Hampshire

Draft Integrated Falls Prevention Strategy

2012 -2015
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1 Executive summary

This commissioning strategy provides a framework to reduce the substantial and growing impact of falls on individuals, families, communities and subsequently on services in Hampshire. It aims to improve bone health, prevent new and recurrent falls and improve treatment outcomes when someone has fallen.

Falls and subsequent fractures are a major cause of morbidity, misery and possible mortality. Both falls and fractures can be prevented by identifying risks and implementing risk reduction programmes.

There is already much good practice in Hampshire, and many people are working hard to prevent falls and improve the outcomes for people who fall. However, there is still need for a more joint and systematic approach to ensure that effective action is taken, both within the wider community and amongst those at higher risk from falls and their consequences. This involves working with individuals and their families to maintain their independence within their own homes; with people in residential and care homes who may be more at risk if they are more physical frail or suffering from dementia, as well as those who are hospitalised due to their fall.

The National Service Framework for Older People (March 2001), and subsequent national and local policies have identified the need for the NHS to work in partnership with local authorities, and other agencies to take action to prevent falls and reduce resulting fractures and other injuries in their population of older people.

The key strategic objectives are to:

1. Prevent frailty, preserve bone health, and reduce accidents through preserving physical activity, healthy lifestyles and reducing environmental hazards
2. Offer early intervention to restore independence amongst those at risk of falls
3. Respond to first fractures in order to prevent further fractures
4. Improve the outcome and improve the efficiency of care after hip fractures

The intention is to ensure that jointly commissioned services are outcome focused, based on prevention and early intervention, improve the quality of people’s experience and consider a range of options for service delivery.
2 Why are falls a problem?

_The definition of a fall is: “An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness.”_ (NICE 2004a)

The risk of falling increases as people get older and falls represent the most frequent type of serious injury in people aged over 65. By 2018, it is estimated that over 25% of the population will be aged 60 plus.

Falls can result in bone fractures, most commonly of the hip. Hip fractures in turn can result in blood clots in the leg, infection and other medical complications. Fractures following falls are a major threat to mobility and independent living, with approximately 50% of hip fracture patients losing their ability to live independently. Up to 14,000 people a year die in the UK as a result of an osteoporotic hip fracture.

The combined cost of social and health care for fragility fractures is over around £2billion annually... Of this 45% can be attributed to acute health care, 50% to social care and long term hospitalisation and 5% for drugs and follow up.

Most falls do not result in serious injury but they can destroy confidence, leading to increased social isolation, deterioration in mental health and erosion of independence. The after-effects of even a minor fall can be significant, affecting an older person’s physical and mental health. Hypothermia is a significant risk, as is pressure-related injury, especially when somebody who has fallen is unable to get up.

The number of falls and their negative consequences can be reduced by up to 30% if local health and social care communities work together effectively to address falls.

Falls affect about one third of all people over 65 and in very elderly people (those over the age of 85) this figure is nearly 40%. With advancing age, the incidence of falls increases, with women more likely to sustain a fracture than men. An ageing population means that the rates of falls and fractures are increasing and will continue to do so unless action is taken to prevent falls and their consequences.

Amongst the over 65 year olds in Hampshire we would expect that around

- 77,500 will fall each year
- 38,500 will fall twice or more
- 11,000 fallers will attend an accident and emergency (A&E) department or minor injuries unit (MIU)
- a similar number will call the ambulance service
- 5,500 will sustain a fracture; 1700 to the hip

Causes of falls in older people are complex; for example the combination of poor eyesight, uneven surfaces underfoot and brittle bones make a fall and consequent fracture much more likely. Assessment of the wide range of factors that could affect an individual’s likelihood of falling is an essential part of a falls prevention pathway and service.
Many of the fractures older people sustain occur because they have increased bone fragility (osteopenia and osteoporosis). This is particularly prevalent in post-menopausal women. Studies have consistently reported that half of hip fracture patients have a history of a previous, clinically apparent fragility fracture such as wrist, ankle or vertebra. Treatment of osteoporosis from the time of the first fracture in these patients would have prevented half of the subsequent hip fractures.

