How can we help older people not fall again?

Implementing the Older People's NSF Falls Standard: Support for commissioning good services.
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<td>Description</td>
<td>Guidance for commissioning to support implementation of the integrated falls services detailed in Standard Six of the National Service Framework for Older People and local achievement of performance indicators set around NSF milestones of April 2004 and April 2005. A distillation of lessons from published material and local practice, incorporating examples of local initiatives and a costs/benefits ready reckoner.</td>
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For recipient use
How can we help older people not fall again?

Implementing the NSF Falls Standard: Support for commissioning good services

Aim:
to provide guidance for commissioners to implement the NSF for Older People Standard 6 falls prevention.

Methods:
Review of published materials and local practices to identify and promulgate elements of falls services that contribute to effective, long term planning and commissioning for services which will:

• secure good outcomes for older people, staff and services;

• reduce the costs and burdens associated with falls and related injury or ill health; and

• increase access and capacity in health and social care services.

Audience:
Primary Care Trusts commissioning services with their Local Authority partners, and organisations that provide services which aim to reduce the negative impacts of falls and increase access and capacity in health and social care. The report will be especially useful for:

• commissioners and managers in PCTs and their Local Authority partners;

• staff seeking to develop sustainable services and influence commissioners across local health and social care systems.

Scope: this report guides implementation of the NSF for Older People Standard 6: falls prevention. It distils lessons from published materials and local practices.
This report was compiled and written for the Department of Health by Liz Haggard, Sarah Buchanan and Margaret Martin. The Department would like to thank them for their excellent contribution to implementing the NSF Falls Standard.

Thanks and acknowledgements:

A very large number of people helped the authors with this report. Our thanks to them all and apologies to any whose names we have omitted below:

1. Introduction

Older people fear falls: “80% of women surveyed would rather be dead than experience the loss of independence and quality of life that results from a bad hip fracture and subsequent admission to a nursing home”. (Salkeld et al 2000).

Many older people fall – over 30% of people over 65 have a fall in any one year and the percentage increases with age.

Most falls don’t have serious consequences: it is better to have an active life than to prevent falls by not being up and about.

Some falls result in fractures or other serious consequences for older people, carers and services.

This report focuses on what we know about preventing serious falls and reducing their impact and how commissioners can:

- release resources for re-investment by reducing the number of emergency admissions due to a fall
- commission services which: demonstrate that they can reduce the risks of falling again, target older people for whom a serious fall is more likely and take effective action
- work in partnerships to make helpful changes to older people’s environments including, older people’s homes and hospitals, nursing and residential homes and service buildings: safer environments for older people are better for everyone
- support services, treatments, exercises and nutrition which strengthen bones and improve balance so that a fall is both less likely to occur and to lead to fracture
- ensure that where falls occur hospital admission is avoided wherever possible and effective support to prevent further falls is provided
- meet commitments for the NSF for Older People, Standard 6, Falls Prevention.
The negative impact of falls and related injuries on older people and health and social care systems is clear. The NSF for Older People Standard 6 aims to prevent falls and reduce their impacts. This document provides guidance, primarily for commissioners, on how to implement that standard and achieve benefits for older people and health and social care systems.

There is evidence that the number of falls and the negative impact of their consequences can be reduced by up to 30% if local health and social care communities work together effectively to address falls and their impact.

This review of published materials and practices on the ground identified elements of good practice in commissioning falls services and falls prevention initiatives, in the context that there is no single best or most effective approach. Some approaches are based in research and evaluation. For others there is, at present, no evidence of effectiveness: where such approaches are low cost, do not divert skilled staff from treatments known to be effective and are liked by older people they have clear value. This review found that good practice in commissioning was as important as the relative merits of different approaches.

Three key elements of good practice in commissioning services to address falls and their impacts were identified:

1. Cost benefit analyses that make the case for investment. To support this, a “Ready Reckoner” for local evaluation against other priorities is proposed.

2. Strategic commissioning is in itself a valuable tool in developing and sustaining effective services. This review identified two commissioning approaches – “stately” and “let’s do it” – and argued that bringing them together makes the most of energy and strategy and achieves effective commissioning and services.

3. Interventions are most beneficial when targeted on those at risk, based on agreed assessment processes, and integrated in a falls strategy developed with the full range of local services. Interventions are most effective when targeted on those who have already fallen once and who have other risk factors.

How can we help older people not fall again?

2. Summary
National policies and initiatives have increasingly directed and supported action to support older people’s independence and wellbeing as valid goals in their own right and as components in effective health and social care services and targeted resource use.

(a) The National Service Framework for Older People (NSF) was launched in March 2001 with Guiding Principles of:

- person-centred care
- whole system working
- timely access to specialist care
- promoting health and active life.

The NSF emphasized that falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK. Standard 6 aims to:

Reduce the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen.

The Standard is:

- the NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people; and
- older people who have fallen receive effective treatment and, with their carers, receive advice on prevention through a specialised falls service.
Key interventions are:

- prevention of falls: including public health strategies to reduce the incidence of falls and the identification, assessment and prevention measures taken for those at most risk of falling
- prevention and treatment of osteoporosis: preventing osteoporosis in those at high risk and treating existing osteoporosis.

The Standard envisages that new integrated falls services will help to:

- improve care and treatment of those who have fallen, with an emphasis on preventing serious injuries which can lead to disability
- provide rehabilitation and long term support needed to help older people regain mobility, confidence and independence.

Milestones are:

**April 2003:** Local health and social care providers (health, social services and the independent sector) should have audited their procedures and put in place risk management procedures to reduce the risk of older people falling.

**April 2004:** The Health Improvement Plan (HimP), and other relevant local plans developed with local authority and independent sector partners, should include the development of an integrated falls service.

**April 2005:** All local health and social care systems should have established an integrated falls service. The **Priorities and Planning Framework 2003/06** requires that 2005 milestones about integrated falls services are met and that all Local Delivery Plans should have set out plans to achieve this.

(b) **The White Paper ‘Saving Lives, Our Healthier Nation** in 1999 led to formation of the **Accidental Injury Task Force**. It’s reports (Preventing Accidental Injury – Priorities for Action 2002; Priorities for Prevention 2003) adopt two priority groups for attention, one of which is older people. The reports and their focus on older people have gained cross departmental support. Actions arising are inevitably linked with implementation of the NSF for Older People and Standard Six.
To support the NSF the **National Institute for Clinical Excellence** (NICE) is producing guidelines on falls prevention (due end 2003) and osteoporosis and appraisal of osteoporosis drug treatments.

During 2003 the **Commission for Health Improvement, Audit Commission and Social Services Inspectorate** will jointly develop a review of the National Service Framework for older people. The work of other agencies, the views of stakeholders and the initiative to support integrated falls services will inform this work. Reviews will be carried out in local health and social care communities during 2004/5 by the Commission for Health Care, Audit and Inspection (CHAI) and the Commission for Social Care and Inspection (CSCI). Reviews will measure progress against all the NSF standards and milestones and inform maintenance and continual improvement and sharing good practice.

A raft of other policies, guidance and legislation have promoted action to support older people's independence and well being, including:

- **Modernising Social Services - Our Healthier Nation**
- **Improving Older People's Services** 2001
- **Preparing older people's strategies linking housing to health, social care and other local strategies. Department of Health.** 2003
- **Intermediate Care: Moving Forward** 2002
- **Better Government for Older People** (since 1997)
- **Building Capacity and Partnership in Care** 2001

Changes in financial systems have sought to reinforce recommended approaches, and the Health Act 1999 in particular encourages financial flexibilities and pooled health and social care budgets.

**Conclusions:**
The number and range of initiatives designed to improve well being and outcomes for older people make it imperative for commissioners to work across organisation and service boundaries if they are to take advantage of available resources.
4. Policy implementation

Actions to increase the independence of older people and, by implication, manage health and social care resources, have invariably addressed issues around falls. Specific attention has also been focused on falls nationally and locally. This multiplicity has meant that coordination and integration of different interests and interventions have become increasingly important.

(a) The national scene

The Department of Health plays the major policy role, through its policy development in health and social care, but many other departments and agencies have interests in falls prevention and older people. Coordination is difficult but the range of departments and agencies with an interest means that funding for implementation is available from a number of sources.

Within the Modernisation Agency, the Ideal Design of Emergency Access (IDEA) programme project team is looking at falls among older people. The National Primary Care Development Team (NPDT) leads two collaboratives that address falls: the Healthy Communities Collaborative and the National Falls Collaborative1. PCT pilots are taking a wide range of actions at local level to contribute to Standard 6 on falls prevention.

The Primary Care Strategy for Osteoporosis and Falls (the National Osteoporosis Society, 2002) sets clear standards for implementation by primary care organisations to offer a high quality osteoporosis service within Standard 6.

(b) The local scene

Local Implementation Teams (LITs) were set up to support local actions on each NSF. Each LIT is multi-agency and often involves older people and carers. LITs bring together and consider the targets for each NSF across different organisations and services. For the NSF for older people,

1 The roles of these initiatives and contact details are given in Appendix 1 section F.
LITs provide:

- a foundation for integrated work
- a stimulus for action in different services and organisations
- a clear multi agency base from which local planning, service changes and new initiatives can be informed and influenced within the context of delivering the NSF targets
- opportunities to access funds from various sources (including: health promotion, community development and involvement, housing improvement, transport, regeneration, social inclusion, leisure, accident prevention, community safety, health and social care, older people’s services and well being initiatives – and more!).

LITs have often provided an anchor for service development and a core focus across NHS and LA organisations, especially during the last two years of changes in NHS organisations and responsibilities.

**Falls groups and integrated Strategies** have brought organisations and services together to specifically address falls and their impacts - on older people’s lives and on health and social care systems. They have created coherence around falls and developed actions within and between organisations, services and interests. By engaging organisation wide commitment they have also provided frameworks that connect single elements to a ‘big picture’. Strategies have indicated local aspirations and provided benchmarks against which change and development can be assessed.

**Local Strategic Partnerships, Prevention Strategies and Community Safety Plans** in different areas have integrated actions to support older people’s wellbeing. Issues around falls have been catalysts for action to address risks associated with housing, transport and environmental issues. Falls have been important in encouraging actions on lifestyle, including exercise, nutrition and social networks.

**Conclusions:**

There is a wealth of instruction and encouragement to health and social care services to make interventions that reduce the negative impacts of falls. Increasingly multi-agency approaches drawing in almost all public services are encouraged.
5. Evidence and Research: falls

(a) Generic studies and evaluations

A wealth of information about falls services is available. New studies are appearing all the time.\(^2\)

Signposts to information resources (Appendix 1) highlight some of the main references currently available (largely on the internet) under the following headings:

(i) **The older person’s perspective** of falls and the risk of falling

(ii) **The impact of falls** on the health and social care systems and the health economy

(iii) **Evidence of what works in falls prevention:**

   - addressing intrinsic risk factors (such as physical/medication review) and extrinsic risk factors (environmental modification)
   - covering a range of environments, settings, levels of system complexity, leadership and delivery arrangements
   - promoting healthy and active living

(iv) **Assessment and modification of risk factors**

(v) **Whole system approaches to planning and delivery.**

(vi) The following documents provide a good (June 2003) working library. Web references are given in Appendix 1 together with signposts to further information resources.

