
Age-Friendly
Futures Summ
Stronger together: uniting community, clinical and care for falls prevention
14:00-15:00
#AgeFriendlyFutures

Falls:

"An unexpected event in which the person comes to rest on the ground, floor, or lower level" (ProFaNE Grp 2015)

1. Falls: the size of the problem
2. Fall prevention
3. Uptake & adherence
4. Population health approach

Prof Chris Todd

School of Health Sciences

The University of Manchester

No conflict of interest:
Funding NIHR Older People and Frailty / Healthy Ageing Policy Research Unit (NIHR PR-PRU-1217-21502, NIHR206119). NIHR ARC-GM (NIHR200174) & Chris Todd's NIHR Senior Investigator Awards (NIHR200299 & NIHR205156). The views expressed are those of the authors and not necessarily those of the National Institute for Health & Care Research, National Health Service, Department of Health and Social Care, or its partners.

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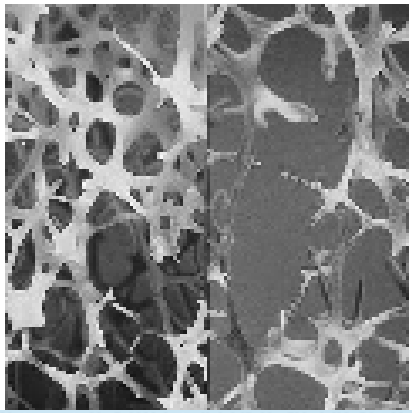
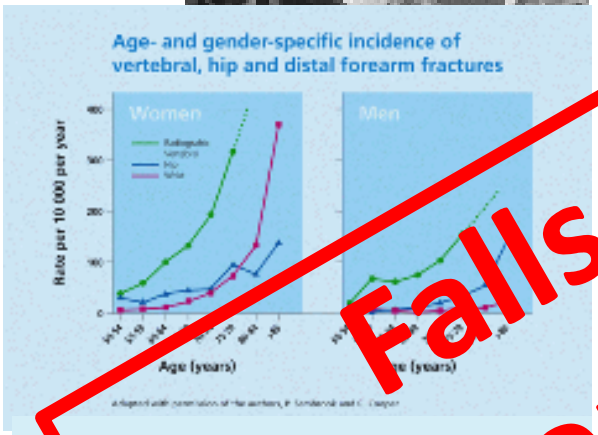
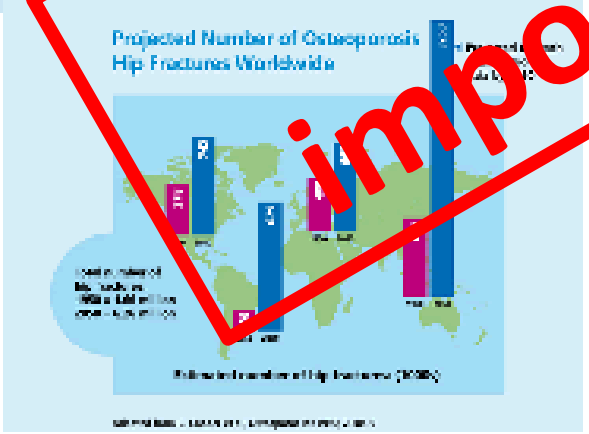


www.iofbonehealth.org





30-40% community dwelling >65yrs fall in year

- 40-60% no injury
- 30-50% minor injury
- 5-6% major injury (excluding fracture: c 5-2% TBI)
- 5% fractures
- 1% hip fractures

Falls most serious frequent home accident

50% hospital admissions for injury due to fall

History of falls major predictor future fall

Falls are a big & important problem !

Masud, Morris Age & Ageing 2001; 30-S4 3-7
Rubenstein. Age & Ageing; 2006; 35-S2; ii37-41

Lawrence et al. BMJ Open 2016;6:e012197

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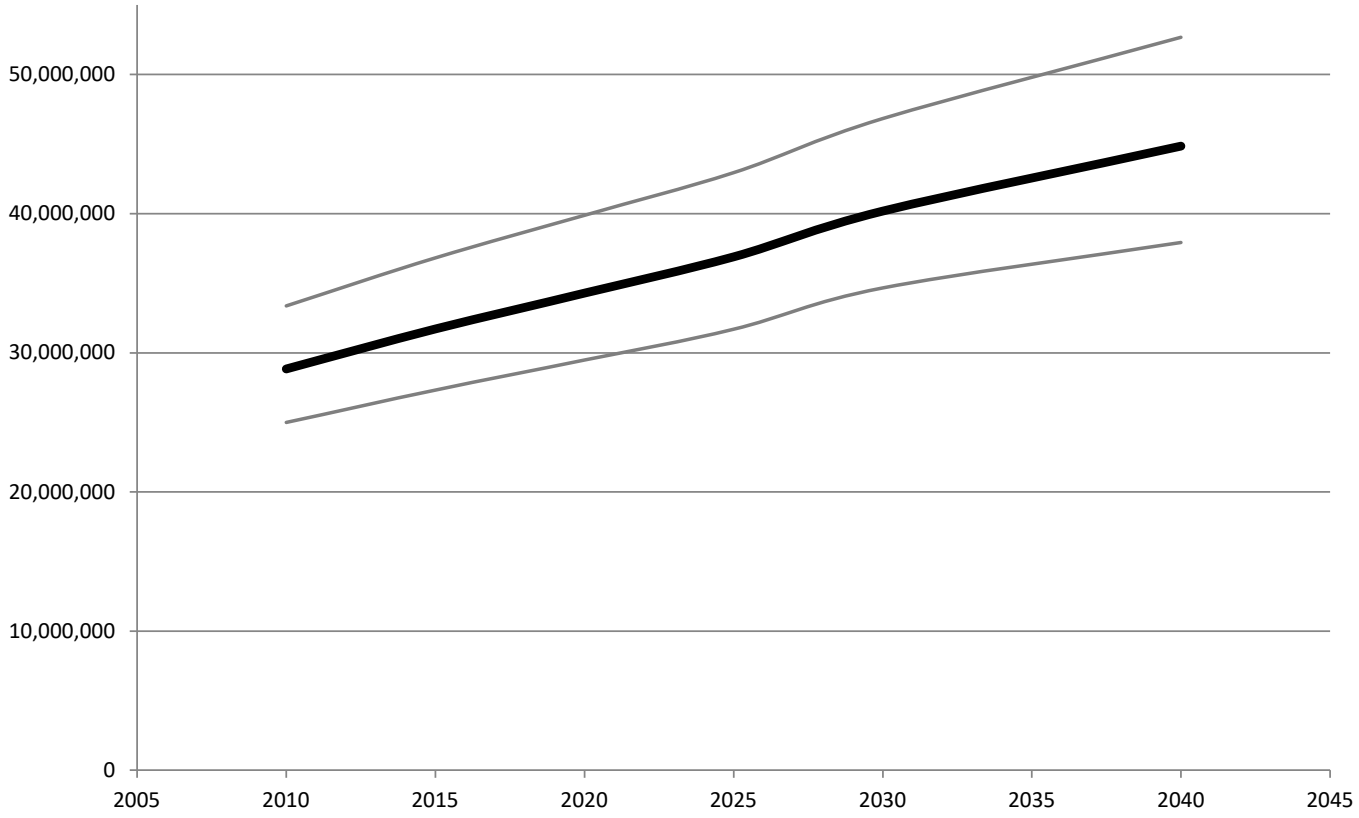
EU28 Falls amongst community dwelling older people (60 and above) 2015-2040 (estimate; 95% CIs) men & women



