

Falls

November 2019

DRAFT

Public Health
London Borough of Lewisham



Contents

Introduction	3
Facts and Figures	3
What are the key inequalities?	8
Targets and Performance	9
National and Local Strategies	13
What works?	16
Current activities and services in Lewisham	18
What is this telling us?	23
What should we be doing next?	24
References	25

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Introduction

A fall is an unexpected event in which a person comes to rest on the ground, floor or a lower level. There are over 400 possible risk factors for falling, including age, muscle weakness, drug therapy, balance deficit, cognitive impairment, the environment, visual impairment and depression¹.

In the UK 30% of people older than 65 and 50% of people older than 80 will fall at least once a year². Each year over 700,000 older people in the UK attend hospital Accident & Emergency departments following a fall³, and many more attend Minor Injury Units or call for ambulance assistance. Approximately 10% of the UK ambulance service calls are to people over 65 who have fallen and about 60% of these cases are taken to hospital.

The associated mortality and morbidity from a fall is high. This includes psychological and physiological stress as well as physical injury, threatening functional independence and resulting in reduced health related quality of life.

Purpose of the Needs Assessment:

- To provide an overview of the epidemiology of falls in Lewisham and nationally.
- To review the evidence and recommendations for effective management of falls and quality care services.
- To identify current service provision.
- To identify gaps in current service and make recommendations for local planning and strategy formulation

This is a refresh of the 2013 needs assessment and provides an update of the previous findings.

What do we know?

Facts and Figures

1. Lewisham has a population of 303,500 with 28,500 residents aged 65+. Thus the proportion of the population aged over 65 years is 9.4%, compared to the England average of 18.2%. This is expected to rise to 10.2% by 2025⁴.
2. Within the borough in 2018 there was a 15% reduction in the number of people aged over 65 who presented to the London Ambulance Service with a fall, 2342 compared to 2739 the previous year⁵.
3. In 2017 6% of the Lewisham ambulance service calls were to people over 65 who had fallen and 73% of these cases were taken to hospital⁶.

- There were also 160 hip fractures in 2017-18, costing Lewisham Borough approximately just over £1 million. Hip fractures for those aged over 80 were lower than the national level at a rate of 1,458 per 100,000 compared to the England rate of 1,539 per 100,000⁷.

Figures 1-3 below show recent trends for admissions to hospital following a fall in the population aged 65+. Within Lewisham over a two year period the number of admissions fluctuated month by month, reaching a peak of 103 in June 2018.

Figure 1. Graph to show the admissions attributed to falls in persons in Lewisham 2016-2018

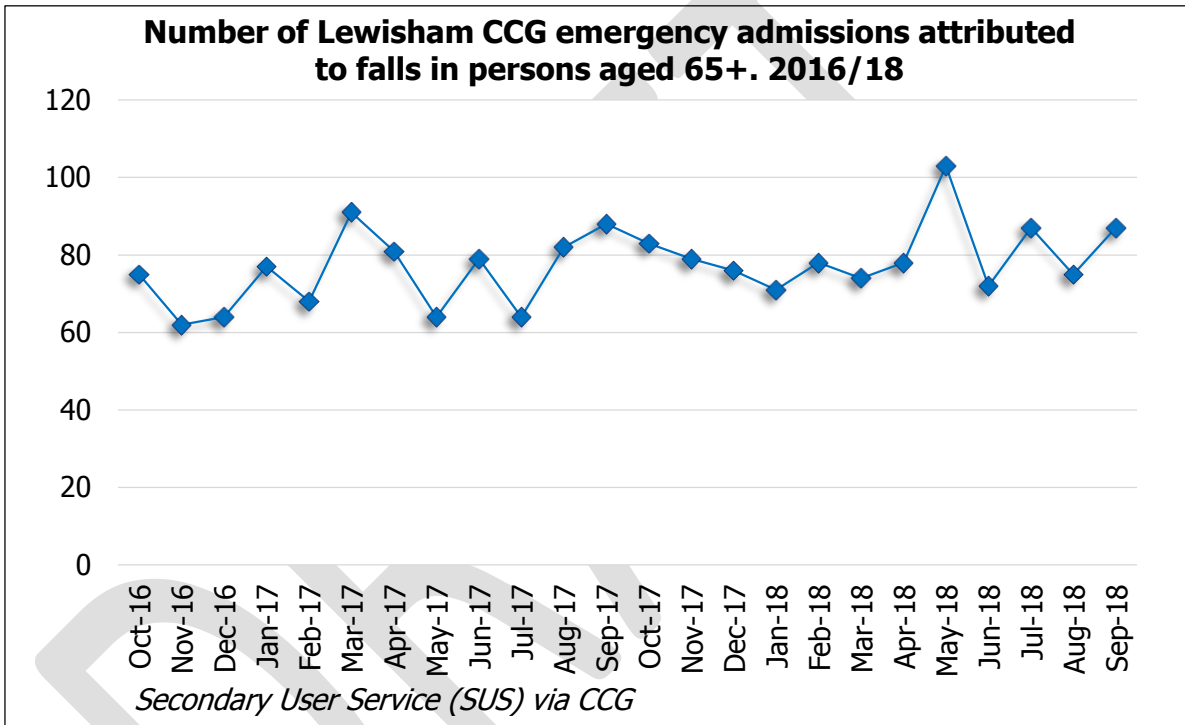
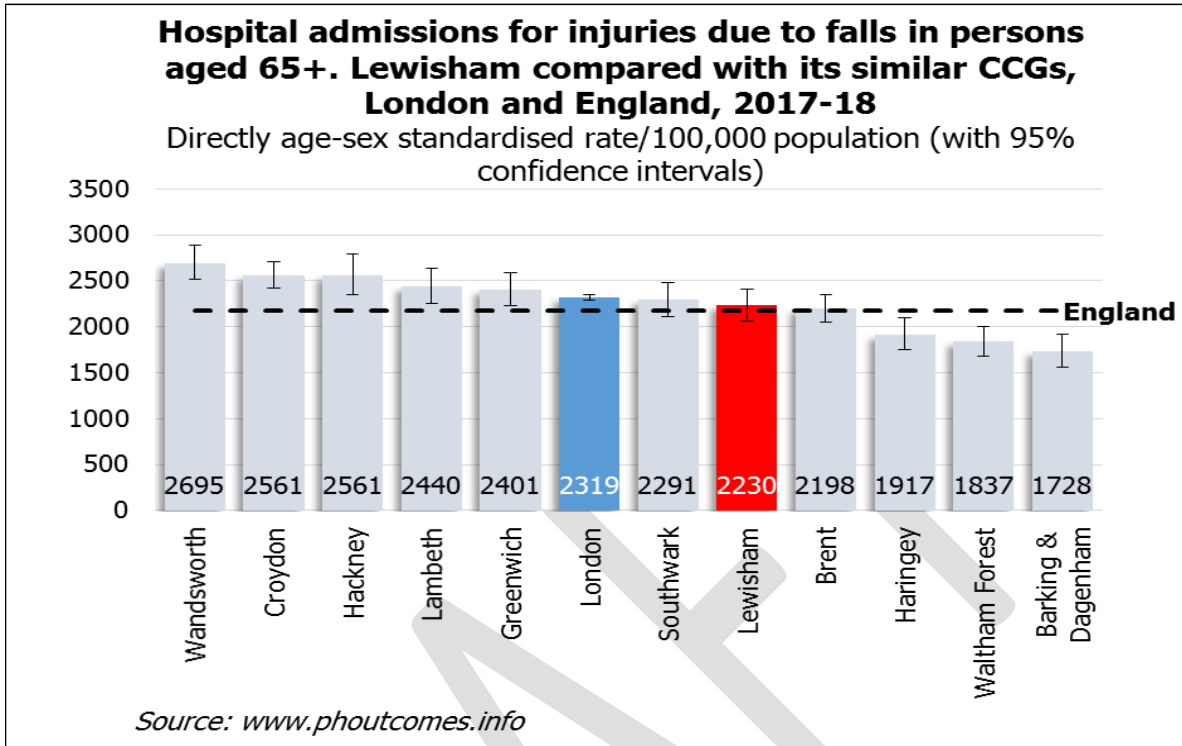
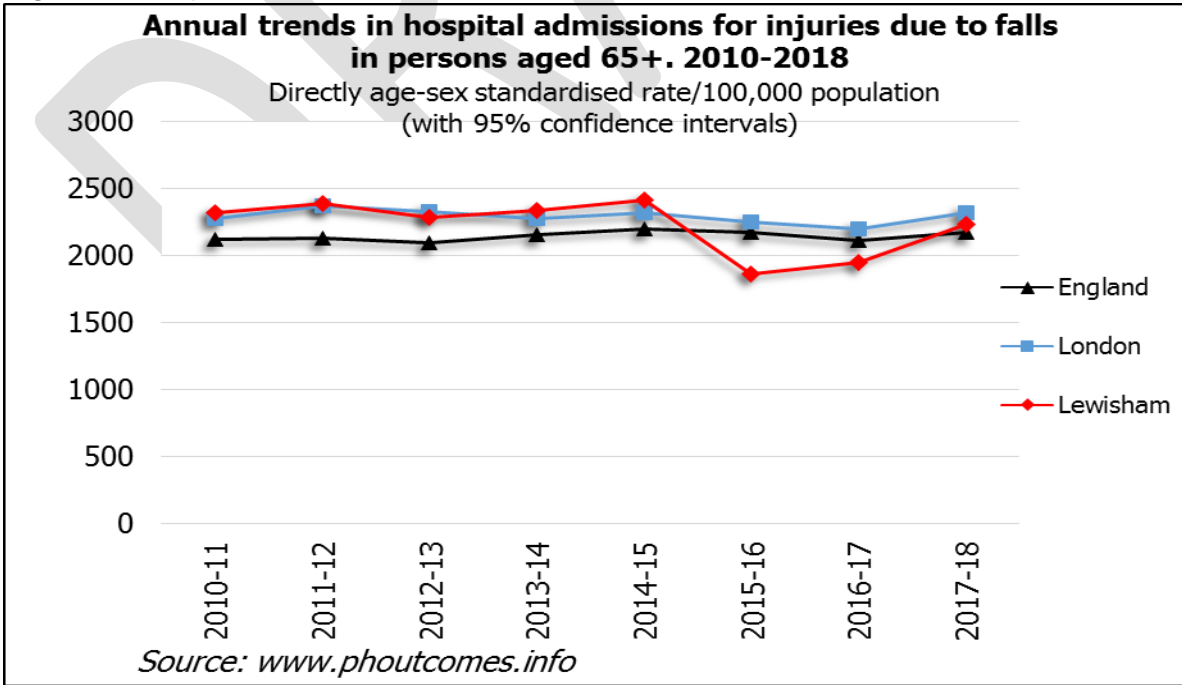


