Notes from Oral Evidence Sessions on 24 and 27 January 2011

Monday 24 January

Session 1: NHS Hampshire – Sarah Elliott [Dir of Commissioning for 'out of hospital services]

Presentation / dialogue with Panel

- Recognised there was a commissioning 'gap', including for example:
    - Additional bone strengthening and balance classes
    - Fracture liaison services
    - Identification of all patients over 50 with low impact fractures
    - Fracture risk and bone health assessment
    - DXA scanning
    - Treatment
    - Education

- Identified 'falls' as a commissioning priority for 2011/12
- Recognised a need to strengthen joint working
- Recognised the need for integrated service delivery such as by involving primary care, pharmacists, optometrists, ambulance service, community health services, social care and secondary care.
- Recognised the need to expand services for falls prevention and fracture liaison services
- It was not clear from the presentation or during dialogue with the Panel what services have been commissioned by the PCT, however discussion confirmed the Panel's understanding that falls work had traditionally been considered part of the more general healthcare provided in the community by the NHS. It was acknowledged that more detailed data and information was now necessary.
- Members of the Panel expressed concern that GPs appeared not to be fully engaged in the identification, assessment and management of their patients who could be, or are known to be at risk of falling. It was responded that efforts to engage GPs may need to be renewed, although some already are. In addition it is understood that GPs in their new commissioning roles will have access to a broader base of information about the risk of falls to their patients and that they could work more closely with other agencies. This would enable them to more effectively identify, prevent and manage falls for their registered patients and in the population more generally.
- Suggestions from the Panel included the possibility of having more people trained in the community, possibly like first aiders who could be taught techniques to check for injury and get people back on their feet if well enough. They could also potentially refer fallers to community falls clinics for assessment.

Top wins identified:

- Clarity of PCT leadership in Hampshire
- Public Health involvement to provide a strong evidence base, to foster multi-agency working and to provide capacity for commissioners to 'tap into'.

Session 2: HCC Adult Services (commissioner) – Gill Duncan and Ruth Dixon [respectively Director and Assistant Director of Adult Services]

Presentation / dialogue with Panel

The Director of Adult Services talked the Panel through some of the key issues that falls present for Adult Services. Given the pressures on social services budgets and the potential in the community for increasing demand due to falls or their consequences, the Director indicated that it was very important to make maximum use of available data to identify older people who may be at potential risk of falling because of multiple co-morbidity. It was important to distinguish between those at higher risk from those at relatively low risk if services are to be well targeted, appropriate and affordable.

As with the NHS, social care has traditionally encompassed its provision for falls related services within its wider remit to respond to older people who experience loss of independence. However the department identifies three important themes or approaches with regard to falls:

- Identification of risk groups through closer working with the NHS to join up strategies for those most at risk of falls so as to include pro-active assessment and interventions in care pathways.
- Include falls related risk assessments (presuming the NHS has not already assessed) as part of community response teams' assessment and care planning, such as the Community Response Service's work in providing short term assessment and re-ablement to help people regain their independence.
- To offer evidence-based support such as balance and exercise programmes or Telecare monitoring technology as pro-active interventions to help reduce risk of falls and injury due to falls.

The presentation highlighted four joint commissioning priorities, including enhanced integration across Health and Social Care.

The Panel sought to discover from the Directors the roles played by Adult Services in 'commissioning' care around falls and falls prevention. It was explained that the department invests primarily at two points in the NHS Falls and Bone Health Pathway. Adult services has invested in the provision of proactive services such as a balance and strengthening

programme in conjunction with NHS colleagues to help show older people that they have potential to improve their own independence and reduce their risk of falling – thus providing input at the very beginning of the pathway. The department also experiences increasing demand from falls as a result of those who have fallen, and have consequently lost confidence or experienced injury that reduces their capacity to remain independent either temporarily or permanently.

Proactive work at the beginning of the falls pathway has known costs for the department, however, at the other end of the falls pathway demand on adult services due to loss of independence are not simple to cost because the service is not triggered by the fall, but by the inability of an older person to function independently without support – regardless of the cause. Adult Services could make use of local Health data concerning demand related to falls, however the NHS has its own challenges in providing reliable data around falls and the consequent demand for services.

