



**Sefton Council  
and Sefton Place**  
Integrated Falls  
Prevention Strategy  

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2025 - 2028

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**NHS**  
Cheshire and Merseyside

Sefton Council 

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# Foreward

Falls have a dramatic impact on individuals, families and the health and social care system. More people are falling in Sefton compared with other areas which has remained largely unchanged over the past four years. Often the fall results in hospital stays which can permanently reduce a person's physical and mental health wellbeing. Sometimes these falls could have been prevented, or the repercussions of the fall reduced with timely intervention.

We know that there are many reasons why people have falls and it is vital that we use the intelligence in our partnership system to help us to tackle this situation locally.

Falling is not an inevitable part of growing old and can be prevented by organisations and the public working together. The Sefton Partnership is committed to working together to support people to age well in Sefton; living longer lives with more years of good health and independence.

Our ambition in Sefton is to reduce the inevitability of falls with all of our services, working together to actively prevent the incidence of falls. This Strategy for 2025-2028 sets out how we will work together to achieve this, identifying residents in Sefton who present with the risk factors associated with a potential fall, and the Strategy seeks to ensure we have embraced the principles of making every contact count when we review and manage falls.

We will work together to create safe home environments and to promote services developed specifically for this purpose.

We know we must work together to have the impact we want in our authority, given the scale of the issue locally, and we want this Strategy to support the local work to reduce the incidence of falls and promote the continued independence of our residents.

**Together we aspire to create a “fall free” Sefton!**



**Cllr Ian Moncur**

Cabinet Member  
Adult Social Care

*Ian Moncur.*



**Deborah Butcher**

Executive Director for  
Adult Social Care, Health

*Deborah Butcher.*

# Introduction

It is acknowledged that anyone of any age can have a fall causing injury.

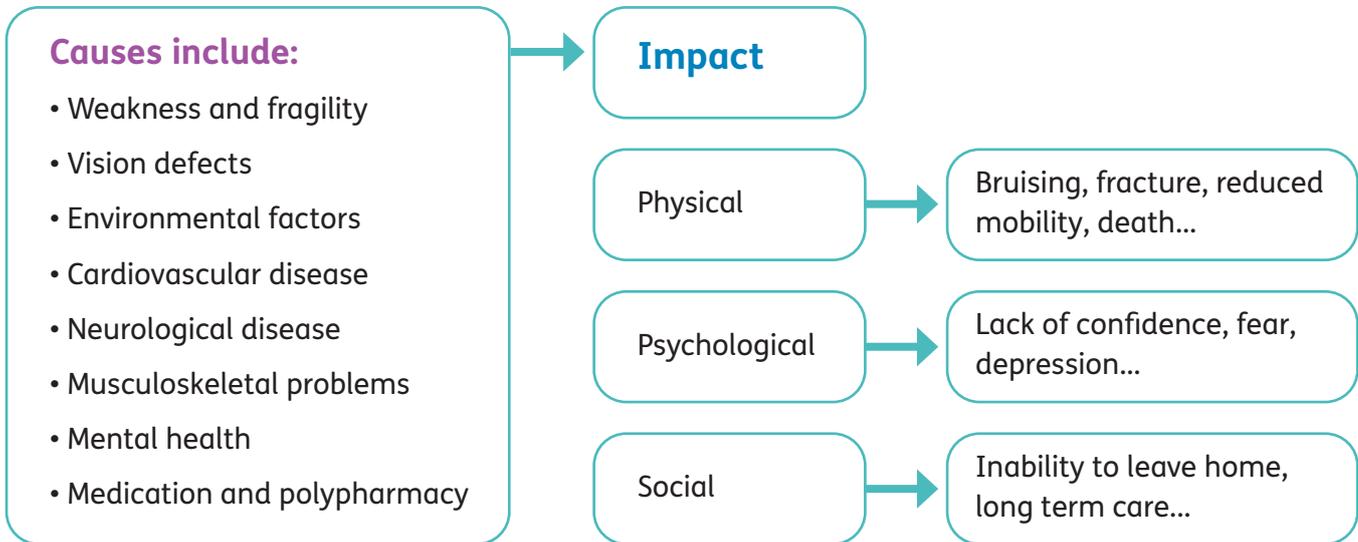
“A fall is distinguished from a collapse that occurs as a result of an acute medical problem such as acute arrhythmia, a transient ischaemic attack or vertigo”.

“A fall is defined as an event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event (such as a stroke) or overwhelming hazard.” (National Institute for Health and Care Excellence (NICE) Quality Standard 86, 2015).

However, those most likely to fall and suffer serious injury are aged 65 or over. Falls are multifactorial, and a major cause of morbidity and mortality among those aged 65 and over in the UK.

The National Institute on Ageing summarises the variation in causes of falls in older adults which includes deterioration of vision and reflexes; conditions such as diabetes, heart disease, postural hypotension, incontinence, and dementia; medication; and hazards at home. While the majority of Falls do not result in serious injury, some other adults can experience broken bones, deconditioning and a loss of confidence and independence. Alongside the Human Cost of Falls (UK Health Security Agency, 2024), falls cost the NHS around £2bn a year and 4 million inpatient bed days, with unaddressed falls risks in the home costing £435m alone (Falls: applying All our Health: Office for Health Improvement and Disparities, 2022).

Around 30% of adults over the age of 65 who are living at home, experience at least one fall a year.  
By the age of 80 years, this statistic rises to 50%.  
NICE Clinical guideline [CG161] Falls in older people: assessing risk and prevention. [2013]



The consequences of a fall are likely to comprise a combination of each of the above physical, psychological and social impacts. Therefore, it is important that falls services address each of these possible outcomes, as well as the causes to ensure an effective and truly patient centred approach.

The Strategy takes into account national guidance and best practice and will provide a framework that underpins the work of the Sefton Partnership over the coming years, preparing the group for the anticipated refreshed NICE guidance, Falls: assessment and prevention in older people and people 50 and over at higher risk (update), due in March 2025.

