Bath and North East Somerset, Swindon and Wiltshire Partnership
Working together for your health and care

Swindon Falls and Bone Health Strategy 2022-2027

Foreword

When someone falls, this can affect the whole health and social care system: from the ambulance that attends the fall, the hospital that provides treatment, support from the voluntary sector, and any social care package needed. But more than that, the fear of falling before or after a fall can affect someone's wellbeing and quality of life in a significant way making them reluctant to go out, experience new things and can increase isolation and immobility. We know that muscle mass decreases approximately 3–8% per decade after the age of 30 and this rate of decline is even higher after the age of 60, increasing the risk of a fall. Building balance and strength into day to day life should be as part of looking after ourselves as brushing our teeth or eating a balanced diet.

This strategy sets out a vision for Swindon which recognises that organisations working together, focusing on prevention, reducing risk and integrated care will make the most difference. It challenges us to think differently about falls risk and how we can all age well. The strategy provides a call to action, building on the work over many years of the Swindon Falls and Bone Health Collaborative, and recognising the opportunities working across the integrated care system of BANES, Swindon and Wiltshire approach will offer.

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Introduction

This strategy sets out how partners will work together to reduce the risk and number of falls in Swindon over the next 3-5 years.

A fall is defined as an unintentional loss of balance resulting in coming to rest on the ground, the floor or other lower level (WHO, 2021). Age is recognised as one of the key risk factors for falls, with around a third of people aged 65 and over, and around half of people aged 80 and over, falling at least once a year (PHE, 2017). However, falling is not an inevitable consequence of ageing. The risk of falling can be reduced through multi factorial falls assessment, exercise that improves strength and balance, and evidence-based interventions, modifying intrinsic and extrinsic risk factors, and multi-disciplinary teams working in partnership across health and social care services.

Falls have a dramatic impact on individuals, families, and the health and social care system. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence, social isolation and increased mortality and morbidity. One in two women, and one in five men in the UK will experience a fracture after the age of 50. Hip fracture is one of the most serious consequences of fall in the older person. Hip fracture mortality is 10% at one month and 30% at one year. There is also significant morbidity with only 50% of people returning to their previous level of mobility, only a minority of people will regain their previous abilities and one quarter of people will require long term care either at home or in a residential setting (RCP, 2019).

In addition to understanding the personal impact of falls on an older person, there is also the financial impact on the health and social care system to consider. The national cost of fragility fractures to the UK has been estimated at £4.4bn, which includes £1.1bn for social care (PHE, 2017). In 2019 to 2020 there were 234,793 emergency hospital admissions in the UK related to falls among patients aged 65, and the trend in hospital admissions is continuing to increase (PHE, 2021).

PHE (2021) have used modelling to predict the impact of the pandemic on the incidence of falls. As a result of reduced strength and balance activity during the pandemic, it is projected that there could be around 250,000 additional falls each year, with potential costs to the health and social care system of £210 million:-

- Nearly 26,000 of these additional falls will require a GP visit
- 30,000 will require an ambulance call-out
- Over 14,000 will require an inpatient stay
- Over 12,000 will require a home care package

A systems approach to reducing the negative health consequences of falls acknowledges that while it may not be possible to stop falls from happening all together, it is achievable to take steps to reduce the chance of a fall occurring and also the amount of harm a person experiences in the event of a fall (WHO, 2021).

The risk of falls can be reduced by professionals, organisations and the public working together. Evidence suggests that the number of falls can be reduced by up to 30% through development of a multi-agency pathway focusing on early identification and prevention, multifactorial assessment and interventions for people at risk of falling (NICE, 2013).

The Falls Strategy primary objective is to develop a system-wide, anticipatory, approach to falls reduction. This will be achieved by services working in partnership, using a left shift approach across acute and primary healthcare, social care, housing, public health, third party organisations and the voluntary sector to reduce falls and support people to age well and remain independent.

A Whole System Approach to Falls Reduction

The Falls and Fracture Consensus Statement (PHE, 2017) calls for a collaborative, whole system approach towards falls reduction and recognises the need for all local systems to work together across boundaries to achieve maximum benefit to reduce risk of falls. There are 8 key interventions that are proposed to support the effective implementation of a falls prevention strategy.

- **Risk factor reduction** – consistent and effective public, private and voluntary sector collaboration and action to reduce exposure to risk factors needs to take place at the different stages of the life course.

- **Case finding** – use population health management data to identify and predict frailty and falls risk earlier in Primary Care. Older people coming into contact with professionals and organisations with health and care as part of their remit should be asked routinely about falls. All patients aged 65 and over admitted to hospital should be regarded as at risk of falling.

- **Risk assessment** – those identified through case finding should be given access to a comprehensive risk assessment carried out by an appropriately trained professional and followed up with appropriate interventions. This may include strength and balance exercises, home hazard assessment, vision assessment, and medication reviews.

- **Strength and balance exercise programmes** – exercise should be increased in line with national recommendations for people aged 65 and over. Older people living in the community with a low to moderate risk of falls should have access to strength and balance exercise programmes. To be effective programmes of exercise should comprise of a dose of 50 hours or more, delivered for at least two hours per week.

