The Greater Manchester Falls Collaborative: Community of Learning, Sharing, and Problem Solving: (12-Month Programme)

Session 10

Thursday 20th March 2025

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

10:35-11:05
Falls Prevention Training App: GM Pilot
(Sean Freeman, The University of Bolton)

11:05-11:55
Deep Dive into our Falls Prevention Pathway: Wigan
(Wigan Team)

11:55-12:00
Any actions and close of the session:
Next meeting: Wednesday 16th April, 10:30am-12pm

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Greater Manchester Moving

HEALTHY AGEING RESEARCH GROUP

MANCHESTER 1824 The University of Manchester

NHS Greater Manchester Integrated Care

#GMFallsCollaborative

#GMFallsPrevention

Healthier Wigan
better care for you and your family

Wigan Strategy for the Prevention and Management of Falls and Bone Health

Dr Christina Heaton, Consultant Nurse Falls & Bone Health

Wrightington, Wigan & Leigh Teaching NHS Trust, NMAHP Clinical Research Lead, NIHR Senior Research Leader Programme, Honorary Clinical Lecturer Edge Hil University

Niamh Kearney Enhanced Service Manager- Early Intervention Wigan Council

Local population

As a borough we have the highest % of people aged over 65 in Greater Manchester

Population expected to rise by 22% of over 75 years of age in next 10 years. Highest in GM.

52 Care homes, with 2285 beds, by 30 operators

Wigan is a high-volume user of care home support – 94% occupancy

Only 20% of population who fall, contact Health & Social professional (of these on 35% attend hospital) (Craig et al (2013)

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Case for change

2017-24 Wigan has the highest admission rates following a fall in GM .

Year	Number of hospital admissions over 50 years old due to falls	% Had fractured	% fractures neck of Femur	% Died as a result
2018/19	2557	43.6	32.4	4.02
2019/20	2666 ↑	42.5 ↓	32.1 ↓	5.2 ↑
2020/21	2957 ↑	37.9 ↓	31.9 ↓	5.37 ↑
2021/22	3077 ↑	37.2 ↓	34.6 ↑	5 ↓
2022 / 23	2780 ↓	40.1 ↑	34.3 ↓	5.46 ↑
2023 / 24	2784 ↑	45.2 ↑	30.5 ↓	5.28 ↓

18/19 Wigan had the lowest Preventable Mortality from falls in Greater Manchester at 14.8, in line with the National average

Over 50 yrs. population 131568 (2021)
=2% admissions

Why are we only measured & focusing on this?