Reducing falls incidences and injuries, has been identified as a key priority by Sefton's Health and Wellbeing Board and has been reflected within our ambition for Age Well within Sefton's Health and Wellbeing Strategy 2020 – 2025.

**Sefton's ambitions for Age Well are as follows:**

- ✓ Older people will stay active, connected and involved by being part of strong communities in which they are important.
- ✓ As people grow older, they will be provided with support, tailored to their needs which respects their dignity and individual preferences, including in relation to caring responsibilities.
- ✓ Our communities and the built environment will meet the needs of people as they get older, through age and disability friendly towns, communities, services, housing and transport.

Delivering the Falls Prevention Strategy contributes to Sefton's 2030 Vision and Core Purpose. The Health and Wellbeing of Sefton residents is a key deliverable of the Sefton Health and Wellbeing Strategy and The Cheshire and Merseyside Health and Care Partnership (CMHCP).

## Adult social care market position statement

Residents' choice and control, as detailed in Sefton's Market Position Statement, is key to achieving our vision. Our strategic direction is to move towards supporting more people to remain in their own homes for longer, but to also work with our care home sector, to better support people at risk of falls, providing solutions to help us deliver this Falls Strategy and complement or reduce the need for additional 1:1 support.

We estimate that the Sefton Partnership current budget is £434.2m, whilst Sefton Adult Social Care (ASC) budget is circa £153m. If combined, we could deliver the most effective service for the people of Sefton.

Sefton's Vision is to embed early help and prevention in health and social care. We will work with formal and informal care providers to support people to live independently, stay connected with their local communities and stay fit and active for longer.

Over the next 3 years, we will develop and deliver a Sefton Falls Prevention service offer, which is accessible across both social care and health.

In order to deliver this element of the Strategy, an approach to co-production needs to be implemented across all services. For most services, this will serve as a reminder of best practice but for others it may provide the opportunity to refresh or develop their approach.

In 2023, Sefton Council, produced a CoProduction Framework, which has supported the facilitation of change within Adult Social Care and it ensures that services are co designed with all stakeholders across Sefton. We are committed to continuing to use a co-production approach to the development and implementation of this Strategy.

# National Context

**The State of Ageing 2023-24 [Centre for Ageing Better] is the most detailed, varied and up-to-date report about ageing in England. It references the growing older population:**

- The older population in England is getting larger. In the last 40 years, the number of people aged 50 and over has increased by over 6.8 million (a 47% increase), and the number aged 65 and over has increased by over 3.5 million (a 52% increase).
- Over 10 million people are currently aged 65 and over, making up 18% of the population.
- The number of people aged 65-79 is predicted to increase by nearly a third (30%) to over 10 million in the next 40 years, while the number of people aged 80 and over – the fastest growing segment of the population – is set to more than double to over 6 million.
- The older population is growing fastest in many rural and coastal areas, where the proportion of older people is already higher. In some rural and coastal local authority areas, one in three people are aged 65 and over compared with one in five across the country.

**Public Health Outcomes Framework (PHOF)** reported that, in 2017-2018 there were around 220,160 **emergency hospital admissions** related to falls among patients aged 65+, with around 146,665 (66.6%) of these patients aged 80+. The estimated UK total annual cost of fragility fractures is £4.4 billion, which includes £1.1 billion for social care; hip fractures account for around £2 billion of this sum.

Analysis presented in the report by TakingCare Personal Alarms, *Elderly People and Falls: How health care can better support the UK's ageing population (2023)*, states an elderly person (aged 80+) falls every ten seconds in the UK. This equates to around 8,500 falls a day.

According to data from the Projecting Older People Population Information (POPPI), the number of people aged over 80 is expected to grow to nearly 4.5 million by 2035. Over 65s will make up a third of the population. POPPI states that one in five falls experienced by people aged over 80 result in hospital visits. For people aged over 70, one in ten falls result in a hospital visit.

Falls are the number one reason people are taken to the emergency department in hospital. Hip fracture is the main reason for an older person to need emergency surgery. (National Hip Fracture Database (NHFD) 2022). Over 60,000 people sustained a femoral fracture in England and Wales in 2022 (NHFD). Of these, 2,033 occurred in inpatient settings; 1,669 (82%) were due to a fall and included as cases in the National Audit of Inpatient Falls. 13% people who sustained a femoral fracture as an inpatient died within 30 days of the fracture.

Unaddressed, fall hazards in the home are estimated to cost the NHS in England £435 million.

