This presentation will cover:

• Brief context/ background of AFFINITY

• AFFINITY 2018-2023 - Where we are at right now, what needs to be done, and how?
The story so far:

2008: Strategy to Prevent Falls and Fractures in Ireland’s Ageing Population

2013: AFFINITY Project commenced

2016: Project Sponsors identify need to re-focus the project

2017: AFFINITY Project 2018-2023 set up
March 2017- Where to start

- Review of AFFINITY to date
- Brain storming with key stakeholders
- Plenty questions

- Outline project proposal for project Sponsors
Why do we need to act now?

- Falls are common
- Falls hurt
- Falls can be life changing
- Falls cost: A technical report for the 2008 Strategy predicted the cost of falls would reach €1 billion by 2020, €2 billion by 2030
The situation we are facing

- An estimated 60,000 people over 65 require for medical attention for a fall each year. (TILDA 2017)

- Low falls (< 2 metres) are the leading cause of injury, accounting for 77% of major trauma presentations in people aged ≥ 65 years (NOCA Major Trauma Audit 2018)

- Hip fractures - 3,629 people over the age of 60 were admitted to Irish hospitals with hip fracture in 2016. (Irish Hip Fracture Database 2016)

- The number of hospitalisations for hip fractures is projected to triple from 4301 in 2014 to 12,709 in 2046 (Kelly et al, 2018)

- 193 people aged 65+ died from fall related incidents in 2015, of those 93 were over 85+(CSO)
NIMS Data – No. of incidents that occurred relating to 'Slips, Trips and Falls' involving 'Patient' or 'Service User' – Hospital Groups

<table>
<thead>
<tr>
<th>Year</th>
<th>65+</th>
<th>85+ (figure also included in 65+)</th>
<th>Legacy Data (unknown)</th>
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<tbody>
<tr>
<td>2017</td>
<td>2,436</td>
<td>159</td>
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<tr>
<td>2016</td>
<td>2,542</td>
<td>329</td>
<td></td>
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<tr>
<td>2015</td>
<td>2,498</td>
<td>380</td>
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Many of these incidents were categorised under negligible, moderate and minor. However, there were 78 major/extreme incidents between 2015-2017.
NIMS Data – No. of incidents that occurred relating to 'Slips, Trips and Falls involving 'Service User' in Residential Care Centres for Older People

Many of these incidents were categorised under negligible, moderate and minor. However, there were 33 major/extreme incidents between 2015-2017.
1 in 3 People over 65 Fall Each Year

Population Projections for age 65+

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
<th>Predicated Falls</th>
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<tbody>
<tr>
<td>2018</td>
<td>604,926</td>
<td>201,642</td>
</tr>
<tr>
<td>2028</td>
<td>805,750</td>
<td>268,583</td>
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<td>2038</td>
<td>999,118</td>
<td>333,039</td>
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</table>
1 in 2 People over 85 Fall Each Year

Population Projections for 85+

- Population:
  - 2018: 78,128
  - 2028: 120,301
  - 2038: 199,039

- Predicted Falls:
  - 2018: 39,064
  - 2028: 60,151
  - 2038: 99,520
Capacity and Capability

• Significant variations in content, governance and coverage of programmes to prevent harm from falls-geographic lottery
• Limited access to Fracture Liaison Services
• Lacking a standardised approach to evaluating impact and outcomes
• Lack of a national standardised suite of data that captures process and outcomes across the system
• Reaction rather than prevention
Potential Requirement for Multifactorial Assessment

NICE CG 161(2013, reviewed 2016) recommends:

Multi-factorial assessment if:

- Has presented for medical attention post fall
- Or reports Recurrent falls in past year (> 2 falls)
- Or Demonstrates or Reports difficulties with balance and gait

Relevant TILDA criteria:

- Has presented for medical attention post fall
- Reports Recurrent falls in past year OR since last interview (> 2 falls)
- Demonstrates or Reports difficulties with balance and gait (TUG>=13.5sec)
Community Dwelling population of Adults aged 50 and over in Ireland in 2014/2015 based on Wave 3 TILDA Data

<table>
<thead>
<tr>
<th></th>
<th>Age 50-64</th>
<th>Age 65+</th>
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<tbody>
<tr>
<td></td>
<td>Weighted</td>
<td>Pop. Estimate</td>
</tr>
<tr>
<td>Injurious OR Recurrent Falls</td>
<td>14.3%</td>
<td>~96,465</td>
</tr>
<tr>
<td>Any of the 3 criteria</td>
<td>27.7%</td>
<td>~186,860</td>
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Looks like we have an elephant to eat!
In case you are all getting a bit dejected!

