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KINGSTON

INTEGRATED FALLS STRATEGY

2005 - 2008

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1. BACKGROUND

Every year between 33 and 50 per cent of people over the age of 65 suffer a fall. Most falls occur in the home (67% in Kingston[1]) whilst performing every day tasks and it is believed that 30-40% of falls could have been prevented. For every 100 of those people who fall, 20 will need medical help and just under 10 will sustain a fracture. 40% of admissions into nursing homes are triggered by a fall[2]. Falls can lead to a long stay in hospital and can result in people experiencing a loss of confidence, self esteem and reduced independence.

Falls can often result in a ‘long lie' for a person who is unable to get up from the floor. This can have potentially serious consequences such as hypothermia, bronchopneumonia and pressure sores. A 'long lie' of 12 hours or more can seriously affect a person's recovery from a fall. Falls can often result in fractures, most commonly in the hips and wrists. People with osteoporosis are likely to sustain fractures more often.

The consequences of a fall can be described in three categories:

Physical Consequences: Discomfort, pain, serious injury, inability to look after oneself, long term disability

Social Consequences: Loss of independence, loss of social contacts, loss of home, move to residential care, financial costs of help/care/hospital, decreased quality of life, changes to daily routine.

Psychological Consequences: Loss of confidence, fear, distress, guilt, blame, anxiety, embarrassment

The Department of Health has identified several key risks associated with falls. The risks have been split into intrinsic and extrinsic factors which relate to an individual’s condition or environmental factors respectively.

Intrinsic risk factors include[3]:

- Balance, gait or mobility problems including those due to degenerative joint disease and motor disorders such as stroke and Parkinson’s disease
- Taking four or more medications, in particular centrally sedating or blood pressure lowering medications
- Visual impairment
- Impaired cognition or depression
- Postural hypotension.

[1] Partnership Progress report, July 2003
[2] http://www.active-for-life.com/
[3] NSF for Older People, Standard 6: Falls, 6.11

Risk factors in the home environment include[4]:

- Poor lighting, particularly on stairs
- Steep stairs
- Loose carpets or rugs
- Slippery floors
- Badly fitting footwear or clothing
- Lack of safety equipment such as grab rails
- Inaccessible lights or windows.

Local work in Kingston has further identified an intrinsic risk for those who have a cognitive impairment.

Alongside these factors has been identified the reluctance in some of those people who have fallen to report incidences of falling due to concerns and fears over losing independence. The following is an example of how falls can affect the individual concerned and their family.

> The patient was 65 when he fell backwards down the stairs of his home. He broke his shoulder and damaged his spine. Already disabled as the result of a mining accident when a young man, this fall took away the mobility he had striven so hard to maintain.
>
> Months later he is still in hospital receiving physiotherapy to try and recover some movement in his legs and arms. It is still not known whether he will walk again. He is deeply depressed by his situation. He and his wife face having to leave the house they have lived in since they married in 1955, and move to a bungalow. His son and daughter-in-law, who have two small children, have taken on an increasing role in the care of both parents. An additional source of care will be needed when the patient leaves hospital. The patient's wife is suffering from stress and anxiety as a result of the uncertainty in their lives. Both the patient's wife and son had given up smoking in the past, but resumed in the aftermath of his accident[5].

This story highlights the burden on individuals, their partners, their families and the repercussions one accident can cause. Multiply this by the thousands of cases throughout the country and the scale of the problem in medical, social and financial terms become apparent.

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[4] NSF for Older People, Standard 6: Falls, 6.12
[5] http://www.fallsprevention.co.uk Cornwall StHA and PCT

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2. NATIONAL TARGETS

National Service Framework for Older People - Targets

The National Service Framework for Older people identified nine standard areas, one of which is related to falls (Standard 6) in Older People. The standard is as follows:

Aim[6]

To reduce the number of falls which result in serious injury
To provide effective treatment and rehabilitation for those who have fallen

To achieve this:

The NHS, working in partnership with councils, will take action to:

- Prevent falls and reduce resultant fractures or other injuries in their populations of older people
- Ensure older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialised falls service.

NSF Key Milestones

April 2003: Local healthcare providers should have audited their procedures and put in place risk management procedures to reduce the risk of older people falling.

April 2004: The Health Improvement Plan (HIMP), and other relevant local plans developed with local partners should include the development of an integrated falls service.

April 2005: all local health and social care systems should have established an integrated falls service

[6] NSF For Older People, Standard 6: Falls

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NICE Guidelines – Falls– The Assessment and prevention of Falls in Older People published in November 2004 outlines 5 key priorities for implementation of a falls service.

- Case/risk identification
- Multi functional interventions
- Encouraging the participation of older people in falls prevention programmes including education and information giving
- Professional education

NHS National Institute for Clinical Excellence Clinical Guidelines 21: Falls The Assessment and Prevention of Falls in Older People November 2004.

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3. NEEDS ASSESSMENT

This assessment is based upon the needs assessment in the Joint Strategy for Services for Older People. The assessment focuses upon and highlights the target population who may benefit from a joint health and social approach to the prevention of falls. A fall is identified locally as follows:

> *"The unintentional coming to rest on the ground, floor, or at some other level not as the result of a major intrinsic event (e.g. a stroke)"*

Included in this assessment are population projections, the number of patients admitted to hospital with falls, prevalence of falls and associated ailments, and the numbers of patients using existing services.

3.1 Population projections

For the purpose of this document "older people" will refer to those aged 65 years and over although it is recognized that people below 65 years also fall which may result in long-term disability.

Across England and Wales there is a national increase in the number of older people although this is not reflected in Kingston projections where numbers are decreasing. Table 1 shows that the total number of older people was expected to fall from 19,959 (13.3%) in 1999 to 18,476 (11.9%) in 2005. After that the numbers of older people will start increasing again as the current cohort of middle aged people reach 65. Women account for 59% of older people and this proportion is expected to decrease slightly to 57% by 2006.

Table 1: Estimated and projected numbers of people of over 45 in Kingston and in England and Wales in 1995, 2000 and 2005

Year	Age Groups			
	45-64	65-74	75-84	85+
Kingston				
1995	30,477	10,544	7,668	2,712
2000	33,144	9,575	7,349	2,832
2005	35,064	9,275	6,724	2,477
England & Wales				
1995	11,730,114	4,554,427	2,734,171	948,153
2000	12,398,139	4,355,595	2,898,190	1,054,699
2005	13,245,166	4,431,518	2,997,810	1,071,171

Source: Compendium of Clinical and Health Indicators, 1986-2001

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3.2 Mortality - Falls

The standardised mortality rate shows how the death rate from falls in Kingston compares with the death rate from falls nationally. Age standardisation adjusts crude death rates to take account of the differences in age structure. A ratio of less than 100 means there were fewer events than the national figures and a ratio greater than 100 means there were more.