Todd et al 2016 report to EC

Risk factors for falls amongst community dwelling older people

- **Socio-demography**
  - Age, sex, ethnicity, living conditions
- **Psychological**
  - Cognition, depression, concerns-about-falling, self-rated health
- **Medication use**
  - Number of medications, anti-epileptics, sedatives, anti-hypertensives
- **Mobility & sensory issues**
  - History of falls, walking aids, gait problems, physical disability, vision or hearing impairment, physical activity

Becker C, Woo J, Todd C. Falls *Oxford Textbook of Geriatric Medicine* 2018

adapted from Deandrea et al, 2010

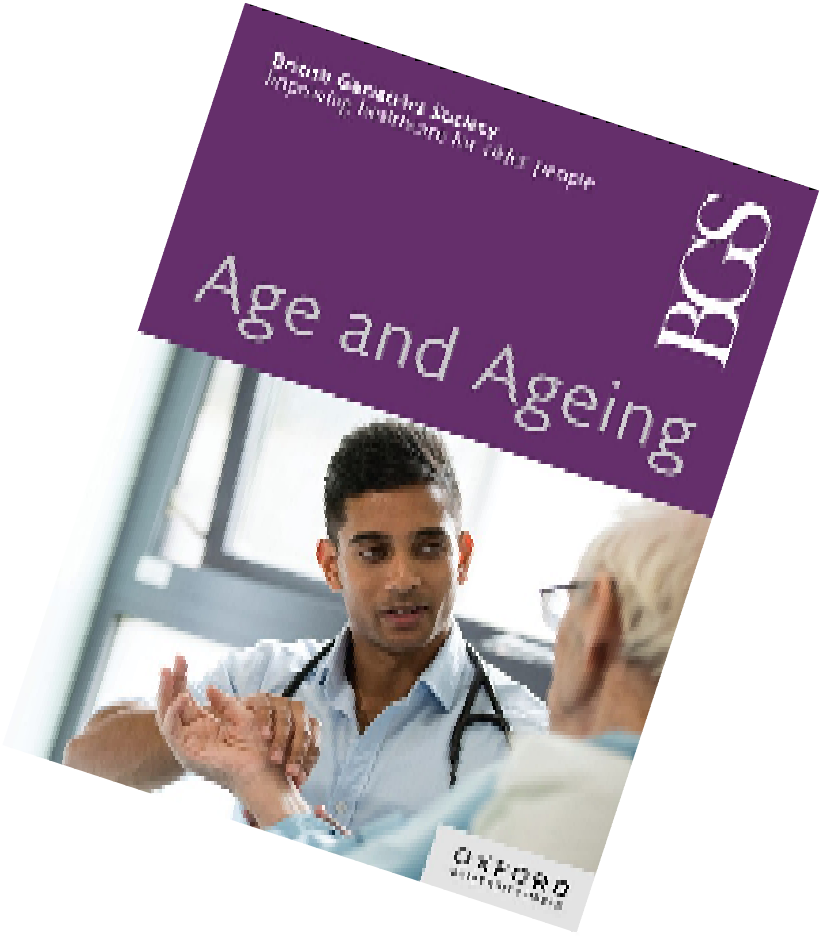
World Guidelines for Falls Prevention and Management for Older Adults 2022

Age and Ageing 2022; 51: 1–36
https://doi.org/10.1093/ageing/afac205

GUIDELINE

World guidelines for falls prevention and management for older adults: a global initiative

Manuel Montero-Odasso[1,2,3,*], Nathalie van der Velde[4,5,*], Finbarr C. Martin[6], Mirko Petrovic[7], Maw Pin Tan[8,9], Jesper Ryg[10,11], Saira Aguilar-Navarro[12], Neil B. Alexander[13], Clemens Becker[14], Hubert Blain[15], Robbie Bourke[16], Ian D. Cameron[17], Richard Camicioli[18], Lindy Clemson[19], Jacqueline Close[20,21], Kim Delbaere[22], Leilei Duan[23], Gustavo Duque[24], Suzanne M. Dyer[25], Ellen Freiberger[26], David Ganz[27], Fernando Gómez[28], Jeffrey M. Hausdorff[29,30,31], David B. Hogan[32], Susan M.W. Hunter[33], José R. Jauregui[34], Nellie Kamkar[35], Rose-Anne Kenny[36], Sarah F. Lamb[37], Nancy K. Latham[38], Lewis Lipsitz[39], Teresa Liu-Ambrose[40], Pip Logan[29], Stephen R. Lord[42,43], Louise Mallet[42], David Marsh[43], Kolin Milisen[44,45], Rogelio Moctezuma-Gallegos[46,47], Meg E. Morris[48], Alice Nieuwboer[49], Monica R. Perracini[50], Frederico Pieruccini-Faria[14], Alison Pighills[51], Catherine Said[52,53,54], Ervin Sejdic[55], Catherine Sherrington[56], Dawn A. Skelton[57], Sabrestina Dsouza[58], Mark Speechley[3,59], Susan Stark[60], Chris Todd[61,62], Bruce R. Troen[63], Tischa van der Cammen[64,65], Joe Verghese[66,67], Ellen Vlaeyen[68,69], Jennifer A. Watt[70,71], Tahir Masud[72], the Task Force on Global Guidelines for Falls in Older Adults[†]



