HALTON BOROUGH COUNCIL

NHS

Halton Clinical Commissioning Group

Falls Strategy

2013 – 2018

'Today, improve the Wellbeing of Others'

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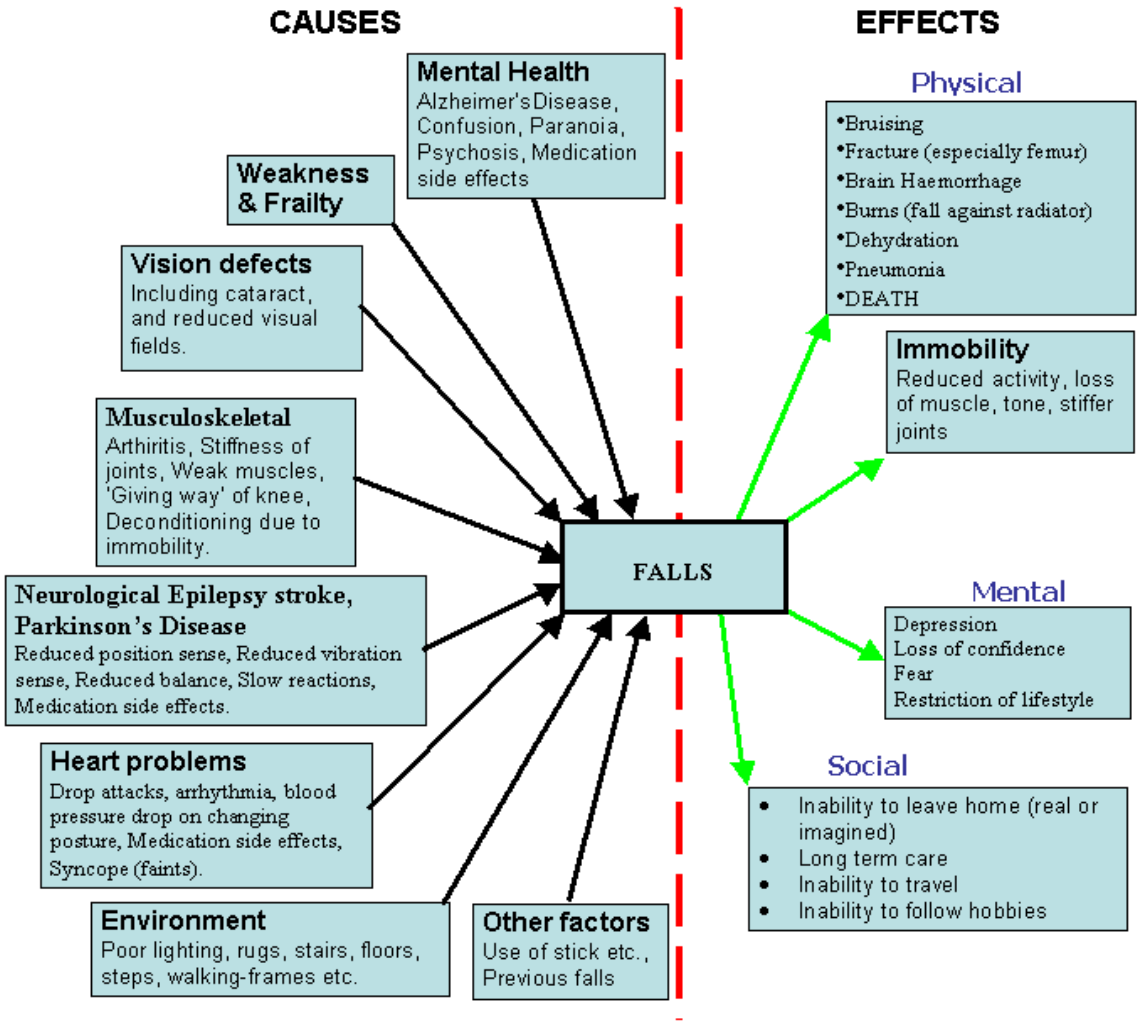
CONTENTS

Appendices

Executive Summary

There is clear evidence on the importance of ensuring that falls prevention and falls care are a high priority within any Local Authority. Halton has a falls rate that is higher than the national average. The hip fracture rate in people over 65 in Halton is 499 per 100,000, this is significantly higher than the national average of 452 per 100,000 people and when you consider that 1 in 3 people over 65 will have at least one fall per year you can see the scale of the problem. The difficulty that professionals have in responding to the issue is to understand the complexities that are involved. There is not one standard risk factor that can cause a fall and it can relate to anything from dementia to poor lighting in the home. However, it is important to consider that whatever the cause of the fall the effects can be significant.

Losing confidence and subsequently losing independence are a major result of someone having a fall and there is still too often a case in which older people receive treatment and very quickly are admitted into residential or nursing care or become isolated at home. The diagram below shows this in more detail.



As we develop the local falls programme we must always keep in mind exactly what a fall can mean to an individual as the story of Mrs A below highlights.

Mrs A was an active member of her local community who lived alone, but was often out socialising with friends or being involved in local groups. On a routine trip into town she tripped as she was disembarking from a local bus and fell into the pavement. The fall caused significant bruising and although there was no other physical symptoms Mrs A did suffer with a panic attack due to the shock of the fall. Her physical recovery was swift; however, the emotional strain of that day had a lasting effect. Mrs A began to offer a number of different reasons to friends as to why she couldn't go out and over time she stopped going to all of her groups that she previously attended. Within twelve months Mrs A had become completely withdrawn and isolated from her local community and her friends.

The story above helps us to focus this strategy, which although considers the current national and local position and offers the first steps towards improving Halton's performance in relation to falls, also should not forget the individual who is at the receiving end. This can be further illustrated by a quote from a local Halton resident who spent a number of weeks in hospital and subsequent rehabilitation after a fall:

I had never thought about having a fall before it happened to me, I was only 68 and very active, I just thought this was the type of thing that happened to other people.