Table 2 - Age standardised mortality rates for the key causes of disease comparing Kingston to national figures

Condition	*Age specific death rates/100,000*			
	65-74		75+	
	National	Kingston	National	Kingston
Accidental Falls	9.4	13.7	76.5	22.7

Condition	*Age Standardised Mortality Rate/100,000*			
	65-84		85+	
Fracture of Femur	7.47	2.03	125.89	23.54

Death rates for the older population in Kingston are generally low compared to England and Wales. However many of the deaths in the 65 to 74 age group could be preventable (accidental falls 9.4 per 100,000 population nationally set against 13.9 in Kingston in this age band). There are local inequalities with the most deprived wards having the highest death rates. So, for example, older people living in Surbiton Hill, Norbiton and Coombe have a significantly higher reported mortality rate compared to other local age-standardised death rates.

3.3 Morbidity - General

The data in this section provides a picture of the local prevalence of a variety of diseases and use of health services by older people.

Limiting Long-term Illness

One measure of morbidity is limiting long term illness (LLTI) which reflects an individual's perception of how healthy they are. It relates to the following census question, new in 1991:

> *'Does the person have any long term illness, health problems or handicap which limits his/her daily activities or the work he/she can do?'*

Table 3 shows the actual numbers and percentages of people with limiting long term illness in England and Wales and in Kingston. Again the population of Kingston appears to be lower than national figures in terms of the percentage of the population with LLTI.

Table 3: Number & Percentages of old people suffering from Limiting Long-term illness in England & Wales and Kingston 2000

	Age Group							
Persons	Under 65		65-74		75 & over		All ages	
	No.	%	No.	%	No.	%	No.	%
England & Wales	3,139,215	7.0%	1,493,575	34.3%	1,881,154	47.6%	6,513,944	12.3%
Kingston upon Thames	5,546	4.2%	2,915	30.4%	4,846	47.6%	13,307	8.8%
2001 census data	9661		3066		5177		17904	

Source: Compendium of Clinical & Health Indicators, 2001

3.4 Morbidity - falls

Recent research[7] carried out with local professionals has identified osteoporosis amongst the most prominent long term illness affecting Kingston's older population. More detail is provided in the 1999 Annual Report of the Director of Public Health for Kingston and Richmond. This population in particular carry the highest risks of fragility fractures if they were to fall.

Table 4 shows the prevalence of falls in Kingston alongside the most common reported diseases and injuries. The number of falls is clear, yet a number of the diseases listed also impact on the number of fallers.

Table 4: Prevalence of the most common diseases among older people

Condition	**prevalence in over 65s in Kingston (2002)**
1. Falls	6,352
2. Ischaemic heart disease	3,013
3. High blood pressure	4,369
4. Stroke	1,000 survivors (includes 500 disabled)
5. Diabetes mellitus	1,100 (Non-insulin dependent) 200 (Insulin dependent)

[7] Joint Strategy for Services for Older People

6. Chronic respiratory conditions (emphysema and chronic obstructive airways disease)	1,300 – Asthma 2,100 – Chronic Obstructive pulmonary disease (10%)
7. Osteoarthritis	14,839
8. Osteoporosis	2,994
9. Fractured necks of femur	161
10. Visual impairment	602 older people are registered as visually impaired
11. Cataracts	6,950
12. Deaf or hard of hearing	521
13. Depression	2,364
14. Schizophrenia	49
15. Dementia	1,315

Source: LRC Ward Population for 2002, Projections based on 1999 estimated figures – LRC 1999, 'Key health statistics from General Practice – Studies on Medical and Population Subjects No. 60' – ONS 1996

Osteoporosis and visual impairment are the most obvious contributing factors to potentially life-changing falls. A large number of medications for other conditions in particular anti-depressants can also increase the risk of falls. The task of reducing falls in Kingston is complex and will require multi-disciplinary working across statutory and non-statutory agencies in order to have any real impact.

In 2005 it is estimated that there will be 18,476 people aged 65 and over in Kingston. Extrapolating this to national data we can estimate that approximately 6200 people aged over 65 will fall. Of these approximately:

- 3700 will sustain some form of injury
- Approximately 678 of these will have major injuries or fractures resulting from falls
- 88 are likely to have a hip fracture
- 1850 will be those aged 80 or above
- 500-650 may fall twice or more
- 264 will come from residential or nursing homes

Local Hospital Data

According to national assumptions we should expect approximately 1,100 residents aged 65 and over to seek attention in A & E for falls leading to 350 patients being admitted annually.

in 2003-04 Kingston Hospital's A&E department recorded 83,532 A&E attendances, of this number 1,390 patients were reported as having a fall or a suspected fall which is 26% above the national assumption. Of these attendances:

- Approximately 400 patients were admitted into hospital.
- 125 of the 400 were referred into the fracture clinic from A&E.

Community Hospitals also record and monitor the number, type and injuries sustained for in-patients. For Tolworth and Surbiton during the period 2003-04 the total number of reported falls was 432.

- Of these 98 patients received minor injuries such as scratches and bruising
- Two patients had more serious injuries (one loss of consciousness and one patient referred to A&E).

Falls in Nursing Homes and in the Borough's Resource Centres
Monitoring across four of our local nursing homes has reported 461[8] falls in 2003-04. Unfortunately the criteria against which a fall is monitored is not consistent.
A small proportion of fallers in nursing homes suffer serious injury.
There are about 30 falls per month in RBK resource centres.

8 Data taken from a 17 month period (Jan 03 to May 04) and pro-rata to 12 months.

4. FINANCIAL CONTEXT

Falls clearly have the greatest consequences for the individual and interventions must be offered on this basis alone. However it should also be noted that a reduction in fractures resulting from falls can save money and resources which outweigh the costs of an integrated falls service. Not all falls can be prevented but even a relatively small reduction will result in savings to the health economy in general.

The cost of treating one emergency fractured neck femur alone is equivalent to approximately £10,000 at Kingston Hospital, this is without the costs that might be associated with increased dependency and possibly admission to a care home. Since April 1996 there have been, on average, 121 hip replacements per annum with a primary diagnosis of fractured neck of femur these numbers equate to around £1.2m of care. The costs that could be released by reducing falls are therefore significant.

