onenortherndevon

Northern Devon Falls and Management Exercise Programme (FaME) Evaluation Report – July 2024

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1. Introduction

Falls is one of the most common problems we see in our community and local population. Although there are many factors that lead to falls, often they can occur because of deconditioning, which occurs because of prolonged inactivity and associated loss of muscle strength. A government report on the impact of COVID-19 on people aged 65 or over concluded that deconditioning became more prevalent during this time with a significant predicted cost to the NHS.

Whilst we have excellent NHS community services locally, there is no consistent approach to addressing deconditioning as Community Services only have capacity to see those people who have already fallen or who have been assessed at being at risk.

2. What is FaME?

- FaME is a structured exercise programme that in clinical trials has been shown to **prevent or reduce falls, reduce the fear of falling and increase habitual physical activity and fitness**. It has efficacy in adults who live independently (not in a care or nursing home).
- The FaME programme is led by a Postural Stability Instructor (PSI) with specialist training for working with older people at risk of falling. They have the ability to tailor the structured exercises and progressions to suit an individual's medical conditions and functional ability. They will do their own health and function assessment of the person on the first visit.
- FaME is delivered over 24 weeks in weekly 1-hour group exercise classes (approximately 10-14 participants per class) plus directed home exercises to ensure effective dose and get quicker functional gains. Elastic resistance training bands and small items of equipment and mats are used throughout the programme.

There are three main expected health outcomes:

- Reduce the risk of injurious falls

- Increase physical activity levels
- Reduce social isolation

3. What we did in Northern Devon.

A FaME course was provided in each of the seven ONE Communities in Northern Devon; Barnstaple, Braunton, Ilfracombe, South Molton, Bideford, Torrington and Holsworthy. These courses were provided free of charge to all participants.

We trained 3 new Postural Stability Instructors and identified two further already qualified instructors to deliver the courses. One of these instructors also acted as project co-ordinator.

Vista Wellbeing were identified as a One Northern Devon partner and undertook the co-ordination and management of the programme.

Each course was supported by volunteers within the sessions, whose role was to assist with meet and greet, facilitating conversations within the social element of the class, prepare refreshments and to assist in the event of an emergency.

Participants were provided with home exercise booklets and resistance bands in order that they could be guided to complete exercises at home and achieve the recommended exercise dose to for desired results.

Conversations were guided within the social element of the session, using behavioural change techniques and providing advice around falls prevention strategies and drawing on shared experiences.

Financial help was also offered to support with transportation in order to enable participation from all those who could benefit.

3.1 Recruitment of Participants

Please also see Appendix 2: Referral Criteria

The referral criteria was informed by the evidence for delivery of FaME and agreed with the One Northern Devon management team and the Professional Lead for Community Physiotherapy and Occupational Therapy at Royal Devon University Healthcare NHS Foundation Trust.

Participants could self-refer or be referred by a health professional. Details of the programme and the referral criteria were disseminated to a range of professionals working in North Devon and Torridge. This included GP surgeries, Health and Wellbeing Teams, Social Prescribing Teams, Community Connectors, Third Sector organisations and Community Strength and Balance Teams. The programme was advertised via the Steady On Your Feet Website https://devon.steadyonyourfeet.org/staying-active/north-devon-evidence-based-strength-and-balance-classes and via social media to encourage self-referrals.

Overall, 132 referrals were received. Of these, 13 referrals were inappropriate, not meeting the referral criteria. 4 from health professionals and 9 self-referrals.

93 people were assessed as suitable and recruited to the programme. 47 of these reported having fallen previously.

14 people requested help with transport. It was found that in most cases, a taxi was the most economical way of providing this, and costs were refunded.

4. Results

In total, 66 people completed the programme. Reasons for not completing the programme were mostly health related. Two people left because they felt that they had already achieved their goals and did not need to continue. Two people left because they were not feeling the benefit of the classes.

Quantitative data was collected at programme start and 24 weeks and an exit survey conducted to obtain participant feedback on the programme. There were some areas of missing detail in data at baseline and this is attributed to the inexperience of some of the newer PSI instructors.

This data was analysed by Professor Dawn Skelton from Glasgow Caledonian University who in partnership with Exeter University, leads the Flexi study into FaME. She observed that **clinically significant results for Falls Prevention were achieved** within the programme as summarised below – full details can be seen in. (Appendix 1).

