

**REVIEW OF FALLS IN OLDER PEOPLE IN
HAMPSHIRE**

FINAL REPORT

**FALLS REVIEW PANEL
MARCH 2011**

Falls Review

Conclusions and Recommendations

1. Introduction

- 1.1 The interest of the Health Overview and Scrutiny Committee which appointed the Review Panel was initially prompted by an assertion by South Central Ambulance Service (SCAS) that falls constituted 30% of their 999 calls. This Panel considered it important therefore to understand better falls demand and falls prevention services in Hampshire.
- 1.2 Falls in the elderly population not only affect confidence but increase the risk of injury to those individuals who fall; falls are also responsible for significant demand for health and social care services. Published evidence has consistently highlighted the need to proactively reduce the risk of falls and subsequent injuries as the numbers of older people increase in relation to the general population. In September 2010 the Review Panel invited NHS Trusts and other stakeholder organisations to provide evidence about falls and falls prevention services commissioned or provided in Hampshire. This paper summarises the responses received against three key themes of interest identified by the Panel, specifically:
- Overall strategy, commissioning and integration
 - Local demand and data
 - Success measures and cost effectiveness

2 Executive Summary

Process

- 2.1 Stakeholders were provided with the scoping document which contained the [Terms of Reference](#) for the review as well as an analysis of government and other national guidance. Each stakeholder was also asked to provide data and information in relation to their particular role in providing and managing health or social care services for people over 65 who experience a fall or who are at risk of falling.
- 2.2 Information was requested from:
- NHS and Adult Services Commissioners
 - NHS Acute hospitals
 - Community health and social care providers
 - South Central Ambulance Service

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- 2.3 Since the Falls Review Panel began its work, two reports of interest have been published that contain local data. Both focus on the consequences of falls. The *National Hip Fracture Database National Report 2010*, was published in August 2010 by the British Orthopaedic Association and includes an analysis of data received from the Basingstoke and North Hampshire, Queen Alexandra and Southampton General hospitals as part of a web-based national audit of hip fracture care.
- 2.4 The second report, *Benchmarking quality of care for fragility fractures in the South Central SHA area*, was published in October 2010 by the South East Public Health Observatory (SEPHO), and like the national report, it is clinically focused. The report for the South Central area is particularly relevant to this review in relation to the the need for fracture liaison services to be commissioned when it states that, “osteoporosis is a long term condition that affects a large number of people in England: one in two women and one in five men over the age of 50 will have an osteoporotic fracture of the hip, wrist or spine”. It goes on to say that, “Hip fractures are the most frequent fragility fracture caused by falls and the most common cause of ‘injury’ related deaths. Good clinical practice, based on national standards and evidence based guidelines, can:
- a) Reduce death and disability resulting from hip fractures, and
 - b) Prevent future falls and fragility fractures”
- 2.5 Later it asserts that “as hip fracture incidence and related costs increase, a key challenge is how to maximise the impact of interventions that reduce rates of osteoporotic fracture, within available resources”.

Themes and Issues

- 2.6 Written evidence from stakeholders has provided valuable insights into why the first two themes, ‘overall strategy, commissioning and integration’ and ‘local demand and local data’ are significant for Hampshire. However progress related to the third, ‘success measures and cost effectiveness’ is dependent upon reaching a clearer position in developing a strategic framework for managing falls and ensuring good data is available to measure demand and effectiveness. Evidence provided to the Panel suggests that this is not currently available. For the most part neither success measures nor cost effectiveness could at this time be supported by good and readily accessible data.
- 2.7 This Executive Summary includes the main findings of the Panel based on written evidence received (see Main conclusions, p.14) and additional [oral evidence](#) provided by stakeholders at witness sessions in January.

Overall strategy, commissioning and integration

Written evidence – Strategy and integration

- 2.8 In July 2003 the Department of Health published “guidance for commissioners to implement the NSF for Older People Standard 6 falls prevention” which sets out what should be included in an effective strategy. The Review Panel drew on this guidance in identifying what it believed were three key themes of relevance for Hampshire (see above). Written evidence from stakeholders included a ‘Falls and Bone Health Strategy’ developed by NHS Hampshire, and a ‘Joint Commissioning Statement’ provided by Adult Services. The NHS Hampshire document is high level and is not yet developed to the point where it could serve as a basis for commissioning or implementation. Specifically, it would require more detail to enable it to provide the following, as suggested by the Department of Health guidance:
- A baseline of information and a commitment to collecting and using good information to inform service development
 - Mechanisms for partnership working across the range of organisations, services and roles that contribute to resolution of falls issues
 - Clear roles and responsibilities for different partners
 - Mechanisms to involve users and carers
 - Evaluation of each element, their contribution to the big picture, and of the whole strategy, and of the relationships between interventions and systems access and capacity
 - Shared care pathways, referral pathways and assessment processes
 - Timetabled and funded plans for implementation
- 2.9 The NHS Hampshire strategy itself noted that the South Central Strategic Health Authority identified falls and bone health provision as a priority and it was working to develop “an audit of the metrics...to establish a baseline of data”. Accurate and consistent data is needed to underpin a good strategy as a framework for commissioning but the challenges this presented were clear in the evidence provided to the Panel. Other statements in the strategy in terms of it becoming ‘good’ were in the view of the Panel, aspirational.
- 2.10 The Adult Services ‘Joint Commissioning Statement’ was also high level and aspirational, and offered no baseline data about actual demand or costs to the service. Both the NHS Hampshire and Adult Services documents appear to have been produced independently and neither stakeholder made reference to the other’s strategy or strategic intentions in the evidence provided to the Panel.
- 2.11 Both NHS Hampshire and Hampshire County Council Adult Services tended to draw on statistical population based data sources that provided the basis for future demographic projections. Evidence

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provided to the Panel suggested that commissioners may have had little option than to resort to statistical data in the absence of good reliable locally rich data about falls that should reflect actual demand and service use in Hampshire.

- 2.12 The exception to this picture based on evidence provided to the Panel was the ongoing falls work in southeast Hampshire where in practice a *de facto* or implicit falls strategy appeared to have been in place over a number of years. Falls care and prevention for older people seemed to be better integrated between provider organisations in the area, and possibly significantly, had been led by clinicians rather than commissioners.

Oral evidence – Strategy and Integration:

- 2.13 NHS Hampshire provided little comment on the extent to which the Hampshire Falls and Bone Health Strategy stood comparison with a 'good' strategy as proposed by DoH guidance, except to acknowledge that more detailed data and information was now necessary.
- 2.14 The Panel noted that there appeared to be greater scope for integration of services and joint working. The southeast of Hampshire exhibited a greater degree of integration than was apparent elsewhere, although the Panel was pleased to acknowledge some work to improve this had been initiated in the Southampton area. Several acute providers expressed concern about the difficulty they have had in being able to plan for the discharge and follow up of falls patients in the community as community based services were inconsistent and that timescales for assessment or other support were so variable. For example one witness said referrals to treatment could take from 2 to 24 hours, another said Rapid Response services could take from 2 hours to 24 or 48 hours, and yet another mentioned time frames of 96 hours and up to 5 months. The overall impression was that acute and ambulance providers were not confident that community based falls services were able to provide consistency, reliability or sufficient capacity except in pockets of provision in the county. If these were accurate perceptions of community based health or social care, it reinforced the need for integrated and appropriately resourced approaches to implementing falls prevention that provide a consistent, reliable level of service across the county.
- 2.15 Comments by providers appeared to suggest that NHS commissioners had not taken ownership for their role in planning and supporting the development of falls prevention and bone health services in conjunction with providers in the county. Comments from providers were strong and consistent about the difficulty found in engaging with commissioners, with the exception of the NHS Hampshire lead commissioner for falls whose efforts to work with providers had been noted and appreciated.

