North Tyneside Council

NHS
North Tyneside
Clinical Commissioning Group

North Tyneside Falls Strategy

2017 – 2020

Contents

Foreword

Falls have a dramatic impact on individuals, families and the health and social care system. More people are falling in North Tyneside compared with other areas which has remained largely unchanged over the past four years. There are on average of 115-140 people over 65 admitted to hospital with a fall each month which costs an average of £4.7 million each year. This doesn't include the cost of social care or money that families pay for care or the unnecessary physical and emotional suffering that a fall can cause for the person and their family.

Falling is not an inevitable part of growing old and can be prevented by organisations and the public working together. North Tyneside partners from Health, Social Care, Private and Voluntary Organisations, North Tyneside CCG, North Tyneside Council and The Tyne & Wear Fire Service are committed to working together to support people to age well in North Tyneside, to not only to live longer but to extend their lives in good health and maintain functional ability and independence.

The impact of the strategy will be measured by a year on year reduction in people being admitted with a fractured neck of femur and a reduction of people falling whilst in Hospital, Nursing Homes or Care Homes.

Together we aim to:

- Ensure that the population understand what they can do to age well and reduce their risk of falls.
- Prevent frailty, promote bone health and reduce falls and injuries
- Early intervention to restore independence
- Respond to the first fracture and prevent the second
- Improve patient outcomes and increase efficiency of care after hip fracture

Together we aspire to create a "fall free" North Tyneside.

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1. Introduction

Falls and related injuries are a significant problem for older people. Falls are common - 30% of over 65's and 50% of over 80's will have at least one fall in a year.[1] Falls lead to physical injuries ranging from cuts and bruises to fractures and head injuries. 5% of falls in older people in the community result in hospital admission, 10-25% of falls in nursing homes and hospital result in a fracture.[1] Falls can also lead to adverse psychosocial outcomes contributing to loss of confidence and independence. Falls can also be a sign of underlying health issues or frailty.

Falls in England lead to 255,000 emergency hospital admission per annum and are estimated to cost the NHS £2.3 billion a year.[2] In North Tyneside 1461 patients aged over 65 were admitted due to falls in 2016/17 at a cost of £4.7 million and this figure is increasing. We are a national and regional outlier for falls.

Hip fracture is one of the most serious consequences of falls in the elderly. Hip fracture mortality is 10% at one month and 30% at one year. There is also significant morbidity with only 50% returning to their previous level of mobility and 10 – 20% of patients being discharged to nursing or residential care.[3]

Osteoporosis is a common condition affecting 2% of the population at 50 and 25% at 80 years of age. Osteoporosis increases bone fragility and susceptibility to fracture. 180,000 fractures per annum in England and Wales are as a result of osteoporosis and 14,000 deaths result from osteoporotic hip fractures. Direct medical costs from fragility fracture were estimated at £1.8 billion per annum nationally and this is projected to rise. Treatment can reduce the risk of fragility fracture and its complications.[4, 5]

Evidence suggests that the number of falls can be reduced by up to 30% through development of a multi-agency falls pathway focussing on early identification and prevention, and multi-factorial assessment and intervention for people at high risk of falling. There is good evidence that a range of interventions can reduce falls and consequent injuries and also provide good return on investment.[1]

This strategy sets out how North Tyneside will reduce falls in older people and address known gaps in local services. The strategy is in line with current NICE guidelines, the National Falls Prevention Coordination Group/ Public health England Falls and Fractures consensus statement and the Department of Health National Service Framework for Older People.

2. Where are we now?

The following figures identify admissions due to falls in the over 65+ age group over the past 4 years.

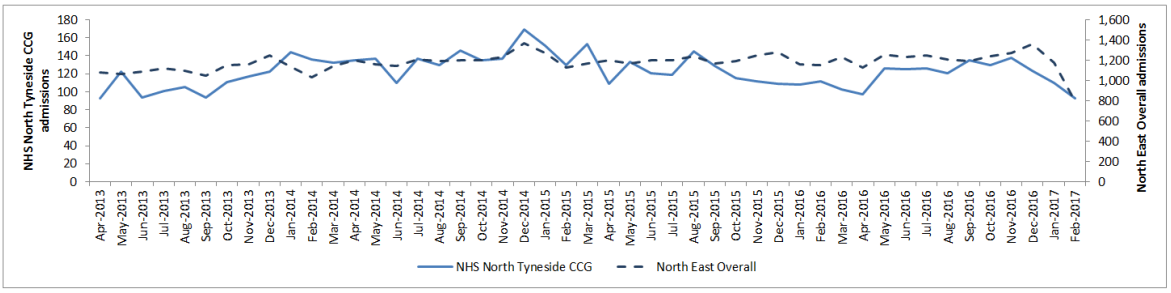
Figure 1 Number of admissions due to falls in the 65+ age group.

