Falls and Bone Health

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Executive Summary

Introduction

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year. Therefore falling has an impact on quality of life, health and healthcare costs. Guidance on the assessment and prevention of falls in older people was updated in 2013 (NICE CG161) [1].

The key issue of concern is not simply the high incidence of falls in older people, but the combination of a high incidence and a high susceptibility to injury. Bone health is therefore considered alongside falls in this JSNA because osteoporosis increases bone fragility and susceptibility to fracture, particularly as a result of a fall (NICE CG146).

Osteoporosis is a disease characterised by low bone mass and structural deterioration of bone tissue, with a consequent increase in bone fragility and susceptibility to fracture. Osteoporosis leads to over 300,000 patients presenting with fragility fractures to hospitals in the UK each year. Because of increased bone loss after the menopause in women, and age-related bone loss in both women and men, the prevalence of osteoporosis increases markedly with age, from 2% at 50 years to more than 25% at 80 years in women. If people at risk can be identified, treatments and therapies are available. Guidance on assessing people at risk was updated in 2012 [2].

Unmet need and gaps

Addressing falls and bone health enables older people in Nottinghamshire to increase healthy life expectancy. Public health outcome measures suggest that Nottinghamshire is performing well overall compared with the East Midlands and England and that fewer people are being admitted to hospital with a non-injurious fall. However a number of factors will widen unmet need and service gaps:

- ◊ increasing population over 65
- ◊ growth in numbers of people with osteoporosis
- ◊ co-morbidities such as dementia

Current unmet needs and service gaps include:

- ◊ capacity in specialist falls teams
- ◊ lack of communication and integration between different teams specialising in different conditions
- ◊ ensuring expertise and leadership in areas without a specialist falls team or lead clinician
- ◊ access to postural stability classes (Otago/FaME)
- ◊ slight increase in admissions to care homes following a fall (and subsequent management of falls in care homes)
- ◊ identifying and treating osteoporosis

Recommendations for consideration by commissioners

Falls and bone health assessments and interventions are multifactorial and may be provided by a range of health and social care providers. Commissioners will need to ensure that services and pathways are consistent with NICE guidance (CG161 and CG146), the recommendations in the Royal College of Physicians audit report and the forthcoming NICE Quality Standard.

Key priorities for implementation brought forward from CG161 (2004) are:

- Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s.
- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multifactorial intervention.
- New priorities include patients at risk of falling in hospital. A multifactorial assessment and multifactorial intervention should also be performed for inpatients at risk of falling.

Osteoporosis guidance (CG146) recommends targeting risk assessment in all women aged over 65 and men aged over 75, and in women and men aged over 50 in the presence of risk factors e.g. history of falls.

In order to achieve this the main recommendations are:

- Explore implementation of comprehensive falls prevention programmes to prmote strength and balance
    - Exercise promotion e.g. using home care providers to encourage exercise
    - Falls prevention focusing on strength & balance training e.g. could also provide in day services
- Reduction of home hazards, use of aids and adaptations
- Learning & development for health and social care staff to:
    - Improve identification and case finding of people at risk of falling
    - Use of the Guide to Action tools
- Medication reviews, especially following hospital discharge
- completion of FRAX assessment for osteoporosis
- Local Falls and Bone Health co-ordinators in line with guidance
- Integration of the pathway across primary and secondary care to include bone health and clear referral to falls services
- Integrated crisis response services, assessing causes of a fall and putting preventative measures in place to reduce chances of further falls, focusing on treatment at home and in the community

Together, these recommendations will::

- Reduce admissions to hospital and care homes as a result of falls
- Reduce falls in care homes and nursing homes
- Reduce falls in hospital

Full JSNA report

What do we know?

A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level (WHO)[3]. A fall resulting in injury is one where there is a fracture or soft tissue damage requiring treatment (NICE CG161). Falls resulting in injury also include fragility fractures - falls that would not ordinarily result in fracture (NICE CG146). The key issue of concern is therefore not simply the high incidence of falls in older people – since children and athletes have a very high incidence of falls – but rather the combination of a high incidence and a high susceptibility to injury. Bone health is considered alongside falls in this JSNA because osteoporosis increases bone fragility and susceptibility to fracture, particularly as a result of a fall (NICE CG146).

1) Who is at risk and why?

Age

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

Gender

Because of increased bone loss after the menopause in women the prevalence of osteoporosis increases markedly with in older women, from 2% at 50 years to more than 25% at 80 years. This increases the risk of injury due to a fall. (NICE CG146)

Other risk factors (WHO)

- underlying medical conditions, such as neurological, cardiac or other disabling conditions;
- side effects of medication, physical inactivity and loss of balance, particularly among older people;
- unsafe environments, particularly for those with poor balance and limited vision.
- poor mobility, cognition, and vision, particularly among those living in an institution, such as a nursing home.

What is the impact?

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls and fragility fractures are estimated to cost the NHS more than £2.3 billion per year. Therefore falling has an impact on quality of life, health and healthcare costs (NICE CG161). Having one fall requiring health care has also been shown to be a key factor leading to admission to a care home (alongside dementia, depression and incontinence)[4].

