5.4 Falls pioneer service

Aim: to provide a quicker response to patients who have fallen, to safely help them up from the floor, assess their physical condition and identify the reason for their fall. This pioneer service will provide effective assessment and timely referrals to community services and falls prevention services to support the patient's wellbeing and reduce the risk of further falls.

We are often called by patients, their family or carers, where a fall has occurred. Falls account for around 11% of our total calls each year. When we attend these patients, we conduct a physical assessment to see whether they have any injuries and try to identify why they might have fallen. One of the key activities that we undertake is to safely assist these patients up from the floor and then to determine whether the patient needs further treatment in hospital. While the majority of fallers are over the age of 65, we also attend patients with physical disabilities or long-term conditions, such as multiple sclerosis, that mean they are at higher risk of experiencing a fall.

Elderly patients that fall are a high risk cohort of patients and we know that they can experience particularly poor outcomes if they remain on the floor for long periods of time. People over the age of 65 have the highest risk of falling, with over 50% of people aged over 80 years falling at least once per year. The ageing population means that falls are one of the most common reasons for calls to the ambulance service and we expect this number to increase to around 133,400 by 2023 (10% increase from 2017/18).

Falls are often an indicator of underlying complex illness, general health decline or acute illness. It is recognised that falls in older people, or patients with underlying health problems, are linked to a significant increase in morbidity and mortality, but that, with careful assessment and preventative measures put in place, many of these patients can have their needs met by care in the community. Falls are one of the most common reasons for patients becoming frequent 999 callers. Addressing patients' needs holistically, and dealing with the reasons for falling, will be of significant benefit to both patients and the service in reducing the likelihood of them falling again.

5.4.1 Service summary

Currently, we send two members of staff in an ambulance to patients who have fallen as they need to assist them up from the floor and, more often than not, convey these patients to hospital. This pioneer service will target fallers who we think are less likely to need conveying to hospitals and a specialist falls paramedic, supported by an assistant practitioner, will be dispatched. By targeting this dedicated falls pioneer service we can increase the effectiveness of our response and reach fallers more quickly.

Our falls pioneer service will see a paramedic who has received additional specialist falls training, paired with an assistant practitioner, attend patients who have fallen and while not seriously injured, may not be able to get up off the floor on their own.

5.4.2 Service model

Our service model was developed by our clinical experts, drawing on expertise from across the London Ambulance Service. We held a number of workshops attended by external clinical experts, who helped to shape the service model and ensure that it would be appropriate for patients in London.

The service breaks into three components:

Hear and treat/ dispatch	• The control room specifically looking to identify calls that would be suitable for the falls pioneer service • Occupational therapy and physiotherapy specialists in iCAT London to provide telephone advice to patients and support crews • Specialist roles will also provide expert advice to the organisation, supporting the design of the service and building levels of expertise across the organisation
See and treat	• A falls specialist paramedic (band 6) will be accompanied by an assistant practitioner (band 3) who would be a non-clinical member of staff with blue-light driving training. This assistant would allow the paramedic to work as efficiently and effectively as possible • The assistant practitioner would receive training to assist the clinician with some tasks such as manual handling and recording observations
Referrals and additional care	• The falls specialist paramedic will be able to make appropriate referrals to or links with further care or support networks, to enable the patient to remain in their own home. These referral options could include: – Occupational therapy – Rapid response teams – Social care – Falls prevention services – Charity support networks e.g. Age UK

The people, process and infrastructure implications are as follows:

	Hear and treat/dispatch	**See and treat**
People		• Solo falls specialist paramedic (band 6) will be accompanied by a blue light driver, to allow the clinician to undertake the role more quickly and work while traveling between patients (band 3) • The driver could assist with other tasks such as manual handling
Process	• Process of identifying calls which should be routed straight through to the new specialist falls service • Process of dispatching the right specialist with a driver for a 'see and treat' • Process of dispatching the right vehicle for a 'see and treat'	
Infrastructure		• Mobile device to provide access to summary care records • Response vehicle will have the capability to convey patients, if needed, who are able to sit up for the journey • Suitable equipment for assisting fallers off of the floor

5.4.3 Summary of potential benefits

Table 8 shows the potential benefits resulting from a single example of our modelled scenarios for the patient cohort we have identified could receive this pioneer service, based on figures from 2017 incident data classification. The table describes the maximum benefit to patients and healthcare systems in London. We describe in Section 7 our assumptions about how much of this is achievable and the associated economic benefits.

