Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 20 March 2013

Subject: Falls in Older People

Report of: Liz Bruce, Strategic Director, Adults, Health and Wellbeing and David Regan, Director of Public Halth

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Summary

Falls in Older People was identified as a priority topic in Manchester's Joint Strategic Needs Assessment (JSNA) in 2012. This report provides a summary overview of the JSNA report and sets out for the Health and Wellbeing Board an outline of the multi-agency approach which needs to be implemented in order to reduce the high levels of falls experienced by older people

Recommendations

The Board is asked to note the report and to support next steps for the programme of work set out in section 7 of the report.

Board Priority(s) Addressed:

Strategic Priority 8: "Enabling Older People To Keep Well And Live Independently In Their Community."

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Background documents (available for public inspection):

- Manchester Joint Strategic Needs Assessment 2012. Manchester City Council
- Report to the Manchester Health Scrutiny Committee – July 2012

1. Introduction

1.1 Falls amongst older people has consistently been identified by policy makers, health economists, practitioners and older people, as an issue which demands multi-agency action. Moreover it is one policy area in which there is robust and internationally acknowledged research-based evidence on which local agencies can act. This paper sets out, in summary, the key elements which need to be put in place for a strategic approach to reduce the high levels of falls in Manchester. The paper describes:

- The national and Manchester policy context.
- An outline of the epidemiology of falls in Manchester.
- The existing services in place which aim to reduce falls.
- An outline of what an effective falls service would look like.
- Next steps, including proposed work programme and timescales.

1.2 Falls amongst older people are common but should not be considered a ‘normal’ part of ageing. Some falls can be a ‘simple trip’ or accident, with an identifiable cause and no physical injury. However, falls often represent a turning point in an individual’s life, reducing confidence, increasing anxiety and leading them to rely upon others for support- even in the absence of physical injury. There may be a very negative impact on quality of life, for example, not leaving the house and social isolation. Falls and risk of falling is a major reason for older people requiring long term care, in their own homes, or a residential facility.

1.3 Falls also generate huge costs for health and social care services. Nationally, it is estimated that a reduction in the number of hip fractures by 4500 per year would result in a net saving of £34 million for the NHS alone.

2. Policy context

2.1 Although the development of a Manchester falls programme takes place in a context of changing and complex organisational relationships, the policy framework for reducing falls – much of which was developed in the 2000s - has remained constant. There is a well-established research and evidence-base for investment in activities that prevent people falling in the first place (primary prevention) and preventing those who have already fallen, from falling again (secondary prevention). Action to reduce falls was set out, for example in:

- The National Service Framework for Older People (2001)
- NICE guidance (2004)
- NHS Older People’s Prevention package (2009)
- World Health Organisation guidance (2007)

2.2 In Manchester, local policy work to reduce falls has been reflected in a number of plans such as the Manchester Ageing Strategy (2009), joint Council/ Primary Care Trust (PCT) plans and, most importantly, in the Integrated Care blueprint for Manchester that will also be considered by the Board today. Despite some progress since 2001, we have known for some time that

Manchester still performs poorly in respect of a number of outcomes associated with falls in older people.

2.3 For this reason, falls were identified by the Joint Strategic Needs Assessment (JSNA) Steering Group and partners, as a priority worthy of further investigation and work in the 2012. The JSNA (2012) made a number of recommendations, namely:

- To prioritise falls in older people as a programme of work for the NHS (Clinical Commissioning Groups, University Hospital South Manchester, Central Manchester Foundation Trust, Pennine Acute Hospital Trust, North West Ambulance Service and Manchester Mental Health and Social Care Trust) and Manchester City Council.
- To develop and implement an overarching Falls Strategy for Manchester.
- This strategy would be informed by a programme of work including:
    - To carry out a detailed epidemiological study of falls in older people in Manchester.
    - To conduct detailed mapping *and* reviews of all falls related services delivered in community, primary, secondary, tertiary and social care settings, and to include the voluntary and third sector organisations, across Manchester.
- To coordinate the work of clinicians, agencies and academics to develop a systematic, integrated, multi-agency and multi-functional approach to falls interventions Manchester, based upon known evidence and best practice.
- To ensure that all appropriate staff be given responsibility to falls risk assess in routine care. Such a measure will need to be supported by appropriate training to ensure common standards *across* the city.

