

**Prevention of falls in older people**  
**A needs assessment**  
**in**  
**Brighton & Hove**

**Public Health Directorate**

**December 2015**

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## Executive summary

This report describes the findings of the rapid Brighton & Hove falls needs assessment 2015. It focuses on the needs of people aged 65 years or over who have fallen in their home or in the community and are at risk of falling again.

The outcome of this assessment will help identify gaps in or changes to service provision that can be addressed through commissioning, and will help agree priorities for future resource allocation to prevent falls, improve health and reduce inequalities.

The findings in this report were obtained from a combination of sources:

- A review of the literature and national policy
- Interviews with older people and service providers to understand people's perception of their risk of falling and views on services for falls prevention; and
- Data collected from GPs on older people who have fallen, hospital admissions data and data collected from the ambulance service.

The literature review found that preventing falls is a cost effective use of resources as the cost and consequences of a fall are considerable. The highest risk factors for falling are age and a previous fall. Other risk factors include taking four or more medications and having an unstable gait (for example due to a stroke or Parkinson's disease). There is strong evidence that community based exercise programmes can prevent falls. The review also looked at other places with good practice, for example Glasgow with an award winning community falls prevention programme.

The interviews found that people are concerned about hazards that might lead to a fall, both in the home and in the street. Those people who had fallen and also those who are involved in falls prevention services report poor co-ordination between the current hospital based falls service and services in the community, with little provision of information about how to prevent falls. People also reported that services to prevent falls are over-stretched with gaps in staffing. Falls prevention in nursing homes is a particular need.

The data collection showed that most falls in Brighton & Hove occur in older people (women more than men) and that as the population ages, the projected number of falls will increase. Whilst admissions to hospital for people who fall and for hip fracture are similar to England in number, carry considerable personal costs and costs to the health and social care system, highlighting the importance of this as a public health issue.

## Key issues and gaps

Key issues and gaps identified by this needs assessment include:

- Variable awareness among staff working in services with older people about falls and falls prevention, and how they should identify people at risk of falling

- Lack of clear guidance for community health services, including GPs, primary care staff and pharmacists, on assessing a person's risk of falling and, where there is concern, who they should send them to for further review
- Lack of clarity about the referral pathway for someone identified as being at risk of falling
- Inconsistent access to equipment to prevent a fall
- Limited provision of exercise classes to prevent falls in the community.
- Variable understanding about the falls prevention services in the community and in the hospital - and about co-ordination between the two
- Variable support for a person back in the community after treatment following a fall, to prevent loss of independence and reduce the fear of falling again.

## **Recommendations for commissioners to consider**

The following recommendations for City Council and Clinical Commissioning Group commissioners to consider as part of a community falls prevention programme in Brighton & Hove have been identified through this needs assessment.

### **1. Raising awareness– Falls are everyone's business**

- 1.1 Review the current falls prevention material used in the community, and how the information is provided. Agree a set of key messages. Agree a multi-agency approach for Brighton & Hove.
- 1.2 Establish a regular awareness raising programme.
- 1.3 Provide training for front line staff in the community about falls and falls prevention, how to assess if someone is at risk of falling, where to refer and available services.
- 1.4 Raise awareness of falls prevention at a strategic level to ensure commitment to a citywide approach.

### **2. Assessment**

- 2.1 Review existing screening tools used to assess a person's risk of a fall in Brighton & Hove, and how and where assessments are made.
- 2.2 Develop a short screening tool for all agencies to use to screen for falls prevention in community settings. Settings could include primary care, pharmacy, care homes, seniors housing and residential schemes, community settings such venues offering day activities for older people, people living at home. An individual may also assess themselves as being at risk. Community assessments should identify factors that may increase people's risk of falling, identify modifiable risk factors, identify how to improve independence and confidence, referral pathways.
- 2.3 Review the multi-factoral screening tool used by the Falls Prevention Service
- 2.4 Consider how to build falls assessments into other existing service provision eg health checks, routine GP reviews, medicines reviews

### **3. Referral pathways**

- 3.1 Review and clarify signposting and referral routes and ensure these are widely publicized
- 3.2 Ensure effective links between key services relevant to falls prevention across the system.

### **4. Service development**

4.1 Develop a multi-agency response for falls prevention in the community in Brighton & Hove to include:

- Occupational therapy (including home hazard and safety)
- Physiotherapy
- Pharmacy
- Aids, adaptations and equipment for example pendant alarms, grab rails
- Strength and balance exercise classes
- Podiatry
- Nutrition
- Sensory Impairment including audiology, opticians etc.

4.2 Review current provision of evidence based exercise programmes. Identify assets and gaps. Support the development of additional programmes of strength and balance exercise classes to be delivered in community settings for those who are screened as needing them. Community settings could include leisure centres.

## **1. Introduction and background**

### **1.1 National incidence of falls**

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 or over have the highest risk of falling, with 30% of people aged 65 or over and 50% of people over 80 falling at least once a year. (1)

Nationally the incidence of falls is increasing at about 2% per year (2) and the rate of increase in falls is expected to continue as the population ages. In England, the number of people aged 65 or over is due to rise by a third by 2025, the number of people over 80 will double and the number aged over 100 will increase fourfold. A significant rise in falls and associated fractures is therefore likely without preventive interventions.

Preventing older people from falling is a challenge for the NHS and local authorities. Both statutory and voluntary services must work together to meet this challenge. (2)

### **1.2 National costs of falls**

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence, social isolation and mortality. Falling also affects family members and carers of people who fall.

Falls are estimated to cost the NHS more than £2.3 billion per year. (1) The 'cost per fall' will obviously vary depending on severity of injury, length of time in hospital, additional care/home support services needed etc. Estimates average around £5000 per fall plus the additional ambulance emergency call-out costs of around £250.

Hip fracture has an impact on life expectancy with case fatality higher for men than women. (3) Overall, hip fracture is fatal in 20% of cases and causes permanent disability in 50% of those affected; only 30% of patients fully recover. (5) Direct medical costs from fragility fractures to the UK healthcare economy were estimated at £1.8 billion in 2000, with the potential to increase to £2.2 billion by 2025, and with most of these costs relating to hip fracture care. (5)

### **1.3 Scope of this needs assessment**

This needs assessment provides a comprehensive assessment of services in Brighton & Hove provided by the statutory, voluntary and private sector aimed at prevention of falls in older people. It looks at current and future needs of people living in Brighton & Hove aged 65 or over years who are at risk of falling, or who have fallen. This will inform whether to commissioning of a primary falls prevention initiative and if so how it will improve outcomes and reduce inequalities. The focus is on services in the community and does not cover falls in hospital.

The needs assessment was a rapid one and is based on information gathered from service providers and users between March and June 2015. A library search of the evidence for good practice around falls prevention was carried out in November 2014.



## 2. National policy relating to services for prevention of falls

There are a number of policy documents and national guidelines relating to falls prevention. The main ones are listed here:

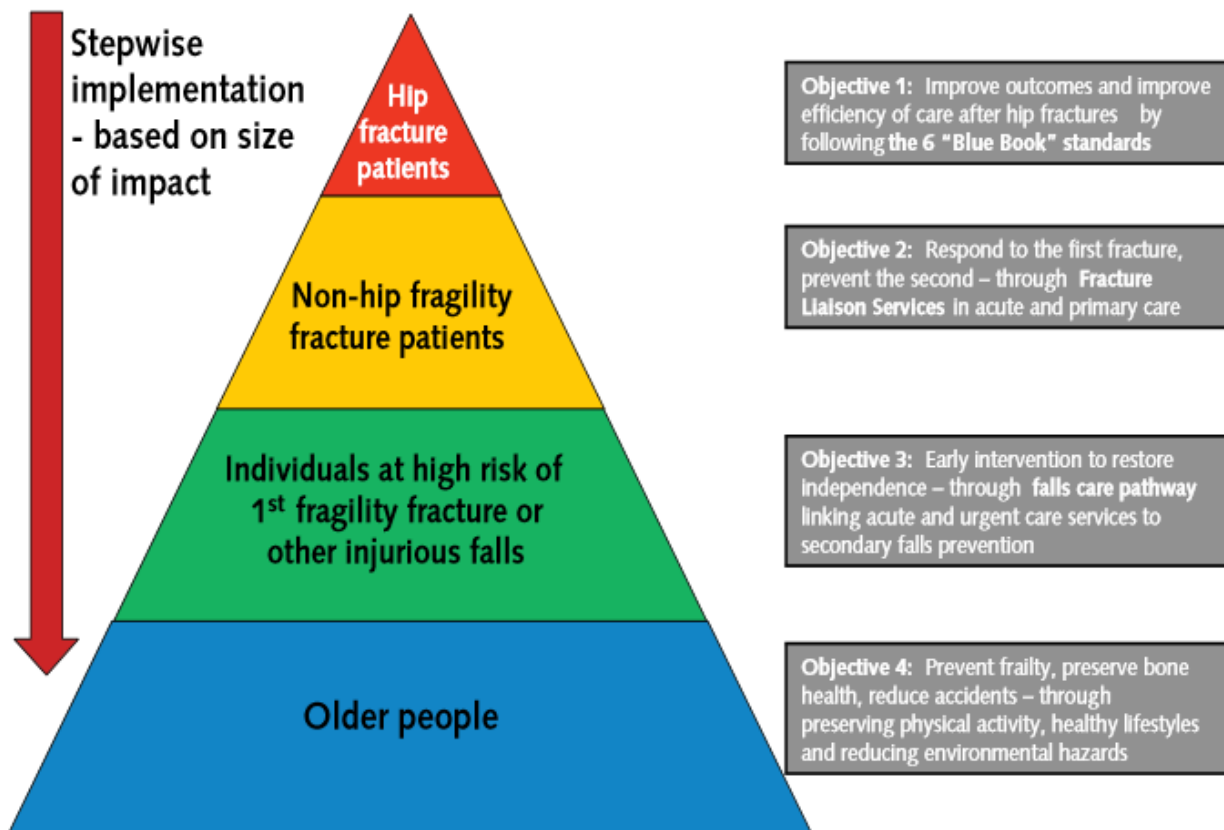
- The National Service Framework for older people (2001) set out the requirement for establishing an integrated local falls service. (7) The service should be part of the overall specialist services for older people in both hospital and community settings.
- In 2009 the Department of Health published a prevention package of resources to support the commissioning of services for older people, including falls prevention. (2)
- NICE guidance:
  - NICE CG161 (2013) provides recommendations for the assessment and prevention of falls in older people. (1)
  - Recognising the importance of osteoporosis as a risk factor for hip fracture, NICE CG 142 (2012) recommends that women aged 65 years or over and men aged 75 years and over are opportunistically assessed for the risk of fracture using FRAX or QFracture. (5)
- Be Active Be Healthy (8) and the Chief Medical Officer's (CMO) recommendations for physical activity (9) both recommend that older people should remain active. Older adults who are at risk of falls should incorporate physical activity to improve balance and coordination on at least two days a week.
- A report from Office for Disability (2008) described the savings that could be made through prevention of accidents and prevention of admission to hospital or to residential care through provision of home adaptations and equipment. (10)
- The Better Care Fund announced in June 2013 aims to help integration of health and social care. (11) It creates a local single pooled budget to incentivise the NHS and local government to work more closely together.

The National Service Framework (NSF) for older people 2001(7) described the need for a service for prevention of falls, including tailored exercise programmes, assessment and treatment for osteoporosis, and identification and management for those older people who fall. It described a falls service staffed by a multi-disciplinary team.

NICE clinical guideline CG161 (1) recommends case finding of people who report a fall or who are at risk of falling, assessing their gait and balance, obtaining a multifactorial risk assessment, and proposing multi-factorial interventions. These include encouraging participation in falls prevention programmes, education, and linking specialist falls services with osteoporosis services.

The Department of Health (DH) report on falls and fractures and interventions for health and social care (2) describes four objectives. These range from acute services for people who have fractured their hip (objective one) to preventive services (objective four). These are shown in the following diagram:



**Figure 1. A systematic approach to falls and fracture prevention - four key objectives (2)**

Source: Department of Health (2009)

### 3. Risk factors for falls

Falls are caused by different risk factors. Age carries the highest risk for falling and NICE guidance (1) recommends that all people aged 65 or over should be assessed for their risk of falling.

