Falls

Initial Scoping Document – version 2

Introduction

'A discussion paper on the strategy for delivering service in the rural territory of the South Central Ambulance Service NHS Trust', 26 October 2009, states that " Falls represent around 30% of all 999 calls." (see SCAS comment on this percentage at the end of this paper). This statement prompted the Health Overview and Scrutiny Committee to set up a Review Panel to investigate this issue in order to understand the causes and extent of demand, and how this concern is being managed in the health and care communities, particularly in view of the consequences of not doing so as the percentage of older people, the most at risk of falling, increases year by year.

Terms of Reference

Purpose

The Review Panel proposes to undertake a 'light touch' review in order to understand better the drivers of demand behind the figures provided by the South Central Ambulance Service and what proactive and active measures are in place to mitigate or reduce the level of demand and the associated costs to the system.

The Panel has identified three themes of particular interest that are considered to be key to managing the significant impact that falls have on the lives and wellbeing of older people in the community, and their significant financial and resource impact on health and care organisations.

The three key themes identified by the Panel can be summarised as follows:

Overall strategy, commissioning and integration
National guidance on falls and falls prevention assumes that it is possible to significantly reduce the number of falls and the serious consequences of falls experienced by a proportion of older people. In 2003 the Department of Health set out "Guidance for commissioning to support implementation of the integrated falls service detailed in Standard Six of the NSF for Older People" (see Documents consulted, ref 12).

The Department of Health (see Documents consulted, ref 6) notes that "Falls Strategies offer a framework for commissioners" and that "Good Falls Strategies contain:

- A baseline of information and a commitment to collecting and using good information to inform service development
- Mechanisms for partnership working across a range of organisations…
- 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…

- Shared care pathways…
- Timetabled and funded plans for implementation.

The Review Panel will consequently consider how successfully the falls strategy for Hampshire provides the sort of 'good' framework indicated above.. Members will also want stakeholders to demonstrate how successfully both the elements and the whole system are working together to manage down demand, improve the wellbeing resilience of older people, and the cost effectiveness of interventions and wellbeing development initiatives

Local demand and local data

Frequent references are made in guidance and other documents consulted on 'falls' to difficulties in finding evidence or data to support, for example:

- The identification of the most effective multifactorial interventions (DH – see Documents consulted, ref 6)
- The evaluation of multi-agency falls prevention programmes (DH – see Documents consulted, ref 6)
- The development of business cases for reducing the incidence of falls or falls (Audit Commission – see Documents consulted, ref 10)

In addition, although Government documents suggest the probable extent of falls in a population, in order to plan for and invest in services, falls prevention interventions and in the 'background' building of wellbeing resilience, the planning needs to be backed by local, reliable evidence of demand and evidence of cost effectiveness of interventions as indicated by reductions in falls and the more severe consequences of falling.

The Panel will thus look for clarity on the extent of demand in Hampshire experienced by services in relation to falls, and for evidence of the impact of falls prevention and wellbeing resilience initiatives in reducing incidence of falls and bone fractures.

Success measures and cost effectiveness

Until recently little had been published about the costs associated with falls in older people and taking a more business-like approach. The Department of Health, 'Fracture prevention services: an economic evaluation', the Audit Commission, 'Financial implications for local authorities of an ageing population', and the Department of Work and Pension, 'LinkAge Plus national evaluation: end of project report' were all published in 2009. All three documents recognise the necessity for the local NHS, local authorities and other stakeholders to recognise the cost implications of not taking action and of not working together to address a potentially large and growing area of demand in health and social care. This is in the face of a conviction that:

- "There is strong evidence about the impact and cost benefit arguments for fracture prevention interventions" (DH, see Documents consulted, ref 11)
- "There is a clear financial case for falls prevention work" (Audit Commission, see Documents consulted, ref 10)

- "The LinkAge Plus approach has facilitated key services to help maintain independence and improve the wellbeing of older people, in a cost effective manner…an holistic approach to service delivery requires some up-front investment over the two-year pilot period but quickly begins to deliver net savings…" (DWP, see Documents consulted, ref 24)

In other words, this area of significant expense to the tax payer and of great significance for older people's wellbeing is an area in which it is possible to make substantial differences provided the will is there. Despite the strongly held belief that falls prevention programmes can be effective, it seems clear that there needs to clarity on success measure and on the information required to demonstrate the cost effectiveness of falls prevention interventions and other 'background' measures that strengthen wellbeing resilience and independence of living.

The Panel will therefore be very interested to know how stakeholders, particularly commissioners decide on success measures used and how the effectiveness of different falls prevention interventions is tracked and turned into information to support business case development for further investment in falls prevention and reduction of demand.

Scope

The review focuses on the population of over 65s who are at risk of falling or who have fallen in community settings. It will look at the health and social care services as a whole, being guided by the Government's expectations that they will be working together to provide integrated care for those at risk of falling with a view to mitigating that risk, reducing the likelihood of falling and suffering serious injury. The expectations of the Panel will therefore be set primarily by guidance provided by relevant agencies of Government.