Figure 2. Graph to show admissions attributed to falls 2017/18 compared locally and nationally.



Lewisham is performing mid-table compared to similar local authorities.

Figure 3. Graph to show the rates of falls in Lewisham between 2010 and 2018.



The general trend for falls admissions is stable.

One of the likely outcomes of a fall in the elderly is a fragility fracture. This occurs when a person falls from standing height or less to the floor or other lower surface and suffers a fracture, the most common of which are wrist, spine, hip, humerus and pelvis⁸. Falls and resultant fractures in people aged 65 or over account for over 4 million bed days each year in England alone and are the leading cause of accidental mortality in older people⁹.

The most serious fragility fracture is a fractured neck of femur, which affects approximately 60,000 people per year in the UK, and costs the NHS around £2 billion per year and results in up to 14,000 deaths¹⁰. Approximately 50% of older people who fracture their hip are never functional walkers again and 20% will die within six months. A further 20% previously living independently will end up in a care home¹¹.

Approximately half of all hip fractures follow a previous fragility fracture. By identifying patients in a consistent, systematic way, it is estimated that up to 25% of hip fractures (about 20,000 a year) could be prevented. When accounting for the national demographic projections for 2025, the number of hip fractures are projected to rise to 682,000.

Figure 4. Fractured neck of femur rates 2017 to 2018 compared locally and nationally.

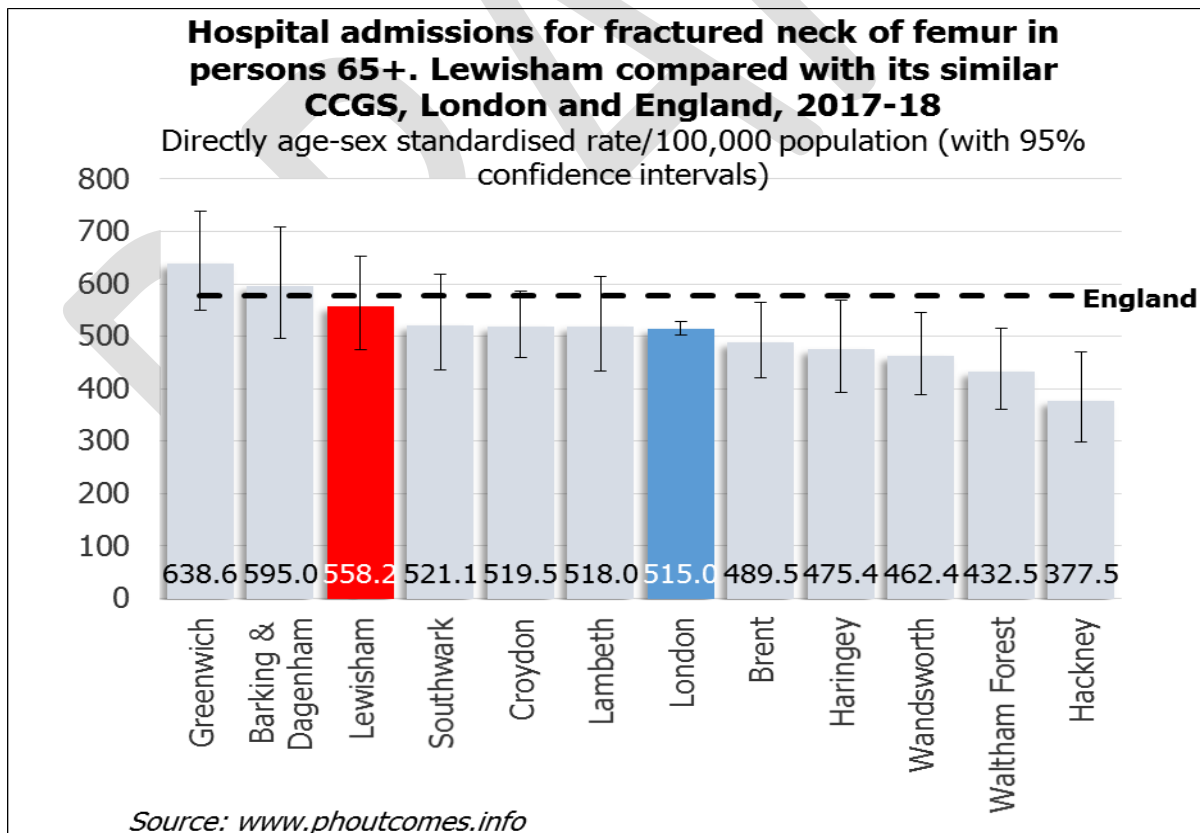
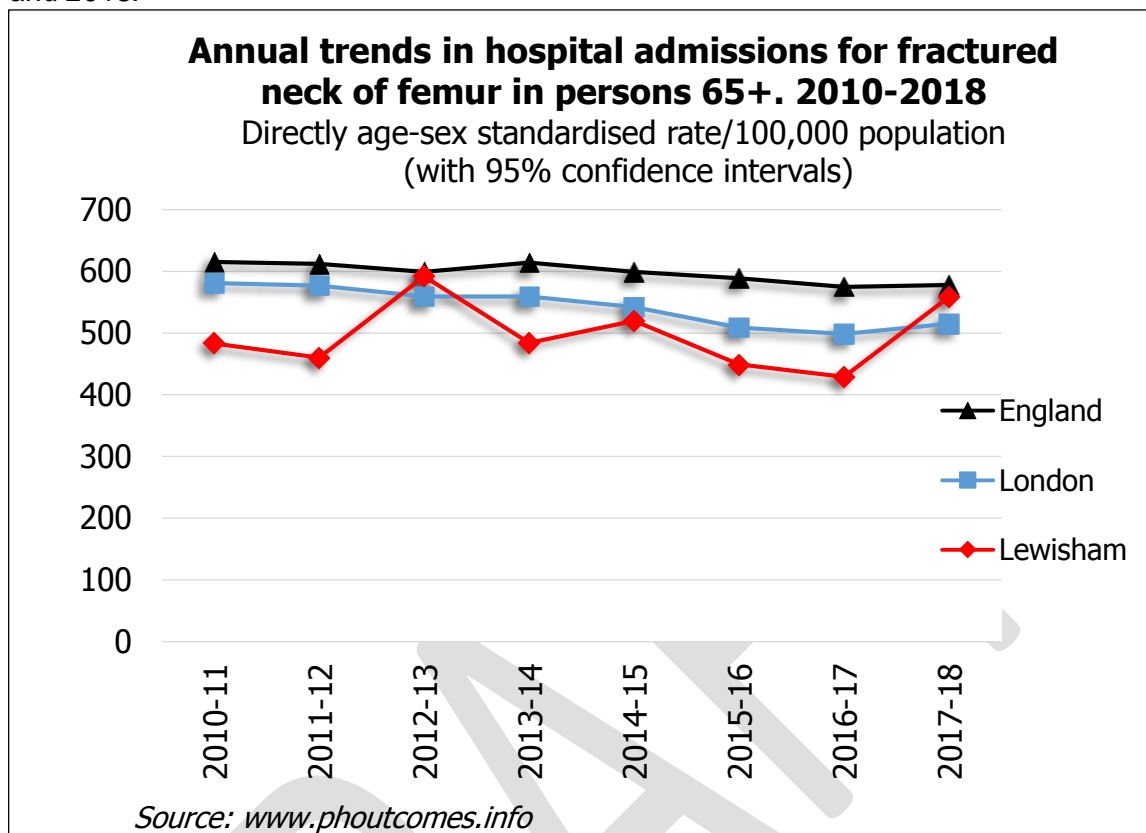