- **Healthy homes** – a systematic review found that home hazard assessments and modifications carried out by Occupational Therapists (OTs) reduced the risk of falling by 12%. Home hazard assessments can be provided using a multiagency approach, such as Fire Service Safe and Well visits, Occupational Therapists, handy person schemes, housing practitioners. Any older person who has received treatment in hospital following a fall should be offered a home hazard assessment.

- **High risk environments** – implementation of multi-disciplinary falls interventions to reduce risk of falls in high risk environments. High risk environments include hospitals, mental health and learning disability units, and residential and nursing homes settings. This is particularly important for patients with dementia or delirium who are at high risk of falls in hospital.

- **Fracture Liaison Services** – patients presenting with a fragility fracture should be assessed for osteoporosis and receive effective management to improve their bone health and reduce their risk of future fractures. It is recommended that patients are referred for a falls risk assessment, strength and balance groups and prevention services where possible.

- **Collaborative care for patients sustaining a severe injury following a fall** – care should be multi-disciplinary and should involve orthopaedic doctors, nurses, geriatricians and allied health professionals within a hospital, but also liaison and integration with related services, particularly falls prevention services and bone health services, mental health, primary care and social services.

Where are we now?

On average 348 patients are admitted each month to Great Western Hospitals NHS Foundation Trust with a fall as the primary diagnosis code (Table 1).

Table 1 Number of hospital admissions due to a fall in the over 65 age group in Swindon.

In 2020/21 195 people aged 65 years and over were admitted to hospital with a hip fracture (Table 2).

Table 2 Hip Fractures in people aged 65 years and over in Swindon

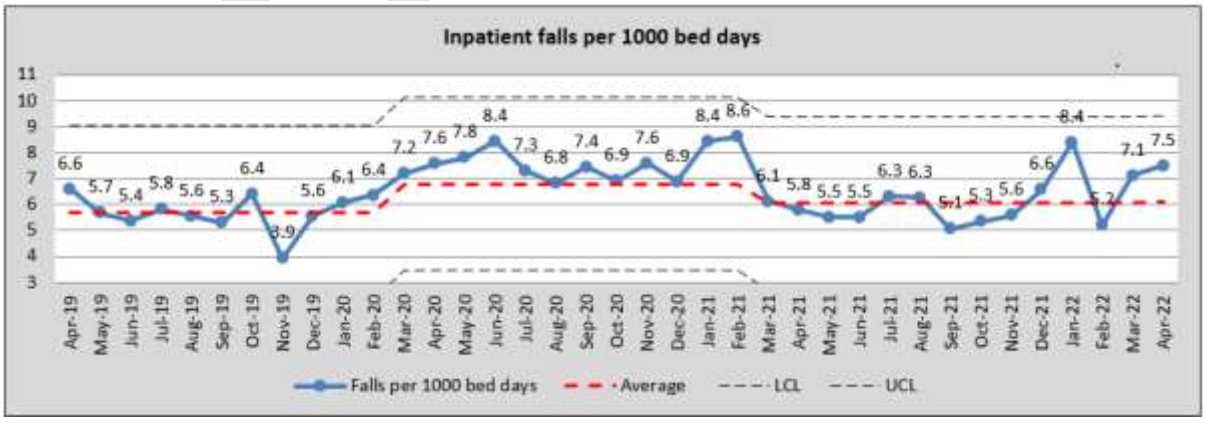
The Royal Osteoporosis Society has provided estimates of the financial costs of a fractured neck of femur to health and social care organisations (Figure 3). The estimated cost of care for 195 people aged over 65, admitted with a fractured neck of femur, during 2020/21 is £ 3,232,905.

Table 3 Royal Osteoporosis Society estimated financial cost of a fractured neck of femur (ROS, 2022)

		Hip fracture (inpatient)
Acute care		£7,894
Community and primary care	*Benefits detail*	£448
Social care		£8,237

On average 111 inpatient falls are reported in the Great Western Hospital each month, equating to an average rate of 6.1 falls per 1000 bed days.

Table 4 Inpatient falls per 1000 bed days



Vision

For Swindon residents to live as independent a life as they are able, free from harm from falls where possible. We commit to:

- ✓ Promoting integrated system wide working
- ✓ Fighting frailty and improving resilience through education, exercise and activity opportunities
- ✓ Promoting prevention
- ✓ Working in a person centred way
- ✓ Providing evidence of our work, outcomes and learning

Aims

To deliver a Falls and Bone Health Strategy for Swindon that enables early identification of risks, planning and implementation of individualised falls reduction interventions for people in our local community who are at risk of falling.