Review Panel

- Cllr Pat West (Chairman)
- Cllr Liz Fairhurst
- Cllr Phryn Dickens
- Cllr Pam Mutton

Cllr Felicity Hindson and Susanne Hasselmann (NHS Hampshire Non Executive Director) to be invited as formal observers.

Indicative Stakeholders

Strategy and commissioning

- South Central SHA
- South Central specialist commissioning group
- NHS Hampshire as commissioners
- HCC: Adult Services

Providers

- South Central Ambulance Service
- Acute providers
- Hampshire Community Health Care
- Adult Services, in particular the Older Person's Wellbeing Team
- Solent Healthcare

Independent

- Third Sector/voluntary organisations, eg. Age UK (Hampshire)

Background

Some key facts (British Geriatrics Society, 2010)

- There are more people over 65 than there are under 18
- In the next 20 years, the number of people in England over 85 will double
- Almost two thirds of general and acute hospital beds are in use by people over 65
- Patients over 65 account for approximately 40% of all hospital bed days
- 43% of NHS spend is on those aged over 65
- Injury due to falls is the leading cause of mortality in people over 75 – (ONS in 2008 - 2,364 people over 75 died as a result of falls in Eng and Wales)
- Taking the BGS figures for their example PCT and LA, the equivalent figures for the Hampshire population would give approximately 181,320 people over 65, of these:
    - 62,455 will fall each year, 26,997 twice or more
    - Most will not seek help
    - 8,865 will attend A&E or a MIU
    - A similar number will call the ambulance service
    - 5,000 will have a fracture, with 1,450 of these likely to be hip fractures
- It has recently been estimated (Age UK) that falls among elderly people cost the NHS more than £4.6 million a day or £1.7 billion per year.

The implications of this for Hampshire are significant. Additional information from the Department of Health 'Fracture Prevention Services: an economic evaluation' (Documents consulted ref 11) cites a study which showed that over the course of a year for people aged between 60-69 of all fractures that year 8.8% were hip for 70-79 year olds it was 28%, 80-89 year olds it was 62.5% and for 90+ year olds it was 75%. For Hampshire this could mean that if 62,455 people over 65 had a fall, then approximately 2% or 1,450 might result in hip fractures. According to figures suggested by the economic evaluation the costs for Hampshire would be approximately:

Cost category per hip fracture (taken from Fracture Prevention Services: An economic evaluation, DH, 2009)	**Cost for each hip fracture** (taken from Fracture Prevention Services: An economic evaluation, DH, 2009)	**Cost for Hampshire assuming a possible 1,450 falls result in a hip fracture** (based on estimates of incidence in the population in the economic evaluation, DH 2009)
Payment by Results tariff	£10,170	£14,746,500 pa
NHS community service costs per community hospital admission	£1,600	£2,320,000 pa
Referral cost to intermediate care	£400	£580,000 pa
Local Authority social care costs (unit cost over 2 years on average)	£3879	£2,812,275 pa

(Table assumes 1,450 hip fractures pa in Hampshire)

It should be noted that this table is based on Department of Health estimates in the 'economic evaluation' paper published in November 2009. However the numbers could be underestimated because the number of actual falls experienced by older people is not known since 'most will not seek help'; ie. if the incidence of hip fractures is based on the number of falls experienced. It should also be noted that the costs for other types of fracture are not included here.

The 2008 CSCI 'Prevention, personalisation and prioritisation in social care' paper asserts that "accidental falls represent an annual cost to health and social care of £1 billion, with some 41% of this falling on social services". The estimates coming from different sources suggest that some take into account factors that others don't. The only thing that is common is that the cost of falls is very high for the older people themselves, and is likely to grow for health and social care unless all opportunities are taken to prevent falls and manage the risks intelligently.

Typical conditions associated with falls (taken from NHS Clinical Knowledge Summaries)

- Conditions that affect mobility or balance (such as arthritis, stroke, Parkinson's disease, arrhythmias, heart failure)
- Visual impairment (including problems with eyeglasses)
- Cognitive impairment
- Urinary incontinence
- Excess of alcohol
- Frailty (for example physical disability, general weakness)
- Drug treatments:
    - Polypharmacy (taking four or more drugs)
    - Drugs that can cause postural hypotension (such as antihypertensives)
    - Psychoactive drugs (such as benzodiazepines, antidepressants)

National Guidance

A selection of representative government guidance and framework documents on falls and falls preventions are briefly discussed below. Key themes and issues have been identified with a view to collectively providing a picture of what a falls programme in Hampshire might aspire to. The significance and implication of the extract in the South Central Ambulance document that drew the Committee's attention to this issue is that if falls comprised 30% of all 999 calls, then it has to be questioned whether all that can be done to contain this demand in the county, is being done? The following is intended to inform members' lines of questioning as they look at this topic in greater detail.

