jit joint improvement team

NHS Quality Improvement Scotland

EXPLORING THE USE OF TELECARE WITHIN APPROACHES TO IMPROVE THE PREVENTION & MANAGEMENT OF FALLS & FRACTURES

BRIEFING NOTE 2: PARTNERSHIP WORKSHOP - 2 SEPTEMBER 2009

BACKGROUND

NHS Quality Improvement Scotland (NHS QIS) and the Joint Improvement Team are working with 3 partnership areas across Scotland (Falkirk/NHS Forth Valley, South Ayrshire/NHS Ayrshire & Arran, and Perth & Kinross/NHS Tayside) to explore the potential role and benefits of using telecare as part of improvements to the prevention and management of falls and fractures in older people. It is the intention of all the involved parties, that the experiences and materials developed during this initiative will be widely shared with other interests and practitioners to promote the exchange of knowledge, ideas and good practice.

An initial scoping workshop was held on 11 May 2009, to establish the early focus and priorities of the individual partnership areas, the detail of which is captured in an earlier briefing note[1]. The purpose of this note is to capture the discussion and actions agreed at a follow up workshop held on 2nd September 2009.

WORKSHOP INTRODUCTION

Moira Mackenzie Telecare Programme Manager (JIT) and Ann Murray - Falls Programme Manager (NHS QIS) welcomed participants and gave a quick summary of the focus of this initiative, and activities to date. Participants agreed that the briefing note produced from the last workshop was an accurate reflection of events. It was generally agreed that the initial workshop had been positive, particularly as a number of key actions had been established by each partnership which although individual to them, were also of interest to the other areas. Purpose of today's workshop was identified as;

- sharing progress to date;
- identifying and debating any issues which have arisen;
- and discussing possible solutions from shared experience.

Moira Mackenzie also advised that there may be potential funding available to support this initiative via the Innovation Fund of the Telecare Development Programme. However any proposals should reflect and be of benefit to the wider approach being taken in these workshops. Moira also advised that it was not intended to pursue any formal evaluation of this activity, but that Liz Sergeant had been commissioned to work with the 3 partnerships to record experiences/views/issues up until the end of this financial year to support the wider knowledge transfer. Ann Murray also noted that the experiences of the local partnerships will be valuable for others involved in developing falls pathways, and that progress from today would be reflected in the 'Falls Prevention and Management - Case Finding Workshop' which is being held at the Beardmore Conference Centre in Clydebank on 9 September and which is targeted primarily at CHP Falls Leads and Rehabilitation Co-ordinators.

SUMMARY OF PARTNERSHIP ACTIVITY

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1 Briefing Note: Initial Workshop to Explore the Use of Telecare within Approaches to Improve the Prevention & Management of Falls & Fractures – *Available via JIT and NHS QIS websites – wwwjitscotland.org.uk and www.nhsquality.org*

Each partnership then gave an update of local activity and focus to date.

Perth & Kinross/Tayside

Carolyn Wilson, Falls Service Manager (NHS Tayside) gave an overview of the work that has been progressing in Perth & Kinross (P&K).

Project objectives are;

- To develop a pathway for clients with a community alarm who are repeatedly falling to be identified and considered for a falls assessment.
- To further enhance the role of telecare in developing falls prevention/management pathways at a local level.

With the overall project goal being to;

- Enable repeat fallers to be identified at the earliest possible stage and for them to be appropriately screened, assessed and treated to reduce future falls risks and prevent an injurious fall.

Carolyn advised that there are already 5 specialist falls clinics in P&K, and circulated a poster outlining information on the Falls Service and the overall falls pathway (Appendix One). However, all of the processes within the pathway have not yet been fully developed, and 2 options for enhancing this are currently being reviewed.

Developing Processes for identifying and assessing CAS Repeat Fallers

It is proposed that the SWIFT database system should be reviewed by appropriately trained staff on a monthly basis to identify repeat fallers, who meet the criteria for the Falls Clinic. This is because staff within the Community Alarm Telecare Service and the Falls Clinic staff are being provided with some of the SWIFT information.

There are two options currently being explored to do this;

1) The Falls Clinic staff review the data input by the Community Alarm Telecare service on SWIFT and identify who is already known to the service, who is new and who would benefit. They then ask the Community Alarm/Telecare staff to make contact with potential clients and send out letters advising them to contact the Falls Clinics.

2) Falls clinic staff review the data on SWIFT but have a member of staff to undertake a lower level assessment of potential clients to identify further detailed information. This may avoid unnecessarily referring all people to the falls clinics for a comprehensive assessment and route them to other more appropriate services. There are concerns that routing everyone down the same pathway would just create blockages and inappropriate demand that may not be able to address and lengthen the waiting list.

