Prevention & Management of Falls: Case Finding Workshop

The Beardmore Hotel & Conference Centre, Clydebank, Glasgow, 9 September 2009

NHS Quality Improvement Scotland

Identifying older people living in the community, who are at risk of falling

On Wednesday 9 September 2009, NHS Quality Improvement Scotland (NHS QIS) convened a workshop on falls prevention and management, focusing on case finding - the identification of older people living in the community who are at high risk of falling.

The event, held at the Beardmore Conference Centre, Clydebank, brought together over sixty participants from a range of professions, services and organisations to discuss effective ways to identify and manage older people in the community at high risk of falls. Participants included CH(C)P Falls Leads, Rehabilitation Coordinators, Long Term Condition Leads and other key stakeholders from across Scotland.

The need to identify systematically and proactively those most at risk of falls and the associated harms (including fractures, increased dependence and avoidable admissions to hospital) has been a subject of great interest to all involved in the NHS QIS Falls Programme over the last 18 months, according to Claire Tester, Professional Practice Development Officer, Allied Health Professions, NHS Quality Improvement Scotland.

This report provides a record of proceedings for the participants, and a means by which valuable knowledge and experience can be shared with others.

The effective identification of those at risk of falling is made even more challenging, she said, by the fact that falls are under-reported. Many of those who fall do not regard it as something worthy of discussing with their GP, and there is evidence to suggest that a person may fall up to eight times before reporting it.

The fact that falls may be the first indication of other health issues, and that one fall is a strong indicator that the individual is at risk of falling again, made the need for effective identification and prevention particularly pressing.

Aims of the day :

1. To promote a common understanding of, and consistent approach to, case finding and falls risk assessment in the community.
2. To provide the policy context, and outline alignment with the national agenda.
3. To clarify the process of risk identification and assessment:
   - The differences between identification, screening and assessment:
   - The role of screening tools.
4. To promote good practice and share experience and learning to date.
5. To explore the issues around the implementation of case finding.
6. To produce a report of the day to offer guidance to CH(C)P Falls Leads for service development.

The programme included presentations from those with knowledge in the field, and provided an opportunity for practitioners from across Scotland to share their successes and experiences in identifying risk and preventing falls. In addition, participants were grouped in workshops to consider possible solutions to their own service delivery challenges, including:

- The development of effective partnerships.
- Where to start in developing a coordinated service response.
- How to assess risk of falling.
- Along the service continuum, who should provide assessment, when and how.
- How best to respond when a person at risk of falling is identified.

Further information on the NHS QIS Falls Programme:

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Contents

Session 1 **An Introduction to Case Finding**

What do we mean by screening for risk? The risk assessment continuum

Considerations for case finding (including the use of screening tools)

Session 2 **Focus on Practice**

Case Finding: examples of implementation

Utilising the shared assessment process: East Renfrewshire Community Health and Care Partnership (CHCP)

Working with mobile emergency care services/telecare: Falkirk Falls Management Project

Working with ambulance services: NHS Tameside Alternative to Transport Service

Falls management in A&E: NHS Scotland

Session 3 **Meeting the challenges**

Maximising Potential, Demonstrating Impact

Some key workshop messages

Workshop notes

Policy Context **Reshaping Care: Improving Quality and Outcomes**

Next Steps

Appendix 1 **The falls and fracture risk assessment continuum**

Appendix 2 **The falls and fracture risk assessment continuum (stakeholders)**

Appendix 3 **Attendance List**

Session 1: An Introduction to Case Finding

What do we mean by screening for risk? The risk assessment continuum

Sarah Mitchell, Programme Manager, Rehabilitation Framework, on behalf of Ann Murray, Falls Programme Manager, Practice Development Unit, NHS Quality Improvement Scotland.

"Up and About: pathways for the prevention and management of falls and fragility fractures" outlines four colour-coded stages in a journey of care (see table 1).

Table 1: Stages from Up and About

Stage	Description
Stage 1	Supporting health improvement and self management to reduce the risk of falls and fragility fractures (maintenance phase)
Stage 2	Identifying individuals at high risk of falls and/or fragility fractures
Stage 3	Responding to an individual who has just fallen and requires immediate assistance
Stage 4	Co-ordinated management including specialist assessment

The focus of our day, case finding, ie identifying individuals at high risk of falls and/or fragility fractures, forms stage two of this four stage journey of care.

At this stage (stage 2):

- An individual at high risk of falls and fragility fractures is identified, triggering referral for appropriate intervention.
- Opportunistic case identification links with both anticipatory care and the shared assessment process.
- Falls risk and fracture risk are considered in combination.
- An initial falls risk screen aims to identify individuals at high risk of falling; it is not intended to determine all contributory factors or specific interventions.
- Data collection, i.e. the recording of a fall, is vital.

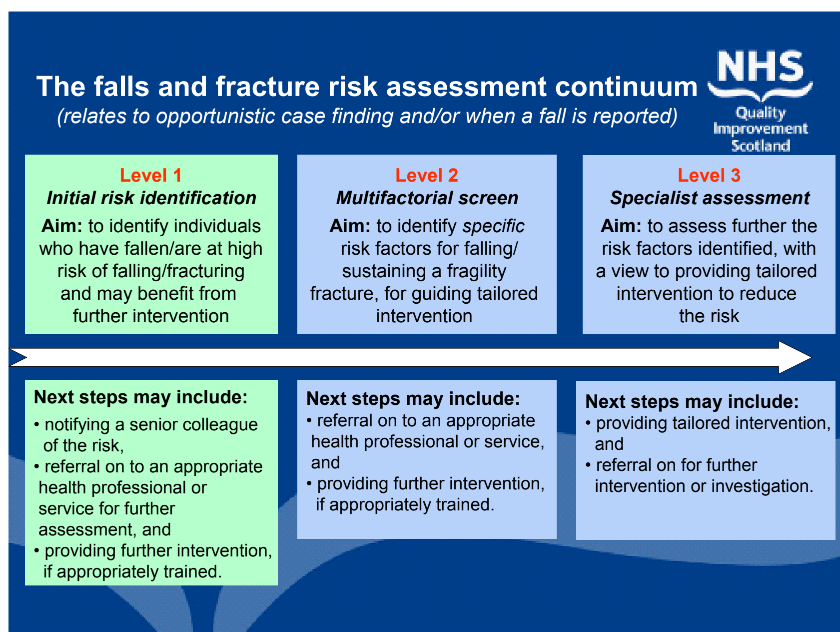
Individuals at risk are identified either when they present to health services with a fall or an injury due to a fall or opportunistically by health and social care practitioners. Establishing a common language and understanding across professions, organisations and services of terms such as "assessment", and "screening" is key to effective collaboration and service planning. With a view to promoting a common language and understanding, the falls risk continuum (see appendix 1) describes three levels of risk assessment:

- Level 1 – initial risk identification, identifying those who have fallen or are at high risk of falling, and may benefit from further intervention.
- Level 2 – multifactorial screening which aims to identify specific risk factors for falling or sustaining a fracture. This process guides more tailored intervention. While this does not necessarily have to be carried out by a specialist, a good level of knowledge is required.
- Level 3 – specialist assessment which further assesses risk factors with a view to providing tailored intervention to reduce the risk.

