Falls Prevention Strategy

2014 – 2017

‘Working Together to Reduce Falls and Promote Independent Living’
Executive Summary

Falls and fractures amongst older people (the majority of which result from a fall) are significant public health issues. Falls are costly to the individual, the NHS and the Social Care System. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality.

Although everyone is at risk of a fall, older people are more vulnerable and at an increased risk. Life expectancy is increasing higher than the England average in St Helens and injuries that are caused by falls are the most common cause of death in people over the age of 75\(^1\).

Hip fractures can be extremely detrimental and the risk of fracturing a hip increases with age and amongst those with conditions such as osteoporosis. With an ageing population the need for falls prevention is likely to increase.

Falls are not inevitable and there is strong evidence that falls can be prevented delivering health and wellbeing benefits for older people and reducing costs for both social care and health. There is clearly a large difference in the cost to the state of a fractured hip (£28,665) compared to the cost of major housing adaptations (£4217) and hand and grab rails (£286).

A recent review of the local Falls Prevention Service identified a need to strengthen provision in identifying people at risk of falls and reducing the risk factors associated with falls through an integrated falls pathway.

Public Health in collaboration with the CCG have provided further investment to the Falls Prevention Service which will now be based at St Helens Hospital with a multidisciplinary workforce, compared with the lone Falls Specialist Nurse of the previous service.

Through this review and engagement with a variety of partners and stakeholders it was also identified that there was a need for a Falls Strategy within the borough of St Helens to bring all interested parties together to reduce the number of falls and to help put Falls on everyone’s agenda.

There are good working relationships amongst services and a willingness amongst all to build an effective falls prevention system throughout St Helens. Some elements are already in place.

Over a period of consultation and engagement with local partners and stakeholders, 4 areas of priority have been highlighted as key to reducing the impact of Falls within St Helens.

\(^1\) Stop Falling: Start saving Lives and Money (Age UK 2010)
Vision – Working together to reduce falls and promote independent living.

The Key priorities of the Falls Strategy are:

Priority 1: Education, Awareness and Training around falls amongst all within the community

Priority 2: Improved partnership working and sharing of knowledge

Priority 3: Identification of those at risk

Priority 4: Development of positive reactive services with clear pathways and guidance

An action plan has been developed to deliver against these priorities (see section 9).

Outcomes

As a result of this strategy there will be:

- More older people able to live independently
- Improved partnership working creating more efficient and effective services
- An integrated Falls pathway throughout St Helens linking all relevant partners
- Workforces throughout the borough with improved specialist knowledge in Falls Prevention
- Residents of St Helens of all ages will know how to reduce their risk of falling and risk to others
- Falls prevention services that are able to identify people at risk through outreach work and case finding to reduce number of people injuring themselves through a fall
- Better collation and use of falls related data to identify gaps and target areas of need
- A reduction in the number of falls and fractures, such as hip and wrist, as a consequence of falls

Performance will be measured in a number of ways including number of people identified at risk of falling, number of people with their risks reduced and a reduction in injuries as a result of falls. The key outcomes measure is the number of hospital admissions as a result of a fall.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Baseline 2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Rate of falls related hospital admissions</td>
<td>3143 (986 count)</td>
<td>2908</td>
<td>2763</td>
<td>2694</td>
</tr>
</tbody>
</table>

*Rate per 100,000
1. Introduction

Everyone can be at risk of having a fall, but older adults (65+) are more vulnerable than others. This is mainly due to long-term health conditions that can increase the chances of a fall.²

Around 30% of adults who are over 65 and living at home will experience at least one fall a year. This rises to 50% of adults aged over 80 who are either at home or in residential care.²

Most falls do not result in serious injury, although 20% of older adults will require medical attention for a fall and 5% will experience a serious injury, such as a broken bone.²

The average age of a person with a hip fracture is 84 years for men and 83 for women, with 76% of fractures occurring in women. About 1 in 10 people with a hip fracture die within 1 month and about 1 in 3 within 12 months (result of associated comorbidities).

