



Havering
LONDON BOROUGH



Outer North East London

Havering

Falls Prevention and Bone Health Needs Assessment

October 2011

A collaboration of NHS ONEL and London Borough of Havering to present a comprehensive picture of need for falls prevention and bone health services in Havering

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1. Introduction

This needs assessment has been produced in order to inform the development of the Falls Prevention and Bone Health Strategy for Havering from 2011 – 2016.

A fall is usually defined as an event which results in the person coming to rest inadvertently on the ground or other lower level, and other than as a consequence of the following: sustaining a violent blow, loss of consciousness, sudden onset of paralysis, or an epileptic seizure¹.

Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged over 75 years in the UK². About 30% – 50% of people aged over 65 fall each year. Over 400,000 older people in England attend accident and emergency departments following an accident and up to 14,000 die annually in the UK, as a result of an osteoporotic hip fracture².

Hip fracture is the most common serious injury related to falls in older people – 20% of older people who sustain a hip fracture die within four months, and 30% within a year³. Hip fractures also result in an annual cost to the NHS of around £1.7billion for England. Of this, 45% of the cost is for acute care, 50% for social care and long term hospitalisation, and 5% for drugs and follow-up².

A fall can precipitate admission to long-term care. After an osteoporotic fracture, 50% can no longer live independently². Falls are a common source of injury, and can have an adverse psychological impact on older people who may lose confidence or feel they have lost their independence following a fall. Fear of falling can provide a significant limitation on daily activities, and falls in later life are also a common symptom of previously unidentified health problems which need to be identified and managed.

2. Background

This needs assessment is a joint project between NHS Havering Public Health and the London Borough of Havering Adult Transformation Board. The population of interest is people aged 65 years and over, living in Havering, because this is the most at risk population for falls, fractures and osteoporosis. Havering has the highest proportion of pensioners in London, with around a fifth of the population being of retirement age.

Although falls are not an inevitable result of ageing since children and active adults also experience falls, the tendency to fall increases with age, and older people are more susceptible to injury and complications. Often a fall can be the first indication of an undetected illness in the older person.

Falls prevention is a priority in the UK and the aim of standard 6 of the National Service Framework for older people published in 2001, is to reduce the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen. Key interventions in the standard are:

- prevention including the prevention and treatment of osteoporosis
- Improving the diagnosis, care and treatment of those who have fallen
- Rehabilitation and long-term support

The National Institute for Health and Clinical Excellence (NICE) in the clinical guideline on the assessment and prevention of falls in older people⁴ has also identified initiatives which if implemented, could reduce the incidence of falls in older people. The NSF was followed by guidance to support commissioners implementing the falls standard. The standard requires that; 'the NHS working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their population of Older People'.

The rationale behind this standard is:

- Falls are a major cause of disability and a leading cause of mortality
- Osteoporosis increases the risk of fracture in older people
- A fall can precipitate an admission to long term care

There is now good evidence that effective falls prevention and bone health strategies can yield results in reducing falls and the severity of their impact. A review of 8 trials indicates that at least 15% of falls in older people can be prevented⁵. It is therefore pertinent that falls prevention and bone health be a priority for the PCT and partners.

3. Aims and Objectives

This report aims to provide a clear picture of the current situation of need in Havering and projections of this need for the future of Falls Prevention and Bone Health for the older population of Havering.

The objectives are:

- To provide information for the development of the Falls Prevention and Bone Health Strategy for Havering from 2011- 2016.
- To identify the interventions required to meet current and future need in Havering.

4. Methodology

This needs assessment is the result of collaboration between NHS ONEL and London Borough of Havering. It builds on existing information in the Havering JSNA (2010) and other local strategic documents and data sets to present a comprehensive picture of need for falls prevention and bone health services as presently identified for the Borough of Havering.

Some of the estimates and assumptions in this needs assessment are based on national rates, due to a lack of local data.

Population and disease projections as well as falls and falls admission projections have been sourced from the Department of Health Projecting Older

Peoples Population Information system (POPPI), and are based on ONS estimates.

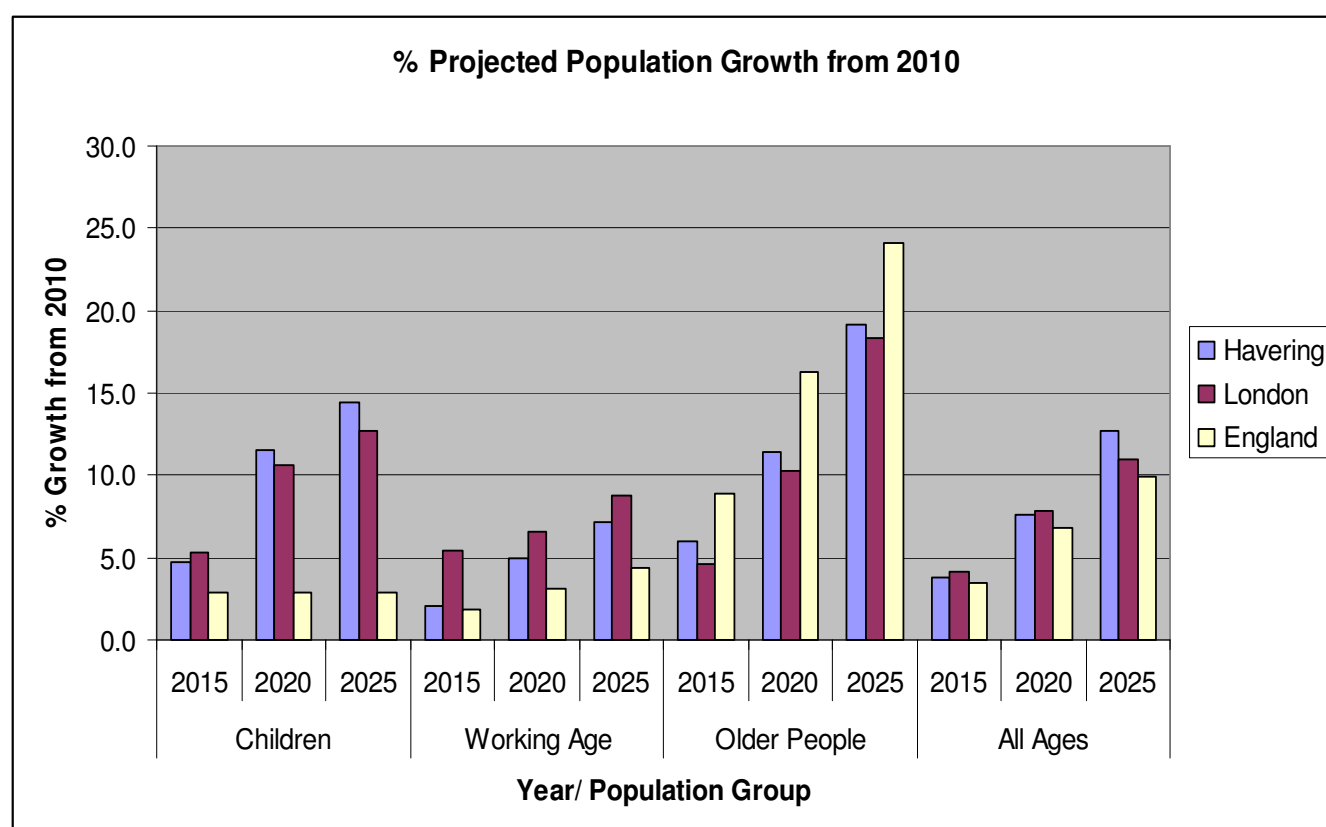
The data collected for this report has been based on the Department of Health guidance and template for the production of a needs assessment for Falls Prevention and Bone Health⁷.

5. Demographics of Havering Older People Population

Since 2007, the total population of Havering has been growing at a faster rate than the England average, and this is expected to continue in the future, with the population rising by 8.3% (from 235,700 to 255,200) by 2020⁶.

Havering has a large elderly population, with 37% of Havering residents aged 50+ and 20% of the population of retirement age. The proportion of the population of retirement age is similar to the England national average (20%), but higher than the London average (14%). A breakdown of the projected population data for Havering also indicates that the largest population growth is expected in the 65+ age group, with the number of older people in Havering expected to continue to increase in the future. The number of people of pensionable age is expected to rise by 23% by 2025 (Figure 5.1a). The fastest rise is expected in the 90+ age group, which is expected to increase by 125% by 2025⁶. The estimated population of people aged 65+ years in Havering in 2010 is 41000.

Figure 5.1a – Havering Projected Population Growth from 2010

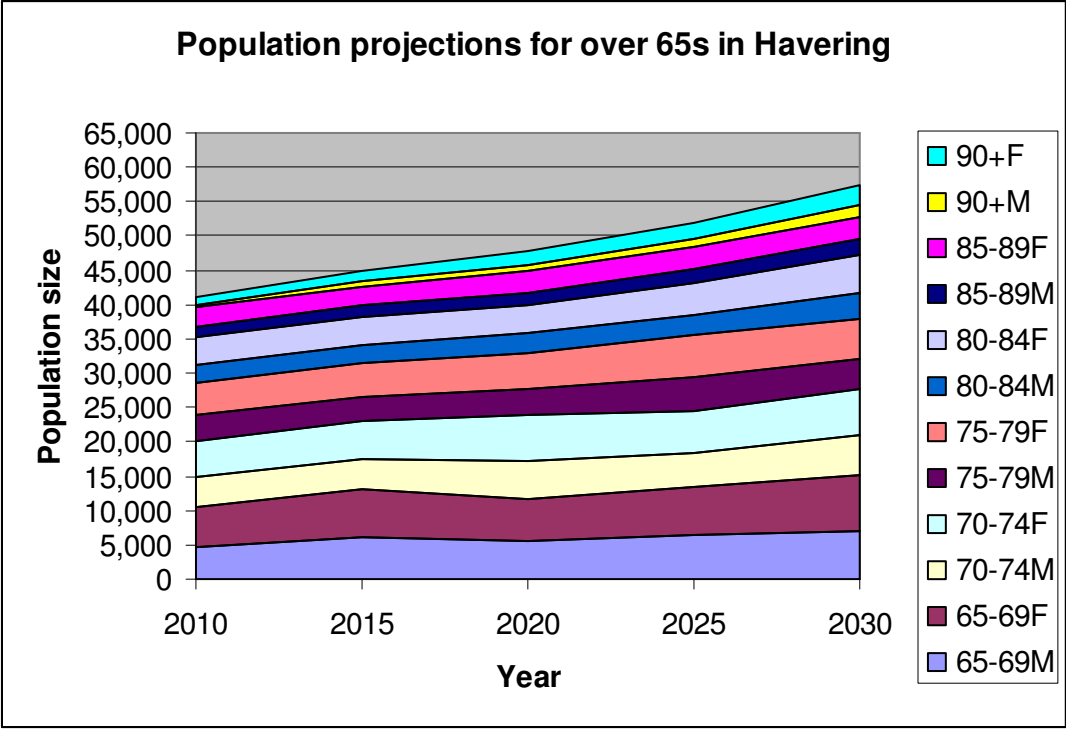


Source: Havering JSNA 2010

There are a greater number of females than males in Havering's older population, particularly among the very elderly. In the 90+ age group, there are twice as many females in 2010 (table 5.1b and Figure 5.1b). It is predicted that there will continue to be a greater number of older women than men in Havering in the future.

Population Projections for over 65s in Havering 2010-2030

Figure 5.1b – Havering population projections for over 65s by gender and age



Key: F - Female, M – Male Source: POPPI 2010

5.1 Older People in Havering at Ward Level

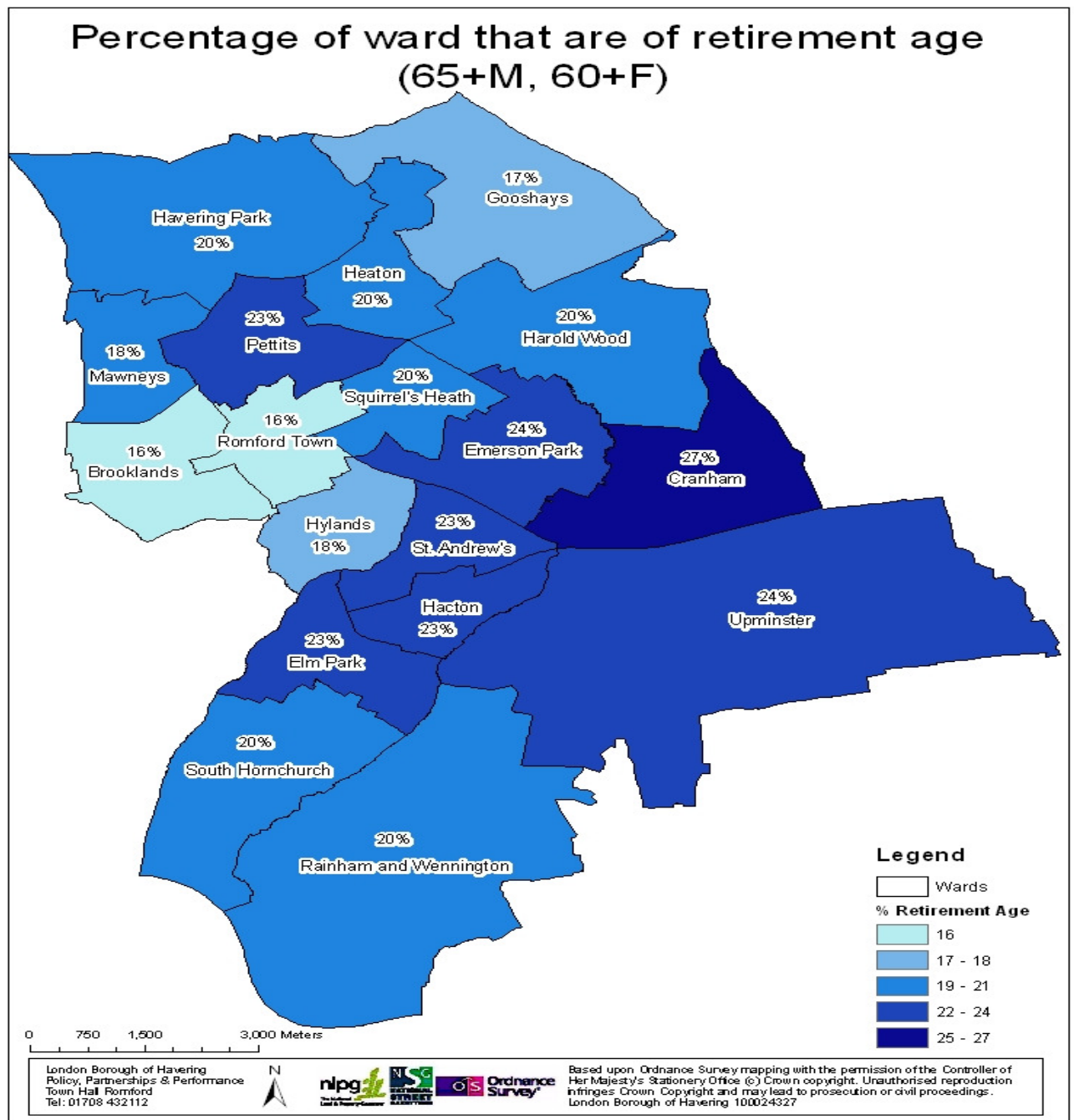


Figure 5.1d – Map of Havering showing percentage of people of retirement age in each ward⁸ (Mid Year Estimates, Office of National Statistics, 2008)

The percentage of Older People in Havering who are of retirement age varies from ward to ward.

The map shows that Cranham (27%), followed by Upminster (24%) and Emerson Park (24%) have the largest proportion of residents of retirement age. Brooklands and Romford Town have the smallest proportions of residents of retirement age

In Havering the biggest group of users of social care services in the community and in residential care are older people (71% and 79% respectively) ⁸.

5.2 Health and Wellbeing of Older People in Havering

5.2.1 Healthy Life expectancy at 65³¹

Life expectancy for males aged 65 in Havering is 17.9 years, and for females it is 21 years. This is slightly worse than for London (males – 18.4, females – 21.2), but slightly better than for England for women (males – 18 and females – 20.6), though not for men (table 5.2.1). Women in Havering also have a greater number of years of good or fairly good health ahead of them than men.

