Ageing Well: Bolton JSNA

Falls in older people 2023

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1. What are falls? What are their implications?

1.1 Falls: the WHO defines falls as "inadvertently coming to rest on the ground, floor or other lower level, excluding intentional change in position to rest on furniture, wall or other objects."

- Falls are the second leading cause of accidental or unintentional injury deaths worldwide
- Older people have the highest risk of falling with 30% of people aged 65 and over and 50% of people aged 80 and over falling at least once a year
- Approximately 5-10 % of falls in older people result in serious injury or hospitalisation
- After a fall, an older person has a 50 per cent probability of having their mobility seriously impaired and a 10 per cent probability of dying within a year
- Falls are complex and multifactorial – the result of the interplay of multiple factors
- Even minor falls can have major psychological impact leading to lower levels of confidence, independence and increased isolation and depression
- 20% of hip fracture patients entered long-term care in the first year after fracture
- Over 240,000 falls in acute hospitals and mental health trusts in England and Wales each year

rb_2013_falls_prevention_guide.pdf (ageuk.org.uk)
National Audit of Inpatient Falls 2020 - data.gov.uk

1.2. Risk factors for falls: falls and resulting injuries in older people are caused by a complex combination of risk factors

The below table of risks has been identified by NICE as the most predictive and should be considered by clinicians assessing individuals at risk of falling:

Falls history
Fear of falling
Mobility, balance or gait impairment
Visual impairment
Cognitive impairment
Urinary incontinence
Home hazards
Polypharmacy

Fall risk escalates as the number of risk factors increases. The 1-year risk of falling doubles for every added risk factor. It starts at 8% with no risk factors and increases by up to 78% with four risk factors.

- Falls history and fear of falling: individuals who have fallen are predisposed to an increased risk of recurrent falls and three times more likely to suffer another fall.
- Up to 70% of recent fallers report fear of falling, of which 50% will limit their daily physical and social activities.
- Mobility, balance and gait impairment: Decline in strength, endurance and muscle power and physical capability increases the risk of falls. Balance and gait impairment affect around 10 % of 60 to 69 year olds and over 60% of those over 80 years
- Visual impairment: increases the risk of falling around 2.5 times

- Dementia, Delirium and Depression: Independently associated with a two to three-fold increase in the risk of falls. 70-80% of those living with dementia fall each year.
- Multiple medications: 4 or more is a significant risk factor for falls.

Other risk factors:

- Age
- Gender: Incidence rates of falls are 2.3 times higher in women. Women are also more likely to suffer osteoporosis-related fractures. However, fall-related mortality disproportionally affects men.
- Vitamin D deficiency is common in older people in residential care and may lead to abnormal gait, muscle weakness, and osteoporosis.
- Dehydration and malnutrition
- Environmental hazards

Falls and Fall Prevention in the Elderly - StatPearls - NCBI Bookshelf (nih.gov)

1.3. Costs of falls:

- Falls and fractures in people aged 65 and over account for over 4 million hospital bed days each year in England alone.
- The healthcare cost associated with fragility fractures is estimated at £4.4 billion a year, including £1.1 billion for social care and £2 billion for hip fractures.
- Unaddressed fall hazards in the home are estimated to cost the NHS in England £435 million.
- Falls in hospitals are the most frequently reported incidents in hospital trusts in England estimated to cost the NHS £15 million annually.
- The impact of Covid-19 and subsequently deconditioning is estimated to result in 250,000+ more falls per year, within an additional £210 million cost to NHS.

Falls: applying All Our Health - GOV.UK (www.gov.uk)

1.4. Osteoporosis and fragility fractures:

Osteoporosis is the most common bone disease characterised by low bone mass and deterioration of bone tissue which can increase bone fragility and susceptibility to fragility fractures. Fragility fracture is a fracture sustained as the result of a force equivalent to a fall.

- Osteoporosis can affect both sexes, but in particular older white women. After the menopause, the prevalence of osteoporosis increases from 2% at 50 years rising to more than 25% at 80 years.
- Secondary causes of osteoporosis include: rheumatoid arthritis, immobility, organ transplantation, type I diabetes, hyperthyroidism, chronic liver disease, pulmonary disease
- Clinical factors that may affect the risk of fragility fracture include: age, sex, low BMI, previous fragility fracture, smoking, alcohol intake of 3 or more units daily
- The WHO diagnostic criteria for osteoporosis is based on the measure of bone mineral density (BMD) at the lumbar spine and proximal femur using DXA.
- The FRAX and QFracture tools are used in the UK to predict the probability of a fracture over a period of time.

Prevalence | Background information | Osteoporosis - prevention of fragility fractures | CKS | NICE

1.5. Fracture of the hip:

Hip fracture is a serious outcome of a fall in people over 65 years. A fall and resulting hip fracture often signal underlying ill health, therefore a comprehensive multidisciplinary approach is needed. The risk is multifactorial including age, body weight, height, poor health, poor depth perception, previous fracture, family history.

- Balance impairment and poor mobility can predict about 40% of all hip fractures compared to osteoporosis which predicts approximately 27%.
- People living in residential and nursing homes are 3 times more likely to suffer hip fractures.
- Approximately 75,000 hip fractures occur per year in the UK, and 95% due to a fall.
- Only 1 in 3 sufferers of a hip fracture return to their former levels of independence, 1 in 3 ends up moving to long-term care
- Following a hip fracture 10% die within 1 month of admission and 30% within 12 months.
- The most deprived areas have higher prevalence of hip fractures and worse outcomes.

897225 (bmj.com)

2. Policy Context

NICE quality standard (QS86), **2015. Falls in older people: prevention of falls and assessment:** This quality standard covers prevention of falls and assessment after a fall in older people (aged 65 and over) who are living in the community or staying in hospital. It describes high-quality care in priority areas for improvement and was updated in 2017.

NICE Clinical guideline (CG161), **2013. Falls in older people: assessing risk and prevention:** Guidance on assessment of fall risk and interventions to prevent falls in people aged 65 and over.

NICE Quality Standard for Hip Fracture (QS16), **2012:** Provides guidance on diagnosing and managing hip fracture in adults (aged 18 and over). It also describes high-quality care in priority areas for improvement. Updated in 2023.

NICE Quality Standard for osteoporosis (QS149), **2017.** Guidance on managing osteoporosis in adults (aged 18 and over), including assessing risk and preventing fragility fractures.

