Falls Prevention in Greater Manchester: Delivering Integration and Reconditioning

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HEALTHY AGEING RESEARCH GROUP

Greater Manchester Health and Social Care Partnership

MANCHESTER 1824 The University of Manchester

#GMFallsPrevention
#GMReconditioning

Office for Health Improvement & Disparities

Wider Impacts of COVID-19 on Physical Activity, Deconditioning and Falls in Older Adults

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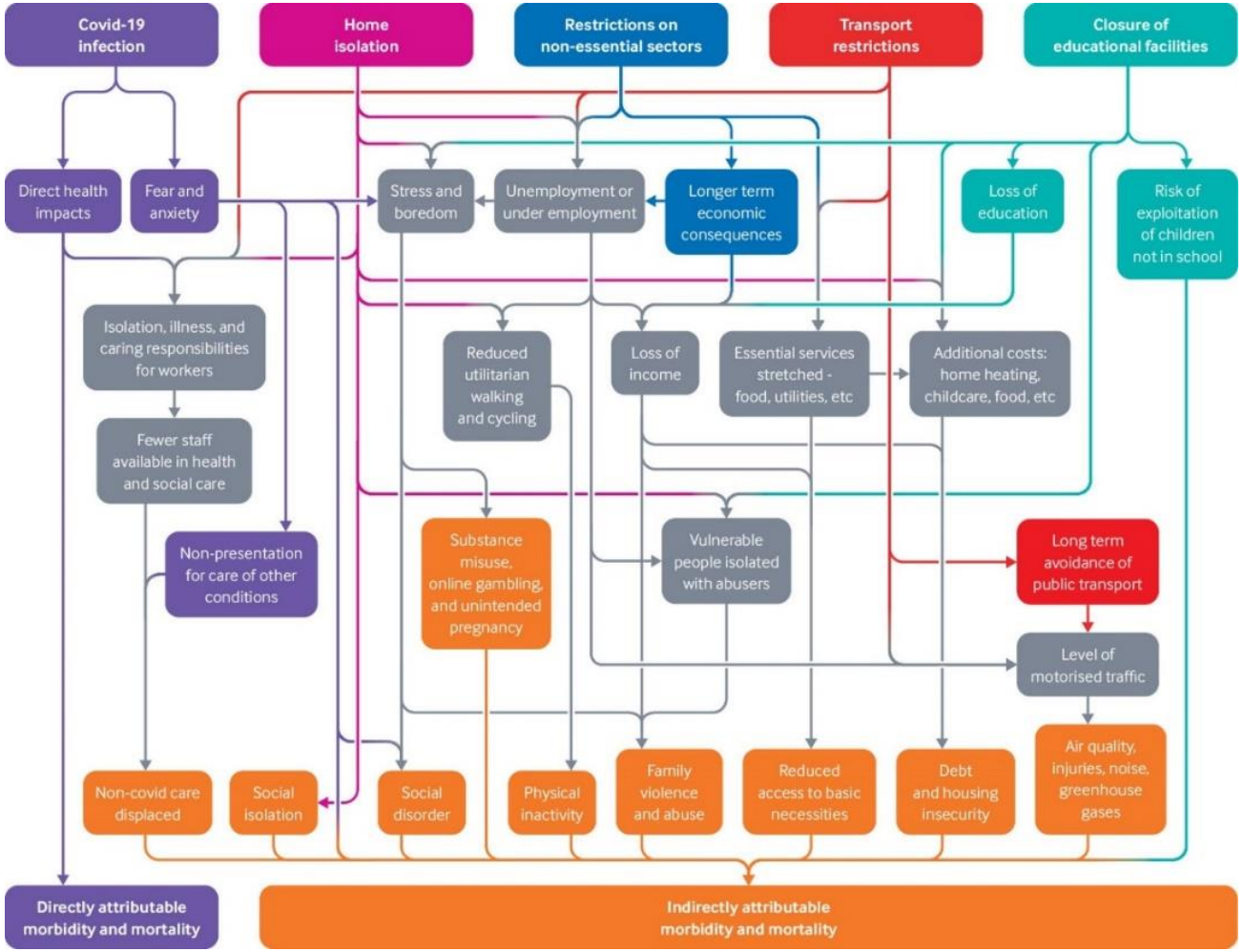
Healthy Ageing Team

