Greater Manchester Falls Prevention: Delivering Integration and Reconditioning

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HEALTHY AGEING RESEARCH GROUP

MANCHESTER 1824
The University of Manchester

Greater Manchester
ealth and Social Care Partnership

Contents

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Introduction

Greater Manchester has a strong history of strategic excellence as the first age-friendly city region in the UK working with local authorities across neighbourhoods to support ageing in place. Including 10 local authorities, this rapidly growing eco-system with well-established person-centred values that are being realised and delivered through a devolved and integrated health and social care system.

Greater Manchester: strategic drivers and context for ageing well

Since devolution and formation of the Greater Manchester Combined Authority (GMCA) the GM Health and Social Care Partnership (GMHSCP), working in partnership with the GM Ageing Hub has worked towards a shared commitment to enable residents to age well across the life course, wherever they may live in GM, equally and equitably.

The 2017-2021 GMHSCP Population Health Plan[1] focussed on a number of critical influencers that would seek to address some of the barriers that exist to ageing well. Initiatives such as GM's Dementia United, and Nutrition and Hydration programmes have delivered real change to the lives of people in GM in enabling good quality person-centred provision to grow and spread across the system. Falls prevention is a key feature of the plan, with a recognition of both the rate of falls across GM, as well as a level of understanding of the impact a fall in mid to later life can have on a person's ability to live and age well[2].

Falls are also a crucial indicator of potential for poor quality ageing in mid to later life for which early preventative interventions can support individuals to age well.

When looking across GM localities, there are examples of highly effective evidence-based work which seeks to nurture good health and wellbeing realised through a broad range of integrated falls prevention and active ageing programmes. Provision is well established, with some districts recognised as exemplars in person-centred, asset-based partnership approaches, working towards delivering impactful and measurable changes to the lives of older people in their communities. This collaborative provision is delivered through place-based provision driven by commissioners and providers with a shared commitment to improve population health.

In spite of this, there remain stark inequalities in health outcomes and life expectancy for people living in GM, both in comparison to national data but also within the city region itself.

The recent publication of Build Back Fairer Report shows between 2017-2019 (pre-Covid-19) life expectancy was declining in GM with eight out of ten boroughs of GM showing both men and women can expect to live shorter lives than those living in other parts of England, this being directly linked to socio-economic deprivation[3]. This situation has been exacerbated by Covid-19 which has seen much higher mortality rates in the North of England[4].

> **"Life expectancy was declining in GM with eight out of ten boroughs of GM showing both men and women can expect to live shorter lives than those living in other parts of England,**

The GM Inequalities Commission Report recognised that to address these inequalities GM is working to understand, and respond to, the complex factors that directly influence a person's ability to age well through the life course, in terms of individual circumstance but more directly at a structural and systemic level. Deep-rooted historical and life-long inequalities that are impacted by intersectionality must be at the forefront of our combined efforts in addressing good health and wellbeing as we age[5].

As the GMHSCP now moves further towards a fully Integrated Care System (ICS) launching in July 2022, GM can build on the success of the past four years, sharing all that has been learnt across the city-region, including the challenges, insight and agility we have witnessed during the pandemic.

Matching this with the GM commitment to age-inclusivity, we continue to work together to improve the health and wellbeing for all our residents, proactively supporting people to live well through reducing health inequalities, embracing prevention across the whole life-course (especially throughout mid to later lives) and addressing discrimination and intersectionality. Through doing so, we can together, change the life course trajectories, improving health and wellbeing at a population level[6,7] into all our later lives and deliver real difference in Greater Manchester.

Importantly the challenges in health and social care investment and workforce generally and in this area specifically need to be recognised. Recurrent investment for the ICS will be via the NHS Long Term Plan (LTP) and Ageing Well programme within it. Resources will need to be focussed and targeted well to achieve positive outcomes around falls prevention.

The GM Frailty Care Reference Group's (FCRG) Report 'GM Falls Prevention – Safe, steady, strong' (Appendix 3) sets this out for population health management (PHM) prioritising falls prevention in care homes and Anticipatory Care (AC).

The system will need to ensure funding, especially related to shortfalls in community health and social care investment, and other potential investment to proactively support falls prevention and reconditioning across the whole system and in all settings especially in the context of greater need due to the pandemic.

The impact of the pandemic and supporting Covid-19 recovery

> **“The Covid-19 mortality rate of Greater Manchester citizens between March 2020 and April 2021 is 25% higher than in England**

Any future plan for the residents of Greater Manchester must also take into account Covid-19 and the extensive impact it has had on the lives of people, families, communities, employment and workforces, in particular those employed within the health and social care, local authorities and public health teams, and other essential services (supermarket staff, delivery service drivers, etc.)

The Covid-19 mortality rate of Greater Manchester citizens between March 2020 and April 2021 is 25% higher than in England as a whole, with those in the most deprived areas being 2.3 times more likely to die than those in the least deprived areas nationally[8].

When looking at men and women, mortality rates for Greater Manchester compared with England averages were consistently worse across the city-region, other than men in Trafford and women in Stockport which were lower.

Covid-19 mortality rates per100,000 (March 2020-April 2021[9])

	Greater Manchester	England
Men	307.1	233.1
Women	195.2	142.0

For those who have survived Covid-19 the potential to develop post-Covid syndrome (Long Covid) is an unfortunate reality affecting older people disproportionately.

When considering the wider public health impact of Covid-19, specifically in relation to reduced levels of physical activity during the pandemic as a result of national lockdown measures, the potential impact of deconditioning will be substantial. Nationally 110,000 additional older people (an increase of 3.9%) are projected to have at least one fall per year as a direct result of reduced strength and balance activity during the pandemic. This would mean an increase in the total number of falls for men by 124,000 (an increase of 3.6%) and 130,000 for women (an increase of 4.4%). Projected costs for each year that the reduction in strength and balance activity persists demonstrates an additional cost to the health and social care system related to additional falls of £211 million incurred over 2.5 year period[10].

Important to note is that this modelling is based on data taken during the first three months of national lockdown, so estimates may be conservative. The University College London’s Covid-19 Social Study found almost 35% of adults aged 60 and over reported doing less physical activity during the January 2021 lockdown than previously[11]. In addition research in those aged 50 and over comparing activity levels prior to lockdown and at the end of July 2020 reported a 36% decrease for this period, with those aged 75 years and older being 42% less active[12]. Prior to the pandemic activity levels across GM were lower than national averages, this is likely to have persisted and increased.

It is anticipated that there will be an ongoing increased demand as we continue to live through the pandemic. Health and social care services will need to look at how to support greater numbers of people to recover in neighbourhood and community settings.

Aligned to this approach will be the need to acknowledge and integrate the Greater Manchester overarching principles that inform and guide any future Covid-19 recovery plan, including: addressing inequalities and poverty; ensuring safety and standards; co-design and co-production; enabling civic society and social infrastructure; embedding behaviour change; building a confident and resilient city region[13]. We of course recognise that achieving this ambition will require sustained commitment and investment, and ongoing evaluation[14].

The purpose of this report

This report focuses on the prevention of falls and enablement of reconditioning for Greater Manchester residents who have been affected by the pandemic and especially those asked to shield and self-isolate. It builds on earlier work undertaken in partnership with the University of Manchester's Healthy Ageing Research Group and GreaterSport supporting GM Moving, which was focussed on improving strength and balance from mid through to later life (Appendix 2).

The report is based on a series of interviews, surveys, meetings and workshops that have taken place across GM between April and July 2021 (Appendix 1). The aim was to understand what had been happening in relation to falls services, workforces and evidence-based interventions before and during lockdown.

Following the data gathering stage, a series of recommendations were identified, socialised and checked both with stakeholders and with GM strategic level leaders who joined a working group and contributed to the development of this report. The broader purpose being to listen and identify what works well, and to amplify the challenges that will need to sit at the forefront of any age-inclusive preventative integrated health and social care frameworks.

This report also takes the opportunity to set out broadly how the available national policy and contractual levers set out in the NHS Long Term Plan[15] and Primary Care Network Directed Enhanced Services (PCN DES)[16,17,18] can be used in Greater Manchester to enable proactive development of falls prevention and enablement services to support these ambitions[19].

Overview

Fostering good health and wellbeing for residents living in our communities requires a shared understanding and commitment that enables multi-sector engagement and involvement founded on collaboration. From policy to practice, the need to deliver strategies that are age-inclusive and processes founded on principles of age-equality, which address inequalities and their intersectionality are vital to enable us all to live well for longer.

Healthy ageing involves a complex interplay of an individual's intrinsic capacity (physical and mental wellbeing) and the environment a person lives in and interacts with.

The World Health Organisation (WHO) defines healthy ageing as "the process of developing and maintaining the functional ability that enables well-being in older age."

Optimising "functional ability" is the goal of the Decade of Healthy Ageing, which began in 2021 and addresses five interrelated abilities that all older people should enjoy: the ability to meet basic needs; to continue to learn and make decisions; to be mobile; to build and maintain relationships; and to contribute to society[20].

When considering an individual's intrinsic capacity, a critical aspect of ageing well is the role of functional ability in enabling people to continue doing the things that they value.

The things that are critical to our psycho-social wellbeing may include: remaining independent and in our home for longer; engaging in work (paid or unpaid); interacting within our local community, playing an active role in civil society, doing the things we enjoy and that bring joy.

The 2019 NHS Long Term Plan set out ambitions to provide more joined-up, coordinated care; more proactive services to support population health management and reduce demand on urgent care; and a more differentiated offer to individuals with further progress on prevention, inequalities reduction and improved responsiveness.

