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

(12-Month Programme)

Session 7

Thursday 28th November 2024

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

10:35-10:45
Housing and Falls Prevention: Housing First & GM Live Well
(Helen Simpson, NHS GM Integrated Care Partnership)

11:15-11:55
Deep Dive into our Falls Prevention Pathway: Stockport
(Stockport Team)

11:55-12:00
Any actions and close of the session:
Next meeting: Wednesday 18th December, 10:30am-12pm

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

Background and purpose

- Falls Collaborative with oversight of the strategic and operational system level priorities and recommendations for falls prevention, and delivery of associated activity.

- The Mayoral Housing First ambitions have brought housing to the forefront of GM priorities and set out that responding to the housing crisis requires input across all parts of the public sector.

- GM Tripartite Agreement provides the formalised relationship between GMCA, NHS GM and housing sector, driving collaboration across housing, health and care on a series of joint projects and programmes.

- Opportunity through this relationship to explore interconnectivity between NHS GM key plans and strategies and Housing First ambitions – focusing on where joint action delivers against multiple aims. With the Tripartite Agreement as the mechanism to take this forward.

gmhp

NHS Greater Manchester Integrated Care

GMCA GREATER MANCHESTER COMBINED AUTHORITY

Housing First

‘The security of a good home is a fundamental foundation for us all to achieve our ambitions in life – our safe space for growing up, getting on and growing old.

The housing crisis means that too many of us don’t have that solid base, and our bold aspirations for the future won’t happen unless we fix that. So, in Greater Manchester, we are putting Housing First.

Our ambition is for everyone in Greater Manchester to live in a home they can afford that is safe, secure, accessible healthy and environmentally sustainable - a healthy home for all by 2038.’

- In order to achieve our bold Housing First ambition and growth aspirations we cannot continue with business as usual in the housing system.
- The housing crisis is complex, multi-faceted and falls across the remits of multiple public sector organisations at local and national level. Progress will only be made with a radical, structured and coordinated approach, with multiple connected interventions.
- The following slides capture the problems faced through the housing crisis, and the package of interventions which will help us to solve them, under the three pillars of Supply, Standards and Support.

gmhp

NHS Greater Manchester Integrated Care

GMCA GREATER MANCHESTER COMBINED AUTHORITY

Supply: building a flexible system to drive growth

We need the whole spectrum of tenure, delivery route, type and size of scheme to achieve 75,000 homes

Small sites | TANZ delivery | Town centres | Growth locations | PfE allocations

Investment

- Integrated Settlement
- Housing Investment Fund extended & flexibilities
- NHS capital reformed
- New model for Homes England AHP & investments
- Long term social rent settlement
- Right to Buy protection to enable LA investment

Land

- Appraisal models for public sector that fully recognise growth outcomes
- Land Commission driving at pace
- Acquisition and site assembly powers and levers fit for purpose
- Effective land value uplift capture mechanisms

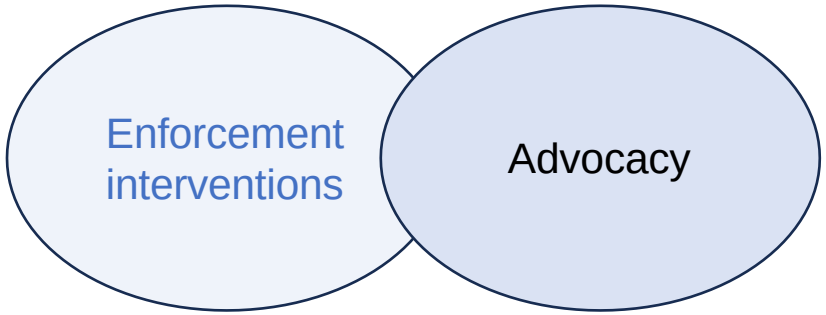
Capacity to deliver

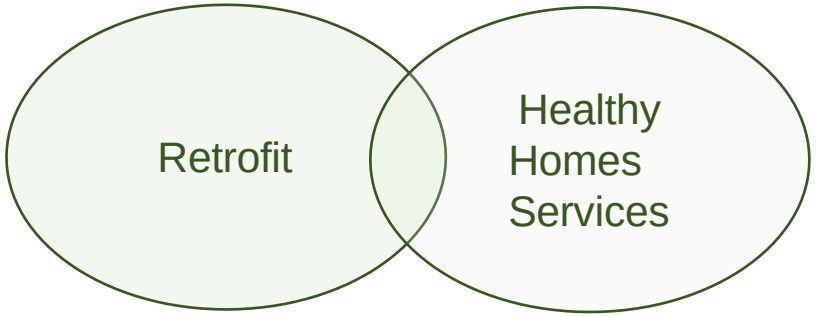
- Homes England commissioned to deliver what we need
- Investment in key functions at LA and GM level – e.g. DM, building control, building safety, viability assessment
- Skills across the development and construction sector, technical and professional
- GM/Mayoral vehicles or models where they add value

Standards: a comprehensive toolkit to improve existing homes

Supporting the development and delivery of interventions and investment to ensure existing homes are safe, secure, warm and dry, across all tenures