A systematic review of 74 studies considered over 30 different risk factors including socio-demographic, mobility, sensory, psychological, medical factors and use of medication. (13) The strongest associations for falls were found for age and a history of falls. Other risk factors were gait problems, including due to long term alcohol and drug misuse, use of walking aids, vertigo, Parkinson's disease, and use of antiepileptic drugs.

### 4. Evidence for interventions that work in falls prevention

There is a wealth of evidence that group and home-based exercise programmes and home safety interventions reduce rate of falls and risk of falling.

#### 4.1 NICE guidance prevention of falls in the community – NICE CG161 (2013 /2004)

The NICE guideline for prevention of falls in the community CG161 is based on previous evidence from the original guideline in 2004 .(1) It recommends that older people should be screened for risk of falling in an opportunistic manner when presenting in primary care, secondary care and other settings. More detail on tests used to assess risk of falling in the community is provided in Appendix 2.

Further assessment and intervention is indicated for those individuals who report a fall in the last year and have a gait or balance problem. NICE identified the essential elements of a falls assessment to be gait/balance, osteoporosis risk, medication review, home hazard and vision.

NICE concluded that individualised multi-factorial interventions should include interventions on strength and balance training, home-hazard intervention, modification or withdrawal of medications, and referral for correction of visual defects.

NICE set out a series of standards for the service and suggested specialist falls services should be linked operationally to bone health (osteoporosis) services.

#### **4.2 Osteoporosis - NICE CG146 (2012)**

This guideline recognises the importance of osteoporosis as a risk factor for hip fracture. (5) It recommends that women aged 65 years or over and men aged 75 years or over should be opportunistically assessed for the risk of fracture using FRAX or QFracture. For those people whose fracture risk is in the region of an intervention threshold, clinicians should consider measuring bone marrow density with a DXA scan to inform treatment.

#### **4.3 Evidence for the benefit of exercise in preventing falls**

The most recent Cochrane systematic review of interventions for preventing falls in older people living in the community states that well-designed exercise programmes, even in the very old and frail, can reduce the risk of falls. (16)

As well as exercise, the review found evidence of effectiveness for a number of different approaches to falls prevention, some with all older people living in the community and others in particular subgroups. This evidence may not be applicable to older people with dementia as most included studies excluded them from participation. The review is summarised here:

- There is strong evidence that certain exercise programmes prevent falls. Group exercise classes and exercises individually delivered at home reduce rate of falls and risk of falling. Tai Chi as a group exercise reduces risk of falling, but is less effective in people at higher risk of falling. Overall, exercise programmes aimed at reducing falls appear to reduce fractures.
- Multifactorial interventions integrating assessment with individualised intervention, usually involving a multidisciplinary team, are effective in reducing rate of falls but not risk of falling.
- Home safety interventions reduce rate of falls and risk of falling. These interventions are more effective in people at higher risk of falling, and when delivered by an occupational therapist. An anti-slip shoe device for icy conditions significantly reduced winter outside falls in one study.

- There is limited evidence for the effectiveness of interventions targeting medications (e.g. withdrawal of psychotropic medications, educational programmes for family physicians).
- Vitamin D does not appear to prevent falls in all older people living in the community, but appears to be effective in people who have lower Vitamin D levels before treatment.
- In people with severe visual impairment, there is evidence from one trial for the effectiveness of a home safety assessment and modification intervention. Expedited eye cataract surgery for people on a waiting list significantly reduces rate of falls compared with waiting list controls. Older people may be at increased risk of falling while adjusting to new spectacles or major changes in prescription.
- In one study, rate of falls was reduced in people with disabling foot pain receiving "multifaceted podiatry" (customised orthoses, footwear review, foot and ankle exercises, fall prevention education in addition to "usual podiatry care").
- Evidence from three studies for effectiveness of cardiac pacing (e.g. pace makers) in people with increased sensitivity of the carotid sinus<sup>1</sup> and a history of fainting and/or falls.
- The evidence relating to the provision of educational materials alone for preventing falls is inconclusive.

A more recent systematic review found that falls prevention exercise programmes for older people not only reduce the rates of falls but also prevent injuries resulting from falls in older people living in the community. (17) The protective effect seems most pronounced for the most severe fall related injuries: the estimated reduction is 37% for all injurious falls, 43% for severe injurious falls, and 61% for falls resulting in fractures.

#### 4.4 How does exercise prevent falling?

All exercise programmes that have proved to be effective for falls prevention emphasise balance training. (17)

Most exercise programmes are multicomponent and include balance and other types of exercise such as gait and functional training, strengthening exercises, flexibility, and endurance. There is evidence that these types of interventions can improve reaction time, gait, muscle strength, coordination, and overall physical functioning as well as cognitive<sup>2</sup> functions, especially executive<sup>3</sup> function. (18) (19) (20) It is thought that regular exercise prevents injury following a fall not only by improving balance and decreasing the risk of falling, but also by improving cognitive functioning, and the speed and effectiveness of protective reflexes (such as quickly extending an arm or grabbing nearby objects).(21)

#### 4.5 Community or home based exercise - The Otago exercise programme

Systematic reviews have looked at both home based and community based exercise programmes and found both to be effective. (16) The Otago exercise programme is a widely used home-exercise programme, combining strength and balance retraining exercises to prevent

<sup>1</sup> A condition where people may experience a sudden drop in blood pressure, dizziness and fainting

<sup>2</sup> Knowledge, memory, reasoning, problem solving, judgement

<sup>3</sup> Organising and regulating

falls in older, community-dwelling people. (22) It has been shown in a systematic review of seven trials, involving 1503 participants, to significantly reduce the risk of death over 12 months and significantly reduced fall rates.(23)

A recent randomised controlled trial from France, the Ossébo trial, looked at community based exercise classes for older women aged 75-85 years. (23a) These classes consisted of weekly, supervised, group sessions of progressive balance training for two years. The classes were supplemented by individually prescribed home exercises. The intervention group was found to have significantly reduced injurious falls compared to the control group. At two years, women in the intervention group also performed significantly better on all physical tests and had significantly better perception of their overall physical function.

#### **4.6 Organisation of services**

- **National survey of falls services**

Falls services across the country have been shown to be of varying standard. A national survey of services for the prevention and management of falls in the UK was carried out in 2008. (24) A total of 231/303 (76%) of services were surveyed. They found that for a substantial number of services, delivery fell below recommended NICE guidance. There was substantial variability in content and quality of screening, assessment and interventions provided, and a failure by many services to implement procedures supported by research evidence.

While services for individual patients needing specialist management in a falls prevention service are needed, community programmes may be less individually expensive and need fewer staff and may reach more people at risk. They are commonly based on a simple assessment, delivered by a single health professional working according to a protocol and suitable for widespread dissemination. One systematic review found that single interventions (for example an exercise programme) were as effective in reducing falls as interventions with multiple components as recommended by NICE. (25) Another systematic review of 17 randomised controlled trials found that interventions that weren't specially tailored to individually assessed risk factors are effective at reducing both the number of people that fall and the fall rate. The review suggests that this approach should be considered as an option for how services are delivered. (26)

- **Primary prevention and secondary prevention**

There is a need to bridge the gap between primary prevention in the community, and secondary prevention which is often provided by a falls service in a hospital and where exercise classes are provided on an individual or very small group basis. Follow up classes back in the community are also needed for these people to continue their exercises once discharged.

- **Barriers to participation in exercise classes for falls prevention**

One systematic review found barriers to participation in classes included older people underestimating their risk of falling and the stigma associated with attending programmes that target

older people.(27) A qualitative study found a major hurdle was reluctance by older people to even tell a health professional that they had experienced a fall. (28) Another qualitative study found that an invitation from a health professional to participate in a falls prevention class can increase the chance of attendance. (29)

#### **4.7 Examples of good practice in primary care**

- In North Tyneside, the falls prevention service (FPS) screened GP case notes for falls risk factors. A screening questionnaire was then sent to clarify risks and invite people to attend for a comprehensive multidisciplinary assessment in the FPS. Over a three year period, 853 people (25.8%) were referred to associated Age UK strength and balance training classes (30)
- An electronic clinic reminder in the notes was effective in asking about falls in a community outpatient clinic in the US. (31)
- In Nottingham, the Better Balance Better Bones initiative searched GP databases electronically for patients at risk of falls who had not received a falls assessment. (32) Data were searched from 26 GP practices over 12 months, and over 340 people were identified needing further evaluation.
- In Liverpool, the Liveability Programme piloted a small study in older people who attended twice weekly classes in a leisure centre run by a trained community instructor.(33) This led to increased physical activity and improved confidence in balance and mobility.
- In Doncaster, a community pharmacy worked with general practitioners to target a standard medicine use review (MUR) with additional assessment of the risk of falling.(34)The service was evaluated over an eight week period and found to be a successful and acceptable way to identify people at risk of falls and refer them to their GP.

#### **4.8 Examples of good practice in the community**

- East Sussex Otago Strength and Balance Exercise Programme – a free 16 week programme to reduce the risk of falls. Referrals made via the GP.
- Greater Glasgow and Clyde osteoporosis and falls prevention programme - a single point of contact is a strength of the Glasgow programme (14b) (Appendix 1).
- Edinburgh Be Able Service - a 16 week programme including OT assessment, multifactorial risk assessment, Otago strength and balance programmes, practicing activities of daily living.
- The following services are highlighted by Age UK :
  - Tameside and Glossop Falls and Osteoporosis Service – developed a multiagency approach, including developing a model of risk assessment for care homes, engaging the local Asian Older People’s network, tri-aging referrals from the ambulance service
  - Hampshire Better Balance for Life –multi-agency approach by the council, CCG and voluntary sector to increase opportunities for older people to take part in physical activity. Designed by physiotherapists and physical activity professionals. To ensure that every community social group includes some exercise.

- Cambridge City Falls Exercise Pathway – has established exercise opportunities across health, statutory and voluntary agencies.

## **5. Level of need in Brighton & Hove**

### **5.1 Ageing population**

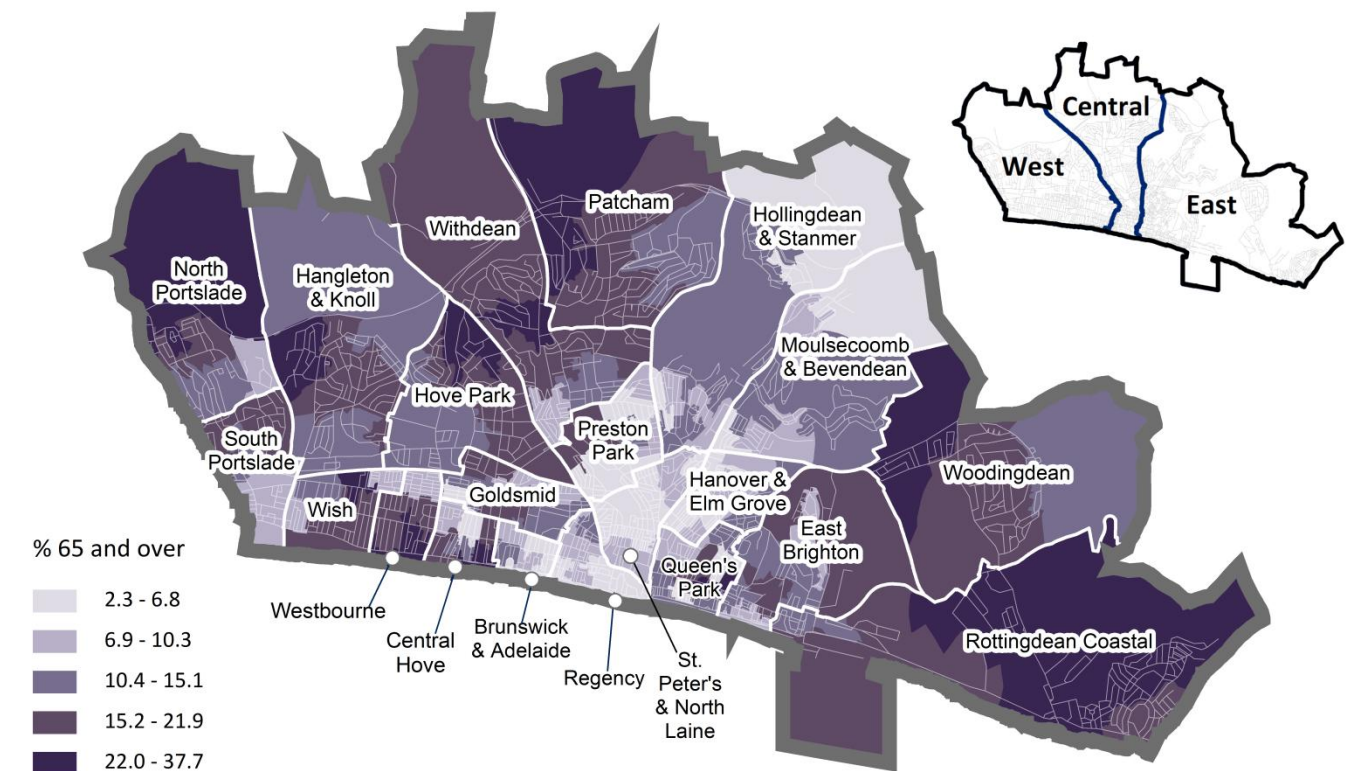
The population of Brighton & Hove is ageing and so more people are at risk of falling. According to 2012 population estimates, older people aged 65 years or over account for 13.3% (36,684 people) of all residents. This proportion is predicted to increase to 13.8% (39,982 people) by 2021, at which point approximately 7,200 residents will be aged 85 years or more. In 2014 there were 6,084 people aged 85 or over in Brighton & Hove<sup>4</sup>.(4)

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<sup>4</sup> Midyear estimates from the Office of National Statistics 2014.

