Manchester Health and Wellbeing Board
Report for Resolution

Report to Health and Wellbeing Board – 2 July 2014

Subject: Falls Prevention in Older People

Report of David Regan, Director of Public Health Manchester

Summary

Reducing falls in older people was identified as a priority topic for Manchester's Joint Strategic Needs Assessment in 2012. The assessment told us that falls amongst the older residents of Manchester, was a significant challenge for the city and one partners needed to address with some urgency.

In March 2013, the Health and Wellbeing Board supported a programme of work designed to address the recommendations of the Joint Strategic Needs Assessment.

This report provides an update of the work that we have being doing since March 2013, both in terms of progress against what we set out to do, new and developing areas of work, and proposed work for the coming year.

Recommendations

The Health and Well Being Board is asked to support the approach taken in this paper. Specifically, it is asked to champion action in their respective organisations during the next twelve months, in line with the proposals in section six.

Board Priority(s) Addressed

This report addresses 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.
World Health Organization Global Report on Falls Prevention in Older Age (2007)
NICE guidelines 21; November 2004, June 2013
National Service Framework for Older People, 2001 – Standard six
Clinical Practice Guideline for prevention of falls in older people (2010).

Appendices:

Appendix 1: NICE Clinical Guideline 161 – Falls: Assessment and Prevention

1. Introduction

1.1 Falls amongst older people continues to be a significant issue for the city. As this report describes, the levels of falls – reflecting broader levels of ill-health amongst older people in Manchester – are higher than the national average. Changing this position involves building a long-term, multi-agency and multi-faceted strategy.

1.2 This report, in sections two and three contain descriptions and definitions of falls, and as far as can be judged with the data available to us, the extent of the incidence of falls in Manchester. Section four is a summary of progress made in 2013/4 against the following key objectives: a review of falls prevention services; improving data collection and sharing of information; falls prevention, physical activity and behaviour change; and, links to social care services.

1.3 Section Five places the falls prevention strategy in the broader strategic and policy context: the links and with the Living Longer, Living Better programme of health and social care integration and the Age-friendly Manchester programme, which supports social and environmental improvements are described. Additional Strategic and Partnership Working opportunities that support the strategy are also considered. The Next Steps section sets out four key areas in which city partners plan to make progress over the next twelve months.

Joint Strategic Needs Assessment (2012) recommendations

●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 identify a designated strategic falls lead for Manchester.

●To develop and implement an overarching Falls Strategy for Manchester.

●This strategy would be informed by a programme of work including:
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 carry out a detailed epidemiological study of falls in older people in 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.

2 Falls: an overview

2.1 Falls are commonly defined as “inadvertently coming to rest on the ground, floor or other lower level, (excluding intentional change in position to rest in furniture, wall or other objects). Falls should not be considered a ‘normal’ or inevitable part of ageing however. Some falls can be a ‘simple trip’ or accident, with an identifiable cause and no physical injury. But it must be recognised that “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 the risk of falling is a major reason for older people requiring long term care either in their own homes or a residential facility

2.3 The World Health Organization (WHO) states that approximately 28-35% of people 65 and over fall each year. This figure increases to 32-42% for those aged over 70 years of age. Approximately 30-50% of people living in residential care fall each year and 40% of that group experience recurrent falls. Furthermore, WHO states that more than 50% of injury related hospital admissions amongst people aged 65 and over are caused by falls. The major underlying causes for fall related hospital admissions are hip fracture, traumatic brain injuries and upper limb injuries.

2.4 The prevention of falls amongst our older population is also major issue for Manchester. The city rates poorly against national averages in terms of falls, injurious falls, mortality related to falls and subsequent costs to the Manchester health and social care economy.

3 Falls Epidemiology – the extent of the Manchester challenge

3.1 As we will discuss below, obtaining up-to-date and accurate epidemiological data is an on-going challenge, not just confined to Manchester. However, the available data suggests that older people in Manchester are particularly vulnerable to injuries suffered as a result of an accidental fall: it may be that more people fall in Manchester than would be expected, but also, it is possible that underlying health status, for example, bone health, could contribute to falls being more injurious than they might otherwise be. 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 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. *(Source: North West Utilisation Management Unit).*

3.3 Indeed, 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 avoid 492 admissions per year. There is a need to better understand this data and the situation it represents to understand why 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.