To illustrate the three levels in practice, the approach used by the Cambridgeshire Falls Prevention Service was presented. In this example, a simple Level 1 tool, comprising 4 questions [(i) have you fallen in the last year, (ii) if yes, did you hurt yourself or need to call a doctor, (iii) were you able to summon help and (iv) are you able to do the things you used to do prior to the fall] is used by a range of workers including care managers, sheltered housing wardens, volunteers, exercise instructors and ambulance service staff to identify individuals at high risk of falling. A more complex, multifactorial screening tool is employed to conduct a Level 2 assessment, which aims to identify specific risk factors for falls and fractures. This tool includes a checklist of risk factors to consider plus an intervention and onward referral guide. This level of assessment is administered by healthcare workers who have received specific training and includes district nurses, physiotherapists and occupational therapists. The need for a level 3, specialist assessment is identified by the multifactorial screening tool. In this example, level 3 assessment includes interventions such as continence assessment, mobility and muscle strength assessment, medication review etc.

It was noted that there is a wide range of partners who potentially could play a valuable role, across the continuum, identifying risk of falling (see appendix 2). Key considerations for the involvement of other stakeholders include:

- which level of assessment (1,2,or 3) do you realistically expect a specific stakeholder to carry out (based on their skill and capacity and the configuration of local services)
- how would you ensure that stakeholders clearly understand their role, and develop and maintain key competencies
- whether there are referral options/mechanisms available to the assessor or not ie have referral pathways been established, and finally,
- at level 1 and 2, would you expect the role to extend beyond identification or screening, for example, providing advice



or other interventions (and how would you support this?)

FURTHER INFORMATION

- Up and About: Pathways for the prevention and management of falls and fragility fractures: Quick reference guide 2009 available at http://fallspathway.nhshealthquality.org
- Copy of presentation slides available at www.fallscommunity.scot.nhs.uk (click on shared space)

Considerations for case finding (including the use of screening tools)

Dr Dawn Skelton, Scientific Co-ordinator of ProFaNE (Prevention of Falls Network Europe) at the University of Manchester, UK and Reader in Ageing and Health for HealthQWest at Glasgow Caledonian University. She is a commissioned author to the World Health Organization Health Evidence Network and the Department of Health, and is Scientific Advisor for the Society of Physical Activity and the Prevention of Osteoporosis, Falls, and Fractures and the British Heart Foundation National Centre for Physical Activity.

Many of us fall, but most of us bounce straight back up again. It was therefore important, said Dr Dawn Skelton, to focus effort on those at risk of injury or inability to get up again. Dr Skelton provided an overview of the current use, advantages and disadvantages of common falls risk assessment tools.

Noting key risk factors for hip fractures in women, ranging from bone mass and geometry to issues of general health, age and genetics, she stressed the importance of looking at falls and bone health concurrently. Similarly, specialist services for falls and for osteoporosis should be operationally linked or dovetailed.

It is important, she said, to provide an assessment of factors that you are in a position to do something about. Otherwise, there is a risk of merely increasing fear without helping to address the problems.

She noted that the level of questions asked during the assessment process would depend on the skills and expertise of those asking the question, and that people with different professional backgrounds bring different perspectives to the task.

A powerful way to identify fallers, she stressed, is to "just ask". This is something everyone can do, and is an important step in overcoming some of the existing issues with poor reporting and documentation of falls. The next step is to try and

identify, of those who had fallen, who are at high risk of fracture.

Which risk assessment tool best predicts someone who will go on to fall?

To be useful, a risk assessment tool should be:

- Reliable, in that it provides the same result in the same person over short intervals of time.
- Consistent, in that it provided the same result regardless of the assessor.
- Valid for the age and functional capacity of the individual.

She discussed some of the commonly used tests:

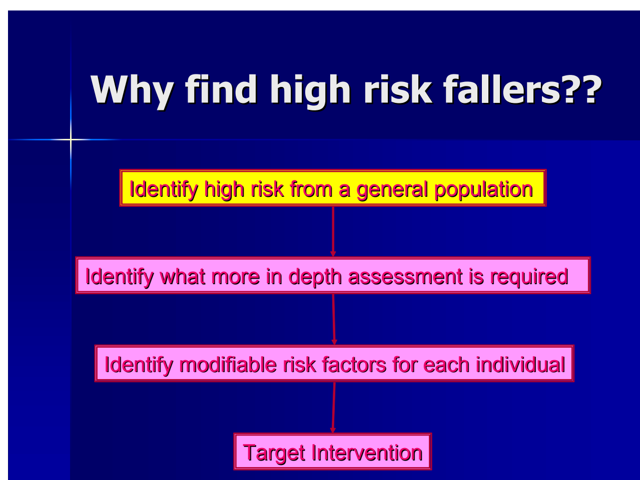
- 'Get Up & Go' or 'Up & Go'. These are useful for use with those who have fallen, but are quite subjective.
- The 'Timed Up and Go' (TUAG) test, a mobility and balance test which shows a strong association with risk of falls. The test is to get up from a chair, walk 3 metres, around a cone, and then walk back 3 metres to the chair and sit down. The movement is timed. While this is a useful tool, it can produce false positives. For example, a person who has learned some techniques to avoid falls may move more slowly and carefully, and therefore 'fail' the time test.
- Falls Risk Assessment Tool ('FRAT') which uses five simple questions, with a score of 3 or more indicating high risk. This tool has shown poor specificity and yields false positives. Dr Skelton explored some of the problems with this tool using two fictional case studies, which demonstrated that while the first three questions may effectively identify risk, the risks identified are not things that could be modified. Only the 2nd two elements are modifiable, and they are both functional. As a result, someone can score 3 out of five and be identified as 'high risk', and yet there is nothing that can be done to ameliorate those risk factors. Using this tool, up to 85% of those assessed as high risk may never fall.
- Fracture risk tool ('FRAX'), developed as a result of a study which mostly comprised Caucasian women. A study has identified that 55% of those identified as not at risk using this tool go on to have osteoporosis. Citing this as an example of the problems in applying a tool to an inappropriate population group, she noted that it is not effective for an older, frailer population group e.g. it does not ask about falls.