Figure 5. Graph to show the rates of fractured neck of femur in Lewisham between 2010 and 2018.



As shown in Figures 4 and %, in 2017/18 Lewisham's rate of fractured neck of femurs was 558 per 100,000, which was higher than London average (515 per 100,000) and lower than England overall (578 per 100,000).

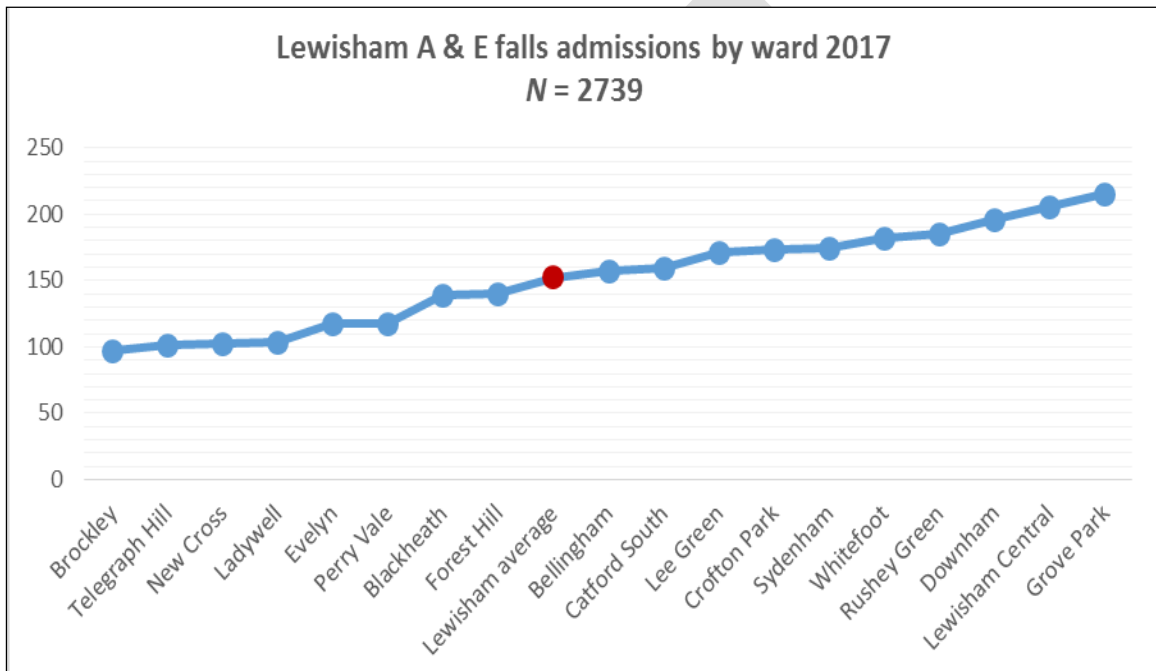
Between 2013 and 2015 the average mortality in Lewisham from accidental falls for people age over 65 was 50.40 per 100,000 in the population, lower than the regional average of 52.57¹².

Falls also result in loss of confidence, continued fear of falling, activity restriction, reduced functional ability, loss of independence, social isolation and thus increased dependency on carers and services. Falls prevention is therefore an important Public Health issue, as it will save lives, decrease disability, improve quality of life and reduce hospital and social care costs.

What are the key inequalities?

There have been very few studies looking into whether rates of falling and admission for hip fractures are related to socioeconomic factors. In one study, based in Nottingham, looking at over 40,000 patients admitted to hospital in Nottingham following a fall seemed to show some evidence of an association at between hospital admissions for falls and socio-economic deprivation, with higher rates in deprived areas. However, no such association has been found for hip fracture¹³.

Figure 6. Graph to show the admission rates via Lewisham A&E of over 65 year olds with a fall in 2017 separated by Lewisham wards.



This graph shows that the lowest rate of falls admissions is from the Brockley ward, with the highest rate of admissions from Grove Park. The most deprived areas of Lewisham, according to the Index of Multiple Deprivation 2015 are Evelyn, New Cross, Downham, Whitefoot and Bellingham. This suggests that there is no link between deprivation and the rate of falls admissions, as the most deprived wards are spread throughout the graph, and not concentrated at the higher rates of falls admissions end.

There are even fewer studies looking at the effect of ethnicity on falls, and there is currently no real evidence to suggest there is any relationship between the two. However, it is well established that people with an Afro-Caribbean background have a far higher bone mass density than Caucasians; up to 29% higher, meaning that it is less likely that a person of Afro-Caribbean ethnicity will sustain fractures following a fall¹⁴. This is of importance in Lewisham, as over a third of Lewisham's population is from black and minority ethnic communities.

Poor housing is often overlooked as a factor contributing to accidents. The English Housing Survey Bulletin¹⁵ presents key findings from housing reports, and indicates housing quality across England. The November 2017 bulletin stated that 11% of the housing stock had some form of Category 1 hazard. The majority of these hazards are those that particularly affect older people, such as damp and excess cold. They also include risk of falls on stairs, floors or in the bathroom. While the private rented sector had the highest proportion of homes with a Category 1 hazard, there was a notable decrease in the proportion of stock with such hazards, from 31% in 2008 to 14% in 2017. This is likely the result of newer homes entering the private rented stock, the installation of energy efficiency measures and improvements in standards due to local enforcement. The single largest risk factor for falls is age. However other factor may increase the risk of falls such as use of alcohol or combinations of prescription drugs.