Top wins identified:

- Training in falls prevention and management could be provided for carers
- Development of re-ablement, particularly at home, supported by simple basic services such as nutrition services, foot and toenail care, and ensuring support to manage visual impairment
- Better information

Session 3: SUHT – Gail Byrne [Dep Dir of Nursing and Head of Patient Safety] and Dr Mark Baxter [Consultant Geriatrician]

Presentation / dialogue with Panel

- Estimate that between 3,700 and 4,000 patients attended the ED due to a fall and that of those 2,280 were admitted.
- Estimate that about half of those attending due to a fall are from Hampshire, and the other half from Southampton.
- Patients diagnosed with Falls receive a comprehensive falls risk assessment in either falls clinic or syncope clinic
- Inpatient Falls pathway specifies that those at highest risk will be checked every 2 hours so that, for example, if they need the toilet (a high falls risk time), someone can assist them. Falls in the hospital are reducing.
- As with Basingstoke, low profile beds are being used for patients diagnosed with conditions that predispose them to risk of falling
- Geriatricians would like a coordinated care pathway for those discharged from the hospital into the community
- Use a root cause analysis with inpatients known to have fallen - to determine whether the falls are avoidable or not

- Geriatricians believe that a significant proportion of their older patients known to fall come from 'border' areas such as Lymington where the proportion of older people in the community is high
- When discharged home they need a follow-up visit at home in a week's time (but who does this?) Most do not need a follow up in weeks time, as part of the frail elderly pilot we are piloting this aiming to reduce re-admissions in the frailest group
- It is believed that falls care and prevention services in the community are patchy
- SUHT is engaged in a project around the integration of hospital and community care services for falls with a view to reducing length of stay in hospital and preventing readmissions – thought to be slightly further on in So'ton than in rest of Hampshire
- Consistency of training and communication across different providers is important – needs to be coordinated and agreed across all types of providers – need to come together to develop agreed principles, modules and communications framework

Important challenges

- Competition in the health community – jostling between providers for 'falls business' and knowing who to talk to or liaise with
- Financial pressures
- To ensure all falls interventions and services are evidence based, thus provide reliable information about demand, efficacy etc.

Top wins identified

- Introduce fracture liaison services ("no brainer")
- Integrate FLSs into a broader bone health/falls service
- Better coordination and integration
- Development of a 'flag' on patients records to indicate attendance due to falling

Session 4: BNH FT – Suzie Bleeker and Dr Sam Arianayagam [Divisional Manager ED, Consultant in Elderly Care Medicine]

Presentation / dialogue with Panel

- A falls service is based in the hospital for inpatients and outpatients
- All older patients are automatically assessed for falls risk
- Introduction of Telecare mats has reduced the number of falls and injuries from falls in conjunction with low profile beds?

- Always look for all risk factors for falls in patients who present with falls. On discharge they are offered a follow up appointment in the falls clinic (run by the hospital)
- Hip fracture patients are reviewed six weeks after discharge in the Orthogeriatric Multidisciplinary Assessment clinic where surgical, medical and functional recovery is assessed according to national quality standards. This is in the interests of the patient and the hospital. This would be necessary for our standards to be monitored for hip fracture patients even if the community has other services.
- Leaflets published by voluntary organisations such as Age UK could be used to inform the public on how to reduce the risk of falls in the older person, and could be left in GP surgeries, supermarkets etc.
- It was suggested that hospital is not a good place to be for older people who have fallen, particularly if patients begin to believe they are vulnerable, dependent and that home is the environment to be feared.
- Concern was expressed by a member of the Panel that BNHFT reported unusually low SUIs (serious untoward incidents) related to falls, and questioned whether reporting at the Trust was robust. The response indicated that their management of falls and falls patients was steadily and consistently improving but were unable to comment on why the SUIs differed from other acute hospitals.
- Recording of falls data in relation to falls care pathways and transparency – was noted as an issue following the above concern. The clinician indicated that one of the down sides to the tendency for increasing specialisation and subspecialisation in hospitals was that patients may experience a string of referrals from one consultant to another and that every handover introduced extra risk that gaps in patient information can result, sometimes requiring patients to be seen again for the same thing because records of consultations get lost or are not passed on.
- In the Emergency Department, coding is based on the clinical diagnosis and not the symptom. Medical students are taught that falls are a symptom, but with time it has become a diagnostic code. In the ED they are more likely to code the injury caused by the fall such as a wrist fracture instead of the fall itself. Both need to be entered.
- A fracture liaison service can be employed by the community; the PCT had been approached for commissioning, but the request “fell on deaf ears”. Members acknowledged they had heard such comments before
- Basingstoke hospital employs a geriatrician for falls and syncope and one for falls/fracture/orthogeriatrics, providing a high quality falls service.
- It was felt that a GP-led fracture liaison service oriented around community/primary health care could be best for patients.
- It was noted by the Chairman that it appeared that there was considerable scope for better partnership working between the acute and community providers in order to provide integrated falls and falls prevention services, albeit falls prevention work in the north of the county has lacked resource.
- It was also observed that Public Health had not been as active as it could have been in addressing some of the simple messages