300,000 people present with fragility fractures to hospitals in the UK each year and this will increase as the population ages. Direct medical costs from fragility fractures to the UK were estimated at £1.8 billion in 2000, with the potential to increase to £2.2 billion by 2025, and with most of these costs relating to hip fracture care. Up to 14,000 people also die annually in the UK as a result of an osteoporotic hip fracture (NICE CG146).

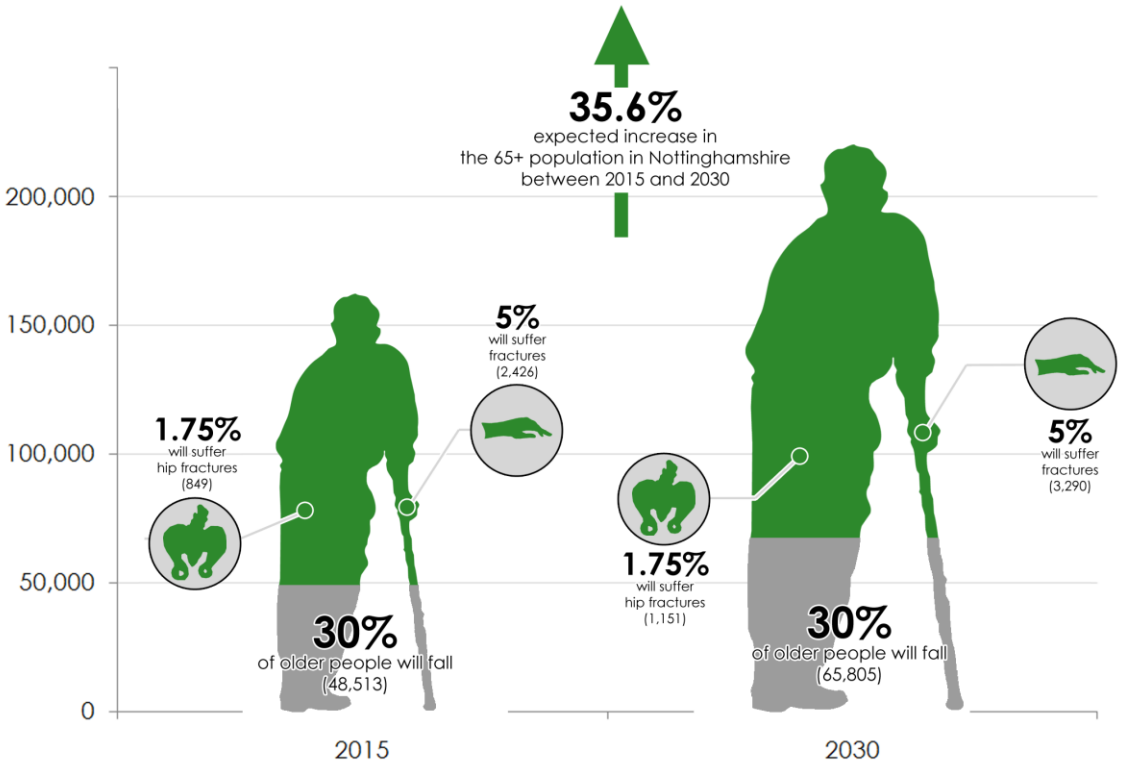
2) Size of the issue locally

The number of people in Nottinghamshire County aged over 65 is expected to rise from 161,709 in 2015 to 219,351 in 2030, an increase of 35.6%. This is associated with a corresponding increase in numbers of falls, particularly in those aged over 80. For Nottinghamshire:

- approximately 30% of older people will fall each year, (48,513), some more than once, **of these**,
    - approx. 5% suffer fractures and
    - 1.75% suffer hip fractures (based on population/actual number of hip fractures 2012-13)

The graphic below applies these rates to the population of Nottinghamshire, assuming a mid-point where there is a range

Figure 1: Infographic showing numbers of people experiencing a fall in Nottinghamshire in 2015 and 2030



The main change in need since the last JSNA (2010) is the increasing number of older people living with frailty and dementia, both of which are risk factors for falls.

Earlier detection and management of both frailty and dementia will help to address falls.

3) Targets and performance

Figure 2: Public Health Outcomes Framework measures related to falls and bone health.

All measures are age/sex standardised rate per 100,000 over 65 population 2012/13