Targets and Performance

Bisphosphonates that contain nitrogen (such as alendronate, risedronate, ibandronate, and zoledronic acid) have the most potent antiresorptive properties and are the most commonly used drugs in the treatment of osteoporosis. They inhibit bone resorption by inducing apoptosis of osteoclasts, thus preventing age related bone loss and deterioration of bone microarchitecture. The graph below shows that since 2015, the prescribing of medications for the secondary prevention of fragility fractures has decreased. This may be due to long term users of bisphosphonates taking a 'drug holiday' due to adverse effects of long term use. Additionally patients may be deterred from taking medication due to fear of adverse side effects. Often side effects information on the medications is misinterpreted or miscommunicated so what is essentially a minor risk is seen as a high risk. Even if a patient refuses medication periodic monitoring to reassess fracture risk and treatment strategies is necessary, along with further discussion of the balance of benefits and risks of treatment¹⁶ The reduction in medication does not directly relate to an increase in the number of falls, any increase is more likely to be attributed to multifactoral reasons.

Figures 7-12 Graphs to show the decrease in prescribing of medications used in the secondary prevention

Figure 7 – Osteoporosis Prescribing – Lewisham CCG

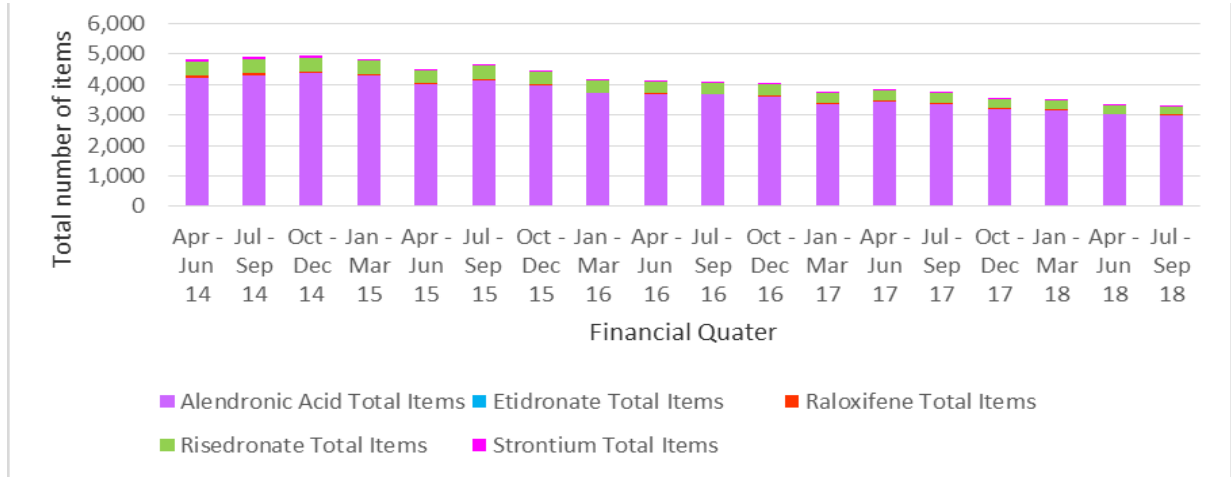


Figure 8 - Alendronic Acid Prescriptions

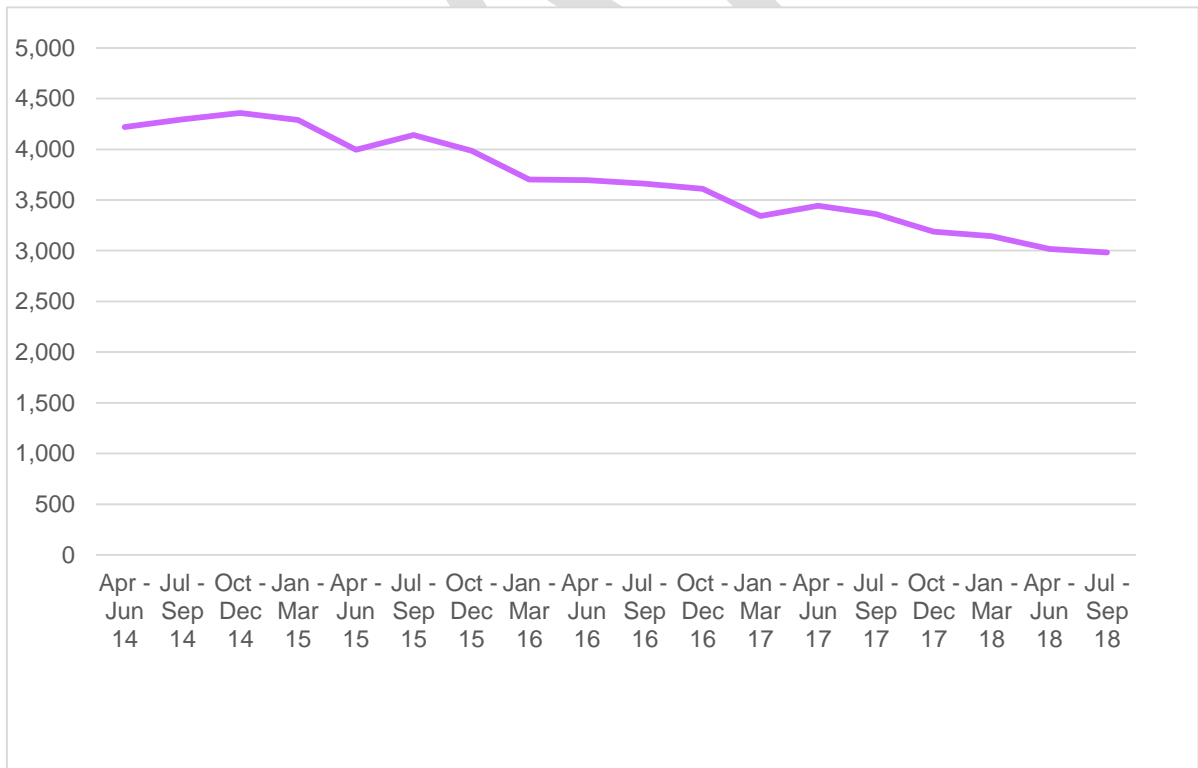
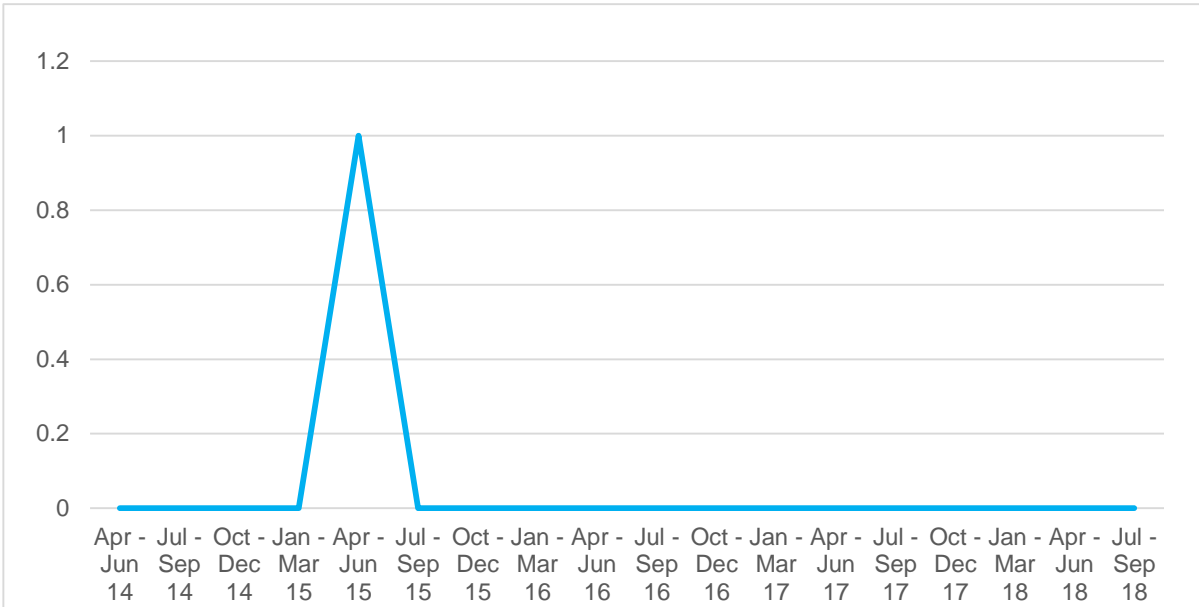


Figure 9 – Etidronate Prescriptions



No longer marketed in the UK.