Written evidence – Commissioning

- 2.16 Written evidence provided no clarity on what falls or falls prevention services were currently commissioned, nor any detail around commissioning, “new integrated falls services (that) will help to:
- improve care and treatment of those who have fallen, with an emphasis on preventing serious injuries which can lead to disability
 - provide rehabilitation and long term support needed to help older people regain mobility, confidence and independence.” (DH Older People’s NSF Standard Six)
- 2.17 Evidence from NHS Hampshire referred to the potential for commissioning ‘enhancements’ to current falls prevention services, but since Panel Members were still not clear what was already commissioned, it was not possible for them to be sure what the enhancements might refer to given the PCT’s written evidence which indicated reluctance to fund fracture liaison services without stronger evidence of cost effectiveness.
- 2.18 Their evidence also considered the potential for commissioning ‘fracture liaison services’, but NHS Hampshire proposed in written evidence that a service should be piloted in order to be convinced that it was cost effective. This was despite recommendations from the Royal College of Physicians (National Clinical Audit of Falls and Bone Health in Older People, 2007), and the Department of Health: Falls and fractures – effective interventions in health and social care (July 2009) that fracture liaison services are cost effective and should be commissioned by PCTs. It was not clear a pilot would be able to demonstrate cost effectiveness in the short to medium term.

Oral evidence – Commissioning:

- 2.19 NHS Hampshire identified ‘falls’ as a commissioning priority and recognised there was a commissioning gap, identifying the following as examples of where the ‘gaps’ existed:
- Additional bone strengthening and balance classes
 - Fracture liaison services
 - Fracture risk and bone health assessment
 - Bone density scanning
 - Education

These indicate that the PCT recognises that fracture liaison services represent a commissioning gap.

- 2.20 Hampshire County Council, Adult Services highlighted four joint commissioning priorities, including ‘enhanced integration across Health

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and Social Care', however it was not clear how this might be achieved in practice.

- 2.21 Both NHS Hampshire and Hampshire County Council Adult Services were unable to advise the Panel what falls provision or falls related provision had been commissioned, or what falls related costs had been incurred by community based services.
- 2.22 Community providers strongly asserted that no falls prevention services had been commissioned, despite attempts by them to engage with commissioners. In similar vein most providers had requested the PCT to commission Fracture Liaison Services, but again, one witness said that such requests had "fallen on deaf ears". Members took this as an expression of frustration by the witness.
- 2.23 A significant number of witnesses identified a lack of capacity in community based services, including Rapid Response Teams that impacted on their ability to respond to people who had fallen.
- 2.24 Significant concerns were expressed that primary care was not properly engaged in supporting the management of people who had fallen or who were at risk of falling, despite primary care being considered a crucial component of falls prevention.
- 2.25 Witnesses stated that falls needed a top down, joined up approach from commissioners – coherence was required to address these issues in a systematic way. There were said to be lots of individual bits of falls related activity on lots of providers' agendas, but it seemed harder now than it was 3 years ago to move forwards.
- 2.26 One stakeholder made the observation that commissioning should be against pathways of care, not historic pockets of provision. This recognised the need for commissioners to take an 'end to end' approach to commissioning within the context of a care activity matrix.
- 2.27 Falls and falls prevention services appeared to have been indirectly commissioned through funding provided for general community based services, for acute hospital activity coded by diagnoses, and for Adult Services for care related to loss of independence. However the inability to disaggregate the reporting and costing of falls related activity has meant that commissioners have not had good local data and instruments to understand and manage demand and associated costs through service innovation and whole systems planning.

Recommendations: Overall strategy, commissioning and integration

Recommendation One

- 2.28 That NHS Hampshire work together with providers of health and social care to develop an integrated falls and bone health strategy to meet agreed local needs and priorities as well as the DoH criteria for a 'good' strategy including an action plan for delivery. *An indicative timeframe would be for this strategy to be shared with the HOSC at its meeting in September 2011.*

Recommendation Two

- 2.29 That NHS Hampshire work together with providers of health and social care to update existing service specifications and care pathways to ensure the integration of services that clearly set out the roles, handover protocols and responsibilities for different partners, as indicated in the DoH criteria for a good strategy. This work will take account of the examples of good practice identified in this document. *An indicative timeframe would be for these specifications and pathways to be shared with the HOSC at its meeting in September 2011.*

Local data and local demand

Written evidence – Local data and local demand

- 2.30 Evidence provided to the Panel revealed significant difficulties experienced by health and social care in obtaining data and information about falls demand experienced by services. This caused consequential difficulties in being able to demonstrate the effectiveness of interventions and their potential impact on the lives of older people and the costs of falls and their consequences for the system.
- 2.31 Without reliable, good quality data it has been difficult or impossible to establish accurate patterns of demand on the system. The Panel is aware that falls in older people create demand at different points in the system; these might be summarised as those experienced by the:
- Ambulance service
 - Acute hospitals
 - Community based services
- (see Appendix One: simplified falls demand flows, pp.31 and 32)
- 2.32 The South Central Ambulance Service experienced demand for every call it received and every fall it attended. It either transported patients to an Emergency Department, or provided any necessary medical care at the scene and then referred the patient to a community based Falls Prevention Service without having conveyed them to hospital.

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Evidence received by the Panel enabled it to associate actual numbers with the demand experienced by the Ambulance Service, including how many older patients were taken to Emergency Departments and how many patients were not transported. It was not clear how many non conveyed patients were referred to community Falls Prevention Teams. Evidence indicated that falls in older people accounted for approximately 9% of 999 demand in Hampshire. This contrasted with a SCAS document that stated falls represented 30% of their 999 demand, but was consistent with other SCAS evidence that put falls demand at below 17% for all ages.

- 2.33 At acute hospitals the Emergency Departments experienced falls demand from patients transported to the hospital by the ambulance service, and from those who attended having travelled there independently. It admitted patients who, for example needed to be kept in for observation or who required treatment for injuries received. It also discharged some patients, referring them to their GP or a community Falls Prevention Service.
- 2.34 All hospitals apart from one either failed to provide information about falls attendances or underestimated them. The reason for this was that data collected in Emergency Departments typically captured only the patient's clinical diagnosis, thus failing to record the cause, such as an inadvertent fall. In this respect the 'core data set' was not fit for purpose, albeit Queen Alexandra Hospital recorded all falls attendances because the clinical lead recognised it was important to understand the impact of falls demand on the trust's services. The Queen Alexandra data indicated that at least as many older patients conveyed by the Ambulance Service due to falls arrived independently at the Emergency Department for the same reason. This pattern of demand was consistent with Department of Health assumptions in 'Falls and Fractures: effective interventions in health and social care' (2009).
- 2.35 Community based Falls Prevention Services experienced demand as a result of referrals from the ambulance service or other health providers. Referrals could come from any health or social care professional who identified older people at risk of falling through contact in normal clinical or social care contexts. Evidence provided to the Panel suggested that the demand experienced can be very high, leading to service deterioration. On the other hand, demand from some expected sources was thought to be less than it should have been. However it was difficult for community based teams to provide good, reliable data to support anecdotal reports of high demand. Furthermore it appeared difficult to provide clear evidence to support the value of falls prevention and interventions unless good data were made much easier to obtain.