North Tyneside CCG - Admissions due to falls in the 65+ age group

Number of admissions due to falls

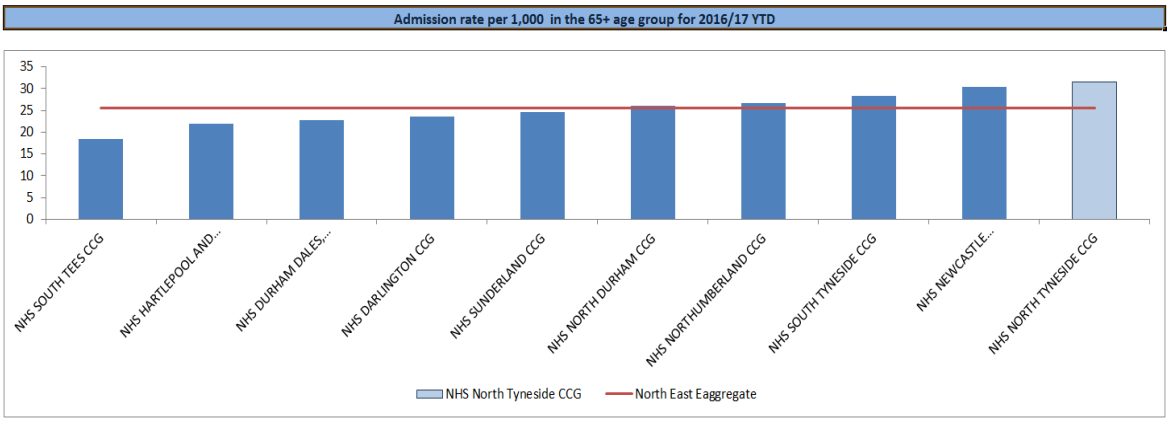
Age group	Year	April	May	June	July	August	September	October	November	December	January	February	March	Total
65+	2013/14	93	122	94	101	105	94	111	117	122	144	136	132	1,371
	2014/15	135	137	110	137	130	146	135	137	169	151	130	153	1,670
	2015/16	109	133	121	119	145	129	115	112	109	108	112	103	1,415
	2016/17	97	126	125	126	121	135	130	138	123	110	93		1,324

Trend in admissions due to falls in the 65+ age group



The numbers in falls for over 65's in North Tyneside has followed a similar pattern over the last four years, averaging between 115 to 140 falls per month with no significant improvements being made.

Figure 2 Admissions rate per 1,000 in the 65+ age group 2016/17



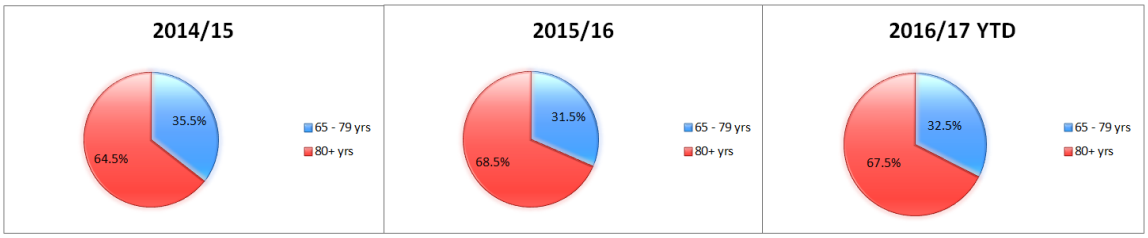
When looking at admissions per rate of 1,000 in the 65+ age group, for the period 2016/17, North Tyneside had a highest aggregate in the North East.

Figure Three – Admissions due to falls in the 65+ age group by age and gender

Admissions due to falls in the 65+ age group by age and gender

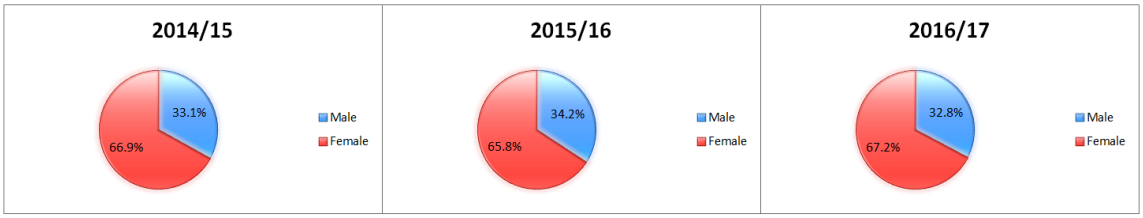
Number of falls by age group

Age group	Year	April	May	June	July	August	September	October	November	December	January	February	March	Total
65 - 79 yrs	2013/14	26	46	42	41	41	25	35	42	41	56	41	46	482
	2014/15	48	47	37	48	44	61	42	49	69	53	47	48	593
	2015/16	28	45	44	37	37	46	41	31	35	38	31	33	446
	2016/17	28	38	32	49	45	43	39	42	34	45	35		430
80+ yrs	2013/14	67	76	52	60	64	69	76	75	81	88	95	86	889
	2014/15	87	90	73	89	86	85	93	88	100	98	83	105	1,077
	2015/16	81	88	77	82	108	83	74	81	74	70	81	70	969
	2016/17	69	88	93	77	76	92	91	96	89	65	58		894