OHID

Introduction: COVID-19 and Deconditioning

Background

- COVID-19 has affected almost every aspect of our lives, and these wider impacts will have consequences for a range of health outcomes.
- Evidence suggests that some of the wider impacts of COVID-19 have affected older people's physical and mental health disproportionately. One of the most acute impacts is reduced physical activity, leading to **deconditioning** (physical, psychological and functional decline).
- Physical activity levels – in particular strength and balance activity - were reduced during COVID-19 lockdowns, but this reduction continues to persist despite the relaxation of restrictions.



Source: Diagram taken from Douglas et al 2020

COVID-19 and Physical Activity

- At population level, levels of physical activity amongst older adults have fallen during the pandemic.
- When we look at the kinds of physical activity people are engaged in, the greatest declines are seen in **strength and balance** activity.
- In 2020, the average duration of strength and balance activity per week decreased from 126 minutes to 77 minutes compared to the previous year (~40% reduction)
- And when we look in more detail, about 25% of older adults reported doing more physical activity, about 40% the same, and about 35% less – people were not affected **equally**.[1]

1. PHE 2021, Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults

Those most likely to have seen a decrease in physical activity include [1 2]:

- people from more deprived backgrounds
- women
- people from black, Asian and other minority ethnic backgrounds
- people from urban areas
- people who shielded
- people living with long-term health conditions
- people living with multimorbidity
- people living with dementia
- people living in social care settings

1. PHE 2021, Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults
2. Sport England 2021, Active Lives Survey May 2020/2021 Report

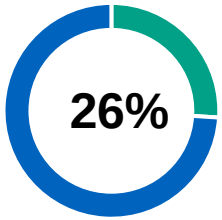
The Impact of Deconditioning

Deconditioning has a range of **medium-** and **long-term** impacts, including:

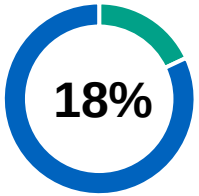
- falls
- depression
- type II diabetes
- cardiovascular disease
- musculoskeletal problems

Immediate impacts are illustrated by the Age UK study on the impact of COVID-19 on older people's mental and physical health:

Since the start of the pandemic:



are unable to walk as far as before



feel less steady on their feet

These changes are morae pronounced amongst people with long-term health conditions or more disadvantaged socioeconomic backgrounds.

22% of older people from more disadvantaged socioeconomic backgrounds **say they feel less steady on their feet** compared to **14%** from the most advantaged.

Modelling The Impact on Falls

The PHE report, 'Wider Impacts of COVID-19 on Physical Activity, Deconditioning and Falls in Older Adults' models the potential national impact of reduced strength and balance activity on falls.

This modelling puts the number of additional falls at over **250,000** a year, leading to costs to the health and social care system of £210 million. Based on the usual healthcare pathways for falls, it is plausible that:

- nearly 26,000 of these additional falls will require a GP visit
- 30,000 will require an ambulance call out
- over 14,000 will require an inpatient stay
- over 12,000 will require a care home package

Modelling predicts that these figures will continue each year for as long as the reduction in physical activity persists.

Recommendations

The PHE wider impacts report contains the following recommendations, combining whole-population and targeted elements:

- **Measures aimed at the whole older adult population**
  - Promote awareness of deconditioning, and the need to gradually build up activity levels to individuals, unpaid carers, and health and social care professionals.
  - Increased access to and promotion of strength and balance activities for all.
  - Ensure falls prevention activities are promoted using positive messaging, aimed at specific communities, emphasising the benefits of strength and balance for wellbeing and safely resuming previous activities.

- **Targeted measures for specific groups:**
  - Individuals with appreciable functional loss or transition towards frailty: support from rehabilitation, falls and physiotherapy services.
  - Individuals with deconditioning related to post-acute COVID-19 syndrome: support from post-acute COVID-19 syndrome NHS services.

This work has been selected for inclusion in the prevention strand of the Adult Social Care white paper, which commits to funding of £3m over 3 years to pilot new ways of addressing deconditioning, as well as to set up a ‘deconditioning network’ to find and share good practice (e.g. Falls Prevention in Greater Manchester).