DH: How can we help older people not fall again? Implementing the Older People's NSF Falls Standard: Support for commissioning good services, 2003 (Documents consulted ref 12)

This guidance report draws on a considerable amount of published material, including the National Service Framework for Older People, 2001 and numerous other sources of information about falls and older people, such as the British Geriatric Society Guidelines: Falls and Bone Health Special Interest Group, 2000. It follows the 'guiding principles' adopted by the NSF which are:

- Person-centred care
- Whole system working
- Timely access to specialist care
- Promoting health and active life

The Standard expects, for example, that:

- The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their population of older people
- Older people who have fallen receive effective treatment and, with their carers, receive advice on prevention through a specialised falls service.

Associated with these expectations, milestones are provided such that by April 2004, local Health Improvement Plans should include the development of an integrated falls service, and by April 2005 all local health and social care systems should have established an integrated falls service.

Amongst the conclusions it draws from previous work and research, the report believes,

> "The number and range of initiatives designed to improve wellbeing and outcomes for older people make it imperative for commissioners to work across organisation and service boundaries if they are to take advantage of available resources."

In addition, despite the wealth of information drawn upon, they state,

> "However, there is remarkably little reliable published information on the cost effectiveness of falls prevention. What there is suggests that certain, targeted interventions are likely to be cost effective."

It is perhaps significant that neither the NICE clinical guidelines, nor the Department of Health's Falls and Fractures guidance have much to say about costs other than the latter which briefly notes that "falls have a significant cost to health and care services". The findings presented in the report, which is, in turn based on the foundation provided by the NSF and the principles it established, inform the subsequent guidance on what falls services are expected to provide. It is of interest, however that more than the later documents below, the 'Implementing the older people's NSF standard' stresses the importance of partnership working with local authorities in taking action to prevent falls and reduce resultant fractures or other injuries in their older population.

NICE Clinical Guidelines 21: Falls – the assessment and prevention of falls in older people, 2007 (Documents consulted ref 8)

The NICE guideline identifies key issues to do with:

- Falls prevention
- Falls assessment
- Interventions

The guideline tends to assume that falls become a focus particularly when healthcare professionals become aware that an older person has had a fall or possibly a history of falling, and therefore prevention work begins once a person is identified as being at risk of falling. The trigger for health professionals to begin an assessment of a person at risk is therefore, normally, awareness of the fall, but this assumes there is a system or process in place whereby awareness will result in a 'multifactorial falls risk assessment'.

A multifactorial falls risk assessment, depending on the person's situation may include:

- Identification of falls history
- Assessment of gait, balance and mobility, including muscle weakness

- Assessment of osteoporosis risk
- Assessment of the older person's perceived functional ability and fear relating to falling
- Assessment of visual impairment
- Assessment of cognitive impairment and neurological examination
- Assessment of urinary incontinence
- Assessment of home hazards
- Cardiovascular examination and medication review

Following the multifactorial risk assessment appropriate relevant interventions are considered. ***The most common and successful intervention programmes include:***

- Strength and balance training
- Home hazard assessment and intervention
- Vision assessment and referral
- Medication review with modification/withdrawal

The guideline establishes what it calls ***Principles of practice*** that include the importance of:

> ***Person-centred care***, including the expectations: that patients and carers be made aware of the guideline; that patients have a right to be involved in decision-making about them; that professions should be prepared to learn from those at risk who have been successfully self-managing; and that older people are made aware of the risk of falling at known critical times, such as when transferring between different care settings.
>
> ***A collaborative multi-disciplinary approach to care***, including that all members of multi-disciplinary teams should be aware of the guideline and that all care should be documented in the patient's records
>
> ***Organisational issues***, including: the importance of implementing a clear strategy and policy that is linked operationally to 'bone health' and 'cardiac pacing' services; the establishment of a culture of continuous improvement; the availability of education and training; and that patients should be treated by trained professionals who know how to initiate appropriate prevention measures.

The guideline does not cover falls in hospitals

It should be noted that the guideline does not cover hospitalised patients or patients who are bed bound. Anecdotal evidence however suggests that falls in hospital settings by older people tends to be more common than in the community, not least because there is a greater concentration of people who are in a more frail state in hospital.

The guideline could not recommend some interventions

On the basis that insufficient evidence currently exists to support the value of some interventions (not on the basis that they have no value), the guideline does not recommend:

- Brisk walking
- Low intensity exercise combined with incontinence programmes
- Untargeted group exercise
- Cognitive/behavioural interventions
- Referrals for correction of visual impairment
- Vitamin D
- Hip protectors

Need for better evidence

Section 4 of the guideline identifies that there is considerable scope to improve the evidence base around falls, for example:

- Further analysis of existing trial data is needed to identify which components of multifactorial interventions are important in different settings and for different patient groups
- Evaluation of multi-agency falls prevention programmes to measure the impact of these programmes on reducing falls, injurious falls and fractures in older people

Most of the guidance is quite specific and, perhaps understandably decontextualised in the sense that the principles need mapping to practical settings, and to patient pathway design in localities as part of an integrated service for patients.

