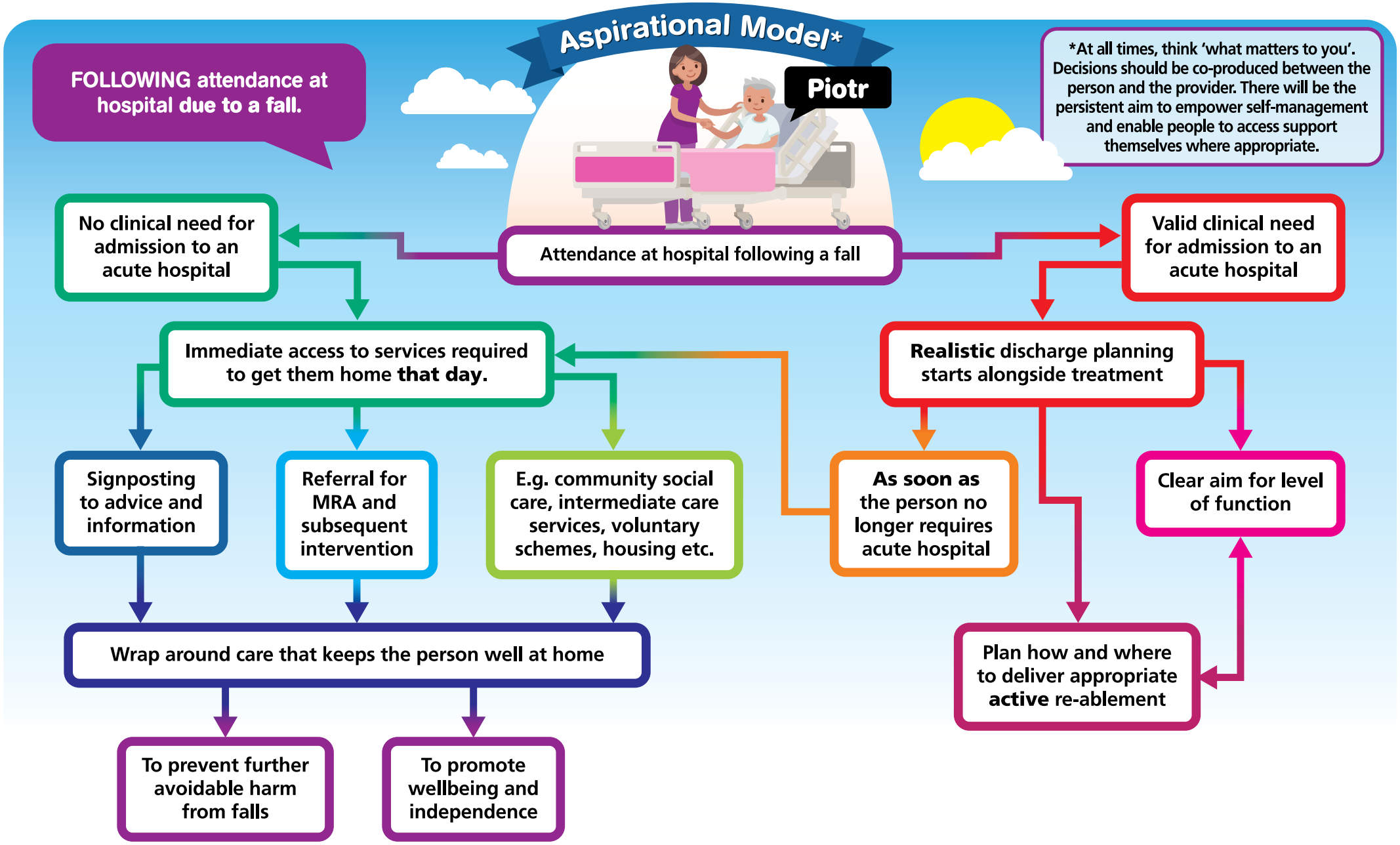
In a few weeks Piotr's wound has healed, and his strength and mobility have improved back to pre-fall levels. The care home staff have been upskilled by the community physiotherapy and nursing teams as to what to look out for and how to continue the rehabilitation process, and so these professionals can step back now. Piotr no longer requires extra carer support either.

As a result of the sharing of skills between the physiotherapists and the carers there are now regular twice-weekly strength and balance exercise classes provided at the care home by the carers themselves, which makes them feel empowered and rewarded, and from which the residents get real benefit and enjoyment.

3. Pathways


Dysfunctional Model
Piotr
FOLLOWING attendance at hospital due to a fall.
Emergency Department/Assessment Unit – assess need for admission
No medical / surgical need for admission
No social / other need for admission
Social / other issue
Timely assessment & management of issue
Unable to assess and manage issue in a timely manner
Home
No holistic multifactorial risk assessment, no risk-reduction, no multifactorial intervention
Recurrent falls
Increased risk of significant physical / psychological harm
No
Surgical / medical reason for admission
Hospital admission
Medically / surgically 'fit' for discharge
Needs social / therapies input
Yes – awaits assessment as inpatient
When the person came from a care home:
Awaits reassessment of needs /escalation of needs requires alternative residential arrangements to be made
Package of care at home
Residential / nursing home placement
Community / rehabilitation hospital placement
Potential lack of true active reablement
Downward trend in independence, quality of life, wellbeing, etc.

3. Pathways


Aspirational Model*
Piotr
*At all times, think 'what matters to you'. Decisions should be co-produced between the person and the provider. There will be the persistent aim to empower self-management and enable people to access support themselves where appropriate.
FOLLOWING attendance at hospital due to a fall.
Attendance at hospital following a fall
No clinical need for admission to an acute hospital
Valid clinical need for admission to an acute hospital
Immediate access to services required to get them home that day.
Realistic discharge planning starts alongside treatment
Signposting to advice and information
Referral for MRA and subsequent intervention
E.g. community social care, intermediate care services, voluntary schemes, housing etc.
As soon as the person no longer requires acute hospital
Clear aim for level of function
Wrap around care that keeps the person well at home
Plan how and where to deliver appropriate active re-ablement
To prevent further avoidable harm from falls
To promote wellbeing and independence

4. Key Themes

These are the frequently occurring or important issues that arose from the information gathered during the course of this review. Many of these themes overlap and merge into one another, but the 'headlines' are the points that merit emphasis.

We have divided the themes into how they appeared to affect or involve the report's different audience groups:

- **Public / Service users,**
- **Service Providers (staff working within the services), and**
- **Service Commissioners (people in charge of deciding how services get provided).**

4.1 Conventional measures and metrics used to evaluate services or guide care are not adequate to reflect good quality integrated care.

Measures such as 'number of falls' and 'number of admissions to hospital' tend to be perceived as being 'easy' to collect but can be poor reflections of the genuine quality of the service.

PUBLIC / SERVICE USERS:

- People can feel like the system concentrates on the numbers rather than the individual issues of the citizens it serves.
- What is important to the general population is not necessarily what services are saying is important to them.
- The public are not always aware of what they should expect from a falls service/integrated care system.

"I think the number of reported falls is nowhere near the real figure anyway – many older people are ashamed to admit they have fallen."

"[as an older person] You're afraid to admit you've fallen in case they put you in a home."

"They [service providers] only do things for you to cover their own backs."

"I've never heard of a falls service, I didn't know they existed."