Although there are many tools available, studies have also shown that very few tools have been tested more than once or in more than one setting. Pitfalls to avoid therefore include using an assessment tool in a context for which it was not designed. For example, a tool designed for use in a hospital setting will be inappropriate in a community setting.

Tools that have poor sensitivity are also to be avoided. While no tool will be perfect, one that clearly gives too many false positives will create fear as well as unnecessary referrals and interventions. Conversely, a tool that provides false negatives may fail to identify those genuinely at risk. A study by Tiedemann et al (2008) suggested that the most sensitive tests were 'Sit to stand x 5' the 'Alternate Step Test' and the '6m walk' test. But these are functional tests and will not pick up those who require medical or psychological intervention!

Systematic reviews consistently cast doubt on assessment tools' predictive validity, and indicate an almost total lack of useful tools tested in community, nursing home, or mental health settings. As a result, no single tool can be recommended for use in all settings or for all sub-populations within each setting. However, research trials were unanimous in finding that the best predictor of a future fall is having had a fall in the past year.

Drawing on the learnings of this review of existing tools, she discussed her work with NHS Greater Glasgow and Clyde, and the tool developed for assessments. In this case, triage is performed by a range of trained staff, but not necessarily health professionals. The tool includes a range of 'triggers' which prompt suggestions for the next steps in the care pathway. How to respond effectively, however, remains an issue for individual assessment, tailored according to the specific risk factors identified.



Her main points, in conclusion were

- Use a tool most suitable for the profession or the role of the professional.
- Use a tool that has been validated for the type of setting in which you intend to use it.
- Ensure there is the capacity for onward referral as required.
- Only assess if you are in a position to respond effectively (including through appropriate referral) to the issues raised.
- Bear in mind that case finding is different from solving the problem. Knowing who is at risk will not tell you who will benefit from intervention. For example, 50% of those advised to do so, will not exercise.

FURTHER INFORMATION

Dawn Skelton presentation slides available at www.fallscommunity.scot.nhs.uk (click on shared space)

- Greater Glasgow and Clyde programme information available at: http://www.nhsggc.org.uk/content/default.asp?page=home_ofps

Session 2: Focus on Practice

CASE FINDING: EXAMPLES OF IMPLEMENTATION

In this session, a series of short presentations outlined current examples of challenges and achievements in implementing falls prevention measures across Scotland.

Utilising the shared assessment process: East Renfrewshire Community Health and Care Partnership (CHCP)

Josephine Wight, Falls Lead, East Renfrewshire CHCP, NHS Greater Glasgow and Clyde.

Developing an effective local approach needs commitment and common sense, said Josephine Wight as she described the experiences of East Renfrewshire CHCP in introducing an assessment tool for use by a broad cross-section of health and community care practitioners.

She said that the project had taken the approach that effective identification of risk was 'everybody's business'. Accordingly, the project started by convening a multi-professional group to work together to develop a response. Key strategies pursued in developing the project included:

- The inclusion of falls within the CHCP's overall outcome measurement framework, thereby ensuring that falls identification and response were recognised as a CHCP priority.
- Development of a shared assessment tool with an outcomes focus.

Early in the project, the group worked to identify potential falls risk assessors. One hundred and sixty potential assessors were identified, including social workers, allied health professionals and assistants, and other health workers including district nurses. Most of these workers were already engaged in various assessments, but were not necessarily well equipped to identify or respond to falls risk.

Existing knowledge was evaluated through an initial questionnaire. A three-hour 'Falls Awareness Training' programme was developed targeting this group, aiming to increase awareness of the impacts of falls, and empower practitioners to engage more effectively with clients in identifying and beginning to manage the risk of falling. The programme was delivered by those involved in the project group, within existing resources. She noted that participant feedback from the programme had been overwhelmingly positive. The training had been very effective in raising staff awareness of the consequence of falls, and in motivating staff to become more involved in falls risk identification and falls prevention.

The programme was being delivered in three phases, as outlined below:

Phase	Target	Date
Phase 1	All assessment staff	August 2008 – December 2009
Phase 2	All care homes, Levern Valley	September 2009 - November 2009
Phase 3	Voluntary Agencies, Day Care Providers, Older People's clubs	April 2010 - July 2010

She noted that one of the key gains has been the development of a Shared Assessment Tool, including an electronic recording system which features automatic prompts for next steps. Information sharing and links have been strengthened throughout the CHCP.

The outcome tool was designed in consultation with all professions involved, meets the applicable standards, incorporates performance indicators and is cross-referenced to other partnerships.

There has been an increase in referrals since the commencement of the programme, and there is no evidence to date that any of these referrals were inappropriate. Existing systems ensure that any false positives are identified.

Other important factors in the success of the programme have been the inclusion of families, particularly in helping them to recognise the impact on an individual's ability to maintain independence, and the involvement of social work, who are a crucial part of identifying the social and financial impact of a fall. Gathering and documenting evidence of the impact of

falls has made the importance of the issue clearer to all involved.

She acknowledged that although there is further work to do, big gains have already been made in addressing key challenges including

- Identifying eligibility for falls services.
- Timely referral to falls services.
- Tackling different perceptions and understanding of falls.
- Establishing a system for assessment staff to support falls intervention.

Working with mobile emergency care services/telecare: Falkirk Falls Management Project

Jillian Rae, Service Coordinator, Falkirk Rehabilitation & Assessment in Community & At Home (ReACH)

The Falkirk Falls Management Project commenced in March 2002 as a joint initiative between health and social care colleagues. Its aim from the outset was to use joint resources to reduce the number of falls by providing early and appropriate education, holistic assessment and intervention. The chosen strategy was to identify vulnerable people in the community who were falling frequently and offer them early access to a Falkirk based Falls Management Clinic for assessment, therapy, equipment and advice, said Jillian Rae.

The project involves the local day hospital, Rehabilitation & Assessment in Community & At Home (ReACH), Fast-Track Services and the Mobile Emergency Care Service (MECS), which aimed to "provide an effective, integrated falls services for the older people's population in the Falkirk area".

As part of this project (which she described as only a part of the work on falls in the local area), a collaborative approach to identification /case finding was undertaken across all the participating partners. As part of the programme, using telecare technology the MECS were able to identify service users who had fallen twice within a 6 month period. Once identified, these individuals are offered referral to the Falls Management Programme. New MECS users were offered a referral if they had been referred to MECS because of a previous fall.