Figure 10 – Risedronate Prescriptions

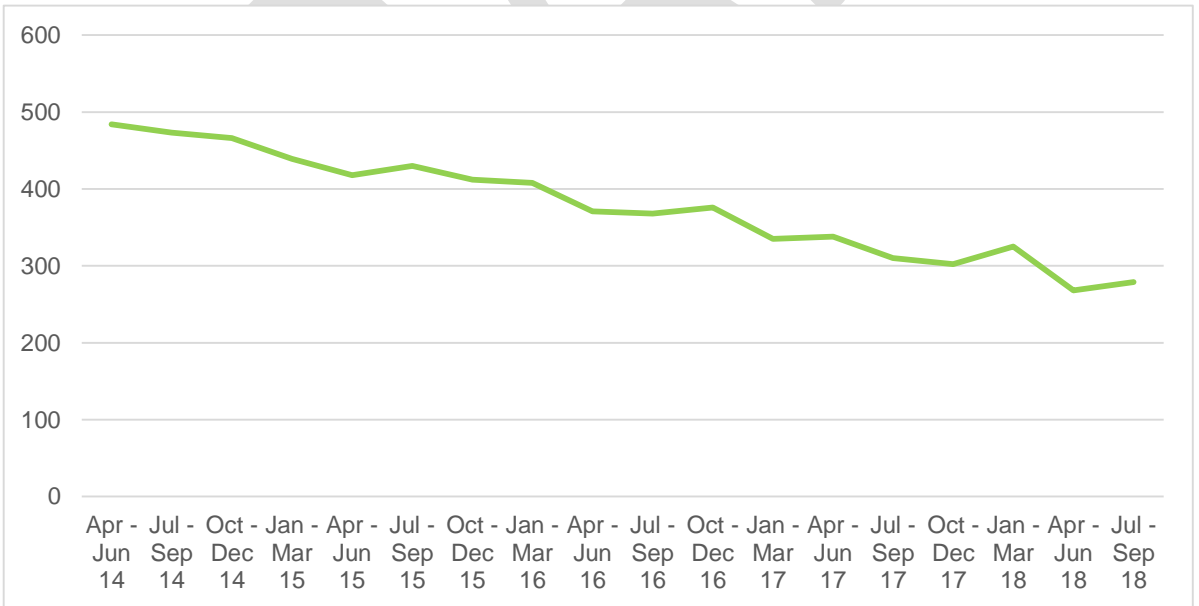


Figure 11 – Raloxifene Prescriptions

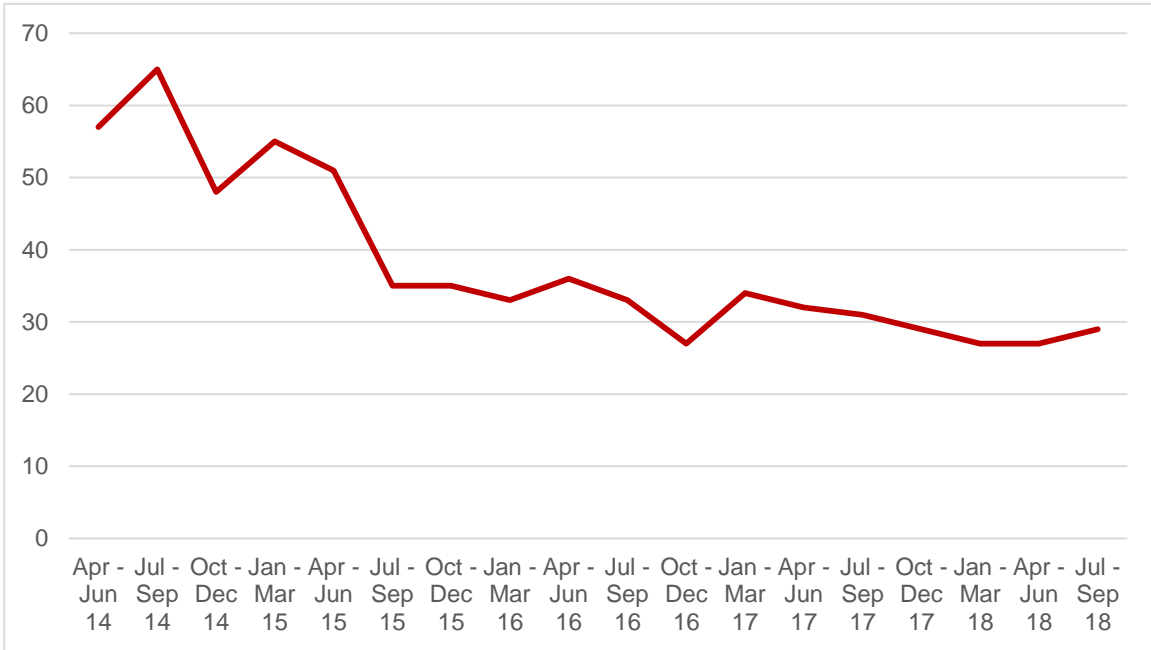
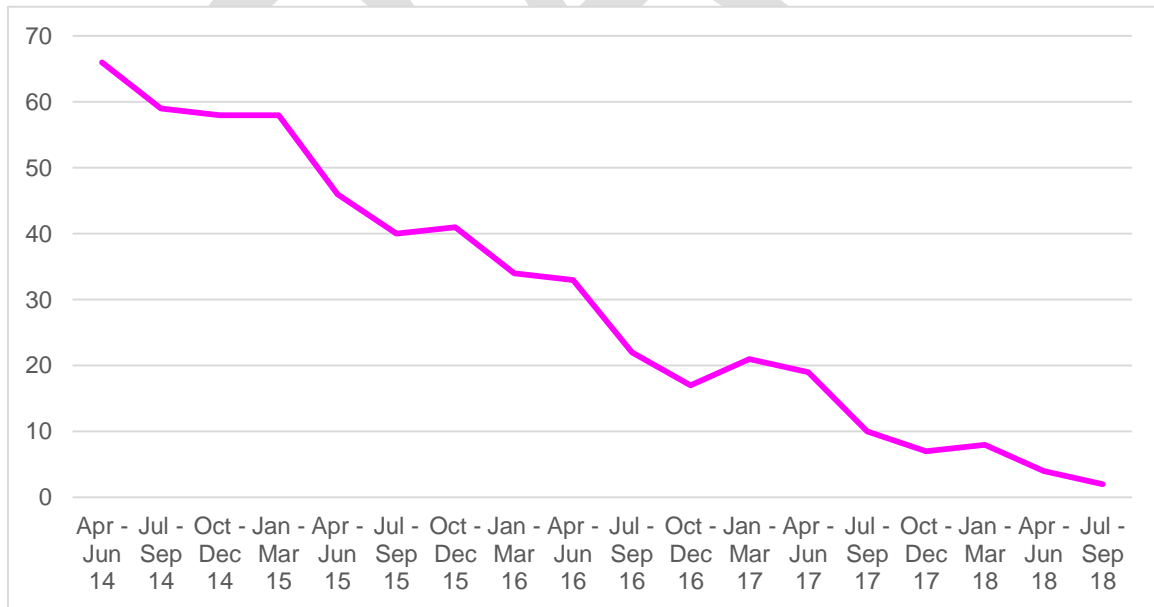


Figure 12 – Strontium Prescriptions



No longer marketed in the UK.

National and Local Strategies

There are several policies and guidelines, which set out measures to reduce the number and impact of falls in older people.