For older people the national Ageing Well programme places emphasis on the following ambitions:

- Promoting a multidisciplinary team approach where doctors, nurses and other allied health professionals work together in an integrated way to provide tailored support that helps people live well and independently at home for longer.
- Giving people the opportunity to be active contributors and co-creation partners with regard to the care and support they receive, particularly towards the end of their lives.
- Offering more support for people who look after family members, partners or friends because of their illness, clinical frailty or disability.
- Developing more rapid community response teams, to support older people with health issues before they need hospital treatment and help those leaving hospital to return and recover at home.
- Offering more NHS support in care homes including making sure there are strong links between care homes, local general practices and community services using the enhanced health in care homes (EHCH) framework[21].

The Ageing Well agenda is focussed on a number of priorities which pivot around a neighbourhood model and includes both targeted and universal contexts – falls prevention including keeping people in their communities and homes longer[22] and reducing crisis falls[23] demonstrate tangible and measurable outcomes. Delivering integration and reconditioning to reduce falls within the above contexts and with targeted investment offers a specific and well-defined paradigm through which to deliver the Ageing Well ambition. Strategic falls prevention contributes directly to this ambition through knitting together the priorities of anticipatory care and support through the provision of evidence-based interventions.

The GM Frailty Care Reference Group Report 'Falls Prevention in GM: Safe, steady, strong' (Appendix 3) discussed how anticipatory care and the GM Enhanced Health in Care Homes can target key populations with policies and investments supporting falls prevention illustrating how these broad ambitions can be achieved with tangible and measurable impact.

The GMCA's Age Friendly Strategy includes a programme of work on 'Ageing Well' to create effective coordination and coverage of healthy ageing, including proactive prevention, to support ageing in place. Building on existing partnerships and by implementing commitments to the Public Health England (renamed Office of Health Improvement and Disparities) and the Centre for Ageing Better Consensus Statement on Healthy Ageing[24], and has positioned this agenda as a GM priority for local authority, NHS and VCSE agencies.

GM has excellent examples of services and programmes aimed at supporting its population to age well, including nutrition and hydration, Dementia, mental health and wellbeing services, culture and creative projects and others. The GM eco-system has a well established reputation for convening public health leaders, academia, NHS and social care, VCSE colleagues and GM's cultural sector to deliver change, so mobilising these actors around a set of shared goals is key to success (as evidenced by the Covid-19 Keeping Well Campaign). These alongside other system priorities demonstrate falls prevention and reconditioning as GM level commissioning priorities.

Partner Spotlight
GM Ageing Hub

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GM Ageing Hub

Creating age-inclusive places to promote healthy ageing

Older people spend more time at home and in their immediate neighbourhood than younger age groups, and the extent to which the neighbourhood is age-inclusive, both physically and socially are critical factors in older people leading active and inclusive lives, reducing some of the risks that can lead to falling. In addition, the neighbourhood offers the opportunity of mobilising services and community organisations to promote falls prevention activities through trusted agencies and peer-support methods.

Creating age-inclusive or age-friendly neighbourhoods has been a strategic priority for GM's ageing strategy.

The Ambition for Ageing and the Ageing-in-place programmes have created neighbourhood scale partnerships, with the ambition of the applying the WHO age-friendly city model at a very local level, through citizen leadership and the reform of local services. In 2019, 53 community projects were awarded Mayoral recognition for their work to make local area more age-friendly.

As we move into the next phase of the Covid-19 pandemic, the GM Ageing Hub will bring together partners to relaunch this work, with falls prevention being a central element of our work.

The problem with falling

> **Every year more than 3 million people aged 65 years and over fall at least once**

For many people falling over can be a common occurrence, indeed falling over repeatedly is a feature of learning to walk in babies and toddlers, however falls in younger years are less likely to cause serious injury or death. When people aged over the age of 60 fall, they are more likely to sustain a moderate to serious injury (bruises, fractures, head trauma, hip fractures) and are at higher risk of death. These outcomes both increase as a person ages throughout later life – being older is a key risk factor for falling[25].

Falls are considered to be a major public health issue, being the second major cause of death and disability after road traffic accidents[26]. They are the largest cause for emergency hospital admissions for older people and are a major precipitant of people moving from their own home to long-term nursing or residential care.

A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level

Every year more than 3 million people aged 65 years and over fall at least once[27]. In terms of reported falls amongst older adults, from 2014-2016 almost three in ten (28%) adults aged 60 and over, and nearly four in ten (38%) adults aged over 80 reported a fall[28]. It is estimated between 5-10% of those who fall sustain serious injury[29] and the falls cost the NHS around 2.3 billion a year.

In the year 2019/2020, there were 234,793 emergency hospital admissions due to falls in people aged 65 years and over in England, of which 10,810 were in Greater Manchester[30].

Six out of the ten boroughs recorded higher hospital admissions due to falls than England overall which is why GM prioritises falls prevention, in hospital and community settings, as an integral part of its implementation planning for Ageing Well as set out in the NHS Long Term Plan. In hospital settings, falls in older adults are the most commonly reported incidents in older people, with almost a quarter of a million incidents reported annually in acute and mental hospital trusts in England and Wales[31].

Women are more likely than men to fall and often sustain fragility fractures as a result of falling over. This is due to a number of factors, including osteoporosis, which is more prevalent in women as is reduced bone density that can be the result of the menopause and reduction in oestrogen leading to a decrease in bone density[32].

In terms of socio-economic status and ethnicity, GM level data insight related to falls and falls prevention carried out for the Department of Health and Social Care in 2007 found that falls were more common in areas of social deprivation, as well as being more frequent amongst Black and mixed ethnic groups[33]. Importantly GM health and social care integration recognises the need, and opportunity, for targeted falls prevention and intervention for those at higher risk via anticipatory care and EHCH while also working towards population level change.

The annual cost of fragility fractures is estimated to be around £4.4 billion, of which £2-billion relates to hip fractures, and £1.1 billion relating to social care costs. The impact of hip fractures on long-term disability found that approximately 20% of people who had experienced hip fractures entered long-term care within the 12 months immediately following the fracture[34].

What causes falls in mid to later life?

There are a wide range of potential risk factors for falling in mid to later life, as such falls are considered to be multifactorial, often being the result of the interplay between a number of intrinsic and extrinsic factors which can include, but are not limited to:

- Functional decline, such as muscle weakness, both due to lifestyle factors such as lack of movement or sedentariness (office work) and muscle deterioration which starts to occur during mid-life
- Sensory changes including visual, and to a lesser extent, hearing loss
- Medical conditions, including multiple long term conditions (and associated pain) and specific medical conditions which make it more likely for a person to fall
- Polypharmacy (multiple medications) and use of certain medications in particular
- Psychological aspects, fear of falling, loss of confidence and self-efficacy
- Diet and nutrition, including low protein diets, malnutrition and lack of vitamin D for those with low levels or during winter months
- Poor balance, which can be caused by ability to integrate sensory information and communicate internally with our musculoskeletal system
- History of falling
- Environmental hazards both inside the home (wet floor, poor lighting) and outside in neighbourhoods and cities

There are differences between women and men in the specific risk factors. For falls amongst women, incontinence and clinical frailty are risk factors, whilst for men older age and depressive symptoms are important indicators[36].

> **Fear of falling is reported by approximately one in four people over the aged of 65...those who have already experienced a fall and older people living in the institutional care settings is higher.**

> **Unaddressed environmental hazards in home settings have been estimated to cost the NHS in England £435 million.**

In terms of psychological risk factors, fear of falling is reported by approximately one in four people over the aged of 65 living in community settings. For those who have already experienced a fall and older people living in the institutional care settings, the prevalence is higher. The potential impacts of fear of falling are many, from increased anxiety, distress and medication use through to reduced and restricted activity leading to a decline in physical functioning. This lack of movement has a knock on effect of increasing falls risk and potentially leading to a move from home into institutional care[37].

When considering environmental factors, an older person's falls risk can vary by residential setting. For those aged 65 and over living in the community, approximately 35% fall over each year, whereas older adults living in long-term care settings have a 50% chance of falling[38].

Unaddressed environmental hazards in home settings have been estimated to cost the NHS in England £435 million[39].

This multifactorial nature of falls risk factors, including changes that occur as part of the natural ageing process, psycho-social aspects, environmental hazards and lack of adaptation for ageing population, result in a complex set of potential causes for falling in mid to later life. As such, multifactorial interventions are effective for individuals who may be older, need to be person centred, integrated and able to respond to complexity of an individual's circumstances and ability.

However, when considering community programmes to be delivered to population groups that would most benefit, then targeted single interventions are more effective than multifactorial interventions, as well as being more acceptable and cost effective[40].

All of the above factors will have been exacerbated during the pandemic, not least due to reduced access to health and social care as well as wider support services such as regular vision tests and access to medication reviews.

Falls prevention, strength, bone health and balance for ageing well: the evidence

Maintaining and improving muscle strength, bone health and balance through life is an important part of functional ability and ageing well. Good strength, bone health and balance helps people to live independently for longer, enjoy good quality of life and reduce costs to health and social care services[41].

There is strong evidence that exercise reduces falls in older adults living in the community by approximately a quarter (23%), with little difference between those with increased risk of falls and those who do not. Specifically exercise that centres on balance and functional training were the most effective in reducing falls, whilst programmes with multiple types of exercise and tai chi probably also reduce falls[42].

There are two evidence-based balance and functional training programmes regularly used in UK for prevention of falling: Otago and the Falls Management Exercise Programme (FaME).