Oral evidence – Local data and local demand:

Local data

- 2.36 It was generally acknowledged by witnesses that better and more locally rich data and information would be necessary for better planning and targeted commissioning.
- 2.37 Public Health involvement was identified as a potentially valuable source of population based information about health needs, including that related to falls and bone health. In addition it was believed to have an important part to play in promoting health and wellbeing messages related to falls.
- 2.38 One witness drew attention to the need for good local assessment data to help distinguish between those at higher risk of falling versus those at relatively low risk, if services were to be well targeted, appropriate and affordable. It was not clear that the data that do exist reached those who needed it for service planning.
- 2.39 Hampshire County Council, Adult Services indicated that the NHS generated a lot of potentially useful data from assessments and referrals but that they were rarely easy to access.
- 2.40 It was also clear from witnesses that more awareness existed for data to be produced in order to provide evidence for the cost effectiveness of falls interventions and other initiatives.
- 2.41 Witnesses confirmed that coding and recording of diagnoses only in Emergency Departments did not help commissioners or providers to understand the extent to which falls in the 65+ population impacted upon the system. Coding was described by one acute trust as “a massive issue”. Data from Queen Alexandra where falls attendances are recorded, have proved very useful.
- 2.42 Some clinicians whilst strongly agreeing that better data is essential in terms of testing out and improving falls care pathways, noted that with the increasing trend towards clinical specialisation and sub-specialisation it is not uncommon for falls patients to experience a string of referrals from one specialist to another; each referral representing the need to cross into another clinical area. Each specialist silo increases the risk that new data gets created and trapped in it, thus working against transparency and effective care. In one clinician’s experience it was not uncommon for patients to be referred again for assessments due to original data getting trapped somewhere.
- 2.43 For another witness one of their ‘top wins’ would be to ‘capture and use data to better target the right people’.

Demand

- 2.44 Data is essential if demand is to be quantified and understood as it is managed as it moves around the system. Care pathways can result in parts of the system getting “flooded” or primary care getting “swamped” as demand moves through the system. Witnesses noted that where capacity was challenged by demand, waiting times increased, and/or patients care could be compromised because of delays in assessing risk or providing falls prevention interventions such as poly-pharmacy.
- 2.45 It is significant that a strong theme emerged from acute and other providers that indicated a concern about the capacity of community based services to provide triage, assessments or interventions within acceptable timeframes. This was concerning since reliable and timely community services are a lynchpin in the evolution of health care as it shifts away from a traditional focus on acute or secondary care settings.
- 2.46 The Panel gained the impression from such comments and observations that clinicians in the acute sector in particular could be reluctant to handover responsibility for care of patients to community based falls services because of uncertainty about their capacity. Whilst good practice almost certainly existed in places, hospital clinicians needed to have confidence that good quality and timely care was provided consistently and reliably by colleagues across the community, not just in pockets. Unfortunately there was usually insufficient data available to demonstrate that care pathways were robust, effective, and delivered in a timely manner.

Recommendations: Local data and local demand

Recommendation Three

- 2.47 That NHS Hampshire work together with providers of health and social care to agree what information will be required to support the effective commissioning and delivery of falls services, and agree how and where the data need to be produced, shared and made accessible. *An indicative timeframe would be for the data and information communication framework/plan to be shared with the HOSC at its meeting in September 2011.***

Success measures and cost effectiveness

Written evidence – Success measures and cost effectiveness

- 2.48 The Department of Health ‘Developing a local joint strategic needs assessment’ (July 2009) estimated that “Falls prevention can reduce the number of falls by between 15 and 30%”. Local evidence provided to the Panel suggested that much better local data are essential to support effective planning, commissioning and focused falls prevention

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services by health and social care if better care is to be provided and costs are to be contained in all parts of the county.

- 2.49 Anecdotal evidence of success must in future be supported by disaggregation of current generic and unfocussed approaches to providing health and social care services. Instead, focused, lean management need to be adopted in order to achieve improved outcomes for patients and whole system efficiencies. Success will need to be evidenced in reduction in preventable falls, reduction of falls risk through good preventative care, and through the introduction of lifelong, sustainable interventions being adopted by older people as lifestyle choices. Data will need to be provided to enable the cost effectiveness of innovations and their impact across the system to be tested.

Oral evidence – Success measures and cost effectiveness

- 2.50 Whilst a number of witnesses could attest to successes within their local sphere of knowledge of falls care and prevention, few were in a position to demonstrate success based on good data in support of service performance, innovation and improvement.
- 2.51 One witness from the southeast area noted that one of the lessons learnt in their achieving more than most areas of Hampshire was to “measure as well as do”.

Recommendations: Success measures and cost effectiveness

Recommendation Four

- 2.52 That NHS Hampshire work with providers of health and social care to identify within an agreed framework how key aspects and components of integrated working can and should be measured to demonstrate success, cost effectiveness and improved patient outcomes. *An indicative timeframe would be for the framework of success measures to be shared with the HOSC at its meeting in September 2011.***

Additional important points raised in oral evidence

Innovation

- 2.53 Several witnesses recognised that the scale of the falls challenge, exacerbated by demographic and financial pressures, made it imperative to consider how better and more effective falls services might be developed for the benefit of older people and the whole system. Examples of new initiatives and ideas were provided by witnesses and suggested by Members, including:

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- A project to achieve greater integration between hospital and community based falls services with a desired outcome to reduce the length of hospital stays.
- A suggestion that an urban equivalent of ‘first responders’ could possibly be trained to provide specific types of care, including falls. This was later raised again as a possibility.
- A suggestion that the ambulance service might provide a dedicated falls resource or falls-based response teams
- The possibility that the ambulance service could provide mobile X-ray facilities for diagnosis of possible fractures.

2.54 It was noted that the danger of all potential ideas for innovation was that they are often conceived in a limited service context rather than taking a care pathway or system wide perspective.

Public Health potential

2.55 Public Health relevance was identified by several witnesses in terms of the promotion of health messages, a potentially significant role if the 85% of older people who are not intensive users of health or social care are to be reached. Public Health was also thought to have an important role in providing population-based health needs analysis and data as a means to prioritise and focus health and social care resources where they will have the most impact. Opportunities may also exist for Public Health to use its strengths in working across boundaries between statutory organisations and the voluntary sector to facilitate integrated planning and identify where innovation and new delivery models are crucial to sustainable solutions for the wider system. The new Health and Wellbeing Board could provide useful leadership and support in progressing the falls prevention agenda with the mechanisms available to it.

Fracture Liaison Services – primary care or acute services led?

2.56 Almost all provider witnesses noted the difficulty they had experienced in trying to persuade commissioners to ‘invest to save’, but to no avail. An often used example was the almost unanimous call by providers (see notes from oral evidence sessions at http://www3.hants.gov.uk/councilmeetings/meetingssummary.htm?sta=0¤tpage=1&tab=1&date_ID=797) for the PCT to commission fracture liaison services; this was considered to be an important component of bone health care for which good clinical and cost effectiveness evidence already exists. However whilst it was assumed by most witnesses that the service is naturally based in acute hospitals, other witnesses suggested it might better be led and provided by GPs or community based services.

Information and training

2.57 Witnesses identified the importance of readily available information and training, suggesting that the following would be useful:

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- Simple and practical information that does not talk down to or patronise the target audience
- Literature, the content of which is developed and agreed upon by all clinical stakeholders, including hospital, community and primary care clinicians – and thus would be consistent across the county.
- Literature / information that focuses on the positives of wellbeing and independence, and factual contact details for relevant services
- One provider emphasised the importance taking a practical and effective approach to training based on the organisation's considerable experience, for example providing practical, generalised falls / falls management training to as many front line – (patient facing) staff as possible in order to release specialists to work with more complex cases.

