Cambridgeshire and Peterborough

Falls Prevention Strategy

2023-2026

Adults and Health Committee

Cambridgeshire and Peterborough Falls Prevention Strategy Group

FINAL DRAFT

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Executive Summary

Falls are a major cause of morbidity and the primary cause of injury related deaths in people aged 75+ in the UK[1]. This can include distress, chronic pain, loss of confidence, activity avoidance, loss of independence, social isolation and increasing frailty[1]. Falls have a significant impact on health and social care services. 255,000 falls-related emergency hospital admissions occur in people aged 65 and older every year in England and these are estimated to cost the NHS £2.3 billion a year[2].

Osteoporosis is a key risk factor for injurious falls as it increases bone fragility and susceptibility to fracture after a fall. Approximately, 549,000 patients present with fragility fractures to hospitals in the UK each year[3]. The estimated cost to the NHS of fragility fractures in 2017 was estimated to be £4.7 billion per annum nationally[3]. Hip fractures make up approximately 69,000 emergency hospital admissions per year, equivalent to 1.3 million bed days and costing the NHS of £1.5 billion per year[4].

In Cambridgeshire and Peterborough, there were 2,699 falls-related emergency admissions in 2022/23 at an estimated cost of nearly £16.3M for hospital treatment alone (excludes costs to the wider health and social care system). This is a substantial increase of over £1.9M compared to the previous year, which can be attributed to an increase in hip fracture admissions in both the North and South Place partnership. In an ageing population, as seen in Cambridgeshire and Peterborough, the prevalence of falls and osteoporosis-related fragility fractures is expected to rise, along with the associated burdens on the wider health and social care services.

A number of interventions have been shown to be cost and clinically effective at preventing some falls and fractures, resulting in improved health outcomes and independence for older people, and savings to health and care services. Research and clinical guidance indicate that this includes multi-factorial falls risk assessment (MFFRAs), strength and balance training, home hazard assessments, and Fracture Liaison Services, to name a few[2]. The effective and integrated commissioning of these interventions will reduce demand by shifting the focus towards prevention, reduce variation in the quality, safety and outcomes of care, and improve efficiency. The recent publication of the World Guidelines provides a detailed blueprint for commissioning evidence-based falls prevention services in practice, with care pathways linking primary and community services to specialists where required[5].

A review of local service provision against NICE clinical guidance for falls prevention has shown that there are some fundamental changes that need to take place in the Cambridgeshire and Peterborough system to improve outcomes for people who are at risk of falling. The analysis shows that local falls prevention services involved in falls risk assessment or providing interventions in primary care, secondary care or community are disjointed and working in isolation. This results in older adults receiving an inconsistent assessment and offer of interventions to reduce their risk depending on where they present in the system. It is paramount that the system addresses this inequity in assessment and multi-factorial intervention and ensures that older adults are receiving all

[1] NICE. Falls: Assessment and prevention of falls in older people. NICE Clinical Guidance 161. 2013. Available at: 1 (nice.org.uk)

[2] Public Health England. Falls and Fragility Fracture Consensus Statement. Supporting Commissioning for Falls Prevention London: Public Health England. 2017. Available at: https://www.gov.uk/government/publications/falls-and-fractures-consensus-statement [Accessed 14 June 2019]

[3] National Osteoporosis Guideline Group (NOGG). Clinical Guideline for the Prevention and Treatment of Osteoporosis. 2021. Full Guideline | NOGG

[4] NHS Right Care falls and fragility fractures pathway. 2017. https://www.england.nhs.uk/rightcare/products/pathways/falls-and-fragility-fractures-pathway/

[5] World guidelines for falls prevention and management for older adults: a global initiative (nih.gov)

the interventions necessary to reduce their risk. The evidence is clear that assessments alone do not reduce risk, but they must be accompanied by multi-factorial intervention. This strategy outlines plans to develop a system-wide, integrated[6] falls prevention pathway linking primary and community services to specialists where required.

Another clear gap is the commissioning and delivery of a Fracture Liaison Service (FLS) in North West Anglia Foundation Trust (NWAFT). FLS's have been shown to benefit patient outcomes, through a significant reduction in subsequent fragility fractures and gains in quality of life, whilst at the same time reducing hospital bed days, surgeries, need for institutional social care, and their associated costs. A previous scoping exercise conducted by Cambridgeshire and Peterborough Public Health Team has shown that there is a gap in the delivery of a resilient and robust Fracture Liaison Service at NWAFT. Resourcing an FLS in NWAFT will provide high quality care to patients across the ICS, currently only available to those with access to CUHFT. This will directly contribute towards the ICS's stated aim to "increase the number of years people spent in good health".

In addition to addressing the two gaps above, this three-year strategy, 2023-2026, outlines the plans of organisations across Cambridgeshire and Peterborough to reduce falls and falls-related injuries by taking a system wide approach to falls prevention and bone health. It details six priorities to achieve the vision of *"working together to reduce the rate of falls and reduce hip fracture admissions amongst older adults, by preventing first falls and reducing the risk of subsequent falls to enable older people in Cambridgeshire and Peterborough to enjoy an active, fulfilling life".*

The priorities are:

1. Prevention and early identification of people at risk of fall
   The aim is to intervene at the earliest opportunity to prevent and reduce the number of people who have a first fall. The focus is on ensuring the public and staff engaging with older adults have the information they need to make informed choices about falls risk factors and have access to opportunities to live and age well. The strategy strongly recognises the importance of scaling up physical activity in preventing falls and reducing the risk of falls, and this is weaved throughout the different priorities and settings. The strategy attempts to define action for active, independent older adults as well less active, dependent adults who may be receiving support from Adult Social Care and Care and Residential Homes. The aim is to ensure that all older adults have the opportunity to be more active and have access to strength and balance training to reduce falls and frailty.

2. Evidence-based and good practice falls prevention interventions and services
   The aim is to ensure that people who have fallen have timely access to services, interventions and opportunities that will support a reduction in the risk of falls and injurious falls. The development of the integrated falls prevention pathway will support this.

3. Action to address risk in hospital
   The aim is to minimise the risk of inpatient falls, repeat falls and re-admissions, and improve quality of life. A key focus in both CUHFT and NWAFT is the development of electronic, multi-disciplinary multi-factorial falls risk assessments. This should support an improvement in

[6] In this context, integration describes the co-ordination of care into a single or coordinated pathway across disciplines and organisations e.g., the development of shared protocols. It does not describe the establishment of a new integrated service.

communication of valuable information with external partners and contribute to a whole system approach.

4. Action to address risk in care homes
   The aim is to prevent, reduce and manage falls in nursing and residential home residents in order to reduce the risk and consequences of fragility fracture and a long lie, improve quality of life and reduce system wide pressures. Key features of this priority include supporting care and residential homes to conduct multi-factorial falls risk assessments, manage people who have fallen and embed movement and activity in the lives of residents.

5. Detection and management of fragility fracture
   The aim is to ensure early identification and management of falls and osteoporosis risk factors to prevent a first or subsequent fragility fracture and provide optimal support after a fragility fracture. This priority outlines how the system plans to address the gap in a robust and resilient FLS identified by the gap analysis. Public Health resource has been allocated to take forward the scoping and development of a strategy and to support the development of a business case in year 1 of the strategy. This is intended to enable the system to take action to reduce inequalities in health outcomes.

6. Inclusive services
   The aim is to ensure early falls prevention services are inclusive and accessible to all service users in line with the Equality Act and Public Sector Equality Duty to enable all older adults to receive falls prevention interventions that meets their needs**.**

The success of the strategy action plan will be measured by the reduction in the rate of hip fracture admissions. The strategy will be monitored by the Cambridgeshire and Peterborough Falls Prevention Strategy Group bi-monthly. It will report to the Joint Commissioning and Executive Group (JCPEG) and Health and Wellbeing Board, as requested.

View the actions agreed in the action plan.

1.0 Strategy

1.1 Vision/aim

“Health, social care and voluntary sector partners to work together over the next three years to reduce the rate of falls and reduce hip fracture admissions amongst older adults, by preventing first falls and reducing the risk of subsequent falls to enable older people in Cambridgeshire and Peterborough to enjoy an active, fulfilling life”.

1.2 Strategic priorities

The strategic priorities are informed by local need and national research and evidence on what works to prevent falls. Our approach is centred on the need to employ a whole-system falls prevention approach comprising an array of evidence-based interventions targeted at specific population groups and the delivery of services in an integrated manner by a range of sectors and partners across the system. The approach will address varying phases of need across the population ranging from older people who are well and mobile with no risks identified; those demonstrating risk factors for falls; those who have fallen and injured themselves; and those with significant frailty and multi-morbidities that may have already had interventions related to falls.

The priorities are underpinned by good communication, information sharing, and workforce development to enable staff and volunteers to be confident and competent in delivering falls prevention support.

This strategy provides the opportunity for partners to work together on agreed priorities to ensure that Cambridgeshire and Peterborough residents are able to benefit from effective, high quality falls prevention.

The six priorities for this falls prevention strategy are:

1. Prevention and early identification of people at risk of falls - to intervene at the earliest opportunity to prevent and reduce the number of people who have a first fall,

2. Evidence-based and good practice falls prevention interventions and services – to ensure that people who have fallen have timely access to services, interventions and opportunities that will support a reduction in the risk of falls and injurious falls,

3. Action to address risk in hospital – to minimise the risk of inpatient falls, repeat falls and re-admissions, and improve quality of life,

4. Action to address risk in care homes - to prevent, reduce and manage falls in nursing and residential home residents in order to reduce the risk and consequences of fragility fracture and a long-lie, improve quality of life and reduce system wide pressures,

5. Detection and management of fragility fractures – to ensure early identification and management of falls and osteoporosis risk factors to prevent a first or subsequent fragility fracture and provide optimal support after a fragility fracture,

6. Inclusive services - to ensure early falls prevention services are inclusive and accessible to all service users in line with the Equality Act and Public Sector Equality Duty to enable all older adults to receive falls prevention interventions that meets their needs**.**

2.0 Introduction

2.1 Background

Falls and related injuries are a common and significant problem for older adults[1]. The combination of high incidence and susceptibility to injury in older adults makes falls a major public health issue. Both the incidence and severity of falls and falls-related injuries increases after the age of 60 years old[7].

Around one in three people over 65 years old, and half of those over 80, experience a fall at least once a year[1,8] . The incidence rates of falls in people living in nursing homes and patients admitted to hospitals are almost three times the rates of those living in the community[8]. Those who fall once are two to three times more likely to fall again within the year[8].

Falls are a major cause of morbidity and the primary cause of injury related deaths in people aged 75+ in the UK[1]. Approximately 10% of falls in the community result in serious injury and 5% of these are fractures[8] . Injury rates are considerably higher in nursing homes and hospitals with 10-25% of institutional falls resulting in fracture, laceration, or the need for hospital care[8]. Hip fractures are one of the most serious injuries resulting from a fall with approximately 10% of people who fracture a dying within one month and a further third within a year[8]. Up to 90% of older patients who fracture their hip do not return to their previous level of mobility or independence[9]. Falls are a significant factor in people having to move from their own homes into high cost long term residential care[9].

Falls have a large impact on quality of life as well as physical health. This can include distress, chronic pain, loss of confidence, activity avoidance, loss of independence, social isolation and increasing frailty[1,2]

The impact of falls on healthcare costs is significant. Approximately, 255,000 falls-related emergency hospital admissions occur in people aged 65 and older every year in England and these are estimated to cost the NHS £2.3 billion a year[2]. Fragility fractures are estimated to cost the UK £4.4bn; £2bn of this can be attributed to hip fractures and £1.1bn to social care[2].

In Cambridgeshire and Peterborough, there were 2,699 emergency admissions due to falls and 1,015 admissions due to a hip fracture in 2022/23. The estimated combined cost of these hospital admissions was £16.3M, an increase of over £1.9M from the previous year (£14.4M in 2021/22)[10]. This does not include wider health and social care costs such as primary care, ambulance or adult

[7] American Geriatrics Society 2001. Guidelines for prevention of falls in older persons. *J Am Geriatr Soc.*49:664-672
[8] Todd C, Skelton D. What are the main risk factors for falls amongst older people and what are the most effective interventions to prevent these falls ? *World Health*. 2004;(March):28. [Accessed 17 May 2022]: Copenhagen, WHO Regional Office for Europe (Health Evidence Network report; http://www.euro.who.int/document/E82552.pdf,
[9] Cambridgeshire JSNA. Preventing ill-health in older people. 2013. Prevention-of-Ill-Health-in-Older-People-JSNA-2013.pdf (cambridgeshireinsight.org.uk)
[10] Costs calculated by Public Health Intelligence Team, June 2023 from DSCRO SusCP.ip_spell_all. Definition: Emergency admissions of 'falls where primary diagnosis is a hip fracture', 'S72.0 Fracture of neck of femur', 'S72.1', 'S72.2' and 'All other falls'. Average cost of hip fracture £9,890 and cost of 'other fall' £3,166.

social care costs. One study estimating costs to health and social care as a result of a fall suggested that 60% of the total health and social care costs were incurred by social services[11].

It was anticipated that the Coronavirus pandemic would have an impact on the incidence of falls as a result of decreased physical activity during the restrictions and the subsequent increase in deconditioning in some older age groups, with some groups disproportionately affected[12]. The level of impact is unclear. Data shows that the overall rate of falls admissions in over 65s in Cambridgeshire and Peterborough has not increased since a statistically significant decrease at the start of the pandemic. However, data shows that there is an increasing trend in the rate of hip fractures across both Cambridgeshire and Peterborough since 2020/21. This could potentially be associated with the decrease in physical activity and deconditioning during the pandemic. Whilst there are signs that physical activity levels have recovered and now exceed pre-COVID levels[13], it is unclear whether the level of activity has increased in the population groups disproportionately affected by deconditioning and whether it is sufficient to reverse the deconditioning or how this relates to hip fractures. Local services (Adult Social Care) have reported a significant increase in service users presenting to the service since the pandemic who are deconditioned and have a higher level of need.

Osteoporosis is another key risk factor for injurious falls that is critical to include in the strategy as it increases bone fragility and susceptibility to fracture after a fall. Osteoporosis is a common condition affecting 2% of the population at 50 and 25% at 80 years of age[14]. Approximately, 549,000 patients present with fragility fractures to hospitals in the UK each year[3]. The estimated cost to the NHS of fragility fractures in 2017 was estimated to be £4.7 billion per annum nationally[3Error! Bookmark not defined.]. People who sustain a fragility fracture are at least twice as likely to sustain a further fracture[15]. Treatment can reduce the risk of fragility fracture and its complications[15].

This strategy sets out Cambridgeshire and Peterborough's plans to reduce falls and falls-related injuries by taking a system wide approach to falls prevention. The strategy has been developed by a multi-agency Falls Prevention Strategy Group (Appendix 1) and informed by a local needs assessment and national policy and guidance, including the Public Health England Falls and Fracture Consensus Statement[2], NHS Rightcare Falls and Fragility Fractures Pathway[4], NICE clinical guidance 161[1] and the recent World Guidelines for falls prevention[16]. It builds upon the achievements of the one-year strategy and enters a period of more stability with the Integrated Care System (ICS) being more established and services having advanced along their recovery journey post-COVID to return to business as usual.

The implementation of the first strategy for Cambridgeshire and Peterborough has seen good progress. It has been used as a tool to help galvanise partners working on falls prevention across the system and facilitate the start of more joined-up system working. It has seen strengthened relationships from a broader group of key stakeholders and opportunities to join-up, and the establishment of structures to monitor and provide accountability for driving forward the key actions in the action plan. Positively, the period of the strategy saw a decrease in hospital admissions due to fall in 2021/22 compared to 2020/21, however, it also saw an increase in admissions for hip

[11] Craig J, Murray A, Mitchell S et al. The high cost to health and social care of managing falls in older adults living in the community in Scotland. Scottish Medical Journal 2013;58(4):198-203. http://scm.sagepub.com/content/58/4/198.
[12] Public Health England. Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults. 2021. Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults (publishing.service.gov.uk)
[13] Active Lives Adult Survey November 2021-22 Report (sportengland-production-files.s3.eu-west-2.amazonaws.com)
[14] NICE. Osteoporosis: assessing the risk of fragility fracture. NICE Clinical Guidance 146: 2012. Overview | Osteoporosis: assessing the risk of fragility fracture | Guidance | NICE
[15] British Orthopaedic Association (2007). The care of patients with fragility fracture. Blue Book (bgs.org.uk)
[16] World guidelines for falls prevention and management for older adults: a global initiative (nih.gov)

fractures during the same period. This highlights the ever-increasing and critical challenge for the local system to come together to prevent and manage falls and their related injuries to help our residents to enjoy and active and fulfilling older age.

This longer-term 2023-2026 strategy will provide clearer direction on what is needed to achieve the vision. The findings of a comprehensive gap analysis against NICE guidance and feedback from older adults about current services have contributed to this. These have shown that the multi-disciplinary management of falls will be important to successfully driving down rates of falls and hip fracture admissions. The establishment of an ICB Falls and Frailty lead and workstream, combined with the priority around personalised care, (leading to a focus on frailty) of the North and South Accountable Business Units (ABUs), provides an opportunity to drive the necessary integration that will improve outcomes for older adults who experience falls:

"We need to make a transformative cultural shift from individual organisational working to a partnership approach." Joint Forward Plan Summary[17]

2.2 Strategic context

2.2.1 NHS Long Term Plan 2019

The NHS long-term plan sets out key ambitions for the NHS over the next 10 years. Supporting people to age well is covered under the government's key commitment to a new NHS service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting[18]. The following commitments are particularly relevant to falls prevention:

- Expansion of community multidisciplinary teams including GPs, allied health professionals, social care and the voluntary sector to work together in an integrated way to provide tailored support that helps people live well and independently at home for longer
- Assessment of risk of unwarranted health outcomes of the local population by Primary Care Networks working with local community services to make support available to people where it is most needed. Falls prevention schemes, including exercise classes and strength and balance training, are explicitly stated.
- Upgrading NHS support in care homes including making sure there are strong links between care homes, local general practices and community services through the delivery of The Framework for Enhanced Health in Care Homes (EHCH)
- Developing more rapid community response teams, to support older people with health issues before they need hospital treatment and help those leaving hospital to return and recover at home.

2.2.2 Integrated Care Systems

In the last year, significant changes have taken place in the way the health and care system is organised following the formalisation of Integrated Care Systems (ICSs) as statutory bodies on the 1 of July 2022. ICSs are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health

[17] Joint Forward Plan | CPICS Website
[18] nhs-long-term-plan.pdf

and care services to meet the needs of their population. Key aspirations of ICSs are to achieve greater integration of health and care services; improve population health and reduce inequalities. ICSs and are a key part of the future direction for the NHS as set out in the NHS Long-Term Plan.

The Cambridgeshire and Peterborough ICS comprises an Integrated Care Board (ICB) and Integrated Care Partnership (ICP) Board and five Accountable Business Units (ABUs) (See Appendix 2 for governance structure). Two of the ABUs are place-based partnerships (the North Care Partnership and the South Care Partnership) and are of relevance to the strategy as they are responsible for the co-ordination, planning and delivery of integrated services and personalised care in the area.