containing falls prevention advice, such as drinking more to avoid UTIs, although some older people may fear loss of bladder control or feeling dizzy when they get up to go to the toilet.
- It was observed that older people like their privacy and it can therefore be difficult to convey public health messages to them.
- Criteria for discharge were identified as an important issue and that is was important for patients themselves to know and understand the criteria from their own perspective.

Top wins identified

- Community rehab services can be clinically and financially cost effective as an intermediate link between the acute hospitals and getting people back into their communities
- Introduction of Telecare/Telemats to residential and nursing homes and to those living at home and at risk of falls, where appropriate, could reduce the rate of falls.
- Simple, practical information which professionals agree on and that is written from an older person's perspective – but not in negative or patronising language.

Session 5: WEHT – Drs Chris Gordon [CX and Consultant Physician Elderly Car] and Gail Loudon [Physician with special interest in elderly care and Falls Lead]

Presentation / dialogue with Panel

- WEHT falls service developed in 2003 following pilot by Chris Gordon.
- Multi-disciplinary falls review and intervention led to reductions in the incidence of falls frequency by about 30% compared to either no intervention *"or (falls) management based in primary care".*
- Consider a one stop multi-disciplinary clinic probably the most effective approach
- Service has continued to develop providing patient centred multi-disciplinary Falls and Bone Health assessment and intervention.
- Link in with HCHCw Falls and Bone Health Strategy Group
- Link in with various local community exercise groups
- Network and aim to influence care home practice indirectly and interact with the voluntary sector – not clear what outcomes are sought here or how the Trust contributes to them.
- Take referrals from a typical range of professionals involved with the health or social care of older people
- Further information was provided about how the falls clinic works and links with the Trust's re-ablement service and community based exercise programmes
- Data was provided that indicated how many patients attended A&E due to a fall (about 1440), how many falls patients were admitted to A&E in 09/10 (517) and how many patients were admitted with a fractured hip (287) ***(note: ED admissions were estimated at about 450 for***

2009/10 and the figures provided said there were 287 admissions for hip fractures = 65% of attendances due to falls. Because there is no ED code for falls – the implication is that the ED attendance figures are 'guestimates'. The 287 admissions for fractured hips however seems unexpectedly high (20%) in relation to the number of falls attendances).

- An outline for a Fracture Liaison Service is proposed that shows how it might link in with other elements of a falls and bone health care pathway, however the Trust does offer a Bone Health service that partly covers the same things.
- There is insufficient data on falls demand and hence costs since falls, as such, are not recorded for attendances at A&E, nor admissions, since only standard diagnostic categories have codes. "Coding is a massive issue"!
- HCHC- west still use the agreed pathway – 'open access' services grew organically.
- Funding and structure of community-based services too thin on the ground
- There is real value re home visits by OTs to indentify environmental trip hazards and where support equipment is indicated.
- Members asked whether, as a GP with special interests, good engagement had been achieved with GPs regarding their role in primary care falls assessment and identification of at risk patients. The response indicated that response from GPs was variable; some having more interest in elderly medicine and falls than others.
- It was agreed that data around falls tended to be approximate, in part due to standard ED coding systems tending to record diagnoses only and not the fall even though it might be the cause or result of a presenting medical condition or injury. No solution to this was suggested.

Top wins identified

- Tighter grip on post bone fracture clinics
- Improve discharge follow up care/rehab
- Capture and use data / system to better target the right people

Session 6: PHT – Dr Sue Poulton [Consultant Geriatrician], Anne Welling [Nurse Consultant A&E] and Julie Windsor [Falls Coordinator and Nurse Specialist]

Presentation / dialogue with Panel

- Falls education and training of all staff who typically encounter older people in clinical or social care contexts is a key issue
- Data – the lack of a code for falls in addition to a diagnosis based on presenting medical condition or injury is not helpful in planning falls prevention, interventions and efficient falls care. However falls

incidents are captured in the ED at QA, including diagnoses such as wrist or other fragility fractures.