Table 5.2.1 Life expectancy at 65

Area	Male			Female		
	Number of years	95% Confidence Interval	Significant Difference with Havering	Number of years	95% Confidence Interval	Significant Difference with Havering
England	18.0	18.0, 18.0	No	20.6	20.6, 20.6	Yes
London	18.4	18.3, 18.4	Yes	21.2	21.2, 21.3	No
Bexley	18.3	18.0, 18.6	No	21.3	21.0, 21.5	No
Havering	17.9	17.6, 18.2		21.0	20.8, 21.3	

Source: ONS Estimates

5.2.2 Disability Free years

Women in Havering live for a greater number of years without a disability than males, with women living on average for 65.6 disability free years and men living on average for 63.4 disability free years⁸ (Table 5.2.2). The number receiving residential and nursing care is expected to rise by 7% in the next 10 years⁶. National data indicates that approximately 50% of older people in residential care facilities fall at least once a year⁹.

Table 5.2.2 – Disability Free Years

Area	Male			Female		
	Number of years	95% Confidence Interval	Significant Difference with Havering	Number of years	95% Confidence Interval	Significant Difference with Havering
England	61.7	61.7, 61.7	Yes	64.2	64.2, 64.2	Yes
London	61.9	61.8, 62.0	Yes	64.2	64.2, 64.3	Yes
Bexley	64.1	63.7, 64.4	No	66.3	66.0, 66.6	Yes
Havering	63.4	63.1, 63.7		65.6	65.3, 65.9	

Source: Neighbourhood statistics

6. Factors that Increase the Risk of a Fall and the Risk of Serious Injury

Preventing falls in older people depends on identifying those most at risk of falling and co-ordinating appropriate preventive action. Published studies have identified specific risk factors for falls and related injuries. These risk factors could be intrinsic factors which are related to the individual e.g. illness, ethnicity, gender, mobility, visual impairment, or extrinsic factors which are related to the environment e.g. degraded pavements, badly fitting footwear/clothing, lack of appropriate walking aids or assistive devices. There are also factors which increase the risk of an individual receiving a serious injury such as a fracture, from a fall. E.g. osteoporosis, history of falls. Many of the risk factors associated with falls and injury from a fall, can be reduced with evidence-based interventions.

6.1 Factors that Increase the Risk of a Fall

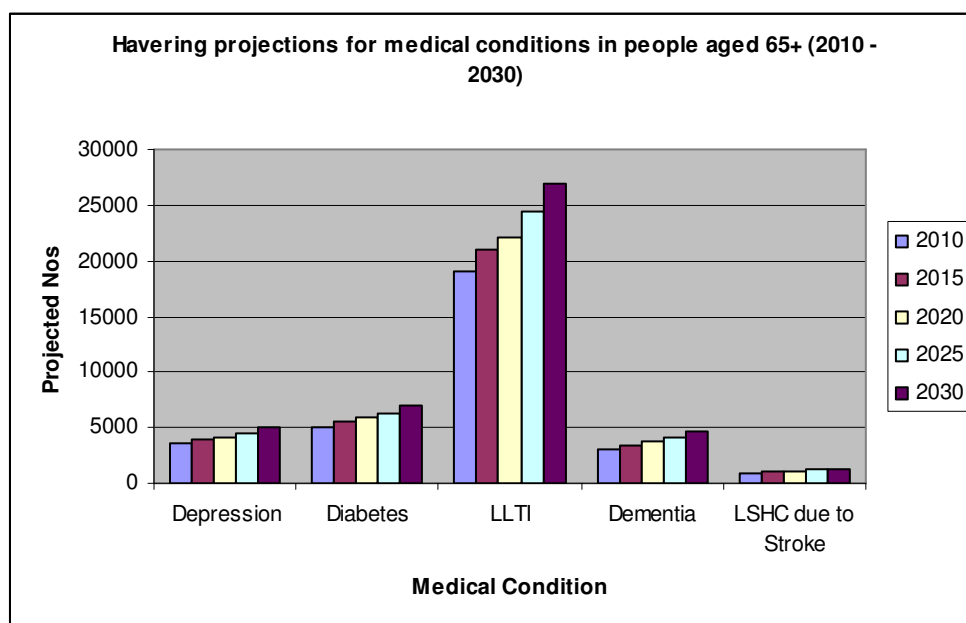
6.1.1 Illness

Medical conditions such as circulatory disease, chronic obstructive pulmonary disease and other long term conditions as well as depression and arthritis are associated with an increased risk of fall¹⁰.

- The number of older people with depression is predicted to increase by 15% by 2020. In line with national trends, it is estimated that in Havering, there are twice as many older women with depression than men.
- Around 12% of pensioners in Havering are estimated to have diabetes, with numbers expected to increase by 10% in the next 5 years
- Around 46% of all Havering pensioners have a limiting long term illness (LLTI), and this number is expected to rise by 16% over the next ten years.
- About 6% of pensioners in Havering are estimated to have dementia, and 45% of all dementia in Havering is estimated to occur in the over 85+ age group.

- A baseline pharmaceutical antipsychotic audit report for Havering for 2010/11 in which 40 of the 52 GP practices participated, indicated that there were 848 patients aged 65+ on the dementia register, and 127 (15%) of these patients are on antipsychotic medication (antipsychotic medications are a range of medications that are used for some types of mental distress or disorder - mainly schizophrenia and manic depression. They can also be used to help severe anxiety or depression).
- About 2% of people aged 65+ in Havering have a longstanding health condition (LSHC) caused by a stroke.
- There is a significant increased risk of a fall with use of centrally sedating or blood lowering medication. The risk of a fall is also increased if a person is on more than four medications, irrespective of the type of medication^{11, 12, 13}.

Figure 6.1.1 – Projections for medical conditions in people aged 65+ in Havering



Source – POPPI 2010

6.1.2 Mobility

It is estimated that in 2010, 19% of Older people in Havering aged 65+ have limited mobility and are unable to manage at least one activity on their own e.g.

going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; getting in and out of bed. This is particularly the case for older women who are more likely than men to be unable to manage at least one activity. Difficulty in rising from a chair is also associated with increased risk of falls^{13,14}. It is estimated that at 65 years, 8% of men and 9% of women are unable to manage at least one of the mobility tasks. This rises to 35% for men and 50% for women, at age 85⁶.

6.1.3 Visual Impairment

Visual acuity, contrast sensitivity, visual field, cataract, glaucoma and macular degeneration all contribute to risk of falls as do bifocal and multifocal lenses^{15,16}. Multifocal glasses impair depth perception and edge-contrast sensitivity at critical distances for detecting obstacles in the environment¹⁷. Visual impairment becomes more common with age, with 5.6% of 65-74 year olds having visual impairment, and rising to 12.4% for those aged 75+. In Havering, the number of older people with a visual impairment is predicted to increase in the future, as is the case nationally. It is estimated that in 2010, about 3718 people aged 65+ have a moderate or severe visual impairment, and that this number will increase by 15% over the next 10 years. Around half of all visual impairments in those aged 75+ are correctable e.g. cataracts^{6,8}.

6.1.4 Drinking Habits

The Havering Health and Lifestyle survey, 2007 reported that in the 65+ age group, more women drink, than men. Respondents aged 75+ also drank more than respondents in the 65-74 age bands. This intake of alcohol in the Older population in Havering was attributed to the high percentage of White British within this population (95%) and the drinking habits associated with the British Culture.

6.1.5 Physical Environment/Pathways

Degraded pavements are one of the environmental risk factors for falls. One of the community strategies advocated for the prevention of falls in the NSF for

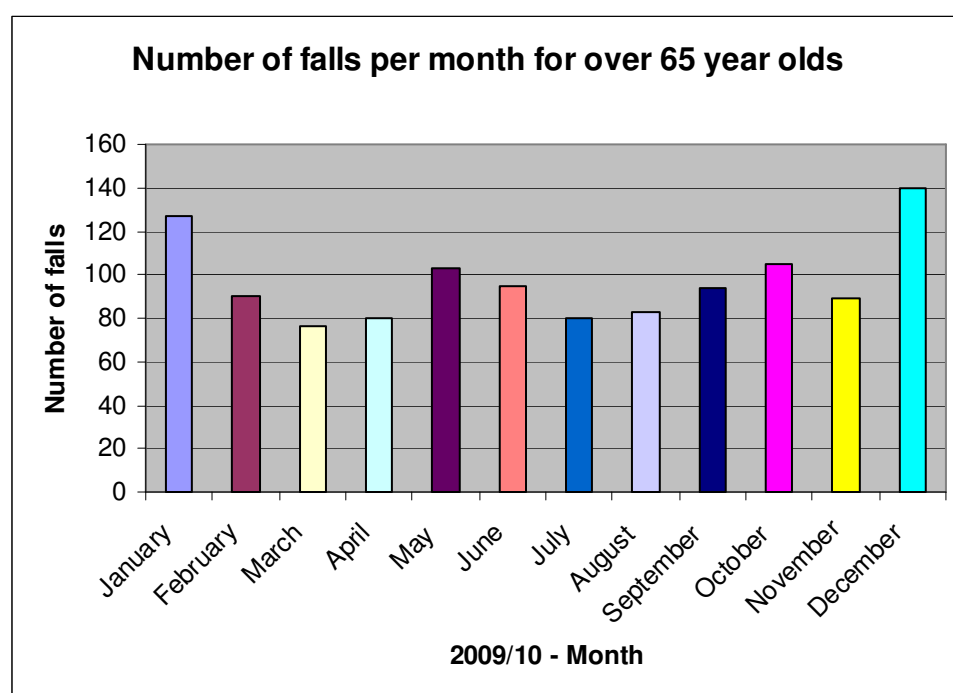
older people standard 6 is: ensuring that pavements are kept clear and in good repair and there is adequate street lighting.

Streets and highways accounted for 7% of falls in Havering in 2009/10, and older people in Havering have also identified road and pavement repairs as one of the issues of most concern to them⁸.

In Havering, routine safety inspections of pavements are carried out based on usage. Areas of high footfall e.g. Market areas are inspected on a monthly basis, and other areas are inspected on a 3-monthly or 6-monthly basis. Repairs are carried out on identified safety defects of 25mm or more, however consideration is being given to an intervention limit of 20mm.

Bi-annual conditions surveys of the borough road networks are carried out to determine major works to be undertaken. Decisions on major works take into account accident history, and also geographical sites of buildings such as residential care homes, hospitals, schools etc. to ensure pavements where there are such sites are well maintained. Main roads are gritted at times of snow and ice, however side roads and pavements are not gritted. Data on hospital admissions for falls for 2009/10, indicates that the months when the most falls occurred, are the months of December and January (Figure 6.1.5).

Figure 6.1.5 – Number of falls per month for people aged 65+



Source: SUS 2009/10

Although accident history is a deciding factor on where major works need to be undertaken, no data is collected about where or why falls occur, or on the numbers of falls that occur outside; therefore the incidence of falls does not influence any major works to be carried out.

6.1.6 Ethnicity

Evidence from the United Kingdom and the United States suggests Caucasian ethnic groups fall more frequently than Afro-Caribbeans or South Asians^{14,19}. This is reflected in the Havering data on rate of falls for 2009/10, where the proportion of falls in the White ethnic group (97.8%) is greater than the representation of the group (95%) in the population of people aged 65+ years (Figure 6.1.6b). It is however possible that the greater number of falls in the older white ethnic group in Havering is due to the fact that the white ethnic group in Havering has a higher proportion of older people in the 75+ age group, which have a higher risk for falls, than people below 75 years of age. Within each age group, the proportion of white ethnic increases with advancing age, but the proportion of non-white ethnic reduces with advancing age. The population of non-whites aged 65 – 74 is about

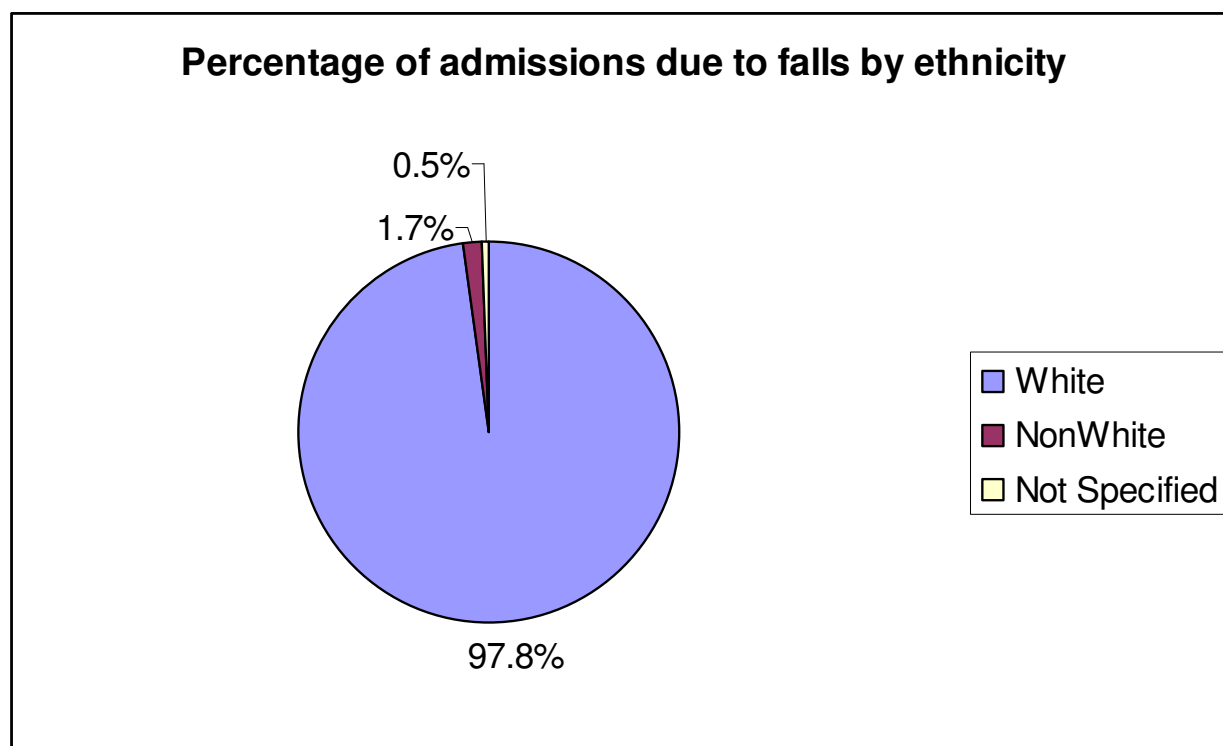
4.7%, and reduces to about 2.2% for those aged 75 – 84, and 1.2% for those aged 85+. (Table 6.1.6)

Table 6.1.6 – People aged 65 and over by age and ethnic group as a percentage of the total population of that age band, year 2007

	People aged 65-74	People aged 75-84	People aged 85+
White (this includes British, Irish and Other White)	95.31%	97.84%	98.80%
Mixed Ethnicity (this includes White and Black Caribbean; White and Black African; White and Asian; and Other Mixed)	0.43%	0.29%	0.17%
Asian or Asian British (this includes Indian; Pakistani; Bangladeshi; and Other Asian or Asian British)	2.29%	1.01%	0.62%
Black or Black British (this includes Black Caribbean; Black African; and Other Black or Black British)	1.40%	0.55%	0.26%
Chinese or Other Ethnic Group	0.57%	0.31%	0.15%

