VALUE FOR MONEY OF FALLS ASSOCIATED INTERVENTIONS IN HILLINGDON

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BACKGROUND - THE STAR APPROACH

The following diagrams are key outputs from a value-for-money methodology called the STAR Approach. Created by health economists at the University of Oxford (Dr. Mara Airoldi) and the London School of Economics (Prof. Gwyn Bevan), its development has been supported by the Health Foundation.

STAR is intended to help people set priorities when they need to make decisions about change. A value-for-money analysis takes place using two key elements:

PARTICIPATION	TECHNICAL ANALYSIS
Bringing together a range of people affected by a specific clinical area - either professionally or personally - at two workshops	A specially designed tool that calculates value for money of different treatments and generates easy-to-understand diagrams.

The process can be informed by an evidence-basis or anecdotal experience of local experts. In this case, the analysis was completed by taking qualitative workshop findings and combining this with data and evidence sourced externally.

INTERVENTION SPEND

OF £4.5m
SPEND ON FALLS

The totals below are an indication of the annual spend for each intervention in the Falls spend category. It is worth highlighting that the figure to the leftdoes not represent the total spend on Falls, rather it is attached to activity that can confidently be linked back to the condition; it is therefore an accurate representation of overall proportions of spend.

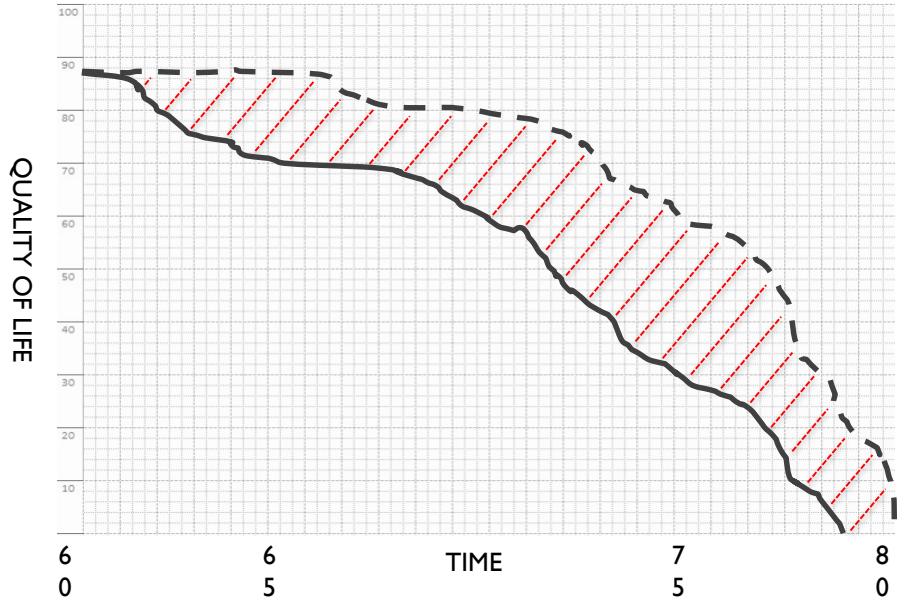
VISION ASSESSMENT & REFERRAL	HOME HAZARD ASSESSMENT	MEDICATION REVIEW	STRENGTH & BALANCE TRAINING	RAPID RESPONSE	HOSPITAL ADMISSION
£6,986	£7,369	£58,800	£81,868	£182,937	£3,685,290
0.2%	0.2%	1.5%	2%	4.5%	91.6%

Q A L Y

We measure health benefit with a unit called a QALY (Quality-Adjusted Life-Year). A QALY traces quality of life over time while also taking life expectancy into consideration.

The two lines below represent two different scenarios - the lower line, what quality of life looks like over time without an intervention, the top, dashed line, what it looks like with it.

The red area between the two equates to the total QALY gain - or health benefit - for that intervention.



VALUE FOR MONEY TRIANGLES

The following pages will illustrate the value for money of interventions provided to people who fall in the Hillingdon area.

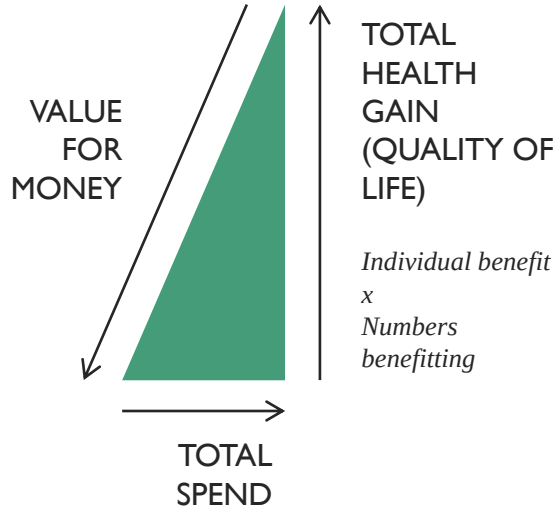
Triangles present this visually.