**Figure 2: Percentage of population by Lower Super Output Area in Brighton & Hove aged 65 or over, November 2012**

Percentage of population aged 65 and over, November 2012



Brighton & Hove:- 13.0%

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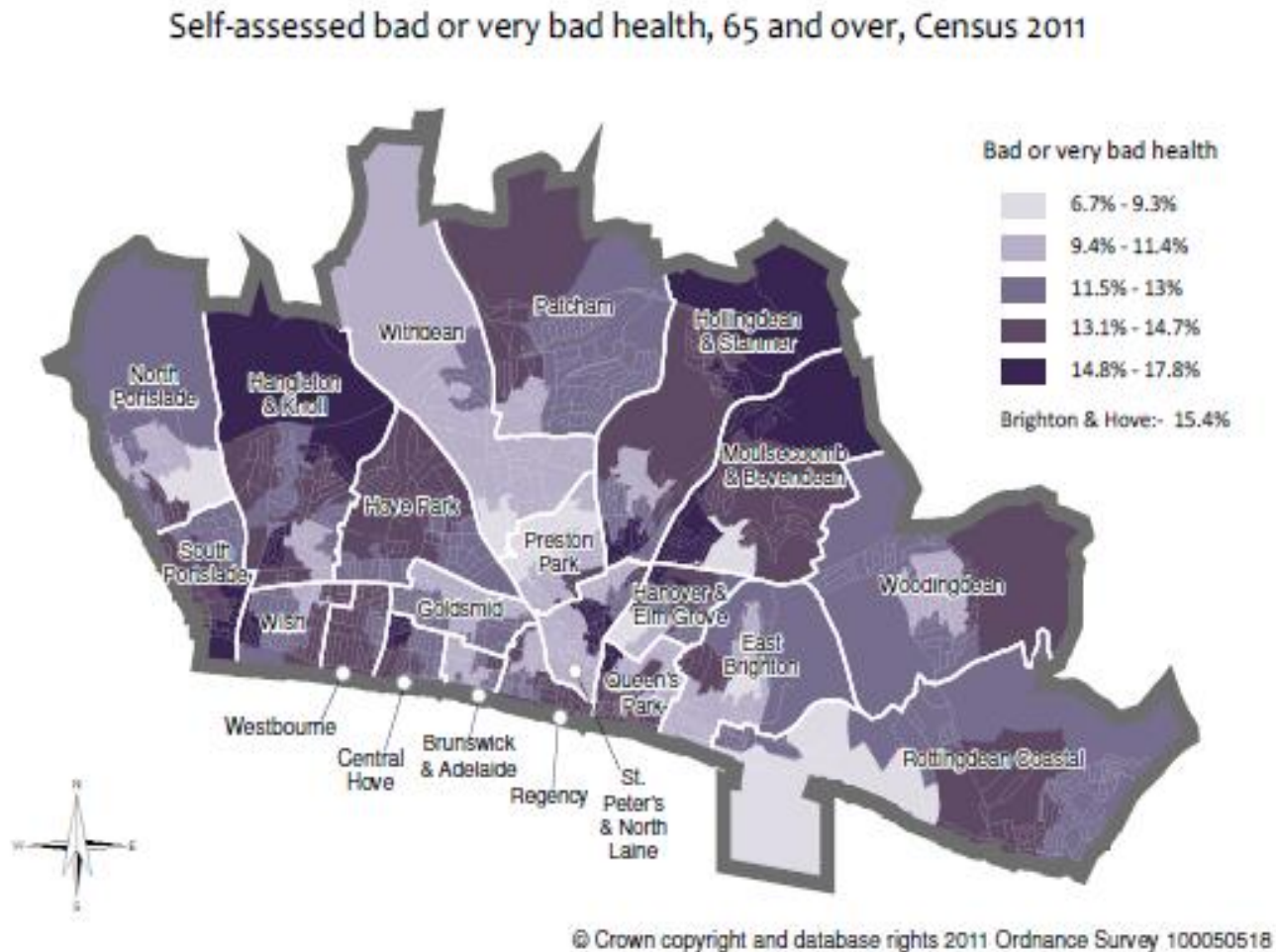
Older people live across all areas of the city. However, the largest communities are in Rottingdean Coastal (22% of the population) and Woodingdean (19%)., with Over half of the city's older people live in the 40% most income deprived areas for older people in England, and some in the 4% most deprived. The West locality has the highest number of older people.(4)Projecting Older People Population Information System (POPPI) (15a) estimates that 10,154 people age 65 or over in the citywere predicted to have a fall in 2014. (15b)

## 5.2 Impact of poor health

Poor health has an impact on falls, in particular mobility, sensory, psychological, medical factors and use of medications are risk factors for falling (see Section 3).

The 2011 census asked residents to self-assess their health and the map below identifies responses by area. Areas where residents report higher rates of bad or very bad health overlap with areas where there are higher rates for both falls and resultant hospital admissions.

**Figure 3: Percentage of people aged 65+ who are in bad or very bad health and report their day to day activities limited a lot**



### 5.3 Prevalence of falls in Brighton & Hove

Not all falls lead to an admission to hospital or attendance at a GP clinic so will not necessarily be recorded. Health and lifestyle surveys are another important method of gathering information about the prevalence of different conditions. Information is obtained by geographical area, and provides trend data over time.

Local Health Counts surveys of adults living in Brighton & Hove in 2003 and 2012 included a question on whether people had fallen in the past six months. The surveys also included questions on other aspects of physical health, in addition to emotional health and wellbeing, lifestyles, social capital and demographic information such as age, gender, and housing tenure which enables us to look at falls in different population groups.



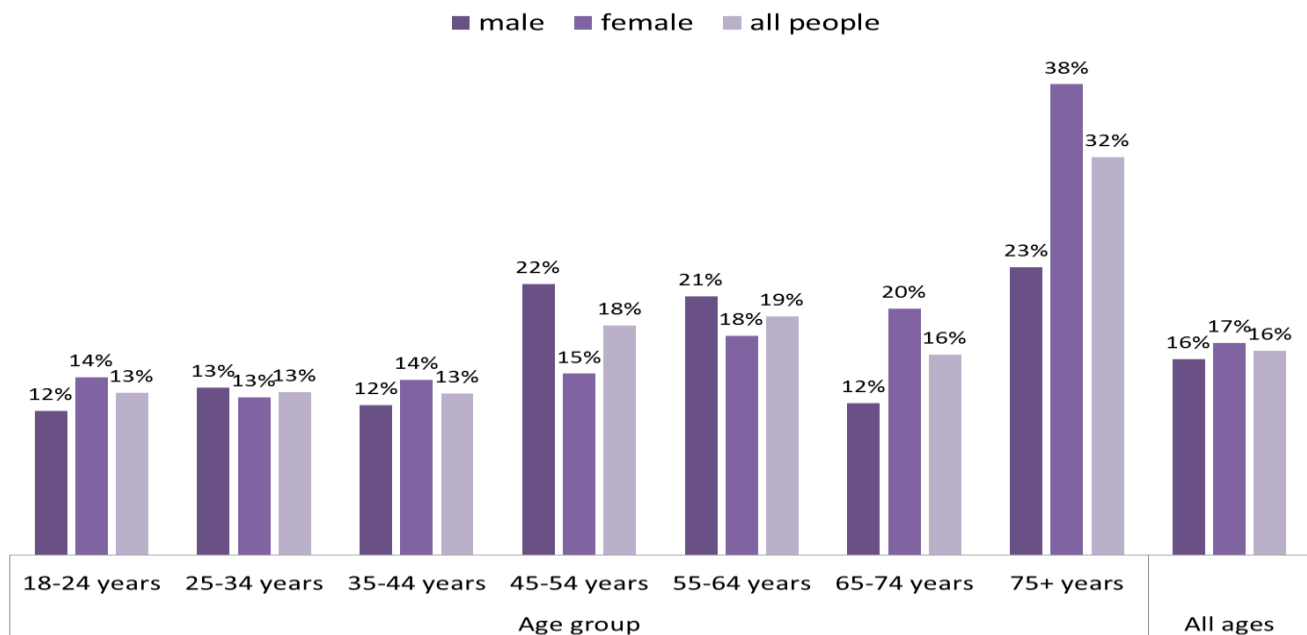
There were 2,025 respondents to the 2003 survey and 2,035 to the 2012 survey. In the 2003 survey 20% of respondents said that they had fallen in the previous six months, this reduced to 16% in 2012.<sup>5</sup> For those aged 65 years or over 24% had fallen in the previous six months (2012).

#### 5.4 Falls by population characteristics

Older people have particular need for interventions to prevent falls as increasing age is a high risk for falling. Women have more falls than men as they age. Asian and Caucasian women may be at increased risk of osteoporosis compared to other ethnicities.

There is a clear relationship between having fallen and age, with the percentage of respondents who say they have fallen ranging from 12-14% of those aged 18-44 years (Figure 3). Up to this age men and women are as likely to say that they have fallen. Between the ages of 45-64 years men were slightly more likely to say that they had fallen but from the age of 65, and particularly for those aged 75 years or over, women were much more likely to say that they had fallen in the past six months. For this oldest age group 23% of men, but 38% of women had fallen.

**Figure 4: Percentage of respondents who have fallen in the past six months by age group and gender, 2012**



#### The rest of this analysis is for those aged 65 years or over:

For those aged 65 years or over, the following groups were significantly more likely to have fallen in the previous six months:

- Those aged 75 or over were twice as likely to have fallen as those aged 65-74 years (32% vs 16%)
- Females (29% vs 17% of males)

<sup>5</sup> Health Counts surveys are available from <http://www.bhconnected.org.uk/content/surveys>

- Those not married, in a civil partnership or living as a couple (17% vs 30% of those who were) – these were mainly people living alone
- Those not in employment (26% vs 8%)
- Those living in the most deprived 20% of areas in the city (31%) compared with other quintiles of deprivation – however there was not a difference between the other quintiles of deprivation, between 22% and 23% of people living in each of the other four quintiles had fallen

There was no difference for the following characteristics:

- Sexual orientation
- Ethnicity (Looking at White British compared with Black and Minority Ethnic (BME) individuals)
- Religion
- Carers/Non Carers (17% vs 25%)
- Living alone (27% vs 21%)
- Whilst not statistically significant, those living in a bungalow were least likely to have fallen (17%), followed by those in a house (21%), ground floor flat (27%) or other flat (31%).
- Those who owned their own home were less likely to have fallen (22% vs 31%) but this difference was not statistically significant as the number of people aged 65 or over in the survey who did not own their own home was small (74 respondents). Broken down further, 27% of those renting from a private landlord had fallen, 28% of those renting from a local authority/housing association and 46% of those in “other” households (this could include living with relatives, in sheltered accommodation or residential homes)

There were too few people in the following equalities groups to be able to look at differences in falling:

- Trans
- Further ethnic breakdowns

### **5.5 Physical and emotional health**

People aged 65 years or over who had fallen were significantly less likely to be in good or better health (48%) compared with those who had not fallen (69%) and significantly more likely to have a limiting long-term illness or be disabled (74% vs 51%). They were also more likely to be at risk of major depression (50%) compared to those who had not fallen (27%).