Objectives

The objectives are to:

- Develop an integrated system-wide, anticipatory, approach to falls reduction.
- Promote exercise and active ageing, population health and well-being, enabling adults to stay well, active and to live as independently as possible.
- Identify those at higher risk of falls or fragility, and making a plan together to reduce the risk of falls
- Respond to an individual who has fallen (including immediate response where appropriate), and plan with them to reduce risk of future falls.
- Coordinated management of the highest risk individuals including specialist assessment

Outcomes

The measures against which the strategy will be assessed are:

- Number of local people reporting as active or meeting physical activity guidelines across the life course
- Number of people accessing evidence based preventative exercise and strength and balance activity and classes
- Number of care homes offering evidence-based activity and exercise to residents
- Number of care homes using an effective, evidence based, post fall management tool.
- Number of SWAST attendances due to falls
- Number of admissions to hospital for individuals over 65 years of age that have fallen
- Number of people admitted to hospital with fractured neck of femur
- Percentage of people who have sustained a fragility fracture being seen by fracture liaison services

- Number of inpatient falls in hospital
- Number of people referred to the Live Well Hub for falls prevention or physical activity services
- Number of people referred to the Specialist Falls Service and Clinic
- The number of two stage multi factorial assessments being completed

Key Priorities of the Strategy

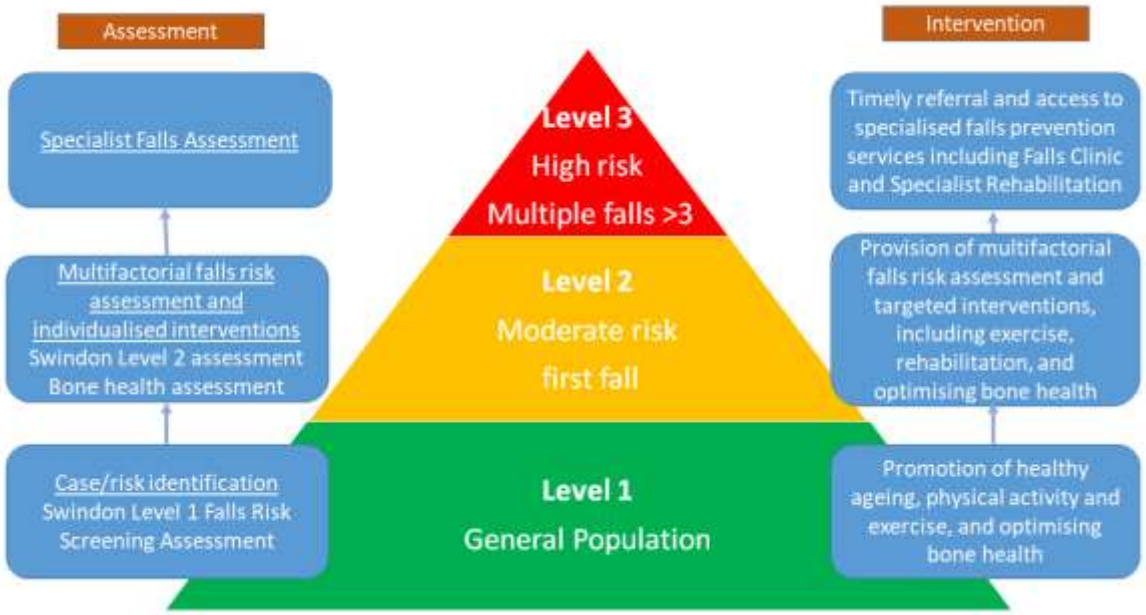
In order to deliver the aims of the strategy we will focus on the following priority areas.

1. **Introducing a Falls Prevention Model and an Integrated Pathway for Falls Prevention in Swindon**

The first priority of the strategy is to implement a model for falls prevention and system wide integrated falls pathway in Swindon.

It is proposed that the model for falls prevention in Swindon (Figure 1) will include three levels of service provision, to illustrate the differing levels of need in the population. Level 1 focuses on health promotion, ageing well, and risk identification to support early interventions. Level 2 focuses on ensuring that people who are at risk of falling, or who have sustained a fall are offered a multifactorial falls risk assessment and individualised interventions by a healthcare professional. Finally, Level 3 emphasises the need for people at the highest risk of falls to be referred and have access to specialist services, such as falls clinics.

Table 1 Model for Falls Prevention in Swindon – Levels of Service Provision



Level 1 – Early interventions to promote healthy ageing, physical activity, bone health, and reduce risk of falls

Reduce the risk of falls in the future through a coordinated approach to health promotion and ageing well in the community. To improve the quality of life of individuals and families, and reduce demand on health and social care services, we will aim to:

- Enable the public of Swindon and Shrivenham to access relevant information about how they can maintain good bone health and reduce their risk of falling, as independently as possible.
- Develop falls services accessible to the local population at the right time, in the right place, and with the right workforce model.
- Raise the awareness that falls are not an inevitable part of ageing.
- Ensure older people in contact with healthcare professionals are asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s.
- Establish systems and processes for voluntary and community sectors to identify people at risk of falling and effectively refer them onto the Integrated Falls Pathway.
- Equip service providers with the knowledge and skills to both reduce risk and facilitate individuals through the Integrated Falls Pathway.
- Ensure older people reporting a fall or considered at risk of falling are observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance. People should be offered or signposted to a range of evidence based preventative exercise and strength and balance classes e.g. Otago, Fame and Tai Chi
- Incorporate and maximise the use of digital technology to facilitate self and virtual assessment and education and to deliver the Integrated Falls Pathway. (E.g. Localised web-based self-assessment, advice and signposting tool, Virtual assessment, intervention and group education, Homeline telecare , Installation of falls sensors alarms in acute inpatient wards including bathroom alarms in high risk areas)
- Offer or signpost to foot health services (eg chiropody and podiatry) including the voluntary and private sector
- Provide education on appropriate footwear to reduce risk of falls ensuring an opportunity for good footwear is recorded and assessed.
- Offer or signpost mental health support for the population
- Offer or signpost to services offering hearing and sight checks
- Provide community-based services to support safety at home.
- Ensure we have the right people, right skills, and right numbers of workforce at a time and location that is appropriate for local residents.