The Kings Fund Improving the Public's Health- A resource for Local authorities, 2013**:** The "Warmer and Safer homes" chapter states that more than one in five homes poses risks to the people living in them, in particular of falls. The report provides a number of recommendations to local authorities on how to reduce the risk of falls amongst older people.

Active Ageing, Active Lives for all: GM Moving, Greater Manchester's movement for movement**:** whole system approach to physical activity. GM Moving is our collective movement for movement. The Greater Manchester Active Ageing programme successfully helped to embed moving into the lives of over 55s. The many GM Moving stories highlight

the ways in which moving helps people to feel better physically and mentally, supports social and economic inclusion.

Ageing Well – Bolton JSNA: This section contains information about the health and wellbeing of older people and how we can make sure Bolton is a place where people can age well. The ambition of this programme is to empower local older people to take the lead in their communities and to build on their strengths. At a Greater Manchester Level, the creation of The Ageing Well Hub demonstrates a real commitment to Ageing Well across Greater Manchester in key areas including age friendly neighbourhoods, transport improvements and policy developments.

3. Best Practices

Most falls are associated with multiple risk factors which can potentially be modified. Evidence shows that multi-factorial assessments and interventions can increase older people's ability to live safely and independently in the community. National guidelines provide key evidence-based interventions that are cost-effective for the NHS and Local Authority in reducing hospital and nursing home admissions and enabling better physical function for individuals.

They are divided in three groups:

3.1 Interventions to improve physical health

3.2 Interventions to prevent falls

3.3 Interventions following a fall to prevent a further occurrence

3.1 Interventions to improve physical health in older people: Being active can play an important part in both positive ageing and reducing frailty, helping to reduce the risk of falls. It can help older people maintain their health, well-being, independence and social participation. Older adults who are not in good health or have mobility issues, as well as other vulnerable adults, may be more at risk of dehydration and so need to be supported to access healthier food and drink.

The Department of Health has outlined physical activity recommendations:

Evidence for physical activity:

- Physical Activity at 65 predicts falls at 90
- Risk of falls and recurrent falls 35-40% lower in those reporting 30+ minutes of moderate intensity physical activity per day compared to those doing less
- Exercise also maintains muscle strength and increases bone mineral density
- Being physically active reduces the risk of later hip fracture by 35-68%

In order to be effective, exercise programmes must:

- Challenge balance and improve strength through resistance training
- Be tailored to the individual
- Be sufficiently progressive
- Be carried out 2–3 times a week
- Be continued over a duration of at least 50 hours
- Be delivered by specially trained instructors

The latest national evidence for primary and secondary prevention of fall programmes, identified Tai Chi, dancing and gardening as activities which reduce the risk of falls. They are appropriate for younger-older adults who have not experienced a fall.

3.2 Interventions to prevent falls in older people: NICE (CG161) guidelines provides evidence and recommendations on how to prevent falls in older people in the community and during hospital stay. Identifying and addressing risk early is effective in preventing incidence of falls and the associated distress, pain, injury, loss of confidence, loss of independence and mortality.

a) Risk identification by:

- Older people should be frequently asked by healthcare professionals about falls and fear of falling as part of their routine care adopting the Making Every Contact Count (MECC) approach.
- It is recommended that the assessment of fracture risk is considered in all women aged 65 and over, all men aged 70, and those younger than this in the presence of risk factors:
  (previous fragility fracture, falls history, multimorbidity, polypharmacy, low BMI, smoking, high alcohol intake)
- Older adults reporting a fall or considered at risk of falling should be observed for balance and gait deficits and abnormalities and referred to appropriate interventions

World Falls Prevention Guidelines recommendations for risk stratification:

- Low risk: education about falls prevention and exercise for general health and/or fall prevention
- Intermediate risk: targeted exercise or physiotherapy referral to improve balance and muscle strength
- High risk: multifactorial falls risk assessment to inform individualised tailored interventions.

b) Multi-factorial risk assessment: for those presenting for medical attention because of a fall, recurrent falls in the past year or demonstrate abnormalities of gait and/or balance. The assessment has to be carried out by an appropriately trained health care professional. The multifactorial assessment should include: falls history, assessment of gait, balance, mobility

and muscle weakness, assessment of osteoporosis risk, fear of falling, visual impairment, cognitive impairment and neurological examination, urinary incontinence, home hazards, and cardiovascular examination and medication review.

c) Multifactorial intervention: Older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention. This involves the delivery of multi-component interventions, combined in different ways based on an assessment of a person's risk factors for falling, such as:

- Strength and balance training
- Environmental modification
- Vision assessment and referral
- Medication review
- Accessible information on falls and falls prevention

3.2.1 High-risk care environments: High-risk care environments include hospitals, mental health units and care and nursing homes. Incidences of falls are much higher for older adults living in care homes or during a hospital stay, with care home residents 3 times more likely to fall than older adults in the community:

- Hospital in-patients experience 1.5% muscle strength decrease per day inactive, up to 1.5kg in muscle mass loss and bone demineralisation
- Approximately 25% with hip fractures are admitted to hospital from care settings.
- 50-75% of residents fall each year and 40% of admissions from care homes due to falls

International and national evidence provides the following recommendations:

- All patients aged 65 years or older and patients aged 50 to 64 years presenting risk factors should be regarded as being at risk of falling in hospital.
- Their care should ensure identification of environmental risk factors, multifactorial assessment and multifactorial intervention.
- Interventions delivered by multidisciplinary teams can reduce patient falls by 20-30%.
- All care home residents should be considered high risk for falls and providing with multifactorial interventions tailored to each individual

3.3 Interventions to prevent recurrent falls in older people: NICE quality standard (QS86), provides guidance for preventing further falls in older people living in the community and during a hospital stay. It specifies the six standards which should be considered:

1. Older people who present for medical attention due to a fall have a multifactorial falls risk assessment

2. Older people in the community with a history of recurrent falls are referred for a strength and balance training programme

3. Older people admitted to hospital after a fall are offered a home hazard assessment and safety interventions

4. Older people who fall during a hospital stay are assessed for fracture and spinal injury

5. Older people who fall during a hospital stay and have signs of fracture or spinal injury are moved using safe manual handling methods

6. Older people who fall during a hospital stay have a medical examination

Risk assessment for fractures are recommended for women aged 65 years and over and all men aged 75 years and over, and younger aged older people with associated risk factors (including postmenopausal women).