Individuals who had fallen in the previous six months were less likely to see or speak to neighbours at least once a week (77% vs 85% of those who had not fallen), although this was not a statistically significant difference.

- **Social capital**

There was no difference in the percentage of people who, if ill in bed, could ask someone for help (73%) between those who had fallen and those who had not.

- **Happiness**

Those who had fallen were significantly less likely to have medium to high levels of satisfaction with life (51%), to think that the things they do in life are worthwhile (55%) or to feel happy (62%) and significantly more likely to have medium to high levels of feelings anxious (62%) than those who had not fallen (75%, 78%, 77% and 34% respectively).

- **Physical activity**

Those who had fallen in the past six months were significantly less likely to be physically active at recommended levels (15%) compared with those who had not fallen (29%).

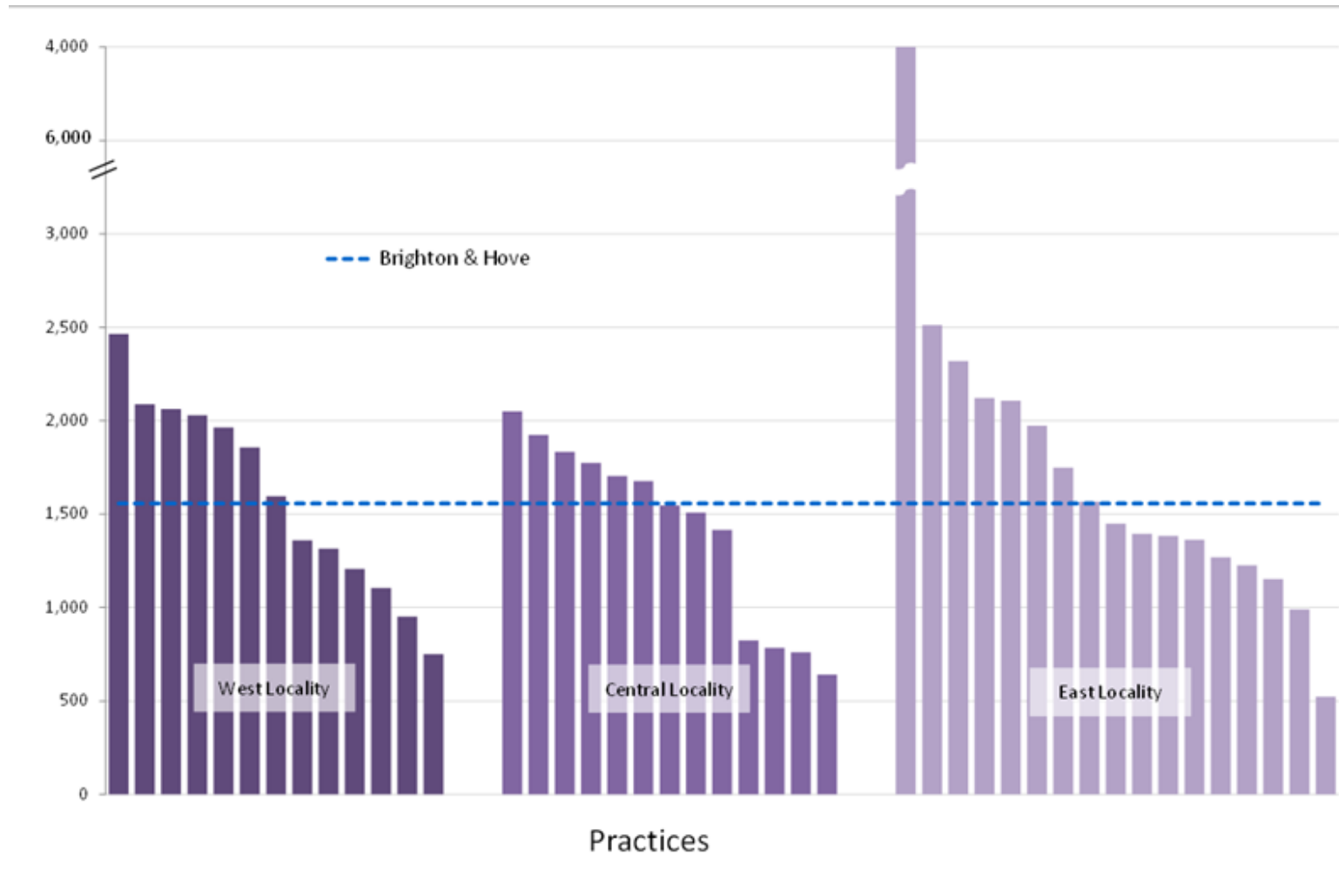
- **Alcohol consumption**

Individuals who had fallen were significantly less likely to be drinking at increasing of higher risk levels (7%) compared with those who had not fallen (16%).

## **5.6 Primary care**

Data on hospital admissions for falls recorded by GP practice are available from the Public Health Outcomes Framework. These are based on ICD10 codes for injuries due to falls in people aged 65 or over by GP practice and also by GP Localities for 2014/15.

We can see from the chart below that the number of people falling varies considerably from practice to practice and between the localities. Although the East Locality has the highest rate of falls if the outlier is not considered then the pattern is fairly similar across the city. The outlying practice warrants further investigation.



**Figure 5: Injuries due to falls in people aged 65 or over 2014-2015, age sex standardised rate/100 and grouped by Practice Locality <sup>6</sup>**

<sup>6</sup>Standardisation is a statistical method that enables us to compare outcomes across differing populations, as it accounts for their differences in age and gender, revealing the true statistical picture and is usually presented as a rate e.g. per 100,000 people.

## 5.7 The Quality and Outcomes Framework (QOF)<sup>7</sup>

In Brighton & Hove, the number and proportion of people aged 50 or more who are included on a GP osteoporosis register has increased considerably. In 2012/13, 228 people were on an osteoporosis register; by 2013/4, 353 people were on a register. Across practices in the city, for those patients aged 50-74 years who have had a fracture in the last two years with confirmed osteoporosis, 93% were being treated with appropriate medication.

However, it is likely that some people with osteoporosis have not been included on a GP register. The proportion of residents aged 50 or more on a GP osteoporosis register is 0.4%, whereas national estimates of the population prevalence of osteoporosis are 2% at 50 years increasing to more than 25% at 80 years in women. In 2013/14, no Brighton & Hove practice had more than five patients on a register and 17 practices had no-one on a register. This indicates that more could be done in primary care to identify these patients.

From 2016, this indicator will be part of the Public Health Locally Commissioned Services (LCS) with a focus on improvements in identification, data collection and management for those aged 75 or over. This LCS will comprise:

- Promotion of exercise in all GP consultations with people aged 65 or over
- Better coordination between primary care and services providing exercise classes for falls prevention
- Systematic identification of people at risk of falling in primary care and referral to the falls prevention service
- Contribution to the reductions in admissions for falls and falls with a fracture.
- Completion of QOF requirements for osteoporosis records.

## 5.8 Falls Requiring hospital admission recorded in Brighton & Hove

In 2013/14, Brighton & Hove recorded a higher rate of emergency admissions to hospital for injuries due to falls in people aged 65 years or over, compared to the rest of England and the South East. In Brighton & Hove there were 900 admissions, a rate of 2,107 per 100,000 population, compared with a rate of 2,050 for the South East region and 2,064 for England. The actual numbers for SE and England were unavailable at the time of this needs assessment. (35)

To help understand the picture further, local hospital admissions data was analysed to identify any potential trend. From the table below of admissions due to falls for Brighton & Hove CCG residents 65 or over, there has been little change in admissions over the last three years.

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<sup>7</sup>The Quality and Outcomes Framework (QOF) is a system for performance management and payment of GPs. GPs can earn QOF points by keeping a register and managing patients with osteoporosis and treating fragility fractures, (Osteoporosis OST002). Available at: <http://www.hscic.gov.uk/catalogue/PUB15751>

**Table 1: Standardised rate of emergency hospital admissions across the Clinical Commissioning Group.<sup>8</sup>**

	2010/11	2011/12	2012/13	2013/14	2014/15 (provisional)
Brighton & Hove CCG	2,624	2,349	2,335	2,107	1,557
South East	1,994	1,982	1,962	2,050	-
England	2,030	2,035	2,011	2,064	-

Figures are standardised for age and sex to enable comparison between different size populations.

### 5.9 Data from the ambulance service

Falls account for between a quarter to a third of all call-outs to the South East Coast Ambulance Service (SECAmb), with the number of repeat fallers increasing.<sup>9</sup> SECAmb recognises the importance of this issue and recently have started analysing their data about the number of call-outs to repeat fallers, time and month of call-out, and area of residence.

The data below shows that there are a higher number of repeat fallers during the evening, during the winter months - especially for men, and numbers increase as people age. For Brighton & Hove, the Hangleton & Knoll ward has the highest number of repeat fallers. NB The data below include a wider geographical area as SECAmb 'Brighton area' includes areas outside of the city boundary which is helpful for comparison.

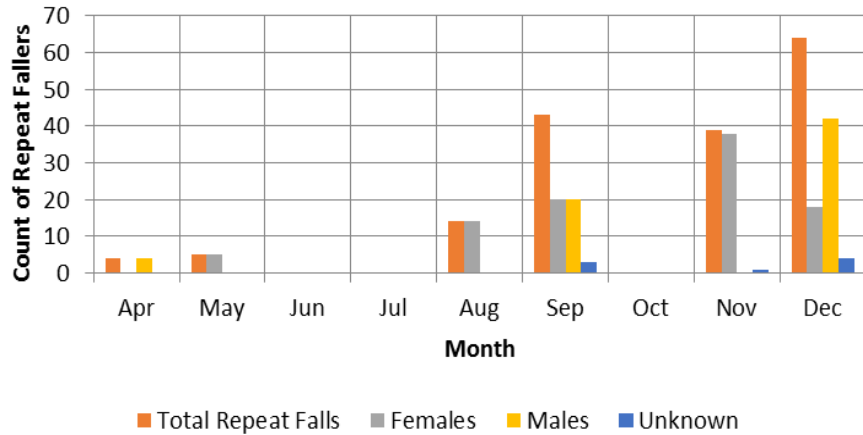
#### Chart 1: SECAmb number of repeat fallers by month and by age 2013-2014 and 2014-1015

NB. The SECAmb area covers a wider area than the Brighton & Hove City boundary

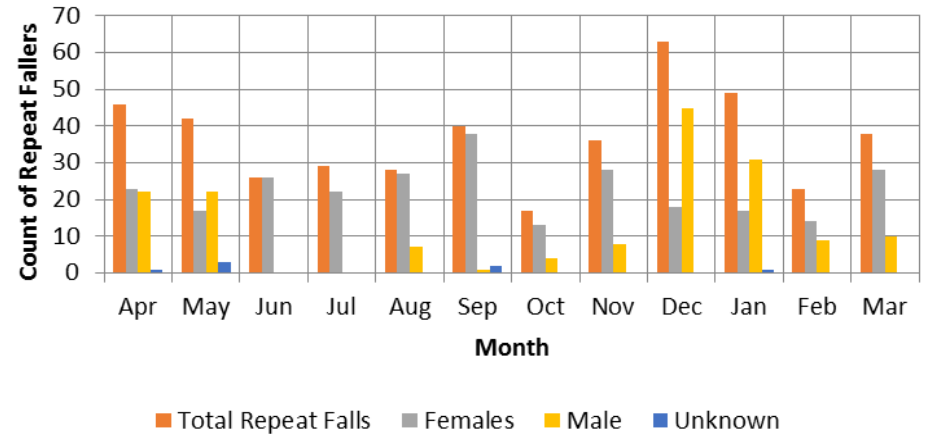
<sup>8</sup>Standardisation is a statistical method that enables us to compare outcomes across differing populations, as it accounts for their differences in age and gender, revealing the true statistical picture and is usually presented as a rate e.g. per 100,000 people.

<sup>9</sup>Information provided during interviews.