4.1 Summary of results

Progress within Fame is measured using a Functional Grid to assess physical function, suitability for the programme, and helps to identify when referral to Community Physiotherapy Services may be more appropriate for the individual. The end results were as follows:

- Timed up and Go (TUG)
  This test is a strong predictor of falls risk. A TUG score above 15 seconds is indicative of high falls risk and >10 seconds of intermediate falls risk. It was reported that the results we obtained denoted a significant reduction in falls risk and are clinically significant.
- Functional Reach
  Functional reach is a measure of stability and confidence in moving out of base of support. It is also related to falls risk and someone with a FR >18.5cm is more likely to have a fall. It was reported that the improvements we achieved in FR denote a reduction in falls risk and is clinically significant as it shows participants have increased in confidence to move out of their base of support for maintaining balance.
- 180-degree turn

Taking more than five steps to turn 180 degrees doubles the risk of two or more falls. It was observed that the results we obtained denote a reduction in falls risk and are clinically significant.

- Hamstring flexibility
  Hamstring shortening may damage length and speed of gait and lead to problems with balance, increased risk of falls, decreased range of motion, and knee/hip injuries. The improvements we observed in hamstring flexibility were reported as clinically significant and will lead to better cadence and step length which will help improve stability in walking.
- Shoulder Internal Rotation (SIR) Flexibility and Shoulder External Rotation (SER) Flexibility
  It is important to be able to reach out quickly if you trip and to be able to use your arms to get up again if you do fall. These measures of flexibility are important for self-care as well. The improvements observed were reported as clinically significant and will improve self-care skills and ensure better range of motion at the shoulder.
- Total Functional Grid Score
  All the above tests are scored on the functional grid. A reduction in total functional grid score denotes improvements in physical function. The report concluded that the reduction in functional grid score observed was clinically significant.
- FRAT Score
  FRAT comprises of 5 self-assessment questions on falls risk validated for use by GPs. A score of 3 or more denotes high risk of falls. There was no discernible change in FRAT score, however it is used as a screening tool and not sensitive to change as only 2 out of the 5 total questions are modifiable with exercise and there were many people who scored 1 or less on FRAT at baseline. These results were NOT reported as clinically significant. However, the use of FRAT helped us to facilitate conversations around falls risk with patients. FRAT scores obtained indicate that some people recruited to the programme may have been better served by general physical activities appropriate to their health conditions, and did not need the approach of FaME. However, all had met the referral criteria.
- Short FES-I – Falls Efficacy International
  The Short FES-I gives an indication of concern in having a fall whilst doing everyday activities. The Scoring on the Short FESI is associated with increased risk of falls and also with avoidance of physical activity. The improvements recorded in Short FES-I score denote a reduced concern about and fear of falling.
- Participant Survey
  Participants completing the programme were asked to complete a survey to feed back on their experience of the programme. 56 responses were received. Most people reported that they had achieved what they expected or to some extent, and this was consistent across all cohorts.

5. Case Studies

5.1 Case Study A.

This 85 year old gentlemen self-referred, having been recommended the programme by the Wellbeing Team at Caen Medical Centre. Had previously completed a course of strength and balance with the community strength and balance team.

He had one fall in previous 12 months, a diagnosis of heart failure, ICD in situ and walked with the aid of one stick. Had withdrawn from most activities outside of the home.

“I would like my life (body) to keep working. I don’t want to be spending the rest of my life in a chair”.

Timed up and Go reduction from 29.3 seconds to 14.6, Functional reach increase from 23 – 36cm and 180 degree turn improvement with a reduction in steps taken from 12 to 4. Overall functional grid score reduction from 22 to 14, FRAT 4 – 3, Short FES-I 17 – 13.

Now able to rise from a chair without using his hands, no longer uses a stick in class and can get up from the floor unaided.

Now can enjoy daily walks with his wife and has returned to some social activities. Is continuing to attend classes provided on a pay as you go basis. He will not be spending the rest of his life in a chair!

Final feedback: “What a lovely and caring staff. Very, very helpful, wonderful.”

5.2 Case Study B

This lady self-referred, having heard about the programme at the South Molton YMCA Community Fridge. She was lacking confidence and unsteady on her feet due to osteoarthritis and used a walker. She had no history of falls in the last 12 months. Medical conditions reported were Type 2 diabetes, Hypertension and Angina.

“I would like to be able to bend down without struggling”

Timed up and go reduced from 25 to 12.2 seconds, functional reach improved from 6 to 11cm, steps taken to make a 180 degree turn reduced from 7 to 5. By the end of the programme she had stopped using her walker in class and was able to rise from the chair unaided. She was able to pick up objects from the floor.

This lady could not afford to pay to continue classes but continues to practice exercises at home using the booklet and band that was provided. Although during the classes she had not had the confidence to get to the floor, she recently reported a non-injurious fall in her garden and that she had got up without help.

Final feedback “I have improved a great deal with balance and not used the walker so much.”