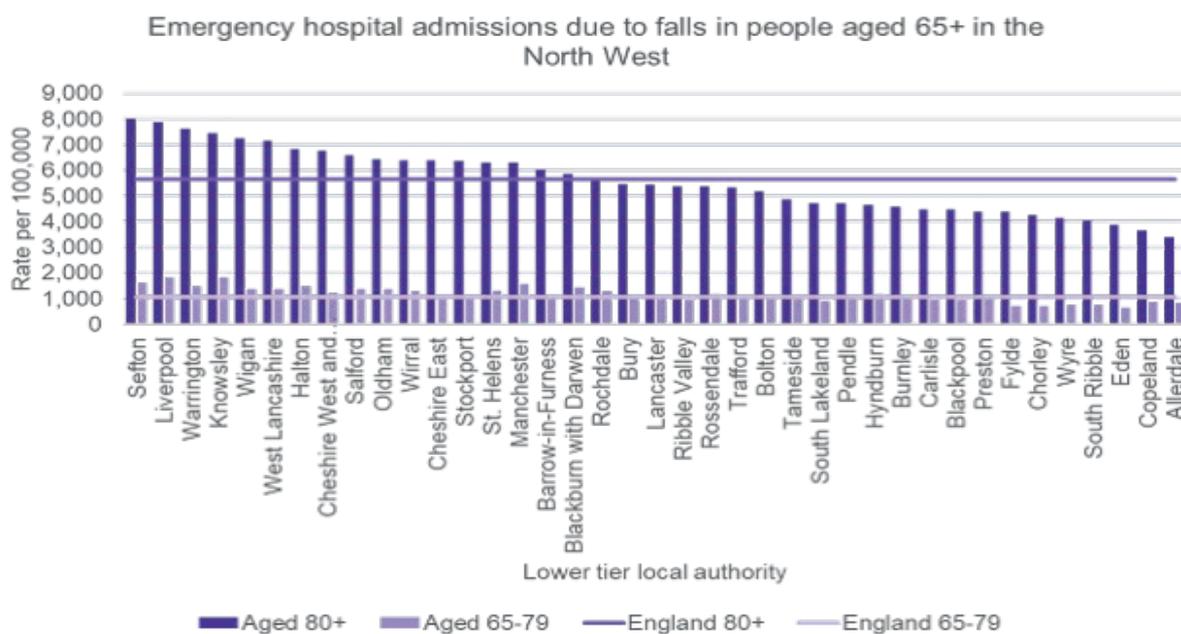


# Local Context

Currently, older adults (those aged 65+) make up 19% of the North West, and this is predicted to increase by 36% by 2040.

State of Healthy Ageing in the North West 2022, a resource to support local health needs assessments, shows Sefton as having the highest falls rates in the region.

**The State of Healthy Ageing in the North West 2022 Resource indicates the emergency hospitals admissions due to falls in people aged 65+ in the North West.**



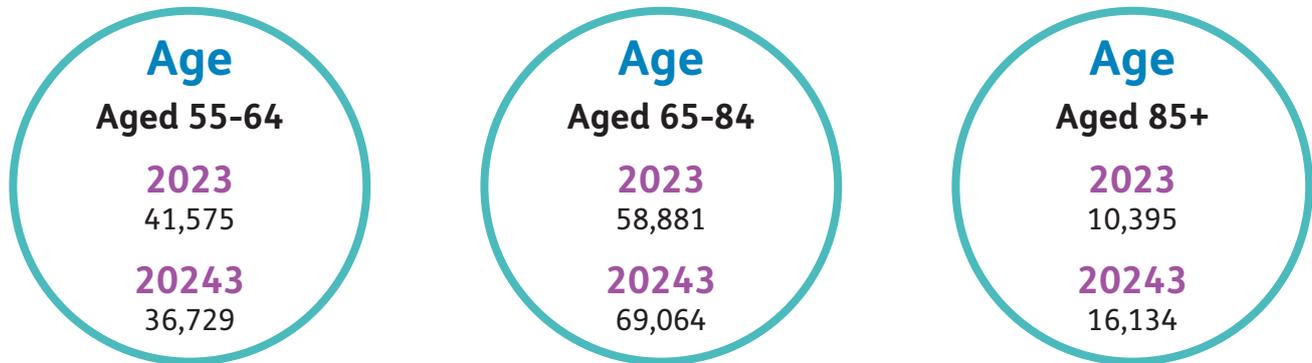
In 2022/23, there were 11,505 hospital admissions in Sefton due to falls (people age 65+). This is significantly above the regional and national averages. When comparing from previous years, there has been a sharp decrease in falls in the region between 2021/22 and 2022/23 from a rate of 2,629 to 2,235 per 100,000.

Sefton has significantly higher rates of emergency hospital admissions (EHA) of falls in people aged 65+ than the regional and national rates, even following adjustment for age.

According to Southport District General Hospital, in 2023, there were 3,311 attendances to the emergency department with falls in those aged 65 and over. This means, on average, there were 9 falls attendances every day of the year. Of those 3311 attendances, there were 2796 individual patients, with 2406 having 1 falls presentation and 390 with multiple falls presentations. 3 patients presented 6 times each with falls in 2023.

# Projections for Sefton

Sefton Population data (Sefton Population Projections 2018), based on the Office for National Statistics (ONS) data, show the following predicted annual population growth rates.



The table below shows the numbers of people living in Sefton aged 65+, predicted to have a fall, as projected to 2040

	2023	2025	2030	2035	2040
People aged 65-69 predicted to have a fall	3,797	3,979	4,417	4,125	3,715
People aged 70-74 predicted to have a fall	3,761	3,842	4,386	4,890	4,601
People aged 75-79 predicted to have a fall	3,406	3,536	3,452	3,939	4,415
People aged 80-84 predicted to have a fall	3,209	3,370	4,147	4,051	4,704
People aged 85 and over predicted to have a fall	4,472	4,558	4,945	5,891	6,407
<b>Total population aged 65 and over predicted to have a fall</b>	<b>18,645</b>	<b>19,285</b>	<b>21,347</b>	<b>22,896</b>	<b>23,842</b>



**58,881**

Residents are aged 65  
(c.25% of population)

(2023 data)



**18,645**

Falls per year in population  
aged over 65.