HEALTHY AGEING RESEARCH GROUP

https://worldfallsguidelines.com

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54 Recommendations

NIHR | Applied Research Collaboration Greater Manchester

WG/domain	Area or Domain	Recommendation	Grade
WG 1 Gait and Balance Assessment Tools to Assess Risk for Falls	Significance	We recommend including gait speed for predicting falls risk.	1A
		As an alternative the Timed Up and Go Test can be considered, although the evidence for fall prediction is less consistent.	1B
	Assessment	We recommend that Gait and Balance should be assessed.	1B
WG 2 Polypharmacy, Fall Risk Increasing Drugs, and Falls	Assessment	We recommend assessing for fall history and the risk of falls before prescribing potential fall risk increasing drugs (PRIDs) to older adults.	1B
	Assessment	We recommend the use of a validated, structured screening and assessment tool to identify PRIDs to inform professional medication review in medication review targeted to falls prevention in older adults.	1C
	Intervention	We recommend that medication review and appropriate deprescribing of PRIDs should be part of multifactorial falls prevention interventions.	1B
	Intervention	We recommend that in long-term care residents, the falls prevention strategy should always include clinical deprescribing of fall-risk-increasing drugs.	1C
WG 3 Cardiovascular Risk Factors for Falls	Assessment	We recommend, as part of a multifactorial falls risk assessment, that a cardiovascular assessment that reliably includes cardiac history, auscultation, lying and standing orthostatic blood pressure, and cardiac electrocardiogram should be performed.	1B
	Assessment	In the absence of abnormalities on initial cardiovascular assessment, no further cardiovascular assessment is required, unless syncope is suspected (i.e. recurrent unexplained falls).	1C
	Assessment	We recommend that the further cardiovascular assessment for unexplained falls should be the same as that for syncope, in addition to the multifactorial falls risk assessment.	1A
	Intervention	We recommend that management of orthostatic hypotension should be included as a component of multifactorial interventions to fallers.	1A
	Intervention	We recommend that interventions for cardiovascular disorders identified during assessment for risk of falls should be the same as that for cardiac conditions when associated with syncope, in addition to other interventions based on the multifactorial falls risk assessment.	1B
WG 4 Exercise Interventions for Prevention of Falls and Related Injuries	Exercise Intervention	We recommend exercise programmes for fall prevention for community-dwelling older adults which include balance challenging and functional activities (e.g. sit-to-stand, stepping), with resource-dense aims to exercise weekly which are individualised, progressed as necessary for at least 12 weeks and continued longer for greater effect.	1A
	Exercise Intervention	We recommend inclusion, where feasible, of Tai Chi and/or additional individualised programme to enhance strength training.	1B
	Exercise Intervention	We recommend individualised supervised exercise as a falls prevention strategy for adults living in long-term care settings.	1B
	Exercise Intervention	We recommend that adults with PD in an early to mid-stage and with mild or no cognitive impairment are offered individualised exercise programme including balance and exercise training exercise.	1A
	Exercise Intervention	We conditionally recommend that adults after a stroke participate in individualised exercise aimed at improving balance (strength) ability to prevent falls.	1C
	Exercise Intervention	We recommend that adults after sustaining a hip fracture participate in individualised and progressive exercise aimed at improving mobility (i.e. standing up, balance, walking, climbing stairs) as a fall prevention strategy.	1B
	Exercise Intervention	We conditionally recommend that such programmes after a hip fracture be commenced as in-patients and be continued in the community.	2C (In-patient) & 1A (Community)
	Intervention	We recommend that community-dwelling adults with cognitive impairment (mild cognitive impairment and mild to moderate dementia) participate in exercise to prevent falls, if walking and able to do so.	1B
WG 5 Falls in Hospitals and Care Homes	Hospital Assessment	We recommend that hospitalised older adults (>65 years of age) have a multifactorial falls risk assessment. We recommend against using several falls risk screening tools in hospitals for multifactorial falls risk assessment in older adults.	2B
	Hospital management and interventions	We recommend that tailored education on falls prevention should be delivered to all hospitalised older adults (>65 years of age) and other high risk groups.	1A
	Hospitals management and Interventions	We recommend that personalised single or multifactorial falls prevention strategies based on identified risk factors or behaviours (as a minimum) be implemented for all hospitalised older adults (>65 years of age), or younger individuals identified by the health professionals as at risk of falls.	1C (Acute care) & 1B (Subacute care)
	Care homes assessment	We recommend against falls risk screening to identify care home residents at risk for falls and we recommend that all residents should be considered at high risk of falls.	1A
	Care home assessment	We recommend performing a multifactorial falls risk assessment in alternative to clinically history considering to fall risk and implementing appropriate interventions to avoid falls and fall related injuries in care home residents older adults.	1C
	Care home assessment	We recommend conducting a post-fall assessment in care home residents following a fall in order to ensure fall risk factors, adjust the intervention strategy for the residents and avoid unnecessary transfers to acute care.	1
WG 6 Cognition and Falls	Cognition Assessment	We recommend that routine assessment of cognition should be included as part of multifactorial falls risk assessment in older adults.	1B
	Cognition Assessment	We recommend including both the older adult's and caregiver's perspectives, when creating the individual falls prevention care plans for adults with cognitive impairment since this strategy has shown better adherence to interventions and outcomes.	1C
WG 7 Falls and PD and common outcomes	Assessment	We conditionally recommend a falls risk assessment for older adults with PD, including a self-report >6 risk factor assessment tool, which includes a history of falls in the previous year, FOG in the past month, and new gait apraxia.	2B
	Management and Interventions	We conditionally recommend that older adults with PD be offered multidomain interventions	2B
	Management and Interventions	We recommend that adults with PD in an early to mid-stage and with mild to no cognitive impairment are offered individualised exercise programmes including balance and resistance training exercise.	1A
	Management and Interventions	We conditionally recommend exercise training, targeting balance and strength, be offered to people with complex phase PD if supervision by a physiotherapist or other suitably qualified professional is available.	1C
WG 8 Falls and Technology	Assessment and Interventions	We conditionally recommend using telehealth and/or smart home systems (when available) in combination with physical exercise as part of the falls prevention programmes in the community.	2C
	Interventions	Current evidence does not support the use of wearables for falls prevention. Emerging evidence show that when wearables are used in exercise programmes to prevent falls, they may increase participation.	2C
WG 9 Falls in Low- and Middle-Income Countries	Implementation	Local context needs to be considered when implementing fall prevention programmes in LMIC.	1B
	Assessment	We conditionally recommend prioritising assessment of risk factors for cognitive impairment, obesity including sarcopenic obesity, diabetes, lack of appropriate footwear and environmental hazards as falls risk factors in LMIC.	2C
	Assessment	We conditionally recommend that in LMIC settings clinicians and caregivers are validated tools that are freely available in their country of residence to assess mobility dependent on resource available in	1
WG 10 Multifactorial Assessment and Interventions for Falls (Exercise-based recommendations followed by the ad hoc expert group on Environment and Falls)	Multifactorial Assessment	We recommend multifactorial, multifactorial assessment should be offered to community-dwelling older adults identified to be at high risk of falling, to guide tailored interventions.	1B
	Multifactorial assessment	We recommend multifactorial interventions, delivered by a multiprofessional, multifactorial falls risk assessment, should be offered to community-dwelling older adults assessed to be at high risk of falling.	1B
	Multifactorial (Environmental) Assessment	We recommend clinical review of an older adult's environmental hazards where they live and an assessment of their capacities and behaviours in relation to these, by a clinician trained to do so, should be part of a multifactorial falls risk assessment.	1B
	Multifactorial (Environmental) Interventions	We recommend modification of an older adult's physical home environment for fall hazards that consider their capacities and behaviours in this context, should be provided by a trained clinician, as part of a multifactorial falls prevention intervention.	1B
WG 11 Older Adults' Perspectives on Falls	Significance	We recommend clinicians should routinely ask about falls at their interactions with older adults.	1A
	Assessment	As part of a comprehensive fall assessment, clinicians should explore about the perceptions the older adult holds about falls, their causes, future risk, and how they can be prevented.	1B
	Interventions	A care plan developed to prevent falls and related injuries should incorporate the goals, values and preferences of the older adult.	1B
WG 12 Concerns about Falling and Falls	Assessment	We recommend including an evaluation of concerns about falling in a multifactorial falls risk assessment of older adults.	1B
	Assessment	We recommend using a standardised instrument to evaluate concerns about falling such as the Falls Efficacy Scale International (FES-I) or Short FES-I in community-dwelling older adults.	1A
	Assessment	We recommend using the FES-I or especially the Short FES-I the screening concerns about falling in acute care hospitals or long-term care facilities.	1B
	Assessment	We recommend exercise, cognitive behavioural therapy and/or occupational therapy (as part of a multidisciplinary approach) to reduce fear of falling in community-dwelling older adults.	1B