5.3 Case Study C

This gentleman self-referred following a recommendation by a Frailty Dr at NDDH. History of 6 falls in the previous 12 months, one resulting in a broken shoulder. Type 2 diabetic, chronic diffuse liver disease and query Parkinson’s disease. We took the decision to proceed to assessment as respected Dr had recommended.

Functional grid assessment was acceptable for the programme, with scores being 4 or less, other than a score of 6 for internal shoulder rotation on injured side, which was to be expected. His goals were “to improve my confidence as I have fallen a number of times. Also to speed up my walking and have less reliance on my stick”.

He was an enthusiastic member of the class, but progress was slow. He often needed the seated options and reported non-injurious falls at home. At week 16 he had a fall at home resulting in a 5 week stay in hospital. He did not complete the programme.

He has now returned to the ‘pay as you go’ classes and following his stay in hospital and full MDT review, is much improved. He is making good progress and currently working on picking up objects from the floor.

Our learning from this is that we should have adhered to the referral criteria and sought confirmation from the community strength and balance team that this gentleman was suitable for the programme, prior to proceeding.

5.4 Case Study D

This lady was referred by the Parish Nurse in an outlying village. She had not had any falls in the last 12 months but had previously broken her leg near her hip and lacked confidence. She reported not have any medical conditions, however was taking bisoprolol, atorvastatin and aspirin.

Very anxious about attending and a friend accompanied her to the first session. Transport was arranged with Torridge Volunteer Cars.

“I want to walk better without my stick after breaking my leg”.

Reduction in timed up and go from 37.9 to 21 seconds, functional reach improved by 1cm, but at end point assessment it took her one more step to turn through 180 degrees. Her overall functional grid score reduced from 16 to 12, FRAT remained at 1 and SHORT FES-I reduced from 11 to10.

Socially this lady improved greatly and had many stories to tell the group from her childhood, which were enjoyed. Another participant also lived in the same village and offered to drive her to class. The volunteer car was cancelled. Sadly, the driver was not able to continue to attend the group after completion, due to caring

responsibilities. This lady reported that she would have willingly attended follow on classes, but did not have transport available, and due to distance, even the volunteer car cost was prohibitive.

Final feedback “My balance has improved, and I have achieved what I had hoped for. I would come again if transport was provided as I do not drive”.

6. Legacy and Learning

Participants can continue to practise the exercises and strategies learned on the project. They have kept the home exercise bands and booklet and have been educated on the importance of remaining appropriately active, and what activities are evidence based for falls prevention and strength and balance. We have explored local opportunities, but sadly, there is little existing appropriate provision across North Devon and Torridge that supports people with multiple health conditions and falls risk.

Walking groups tried have been too fast for this client group, (fast walking is evidenced to increase falls), and although widely offered, seated exercise is not evidence based for falls prevention. There is a need for community-wide education of instructors, leisure providers and professionals around appropriate messaging and the evidence base for falls prevention exercise. Of course, these other activities are evidenced to increase physical activity levels and reduce social isolation, so are still beneficial for many of our local population who do not live with multiple health conditions and are not at risk of falls.

The people of Northern Devon will continue to benefit from the skills gained from the Postural Stability Instructors who delivered sessions within this project. Classes continue in South Molton, Braunton, Westward Ho! and Barnstaple, on a pay as you go basis, (£6 per session), with both Barnstaple and Braunton operating a waiting list.

Our delivery partners for Torrington and Holsworthy, Active Torridge, have offered a follow-on 12 week strength and balance course in Torrington, but have struggled to recruit participants as those people who expressed interest were outside the scope of practise of their instructor. It is reported that the GPs have been too busy to respond when asked to confirm suitability for exercise. It is worth noting that they have not provided a social opportunity alongside this due to time and financial restraints. In Holsworthy, they have no plans to continue, but the supporting volunteer has plans to offer a strength and balance class (she is not a PSI, but is qualified in exercise referral).

Interestingly, many of the people who are now attending these follow-on sessions did not participate in the free sessions provided by the project and have joined since. Braunton is the exception here, in that the whole cohort wanted to continue and a waiting list is in operation. The community, with support from Live Well Braunton are

fundraising to enable a second class to take place, with the intention of starting in October 24.

Referral pathways between health professionals and PSIs should be clearly established, and criteria followed. Short cuts when referrals and recommendations are received from professionals led to inappropriate referrals. We have learned the importance of adhering to the referral criteria, even when a referral is received from a trusted health professional working in the field of frailty. A willingness from busy GPs and other healthcare professionals to confirm suitability of participants for exercise, would enable more participants who self-refer to be accepted into the programme.