4. Key Themes

SERVICE PROVIDERS:

- We heard that service providers sometimes felt that they were being judged on the wrong measures, leading to decreased satisfaction in work.
- We heard that reducing **harm** from falls, such as fragility fractures (as opposed to reducing absolute numbers of falls) or increasing the age at which the first fall happens, are some suggestions for more sensible aims.
- The 1000 Lives Improvement team have been considering piloting approaches that teach older people how to fall more safely, based on research which has shown this can effectively reduce the number of falls that result in injury[15], therefore achieving the more meaningful outcomes of preserved independence and improved quality of life.

"You can't measure the full impact of good wraparound preventative care – like making sure the person has food in their cupboards when you assess them for falls risk at home." – WAST service provider

"It is difficult to measure the absence of harm. How can we prove that a fall happened later than it would have done without the preventative services, or that it would have resulted in more harm? However we do work with a range of community partners with a proven track-record and with clear evidence of positive impact on the reduction of falls risks." – Taskforce representatives

"Mental health and wellbeing is more important than anything else for our residents." – Care Home Manager

SERVICE COMMISSIONERS:

- By putting the person at the centre of the service and working backwards from this, we could come up with some measurements which usefully guide us towards our aim of a high quality service, but that don't act as targets.
- It can be difficult to justify funding a service unless you can demonstrate the benefits of it; in falls this could mean demonstrating the delay in a first fall or a decrease in the harm caused by a fall, i.e. measuring the absence of something, which is intrinsically difficult. However, the temptation to rely on bad but easy measures in order to do so must be avoided, for the reasons outlined earlier in this report.
- Using metrics such as increased confidence measures and the Camden 'time spent at home' measure[16] are feasible options to pursue this approach.
- Measuring a system in a way that is both meaningful to individuals and also justifies its funding is challenging. Think tanks such as the Health Foundation[17] are grappling with concepts such as this, and it may be that we need to consider supporting services based on alternative evaluation methods in order to provide the best network of preventative care in order to see the benefits in years to come.

15 *Groen, B. (2009). Martial arts fall training to prevent hip fractures in the elderly. Osteoporosis Int., 21, pp 215-221*

16 *http://bit.ly/NEJM_TimeSpentatHome*

17 *https://www.health.org.uk/*

4. Key Themes

4.2 Meaningful engagement with the public is of paramount importance.

PUBLIC / SERVICE USERS:

» If you are meaningfully engaged in the health and care services being provided to you, you play an active part in two-way communication about them:

» This could lead to services being designed better for you in the first place, or to you getting more benefit from them when you use them - people who have sought out their own assessment and treatment are much more likely to benefit greatly from it than someone who has had the 'solution' imposed upon them.

» In order to do this you must first of all be **aware** that there is a service for you to engage with. Then you must be motivated to engage with it.

"I've never heard of a falls service, but I would be interested in having an assessment."

"My mother-in-law never drank tea, and she was offended when the therapist came to the house and offered to make her a cup in her own kitchen – so she told her she didn't need any help and the therapist left."

SERVICE PROVIDERS:

» A 'what matters to you'[18] approach should be taken, making every contact count, rather than a 'what is the matter with you' approach. If we ingrain these behaviours we can grow a culture where this depth of interpersonal connection is 'the norm'. This needs to be woven right through the fabric of the health and care system in the everyday interactions that take place between staff and public.

» We saw that where providers make efforts to engage meaningfully with service users, this provided greater benefit. For example, contacting referred people by phone prior to their appointment with the falls clinic. By doing this we can ascertain that this is what they want, what they should expect and even just remind them that they have the appointment. This seems to motivate much better than an impersonal letter.

"We believe that you have to offer an open-ended exercise programme because in order to get meaningful engagement you need strong, stable, regular connections – and once you have this you mustn't let it slide." – Voluntary sector organisation delivering group exercise programmes

"The idea behind the 'brief intervention' conversation is that it empowers people to have otherwise difficult conversations that are productive." – Brief Intervention Conversation Trainer

"The people who have self-referred to the service get the most out of it." – Falls Practitioner

"I am mindful that I am in their home and if they don't want to work with me then I don't force them to. I do encourage them if it's been some weeks since they worked with me though – having a regular day for your physio can remind residents of what it was like when they were independent and had appointments and routine/ structure, and many of them really benefit from this and enjoy it." – Physiotherapy Technician, Care Home.

18 *Paragraph 61, Part 3 Code of Practice – Social Services and Wellbeing Act (Wales) 2014 http://bit.ly/30krggi*

4. Key Themes

SERVICE COMMISSIONERS:

- As well as considering the implications for redesigning and evaluating services, commissioners should consider the fact that they get better value care when the recipients are engaged in the whole process.
- Strategies that enable better public awareness of prudent healthcare approaches, and their benefits to individuals, are lacking in efficacy and prevalence, and systems are still not allowed to run in a way where they have enough 'space' to foster productive relationships between services and public.
- If commissioners are to turn the model of care on its head, and advocate that people access their care differently and expect different things from it, for example to have it delivered by different people or in a different structure to the traditional one that they are used to, then commissioners **must** engage the support of the service users.

4.3 Information exchange and communication between social care, health and housing workers is key to quality care

PUBLIC / SERVICE USERS:

- People are still let down by the lack of ability of different professionals to see their records when it seems important and sensible to them.

"There are problems with hospitals not communicating. After my hip came out following a fall, one hospital put me in a brace for six weeks. When I went back to the other hospital for an outpatient appointment with the consultant who did the operation he told me to take it off as it wouldn't do any good. I was in agony for six weeks for nothing, and it was a waste of money. I was told that they couldn't see what had happened because they didn't have access to the other hospital's documents."

4. Key Themes

SERVICE PROVIDERS:

- A significant theme is that where people worked in close proximity with others in different specialties, they found much lower barriers to timely referral, good advice and satisfying patient-centred care.
- Unfortunately it is still very common to hear that people from different organisational backgrounds speak 'different languages', and feel they have different priorities. How can this be, in a system where all are meant to have the same shared aim? What is best for the individual at the centre of the system?
- This could mean that a link in the chain is not listening or communicating well.

"Our weekly CRT (Community Resource Team) meetings are good because they encourage shared decision-making, which results in better outcomes for the patient, and also has built a good network of professional relationships which enables us to treat patients seamlessly between each other. The biggest barrier is still IT – we have formed a drive through which we can all access documents except for social care, as they don't have the right format user number." – District Nurse, CRT member

"I was really struck, when attending a health board-wide falls event last week, by how everyone is pulling together to try and improve each other's quality of life." – Care Home Physiotherapy Technical Instructor

SERVICE COMMISSIONERS

- It was apparent that some services are still designed in such a way that they make it difficult for people to do their day-to-day jobs, whether this is technological systems that create blocks to access of vital patient information, or methods of working that favour the 'silo' approach rather than allowing space for staff to exercise creativity and ingenuity in finding a better way to care for their recipients.

4.4 Governance / strategic oversight is sometimes lacking or insufficient.

This theme underpins many of the others listed in this review.

PUBLIC / SERVICE USERS:

- The consequence of insufficient oversight or governance is when services you use are not designed (or run) well enough to do the job of delivering high quality care for you.
- We found evidence of cases when individuals don't 'fit' the service they were referred to, resulting in them potentially not being seen at all.
- Person-centred care should mean that the services should be wrapped-around you and your needs, so you shouldn't experience the phenomenon of 'falling through the net'.