In Hampshire we estimate that there are around

- 220,000 post-menopausal women
- 70,000 post-menopausal women with osteoporosis
- 26,700 post-menopausal women with a prior fracture history
- 3,600 post-menopausal women with a new fracture each year

In care homes the rate of falls is almost three times that of older people living in the community. Injury rates are also considerably higher with 10-20% of falls resulting in a hip fracture, and 30% of people admitted to an acute hospital with a hip fracture coming directly from a care home.

There is considerable evidence for the effectiveness of interventions that reduce the risk of falling and for medications that reduce the risk of fracturing. Nationally it is estimated that if all services implemented this evidence in a fully integrated falls and bone health service it would lead to an estimated reduction of 4500 hip fractures and a saving of £34 million overall.

**Hospital admissions for injuries from falls in people aged 65 and over**

In the UK falls and fractures in people aged 65 and over account for 4 million bed days each year, and the healthcare cost associated with fragility fractures is estimated to be £2 billion a year.

In 2009/10 South Central Ambulance Service responded to nearly 24,000 emergency calls related to falls amongst Hampshire residents; 12,500 of which were from people over 65. Of these fallers aged over 65, around half needed hospital admission.

In Hampshire, in 2010/11 there were 10782 emergency admissions to hospital for falls. Of these 71% occurred in the over 65 age group.

**Table 1: Trend in Emergency Fall Admissions – Hampshire residents (all ages) at all hospital providers**

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Emergency Admissions with a Falls Diagnosis (Actual falls only)</th>
<th>% change year on year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>9268</td>
<td></td>
</tr>
<tr>
<td>2009/10</td>
<td>10249</td>
<td>11%</td>
</tr>
<tr>
<td>2010/11</td>
<td>10782</td>
<td>5%</td>
</tr>
</tbody>
</table>

*Source: CDS received from provider trusts via secondary uses service (SUS)*

(Data only from 2008/09 is shown in table 1 because variation in coding makes comparison with previous years invalid.)
There are no benchmarking data available for this indicator. Hospital admissions for falls reflect not only the rate of falls in an area, but also the type of community services available, such as falls prevention teams and intermediate care beds. Therefore changes in the rate of hospital admissions are as likely to reflect changes in the provision of health services as changes in the numbers of people falling. The trend in the rate of falls varies widely between districts in Hampshire. Some of this variation will be real changes in the number of falls, while the impact of changes in coding practices in hospitals and the provision of local services will also be a contributory factor.

Gathering comparable and meaningful data will be a important to help monitor progress in implementing the strategy.

**Hip fractures**

The most common serious consequence of falling is a hip fracture (fractured neck of femur) and over 70,000 hip fractures occur each year in the UK. Half of people suffering a hip fracture never return to their previous level of independence. About 10% die within a month, a third within 12 months and approximately 20% enter a care home.

The rate of hospital admissions for a broken hip in people over the age of 65 in Hampshire during 2009/10 was significantly lower to national and lower than the regional rate. Rushmoor and Havant have rates that are significantly lower than the national rate. All the other districts have rates that are not significantly different from the national rate. However these district comparisons should be treated with caution as they fluctuate between one year and the next.

![Emergency admissions for FNOF in over 65s - 2008/09 and 2009/10](source: Health Profiles)
In 2010/11 there were 1665 emergency admissions for fractured neck of femur for people registered with a GP Practice in Hampshire. Between 2005/06 and 2010/11 there has been an 8% increase in the number of emergency admissions for fractured neck of femur (FNOF), which reflects the increase in the number of people aged over 65 in Hampshire during this time.

Table 2: Trend in Fractured neck of femur (FNOF) Emergency Admissions – Hampshire residents (all ages) at all hospital providers

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Emergency Admissions for FNOF</th>
<th>% change year on year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/06</td>
<td>1535</td>
<td></td>
</tr>
<tr>
<td>2006/07</td>
<td>1517</td>
<td>-1%</td>
</tr>
<tr>
<td>2007/08</td>
<td>1555</td>
<td>3%</td>
</tr>
<tr>
<td>2008/09</td>
<td>1620</td>
<td>4%</td>
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<tr>
<td>2009/10</td>
<td>1593</td>
<td>-2%</td>
</tr>
<tr>
<td>2010/11</td>
<td>1665</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: CDS received from provider trusts via secondary uses service (SUS)

More than 90% of all emergency hospital admissions for FNOF occurred in the over 65's age group. For female admissions only, this rises to 94%.