Number of falls by gender

Gender	Year	April	May	June	July	August	September	October	November	December	January	February	March	Total
Male	2013/14	29	30	25	27	38	31	46	41	35	53	43	39	437
	2014/15	44	48	34	39	36	52	49	47	57	51	47	48	552
	2015/16	34	48	45	47	50	41	38	46	37	36	36	26	484
	2016/17	40	33	42	42	43	47	40	46	34	29	38		434
Female	2013/14	64	92	69	74	67	63	65	76	87	91	93	93	934
	2014/15	91	89	76	98	94	94	86	90	112	100	83	105	1,118
	2015/16	75	85	76	72	95	88	77	66	72	72	76	77	931
	2016/17	57	93	83	84	78	88	90	92	89	81	55		890



The data shows that for the past three years, the majority of admissions from falls has come from those patients aged 80+ and similarly two thirds of fallers have been female.

Figure Four – Primary reason for admission (65+)

Primary reason for admission by financial year (65+)

2014/15			2015/16			2016/17 YTD		
Top 10	Primary ICD10 reason	Number	Top 10	Primary ICD10 reason	Number	Top 10	Primary ICD10 reason	Number
1	Injuries to the head	305	1	Injuries to the head	313	1	Injuries to the head	311
2	Injuries to the hip and thigh	304	2	Injuries to the hip and thigh	271	2	Injuries to the hip and thigh	250
3	Injuries to the knee and lower leg	105	3	Injuries to the shoulder and upper arm	90	3	Injuries to the knee and lower leg	88
4	Injuries to the elbow and forearm	104	4	Injuries to the knee and lower leg	82	4	Injuries to the shoulder and upper arm	77
5	Injuries to the shoulder and upper arm	84	5	Injuries to the elbow and forearm	81	5	Injuries to the elbow and forearm	76
6	Injuries to the abdomen, lower back, lumbar spine and pelvis	81	6	Injuries to the abdomen, lower back, lumbar spine and pelvis	72	6	Injuries to the abdomen, lower back, lumbar spine and pelvis	70
7	Orthostatic hypotension	44	7	Injuries to the thorax	52	7	Injuries to the thorax	64
8	Pain in joint: Pelvic region and thigh	44	8	Pain in joint: Pelvic region and thigh	46	8	Tendency to fall, not elsewhere classified	28
9	Lobar pneumonia, unspecified	43	9	Urinary tract infection, site not specified	30	9	Pain in joint: Pelvic region and thigh	24
10	Injuries to the thorax	43	10	Injuries to the wrist and hand	29	10	Lobar pneumonia, unspecified	20

The data shows that for the past three years, the primary reasons for admission (65+) has not changed with injuries to the head, hip and thigh continuing results in the highest percentage of admissions due to falls.

3. AHSN data – Improving Bone Health and Fracture Prevention

Analysis of 2015 data from the report AHSN Falls and Fractures Profile suggests that North Tyneside has vast opportunities for improving bone health and fracture prevention. The data in the report highlights the following:

What the data is telling us about our providers

- ✓ **Surgery:** NHCFT significantly better for % of patients undergoing surgery within 48 hours of EA for hip fracture
- ✓ **Pre-Op**: NHCFT have the 4th shortest (nationally) for pre-op avg. LOS for hip fracture
- ✓ **Admission:** NHCFT in top quartile (nationally) for % of cases admitted to an orthopaedic ward within 4 hours of presenting to A&E
- ✓ **Discharge:** NHCFT in top quartile (nationally) for % not to have developed a pressure ulcer
- × **Post-Op:** NHCFT and NUTH post-op avg. LOS are both higher than national average
- × **Admission:** NUTH in lowest quartile (nationally) for % of cases admitted to an orthopaedic ward within 4 hours of presenting to A&E
- × **Discharge:** NUTH in lowest quartile (nationally) for % not to have developed a pressure ulcer
- × **Readmission:** NHCFT ratio within 30 days for hip fracture higher than national average and highest in region
- × **Mortality:** NHCFT significant outlier for mortality (SHMI) for hip fracture

North Tyneside Provider Analysis

Northumbria – The data suggests that hip fracture patients at NHCFT will receive shorter waiting times on admission, a shorter length of stay pre-op, are more likely to undergo surgery with 48 hours and are less likely to develop a pressure ulcer after discharge. This however is countered by the suggestion that a patients post-op stay is likely to be longer and that they are more likely to be readmitted within 30 days. NHCFT is also a significant outlier with regards to mortality for hip fracture. In summary, the data suggests (although not validated) that acute care for hip fracture is excellent although post-op and readmissions concerns suggest that the care in the community may be limited and not of the same quality.

Newcastle – Issues arising across all elements of care although none of statistical significance. Poor conversion rate from admission to orthopaedic ward is further compounded with longer post-op length of stay and a greater chance of developing a pressure ulcer after discharge.