In addition, GPs agreed that referrals could be made directly from MECS to the Falls Management programme. This has made access to the Falls Management Clinics quicker, and also made the process more acceptable to service users.

MECS users were also being asked to sign a waiver to allow sharing of information between MECS and NHS Forth Valley. This was noted as a particularly useful step in improving information sharing and care coordination.

Statistics demonstrated that the number of falls per service user has decreased since the project began. Other sources of referral to the programme included fast-track services, health and social work colleagues, and the Scottish Enhanced Services Programme, under which GPs identify patients over 60 years who have fallen in the past year, and employ a "Timed Up And Go" (TUAG) screening tool to determine the need for a further assessment. This may or may not lead to referral to ReACH or the Day Hospital.

She noted that GP rooms are not always suitable to carry out the TUAG, and the SESP has resulted in a higher number of referrals to the ReACH team. However, of the 57 referrals from GPs so far, only 13 have been assessed as having been appropriate for further intervention. She noted that there was a significant workload involved in assessing these false positives.

She reported that approximately 200 of the 400 people who had been offered referral to the Falls Management Programme had chosen to take up the offer with approximately a further 300 who had multiple falls already being known to ReACH and/or Day Hospital.

Working with ambulance services: NHS Tameside alternative to transport service

Joy Kelly, Falls Coordinator, Tameside & Glossop

Although only officially a team of two, the Tameside & Glossop NHS Falls and Osteoporosis Service is bigger than it looks, said Joy Kelly, Falls Coordinator. This is because it also has an extensive 'virtual' team comprising a range of local statutory and voluntary services, including the Greater Manchester Ambulance Service (GMAS).

Local statistics demonstrated the huge workload associated with falls in the area, and the need to ensure an effective response. In 2006/2007 there had been 2446 calls to the Tameside and Glossop Ambulance Service to respond to falls. 69% of the callers who were attended were conveyed to the Accident & Emergency (A&E) Department.

In 2008 2,018 people attended the Accident & Emergency because of a fall.

Joy reported that before she was in post in 2004, the number of fractured neck of femurs (NOF) sustained in Tameside and Glossop as a result of falls was twice the national average. Since then, the frequency had been greatly reduced following an array of interventions and an 'everybody's business' approach.

2006/7	218
2007/8	149
2008/9	134

Number of neck of femur fractures sustained in Tameside and Glossop between 2006 and 2009.

The Tameside & Glossop Alternative to Transport Found (ATF) pilot commenced in 2006. Following the introduction of the ATF protocols and a support programme, the number of fallers without injury taken to A&E via ambulance over a six month period was reduced by 68% from the previous year.

The overall aims of the project were to:

- reduce the rate of repeat fallers requesting ambulance assistance
- develop protocols to enable ambulance personnel to identify patients who can be safely left at home
- develop closer links between the ambulance service, support agencies and falls services to reduce hospital admissions and support people left at home, and
- raise awareness of falls and fracture prevention.

An ATF assessment process was developed for the ambulance service to follow when responding to an older person who had fallen. This includes Alternative to Transport Found protocols for falls. The protocol outlines the correct assessment procedure to follow, includes 5 key questions relating to falls risk, and identifies appropriate actions to take in various circumstances.

The Tameside Alternative to Transport Service Pilot had the following specific aims:

- To test the safety and accuracy of the ATF assessment process.
- To develop more effective integration with the PCT Falls Services and Community Assessment and Rapid Access (CARA) Team.
- To test the appropriateness of referrals to CARA and A&E departments.
- To improve sharing of information.
- To develop a referral process that could be utilised across the North West.
- To improve the appropriateness and quality of care.

Over the period of the pilot, there were 155 patients with the ATF protocol completed. Many of the falls took place in the home and some were alcohol related or high impact such as a fall on stairs. Most resulted in no apparent injury, with the individual not transferred to A&E.

- 22 patients transported outside CARA hours (9pm-7am)
- 37 patients transported during CARA hours
- 52 patients not transported and referred to CARA
- 44 patients not transported and not referred to CARA. 24 of these were outside CARA hours.

Reasons for advising patients to transport to hospital included the presence of an injury, the presence of an abnormal cardiac rhythm, inability to bear weight as normal, and a concern for the individual's on-going safety.

During the pilot, a paramedic would perform the ATF assessment to establish if the patient could be left safely at home. The protocol was used to initiate a CARA/Rapid Response (RR) referral. The ambulance office would alert the CARA Rapid Response Team by fax, and the team would aim to respond within an hour. The CARA Rapid Response team is a joint health and social care multidisciplinary team. They would carry out an initial assessment, undertake appropriate interventions and identify the means to support the patient at home, thus preventing hospital admission. During the pilot, the Falls Co-ordinator constantly monitored the cases to ensure that the referrals worked effectively and no-one "fell through the gaps".

The project has demonstrated that using this approach, appropriate referrals were made to CARA and A&E. As a result, there had been a significant reduction in A&E referrals during the hours when CARA team were available.

Next steps:

- Concurrently, an Ambulance Capacity Management System (CMS) is being developed and this has caused some delays in rolling out the service.
- A one-stop referral desk (CMS) will enable the North West Ambulance Service to provide a uniform referral system for the ambulance crews.
- Further training work is also required to improve uptake of the ATF among ambulance crews.
- Raising awareness across the health economy to reduce expectation that older people will automatically be taken to A&E following a fall.

There are now plans to roll out the system across the North West, which will follow the establishment of information sharing agreements and the development of the capacity management desk.

Noting the potential for the ATF to be adapted to fit other health conditions (e.g. head injury, diabetes), Joy said that clear links with other agencies, working across primary and secondary care, allowed care to be delivered closer to home. It provided a person-centered approach, with both voluntary and community agencies involved, and developed and strengthened an 'everybody's business' approach to falls and facture prevention.

CASE STUDY:

A case study was presented in which the ambulance was called to find the patient had fallen out of bed. Having completed the ATF Protocol for Falls Assessment Pro-forma, the crew initiated CARA/RR and completed and faxed the North West Ambulance Service form and Falls ATF to CARA and the Falls Coordinator. The referral was accepted by CARA at 11:25, and the patient was visited at 12:30. At this point CARA competed the screen/ assessment tool, initiated the CARA nurse, faxed information to the falls coordinator and a referral to social services. Outcomes had included referral to social services and engagement with the family, provision of a pendant alarm, and referral to a vascular clinic to help with the leg problem that was inhibiting the patient's mobility.