Otago

The Otago Exercise Programme (OEP) is a lower limb strength and balance programme (plus walking and motivational support strategies) of pre-set exercises with progression guidance delivered by OEP Leaders.

FaME (Falls Management Exercise Programme)

FaME progresses the Otago Exercise Programme balance exercises to include other components of fitness and activities. FaME includes upper limb strength exercises to support getting up off the floor. Suitable for all older adults and appropriate for a range of older people and is delivered by Postural Stability Instructors (PSIs).

Both programmes can be delivered in groups in community settings as a primary prevention programme, which aims to improve strength and balance as a falls risk reduction intervention.

Partner Spotlight
University of Manchester – FaME (Falls Management Exercise) Implementation Study

The University of Manchester has supported the development of the FaME programme in Greater Manchester over a number of years and all areas of GM are implementing versions of it. In 2022 the university will be looking for GM partners to participate in an implementation study to understand how best to increase its availability to residents, and to ensure delivery meets the necessary quality standards required to deliver meaningful outcomes. The FLEXI study will offer partners support with advice, quality assessment and a community of practice.

The evidence-based Falls Management Exercise (FaME) programme is a group-based, face-to-face, six-month exercise programme specifically aimed at improving the strength and balance of people aged 65 and over. Research has shown that FaME results in fewer falls, improved confidence, and reduced fear-of-falling. Currently, FaME in its evidence-based form is not fully available/implemented across Greater Manchester.

Overarching FLEXI Study Aims:

1) To understand how best to increase availability of FaME in two localities in GM and two localities in the South West and assess the role that the FaME Toolkit (developed and implemented in the Midlands) can play in supporting this.

2) To investigate the delivery of FaME as per evidence in new areas, populations and/or contexts and measure improvements in participating individuals.

3) To test ways of maintaining the quality of FaME programmes over time. Working with Later Life Training, a national not-for-profit organisation with expertise in FaME, who will support a Community of Practice we will together also measure the quality of programmes and test what works to make them better.

The information will be used to improve the FaME implementation toolkit and develop plans to support the improved delivery of FaME across the whole of Greater Manchester as an evidence-based falls prevention programme. And by doing so leading to better outcomes for older adults and achieving equity in provision.

Adopting a life course approach

> **Changing the narrative through a proactive shift towards positive age-inclusive language, practice and gain framing to reduce stigma and overcome ageism.**

The critical role of exercise in falls prevention indicates that greater emphasis should be given to the widespread implementation of a life course approach, to enable ageing well through mid and later life[43]. Integration of muscle strengthening and balance activities across the life course[44], with particular emphasis on mid to later life, will lead to lifelong benefits. Muscle and bone strength play a critical role in ensuring good muscular and skeletal health, and in maintaining functional ability; whilst challenging balance as we age will be beneficial for reducing mid to later life falls risk.

Strengthening activities are important throughout life to develop strength and build healthy bones during childhood and young adulthood; to maintain strength in adulthood; and to delay the natural decline in muscle mass and bone density which occurs from around 50 years of age. When undertaking muscle strengthening activities, it is important to work all the major muscle groups. Bone strengthening involves moderate and high impact activities to stimulate bone growth and repair. (PSIs).

Balance activities are important to engage with at mid-life and through later life, as it enables dynamic agility – being able to change the position of the entire body with both speed and accuracy. Engaging in balance challenging activities on a regular basis will ensure ongoing ability to maintain body balance when stationary or moving.

When considering what types of strength and balance activities are best suited to people of differing abilities and life stages, physical activity programmes that are tailored to individual abilities, circumstances and motivations are of greatest importance. For older adults whose functional capacity has declined, or for those who have experienced significant loss of capacity, for example as a result of health conditions and or/deconditioning, interventions need to be evidence-based as outlined above. For active adults, incorporating regular strength and balance activities into existing routines and exercise would be beneficial, as in the table beside from the Raising the bar on strength and balance Report. For those who are less agile programmes need to steer towards the evidence-based-falls prevention interventions as detailed above.

Type of sport, physical activity or exercise	Improvement in muscle function	Improvement in bone health	Improvement in balance
Running	★	★★	★
Resistance Training	★★★	★★★	★★
Aerobics, circuit training	★★★	★★★	★★
Ball Games	★★	★★★	★★★
Racquet Sports	★★	★★★	★★★
Yoga, Tai Chi	★	★	★
Dance	★	★★	★
Walking	★	★	☆
Nordic Walking	★★	?	★★
Cycling	★	★	★

★★★ Strong effect ★★ Medium effect ★ Low effect ☆ No effect ? Not known

The impact of Covid-19 and physical deconditioning

> **Between March 2020 and May 2021 there was a considerable reduction in strength and balance activity, 45% reduction in men and 49% reduction in women.**

Physical distancing measures put in place in response to the Covid-19 pandemic have led to a large proportion of the population spending significantly more time at home and, as a result, becoming more physically inactive. Additionally less formal and informal activities around exercise and rehabilitation due to this as well as workforce constraints and redeployment in this period will have exacerbated the reduction in strength and balance especially in older people.

Anyone moving less and sitting more will decondition to some extent, experiencing loss of muscle mass, stiffening of joints, loss of bone density (musculoskeletal deconditioning) and decreases in aerobic fitness (cardiovascular deconditioning). Lack of movement and activity in daily lives can also impact on psychological wellbeing. Older adults and those who were shielding during the pandemic are at greater risk of deconditioning, which in turn may be associated with a greater need for future healthcare and support.

Deconditioning is the syndrome of physical, psychological and functional decline that occurs as a result of prolonged inactivity and associated loss of muscle strength. Among adults in mid and later life is associated with an increased risk of falls and loss of functional ability, directly impacting on our independence and ability to do the things one enjoys.

Pre-COVID-19 there was already a need to increase levels of physical activity among the general population, particularly older adults, to improve health outcomes and wellbeing.

In the period from March 2020 to May 2021 older people experienced a considerable reduction in strength and balance activity with the greatest change being in the 70-74 age group, 45% reduction in men and 49% reduction in women.

There was also a reduction in the duration of strength and balance activity which decreased by more than 40% during the same period[45].

When looking at GM specific data in relation to inactivity levels, GM saw a greater increase in inactivity when compared nationally during Covid, with inactivity up 4.3% since before the pandemic (Nov 18-19) and 2.0% since baseline (Nov 15-16)[46]. The inactivity age gap (the difference between 16-34 and 75+) in GM is 26.7% compared to nationally where it sits at 18.2%. For those aged 55-74 years a similar trends followed as nationally, however this has now returned to 33.5% for those of this age group which is the same as was at baseline[47].

Between November 2019 and November 2020 those aged 55 – 74 show the greatest increase in inactivity (+6.7%), whilst those aged 75 and over showed inactivity rates during the pandemic at similar levels to other age groups (+4.6%, 35-54 +4.4% and 16-34 +3.8%). In the over 75 group women were more likely to be inactive than men[48].

Of those aged 55-74 living with a disability or long term health condition inactivity rose to 68.7% compared to those without a disability or long term health condition where current activity levels are 51.8%. Whilst to those aged 75 and over, those living with a disability or long term health condition compared to those who do not, the difference in activity levels of 13.6% (40.0%/26.4%)[49]

Inequalities in physical activity levels have persisted, with older people in the most deprived group being more likely to be inactive than those in the least deprived group in 2019 and 2020[50].

This in addition to those on low incomes, people living alone, people ageing without children in the household, people with a longstanding condition or illness, people self-isolating because they are at increased risk, and people without access to private outdoor space, were all finding it harder than normal to be active during the outbreak[51].

Proactively supporting Covid-19 recovery presents an opportunity to deliver a more age-inclusive offer that addresses the social and health inequalities that have been exacerbated by the pandemic. The role of primary care, community teams, social prescribing and the fitness and leisure sector, will be critical in helping support assessment and signposting to enable individuals to become active again, or indeed for the first time.

There is also a wider opportunity here via the GM integrated approach to target anticipatory care via the Ageing Well programme and the Primary Care Networks (PCN) falls prevention priorities to both stimulate demand through pro-active provision of evidence-based interventions, preparing and upskilling the workforce, testing and enabling the cascading of good practice approaches to grow throughout the GM wide ecosystem.

Consultation Process

The Healthy Ageing Research Group at the University of Manchester, GreaterSport supporting GM Moving in collaboration with the GM Ageing Hub, came together to undertake a consultation to better understand current practice in relation to falls prevention pathways and evidence-based strength and balance interventions across the GM eco-system.

The consultation process included 18 qualitative semi-structured interviews and meetings with up to 2-3 clinical and community practitioners, strategic leads and commissioners based within the NHS, public health and voluntary sectors across the 10 GM local authorities (see Appendix 1). Because of Covid-19 restrictions all interviews and meetings were conducted remotely- by phone or on video-call. Whilst not exhaustive and conducted in challenging period the consultation provides an indicative 'snapshot' of practice, challenges and aspirations[52].

Themes discussed at the informal interviews and meetings included:

- falls prevention practice, pathways and interventions;
- what works and challenges;
- funding and commissioning;
- specific Covid-19 responses and issues;
- potential interest, ideas and remit for a Greater Manchester Falls Collaborative;
- other related issues

Additionally three workshops were held, two hosted by the GM Ageing Hub and one by Ambition for Ageing which included representatives from the Greater Manchester Older People's Network (GMOPN), older people, Ageing Leads based across the 10 localities, as well as stakeholders working across health and social care, housing, employment, transport and academia (see Appendix 2: Meetings, workshops and interviews held during the consultation process). Again these workshops were conducted remotely using video-call.

