Waltham Forest

NHS
Waltham Forest
Clinical Commissioning Group

Waltham Forest Falls Prevention and Bone Health Strategy (refresh) 2013 - 2018

Joint Strategy

Document revision history

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Contents

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1. Introduction - Why do we need a falls and bone health strategy?

The Falls Prevention and Bone Health Strategy aims to promote mobility and independence in people over 65 by reducing the number and the impact of falls.
Falls in older people represent a significant national public health challenge and, as the population ages, the incidence of falls is increasing at about 2% per annum. Although falls are not an inevitable result of aging the tendency to fall increases with age, and older people are more susceptible to injury and complications. Often a fall can be the precipitating event to long term residential care for an elderly person.

Most falls do not result in serious injury but there is often a psychological impact. Evidence suggests that approximately 25% of people aged 75 or over unnecessarily restrict their activities because of fear of falling. Falling and fear of falling have a considerable impact on physical, psychological and social functioning and on perceived quality of life.

The human cost and financial burden of falls is substantial and will increase as the population ages. Therefore prevention of falls in older people is a national priority in the UK.

The evidence suggests that:

- The number of falls can be reduced by up to 30% through development of a multi-agency falls pathway focussing on early identification and prevention, and multi-factorial assessment and intervention for people at high risk of falling.[1]
- The severity of the impact of falls can be reduced by promoting bone health, and through early identification and treatment of osteoporosis.[2]

All agencies providing care and support to older people have a part to play in the prevention and management of falls, and the National Service Framework for older people, standard 6, therefore requires that 'the NHS work in partnership with councils to prevent falls and reduce the resultant fractures or injuries in their population of older people'.

This strategy was jointly developed with our local partner agencies in the health, social care and voluntary sectors.

[1] NICE: Falls: assessment and prevention in older people 2013
[2] Fragility Fracture Toolkit, Novartis 2010

2. National Context

Falls in older people are a common occurrence with 30% of people over 65 experiencing a fall each year, rising to 45% for people over 85 living in the community. Between 10% and 25% of these falls will result in a serious injury, and are the main cause of accidental death in the elderly population; 20% of people who sustain a hip fracture die the following year, 50% are not able to continue to live independently and 80% do not retain their pre-fracture level of function and independence.
Falls have considerable impact on health service demand for acute and long term provision. Fracture management alone is estimated to cost £1.7 billion per annum in the UK and hip fractures account for approximately 20% of orthopaedic bed occupancies.

Most people who fall are living at home and fall in the home or the street, but there are a number of falls in residential care home and on hospital wards. In care homes falls account for around 90% of reportable injuries to residents, and many of these falls are preventable.

The relationship between falls, bone health and fractures is acknowledged within the National Service Framework (NSF) and NICE guidance. There are over 70,000 hip fractures per year in patients with osteoporosis in the UK. The admission rate for hip fractures has increased in England by 2.1% per year since 1999, whilst hospital bed days have increased by 5.9% per year.

Fragility fractures are bone fractures caused by a force that would not normally result in a break in a healthy bone, such as falling from a standing height or less. The occurrence of a fragility fracture is often the first sign that an individual has osteoporosis and is at a higher risk of sustaining a future fracture. One in three women and one in twelve men over 50 has osteoporosis, and almost half of all women will have experienced an osteoporotic fracture by the time they reach the age of 70. Each year in the UK over 300,000 people are seen in hospital because of fragility fractures, with the most common sites for these fractures being the spinal vertebrae, hip and wrist. It is a fact that half of all hip fracture patients have suffered previous fragility fractures. The ageing of the UK population will give rise to a doubling of the number of osteoporotic fractures over the next 50 years if changes are not made in present practice.

Annually ambulance services respond to around 700,000 calls and of these 10% are for people who have fallen. It is estimated that approximately 25% of these calls will lead to an unnecessary hospital admission. This increases the pressure on ambulance and A&E services and also causes unnecessary stress and disruption for the older person themselves.

3. Waltham Forest Context

3.1 Falls

Waltham Forest has a younger population profile than England as a whole, and in comparison to a number of other London Boroughs. However, the older population is growing. Office of National Statistics (ONS) data for 2013 show a Waltham Forest population of 265,800, with 27,500 people over 65 and the number is predicted to rise to 33,700 over the next 10 years.
On the basis of the national prevalence of falls this would translate to more than 8,250 falls each year in people over 65 in Waltham Forest, resulting in 1,237 (15%) serious injuries per annum.

Most people who attend hospital for a fall in Waltham Forest are seen in Whipps Cross Hospital. However, the number and cost of hospital admissions for a fall, and the number of repeat falls, is difficult to estimate with any degree of accuracy because of the way that falls are recorded. A Commissioning for Quality and Innovation payment (CQIN) was introduced in 2014/15 with one objective being to improve recording of falls for hospital admissions in Whipps Cross Hospital. A small scale CQIN audit in the Emergency Department found that 29% of patients who presented to the Emergency Department with a fall did not have 'fall' recorded in their discharge summary. 11% of people attending for a fall over a two month period had presented to the Emergency Department (ED) at least once before during the two month audit period and one person re-presented on the same day. Of the repeat attenders, 2 patients attended 3 times with a fall during the audit period. This suggests that the data in figure 1 below are an underestimate of the actual number and cost of falls.