In view of the current local position the falls strategy offers a number of ways in which we will tackle the issues and improve outcomes. Some of the areas of work are further developed than others and some of process driven whilst others are firmly rooted in service delivery.

The key deliverables of the falls strategy are:

1. **Develop current workforce training**
2. **Develop a plan for awareness raising with both the public and professionals**
3. **Improve partnership working**
4. **Set and deliver specific targets to reduce falls**
5. **Develop an integrated falls pathway**
6. **Develop a prevention of falls pathway**
7. **Identify gaps in funding of the pathway**
8. **Improve Governance arrangements to support falls**

The actions and work areas that have been identified within this document are at different stages of development for example the Postural Stability Exercise Programme is in place, but needs to increase capacity or the falls training programme is limited and has no sustainable plans in place. Therefore the multi-disciplinary steering group needs to work effectively and creatively to offer solutions to the problems faced in Halton.

It is also clear when using both the performance framework and action plan attached to this document that a number of the development areas that have been identified are process related. This is important as we have to ensure that the systems are in place and functioning before we can move to improve the services that exist and propose new services to commission.

1.0 Introduction

Falls are one of the Health and Wellbeing Boards key priorities in Halton. Falls are a leading cause of mortality due to injury amongst people over 65. Falls can have a serious impact on the quality of life of older people and can undermine the independence of an individual. Falls may be caused by a person's poor health or frailty, or by environmental factors, such as trip hazards inside and outside their home.

One of the major difficulties in relation to falls services is the fact that there are a number of potential consequences of a fall, these include:

- Physical (discomfort, hypothermia, pressure related injury, infection, pain, serious injury, inability to look after oneself, long term disability)
- Social (loss of independence, loss of social contacts, loss of home, move to residential care, financial costs of help / care / hospital, decreased quality of life, changes to daily routine)
- Psychological (loss of confidence, fear of falling, distress, guilt, blame, anxiety)

As services are developed we must always consider the importance of cause and effect in relation to falls. As mentioned there are many reasons why a person may fall, but the impact can be far more than just physical as outlined in the case study in the executive summary above.

As well as understanding the impact on an individual; professionals also need to understand the scale of falls nationally and locally. Between a third and a half of people aged over 65 falls each year and this percentage increases with age. Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged over 75 in the UK. Over 190,000 older people in England are admitted to hospital as a result of a fall every year.

Therefore, when we are considering falls and particularly on how we improve performance, we need to be mindful of the four areas that are impacted:

1. **People –** we have already considered the cause and effect of falls for an individual and that can certainly be extended to carers.
2. **Hospital –** falls can impact hospitals due to the need for an emergency admission and the initial recovery time required before discharge, but they can also be an area in which people can be more vulnerable to the risk of falling. Often this is due to people being in an unfamiliar environment.
3. **Care –** If people deteriorate from a fall rapidly they can find themselves requiring a level of care they had not previously needed. This transition can be very sudden and can have a significant impact on an individual's emotional wellbeing.
4. **Cost –** Hip fractures alone cost the UK an estimated £5 million per day (that is £2 billion pounds per year) the cost to treat one hip fracture is £13,000 in the first year and £7,000 for the subsequent year. Furthermore, fragility fractures account for costly aftercare, with an average hospital stay of 26 days. The current population and incidence projections developed by the National Hip Fracture Database, suggest that by 2020 the cost of managing a hip fracture will increase by 50% to £3 billion per year.

Falls are also a major reason for care home admissions with up to 40% of people moving as a result of a fall. Once in a care or hospital setting older people are three times more likely to fall compared to those residing in the community. In addition one in three women and one in twelve men over 50 are affected by osteoporosis fracture by the time they reach the age of 70.

The Department of Health has identified key intrinsic and extrinsic risks associated with falls. Intrinsic (i.e. associated with the individual's condition) include

- Balance, gait, mobility problems including those due to degenerative joint disease and motor disorders.
- Conditions requiring complex medication (e.g. four or more medications) and sedating or blood pressure lowering medications.
- Visual impairment
- Impaired cognition or depression
- Postural hypotension

Extrinsic, or environmental risk factors for example, include:

- Poor lighting
- Steep stairs
- Loose carpets or rugs
- Slippery floors
- Badly fitting footwear or clothing
- Lack of safety equipment such as grab rails
- Inaccessible lights or windows
- Assistive devices such as use of a stick, frame or wheelchair.

2.0 Context

2.1 National Context

There are two key documents that set the standards for best practice in the management of falls among older people. One of the issues for these two documents is when they were produced, The **National Service Framework for Older People** was published in 2001 and the **National Institute for Clinical Excellence** (NICE) published their guidelines in 2004. The NICE guidelines were reviewed in 2011 and updated to include an extension of the scope to cover inpatient settings and service delivery.

The **National Service Framework for Older People** identified the need for the NHS to work in partnership with councils to take action to prevent falls and reduce the resultant fractures or other injuries in their populations of older people and to ensure effective treatment and rehabilitation for those who have fallen through a specialised falls service. Health and social care organisations were required to put in place falls risk management procedures and put in place an integrated falls service by 2005.

Within the National Service Framework there were a list of 10 interventions that were proposed to support the effective implementation of a falls service in the borough, these being:

- Prevention, including the prevention and treatment of osteoporosis
- Provision of information, advice and support
- Specialist falls service within specialist multi-disciplinary and multi-agency services for older people to work with those at high risk of falling
- Encouragement of appropriate weight-bearing and strength enhancing physical activity
- Promotion of healthy eating (including adequate intake of calcium
- Smoking reduction
- Good pavement repair and street lighting
- Making properties safer
- Improving the diagnosis, care and treatment of those who had fallen
- Rehabilitation and long-term support

The National Institute for Clinical Excellence (NICE) give recommendations for good practice based on the best available evidence of clinical and cost effectiveness. The NICE guideline identifies five key priorities for implementation of a service for the assessment and prevention of falls in older people, as described in the table below.