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\(^2\) The National Institute for Clinical Excellence is currently (mid 2003) preparing guidelines on falls prevention and treatment based on a review of the evidence to date. Publication is expected end 2003.
1. The NSF for Older People. DoH. 2001


(b) Health economics

Common sense suggests that good falls interventions are likely to save resources and have resource benefits. Both are increasingly important when, despite significant extra money being put into health and social care nationally, most PCTs are having trouble funding current commitments and many LAs find budgets overstretched. Resource savings are likely to follow reductions in the number of falls which lead to hospitalisation, residential or nursing care.

However, there is remarkably little reliable published information on the cost effectiveness of falls prevention. What there is suggests that certain, targeted interventions are likely to be cost effective.
Local economics – demonstrating the relationship between costs and savings

Good facts and figures are needed to back up common sense, demonstrate potential and real savings and ensure that resources really are used to best effect. Making the case for local action needs local information.

“We need valid information about how effective fall services save PCTs and LAs money and help them meet targets.”

— Local Falls Service Project lead.

This has been the first hurdle for many falls services: the information needed to find out about falls and their impact has all too often not been available. IT difficulties (systems that are non existent, incompatible or complicated by NHS organisational changes) mean that collating information across organisations has been pragmatic (and often cumbersome) in order to:

• gather information that sets a baseline for initial planning and measurement of improvement

• identify people at risk

• target people at risk – across services and organisations

• gather better information for evaluation and further planning.

A system that brings together information from different local services and organisations can show:

• the likely incidence of falls

• the resources currently being deployed on treating people who have fallen and therefore:

  — the potential resource savings, and in particular financial resources, from reducing the number and impact of falls

  — the opportunity cost of treating people who fall (ie the potential increase in access and capacity in other areas if resources were deployed elsewhere)
Information about the incidence of falls and their consequences informs a ‘Ready Reckoner’ to help local falls services demonstrate the potential financial benefits of interventions (section 6). It provides ideas for developing this kind of system at local level. Gathering information to demonstrate connections (between costs and savings and between falls, access and capacity) will inevitably cross roles and interests. Staff developing falls services can find support for information collection among colleagues working to contain costs, develop financial recovery plans and achieve waiting list commitments.

Conclusions:

Lack of information (or lack of the right information) has made it difficult to demonstrate the connections between the impact of good falls services on increased access and capacity and reduced costs in health and social care systems. The need to make this case is increasingly clear and local Falls Strategies need to be able to do so convincingly.
6. Costs and benefits: making the case for funding

(a) ‘Ready Reckoner’ based on opportunity costs of falls in a local health and care economy, Tripless PCT (population 250,000).

Falls enthusiasts are looking for a practical approach based on good evidence that demonstrates the case for investing in falls services. The case of ‘Tripless PCT’ provides a model to demonstrate costs and benefits.

Information is required from a variety of local sources - public health services, finance teams in health and social services, acute trusts and ambulance services, housing services, the private and voluntary sectors.

Local variation will affect how the model is applied, for example:

- if Tripless has a high number of nursing beds (because a stock of larger, older properties has been low in cost) there may be less incentive to develop ‘hospital at home’ or similar schemes
- if the LA has used it’s budget to fund residential care places, length of hospital stay may be lower
- if good day hospital and intermediate care schemes have been set up, length of stay should be reduced
- if the LA has funded intensive home care schemes to maintain older people at home, the average length of hospital stay may be longer for those admitted, although the proportion of older people who fall and are admitted should be smaller
### Key issues in arguing the case for funding falls prevention services locally

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<th>Applying the evidence to Tripless PCT’s population of 250,000</th>
<th>References – details in Appendix 1</th>
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<tr>
<td>1. What is the evidence that falls prevention services are effective?</td>
<td>A review of 8 trials shows that various initiatives can reduce falls by 15% (low estimate) to 30%. It is probably wiser to base your local bids on the lower figure. Everyone will be delighted if you do better – you have a good chance.</td>
<td>e.g. BGS Guidelines Cochrane Review Effectiveness Bulletin.</td>
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<td>2. Effective interventions are not necessarily high cost.</td>
<td>Many are relatively simple, can be achieved by re-thinking current services. Osteoporosis treatment in primary care is effective, low cost, and prevents fractures.</td>
<td>For examples: Falls Strategies, Help the Aged Review, Falls and Healthy Communities Collaboratives.</td>
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<td>4. The benefits to the health and social care service are considerable.</td>
<td>Falls require emergency and unscheduled treatment. Each fall prevented reduces unpredictability in the system and increases the proportion of work which can be planned to make the best use of resources like theatre time, staff availability and capacity generally. Local figures show that for every (insert local number) older people admitted because of a fracture, (insert local number)..... will be admitted to long term residential care or require significant home help services”. “A planned admission for hip replacement has an average length of stay of  x days (insert local time – some places can achieve 5 days, the national average is nearer 10 days) and theatre time averages (local time)” ”A fractured neck of femur has an average length of stay of (insert local time – national time is about 26 days) and theatre time averages (local time)”</td>
<td>Bandolier: East Anglian Hip Fracture Study by Todd et al, BMJ 1995 referenced by Kisely, see Appendix 4 Section ii (b).</td>
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<td>5. How many serious falls happen locally to older people?</td>
<td>“Locally the number of admissions due to falls is …” (720 is an estimate from national figures available). “There are approximately 800 fractures due to falls, but not all of these will be admitted. Of these (600 about 250/260) are fractured neck of femur, which have the most serious consequences”.</td>
<td>Guideline for the Prevention of Falls in Older Persons (JAGS 49:664-672, 2001), Tinetti et al (1988) (referenced in Cryer); DH assumption; HES data (2001/2).</td>
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<td>6. What is the opportunity cost of e.g. fractured neck of femur to the NHS locally?</td>
<td>Admissions are emergencies, advance planning for discharge is not possible, older person and family/carers disturbed and distressed – arrangements tend to be more complex. “Annual number of older people with fractured neck of femur due to falls (250)”. “Bed days (250) x average local length of stay (26 days is national average for fractured neck of femur) gives total bed days of (6500). If 15% can be prevented we “save” (15% of 6500 = 975) bed days and (15% of 250 = 37) emergency operations.” “Which will mean we can do ( xx ) more planned operations such as hip replacements”.</td>
<td>Bandolier: East Anglian Hip Fracture Study by Todd et al, BMJ 1995 referenced by Kisely, see Appendix 4 Section ii (b).</td>
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<td>7. What is the opportunity cost of e.g. fractured neck of femur to social care locally?</td>
<td>“Of the (250) older people with fractured neck of femur, after 90 days: 45 will have died (18%). Of those alive at 90 days: 49 will be at home and self managing (24%); 86 (42%) will need extra carer help; 43 (21%) will need residential or hospital inpatient care; 72 (35%) will need community or social services at home.</td>
<td>Bandolier: East Anglian Hip Fracture Study by Todd et al, BMJ 1995 referenced by Kisely, see Appendix 4 Section ii (b).</td>
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</table>
Key issues in arguing the case for funding falls prevention services locally | Applying the evidence to Tripless PCT’s population of 250,000 | References – details in Appendix 1
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7. What is the opportunity cost of e.g. fractured neck of femur to social care locally? | If we can reduce falls by 15% we reduce all these figures by 15%. For example if 6 fewer people are admitted to residential / nursing home care money saved for support for older people at home is (6people x104weeks x £350= £218,400), or we can admit (6) other older people who meet criteria for admission to care.” | Bandolier: East Anglian Hip Fracture Study by Todd et al, BMJ 1995 referenced by Kisely, see Appendix 4 Section ii (b).
8. Are admissions for falls due to causes other than fractures avoidable? | Yes. Evidence shows that schemes which assess and support at A and E and work with ambulance call-outs for falls can prevent admission, assess the older person and reduce risk of future falls. (Most older people who fall self manage and don’t seek any help). | Help the Aged Review. Falls strategies
9. Have we the commitment of local partners and older people? | Supporting information about the multi-agency group who know of good local work, champion it, and are supporters of further initiatives and mainstream work to prevent as many falls as possible. Examples of “let’s do it” local schemes and their outcomes. | 
10. Are local partners willing to fund suggested interventions? | Yes, because they can see the benefits for older people and their services. | 

**Conclusions:**

Lack of clear information has made it difficult to make the case for investment in services that implement Standard 6. The Ready Reckoner proposed provides a potential model for collection and demonstration of information.
7. Local enthusiasm for falls services

The emphasis of the NSF for Older People on falls has been enthusiastically welcomed at local level because this practical issue is of great importance to older people and actions do not necessarily or immediately involve costly or new services.

Local falls groups routinely bring together representatives from 10 or more organisations that share a commitment to reducing the impact of falls. Older people and their representatives have been involved in developing many initiatives and falls groups. LITs and local falls groups considering the Standard have generated energy for falls services, evident in the huge variety of initiatives in place and attendance at local meetings about service development by upwards of 100 people.

Key issues have arisen:

- the need for co-ordinated information systems, from shared approaches to records, to easy referral systems and compatible IT

- pressures to maintain development in a context of organisation changes (including new PCTs and Strategic Health Authorities, staff movement between organisations)

- time and resources needed to co-ordinate activities and encourage further collaboration

- the need to respond to various other national policy initiatives (with what seem, to staff, a multitude of equally urgent commitments) which may make access to resources to reshape or refine services difficult

- moving from enthusiastic and often fragile initiatives to system wide, commitment and sustainable services is a challenge requiring different ways of planning and working

- approaches to commissioning in the old Health Authorities, the new Strategic Health Authorities and PCTs may differ; PCTs may have more direct contact and experience and be more in touch with local energy than Health Authorities or Strategic Health Authorities.
Falls Strategies are important local and sub regional tools in developing responses and, by documenting experiences of different systems and settings, they can inform work in other places. To make the most of this resource a selection of Falls Strategies has been placed on the web at http://www.doh.gov.uk/nsf/olderpeople/index.htm

“Integrating the work of all sorts of local organisations has been valuable – we provide support and training to assist but just as important has been the Falls Strategy. It brings all the different elements together around a focus – older people and falls. It’s like an umbrella that different organisations see the benefit of sharing.”

– PCT Older People’s Lead.

Conclusions:

The picture is of many people and organisations doing something about falls in pursuit of the NSF and other policy directives and, as a result, recognising and acting on the need for co-ordination and funding. Falls Strategies (and groups brought together to develop them) have been recognised as essential tools in developing good commissioning and services.
8. Developing Strategic Commissioning

Commissioning allocates resources to services and addresses multiple (and conflicting) demands and interests for resources for different services. Through commissioning LAs and PCTs specify and secure services and Government policy is implemented. For older people, commissioning decisions and practices determine what is available locally.