The Cambridgeshire and Peterborough ICS has published its Joint Forward Plan and Health and Wellbeing Integrated Care Strategy 2023-28 setting out their vision for health and care services in Cambridgeshire, Peterborough and Royston for the next five years. The shared vision across partners 'All Together for Healthier Futures' centres on four priorities as follows:

- Our children are ready to enter education and exit prepared for the next phase of their lives
- Reducing poverty through better employment and housing
- Creating an environment to give people the opportunities to be as healthy as they can be
- Promoting early intervention and prevention measures to improve mental health and well-being.

The North Care Partnership and the South Care Partnership delivery plans have priorities around frailty and/or falls.

2.2.3 Care Together

Care Together is a co-produced place-based programme to help older people remain living independently in their own homes for longer. Work began in East Cambridgeshire in 2021-22 and has been expanded across the rest of Cambridgeshire, following significant investment by Cambridgeshire County Council and partnerships with multiple stakeholders, including PCNs and local voluntary, community and voluntary and community sector (VCSE) organisations. A key aim of the programme is to collaboratively improve care and support for older people in the community to promote independence and delay demand for long term health and social care services. This means rethinking how services are commissioned and delivered, transforming them into an easy-to-access local offer wrapped around individuals, rather than a one-size fits all approach.

2.3 Causes of falls and fractures

The causes of falls are multifactorial, and over 400 separate risk factors have been identified[1]. These risk factors can be classified as either intrinsic or extrinsic and may be modifiable or non-modifiable.

Major intrinsic risk factors include muscle weakness, poor balance, visual impairment, and a number of specific conditions. These include a wider range of long-term conditions such as arthritis, cognitive impairment, depression, diabetes, high alcohol consumption, incontinence, Parkinson's disease, stroke and syncope[2]. Major extrinsic risk factors include polypharmacy (i.e., taking over four prescription medications), psychotropic medications, and environmental hazards such as inadequate lighting, poorly fitted carpets, and lack of equipment for bathing[2].

The risk of falling has been shown to increase as the number of risk factors increases[7] - a fall generally results from an interaction between multiple diverse risk factors and situations[19]. For example, environmental hazards may create conditions likely to cause trips or slips for an older person who may already have multiple risk factors for fall and this risk may be aggravated by behavioural risk factors – such as the faller was hurried or moving beyond limits of stability - leading to a fall[19].

Previous history of falls is a significant predictor of future falls[4].

Major risk factors for fragility fractures are varied. They include low bone mineral density, previous fracture, age, female sex, previous falls, use of glucocorticoids, rheumatoid arthritis, smoking, high alcohol consumption, low BMI and visual impairment[4].

Falls can affect a diverse range of older adults right through from the youngest-old to the oldest-old. Falls can be a sign of a new health condition (potentially temporary one) or the worsening of chronic underlying health issues such as frailty[2].

2.4 Local context

2.4.1 Demography

The resident population aged 65+ in Cambridgeshire and Peterborough in 2021 was 127,090 and 30,685 respectively. The number of older people aged 65 and over is forecast to increase significantly between 2021 and 2041, increasing by 58,445 in Cambridgeshire and 13,895 in Peterborough, an increase of 46% and 45.3% respectively.

Based on the population in 2021, approximately 38,127 people aged 65 and over in Cambridgeshire and 9,206 people in Peterborough will have experienced a fall at least once during the year. Applying modelled proportions of people who fall to local population estimates in 2041 suggests that 55,661 over 65s in Cambridgeshire and 13,374 in Peterborough will fall in 2041.

Table 1: Cambridgeshire and Peterborough 65+ Population forecast

	2021	2026	2031	2036	2041	% change between 2021 and 2041
Cambridgeshire	127,090	141,590	160,275	176,130	185,535	46%
Peterborough	30,685	33,775	37,915	42,030	44,580	45.3%

Source: Cambridgeshire County Council 2021 based population forecasts[20]

[19] Karen L. Perell, et al., Fall Risk Assessment Measures: An Analytic Review, *The Journals of Gerontology: Series A*, Volume 56, Issue 12, 1 December 2001, Pages M761–M766, https://doi.org/10.1093/gerona/56.12.M761

[20] Cambridgeshire Insight – Population – Local Population Estimates and Forecasts

2.4.2 Incidence of falls and hip fractures

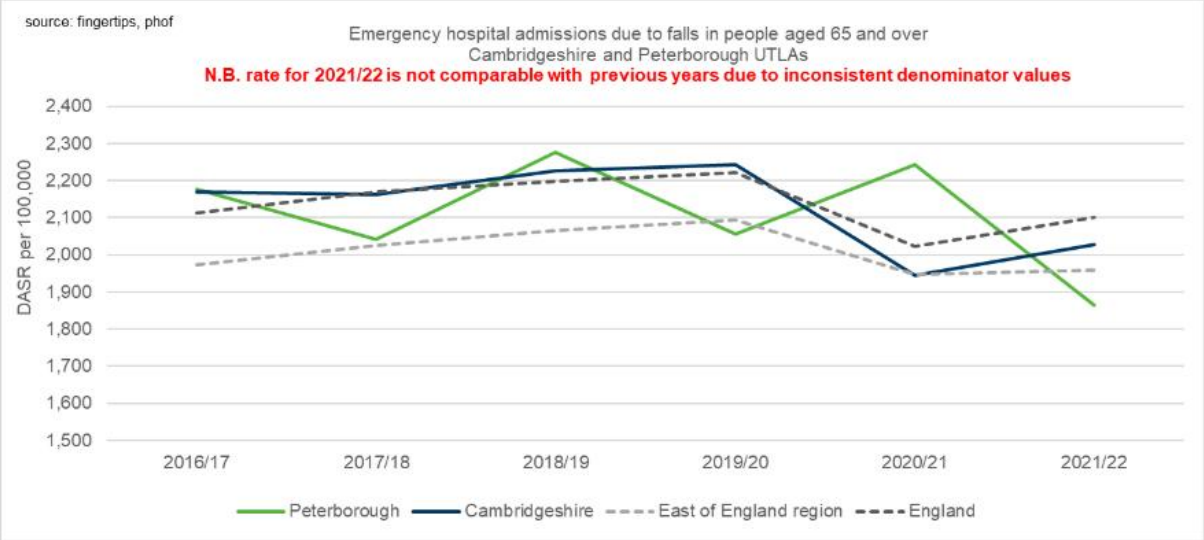
2.4.2.1 County level

The Public Health Outcomes Framework reports on admissions for injury due to falls and hip fractures. In 2021/22, the directly age-standardised rate (DASR) of hospital admissions for injury *due to falls* in people aged 65+ years in Cambridgeshire was statistically similar to the national average (2,027 per 100,000 in Cambridgeshire compared to 2,100 per 100,000 in England) and in Peterborough it was statistically significantly better than the England average (1,865 per 100,000 in Peterborough compared to 2,100 per 100,000 in England)(Figure 1)(Appendix 3)[21].

Compared to its nearest CIPFA[22] neighbours, Cambridgeshire was ranked 9th out of 16 when ranked by highest (worst) to lowest (best) rate of admission due to falls in 2021/22 and Peterborough was ranked 13th out of 16 neighbours.

The risk of falling and emergency admissions for injury due to falls and hip fracture increases substantially with age and the highest rates of admission are in those aged 80 years and above (Cambridgeshire in 2021/22: rate of admissions due to falls in 65-79 years was 876 per 100,000 compared to 5,367 per 100,000 in the 80+. Peterborough rate of admissions due to falls in 65-79 years was 995 per 100,000 compared 4,388 per 100,000 in the 80+).

Figure 1: Emergency admissions due to falls in over 65s in Cambridgeshire and Peterborough



Source: Fingertips, Public Health Outcomes Framework

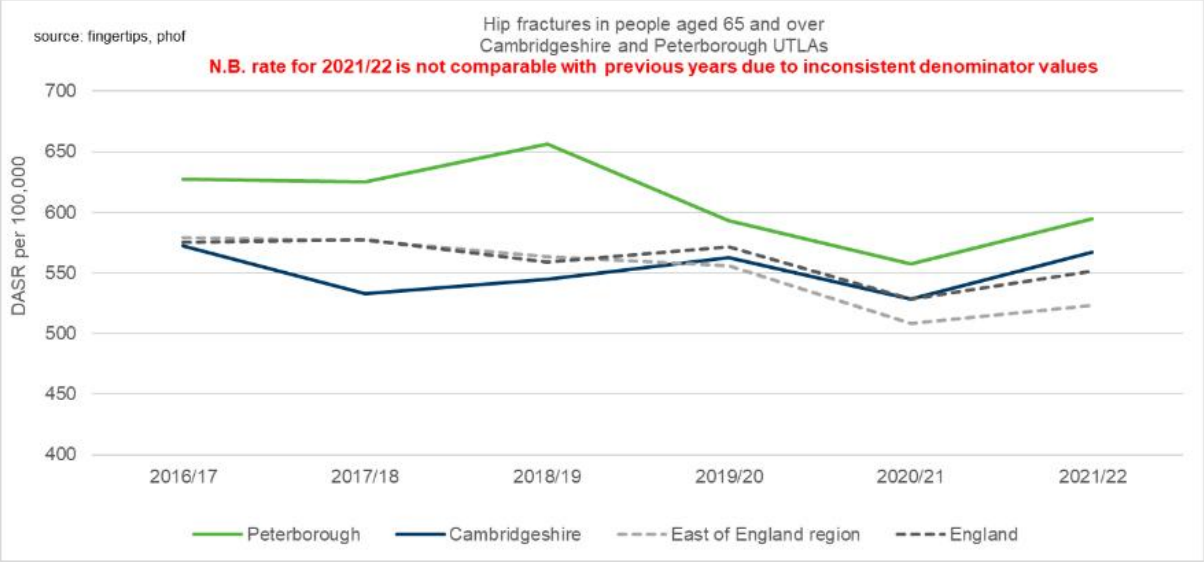
The age-standardised rate of admissions due to *hip fractures* in people aged 65+ in Cambridgeshire and Peterborough was statistically similar to the England average in 2021/22 (Cambridgeshire: 567 per 100,000; Peterborough: 594 per 100,000; England 551 per 100,000)(Appendix 4)[21]. Compared to

[21] Office for Health Improvement & Disparities. Public Health Profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022

[22] Chartered Institute of Public Finance and Accounting (CIPFA) nearest neighbours model uses statistical processes to classify local authorities into similar groups based on a range of socio-economic indicators to allow comparison and benchmarking across local authorities.

their nearest CIPFA[23] neighbours, Cambridgeshire was ranked 4th out of 16 when ranked by highest (worst) to lowest (best) rate of admission due to hip fracture in 2021/22 and Peterborough was ranked 6th out of 16 neighbours.

Figure 2: Emergency admission due to hip fracture in 65+ in Cambridgeshire and Peterborough



Source: Fingertips, Public Health Outcomes Framework

2.4.2.2 District level

Analysis of the rate of admissions *due to falls* in 2021/22 by district shows that all the districts in Cambridgeshire had a rate of admissions for falls that was similar or better than the national average[21] (Appendix 5). Similarly, the rate of admissions for *hip fractures* was similar to the national average in all Cambridgeshire districts in 2021/22.

2.4.2.3 Falls and hip fractures by deprivation

Analysing the PHOF data by deprivation shows that there are health inequalities associated with admissions due to falls and hip fractures. The data shows that there are higher rates of admissions due to falls and hip fractures in the most deprived lower super output areas (LSOAs) in England compared to the least deprived LSOAs (Appendix 6)[21]. There is no data available to reflect this at the Cambridgeshire or Peterborough level but national level data can be used as a proxy.

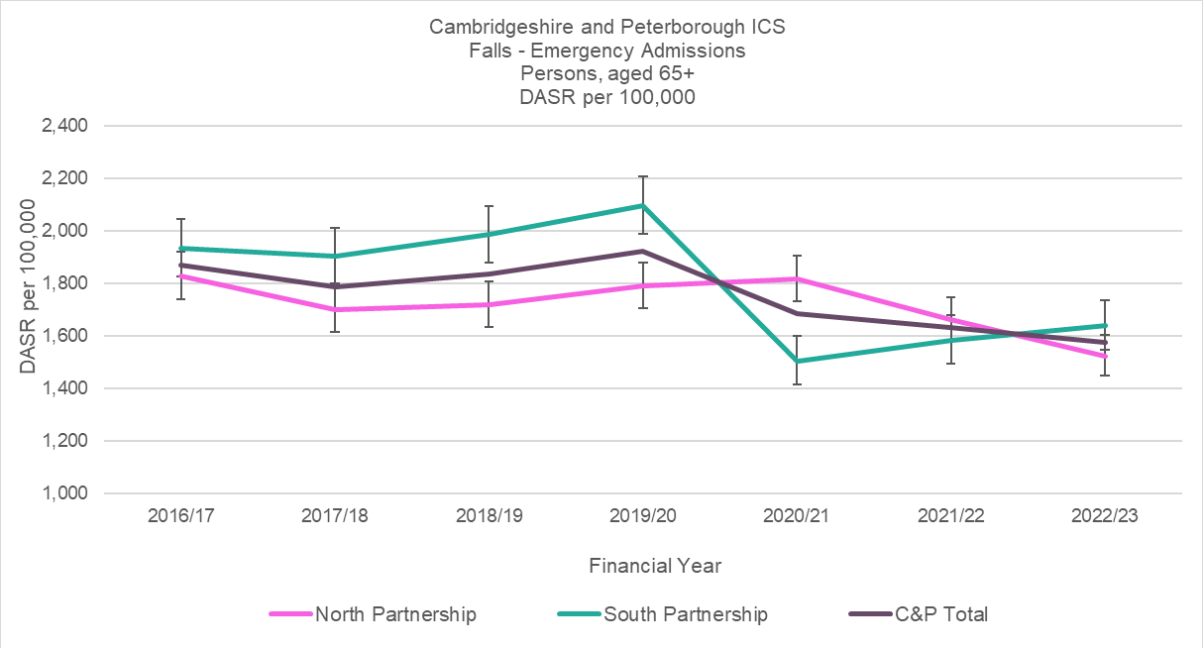
2.4.2.4 North and South Place

The directly age-standardised rate (DASR) of hospital admissions for injury *due to falls* in people aged 65+ years living in the North and South Partnership Places of Cambridgeshire and Peterborough in 2022/23 was 1,524 per 100,000 and 1,639 per 100,000 respectively (number of admissions was 1,496 in the North Place and 1,203 in the South Place)(Figure 3). This continues the slight downward

[23] Chartered Institute of Public Finance and Accounting (CIPFA) nearest neighbours model uses statistical processes to classify local authorities into similar groups based on a range of socio-economic indicators to allow comparison and benchmarking across local authorities.

trend in admissions since 2020/21 in the North Place (DASR = 1,816 per 100,000 in 2020/21 and number of admissions was 1,714) and continues the upward trend in admissions since 2020/21 in the South Place (DASR = 1,505 per 100,000 and number of admissions was 1,046)(Appendix 7). It should be noted that a statistically significant decrease in the rate of admissions due to falls was observed in the South Place between 2019/20 and 2020/21, decreasing from the highest to the lowest rate in the South Place during the last 5 years (DASR of falls admissions was 2,095 per 100,000 in 2019/20 and 1,505 per 100,000 in 2020/21). This decrease correlates with the onset of the first lockdown of the coronavirus pandemic in March 2020. However, as stated previously, the trend has now reversed and is on an upward trajectory.

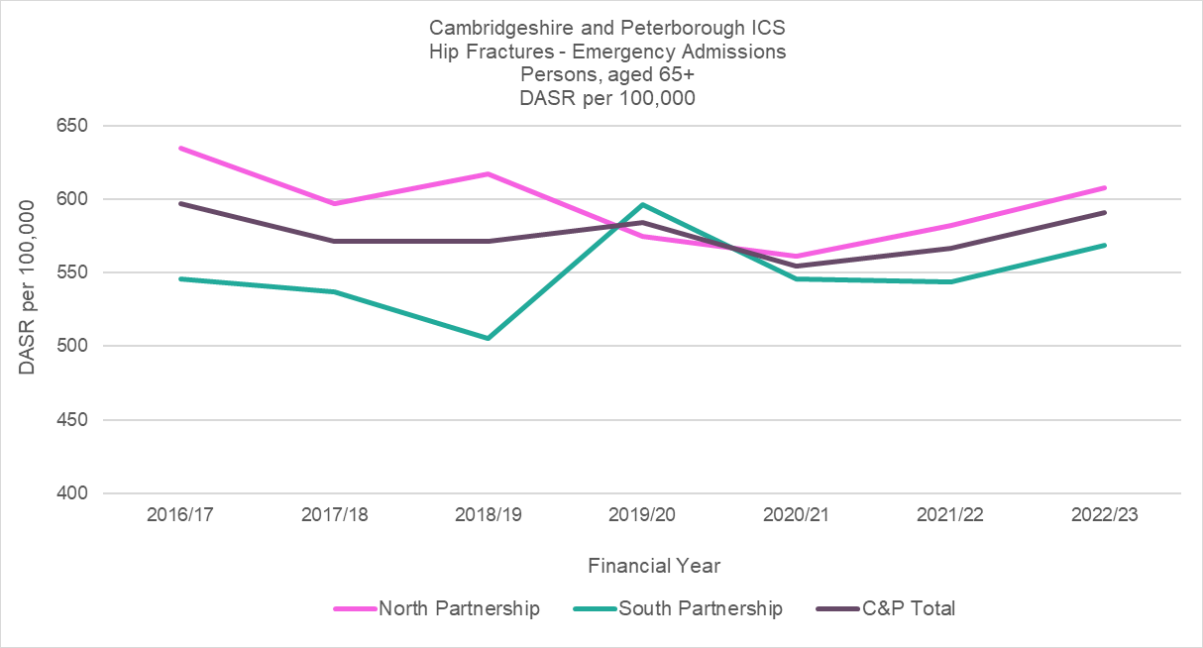
Figure 3: Age standardised rate of admissions for injury due to fall by in 65+, by Place



Source: CCG DSCRO SusCP.ip_spell_all

The directly age-standardised rate (DASR) of hospital admissions due to *hip fracture* in people aged 65+ living in the North and South Places of Cambridgeshire and Peterborough in 2022/23 was 608 per 100,000 and 569 per 100,000 respectively (number of hip fracture admissions was 599 in the North and 416 in the South)(Figure 4). This represents an upward trend in admissions in the North Place in the two years since 2020/21 (DASR = 561 per 100,000 in 2020/21 and n=529)(Appendix 8). The admissions in the South Place have increased in the last year between 2021/22 and 2022/23 having been on a decreasing trajectory for two years between 2019/20 and 2021/22.

Figure 4: Age standardised rate of admissions due to hip fracture by Integrated Care Partnership



Source: CCG DSCRO SusCP.ip_spell_all

2.4.2.5 Primary Care Network (PCN) level

Analysis of the rate of admissions by Primary Care Network (PCN) shows that Cambridge City PCN was the only PCN in the ICS to have a statistically significantly higher rate of hospital admissions due to *injurious falls* in people 65+ than the ICS average in 2022/23 (2,026 per 100,000 in Cambridge City PCN compared to 1,575 per 100,000 in the ICS)(Appendix 7). Furthermore, rates were statistically significantly high in this PCN in six of the last seven years between 2016/17 and 2023, with the exception of 2020/21 where the rate was similar to the ICS average. Central Thistlemoor and Thorpe Road PCN and BMC Paston PCN were the only PCNs to have a statistically significantly lower rate of admissions *due to falls* than the ICS average in 2022/23 (1,005 per 100,000 in Central Thistlemoor and Thorpe Road PCN and 1,240 per 100,000 in BMC Paston compared to 1,575 per 100,000 in the ICS). The rates in Central Thistlemoor and Thorpe Road PCN were statistically significantly lower in six out of the last seven years, with the exception of 2018/19 which was similar to the ICS average. All the other PCNs had rates similar to the ICS average in 2022/23.