However, the current data do provide an indication of the cost in human and financial terms. If we look at the number of hospital admissions with a primary diagnosis of a fall in 2014/15 (full year data extrapolated from 6 months data) this shows that 1,432 people presented with a primary diagnosis of a fall at a cost of £4.37 million. If we also include secondary diagnosis this increases to 2,828 at a cost of £7.7 million. Of these falls 98% were emergency admissions and 90% were admitted to Whipps Cross Hospital.

Figure 1: Hospital admissions and costs due to a fall in Waltham Forest (65 and over)

	2012/13		2013/14		2014/15	
Fall as a primary diagnosis	2,098	£5,348,748	1,786	£4,501,684	1,432	£4,370,000
Fall as a secondary diagnosis	1,813	£4,097,497	1,579	£4,134,270	1,396	£3,307,916
Total	**3,911**	**£9,446,245**	**3,365**	**£8,635,954**	**2,828**	**£7,677,916**

NB: 2014/15 full year projection based on 6 month's data

Hospital admissions for a fall have been decreasing over the past three years, with a 14% decrease in people with a primary or secondary diagnosis of a fall from 2012/13 to 2013/4 and a projected further fall of 16% in 2014/15. This could be due to a number of factors including weather patterns and coding/recording issues, but also coincides with the development of the Rapid Response and the Care Co-ordination Services which aim to prevent unnecessary admissions, and could be an indicator of their success.

3.2 Osteoporosis and fragility fracture

Osteoporosis is the condition where bone tissue deteriorates and bone density is lower than normal. Fragility fractures are often linked to osteoporosis.

Osteoporotic fragility fractures can cause substantial pain and severe disability, often leading to a reduced quality of life, and hip and vertebral fractures are associated with decreased life expectancy. The NICE costing template uses national data for osteoporosis to give local population estimates for osteoporosis and fragility fractures. This template estimates that there are 30,314 post-menopausal

women in Waltham Forest of whom 3,434 (11.3%) women have osteoporosis without a prior fracture, and 3,232 (10.7%) women have osteoporosis with clinically apparent osteoporotic fragility fractures.

Osteoporosis and consequent fracture are not limited to postmenopausal women. There is increasing attention being paid to osteoporosis in older men. Men suffer osteoporotic fractures about 10 years later in life than women, but life expectancy is increasing faster in men than women. Thus, men are living long enough to sustain fractures, and when they do the consequences are greater than in women, with men having about twice the 1-year fatality rate after hip fracture, compared to women. The majority of men will have an underlying reason for developing osteoporosis and some common medications cause osteoporosis in men such as corticosteroid therapy for arthritis or asthma, and androgen deprivation therapy for prostate cancer. Around 1 in 12 men over 65 are estimated to have osteoporosis which gives a local expected prevalence of around 1,000 in Waltham Forest.

We do not have data for the overall number of fragility fractures but in-patient admissions for hip fractures alone accounted for an annual spend of over £1 million in Waltham Forest in 2013/14.

Figure 2: Fractured Hip/NOF analysis of activity and spend Waltham Forest

	2011/12		2012/13		2013/14	
Fractured Hip/NOF	**133**	**£722,081**	**136**	**£750,994**	**140**	**£1,069,676**

Most people with osteoporosis will be identified, diagnosed and treated in primary care. Currently we have no reliable Waltham Forest data as to the number of people diagnosed with osteoporosis and receiving bone sparing treatment. The osteoporosis Quality Outcome Framework data (QOF) for 2012/13 show only 154 people on the osteoporosis register with 126 people receiving treatment, against an expected prevalence rate in the thousands. Waltham Forest is performing poorly against comparable boroughs in achieving this QOF outcome.

The current spend on GP prescribed treatments, including vitamin supplements and prescribed drugs is circa £120,000 per annum.

3.3 Mortality rates

Hip fracture nearly always requires hospitalisation, is fatal in 20% of cases and permanently disables 50% of those affected; only 30% of patients fully recover. Projections suggest that, in the UK, hip fracture incidence will rise from 70,000 per year in 2006 to 91,500 in 2015 and 101,000 in 2020[3].

In 2009-2011 Waltham Forest had the highest falls mortality rate for the outer north east London boroughs, with higher mortality from fracture of femur for 65-84 years age group than its comparators. The mortality from fracture of femur for over 85 years age was also higher although the differences were not significant.

[3] NICE: Assessing the risk of fragility fracture

3.4 Social Care Costs

Although we know that a fall is frequently the precipitating factor in increases in packages of care and admissions to care homes, it is difficult to accurately estimate the cost of falls to adult social care.

Total expenditure in residential care was £13,732,349 in 2011/12. The cost of residential care reduced over the three years prior to this from £16.77million. This was due to the Waltham Forest Joint Prevention and Early Intervention Strategy (2010 -2015) and the implementation of the Personalisation agenda which meant that more people were able to have choice and control over the care they received and opted to receive care at home.