Carolyn advised that although both options are being considered, a 'triage' team member would require additional resources that are not currently available, and so they are unable to demonstrate that Option 2 may provide value for money over the long term. Option 1 has therefore been pursued since June. This is intended to clarify the process and resourcing issues required.

A draft pathway summarising the communication flow between the Community Alarm/Telecare service and the Falls Clinic has been developed (Appendix Two). The new process has been implemented in an incremental way over the past 2 months with 19 letters being sent out by Telecare/CAS to potential clients. The Falls Clinics have had responses from 3 new people who were previously unknown, plus 4 responses from people who were previously known. The impact of this on the waiting list is being monitored, and further falls education work with the Community Alarm Telecare mobile responder staff has been undertaken. As part of the refined process, Perth & Kinross have developed a 'Falls History Collection Tool' which is completed by the Mobile Response Team and input to SWIFT. This provides more detail about the fall and enables a history to be built up over time (recorded in SWIFT as an incident). P & K also receive referrals from Sheltered Housing Wardens and are currently reviewing the process for Home Care referrals.

P & K are currently investigating how they can best extract a report from the SWIFT system

using Business Objects. A staff member involved in the management of the SWIFT database has now been invited onto their project steering group to advise. They are also adding on more detailed drop down information about the fall to aid reporting purposes.

Discussion Points:

Lack of Database Integration: Key issue at the moment is the number of different data collection systems. Perth & Kinross already have the SATURN call handling equipment, SWIFT and the single Shared Assessment system so there is a degree of double entry at the moment which will need to be addressed, and this is not even including the systems used by Health!

Possible Low Uptake: Although early days for the Perth & Kinross approach, having a member of staff who could undertake lower level screening/assessment may prove to be an effective way of routing people to different areas of the pathway I.e. not just falls clinics, but there is clearly an issue about evidencing effectiveness to secure the appropriate resources. Falkirk advised that their MECS staff undertake a physical visit to repeat fallers to reassure the person that falling is not a natural part of growing old. This also addresses some of the perceived stigma/concern around engaging with a 'day hospital'. It was suggested that one-to-one contact has a significant impact on agreeing to referral (100% in Falkirk), but it was acknowledged that the individual skill of the visiting staff member would also play a critical part.

South Ayrshire/Ayrshire & Arran

An overview of the approach taken in this partnership area was provided by Wendy McGeachie, Project Lead (SA Council) and Heather Hall, Falls Coordinator in the Community Health Partnership. They advised that;

- The project aim "is to bring about service improvement for the Ayrshire Alert Service in its care and response to people who fall".

Project Objectives are to:

- Reduce the rate of falls and decrease the number of fractures occurring amongst older people living in the local community.
- Impact favourably on the rate of hospital admissions in North & South Ayrshire.

The project has been broken into the following four distinct implementation phases ("bite-sized chunks") with associated tasks;

Identify:	Identify repeat fallers amongst the alert service users
Respond:	Respond effectively to the healthcare needs of fallers within the Alert Service
Screen:	Establish a falls screening service for fallers within the Alert Service to trigger referral for a multifactorial Risk Assessment; Supply 'falls' advice and guidance leaflets; Identify people who would benefit from additional Telecare support.
Refer:	Act as an onward referral source, referring fallers to; health professionals within community rehabilitation teams permitting fallers streamlined access to multifactorial Falls Risk Assessment; Care & Repair Services; Case Managers.

Identify Repeat Fallers

Wendy advised that SWIS is their main social care database but this does not currently link to their Telecare/Community Alarm call handling equipment - PNC5. However to make progress as quickly as possible, Wendy is working with their supplier to undertake changes to their PNC5 call handling system to enable repeat fallers to be identified. A format has been

developed to enable the CAS staff to record the details of a fall within this database, but this is not yet operational pending the database changes. The impact on the workload of the CAS staff is unclear at this stage, but there may be opportunities for better joint working with the Home Care staff to assist in the identification of repeat fallers. The partnership have consciously avoided having a separate 'falls service', partly reflecting the fact that there are very limited specialist falls services currently available to link in to. However they have in place an agreement with the Community Rehabilitation Team who are willing to undertake the multi-factorial assessments.

Wendy acknowledged that this is potentially a very large project with specific timescales, and there is a need to ensure strategic ownership by the partnership. To reflect this, the project has established clarity around their governance and reporting structures. The approach sits clearly within the Reablement workstream of their local Joint Planning Structure, and Progress Reporting will be undertaken by the NHS Board's Long Term Conditions Manager who has a wider remit for Telehealthcare across the partnership.