DH: Falls and fractures – developing a local joint strategic needs assessment, 2009 (Documents consulted ref 6)

Whilst the NICE document tends to address specific issues that are significant for providing a falls service to individuals within a population, the Department of Health paper points out that commissioners have responsibility to ensure that they understand the potential demand within the whole population and should have reliable estimates of expected levels of falls and fractures based on local demographics and compared to national prevalence. Key to planning and commissioning must be clear evidence of the needs of the population

'Falls and fractures' highlights the seriousness of falling for people aged 65 and over. It notes for example that:

- each year 35% of over 65s experience one or more falls
- about 45% of people over 80 who live in the community fall each year, and of those 10 – 25% will sustain a serious injury
- Fewer than half of older people with a hip fracture return to their usual place of residence
- 80% of older women surveyed said they would rather be dead than experience the loss of independence and quality of life that results from a bad hip fracture.

The statistics give an indication of the human costs, but the costs of falls and their consequences for Health and Care are considerable (see the Age UK estimate above). Population need, the paper says, should be "captured in a Joint Strategic Needs Assessment (JSNA)" and "translated into services that support individuals who have these needs".

Outcomes from assessing needs, strategic planning and commissioning should be threefold, that is they should aim to:

- Reduce the number of falls
- Reduce the number of fractures
- Reduce the consequences of falls

The paper thus states that, "Commissioners across health and care therefore should assess the level of falls in their local population to ensure that sufficient preventative and treatment services are available". It goes on to say that commissioners should ensure that appropriate models of rehabilitation are in place for managing long term care costs by supporting individuals to reach their maximum potential for recovery following a fall.

It is assumed that the guidance is designed to ensure not just that commissioning addresses evidenced/real need, but that it will target health and care such that it reduces avoidable costs to the system. However it would appear that the extent to which focused commissioning and integrated implementation of falls services reduce the high financial costs associated with falls will remain unclear until good quality evidence/data becomes available, as suggested by the NICE paper.

CSCI: Prevention, personalisation and prioritisation in social care: Squaring the circle? 2008 (Documents consulted ref 22)

This report arose from and built upon the earlier review of Fair Access to Care Services (2008) out of concern about the potential tightening of eligibility criteria. The clear assumption is that access/eligibility criteria can provide a way of controlling demand and hence costs to the system. The authors observed there are competing drivers within the system such that one agenda may suggest a cost saving should be achieved in one place whilst another may provide motivation for an alternative approach (eg. paragraph 2.11ff), therefore careful analysis is required, particularly because different approaches may have different unforeseen consequences for people and the system itself.

The point is made that accidental falls represent an annual cost to health and social services of £1 billion, with some 41% of this falling on social services, therefore apart from the potential savings that could arise from preventing falls, benefits would also be won by avoiding a downward spiral of increasing dependency that can follow particularly serious falls. Despite the logic, the report quotes research that concludes it is "…impossible from this information to make generalisations about the cost effectiveness of falls prevention services" (Curry, 2006). This simply echoes the DH finding in 2003 (above) which identified the lack of published data or useful evidence around the costs associated with falls prevention services.

The report also cited other evidence which showed that participants in a prevention programme had better physical functioning that was not counted within the cost-effectiveness judgement.

Audit Commission: Financial implications for local authorities of an ageing population, 2009 (Documents consulted ref 10)

This review takes a mainly social care perspective that attempts to argue that it should be possible to make a business case for each intervention in terms of its cost-effectiveness. It assumes Opportunity Age (DWP, 2005) a cross-cutting older people's strategy, and Don't Stop Me Now (Audit Commission, 2008) report into older people's services. Underpinning the review is evidence from 8 LinkAge Plus pilots that accompanied the Opportunity Age strategy. The review states, "The final business case and LinkAge Plus end-of-project report give some cost cases for different approaches; the most solid case is for falls prevention...". Thus the cost dimension provided in this paper provides a useful supplement to other work considered in this scoping document. The interesting comment is made that, "There is a clear financial case for falls prevention work, but for other types of prevention, the argument is that prevention ought to lead to savings – but there is little evidence of this…". A distinction is therefore made between the 8 LinkAge Plus pilots in which the Audit Commission believes the evidence for the cost effectiveness of falls prevention work is more convincing than for some other interventions.

Despite being convinced by the "…clear financial case for falls prevention work…" from the LinkAge pilots, the final business case work accepted that there is "…currently a lack of cost-effectiveness evidence" but they believe that rigorous trials have a good chance of establishing the cost-effectiveness of falls prevention. It would seem to be incumbent upon commissioners and service providers to ensure that the funding is prioritised to those interventions that represent good value for money for the older person and the system as a whole. The system should therefore be designed to show the links between investment in interventions and reductions in demand and costs of treatment for the consequences of falls.

Summary of National Guidance

A considerable amount of government guidance, based on a large quantity of research has been produced over the last decade and beyond. Each of the documents cited above brings a particular perspective to falls in older people aged more than 65.