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 asked about the frequency, context and characteristics of the fall. • Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance. **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 multi-factorial falls risk assessment. This assessment should be performed by healthcare professionals with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multi-factorial intervention. • Multi-factorial 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 **3) Multi-factorial interventions** • All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multi-factorial intervention. • In successful multi-factorial intervention programmes the following specific

components are common (against a background of the general diagnosis and management of causes and recognised risk factors):
    - Strength and balance training
    - Home hazard assessment and intervention
    - Vision assessment and referral
    - Medication review with modification / withdrawal
- Following treatment for an injurious fall, older people should be offered a multi-disciplinary assessment to identify and address any future risk, and individualised intervention aimed at promoting, independence and improving physical and psychological function.

4) 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.

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 assessment and prevention

2.2 Local Context

As identified in the introduction falls are an important issue for Health and Social Care organisations and are certainly an area in Halton that has been identified in a number of ways. The importance of this is clearly defined when we consider the different local strategies that link to falls.

- The Health and Wellbeing board has identified falls as one of its priorities, falls are included in the Health and Wellbeing strategy and an associated action plan, which is included in this document, has been completed.
- The Prevention and Early Intervention strategy outlines the importance of ensuring people are supported to have a healthy lifestyle no matter what their own personal circumstances. A significant part of this is raising awareness of falls prevention and falls safety.
- The Urgent Care Strategy considers all of the relevant pathways and protocols to support people through primary and secondary care in an appropriate and timely way. This is particularly pertinent when considering the responses that someone who has fallen requires.
- The Older People's Commissioning Strategy offers an overarching view of the needs of older people in Halton. This covers prevention through to end of life care.
- The Overview and Scrutiny Board has also agreed that falls prevention will be one of their annual scrutiny topics with a report available from June 2013. This review once complete will include a series of actions that will be added to the Health and wellbeing action plan that appears at the end of this document.

2.3 Why is Change required?

The introduction of this document sets out the impact of falls and why they are a priority for Health and Social Care Nationally. It is also worth considering the following statistics when assessing the needs in a local area:

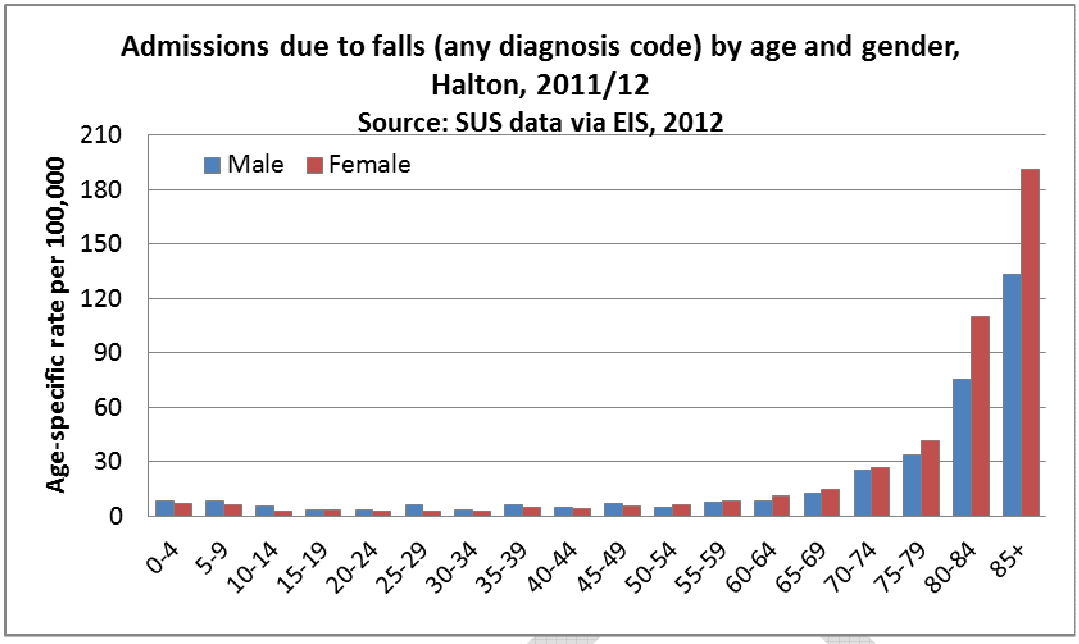
- 1:3 people aged 65+ experiences a fall at least once a year.
- 14,000 people die annually as a result of hip fractures
- Falls are a major cause of disability and mortality resulting from injury in over 75s
- Incidence rates for falls in nursing homes / hospitals are 2-3 times greater than community settings
- Approximately 5% of Older People who fall, experience a fracture or require hospitalisation
- 648,000 attendances at Accident and Emergency Department each year
- Cost to the NHS over £900 million per year

Although Halton has an integrated falls service it is small in resource and as a result capacity is affected. The service has operated for five years and the despite a considerable year on year increase in referral rates (as illustrated in the table below), there has been no increase in the size of the team.