"The hospital physio can only give you 10-15 minutes as they don't have the resources to offer more. They give you exercises to take home but I either forget or can't be bothered to do them. I much prefer going to a class – it's more fun, isn't it?"

4. Key Themes

"There's so much out there, all of them saying 'it isn't down to us!' We need one message, someone to take responsibility – they all think someone else is doing it."

SERVICE PROVIDERS:

- From speaking to operational level staff it is clear that often there is the willingness to work more flexibly and responsively, but that this space is not created by e.g. governance or service design.
- An excellent example of a team overcoming this is seen in a Community Resource Team where they have a 'blockage template' – meaning they escalate any blockage to seamless integrated care to higher management who provide rapid and appropriate resolution.
- Some staff receive training in falls and are then redirected from the falls service to other areas of need by service managers under pressure – this causes frustration amongst service providers and also undermines the falls services that are suffering from de-prioritisation.

"We can no longer offer group exercise classes because the service manager cancelled them." – Falls Service Locality Lead

"We don't use the 'single point of access' referral for occupational therapy because it can take much longer to reach them as there are more steps inserted into the process – we are in the same building as them, so we just walk across and talk to them, but it's not what we're supposed to do." – Falls Practitioner

SERVICE COMMISSIONERS:

- There are examples where health board policies stand directly in the way of seamless care, for example rules about referral pathways and criteria which mean that certain members of the health and care workforce are unable to communicate directly with one another, leading to unnecessary bottlenecks in the system (e.g. commonly at GP level).
- Consideration must be given to how the service providers are allocated – if staff are placed in roles against their preference they are unlikely to perform the role with enthusiasm and to the best of their ability to benefit the service recipient.
- Frequent changes at managerial or executive level can lead to blurring of overall strategic direction and momentum.

4.5 There is unnecessary variation in services and supporting activities

PUBLIC / SERVICE USERS::

- In different areas you may experience vastly different availability and quality of care and community resources.

"I used to go to pilates regularly, but when I moved there was nothing anywhere nearby and so I don't do anything now."

"The fire service in our area would ask you about falls when they came and checked your smoke detectors, and they referred me to my local falls service." – this was a solitary experience in one geographical area – most of the people asked had never been questioned on falls, despite many of them actually already having had one.

4. Key Themes

SERVICE PROVIDERS:

- There has to be balance between adopting protocols and guidelines that have been accepted nationally as effective, and maintaining practices that have been shown to work well locally.
- Part of the answer to finding this balance must lie within service provider/ coordinator engagement. Operational level providers often don't feel engaged enough in the method of going about this. They describe feeling 'steam-rollered' by decisions made about their services, without due consideration given for local variation in personnel, links with the rest of the system and community resources which often shapes the way in which their service is provided.

"We use iStumble every time a resident falls. We find it very helpful. It has meant that we genuinely assess the residents and don't automatically reach for the phone to call 999. This has resulted in residents spending less time on the floor after they have fallen, less harm to residents and less embarrassment." – Nursing Home Manager

"They want us to adopt this new protocol for assessing people who have fallen, however we already have one which we developed in-house and it works really well – everyone is trained in it, and it includes everything that is needed - it makes no sense to switch to something else." – Senior Social Carer, Residential Home

SERVICE COMMISSIONERS:

- There needs to be recognition that in complex pathways such as falls there are some common principles that can be to be standardised – not least because there is no value in varying them and re-inventing them many times over.
- The reward lies in engaging successfully with service providers and reaching the mutual conclusion that structuring services in this way will create space to deal effectively with the necessary variations in a complex system that is concerned with multiple individuals.

4.6 Sources of funding for services can be an important enabler or barrier to integration.

PUBLIC / SERVICE USERS:

- People may wish to receive a certain type of care or treatment from a certain provider who already sees them for example, but then are told that this cannot be provided in this way – not because they wouldn't be able or willing to, but because that's 'not the way it works'. This may be because the funding for that job or service dictates what that person can or can't do. This can result in multiple appointments with carers or health professionals, or being obliged to travel unnecessarily for your care.

4. Key Themes

"We had a lady who was being palliated and wanted to die in our residential home where she had been living for a few months. We put on extra care staff and liaised with the nurses from the palliative team for the necessary medicines etc. that we weren't used to. She passed away peacefully as she had wanted and we felt we had helped her achieve that." – Residential Care Home Manager

SERVICE PROVIDERS:

- Many providers commented that where their services had been funded in a joint way – for example money from the Integrated Care Fund (ICF)[19] – this made it easier to shape and run the service as it was required by its users, and made them more effective and ground-breaking in the way they work.
- There have been instances where lack of clarity about funding source/ responsibility can lead to lack of provision of vital linking resources such as transport to and from exercise classes.
- The source of funding can create problems with dividing up your clinical time when you have other health responsibilities.

"We've tried multiple times but no-one says it is within their remit to fund transport to the NERS (National Exercise Referral Scheme[20]) class. I'm sure we would get a much bigger uptake if transport was provided, and the class is really beneficial in so many ways. It's a real missed opportunity." – Falls Service Provider.

"The service managers expect me to do more and more with the same amount of time, I'm expected to cover other clinics and always end up writing my notes in my own time."– Falls Service Provider

"Some people criticise the ICF (Integrated Care Fund) for not being ongoing indefinitely. It can make it harder to recruit staff sometimes as the posts are short term etc. but it does mean that no one organisation owns a service, and this allows development of truly shared aims and outcomes, which is invaluable, and difficult to achieve with other more defined sources of funding." – Service Provider involved in an ICF funded project.

19 *http://bit.ly/IntCareFund2019*

20 *http://bit.ly/NERS2*

4. Key Themes

SERVICE COMMISSIONERS:

- Generic sources such as the ICF are hailed as being good for integrated services as explained above.
- Pooled funds for certain priorities of regional partnership boards are one of the deliverables that was required by Welsh Government by April 2019[21], but despite this, true pooled funds remain elusive in some cases. Even where pooling has been achieved in name, the nature of the allocation and spending does not necessarily follow the boundary-less path between health and local authority services as intended.
- In some cases it has been suggested that this is because pooling funding in this way is not the correct intermediary step in these boards producing joint outcomes.

4.7 The importance of the voluntary and independent sector in providing a good integrated pathway.

PUBLIC / SERVICE USERS:

- It is not always possible, practical or desirable to access all aspects of illness prevention and wellbeing promotion through the public sector.
- Many feel that it is not the responsibility of the publicly-funded NHS to provide everything, such as exercise classes and wellbeing activities.
- Conversely we have the mounting evidence that it is exactly this rich and diverse network of resources and activities that help provide us with the solid foundations of good health, and reinforce healthy behaviours and prudent health and care-seeking philosophies.
- Often it is in the best interests of public services to ensure the basics are being done well, and this is where the charities and voluntary organisations can play such a vital role – in filling the gaps and bolstering the resources in communities, making them more conducive to happy healthy citizens living there and also improving their resilience for when crises hit.

"We no longer have contact with postmen and milkmen in our community – these used to be important sources of information and sometimes help, but you don't realise how important they are until they're not there anymore."

"Our hospital exercise class was coming to an end, but I was advised to attend one led by a local fitness instructor instead. She picked right up where they left off as she had attended several classes before taking over. They arranged a lift for me with a couple who were already attending this class and now we're good friends and go out regularly for coffee as well."