Green shows **better** than England performance

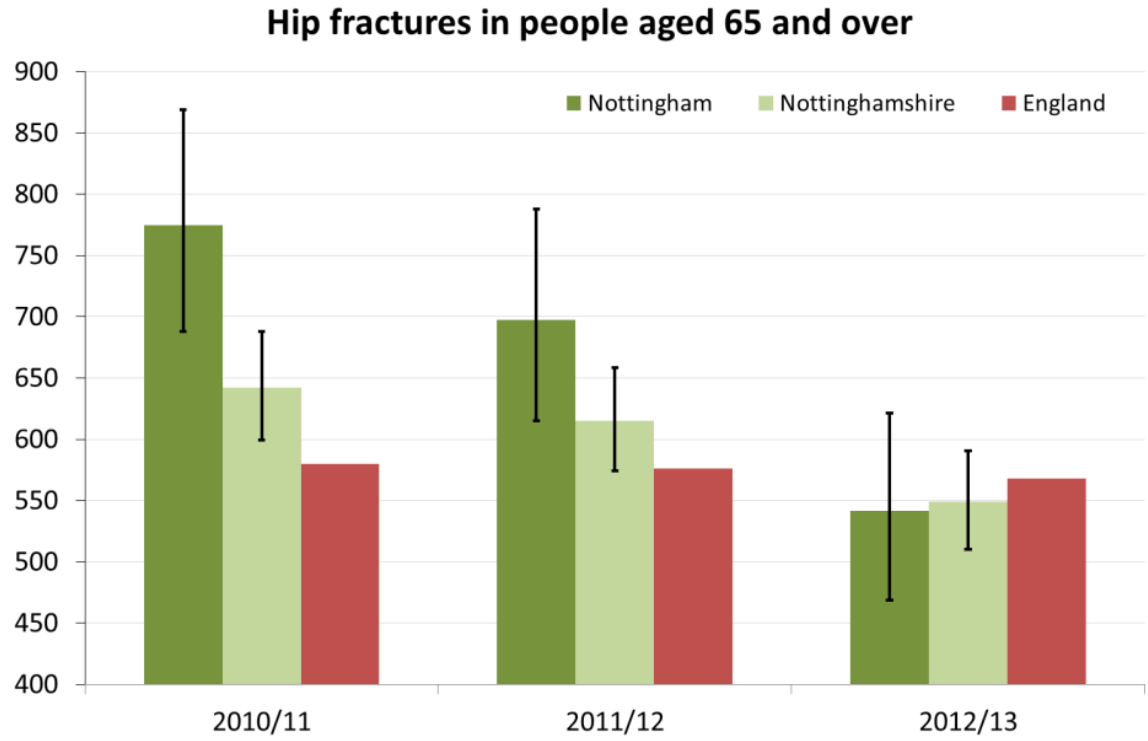
Amber shows **similar** to England performance

	England	East Midlands	Nottinghamshire	Count
Healthcare & premature mortality - Hip fractures in people aged 65 and over				
Rate of emergency admissions for fractured neck of femur in those aged 65+	568.1	556.0	549.4	818
Rate of emergency admissions for fractured neck of femur in those aged 65-79	237.3	232.3	236.6	252
Rate of emergency admissions for fractured neck of femur in those aged 80+	1528	1492	1456	566
Health improvement - Injuries due to falls in people aged 65 and over				
Rate of emergency admissions for injuries due to falls in males/females aged 65+ (Female)	2420	2264	2307	2018
Rate of emergency admissions for injuries due to falls in males/females aged 65+ (Male)	1602	1467	1572	892
Rate of emergency admissions for injuries due to falls in persons aged 65+ (Persons)	2011	1865	1940	2910
Rate of emergency admissions for injuries due to falls in persons aged 65-79 (persons)	975	890	918	983
Rate of emergency admissions for injuries due to falls in persons aged 80+ (persons)	5015	4692	4903	1927

From http://www.phoutcomes.info/ accessed 6 October 2014

Nottinghamshire is performing well compared with England and East Midlands on all measures and the rate for hip fractures in people aged over 80 has improved compared with 2010/11 and 2011/12. The actual number (count) of hip fractures for over 65s has reduced from 928 in 2011/12 to 818 in 2012/13.

Figure 3: Healthcare and premature mortality - hip fractures in people aged 65 and over; age/sex standardised rate per 100,000 population 2012/13



Adult Social Care Outcomes Framework

As noted above, falls are a key factor in admission to residential care. The relevant ASCOF measure included here is the number of permanent admissions to residential care (care homes and nursing homes).

Figure 4: Adult Social Care outcomes framework measures relating to falls and bone health.

Permanent admission to care homes: people aged 65 and over 2013-14	England	East Midlands	Nottinghamshire
Standardised rate per 100,000 population	697.2	759.1	651.2

Note: Figures do not include self-funders

HSCIC accessed 6 October 2014

http://ascof.hscic.gov.uk/Outcome/511/

Nottinghamshire is ranked 69 of 151

The England and East Midlands rates have reduced however the Nottinghamshire rate has increased from 648.5 to 651.2 thus slightly reducing its ranking.

NHS Outcomes Framework 2014/15

Domain 3 - Helping people recover from ill-health or following injury

Domain 3.5 Proportion of patients with a fragility fracture recovering to their previous levels of mobility at i. 30 days and ii. 120 days

In year data will be available **after December 2015** from National Hip Fracture Database

http://www.nhfd.co.uk/20/hipfractureR.nsf/welcome?readform

CCG Outcomes Indicator Set 2014/15

Improving recovery from fragility fractures

- Proportion of patients recovering to their previous level of mobility or walking ability (NHS OF 3.5 i and ii) (as above)
- Hip fracture: formal hip fracture programme, timely surgery, and multifactorial risk assessment. Hip fracture care is audited annually against the fragility fracture hip fracture **Best Practice Tariff (BPT)** criteria. The tariff is applied for individual patients where all the criteria are met. The criteria have been amended and expanded to include an AMT (Abbreviated Mental Test) to determine whether a dementia risk assessment is needed. The complete list is:

a) time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an admitted patient, to the start of anaesthesia
(b) admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon
(c) admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia
(d) assessed by a geriatrician in the perioperative period (within 72 hours of admission)
(e) postoperative geriatrician-directed multi-professional rehabilitation team
(f) fracture prevention assessments (falls and bone health)
(g) two Abbreviated Mental Tests (AMT) performed and all the scores recorded in NHFD with the first test carried out prior to surgery and the second post-surgery but within the same spell.