Analysis of the rate of admissions for *hip fracture* by PCN shows that Meridian PCN had a statistically significantly lower rate of admissions than the ICS average in 2022/23. All the other PCNs had a rate of hospital admissions for hip fracture similar to the ICS average in 2022/23 (Appendix 8).

2.4.2.6 Admissions by age, gender and ethnicity

Analysis of the characteristics of individuals admitted as a result of injury due to falls in 2022/23 shows that 48% were aged 85+ years, 67% were female and 83% were White British. Admissions due to hip fracture showed a similar picture (Appendix 9).

2.4.3 Summary of epidemiology

- the population is ageing and rapidly increasing in number

- falls and fracture risk increases substantially with age
- the coronavirus pandemic is expected to increase the number of people experiencing a fall as a result of deconditioning
- costs to the health and social care system are substantial and will increase over time.

3.0 The evidence

The evidence base to support falls prevention activities is strong and a number of national documents have been published in recent years to provide guidance to local areas on the high-impact interventions needed to reduce falls in older people living in the community.

3.1 World Guidelines for falls prevention and management for older adults: A global initiative

The World clinical guidelines outline a framework and set of evidence based and expert recommendations to support the identification and assessment of falls risk[5]. The guidelines, developed by a World Falls Task Group and published in Age and Ageing in 2022, offer a more up-to-date and accurate understanding of current research evidence and implications for practice in the interim of the National Institute for Health and Care Excellent (NICE) updating their 2013 guideline.[24] The framework is based around the following principles:

- Falls Risk Stratification

- Assessment

- Management and Interventions

- Assessment and Treatment algorithm.

The full list of recommendations that should be offered can be found in Appendix 10.

3.2 NICE guidelines

3.2.1 NICE Clinical Guideline CG161 - Falls: assessment and prevention of falls in older people

NICE Clinical Guideline CG161 (2013) outlines the preventable nature of some falls and provides guidance on the assessment and prevention of falls in older people both in the community and in hospital settings[1].

The key recommendations are:

- ***Case or risk identification***: Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall(s). Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.

- ***Multifactorial risk assessment:*** All older people with recurrent falls, or assessed as being at increased risk of falling, should be considered for an individualised multifactorial intervention assessment by a multi-disciplinary team. This assessment should identify and

[24] Surveillance decision | Evidence | Falls in older people: assessing risk and prevention | Guidance | NICE

address future risk, and offer individualised intervention aimed at promoting independence and improving physical and psychological function.

- ***Multifactorial intervention programmes:*** All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention. In successful programmes the following specific components are common:

    o strength and balance training,

    o home hazard assessment and intervention,

    o vision assessment and referral,

    o medication review with modification/withdrawal.

- ***Strength and balance training:*** Recommended particularly for older people living in the community with a history of recurrent falls and/or balance and gait deficit

- ***Exercise in extended care settings:*** Multifactorial interventions with an exercise component are recommended for older people in extended care settings who are at risk of falling

- ***Home hazard and safety intervention:*** Older people who have received treatment in hospital following a fall should be offered a home hazard assessment and safety intervention/modifications by a suitably trained healthcare professional

- ***Psychotropic medications:*** Older people on psychotropic medications should have their medication reviewed, with specialist input if appropriate, and discontinued, if possible, to reduce their risk of falling

- ***Cardiac pacing:*** Cardiac pacing should be considered for older people with cardioinhibitory carotid sinus hypersensitivity who have experienced unexplained falls

- ***Information and education:*** Older people should be encouraged to participate in falls prevention programmes including education and information about how to prevent further falls

- ***Professional education:*** All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.

The key recommendations for preventing falls in older people during a hospital stay are:

- Regard as being at risk of falling in hospital: inpatients over 65; and patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition and manage their care according to guidelines

- For patients at risk of falling in hospital, consider a multifactorial assessment and a multifactorial intervention

- Ensure that any multifactorial assessment identifies the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay.

3.2.2 NICE clinical guideline 146: Osteoporosis

NICE guidance on osteoporosis is relevant to reducing the risk of fractures from falls[14]. The short clinical guideline (CG 146) on osteoporosis for people 18+ years aims to provide guidance on the selection and use of risk assessment tools in the care of people who may be at risk of fragility fractures in all settings in which NHS care is received. It recommends considering assessment of fracture risk:

- In all women aged 65 years and over and all men aged 75 years and over
- in women aged under 65 years and men aged under 75 years in the presence of risk factors[25]
- In people aged under 50 years if they have major risk factors.

To accompany the clinical guideline, NICE have produced a number of technical appraisals to support the primary and secondary prevention of osteoporosis and to provide guidance around the use of bisphosphonates for treating osteoporosis[26,27,28].

3.2.3 NICE clinical guideline 124: Hip fracture management

This guideline aims to improve care from the time people aged 18 and over are admitted to hospital with a hip fracture through to when they return to the community[29]. Recommendations emphasise the importance of early surgery and coordinating care through a multidisciplinary hip fracture programme to help people recover faster and regain their mobility. It includes recommendations on imaging options in occult hip fracture, timing of surgery, pain relief, anaesthesia and surgical procedures, mobilisation strategies, multidisciplinary management, patient and carer information.

3.3 NHS RightCare pathway: Falls and Fragility fractures

The NHS RightCare pathway: Falls and Fragility fractures defines the key interdependent components required for an optimal system for the prevention and management of falls and fragility fractures[4]. It states that commissioners responsible for falls and fractures should:

- focus on the three priorities for optimisation:
    i. Falls prevention
    ii. Detecting and Managing Osteoporosis
    iii. Optimal support after a fragility fracture
- work across the system to ensure that schemes to deliver the higher value interventions are in place to address variation, improve outcomes and reduce cost to the NHS:
    - Targeted case-finding for osteoporosis, frailty and falls risk
    - Strength and balance training for those at low to moderate risk of falls
    - Multi-factorial intervention for those at higher risk of falls
    - Fracture liaison service for those who have had a fragility fracture
- use the Falls Prevention Consensus Statement and Resource Pack.

25 Risk factors include: previous fragility fracture; current use or frequent recent use of oral or systemic glucocorticoids; history of falls; family history of hip fracture; other causes of secondary osteoporosis; low body mass index (BMI) (less than 18.5 kg/m2); smoking; alcohol intake of more than 14 units per week for men and women.
26 https://www.nice.org.uk/guidance/ta160
27 http://www.nice.org.uk/guidance/TA161
28 https://www.nice.org.uk/guidance/ta464
29 NICE. The management of hip fracture in adults. 2011. Available from: www.nice.org.uk/guidance/cg124

3.4 Falls and fractures consensus statement and resource pack and Return on Investment Tool

Public Health England (PHE) and the National Falls Prevention Coordination Group member organisations have produced a falls and fractures consensus statement and resource pack detailing key interventions, approaches to commissioning and the commitment to national support[2]. These documents were followed by a Return on Investment Tool in 2018[30].

The consensus statement advocates a whole system approach to prevention, response and treatment which includes:

- promotion of healthy ageing across the different stages of the life course to reduce exposure to risk factors e.g., physical inactivity, inadequate nutrition, smoking, and high alcohol consumption
- optimising the reach of evidence-based case finding and risk assessment (around both falls and fractures)
- commissioning of services that provide:
    i. an appropriate response attending people who have fallen
    ii. multifactorial risk assessment and timely and evidence based tailored interventions for those at high risk of falls (shown to reduce the incidence of falls by 24%)
    iii. evidence based strength and balance programmes and opportunities for those at low to moderate risk of falls (home-based and group-based strength and balance programmes (e.g., FaME) reduce the incidence by 29% and 32% respectively. Both demonstrate a £1:£1 financial return on investment, and a societal return on investment of around £2.20:1)
    iv. home hazard assessment and improvement programmes (shown to reduce the rate of falls by 31% with a financial ROI of £3.17:£1 spent and a societal ROI of £7.34:£1[31])
- ensuring that local approaches to improve poor or inappropriate housing address falls prevention and promote healthy ageing
- action to reduce risk in high-risk health and residential care environments
- providing fracture liaison services in line with clinical standards including access to effective falls interventions when necessary
- providing evidence-based collaborative, interdisciplinary care for falls-related serious injuries supported by clinical audit programmes.

[30] Public Health England (2018). A Return on Investment Tool for the Assessment of Falls Prevention Programmes for Older People Living in the Community. London: Public Health England. Available at: https://www.gov.uk/government/publications/falls-prevention-cost-effective-commissioning [Accessed 14 June 2019]

[31] Delivery of an Occupational Therapy-led Home Hazard Assessment and Improvement Programme reduces the rate of falls by 31% and shows a good ROI (Financial ROI is £3.17:£1 spent and a societal ROI of £7.34:£1)[(Error! Bookmark not defined.,30).] The effectiveness is greatest when delivered by OTs and targeted at those at highest risk of falls (People aged 65+, with a history of falls, and also possess more than one other risk factor for falls e.g. use of mobility device, requiring assistance for activities of daily living (ADLs), use of psychoactive medicines.)[31&31.]

3.5 Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults

Public Health England reviewed and modelled the impact of COVID-19 on falls in older people and proposed a number of recommendations to address the predicted increase in rate of falls as a result of decreased physical activity and deconditioning[12,32]. The report recommends a population level approach and a targeted approach to increase participants' levels of strength and balance activities so that they can also safely resume activities they engaged in before the pandemic, such as other forms of physical activity, social activities, accessing healthcare, and work.

Key recommendations for the whole population are:

- promotion and increased availability of strength and balance activity for older adults, involving a gradual increase in activity in order to reduce falls risk and to enable safe and confident participation on other forms of exercise and physical activity
- ensuring that physical activity recovery measures reach those who stand to benefit most from them, including older adults who shielded, with multimorbidity, with dementia, in social care settings and from more deprived backgrounds
- identifying locally which older adults have reduced their levels of physical activity during the COVID-19 pandemic, with a focus on populations where the largest reductions are likely to be found. The largest reductions in strength and balance activity identified in this report were seen in males aged 65 to 74 and females aged 65 to 84.

Key recommendations for the targeted population are:

- referral of older adults with functional loss, transition towards frailty or fear of falls resulting from deconditioning to appropriate rehabilitations services
- raising awareness amongst health and social care staff of post-COVID-19 syndrome, communicating the risks of building up levels of activity levels too rapidly and the need to refer to post-COVID-19 syndrome clinics where symptoms are severe, in order that clinical judgement can be used about whether graded exercise therapy should be recommended.

3.6 Cochrane reviews

The Cochrane Collaboration has produced a series of systematic reviews pertinent to falls prevention with the following being the most recent.

3.6.1 Multifactorial and multiple component interventions for preventing falls in older people

This 2018 review assessed whether fall-prevention strategies which target two or more risk factors for falls (multifactorial interventions) or fixed combinations of interventions (multiple component interventions) are effective in preventing falls in older people living in the community[33]. The conclusion was that:

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[32] Deconditioning is the syndrome of physical, psychological and functional decline that occurs as a result of prolonged inactivity and associated loss of muscle strength

[33] Hopewell S., et al. Multifactorial and multiple component interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2018, Issue 7. Accessed 04 July 2022. Multifactorial and multiple component interventions for preventing falls in older people living in the community - Hopewell, S - 2018 | Cochrane Library

- Multifactorial interventions may reduce the rate of falls[34] by 23% (low-quality evidence). However, there may be little or no effect on other fall-related outcomes.
- Multiple interventions probably reduce the rate of falls by 26% and risk of falls[35] by 18% (moderate-quality evidence).

3.6.2 Exercise for preventing falls in older people living in the community

This 2018 review assessed the effects of exercise interventions for preventing falls in older people living in the community[36]. The conclusion was:

- Balance and functional exercises reduce the rate of falls by 24% and the number of people experiencing one or more falls by 13% (high-certainty evidence)
- Multiple types of exercise (most commonly balance and functional exercises plus resistance exercises) probably reduce the rate of falls by 34% and the number of people experiencing one or more falls by 22% (moderate-certainty evidence)
- Tai Chi may reduce the rate of falls by 19% (low-certainty evidence) as well as reducing the number of people who experience falls by 20% (high-certainty evidence).

3.6.3 Interventions for preventing falls in older people living in the community

This 2012 review assessed the effects of interventions designed to reduce the incidence of falls in older people living in the community[37]. Some of the interventions have been reviewed in more recent Cochrane reviews covered above but other interventions not covered by more recent reviews include:

- Home safety assessment and modification interventions reduced the rate of falls by 19% and risk of falling by 12%
- Pacemakers reduced the rate of falls in people with carotid sinus hypersensitivity by 27% but not the risk of falling
- First eye cataract surgery in women reduced rate of falls by 34%, but the second eye cataract surgery did not
- Gradual withdrawal of psychotropic medication reduced rate of falls by 66%, but not the risk of falling
- A prescribing modification programme for primary care physicians significantly reduced risk of falling by 39%
- An anti-slip shoe device reduced rate of falls in icy conditions by 58%
- Multifaceted podiatry, including foot and ankle exercises with standard podiatry in people with disabling foot pain, significantly reduced the rate of falls by 36%, but not the risk of falling.

3.6.4 Interventions for preventing falls in older people in care facilities and hospitals

This 2018 review assessed the effectiveness of interventions designed to reduce falls in older people in care facilities and hospitals[38].

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[34] Rate of falls refers to the number of falls and is measured as the number of falls per person in time

[35] Risk of falls is defined as the number of people with 1 or more falls

[36] Sherrington C., et al. Exercise for preventing falls in older people living in the community. 2019. Cochrane Database of Systematic Reviews. Exercise for preventing falls in older people living in the community - Sherrington, C - 2019 | Cochrane Library. Accessed 04 July 2022.

[37] Gillespie LD., et al. Interventions for preventing falls in older people living in the community. 2012. Cochrane Database of Systematic Reviews. Interventions for preventing falls in older people living in the community - Gillespie, LD - 2012 | Cochrane Library. Accessed 04 July 2022

[38] Cameron ID., et al. Interventions for preventing falls in older people in care facilities and hospitals. 2018. Cochrane Database of Systematic Reviews. Interventions for preventing falls in older people in care facilities and hospitals - Cameron, ID - 2018 | Cochrane Library Accessed 04 July 2022.

Key conclusions for hospital settings:

- Multifactorial interventions in hospitals may reduce rate of falls in hospitals although the reduction may be more likely in a subacute setting (there is a statistically significant reduction of 33% in a subacute setting)(low-quality evidence).

Key findings for care facilities:

- Prescription of vitamin D reduces the rate of falls in care home residents but it probably makes little or no difference to the risk of falling in care home residents (moderate quality evidence)[39]. The population in the studies were deficient in vitamin D.
- The effectiveness of other interventions such as exercise, multifactorial interventions, general medication review and psychological interventions on the rate of falls was uncertain in 2019. The quality of evidence was low or very low quality and therefore the authors proposed more research is required to address the inconclusive findings.
- Further research specifically around environment/assistive technology and knowledge/education is warranted as there was a lack of evidence around these topics.

3.6.5 Interventions for preventing falls in Parkinson's disease

This 2022 review has shown that exercise probably reduces the rate of falls by 26% and the number of people experiencing one or more falls by 10% in people with low to moderate Parkinson's disease[40].

3.7 World Health Organisation Strategy for preventing falls across the lifecourse

The World Health Organisation strategy recommends key interventions to prevent falls[41]. In addition to the strongly evidence-based recommendations covered previously, it promotes:

- Implementing community wide, low-cost home modification programmes which can include modifications such as grab rails, stair rails, non-slip surfaces, improved lighting and reduced slip and trip hazards
- To deter the use of ladders, chairs, etc. to access heights, as ladder related deaths are high among older people, make alternatives available such as home help services or tradespersons to older people
- Requiring landlords to make necessary modifications to homes
- Homes and other buildings to be built to safe standards, including universal access and design principles
- Wearable personal alarms, fall sensors, mobile phones with SOS emergency buttons for older people at high risk of falls who spend much of their time alone
- Encouraging older people to wear enclosed sturdy shoes around the house, rather than slip-on footwear
- Improved accessibility of neighbourhoods and public spaces to help older people remain safe and active. This includes the need for road crossings designed and timed to allow older people to cross safely, and for parks and recreation spaces to be inviting, safe and accessible to older people in order to encourage regular physical activity
- Make Tai Chi (also called Tai Chi Chuan and Tai Chi Quan) accessible to older people living independently in the community

[39] Interventions for preventing falls in older people in care facilities and hospitals - Cameron, ID - 2018 | Cochrane Library
[40] Allen, N.E. et al. Interventions for preventing falls in Parkinson's disease. 2022. Cochrane Database of Systematic Reviews Interventions for preventing falls in Parkinson's disease - Allen, NE - 2022 | Cochrane Library
[41] Step Safely: Strategies for preventing and managing falls across the life-course (who.int)

- Make specialized, local “falls-prevention” (evidence-based balance and functional exercise) groups and home programmes available as an accessible part of preventative health care.
- Provide education about falls and specific factors such as footwear, glasses, high-risk situations and behaviours: Knowledge and education alone does not prevent falls, but improving awareness of the resources, behaviours and support available, and of the preventable nature of falls, is important.

3.8 National audit of inpatient falls 2022

The Falls and Fragility Fracture Audit Programme (FFFAP) is a national clinical audit run by the Royal College of Physicians (RCP). It is committed to improving patient outcomes and the efficiency of care that patients with fragility fractures and inpatient falls receive in acute and primary care settings, and to facilitating quality improvement (QI) initiatives.

The Falls and Fragility Fracture Audit Programme (FFFAP) is a suite of three national clinical audits, commissioned by the Healthcare Quality Improvement Partnership (HQIP), funded by NHS England and the Welsh Government. It includes:

- the National Audit of Inpatient Falls (NAIF)
- the National Hip Fracture Database (NHFD)
- Fracture Liaison Service Database (FLS-DB).

The audits provide a quality improvement platform for trusts in England, aiming to help local clinical teams and health service managers understand why people fall in hospital, the care that should be provided for fragility fractures, and what can and should be done to prevent future fractures.

The findings of the 2022 National Audit of Inpatient Falls annual report continues to emphasise the importance of risk factor detection and management using a Multi-factorial Falls risk Assessment (MFRA) and corresponding interventions[42]. KPIs have been set to focus on individual components of MFRA to effectively assess MFRA quality and improvements over the next year.

3.9 Rapid review of Care homes

Since the Cochrane review assessing effective interventions for preventing falls in older people in care facilities and hospitals was published in 2018 (Section 3.5.4), several studies showing evidence of effect in care homes have been published.