SERVICE PROVIDERS:

- Having a robust and effective voluntary/ independent sector working to support services in your area can be invaluable.
- Good relationships with the voluntary or independent sector can help with identifying people who would benefit from your service, or provide practical support in some instances such as transport.

21 *Paragraph 10: http://www.legislation.gov.uk/wsi/2019/760/made*

4. Key Themes

» If true integrated working takes place then it can join seamlessly with your interventions – complimenting them, adding extra variety of options or even take the place of some things that can free up resources for you to do what only you can do as professionals.

"I've been volunteering as a physio assistant with the local falls class as I want to study physiotherapy in university. I have also been volunteering with the Community First Responders for the last 4 years. Since October last year we have been attending uninjured fallers, which are 'green' calls. We take obs and relay information back to ambulance control, who will then stand down the emergency ambulance if not needed. We could do with better manual handling training for getting people up maybe, and I think it would be good if we could refer them on to the falls team afterwards, but I wouldn't know where to start as we haven't had any training for this." – Physiotherapy Assistant, helping to deliver strength and balance classes.

"The findings of 'My Home Life Cymru[22]' – a university-led piece of work into wellbeing in care homes – were communicated back to people working in the health and care sectors via a stakeholder meeting. With the narrative, story-telling approach it was really powerful." – My Home Life Cymru' Stakeholder

SERVICE COMMISSIONERS:

Integrated systems of care involve voluntary, charity and independent/private organisations within the same community of the health and care services.

» Consideration needs to be given to the value that advocating and supporting the third sector can add to the public sector, not only in 'taking the pressure off' in some cases, but importantly in strengthening robust, resilient, healthy local populations.[23]

» Opportunities to partner with these institutions should be actively sought out and every effort made to avoid them being made the first casualties of 'cost-saving' strategies.

22 *https://www.walesscr.org/en/my-home-life-cymru*

23 *Part 2, Section 16 of the Social Services and Wellbeing Act (Wales) 2014: http://www.legislation.gov.uk/anaw/2014/4/section/16*

4. Key Themes

4.8 The social care workforce needs to feel – and be – valued.

PUBLIC / SERVICE USERS:

- When people told us that their lives were affected by inconvenient care package arrangements or interaction with care staff, often the perception or actual lack of recognition of the value of the social care workforce was at least in part the driver behind the service being delivered in this way.
- Social care workers often lack the support to work more flexibly and put the person receiving their care at the centre of the job that they do.
- Unfortunately we have seen instances where doing the parts of their jobs that involve directly helping people has to be 'fitted in' around time and other constraints.
- One of the main problems mentioned over and over again was lack of social care resources – staff numbers and time, with factors such as communicating with relatives, time spent helping residents walk about (care homes) and amount of time spent per house call (domiciliary care) named specifically as aspects which suffer as a direct result.

"I could do with someone to help me with my husband at bedtime, but even though we have 4 carers per day, the latest they can come is 6.30pm and that's too early for him to get into bed. Even then they put him in his pyjamas."

SERVICE PROVIDERS:

- Sadly there is still an evident culture of the social care workforce feeling undervalued as a cohort in comparison to those in the health sector.
- This is seen in the responses we received about lack of investment (of time and money) in training, communication between the two sectors at almost every level, and rates of attrition/employee turnover.
- With the concept of wellbeing and 'joy in work'[24] emerging as increasingly important to successful realisation of an organisation's shared aim, the comments at a care providers event were especially meaningful.

"We were really proud to have received an email of commendation following our involvement with the 'My Home Life Cymru' work. It's not very often you get positive feedback from other professionals or organisations." – Residential Home Manager

"The care workforce should receive the same level of care and consideration that we expect them to deliver to the recipients of the service." – Domiciliary Carer

SERVICE COMMISSIONERS:

- The problems of turnover and insufficiencies in training are a chicken-and-egg situation, but in this instance there is clearly a requirement for better engagement with employees in order to retain them and then train them.
- There is a suggested danger that improving working conditions in residential care and health may draw motivated and capable people away from the domiciliary care sector, creating a drain of skill, which may be important to recognise.

24 *http://bit.ly/HI_JoyInWork*

4. Key Themes

"We should encourage reflective practice." Social Worker

"The level and constancy of pressure on social care managers in the social care sector is difficult." – Domiciliary Care Manager

"To achieve better continuity of staff, the roles should be allowed to be more flexible and advertised as so from the outset." – Domiciliary Care Service Provider

4.9 Investment in person-centred, community-based preventative resources is money well spent.

PUBLIC / SERVICE USERS:

- Put simply, this could be translated as: prevention is better than cure!
- This links back to the earlier point about choosing the correct measurements in order to 'prove' this, and justify the reallocation of funds in this way.
- The generally accepted shift in thinking is that it is sensible to invest resources in models that keep people well at home and prevent (or delay) the start of the downwards spiral of falling, fear, hospitalisation, deconditioning and increased dependency.
- Some innovation that is already having an effect on the lives of the public in Wales is the Welsh Ambulance Services NHS Trust (WAST falls framework, where a 'Falls Assistant' may attend certain falls following a 999 call, instead of an emergency ambulance/Paramedic). This scheme has already started to prove beneficial to the outcomes that matter to people (e.g. time to response from the ambulance service) and to the system it is embedded within, but its continued funding has not been assured at this time.

"When a fall is not life-threatening, sometimes you just need someone to help pick you up. You don't need a full ambulance but you might not know this at the time."

"I live in a block of retirement flats with a pull-cord emergency alarm system. The main reason for pulling the alarm cord is falls. We have a variety of services who respond to these calls and we have our own cushioned lifting equipment. People need to be more imaginative in order to avoid unnecessary admission to hospital."

4. Key Themes

SERVICE PROVIDERS:

- People often come to the attention of the falls services too late – when physical or psychological harm from at least one fall has already happened.
- This makes it harder for the staff to provide an effective service.

"One of our biggest challenges is picking people up too late – getting people referred after a fall is often too late to start intervening. They would benefit much more from earlier recognition." – Falls Service Lead.

SERVICE COMMISSIONERS:

- The age at which the preventative measures begin can be perceived as too high, there is evidence to suggest that strength and balance training needs to start at 50 years of age in order to be most effective. Most falls services are aimed at those aged 65+ and so this may need to be considered an area in need of change in order to increase impact.
- In order for more people to be seen by the falls service, there would need to be an increase in service capacity, regardless of which model is being used in which locality.
- If there was a universally agreed set of preventative measures which could be applied then this would help, e.g. a screening tool and guidance on how it can be used.

4.10 An overly risk-averse culture is counter-productive to integration.

PUBLIC / SERVICE USERS:

- Risk-averse behaviour negatively affects the public when we hear providers of a service fear professional criticism or worse if they attempt to deliver person-centred care according to what matters to that individual.
- No-one advocates health and care practitioners acting without due care and consideration – people should still expect high quality, safe care, and any care that departs from that standard should expect to be addressed appropriately.
- If a course of action (or inaction) is accepted to fulfil certain 'tests' (for example: what the person wants, realistically achievable, legal, etc.) then it should be allowed to happen - within a supportive and flexible system.
  - For example: an older person wants to go home from hospital after a fall. Social care is arranged and home hazards mitigated. In short, all reducible risk factors have been addressed, but there remains a risk that they will fall. All alternatives are discussed, but the person still wants to return to their own home, and they have the capacity to make this decision. In this case, this person should be supported to achieve what matters to them, even if it potentially means ongoing falls at home.

