Falls Strategy for East Berkshire

Creating an Integrated Falls Service

"Reducing the number of falls that result in serious injury and ensuring effective treatment and rehabilitation for those who have fallen" **(***National Service Framework for Older People: Standard Six***)**

Creating an Integrated Falls Strategy for East Berkshire

Executive Summary

Falls are a major cause of the loss of mental and physical well-being among older people. At the same time as promoting independence and active living, the primary aims of this strategy are to:

- Reduce the number of falls that affect older people
- Reduce the number of serious injuries that result from falls
- Reduce the fear of falling among older people

This document relates to East Berkshire and builds upon solid foundations. In particular, the local health economy was one of 20 national Healthy Community Collaborative sites that focused on falls prevention work. As a result, there are relatively high levels of awareness and a range of services already in place. These include:

- The falls clinic in Slough and fallers service at St Mark's Day Hospital
- Various programmes providing strength and balance training in the community
- Intermediate care teams with a strong rehabilitative focus
- A website managed by Berkshire Health Promotion that provides information to professionals, older people and carers (www.bhps.org.uk/falls)
- The hip protector project in certain care homes in Windsor, Ascot and Maidenhead
- Pilot schemes that have looked at, for example, improved prescribing for osteoporosis, fallers within A&E and referral protocols with the Royal Berkshire Ambulance Trust (RBAT)
- The use of in-patient falls risk assessment tools
- Falls groups within each locality

Nonetheless, there are significant variations in service provision across East Berkshire. So, one contribution of this strategy is to identify and address inequalities, as well as providing a coherent and consistent framework for falls and fracture prevention work both locally and at East Berkshire level.

Moreover, the strategy acknowledges the critical role that so many organisations have to play in this area, reflecting the multi-factorial causes of falls and the holistic approach that is often necessary to reduce their number. We therefore call upon individuals and agencies across all sectors to challenge themselves to see what they can contribute to the aims of this strategy.

Finally, we place older people at the centre of the strategy. They are in a great position to contribute to falls prevention work by, for example, insisting upon regular reviews of their medication, checking their home environment for hazards that might cause a fall, arranging regular check-ups of their eyes and by taking regular exercise that improves their strength and balance.

Consultation

This document was widely distributed in draft version. Stakeholders were given at least four weeks to respond and it was also discussed with local falls groups, the East Berkshire Older People's Strategy Group and at the stakeholder meeting that took place on 19th July (attended by over 70 people). Invitations for that event have already been distributed.

We were particularly interested in local views on the following questions:

1. Is the proposed referral form (FRAT Extra) clear and easy to use?
2. Are the referral criteria well-judged?
3. Are we right to invite referrals to two separate places (the falls programme and the falls clinics) or should they be sent to a single point?
4. How do we engender a wide sense of ownership of falls prevention among partner agencies?
5. Are the right structures in place to secure appropriate priority for work on falls prevention?
6. Are there any gaps in services that are not addressed by the strategy?

Comments were received from various sources, many of which are reflected in this final text. They included:

- The importance of effective risk assessment of fallers and appropriate ongoing management within acute and community bedded settings
- The need to simplify the referral form
- The suggestion that the *get up and go* test might be incorporated into the A&E assessment for onward referral to identify those most likely to benefit from comprehensive assessment
- The importance of pulling out key recommendations that can be understood by local providers
- The suggestion that the assessment tool is simplified
- The value of introducing a nurse specialist in the fracture clinic/orthopaedic wards to undertake case finding and advise on falls prevention
- The possibility of increasing our focus on fallers who attend A&E since they are likely to be at high risk of falling again
- The need to make sure that residential home staff are sufficiently confident to pick up uninjured fallers without having to call the ambulance, and to ensure that care home staff are well trained and can carry out risk assessments.
- That RBAT leaves basic falls prevention information with all fallers that they attend, which is locally targeted and describes available support

The feedback from the stakeholder event is reproduced in full on the East Berkshire falls prevention website at www.bhps.org.uk/falls

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This strategy was written by Anya Ryan and Graham Box. We would like to express our thanks to all those who guided and advised us.

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1. Introduction

Falls are among the most common and serious problems facing older people. They result from the interaction of multiple and diverse risk factors and situations, many of which can be corrected. Critically, older people themselves are often not aware of their risks of falling, nor do they report the presence of risk factors to others who might be able to help.

By introducing an integrated falls service for East Berkshire, we aim to reduce the number of falls and their seriousness. As osteoporosis increases the risk of an older person sustaining a fracture resulting from a fall, osteoporosis too must be targetted in a joint approach (See the National Service Framework for Older People, 2001). This will secure improved outcomes for older people, including greater independence and an improved quality of life. It will also reduce pressure on the NHS and social services.

This strategy begins by describing the current and forecast demographics for East Berkshire. The numbers of over 80s are increasing significantly and, although they are likely to be healthier than previous cohorts, the impact on falls prevention and treatment services is likely to be substantial.

It continues by presenting the national guidance in this area, notably that produced by the National Institute for Clinical Excellence (NICE). Local health and social care communities are expected to review their existing practice against these NICE guidelines. They are also required to consider the resources required for full implementation.

The fourth section describes current provision across East Berkshire where considerable progress has been made in recent years. Local variations remain, however, emphasising the relevance and importance of the vision for East Berkshire that is presented in Section 5. Once realised, this will ensure that the essential elements of a falls service are in place across the patch.

The strategy then looks at implementation, highlighting the need for careful development of the service to ensure that it is not overwhelmed by the sheer numbers of fallers. The closing sections reflect on resource implications, decision-making structures and offer summary conclusions.

We suggest that the development of a comprehensive falls and fracture prevention service is a good medium- to long-investment. The full benefits will require awareness raising with older people, continuing development of staff and enhancement of relationships between organisations.

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2. Demographics and epidemiology

The population estimates from the Office for National Statistics indicate that there were 47, 000 people aged 65 and over living in East Berkshire in 2003.

Locality	Over 65s ('000s): 2003
Bracknell Forest	12.9
Slough	13.7
Windsor and Maidenhead	20.8
Total	**46.9**

National data included within *How Can We Help Older People Not Fall Again (DoH, September 2003)* indicates that we would expect the following across East Berkshire in a single year:

- 16,000 over 65s will fall
- 8,000 fallers will be aged 80 or more
- 10,000 will sustain some sort of injury
- 1,700 will have major injuries or fractures resulting from falls
- 1000 will suffer fractures, including 350 hip fractures
- 1,600-3,200 may fall twice or more
- Each year approximately 2900 older people will seek care in A&E for falls related injuries and some 900 will be admitted
- Note that in 2004/2005, 3000 fallers contacted RBAT after a fall and were left on the scene having sustained no injuries

A dramatic increase in the population aged 65 and over is anticipated in the next 25 years, as described below. Without a concerted response, this will lead to a further rise in falls and fractures, though it is important to remember that our older population in the future may well be healthier than the current cohort. Figures are in thousands.

Locality	2003	2008	2013	2018	2023	2028
Bracknell Forest	12.4	12.9	14.9	16.7	18.5	20.7
Slough	13.7	13.7	14.3	15.2	16.8	18.7
Windsor and Maidenhead	20.8	21.3	23.3	24.8	26.1	28.3
Total	**46.9**	**47.9**	**52.5**	**56.7**	**61.4**	**67.1**

The consequences of falling

Older fallers suffer significantly higher rates of mortality. One in twenty patients who suffer a hip fracture will die during their stay in hospital and a 1995 study published in the British Medical Journal (Todd et al) indicated that 18% will have died within 90 days of the fracture. At the end of that same period, only one-quarter will be at home and entirely self-managing.