Effective commissioning can support service change and development, effective use of resources and improved outcomes\(^3\). The financing flexibilities in the Health Act (1999) and Local Government Act (2000) offer opportunities to fund the development of integrated services. Similarly the Building Capacity and Partnership in Care initiative (2001) sets out inclusive commissioning in agreements between statutory and independent social care, health care and housing sectors. However, national research\(^4\) has identified barriers to effective commissioning of services for older people including:

- inflexible organisation cultures
- inadequate management information
- lack of monitoring frameworks
- lack of, or unwillingness to undertake, joint or multi agency commissioning
- poor assessment processes
- a limited range of local service options/awareness
- resistance to multi sector working
- staffing difficulties

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\(^3\) Commissioning is one way of improving services. Others include work under the banners of the Modern NHS and Modernisation Agency (such as: re-design, service mapping, care pathways, capacity and demand analysis, collaboratives and clinical networks). Good commissioning needs to ensure these tools inform and are applied in falls work.

\(^4\) Such as: Out in the Open. Breaking Down the Barriers for Older People. DH. Public Services Productivity Panel. 2000
poor involvement of users, carers and front line staff in informing service planning, development and commissioning.

The review reported here looked for evidence of commissioning that is strategic, system wide and committed to sustainable falls services. The time is right to move falls services from ‘local enthusiasm’ to ‘strategic commissioning’ to make the most of the energy of committed staff and services working with older people.

Two broad processes in commissioning falls services\(^5\) were identified:

- the “stately”, formal or classic process
- the “sounds good – let’s do it” process.

(a) “Stately” commissioning

The “stately” commissioning process is directly affected by national guidance including:

- PCT commissioning in general
- development of the PCT Commissioning Competencies, March 2003
- the development of specific services (such as NSF commitments and NICE guidelines)
- inspection and assessment (such as by CHI /CHAI and Best Value Reviews in Local Authorities).

Increasing evidence of cost effective interventions and the use of nationally accepted guidelines will mean that commissioning for falls initiatives will become “stately”, incorporated into PCT and LA commissioning plans through the development of Local Delivery Plans, Prevention and other strategies and then Service Level Agreements with providers. In turn this trend will support planning and review, data collection and development that will create, support and sustain effective falls services.

\(^5\) Our review suggests these are relevant to other multi-factor, multi-agency and high frequency issues.
(b) “Sounds good – Let's do it” commissioning

The “Sounds good – Let's do it” commissioning process describes an approach that has instigated hundreds of small falls initiatives and services. It takes account of evidence and information to hand, what will work locally and what is needed to get going, and gets started with small schemes. Work is usually commissioned as a short term measure and often pilot or project based. Enthusiasm and energy are essential ingredients. The Help the Aged review of falls services (2003) provides an overview of initiatives and case studies of many that have begun in the spirit of “Let’s do it” while the Falls and Healthy Communities Collaboratives have generated a number of “Let’s do it” initiatives (Appendix 1 gives contact details).

Our review of local practices (Appendices 2 and 3) found that many system wide services have their origins in several “Sounds good – Let's do it” schemes (that built partnerships, interest, credibility and support across local areas and organisations) that have been brought together into a system wide approach. Working in partnership to make small, evaluated service changes and in ways that harness local interest may be an essential first stage in developing “stately” commissioning:

- small changes which can be made quickly and can be shown to have big benefits for older people and services win support
- drawing organisations and services together creates a strong base to attract and retain resources
- good outcomes build interest, commitment and support.

“Building small projects and ideas, making small changes, using ‘funny money’ – that’s only OK if each small thing is evaluated and linked to the bigger picture. Without that nothing connects and it’s much easier to lose every small change and development.”

– PCT Falls Coordinator.

“Sounds good – Let's do it” may lead to disillusionment if too many small projects start up, don't deliver measurable outcomes, fail to gain further funding, and the people with energy tire or move on. Then resources at the edge that allow “Let’s do it” are harder to find.
Making the most of “Sounds good – Let’s do it” energy and evidence requires conscious planning and preparation linked to “stately” commissioning.

It’s about moving from “Sounds good – Lets do it” to “This really works, Let’s move it forward and sustain it.”

– LA Social Services Older People’s Lead

(c) Linking “Stately” and “Sounds good – Let’s do it” commissioning.

Our review (Appendix 2) found that structures and strategies that integrate and co-ordinate development and delivery of falls services (as in falls strategies) make the most of “Let’s do it” interventions and expectations. Structures and strategies provide a framework that can contain and inform the energy that drives “Let’s do it” interventions so that different small schemes support the agreed direction for local services. At the same time it is easier to find and allocate resources for different “Let’s do it” initiatives if they are framed by an overall strategy.

“The EUREKA moment: realising that no specialist service could see all older people that fall and needing to harness the potential of existing community teams in line with the Single Assessment Process.”

– Unitary Borough Council, Older People’s Service Development Project Manager.

Falls Strategies offer a framework for commissioners to make best use of “Let’s do it” enthusiasm. Good Falls Strategies contain:

- a baseline of information and a commitment to collecting and using good information to inform service development
- mechanisms for partnership working across the range of organisations, services and roles that contribute to resolution of falls issues
- clear roles and responsibilities for different partners
- mechanisms to involve users and carers
evaluation – of each element, their contribution to the big picture, and of the whole strategy, and of the relationships between interventions and systems access and capacity

shared care pathways, referral pathways and assessment processes

timetabled and funded plans for implementation.

“There are so many things going on about falls – in different organisations and services – and more can be developed. As commissioners we can see how and why services start in a fragmented way. Bringing them together - across care pathways, in a managed clinical network and in a falls strategy or programme – can strengthen each, share skills and experiences, highlight gaps and just make it easier for us to see how fragments connect. Without that we, as Commissioners, can make services even more fragmented.”

– Unitary Borough Council, lead on older people’s services.

PCTs as commissioners need to bring “Let’s do it” energy and interventions into a “Stately” process. This requires co-ordination – through a falls co-ordinator or other role - that builds on tools for practical collaboration such as:

• collation of reporting by all local falls initiatives, under agreed headings, to all relevant partners and interests, at agreed intervals

• release of funding through a proforma for project design and delivery that links different elements into the wider strategy

• exchange of experiences, by bringing local initiatives together for recognition within the overall strategy.

Each of these tools uses a group of consistent ‘headings’ under which information is gathered, presented and reviewed so that commissioners (and others) can recognise similarities and differences and identify gaps. The headings include:

• Why was the initiative developed?

• How does the initiative contribute to meeting the NSF Falls standard?
• Does the initiative contribute to other local or national standards and Planning and Priorities Framework targets? If so what and how?

• Which stakeholders are involved? And how?

• How are older people involved?

• How are carers and family members involved?

• How does the initiative link health, social care, transport, housing, leisure and environmental services and organisations?

• What resources are used and where do they come from?

• What resources are needed to continue the initiative – and where will they come from?

• What outcomes are expected – for older people and health and social care economies?

• How will impacts and outcomes be reported and monitored, lessons identified and appropriate action taken?

“Joint commissioning at local level was recommended for our area – it builds on joint work between social and health services and extends it to involve housing. We think it’s the way forward and it makes good use of the Health Act Flexibility arrangements.”

— PCT Older People’s lead.

The development of PCT commissioning skills and experience will inform and lead good practice if ways are found of sharing it. Our review, and research in other settings6, emphasises key ingredients in successful commissioning in health and social care systems as:

• shared values – that the interests of users should be a paramount consideration

• improved – and shared – assessment processes and tools

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6 such as: Commissioning and Purchasing. Bamford, T. 2001. Routledge; The organisational development needs of PCTs in Mental health commissioning and service provision; Lester, H and Sorohan, H. www.icmh.bham.ac.uk/info/Download/PCTRaport.doc
• knowledge of the market – strengths and weaknesses, opportunities and constraints among local organisations and services

• understanding – of all costs and benefits

• fairness – equity should be visible

• openness and honest dialogue – between all stakeholders

• partnership working - increasingly evidenced in good Falls Strategies and requiring sound understanding among partners of different organisation cultures and common goals.

Conclusions:

Strategic commissioning builds on the energy of “Let’s do it” to support, through “Stately” approaches, the development of robust frameworks (for shared work, evaluation, support and measures to track performance) that can sustain services.
(a) **Defining good practice**

Published research demonstrates key elements of effective falls initiatives:

- **Strategies and connections**
  - connections between organisations and services
  - multi-systems working
  - shared visions and missions across services and roles
  - work across statutory, voluntary and private sector providers
  - integrated planning and target setting across organisations and services
  - shared budgets and risks across services and roles
  - linked to osteoporosis assessment and prevention
  - using IT and management tools that are compatible with others

- **Focus and activities**
  - a wide range of interventions
  - a range of staff and roles
  - work in several settings
  - defined target audiences

- **Access and impact**
  - multiple referral sources and routes
  - shared Single Assessment Processes and tools
— assessment by the experiences of older people who use the service and those who care for them

• by work to involve older people and carers directly

• by work to involve organisations that represent older people and organisations that represent carers

— monitoring and evaluation of outcomes

— clinical governance processes

— ‘Best Value’ frameworks

(b) Finding good practice

We hoped to find services that contained or aspired to those elements and, from those services, to identify messages for good commissioning decisions. We used a questionnaire (Appendix 2) to identify services. Follow up discussions refined our understanding of elements of effective services, their planning and evaluation and of structures needed to support success.

We found that there is not one model service, approach or structure for effective work to implement the NSF Standard for Falls, but core principles (that can frame local variation in design and implementation) and essential structures to support services (such as effective IT networks and administrative back up) are ingredients and determinants of success.

Appendix 3 provides ‘snapshots’ of different services and approaches:

**Greenwich:** highlighting development of a strategy that brings osteoporosis and falls work together and emphasises the relationship between service costs and system benefits

**Cambridgeshire:** highlighting the value of long term and cumulative work

**Hammersmith and Fulham:** highlighting how a ‘falls team’ can develop with existing roles and services, involving people who are regularly in contact with older people
**Portsmouth**: highlighting a key role for LA leadership

**Dorset**: highlighting the growth of a multidisciplinary focus on falls within an existing NHS service

**East Kent**: highlighting the value of working across areas and organisations where boundaries are complex, populations and resources scattered

**Kirklees**: highlighting how different approaches in adjacent PCTs can be brought together, sharing skills and experience and generating consistent standards and information across a wider area

**Blackpool and Fylde Coast**: highlighting the value of coordinating multiple efforts to identify implementation of the NSF Falls standard and other commitments

**Cornwall**: highlighting the value of short term, area based funding in providing a basis for wider work

**Medway and Swale**: highlighting links between falls and osteoporosis

**Bolton**: highlighting how system redesign can be the catalyst for funding and other support for falls services.

**Bradford**: highlighting the opportunity of ‘redesign’ techniques to join together elements of a falls service into a whole system that follows the Patients’ perspective and informs commissioning.

These snapshots should be read in conjunction with the report developed by Help the Aged.