GM Falls Prevention Delivering Integration and Reconditioning

Jane McDermott,
Healthy Ageing Research Group,
University of Manchester

Beth Mitchell, Active Ageing Lead,
GreaterSport supporting GM Moving

Jason Bergen, Research Associate,
University of Manchester

Consultation process and timeline

Feb 19

Raising the Bar

CMO Guidelines

Jan 20

Roadshow

Mapping system

April 21

Interviews Workshops

GM Strategic Working Group

Sep 21

Sense-Check Findings

GM level Integration

Ageing Well Alignment

Jan 22

Launch

[Raising the Bar on Strength and Balance: The Importance of Community Provision]
[Keeping well at Home] [Keeping well this Winter]

Themes arising

- GM ecosystem strategic and operational infrastructure: services, provision and pathways.
- Delivering prevention across the life course: community, clinical and care settings.
- Joined-up commissioning for evidence-based practice and prevention priorities.
- Workforce resource and capacity, cross-working and collaboration.
- Innovation and technology delivering falls prevention interventions: learning from the pandemic.

Changing the Narrative

Recommendations

Establish GM Falls Collaborative

- Equity, access and equality
- Embedding evidence and evaluating what works
- Data improvement, insight and interrogation
- Workforce development, recruitment and training
- Community of learning, sharing and problem solving
- Digital technologies that enhance and enable

New Post Created

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Greater Manchester Health and Social Care Partnership

Greater Manchester Falls Collaborative

Equality & Equity

Data Insight

Evidence & Evaluation

Community

Care

Clinical

Enabling Technologies

Workforce Development

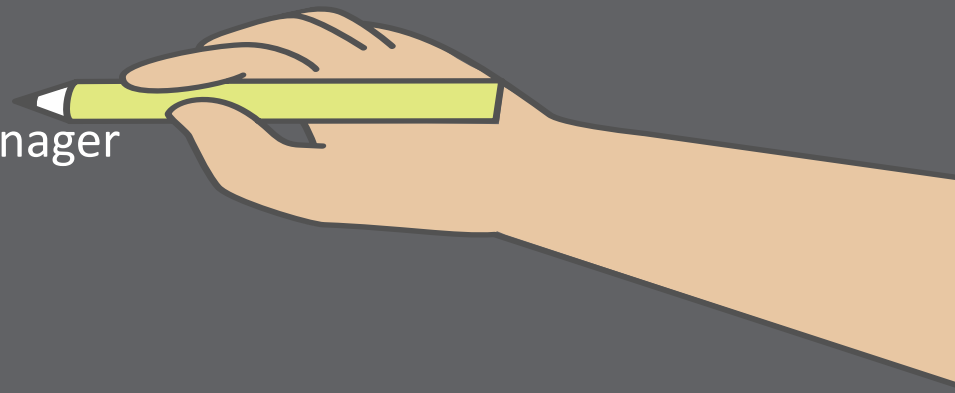
Community of Learning

Ageing in place

Greater Manchester Health and Social Care Partnership

Enhanced health at home (EHaH)