We also know that:

- 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
- 42% of fallers reduce activity after a fall

Risk factors for falling

The risk factors for falling are now well understood with the following table summarising findings across eleven variables. It indicates the relative risk in each case.

Risk Factor	**Mean Relative risk/odds ratio across 16 studies**
Muscle weakness	4.4
History of falls	3.0
Gait deficit	2.9
Balance deficit	2.9
Use of assistive device	2.6
Visual deficit	2.5
Arthritis	2.4
Impaired daily living activities	2.3
Depression	2.2
Cognitive impairment	1.8
Age > 80 years	1.7

Source: American Geriatric Society Panel on Falls Prevention, Journal of the American Geriatric Society, 2001

The risk of falling increases dramatically with the increase in interactions between risk factors. The Robbins study (see Arch Intern Med 1989) found that maximum predictive accuracy could be obtained by looking at (in algorithm format) just hip weakness, unstable balance and taking four or more medications. With this model, the predicted 1-year risk of falling ranged from 12% for persons with none of the three factors to 100% for persons with all three.

Risk factors for hip fractures resulting from a fall

The previous section looked at risk factors relating to falling. We also need to understand the risk factors associated with suffering serious injury as a result of falling. Here the critical element is susceptibility to osteoporosis. For example, 90% of hip fractures occur in older people with osteoporosis. Other, though not necessarily independent, factors are a previous low trauma fracture, maternal history of hip fracture, low body weight (BMI < 19), current smoking and use of corticosteroids.

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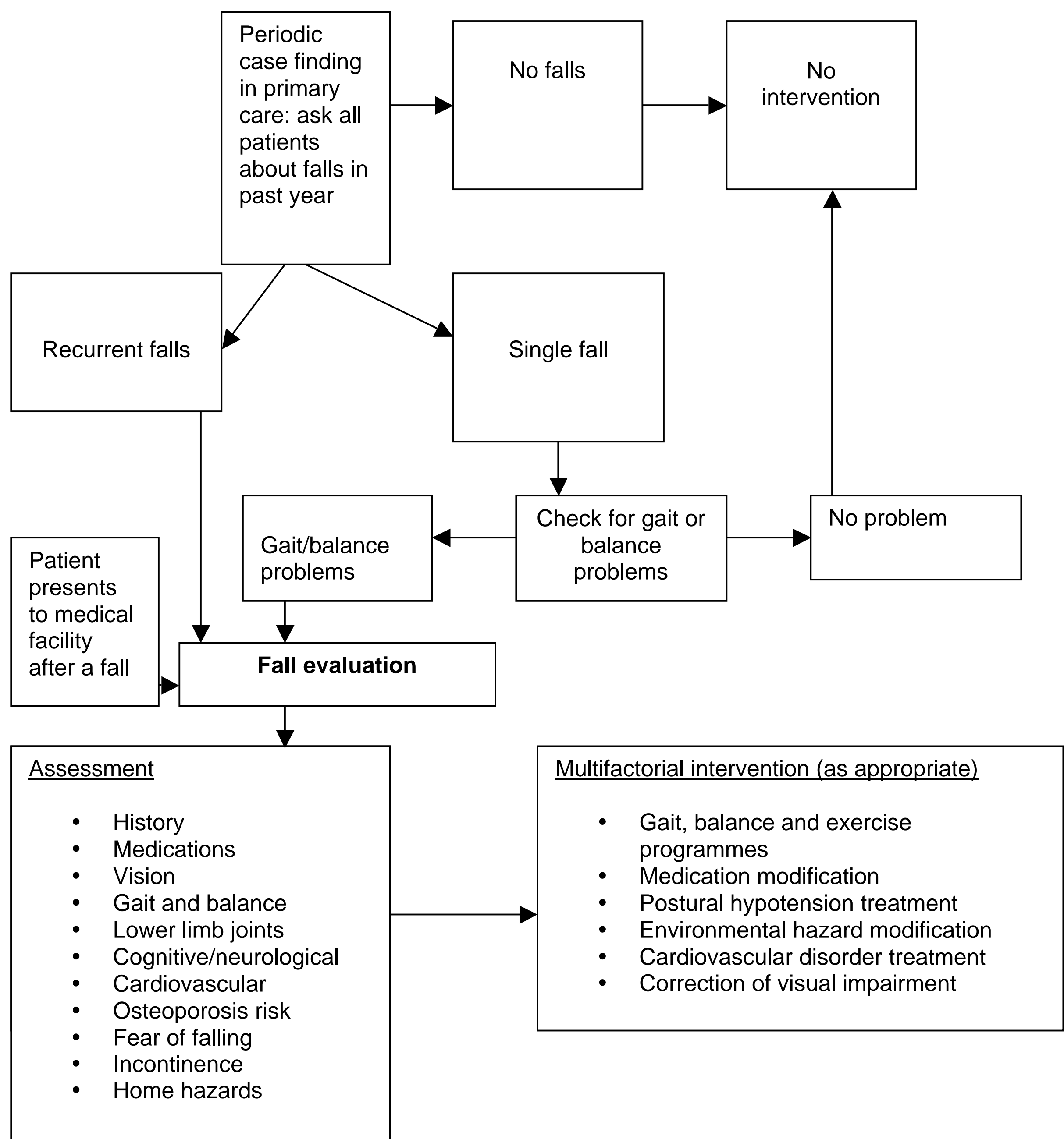
3. National guidance on the identification, assessment and treatment of fallers

We know a great deal about the prevalence of falls, their causes and the consequences of falling. For this strategy to be effective, it will need to specify how fallers will be identified, how they will be assessed and how they should be treated. The diagram below draws heavily on the recommendations of the American Geriatric Society (AGS) Panel on Falls Prevention. But it is slightly more comprehensive than the AGS model in order to reflect fully the NICE guidance described in the next section.



Guidance from the National Institute for Clinical Excellence

The NICE guidance on the assessment and prevention of falls in older people was published in November 2004. This establishes the following priorities, most of which are incorporated within the diagram above.

1. Older persons should be asked about falls at least once a year.
2. Those who report a single fall should be observed undertaking a simple *Get up and go* test. Those who experience difficulty should be referred for further assessment.
3. Full evaluations should be given to those who present for medical attention because of a fall, who report recurrent falls or demonstrate abnormalities of gait and/or balance.
4. The comprehensive evaluation should include those areas covered in the assessment box in the diagram above.
5. A range of interventions should be available to address the reversible causes of falls and fractures, again as described in the relevant box above.
6. Those at risk of falling, and their carers, should be offered information orally and in writing about the measures that they can take to prevent further falls.
7. 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.

Preventing fractures

As mentioned earlier, there is a strong link between falls, osteoporosis and resulting fragility fractures. Therefore, to be effective, both falls and osteoporosis should be targeted together within the context of developing an integrated, falls service for East Berkshire. While services such as the smoking cessation programme and the offer of hip protectors to very high risk individuals in care homes in WAM are valuable in relation to fracture prevention, we need to develop a comprehensive, evidence-based approach to reducing osteoporosis.

Osteoporosis is a silent disease, not just because it only produces symptoms once a person sustains a fracture but also because it is frequently left undiagnosed and untreated (All Party Parliamentary Group on Osteoporosis, 2004). Rather than population-wide screening which has no proven effectiveness, a selective-case finding approach is advocated by national and international bodies including NICE (2005) and the Royal College of Physicians (2000).

This allows resources to be targeted at those most likely to benefit from treatment, *eg* those at high risk from falls, those who have already experienced a fragility fracture and those on corticosteroids. Evidence-based guidelines help us to deliver care to those who need it most although unfortunately NICE has so far not provided us with guidance for men with osteoporosis.