Source: POPPI, 2010

Figure 6.1.6b Percentage of falls by ethnicity



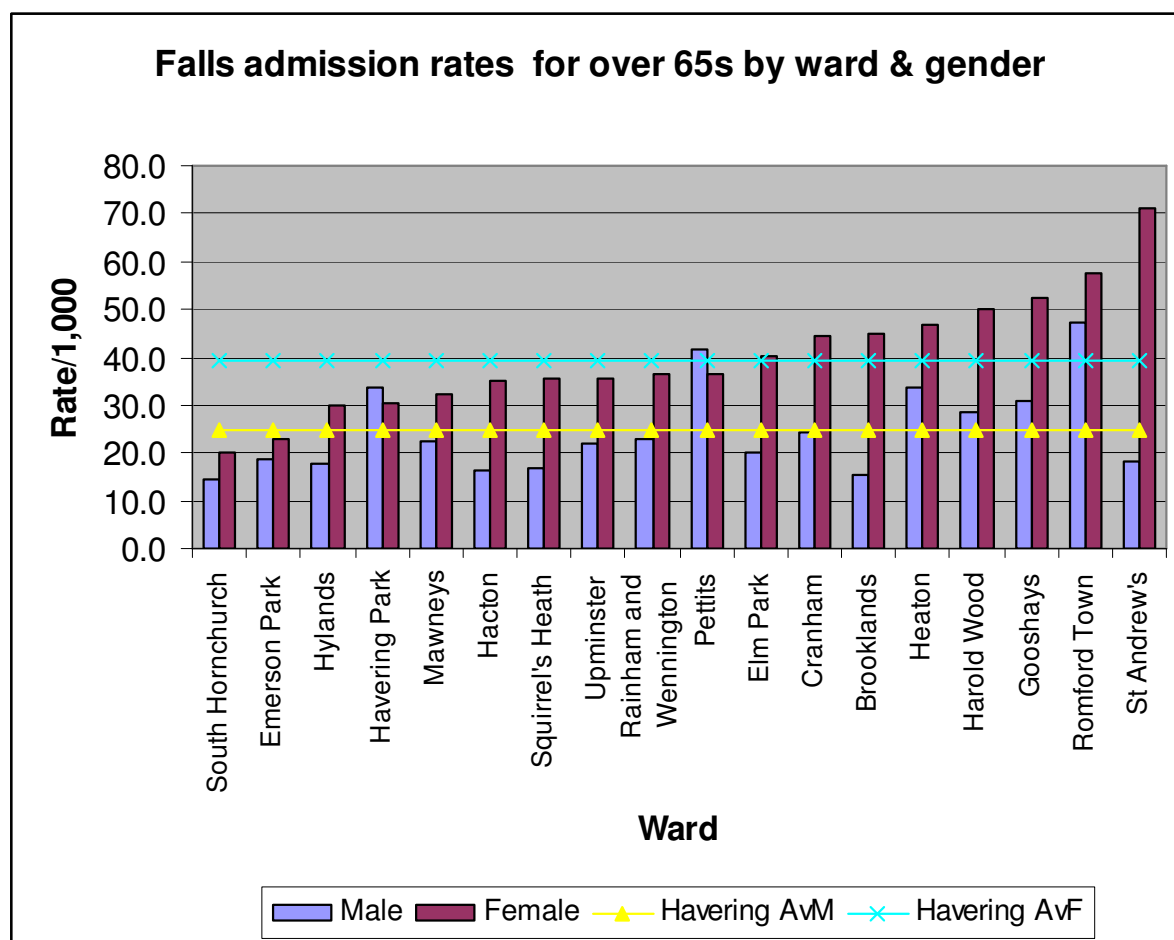
Source: SUS 2009/10

The population of over 65s in Havering is 95% white ethnic origin. Among people aged 65 and over in Havering who have a limiting long term illness, 98.51%, are of white ethnic origin⁶. This equates to about 49% of people of white ethnic origin aged 65years and above, and means that the risk of a fall is further increased for this group.

6.1.7 Age and Gender

The incidence of falls increases with age. For the younger old (those aged 50 – 64), fall rates for men and women are similar, but among the older old, women fall more often than men, and are far more likely to incur fractures when they fall^{12, 20}. Falls figures for 2009/10 (figure 6.1.7a), indicate that with the exception of Havering park and Pettits wards, all the wards in Havering had higher rates of falls for women than for men. Falls admissions data by gender and age group (table 6.1.7b) indicates that in the age group 0 – 49years, falls rates are higher in males, and from age 50 -64 years (younger old), the rates are similar. However from age 65, the rates in females are higher than in males.

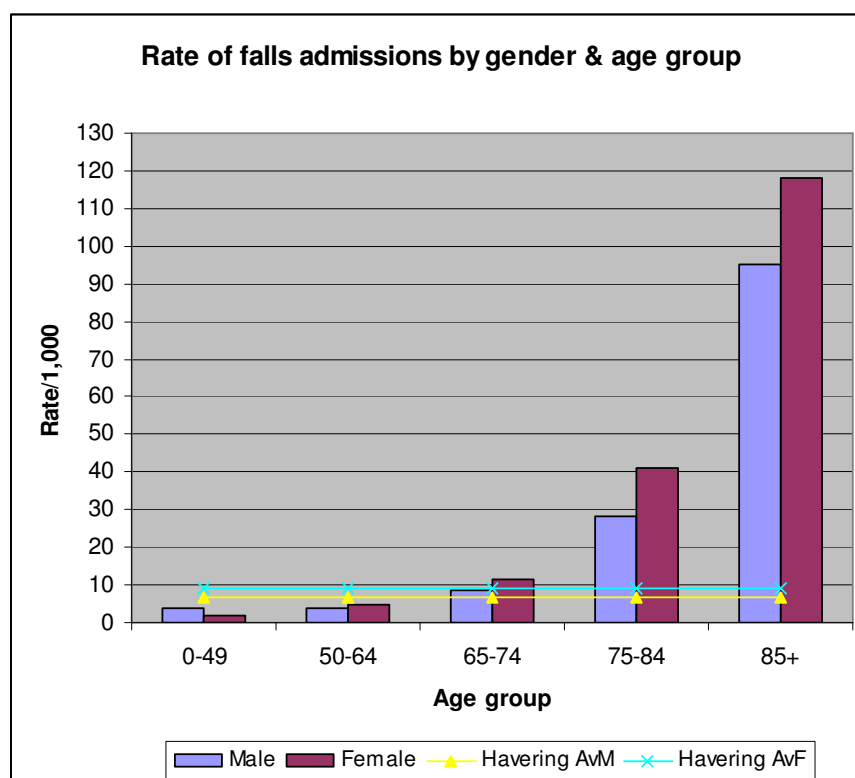
Figure 6.1.7a Falls Admission rates by gender and ward for over 65s in Havering 2009/10



SUS 2009/10

Rates in Males are highest in Romford town and in women the highest rate is in St Andrews. South Hornchurch has the lowest rate for both males and females, and the lowest rate among wards. Although Romford town has the smallest proportion of people of retirement age, it has the highest rate of falls for males, and the second highest rate for females. This could be linked to deprivation, as areas of deprivation have higher rates of falls, and Romford lies within the most deprived quintiles for Havering (quintile 2). This is the quintile with the highest rate of falls.

Figure 6.1.7b – Falls admission by gender and age group (2009/10 admissions data)



SUS 2009/10

6.1.8 Physical Activity

Physical activity is defined as any bodily movement produced by skeletal muscles that requires energy expenditure. Physical inactivity, (a lack of physical activity) is an independent risk factor for chronic diseases, and overall is estimated to cause 1.9 million deaths globally.

Regular physical activity – such as walking, cycling, or dancing – has significant benefits for health, and can reduce the risk of adverse health conditions, including osteoporosis²¹. Everyone should engage in at least 30 minutes of moderate physical activity every day. WHO global recommendations on physical activity for health, recommends that:

- In older adults aged 65 years and above, physical activity includes leisure time physical activity (for example: walking, dancing, gardening, hiking, swimming), transportation (e.g. walking or cycling), occupational (if the individual is still engaged in work), household chores, play, games, sports

or planned exercise, in the context of daily, family, and community activities.

- Older adults, with poor mobility, should perform physical activity to enhance balance and prevent falls on 3 or more days per week.
- Muscle-strengthening activities, involving major muscle groups, should be done on 2 or more days a week.
- When older adults cannot do the recommended amounts of physical activity due to health conditions, they should be as physically active as their abilities and conditions allow.

Havering Health and Sports Development adult activities data indicates that only 33 of the 86 women aged 65+ who registered in 2009, indicated that they participated in 30 minutes of physical activity at least 3 times a week. Of the 52 men who registered, 26 indicated that they participate in 30 minutes of physical activity at least 3 times a week.

In 2010, of the 75 females aged 65+ who registered for the programme, only 21 indicated that they participate in 30 minutes of physical activity for at least 3 times a week. Of the 33 males who registered, 15 indicated that they participate in 30 minutes of physical activity for at least 3 times a week.

For both years combined, only 33% of females and 48% of males aged 65+ who registered on the programme, indicated that they participated in 30 minutes of physical activity for at least 3 times a week.

6.2 Factors that Increase the Risk of Serious Injury from a Fall

6.2.1 A history of falls

A history of falls is associated with increased risk^{14, 20, 21}, and adults who sustain a fracture are at greater risk of sustaining another fracture of a different type. A prior hip fracture increases the incidence of another hip fracture by 2.9% in the first year, and half of hip fracture patients have a history of previous clinically apparent fragility fracture such as wrist, ankle or vertebra. Table 6.2.1 outlines the number of secondary fractures anticipated in Havering, based on 2009/10 fragility fracture data, if there is no intervention.

Table 6.2.1 Anticipated secondary fractures in Havering, based on 2009/10 fracture admissions data

Total no of prior fractures of Hip, Forearm, Spine and Humerus (n = 397)						
	Year 0-1	Year 1-2	Year 2-3	Year 3-4	Year 4-5	Year 0-5
Site of new fracture						
Hip	12	8	8	5	3	36
Forearm	7	3	2	2	1	15
Spine	7	6	5	3	2	23
Humerus	4	2	2	2	2	12
Totals	30	19	17	12	8	86

Estimates of secondary fractures (without intervention) based on study by Johnell et al 2004²⁵

6.2.2 Osteoporosis

Osteoporosis is a condition characterised by a reduction in bone mass and density, and which increases the risk of fracture when an older person falls. As the condition progresses, there is an increase in bone fragility that consequently increases the susceptibility to fracture.

Fractures from osteoporosis occur most commonly in the hip, spine and wrist; however the effect of osteoporosis on the skeleton is systemic and prospective studies have shown that osteoporosis heightens the risk of almost all types of fracture, irrespective of fracture site. Vertebral fractures due to osteoporosis can cause loss of height, curvature of the spine and chronic back pain. Women are at greater risk of osteoporosis as they have smaller bones and hence lower total bone mass. Women also lose bone more quickly following the menopause, and typically live longer. About one out of every two women and one in eight men aged 50 years will have an osteoporosis related fracture³². Local data has not been available for this report. The expected prevalence of osteoporosis in Havering is as identified in the table below, based on national rates:

Table 6.2.2 – Estimates of osteoporosis prevalence in Havering (2010)

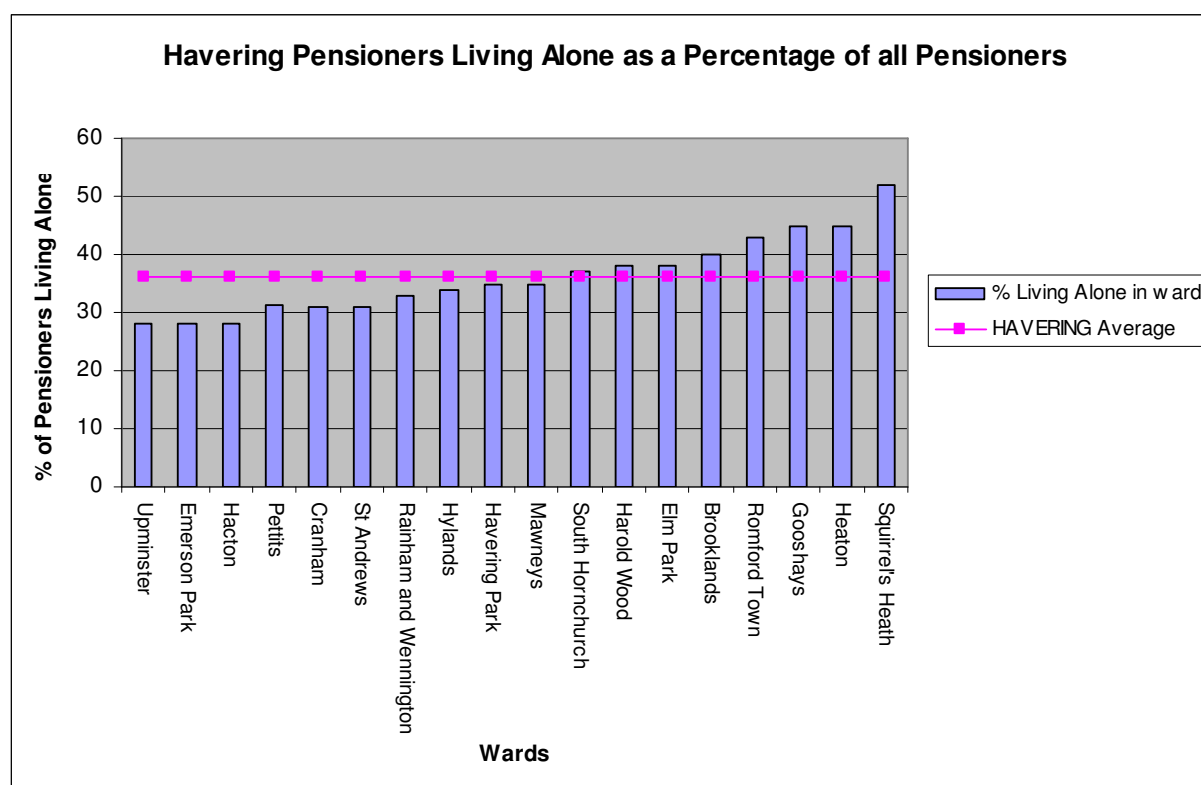
Age group	Population (2010)	Rate %	Estimated Havering prevalence
Over 50 (M)	39,014	12.5	4,877
Over 50 (F)	46,985	50	23,493
Total	85,999		28,369

Source: Estimates are based on ONS population estimates for 2010

There were 63 day cases and 5 admissions of persons aged 65 and over with a primary diagnosis of osteoporosis in 2009/10³³.

6.2.3 Living Alone

Table 6.2.3 – Havering Pensioners living alone by Ward 2010



Based on GLA 2010 population estimates and Census 2001

An older person living alone may imply greater functional ability; however injuries and outcomes from falls can be worse, especially if the person cannot rise from the floor.

Havering has a higher proportion of older people living alone than is the average nationally. It is estimated that for 2010, there are 5,150 people aged 65 – 74 years and 10,623 people aged 75+ years living alone in Havering⁶. Older people in Squirrel's Heath, Heaton and Gooshays wards are most likely to be living alone. The number of elderly people living alone in Havering is projected to continue to grow, increasing by 14% in the next 10 years (by 2020) when compared with current (2010) levels⁶.

It was estimated that 48% of Havering residents aged 65+ living alone in 2010, also have a limiting long term illness. The combination of living alone and having a limiting long term illness is both a risk factor for a fall, as well as injury following a fall.

The assistive technologies team (Social Care) works with older people living alone in sheltered housing, installing telecare devices which provide a means to

access care and support if required by the older person living alone. There were 895 calls (32%) for assistance following a fall in 2009/10.