KEY MESSAGES

- Falls prevention at point of care: multidisciplinary perspective
- Engaging older adults integral to preventing falls: understanding beliefs, attitudes, & priorities is key
- Low risk does not mean no risk
- Multifactorial interventions effective in intermediate- high-risk community older adults
- Managing many fall risk factors have wider benefits for physical and mental health
- Concerns about falling important but neglected
- Assess fall history & risk before prescribing potential fall risk increasing drugs
- Hospital & care home settings: all older adults high risk & benefit from prevention
- Vitamin D for those at risk of vitamin D deficiency
- Application of some recommendations may need modification in LMICs

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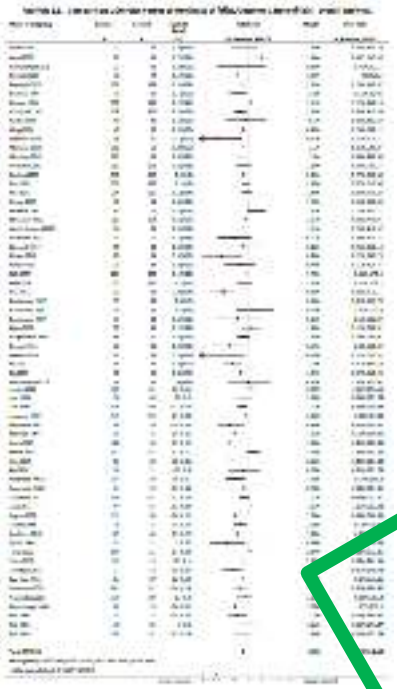

Comparison 1. Exercise versus control (rate of falls)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Rate of falls - overall analysis	59	12981	Rate Ratio (Random, 95% CI)	0.77 [0.71, 0.83]
2 Rate of falls - subgrouped by baseline falls risk	59		Rate Ratio (Random, 95% CI)	Subtotals only
2.1 Not selected for high risk of falling	29	6123	Rate Ratio (Random, 95% CI)	[0.65, 0.84]
2.2 Selected for high risk of falling	30	6858	Rate Ratio (Random, 95% CI)	0.80 [0.72, 0.88]
3 Rate of falls - subgrouped by age (threshold 75 years)	59		Rate Ratio (Random, 95% CI)	Subtotals only
3.1 Age < 75	46	9605	Rate Ratio (Random, 95% CI)	0.75 [0.63,
3.2 Age 75+	23	3376	Rate Ratio (Random, 95% CI)	0.83 [0.72,
4 Rate of falls - subgrouped by personnel	59	12981	Rate Ratio (Random, 95% CI)	0.77 [0.71, 0.83]
4.1 Health professional delivering intervention	25		Rate Ratio (Random, 95% CI)	0.69 [0.60, 0.79]
4.2 Health professional assisting intervention	34		Rate Ratio (Random, 95% CI)	0.82 [0.75,
5 Rate of falls - subgrouped by group or individual exercise	59	12981	Rate Ratio (Random, 95% CI)	0.77 [0.71, 0.83]
5.1 Group exercise	41	8163	Rate Ratio (Random, 95% CI)	0.76 [0.69, 0.85]
5.2 Individual exercise	21	4818	Rate Ratio (Random, 95% CI)	0.79 [0.71, 0.88]
6 Rate of falls - subgrouped by exercise type	59		Rate Ratio (Random, 95% CI)	Subtotals only
6.1 Balance and functional exercises vs control	39	7920	Rate Ratio (Random, 95% CI)	0.76 [0.70, 0.83]
6.2 Resistance exercise vs control			Rate Ratio (Random, 95% CI)	1.14 [0.67, 1.97]
6.3 3D exercise (balance) vs control		265	Rate Ratio (Random, 95% CI)	0.81 [0.67, 0.99]
6.4 3D exercise (balance) vs control	1	322	Rate Ratio (Random, 95% CI)	1.34 [0.98, 1.83]
6.5 Walking programme vs control	2	441	Rate Ratio (Random, 95% CI)	1.14 [0.66, 1.97]
6.6 Multiple categories of exercise vs control	11	1376	Rate Ratio (Random, 95% CI)	0.66 [0.53, 0.88]
7 Rate of falls - longest follow-up by exercise type	4		Rate Ratio (Random, 95% CI)	Subtotals only
7.1 Balance and functional exercises vs control	2	858	Rate Ratio (Random, 95% CI)	0.82 [0.65, 1.01]
7.2 Walking programme vs control	1	97	Rate Ratio (Random, 95% CI)	1.27 [0.81, 1.81]

Exercise for preventing falls in older people living in the community (Review)
Copyright © 2019 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.