Guidance from the National Institute for Clinical Excellence

The NICE guidance on the secondary prevention of osteoporotic fragility fractures in postmenopausal women was published in January 2005. The most important points in relation to women aged 65 and older are:

- Bisphosphonates are recommended as treatment options for the secondary prevention of osteoporotic fractures in women aged 75 and over *without* the need for a DXA scan.
- Women aged between 65-74 with a fragility fracture, should be scanned to confirm the presence of osteoporosis in which case treatment with bisphosphonates is recommended.
- Unless clinicians are confident that those receiving osteoporosis treatment have an adequate Calcium intake and are Vitamin D replete, Calcium and/ or Vitamin D supplementation should be provided.

The Royal College of Physicians (RCP) has also produced guidelines applicable to the high-risk groups that should be targeted:

- It is recommended that frail older people who may or may not be housebound but who are at increased risk of falls are offered Calcium and Vitamin D supplementation (RCP 2001), if depleted.
- Individuals at high risk, eg aged 65 or over, on glucocorticoids for 3 months or more should be advised to commence bone-protective therapy at the time of starting corticosteriods. DXA scanning is *not* required before starting treatment (www.rcplondon.ac.uk/pubs/books/glucocorticoid/glucocortConcise.pdf)

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4. Current provision across East Berkshire

In fact, most of the NICE recommendations are in place in at least one of the localities. This can be seen from the checklist below which compares the services that are required by NICE with a summary description of what is currently in place.

	NICE requirements on Falls	Current provision
1.	**Periodic case finding** from healthcare professionals	Patchy within GP surgeries (partly due to exclusion from new GMS contract) but RBAT now supplying regular information.
2.	Use of '**Get up and go test'** to assess gait and balance	
3&4	**Falls Clinics:** 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.	Falls clinic in Slough but transport only for Slough patients. No specific clinic but fallers service at St. Mark's. Transport limited to Maidenhead area.
5.	**Exercise programmes:** 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 method). Exercise needs to be maintained for sustained benefit.	Schemes vary across East Berkshire, both in terms of capacity and the extent to which they are tailored specifically to fallers. Some are highly popular and have secured positive outcomes. One-off meetings in Slough and Bracknell have identified current provision and increased joint working.
5.	**Environmental modification:** 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.	Carried out by OT's, intermediate care teams, handymen etc but not usually as part of a broader falls prevention programme.
5.	**Medications:** 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.	Guidance on medications that may increase falls has been produced by a pharmacist with a special interest in falls. Implementation remains uncertain and there is scope for greater awareness raising and training in this area.
5.	**Assistive devices**: Assistive devices (bed alarms, canes, walkers, hip protectors etc) are effective elements of a multi-factorial programme. Hip	Falls clinic in Slough and Day Hospital in St Mark's, among others, are making use of assistive devices. Hip protector project is exclusive to care homes in

	protectors do not reduce the risk of falling but the evidence supports their use to prevent hip fractures in very high-risk individuals.	Windsor, Ascot and Maidenhead.
5.	**Cardiovascular intervention:** Cardiac pacing should be considered for older people with cardioinhibitory carotid sinus hypersensitivity who have experienced unexplained falls.	Only manual tilt table testing available in Slough. Most patients with syncope are presently referred to Chelsea and Westminster Hospital.
5.	**Visual intervention:** Patients should be asked about their vision and, if they report problems, their vision should be formally assessed, and any remediable 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.	Little is known about current performance against this requirement, but falls are likely to be reduced through greater health promotion work with older people themselves.
5.	**Footwear interventions**: Although there seem to be no experimental studies relating falls to footwear, some trials report better balance and reduced sway through improved footwear.	Falls awareness roadshows have highlighted the dangers from sloppy slippers. Podiatrists participated fully in these.
6.	**Oral and written information** should be available for those at risk of falling and their carers.	Information exists in various forms, including roadshows, personal contacts, a range of leaflets, videos etc. and the Berkshire Health Promotion website on falls.
7.	Maintenance of **basic competences** among health professional dealing with those at risk of falling.	No formal training programme in place and generally variable knowledge base. Good local awareness among some professionals due to participation in falls collaborative, the work of local falls groups and the Berkshire health promotion website.
	NICE/ RCP requirements on osteoporosis	
8.	Implementation of treatment guidance as in Section 3 above, following the selective case finding approach	↑Design of Medical Management Plan for osteoporosis in Care Home residents but dissemination among GPs variable. ↑Assessment and initiation of osteoporosis treatment following fracture at Upton Falls Clinic, St Mark's Day Hospital and by some

		GPs. ↑Prescribing in Primary Care for Calcium and Vitamin D and Bisphosphonates has increased substantially in East Berkshire. ↑WAM only: GIOscope project identified those over 65 who need bone protection while taking steroids
9.	Provision of DXA (bone densitometry) scanning as in Section 3	Recent donation of DXA scanner but present capacity at St Mark's Hospital about 700/ year (waiting list 2-3 months) compared to NOS figures suggesting 3600 required across East Berkshire annually

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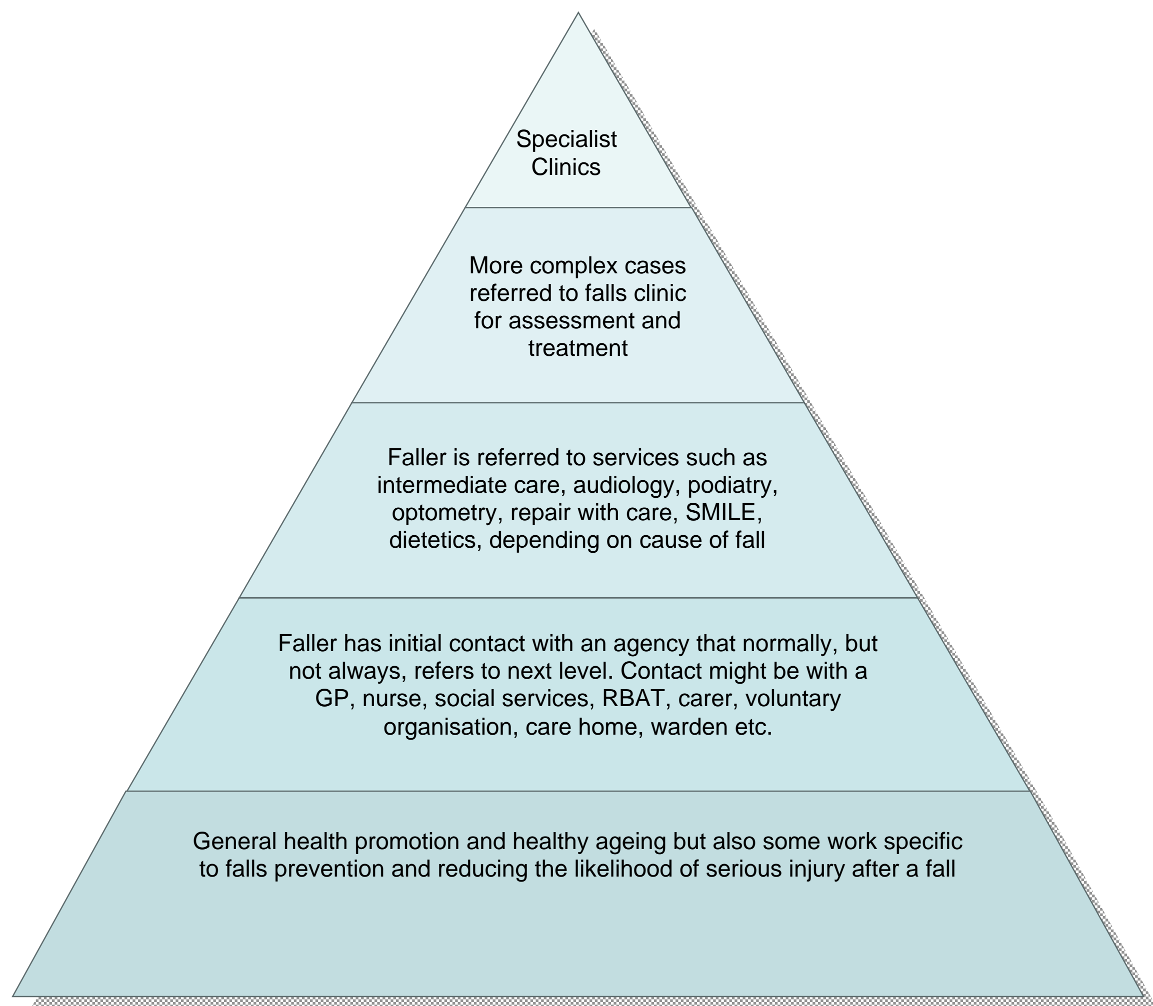
5. The future model