As this is such specialist provision and the skills required to deliver are technical, we have learned the importance of instructors being supported by an organisation specialising in this field and with scope of practise beyond PSI (e.g. cardiac disease). Active Torridge were unable to support their instructor sufficiently to enable them to complete the reporting and behavioural change work that is required outside of the taught session. They were unable to provide a volunteer workforce to support their sessions which led to additional costs being incurred to the project as it is inappropriate for a PSI to work alone. They do not have any other professionals trained to this level within the organisation, therefore limiting scope. This supports our call for more instructors to be qualified to Level 4 clinical populations to adequately support our ageing population.

Most people reported that the social opportunity was either very important or somewhat important to them. Some participants reported that they had found it challenging to get to classes yet had refused help with transportation. This needs consideration for future cohorts, and perhaps some more detailed information of the transport offer in a separate leaflet may help with understanding.

Some potential referrers were frustrated that this programme was not available to under 65s, but that was the evidence base at that time. Recently, new research has shown that this programme is of benefit to those over 55, so that needs consideration for future cohorts. Later Life Training, who train PSIs are in the process of producing new guidance.

7. Conclusion

Results achieved through the FAME programme in North Devon indicate that the project was successful in reducing the risk of falls amongst those who participated. Feedback from those who attended was positive – with many reporting the positive impact of the social aspect of the programme as well as the exercise component.

It must be acknowledged that to maintain the gains and reduced falls risk that they have achieved, they must continue with appropriate exercise. However, it is known that many lack self-efficacy and struggle with the motivation to exercise at home, so drop-off is likely if this is the only appropriate method of remaining active.

It is felt that although the project covered a wide geographical area, the reality is that it only reached a small number of the population who could benefit from this approach and further provision is recommended, together with a larger workforce of postural stability instructors leading community classes with fidelity to the research.

Appendix 1

Detailed Functional Grid Changes Report: Author Professor Dawn Skelton

Timed Up and Go

This test is a strong predictor of falls risk. A TUG score above 15 seconds is indicative of high falls risk and >10 seconds of intermediate falls risk[1].

63 people pre-and post-functional grid TUG scores

At baseline = average functional grid score 2.8 (0.8)
At Follow up = average functional grid TUG score 2.3 (0.8)
Reductions in score on functional grid are positive.
This improvement in functional grid score was statistically significant ($p<0.001$)

43 people pre-and post-TUG times (missing data on 20 peoples baseline times)

At baseline = average (standard deviation) TUG Time 18.4 (8.1) seconds highlighting the high risk population included in the classes
At Follow up = average (standard deviation) TUG Time 15.3 (6.4) seconds (13.3% improvement)
This improvement in TUG time was statistically significant ($p<0.003$)

These improvements in TUG denote a reduction in falls risk and is clinically significant as participants have also been shown how to turn more safely and 'feel the seat before they sit after their exercise programme so this can slow their time, but they are moving more safely. Had they not been shown this safer method of turning and sitting the average time would likely have fallen just below the 15 second cut off for reducing to intermediate risk.

Functional Reach

Functional reach is a measure of stability and confidence in moving out of base of support. It is also related to falls risk and someone with a FR >18.5cm is more likely to have a fall[2].

63 people pre-and post-functional grid FR scores

At baseline = average functional grid score 2.6 (1.0)
At Follow up = average functional grid TUG score 2.0 (0.9)
Reductions in score on functional grid are positive.

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[1] *World guidelines for falls prevention and management for older adults: a global initiative. Montero-Odasso M, et al. Age Ageing 2022*
[2] *A pilot study to explore the predictive validity of 4 measures of falls risk in frail elderly patients. Thomas JI, Lane JV. Arch Phys Med Rehabil. 2005*

This improvement in functional grid score was statistically significant (p<0.0001)

47 people pre-and post-FR distance (missing data on 16 peoples baseline reach)
At baseline = average (standard deviation) FR distance 23.8 (9.4) cm highlighting the high risk population included in the classes
At Follow up = average (standard deviation) FR distance 29.1 (8.9) cm (33.5% improvement)
This improvement in FR distance was statistically significant (p<0.0001)

These improvements in FR denote a reduction in falls risk and is clinically significant as it shows participants have increased in confidence to move out of their base of support for maintaining balance.

180-degree turn
Taking more than five steps to turn 180 degrees doubles the risk of two or more falls[3].

63 people pre-and post-functional grid 180-degree turn scores
At baseline = average functional grid score 2.3 (1.1)
At Follow up = average functional grid TUG score 1.5 (0.7)
Reductions in score on functional grid are positive.
This improvement in functional grid score was statistically significant (p<0.0001)

40 people pre-and post-FR distance (missing data on 23 peoples 180-degree turn steps)
At baseline = average (standard deviation) 180 degree turn 5.9 (1.9) steps
At Follow up = average (standard deviation) 180 degree turn 4.5 (0.9) steps (18.9% improvement)
This improvement in FR distance was statistically significant (p<0.0001)

These improvements in 180 degree turn denote a reduction in falls risk and is clinically significant as it shows participants have increased in confidence to turn safely.