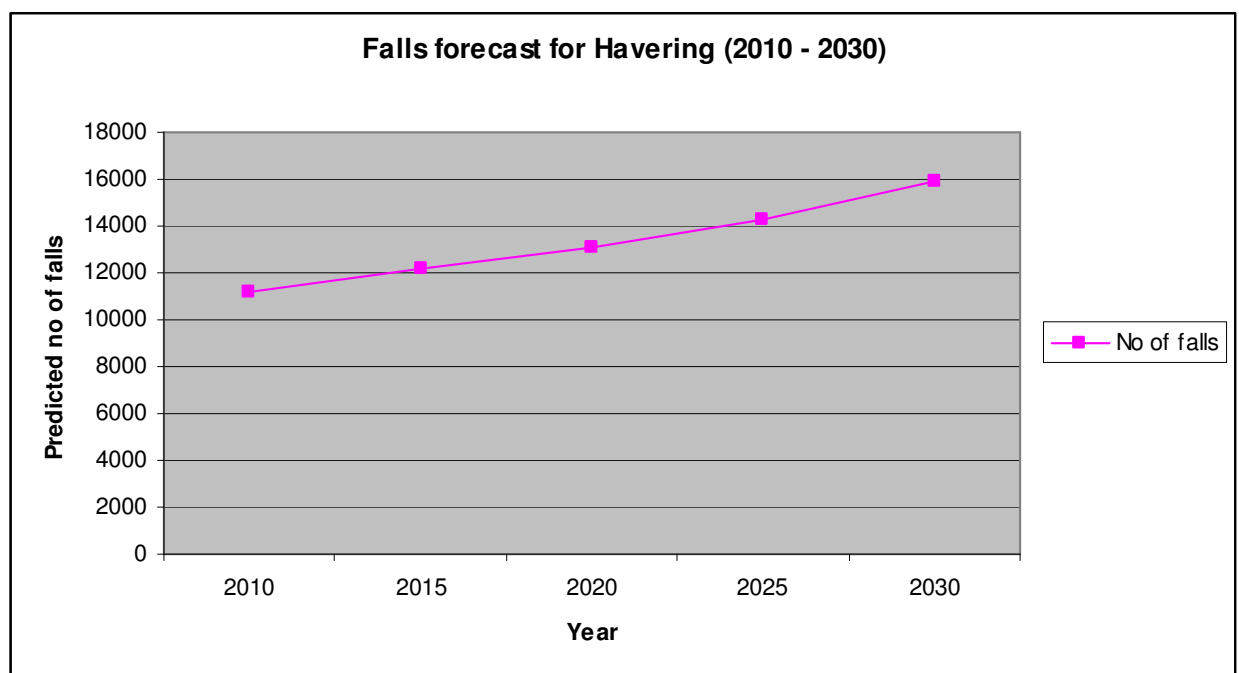
Commissioners to note

- Previous fall and limiting long term illness are risk factors for a fall, and living alone is one of the risk factors for serious injury or outcome following a fall. Health and social care therefore need to work closely in partnership, to ensure that preventive action is implemented to effect a reduction in risk for those older people living alone with a limiting long term condition who have a fall or are at risk of a fall.
- Osteoporosis is a condition that can be effectively managed with anti-resorptive drugs, and at less than the cost of managing a fracture. Available evidence is that a fracture liaison service and an osteoporosis service in primary care are cost effective means of managing osteoporosis.
- Fracture of the hip is associated with higher cost and mortality than fractures of other sites. Evidence base for hip fracture care shows that prompt effective multi-disciplinary management can improve quality and at the same time reduce costs. Commissioners therefore need to commission hip fracture care to the best quality standards as specified in the blue book. These standards reflect good practice at key stages of hip fracture care, and compliance with them would improve the quality and outcome of care and reduce costs. The Barking Havering and Redbridge Hospitals Trust Queens hospital was signed on to the National Hip Fracture Database (NHFD) which reports on hospital performance on the blue book standards, but at the time of carrying out this needs assessment, was not submitting sufficient data to be included in the 2010 NHFD report, (NHFD Report 2010).

7. Falls in Havering

Data on falls in Havering has been sourced from hospital admissions data. There were 1824 admissions for falls in Havering in 2009/10 and 1231 (67%) of these were admissions of people aged 65+. Around 11,190 pensioners (27%) in Havering are predicted to have a fall in 2010. This is just below the national rate of 30%.

Figure 7 falls forecast for Havering 2010 – 2030

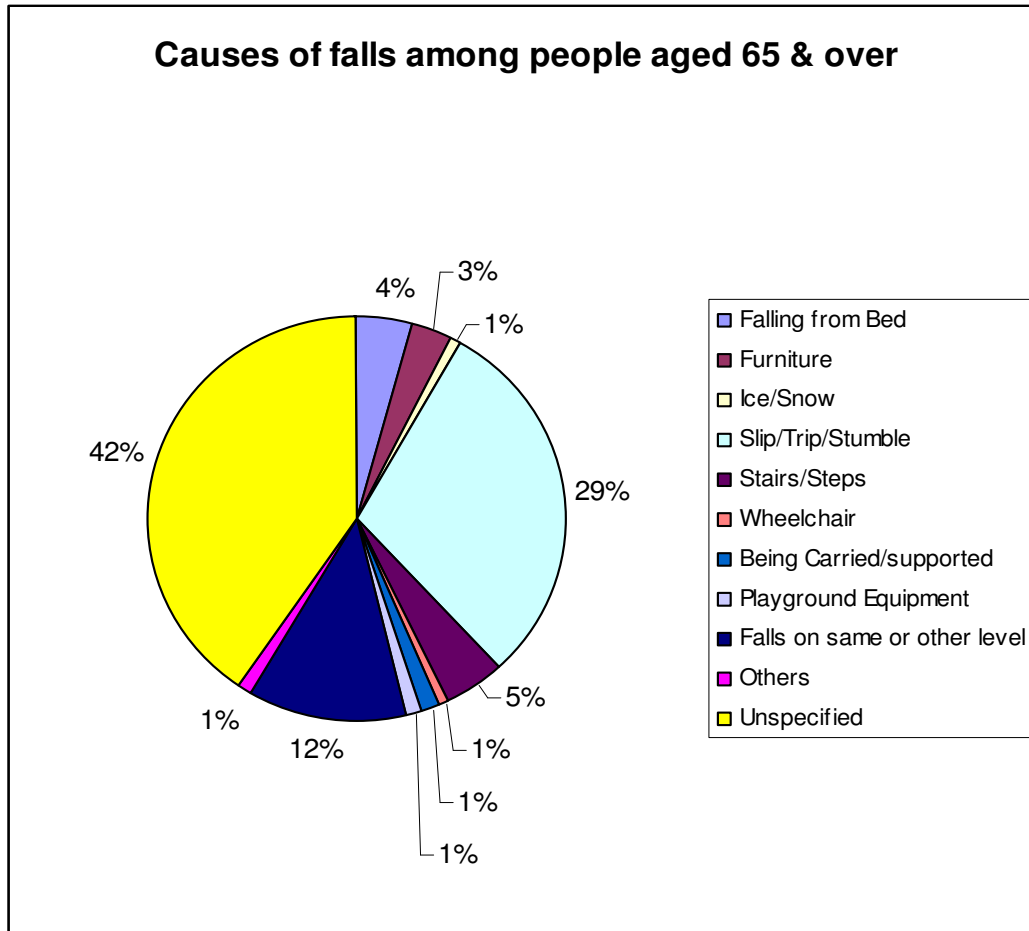


Source: POPPI, 2010

The falls forecast in figure 7 above is based on national figures for prevalence and number of falls in the last 12 months by age and sex, taken from Health Survey for England (2005). The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers predicted to have fallen at least once in the last 12 months, to 2030. The data indicates that without any intervention, there will be a continuous rise in falls in Havering, and it is expected that there will be an attendant increase in hospital admissions, and health and social care costs.

7.1 Why and where do people fall?

Figure 7.1a – Cause of fall for Havering Residents aged 65+
(based on hospital admissions data)



Source: SUS 2009/10; Others includes: Ladders, Buildings, Scaffolding, Collisions

The cause of falls for Havering residents aged 65+ was not specified in 42% of cases. This is the highest proportion for cause of falls, and could be as a result of any of the other specified causes. Slip/trip/stumble was the second highest cause of a fall, accounting for 29% of falls.

Place of fall for Havering Residents aged 65+

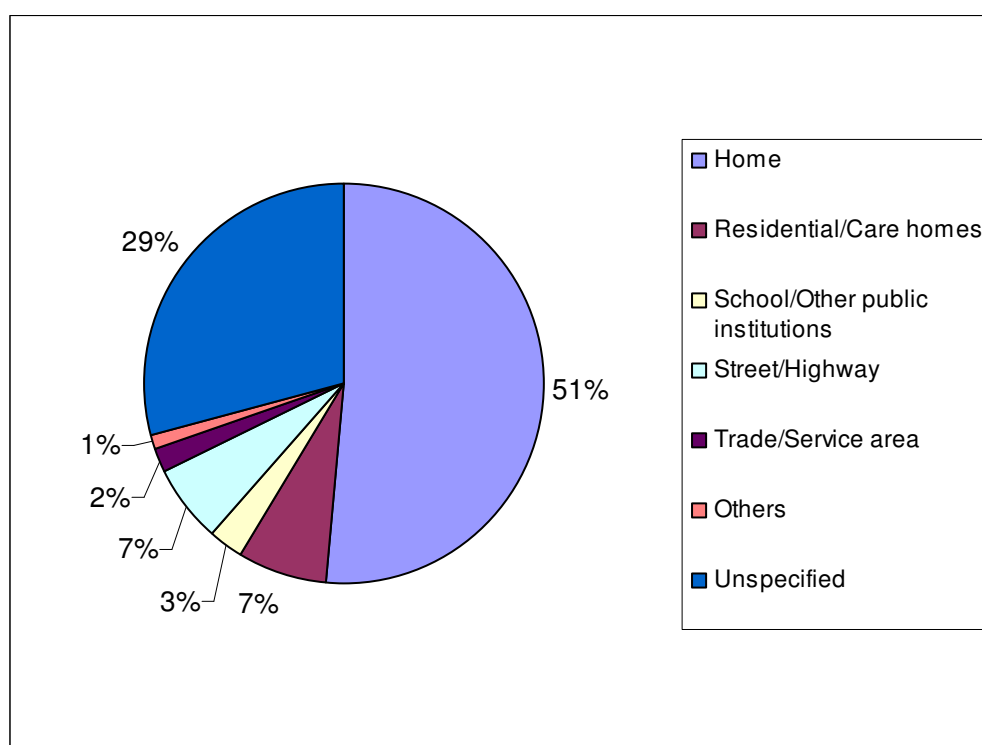
The home was the most common site of a fall in 2009/10, accounting for over half of all falls (51%). Information is however not available as to what percentage of these homes are council property, and what percentage are privately owned property. The standards for better homes survey identified that in Havering, 56%

of council properties do not reach Decent Homes Standard - the highest figure for any local authority in the UK³⁴. The standard comprises of four key components: Fitness for Habitation, Disrepair, Modern Facilities, and Reasonable Degree of Thermal Comfort. Pensioners who live in privately owned property have to fund the cost of repairs or adjustments to ensure there are no hazards in the home which could increase the risk of a fall. Any recourse to public funds for such adjustments, have to be means tested.

The place of fall was not specified in 29% of cases, however, this could be any of the other sites named by patients. The streets and highways accounted for 7% of falls, as did care and residential homes. The proportions for place of fall for all falls, is reflected in the place of fall for a slip/trip/stumble (table 7.1c).

Figure 7.1b – Havering – Place of fall – 2009/10

(based on hospital admissions data)



Source: SUS 2009/10

A breakdown of the place of occurrence for falls that occurred as a result of a slip/trip/stumble (the 2nd highest cause of a fall, indicates that the home (61%) is

the commonest place of occurrence of a slip or trip or stumble, streets/highways accounted for 10%, and residential/care homes accounted for 6% (table 7.1c).

Table 7.1c – Place of slip/trip/stumble (based on hospital admissions data)

Place of slip/trip/stumble	Percentage of total slip/trip/stumble
Home	61%
Unspecified	14%
Street/Highway	10%
Residential	6%
Trade/service	5%
Schools/Other public Institutions	2%
Others	2%
Total of slip/trip/stumble	100%

Source: SUS 2009/10

A breakdown of the place of fall for those falls for which the cause is unspecified, also indicates that the home is of great importance in the occurrence of a fall, as it is cited as the place of occurrence of almost 39% of the falls for which the cause is unspecified. Care/residential homes also accounted for almost 7% of the place of occurrence for falls due to an unspecified cause (table 7.1d).

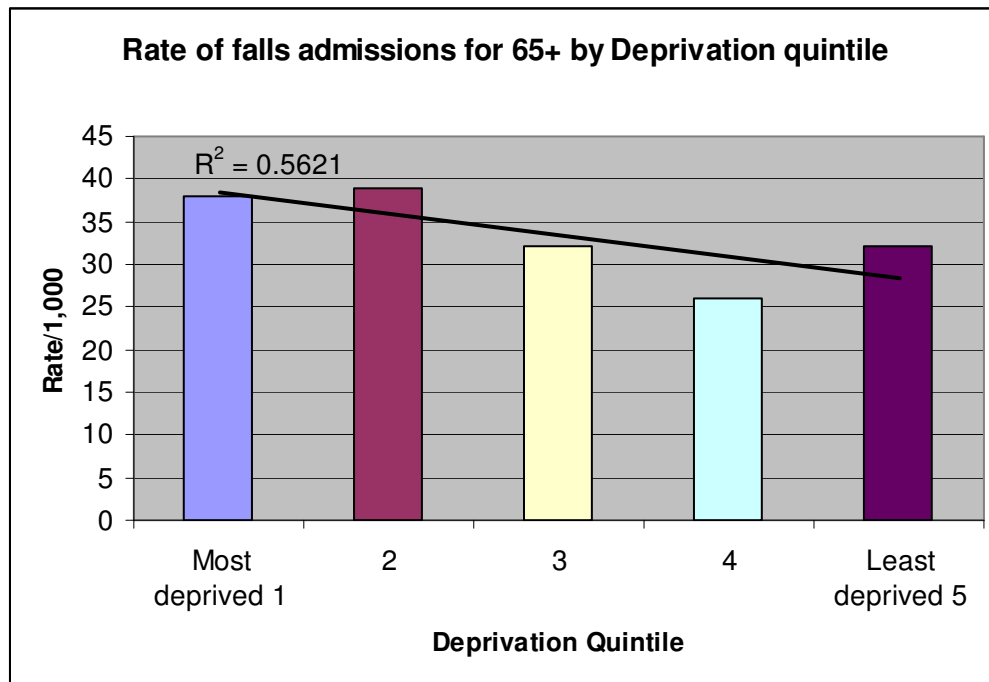
Table 7.1d: Place of fall where cause of fall was not specified

Place of fall	Number of falls	%
Home	193	38.6
Care/Residential Home	33	6.6
Street/Highway	13	2.6
School/Other Public Institution	10	2.0
Others*	7	1.4
Not Specified	244	48.8
Total	500	100

*Includes; Trade/Service area, Sports area, Beach, Camp site, Park (Source: SUS 2009/10)

Deprivation and Falls

Figure 7.1d Falls by Deprivation Quintile



Admissions data – SUS 2009/10, Ward profiles – GLA 2010, Deprivation – IMD 2007

The rate of falls admissions for over 65s in Havering are higher in the most deprived quintiles (1 & 2) as compared to the least deprived (4 & 5). However, the difference is not statistically significant.

Commissioners to note

There is growing evidence that investing in falls prevention services is cost effective. Havering with a rising older population needs to invest in falls prevention services, to ensure adequate intervention to stem the forecast rise in falls, and the attendant morbidity, mortality and health and social care costs.

7.2 Hospital Admissions

Admissions data was obtained from Secondary Uses Services (SUS). Admissions for falls was defined as admission for which a fall was cited as a secondary cause of admission. For fractures, only admissions for which the primary cause of admission was a fracture with a fall cited as a secondary cause, were included. Fractures which were cited as secondary to another cause of admission were not included, as the fracture might have been secondary to another cause e.g. road traffic accident, cancer etc, and not a fall.

Although falls can occur at any age, a fall is more likely to result in injury requiring hospital admission, in the older age group. This is reflected in the falls admission data for Havering. Nationally, About 45% of people aged 80 and over living in the community fall each year, of which 10-25% sustain a serious injury³. In Havering 9.4% of persons aged 80+ were admitted in hospital after falling in 2009/10. Havering falls data for 2009/10 also indicates that there were more admissions for women than for men.

Table 7.2.1 Falls Admission rates for Havering PCT residents 2009/10 (age, and gender).