GM LWAH PROGRAMME



- Debbie Ward, Senior Programme Manager
- ASC Transformation
- 21 January 2022

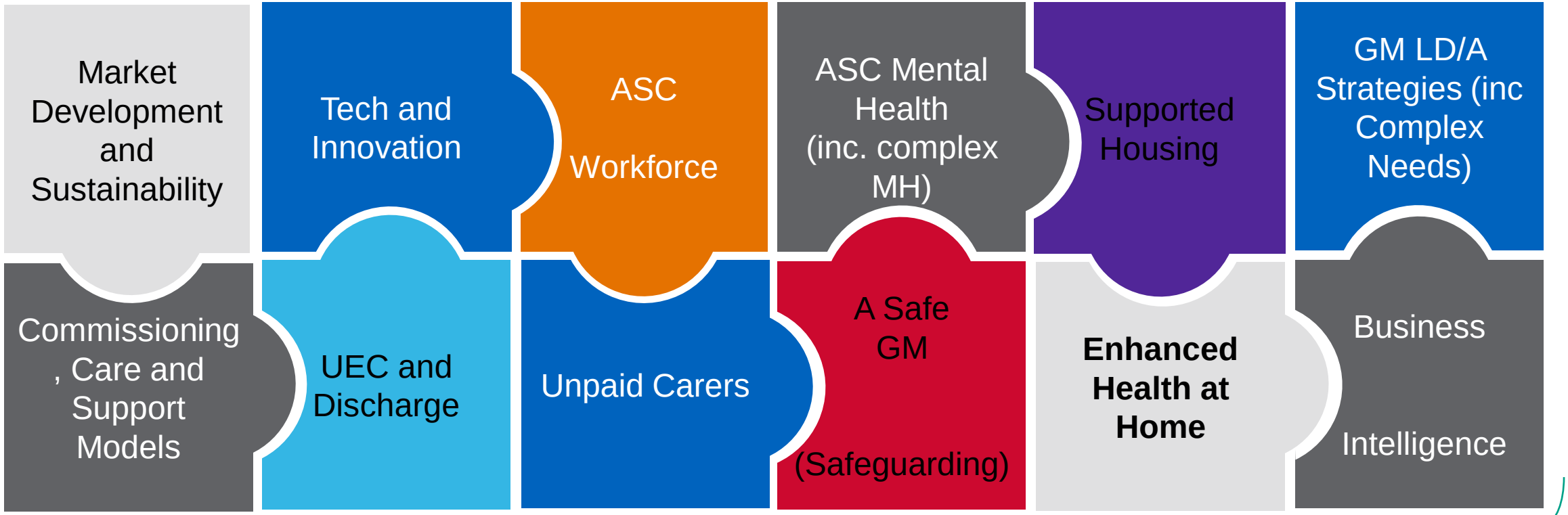
GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

ASC TRANSFORMATION PRIORITIES

LIVING WELL AT HOME

QUALITY MARKETS AND COMMISSIONING PAYMENT AND SYSTEM REFORM
PERSON CENTRED CARE AND SUPPORT WORKFORCE SUPPORTED HOUSING



Underpinned by **Co-Production, VCSE,** **Data Management** and **Performance**

NATIONAL AGEING WELL PROGRAMME

Urgent Community Response

2 hour standard for UCR, **2 day standard** for reablement and a **single point of access** for UCR utilising 111

Enhanced Health in Care Homes

Enhanced support & better co-ordinated care, **reablement** and **rehabilitation**

Anticipatory Care

Helping people with **complex needs stay healthy** and functionally able

SCOPE OF THE EHAH FRAMEWORK

1. Enhanced Primary and Community Care Support	Each care home aligned to a named Primary Care Network which leads a weekly MDT 'home round, medicine reviews, hydration and nutrition support, oral health care
2. MDT support including coordinated health and social care	Expert advice and care for those with the most complex needs, continence promotion and management, flu prevention and management, wound care- leg and foot ulcers, helping professionals, carers, and individuals with needs navigate the health and care system
3. Falls prevention, Rehab and reablement; inc strength and balance	Rehabilitation/reablement services, falls, strength and balance, developing community assets to support resilience and independence
4. High quality palliative/end-of-life care, Mental health, dementia care	Palliative and End of Life, mental health, dementia care
5. Joined up commissioning collaboration between health and social care	Co-production with providers and networked care homes, shared contractual mechanisms to promote integration (including Continuing Healthcare), access to appropriate housing options
6. Workforce development	Training and development for social care providers staff, joint workforce planning across all sectors
7. Data, IT and technology	Linked health and social care data sets, access to care records and secure email, better use of technology in care homes

FALLS STOCKTAKE

Greater Manchester RAG Rating summary from sub-elements				
Core Model Elements	**Green**	**Amber**	**Red**	**Grey**
Falls prevention, Rehab and reablement; including strength and balance	**38%**	**42%**	**17%**	**4%**

Legend

- In place no change needed
- In place needs change
- Not in place
- No response

RAG rating is based on locality responses on how far progressed they were in delivering against:

- Rehabilitation/reablement services
- Falls, strength, and balance
- Developing community assets to support resilience and independence