Table 8: Falls pioneer service – summary of potential benefits for a scenario balancing reduced conveyance and LAS and wider NHS economic impact

Quantitative benefits (projected for 2023)	Qualitative benefits
94,700 patients could benefit from this service (based on figures from 2017 incident data classification), of which: • 39,800 (42%) would receive 'see and treat'/be referred • 54,900 (58%) would be conveyed • 44,400 (46.9%) would be conveyed to emergency department **Performance** A reduction in emergency department conveyance rate from 52.8% to 46.9% for a selected cohort	• A quicker response to patients who have fallen, to safely help them up from the floor, assess their physical condition and identify the reason for their fall. • Enhanced referrals to an expanded range of community services, occupational therapy, rapid response teams, social care, falls prevention services and provide wider health promotion to help facilitate a patient's full recovery from their fall and help them remain in their own home rather than needing to go to hospital for treatment.

5.4.4 Enid's story – a falls case study

Enid is 87 and lives with her husband George, who is 92 and has difficulty walking. Enid has been having a few dizzy spells recently and on the way to the kitchen trips. She doesn't feel seriously hurt but has grazed her knee and cannot get up without help. George calls 999 and explains what has happened.

Control room

The 999 emergency medical dispatcher speaks to George and identifies that Enid has fallen, does not appear to be seriously hurt, but cannot get up off of the floor. The pioneer service specialist in the control room identifies Enid as a suitable patient for the falls response service and a falls specialist paramedic is dispatched to Enid.

Assessment and clinical intervention

Helen is a paramedic with additional training to assess and support falls patients. She arrives with a specialist lifting chair and after confirming that Enid has not seriously injured herself, quickly gets Enid up and comfortable before conducting a full physical and environmental assessment.

Helen's assessment includes dressing the small wound on Enid's leg, making sure there are no other injuries, conducting cardiorespiratory and neurological assessments including acquiring and interpreting a 12 lead electrocardiograph. Helen then goes on to have an in-depth conversation with Enid and George looking at Enid's medical history, their home environment and wider issues. From this Helen identifies:

- Today's fall was caused by a loose carpet between the kitchen and living room, but it's not the first time Enid has fallen this month.
- Enid is taking a range of medication for a number of long-term conditions including a new drug she started 3 weeks ago.
- With George's difficulty walking and Enid's recent dizzy spells they have been reluctant to go out and feel increasingly isolated.

Referrals and further care

Helen uses her digital tablet to find what local community healthcare services are available and gets Enid registered with the local falls prevention service. They arrange for the council's maintenance service to visit the next day to fix the carpet and identify other improvements that might help. An occupational therapist will also visit Enid and George the next day. As part of being registered with the community falls prevention service Enid will get a medication review to check if the mix of medicines she uses could be causing the dizziness. Enid and George are also put in touch with a local charity who send volunteers in to carry out exercises with elderly fallers to increase their strength and build their confidence so they can get out and about more often.

Enid's story

"Helen was lovely and got me up and comfortable straight away. She sat with us and listened to everything we had to say – including us nattering on about the grandchildren. Helen spotted that my dizziness might be due to all the pills I'm taking and a pharmacist later confirmed that was right. I've changed pills now and the dizziness has gone. We've also had the carpet fixed, handrails put in and I've got a new arm chair that's much easier for me to get up from. George and I feel so much happier now we have had some more support including help with some exercises to keep our strength up. I was really worried that I would end up being admitted to hospital so was so thankful when Helen said that I didn't even have to go to an emergency department at all after my fall."