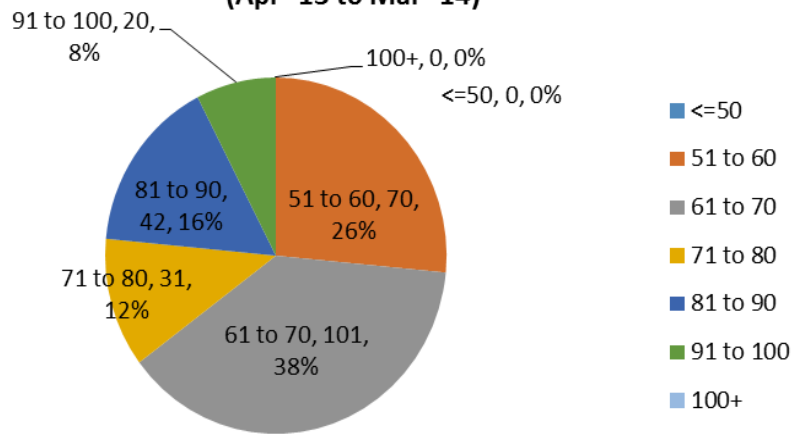
**SECAmb Repeat Fallers Brighton Area by Month  
(Apr -13 to Mar 14)**



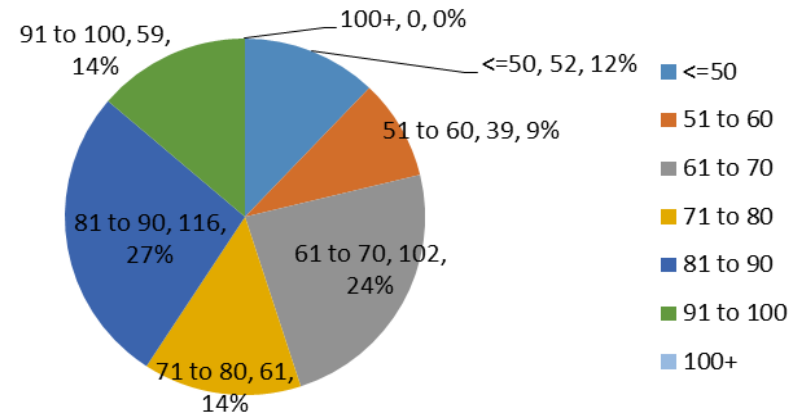
**SECAmb Repeat Fallers Brighton Area by Month  
(Apr -14 to Mar 15)**



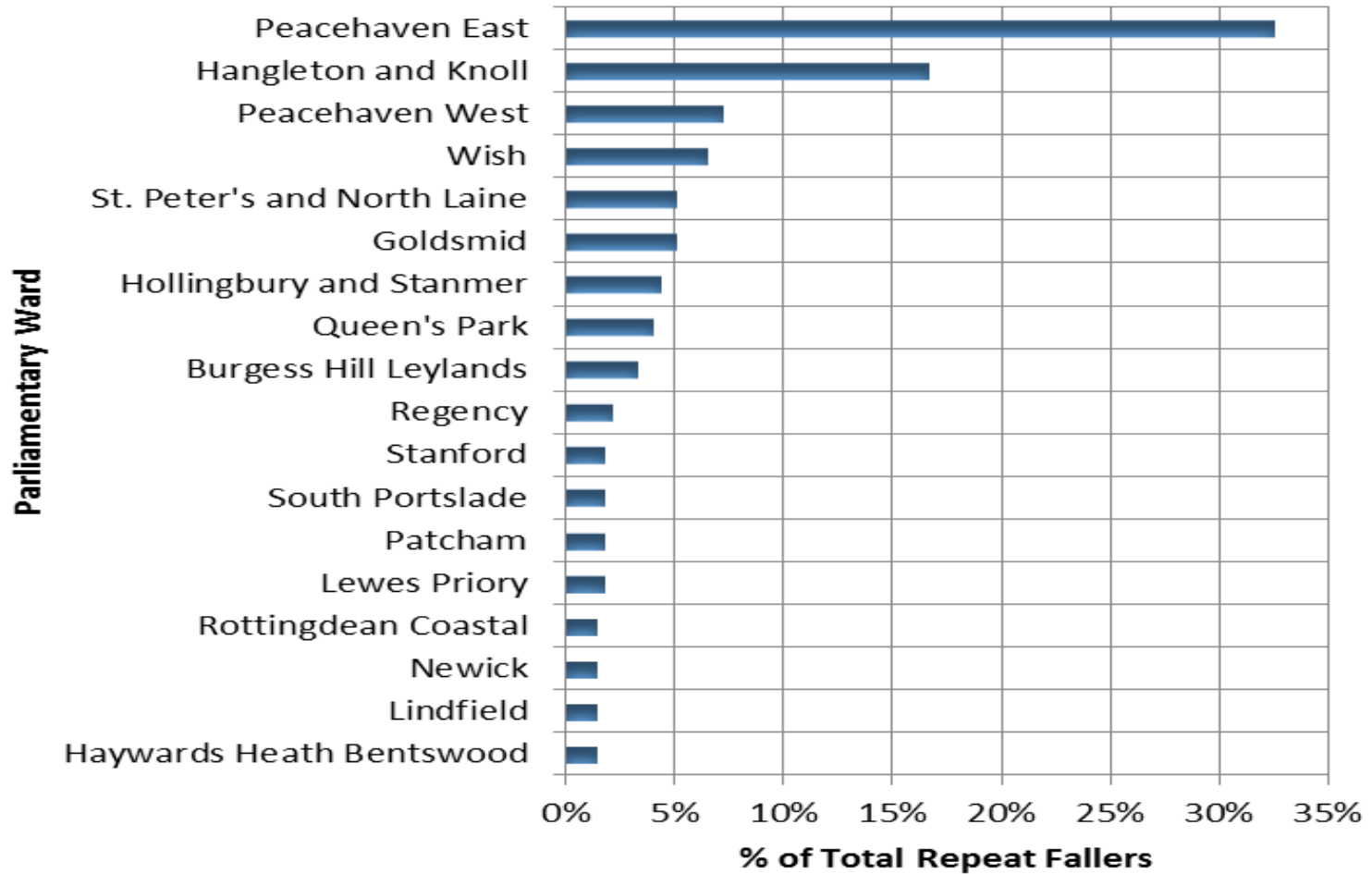
**SECAmb Repeat Fallers Brighton Area by Age Band  
(Apr -13 to Mar -14)**



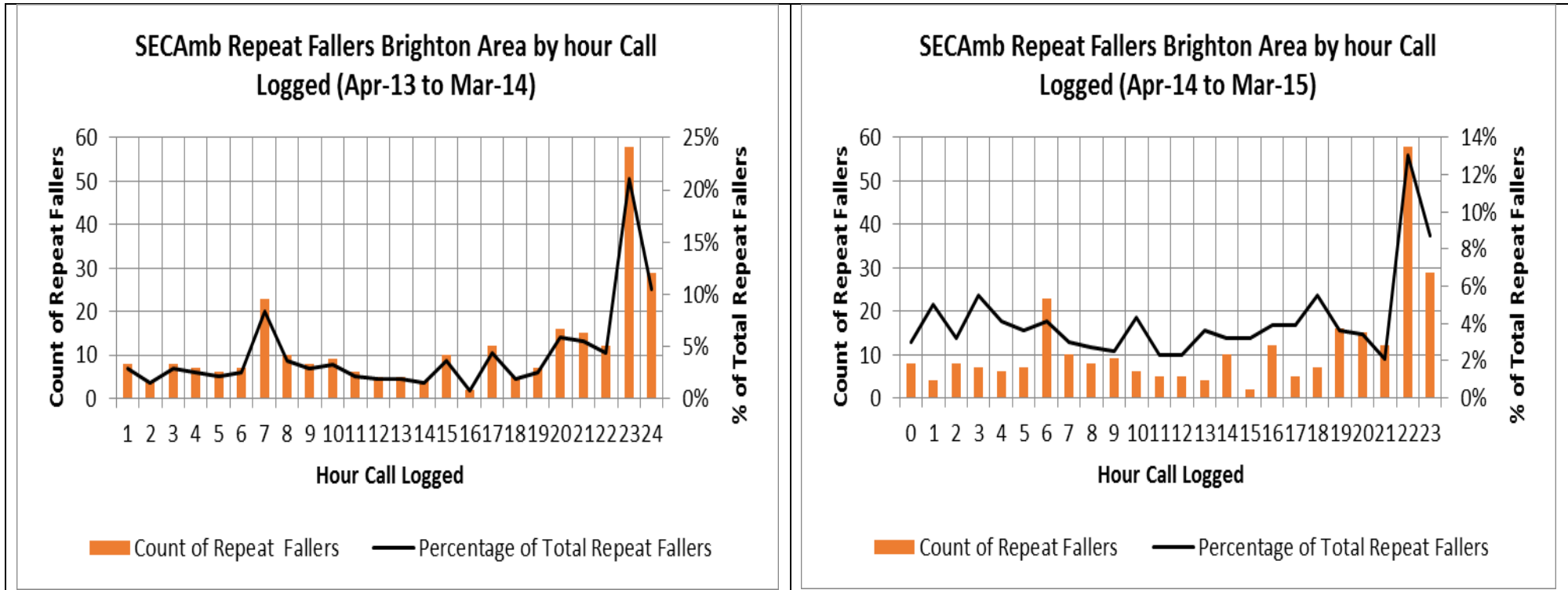
**SECAmb Repeat Fallers Brighton Area by Age Band  
(Apr -14 to Mar -15)**



### SECamb Repeat Fallers Brighton Area by Parliamentary Ward (Apr-13 to Mar-14)







**Chart 2: SECamb Repeat fallers by area and hour of call 2013-2014 and 2014-2015**  
**NB. The SECamb area covers a wider area than the Brighton & Hove City boundary**




## 5.10 Costs of falls

The cost and consequences of a fall are considerable. The table below shows the annual costs for the past three years of falls at Brighton and Sussex University Hospitals. While there is an encouraging downwards trend in the cost of falls with fractures, the average cost of falls without a fracture is increasing.

**Table 2: Costs of falls at BSUH 2013/6**

### Falls - Costs at BSUH

<i>Annual cost in £s</i>	<b>2013/14</b>	<b>2014/15</b>	<b>2015/16</b> (Year to date: 5 months)
Non fractures	1,078,137	949,766	438,713
Fractures	2,571,434	2,617,598	922,659
All Falls	3,649,571	3,567,364	1,361,372

<i>Average cost / month in £s</i>	<b>2013/14</b>	<b>2014/15</b>	<b>2015/16</b>	<b>Trend</b>
Non fractures	89,845	79,147	87,743	
Fractures	214,286	218,133	184,532	
All Falls	304,131	297,280	272,274	

## 6. Projected need for falls prevention services in Brighton & Hove

### 6.1 Modelling of falls and fractures

The Department of Health has modelled the prevalence of falls and fractures in a standard population in England of 300,000 people. (2) Simply applying these figures to Brighton & Hove with its population of 281,000 people, and younger age structure, with 31,700 people aged 65 years or over (Office for National Statistics Mid-year estimates for 2014) would suggest that each year:

- 10,900 people will fall and 4,700 will fall twice or more
- 1,500 fallers will attend an accident and emergency (A&E) department or minor injuries unit
- A similar number will call the ambulance service
- 800 people will sustain a fracture, 250 to the hip.

Projecting Older People Population Information System (POPPI) (15a) projects both the number of people falling, and the number of people being admitted to hospital as a result of a fall to 2030 for

local authorities. The figures for Brighton & Hove are given in Tables 3 and 4. The projections for admissions to hospital are not available by gender or for 5 year age bands for those aged 75 or over.

The greatest predicted increases are for men aged 85 or over and for women aged 65-69, with the greatest projected increase overall in the 85 or over group. In general, the number of falls rises over time and with age. However, there is a projected population dip in 2020 which is reflected in the lower number of falls predicted.

For hospital admissions resulting from a fall the numbers are projected to continue to rise for people aged 70 or over from 804 in 2014 to 1,089 a year by 2030.