In 2010 both organisational and clinical national audits were conducted by the Clinical Effectiveness and Evaluation Unit (CEEU) of the Royal College of Physicians of Services for Falls and Bone health of older people¹⁷. Information on nearly 10,000 patients came from all NHS Acute Trusts, or equivalent, in England, Wales and Northern Ireland, as well as Primary Care Organisations, Mental Health Trusts, and a sample of care homes.

The report [*Falling Standards, Broken Promises*](#) made these key recommendations:

- Local NHS services should commission a fracture liaison service (FLS) in line with best evidence for fracture prevention.
- Health and local authority commissioners should ensure adequate local provision of therapeutic exercise programmes for falls prevention.
- Local NHS services should ensure that there is adequate provision of falls clinics, or similar, particularly for those older people who have fallen and fractured or who are at risk of fracture.
- Emergency departments and minor injury units should introduce routine screening for falls risk and osteoporosis for all older people presenting with falls and fractures.
- Local health commissioners should ensure that care home residents receive regular medication reviews, including treatment of osteoporosis, and, where appropriate, have access to therapeutic exercise for falls prevention.
- Acute hospitals should review and improve their procedures for admission and care of hip fracture patients, with particular regard to pain relief, pressure sore prevention and intravenous fluids.

In 2011, the [*Older people's experience of therapeutic exercise as part of a falls prevention service*](#) was conducted by the CEEU. It summarises results from a postal questionnaire which asked about older people's experiences of therapeutic exercise, and asked staff about exercise provision in NHS trusts around England, Wales and Northern Ireland. The main findings were:

- Health officials need to commission a local, integrated exercise continuum across health and local authorities/voluntary sector to ensure long term provision of evidence-based exercise programmes for reducing falls run by appropriately qualified staff.
- The quality of training and delivery of exercise programmes for reducing falls needs to be monitored locally and nationally against the evidence base for delivering effective exercise programmes to reduce falls.

The aim of the 2013 National Institute for Health and Clinical Excellence (NICE): Clinical Guideline 161- The Assessment and Prevention of Falls in Older People¹⁸ was to

formulate evidence-based clinical practice relating to the assessment of older people and the prevention of falls. Key priorities for implementation include:

1. Case/risk identification
2. Multi-factorial falls risk assessment
3. Multi-factorial interventions

In 2013 NICE updated guidance on secondary prevention of osteoporotic fragility fractures in postmenopausal women¹⁹ who have osteoporosis and have sustained a clinically apparent osteoporotic fragility fracture. It recommends the use of alendronate, raloxifene and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. Guidance on strontium ranelate and etidronate was removed because these drugs are no longer marketed in the UK.

The National Falls Prevention Coordination Group (NFPCG) is made up of organisations involved in the prevention of falls, care for falls-related injuries and the promotion of healthy ageing. It was formed with the aim of coordinating and supporting falls prevention activity in England.

At the first NFPCG meeting in July 2016, it was agreed that the range of different professions and providers carrying out falls and fracture prevention activities, and the different ways of resourcing these, created the need for a consensus on ways to support and encourage 'whole-system' local commissioning.

Subsequently in 2017, member organisations of the NFPCG, along with Public Health England (PHE), produced a falls and fracture consensus statement and resource pack²⁰ with the aims of reducing falls and fracture risk and improving management of fracture, including secondary prevention.

Leading on from this, NHS RightCare, in collaboration with PHE and the NOS, developed a [Falls and Fragility Fractures Pathway](#) which defines three priorities for optimisation.

NHS Right Care Pathway - Falls and Fragility Fractures 2017

The pathway provides a national case for change and a set of resources to support Local Health Economies to concentrate their improvement efforts where there is greatest opportunity to address variation and improve population health. It states that:

Commissioners responsible for Falls and Fragility Fractures for their population should:

- focus on the three priorities for optimisation
 - Falls prevention
 - Detecting and Managing Osteoporosis
 - Optimal support after a fragility fracture
- work across the system to ensure that schemes to deliver the higher value interventions are in place

- Targeted case-finding for osteoporosis, frailty and falls risk
- Strength and balance training for those at low to moderate risk of falls
- Multi-factorial intervention for those at higher risk of falls
- Fracture liaison service for those who have had a fragility fracture,
- Use the [Falls Prevention National Consensus Statement and Resource Pack](#), especially the implementation checklist

2018 NICE impact report on falls and fragility fractures

The report focused on what is known about the uptake and impact of recommendations linked to the above Falls and Fragility Fractures Pathway 3 main priorities.

NICE first published guidance on assessing the risk of fragility fractures in 2012. In 2013 it published guidance on falls in older people, and in 2015 we went on to issue a quality standard on this topic. Since their publication, monthly survey data revealed a reduction in the proportion of people experiencing a fall while in care and an increase in the recognition of the importance of frailty.

The data also found that the proportion of trusts using fall risk prediction tools has reduced since NICE issued a recommendation that they should not be used in hospitals. These tools have not been shown to accurately predict the risk of falling. Instead, all patients over 65, and those aged 50 to 64 who may have a relevant underlying condition, should be considered as being at risk. They should be offered a multifactorial risk assessment taking account of things like any history of falls, medication they are on and visual impairment. These assessments now take place in Lewisham, however it is difficult to demonstrate/correlate any referral for intervention with a reduction in falls.

Identification and management of patients with frailty

From 1 July 2017, the General Medical Services (GMS) contract requires GP practices in England to routinely identify moderate and severe frailty in patients aged 65 years and over. Data collected will include the number of patients with severe frailty who are recorded as having had a fall in the preceding 12 months. This is now happening in Lewisham, patients are assessed at a multi-disciplinary team meeting and referred to services when appropriate to prevent escalation of needs.

The guidance states that:

If the patient has reported a fall, clinically appropriate intervention is offered, such as referrals to a falls clinic, which practices would routinely record. NHS England will use this information to understand the nature of the interventions made and the prevalence of frailty by degree among practice populations and nationally. This information will be used to identify patient and commissioning need to support practices in the management of frailty. The routine identification of those most vulnerable of falling will allow General Practitioners to target those patients who are most likely to benefit from interventions.

EU Falls Festival

The European Falls Festival annually brings together leading academics, researchers, health care practitioners, clinicians, industry representatives and key stakeholders from across the globe to celebrate best practice research and innovation in the multidisciplinary study and implementation of falls prevention in older people.

NHS Long Term Plan 2019 - Falls

The plan aims to “*work on falls and fracture prevention*”, recognizing that “*a 50% improvement in the delivery of evidence-based care could deliver £100 million in savings*”.

It identifies that:

*Extending independence as we age requires a targeted and personalised approach, enabled by digital health records and shared health management tools. **Primary care networks will from 2020/21 assess their local population by risk of unwarranted health outcomes and, working with local community services, make support available to people where it is most needed.** GPs are already using the Electronic Frailty Index to routinely identify people living with severe frailty. Using a proactive population health approach focused on moderate frailty will also enable earlier detection and intervention to treat undiagnosed disorders, such as heart failure. Based on their individual needs and choices, people identified as having the greatest risks and needs will be offered targeted support for both their physical and mental health needs, which will include musculoskeletal conditions, cardiovascular disease, dementia and frailty.*

Integrated primary and community teams will work with people to maintain their independence: for example, 30% of people aged 65 and over, and 50% of those aged 80 and over, are likely to fall at least once a year²¹. Falls prevention schemes, including exercise classes and strength and balance training, can significantly reduce the likelihood of falls and are cost effective in reducing admissions to hospital²².

What works?

Over recent years systematic reviews of falls intervention studies have established that prevention interventions can reduce falls. These prevention strategies can be split into three main groups;

- Exercise based interventions,
- Home modification interventions
- Multifaceted interventions^{23,24,25}.

