REPORT TO THE HEALTH AND WELLBEING BOARD

30th January 2018

Falls Prevention, Early Help and Frailty

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1. Purpose of Report

1.1 To inform the H&WB board of the developments of the work taking place across the borough around Falls, Early Help and Frailty

1.2 To acknowledge and promote the effective communication and workstreams across organisational boundaries in order to best serve Barnsley people

2. Recommendations

2.1Health and Wellbeing Board members are asked to:-

- Note the multi-agency work taking place around Falls and Frailty
- Continue to endorse and support the Falls work
- Provide leadership within their organisations to pursue further work

3. Introduction/ Background

In Barnsley, 18% of the total population are aged over 65 years[1]. Care of older people forms a large part of the health and care budget. During 16/17, over half (53%) of non-elective admissions, and 57% of A&E attendances were amongst the over 65 age group.

Falls are the largest cause of emergency hospital admissions for older people and significantly impact on long term outcomes.[2] One in three people over the age of 65 will fall each year, which is 25,500 people in Barnsley. This figure rises to one in two people aged 80 years old and above. In Barnsley the rate of emergency admissions for falls injuries in people aged over 65 years old has increased over time.[3]

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[1] ONS, October 2016.

[2] [10]Department of Health (2012), Improving outcomes and supporting transparency. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

[3] Barnsley JSNA 2016

The work described below aligns with the H&WB Strategy 03.09: “Develop comprehensive pathways to help to prevent, identify and minimise the impact of frailty and falls”, and the Barnsley Based Plan Priority Area 4: “Improving support for older people (Barnsley)”.

3.1 Falls

There is work taking place across the borough from within and across various organisations in order to prevent and reduce falls and the impact this has on lives.
In addition, there is a borough-wide review of assisted living services which will contribute to the falls prevention agenda.

The following projects have either started or due to begin in the next few months:

3.1.1 Back on Your Feet in Barnsley

A new concept has been developed and branded “Back on your Feet in Barnsley”.
The Universal Offer will:

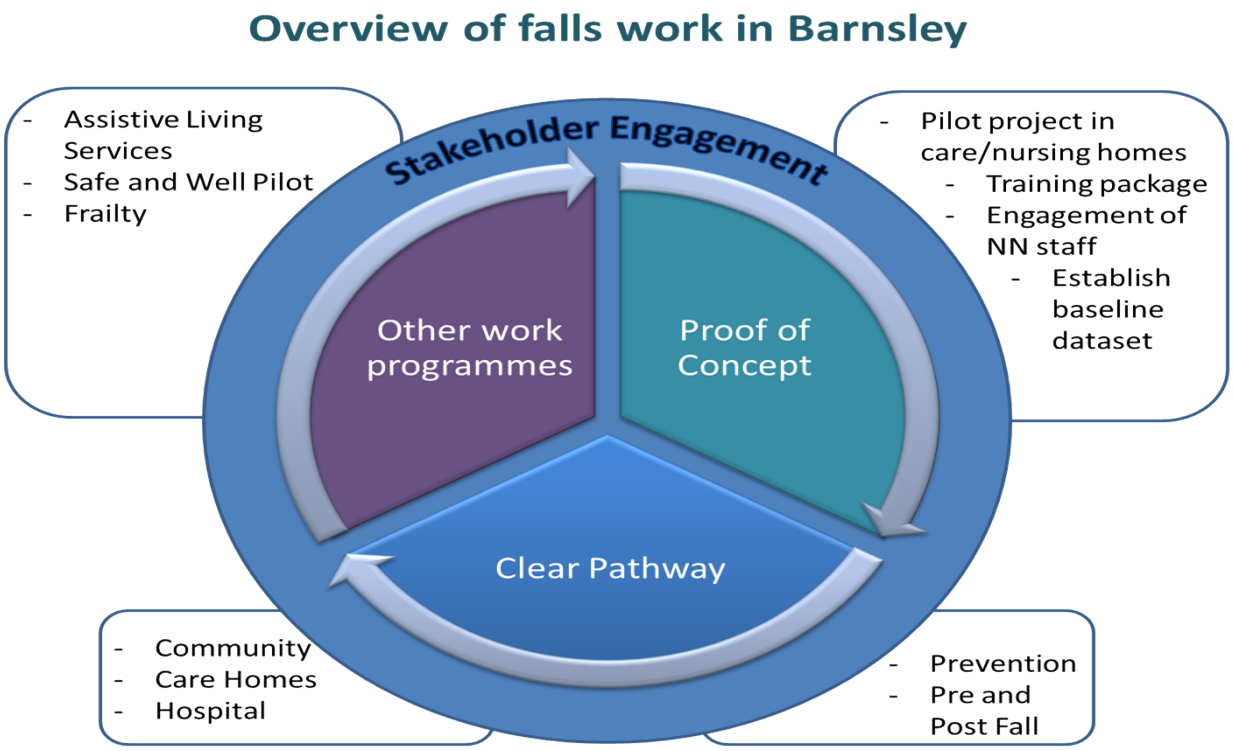
- Identify opportunities for prevention
- Increase the number of risk assessments
- Provide a 1st line treatment
- Establish a clear pathway