In brief, the slope of the triangle indicates value for money.

Steeper incline = high value for money.
Gradual incline = low value for money:

HIGH VALUE FOR MONEY

LOW VALUE FOR MONEY

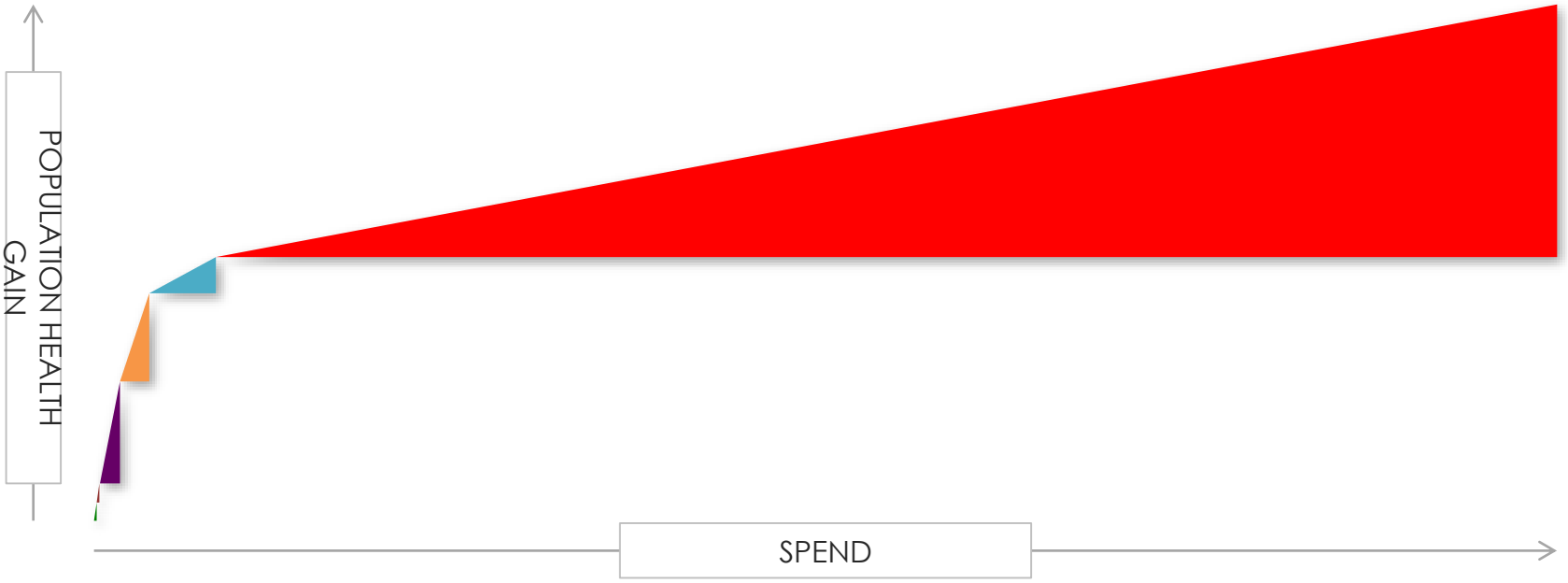


TRIANGLES EXPLAINED

1. **Width =** How much it costs to fund a treatment for a population
2. **Height** = How much a population benefits from these treatments
   This is calculated by:
   a) Identifying how much a treatment 'typically' benefits one patient. This value is measured in Quality-Adjusted Life Years (QALYs)
   b) And multiplying this by the total number of people who benefit
3. **Slope of the triangle** = the value for money of the treatment