In regard to physical activity, a recent systematic review has been completed (not by the Cochrane Collaboration) and in addition to this, several individual studies have emerged. The systematic review and meta-analysis of 14 randomised controlled trials (RCTs) showed that long-term balance exercise significantly reduced falls in nursing homes.[43] The Sunbeam program, a combined high-level balance and moderate intensity progressive resistance training programme, was shown to significantly reduce the rate of falls in long-term residential care and was judged to be cost-effective

[42] Royal College of Physicians. National Audit of Inpatient Falls annual report 2022. London: RCP, 2021. National Audit of Inpatient Falls annual report 2022 – HQIP

[43] Wang, F., & Tian, B., 2022. The effectiveness of physical exercise type and length to prevent falls in nursing homes: A systematic review and meta-analysis. Journal of Clinical Nursing (John Wiley & Sons, Inc.) 31(1), pp. 32-42

by the authors in the country of the study[44,45.] The Sunbeam program was also shown to significantly reduce the rate of falls (50%), risk of falls (31%), multiple falls (40%) and injurious falls (44%) in long term care residents with mild-moderate cognitive impairments/dementia[46]. In regard to the OTAGO exercise program, individual RCTs have shown the programme to be feasible and effective at improving balance and physical performance in older adults living in a nursing home[47] and at reducing the number of falls in older adults living in a nursing home[48].

Cholinesterase inhibitors may reduce the rate of falls by 50% but the effectiveness on the risk of falls is uncertain[49]. Cholinesterase inhibitors may increase the rate of non fall-related adverse events by 60%. Most adverse events were mild and transient in nature. No data was available regarding the cost-effectiveness of medication for fall prevention.

An RCT has shown that the Guide to Action for falls prevention in Care Homes (GtACH) programme reduces the rate of falls by 43% during months 4-6[50,51.]The programme systematically trains and supports care home staff in the assessment of residents' risk of falling and the generation of a falls reduction care plan. Embedding the programme into usual practice routines is important for long-term effectiveness.

It is expected that these individual RCTs will be included in future Cochrane systematic reviews on the topic of preventing falls in care homes and a robust assessment of the quality of the studies will be conducted, but in the interim, they provide promising indications of some potentially effective interventions to reduce falls in this setting.

3.10 Housing

The BRE paper Home and Ageing in England provides an overview of the housing conditions of older people and estimates the costs to the NHS in England of leaving people living in the poorest housing in England in 2012. 1.3 million households aged 55 years and over lived in 'poor housing'[52] in 2012 at an estimated cost of £624 million per annum to the NHS in first year treatment costs[53]. A significant proportion of the category 1 hazards were associated with falls (on stairs, on a level, between levels and baths; n=794,689) and excess cold (n=689,666). Cold homes have been linked to an increased risk of lower strength and dexterity leading to an increased risk of falls[54]. Category 1 hazards are

[44] Hewitt et al., 2018. Progressive Resistance and Balance Training for Falls Prevention in Long-Term Residential Aged Care: A Cluster Randomized Trial of the Sunbeam Program. Journal of the American Medical Directors Association 19(4), pp. 361-369

[45] Hewitt, J. et al. 2019.An economic evaluation of the SUNBEAM programme: a falls-prevention randomized controlled trial in residential aged care. Clinical Rehabilitation 33(3), pp. 524-534

[46] Mak, A. et al. 2022. Sunbeam Program Reduces Rate of Falls in Long-Term Care Residents With Mild to Moderate Cognitive Impairment or Dementia: Subgroup Analysis of a Cluster Randomized Controlled Trial. Journal of the American Medical Directors Association 23(5), pp. 743

[47] Zou, Z., et al. 2022. The effect of group-based Otago exercise program on fear of falling and physical function among older adults living in nursing homes: A pilot trial. Geriatric Nursing 43, pp. 288-292

[48] Jahanpeyma, P., et al. 2021. Effects of the Otago exercise program on falls, balance, and physical performance in older nursing home residents with high fall risk: a randomized controlled trial. European Geriatric Medicine 12(1), pp. 107-115

[49] Allen, N.E. et al. 2022. Interventions for preventing falls in Parkinson's disease. Cochrane Database of Systematic Reviews 2022, Issue 6. Art. No.: CD011574. DOI: 10.1002/14651858.CD011574.pub2.

[50] Logan, P. et al. 2021. Multifactorial falls prevention programme compared with usual care in UK care homes for older people: Multicentre cluster randomised controlled trial with economic evaluation. BMJ2021;375:e066991 http://dx.doi.org/10.1136/ bmj-2021-066991

[51] Logan, P et al. 2022. A multidomain decision support tool to prevent falls in older people: the FinCH cluster RCT. Health Technology Assessment. Vol. 26 Issue 9, pp. 1–136

[52] with at least one Category 1 hazard under the Housing Health and Safety Rating System (HHSRS) i.e., a home that did not meet the minimum standard for housing in England

[53] BRE. Homes and Ageing in England. 86749-BRE_briefing-paper-PHE-England-A4-v3.pdf

[54] Briefing7_Fuel_poverty_health_inequalities.pdf (publishing.service.gov.uk)

more common in houses that were built before 1919 and generally, the houses in rural areas are older. Mitigating the risks of falls and cold by instigating repairs to the poorest housing would result in savings to the NHS of nearly £100 million and £440 million per annum, respectively. Some of the repairs for falls are inexpensive and include providing additional lighting and the repair or installation of handrails to reduce risks on stairs and repairing paths and floors to reduce risk on the level. The BRE estimated that work to repair category 1 hazards on stairs and on the level would pay for itself in 6.5 years and 4.5 years respectively. In regard to the impact of cold homes on falls, PHE recognise that people who have attended hospital due to a fall are a group who are vulnerable to health problems associated with cold homes and suggest falls and fracture liaison services consider using an opportunistic 'Making Every Contact Count' (MECC) approach for referral to cold homes services[55].

4.0 Current Cambridgeshire and Peterborough services

There are a number of services that provide interventions for people who have fallen or at risk of falling. These have been mapped out in the Falls Prevention and Management Pathway (Appendix 11) and key services are detailed in Appendix 12.

The two main organisations that deliver multi-factorial falls risk assessments and strength and balance exercise programmes (OTAGO or FaME) for older people 65+ years are Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and Everyone Health. They are part of an integrated community falls prevention pathway that work together to provide evidence-based interventions for different cohorts based on specific eligibility criteria. A specific community falls prevention pathway is in Appendix 13.

5.0 Assets/achievements

Much good work has taken place in Cambridgeshire and Peterborough over recent years to implement the evidence base and good practice in order to improve outcomes. The following indicates key pieces of work that has taken place in Cambridgeshire and Peterborough (not an exhaustive list) and these serve as a basis for further work.

5.1 Community

- ***New community falls prevention pathway*** - Roll out of the pathway across Cambridgeshire and Peterborough to standardise the provision of quality multi-factorial falls risk assessments (MFRAs), improve equity of access and increase the scale of delivery by CPFT and Everyone Health (includes the St Ives Falls Pilot in 2016-2017 funded by the CCG and STP Falls Prevention Programme in 2017-2019 joint-funded by the STP, Cambridgeshire County Council and Better Care Fund)
- ***Enhanced Falls Prevention Pathway*** – Delivery of enhanced MFRAs containing occupational therapy-led home hazard assessments and subsequent modifications in Cambridge City and Fenland from 1 April 2022 by CPFT as part of a new 3-year falls prevention programme (Funded by CCC)

[55] Data sources to support local services tackling health risks of cold homes (publishing.service.gov.uk)

- ***Falls Prevention Lead/Co-ordinator*** – Post to strengthen the co-ordination of falls prevention across the health and care system (Funded by STP Falls Prevention Programme, 2017-2021)
- ***'Stronger for Longer' social marketing campaign*** (STP Falls Prevention Programme, 2017-2021 and CCC Falls Prevention Programme, 2022-2025):
    - Development and launch of a campaign in 2018 alongside a suite of assets e.g., Super Six leaflets and primary prevention booklets based on the Chartered Society of Physiotherapy 'Get up and go' leaflet.
    - Delivery of regular communications and campaigns under this branding including news articles and distribution of materials through multiple mechanisms and routes including Stay Well the Winter Packs, PCN Flu clinics and COVID vaccination centres.
- ***Continued development of the falls exercise pathway*** for both primary and secondary prevention to ensure a progressive, long-term, quality assured and evidence-based exercise pathway as part of the 3-year Falls Prevention Programme (CCC Falls Prevention Programme, 2022-2025) including:
    - ***Falls Management Exercise (FaME) programme*** – Roll out of the programme by the Healthy You Falls Prevention Health Trainer service with an increase in staff capacity from April 2021
    - ***Community Strength and Balance Activities*** – Commissioning of leisure providers to ensure a continuum of falls prevention exercise interventions are in place across Cambridgeshire and Peterborough from February 2022.
- ***Enhanced Response Service (ERS)*** – Commissioning and deployment of the ERS in Cambridgeshire in 2017 by Cambridgeshire County Council and extension to cover Peterborough in 2022 to provide an equitable and appropriate 24/7 response to telecare alerts for people who require non-emergency assistance, including non-injured fallers who require help (See appendix 12).
- ***Lifelines -*** Cambridgeshire County Council became a provider of lifeline Services in Cambridgeshire in October 2020 and Peterborough in March 2022 to support people through the provision of digital lifelines and peripheral services. This supports a host of other lifeline providers including South Cambridgeshire District Council, Sanctuary, Chorus, Circle, Kings Lynn Careline, Anchor/Hanover, Housing and Care 21 and Age UK.
- ***Cambridgeshire County Council and Peterborough City Council Falls Prevention pathway*** – Development and implementation of policy and guidance in 2021 to support frontline staff to screen and make onward referrals for falls interventions
- ***Peterborough City Council Handyperson service*** – Continued delivery of the service to maintain, repair and assist people to continue to live independently at home following confirmed continuation of funding into 2022/23
- ***Age UK Cambridgeshire and Peterborough*** – continued provision of services, which whilst taking a holistic approach to support needs, do have a specific element of giving falls prevention input. These include: the Cambridgeshire Handyperson Service; Community Wardens; Home Support and Day Services; Hospital discharges; and admission avoidance (Appendix 11)
- ***Cambridgeshire Fire and Rescue Service*** - Continued delivery of Safe and Well visits (Home Safety Check) since 2016, including assessment of falls risk factors, to support the safety and

wellbeing of the most vulnerable residents aged 65+ in the community, by Cambridgeshire Fire and Rescue Service.

- ***REACT Falls Cars -*** Commissioning of two 'falls' urgent response vehicles staffed by a Paramedic or Nurse and a Therapy Assistant in Cambridgeshire for Autumn/Winter 2022/23, to provide enhanced clinical assessment and assistance for people who have fallen within their own home, who may have sustained an injury, but who do not need to attend hospital.
- ***Care Together Programme*** - Roll out of the place-based approach to co-production at Integrated Neighbourhood level of services that support older adults to live happily and healthily at home, including seed-funding for expansion of strength and balance exercise classes for over 65s and support for Fitness Rush mobile gymnasium to visit rural villages in Fenland and Huntingdonshire. Care Together has transformed the way Early Intervention and Prevention services are commissioned, incorporating physical activity and healthy lifestyles into specifications alongside opportunities for social inclusion of older adults.

5.2 Primary care

- ***Falls Prevention Pathway*** – Development and incorporation of primary care specific pathway on SystmOne with training delivered to GPs by CPFT to support appropriate referrals

5.3 Hospitals

- Cambridge University Hospital Foundation Trust (CUHFT):
    - ***Fracture Liaison Service (FLS)*** - Launch of a comprehensive, multi-disciplinary FLS in 2017 to reduce the risk of subsequent fractures by systematically identifying, assessing, treating and referring to appropriate services all eligible patients aged 50+ who have suffered a fragility fracture (Funded by Cambridgeshire and Peterborough CCG).

- North West Anglia Foundation Trust (NWAFT)
    - Development of enhanced care policy in support of the falls policy to enable enhanced care risk assessment and increased frequency of observations for patients at risk of falls.

5.4 Care Homes

- ***Dedicated Falls Prevention Therapy Assistant*** – New CPFT post in 2022 to support care homes to identify and manage falls risks. Currently focussing on the development and testing of training tools.

5.5 Pharmacy

The following national pharmacy services are outlined within the Community Pharmacy Contractual Framework and provide an opportunity to consider falls risk locally:

- ***The New Medicine Service (NMS)* -** provides support for people with long-term conditions prescribed a new medicine to help improve medicines adherence; it is focused on specific patient groups and conditions[56]
- ***The Discharge Medicines Service (DMS)* -** supports patients with their medication when they are discharged from secondary care back to primary care. The service seeks to ensure better communication of changes made to a patient's medicines in hospital[57].

6.0 Gap analysis

A gap analysis was undertaken to assess local falls prevention service provision and quality compared with NICE clinical guidance 161: Falls in older people, to understand areas for improvement. Service leads across CPFT, CUHFT, NWAFT, Healthy You and others contributed to a review of provision in their organisation (Appendix 14).

Key findings of the analysis:

1. **Falls Prevention services (and services providing comprehensive geriatric assessment (CGA) or interventions) are disjointed,** with medical and therapy teams in primary care, secondary care and community services working in isolation, with a lack of awareness of other services and poor inter-service communication resulting in duplication and inefficiencies (and/or sharing of assessments or assessment outcomes between services).

2. **There is an inadequate system-wide risk assessment and stratification in place** to ensure people who experience a fall are seen by the professional with the right skills to assess and facilitate necessary multi-factorial intervention and in a place-based manner. This is particularly noticeable around the absence of multidisciplinary assessment of unexplained fallers.

3. **Unwarranted variation in the delivery and receipt/uptake of recommended multi-factorial interventions** to reduce the risk of fall after assessment, including:

    - Medication review and modification of fall-risk increasing drugs (FRIDs) in primary and secondary care
    - Bone health assessment and proactive review of people with fragility fractures or 2+ falls in a year
    - Strength and balance training and step-down exercise pathway for a cohort of frailer, housebound older adults.

4. **Older adults who have had a serious fall and present to hospital are falling through the net, as demonstrated by:**

    - Inequity in all this cohort being offered multi-factorial falls risk assessment to help reduce their risk of a future fall
    - Inequity in all this cohort being offered multidisciplinary assessment at the front door, as an inpatient or in the community

[56] https://psnc.org.uk/national-pharmacy-services/advanced-services/nms/
[57] https://psnc.org.uk/national-pharmacy-services/essential-services/discharge-medicines-service/

- Home hazard assessment and safety intervention/modifications by trained healthcare professionals not being routinely considered and offered as part of discharge planning.

5. **Prevention and early intervention opportunities are being missed** as opportunistic case finding and risk identification is not routinely implemented (based on NICE guidelines):
    - Health and care professionals do not routinely ask all older adults if they have had a fall in the last year (Acute sector, All CPFT Older People's services, Primary care)
    - There is no local definition of people 'at risk of falling' and people with long-term health conditions under 65 may be being missed
    - Older adults in all settings are not routinely being observed for strength and balance deficit and considered/referred by non-therapy staff for strength and balance training.
6. **Limited therapy capacity in acute sector and community** to support multi-factorial falls risk assessments and interventions such as strength and balance training and home hazard assessments. Includes therapy capacity at the front door, inpatient and community trust and is demonstrated by inequity of offer of MFFRA and long waiting times in the community.
7. **Prevention of deconditioning is not being addressed** at scale in hospital and care home settings.

7.0 Engagement with patients

CPFT patient views on experience of the local falls prevention pathway

CPFT Enhanced Falls Prevention pathway practitioners conducted a face-to-face survey between August and September 2023 with patients who had received a multi-factorial falls risk assessment in Cambridge City and Fenland (n=14). 93% of respondents received a falls assessment within 4 weeks of referral and the majority thought this length of wait was 'just right' (64%) and a fifth reported it was too long (21%). The most common interventions recommended in the assessment were a referral to the GP to review medications (93%), assessment of home hazards and provision of equipment (92%), developing a falls plan (86%) and a referral to the GP to review possible medical causes of fall (85%). Patients reported a positive experience of the pathway and the support given. Key themes emerging were that a third of patients recommended a medication review had not received one by 6+ weeks after the assessment (30%), half of patients recommended a medical review with their doctor had not received one by 6+ weeks after assessment (50%), and one patient mentioned they had encountered issues reaching their specialist healthcare team between appointments.

8.0 What does success look like?

The Falls Prevention Strategy Group will be responsible for monitoring the success of the strategy. Success will be monitored by reducing the direct age-standardised rate of admissions due to hip fractures in people 65+ in Cambridgeshire and Peterborough from 590.9 per 100,000 in 2022/23 to 588.1 per 100,000 in 2023/24 (SUS data). This equates to 5 hip fractures over the next year. The aim is to reduce the number of hip fractures by 5 every year over the next three years – a total of 15 hip fractures. It is not possible to calculate a reduction in age-standardised rate over the full three years.

9.0 Monitoring plan

The overarching outcomes are as listed above. All of the actions in the action plan will contribute to these population outcomes. The action plan of the Peterborough Falls Prevention Working Group will contribute to the overarching Cambridgeshire and Peterborough Falls Prevention action plan. To enable timely monitoring of admissions data, the strategy group will monitor SUS admissions quarterly.

Each of the actions in the action plan will establish outputs and these will be monitored by action leads with overall programmes monitored by the falls strategy group.

The overarching governance is as follows:

- ***Joint Clinical and Professional Executive Group –*** The Falls Prevention Strategy Group will report into the group upon request.
- ***Health and Wellbeing Board -*** The Falls Prevention Strategy group will provide updates as requested to the Health and Wellbeing Board which has overall responsibility for monitoring the health of the population.
- ***South Care Partnership -*** The Falls Prevention Strategy Group will provide updates to the Proactive and Personalised Care Programme Board, which reports to the Cambridgeshire South Care Partnership Joint Strategic Board.
- ***North Care Partnership -*** The reporting structure in the North is to be defined.
  Peterborough Falls Prevention Working Group – This working group will report into the Cambridgeshire and Peterborough Falls Prevention Strategy Group.

10.0 Action

10.1 Priority 1: Prevention and early identification of people at risk of falls

Aim: to intervene at the earliest opportunity to prevent and reduce the number of people who have a first fall

Objectives:

A. Raise awareness and understanding of falls risk factors and the benefits of an active, healthy lifestyle across the life course,
B. Enable and empower older adults to make informed choices about interventions to reduce their falls risk and to take responsibility for looking after their health,
C. Use technology to promote physical activity amongst adults in mid to later life,
D. Ensure adults 50+ years are able to access a range of accessible physical activity in the community, including strength and balance activities as a general community provision and as a referral route from the FaME programme delivered by the Healthy You,
E. Increase professional and volunteer knowledge and skills around physical activity,
F. Support the development of Age Friendly Communities in Cambridgeshire and Peterborough.