The future falls service for East Berkshire will address the inconsistencies described above, planning for a gradual expansion of those components that are already in place so that the NICE priorities are addressed in all three localities.

We find it useful to conceptualise these service developments 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. We emphasise that the model is a rehabilitative one, looking to move patients or clients back down the levels wherever possible.

The foundation of this model, Level One, is the broad health promotion and falls prevention work that takes place within the community. This will come from a wide range of professionals, such as housing agencies undertaking home hazard assessments, leisure services providing strength and balance training in the community, pharmacists recognising medication risks etc.



The second level includes those who have initial contact with a faller. The diversity of these initial contacts is a challenge to the falls service since there are so many people who need to understand its processes and purpose. First contact may come, for example, with a home carer, RBAT ambulance staff, a district nurse, a GP, a sheltered housing warden, voluntary sector employee, a pharmacist and so on.

Where possible, this first port of call will be able to identify the cause of the fall and reverse it. The pharmacist may initiate a medication review, the GP may make a referral to optometry, the district nurse may identify postural hypotension and refer the faller to the GP, the housing manager might ensure that proper lighting is introduced to a poorly lit property.

Where falls are thought to be caused by environmental factors and /or mobility problems, and they need specialist assessment, the fallers may benefit from a referral into the Intermediate Care Team that runs the Community Falls Programme. This would trigger therapeutic and practical interventions that could significantly reduce the risk of future falls. For example, 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. The intermediate care team might also refer directly to an appropriate service or to the falls clinic if necessary.

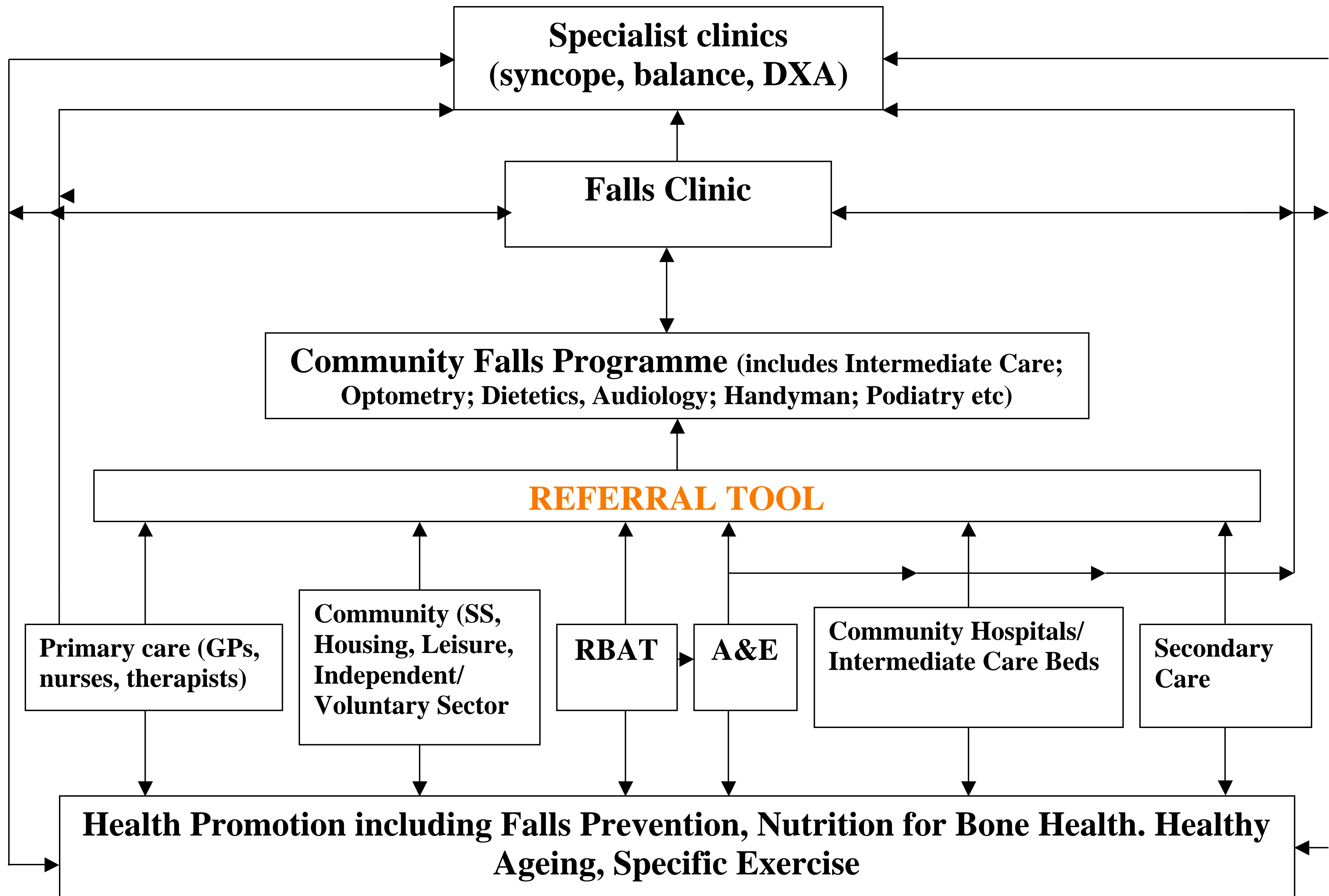
Those who:

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

should be referred into Level Four which is the falls clinic. This can offer a comprehensive multi-factorial (including medical) assessment and trigger various forms of treatment and interventions.

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

The five levels of the proposed East Berkshire falls service can be captured in a different format that clarifies the organisations involved and the referral routes. This is described on the next page and makes use of a referral form which helps professionals to decide whether the faller should be referred to the falls clinic or the community falls programme.


Specialist clinics
(syncope, balance, DXA)
Falls Clinic
Community Falls Programme (includes Intermediate Care;
Optometry; Dietetics, Audiology; Handyman; Podiatry etc)
REFERRAL TOOL
Primary care (GPs, nurses, therapists)
Community (SS, Housing, Leisure, Independent/ Voluntary Sector
RBAT
A&E
Community Hospitals/ Intermediate Care Beds
Secondary Care
Health Promotion including Falls Prevention, Nutrition for Bone Health. Healthy Ageing, Specific Exercise

When using this form, the referrer will consider whether the older person should be referred directly into a local Falls Clinic. They will do so if they are able to answer yes to one or more of the following questions.