What the data is telling us about our District and Unitary Authority area

- × North Tyneside is a statistically significant outlier for % of physically inactive adults. This is the same for the North East as a whole

- North Tyneside is a statistically significant outlier for emergency admissions for injuries due to falls in people aged over 65, which is also the highest in the North East. Falls in North Tyneside were comparable nationally in 2013/14 but have since risen.
- North Tyneside is a statistically significant outlier for emergency admissions for injuries due to falls in people aged 65-79, which is also the highest in the North East.
- North Tyneside is a statistically significant outlier for emergency admissions for injuries due to falls in people aged 80+, and again highest in the North East
- North Tyneside is a statistically significant outlier for emergency admissions for hip fractures in people aged 65 and over although this has slightly improved, year on year, over the last 3 years (2012/15).
- North Tyneside is a statistically significant outlier for emergency admissions for hip fractures in people aged 65-79 and the worst in the region. In comparison to looking at just 65 and over data, this has got worse, year on year, over the last 3 years (2012/15). This is because, emergency admissions for hip fractures in people over 80 is showing improvements. ***There may be rationale here for the age category (65-79) being the prioritised target group?***

- NHCFT reported a higher percentage of admissions with injuries due to falls (aged 65+) with a secondary diagnosis of dementia and/or delirium than the national average for both 14/15 and 15/16.
- North Tyneside is a statistically significant outlier for % of patients aged 75+, with a fragility fracture on or after 01/04/14, who are currently treated with an appropriate bone-sparing agent
- North Tyneside has the greatest spend on prescribing of Osteoporosis medicines by CCG in the North East region. The biggest spend is in Alendronic Acid and we've spend £38k more than our neighbouring CCGs
- The expected annual cost of falls in North Tyneside is circa. £5.2 million

North Tyneside District and Unitary Authority Analysis

North Tyneside is an outlier for bone health and fracture prevention across the board although it may be prudent to prioritise:

- Focus on the age group 65-79 for admissions due to falls. This is where the most activity has been. The over 80's cohort has remained fairly stagnant.
- Patients aged 75 plus for fragility fracture who are currently treated by an appropriate bone-sparing agent. The AHSN Bone Health programme should help with this?
- Prescribing. In comparison to our peers it looks like we are over prescribing medication. This may be because of the lack of social prescribing available to this cohort of patients.

4. Current service provision

A meeting with stakeholders to look at current service provision found that there are a number of services available for people who had fallen or were at risk of falling. However, there are also a number of gaps in the current falls service provision in North Tyneside and there is a lack of integration of services.

In terms of identifying at patients at risk of falling a number of agencies hold data on falls and frailty (GPs, secondary care, Care Call, social care, NEAS, the fire service and community nursing teams) but this information is not being shared and utilised. Northumbria Healthcare trust are also making efforts to screen patients presenting to A+E or Urgent care centres. All patients aged over 65 are asked if they have fallen in the last year and if so referred on to the hospital falls clinic. This clinic has limited capacity and is likely better utilised for more complex patients.

For patients who have fallen or are identified as being at risk of falling there are a number of services available. These include

- Exercise schemes
    - North Tyneside council have worked alongside Northumbria University on an exercise programme for patients in assisted living/ sheltered accommodation units.
    - Age UK offer fitness classes.
- Inpatient falls – Northumbria FT has a falls strategy in place for inpatient falls management. This includes a review by a falls nurse for the majority of patients, an MDT assessment and datix completion for every fall. Data from inpatient falls is coded but not always communicated to the GP on discharge.
- Hospital consultant led falls clinic – sees GP referrals and patients referred following admission/ A+E attendance.
- The community nurses have developed their own brief assessment and intervention.
- Routine GP workload
- Care Plus – frailty team covering a limited area
- AART team – provide community assessment and therapy input.
- Community reablement and rehab teams
- Intermediate care and rehab beds are available.
- Care homes and domiciliary care agencies in the area have their own tools and strategies for assessing falls risk.
- Care Call - Council community alarm and telecare service offers a range of telecare options and lifestyle monitoring to help prevent falls and support people who are at risk of falls

5. Best practice

Community falls

NICE guideline CG161 published in 2013 sets out current best practice for assessing falls risk and falls prevention in older people.[1]

- Case/ risk identification
    - 'Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and if so the details of the fall/s
    - 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.'
- 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 falls risk assessment.
    - Multifactorial assessment may include
        - 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.
- Multifactorial interventions
    - Strength and balance training
    - Home hazard assessment and intervention
    - Vision assessment and referral
    - Medication review with modification/ withdrawal.
    - Cardiac pacing
    - Encourage participation of older people in falls prevention programmes
    - Education and information giving

Inpatient falls

NICE guideline CG161 recommends: -

- Consider all patients aged over 65 or aged 50-64 who are judged by a clinician to be at higher risk of falling because of an underlying condition to be at risk of falling. Consider multifactorial assessment and intervention in the cohort. Ensure that aspects of the inpatient environment that could contribute to falls are identified and modified. [1]

Hip fracture care

The Blue Book sponsored by the British Orthopaedic Association and the British Geriatric Association summarises current best practice.