British Orthopaedic Association Blue Book on Fragility Fractures summarises best practice in the care and secondary prevention of hip fractures, including the need for bone protection treatment and the offer of multidisciplinary assessment and intervention. The full integration of orthogeriatricians is crucial to ensure best standards of care and early rehabilitation.

The Department of Health guide on “Falls and Fractures” recommended the implementation of Fracture Liaison Services (FLSs) in all units to ensure that identification, investigation, initiation of treatment and monitoring are consistently delivered to all patients with fragility fractures.

4. Falls in Bolton – the local picture

4.1 Older People in Bolton by age and gender groups: From the latest available census data (2021), 29% of Bolton’s population are over 55 years of age, which reflects a 15% increase since the 2011 census. The proportion of older people is slightly higher than across Greater Manchester (28%).

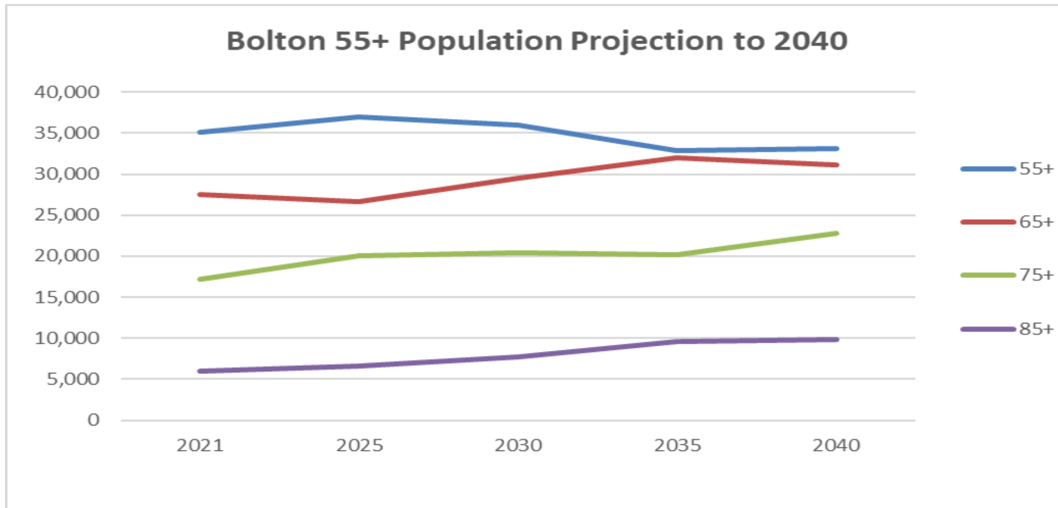
Table 1. Bolton population aged 55 and over in 10 year age groups as a number and percentage of the total population

Locality	Over 55s	Over 65s	Over 75s	Over 85s
Bolton	86,547	51,000	22,939	5,845
Bolton % of total population	29%	17%	8%	2%
Greater Manchester %	28%	16%	7%	2%
England %	31%	19%	9%	2%

https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland/mid2021/ukpopestimatesmid2021on2021geographyfinal.xls

Figure 1 shows the estimated Bolton population aged 55 and over projected to 2040 by age groups. Projections to 2040 show that the number of older people in Bolton will increase to 96,982, and the proportion they represent will increase slightly to 32.6%. Significantly, the 55 to 64 years cohort will decrease, contrasting an increase in older age groups. By 2040, those aged 85 and over will increase by 66% to 9,872 representing 3.3% of Bolton’s population. Those aged 75 and over are also projected to increase by 33% to 22,786 representing 8% of Bolton’s population.

Figure 1. Population aged 55 and over, projected to 2040



https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2

4.2 Bolton population aged 55 and over and physical inactivity: Sport England's Active Lives Tool measures sport and physical activity across England. Historically more older people aged 55 to 74 years in Bolton have been inactive compared to Greater Manchester and England. However, in the past 12 months the inactive aged 55 to 74 has decreased to 29%, which is lower than Greater Manchester (30.5%), but higher than national levels (27%).

Figure 3 shows inactivity among 75 years and over. Inactivity among 75 years and over in Bolton (42%) has decreased to below Greater Manchester (46%) and national levels (46%), following a significant increase during the national lockdown.

