VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Falls in older people—can we really make a difference?

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This month an *Observer* headline reported a 177% increase in deaths from falls among men over 85 from 2008 to 2016, although the population of over 85s rose only 19%. It linked the story to serious cuts in social care funding and provision in that period: a fall from 15% to 9% of over 65s receiving council funded care.¹ It's hard to establish a causal link, but the story highlights the importance of falls to our health and care services.

Around a third of over 65s and half of over 80s fall at least once a year, and half fall again in the same year.² Falls are the leading cause of death from injury in over 70s³ and account for around half of all hospital admissions for injury.⁴ Even “minor” soft tissue injuries can be disabling in frailer older people, and falls can lead to loss of confidence and independence.⁵

Falls lead to fractures, including around 80 000 hip fractures a year in the UK⁶ and a further 200 000 non-hip fractures.⁷

For several years the Department of Health and national arm's length bodies have led programmes on prevention, assessment, and treatment of people with falls and fragility fractures,^{8,9} with the momentum around this issue including a coalition of interested professional bodies and charities.⁴ The Royal College of Physicians (RCP) leads a long running national audit of falls and fragility fractures,¹⁰ and NICE has guidelines on them.^{11 12} Outcomes and processes for patients with hip fractures have improved.

Falls result from individual patients' risk factors, the activities they engage in, and their physical environment.¹³ As such, fall prevention is ideal territory for structured, multidisciplinary, comprehensive geriatric assessment and tailored interventions for each risk factor.^{3 14} And it's amenable to well evidenced single interventions—most notably, structured strength and balance training exercise,¹⁵ which can be formally supervised by trained instructors who needn't be clinicians.

Perhaps the answer is not to silo falls off from the rest of frailty and age related problems

Even if we can't stop people falling (or at least reduce the frequency) we can help with alarm raising, provide rapid community responses at home, and help avoid some unnecessary

ambulance conveyances to hospital.¹⁶ We can also work to improve confidence and mobility and reduce the fear of falling.¹⁷ This in turn may improve independence and reduce isolation. For all this knowledge, national policy, and concerted effort and despite pockets of excellent local practice, our attempts to reduce falls and related injuries or admissions have not delivered major benefits at population level. Falls clinics, coordinators, and exercise programmes just can't cover enough of the population, for enough of the time, to have an impact on service demand, and the RCP's national audit shows major variations and gaps in provision of best practice.¹⁰

Perhaps the answer is not to silo falls off from the rest of frailty and age related problems—and to focus on preventing or delaying people becoming frail, to maintain their independence and confidence in the mobility needed for daily activities. Research tells us that older people are more receptive to messages based on what they can do—their assets—than to being defined by their deficits, such as their falls, and are thus likely to engage with interventions to reduce further falls.^{18 19}

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