A reduction in falls could free up beds for planned admissions and provide an element of funding to increase access. The average number of bed days per hip replacement is about 13.3 nationally. If we apply this average to Kingston Hospital we can see that in the region of 1603 Orthopaedic bed days in Kingston Hospital were being used for hip replacements.

One emergency ambulance visit, whether or not the patient is taken to hospital costs about £200. If all 3,700 people who fall and sustain an injury were to call an ambulance then it would cost in the region of £740,000, reducing falls by 20-30% would save £148,0000 to £200,000 of resources.

If elderly women in residential care were offered calcium and Vitamin D supplementation estimates suggest that 30% of osteoporotic fractures could be prevented. People with a previous fragility fracture have five times the likelihood of subsequent fracture. Bone density scanning can provide savings by ensuring that high risk patients with osteoporosis are identified and treated. For example, bone density scanning would help diagnose those patients with osteoporosis who suffer a Colles fracture of the wrist, often the first low impact fracture sustained by active people. These patients can then be treated to prevent more severe hip and vertebral fractures.

5. SUMMARY OF EXISTING SERVICES

5.1 Assessment and Prevention

All teams in the hospitals (acute, community and mental health), Intermediate Care, and the community are using a range of assessment tools to identify those at risk of falling. Upon assessment the service user is identified as being at high, medium or low risk of falling. Those people identified as having a high risk of falling are referred into the Stay on Your Feet groups or into the Falls Prevention Programme at Kingston Hospital for further assessment and possible treatment (e.g. Osteoporosis screening). Most people at Tolworth Hospital who complete the Stay on Your Feet group (run through Surbiton Hospital) will then move on to a balance group.

South West London & St Georges are currently involved with a research project focusing on patients with dementia who fall. This is being completed alongside Brunel university and is expected to produce an action plan and generate learning opportunities within the trust.

There has already been a lot of joint work with social Services, sheltered housing, nursing homes, community services and the voluntary sector across Kingston through the Community Falls group. A Community Falls Prevention Strategy was produced in 2002. and covers work to:

- To prevent falls in the community through addressing environmental factors, the home environment and improving balance and fitness in older people
- To identify and target people at risk of falls
- To prevent further falls in people who have fallen

It has co-ordinated the development of a joint assessment and referral tool including the Morse validated assessment tool (appendix 2). This tool (and associated referral pathway) (appendix 3) will also form part of the Single Assessment Process adopted across Social Services and the community.

The Community Falls Group has also co-ordinated the training and support of practitioners who now provide specialist exercise courses for Older People in community settings. More recently the Active Ageing strategy has been produced which aims to extend the healthy life expectancy of older people. One of the issues it is addressing is increasing physical activity which will contribute to the prevention of falls. Regular physical activity can increase strength and balance and so reduce the risk of falls and the active ageing strategy is aiming to increase opportunities for exercise for the general population to improve balance and build up strength. Further information can be found in "An Active Ageing Strategy for Kingston 2004-2007".[9]

9 http://www.kingston.gov.uk/council_and_democracy/committeeminutes.htm Active Ageing strategy

5.2 Provision of Falls Service

People who have fallen are currently referred to either the Stay on Your Feet group at Tolworth Hospital, or the Falls Prevention Programme at Kingston Hospital. The groups are almost identical, but have some important differences. Both groups accept referrals from multi-agency colleagues in the community (including Age Concern) and from within both hospitals. The Kingston Hospital Group receives more hospital referrals, including some from A&E, intermediate care, and from other outpatient departments. Kingston Hospital does not run balance and exercise classes following on from the educational group at present. All those entering both groups have been identified as having a high risk of falling.

The groups provide a six week package which delivers the following support for older people who have fallen or are at a high risk of falling:

- Information eg. DTI's *Avoiding Slips, Trips and Broken Hips*
- Identify risk factors
- Establish strategies for coping with falls
- Identify psychological consequences of a fall
- Rehabilitation including physiotherapy, occupational therapy and provision of equipment to improve the safety of older people in their own homes.
- Individually tailored exercise program administered by a qualified trained professional.

Kingston Hospital
Kingston Hospital provides access to Stay on Your feet groups and a medical assessment for fallers. Emergency admissions with fractured neck of femur are treated within the advised 24hrs in order to maximise the best outcomes for patients. Patients admitted to hospital who are identified as having fallen are reviewed in the ward area.

Exercise classes
Trained practitioners are currently providing specialized falls prevention exercises classes in nursing homes and day centres and are seeking to provide services to those in sheltered housing. The courses are based on a Leicester College program.

Osteoporosis Screening
All patients referred to the falls service are screened for osteoporosis. Currently Bone Mineral Density (BMD) assessments are commissioned from the New Victoria hospital and are accessible via referral from consultant or GP in line with the accepted protocols.

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Careline
The Royal Borough of Kingston provides 24 hour emergency alarm scheme through Careline which is available for people at risk of falling or of needing emergency medical help who do not have access to sheltered housing officers. Additional sensors and detectors can be fitted to the alarm system, e.g. smoke alarms, flood detectors and gas detectors. These additional alarms are available to people who have specific risks that have been identified in a risk assessment.

5.3 Accountability Structure

There are five separate groups in the Kingston health economy which focus on treating those who have fallen and on the prevention of falls.

Kingston Falls Steering Group
The Steering Group is accountable to the Kingston Joint Older People's Partnership Board who are accountable for the delivery of the NSF for Older People. The falls steering group is responsible for the delivery of the Kingston Integrated Falls Strategy as set out in Standard 6 of the NSF for Older People: Falls.

Community Prevention of Falls Group
The role of the Community Prevention of falls group is to oversee the implementation of the prevention agenda of standard Six of the Older People NSF. The group focuses on prevention of falls in the community and has created links with the voluntary sector, day centres, nursing and residential homes, the Royal Borough of Kingston, Health Professionals and GP Practices. The group is accountable to the Steering group with regard to the Integrated Falls Strategy.

Inpatient Falls Groups
There are three multi-disciplinary in-patients falls groups involved with the Kingston Integrated Falls Strategy. Their purpose is to facilitate a reduction in the number and severity of falls sustained by in-patients who have been admitted to Kingston NHS Trust, South West London & St Georges Mental Health Trust, Tolworth and Surbiton Hospitals. These groups focus on individual patient needs within the two community trusts in Kingston and review equipment needs and protocols for patients.