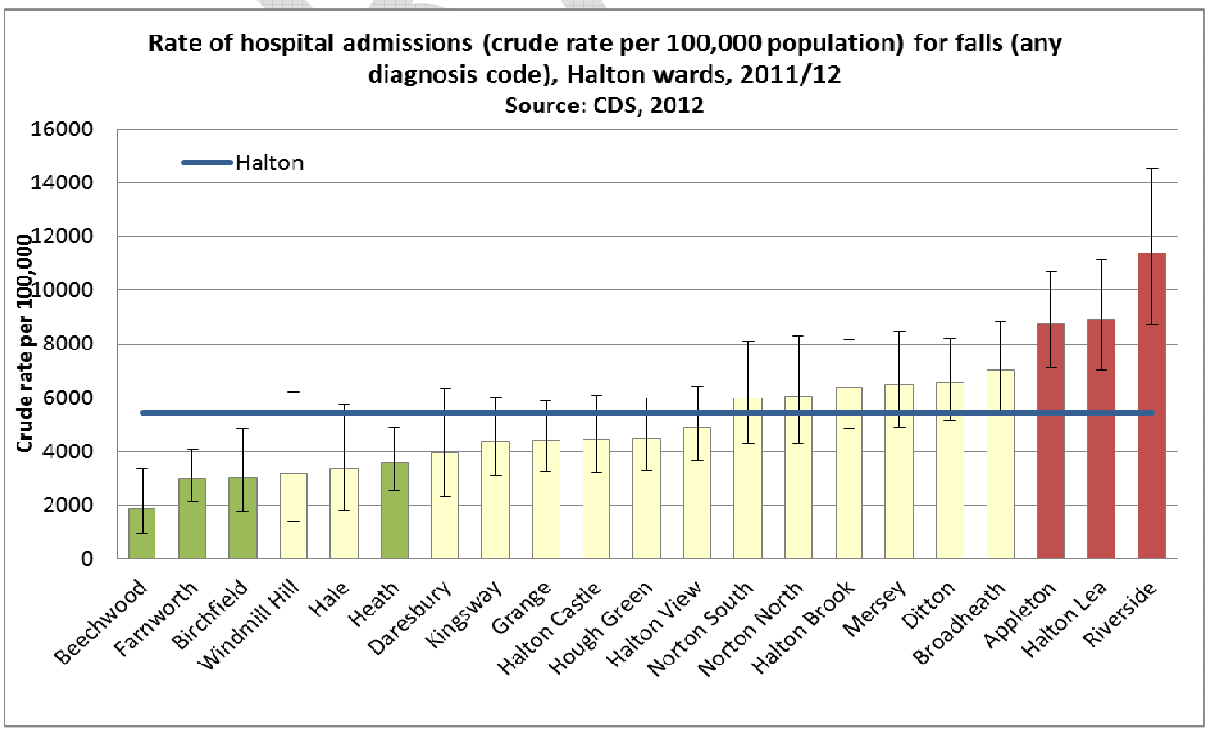
Halton Falls Prevention service started as a pilot in 2005. The service was extended to accept referrals from GPs, other health and social care practitioners and self-referrers in 2006. The current service consists of a full-time falls prevention practitioner, a 0.5 wte Project Officer, 0.3 wte of physiotherapist; 7 hours (0.46 wte) occupational therapy and10 hours (0.3 wte) Therapy Assistant.

Year	Male referrals	Female referrals	Total referrals
2008	39	66	105
2009	83	172	255
2010	121	226	347
2011	113	207	320
2012	155	338	493

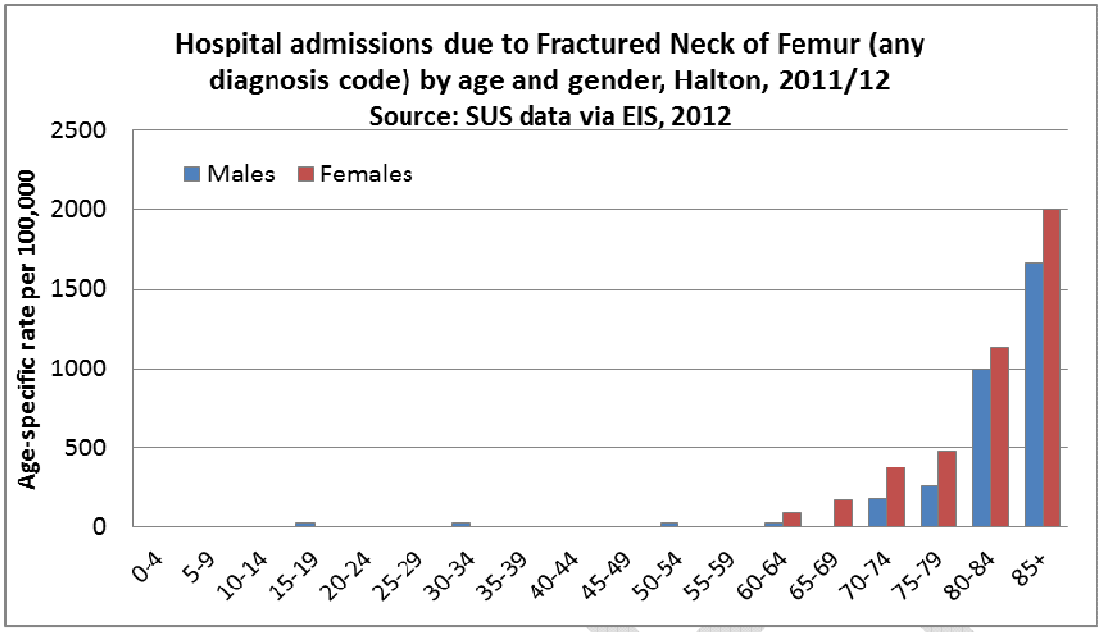
The following three graphs illustrate the local picture in relation to falls. The first graph shows the hospital admissions due to falls for people living in Halton in 2011/12. It is clear that the trend locally follows the National average with a dramatic increase in the number of fallers admitted aged 70+ and a very steep increase in the over 80s.



The table below shows the rate of hospital admissions per 100,000 populations for falls across each of the wards in Halton. The crude rate in Riverside is 11,371/100,000 population. This figure is almost double the local average and although the actual numbers can be quite small the impact is significant. It is also important to consider that in Riverside there 63 older people admitted to hospital due to a fall out of a ward population of 554; however Beechwood with a comparable ward population of 583 only had 11 fallers.



The final graph below shows the level of admissions to Hospitals for a fractured neck of femur that are a particularly common result of a fall in older people.



2.4 Public / patient involvement

On the completion of this strategy a consultation event will take place to launch the strategy, but also to invite attendees to be further involved in the design and delivery of services over the next three to five years. This consultation will be extended to local older people's group, voluntary sector organisations, health improvement services and Registered Social Landlords. The main aim will be to raise awareness of falls, help people understand where to get information from and then understand how they will be supported if they do have a fall.