1. All patients with hip fracture should be admitted to an acute orthopaedic ward within 4 hours of presentation
2. All patients with hip fracture who are medically fit should have surgery within 48 hours of admission, and during normal working hours
3. All patients with hip fracture should be assessed and cared for with a view to minimising their risk of developing a pressure ulcer
4. All patients presenting with a fragility fracture should be managed on an orthopaedic ward with routine access to acute orthogeriatric medical support from the time of admission
5. All patients presenting with fragility fracture should be assessed to determine their need for antiresorptive therapy to prevent future osteoporotic fractures
6. All patients presenting with a fragility fracture following a fall should be offered multidisciplinary assessment and intervention to prevent future falls

Fragility fracture

NICE guideline CG146 Osteoporosis: assessing the risk of fragility fracture set out current best practice. This recommends identification of high risk groups of people to assess fragility fracture risk. These include all women over 65 and all men over 75 and also younger individuals who have additional risk factors for osteoporosis. To assess an individual's fragility fracture risk consider using online risk calculators (Qfracture of FRAX) and arrange DXA scan as required. Also assess for vitamin D deficiency and calcium intake. Exclude non- osteoporotic causes of fragility fracture such as metastatic disease, multiple myeloma, osteomalacia, Paget's disease.

Following assessment risk is determined to be high, medium or low and drug treatment with bisphosphonate, calcium and vitamin D may be indicated. Patients should also be advised to exercise regularly, eat a balanced diet, stop smoking and drink no more than recommended limits.
The NOGG guidelines recommend treatment without assessment for women who have had a previous fragility fracture, people over 70 years of age who are taking high dose corticosteroids. Once started on bisphosphonates annual medication review should include enquiry into adherence and side effects. The ongoing need for treatment should be reviewed after 3-5 years with a repeat DXA scan. For people at high risk of fracture treatment can be continued for up to 10 years. Patients at intermediate risk of fracture should have repeat DXA scanning after 2 years.[6]

Population based strategies

For the elderly, muscle weakness, physical inactivity and balance impairment increase the likelihood of falling. Environmental risk factors such as poor housing can also contribute towards an increased risk of falling. Being physically inactive, poor work posture, repetitive movements, weak muscles and joints contribute towards MSK conditions.

Secondary prevention aims to reduce the impact of a disease or injury that has already occurred. This is done by detecting and treating disease or injury as soon as possible to halt or slow its progress, encouraging personal strategies to prevent reinjury or recurrence, and implementing programs to return people to their original health and function to prevent long-term problems.

The most recent Cochrane systematic review considered the effectiveness of a number of typical fall reducing interventions amongst the over 65s[7].

- Multiple-component group exercise
- Multifactorial interventions
- Home Safety Interventions
- Withdrawal of Medications
- Education interventions

Conclusions from this systematic review reported that; there is strong evidence that certain exercise programmes prevent falls. Group exercise classes and exercises individually delivered at home reduce rate of falls and risk of falling. The systematic review found that group exercise reduced the rate of falls by 29% and the risk of falling by 15%. Home-based exercise reduced the rate of falls by 32% and the risk of falls by 22%.

Multifactorial interventions integrating assessment with individualised intervention, usually involving a multidisciplinary team, are effective in reducing rate of falls but not risk of falling. The Cochrane Collaboration systematic review found that risk assessment followed by a multifactorial intervention reduced the rate of falls by 24%.

Home safety interventions reduce rate of falls by 19% and risk of falling by 12%. These interventions are more effective in people at higher risk of falling, and when delivered by an occupational therapist. NICE recommends that older people who have received treatment in hospital following a fall should be offered a home hazard assessment carried out by a suitably trained healthcare professional, such as an occupational therapist, followed by necessary safety interventions/modifications[2].

There is limited evidence for the effectiveness of interventions targeting medications (e.g. withdrawal of psychotropic medications, educational programmes for family physicians). The evidence relating to the provision of educational materials alone for preventing falls is inconclusive.

There was some, although limited, evidence that falls prevention strategies can be cost-saving. The results indicate that, to obtain maximum value for money, effective strategies need to be targeted at particular subgroups of older people.

Public Health England recommends that fall prevention interventions should form part of a whole system approach taking place right across the patient pathway. Commissioners, when designing services should take into account the following[3]:

- An effective mechanism to respond to fallers and to case find those at risk: Local areas are recommended to agree systems and services for responding promptly to a fall, which help

the person who has fallen to get up from the floor where appropriate, and ensure assessment and onward referral to avoid hospital attendance and admission if possible.

- Assessment of fracture risk is considered in all women aged 65 and over, all men aged 70, and for men and women younger than this in the presence of risk factors and that fracture liaison services aim to identify all patients aged 50 and over with a fragility fracture .
- Older people coming into contact with professionals and organisations which have health and care as part of their remit should be asked routinely about falls. Older people reporting a fall or at risk of falling should be observed for balance and gait deficits and considered for risk assessment and risk reduction interventions ii.
- Comprehensive evidence based risk assessment should be carried out by a trained healthcare professional for people identified via case finding that are potentially at high risk of falls or fractures. [4]
- That there is a range of falls prevention services: Including specialist falls services or services that include a component of falls prevention such as frailty services/pathways. A specialist falls service might involve a single point of access for referrals, multifactorial interventions, and strength and balance exercise programmes. It is important to note that services focussing solely on frailty will not necessarily target older people with low to moderate falls risk.
- Prevention is embedded: Embedded prevention covers case finding, developing workforce competencies in areas such as motivational interviewing and making every contact count, the delivery of brief interventions promoting physical activity, and incorporating strength and balance training into physical activity services. Services that reduce exposure to relevant risk factors such as smoking cessation, alcohol, and dietetic services should be acknowledged as improving bone health and reducing falls risk.
- Improving quality: Being clear and evidenced based in service specifications for example; all strength and balance programmes should take place for two or more hours per week for a total of 50 hours or more, involve highly challenging balance training and progressive strength training[8, 9].

