practitioner (GP) and the local geriatrician-led multidisciplinary clinic. Each GP practice now has a nominated falls nurse, each PCT several gait and balance groups including a class for Asian elders. Fallers who attend Accident and Emergency (A&E) are referred to the relevant falls nurses. North Bradford PCT will shortly require their GPs to document falls. Home care staff are trained in falls awareness and, with the community nurses, are using the Cryer screening tool to pick up those at highest risk. This tool is included in the Bradford single assessment document. Nursing and residential homes have access to training in falls awareness and risk assessment, and some staff have undergone training in the Extend exercises.

Finally we are piloting data collection using Systm One. The collected data mirrors the existing risk assessment tool and meets most of the falls dataset proposed recently by the DOH. Systm One will enable immediate sharing of the assessments between relevant health professionals whether they are based in primary, secondary or intermediate care, outpatient or inpatient.

In December 2004 we celebrated our achievements with a falls conference co-sponsored by Age Concern; 223 local delegates attended.

So is it working? North Bradford PCT, which is the furthest ahead with the falls work, had 12% fewer fallers attending A&E in 2004 than 2003. It is too early to say more, so watch this space.


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2. www.pursuingperfectionbradford.nhs.uk/

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Reply

SIR—Dr Brierly and colleagues are to be congratulated on their efforts to apply existing evidence-based approaches in preventing falls to a whole community. The involvement of the ‘whole system’ including service users is both highly commendable and essential for the development and delivery of health care and its long-term sustainability. The reduction in A&E attendees is encouraging at this point.

Southwark and Lambeth (a Pursuing Perfection site) are taking a similar approach to the development of falls services across a whole community (SLIPS—Southwark and Lambeth Integrated Care Pathway for Falls). One particular area of interest has been the consensus approach to the assessment and intervention for people with postural instability. All therapists across the two PCTs and two acute trusts involved in falls services now use the same assessment tool and exercise intervention for patients. Choice in the method of delivery of exercise has been key to dramatically reducing refusal rates for exercise to <10% at one of the sites. Home- and group-based exercise are offered to those with moderate falls risk scores and, when offered choice, more patients (66%) opt for the home-based exercise. Preliminary evaluation of the outcomes is showing statistically significant improvements in measures of strength, balance and reaction times for both groups. By offering choice, more people are undertaking interventions from which they stand to benefit.

However, whilst acknowledging that pockets of good practice exist, we should be aware that considerable effort is still required to ensure that all high-risk fallers receive appropriate intervention. Care remains fragmented in many areas and in some areas is not evidence based. As clinicians, we have a responsibility to work with acute trusts and PCTs to ensure that local services are developed in keeping with national and international recommendations and guidelines.

In the recent Cochrane review of population-based interventions for the prevention of fall-related injuries in older people, the authors conclude that there is some evidence to support a population-based approach to fall-related injury prevention [1]. This is based on five studies all undertaken outside the UK. The authors state that more research is required to ‘elucidate the barriers and facilitators in population-based interventions that influence the extent to which population programmes are effective’. With appropriate evaluation of their respective approaches, both Bradford and Lambeth & Southwark should be able to contribute to the next version of this Cochrane review.

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Prevention of falls—a time to translate evidence into practice

SIR—I write with reference to an article by Close in a recent issue of Age and Ageing [1]. I would like to take this opportunity to correct some inaccurate statements made within
the article. I am sure that the statements were made in good faith, but as they are inaccurate, they are liable to mislead and misrepresent the work of the Healthy Communities Collaborative. The statements under dispute are as follows.

Page 99, paragraph 2: ‘However the reported benefit is dwarfed when compared to the 60% reduction in falls reported by the National Falls Collaborative in its “Sloppy Slipper Campaign” (13) whereby older people “exchange their old, potentially dangerous slippers for a newer safer pair”. In a similar vein, this collaborative reports 60% reductions in falls for single interventions such as battery operated lights and light exercise [14].’