3 Main conclusions – Overall strategy, commissioning and integration

National guidance

- 3.1 The Department of Health in its guidance for strategy development, commissioning and for establishing the underpinnings for commissioning, consistently assumes that strategy needs to take an integrated perspective between health, social and independent agencies and that commissioning should be based on a joint strategic needs assessment (JSNA). The *Falls and fractures: developing a local joint strategic needs assessment* states that "An effective JSNA process is underpinned by:
- Partnership working - contributions from Local Strategic Partnerships members, including providers from all sectors
 - Community engagement
 - Evidence of effectiveness
- 3.2 Evidence from stakeholders has been considered against national guidance and expectations such as those cited above, and the 2003 Department of Health *guidance for commissioners to implement the National Service Framework for Older People – Standard 6 falls prevention*.
- 3.3 The Department of Health guidance suggests that a 'good' strategy should contain:
- A baseline of information and a commitment to collecting and using good information to inform service development
 - Mechanisms for partnership working across the range of organisations, services and roles that contribute to resolution of falls issues
 - Clear roles and responsibilities for different partners
 - Mechanisms to involve users and carers

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- Evaluation of each element, their contribution to the big picture, and of the whole strategy, and of the relationships between interventions and systems access and capacity
- Shared care pathways, referral pathways and assessment processes
- Timetabled and funded plans for implementation

Local strategy, commissioning and integration

- 3.4 **NHS Hampshire:** referred in their evidence to the establishment of a 'Hampshire Falls Commissioning and Advisory Group'. This group was described as being comprised of key stakeholders, and developed the *Falls and Bone Health Strategy* for Hampshire which was completed in late 2009. The strategy considered the demographic profile of Hampshire, district by district, and was informed by the Care Services Improvement Programme, and a number of other health data sources, the Office of National Statistics (ONS) and Hampshire County Council small area population forecasts. On the basis of the statistical evidence the strategy concluded that numbers of older people were rising and that falls admissions had continued to increase in recent years. The strategy appeared to assume there was potential for falls prevention services to reduce admission rates for people aged 65+ by 30%. This would be at the top end of Department of Health estimates for the impact of falls prevention (*Falls and Fractures: developing a local joint strategic needs assessment, 2009*)
- 3.5 NHS Hampshire anticipated " that the Hampshire Falls and Bone Health Care Strategy would provide the following outcomes:
- "An evidence based pathway of care that ensures a positive patient experience and the effective management of people who have fallen or who are at risk from falling. The strategy is to deliver equity of access to and consistency of provision of services across the County.
 - Evidenced based falls and bone health assessments and subsequent interventions.
 - Reduction in number of secondary osteoporotic fractures.
 - Reduced Emergency Department admissions due to fractures and falls."
- 3.6 The NHS Hampshire document seemed to be a work in progress in that it expressed the intention to undertake "a review and redesign of Falls and Bone Health Service" which indicated that key background work to understand current services and working arrangements across the county still needed to be put in place. In addition, it was currently at too high a level to provide the basis for a programme of implementation.
- 3.7 It is not clear whether the NHS Hampshire falls prevention service specification included the 'enhancement' of fall prevention services

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referred to in NHS Hampshire evidence, or whether it presented a new vision of what, in principle, should be provided.

- 3.8 In its response to the Panel, NHS Hampshire indicated that business cases were to be developed for the “*enhancement of falls prevention services and the introduction of Fracture Liaison Services*” with potential implementation from May 2011. However it also indicated it planned to set up a pilot in order to be assured that Fracture Liaison Services would be cost effective and justify the investment in setting them up.
- 3.9 The Hampshire Falls and Bone Health Pathway must also be considered a work in progress in that a) it omits reference to ambulance service involvement, and b) includes reference to fracture liaison services which are currently not commissioned and do not appear to exist in Hampshire, however the South East Public Health Observatories (SEPHO) report for South Central notes that Basingstoke and North Hampshire NHS FT “reported having a Fracture Liaison Nurse (FLN) or similar”; this could have inferred that the hospital provided fracture liaison services. However no evidence was provided by the Trust to support this however. The pathway diagram called itself ‘high level’ and provided little clarification around how falls services provided by different organisations were or should be integrated.
- 3.10 The NHS Hampshire response to the Panel made it clear that it was reluctant to invest in fracture liaison services until additional work was undertaken to provide evidence of their cost effectiveness. Service providers Solent Healthcare, Hampshire Community Health Care and Portsmouth Hospitals Trust (PHT) identified in their evidence the need for a ‘fracture liaison service’ to be commissioned. The 2010 SEPHO report also identified this need and echoed earlier national guidance in its key recommendations:
- “6) PCTs and local government should ensure a partnership approach to address local gaps in provision of an integrated falls and fracture prevention care.
 - 7) PCTs must ensure commissioning and provision of a fracture liaison service for the local population.”
- 3.11 **Adult Services:** recognised that a partnership approach was necessary for tackling falls and ‘maximising the impact of falls prevention’. In their evidence they said that, “A joint approach has been taken with NHS Hampshire through the development of ‘Joint Commissioning Intentions’. They then stated that the principles listed in the commissioning intentions “underpin Hampshire County Council and NHS Hampshire approach”. NHS Hampshire evidence however made no mention of the Joint Commissioning Statement, but neither did Adult Services make reference to the Falls and Bone Health Strategy developed by the Hampshire Falls Commissioning and Advisory Group.
- 3.11 Statistical data were provided by Adult Services, drawing on some of the same data sources as NHS Hampshire. These provided a basis for

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future demographic projections and both organisations took a similar approach in that the statistics pointed to growing demand for falls and bone health services as the proportion of older people in the population continues to grow.

- 3.12 Falls Prevention Services have historically been provided by Solent Healthcare and Hampshire Community Health Care (HCHC) in the southeast of Hampshire. A service has also been provided by HCHC in the Southwest of Hampshire, but it was not clear how these services had been commissioned and funded. A recent appointment by HCHC of a falls co-ordinator for the North of the county should help address the gap in falls prevention in that part of Hampshire which was identified as a key issue in the NHS Hampshire response.
- 3.13 The HCHC falls coordinator in the South East area participated in the following groups:
- The Portsmouth and SE Hampshire falls prevention team, working closely alongside Solent Healthcare
 - The HCHC specialist falls team
 - The South Central falls coordinators network
- 3.14 The HCHC falls coordinators also appeared to work closely with the Adult Services Older Person's Wellbeing team on strengthening and balance interventions, and with community matrons or specialist nurses for care homes. They have provided literature on falls prevention and support local councils and charities as resources have permitted.
- 3.15 The Adult Services 'Joint Commissioning Statement' provided in evidence and which was said to underpin the Hampshire County Council and NHS Hampshire approach to commissioning care, was high level and aspirational. The outcome sought was a "reduction in falls and associated injuries and fractures". "The measurements *that will be used to evidence improvements will be:*
- Reduced A&E attendance due to falls
 - Reduced number of falls related admissions into acute care
 - An effective universal pathway which is adopted and embedded
 - The wide spread use of an effective falls risk assessment tool
 - Better standards for effective prevention and rehabilitation services using benchmarking
 - Reduction in acute, community, rehabilitation and social care costs"
- 3.16 However, no mention was made in the Adult Services evidence of specific demand issues, commissioning costs or issues related to any of the proactive work undertaken by the department. It was not possible to determine the impact on other services or costs incurred by Adult Services as a result of falls or in support of falls prevention. Two factors need to be borne in mind, however, firstly, a fall is unlikely to be a presenting need for social care in its own right. Secondly, it would

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be more usual for the consequences of a fall to trigger the need for social care, such as the loss of independence, and therefore a 'fall' as such may not have been recorded by the system

- 3.17 Solent participated in the following strategy and co-ordination groups:
- The Falls Strategy Group – includes representation from Portsmouth City Council and local voluntary and private providers (since 2001)
 - The District Falls Prevention Strategy Group – covers patients in the geographical area of Portsmouth and South East Hampshire (“aims to overcome and direct strategic falls prevention issues that cross organisational boundaries”)
 - The Pan Solent Healthcare Falls Strategy Group – “to ensure that appropriate pathways are agreed and governance structures exist to support their delivery and monitoring...”
- 3.18 In 2008 Portsmouth became one of 18 national Health Reform Demonstration Systems in a collaborative project with PHT and Portsmouth City Council (PCC) to “improve the care of older people who have fallen by increasing the effective use of resources and infrastructure across the whole health and social care system operating in Portsmouth”. This project is ongoing and is very relevant to the interests of this review. It is built on sustained falls work in the area and has potential to provide valuable input to the development of falls prevention work in the county.
- 3.19 Since 2003 an agreed Falls Pathway has been in place between Portsmouth Hospitals and Solent Healthcare (formerly part of Portsmouth City tPCT) to refer on high risk patients to Specialist Falls Prevention Clinics. Low to moderate risk falls patients would be referred back to their GP for primary care-led assessment.

