The Greater Manchester Falls Collaborative: Community of Learning, Sharing, and Problem Solving:

(12-Month Programme)

Session 1

Thursday 30th May 2024

10:30-10:35am
Welcome & Overview of the CoLSP Programme
(Beth Mitchell, The Greater Manchester Combined Authority)

10:35-11:15am
The Royal Osteoporosis Society:The new mandate for Fracture Liaison Services
(Craig Jones, The Royal Osteoporosis Society)

11:15-11:55am
Deep Dive into our Falls Prevention Pathway: Bury
(Clare Hunter & Colleagues, NHS Bury)

11:55am-12:00pm
Any actions and close of the session:
Next meeting will be on Wednesday 26th June @10:30am-12:00pm
(Beth Mitchell, The Greater Manchester Combined Authority)

GREATER MANCHESTER DOING AGEING DIFFERENTLY

Greater Manchester Moving

HEALTHY AGEING RESEARCH GROUP

MANCHESTER 1824 The University of Manchester

NHS Greater Manchester Integrated Care

#GMFallsCollaborative

#GMFallsPrevention

GM Falls Collaborative – Community of Learning “Bury Update”

Part of Greater Manchester Integrated Care Partnership

Presentation by:

Shelley Caulfield – Bury Live Well Lead

Ursala Shahid – Falls and Fracture Liaison Service Team Lead

Fauve Syers – IMT Therapy Lead and **Emily Jackson** – IMT Nurse Lead

Dr Wiebke Wentzlau – Consultant Physician and Geriatrician

Clare Hunter – Project Manager Bury IDC

Self-Care and Prevention

Shelley Caulfield

Bury Live Well Service

Self-Care and Prevention

- Referral into Live Well – Strength & Balance pathway
- Integration into the wider community wellness offer
- Proactive Case Finding – Clear project – Frailty
- Care Home engagement

Falls and Fracture Prevention Team

Ursala Shahid

Falls and Fracture Liaison Service Team Lead

Falls and Fracture Prevention Team

BURY INTEGRATED CARE PARTNERSHIP

Two services in one: Falls and fracture prevention team and the Fracture Liaison service.

The team: 2 FT Therapy support workers, FT Physio team lead, 1 PT Physio, PT admin who works over both services and a FT Fracture Liaison Nurse.

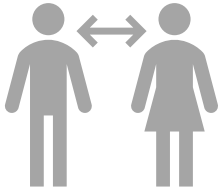
Awaiting new starters for PT Physiotherapist and FT Support worker.

Fracture Liaison service

- The Bury Fracture Liaison Service was initiated in 2019
- We are a community-based service for patients who live in Bury or registered with a Bury GP and have sustained a fracture from a standing height [fragility fracture]
- All our referrals are from the radiology department at FGH although we do accept GP referrals as well.
- The service is currently led by 1 full time nurse and has captured & screened over 2100 patients.

The Falls team

The Falls team has had a lot of changes, ups and downs over the years, Established in 2012 previously under Pennine care, the service shut down and opened back up prior to Covid



During Covid all staff were redeployed in non-essential community teams, the service however stayed open and was remote based by one member of staff.

2021 the service started to open back up for Face to face, moved premises to RPCC and gained a new OT team lead, with 2x FT support workers.

2022 service development, changed from 65+ to 50+, MFA for all new assessments, previous neuro accepted (previous Stroke, dementia).

Falls team Spec

- 50 and above
- No long-term rehab neurological condition reason for falls.
- Bury GP
- Falls or at high risk of Falls.
- P1- Lives alone/high risk, P2- Lower risk/lives with someone, P3 Care homes.

Delivery

- Telephone triage is completed and added to a waiting list taking into consideration priority, advice and signposting on may be discussed.
- Patient will then be offered either a home visit or Clinic.
- Clinician completes a Multifactorial Assessment (MFA) with outcome measures.
- Onward referral, exercise programme, equipment ordered, advice given, GP follow up, signposting, mobility aid.
- Follow up may be offered with Clinician or support worker.
- Follow up to include equipment review, outdoor mobility practise, exercise review, confidence building to reduce fear of falls.

Multifactorial Assessment

As stated in NICE guidelines 1.1.2.1Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment.

