

# OLDER PEOPLE'S FALLS STRATEGY

## 2009 - 2014



London Borough  
of Hounslow



West London Mental Health 

West Middlesex University Hospital



**London Borough of Hounslow  
NHS Hounslow  
West Middlesex University Hospitals Trust  
West London Mental Health Trust**

# **Older People's Falls Strategy 2009 - 2014**

**August 2009**

# Contents

Section	Page
1. Executive Summary	3.
2. Introduction	8.
3. Needs Analysis	10.
4. Good Practice	14.
5. Current Services	17.
6. Gap Analysis	21.
• NICE Guidelines	
• Royal College of Physicians Organisational Audit 2008: Hounslow's Position	
• Local Views	
• Patients' perspective	
7. Future Services	27.
• Vision	
• Integrated Falls Service Model	
8. Conclusion	33.
Appendix 1 Provisional Pathway	34.
Appendix 2 Action Plan	35.

# 1. Executive Summary

## 1. Background

- 1.1 The Hounslow Joint Commissioning Strategy for Older People (2007 – 2010) identified the need for a strategic approach to falls. This strategy builds on significant progress already made towards developing an effective response to the issue of falls within the London Borough of Hounslow. While recognising the need to develop an integrated care pathway across all services, it does not consider in detail the prevention and treatment of osteoporosis, the management of hip and other fractures, or the prevention of falls in general acute and mental health settings.
- 1.2 Falls can have a serious impact on both the quality of life of older people and on health and social care costs. They can undermine the independence of older people, cause multiple A&E attendances, inpatient stays and increase the level and cost, of social care services provided. Falls may be caused by the person's poor health or frailty, or by environmental factors, such as trip hazards inside and outside their home.
- 1.3 There is good research evidence which shows the effectiveness of different interventions to reduce the risk and impact of falls amongst older people. Good practice is described in the National Service Framework for Older People (2001) and the NICE Clinical Guideline on the Assessment and Prevention of Falls in Older People (2004).
- 1.4 There are four key stages in an integrated approach to falls:
- **population approaches** to the prevention of falls, including the promotion of healthy lifestyles, diet and exercise and the reduction of environmental risks
  - **screening** groups of older people to identify individuals at high risk of falls or fracture
  - **assessment** to identify risk factors and plan measures to address them.
  - **treatment** to minimise the risk of falls and injury, and address underlying risk factors.

### Current Provision

- 1.5 The Council and the NHS in Hounslow provide a range of services which help prevent falls and minimise their negative impact on older people.

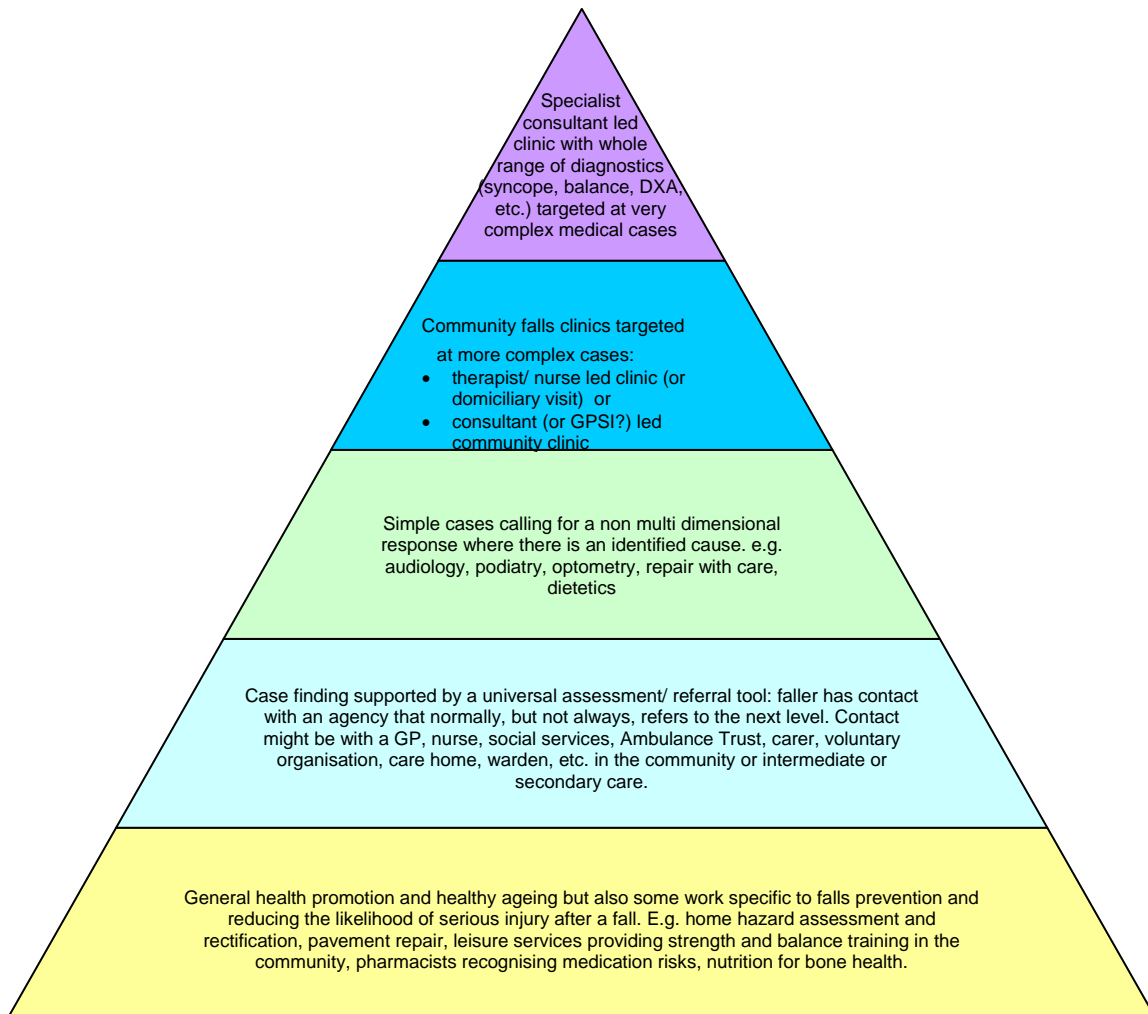
- 1.6 Services are not always well coordinated or consistently delivered. An analysis against best practice as represented by the NICE guidelines, and the Royal College of Physicians *National Audit of the Organisation of Services for Falls and Bone Health of Older People* 2009, indicates there is still considerable room for improvement. For example, Hounslow does not yet have a fully integrated falls pathway with a single point of access. Case finding initiatives are limited and there is a perceived shortage of capacity for the specialist assessment and treatment of people at risk of falls and osteoporosis.
- 1.7 The challenge for services is to identify individuals at risk of falling and ensure there are local services with sufficient capacity to deliver a personalised assessment and interventions which address their needs. Effective falls prevention and treatment require disparate services and professionals to work together as a team to provide a seamless service.

### **The Vision**

- 1.8 The vision of the falls strategy is that all people at risk of falling and sustaining fractures and injuries:
- know of this risk and what they can do to minimise it
  - are supported by health and social care staff to minimise the risk
  - receive timely good quality assessment, treatment and care should they sustain a fracture or injury through falling
  - are rehabilitated to their pre-fall health and wellbeing or even better
  - are provided with services irrespective of their gender, ethnicity, culture or disability
  - have their right to make choices and take risks respected.

### **Care Model**

- 1.9 This strategy proposes the development of an integrated falls care pathway with sufficient capacity to deliver a five tier model of care to older people in Hounslow who are at risk of falling.