Summary

- 3.20 Possibly because the strategic framework is still at an early stage of development, evidence has revealed little of the commissioning challenges that currently exist. It is also apparent that in the absence of a clear and more fully worked out joint strategy, commissioners appear to have only high level aspirations to guide them. The expectation of the Department of Health was that a falls strategy offered a framework for commissioners, and it defined what a 'good strategy' should include. It is not clear when the Hampshire falls and bone health strategy might be expected to meet the Department of Health's criteria for a good strategy.
- 3.21 NHS Hampshire in its “Next Steps” section of evidence included a proposal to develop a business case for the enhancement of falls prevention services, but the Panel was not clear what this might

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include. The reference to a 'gap analysis' that might lead to more falls exercise classes would appear to be too limited, however the possible introduction of Fracture Liaison Services was possibly part of what the PCT was referring to.

- 3.22 It was not clear how Adult Services would be impacted by falls in the 65+ population. Examples of proactive work by the department to improve the health and wellbeing of older people were helpful, in particular the Better Balance for Life programme and Telecare initiatives that supported the falls agenda. However it is possible that these initiatives represented only a limited understanding of work undertaken by Adult Services that is relevant to falls and falls prevention.
- 3.23 Evidence provided to the Panel did not clearly demonstrate that commissioning for falls and falls prevention was driven by a joint strategic approach or framework, despite the Joint Commissioning Statement on Falls Prevention provided by Adult Services and the Falls and Bone Health Strategy developed by NHS Hampshire. It also seemed clear that commissioners of falls and falls prevention services must struggle to understand demand and related consequential costs in the absence of good data. Reference to actual local demand issues by either NHS Hampshire or Adult Services was conspicuous by its absence.

4 Main conclusions – Local demand and data

- 4.1 The Falls Review was initiated in part on the basis of information from South Central Ambulance Service (SCAS) that 30% of the 999 demand was due to falls. The ability of the service to respond to calls within the standard time frames set by Government depends on the availability of resources to respond to the demands made on it. If 30% of calls are for falls, then while the resources are being used for that purpose they cannot be used for other calls, some of which may be life threatening. Evidence from SCAS and other stakeholders is considered in this section in order to better understand demand for services associated with falls and falls prevention, how they are managed and where the system is challenged.
- 4.2 Each service considered below has its own demand challenges, but each is also impacted by, and impacts on, other services in the wider system. For example, demand for the ambulance service consists of responding to calls for people who have fallen. Demand then moves to Emergency Departments for those patients conveyed to acute hospitals, and to community falls prevention services for patients who are not conveyed, but who are then referred on by the ambulance service to a falls prevention service.
- 4.3 Falls demand on acute hospitals is not limited to falls patients conveyed by the ambulance service to Emergency Departments; other

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patients find their way independently to the hospital following a fall. Not all falls patients are admitted, but if they are, demand is transferred to bone healthcare services or other specialist areas. Non-admitted patients may either be referred to their GPs, falls clinics for assessment or to community based falls prevention services. Evidence indicates that one hospital has signed up to a pathway that includes undertaking an initial assessment of non-admitted patients whilst they are on site.

4.4 Ultimately, falls prevention services, including fracture liaison services are the downline recipients of much of the demand that has been channelled through the system. Therefore, this section on local data and local demand tracks, as far as possible, the falls journey as described by stakeholders in their evidence through the three main areas of demand:

- On the ambulance service
- On acute hospitals
- On community-based falls services

Simplified falls demand flow diagrams are included at Appendix One at the end of the document.

Demand on the ambulance service

4.5 Data received from SCAS indicates the following:

Falls demand for a 999 ambulance response for people aged 65+ and for all ages for 2009/10 in the county of Hampshire

Falls demand for people aged 65+			
Category A¹	Category B	Category C	Total

¹ Note that the ambulance service control centres classify the 999 calls they receive on the basis of telephone triage into three types:

Category A (emergency)

- Category A calls are those assessed as immediate life-threatening conditions where the speed of response may be critical in saving life or improving the outcome for the patient, e.g. heart attack, serious bleeding, etc.

Category B(urgent)

- Category B calls that are assessed as conditions which need to be attended quickly, but which will not deteriorate or suffer by a slightly slower response. These calls take precedence over any call time except those in Category A.

Category C (non-urgent)

Category C calls are considered on the basis of information provided as non life-threatening conditions. These are generally assistance calls in which someone needs help - perhaps to get up following a fall where no injury has been sustained - or where a minor or non-clinical issue is the prime cause for the call.

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555	5,039	6,906	12,500
(Falls demand for all ages)			
1,228	11,502	10,384	23,114

- 4.6 Category A calls (emergencies) comprised only 4% of falls related calls for the 65+ age group who had fallen, category B calls (urgents) comprised 40% of the calls, and category C calls (non-urgents) 55% of calls for this age group who had fallen.
- 4.7 The category A calls for the 65+ age group comprised 45% of all 'emergency' calls for falls. Category B calls for over 65s amounted to 44% of all 'urgent' calls for falls, and category C calls for over 65s 'non-urgents' comprised 66% of demand of all category C calls for falls.
- 4.8 Falls in over 65s (12,500) amounted to just over half the 999 demand for all falls (approximately 24,000). Seen in the context of all 999 calls made to SCAS in 2009/10 falls in older people represented about 9% of the total 999 demand (Categories A, B and C). This contrasts with the 30% figure that the earlier SCAS report referred to that was a catalyst for this review.

SCAS falls conveyances and non-conveyances for people aged 65+ for 2009/10

Falls destinations	Number of conveyances	Percentage of total ambulance falls demand for 65+
Queen Alexandra Hospital	2450	20%
Southampton University Hospitals	1829	15%
Royal Hampshire County Hospital	775	5%
Basingstoke and North Hampshire Hospital	682	5%
Other (eg. MIUs)	489	4%
Sub Total	6,225	49%
Non conveyances		
Number of falls attended but not conveyed to hospital	6,275	50%
Total falls attendances for 65+ (conveyances + non-conveyances)	12,500	

- 4.9 The above figures provided by SCAS show that:

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- Just over half the calls were resolved at the scene than were transported to an acute hospital.
- More calls were classified as non-urgent than the emergency and urgent categories combined.

4.10 The cost implications of each decision, eg. to convey a patient to an Emergency Department or to refer should be understood to complement the above data. If the average cost of attending an incident is £257, then 12,500 attendances would equate to £3,212,500. If the minimum Emergency Department attendance tariff (approximately £87 each for 6,225 patients conveyed to EDs) were added, the cost would rise by at least another £541,575. Not included here are admissions costs, nor the cost of referrals for non-conveyed fallers to local falls prevention services for assessment and possible interventions, because costs associated with community based falls prevention have not been provided in evidence (by commissioners or service providers).

Numbers of calls to SCAS for falls incidents at Care Homes in Hampshire

4.11 A significant part of falls demand for older people is from care homes. Data provided by the Specialist Commissioners for ambulance services showed the number of falls incidents per care home to which SCAS was called out during 2009/10. Over that period SCAS received a total of 1829 calls to attend care homes for residents who had fallen which was about 29% of falls calls for the 65+ age group. This equated to £470,053 for attendance costs.