Key issues brought out in national guidance publications

Falls risk factors and assessment

There is little general dispute that there are predisposing risk factors for falls and that they are more prevalent in the older population, becoming more so as people become more frail. Risk assessments undertaken after a person has experienced a fall or several falls are designed to identify where intervention may be indicated, this might include a review of medications (polypharmacy – where a person is taking a number of medicines), or it could be a review of 'low level' risks in the home with a view to support people in living independent lives. Ideally an assessment by health or social care professionals would be better undertaken before the person falls, thus some documents say

that falls awareness and training is important for health and care professionals who often come into contact with older people, implying that knowledge of risk factors could be used more effectively to intervene early.

Interventions
As indicated above, interventions which focus on admissions avoidance occupy a continuum. They may range from 'high risk' interventions which are targeted at specific issues such as reviewing medications, to 'low risk', more generalised approaches such as supporting independent living. The National Service Framework lists a number of risk factors in the chapter on Standard Six: Falls, which seem to be linked to the intention to reduce the number of falls and their impact through:

- Prevention including the prevention and treatment of osteoporosis
- Improving the diagnosis, care and treatment of those who have fallen
- Rehabilitation and long term support

The first two bullets clearly reflect a medical model, however, the last implies the need to move beyond medical diagnoses to encompass a wider range of considerations and opportunities to reduce what might be called the 'background' level of risk, ie. those everyday things that benefit patients / older people. Government guidance seems to illustrate the existence and influence of two agendas or drivers. For example the NICE guideline (medical model) on falls specifically draws back from recommending some interventions because of lack of evidence, including group exercise if it is not "individually prescribed". However the business case for the LinkAge Plus work (social model) comments that "we have found evidence in the literature that exercise classes, particularly Tai Chi classes, provide benefits to taxpayers and participants by reducing the likelihood of falling and breaking a hip."

This distinction seems to draw out a medical model that is more comfortable with targeted interventions as part of falls prevention, and a social model that understands that reducing the background level of risk in the older person's everyday life may reduce the incidence of falls, their expensive consequences to the taxpayer, and threat to the lifestyle and outcomes for the older person.

Evidence
Falls prevention includes recognising risk factors, and consequently those who may be at most risk of falling. It also includes a range of potential interventions. As noted above there appear to be two perspectives on intervention; a tendency for health to value specific interventions for specific risk areas, whilst a more socially biased conviction that 'background' interventions are important and effective. Of interest is that NICE declines to recommend for example one type of intervention on the basis there is no convincing (or conflicting) evidence to support its value, and yet the LinkAge Plus business case finds evidence that does support it. Is it the case that different perspectives on falls prevention and intervention look for different kinds of evidence (or outcomes)? One of the difficulties here is that interventions designed to reduce background risk may be cumulative, for example, strengthening muscles, improving general body tone, installing grab

rails, improving lighting and/or visual performance, etc. may all be classed as 'low level', but together may have a significant impact on reducing the likelihood of a fall. Specific clinical interventions may be easier to measure or evaluate, for example, UTIs can seriously discomfort and disorientate an older person, but treatment may limit a period of higher risk to a discrete incident.

The CSCI paper, 'Prevention, personalisation and prioritisation in social care' (Documents consulted ref 23) captures this issue, "There are obvious problems with identifying cause and effect in falls prevention programmes, and the range of approaches…make it "impossible from this information to make generalisations about the cost effectiveness of falls prevention services.

Information and education

Consistent with the importance NICE attaches to 'person-centred care', its clinical guideline (2004 , Documents consulted ref 9) says that patients and their carers should be made aware of their 27 page 'information for the public' version also issued in 2004. Despite the clinical bias of NICE the principle that patients / older people should be made aware of the risks of falling, and how the risks can be minimised is right. It is also right that professionals recognise the opportunities they have to alert older people to possible risks and signpost them to where they can get further support and advice about risk avoidance. In order for an integrated falls prevention programme to work, it would seem clear that health and social care professionals who come into contact with older people, particularly those who may be at risk of falling, should encourage those people to actively take advantage of every opportunity to reduce background and specific areas of risk.

NICE (2004, see Documents consulted ref 9) says that to encourage the participation of older people in falls prevention programmes:

- Information should be relevant
- Programmes should be flexible enough to accommodate different needs, and
- Programmes should promote their social value

The NICE logic appears to be reasonable, however research commissioned by Help the Aged in 2005 revealed that the focus on falls and even falls prevention held negative connotations for many older people. Even when prepared to acknowledge the risk to themselves, it was common for them to prefer to take a chance rather than to accept the unpalatable association of falls with their old(er) age – unless with respect to someone else. Practical advice to do with home safety tended to be viewed as 'patronising', and wearing protection for hips was often regarded as 'unattractive' and therefore rejected.

The conclusion and advice from older people is that generally they will tend to respond more favourably to positive wellbeing enhancing initiatives typical of the 'background' interventions, than to being told they should do something to avoid negative consequences (Help the Aged, Don't mention the f-word, 2005 – see Documents consulted ref 21). The message, perhaps is that older people comprise a very large and growing customer group and it is in the interests of

health and social care to understand how their customers think and how to dialogue with them?