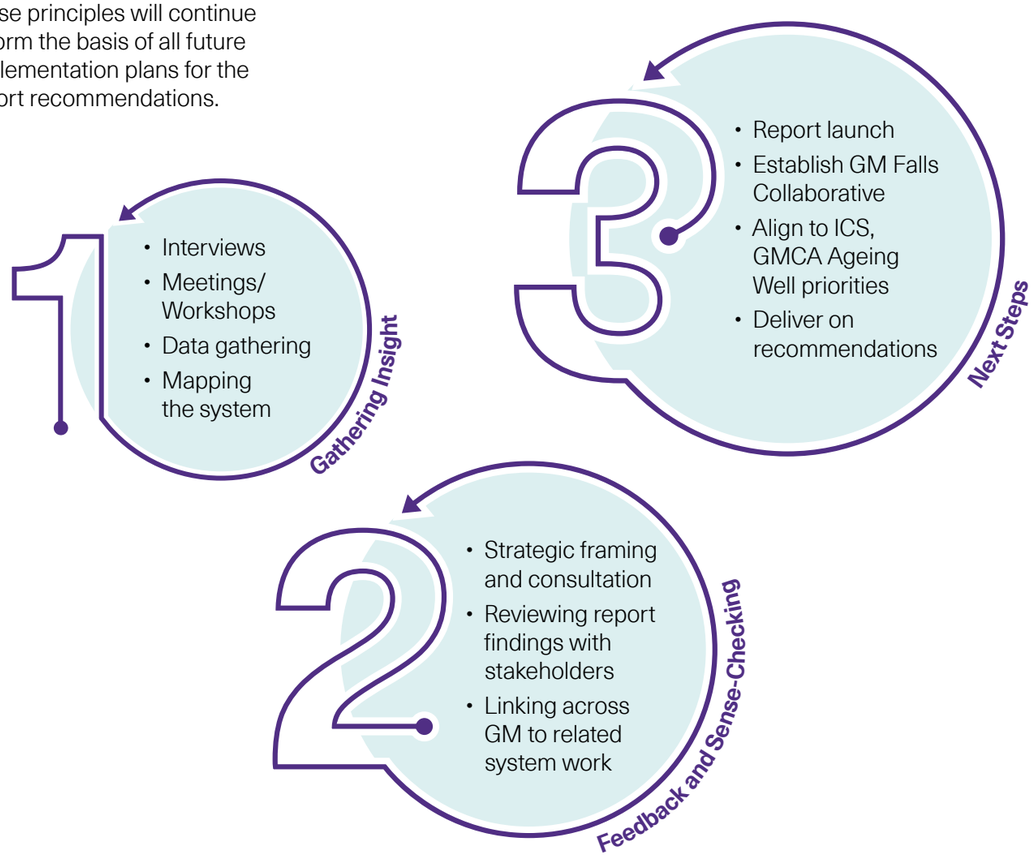
Following the initial consultation phase, a series of recommendations were identified and then circulated to those who had taken part in interviews, meetings and workshops.

An information table was also circulated overviewing details about evidence-based strength and balance interventions (FaME and Otago) to inform insight on current provision across GM. A presentation was also delivered at the GM Ageing Hub Executive Group to gain feedback on findings and recommendations, this included ongoing follow up meetings with system leaders to identify how best to take forward this work. Prior to publication, this report was also circulated to all stakeholders involved, including the strategic leadership working group, for sense-checking and approval.

Stages of Consultation

Through all stages of the consultation process, the project team adopted a collaborative approach, working to principles of co-design and co-creation.

These principles will continue to form the basis of all future implementation plans for the report recommendations.



Partner Spotlight
GMHSCP – Adult Social Care Transformation

Greater Manchester Health and Social Care Partnership

Enhanced Health in Care Homes

Falls Prevention Response in Care Homes

As part of the Ageing Well programme, Adult Social Care Transformation is focusing on delivering the contractual elements of enhanced health in care Homes, alongside a wider ambition of enhanced health in all homes, aligned to their Living Well at Home model.

Falls prevention and response models are underway in each locality, and the GM programme will enhance existing approaches, bolstering through sharing best practice.

Working in collaboration with the North West Ambulance Service (NWAS), priorities are being informed by ongoing analysis of high intensity referrers from care homes, for people who have fallen. This will determine the rollout of tools and models, where appropriate utilization of technology enabled care to support people who have fallen to remain in their homes where this is the most appropriate place for them to be supported to recover.

An overarching cross-system strategy is being considered to define targets on falls. Deliverables of this work are expected to include training and upskilling of care staff, a consistent community response offer across GM and a revised threshold for referring falls to NWAS.

This will include application of technology enabled care, MDTs, virtual wards, co-ordination of community response, role of the voluntary sector, falls triage, and falls prevention, in partnership with Ageing Well and other partners.

Summary of discussions/ findings

There has been widespread support for this consultation and a shared desire to better understand collaborative approaches for integrating evidence-based strength and balance, person-centred whole-system pathways to prevent falls in later life.

The summary of discussions and findings from the consultation have been divided into the following themes:

- GM ecosystem strategic and operational infrastructure - services, provision and pathways towards integration
- Towards prevention across the life course - community, clinical and care settings
- Commissioning for evidence-based practice and prevention priorities
- Workforce resource and capacity, cross-working and collaboration
- Innovation and technology delivering falls prevention interventions: learning from the pandemic

GM ecosystem strategic and operational infrastructure: services, provision and pathways – towards integration

> **Benefits of having strategic and operational infrastructure worked to enable specialist knowledge and insight to be easily shared and learnt across and within localities.**

There is recognition that strategy, priority, services, pathways, information and guidance on falls prevention is somewhat different between, and for some, within localities. Challenges around the emphasis on outcomes around rehabilitation and preventing a second fall influences the allocation of resources which impacts directly on priorities and activities. This in turn results in variable levels of provision and how it is operationalised across the GM ecosystem with generally far less resource and provision around preventing the first fall. Localities have different levels of strategic coordination around falls prevention services and provision. Some have well established falls coordination meetings or 'collaboratives' and others do not. The GMHSCP is focusing on falls prevention as a key priority using falls as a tracer condition to embed approaches to targeted investment using the Ageing Well and PCN EHCH as policy and contractual enablers for AC as set out in the NHS LTP.

The importance of equity of access across GM in relation to services, provision and pathways was highlighted throughout the consultation. This was described as a 'post-code' lottery in some areas, which needs to be addressed by a proactive strategy founded on principles of equality, diversity and inclusion for all residents. Ageism and its many intersectionalities were highlighted as a further influencer on access to services, provision and pathways for residents. The need to ensure provision is inclusive and equitable across the city-region is paramount to a future successful GM falls prevention programme.

As a result of GM Health and Social Care Devolution, all 10 GM localities described working towards greater integration of services both strategically and operationally to enable realisation of person-centred and asset-based approaches.

This builds upon the extensive health and social care devolution which has taken place over the past four years, learning from good practice and feeds into the evolving GM integrated health and social care system. As GM moves further towards a single Integrated Care System in July 2022[53] there is opportunity to use the AC and EHCH investments to support targeted interventions as well as using any new NHS investment for the fuller provision and promotion of evidence-based falls prevention services across GM, learning from what works and what can be improved.

What has worked?

At a strategic level a number of localities have well-established falls coordination and/or a 'Collaborative' some of which included clinical, local authority, community, voluntary and academic membership matched with a clear programme of work. Proactive leadership which supported collaborative strategies, priorities and practice founded on principles of shared learning and knowledge were key aspects of success.

At operational levels, some localities maintained a dedicated clinical falls service, whilst for others falls prevention featured across integrated clinical and community level pathways with good practice observed[54].

Benefits of having strategic and operational infrastructure worked to enable specialist knowledge and insight to be easily shared and learnt across and within localities.

This includes the value of collective shared leadership as well as the presence of a 'falls lead' who is able actively to join up points of connection across health, social care and community strength and balance services, enabling more integrated approaches.

What are the challenges?

In addition to good practice a number of challenges were identified when trying to work in a truly integrated way. Falls prevention may not be a priority across all services, potentially resulting in issues of capacity to engage and resource. It was discussed that these may follow as a result of the widening of integrated services over the coming months/years.

When developing pathways the importance of who is, and who is not, involved in decisions will have further consequences for a truly integrated and person-centred approach. An example of this is the need to ensure the inclusion of experts by experience at strategic and operational levels as well as staff working across systems, from fire and ambulance services, community pharmacy through to physiotherapy, occupational therapy, community navigators (increasingly social prescribers) and specialist exercise instructors.

Extending pathways to include specific links from care homes to clinical falls and community based teams would also be beneficial, as would be the introduction of multifactorial assessments in this context. From this consultation a few localities provided examples of good practice spanning clinical, community and care settings with other areas working towards this.

The impact of the pandemic on provision and services which were adapted, stretched and often reduced cannot be under-estimated. Concerns over increased needs for specific services (e.g. vestibular, neurological) as well as the impact of the long-Covid pandemic were raised. There are broader implications of physical and mental deconditioning, with a predicted increase in falls and wider health service provision challenges which will continue to impact for the foreseeable future[55].