Those living in the community and potentially at risk of a fall have additional needs. From January to October 2012 there were 145 referrals to the re-ablement service as a result of a fall, and 900 people using tele-care services with basic pendant alarm and or tele-care sensors installed, the majority of whom will be older people.

The high number of falls and the response to falls in care homes is frequently cited by care home providers and by health and social care staff as an issue which needs to be addressed. Falls in care homes frequently result in call outs for the ambulance service and inappropriate conveyances to hospital. Although there has been discussion with care homes in Waltham Forest about developing a local register of falls in care homes which is collated by the local authority, implementation has been sporadic.

Irrespective of these potentially measurable costs to health and social care services, the human cost of injury, pain, distress, loss of self-confidence and mobility and the consequences to health and independence are substantial.

4. Evidence and guidance on falls reduction

The evidence indicates that between 15% and 30% of falls can be prevented, and the impact of a fall can be reduced, through effective, integrated services aimed at prevention, early identification, and multi-factorial assessment and interventions. The relationship between the impact of a fall and osteoporosis is well established and the guidance indicates that early identification and treatment of osteoporosis is an important component of a falls pathway and can reduce the risk of bone fracture by up to 50%.

There is a considerable body of evidence nationally which demonstrates that it is possible to reduce the number of falls (by up to 30%) and the severity of the impact of falls by adhering to the guidance. Key documents are:

- The Care of Patients with Fragility Fracture ("Blue Book") British Orthopaedic Association (2007) sets out the standards for the treatment and management of osteoporosis, which is under diagnosed and poorly treated across the UK, and also sets standards for the management of people in acute care with fragility fractures.
- The National Service Framework for Older People 2010
- NICE guidelines, Falls: Assessment and Treatment of falls in older people (updated 2013)

Falls should be considered to be a symptom rather than a diagnosis, so that when a patient presents with a fall, efforts should be made to find the cause or causes. Woolf and Akesson divided the main risk areas into eight categories:

- Age-related deterioration
- Visual Impairment
- Problems with balance, gait and mobility
- Cognitive Impairment
- Blackouts
- Incontinence
- Drug therapy
- Hazards – personal and environmental[4]

NICE identifies the key features of a successful falls service:

- Case/risk identification
- Multifactorial falls risk assessment
- Multifactorial, individualised interventions
- Encouraging the participation of older people in falls prevention programmes including
- Education and information giving, and strength and balance training
- Professional education

The Department of Health (DOH) estimates that adherence to the guidance will result in 15-30% reduction in falls, admissions for fragility fractures and neck of femur fractures (NOF). The Glasgow Falls Service model which is recognised to be an example of best, evidence- based practice reported a 32% reduction in admissions, and a 3.6% reduction in NOFs. No data were recorded for fragility fractures. This was achieved through the implementation of their falls pathway which includes a falls prevention service in the community and a fracture liaison service.

Savings Source	DOH, 2003	Glasgow
Fractured NOF admissions	15-30%	3.6%
Fragility fracture admissions	15-30%	Unreported
Falls admissions	15-30%	32%

In 2009 the Department of Health developed the Prevention Package for Older People which identified objectives to improve NHS care for older people including fractures:

- Improve patient outcomes and improve efficiency of care after hip fractures through compliance with core standards
- Respond to the first fracture and prevent the second – through Fracture Liaison Services in acute and primary care settings
- Early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries

[4] Preventing fractures in the elderly, Woolf and Akesson, BMJ 2003

5. Policy and Guidance

5.1 National

This strategy is based on a number of key documents which set out the considerable body of evidence and guidance, some of the key points are summarised above.

- NICE Clinical Guidance 161 Falls: assessment and prevention of falls in older people (2013)
- National Service Framework for Older People - Standard 6: Falls
- National Service Framework for Older People - Standard 8: The promotion of health and active life in older age
- The Department of Health (DH) Prevention Package (2009) Falls and Fractures.
- Department of Health (2010): A vision for Adult Social Care: Capable Communities and Active Citizens
- British Orthopeadic Association and British Geriatrics Society, 2009, the Care of Patients with Fragility Fractures (Blue Book).
- SIGN (2003) Management of osteoporosis. SIGN clinical guideline 71.
- AGS/BGS Clinical Practice Guideline: Prevention of Falls in Older Persons (2010)
- Department of Health (2009): Fracture prevention services: An economic evaluation.
- NICE (2008): Technology Appraisal Guidance 160: Primary prevention of osteoporotic fragility fractures in postmenopausal women.
- NICE Technology Appraisal Guidance 161 Review of treatments for the on secondary prevention of osteoporotic fragility fractures in postmenopausal women (2008).
- NICE Clinical Guidance 146 (2012) Osteoporosis: assessing the risk of fragility fracture.
- Royal College of Physicians' Falls and Bone Health Audit 2010.