1. Did the person require medical treatment following their fall?
2. Has the person fallen more than once in the past 12 months?
3. Has the person fallen once and, if so, do they have a diagnosed gait and/or balance problems?
4. Did the person fall as a result of a loss of consciousness?
5. Are the causes of the fall unexplained and are they likely to be the result of complex medical causes?

Note that the falls clinics are intended for those aged 65 and over, who have no serious memory problems and who are able to mobilise independently (using a frame or stick if necessary).

If the fall(s) appear to be caused by environmental and/or mobility factors only, or if referral to the falls clinic is inappropriate, the faller may benefit from an assessment by the intermediate care team. This service may be more appropriate to single fallers, immobile people or those with a memory impairment.

Referral into the falls clinic or falls programme will be unnecessary if there is an identified cause that can best be addressed through other means. A GP, for example, may review medication that is likely to have caused the person to fall. Equally, a district nurse may first recommend an eye examination if this is the probable cause of the slip or trip.

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6. Implementing the model

The NICE guidance is clear but it is also extremely challenging. Falls services around the country risk being overwhelmed if they follow the guidance to the letter. In our own case, we expect a minimum of 1600 older people to fall twice or more each year across East Berkshire. Even with two additional falls clinics, as described below, there will not be sufficient capacity for each of these to receive the comprehensive assessment required by NICE.

It is vital, therefore, that the service develops in a flexible manner, able to adjust to the demand that is identified through a greater emphasis on falls prevention. Equally, it is of fundamental importance that the number of fallers should not be treated as a given. With appropriate policies in place, it can be significantly reduced, as can the number of injuries resulting from falls.

This section on implementation describes what needs to be different, as well as offering suggestions on the timescale for delivery. It is structured according to the different levels that were described above.

Level One

The following Level One preventive measures need to be in place to reduce the number of falls and the number of serious injuries resulting from falls.

Closer working with the voluntary sector to deliver key messages	2006/07
Partnerships with housing providers to identify and correct home hazards	2006/07
Implementation of osteoporosis guidelines	2005/06
Continued development of website for users, carers and professionals and stakeholder events	Ongoing
Communications strategy and materials in place	2006/2007
Annual medication reviews taking account of falls and osteoporosis risk factors	2005/06
Continued falls roadshows and other awareness raising activities	Ongoing
Further development of general health promotion work, such as exercise, smoking cessation, healthy eating to promote bone health etc	Ongoing

Level Two

There are many agencies and professionals with whom older people may have their first contact after a fall. Education and a common approach are critical to the successful operation of Level Two.

Training for front-line staff when older people present following a fall, including introduction of a standard risk assessment tool and guidance on how to make appropriate referrals in line with the emerging care pathway	2005/06 and ongoing
Established links between community services and RBAT, A&E and hospital wards so that fallers are referred appropriately into Levels Three/Four	2005/06
Widespread use of Get up and go test to identify fallers with gait and balance problems that require a multidisciplinary assessment	2005/06
Introduction of an agreed approach to uninjured fallers who cannot get off the floor unaided	2005/06
Initiatives within the Acute to identify fallers who would benefit from advice, intervention and possibly referral into the falls clinic. This might include referring (to falls clinics) injured fallers who present to A&E and the recruitment of a nurse specialist to address fallers who present to a fracture clinic.	Look to secure funding from 2006/07
Periodic case finding within primary care	Links to the new GMS contract for GPs

Level Three

Level Two will frequently have identified the causes of a fall and Level Three serves, in part, to reverse those causes. Key developments include:

Continued medical input from specialist areas such as podiatry, optometry, dietetics, informed by a greater awareness of issues relating to falls and a sound understanding of the falls care pathway	2005/06
Consistent availability across East Berkshire of local exercise schemes to increase mobility and build up muscle strength, balance and bone density	2006/07
Interventions from intermediate care, social services, housing associations etc to improve mobility and make home environments safer	2005/06

Greater support to carers to identify and manage risks relating to falls	2006/07
Extended availability of hip protectors within nursing home settings	2006/07
Medication reviews for fallers from GPs, pharmacists, consultants etc to assess falls-related risks and set these against benefits in other areas. Treatment or prevention of osteoporosis.	2005/06
Sound risk management of potential fallers in inpatient settings, including acute, community and care home settings	2005/06

Level Four

Level Three is well-placed to identify and correct falls resulting from a single cause. Level Four is critical in serving those whose needs are more complex, offering multi-disciplinary assessment.

Introduction of falls clinics at St Mark's Hospital and to serve the Bracknell/Ascot area	2005/06
Ongoing review of the capacity of all three clinics, in line with anticipated further guidance from NICE	Ongoing

Level Five

Level Five incorporates specialist input, notably syncope clinics and balance clinics. These are in place but, as with other medical interventions relating to falls, they need to become an established element in the falls pathway.

Introduction of a specialist syncope clinic and continuation of the audiology and balance clinics for fallers	Ongoing
Purchase of automatic tilt table for syncope clinic as agreed in LDP for 2005/06 and siting of clinic, ideally at King Edward VII.	2005/06

Engaging with all of the relevant stakeholders

It is important that these objectives and intentions are clearly stated and that they provide a sense of direction to the development of the falls service for East Berkshire. Yet, at the same time we want to encourage local organisations, departments, groups etc to develop their own approaches to falls prevention, identifying problems and solutions that work for their

patients. In short, we invite organisations to reflect at length about what they can do to support falls prevention work.

Take the example of care homes. We know that older people living in care homes are three times more likely to fall than older people living in the community. So, what steps might care homes take to minimise the number of falls and to reduce the risk of serious injury among their residents?

Falls Prevention Checklist for Care Homes
Compile targeted falls assessments and care plans for residents whose regular assessment identifies high risks of falling, and suggest hip protector underwear for those at greatest risk
Record the time and place of falls to identify patterns so that action can be taken to reduce risks
Ensure that multiple fallers, when appropriate, receive a comprehensive assessment from a falls clinic and all residents receive regular medication reviews
Manage staff workload to minimise risk of falling eg by asking carers to follow behind the nurse who is providing diuretics so that older people are less likely to have to get out of bed unassisted
Ensure that the environment minimises the risk of falling, to include firm surfaces on garden walkways, white edges to steps and stairs, night lights for residents who need them, non-slip carpets, regular OT assessments of residents' rooms and the whole home
Offer strength and balance training within the care home (or encourage residents to use external providers) and promote active residents
Educate residents and staff about the risk of falling and the steps that can be taken to minimise it, including vision checks, appropriate footwear, medication risks, balance and ear-checks, and one to one 'training' for residents on moving safely between chair and bed.
Offer an appropriate diet with particular importance attached to Calcium and Vitamin D intake. Those who are likely to be depleted should be considered for a supplement.
Domestic staff help residents to reduce bedroom "clutter"

This is just one example, albeit an important one, where partner organisations can contribute enormously to the success of our falls prevention work. A couple more examples are provided in the Appendices relating to the contribution of older people themselves (Appendix Two) and of district nursing (Appendix Three).

The philosophy of this strategy is to encourage such reflection and action, providing advice and support where possible, but acknowledging that responsibility for falls prevention work has to be widely shared. The diagram below illustrates the wide range of stakeholders who have a contribution to make.