Towards prevention across the life course - community, clinical and care settings

> **“There is wide-spread support for integrating evidence-based strength and balance, person-centred, wholesystem pathways to prevent falls, increase activity and enable reconditoning.**

Falls are multifactorial and as such falls prevention services operate within a complex eco-system which cross over a broad range of clinical, community and care services and provision. As noted above, this ranges from geriatric medicine, clinical podiatry, fracture, and stroke services through to fire and ambulance services, housing adaptations and community based strength and balance exercise.

There was a general consensus that priorities and resources for falls prevention within the health and social care system is focussed on people aged 65 and over who had experienced a fall resulting in a fracture and/or hospital admission. The focus being on reactive measures to prevent the second fall, including multifactorial assessments and referral into evidence-based exercise programmes.

This mainly reactive model is not sustainable, and there is a wide-spread acknowledgement that there needs to be a significant shift away from singularly focussed multifactorial intervention offers to a broader population level intervention delivered at community level. Due to the multifactorial nature of falls, provision should be characterised as an ‘everybody’s business’[56] model, delivered through a fully integrated whole systems approach. Recognising this, as discussed previously, there is a need to focus investment for population health management on falls prevention and reconditioning proactively targeted towards at risk populations using available data and or/geographical approaches to ensure a consistent offer across GM and addressing known inequalities of access and outcomes across clinical and care/community settings.

What has worked?

There were some excellent examples in localities where integrated teams worked very effectively and in some areas self-referral and social prescribing playing an increasingly important role towards a more preventative and proactive life course approach.

Older adults falling were addressed in a myriad of ways across localities, from falls service teams, rehabilitation and reablement through to fully integrated care teams. There are some excellent examples of collaborative integrated working which made person-centred and asset based approaches effective in practice.

What are the challenges?

There were only a few examples of holistic preventative and proactive activity focussed on developing muscle strength and balance. Whilst some locality pathways enabled self-referral, this was not common and tended to be in localities where integrated pathways, services and provision were the most advanced. Potential reasons for this are many, including resources and priorities in terms of earlier upstream falls prevention. Added to this is the difficulty in attributing cost savings for prevention within a complex health and social care system.

The legacy of the reactive and clinically based provision meant that narratives around falls were framed in clinical and medicalised language, rather than in more positive framing which aligned to age-inclusive and ageing well narratives and aspirations.

As a result the continued use of the ‘F words[57] ’ (falls, frailty[58], fragility), which reinforce the myth that falls are an inevitable part of ageing, is potentially impacting on the fear of falling and personal agency of older adults. Work in some districts introducing falls as part of broader active ageing/health conversations, helps to de-medicalise and empower people around what they can do and an example of a more asset-based approach. Again ageism plays a role in how older age is defined and considered all of which have been demonstrated and impacted by the pandemic.

Work within and linked to the care home setting was not part of this consultation, however most localities mentioned this work, and work is being developed on falls prevention in this regard by GMHSCP via the Enhanced Care at Home programme (and in all homes not just care homes). Further insight into good practice related to falls prevention in a broad range of ‘at home’ settings would be beneficial.

Commissioning for evidence-based practice and prevention priorities:

Falls are not an inevitable part of ageing and can be prevented through whole-system programmes that ensure the right programme, is delivered at the right time for the right person. Evidence-based commissioning is a key aspect of successful falls prevention practice to ensure programmes being delivered will in turn, deliver outcomes for all.

What has worked?

There is good practice for falls prevention in a number of localities, with some having very clear and dedicated falls prevention commissioning which including extensive quality assurance, monitoring and evaluation frameworks to support business cases. These programmes adhered to the guidelines, delivering interventions (FaME, Otago) that were consistent with the evidence through replication of duration, dose, frequency and progression.

These programmes also included person-centred and asset based assessments, tailored programmes to enable individual progress through, but also on to other programmes and activities, as well as support for instructors to deliver evidence through good quality assurance procedures.

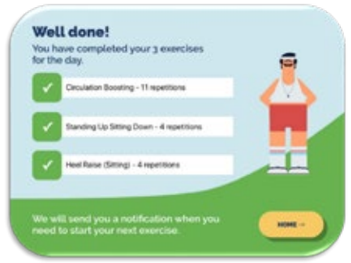
All these factors are critical aspects of effectiveness and safety in achieving anticipated functional and quality of life outcomes, and also more importantly, to ensure individual levels of enjoyment and agency.

What are the challenges?

Commissioning (although this will change as we move to the ICS) is different between districts as some have a dedicated falls commissioning whilst for other areas it is part of a fully integrated service. This variance directly influences how programmes are monitored and evaluated for specific falls related outcomes.

For example all districts delivered FaME, but for some this was a shortened or adapted programme and it is unclear whether these can deliver effective outcomes. Some areas discussed a need for a GM standardised approach that would in turn ensure services were less of a 'post code' lottery but rather equitable and accessible for everyone. The changes to the GM ICS commencing in July 2022 offer an opportunity to achieve this goal. The purpose and use of data related to monitoring and evaluation was also not always clear, especially in terms of how it was used by commissioners as part of future resource planning. This may also become more challenging in the context of increased Covid-19 deconditioning and understanding of increased need. Further sharing of evidence-based commissioning and good practice between commissioners may demonstrate the potential for falls prevention to become an ICS commissioning priority.

Partner Spotlight
The University of Manchester - Keep on Keep Up (KOKU)



Keep-On-Keep-Up (KOKU) digital personalised, progressive strength and balance programme for older adults (based on FaME/OTAGO) with embedded behaviour change theory and gamified health literacy modules. KOKU aims to assist older adults to independently engage with evidence based interventions and games on how to maintain bone health, home safety and staying hydrated.

KOKU was developed with, and for older people many of whom living in deprived communities with a high risk of falls. It is NHS Digtal/X compliant and ORCHA approved, with a scoring of 84% currently the highest rating for a wellbeing application for older adults.

The KOKU Digital programme supports older people to engage with simple but effective tailored exercises that start with simple seated routines (e.g ankle circulation boosting) and progress with the user.

These exercises have been tested in randomised controlled trials with older adults, and shown to reduce falls by at least a third. Additional known benefits of exercise are improved mood, brain functioning and reduced risk on other long term health conditions.

Feasibility trials in Greater Manchester and Staffordshire have found that KOKU has high usability with trends in improved outcomes (e.g. balance, health status and confidence) after 6 weeks independent use. This short film shows the positive physical and mental improvements experienced during and after completion of the KOKU programme (short film). Health economic analysis demonstrates a high return on investment.

As part of the Covid-19 rapid response, in the context of the Living well at Home Scheme, KOKU has been used by Care Provider Managers to further support older adults in receipt of home care who were at high risk of falls and physical deconditioning due to shielding/ self-isolation. This work carried out in partnership with Tameside Borough Council (alongside others) includes analysis of training, resources, usability, barriers, facilitators and will soon be published to inform future scale up. The digital programme is currently being translated to Chinese and Urdu for use with more communities across GM and nationally.

For more information visit www.kokuhealth.com or view this short film

Workforce: resource and capacity, cross-working and collaboration

Those working within and across the falls prevention workforce are from a diverse set of professional back-grounds, each with different skill sets and training that informs their work. The benefit and breadth of this expertise meant that colleagues regularly shared knowledge through informal learning pathways. Formal learning and development pathways were also referred to during informal interviews and meetings, specifically the Health Education England 'all our health: falls and fractures' e-learning module had been completed and was promoted by professionals working in clinical settings specifically.

The levels of commitment and agility of workforces to respond at pace was evident, with practitioners finding creative ways to continue to work with and remain in touch with residents during Covid-19.

In areas with established falls collaboratives and/or regular meetings, cross-working and collaboration was a common feature even though there had been some impact during the pandemic. Those areas who had well integrated pathways also demonstrated strong relationships built on levels of trust and respect that was founded on shared values and purpose.

What are the challenges?

Workforces are often based on available resource rather than need which means that areas are not always equipped with sufficient number of practitioners to deliver interventions. This is an increasing concern in light of the pandemic and the potential impact of physical deconditioning and long-Covid on the health and social care system.

There is a recognition that there needs to be intelligent joined up thinking to both develop the workforce training and development pathways, as well as utilising wider system assets such as the GM Active partnership and community and voluntary sectors workforces.

In terms of those holding specific training to deliver strength and balance (falls prevention) evidence-based programmes, health and social care teams including physiotherapists and specialist falls response teams have been under immense pressure throughout the pandemic and will continue to be so in the future. Most of those trained to higher levels in the fitness and leisure sector had been furloughed or redeployed to respond to Covid-19 related priorities and are returning to work to find increased need.

Partner Spotlight
GreaterSport - supporting GM Moving Active Ageing

GreaterSport supporting Greater Manchester Moving has developed a GM system-wide Active Ageing programme aimed at working with key partners to redesign systems and promoting change culture to enable active ageing. It is aimed primarily at those over 50 and areas of work/ focus include:

Active Travel

Working with the Active Travel and Over 50's steering group to embed key recommendations for over 50's within the Active travel strategy for Greater Manchester and across the whole system, influencing policy and practice for this cohort by increasing inclusive walking and cycling for those in mid to later life.

Falls Prevention

Supporting the development of the GM Falls Collaborative through the capacity of the Active Ageing Lead, having been a partner in supporting the Falls Prevention research and launch of this report.

Adult Social Care Transformation

Work to integrate physical activity across all services/programmes within health and social care; focusing on key areas such as lived experience, quality care standards, personalised care, community-based support, technology and innovation and workforce development.

Work & Health

Enabling system change to support people in mid to later life who are out of work, within the workplace and transitioning into retirement to integrate strength and balance across the workforce.