A range of Falls Strategies have been placed on the Department of Health website at: [http://www.doh.gov.uk/nsf/olderpeople/index.htm](http://www.doh.gov.uk/nsf/olderpeople/index.htm) Again, these aim to demonstrate variation in pursuing shared objectives.
(c) Principles for falls services

- **Older people’s perspectives**
  - involving older people in defining and developing interventions
  - focus on priorities for older people
  - involving older people in the development of care pathways

> “The Patient and Public Involvement agenda will be a resource for falls work because it makes us look at what we do from the perspective of the people we are doing it for.”

- **Building on the care pathway approach**
  - demonstrating how interventions along the journey create savings up and down the line
  - involving all relevant services and aspects of care (especially osteoporosis and medication)
  - using single assessment processes and tools that are relevant to different parts of the pathway
  - ensuring that different roles and contributions can be part of an assessment process.

> “We need to get people away from their own professional perspectives. We’ve found that using process mapping and older people’s perspectives help do that.”

- **Defined local outcomes, outputs and time scales**
  - what will be done and over what time scale – enabling proper staff and project planning
  - what will be reported – to commissioners and to clinicians
  - ensuring that promises can be met and services sustained
  - what will be achieved over a 3 year plan
agreed and confirmed future allocations of funds – however small for 2 or 3 years hence

- **Integrated evaluation – including costs and benefits**

  - what will be measured and how defined from the start, informing reviews and modifications to the initiative and related services

  - involving shared and mutually respected tools and measures support for each player’s own audits/outcome measures alongside shared tools and measures appropriate indicators of effectiveness – for different agencies and for older people

  - apply economic assessments of the impact of falls services

  - build on analyses of local needs – among older people and among health and care services

  - measurements of progress.

“Vital elements are: good and relevant outcome measures, audits and demonstrations of success (in economic and clinical terms and from the perspective of the older person) that can be used by all the organisations that support and benefit from falls services.”

– PCT Falls Coordinator, working across three PCTs

- **Multi agency and service commitment – operational and strategic**

  - working across areas to define and implement consistent standards (this involves working across multiple PCTs where boundaries do not coincide with Social Services and / or acute NHS Trusts) to achieve shared information and evaluation and make the most of staff resources

  - working with local Acute Hospitals

  - working with various LA services – not only Social Services but housing, environment, leisure and transport

  - working with private and voluntary providers, voluntary and community organisations that support older people and their carers
– sharing and spreading information about the impact of falls on other services

– making connections between different organisations and services and falls services so that wider packages of work about healthy ageing can make most impact

“We want to enable variety and flexibility within consistent standards – that’s why we have worked hard to develop and support county wide principles among LA and NHS organisations working locally and at county levels”.

– PCT Older Person’s Lead working across 4 PCTs in one county

“Our key ingredients: a committed consultant, social services involvement and staff spread across the PCTs who had worked together in predecessor NHS trusts.”

– PCT lead commissioner on older people’s services

• **Build on small beginnings**

  – success must be demonstrated and supported by evidence of benefits – to patients, organisations and services

  – analysis of costs and benefits for each intervention

  – connect small and big interventions

  – foundations in baseline mapping, shared events and awareness approach developments in a stepped manner so that expectations can be met

  “Stepped changes have helped everyone here – it means we work to realistic expectations.”

  – Falls Coordinator, working across PCT, Acute and Ambulance Trusts and with Social Services
(d) **Structures for falls services**

- **Integration in corporate structures – for strategy and implementation**
  - bringing together existing services and roles that contribute to reducing the impact of falls
  - steering and strategy groups linked to Local Implementation Teams for the NSF for Older People and commissioners
  - staff leading or co-ordinating falls services connected to senior management teams and Professional Executive Committees
  - connections to joint commissioning approaches and flexibilities
  - organisations and services involved in falls services supported by shared or compatible IT systems and databases
  - access to specialist knowledge and information about older people with mental health needs
  - working with specialist therapists

“A large part of my job is helping different people and organisations see that they can make a difference – to what their own organisation or service is trying to achieve in general and to older people’s lives.”

– PCT Falls Coordinator working across 2 PCTs

- **Dedicated staff time and posts**
  - provide a resource for planning, support and encouragement of co-ordination and collaboration between agencies and services
  - taking an overview
  - identifying connections with various organisations and settings and enabling others to pursue the goals of falls services
  - supporting identification of common goals
  - implementing and monitoring projects.
“The most valuable thing for us has been using core staff to develop new services and projects with locums and temporary staff filling their posts. That has provided a depth of experience, contacts and local knowledge that temporary post holders are unlikely to bring”.

– PCT Falls Coordinator

- **Skilled and knowledgeable Co-ordinators**
  - working at an operational level to deliver services and at a strategic level to encourage support and inform commissioners of effectiveness and outcomes
  - able to spot and take opportunities: to work with various services and organisations, to access other services’ resources
  - in touch with older people and the services they use
  - able to involve and secure the commitment of all partners and potential commissioners at strategic and operational levels
  - developing and supporting integrated research and audit
  - supporting change management
  - seconded or appointed from existing locally relevant posts in health or social services, with bank or locum cover for their roles

“I have worked to bring organisations, roles and services together – and we have achieved a great deal. We now need someone who can take things to the next stage – and release my time for other work.”

– PCT Older Persons Lead.

- **Reviews of staffing and resources, once schemes are in place**
  - new patterns for commissioning will follow implementation of shared work and new initiatives by other agencies
  - identification of specific roles and responsibilities for players
“As more organisations and services have become involved the NHS role in providing services should change – we need to support others in providing interventions that are less about health and more about social care, exercise and so on. That way everyone’s resources are used to best effect and everyone benefits.”

– PCT Falls Coordinator.

• Incentives for individual organisations and services to join in
  – identified benefits for each organisation or service of working to prevent, manage and limit the negative impacts of falls.

Conclusions:

There is no one approach for effective falls services. A range of principles for services and the structures that support them allow consistent standards alongside varied and flexible implementation. Principles and structures come together in different ways in different contexts and times reflecting local circumstances.
10. Conclusions

Hip fractures are a major cause of morbidity and mortality, and almost all occur after a fall. In the next 50 years the number of hip fractures will probably increase greatly. About 20% of people who fracture their hips are dead within a year, and many of those who recover from hip fracture require additional assistance in daily living. Population data tend to obscure the personal impact of falls – which do and do not result in hip fracture: older people fear falls and, with the impact of fractures, their quality of life is adversely affected (Salkeld et al 2000).

The resource cost to health and social care systems of falls (and fractures) is large – in direct costs and in lost opportunity costs.

Recognition of the need and value of action to reduce falls and their impact on older people is set out in the NSF for Older People Standard 6 and evident around the country in many and varied falls interventions. The review reported here considered and emphasised how commissioning can minimise the multiple costs of falls and make the most of energy and enthusiasm (in health, social care, public, private and voluntary organisations) to reduce falls and their impact. The need to follow core principles and to demonstrate cost effectiveness of interventions is essential, alongside inevitable and welcome variety in interventions.

This variety, and the need for evidence of effects, requires collation of information and use of a clear format to demonstrate costs and savings. Sharing experience and ideas is important. Signposts to information resources and snapshots of services are especially useful in a context of developing experiences.
Appendix 1
Signposts to information resources, largely available on the internet.

A wealth of resources about falls services is available. New studies are appearing all the time\(^8\). Keeping in touch with what works can be problematic while lack of supporting research or evidence may be used to stall or sideline actions. To support commissioning, development or provision of falls initiatives, selected resources are listed in the following pages. This list is not intended to be comprehensive but to provide an overview of (and directions to find more) available information. Each resource provides directions to others that will be valuable. To ease access, web links are given where possible. (Links are also at web based document at: http://www.doh.gov.uk/nsf/olderpeople/index.htm)

The following documents provide a good (May 2003) working library.

- The NSF for Older People. DoH 2001  [www.doh.gov.uk/nsf/olderpeople](http://www.doh.gov.uk/nsf/olderpeople)

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\(^8\) The National Institute for Clinical Excellence is currently (mid 2003) preparing guidelines on falls prevention and treatment based on a review of the evidence to date. Publication is expected end 2003.


• Preventing falls and subsequent injury in older people. 1996 Effectiveness Health Care Bulletin NHS Centre for Reviews and Dissemination. [http://www.york.ac.uk/inst/crd/ehc24.htm](http://www.york.ac.uk/inst/crd/ehc24.htm) (Appendix 4)

• Guidelines for the prevention of falls in people over 65. 2000

• Feder G., Cryer C., Donovan S., Carter Y. BMJ 2000;321:1007-1011 (21 October) [http://bmj.com/cgi/content/full/321/7267/1007](http://bmj.com/cgi/content/full/321/7267/1007)


Selections of further resources are presented below in sections linked to the five elements of falls prevention services that are most likely to be part of good planning and commissioning:

i. **The older person's perspective of falls and the risk of falling**

ii. **The impact of falls**

   (a) health and social care

   (b) the health economy

iii. **Evidence of what works in falls prevention**

iv. **Assessment and modification of risk factors**

v. **Whole systems approaches to planning and delivery**

vi. **Further information and resources**
i. **The older person’s perspective of falls and the risk of falling**

Understanding the perspective and expectations of each older person is an essential part of successful falls initiatives. Good initiatives and strategies need to reflect the variation among older people of: health status, life experience, education, past employment, beliefs and attitudes, behaviours and cultures. Effective services work with older people to enable their direct involvement in service planning and implementation.

Although there is a large body of research on falls in older people, few studies address the issue of how older people perceive and construct falls and the risks of falling. The following are valuable resources.


http://www.hebs.scot.nhs.uk/topics/topicsection.cfm?topic=accidents&TCode=287&TxtSNo=0.1&TA=topictitles&TNav=1&ConNav=1&TCA=topiccontents

This is the most comprehensive study of older people’s perspectives on falls and the risks of falling. The main findings are:

- the language of falls and of old age is critical. The term “fall” is contentious: those who fall are perceived in negative terms to be old, frail and dependent and, possibly, to have a drink problem. ‘Trips’ distances respondents from negative connotations of falling

- targeting “older people” is likely to provoke negative or no responses among people who do not relate to portrayals of older age

- the emotive connotations of falls suggest that a simple focus on the issue may be negatively received or, more likely, not received at all. For many, especially younger, older people falls are perceived to be, at most, a distant future risk

- falls become salient if the person has had a ‘bad’ fall, although awareness of health problems such as osteoporosis presents options for discussion and information about falls

- most older people want to live their lives as they have done, doing things they enjoyed, and managing everyday activities for themselves
feeling young is highly valued and perceived to derive from being independent and having interests. The promotion of healthy ageing rather than a healthy old age may therefore be better received. Finding ways to enhance confidence, social activity and promote independence may be particularly effective among people for whom falls and, older age, are perceived to be a distant future risk.

http://bmj.com/cgi/content/full/320/7231/341?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Salkeld&searchid=1046189079513_13893&stored_search=&FIRSTINDEX=0&fdate=1/1/2000&resourcetype=1,2,3,4,10

This research found that the distinguishing feature between a good and a bad hip fracture was admission to a nursing home. Nearly all women would trade off almost their entire life expectancy to avoid being admitted to a nursing home: 80% of respondents said they would rather be dead.