In the older age groups, women are admitted to hospital as emergencies with FNOF more frequently than men.

Overall, the time people stay in hospital because of a hip fracture (length of stay) has increased slightly over the past six years. There was a marked increase in length of stay between 2005/06 and 2007/08 but this has been reversed in the last three years. The Hampshire average for 2010/11 of 22.18 days is in the mid range of those nationally (12.8 - 39.5). Length of stay may vary according to the range of services provided within hospital, particularly rehabilitation which can be hospital or community based.

Many of the people who have lengthy and often inappropriate stays in hospital have complex health and social care needs; in particular those with mental health problems and dementia stay in acute settings longer than necessary. Well integrated, holistic services are vital to improve both the quality and cost effectiveness of their treatment and care.

Clinical guidelines recommend that for optimal outcome patients with fractured neck of femur should receive their operation on the day of, or the day after admission. In Hampshire in 2010/11 79% of patients had their operation on the same day or the day after admission; the number of patients waiting for three nights or more for their operation has reduced over the six years.

A national audit of falls and bone health in older people by the Royal College of Physicians in 2010 showed that across the UK older people with fractures do not
routinely receive key aspects of care for falls prevention or bone health, needlessly exposing them to greater risk of further falls or fractures.

Key messages from the 2010 national audit were:

- Many patients do not receive adequate pre-operative assessment and care
- Even if older people attend hospital with serious injuries they are not being properly assessed in order to prevent further injuries. Patients with non-hip fragility fractures are only half as likely to receive assessment or treatment for secondary prevention as patients with hip fractures
- Few local healthcare organisations provide adequate falls prevention services that are attended by a majority of older people who have already sustained a fracture following a fall
- Many providers are failing in their responsibility to provide expertise to reduce falls in the high risk care home population

Although Hampshire services generally appeared to perform well when reviewing local results against key indicators, the number of cases audited from individual hospital and community trusts was too small to make statistically significant comparisons. However, there are still gaps in local services and the national key messages remain highly relevant to local commissioners and providers.

3 What are the solutions?

Well organised services using interventions based on national standards and evidence based guidelines can prevent future falls and reduce death and disability from fractures.

There are four key areas that commissioners working across health and social care should consider in the context of local services for falls prevention, falls and fractures. These are described as four objectives, relating to people in different risk groups. Interventions may be applicable across several risk groups, such as multi-factorial falls risk assessments and postural stability exercise; others are more specific, such as guidelines for the treatment of hip fractures.
Figure 1: A systematic approach to falls and fracture prevention: Four key objectives

Objective 4 Improve outcome and improve efficiency of care after hip fractures - by following recognised national standards

Objective 3 Respond to the first fracture, prevent the second – through fracture liaison services in acute and primary care

Objective 2 Early intervention to restore independence – through falls care pathway linking acute and urgent care services to secondary falls prevention

Objective 1 Prevent frailty, preserve bone health reduce accidents – through preserving physical activity, healthy lifestyles and reducing

3.1 Preventing falls

People want to live actively and independently into old age. Falling and the subsequent fear of falling again tend to make people lose confidence in carrying out their normal activities. Although the risk of falls increases as people get older, falling is not an evitable result of ageing.

The causes of falls are varied with numerous risk factors, many of which are potentially modifiable. Evidence suggests that the risk of falling increases with the number of risk factors. Interventions which address multiple risk factors are most effective in helping to reduce the loss of function and independence many older people face due to falls, as well as reducing the financial implications.

Raising awareness of risk factors will help to empower people to make more informed choices. Multifactorial interventions should look to:

Increase physical activity
Weight bearing exercise throughout life promotes healthy, strong bones. Specifically developed exercise regimes that improve posture, by promoting balance and strength help to prevent falls, reduce fear of falling and increase confidence.
Adopting a more physically active lifestyle adds years to life, even for people who were previously inactive. Regular activity can relieve some of the pain and disability associated with common diseases that affect older people including cardiovascular disease, arthritis, osteoporosis, and hypertension. Having an active lifestyle also helps to maintain independence and provide opportunities for social interaction, reducing social isolation and reducing the risk of depression. The prevalence of mental illnesses is lower among people who are physically active. Yet only 60% of men and women over 50 are active and amongst the over 80s only 60% of men and 35% of women are active.