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Strong evidence exercise prevents falls

Exercise for community dwelling
Sherrington et al 2019
108 trials : 23,407 participants

Sherrington et al, Exercise for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2019

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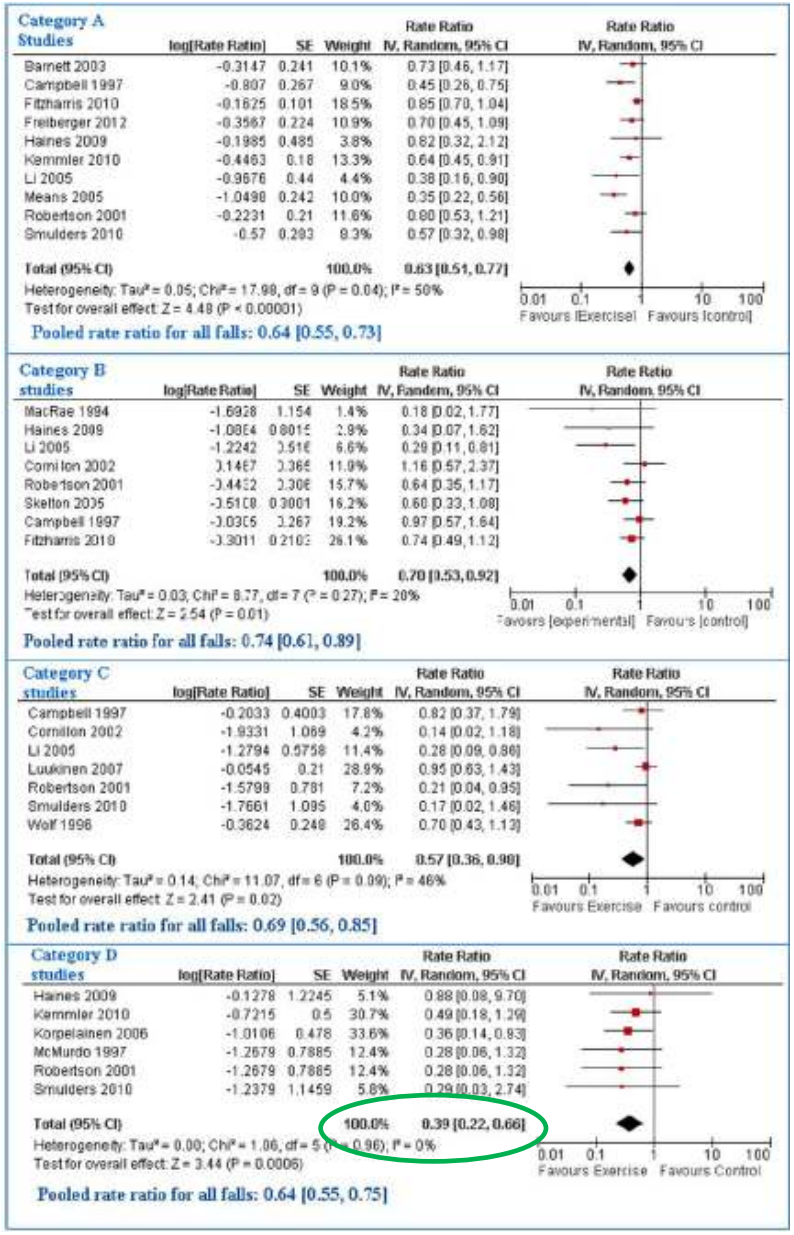
Fall injuries & exercise



A= all injuries
B= medical care injuries
C= serious injuries
D= fractures

El-Khoury F. et al The effect of fall prevention exercise programmes on fall induced injuries in community dwelling older adults: systematic review and meta-analysis of randomised controlled trials BMJ 2013; 347:f6234

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The Falls Management Exercise (FaME) Programme

Developed in the late 1990s published 2005 by Dawn Skelton
RCT reduction in falls in FaME intervention group

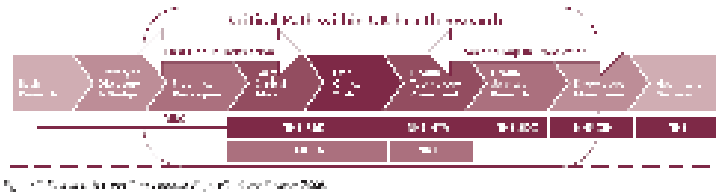
ProAct65+ UK based RCT (2014/15)
FaME ↑ physical activity ↓ falls ↑ confidence ↓ fear of falling

PhiSICAL implementation study in East Midlands, UK (2016)
Production of the FaME Implementation Toolkit

The Falls Exercise Implementation (FLEXI) study
3 regions of UK: Greater Manchester, Devon and East Midlands

http://profound.eu.com/resources/

Implementation



- Prevention programmes are effective
- Implementation gap
  - Falls prevention not a priority
  - Services not available
  - Evidence not used or modified
    - *Training needs to be to dose, challenging, progressive & regular*
    - Programmes often too short term – commissioning
  - Not me it's other older people!
  - Presentation as "be more active" NOT "falls"

1. Map out local need & available resources
2. Identify key commissioning figures to support fall prevention agenda
3. Intervention with evidence
4. Create & utilise networks & partnerships across the pathway
5. *Train the trainer* to increase replication of intervention
6. Plan required resources for delivery

(Ventre et al Age & Ageing 2025)

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Population based interventions:

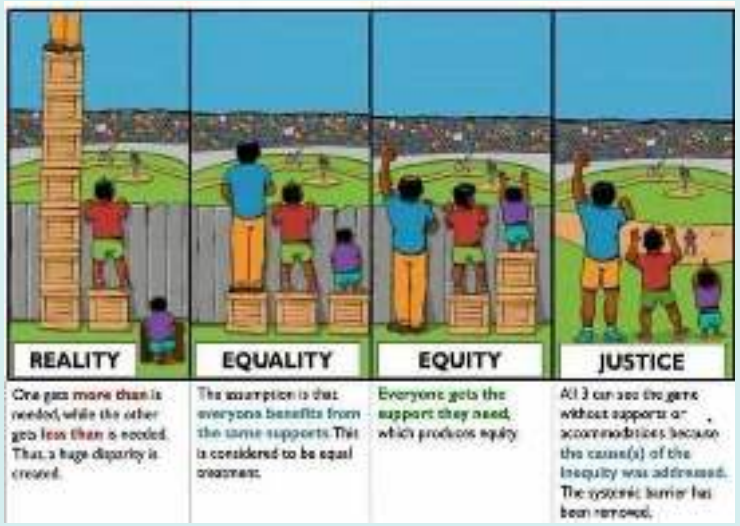
- attempt to change underlying social, cultural, or environmental conditions of risk **for the whole population**
- utilise **'upstream' approach** to reduce risk factors for falls across the whole population
- involve wide range of individuals at **societal level**
- **ecological interventions**

Cochrane Library

Cochrane Database of Systematic Reviews

Population-based interventions for preventing falls and fall-related injuries in older people (Review)

Lewis SR, McGarrigle L, Pritchard MW, Bosco A, Yang Y, Gluchowski A, Sremanakova J, Boulton ER, Gittins M, Spinks A, Rapp K, MacIntyre DL, McClure RJ, Todd C