**Table 3: People aged 65 or over predicted to have a fall, by age and gender, projected to 2030 in Brighton & Hove.**

	2014	2015	2020	2025	2030
<b>Males 65-69</b>	1,044	1,062	972	1,080	1,350
<b>Males 70-74</b>	780	800	1,040	960	1,080
<b>Males 75-79</b>	589	608	646	855	798
<b>Males 80-84</b>	713	713	775	868	1,147
<b>Males 85 and over</b>	860	903	1,032	1,204	1,462
<b>Total males aged 65 or over predicted to have a fall</b>	<b>3,986</b>	<b>4,086</b>	<b>4,465</b>	<b>4,967</b>	<b>5,837</b>
<b>Females 65-69</b>	1,288	1,311	1,242	1,403	1,748
<b>Females 70-74</b>	1,134	1,161	1,404	1,350	1,512
<b>Females 75-79</b>	972	972	1,026	1,269	1,215
<b>Females 80-84</b>	1,054	1,020	1,020	1,122	1,360
<b>Females 85 and over</b>	1,720	1,763	1,720	1,849	2,064
<b>Total females aged 65 or over predicted to have a fall</b>	<b>6,168</b>	<b>6,227</b>	<b>6,412</b>	<b>6,993</b>	<b>7,899</b>
<b>People 65-69</b>	2,332	2,373	2,214	2,483	3,098
<b>People 70-74</b>	1,914	1,961	2,444	2,310	2,592
<b>People 75-79</b>	1,561	1,580	1,672	2,124	2,013
<b>People 80-84</b>	1,767	1,733	1,795	1,990	2,507
<b>People 85 and over</b>	2,580	2,666	2,752	3,053	3,526
<b>Total population aged 65 or over predicted to have a fall</b>	<b>10,154</b>	<b>10,313</b>	<b>10,877</b>	<b>11,960</b>	<b>13,736</b>

Figures may not sum due to rounding. Crown copyright 2014. These figures are based on a study of 647,721 A&E attendances and 204,424 admissions to hospital for fall related injuries in people aged 60 years and over. (16a) The prevalence rates have been applied to ONS population projections of the 65 or over population to give estimated numbers predicted to be admitted to hospital as a result of falls to 2030.

**Table 4: People aged 65 or over predicted to be admitted to hospital as a result of falls, by age, projected to 2030 in Brighton & Hove.**

	2014	2015	2020	2025	2030
People 65-69	59	60	56	63	79
People 70-74	75	76	96	90	101
People 75 and over	670	670	707	821	909
<b>Total population aged 65 or over predicted to be admitted to hospital as a result of falls</b>	<b>804</b>	<b>806</b>	<b>858</b>	<b>974</b>	<b>1,089</b>

Figures may not sum due to rounding. Crown copyright 2014. These figures are based on a study of 647,721 A&E attendances and 204,424 admissions to hospital for fall related injuries in people aged 60 years and over (16a) The prevalence rates have been applied to ONS population projections of the 65 or over population to give estimated numbers predicted to be admitted to hospital as a result of falls to 2030.

## 7. Interviews with public and professionals in Brighton & Hove

### 7.1 Views of the public

Interviews were conducted with representatives from the Older Peoples Council<sup>10</sup>. Their views are summarised here.

- Outdoor hazards in the street are a problem for older people, including poor pavements, poor lighting in public places, cycle lanes and cyclists
- More equipment is needed, walking sticks and equipment need to be available to borrow from GP surgeries, including snow 'clip-ons' to prevent slipping in poor weather
- Home adaptations are important and need to be more widely available
- Consider NHS health checks for the over 75s. This could include a review of multiple medication
- Sometimes an individual's resistance to change does not help the situation e.g. reluctance to move favourite furniture that may be a trip hazard etc.

### 7.2 Views of professionals and service providers

Professionals working with older people's services in Brighton & Hove were consulted via 26 interviews and two forums between March and June 2015. The interviews identified data collected, assets (what is working well), things that need changing and gaps in services.

<sup>10</sup>The OPC is an independent group supported by Brighton and Hove City Council. The OPC works to ensure that all older people in Brighton and Hove are treated with respect and dignity and have access to services, support and opportunity to lead a fulfilling life. Members are elected for a 4 year period. See <http://www.olderpeoplescouncil.org/>

There are recurring themes emerging from these interviews, which have been grouped into four categories:

- Links between clinical and non-clinical community services
- The Osteoporosis and Falls Prevention Service current configuration
- Falls prevention is everybody's business
- Motivation and confidence building

Below are some of the quotes from the interviews grouped under these four headings:

### **7.2.1 Links between clinical and non-clinical community services**

Many of those interviewed recognised the importance of the clinical work carried out with those who had already fallen and likely to fall again. They see potential for improving the sharing of information about services, activities and learning between the sectors as well as developing opportunities for cross-referral, in particular between front line workers such as GPs, pharmacists, Home Care providers and Occupational Therapists (OTs). In addition there was recognition of the need for better links to community services post discharge.

Specific comments included:

*Would be good if clinical services recognised the role that community services can play in supporting people around softer outcomes*

*Would be good to have the 'journey' clearly mapped so clinical and community services can know how best to work together to support people*

*When a community worker generates a referral to falls prevention service or specialist team they would like to know what happened.*

*Need better joining up between initiatives*

*Better data sharing systems are needed and regular info from hospital admissions, ambulance CCG etc. Post code data is useful to identify fallers.*

*Re-direct those from primary care who don't need specific falls prevention interventions to more general community initiatives to build strength and balance*

*The falls service in the hospital needs to improve its relationship with the community – a two-way information flow is needed. Recognise important role of GPs.*

*Not clear for the hospital services what is happening 'out there'.*

### **7.2.2 The Osteoporosis and Falls Prevention Service (FPS) current configuration**

The FPS is recognised as offering excellent support using good practice interventions to the people it sees. The proactive work with Care Homes is regarded as excellent practice, although at the time of the interviews (March – June 2015) this was not offered due to gaps in staffing. The staffing gaps in the FPS were mentioned as problematic by several people.

Specific comments included:

*FPS could be working better as it has recruitment and retention issues – so it can't meet its capacity. The osteoporosis nurse has not been replaced. Why are staff leaving the falls assessment team?*

*FPS – this is neither accessible nor suitable for all. Need to tighten up the link with the wide range of activity classes in the city.*

*Need clear referral for the 'concerned but not fallen yet' people, as the FPS is not contracted to do such assessments. Clear signposting to other groups that can help keep people active.*

*All prevention is focused on a medical model approach, mostly with the most vulnerable – but this leaves primary prevention of falls as a huge gap.*

*The ambulance service should be able to refer to the FPS and other services/activities for primary prevention*

### **7.2.3 Falls prevention is everybody's business**

There is a need for awareness raising and dissemination of health promotion messages around falls prevention across the city and with a wide range of front line workers.

There are examples of good practice in the monitoring, reviewing and prevention of falls in the city's Residential and Nursing Care Homes. Residents in these settings tend to be more vulnerable adults with greater health needs. Keeping residents as active as possible with suitable tailored exercise plans markedly reduces their likelihood of falling. Staff training around falls prevention needs to be ongoing to accommodate staff changes.

Pharmacists have a key role which could be developed, not only their Medicines Use Reviews (MURs), but also to include advice and guidance around how to keep active when taking medication that could cause hypotension, dizziness, dehydration or confusion.

Within clinical settings there is a good multi-disciplinary approach to care, rehabilitation and support, however stronger links could be made with community based activities for patients post-discharge.

Workbook-based training is being rolled out through certain teams within the NHS providers to ensure falls prevention becomes everyone's business.

Several of those interviewed from community services were very aware of their role in preventing falls, however this was not the case across all community services. This is an area where

increased awareness raising and dissemination of health promotion messages would be both constructive and helpful.

Specific suggestions include;

*Active ageing needs to start when people are younger*

*Strength, balance and mobility classes are needed, not a Osteoporosis and Falls Prevention Service*

*Consider adding links directly from GP practice computer screens to e.g. Active4life webpages, as supportive signposts*

*GPs to proactively case find those at high risk of falling in their patient population*

*Need GPs to routinely ask about falls as there needs to be better assessment of those at home with a possible risk of falling*

*Could have top tips on GP surgery walls – try not to over medicalise things*

Suggestions for other areas that GPs could focus on include:

- Collate more information on patients who fall – context, frequency etc.
- Routinely ask older people and those on a 'frailty' pathway or with osteoporosis etc. about falls.
- Check people aged 65 or over for morbidities and risk factors
- Carry out an analysis of the IT codes used in GP practices to record falls
- Earlier referral of those at risk.
- Mark patients' notes with a falls risk rating - Red/Amber/Green

#### **7.2.4 Environmental assessments**

The value of home assessments for potential slips, trips, bumps and falls, were specifically mentioned. Examples of good practice include home care staff visiting and assessing people's homes prior to their return after rehabilitation.

There are a number of community projects, good neighbour schemes and services that visit people in their homes who may be in a position to raise these issues appropriately. Small projects such as slipper exchanges can help.

There are many examples of good practice in respect of housing adaptations and accessibility and refurbishments, with OT assessments and training for housing providers, planners and developers.

Here are some recorded comments with interviewees:

*There needs to be better assessment in the community of those at home but at possible risk of falling.*



*Home environment assessments are needed and help to make it safe.*

*Confidence building is needed as 'fear of falling' can be a barrier preventing people going out and taking part in activities and social events – which could lead to greater isolation.*

### **7.2.5 Equipment**

There are a number of equipment schemes in the city such as Carelink Plus, which is especially effective when combined with OT support. However many felt such schemes were not accessible enough and walking aids and other equipment should be available more widely, for example via GP practices and community centres. There is a need for a greater range of appropriate equipment (aids and adaptations etc.) to be developed and made readily accessible. A good practice example is a project with the University of Brighton who designed gardening equipment for older residents with mobility issues.

Here are some specific comments:

*There is a rising demand for equipment linked to the ageing population.*

*Advice is needed for self funders about products on the market*

*The correct equipment can go a long way to support confidence and ability and help maintain activity.*

### **7.2.6 Ambulance as a route of referral to early prevention**

Given that a quarter to a third of ambulance call outs are to help a faller, the ambulance service needs to be part of the wider prevention debate and a route of referral to early intervention and prevention services and activities.

Other specific comments included:

*Frequent fallers are the largest group of frequent callers to the ambulance service. Crews are becoming increasingly aware of frequent fallers. They often pick the same person up nine times and on the 10th they take them to hospital with a break.*

*Ambulance service needs referral routes for those at lower risk for health and falls prevention assessments, strength and balance etc.*

### **7.2.7 Pharmacy as a route of referral**

Pharmacists are recognised as having an important role in prevention. They can review medication combinations and alert people to potential side effects of medication such as low blood pressure or balance problems. There is the potential for them to expand their health promotion role, for example by encouraging people to remain physically active, actively promoting or signposting to local physical activity sessions, groups etc.

Other specific comments included:

*More co-ordinated approach to medicines use reviews (MURs).*

*Pharmacies need information on community activities and classes to recommend when prescriptions are being issued*

### **7.2.8 Transport**

Brighton & Hove buses are considered an asset for the city but some interviewees expressed concerns about the kind of seating available whilst waiting, handrails, the speed at which the drivers accelerate/decelerate and take corners etc. There is also a need for flexible transport options and support to enable frailer people to get out and about (See The Fed's 'Out and About' project).<sup>11</sup>

*Volunteers are needed to help frail older people get out and about, for example take older people to attend falls prevention talks.*

*Transport is needed to/from exercise activity sessions.*

### **7.2.9 Trainers for exercise activity**

There is a wide range of physical activities and groups in the city for older people including dance, pilates. Tai Chi, Boccia, walking football, gardening, yoga. There is potential for those leading such sessions to be trained in specific skills relevant for falls prevention and for falls prevention components to be added to sessions, for example balance exercises as a warm up. Many of those interviewed identified this as an 'easy win'. Other specific points raised include:

*Need a 'train the trainers' programme for taking evidence based suitable exercise and activities out to care homes and possibly wider.*

*Teach staff in care homes how to teach people basic exercises and also look at what simple changes can be made when working with residents to increase their general activity levels such as encouraging walking to the dining room, 'pottering', sit to stand etc.*

### **7.2.10 Motivation and confidence building**

Interviewees recognised the importance of disseminating and embedding health promotion messages about keeping active, maintaining bone density and balance to prevent falling: 'move it or lose it'. Also considered key is supporting people to be 'confident' in their abilities, as lack of confidence may lead to increasing inactivity with the knock on effects of a further decrease in physical strength, stamina and balance. The potential for community based organisations to follow up from Physiotherapy and/or OT interventions to encourage people to continue their exercises at home was seen as an opportunity along with accompanying people to groups and activities.