6. VISION

The vision is to reduce the number of people falling in Kingston by establishing an integrated falls care-pathway whereby any person who is “at risk” of falling, or has fallen, is able access appropriate and standardised assessment, high-quality treatment and support from a wide range of service providers in order to promote a better quality of life for the residents of Kingston. The service will be provided to older people irrespective of their gender, ethnicity, culture or disability.

6.1 Aims

To ensure that:

- All relevant persons who may be in contact with potential fallers have the skills and ability to identify those at risk of falling and refer them to appropriate services through the use of a single agreed assessment tool agreed by all local stakeholders.

- All persons identified as at risk of falling have timely access to a seamlessly integrated local care pathway through which access to a range of services is equitable and timely.

- Those individuals who provide a first point of contact for service users adopt standard protocols and referral criteria as agreed by all relevant agencies.

- To raise awareness and prevent falls in the community and in areas of service delivery by improving the environment in which those at risk are living.

6.2 Outcomes

- Reduced falls and associated injuries and fractures

- Co-ordinated risk assessment

- Universally adopted care pathway

- Improved partnership working

- Better standards for effective prevention and rehabilitation services

6.3 The Integrated Falls Service

The diagram below draws a simplified picture of the new patient pathway which this strategy is aiming to implement.

Referral:

Referrals will be sent into the falls service from all sources. Fitness/extend classes run in the community will continue to be on a self-referral basis for people who wish to maintain an exercise programme.

Community & Primary Care:
Health and Social Care professionals working in the community and primary care will be able to refer into the falls service where, if it has not already been completed, the Morse assessment tool will be used to identify the level of need.

Inpatients:
It is envisioned that health professionals working with inpatients will access the falls service in order to arrange follow-up care for patients as appropriate. It is assumed that whilst a patient is in an inpatient environment they will receive both appropriate medical assessment and a multidisciplinary assessment through the Morse assessment tool to determine whether a referral into the pathway is required

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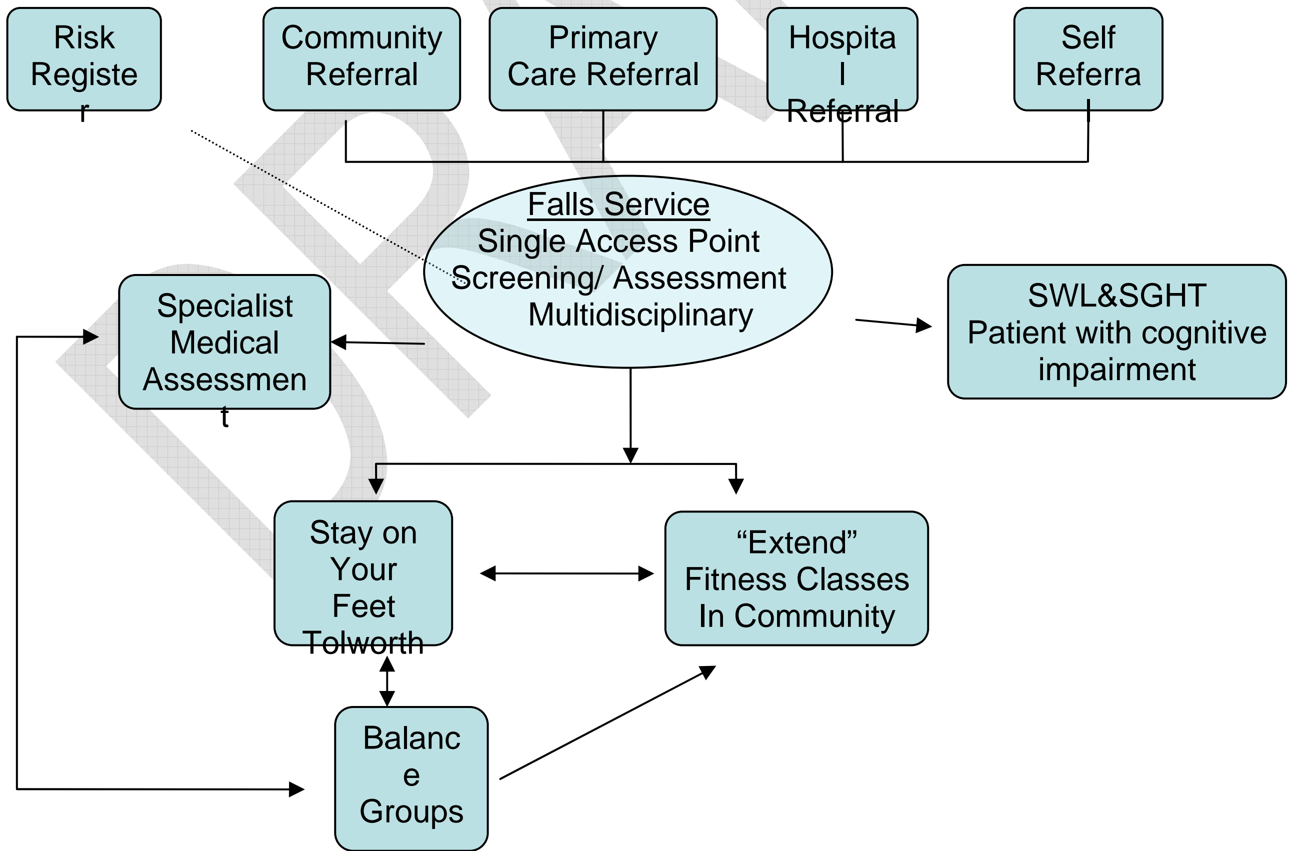
Falls Pathway



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Accident & Emergency (A&E)
Those Patients presenting in A&E who have fallen but are not admitted into hospital will be assessed using the Morse risk assessment tool and referred on to the portal if required. Information on falls and the availability of local services should be readily available in A&E departments.

The Single Access Point:

The falls service based in a community setting, will use the Morse validated assessment tool to establish the needs of persons referred into the service. The service user will then be referred into the appropriate service according to the needs of the individual. Where the Morse assessment has already been carried out the falls service will perform the role of booking service-users into the appropriate service.

The majority of service users will be directed into existing services such as the Stay on Your Feet group or one of the fitness/extend classes available in the community.

Service users that are identified in the community and are assessed as being in need of further assessment will have access to a multi disciplinary assessment including a specialist medical assessment at Tolworth Hospital. This will ensure an equitable service available to all Kingston residents who may have been discharged from other NHS trusts or who may not have been picked up by their local GP. Access to the medical assessment unit is already available to inpatients in Kingston NHS Trust and via GP referral.

A risk register will be established and held by the falls service.