Active living: Healthy Hampshire and Isle of Wight 2010-2012 is a Hampshire and Isle of Wight Strategy to increase physical activity across all age ranges, with a local Hampshire implementation and action plan

Health Promotion, Exercise and Falls Awareness

Better Balance for life, a community based physical activity falls prevention programme, has been developed to promote falls awareness, to prevent falls and to minimise their harm both physically and mentally when they do occur. This is led by Hampshire County Council’s Older People’s Well-Being team in partnership with Southern Health NHS Foundation Trust, District and Borough councils and voluntary organisations. It is part of the Ageing Well in Hampshire Older People’s Well-Being strategy 2011-2014, which aims to promote the independence and wellbeing of older people living in the community. There are approximately 235,000 older people over 65 in Hampshire who are not intensively using health and social care. Falling and the fear of falling is one of the major ways their independence can be lost.

This project promotes the use of simple and accessible exercises that can form part of the regular activities in community social clubs or at home to maintain and improve an individual’s strength, flexibility and balance. There is a training pack, and simple facilitators workshops run across the county, to promote the use and understanding of the exercises in the prevention of falls. The programme is also being taken up within care homes and sheltered housing.

The creation of a co-ordinated prevention and early intervention falls initiative, is providing a more joined up approach to exercise provision across the county to prevent falls. It is identifying the gaps, for example the need to expand the provision of Postural Stability exercise classes and crucially developing the pathways to and from the NHS provision.

There is a need to ensure the benefit of this approach is expanded to include those who are not yet defined as older people, as part of a wider prevention agenda and promotion of positive healthy living messages.

Review medication

Some medicines make an older person more likely to fall, such as drugs for treating high blood pressure, heart arrhythmias and those acting on the central nervous system such as antidepressants, tranquilisers and sleeping tablets.

As the consequences of falling may outweigh the benefit obtained from taking some medication; and many older people take several drugs which may interact to increase the risk of falling there is a good case for regular medication review.
Local community pharmacists currently undertake general medication reviews: searching for overlaps and interactions between medications; identifying problems experienced by patients with their medication; and endeavouring to improve the effectiveness of medication by finding out how and when they are taken. Local falls co-ordinators are developing a training project to enhance medication reviews to take account of falls prevention and osteoporosis identification and treatment.

**Reduce alcohol consumption**

Alcohol acts in the central nervous system and alters perception and our ability to keep our balance. This increases the risk of falling at all ages, but more so as we get older and our bodies become less efficient in metabolising alcohol - which tends to stay in the bloodstream longer. Many medicines interact with alcohol and put a person at risk.

Alcohol also increases the risk of high blood pressure, digestive disorders, poor circulation, memory loss and incontinence. Yet alcohol misuse amongst older people is often described as a ‘hidden’ or ‘neglected’ area of research in the UK.

Hampshire Alcohol strategy 2011-2014: Alcohol Outcomes has been prepared by the Hampshire Alcohol Partnership. It’s vision is to minimise the risks, harms and costs caused by alcohol to individuals, families, communities, business and public services in Hampshire. It has four key messages:

- Establish sensible drinking as the norm
- Identify and support those who need help
- Reduce alcohol related disorder
- Work in partnership with shared responsibility

**Check eyesight**

Poor sight can contribute to falls. It is important that older people have their eyesight checked regularly. NHS eye tests are free to all people aged over 60. People over 60 are advised to have an eye test every two years and people over 70 should have their eyesight checked every year. As well as checking the quality of sight, optometrists can also check eye health. They are trained to recognise abnormalities and diseases in the eye such as cataracts, glaucoma and age-related macular degeneration.

**Stumbling at night**

The need to go to the lavatory at night is a serious issue for many older people. Moving about at night is never easy and to prevent falls people need a clear and lit path from their bedroom to the bathroom.

An estimated 6 million adults in the UK cannot control their bladders as they wish to. Urgency and nocturia (waking at night with the need to pass urine), have both been linked with falls. There are practical measures that can be taken to tackle this.