<sup>11</sup><http://www.thefedonline.org.uk/services/out-and-about/accessible-city-guide>

*Confidence building is needed as ‘fear of falling’ can be a barrier to preventing people going out and taking part in activities and social events.*

*People don’t do anything until they have fallen. Reasons – pride? fear? denial?*

*People need guidance on getting up safely from a fall.*

*People need information about key signs and when to go to GP e.g. feeling dizzy so to prevent a fall.*

*People may have been through falls prevention but are still wary of falling again and need support.*

*Maximise opportunity to use volunteers to support people to do their exercise post discharge or as preventative measure.*

*Clear messages for the public are needed about keeping active to prevent balance problems and falling. Need to change public attitudes.*

*We should avoid confining people to their homes, making them ‘housebound’ for the convenience of services. This will decrease their confidence and levels of activity – with the right timely support most people CAN get out and participate in activities.*

*Checklists would be helpful for a carer to use with their client/cared-for to assess risk of falls and then refer to FPS.*

## **8. Services for falls prevention in Brighton & Hove**

### **8.1 NHS Sussex Community Trust– Osteoporosis and Falls Prevention Service (based at Brighton General Hospital)**

This service is targeted at those who have fallen, are at higher risk of falling and those with osteoporosis. It is provided by a multi-disciplinary team.

The Osteoporosis and Falls Prevention Service provides:

- Falls pathway – for patients with one or more falls in the last 12 months, consisting of multi-factorial falls risk assessments on all patients either at home or in clinic
- Rapid assessment service
- An osteoporosis /fracture liaison pathway
- Support for staff in care homes to reduce the risk of falls by providing 1:1 assessment, and also group interventions in homes with the highest number of fallers.

In addition, the OFPS offers:

- Postural Hypotension management

- Balance Blaster Classes
- Evidence based home exercise programme
- Vertigo assessment and treatment
- Diagnostic falls clinic
- Equipment provision and home safety advice
- Training of care home staff and managers

There are a range of staff are employed by the service including clinicians, falls specialist practitioners and physio and occupational therapists. The service is contracted to have just over 7,500 contacts for 2015/16.

The Local Brighton & Hove Joint Strategic Needs Assessment JSNA (2013) (12) identified various elements of the Brighton & Hove Osteoporosis and Falls Prevention Service that work well. These include:

- A focus on education about prevention in care homes, training and supporting and developing their prevention agenda
- A part time fracture liaison post strengthening the fracture liaison service
- Funding for the rapid response falls pathway
- Partnership working with the ambulance service to reduce conveyance to and hospital admissions for non-fracture related falls
- Development of a telecare project to provide a 24/7 response centre and telecare products such as falls detectors, bed/chair occupancy sensors and environmental sensors.
- Work with Albion in the Community's 'Standing Tall' programme

The service is currently under review with a Service Development Improvement Plan or SDIP in place. This includes a requirement to review recruitment to posts and an overall improvement in their key performance indicators.

## **8.2 NHS Brighton & Hove Clinical Commissioning Group (CCG)**

The CCG has a number of posts proactively working on falls prevention, including:

- Pharmacy Adviser and Public Health, Healthy Pharmacies project.
- Clinical lead for falls prevention – Practice Nurse Specialist.
- Clinical Quality Manager – visits Nursing Homes to assure standards including monitoring, training and prevention of falls.
- Joint Commissioner for Older Peoples services.
- Commissioning Manager – Secondary care falls services.
- Commissioning Manager – Integrated Primary Care Teams – supporting people with higher needs in their homes.

### 8.3 Brighton & Hove City Council (BHCC)

Services provided by the council which are relevant to falls prevention include:

- **Adaptations, assistive technologies, telecare and community equipment** - The council funds and commissions a range of housing adaptations and equipment to support people in their homes and in the community. For example; there are 5000 Telecare users.
- **Home Care and community support**– the council contracts with 12 of the city's 43 Registered Home Care Agencies to provide a range of personalised support to enable people to stay well and as independent as possible in their own homes. In 2012/2013 BHCC spent nearly £16 million in on this type of care both through Council services (Independence at Home) and 67% in contract with independent agencies. 62% of clients were aged 65+ (1248 people).
- **Care homes – both residential and nursing** – there are 110 registered care home in the city, with 1439 places occupied by people aged 65 and over, funded by the Council totaling £43m in 2012/2013. The average length of stay is 27 months. People can also 'self fund' their place. National estimates are that self-funders account for 50% of available places.
- **Community short term services**- CSTS is a short term health and social care service for people living in their own home or using care beds at Craven Vale Resource Centre, Knoll House, and Highgrove nursing home. Home care is mainly provided by the Council's Independence at Home care service. The aim is to support people discharged from hospital and prevent unnecessary admission to hospital or long stay care. It offers the opportunity for recovery and rehabilitation through a planned programme of care and treatment.

Social workers, nurses, home care support workers, physiotherapists, and occupational therapists work together and provide a programme of sessions on rehabilitation, well-being, and health promotion for those recuperating and will include advice and support around preventing falls.

- **Day centres** – The council provides and commissions day centres offering care and suitable activities for vulnerable people.
- **Older Peoples Housing**  
Specialist housing for older people is sometimes called 'sheltered housing' 'warden-assisted housing' or 'retirement housing'. There are over 90 'Seniors Housing' schemes providing homes for nearly 3000 older people in the city and council runs 23 of these. These schemes enable residents to stay in the community and maintain their independence with low level support. There are 3 'extra care' schemes which provide additional social care and are aimed at those with a higher support need.

The Council also works with private developers on design and delivery of new accessible homes, refurbishments with a view to designing in safety features that may help prevent older residents falling.

- **Contract monitoring and Health & Safety** legislative reporting requirements for all Council provided and commissioned services may include questions about the number of falls and steps taken to prevent further falls both in terms of the individual's needs and also any resultant environmental changes.
- **Services commissioned from the Community and Voluntary sector- Day Activities for Older People - 'The Locality Hubs'**

The Locality Hubs (east, west and north/central) aim to improve health and wellbeing; reduce social isolation and maintain the independence of older people. A partnership of organisations deliver a mix of services including community based interest and activity groups, befriending and outreach services and building based day services. Promoting physical activity to maintain strength and balance is an element of this work. The programme is linked together by City Wide Connect which supports and develops the locality hubs. The views of these provider organisations have been included in this needs assessment:

- East Hub: Somerset Day Centre, Lifelines (a volunteer-led project), Neighbourhood Care Scheme
- Central/North and West Hub: St Johns Centre and Café, Trust for Developing Communities (North/Central only), LGBT Switchboard, Hangleton and Knoll Project (West only)
- City Wide Connect - supports and develops the Locality Hubs, including regular Hub networking meetings.

#### **8.4 Community, voluntary and independent providers**

There are numerous groups, activities, third sector and independent services in the city that are relevant to helping people age healthily. Below is a summary of specific initiatives relevant to preventing falls.

- **Age UK Brighton & Hove**

Age UK Brighton & Hove is concerned with the welfare and needs of older people in the city. They provide information, advice, advocacy and a range of services. The most relevant for this needs assessment include: a crisis service for help with accidents and emergencies and post discharge, help at home for practical domestic services, and Horizons – whose volunteers support people to work towards goals they identify themselves. Age UK also runs a range of activities and events such as Stretch & Relax, Extend and TaiChi.

- **Albion in the Community (AitC) Standing Tall**

This service offers a structured exercise programme for people over the age of 60 years who have already fallen and are referred from the falls service. It is a 12 week course plus 'moving-on' home based exercise programme. They also signpost participants to other community based services.

There is a wide range of community and voluntary organisations offering activities for older people. Information about them is available on the following websites:

- Its Local Actually – [www.thefedonline.org.uk/local](http://www.thefedonline.org.uk/local)
- My Life - for Health & Social Care information <http://www.mylifebh.org.uk/>
- Community Works – for a list of older people’s groups  
<http://www.bhcommunityworks.org.uk/member-directory/>
- Sport and physical activity opportunities for people over 50 in Brighton & Hove;  
<http://www.brighton-hove.gov.uk/content/leisure-and-libraries/sports-and-activity/sport-physical-activity-opportunities-people-over>

## 9. Costs of falls services in Brighton & Hove

Preventing falls is a cost effective use of resources as the cost and consequences of a fall are considerable. In Brighton & Hove, the cost to the health economy of hospital admissions for falls and fractures far outstrips the amount of resources allocated to falls prevention.

### 9.1 Cost of hospital admissions in Brighton & Hove

In Brighton & Hove in 2014/15, admissions to hospital for people aged 65 or over cost a total of £3,567,364. £2,697,518 (76%) was spent on those who sustained a fracture, with most being spent on those with a hip fracture. (6)

### 9.2 Cost of current falls prevention service in Brighton & Hove

The Osteoporosis and Falls Prevention Service costs £982,630 pa, however, as outlined above, this service is targeted at those who have fallen, are at higher risk of falling or who have osteoporosis.

The Standing Tall programme, which is a follow on service from the hospital based Falls Prevention Service costs £15,000pa.

## 10. Issues related to workforce

There are gaps in the workforce and the failure to recruit to vacancies in the Brighton & Hove Falls Prevention Service has been identified as an issue in a number of the interviews. This is a particular concern regarding the prevention work previously undertaken in care homes. Staff training around falls prevention needs to be ongoing to accommodate staff changes.

Within clinical settings there is a good multi-disciplinary approach to care, rehabilitation and support, however there is a need for stronger links between clinicians and community based organisations to ensure that patients are linked in to community based activities after any clinical interventions. This would improve the sharing of information about services, activities and learning between the sectors as well as develop opportunities for cross-referral.

Pharmacists have a key role which could be developed. Currently they offer routine Medicines Use Reviews (MURs). This could be expanded to include general advice and guidance around how to keep active, particularly when people are prescribed medication which might affect balance.

There is also a need for awareness raising and dissemination of health promotion messages around falls prevention across the city and with a wide range of front line workers. It is likely that this would require a comprehensive training programme, delivered via a range of formats including workbook, e-learning, short courses.

Specific training needs identified in the interviews include:

- Training of staff in care homes to deliver exercise programmes
- Training for Adult Social Care staff on falls prevention (to be delivered by the Falls Prevention Service staff)
- Training for community based health and exercise professionals to deliver exercise programmes for older people<sup>12</sup>
- Training for generic frontline workers in early identification of balance, strength and stability issues and referral pathways

## 11. Unmet need, service gaps and over provision

The Local Brighton & Hove Joint Strategic Needs Assessment JSNA (2013) (12) identified future local priorities for osteoporosis and falls prevention. These were:

- Develop pathways and improve integrated working between the acute and community sectors
- Further build the preventative agenda in partnership with statutory, voluntary and private sector providers
- Continue to develop the urgent care pathway
- Increase early detection of osteoporosis and strengthen the fracture liaison service
- Continue to invest in telecare and other assistive technologies

Gaps identified in this 'Prevention of falls needs assessment' include:

- A need for greater awareness across the board about the importance of maintaining physical strength, stability and balance as people age
- People need to know where they can go to take part in appropriate activities
- There needs to be a wider range of strength and balance exercise classes for older people in the community aimed at the prevention of falls, which could include building strength and balance components into other physical activities e.g. dance

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<sup>12</sup>The Department of Health funded the development and pilot of a specialist exercise qualification and training for health and exercise professionals to help address this need – The Postural Stability Instructor - trained to L4 (S) NVQ. The Otago home exercise leader qualification trains people to deliver and support an evidence based home based exercise programme (36)



- A need for better identification of people at risk of falling, before they fall—currently there is no clear guidance on how to assess a person’s risk of falling and, where there is a concern, how to refer a person for assessment
- There is a need for referral pathways for individuals identified as at risk of falling to include community based activities
- There is also a gap in the provision of staff to assess people in the community who have fallen (with a fracture) and who can provide information on how to prevent a further fall
- There is limited awareness about the falls prevention services in the community and in the hospital - and a need for better co-ordination and collaboration
- There is insufficient information about and access to equipment that can help prevent a fall (for example walking frames, grab rails)