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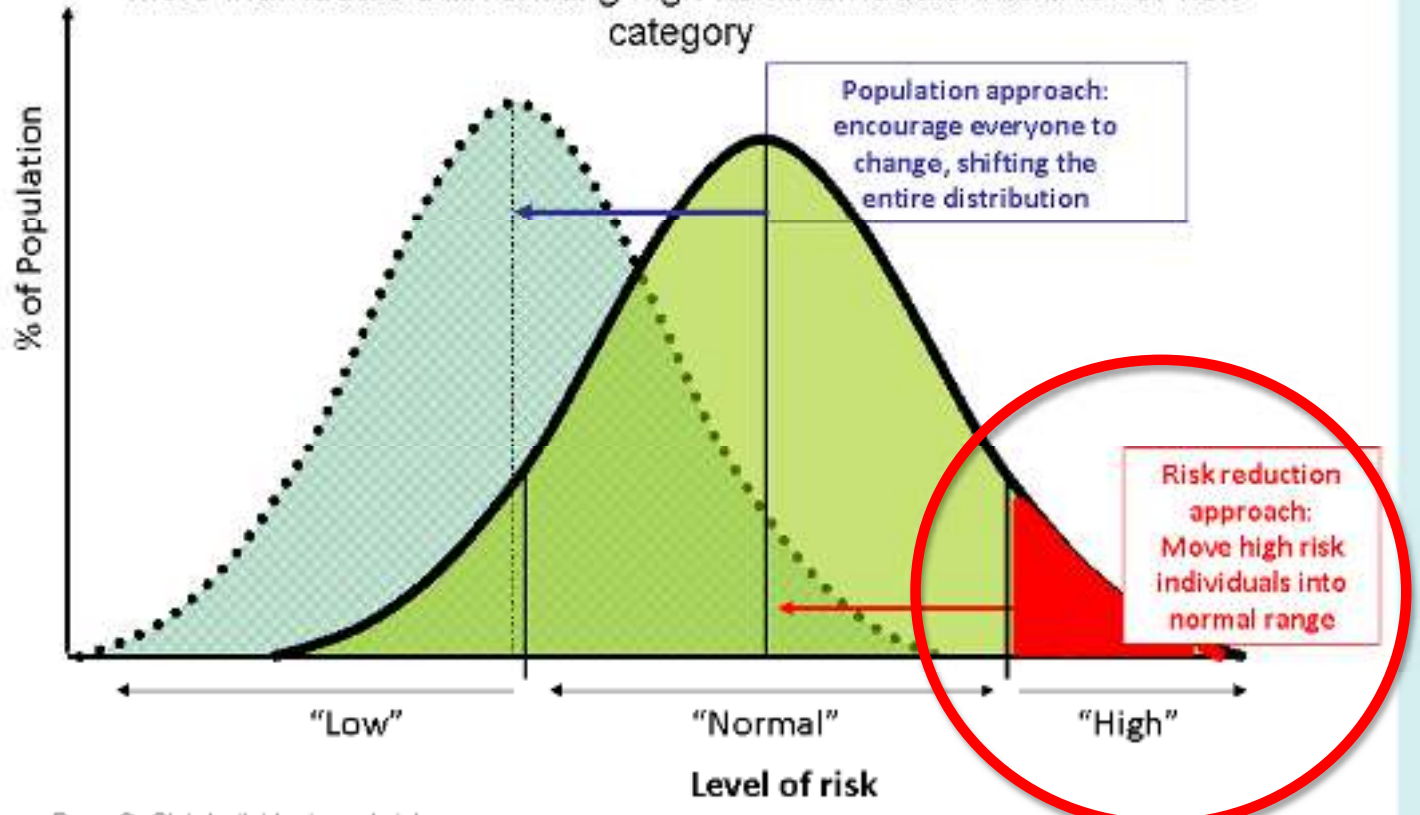
The Bell-Curve Shift in Populations

Shifting the whole population into a lower risk category benefits more individuals than shifting high risk individuals into a lower risk category



Source: Rose G. Sick Individuals and sick populations. *Int J Epidemiol.* 1985; 12:32-38.

This presentation presents independent research funded by different bodies including the EC and the National Institute for Health and Care Research via the Applied Research Collaboration-Greater Manchester (NIHR200174), Policy Research Unit in Older People and Frailty / Healthy Ageing (NIHR PR-PRU-1217-21502 & NIHR206119) & NIHR Senior Investigator Awards to Prof Todd (NIHR200299 & NIHR205156). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care, or its partner organisations.

British Geriatrics Society
Improving healthcare for older people

3rd World Falls Congress 2026

24 - 26 June 2026
University of Manchester

bgs.org.uk/WFC26

Join us in Manchester!

EUROPEAN FALLS FESTIVAL

World Falls Prevention Society

Case-Finding for Falls Prevention
SWAN Primary Care Network, Wigan

Dr Nikesh Vallabh
Clinical Director SWAN PCN
Proactive Care Clinical Lead GM

Wigan Locality

Part of Greater Manchester Integrated Care Partnership

Falls Prevention – changing the approach

NHS Greater Manchester Integrated Care

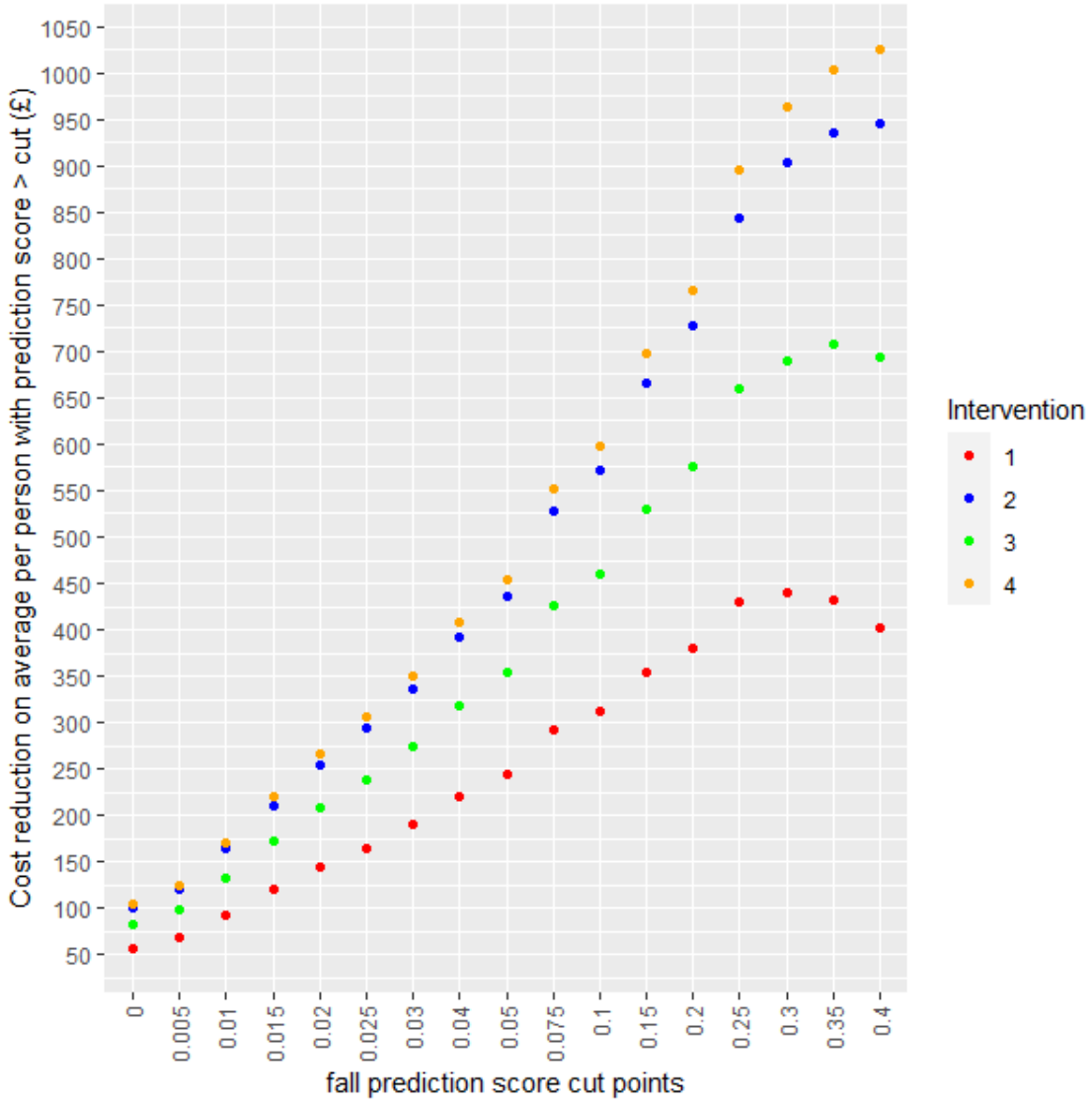
- Falls Prevention – key element of Liver Well in later life
- We need to do things differently
- Opportunity to do things better – Proactively
- Local approach for local people
- Integrated teams based in community
- Right systems/infrastructure to deliver the new approach