Figure 2. Population aged 55 to 74, inactive cohort

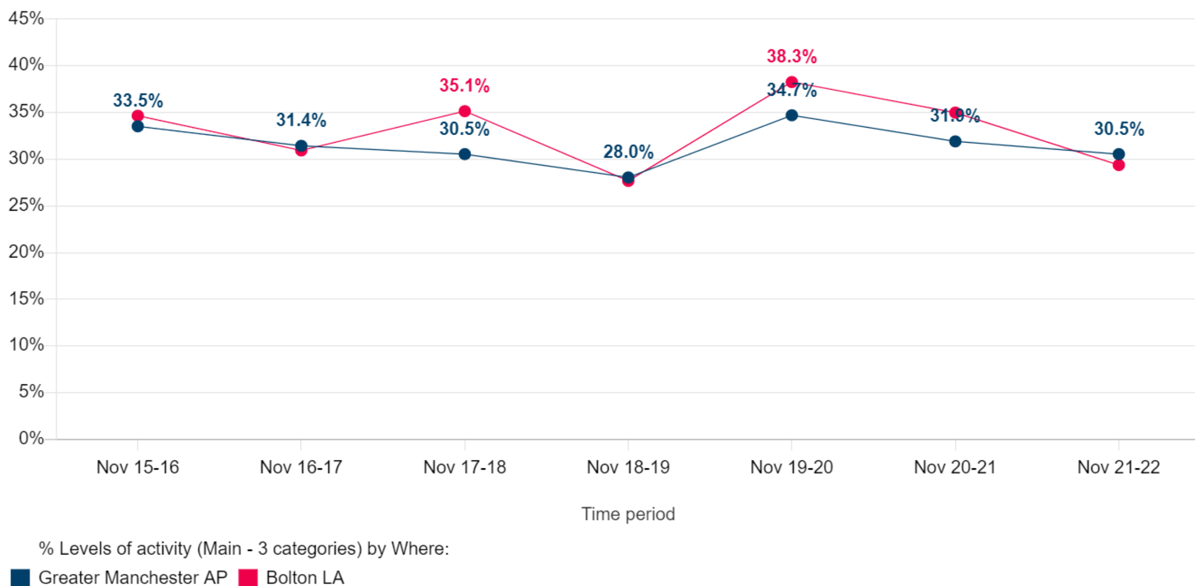


Figure 3. Population aged 75+, inactive cohort

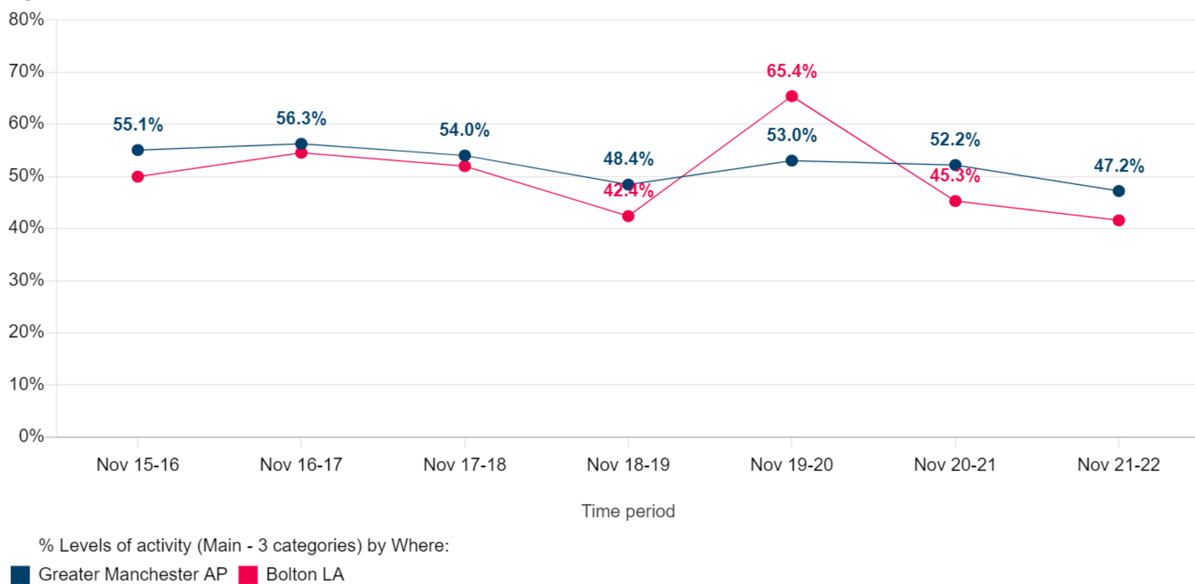
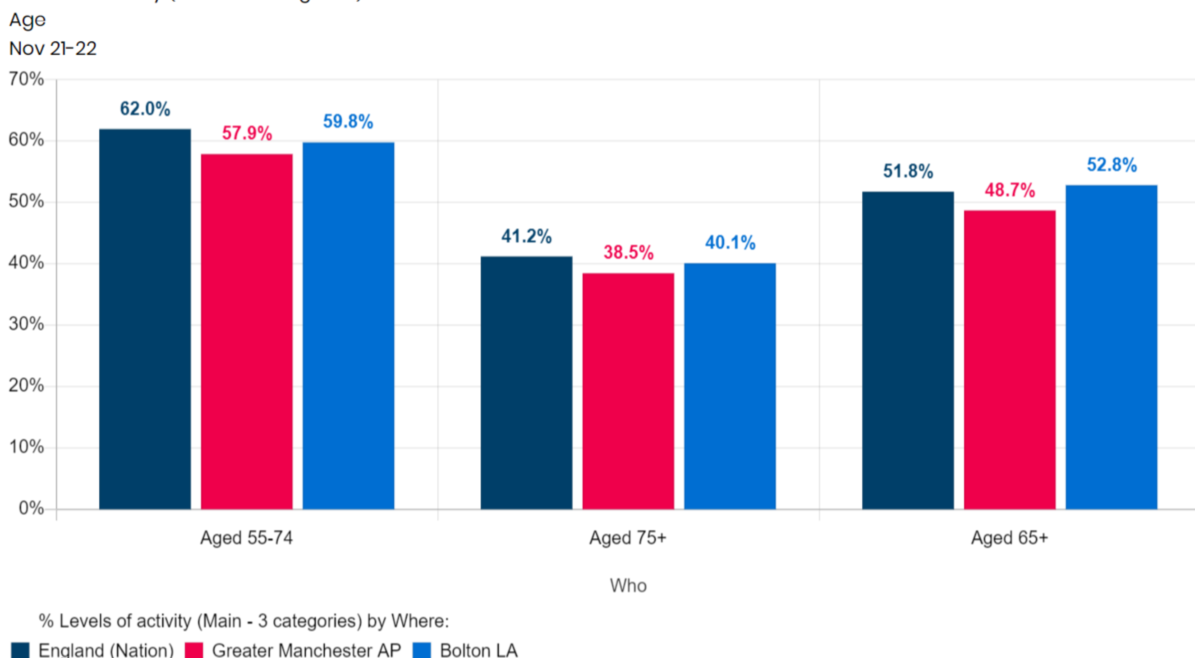


Figure 4. Population aged 55+, active cohort

In the past 12 months 52.8% of adults aged 65 and over have met the CMO's guidelines for physical activity, which is higher than GM and national levels. There's been an increase in those meeting the guidelines in the 55 to 74 years age group to 59.8%, which marks a steady trend of increasing activity over the past 5 years, although still below national levels.



4.3 People in Bolton expected to fall: According to the Health Survey for England (2005) the national incidence of falls varies across age groups and gender. The percentage of people expected to have a fall increases with age, and more women than men are expected

to have a fall, except in the population aged 85 and over, of whom the same percentage (43%) of both men and women are expected to have a fall (Table 2).

Table 2. Percentage of males and females expected to have fallen in the last 12 months in England

Age range	% males	% females
65-69	18	23
70-74	20	27
75-79	19	27
80-84	31	34
85+	43	43

It is estimated that 30% of people aged 65 and over, and 50% of those aged 80 and over fall each year. In Bolton, this equates to 15,300 falls in over 65s and 6,341 falls in over 80s. Based on ONS population growth projections, by 2030 falls in over 65s is estimated to increase by 13% (1,976) and 37% (2,326) in over 80s.

4.4 Hospital admissions due to falls: Falls are the largest cause of emergency hospital admissions for older people and a major precipitant of people moving from their own home to long-term nursing or residential care. In 2022-23, there were 1,161 emergency admissions for injuries due to falls in older people living in Bolton. Sixty per cent (699) of those falls were in females and 461 (40%) were in males. This represents an overall standardised rate of 2,218 per 100,000 population, which was significantly worse than England (2,100).