Environmental factors

Studies have reported that between 20 and 50% of falls among community dwelling older people are due to environmental causes including poor lighting, slippery floors, degraded pavements and uneven surfaces.[10] In the Highways Act 1980 Section 41 there is a requirement which places a duty on the highway authority to maintain highways maintainable at public expense. Whilst there is no prescriptive description for how the highways should be maintained each highway authority should introduce a highway safety inspection procedure to monitor the performance of the highways.

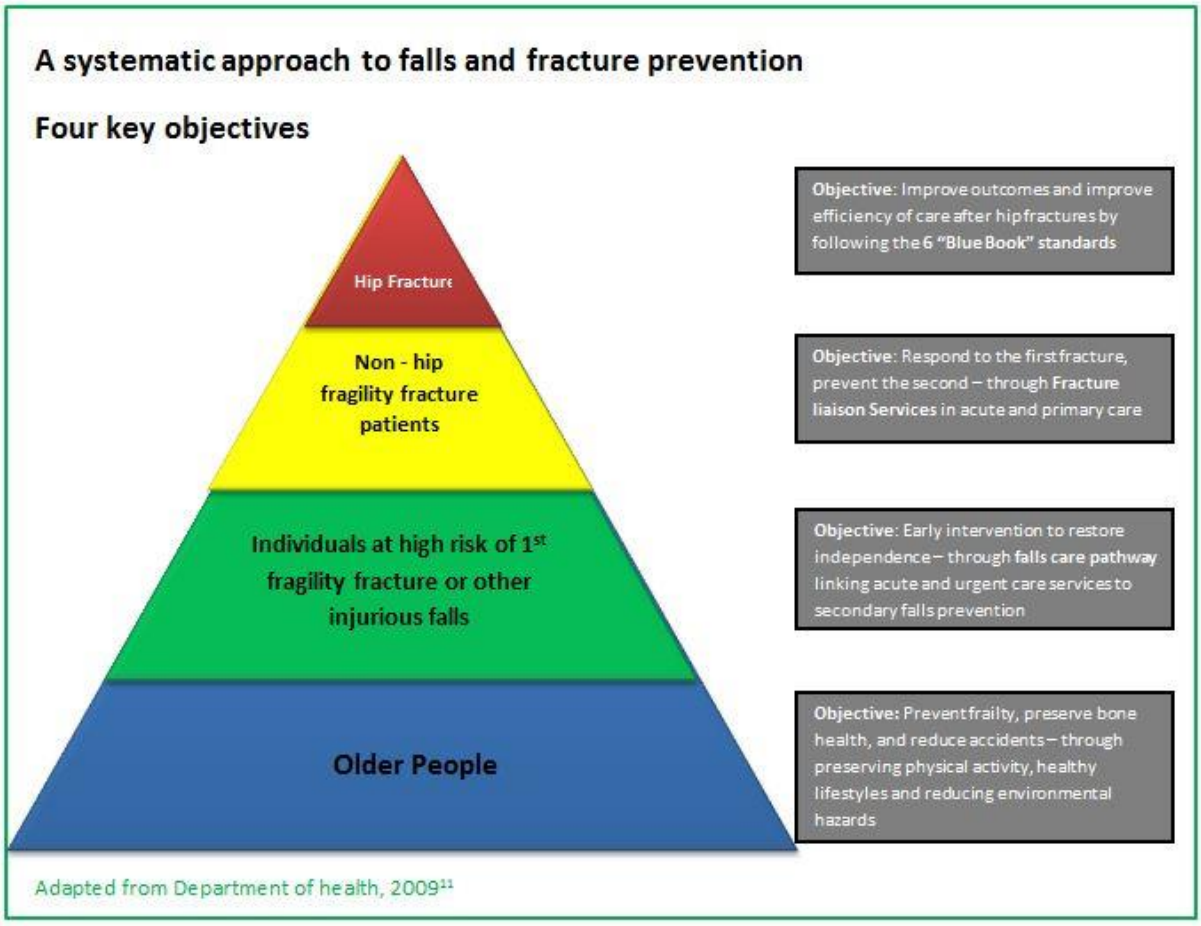
6. Strategy

Aim

To reduce falls and fracture risk and ensure effective treatment, rehabilitation and secondary prevention for those who have fallen. To promote independence and support people to age well in North Tyneside.