3.0 Vision, outcome and aims of falls service in Halton

3.1 Vision

The vision of the Halton falls strategy is to reduce the number of falls and subsequently the number of hospital admissions due to a fall.

3.2 Outcome

Halton Borough Council and the Clinical Commissioning Group seeks to achieve the following outcomes in relation to falls:

- Know of this risk and what they can do to minimise it
- Are supported by health and social care staff to minimise the risk
- Receive timely good quality assessment, treatment and care should they sustain a fracture or injury through falling
- Are rehabilitated to their pre-fall health and wellbeing or even better

Outcome 1	A reduction in falls and associated injuries and fractures	• 3% in 2013/14 • 4% by 2014/15 • 12% by 2015/16
Outcome 2	A reduction in the number of falls related admissions into acute care	• 3% in 2013/14 • 4% by 2014/15 • 12% by 2015/16
Outcome 3	An effective integrated care pathway which is universally adopted	Agreed by May 2013
Outcome 4	The widespread use of an effective falls risk assessment tool	Agreed protocol for all providers
Outcome 5	Improved partnership working	Evidenced through the multi-disciplinary Team falls steering group
Outcome 6	Better standards for effective prevention and rehabilitation services	Checked through existing monitoring methods
Outcome 7	Increased patient satisfaction / wellbeing	• 5% increase on baseline data
Outcome 8	A reduction in acute, community, rehabilitation and social care costs related to falls	• 5% reduction on costs relating to falls

4.0 Current Services

4.1 Specialist

Profile of Current Services

The aim of the Falls Prevention Service is "To reduce the number of falls which result in serious injury and to ensure effective treatment and rehabilitation for those who have fallen. Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialised falls service.

The service is targeted to provide in some form each of the following list of activities, however, in Halton there are difficulties due to capacity and resource implications.

- **Falls prevention awareness raising –** We have recently been fortunate to receive some support from ROSPA to deliver some free falls awareness training to 15 frontline staff. A follow-up offer for a second session has been made and will be taking place sometime in 2013. However, there is still a risk in how as a borough we are able to deliver a sustainable training and awareness raising programme. This is currently part of the falls specialist nurse role, however, due to an ever increasing work load of assessments the prevention element is becoming more challenging.

- **Postural Stability Exercise Programmes (APEX) -** this is an exercise programme specifically designed to prevent falls and Osteoporosis. Currently this is delivered in Halton by the Health Improvement Team and there are 2 x 15 week courses. These courses have had some excellent outcomes, however, the current number of sessions does not meet the need of the local

population and we would need to find a way of increasing the number of courses. One of the biggest risk factors in relation to this is the fact that the course and the transport are funded through the existing falls budget. For this to be fully sustainable and increased there needs to be a shift to charge for the courses.

- **Intermediate care team with a strong rehabilitative focus** – Intermediate Care services in Halton offer assessment, treatment and care that aims to rehabilitate adults and older people who have been unwell and this includes people who have become unwell as a result of a fall. The team works directly with people who are being discharged from hospital and also with people who have been receiving a service in the community. The service aims to work with the individual and the family to design a programme of activities that aims to help people to live as independently as possible.

- **Telecare** – This is a set of electronic sensors installed in a person's home. These include: temperature sensors, fall detectors, smoke alarms, motion detectors, a personal alarm pendant and a 24 hour 7 days a week emergency response service. When coupled with an appropriate support plan Telecare helps individuals to live more independently and safely at home. Once installed, it can reduce risk by providing reassurance that help will be summoned quickly if a problem occurs. Telecare in Halton comprises three components: an emergency response, environmental monitoring and lifestyle monitoring

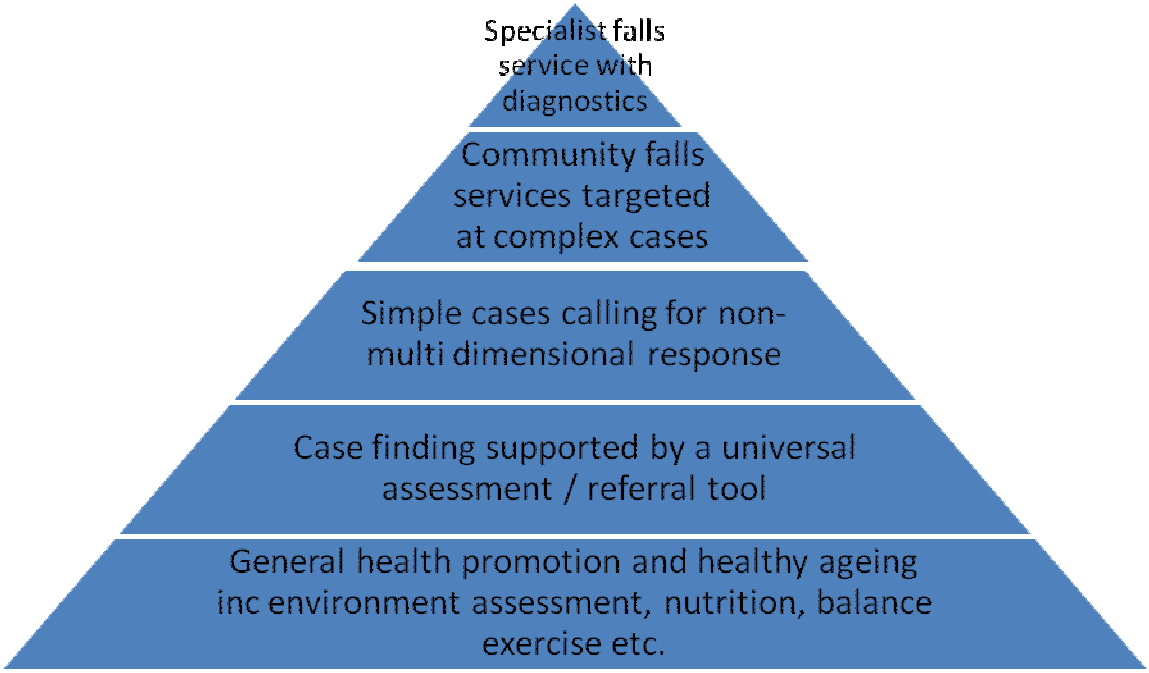
- **Improved prescribing for osteoporosis** – a Clinical Commissioning Group led initiative that has seen work with GPs to raise awareness with respect to falls.