- Who knew this was going to happen?
AFFINITY- National Falls & Bone Health project
2018-2023
A system wide approach should address the following elements:

**OBJECTIVE: To**
Provide an overarching framework for implementation of a system wide approach to prevention of falls and harm from falls in Ireland

- Evidence informed community based exercise programmes that address balance and strength. (potential for cross sectorial collaboration)
- Building community capacity for identifying and responding to those people at risk of falling and harm from falls
- Development of integrated clinical care pathways for assessment and treatment of those who have fallen
- Evidence of prevention for older persons at high risk of falls such as in continuing care/ residential and acute services.
- Lifelong optimisation of bone health and fracture liaison services for secondary fracture prevention
Context: Person Centred Approach to Preventing Harm from Falls

Risk Spectrum for Falls

Low Risk
- Message – Falls are preventable, take care of your Health
- Exercise opportunities that promote strength, balance and coordination
- Bone Health Optimisation

Increased Risk
- Case identification
- Multi-factorial assessment (MFA)
- Appropriate interventions for those highlighted by MFA

High Risk
- Integrated care pathways for frail older persons at highest level of fall risk spectrum supported by audit
- Demonstrate actions to reduce risk in high-risk health and residential settings
- Fracture liaison services

Strategic lead and governance structure with oversight of falls and bone health and related areas including frailty and multi-morbidity.
A systematic approach to falls and fracture prevention and management

- 20 Point Work Plan -

1. Fracture liaison and falls prevention pathway developed.
2. All comprehensive clinical assessment, including SAT information, is used to inform a falls prevention care plan.
3. Strength and balance exercise groups in the community are identified and utilised by those at risk of falls.
4. Bone health assessment and fall risk screening is conducted on those 50+ years in general practice.
5. Vitamin D is prescribed for those who are Vitamin D deficient, have no or low exposure to sunlight, are cared for in residential centres for older people, or have suffered fragility fracture.
6. Medications are routinely reviewed in those 50+ yrs. who take greater than five meds (polypharmacy), and identified as at risk of falling or have fallen.
7. A single point of contact for referrals of those 50+ years who are unsteady on their feet or who have fallen.
8. 50+ years persons who have fallen and fractured a bone will be identified and contacted by the fracture liaison nurse and connected to required services and treatment.
9. Ortho-geriatrician will review the older persons who have fallen and sustained a fracture requiring hospital admission, advise on optimal management and improving bone health. A working partnership will exist between the A& E nurse and the ortho-geriatrician.
10. Irish Hip Fracture Database and the Clinical Care Standards have been implemented.
11. Availability of a choice of strength and balance exercises as part of the falls prevention strategy.
12. Ambulance officers’ conduct falls risk screening for older persons they visit who do not need ED transfer and refer those at risk to a single point of contact for follow up.
13. Standardised best practice (evidence informed) strength and balance exercises are advocated for in aged residential care.
15. Falls risk screening programme (level 1) will occur in all services such as outpatient clinics that provide healthcare to older persons.
16. Health and Social Care falls process markers meet expected threshold and quality expectations in clinical areas.
17. Develop an in-home falls prevention programme including assessment and treatment for the frail and elderly at home.
18. Communication regarding falls risk and the individualised plan of care (to mitigate risks) occurs at all ‘transfer of care’ points.
19. A ‘Knowing How We Are Doing’ report is developed utilising data from …………… (to be defined)
20. Governance of falls and fracture prevention programmes are maintained at national and at CHO/Hospital alliance leadership level, and incorporate a cross sector/system

Please note: Text box colour default is red, please alter as per code below to reflect region/local area

- routinely occurs - in part/at times - not yet occurring/ don’t know

Adapted for AFFINITY National Falls & Bone Health Programme, Oct 2016
• Guiding Principles
  – Person centred approach
  – Integrated Care Framework
  – System wide approach
  – What implementation science is telling us:
    • Evidence (research, people’s experiences of services, and the learning from frontline practice)
    • Evaluation- Logic framework
    • Co-design
    • Continuous improvement supported by data
10-Step Integrated Care Framework for Older Persons