Falls admission rates (per 1,000) by age group, gender and persons, 2009/10

Age group	Male	Female	Persons
0-49	3.8	1.7	2.7
50-64	4.0	4.7	4.3
65-74	8.7	11.5	10.2
75-84	28.2	41.2	35.9
85+	95.1	118.3	110.8
All ages	6.8	9.2	8

Source: SUS 2009/10

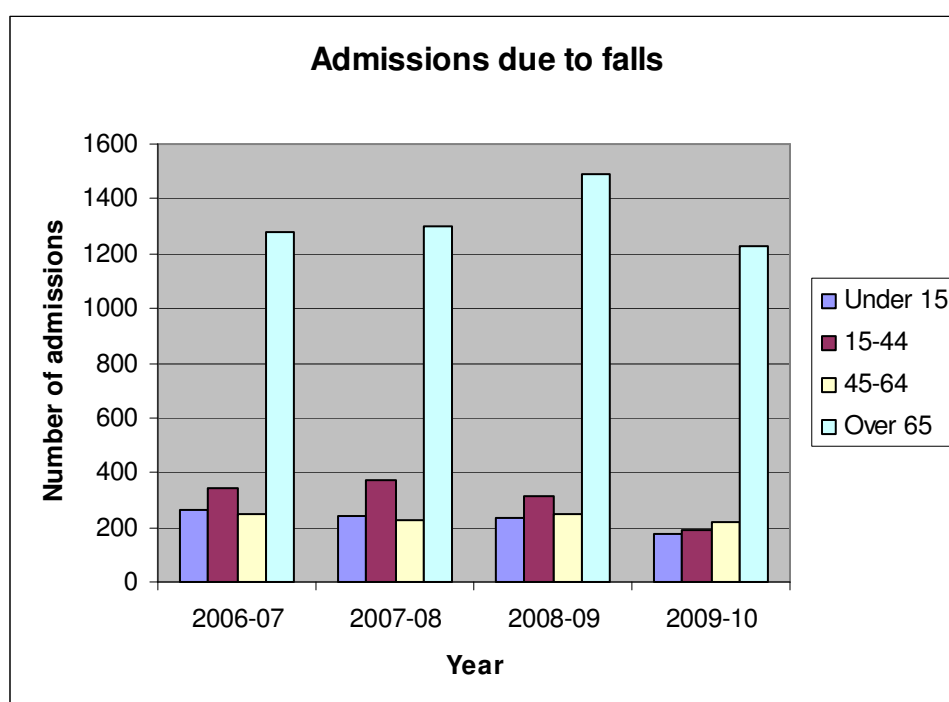
Trends in Total Falls Admissions

Table 7.2.2 below shows trends in total fall admissions over a four year period, by age group. Age groups below 65 have seen a fluctuation in number of admissions over the four year period, with a downward trend by the end of the four year period. For these age groups, the numbers admitted for falls by 2008/09, had gone below (or was at par with) the 2006/07 level. This decline was maintained in the 2009/10 data. In the over 65 years age group however, there was an increase in admission numbers over the period 2006/07 to 2008/09, with a decline in 2009/10, below the 2006/07 levels. Falls admissions in the over 65 age group accounts for the greatest percentage of admissions for falls in any year, rising from 60% in 2006/07 to 67% in 2009/10.

Table 7.2.2 All admissions with fall as external cause				
Age Group	2006-07	2007-08	2008-09	2009-10
Under 15	260	241	237	178
15-44	347	375	312	193
45-64	249	223	249	222
Over 65	1278	1302	1493	1231
Total Admissions	2134	2141	2291	1824
Percent over 65 years	60%	61%	65%	67%

Source: SUS 2009/10

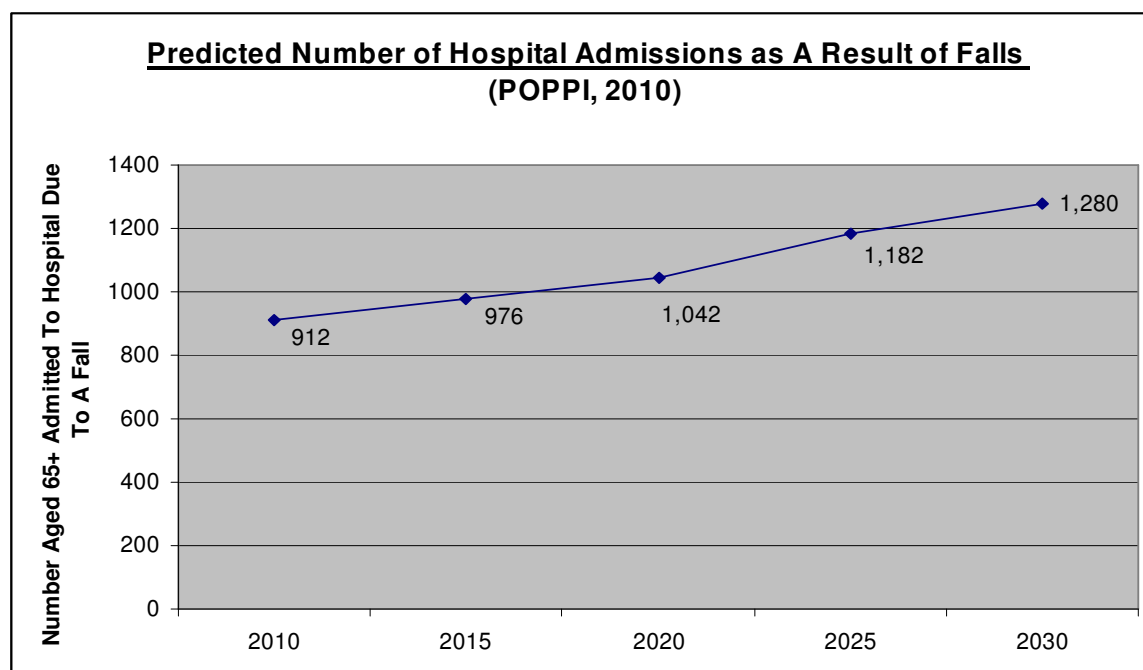
Figure 7.2.2 – All admissions with fall as external cause



Source: SUS 2009/10

It is expected that in 2010/11, around 8% (912) of falls in people aged 65+ years in Havering, will result in hospital admissions. Within this age group, those aged 75 and over are most likely to be admitted to hospital as a result of a fall. Although the prediction for admissions due to falls in 2010/11 is much lower than the number of admissions for 2009/10, it is expected that the number of older people admitted to hospital due to falls will increase in Havering in the future, as is the case nationally, increasing by 14% by 2020 (figure 7.2.3). This is not surprising, as the number of people in the 75+ age group is expected to rise, and unless initiatives for falls prevention are implemented, falls in this age group will rise. In 2009/10, there were 1231 hospital admissions for falls for people aged 65+ years⁸.

Figure 7.2.3 – Projection of hospital admissions as a result of falls (2010–2030)



Admissions data for people aged 65+ hospitalised as a result of a fall in 2009/10 indicates that length of stay in hospital following a fall ranged from less than 5 days to over one and half months. About 40% spent less than 5 days in hospital, 27% spent between 5 and 14 days and 11% spent more than 35 days (Table 7.2.4)

Table 7.2.4 Length of stay (LOS) for 65+ patients admitted with falls – 2009/10

Length of Stay	Number of cases	%
<5	495	40.2
5-14	335	27.2
15-24	181	14.7
25-34	89	7.2
35-44	48	3.9
45+	83	6.7
Total	1231	100.0

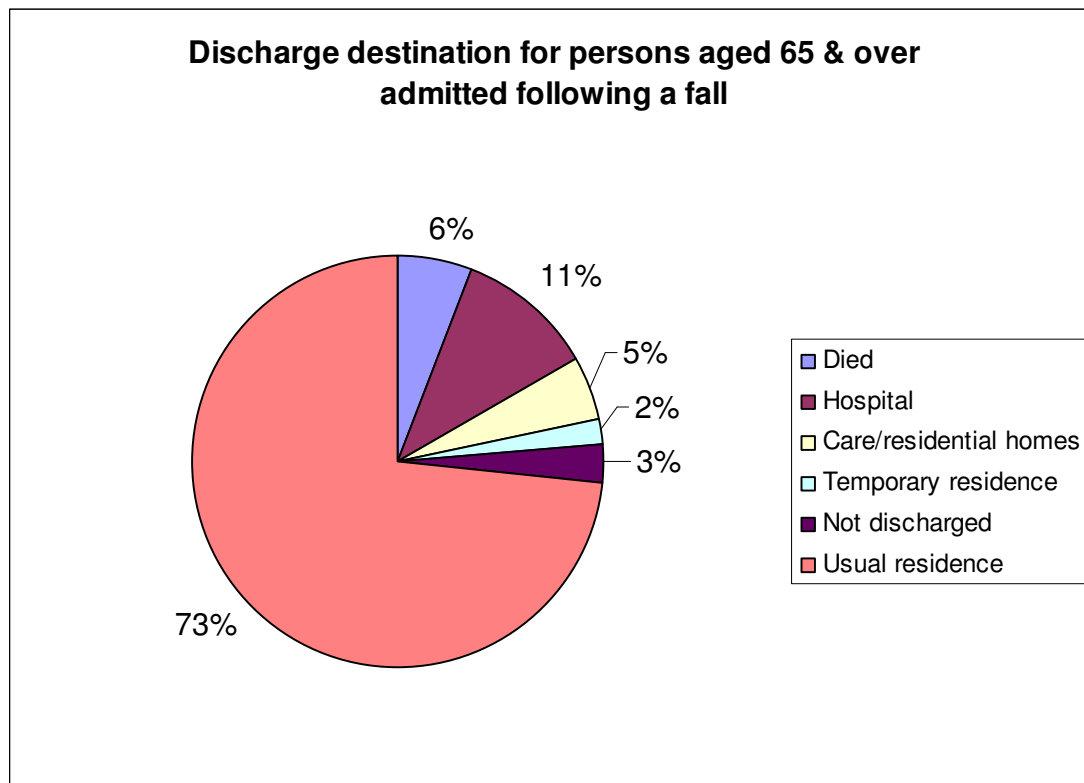
Source: SUS 2009/10

Discharge Destination

Discharge data for 2009/10 indicates that most of the patients admitted to hospital after a fall, were discharged to their usual place of residence. However almost 6% (74) of patients died in hospital, 11% (138) were discharged on to

another hospital e.g. community hospital for further care, and 5% (62) were discharged into care or residential homes.

Figure 7.2.5: Percentage of older people discharged to each possible destination after a fall.

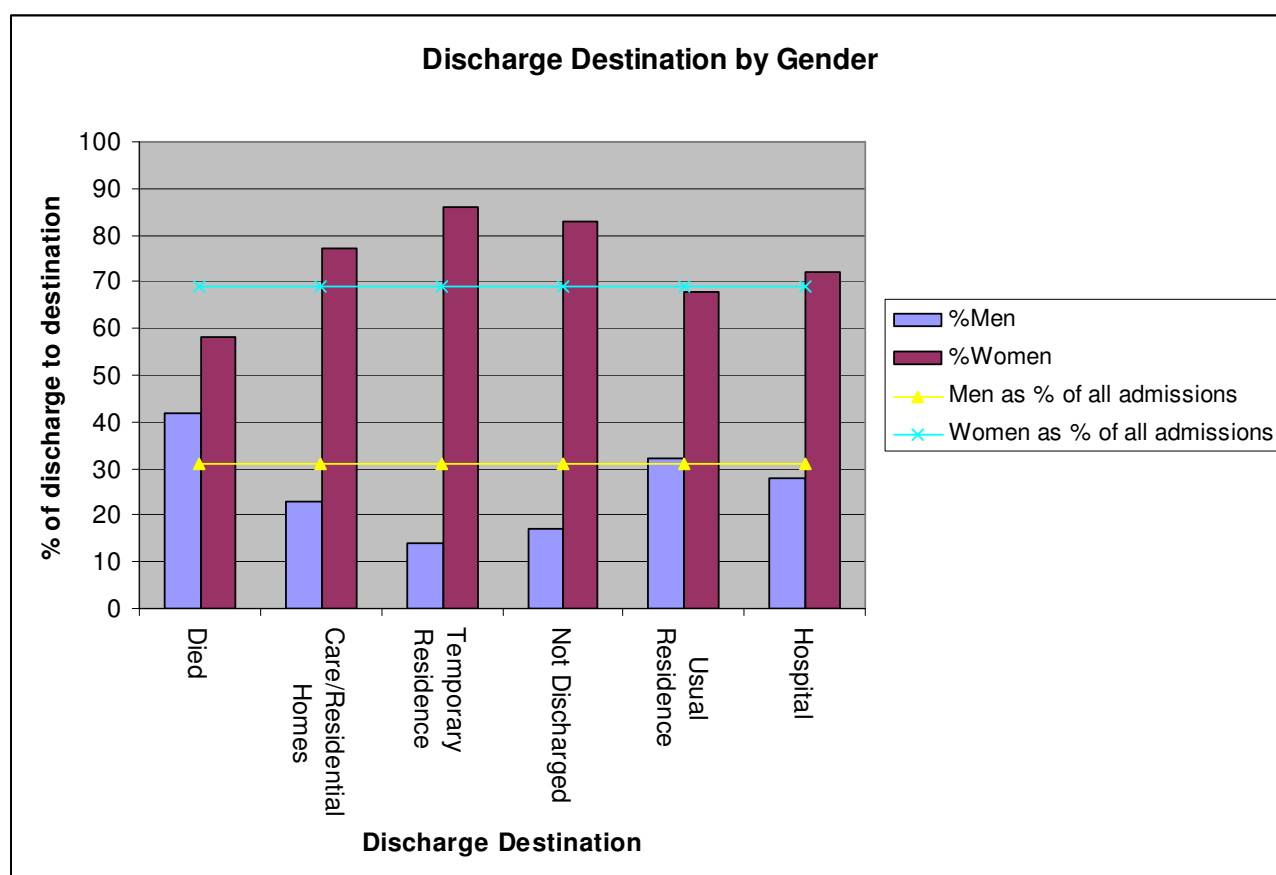


Source: SUS 2009/10

Discharge Destination by Gender

A breakdown of discharge destination for 2009/10 by gender (Figure 7.2.5b), indicates that there was a higher proportion of admissions for women (green line) than for men (blue line). Women were at least 2 times more likely than men to be admitted for a fall.

Table 7.2.5b – Discharge destination by gender (2009/10 Admissions data)

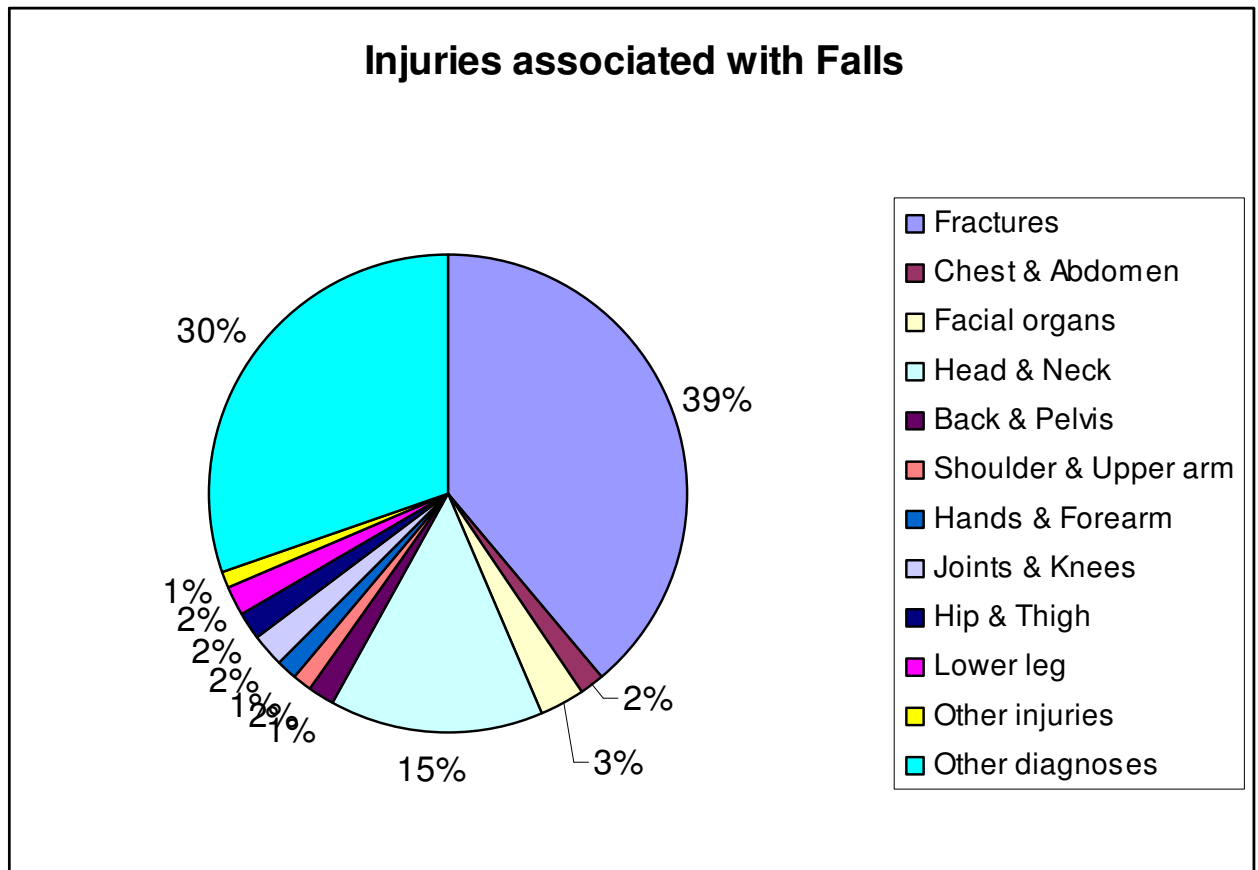


Source: SUS 2009/10

The proportion of deaths and discharge to usual residence was higher in men. The proportion of discharges to care/residential homes, temporary residence, not discharged or discharged to hospital was higher in women. Women were 3.4 times more likely to be discharged to a care/residential home than men, and men were 1.4 times more likely to die on admission.