Next steps

- Finalise the stocktake with localities (CCG and LA)
- Share findings with locality leads to agree priority and lead areas, and what support will be designed and delivered at GM to support local delivery

PRIORITY AREAS

Delivery plan to be co-designed to delivery strategy

Based on the outcome of the locality stocktake. Will include both prevention and response activities

Cross system strategy development

Ongoing engagement with partners across GM to understand existing activity and research, to inform and align activity with this workstream

NWAS high intensity areas

- Data analysed over 12 month period and high intensity localities contacted with information on highest referrers, information on their CQC rating, use of tech etc.
- Engagement underway with NART to understand current usage and potential to grow this to reduce NWAS referrals – potential to pilot community triage tool in development.
- Access to NWAS portal and live Tableau data feed on referrals underway
- Working with HInM and others to understand implementation and impact of deterioration tools such as Safe Steps

NHSX proposal for use of technology to prevent falls

Waiting for funding timelines from NHSX, but agreed to explore bid to support further rollout of tech to prevent falls

LINK INTO: GM ASC MARKETS PROGRAMME

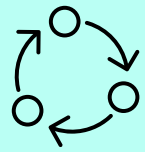
Market Shaping

- All regulated care (not just care homes)
- How we invest as a targeted response to recover, but not to return to, pre-COVID situation
- Capacity and demand modelling
- Risk, quality and market data intelligence to be overlayed to determine investment priorities (TBC if delivered in this programme or another)

Deliverables

- Market position statement and ambition
- Dynamic dashboards
- Analysis of intelligence at GM and locality levels (TBC)

Commissioning/Contracting Models



- Reduce reliance on care homes
- Payment system reform agenda
- Exploring alternative contracting approaches
- Outcomes-based commissioning models and payment by result/incentives
- ICS Commissioning framework – opportunities

Deliverable

- Customised menu/toolkit of commissioning/contracting options – at ICS/GM and locality levels

ENABLERS

- Market intelligence – Tableau dashboards and analysis across all elements of the market shaping workstream (link)
- GM Flexible Purchasing systems – existing and option to explore new
- Quality programme
- NECs Capacity Tracker
- GM ASC Workforce programme
- Digital investment, technology enabled care, innovative use/delivery models
- Housing provision and strategy
- Ethical Care Charter

Falls Prevention in GM

Safe, Steady, Strong

An Anticipatory Care Paradigm

Prof Martin Vernon

Consultant Geriatrician & Clinical Advisor

SCN Older People's Lead

Anticipatory Care-what is it?

Population health management

Proactive health and care intervention at individual and population levels to achieve specified outcomes

Targeted towards people living with frailty, multi-morbidity and/or complex needs to help them stay independent and healthy for as long as possible at home or the place they call home focusing on what is important to the individual

Enabling Integration

Community health services including mental health services

PCNs including community pharmacy

Social care providers

Housing providers

Voluntary and charitable sector

Urgent and secondary care NHS providers

National expectation

Through the NHS Standard Contract and the Primary Care Network Contract Directed Enhanced Service, Community Services will work alongside Primary Care Networks to deliver Anticipatory Care

Anticipatory Care-NHSE/I expectations

Introduction of requirements for this (PCN) service are deferred (as of August 2021)

By 30 September 2022, PCNs will be required to agree a plan for delivery of Anticipatory Care with their ICS and local partners with whom the service will be delivered jointly – in line with *forthcoming* national guidance

Long Term Plan Ageing Well monies are in CCG baseline allocations currently (since 2019) and the mechanism to deliver AC for NHS community services already sits within the NHS Standard Contract

It is suggested that commissioners and leadership across nascent ICSs should be working on this now mindful of:

PCN service guidance being published and the stated national ambition
The long lead team for population health management to achieve discernible impact
The need to support community services workforce expansion
The need to address the ongoing impact of Covid-19 on all sectors and importantly on patients