The average length of stay for a hip fracture in England is between 17 and 40 days³. Patients who fracture a hip have a high mortality and morbidity rate with up to 20% needing long term care post fracture and a further 30% not returning to their pre fracture function. Hip fracture accounts for 87% of total fragility fractures⁴.

Falls can also have an adverse psychological impact on elderly people. For example, after having a fall a person can lose confidence, become withdrawn and may lose their independence.²

The financial impact of falls and fractures on the NHS and social care system is significant. Falls impact upon a range of health and social care resources including GP visits, ambulance journeys, acute and community care. Nationally falls and fractures take up 4 million hospital beds each year in England. The total cost of falls to the NHS is more than £2.3 billion⁵.

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² Falls: Assessment and prevention of falls in older people (NICE CG161 2013)
³ Fractured neck of femur – rapid improvement programme (NHS Institute for Innovation and Improvement 2009)
⁴ Delivering Quality and Value, Focus on: Fractured Neck of Femur (NHS Institute for Innovation and Improvement 2006)
⁵ Later Life in the United Kingdom (Age UK 2014)
2. What causes a fall?

The natural ageing process often places older adults at an increased risk of having a fall\(^2\). In the UK, injuries that are caused by falls are the most common cause of death in people over the age of 75\(^2\). There are four main reasons why older people are more likely to have a fall\(^2\).

These are:

- Chronic health conditions such as heart disease, dementia and low blood pressure (hypotension), which can cause dizziness
- Impairments, such as poor vision or muscle weakness
- Disabilities that can affect balance, such as labyrinthitis (inflammation of the delicate structure deep inside the ear known as the labyrinth)
- Medication (side effects associated with certain medications)\(^6\)

Chronic health conditions, such as those listed above, can sometimes cause a loss of balance, a brief loss of consciousness (known as a drop attack) or a sudden feeling of dizziness, all of which could contribute to a fall. Visual impairment or muscle weakness may also make it more difficult for an older person to prevent a fall.

Among older adults, the most common reasons for accidentally falling or slipping include\(^2\):

- Wet or recently polished floors, such as in a bathroom
- Dim light
- Rugs or carpets that are not properly secured
- Reaching for storage areas, such as cupboards
- Stairs

Another common cause of falls, particularly among older men, is falling from a ladder while carrying out home maintenance work.

In older women, falls can be particularly troublesome because osteoporosis is a widespread problem. At the age of 50, about 2 in 100 women have osteoporosis. This rises to 1 in 4 women at the age of 80. Over a third of women and one in five men in the UK have one or more bone fractures because of osteoporosis in their lifetime\(^7,\(^8\).

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\(^6\) Medication-related falls in the elderly: causative factors and preventive strategies (Drugs Aging Journal; Huang AR, Mallet L et al 1;29(5):359-76)

\(^7\) Osteoporosis - primary prevention (NICE Technology Appraisal Guideline January 2011)

\(^8\) Osteoporosis: assessing the risk of fragility fracture (NICE Clinical Guideline August 2012)
Diagram 1: Department for Work and Pensions – Cause and Effects of a Fall

CAUSES

Mental Health
Alzheimer’s Disease, Confusion, Paranoia, Psychosis, Medication side effects

Weakness & Frailty

Vision defects
Including cataract, and reduced visual fields.

Musculoskeletal
Arthritis, Stiffness of joints, Weak muscles, ‘Giving way’ of knee, Deconditioning due to immobility.

Neurological Epilepsy stroke, Parkinson’s Disease
Reduced position sense, Reduced vibration sense, Reduced balance, Slow reactions, Medication side effects.

Heart problems
Drop attacks, arrhythmia, blood pressure drop on changing posture, Medication side effects, Syncope (Faints).

Environment
Poor lighting, rugs, stairs, floors, steps, walking-frames etc.