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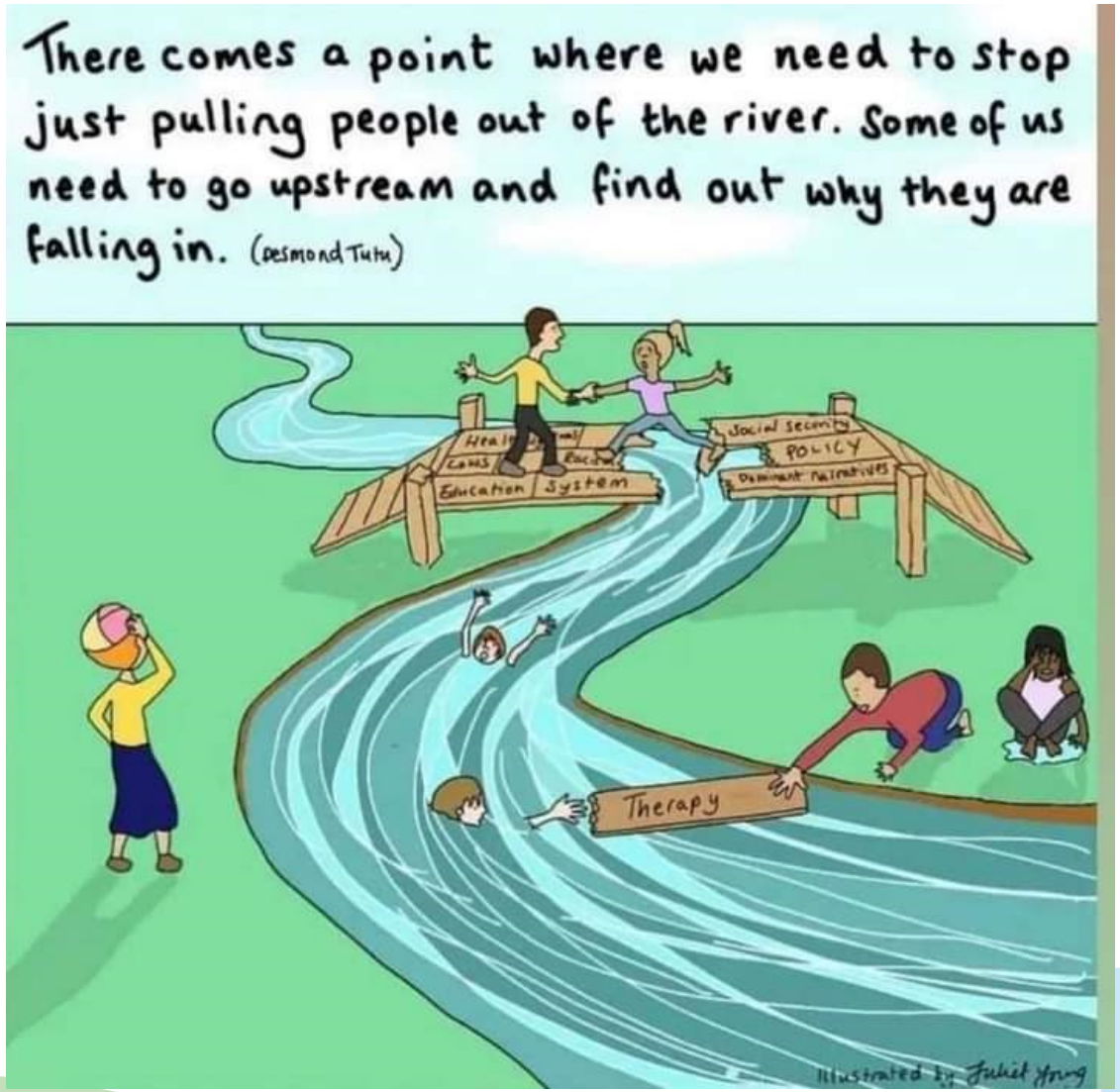

What we did?

Falls & Bone Health strategy

We collaborated across all organisations to develop a Wigan wide Strategy

operational guide

Falls Conversation

Falls conversation

- Replaces the FRAT risk assessment tool
- Developed a single question about falls
- Encourages everyone to have a conversation about falls, changing the narrative
- Rolled out training for this via short video https://vimeo.com/436737712/91a2789a22

Evidence based Multifactorial Falls Assessment and Intervention

- Provided specialist training to staff in health & social care to be able to completed a falls multifactorial assessment, then to commence or refer for appropriate interventions
- Evidence based assessment and intervention supported by NICE guidance (2013)

Training provided so far...

Falls conversation training film

- Be Well, Age UK, Community Link workers, Care co-ordinators, Reablement, Pensioners link, AT Wardens, EIT staff & Health route, Public health Outreach workers (80-100%)
- Falls prevention training (2023)-Primary care, Practice nurse, ACP & FCP

Falls specialist MFA training (2018-24)

- CRT (98), CTT(36), Stroke & Neuro Team (33), EIT OT's/PA's (52), Falls clinic & FLS team (6), Heart failure team (7), IMC Therapists (10), Acute Therapy staff (73)
- 20 staff from the dashboard teams had train the trainer sessions (2024)
- Reviewed & updated Falls clinical mandatory training for WWL staff
- Updated HIS and S1 IT systems to reflex strategy changes