4. Key Themes

"If a resident hates being accompanied whilst walking then we won't insist, even if they are at risk of falling. We will try and minimise the risk of harm to them and support them if they do fall." – Care Home staff member.

SERVICE PROVIDERS:

- Fear of repercussions in the event of 'causing more harm' by assisting someone following a fall is rife
- There is a perception of lack of support from their organisation or regulatory bodies if they try to help and something 'goes wrong'.

"We're not allowed to pick people up if they fall. I want to, but I don't feel safe if something goes wrong." – Carer working in an extended care (supported housing) setting

"Refusal to go to hospital should be seen as a valid decision they (the person who has fallen) have made about their care. They may well require increased care at home in order to achieve this."– WAST Paramedic

SERVICE COMMISSIONERS:

- The emphasis on a blame-free culture[25] is not being felt as it filters through the workforces.
- People working in the health and care sectors are in some cases reluctant to give the best, person-centred, responsive, compassionate care due to fears for their own accountability.
- The message that 'you will be commended for doing your best for a service-user' coming from inspectorates and governing bodies is not strong enough.

25 *http://bit.ly/FromBlameCultureToLearningCulture*

4.11 Care should be person-centred, and not service-convenient.

PUBLIC / SERVICE USERS:

- We heard about several instances where the requirement placed on the individual by the service is still weighted towards what is convenient for the service itself.

"We make the full-day round-trip to the hospital for my husband's COPD clinic every 3-4 months because that's how the consultant likes to keep track of how he's doing. He is very unsteady on his feet and it is an ordeal with his walking frame and his oxygen machine."

SERVICE PROVIDERS:

- There is a, probably well-meaning, perception that it is important to protect the service from 'misuse' in order that it can effectively provide assistance for those who need it.
- This can sometimes be displayed by complicated or defensive referral processes, without consideration for who will take responsibility for the individual at the centre of the process if they don't 'fit' the service they are referred to.
- There is limited data on referrals to community resource teams or falls services that are deemed 'inappropriate', and therefore these patients are at high risk of slipping through the net and not being picked up as 'at risk of harm'.

4. Key Themes

"We always see referrals, even if they haven't filled in the correct referral process or fulfilled the criteria – there must have been something that made that person think they needed the falls service, and if we can't help – we make sure they are put into the care of someone who can." – Falls Service Lead.

"We've been trying to encourage Emergency Department nurses to refer people to the falls service when they are seen out of hours, but one got refused as they hadn't yet fallen, and this discouraged that nurse from doing it again." – Physiotherapist

"We don't think of it as spoon-feeding or mollycoddling people, we think of it as caring passionately about people in a practical way." – Falls Support Worker

SERVICE COMMISSIONERS:

- Systems that truly put the person at the centre need to be flexible and responsive, and the people working within them need to have the support to exercise their responsibilities in that way too.
- There could be room for more creative ways of capturing information about recurring deficiencies or gaps in the care that your service provides, and finding a team-based approach to solving these issues.
- If you look at every service through the eyes of a user of that service, you quickly identify important flaws that may even be easily rectified.

4.12 The contribution of outstanding individuals makes a huge impact on services such as falls.

PUBLIC / SERVICE USERS:

- We saw numerous instances of feedback received by services detailing individuals who have gone 'above and beyond' the requirements of their jobs in order to help them.
- This is usually associated with staff who have spent time establishing 'what matters' to that individual. This links with points made earlier in this report on staff having the time and energy for meaningful engagement with people.

SERVICE PROVIDERS:

- We heard from staff who have come back to work following retirement and who regularly work outside their contracted hours, using skills and knowledge from previous positions to add value to their current job in falls.
- Some people have taken the initiative to disseminate learning from personal development opportunities to the rest of the staff at their organisation for the benefit of service users. We also saw examples of assessments being done during evenings and weekends if that is what is best for the recipients, transporting service users to appointments using their personal vehicles, providing staff training in their own time and people generally 'bending over backwards' to help their clients of falls services in creative and ingenious ways.

4. Key Themes

"The interest in the brief intervention training currently far outstrips the capacity to run it as there is no designated team of people to provide it and so it gets provided alongside other job roles and responsibilities – which is not sustainable." – Brief intervention trainer

"Your own personal approach in this job matters. You must win people over. I like people and I'm good with them, so I love doing this." – Falls support worker

"I went with a resident to the physio's when she needed some strengthening exercises for her gait and balance. Now I do exercise classes with the other residents in the afternoons – we put music on and they enjoy it. I would really like to have proper training in preventing falls so that I could take this further."– Care Support Worker, Care Home.

SERVICE COMMISSIONERS:

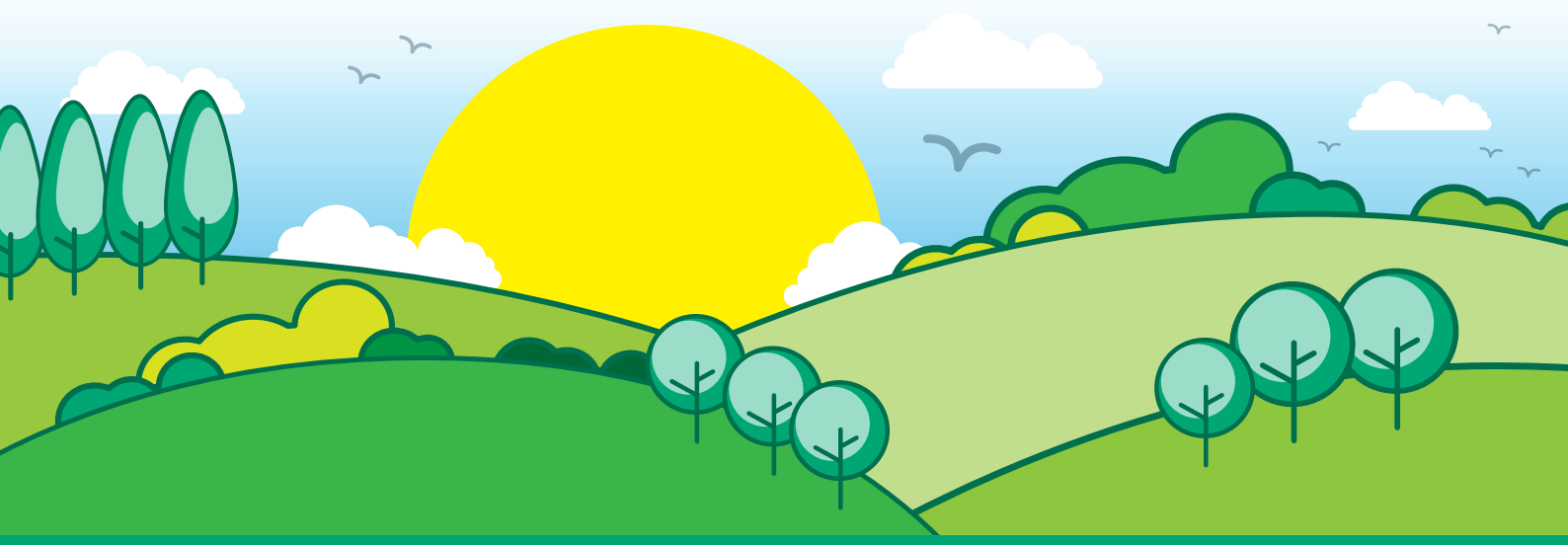
- It is excellent to see inspiration and energy in the health and care system. Perhaps service designers should ask, how can we encourage and / or replicate these shining examples of personality traits?
- Some responsibility for this lies within recruitment[26], retention and continuous development of the workforce, and links too with valuing our workforce and creating engagement, linking with previous comments in this review.
- Care should be taken not to take advantage of these of these individuals and rely too heavily on them, in the interests of ensuring a sustainable system for the future.