Work area





Activity

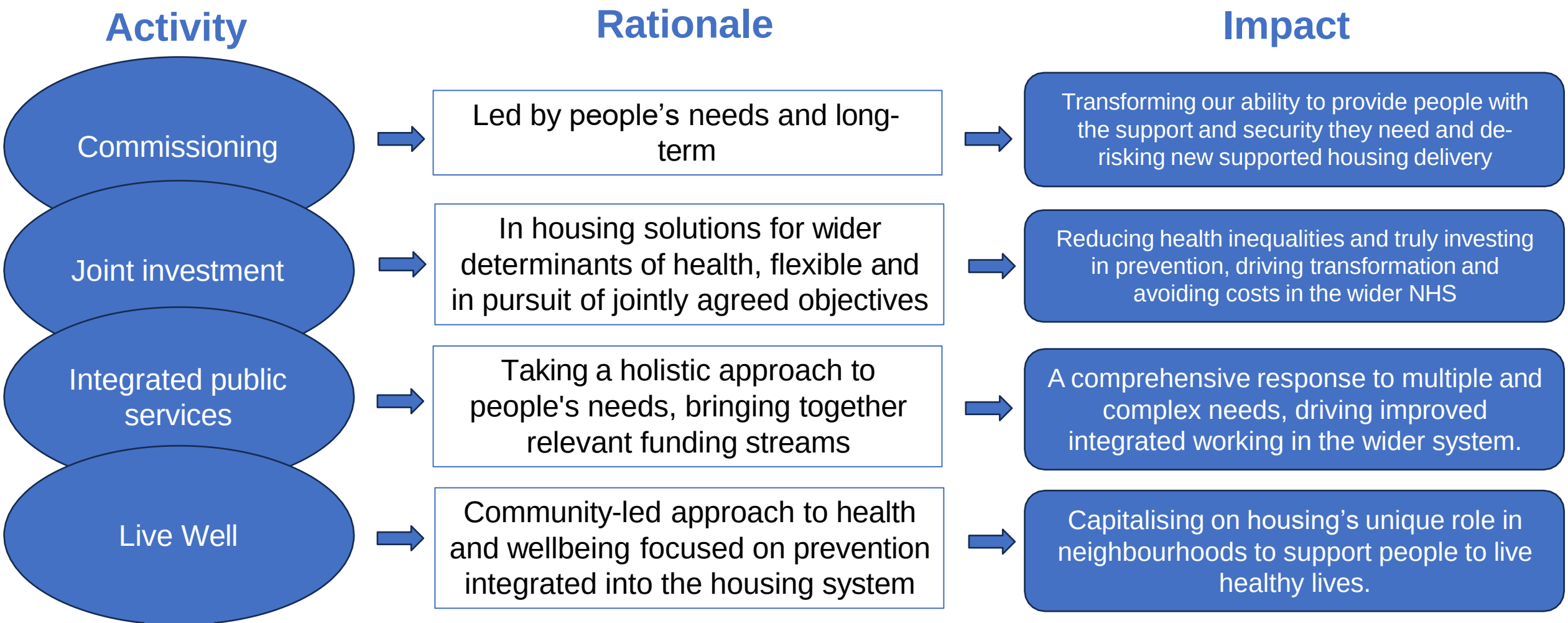
Enhancing LA capacity and capability GM Property Check Pilots e.g. illegal evictions	Improved Decent Homes Standard in PRS Renters' Rights Bill Good Landlord Charter	Devolution of Warm Homes Plan Social housing grant settlement Innovative funding and procurement, including for 'able to pay' households	Continued uplift and sustainability of Disabled Facilities Grant Flexibilities around deployment of DFG Innovative funding and procurement

Impact

Enhanced ease of use, pace and impact of enforcement options open to authorities working across the public sector to rapidly improve PRS standards.	Investment in targeted preventative health interventions aligned with efforts across the public sector to take a cross-tenure, long-term approach to retrofitting existing stock.

Support: a system that enables healthy independent living

Housing at the centre of transforming how residents are supported to live healthy, independent lives at home, delivering better outcomes and reducing costs within wider public services



Housing First, NHS GM & Falls Prevention

Workstreams within Housing First, invested and targeted in the right way, can play a large part in delivery of the Sustainability Plan 'Reducing Prevalence' pillar.

Analysis underpinning the Sustainability Plan demonstrated significant ROI through investment in interventions such as adaptations, falls prevention and improvements that keep homes safe, warm and dry.

Builds on national evidence - minor adaptations, repairs and trip hazard removal as interventions in the home that prevent falls and injuries. One in three people aged over 65, and half of those aged over 80, fall at least once a year, with unaddressed fall hazards in the home estimated to cost the NHS in England £435 million p.a.

Setting Housing First activity in the context of the Sustainability Plan highlights three initial areas of focus where collaboration would deliver against both plans.

1. **Supported Housing** – improving and upscaling supported housing offer to meet increasing needs, including for those currently in institutional settings.
2. **Improving housing standards** – alignment with projects to improve the quality of homes, such as the Good Landlord Charter and GM Property Check.
3. **GM Healthy Homes (Home Improvement Agencies)** – delivery of preventative housing interventions that support people to live independently in good quality homes for as long as possible, such as adaptations, handyperson and warm homes services.

gmhp

NHS Greater Manchester Integrated Care

GMCA GREATER MANCHESTER COMBINED AUTHORITY

Falls Prevention – opportunities for collaboration

What do housing related falls prevention opportunities look like?