Integrated working

Two guidance papers make clear reference to joint working between health and social care. Both are examples of Department of Health guidance. The NSF for Older People expects that the NHS will work in partnership with councils in taking "action to prevent falls and reduce resultant fractures or other injuries in their populations of older people." (2001). Most of the guidance is based around clinical or NHS orientated elements of falls prevention, as is most of the suggested Falls Care Pathway. Social care comes into play around the protocols for discharge from hospital and subsequent non medical care in the community. For some patients, district or unitary councils will have a housing role.

More focused on integration of approach between health and social care is the recent guidance from the DoH, including the need to underpin commissioning priorities with evidence provided by a Joint Strategic Needs Assessment. The guidance puts the responsibility on commissioners to ensure that they base their commissioning on evidence of local need. Part of this should come from the JSNA, but where it is lacking or unreliable, the expectation is that commissioners will take steps to indentify strengths and weaknesses and develop reliable data. This should be the basis for understanding the level of demand and what health and social care needs to be commissioned.

The system

For a falls service to be truly integrated, all the parts need to work together. Most of the guidance assumes this is necessary, but is non prescriptive and not detailed. Local commissioners for health and local authority services will need to demonstrate how in their areas the individual parts join up into a coherent falls service. Guidance focuses more on principle and what needs to happen rather than how this is achieved locally.

Summary tables

Table One, below briefly summarises the main themes and concerns of the guidance and framework documents discussed earlier in this document.

Table Two, proposes indicative questions for stakeholders in Hampshire that are prompted by issues addressed in the guidance documents.

Table One: Summary of National Guidance

Document	Primary focus	Orientation	Key issues
Department of Health: How can we help older people not fall again, 2003 / National Service Framework for Older People – Standard Six – Falls, 2001	• Primarily clinical • Secondarily social • Person centred • Process	Health in partnership	• Consequences of falls • Risk factors • Assessment • Interventions • Fall prevention
NICE Clinical Guideline 21: Falls – the assessment and prevention of falls in older people, 2004	• Clinical / Health • Process oriented	Health	• Risk identification • Falls risk assessment • Falls interventions • Education and information giving • Research recommendations
Department of Health: Falls and Fractures – developing a local joint strategic needs assessment (JSNA), 2009	• Joint Strategic Needs Assessment applied to falls • System focus	Health & social care	• Partnership working • Community engagement • Evidence of effectiveness • Use of evidence and data to underpin commissioning
Commission for Social Care Inspection: Prevention, personalisation and prioritisation in social care: Squaring the circle? 2008	• Considers the relationship between costs to the system of interventions like falls prevention and uncosted benefits	Social care	• Costs to the system of interventions • Benefits to people that either are not or cannot be measured easily to justify costs
Audit Commission: Financial implications for local authorities of an ageing population, 2009	• Spending on services and the 'business case'	Social care	• Value for money • Business case thinking applied to falls prevention etc.

Table Two: Proposed indicative questions for stakeholders prompted by the 'three key themes'

Theme	Indicative Questions
Overall strategy, commissioning and integration National guidance on falls and falls prevention assumes that it is possible to significantly reduce the number of falls and the serious consequences of falls experienced by a proportion of older people. In 2003 the Department of Health set out "Guidance for commissioning to support implementation of the integrated falls service detailed in Standard Six of the NSF for Older People" (see Documents consulted, ref 12). The Department of Health (see Documents consulted, ref 6) notes that "Falls Strategies offer a framework for commissioners" and that "Good Falls Strategies contain: • A baseline of information and a commitment to collecting and using good information to inform service development • Mechanisms for partnership working across a range of organisations… • 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… • Shared care pathways… • Timetabled and funded plans for implementation.	*The Review Panel will consequently consider how successfully the falls strategy for Hampshire provides the sort of 'good' framework indicated above. Members will also want stakeholders to demonstrate how successfully both the elements and the whole system are working together to manage down demand, improve the wellbeing resilience of older people, and the cost effectiveness of interventions and wellbeing development initiatives* ***Questions for strategy and commissioning stakeholders*** 1. *Can you explain how the falls strategy in Hampshire was jointly developed with partners and how older people themselves contributed to it?* 2. *How would you evaluate the Hampshire Falls Strategy against the Department of Health document 'support for commissioning good services' issued in 2003?* ***Questions for provider stakeholders*** 1. *In what ways do you believe you could influence demand for unscheduled/urgent care through better system integration with respect to falls, and falls prevention work for older people?* 2. *What would be your top recommendations to encourage older people to take proactive steps to increase active, independent living and to reduce their risk of falling?*