Wigan Falls & Bone health Pathway

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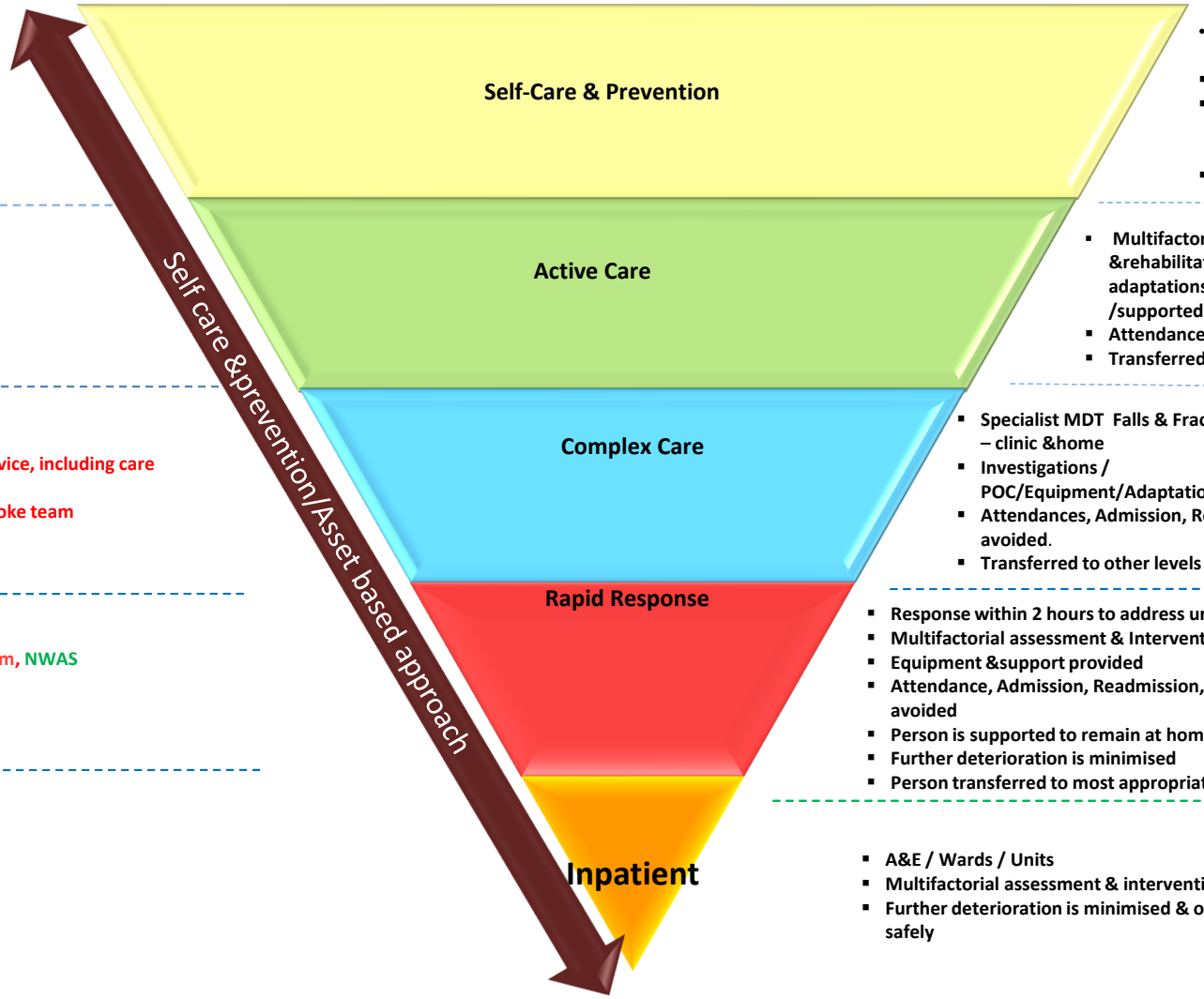
Who delivers? NWAS, Council, WWL, VCSE

What is the impact?



Be Well Wigan, Home safe, Awarm, Handy person, range of community activities , Housing &care options

- Falls prevented, fear of falls improved
- Healthy, active lifestyles
- Admissions/ attendances/conveyances avoided
- Quality of life

Community Therapy, Early Intervention Social Care,

- Multifactorial assessment &rehabilitation/ Equipment/ adaptations/technology/advice /supported POC
- Attendance/conveyance avoided
- Transferred to other levels as required

Specialist Falls & FLS service, including care homes
Community Neuro & Stroke team

- Specialist MDT Falls & Fracture assessment & intervention – clinic &home
- Investigations / POC/Equipment/Adaptations/Technology/Advice
- Attendances, Admission, Readmission &NWAS conveyances avoided.
- Transferred to other levels as required

Community React Team, NWAS

- Response within 2 hours to address urgent needs
- Multifactorial assessment & Intervention on System one
- Equipment &support provided
- Attendance, Admission, Readmission, NWAS conveyance to trust avoided
- Person is supported to remain at home with the right support &care
- Further deterioration is minimised
- Person transferred to most appropriate level of ICS support.