Development of Mobile Attendant Response Service
Heather advised that they they have added on two extra pathways for fallers into the current response process. The first is around enhanced training for Mobile Attendant responders (who are the first line response to fallers), and they have reviewed what could be usefully included within their induction and development programmes. Six care areas were identified in discussion that could benefit from further educational development;

- Emergency first aid to fallers, including the recognising of minor and major injuries;
- The adoption of regulated and standardised response formats and care duties for MA's attending service users who have fallen (e.g. assessment of client balance and mobility)
- The causes of falls and risk identification
- Fall management and prevention
- Recognising and understanding the 'falls' criteria that should trigger a referral to the Care & Repair Service
- Recognising and understanding the 'falls' criteria that should trigger an onward health care referral

The second process change involves the attendant asking the person who has fallen if they would agree to a referral to a health professional (not much more than this at this early stage).

Discussion Points:

Identification of Repeat Fallers by Home Care Service: Experience from P&K identified that Home Care staff note reported incidents of falls within the hand held record in the home, and then report this onwards to the Home Care Organiser for any follow up. The staff member needs to demonstrate this awareness as part of their SVQ. This could then be recorded within the database to be used for monitoring repeat fallers. (Appendix Three: Falls Record Sheet used by Tayside).

Falkirk/Forth Valley
Linda MacPherson, MECS Manager (Falkirk Council) reported on progress that has been made on the Falkirk Falls Management Project, although noted that a falls co-ordinator had not yet been appointed by the Health Board.

The project commenced operation in March 2002 as a joint initiative between colleagues in Forth Valley Trusts ReACH, Day Hospital, Fastrack Services and Falkirk Councils Social Work MECS service. There is a regular reporting format in place for the project and the updated copy for August was provided in the workshop pack (Appendix Four). This identifies that in the period from March 2002 to end July 2009, 11,749 falls have been attended by MECS Mobile Wardens. A total of 536 frequent fallers amongst the MECS service users have been provided with a multifactorial assessment in relation to their falls. It is estimated the service is reducing falls by around 600 per year, which is anticipated to represent 30 avoided fractures (5%).

A similar monitoring exercise and direct referral procedure has now been put in place in 5 Housing with Care units, and work has commenced to expand these arrangements to

Residential Care Units in the Falkirk Council area. Linda advised that the service had recently brought on a number of frequent fallers as prioritised by other areas - not in accordance with own service criteria. This has had an impact on the overall performance of the service by way of an increased incidence of falls and referrals, I.e average rate has been affected, and there are impacts on waiting time for multifactorial assessments. There are also issues with the telecare falls detectors that are currently being used, and people are often put off by the level of sensitivity, resulting in them going off all the time.

The project has recently up scaled the monthly reporting to General Practitioner's to weekly, which gives the local practice an opportunity to engage with patients at an earlier stage.

Linda also reported that the project commenced a programme of falls awareness raising from May 2009. This has included staff from Voluntary Organisations, Dundas Ability Centre Team (Phy and Learning Disability), Forth Valley Sensory Centre Team and the Home Care Service. A positive result of this is that Home Care are now looking at how the information can be cascaded to their 600+ staff, service users and unpaid carers. Also as a result of this, Home Care are looking at whether they can report frequent fallers directly to GP's (with consent), to ensure that the information is recorded and reported in a way which supports consistent information logging. Falkirk regard the GP surgery as at the centre of the falls pathway - and if they receive info from MECS and Home Care the data is at least going to same place.

<u>What is holding us back?</u>
Linda summarised that;

- The sensitivity of current Falls Detectors is an issue, and Falkirk is exploring a new sensor which is reported to have the capacity to be set at different levels of sensitivity, reflecting the differing weights of individuals and the kind of falls they are prone to e.g. no alert if bending over to pick up the paper. They are going for a field trial pilot with the new detector and will work with fallers to support the use of the equipment and get their views. There is a poor rate of compliance with many falls detectors, and there is a need to do more about visiting and persuading them to continue with the telecare or look at other options that may be more appropriate for the individual's needs and preferences.

- Falkirk are also taking forward some of the simple interventions that can be undertaken rather than referring multifactorial assessments for all people. What other forms of telecare may be more appropriate, different set ups tried out. They would like to engage in a full range of activity, but there is a limited capacity to do it.

- The waiting list for telecare assessments is lengthening - 311 referrals already outstanding. The recent awareness raising exercise has produced a huge rise in the number of referrals and there is a frustration about not engaging with people in a timely way.

- Capacity to undertake Otago exercise programme (assessments and audits in 10 locations) is also limited. This approach requires a proper evaluation to assess its value and identify if it does have any real benefits?

- Capacity to deliver further changes to social care personal.

- Global issues around interconnectivity of equipment and lack of falls Co-ordinator.

- There is a need to have the capacity to record more information about falls and detect their occurrence more robustly. Linda suggested that we use combined weight to more effectively tell suppliers what is needed, rather than being supplied with inadequate options.