- PHT approach is to communicate with patients' GPs on discharge, and if not admitted, a copy of the patients notes are sent to the GP (argument for single patient record – eliminate need for 'sending' notes/data around the system)
- When considering if it is safe for a patient to return home, the falls pathway requires that a check is made on whether appropriate support will be available to the patient, and a referral is made to a falls clinic or GP – OOH is an issue
- The referrals process to intermediate care needs to be improved and capacity issues addressed to ensure support is there
- Community ED team in place recently – intention to better manage discharges
- Community liaison? "but the system is flooded" waiting times are longer than they should be and they "compromise the safety of patients".
- Too much being driven by providers – commissioners need to take ownership
- There is a "so called single point of access" originally initiated by the PCT but there is lack of capacity.
- GP engagement – the falls service is "swamped". "If we can't get primary care engagement we are swimming against the tide" but because GPs are independent contractors to the NHS, there is a lack of drivers/incentives or sticks.
- Falls care and prevention should include good commissioning leadership with a clear strategy
- Falls needs a top down, joined up approach from commissioners – coherence is required, there are lots of bits of falls related activities on lots of agendas, but it seems harder now than it was 3 years ago to move forwards.
- Should Falls and fractures be considered an equivalent to a 'long term' condition?
- Solent Healthcare East follow up on all referrals made to them by PHT
- PC PCT has been completely disengaged and unresponsive, but there has been some dialogue with the lead commissioner for falls at NHS H.
- Frank and open discussions with commissioners never happen, but when there is dialogue it is always at the initiative of providers.

Top wins identified

- There must be investment to save – the problem now is that it is not happening – must get the 2nd tier right!
- A commissioning strategy that is clear, practical and evidence based needs to be developed in close partnership with the clinical experts 'on the ground'.
- Falls need to be pushed up the Public Health agenda – they should be looking at demographic projections, joint strategic needs analysis AND be rich in local data to provide a baseline for commissioning focused services that meet the real needs of the population.

Thursday 27 January

Session 7: Solent Healthcare – Melody Chawner [Falls Coordinator and Physiotherapy Specialist] and Debbie Clarke [Assoc Dir Operations, HASP Programme]

Presentation / dialogue with Panel

- Falls are "very big business" for provider economy
- Need enlightened innovative management
- Providers should be willing to look at needs rather than historic models – needs support of senior management
- Commissioners need to comprise a team that commissions against pathways not pockets of provision
- Referrals from:
    - SCAS (predominantly?)
    - Inpatient services (eg. rehab services post treatment and post falls not resulting in fracture)
    - ED
    - Falls clinic triage
- Services that are impacted:
    - Rapid Response team
    - Community Rehab team
    - Community Physio team
    - Community OT team
    - Community Nursing team (indirectly)
- Manual stats indicate falls referrals constitute one third to a half of demand/business for the above services
- Solent undertake triage and care coordination for falls patients
- Data and communication issues eg. lot of inconsistent data and data trapped in silos
- Commissioners interested in outcomes, and providers need to demonstrate activity, however outcomes can be attributable to multiple factors
- SCAS and OOH have stats on fallers – ACGs(?) could identify patients at risk
- Obtaining, providing and communicating data/information across organisational boundaries is a challenge
- GPs involved – Adrian Higgins Clinical Leadership Board (Soton City?)
- Hip fractures represent approximately 1% of falls – proxy???
- PH role in providing and collating health data on falls, fractures and predisposing conditions – should be informing commissioning
- Creating a local data and information strategy
- Committed to obtain the following during 2011/12:
    - No of ED attendances with falls | repeat fallers (for all 4 acute hospitals?)
    - No of patients attended by SCAS with falls | repeat fallers (?)