WWL

- A&E / Wards / Units
- Multifactorial assessment & intervention undertaken via HIS
- Further deterioration is minimised & optimised for discharge home safely

Falls dashboard

Pathways

- Number of people assessed by service at INITIAL ASSESSMENT per level
- Number of Falls Conversations by volume of assessments undertaken per level in Community levels
- Falls Multifactorial Assessments (MFA) by volume of assessments undertaken per level in Community services
- Two yearly Clinical audit of all levels against NICE
- Quarterly Case study from each level

People

- Outcome measures
- Feedback surveys
- Council only- Volume & type of formal support adaption & equipment for care package in place for people as a result of falls or at risk of falls. Percentage of people where unnecessary use of health & social care services has reduced

Hospital

- Admission, falls & fracture rates
- Hospital Avoidance due to pilot Lifting service (sept 23 onwards)
- Inpatient risk assessment & MFA, BP audits
- Inpatient harms reviewed & learning shared

Wigan Reduction Of Long Lies (WROLL) 6 months (Sept 22-March 23) PILOT by Community REACT team (CRT)

- Patient not injured, seen by ACP & a Therapist (PT/OT)
- 364 referrals of which 295 appropriate (81%)
- 177 out of the 295 were out of hours (60%)
- 20% of appropriate referrals were responded to by CRT
- 16.2% of appropriate referrals unable to be seen due to existing workload
- 2.4% patients managed themselves and not requiring CRT or NWAS
- 1.4% ambulance response quicker than CRT
- 51% admissions avoided
- 100% reduction of longer lies
- No future funding secured, now undertaken as part of daily workload

Falls dashboard 22-23 outcomes

Important to note the potential effect COVID had on falls data:

- ✓ 10% reduction in admission rates since the strategy was launched 2022
- ✓ WROLL CRT service since September 22, has had 31 admissions avoided with a 50% admission avoidance rate and 100% lifting rate
- ✓ Fractures have seen a downward trend since 2018, but this year saw a 7% increase
- ✓ Quality audit undertaken 2 yearly against NICE guidance (2013) assurance provided
- ✓ All levels provide a case study each per quarter, which provided narrative to the data
- ✓ Council data- 58% of formal support adaption & equipment for care package in place for people as a result of falls or at risk of falls
- ✓ COUNCIL only -82% of people where unnecessary use of health & social care services has reduced. (Completed EI /Reablement cases)
- ➢ Ongoing issues with WWL community data, require clear inputting for all services, as at present dashboard data does not reflect actual clinical assessments undertaken
- ✓ Inpatient increase in compliance by staff
  - Falls MFA 7 days or change of condition or on ward transfer- 82%
  - Have had lying completed within 2 hrs of admission- 86%
  - Falls MFA reviewed every & standing NP checked since admission- 48%
- ✓ Reduction of moderate & severe harm from an inpatient fall- had total of 30, all were reviewed at Falls Panel, where lessons were learnt, good practice found and action for improvements were discussed and then shared with trust wide Falls Improvement group.

Falls dashboard 23-24 outcomes

- ✓ There has been an increase in admission rates of 0.1% which is 4 more patient admissions, this is positive in view of the ageing local population
- ✓ Although Fractures have increased by 5%, the fractured neck of femur have reduced by 3.8% and deaths from these have reduced by 0.18%
- ➢ Ongoing issues with WWL community data, require clear inputting for all services, as at present dashboard data does not reflect actual clinical assessments undertaken
- ✓ All levels provide a case study each per quarter, which provided narrative to the data
- ✓ COUNCIL only 56% volume & type of formal support adaption & equipment for care package in place for people as a result of falls or at risk of falls - Completed EI/Reablement cases
- ✓ COUNCIL only -88% of people where unnecessary use of health & social care services has reduced.
- ✓ Inpatient increase in compliance by staff

  Falls MFA completed within 2 hrs of admission- 89% up from 86%

  Falls MFA reviewed every 7 days or change of condition or on ward transfer- 85% up from 82%

  Have had lying & standing BP checked since admission- 57% up from 48%
- ➢ Reduction of moderate & severe harm from an inpatient fall- had total of 29 down from 30, all were reviewed at Falls Panel, where lessons were learnt, good practice found and action for improvements were discussed and then shared with trust wide Falls Improvement group.