Other factors
Use of stick etc., Previous falls

EFFECTS

Physical
• Bruising
• Fracture (especially femur)
• Brain Haemorrhage
• Burns (fall against radiator)
• Dehydration
• Pneumonia
• DEATH

Immobility
Reduced activity, loss of muscle, tone, stiffer joints

Mental
Depression
Loss of confidence
Fear
Restriction of lifestyle

Social
• Inability to leave home (real or imagined)
• Long term care
• Inability to travel
• Inability to follow hobbies
3. National Framework for Falls

Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged above 75 in the UK\(^9\). More than 400,000 older people in England attend accident and emergency departments following an accident, while up to 14,000 people die annually in the UK as a result of an osteoporotic hip fracture\(^10\). It’s clear that falling has an impact on quality of life, health and health care costs. Hip fractures from Falls costs the ‘NHS and social care an estimated £6 million a day or £2.3 billion per year’\(^11\). The Kings Fund ‘Exploring the system-wide costs of falls in older people in Torbay’ showed that the total costs (Social Care, Community and Acute Hospital) in the 12months following a fall (£4.2 million) were almost double the cost before a fall (£2.5 million).

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The National Service Framework for Older People 2001 set out some aims and standards for the prevention and management of falls.

**Aim**

To reduce the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen.

**Standard**

- 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 carer’s, receive advice on prevention through a specialised falls service.

**Key Interventions**

This standard sets out changes needed to reduce the number of falls and their impact through:

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

Even though high on the agenda and costly to health services and individuals, Falls can still be seen as an inevitable part of the aging process.

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\(^9\) Incidence and costs of unintentional falls in older people in the United Kingdom (J Epidemiol Community Health. Sep 2003; 57(9): 740–744 Scuffham & Chaplin)

\(^10\) National Service Framework for Older People (Department of Health 2001)

4. Local Issue – why a St Helens Falls Strategy?
The need for a strategy became apparent from a review conducted on the local Falls Prevention Service. Engagement with local services, partners and stakeholders identified gaps as well as the impact falls has across the breadth of health, housing and social services operating within the borough. This review also highlighted a need for change in the Falls Prevention Service, a change that will be integral to future success of the strategy.

Some key local statistics also identify the necessity for a strategy:

- 8 deaths directly from a fall in 2012
- 10% of people aged 65 or over with hip fracture die within 1 month
- 1 in 3 of people aged 65 or over with hip fracture die within 12 months
- St Helens has one of the highest rates of injuries from Falls in England. Almost double the national average in those aged 65+ and 80+.
- 1629 ambulance responses for Falls costing £187,335 (2013/2014)
- Cost of each fractured hip to state is £28,665 (all costs from ambulance to social etc)
- Estimated over £6 million cost to St Helens of Hip fractures (Health and Social costs)

The triangle highlights the serious nature of falls by detailing data from 2012/13 with the total number of the population aged 65+ in St Helens (whom are at greatest risk) through to those whom die as a result of a fall.

Diagram 2: Triangle to show impact of falls

8 Deaths directly from a Fall

206 Fractured Neck of Femur

987 Emergency Admissions Due to a Fall

8118 Projected Number of Falls

30,800 Population Aged 65 Years and Over
In St Helens the wards presenting with the highest rate of falls are Thatto Heath, Town Centre and Earlstown respectively. There is evidence of an association of electoral ward level between hospital admissions for falls and socio-economic deprivation, with higher rates in deprived areas. Higher hospital admissions are likely to be linked with poorer housing conditions, comorbidities and poorer social support network. There is no evidence that fractures are elevated in wards of higher rates of deprivation.

Falls hospital admissions, 2011/12, categorised by age and sex shows that the majority of falls are occurring in females and those aged 85+. This is a common trend in other areas and nationally. The ratio of male to female admissions over the years has remained similar at 2:1.

The charts below also show the incidence of injuries sustained in St Helens residents aged 65+, and details that most occur in those aged females.
There is a large difference in the rate of injuries sustained in those aged 80+ compared with those aged 65 – 79. The rate in St Helens for 80+ injuries is much higher than both the regional average, almost double the England average and almost three times higher than the best rate in England.

Rates of hip fractures are also high in St Helens with the majority again occurring in those aged 80+.