**Shoes and feet**

Poor footwear and foot problems contribute to the risk of falling. Shoes need to fit and ideally be fastened securely. Ill-fitting and loose-fitting shoes lead to loss of balance, as do backless and high-heeled shoes. Corns, bunions and verrucas should be dealt by a chiropodist or podiatrist.
Make homes safer
Older people typically spend between 70 - 90% of their time at home so it is important that homes provide a safe environment. Understanding potential risks and making improvements to home safety can help to reduce the risk of falls.

Older people who have fallen should receive a home hazard assessment following discharge, and be supported to have necessary modifications made, along with follow-up to ensure alterations have taken place.

Handyperson services can provide basic help with repairs and adaptations in the home. This would help in preventing deterioration of an older person’s living conditions, as well as enable them to retain their independence in a safe and secure environment.

To assist all those who visit older people in their own homes to identify the possible hazards that could result in a fall, and importantly where to go for assistance, a partnership Older People’s Well-Being Trigger Tool has been developed. This provides contact details of a range of relevant organisations that can help. Supporting training, based around scenarios in an older persons home is provided to increase people’s knowledge and understanding of the possible issues and how to respond.

Care homes
Residents in care are a vulnerable group at high risk of falling. Around 40% of moves into care homes can be attributed to a previous fall and it is widely acknowledged that people who have already fallen are at high risk of falling again. Residents are also likely to be physically frail, have an existing medical condition (such as Parkinson’s, arthritis or dementia) or have a sensory or physical impairment that can increase the risk of falling. Medication and combinations of medications may also increase the risk of falling, though regular medication review should be standard in these settings. Patients in any health care setting may also be at higher risk of falls and injury.

Although there is good evidence that the type of multi-factorial interventions described can reduce the risk of falls and fractures for people in care homes, for those with dementia the evidence base is less clear.

3.2 Preventing fractures
Fractures, particularly hip fractures, are one of the most debilitating results of an accidental fall. Hip fractures can result in medical complications, infections, blood clot in the leg and failure to regain mobility. Half of hip fracture patients lose the ability to live independently. Up to 14,000 people a year die in the UK as a result of a hip fracture due to osteoporosis.

Preventing, identifying and treating osteoporosis
Approximately three million people in the UK have osteoporosis. The condition is responsible for 70,000 hip fractures, 50,000 wrist fractures and 40,000 spinal fractures every year in the UK. There are estimated to be over 70,000 women and 19,000 men with osteoporosis in Hampshire.
Ideally we would like to prevent osteoporosis from occurring in the first place by reducing risk factors.

Risk factors include:

- **Age** The risk of osteoporosis increases with age as bones naturally become weaker and less dense. Evidence suggests a significant increase in prevalence of osteoporosis with each decade after age 60.
- **Gender** Women are at greater risk of osteoporosis due to smaller bones and therefore lower total bone mass. Additionally, women lose bone more quickly following the menopause and on average live longer. Osteoporosis is less common in men but is still a significant problem (around one in twelve men over 50).
- **Hormones** Women are at greater risk of osteoporosis than men due to the decrease in the hormone oestrogen after the menopause. Women are at greatest risk of developing osteoporosis if they have had:
  - Early menopause (before the age of 45)
  - Hysterectomy before the age of 45, especially when the ovaries are also removed
  - Absent periods for a long time (more than 6 months) as a result of over-exercising or over-dieting
  - The male hormone testosterone helps to keep bones health and men continue to produce this hormone into old age. The risk of osteoporosis is increased in individuals with low levels of testosterone.
- **Ethnicity** White women have a 2.5-fold greater risk of getting osteoporosis. Afro-Caribbean women have a higher Bone Mass Density BMD than white women at all ages due to a higher peak bone mass and slower rate of loss.
- **Medical** Long-term use of high dose corticosteroid tablets increases the risk of osteoporosis. The risk of osteoporosis seems mainly to be associated with corticosteroid tablets so doses should be kept as low as possible or delivered in a different way such as inhalers for asthma. People vary in the amount of bone they lose but the loss is usually greatest in the first six months of taking corticosteroid tablets.
  - People with medical conditions which affect the absorption of foods, such as Crohn’s disease, coeliac condition or ulcerative colitis may also be at increased risk.
- **Family history** A family history of osteoporosis greatly increases the risk of developing the disease.
- **Activity levels**: Physical activity is highly recommended as the first step of preventing osteoporosis.
- **Diet** Calcium gives bones strength and rigidity and Vitamin D is vital to help the body absorb calcium.
  - There is evidence showing that giving Vitamin D and calcium supplementation to care home residents aged over 75 results in a 27% reduction in hip fracture and also has an effect on improving balance and reducing falls.
- **Smoking** Although many people are aware of the main dangers of smoking, the harmful effect smoking has on bone health is less recognised. Smoking destroys nutrients that bones need for healthy growth including Vitamin D. Smoking also damages the cells that rebuild and repair bone.
- **Tobacco** lowers the levels of hormones in the body which help keep bones strong and a reduction in oestrogen levels in women may cause early menopause.
• **Alcohol** A high alcohol intake reduces the ability of the body's cells to make bone.