Action Ref	Objective	Action	Lead
1.1	A & B	Implement, promote and evaluate an online multi-factorial falls self-assessment tool across Cambridgeshire and Peterborough to enable adults to independently screen their own risk factors and take action to reduce their risk.	Senior Partnership Manager, Public Health, Cambridgeshire County Council (CCC)
1.2	A & B	Provide older adults across Cambridgeshire and Peterborough with accurate written information on falls risk factors, healthy ageing and signposting to further resources/information.	Senior Partnership Manager, Public Health, Cambridgeshire County Council (CCC)
1.3	A, B & C	Inform and educate members of the public across Cambridgeshire and Peterborough about the early signs of increasing falls risk and services/interventions to support healthy ageing, to include the use of validated apps.	Senior Partnership Manager, Public Health, Cambridgeshire County Council (CCC)

Action Ref	Objective	Action	Lead
1.4	D	Support and strengthen community strength and balance activities across Cambridgeshire and Peterborough in line with the local falls prevention exercise framework (to include the role of grass root and voluntary sector organisations).	Senior Partnership Manager, Public Health, Cambridgeshire County Council (CCC)
1.5	D	Strengthen the offer and/or public awareness of primary prevention physical activity opportunities in the community across Cambridgeshire and Peterborough to increase uptake in older adults and prevent falls and frailty.	
1.6	A & E	Support education, awareness and training for all professionals and volunteers involved in promotion of physical activity for older people across Cambridgeshire and Peterborough.	
1.7	F	Support the development of the Healthy Places Joint Strategic Needs Assessment and the inclusion of Age Friendly communities.	Public Health Registrar, CCC

10.2 Priority 2: Evidence-based and good practice falls prevention interventions and services

Aim: to ensure that people who have fallen have timely access to services, interventions and opportunities that will support a reduction in falls risk and injurious falls

Objectives:

A. Improve the join-up of services in primary care, secondary care and community services involved in falls risk assessments and/or falls prevention interventions to improve the assessment and outcomes of older adults who experience a fall,
B. Strengthen the community falls prevention pathway to improve the onward referral pathway for medication review to ensure older people living at home receive consistent, robust and high-quality medication reviews and action is taken to change medication to reduce falls and osteoporotic risk,
C. Increase capacity of CPFT to deliver the multi-factorial falls risk assessment (MFRA) for older people at high risk of falls to improve identification and management of falls risks,
D. Increase staff awareness of falls prevention and early intervention services to improve access to timely, holistic support to reduce risk,
E. Identify new technology to improve the detection and management of falls,
F. Improve identification and referral for an MFRA of people who have fallen and present to primary care,
G. Reduce sedentary behaviour and increase mobilisation and physical activity in clients receiving support from Adult Social Care and improve participation in home-based or community strength and balance classes post-support,
H. Raise awareness amongst frail older people, their families and frontline staff of deconditioning and provide access and encouragement to participate in strength and balance activity to enable a safe, confident and gradual increase in physical activity.

Action Ref	Objective	Action	Lead
2.1	2A, C, D & F 3A, B & C	Develop and implement a robust, whole system, integrated falls response, support and prevention pathway across Cambridgeshire and Peterborough to ensure equity of access to multifactorial interventions.	

2.2	B	Continue to implement, monitor and evaluate the 'Enhanced Falls Prevention Pathway' pilot in Cambridge City and Fenland, including the development of strong referral pathways and links with key stakeholders such as hospitals, reablement and primary care.	
2.3	E	Technology Enabled Care (TEC) Teams to focus on identifying and testing more robust falls prevention solutions, considering proactive smart solutions that can predict changes in needs to prevent deterioration reducing the need for reactive services. Promote shared knowledge between the authorities through the TEC Steering Group.	TEC Strategy Board Chair, CCC
2.4	G	Explore the incorporation of appropriate exercises into the support plan of clients attending Cambridgeshire County Council Reablement Service.	Head of Service Operations Prevention & Early Intervention, CCC
2.5	G	Develop a list of options to pilot to support maintenance of strength and balance in people who are housebound.	Public Health, CCC
2.6	D	Support falls prevention education, awareness and training for all professionals and volunteers involved in engaging older people across Cambridgeshire and Peterborough.	
2.7	G	Work with the Peterborough City Council Older People's Day Services manager to investigate the opportunity for the staff to be trained in strength and balance, so that clients can be offered structured movement as part of their day centre experience and falls prevention.	
2.8	G	Work with Peterborough City Council colleagues in Housing Needs regarding the two new posts being developed to work in the hospital with a housing/homeless prevention	

		focus. To ensure that falls prevention is part of their conversation and that clients who had fallen prior to admission are identified.	
2.9	G	Work with colleagues in Adult Social Care to work towards the inclusion of exercise/structured movement within care and support plans. To explore whether the Adult Social Care trainer can incorporate this into the strength-based conversation training and refreshers.	Consultant in Public Health, CCC
2.10	A & B	Strengthen the links with the Integrated Neighbourhoods to enable scoping of opportunities to strengthen falls prevention in a personalised and place-based manner.	Senior Partnership Manager (Public Health) and Integrated Neighbourhood Managers

10.3 Priority 3: Action to address risk in hospital

Aim: to minimise the risk of inpatient falls, repeat falls and re-admissions, and improve quality of life

Objectives:

A. Improve completion and communication of inpatient MFRA and falls-related care plan actions to ensure the patient receives the right care both in and out of hospital,
B. Ensure onward referral of patients for appropriate interventions and services following an MFRA,
C. Improve the two-way communication of medical and multi-factorial falls risk assessment information between acute and community services,
D. Ensure people attending hospital ED as a result of a fall are offered information, advice and referral to community services as relevant to support them to reduce their falls risk when back at home,
E. Prevent inpatients from deconditioning and support the reconditioning of patients who have deconditioned.

Action Ref	Objective	Action	Lead
3.1	A & C	Cambridge University Hospital NHS Foundation Trust (CUH) to complete ongoing project to roll out a multi-disciplinary, multi-factorial falls risk assessment across wards at CUH and communicate the findings and care plan in the discharge summary.	
3.2	A & B	Cambridge University Hospital NHS Foundation Trust (CUH) to complete ongoing project at CUH to develop, roll out and monitor the role of ward falls advocate to improve falls prevention and management at ward level.	
3.3	A & B	Cambridge University Hospital NHS Foundation Trust (CUH) to use learning from thematic analysis and investigations into inpatient falls at CUH to develop Quality Improvement Projects (QIPs).	
3.4	D	Cambridge University Hospital NHS Foundation Trust (CUH) to develop and implement a robust falls pathway when a patient is medically fit to go home from ED.	

3.5	A & C	North West Anglia Foundation Trust (NWAFT) to start project to switch multifactorial falls risk assessment to an electronic format then rollout to all staff.	
3.6	A & C	North West Anglia Foundation Trust (NWAFT) to further develop the falls link role within the falls advisors.	
3.7	E	North West Anglia Foundation Trust (NWAFT) to work with the therapy team to implement keep moving project and make changes to our training to help support staff have the confidence to mobilise patients.	
3.8	D	North West Anglia Foundation Trust (NWAFT) to develop the volunteer role in ED.	

10.4 Priority 4: Action to address risk in care homes

Aim: to prevent, reduce and manage falls in nursing and residential home residents in order to reduce the risk and consequences of falls, fragility fracture and a long lie, improve quality of life and reduce system wide pressures

Objectives:

A. To ensure nursing and residential home residents receive high quality multi-factorial falls risk assessment (MFRA) and interventions on admission and after a fall and/or a change in their condition,
B. To ensure a robust onward referral process is in place and implemented to review, reduce and/or stop medications that increase the risk of falls and to ensure that bone strengthening medications, calcium and vitamin D supplementation are prescribed where appropriate,
C. To ensure that residents are offered and encouraged to participate in opportunities and activities to improve activity levels and strength and balance with support from their staff, family, and relevant services,
D. To ensure staff have knowledge and skills to provide assessment and lifting support following a fall in a timely, caring and dignified way to reduce the amount of time that residents spend on the floor after a fall.

Action Ref	Objective	Action	Lead
4.1	A & B	Develop a toolkit and provide training to support nursing and residential home staff to systematically embed a systemic approach to reducing falls risk within care homes.	
4.2	B	Review the onward referral process following a fall in a care home.	
4.3	C	Explore opportunities to provide access and support for nursing and residential home residents to participate in strength and balance activities to build muscle strength.	
4.4	C	Embed physical activity within care plans for older adults in residential care.	Consultant in Public Health, CCC

4.5	D	Continue to deliver and evaluate the impact of the falls lifting equipment pilot, offering a choice of 2 lifting chairs supported by a post fall assessment App, and offer support to care homes as relevant.	

10.5 Priority 5: Detection and management of fragility fracture

Aim: to maximise primary and secondary prevention of osteoporosis-related fragility fractures and ensure optimal support is provided after a fragility fracture has occurred

Objectives:

A. To understand what action to take locally to improve the detection and management of osteoporosis and improve outcomes of people with risk factors for osteoporosis and those who have experienced a fragility fracture,
B. To obtain investment to implement a robust Fracture Liaison Service at NWAFT,
C. To ensure that people accessing the CUH or NWAFT Fracture Liaison Services are referred to and receive strength and balance training to reduce risk the risk of a fall and a subsequent fragility fracture.

Action Ref	Objective	Action	Lead
5.1	A	Review current pathways and service provision against evidence base and local insight, to understand and develop a strategy to address any gaps and maximise opportunities for integration and joined-up working.	Public Health Registrar, CCC
5.2	B	Develop a FLS business case for NWAFT.	TBC
5.3	C	Develop and implement a formal onward referral pathway from the CUHFT and NWAFT Fracture Liaison Services to Healthy You FaME programme for strength and balance training.	

10.6 Priority 6: Inclusive services

Aim: to ensure early falls prevention related services are inclusive and accessible to all service users in line with the Equality Act and Public Sector Equality Duty to enable all older adults to receive falls prevention interventions that meets their needs

Objectives:

A. To provide support and guidance around different types of data to support inclusive service design,
B. To embed co-production into the design and delivery of falls prevention services to ensure the voice of older adults is heard and acted upon,
C. To ensure disabled older adults enjoy the benefits of an active lifestyle without the barriers placed by society.

Action Ref.	Objective	Action	Lead
6.1	A	Provide guidance to support and enable services to review the needs of all their clients and to consider improvements if needed.	All
6.2	B	Involve older adults in the co-production of services, campaigns and projects to obtain meaningful qualitative feedback to inform delivery.	All
6.3	C	Strengthen the links between the Falls Prevention Strategy Group and the Disability Strategic Group to support the implementation outcomes of the county-wide disability strategy.	

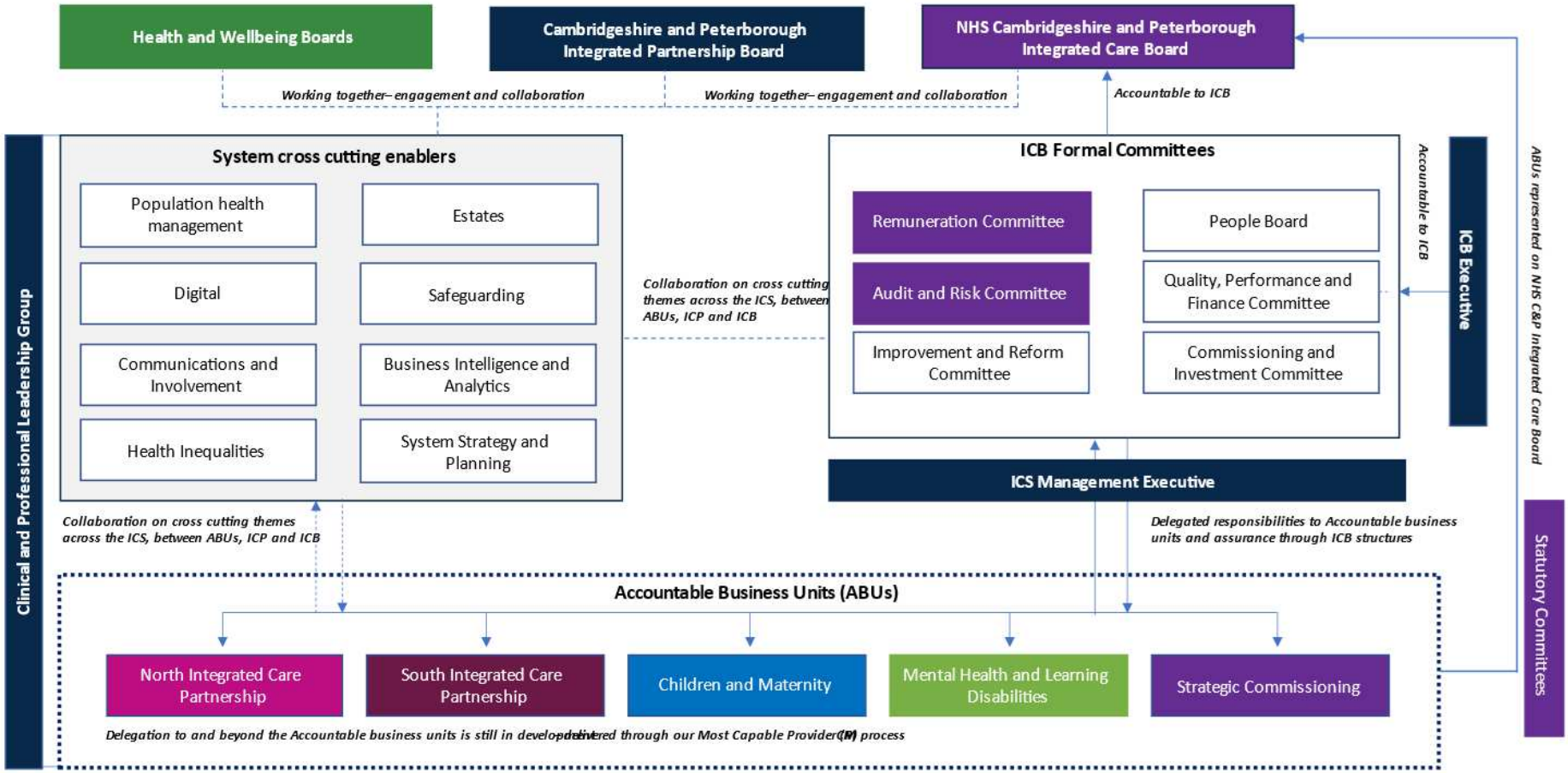
11.0 Appendices

Appendix 1 – Cambridgeshire and Peterborough Falls Prevention Strategy Group membership

Dr Abby Richardson	Acting Deputy Medical Director and Clinical Lead for Primary Care & Clinical Policies and Clinical Lead for Integrated Neighbourhoods. North Place, Cambridge University Hospital Foundation Trust (CUHFT)
Amber O'berg	Integrated Neighbourhood Project Manager North Place - Cambridgeshire & Peterborough Integrated Care System (ICS)
Annami Palmer	Falls Prevention Clinical Lead - CPFT and on behalf of Neighbourhood Teams
Ashling Bannon	Integrated Neighbourhood Programme Manager - East Cambridgeshire, South Integrated Care Partnership - Cambridgeshire & Peterborough integrated Care System (ICS)
Belinda Child – **Vice Chair**	Head of Housing, Prevention and Early Intervention - Peterborough City Council
Erin Lilley	Director, ICP Development & Transformation – South - Integrated Care Partnership - CUHFT
Dale Parnell	Health and Wellbeing Manager - Vivacity
Diana MacKay	Commissioning Manager - Early Intervention and Prevention – Cambridgeshire County Council
Emma Goddard	Business and Partnerships Lead –East of England Ambulance Service NHS Trust
Graeme Hodgson	Senior Commissioning Manager – Adult Social Care - Cambridgeshire County Council
Hayley Korsman	Senior Improvement & Transformation Manager - CUHFT
Helen Garfoot	Acting Clinical Quality Lead - Cambridgeshire and Peterborough Integrated Care System (ICS)
Helen Tunster - **Chair**	Senior Partnership Manager (Healthy Ageing), Public Health - Cambridgeshire County Council
Dr Jane Wilson	Geriatrician and Clinical Falls Lead - Cambridge University Hospital Foundation Trust (CUHFT)
James Ball	Community Risk & Resilience Manager (South) - Cambridge Fire and Rescue Service
Joanna Clarke	Falls and Fracture Specialist Nurse - Peterborough City Hospital
Jo Peadon	Active Lifestyles and Health Manager - Huntingdonshire District Council)
Dr Lelane Vanderpoel	Geriatrician and Clinical Frailty Lead - Cambridge University Hospital Foundation Trust (CUHFT)
Lewis Holland	Falls Prevention Service Co-ordinator, Healthy You
Lesley McFarlane	Development Officer, Health Specialist - South Cambridgeshire District Council

Lucy Davies	Head of Commissioning, Early Intervention and Prevention – Cambridgeshire County Council
Dr Madhavi Vindlacheruvu	Orthogeriatrician - Cambridge University Hospital Foundation Trust (CUHFT)
Melanie Pittock	Chief Executive Officer - Age UK
Nicole Uyan	Service Lead, Early Intervention Team - Cambridge University Hospital Foundation Trust (CUHFT)
Rebecca Marr	Occupational Therapist Team Lead – Cambridgeshire County Council
Rita Bali	Executive Officer - Cambridgeshire and Peterborough Local Pharmaceutical Committee
Sara Rodriguez-Jimenez	Associate Director of Performance and Operations - Cambridgeshire and Peterborough Integrated Care System
Simon Hanna	Senior Clinical Exercise Specialist - CPFT
Teresa Stratton	Falls and Fracture Specialist Nurse - Peterborough City Hospital
Vicki Dye	Project and Service Improvement Manager – Cambridgeshire and Peterborough Integrated Care System (ICS)
Dr Viveca Kirthisinga	Community Geriatrician - CPFT

Appendix 2 - Cambridgeshire & Peterborough Integrated Care System function and decision map



Appendix 3 – Trends in emergency admissions due to falls in Cambridgeshire and Peterborough between 2010/11 and 2021/22

Table 1: Admissions due to falls in Cambridgeshire up to 2020/21

	Cambridgeshire						
Period		Count	Value	95% Lower CI	95% Upper CI	East of England	England
2010/11	🟢	1,973	1,965	1,879	2,054	1,886	2,126
2011/12	🟢	2,080	2,002	1,916	2,090	1,917	2,128
2012/13	🟡	2,291	2,119	2,033	2,208	1,973	2,097
2013/14	🔴	2,577	2,316	2,227	2,408	2,025	2,154
2014/15	🟡	2,448	2,130	2,046	2,217	2,026	2,199
2015/16	🟡	2,613	2,232	2,147	2,320	1,989	2,169
2016/17	🟡	2,600	2,170	2,088	2,256	1,974	2,114
2017/18	🟡	2,659	2,164	2,082	2,248	2,026	2,170
2018/19	🟡	2,785	2,225	2,143	2,310	2,065	2,199*
2019/20	🟡	2,895	2,242	2,161	2,326	2,094	2,222
2020/21	🟢	2,560	1,945	1,870	2,022	1,946	2,023

Source: Public Health Outcomes Framework[58].

Table 2: Admissions due to falls in Cambridgeshire in 2021/22

Recent trend: Could not be calculated

	Cambridgeshire						
Period		Count	Value	95% Lower CI	95% Upper CI	East of England	England
2021/22	🟡	2,640	2,027	1,950	2,106	1,959	2,100

Table 3: Admissions due to falls in Peterborough

	Peterborough						
Period		Count	Value	95% Lower CI	95% Upper CI	East of England	England
2010/11	🔴	678	2,746	2,540	2,964	1,886	2,126
2011/12	🔴	680	2,634	2,438	2,842	1,917	2,128
2012/13	🔴	648	2,480	2,291	2,681	1,973	2,097
2013/14	🟡	619	2,287	2,109	2,476	2,025	2,154
2014/15	🔴	665	2,440	2,256	2,634	2,026	2,199
2015/16	🔴	663	2,348	2,171	2,535	1,989	2,169
2016/17	🟡	628	2,176	2,008	2,355	1,974	2,114
2017/18	🟡	602	2,041	1,880	2,212	2,026	2,170
2018/19	🟡	685	2,275	2,107	2,453	2,065	2,199*
2019/20	🟡	635	2,057	1,899	2,224	2,094	2,222
2020/21	🔴	700	2,243	2,080	2,416	1,946	2,023

Table 4: Admissions due to falls in Peterborough

Recent trend: Could not be calculated

	Peterborough						
Period		Count	Value	95% Lower CI	95% Upper CI	East of England	England
2021/22	🟢	585	1,865	1,716	2,023	1,959	2,100

Red dots are statistically significantly higher (worse) than the England average; Green dots are statistically significantly lower (better) than the England average; Orange dots are similar to the England average.