This is also an opportunity to better understand root causes of over reliance on transporting to hospital, rectify them and enhance preventative measures within care homes.

A pilot project working with selected care homes and neighbourhood nursing teams is due to begin imminently. A training pack has been developed to improve the confidence of front-line staff to provide a first line of treatment following a fall. A “test the pilot” event took place on October 5th with representatives from designated care homes and the neighbourhood nursing service attending, to help test and reshape the training pack. Feedback from the staff was positive and constructive, and the first training sessions are scheduled to be delivered to Buckingham Care Home in January 2018. An evaluation of the changes in practice and the impact on post-falls interventions in the care home will be monitored over 3 months, with a view to rolling out to other care homes in the future.

3.1.2 Safe and Well Checks Pilot

Using Barnsley data and local referrals to target high-risk individuals in the community, Fire Safety officers will deliver training on interventions to engage the public and raise awareness, reduce hazards, modify behaviour and reduce harm through early warning. The Safe and Well Checks, supported by a multi-agency steering group including health, local authority, police, fire and third sector, will be launched in 2018: in January 2018 Fire Officers will be trained, and in February 2018 the pilot will be launched from Cudworth fire station.



3.2 Frailty

The Falls work discussed above contributes to the wider agenda of the Frailty programme. Frailty has been identified as one of the Accountable Care Shadow Delivery Board programmes for 2018, and is being supported locally by a multi-stakeholder group.

Barnsley CCG and Barnsley Hospital have joined the Acute Frailty Network (AFN), a 12 month improvement programme designed to support participating sites to rapidly adopt best practice to improve emergency services for frail older people. The programme, hosted by NHS Elect, is delivered by an experienced team of clinicians, operational managers and improvement leaders and is made up of national collaborative events workshops, site visits, webinars and on-site individual support for participating teams. The AFN aims to support local teams to adopt and spread best practice using the 'Silver Book' and the 'AFN toolkit' as examples of best practice with a focus on the urgent care of frail older people in the first 72 hours of hospital attendance. This commenced in October 2017and will be monitored for changes/improvements.

Diagram 2 (below) illustrates the work that the DRAFT Frailty programme is undertaking.

Frailty Workstream

Objectives

- Provide better, quicker, more consistent care across the whole system
- Provide better, more joined up support for frail patients in their own homes and local community
- Better support for carer's (formal and informal)
- Better targeting of interventions to reduce health inequalities

Inputs

Communications expertise, social media, materials and printing.

Practice Development Agreement

Informatics and information governance expertise.

Development of online resources.

Staffing resource to support virtual multi-disciplinary team working across primary, community and secondary care.

Funding for new workforce roles.

GP online consultation systems funding.

