Havering
LONDON BOROUGH

INDIVIDUALS OVERVIEW AND SCRUTINY COMMITTEE

Subject Heading:	Prevention Strategy including Falls Prevention and Reduction
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Policy context:	Prevention enables a better quality of life for individuals while at the same time securing better value for money and reduced spending for health and social care services. It also underpins a whole system approach across a range of statutory, community and voluntary organisations to support effective partnership working.

SUMMARY

In 2011, the Adults and Health Transformation Programme developed a Prevention Strategy which sets out prevention as the primary focus for all services that support adults with a disability and older people.

In early 2011, a Falls Prevention and Bone Health Strategy was developed by the Public Health team within NHS Havering which outlines the vision for falls prevention in Havering. The strategy aims to reduce the incidence and impact of falls through evidence-based action and integrated partnership working between Health and social care, older people's services and partners from the voluntary, public and private sector.

During 2011/12 and 2012/13, the Council received NHS Support for Social Care programme funding from the Department of Health to support the delivery of a series of projects to help people to leave hospital more quickly, get settled back at home with the support they need, and prevent unnecessary admissions to hospital or residential care, and in so doing achieve financial savings for adult Health and social care services.

Funding from this programme was allocated to support the implementation of the Falls Prevention and Bone Health Strategy and this became known as the Falls Prevention project.

This report provides Members with an overview of both the Prevention and Falls Prevention and Bone Health strategies and informs on the progress made to date with their implementation.

RECOMMENDATIONS

Members of the Overview and Scrutiny Committee are asked to consider the Prevention Strategy and the Falls Prevention and Bone Health Strategy and to note the progress with their implementation.

REPORT DETAIL

Background

1. In 2011, the Adults and Health Transformation Programme developed a Prevention Strategy on behalf of the partners participating in the programme including: London Borough of Havering (LBH), NHS Outer North East London (ONEL) and now subsequently the Havering Clinical Commissioning Group (HCCG), North East London NHS Foundation Trust (NELFT) and HAVCO. It sets out prevention as the overarching strategy and the primary focus for all services that support adults with a disability and older people.

2. Promoting independence through the prevention of ill health helps to support a better quality of life whilst securing better value for money and reduced spending for health and social care services. Prevention also underpins a whole system approach across a range of statutory, community and voluntary organisations.

3. In early 2011, a Falls Prevention and Bone Health Strategy was developed by the Public Health team within NHS Havering which outlines the vision for falls prevention in Havering. The aim of the strategy is to reduce the incidence and impact of falls through evidence-based action and integrated partnership working between health and social care, older people's services and partners from the voluntary, public and private sector.

4. Both of these strategies support our Living Ambition Goal for Individuals – to value and enhance the lives of our residents.

Prevention Strategy

5. The Prevention Strategy is being delivered within the Adult Social Care and Commissioning Services supported by the Transformation programme team through a range of projects and initiatives that will see services transformed for the future. Each project aims to address one of the three strands of prevention:

   Promoting wellbeing (primary prevention) – aimed at people with no particular social care needs.

Early intervention (secondary prevention) – aimed at identifying people at risk to stop or slow down any deterioration.

Enablement and reablement (tertiary prevention) – aimed at minimising disability and deterioration from established health conditions.

6. The Prevention Strategy sets out the Case for Change in Havering, highlighting the projected population growth of 8.3% between 2010 and 2020 and the particularly high predicted increase in the number of elderly residents. As this will result in more residents experiencing cardiovascular diseases, cancer, respiratory illness, dementia, osteoporosis, incontinence and hearing impairment, it is likely that demand of health and social care services will increase.

7. It also sets out Havering's vision for prevention which stems from our overarching vision for Adult Social Care in the borough and seeks to:

   - Establish prevention as the recurring theme that runs throughout all our work
   - Shift investment away from intensive and reactive services to save money and improve outcomes for individuals
   - Enable adults to make choices that improve their own and others' outcomes in a sustainable way through available, accessible and targeted advice and information services
   - Ensure that safeguarding remains a key focus

8. Importantly, the strategy recognises that prevention requires individuals and communities to take responsibility for themselves and to make informed choices based on the information available to them. We want to increase independence and build capacity in our communities to strengthen voluntary and community support and to prevent, wherever possible, the need for hospitalisation or time spent in residential care.

9. The themes of prevention are set out and include: strong leadership and a clear vision; a coordinated approach across the Council and other stakeholders; sustainable community capacity that increases engagement and motivation; a focus on safeguarding to help reduce social isolation and encourage participation; accessible and targeted information and advice; enabling and empowering workforce culture; and stimulating the development of a diverse market.