7.3 Falls and Injury

Figure 7.3a: Injuries associated with falls (based on primary diagnosis) for over 65s admissions, 2009/10 in Havering



Source: SUS 2009/10

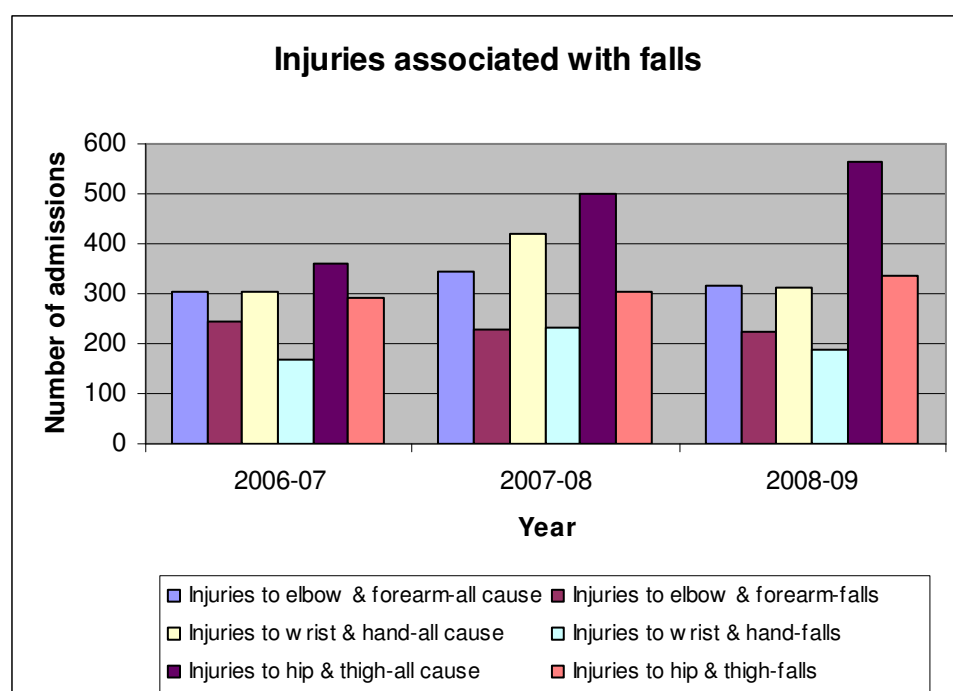
People aged 65+ were admitted for 1231 injuries as a result of falls in 2009/10. Fractures accounted for the highest number of injuries at 39% (479 fractures), followed by other injuries such as injuries to the head and neck which accounted for 15% of all injuries. A breakdown of the type of fracture (table 7.3b) indicates that the highest fracture incidence was fracture of the hip at 51.3% of total fractures due to a fall. Hip fracture is the most common serious injury related to falls in older people. It also accounts for approximately 20% of orthopaedic bed occupancy, by people aged 65+

Table 7.3b: Havering patients admitted with Fractures as a result of falls, 2009/10

	No of fractures	% of total fractures
Fracture Foot	0	0.0
Fracture Forearm	80	16.7
Fracture Hip	246	51.3
Fracture Humerus	34	7.0
Fracture Lower Leg	41	8.5
Fracture Ribs	10	2.0
Fracture Shoulder	8	1.7
Fracture Skull & Facial Bones	12	2.5
Fracture Spine	37	7.7
Fracture Wrist & Hand	10	2.0
Multiple Fractures Upper Limbs	1	0.2
Total	479	99.6%

Source: SUS 2009/10

Figure 7.3c Trends in Injuries as a result of falls, 2006-09



Source: SUS 2009/10

Injuries to hip and thigh are the major injuries associated with falls. There was an increase in these types of injuries from 2006/07 to 2008/09 as a result of falls, and from all causes. The rise in injuries as a result of falls was however not as steep as the rise in injuries from all causes.

7.4 Mortality from Falls

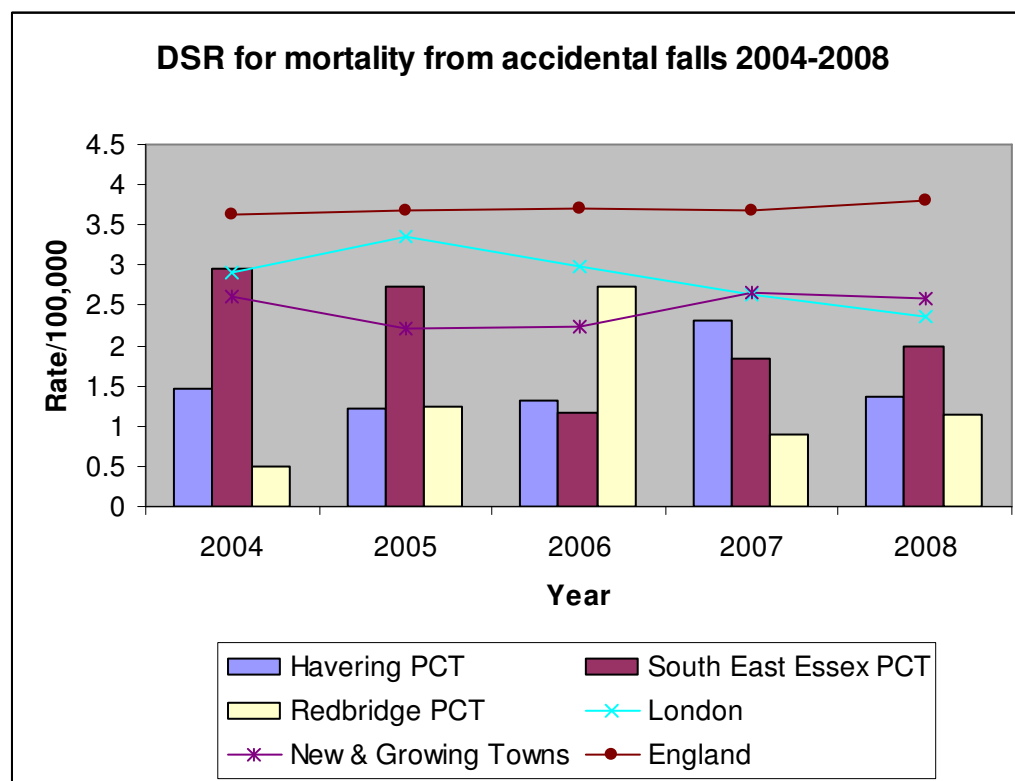
Directly Age Standardised Rates (DSR) for mortality from accidental falls (per 100,000 European Standard Population) for the period 2004-2008: Havering and other comparators

Table 7.4a Mortality from accidental falls 2004 – 2008 (DSR)

Area	2004	2005	2006	2007	2008
Havering	1.46	1.23	1.33	2.31	1.37
South East Essex PCT ¹	2.97	2.74	1.16	1.84	1.99
Redbridge PCT ¹	0.5	1.24	2.74	0.89	1.15
London	2.92	3.35	2.98	2.63	2.35
New & Growing Towns	2.62	2.21	2.24	2.65	2.59
England	3.64	3.69	3.71	3.68	3.81

1. Similar morbidity profile to Havering's Source: NCHOD

Figure 7.4a – Mortality from accidental falls 2004 – 2008 (DSR)



Source: NCHOD

Between 2004 and 2008, the mortality rate due to accidental falls in Havering remained consistently lower than that of London, New & Growing Towns and England. The rates remained stable at about 1.3 annually up to 2006 but rose significantly to over 2 in 2007. This rate was higher than that of other comparable PCTs (Redbridge & South East Essex). However, in 2008 there was a decrease to 1.4 which was lower than that of South East Essex but higher than Redbridge's.

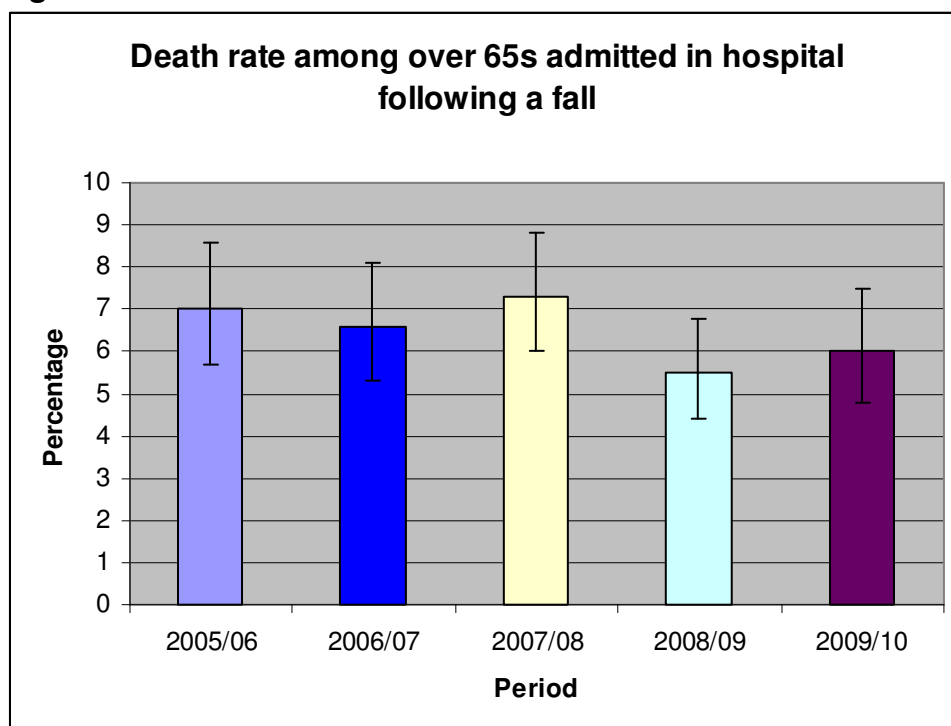
Table 7.4b shows number and proportion of deaths for over 65s in Havering admitted in hospital following a fall based on discharge destination as specified in Secondary User Service (SUS) datasets for the period 2005/06 to 2009/10. The death rate among over 65s admitted following a fall appears to have reduced slightly over the years from 7% in 2005/06 to 6% in 2009/10. However, across the five year period the differences were not statistically significant as indicated by overlapping confidence intervals (Figure 7.4b).

Table 7.4.b Number & proportion of over 65s in Havering who died after admission with fall as a secondary diagnosis: 2005/06 – 2009/10

Year	Number of Admissions	Number of deaths	%	95% Confidence Interval
2005/06	1168	82	7.0	5.7, 8.6
2006/07	1278	84	6.6	5.3, 8.1
2007/08	1302	95	7.3	6.0, 8.8
2008/09	1493	82	5.5	4.4, 6.8
2009/10	1231	74	6.0	4.8, 7.5

Source: SUS 2005/06 – 2009/10

Figure 7.4b



Source: SUS 2005/06 – 2009/10

7.5 Financial Impact

Hospital admissions costing is based on the main procedure or HRG^a. This means that the costs for hospital admissions related to falls would be based on the main health condition associated with the fall (e.g. fracture), as a fall in itself is not a health condition. The cost of hospital admissions related to falls in people aged 65+ in Havering in 2009/10 was approximately £4,766,903, and the cost of the community falls service at St George's hospital was £76K.

Primary care prescribing costs for osteoporosis drugs and calcium supplements from 2007/08 to 2009/10 was £1,767,995. It has not been possible to identify the health condition nor the age group for which the prescription costs for the drugs were incurred; however the costs for children are likely to be very small. There was an increase in volume of prescription of osteoporosis drugs from 2007/08, rising from 36,818 in 2007/08 to 43,180 in 2008/09 and 47,883 in 2009/10.

There is no data on cost of falls to social services, however it is estimated that the 62 people discharged from hospital to care/residential homes in 2009/10 as a result of injuries sustained from a fall, resulted in a cost of £1.6m to social services.

The cost of minor adaptations and equipment below £1K was £416,549 and £821,242 was approved as disability funding grant for adaptations in owner occupied or private rented accommodation. It has however not been possible to identify how much of this cost is as a result of falls.

^aAn HRG is essentially a casemix grouping. Different patient treatments within a cluster of both diagnosis and procedure which are deemed to have consumed the same level of resources are assigned to an HRG. Prices in the national tariff have been set on the basis of the average (mean) cost of providing a particular procedure, using data gathered from all NHS hospitals. They include non-clinical costs such as food, cleaning and estate costs. The price for a particular procedure in the tariff is called the reference cost.

8. Current Service Provision

The findings from the audit conducted by the Health Care Commission (now known as Care Quality Commission - CQC) in 2008/09 are that there are gaps in falls prevention and bone health services for Havering and there is no Integrated falls prevention and bone health strategy to ensure that these services are developed. It also identifies that commissioners and providers do not have the information required to inform these decisions. The responses to the 2009/10 audit (appendix 13.2) indicate that there is not much of a change from the 2008/09 findings. This needs assessment provides much needed information to enable services to be developed and existing services adequately resourced.

8.1 Falls Service

A falls service made up of a multidisciplinary team of 0.1WTE consultant, 0.2WTE associate doctor, 1WTE band 7 physiotherapist (specialist in falls), 1WTE rehabilitation assistant, 1WTE band 7 occupational therapist, 1WTE band 4 rehabilitation assistant and a band 3 occupational therapy assistant is operated from the day hospital at St George's Hospital. The service provides a range of intensive prevention and evidence based exercise programmes based on OTAGO (a programme designed specifically to prevent falls, and which consists of a set of leg muscle strengthening, balance retraining exercises and a walking plan), and delivered on a one to one basis. The waiting list for this service is 8 – 10 weeks.

Referral to this service is from the GP, district nurse, acute trust, care home manager, Social services or other healthcare professionals. Patients are provided with a management plan, and referred as appropriate (table 8). The care pathway for the service is attached as appendix 13.2.

Table 8 – Onward referrals from Havering falls service

Service	No of patients seen or referred
Physiotherapy	Physiotherapy carried out by falls team. About 300 new patients were seen in 2009/10.
Home treatment plan	All patients get a home treatment plan
Exercise programme delivered by leisure services	This service is not available
Other multidisciplinary referrals e.g.	This data is not available
Referral to osteoporosis clinics	This data is not available
Referrals for DEXA Scan	Approximately 30 referrals a month
Provision of equipment e.g. (give e.g. of type of equipment)	This data is not available
Orthotics/prosthetics	This data is not available
Other referrals e.g. for medical conditions	Patients are sometimes referred on to cardiology, dietitians, continence services and GPs – Data on exact number of referrals is not available
Total number of patients seen by the falls service	453 people accessed the service in 2009/10, but this figure has now increased and is continuing to do so.

The service through the occupational therapist carries out a full home and functional assessment, cognitive test and confidence test. It also runs a handy man scheme for rails and works with social services to organise care packages and carry out telecare assessments, however the service does not carry out any prevention activities, and does not work with care/nursing homes. The service also carries out edge contrast eye tests, however acuity tests are not delivered by this service, and there is no referral system for sending patients to the optician.

8.2 GP Services

There are 52 GP practices in Havering, and 42 of these practices are signed on to the osteoporosis DES (direct enhanced service). The aim of the DES is to encourage practices to confirm the diagnosis and prescribe the appropriate pharmacological secondary prevention in women aged 65+ with osteoporosis. There are 3 criteria upon which payment is made, and these are:

1. the proportion of women aged between 65 and 74 years with a history of fragility fracture in the previous 12 months who have had a diagnosis of osteoporosis confirmed by a DEXA scan
2. the proportion of women aged between 65 and 74 with a positive diagnosis of osteoporosis confirmed by a DEXA scan (i.e. criterion 1) who are receiving treatment
3. the proportion of women aged 75 and over with a history of fragility fracture in the previous 12 months who are receiving treatment with a bone-sparing agent.