5.2 Local Policy Context

A number of local strategies and needs assessments documents have contributed to this strategy including the following:

- The Joint Strategic Needs Assessment (JSNA 2013/14)
- The Falls Prevention and Bone Health Needs Assessment (November 2011)
- Waltham Forest Joint Prevention and Early Intervention Strategy (2010 -2015)
- Safeguarding of Vulnerable Adults - Safeguarding Adults is a high priority for Waltham Forest - specific outcomes in adult protection work contained in the National Framework for Safeguarding Adults Policy.
- Waltham Forest Health and Wellbeing Strategy: Creating the Place for a good life (2013)
- Waltham Forest Carers Strategy 2010 - 2015
- Waltham Forest Commissioning Strategy Plan 2012/13 – 2014/15
- National Audit of Falls and Bone Health Services for older people in 2010 by the Royal College of Physicians.

One of the Waltham Forest CCG strategic objectives is to improve the health outcomes of the local population and the relevant NHS local commissioning strategy plan 2012/13 – 2014/15 priorities are:

- Commission safe, sustainable, high quality services for the local population
- Integrate care and develop community services
- Stay healthy

6. Where are we now?

The London Borough of Waltham Forest and Waltham Forest CCG and its partners, including Bart's Health Trust and North East London Foundation Trust, provide a range of services which offer assessment, treatment and management of falls and osteoporosis (see Appendix 1).

Findings from the needs assessments, listed above, and a review of Waltham Forest services against the NICE guidance in 2012 (see Appendix 2) found the local falls pathway to be fragmented. Whilst each service had its own care pathways, they were not linked together and there were significant gaps.

A survey of users of the existing falls and fracture services in October 2012, and an Integrated Falls Care Pathway Workshop in March 2012 supported these findings. Those people who had received a service were happy with it, but they also reported poor communication between different healthcare professionals and lack of falls prevention services and exercise programmes. The majority of people wanted more help with continuing to exercise, for example, options for home visits, follow up from courses, more local classes and help with transport.

This strategy addresses the recommendations and guidance through the development of a re-designed falls pathway that will offer a whole systems approach and will address the gaps in the current pathway.

7. Strategic Aims and Objectives

The strategy aims to:

- Prevent avoidable falls and reduce the number of hospital admissions for a fall
- Reduce the number of fragility fractures
- Improve outcomes for people who have sustained a fracture.
- Promote mobility, independence and improved quality of life for older people

In order to achieve these outcomes we will:

7.2 Promote healthy aging and awareness of falls prevention

- Educate the public about what they can do to maintain good bone health and reduce the risk of falling through awareness raising, social marketing and provision of holistic information to the general public.
- Provide comprehensive evidence-based training programmes for health and social care staff who provide a service to older people, to increase awareness and skills.
- Ensure timely access to appropriate aids and technologies i.e. walking aids
- Offer a range of evidence based preventative exercise and strength and balance classes e.g. Tai Chi
- Reduce environmental risk factors

7.3 Promote early identification and intervention to reduce risk and maintain independence

- Introduce the use of standardised screening tools to be used by all professionals in contact with older adults to identify those at risk of falling.
- Provide direct access via a 'one stop' telephone number to advice and information about falls, signposting and onward referral for older people, their relatives and carers.

7.4 Provide community based prevention and management for people at high risk of falling

- Commission a Community Falls Prevention Service offering multi-factorial assessment and interventions including lifestyle and environmental risks, medication review, individualised exercise programmes and access to appropriate equipment and assistive technology.
- Develop and operate a robust pathway to ensure that older people who are at high risk of falling or have sustained a fracture receive appropriate and timely multi-factorial interventions including individualised exercise programmes.

7.5 Reduce the number of falls in care homes

- Develop mechanisms for reporting and monitoring falls and responses to falls
- Develop a sustainable approach to understanding the pattern of falls and support implementation of best practice to improve the response to falls.

7.6 Prevent unnecessary hospital admissions

- Review existing arrangements and implement an appropriate care pathway and clinical protocols for use by the London Ambulance Service where the person is not acutely unwell.
- Review and revise existing pathways to ensure clarity and timely access to:
    - equipment and tele-care e.g. community alarms
    - community based services e.g. Rapid Response, Re-ablement and Care Co-ordination, as an alternative to the ambulance service.
- Work with residential and extra care providers to improve patient falls policies and procedures, and to reduce unnecessary use of emergency services following a fall.
- Work with the Care Co-ordination Service to implement risk stratification of high risk patient groups.

7.7 Develop a pathway to improve early identification and management of osteoporosis and reduce fragility fractures

- Implement use of an osteoporosis screening tool (FRAX) for use by GPs and clinicians within secondary health services for patients over 50 at risk of osteoporosis.
- Introduce direct access to DXA scans where appropriate
- Identify all patients who have sustained a fragility fracture and provide assessment and treatment for osteoporosis and referral for a multi factorial falls assessment.
- Implement Nice guidance for primary and secondary prevention of fragility fracture

7.8 Improve understanding of the prevalence and patterns of falls and injuries locally

- Work with partner agencies to improve data collection processes and mechanisms
- Regularly review information and data to assess implementation of the strategy and to inform future commissioning.