[58] Office for Health Improvement & Disparities. Public Health Profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022

Appendix 4 – Trends in emergency admissions due to hip fractures in Cambridgeshire and Peterborough between 2010/11 and 2021/22

Table 1: Admissions due to hip fractures in Cambridgeshire

Period		Cambridgeshire Count	Value	95% Lower CI	95% Upper CI	East of England	England
2010/11	🟡	639	636	588	688	607	615
2011/12	🟡	600	572	527	620	597	612
2012/13	🟡	683	630	583	679	601	599
2013/14	🟡	698	628	582	677	616	614
2014/15	🟡	635	554	512	599	582	599
2015/16	🟡	681	583	540	629	583	589
2016/17	🟡	684	572	530	617	579	575
2017/18	🟢	654	533	493	575	577	578
2018/19	🟡	680	545	505	588	563	559*
2019/20	🟡	725	562	522	605	556	572
2020/21	🟡	700	528	490	569	508	529

Table 2: Admissions due to hip fractures in Peterborough

Period		Peterborough Count	Value	95% Lower CI	95% Upper CI	East of England	England
2010/11	🟡	157	620	526	727	607	615
2011/12	🟡	180	686	588	794	597	612
2012/13	🟡	177	674	577	781	601	599
2013/14	🔴	196	722	624	832	616	614
2014/15	🔴	192	705	608	813	582	599
2015/16	🟡	164	573	488	669	583	589
2016/17	🟡	181	627	539	726	579	575
2017/18	🟡	185	625	538	723	577	578
2018/19	🔴	195	656	567	755	563	559*
2019/20	🟡	185	593	510	686	556	572
2020/21	🟡	175	557	477	647	508	529

Source: Public Health Outcomes Framework[59].

Table 2: Admissions due to hip fractures in Cambridgeshire in 2021/22

Recent trend: Could not be calculated

Period		Cambridgeshire Count	Value	95% Lower CI	95% Upper CI	East of England	England
2021/22	🟡	740	567	527	610	523	551

Table 4: Admissions due to hip fractures in Peterborough 2021/22

Recent trend: Could not be calculated

Period		Peterborough Count	Value	95% Lower CI	95% Upper CI	East of England	England
2021/22	🟡	185	594	512	686	523	551

Red dots are statistically significantly higher (worse) than the England average; Green dots are statistically significantly lower (better) than the England average; Orange dots are similar.

[59] Office for Health Improvement & Disparities. Public Health Profiles. 2022 https://fingertips.phe.org.uk © Crown copyright 2022

Appendix 5: Admissions to hospital due to injurious falls and hip fracture in 65+ in 2021/22, by district

	Number of admissions due to injurious falls in 65+	Rate of admissions due to injurious falls in 65+ (per 100,000)	Number of admissions due to hip fractures in 65+	Rate of admissions due to hip fractures in 65+ (per 100,000)
Huntingdonshire	770	2,145	215	603
Fenland	495	2073	140	584
East Cambridgeshire	390	2088	105	556
Cambridge City	400	2,214	110	601
South Cambridgeshire	585	1729	170	501
Cambridgeshire	2,640	2027	740	567
England	223,101	2100	58,685	551
East of England	25,405	1959	6,805	523

Key: The Districts statistically significantly lower than the England average are shaded green and those statistically significantly similar to the England average and amber.

Source: Public Health Outcomes Framework - Productive Healthy Ageing Profile - Data - OHID (phe.org.uk)

Appendix 6 – Graphs showing admissions for injury due to falls and hip fracture in England in 2021/22 by deprivation decile

Table 1: Emergency hospital admissions due to falls in people aged 65 and over – rate per 100,000

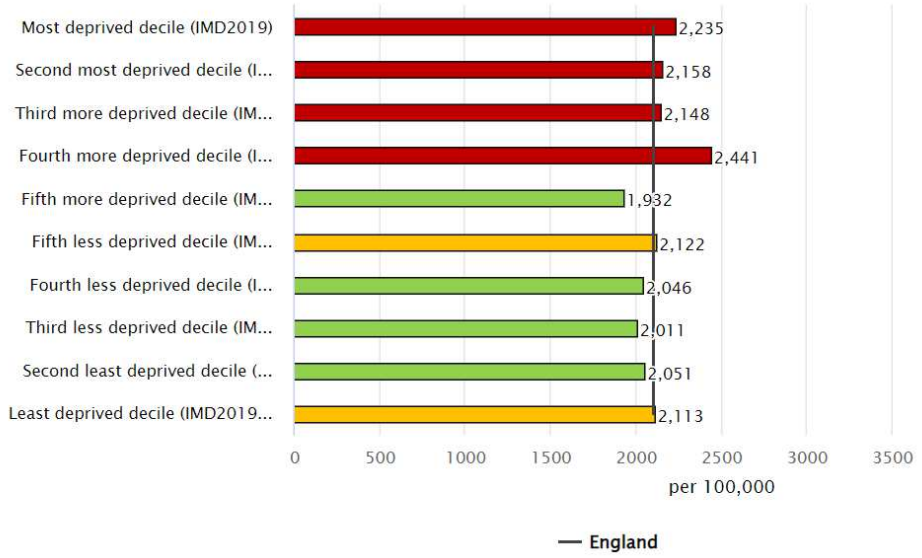
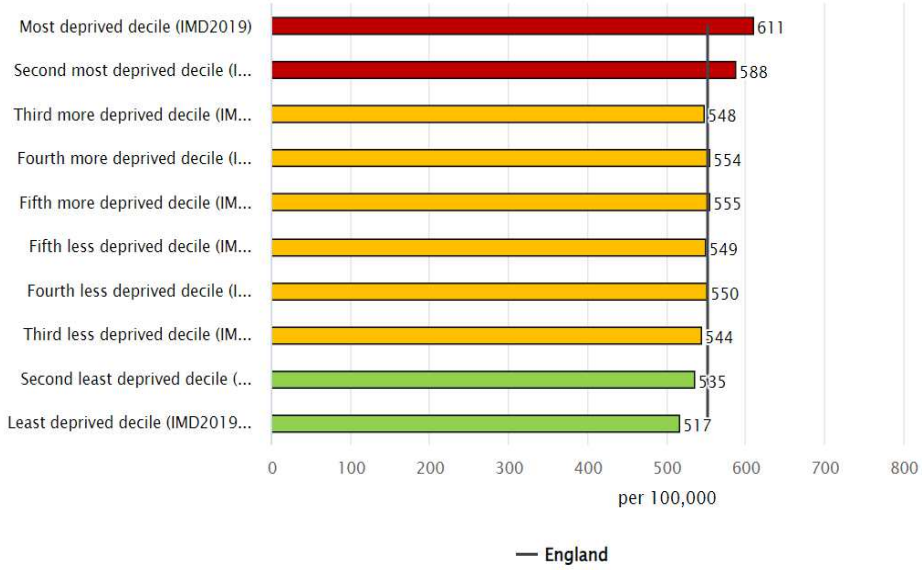


Table 2: Hospital admissions due to hip fractures in people aged 65 and over - rate per 100,000



Key: The deciles of deprivation statistically significantly lower (better) than the England average are shaded green. The deciles of deprivation statistically significantly similar to the England average are shaded amber and the deciles of deprivation significantly higher (worse) than the England average are shaded red.

Source: Public Health Outcomes Framework - Productive Healthy Ageing Profile - Data - OHID (phe.org.uk)

Appendix 7 – Emergency admissions for injury due to falls in persons aged 65+, broken down by PCN, 2016/17 to 2022/23

Emergency Admissions, Falls, Age 65+ (rates compared to ICS)

PCN	2016/17		2017/18		2018/19		2019/20		2020/21		2021/22		2022/23	
	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000
A1 Network PCN	141	1,963	129	1,730	132	1,720	148	1,863	151	1,824	153	1,741	159	1,759
BMC Paston PCN	93	1,236	108	1,442	115	1,518	125	1,610	162	2,048	124	1,595	96	1,240
Bretton, Park and Hampton PCN and Peterborough and East PCN*	246	1,801	221	1,585	237	1,665	251	1,746	245	1,713	232	1,609	211	1,468
Central Thistlemoor and Thorpe Road PCN	25	1,100	24	962	33	1,327	36	1,280	26	914	34	1,068	33	1,005
Fenland PCN	123	1,677	110	1,485	143	1,883	149	1,947	125	1,584	137	1,733	145	1,840
Huntingdon PCN	129	2,070	131	2,032	136	2,080	168	2,510	128	1,911	123	1,780	120	1,681
Peterborough Partnerships PCN	38	1,246	53	1,736	56	1,843	51	1,704	72	2,329	43	1,312	51	1,487
South Fenland PCN	105	1,818	100	1,683	121	1,966	91	1,452	120	1,873	103	1,602	116	1,764
South Peterborough PCN	160	1,712	121	1,268	108	1,093	151	1,483	186	1,807	179	1,712	140	1,293
St Ives PCN	162	1,851	153	1,690	145	1,550	150	1,540	175	1,778	143	1,427	174	1,698
St Neots PCN	119	2,051	128	2,137	126	2,022	135	2,103	131	2,050	128	1,942	109	1,613
Wisbech PCN	239	2,449	229	2,303	210	2,096	211	2,057	193	1,868	197	1,910	142	1,343
North Total	**1,580**	**1,826**	**1,507**	**1,699**	**1,562**	**1,720**	**1,666**	**1,790**	**1,714**	**1,816**	**1,596**	**1,663**	**1,496**	**1,524**
CAM Medical PCN	71	1,995	86	2,341	72	1,923	71	1,799	44	1,077	58	1,423	52	1,237
Cambridge City 4 PCN	160	2,213	162	2,262	159	2,198	146	2,007	119	1,591	126	1,720	137	1,818
Cambridge City PCN	181	2,293	174	2,170	180	2,265	240	2,996	133	1,670	168	2,139	162	2,026
Cambs Northern Villages PCN	144	1,760	160	1,899	202	2,275	179	2,000	136	1,504	160	1,715	155	1,616
Cantab PCN	92	1,971	81	1,705	67	1,333	97	1,837	63	1,211	75	1,416	88	1,577
Ely North PCN	137	1,941	137	1,896	175	2,382	173	2,241	133	1,706	132	1,646	137	1,639
Ely South PCN	131	2,138	104	1,662	104	1,654	126	1,914	103	1,519	99	1,443	102	1,439
Granta PCN	191	1,735	208	1,831	206	1,761	233	1,925	190	1,532	169	1,319	220	1,654
Meridian PCN	122	1,583	123	1,533	153	1,868	167	1,949	125	1,419	132	1,464	150	1,546
South Total	**1,229**	**1,933**	**1,235**	**1,903**	**1,318**	**1,985**	**1,432**	**2,095**	**1,046**	**1,505**	**1,119**	**1,585**	**1,203**	**1,639**
C&P Total	**2,809**	**1,871**	**2,742**	**1,786**	**2,880**	**1,835**	**3,098**	**1,922**	**2,760**	**1,686**	**2,715**	**1,631**	**2,699**	**1,575**

** Bretton, Park and Hampton and Peterborough and East PCNs are shown together due to data coding issues.*

Definition of emergency admission for falls:
Persons aged 65+, ICD10 Primary Diagnosis: Injury, Poisoning and certain other consequences of external causes (S00-T98) and ICD10 Falls (W00-W19) at any position
Key: PCNs statistically significantly lower than the ICS average are shaded green**.** PCNs statistically significantly higher than the ICS average are shaded red
Source of the data: DSCRO SusCP.ip_spell_all

Appendix 8 - Emergency admissions due to hip fracture in persons 65+, broken down by PCN, 2016/17 to 2022/23

Emergency Admissions, Hip Fractures, Age 65+ (rates compared to ICS)

PCN	2016/17		2017/18		2018/19		2019/20		2020/21		2021/22		2022/23	
	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000	Number	DASR per 100,000
A1 Network PCN	41	567	43	575	43	577	51	639	56	694	53	613	60	675
BMC Paston PCN	44	603	44	593	37	501	46	596	50	635	59	757	49	629
Bretton, Park and Hampton PCN and Peterborough and East PCN*	99	714	97	698	101	713	100	693	83	579	89	617	86	589
Central Thistlemoor and Thorpe Road PCN	7	314	12	531	12	492	17	612	13	493	13	436	13	419
Fenland PCN	39	539	49	657	49	644	35	452	34	431	48	604	58	736
Huntingdon PCN	34	542	46	717	45	687	41	615	33	485	38	545	49	673
Peterborough Partnerships PCN	12	434	24	788	27	905	13	387	15	472	18	544	16	477
South Fenland PCN	29	512	33	563	36	597	32	514	44	681	29	445	48	738
South Peterborough PCN	75	801	47	491	50	505	65	640	50	486	75	719	58	532
St Ives PCN	56	636	47	517	55	580	42	437	52	542	51	498	73	692
St Neots PCN	40	695	27	454	40	646	42	658	29	449	38	573	33	481
Wisbech PCN	72	740	60	605	65	650	50	487	70	676	49	474	56	528
North Total	**548**	**635**	**529**	**597**	**560**	**617**	**534**	**575**	**529**	**561**	**560**	**582**	**599**	**608**
CAM Medical PCN	13	363	22	595	19	509	24	613	21	513	20	490	14	334
Cambridge City 4 PCN	41	565	34	470	36	492	51	689	44	588	37	506	49	645
Cambridge City PCN	50	635	61	770	40	491	55	689	46	578	61	776	51	659
Cambs Northern Villages PCN	40	492	50	594	54	614	52	582	50	546	59	635	60	624
Cantab PCN	26	554	16	343	15	302	25	467	22	418	25	467	27	497
Ely North PCN	48	684	33	456	42	573	52	675	48	614	51	643	44	520
Ely South PCN	52	849	30	479	32	514	38	579	26	384	28	406	41	582
Granta PCN	48	440	67	591	62	529	70	575	70	564	57	445	91	686
Meridian PCN	29	382	35	430	36	441	41	479	52	589	46	513	39	397
South Total	**347**	**546**	**348**	**537**	**336**	**505**	**408**	**596**	**379**	**546**	**384**	**544**	**416**	**569**
C&P Total	**895**	**597**	**877**	**571**	**896**	**571**	**942**	**584**	**908**	**554**	**944**	**566**	**1,015**	**591**

** Bretton, Park and Hampton and Peterborough and East PCNs are shown together due to data coding issues.*

Definition of emergency admission for hip fractures:
Persons; aged 65+, ICD10 Primary Diagnosis: S72.0 Fracture of neck of femur, Fracture of hip NOS. S72.1 Pertrochanteric fracture, Intertrochanteric fractures, Trochanteric fracture. S72.2 Subtrochanteric fracture
Source of the data: DSCRO SusCP.ip_spell_all
Key: PCNs statistically significantly lower than the ICS average are shaded green. PCNs statistically significantly higher than the ICS average are shaded red

Appendix 9 – Age, gender and ethnicity of admission

Cambridgeshire and Peterborough ICS , Falls – Emergency Admissions, Persons, aged 65+

Age Band	No. of Spells
n65 - 69	153
o70 - 74	272
p75 - 79	446
q80 - 84	545
s85+	1,283
Total 2022/23	**2,699**

Gender	No. of Spells
Female	1,800
Male	899
Total 2022/23	**2,699**

Ethnic Group	Ethnicity	No. of Spells
Asian or Asian British	Any other Asian background	<=5
	Bangladeshi	<=5
	Indian	6
	Pakistani	8
Black or Black British	African	<=5
	Caribbean	<=5
Mixed	White and Black African	<=5
	White and Black Caribbean	<=5
Not Stated	Not known	233
	Not stated	97
Other Ethnic Groups	Any other ethnic group	<=5
	Chinese	<=5
White	Any other White background	80
	British	2,241
	Irish	16
	Total 2022/23	**2,699**

source: DSCRO SusCP.ip_spell_all

Falls:
Emergency Admissions; Persons; aged 65+
ICD10 Primary Diagnosis: Injury, poisoning and certain other consequences of external causes
(S00-T98) and
ICD10 Falls (W00-W19) at any position

Cambridgeshire and Peterborough ICS, Hip Fractures – Emergency Admissions, Persons, aged 65+ - DASR per 100,000

Age Band	No. of Spells
n65 - 69	38
o70 - 74	92
p75 - 79	170
q80 - 84	210
s85+	505
Total 2022/23	**1,015**

Gender	No. of Spells
Female	711
Male	304
Total 2022/23	**1,015**

Ethnic Group	Ethnicity	No. of Spells
Asian or Asian British	Indian	<=5
	Pakistani	<=5
Black or Black British	African	<=5
	Caribbean	<=5
Not Stated	Not known	103
	Not stated	21
Other Ethnic Groups	Any other ethnic group	<=5
White	Any other White background	27
	British	849
	Irish	7
	Total 2022/23	**1,015**

source: DSCRO SusCP.ip_spell_all

Hip Fractures:
Emergency Admissions; Persons; aged 65+
ICD10 Primary Diagnosis: S72.0 Fracture of neck of femur Fracture of hip NOS
S72.1 Pertrochanteric fracture Intertrochanteric fracture Trochanteric fracture
S72.2 Subtrochanteric fracture

Appendix 10 – List of World Guideline recommendations

The recommendations below are taken from the World Guidelines for falls prevention and management for older adults: a global initiative[60].

The recommendations have been graded by strength and quality. Strength of recommendations is reflected by a 1 for strong and 2 for weak or conditional. Quality is denoted by A for high quality, B for intermediate quality and C for low quality. E refers to expert opinion as a result of no quality evidence being available.

1. Falls risk stratification and algorithm

1.1 Opportunistic case-finding

Strong recommendation. Clinicians should routinely ask about falls in their interactions with older adults, as they often will not be spontaneously reported. GRADE: 1A.

Expert recommendation. Older adults in contact with healthcare for any reason should be asked, at least once yearly, if they have (i) experienced one or more falls in the last 12 months, and (ii) about the frequency, characteristics, context, severity and consequences of any fall/s. GRADE: E.

Expert recommendation. If resources and time are available, we conditionally recommend to additionally ask (iii) if they have experienced dizziness, loss of consciousness or any disturbance of gait or balance and (iv) if they experience any concerns about falling causing limitation of usual activities. GRADE: E.

Strong recommendation. Older adults who affirm any of the above inquiries should be offered an objective assessment of gait and balance for differentiating intermediate and high from low risk of falls as a component of initial falls risk stratification. GRADE: 1A

1.2 Older adults presenting with falls or related injuries

Expert recommendation. Older adults presenting with a fall or related injury should be asked about the details of the event and its consequences, previous falls, transient loss of consciousness or dizziness and any pre-existing impairment of mobility or concerns about falling causing limitation of usual activities. GRADE: E.