The case study provides an example of delivering safe care at home, where a transport to hospital would otherwise have been likely. This was a cost-effective way to manage care with minimal disruption to the older person. Feedback from team members, staff and patients has been positive.

Falls management in A&E: NHS Scotland

Ms Sarah Mitchell, Programme Manager, Rehabilitation Framework, Scottish Government.

Following on from the previous presentation, Sarah Mitchell agreed that the A&E departments have a huge role to play in better managing falls.

She briefly described a model implemented in New South Wales (Australia) in which older people coming to the A&E with complex needs were being seen by a team comprising a social worker and an Aged Care nurse, rather than a house physician. This model, she said, was being investigated for possible roll-out across Scotland.

Session 3: Meeting the challenges

Maximising potential, demonstrating Impact

June Wylie (facilitator), Development Manager, Implementation and Improvement Support, NHS Quality Improvement Scotland

Despite strong evidence, implementing initiatives to improve quality and care is often a struggle, said June Wylie, introducing the workshop session. Degree of difficulty, competing agendas and lack of evidence of cost-effectiveness all contributed to slow and often frustrating progress. She also noted that it is difficult to change systems within complex organisations where the culture and local politics play an important role.

A shared language is key to effectively sharing information and understanding, she said, and it is therefore important to ensure that service proposals are presented in a way that resonates with the strategic objectives of decision-makers, particularly when trying to secure project funds.

Referring to Davies et al's narrative overview of quality improvement in health care, she cited some of the core conditions identified as necessary to successful change. These include:

- Alignment with strategic objectives.
- Engagement with the health professions.
- Identified benefits for staff as well as patients.
- Strong leadership at all levels.
- Multifaceted interventions.
- Sustained action at different levels.
- Support from leadership team of change agenda.
- Robust and timely data of different kinds.
- Resources - finance, staff cover etc.

She also discussed the US-based Institute for Healthcare Improvement's (IHI) model for improvements, which involves identifying what are you trying to accomplish, how you will know whether the change is an improvement, what changes can be made that will result in the improvement, and the key changes to be made to bring about the desired outcome.

The IHI model then recommends testing the factors using the Plan-Do-Study-Act ('PDSA') cycle, in which improvements are planned, tried and observed, and then the results of this testing process are acted on to further refine the approach. Ms Wylie noted that in order to complete this cycle effectively, it is necessary to be able to measure the outcomes.

The Six Sigma approach to quality and the practice development framework were also noted as useful, and commonly used within the NHS. Many workshop participants indicated that the "LEAN" model of total quality management is being used in their organisations. Ms Wylie noted that, regardless of which models are being used internally, ensuring that information is reliable and presented succinctly is an important part of capturing the attention of decision makers in any organisation.

The spread and sustainability of improvement initiatives is a further challenge which needs to be considered and managed as part of the process. It was noted that there were three key elements to consider.

Process:

- Benefits beyond the patients.
- Credibility of the evidence.
- Adaptability of the process used.
- Effectiveness of the system of monitoring.

Staff:

- Staff involvement in development.
- Training requirements to sustain the process.
- Staff attitudes toward change.
- Senior leadership and engagement.
- Clinical leadership and engagement.

Organisation:

- Strategic aims and culture.
- Infrastructure for sustainability – including funding and other resources.

Ms Wylie concluded her introduction by reminding participants of the importance of achieving cultural change, citing Don Berwick (IHI), an international leader in the quality movement, who had commented that "meaningful improvement work depends on collaborative wisdom – new mental models, new insights grow out of ongoing dialogue."

Distributing an example of a business case to act as a model, she invited participants to work together with others from their local area to identify one area within stage two, identifying high risk, of the Up and About Pathway, in which they believed that they could make a difference, and develop a rough business case for it. The objective was to begin to develop a 'pitch' that could be presented to CEOs and other senior members in organisations to garner their support.

FURTHER INFORMATION:

- Institute for health care improvement: http://www.ihi.org/ihi
- Powell AE, Rushmer RK, Davies HTO, A systematic narrative review of quality improvement models in health care Social dimensions of Health Institute at the Universities of Dundee and St Andrews, February 2009. Available at: www.nhshealthquality.org/nhsqis/files/CorporateDocument_SystematicNarrativeReviewOfQualityImprovementModelsInHealthCare_FEB09.pdf
- Integration, Collaboration and Empowerment – Practice Development for a New Context (distributed at the meeting), copies available at: www.nhshealthquality.org/nhsqis/files/CorporateDocument_SystematicNarrativeReviewOfQualityImprovementModelsInHealthCare_FEB09.pdf
- Berwick, D, Escape Fire: Designs for the Future of Health Care, Institute for Healthcare Improvement, Jossey-Bass, San Francisco 2004

SOME KEY WORKSHOP MESSAGES

EVERYBODY'S BUSINESS

Identifying falls risk and providing an effective response is everybody's business.

Cross-programme approaches involving the range of health and social care services are important.

Both professional and non-professional staff can play an important role in screening, referral and data collection.

Screening, assessment and appropriate referral can and should be carried out in a range of settings, including the home.

STRATEGIC PLANNING AND STRATEGIC POSITIONING

Ensuring that programme proposals and business cases are consistent with corporate language, priorities and goals is an important part of securing vital leadership support within the organisation.

Similarly, ensuring that falls management and prevention is reflected in corporate plans and targets can be a powerful tool in garnering support from other service providers in the organisation, so that falls become 'everybody's business'.

An influential project 'champion' can be an important asset.

RESPONDING TO ACCIDENTS AND EMERGENCIES

Falls require a rapid response, but this does not necessarily have to be provided by police, ambulance, or other emergency services.

Providing a pickup service to ensure that the person falling can get up again, coupled with an effective screening tool to ensure proper referral and follow-up, is a viable alternative.

Models exist which have demonstrated that safe, effective care can be provided to those who have fallen while they remain in their own home.

DATA AND DATA COLLECTION

Data collection is vital in order to provide an evidence base for the design and testing of programmes, but also to ensure that proposals and arguments can be supported with verifiable data.

The collection and recording of falls data remains a challenge. This needs to occur in a range of settings (e.g. A&E, GP practices, residential care), and a range of service providers need to contribute to collecting this information and making appropriate referrals.

Securing the appropriate systems, protocols consents and permissions to allow the sharing of data is a key foundation plank to the better coordination of services and better provision of client centred care.