10. The strategy sets out what will be done in order to ensure that the objectives are met. This includes:

    - Age proofing existing mainstream services to ensure inclusion
    - Provide information for all, including self funders, so that everyone can make informed choices about their lives and their care
    - Build capacity in local neighbourhoods and encourage volunteering
    - Support all services that promote wellbeing and reduce social isolation
    - Encourage participation in the diverse range of social, cultural and leisure services in the borough

- Develop a pathway for those not eligible for ongoing care support to enable them to look after their health and wellbeing and retain their independence as long as possible
- Use case finding and case coordination to proactively identify people who could benefit from accessing targeted services
- Optimise our reablement services

11. The strategy stresses the need for a whole systems approach to delivering its aims and how important partnership working is within organisations, across sectors and with individuals and communities. All partners must be engaged and committed to the vision of embedding prevention into their ways of working and will share resources, skills and intelligence in order to deliver preventative services.

12. The Prevention Strategy captures out commitment to working towards a reform of the whole system across health and social care and improving services for our residents whilst also saving money and working more efficiently.

Implementation progress

13. There are a number of projects being implemented in order to help achieve the aims of the Prevention Strategy. These also link in to Havering's Health and Wellbeing Strategy, which has prevention at its heart as evidenced by one of its key themes: 'Prevention, keeping people healthy, early identification, early intervention and improving wellbeing'

14. Projects include:

Improving the Provision of Information and Advice

15. This is being delivered by the Carepoint website and advice service which is run by a consortium of local organisations to improve access to health and social care information across the borough and not just those services delivered by the Council.

Increasing the Availability of Extra Care Housing

16. This project aims to increase the number of Extra Care Housing units available in the borough and therefore increasing the number of older and vulnerable people able to live more independently and as part of a community.

Developing Activate Havering

17. This project aims to coordinate the Council's approach to preventative services by working with the community to meet its needs. The type of activities being offered through Activate Havering will improve residents' wellbeing by reducing isolation and loneliness.

Broadening Day Opportunities for People with a Learning Disability

18. This project has successfully increased and enhanced the day opportunities for people with a learning disability, offering more personalisation and independence.

Improving Financial Inclusion

19. By supporting people to have access to appropriate financial services and advice, we can ensure that our most vulnerable residents have the confidence to manage their money effectively.

Implementing Integrated Case Management

20. This project focuses on patients who have a high risk of A&E admission and consists of a team of community matrons and social workers providing support to individuals in their own homes, coordinating other interventions and helping patients develop a capability to support themselves.

Piloting the use of Telehealth Equipment for patients with COPD

21. This project provides equipment to monitor vital signs, linked remotely to clinicians who can respond, preventing hospital attendance and admission. There are currently 31units in the community and patient feedback is very positive.

Piloting the Pulmonary Rehabilitation *for patients with COPD*

22. This service offers a comprehensive rehabilitation programme for people suffering from Chronic Obstructive Pulmonary Disease. There are two programmes running that aim to improve health-related quality of life and reduce the length of hospital stays.

Mainstreaming the use of Assistive Technologies for Social Care clients

23. Establishing systems and practices to enable provision of AT to a wide client group, and to understand and maximise its impact.

Establishing an Assistive Technologies Rapid Response Service

24. This project has established a specialist Rapid Response Telecare Installation Team, able to install a range of Telecare and technology-based solutions designed to support elderly or disabled people being discharged from hospital or identified a at risk within their own home within a 12-hour target period following assessment and referral.

Piloting the Use of Assistive Technologies for people with dementia

25. This project uses Telecare and GPS devices to enable people with dementia to safely walk from and return to their homes more independently. Forty-one units have already been deployed.

Further developing Assistive Technologies for Learning Disabilities and Complex Needs

26. This project will use Assistive Technology to provide increased choices and better outcomes for people with long-term conditions, high support needs and/or people with learning difficulties.

Commissioning Dementia Peer Support Services

27. The service is delivered by the Alzheimer's Society, with a dedicated peer support group facilitator, and aims to provide support for people with dementia and their carers by recruiting and matching volunteers and people with dementia and their carers to others on the basis of shared needs and preferences.

Commissioning Additional Support for Carers of people with Dementia

28. The service is delivered by Crossroads Care Havering and provides a specialist, carer-needs led and client-centered service, in the main to people who have a diagnosis of moderate to advanced stages of dementia by way of home-based respite support.