Innovation and technology delivering falls prevention interventions: learning from the pandemic

As a result of the pandemic a number of local areas have established new practices including the use of on-line digital platforms such as Zoom, YouTube, Facebook etc. to deliver falls prevention sessions, some providing tablets or other digital devices, as some form of offer. In some areas this was matched with regular keep in touch telephone calls, including talking through exercises for some, for those who had previously been attending community based strength and balance classes.

Digital options can be good but some people and groups of staff do need face to face training, assessment and intervention.

What has worked?

A number of digital technologies were shared that had been effectively utilised during lockdown. This included use of newly produced or pre-recorded video versions of evidence-based strength and balance exercises, which were shared and promoted on centralised websites. This was often offered as part of an integrated model of contact and support from physiotherapists and specialist exercise instructors, for example including regular keep in touch calls. Some areas were also encouraging use of the Make Movement Your Mission (MMYM) a Facebook group, delivered by postural stability instructors and made available during lockdown, delivering three ten minute exercise snacks per day, seven days per week. Added to this the Keep on Keep up (KOKU) app was also made available to use across GM for anyone who had access to an iPad (an android version was launched in 2021).

Use of the Keeping Well At Home/This Winter booklet (produced during lockdown) to help with clear exercise references, matched with regular telephone calls for checking in was also found although there is currently no evidence that this has worked/been effective as an intervention.. The Safe Steps app developed originally as a falls management tool in care homes was mentioned as being used in a few localities and was adapted as a Covid-19 measurement tool that was being evaluated at the time of writing.

> **“The importance of supporting and embedding behaviour change and motivation in any exercise intervention or activity promotion must not beunderestimated.**

What are the challenges?

The delivery of face to face support and services was a shared value amongst those who took part, this especially in relation to understanding a person's history (assessment), ensuring accuracy in replication of exercises (fidelity) and for social support and benefits.

Moving to a digital offer presented a number of challenges which were highlighted. Respondents acknowledged that digital by default was not the most inclusive method of engagement. Some digital offers were particularly problematic due to lack of infrastructure (Wi-Fi or 4G connectivity) and hardware (tablets, laptops), as well as limited digital skills and self-efficacy amongst some groups of older adults.

The importance of supporting and embedding behaviour change and motivation in any exercise intervention or activity promotion must not be underestimated.

Whilst some of the digital offers have this integrated (MMYM, KOKU) it remains that behaviour change is a vital component and needs to be present in future blended models, which will themselves need to be defined with reference to available evidence on digital interventions[59].

The need for in-person face-to-face support to properly assess, prescribe treatment and maintain quality at certain points of intervention (for patients and staff) was emphasised by many. The possibility of taking what has been learnt during the pandemic in terms of blended/hybrid models of delivery, that include face to face and digital components was generally seen as an opportunity.

Discussion and surveying across all of these areas as part of the consultation during the beginning of the pandemic recovery gave an indicative picture/map of practice and challenges.

All localities continued work, to varying levels, throughout the pandemic and are working now to address needs as services restart or scale-up. Concern about deconditioning/reconditioning as well as workforce to address this were highlighted. Some localities have been able to access additional funding and support towards recovery and addressing backlogs with others working towards this.

Recommendations and Next Steps

There remains much to be done in Greater Manchester in terms of action and communicating what people can do in order to prevent falls, support reconditioning, build and maintain good strength, bone health and balance throughout mid to later life.

.Recognising the significant work to be done alongside the commitment and investment in response to this consultation in the context of GM system level realities and working towards priority areas identified

This includes within the context of the NHS Long Term Plan and its Ageing Well priorities directly linked to GM's developing Integrated Care System and related to recommendations from the Inequalities Commission Report (specifically around integrated public services and potential pathfinder programmes) as well the GM Build Back Fairer Report.

The GM system approach to falls prevention: delivering integration and reconditioning recommends:

> **Improving the health and wellbeing of GM residents in preventing falls, improving strength and balance and supporting reconditioning.**

1

To establish and maintain a GM level strategic and operational Falls Collaborative, supported by a funded Programme Management post to lead on the GM Falls Collaborative system level priorities and recommendations across community, clinical and care settings.

This includes strategic level priority drivers: Equity, access and equality; embedding evidence and evaluating what works; data improvement, insight and interrogation; workforce development, recruitment and training; community of learning, sharing and problem solving, digital technologies that enable and enhance.

2

To increase the GM provision of community evidence-based strength and balance falls prevention programmes (such as FaME), building on the recommendations laid out in the Centre for Ageing Better's Report: Raising the bar on strength and balance. As well as integrating and scaling evidence based digital technologies and innovation. This includes blended models which have been tested and delivered during the pandemic, alongside new technologies developed using user-centred design and co-created.

3

To adopt a GM system approach taken towards falls prevention and reconditioning as a priority within population health management (PHM) using the policy and contractual frameworks set out for PHM and Anticipatory Care in the NHS LTP. This should use falls as a tracer condition to embed approaches to targeted investment aligned to clearly defined individualised and measurable outcomes to support the narrowing of inequalities of access and outcomes across GM localities.

4

To ensure falls prevention in the early years be a priority Anticipatory Care in GM, implemented through Primary Care Networks and NHS Community Services working with the GM Falls Prevention Collaborative, voluntary and community services and using evidence based programmes and data available within the GM Care Record, where possible, to support population segmentation and identification of those residents who would benefit the most, whilst equally addressing local health inequalities.

5

To embrace the opportunity of further development of the GM ICS beyond July 2022 to deliver greater integrated joint commissioning. This to ensure that evidence-based practice is implemented across GM in a way that addresses health inequalities and prioritises prevention across and throughout the life-course.

6

To enable a proactive shift via the GM Falls Collaborative and through system level leadership towards delivering positive age-inclusive narratives, practice and gain framing to reduce stigma and to overcome ageism, delivering a population prevention agenda for all.

Greater Manchester Falls Collaborative

The GM Falls Collaborative will be established to oversee and deliver the strategic and operational system level priorities and recommendations for falls prevention, integration and reconditioning across community, clinical and care settings.

This group would send a clear message that falls prevention is a continued priority, in enabling improved health outcomes for all, working towards co-created integrated pathways, raising the profile of what works in terms of life course approaches, prevention and evidence-based interventions.

It would also offer an invaluable central point of excellence and reference for the area of falls and falls prevention, including GMs post-pandemic reconditioning response.

The creation of a new post to specifically support a falls collaborative and the full implementation of these recommendations would also ensure that this work continues to move forward.

The new post to specifically support the work of the falls collaborative and the full implementation of the following key priorities will be based in the GM Ageing Hub and space the GM HSCP and future ICS.

GM Falls Collaborative:

Improving the health and wellbeing of GM residents in preventing falls, improving strength and balance and supporting reconditioning.

- Establishing clear governance and membership to broaden integration, reach and impact of specific and wider strategic programme priorities
- Championing implementation of evidence-based programmes
- Developing a Theory of Change for integrated action based on priority areas identified
- Ensuring and facilitating linkages and support within the GMHSCP/ICS to support the enablement of falls prevention programming and investment across the GM system
- Changing the narrative through a proactive shift towards positive age- inclusive language, practice and gain framing to reduce stigma and overcome ageism

Equity, access and equality	Embedding evidence and evaluating what works	Data improvement, insight and interrogation	Workforce development, recruitment and training	Community of learning, sharing and problem solving	Digital technologies that enhance and enable

Strategic Priority Areas

Creating a new narrative and over coming ageism

Equity, access and equality	**GM Quality Standards** minimum agreed set of standards for provision, outcomes, assessment, monitoring and evaluation **Addressing inequity** across the system using strategic programme and investment levers, underpinned by effectively tailored and inclusive provision and good practice **Developing/Sharing Integrated** models of community, clinical and care pathways
Embedding evidence and evaluating what works	**Co-creation and co-production** at the heart of work **Ensuring evidence-based programmes** are adopted at scale **Evaluating what works** and developing new evidence and insight on fully integrated services that deliver a reduction in falls **All commissioning is evidence-based** with potential to work towards a model of joint commissioning that spans borders (e.g. across GMHSCP/ICS and/or localities)
Data improvement, insight and interrogation	**Enhancing data insight** to inform needs based commissioning and enable tailored and targeted provision to address system inequity **Expand** on current outcomes for a more holistic person and place-based indicators **Effective use of data** (including developing electronic care records) to identify those who may benefit the most whilst leaving nobody behind
Workforce development, recruitment and training	**Developing workforce capacity** jointly across GM through appropriate level qualifications and progression through to higher levels. **Recruitment targets** for a representative workforce (age, ethnicity, sexuality, gender) to enable true equity of access to provision and to reduce barriers **Cross-work shadowing** and development opportunities to enhance skills and build relationships across providers
Community of learning, sharing and problem solving (CoLSP)	**Establishing a GM CoLSP** bringing together a collective with a shared purpose **Developing mechanisms for effective sharing,** including workshops, action learning sets, updates, conferences, etc. **Diverse and unrestricted membership** to enable collaboration to feed into and across priority areas **Showcasing and celebrating** what works effectively across Greater Manchester, within communities and neighbourhoods
Digital technologies that enhance	**Scaling innovation** and technologies that are developed using human-centred design, co-created and evidence-based **Identification** and 'test-bedding' blended models of intervention, building on what was grown during pandemic

[i] The NIHR Applied Research Collaboration GM Healthy Ageing Theme launched the FLEXI project in late 2021. FLEXI aims to enable greater levels of uptake of the FAME evidence-based intervention.