3. Epidemiology of Falls in Manchester

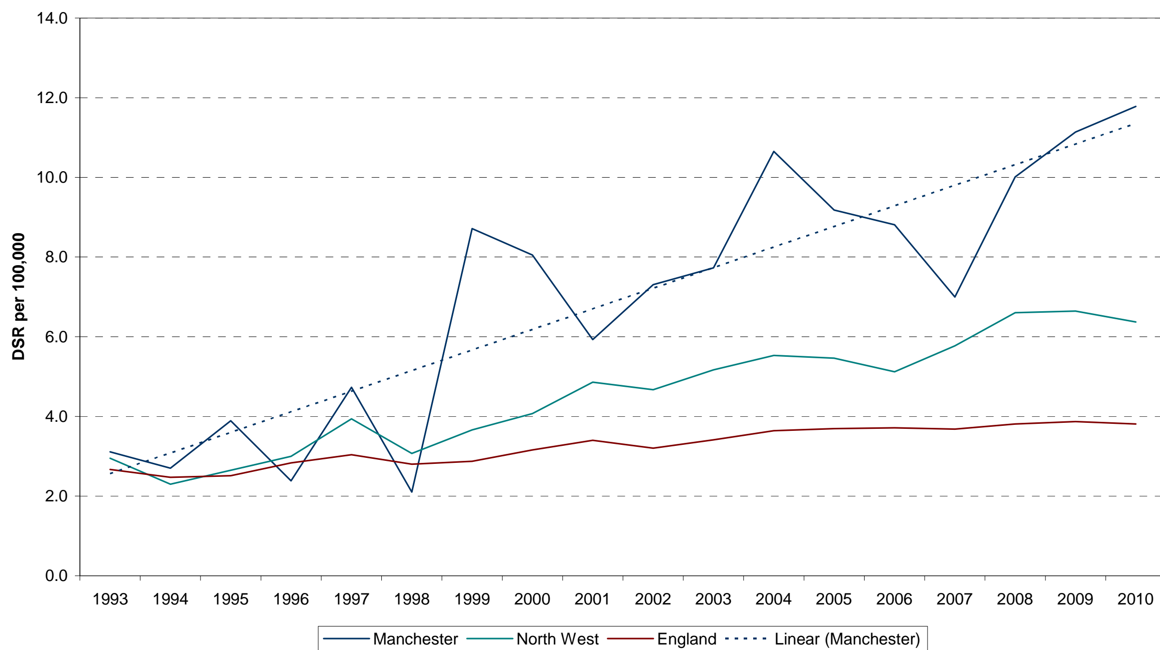
3.1 Falls are a major cause of injury, disability and the leading cause of mortality resulting from injury for people aged 75 and over. The available data suggests that older people in Manchester are particularly vulnerable to injuries suffered as a result of an accidental fall. It is hard to quantify the numbers of older people who do have a fall, as many are unreported and those who do report to (various) services will be coded according to the ensuing injury e.g. a fracture, or other physical illness e.g. urinary tract infection.

3.2 In the three year period 2008-10, there were 192 deaths from unintentional (accidental) falls to Manchester residents – an age standardised rate 11.0 per 100,000 population. This compares with the England average of 3.8 per 100,000.

3.3 Compared with England as a whole, Manchester has a significantly worse rate of hospital admissions (and emergency hospital admissions) due to an unintentional fall in older people aged 65 and over. In 2010/11, there were 2,313 hospital admissions resulting from an accidental fall among older people aged 65 and over in Manchester - a rate of 3,457 per 100,000 population

compared with the England average of 2,475. Over 60% of older people admitted to hospital as a result of an accidental fall arrive at hospital via A&E and are admitted as an emergency. Falls in older people therefore make a major contribution to the above average rates of non-elective (i.e. emergency) admissions, non-elective bed days and A&E (type 1) attendances/ 4 hour performance in people aged 65 and over in Manchester.