    - No of patients admitted with hip fractures (for all 4 acute hospitals?)
    - No of patients attending EDs or MIUs with other fragility fractures (for all sites?)
- Solent Healthcare integrated Governance and Performance Committee will then set targets to reduce those figures
- 'Lead Professional' model to ensure compliance with the care pathway so that patients do not experience recurrent falls and/or re-admissions due to previous poor management/compliance with best practice. They would also ensure that data and communication flows are working, eg. GPs are provided with notes from falls assessments etc.
- Referral to 'treatment' can take from 2 to 24 hours, but situation could be improved and made more consistent through extending basic falls training to all front line staff and allow more highly skilled staff to deal with the more complex cases.
- Lessons learnt by Solent through its development of falls prevention services:
    - Measure as well as do
    - Know your commissioners and work with them
    - Upskill indigenous staff rather than create specialist teams
    - Have a Falls Coordinator who is given the space and time to reflect on provider outcomes, processes, coordination and communication, feed into develop of strategy and innovation, thus managing the service development cycle.
- Don't have a mountain to climb because there are many elements already in place and working well - a lot of falls training has been provided.
- Intending to build a system where all staff are skilled, but would require two levels: one general, one specialist
- It is anticipated Portsmouth City Council 'Independent Living' service could assess provision against how well the needs of patients/fallers have been met with a view to supporting a culture of continual improvement?

Top wins identified

- A robust, effective 'single point of access' system
- Rapid assessment service
- Integrated falls management to quickly follow the rapid assessment service

Session 8: HCC Adult Services (provider) – Alex Burn [Head of Older People's Wellbeing Team]

Presentation / dialogue with Panel

- Older People's Wellbeing strategy identified falls as a loss of independence

- Aim to target the 84% of over 65s not intensively using health and social care
- Hampshire CC provides Early Intervention and Prevention Services with a view to proactively promoting and supporting independence in the older population
- Initiatives include:
    - The Trigger Tool – A multi-agency information tool that contains useful contact details of a range of organisations and agencies for anyone visiting an older person in their own home. Through this it can promote and offer a range of support services that foster healthy and safe independence through a variety of natural contact opportunities with older people.
    - Better Balance for Life – HCC led project in partnership with NHS to provide a simple evidence based exercise programme in community settings and care and sheltered home to reduce falls. This provision also expands the capacity of the NHS by providing community exercise opportunities for older people who have received an NHS intervention..
    - Telecare – "Telecare is the remote monitoring of real time emergencies using hand activated and/or automatic peripheral devices (alarms)" that provide alerts to a call for help, or change of state that indicates help may be needed, such as providing a warning that a fall has occurred, if a person cannot get up again, or has fallen out of bed. Hampshire commissions devices and issues them to vulnerable older people (the NHS also uses them, eg. see Session 4) who have been identified as benefitting from Telecare from within ASD criteria. Also anyone from the community can purchase the equipment.

Top wins identified

- Hampshire CC AS has a good proactive approach and successful model of social care, however capacity is limited, particularly in view of the aspiration* to reach the 84% of over 65s who currently do not intensively access health and social care services
- Make every client facing employee in AS a falls champion backed by the training to identify and refer appropriate clients to falls prevention services , using already existing mechanisms including the FRAT tool.

* How the OPWB team works:- It does not expect to reach people on its own but rather by working with and through the partnerships developed across the county. A simple example is - it trains up Brendoncare volunteers in use of the Trigger Tool and the Better Balance for life exercise programme ,and they in turn can use these resources and skills with the older people they come in contact with.

Session 9: Hampshire Community Health Care – Jude Diggins [Asst Dir Nursing and Allied Health Professionals], Jill Phipps [Falls Coordinator and Physio Specialist] and Sue Morris [Falls Coordinator and Nurse Specialist]