Services:

The falls service will provide a central referral point and manage demand into the existing service. A single Stay on Your Feet service will be established in the community – this will bring together the two previous groups into one location. This will allow the full twelve week rehabilitation programme to be offered to all participants. The falls service will also hold information on the other fitness and balance groups in Kingston run by the Royal Borough of Kingston and the independent sector which individuals will be referred to who have an ongoing need for exercise and this service will then review their needs regularly.

The service will provide hip protectors for the prevention of hip fractures in older people living in extended care settings who are considered at high risk. There has been no evidence provided for the effectiveness of hip protectors to prevent fractures when offered to older people living in extended care settings or in their own homes who are not at risk. (Nice Guidance on Falls November 2004).

7. STRATEGY FOR AN INTEGRATED FALLS SERVICE

The integrated falls service will focus on prevention of falls, identification of potential fallers and rehabilitation of those that have fallen. The key areas at which this strategy is targeted are summarized below and the resulting actions are detailed in the action plan in Section 9. The central themes are outlined below:

7.1 Prevention and identification of fallers

- Information and communication – latest advice on best practice and services available to all interested parties.
- Environmental – i.e. make physical surroundings safer and reduce risk.
- Physical – promoting healthy lifestyles as detailed in the Kingston Active Ageing Strategy (Standard 8 of the NSF for Older People).
- Behavioural – challenging attitudes towards and fears of reporting minor falls
- Assessment – standardised screening tools for use by all in contact with potential fallers.
- Osteoporosis screening and treatment
- Regular incident reporting and monitoring

7.2 Treatment and long term rehabilitation

- Upon identification the service user is offered services in line with the agreed Patient Care Pathway for falls.
- Equitable & timely access to services both in terms of non-elective access and community services.
- Increasing awareness of services available to all fallers and high risk persons.
- Medication Review – with view to reducing number and doses. Plus prescribing calcium and Vitamin D supplements for high risk individuals.
- Frequent Health Checks of those at risk. GP or Specialist Nurses – promote early diagnosis of new problems.
- Monitoring and revision of services to meet need.

8 IMPLEMENTION AND ACTION PLAN

The key milestones identified locally to deliver an integrated falls service in Kingston are outlined in the action plan in this section.

Key stages in the delivery are summarised below:

1. Agree standardised care-pathway and protocols with all stakeholders

2. Agree standard risk assessment with all stakeholders

4. Agree the changes and developments to current services to deliver the agreed care pathway within realistic timeframes.

5. Agree communication & Information sharing strategy

6. Develop robust monitoring and audit protocols

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8.1 Universal Care Pathway, Protocols and Assessment tools

	Action	Outcome	Timeframe	Lead
1.	Agree universal risk screening and assessment tools and ensure use.	1. Generic screening tool to assess balance fully operational 2. Validated specialist assessment tool fully operational e.g. Morse and Phrase (Mental Health Services)	April 2005	Strategic Falls Group and Single Assessment Working Group
2.	Launch and provide training to all staff caring for older people in:- ➢ Falls risk assessment ➢ Appropriate referral of people at increased risk of falls ➢ Measures to decrease the likelihood of falls • Devise a training plan for ➢ Residential and Nursing Home Providers ➢ Primary Care Teams	Earlier identification and intervention for potential fallers. Use of assessment tools and awareness of referral options and pathways	Complete initial training programme by December 2005 Review of outcomes of training and training plan devised for 06/07	PCT Physiotherapy Lead, alongside Single Assessment Officer
3.	Identify points of referral for "at risk/fallers" in the community and those in hospital environments	Single point of access to patient pathway	April 2005	Strategic Falls Group
4.	To develop an Immediate pathway for those people who have experienced a fall and need the services of primary or secondary care. The immediate care pathway will cover from the point the fall occurred to when an urgent call is made either to a: General Practitioner 999 call to ambulance service Self presents to Kingston Hospital Accident & Emergency (including pathway within A&E) Self presents to Teddington walk in centre including pathway within the centre	Clinically responsive A&E pathway that enabled the patient to be seen as a Falls patient. Targeted and appropriate information throughout the A&E attendance to enable patients and carers to be aware of pathway and whats expected. Potential to fast track falls patient resulting in reduced time spent in A&E. Potential of reduced length of stay for those people admitted with falls through timely diagnosis.	December 2005	Urgent and Unplanned Care Project

	Action	Outcome	Timeframe	Lead
5.	Work with the ambulance service (London and Surrey Ambulance Services) to establish an ambulance care pathway and a protocol for referring fallers to the local falls service to prevent hospital attendance	Update ambulance service on referral point and latest information pack. Agree a robust protocol for care pathway	December 2005	Urgent Care of Older Peoples Project Manager
6.	Agree and implement Kingston Integrated Falls Care Pathway, operational policy and supporting protocols. Ensure the service is inclusive to people irrespective of gender, ethnicity or culture. • Develop protocols with learning disability services and mental health services for people with dementia	Clear and accessible care pathway for service users and professionals. Provision of a service which is inclusive and recognises the specialist needs of people with learning disabilities and dementia	Pathway and operational policy for falls service in place by April 2005 Supporting protocols in place by July 2005	Strategic Falls Group Strategic Falls Group
7.	Evaluate and audit the success of the Single Assessment Process in triggering community referrals to The Falls Service	Single Assessment Process and falls risk assessment appropriately triggering the Falls Service	January 2006	Single Assessment Working Group and Falls Steering Group
8.	Adapt reports book to include referral for falls assessment	Improved information for planning and development of services.	January 2005	Sheltered Housing Management
9.	Invite London Ambulance and Surrey Ambulance Service representatives to be part of the Falls Steering Group	Ensure a multidisciplinary approach to the development of the Falls Service	March 2005	Chair of the Falls Steering Group

8.2 Evaluate the range of services and demand – Identify Shortfalls

	Action	Outcome	Timeframe	Lead
1.	Review the literature around screening and management of Osteoporosis and clarify the requirements of the Nice Guidance for Osteoporosis (expected publication date June 2005) and obtain a position statement regarding performance against the guidelines Review the commissioning arrangements and provision of osteoporosis screening/treatments and identify the shortfalls in commissioning	Adopt NICE guidelines and complete the review of commissioning arrangements for Osteoporosis	October 2005	Consultant Genetrician and Commissioning Manager for Acute and Older People Services Kingston PCT
2.	Review protocols for the use of hip protectors for Older People at high risk living in extended care settings	Adoption of best practice and clear protocols in place	By May 2005	Physiotherapy Lead and Mental Health Lead on Falls Steering Group in co-operation with provider services and private homes
3.	Review protocols and evaluate use of bed-rails	Adopt best practice and clear protocols in place	May 2005	KPCT – Physiotherapy Lead RBK – Commissioning Manager Older People SWSTSTG – Mental Health Lead KHT - ?

