

Costing statement

Falls: assessment and prevention of falls in older people

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<http://guidance.nice.org.uk/CG161>

1 Introduction

- 1.1 This costing statement considers the cost implications of implementing the recommendations made in Falls: assessment and prevention of falls in older people (NICE clinical guideline 161).
- 1.2 The guideline is an extension to the remit of NICE clinical guideline 21 (published November 2004). The original recommendations cover the assessment and prevention of falls in older people living in the community (that is, in their own home or in extended care). The new recommendations cover recommendations on the assessment and prevention of falls in older people during a hospital stay (inpatients). The 2004 recommendations are just as relevant and important now as they were when they were originally published.
- 1.3 Costing work has considered both the new recommendations on assessing and preventing falls in older people during a hospital stay and the 2004 recommendations on assessing and preventing falls in older people living in the community.
- 1.4 A costing statement has been produced for this guideline because the new inpatient section of the guideline is unlikely to have a significant cost impact for the NHS, as most components of multifactorial assessment and multifactorial intervention (assessing mobility and continence) are already standard practice.
- 1.5 There could be cost implications associated with ensuring that staff attain the knowledge and skills needed to put the guidance into practice. However, with most of the relevant training available without cost (apart from staff time), it is anticipated that implementation will not have a significant cost impact on the use of NHS resources.
- 1.6 The section of the guideline on preventing falls in older people living in the community was originally published in 2004, and the content is unchanged. It will result in new costs only if organisations have failed to

implement it previously. Costs would come from increasing capacity to deliver falls prevention and assessment to everyone who needs it.

- 1.7 We encourage organisations to evaluate their own practices against the recommendations in the NICE guideline and assess costs locally. Some of the resource effects to be considered locally are discussed in this statement.

2 Background

- 2.1 Each year around 282,000 patient falls are reported to the National Patient Safety Agency (NPSA)¹ from hospitals and mental health units in England. A significant minority of these falls result in death or in severe or moderate injury (including around 840 hip fractures, 550 other types of fracture and 30 intracranial injuries)².
- 2.2 Around 30% of adults who are over 65 and living at home will experience at least 1 fall a year (approximately 2.5 million people in England). This rises to 50% of adults over 80 who are either at home or in residential care. Most falls result in no serious injury, but annually approximately 5% of older people living in the community who fall experience a fracture or need hospitalisation³.
- 2.3 Fragility fractures are the commonest significant injury resulting from falls. The most common are hip or femur fractures, but other serious injuries that can occur include skull fracture, head injury, subdural haematoma (bleeding on the brain following a head injury), other fractures and soft-tissue injuries.

¹ From June 2012 the key functions and expertise for patient safety developed by the National Patient Safety Agency (NPSA) transferred to NHS England.

² National Patient Safety Agency (2011) [Rapid Response Report NPSA/2011/RRR001 – Essential care after an inpatient fall](#). Accessed on 21 May 2013.

³ Rubenstein LZ (2001) Fall risk assessment measures: an analytic review, Journals of Gerontology. Series A, Biological Sciences and Medical Sciences, 56(12):M761-M766.

- 2.4 In 2012 there were approximately 63,500 hip fractures in England⁴. About 95% of hip fractures are a result of falls⁵. Therefore an estimated 60,300 hip fractures were likely to be as a result of falls.
- 2.5 The guideline covers people aged 65 years or older in the community and in hospital. It also covers patients aged 50 to 64 years who are in hospital and have been judged by a clinician to be at higher risk of falling.
- 2.6 The national audit ([Falling standards broken promises](#) 2010)⁶ indicated that the original 2004 guideline recommendations have been poorly implemented. The audit examined the organisation and commissioning of falls prevention and bone health services for older people, and the clinical care delivered to people who have fallen and fractured a bone. It also covered the patient pathway across acute and primary or community care, and looked at falls prevention services in mental healthcare and a sample of care homes.
- 2.7 The audit highlighted that there are still major variations in the provision of care between organisations. The audit also indicated that healthcare professionals miss the best, or only, opportunities to identify the falls and fracture risk for high-risk patients in most hospitals (whether they attend A&E or are admitted as inpatients) and most primary care organisations lack adequate services for preventing secondary falls and fractures.

3 Recommendations with potential resource impact

3.1 *Preventing falls in older people during a hospital stay – section 1.2*

- 3.1.1 The new inpatient section of the guideline is unlikely to have a significant cost impact for the NHS, as most components of multifactorial

⁴ The National Hip Fracture Database (2012) [National Report](#).

⁵ National Collaborating Centre for Nursing and Supportive Care (2004) Clinical practice guideline for the assessment and prevention of falls in older people. NICE clinical guideline 21. London (UK): Royal College of Nursing.

⁶ Royal College of Physicians (2011) *Falling standards broken promises: report of the national audit of falls and bone health in older people* 2010.

assessment and multifactorial intervention (assessing mobility and continence) are already standard practice.