3.4 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. (*Source: NHS Institute for Innovation and Improvement.)*

3.5 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. 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. *Source: Injury Profiles for local authorities (see www.injuryprofiles.org.uk).*

3.6 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. There is some evidence 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 social and environmental issues.

4. Summary of Progress: 2013 – 2014

4.1 Good progress across the programme has been made since March 2013. In summary these are:

- All “falls” contracts transferred from the former Primary Care Trust to Manchester City Council have been reviewed and signed off as “interim” and subject to further review.

- All falls services provided by Central Manchester Foundation Trust (CMFT) and Pennine Acute Trust (PAT), including University Hospital South Manchester (UHSM) in acute and community settings have been “desktop” reviewed in detail.

- A Falls Data Workshop was held at Manchester University.

- A new falls prevention exercise project has been established as part of the Council’s Behaviour Change programme.

- The process of integration of public health functions into the council has improved links with social care to improve links between prevention, medical treatment and social care support.

- Links with academics at local universities, giving the programme the benefit of world class expertise *and* help academics to show the impact of their work – for the benefit of Manchester residents.

- The programme has gained momentum linking to projects such as the NWAS Pathfinder Project and GM sector-led peer reviews, amongst others.

- The Director of Public Health took ownership of the Falls Programme and established a multi-agency task group including representatives from the Council, CCGs, acute trusts, and the Valuing Older People Board.

Each of the areas above is explored in more depth below.

4.2 Service Reviews

4.2.1 Community falls services exist in north, central and south Manchester. They, were developed independently by the former Manchester Primary Care Trusts and later transferred to Manchester Community Health and subsequently transferred to the three acute trust providers. The services are provided by Pennine Acute Trust and Central Manchester Foundation Trust In April 2013, Public Health Manchester, for Manchester City Council, became the commissioner of the Pennine Acute Trust and Central Manchester Foundation Trust contracts to the value of £700,503. One of our primary objectives since then has been to review these services. We need to fully understand the complex historic commissioning arrangements which exist across the city and to fully understand whether or not this has lead to inequity of provision and access to falls services. This work is currently in progress. The service provided by Manchester Mental Health and Social Care Trust is a series of 18 weekly exercise classes for older people, the “Get Active Through Exercise” programme. The latter has been commissioned by the Council since 2002.

4.2.2 To gain a further understanding of the services, a detailed questionnaire was sent to providers in the summer of 2013. These responses have been analysed and the intention is to visit each service to understand the services in more detail. Each acute trust was also asked to complete the questionnaire for the outpatient-based hospital falls clinics to complete the picture of falls service provision in Manchester. The responses revealed that there is differing service provision in each of the three Clinical Commissioning Group (CCG) areas, reflecting the historical development of services. The review’s key findings were:

Table 1: Service review key findings

- Provision of service is not equitable across the city
- The services have differing referral criteria on the basis of age and use of screening tools.
- Variation in the clinical background of the staff and this is reflected in the assessments, interventions and referrals.
- Variation of staffing numbers and capacity between services.
- For Pennine Acute Hospital Trust (PAHT) and Central Manchester Foundation Trust (CMFT), 40-44% of staff are Rehabilitation Assistants or Assistant Practitioners.
- Waiting times to a first appointment are variable up to 16 weeks.
- Not all patients have an assessment of their gait and balance.
- Variability in assessments undertaken.
- Variability of bone health and osteoporosis assessment.
- All services say they carry out medication reviews, but only University Hospital South Manchester has a Pharmacist attached to the service.
- No service is fully compliant with the recommendations in NICE Clinical Guideline 161 (June 2013), see Appendix 1.
- The number of appointments/contacts are given and vary between services. More information is required to understand what activity takes place in each contact.
- The provision of “Strength and Balance” training is variable and capacity is very limited.
- There is more provision for OTAGO home exercise programmes, but still very limited. (NB. The Otago programme is an evidence based exercise programme which has been shown to be effective in reducing falls and preventing deaths from falls (Davis et al, 2009; Sherrington et al, 2008; Robertson et al, 2001).
- None of the services accepts referrals from North West Ambulance Service (NWAS).
- Only PAHT stated that they have a written “falls pathway”.
- PAHT and CMFT have patient/services user feedback available from within the last 12 months.