Appendix 1: Consultation Partners

Meetings, workshops and informal interviews held during the consultation process

Meetings: GMHSCP Population Health, University of Manchester Healthy Ageing Research Group Members, Manchester Falls Collaborative Falls Prevention Subgroup; GM Ageing Hub Executive. Bolton Age Friendly Board; ongoing system leaders meetings.

Workshops: 2 workshops with GM Ageing Hub (including GMOPN members), Ambition for Ageing/GMCVO

Informal interviews:

Informal interviews were held with a range of stakeholders situated across localities and working in a range of settings related to falls and falls prevention. This includes clinical, community and voluntary sector personnel as well as commissioners. It was not possible to meet with representatives from all stakeholder groups in each area, due to the different localised infrastructure as well as availability of teams during the pandemic.

- **Bolton Community/VCSE**
  - Meeting with Age UK CEO/ GM Age UK Chair
- **Bury Clinical/Community/VCSE**
  - Meeting with BEATS Service
  - Meeting with Community Physiotherapist
- **Manchester Clinical (Commissioner/ providers/AF Manchester Team)**
  - Manchester Falls Service/ Age Friendly Manchester Team
  - Meeting with Commissioners
- **Oldham Clinical/Community/VCSE**
  - Meeting with Falls Team/ Physiotherapist
  - Meeting with Age UK Falls Service Team
- **Rochdale Clinical (Physiotherapy Team Lead, Community Rehab and Falls Service)**
  - Meeting with Falls Team Lead and Falls Nurse (Rochdale Care Organisation)
  - Meeting with Consultant (working across Bury and Rochdale)
- **Salford Clinical/Community/VSCE**
  - Meeting with Inspiring Communities Together Age Friendly Programme
  - Meeting with Clinical Coordinator, Intermediate Care Rehabilitation
- **Stockport Clinical/Community/VCSE**
  - Meeting with Life Leisure, Age UK and Falls Service Clinical Lead
- **Tameside Clinical /Community**
  - Meeting with Associate Directorate Manager – Integrated Therapies
- **Trafford Clinical/Community/VCSE**
  - Meeting with Age UK Trafford (CEO)
  - Meeting with Trafford Commissioner
- **Wigan Clinical/Community/VCSE**
  - Meeting with Consultant Nurse, Community Falls Prevention & Fracture Liaison Meeting with Fall Commissioning Lead

Appendix 2:

About us

Healthy Ageing Research Group, University of Manchester

HEALTHY AGEING RESEARCH GROUP

The Healthy Ageing Research Group (HARG) at the University of Manchester is a multi-disciplinary group conducting research aimed at promoting healthy and active ageing for participation in community and society.

The work of the HARG covers the range of ages considered for older people, including mid-life 55+/retirement age through to those surpassing centenary years.

Areas of expertise include: falls and falls prevention, activity and exercise promotion (strength and balance), nutrition and diet, development and evaluation of novel mHealth and eHealth technologies, clinical decision making support tools, health behaviour change and health literacy, musculoskeletal conditions, mixed-methods research methodology, critical appraisal and evidence synthesis, and user-involvement in design of technologies to support healthy ageing.

HARG's high quality population health research uses quantitative, qualitative and evidence synthesis review techniques and has an emphasis on healthy and active ageing so to promote active participation in society. We develop research capacity in the topic, ensure our work has direct relevance to policy and practice for older adults at a local, national and international level. We engage with and involve the public, patients and stakeholders in our research activities.

GreaterSport supporting Greater Manchester Moving

GreaterSport is a Greater Manchester charity with a clear purpose to Change Lives Together through movement, physical activity and sport. We lead, support and connect people and partners across the system to develop and deliver on the whole system vision and approach to GM Moving in Action.

We are one of 42 Active Partnerships; a network across the country who work collaboratively to create the conditions for an active nation and use the power of sport and physical activity to transform lives. We also work with Sport England to support the local implementation of the Uniting the Movement Strategy.

We work to contribute to Greater Manchester's vision of older residents being able to contribute to and benefit from sustained prosperity, and enjoy a good quality of life. Greater Manchester's population is ageing rapidly. By 2036, 14% of the total population will be 75 and over - an increase of 75% from 2011. If we do not do things differently those at risk of social isolation and loneliness is forecast to increase, with related impacts on physical and mental health and wellbeing. Physical Activity and sport are well positioned to support this aspiration.

Greater Manchester Ageing Hub

The GM Ageing Hub, based at Greater Manchester Combined Authority (GMCA), is a partnership of organisations across the public, voluntary and community and private sector, working to make Greater Manchester a great place to grow older.

By bringing together research and innovation with policy and practice, we promote evidence-based decision making to improve the lives of older people in our city region. GM is fortunate to have some of the world's leading experts on ageing in its universities, and we work closely with academic partners across our work.

We have a strategic partnership with the Centre for Ageing Better, a charitable foundation, funded by The National Lottery Community Fund, to develop and share innovative approaches to tackling social, economic and health inequalities in later life. Since 2016, our joint working has included age-friendly transport, housing and employment.

GM Frailty Care Reference Group (FCRG)

Greater Manchester Health and Social Care Partnership

Established under the GM & Eastern Cheshire Strategic Clinical Networks (SCN) and operating as a member of the GMHSCP Ageing Well Steering Group, the FCRG aims to align GM services with national planning and strategy to support delivery of high quality and consistent services for older people with complex needs across GM.

Its objectives are to bring together clinical leadership, service providers and commissioners to:

- Support delivery of the national objectives;
- Identify and reduce unwarranted variation in clinical outcomes;
- Improve clinical outcomes and patient experience;
- Act as a clinical reference group for the GM Health & Social Care Partnership Ageing Well Steering Group;
- To ensure key groups of people with specific needs are not left disadvantaged by new service offers as they are developed.

The purpose and remit of the group include:

- Promote action to reduce inequalities of service access and health outcomes for older people across GM;
- Improve quality of AW and SDEC AFS services for older people across GM;
- Engage localities to support joint working across key work streams including older people's mental health (OPMH) and palliative and end of life care (P&EOLC) services across GM;
- Provide impartial clinical advice and subject matter expertise to GM localities and the GMHSCP Ageing Well steering group, including constructive challenge to service plans and assumptions where:
  - There is lack of underpinning supportive clinical evidence
  - Patient outcome benefits are unclear
  - There may be misalignment with accepted best clinical practice
  - There may be opportunities to improve outcomes through greater collaboration.
- Build a community of shared clinical practice to support service quality improvement across GM;
- Uphold and support local adoption of the GM Resilience and Independent living strategic objective and care standards
- Support GMHSCP AW and UEC programmes with local system intelligence and data to guide wider system planning and service implementation decisions.

Appendix 3 GM Frailty Care Reference Group
GM Falls Prevention Report
Jan 2021

Falls Prevention in Greater Manchester Safe, steady, strong

1. Background

The 2019 NHS Long Term Plan set out ambitions to provide joined-up, coordinated, proactive services to support population health and reduce demand on urgent care, with a more differentiated offer to groups of individuals at greater risk of poor outcomes and emphasis on reduction of inequalities. Alongside this the Government emphasised that the 2020s will be the decade of proactive, predictive, and personalised prevention, specifically meaning targeted support, tailored lifestyle advice, personalised care and greater protection against future threats.

For older people the national Ageing Well (AW) programme promotes a multidisciplinary team approach, rapid community responses, and greater NHS support for older people with complex needs, including care home residents, before they need hospital treatment.

The Greater Manchester (GM) Frailty Care Reference Group (FCRG) has been established to support the GM Health & Social Care Partnership (GMHSCP) Ageing Well Steering Group (AWSG) to support implementation of this programme with emphasis on delivery of national objectives in GM localities, reducing unwarranted variation and improving clinical outcomes.

In August 2021 Public Health England published 'Wider impacts of COVID-19 on physical activity, deconditioning and falls in older adults' which identified and quantified priority areas of concern for the health and social care system with recommendations for early local mitigating interventions.

The report highlights increasing numbers of older people who have been inactive and persistence of inequalities in physical activity which occurs more frequently in those living in deprivation, with greatest concern among the 70 to 74 age group. This can be expected to lead to greater numbers of older people falling as a result of reduced strength and balance during the pandemic.

2. Introduction

In the coming months and years we therefore anticipate a significant increase in falls frequency among adults in GM which may exceed national predictions due to higher level of deprivation among the most vulnerable groups. It is also of ongoing concern that GM may have been affected disproportionately by longer tier lockdown measures earlier in the pandemic. This will in particular impact on older people, those who have shielded, people living with multiple long term conditions including those living with dementia and or identified as living with clinical frailty, those living in social care settings and those subject to deprivation.

This can be expected to lead to emergency hospital attendance and admission, and subsequent increased need for health and social care support is also anticipated over the coming two years.

Falls can have serious personal consequences including injury, functional loss and death together with loss of psychological resilience through fear of future falls . Falls risk can be in many cases be reduced though proactive identification of people at risk followed by home environmental risk assessment, medical optimisation (including addressing sensory deconditioning such as visual impairment) and strength and balance training to address deconditioning .

The PHE report recommends a combination of actions at whole population and targeted levels to address deconditioning (see Figs 1 & 2).