- Home Improvements / physical home environment
- Environmental checklists
- Targeting those most at risk of falls
- Service delivery – community alarms, lifting services
- Local conversations and governance – joint strategic priorities

Potential risks and issues

- National and local investment / prioritisation
- Commissioning services
- Understanding existing practise and provision

NHS Greater Manchester

Stockport Falls Prevention

Tania Ravenscroft
Tania.ravenscroft@nhs.net

Part of Greater Manchester Integrated Care Partnership

NHS Stockport NHS Foundation Trust

VIADUCT CARE CIC

lifeleisure

STOCKPORT METROPOLITAN BOROUGH COUNCIL

Stockport ageUK

Stockport Falls Data

NHS Greater Manchester

Ageing population above GM and England averages

20.3% of Stockport residents are aged **65+**

38,673 of Stockport residents are aged **75+**

Estimates of falls prevalence

18,100 Falls among those aged 65+

7,150 Falls recorded by GPs

70 Deaths/Year on average

62% Of falls occurred **at home**, followed by **15%** in **residential institutions**

Hospital Admissions 2022.2023

1495 Emergency hospital admissions recorded for Stockport patients aged **65+** as a result of a fall

455 Of these were for patients **aged 65-79** and **1040** were for patients aged **80+**

Stockport Stay Steady

- In 2018 Stockport started looking at falls prevention strategies and created the ‘Stay Steady’ slogan.
- Mobilised 2 key services:

Steady in Stockport (SIS)

NHS commissioned falls prevention service

Stay Steady

Public health commissioned postural stability classes.

Falls workstream

Falls has been established as one of the workstreams under the Stockport Frailty Programme.
Stockport Falls Collaborative meetings every 8 weeks

Key stakeholders include:

- GM Aging Well lead
- Community Services including SIS
- Life leisure – Stay Steady Service
- Council colleagues for care homes
- Orthopaedic Consultant
- Trust falls lead
- Public Health
- Stockport Homes including Care Call (Pendant Alarm)
- Urgent Community Response
- Primary Care including Frailty health coaches and care coordinators
- AGE UK
- KOKU

Underpinned by EHCH Enhanced Health in Care Homes Principles

Primary Care / PCN ARRS roles

GP

Frailty & Dementia Care Coordinator/ Health coach

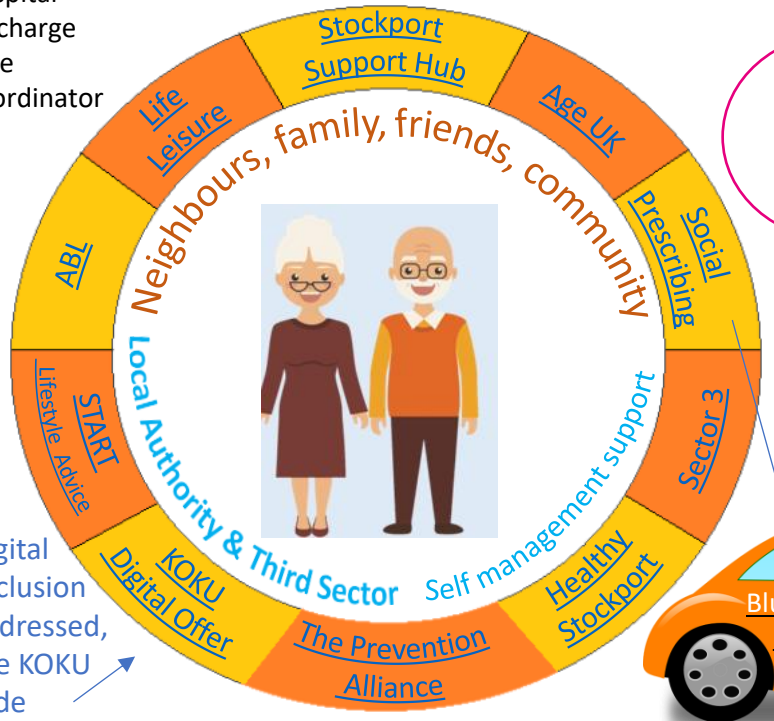
Long Term Care & Care Home Care Coordinator

Urgent Care/ Hospital Discharge Care Coordinator

Care Homes Health Coach

Stockport Frailty Offer – Key Stakeholders

Living Well at Home



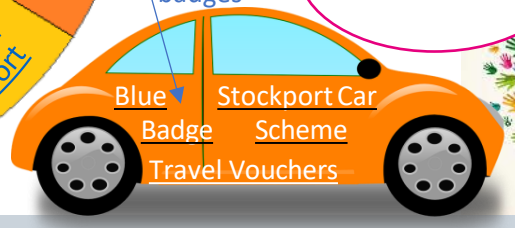
Digital exclusion addressed, see KOKU slide

Nursing/Residential Care Homes

Community HealthServices

- Steady in Stockport FPS Falls Prevention Service
- Stay Steady
- FLS Fracture Liaison Service
- ACTT Adult Community Therapy Team
- GM Falls Lifting Service
- GP Out of Hours
- SALT Speech And Language Therapy
- District Nursing
- Specialist Palliative Care
- Podiatry
- Wheelchair & Specialist Equipment
- Community Neuro Rehab
- Advanced Clinical Practitioners
- Orthotics
- MSK Physio-therapy
- Audiology
- Adult Continence Service
- Memory Clinic
- Nutrition and Dietetics

SPs can issue blue badges



Care Call Falls Monitoring and Response Services

AAU Admission Avoidance Unit

Short Stay Admission Unit

Acute Frailty Unit (AFU) consisting of Same Day Frailty Unit and Inpatient Acute Frailty Unit