Hamstring flexibility
Hamstring shortening may damage length and speed of gait and lead to problems with balance, increased risk of falls, decreased range of motion, and knee/hip injuries[4].

63 people pre-and post-functional grid hamstring flexibility scores
At baseline = average functional grid hamstring flexibility score 3.5 (0.8)
At Follow up = average functional grid hamstring flexibility score 2.5 (1.2)
Reductions in score on functional grid are positive.
This improvement in functional grid score was statistically significant (p<0.0001)

These improvements in hamstring flexibility will lead to better cadence and step length which will help improve stability in walking.

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[3] *Risk factors for injurious falls: a prospective study. Nevitt MC, Cummings SR, Hudes ES. J Gerontol. 1991*
[4] *Independent influence of gait speed and step length on stability and fall risk. Espy DD, Yang F, Bhatt T, Pai YC.*
Gait Posture. 2010

Shoulder Internal Rotation (SIR) Flexibility
It is important to be able to reach out quickly if you trip and to be able to use your arms to get up again if you do fall. This measure of flexibility is important for self-care as well[5].

63 people pre-and post-functional grid SIR flexibility scores
At baseline = average functional grid SIR flexibility score 3.2 (1.0)
At Follow up = average functional grid SIR flexibility score 2.8 (1.0)
Reductions in score on functional grid are positive.
This improvement in functional grid score was statistically significant ($p<0.0001$)

These improvements in shoulder flexibility will improve self-care skills and ensure better range of motion at the shoulder.

Shoulder External Rotation (SER) Flexibility
It is important to be able to reach out quickly if you trip and to be able to use your arms to get up again if you do fall. This measure of flexibility is important for self-care as well[6].

63 people pre-and post-functional grid SER flexibility scores
At baseline = average functional grid SER flexibility score 2.4 (1.0)
At Follow up = average functional grid SER flexibility score 2.0 (0.8)
Reductions in score on functional grid are positive.
This improvement in functional grid score was statistically significant ($p<0.001$)

These improvements in shoulder flexibility will improve self-care skills and ensure better range of motion at the shoulder.

Total Functional Grid Score
All the above tests are scored on the functional grid. A reduction in total functional grid score denotes improvements in physical function.

63 people pre-and post-total functional grid score
At baseline = average total functional grid score 16.8 (3.5)
At Follow up = average total functional grid score 13.5 (3.1)
Reductions in score on functional grid are positive.
This improvement in functional grid score was statistically significant ($p<0.0001$)

These improvements in shoulder flexibility will improve self-care skills and ensure better range of motion at the shoulder.

FRAT Score

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[5] *Range of Motion Requirements for Upper-Limb Activities of Daily Living. Gates DH, Walters LS, Cowley J, Wilken JM, Resnik L. Am J Occup Ther. 2016*
[6] *Range of Motion Requirements for Upper-Limb Activities of Daily Living. Gates DH, Walters LS, Cowley J, Wilken JM, Resnik L. Am J Occup Ther. 2016*

FRAT comprises of 5 self-assessment questions on falls risk validated for use by GPs. A score of 3 or more denotes high risk of falls[7].

62 people pre-and post-FRAT score (one person missing data at baseline)
At baseline = average FRAT score 2.3 (1.0)
At Follow up = average FRAT score 2.1 (1.1)
Reductions in score on FRAT are positive.
This improvement in FRAT score was NOT statistically significant (p=0.221)

There was no discernible change in FRAT score, however it is used as a screening tool and not sensitive to change as only 2 out of the 5 total questions are modifiable with exercise and there were many people who scored 1 or less on FRAT at baseline.

Short FES-I – Falls Efficacy International
The Short FES-I gives an indication of concern in having a fall whilst doing everyday activities. The Scoring on the Short FESI is associated with increased risk of falls[8] and also with avoidance of physical activity[9]. It has a minimum score of 7 (no concern about falling) to a maximum of 28 (severe concern about falling). Scores >14 indicate high concern about falls.

62 people pre-and post-Short FES-I score (one person missing data at baseline)
At baseline = average Short FES-I score 13.8 (4.7)
At Follow up = average Short FES-I score 11.3 (3.7) (16.4% improvement)
Reductions in score on Short FES-I are positive.
This improvement in Short FES-I score was statistically significant (p<0.0001)

These improvements in Short FES-I score denote reduced concern about and fear of falling.