• **Weight** Weight loss or low body mass index is an indicator of lower BMI.

A healthy, well-balanced diet and physical activity are key factors in having strong bones and helping to reduce fractures. Current joint strategies to improve nutrition and reduce obesity, increase physical activity, reduce alcohol misuse and reduce the number of people smoking amongst the wider Hampshire population should all have a longer term impact on people's future bone health and risk of falling.

The Community Nutrition Strategy being produced as part of the Ageing well in Hampshire Older People’s Well-Being strategy recommends key actions for the promotion of a nutritionally complete diet and physical activity.

If someone develops osteoporosis there are a range of effective treatments available which can ameliorate the effects and reduce the incidence of fractures. NICE gives guidance on the most cost effective ways to treat people with osteoporosis at risk of fragility fractures and those who have already sustained a fracture (NICE TAs160 and161).

However, osteoporosis is often silent and may not be diagnosed until someone has already had a fracture. When this happens it is crucial that the person with any fragility fracture has a comprehensive assessment of their risk of further fall and fractures, whether they need to start treatment for osteoporosis and what other interventions would most help them to stay safe and independent.

This needs an extremely well co-ordinated approach from a range of professional and agencies, both within the hospital, in primary care and in the community – usually described as fracture liaison services.

### 3.3 Minimising harm

For a person who lives alone or who spends long periods of time without contact, the fear of falling and being unable to get up again can be overwhelming. The fear of falling can be as disabling as a fall itself. If someone is unable to summon help, they may spend hours on the floor in considerable discomfort. Possible consequences of having a fall and not being able to get up include hypothermia, pressure-related injury and infection.

Although not all falls can be prevented, steps can be undertaken to help minimise harm for those who do fall:

**Coping with a fall**
If someone has fallen but is not hurt, it is important that they try to get up to avoid any possible complications. Learning how to get up after a fall can be beneficial but clinical experience and research shows that old people at risk of falling can become anxious at the thought of being on the floor.
Some precautionary steps will help to reduce discomfort for people who are unable to get up following a fall as they wait for assistance, such as keeping warm, access to responsive call systems and changing position.

**Home risk assessment** will facilitate safer discharge from hospital and will contribute to falls prevention (see Trigger Tool page 12).

**Hip protectors for older people in care homes.**
A number of studies have shown that hip protectors can be effective in reducing the incidence of fractures, particularly for confused older residents who cannot participate in a falls prevention programme. However, they only work when they fit properly and are being worn. Compliance can be an issue if people find them uncomfortable or need to change frequently. There are a large number of people in care homes in Hampshire, and further work is required to establish who would most benefit.

**Telecare**
Telecare systems offer the ability to monitor people who are at risk of falls in their own homes and can therefore improve their safety and help them to stay independent for longer. It benefits all those involved in delivering care, most importantly clients, by providing non intrusive but highly effective care in the least intensive setting – the person’s own home.

Both the NHS Hampshire and Hampshire County Council are committed to the use of this technology for people who might benefit whatever their circumstances.

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**4 National and local policy context**

There are several policies and guidelines that set out measures to reduce the number and impact of falls, and to support older people’s independence and wellbeing.