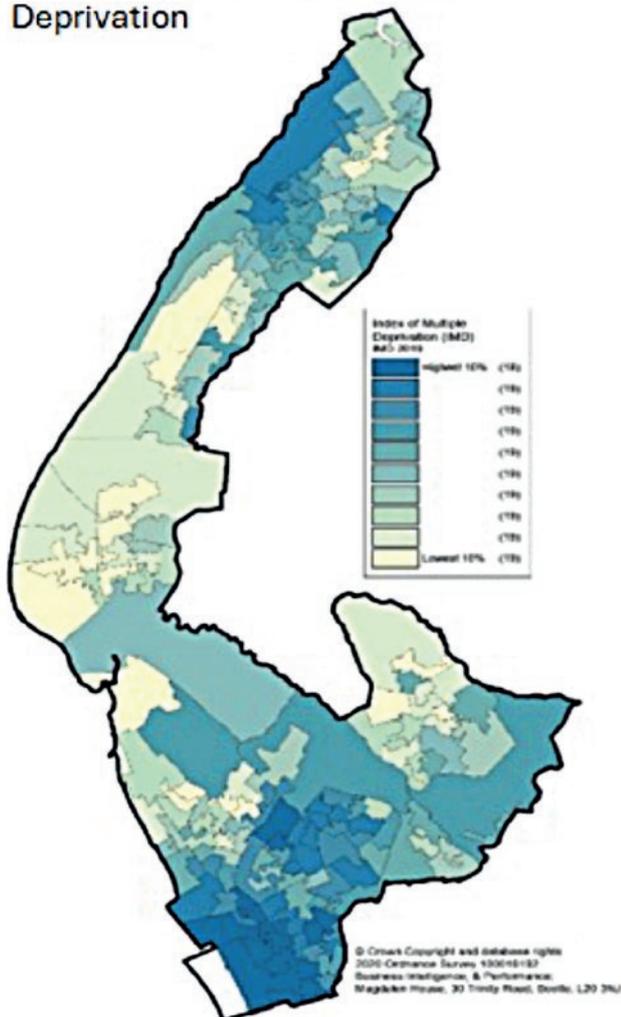
**2,308**

Predicted numbers of  
hospital admissions due to  
falls in Sefton.

# Contributing Factors

There are multiple contributing factors for the high falls rate in Sefton including;

## Sefton 2019 Index of Multiple Deprivation



- There are extremely high levels of deprivation in some areas of the Borough, with multiple endemic issues associated with housing, employment, and environmental issues. There are also significant gaps in health status and life expectancy between those living in the most deprived and least deprived areas. This creates additional challenges when addressing health inequalities and targeting services to those most in need.
- Overall, Sefton has a higher Index of Multiple Deprivation (IMD) score than that of England with Sefton being ranked 45 out of 151 upper tier local authorities (where 1 had the highest IMD score, please note the IMD is from 2019)

- Average earnings in Sefton are below the national average, contributing to several issues including food poverty, homelessness, mental health and wellbeing, and fuel poverty.
- There are increasingly changing patterns of smoking, excess weight, physical activity, diet, alcohol, drug use and other behaviours, which impacts the planning of future interventions.
- There is a growing number of people with long-term conditions, sensory impairment, dementia, cancer, and other health problems, with an increasing focus on those living with multiple health conditions.
- There are growing levels of severe frailty in the population.

# Impact of Covid-19

Older people have been disproportionately affected by COVID-19. Many older people have lost confidence about things like leaving the house or engaging with health and community services. One of the most acute impacts being reduced physical activity, leading to deconditioning.

In its 2021 publication, *Wider Impacts of COVID-10 on Physical Activity, Deconditioning and Falls in Older Adults*, Public Health England predicted that the rate of falls in older people would significantly increase as a result of their experience of the wider impacts of the pandemic by this group. These wider impacts included mental health, access to services, employment, and changes in behaviours including smoking, diet, alcohol consumption and physical activity.

Deconditioning is the syndrome of physical, psychological and functional decline that occurs as a result of prolonged inactivity and associated loss of muscle strength. This can occur at any age, but amongst older adults can occur more rapidly, be more severe, and be extremely challenging to reverse.

**Age UK conducted a study on the impact of COVID-19 on older people's mental and physical health. When older people were asked how their health has changed since the start of the pandemic:**

- 26% are unable to walk as before
- 18% feel less steady on their feet
- 34% have less energy

**Furthermore, these changes are more pronounced amongst people with long-term health conditions and people from more disadvantaged socioeconomic backgrounds:**

- 43% of people with a long-term health condition are unable to walk as far as before, compared to 13% of people without a long-term health condition
- 22% of older people from more disadvantaged backgrounds say they feel less steady on their feet compared to 14% from the most advantaged
- 39% of older people from more disadvantaged backgrounds say they have less energy compared to 26% of those from the most advantaged



# Vision and Principles

We have developed six principles which we are using to deliver our vision.

**1. Consultation & Engagement:** Involve the public in the implementation of the Strategy:

- Formal involvement of Healthwatch on the Sefton Falls Prevention Partnership Board
- All falls prevention services routinely gathering user feedback and learning from this feedback
- Through engagement with Community groups.
- Planned multi agency Consultation and Engagement Sessions

**2. Continue to commission and develop borough-wide evidenced based services which reduce the likelihood of falls and their severity, and ensuring those at risk of falling and injuring themselves are able to:**

- Access a formal risk assessment from an appropriate qualified professional
- Access falls specific exercise classes that can improve their posture, balance and muscle strength
- Be provided with a home hazard check to reduce the likelihood of them falling
- Access Technology Enabled Care Solutions: remote and acoustic monitoring equipment and a falls response service to safeguard people at home and in shared care settings.
- Access community equipment to reduce their risk of falling
- Additional support to care home residents to reduce their falls risk.
- No basic assessments on simple things like – sloppy slippers and appropriate mobility support

**3. Communicate the issue of falls to professionals and the public**

- Produce a Communications Plan to improve awareness of falls prevention. This will include an annual falls awareness week.
- Use the falls prevention group to promote falls initiatives
- Ensure professionals discuss falls with those at risk and refer to appropriate services
- Standardised training for all care home staff.
- The involvement of care homes in how they manage falls.

## Our Vision

Our vision is to make prevention of falls everybody's business by developing a culture in which falls are not inevitable and where our system partners are working together to actively prevent the incidence of falls.

Wherever we can, we will utilise technology to support our falls prevention and falls monitoring work.



#### 4. Produce updated intelligence to help inform commissioning/delivery approaches

- Refresh the Joint Strategic Needs Assessment to consider new data.
- Continuously monitor local progress.
- Use of available statistics from public health / data analysts

#### 5. Ensure local authority, health and third-party colleagues take account of the importance of falls prevention within their strategic plans, so that any new relevant Strategy and plan takes account of the issue of falls.

#### 6. Improve alignment of reporting Falls

- Scope and better align presentation of data to specific areas – falls at home / falls in care homes
- Improve quality and timeliness of falls reporting in shared care settings.
- Develop a Generic falls assessment template for all Sefton shared care settings (Sample pro forma template).