Intervention	Reduction in risk of falling
Community based group exercise sessions (additional home based content)²⁶	40%
Home based Otago exercise program^{27, 28} (Physiotherapist visits and independent practice encouraged)	35%
Community based group Tai Chi (Independent practice encouraged)^{29,30}	55%

Exercise based interventions

During the visits, the physiotherapist/nurse prescribes a set of in-home exercises (selected at appropriate and increasing levels of difficulty) and a walking plan. The exercises include strengthening exercises for lower leg muscle groups using ankle cuff weights, balance and stability exercises such as standing with one foot in front of the other and walking on the toes and active range of motion exercises such as neck rotation and hip and knee extensions. The exercises take about 30 minutes and participants are encouraged to complete the exercises three times a week and to walk outside the home at least twice a week. This is then continued on an ongoing basis.

Home modification interventions

The home modification interventions (now running in Lewisham), is proven to have a benefit, are home visits by an occupational therapist and a falls home intervention team (HIT). Home visits by an occupational therapist who identified environmental hazards and unsafe behaviours, and recommended home modifications and behaviour changes, reduced fall rates by one-third among men and women who had experienced one or more falls in the previous year³¹. The occupational therapist should visit each participant's home and conduct an assessment to identify environmental hazards such as slippery floors, poor lighting, and rugs with curled edges, and discuss with the participant how to correct these hazards. Based on standard occupational therapy principles, the therapist can also assess each participant's abilities and behaviours, and how each functions in his or her home environment³². Specific unsafe behaviours can be identified such as wearing loose shoes, leaving clutter in high-traffic areas, and using furniture to reach high places³³.

The home intervention team also provides home visits to identify environmental hazards that can increase the risk of falling, provide advice about possible changes, offer assistance with home modifications, and provide training in using safety devices and mobility aids. This has shown to reduce the fall rate by 31 percent³⁴. It is shown to be most effective among those who have experienced two or more falls in the previous year; the fall rate for these participants can be reduced by 37 percent. The first home

visit should be conducted while a patient is still hospitalized following a fall. Two team members, an occupational therapist with either a nurse or a physiotherapist, depending on patient's anticipated needs, conduct a home assessment. They can identify home hazards and determine what safety equipment a patient may need. During two to three subsequent home visits, an occupational therapist or nurse can meet with the patient to discuss home hazards, recommend home modifications, facilitate necessary modifications and teach patients how to use safety devices and mobility aids when necessary³⁵.

Multifaceted interventions

This approach includes both exercise and home modification interventions. Studies have also shown that educating patients on how to prevent falls, along with structured exercise programmes and home hazard interventions, have the best results. By educating patients and teaching them fall prevention strategies, falls rate can be reduced by up to two thirds^{36 37}.

Current activities and services in Lewisham

The falls service at Lewisham Hospital has expanded over the last few years with the introduction of the Falls and Fracture Liaison Service and the new DEXA scanner.

Consultant led hospital based falls clinics

The falls clinics at Lewisham Hospital are for those who have specific medical and clinical requirements which may attribute to their risk of falling. Patients can be referred to the falls clinic from health professionals; general practitioners, emergency department and the in-patient wards.

Patients referred to the falls clinic are seen by a multidisciplinary team. In addition to the frailty, nutrition, bone health assessments and abbreviated mental test they have a comprehensive geriatric assessment completed by a consultant physician. As there is no occupational therapist in the falls clinic patients can be referred to either the Community Falls Team or to Lewisham Adult Therapy Team.

Patients have an initial follow up appointment in the falls clinic to follow up any investigations that may be requested including ECG, blood test, 24 hour ECG and CT head scan. Any additional follow up appointments that may be needed are usually in the consultants' general medical clinic.

An audit was undertaken in line with the NICE Falls Guidelines and in response to the Falls and Fracture consensus statement on those attending the Stable and Steady classes. In conclusion the audit has shown that a programme of targeted strength and balance exercises has improved outcome measures which impact on falls risk in those aged over 65 years. This includes physical improvements demonstrated by the TUAG (Timed Up and Go) and 6 meter walk and psychological improvements relating to improved confidence and reduced fear of falling (short FES-I). Although the EQ-VAS (subjective quality of life measure) showed a small overall reduction it can be suggested that this measure does not accurately reflect changes in falls risk factor reduction since it

is likely to be affected by non falls factors such as changes in health status and life events as well as how the person feels on that particular day.

The Hospital Falls group (Balance Group) no longer runs as the majority of patients go to the Community Falls Service Stable and Steady classes. One to one treatment sessions are offered to elderly fallers.

Community Falls Service

The Community Falls Service was established clinically in February 2017 following significant preparatory work by a group of stakeholders from Health, Social Care and the third sector. The service is therapist led and consists of physiotherapists, occupational therapists and therapy assistant practitioners/postural stability instructors. The service supports the provision of an integrated falls pathway for older people (over 65) to reduce the incidence of falls and falls related injuries in Lewisham residents and/or those with a Lewisham GP. A joint referral system for general practitioners enables the service to triage all referrals appropriately. The total number of referrals from April 2018 to March 2019 was 1,336. The team have seen a significant increase in referrals from 696 in 2017/18. This reflects increased awareness of the service and the creation of a new referral route with the London Ambulance Service. A service review evidencing impact is taking place as of Autumn 2019.

Referrals are mainly from Accident and Emergency or General Practitioners, and the clinic aims to see individuals with:

1. unexplained falls
2. two falls in six months
3. balance difficulties
4. a fear of falling
5. syncope (fainting) aged 65 or over

Patients are assessed by all members of the team as to the underlying reason for their falls and to assess their bone health. Appropriate investigations can then be arranged, and they may be referred on if necessary. Patients with syncope can be referred onto specialist investigations for their syncopal episodes, and there is also access to ECG and 24 hour ECG if cardiac investigations are deemed necessary.

Patients can be referred to the community occupational therapists who will assess the patient and decide whether the home environment needs to be assessed, and a home visit will normally then be done within a week. They can also be referred to additional community services such as social services or district nurses for further help at home.

Patients are assessed for their gait and balance by the physiotherapists and can be referred onto a group or for individual physiotherapy if required.

Patients will be assessed for their individual falls risk and interventions and advice will be given for each as necessary. The recommendations for any treatment according to national guidelines will be conveyed to the General Practitioner. Patients will also receive information on healthy lifestyles and healthy ageing.

The service model (displayed below) is based on the evidence set out in the Falls and Fracture Consensus Statement³⁸

Community Falls Service Model

The service model is split into two arms. The reactive arm takes referrals in response to need / incident much as per usual systems in community health care. The proactive arm encourages 'case finding' of patients whom are known to be at risk of falls – with a view to establishing early intervention to focus on prevention. To support the evidence base and 'case find' patients the service has established direct referral routes with the [Safe and Independent Living](#) (SAIL) project and with Linkline.

The service has a single point of access. All referrals (unless part of an agreed and pre-determined direct referral pathway) are accepted verbally via the Falls Helpline. This helpline is staffed by clinicians and also provides advice and onward signposting. The service has recently developed a general practitioner referral form which will enable general practitioners to refer via EMIS.

Referrals received are clinically triaged. All new patients receive a Multifactorial Falls Assessment and Home Hazard Assessment. In addition to this the service currently provides the following interventions:

Physiotherapy

Physiotherapy assessment and intervention for falls related to complex physical and neurological problems and vestibular disorders as well as gait analysis and re-education, strengthening and balance programmes and assessment for appropriate walking aids.

Occupational Therapy

Occupational Therapy assessment and intervention for falls related to activities of daily living, visual impairment, cognitive impairment and environmental issues.

Assistant Led home exercise programmes based around the Otago/Falls Management Exercise (FaME)

Otago is a lower limb strength, balance and walking programme of pre-set exercises with progression guidance. FaMe is a tailored and progressive programme of strength and balance which also includes upper limb strength exercises to support backward chaining approaches to retrain getting on and off the floor. Public Health England and the Falls and Fractures Consensus Statement 2017 Resource Pack recommends Otago and FaME as cost effective evidence based programmes to reduce falls. These are home based exercise programmes which are tailored to the individual and which run for up to 6 months.