Payment is a fixed payment which is based on lower and upper thresholds of achievement of the criteria. This means that there is a risk of variation between GP practices, in implementation of this DES, as well as a risk of widening health inequalities, as there is currently no provision for eligible patients on the registers of the 10 GP practices who are not signed on to the DES. The number of women on the registers of the 10 GPs who may be eligible for this DES, is 2,721, constituting almost 11% of the total number of women who may be eligible for the DES in Havering. Of the 42 GPs who are signed on to the DES, 21, have not yet begun implementing the DES, so eligible women on the registers of these GPs are also not benefiting from treatment. Between April 2008 to April 2010, 61 women aged 65 – 74 years were identified with a history of fragility fracture, and 45 of them (74%) were referred for a DEXA scan. Of those referred for a DEXA scan, 34 were confirmed with a diagnosis of osteoporosis, and 29 (85%) of them were prescribed treatment. For women aged 75+, 130 of them were identified with a history of fragility fracture in the previous 12 months, and 103 (79%) of them were prescribed treatment.

There has been a steady increase in the volume of osteoporosis drugs prescribed from 2007 rising from 36,818 items in 2007 to 43,180 in 2008/09, and 47,883 in 2009/10.

8.3 Fracture Liaison Service

There is a fracture liaison service based at the acute trust Queen's hospital, staffed by a 0.8WTE fracture liaison/osteoporosis nurse specialist, and supported by a rheumatology consultant as necessary. The service delivers care to patients aged 50+ years, from 3 ONEL PCT areas (Barking and Dagenham, Havering and Redbridge) as well as occasional South West Essex patients. The service is based on national guidance for best practice, and although should ideally attend to patients over the age of 50 who have had a fragility fracture, the service due to work load, currently assesses only patients with specific fracture types (wrist, shoulder, hip and spine fractures). Each patient is evaluated for future risks of osteoporosis, falls and further fracture.

Referral to this service is from all wards/departments (A&E fracture clinics) in the hospital, GPs, and other healthcare professionals. First contact with patients is via a telephone review during which in addition to osteoporosis assessment, patients over 65 are given a falls review and based on the responses, such patients are referred to the falls clinic corresponding to the area in which the patient lives. Patients are reviewed for clinical risk factors and if a DEXA scan is needed, the patient is referred for the scan. Patients are given the result of the DEXA scan and given explanations of future fracture risk and lifestyle advice to promote bone health. Patients are also given appropriate written information on falls prevention, osteoporosis and treatment. There were 810 referrals to the service between January 2010 and December 2010. There are approximately 30 referrals a month from the falls service, for DEXA scans.

The clinic is run as a one-stop shop, but there is help line support for patients who require further help/support. Onward referrals from this service is to the GP who is informed of the patients results and further recommendations for

management, or to the falls service for patients over 65 at risk of falls (after a falls risk screen).

FALLS RISK SCREEN	
1. One or more falls in past year?	Yes/No
2. More than 4 prescribed medications?	Yes/No
3. Diagnosis of stroke or Parkinson's disease	Yes/No
4. Problems with balance?	Yes/No
5. Unable to rise from knee-height chair without using arms?	Yes/No
If YES to two or more of the above refer to Falls clinic (Referral forms available in clinic)	

Inpatients aged 75+ with hip fracture are treated without further assessment (NICE guideline), however the service is not available to inpatients aged 50+ with any fracture who should be assessed, and patients aged 50 – 75 years with hip fractures, who should be seen by the service.

In addition to the fracture liaison service, the COPE team (Community Orthopaedics Project in Essex team) also works from the acute trust. It is a multi-disciplinary specialist orthopaedic team that supports early discharge and rehabilitation in the patient's home environment. Patients with hip fracture are discharged with the support of the COPE team which carries out an assessment of the patient's home and assesses the ability of the patient to cope at home in liaison with ward inpatient therapists. COPE nurses and physiotherapists continue rehabilitation, nursing and physiotherapy treatment of the patient at home and if the patient needs further long- term rehabilitation (beyond approximately 6 weeks), will refer on to other community services as appropriate. The team does not usually work with care/residential homes as the home will usually have their own rehabilitation service, however, the team will work with a home if the patient would benefit from specialised multi- disciplinary orthopaedic input.

8.4 Social Care Services

Falls are a key event in provoking a change in an individual's social care needs, and someone who has had a fall whether or not they receive inpatient treatment is more likely to need social care intervention. A fall can precipitate admission to long-term care and after an osteoporotic fracture, 50% can no longer live independently. Even in the absence of a fall, the fear of falling in old age limits activity and increases the risk of admission to care. A prevented fall, therefore avoids a cost to social care.

Social services provides an alarm call system for older people who are at risk, so that if they have a fall they are able to use the alarm system to summon help. There is however no falls management plan to prevent a second fall for people on the system. In 2009/10, there were 2,828 people on the alarm call system, and 895 (32%) of them had a fall.

In Havering, the social care occupational therapy (OT) team work with the hospital discharge team to assess the needs of the person who has had a fall and is being discharged from hospital. Required equipment e.g. grab rails, stair lifts are provided to the individual, and this is reviewed from time to time. Equipment below £1K is funded out of the occupational therapy budget. In addition, the home environment of the individual is assessed, and an adaptation plan is developed to suit individual need. These plans are funded to a maximum of £30K for individuals in council owned property, and for people in privately owned homes, an application is made for a means tested disability funding grant (DFG) also to a maximum of £30K to fund the adaptations.

Cost of all the minor adaptations and equipment (equipment below £1K) rose from £445,797 in 2007/08 to £473,412 in 2008/09, but fell in 2009/10 to £416,549. Adaptations over £1K in owner occupied and private rented accommodation approved through grant (DFGs) cost £959,034 in 2007/08, reduced to £838,972 in 2008/09, and further reduced to £821,242 in 2009/10. It has not been possible to identify how many of these equipment/adaptations and how much of the cost, is as a result of a fall.

The reablement team assess the needs of individuals, and develop a care package for each individual, which would include provision of any aids required. In 2009/10, 1500 people received reablement services, but, it is not possible to obtain a breakdown of ages and the numbers who went through reablement as a result of a fall. The majority of people accessing reablement services are however, over 65 years. Anecdotally, it is estimated that about 27% of patients on reablement do not reach the end of the pathway as they fall and end up in acute care.

For residents living in residential/care homes, if the individual is a social care service user, they are subject to periodic reviews from care assessors. If a fall occurs and as a result of that the person ends in hospital, the care assessor would review the service user and would also make an assessment of the risk involved should the resident return to the same home.

Care and Nursing Homes

One of the recommendations in the NSF for older people standard 6 for falls, is that falls in service settings (hospital and residential care or nursing care homes) should be recorded on registers. A survey of the 38 nursing and residential care homes providing care for people aged 65+ indicated that although they all have incident forms and when a resident has a fall the incident is recorded, only 13 (34%) of the homes, have an actual falls register.

8.5 Ambulance Services

London Ambulance Service (LAS) provides ambulance services for Havering patients after a fall. The service either conveys the patient to A & E, or where the fall is uncomplicated and non-injurious, the patient is referred to the Havering Rapid Response Team which is a nurse/emergency care practitioner led team which aims to reduce unnecessary admissions to hospital, providing multidisciplinary assessment in the patients home within four hours of referral.

Falls patients accepted by the Rapid Response team include those patients who have had an uncomplicated non-injurious fall, and meet the following criteria:

- Mechanical fall or fall related to medication compliance
- No evidence of fracture or any other serious injury
- Normal vital signs.

Data from the service records falls as an incident type only from September 2010. Between September and November 2010, there were 1032 ambulance callouts for falls, and 776 (75%) of these were conveyed. The LAS contract is a block contract and not at HRG level, however, the cost of an incident is £241.

Although the age group for which ambulance callouts for falls were made is not recorded, it is reasonable based on hospital admissions data (table 7.2.2), to assume that at least 60% of the conveyed calls, were for people aged 65+ years.

Month	No of callouts	Conveyed (All)	Conveyed (Estimate for people aged 65+)	Non conveyed (All)	Non-conveyed (Estimate for people aged 65+)
September	358	280 (78%)	168	78 (22%)	47
October	355	254 (72%)	152	101 (28%)	61
November	319	242 (76%)	145	77 (24%)	46
Total	1032	776 (75%)	465	256 (25%)	154

9. Key Findings from this Needs Assessment

- i. Havering population is an older population and has a high proportion of the risk factors for falls and injury from falls.
- ii. The number of falls in older people in Havering is projected to increase, rising to over 12,000 by 2015, and with a proportionate increase in admissions.
- iii. The falls service commissioned in the community delivers evidence based falls prevention service, where patients receive a full in-depth assessment.
- iv. The falls service commissioned in the community:
 - a. Currently does not run any primary prevention services, and there are no falls specific exercise programmes in the community, for patients.
 - b. Does not work with care/nursing homes to assess general risk of falls and advice on improvements to minimise risk.
 - c. Not all patients who are entitled to the service are currently receiving it, due to poor referral into the service. There is a need to ensure an effective referral pathway is implemented.
- v. About 80% of GPs are signed on to the osteoporosis DES.
- vi. About 1 in 10 women, who may be eligible for secondary prevention of osteoporosis via the osteoporosis DES, are not receiving this intervention.
- vii. The fracture liaison service provided by the acute trust is short staffed (0.8WTE specialist nurse to 3 PCT areas), so is unable to deliver the full complement of services e.g.
 - Service should assess all patients 50+ who have had a fragility fracture, however, this is currently reduced to assessment of patients who have had specific fracture types

- Service is not available to all in-patients (only to those aged 75+ with a hip fracture, who are treated based on NICE guidance).
 - The service should run a telephone clinic 4 months after the start of osteoporosis treatment to ensure medication compliance and find out about further falls, however this is not happening.
- viii. The alarm call system provided by social services ensures that help can be summoned quickly if an older person at risk has a fall.
- ix. Although there is evidence that multi-disciplinary, multi-factorial assessments, screening and interventions programmes have a significant impact on reducing falls, there is no evidence that health social care and other agencies are working together to deliver seamless falls prevention in Havering. Care of the patient appears fragmented.
- x. London Ambulance service which provides ambulance service for Havering has developed a care pathway for uncomplicated non-injurious falls. This pathway needs to be aligned with the Havering whole system falls pathway when it is developed, to ensure that such patients receive comprehensive management to prevent further falls.
- xi. There is a need to ensure that the wider environmental dimension (streets/pavements, lighting, housing etc) is considered in developing a strategy for falls, and that town planners, architects, housing and environment take account of the risk of falls to older people, in design and planning.
- xii. There is data on service provision and cost of service provision by the falls clinic, the fracture clinic and social services, however it has not been possible to identify the social services care services and costs which have occurred as a result of a fall.

- xiii. The expected large future increase in the number of older people in Havering, and the expected increased numbers of older people experiencing health issues (including risk factors for falls and health issues as a result of falls) is likely to place hugely increased demands on health and social care services.

10. Guidelines for Falls Prevention/Evidence Based Interventions^{2,4}

At least 15% of falls in older people can be prevented through preventive strategies such as case/risk identification, risk assessment and multi-factorial interventions⁵.

Standard six of the NSF for older people focuses on primary and secondary prevention of falls, stating that:

- The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people.
- Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialist falls service.

Key interventions outlined in the NSF are:

1. Prevention including the prevention and treatment of osteoporosis – prevention should have:
 - i. population approach, which includes actions to encourage appropriate weight-bearing and strength enhancing physical activity, promote health eating and reduce smoking in the general population, and should also include action to ensure pavements are kept clear and in good repair, with adequate street lighting, as well as making property safer, and information leaflets on avoiding falls.
 - ii. Prevention in individuals which depends on identifying those most at risk of falling and co-ordinating appropriate preventive action. This would involve referral of older people who fall to a specialist falls service, where a specialist assessment would be carried out by the falls service in collaboration with primary and social care professionals, and building on the single assessment process. Interventions should be agreed with the older person who has fallen.
 - iii. Residential care or nursing care homes – falls in these settings should be recorded on registers, and should be followed by critical incident analysis, to develop an awareness and learning culture.

- iv. Strategies to prevent osteoporosis, based on selective case finding, whereby people are identified for intervention because of fragility fracture or the presence of strong risk factors. Evidence suggests that intervention should focus on people with multiple risk factors. People at risk should also be offered life style advice to reduce the risks of osteoporosis.
2. Improving the diagnosis, care and treatment of those who have fallen –
- i. GPs should take responsibility for assessing risk of osteoporosis and identifying those who need prevention or treatment. GPs should also determine the referral pathway for the patient (the falls service for assessment, hospital for treatment of specific injuries, or intermediate care for assessment and rehabilitation).
 - ii. Older people taken to hospital after a fall should be assessed for injury and care need. Where there is a high risk of osteoporotic fracture, the older person should be referred for a DEXA scan. Where admission is not required, the older person should be discharged home with adequate support.
3. Rehabilitation and long term support – the aim of rehabilitation is to maximise an older person's independence and enable them to carry out their normal activities of daily living and social participation. The older person who has had a fall may require longer term support, and care practices should not aim to restrict mobility, but explore how older people can manage safely in their own home, or in a residential or nursing home. Longer term social and emotional support may also be required to minimise any loss of independence caused by the effects of the fall.

NICE in the clinical guideline on the assessment and prevention of falls in older people⁴ recommends five key priorities for implementation:

- 1. Case/risk identification – older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and the frequency, context and characteristic of the fall(s).

Those reporting a fall or considered at risk should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.

- A previous fall is the most frequently reported risk factor in prospective cohort studies, suggesting that an older person with a history of falling would be at high risk of a subsequent fall. Ten studies reported falls history as statistically significant, among community dwelling older people and among residents of extended care facilities.
- Mobility impairment, gait disorders and balance deficits have frequently been reported as significant risk factors in prospective cohort studies. Intervention trials focusing on gait and balance have shown a reduction in falls.

2. Multifactorial falls risk assessment – 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 risk assessment performed by healthcare professionals with appropriate skills and experience in the setting of a specialist falls service, and as part of an individualised multifactorial intervention.

Multifactorial assessment may include the following:

- Identification of falls history
- Assessment of gait, balance and mobility and muscle weakness
- Assessment of osteoporosis risk
- Assessment of the older person's perceived functional ability and fear relating to falling
- Assessment of visual impairment
- Assessment of cognitive impairment and neurological examination
- Assessment of urinary incontinence
- Assessment of home hazards
- Cardiovascular examination and medication review

Many individual risk factors have been proven to be predictive of a subsequent fall; therefore presence of more than one risk factor, increases the risk of falling.

3. Multifactorial interventions – Multifactorial assessment is an important process, but must be linked to interventions. Evidence suggests that multifactorial interventions targeted to risk factors are effective in reducing falls in older people. However it is difficult to make a definite recommendation of the key effective components for specific settings and populations. It is sensible therefore to refer a patient for intervention(s) that target known risk factors.
- All older people with recurrent falls or at increased risk of falling should be considered for an individualised multifactorial intervention. In successful multifactorial intervention programmes, the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):
 - i. Strength and balance training
 - ii. Home hazard assessment and intervention
 - iii. Vision assessment and referral
 - iv. Medication review with modification/withdrawal
 - Older people who have been treated for an injurious fall should be offered a multidisciplinary assessment and individualised intervention to identify and address future risk and individualised intervention, aimed at promoting independence and improving physical and psychological function. Multidisciplinary, multifactorial, tailored interventions are effective in reducing falls in the following population groups and settings:
 - i. Community dwelling older people
 - ii. Older people in extended care settings
 - iii. Older people presenting at A&E following a fall.
 - Encouraging the participation of older people in falls prevention programmes including education and information giving – Individuals at risk of falling and their carers should be offered information orally and in writing about what measures they can take to prevent further falls.

4. 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.

10.1 Specific Interventions

1. Strength and balance training:

- A programme of muscle strengthening and balance training, individually prescribed at home by a trained health care professional is effective in reducing falls. Those most likely to benefit are older community dwelling people with a history of recurrent falls and/or balance and gait deficit. A muscle strengthening and balance programme should be offered, and this should be individually prescribed and monitored by an appropriately trained professional.
- A 15 – week Tai Chi group exercise intervention is likely to be beneficial.
- Exercise in extended care settings: There is insufficient evidence to recommend exercise as a single intervention in extended care settings, however, multifactorial interventions with an exercise component are recommended for older people in extended care settings who are at risk of falling.

2. 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 health care professional. Normally this should be part of discharge planning and carried out within a timescale agreed by the patient or carer, and appropriate members of the health care team. Evidence for the effectiveness of home hazard management in people with a history of falling is strengthened by new data from the updated Cochrane review.

- Home hazard assessment is shown to be effective only in conjunction with follow-up and intervention, not in isolation.