#### We will deliver these principles through:

##### 1. Evidence-based practice

- We recognise the value of data to inform our practice and will ensure we identify those at higher risk of falls, and their carers, so they have the knowledge to be active participants in falls prevention.
- Benchmark our Falls Prevention model and services with other areas and consider best practice and national guidance to further improve local services.



##### 2. Work in partnership around the management of falls

- Develop a coordinator role to act as a single point of contact to triage referrals received via the Occupational Therapy teams, liaising with community falls prevention services to support and provide advice, guidance, alternative Technology Enabled Care Solutions (TECS) and devices for people living at home who are at risk of falling.
- The Enhanced Health offer to care homes has built relationships between primary care and care home settings, facilitating homes to get the clinical help and support for residents at risk of falls or in the aftermath of a fall, and promoting Personalised Care and Support Plans.
- As part of the weekly round, South Sefton Primary Care Network (PCN) team will ask for information on residents that have falls in the previous week which supports the monitoring and review of patients likely to fall.
- Where residents have need of rehabilitation, ongoing therapy, mobility assessment or falls with advanced dementia, a referral can be made to Southport and Formby ICRAS team.
- The Community Response Team has supported care homes to meet the needs of their residents in

the home, reducing the need for a hospital admission. There is a 2 hour response team that care homes can contact if a resident has fallen.

- Sefton is a represented member of the Cheshire & Merseyside Falls Collaborative, which seeks to ensure an integrated end to end falls pathway across Primary, Community, Secondary and Voluntary services utilising an evidence-based approach to managing falls.
- We will develop current Community Falls Team and ICRAS provision in North and South Sefton to include provision for residents with Dementia

### 3. Raise awareness of falls prevention and falls management making falls everyone's business

- Develop a set of short videos highlighting Falls Prevention services in Sefton including information around falls hazards. Loop these videos to GP waiting rooms, community settings such as libraries, Sefton Carers Centre, Day Opportunity facilities, shared residential and care settings and Council One Stop Shop waiting areas and NHS waiting areas.
- We will implement the Active Hospitals Model in Sefton Active Hospitals. Active Hospitals aims to change the physical activity culture within hospitals to encourage patients to move more. Active Hospitals is a programme to encourage patients to move more and to be active, to prevent the serious risks of hospital associated deconditioning.

### 4. Promote the prevention offer

- Explore more ways to support people to access activities and gym memberships.
- Falls Prevention and Reduction colleagues will consider people in terms of risk stratification, rather than age, when assessing a person's mobility, health and their living environments.

#### Work with housing providers to:

- Identify tenants over the age of 60 / under 60 with mobility issues
- Survey history of falls or mobility issues
- Work with the fire service to understand partner roles in home assessments
- Include agreed falls prevention commitments prior to receiving planning approval on new developments.

#### Housing providers will:

- Consider options for older stock in conservation areas.
- Care homes will record resident hydration, as dehydration can contribute to falls.
- Sefton Arc will explore options to introduce a welfare visit and a lifting service into our careline services. This would be either 24/7 365 days service or as required by NHS England 08:00 – 20:00 the team would respond to any “no response” telecare activations if the client's contacts don't pick up the call to act as a responder.



## 5. Promote the use of innovative technology in the management of falls

- Expand Telehealth equipment and remote monitoring devices in homes to support health needs and engage in wider community involvement.
- We will use innovative and adaptive technologies as a tool to help support people to manage their own health needs and enable the better coordination and personalisation of care and to support daily activities. TECS can provide various solutions to falls management, reduction and prevention – providing devices and alerts for care staff to respond to earlier and to better manage falls in supported living settings are safe.
- Piloting remote falls prevention monitoring devices. This equipment collects data and over time “learns” residents’ patterns of behaviour. The devices can alert staff when a resident is exhibiting unusual behaviour, which could indicate they are trying to get out of bed unsupported, or they have fallen, so staff can take action to prevent or manage the fall.
- Promotion of TEC solutions in all care settings to reduce falls such as promotion of medication prompts devices, remote acoustic monitoring in all shared care settings and promotion of low level TEC solutions in peoples own homes to sustain independent living at home for longer.
- Promotion of Sefton’s Ask SARA online self assessment and information toolkit which offers independent advice and guidance for people to access and purchase low level TEC solutions themselves without the need for a more formal referral and assessment via ASC front door.



## 6. Develop a directory of services that contribute to the management of falls

- Develop a step up / step down approach to falls, and review the current provision and coordination of services to prevent and reduce falls.
- Ensure strong links to our social prescribers for advice and targeting of falls interventions.

## 7. Use a set of consistent falls assessment tools across the system

- Develop, and increase, the recognition of the referral pathway into the Active Ageing programme through the frailty scoring management process.
- Develop a clear and accessible Falls Conversation Model that will improve staff awareness about how to open a conversation up with a person in a sensitive way and without the threat that independence could be taken away is really important.
- In order to ensure equity and equality of falls prevention, this Strategy will align with the Cheshire and Merseyside Falls Framework pillars for future working, which will enable a consistent, integrated approach to falls. In reducing inequalities and to ensure equity in access to services across Sefton locally and Cheshire and Merseyside, regionally, we will develop shared Falls pathways, improving integrated working, creating standardised approaches to falls prevention and care.