Objectives

- Ensure that the population understand what they can do to reduce their risk of falls.
- Prevent frailty, promote bone health and reduce falls and injuries
- Early intervention to restore independence
- Respond to the first fracture and prevent the second
- Improve patient outcomes and increase efficiency of care after hip fracture



Key priorities:

Prevent frailty, promote bone health and reduce falls and injuries

Promote health ageing:

- Public health campaigns – healthy lifestyle choices
- Promote physical activity – Local authority exercise classes

Structured approach to case finding/ proactive identification of at risk individuals:

- AHSN bone health tool
- Electronic frailty index
- Screening of all patients over 65 'have you had a fall in the last 12 months' – establish as routine practice in primary and secondary care
- Direct referral into community falls service by NEAS, fire service, community nursing teams, social care, Care Call, domiciliary workers, patients and their friends or relatives.

Proactive management of frailty:

- Care Plus
- GP annual review

Communications and engagement:

- Falls prevention/ awareness campaign – work with North Tyneside patient forum
- 'Falls free North Tyneside' campaign
- Promote self-management of chronic disease
- Education for healthcare professionals
    - Primary care staff (clinical and non-clinical)
    - Secondary care staff – include falls prevention in induction and rolling education programmes
    - High risk environments (care home staff)
    - Community carers and nursing staff

Multifactorial falls risk assessment and interventions.

Home hazards:

- Work with fire service to identify and modify home hazards

Exercise:

- Age UK fitness classes
- Local authority fitness classes
- Falling on your Feet Dance Programme

Environmental factors

- Additional monies are being invested in North Tyneside by the Mayor and Cabinet to carry out a planned improvement programme of works on the borough's footways. Using local knowledge and intelligence sources illustrated above, we can ensure we target our works to improve the movement of highway users in and around the borough.
- There is a programme of footway improvements works currently being prepared. Once the programme of improvement works has been agreed the work will commence.

Early intervention to restore independence

In North Tyneside there is currently no community falls service and no integrated falls pathway. In other areas these have been shown to be a cost effective way of reducing falls in other areas.

Develop an integrated falls pathway and community falls service with easy to access multifactorial assessment and intervention:

- Single point of access for referrals
- Offer a standardised multifactorial assessment as per NICE guidelines
- Assess bone health and treat at risk patients as per guidelines
- Direct referral for multifactorial intervention as per NICE guidelines
    - Strength and balance training.
    - Exercise classes
    - Education and training – coordinated falls education programme
    - Cardiac pacing.
    - Modification of environmental hazards – Fire service, Care Call
    - Medication review

Develop fracture liaison service – to identify fragility fractures and ensure appropriate investigation/ prescription/ communication with GP.

The North Tyneside Health Economy has 3 ambitions relating to **early intervention to restore independence:**

- ✓ **Ambition 1: 100% of patients seen in the falls clinic within 3 months of first fall**
- ✓ **Ambition 2: Reduce the number of inpatient falls**
- ✓ **Ambition 3: Reduction in the number of admissions for falls in patients aged >65**

Respond to the first fracture and prevent the second

Ensure robust systems are in place to identify all fragility fracture patients presenting to MIU/ A+E and that this is communicated with GP and the patient.

Develop a fracture liaison service to identify patients who have suffered fragility fracture and ensure they have the correct investigations +/- treatment and follow up arrangement.

Improve mechanisms for review of patients on bone protection:

- Develop a template for use in the community when following up patients with osteoporosis
- Fracture liaison service for advice on bone health

Direct referral into the community falls service for patients who suffer fragility fracture.

Reduce inpatient fractures.

The North Tyneside Health Economy has one ambitions relating to **respond to the first fracture and prevent the second**

- ✓ **Ambition: reduction in % of patients aged >75 sustaining a fracture**

Improve patient outcomes and increase efficiency of care after hip fracture

Follow blue book standards with continual evaluation of service provision against these standards.

Develop fracture liaison service to ensure fragility fractures are identified and information on bone protection is communicated on discharge summaries/ fracture clinic letters.

Ensure all hip fracture patients are able to access the community falls service and multifactorial assessment/ interventions.

Ensure multifactorial assessment and interventions as appropriate.

Training for community staff for care post fracture.