Improving Dementia Training and Development

29. A Dementia Liaison Worker has been recruited to facilitate a comprehensive training programme in caring for people with dementia in care homes across Havering.

Commissioning a Dementia Information and Advice Service

30. Establishing ways and locations for providing information to public and professionals about dementia and support networks available.

Increasing the Reablement Capacity at Royal Jubilee Court

31. This project has increased the number of reablement units at Royal Jubilee Court to address unmet demand by converting a number of void bedsit units in Philip House.

Increased Commissioning of Reablement

32. This is focusing on the ongoing work to develop the offer of reablement.

Piloting a Help Not Hospital Service

33. Delivered by the British Red Cross and providing a referral-based, targeted service using volunteers to provide a range of practical support to meet the needs of approximately 250 older people for up to six weeks to: prevent admission or readmission into hospital; facilitate speedier discharges and freeing of hospital beds; and help people to maintain or increase their independence and wellbeing in their community setting.

How these services have benefitted some of our residents

In September, Mrs E began the Yew Tree reablement programme, after suffering from a stroke. As a result of the programme, Mrs E was able to walk further than before without assistance, her kitchen skills improved with practice and she can now make sandwiches and hot drinks with the aid of new kitchen equipment and lots of encouragement. This approach has enabled Mrs E to regain her dignity and independence.

Ray from Hornchurch has been attending the COPD rehabilitation programme offered at his local sports centre. He says: Before I started the programme, I could not even climb the stairs. Now, after a few sessions, I'm able to do this without getting short of breath. I can even manage some hovering which my wife is very pleased about."

Falls Prevention and Bone Health Strategy

34. The Falls Prevention and Bone Health Strategy has four objectives:

- To improve patient outcomes and improve efficiency of care after hip fractures through compliance with core standards.
- To respond to the first fracture and prevent the second through fracture liaison services in acute and primary care.
- To ensure early intervention to restore independence through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries.
- To prevent frailty, preserve bone health and reduce accidents through encouraging physical activity and healthy lifestyles and reducing unnecessary environmental hazards.

35. It also sets out a series of initiatives to help achieve these objectives, including:

- Development and implementation of a whole systems integrated falls care pathway.
- Provision of hip fracture care to guideline standards.
- Prevention of falls via falls management and balance exercises.
- Identification and management of care/nursing home residents and telecare clients at risk of a fall.
- Training and support of care/nursing home and telecare staff in falls prevention and management.

Implementation Progress

Care pathway

36. A falls care pathway was developed in collaboration with GPs, clinicians from the acute trust, LBH, voluntary groups and service users. The pathway was developed to guideline standards and was designed to ensure that patients who attended BHRUT as a result of a fall, receive quality care and are referred as appropriate.

Hip fracture care to guideline standards

37. There are 6 standards for hip fracture care set out in the British Orthopaedic Association & British Geriatrics Society Blue Book. In 2012, performance was generally below levels achieved in 2011 and an improvement plan is in the process of being developed.

Osteoporosis prevention and management

38. Osteoporosis is a major risk factor for fracture following a fall and increases the chance of hip fracture in patients who have a second fall. Data for 2009/10 indicates that approximately 60% of women who are eligible for osteoporosis medication might not be receiving it. In order to address this, education and training sessions have been organised for GP practice staff and BHRUT is implementing the inclusion of fragility fractures on patients' A&E discharge letters.

Community services

39. Three new services were commissioned using the NHS Support for Social Care programme funding to support the work of the falls clinic and to ensure that Havering residents receive effective, preventative falls services. These are:

40. Community falls exercise programme – this started in February 2012 with weekly classes in Romford to promote better balance, improved coordination and increased strength. Interest in the service has grown and there are now four classes running at two locations in Romford and Upminster.

41. Falls outreach into nursing homes and for telecare staff – approximately 40 service users in nursing homes have had a cognitive screen and environmental assessment since the service started in February 2012. Thirty-one of these were referred to the falls clinic or the community exercise programme as appropriate.

42. Training programme for nursing home and telecare staff – 262 staff from nine care and residential homes have received training in falls awareness and recognising environmental risks. It is anticipated that a further 800 staff members will be trained and all training will be evaluated by the service provider on completion.

How the community exercise programme has benefitted some of our residents

"It is much easier and more enjoyable doing the exercises together rather than on your own." Ron, Romford

"The classes have definitely improved my confidence and balance." Rae, Romford

Financial impact

43. There were 775 admissions for falls between April 2011 to August 2011 at a cost of £2,754,017. Within the same period in 2012, there were 548 admissions due to falls at a cost of £1,642,497, indicating a 29% reduction in admissions due to falls and a £1,102,520 reduction in admission costs. See figures 4 and 5 below.