Table of Falls Prevention Stakeholders

GPs	Housing	Podiatry	Dietetics	HWWP
Day centres	Local pharmacy	Occupational Therapy	Community hospitals	Care homes
RBAT	Voluntary sector	**Older people**	Leisure services	Private sector
Local media	District nurses	Health promotion	Intermediate Care	Continence service
Social services	Optometry	Physio	Transport	Falls clinics

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7. Resource implications

It is important to remember, from the outset, that NICE has already studied the resource implications of falls prevention work, and recommended those that are effective and cost-effective. Nonetheless, it is worthwhile restating the reasons why the measures described earlier in the strategy represent an important contribution to a sound commissioning strategy.

Benefits of reducing the numbers of hip fractures

The following table summarises hip fractures across East Berkshire that are dealt with by Heatherwood and Wexham Park Hospitals. The increased occurrence with age is of particular importance given our ageing demographics. The average for the six full years described below is 280.

East Berkshire hip fractures to October 2004 by age							
	65-69	**70-74**	**75-79**	**80-84**	**85-89**	**90+**	**Total**
1998	18	22	59	59	72	62	**292**
1999	10	33	48	63	74	58	**286**
2000	14	23	47	68	60	59	**271**
2001	12	33	54	63	76	48	**286**
2002	18	20	47	58	70	55	**268**
2003	14	34	48	76	47	62	**281**
To Oct-04	7	20	42	60	49	43	**221**
Total	**93**	**185**	**345**	**447**	**448**	**387**	

The numbers of hip fractures run at 80% of that which would be expected using national prevalence data (ie 350) This might be explained by the fact that some hip fractures will be dealt with by other hospitals (eg Bracknell patients going to Reading) or that we have relatively good levels of health.

Working with this lower figure, we can see the substantial impact of reducing the number of hip fractures. National guidance suggests that it should be possible to maintain a 15-30% reduction below trend. But even a much less successful approach would secure major savings, as modelled below, on the assumption that the hospital and community costs of each hip fracture are £21,000 (Source: *Primary Care Strategy for Osteoporosis and Falls* – National Osteoporosis Society 2002).

	Current	-5%	-10%	-15%	-20%	-30%
Annual hip fractures	280	266	252	238	224	196
Cost of hip fractures (£m)	5.88	5.59	5.29	5.00	4.70	4.12
Savings (£'000)	0	294	588	882	1176	1764

Wider benefits of falls and fracture prevention work

These savings can be verified by applying the model developed by Scuffham, Chaplin and Legood to our particular situation in order to understand the position better (See Journal of Epidemiology and Community Health 2003 (57) 740-744). They made use of reference costs which were notably lower than the estimated cost per hip fracture from the National Osteoporosis Society and considered a wide range of falls-related costs including ambulance journeys, A&E attendance, inpatient and outpatient services etc.

They identify the following costs per 10,000 population in defined age groups. Note that the data were initially expressed in UK pounds in year 2000 and a more accurate picture is drawn by adding inflation over the past five years. Based on Office of National Statistics data for inflation in the health sector from April 2000 to April 2005, we have inflated the figures by 16%.

Age	Cost per 10000 population (£'000)	Cost at 2005 values
60-64	279.2	323.8
65-69	587.4	681.4
70-74	431.5	500.5
75 and over	1,496.1	1735.5

The East Berkshire population, as stated in the mid-2003 population estimates is described below. Note that with our ageing population, the numbers will increase over the coming years, especially among the over 85s where costs are highest.

Age	East Berkshire population in that age range (mid-2003)
60-64	15,200
65-69	13,100
70-74	11,900
75 and over	21,900

We can now apply the costings to our model and consider the implications, once more, of securing a range of percentage reductions to our falls related expenditures. These figures use the 2000 prices but the final row states the after inflation savings.

Age range	Estimated spend ('000)	-5%	-10%	-15%	-20%	-30%
60-64	424	403	382	360	339	297
65-69	766	727	689	651	613	536
70-74	513	488	462	436	410	359
75 and over	3276	3112	2948	2784	2621	2293
Total	4979	4730	4481	4232	3983	3485
Estimated saving	0	249	498	747	996	1494
Savings after inflation	0	289	578	867	1156	1734

Summary of potential savings

This combination of the two approaches is useful because the focus on hip fractures alone seems too narrow and some argue that the estimated additional cost of the hip fracture is too high at £21,000. The epidemiological approach is clearly more comprehensive and some might feel that the costings are more realistic.

By coincidence, the two approaches lead to remarkably similar conclusions. If we can reduce the incidence of falls and fractures by just 5% across East Berkshire, the estimated savings across health and social care approach £300,000. Attaining 15%, the target suggested by the Department of Health in its 2003 guide to commissioning good falls services (*How Can we Help Older People Not Fall Again?)* would realise nearly £900,000. Reaching the 30% success rate claimed by some of the Healthy Communities Collaborative sites could be worth as much as £1.75million.

Costs of delivering the East Berkshire integrated falls service

These savings will initially be used to establish falls clinics across all three localities and a syncope clinic serving East Berkshire. Additional ongoing investment is likely to be required in the following six key areas:

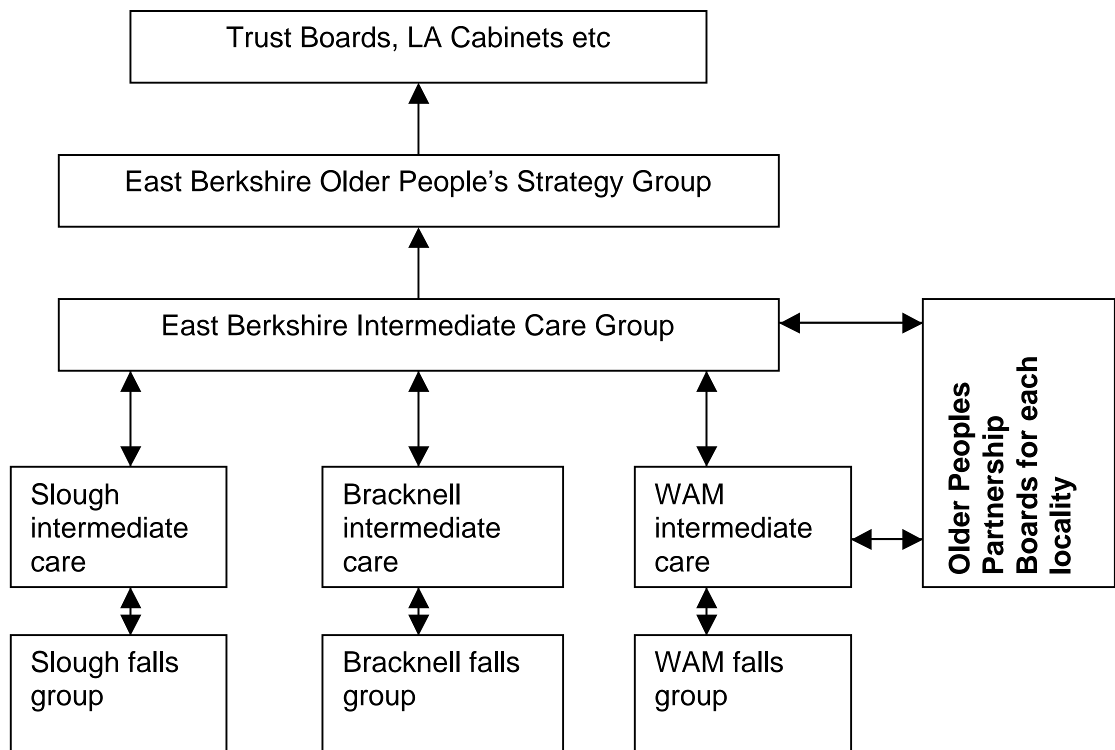
- to ensure that intermediate care is able to respond to the growing number of referrals that can be expected
- to provide ongoing training for health and social care professionals as required by NICE
- to implement a communications strategy that radically increases falls awareness among older people and their carers, incorporating techniques and materials that are appropriate to the diverse communities across East Berkshire
- Ongoing coordination of the falls prevention work to ensure that it is sufficiently flexible and responsive.
- Investment in the acute sector both to improve the capacity within A&E to deal with fallers, to identify and respond to fallers identifying fracture clinics and to reduce the number of people falling while they are inpatients.
- Funding improved management and treatment of osteoporosis.