SSOP Short Stay Unit for Older People

Admission Avoidance

111
999

Hospital Care

- Frailty Service
- Specialist Pathways
- Early Supported Discharge
- Discharge to Assess
- Palliative Care Team

Moderate Frailty: Rockwood 5-6

Mild Frailty: Rockwood 1-4

Severe Frailty: Rockwood 7-9

Stockport NHS Foundation Trust

Integrated Therapies

ACTT - SIS - FLS

NHS
Stockport
NHS Foundation Trust

Making a
DIFFERENCE
every day

Sophie Bussey -
Team Lead ACTT & SIS

Adult Community Therapy Team

Aim of the service:

- Help patients to achieve their optimum level of functional independence within their place of residence
- To advise on management of long-term conditions for patients and their carers
- To improve mobility and reduce the risk of falls
- Demonstrate self-management techniques
- Onward referrals to FLS, ASC, KOKU, EAAT, Age UK
- Reduce hospital admissions/length of stay

Adult Community Therapy Team

NHS Greater Manchester

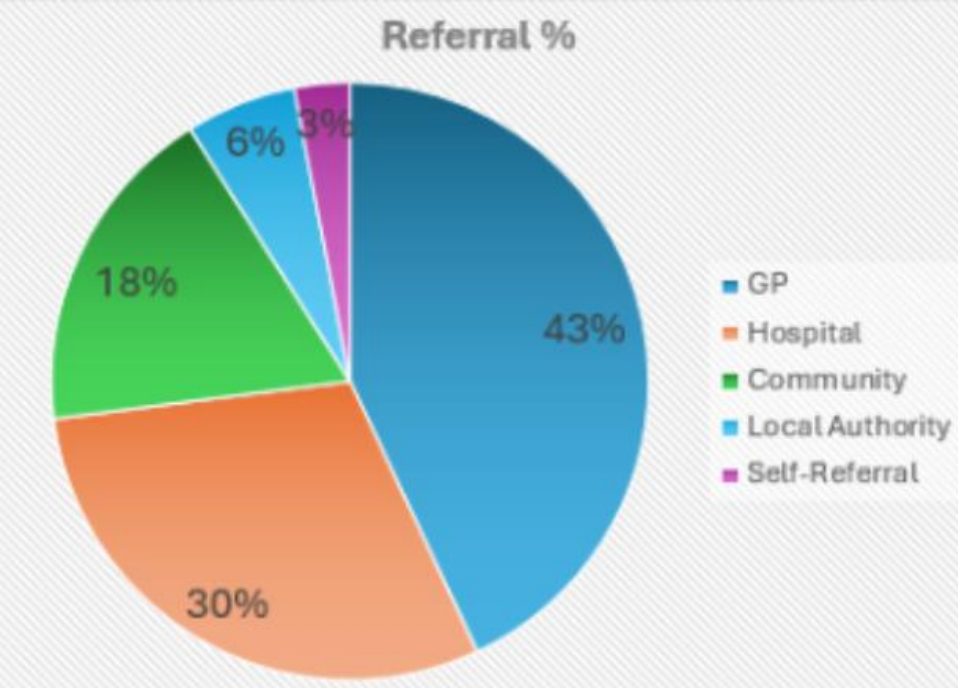
Access Criteria:

- Adults 18+ years old with a Stockport GP
- Recent change in functional ability or skill level
- SMART goal(s)
- Compliance and co-operation of the patient
- Housebound and needing rehab within the home environment
- Patients who require short-term rehabilitation only

NHS Stockport NHS Foundation Trust

Adult Community Therapy Team

- **Referral Data**: on average, 76 referrals received weekly



Steady in Stockport - Falls Prevention Service

NHS Greater Manchester

Aims of the service:

- Provide a multifactorial falls assessment and home environmental assessment
- Provide falls prevention advice, simple ADL equipment and mobility aids
- OTAGO HEP
- Onward referrals i.e. Life Leisure, KOKU, FLS, Age UK
- Falls prevention education sessions at various community group settings

NHS Stockport NHS Foundation Trust

Steady in Stockport - Falls Prevention Service

Access criteria:

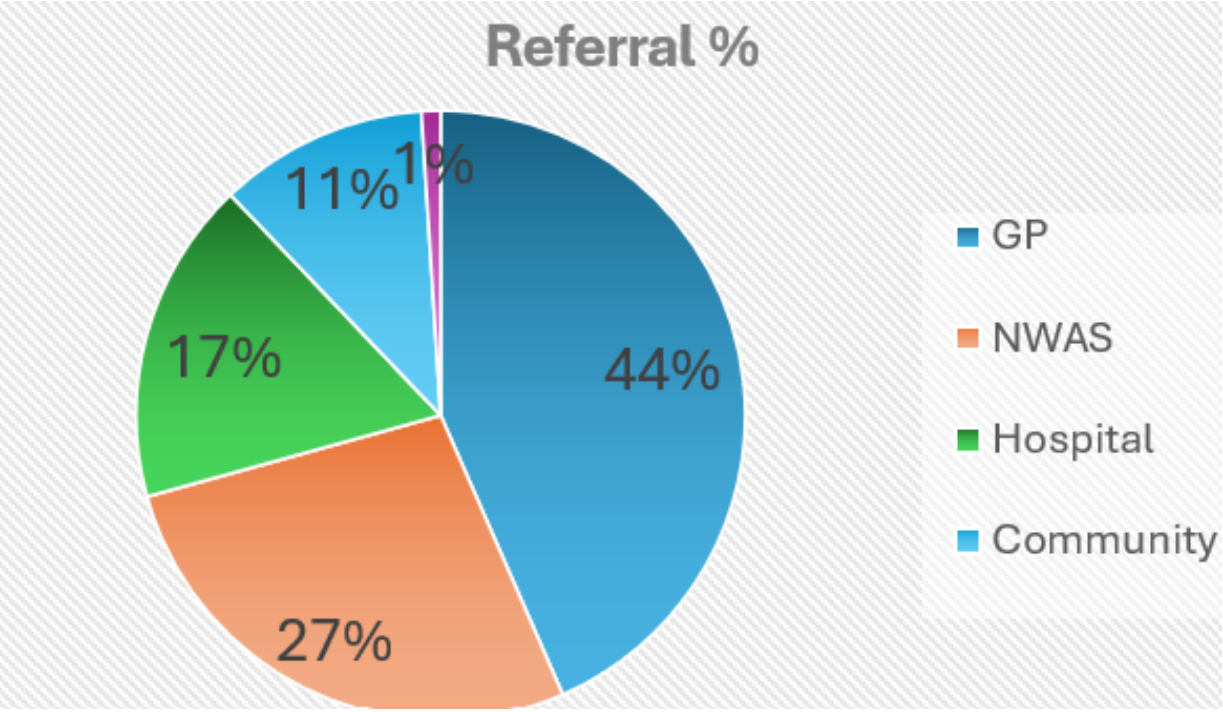
- Adults aged 65+ years old with a Stockport GP
- First time faller / near miss
- Reduced confidence / fear of falling
- Co-operative and compliant with advice/exercises
- Not currently receiving therapy input from another service
- Not under investigations for significant balance problems e.g. vertigo

Steady in Stockport - Falls Prevention Service

NHS Greater Manchester

Referral Data:

- On average, 32 referrals received weekly



NHS Stockport NHS Foundation Trust

Steady in Stockport – Fracture Liaison Service

Aim of the service:

- Screen and assess for osteoporosis
- Refer for a DEXA scan to assess bone mineral density
- Provide clinic and telephone consultations for bone health advice and treatment
- Bisphosphonate medication recommendation and first year monitoring of treatment
- Invite patients to peer support groups and educational sessions (in association with the ROS)

NHS Greater Manchester

Steady in Stockport – Fracture Liaison Service

Access Criteria:

- Adults 50+ years old with a Stockport GP
- Sustained a fragility fracture
- Needs support regarding management of Osteoporosis
- Requires a bone health review
- Must be mobile and able to attend clinic

Referral Routes:

- Bluespier
- Advantis CDS / PACS
- GP referrals via EMIS/email
- Direct referrals from hospital consultants

