

Delivering Healthy Ambitions Better for Less



Overview.

Health and social care working together locally to establish comprehensive falls care pathways can drive up quality, efficiency and effectiveness simultaneously.

Why Falls?

Falls present a huge problem for the health and independence of older people. Having a fall as one ages is not inevitable, however the associated mortality and morbidity from a fall is high (for hip fractures mortality at 12 months is 30%).

Individual consequences range from distress, pain, physical injury and loss of confidence to complete loss of independence.

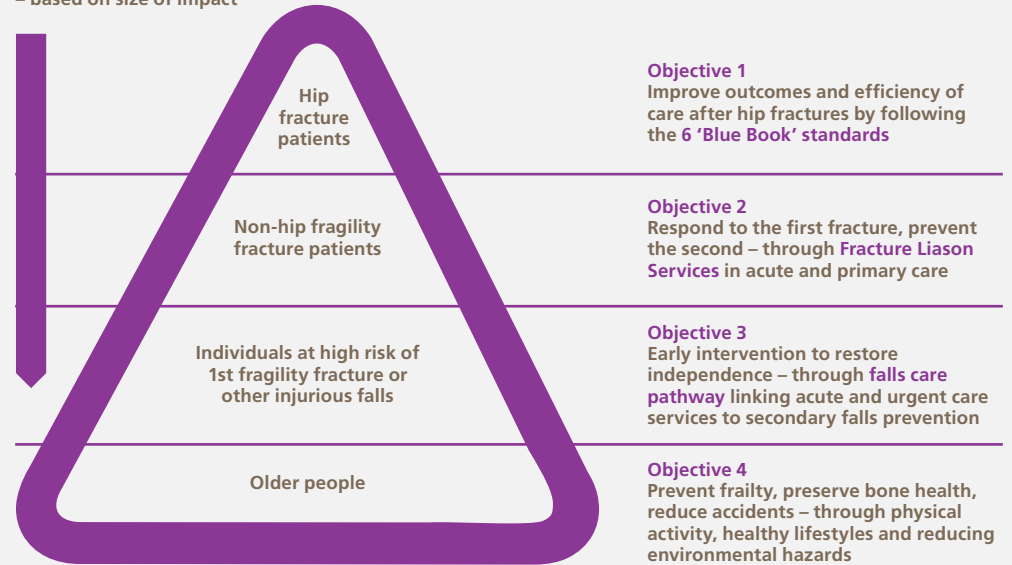
In addition to direct healthcare costs, other costs may also include residential and home care.

Many strategies target those who have already had a fall or fracture. There is also much work that can be done in earlier years to systematically target intervention at those at risk of osteoporosis, promoting peak bone mass through diet and weight bearing exercise. Recognising and modifying underlying risk factors is possible in the community, home and hospital.

The graphic illustrates the potential to develop a comprehensive and tiered approach to the delivery of falls and fracture prevention services consistent with the population group being targeted and the level of need.

A systematic approach to falls and fracture prevention
Four key objectives

Stepwise implementation
– based on size of impact



What is the challenge?

It is estimated that falls affect up to 33% of people over 65 and 42% of over 75 year olds each year. Around 160 people each year die as a result of falls, 7,000 people suffer a hip fracture as a result of a fall, and 20,000 suffer other fragility fractures. These figures will grow with increases in the numbers of the frail and elderly population.

Falls impose a significant financial burden on the NHS and social care. It is estimated that the direct cost following a hip fracture is around £10,000 to the NHS and £5,400 to social care. Hip fractures cost around £110m in health and social care costs in our region every year.

Recovery from a fall is much more significant than the mending of broken bones. Following a fall some people never return to independent living.

How could we provide better care for less?

Falls prevention is a very cost effective intervention. There is clear evidence that comprehensive integrated falls prevention and management programmes reduce the incidence and severity of first falls. Proactive preventative management of "first fallers" reduces the likelihood of a subsequent and more serious fall occurring.

Patient and Quality benefits

Engaging people in targeted and evidence based prevention, self care and management programmes increases their overall fitness, sense of well-being, compliance with medication regimes and their opportunity to live a life with improved confidence and free from disability.