- Need to improve the screening of all those referred as 'frequent fallers' and sort them out into different directions/individualised solutions.

<u>Common Issues Emerging</u>

There are a range of existing databases at a local level that provide pieces of useful information, but the data is not currently integrated or comprehensive enough to flag up repeat fallers and enable trend analysis. There is a need for a common and accessible depository, but currently partnerships are progressing with what they have just now and learning what information is most useful and what they need to record to see patterns emerging. A layered approach seems to be developing to data on detail of falls and fallers, and it was acknowledged that it will be interesting to compare and contrast different approaches over time.

NEXT STEPS

Perth & Kinross/Tayside

1. Revisit History Collection Tool and refine the detail.
2. Meet with Home Care Organisers to review the recording in hand held records and reporting to Home Care Organiser to ensure relevant information on frequent fallers goes into SWIFT.
3. Have a look at different Falls Monitor.
4. Explore what information GP's wish on clients referred to the Falls Clinic.
5. Need to look at ways of identifying repeat fallers out with community alarm/telecare service.
6. Submit Innovation Funding proposal to JIT.

Falkirk/Forth Valley

1. Continue to promote falls reporting in the Home Care service, linking data to GP surgery to enable composite falls record.
2. Continue to encourage falls management within residential care settings on potential role and use of telecare.
3. Explore different types of falls detectors/other telecare solutions along with other approaches to extend the suite of other community based services that can be used to prevent/better manage falls.
4. Explore better links with the Ambulance Service.
5. Submit Innovation Funding proposal to JIT.

South Ayrshire/NHS Ayrshire & Arran

1. Insert Home Care co-ordinator sheet into hand held file and undertake training on this.
2. Work with supplier to get database set up and established. Mobile attendants to support monitoring staff to input relevant data into system and SWIS.
3. Explore remote access.
4. Submit Innovation Funding proposal to JIT.

Joint Improvement Team

Develop a section on the JIT website to enable the sharing of learning/expertise and materials from this initiative with a wider audience. Links to be established with NHS QIS Falls Management Site.

NEXT WORKSHOP

2nd December – Grangemouth
(10.30am - 1.30pm Sandwich lunch to be provided)

APPENDICES

One: Perth & Kinross Falls Service Diagram
Two: Perth & Kinross Pathway from Community Alarm/Telecare to Falls Clinic
Three: Perth & Kinross Falls Record Sheet
Four: Falkirk Falls Management Project Report – Aug 2009

Briefing Note prepared by M Mackenzie: 9th September 2009

Carolyn Wilson
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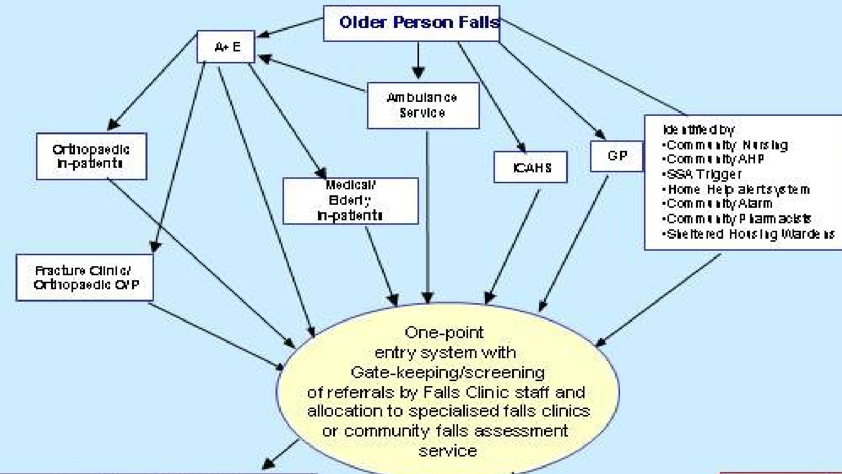
Perth and Kinross Falls Service

Helping older people in Perth and Kinross reduce their risk of falling

"To develop a comprehensive falls service in Perth and Kinross, which will be clinically effective in reducing falls in the elderly involving joint partnership across health, social, private and voluntary care settings.

Falls Partnership Working in P&K

Pathway for Community Fallers requiring Falls Clinic Services



Specialised Falls Clinics

Provide specialised multi-disciplinary falls assessment/interventions following evidenced based guidelines

- Blairgowrie
- Aberfeldy
- Perth
- Crieff
- Auchterarder

Graded Falls and Postural Stability Exercise Programme

Community Falls Pathways
(under review)

- Community Falls Assessment Service undertaken by either Nursing, Occupational Therapy or Physiotherapy staff.
- Cause of fall is not likely to be medically related.
- Patient refuses /cannot attend Falls Clinic

Falls Assessment and possible Referral Pathway

- Medical reason for fall – Falls Clinic
- Medication – Pharmaceutical Review
- Stellen Visual Acuity – advise Optician
- Dietary – advice on diet or Dietician
- Footcare/wear – advice or Podiatry
- ADL/Transfers/ Environmental – advice or OT
- Mobility/Balance – Physiotherapy

Population "Falls Awareness" strategy Roadshows, press articles, posters, literature, presentations, bookmarks, calendars, buses

Safer Community Environment
Involve Community Safety, Road Safety dept., Transport services, Home Safety Officer, Care and Repair etc.