AIM: EVERYBODY'S BUSINESS

Issues & Ideas:

- Ownership of providing better responses to falls across the organisation can be a challenge
- Risk that effectively responding to falls can be perceived as the sole responsibility of the falls service
- Issues of developing an 'everybody's business' approach to be discussed with others including Rehabilitation Coordinator

AIM: BETTER IDENTIFY THOSE IN ACCIDENT AND EMERGENCY AT RISK OF FURTHER FALLS

Issues & Ideas:

- Get the evidence: Liaise with IT department to identify the current numbers of those in A&E over 65 who have fallen
- Investigate IT coding systems as a means to better capture data
- Note existing models where discharge information includes an item on falls which automatically 'pops up' if over 65.

AIM: AVOID HOSPITAL ADMISSIONS BY BETTER COMMUNITY CARE

Issues & Ideas:

- Embed individual elements in existing strategies but compile together in writing so outcomes can be demonstrated
- Reduce ambulance involvement
- Improve referrals

AIM: DEVELOP A UNIVERSAL NATIONAL FALLS CODING SYSTEM TO BE INTRODUCED ACROSS THE SERVICES SYSTEM

Issues & Ideas:

- Engage the Board by providing an ambitious vision
- Meanwhile, develop local system that can be implemented locally
- Prioritise assessment to ensure identification of (1) recurrent fallers with fractures, and (2) fallers at risk of further falls

AIM: CONTINUE DEVELOPMENT OF THE OSTEOPOROSIS SERVICE

Issues & Ideas:

- Need to overcome perceived clashes between Board/corporate priority and clinical priority
- Need better links with service reform initiatives and higher-level corporate vision
- Improve influence by identifying a senior mentor for the services

AIM: IMPROVE IDENTIFICATION OF THOSE AT RISK OF FALLS

Issues & Ideas:

- Note issues of remoteness and limited access to specialist falls services
- Better evidence base on numbers potentially at risk would support advocacy efforts in the future
- Need better engagement with GPs so they (1) ask patients about falls, and (2) record data and refer appropriately
- Create incentives for GPs? Prizes offered for referral rates? Note that financial incentives have been tried elsewhere but sometimes are problematic.
- Investigate others in the practice, e.g. reception staff, asking and recording falls information, rather than the GP?

AIM: INCREASE AWARENESS OF ACCIDENT & EMERGENCY STAFF OF THE IMPORTANCE OF APPROPRIATE FALLS SCREENING AND REFERRAL

Issues & Ideas:

- Falls being adopted as a key priority for A&E at corporate level
- Can demonstrate need with local data including collecting (1) numbers who have fallen (2) numbers who have fallen more than once in 3 months
- Training priorities include (1) better recording of fallers, and (2) providing preliminary screening
- Training strategy needs to take into account that there is often high turnover in A&E departments, creating ongoing training needs

WORK WITH THE AMBULANCE SERVICE TO BETTER IDENTIFY AND RESPOND TO THOSE AT RISK

Issues & Ideas:

- Identifying a source of funds critical to success.
- identify any unspent allocations in current business plan?
- Note that systems are already in place to address many of the other issues.
- '2 women in a van' model to pick up those who are fallen (police often doing it now)
- Incorporate falls awareness training into corporate induction and home care induction for staff
- Huge ongoing commitment but full of potential: investigate train the trainer model?
- Improve senior level awareness of impact of falls: collect evidence base
- Access ambulance data as a key outcome indicator?

AIM: REDUCE THE IMPACT OF FALLS ON THE ACCIDENT & EMERGENCY DEPARTMENTS

Issues & Ideas:

- Note that as a result of established HEAT targets, this is already high up on the list of strategic priorities
- Target sources of A&E referral
- Ensure clear referral pathways
- Ensure timely access to more appropriate services and options
- Develop communication and education strategy

AIM: REDESIGN REHABILITATION SERVICES

Issues & Ideas:

- Take advantage of existing pockets of excellent practice
- Improve identification at Primary Care end – aim to prevent falls.
- Launch communication strategy with 'Everybody's Business' message
- Ensure all involved in asking about falls and recording responses
- CHCP Rehabilitation Coordinators identified as a key partner
- Investigate IT strategies to better capture and share data

AIM: IMPROVE EVIDENCE BASE AND DATA CAPTURE

Issues & Ideas:

- Need to establish good baseline data and profile of those at risk
- Liaise with Ambulance Service to collect data on their workload associated with falls
- Work with A&E to establish better referral protocols
- Investigate whether data compliance could be improved by getting reception staff to assist with data collection and entry
- Note nurses also important identification and referral source
- Ensure that the service system is geared to cope with increased referrals

AIM: REDESIGN AMBULANCE SERVICES

Issues & Ideas:

- Ambulances currently attending all falls: 60-70% of these stay at home: others transported to A&E.
- Potential savings from reduced ambulance visits could fund establishment of "man with a van" service as an alternative to ambulance attendance
- Establish a single point of access for services to assess falls.
- Engage Ambulance Service more closely in discussions of falls leaders in order to develop better coordinated approach.
- Analyse NHS 24 data for further evidence

Policy Context

Dr Anne Hendry is a consultant geriatrician and stroke physician in Lanarkshire, currently seconded part time to the Scottish Government as national clinical lead for the Long Term Conditions Collaborative and as Associate with the Joint Improvement Team. The purpose of this work is to help accelerate the pace of service improvement to achieve better outcomes for older people, people living with long term conditions and their carers and to support health, social care, housing and voluntary sector partners shift the balance of care.

The day concluded with a presentation from Dr Anne Hendry, who provided an overview of some of Scotland's key demographic changes, the challenges that this presented to the provision of care services, and some of the key strategic responses to these challenges.

She produced data on the projected ageing of the Scottish population, noting that

- Scotland's 65+ population is projected to rise by 21% between 2006 and 2016.
- By 2031 it will have risen by 62%.
- For the 85+ age group specifically, a 38% rise is projected for 2016.
- And, for 2031, the increase is 144%.

This will have significant implications for the demands placed on a range of services, including emergency beds, specialist care services and home care. These demographic changes, she said, necessitate changes to the way services are delivered. This creates opportunities as well as challenges.