The most important factor (threat) seemed to be loss of independence, dignity, and possessions that accompanied the move from living in their own home to living in a nursing home. The findings indicate the need for older people to be active participants in decision making around priorities for prevention and management of falls and hip fracture.

How do older people use their stairs? DTI. 2000

Interviews with 157 people aged between 65-96 years and living in their own homes sought information about risks and actions related to falls on stairs. Respondents were often able to recognise hazards that increase the chances of falling on stairs, such as leaving items on steps or carrying objects. Despite this, many did not reduce hazards. Reducing falls on stairs among this age group requires a holistic approach, with attention to environment and behaviour. However 87 % of respondents reported they had not received information on stair safety.
ii. The impact of falls

Note: Information from these sources was used to construct the Ready Reckoner for Tripless PCT (section 6)

(a) Health and social care

The National Service Framework for Older People, Standard 6 – Falls


- falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK
- osteoporosis increases the risk of fracture when an older person falls. One in three women and one in twelve men over 50 are affected by osteoporosis and almost half of all women experience an osteoporotic fracture by the time they reach the age of 70
- over 90% of hip fractures occur in older people with osteoporosis
- over 400,000 older people in England attend A&E Departments following an accident
- 14,000 people a year die in the UK as a result of an osteoporotic hip fracture. Up to 33% of hip fracture patients die within one year of fracture.

DTI statistics
http://www.dti.gov.uk/homesafetynetwork/fl_intro.htm

- each year in Britain a third of the population aged over 65 has a fall, and half of these people fall at least twice
- of the categorised falls in older people (over 65 years), 57% were due to falls on or from stairs or steps, 18% were falling from one level to another such as out of bed and 14% were due to slipping, tripping and stumbling
75% of falls-related deaths occur in the home

40% of care home admissions are as a result of a fall

falls at ages under 75 are more often associated with extrinsic or external factors like uneven pavements, loose carpets, ill-fitting shoes

falls at ages over 75 are more often associated with intrinsic or physical factors linked with ageing

it is estimated that syncope or loss of consciousness is responsible for 5% of falls in older people.

(b) The health economy

Estimates of average costs per stay following hip fractures each year bring estimated annual hospital costs to the NHS of £280 million. The East Anglian audit of cost differences across different hospitals related costs to treatments and predispositions. This audit is referred to in:
http://www.jr2.ox.ac.uk/bandolier/band25/b25-2.html

Hip fracture is the most common serious injury related to falls in older people, resulting in an annual cost to the NHS of around £1.7 billion for England (NSF for Older People 2001). 45% of this cost is for acute care, 50% for social care and long term hospitalisation and 5% for drugs and follow up. The overall cost does not include costs to carers and others of stopping work or reducing hours of employment to care for a relative injured as a result of a hip fracture.

It has been estimated (Cryer & Patel 2001; Section C below) that, in a PCT area with a population of 100,000, 420 people over 50 are admitted to hospital due to a fall each year and 140 are admitted to hospital with a hip fracture each year.

http://www.kent.ac.uk/chss/publications/fallsfragility&fractures.pdf

iii. Evidence of what works in falls services

Published research about falls services is extensive. Key findings from systematic reviews are:
• multi-factor, interdisciplinary approaches to falls prevention which address the complexity of older peoples’ lives are the most successful. This includes review of drug treatment, modification of the home environment, the identification and treatment of postural hypotension

• some evidence suggests that exercise, such as balance training (e.g., Tai Chi), reduces the risk of falls in older people

• home assessment of older people who have not been referred as at risk of falls or having fallen is not recommended as a cost effective measure

• assessment and modification of risk factors of older people who have presented to an accident and emergency department after a fall is effective

• the provision of hip protectors for some residents of nursing homes is effective.

Accidental falls: fatalities and injuries – an examination of the data sources and review of the literature on preventative strategies.
University of Newcastle upon Tyne.

This report, commissioned by the DTI, describes mortality and morbidity resulting from falls injuries in different age groups, including older people (Section 8) and reviews the literature on preventive strategies. It finds that the most successful programmes include strategies to address intrinsic risk factors (such as medical review) and extrinsic risk factors (such as environmental modification). The strongest evidence relates to these programmes.

Guidelines for the prevention of falls in people over 65
http://bmj.com/cgi/content/full/321/7267/1007

This DOH funded research was to produce guidelines which translated trial evidence about prevention of falls into recommendations that can be implemented in different settings, with the aim of reducing the rate of falls and injurious falls in people over 65. The main findings were:

• Multifaceted interventions reduce falls in older people (those over 65)

• Home assessment of older people at risk of falls without referral or direct intervention is not recommended
Assessment of high risk residents in nursing homes with relevant referral is effective

Evidence from well designed single trials shows that assessment and modification of risk factors of older people who have presented to an accident and emergency department after a fall and the provision of hip protectors in residents of nursing homes are effective

**British Geriatric Society Guidelines. Falls and Bone Health Special Interest Group. 2000**


The British Geriatric Society Guidance for falls prevention sets the ‘gold standard’ for falls service development. Many services around England are working towards this. The Falls and Bone Health Special Interest Group Resources section contains:


- examples of other guidelines for falls prevention services

  See Appendix 4


[http://www.smd.qmul.ac.uk/gp/fallsproject/implementationreport.rtf](http://www.smd.qmul.ac.uk/gp/fallsproject/implementationreport.rtf)

Also the Falls Prevention Website:

[http://www.smd.qmul.ac.uk/gp/fallsproject/](http://www.smd.qmul.ac.uk/gp/fallsproject/)

This pilot was “a multi-agency falls prevention programme within one primary care group (PCG) area. A facilitator was employed by the PCG for nine months to facilitate the implementation of the programme. The programme was developed from the evidence-based falls prevention guidelines described above and consisted of:

- implementation of risk assessment across health and social care within the PCG area

- development of a referral network capable of managing problems identified during the risk assessment.
The programme was implemented in the Romford PCG area, within primary and secondary healthcare services and social services as evidence from explanatory trials suggests that intervention within these settings can effectively reduce falls. A key element of the programme was the development and use of a falls risk assessment tool.” (see section D below)

**Preventing falls and subsequent injury in older people. 1996**
Effectiveness Health Care Bulletin, the NHS Centre for Reviews and Dissemination, York University.
http://www.york.ac.uk/inst/crd/ehc24.htm
See Appendix 4

**Interventions to reduce the incidence of falling in the elderly.**
http://www.update-software.com/ccweb
cochrane/revabstr/ab000340.htm

Interventions likely to be beneficial:

- A programme of muscle strengthening and balance retraining, individually prescribed at home by a trained health professional

- A 15 week Tai Chi group exercise intervention

- Home hazard assessment and modification that is professionally prescribed for older people with a history of falling

- Withdrawal of psychotropic medication

- Multidisciplinary, multifactorial, health/environmental risk factor screening/intervention programmes, both for unselected community dwelling older people

**Randomised controlled trial of general practice programme of home based exercise to prevent falls in elderly women.**
http://www.bmj.com/cgi/content/full/315/7115/1065

A study to assess the effectiveness of a home exercise programme, of strength and balance retraining exercises, in reducing falls and injuries in elderly women. The conclusion is: “An individual programme of strength
and balance retraining exercises improved physical function and was effective in reducing falls and injuries in women 80 years and older.”

**Impact of a dedicated syncope and falls facility for older adults on emergency care.** Kenny, R.A. et al. 2001

This review of the impact of a dedicated syncope and falls facility for older adults on emergency beds at the Royal Victoria Infirmary. Findings suggest that, while only 5% of falls are related to syncope, resources for facilities could contribute to the reduction of pressures on health and social care.

**National Osteoporosis Society Primary Care Strategy for Osteoporosis and Falls.** 2002

Clear standards are presented to enable PCTs to offer a high quality osteoporosis service as a component of Standard 6 of the NSF for Older People. PCTs can use a stepwise approach to implementation, identifying which of the high risk groups detailed in the report require immediate, medium and long-term action and to target resources as appropriate.

**Falls Fragility and Fractures. The case for and strategies to implement a joint Health Improvement and Modernisation Plan for Falls & Osteoporosis.** Cryer C and Patel S. 2001

Recommends that “healthcare providers include assessments for falls risk factors and treatment or referral to modify identified risk factors in the routine care of all older people; and particularly among those with osteoporosis. Likewise, in these same people, it is recommended that there be routine assessment of osteoporosis clinical risk factors and where they exist that the person be referred for bone densitometry”.

**Quality indicators for the management and prevention of falls and mobility problems in vulnerable elders**

“Improvements in processes of care for falls in this high-risk population may lead to substantial improvements in patient outcomes. Six indicators of these care processes were judged sufficiently valid for use as measures
of the quality of fall and mobility disorder management for vulnerable elders. These indicators can potentially serve as a basis with which to compare the care provided by different health care delivery systems and the change in care over time.”

www.helptheaged.org.uk/adviceinfo

This provides detailed case studies of various services and looks at risk assessment pathways, partnership working and specific interventions such as exercise, medication review tools and assistive devices.

Implementing the National Service Framework for Older People: Falls Conference Delegate Pack: Barnet, Enfield and Haringey Health Authority. 2002

This pack contains useful presentations and supporting OHPs.

iv. Assessment and modification of risk factors: targeted and addressing specialist needs

The contribution an older person can make to their care should not be underestimated or under-valued (see A above). Assessments should focus on the needs presented by older people and the strengths and abilities that older people bring to bear to resolve needs.

Specialist assessment should build on the Single Assessment Process (SAP) (see www.doh.gov.uk/scg/sap) in order to:

- identify and diagnose risk factors for falls associated with an older person’s health and environment
- establish how the older person (their carer and family members) have coped following previous falls and their strategies for future coping with
- identify any psychological consequences of a fall that might lead to restriction of activity
- investigate and treat for osteoporotic risk.
The depth and detail of assessment should be proportionate to individual needs.

**Single Assessment Summary: worked example**

[http://www.doh.gov.uk/scg/sap/sas.htm](http://www.doh.gov.uk/scg/sap/sas.htm)

To help local NHS bodies and councils develop their single assessment summaries as part of implementation of the single assessment process for older people the Department of Health has drafted a worked example.

**Falls Project Risk Assessment Guidelines 2002**

*Queen Mary College, University of London*

[http://www.smd.qmul.ac.uk/gp/fallsproject/riskas.rtf](http://www.smd.qmul.ac.uk/gp/fallsproject/riskas.rtf)

Multi-professional guidance for primary health care and hospital staff and social care workers derived from longitudinal studies of factors predicting falls in older people and randomised controlled trials that have shown a reduction in the risk of falling.