Other aspects

Staff Falls Awareness Education Sessions

- Community Social Work Department
- Community Nursing
- Hospital In-patients
- Mental Health
- Care Homes
- Private Home Care
- Sheltered Housing
- Day Care

Hospital Falls Risk Management

- Root Cause Analysis
- Falls Risk Assessment Tools
- Falls Risk Management Triggers
- Observation Management
- Patient and staff Falls Education
- Bed/Chair alarms
- Ward Falls Log
- Falls Manual

P&K Falls Educational Resource Manual

P&K Falls Education Booklet

Telecare developments

Active Living for Older Adult Group
Involving P+K Leisure, Age Concern, Physiotherapy, Falls Service and an older adult developing physical activity opportunities for older frailer adults including falls and postural stability exercise programmes, chair-based exercise, Otago, community walks, Kurling, play parks for adults.

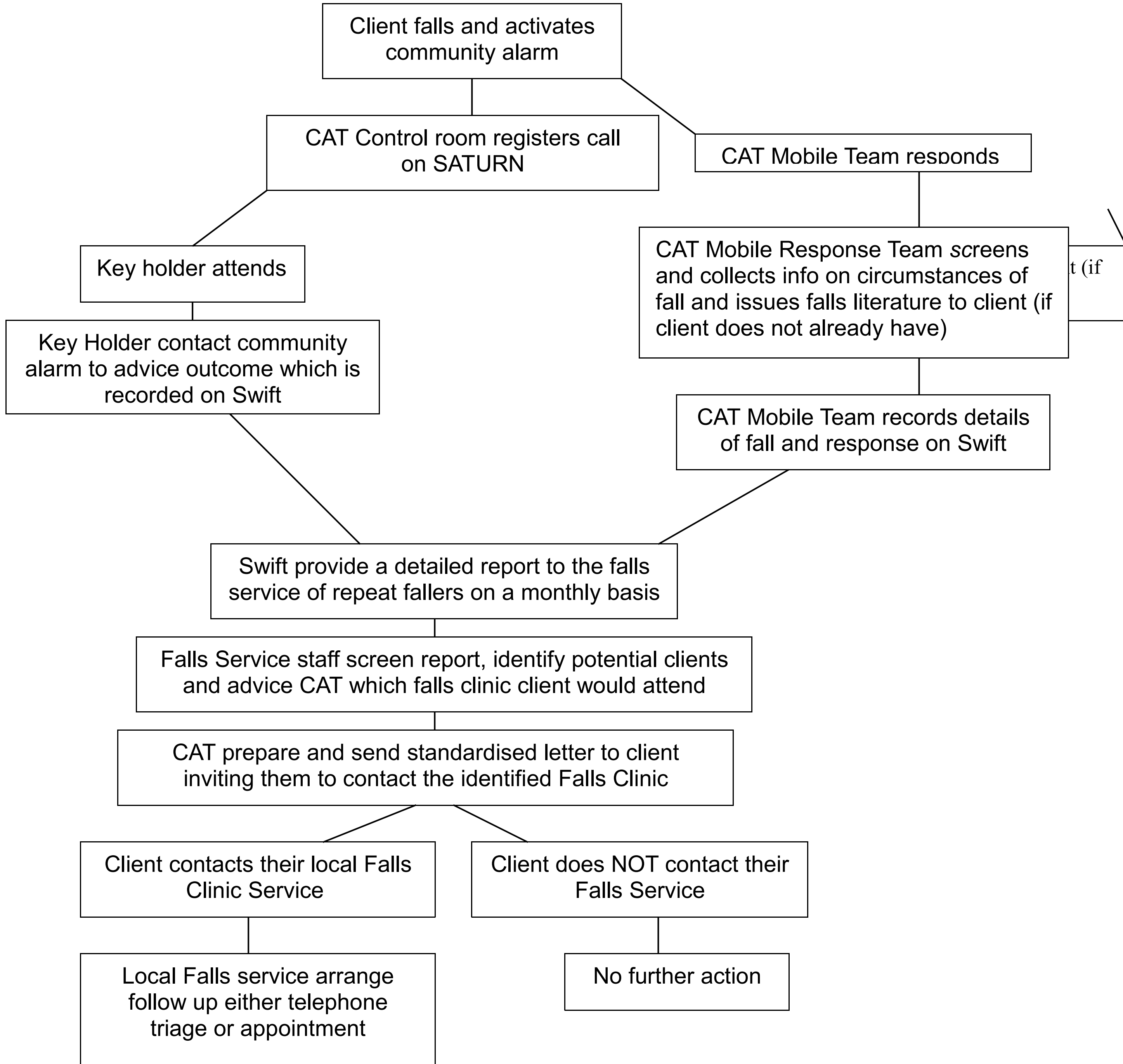
P+K Home Safety Partnership
Involving Fire, Police, Trading Standards, Care/Repair, Housing, older adult and Falls Service. Home Safety Officer appointed, intergenerational home safety pod, electric blanket testing, Datalink bottles, Health/Safety Calendar.