Calls to SCAS due to falls at nursing / care homes during 2009/10 for 65+	
Number of care homes	Made the below number of calls
2	40-49
3	30-39
8	20-29
43	10-19
13	9
10	8
15	7
17	6
33	5
28	4
33	3
32	2
64	1

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- 4.12 An attempt was made to correlate the numbers of calls to SCAS by the size of care home and by registration category. For example it was thought that larger care homes might be responsible for most calls, or that a care category such as dementia which can be a predictor of falls would correlate with a higher volume of demand for patients who fall. However, no obvious patterns emerged. It is possible falls management varies according to the level of falls training received by staff who work at the homes.
- 4.13 It was not clear from evidence provided to the Panel whether falls training provided by Adult Services or community health care organisations is prioritised for care homes that make the most use of ambulance services for falls or whether other factors are used to prioritise training.

Demand on acute hospitals

- 4.15 Data provided by the acute trusts themselves reveal more about the ways in which falls are, or are not recorded, than about the actual demand that falls represent for Emergency Departments. As indicated in the Solent Healthcare evidence, falls are often regarded as a 'symptom' rather than a 'diagnosis', thus when patients attend Emergency Departments the coding system may reflect the cause, for example, a polypharmacy issue, or result of the fall, such as a broken wrist, rather than the fall itself for which no code may be available.
- 4.16 This situation appears to be exemplified by the evidence where one hospital was only able to identify from the standard recording codes 77 patients who may have attended Emergency Department because of a fall during 2009/10 despite SCAS reporting that 682 patients were conveyed there for that reason.
- 4.17 At the other end of the spectrum, another hospital that had recognised the difficulty of knowing which patients had attended the Emergency Department due to a fall, decided to enhance their reporting system to ensure that all attendances at the Emergency Department because of a fall were recorded. Over the year 2009/10 the hospital recorded 5,408 attendances for falls by patients aged 65+, while SCAS records conveying 2,450 patients (aged 65+) because of a fall. This example suggests that SCAS conveyances to the hospital comprised about 45% of the total falls attendances for patients of 65+. The actual attendances (those conveyed by SCAS plus those who arrived independently) represented about 5.8% of all people in that age group who attended the Emergency Department. That similar numbers of older patients arrive independently because of a fall confirms Department of Health assumptions.
- 4.18 Unless additional information is sought from patients when presenting at Emergency Departments and recorded by the system, demand on acute hospitals due to falls will be very difficult or impossible to obtain.

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Acute hospital data on falls attendances during 2009/10

Acute Hospital	'Falls' attendances recorded in the Emergency Department	Admissions	Non-admissions
Queen Alexandra Hospital	5408	3454 (64%)	1954 (36%)
Southampton University Hospitals	969	No information provided	No information provided
Royal Hampshire County Hospital	No information provided	No information provided	No information provided
Basingstoke and North Hampshire Hospital	77	39	38

- 4.19 The high figure for falls attendances recorded by the Emergency Department at Queen Alexandra Hospital results from an “internal process (that) has been developed with expert clinicians working with the Business Intelligence unit to implement a method of proxy coding” to “improve our understanding of the actual demand on the service”. This is a clear recognition of the limitations of the standard coding system with respect to providing useful data about falls and their potential impact on demand for falls related services.
- 4.20 The evidence from Portsmouth Hospitals Trust noted that prior to the enhancement of reporting on falls, under-reporting on falls was in the order of 31-32%. In all, during 2009/10 according to the enhanced recording system, the hospital had 5014 older patients coded with falls admissions equating to 64,000 bed days or averaging nearly two weeks each as in-patients. The minimum cost of 5014 patients presenting at the Emergency Department would be £436,218 regardless of whether they were admitted or sent home. The tariff for attendance at an Emergency Department ranges from £87 to £117.
- 4.21 If the QA falls admissions were to incur a relevant modest tariff of £1,300 then the 3,454 admissions would result in an approximate cost of £4.5 million. Admissions for hip fractures, fortunately a small proportion of the total, can cost six times the lower tariff for a falls related admission.

Demand on Community-based falls services

- HCHC

- 4.22 Demand from SUHT: despite attempts by HCHC falls prevention staff to raise awareness of falls / falls prevention with Emergency Department staff and to encourage them to refer at risk patients to community teams for falls assessments, “the number of referrals is extremely low compared with the number of patients attending those settings”.
- 4.23 Demand from PHT: older people attending QA Emergency Department after a fall are:
- assessed using a dedicated falls proforma
 - referred to one of three locality falls clinics. Patients are followed up according to need
- 4.24 Data from falls clinics are collated and show a 53% increase in referrals over the past two years. The consequence of this ‘success’, ie. the increase in referrals, is an increase in waiting lists for appointments. In addition, “The provision of specialist falls clinics (for older people) is patchy ... and has never been commissioned.”
- 4.25 Demand from SCAS: For the past year HCHC falls coordinators have worked closely with SCAS to develop a new system for the care of older patients who fall. SCAS crews are able to refer the non-conveyed patients directly to the patient’s local falls prevention service for further assessment. However, the consequent “...large number of referrals have caused huge resource issues...” HCHC indicates that possibly some filtering mechanism may be required if falls prevention services are to focus primarily on the over 65s and those at greatest risk.
- 4.26 Data for the three months from July 2010, indicates that referrals to HCHC from SCAS, were averaging about 66 per month. Previously referrals from SCAS averaged about 10 per month. SCAS itself has reported that referrals following attending falls across all of South Central amounted to about 20 per day (ie. approximately 600 per month). Further data are required to understand where SCAS is referring the patients to, and how many patients follow through with the referrals made for them.
- 4.27 HCHC says that initial signs indicate this initiative is helping prevent admissions, a claim independently echoed by SCAS which states that there are now less 999 incidents due to falls. HCHC have put further monitoring in place to provide better information about the number of referrals and prevented admissions. However no figures are yet available to indicate whether falls prevention is having a sustained impact on prevention of admissions; in addition it may be difficult to

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establish a clear cause and effect link between specific falls interventions and reductions in admissions due to injuries sustained from falls.

- Solent Healthcare

4.28 Solent Healthcare (East): has worked to a Falls Pathway established since 2003, initially agreed between PHT and what was Portsmouth City tPCT. The Secondary Care Falls Pathway generates demand from the Emergency Department which refers on high risk patients to the Specialist Falls Prevention Clinic. However, care pathways are only as good as how well they are put into practice, and evidence suggests that they work best when new or temporary staff are fully briefed not only on their own roles, but also on how their work affects or is affected by other parts of the system for successful outcomes for the patient. Solent evidence identifies, for example, instances where it appears that inappropriate referrals are made to intermediate care and rehabilitation teams. In integrated, complex care pathways like the Secondary Care Falls Pathway such experience reinforces the need for care pathways, systems and practice to recognise the challenges posed by boundaries and the tendency for silo working to introduce avoidable inefficiencies and affect outcomes.

Local Portsmouth 65+ patient falls attendance at QA Emergency Department for 2009/10

Total Falls Attendances	Admissions	Non-admissions
1730	1121 (65%)	609 (35%)
Hip Fractures for Solent Healthcare (East) Population		Hip fractures as a percentage of falls admissions
175		10%

4.29 Solent also comments that:

- About 20% of hip fracture patients are from care homes
- Hip fractures are considered an index marker of overall falls rates and that about 1% of all falls result in a hip fracture in any given area.
- “focused work may result in cost effective falls reduction”.

4.30 Solent Healthcare had previously sought to engage with and financially incentivise GPs through a ‘Locally Enhanced Service’ (LES) agreement to provide an agreed level of assessment for those not admitted to the acute hospital, but who had a low to moderate risk of falling. Take up of this ‘LES’ was poor and subsequently discontinued.

4.31 Manually collected data indicates that 49% of intermediate care Occupational Therapy, and 38% of intermediate care Physiotherapy

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referrals were for patients who had fallen. Such data, however was time consuming to obtain. Current management information systems do not provide the tools for good data collection and analysis.