1.10 This model is rehabilitative, looking to move individuals back down the care levels wherever possible.

**Tier one** involves a wide range of organisations and professionals contributing to broad health promotion and falls prevention work.

**Tier two** involves screening to identify individuals at high risk of falls or fracture and effectively triaging them to the next level, if required.

**Tier three** involves to an appropriate professional for mitigation of a relatively straightforward risk.

**Levels four** and **Level five** call for triaging patients for specialist assessment, e.g.

- to a nurse/therapist led clinic
- to consultant or GPSI led community based clinic with access to a limited range of diagnostic equipment
- or to a specialist clinic with a full range of diagnostics.

## **Outcomes**

- 1.11 The Strategy seeks to achieve the following **outcomes**.
- a reduction in falls and associated injuries and fractures
  - a reduction in the number of falls related admissions into acute care
  - an effective integrated care pathway which is universally adopted
  - the widespread use of an effective falls risk assessment tool
  - improved partnership working
  - better standards for effective prevention and rehabilitation services
  - increased patient satisfaction/wellbeing
  - a reduction in acute, community, rehabilitation and social care costs.

## **Implementation**

- 1.12 It is proposed that a new integrated falls pathway be developed to support the operation of the care model outlined above. Further work will be undertaken to develop systems, protocols and staff skills needed to make the pathway work effectively. Where gaps or lack of capacity in the pathway are identified a business case will be made to secure any additional resources required.
- 1.13 In developing a new integrated falls pathway, consideration would be given to:
- the need for a falls coordinator to develop and support the care pathway and ensure effective integration of the different services involved
  - the establishment of a central referral point to facilitate access and manage demand
  - the adoption of a shared falls assessment tool
  - the establishment of systems to enable proactive “case finding” of people who have fallen or are at risk of doing so
  - working with contracted domiciliary and residential/nursing home providers to ensure they have effective policies and procedures in place to manage falls
  - working with the London Ambulance Service to ensure that fallers are triaged to the most appropriate part of the care pathway, which may not be Accident and Emergency
  - the establishment of falls registers, e.g. within residential and nursing homes, hospital in-patients and primary care
  - the capacity and ease of access to the services offered in a “falls clinics”
  - the capacity and ease of access of strength and balance training opportunities

- processes to trigger a review of medication where this may contribute to the person's falls
- the provision of training and information on initial falls assessment, falls pathways, protocols, etc for all in contact with older people
- the involvement of mainstream services, such as pavement repairs, transport, leisure, in supporting the prevention of falls
- the need to establish rigorous monitoring and evaluation procedures to demonstrate the effectiveness in delivering strategic outcomes.

1.14 The strategy will be implemented as a project led by the Partnerships and Commissioning division of LBH Community Services and the reconstituted Falls Strategy Group.

## 2. Introduction

2.1 Between a third to a half of people aged over 65 falls each year. This percentage increases with age. Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged over 75 in the UK. Over 400,000 older people in England attend accident and emergency departments following an accident and up to 14,000 people die annually in the UK as a result of an osteoporotic hip fracture (National Service Framework for Older People 2001). Falls are a major reason for 40% of care home admissions and the incidence of falls in nursing homes and hospitals is almost three times the rate for community dwelling over 65s. One in three women and one in twelve men over 50 are affected by osteoporosis fracture by the time they reach the age of 70.

2.2 The prevalence of falls within Hounslow is very high and corresponding admission rates for accidental falls were the highest of all London PCTs in 2005/06 impacting on bed availability at the West Middlesex University Hospital contributing to winter pressures. In 2008 there were approximately 72 documented falls involving care home residents in the Borough of which 31 involved emergency services.

2.3 The consequences of a fall may be:

- physical (discomfort, hypothermia, pressure related injury, infection, pain, serious injury, inability to look after oneself, long term disability)
- social (loss of independence, loss of social contacts, loss of home, move to residential care, financial costs of help/care/hospital, decreased quality of life, changes to daily routine)
- psychological (loss of confidence, fear of falling, distress, guilt, blame, anxiety, embarrassment).

Falling, therefore, has a serious impact on quality of life and health of older people and on health and social care costs.

2.4 The Department of Health has identified key intrinsic and extrinsic risks associated with falls. Intrinsic (i.e. associated with the individual's condition) include:

- balance, gait, or mobility problems including those due to degenerative joint disease and motor disorders due, for example, to a stroke or Parkinson's Disease
- conditions requiring complex medication (e.g., four or more medications) and sedating or blood pressure lowering medications

- visual impairment
- impaired cognition or depression
- postural hypotension.

2.5 Extrinsic, or environmental risk factors for example, include:

- poor lighting
- steep stairs
- loose carpets or rugs
- slippery floors
- badly fitting footwear or clothing
- lack of safety equipment such as grab rails
- inaccessible lights or windows
- assistive devices such as use of a stick, frame or wheelchair.

2.6 Standard Six on Falls in the National Service Framework for Older People set councils, the NHS and voluntary sector the challenge of reducing the number of falls that result in serious injury and establishing specialist services primarily for those who have already fallen.

2.7 There is a good body of research which shows how the risk of falls amongst older people living in the community can be reduced. The challenge for services is to identify high risk individuals and ensure there are well coordinated local services able to deliver assessment and intervention tailored to individual need. Falls prevention requires a range of services and professionals to work together effectively as a team.

2.8 For the purposes of this strategy older people are defined as those 65 years or older. This strategy builds on earlier achievements in this area, such as the joint finance research project that reported in 2002. It also takes forward the "falls and bone health" work stream identified in the *Hounslow Joint Commissioning Strategy for Older People 2007-2010*. This proposed the production a local falls strategy, the development a specialist falls service to be integrated within intermediate care and the provision of basic falls awareness training to a broad range of staff, including primary and secondary health care staff, adult social care and independent sector providers. GPs, practice staff and contracted care providers.

2.9 This strategy makes reference to but does not cover:

- the prevention and treatment of osteoporosis specifically
- the management of hip and other fractures
- the prevention of falls in general acute and mental health settings.

The latter is addressed under the risk management regimes in Trusts, in accordance with their "slips, trips and falls policy".

### 3. Needs Analysis

#### Population projections

- 3.1 The risk of falls and osteoporosis is strongly correlated with age. It is known, for example, that the prevalence of osteoporosis in men in the older population is 6% for 60-69 year olds, 14% for 70-79 year olds and 24% for those aged 80 and over. For women the figures are 14%, 37% and 61% respectively.
- 3.2 The UK population is becoming older with the number of people aged 65 and over is projected to increase by over 2 million (30%) between 1996 and 2021. The number aged 75 years and over is set to rise to over 2 million and those over 85 years to 470,000 by 2026.
- 3.3 Hounslow's age profile is markedly different from that for the country as a whole. The Office of National Statistics (ONS) data shows a decrease in the number of older people in the Borough since 2001, which they predict will continue for some years to come.
- 3.4 However, the latest GLA projections, using a different methodology, show a somewhat different picture, as can be seen in the **Table 1** below:

	2008	2011	2014	2017	2020
<b>65-74</b>	12,920	13,196	13,968	14,030	15,165
<b>75-84</b>	8,283	8,409	8,639	8,543	8,658
<b>85+</b>	3,244	3,485	3,639	3,858	4,022
Total	24,447	25,090	26,246	26,431	27,845

The GLA predicts that between 2008-11 in the London Borough of Hounslow there will be:

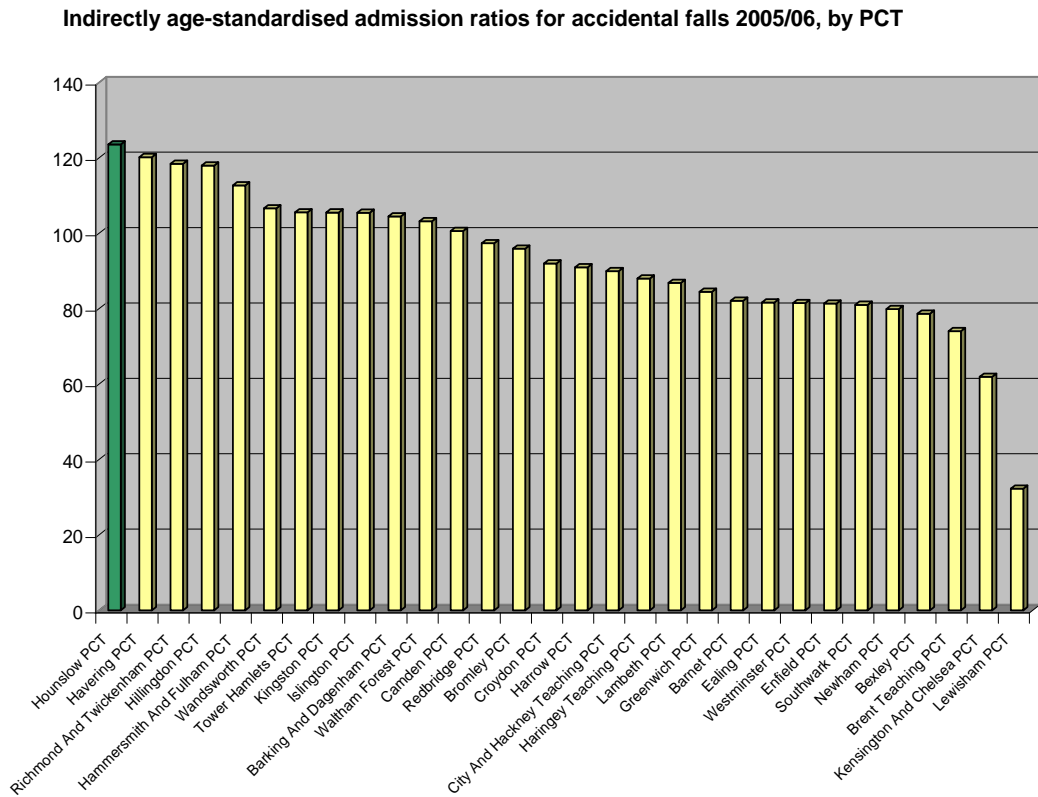
- 276 (2.1%) more people aged 65-74
  - 126 (1.5%) more people aged 75-84
  - 241 (7%) more people aged 85+ :
- 3.7 According to the 2001 Census, West Area had the highest proportion of over 65s in the Borough. Recent ward projections show Chiswick has a considerably higher proportion of people aged over 85.
- 3.8 The predicted increase in the number of older people in the Borough will result in an increase in the number of people suffering falls and fractures unless there is a concerted effort to prevent such falls.

Services will need to be ready to respond to this predicted growth in the number of people injured by falls.

### Falls in Hounslow

- 3.9 Prevalence of falls within Hounslow is very high. This is indicated by admission rates for accidental falls, which in 2005-06, were the highest of all London PCTs.

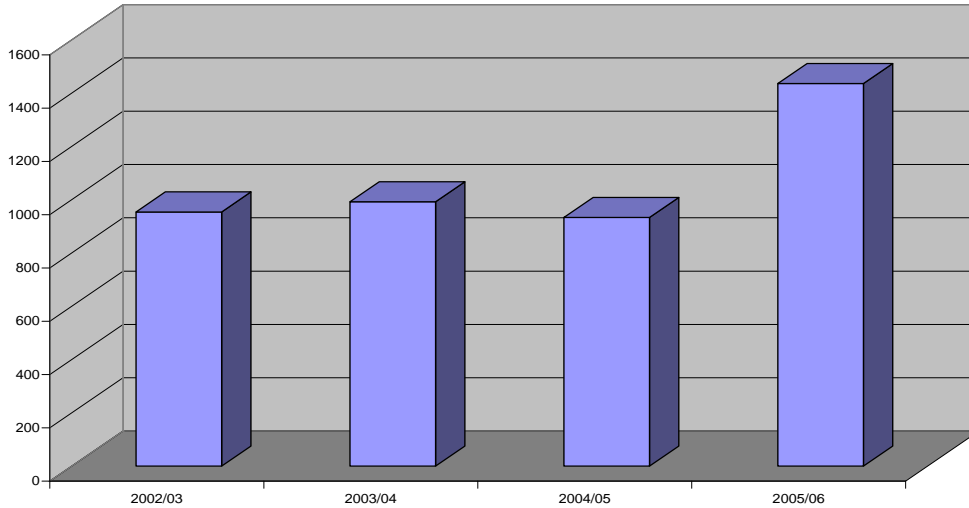
**Graph 1 Indirectly age-standardised admission ratios for accidental falls 2005/06, by PCT**



- 3.10 The rate of falls is also increasing significantly. **Graph 2** shows that accidental falls leading to admission in Hounslow have increased by 49.6% since 2002. This increase represents approximately 500 additional falls related admissions, costing the PCT an estimated £1.5m for the hospitalisation. There is also additional health and care costs as people are frequently more dependent after discharge.

**Graph 2 Accidental falls in Hounslow leading to admission 2002 – 2006**

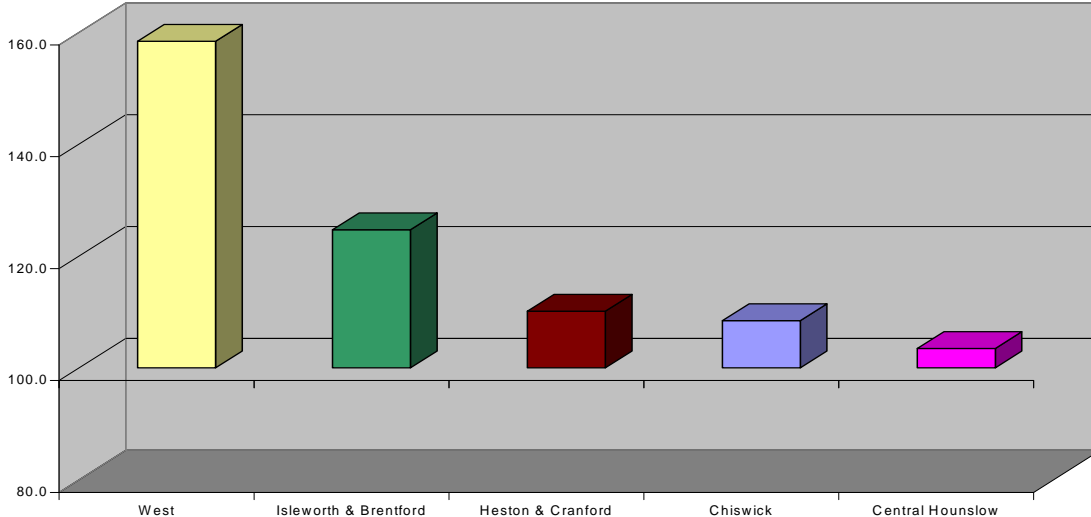
Accidental Falls leading to Hospital Admission, Hounslow PCT (2002/06)



3.11 **Graph 3** indicates that a very high proportion of admissions due to falls are from West area.