4.2.3 Broadly speaking, these findings suggest that work is needed in the following areas:

- Contractual arrangements for the provision of services may need to be amended to ensure that we have similar contracts in north, central and south Manchester.

- A need to ensure that all the community falls services we commission are delivered in line with NICE guidance (see appendix 1).

- A need to agree minimum expected outcomes for services in north, central and south, so that whilst allowing providers to develop services to meet the needs of their local population, we can ensure that residents can expect to receive equally good services whichever part of the city they live in.

4.3 Data Collection and Sharing of Information

4.3.2 As discussed in earlier sections, gathering the information and data that we need in respect of numbers and types of falls in Manchester, as well as who falls, how, when and where, is very challenging. This relates to how falls are coded by services, the number of hospitals in Manchester and that some services, e.g. North West Ambulance Service (NWAS), work to a regional footprint. These problems are not therefore unique to Manchester and some are reflected nationally, regionally and also on the Greater Manchester footprint too. The fact that Public Health England and the Greater Manchester Public Health Network are now also examining these issues is testament to the extent of the problem.

4.3.3 However, accurate and detailed information is needed in order to plan services that meet the needs of local people, specifically:

- The numbers of older people in Manchester who are at risk of falls.
- Services to which, ”fallers” present.
- The causes of falls amongst our population.
- Types and numbers of injuries sustained.
- Demand on services and service outcomes.

4.3.4 In order to improve the city’s intelligence and data collection, a multidisciplinary workshop hosted by Manchester University and attended by:

- Public Health Manchester and Community Alarms Service, Manchester City Council.
- Primary Care Providers.
- North West Ambulance Service.
- Trauma and Injury Group, Liverpool John Mores University.
- Greater Manchester Commissioning Support Unit.
- University of Manchester, School of Nursing, Midwifery and Social Work – ProFouND Network – Professor Chris Todd.

The workshop partners agreed to collaborate on data collection to support the a range of interventions, including:

- Programmes for the ‘baby boomer’ generation to encourage exercise as a normal behaviour.
- Opportunities for services to be more joined up, which are currently missed, for example between NWAS, community alarms and first response services.
- Explore the potential for services in the community which are able to assess and investigate older people who have fallen to avoid hospital attendances and admissions.
- Invest in strength and balance exercise training which is delivered with the right frequency, intensity and duration.
- Opportunities for falls prevention will be greater in some groups than others, particularly those who sustain no injury or a minor injury.
- Look further at the ‘hot spots’ of activity for opportunities to reduce the number of falls and consequences of the falls.

- Opportunities to develop falls prevention programmes in high risk populations, e.g. disadvantages, and, minority ethnic groups.
- Community programmes including the use social marketing and other techniques

4.4 Falls Prevention, Physical Activity and Behaviour Change

4.4.1 The Get Active Through Exercise (GATE has been funded by the Council since 2002/3, via the former Joint Health Unit). The service now consists of 18 classes which are held in community settings and are to a degree, self organising. The classes were originally commissioned as a Falls Prevention service, because the council and NHS partners have long recognised the link between physical activity and the reduction in risk of falls by increasing strength, balance, flexibility, bone strength and confidence to move safely.

4.4.2 In recent years, these links have been the subject of international research and the evidence base for the importance of exercise generally, and strength and balance training specifically, as a way to reduce the risk of falls is now overwhelming. The World Health Organization states that:

"Promoting appropriate physical activities or exercises to improve strength, balance and flexibility is one of the most feasible and cost effective strategies to prevent falls among older adults in the community"

Therefore, a key component of the Manchester Falls Strategy, going forward, will be around falls prevention classes (i.e. Strength and Balance training) and physical activity, with the aim of increasing the numbers of older people who can access good exercise instruction and opportunities *and* to increase the numbers of older residents who take regular and appropriate exercise, with a view to being well, independent and reducing the risk of falls in later life.