Presentation / dialogue with Panel

- HCHC took referrals to the falls prevention service from SCAS, EDs, GPs, community health professionals, Adult Services and acute hospitals following discharge.
- HCHC asserted that it continued to respond to all referrals received in every team/area by triaging and prioritizing according to clinical need. Staff provided a rapid response within 2 hours whenever required.
- SCAS non-conveyed falls referrals since June 2010 had contributed to resource issues in some community teams resulting in variable waiting lists for falls assessments.
- There had been gaps in the provision of falls prevention exercise for a long time – the increase in referrals had highlighted these gaps and the need for more exercise classes to improve balance and prevent falls.
- Faxes from SCAS for non-conveyed fallers – there had been delays in the system which were being addressed by SCAS. An email system was being developed which may improve reliability and reduce delays.
- Any older person considered to be at risk of falling that comes onto the community care teams radar would receive an assessment (including falls) although the waiting times were variable and in SW run to 6-7 months – however the average wait across the county is weeks and not months. Ways were being explored to shorten the long waits in South West
- In order to manage the increasing referrals HCHC were looking to develop alternatives to provide a wider range of assessment opportunities for patients and reduce waiting lists. These would use the skills of the specialist falls clinicians in clinics in local health centres. The recent appointment of new Community Geriatricians in the South West, provided other clinic or domiciliary opportunities. These solutions offered cost efficient and patient friendly services by allowing care closer to home.
- Two thirds of patients at QA are Hampshire patients.
- Witnesses asserted there was no explicitly commissioned Falls prevention service as much of the work is 'core business' for clinical staff working with older people. However, some elements of a falls service, such as Specialist (ie Consultant led) Falls Clinics, the provision of sufficient falls prevention exercise classes to ensure an impact on the local population, and a fracture liaison service do require separate commissioning.
- Historically falls have been an integral part of community care teams' workload – approximately 75-80% of it.
- Care home falls training was typically initiated by requests from care homes themselves, by encouragement from Community Matrons, or by recommendation from Social Care prompted by safeguarding concerns.
- Other ongoing training also has not been formally commissioned although in providing training other demands on the service are avoided

- 3 training sessions per year for **Pa**rtnership in **C**are **T**raining programme have been provided in each area of Hampshire. Other training as requested by PBC or Care Home groups has been provided by the Falls Coordinators free of charge.

Top wins identified

- Ideally would want all falls to be coded
- Common coding between NHS and Social Care
- Fracture Liaison Service in Acute Care or as an Osteoporosis Nurse in the PCT, inreaching into Fracture clinics and ED's
- Funding for evidence based exercise programmes providing sufficient regular classes to make an impact on falls referrals.

Session 10: South Central Ambulance Service – Phil Pimlott [Divisional Director, Hampshire]

Presentation/dialogue with Panel

- Referrals of non-conveyed falls patients to Falls Prevention Teams – it is estimated that the number of referrals for patients aged under 65 is estimated to be about 1% or less of falls referrals.
- Time consuming paperwork? – It is true that some additional paperwork is required for referring non-conveyed falls, however it is quite simple and should not take long, however the form needs to be faxed which can only be done from base – this can involve delays of several hours if the ambulance is unable to get back to base sooner (note: critical cases would have been transported to an ED)
- Falls pathway indicates that a SCAS crew can contact a patient's GP if they have experienced a fall and that the GP will get back to the crew within 15 minutes. Commonly if a GP does respond, they usually appear to take a low risk option and ask for the patient to be taken to the ED. There are no levers to encourage GPs not to advise falls patients to call 999, or to encourage assessment at the surgery or at home by practice nurses etc.
- SCAS initiated a trial in the Havant area to improve communication with GPs in which GPs were provided with a dedicated mobile phone – this has been partially successful
- Problem for SCAS is that community based Rapid Response Teams are reported as taking up to the following periods of time to see a falls patient referred to them:
    - 72 hours in Southampton
    - 96 hours in Portsmouth
    - And up to 5 months (days?) elsewhere

  It is therefore difficult for the ambulance service to assume that these clinical teams would provide a safe and reliable response as an alternative to their own service.
- Issues in getting referrals to appropriate falls prevention teams quickly, including:
    - Problems in getting faxes to services at all (reliability?)

    - Problems in not being able to fax forms until the end of a shift
- Variable use by care homes of the ambulance service for falls sometimes results from the risk management approach adopted by the home – SCAS plans to provide such premises with falls protocols that can be incorporated by the homes into how they manage these situations. It was noted that it is illegal to have a 'no lift' policy.

Top wins identified

- Reduce the number of falls in nursing homes
- Improve responsiveness of GPs
- Better defined transfer protocols for clinical responsibility when a patient is handed over to a different clinical team, eg. from ambulance to acute hospital
- In addition it was suggested a context for innovation should exist where providers could dialogue with commissioners and possibly trial potential innovation, such as:
    - The development of special falls training for urban responders
    - Exploring or trialling specialist ambulance-based falls teams
    - Providing mobile X-rays for use by ECPs

Summary of main themes from oral evidence

Strategy

- Witnesses confirmed a lack of leadership and ownership by commissioners of the falls agenda. Strategy and leadership of falls has been left to able clinicians in south east Hampshire to take forward. This has been beneficial for the immediate and neighbouring areas, but overall strategic direction for falls and falls prevention services has been lacking in Hampshire.
- The falls and bone health strategy developed by NHS Hampshire has not received sufficient support for it to be progressed into a framework that could serve as a basis for implementation and commissioning.