4.13 There is a place for in-reaching to acute care settings and extracting suitable people for active reablement

PUBLIC / SERVICE USERS:

- People felt they spent too long either waiting in the emergency department or on a ward for discharge, following a fall.
- People felt that they did not receive any/enough appropriate support (either in the form of advice, follow-up or practical interventions) following hospitalisation for a fall.

26 *wecare.wales – Social Care Wales recruitment campaign, for example. https://www.wecare.wales/*



4. Key Themes

"I had to be admitted for antibiotics when I grazed my arm because of a fall. I wasn't assessed for my risks of falling again before being discharged home."

"I was never asked in the hospital about how I came to fall."

"When I came home from hospital after having my hip replacement the district nurse came round and they were very good. They fitted aids and adaptations for my new hip, but they never mentioned falling."

"My discharge process took 9 weeks – too long! I was told I could go in January, but it wasn't until March that I actually left hospital. As far as I can tell they couldn't get the doctor, social services and my family together to agree a package of care. Discharge planning need to happen much earlier in the admission."

SERVICE PROVIDERS:

- This theme links with many previously mentioned in this review:
  - Risk aversion: Not wanting to send someone home 'just in case'
  - Lack of emergency community-based care and therapy services, showcasing a need for more investment in preventative services
  - Variation in services geographically – making it difficult to create a robust, safe pathway that is an alternative to unnecessary acute admission to hospital, and
  - Cooperation and communication between different members of the integrated care team – here referring not only to health and social care, but primary and secondary health care as well.

"We trawl the computer system to find older people who can be taken from the 'front door' area of the hospital and linked in with support services which mean they can return home rather than endure an unnecessary hospital admission. However we know we miss plenty during weekends and nights, as we pick them up from the wards too. One of the biggest challenges is variation in policies – even within different areas of the same health boards! It can be very time-consuming and frustrating to try and work with the many different methods of referring people on to all these areas, and it leads to some avoidable admissions unfortunately." – Physiotherapist

SERVICE COMMISSIONERS:

- This is an area of significant emerging and established work. The value in having a system which prevents unnecessary admissions to acute hospitals is already recognised as being of incredible benefit to the individuals concerned, and then has a positive effect on the wellbeing of the population and the care system.
- There are barriers created at service planning level that need to be taken down in order to make the appropriate flow of patients through the system safer.
- When considering older people unnecessarily 'stranded' in acute care settings, the balance of responsibility between community and secondary care in solving this issue remains to be agreed upon.

4. Key Themes

4.14 New technology should be used to enhance care and enable practitioners to do the best job they are capable of doing, and not to replace interactions that should only be done by people.

PUBLIC / SERVICE USERS:

- There is variation in how happy and familiar older people are with new technology. Resources that are available to help 'upskill' older people specifically in areas such as using the internet are probably under-exploited.
- Older people have said that they worry about technology replacing vital human interactions, but there is evidence that, where used appropriately, it may be beneficial.

"The residents know the 'dementia cat' isn't a real animal, but they still like to name it and their faces light up when it meows and rolls over!" – Deputy Care Home Manager, introduced robotic cats as companions for the residents.

"I heard about these pressure pads you can get for your home that can sense when you've got up or when you've fallen over, but my worry is that people will stop coming round and checking on you then."

SERVICE PROVIDERS:

- There are a variety of devices and programmes available that are designed to make life easier and safer for older people, and older people have a very wide range of technological ability (as do the rest of the population). Effort should be made on a case-by-case basis to find any technology that would help in a certain situation and evaluate its effects, good and bad, following proper 'training' on the new technology for the users.
- Consider once again 'what matters' – do they really need a 'humanoid chatbot' that can 'socialise' with them, or do they actually need an intelligent toilet seat that lights up, warms and adjusts height to help prevent falls?

"We use a messaging service to support delivery of our falls education and exercise programme. We don't force people to take it up, and the handful that do seem to get benefit from it, although when people struggle with getting signal at home this is a barrier to its usefulness." – Physiotherapist, Exercise Programme Coordinator

SERVICE COMMISSIONERS

- Understand that technology offers some exciting opportunities for improving quality of life for older people and be vigilant for prudent investment in appropriate systems. However, also recognise that there are limitations and that the overall culture of an age-friendly society is of greater importance than simply 'digitalising' the system.

"I can see alarm pendants becoming obsolete with newer voice-activated and internet-connected devices." – Falls Service Lead.

"Older people don't necessarily HAVE to be 'online' as long as they feel they are getting the person-centred care and social-connectedness that they want." – UK Digital inclusion charity.

4. Key Themes

4.15 Falls are everyone's business

PUBLIC / SERVICE USERS:

It seemed apparent that many people who were at some risk of falls and in regular contact with multiple health and care professionals had not had the opportunity taken with them to explore their potential for harm-reduction.

"I am under close observation by the orthopaedic hospital for my rheumatoid arthritis, but I've never heard of a falls assessment or a falls service."

"I went to the GP about osteoporosis, but neither the GP nor the pharmacist asked me about falls."

SERVICE PROVIDERS:

- Perhaps not all people at 'some' risk of falls need to be seen by a specialist falls practitioner.
- Screening and risk-stratification tools to guide this exist but are not standardised and as a result can be used with varying accuracy and effectiveness.
- 'Only do what only you can do' should be balanced with intervening where you are ideally placed to do so, in order to get the best efficiency from a system.

"I get frustrated when I get a referral simply asking for some equipment to be issued – I prefer to assess people myself and make a decision as I am a clinician and not a delivery service. Our falls team don't have to do this now however – they are OT assessors and can assess and order equipment as they need to and only involve us for specialist cases – which is good as we're really busy and have a long waiting list sometimes." – Occupational Therapist, Community Resource Team

"We do get used as a diagnostic tool sometimes, due to the holistic and thorough nature of our multi-factorial risk assessment for people at risk of falls, but I find it difficult to argue against this as it answers a need for the patients and for the GPs." – Falls Service Lead

SERVICE COMMISSIONERS:

- A 'pre-falls' service has been proposed, to decrease the incidence of falls services being saturated with referrals for people who have already fallen. There is great potential to add value here, focussing on people who have yet to experience a fall.
- Upskilling of individuals within integrated teams to deliver services which add most value seems an option with merit; for example delivering non-specialised exercise advice where specialised strength and balance intervention is not warranted, to free-up precious physiotherapy resource etc.
- Incorporation of more services into the integrated team model in the form of pharmacists is an avenue ripe for exploration at this time, that way medication reviews could be done without referring back to the GP.

5. So what do we think?

There is a lot of good work going on around prevention of avoidable falls for older people, promotion of wellbeing and good quality of life and management of falls when they do happen. We have also seen examples of care being more community-based and person-centred, minimising unnecessary time spent in hospital.