It is within this context that the Reshaping Care for Older People Programme is being developed, which includes eight workstreams:

- Vision and Engagement
- Future funding of Long-term Care: Demographic Pressures
- Care at Home
- Future Role of the Care Home sector
- Wider Planning for an Ageing Population - Housing and Communities
- Promoting Healthy Life Expectancy
- Workforce
- Embedding Specialist Care in Whole System Pathways across Acute, Primary and Social Care Sectors

She said that the Pathways workstream, which had drawn from a range of other pathways work carried out over the last year, is looking at many of the themes and areas of work discussed during the day:

- Early identification of those at risk of dependency, including how to use EDIS and SPARRA data better, and looking at how to develop an anticipatory approach to care planning. As part of these efforts, she said, the introduction of falls data as part of a core A&E dataset is being encouraged.
- Early interventions that reduce escalation of need and dependency, including identifying fallers and providing realistic responses for non-hospital based care. This includes better addressing related issues such as medication management amongst the elderly.
- Early assessment and 'pull' through hospital to optimise the ability to return/remain at home, such as nurse-led streaming of older admissions, comprehensive geriatric assessment, management of delirium and discharge planning.

She noted that there were many excellent projects already being implemented across the country, and effective ways to spread information and best practice continue to be pursued.

She also spoke about the potential for telecare solutions as a means to both prevent falls and ensure a quick response to a fall. The potential to reduce bed-based care through effective telehealth options had been demonstrated in West Lothian.

She said that the Long Term Conditions National Action Plan followed a mutual care model, and comprised seven High Impact Bundles, each of which has a suite of Improvement Actions that outline how the strategic vision will be moved toward practical action. The 7 Bundles are:

- Partnership and empowerment
- Support for person centred care planning
- Information and support for self management
- Building Workforce Capability
- Balance of Care – faster local access
- Contribution of MCNs
- Information systems – ehealth / ecare solutions

Three workstreams have been identified, and the range of partners involved are seeking to move all of those involved in

the system as far as possible down the pyramid, toward self-management.

She briefly outlined a range of initiatives which were being conducted under the programme, including

- 'SPARRA Made Easy': Scottish Patients at Risk of Readmission and Admission
- 'Gaun Yersel!' the self management strategy for long term conditions in Scotland
- Improvement & Support team guidance on:
    - Care Management
    - Anticipatory Care Planning
- 'Better Together', focusing on improving people's experience of care and particularly relevant for falls

She also noted that NHS Scotland was inviting comments on the development of a National Healthcare Quality Strategy and encouraged workshop participants to review the consultation document with a view to identifying where falls fits in by focusing on the experience and quality of care.

FURTHER INFORMATION

- Reshaping Care for Older People Programme: http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/
- Long term Conditions Collaborative High Impact Changes available at: http://www.scotland.gov.uk/Resource/Doc/263109/0078695.pdf
- 'Gaun Yersel!' the self management strategy for long term conditions in Scotland available from Long Term Conditions Alliance Scotland website at: http://www.ltcas.org.uk/index.php?id=47
- NHSScotland leading in Healthcare Quality – Becoming and world leader in patient- centred care: http://www.scotland.gov.uk/Publications/2009/06/15093408/1

Next Steps

Claire Tester closed the workshop, thanking all presenters for their participation. She also thanked those who attended and contributed their experiences and ideas.

She noted that the Falls Programme would be continuing until December, after which she hoped that all involved would continue to share their learnings and experience by becoming part of the online Prevention and Management of Falls Community of Practice:

www.fallscommunity.scot.nhs.uk

Through this on-line 'space' members from a range of professional backgrounds could share knowledge, ideas, experience and good practice, as well as finding useful resources including copies of the presentations made by today's speakers.

In addition, the Community of Practice provides a convenient way to find and contact colleagues who share an interest in falls, and to stay up-to-date on the latest news and developments.

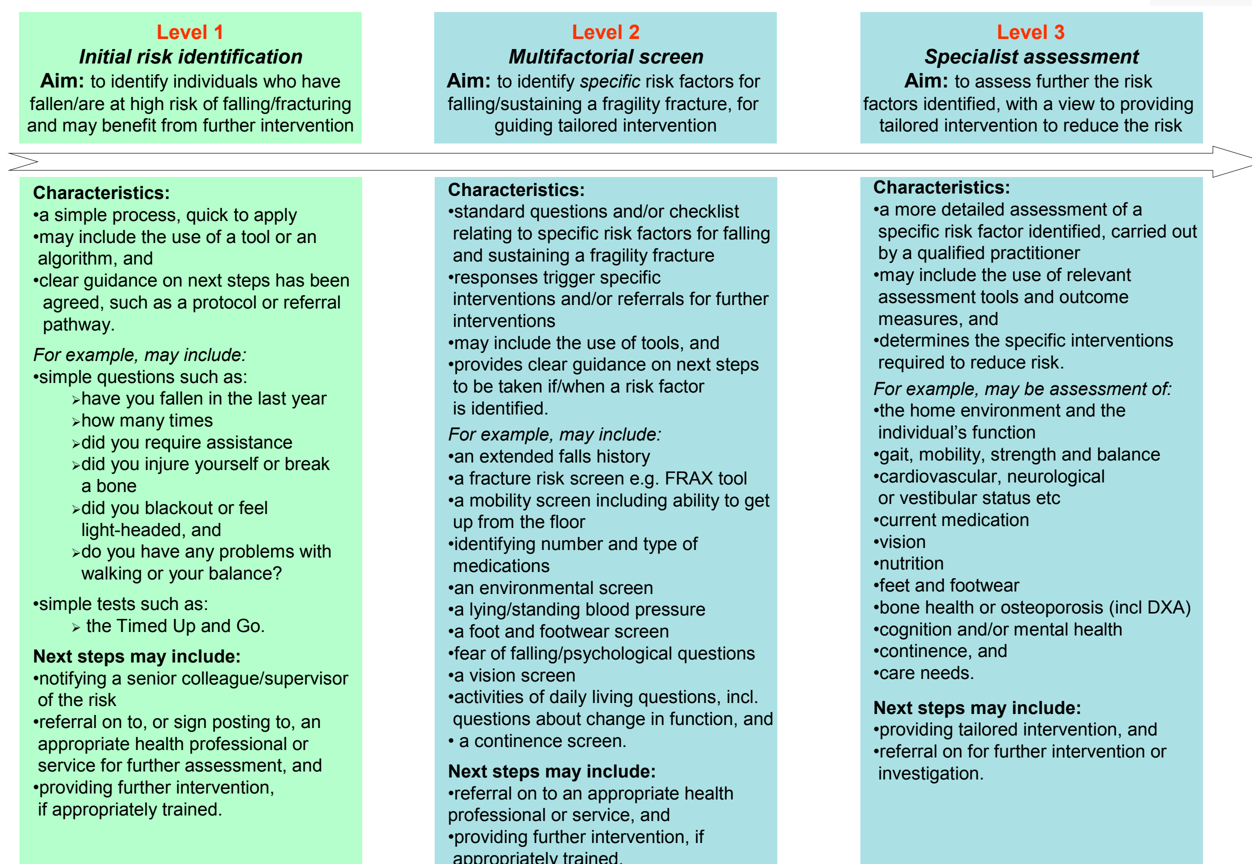
She also thanked the NHS QIS staff for their work on the day including Leslie Humphries and Rosemary Hector. Ann Murray, who had been unable to attend, was also thanked for her continued work managing the Falls Programme.