Anticipatory Care-core components

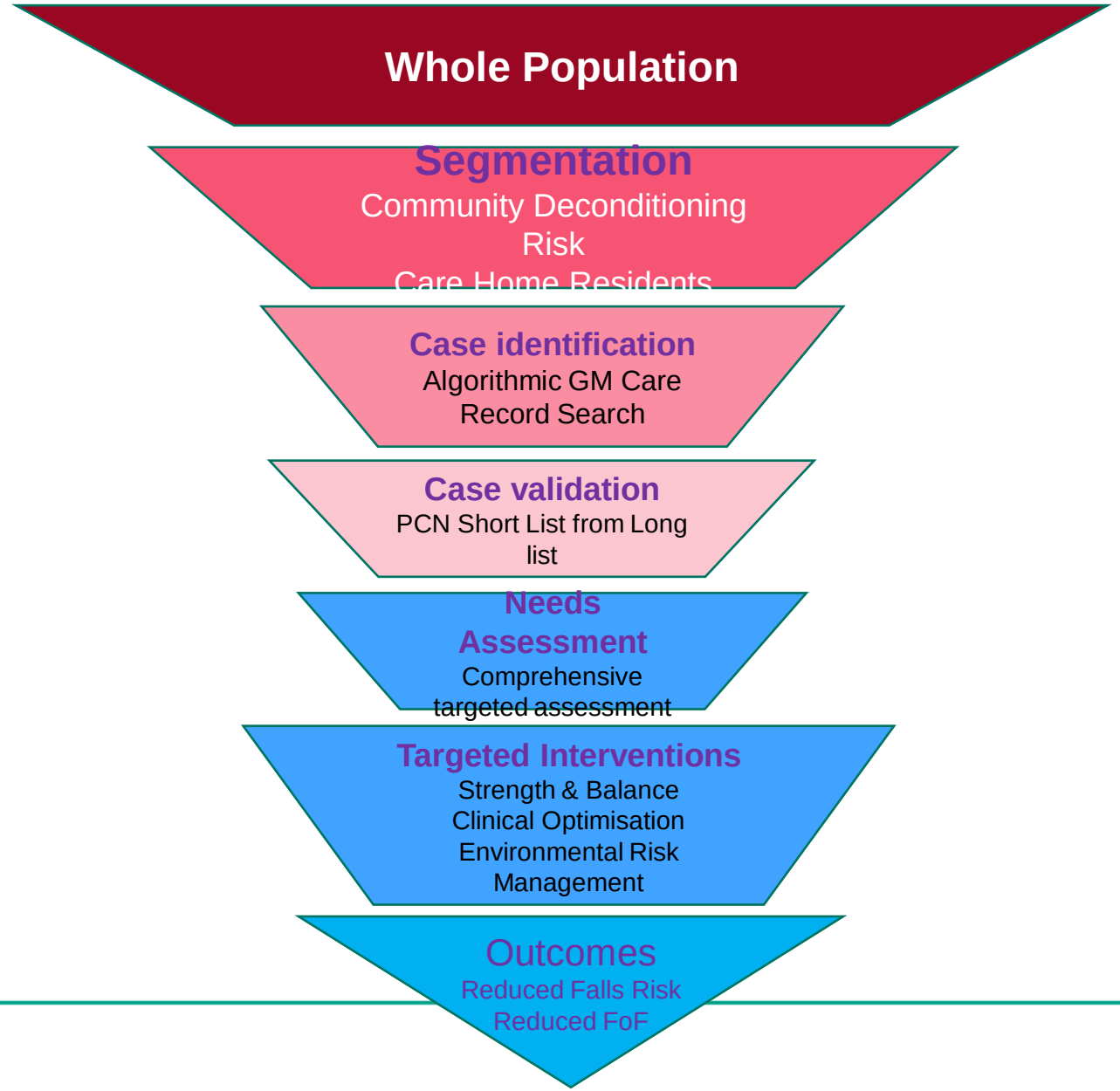
Population Cohort Identification

Proactive Care Needs Assessment

Personalised Care and Support Planning *

Multi-Disciplinary Team (MDT)working*

Care Coordination*



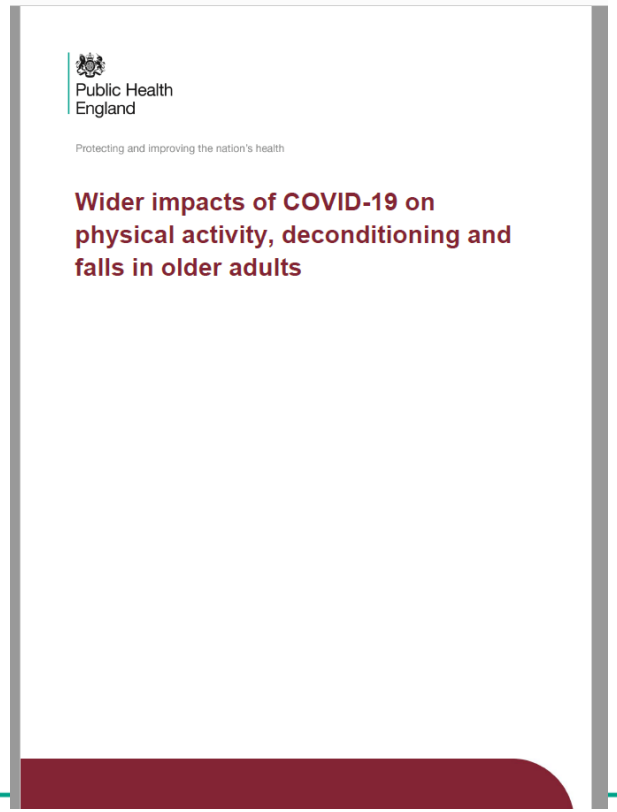
*Digitally enabled

Why Falls Prevention as a GM AC paradigm?

Development focused on outcomes linked to pandemic deconditioning

Falls risk reduction in communities

Care Homes population
Care at home population



Whole Population Recommendations

Promote and increase availability of strength and balance activity for older adults

- Involving a **gradual increase in activity** in order to reduce falls risk and to enable **safe and confident participation** on other forms of exercise and physical activity

Ensure physical activity recovery measures reach those who stand to benefit most

- **Older adults who shielded**
- **People with multimorbidity (2 or more long term conditions)**
- **Adults with dementia**
- **People in social care settings**

Identify locally which older adults have reduced their levels of physical activity during the COVID-19 pandemic

- **Focus on populations where the largest reductions in physical activity are likely to be found**
- The largest reductions in strength and balance activity identified in this report were seen in **males aged 65 to 74** and **females aged 65 to 84**

Developing a GM response focused on falls prevention

1) Identify the **right people**