	Action	Outcome	Timeframe	Lead
4.	Investigate services for those at risk of falling with a mild cognitive impairment – see section 8.1.5	Provide a service and develop protocols for those with a mild cognitive impairment	July 2005	Mental Health Lead on Falls Steering Group
5.	Evaluate current partnership funded falls services, agree future configuration of services from April 2005 and identify appropriate resources	Agree the level of activity for the falls service from April 2005 until March 2006. Agree process for identifying future financial requirements from September 2005 as tapering commencing from April 2006 and finding shortfall	By February 2005	Strategic Falls Group
6.	Re-modelling of existing Falls Services into a single service based on a "one-stop-shop" principle	Integrated Care Pathway Service and service in place	By March 2005	Strategic Falls Group
7.	Audit the use of 'extend' (and other specialist exercise) and its effectiveness in falls prevention	Ensure service represents Best Value and meets the need of Kingston residents	By September 2005	Community Falls Group alongside Community Activity Co-ordinator
8.	Audit of different care settings where people are known to be at high risk of falling, Accident and Emergency and extended care settings	Clarity as to whether the care pathway is robust and identify any amendments to processes and training	November 2005	Falls Steering Group
9.	Set up a group of trainers providing exercise classes and evaluate standards of training	Develop a consistent approach to exercise classes to ensure best practice	By November 2005	Falls Community Group

8.3 Appropriate Support and Interventions available to all

	Action	Outcome	Timeframe	Lead
1.	Review the components of the Falls Service (Stay on Your Feet, Extend, Balance Groups, Active Ageing Strategy (Std 8), Intermediate Care and Rehab services) to ensure that (i) best practice is incorporated in service design (ii) capacity developed as appropriate	Best Practice adopted in all services Report to the Falls Steering Group/Older Peoples Partnership	October 05	Falls Steering Group
2.	Through the osteoporosis project care home staff will be trained to identify residents at risk of osteoporosis, falls and fracture	A process of identifying older people at risk of falling in the homes and referring residents to GP for treatment will be established. Project outcomes evaluated.	August 2005	Falls Strategic Group
3.	Independent Sector: Work with Residential and Nursing Homes to enable equity of access to falls services and increase the level of prevention and advice. (links to osteoporosis project)	Reduction of patients transferred into hospital and number of falls in residential and nursing home care	April 06	Independent Sector Representative on Partnership Board
4.	Investigate the potential for the use of preventative equipment in Fountain Court. Review access and useage of the Falls Services by all communities.	Reduce falls in Fountain Court	December 2005	Housing/Social Care Steering Group

	Action	Outcome	Timeframe	Lead
5.	Enhance and extend training within black and minority ethnic communities and train Milaap (Kingston Asian Elders Association) co-ordinator in falls prevention exercise	Extension of existing exercise programmes	June 05	Community Falls Group
6.	Explore new technologies with regard to monitoring high risk patients and review current arrangements with Careline	Improved safety of service users	March 05	Strategic Commissioning Manager
7.	Medication reviews to be undertaken with patients on 4 or more treatments	Aim to reduce medications where appropriate in order to avoid falls	July 2005	Medicines Management Project Falls Steering Group

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8.4 Ensure Robust Monitoring and Audit Protocols are maintained

	Action	Outcome	Timeframe	Lead
1.	To develop an approach to capture a standard minimum data set across all agencies, for people at risk or who has experienced a fall	Establish a consistent and single data set which captures a person who has fallen or is at risk of falling which will lead to a more responsive pathway and development of service provision	December 2005	Urgent and Unplanned Care Project
2.	Comprehensive audit systems established to review falls on a quarterly basis to identify areas of risk and instigate appropriate action. To cover Hospitals, community and homes	Areas of risk identified early and appropriate preventative interventions implemented.	April 2006	Falls Steering Group Service Leeds
3.	Set performance targets within service areas	Reduction in falls resulting in an injury	December 2005	Falls Steering Group
4.	Review current falls groups and role of strategic group	Accountability arrangements clarified	March 2005	Falls Steering Group

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8.5 Communication and Information Sharing

	Action	Outcome	Timeframe	Lead
1.	To have in place an appropriate and consistent approach to communicating awareness and service provision for people affected by a fall(s) in Kingston	Development and implementation of an appropriate and consistent approach to communicating awareness and service provisions for people affected by a fall(s). People affected by falls have timely and responsive access to support and information and have a facilitated voice into developments around Falls communication	December 2005	Community Falls Group and Urgent and Unplanned Care Project
2.	Explore options and value of a falls risk register link	Evaluation completed as to whether this will add value to an Integrated Falls Service	March 2005	Urgent and Unplanned Care Project
3.	Ensure regular communication links between the "Urgent and Unplanned Care of Older People Project" (DoH) and the Strategic Falls Group	Obtain joined up thinking/synergy (link approach between the two groups)	April 2005	Urgent and Unplanned Care Project

8.6 Prevent Falls in the General Population

	Action	Outcome	Timeframe	Lead
1.	Raise awareness re: highways repair KCIL to promote RBK contact details for highway repairs in their newsletter	Reduce falls due to uneven pavements and surfaces	April 2006	Community Falls Group
2.	Members of the falls group to promote RBK contact details for highway repairs	Increased awareness of RBK Highway repair contact details	Ongoing	Community Falls Group
3.	RBK to keep record of notified incidents, review pattern of falls and report back to the falls group	Develop intelligence on the location of falls and the underlying causes	Annually	RBK Highways dept and insurance dept
4.	Map clusters of vulnerable people in the borough and hazards and use this data for future action, e.g. to justify resource allocation	Target resources in appropriate localities	April 2006	Community Falls Group
5.	KCIL Access Officer to make contact with Occupational Therapists department to identify ways for them to work more closely with RBK Access Officer, Environmental Services and KCIL Access Officer.	So that the whole environment of vulnerable clients is considered rather than just the home environment.	August 2005	RBK/Falls Group
6.	Approaching mobility forum to promote safer travel on public transport and promote improved access at bus stops. Maintain regular contact with TFL bus companies to achieve this, thus making bus transfers/journeys safer for vulnerable passengers.	Reduce falls on public transport	Ongoing	

	Action	Outcome	Timeframe	Lead
7.	Publicise home repair grants	Awareness of grants amongst Kingston residents	September 2005	Environmental Health/Community Falls Group
8.	Develop a potential hazards checklist to assist health and safety inspections of all RBK sheltered housing units and carry out repairs where necessary	Reduce occurrence of falls in sheltered accommodation units	December 2005	RBK Sheltered Housing Management/Community Falls Group

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9 Monitoring and Evaluation

The integrated falls service will be coordinated through the Strategic Falls Group. The four operational groups in Kingston will be accountable to this group. The Strategic Falls Group will be accountable to the Partnership board and will be responsible for the monitoring and implementation of this strategy.