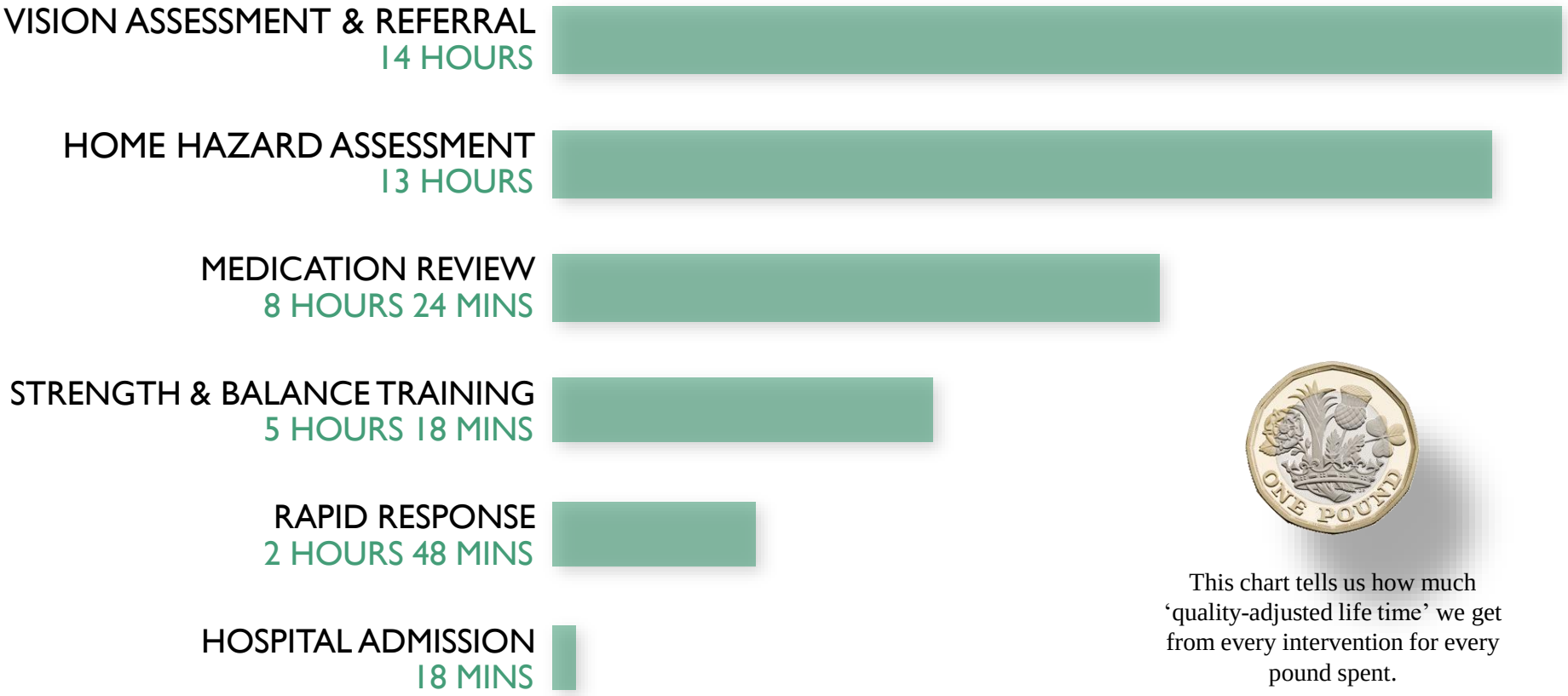
VALUE FOR MONEY OF INTERVENTIONS

This chart shows the value for money of Falls interventions. The percentages above each intervention name are indicative of the total contribution each one currently provides to population health gain with regard to the condition. It is worth contrasting this with the percentage of total spend, detailed underneath each intervention.



3.9%	3.8%	19.7%	17.2%	6.9%	48.5%
VISION ASSESSMENT & REFERRAL	HOME HAZARD ASSESSMENT	MEDICATION REVIEW	STRENGTH & BALANCE TRAINING	RAPID RESPONSE	HOSPITAL ADMISSION
£6,986 0.2%	£7,369 0.2%	£58,800 1.5%	£81,868 2%	£182,937 4.5%	£3,685,290 91.6%

HOW FAR DOES A POUND GO



This chart tells us how much 'quality-adjusted life time' we get from every intervention for every pound spent.

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QUALITATIVE FINDINGS - THE WORKSHOPS

The preceding slides provide a visual overview of the current value for money of different falls associated interventions in the context of population health gain.

This analysis is complemented by workshops where conversations take place involving a variety of people affected by falls either personally or professionally, to explore how transformation could be kickstarted. Clinicians, commissioners, service users and carers are all involved.

The following pages detail the structured discussions that took place about the current provision of care, what changes are necessary to improve outcomes, and of these, which should be prioritised.

QUALITATIVE FINDINGS

POSITIVES AND NEGATIVES OF CURRENT PROVISION

Before participants began thinking about potential improvements, they were asked to consider the best and worst aspects of current care.

PROs

Both service users and staff recognised that it was the people providing falls related care in Hillingdon that were its greatest asset.

In particular, the wealth of experience of staff at CNWL and the hospital Trust was referenced, and similarly that staff stayed in the service for many years allowed them to build strong relationships with local people. The duration of visits carried out by Age UK was deemed a huge plus by people in the community, who felt that this contrasted with other services that seemed to be more time pressured.

Stakeholders felt that while different IT systems between different providers could pose obstacles, overall, an integrated and multi-disciplinary approach was working well. The holistic approach of Age UK to falls prevention was also highlighted as a positive.

Service users at the workshops said that overall they had had a very positive experience, with highly complimentary words for staff and acknowledgement of short waiting times for treatment.

In terms of education, there has been a highly successful initiative to train individuals in care homes to be more aware of how falls can be prevented.