The Length of stay in hospital per falls admission has been gradually increasing since April 2017 from 8.3 days up to 11.7 days on average in the last 12 months. Improved bed management to reduce delayed discharges and wasted days is likely to have contributed to lower growth seen before Covid and will be key to reducing the average in future.

Figure 5. Non-elective admissions for falls, Bolton CCG to all provider trusts

Figure 6 shows falls admission trends since 2015 by gender. There has been an average 3.5% increase in males falling and becoming admitted while female fall rates remain consistent reducing on average by -0.1% per year (overall 60/40 split f/m). The proportion of frequent fallers (more than one fall in year) pre-Covid was 9.9% on average which increased during Covid to 12.8% but has since reduced to 8% in the past 12.

Figure 6. Falls admissions by gender

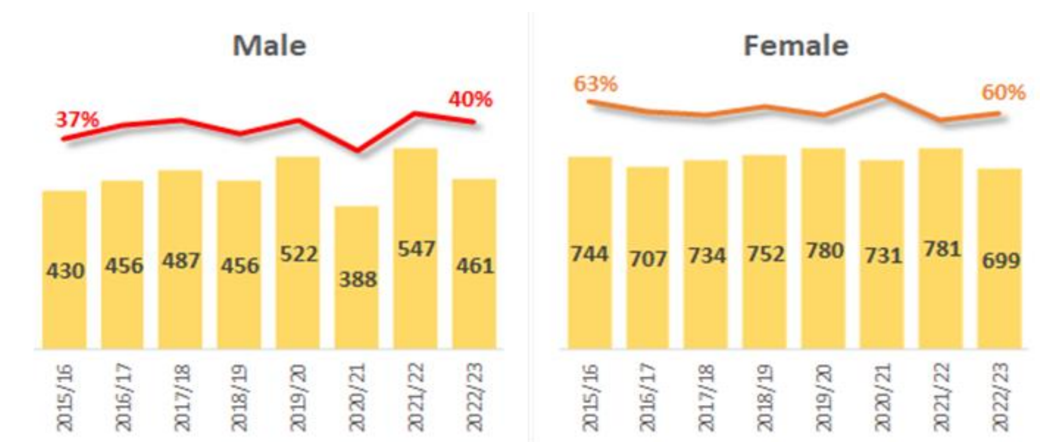
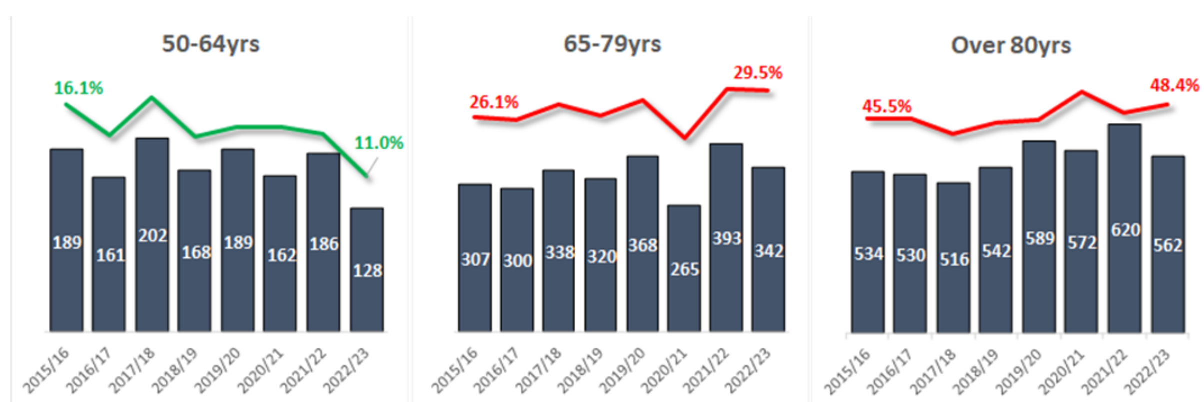


Figure 7 presents falls admissions with a breakdown by age groups. Those aged over 80yrs remains the highest risk for falls admission, the proportion of fallers in this age bracket account for just under half of all falls (48.4%) but only 4.1% of the population.

Falls for older adults 65-79 years have reduced by 9.2% in 2022/23 compared to the previous year and account for 29% of all falls and currently 9.3% higher than pre-Covid levels. The greatest reductions for falls by age group is for those aged 50-64yrs which have reduced from 16% in 2015/16 to 11% last year as a proportion of all falls.

Figure 7. Falls admissions by age

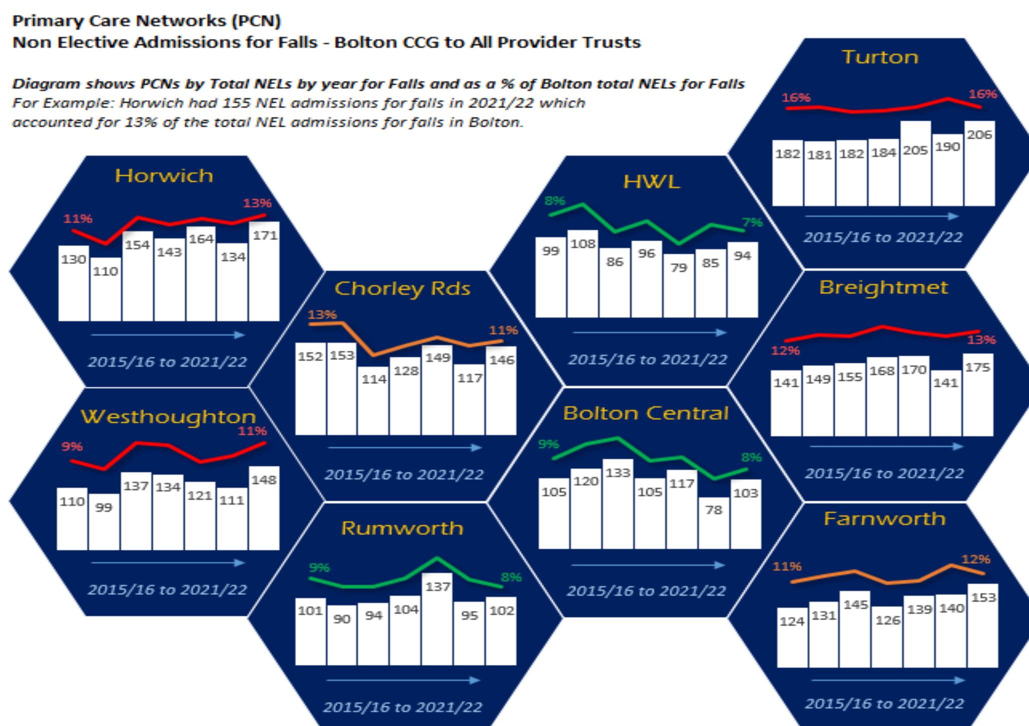


Falls admissions outcomes and injuries: The injuries obtained over the past 8 years mostly relate to head injury and hip/thigh injury (including fractured neck of femur) accounting for a combined 62% of all falls NEL admissions.