Five questions are directed at assessing risk:

- is there a history of any fall in the previous year? How assessed? Ask the person.
- is the patient / client on four or more medications per day? How assessed? Identify number of prescribed medications.
- does the patient / client have a diagnosis of stroke or Parkinson’s Disease? How assessed? Ask the person.
- does the patient / client report any problems with their balance? How assessed? Ask the person.
- is the patient/client unable to rise from a chair of knee height? How assessed? Ask the person to stand up from a chair of knee height without using their arms.

These questions are followed by a useful and practical chart giving suggestions for further assessment, referral options and interventions.
Medication Review: Implementing medicines-related aspects of the NSF for Older People. 2001
http://www.doh.gov.uk/nsf/medicinesop/interventions.htm

Guidance on an in-depth evaluation of a patient’s medication (prescribed and non-prescribed) targeted at older people known to be at risk of medicines-related problems.

http://content.nejm.org/cgi/content/short/319/26/1701

The number of risk factors is correlated with the risk of falling. A study by Tinetti and colleagues found the risk of falling increased from 19% when one risk factor was present to 78% in the presence of 4 or more risk factors.


A randomised controlled study to assess the benefit of a structured interdisciplinary assessment of people who have fallen in terms of further falls. Risk of falling and the risk of recurrent falls were significantly reduced in the intervention group. The chances of admission to hospital were lower in the intervention group. Decline in Barthel [functional assessment] score with time was greater in the control group.


Demonstrates that using a risk-factor based approach to assess older people who fall can prevent over 50% of falls. See below, under Kings College Hospital Specialist falls service.
v. Developing a ‘whole system’ approach

Drawing from published research the key features of a whole systems approach to falls services are:

- integrated planning and target setting for falls prevention coordinated with other services
- integrated care pathways: patient/client journey jointly mapped and monitored and action taken by range of staff / roles and skill sharing
- direct involvement of older people
- involvement of organisations that represent older people
- involves all providers on patients’ journey, including private and voluntary sector
- integrated with to clinical governance
- budget and risk sharing
- connected to other services – information and record sharing, with compatible IT systems
- uses ‘Best Value’ frameworks

http://www.audit-commission.gov.uk/reports/ACREPORT.asp?CatID =PRESS-CENTRE&ProdID=0CDF060-E76E-11d6-B1E3-0060085F8572&fromPRESS=AC-REPORT

The report argues that agencies need to develop a “whole system” approach, one built around the needs of older people. They need to share the same vision, objectives, action, resources and risk and recognise that the action of one part of the system has an impact elsewhere in the system. Service users should not be aware of the boundaries between the different organisations.

The work of one general practice in Runcorn, Cheshire is highlighted. It reduced the number of admissions to hospital among older people at the practice by 15%, to reduce the average length of stay from 6.2 days to 4.3 days, and to reduce the total hospital bed days used by the practice
by 41%. Achievement reflected work with social services to identify people aged over 65 who met three or more criteria that made them at high risk of hospital admission. Criteria included: four or more active chronic diagnoses; being in the top 3% of frequent visitors to the practice; taking four or more medications prescribed in the past six months or more.

**Out in the Open. DH Public Services Productivity Panel. 2000**
[www.doh.gov.uk/outintheopen](http://www.doh.gov.uk/outintheopen)

A focus on LA commissioning makes this a particularly valuable document.

**NeLH: Care Pathways Know-How Zone**
[http://www.nelh.nhs.uk/carepathways/icp_about.asp](http://www.nelh.nhs.uk/carepathways/icp_about.asp)

This section of the National Electronic Library for Health provides guidance, resources and literature references on best practice for designing, developing and implementing integrated care pathways.

**Falls and bone health services for older people**
*Jacqueline Close, Marion McMurdo 2003* on behalf of British Geriatrics Society Falls and Bone Health Special Interest Group. Age and Ageing, August 2003

The purpose of the paper is to share brief guidance drawn up by the British Geriatrics Society Special Interest Group on the key components of a comprehensive falls and osteoporosis service. The guidance is summarised at Appendix 4 (a).

**vi. Further information and resources**

**Preparing older people’s strategies linking housing to health, social care and other local strategies. DoH. 2003**

This document complements 2002-03 guidance on producing effective housing strategies produced by the Chartered Institute of Housing on behalf of the Department of Transport, Local Government and the Regions. It aims to: ease the process of preparing strategies; ensure that all relevant strategies include appropriate housing components in a consistent way and within a unified vision and strategic direction; enable an easy ‘read across’ from one strategy to another; and assist ‘joined up’ planning, commissioning and service delivery.
Dementia Centres

These are important sources of information and support for services for people who have dementia. To find local centres use: www.dementia-voice.org.uk

Dementia Voice has access to information resources and can provide a useful reference list on falls and people with dementia. Contact: craisbeck@dementia-voice.org.uk

NICE Falls Guidelines – due end 2003
Contact: Liz McInnes Email: liz.mcinnnes@rcn.org.uk
http://www.nice.org.uk/cat.asp?c=20116

NICE has commissioned the National Collaborating Centre for Nursing and Supportive Care to develop a clinical guideline on the assessment and prevention of falls in older people for use in the NHS in England and Wales. The guideline will provide recommendations for good practice that are based on the best available evidence of clinical and cost effectiveness.

Lead Collaborating Centre: National Collaborating Centre for Nursing and Supportive Care.

The NHS Modernisation Agency aims to support NHS organisations in improving services.

(a) IDEA – the Ideal Design of Emergency Access Programme. This two-year programme aims to redesign the emergency health care system. It is applying the best redesign principles from modern operations management to healthcare to develop new ways of working within emergency care.

(b) The National Primary Care Development Team Healthy Communities Collaborative
http://www.npdt.org/scripts/default.asp?site_id=4

The Healthy Communities Collaborative aims to:

- provide a template for multi-agency working
- reduce falls in older people within the geography of the participating site by 30%
• stimulate a desire in the communities to impact on other health topics

• remove barriers to organisations engagement with communities.

Three sites are participating in the pilot wave: Easington, Gateshead and Northampton. The collaborative change package is:

• understanding the need

• reducing personal risk

• reducing environmental risk.

The main focus of the HCCP is prevention in the community and many service changes have arisen from the multi-agency approach. For details of how they achieved reductions in falls see page 3 of the latest NPDT Bulletin


(c) The National Primary Care Development Team, National Falls Collaborative


These 20 sites were funded outside the Healthy Communities Collaborative and arose from the high volume of applications for the HCCP. The sites each have one team which is composed of a wide range of service providers and there is some involvement from service users. The teams investigate the pathway from the community through services back home and work with colleagues across primary, secondary, tertiary and the care sector. The Falls Collaborative involves making small system changes and maximising on the benefits. The NFC shares the same change package as the HCCP and a number of initiatives have resulted in a reduction in falls. Other aims are to:

• reduce falls in a care home by 50%

• reduce admissions from a care home into acute services, as a result of a fall, by 50%

• develop falls register

For further information see the latest NPDT bulletin – above.
AGILE Falls Network
Chartered Society of Physiotherapists
http://www.agile-uk.org/fallsnet.html

CSP has established a list of contacts of physiotherapists who belong to a ‘Falls Network’. This will be useful to Allied Health Professionals trying to set up Clinics, Assessment proformas, outcome measures and the like, who can ring others for information without having to reinvent the wheel.

Preventing accidental falls in and around the home. DTI
http://www.preventinghomefalls.gov.uk/preventinghomefalls/carers.htm

Guidance on preventing accidental falls in the home aimed at friends, neighbours, relatives and carers of older people. The booklet provides guidance on how to recognize those at risk and indicates the sorts of things that can be done in the home, often at low cost, to make a safer home environment. A comprehensive contacts list is also provided.

Bandolier
http://www.jr2.ox.ac.uk/bandolier

This is a useful internet site containing several interesting short reports on falls. Use the search engine for falls.

DTI Home Safety
http://www.dti.gov.uk/homesafetynetwork/fl_goodp.htm

This site gives good practice examples

http://www.dti.gov.uk/homesafetynetwork/mm_winners.htm

This site shows current Modernisation Fund applications.

‘Active for Life’
http://www.active-for-life.com

A number of falls coordinators have found this site useful as a retail source of information, videos and CDs.
1. **Methods**

Analysis of research literature and evaluations of falls services informed a brief questionnaire that aimed to identify transferable lessons for commissioning. We sought information under three headings:

- strategies and connections
- focus and activities
- access and impact.

The questionnaire was emailed to 125 organisations, services or people working with services for older people including:

- older people’s leads in strategic health authorities
- leading researchers in the context of falls
- Local Authorities Policy into Practice sites
- the AGILE falls network
- the Kings Fund falls database
- NICE falls guidelines contacts
- a selection of services highlighted in other research
- relevant voluntary organisations.
We had not initially contacted PCTs because Help the Aged shared with us a draft of their review based on contact with 98 PCTs (www.helptheaged.org.uk/adviceinfo).

Databases for making field contacts were far from up to date – largely reflecting changes in NHS structures and systems and what we know to be high turnover among staff in short term schemes. Some recipients forwarded the questionnaire to others. This was especially the case for Strategic Health Authority leads, many of whom forwarded our request to PCTs.

85 responses were received from:

<table>
<thead>
<tr>
<th>Category</th>
<th>Responses</th>
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<tbody>
<tr>
<td>PCTs</td>
<td>54</td>
</tr>
<tr>
<td>Hospital Trusts</td>
<td>18</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>7</td>
</tr>
<tr>
<td>Ambulance Trust</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health Trust</td>
<td>1</td>
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<tr>
<td>Voluntary organisation</td>
<td>4</td>
</tr>
<tr>
<td>North East</td>
<td>17</td>
</tr>
<tr>
<td>South East</td>
<td>16</td>
</tr>
<tr>
<td>London</td>
<td>14</td>
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<tr>
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</tr>
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<td>South West</td>
<td>11</td>
</tr>
<tr>
<td>North West</td>
<td>12</td>
</tr>
<tr>
<td>Midlands</td>
<td>6</td>
</tr>
</tbody>
</table>

This pattern reflects response rates only, not activity or interests in activity.

Follow up ‘phone calls, emails and visits to 20 initiatives provided more information and insight about:

- how commissioners had been engaged
- how partner organisations / services had been brought together
- how the views and experiences of older people were assessed and integrated into learning.

Various services were brought to our attention, varying from very local and small scale schemes to county wide Strategies integrating diverse components. We were particularly looking for schemes that demonstrated lessons for commissioners that would support good decisions – about small and large schemes.
2. Findings (Note: not all responses answered all questions).

