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Telford and Wrekin
Clinical Commissioning Group

NHS
Shropshire
Clinical Commissioning Group

Shropshire Council

Shropshire Telford and Wrekin Falls Prevention and Bone Health Strategy 2019 - 2022

The Evidence

NICE Quality Standards: Falls in Older People	
1	Identify people at risk of falling
2	Multifactorial risk assessment for older people at risk of falling
3	Multifactorial intervention
4	Checks for injury after an inpatient fall
5	Safe manual Handling after an inpatient fall
6	Medical examination after an inpatient fall
7	Multifactorial risk assessment for older people presenting for medical attention
8	Strength and balance training
9	Home hazard assessment and intervention

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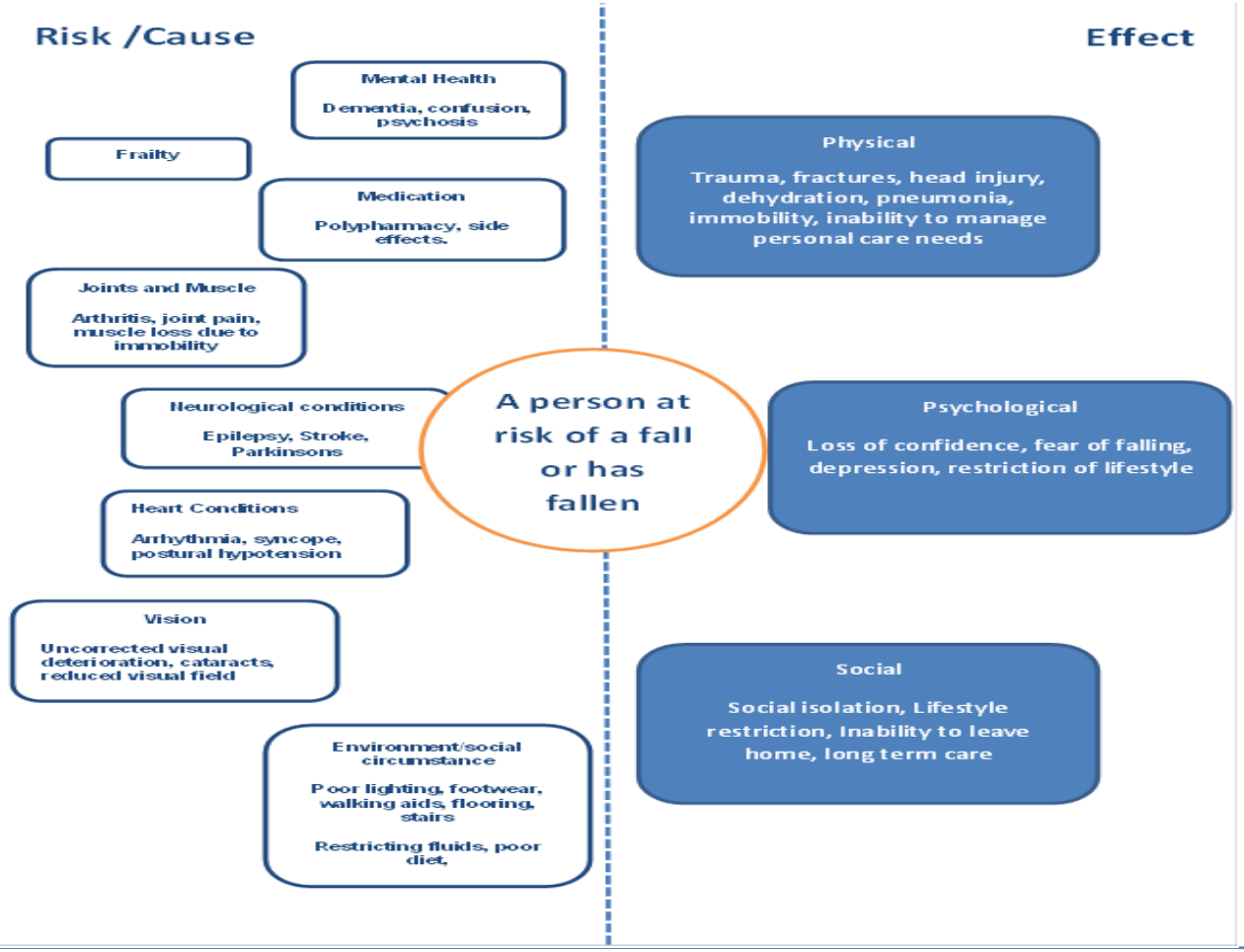
Cause and Effect



The Data (1/2)