**Graph 3. Indirectly age- standardised admission rates for accidental falls 2005/06 by Area.**

Indirectly age-standardised admission ratios for accidental falls 2005/06, by Area



3.12 An analysis of admissions into West Middlesex University Hospital between April 2007 and September 2008 of older people with a condition (HRG) related to a fall or risk of future falling (such as neck of femur fracture) indicates the prevalence of serious falls and the cost implications of treating such falls.

**Table 2. Summary of admissions to WMUH of older people with a falls related condition April 2007- September 2008**

	65-74	75-84	85+	Total Admissions	Total bed Days
<b>Total Admissions</b>	63	80	65	208	3,592
<b>Average per month</b>	3.5	4.4	3.6	11.6	199.6

- 3.13 A further indication of the prevalence of falls is given by the London Ambulance Service (LAS). **Table 3** below indicates that in 2008 the London Ambulance Service attended an average of 145 incidents per month involving older people falling in Hounslow.

**Table 3. Hounslow PCT falls of people 65 years and over with London Ambulance Service attendance January – June 2008**  
(Source: London Ambulance Service)

Month	LAS calls
January	163
February	134
March	127
April	130
May	161
June	155
<b>Total</b>	<b>870</b>
<b>Average per month</b>	<b>145</b>

### Impact of falls

- 3.14 People aged over aged 75 have almost five times the rate of accidental death of general population, having a death rate of 114 per 100,000 compared to 21 per 100,000 in all age groups. Falls, along with traffic accidents and fires, are the main causes of accidental death in people aged over 65. The most common location for accidental deaths among older people is their own home, with 1000 people dying each year as a result of a fall on the stairs.
- 3.17 Additionally, half of the people who suffer a hip fracture lose the ability to live independently and over 90% of hip fracture patients die within one year of the fracture (Eddy 1998).

## 4 Good Practice

Three key documents set the standard for best practice in the management of falls among older people.

### **The National Service Framework for Older People**

- 4.1 The National Service Framework for Older People (2001) identified the need for the NHS to work in partnership with councils to take action to prevent falls and reduce the resultant fractures or other injuries in their populations of older people and to ensure effective treatment and rehabilitation for those who have fallen through a specialised falls service. Health and social care organisations were required to their current procedures, put in place falls risk management procedures and put in place an integrated falls service by 2005.
- 4.3 The NSF proposed the following interventions:
- prevention, including the prevention and treatment of osteoporosis
  - provision of information, advice and support
  - specialist falls service within specialist multi disciplinary and multi agency services for older people to work with those at high risk of falling
  - encouragement of appropriate weight-bearing and strength enhancing physical activity
  - promotion of healthy eating (including adequate intake of calcium)
  - smoking reduction
  - good pavement repair and street lighting
  - making properties safer
  - improving the diagnosis, care and treatment of those who had fallen
  - rehabilitation and long- term support.

### **Clinical Guideline on the Assessment and Prevention of Falls in Older People.**

- 4.4 The National Institute for Clinical Excellence (NICE) published clinical guidelines on the assessment and prevention of falls in older people for use in the NHS in England and Wales. The guidelines, published in 2004, give recommendations for good practice based on the best available evidence of clinical and cost effectiveness. Its

publication had the effect of updating the National Service Framework for Older People.

- 4.5 The NICE guideline identifies five key priorities for implementation of a service for the assessment and prevention of falls in older people. These are described in the table below.

### **Key priorities for implementation**

#### **1. Case/risk identification**

- Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall.
- Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.

#### **2. Multifactorial falls risk assessment**

- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and /or balance should be offered a multi-factorial falls risk assessment. This assessment should be performed by healthcare professionals with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multi-factorial intervention.
- Multi-factorial assessment may include the following:
  - identification of falls history
  - assessment of gait, balance and mobility, and muscle weakness
  - assessment of osteoporosis risk
  - assessment of the older person's perceived functional ability and fear relating to falling
  - assessment of visual impairment
  - assessment of cognitive impairment and neurological examination
  - assessment of urinary incontinence
  - assessment of home hazards
  - cardiovascular examination and medication review

#### **3. Multi-factorial interventions**

- All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multi-factorial intervention.

- In successful multi-factorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):
  - strength and balance training
  - home hazard assessment and intervention
  - vision assessment and referral
  - medication review with modification/withdrawal.
- Following treatment for an injurious fall, older people should be offered a multi-disciplinary assessment to identify and address future risk, and individualized intervention aimed at promoting independence and improving physical and psychological function.

**4. Encouraging the participation of older people in falls prevention programmes including education and information giving**

Individuals at risk of falling, and their carers, should be offered information orally and in writing about what measures they can take to prevent further falls.

**5. Professional education**

All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.

- 4.6 Recommendations take account of the psychosocial aspects of falling, including fear of falling and loss of confidence that may result from a fall.

## 5 Current Services

5.1 The Council and the NHS in Hounslow both provide a range of services aimed at reducing and treating falls amongst older residents.

5.3 Council services include:

- care managers who undertake a risk assessment, which includes falls risks, as part of the comprehensive needs assessment and review
- care providers, in particular, in-house and independent sector home care providers also undertake risk assessments, including falls risks, in the users home, and their frequent contact with users enables them to monitor for falls and falls risks
- occupational therapists work with people to help them find ways of managing within their homes in spite of physical illness or disability. This also includes advice and assistance in managing falls risks
- “Footsteps” social foot care service commissioned from Age Concern in Hounslow. This is a nail cutting service set up with support from the NHS podiatry team
- promoting Healthy Lifestyles activities including exercise for older people in leisure centres run by the Borough’s leisure service provider
- Care and Repair and handyperson schemes, which can be used to rectify potential trip hazards in the home.

5.4 The **Community Rehabilitation Service (CRS)** provides:

- a mobility clinic at the Heart of Hounslow Centre for Health. Six to eight new patients are seen each clinic day for assessment and interventions including mobility aids and exercise. Follow-up support is provided at home when required. The mobility clinic has helped to reduce the CRS waiting list and provides quicker access for people needing mobility assessment and aids. It has helped reduce the risk of falls whilst the person waits for home assessment/intervention by the CRS
- home visits to around 150 people per year who have fallen, to improve their level of safety
- support to day centres in managing clients with mobility problems
- mobility equipment and advice on reducing the risk of falls.

## 5.5 Additional services include:

- Community Matrons, who visit patients needing complex case management who have had more than two falls in the previous two months;
- a weekly Falls Clinic at West Middlesex University Hospital, which is run by a consultant ortho-geriatrician and the falls nurse practitioner. The clinic keeps a register of admissions due to fractured neck of femur and provides regular training to WMUH clinical staff;
- Approximately 2000 people benefit from a pendant alarm provided by Linkline which enables them to summon help should they fall. Of these, approximately 74 have additional telecare sensors. Twenty seven people are provided with equipment to manage a falls risk specifically e.g. bodily worn falls detectors, wall mounted panic buttons or bed occupancy bed sensors. Not only does this equipment enable people to summon help quickly should they fall, it increases their confidence (and that of their families) in their ability to manage at home following a fall.

5.6 There is scope to further improve the effectiveness of these services by ensuring they are well co-ordinated and consistently delivered.

### **Past Falls Initiatives**

5.7 There have been a number of local time-limited initiatives to promote falls prevention. This strategy proposes to build on those initiatives and the lessons learnt from them.

5.8 The joint finance **Prevention of Falls in Older People Research Project**, which ran between 1999-2002, looked at the prevention of falls in older people. The project team, consisting of a Project Lead (a physiotherapist), a senior physiotherapist, a senior occupational therapist and a senior podiatrist, devised a rehabilitation programme for people who fell or were at risk of falling. The programme consisted of 12 two hour sessions together with an initial assessment and two reviews. The sessions included:

- group exercise to improve balance, strength and function
- discussion and group activities on hazards found in and outside the home and how to overcome them
- discussion on foot health, footwear and podiatry (chiroprody) treatment if necessary.