4.4.3 A review of GATE service in year in order to benchmark classes against latest methodologies. Commissioning a modern, fit-for-purpose exercise service, designed to reduce the risk of falls for participants, is however only a part of the story. An equally big challenge, is encouraging older residents to take part in exercise and crucially, to adhere to a programme for a period of time (weeks/months) and frequency, which will result in the desired physical benefits. We know that the people of Manchester are more inactive than national averages, and this includes older adults.

4.4.4 In the last year working with leading researchers in this field we have been examining more closely, the effectiveness of falls prevention exercise models and methodology. Drawing on international research, we know that to be effective, falls prevention classes have to be delivered in the right way, by a suitably qualified instructor, to the right client group, in the right setting and in a supportive, welcoming and enjoyable manner- in order for participants to feel confident enough to exercise and for them to adhere to a programme long enough to benefit from it.

4.4.5 As part of the Council's **"**behaviour change**"** programme we have been testing research-led approaches in a pilot project at an Eastlands Sheltered Housing unit in Clayton. The class has been a success and now has a regular and constant group of

participants who are progressing very well in terms of confidence and ability. These are people who had not exercised in this way previously and all say they feel better for doing so. The experience of this pilot will inform decisions, along with other evidence, how we will deliver falls prevention classes and exercise for older people and a number of options are being explored at this time and decisions should be taken in year.

4.5 One of the benefits of public health integration into local authorities is improved collaboration with social care, and other local authority services. Our strategy favours a shift to much better prevention of falls through improved preventative services, behaviour change initiatives and environmental and social improvements. However, good medical treatment is essential as is the right package of follow up support in social care terms. Manchester Equipment and Adaptations Partnership (MEAP) is an example of how the correct type of follow up support can help an older and/or disabled people back to independence through the provision of timely equipment, minor adaptations or major adaptations. As well as minimising the complications which can occur if a late or poor response to a fall is experienced, provision of the right equipment, for example, can really help to prevent a further (perhaps more serious) fall.

5 Strategic links and partnership building

5.1 The aims of Living Longer Living Better to ensure that local people receive high quality personalised and integrated services which support them to manage their own health and well-being, and live long, healthy lives are very relevant to older people who have had a fall. “Frail older people and Dementia” is one of the first phases of population groups to be considered as part of the Living Longer Living Better programme for integration. New Delivery Models (NDM) have been developed by each locality and whilst there is reference to falls, this is not covered in any detail.

5.2 The pathways for older people who have a fall are complex and can involve a number of health and local authority services. Many older people could be better managed outside of a hospital setting if there were services in place, and there are many opportunities currently not realised to deliver joined up care with better outcomes. Encouraging older people to be more active and manage their own health and well being will reduce their risk of falling. This has been alluded to in other parts of this report. It is hoped that LLLB will be part of making this happen.

5.3 The models developed for Living Longer Living Better are based on generic teams in each locality, with input of specialist teams. There are many staff currently working in generic teams who have regular contact with older people who have had a fall, or falls. Their role needs to continue to ensure there is capacity in the system for the number of older people who are falling and to reduce duplication of services and professionals involved. They are a ‘virtual’ part of the falls services and falls prevention should be seen as part of core business’.

5.4 Generic teams do need to be supported by specialist teams in the community and hospital. It is important to have clarity however, as to who should be seen within each service, to ensure that those with the most complex problems who need to be seen by the specialist tier of services can be seen in a timely manner and the

services are not seeing those who can be safely managed by other tiers of the service.

5.5 Multifactorial risk assessments and the interventions require significant time and can be resource intensive. This needs to be recognised if generic teams are to be required to take on this role and make fall prevention part of their core offer. The scope of the risk multifactorial risk assessment is such that it requires the skills of a range of different disciplines, including physiotherapy, occupational therapy, pharmacy and nursing. This multifactorial risk assessment is best delivered by a multi disciplinary team. Medical input by doctors is also required. This can be from the patient's GP or more specialised, such as a Care of the Elderly Consultant and Cardiologist with an interest in Syncope, for those who have more complex needs. Other specialists should continue to support those with conditions which put them at high risk of falls, such as Parkinson 's disease.