Nottingham University Hospital (71.8%), Kings Mill Hospital (75.9%) and Bassetlaw Hospital (72.5%) all met the criteria for the BPT for over 70% of their patients. This is better than the overall England rate of 60.6%. Further information is available at http://www.nhfd.co.uk/2014report

General Practice Quality Outcomes Framework (QOF)

The QOF for Osteoporosis - secondary prevention of fragility fractures is a register of patients aged over 50 with a record of a fragility fracture since April 2012. Achievement is available at practice, CCG and Area Team level. The range for Nottinghamshire CCGs is between 92% and 100% of practices having a register. This has improved between 2012/13 and 2013/14 with the number on the register increasing from 836 to 1,455. (Public Health Information Team)

4) Current activity, service provision and assets

Falls mainly affect older people, especially people aged over 80. Therefore many people who fall may have other medical conditions and require an integrated approach wherever possible. Falls services are therefore provided by a wide range of organisations including the NHS, social care, and voluntary groups.

4.1 Local Guidelines

The **Nottinghamshire Falls Pathway** may be found at **here.**

Nottingham and Nottinghamshire have also developed a **Guide to Action for Falls Prevention** tool (GtAT) and the **Guide to Action for care Homes** (GtACH) to help anyone working with older people to recognise and mitigate falls risks. The tool has been designed to raise awareness of falls and fractures and offers advice on reducing risk, advice on further management and referral to the Primary Care Falls or Rehabilitation Service.

Bassetlaw has a separate, local pathway and this is being reviewed..

Nottinghamshire's **Osteoporosis Guidelines** have been reviewed and are available at:

http://www.nottsapc.nhs.uk/index.php/clinical-guidelines

These guidelines are used by organisations across the County except for Bassetlaw. The Bassetlaw guidelines are currently being reviewed and will be available in 2015.

The section below is an overall summary of the services available.

4.2 Primary Prevention

Primary prevention aims to prevent the first fall in a person who is vulnerable to falling because of, for example, unsteady gait, but who has not yet fallen. The Guide to Action tool helps to identify those at risk of falling in order to target effective intervention(s).

People aged over 65 may be at risk of vitamin D deficiency and Public Health England has published new guidance about protecting bone health by ensuring people have sufficient Vitamin D. https://www.gov.uk/government/publications/vitamin-d-for-healthcare-professionals-and-the-public

The Public Health England Report *Everybody Active, Everyday (September 2014)* finds that older adults who remain active, are more engaged in the community, contribute more to society, and protect themselves from falls and circulatory problems. The Report further recommends that older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.

Community and voluntary groups play an important role in providing opportunities for physical activity, advice and information. These include walking groups, exercise and dance classes provided by organisations such as Age UK Nottingham and Nottinghamshire. Local CVSs provide information and talks to local groups to promote good health and may run specific projects such as the Slips, Trips and Falls project run by Ashfield Voluntary Action. These may be supported by the local Clinical Commissioning Group (CCG).

http://www.ageuk.org.uk/notts/

http://www.ashfieldvoluntaryaction.org.uk/health-news/slips-trips-falls-project/

http://www.bassetlaw-health.co.uk/

Nottinghamshire County Council commission a range of preventive services that help older people who may be at risk of falling. First Contact is a multi-agency checklist used by organisations across the County to enable older people to access a range of services, including repairs and adaptations, and includes a specific question about falls. This can be accessed on line

http://www.nottinghamshire.gov.uk/caring/adultsocialcare/supporttoliveathome/arranging-your-own-support/

The Handy Persons Adaptation Scheme (HPAS) carries minor adaptations to help older people move around the home and stay steady on their feet. These include:

- grab rails
- second stair rails
- half-steps
- exterior hand rails

http://www.nottinghamshire.gov.uk/caring/adultsocialcare/supporttoliveathome/equipment-adaptations/hpas/

4.3 Secondary Interventions/Rehabilitation

Secondary interventions are targeted at a person who has already fallen or who has a history of falls.

Primary Care

GPs may undertake a multi-factorial clinical assessment to exclude medical causes of falls and injuries from falls e.g. Parkinson's, dizziness, medication, osteoporosis. For patients in hospital, this may be carried out by a hospital doctor.

Specialist Falls Teams and Primary Care Rehabilitation

All patients on community caseloads are asked if they have had a fall in the last 6 months and if so, the Guide to Action Tool is used to identify the next action.

Patients referred to specialist falls services will receive a multi-factorial assessment including: falls, medical and bone health history, assessment of balance, mobility and muscle weakness, osteoporosis risk assessment, home hazard assessment, mental health assessment, health assessment including postural blood pressure, continence and medication review. Therapists prescribe and deliver individually tailored exercise programmes to improve strength and balance, home hazard assessments and referral to other services e.g. for vision assessment where appropriate.