- 4.32 Additional evidence included the following local data and cost estimates:
- there are 28,600 older people in Portsmouth
 - about 3,771 falls incidents (all ages) in Portsmouth are attended each year by SCAS
 - falls attendance (at £200 per attendance?) are estimated to cost £754,000
 - 2,000 falls admissions to the secondary pathway are estimated to cost £2,600,000
- 4.33 The figures provided indicated that the all ages falls demand on SCAS amounted to about 16% of 999 calls in Portsmouth city in 2009/10. Recent reference costs for an ambulance attendance were said by SCAS to be £257, this would have made the cost for attendances approximately £963,000 based on 2009/10 figures
- Adult Services**
- 4.34 No information was provided to indicate levels of demand on services or where the demand comes from. Consequently there is no clear information about the impact of falls related demand on resources or about what is commissioned against what assessed needs.
- 4.35 Adult Services evidence did, however highlight that “increasing numbers of older people falling will have an impact on the demand for social care provision”. It also stated, “..it is not currently possible to define exactly how many people utilise social care service just because they fall...”. The Adult Services evidence referred to independent research (Preventing Falls:..., Help the Aged, 2004?) that said 40% of people who enter care homes do so due to falls. It then went on to point out that residents of care homes were more than 3 times as likely to fall than those living in the community.
- 4.36 Adult Services appended statistical data to demonstrate variations in the rates of admissions due to accidental falls and for fractured neck of femur. While the standardised rates point to variations between districts, in terms of understanding actual demand faced by health and social care, the recording and reporting of good quality data is essential. In order for Adult Services to understand actual needs and demand, it would seem essential that good quality local data will be needed to complement current reliance on statistical sources.

Summary

4.37 Understanding demand on public services that arises when people experience a fall is a major issue in the consideration of falls and falls prevention services. There needs to be consistent and robust information provided to help service providers and commissioners understand how this demand can most effectively be managed. Demand has to be managed at three key points within the system:

- Demand on the ambulance service
- Demand on acute hospitals
- Demand on community-based falls prevention services

Demand on the ambulance service

4.38 Demand begins where the system and the patient first come into contact because someone has fallen. Ambulance services experience a significant proportion of the initial demand and evidence shows that for 2009/10 SCAS attended approximately 12,500 falls related calls for people aged 65+. However just over half this number were not conveyed to Emergency Departments, but were initially resolved by the service and referred to an alternative pathway. The rest, just under half, were conveyed by SCAS to Emergency Departments or similar facilities.

Demand at Emergency Departments

4.39 Evidence suggests that for every older patient transported to an Emergency Department by SCAS because of a fall, at least one other may arrive independently of the ambulance service, if the QA experience can be generalised across the county.

4.40 Emergency Departments generate demand for community-based falls prevention services, but based on QA experience more than 60% patients may go on to being admitted. Those not admitted may either be referred to their GP, assessed whilst in the Emergency Department and referred for community-based follow-up, or referred to a falls clinic.

Demand for falls prevention interventions

4.41 Demand for falls prevention may come from referrals from Adult Services, GPs, mental health services, care homes and secondary care as well as by SCAS. A recent policy adopted by SCAS in Hampshire has resulted in non-conveyed patients now being referred to falls prevention teams and these constitute a significant element of the demand experienced by HCHC teams.

4.42 The referral process is being reviewed to consider whether the most appropriate cohort of patients is seen by falls prevention teams; the demand is currently challenging resources and leading to long waits. It was also noted in evidence, however, that expected demand from one

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busy Emergency Department is low in relation to the number of patients believed to be attending in that setting.

- 4.43 The Solent evidence reported their attempts to incentive GPs to assess patients who have been identified as at risk of falling. GPs however have been reluctant to provide this service even though the evidence indicated this is important for focused falls prevention interventions. It would seem to be essential that primary care services are fully engaged in falls prevention.
- 4.44 Falls prevention includes a range of interventions, ranging from poly-pharmacy reviews, strength and balance exercise programmes, to assessments of living conditions to minimise risks and increase potential for independent living. Whilst patients can sometimes self refer, the system itself generates much of the demand for these services, some of which are provided by health, others by social services, and yet others by the voluntary sector.
- 4.45 In principle, a high demand for falls prevention services should in the longer term lead to reduction of demand for ambulance and acute care, and ultimately for falls prevention services themselves. Nevertheless the expected increase in numbers of older people over the next two decades make it imperative for falls prevention services to be well integrated, and play a significant role in managing down demand and costs in the system.
- 4.46 The design of care pathways needs to consider where scope may exist for efficiencies in a system that has considerable power to move demand around it, even when it appears to reduce demand and cost in one part of it. A system-wide approach will be essential to prevent sub-optimal solutions re-distributing demand and cost without benefiting the whole system.
- 4.47 HCHC comments that the provision of a Fracture Liaison Service based in acute hospitals is an essential component in reducing the longer term demand for unscheduled care for fractures resulting from falls in the over 65s. This has been identified as a service gap in Hampshire since the 2007 Royal College of Physicians falls and bone health audit. Despite attempts of HCHC and Solent Falls Co-ordinators to persuade commissioners to move this forward, they had achieved “no success”. It is not clear why existing national guidance failed to be sufficiently convincing that NHS Hampshire considered a local business case was necessary before Fracture Liaison Services might be commissioned. In addition, the recent SEPHO report on fragility fracture care in South Central has included within its recommendations that “PCTs must ensure commissioning and provision of a fracture liaison service”. Their argument is that “quality and cost of care are not in conflict”; better care is less costly to the wider system.