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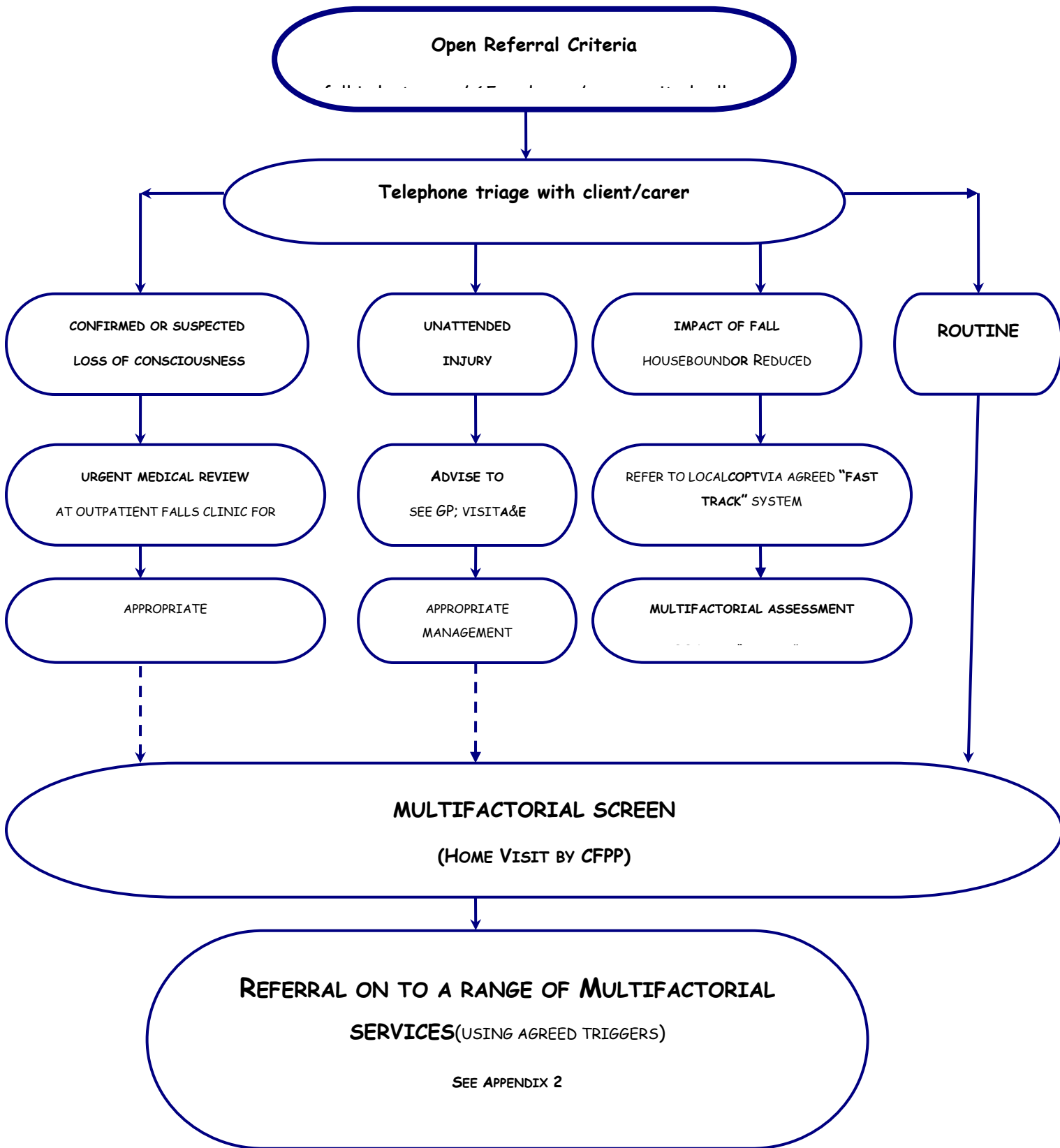
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## **Appendix 1 Greater Glasgow Falls Prevention Programme**

### **Referral pathway**



NB. Please do not refer to Community Falls Prevention Programme where client/patient is already being seen by COPT/IRIS/DART Community Rehabilitation Teams as these services also deliver multi-factorial falls assessment and interventions.

## **Multifactorial Screen (Home Visit)**

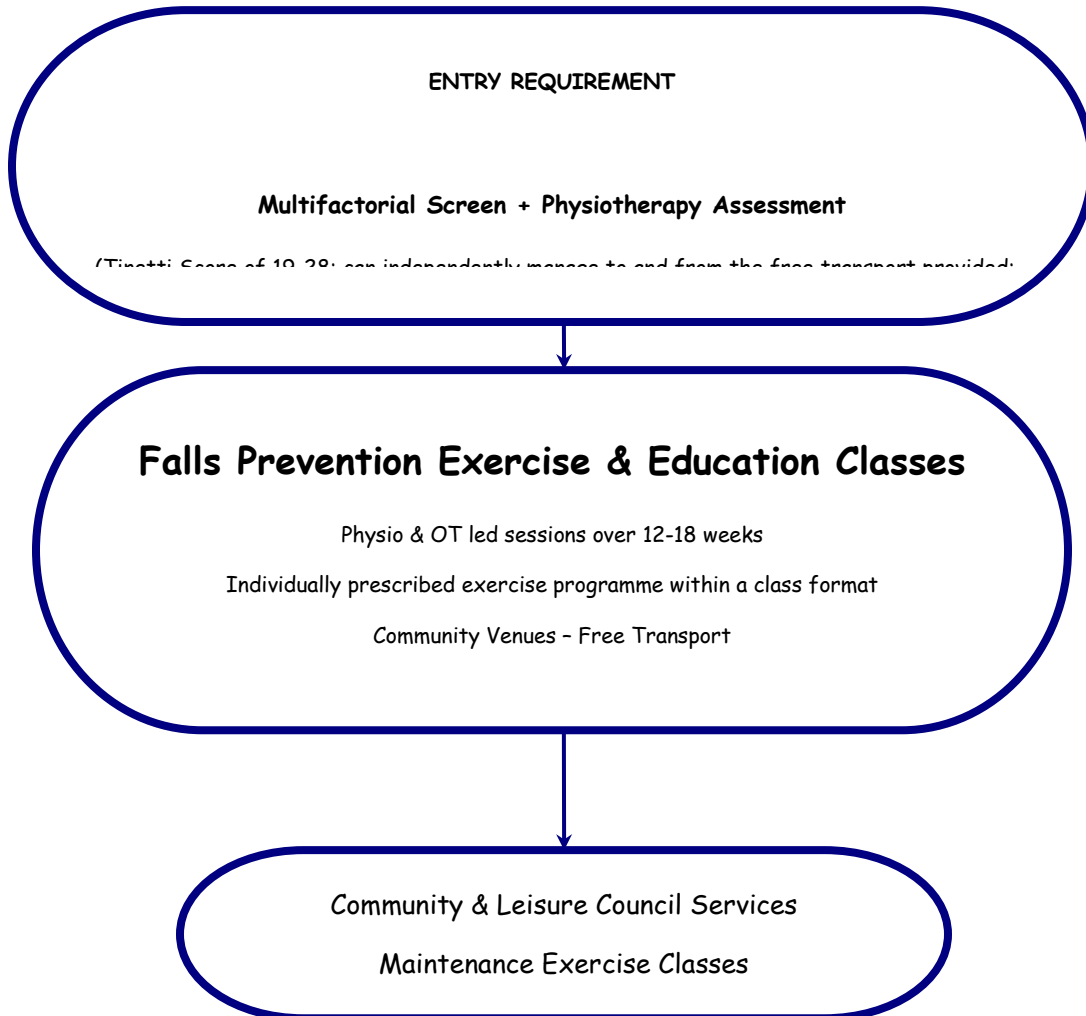
### **Series of questions and observations:-**

- Home circumstances
- Identification of Falls History
- Coping strategies and fear related to falling
- Osteoporosis risk
- Foot care/ footwear
- Continence
- Nutrition
- Visual impairment
- Hearing
- Cardiovascular symptomology/history
- Neuromuscular symptomology/history
- Medication
- Cognitive impairment (AMT)
- Mobility
- Home hazards
- Person's perceived functional ability
- Alcohol intake
- Pain

### **Interventions:-**

- Falls Prevention/Risk Reduction Advice
- Coping strategies for future falls
- Literature, issued as appropriate
- Discussion re recommended services indicated by triggers
- Action Plan agreed and documented with written consent.
- Copy left with client/carer
- Copy sent to GP, referring agent and other agreed services as per Action Plan.

## Community Exercise & Education Classes





## Appendix 2 NICE guidance on assessing risk

Recommendations from NICE are that assessment of risk should be a two stage process:

### Case risk and identification

NICE recommends that all older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall.

NICE recommends that older people reporting a fall or considered at risk of falling should have their balance and gait observed, and considered for their ability to benefit from interventions to improve strength and balance.

### Multifactorial falls risk assessment

NICE recommends that older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multifactorial intervention.

Multifactorial risk assessment may include the following:

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards
- cardiovascular examination and medication review.

### Tests used to assess risk of falling

A suggested self-assessment tool is available on the NHS Choices website for people aged 65 and over. (13a) It is based on the Falls Risk Assessment Tool (FRAT). (13b)

**NHS Choices falls risk assessment. Your risk is:**

- Low if you answer 'No' to all the questions in the test, or answer 'Yes' to only one question.
- Medium if you answer 'Yes' to two questions in the test. You are advised to discuss your risk of falls with your GP.
- High if you answer 'Yes' to three or more questions in the test. Your GP may refer you to a specialist falls clinic.

**Fall risk test**

**Have you had a fall in the last 12 months? Yes / No**

**Are you on four or more medications a day? Yes / No.**

**Do you have Parkinson's disease or have you had a stroke? Yes / No.**

**Do you feel unsteady or have problems with balance? Yes / No:**

- Can you walk while talking?
- Do you sway significantly while standing?
- Take your weight on to one leg and try to lift the other foot off the floor by about an inch. If you struggle to balance on one leg, you should answer 'Yes' to the question.

**The 'Timed Up and Go' test:** If you take more than 12 seconds to complete the Timed Up and Go test, you should answer 'Yes' to the question.

1. Stand up from the chair
2. Walk three metres at your normal pace
3. Turn
4. Walk back to the chair at your normal pace
5. Sit down again

**Do you struggle to get up from a chair? Yes / No**

**Tests used in the community.**

There are many falls assessment tests that have been developed for specific purposes and settings. Some tools exist purely as a mechanism to screen for high-risk populations, while others are used to assess the effect of an intervention.

One systematic review looked at the validity and reliability of fall-risk assessment tools for use among older adults in a variety of settings.(14) A total of 23 different tools were used in a community setting. No single tool was recommended for falls assessment. Assessment of fall risk typically involves

- A multifactorial assessment tool (MAT). This is usually a checklist of questions that covers a wide range of risk factors. It is used to screen the level and nature of risk (for example mobility, acute/chronic illnesses, sensory deficits, medication use and a history of falling). The checklist may also include physical assessments of health (e.g. blood pressure) or mobility function. Most tools are administered in person and some are conducted by telephone or a postal survey. Some take as little as one minute to complete and others can take over an hour.
- A functional mobility assessment (FMA). This typically focuses on the physiological and functional domains of postural stability including strength, balance, gait and reaction times

The most frequently used tests of balance and gait used in the community are:(1)

- Timed up and go test
- Turn 180°
- Performance - oriented assessment of mobility problems (Tinetti scale)
- Functional reach
- Dynamic gait index
- Berg balance scale

NICE guidance does not recommend any specific tool, although recognises that some appear more useful than others. (1) For example, the ‘timed up and go’ test (TUGT) – referred to in the American and British geriatric society guidelines – is frequently cited, (14a) It can be used in any setting, and does not need any special equipment. The ‘turn 180°’ can also be used in any setting. However, both tests rely on clinical judgement and may be better used by a multidisciplinary team.

### **Glasgow – case/risk identification and multifactorial falls risk assessment**

The Greater Glasgow and Clyde Community Falls Prevention Programme is the largest in the UK. (14b) It has an open referral system taking referrals (including self-referral) from anyone in the community aged 65 years and older who has had at least one fall in the past year, lives at home and has agreed to the referral.

The programme sees nearly 175 patients per month in their own home to assess risk factors and intervene on modifiable risk factors.

More information on the referral pathways used in Glasgow is shown in the Appendix1