Rates of falls, injuries sustained and hip fractures are generally higher in St Helens than across the North West region. Many of St Helens neighbours already have a Falls Strategy as well as a comprehensive Falls Prevention Service.
5. Current Falls related services

- **Falls Prevention Service**

Newly commissioned to St Helens Hospital the service has received an additional 100k of funding from the CCG allowing the service to greatly expand and increase capacity. Will now offer a robust preventative as well as reactive service and wide reaching education and awareness work.

- **Allan Day Unit**

Service operating out of St Helens hospital helping older people who have fallen who are higher risk fallers requiring clinical intervention.

- **Re-ablement Team**

The Homecare Re-ablement Service aims to provide short-term care and support for people who need help to care for themselves and maintain their independence in their own home.

The aim of the service is to help the service user become as independent as possible.

- **Health Improvement Team**

Provides exercise advice to individuals who have fallen and/or at risk of falling including Postural Stability instruction & Tai Chi to St Helens community. Team delivers 17 tai chi (7 categorised as Falls Prevention), 1 Chair Exercise and 3 Postural Stability classes.

- **Occupational Therapy**

This service provides a service to people of all ages who have a permanent substantial disability; completing practical and functional assessments of people's ability to carry out normal activities of daily living. Supports maintaining independence within the home through the provision of equipment, major and minor adaptations to properties and where required assist in rehousing to properties which are better suited to the individual.

- **Careline**

The Careline Service works via a special alarm unit connected to your telephone line. The alarm can be activated by pressing a button on a pendant worn around your neck or on your wrist. The pendant will work around the house and in the garden.

- **Home Improvement Team/Handy Man Service**

This service reaches many residents of St Helens undertaking various home improvements to homes. It responds to many homes with fallers in and their interventions can reduce/prevent falls.
• **Care Home Support Team Service**

Provide care home staff with on-going professional education and assisting them to meet national standards. Undertake assessments on residents with recent A&E admission, many of whom have been admitted as a result of a slip, trip or fall. The service undertakes nursing assessments and medication reviews to establish a medical cause and provide a plan of action. A&E information also enables identification of homes that have the most fallers allowing advice and support to be targeted.

6. **What are the Gaps?**

Gaps have been highlighted that will be addressed by the strategy:

- Training on guidelines and procedures amongst Care and Residential Home staff on when to help a faller and when to call North West Ambulance Service.

- Training and awareness raising on Falls Prevention within the community

- Links with local partners who see high risk fallers who can help educate on dangers of falls and reduce risk (after receiving appropriate training) and who can also refer to other services.

- Prevention element to the Falls Prevention service – minimal outreach work, no or minimal case finding in GP surgeries, Care Homes or domiciliary care etc.

- Capacity of services not adequate enough to address needs of local population

- Referral rates into local community Falls Prevention exercise class

- No exercise classes currently provided in care settings by exercise specialists

- Case findings of those at risk of osteoporosis to enable effective treatment.
7. The Strategy – what are we going to do?

Vision

‘Working Together to Reduce Falls and Promote Independent Living’

The strategy will ensure all services work closely together to address all aspects and issues associated with falls.

The first cog is about raising awareness right across the whole community. This involves making falls ‘everyone’s business’ from children with grandparents at risk of falling through to the elderly who have already fallen. Community outreach events will take place with the aim to create Falls Champions. Marketing and communication will increase residents’ awareness of the issue of falls and provide information on how to reduce the risk of falling. The specialist Falls Service will also proactively seek to find individuals at risk of falling in GP surgeries by analysing patient medical forms. The Care Home Service is currently working with homes to reduce risk of falls.

The second cog is detailing the comprehensive and robust specialist services including the newly commissioned Falls Prevention service as well as the Allan Day Unit Service and many
other services such as Adult Social Care and Health, The Home Improvement Team, Occupational Therapy and Reablement. These services will work closer together to help those who have fallen to recover and build towards continued independence and being free from fear of falling. The services will improve communication by development of to provide a more holistic service to help rehabilitate those who have fallen. They will work with housing agencies to reduce hazards in the home and reduce the risk of falling. A holistic approach means that the risk of further falls can be greatly reduced and prevented through a variety of cross cutting measures.