8. The model of care

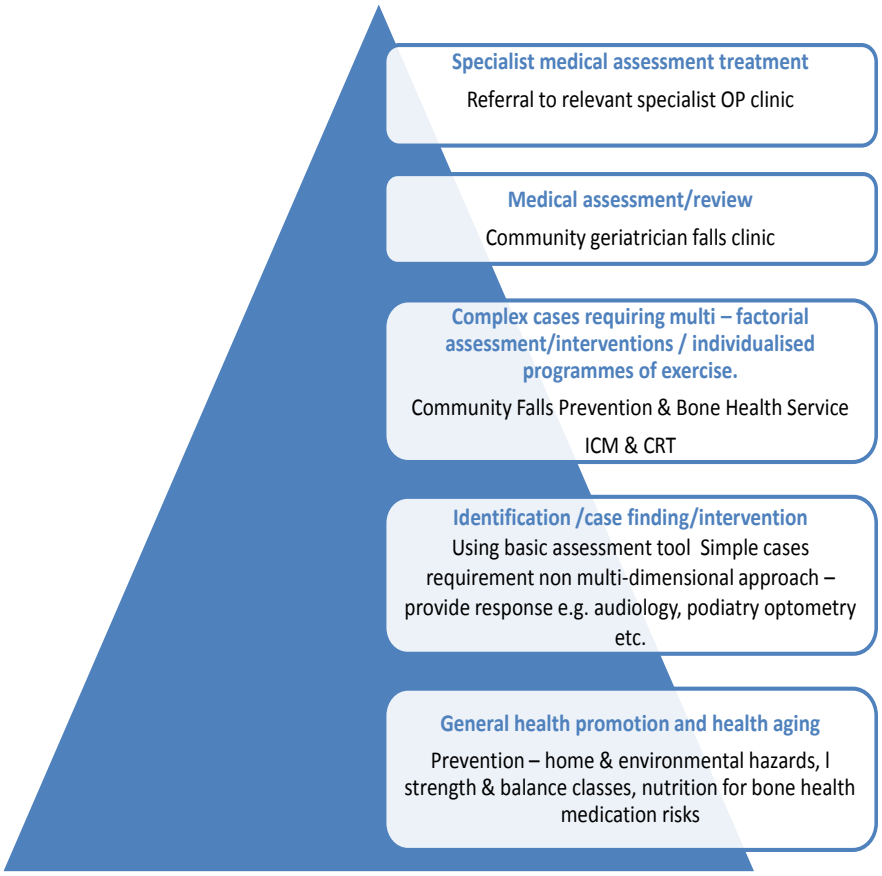
The pyramid diagram below shows the different levels of intervention,
Level One is the broad health promotion and falls prevention work that takes place within the community including the promotion of healthy lifestyle, diet and exercise programmes and environmental improvement. This is provided by a range of agencies for example: housing agencies, leisure services, pharmacists, smoking cessation service (smoking increases the risk for hip fractures by up to one and a half times), sensible drinking educationalists, GPs and so on.

Level two – a range of health and social care agencies will identify older people at risk of falling, and this will be supported through implementation of a basic falls screening tool. This offers an opportunity to undertake preventive work and to refer to a range of services for simple interventions. Older, people their relatives and staff will also be able to access a 'one stop shop' provided by the Community Falls Prevention Service for information, advice and sign-posting.