Perth and Kinross Healthy Communities Collaborative
Project involving older community adults working alongside professionals addressing health related topics within their communities and taking action. The topics include falls, physical activity and mental health and well-being in later life. This has led to an increase in falls awareness, physical activity, social capital, community cohesion and a reduction in social isolation

Appendix Two

National Telecare and Falls Management Pilot Project

Pathway from Community Alarm/Telecare (CAT) to Falls Clinic



Falls/Telecare Project

Post Falls Screening Questionnaire

Appendix Three

Name……………………………………………………………………………………..

Address……………………………………………………………………………………

Telephone Number…………………………………………………………………….

Date: ……………………………………………………………………………………..

First fall?	Yes/No	Time of fall:
Where fell?		
Activity at time of fall? Include what client was doing just before fall e.g. rising from chair/bed etc.		
Any warning immediately prior to fall?	Palpitations O Dizziness O Blackout O Slip/Trip O Associated movement O None O	
Any other known contributory conditions e.g. stroke, Parkinson's disease, epilepsy, poor eyesight, poor memory.		
Why? – list causes, if appropriate ask client why they think they fell		

Any obvious environmental factors e.g. wet floor, rugs, clutter, limited space for manoeuvring, stairs, lighting, heating	
Were they wearing appropriate footwear was clothing a factor?	
Were they using walking aid? If so what?	
Was alcohol a factor?	Yes/No
Is client injured?	Yes/ No
Able to get up unaided?	Yes/ No

Responders Name………………………… **…Designation**…………………….. **Date**…………………

APPENDIX FOUR

FALKIRK COUNCIL

SUBJECT: FALKIRK FALLS MANAGEMENT PROJECT REPORT (MECS)

1. INTRODUCTION:

1.1 National statistics show that 30% of people over 65 and 50% of people over 80 fall each year.
1.2 5% of all falls result in a fracture which, if a hip fracture, will cost the National Health Service around £20,000 to treat and at least 20% of these will result in the faller requiring intensive social care service inputs for at least 120 days post-op.
1.3 40% of all care home admissions have falls as a contributing factor for admission.
1.4 Of those people who sustain a fracture as the result of a fall 12% die within 30 days.
1.5 Falls account for 71% of all the fatal accidents in the over 65 age group annually and most occur within peoples own homes.
1.6 These kinds of statistics render joint working in falls prevention a matter of some priority for both Health and Social Care organisations throughout the country and in late 2002 the National Institute for Clinical Excellence (N.I.C.E.) produced guidelines on falls reduction.
1.7 The purpose of this report is to update information on the Falkirk Falls Management Project which has involved joint working between Forth Valley Health Trust and the Falkirk Council Housing and Social Work Service to reduce falls within the Falkirk Council area since early 2002, slightly ahead of the N.I.C.E. Guidleines.

2. BACKGROUND:

2.1 The Falkirk Falls Management Project commenced operation in March 2002 as a joint initiative between colleagues in Forth Valley Trusts ReACH, Day Hospital and Fastrack Services and Falkirk Council Social Work Services MECS Service who shared a concern about older people who experienced falls at home.

2.2 It was recognised that the myriad of workers from both Social Work Services and also Healthcare Services who were dealing with people who had had falls were largely unco-ordinated in their efforts and that information about who was experiencing falls in the community was available to MECS staff but was not then used to facilitate any remedial work with fallers.

2.3 The Joint Working Team involved in the operation of this Project came together from multi-disciplinary backgrounds including MECS staff, physiotherapists, occupational therapists, nursing staff, general practitioners and hospital consultants.

2.4 The Project aimed from the start to use the joint resources available to attempt to reduce the number of falls being experienced by people in their homes and provide early and appropriate education, intervention and holistic assessment.

