

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

**BRIEFING NOTE 6: PARTNERSHIP WORKSHOP – 9<sup>th</sup> September 2010**

## **INTRODUCTION**

This is the sixth workshop in a series exploring whether telecare can assist in local falls management and prevention programmes. Ann Murray, Falls Programme Manager within the Scottish Government's Nursing Directorate and Moira Mackenzie, Telecare Programme Manager within the Joint Improvement Team welcomed everyone and outlined the programme for today's workshop. Key elements include a continuation of the last workshop's discussion on how best to measure core impacts, and a 6 monthly review of progress that has been made by the local projects.

## **NOTE FROM LAST WORKSHOP**

The briefing note from the last meeting was agreed as an accurate reflection.

## **FALLS MANAGEMENT WORKSHOP 28<sup>TH</sup> OCTOBER 2010**

This workshop will be predominantly aimed at falls leads and rehabilitation co-ordinators working at a local level, although those with an interest in falls management from a local authority perspective will be very welcome. The workshop will explore suitable impact measures, learning from the experience of others. Claire Tester will be presenting on the experience from the NHS Quality Strategy Framework, and Dr Anne Hendry from the perspective of the Long Term Conditions Collaborative. In the afternoon, the workshop will consider key strategic planning data to identify the key areas of the pathway that can be measured and are considered indicative of progress. Experts from Health Informatics will input to see how these can best be mapped.

**Action:** Details of the workshop are available on the Telecare Learning Network/Falls Management Section of the JIT website, and will be circulated to workshop participants.

## **TELECARE & FALLS PREVENTION GOOD PRACTICE GUIDE/WORKBOOK**

The Telecare Programme has developed a series of workbooks identifying how telecare could be utilised to help meet particular needs i.e. Dementia, Learning Disabilities, Physical Disabilities and Sensory Impairment. Interest has been shown in developing a further workbook around telecare & falls management, and Linda MacPherson and Ann Murray have agreed to provide key input to this. Brian Kerr from the Joint Improvement Team will be leading on the workbook development, with a draft anticipated in December. It was suggested that the contents can be reviewed at the next workshop if available.

**Action:** Draft of workbook to be circulated to workshop participants for comment when available, or input to be provided at next workshop.

## **DEVELOPING CORE IMPACT MEASURES**

The workshop gave further consideration to a discussion paper on measuring the impact of telecare on improvements to falls management pathways. It was agreed to;

- Focus on those areas that participants had control over and could be measured from existing data/systems, e.g. Number of repeat fallers identified via the telecare service, effectiveness of assessment, referral and response arrangements.
- Use a range of qualitative and quantitative measures

- Develop a means of stratifying interventions and prioritising referrals/assessments e.g. some individuals may choose not to participate in better management but still require timeous response to falls; home from hospital referrals.

**Action:** Local Areas to review agreed measures and report back to next meeting on progress against these/any issues collating. The suggested core measures can then be further discussed and refined.

## **LOCAL PARTNERSHIP PROGRESS REPORTS**

SOUTH AYRSHIRE/AYRSHIRE & ARRAN: Apologies

### TAYSIDE/PERTH & KINROSS

5 falls clinics in place and pathway work already undertaken in Perth & Kinross. However, experience from an early phase of service development identified a poor response to using a letter to invite repeat fallers identified via the community alarm service to falls clinics.

The project proposal therefore involved;

- Employment of a part time dedicated “Falls Screener” within the Community Alarm Service
- Undertake home visits to repeat fallers to undertake detailed falls screening/assessment and identify causes of falls
- Identify or rectify remedial interventions
- Consider referrals to Health or Social Care service
- Discuss appropriate referrals to Falls Clinic
- Provide a telephone screening service to Blairgowrie/Aberfeldy areas
- Compare the two different approaches
- Pilot of “Easylink” stand alone chair/bed carer alert system with 10 clients

Specific project objectives and anticipated outcomes have been identified, with measures and monitoring put in place to evidence the impact of these.

### 6 Month Progress:

Approximately 4 months slippage has occurred in the appointment of the Falls Screener role, however the following progress has been made;

- Data systems have been adjusted to enable recording of data on repeat fallers, with links from the Community Alarm to the Social Work System (SWIFT). This information can then follow the person to the Falls Clinic where appropriate, and allow general data on repeat fallers to be pulled out the system.
- The Falls Screener post has been advertised, and was appointed in August 2010.
- Induction/preparation/training/visits to falls clinics have been undertaken
- Home visits have commenced, with 5 undertaken to date (client telephoned in advance with follow up letter confirming appointment)
- Falls Screening Tool has been developed, although will continue to ‘evolve’ with practice
- 5 “Easylink chairs have been purchased to try out in a community setting, which activates a voice to reassure service users whilst alerting the carer to respond.
- A GP letter has been devised to advise of repeat faller, and all GP’s are notified.
- a form has been developed to be left in the home for the client/relative. This is intended to reinforce the home visit discussion/actions agreed, accompanying education booklets etc.