Community health services are provided by Nottinghamshire Healthcare NHS Trust. More information is available at:

http://www.nottinghamshirehealthcare.nhs.uk/our-services/health-partnerships/

General Social Care Services

Nottinghamshire County Council's Adult Social Care & Health department commissions a range of services that enable people to live at home independently. These include:

Advocacy, Home Care, Day services, Meals at Home, Carer Support, Integrated Community Equipment Loan Store (ICELS), Short Term Assessment and Reablement (START) and

Telecare. Further information is available at:
http://www.nottinghamshire.gov.uk/caring/adultsocialcare/

4.4 Urgent and Acute Care

East Midlands Ambulance Service (EMAS)

Falls comprise the largest proportion of 999 calls which require an ambulance and are a high priority for healthcare services nationally. Across the East Midlands in 2012/13, 16% of all emergency responses had 'falls' categorised as the chief complaint. There is potential to better manage non-life-threatening falls by increasing the number of people who can be treated at home, thus avoiding unnecessary hospital admissions.

Hospital Admissions

Falls, with or without an injury, are a major cause of admission to hospital for people over 65. Reducing demand on hospitals in the form of Emergency Department attendances, acute admissions and potential loss of independence following a hospital stay, is an important priority across health and social care. (see also Section 3 for local hospitals' performance in relation to the Best Practice Tariff for hip fractures.)

In accordance with the Falls Pathway, GPs are alerted when one of their patients attends A&E or is admitted to hospital following a fall. People should then have a Clinical Assessment to rule out medical causes and be referred to the Falls service for a Multifactorial Assessment.
An important addition to the NICE guidelines CG161 June 2013 is the identification and inclusion of inpatients at risk of falling in hospital. The guideline includes:

- ◊ all patients aged 65 years or older
- ◊ patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition

NUH and Sherwood Forest hospitals have set targets for reducing inpatient falls as follows:

- ◊ Reduce the rate of falls (per 1000 bed days)
- ◊ Reduce the rate of falls resulting in harm (per 1000 bed days)
- ◊ Reduce the number of repeat fallers

Bassetlaw has introduced a CQUIN to prevent repeat falls for inpatients resulting in a reduction in the number of serious injuries from repeat falls from 101 to mid-20s in 2014/15.

4.5 Care Homes & Nursing Homes

Research has shown that people being admitted to a care home have a number of predominant characteristics and that a fall requiring a healthcare intervention is one of these. People in a care home or nursing home continue to have a higher risk of falling [5]

Good Practice guidance was issued to care homes in Nottinghamshire County in 2012 and this recommended that residents were assessed for falls risk on admission and ambulant residents were offered regular calcium and Vit D. A Guide to Action Tool has been developed specifically for care homes to use. Where a risk is identified, homes are expected to refer to the GP and Falls services for assessment.

Bassetlaw CCG has developed a CQUIN to encourage care homes to identify people who have suffered a fall in the last 6 months and carry out a risk assessment.

4.6 Service activity

Community Falls Services Activity

The tables below show referrals and activity for 2012/13 and 2013/14. The total number of referrals to County falls services was 5429 in 2012/13 and 5422 in 2013/14.

Figure 5: Referrals and activity for the Nottinghamshire Community Falls Service

2012/13:		Face to face Contacts	
Locality	**Referrals**	**New**	**Follow Up**
Bassetlaw	1039	622	2636
Mansfield & Ashfield	1232	951	3073
Newark & Sherwood	926	766	2452
Nottingham East	553	458	1023
Nottingham West	1028	875	2528
Rushcliffe	651	626	1830

2013/14:		Face to face Contacts	
Locality	**Referrals**	**New**	**Follow Up**
Bassetlaw	980	600	2240
Mansfield & Ashfield	1388	1120	3760
Newark & Sherwood	1104	844	2734
Nottingham East	324	249	739
Nottingham West	989	888	3713
Rushcliffe	637	631	1220