CONs

People at the workshop felt that there was room for improvement in terms of information about falls services. Service users stated that messages from GPs were not always clear in terms of what next steps might be for a patient, and differed from practice to practice; one service user at hospital had been told there would be follow-up to her admission, but none took place. Navigating services is not easy; given the number of these, and the number of providers, stakeholders felt that one single source of information i.e. a leaflet was missing.

Conversations took place around how best to motivate people at risk, or who had fallen. There was potential for the terminology - ‘Falls’ - to have a negative connotation. Workshop service users mentioned that while they had kept up good habits following a fall they felt that their peers did not always understand that these were long-term requirements, and this message could be clearer.

It was also hard for local people - both patients and staff - to distinguish between different services that feature the name Falls and creates more confusion than clarity. After discharge there are many services and patients are not clear on what distinguishes them, and it was felt there was potential for duplication. Participants also reflected on the number of entry points into services and that this could be better documented to promote universal understanding.

Different provider IT systems don’t interact well, fostering a less cohesive system of care.

PRIORITIES

Solutions that could improve the current provision of care were explored, with the top three priority areas detailed below. If implemented, it is key to track the impact of any change, so that quantitative and qualitative data can be used in future to understand what has effectively been implemented.

1

EARLY & PROACTIVE IDENTIFICATION IN THE COMMUNITY

While the pathway is established for those who have fallen, it became clear throughout discussions that there was little proactive identification of those at risk of a fall but who hadn't yet entered the system. Areas for exploration included: Addressing how to best involve H4All, home care, Care Connection Teams, dieticians, podiatrists, etc.; Assigning AHP i.e. physiotherapist or other therapist to allocated GP practices within neighbourhood, to do comprehensive falls assessment by risk category i.e. high/medium/low, and then signpost to right service and support; This would need to feed into a holistic care plan, incorporating mental health, housing, anxiety with appropriate equipment provision i.e. telecare, and clearly identifying to service user a contact point for queries and if deterioration occurs. Reference was made to a systematic means of identifying people at risk of falls/or who have fallen i.e. community rehab use a multi-factorial falls risk assessment tool.

2

SINGLE POINT OF COORDINATION IN THE COMMUNITY

To better manage cross-boundary issues with providers, there is scope to integrate health (acute/community), social care and third sector. Additionally, a single point of coordination at Hillingdon Hospital would be beneficial. An integrated discharge process could be considered to specifically meet falls needs. The message about the system needing to talk to one another was reiterated - both in the sense of different providers, but also in the context of IT.

3

FALLS AWARENESS & PREVENTION TRAINING ACROSS THE BOARD

With reference to the effective training that has happened throughout care homes, it felt that this could be built upon in other settings. A falls education pack for staff could be created with information on services and how exercise, diet and medication play a part in falls prevention. The latter overarching themes should be linked to general long-term conditions management. The need for a consistent message from all settings was emphasised. A consequence of the above, would be education coming from all staff that prompts the patient to also own their self-care, empowering them through understanding and actively becoming more compliant with effective falls-preventing behaviour.

FURTHER PROPOSED IMPROVEMENTS

Additional solutions introduced throughout the workshops are set out here.

PROMOTING IMPROVEMENT

- Spreading message that a fall is never/rarely an isolated thing
- Exploring Falls prevention financial incentives for care homes (similar to award for reduction in pressure ulcers)
- Using data to more proactively identify those at risk
- Understanding if falls are coded in a uniform way (EMIS was specifically referenced)
- Improved access to transport
- More talking therapies (targeted at those most in need)
- Direct referral between services rather than via GP
- Holistic elements are in place but the process is complicated and needs to be improved
- Treating falls holistically with respect to other conditions
- Provision of geriatric MDT
- Longer home visits - shorter visit has reduced impact
- Streamline & foster equity of provision (currently lottery)
- Implementation of systematic follow-up after diagnosis
- Provision of dedicated start-to-end falls service
- Get people doing more of things that they enjoy
- Increased provision of support & benefits for housework and major adaptations i.e. showers, home fittings
- More local groups to refer into after discharge locally (i.e. Age UK)

TRAINING

- More training for transport services (with regard to number of falls on buses) and education about those not obviously frail
- Wider engagement with social care staff and home care
- Rolling training for GPs (once a year)
- (Ongoing) education and briefings re new pathways
- Implement Peer-to-Peer learning - buddy system

COMMUNICATION

- Better communication between services (shared care record)
- Sharing of information to avoid duplication between health and social care providers
- More positive terminology i.e. mobility assessment
- Earlier education on managing condition
- Providing appropriately presented and accessible information
- Information needs to be accessible in physical formats as well as online
- Services need to be clearer (defined)
- Interactive map of services (for GPs), to be included on GP extranet
- More public health style initiatives for people preparing for retirement (+ educational talks)