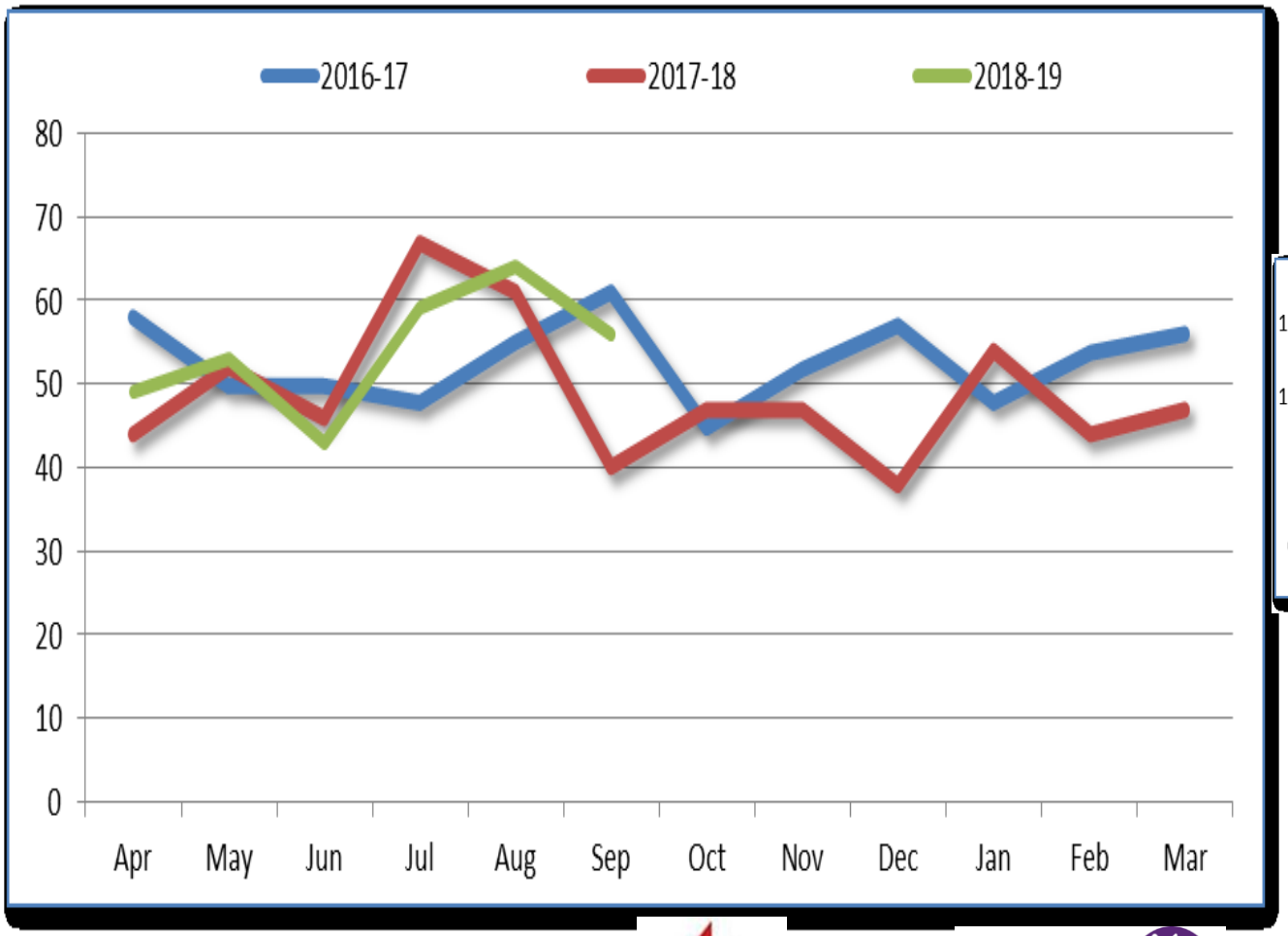
Our population is predicted to increase at a greater rate than the rest of England, with the biggest increase in people over the age of 85

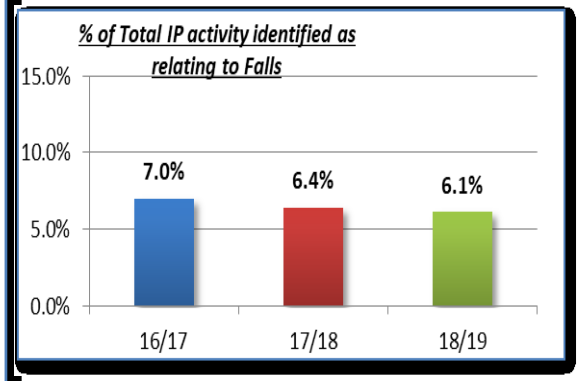
Shropshire	2019	2020	2021	2022	2023
Total population aged 65 and over predicted to have a fall	21,000	21,442	23,995	27,348	30,362
Total population aged 65 and over predicted numbers of hospital admissions due to falls	2,505	2,571	3,022	3,569	3,943