2) Offer the **right interventions**
3) Develop an **effective delivery model**

Targeted Population Recommendations

Refer to appropriate rehabilitation services, older adults with

- **Functional loss**
- **Transition towards clinical frailty**
- **Fear of falls** resulting from deconditioning

Raise awareness

- Amongst health and social care staff of **post-COVID-19 syndrome**

Communicate the risks

- **Of building up levels of activity levels too rapidly** and the need to refer to post-COVID-19 syndrome clinics where symptoms are severe, in order that clinical judgement can be used about whether graded exercise therapy should be recommended

Matching the right people to the right interventions

Finding the right people using the GM care Record

Algorithmic searching: for example

- All 70+ and/or
- Those with some or all of the following characteristics
  - **Shielded in 2020** and/or
  - **Two or more long term conditions*** and/or
  - **Dementia diagnosis** and/or
  - **Live in social care setting** (care homes/home care) and/or
  -
  - A **home address in a deprived area** and/or
  - **Diagnosed clinical frailty:**
    - Mild frailty: eFI (electronic frailty index): eFI=0.13 to 0.24 [~35% of 65+]
    - Moderate frailty: eFI=0.25-0.36 [~12% of 65+]
    - Severe frailty: eFI>0.26 [~3% of 65+]

*See 2019 NICE indicator guidance (NM184) : relies on a register of people with conditions in 4 or more disease clusters (based on the Public Health Scotland SPIRE approach)