The project demonstrated that exercise and education improve the ability of the users to perform daily activities. Standardised tests showed a general improvement in the maintenance of strength,

balance and function in the majority of clients and an increased awareness of the suitability of different footwear. Participants demonstrated a greater understanding of the hazards both inside and outside the home. The project highlighted the need to target people with mental health needs and those from black and ethnic minority groups. It recommended the appointment of a **Falls Clinical Practitioner** to provide advice, education and clinical support to both professionals and residents in Hounslow and to address the need for rehabilitation, maintenance of function and the prevention of falls.

- 5.9 The **Falls Strategy Group**, which included NHS Hounslow, West Middlesex University Hospital, London Borough of Hounslow and London Ambulance Service, was set up in 2001. It provided a co-ordinated approach to falls issues for several years. It began the development of a falls pathway, which will be implemented as part of this strategy. It is proposed that this group be re-established to implement the new strategy.
- 5.10 In August 2002 the West London Health Promotion Agency carried out a **Falls and Injury Prevention Audit** to establish a baseline of the falls/injury prevention work being undertaken at that time. A survey of statutory and voluntary organisations, undertaken as part of the audit, highlighted the following priorities for development:
- the provision of practical advice on falls and injury prevention in various languages and formats
  - the establishment of exercise groups
  - that an OT assessment of the older people's environment be a standard element in the over 75 check.
- 5.11 An **Independent Living and Training Co-ordinator**, employed by the Council until July 2009, has promoted falls prevention in the following ways:
- providing information and advice on the prevention of falls and osteoporosis including information on footwear/care, medicine management, osteoporosis, risks and hazards around the home, diet, exercise to various groups and events
  - by providing falls awareness training for local residential and nursing homes, community groups and for the general public on Falls Awareness Day
  - Devising training programmes for the general public, paid care staff and professional staff in NHS Hounslow and the West Middlesex University Hospital. (WMUH). This was provided free to all nursing/ residential care homes across the borough and the voluntary/ independent sector, sheltered housing, community and social groups, WMUHT and PCT staff. It was offered to all adult groups not just older people

- producing the booklet '*Staying Healthy, Staying Active*' that covers information on how to keep physically and mentally active, exercise, healthy eating, health checks, medicines and keeping safe in the home
- creating the website [www.stayactive.org.uk](http://www.stayactive.org.uk), an online directory of social and leisure opportunities in Hounslow which includes falls related information and advice. This includes a link to Hounslow Age Concern Handyman service.

5.11 This new strategy builds on the lessons learnt and the services developed by these earlier initiatives.

## 6. Gap Analysis

- 6.1 In order to identify priorities for development current falls services were assessed against:
- NICE guidelines
  - The Royal College of Physicians *National Audit of Services for Falls and Bone Health of Older People (2009)*
  - User feedback.

### 6.2 NICE Guidelines

The following is an assessment of Hounslow falls services against NICE guidelines.

	NICE requirements on falls	Current provision in Hounslow
1.	<b>Periodic case finding</b> from healthcare professionals.	Hounslow does have a risk register(s) for falls and case finding is not planned. Case finding is done at National Falls Awareness Day, at the Day Centre Project (physiotherapy advice to day centre's on mobility and falls prevention), and general awareness raising work by the Independent Living and Training Coordinator appointed by the local authority.
2.	Use of <b>"Get up and go test"</b> to assess gait and balance.	This is used as part of a battery of tests for the balance group but is in itself not sufficient to identify the risk of falls.
3&4	<b>Falls Clinics:</b> Full evaluations for those who have required medical attention after a fall, or who have abnormalities of gait and /or balance, or who fall frequently.	There is a Falls Clinic run at WMUH by a Consultant Physician in Elderly Care and a Falls Specialist Nurse – referrals are from GPs to Consultant and usually for people with complex medical presentation. – there is no therapy linked to this clinic. Clinic running ½ day per week, currently has 2 months waiting list.
5.	<b>Exercise programmes:</b> successful programmes are typically of more than ten weeks duration with the evidence of benefit being strongest for balance training (with Tai Chi a promising but, as yet, unproven methods). Exercise needs to be maintained for sustained benefit.	The Community Rehabilitation Service (CRS) is currently providing individual exercise programmes for people who are at risk of falls or have fallen. A Balance Group with an 8 session programme over a 3 month period (evidence based) combined with individual programmes and home exercises started in January 09.  There is an exercise class for high-ability patients at the "Indiana

		Gymkhana Club" in Osterley (funded by LBH).
6.	<b>Environmental modification:</b> this has greatest benefit when older patients at increased risk of falls are discharged from hospital. Environmental modification without other interventions has no proven benefit.	This is done by hospital OTs prior to discharge, on referral by OTs of the Community Rehab Service or Able 2 (LBH).
7.	<b>Medications:</b> Patients who have fallen should have their medications reviewed, modified or stopped as appropriate in the light of the risk of future falls. Particular attention should be paid to older persons taking four or more medications and to those taking psychotropic medications.	Some medications can have a deleterious effect on bone mineral density (e.g. prednisolone) and many can have an effect on the central nervous system more likely (e.g. sleeping tablets making a person unsteady on their feet). Work was undertaken locally on medicines reviews 4 or 5 years ago (including an audit with most GP practices of over 75s). One problem is the different interpretation that can be put on medication review e.g. with/without the patient being present. Findings included the view that dosage instructions on the medicine label are sometimes inadequate so that neither the patient nor carer has access to the correct dosage information; as many as 50% of older people might not be taking their medicines as intended. No initiatives at present. The new GMS contract had two organisational indicators concerning medication review included in the Medicines Management section.  An audit of calcium and vitamin D in care homes commenced in 2006 but was not completed with a final report.
8.	<b>Assistive devices:</b> assistive devices bed alarms, canes, walkers, hip protectors etc) are effective elements of a multifactorial programme. HIP protectors do not reduce the risk of falling but the evidence supports their use to prevent hip fractures in very high – risk individuals.	CRS provide mobility equipment and information on safety devices like link-line. Social worker arranges telecare where needed GPs do not provide hip protectors because compliance rate is low; patients may be advised to buy their own, if they wish.

9.	<b>Cardiovascular intervention:</b> cardiac pacing should be considered for older people with cardio inhibitory carotid sinus hypersensitivity that has experienced unexplained falls.	
10.	<b>Visual Intervention:</b> Patients should be asked about their vision and, if they report problems, their vision should be formally assessed, and any remedial visual abnormalities should be treated. Those with poor vision are not only more likely to fall; they are also more likely to suffer fractures as a consequence.	This should be part of general holistic care; patients will be advised to contact their GP for a referral to an optician.
11.	<b>Footwear interventions:</b> although there seem to be no experimental studies relating falls to footwear, some trials report better balance and reduced sway through improved footwear.	The Podiatry team and the CRS therapists provide advice on suitable footwear. Awareness raising sessions arranged by the Independent Living and Training Coordinator appointed by the local authority.
12.	<b>Oral and written information</b> should be available for those at risk of falling and their carers.	The CRS currently does not have local information on falls but is using a leaflet by "Help the Aged" for this. There will be a booklet developed as part of the balance group.
13.	Maintenance of <b>basic competences</b> among health professional dealing with those at risk of falling.	CRS had an internal training session this year; there was a lunch-and-learn session at WMUH on Falls and Osteoporosis within the last 2 years.