**4.1 National Service Framework for Older People - Standard 6: Falls**

**Aim:** To reduce the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen.

**Standard:** The NHS, working in partnership with councils, should take action to prevent falls and reduce resultant fractures or other injury in their populations of older people. Older people who have fallen should receive effective treatment and, with their carers, receive advice on prevention through a specialised falls service.

**Recommended interventions:**
- Identification of people most at risk, assessment and putting in place of preventive measures
- Prevention of osteoporosis and treatment of osteoporosis in affected people.
4.2 National Service Framework for Older People - Standard 8: The promotion of health and active life in older age

**Aim:** To extend the healthy life expectancy of older people by ensuring the health and well being of older people is promoted through a co-ordinated programme of action led by the NHS, with support from Local Authorities.

4.3 National Institute of Clinical Excellence: Clinical Guideline 21 - The Assessment and Prevention of Falls in Older People

**Aim:** To formulate evidence-based clinical practice relating to the assessment of older people and prevention of falls in older people.

**Key recommendations:** Risk identification, multi-factorial assessment and interventions to promote independence, improving physical and psychological function.

4.4 A vision for adult social care: Capable communities and active citizens

The Vision for a modern system of social care is built on seven principles:

- **Personalisation:** individuals not institutions take control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people. Information about care and support is available for all local people, regardless of whether or not they fund their own care.
- **Partnership:** care and support delivered in a partnership between individuals, communities, the voluntary and private sectors, the NHS and councils - including wider support services, such as housing.
- **Plurality:** the variety of people’s needs is matched by diverse service provision, with a broad market of high quality service providers.
- **Protection:** there are sensible safeguards against the risk of abuse or neglect. Risk is no longer an excuse to limit people’s freedom.
- **Productivity:** greater local accountability will drive improvements and innovation to deliver higher productivity and high quality care and support services. A focus on publishing information about agreed quality outcomes will support transparency and accountability.
- **People:** we can draw on a workforce who can provide care and support with skill, compassion and imagination, and who are given the freedom and support to do so. We need the whole workforce, including care workers, nurses, occupational therapists, physiotherapists and social workers, alongside carers and the people who use services, to lead the changes set out here.


4.5 Equity and Excellence, liberating the NHS

The coalition government’s White Paper Equity and Excellence, liberating the NHS will influence the context within which this strategy will have to be implemented, with Clinical Commissioning Groups (CCGs) taking the lead in commissioning health services, including the health element of falls prevention services.
4.6 Healthy Lives, Healthy People

Healthy Lives, Health People is the White Paper outlining the coalition government’s strategy for public health in England. It looks at health and wellbeing throughout life including ageing well.

It proposes a new role for local government in public health that will enable better integration with areas such as social care, transport, leisure, planning and housing, keeping people connected active and independent in their own homes.

4.7 National outcomes frameworks for NHS, Social Care and Public Health

National outcome frameworks have been produced for the NHS and Social Care, a draft framework has been published for Public Health with the final version due imminently. Within the high level outcomes shown below are some more detailed ones which are more specific to falls and will become part of the monitoring measures for this strategy.

<table>
<thead>
<tr>
<th>NHS</th>
<th>DEATH</th>
<th>WELLBEING</th>
<th>RECOVERY</th>
<th>EXPERIENCE</th>
<th>SAFETY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing people from dying prematurely</td>
<td>Enhancing quality of life for people with long term conditions</td>
<td>Helping people to recover from episodes of ill health or following injury</td>
<td>Ensuring that people have a positive experience of care</td>
<td>Treating &amp; caring for people in a safe environment &amp; protection from avoidable harm</td>
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<th>SOCIAL CARE</th>
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<tr>
<td>Promoting personalisation and enhancing quality of life for people with care &amp; support needs</td>
<td>Preventing deterioration, delaying dependency and supporting recovery</td>
<td>Ensuring a positive experience of care and support</td>
<td>Protecting from avoidable harm &amp; caring in a safe environment</td>
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<tbody>
<tr>
<td>Preventing people dying prematurely</td>
<td>Tackling the factors which affect health and wellbeing</td>
<td>Helping people to live healthy lifestyles and make healthy choices</td>
<td>Reducing the number of people living with preventable ill health</td>
<td>Protect the population’s health from major emergencies &amp; remain resilient to harm</td>
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4.8 Quality and outcomes framework (QoF)

The quality and outcomes framework is part of the contract for general practice which rewards the provision of quality care and helps fund further improvements in the delivery of clinical care.