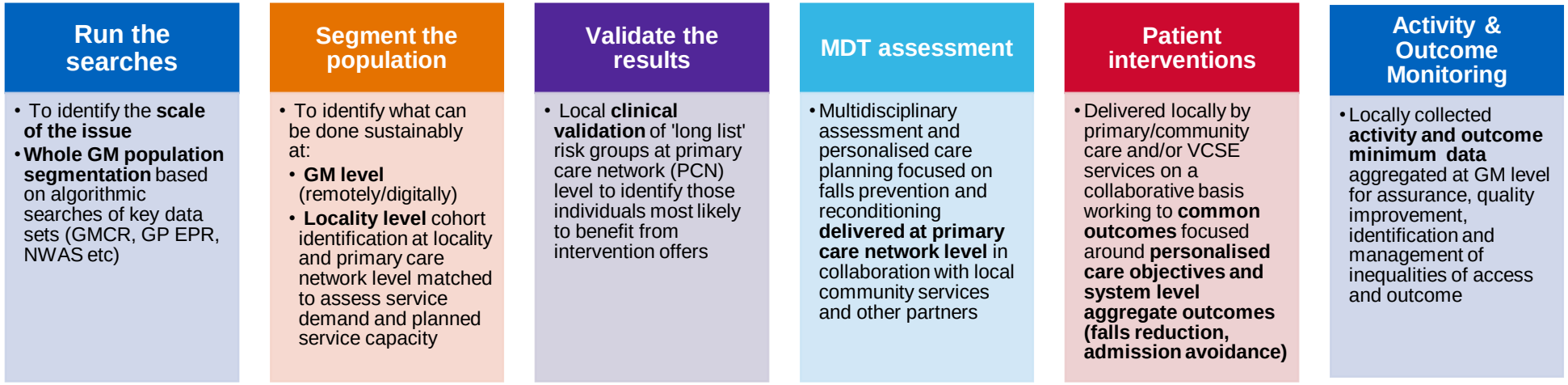
Offering the right evidence based interventions

- **Exercise** is the most effective intervention and must be central to the GM delivery model for falls prevention
- **Core interventions** which will create most benefit for patients and drive **desired outcomes (*preventing the progression of clinical frailty and hospital admissions***) will be:

1. **Home environmental risk assessment** and reduction, for example safe & well checks
2. **Medical checks** including functional fitness (undertaken by clinical staff)
3. **Medications review** and optimisation
4. **Strength & balance training** (face to face or virtual/remote)
5. **Mental health interventions** to reduce **anxiety and fear of falling**

1. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012221.pub2/full
2. https://academic.oup.com/ageing/advance-article/doi/10.1093/ageing/afab201/6399893
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4932244/
4. https://www.laterlifetraining.co.uk/courses/fully-functional-mot/functional-fitness-mot/
5. https://www.laterlifetraining.co.uk/wp-content/uploads/2017/07/LLT-Guidance_Evidenced-Based-Falls-Prevention-Programmes_FaME_Otago_commissioning_240717.pdf
6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4820267/
7. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6514257/

Implementing a GM falls prevention delivery model



Clinical leadership and system/locality ownership will be vital in order to develop the delivery model

Potential delivery partners could include:

- GM Fire & Rescue Service (home assessments)
- Community multidisciplinary teams
- VCSE groups & GM Active (to support delivery of local strength & balance interventions)
- Primary care networks
- Community services including local care organisations
- Acute and mental health provider Trusts
- Local authorities

Recommendations

1. Use national Ageing Well (***Discharge and Community Services***) policy, contractual and investment levers, specifically linked to **Anticipatory Care** and **Enhanced Health in Care Homes** to support development of the **GM falls prevention collaborative and local service offers**

2. **Proactive case finding** through data held within the GM Care Record based on an agreed and validated algorithm

3. **Case validation** of PCN level risk cohorts to identify individuals at risk

4. **Develop GM level falls prevention service offers**, service implementation standards and outcomes

5. Work with PCNs, Local Care Organisations (LCOs) and the GM Falls Prevention Collaborative to **agree GM wide implementation and outcomes frameworks**

6. Develop a **GM level community of practice** to support localities in developing and sustaining their falls prevention offers aligned to the **GM implementation framework**

7. **Agree a GM level framework** for falls prevention activity and outcome reporting and monitoring

https://www.engage.england.nhs.uk/survey/primary-care-networks-service-specifications/supporting_documents/Draft%20PCN%20Service%20Specifications%20December%202019.pdf
https://www.england.nhs.uk/publication/enhanced-health-in-care-homes-framework/