- 3.1.2 Clinical opinion suggests that most of the new upfront costs for the inpatient setting would be for providing knowledge and skills, both of which are freely available online via [eLearning packages](#) for nursing staff.
- 3.1.3 The report of the 2011 inpatient falls pilot audit indicates that only 30% of the 46 participating hospital trusts could provide walking aids for new patients admitted at weekends. Clinical opinion suggests that, to address this, a 24-hour physiotherapy service for patients who need mobility aids outside normal hours may be necessary. Some comments from the consultation on the guideline suggested that having rehabilitation support workers on the wards may be a more effective way of ensuring that staff who are competent to support the provision of walking aids and mobility practice are available 24 hours a day. In addition, rehabilitation support workers could have input on therapy, which would help to provide a much more comprehensive package of care for patients at risk of falls.
- 3.1.4 Consultation comments also revealed that many acute trusts already operate some form of a late-shift service provision until about 20.00 to 21.30 hours, in addition to weekend services. Although this is not a true 24-hour service, these staff would often pick up mobility assessments if a patient is ready for discharge or a new patient arrives, as a matter of priority.
- 3.1.5 Training staff to carry out assessments and to provide older people with walking aids may incur costs. Older people often have a history of multiple falls, multiple comorbidities and difficult social circumstances. The training is expected to take less than 1 hour. However, some clinicians suggest that a 1-hour training session may not be sufficient to teach the important underpinning knowledge that is essential to enable healthcare staff to prescribe aids appropriately.
- 3.1.6 Other costs include additional staff when needed and overtime work to provide temporary walking aids outside normal hours. Consultation

comments suggested that many weekend therapy mobility assessments could be provided by a therapy technician (band 3 or 4), with supervision from qualified therapists. These posts cost £21,000 per year for a band 3 position and £25,000 per year for a band 4 position. The cost is based on the NHS agenda for change (AfC) pay at the midpoint of the scale.

- 3.1.7 If overtime is involved, a physiotherapist is estimated to cost £21.70 per hour, based on the AfC band 6 midpoint of the scale. Band 3 and 4 therapy technicians would cost £12.77 and £14.89 per hour respectively.

3.2 ***Preventing falls in older people – section 1.1***

- 3.2.1 The [National audit of falls and bone health in older people 2010](#) found that 64% of community service providers had a local coordinated, integrated, multi-professional and multi-agency falls service.
- 3.2.2 In addition, 25% of community service providers indicated that they provided all of the local falls service, with 71% providing parts of the service only.
- 3.2.3 Based on clinical opinion, there is a very low specialist falls assessment capacity in the community compared with the number of falls and fractures in England.
- 3.2.4 Increasing the capacity of falls teams to assess all older people who need multifactorial assessment and multifactorial intervention may be the key cost of implementing the recommendations from the original 2004 falls guideline. Increasing capacity to provide specific interventions, such as evidence-based strength and balance exercise programmes delivered in community group settings and home-based exercise programmes, might also have cost implications.
- 3.2.5 Staff training needs would depend on local circumstances. Organisations should review their services and assess costs at a local level, based on the staff competencies that are needed to deliver all recommendations about preventing falls in older people in the community.

4 Benefits

- 4.1 The most common serious consequence of falling is hip fracture. Half of the people who have a hip fracture never return to their previous level of independence, and approximately 20% enter a care home.
- 4.2 Undertaking multifactorial assessments and multifactorial interventions for people at risk of falls could result in a reduction of the incidence of falls, saving the NHS and the wider public sector the resources needed to care for people following a fall.
- 4.3 Preventing falls and fractures could reduce hospital costs. For example, avoiding a hip fracture might save hospital admission costs averaging £5744 per patient⁷.
- 4.4 There may also be reduced ambulance service costs as a result of reduced falls in the community, saving around £230 per call-out⁸.

5 Conclusion

NHS organisations are advised to assess the resource implications of this guidance locally. Potential areas for additional costs locally are:

- provision of knowledge and skills, both of which are freely available online via eLearning packages
- staff costs outside normal working hours.

Potential areas for savings locally are:

- reduction in the incidence of falls
- reduction in costs to the NHS such as emergency admissions resulting from falls and the associated treatment costs
- reduction in the cost of social care for people with falls-related conditions.

⁷ 2013–14 tariffs – admitted patient care and outpatient procedures. Average tariff based on Health Resource Group codes HA11A–HA14C (hip procedures).

⁸ National Schedule of Reference Costs 2011–12 – NHS trusts and NHS foundation trusts. Currency code ASS02: See and treat and convey.

6 About this costing statement

This costing statement accompanies the clinical guideline: Falls: assessment and prevention of falls in older people. <http://guidance.nice.org.uk/CG161> (NICE clinical guideline 161).

Issue date: June 2013

This statement is written in the following context

This statement represents the view of NICE, which was arrived at after careful consideration of the available data and through consulting healthcare professionals. It should be read in conjunction with the NICE guideline. The statement is an implementation tool and focuses on those areas that were considered to have potential impact on resource utilisation.

The cost and activity assessments in the statement are estimates based on a number of assumptions. They provide an indication of the potential impact of the principal recommendations and are not absolute figures.

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