- Falls history.
- Assessment of gait, balance, mobility and muscle weakness using Tinetti or times up and go.
- FRAX.
- Fear of falls.
- Visual impairment.
- Cognitive impairment and neurological examination.
- Continence assessment.
- Home hazards.
- Environmental check.
- Medication review plus BP check with recommendation to GP.
- Nutrition advice and assessment.

Business Continuity Plan Examples

BURY INTEGRATED CARE PARTNERSHIP

Escalated to senior management.

NHSP use for relief following long term sickness.

Home working or alternative staff site when premises is unavailable.

Non-essential meetings/training cancelled.

Assess parts of the service which can be cancelled and prioritise.

Reporting incident through Datix.

Commence paper record keeping following IT issues.

Consider joint working across services to reduce travel.

Gaps

- Staffing levels
- Recent sickness struggled for relief.
- No permanent clinic.
- Banding limitation of support workers.
- Limited funding available.
- Misinterpretation of what service offers, not an urgent service.
- Care home duplicate referrals and unclear on pathways/support.
- Wait on minor adaptations, further falls.

Within the next 12 months.

- Back to Full staffing levels.
- KPI’s re-evaluated for 72 working hours triage, P1, P2 and P3 realistic time frame.
- Number of follow up visit discussed
- More Element on Preventing Falls.
- Clinics on a permanent monthly basis.
- Staff to be OTAGO trained.
- Prevention exercise classes to be offered.
- Greater collaboration with services.

Urgent Community Response “Falls Lifting Service” and Intermediate Care

Fauve Syers – IMT Therapy Lead

and

Emily Jackson – IMT Nurse Lead

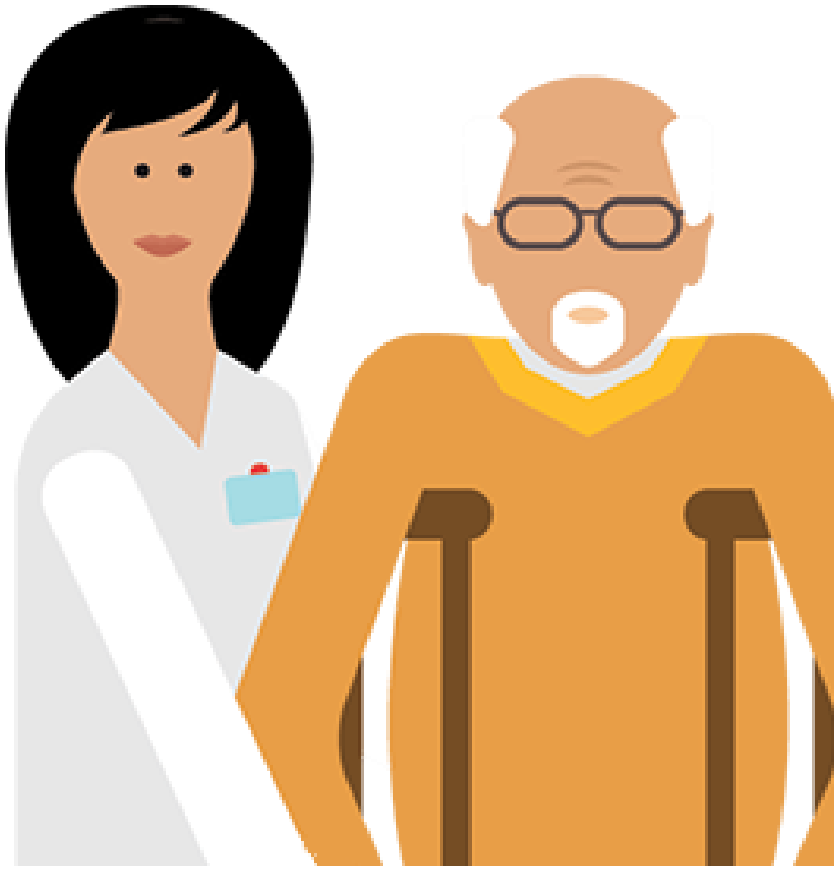
Urgent Community Response

Falls Lifting Service

- Emergency Falls Response Service – respond to all L1 falls across Bury (non-injury but requires support to be lifted)
- The service will be launched summer 2024.
- The service is available to all professionals; including NWAS, Care Homes, GP's and wider stakeholders.
- Pathways into IMC services will support further rehab potential.
- Co-location with Rapid Response UCR will support the development of a L2 offer in Bury.