### 6.3 Royal College of Physicians Organisational Audit 2008: Hounslow's Position

The Royal College of Physicians *National Audit of Services for Falls and Bone Health of Older People (2009)* assessed services against six domains with indicators of best practice within each domain. The 2008 return for Hounslow, which was predominantly completed from the point of view of the PCT's provider arm community rehabilitation team, suggests that Hounslow were falling short on the following indicators:

<b>1.</b>	<b>Strategies and Commissioning</b> <ul style="list-style-type: none"> <li>• medication reviews for care home residents</li> </ul>
-----------	--

	<ul style="list-style-type: none"> <li>• consideration of patients within mental health services</li> <li>• reporting on non hip related fragility fracture rates and the rate of serious injury or fractures sustained by patients of acute or mental health services</li> <li>• a service level agreement or contract which specifies details of hip fracture patient management</li> <li>• a service level agreement or contract specifying details of case finding secondary prevention after a fragility fracture</li> <li>• a mechanism at PCO level for assessing whether primary care treatment for people who have a fragility fracture is provided in accordance with TAG 87</li> <li>• a PCO agreement for added incentives for primary care compliance with NICE guidance</li> <li>• availability to PCO of information on care home resident falls and a register of older people that fall in care homes.</li> </ul>
<b>2.</b>	<p><b>Case Finding and Referral</b></p> <ul style="list-style-type: none"> <li>• implementation and comprehensive usage in the community for older people of a first level screening tool</li> <li>• identification by the tool of those who have had a fragility fracture or are at risk of osteoporosis</li> <li>• triggering and directing by the tool of further assessments according to a locally agreed falls pathway.</li> </ul>
<b>3.</b>	<p><b>Structure and Staffing</b></p> <ul style="list-style-type: none"> <li>• a local coordinated , integrated, multi- professional and multi agency falls service</li> <li>• referral links to medical consultants from PCT provider arm clinics without trained medical staff</li> <li>• a falls service coordinator.</li> </ul>
<b>4.</b>	<p><b>Specialist Falls Management</b></p> <ul style="list-style-type: none"> <li>• a multi- factorial falls risk assessment tool specifying the individual components and assessing for fracture risk or osteoporosis risk factors, vision impairment, urinary pattern including incontinence, orthostatic hypotension, cardiac causes of syncope including routine ECG recording, documentation of medicines</li> <li>• use of a validated home hazard assessment</li> <li>• written intervention plans for handing to patients.</li> </ul>
<b>5.</b>	<p><b>Service settings</b></p> <ul style="list-style-type: none"> <li>• service for care homes including signposting of when to refer to primary care teams, how to undertake critical incident analysis following a fall, how to identify falls risks to minimise future incidents.</li> </ul>
<b>6.</b>	<p><b>Training and Audit</b></p>

- |  |  |
|--|--|
|  | <ul style="list-style-type: none"><li>• comprehensive training coverage audits to assess aspects of the falls service.</li></ul> |
|--|--|

#### 6.4 Key messages from patients and users

*"People's Experiences of Falls and Bone Health Services"* was a joint public involvement project commissioned by the Healthcare Commission, Healthcare Quality Improvement Partnership and Help the Aged. The project aimed to gather patients' views and experiences and make recommendations. The final report was published in September 2008.

##### **Key messages:**

- participants were often unaware of what falls services were available, how referral took place and how they related to other primary and community services
- participants often thought that their GPs were probably not aware of these services
- some participants felt that the name *"falls clinic"* was odd and off putting and open to misinterpretation
- most participants reported having experienced a thorough assessment but some were not aware of the outcomes or conclusions or of their right to ask for the results
- on the whole, participants reported their attendance at falls clinics to have been a positive experience, highlighting both physical and psychosocial benefits
- they considered their thorough health assessment or "MOT" to be an added benefit, but it was generally unclear to them how the assessment outcomes were used to develop individualised management plans, or how interventions might reduce their own falls risk
- The range of interventions experienced by participants reflects many of those recommended in the NICE 2004 guidelines e.g. strength and balance training, home hazard and safety intervention, medication review, dietary advice and where patients can seek further advice
- Some participants found the experience of falling very frightening with fear of recurrence affecting their confidence and they appreciated the chance to reflect on this as part of the focus group discussion
- Once participants had accessed falls services few had any negative comments on the treatment provided except some issues with regard to the lack of reliable transport and the wish for longer term follow –up in group settings.

6.6 The next section outlines how the strategy proposes to address the limitations and implement best practices as highlighted above.

## 7. Future Services

7.1 The strategic **vision** is that all people at risk of falling and sustaining fractures and injuries:

- know of this risk and what they can do to minimise it
- are supported by health and social care staff to minimise the risk
- receive timely, good quality treatment and care should they sustain a fracture or injury through falling
- are rehabilitated to their pre-fall level of health and well-being or even better
- are provided with services irrespective of their gender, ethnicity, culture or disability
- have their right to make choices and take risks respected.

7.2 The strategy **aims** to ensure that:

- people in contact with potential fallers have the ability to identify those at risk of falling and refer them to appropriate services, using a simple, locally agreed assessment tool
- all those identified as at risk of falling have timely access to a seamlessly integrated local care pathway
- the people who are the first point of contact for users respond in accordance with locally agreed protocols and referral criteria
- There is a raised awareness on how to prevent falls by improving the environment in which those at risk are living.

7.3 The strategy's **objectives** are to:

- encourage more people, especially older people, to enjoy healthier lifestyles, with physical activity, a good balanced diet and an adequate intake of calcium and vitamin D, while avoiding excessive alcohol, and not smoking
- identify people at risk of falling
- modify the risk factors by, for example improving the person's sight, gait, balance, environment and medication
- reduce the number of falls resulting in serious injury and ensure effective treatment and rehabilitation of those who have fallen
- ensure consistent, systematic and effective falls risk management in all care settings
- set up and monitor systems and processes that effectively link professionals, users and carers to prevent falls and improve services.

- 7.4 The Strategy aims to achieve the following **outcomes**:
- a reduction in falls and associated injuries and fractures
  - a reduction in the number of falls related admissions into acute care
  - risk assessments are comprehensive and well coordinated
  - there is an effective integrated care pathway
  - partnership working is improved
  - prevention and rehabilitation services are effective and provided to a high standard
  - patient satisfaction and wellbeing is increased
  - acute, community health and social care costs are reduced.
- 7.5 The implementation of this strategy will require effective multi-agency working drawing on a broad range of statutory and independent sector organisations.
- 7.6 Hounslow's integrated response to the issue of falls will focus on prevention, early identification of potential fallers, rehabilitation and the longer term support of fallers.

Key actions in relation to each of these are summarised below.