1. Establish Governance Structures
2. Undertake Population Planning for Older Persons
   - Frailty Prevalence
     - 11% Severely Frail (Very High Risk)
     - 21% Moderate Frailty (High Risk)
     - 36% Mild Frailty (At risk)
     - 32% Fit (Minimal risk)
   - Ref: O'Halloran, A (2017) Risk stratification based on frailty prevalence. Tilda, Irish Longitudinal study on aging. TCD
3. Map Local Care Resources
4. Develop Services & Care Pathways
   - Rehabilitation
   - Ambulatory Day Care
   - Acute Care
   - Nursing Homes
   - Dementia
   - Falls etc..
5. Develop New Ways of Working
   - New roles including case management approach for long term complex needs
   - In-reach and outreach
6. Develop Multidisciplinary Teamwork & Create Clinical Network Hub
   - Co-ordination between care providers
7. Person-centred Care Planning & Service Delivery
8. Supports to Live Well
   - Enable older persons to live well in the community
     - Community Transport
     - Social Activities
     - Home modifications & handy person
     - Medication Management
     - Shopping
     - Harness Technology
     - Support carers
     - Information & Advice
9. Enablers
   - Develop workforce
   - Align finance
   - Information systems
10. Monitor & Evaluate
    - Track service developments
    - Measure outcomes
    - Staff and service user experience
Work To Date and Next Steps

• Governance established under the Integrated Care Programme for Older Persons (ICPOP)

• Working Group established – Project plan including deliverables, work break down structure, timelines etc.

• Stakeholder Analysis & Communication Plan

• Links / Collaborations- e.g. Age Friendly Ireland, Clinical Programmes including NCPOP, Trauma & Orthopaedics, Emergency Medicine.

• Links with international programmes - New Zealand and Scotland.

• Evaluation : LOGIC framework, need to agree metrics to measure and monitor, address cost effectiveness & budgetary impact of recommendations, recommend priorities
## AFFINITY National Working Group

<table>
<thead>
<tr>
<th>NAME</th>
<th>AREA</th>
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<tbody>
<tr>
<td>Michael Fitzgerald</td>
<td>Older People &amp; Pallitive Care, Strategy</td>
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<td>Eileen Moriarty</td>
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<td>Irene O'Byrne Maguire</td>
<td>State Claims Agency</td>
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<td>Helena Maguire</td>
<td>Primary Care</td>
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<td>Gareth Clifford</td>
<td>Acute Hospitals</td>
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<td>Margaret O'Neill</td>
<td>Health &amp; Wellbeing</td>
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<tr>
<td>Catherine McGuigan</td>
<td>Age Friendly Ireland</td>
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<tr>
<td>Daragh Rodger</td>
<td>ANP, Services for Older People</td>
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<tr>
<td>Dr. Tara Coughlan</td>
<td>NCPOP Rep</td>
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<tr>
<td>Dr. Pat Barry</td>
<td>NCPOP Rep</td>
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<tr>
<td>Ciara Rice</td>
<td>MISA, St. James Hospital</td>
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<tr>
<td>Helen Ryan</td>
<td>VHARMF</td>
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Outcomes- our initial thoughts

• Guidance to support CHO/ Hospital/Community Alliances working together to reduce harm from falls
• Service user- aware, informed, enabled and active!
• Clinicians - supported through evidence, training, tools and organisational supports
• Awareness throughout the system to identify people who need to access assessment and intervention
• Integrated Pathways- making best use of existing and new resources
• A standardised approach to measuring and monitoring our efforts to prevent harm form falls.
• Support budget holders to make decisions about evidence informed, feasible and cost effective services.
In summary

The Intent of AFFINITY (2018-2023) is to:

• *Increase awareness of the preventable nature of falls*

• *Empower older people, communities and health and social care providers to work together to reduce risk and rate of falling, to reduce severity of injuries and to promote best possible outcomes for people who have suffered harm from a fall*
Reasons to be hopeful - Enablers

- Pockets of integrated falls services in Ireland which provide proof of concept in terms of new ways of working
- The availability of data - Irish Hip Fracture Database, NIMS, TILDA, HaPAI and Major Trauma Audit
- The HSE Quality Improvement & Quality Assurance & Verification structures
- The lessons to be gleaned from implementation programmes in other jurisdictions
- The Healthy Ireland programme, Positive Ageing programme and opportunities for collaboration with Age Friendly Ireland
- The ground work already done by Integrated Care Programme
- The recognition in Sláintecare that the model of service provision needs to shift towards primary and community care with appropriate resourcing.
- The complementary scoping work underway on Fracture Liaison Services led by the Trauma & Orthopaedic Programme and Rheumatology
- The project group and all of you here today!
Finally

Thanks for listening

Going to leave you with two reasons why we asked you here today:

• Preventing harm from falls is a team sport
• There is an elephant to eat!