The costings relating to these headings will be worked up more fully in the Action Plan that will relate to this strategy.

Creating an Integrated Falls Strategy for East Berkshire

8. Decision-making structures

From April 2005, responsibility for East Berkshire's falls and fractures prevention work sits with the East Berkshire Intermediate Care Group. This is advised by local Falls Groups who in turn will report to their local intermediate care structures. Localities will also be influenced by the requirements of Partnership Boards for Older People and significant changes will require approval by NHS Boards or local authority decision-making structures. Users and carers should be represented within each of the falls groups, intermediate care groups and Partnership Boards.



Creating an Integrated Falls Strategy for East Berkshire

9. Conclusions

The NICE guidance establishes clear expectations for the provision of a falls and fracture prevention service. Many aspects are already in place across East Berkshire. But provision remains uneven across localities, resulting in variable access to falls prevention services for older people. This strategy proposes a clear structure and framework for the development of an integrated service across East Berkshire.

It also acknowledges the difficulties (apart from the initial cost) associated with comprehensive compliance with national requirements. Aspects of the service, especially the intermediate care teams and the falls clinics, risk becoming overwhelmed with the sheer numbers of fallers who might be referred into the community falls programmes or the specialist falls clinics.

The situation must be continually monitored so that adequate supply is in place to match the demand that will be generated by the awareness-raising measures described earlier. Adjustments may have to be made to the referral criteria, or additional investments may be required to ensure that services can respond in a timely and effective manner.

These pressures can be dramatically alleviated if we are able to generate a shared sense of ownership and engagement across the many stakeholders that relate to falls prevention work. By undertaking their respective tasks relating to medication reviews, the treatment of osteoporosis, assessment and correction of vision, reduction of environmental hazards and the provision of individually tailored strength and balance training, partner agencies have a major contribution to make in preventing falls.

Not only must the engagement come from providers of services, it must come from older people themselves, along with their carers. By managing their risks, and looking after themselves as well as possible, older people can reduce the likelihood of serious injury and maximise their independence while continuing to live fulfilling lives.

There are some simple quick fixes that can prevent falls and fractures and these must be grasped. Equally, there are more complex causes of falls that should be identified and reversed wherever possible. These facts remind us that falls and fractures are not an inevitable part of ageing. On the contrary, partnership working between a wide range of organisations can have a real and lasting impact, to the very great benefit of large numbers of older people, their carers and their families.

We close by summarising the major changes that are required by this strategy over the next 12 months. It is tempting to provide a long list but it is important to recognise that the achievement of an integrated falls service will take 3-5 years. Some of the cultural change and capacity building cannot

take place in a shorter timeframe. But for the next 12 months, and in keeping with the views of stakeholders at the July event, the following should be seen as priorities:

1. Establishing a falls clinic that serves the Bracknell/Ascot area and increasing the capacity of both the Slough Falls Clinic and the St Marks Fallers Service.
2. Establishing a syncope clinic, making use of a newly acquired automatic tilt table, that serves all of East Berkshire and will probably be located in Windsor.
3. Enhancing risk assessment and management of fallers in the full range of inpatient settings so that the number of fallers in this environment is kept to a minimum.
4. Improving case finding of fallers within both A&E and fracture clinics
5. Developing a comprehensive programme of training for staff across private, statutory and voluntary sectors that includes the emerging care pathway, engagement with primary care, moving and handling of fallers and knowledge transfer into care homes relating to (eg hip protector assessment and strength and balance training)
6. Improving the response to uninjured fallers so that it is timely, efficient and leads to appropriate follow-up.
7. Improved medicines management for fallers and those with osteoporosis

Selected references

All Party Parliamentary Osteoporosis Group, Falling Short, Delivering Integrated Falls and Osteoporosis Services in England

American Geriatrics Society, Guideline for the Prevention of Falls in Older Persons, 2001

British Geriatrics Society, Guidance on Services for Falls and Fracture Prevention in Older People, 2001

Cryer and Patel, Falls, Fragility and Fractures, November 2001

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Department of Health, How Can We Help Older People Not Fall Again? 2003

Health Education Board for Scotland, the construction of the risks of falling in older people: lay and professional perspectives, 2003

Help the Aged, Reducing Falls Among Older People, 2003

National Institute for Clinical Excellence, The Assessment and Prevention of Falls in Older People, 2004

Oliver, McMurdo, Patel, Secondary Prevention of falls and Osteoporotic Fractures in Older People, BMJ 2005 123-124

Appendix One:
Referral Form for Falls Assessment Clinic or Intermediate Care Teams

Falls Risk Assessment Tool EXTRA

Client details Name: DOB: Address: Telephone no:	Other contact: Name: Telephone no:
GP details: Name: Address: Telephone No:	Medical History: Reason for Hospital admission:
Social History: Any other services?	English first language: Yes/ No Any safety considerations?

Referral Routine/ Soon/ Urgent

Brief description of Falls (*eg* indoors/ outdoors, possible cause etc)
Referrer details: Name/ Position: Telephone no: Signature: Date

To decide whether a client should be referred to either the Falls Clinic or the intermediate care team, please complete this questionnaire.

Falls Clinic referral:

If 'yes' is answered to any of questions 1-5, a referral to the medically led, multi-disciplinary Falls Clinic would be appropriate, providing all criteria in 6-9 are met.

	Please tick as appropriate	**YES**	**NO**
1.	Injured faller-following treatment at medical facility		
2.	Recurrent faller (2 or more in last year)		
3.	Single faller with established gait and / or balance problem (*eg* by Get Up and Go Test)		
4.	Fell due to loss of consciousness		
5.	Unexplained fall with apparent complex medical cause(s)		
	Criteria For Falls Clinic (must meet all 4)		
6.	Aged over 65		
7.	No serious memory problem		
8.	Able to mobilise with frame or stick(s)		
9.	Willing to attend		

Please discuss with the unit anyone who needs referral but does not meet the criteria.

Please send to: [[local details to be provided]]

Intermediate Care Team referral:

If you believe that the falls are caused by mobility and/ or environmental hazards only, or if a referral to the Falls Clinic is inappropriate (eg because of memory problems) please consider referring to the intermediate care team. This referral form should then be sent to: [[local details to be provided]]

Appendix Two
What should older people do to support the falls strategy?

Life cannot be risk-free and some older people will fall in the course of living their lives to the full. Nonetheless, the consequences of falling can be far-reaching and so it is an area of risk that is worth managing skilfully. Some of the pointers below are simple common sense but, together, they provide a useful checklist.

1. Contact your GP surgery if you have had a fall as there may be an underlying cause that can be addressed.

2. Have your medication reviewed at least annually. Let your GP or pharmacist know if your pills are making you dizzy.

3. Keep physically active to stay strong, mobile and well balanced. Your activity can take many forms (gardening, walking, dancing, tai chi, keep fit). Start gently, progress slowly and listen to your body.

4. Eat ample quantities of calcium and vitamin D and limit your alcohol intake. Your GP or pharmacist can advise you how.