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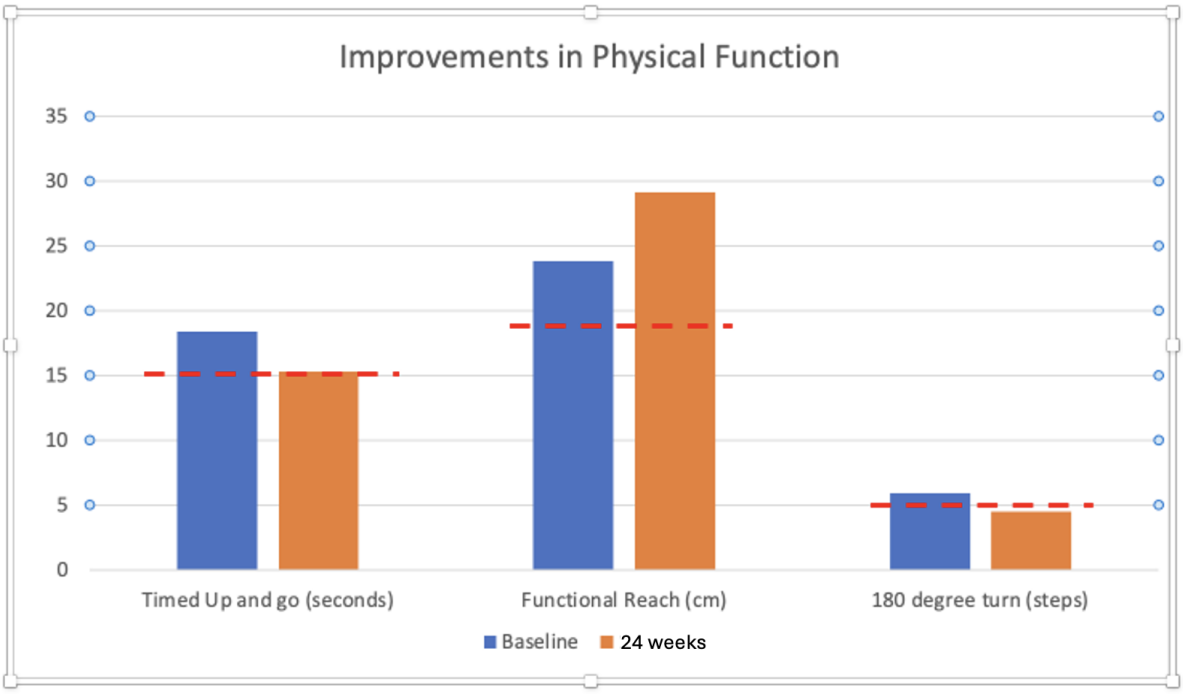
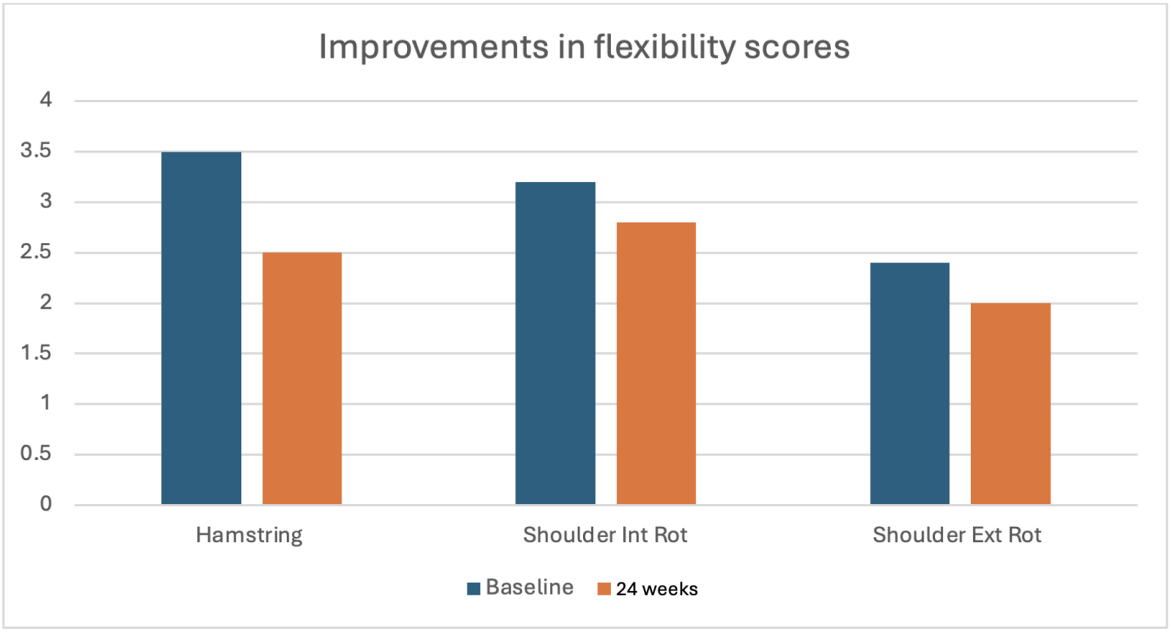
[7] Development and preliminary examination of the predictive validity of the Falls Risk Assessment Tool (FRAT) for use in primary care. Nandy S, Parsons S, Cryer C, Underwood M, Rashbrook E, Carter Y, Eldridge S, Close J, Skelton D, Taylor S, Feder G; Falls Prevention Pilot Steering Group. J Public Health (Oxf). 2004
[8] Fall-related efficacy is a useful and independent index to detect fall risk in Japanese community-dwelling older people: a 1-year longitudinal study. Kamide N, Shiba Y, Sakamoto M, Sato H, Kawamura A. BMC Geriatr. 2019
[9] The Falls Efficacy Scale International (FES-I). A comprehensive longitudinal validation study. Delbaere K, Close JC, Mikolaizak AS, Sachdev PS, Brodaty H, Lord SR. Age Ageing. 2010