Commissioning

- NHS Hampshire identified falls as a commissioning priority but virtually all providers attest to a singular lack of falls and falls prevention commissioning. Instead commissioning of falls services has been hidden or included within funding provided for general community based care for older people. Falls work has therefore been developed and provided primarily at the initiative and direction of clinical leads in the provider community.

- Community providers of NHS falls prevention services attest to the falls services not being explicitly commissioned, and unresponsiveness of commissioners when funding has been sought for fracture liaison services despite DoH guidance and significant evidential support for their cost effectiveness.

Data

- The experience of the Panel and of most witnesses was that locally rich data is often not readily available, or that it may be available but other witness who might find it helpful, do not know it has been collected. In short, this was identified many times as a problem.
- DoH guidance on commissioning for falls, in which a 'good strategy' is proposed, highlights the need for "a baseline of information and a commitment to collecting and using good information to inform service development". This basic and essential requirement for a good strategy has clearly not been followed by commissioners in Hampshire.
- The DoH often refers to an "integrated" falls strategy because falls and falls prevention calls upon a number of clinical areas of expertise as well as health and social care providers. In such a complex context, data and information flows are very important if different providers within care pathways are to work together seamlessly and find optimal, cost effective ways of working.
- It was widely acknowledged by witnesses that it would be very helpful for all older patients who attend EDs because of a fall to have a fall flag included as well as the diagnostic code.
- Because much falls work is not disaggregated from other services that are provided for older people by health and social care professionals, actual expenditure on falls care is almost impossible to determine, despite it being identified in national guidance for the last decade as being a very high cost to health and social services. Commissioners may have conceded that statistical population based projections need to be enriched with reliable local data to support focused commissioning around care pathways.

Public Health role(s)

- Witnesses recognised the potential for PH to play a valuable health promotion role in developing and delivering positive messages related to falls to encourage older people to remain healthy and independent – strengthening and balance exercises, medication reviews etc? This might form the basis for reaching those older people who do not regularly access health or social care services.
- Witnesses also saw the value of PH expertise in developing and maintaining population level health data related that would feed into to falls prevention planning and commissioning.
- Another suggested role for PH was around its experience in working partnership contexts if it could develop a stronger advisory capacity in ***integrated*** strategy development and commissioning for falls prevention.

Training / education

- Some witnesses suggested it was important to give basic falls training to all health and social care professionals who work with older people so as to enable specialist falls clinicians to use their time more effectively to help falls patients with more complex underlying conditions.
- Witnesses agreed that scope existed for falls and falls prevention care pathways to better contextualise and clarify the role of individual services this was seen as an important training element that would support better communication.

Info / literature

- A number of witnesses noted that different information was available from services, some of which other services preferred not to use. They suggested that providers should get together to develop and produce a set of literature/information that was agreed upon by all parties so that consistent advice and information was available in all settings for health and social care professionals and for patients.

Top wins

Relatively little said about:

- Extra funding or commissioning

More about:

- Need for integrated and effective Hampshire-wide leadership
- Need for integration between the many provider elements
- Getting different services including primary care to play their full part
- Protocols to ensure safe handovers from one clinical service to another
- Greater role for PH
- Better information for professionals and patients that should be appropriately targeted, practical and straight forward
- Improve coding of falls in the acute sector, and ensure that good, useful data/information is generated, recorded and made available across the system – this should be made as simple to achieve as possible; a 'light overhead' for clinical services.
- Falls training at basic and higher levels should be pervasive through the parts of health and social care that are customer facing re older people to provide early and best access and signposting.
- Maximisation of re-ablement opportunities for older people subject to falls delivered in their homes/community, eg. from foot care to promoting use of 'peace of mind' technologies such as Telecare devices.

- Facilitating better access to and use of the system pathways through appropriately supported ‘single point of access’ and such routes, particularly OOH.
- Establishment of Fracture Liaison services, whether acute or primary care based – this was one element for which all witnesses had associated with a need for additional funding, but which are considered by the DoH to be cost effective, saving the system more than the funds spent on them.
- Innovation and exploring new approaches to provide falls prevention services was considered essential by witnesses.