- We are working with the **Ageing in Place Pathfinder programme in the SWAN area** to engage directly with the voice and lived experience of local older people to design and test innovation.
- Establish an outcomes evaluation framework that will monitor and collect sufficient evidence from this approach, such as the following **(See Evaluation Protocol):**

  -Patient's understanding of the intervention
  -Falls risk
  -Awareness raising
  -Satisfaction with the process undertaken
  -Satisfaction with what was offered to them because of their inclusion; focusing on improvements to the service/ intervention
  -Barriers and enablers to this type of intervention

- **This approach will be tested and validated in Wigan, with a plan to roll this out across other areas of Greater Manchester.**
- Devise a dissemination plan of how we plan to spread the learning across a GM, National and International footprint.

- Abdominal pain
- Activity limitation
- Alcohol
- Anaemia & haematinic deficiency
- Anxiety
- Asthma
- Atrial fibrillation
- Back pain
- Bone disease
- Cancer
- Chronic kidney disease
- Cognitive impairment
- COPD
- Dementia
- Depression
- Diabetes mellitus
- Dizziness
- Dressing & grooming problems
- Dyspnoea
- Environment problems
- Faecal incontinence
- Falls
- Fatigue
- Foot problems
- Fracture
- Fragility fracture
- Gardening problems
- General mental health
- Headache
- Hearing impairment
- Heart failure
- Housebound
- Hypertension
- Hypotension/syncope
- Inflammatory arthritis
- Inflammatory bowel disease
- Ischaemic heart disease
- Liver problems
- Meal preparation problems
- Memory concerns
- Mobility problems
- Mono/hemiparesis
- Motor neuron disease
- Musculoskeletal problems
- Obesity
- Osteoarthritis
- Osteoporosis
- Palliative care
- Parkinsonism & tremor
- Peptic ulcer disease
- Peripheral neuropathy
- Peripheral vascular disease
- Polypharmacy
- Problems managing finances
- Problems with cleaning and domestic tasks
- Requirement for care
- Respiratory disease
- Seizures
- Self-harm
- Severe mental illness
- Shopping problems
- Skin ulcer
- Sleep problems
- Smoker (current)
- Smoker (ex)
- Social vulnerability
- Stress
- Stroke
- Telephone problems
- Thyroid problems
- Toileting problems
- TIA
- Travelling problems
- Unable to manage medications
- Urinary incontinence
- Urinary system disease
- Visual impairment
- Washing & bathing problems
- Weakness
- Weight loss



- Intervention 1 = exercise
- Intervention 2 = combined exercise, vision assessment and treatment
- Intervention 3 = combined exercise, vision assessment and treatment, and environmental assessment and modification
- Intervention 4 = combined clinic-level quality improvement strategies, multifactorial assessment and treatment (e.g comprehensive geriatric assessment), calcium and vitamin D supplementation

Care at the Right Time in the Right Place

NHS Greater Manchester Integrated Care

SEARCHES RUN TO IDENTIFY PATIENTS AT MODERATE RISK OF FALLS

PRACTICES PROVIDE LIGHT TOUCH CLINICAL VALIDATION/PRIORITISATION

GPAS ARRANGE APPOINTMENTS

HEALTH SCREEN WITH GPA

FALLS REVIEW WITH CARE COORDINATOR (GPPAQ AND SHORT FES-I)

Benefits of Delivering Falls Prevention at a Neighbourhood Level

NHS Greater Manchester Integrated Care

- Improved Accessibility and Reach
- Enhanced Community Engagement and Support
- Better Integration of services
- Cost effectiveness
- Stronger social determinants of health
- Positive long-term outcomes
- Support for Aging in place
- Engagement and uptake

What Could the Future Look Like for Falls Prevention?

- Complete the project within the SWAN neighbourhood
- Scalability and Sustainability
- Falls Prevention as part of a proactive approach to Ageing Well
- Commitment to invest and develop proactive care in Primary and Community Settings

The Greater Manchester Falls Collaborative

Advancing Age-Friendly Futures through research: Wednesday 26th March

Beth Mitchell
Ageing Well Programme Manager
The Greater Manchester Ageing Hub, Public Service Reform
Greater Manchester Combined Authority

GREATER MANCHESTER DOING AGEING DIFFERENTLY · GREATERSPORT · Greater Manchester Moving · HEALTHY AGEING RESEARCH GROUP · MANCHESTER 1824 The University of Manchester · NHS Greater Manchester Integrated Care

#GMFallsPrevention

The background of Falls Prevention in Greater Manchester

- Undertook a system-wide consultation with key leads from across **community, clinical and care** within each of the 10 boroughs of Greater Manchester.
- With the information gathered, we launched the **'Greater Manchester Falls Prevention: Delivering Integration and Reconditioning'** Report (January 2022)
- Commitment to develop a **'Greater Manchester Falls Collaborative'** to deliver on the 6 key recommendations detailed in the report.
- Commitment to co-design a delivery/action with the whole-system following a **consultation workshop** in January 2023.
- The transition to a **'Greater Manchester Integrated Care System'** bringing together the NHS and Social Care.
- Reconvened the system in February 2024 to **review the action plan** and agree how best to take the action plan forward.