Data collection will also be an important aspect of this second cog. Services such as NWAS, Careline and the various Care and Residential homes have robust recording mechanisms following a fall. Collating all this information will allow for accurate monitoring of the rates of incidents and improve the ability to address areas where multiple falls occur. Sharing of data between stakeholders such as NWA, Care homes and Care line will inform targeted interventions.

Providing support to hospitals to reduce inpatient falls will also be intensified.

The third cog shows the overall aims of these services; the reduction in the number of fallers in the borough and thus reducing hospital admissions and injuries sustained in the elderly and improve the independence and quality of life of those who have fallen.

## 8. Outcomes Measures

The national Falls related indicators below will be monitored to help measure the success of the strategy:

- Injuries due to falls in people aged 65 and over (males/females) (female)
- Injuries due to falls in people aged 65 and over (males/females) (male)
- Injuries due to falls in people aged 65 and over (persons)
- Hip fractures in people aged 65 and over
- Hip Fractures in people aged 65 and over – aged 65 – 79
- Hip Fractures in people aged 65 and over – aged 80+
- Injuries due to falls in people aged 65 and over – aged 65 - 79
- Injuries due to falls in people aged 65 and over – aged 80+
## 9. ACTION PLANS

### Priority 1 Development of positive reactive services with clear pathway, guidance and procedures

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Supporting</th>
<th>Description</th>
<th>KPI’s</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
</table>
| Development of an Integrated Pathway and agreed Guidelines and Procedures | Public Health (PH) | Falls Strategy Group, All those associated with falls | Pathway to be created ensuring all services are linked systematically and providing the most care centred and efficient route for clients. All service providers to send to PH details of their service and clear entry and discharge pathways/criteria. Intermediate pathway and Community pathway. | - Complete pathway  
- Everyone to update any changes with Public Health | ✔️ | ✔️ | ✔️ |
| Creation of a Falls Directory | PH | Falls Strategy Group, All those associated with Falls | Contacts of services and a short description. For use by general public and professionals. | - Complete directory on Public Health page located on St Helens Council site  
- Services to update | ✔️ | ✔️ | ✔️ |
<p>| Improve Commissioning links | Adult Social Care and Health (ASCH), Clinical Commissioning group (CCG) and | | Falls related commissioners to work closely and communicate to ensure services working cohesively and to avoid potential duplication or gaps in services. Senior level commissioning plan. | - Determine a commissioner’s forum for ensuring clear communication. | ✔️ | | |</p>
<table>
<thead>
<tr>
<th>PH</th>
<th>Integrated commissioning between ASCH and CCG – changes to intermediate care. Additional investment in Falls Prevention Service from PH and closer links with CCG</th>
<th>• Decommission the current Falls Prevention Service and tender expanded service</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-commissioning of services</td>
<td>ASCH, CCG, PH</td>
<td>• Integrate ASCH and CCG to develop Intermediate care changes</td>
<td>✓</td>
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<tr>
<td>Reduce number of falls within St Helens and Whiston Hospital</td>
<td>St Helens and Knowsley Hospitals NHS Trust</td>
<td>Continued monitoring and effective interventions for patient falls.</td>
<td>✓ ✓ ✓</td>
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**Priority 2 Improved partnership working and sharing of knowledge**