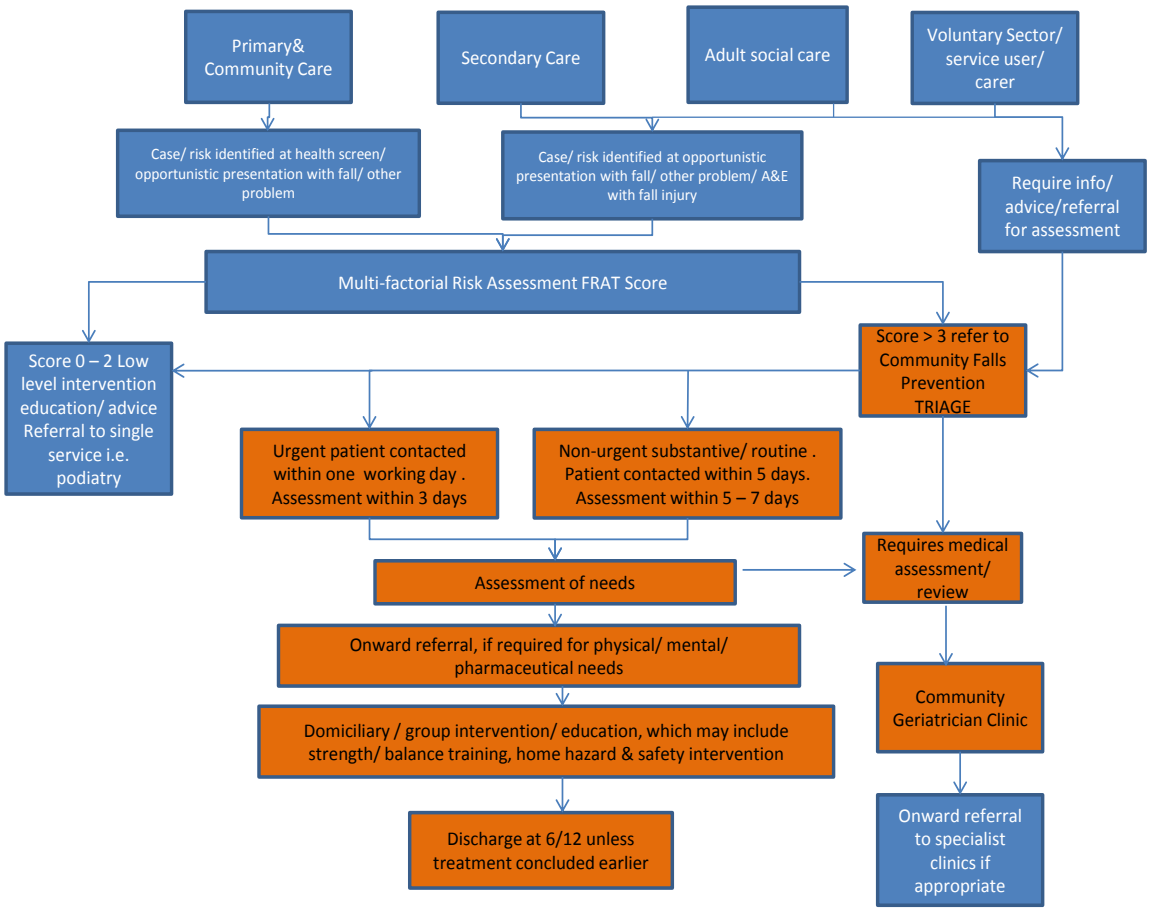
Level three – the Community Falls Prevention Service will also provide triage, and a full falls assessment and multi-factorial interventions for older people at higher risk. Other services such as the Community Rehabilitation, the Care Co-ordination and the Rapid Response services will also have a role to play in the undertaking multi-factorial interventions and treatments for older people who meet their service thresholds.

Level four – the community geriatrician will offer a weekly clinic hosted by the Community Falls Prevention Service for people requiring assessment of medical causes of a fall.

Level five - some fallers will require specialist interventions provided within, for example, cardiology or audiology clinics.


Specialist medical assessment treatment
Referral to relevant specialist OP clinic
Medical assessment/review
Community geriatrician falls clinic
Complex cases requiring multi – factorial assessment/interventions / individualised programmes of exercise.
Community Falls Prevention & Bone Health Service
ICM & CRT
Identification /case finding/intervention
Using basic assessment tool Simple cases requirement non multi-dimensional approach – provide response e.g. audiology, podiatry optometry etc.
General health promotion and health aging
Prevention – home & environmental hazards, l strength & balance classes, nutrition for bone health medication risks

8.1 Community Falls Prevention Referral Pathway



Community Falls Prevention Service assessment and interventions

9. Performance management and delivery of the strategy

A multi-agency Falls Working Group will develop the detailed implementation plan and oversee the implementation process. This group will report to the Better Care Fund Board, Clinical Commissioning Group Board and Joint Commissioning Board.

Implementation will be phased to take account of the work required by a number of agencies and services across the pathway, and to ensure that the pathway is built on strong foundations.
In Phase 1 we will develop the Community Falls Prevention Service. The CCG has made a significant investment in this service which will play a central role in the new falls pathway and in the next phase of the implementation process.

The CCG will also develop a community geriatrician post which will have responsibility for developing older people's community services including the falls pathway. The community geriatrician will provide consultation to the staff in the Community Falls Prevention Service, and will offer weekly clinics within the service to undertake medical assessment and review of people with medical reasons for falling.

In the next phase we will implement the wider falls pathway focussing on early intervention and prevention in phase 2 and developing a fragility fractures pathway in phase 3.