<table>
<thead>
<tr>
<th></th>
<th>Yes Advanced</th>
<th>Yes Just begun</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connected to other services</td>
<td>51</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>Involved in wide multi-systems working</td>
<td>45</td>
<td>27</td>
<td>5</td>
</tr>
<tr>
<td>Sharing visions and missions across services and roles</td>
<td>52</td>
<td>21</td>
<td>4</td>
</tr>
<tr>
<td>Working with independent voluntary and private sector providers</td>
<td>31</td>
<td>27</td>
<td>11</td>
</tr>
<tr>
<td>Integrating planning and target setting with other services</td>
<td>23</td>
<td>37</td>
<td>16</td>
</tr>
<tr>
<td>Sharing budgets and risks across services and roles</td>
<td>21</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>Linked to osteoporosis assessment and prevention</td>
<td>30</td>
<td>29</td>
<td>15</td>
</tr>
<tr>
<td>Using IT and management tools that are compatible with others</td>
<td>5</td>
<td>14</td>
<td>48</td>
</tr>
</tbody>
</table>

B. Focus and activities: respondents involved:

74  a wide range of interventions
74  a range of staff / roles
63  work in several settings
62  defined target audiences

C. Access and impact: respondents used:

67  multiple referral sources and routes
34  shared Single Assessment Processes and tools
52  assessments of the experiences of older people who use the service
by work to involve older people directly
by work to involve organisations that represent older people
monitoring and evaluation of outcomes
clinical governance processes
‘Best Value’ frameworks.
The snapshot summaries of services provided here are intended to highlight ways of working that inform commissioning to implement the NSF for Older People Standard 6, Falls. To find out more about any one service please contact the organisation cited. A full description of a range of local falls initiatives is available from Help the Aged: www.helptheaged.org.uk/adviceinfo

Snapshot Greenwich:

– highlighting development of a strategy that brings osteoporosis and falls work together and emphasises the relationship between service costs and system benefits

A multi agency falls advisory group has developed a strategy for work on falls across community and acute settings. The group is accountable, and reports, to the NSF LIT. A project manager appointed as part of the London Older People’s Service Development Programme (www.london.nhs.uk/olderpeople) led development of the group and its work. Priority has been given to:

• building on existing provision and involving existing teams

• development of an integrated falls service across primary and secondary health care and social care

• a single point of contact for referral

• shared pathways and the single assessment process

Interventions have been defined and supported in a clear model for screening and referral in line with the Single Assessment Process
How can we help older people not fall again?

Contact: Maggie Rastall Unitary Borough Council, Older People’s Service Development Project Manager, Greenwich Social Services, 20 Orangery Lane, Eltham SE9 1HN.
Tel: 07931 595671
Email: Maggie.Rastall@Greenwich.gov.uk

Snapshot Cambridgeshire:

– highlighting the value of long term and cumulative work

This service began in the late 1990s as local NHS organisations worked to reduce above average incidence of hip fractures among older people living in both urban and rural areas. Steady development has rested on:

• successive commitment of funding for more than a year at a time – and sometimes for future rather than present funds

• the early appointment of a falls coordinator working across LA, SS and NHS services

• an inter agency steering group involving PCG/Ts, Social Services Adult and Homecare teams, LA Housing services and wardens, City and District Leisure services, Age Concern and secondary care

• operational and strategic work based on knowledge of local working arrangements and an ability to make connections between different services and the falls programme

• direct connections between the falls service, Senior Management Teams, Professional Executive Committees and Joint Vulnerable People’s Group
• integrated evaluation, data collection and reporting on every initiative to every partner

• pragmatic actions that respond to opportunities and interest.

The project supports a wide range of interventions across the partner organisations. Over time the emphasis on working with older people in the community and especially in their own homes has increased. This has tailored action plans and supported the active involvement of older people in work to manage the risks associated with falling.

Evaluation is integrated with all interventions and informs development and review. The steady development and integration of falls initiatives in this area – across organisation and service boundaries – is clearly linked to this approach and the sound information base generated – about costs, benefits, contributions and successes.

“A large part of my job is helping different people see that what they do can make a difference – to what their organisation is trying to do and to older people’s lives.”

– PCT Falls Co-ordinator

Contact: Jackie Riglin, Falls Co-ordinator Cambridge City and South Cambs PCTs, Chesterton Medical Centre, Union Lane, Cambridge CB4 1PT
Tel: 01223 883710
E mail: jackie.riglin@cambcity-pct.nhs.uk

Snapshot Hammersmith and Fulham:

– highlighting how a ‘falls team’ can develop with existing roles and services, involving people who are regularly in contact with older people

This service involves multidisciplinary, interagency, client centered interventions and health promotion to residents at risk, or who have fallen, in the Borough. A multi disciplinary ‘team’ brings staff working in Social Services, the Acute Hospital Trust and the PCT together around a focus on falls. Except for the core inter-disciplinary team including the coordinator, falls is one part of the work of each staff member.

Key ingredients in developing the team have been:

• consultant commitment to action

• initially, release of permanent staff to set up and then provide coordination for the service, with their posts backfilled by new / temporary staff
• linkage with acute and social services, community and leisure initiatives to support older people in their own homes

• integration of roles for dieticians, nurses and OT in the falls service

• long term working links between key staff and some staff moving between organisations, sharing knowledge and understanding of roles and responsibilities as they did so.

Proactive audits, outcome measures and demonstrations of effectiveness – in terms of older people’s experiences and for clinical outcomes – are integrated throughout the service. Evidence of benefits for all interests has achieved permanent staffing for coordination.

Contact: Falls Intervention Service Co-ordinator, Physiotherapy Dept, Charing Cross Hospital, Fulham Palace Rd
Tel: 020 8846 7619
Email: until August 2003: sarah.cox@hf-pct.nhs.uk

Snapshot Portsmouth:

– highlighting a key role for LA leadership

The City Council Social Services Older People’s team leader chairs the LIT for the older people’s NSF. It’s focus on strategic information about falls led to questions about causes and management and the development of a district wide operational falls group, linked to the LIT.

The work of the falls group reflects:

• major pressure on A and E services from falls

• poor scores on A and E indicators

• local commitment to prevention services

• use of short term resources in a long term strategy

• the passion of key staff – a local Consultant Geriatrician, a Social Services prevention manager and a lead physiotherapist

Work includes:

• staff awareness and education about the causes of falls
- pilot projects in residential care settings (LA and independent, using LA capacity building partnership funding)

- exercise classes (HAZ funded)

- joint SSD and NHS podiatry services in day and health centres

- links between GPS and the Ambulance Service after falls

- a specialist nurse post (using NHS growth monies)

- LA funded physiotherapy services (training funds).

Contact: Sarah Mitchell, Assistant Director Older People, Social Services Department, Portsmouth City Council, 1st Floor Civic Offices, Guildhall Square, Portsmouth PO1 2EP
Tel: 023 9284 1155
Fax: 023 9284 1185
Email: sarah.mitchell@portsmouthcc.gov.uk
Web: www.portsmouth.gov.uk

Snapshot Dorset:

- highlighting the growth of a multidisciplinary focus on falls within an existing NHS service

A PCT intermediate care service and resource team provided the evidence and clinical base for focused work on falls. A falls service builds on the approach of the team (promoting independence, preventing hospital admission and enhancing discharge) and its daily work (assessment, treatment and rehabilitation in the older person’s home or in an outpatient setting).

Evaluation of a pilot falls service refined plans and ways of working so that the falls service became a core element of the wider resource team, funded by PCTs and Social Services and supported by the Acute Trust. Key ingredients in successful outcomes for older people and services have been:

- clinical commitment and leadership – consultants from the acute hospital, the PCT Nurse Consultant and the PCT specialist nurse who screens referrals and co-ordinates the clinic
• strategic leadership and management – the PCT project manager for older people

• integration within the wider multi-agency and multidisciplinary team which was already well regarded and securely funded.

Contact: Dr Matt Thomas, Consultant Physician, Poole Hospital NHS Trust Tel: 1202 448160
Fax: 1202 442993
Email: Matt.Thomas@poole.nhs.uk

Snapshot East Kent:

– highlighting the value of working across areas and organisations where boundaries are complex, populations and resources scattered

Consistent falls interventions across four PCTs and LA Social Services teams within one county area have been planned by a multi-agency and multi disciplinary group as an evidence based service that will go on to develop into an Integrated Care Pathway. In line with recommendations regarding Integrated Care Pathways, decisions about the service have been shared following consultation with all agencies:

• four PCTs

• the Acute Trust

• Social Services

• voluntary and community organisations

• the Ambulance Trust.

Securing multiple agency and service commitment to the service has been linked to the cumulative development of the service:

• from a late 1990s Health Authority focus on falls to encompass and pursue the NSF

• a coherent district focus that brings four PCTs working with one Acute Trust together

• consistency among staff working at strategic levels – especially in the appointment to the post of Fall and Fracture Strategy Facilitator
• connections between strategic and operational work

• ‘change management’ skills and approaches among strategic staff – to support the development of new ways of working and support change and encourage people to contribute

• research based training

• comprehensive information and training for staff in all relevant sectors and services.

At the same time recognition of the need for cultural change has guided work to integrate training about managing falls in the educational and training structures used locally – from non NVQ structures to degrees.

“We work across all the PCTs to ensure consistent standards, share scarce resources and support new ways of working.”

Contact: Alison Knox, Fall and fracture strategy facilitator, Canterbury and Coastal PCT, Unit 118 John Wilson Business Park, Reeves Way, Chestfield, Nr Whitstable, Kent.
Tel: 01227 795056
E mail: Alison.Knox@ekentha.nhs.uk

Snapshot Blackpool and Fylde Coast:

– highlighting how different approaches in adjacent PCTs can be brought together, sharing skills and experience and generating consistent standards and information across a wider area.

The Local Implementation Team for the NSF supported the different approaches and work of two Falls Co-ordinators who worked together in the development of a holistic approach across the Fylde Coast (three PCT’s & three Borough Council areas). They worked with a wide range of agencies and services supporting older people in developing a service mapping exercise which included voluntary and statutory services and networks

• Care pathways for older people after a fall (this includes Prevention & Rehabilitation strategies)

• Process maps, highlighting areas for change to improve service outcomes and users experiences
• A service users’ forum across three PCTs.

• Education programme for all those establishments who are involved in care of older people.

The work was multi-agency and multidisciplinary, involving the whole range of public, private and voluntary services with which older people have contact. A strategy to reduce falls and fractures amongst older people in the three PCT areas was agreed in principle by the LIT and local commissioners (PCTs and Social Services). Continued funding (PCTs and Social Services) for both falls service coordinators has now been received and with the support of community agencies such as Care and Repair etc. will enable implementation.

Contact:
Fylde and Wyre PCT, Richmond Rehabilitation Unit, Devonshire Road Hospital, Devonshire Road, Blackpool, Lancs FY3 8AZ
Ashok Khandelwal, Chair, NSF Older People Standard V1
Tel: (01253) 303359
E-mail: ashok.khandelwal@bwfchs-tr.nwest.nhs.uk
Diane MacDonald, Falls Services Co-ordinator
Tel: (01772)686031

Snapshot Kirklees:

– highlighting the value of coordinating multiple efforts to identify implementation of the NSF Falls standard and other targets.

