

Scoping Exercise on Fallers' Clinics

***Report to the National Co-ordinating Centre
for NHS Service Delivery and Organisation
R & D (NCCSDO)***

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Executive Summary

The National Service Framework for Older People has stated the need for fall-prevention programmes. An appraisal of fallers' clinics launched by the National Institute for Health and Clinical Excellence (NICE) was suspended because of a lack of information regarding existing services and typology. This project aimed to determine the feasibility of conducting economic modelling to appraise fallers' clinics. To achieve this a national survey of services and reviews of the evidence of effectiveness of various models of fallers' clinics and screening tools were undertaken.

We have defined a fallers' clinic as 'a facility based in either primary or secondary health care that administers services to individuals with the purpose of preventing falls and involves qualified health professionals in the delivery of some or all of the assessment and intervention.' The national survey was conducted by contacting all falls services in the UK by telephone or e-mail. Interviews were undertaken using a standardised template previously developed by the Prevention of Falls Network Europe (ProFANE) group, establishing the approach of the clinic, its geographical base and characteristics, the assessments undertaken and the interventions used. A total of 298 services were identified and 231 (78%) agreed to participate. Most services were urban (61.5%) with an equal split between community- and acute-sector bases. Only 2% of services were based in emergency departments. Referral was mostly from health professionals (63%), although some had open referral systems and 3% required referral from a doctor. Most (92%) used specified criteria for referral, with most using falls/near falls/fear of falls (74%) and/or specified screening tools (61%). The most common tool was the Falls Risk Assessment Tool (FRAT). The median number of attendances was 180 per annum and most clinics were staffed by a multi-disciplinary team (92%) although composition was highly variable. Ninety-nine per cent undertook a multi-factorial assessment but the components varied considerably. The majority (91%) undertook gait and balance assessment and many undertook environment (76%), medication (72%) and cardiovascular (69%) assessments. The most commonly used interventions were information provision (94%), exercise (81%) and medication review (66%). Post-intervention follow-up was undertaken by 51% of services. The total cost of services provided in the UK is estimated to be approximately £32 million per annum.

A systematic review of randomised studies of effectiveness of fallers' clinics was undertaken. The search strategy included Cochrane reviews (including repeating their search strategies) and searches of the MEDLINE and EMBASE databases. All articles were reviewed by two authors. A total of 202 studies were reviewed of which 18 were studies of eligible interventions. The quality of some of the studies since the

last Cochrane review is poor. The evidence to support multi-factorial fall-prevention interventions is inconclusive; with a range of conclusions from no advantage to a 20% reduction in falls. The overall estimate of risk reduction for further falls is 0.9 (95% confidence interval 0.8–1.0). There were no clear advantages of location, of selecting high-risk populations or from inclusion of a doctor in the multi-disciplinary team. There is no clear effect on subsequent fall-related injury, health-related quality of life or health care usage.

The systematic review of screening instruments focused on prospective studies of community-dwelling people. A range of electronic databases were searched (MEDLINE, EMBASE, PsycINFO, CINAHL and Social Science Citation Index Expanded). This was supplemented by hand searching of journals. Assessment was by two independent reviews, using recognised quality-assessment tools. Twenty-three articles were determined to be suitable for inclusion, which included data on 28 different screening tools. Many studies were excluded because they failed to report the data necessary for evaluating test performance. The tests assessed by most studies were the Tinetti mobility test, the Stops Walking When Talking test (SWWT test) and the Timed Up and Go test (TUG test). There was, however, variation in cut-off points to determine a positive test, the way tests were utilised and the definitions of outcomes. It was therefore not possible to combine results from different studies. The Tinetti mobility test had an overall positive predictive value (PPV) of 0.31–0.68 and a negative predictive value (NPV) of 0.67–0.88, with a reduced PPV if only the balance element was used. The SWWT test in an unselected population has a high PPV (83%) and NPV (76%), although sensitivity was low (48%). The TUG test had variable cut-offs and hence studies could not be combined. There is insufficient evidence to reliably determine the quality and effectiveness of the screening tests.

A third systematic review was undertaken to study the cost-effectiveness of fallers' clinics in the UK. An extensive search strategy was developed from that used by NICE and searched MEDLINE, CINAHL, EMBASE, NHS EED, OHE HEED, the National Research Register and bibliographic review. Data extraction and appraisal used the Drummond and Jefferson framework. No suitable studies were found on cost-effectiveness of UK fallers' clinics although one study is due to report in 2007. International studies were found but cannot be used to inform UK cost-effectiveness.

The limitation of the information available means that the effectiveness of various models cannot be confidently assessed and economic modelling cannot be recommended. Present service provision is highly variable in its format and activity. Hence it is not possible to construct a cost-effectiveness model representative of present falls-prevention activity in the NHS. To establish cost-benefit outcomes we need reliable data, which are not available. Present policy recommendations are not based on high-quality evidence. More primary research on the predictive performance of screening tools, the

effectiveness of interventions and the cost-effectiveness of falls prevention programmes are required. In the absence of such research, we cannot be confident that falls-prevention programmes are an efficient use of limited NHS resources.

Disclaimer

This report presents independent research commissioned by the National Institute for Health Research (NIHR). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the SDO programme or the Department of Health

Addendum

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