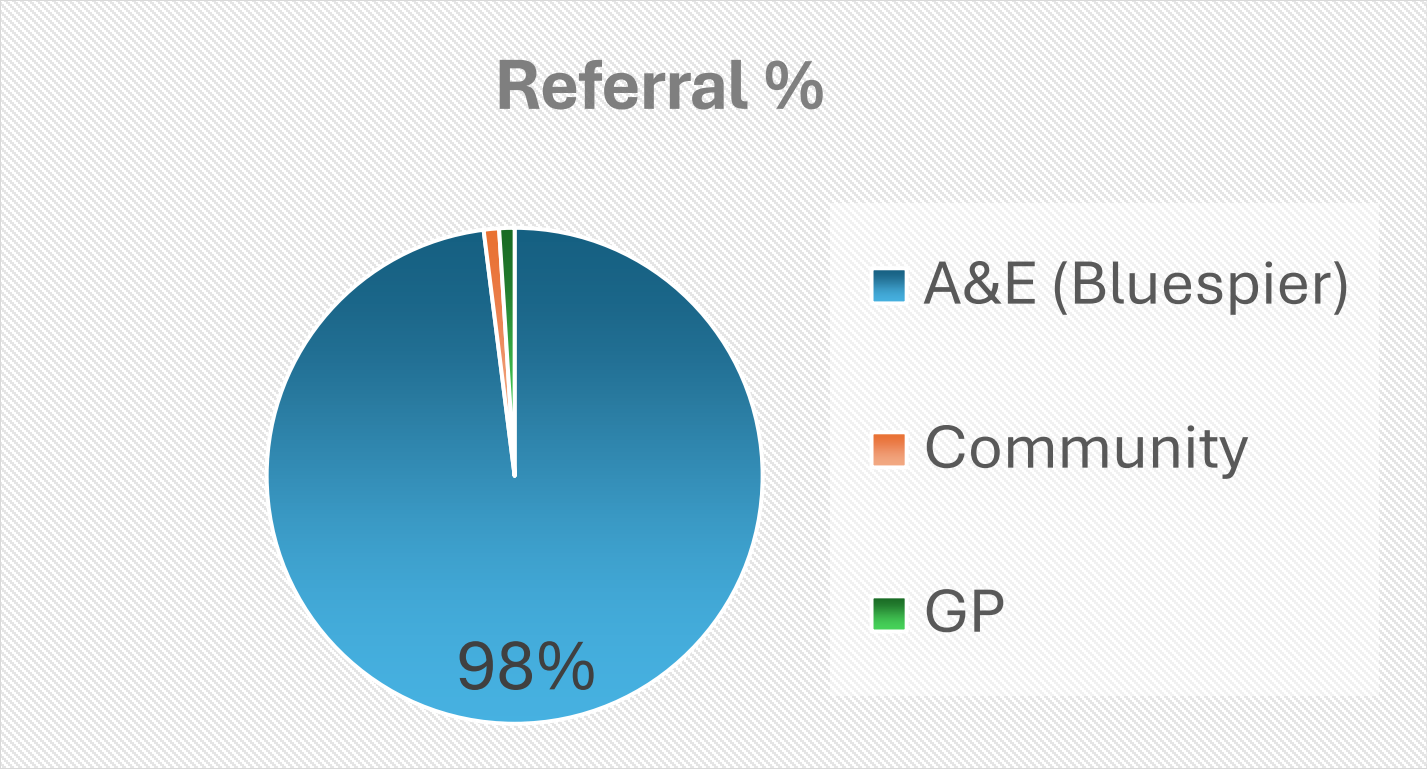
NHS Stockport NHS Foundation Trust

Steady in Stockport – Fracture Liaison Service

NHS Greater Manchester

Referral Data:

- On average, 15 referrals received weekly



NHS Stockport NHS Foundation Trust

Specialist & Targeted Falls Prevention Activities at Life Leisure

Specialist

Postural Stability – Stay Steady

- 250 referrals per year
- 15 PSI led sessions per week
- Rockwood 3-5
- Initial assessment including TUAG, 180-degree turn, FRAT and Confal Bal
- 6-month x 1 per week with home activity
- Commissioned through Public Health

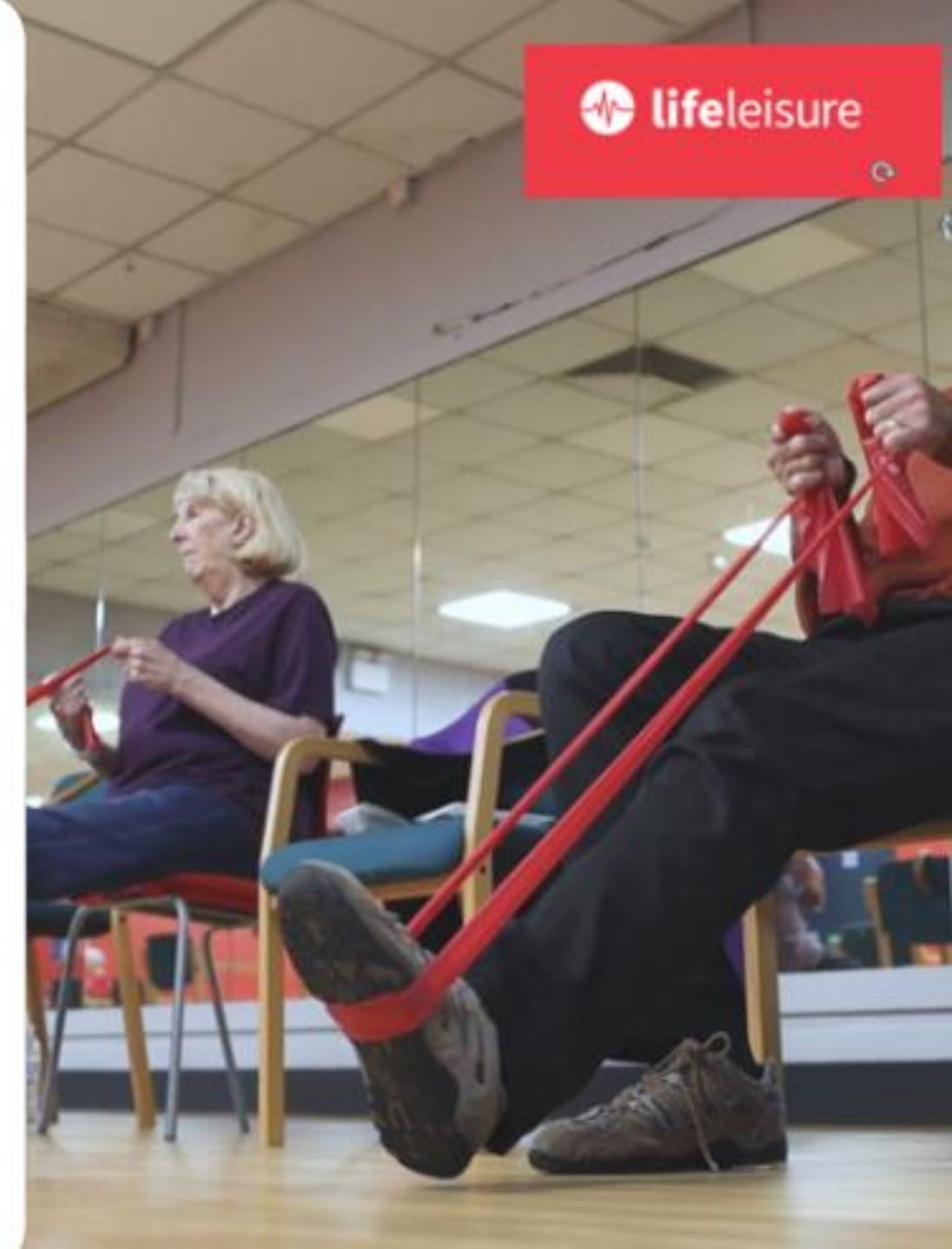
Targeted

Exercise Referral – PARiS (2600 referrals per year)

Confidence Walks – 5 across Stockport in collaboration with AgeUK. Incorporates some of the Super 6 exercises

SMILE – Chair based and standing classes aimed at Older Adults

IWIT – I wish I Tried. Activities for social activity. Includes Pickleball, Walking Football, Nordic Walking



NHS
Greater Manchester

Primary Care – Frailty Roles

Primary Care – Frailty Roles

- Using the Additional Roles Reimbursement Scheme (ARRS), PCNs employed Care Coordinators and Health Coaches either through Viaduct Care or through their PCN; many of these roles work specifically on Frailty and Falls.