Inpatient Admissions

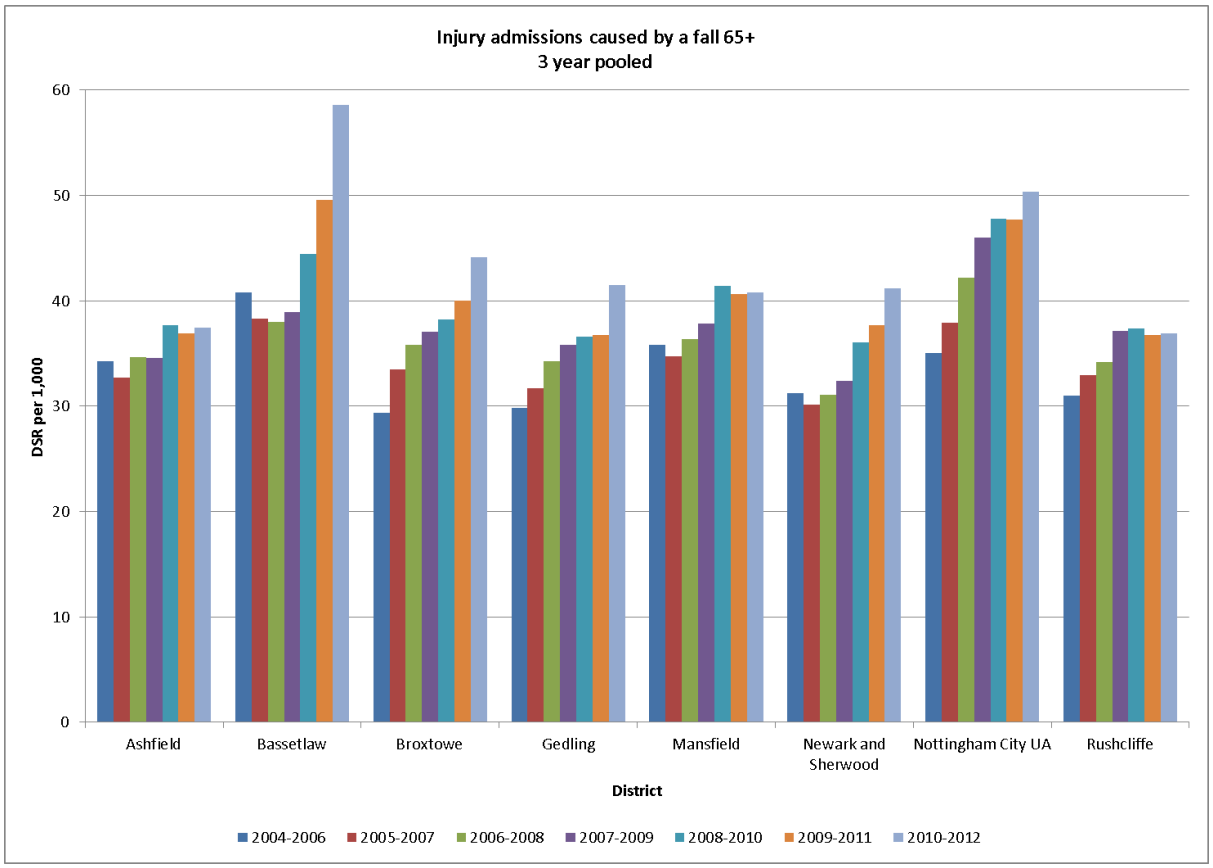
The figures below show the rate of admissions for a fall with injury and admissions for all falls (whether there was an injury or not).

These graphs show:

- Trends in admission rates caused by a fall 65+ per 1000 population since 2004
- Trends in admission rates by District

The data are only up to December 2012 and are not currently available to update. This may be revisited in the future however, it does show a useful picture of trends over the last decade.