Level 2 and 3 – Reducing risk amongst people who are at moderate or high risk of falling

For those who have already fallen or at a high risk we will:

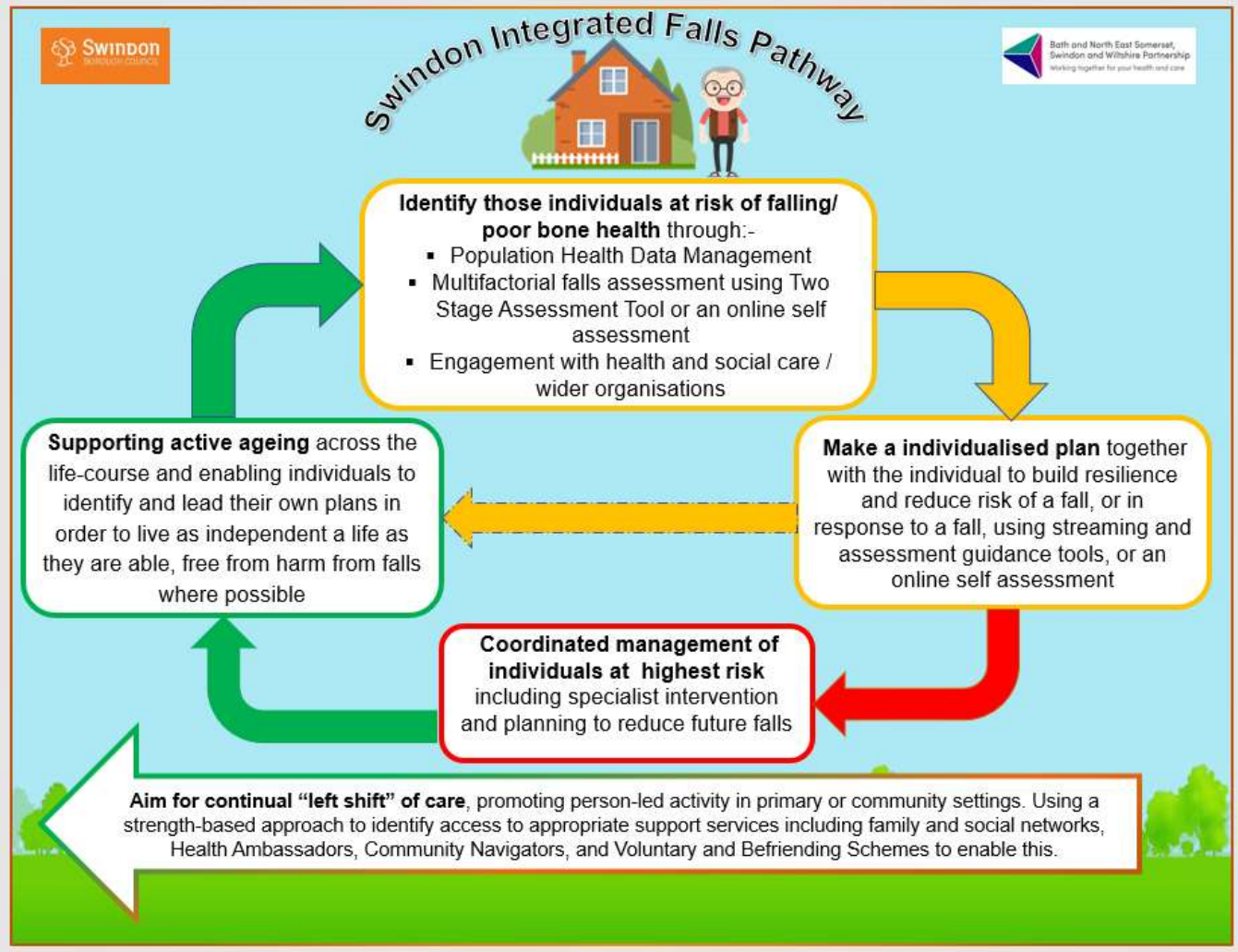
- Commit to engaging multi agency services and teams with the Integrated Falls Pathway
- Develop specialist falls services accessible to the local population at the right time, in the right place, and with the right workforce model.
- Work to ensure that older people who present for medical attention 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. NICE CG 161 (2013) recommends that multifactorial assessment may include the following:

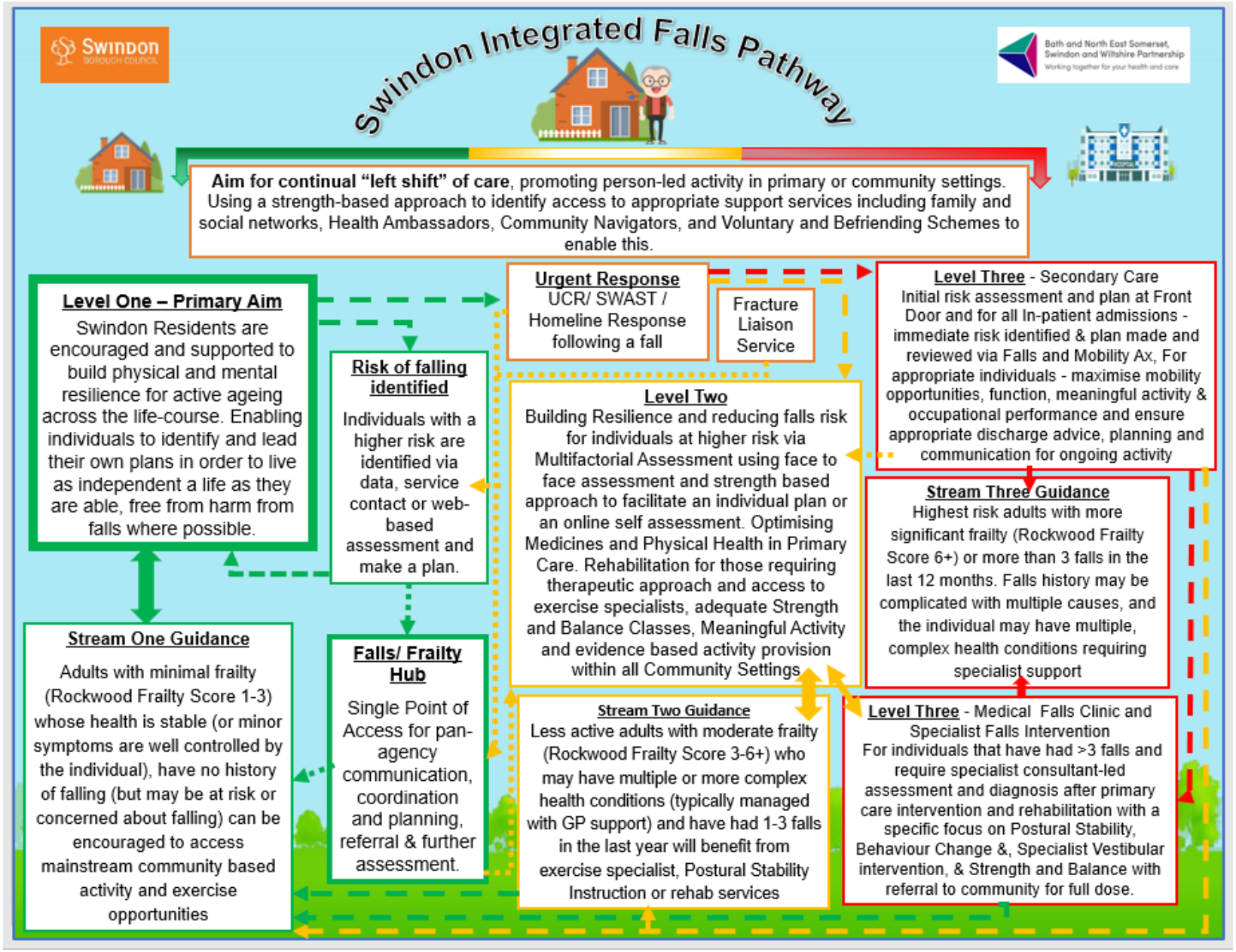
    - Identification of falls history
    - Assessment of gait, balance and mobility, and muscle weakness with appropriate exercise and activity interventions prescribed, delivered and supported across the pathway
    - Assessment of osteoporosis risk
    - Assessment of the older person's perceived functional 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

- Work to ensure that all older people who have been assessed as being at increased risk of falling, or who have recurrent falls, should be considered for individualised multifactorial interventions. In addition to management of causes and identified risk factors, interventions should include the following:-
    - access to strength and balance training
    - home hazard assessment
    - vision assessment and referral
    - opportunity for medicines to be reviewed by an appropriate healthcare professional.
- Develop effective falls policies, procedures and training for staff, in all inpatient settings and other nursing and care settings.
- Work in partnership with Urgent Community Response and SWAST to develop local pathways to manage frailer older adults who are able to be supported at home following a fall, or those who have been identified as high risk of falling.

Swindon Integrated Falls Pathway

An operational Swindon Integrated Falls Pathway (Table 2) has been developed to enable a whole system, multi-agency approach to falls prevention in Swindon.