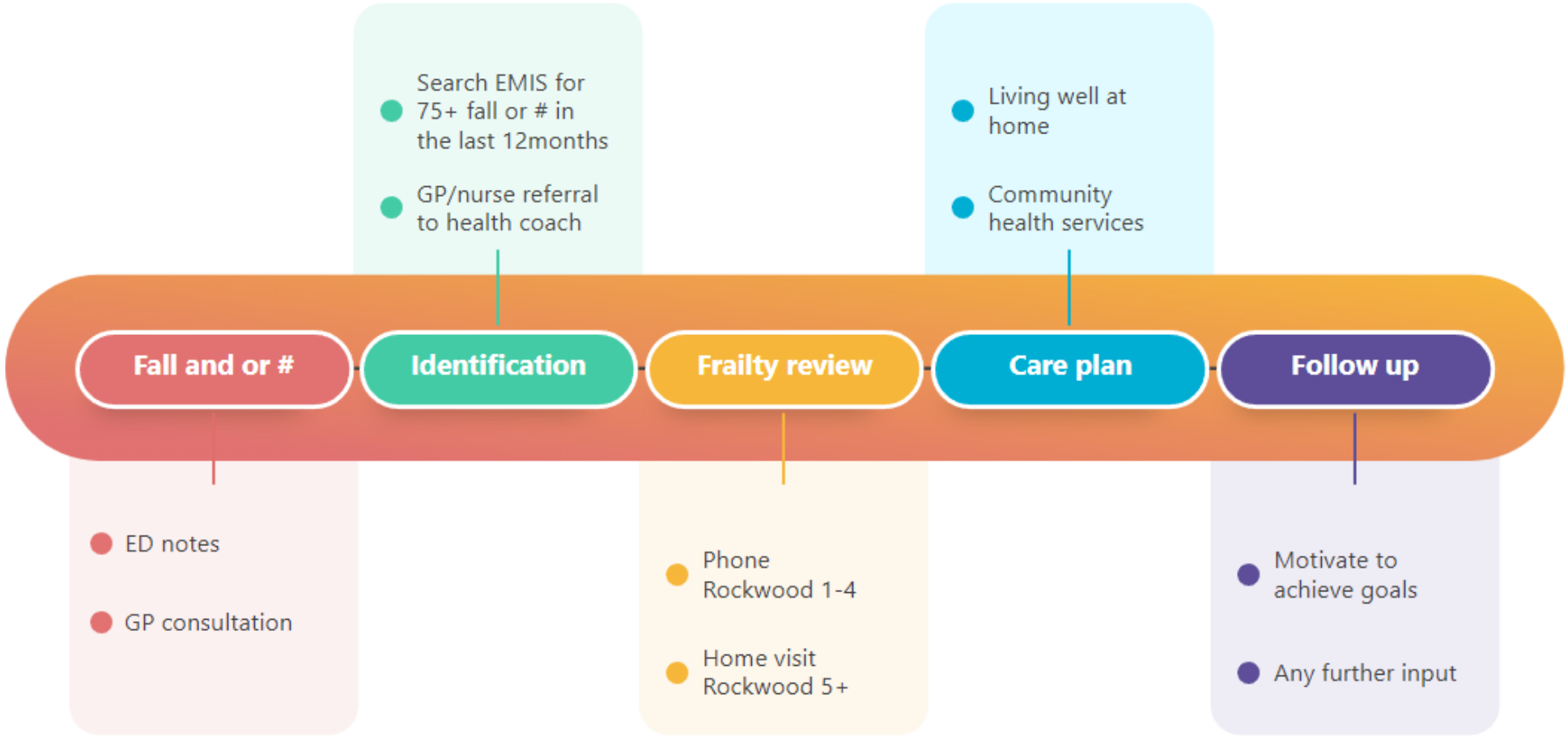
- **All work towards the Primary Care LCS Frailty Indicator:**

‘Frailty Assessment completed and referral to Falls Service for 50% of the cohort (Over 75s and/or on Frailty Register and/or on Dementia Register, with an ED Falls Attendance or Admission) in year 1 (23/24), and 90% of cohort in year 2 (24/25)’.

LCS Frailty Pathway

NHS Greater Manchester

Patient Journey



Frailty Reviews

NHS Greater Manchester

- Home environment
- Social interaction
- Finances

- Blood tests due
- Blood pressure
- Pulse/o2/temperature

- Falls (FRAT)
- Mobility
- Fear of falling (FES-I).

- Goals
- Care plan
- Advanced care plan

- ADL's
- Transfers
- Support/equipment.