Expert recommendation. An adult who sustains an injury requiring medical (including surgical) treatment, reports recurrent falls (≥2) in the previous 12 months, was laying on the floor unable to rise independently for at least one hour, is considered frail or is suspected to have experienced a transient loss of consciousness should be regarded as at high risk of future falls. GRADE: E

Strong recommendation. Regarding specific tests, we recommend including Gait Speed for predicting falls risk. GRADE: 1A. As an alternative, the Timed Up and Go Test can be considered, although the evidence for fall prediction is less consistent. GRADE: 1B

1.3 Assessment and algorithm flow

Strong recommendation. Regarding specific tests, we recommend including Gait Speed for predicting falls risk. GRADE: 1A. As an alternative, the Timed Up and Go Test can be considered, although the evidence for fall prediction is less consistent. GRADE: 1B

[60] World guidelines for falls prevention and management for older adults: a global initiative - PMC (nih.gov)

2.0 Assessment

2.1 Incorporating the perspective of the older adult

Strong recommendation. As part of a multifactorial falls risk assessment clinicians should enquire about the perceptions, the older adult holds about falls, their causes, future risk and how they can be prevented. GRADE: 1B.

Expert recommendation. As part of a multifactorial falls risk assessment clinicians should enquire about the goals and priorities; attitudes to activities, independence and risk; and willingness and capability of older adults to inform decision making on potential interventions. GRADE: E

2.2 Multifactorial falls risk assessment

Strong recommendation. Offer multi-professional, multifactorial assessment to community-dwelling older adults identified to be at high risk of falling, to guide tailored interventions. GRADE: 1B.

2.3 Assessment details for individual components

2.3.1 Gait and balance assessment

Strong recommendation. Gait and Balance should be assessed as part of the risk assessment of falls. GRADE: 1B

2.3.2 Medication assessment

Strong recommendation. Assess for fall history and the risk of falls before prescribing potential fall risk increasing drugs (FRIDs) to older adults. GRADE: 1B.

Strong recommendation. Use a validated, structured screening and assessment tool to identify FRIDs when performing a general medication review or medication review targeted to falls prevention. GRADE: 1C.

2.3.3 Cognitive assessment

Strong recommendation. Assessment of cognition should be included as part of a multifactorial falls risk assessment in older adults. GRADE: 1B.

2.3.4 Concerns about falling and falls

Strong recommendation. Include an evaluation of concerns about falling in a multifactorial falls risk assessment of older adults. GRADE: 1B.

Strong recommendation. Use a standardized instrument to evaluate concerns about falling such as the Falls Efficacy Scale International (FES-I) or Short FES-I in community dwelling older adults. GRADE: 1A.

2.3.5 Cardiovascular assessment

Strong recommendation. Perform, as part of a multifactorial falls risk assessment, a cardiovascular assessment that initially includes cardiac history, auscultation, lying and standing orthostatic blood pressure, and surface 12-lead electrocardiogram. GRADE: 1B.

Strong recommendation. In the absence of abnormalities on initial cardiovascular assessment, no further cardiovascular assessment is required, unless syncope is suspected (i.e., described or witnessed syncope/pre-syncope or recurrent unexplained falls). GRADE: 1C.

Strong recommendation. We recommend that the further cardiovascular assessment for unexplained falls should be the same as that for syncope, in addition to the multifactorial falls risk assessment. GRADE: 1A.

2.3.6 Dizziness and vestibular disorders assessment

Expert recommendation. Routinely ask about dizziness symptoms, and undertake follow-up assessment as necessary to identify cardiovascular, neurological and/or vestibular causes. GRADE: E.

2.3.7 Vision and hearing assessment

Expert recommendation. Enquire about vision impairment as part of a multifactorial falls risk assessment, measure visual acuity and examine for other visual impairments such as hemianopia and neglect where appropriate. GRADE: E.

Expert recommendation. Enquire about hearing impairment as part of a multifactorial falls risk assessment, measure and examine for hearing impairments and refer to a specialist where appropriate. GRADE: E.

2.3.8 Urinary symptoms and incontinence assessment

Expert recommendation. Enquire about urinary symptoms as part of a multifactorial falls risk assessment GRADE: E

2.3.9 Pain assessment

Expert recommendation. Enquire about pain as part of a multifactorial falls risk assessment, followed as indicated by a comprehensive pain assessment. GRADE: E

2.3.10 Environmental assessment

Strong recommendation. Identification of an individual's environmental hazards where they live and an assessment of their capacities and behaviours in relation to them, by a clinician trained to do so, should be part of a multifactorial falls risk assessment. GRADE:1B.

2.3.11 Depression assessment

Expert recommendation. Enquire about depressive symptoms as part of a multifactorial falls risk assessment, followed by further mental state assessment if necessary and referral to a specialist where appropriate. GRADE: E

2.3.12 Nutritional assessment including vitamin D

Expert recommendation – Assess nutritional status including vitamin D intake as part of a multifactorial falls risk assessment, followed by supplementation where appropriate. GRADE: E

1.0 Management and interventions

3.3 Management of older adults at low fall risk

Expert recommendation. Provide advice on how to maintain safe mobility and optimise physical functioning to older adults at low risk of falls from a clinician trained to do so. Such advice should consider the circumstances, priorities, preferences and resources of the older adult. This advice should

reinforce health promotion/prevention messaging relevant to falls and fracture risks such as those on physical activity, lifestyle habits and nutrition including vitamin D intake. GRADE: E.

3.3 Interventions for community dwelling older adults at intermediate fall risk

Expert recommendation. Offer an exercise programme based on an individual assessment and according to the recommendations in the Exercise Interventions section. GRADE: E.

3.3 Multidomain interventions for community dwelling older adults at high fall risk

Strong recommendation. A care plan developed to prevent falls and related injuries should incorporate the values and preferences of the older adult. GRADE: 1B.

Strong recommendation. When creating falls prevention care plans for older adults with cognitive impairment, both the older adults' and their caregivers' perspectives should be included as it improves adherence to interventions and outcomes. GRADE: 1C.

Multidomain falls risk intervention Strong recommendation. Offer multidomain interventions, informed by a multi-professional, multifactorial falls risk assessment to community-dwelling older adults identified to be at high risk of falling. GRADE: 1B.

3.4 Component interventions

3.4.1 Exercise and physical activity interventions

Strong recommendation. Exercise programmes for fall prevention for community-dwelling older adults that include balance challenging and functional exercises (e.g., sit-to stand, stepping) should be offered with sessions three times or more weekly which are individualised, progressed in intensity for at least 12 weeks and continued longer for greater effect. GRADE: 1A.

Strong recommendation. Include, when feasible, of Tai Chi and/or additional individualised progressive resistance strength training. GRADE: 1B.

3.4.2 Medication interventions

Strong recommendation. A medication review and appropriate deprescribing of FRIDs should be part of multidomain falls prevention interventions. GRADE: 1B.

Strong recommendation. We recommend that in long-term care residents, the falls prevention strategy should always include rational deprescribing of fall-risk-increasing drugs. GRADE: 1C.

3.4.3 Cardiovascular interventions

Strong recommendation. Management of orthostatic hypotension should be included as a component of a multidomain intervention. GRADE: 1A.

Strong recommendation. Interventions for cardiovascular disorders identified during assessment for risk of falls should be the same as that for similar conditions when associated with syncope, in addition to other interventions based on the multifactorial falls risk assessment. GRADE 1B.

3.4.4 Telehealth and technology interventions

Expert recommendation. Use telehealth and/or smart home systems (when available) in combination with exercise training as part of falls prevention programmes in the community. GRADE: E.

Conditional recommendation. Current evidence does not support the use of wearables for falls prevention. However, emerging evidence show that when wearables are used in exercise programs to prevent falls, they may increase participation. GRADE: 2C.

3.4.5 Environmental interventions

Strong recommendation. Recommendations for modifications of an older adult's physical home environment for fall hazards that consider their capacities and behaviours in this context should be provided by a trained clinician, as part of a multidomain falls prevention intervention. GRADE: 1B.

3.4.6 Vestibular interventions

Expert recommendation Managing vestibular issues should be considered as part of multifactorial approach. GRADE: E

3.4.7 Pain interventions

Expert recommendation. Adequate pain treatment should be considered as part of the multidomain approach. GRADE: E.

3.4.8 Concerns about falling and falls interventions

Strong recommendation. We recommend exercise, cognitive behavioural therapy and/or occupational therapy (as part of a multidisciplinary approach) to reduce concerns about falling in community-dwelling older adults. GRADE: 1B.

3.4.10 Vision interventions

Expert recommendation. Management of impaired vision should be considered as part of the multifactorial approach. GRADE: E.

4.0 Falls in hospitals

4.1 Risk stratification and assessment

Conditional recommendation. Perform a multifactorial falls risk assessment in all hospitalised older adults >65 years of age. We recommend against using scored falls risk screening tools in hospitals for multifactorial falls risk assessment in older adults. GRADE: 2B.

Strong recommendation. We recommend using the FESI or especially the Short FES-I for assessing concerns about falling in acute care hospitals. GRADE: 1B.

Expert recommendation. We recommend conducting a post-fall assessment in hospitalised older adults following a fall in order to identify the mechanism of the fall, any resulting injuries, any precipitating factors (such as new intercurrent illness, complications or delirium), to reassess the individual's fall risk factors, and adjust the intervention strategy accordingly. GRADE: E.

4.2 Management and interventions

Strong recommendation. A tailored education on falls prevention should be delivered to all hospitalised older adults (≥65 years of age) and other high-risk groups. GRADE: 1A.

Strong recommendation. Personalised single or multidomain falls prevention strategies based on identified risk factors, behaviours or situations should be implemented for all hospitalised older adults (≥65 years of age), or younger individuals identified by health professionals as at risk of falls. GRADE: 1C (Acute care), GRADE: 1B (Sub-acute care)

5.0 Falls in care homes

5.1 Risk stratification and assessment

Strong recommendation. Do not perform falls risk screening to identify care home residents at risk for falls as all residents should be considered at high risk of falls. GRADE: 1A.

Strong recommendation. Perform a comprehensive multifactorial assessment at admission to identify factors contributing to fall risk and implement appropriate interventions to avoid falls and fall-related injuries in care home older adults. GRADE: 1C.

Expert recommendation. We recommend conducting a post-fall assessment in care home residents following a fall in order to identify the mechanism of the fall, any resulting injuries, to reassess the resident's fall risk factors, adjust the intervention strategy for the resident and avoid unnecessary transfer to hospital. GRADE: E.

Strong recommendation. We recommend using the FES-I or especially the Short FES-I for assessing concerns about falling in long-term care facilities. GRADE: 1B.

5.2 Management and interventions

Strong recommendation. Take a multifaceted approach to falls reduction for care home residents including care home staff training, systematic use of a multidomain decision support tool and implementation of falls prevention actions. GRADE: 1B.

Strong recommendation. Do not use of physical restraints as a measure for falls prevention in care homes. GRADE: 1B. Strong recommendation. Perform nutritional optimisation including food rich in calcium and proteins, as well as vitamin D supplementation as part of a multidomain intervention for falls prevention in care home residents. GRADE: 1B.

Strong recommendation. Include the promotion of exercise training (when feasible and safe) as part of a multidomain falls prevention intervention in care homes. GRADE: 1C.

6.0 Specific clinical populations

6.1 Falls and PD and related disorders

6.1.1 Assessment

Conditional recommendation. Consider a falls risk assessment for older adults with PD, including a self-report 3-risk factor assessment tool, which includes a history of falls in the previous year, freezing of gait (FOG) in the past month, and slow gait speed. GRADE: 2B.

6.1.2 Management and interventions

Conditional recommendation. Older adults with PD should be offered multidomain interventions, based on PD specific assessment and other identified falls risk factors. GRADE: 2B. Strong recommendation. Older adults with PD at an early to mid-stage and with mild or no cognitive impairment should be offered individualised exercise programmes including balance and resistance training exercise. GRADE: 1A.

Strong recommendation. Consider offering exercise training, targeting balance and strength to people with complex phase PD if supervised by a physiotherapist or other suitably qualified professional. GRADE: 1C.

6.2 Stroke

Conditional recommendation. Older adults after a stroke should be offered participation in individualised exercise programmes aimed at improving balance/strength/walking to prevent falls. GRADE: 2C.

6.3 Mild cognitive impairment and dementia

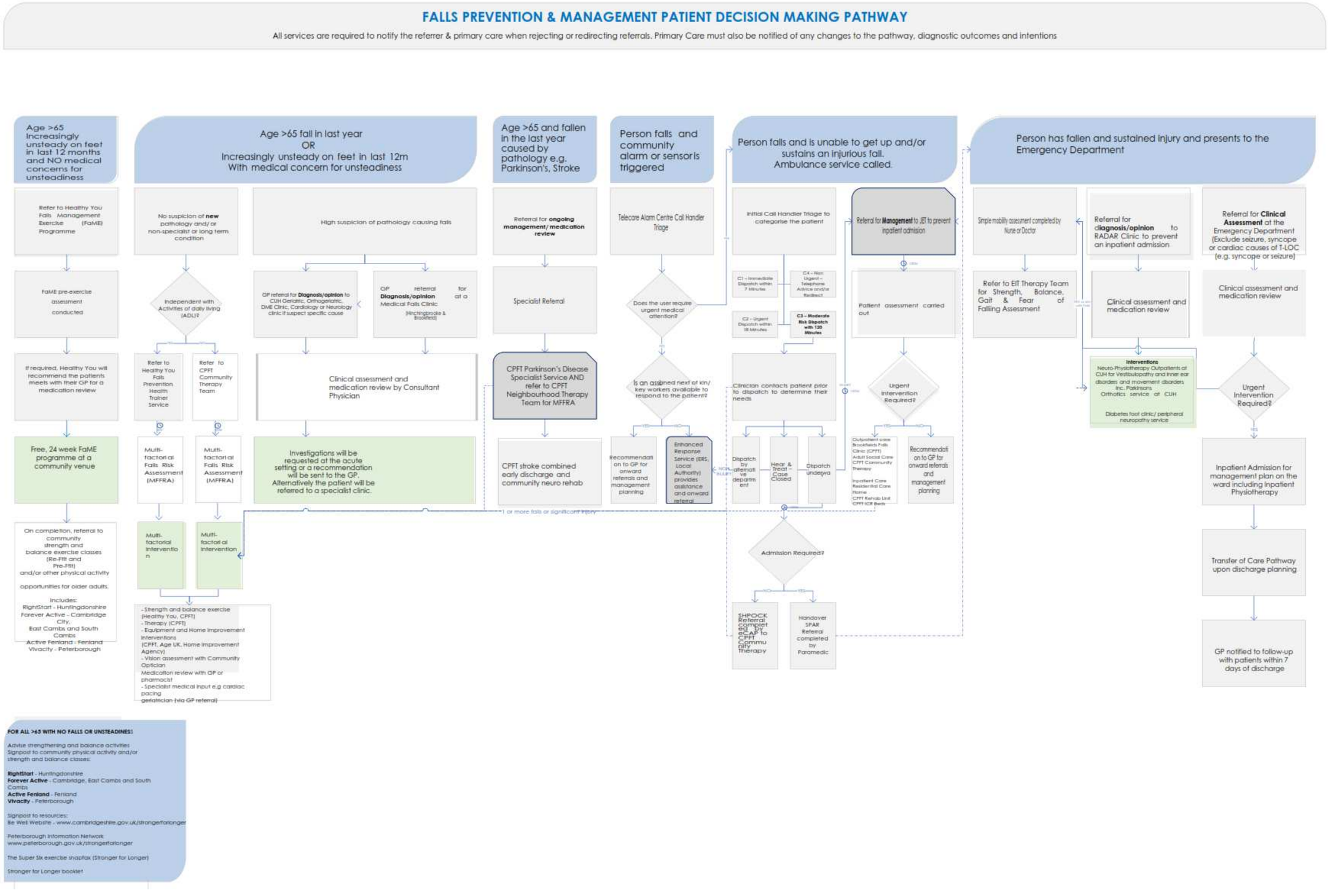
Strong recommendation. Community-dwelling older adults with cognitive impairment (mild cognitive impairment and mild to moderate dementia) should be offered an exercise programme to prevent falls. GRADE: 1B.

6.4 Hip fracture Strong recommendation.

Older adults after sustaining a hip fracture should be offered an individualised and progressive exercise programme aimed at improving mobility (i.e., standing up, balance, walking, climbing stairs) as a fall prevention strategy. GRADE: 1B.

Conditional recommendation. Such programmes for older adults after a hip fracture are best commenced in hospital (GRADE: 2C) and continued in the community (GRADE: 1A).

Appendix 11 - System wide Falls Prevention and Management Pathway



Appendix 12 - Summary of key falls-related services

SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
CPFT Community Therapy	CPFT Community Therapy are part of the CPFT Neighbourhood Teams, supporting all adults requiring community services. The wider Neighbourhood team includes integrated District Nurses, Integrated Support Workers and Mental Health Practitioners and works in partnership with other services including out-of-hours nursing, intermediate care, podiatry, dietetics, mental health teams, speech and language therapy and JET. Evidence based patient pathways have been developed for a number of health conditions to ensure the services in the Neighbourhood team manage their patients in the same way and teams work in a coordinated way to support those at highest risk of hospital or care home admission. The falls prevention pathway forms part of the Community Therapy remit. This includes the provision of multi-factorial falls risk assessments, strength and balance exercise programmes, rehabilitation programmes, equipment and housing adaptations. Equipment is prescribed from the Integrated Community Equipment Service (NRS contract) - a service commissioned by CCC.	Eligibility for a multi-factorial falls risk assessment: 1) Person 65+ who has had one or more falls in the last 12 months and 2) are not independent with their activities of daily living i.e. they are not able to complete one or more of the following: • Transfer on and off toilet •Transfer on and off the bed and chair without help • Walk safely and independently with or without a walking aid •Manage to wash, dress and prepare meals and drinks independently or have adequate help to enable to complete these tasks •Leave the house with or without help	Countywide - Cambridgeshire and Peterborough	08:00-16:00	Cambridgeshire and Peterborough ICS	Area Therapy Managers: •Hayley Litchfield Falls Prevention Clinical Lead: Annami Palmer	Hayley.litchfield@cpft.nhs.uk Louise.pitt@cpft.nhs.uk Sarah.wood@cpft.nhs.uk Annami.palmer@cpft.nhs.uk
Healthy You/Everyone Health Falls Prevention Health Trainer Service	The service forms part of the integrated community falls prevention pathway with CPFT and offers multi-factorial risk assessments for people who are independent with ADLs, followed by appropriate referral for interventions. In addition, it offers a free, 24 week programme of group strength and balance classes (Falls Management Exercise programme, FaME).	•Cambridgeshire and Peterborough residents 65+. •Criteria for a multi-factorial falls risk assessment: 1) Have fallen one or more times in the last year and 2) Be able to manage activities of daily living (with or without support). •Criteria for the FaME programme: 1) Have become increasingly unstable on their feet in the last year 2) Be able to manage activities of daily living (with or without support)	Countywide community clinics - within the local authority boundaries of Cambridgeshire County Council and Peterborough City Council	Monday-Friday 09:00-17:00	Cambridgeshire County Council and Peterborough City Council	Charlina Robinson	CharlinaRobinson@healthyyou.org.uk
CPFT Enhanced Falls Prevention Pathway	3-year funded programme in Cambridge City and Fenland only commissioned by Cambridgeshire County Council to deliver multifactorial falls risk assessments (MFRA)	Cambridgeshire residents 65+ who has had two or more falls in the last 12 months, and/or they have been admitted to hospital as a result of a fall, and live within the catchment areas of the following NTs: Cambridge City North, Cambridge City South, Fenland, Wisbech	NTs: Cambridge City North, Cambridge City South, Fenland, Wisbech	08:00-16:00	Cambridgeshire County Council	Annami Palmer	Annami.palmer@cpft.nhs.uk

SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
Addenbrooke's Hospital - Emergency Department	The ED provides an assessment of people who have fallen which includes: medical history, medication review, examination, lying & standing BP, investigations (i.e., CG/glucose check), bone health assessment	All Falls Patients excluding seizure, syncope or cardiac causes of Transient loss of consciousness (TLoC) (e.g., syncope or seizure)	Hills Rd, Cambridge CB2 0QQ	24/7	Cambridgeshire and Peterborough ICS	Dr Diane Williamson	diane.williamson1@nhs.net
Addenbrooke's Hospital – Front Door Frailty Service	The CUH Front Door Frailty Service, initiated in August 2023, offers a Comprehensive Geriatric Assessment (CGA) to patients presenting to ED. The team comprises 2 Consultant Geriatricians and a Pharmacist.	Patients with a frailty score of 6 and over on the Clinical Frailty Scale, 80+ years of age and Care and Residential home residents.	Hills Rd, Cambridge CB2 0QQ	08:00-17:00 Monday - Friday.	Cambridgeshire and Peterborough ICS	Dr Lelane Vanderpoel	l.vanderpoel@nhs.net
Addenbrooke's Hospital - Early Intervention Team (EIT)	The EIT carry out a simple mobility test; based on this outcome patients will either continue to be managed in the Emergency Department or EIT will use the assessment to create appropriate referrals to onward services to avoid an admission.	All patients age >65 years who present to the ED with a fall	Hills Rd, Cambridge CB2 0QQ	08:00 - 20:00 Monday - Sunday (Therapy is limited to 08:00 - 18:00 due to workforce shortage)	Cambridgeshire and Peterborough ICS	Service Lead: Jo Barker Therapy Lead: Nicole Uyan	jo.barker3@nhs.net Nicole.uyan1@nhs.net
Addenbrooke's Hospital – General Medical Clinics	The Geriatrician-led Medical Falls Clinics provide the medical part of a CGA including full clinical exam, medical review, medication review and social history. Approximately two new referrals and two returning patients are seen per clinic (or up to five returns). The clinic can refer into other CUH specialist clinics e.g., Syncope clinic, Cardiology, ENT, Dexa scan etc.	No explicit criteria (person fallen and GP requests review) but referrals are triaged into appropriate geriatric service clinics as needed.	Hills Rd, Cambridge CB2 0QQ	Clinics run afternoons every day, Monday to Friday.	Cambridgeshire and Peterborough ICS	Dr Joanna Hampton	joanna.hampton@nhs.net
NWAFT Front Door Frailty Team	The NWAFT Front Door Frailty Service, initiated in Peterborough City Hospital (PCH) in September 2021 and Hinchingbrooke Hospital (HH) in April 2023, offers a Comprehensive Geriatric Assessment (CGA) to patients presenting with acute frailty to the emergency department at PCH or HH. The CGA is an in-depth medical review and covers 5 core pillars of the CGA. In PCH, the team liaise with the NWAFT Front Door Therapy Team and in HH, the team liaise with the CPFT Front Door Therapy Team. The team comprises 1.5 Consultant Geriatricians, 4 Physician Associates, 1 Registrar, 2 Lead Nurses, and 3 Frailty Nurses.	Patients with a Rockwood frailty score of 6 and above	Peterborough City Hospital, Bretton Gate, Peterborough, PE3 9GZ Hinchingbrooke Hospital, Hinchingbrooke Park Huntingdon, PE29 6NT	PCH: 7 days a week, 08:00-18:00 weekdays and 08:00-16:00 on weekends HH: 5 days a week (Monday to Friday), 08:00-18:00	Cambridgeshire and Peterborough ICS	Dr Lucy Daniels	lucy.daniels3@nhs.net

SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
NWAFT General Medical Clinics	The Geriatrician-led General Medical Clinic offers comprehensive medical assessment (similar to a CGA) and medication review for patients referred from the GP or hospital therapists. The Peterborough City Hospital (PCH) clinic is run by four Consultant Geriatricians who see up to five new patients per week. The Hinchingbrooke Hospital clinic is run by two Consultant Geriatricians.	There is no explicit referral criteria for the General Medical Clinics although the patients are triaged by the Geriatric Service into the appropriate clinics. Patients with recurrent falls are accepted into the General Medical Clinic.	Peterborough City Hospital, Bretton Gate, Peterborough, PE3 9GZ Hinchingbrooke Hospital, Hinchingbrooke Park Huntingdon, PE29 6NT	PCH: Clinics run on a Tuesday and a Wednesday afternoon every week HH: Clinics run on Monday afternoon and Friday morning	Cambridgeshire and Peterborough ICS	Dr Olugbenro Akintade HH: Dr Alice Cole or Dr Elizabeth Ellis	olugbenro.akintade@nhs.net Alice.cole1@nhs.net elizabeth.ellis2@nhs.net
CCC & PCC Reablement Team	The reablement service takes a holistic approach to assessment and goal setting of people discharged from hospital to maintain or enhance their level of independent function in daily living activities. This involves the person and their family / carers but also aims to consider the benefits of accessing wider, preventative services such as technology enabled care, therapy services, housing related support, housing services and community navigators. The team also follow the Falls Prevention pathway. The programme lasts up to 6 weeks (longer if required). The service is led by Occupational Therapists.	**Inclusion** 18+ years and is a resident in Cambridgeshire or Peterborough. Person would benefit from a short-term, targeted programme of reablement, and / or reassessment, in order to maintain or enhance their level of independent function in daily living activities and reduce their need for statutory services. **Exclusion** The person has: • a rapidly deteriorating condition or prognosis, with complex needs that cannot be met by the reablement service and would be best met by health services – either Intermediate Care or NHS Continuing Health Care • a health need that requires a specific clinical rehabilitation programme or Intermediate Care • requires care and support while their family carers are on holiday • Adults who are homeless and do not have suitable accommodation for a Reablement programme to take place. • Adults who have No Recourse to Public Funds (NRPF). • People who are unable to engage in a reablement intervention due to severe cognitive ability and / or are not engaged in a programme of rehabilitation support.	Countywide - within the local authority boundaries of Cambridgeshire County Council and Peterborough City Council.	7-days per week between the core operating hours of 7am and 10pm. The services operate adequate 'on call' and 'out of hours' cover	Cambridgeshire County Council and Peterborough City Council	Rebecca Garry (CCC) Carol Farrar (PCC)	Rebecca.gary@cambridgeshire.gov.uk carol.farrar@peterborough.gov.uk

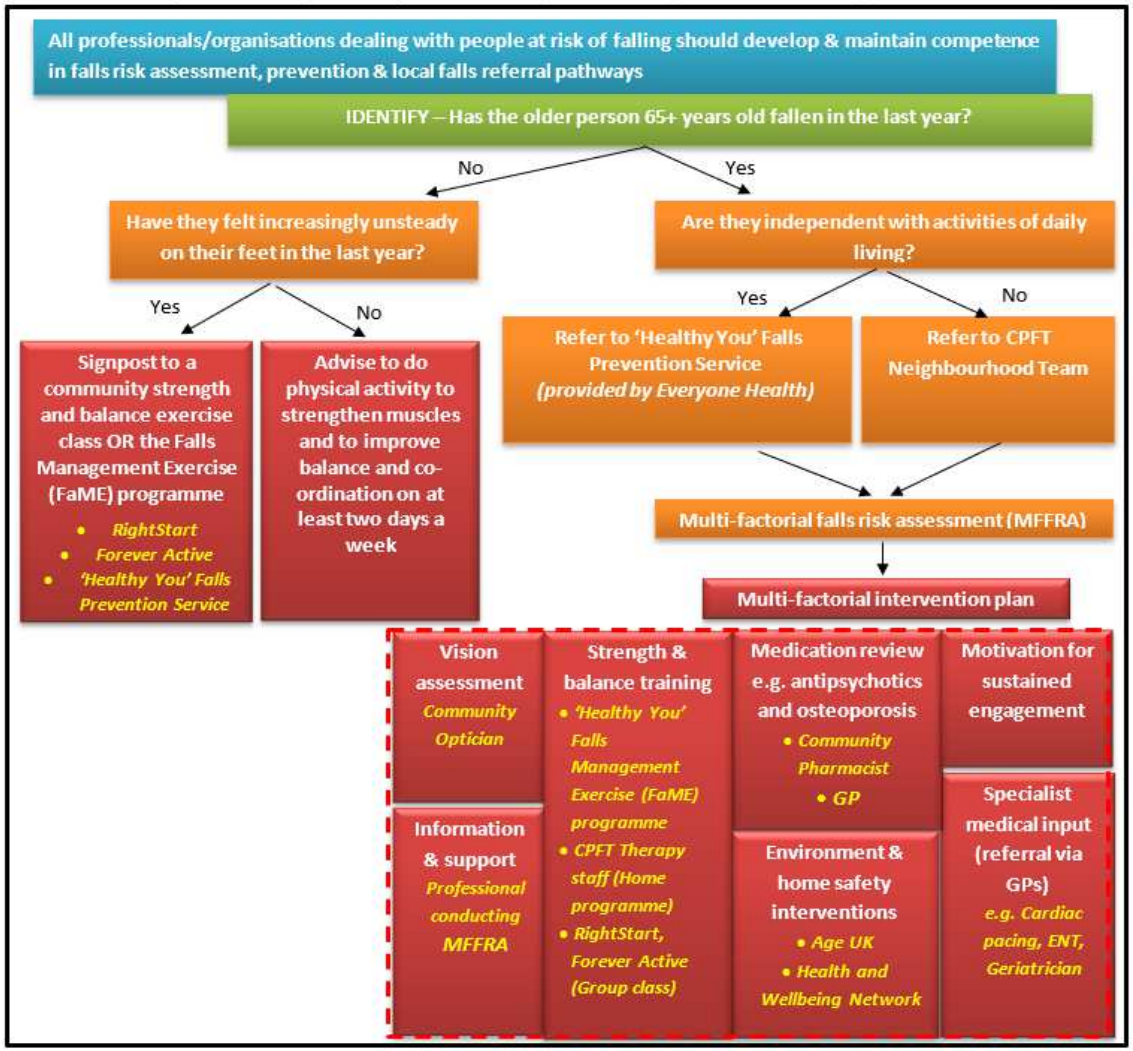
SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
CPFT Intermediate Care Team	The intermediate care service comprises of two main community pathways supporting patients with different levels of dependency: Pathway 1: Home with care and therapy Pathway 2: Rehabilitation in a bedded facility (health interim) The aim of Intermediate Care services is to promote faster recovery from illness; support safe and timely discharge from hospital; prevent unnecessary hospital admission; prevent premature admission to long-term residential care; maximise independent living in the community. Each intermediate care service provides a range of functions that include: Triaging of referrals and discharge planning from acute hospitals; Initial Assessment within 48 hours of admission to pathway; Care and therapy goal planning in the community; Care co-ordination, allocation and management; Delivery of care; Transfer of care planning from intermediate care services.	**Inclusion** • Patients who are clinically fit to leave hospital OR •Patients who can be prevented from being admitted to an acute hospital AND are: • Adults aged 18+ registered with a Cambridgeshire and Peterborough GP • People rehabilitating following acute medical or surgical health conditions where it is anticipated that their functional status will improve. E**xclusion** • Patients who need long term care packages • Patients whose existing care package meets their needs • Patients who require permanent placement into a nursing or care home • Patients whose needs can be met by Local Authority reablement services because the primary need is not related to an acute health medical or surgical illness • Patients who have an acute mental health need or who have a psychiatric crisis • Patients who require maintenance for a long-term condition • Patients whose only need is medicines management • Patients who require assessment for NHS Continuing Health Care, including Fast Track end of life care and complex case management.	Countywide	7 days a week, 07:00-22:00	Cambridgeshire and Peterborough ICS	Vanessa Bunn Barry Underwood	Vanessa.bunn@cpft.nhs.uk Barry.underwood@cpft.nhs.uk
Peterborough City Council Home Service Delivery Team	The Home Service Delivery Team brings together teams across Adult Social Care and Housing to keep people living in their homes independently and safely for as long as possible. It is a 'One stop shop' approach for clients which looks at both their ability to carry out activities of daily living and their physical home environment. The service brings together Reablement; Therapy Services (including sensory impairment and assistive technology); Care and Repair Home Improvement Agency (including Handyperson Service); Housing Programmes; Adult Early Help; and Older Peoples Day Services at the Cresset	Varies but is for Peterborough residents only	Peterborough wide	Varies	Peterborough City Council	Belinda Child	belinda.child@peterborough.gov.uk

SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
CCC Enhanced Response Service (ERS)	ERS respond to telecare alerts via Lifeline Alert centres or referrals from EEAST for people who need non-emergency assistance, 24 hours a day, 7 days a week. Their target response time is 60 minutes. The service: • Provides assistance to get a person up from the floor following a fall • Provides personal care that is needed in an urgent and unplanned circumstance, i.e., not part of a regular care package. • Provides reassurance following an incident at home • The Enhanced Response Service is not an emergency service, nor are they clinical or medical responders. They are registered with the Care Quality Commission to provide social care activities.	Cambridgeshire and Peterborough residents who have a lifeline	Countywide - Within the local authority boundaries of Cambridgeshire County Council and Peterborough City Council	24/7	Cambridgeshire County Council	Grace E Clarke (CCC) Belinda Child (PCC)	GraceE.Clark@cambridgeshire.gov.uk belinda.child@peterborough.gov.uk
Age UK Cambridgeshire and Peterborough Handyperson Service	The Cambridgeshire Handyperson Service offers wellbeing assessments to older people and adults with a disability, whether short or long term. Following assessment, measures such as grab and banister rails and half steps can be installed, as well as carrying out small jobs around the home, which can also prevent a fall. In carrying out lower level interventions, pressures on statutory therapy services can be reduced and ultimately those requiring such support wait less for this to be implemented.	Any older person aged 65+. Any adult aged 18 plus with a disability, whether short or term, physical or mental.	Cambridgeshire wide (not Peterborough)	9am to 4.30pm Monday to Friday	•Cambridgeshire County Council • South Cambridgeshire DC •Cambridge City Council •East Cambridgeshire DC •Huntingdonshire DC •Fenland DC	Diana MacKay	Diana.Mackay@cambridgeshire.gov.uk
Age UK Cambridgeshire and Peterborough Community Wardens, Home Support and Day Services	Community Wardens, Home Support and Day Services - Regular input from these services ensures needs are continuously assessed and potential risks from falls can be averted. Close communication with clinicians ensures medical needs are reviewed on a timely basis, again reducing the risk of falls.	•Aged 60 plus, living alone or with another older person who would benefit from the support •Residing in the areas a Community Warden service is offered	Wardens in 20 areas of Cambridgeshire and Peterborough. Home Support in Peterborough. Day Services in various areas countywide	Each weekday	Various including County, District and Parish councils. Local charities, trust funds and donations	Various Contact: Melanie Pittock	Melanie.Pittock@ageukcap.org.uk
Age UK Cambridgeshire and Peterborough Hospital Discharge support and	In assisting hospital discharges and admission avoidance, Age UK Cambridgeshire and Peterborough ensure timely help is given, regular visits from staff and volunteers are made, meaning further decline in health and mobility is less likely. Installing key safes and other falls prevention measures on discharge enables care	Aged 60 plus, recently discharged from hospital or at risk of being admitted.	Cambridgeshire and Peterborough	10am to 4pm 7 days per week	Collaboration through Voluntary Sector Alliance (VSA), ICS funding	Various Contact: Melanie Pittock	Melanie.Pittock@ageukcap.org.uk

SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
admission avoidance	or reablement to begin as soon as a person is home.						
Right Start Group Exercise Classes	Delivers a programme of exercise classes for older people from Chair Based, Strength and Balance (Otago), Postural Stability Exercise (including floor work). Full list available at www.huntingdonshire.gov.uk/rightstart	Older adults and those who require additional support to exercise. Different levels from 1-5 depending on ability. For those who have fallen, who are unsteady or to generally improve balance and co-ordination. Also available Right Start Aqua and Right Start Indoor Cycling www.huntingdonshire.gov.uk/rightstart	Huntingdonshire District including: Huntingdon, Ramsey, St Ives, St Neots and villages: Alconbury Weald, Brampton, Catworth, the Hemingfords, Houghton, and Warboys. Programme subject to change and growth.	Monday - Friday Generally daytime	Customers pay as they go or a variety of payment methods are available. Funding from Public Health for new 'strength and balance activities' project	Jo Peadon	jo.peadon@huntingdonshire.gov.uk
Forever Active	Provides exercise/activity sessions for the over 50 age groups within Cambridge City, South Cambridgeshire and East Cambridgeshire. Sessions range from chair-based exercises, which are suitable for people with mobility problems, to activities and sports for the active 50+. Full list available at: https://www.forever-active.org.uk/classes/sports/	Generally open access but my vary by exercise class	Cambridge City, South Cambridgeshire and East Cambridgeshire - list on website https://www.forever-active.org.uk/classes/sports/	Monday - Friday Generally daytime	Customers pay as they go or become a member. Funding from Public Health for new 'strength and balance activities' project	Jane Jones	jane.jones@forever-active.org.uk
Vivacity	Delivers a range of exercise classes for older people including strength and balance classes and other activities. https://www.vivacity.org/sport-events/health-wellbeing/strength-balance-classes/	Generally open access but my vary by exercise class	Peterborough wide	Monday - Friday Generally daytime	Customers pay as they go or a variety of payment methods are available. Funding from Public Health for new 'strength and balance activities' project	Emma Walker	emma.walker@vivacity.org

SERVICE NAME	SERVICE OVERVIEW	ELIGIBILITY CRITERIA	LOCATION(S)	OPERATING TIMES	FUNDING SOURCE	CLINICAL LEAD	CLINICAL LEAD EMAIL
Active Fenland (Fenland District Council's Physical Activity and Healthy Lifestyle department)	Provides physical activity and healthy lifestyle opportunities which includes but is not limited to opportunities for older adults such as FaME, Strength and Balance, Yoga (low level seated can be accommodated where needed) Forever Fit (Table Tennis, badminton, short tennis and indoor curling) Walking Sports (Football, Netball and Cricket), Walking Groups, Tea Dance, Health MOTs, Love to Move, metal wellbeing sessions, 12 week physical activity interventions /taster sessions and many more physical activity opportunities.	Projects vary on eligibility but the service as a whole is for anyone living England.	Fenland	Sessions are at varied times a coordinator is available office hours Monday-Friday	Pay as you go, variety of payment methods. Funding from Public Health Healthy You Project and the new 'strength and balance activities' project.	Lauren Bremner	lbremner@fenland.gov.uk

Appendix 13 – Community Falls Prevention pathway



Appendix 14 – Gap analyses from organisations

1) Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)

CPFT Falls Prevention Gap Anal

2) Healthy You

Healthy You Falls Prevention Gap Anal

3) Cambridge University Hospital NHS Foundation Trust (CUHFT)

CUHFT falls prevention gap analy

4) North West Anglia Foundation Trust (NWAFT)

NWAFT Falls Prevention Gap Anal