#### Client Studies:

Some very interesting insights were shared around the first 5 home visits.

Approx Average Time

Visit time – 1 hour 5 minutes

Travel Time – 15 mins

Paper work time – 15 mins

Pre-visit – 15 minutes

#### FALKIRK FALLS MANAGEMENT PROGRESS REPORT

Falkirk undertake ongoing monitoring of the impact of MECS service on repeat fallers, with statistics going back to 2002. This identifies the MECS wardens have responded to almost 14,000 falls, with a relatively small number of people having 2 falls within a 6 month period i.e. 506 people. More people with a history of falls are now being referred to the service as it is considered a reliable form of help. Referrals come mainly from social work and primary care, although a number of self referrals are also made. Current average number of falls per user is 0.28 which represents a downward trend (1179 falls across 6,231 users). The MECS Service will be introducing a service charge of £3 per week from 1 November.

#### Project Proposal

- Release dedicated time from Mobile Operations Co-ordinator
- Undertake & prioritise assessment of referrals to MECS service as a result of falls
- Undertake more comprehensive falls assessment to include; telecare solutions, home fire safety, home environmental risk, falls risk and timed 'get up and go'
- Provide additional support for telecare solutions to achieve maximum compliance
- Increase appropriate onward referrals to other services
- Train other MECS assessors to work in similar ways as part of exit strategy

#### 6 month Progress

- Mobile Operations Co-ordinator in place, and 55 initial assessment visits have been undertaken since July
- Flowcharts have been developed and implemented to capture redesigned falls management assessment process
- Currently providing support for 6 people to increase compliance with Tynetec Sayphone (individually set for each client). Early indications seem positive, but early days and statistics being gathered as progress. Onward referrals to other services being tracked.

Falkirk are also engaged in discussions with the Scottish Ambulance Service and two other neighbouring LA's to see if improvements can be made to the way non-injured fallers are dealt with. SAS attend to 200 uninjured fallers per month but no onward referrals to other services are currently made. Complications have already arisen as the local authorities have 3 different referral/assessment processes/emergency service provision and it is not considered appropriate to simply refer all these cases to the Social Care Duty Team. However, MECS have developed the following outline proposal for the Falkirk area;

- Fallers to be referred to MECS & Fastrack through agreed falls screening tool
- Fallers would be provided with alarm equipment to reduce number of calls
- Included in falls management process at an early stage

This is anticipated to result in;

- Reduction in unnecessary future calls for assistance to SAS
- Reduction in unnecessary admissions to hospital
- Reduction in future social care requirement by Crisis Care inputs aimed at re-ablement

- A clear pathway for non-injured fallers who contact the Scottish Ambulance Service

It is hoped that agreement will be reached at a meeting tomorrow to progress this approach in Falkirk and an uninjured faller referral form has been developed for completion by SAS. Repeat fallers will be visited within hours of them falling to assess if they have any immediate care needs. P & K advise they are involved in a similar joint working approach with the Scottish Ambulance Service and have developed a similar referral form. Ann Murray has already proposed to SAS that a more collaborative approach would be beneficial to draw the good practices around this together.

### **CHALLENGES/SOLUTIONS**

Some discussion took place on the purpose and expectations around the GP letter. It was thought that this is likely to just be for information/optional follow-up purposes, and may result in limited action. There is a need to clarify if it could be useful to add high priority information only to the Emergency Care Summary which is accessed by GP's and A&E/NHS24 out of hours. **Action:** Local areas to discuss this with GP's during protected learning to get views, and try and identify what exactly would be useful to record and share, and the most effective method of doing this.

Quite a few clients are already known to services and have a history of refusing to engage. **Action:** Need to consider what can be realistically achieved with them, including consideration of referrals to non-medical services as part of client 'outcomes' approach.

There remain gaps in knowledge about the total incidence of falls via the telecare service as some alerts are unclear and relatives don't always phone back to advise if a fall has actually occurred.

Initial progress has focused on getting the projects in place. Now this has been achieved some further thought will be given to tracking and evidencing the impacts of the projects. **Action:** Further work is to be done to compare the unit costs of the 'downstream' Home Screening service and its impacts against the unit costs of other 'upstream' interventions, e.g. value of less inappropriate referrals to Falls clinics, more targeted use of OT assessments at home.

**Action:** There remain a number of data integration issues with different IT solutions, and further consideration needs to be given to how this could best be addressed. In addition, is there a need to do some more formal to evaluate and draw out the good practice from the local work ongoing?

**Action:** All presentations to be made available via the Telecare Learning Network section of the JIT website.

### **DATE OF NEXT MEETING**

10am – 1pm on 2<sup>nd</sup> December 2010 (Sandwich lunch will be provided).

Venue to be confirmed.