[ii] https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document
[iii] Now renamed the Discharge and Community Services programme
[iv] https://www.gov.uk/government/publications/covid-19-wider-impacts-on-people-aged-65-and-over

Figure 1: Whole population recommendations

Ensure physical activity recovery measures reach those who stand to benefit most	– Involving a gradual increase in activity in order to reduce falls risk and to enable safe and confident participation on other forms of exercise and physical activity
Promote and increase availability of strength and balance activity for older adults	– Older adults who shielded – People living with multiple conditions (2 or more long term conditions) – Adults living with dementia – People in social care settings
Identify locally which older adults have reduced their levels of physical activity during the COVID-19 pandemic	– Focus on populations where the largest reductions are likely to be found – The largest reductions in strength and balance activity identified in this report were seen in males aged 65 to 74 and females aged 65 to 84

Figure 2: Whole Targeted population recommendations

Refer to appropriate rehabilitation services, older adults with:	– Functional loss – Transition towards clinical frailty – Fear of falls resulting from deconditioning
Raise awareness	– Amongst health and social care staff of post-COVID-19 syndrome
Communicate the risks	– Of building up levels of activity levels too rapidly and the need to refer to post-COVID-19 syndrome clinics where symptoms are severe, in order that clinical judgement can be used about whether graded exercise therapy should be recommended

[v] https://www.nice.org.uk/guidance/cg161/chapter/Introduction
[vi] https://www.acc.co.nz/about-us/preventing-injury/trips-falls/

3. Understanding the scale and nature of the problem

Case-finding data searches will be required in order to identify people most likely to benefit from falls prevention. This will involve:

a) Identifying validated groups of named individuals at risk of deconditioning (and hence future falls) through a number of means:

- Systematic
- Opportunistic
- Self (or family/carer) identification
- There may be other groups in seldom head/marginalised populations

b) Potential data sources for interrogation to identify those most likely to benefit may include:

- GM Care Record (GMCR)
- GP electronic patient record (EPR) systems
- Hospital data
- Social care data
- North West Ambulance Service (NWAS) data
- There may be other data sources of patient level data

The most efficient and consistent approach would involve systematic GM level identification which then enables locality level cohorts of patients to be identified who may be amenable to one or more preventative interventions.

Cohorts would in all probability need local case validation and eligibility assessment to improve case finding accuracy.

Each locality should also be supported to build on existing local falls prevention service offers to develop a common GM core falls prevention offer matched to the scale of local need, the individual outcomes and aggregate impact being sought.

4. Developing a GM response

We need to assess whether this can be done through the GMCR and consider the definition of an algorithm that would output the required results. However, clarity will be required on what we would do with these results and what the offer is to the system (ie the 'so what' question). We will need to:

a) Identify the people who will benefit the most

b) Offer the right evidence based interventions

c) Describe an effective GM delivery model for implementation

The right interventions

Multifactorial interventions are important but ultimately exercise will be the most effective intervention and must be a central part of any GM delivery model for falls prevention . Keeping this in mind the core interventions which will create most benefit for patients and drive the desired outcomes (preventing the progression of clinical frailty and hospital admissions) will be:

1. Home environmental risk assessment and reduction (for example safe and well checks)
2. Medical checks including functional fitness (undertaken by clinical staff)
3. Medications review and optimisation
4. Strength & balance training (face to face or virtual/remote),

These interventions should also address mental health issues, specifically anxiety related to fear of falling. It will be important to clarify the assessments to be carried out for the above and agree who can carry them out in each locality and what economies of scale are available via GM offer (Fire & Rescue Service 'safe-and-well' checks or virtual strength and balance training, for example).

Identifying the right people

We need to clarify the criteria that describe the patient cohort (a above) and confirm whether it is possible to interrogate the GM Care record to identify them. It may also be important at this stage further segment the data by wider determinants of health to account for inequalities resulting deprivation and/or ethnicity.

The potential GP-EPR/GM-CR search criteria could include:

- All aged 70+ (mindful that in some localities younger groups may also be at greater risk)
- Those who have some or all of the following characteristics
  - Shielded in 2020 and/or
  - Two or more long term conditions and/or
  - Living with Dementia and/or
  - Living in social care settings (needs defining though care homes and extra-care would be a good starting point) and/or
- A home address in a deprived area and/or
- Clinical Frailty:

  'Pre-frailty': eFI (electronic frailty index) mild frailty: eFI=0.13 to 0.24 [~35% of 65+]

  Moderate frailty: eFI=0.25-0.36 [~12% of 65+]

  Severe frailty: eFI>0.26 [~3% of 65+]

Implementing a delivery model

Clinical leadership and ownership will be vital in order to develop a delivery model. Potential delivery partners could include:

- GM Fire & Rescue Service (home assessments)
- Intermediate care teams (MDT Assessments)
- Safety Medications Dashboard (to help validate results for medications reviews)
- VCSE groups & GM Active (to support delivery of local strength and balance interventions)

Key system partners will need to include:

- GP and community services
- Intermediate MDTs
- LCO & provider trusts
- The GM ICS/ICB

A delivery model will likely have to include the elements below:

vii https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012221.pub2/full
viii https://academic.oup.com/ageing/advance-article/doi/10.1093/ageing/afab201/6399893
xi https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4932244/
x https://www.laterlifetraining.co.uk/courses/fully-functional-mot/functional-fitness-mot/
xi https://www.laterlifetraining.co.uk/wp-content/uploads/2017/07/LLT-Guidance_Evidenced-Based-Falls-Prevention-Programmes_FaME_Otago_commissioning_240717.pdf
xii https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4820267/
xiii https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6514257/

Run the searches

- To identify the scale of the issue
- Whole GM population segmentation based on algorithmic searches of key data sets (GMCR, GP EPR, NWAS etc)

Segement the population

- To identify what can be done sustainably at:
- GM level (remotely/ digitally)
- Locality level cohort identification at locality and primary care network level matched to assess service demand and planned service capacity

Validate the results

- Local clinical validation of 'long list' risk groups at primary care network (PCN) level to identify those individuals most likely to benefit from intervention offers

MDT assessment

- Multidisciplinary assessment and personalised care planning focused on falls preventon and reconditioning delivered at primary care network level in collaboration with local community services and other partners

Patient interventions

- Delivered locally by primary/community care and/or VCSE services on a collaborative basis working to common outcomes focused around personalised care objectives and system level aggregate outcomes

Actvivity and Outcome Monitoring

- Locally colected activity and outcome minimum data aggregated at GM level for assurance, quality improvement, identification and managment of inequalities of access and outcome

xiv NICE produced indicator guidance on this (NM184) in 2019: it relies on a register of people with conditions in 4 or more disease clusters (based on the Public Health Scotland SPIRE approach
xv https://www.england.nhs.uk/wp-content/uploads/2017/04/gms-contract-batch-coding-statement-v1.pdf

5. Opportunities & potential challenges

We will need to clarify opportunities, challenges and contextual issues which are relevant to this work and could impact on delivery. This list will need to be developed but could include those listed below:

Opportunities

- It is noted that some Primary Care Networks (PCNs) in GM are already developing ideas on risk stratification and case identification and other PCNs should work collaboratively via the FCRG to build a community of best practice.
- Delivery of some aspects of the work could can be commissioned once at GM level, particularly work which is best done at scale such as data analysis, risk stratification, population segmentation and remote monitoring. Clinical Frailty mapping data will help to support this process .

Challenges

- We will need to consider information governance (IG) requirements/issues early to avoid later challenges. If case finding based on GP EPR, IG may be less of an issue?
- An MDT (multidisciplinary team) approach would be required to ensure that social, medical and wider aspects of care an intervention are incorporated into an anticipatory care plan.

Contextual considerations

- We must agree who the outputs are directed at and how we segment the population then case validate at primary care network level in order to direct the interventions effectively.
- It is noted that care home residents are a subset of the overall population of interest and may not be the most appropriate focus for our work here. It is also noted that a lot of the support/intervention for that group is based around environmental management and supervision.
- Primary care networks (PCNs) will need to agree a model of clinical care co-ordination, identifying who is responsible for interventions and how work load is distributed and managed between primary, community services, social care and voluntary sectors locally while working towards core GM outcomes.
- We also need to develop and agree an optimised GM falls prevention delivery model.
- It will be important to understand the picture at a GM level and support delivery at a local level, building from existing service offers and interventions in order to best identify and address inequalities of service access and outcome.

[xvi] https://www.opfpru.nihr.ac.uk/our-research/projects/frailty-data/

6. Recommended next steps

Building from the evidence base and work already undertaken and set out in the 2022 GM Falls Mapping Report, further GMHSCP level agreement is required on the following issues to develop a GM Falls Prevention Service implementation framework:

- Use of national Ageing Well (Discharge and Community Services) policy, contractual and investment levers, specifically linked to Anticipatory Care and Enhanced Health in Care Homes to support development of the GM falls prevention collaborative and local service offers;
- Case finding through data held within the GM Care Record (subject to IG agreements) based on an agreed and validated algorithm;
- Case validation of PCN level risk cohorts to identify individuals at risk;
- Develop GM level falls prevention service offers, service implementation standards and outcomes;
- Work with PCNs, Local Care Organisations (LCOs) and the GM Falls Prevention Collaborative to agree GM wide implementation and outcomes frameworks
- Develop a GM level community of practice to support localities in developing and sustaining their falls prevention offers aligned to the GM implementation framework
- Agree a GM level framework for falls prevention activity and outcome reporting and monitoring.

We will need to agree a structure/ group for taking forward the above.

[xvii] https://www.engage.england.nhs.uk/survey/primary-care-networks-service-specifications/supporting_documents/Draft%20PCN%20Service%20Specifications%20December%202019.pdf
[xviii] https://www.england.nhs.uk/publication/enhanced-health-in-care-homes-framework/

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Greater Manchester Falls Prevention: Delivering Integration and Reconditioning

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