Ongoing developments & issues

- Falls dashboard ongoing development, analysis & actions
- Ongoing GM Falls Collaborative work
- Development of GM wide falls business case
- Issues with care home provision of lack of specialist team and education provision

Recommendations

- Action to correct issues with Systm One (IT system) for all WWL Community Services to ensure correct inputting of data codes and activity demonstrates assessments, interventions and outcomes.
- Sept 2024- Agreed to measure own services feedback & add to annual report
- April 2025 to refresh strategy when new NICE guidance is published
- Develop strategy with GMMH

References

- Craig et al (2013) The high cost to health and social care of managing falls in older adults living in the community in Scotland The high cost to health and social care of managing falls in older adults living in the community in Scotland | Request PDF
- NICE guidance http://www.nice.org.uk/guidance/cg146
- NICE (2004) National Institute for Clinical Excellence Clinical Guidance 21: Clinical practice guideline for the assessment and prevention of falls in older people. DOH
- NICE (2013) National Institute for Clinical Excellence Clinical Guidance 161: Clinical practice guideline for the assessment and prevention of falls in older people. DOH (accessed 10/5/15) from http://www.nice.org.uk/guidance/cg161
- NICE (2015) Falls in older people 86 Quality Standard. DOH (accessed 1/5/2018) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/586382/falls_and_fractures_consensus_statement.pdf

Thank you any questions?

Be Well

Active Ageing

The Active Ageing Offer

Wigan Council

Group Strength & Balance	Home Exercise	Adapted Cycling	Swim Sessions
Wellness Football	Dementia Friendly Short Walk	Specialist LTC Sessions	Confidence Walks
	Support to access the universal offer	Online and physical resources	

Strength and Balance

- Evidenced based falls prevention sessions
- 23 sessions across the neighbourhoods delivered by 4 FTE Specialist Wellness Coaches
- In 2024 there were 426 new participants and 9,456 attendances to groups
- As well as 330 home assessments and 250 people supported to exercise at home

Falls History

- Participants are asked when they start our strength and balance offer whether they have had a fall in the last 6 months.
- We ask the same questions again 6 months later.
- This was introduced in December 2022 and in two years we had data for 337 participants.

Baseline	6 Month Follow Up
136 people fell	58 people fell
381 falls in total	104 falls in total
23 people had fractures	1 person had a fracture
On 76 occasions an ambulance was required	On 16 occasions an ambulance was required
325 days spent in hospital	15 days spent in hospital

Raising Awareness

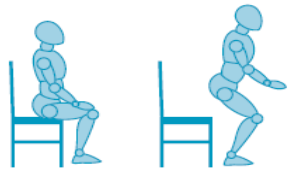
Improve your **strength** and **balance**

THE SUPER 6

6 simple exercises, 3 times a-week as well as a daily walk can help improve strength and balance.

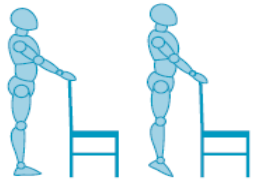
Be Well Wigan Council

Sit To Stand



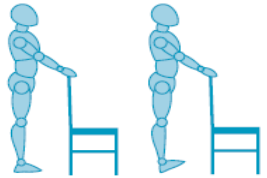
1. Sit up tall near the front of your chair
2. Place your feet slightly back and hip width apart
3. Lean forwards slightly and stand up slowly (use hands if needed)
4. Step back until your legs brush the chair
5. Slowly lower your bottom (use hands if needed)
6. Repeat up to 10 times

Heel Raises



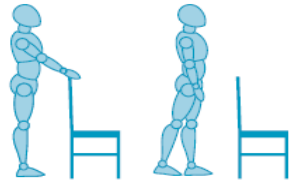
1. Stand tall with your feet hip width apart
2. Slowly lift your heels (light touch on support if needed)
3. Place your weight over your big toes
4. Try not to lock your knees
5. Aim to lift for a count of 3 and lower for a count of 5
6. Repeat up to 10 times

Toes Raises



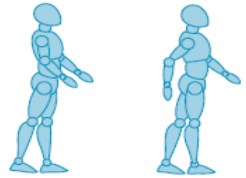
1. Stand tall with your feet hip width apart
2. Hold onto your support (if needed) and slowly lift the front of your foot
3. Keep your knees soft and try not to stick your bottom out
4. Lower your toes slowly
5. Aim to lift for a count of 3 and lower for a count of 5
6. Repeat up to 10 times