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Supporting</th>
<th>Description</th>
<th>KPI’s</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working knowledge of other services</td>
<td>All</td>
<td></td>
<td>Directory of services created. See priority one. Opportunities for service personnel to shadow other providers.</td>
<td>• Each service to openly offer shadowing opportunities</td>
<td>✓ ✓ ✓</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Monitor uptake of opportunity</td>
<td>✓ ✓ ✓</td>
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<td>• Offer training to GP’s, Care homes and Community Professionals; including offer to attend Allen Day Unit Clinics to observe.</td>
<td>✓ ✓ ✓</td>
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<td></td>
<td></td>
<td>• Care Home training and identifying link falls champions</td>
<td>✓ ✓ ✓</td>
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</tbody>
</table>
| St Helens Falls Strategy Operational Group Established | St Helens and Knowsley Hospitals NHS Trust | All frontline providers | Group to meet to discuss all services, clients, latest research, events, best practice and future work to reduce falls. All services to examine all possible feedback mechanisms and use group as conference to discuss patients. | • Forum to be created to meet alternate months. St Helens Falls Forum.  
• Each service to identify feedback mechanisms to ensure robust communication.  
• Services regularly providing feedback and working more cohesively  
• New Terms of Reference to be created encompassing the above. | ✓ ✓ ✓ ✓ |
| Monitor progress of strategy | Falls Strategy Group | To review the strategy to ensure actions are being worked towards and to make any changes were necessary. Quarterly meetings should be held to discuss and monitor progress. | • Falls strategy group to become quarterly meeting forum to monitor progress of strategy  
• Share data in relation to falls, including knee, hip operation delays and impacts on falls | ✓ ✓ ✓ |
| Launch event for Strategy | PH | Falls Strategy Group | Event for professionals associated with Falls. Invite various speakers and use event to inform and network. | • Present strategy at Public Health conference in Autumn 2014 | ✓ |
| Reduce risk of falls through home improvements | Home improvement team Housing associations | Identify hazards in the home and reduce the risk of falls in targeted groups | • Number of homes identified  
• Number of people supported to reduce risk of falling | ✓ ✓ ✓ |
## Priority 3 Education, Awareness and Training around Falls amongst all within the community