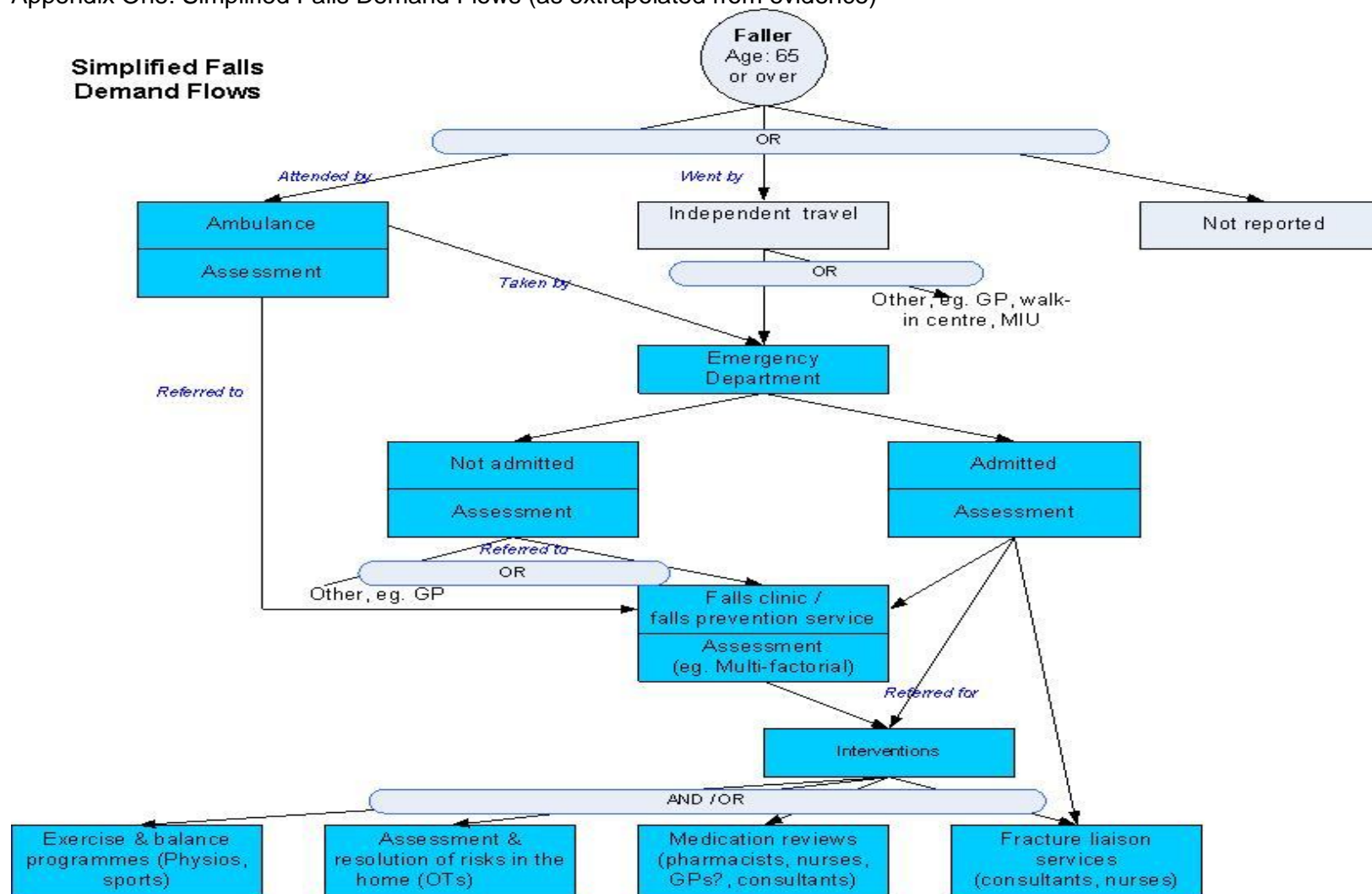
- 4.48 Another aspect of demand that is addressed by the Adult Services evidence is the department's focus on older people's wellbeing and associated work. This aims in general to promote physical and mental healthy independence for older people and is supported by the provision of good information, strengthening natural ties with society and practical help. In addition Adult Services has been playing a targeted role in conjunction with HCHC colleagues in falls training for care home staff, and running the 'Better Balance for Life' exercise programme for at risk frail older people. The demand here seems to result from older people self selecting to take advantage of programmes offered in literature and/or organisations/networks to which they belong. Evidence did not make clear the extent of demand, capacity to meet it or whether the health contribution is commissioned. Nor did Adult Services evidence indicate how or to what extent social care is impacted by the loss of independence experienced by older people following a fall or fall related injury.

5 Conclusions – Success measures and cost effectiveness

- 5.1 The Panel, aware of the financial pressures on health and social care organisations, recognised that the review should consider where evidence pointed to improvements in care due to integrated working and for which evidence existed for cost effectiveness and potential savings for the wider system particularly over the longer term, since benefits gained from falls interventions and prevention may not be realised immediately.
- 5.2 Evidence provided to the Panel, however indicated that insufficient progress had been achieved in terms of the development of a 'good' integrated strategy, also that local data, by and large, was inadequate to demonstrate cost effectiveness, especially with respect to being able to show how "quality...care that is prompt and effective – minimising delay, maximising recovery, and promoting early return home – is not only better care, but is also less costly" (SEPHO report, 2010)
- 5.3 Examples of progress and good practice were evident in evidence, but the impression was that it often tended to be clinically led, and happened despite the system, rather than with the support of commissioning or a good strategic framework and well defined outcomes that benefit the whole system, and hence the patient. In view of the dependence of success measures and cost effectiveness on the two previous sections of the review, the Panel considers that the priorities for Hampshire must be for improvements in strategy development and commissioning, and in establishing a "baseline of information and a commitment to collecting and using good information to inform service development" (How can we help older people not fall again? Implementing the Older People's NSF Falls Standard: Support for commissioning good services, DH, 2003)

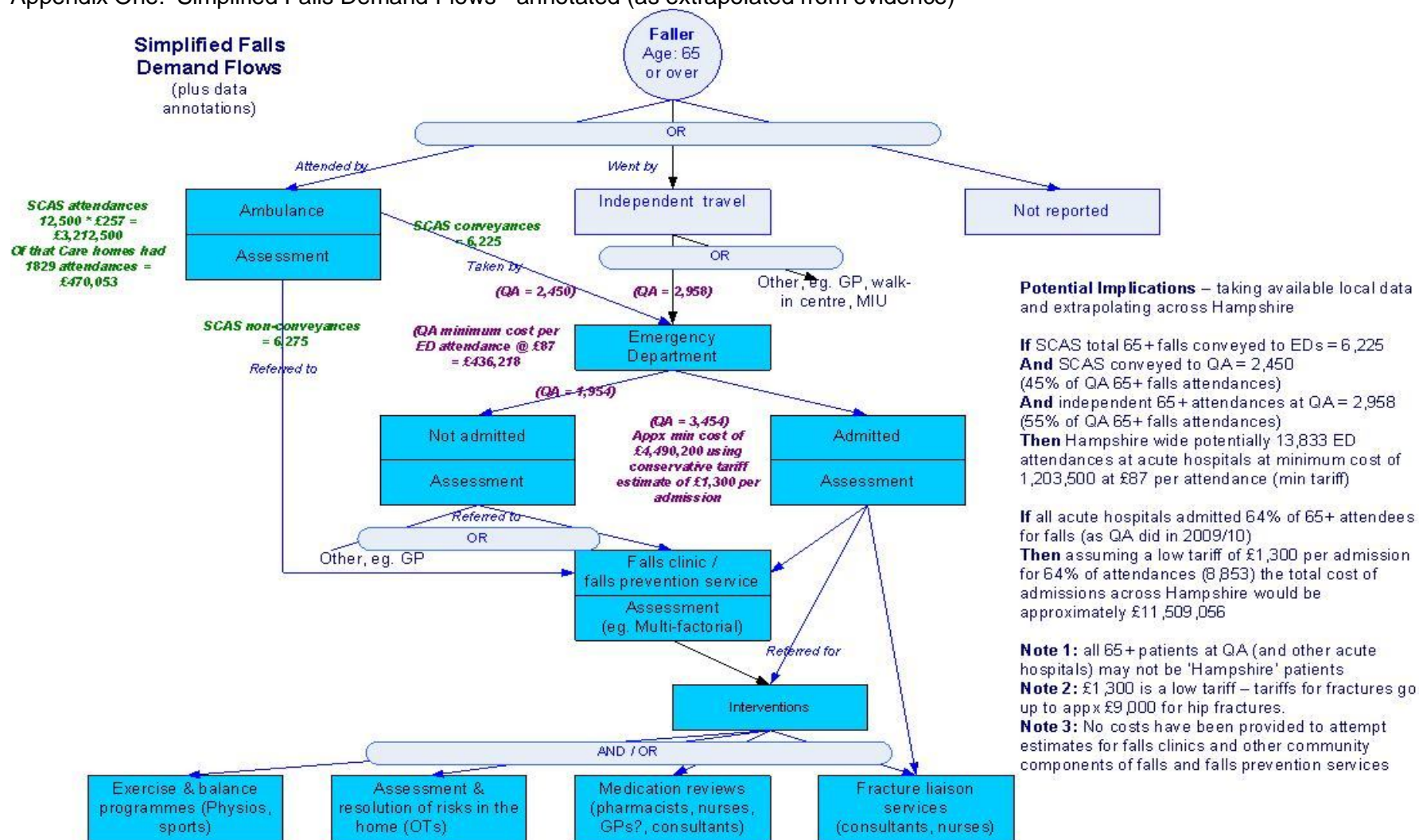
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Appendix One: Simplified Falls Demand Flows (as extrapolated from evidence)



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Appendix One: Simplified Falls Demand Flows - annotated (as extrapolated from evidence)



Draft