From April 2012 three new indicators, based on NICE guidance on osteoporosis have been agreed. This includes:

- producing a register of patients over 50 with previous fragility fractures and a diagnosis of osteoporosis
- recording the percentage receiving appropriate bone sparing treatment
- recording those over 75 with a fragility fracture and percentage on appropriate treatment.
This has the potential to greatly improve the care of patients with osteoporosis, as well as providing much better information to monitor the strategy.

4.9 Key Local Strategies

The emerging Joint Hampshire Health and Wellbeing Strategy is a potential vehicle to ensure the joint commissioning of an effective and coherent fall prevention pathway across the whole of Hampshire.

Ageing well in Hampshire; Older People’s Well-Being Strategy April 2011 – March 2014 a joint partnership strategy between statutory and voluntary/community organisations to improve older people’s independence, health and wellbeing.

District and Borough Councils have joint Health and Wellbeing action plans, many of which identify falls prevention as a priority, and provide a route to develop local falls prevention interventions.

Several of the emerging Clinical Commissioning Groups (CCGs) Commissioning Strategies are considering falls prevention as a priority, and so will be key partners in implementing the strategy.

Falls Strategy Groups in the South of the county have been working for some time with local clinicians to prevent falls and improve the treatment of osteoporosis and fragility fractures. Their local experience and expertise will be a great asset and will help to shape the county wide implementation plan.

5 Care Pathway

A workshop was held with stakeholders working in falls prevention both in community and hospital settings to better understand the current pathway for people who fall, and where outcomes could be improved.

This will need to be refined following consultation on the draft strategy.
6 Current provision in Hampshire

There are currently a range of falls prevention and treatment services across Hampshire, some of which are part of general acute, community and primary care services; others have been set up specifically to address falls.

There is an active falls prevention group in the south of the county, and developing groups in the north.

Provision is variable across the county. A map of dedicated falls services is being updated and will be included in the final strategy.
The following diagram provides a summary of the aim and key outcomes of the joint commissioning strategy.

**Aim**
To minimise the risks, harms and costs caused by falling to older individuals, their families, communities and services in Hampshire.

- **Older people**
  - Prevent frailty, preserve bone health, reduce accidents

- **Individuals at high risk of 1st fragility fracture**
  - Early intervention to restore independence

- **Non-hip fragility fracture patients**
  - Respond to the first fracture, prevent the second

- **Hip fracture patients**
  - Improve outcome and improve efficiency of care after hip fractures

- **More effective exercise classes**

- **Home risk assessments**

- **Use of trigger tool**

- **Extend Better Balance for life initiative**

- **QoF indicators**
  - OST 1, 2 & 3

- **Better identification of people at risk of falling and osteoporosis**

- **Use of NICE CG 21/AGS/BGS Guidelines**

- **Use of Trigger tool**

- **Extend Better balance for life initiative**

- **NICE TA 160**

- **QoF indicators**
  - OST 1,2 &3

- **Equitable access to fracture liaison services across Hampshire**

- **More people with 1st fragility fractures referred to fracture liaison service**

- **Improvement in RCP outcomes on nos fragility fractures offered assessment, intervention and treatment**

- **NICE TA 161**

- **QoF indicators**
  - OST 1,2 & 3

- **National Outcomes Framework PH**
Underpinning this will be the need for accurate, timely and agreed data against which to monitor these outcomes.

This draft strategy will be refined and improved as we respond to the consultation, and a final version published in March 2012.

A detailed implementation plan will follow, which will need to feed into and take account of CCGs commissioning intentions; adult services commissioning plans and District and Borough Health and Wellbeing plans.

A Hampshire Falls Strategy Board will be accountable ultimately to the Hampshire Health and Wellbeing Board for implementation of the joint strategy; and will work closely with established local falls groups to support current good practice and help to further develop effective local services.

8 References

1. Source: Synthetic estimates from DH Prevention Package for older people

2. Department of Health Prevention Package for Older People Source: Synthetic estimates from DH Prevention Package for older people


4. NICE Clinical Guideline 124
   Length of stay for emergency admission from Right Care Atlas