Local demand and local data Frequent references are made in guidance and other documents consulted on 'falls' to difficulties in finding evidence or data to support, for example: • The identification of the most effective of multifactorial interventions (DH – see Documents consulted, ref 6) • The evaluation of multi-agency falls prevention programmes (DH – see Documents consulted, ref 6) • The development of business cases for reducing the incidence of falls or falls (Audit Commission – see Documents consulted, ref 10) In addition, although Government document suggest the probable extent of falls in a population, in order to plan for and invest in services, falls prevention interventions and in the 'background' building of wellbeing resilience, the planning needs to be backed by local, reliable evidence of demand and evidence of cost effectiveness of interventions as indicated by reductions in falls and the more severe consequences of falling.	*The Panel will thus look for clarity on the extent of demand in Hampshire experienced by services in relation to falls, and for evidence of the impact of falls prevention and wellbeing resilience initiatives in reducing incidence of falls and bone fractures.* ***Questions for strategy and commissioning stakeholders*** 1. *Can you explain what sources of information were used to support commissioning of falls and bone health in older people, what services were commissioned, and what proportion of spend was invested in falls prevention?* 2. *What reporting mechanisms/processes were put in place with providers to allow commissioners to determine the levels of demand, their potential impact on provider organisations, and to allow commissioning to obtain evidence of cost effectiveness in relation to investment in prevention approaches?* ***Questions for provider stakeholders*** 1. *What information have you typically provided about falls patients and what additional useful information to support better local integration of services could you provide without adversely affecting front line services?* 2. *Are all staff clear about information they can provide or that could be usefully provided to them by other health or social care providers for improved integration – and are they able to influence data flows to fit better with operational demands and improved outcomes?*

Success measures and cost effectiveness Until recently little had been published about the costs associated with falls in older people and taking a more business-like approach. The Department of Health, 'Fracture prevention services: an economic evaluation', the Audit Commission, 'Financial implications for local authorities of an ageing population', and the Department of Work and Pension, 'LinkAge Plus national evaluation: end of project report' were all published in 2009. All three documents recognise the necessity for the local NHS, local authorities and other stakeholders to recognise the cost implications of not taking action and of not working together to address a potentially large and growing area of demand in health and social care. This is in the face of a conviction that: • "There is strong evidence about the impact and cost benefit arguments for fracture prevention interventions" (DH, see Documents consulted, ref 11) • "There is a clear financial case for falls prevention work" (Audit Commission, see Documents consulted, ref 10) • "The LinkAge Plus approach has facilitated key services to help maintain independence and improve the wellbeing of older people, in a cost effective manner…an holistic approach to service delivery requires some up-front investment over the two-year pilot period but quickly begins to deliver net savings…" (DWP, see Documents consulted, ref 24) In other words, this area of significant expense to the tax payer and	*The Panel will therefore be very interested to know how stakeholders, particularly commissioners decide on success measures used and how the effectiveness of different falls prevention interventions is tracked and turned into information to support business case development for further investment in falls prevention and reduction of demand.* ***Questions for strategy and commissioning stakeholders*** 1. *What 'success factors' have been the main 'drivers' for commissioners and provider organisations in Hampshire?* 2. *How have the different cost and prevention 'elements' associated with 'success factors' been linked, monitored and measured in order to know where investment in interventions is most effective?* ***Questions for provider stakeholders*** 1. *What examples can you provide where you feel sure that fall prevention interventions or other initiatives to improve older people's wellbeing and independence of living have reduced the risk of falling?* 2. *What evidence could you provide that would strongly suggest where and which falls prevention interventions are successful, and how would you establish a causal chain of data/information to support greater funding for falls prevention?*

of great significance for older people's wellbeing is an area in which it is possible to make substantial differences provided the will is there. Despite the strongly held belief that falls prevention programmes can be effective, it seems clear that there needs to clarity on success measure and on the information required to demonstrate the cost effectiveness of falls prevention interventions and other 'background' measures that strengthen wellbeing resilience and independence of living. Further useful reviews of evidence for the value of interventions and approaches to them can be found at www.thecochranelibrary.com (see also Documents consulted refs 13 and 21)	

Hampshire Stakeholders: overview of known falls work by the Panel prior to commencement of the Review

The following attempts to capture a skeleton of known work and initiatives undertaken by key stakeholders in the county. Falls prevention is not new in Hampshire, and recent initiatives have added to ability of health and local authorities to provide a better service for older people, however the full range of provision and its impact on demand, including for emergency or urgent care is currently unclear.

South Central Ambulance Service

- SCAS 'discussion paper' states "Falls represent around 30% of all 999calls", however falls have also been said to comprise 16.58% of service demand in Hampshire for the year 2009/10.[1]
- A recent requirement is for ambulance crews to complete a form for every non conveyed 'falls' call they attend to refer the person to the falls prevention service.[2]

Hampshire Community Health Care

- HCHC has two Falls Coordinators covering the SE Hampshire and the SW / W Hampshire. The Review Panel may wish to ascertain how this service is actually commissioned.

Hampshire County Council

- The Adult Services Older People's Wellbeing Strategy is strengthened by the work taken forward by the Older People's Wellbeing Team. This proactive section is very effective in working with both statutory partners and voluntary agencies in developing and supporting initiatives to promote wellbeing and support older people's independence including falls interventions. Some examples include:
    - Older Peoples Wellbeing Team Falls pack and training due to start on 6 Sept with SCAS (Jim Hunt) for community responders!
    - *Better Balance for Life*: HCC OPWb Team (with HCHC/NHS support) programme aimed at over 65s. Pack of materials includes assessments, slide handouts, DVDs etc. for people attending workshops.