Dementia is one of the greater co-morbidities to show year on year increase related to falls NEL admissions with increases from 17% of all falls in 2015/16 to 21% in 2022/23. Diabetes (15%), Atrial Fibrillation (16%) and COPD (10%) remain constant as risk factors for falls and reducing but still significant risks are from Hypertension (35%) and Drugs/Alcohol.

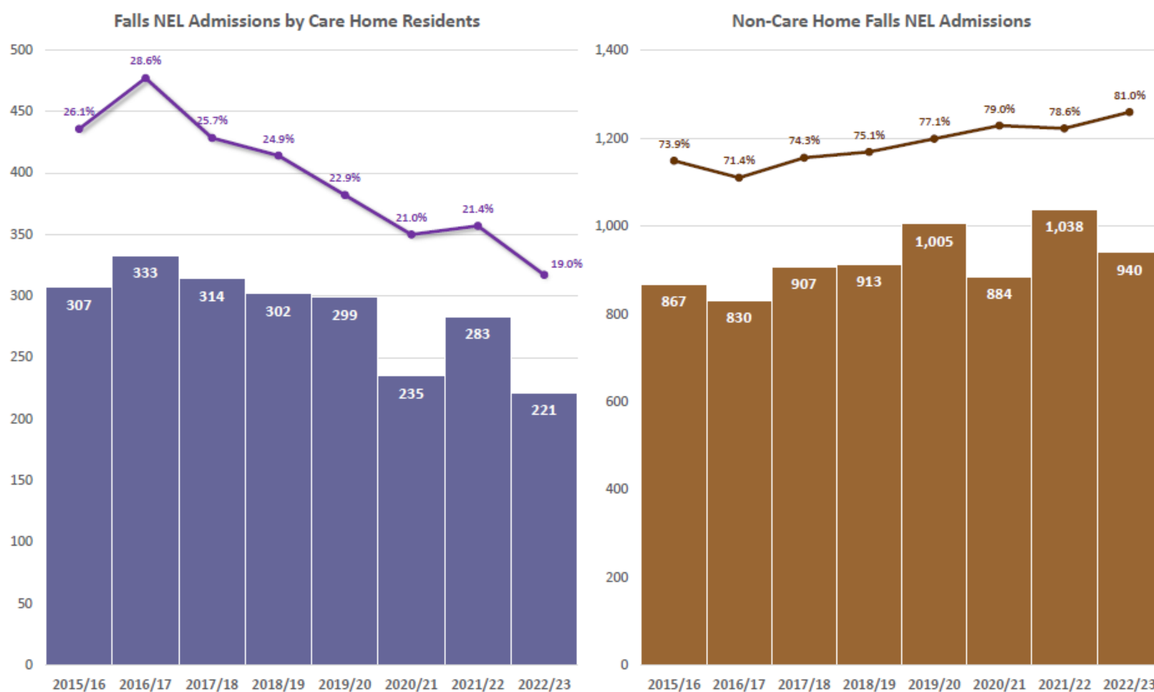
Falls by location: Figure 9 shows the geographical spread of falls occurrences across Bolton. Turton PCN has the highest proportion of NEL admissions for falls accounting for 16% of activity however also has the highest population of older residents in Bolton (19% of over 80's). The 3 next PCNs with the highest increasing proportion of NEL admissions for falls are; Westhoughton, Farnworth/Kearsley and Horwich (37% of all falls in 22/23 from 31% baseline in 15/16). Chorley Roads, HWL Network and Bolton Central are the 3 PCNs with the greatest reduction in NEL admissions for falls (26% in 2021/22 from a baseline of 30% in 2015/16)

Figure 9. Falls admissions by location



Falls admissions from Bolton's care homes: Figure 10 shows NEL falls admissions from care homes across Bolton. Falls admissions from Bolton care homes have shown great reductions since 2016/17 from 28.6% of all admissions for down to 19.0% in 2022/23 (25.8% below pre-Covid baselines).

Figure 10. Care home and non-care home falls NEL admissions



5. Current Services Provision in Bolton

This section presents the current range of Falls Services provision in Bolton, shown by different types of provider – primary health care, community health care, NHS acute Trust, local authority and commissioned voluntary organisations.

The following services are responsible for providing the 3 levels of falls prevention:

- Primary prevention – focusing on the general population and those at high risk of falls and providing initiatives to prevent falls occurring.
- Secondary prevention – focusing on the population who have suffered a fall and providing initiatives to prevent further falls or complications.
- Tertiary prevention – focusing on the population who had suffered a fall and are experiencing complications and on initiatives to maintain optimum health.

5.1 Bolton Falls Collaborative: The Bolton Falls Collaborative recommenced in April 2022, following a hiatus during the Covid-19 pandemic and subsequent national lockdown. It brings together partners from the voluntary sector, NHS, Local Authority and other public sector organisations, to deliver a whole system pathway for falls in Bolton. The collaborative promotes a strong focus on improving outcomes and maximising the opportunities for prevention and encouraging healthy ageing.