## 8. Set out falls training that is available locally and ensure all training promotes a set of shared principles

- Sefton care homes are encouraged to implement Restore 2, a tool that supports more effective assessment and triage in partnership with the North West Ambulance Service. This ensures that individuals receive the correct emergency support at the right time and in the right place.
- South Sefton PCN hold quarterly care home events for networking and training and this includes training opportunities and information that can support the reduction of falls and risk of falls.
- The Cheshire & Merseyside Regional Hydration Improvement Practitioner has arranged and offered our Residential and Nursing Care Homes Hydration for Health training, covering impact on falls, Urinary Tract Infections, communicable diseases and cognition to our care homes. Additionally, training and masterclasses on hydration and nutrition are being offered and promoted across South Sefton care homes and Sefton Day Centre staff. Online Hydration Training website has been designed and developed by NHS Cheshire and Merseyside for all staff who cannot attend face to face training. There has also been a Hydration Hub resource pack developed for the adult social care setting with additional evidence-based training resources and these additional resources are also available to our domiciliary care, supported living and day centre staff as well. Therefore everyone has the same consistent level of training provided on Hydration Awareness..
- Develop a Train the Trainer model for providers on falls prevention and management. The training will promote reablement, improved independence and quality of life, accessing community equipment, improved monitoring and recording and improved access to Sefton's falls services and secondary care provision and also in hospital settings.
- Sefton Council has developed TEC e-learning for our workforce and prescribing staff teams in adult social care to raise awareness and build staff confidence to begin to have conversations earlier about TEC with individuals at risk of falls and to support independent living.
- Development of a Hydration Awareness leaflet that both adult social care, and health professionals along with our community partners can share and refer to on the importance of keeping hydrated to prevent a number of health issues including falls prevention.





# Conclusion

Key to the success of this Strategy is the partnership approach being delivered the Cheshire and Merseyside Health and Care Partnership (CMHCP).

A delivery plan will be developed that will deliver the ambitions of this Strategy and ensure that our priorities are achieved. This plan will have clear actions and timelines for implementation.

The Strategy was coproduced throughout its development, and the partnership remains committed to a coproduction approach for its delivery. We will actively seek out opportunities to shape, develop and review our work with those who currently use our services or who will use them in the future, and bring learning from this into to the partnership for regular review.

## Local Strategies and References

Sefton's Health and Wellbeing Strategy 2020 – 2025

Sefton Council ASC plans and policies ([Sefton Council ASC plans and policies](#))

Cheshire and Merseyside [All Together Active Strategy](#), specifically the Age Well section.

Sefton Population Projections 2018

## National Strategies and References

- Quality Standard 86, 2015: National Institute for Health and Care Excellence (NICE)
- Falls and Fractures in Older Adults: Causes and Prevention, 2022: National Institute on Aging
- Human Cost of Falls, UK Health Security Agency, 2024
- Falls: applying All our Health: Office for Health Improvement and Disparities, 2022
- State of Ageing 2023-24, Centre for Ageing Better
- TakingCare Personal Alarms, Elderly People and Falls: How health care can better support the UK's ageing population (2023)
- Projecting Older People Population Information (POPPI)
- National Hip Fracture Database (NHFD) 2022
- Public Health Outcomes Framework (PHOF)
- State of Healthy Ageing in the North West, OHID, 2022
- Wider Impacts of COVID-10 on Physical Activity, Deconditioning and Falls in Older Adults, Public Health England 2021
- The impact of COVID-19 to date on older people's mental and physical health, Age UK, 2020

# Acknowledgements

This Strategy has been co produced with the following partners

Sefton Council ASC – OT and SW Teams

Sefton Council ASC - Contracts and Commissioning Team

Sefton Council Quality and Commissioning Team –  
(Care Homes, Supported Living and Dom Care and Day Opps)

Senior Care Co-ordinator (Enhanced Health in Care Homes)

Cheshire and Merseyside ICB

Sefton Place

Active Sefton / Sefton Active Lifestyles

Sefton Community Matron and District Nurse Team

Falls Clinical Specialist, Southport & Formby Falls Prevention Team

Cheshire & Merseyside Regional Hydration Improvement Practitioner

Public Health

South Sefton PCN

North Sefton PCN

Southport and Ormskirk Hospital

Sefton Falls Prevention Team

MerseyCare – Enhanced Health in Care Homes

Primary Health partners (GP and EHCH Formby)

Merseyside Sport – Partnership Manager

Sefton Falls Pick Up Service

Southport and Formby GP

Sefton Ageing Well Team

Cheshire and Merseyside Falls Prevention Collaborative

Sefton CVS Hospital Discharge Team

Cheshire & Merseyside Urgent Care and Community

Healthwatch – Sefton

Sefton Partnership for Older Citizens

Dementia Friendly – Sefton

Experts by Experience



# Sefton Falls Prevention Strategy 2025-2028: Delivery Plan

## Consultation and Engagement

What we want to achieve	How we want to do it	What difference will it make	Who will do it
<p>Involve the public in the implementation of the Strategy</p> <p>Engagement with Community groups</p> <p>Planned multi agency Falls prevention Consultation and Engagement Sessions – expansion and development of Let’s Talk About Falls Workshops</p>	<ul style="list-style-type: none"> <li>• All Falls Prevention services routinely gathering user feedback and learning from this feedback</li> <li>• Engage with Consultation and Engagement group/SPOC and public surveys to be established</li> <li>• Establish Sefton Falls prevention Consultation and Engagement Sub Group</li> <li>• Annual consultation and Engagement Sessions</li> </ul>	<ul style="list-style-type: none"> <li>• An improved joined up approach to falls management, awareness reduction and prevention of falls for everyone living in Sefton.</li> <li>• Codesigned and coproduced falls prevention schemes, planned and improved coordination and facilitation of falls prevention activity.</li> <li>• Increased local knowledge and awareness for professionals and stakeholders of people with lived experience.</li> </ul>	<p>Sefton Falls Strategy Working Group and partners</p> <p>C&amp;M Falls Collaborative</p>

## Commission and Develop borough wide evidenced based services/ assessment tools which reduce the likelihood of falls and their severity.