In the absence of a falls co-ordinator and in the presence of a plethora of activity a district wide Falls Strategy Group was formed, linked with two Local Implementation Teams for the NSF for Older People and involving LAs, NHS Trusts, PCTs, Social Services and voluntary organisations. The Group built on longstanding local partnerships – a multi agency group focussed on falls, health promotion functions crossing services and public service strategies for different services.

A forward plan, initially for 2003-2005, for partnership working aimed to implement the NSF standard 6, locally identified falls prevention action and the Local Public Service Agreements for accidents. It included action on:

• data collection and analysis

• safe home and hospital environments
• mobility, activity and healthy living for older people

• medication

• information

• reduced injuries associated with falling.

The plan enhances the value of different local activities and provides a timetable and framework for new interventions, ad hoc and short term resources and for redirection of existing resources. The agencies and services involved have achieved major improvements in health outcomes and patient experiences with limited new resources.

Contact: Julie Tolhurst, Health Promotion, Huddersfield Central and South Central PCTs, Princess Royal Health Centre, Greenhead Road, Huddersfield HD1 4EW
Tel: 01484 344276
Fax: 01484 344281
E mail: julie.tolhurst@cht.nhs.uk

Snapshot Cornwall:
– highlighting the value of short term, area based funding in providing a basis for wider work.

Health Action Zone funding in the late 1990s supported a Consultant led focus on falls prevention and management. A local steering group defined actions and paved the way for the Health Authority to develop work to implement the NSF Standard 6 across the county. The HA approach emphasised primary care and the development of common principles for action across the county within which (then) PCGs could develop local design and implementation.

A county wide steering group developed the principles and strategy and brought organisations together to define action plans for local areas, organisations and services. The group has been chaired by a PCT NSF Implementation Manager who had worked in various roles in the area for many years.

Achievements across the county include:

• mapping services and gaps to inform commissioning plans

• assessment tools for all settings
• agreed protocols for risk identification
• awareness raising
• improved communication between services and organisations

Local and county-wide work has sought to define practical, achievable and sustainable outcomes by each of the different organisations and services involved. This has involved changing ways of working to achieve better outcomes with the same resources. Sustaining motivation during transition has been essential, achieved through recognition of success, valuing different perspectives and approaches and the continued encouragement and leadership of the Steering Group Chair.

Contact: Lynne Kendall, Acting Director of Public Health, North & East Cornwall Primary Care Trust, Lamellion Hospital, Station Road, Liskeard Cornwall PL14 4DG
Tel: 01579 335375
Email: lynne.kendall@nepct.cornwall.nhs.uk
Web: www.fallsprevention.co.uk

Snapshot Medway and Swale:

– highlighting links between falls and osteoporosis.

The impetus for the group grew out of project work to screen older people for osteoporosis and recognition that falls were an essential part of osteoporosis services. This joint initiative between a local GP Practice, Osteoporosis Unit, nurses and allied health professionals developed into a wider steering group two PCT areas and made up of representatives from health and social services, other LA services, older people, independent providers and voluntary organisations.

The group has focused on achievable changes that demonstrate improved outcomes – quickly. A strategy based on assessment of existing services and resources relies on new ways of working to achieve success. Local commitment to improving outcomes for services and older people includes:

• the development of a simple risk assessment tool for wide use
• education and training – including awareness raising, workshops and learning modules for service providers
• public health promotion
• a proposed project with pharmacists visiting older people at risk of falling

• information exchange with older people and their carers

• replicating the original project considering how integrated work could prevent fractures associated osteoporosis and falls.

• consideration of how the Out Of Hours services (eg ambulance, community nursing, GP co-operative) can work more effectively together to manage vulnerable people during the evening and at night in particular residents of care homes

• build on the existing falls service at one of the local community hospitals to provide a comprehensive service for the identified ‘high risk’ groups

Notwithstanding success to date the group have proposed the appointment of a falls co-ordinator to take the work forward, work more strategically across the area and with the various relevant organisations (and release the PCT manager who has led this as one of many roles).

Contact: Helen Martin, Professional Lead, Integrated Working, Hawthorn Road Clinic, Hawthorn Road, Strood, Kent ME2 2HU
Tel: 01634 294654
Email: helen.martin@tgt.sthames.nhs.uk

Snapshot Bolton:

- highlighting how whole system redesign can change commissioning.

A whole systems re-design programme for Older People's services in Bolton (commissioned by the PCT, Acute Trust and LA and led by the PCT) provides the context for commissioning an integrated fall service. The service builds on earlier achievements:

• A multidisciplinary falls service (Launched in January 2003)

• Appointment of a falls co-ordinator

• A risk assessment tool across primary and secondary care

• Expansion of primary care prevention (including work in sheltered housing, day centres and voluntary services).
Agreed priorities to support the development of an integrated model of care for falls include:

- setting up assessment and care co-ordination teams in each district / local health group
- a robust capacity modelling process across the whole system
- joint commissioning processes through the Partnership Board for Older People.

Joint commissioning between the PCT and LA supports local flexibility in response to local need and creates a critical mass that will provide a lever for change and an opportunity to ensure a greater focus on work around prevention, health inequalities, addressing the needs of minority groups and ensuring Best Value principles are applied.

Contact: Genese Warburton, Programme Manager Older Peoples Services, Bolton Primary Care Trust
Tel: 01204 547842
Email: Genese.Warburton@BOLTON.NHS.UK

Snapshot Bradford:

- highlighting the opportunity of ‘redesign’ techniques to join together elements of a falls service into a whole system that follows the patients perspective and informs commissioning.

A District Falls Prevention coordinator post developed from a generic post about accidents, first funded by HAZ in 1999. This was the focus for development of:

- a peer mentor scheme educating people about falls prevention
- a protocol for the local ambulance service to refer to a fast response intermediate care service as an alternative to A&E
- falls assessment by Home Care services and Rapid Access Clinic.

Bradford became a ‘Pursuing Perfection’ site in 2002. Falls is one of two initial work areas. The ambition is to create a truly integrated service that makes sense from a patient’s point of view.
Initial progress has included work towards:

- a follow up system, in each primary care trust in the area, for people who go to A&E having fallen
- a consistent and transparent assessment framework for falls across primary, secondary and social care that is integrated with the EASYcare single assessment tool for older people, and linked with osteoporosis risk assessment. Three levels:
  - First level (screening): a 5-question screening tool used by first contact agencies to identify people at high risk of falling
  - Second Level (primary care, comprehensive assessment): in the older person's home, covering intrinsic and external risk factors for people at high risk. This links to interventions – exercise, handyman scheme, specialist OT and Physiotherapy – and identifies unexplained falls that need specialist multi-disciplinary assessment
  - Third level (specialist, multi-disciplinary assessment): hospital based with facilities for further medical assessment and intervention
- mapping exercise provision
- integrating medicines management and information
- gathering feedback from older people about their needs, likes and dislikes in a falls service.

The Pursuing Perfection initiative is work in progress. Over the next year this work at a whole system level will clarify roles, capacity and demand for different elements of a falls service, and will inform commissioning decisions.

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Appendix 4
Guidelines on falls services

(a) **Guidance on services for falls and fracture prevention in older people. British Geriatric Society (BGS) Guidelines for the prevention of falls in older persons. 2001**


1. Primary Care Assessment – routine enquiry about falls whenever older people have contact with the primary care team or social services (as part of single assessment process). Agree initial primary care assessment and local secondary care referral criteria.

2. Referral pathway from the community for outpatient multidisciplinary assessment and treatment of community dwelling fallers, including strength and balance training by a physiotherapist. A home visit by an experienced occupational therapist to raise awareness of safety issues may be appropriate for selected patients.

3. Referral pathway from A&E for the multidisciplinary assessment of older people presenting to A&E with a fall including access to specialist medical review and access to detailed cardiovascular investigation for patients with non-accidental falls. A home visit by an experienced occupational therapist to raise awareness of safety issues may be appropriate for selected patients.

4. Referral pathway from community to physiotherapist-led (or nurse-led following training by a physiotherapist) home exercise programme for community dwelling, cognitively intact people aged 80 years or over.

5. Referral pathway from secondary care to a syncope/cardiovascular investigation/unexplained falls assessment service.

6. Use of calcium+vitamin D supplements in ambulatory female nursing/residential home population.

7. Risk factors for falls and osteoporosis to be considered and addressed in a combined approach to prevention, particularly in those who have already sustained a low trauma fracture.
8. Hip protectors are recommended for those at risk of hip fracture, particularly older people in care, although problems with compliance should be recognised.

9. Appoint a falls coordinator (e.g. a clinical nurse specialist) who will have management responsibility (important that he/she is within the PCT hierarchy) to liaise with primary and secondary care, social services, housing, ambulance, voluntary sector etc. to develop a coordinated approach to falls services, health promotion and audit.

http://www.update-software.com/ccwebcochrane/revabstr/ab000340.htm

The Cochrane review found a number of interventions which appeared to be successful in reducing falls. The interventions most likely to be beneficial were:

- a programme of muscle strengthening and balance retraining, individually prescribed at home by a trained health professional (3 trials, 566 participants, pooled relative risk (RR) 0.80, 95% CI 0.66-0.98)
- a 15 week Tai Chi group exercise intervention (1 trial, 200 participants, risk ratio 0.51, 95% CI 0.36-0.73)
- home hazard assessment and modification that is professionally prescribed for older people with a history of falling (1 trial, 530 participants, RR 0.64, 95% CI 0.49-0.84)
- withdrawal of psychotropic medication (1 trial, 93 participants, relative hazard 0.34, 95% CI 0.67-0.94)
- multidisciplinary, multifactorial, health/environmental risk factor screening, intervention programmes, both for unselected community dwelling older people (data pooled from 3 trials, 1973 participants pooled RR 0.73, 95% CI 0.67-0.94).
It seems plausible that a 20-30% reduction in falls could be achieved. There is a lack of good evidence about reduction in injuries, but this is likely to be simply because the studies were too small to pick up this effect.

(c) Preventing falls and subsequent injury in older people (1996) Effectiveness Health Care Bulletin, the NHS Centre for Reviews and Dissemination at York University http://www.york.ac.uk/inst/crd/ehc24.htm

Key findings:

- Some evidence suggests that exercise, such as balance training, is effective in reducing the risk of falls in older people. Access to such interventions should be offered and ways of promoting uptake should be investigated. New programmes should be part of controlled evaluations.
- Home visits and surveillance to assess and where appropriate, modify environmental and personal risk factors can be effective in reducing falls. This can be carried out by nurses, health visitors, occupational therapists or trained volunteers.
- Soft hip protector pads have been shown to dramatically reduce hip fractures in frail older people in residential care. Their effect and acceptability in the community needs further research.
- High dose Vitamin D supplementation with or without calcium appears to be effective in reducing fractures. Research is needed to identify the most cost-effective strategy.

8 The National Institute for Clinical Excellence is currently (mid 2003) preparing guidelines on falls prevention and treatment based on a review of the evidence to date. Publication is expected end 2003.
How can we help older people not fall again? Implementing the Older People’s NSF Falls Standard: Support for commissioning good services is available on the department’s website at: www.dh.gov.uk/