An information sub-group will meet on an ad-hoc basis in order to clarify definitions and ensure data quality is maintained at an acceptable level.

The implementation & maintenance of the Falls Strategy will be monitored against the Action Plan (Section 7) by the Strategic Falls Group.

Timescale	Target	Monitoring & Evaluation
April 2005:	All local health and social care systems should have established an integrated falls service	• Audit awareness of risk factors associated with falls and fractures • Audit integrated care pathway • Ongoing audit: rate of falls in Kingston • Ongoing audit: rate of hip-fractures

10 Requirements for Implementation of Strategy

There are already resources and interventions available for those at risk or who have fallen through the various partner-agencies in Kingston. Implementation of this strategy will require greater co-ordination and re-engineering of existing resources although there will be a requirement for investment as the non-recurrent elements of funding comes to an end. Further resource needs may be identified after initial demand and capacity analyses are complete.

At the heart of this strategy is the need for all agencies to work in partnership so as to ensure that a seamless and multidisciplinary service is provided for and with Kingston residents.

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Appendix 1

GLOSSARY OF TERMS

A&E	Accident and Emergency Dept
KHT	Kingston Hospital NHS Trust
KPCT	Kingston Primary Care Trust
LDP	Local Delivery Plan
MDT	Multi-disciplinary Team
NICE	National Institute of Clinical Excellence
NSF	National Service Framework
RBK	Royal Borough of Kingston
StHA	Strategic Health Authority
SWL & SGMHT	South West London and St Georges Mental Health Trust

Appendix 2 Falls Assessment and referral form **(Based on Morse J.M, (1997) Preventing Patient Falls. Sage Publications Inc, London)**
(For use by all professionals working with Older People (Housing, voluntary sector, health and social services)

Form 1 Risk Screening Tool: Fill in this form first and then if the person you have assessed scores more than 45 turn to form 2.

Older Person's Name .... Centre .... Named Professional ....

		Score	Dates/ of assessment/re-assessments				
History of falling Score 25 if the patient has fallen within the last 6 months, if not score 0	NO YES	0 25					
Secondary diagnosis (including sensory impairment) Score 15 if more than one medical diagnosis is listed in the patient's record, if not score 0	NO YES	0 15					
Mobility aids Score 0 if patient has wheelchair, does not get out of bed or **only** mobilises with nurse assistance. Score 15 if patient mobilises using equipment. Score 30 if patient clutches onto furniture when walking.	Wheelchair/bed-rest/nurse Unsteady/stick/frame Furniture	0 15 30					
Gait Normal gait = upright position Weak – stooped but able to lift head without losing balance, independent Impaired = poor balance, need assistance	Normal Weak Impaired	0 10 20					
Equipment Score 20 if patient is attached to equipment e.g. IV infusion, urinary catheters, PEG, Cardiac monitor etc.	NO YES	0 20					
Mental status Score 0 if patient is consistently aware of own limitations. Score 15 if patient tends to overestimate ability, or forgets e.g. to ask for assistance when attempting to mobilise	Orientated to own ability Overestimates/forgets limitations	0 15					
	TOTALS						

Low risk = up to 30 Medium risk = 35-40 High risk = 45+

Always err on the side of caution, e.g. if patient's communication skills make it hard to assess awareness of limitations

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Appendix 3 - Form 2: Recommendations for referral for those at HIGH RISK of falling

If you have assessed that someone is at high risk of falling refer them to the 'Stay on Your Feet Group and discuss referral to social services for personal alarm. Then ask what happened and discuss realistic preventive measures using Slip trips and Broken hips materials and the questions below. If the fall occurred on a pavement in Kingston report details to **RBK** Maintenance team on **8547 5929**.

RISK FACTOR		INTERVENTION	REFERRAL OPTIONS	Comments
1.	**Number of Medications** Do they takes more than 4 medications per day?	• Identify type of medication being prescribed • Ask about symptoms of dizziness • Raise awareness of the need to inform GP of side effects of medication	GP Community pharmacist	
2.	**Antidepressants, sleeping pills or tranquillisers** Do they have trouble sleeping or suffer from depression?	• Identify type of medication being prescribed e.g. antidepressants, sleeping pills, tranquillisers • If they have used of 1 or more of the above for more than 2 weeks refer to GP for review	GP	
3.	**Alcohol Intake** Do they drink more than 1 unit of alcohol per day e.g. 1 small sherry, ½ pint of beer, 1 small glass of wine, 1 measure of spirit	• Teach regarding immediate and long-term fall risk due to dulling of neurological capacity from alcohol. If still concerned re amount of alcohol refer to GP	GP	
4.	**Fluid Intake**	• Advise to increase water intake • If still concerned about dehydration advise to increase water	GP	
5.	**Do they get light headed or dizzy when they are standing or turning?**	• Suggest sleeping with more pillows if severe • Teach to stabilise self after changing position and before walking • If person is on medication for blood pressure refer for review of medications if concerned	Practice Nurse/ District Nurse/ GP	
6.	**Vision** Do they have difficulty reading newspaper/book, recognising objects across the room/ Have they recently started wearing bi-focals?	• Advise disuse of bifocals or care when 1st wearing, especially on stairs, because of risks due to blurring and difficulty in judging distance • Advise to concentrate on walking and be deliberate/cautious, especially in new situations and on uneven surfaces • Raise awareness of the need to have regular eye check ups • Raise awareness of the need to have good lighting levels	Optician/ Sensory impairment team	