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What is the purpose of the collaborative?

- **Oversee and deliver the strategic and operational system level priorities.**
- **Provide recommendations for falls prevention**, integration and reconditioning across community, clinical and care settings.
- To send a clear message that **falls prevention is a continued priority**, in enabling improved health outcomes for all, working towards co-created integrated pathways.
- To raise the profile of what works in terms of **life course approaches, prevention and evidence-based interventions.**

What impact have we had so far?

Equity, access and equality

- Developed a **system-wide action plan** for implementation across community, clinical and care.
- Embedded **'Falls Prevention & Frailty'** in the Greater Manchester Integrated Care Partnership Strategy & **'Joint Forward Plan',** working to **'embed evidence into policy'.**

Embedding evidence and evaluation what works

- A **'Case-Finding for Falls Prevention'** pilot, looking at the use of the eFalls tool*in primary care.
- The **FLEXI** Programme
- The **'Keep On Keep Up' (KOKU)**
- Literacy awareness project for **strength in later-life.**

Data improvement, insight and interrogation

- Pulling together a **'Greater Manchester Falls Prevention Outline Business Case'** to look at the **'primary prevention of falls'** across the system, to reduce the demand on the health and care system and improve the quality of life across Greater Manchester.

*Development and external validation of the eFalls tool: a multivariable prediction model for the risk of ED attendance or hospitalisation with a fall or fracture in older adults

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Workforce development, recruitment and training

- Working with the **Greater Manchester Organisation Development and Good Employment team** within the Integrated Care Partnership.
- Supporting **cross-locality training and development** to upskill across the broader system through projects such as **FLEXI and the community of practice.**

Community of learning, sharing and problem solving

- Launched a **12-month 'Community of Learning, Sharing and Problem Solving' (CoLSP) programme,** with between **30-50 people attending per month** to discuss a range of key themes and 'deep dives' into locality pathways.
- Delivered **12 sessions** over the course of the year, with a total of around **330x across the fall's prevention community including workforce and people with lived-experience** attending across all sessions.

Digital technologies that enhance and enable

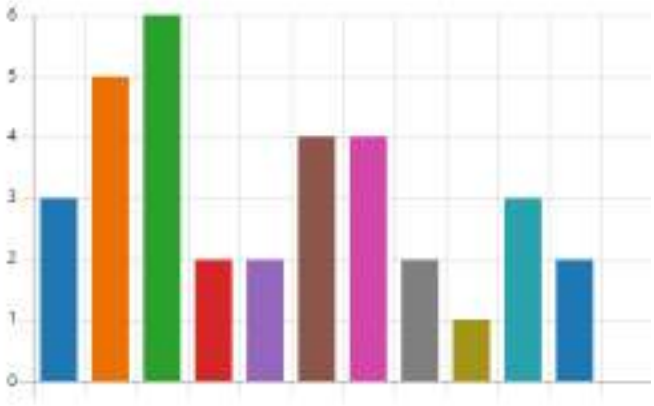
- Supported the development and implementation of the **'Keep On Keep Up'** application across the system, showcasing the impact through the collaborative and raising awareness of this across **community, clinical and care.**

The Greater Manchester Falls Collaborative: Impact Survey

- We wanted to **evaluate the CoLSP impact** by developing a survey of **13 questions** was distributed to the collaborative members.
- We received **34 responses** (16% response rate) from local government (6), regional government (1), NHS (10), social care (3), housing (1), voluntary/community sectors (3), research (2), leisure (4), and charities (4).
- **All 10** Greater Manchester Combined Authority localities were represented.

1. Which locality are you based in?

Bolton	3
Bury	5
Manchester	6
Oldham	2
Rochdale	2
Salford	4
Stockport	4
Tameside	2
Trafford	1
Wigan	3
Greater Manchester (re...	2
Other	0



What did we find out?

Key headlines:-

- The collaborative membership has **influenced decision-making and driven policy, evidence-based practice, and commissioning.**
- Respondents also shared barriers to implementing falls prevention initiatives and suggested future priorities, which include **sustaining collaboration, enhancing equitable approaches, and addressing systemic challenges.**

Conclusion & next steps:-

- Future work will incorporate the survey's priority areas to **strengthen integration and promote innovative, community-informed solutions for falls prevention.**

Thank you for listening!

Happy to connect via email ☺
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STOCKPORT AGE FRIENDLY

ONE STOCKPORT

THE ROLE OF ADULT SOCIAL CARE IN FALLS PREVENTION IN GM

WHY ARE FALLS SUCH AN ISSUE FOR THE WORLD OF ADULT SOCIAL CARE?

- Create loss of independence / cause increased mobility issues requiring more support and care and costing the system more.
- Once someone has fallen, they have an increased risk or further falls – need high levels of support. Loss of confidence, social isolation.
- Significant impacts on people health and mortality

ONE STOCKPORT

WHAT SUPPORT DOES ADULT SOCIAL CARE NEED TO BE ABLE TO DELIVER AND SUPPORT THIS AGENDA?

STOCKPORT AGE FRIENDLY

STRONG FOCUS ON PREVENTION

Prevention is a key strategy in adult social care to reduce the occurrence of falls before they happen. By focusing on preventive measures, we can improve overall health outcomes and reduce the pressure on healthcare services.

FUNDING

Investing in technology is crucial for modernising adult social care and enhancing the quality of care provided. Specifically, funding should be directed towards tech-enabled care solutions that can improve accessibility, efficiency, and patient outcomes.

Examples include personal alarms and fall detectors that allow people to call for help in an emergency. These devices can be worn or installed in the home and are connected to a monitoring centre that provides 24/7 support

EARLIER FALLS PREVENTION

All-Ages Strength and Balance Campaign

Implement a public health campaign and program that promotes strength and balance exercises for all ages. The goal is to keep people steady and prevent falls rather than waiting until they have already fallen.

STAFF TRAINING

Training staff to recognise early signs of mobility decline is crucial for preventing falls and ensuring the safety and wellbeing of individuals. This proactive approach involves educating staff on how to identify mobility issues early and understand the associated risks.

STRONG SYSTEM COLLABORATION AND INTEGRATED PATHWAYS

Housing, NHS, ASC, PH, Community Services

Developing integrated care systems where local authorities, NHS organisations, and community services work together to create seamless care pathways for patients, ensuring they receive comprehensive support

IMPROVED OFFER AMONGST PARTNERS FOR FALL RESPONSE AND REDUCTION IN CARE SETTINGS

Effective collaboration among various partners such as PCN, ASC, NWAS, and the NHS is essential for enhancing fall response and reducing fall-related incidents in care settings. This integrated approach ensures comprehensive care and timely interventions.