Stable and Steady classes

Stable and Steady classes are run by Qualified Postural Stability Instructors who have been trained in FaME. As well as having robust evidence in both primary and secondary falls prevention, it has also been shown to increase physical habitual activity in older people as well as improving confidence, activity and independence. In line with the evidence which shows that 50 hours exercise is required in order to be clinically effective, the classes run for 25 weeks (1 hour per week) plus 1 hour per week exercise 'homework'

Of those accessing the service over half (54%) are aged between 80 and 89 years old, with the majority of assessments (85%) taking place within the clients' home.

Falls awareness days

Lewisham Healthcare NHS Trust has a Falls Awareness Day once a year, with the aim of highlighting the importance of falls and falls prevention. There are stalls at the hospital run by nurses, physiotherapists and occupational therapists, and visitors are able to get their blood pressure checked and find out about how to access Falls' and exercise services within the borough.

Age UK Falls Campaign and handyman services

Age UK have launched the 'Stop Falling: Start Saving Lives and Money' campaign calling for improved access to falls prevention services and special exercise programmes.

The [Stop Falling: Start Saving Lives and Money](#) campaign calls for:

1. Falls prevention services to be a priority across the country. They want lots of different groups, including the Department of Health, general practitioners, primary care trusts and local authorities to work together to make sure that, wherever we live, when patients fall, they receive all the support needed to prevent a further fall in the future.
2. Evidence-based exercise programmes that have been proven to work to be made available. It is known that these exercise programmes can reduce the risk of falls by up to 50%. All older people who are at risk of falling should be encouraged and supported to take part.
3. General practitioners and other health services staff should make sure that those who are at risk get the help they need.

Age UK also operates a handy man service called [HandyVan](#). They can help with small repairs such as putting up curtain rails, shelves and pictures, safety measures including fitting smoke alarms, carbon monoxide detectors and grab rails, home security such as door and window locks, door chains and door viewers and energy efficiency checks including installing draught excluders, radiator heat reflectors and energy efficient lightbulbs. Many of these measures, such as the small repairs and safety measures can help prevent falls in the home.

Community exercise programmes

There are numerous community based exercise groups and falls groups based in Lewisham. These are normally run on a voluntary basis and require funding to keep going. They tend to be for more able bodied people, and those that can organize their own transport.

London Ambulance Service Direct Referral Pathway

London Ambulance Service have an agreed pathway with Community Rapid Response Team for referrals from patients who have fallen. Between 1 October 2018 and 31 March 2019, 166 patients were referred to the CFS by the LAS. Of these 42 patients (25.30%) were already known to the service. An audit of the data from the first 6 months has shown that it is possible to case-find older people who have fallen and who are not currently known to the local falls service. The audit also provides a means of establishing the most frequent fallers in Lewisham who can then be discussed at neighbourhood MDT meetings. Using the Return in Investment Tool (ROI Tool) (Public Health England, 2018) it can be estimated that the intervention provided to those referred by the LAS prevented 50 falls (compared to usual care) and 3 admissions to hospital including one admission due to hip fracture.

Telecare/Linkline

Lewisham established Linkline in 1987 to help vulnerable people in their own homes, people living in assisted housing and also in private residences. There are now 4,500 users throughout Lewisham, the majority of whom are over 80 years old. It operates 24 hours, 365 days a year offering reassurance and practical advice in emergency situations.

As well as the pendant alarms, and alarms that go on watches, they can provide a variety of assistive technologies that may benefit fallers. These include sensor mats, automatic lights and fall detectors. These can then be linked to carer-pagers to alert a carer if a service user has had a fall or has got up from bed and not returned after a certain period of time.

The pendant alarms are linked to a central hub, and when the alarm is pressed the service user is called and the situation is assessed. If the service user does not answer the call, or they are distressed and require assistance a first responder will go out to them, or an ambulance will be called.

The service currently receives referrals from general practitioners, social services, hospitals, community nurses, and from individuals themselves or their families.

SLaM Falls pathway

The 4-step pathway for inpatients with mental health illness or dementia and specialist care units was revised in 2018

1. On Admission – Assessing Risk
Patients are assessed within 4 hours of admission
2. Undertaking detailed assessment to inform a multi-disciplinary team (MDT) Care Plan to minimize risk of person falling
Assessments by MDT professionals completed within 72 hours of admission and documented
3. Creating a plan of care to minimize risks of falling

- All clinical outcomes from the fall's assessment process form a "Falls Care Plan" and copy given to patient
4. Care Plan - Review and Evaluation
Falls Risk are discussed at weekly MDT and documented in the Ward Round notes

A similar community pathway exists which is carried out at clients' home by an occupational therapist, with an option to refer to the Community Falls team.

What is this telling us?

What are the key gaps in knowledge and/or services?

Currently documentation and reporting of falls that occur in residential homes and care homes is as follows:

- When a resident has a fall in a care home where no injury is sustained or a minor injury (Skin Tear) then an incident/accident form is completed and followed by review of falls risk assessment, falls/mobility care plan and recorded in falls diary.
- If a resident sustains serious injury (Fracture; Head Injury) and admitted to hospital a Care Quality Commission notification is completed and sent. Alongside completion of Duty of Candour and incident/accident form, review of falls risk assessment, falls/mobility care plan and recorded in falls diary.
- Some care homes send a copy of the incident/accident form for all falls to resident's Social Worker, however this is not universally done. Very few patients are referred from these homes to the Falls Clinic by their general practitioner, most self refer directly. Jointly agreed processes with care home providers is preferred as it improves procedures for both parties.

Patients referred to the falls clinic get seen by a multidisciplinary team. However, there is currently no occupational therapist that works at the clinic, and so patients are referred to the community falls service. Most patients who require occupational therapy assessment are assessed at home, which has the advantage of them being assessed in their own environment.

The community falls groups are popular with patients but tend to be for the more abled patients as they have to organise their own transport.

There are a variety of assistive technologies available to help in the prevention of falls, and to aid in early intervention for fallers. These technologies are readily available, but are not frequently prescribed or provided for those that may need it. Those that work within Telecare and Linkline Assistive Technology Service feel that the major hurdle to their work is lack of awareness amongst other healthcare professionals including general practitioners and the Falls Service of the services that they can provide. They currently run Telecare awareness training with social services and the occupational therapists at Lewisham Hospital, but they would like to see this offered to other health professionals.

What is coming on the horizon?

Due to increasing numbers in the The Community Falls Service Stable and Steady classes a falls class at Lewisham hospital is planned to start in early 2020. It has also been found that within the Stable and Steady classes there are clients that would benefit as they have a higher level of dependency.

What should we be doing next?

- Provide support to residential care providers to ensure they keep falls registers, record falls and are able to prompt general practitioners to refer to the falls service. This could be done through an outreach function of the falls service or through working with other professionals who already provide support to residential care.
- Present clear and accurate information for all aspects of the boroughs Falls provision linking both community and hospital services. At present it is difficult for referrers and patients to navigate the services effectively. The Lewisham and Greenwich NHS Falls rehabilitation website mentions that there is a hospital Balance Group but no this longer runs and there is no signposting to other services.
- Continue to promote the local falls service to increase and maintain general practitioners' awareness of both the Quality Outcomes Framework requirements and the benefits of referral.
- Develop a closer relationship with the London Ambulance Service and Telecare to record and pass on all those patients that fall but are not admitted to hospital so that they can be followed up by the Fracture Liaison Coordinator.
- Establish accessible exercise/falls groups for individuals who have completed a formal falls group of fixed sessions but may require some ongoing or 'top up' support. This may be facilitated through exercise on referral schemes run by general practitioners.
- Improve awareness about the service that Telecare provides, and involve other healthcare professionals, including general practitioners in the Telecare training sessions.
- Ensure that existing falls services can meet the needs of the ageing BME population and that these individuals are being referred into services by their GPs. Improve ethnic monitoring of all falls services in support of this.
- Audit to be conducted on patients admitted to hospital for falls to determine different types of fall and any associated conditions
- Contact other areas who have implemented a Falls service to understand what difference/impact has been made
- Independent evaluation of the Falls service to be carried out and include feedback gathered from service users

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