Figure 6: Admissions caused by a fall with an injury, 65+, 3 year pooled



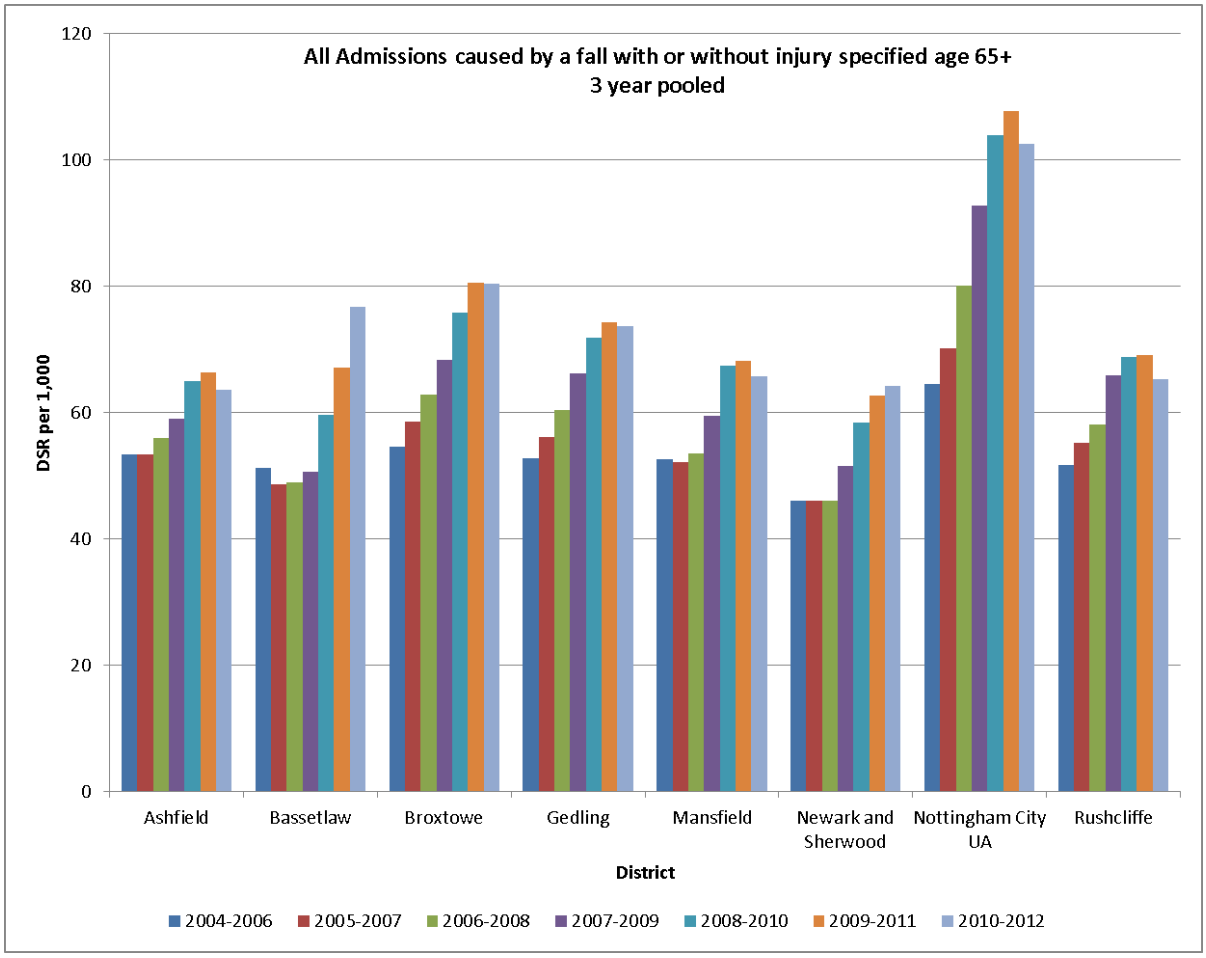
Source: eHealthScope

The overall trend in **admissions for an injury caused by a fall** (Figure 6) shows an **increase** in 5 out of 8 areas and this may be partly explained by the growth in the number of people aged over 65. Between 2009 – 2012, Ashfield, Mansfield and Rushcliffe admissions for an injury after a fall reduced. These areas represent the most deprived and least deprived in Nottinghamshire County and this requires further investigation.

The overall trend in **all admissions caused by a fall** (Figure 7) shows an initial increase followed by a **decrease** in all areas except Bassetlaw and Newark & Sherwood. Newark & Sherwood had a lower rate of admissions which could be expected for a more rural area. The figure shows Bassetlaw as an outlier for 2010-12, although local information suggests this may now be improving.

The two graphs taken together show that the number of people admitted, who have not suffered an injury, has reduced as a proportion of all admissions caused by a fall. This suggests that people are being admitted to hospital more appropriately.

Figure 7: all admissions caused by a fall, 65+, 3 year pooled



Source: eHealthScope

5) Evidence of what works

Preventing falls and fractures needs a combined approach that encompasses both[6]:

- ◊ Falls prevention intervention and
- ◊ Identification and treatment of osteoporosis where indicated

Evidence based interventions include population-wide strategies to promote appropriate weight-bearing and strength enhancing physical activity and healthy eating, through to maintenance of pavements [7] and providing general information such as the ROSPA website Facing up to Falls at www.rospa.com

5.1. Falls

5.1.1. Assessment and Prevention of falls

The full NICE guideline CG161, June 2013, summarises the evidence for:

- Risk factors
- Assessment tools including balance and gait, home hazards and fear of falling
- Interventions for preventing falls i.e. evidence of what works including compliance and cost effectiveness

The guideline recommends the following:

- ◊ Older people presenting with falls should be asked about history of falls (Case/risk Identification)
- ◊ Multifactorial risk assessment and interventions should be offered as listed below:
    - Strength and balance training – see Department of Health Document; Falls and fractures -Exercise Training to Prevent Falls *(*http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103151.pdf)
    - Home hazard assessment and intervention
    - Vision assessment and referral
    - Medication review with modification/withdrawal

Research supports and shows that the most effective intervention for falls prevention is a multifactorial assessment and management programme
http://www.bmj.com/content/328/7441/680,
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007146.pub3/abstract,
http://www.cph.org.uk/wp-content/uploads/2012/08/falls-in-older-people-a-review-of-evidence-for-prevention.pdf,
http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?LinkFrom=OAI&ID=12009105464

The College of Occupationla therapists has produced an up to date practice guideline reviewing evidence and setting out recommendations on the management and prevention of falls
http://www.cot.co.uk/sites/default/files/publications/public/Falls-guideline.pdf

5.2. Osteoporosis

NICE recommends: using GP lists to identify people at high risk of osteoporosis. Guidance on the use of bisphosphonates to treat and prevent osteoporosis is set out in TA161.

http://www.nice.org.uk/guidance/TA161

The British Orthopaedic Society *'Blue Book'* (2007) set out the evidence base for the care of patients with fragility fractures and in particular informed the development of the National Hip Fracture database.

http://www.bgs.org.uk/pdf_cms/pubs/Blue%20Book%20on%20fragility%20fracture%20care.pdf

http://www.nhfd.co.uk

Nottinghamshire Osteoporosis guidelines for men and postmenopausal women can be accessed using the following link:

http://www.nottsapc.nhs.uk/index.php/clinical-guidelines

5.3. Vitamin D

There is evidence to support that Vitamin D supplementation and combined Vitamin D and calcium in older people with deficiencies may reduce the risk of falling however there is varying evidence to support whether also contributes towards reduced fractures in this population.

http://www.bmj.com/content/339/bmj.b3692,

http://qjmed.oxfordjournals.org/content/99/6/355.full

NICE has issued new guidance on promoting Vitamin D supplements in at risk groups including older people and this is available at:

https://www.nice.org.uk/guidance/PH56

6) What is on the horizon?