- Cognition (6-CIT)
- Mood (PHQ-9)
- Behaviour

- Nutrition
- Smoking status
- Alcohol intake

- Bone health (FRAX)
- Foot health
- Vision/Hearing/Continence

Frailty ARRS Roles

NHS Greater Manchester

- Each PCN decided specifics of the roles that would benefit their patients and how they would like them to work and what their Frailty review will encompass.

- **Frailty & Dementia Care Coordinator/ Health coach –** Complete Dementia and Frailty reviews, and monitor patients where needed
- **Care Homes Health Coach** – Support ward rounds, advanced care planning, falls data analysis, falls risk assessments
- **Long Term Care & Care Home Care Coordinator**
- **Urgent Care/ Hospital Discharge Care Coordinator –** meet/contact patients recently discharged from hospital with new diagnosis/ post fall

VIADUCT CARE CIC

Frailty Health Coaches

NHS Greater Manchester

Challenges:

1. Once a patient has been seen they will not appear in the EMIS search for 12 months even if they have another fall or # within this period.
2. If falls are not reported to GP or the hospital, we are unable to capture these patients.
3. Each frailty health coach works differently there is no guidance to requirements.
4. Unable to access notes from adult social care & some community services.

What works well:

1. Enough time with patients to discuss concerns and create a plan to reach their goals.
2. Working alongside community matrons for more complex patients.
3. Identification of patients at risk of falls from other health professionals.
4. Networking – having a point of contact for each service.

Keep on Keep up

KOKU Champions
Age UK / Life Leisure / SIS / Viaduct Social Prescribing Team / Stockport Homes / DigiKnow

Stockport - **monthly KOKU meetings** to track the work ongoing across the Stockport system.

DigiKnow – Digital lending library – holds 10 tablets for KOKU – further 10 to be purchased.

Staff in Stockport funded by University to support the KOKU RCT

KOKU

- a Digital Strength & Balance Program with healthy literacy games

NHS Greater Manchester

Developed with older people *for* older people

1. Reduces falls
by 1/3 through proven strength & balance exercises, home hazard, hydration and bone health awareness

2. Increases engagement
through personalised & progressive exercise plan & gamification (feedback, progression, rewards); high usability & acceptability results from clinical trials

3. Advantages
Self-manageable, scalable, accessible, affordable and user friendly

The Stockport KOKU referral pathway is in place at the Social Prescribing Team – link with DigiKnow to ensure digital inclusion offering tablets and data where required.

GM falls lifting service.

NHS Greater Manchester

GM Falls Lifting Service; Additional Support to Care Homes

Winter Initiative: Now – 31st March 2025

The GMUPCA is running a **Falls Lifting Response Service** for people aged 18 and over who have fallen but are **not significantly injured** at the time of the call.

The service operates from **8 AM to 6 PM, 7 days a week** (including bank holidays). Please note that the **last referral will be at 5 PM**.

This service is **free to use** and will **accept direct referrals**.

Aims of the Service:

- **Improve response times**: The goal is to respond to lifting requests within **1 hour**.
- **Improve outcomes for people**: Reducing long lies after a fall, which can have negative health consequences for your residents
- **Reduce unnecessary ambulance callouts** for non-emergency falls.
- **Increase referrals** to appropriate services like Urgent Care Response Teams and other community teams.
- **Keep people at home**

If you have any residents that require this service, please contact the below for immediate support:

0161 476 9652

Greater Manchester Urgent Primary Care Alliance

Greater Manchester Urgent Primary Care Alliance

Falls Response Service Pathway

Phase 2: referrals are received from Care homes directly (Stockport is live)

Phase 1: NWAS refer person suitable for Falls Response service

Phase 3: Referrals are received from community Health care professionals verbally on scene with someone who has fallen and unable to get up

Case is passed to Falls response service via SMS or verbally and added to Adastra

Falls response team attend, assess person and undertake a set of observations and calculate News 2 score

Requires a clinical assessment, forwarded to CAS on adastra

Case closed, no concerns, News 2 0 offered referral to falls prevention team (via email)

Remote consultation undertaken by CAS clinician, no clinical concerns, safe to stay at home. Offered referral to falls prevention team. Case closed

Remote consultation undertaken by CAS clinician, requires onward referral for f2f assessment (referral made to UCR, own GP, DNs, OOHs, UTC, ED) arrange ambulance via CAS Coordinator/ NWAS Taxi conveyance

Urgent ambulance response required for Life threatening emergency, obvious fracture, severe pain and/or unable to weight bear, head injury*

*if no evidence of Advanced care plan in place and on anticoagulants

Future Falls projects

NHS Greater Manchester

- Care homes – Currently have a care home working group to review Frailty/ falls offer. Continued system work is needed
- Review of LCS frailty domain - identification of frailty and support prior to fall
- Falls lifting service implementation
- Standardise frailty care coordinator/health coach offer across the Stockport system
- Develop KOKU offer and embed pathways
- Improved falls prevention comms across the full system for earlier intervention – link with GM.
- Integrated services to reduce duplication / increase patient experience – create sustainable pathways

Key Challenges across the system

NHS Greater Manchester

- Duplication across the system due to the lack of visibility/ information sharing across services – GMCR. E.G Rockwood scoring in Community services cannot be seen by primary care.
- Care homes/ providers following own/ internal protocols e.g responding to unwitnessed falls.
- We don’t have an equitable offer for all low - level falls responses offer now we have the GM service as this is free and better than pendant alarm company.
- Lack of clear public health messages across the system on early intervention aimed at 50 +. Still focus on reactive and secondary prevention.