Swindon Integrated Falls Pathway
Swindon Borough Council
Bath and North East Somerset, Swindon and Wiltshire Partnership
Working together for your health and care
Aim for continual "left shift" of care, promoting person-led activity in primary or community settings. Using a strength-based approach to identify access to appropriate support services including family and social networks, Health Ambassadors, Community Navigators, and Voluntary and Befriending Schemes to enable this.
Level One – Primary Aim
Swindon Residents are encouraged and supported to build physical and mental resilience for active ageing across the life-course. Enabling individuals to identify and lead their own plans in order to live as independent a life as they are able, free from harm from falls where possible.
Risk of falling identified
Individuals with a higher risk are identified via data, service contact or web-based assessment and make a plan.
Urgent Response
UCR/ SWAST / Homeline Response following a fall
Fracture Liaison Service
Level Two
Building Resilience and reducing falls risk for individuals at higher risk via Multifactorial Assessment using face to face assessment and strength based approach to facilitate an individual plan or an online self assessment. Optimising Medicines and Physical Health in Primary Care. Rehabilitation for those requiring therapeutic approach and access to exercise specialists, adequate Strength and Balance Classes, Meaningful Activity and evidence based activity provision within all Community Settings
Level Three - Secondary Care
Initial risk assessment and plan at Front Door and for all In-patient admissions - immediate risk identified & plan made and reviewed via Falls and Mobility Ax, For appropriate individuals - maximise mobility opportunities, function, meaningful activity & occupational performance and ensure appropriate discharge advice, planning and communication for ongoing activity
Stream Three Guidance
Highest risk adults with more significant frailty (Rockwood Frailty Score 6+) or more than 3 falls in the last 12 months. Falls history may be complicated with multiple causes, and the individual may have multiple, complex health conditions requiring specialist support
Stream One Guidance
Adults with minimal frailty (Rockwood Frailty Score 1-3) whose health is stable (or minor symptoms are well controlled by the individual), have no history of falling (but may be at risk or concerned about falling) can be encouraged to access mainstream community based activity and exercise opportunities
Falls/ Frailty Hub
Single Point of Access for pan-agency communication, coordination and planning, referral & further assessment.
Stream Two Guidance
Less active adults with moderate frailty (Rockwood Frailty Score 3-6+) who may have multiple or more complex health conditions (typically managed with GP support) and have had 1-3 falls in the last year will benefit from exercise specialist, Postural Stability Instruction or rehab services
Level Three - Medical Falls Clinic and Specialist Falls Intervention
For individuals that have had >3 falls and require specialist consultant-led assessment and diagnosis after primary care intervention and rehabilitation with a specific focus on Postural Stability, Behaviour Change &, Specialist Vestibular intervention, & Strength and Balance with referral to community for full dose.

Swindon Integrated Falls Pathway

Level One- Early intervention to promote healthy ageing, physical activity and bone health via Upstream, Anticipatory, Preventative Intervention

How?

- Public Health Promotion & Lifelong Learning enabling adults to stay well, active & independent, giving importance to activity across the life-course
- Active ageing across life-course (CMO and WHO Guidelines) that is accessible and appropriate
- Evidence based stamina, Strength and Balance and Falls Prevention class provision (PSI and L4 Specialist Exercise Instructors) in all community settings (including residential care)
- Equitable Pathway Access to appropriate services/ organisations to offer and enable physical literacy, exercise, activity, social integration & support to build resilience in older years
- Meaningful Activity opportunities for all older/at risk adults in all communities.
- Integrating and standardising exercise referral schemes and pathways, linked to frailty, to enable clear equitable access. Integrating rehabilitation, exercise referral and health coaching to transition more adults from inactive to active with sustained lifestyle change.
- Enabling influencers of inactive adults
- Promoting and maximising use of digital technology for assessment and advice
- Use of Behaviour Change models of support, and Strength Based Approach
- Publicise and promote the additional benefit of meaningful exercise and activity on reducing loneliness, fear and reduced mood and confidence
- Promoting bone health specific education, appropriate activity and signposting
- Confidence and Competence in the workforce across all services in contact with inactive and older adults to advise on activity opportunities however big or small
- Assessment, advice and support to be offered face-to-face, virtually, through a web-based assessment (as a priority) and in "information libraries" in a variety of formats and languages, accessible to all
- Prioritise identifying and reversing deconditioning within communities and care homes (including enhanced MDT and Senior Games etc)
- Target populations inversely affected by Covid-19
- Support populations with lower socio-economic opportunity and offer subsidised exercise and activity opportunities, equitable to all
- Using tools to standardise recognition (Clinical Frailty Score, Comprehensive Geriatric Assessment, Stage1/Stage 2 Falls Assessment, Functional Fitness MOT)
- Optimising Medications and Physical Health in Primary Care
- Safe Home & Community environments, conducive to activity
- Use of tools and training to identify injuries and who does and doesn't require emergency assistance post fall
- Promoting childhood exercise with impact activities and supporting pre-teen and teenage engagement with exercise especially for girls
- Importance of activity and "impact shock" exercise on bone health for pre-menopausal women in midlife
- Reducing inequality of access to health information and functional activity and exercise opportunities
- Easier and Sustainable access and support to access activity for all
- Building exercise activity into what is already there (eg Care Homes, Day Centres, lunch clubs, knit and natter etc)

Who? (Wider Community Led Activity)

- All to signpost using guidance document and local streaming tool
- All Stream One Activity opportunities
- Dorset & Wilts Fire –Safe and Well Team
- Active Partnership, Private exercise, Charities and 3rd Sector
- Care Homes & Day Centre exercise and meaningful activity programming
- Local Authority, Supported Housing, Telecare/Telehealth and Homeline
- Pharmacy Teams, Drugs and Alcohol Services, Opticians
- Community Services – Bars, Hairdressers, Libraries etc

Swindon Integrated Falls Pathway

Level Two – Identifying those at moderate risk of falling, building resilience and reducing the risk of future falls

How?