2.5 It is actively working in compliance with the N.I.C.E. Guidelines 2002 in relation to falls reduction.

2.6 The chosen strategy was to identify vulnerable people in the community who were falling frequently and offer them early access to a Falkirk based Day Hospital setting

where assessment, therapy, equipment and advice would be made available (hereafter referred to as Falls Management Clinics).

2.7 In the Falls Management Clinics a multifactorial assessment is undertaken to, amongst other factors, risk assess the living environment of the person, comprehensively review their medication regime, look at dietary issues and offer balance and strength exercise programmes tailored to the needs of the individual.

2.8 A jointly agreed Falls Risk Assessment Form was produced to indicate those people who were particularly vulnerable as the result of successive falls or complex medical/social conditions.

2.9 Falls Risk Assessment was put into use by both organisations and has proved most useful in determining the risk of falls for individuals.

2.10 Automatic fall detectors, which are fitted for some people as the result of such a risk assessment, facilitate information about falls being provided even when the person who has fallen is not able to use the more conventional methods such as pressing a buzzer unit or pulling a pullcord.

2.11 Automatic fall detectors are part of mainstream service provision in Falkirk MECS.

2.12 Falkirk MECS Service has long used passive and assistive alarm technology through its Community Alarm Service, including technology to monitor environmental hazards for those with dementia and also for people who live alone and who have tonic clonic seizures as part of their Epilepsy Monitoring Project and automatic falls detectors are a natural and welcome addition to these types of alarms although some issues have been identified in relation to compliance, due to the level of sensitivity, which require to be resolved.

2.13 MECS staff began in 2002 to provide everyone referred for the Community Alarm Service, for whatever reason, with an information booklet or tape, “Avoiding Slips Trips and broken Hips” which offers much useful advice and guidance on the many ways in which falls may be avoided.

2.14 The booklet is easy to read and the MECS staff stress that it contains information which can help prevent falls from even beginning for some people.

2.15 MECS staff also provide an emergency response to people in their homes when they experience a fall, applying their skills as registered first aiders and utilising a range of Moving and Handling equipment which they carry in their vehicles and have been specifically trained to operate. This has recently been supplemented with moving and handling equipment suitable for bariatric moving and handling.

2.16 All permanent MECS staff are fully registered First-Aiders and are required to maintain their registration status.

2.17 MECS staff are trained to carry out a comprehensive assessment of the individuals situation as the result of their fall, using safe manual handling procedures to move if this is indicated as advisable, and when to seek professional guidance where there may be a resultant injury.

2.18 Service user falls are closely monitored by MECS and identification of two falls being experienced by anyone within a period of six months results in a Mobile Operations Co-ordinator visiting the person to have discussion with them about the identified pattern of falling, inform them about the Falls Management Clinics and offer a direct referral for assessment, advice, therapy and equipment from the multi-disciplinary staff available there.

2.19 Improvements to process made in late 2007 mean that where a new referral for the MECS service indicates that the person has had a previous fall there is an immediate offer of a referral to the Falls Management Clinic in order that the Service does not wait for 2 more falls to occur before attempting to engage the person in falls

prevention and advice. This is considered particularly important given the large number of people who have been introduced to the MECS service in late 2007 and throughout the whole of 2008 primarily as the result of previous falls.

2.20 General Practitioners, who endorsed the strategy by agreeing to direct referrals being made by senior MECS staff, are routinely advised by MECS of all patients who have experienced a fall in the preceding month. They are also informed as to whether there has been acceptance or refusal of an offer to attend the Falls Management Clinic where their patient has already been identified as a frequent faller.

2.21 Previously such referral was the remit of the GPs and the capacity for MECS staff to bypass them in the referral process has greatly speeded up access to the Falls Management Clinics and also made the process more acceptable to the service users who are less reluctant to have their falls addressed because of concerns about what this might mean for their longer term care needs.

2.22 The table below illustrates the statistics gathered by MECS from March 2002 to July 2009

YEAR Actual or Projected	Falls Attended	Service Users	Falls per User
2002 Projected	1768 *	4213	0.42 projected
2003 Actual	1429	4600	0.31 actual
2004 Actual	1409	4904	0.28 actual
2005 Actual	1487	5600	0.26 actual
2006 Actual	1524	5598	0.27 actual
2007 Actual	1291	5939	0.22 actual
2008 Actual	1964	6014	0.33 actual #
2009 Actual	1172	6131	0.32 actual

*1473 actual March to December 2002 (10 months)

As previously noted significant numbers of people were introduced to MECS throughout 2008 who had been referred primarily because of a previous falls history and the substantial increase in falls attended in 2008 reflects their inclusion on the Service. These figures represent a prevention of some 560 falls for 2008 if compared with the pre-intervention rates of falls per service user.

2.23 In this period of seven years over 5500 new MECS Service Users have been provided with the information booklets or tapes about falls prevention and 11,749 falls have been attended by MECS Mobile Wardens.