Integration falls service review (expected to be cash releasing or cost neutral)

Acute Frailty Network (funded)
Assisted Living Service Review (funded)

SWYPFT Funded post for care homes training

BHNFT, SWYPFT internal training and CCG BEST events (funded)

Activities

1. Public awareness campaign
- Frailty friendly
- Social isolation
- Community support
- Prevention

2. Identification and screening
- Electronic Frailty Index
- Edmonton Frail Scale for diagnosis
- GP practice frailty registers

3. Joint care planning for moderate and severe frailty
- Advanced care planning
- Access to specialist advice
- Person held records/hospital passport or red bag
- Information sharing

4. Enhanced Case management for moderate and severe frailty
- Multi-disciplinary team review of most at risk
- Lead professional (GP/Matron/Geriatrician) and care navigation/coordination for severe frailty
- Supported self-management and care coordination
- General support services

5. Service/pathway redesign
- Falls service
- Assisted Living service review
- Virtual (online/video consultations)
- Acute Frailty Pathway
- Support for carer's

6. Training and education
- Primary and acute care
- Care homes
- Domiciliary care providers

Short-term outcomes

Improved and quicker access to information, advice and guidance (patients and staff).

Better care planning; increased patient knowledge of conditions; increased ability to self-manage.

Care is person-centred and better coordinated, improved sharing information and preventing duplication.

More proactive, targeted diagnosis and management of frailty.

Improved access to care (for example by using virtual consultations)

Increased knowledge and confidence within the health and care workforce.

People supported to live independently at home using technology and assisted living services.

Medium-term outcomes

Frailty friendly communities.

Reduced unwarranted variation in care.

Increased capacity and capability in primary and community care; more care provided outside of hospital.

Improved dignity in dying; patients more likely to die in place of choice.

Patients and their care's are more activated, in control of their care and self-managing

New roles which mean the workforce is better matched to need.

Improved access to support services from the community and voluntary sector.

Create a shared culture and understanding of risk across the system

Impacts

Improved outcomes for patients with moderate and severe frailty and reduction in health inequalities (associate savings).

Reduced and more appropriate use of secondary care and improved hospital discharge (associated savings).

Improved patient experience of care, reduced social isolation, better quality of life including at the end of life (associated savings).

Increase empowerment and engagement of health and care professionals (associated savings).

4. Next Steps

The further development of Back on Your Feet in Barnsley, the safe and well checks in Barnsley, and the membership of the frailty network alongside the other work taking place in the borough will contribute to addressing the high hospital admission rate due to falls. Perhaps more importantly, the intention is that it will allow Barnsley people a greater sense of control over their lives by preventing a fall which can result in so many negative impacts on a person's life.

Once the pilot project in care homes is completed and evaluated, consideration of it's effective usage will be made.

5. Financial Implications

Back on Your Feet in Barnsley: £0 Refocusing of existing resources
Safe and Well Checks: £0 Commitment to support partnership working between BMBC and the Fire Service
Frailty network membership: £10k (CCG), £10k(BHNFT)

6. Consultation with stakeholders

Key stakeholders such as clinicians, care home staff, and strategic partners have contributed to the work taking place above. Two consultation workshops have been facilitated for key stakeholders for Back on Your Feet in Barnsley.

7. Appendices:

Appendix A : Training programme for Care Homes: Back on Your Feet in Barnsley

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Appendix A – Training Programme

‘Back on your feet in Barnsley’

Care Home pilot training – first line intervention

Post fall workshop

Weds 10th January 2018, 10-1pm

Buckingham Care Home, Penistone

10:00 **Welcome & Introductions**
Self assessment
Ground rules & Icebreakers

10.15 **Setting the scene**

10:20 **What do you know? - true/false continuum**

11:00 **Challenges and Barriers facing care home staff**

BREAK

11:30 **Case studies & Practice**
How confident are you in managing the situation?

12:00 **DISCUSSION: Sharing and learning from your experiences of managing falls**

12:30 **Have we addressed the challenges/barriers?**

12:45 **Taking the pilot forward**

13:00 **FINISH**