Figure 4: Havering admissions due to falls April 2011/12 – August 2012/13

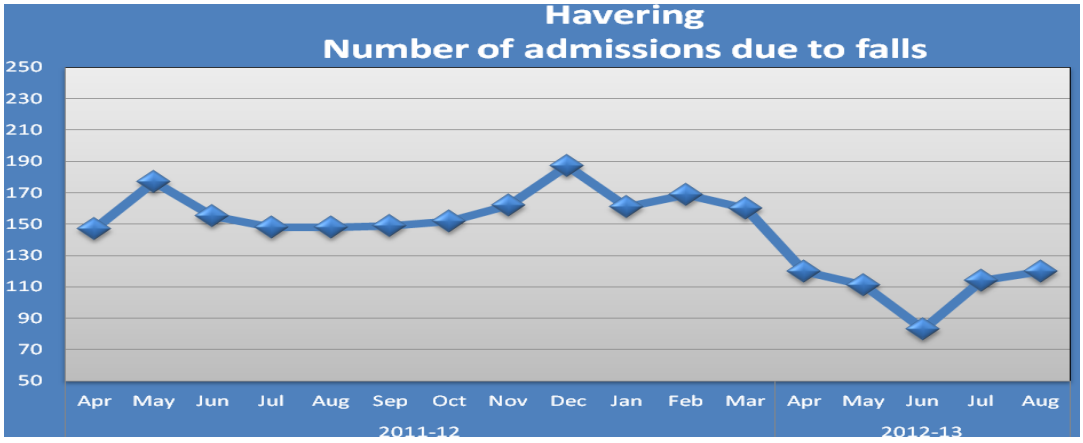

Figure 5: Havering admissions due to falls April - August (2011-12 & 2012-13) Source: SUS

Year	Month	Values admissions	Total Cost
2011-12	Apr	147	£463,441
	May	177	£663,491
	Jun	155	£583,341
	Jul	148	£524,034
	Aug	148	£510,710
2011-12 Total		**775**	**£2,745,017**
2012-13	Apr	120	£379,857
	May	111	£373,171
	Jun	83	£271,290
	Jul	114	£319,781
	Aug	120	£298,398

2012-13 Total		**548**	**£1,642,497**

IMPLICATIONS AND RISKS

Financial implications and risks:

44. The initiatives outlined above are largely funded through Department of Health funding for social care, which is a grant that has been passported to the Local Authority since 2010/11 via Havering PCT. The grant is governed via a Section 256 agreement, which sets out the plans to utilise the funding and is signed up to by both Health and the Council. 2013/14 allocations have just been announced. These will be allocated to the Council via the Clinical Commissioning Group, and again will be subject to a S256 agreement before the funding will be released to the Local Authority. This grant is announced annually and can not be assumed as ongoing revenue. Therefore projects funded by this source will either need a provisional exit strategy should funding cease or to be mainstreamed. The Falls Prevention and Bone Health Strategy is funded by this grant.

45. There are also some Council budgets that support the prevention strategy.

46. There will be resultant revenue savings arising from the initiatives listed above which fall to both the Council and Health. The Council has related MTFS savings arising from reducing demand due to preventative activity. These are £660k from 2012/13, £1.175k from 2013/14 and £1.300k from 2014/15. Preventative savings can be difficult to evidence so robust performance data is necessary to monitor changes in demand for services. There is also a MTFS saving related to Extra Care Housing of £100k from 2013/14 rising to £250k from 2014/15.

Legal implications and risks:

47. There are no apparent legal implications from noting the progress in implementation of the Strategy.

Human Resources implications and risks:

48. There are no apparent HR implications arising from this report.

Equalities implications and risks:

49. Prevention Strategy and the Falls Prevention and Bone Health Strategy will have positive impacts for some of the borough's most vulnerable residents, and are designed to prevent ill health and improve people’s quality of life by reducing the likelihood of falls occurring and ensuring early intervention.

50. At the time of producing the strategies, a partial equalities analysis was carried out by NHS ONEL's Public Health team in September 2011 on the Falls Prevention and Bone Health Strategy. However, no equalities analysis was carried out on the Prevention Strategy.

51. It is recommended that a full equalities analysis is carried out on the Council's EA template.

BACKGROUND PAPERS

Prevention Strategy for adults with a disability and older people.

Falls Prevention and Bone Health Strategy

Falls Prevention and Bone Health Implementation Report draft (October 2012)