However, this review has highlighted some recurring messages, from people directly involved in the falls integrated care pathway, about what still needs to change, develop or improve. These improvements are needed in order to achieve the ultimate aim of a seamless, person-centred, high-quality health and social care system.

The recommendations that we have made reflect the potential for high-value impact in furthering integrated care and falls management in Wales when implemented, largely through better coordination and communication. Coordination and communication are essential to both regional and national progress in this area.

6. Recommendations

Recommendation	Who is responsible?
1. Prioritise appropriately Falls in people aged over 65 years should be made a priority in their own right and not a sub-section of other ageing-well strategies in order to give the issue sufficient focus.	» Welsh Government
2. Public engagement and information Much more work is required around increasing public awareness of the significance and preventability of falls in older people. Any public engagement campaign should incorporate an intergenerational element. Consideration should also be given to the creation of a standardised source of written information to support public health promotion that will enable staff across the whole system to have access to appropriate, consistent information.	» Welsh Government » Health Boards » Local Authorities
3. Value the social care workforce Health and social care need to ensure that people with vital roles in delivering care to the public feel valued and able to engage and contribute to the improvement of the service in which they work. Specifically, communication between the health sector and other partners need to be made easier.	» Health Boards » Local Authorities
4. Fund preventative resources Whilst dedicated integrated care funds have encouraged the emergence of many initiatives, consideration should be given to the adequacy of allocation of sustainable funds towards regional preventative, community-based resources that support the resilience of individuals, leading to decreased dependence on secondary healthcare.	» Welsh Government

6. Recommendations

Recommendation	Who is responsible?
5. National standardised approach A nationally accepted deployment framework of falls services should be considered in order to provide a more coordinated approach demonstrating good integration between community and hospital care, health, social care, housing and also public and voluntary/independent sectors. Within this framework there should be appropriate measures and methods of evaluating the services that truly reflect good person-centred care.	» Welsh Government » Health Boards » Local Authorities
6. Clear local pathways There needs to be clearly described local falls pathways in all health board areas, especially in the community, and there is a need to identify all local coordinators (not just health and social care professionals) within these pathways.	» Health Boards » Local Authorities
7. Operational-level behaviours In order to bring about a culture shift towards a multi-agency approach to reducing risk factors and prevention, behaviour that embodies person-centred care needs to be visibly reviewed, renewed and reinforced amongst all who work in the services and organisations with the potential to contribute to the solution.	» Health Boards » Local Authorities
8. Workforce training Organisations need to ensure that sufficient people are both trained and empowered to deliver tiered falls assessment and management. This should involve a robust triage element and be supported by a suitable referral system, and should enable a sustainable system-wide approach to meeting the varied needs of the population.	» Health Boards » Local Authorities

7. Areas for further work

The issues below are areas that emerged during the review as things that may benefit from further consideration and action from other bodies:

- Mapping exercise of networks of organisations within care systems to better understand barriers to integration – either undertaken nationally or done by locality and then joined to make a full picture
- Scoping exercise to provide more information for future workforce planning to ensure the need for community-based, tiered systems of care delivery can be accommodated sustainably
- Better understanding of how the health and social care public sector can engage more effectively with our workforce and our public
- More data on falls services that is accurate, complete and meaningful in order to be able to make the right decisions regarding models of care delivery
- The issue of reablement in community hospitals and other community and hospital settings is vast and not covered in any detail by this review. A joint report by HIW and CIW will be published later this year which will give a much more detailed picture of this area, which is intrinsic to the question of integrated care for older people. We advise anyone who has an interest in this to look out for those findings.

8. Appendix A

Glossary of Terms:

CIW: Care Inspectorate Wales. Independent regulators and inspectors of care services in Wales – including domiciliary and residential care, child care, fostering and adoption services.

Clinical Support Desk (CSD): Clinically trained practitioners who speak to 999 callers over the telephone at the ambulance service and can 'triage' (judge) the urgency of the problem and refer to the most appropriate help whilst also giving support and advice to the caller.

COPD: Chronic Obstructive Pulmonary Disease. A group of progressive lung diseases including emphysema and chronic bronchitis that cause breathing difficulties.

CRT: Community Resource Team. A team of people from health and social care and potentially other services that work jointly to try and coordinate and streamline good quality care for the local population. Usually several per Health Board area, and the precise membership/make-up of these teams varies as does their way of working and their strategic aims/priorities.

HIW: Healthcare Inspectorate Wales. The independent inspector and regulator of independent and NHS healthcare in Wales.

Holistic: The view that human beings function as complete, integrated units of many different interdependent factors, and not simply a collection of separate parts.

Metrics: Systems or standards of measurement, for example 'length of stay'.

Multidisciplinary: An approach consisting of more than one type of health, social care or other services provider.

Multi-factorial Intervention: An intervention with multiple components that aims to address the risk factors for falling that are identified in a person's multi-factorial assessment, e.g. an eye test, a medication review, installation of handrails at home, an exercise programme, etc.

Multi-factorial Risk Assessment (MRA): An assessment with multiple components that aims to identify a person's risk factors for falling. May include:

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards
- cardiovascular examination and medication review.

8. Appendix A

NERS: The National Exercise Referral Scheme. A Public Health Wales funded scheme in existence since 2007, centrally managed by Welsh Local Government Association. Consists of evidence-based physical activity and behavioural change techniques to support referred people to improve their health and wellbeing.

Occupational Therapist: A science-degree-based profession, regulated by the Health and Care Professions Council. They aim to help you improve your ability to do everyday activities with an whole-person approach.

Orthotics: Equipment (usually wearable) used to support or augment the functioning of parts of the body.

Physiotherapist: A qualified, regulated professional who focuses on improving a person's ability to perform movement of their body for the benefit of their overall health and wellbeing, and prevention of illness/injury.

THB: Teaching Health Board. In Wales this only applies to the Powys area, as it still hosts teaching opportunities but doesn't have a university within the geographical boundary of its health board. All of the others are referred to as 'University Health Boards'. See UHB

UHB: University Health Board. Wales is split geographically into six University Health Boards and one Teaching Health Board. They plan, secure and deliver healthcare services in their areas.

WAO: Wales Audit Office. They support the Auditor General in ensuring the people of Wales know whether public money is being managed wisely and that public bodies in Wales understand how to improve outcomes.

9. Appendix B

Summary descriptions of local falls service models

The model of care which is delivered locally under the same term 'Falls Service' varies considerably as you travel between (and even within) health board areas.

Here are some examples of Falls Services throughout Wales and how they work:

In Aneurin Bevan University Health Board area there are 5 boroughs, each with at least one falls clinic.

Torfaen

One of five boroughs, is currently following the ABUHB falls pathway (under review). This service, managed by a LA-funded post, is the longest-standing falls service in the area, and delivers its holistic and seamless service via a multidisciplinary team of local authority staff, administrative support, nursing, physiotherapy, occupational therapy and multi-skilled reablement technicians. They are located in the same hub as social care and mental health services, and have excellent links out to specialties such as dietetics, continence, wound care and podiatry. Showing flexibility, the Mental Health nurse situated in the hub has helped with joint assessments at home along with physiotherapy of people referred with cognitive impairment – helping to address the gap in provision in the original pathway for this group of people who are at particularly high risk of harm from falling. The advantage of being co-located with social services help with two-way flow of information and also with timing of assessments and interventions for the convenience of the individual too.