- Home safety interventions/home hazard modifications have been shown to reduce the incidence of falls, especially in older people with a history of falling (pooled results from four trials).
 - There is no evidence for the effectiveness of home hazard modification in those without a history of falls in the previous year before enrolment (one trial, non-significant).
3. Psychotropic medications and medication review: Older people on psychotropic medications (medications which are capable of affecting the mind, emotions and behaviour; examples are anti-depressants, and sedatives) should have their medication reviewed, with specialist input if appropriate, and discontinued if possible to reduce their risk of falling. One trial of older people above 65 years suggests that a psychotropic medication withdrawal programme, involving a gradual withdrawal of psychotropic medication over a 14 week period, is effective in reducing the risk of falls. In addition to the evidence for psychotropic medication review, polypharmacy was identified as a risk factor for falling and medication review should be part of a multifactorial assessment.
- Cardiac pacing – cardiac pacing should be considered for older people with cardioinhibitory carotid sinus hypersensitivity who have experienced unexplained falls – a cardiovascular assessment should be carried out as part of a multifactorial assessment where appropriate.
4. Encouraging participation of older people in falls prevention programmes
- Individually tailored interventions delivered by a health professional are more effective than standard or group delivered programmes.
 - There should be more emphasis on finding out what characteristics a person is willing to modify and what changes they are prepared to make at what stage in their lives.
 - The following factors are associated with activity avoidance: increasing age, being female, increasing anticipation of loss of function, not facing up to the risk of falling, lack of perceived ability, fear of falling and fear of exertion.

- Falls prevention programmes that address self-efficacy and encourage activity change may result in increased uptake.
 - Barriers need to be addressed prior to participation in a falls prevention programme to ensure commitment to the strategies.
5. Education and information giving: research commissioned by Help the Aged, which draws on feedback from older people through falls prevention focus groups, has found that the key messages to maximise the impact of lifestyle advice relevant to preventing falls are:
- Focus on improving strength and balance, not falls.
 - Encourage people to personally choose the advice and activities that suit them.
 - Don't focus on avoiding 'hazards' or physical restriction such as wearing hip protectors – this is perceived as overbearing.

NICE does not recommend the following interventions either because they have not been found to be effective, or because of insufficient evidence to determine their efficacy:

- Brisk walking – there is no evidence that brisk walking reduces the risk of falling. One trial showed that an unsupervised brisk walking programme increased the risk of falling in post-menopausal women with an upper limb fracture in the previous year. However, there may be other benefits of brisk walking in older people.
- Low intensity exercise combined with incontinence programmes – there is no evidence that low intensity exercise interventions, combined with continence promotion programmes, reduces the incidence of falls in older people in extended care settings (one trial, non-significant)
- Group exercise (untargeted) – exercise in groups should not be discouraged as a means of health promotion, but there is little evidence that exercise interventions that were not individually prescribed for community dwelling older people are effective in falls prevention. The evidence for effectiveness of group exercise

interventions remains limited, apart from the Tai Chi intervention of Wolf (1996) and Day (2002).

- Cognitive/behavioural interventions – There is no evidence of effect that cognitive/behavioural interventions alone reduce the incidence of falls in community dwelling older people of unknown risk status (two single trials, non-significant). Such interventions have included risk assessment with feedback and counselling and individual education discussions.
 - There is no evidence that complex interventions in which group activities included education, behaviour modification programme aimed at modifying risk, advice and exercise are effective in falls prevention with community dwelling older people (four single trials, non-significant).
- Referral for correction of visual impairment – whilst there is insufficient evidence that single interventions targeting vision impairment are effective in reducing falls, referral for visual correction as part of a multifactorial intervention has a significant impact on falls reduction. Identifying older people with visual impairment and referral for intervention should be considered within a multifactorial intervention.
- Vitamin D and oral supplementation – there is evidence that vitamin D deficiency and insufficiency are common amongst older people and that when present they impair muscle strength and possibly also neuromuscular function. In addition, the use of combined calcium and vitamin D3 supplementation has been found to reduce fracture rates in older people in residential/nursing homes and sheltered accommodation. Although there is emerging evidence that correction of vitamin D deficiency or insufficiency may reduce the propensity for falling, there is uncertainty about the relative contribution to fracture reduction via this mechanism and on the dose and route of administration required. NICE therefore currently makes no firm recommendation on its use for fracture prevention.
- Hip protectors – Reported trials that have used individual patient randomisation have provided no evidence for the effectiveness of

hip protectors for the prevention of hip fractures when offered to older people living in extended care settings or in their own homes. Data from cluster randomised trials provides some evidence that hip protectors are effective in the prevention of hip fractures in older people living in extended care settings who are considered at high risk, however, the evidence is insufficient to make a potentially expensive recommendation about the use of hip protectors, until there are trials evaluating the newer types of hip protectors and national standards for their manufacture and safety are made.

11. Recommendations

1. A whole systems falls pathway which is agreed and signed up to by all partner organisations, and which should encompass:
 - i. Prevention including the prevention and treatment of osteoporosis and prevention of falls in service settings.
 - ii. Improving the diagnosis, care and treatment of those who have fallen including specialist assessment carried out by the falls service in collaboration with primary and social care professionals and which should build on the single assessment process.
 - iii. Rehabilitation and long-term support aimed at maximising independence and enabling the individual to carry out their normal activities of daily living and social participation.
2. The majority of falls (at least 50%) occur in people's home. There is therefore a need to work with older residents to raise awareness of fall risk factors, and carry out home hazard assessments (following a structured falls assessment), to reduce these risk factors.
3. A falls prevention strategy to ensure implementation and development of these services.
4. The falls strategy should have a wide enough dimension to include the wider environment, so that health and social care are able work with town planners and housing/environment departments to reduce environmental hazards.
5. Prevention initiatives aimed at highlighting the risk factors for falls and reducing the occurrence/severity of falls (e.g. awareness, training, exercise programmes), should be a priority.
6. A falls management plan for older people on the alarm call system, to ensure that older people on the system who have a fall are given

a multi-factorial risk assessment and multi-factorial interventions are implemented to prevent a second fall.

7. Development of data collection systems which clearly indicate cause/areas of service provision and spend, to ensure proper prevention planning.

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For further information on this report, please contact folake.abayomi-lee@havering.nhs.uk, Acting Senior Public Health Strategist, NHS Outer North East London.

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14. Appendices

Appendix 14.1 – NHS Havering Response – National Falls Prevention and Bone Health Audit 2009/10

Information Contained in the Audit on Havering PCT is as follows:

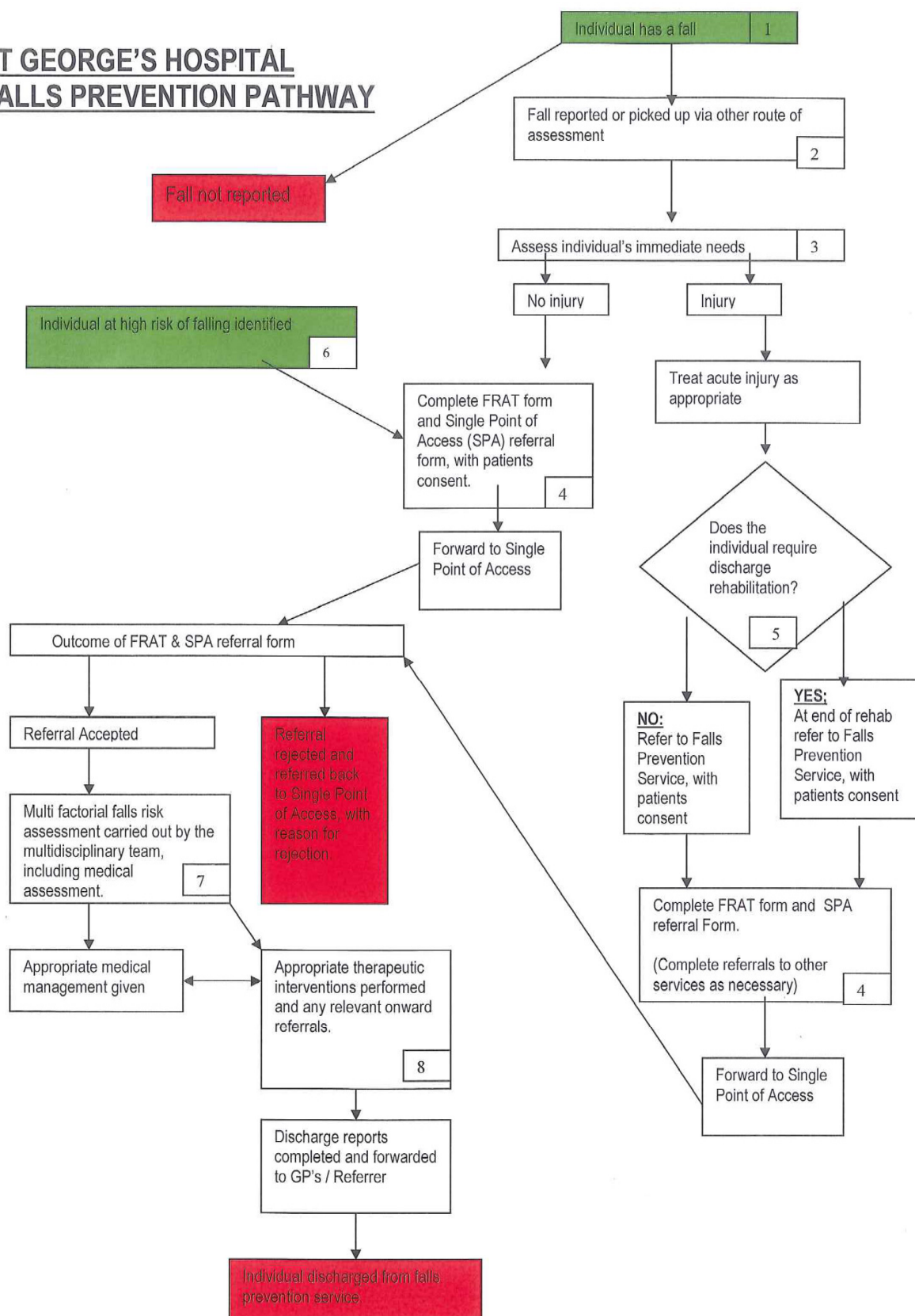
1.1.1	1.1.1 Is there a written local commissioning strategy which covers issues pertaining to falls prevention?	YES.
1.1.7	Is there a written local commissioning strategy for Bone Health?	No
1.3.3	Is there a local population based report on health needs and outcomes relevant to falls and bone health services including hip fracture rates?	Unknown
1.4.1	Is there a mechanism at PCO level for assessing whether primary care treatment for people who have a fragility fracture is provided in accordance with TAF 87?	No
	Domain 2: Case Finding and Referral	
2.1.3	Is a first level screening tool in use, including people who have fallen within a defined time period?	Yes partially used
2.1.3	Does the screening tool trigger and direct further assessments according to a locally agreed falls pathway?	Yes
	Domain 3: Structure and Staffing	
3.1.1	Is there a local coordinated, integrated, multi-professional and multi-agency falls service?	Yes

3.2.1	Does your trust provide a clinic(s) or equivalent facility where individual patients attend for assessment and interventions related to falls prevention with direct clinical involvement of consultant grade or medical trained staff?	Yes
3.5.1	Do you have a consultant(s) in geriatric medicine with a commitment to the falls prevention service within their job description/ job plan?	Yes
3.5.9	Do you have a fracture Liaison Nurse(s) or similar designated person(s)?	NO
	Domain 4: Specialist Falls Management	
4.1.1	For all patients considered locally to need a multi-factorial falls risk assessment is this undertaken by your trust using a clinical note proforma or similar tool which specifies the individual components?	Yes Fully
4.1.4	Does the tool include assessment for fracture risk or osteoporosis risk factors?	Yes
4.1.14	Is a validated home hazard assessment used for assessment of potential hazards within the home?	Yes
4.3.1	Does the service provide written, agreed intervention plans which are given to patients?	NO
4.4.3	Does the intervention include a validated exercise programme delivered by appropriately trained healthcare professionals and/or exercise specialists?: FAME and/or OTAGO	YES OTAGO
4.6.1	Is there an agreed process/ pathway to access syncope services for patients who have 'unexplained falls' / blackouts?	YES
	Domain 5: Service Settings	
5.3.1	Is there an inpatient or resident falls prevention/ reduction policy?	YES/no but inpatients
5.3.12	Has the trust calculated its overall inpatient falls rate against activity (e.g. per admission or occupied bed day)?	No answer ie null

		response.
5.3.13	Has the trust calculated its injurious inpatient falls rate against activity (e.g. per admission or occupied bed day)?	No answer received i.e. null response.
5.3.15	Is there provision for all patients who need walking aids to be able to routinely access these within 24 hours of admission?	No answer received i.e. null response.
5.4.1.	Are older people who fall and attend A&E departments or MIUs routinely screened for risk of future falls? (This may not apply to your site and will need to be interpreted locally)	No A&E or MIU
5.8.4	Are there arrangements for routine pre-operative medical assessment and treatment on the orthopaedic ward by a senior physician with relevant training?	No answer received i.e. Null response
	Domain 6: Training and Audit	
6.3.1& 6.3.2	Is there a mechanism to record patients' views of the falls and bone health service using questionnaires and/or interviews?	YES

Appendix 14.2 – St George’s Hospital Falls Clinic Care Pathway

ST GEORGE’S HOSPITAL FALLS PREVENTION PATHWAY



Appendix 14.3 – St George's Hospital Falls Clinic Referral Form

FAX COMPLETED FORM TO:

HAVERING Falls Clinic:

Fax: 01708 465247 / Tel: 01708 465246

BARKING & DAGENHAM Falls Clinic:

Fax: 020 8724 1445 / Tel: 020 8724 1413

REDBRIDGE Falls Clinic:

Fax: 020 8970 8406 / Tel: 020 8970 8402

BRENTWOOD Falls Clinic:

Fax: 01277695056/ Tel: 01277695031

ATTACH PATIENT LABEL if available

Patient's Name: Hospital No/A&E No/SWIFT No:

Address:

Telephone Number: Date of Birth: Age:

Mobility Aid: YES NO Types:

Patient's GP: Tel: Fax:

Number of falls in last 12 months (if known):

Injuries sustained:

.....

The patient detailed above has been identified as at risk of falls
and has 1 or more of the following risk factors (please circle)

History of Falls	YES	NO
Patient on more than 4 prescribed medications	YES	NO
Diagnosis of Stroke/Parkinson's Disease	YES	NO
Problems with balance	YES	NO
Patient unable to rise from a chair of knee height without using their arms	YES	NO

Relevant medical history: (Please give as much detail as possible including history and physical signs of stroke, parkinsons, blackouts, fits/faints, arthritis, trauma/deformity of limbs or other significant illness)

Medication/s (Block Capitals Please)

INVESTIGATIONS DONE (delete where applicable)

Mental State: Normal / Mildly forgetful / Confused / Dementia

Blood Pressure – Lying:

Standing:

Heart Rate:

FBC: ☐

U&E: ☐

ECG: ☐

(Indicate ➡ if attached)

Blood glucose: ☐

Other (Please state)

Referrer Details:

Appendix 14.4 – Havering 65+ Population Projection by Age & Gender

14.4a Table 5.1b– Havering population projections for over 65s by gender and age

Age & Gender	2010	2015	2020	2025	2030
Males aged 65-69	4,800	6,100	5,400	6,400	7,000
Males aged 70-74	4,300	4,300	5,500	4,900	5,800
Males aged 75-79	3,600	3,700	3,800	4,900	4,400
Males aged 80-84	2,600	2,700	3,000	3,100	4,000
Males aged 85-89	1,400	1,600	1,900	2,100	2,300
Males aged 90 and over	500	700	1,000	1,300	1,700
Total males 65 and over	17,200	19,100	20,600	22,700	25,200
Females aged 65-69	5,800	7,100	6,400	7,100	8,200
Females aged 70-74	5,300	5,400	6,700	6,000	6,700
Females aged 75-79	4,900	4,900	5,000	6,200	5,700
Females aged 80-84	4,100	4,100	4,100	4,400	5,400
Females aged 85-89	2,700	2,800	3,000	3,200	3,400
Females aged 90 and over	1,200	1,600	1,900	2,200	2,700
Total females 65 and over	24,000	25,900	27,100	29,100	32,100

Source: POPPI, 2010