- In addition, Adult Services is engaged in:
    - Care homes falls training
    - Piloting a Telecare warning devices, including one that automatically detects if an older person suffers a fall and raises an alarm call.

Portsmouth Hospitals Trust

- Portsmouth Hospitals has a Falls Coordinator who works in the acute hospital and across the Portsmouth area. This service apparently links in with the falls prevention work in SE Hampshire.

NHS Hampshire (PCT)

- NHS Hampshire apparently has a 'falls and bone health' commissioner and a falls service specification.

NHS South Central (SHA)

- NHS South Central has an executive lead for falls, what role the SHA takes vis-à-vis Hampshire or other localities is unclear.

Documents consulted

1. A discussion paper on the strategy for delivering service in the rural territory of the South Central Ambulance Service NHS Trust, SCAS, 2009
2. Ageing Populations: strategies for best practice, Audit Commission, 2008
3. Clinical practice guideline for the assessment and prevention of falls in older people, NICE/Royal College of Nursing, 2004
4. Determinants of disparities between perceived and physiological risk of falling among elderly people: cohort study, BMJ, 2010; 341:c4165 doi: 10.1136
5. Don't stop me now: preparing for an ageing population, Audit Commission, 2008
6. Falls and Fractures: Developing a local joint strategic needs assessment, DH, 2009
7. Falls and Fractures: Effective interventions in health and social care, DH, 2009
8. Falls: The assessment and prevention of falls in older people, Clinical Guideline 21, NICE, 2004
9. Falls: the assessment and prevention of falls in older people: understanding NICE guidance…, NICE, 2004
10. Financial implications for local authorities of an ageing population: policy and literature review, Audit Commission, 2009
11. Fracture prevention services: an economic evaluation, DH, 2009
12. How can we help older people not fall again? Implementing the Older People's NSF Falls Standard: Support for commissioning good services, DH, 2003
13. Interventions for preventing falls in older people living in the community (Review), The Cochrane Collaboration, 2009
14. LinkAge Plus national evaluation: End of Project Report, Department of Work and Pensions, 2009
15. Mortality statistics: Deaths registered in 2008, Office for National Statistics, 2009
16. National Clinical Audit of Falls and Bone Health in Older People, Healthcare Commission/Royal College of Physicians, Nov 2007
17. National Service Framework – for Older People: Standard Six: Falls, DH, 2001
18. Older People's Experiences of Falls and Bone Health Services (England), HQIP, Help the Aged, Royal College of Physicians, 2008
19. Older People's Experiences of Falls Prevention Services, HQIP, Age UK, Royal College of Physicians, 2010
20. Older People's views of advice about falls prevention: a qualitative study, Health Education Research, 2006
21. Population-based interventions for the prevention of fall-related injuries in older people (Review), The Cochrane Collaboration, 2008
22. Prevention, personalisation and prioritisation in social care: Squaring the circle? CSCI, 2008
23. Preventing Falls: Don't mention the f-word! Advice to practitioners on communicating falls prevention messages to older people, Help the Aged, 2005
24. The Business Case for LinkAge Plus (updated version), Department of Work and Pensions, 2009
25. Urgent Care Pathways for Older People with Complex Needs – best practice guidance, DH, 2007

Notes

Comment from SCAS on two points above

[1] The 30% is mostly likely to be primary and secondary causes and obviously patients of all ages. i.e. a toddler who has fallen over and knocked his head. Over 65 year old fallers represents between 12 – 16% of our work load, we will be doing a piece of work to assess this figure further. There are also variations in these figures based on time of year for example during the bad snow and ice last year our attendance to fallers of all ages increase.

[2] A comment on page 16 of your document under South Central Ambulance Service point 2.
12th of July saw SCAS roll out a new referral process for non-conveyed over 65 year old fallers. On average before this across SCAS we would refer about 40 fallers to specialist fall teams in the first month of using a central form to a central number we have referred over 500 patients. We are now going to start collecting data from the individually teams to access what they have done for this group of patients and over what time period. So just a correction we don't refer all fallers only non-conveyed over 65 year old fallers.

Indicative Timeline for Falls Review

Task	September	October	November	December	January
Update scoping document (SD) -MC	V2 distributed 8/9				
Review Panel approval of SD -Panel					
Distribute to stakeholder organisations with letter/questions requesting responses by 22 October (4 weeks) -MC	By latest 17/9				
Meeting of Review Panel early November to consider responses and decide next steps, eg. possibly setting up evidence session(s) -MC, Panel			Nightingale booked 1/8/2010		
Write draft report -MC					
Review Panel consideration of draft and recommendations -MC, Panel					Nightingale booked 5/1/2011
Draft report consideration at HOSC -MC					By 19 Jan