Heel Toe Stand



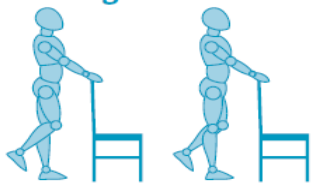
1. Stand tall side on to your support (light touch on your support if needed)
2. Place one foot in front of the other so your feet form a straight line
3. Look ahead and balance for 10 seconds
4. Take foot back to start position
5. Repeat with other foot forwards

Heel Toe Walking



1. Stand tall, side on to your support
2. Hold on to the support (if you need to) and look straight ahead
3. Place one foot directly in front of the other so that they form a straight line, bring the other foot in front and repeat for 10 steps (imagine you're walking along a line!)
4. Turn around and repeat the exercise until you're back to your start position

One Leg Stand



1. Stand close to your support and place hands on support (if you need to)
2. Balance on one leg, keeping your supporting leg straight but knee soft
3. Stand tall and hold for 10 seconds
4. Repeat on the other leg

Backward Chaining

A participant who attends a session with her husband said that he fell at home over Christmas. She assisted her husband following the backward chaining process to get back up. Their granddaughter was there who is a nurse, and she couldn't believe that he managed to get up using backward chaining steps as shown the group session.

A participant was out for a meal with his wife. He had gone to the toilet to find another man had fallen in the toilets. Using the backward chaining process that he had learnt in the group sessions he managed to help the man in the toilet get back up to standing (with support from another member of the public). Without knowing these steps this man would've required an ambulance callout to get him back up to standing.

Upskilling

14 Coaches across Be Well hold the PSI or Otago Qualification, spreading the importance of strength and balance across the universal offer.

14 Coaches who don't hold the above qualifications signed up to a Level 3 Qualification – Designing Physical Activity Programmes for Older Adults.

The team has delivered internal CPD workshops discussing the importance of strength and balance exercise in mid to later life and provided practical advice for supporting people.

Two workshops for anyone supporting older adults were delivered in September 2024, including the VCFSE sector.

Case-Finding for Falls Prevention:

Project Overview

Beth Mitchell
Ageing Well Programme Manager
Public Service Reform
Greater Manchester Combined Authority

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Project Plan:-

The GM Ageing Well Programme secured a grant of a total of £100,000 from OHID and Centre for Ageing Better to design and deliver a project that tests system innovation in the Case-Finding for Falls Prevention. The identified steps to execute the project are:

•We are using data to identify individuals who are at an intermediate risk **(10-25%)** of a fall within the next 12 months using the eFalls Tool (embedded in Version 2 of eFI) and provide an evidence-based intervention to reduce their risk and improve their overall health and wellbeing.

•Once we have a list of individuals, a **'light touch'** validation of the data set will take place to make sure that the individuals are appropriate for this type of intervention.

•We are working with the **Be Well team at Wigan Council and other local stakeholders,** to refine and build on the existing community-intervention package available in Wigan (inclusive of strength and balance provision, the FAME (Falls Management Exercise) programme and sharing information and advice on having a vision assessment if they haven't had their eyes tested within the last 2 years **(based on the evidence paper from Prof Andrew Clegg).**

- We worked with the **Ageing in Place Pathfinder programme in the SWAN area** to engage directly with the voice and lived experience of local older people to design and test innovation.
- Established an outcomes evaluation framework that will monitor and collect sufficient evidence from this approach, such as the following **(See DRAFT Evaluation Protocol):**

  -Patient's understanding of the intervention
  -Falls risk
  -Awareness raising
  -Satisfaction with the process undertaken
  -Satisfaction with what was offered to them because of their inclusion;
  focusing on improvements to the service/ intervention
  -Barriers and enablers to this type of intervention

- **This approach will be tested and validated in Wigan, with a plan to roll this out across other areas of Greater Manchester.**
- Devise a dissemination plan of how we plan to spread the learning across a GM, National and International footprint.

Timeline…and we are on track!!

September 23-October/December 2024

Phase 1

Planning/scoping phase

January 2025

Phase 2

Implementation phase

(Contacting process)

February 25 Onwards Delivery phase

(Set-up of the FaME provision)