- Encouraging individuals to lead their lifestyle plans using strength based conversations
- Population Health data management
- Falls/ Frailty MDT Hub for pan-agency communication, coordination and planning, referral & further assessment.
- Multifactorial falls assessment using Two Stage Assessment Tool, In-patient Falls and Mobility Assessment or an online self assessment (with training so that stakeholders feel confident and competent to complete)
- Individually tailored plans to reduce risk of a fall or in response to a fall, using streaming and assessment guidance tools, or an online self assessment
- Rehabilitation for those requiring therapeutic approach
- Access to exercise specialists, adequate Strength and Balance Classes and evidence based activity provision within Community Settings
- Signposting to appropriate activity opportunities within wider community using streaming and assessment guidance tools
- Maximising individual's environments and approaches to reduce risk
- Signposting and Activity Advice from Fracture Liaison Service
- Optimising Medicines and Physical Health in Primary Care
- Maximising technology for shared documentation
- Engagement with health and social care / wider organisations

Who?

- All individuals, Health and Social Care staff, Care Home Teams and Services in contact with inactive and older adults (Multi-Agency/ Multi-Professional Approach)
- Primary Care, MDT Rehabilitation and Specialist Exercise provision
- Community Activity/ Falls Champions

Level Three - Coordinated management of individuals at highest risk including specialist intervention and planning to reduce future falls

How?

- UCR 2 hour response for individuals not needing conveyance
- Front Door and all In-patient admissions - immediate risk identified & plan made and reviewed via Falls and Mobility Ax
- For all appropriate in-patient admissions – maximise mobility opportunities, function, meaningful activity & occupational performance and appropriate discharge advice, planning and communication for ongoing activity
- Referral to Medical Falls Clinic for individuals that have had >3 falls and require specialist assessment and diagnosis after primary care intervention
- Specialist Falls Intervention from rehabilitation therapists for individuals that have had >3 falls, have marked frailty &/or sarcopenia with a specific focus on Postural Stability, Behaviour Change &, Specialist Vestibular intervention, & Strength and Balance with auto referral to community for full dose.
- Identification via Homeline and SWASFT of highest risk individuals and individuals having frequent falls with route to Falls/Frailty Hub for pan-agency communication, coordination and planning, referral & further assessment

Who?

- Falls Lead Consultant, Primary Care and Integrated and Community Care
- Secondary Care and Specialist Services Provision
- Specialist Rehabilitation Therapists
- All individuals, Health and Social Care staff, Care Home Teams and Services in contact with highest risk individuals and individuals having frequent falls. (Multi-Agency/ Multi-Professional Approach)

2. Reducing the number of falls in care homes

People in care homes are particularly vulnerable to falls and so we will work collaboratively to:

- Use data, including ambulance, GP and/or Community Nurse call outs for falls to identify homes with the greatest number of falls and potential for reduction.
- Work with care home managers and teams to implement evidence-based practice in falls risk identification and prevention in the care home setting.
- Develop a sustainable approach to ensure that all staff in care homes have a fundamental understanding of falls awareness and knowledge of referral pathways for people who are at risk of falling or who have fallen.
- Work in partnership with care homes to identify the importance of strength and balance exercise, meaningful activity and appropriate footwear and ensure training and information is available to increase understanding amongst care home teams.

3. Addressing inequality locally

In 2021 Dr Bola Owolabi, the Director for Health Inequalities Improvement at NHS England stated "The biggest opportunities are at the margins of our communities" re-emphasising the need to address health inequality at the centre of all health improvement.

Falls are a significant public health issue, being the second major cause of unintentional death and disability globally after road traffic accidents. They are also the most preventable cause of needing placement in long term care. Falls are more prevalent in community dwelling adults over 65 years of age, (women more than men) and are recorded more frequently in older people living in long-term care institutions. Physical inactivity is one of the leading risk factors for poor health and disability in later life, the proportion of people who are inactive rises with age.

During the Covid-19 Pandemic Lockdowns shielded and older adults experienced a reduction in opportunity for physical and social activity, with significantly fewer engaging in strength and balance physical activity. Consequently, there is a disproportionate increase in deconditioning amongst these groups.

Age UK and Kantar Polling found post lockdown that 1:3 older adults were less motivated to do the things they enjoy, 1:4 were not able to walk so far and 1:5 felt less steady on their feet. These results were more pronounced amongst people with long term conditions and from more disadvantaged socioeconomic backgrounds.