Graphs showing improvement

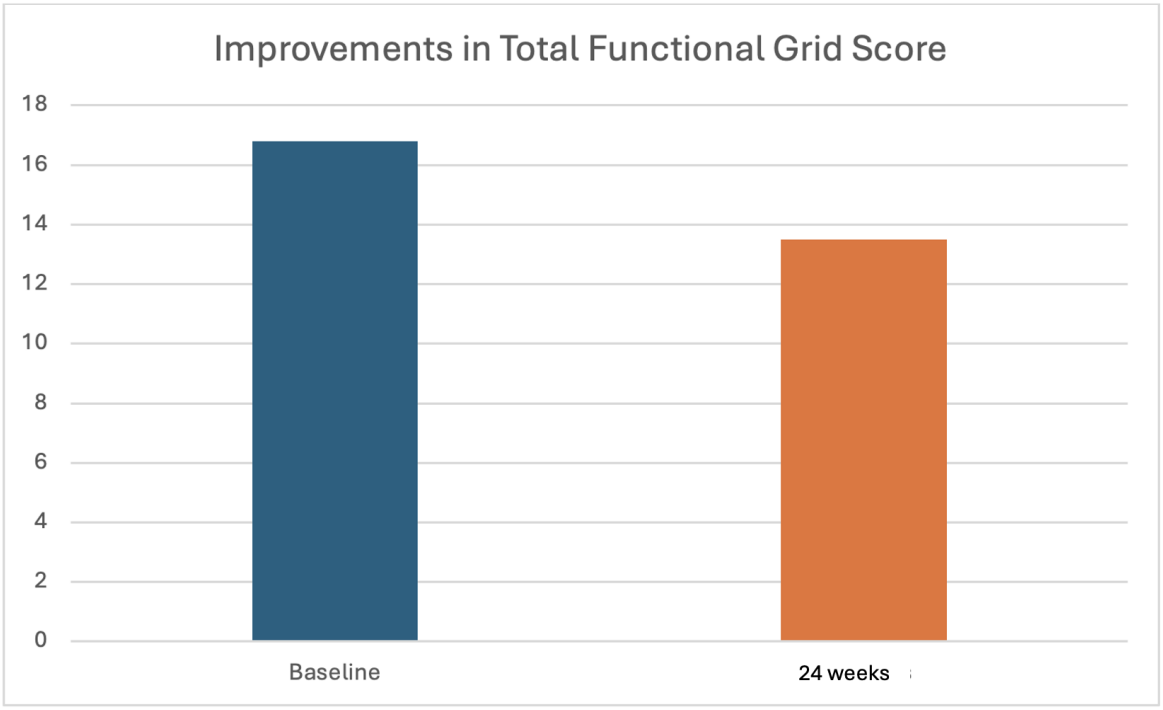


Denotes cut off for high risk of falls

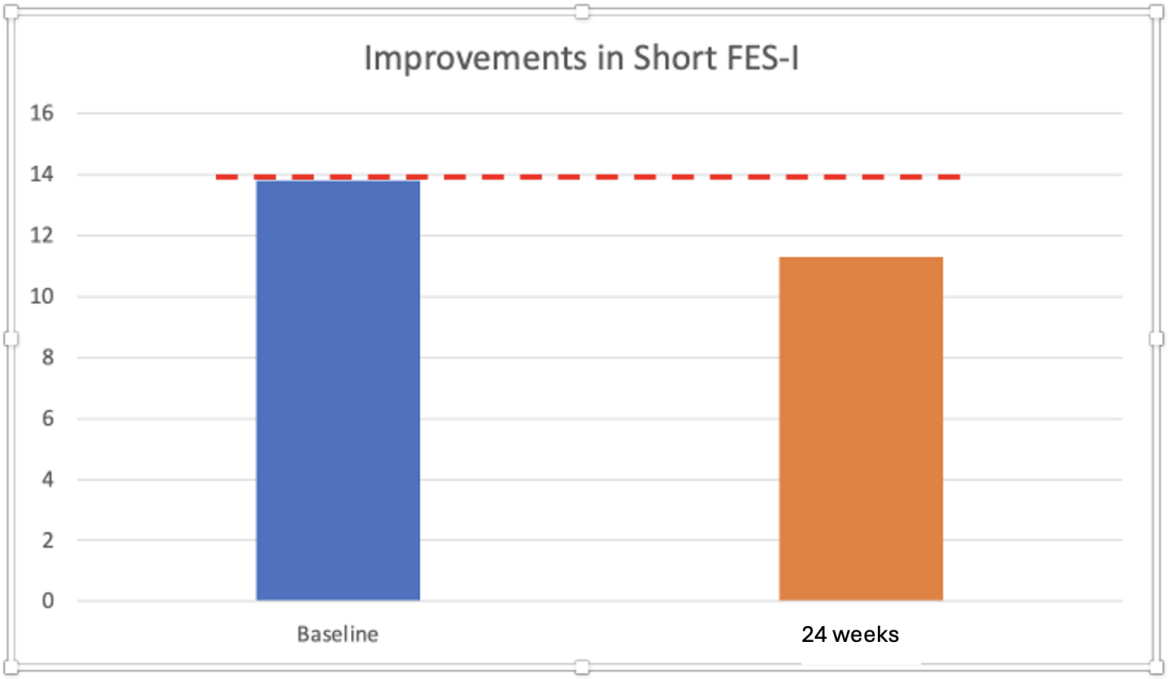
Positive direction – TUG time reduces, number of steps in 180 turn reduces and distance reached forward in functional reach increases.



Positive direction is a reduction in score on the grid.



Positive direction is a reduction in score on the grid.



Positive direction is a reduction in score on Short FES-I.

Denotes cut off for high concern about falls – – –

Appendix 2 Referral Criteria

One Northern Devon is the lead co-ordinator for the NHS funded Steady on your Feet programme in Northern Devon and has contracted Vista Wellbeing CIC to co-ordinate delivery of classes.

Steady on your Feet (FaME – Falls Management Exercise Programme) is a community-based strength and balance programme, which is evidenced to prevent falls. The programme is aimed at those aged 65 and over who are deemed to be at heightened risk of falling and is delivered over 24 weeks.Sessions will be free of charge for participants, and we are able to assist with transport for people who are unable to get themselves to the venues. Sessions will take place in Barnstaple, Ilfracombe, Braunton, South Molton, Torrington, Bideford and Holsworthy. Please refer to the Vista Wellbeing www.vistawellbeing.org.uk or Steady on your Feet website https://involve.onedevon.co.uk/steadyonyourfeet for locations, days and times in your area.

Referral Criteria:

We can accept referrals from health and community professionals, but patients can also self-refer.

Participants must be:

- Over 65
- At risk of falls (FRAT score above 3), have a fear of falling or have fallen in the previous year. People who have had 3 or more falls in the previous year and are **not being referred following community specialist falls rehabilitation**, should be referred to the local falls service first.
- Able to follow instructions
- Able to walk independently indoors and outdoors (with or without a walking aid and without help from another person)
- Able to get up from a dining room type chair (it is ok to find this difficult)
- Prepared to attend weekly for 24 weeks and complete prescribed home exercises between sessions. (we accept there may be the occasional holiday, illness and medical appointments).

Exclusion criteria

Uncontrolled Angina

Resting Systolic BP> 180mmHg or resting Diastolic BP> 100mg

Tachycardia >100 bpm

Significant dizziness due to postural hypotension or significant drop in blood pressure during exercise

Acute systemic illness (e.g acute cancer-related problems, pneumonia, febrile illness)

Visual or vestibular disturbance affecting safe mobility

Unstable or acute heart failure

Recent **injurious** fall **without** a medical examination

Unable to maintain seated upright posture due to neurological deficits

Impaired cognition where simple movement instructions cannot be followed.

People who place themselves or others at risk

People who score mostly 5s/6s on the FaME functional grid (refer for specialist physio