APPENDIX 1

6.4 Summary of falls related Services in Waltham Forest

The Falls Clinic	The clinic is based at Connaught Day Hospital, Whipps Cross Hospital. It is a Consultant Geriatrician led, multi-disciplinary specialist falls assessment service. The clinic runs one half day per week. Referrals are accepted from GPs, A & E, EUCC, Ambulatory Care Clinic and the Ortho-geriatrician. The clinic runs balance classes, and a Falls Education Group.
Balance Classes Ainslie Rehab Unit	This is an 8 week class which is held one day a week in the Ainslie Rehabilitation Unit in Chingford. It is aimed at improving balance and confidence in people who have fallen or are afraid of falling. The group consists of up to 6 people participating in a circuit class, which incorporates different balancing activities and exercise components at each workstation.
Age UK Waltham Forest	The Wellbeing Programme delivers a range of accessible exercise classes to older adults in partnership with local organisations from a number of community venues across the borough, with the view to prevent falls and improve health and well-being. Age UK Case Finding uses a pro-active approach to identify older people at risk of preventable deterioration, accident or crisis
Waltham Forest Telecare	The service enables vulnerable people to maintain independence and security within the home. This is a service jointly funded by LBWF and NHS WF. The service uses technology linked to a response centre. Telecare builds on a community alarm system, which allows people to call for help in an emergency by pulling a cord or a pendant worn around the neck. Service users can be assessed for additional sensors that are available
Care Co-ordination service	Provides offers care co-ordination to older people at high risk of a hospital admission, and includes assessment and management of falls in people who meet their risk profile.
Admission avoidance team	Base in A&E they work with people presenting to A&E and aim to reduce avoidable admissions. A significant percentage of people they see will have fallen.
Rapid response service	This nurse led team provides an urgent response to people at risk of admission to enable them to remain in the community. They will undertake falls assessments and undertake initial work before referring on for longer term support.
Re-ablement Service	The service provides planned, short term, intensive support. It is designed to help a person restore independence and confidence, as well as to support them to do as much as they can for themselves. Re
Integrated Substance misuse services	This service will begin in August 2015 and will have a recovery and harm reduction focus for the whole service pathway to include reducing alcohol related falls in older people building on an existing A&E alcohol liaison and frequent attenders service.
Intermediate Care Team	The team supports service users experiencing a crisis, such as a fall, to regain and maintain functional independence and restore their confidence. Inpatient units: for people who need a short period of rehabilitation, and Community Service is for people who require a short period of rehabilitation at home, supported housing/care homes.

The Osteoporosis Clinic	Referrals taken from GPs, hospital consultants or private patients. A diagnosis of osteoporosis is usually made based on the results of a DXA (dual energy X-ray absorptiometry) scan to measure bone mineral density. FRAX 10 year fracture risk is calculated on all appropriate patient and all DXA scans are reported with advice regarding treatment if necessary. Advice is available for local GPs and other health professionals by email/phone or letter. More complex patients can be referred to the osteoporosis clinic, where further advice can be given and parenteral treatments can be offered. There are around 2700 DXAs scans done a year at the clinic and this has not changed over the last few years. Waiting times can vary, but usually around four weeks.
The National Osteoporosis Society Support Group	The group is for residents in the borough. It holds bi-monthly meetings for service users who have osteoporosis or have been diagnosed to be at risk of osteoporosis. The support group offers information, support and medical updates.
The Fracture Clinic	The clinic (at Outpatients Department at Whipps Cross Hospital) offers a service for patients who have fractures, referred by A&E, or have previously been inpatients having had treatment for an acute injury.

APPENDIX 2

Service mapping of Waltham Forest's falls services against NICE guidelines.

	NICE requirements on Falls	Current provision	Gaps in services
1.	**Case/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'	Age UK provides a case finding service aimed at identifying vulnerable older people in the community, who may be at risk of increasing dependency on services. There is very limited use in the borough of routine screening of falls risk for older people in contact with healthcare professionals.	There is a need for a standardised risk identification tool for use across all agencies to identify high risk fallers.
2.	Use of **'Get up and go test'** (or other tests) to assess gait and balance.	There is limited use of the tests to assess balance and gait, such as the 'Get up and go test' within GP surgeries.	This in itself is not sufficient to identify the risk of falls.
3.	**Multi-factorial falls risk assessments and interventions.** 'Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment'	There is a Falls Clinic at Connaught Day Hospital, Whipps Cross Hospital that is Consultant led. Clinic runs one half day per week.	Referrals at Falls Clinic are only taken from GPs/ A& E and only for people who have had a fall.
4.	**Patient engagement:** encourage the participation of older people in falls prevention programmes including education and information giving	Age UK provides good leaflets on Staying Steady, Health and Wellbeing, and patient information. The programme for the Balance Classes at Ainslie Rehab Unit also incorporates falls prevention education. Falls Clinic provides a Falls Education Group.	There is poor provision of falls prevention programmes and information giving by domiciliary care providers, and in care homes, day centres, voluntary groups and other care settings.
5.	**Professional education** – 'all healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls	Three training days are provided for staff working in the Older Adult Mental Health Team and Memory Service. At Ainslie Rehab Unit Community Physiotherapists are qualified HCPC (health & care professionals council)	There is no other formal training programme in place. There is a need to provide a staff training programme for health and social care professionals (including care home staff and domiciliary carers).