On the wall of the clinic room the unique selling point of Torfaen Falls Service is displayed:

"A patient is the most important person in our hospital. He is not an interruption to our work, he is the purpose of it. He is not an outsider in our hospital, he is part of it. We are not doing him a favour by serving him, he is doing us a favour by giving us an opportunity to do so."- Gandhi.

Monmouthshire

Runs a falls service with a core staff of one falls specialist (a physiotherapist) and one falls support worker (multiskilled) per each of the 3 locality areas of the borough, although they believe that 'falls are everybody's business' and as such include everyone in the integrated Services Team as virtual members of the falls team. They receive referrals from all health and care practitioners and outreach actively and regularly to other staff groups such as GPs, care homes, other people working in the integrated care team etc. in order to raise awareness of falls risk factors and what they should do about them. They follow the 'what matters' approach, and encourage other staff members to discuss what the person wants and consider this before referring, in order to get the best possible outcome for the individual. They evaluate

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their service using an 'exit questionnaire' for service users about their personal outcomes and whether 'what matters' has been achieved, which has been overwhelmingly positive. In Monmouthshire, they do not use any formalised assessment tool but rather a bespoke, thorough assessment and intervention approach. They can carry out or arrange the majority of interventions required following assessment themselves, with the exceptions of bloods, ECGs, memory clinic, mental health and orthotics – all of which are directed through the pinch-point of the General Practitioner.

The unique selling point of Monmouthshire service in their eyes is their **'what matters to the person' approach and that they aim to 'add life to years'.**

Throughout Powys there are also five community falls clinics

Ystradgynlais

Clinic is situated in the Day Hospital, and accepts self-referral, professional referral and also screens **all** people aged over 65 who attend the hospital for any reason. Here there are some exclusion criteria applied – people who fall from height, on ice or due to leisure/sporting activities, medical reasons for fall e.g. cardiac, and acute unexplained deterioration in activities of daily living. The core of these clinics are nurse-led, however they too have excellent links to all of the necessary specialties that could potentially be needed following a thorough falls assessment. Like almost all of the falls services described in this review, pharmacy is a gap in the provision here, with medication reviews needing to go back to the GP. The exercise component here is delivered through referral to the local NERS classes (National Exercise Referral Scheme) – as Newtown, see explanation below. There is limited involvement with local residential homes but none with nursing homes.

The 'unique selling point' of Ystradgynlais Falls Service is that it is **"delivered by people who know the services in their area and how to get the right service for their patient".**

Newtown

Has been running a falls service for 15 years from the community hospital, alongside 14 inpatient beds for stroke and rehabilitation, outpatients department and midwife-led unit. Core staff of the service is one Staff Nurse with various Occupational Therapists and Physiotherapists. Funding is from

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the locality health budget. Referrals are accepted from OT/ Physio, GPs, Community Pharmacists, Practice Nurses, District Nurses, specialist nurses, Ambulance Service if appropriate but not currently self-referral. The service's OT has had a lot of input within the care home sector in their area. As far as acceptance criteria go they will see all that are referred, including those with cognitive impairment and ongoing alcohol misuse for example, unless they have become totally immobile i.e. bed bound since referral. The shape that the multi-factorial interventions take in this service are a confident strides programme in-house twice a year run by OT and Physio. They also do OT and Physio in-house and podiatry balance and gait assessments, and also continence advice can be given in-house. For strength and balance classes, they refer on to NERS, social services and Local Authority, or they offer one-to-one exercise programmes from OT and PT – either in clinic or at home. There is no real evaluation of the service done, which is highlighted by the service providers as an area in need of development – but this is constrained by lack of administrative staff and time.

The unique selling point of Newtown Falls Service is that **'we are all so passionate about providing the highest standard of care to all of our patients and hopefully making positive improvements to their lives.'**

Gwynedd

Located in Eryri Community Hospital alongside Community Physiotherapists and Occupational Therapists and Inpatient Physiotherapists. The core staff are 4 part time falls practitioners and one coordinator, with the potential for an extra falls practitioner and falls assistant role coming soon. All funding is currently from the Integrated Care Fund, and in the next 1-2 years this will need to be converted to NHS funding in order for the service to continue. They accept referral from any source – for example public themselves, GPs, ambulance service, fire service, etc. and where possible they base their assessment on the Falls Risk Assessment Tool (FRAT) – with triage of absolutely everyone regardless of score. Being a new (established 2018) and still developing service it does not yet have care home involvement but this is coming soon. They have no set acceptance criteria, but target their interventions according to several recognised features as to what is most appropriate. All multi-factorial risk assessments (MRAs) are offered in the person's own home. Interventions: Direct referral to exercise classes, OT (falls practitioners in some cases have the ability to assess for and order simple OT equipment themselves, taking yet another step out of the process), Care and Repair, Social Services, third sector agencies, community and outpatient PT, GP, podiatry and most recently pharmacy (a rare find amongst falls services Wales-wide). Audiology still require referral through the GP route however. Exercise classes are hospital and community based, with the intention that participants move from hospital to community to privately run classes in an attempt to create a sustainable model. Evaluation of the service is through a developing use of patient satisfaction questionnaires.

The unique selling point of their service is that **'anyone can refer and we aim to keep people as independent as we can for as long as we can, age is no barrier.'**

"Man does not cease to play because he grows old, he grows old because he ceases to play. - George Bernard Shaw.

10. Appendix C

Who else is looking at falls?

Other organisations are also looking at falls in developing approaches and initiatives. Here are some further details regarding approaches being taken by the Welsh Ambulance Services (WAST) NHS Trust and the 1000 Lives / Public Health Wales National Prudent Healthcare Falls Taskforce:

WAST has deployed a 'Falls Framework'[27] consisting of five domains:

- Prevention
- Supporting Community Resilience
- Assessment
- Response, and
- Avoiding Further Harm

The aim is to dramatically reduce harm to the older person who has fallen and also be efficient and sustainable. The framework aims to complement and support services in some geographical areas by being integrated into existing pathways, and bring a new level of consistent quality to areas where such services are not yet benefiting the local population.

The framework also considers older people living in care homes, in that they are supporting the implementation of the 'I STUMBLE' tool[28] in conjunction with a robust assessment and management protocol for post-falls assessment in care home residents, which has pilot data showing a 41% reduction in 999 calls across 10 care homes, with follow-up data from a larger sample anticipated to be equal if not better in efficacy. Other similar, effective protocols, such as the 'red flag' is used in North Wales, which aims to support the management of falls prevention in care homes via a tiered educational programme on providing post-falls assessment. The pilot data for this approach has shown a positive effect of reducing falls within care homes by 44%; which is critical to avoid harm, and supporting residents towards a healthy, happy future.

The 1000 Lives /Public Health Wales National Prudent Healthcare Falls Taskforce[29] (of which WAST are a member) is poised to begin deployment of their Wales-wide framework – similar to WAST's and co-developed with them - which aims to unite existing efforts in community falls work. The taskforce is a collaboration of health, social care, housing and independent/voluntary sector people with the potential to lead the deployment of an integrated strategy of falls prevention and management approaches nationally.

27 *https://aace.org.uk/best-practice/wast/*

28 *http://bit.ly/iSTUMBLE*

29 *http://www.1000livesplus.wales.nhs.uk/falls*

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