2.24 409 people who have previously experienced more than two falls in a 6 month period have been offered a referral into the Falls Management Clinics and 223 have accepted this up to end June 2009. 3 referrals have been made to the Day Hospital and 310 other people who had multiple falls were already known to the Day Hospital or to ReACH and already therefore in receipt of ongoing falls advice from ReACH staff making a total of 536 frequent fallers amongst the MECS service user group who have been subject to mutifactorial assessment in relation to their falls.

2.25 All people who have fallen have had their GP notified of their falls in order for GPS to consider an approach to their patients needs.

2.26 All MECS Service Users who accept referral into the Falls Management Clinic sign a waiver which permits information sharing in relation to their falls between MECS and the Forth Valley Acute Trust staff.

2.27 This was jointly developed to try to overcome the difficulties often experienced

within the Social Work/Health Joint Working arena in relation to patient/service user confidentiality and this has proved invaluable to both organisations.

3. MONITORING ARRANGEMENTS IN OTHER AREAS OF CARE PROVISION:

3.1 A similar monitoring exercise and direct referral procedure has been put in place in 5 Housing with Care Units throughout the Council area.

3.2 Work has commenced to expand these arrangements to Residential Care Units in the Falkirk Council area but is making slow progress. The Care Commission are asking searching questions within some care homes regarding the number of falls experienced by residents which makes this an imperative to progress.

3.3 **R**eports received indicate that staff in Falkirk Councils Residential Care Homes dealt with 679 falls with 95 people who would have been identified as frequent fallers by virtue of experiencing 2 or more falls in the period 1st April 2006 to 31st march 2007 and further specific work is required in this area to update these figures.

3.4 Arrangements require to be put in place to look at the potential for the collection of similar information through Home Care Service staff and a means of offering falls awareness inputs to Home Care Staff. Home Care Managers have had awareness raising inputs in July 2009 and are beginning to look at how Home Care staff could be enabled to make notifications to GPs about their patients falls routinely.

3.5 When the foregoing are all in place this will represent a significant step towards the goal of identifying all frequent fallers amongst older people in receipt of Social Work services in the Falkirk Council area and offering early interventions.

4. TRAINING:

4.1 Five training courses on Otago exercise therapy training have been delivered to staff in Housing with Care Units, 24/7 Rehab carers, Residential Care homes and Community Day Care staff throughout 2007 and early 2008 and therapeutic sessions for tenants/residents have commenced in some of those settings to improve balance and strength and thereby seek to reduce the incidence of falls/prevent some people beginning to fall as a result.

4.2 Otago is an internationally applauded and well evaluated exercise and therapy programme for older people at risk of falling and the Falkirk Council staff trained appear to be the first community-based social care staff in Scotland to be equipped with the skills to take this forward within their care settings.

4.3 Four of the five training courses were funded from prize money awarded to the Falls management project in late 2005, which is now exhausted, with one funded directly from Housing and Social Work staff training budgets.

5. CONTRIBUTION TO WIDER PLANNING:

5.1 The Falkirk Falls Management Project was used as a model in discussions for the proposed development of similar services in the Stirling and Clackmannan areas in 2003.

5.2 The Falkirk Falls Management Project Group meets on a regular basis to review the effectiveness of its activities and to develop the joint service offered.

5.3 Members of the Falkirk Project Group joined the Forth Valley Falls Prevention

Strategy 2008 – 2013 Consultation Group in July 2007.

5.4 The Project Group welcomes the requirement for CHP's to appoint a local Falls Co-ordinator or lead and looks forward to working actively with the appointee for Falkirk CHP in due course.

6. RECOGNITION:

6.1 The Falkirk Falls Management Project was the outright winner in the "Guidelines in Practice Magazine" Awards 2005 in the Older People category, winning a certificate of recognition and £3000 to further the work of the project.

6.2 The Falkirk Falls Management Project was also chosen as the Runner-Up in the entire "Guidelines in Practice Magazine" Awards 2005 competition, winning a certificate of recognition and a further £1000 to further the work of the project.

6.3 The Falkirk Falls Management Project was the winner of the Falkirk Council "Celebrating Success" Awards 2005 in the Community Involvement and Joint Working category.

6.4 The 2007 MAISOP report on the inspection of services for older people in the Falkirk area cited the Falkirk Falls Management Project as an example of good practise in joint working.

6.5 The Scottish Telecare Development Fund benchmarking report published in March 2008 cites the Falkirk Falls Management Project as an example of good practise in effective use of telecare technology as part of its work.

6.6 The Falkirk Falls Management Project was the winner of a Gold COSLA Excellence Award on 5th March 2009 in the category for Advancing Community and Citizen Wellbeing.

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