- **The use of a validated Falls Risk Assessment Tool on both sides of the trust** – There have been successes in agreeing to use a standard assessment tool for falls in different areas and now the Falls Risk Assessment Tool (FRAT) is used in both Health and Social Care. There is still work to be done in other parts of the falls pathway that do not use the FRAT, for example the voluntary sector.

- **Falls steering group** – 2012 saw the establishment of a multi-disciplinary falls group in Halton. Members were invited from Halton Borough Council operational and commissioning services, Health Improvement, Clinical Commissioning Group, Occupation Therapy, Physio, Podiatry, and Voluntary Sector. This group will be expected to implement the Falls Strategy and report against performance for falls in Halton.

5.1 Taking forward the vision for falls services in Halton

This strategy proposes the development of an integrated falls care pathway with sufficient capacity to deliver an agreed model of care to older people in Halton who are at risk of falling. The model would build on an agreed model of care that is highlighted in the local **prevention and early intervention strategy.**



This model is rehabilitative, looking to move individuals back down the care levels wherever possible. The starting point is the broad health promotion and falls prevention work and will be mainly delivered through the Health Improvement Team, however, will also be the responsibility of a wide number of organisations. This will also include training and awareness raising and the partnership with Age UK and Cheshire Fire and Rescue to deliver environmental assessments.

The next stage should include wider use of the Falls Risk Assessment TOOL (FRAT) to identify individuals at a higher risk of falls or fracture. This should be carried out by an appropriately qualified member of staff and would act as the decision making element of the pathway. It should also be supported by appropriate baseline data from across health and social care. The third stage includes a response to cases where there is an identified cause e.g. podiatry, optometry, dietetics etc.

Stage four and five are linked to specialist assessment and mainly focus on complex cases that need specific input. Each of these stages must be integrated into a local health and social care initiative in Halton "Making Every Contact Count". This work is a means of describing how to provide the workforce at all levels with the knowledge and skills to offer health chats and signpost to appropriate services. The vision being that everyone has a role to play in public health service delivery. It recognises that the workforce is our greatest asset and that harnessing the skills of the workforce across organisational boundaries and settings provides a large-scale opportunity to improve health and reduce inequalities.

5.2 Implementation of the strategy

It is proposed that an integrated falls pathway is developed and agreed in Halton to support the principles of the above model of care. Further work will be undertaken to develop protocols, workforce and any service redesign. Where gaps or lack of capacity in the pathway are identified these will be reported to the falls steering group for consideration and action.

In developing an integrated falls pathway the following needs to be considered.

- The role of the falls specialist nurse and how this role effectively supports the current pathway and how the role will change with any alterations to the existing pathway.
- The possibility of creating a central or shared referral point to facilitate access and manage demand
- Full use across all identified services of an agreed falls assessment tool
- Systems in place to support case findings
- Work with commissioners to ensure that the new domiciliary and residential care tenders have effective policies and procedures in place to manage falls
- Work across Urgent Care services to ensure that fallers are supported to the best location to support their needs.
- Increase awareness of the falls register and ensure that the information is maintained and communicated to relevant partners
- Clarity on the educational needs of the workforce.
- Systems in place to clearly identify the need for a review of medication
- Increase the variety of stakeholders to include transport, leisure, pavement services etc.
- Agree monitoring and evaluation framework

6 Governance Arrangements and Performance Framework

6.1 Governance arrangements

This strategy will be managed through the falls steering group that is a multi-disciplinary meeting chaired by the Local Authority. Any service development will be reported through the Urgent Care Board and the Health and Wellbeing Board will receive quarterly performance updates.

6.2 Performance frameworks

This Evaluation Framework has been developed to support the review of falls services in Halton being carried out by the Falls Steering group. The framework aims to bring together a range of performance measures that can be applied across a number of services across Health, Social Care, voluntary and independent sector.

Aims

- To reduce the number of falls in people living in Halton that result in an emergency admission to Hospital.
- To reduce the severity of fall related injuries in people living in Halton.

Objectives

1. To build the capacity of the Falls Prevention service in Halton.
2. To engage with the local community in the development of local falls prevention services and related action plans.
3. To achieve planned and shared responsibility for falls prevention addressing the following components:

    i. Education / awareness
    ii. Exercise / balance programs
    iii. Referral and reporting
    iv. Risk assessment
    v. Environmental factors

4. To implement local action plans to reduce the number of falls and fall related injuries of people living in Halton.

Objective 1 – To build the capacity of the Falls Prevention service in Halton.

STRATEGIES	KEY PERFORMANCE INDICATORS	Targets	DATA COLLECTION, METHOD & TIMELINES
Establish and maintain Falls Prevention Steering Group	• Regular attendance and participation at meetings • Partnership development in program delivery	• Monthly operational meeting • All stakeholders involved	• Meeting minutes – on-going • Qualitative feedback from members - on-going
Establish and maintain a Halton performance group	• Regular attendance and participation at meetings • Partnership development in program delivery • Agreed process for data collection	• Report to Urgent Care Board quarterly • All Stakeholders involved • Shared data collection by Sept 13	• Meeting minutes – on-going • Qualitative feedback from members – on-going • Quarterly update on performance
Steering Group to collate best practice options for local plans	• Completion of best practice options • Options adopted and delivered at a local level	• Collected by Aug 13 • Commissioned plans by Dec 13	• Meeting records – on-going • Implementation of best practice results
Increase Service provider's awareness and understanding of falls prevention issues through targeted awareness raising program	• Awareness program developed • Awareness program implemented • Evaluation of service providers knowledge	• Complete by July 13 • Initial 5 sessions booked • Minimum 50 staff attending	• Survey service providers post program about changes in knowledge and behaviour • Follow-up survey on changes in practice

Objective 2 – To engage with the local community in the development of local falls prevention services and related action plans.