Figure 1: Deaths from Accidental Falls in 1993-2010 (All Ages) Directly Standardised Rate (DSR) per 100,000 Manchester, North West and England



3.4 Analysis also suggests that in Manchester, around 37% of older people are admitted to hospital as a result of a non emergency fall, compared with just 20% in England as a whole, possibly implying that in Manchester, older people are admitted to hospital when they may not have been in other parts of the country. If Manchester reduced non-emergency admissions to national averages in percentage terms, we could potentially save some 492 admissions per year. We need to better understand this data and the situation it represents to understand why our non-emergency admission rates are so high. There may be potential for cost savings by making policy and service changes and reinvestment in other more appropriate falls services.

3.5 Falls can result in a physical injury which can be minor, or more serious, for example a fractured neck of femur (hip). Approximately 10% of people who fracture their neck of femur will die within one month of suffering the injury, approximately 20% of injured people will have died four months later and after one year of a neck of femur fracture, 30% will have died. Furthermore, up to 20% will need long term care post fracture and 30% will not return to their pre-fracture level of function.

3.6 In a small number of cases, an unintentional (accidental) fall will directly lead to the death of an individual. The latest data suggests that there are around 65 deaths a year from falls in Manchester, the majority of which are in older people. The mortality rate from falls in people aged under 35 is less than 5 per 100,000 compared with a rate of 194 per 100,000 in people aged 75 and over. Overall, the mortality rate from falls in Manchester is around three times higher than that for England as a whole.

3.7 While there is very little routinely available data with respect to inequalities in falls related injuries and mortality within Manchester, it is very likely that the impact of falls is felt more by some groups of older people than others. Anecdotally, it is believed that people in more deprived wards of the city are more affected by some of the factors that can contribute to falls, such as housing and its state of repair and other environmental issues.

3.8 Further detailed information on falls among older people in Manchester is available in the JSNA.

4. Risk Factors for Falls

4.1 Research has identified over 200 risk factors for falls. An episode of a fall in an older person can be due to a unique combination of one or several risk factors combining at that particular point in time. There are a range of what are called, ‘Intrinsic risk factors’, which refer to features of a person’s health and which include, low blood pressure, heart arrhythmias, previous stroke, Parkinson’s Disease, diabetes, poor eyesight. These risks often interact with environmental, or what are known as, ‘Extrinsic risk factors’, which include: medication (polypharmacy causing drug interactions, poor compliance or side effects), poor fitting footwear (sloppy slippers), home hazards (rugs, loose wires, poor lighting) uneven paving stones.

4.2 It is important to remember that falls can be are a marker of frailty in older people. A fall is not a diagnosis in itself, but a symptom, or marker, of an underlying problem. Falls are often labelled ‘mechanical fall’ and this in itself indicates a failure to look at potential risk factors.

4.3 Effective falls prevention approaches look for as many risk factors as possible, with a focus on those where there are evidence-based interventions available. There are a number of different risk assessment tools available for use in different settings. However, clinical judgement and common sense can also be effective in reducing the risk of falls for an individual.

4.4 Some falls can be prevented, but in many cases it would be more accurate to view this as risk reduction. There is too, a balance to be had between absolute falls prevention and allowing autonomy and choice of lifestyle.

5. Overview of Existing Services

5.1 The National Service Framework for Older People, 2001 was the catalyst for a focus on older people who were falling and falls services across Manchester. There are a number of enthusiasts who helped set up new services, for example consultant-led falls clinics in each acute trust and community falls services. The funding for these was often derived from individual business cases, or opportunistically from discrete funding streams.

5.2 Whilst there are a number of examples of good practice across the city, they have not necessarily been developed in a joined up “whole-system” approach. There is evidence of inequity across Manchester in terms of services available, with the result that it can be confusing for professionals to know which service to refer to, and for older people, which services they can access.

5.3 Since 2001 the acute trusts have developed their falls services and in recent years, targets set nationally for acute trusts, around for example, fractured neck of femur treatment, have also driven some improvement in performance and outcomes.