Appendix 1

THE FALLS AND FRACTURE RISK ASSESSMENT CONTINUUM

The falls and fracture risk assessment continuum

(relates to opportunistic case finding and/or when a fall is reported)



Appendix 2

THE FALLS AND FRACTURE RISK ASSESSMENT CONTINUUM (STAKEHOLDERS)

Please Consider:

- What roles and responsibilities do you realistically expect specific stakeholders to adopt: initial risk identification, mulitfactorial screening or assessment?
- Depending on the skill and capacity of the assessor, and the configuration of local services, he/she may have more than one role.
- How would you ensure a stakeholder's understanding of, and ongoing competency in, their allocated role?
- What are the referral options/mechanisms available to the stakeholder at each stage, ie have referral pathways been established?
- At Level 1 and Level 2, would you expect the role to extend beyond identification or screening, for example, providing advice or other intervention? If yes, how do you support this?

Appendix 3

ATTENDANCE LIST

Delegates

Name	Designation	Organisation
Donna Ainslie	Physiotherapist	NHS Forth Valley
Margaret Anderson	Lead for Falls Prevention in Acute & Community	NHS Greater Glasgow and Clyde
Elaine Auld	Falls Lead	NHS Borders
Irene Bannerman	Falls Lead	NHS Greater Glasgow and Clyde
Rosie Cooper	Physiotherapist	NHS Grampian
Greg Cox	Acting Falls Lead	NHS Tayside
Emma Cummings	Rehab Coordinator	NHS Greater Glasgow and Clyde
Caroline Davidson		NHS Greater Glasgow and Clyde
Emma Dear	Rehab Coordinator	NHS Tayside
Louise Deeks	Falls/Osteoporosis Specialist Pharmacist	NHS Greater Glasgow and Clyde
Roz Eccles	Falls Lead	NHS Lothian
Hilary Fantom	Service Co-ordinator	NHS Forth Valley
Wendy Feeney	Osteoporosis Nurse Specialist	NHS Lanarkshire
Jacqualine Ferguson	Head Occupational Therapist	NHS Greater Glasgow and Clyde
Marie Freedman	Outcomes into Practice Development Officer	East Renfrewshire Council
Georgie Garrick	Falls Lead	NHS Ayrshire & Arran
Judith Gordon	Physiotherapist	NHS Greater Glasgow and Clyde
Norma Hamilton-Dyer	MCaN Manager	NHS Fife
Sharon Hodge	Falls Lead	NHS Ayrshire & Arran
Caroline Horn	Falls Lead	NHS Greater Glasgow and Clyde
Marna Howie	Falls Lead	NHS Greater Glasgow and Clyde
Carole Jackman	Falls Lead	NHS Highland
Margaret Jackson	Rehab Coordinator	NHS Dumfries & Galloway
Christine Jackson	Falls Lead	NHS Greater Glasgow and Clyde
Shiona Johnston	Rehab Coordinator	NHS Ayrshire & Arran
Sarah Kirk	Falls Lead	NHS Dumfries & Galloway
Sandra Lawler	Falls Specialist Physiotherapist	NHS Lanarkshire
Angie Lloyd-Jones	Rehab Coordinator	NHS Borders
Carol Lumsden	Modernisation Manager	NHS Lothian
Gail MacNamara	Team Manager Housing with Care/ Peripatetic OT	NHS Forth Valley
Iain MacRitchie	Rehab Coordinator	NHS Highland
Gwen Madden		East Renfrewshire Council
Christine McArthur	Falls Lead	NHS Highland
Joan McGinnes	Information Manager	NHS Tayside
Lianne McInally	Specialist Occupational Therapist	NHS Lanarkshire
Mary Angela McKenna	Falls Lead	NHS Greater Glasgow and Clyde
Anne McKenzie	Rehab Coordinator	NHS Grampian
Elspeth McKinlay	Community Older People's Team	NHS Greater Glasgow and Clyde
Angela Millar	Acting Falls Lead	NHS Tayside
Maggie Morrison	Falls Lead	NHS Dumfries & Galloway
Lorraine Perry	Falls/Osteoporosis Specialist Pharmacist	NHS Greater Glasgow and Clyde

Claire Ritchie	Rehab Coordinator	NHS Lanarkshire
David Robertson	Paramedic Area Service Manager	Scottish Ambulance Service
Melinda Shakespeare	Acting Falls Lead	North Lanarkshire Council
Lynn Shand	Physiotherapist	NHS Grampian
Millie Shepherd	Fracture Liaison Nurse	NHS Grampian
Kenneth Slater	Fast-Track Therapy Service	NHS Forth Valley
Kirstie Stenhouse	Falls Lead	NHS Lothian
Lisa Stewart	Falls Lead	NHS Lothian
Shona Strachan	Falls Lead	NHS Grampian
Catherine Tully	Falls/Osteoporosis Specialist Pharmacist	NHS Greater Glasgow and Clyde
Josephine Wight	Falls Lead	NHS Greater Glasgow and Clyde
Carolyn Wilson	Falls Service Manager	NHS Tayside

Speakers

Name	Designation	Organisation
Anne Hendry	National Clinical Lead, Long Term Conditions Collaborative	Scottish Government
Joy Kelly	Falls Co ordinator	NHS Tameside & Glossop
Sarah Mitchell	Project Manager - Rehabilitation Framework	Scottish Government
Jillian Rae	Service Co-ordinator	NHS Forth Valley
Dawn Skelton	Reader in Ageing and Health	HealthQWest, Glasgow Caledonian University
June Wylie	Development Manager	NHS Quality Improvement Scotland
Josephine Wight	Falls Lead	NHS Greater Glasgow and Clyde

Staff

Name	Designation	Organisation
Angela Balharrie	Practice Development Project Co-ordinator	NHS Quality Improvement Scotland
Rosemary Hector	Practice Development Project Co-ordinator	NHS Quality Improvement Scotland
Leslie Humphries	Administrator	NHS Quality Improvement Scotland
Claire Tester	Practice Development Professional Officer - AHP	NHS Quality Improvement Scotland
Bridget Weller	Event Reporter	