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
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<th>Description</th>
<th>KPI’s</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
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<tbody>
<tr>
<td>Deliver Awareness raising events</td>
<td>St Helens and Knowsley Hospitals NHS Trust</td>
<td>All involved in Falls. Public Health Communications Group</td>
<td>Events to raise awareness of the impact of falls and how to reduce risk.</td>
<td>• Minimum of 3 awareness raising events yearly (to be reviewed yearly).</td>
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<td>Link in with Falls Week and Older Persons day</td>
<td>• All Falls providers to create email group to communicate events, press release etc to ensure collaborative working</td>
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<td>Use local radio, papers and community groups. TBC by communications group</td>
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<tr>
<td>Identify and support Volunteer Champions</td>
<td>St Helens and Knowsley Hospitals NHS Trust</td>
<td>Senior Voice. Age UK. St Helens Community Voluntary Action (CVA)</td>
<td>Create champions, in the form of volunteers, to assist with events, education, training and informing local people about Falls</td>
<td>• Definition and levels of champions to be established</td>
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<td></td>
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<td>• Community Champions to be identified and trained.</td>
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<td></td>
<td>• 10 Champions trained across care/residential homes</td>
<td>☑ 10</td>
<td>☑ 15</td>
<td>☑ 20</td>
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<td></td>
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<td></td>
<td></td>
<td>• Domiciliary care staff to be identified to become champions</td>
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<td>• 10 primary and 3 high schools to</td>
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<tr>
<td>Create an agreed Falls Screening tool</td>
<td>Falls Strategy Group</td>
<td>Allen Day Unit</td>
<td>Tool to be created that can be used by all in statutory, voluntary and private sectors as well as the community to identify if an individual is at risk.</td>
<td>be given champion training</td>
<td>10/3</td>
<td>15/3</td>
<td>20/4</td>
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<tr>
<td>Be given champion training</td>
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<td></td>
<td>• Create new tool</td>
<td>√</td>
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<tr>
<td>Clear Guidelines and training for Front Line Services</td>
<td>North West Ambulance Service (NWAS)</td>
<td>Care Home Representatives. Rapid Response Team. ASCH provider forum. ASCH Intelligence and Outcomes Unit team</td>
<td>Frontline services who respond to falls agree clear guidelines (Careline, NWAS etc) to ensure correct methods and persons attending to issue and to also protect those attending to the fall and the faller.</td>
<td>• Care Home Service to request data sharing protocol with NWAS</td>
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<td>• NWAS to share data on Care Homes (number of calls, number of responses, number taken to A+E).</td>
<td>• NWAS to provide guidance to Care/Residential homes on picking up those who have fallen</td>
<td>√</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Promoting Healthy Lifestyles</td>
<td>Health Improvement (HIT) Team</td>
<td>Helena, All</td>
<td>Promote Active and Healthy Lifestyles to help reduce individual’s risk of falling.</td>
<td>• HIT Falls Instructor to provide training to activity coordinators in Care Homes</td>
<td>√</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Visiting Homes</td>
<td>Merseyside Fire and Rescue Service, Age UK</td>
<td>St Helens and Knowsley Hospitals NHS Trust</td>
<td>Opportunity to discuss Falls in homes</td>
<td>• Fire service to provide all residents visited over age 55 with information on Falls Prevention</td>
<td>√</td>
<td>√</td>
<td>√</td>
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<td>Development of a Falls Directory booklet/online</td>
<td>PH and The Royal Society for the</td>
<td>All</td>
<td>Creation of a falls advisory booklet for the general public</td>
<td>• Scope out the cost and feasibility of such a booklet and the level of distribution possible.</td>
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<td>resources</td>
<td>Prevention os Accidents ROSPA</td>
<td>Tailored and relevant training packages to be delivered for care homes, professionals, those in the community.</td>
<td>Through Helena, Fire Service, Home Improvement and Care Home Service deliver booklets to targeted individuals.</td>
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<td>Development of Training courses/packs and E Learning</td>
<td>St Helens and Knowsley Hospitals NHS Trust</td>
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<td>Falls Service to link with Care Home service to deliver Care Home training packs</td>
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<td>Home Improvement Officers to receive training</td>
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<td>Training packages to be adapted into E Learning for easier distribution and increased uptake of training</td>
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<td>Priority 4 Identification of those at risk</td>
<td>Action</td>
<td>Lead</td>
<td>Supporting</td>
<td>Description</td>
<td>KPI’s</td>
<td>Year 1</td>
<td>Year 2</td>
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| Knowledge and Data sharing                | All    | All  | All        | All services to agree policies etc to allow easy access and data sharing to better inform decision making and delivery of services. Data sharing agreements to be developed. | • Explore and possibly set up data sharing across services  
• All services to bring Falls related data to quarterly Strategy Forum | ✓     | ✓     | ✓      |
| Identification of those with osteoporosis | St Helens and Knowsley Hospitals NHS Trust | PH   | Work collaboratively with CCG and stakeholders to improve case finding for those with osteoporosis | • To explore implementation of FRAX tool to improve identification and treatment of osteoporosis | ✓ |
| Identifying those at risk of falls        | St Helens and Knowsley Hospitals NHS Trust Care Home Service (ASCH) | HIT Helena etc HIT/Helena St Helens and Knowsley Hospitals NHS Trust SW etc | Close links with GP Surgeries, Housing associations, Retirement Homes, Care Homes, and all relevant areas covered by ASCH and Social Services to identify potential Fallers | • Falls Prevention Service to identify 250 at risk patients from GP surgeries each year.  
• All services to identify clients at risk of falling and to provide relevant interventions | ✓     | ✓     | ✓      |
| Development of a Screening tool for all services/staff | St Helens and Knowsley Hospitals NHS Trust | Allan Day Unit, ASCH | See priority three. A screening tool to be easily used by all to be created. A general tool, not the FRAT. | • Complete agreed screening tool | ✓ |
St Helens Falls and Bone Health Pathway

Presents with a Fall
eg. at GP Surgery, Hospital, Walk in Centre Ambulance Service, Social Care, Voluntary sector etc.
Injuries & medical conditions need to be treated before referral onto the pathway.

Use FRAT Falls Risk Assessment Tool

Score 3 or More refer to Falls Prevention Team
Recurrent Falls
Single Injurious Falls

Medical Problem/unexplained Fall refer for Focused Medical Assessment GP/Consultant

Score 2 or less

Single Explained Fall with Normal Gait and Balance

Give Health and Well Being Advice

Routine Check or assessed by Integrated Access St Helens
Enquire about falls in the previous year

Yes

No

Multifactorial Assessment
by Falls Prevention Nurse
Appropriate interventions carried out by Nurse,
Home safety advice given, information pack discussed
If appropriate, refer to, Podiatry, Falls Class, Consultant, GP
Long term Therapy need refer to Community Therapies