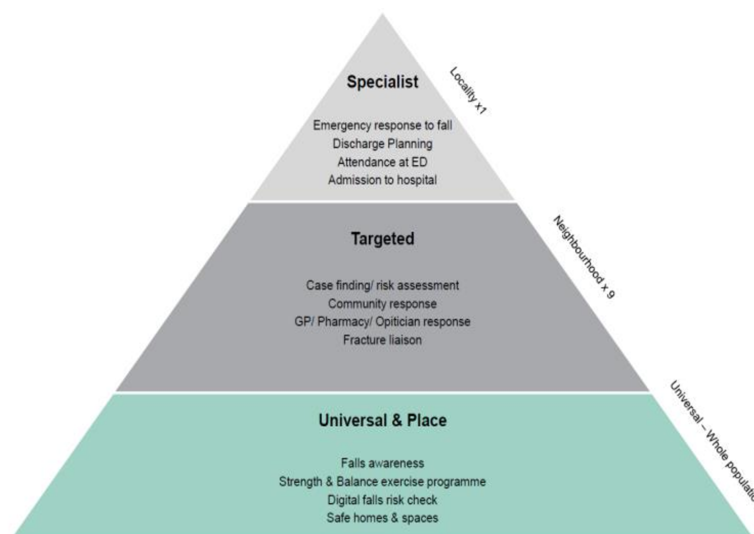
The collaborative aims to progress a number of locally agreed key outcomes:

- Whole system approach to prevention addressing lifestyle, diet, activity levels, well-being and social isolation
- Proactive prevention

- Population level behaviour change
- Improved identification and access for vulnerable and socially isolated people
- Safe environments and homes
- Holistic assessment and coordination of services
- Right support, at right time in the right place

To achieve these aims, Bolton Falls Collaborative employs a falls tiered model approach as outlined in figure 11. This approach provides a clear plan for delivering services and reaching residents according to their needs. Due to the complex and multifactorial nature of falls, it is expected that some individuals will move between the different tiers, and thus will be provided with a universal offer integrated at each step of the person's experience with services.

Figure 11. Bolton Falls Collaborative tiered falls model



5.2 Age UK Bolton's Strength and Balance Service: Age UK Bolton's Strength & Balance Exercise programme has been delivered as part of the multi-agency community Falls Prevention programme funded by Bolton Locality Transformation Fund from 2017.

The programme is entirely consistent with the Greater Manchester Quality Standard recommendations and based on the 7 evidence-based activity components of the Falls Management Exercise (FaME) programme:

- Dynamic endurance training
- Dynamic balance training
- Resistance/strength training
- Skills to rise from the floor
- Floor coping strategies and targeted strength
- Flexibility
- Adapted Tai Chi

The Age UK Bolton strength and balance coach/instructors are trained and certificated in Postural Stability Instruction (PSI), Otago, Tai Chi, GP referral, Dementia Awareness, "1st Steps in Dementia" and First Aid.

The strength & balance team delivers 32 classes across Bolton in a wide range of community venues. There are also additional sessions including low impact circuit and supervised gym classes at Bolton Arena, a specialist pulmonary rehab session to patients and carers within Bolton Hospice Wellbeing Hub, and a newly formed PSI backward chaining class at Nuffield Health.

In addition, the team deliver strength and balance sessions to a sample of residents at selected care homes across Bolton as part of a Falls Prevention in Care Homes, following the successful completion of a 15 months pilot project commissioned by Bolton Foundation Trust.

5.3 Hospital Services:

There are three separate pathways for falls within Royal Bolton Hospital's services:

1. Admission due to a fall
2. Treating those who have fallen on a ward
3. Those admitted who are at high-risk of falling

Those admitted due to a fall are assessed by relevant teams including the Hip Fracture Nurse, who manage and deliver appropriate treatment for patients, conducting holistic assessments to determine patient risk level and create effective patient management plans. They also support hospital discharges as part of a multidisciplinary team to help prevent repeated falls and hospital admissions.

Falls prevention measures on the wards include the effective use of fall mats and low-rise beds to minimise risk for patients. Post-fall huddles are conducted within 30 minutes of falls occurring and regular handover huddles take place during shift changes to maintain effective management and risk mitigation.

The Enhanced Care team: manage and deliver care to repeat fallers and those with high-level needs of care. The team deliver person-centred care to improve patient outcomes. Their vital services have supported a 10% reduction of in-patient falls since April 2023.

Think Yellow Scheme: set up as a trial in the Emergency Department as a tool to reduce falls amongst vulnerable patients in hospital. The bright yellow colour socks and blankets, recognised internationally as a fall risk factor, aims to make it easier for staff to identify the most at-risk patients and offer support and assistance if they are trying to stand or move. More than 700 yellow items have been supplied to staff in the Emergency Department ready to hand out to those who need them. The scheme is being relaunched in June 2023 following the considerable successes in falls prevention.

5.4 Primary Care:

5.4.1 GPs: are in contact with patients who are potentially at increased risk of falling or who have had a fall that did not require emergency intervention, and are expected to routinely monitor and modify risk factors for falls in patients aged 65 and over. Implementation of the Integrated Care NIS100 however, is expected to improve identification and management of people at risk of unplanned hospital admission, including from falls and injuries derived from them. Patients in the Integrated Care Programme are assessed by GPs for a number of conditions which can lead to a fall and should be referred to appropriate services. These include:

- Number of falls in the last year and if there has been any referral for falls assessment
- Mobility: walking pace and use of wheelchair, referral to Physiotherapist/ community health services, musculoskeletal services and/or occupational therapy.
- Referral to podiatry
- Ability to manage bathing, dressing, toileting, incontinence, feeding.
- Checking sight and hearing and referral if needed
- Review of medication at least once a year (eg: benzodiazepines, antihypertensives, etc.)
- Blood pressure (to exclude postural hypotension), pulse rate, weight and HbA1c.
- Presence of urinary/faecal incontinence
- Alcohol consumption
- Dementia assessment and family history of dementia
- Referral to geriatrician if appropriate

GPs are encouraged to refer older patients to community-based service when appropriate in particular, to attend falls prevention exercise classes like Tai-Chi. Anecdotal evidence suggests that referral to this service is low though improving.

GPs refer older patients at risk of falling to the local Community Health Teams for assessment of balance and gait deficits and multifactorial risk assessment and multifactorial intervention if appropriate.

5.4.2 Medicines Use Reviews (MURs) undertaken by pharmacists: they are also important tools in identifying older people who may be at increased risk of falling due to the type or number of medications they are taking.

5.5 Admission Avoidance and Community Health Services:

Our Admission Avoidance and Community Therapy Hub service provides assessments and support for patients over 18 in a crisis, to prevent unnecessary hospital admissions. Both services accept referrals from any service including self-referrals.

Admission Avoidance teams have both a community and acute pathway for falls including an urgent 2-hour assessment for those assessed as needing treatment for severe injuries, and a 72-hour response for those who are non-urgent cases. Their holistic assessment includes a falls assessment and facilitates subsequent referral to relevant teams.