5. Have your sight and your feet checked regularly.

6. Many of the problems after a fall (hypothermia, pneumonia) are due to the “long lie” when somebody cannot get up even if they have not injured themselves. Try to use furniture to help you get up if you cannot get someone to help you. Consider having an alarm pendant that can call for assistance when it is needed.

7. Have your annual flu jab as illnesses like flu can make you more likely to fall, and who wants to get flu anyhow?

8. Check your house for things that might cause you to trip:

    - Don’t stand on chairs or steps
    - Tack down any carpet edges
    - Try to avoid rugs and only use those that have non-slip backing
    - Ensure that the house is well-lit, especially between the bedroom and the bathroom
    - Nothing should be stored on the stairs
    - Furniture should not have casters & tack cables to the wall
    - Try to keep your house warm as cold muscles work less well and will increase your chance of accidents
    - Wear proper shoes or slippers with an enclosed heel
    - Don’t wear a long dressing gown or highly flared trousers
    - Fit handrails where these will help you around the house
    - Take time to recover your balance when rising from the bed or chair

Appendix Three:
What should district nurses do to support the falls strategy?

When dealing with an older person following a fall, district nurses are encouraged to run through the following review, if it has not already been undertaken. It is adapted from *Falls, Fragility and Fractures,* Cryer and Patel, 2002.

Problem	Risk indicator	**Yes**	**No**	Intervention	Referral route
History of falling	More than one fall in last 12 months			Review incidents, listening for how to prevent future fall. Discuss fear of falling and realistic preventive measures.	OT/Physio/GP/Day hospital
Medications	Takes 4 or more medications per day			Ask about symptoms of dizziness. Identify type of medication being prescribed and, if appropriate, contact GP or pharmacist	GP or pharmacist
Central Nervous System Depressants	Use of 1 or more for more than 2 weeks			Identify type of medication being prescribed. Discuss normal changes in sleep patterns with ageing if appropriate and teach sleep promoting behaviours. http://www.bhps.org.uk/falls/documents/MedicinesThatMayContribute.pdf	Refer to GP or pharmacist if medications involve falls risks.
Alcohol and diet	More than one unit per day			Discuss regarding immediate and long-term fall risk, dulling of neurological capacity from alcohol. Longer clearance times in older age and potential interaction with medication.	District/Practice nurse/GP
Postural hypotension	Take reading after 5 mins rest in supine position, check again after one minute while standing up. A drop in systolic of >20mm Hg or in diastolic of >10mm HG suggests postural hypotension			Teach to stabilise after changing position and before walking. Extra pillows to raise head or bed raise if severe. Refer to GP practice for medication review if appropriate.	District/Practice nurse/GP
Vision	Test difficulty reading newspaper or book, cannot recognize an object across the room, recently started wearing bifocals			Raise awareness of risk due to blurring and difficulty in judging distance. Advise on disuse of bifocals or care when first wearing them. Advise on use of contrasting colours for risk areas eg top of stairs. Vision tested and corrected? Diabetes and glaucoma monitored regularly? Cataracts?	Optician or GP (for referral to eye clinic)

Hearing	Has difficulty hearing conversation or speech			Remove wax. Hearing tested and corrected to best possible extent? Teach use of visual cueing, lowering of voice and speaking in best ear to maximise hearing. Hearing aid may be of use.	Audiologist or GP (for referral to ENT)
Walking gait	Is unsteady on feet, shuffles or takes uneven steps or is housebound			Teach about risk. Physio for evaluation of range of movement and/or gait, balance and strength exercises. Appropriate selection and use of walking equipment.	Podiatry/Physio/ Day hospital/OT
Transfers	Lack of control when moving between surfaces			Advise on risks Refer for more detailed assessment and help, environmental modifications to increase safety	Podiatry/Physio/ Day hospital/OT
Balance	Needs to hold on to furniture, requires stick or walking frame			Teach about risk and how to manoeuvre safely. Consider modifications to avoid stooping or overhead stretching. Refer for more detailed assessment or refer to exercise programmes	Physio/OT/exercise referral/Day Hospital
Environment	Identified slip/trip hazards, untidiness			Advise about risks eg irregular floor heights. Remove/secure rugs, remove obstacles, advise on lighting, suggest personal alarm, pull cords within reach from floor	OT/handy person service
Confusion	Does the patient show signs of being confused or being muddled?			If chronic, consider memory and orientation aids. If acute, is there an underlying medical reason?	GP/CPN
Osteoporosis risk	**Women**: Early menopause or hysterectomy <45; missed period for 6 months or more **All**: Steroids for 3 months or more, previous low trauma fracture, malabsorption, inflammatory bowel disease, gastric surgery, long-term immobility, heavy drinking, smoking, low BMI, height loss, maternal history of hip fracture, chronic renal failure, liver disease			Hip protectors if in care homes. Are they having medication to treat/prevent osteoporosis?	GP or falls clinic or day hospital
Depression/anxiety	Identified depression			Follow depression care pathway	GP

REDUCING THE RISK OF A FALL

Everyone is different, but some people can reduce the risk of falling by:

- Checking your home for hazards and putting right any problems
- Undertaking exercises that will improve your strength and balance
- Having your eyesight assessed
- Getting someone to look at your medicines to see if changes are needed
- Getting up slowly from bed or out of a chair

WHAT TO DO IF YOU FALL

STOP – THINK – PLAN

ATTRACT HELP!

Use your care alarm pendant or crawl to a telephone or bang on the floor or shout.
Try to get up.

KEEP WARM

Cover yourself with anything to hand e.g. a towel, a rug, a blanket

KEEP MOVING

Move the parts of your body that don't hurt to stop pressure on the bony parts

Appendix Four

East Berkshire FALLS Service

INFORMATION FOR OLDER PEOPLE WHO HAVE FALLEN OR WHO FEAR FALLING

What is the East Berkshire falls service?

The East Berkshire falls service provides programmes to help reduce the risk of you falling again.

If you are an older person and have fallen once, unfortunately you are more likely to fall again.

With your permission, we would like to refer you to the falls service. You will be contacted by phone to discuss how we might help.

The falls service may decide that it would be helpful for you to attend a falls clinic. You can bring a family member of friend to accompany you.

Or you may be contacted by the intermediate care team whose job is to help people regain their independence.

- If you go to the falls clinic, skilled staff will carry out a falls risk assessment, an osteoporosis assessment and a medication review. Please ensure that you bring along all your current medications for the specialist to see.
- The assessment will involve you answering a few questions and will include a basic physical examination. Please allow up to 2 hours as the specialist needs to gain a good understanding of your falls.
- If the falls specialist believes that you may have osteoporosis, we can arrange for you to have a scan if necessary.
- The falls clinic will be able to advise you on why you may have fallen and how to reduce the risk of further falls.
- Following your assessment the falls clinic will write a report that will be sent to you and your GP.
- The falls clinic may suggest that you are referred to another service if a specific problem is identified.

If you fall again before you receive a phone call from the falls service, or before your appointment at the falls clinic, please contact your GP immediately. **Do not wait until your appointment with the falls specialist.**

For further information/advice please contact the Falls Information Line

Tel: 01xxx xxxxxx

Osteoporosis in Care Homes

Medical Management Plan for Men & Women over 65 years who have, or at risk of, Osteoporosis

These guidelines are based on the RCP Guidelines (2001), the NICE Guidelines on Secondary Prevention in Postmenopausal Women (2005) and have been agreed by East Berkshire PCTs

Please note - from December 2003 Hormone Replacement Therapy is no longer being recommended as a first line treatment for osteoporosis. For more information refer to the National Osteoporosis Society position statement on www.nos.org.uk