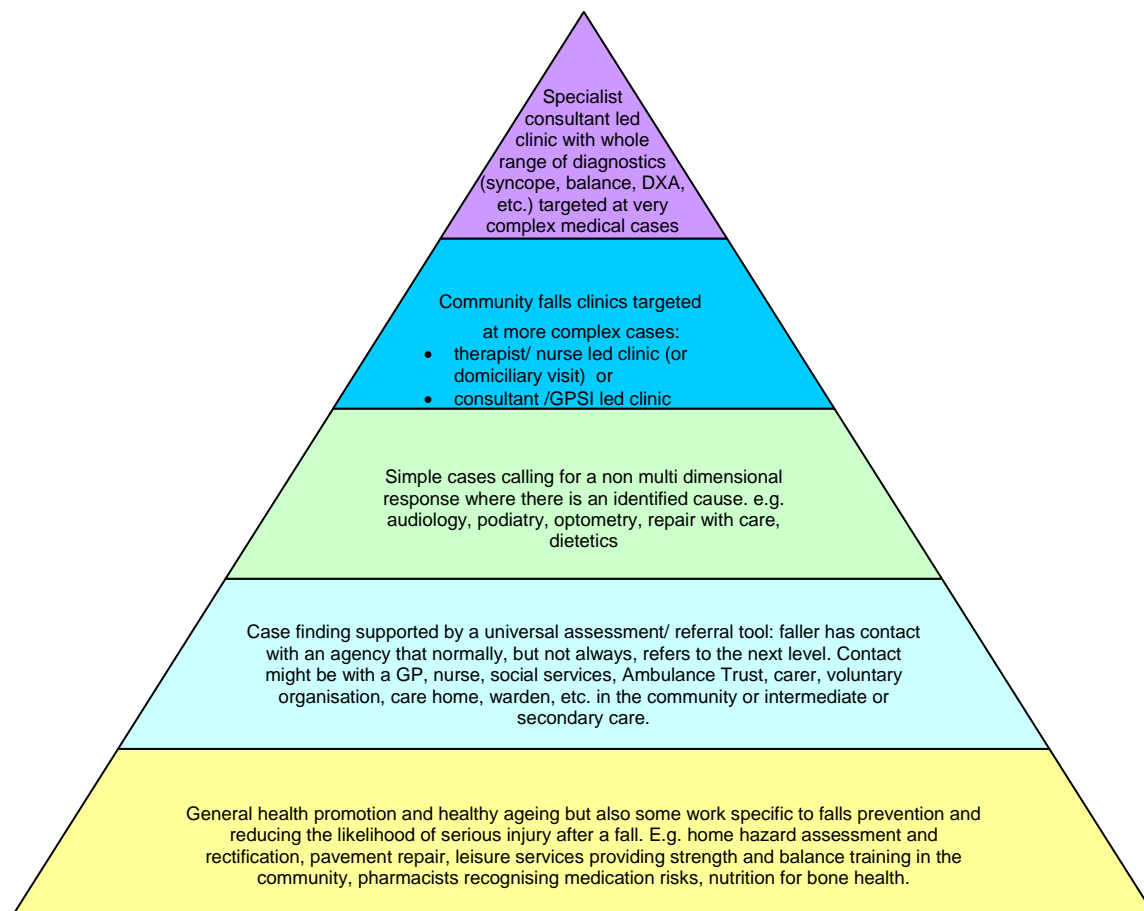
<p><b>Preventing falls</b></p> <ul style="list-style-type: none"> <li>• ensuring the latest advice on best practice and services is made available to all interested parties</li> <li>• ensuring the physical environment both inside and outside the person's home is made safe by identifying and reducing risks</li> <li>• promoting healthy lifestyles, including physical activity.</li> </ul>
<p><b>Identifying potential fallers</b></p> <ul style="list-style-type: none"> <li>• changing people's attitudes towards and fear of reporting minor falls</li> <li>• introducing standardised screening tools for use by all in contact with potential fallers</li> <li>• osteoporosis screening and treatment</li> <li>• regular incident reporting and monitoring.</li> </ul>
<p><b>Treatment and long term rehabilitation</b></p> <ul style="list-style-type: none"> <li>• developing a clearly defined integrated care pathway for falls, which ensures that fallers and potential fallers are offered the support and assistance they need to regain or maintain their independence</li> <li>• this pathway should ensure equitable and timely access to both acute and community based services</li> <li>• ensuring that all fallers and potential fallers are aware of the help that is available and know how to get this help</li> </ul>

- reviewing the medication taken by people at risk of falling to identify any medication that may be contributing to the tendency to fall. Where indicated, prescribing medication to promote bone strength, such as calcium and Vitamin D supplements, to high risk individuals
- offering those at risk frequent health checks by their GP or specialist nurses to ensure the early diagnosis of new problems
- monitoring and reviewing services to ensure they continue to meet the person's needs.

7.8 The advantages of establishing a well publicised central referral point for falls has been demonstrated elsewhere. The feasibility of establishing such an access point in Hounslow will be investigated as part of this strategy.

### The Proposed Model

7.9 The development of an effective falls service in Hounslow that meets NICE guidelines and local need requires the integration and coordination of existing and future components and an expansion in service capacity. The proposed model is summarized in the “triangle of care” below.



Service developments are conceptualised across five levels in the shape of a triangle. This illustrates the fact that there will be fewer patients or clients, the higher one progresses up the levels. The model is a rehabilitative one, seeking to move patients or clients back down the levels wherever possible.

**7.10 Level One** is the broad health promotion and falls prevention work that takes place within the community including the promotion of healthy lifestyle, diet and exercise programmes and environmental improvement. This is provided by such as:

- **housing agencies** undertaking home hazard assessments
- **leisure services** providing strength and balance training in the community
- **pharmacists** recognising medication risks, etc. Many of the medicines prescribed for older people for very good reasons may contribute to falls so ensuring that patients are on the right medicines may reduce the risk of falling. Smoking cessation service (smoking increases the risk for hip fractures by up to one and a half times) and
- **sensible drinking educationalists** - reducing the heavy drinking of alcohol will lessen the risk of falling and of osteoporosis)
- **GPs**; the diseases that affect the cardiovascular, neurological, or musculoskeletal systems can increase an older person's risk of falling. Therefore ensuring that these are well treated and managed can reduce the risks of falling
- **homecare and residential home providers**
- **care managers.**

**7.11 Level two** relates to the screening of groups of older people to identify those at high risk of falling or fracture. Case finding is used to open the way for preventative work with those who have slipped or tripped without injury ("near misses") and have not reported the occurrence and with those who have sought help following minor injury. An older person will fall an average of five times before sustaining a fractured neck of femur. This gives a window of opportunity to minimise environmental risks and develop the range of people who may be in a position to identify those at risk of falling, e.g. a home carer, London Ambulance Service, a district nurse, a General Practitioner, a sheltered housing warden, voluntary sector employee, a pharmacist and so on. It is important that they all understand the importance of identifying those at risk of falls and the process for ensuring these risks are addressed.

7.12 The person who first identifies a potential faller would ideally have the knowledge and skills to identify easily resolved causes of the fall/ near miss and triage the person to an appropriate professional

where the need is more complicated i.e. to **Level three**. For example, a pharmacist may initiate a medication review. A GP may make a referral to optometry. A district nurse may identify postural hypotension and refer the faller to the GP. A housing manager might ensure that proper lighting is introduced to a poorly lit property.

7.13 **Levels four and five** call for triaging of patients for specialist assessment to either a nurse/ therapist led clinic, a consultant or GPSI (GP with a special interest in falls) led community based clinic with access to some diagnostic equipment or a specialist clinic with a full range of diagnostics for complicated medical cases. This would trigger therapeutic and practical interventions that could significantly reduce the risk of future falls. For example, an assessment by a physiotherapist could lead to a targeted strength and balance training programme while occupational therapist interventions might include adaptations that allow the faller to remain independent in their own homes.

7.14 Patients who

- fall recurrently, or
- require medical treatment after a fall, or
- demonstrate gait and balance problems, or
- who fell after a loss of consciousness, or
- fall as a result of complex medical cause

would be referred into **Level Five**, the specialist falls clinic. This can offer a comprehensive multi-factorial (including medical) assessment and trigger various forms of treatment and interventions.

7.15 Finally, some fallers will require specialist interventions provided within, for example, syncope, balance or audiology clinics.

7.16 It is proposed that a new integrated falls pathway be developed to support the operation of this care model (**see Appendix 1**) Further work will be undertaken to develop systems, protocols and staff skills needed to make the pathway work effectively. Where gaps or lack of capacity in the pathway are identified a business case will be made to secure any additional resources required.