	assessment and prevention' There are different training/qualifications available to professionals.	registered health professionals.	
6.	**Strength and balance training:** 'A muscle-strengthening and balance programme should be offered... individually prescribed and monitored by an appropriately trained professional'.	Exercise classes are provided by the Falls Clinic, Age UK WF, and Ainslie Rehab Unit. Most recent evaluations undertaken by Age UK and Ainslie Rehab Unit secured positive outcomes. There is provision of exercise classes by Age UK WF, in 5 of the 8 Extra Care Sheltered Housing Schemes. Only trained practitioners can provide the specialized exercise classes.	There is no provision of exercise classes for care home residents, and in day centres.
7.	**Medications:** 'older people on psychotropic medications should have their medications reviewed… to reduce their risk of falling'. Particular attention should be paid to older persons taking four or more medications.	Local pharmacies undertake medicines review to help manage patients' medicines more effectively.	Poly-pharmacy was raised as an issue especially in care homes. Polypharmacy, defined as the use of more than three or four medications, is regarded as an important risk factor for falling in the elderly, only when at least one established fall risk-increasing drug is part of the daily regimen[5]. There is a need to review the medication management processes.
8.	**Home hazard and safety intervention:** is shown to be effective only in conjunction with follow-up and intervention, not in isolation.	Occupational Therapies (O.T.) from the Falls Clinic can carry out an environmental hazard check if required from the multifactorial falls assessments. In addition appropriate inpatients presenting to Whipps Cross Hospital A&E department will have home hazard checklist completed if referred to Occupational Therapy.	Currently there is no funding for Occupational Therapists to be attached to the Balance Classes yet many of the patients in the balance classes have potentially not been assessed at home by an O.T.
9.	**Assistive devices:** Falls prevention strategies, using telecare and other	**Waltham Forest Telecare** services provide Assistive Technology equipment	There is a need to increase awareness of the service to all

[5] Ziere G et al (2006) Polypharmacy and falls in the middle age and elderly population: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1885000/

	assistive technology, have been shown to significantly reduce the incidence, severity and associated costs of falls in older people[6].	through referral. The service receives a list from the monitoring centre regarding service users who have had a fall(s) – since May 2013 these patients have been guided to consult with their GP in the first instance.	health professionals in the borough.
10.	**Cardiovascular intervention:** cardiac pacing should be considered for older people with cardio inhibitory carotid sinus hypersensitivity that have experienced unexplained falls.	The Consultant at the Falls Clinic decides if patients need further medical investigations. There is no transient loss of consciousness (TLoC) clinic in the area.	
11.	**Visual Intervention:** assessment of visual impairment. Studies showed that visual impairment is an independent risk factor for falls and hip fractures.	Local opticians carry out eye tests to check the quality of 'your sight'. Older people aged 60 and over qualify for free NHS funded sight tests.	Current performance against the criteria is unknown. Simple intervention strategies such as regular eye examinations, use of correct prescription glasses, cataract surgery and the removal of tripping hazards in the home and public places have the potential to prevent falls in older people[7].
12.	**Footwear interventions:** although there seems to be no experimental studies relating falls to footwear, **AGS/BGS guidelines** recommend: 'Older people should be advised that walking with shoes of low heel height and high surface contact area may reduce the risk of falls'[8].	Age UK have highlighted the importance of appropriate footwear during their Falls Awareness programmes. At the Falls Clinic advice is given on suitable footwear. At the balance classes at Ainslie Rehab, talks are given on suitable footwear.	
NICE requirements on osteoporosis			

[6] Dorset County Council Adult in collaboration with Department of Health November 2007.

[7] Lord SRL, (2006) Visual risk factors for falls in older people. Age and Ageing 2006; **35-S2**: ii42–ii45.

[8] Summary of the Updated American Geriatrics Society/British Geriatrics Society Clinical Practice Guideline for Prevention of Falls in Older Persons. Developed by the Panel on Prevention of Falls in Older Persons, American Geriatrics Society and British Geriatrics Society. 2011. Available at: http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2010.03234.x/pdf

13.	Targeting risk assessment: consider assessment of fracture risk: in all women aged 65 years and over and all men aged 75 years and over.	There are Locally Agreed Guidelines for GPs. These are in the process of being updated to include guidance on risk assessment. They are in the process of being approved across NELFT and across Barts Health. However, there has been no monitoring of the usage of the guidelines. Referral rate to the Osteoporosis clinic from the Fracture Clinic is 'patchy'. Fracture Liaison Nurse (FLN) used to case find patients from the Fracture Clinic; The post was stopped in September 2012. Since September 2012, if a patient has had a fracture, when the patient is seen at the Fracture Clinic, a letter should be copied to the Osteoporosis Clinic so that a decision can be made to DXA scan the patient or not. This is a new initiative so it is too early to comment on the outcomes.	1) There is no physical presence of a FLN to ensure that all the patients that have fractured are assessed for the need of a dual energy X-ray absorptiometry (DXA) scan. 2) Targeting risk assessment is currently 'patchy'. 3) The opportunity for patient education on osteoporosis and medications is being missed as there is not enough time for this in a consultation session with the GP. Prostraken audits have been conducted in some GP practices focused on ensuring that the patients with osteoporosis or at risk are receiving optimal pharmaceutical management.
	Risk assessment for osteoporosis should use either FRAX or QFracture to estimate the 10 year fracture risk in an individual	Any person referred for a DXA scan has their falls risk assessment tool (FRAX) 10 year fracture risk assessed and this is reported in the DXA report to the referring physician, The DXA referral form has been redesigned to include the FRAX risk being calculated. This is currently out to consultation from local primary care physicians.	GPs may not be aware of the FRAX and QFracture tool.