Efficiency benefits

The savings from reduced falls are potentially significant, resulting from:

- Reductions in ambulance journeys and A&E attendances (£277 for an ambulance journey and up to £101 for an A&E attendance)
- Reductions in emergency admissions for fragility fractures (£6,800 for a fractured neck of femur, £3,400 for vertebral fractures and £2,400 for wrist fractures).
- Reduced cost of care home and rehabilitation services. Estimates suggest that local authority care home costs an average of £3,744 per hip fracture.

Implementation

Comprehensive falls care pathways require primary, community, acute and social care working effectively together.

What needs to happen?

- Compliance with core standards after hip fractures
- Respond to a first fracture and prevent the second
- Fracture liaison services in acute and primary care
- Falls care pathways - linking acute services to secondary prevention
- Prevent frailty, promote bone health and reduce accidents

Fracture liaison

Patients aged over 50, who are admitted to hospital or who attend outpatient clinics or A&E due to a low impact fracture, gained from a fall, slip or trip, are highlighted to the service and assessed by a specialist osteoporosis nurse.

For a 300,000 population the service would assess around 1000 older people with fragility fractures each year, about half of which would be recommended for osteoporosis treatment.

The nurse can:

- investigate bone density using scans and measurements
- start drug and other treatments to reduce the risk of a future break if someone has osteoporosis
- liaise directly with falls services
- monitor and maintain medication adherence

30% of hospitals in England currently operate this service with good evidence for its effectiveness in reducing hip fractures

Primary care

A primary care-based fracture liaison programme can undertake proactive case finding of unassessed fragility fracture and other high-risk patients across a much wider group. The nationally directed enhanced service (DES) for Osteoporosis prevention and care provides an incentive for primary care to participate in this work.

Using primary care records and the FRAX osteoporosis risk assessment tool, the service can proactively identify people whose fragility fractures have not previously been assessed and other patients at high risk of primary fractures.

A primary care-based fracture liaison nurse, working to agreed protocols, can:

- carry out assessments
- review patients' medication
- recommend treatment for long-term management of osteoporosis.

This approach also enables systematic annual follow-up to ensure medication compliance.

Falls care pathway

A falls care pathway, commissioned locally by health and social care from a multi-agency team, can use the expertise of a range of professionals to deliver a "right place, right time" intervention. The pathway should agree:

- the contribution of each professional group to the pathway
- specific proposals for incorporating falls prevention and awareness into mainstream health and social care services, with criteria for identifying people suitable for falls assessment, including bone scanning where appropriate
- what sort of assessment activity is undertaken between GPs, a primary care-based falls team, and secondary care based falls clinics.
- opportunities to consider any adaptations needed to a home environment, including the use of aids and adaptations, community equipment and assistive technology, such as fall detectors and related community alarm or telecare packages

Falls service

A falls service can triage and assess older people who have fallen or are at high risk of falling. Anyone presenting with a fall or fracture in any urgent care setting should be assessed for the following:

- Falls risk, via a risk assessment. This should include a review of any medical conditions, strength and balance tests, visual impairment and medication review.
- Fracture risk using professional consensus guidance such as the FRAX assessment tool. NICE technology appraisals 160 and 161 provide guidance on the treatment of primary and secondary osteoporosis.

Falls assessment service can be run from a range of settings including community hospitals, GP surgeries, intermediate care teams or secondary care. The key requirement is practitioners with appropriate skills, including access to secondary care specialists and facilities where appropriate.

Falls co-coordinator

A falls co-coordinator can ensure that hospital and community efforts to prevent falls are co-ordinated and integrated. This post can also promote falls management and prevention.

Targeted interventions

Targeted interventions, based on risk assessment, are likely to include: optimising medication, reducing visual disability, avoiding unnecessary environmental hazards. The most effective component of multi-factorial interventions is therapeutic exercise.

Broader prevention

Home assessments should be an option following a falls assessment. A significant number of environmental hazards exist in the nursing and residential care home sector and in NHS maintained premises. A programme targeting the incidence of falls in these circumstances provides additional opportunity for prevention.