What we want to achieve	How we want to do it	What difference will it make	Who will do it
<p>Improved access to formal falls risk assessment from appropriate qualified professionals</p> <p>Use of a set of consistent falls assessment tools across the system</p> <p>Review of services to support mental health and psychological barriers to recovery from falling</p>	<ul style="list-style-type: none"> <li>• Develop, and increase, the recognition of the referral pathway into the Active Ageing programme through the frailty scoring management process.</li> <li>• Develop a clear and accessible Falls Conversation Model that will improve staff awareness about how to talk about falls – without being perceived as taking away a person’s independence.</li> <li>• Mental Health / psychological support for people who have suffered a falls related injury on return home to support confidence and rehab.</li> </ul>	<p>Better coordination of Falls prevention services and support for Sefton residents</p>	<p>Sefton Falls Strategy Working Group and partners</p> <p>Active Lifestyles</p>

**Set out falls training that is available locally and ensure all training promotes a set of shared principles**

What we want to achieve	How we want to do it	What difference will it make	Who will do it
<p>Improved Falls Prevention Training and Development for Health and Social Care practitioners and for Carers</p> <p>Baseline knowledge around Falls prevention and Moving and Handling / Falls Management</p>	<ul style="list-style-type: none"> <li>• Develop Home hazard checklists and information packs for those at risk of falling or who are falling regularly</li> <li>• Scope training opportunities for carers in Falls management and moving and handling</li> <li>• Promotion of Falls Management Apps such as ISTUMBLE</li> <li>• Residential and Nursing care Homes will be offered Hydration for Health training - Training and masterclasses on hydration and nutrition are being offered and promoted across South Sefton care homes.</li> <li>• Sefton care homes are encouraged to implement Restore 2, a tool that supports more effective assessment and triage in partnership with the North West Ambulance Service</li> <li>• South Sefton PCN hold quarterly care home events for networking and training and this includes training opportunities and information that can support the reduction of falls and risk of falls.</li> <li>• Develop Train the Trainer model for providers on falls prevention and management.</li> <li>• Roll out Sefton Council's TEC e-learning module to partner orgs</li> </ul>	<ul style="list-style-type: none"> <li>• Care homes will record resident hydration, as dehydration can contribute to falls.</li> <li>• Individuals will receive the correct emergency support at the right time and in the right place.</li> <li>• Supports reduction in falls and risk of falls</li> <li>• The training will promote reablement, improved independence and quality of life, accessing community equipment, improved monitoring and recording, improved access to Sefton's falls services, secondary care provision and also in hospital settings.</li> <li>• Builds staff confidence to begin to have earlier conversations about TEC with individuals at risk of falls to support independent living.</li> </ul>	<p>Sefton Falls Strategy Working Group and partners</p> <p>Merseyside Fire and Rescue Service</p> <p>Sefton Council OT service</p> <p>Sefton Council TEC webpage</p> <p>Sefton TEC Steering Group</p> <p>TEC</p> <p>Care Home Providers</p> <p>Merseycare partners (Falls and Frailty)</p> <p>Enhanced Health in Care Homes (EHCH)</p> <p>NWAS</p>

**Improved falls data and intelligence to support commissioning and delivery approaches and evidence based practice**

What we want to achieve	How we want to do it	What difference will it make	Who will do it
<p>Recognise the value of data to inform our practice and to ensure earlier identification of those at higher risk of falls, and their carers, so they have the knowledge to be active participants in falls prevention.</p> <p>Benchmark Sefton's our Falls Prevention model and services with other areas.</p> <p>Consider best practice and national guidance to further improve local services.</p>	<ul style="list-style-type: none"> <li>• Regular and accessible Information sharing of local, regional and national falls dashboards with the Falls Strategic Working Group (Sefton Council, Health, NWASS etc)</li> <li>• Develop shared Falls pathways, improving integrated working, creating standardised approaches to falls prevention and care</li> <li>• Ensure Sefton's Falls Prevention model is aligned to C&amp;M Falls Collaborative Falls Prevention Framework – review annually</li> <li>• Reference to SCIE and NICE guidelines around Falls Prevention</li> </ul>	<ul style="list-style-type: none"> <li>• Improved access to data relating to falls</li> <li>• Improved service alignment and oversight of falls that will support future falls prevention planning and service design</li> </ul>	

**Promote the use of innovative technology in the management of falls**  
**Digital and TEC solutions to support prevention, reduction and management of falls**

What we want to achieve	How we want to do it	What difference will it make	Who will do it
<p>Promotion of TEC solutions to support independence at home and reduce falls in the home.</p> <p>Increase the use of innovative and adaptive technologies as a tool to help support people to manage their own health needs and enable the better coordination and personalisation of care and to support daily activities.</p>	<ul style="list-style-type: none"> <li>• Build on the use of remote monitoring technology to support people to live as independently as possible in their own homes and in shared care settings.</li> <li>• Promotion and development of TEC Roadshow events across the Borough throughout the year.</li> <li>• Increase the use of remote monitoring in all settings to reduce falls.</li> <li>• Develop a “Virtual House” to identify where TEC can be used in a person’s Home</li> <li>• Ongoing promotion of Ask SARA to enable people to purchase low level aids and TEC equipment independently without the need for formal assessment.</li> <li>• Care Transfer Hub – signpost and review equipment provision to include TEC; packages of care; therapy at home; ICRAS offer north and south of the Borough.</li> </ul>	<p>Early Help and prevention of falls using remote monitoring and TEC equipment in the home and in the community</p> <p>Earlier detection of risk of falls and maintain independent living.</p> <p>Sefton TEC service and Careline will promote the use of TEC via Sefton Council TEC web Page.</p>	<p>SMBC TEC offer</p> <p>TEC Steering Group</p> <p>Sefton MBC TEC Officer</p> <p>Falls Strategy TEC Sub Group</p> <p>Ageing Well Partners</p> <p>Hosp Discharge and Reablement Teams</p> <p>Sefton Careline</p>