5.6 It is important that New Delivery Models for falls are developed in line with current guidelines and evidence base. Research has shown that older people do not respond to messages which are on the theme of preventing falls. More positive messages, such as "staying active and healthy" are more likely to be received and the intended outcomes realised. 'Don't mention the 'F' word' research was led by Professor Chris Todd at the University of Manchester

5.7 The Age-friendly Manchester (AFM) programme can make an important contribution to reducing falls amongst older people. The AFM Development Plan 2014-16, sets out actions against four themes: Age-friendly neighbourhoods; Age-friendly Services; Knowledge and Innovation; and, Communication and Information. Table 2 below illustrates how these themes contribute.

Table 2: Reducing demand on high-cost services through age-friendly city projects

Age-friendly neighbourhoods:

- Support to community groups that promote active ageing.
- Development of new community projects that promote social participation.
- Coordination of healthy ageing activities through Age-friendly networks.
- Promotion of information about services.

Age-friendly Services:

- Forthcoming Housing for an Age-friendly City will contain measures to reduce falls in the home and neighbourhood.
- Cultural offer for older people promotes social participation.
- Training of front-line staff in ageing studies course.
- Linking falls agenda to wider determinants of health, including Food and Nutrition working group.

Knowledge and Innovation:

- Strategic research agenda that includes investment in falls-related research.
- Practical action-research partnerships that promote active ageing.
- Publication of research findings for commissioners and policy-makers.

Communication and Information:

- AFM information project is investigating how best to promote key messages to local communities.

5.8 An additional success of the last year has been the extent to which partnerships have been built between organisations that have an interest in the prevention or response to falls in older people (supplementary to day-to-day work with Acute Trusts and CCGs). The scale of the problem, resulting demand and costs placed on systems may well be one of the drivers for the high level of concern both nationally and locally about falls and their impact.

6 Next Steps

6.1 The Health and Well Being Board is asked to support the approach taken in this paper. Specifically, it is asked to champion action to be taken under the following five headings in their organisations during the next twelve months. As indicated above, good progress has been made since April 2013 in a number of areas, laying the basis for service improvements and action that can be taken in local communities. However, the partners are acutely aware that we need to translate this programme – sooner, rather than later - into reductions in the numbers of falls occurring in the city. We therefore have set out where further work needs to be concluded by March 2015.

Service Reviews and Commissioning

- Reviews of all falls related services commissioned by the Council will be concluded. The reviews will inform an "options appraisal" paper, outlining how improvements can be made and more equitable services achieved. Decisions will be made about proposed changes to services by 31 March 2015. We will subsequently aim to carry out any renegotiation of contracts, changes to Service Level Agreements, or new commissioning, between April 2015 and March 2016.

Improving data and intelligence

- Work will continue to secure accurate and up-to-date data about falls in Manchester. In the interim, decisions will be taken about what we can reliably use as proxy measures. The latter will be agreed by September 2014.

Strategic Integration

- Continue to integrate falls-related initiatives by public health, social care, NHS and other agencies through the Living Longer, Living Better programme delivery models.

- Further development of age-friendly city programmes that promote active ageing, high-quality housing and built environments, and food and nutrition, reducing demand on high-cost services. These are initiatives in which older people can take further responsibility of local projects.

Partnership building

- Continue to explore opportunities to do so by working corporately, with partners in the GM Behaviour Change Commission and also by taking learning from NICE, Public Health England and the World Health Organization.

Appendix 1: NICE Clinical Guideline 161 – Falls: Assessment and Prevention

Who is the guideline for?
Older people who present for medical attention because of a fall
Report recurrent falls in the past year
Demonstrate abnormalities of gait and/or balance

Multi-factorial falls 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

Interventions
Older people with recurrent falls or assessed as being at increased risk of falling
Common components, in addition to general diagnosis and management of causes and recognised risk factors:

- Strength and balance training
    - Older people living in community, with history of recurrent falls, balance and gait deficit
- Home hazard assessment and intervention
    - Part of discharge planning
    - In conjunction with follow up and not in isolation
- Vision assessment and referral
- Medication review with modification/withdrawal
- (Cardiac pacing for cardioinhibitory carotid sinus hypersensitivity who have unexplained falls)

Following injurious fall:
Multidisciplinary assessment to identify and address future risk
Individualised intervention aimed at

- promoting independence
- Improving physical and psychological function