Telford and Wrekin	2019	2020	2021	2022	2023
Total population aged 65 and over predicted to have a fall	7,962	8,229	9,211	10,569	11,765
Total population aged 65 and over predicted numbers of hospital admissions due to falls	908	939	1,111	1,318	1,467

The Data (2/2)

In Patient spells identified as relating to Falls (Using ICD10 codes relating to falls to identify activity within Diagnosis 1 and 2)





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The Strategic Direction for our region

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Our Vision

Falls Prevention and Bone Health Strategy
Vision Statement

Working together to support people to stay well and live independently, by encouraging an active healthy lifestyle and reducing the risk of falls

Our Aims and Objectives (1/3)

AIM	OBJECTIVE
To support people to stay well and to be able to care for their own health needs	To have a proactive approach to the adoption of Making Every Contact count within all care services to support early identification of people who may be at risk of falls and to deliver a level of intervention that reduces this risk To create a single point of contact to enable services to refer people at risk for follow up To create robust links between Community and Voluntary organisations and Statutory Health and Care Services
To integrate current falls prevention services and close any gaps to ensure that people get the right service at the right time in the right place and preventing duplication	To implement the integrated falls care pathway across Shropshire Telford and Wrekin To deliver evidence based assessments and interventions that are standardised across the Integrated Falls Prevention and Bone Health Pathway To develop a fully costed business case to deliver the pathway

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Our Aims and Objectives (2/3)

AIM	OBJECTIVE
To reduce an individual's risk of falling and reduce the number of falls related hospital admissions	All care services will recognise the responsibility they have to identify people at risk of falls, to plan for any interventions or to refer to an appropriate postural support and balance programme or falls service Integration of falls related services Standardise the approach to falls assessment Create a single point of access for referral to falls services Develop a standardised criteria for falls clinics and medical review Provide training and development for all appropriate services to include care homes

Our Aims and Objectives (3/3)

AIM	OBJECTIVE
To ensure there is a timely response and action to when attending to someone that has had a fall	To work with the Ambulance Trust, community services and out of hours services to ensure there is a rapid response to attend someone who has fallen and to deliver appropriate interventions to reduce the need for an individual to go to hospital
To improve the outcomes for people that have had an injurious fall	Link community based falls prevention services with acute hospital services Ensure that people that are discharged from hospital following a fall (or following a fall in hospital) are followed up at home to include care homes To establish close links with Falls Services and Fracture Liaison Services

Frailty/Falls link

Multifactorial interventions

Falls risk + frailty scale

Link between falls and fractures

Frailty Score

Clinical Frailty Scale*

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 Managing Well – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY *Inspiring Minds*

Falls risk score

Instructions: For each statement, circle the number that best represents the level of confidence expressed, using the code shown below.

1 = No confidence at all to 10 = Extreme confidence

"How confident are you that you can...

1. Take a bath or shower	1	2	3	4	5	6	7	8	9	10
2. Reach into closets	1	2	3	4	5	6	7	8	9	10
3. Do "light" housekeeping (e.g., clean up your nightstand or dresser)	1	2	3	4	5	6	7	8	9	10
4. Walk around the nursing home	1	2	3	4	5	6	7	8	9	10
5. Get in and out of bed	1	2	3	4	5	6	7	8	9	10
6. Get up at night to go to the bathroom	1	2	3	4	5	6	7	8	9	10
7. Get in and out of a chair	1	2	3	4	5	6	7	8	9	10
8. Get dressed and undressed	1	2	3	4	5	6	7	8	9	10
9. Do personal grooming (e.g., wash your face, comb your hair)	1	2	3	4	5	6	7	8	9	10
10. Get on and off the toilet	1	2	3	4	5	6	7	8	9	10

...without falling?"

____ = of Total 100

Figure. Modified falls efficacy scale. Adapted with permission from Tinetti, M.E., Richman, D., & Powell, L. (1990). Falls efficacy as a measure of fear of falling. *Journal of Gerontology*, 45(6), P239-P243.