STRATEGIES	KEY PERFORMANCE INDICATORS	Targets	DATA COLLECTION, METHOD & TIMELINES
Service user representation on falls steering group	• Ensure inclusion of service users • Develop and implement a wider consultation plan	• Minimum of 2 service user reps on the steering group • Work with existing groups to develop consultation plan Dec 13	• Minutes of meetings – on-going • Qualitative feedback from service user representatives

Create supportive environment for service user representatives	• Each service user representative to receive a background briefing and induction • Each service user representative to have service provider mentor • All service providers to receive a background briefing • All service user representatives feel confident / comfortable to contribute freely at meetings	• Complete as part of joining • Allocated on joining • Completed through induction • Complete quarterly review with service users	• Minutes of meetings – on-going • Survey of service user representatives – including an intermittent review • Survey of service providers – intermittent review

Objective 3 – To achieve planned and shared responsibility for falls prevention addressing the following components:

i. **Education / awareness**
ii. **Exercise / balance programs**
iii. **Referral and reporting**
iv. **Risk assessment**
v. **Environmental factors**

STRATEGIES	KEY PERFORMANCE INDICATORS	Targets	DATA COLLECTION, METHOD & TIMELINES
Facilitate interagency partnerships	• All key stakeholders involved in steering groups • Key stakeholders including community representatives contributing time / resource to implementing the falls review and strategy	• All stakeholders initially agreed and invited • All to agree at establishment of the implementation group	• Minutes of meetings – on-going • Progress reports on implementation of the falls strategy • Evaluate and document any changes in practice and the impact they have
Implementation of local action plans	• Agreement by all parties to local action plan	• Agreed through Health and Well Being-Board	• Minutes of meetings – on-going • Feedback from members – on-going

	• Local action plans to be implemented	• Implementation by March 13	• Evidence of implementation of action plan
Local action plan containing strategies to address: i. Education / awareness ii. Exercise iii. Referral and reporting iv. Risk assessment v. Environmental factors	• Local action plans include strategies to address each of the five key components • Local action plan and strategy to include evaluation framework to assess: i. Enhanced education / awareness ii. Increased number of exercise programs or increased access and participation rates to existing programs iii. Enhanced referral and reporting by service providers iv. Increased use of risk assessment v. Reduced impact of environmental factors	• Action plan agreed through Health and Well-Being Board with relevant timescales	• Content of action plans – review and provide feedback as required

Objective 4 – To implement local action plans to reduce the number of falls and fall related injuries of people living in Halton:

STRATEGIES	KEY PERFORMANCE INDICATORS	Targets	DATA COLLECTION, METHOD & TIMELINES
Local Steering Group to implement education / awareness programs for service providers and communities	• Education / Awareness strategies implemented by adopting 'best practice' models. • Participation rate in education / awareness events	• Complete By Sept 13 • Minimum of 75 attendees on training by March 2014	• Survey service providers awareness and practices comparing pre and post intervention • Survey of service users experience

	• Increased number of referrals to falls service	• 10% increase in the number of referrals to the falls service	• NHS referral data
Local steering group to facilitate development of new exercise / balance programs or increased awareness of target population to existing programs	• Increased number of exercise / balance programs available • Increased participation rate to existing programs • Sustainability of exercise programs • Increased number of referrals to exercise programs • Improved strength / balance of participants	• Increase to six 15 week sessions per year • 12 people attending each session • Provide evidence of outcomes • 5% increase in referrals to exercise • 10% increase in the numbers of people with improved strength / balance	• Bridgewater exercise data • NHS referral data • Survey participants • Review existing and new exercise and balance programs on a regular basis to identify outcomes
Facilitation of enhanced referral & reporting mechanisms using the Falls Risk Assessment Tool (FRAT).	• Number of service providers using FRAT for falls • Number of interagency referrals via FRAT.	• 20% increase in the number of providers using FRAT for falls	• Pre and post service evaluation to establish impact of the intervention.