The Community Therapy Service run a ‘traffic light’ triage and prioritisation model. Patients are triaged at the point of referral depending on their urgency, red, amber and green with a 24-48 hour, 1 week or 4 week target response time respectively. Every patient will get a Holistic team assessment which does cover falls. If Falls are a concern then falls prevention from OT, Physio will be undertaken and evidence-based Otago and falls prevention measures will be completed.

5.6 Adult Social Care & Reablement teams:

Bolton Council provides adult social care services for the residents of Bolton. there were an estimated 8,500 posts in adult social care, split between local authorities (8%), independent sector providers (82%) and posts working for direct payment recipients (11%). As at March 2022, Bolton contained 123 CQC-regulated services; of these, 63 were residential and 60 were non-residential services.

Hospital Social Work Team: the team liaises with the Community Care Services Hospital Admission Avoidance Team in assessing patients who have attended the Royal Bolton Hospital, to avoid unnecessary admissions. They also assess patients before discharge to identify any social care needs.

Reablement service: this provides short term support following a change in circumstances such as a fall, a stay in hospital or a stroke. Support is provided usually for six weeks but there is flexibility to extend for people whose independence is likely to increase further with a slightly longer service. The support involves working intensively with the individual to reduce any potential long term loss of independence following a fall and avoid any subsequent need for longer term services.

Bolton Cares: Bolton Cares was established in 2016 and offer the residents of Bolton the following services: Outreach; Supported Living; Extra Care schemes; Short Breaks; Shared Lives; Mental health support; Life Opportunities for older people and people with autism and learning disabilities.

5.7 Independent Living Services:

The Independent Living Service support those with physical disability, are deaf or hard of hearing, have a visual loss, are struggling to manage every day activities, or have caring responsibilities. The service aims to minimise risks of accidents including falls and avoidable hospital admissions by making suitable modifications and adaptations to people homes to maintain individuals’ independence and safety.

The service has a broad scope of support providing a range of equipment, telecare, and home support reablement. The service accepts referrals from any service including self-referrals, which are then assessed regarding to level or urgency. 12 month reviews are conducted for long-term clients with more serious needs, will referrals to suitable follow-on services.

Homecare: provide short term intensive support if you have a physical or mental illness, injury or disability, or being discharged from hospital with personal care, mobility, household activities and day to day tasks to avoid the need to go into residential care.

Telecare: provide equipment for the home that promotes a person's independence and safety and helps to give them a better quality of life. It helps minimise the need for formal care and prolong the length of time a person can live independently in their own home.

Types of home equipment include: bed sensor, fall detector, chair sensor, pressure mat sensor, epilepsy sensor, property exit sensor, medication dispenser, Buddi GPS locator, GPS SOS button.

5.8 Housing:

Oversee provision of Bolton Care and Repair across all tenures which aims to tackle fuel poverty, improve housing conditions, and deliver major adaptions to support individuals. The professional, technical and administrative services provided by the Housing Team covers all disabled private sector residents and therefore a great number of the adaptations they provide contribute to the falls prevention agenda.

Bolton Care and Repair: Bolton Care and Repair can help from providing general advice, right through to supporting and assisting you through the grant process to adapt or improve your home. aim is to help people maintain their independence and remain living in the comfort of their own home. Our primary focus is to help prevent, reduce and delay care and support needs by delivering a 'one stop shop' for home improvement and adaptations depending on individual needs and circumstances.

Bolton at Home: a charitable community benefit society providing social housing and manage/maintain over 18,000 properties in Bolton. They also run the careline service which currently help 7,000+ customers to live independently, whether they're an owner occupier or tenant. We offer a 24 hour, 365 day a year community alarm service.

6. Gaps

Fracture Liaison Service: The Department of Health guide on "Falls and Fractures" recommended the implementation of Fracture Liaison Services (FLSs) in all units to ensure that identification, investigation, initiation of treatment and monitoring are consistently delivered to all patients with fragility fractures.

The FLS model is usually delivered by a nurse specialist supported by a lead clinician in osteoporosis. Patients identified by the nurse with new fragility fracture who are either admitted to the orthopaedic inpatient ward or who are managed as outpatients through the fracture clinic.

Estimates show that in England, national FLS coverage should prevent 31,000 fractures including 13,000 hip fractures over 5 years in people aged over 50 years, giving a 5-year saving of at least £156.2 million in NHS acute care costs.

Fracture Clinic/Service in the Community: GP and community nurse collaborations to carry out a multi-factorial falls assessment including blood tests and accurate medication review as per ICP Integrated Falls Pathway. Option to have ACP lead the clinic instead of a Consultant, provide falls education as part of this – how to fall 'correctly/more safely' and

how to get up after a fall, advice and guidance – from GP to Consultant on ERS to avoid potentially unnecessary referrals to secondary services.

7. Recommendations

1. To build on the work done by the falls collaborative in bringing together partners with a role to play across the whole falls pathway from prevention to treatment.

2. Universal promotion of older people in physical activity programmes and in falls prevention programmes (in particular Tai-chi, gardening and dancing). The benefits of greater physical activity include reduction of the number of admissions for first falls and fractures. Requires general population approach to prevent those in younger older age groups becoming at risk of falling.

3. Routine questioning by GPs, healthcare professionals and all individuals in contact with older adults. Adopting a Make Every Contact Count approach to support identification, assessment and intervention. National studies show that asking “do you have impaired balance? Can predict about 40% of all hip fractures.

4. Older people who presents for medical attention (in a variety of settings and to different health professionals) because of a fall, or recurrent falls in the past year or with gait and/or balance abnormalities should be offered a multifactorial falls risk assessment.

5. The development of a Facture Liaison Service. This has been shown to be effective in providing cost effective osteoporosis care for patients presenting to hospital with fragility fractures.

6. Conduct regular medication reviews for in-patients and individuals in contact with primary care and community health services. Medication review can play an important part in preventing fall-related injuries, fractures and manage contraindications.

7. Proactive case finding through data held within the GM Care Record based on an agreed algorithm to enable earlier identification and subsequent appropriate intervention at an earlier stage to prevent future first time fallers.

8. Education & Information: All health professionals dealing with patients at risk of falling or who have had a fall, should educate older people regarding the preventable nature of some falls, where to seek further advice and assistance, how to cope if they have a fall, nutrition and hydration.

9. Expanding use and scope of telehealth as a way of providing health care monitoring at a distance rather than face to face. Offering a virtual ward environment at home, using telehealth technology as an alternative to hospital admission or facilitating hospital discharge.