7.17 In developing a new integrated falls pathway, consideration would be given to:

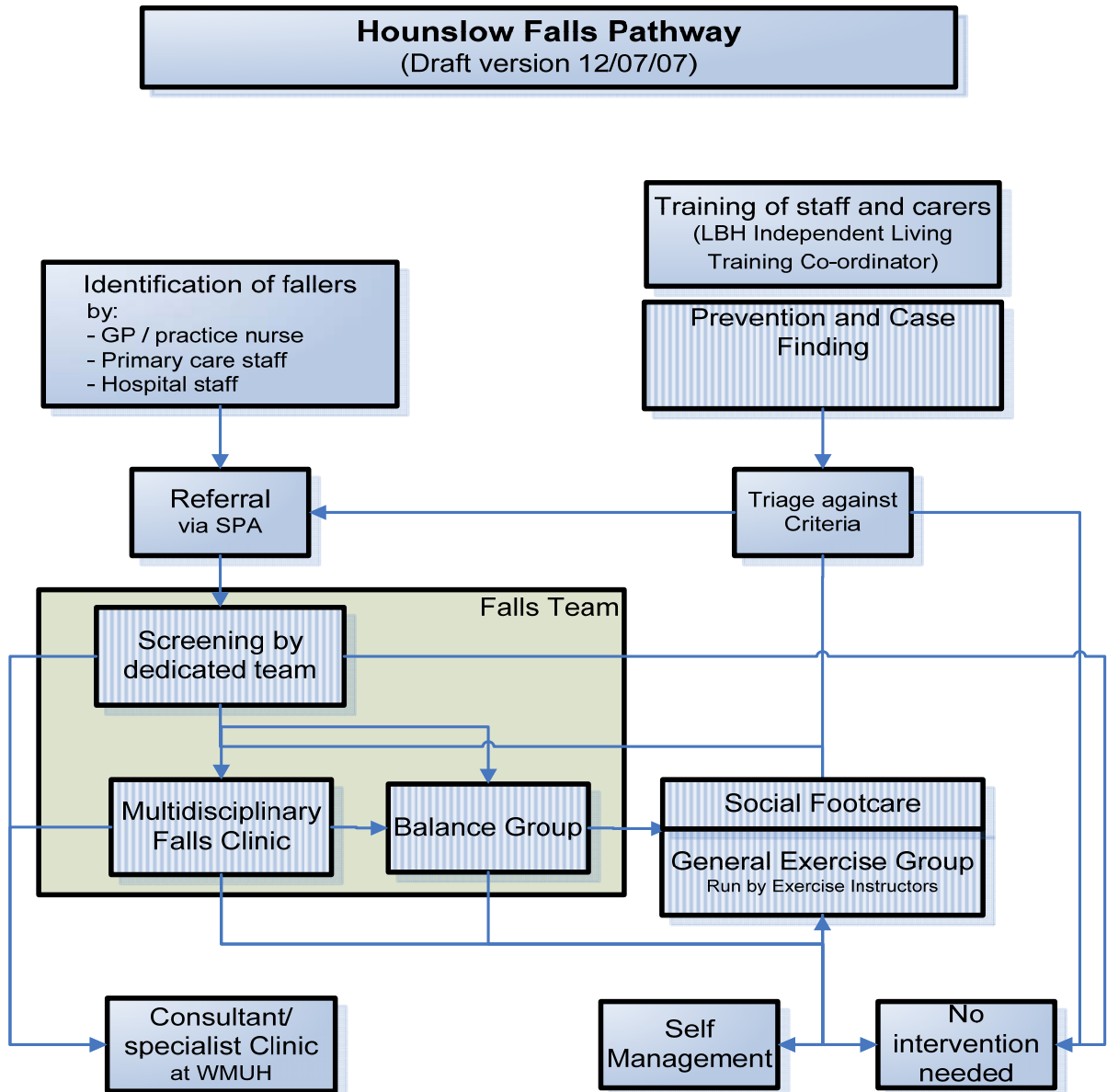
- the need for a falls coordinator to develop and support the care pathway and ensure effective integration of the different services involve

- the establishment of a central referral point to facilitate access and manage demand
- the adoption of a shared falls assessment tool
- the establishment of systems to enable proactive “case finding” of people who have fallen or are at risk of doing so
- working with contracted domiciliary and residential/nursing home providers to ensure they have effective policies and procedures in place to manage falls
- working with the London Ambulance Service to ensure that fallers are triaged to the most appropriate part of the care pathway, which may not be Accident and Emergency
- the establishment of falls registers, e.g within residential and nursing homes, hospital in-patients and primary care
- the capacity and ease of access to the services offered in “falls clinics”
- the capacity and ease of access of strength and balance training opportunities
- processes to trigger a review of medication where this may contribute to the person’s falls
- the provision of training and information on initial falls assessment, falls pathways, protocols etc for all in contact with older people
- the involvement of mainstream services, such as pavement repairs, transport, leisure, in supporting the prevention of falls
- the need to establish rigorous monitoring and evaluation procedures to demonstrate the effectiveness in delivering strategic outcomes.

## **8. Conclusion**

- 8.1 This strategy reviews the current provision of fall services in the London Borough of Hounslow and proposes a strategic approach to addressing shortfalls by increasing the coordination, cohesiveness and comprehensiveness of falls services with the objective of reducing the number of falls amongst older people and their consequences. The strategy will build on existing initiatives and seek service improvements by improving the skills of staff and the co-ordination of services as part of an integrated care pathway. In the longer term it proposes making the case for invest to save initiatives which would increase local capacity to assess and treat the greater numbers of potential fallers identified through more robust case finding. Implementation of good practice with respect to preventing osteoporosis remains a related but separate strategic area.

# Appendix 1. Draft integrated falls pathway



## Appendix 2: Action Plan

Item	Action	Completion date
1	Re-establish the Falls Strategy Group as the multi-agency body responsible for leading the implementation of the strategy.	Sep-09
2	Agree an integrated falls care pathway.	Nov-09
3	Develop operational policies, protocols and systems to support the pathway.	Feb-10
4	Assess current services and resources in relation to the integrated care pathway to indentify gaps and lack of capacity.	Mar-10
5	Set up systems to monitor the local incidence of falls, to provide a basis for evaluating the impact of the strategy, to help identify patterns and address issues, and to help assess the business case for any additional resources that may be required to improve the effectiveness of the care pathway.	Dec--09 /on-going
6	Include any funding proposals for additional coordination, preventative, assessment and rehabilitation capacity in PCT/Community Services commissioning intentions for 2010/11 and subsequent years.	Sept-09/ongoing
7	Support initiatives to prevent falls among the wider population, for example, by promoting falls risk awareness, encouraging the assessment and reduction of falls risks inside and outside the home, and encouraging active and healthy lifestyles.	2010/11 & ongoing
8	Encourage and support proactive case finding in acute and community settings, including residential and nursing care and supported housing.	Apr-10
9	Agree a simple falls risk assessment tool, and encourage its' widespread application among frontline staff in the statutory, voluntary and private sector to ensure the early identification of people at risk of falling.	Apr-10

10	Pilot the use of risk registers in different settings to assess their usefulness, with a view to extending their use across the health and social care community.	Jun-10 and ongoing
11	Establish procedures for ensuring a medication review when medication may be a contributing factor to the user's risk of falling.	Apr-09
12	Develop an on-going training programme to develop and share skills of everyone involved in the care pathway. Encourage professional dialogue between people contributing to different sections of the pathway to facilitate the effectiveness of the pathway and the exchange of skills and best practice.	2010/11 & on-going