6.3 Health and Well-Being Action Plan

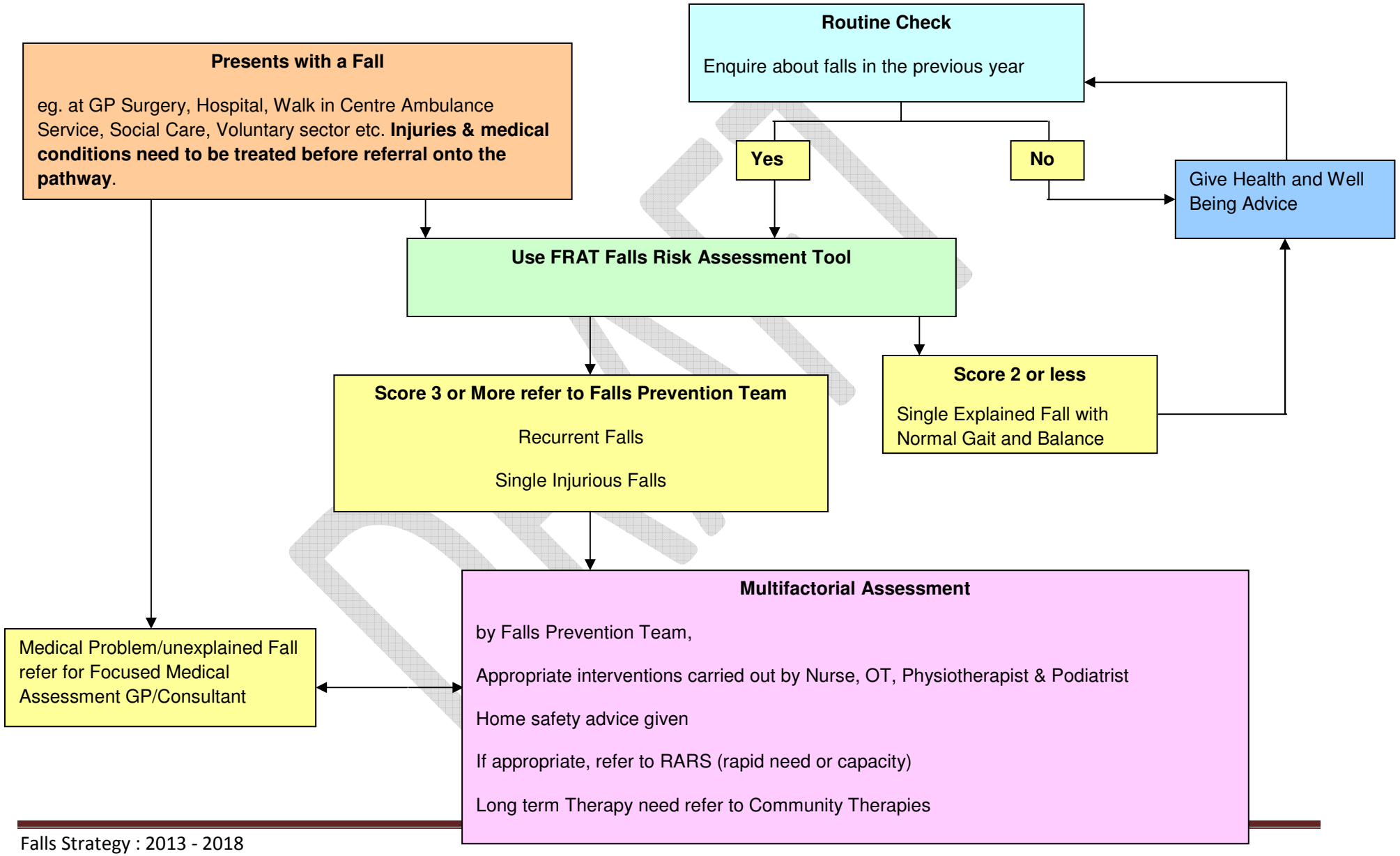
Name of Priority: Reduction in the number of falls in Adults

Adulthood (25-64) Older People (65+)				
Outcomes	**Targets**	**Actions**	**Timescales**	**Lead Officer**
Reduction in hospital admissions due to falls	5% annual reduction in hospital admissions as a result of falls (2012/13 baseline) 10% increase in the number of people accessing falls services (2012/13 baseline) Decrease the number of repeat fallers by 5% on discharge from the falls service (2012/13 baseline)	Increase the number of people who access the Falls service by 5% Increase the number of people discharged from the falls service who access low level prevention services by 10%. Increase the number of people accessing community services on discharge from hospital a minimum of 10%.	By 1st April 2014 By 1st April 2014 By 1st April 2014	Sue Wallace-Bonner (Falls steering group)
Reduction in the number of readmissions to hospital due to falls	5% annual reduction in hospital readmissions due to falls (2012/13 baseline)	Increase the number of people who have been admitted to hospital as a result of a fall who are subsequently referred to the falls service by 10%	By 1st April 2014	Sue Wallace-Bonner (Falls steering group)
Reduction in the risk of falls at home amongst older people	5% annual increase in the numbers of people, at risk of falls, accessing prevention services (2012/13 baseline) 10% annual increase in falls screening completed (2012/13 baseline)	Increase the number of people who access the Falls prevention service from 93 per year to 200 per year Provide falls awareness sessions twice yearly for --- number of Older People Introduce whole system screening for people at risk of falls	By 1st April 2014 By 1st April 2014 December 2013	Sue Wallace-Bonner (Falls steering group)

	20% increase in the number of providers using Falls Risk Assessment Tool (FRAT)	Targeted approach to those GP practices with higher incidences of falls. Specific training developed relating to the Falls Risk Assessment Tool (FRAT)	September 2013 March 2014	
Improved access to falls services	Redesign and implement the new service by 2013/14	Develop a falls strategy for Halton. Review the falls pathway for people who have fallen Review the falls pathway for people at risk of falls. Implement performance management system, across all falls services. Review access and range of falls prevention services Review age criteria for access to the falls service Develop a business case for additional resources for falls prevention services	September 2013 September 2013 September 2013 October 2013 August 2013 April 2013 December 2013	Sue Wallace-Bonner (Falls Steering Group)
Reduction in the number of people in care homes who experience a fall	5% annual reduction in recorded falls (2012/13 baseline)	Develop robust data collection methods Carry out provider forum awareness raising	August 2013 Sept 2013	Sue Wallace-Bonner (Falls Steering Group)

		Identify specific training for providers to support their individual needs.	Dec 2013	
Reduction in the severity of fall related injuries	5% annual reduction in number of fractured neck or femurs (current baseline 499 per 100,000 people)	Increase in the number of Exercise / balance programmes to six per year Develop and implement specific training programmes around the needs of different providers	April 2014 April 2014	Sue Wallace-Bonner (Falls Steering Group)
Increase in the number of frontline staff who receive specialist falls training	Provide initial training to 20 frontline staff	ROSPA accredited training for 20 frontline staff Increase provider training sessions to raise awareness of the risk of falling from 2 sessions to 5 sessions per year. Train 50 frontline staff in identifying the risk of falling	January 2013 - Completed March 2014 March 2014	Sue Wallace-Bonner (Falls Steering Group)

Appendix 1 – Halton Falls & Bone Health Pathway



Appendix 2 – Prevention Pathway