5.4 The Council has also developed services which address the primary prevention of falls and services including, Community Alarm. The Council has also funded services, aimed at reducing the risk of falls, which are delivered by partners, such as ‘Handy Person’ service and exercise classes delivered by the Public Health Development Service

6. What would a good falls service look like in Manchester?

6.1 Although a mapping exercise is the essential first step of any service review, it is important to describe what a “good” falls service would look like in Manchester. This provides the basis upon which to produce and implement a comprehensive falls strategy. By making use of the significant advice available via academic research, (both national and international) and NICE guidance the following features of a ‘good service’ are outlined below.

6.2 Research shows that falls can be reduced by 20-30% through multi-factorial assessments and interventions. The aim of these assessments and interventions is to identify and treat the underlying reasons for falls, such as muscle weakness, cardiovascular problems, dementia, delirium and medication.

6.3 A good falls service will:

- Be led by people who are **adaptable** and committed to deliver improvements in ways that suit their clients (customers, patients) and their teams. It will ensure that wherever a person who has fallen (or is at risk of doing so) comes into contact with a health or care service, the response will be consistent, evidence-based and effective.
- Create a **community** led by people with high levels of professional competence in falls assessment and prevention, where ideas and experience is shared within and across organisations, with the common aim of improving outcomes.

- Ensure that everyone who would benefit from a falls risk assessment gets one at the right time, in the right place and receives the right treatment as a result.
- Have service users, older people and carers at the heart of the development of preventative programmes of education advice and support.

7. Next Steps for Manchester

7.1 In summary, not only have services in NHS primary, secondary, tertiary and community settings developed in a somewhat piecemeal fashion, but the linkages between the council, NHS services and partners, are not as well understood as they might be. With the development of the city's blueprint for Integrated Care, now is overwhelmingly, the right time to address and correct these issues.

7.2 The transfer of funding for community based falls services from the Primary Care Trust to the City Council on 1st April 2013, as part of the Public Health transition, and a commitment to review all public health programmes gives further impetus to develop thinking and strategy about how to improve, develop and commission better falls services for the city.

7.3 Indeed, work is now well underway, benefiting from the clinical guidance of Dr Helen Hosker and a small team of staff from Adults, Health and Wellbeing, (including Public Health Manchester) to complete the detailed mapping *and* review of all falls-related services as recommended in the JSNA.

7.4 The current cost of falls to the health and social care economy in Manchester still needs to be fully quantified. This must include costs incurred by hospital activity (in patient, out patient and A&E attendances), community services, North West Ambulance Service and the Mental Health and Social Care Trust and the costs to Manchester City Council, (such as the Community Alarm service, home care, residential and nursing care). This will be an integral part of the economic modelling work and will be informed by the community budget investment and delivery model approach.

7.5 The mapping exercise will also identify the pathways and links between all health and social care services and will take account of the Council's work on 'One Customer Journey' and the introduction of the NHS 111 service. It will have a greater focus on patient experience and involve groups such as the Valuing Older People (VOP) Partnership Board in the development and design of services.

7.6 Furthermore, the programme will utilise the academic expertise of Professor Chris Todd of the University of Manchester. Professor Todd is an expert in falls and falls services providing advice to the World Health Organisation and has given his commitment to support the work in Manchester.

7.7 Finally, it is envisaged that the mapping exercise and falls strategy will be completed in 2013/14 and the service redesign work will take place in

2014/15. The strategy will spell out clearly how Manchester will achieve a good falls service as described in section six of this report by 2015.

8. Summary and Conclusions

8.1 An integrated approach to falls prevention is required. The causes of falls are complex and multiple, interventions for reducing falls cannot be "simple fixes", but instead need to have multiple elements. Falls prevention will be effective when all partners commit to improvements and transformation of services within their own setting.

8.2 A measurable impact on falls prevention in Manchester will be achieved by a consistent approach by all partners; leading to the development and implementation of a citywide falls prevention strategy that is informed by a strong evidence base. It is recommended that all partner organisations review their response to older people and those at risk of falls and to identify where improvements may be made in terms of identification of those at highest risk, multi-factorial risk assessment and interventions