Intermediate Care

- Every individual receives a comprehensive MDT assessment which includes a multi-factorial FRAT (Falls Risk Assessment Tool)
- The whole Therapy team are trained in OTAGO, which is a series of 17 strength and balance exercises, which is evidenced to reduce falls in older people by 40%
- A monthly virtual falls clinic is held with a Consultant Geriatrician specialising in Frailty. This provides an independent comprehensive review with the full MDT. This ensures a robust approach in relation to minimising falls risks with patients under our care. The Consultant then provides feedback to the individuals GP to ensure continuity of care and inform longer term management of the individual's needs.
- We recognise, on discharge from the service, we need to develop stronger links with community services and the voluntary sector.
- We have an established Falls Steering Group, building connectivity across all IMT services, with a clear action plan to develop our falls offering, which includes engagement with wider stakeholders.



Inpatient Care

Dr Wiebke Wentzlau

Consultant Physician and Geriatrician

Specialty Training Lead for Medicine

Falls & Dementia Lead Consultant

Fairfield General Hospital

Northern Care Alliance NHS Foundation Trust

In-patient Care

Primary Prevention:

- ❑ Nursing Falls Risk Assessment completed upon admission
- ❑ Nursing Falls multifactorial risk reduction assessment completed on movement to a ward.
- ❑ Frail patients identified and reviewed by the Frailty Team/ Consultant, this includes a falls risk medication review and care planning.
- ❑ Red tubing placed on bed to identify person at risk of falls.
- ❑ Lying and Standing blood pressure routinely done on AMU
- ❑ Previously had a pharmacist with a specialist in falls that would routinely review medication (current gap)

Secondary Prevention:

- ❑ Therapy teams actively see patients subject to falls, in-reach also into SDEC
- ❑ Medication reviews complete, actively deprescribing for those patients having fallen as well as falls risk reduction methods (FRAX, therapy ETC).
- ❑ Consultants supporting with TOC around 24hr in-reach into care homes to prevent ambulance call outs, utilising community provision (via Hospital at Home service)
- ❑ Discussions around developing a TOC to develop an MDT via a Falls clinic

Care Home In-reach and Gaps Identified within Falls Service Provision

Clare Hunter

Project Manager – Bury IDC

In-reach into Care Homes

Over the past 18mths Bury have been supporting the role out of a fall's prevention app called "SafeSteps". This work was initially developed alongside the Frailty and Ageing Well programme and has been running in conjunction with a HInM led proof of value around utilising digital tools within care home inc. falls and Restore.

Safe Steps for Falls, is a:

- Multifactorial risk assessment, enabling early identification of risks inc. Falls
- Provides a personalised action plan to reduce risks
- Tracks actions and interventions to prevent falls
- Collects evidence of falls when they occur
- Creates a digital audit trail
- Provides the LA commissioning team with an overview to monitor trends and drive improvement

the **aim** of the digital tool is to support care homes with the reduction of falls and management of deterioration within residents. The benefits of utilising these tools will

- Have a Reduction in Falls
- Reduction in NWAS call outs
- Enable staff to Identify risks earlier, leading to earlier identification and intervention, preventing a further decline in residents health.

To date:

✓ 245 Staff have been trained in utilising the SafeSteps Fall App within 37 Bury care homes

✓ 914 residents are on board and 5902 screenings have taken place

Evaluation: HInM are in the process of collating an end of project report for GM using Bury as a Blue-print for this work. The paper will articulate the benefits and data, which will support the use of this digital concept across localities within GM.

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Areas for Improvement:

- No Falls Strategy
- No clear routes for referrals relating to Falls.
- Limited in reach into care homes “Falls Specific”– Falls prevention training, advice, awareness. No consistent activity packages to keep residents active.
- No falls MDT
- SPoA – Nonclinical triage person
- Duplication of referrals and interventions, due to limited or no visibility of patient information as services are using different systems.
- Information sharing oversight

Thank you!