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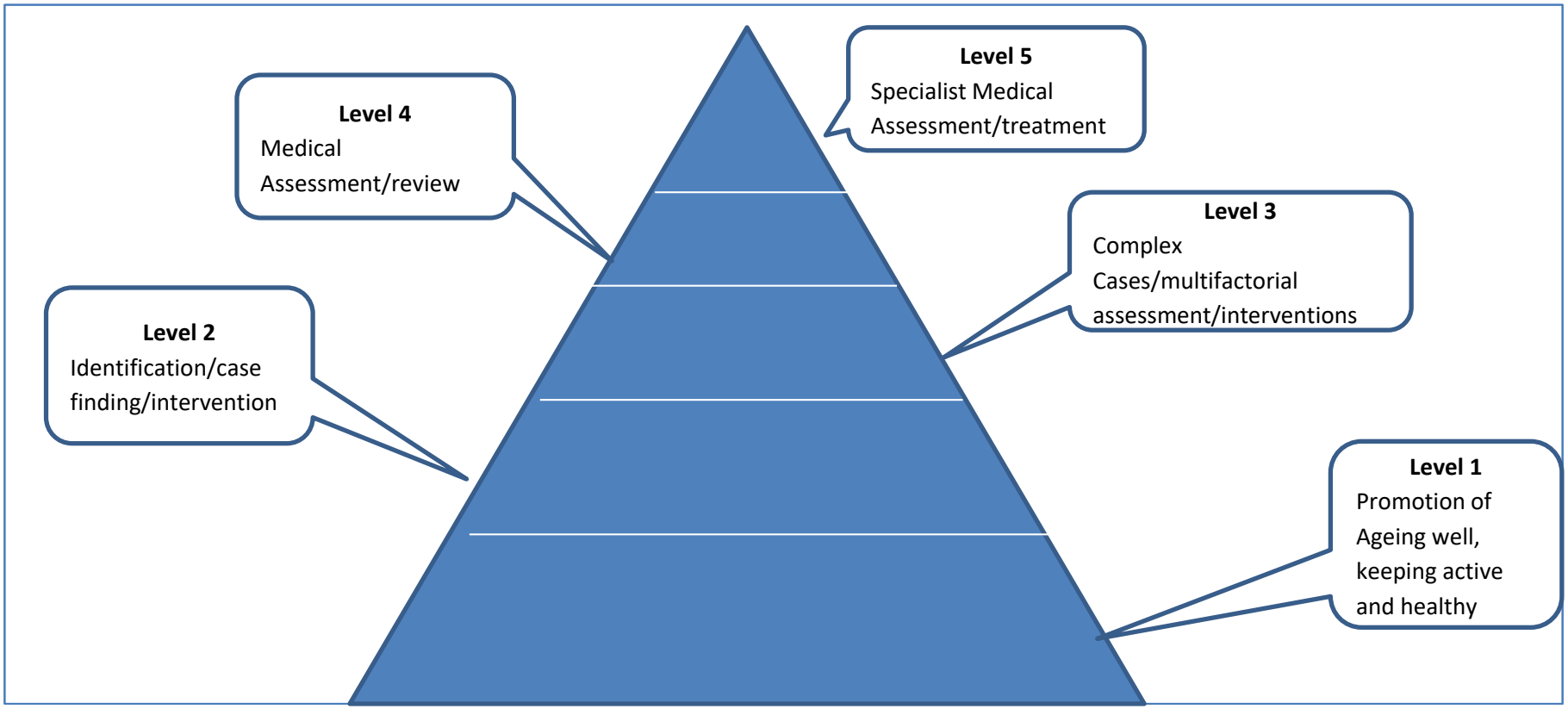
Model of Care



Falls Prevention and Management

Falls prevention and management is routinely stratified into interlinked groups; the challenge for care systems is to enable joint working to ensure interventions are appropriate and at the right point of the pathway, supporting joint working, preventing duplication and to close any gaps.

Keeping older people physically active

- Public health awareness/campaigns
- Advice and guidance
- Community based postural support and exercise programmes
- Identification of people at risk of falls
- Identification of people who have had a fall
- Identification of people that are at risk of fracture
- Medication review and optimisation
- Social prescribing

Access, wellness and engagement

Screening and Primary Prevention

- Risk assessment
- Interventions
- Postural support and balance exercise programmes
- Medication review and optimisation

Prevent escalations, unplanned hospitalisation and avoidable admissions

Intervention

- Personalised care planning to manage and reduce risk
- Maintaining levels of strength and balance and physical activities via domiciliary support or community based activity programmes
- Optimised treatment for osteoporosis
- Lifestyle changes
- Self management
- Social Prescribing

Manage goals, empower, prevent avoidable decline, and treat in least restrictive setting

Secondary prevention and intervention

- Multifactorial risk assessment
- Personalised, home based postural support and exercise programmes
- Postural support and balance exercise programmes
- Community based activities
- Social Prescribing

Tertiary prevention and intervention

- Diagnosis and treatment following fragility fracture
- Keeping people safe during hospital admission
- Multifactorial risk assessment
- Personalised, home based postural support and exercise programmes
- Postural support and balance exercise programmes

Keeping people well following a fall

- Step down options available
- Community based postural support and exercise programmes
- Community based activity
- Social Prescribing

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Next Steps

- A detailed implementation plan will be developed and overseen by a defined governance process.
- Align existing services across Shropshire, Telford and Wrekin which will see delivery of the strategy and integrated pathway
- Prime provider Business Case for Shropshire to develop the pathway over two phases to allow for redesign to be established and to ensure that success is built on strong foundations.