## Raise Awareness of Falls Prevention and Falls Management making falls everyone's business

What we want to achieve	How we want to do it	What difference will it make	Who will do it
<p>Develop generic and bespoke falls prevention and awareness information packs and short videos highlighting Falls Prevention services in Sefton including information around falls hazards.</p> <p>Promote National Falls Awareness Initiatives</p>	<ul style="list-style-type: none"> <li>• Falls Prevention Information packs and short videos will be available in primary health care settings such as GP surgeries, community settings such as libraries, Sefton Carers Centre, Day Opportunity facilities, shared residential and care settings, Leisure Services, Council One Stop Shop waiting areas and NHS waiting areas.</li> <li>• Falls Awareness week will be promoted through a Partnership approach.</li> <li>• Falls Prevention and Awareness Networking Days to be delivered x2 per year (for care providers, members of the public and professionals working with people at risk of falls)</li> </ul>	<ul style="list-style-type: none"> <li>• More accessible information for all working in and living in Sefton around Falls Prevention, risk aversion and Falls service provision</li> </ul>	<p>Sefton Falls Strategy Working Group partners</p> <p>All Falls Prevention partner Groups</p> <p>Sefton Council Communications Team</p> <p>Merseycare Communications Team</p>

## Promote Falls Prevention Offer

What we want to achieve	How we want to do it	What difference will it make	Who will do it
<p>Raise awareness of physical activity to help to reduce/prevent/delay falls</p> <p>Access local falls specific exercise classes that can improve balance and muscle strength</p> <p>Encourage people living in their own homes to think about how their homes can be future proofed – ageing at home / a home for life</p>	<ul style="list-style-type: none"> <li>• Implement the Active Hospitals Model in Sefton Active Hospitals</li> <li>• Explore more ways to support people to access activities and gym memberships.</li> </ul> <p><b>Housing colleagues will:</b></p> <ul style="list-style-type: none"> <li>• Identify tenants over the age of 60 / under 60 with mobility issues</li> <li>• Survey history of falls or mobility issues</li> <li>• Work with the fire service to understand partner roles in home assessments</li> <li>• Include agreed falls prevention commitments prior to receiving planning approval on new developments.</li> <li>• Housing providers will consider options for older stock in conservation areas.</li> <li>• Housing, social care and health partners to review home assessment and planning around future proofing residences and consider new builds can be designed with digital solutions / home safety / accessibility.</li> </ul>	<ul style="list-style-type: none"> <li>• Encourage patients to move more and to be active to prevent serious risks of deconditioning.</li> <li>• Improved consideration of people in terms of risk stratification, rather than age, when assessing a person’s mobility, health and their living environments.</li> </ul>	<p>Active Hospitals Programme</p> <p>Sefton Falls Strategy Working Group members and wider community stakeholders</p> <p>Falls Prevention and Reduction – Sefton Falls Strategy Delivery Group will work with Housing partners</p>

Information	Falls Prevention and Support Services	Health and Well being	Falls Pathways
<p><b>Information Packs re falls</b></p> <ul style="list-style-type: none"> <li>• Care Transfer Hub – signpost and look at equipment provision to include TEC; packages of care; therapy at home; ICRAS offer north and south of the Borough.</li> </ul> <p><b>Directory of fall prevention and support services</b></p> <ul style="list-style-type: none"> <li>• Single point of access to advice for unpaid carers.</li> <li>• Campaigns and Roadshow/ provider networking days</li> <li>• Falls Awareness Week</li> <li>• Short videos</li> <li>• Utilise GP surgeries loop systems and tv</li> <li>• Utilise community spaces to raise awareness about falls prevention and support services</li> <li>• GP surgeries – use loop systems to promote falls prevention and falls services</li> <li>• Dementia awareness for professionals and carers</li> </ul>	<p><b>Improved links with community falls services</b></p> <ul style="list-style-type: none"> <li>• Scope of service provision in Sefton</li> <li>• Day centre Activity Programmes re exercise and respite for someone who has poor mobility / high falls risk</li> <li>• How to access day centre and respite services for carers – links to Carers Strategic objectives</li> <li>• Review criteria to receive services from falls prevention team</li> <li>• Home visits to people at risk of falling</li> <li>• Escort service to and from hospital – care homes</li> <li>• Frailty wards?</li> <li>• Wrap around support and provision – dementia, carers, falls, TEC and community providers</li> </ul>	<p><b>Promotion of health and community nutrition programmes</b></p> <ul style="list-style-type: none"> <li>• Exercise / Falls Prevention / Leisure services</li> <li>• Exercise and home workouts</li> <li>• Mental health information</li> <li>• Hydration advice</li> <li>• Social isolation</li> <li>• Strength and balance programmes / Active Lifestyles/ Gym Memberships</li> </ul>	<p><b>Develop a Pre Falls Pathway before/during and after</b></p> <ul style="list-style-type: none"> <li>• Identify who can screen for falls / who can complete falls assessments incl NHS staff</li> <li>• Escort service provision for residents admitted from shared care settings – processes and procedures, duty of care and responsibilities of providers and health care staff in hospital setting.</li> <li>• Repatriating patients/ residents at night does not take into account lower staff ratios in care homes – in the past there were Frailty wards to support capacity issues and patient welfare.</li> </ul>

TEC / Home Safety Person Centred approaches to falls		Professional Responsibilities	Training and Education
<ul style="list-style-type: none"> <li>· Dignity – patient choice and person-centred approaches even in planning around hosp discharge and preparing the home – ask them what they want and need re moving furniture without discussing this in detail with the person.</li> <li>· Ask SARA</li> <li>· TEC Roadshow Events</li> <li>· TEC Demos in community spaces</li> <li>· Remote Monitoring and Falls prevention</li> <li>· LA TEC webpage</li> <li>· Home Adjustments / home safety</li> <li>· Checklists for family and people who have fallen</li> <li>· Telehealth</li> <li>· Virtual Wards</li> <li>· Digital Inclusion and Day Opps</li> <li>· Falls prevention boxes</li> </ul>		<ul style="list-style-type: none"> <li>· Wider professional Involvement – who else knows/backstory</li> <li>· Improved language between social car and health care professionals</li> <li>· Different ways of working</li> <li>· Working with younger cohorts as part of early help and prevention</li> <li>· Out of hours support for falls – weekend service provision</li> </ul>	<ul style="list-style-type: none"> <li>· Training for professionals in all care settings</li> <li>· Training for family members in managing falls</li> <li>· Improving language and approach by professionals – social care and health professionals when talking bout falls with people they are supporting.</li> </ul>