Ambulance services

Ambulance staff assess the need for patients to be conveyed to A&E departments and around 25% are not conveyed. This assessment offers staff direct experience of a person's living conditions, including environmental safety and other risk factors.

For non-conveyed patients there is a clear opportunity to flag up the event and patient's circumstances to primary care or the community falls services, depending on the local pathway. Some services have gone a step further and ambulance staff can refer non-conveyed patients directly to a single point of access to PCT community falls or intermediate care services.

Workforce planning and development

The regional Prevention and Lifestyle Behaviour Change: Competence Framework helps embed workforce transformation promoting every contact counting in terms of prevention and wellbeing.

NHS North Yorkshire and York - falls prevention in action

Falls prevention services are being implemented across NHS North Yorkshire and York. Local steering groups drive integrated service improvement across health and social care, housing and the voluntary sector.

Services are based around comprehensive falls pathways, which proactively identify those at highest risk of falling and carry out an assessment of internal (health & social) and external (environmental) risk factors. The service is supported by dedicated falls practitioners, who ensure an individual care plan is in place and manage risk through onward referral, including for strength and balance training, home hazard intervention, physiotherapy/occupational therapy, visual/hearing specialist and medication review.

Good practice includes:

- Falls prevention services working closely with local acute trusts to identify patients who have been in A&E following a fall, with community follow up.
- Yorkshire Ambulance Service has developed a pathway allowing a paramedic to make a clinical decision to directly refer the patient to the Fast Response Team for further management and then onto the falls prevention service.
- North Yorkshire County Council are currently establishing a pathway for clients at risk of falling, which will include the FRAT assessment tool and will address the training needs of their staff.
- A Falls Co-ordinator identifies inpatients who would benefit from a multifactorial risk assessment and refers these on to the community based falls prevention service.
- A fracture liaison service is being developed to identify high risk patients who have sustained a fragility fracture following a slip, trip or fall from a standing height or lower. Each patient, who has a multi-factorial risk assessment by a falls practitioner, is assessed using the FRAX osteoporosis risk assessment tool. The GP is notified of the result and the intervention that is required, e.g. Lifestyle advice, bisphosphonates or DEXA scan.
- A patient leaflet 'STEPS to Prevent a Fall' is now being used across the county.

Outcomes

In its first year of operating in the Hambleton and Richmondshire locality falls related admissions (2008/2009) fell 6.3% on the previous year.

Key contacts

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Other resources and references

NICE Clinical Guidance 21
Clinical practice guideline for the assessment and prevention of falls in older people (2004)
<http://www.nice.org.uk/nicemedia/pdf/CG021fullguideline.pdf>

NICE Technology Appraisal (TA) 87
The clinical effectiveness and cost effectiveness of technologies of the secondary prevention of osteoporotic fractures in post-menopausal women

NICE Technology Appraisal (TA) 161
Review of treatments for secondary prevention of osteoporotic fragility fractures in post-menopausal women

National Hip Fracture Database
www.nhfd.co.uk

National Clinical Audit of Falls and Bone Health in Older People
www.rcplondon.ac.uk/clinical-standards/ceeu/Documents/fbhop-nationalreport.pdf

High Impact Actions for Nursing and Midwifery [Staying safe - preventing falls]
NHS Institute for Innovation and Improvement

National Evaluation of Partnerships for Older People Projects Final Report
www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/PartnershipsforOlder

Falls and fractures: Effective interventions in health and social care
Department of Health July 2009

Osteoporosis Directed Enhanced Service
<http://www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/DirectedEnhancedServices>

Protecting fragile bones
A strategy to reduce the impact of osteoporosis and fragility fractures in England
National Osteoporosis Society May 2009

Delivering Quality and Value Focus on Fractured Neck of Femur
Institute for Innovation and Improvement 2006

DH. Prioritising Investments in Public Health. Oct 2008
<http://www.library.nhs.uk/PUBLICHEALTH/ViewResource.aspx?resID=318942>

NSF older people standard 6: falls (2001)
http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/OlderpeoplesNSFstandards/DH_4002294