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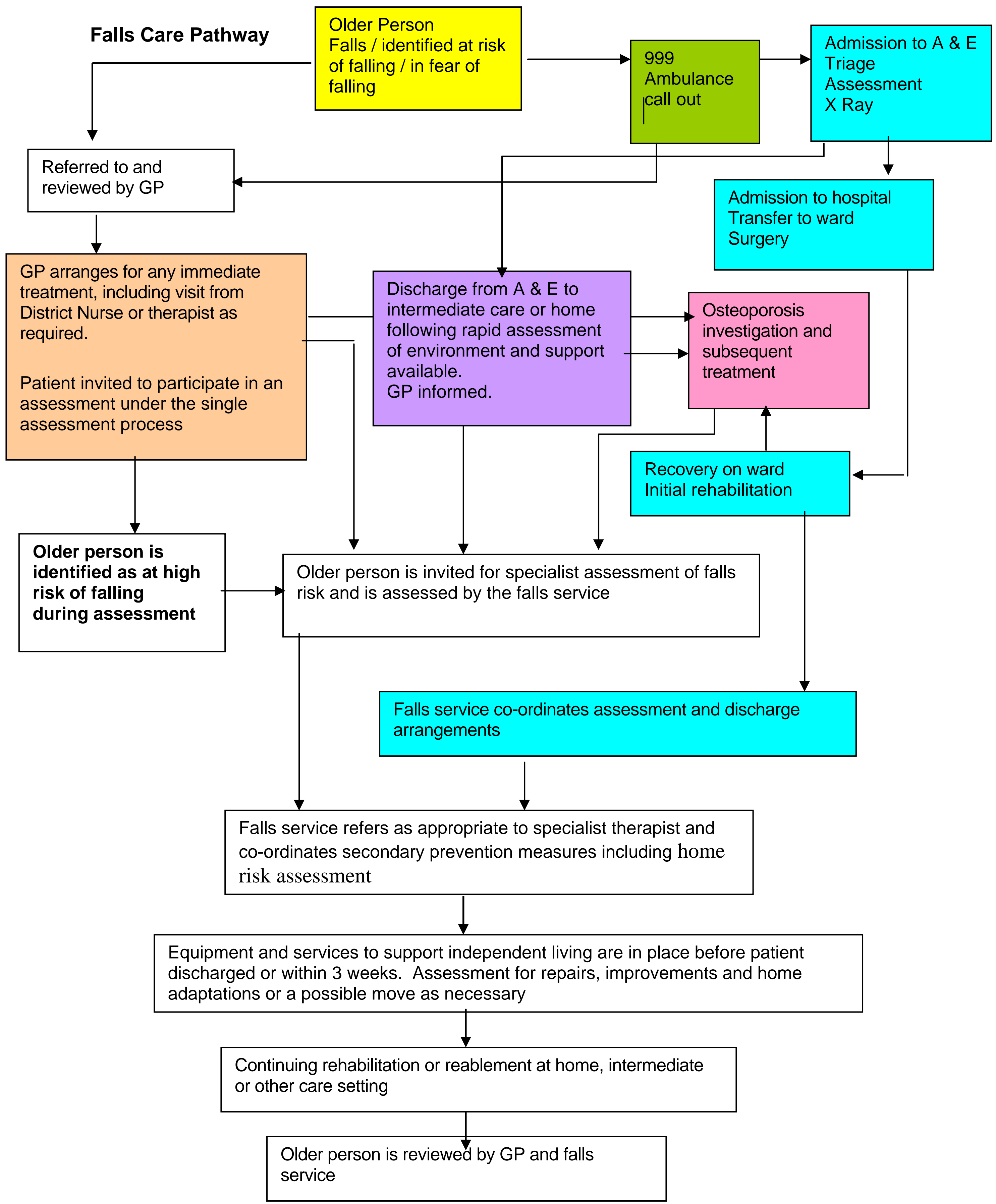
7.	**Hearing** Has difficulty in hearing telephone/ doorbell and so may rush to answer it	• Check if hearing tested and corrected to extent possible. If yes refer to sensory impairment team, if no refer to nurse or GP	Practice Nurse GP Sensory Impairment Team etc	
8.	**Do they have difficulty walking or rising from a low chair/**Are they unsteady on feet, shuffle or take uneven steps/housebound	• Teach about risk use Slips trips and broken Hips leaflet • Depending on level of ability and previous treatment provide exercise sheets, Provide information on the Kingston walking for health project, adult education exercise classes, refer to specialist falls group, stay on your feet group • Refer to: Community Physio for evaluation for Range of Movement, strength, balance, gait and need for sticks or frames • Refer to: Occupational therapist for Environmental modifications to compensate for disability and to maximise safety • Advise about the need to have regular foot care check ups	Stay on your feet group Community Physio Social Services Occupational therapist Podiatry	
9.	**Do they have poor balance** (Needs to hold onto the furniture, requires stick or frame) **or show lack of lack of control** when moving from one type of floor surface to another e.g. from bed to chair	• Teach about risk use Slips trips and broken Hips leaflet • Depending on level of ability and previous treatment provide exercise sheets, Provide information on the Kingston walking for health project, adult education exercise classes, refer to specialist falls group, stay on your feet group • Refer to Community Physiotherapist for evaluation for Range of Movement, strength, balance, gait and need for sticks or frames • Refer to Occupational therapist for Environmental modifications to compensate for disability and to maximise safety or so that daily activities do not require stooping or reaching overhead	Stay on your feet group Community Physio Social Services Occupational therapist	
10.	**Environmental Hazards** Is their home or environment cluttered or badly lit?	• Raise awareness of dangers and risks in the home using Slips trips and broken hips leaflets • Remove obstacles including rugs or at least get rubber skid guards - provide contact details for the Handyman if they are a community care service user, if not advise to use family friends of care groups • Refer to Occupational therapist for Environmental modifications to compensate for disability and to maximise safety	Social Services Occupational therapist Handyman Care groups	


Falls Care Pathway
Older Person
Falls / identified at risk of falling / in fear of falling
999
Ambulance
call out
Admission to A & E
Triage
Assessment
X Ray
Referred to and reviewed by GP
Admission to hospital
Transfer to ward
Surgery
GP arranges for any immediate treatment, including visit from District Nurse or therapist as required.
Patient invited to participate in an assessment under the single assessment process
Discharge from A & E to intermediate care or home following rapid assessment of environment and support available.
GP informed.
Osteoporosis investigation and subsequent treatment
Recovery on ward
Initial rehabilitation
Older person is identified as at high risk of falling during assessment
Older person is invited for specialist assessment of falls risk and is assessed by the falls service
Falls service co-ordinates assessment and discharge arrangements
Falls service refers as appropriate to specialist therapist and co-ordinates secondary prevention measures including home risk assessment
Equipment and services to support independent living are in place before patient discharged or within 3 weeks. Assessment for repairs, improvements and home adaptations or a possible move as necessary
Continuing rehabilitation or reablement at home, intermediate or other care setting
Older person is reviewed by GP and falls service