We will commit to the Public Health England recommendations to:

- Identify local populations where the largest reductions in physical activity can be found and ensure that physical activity recovery measures reach those

who stand to benefit from them most (including those who shielded, and older adults with multi-morbidity, dementia, in social care settings and from more deprived backgrounds).
- Promote and increase accessibility and availability of gradual strength and balance activity for older adults.
- Identify and refer older adults with functional loss, who are transitioning towards frailty and who have a fear of falling resulting from deconditioning to appropriate rehabilitation services

4. Improve bone health and reduced risk of fragility fracture

By improving bone health, we can reduce the risk of fragility fractures. This will be achieved by:

- Implementing the NICE guidance for primary and secondary prevention of fragility fracture, including osteoporosis screening and management.
- Developing a business case to run a Fracture Liaison Service, to enable a proactive approach to 'respond to the first fracture to prevent a second'. Through this service, patients who have sustained a fragility fracture would be actively identified, falls risk and bone health assessed, individual falls interventions such as balance and strength exercises initiated, and bone therapy prescribed and monitored where required.

5. Use population health management data, including falls and frailty coding, to analyse the prevalence of falls and harm in the community, and use data to anticipate the needs of our local population and plan falls service development

- Work with partner agencies to improve data collection processes and mechanisms and expand local information availability.
- Use data to understand the prevalence of falls and injuries across Swindon and Shrivenham.
- Develop an anticipatory approach to falls service provision by using local population data to 'find the right people' from at risk groups.
- Regularly review information and data to assess implementation of the strategy and to inform future improvement work and commissioning intentions.

6. Recognise and address the wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults

Public Health England commissioned a piece of work to identify the wider impacts of Covid-19 and part of this looked at how the impacts have affected older people (over 65 yrs), with a focus on deconditioning and falls. The headline projections were that:

- Older people experienced a considerable reduction in strength and balance activity between March to May 2020, with the greatest change in the 70 to 74 age group with a 45% (males) and 49% (females) decrease observed in activity.
- 110,000 more older people (an increase of 3.9%) are projected to have at least one fall per year as a result of reduced strength and balance activity during the pandemic.
- The total number of falls could increase by 124,000 for males (an increase of 6.3%) and 130,000 for females (an increase of 4.4%).

There were key recommendations identified, some intended for the whole population and some with more targeted action. As a Falls collaborative, we will consider this report and the recommendations and aim to implement learning into the Integrated Swindon Falls Pathway.

7. Developing the workforce

Increase the knowledge, skills and expertise in falls evidence-based practice in relevant staff groups and volunteers. This will be achieved by:

- Developing and evaluating programmes of education and training materials to meet the needs of all staff groups.
- Ensuring that opportunities for further education and training resources will be accessible to the workforce in all settings.

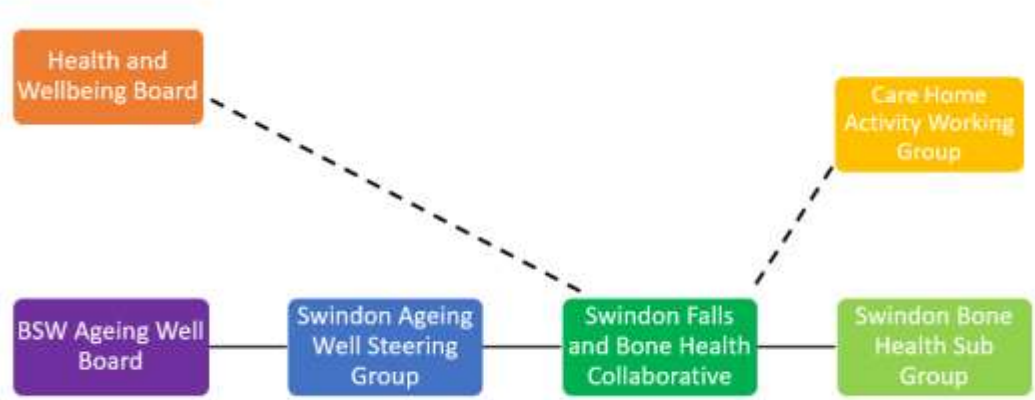
8. Building opportunities for public engagement

- To deliver the strategy and develop falls services we will ensure that individuals with lived experiences and their families are involved and engaged in falls service development. An advisory group will be established to feed in lived experience as the action plan is further developed.

Delivering the Swindon Falls Strategy

To deliver the Falls Strategy an **immediate** review of service capacity is required in order to propose a business case to address already known gaps and those newly identified. The business case must make specific recommendations about the function, structure, and workforce of the specialist falls services required to meet the needs of the local population. Without additional capacity it will not be possible to deliver the pathway and individuals who are identified as being at risk will not be offered appropriate support or intervention.

Governance Arrangements



The multi-agency Swindon Falls and Bone Health Collaborative will oversee the delivery of this system wide approach to falls prevention. Progress with the key priorities will be evaluated and reported into the BSW Ageing well Board via the Swindon Ageing Well Steering Group.

The group will ensure that a detailed implementation plan is developed, monitor progress of implementation and ensure that risks to delivery are identified and escalated.

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