Projected service use and outcomes in 3-5 years and 5-10 years

- ◊ The number of people in Nottinghamshire County aged over 65 is expected to rise from 154,100 in 2013 to 180,073 in 2021, an increase of 17%. This is likely to be associated with a corresponding increase in numbers of falls and fragility fractures, especially in people aged over 80.
- ◊ More complex co-morbidities e.g. dementia
- ◊ Publication of Falls Quality Standard expected in February 2015
- ◊ NICE guidance on Falls and Secondary Prevention in Older People May 2015

7) Local Views

Clinical views were collected via a stakeholder event on 15 May 2014

- ◊ Falls are 'everybody's business'
- ◊ Specialist falls teams were recommended by the NSF for older people[8] and many staff consider they are still required and should also address bone health
- ◊ However some concern about lack of communication between different teams
- ◊ Support for falls' lead clinicians
- ◊ More people fall than the specialist teams are able to manage
- ◊ Falls are a particular issue in care homes
- ◊ Access to postural stability classes is variable
- ◊ Integrate falls and bone health

Patient and Public views are available from the national Falls & Fractures Alliance members event report

Working Towards an Integrated Care Pathway for Falls and Fractures

http://www.nos.org.uk/document.doc?id=1518

What does this tell us?

8) Unmet needs and service gaps

Addressing falls and bone health enables older people in Nottinghamshire to increase healthy life expectancy. Public health outcome measures suggest that Nottinghamshire is performing well overall compared with the East Midlands and England and that fewer people are being admitted to hospital with a non-injurious fall. However a number of factors will widen unmet need and service gaps:

- ◊ increasing population over 65
- ◊ growth in numbers of people with osteoporosis
- ◊ co-morbidities such as dementia
- ◊ variation in outcomes across the county

Current unmet needs and service gaps include:

- ◊ capacity in specialist falls teams
- ◊ lack of communication and integration between different teams specialising in different conditions
- ◊ ensuring expertise and leadership in areas without a specialist falls team or lead clinician
- ◊ access to postural stability classes (Otago/FaME)
- ◊ slight increase in admissions to care homes following a fall (and subsequent management of falls in care homes)
- ◊ identifying and treating osteoporosis

Audit by the Royal College of Physicians, published in 2011, made 4 recommendations covering the Falls and Bone Health pathway[9].

- Improve outcomes and efficiency of care after hip fractures
- Access to Fracture Liaison Services in acute and primary care
- Early intervention to restore independence - through falls care pathway linking to acute and urgent care services to secondary prevention
- Prevent frailty, preserve bone health, reduce accidents through preserving physical activity, healthy lifestyles and reducing environmental hazards

9) Knowledge gaps

Information to audit the effectiveness of the falls pathway would be helpful i.e.

Information from hospital

- number of people aged over 65 identified within 2 days of an emergency admission who then
  - admitted following a fall receiving a CGA/multifactorial falls assessment
  - are discharged to GP with request for a multifactorial assessment (including bone health)
  - are readmitted due to a further fall

Information from General Practice

- number of people receiving a multifactorial clinical assessment (including bone health)

What should we do next?

10) Recommendations for consideration by commissioners

Falls and bone health assessments and interventions are multifactorial and may be provided by a range of health and social care providers. Commissioners will need to ensure that services and pathways are consistent with NICE guidance (CG161 and CG146), the recommendations in the Royal College of Physicians audit report and the forthcoming NICE Quality Standard.

Key priorities for implementation brought forward from CG161 (2004) are:

- Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s.
- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multifactorial intervention.
- New priorities include patients at risk of falling in hospital. A multifactorial assessment and multifactorial intervention should also be performed.

Osteoporosis guidance (CG146) recommends targeting risk assessment in all women aged over 65 and men aged over 75, and in women and men aged over 50 in the presence of risk factors e.g. history of falls.

In order to achieve this the main recommendations are:

- Explore implementation of comprehensive falls prevention programmes to prmote strength and balance
    - Exercise promotion e.g. using home care providers to encourage exercise
    - Falls prevention focusing on strength & balance training e.g. could also provide in day services
- Reduction of home hazards, use of aids and adaptations
- Learning & development for health and social care staff to:
    - Improve identification and case finding of people at risk of falling
    - Use of the Guide to Action tools
- Medication reviews, especially following hospital discharge
- completion of FRAX assessment for osteoporosis
- Local Falls and Bone Health co-ordinators in line with guidance
- Integration of the pathway across primary and secondary care to include bone health and clear referral to falls services
- Integrated crisis response services, assessing causes of a fall and putting preventative measures in place to reduce chances of further falls, focusing on treatment at home and in the community

Taken together these will:

- Reduce admissions to hospital and care homes as a result of falls
- Reduce falls in care homes and nursing homes
- Reduce falls in hospital

11) References

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[9] Falling standards, broken promises Report of the national audit of falls and bone health in older people 2010. Royal College of Physicians 2011