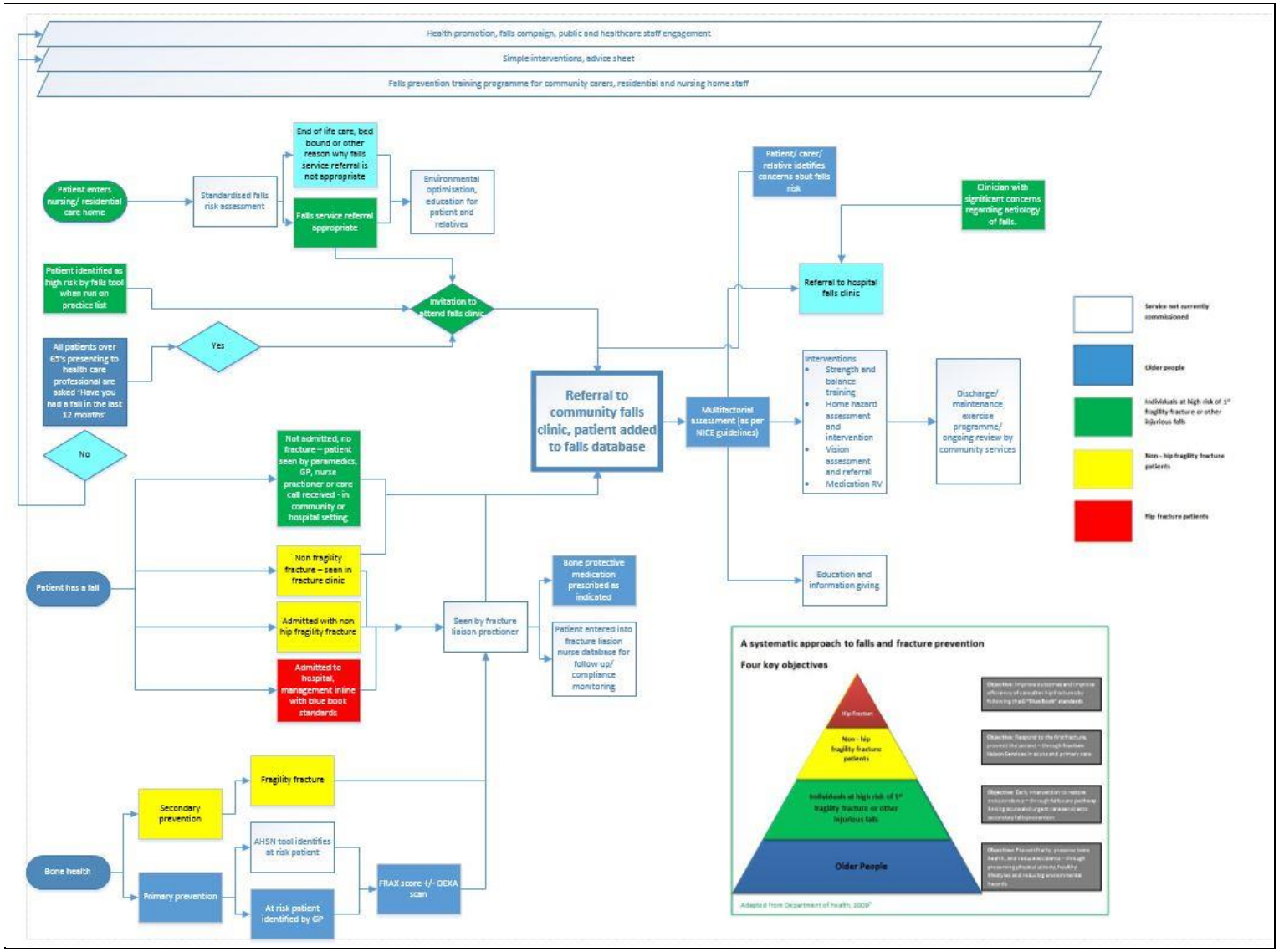
The North Tyneside Health Economy has one ambitions relating to **improve patient outcomes and increase efficiency of care after hip fracture**

- ✓ **Ambition: increase in % of patients returning to usual place of residence**

7. Draft Falls Action Plan

No	Priority	Action	Task
1	Improve patient outcomes and increase efficiency of care after hip fracture.	Continual evaluation of secondary care service provision against blue book standards	Liaise with hospital trusts to find out what current audit arrangements are
		Start bone protection for patients who sustain a hip fracture and ensure this is communicated to the GP via discharge summary.	Liaise with hospital to discuss modifying current summaries/ education for junior doctors.
		Develop direct referral pathway for hip fracture patients to the commnuity falls service for multifactorial assessment/ intervention	Business case for community falls clinic/ develop integrated referral pathway
2	Early intervention to restore independence	Develop an integrated falls service	Business case for community falls clinic/ develop integrated referral pathway
			Develop a fracture liaison service to assist with identification of fragility fractures
			Collate data from social care, NEAS, fire service, community nursing teams on patients who fall for direct invitation for referral to falls clinic
3	Respond to the first fracture and prevent the second	Patient identification	Develop a fracture liaison service to assist with identification of fragilty fractures
			Direct referral to community falls clinic for multifactorial assessment and intervention
		Improve bone health	Develop a CCG osteoporosis template to assist with assessment and management
			Develop a fracture liaison service to assist with identification of fragilty fractures
			Include information on fragility fractures and bone proteciton medication on discharge summaries.
4	Prevent frailty, promote bone health and reduce injuries.	Case identification	AHSN bone health screening tool
			Train practice staff to ask over 65's if they have had a fall in the last 12 months.
			Direct referral to community falls clinic for multifactorial assessment and intervention by NEAS, community nurses, social care, fire service, patients.
		Public awareness	Falls prevention and awareness campaign
		Staff awareness	Falls prevention and awareness campaign
		Home hazard assessment and modification	Work with the fire service to develop home hazard modification programme

Appendix One – Falls Pathway



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Name of Group	Date	Comments
North Tyneside Falls Group	4th July 2017	Ratified
North Tyneside CCG Governing Body	26th September 2017	Verbal update
	23rd January 2018	Final version to be ratified
North Tyneside Local Authority	To be confirmed	
Health & Wellbeing Board	To be confirmed	