I would like to highlight the facts around these issues.

The National Falls Collaborative has never run a ‘Sloppy Slipper Campaign’ (see Note). It is possible that a participating site ran such an event, but as we were neither consulted nor asked to contribute to the referenced article, I am unable to identify the source of the statement.

As you can see from the detail in the ‘Sloppy Slipper Event’, we have never advocated single interventions for falls reduction. Our earliest advice on falls reduction in non-cognitively impaired older people living in the community came from Professor R. Kenny, Royal Victoria Infirmary, Newcastle. We have strongly advocated that multi-factorial falls require multi-agency responses and we believe that we have been particularly successful in promoting multi-agency working in falls reduction.

The Health Development Agency (HDA) press release does not refer to the National Falls Collaborative (NFC) but to the Healthy Communities Collaborative (HCC); these are very different programmes. This is an important distinction and one which is often lost on people reviewing the two programmes.

The NFC was a service-led attempt to reduce falls in 20 sites across England. The HCC is a community-led programme, initially piloted in three sites and now spread to an additional 16 sites, which seeks to create multi-agency teams and develop communities in very deprived areas. The topic of the HCC in 2002/3 was reducing falls in older people.

The press release does indeed cite a 60% reduction in falls and this was derived from a comparison of one site’s baseline data with their final month’s data (12 months). Across the three sites they achieved a reduction of 32% against a target of 30% in a year. At 20 months they had continued the reduction and had reached 37%. We no longer collect data from them and they use Ambulance Trust data as their source.

The press release cited actual examples that the communities had taken part in but they were selected from a range of examples in the areas. The participating sites all use the evidence provided by the HDA in the paper by Easterbrook et al. [2] as the basis for their interventions. This review advises that interventions should include exercise, medications management, eyes, feet and environment. This has been tailored for a lay audience.

Other sources of evidence that the sites routinely use and which are included in their reference manual include the following: (i) ‘Falls, Fragility and Fractures’, C. Cryer and S. Patel, June 2002; (ii) Accidental Injuries Task Force, DH 2002; (iii) ‘Cardiac pacing for the prevention of recurrent falls in carotid sinus Hypersensitivity’, Professor R. A. Kenny; (iv) ‘Falls and the use of health services in community-living elderly people’, Stoddart et al. British Journal of General Practice, 2002; (v) ‘Aiding slips, trips and broken hips’, HTA; and, more recently, (vi) NICE. ‘The assessment and prevention of falls in older people’, Clinical Guideline 21, November 2004; and (vii) Help the Aged ‘Encouraging positive attitudes to falls prevention in later life’, 2004, both of which the HCC contributed to the development of either directly or through the HDA.

I hope that this goes some way to clarifying some of the inaccuracies in the published article. I was gratified to also read in the same article (page 98, paragraph 2) that the author advocates that after 10 years of randomised controlled trials we might have enough evidence to now begin to implement what evidence we have. This is something that I have been promoting for the last 3 years.

I would be more than happy to expand on some of these points, providing data, evidence and information as requested. Much has been written by third parties about the HCC and NFC, and to date a request for a contribution to such articles has never been made.

Thank you for your attention to this.

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Note: Sloppy Slipper events were designed by participating sites as a gimmicky way of bringing in to a central venue previously underserved older people, and commonly 50–200 people attended these events who previously were not engaged in any services. The hook was a free pair of slippers which had been purchased using funds from charities, lotteries, etc., not mainstream NHS funds. Once into the central venue, the participants were screened for falls risk using a validated tool, and offered interventions from a range of agencies such as podiatry, ophthalmology, pharmacy, exercise and lifestyle specialists, and a range of non-clinical expertise such as housing, transport and benefit advice.

A note about Collaboratives: Collaboratives are an evidence-based approach to transferring knowledge and skills to multiple settings. They are rigorous in their measurement of success of interventions and improvement can be easily demonstrated.


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