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Evidence based OTAGO and FaME Delivery

Implementation Guidance for Commissioners, Public Health Officers and Leisure Service Managers

(*with a remit to establish evidence based exercise programmes for older people to prevent falls - secondary and primary prevention*)

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Why this guidance?

This guidance aims to support Commissioners, Public Health and Leisure Service Managers to better understand the implementation considerations for each of these two **evidence based falls prevention programmes** in order to support effective service delivery. This guidance does not address the supporting evidence for each of these programmes, which is in the public domain (eg. Public Health England, Department of Health Prevention Package), and can also be found on the Later Life Training website. We have previously issued a Statement on Consistent and Accurate Messaging for Commissioners and Stakeholders in Frailty and Falls Services.

Important Comparisons between OEP & PSI (structured exercise) Evidence Based Falls Prevention Interventions NB. Structured exercise programmes in this document are defined as those that are **delivered as structured group exercise formats**. It **does not** include *any other formats or delivery methods (eg. dance).*	
The OTAGO Exercise Programme (Otago) led by qualified OEP Leaders	**The FaME (Falls Management Exercise) Programme led by qualified Postural Stability Instructors (PSIs)**
OTAGO Background Essentials ✓ Original research was as **secondary prevention** - older people at high risk of falls exercised at home with support (home visits and telephone calls) over **1 year**. At the start they were able to mobilise around their own home with or without walking aid. Cost effective in over 80s ✓ Follow up research suggests falls risk factors (strength/balance) improve **more quickly** when delivered in groups ✓ Follow up research as a **primary prevention** - programme **not** effective (i.e. more appropriate for frailer older adults) ✓ OTAGO is a lower limb strength and balance programme (plus walking) of pre-set exercises with progression guidance	**FaME Background Essentials** ✓ FaME was designed as a **progression** from OEP and extends/increases components of fitness targeted ✓ Original research was as **secondary prevention** - frequent fallers who could access a group session with transport provided over a **9 month** period ✓ Follow up research was as **primary prevention** - lower falls risk older adults who accessed group sessions with NO transport provided over a 6 month period ✓ FaME also increases **habitual physical activity** (MVPA)

OEP Background Essentials	FaME Background Essentials
✓ OEP requires older people to use **ankle weights**, and progress the weights over time ✓ OEP **requires** remote support/motivational strategies (visits, telephone calls, DVD etc.) if used as a home exercise programme only – it does NOT reduce falls without these in place (adherence and progression issues) ✓ OEP training includes motivational and support strategies for increasing adherence to home exercise in addition to the original research based strategies ✓ OEP is **not** appropriate for all older people	✓ FaME progresses the OEP balance exercises to include reactive and compensatory stepping ✓ FaME includes upper limb strength exercises to support backward chaining approaches to retrain getting on and off the floor ✓ FaME uses **resistance bands** as opposed to ankle weights ✓ FaME includes a dynamic endurance component (heart and lung functional capacity) and adapted tai chi moves ✓ PSI training has motivational and support strategies embedded including fostering group coherence and peer support ✓ FaME is appropriate for all older people
The case for commissioning Otago (OEP)	**The case for commissioning FaME**
✓ *Public Health England* Falls and Fractures Consensus Statement 2017 Resource Pack recommends Otago as a **cost effective** evidence based programme to reduce falls ✓ Evidence based strength and balance structured exercise programmes recommended in *National Institute of Clinical Excellence* Falls Guidance and Quality Standards NICE 2015 ✓ A *Royal College of Physicians Audit* of Older Peoples experience of therapeutic exercise as part of a falls prevention service 2012 advised that only 41% of staff delivering falls exercise provision had Otago training and recommended OEP training ✓ Recommended in *Department of Health Prevention Package* Exercise Training to Prevent Falls DOH 2009	✓ *Public Health England* Falls and Fractures Consensus Statement 2017 Resource Pack recommends FaME as a **cost effective** evidence based programme to reduce falls ✓ Evidence based strength and balance structured exercise programmes recommended in *National Institute of Clinical Excellence* Falls Guidance and Quality Standards NICE 2015 ✓ A *Royal College of Physicians Audit* of Older Peoples experience of therapeutic exercise as part of a falls prevention service 2012 advised that only 54% of staff delivering falls exercise provision had FaME training and recommended PSI training ✓ Recommended in *Department of Health Prevention Package* Exercise Training to Prevent Falls DOH 2009 ✓ Has been shown to not only reduce falls but also increases habitual moderate physical activity, as recommended in the Department of Health Start Active Stay Active 2011 Recommendations for Older Adults – wider health benefits

Training and Educational Considerations - Not everyone is appropriate for OEP/PSI training

- Learning itself is a skill, the OEP/PSI training requires candidates to engage with learning and be prepared to dedicate time to learn. There are significant differences in the learning/academic requirements of the OEP and PSI courses
- The PSI training is a qualification and the OEP is a leadership award; they are not attendance certificates. Both have practical assessed elements. For candidates who are not successful in achieving the assessment criteria, the majority go on to resit and pass the assessment with additional tutor support. Commissioners should be aware of this at implementation planning stage
- Courses can be hosted (by a whole service/organisation), or individually funded
- Hosted courses require the host to provide a suitable venue

Training and Educational Considerations - OEP	**Training and Educational Considerations - PSI**
✓ OEP is a 'leadership' award informed by the original research programme ✓ OEP is only delivered by Later Life Training (LLT) and is not part of the nationally recognised training framework for exercise professionals ✓ Minimum 8 hours of online e-learning tasks followed by 1 day face to face training for physiotherapists, 2 day training for fitness professionals, therapy assistants and other professions). There is an additional day for practical assessment ✓ OEP training has a worksheet and practical delivery assessment	✓ PSI is a qualification at undergraduate level requiring decision making skills to rationalize exercise tailoring and management ✓ PSI is only delivered by Later Life Training (LLT) and sits at Level 4 on the current nationally recognised Exercise training framework ✓ Minimum of 12 hours on the e-learning tasks during and after the face to face training. There are 4 days of face to face training spread over a 4 month period ✓ There are certain qualifications and experience pre-requisites for attending this training (eg. Physiotherapists, L3/4 Fitness Instructors, Therapy Assistants working in falls services) ✓ PSI has both a theory exam and practical delivery assessment.

Participant Assessment for Suitability to undertake Otago Exercise	**Participant Assessment for Suitability to undertake FaME Exercise**
✓ Assessment for inclusion/suitability should be undertaken by a physiotherapist, or by a PSI who should have agreed links to physiotherapy - two-way referral pathway in place ✓ Not all OEP Leaders are the same; other qualifications and experiences held will inform the appropriateness of settings suitable for delivery i.e. a physiotherapy assistant with the OEP Leader Award will have different scope of practice and governance to that of an exercise instructor	✓ PSI's are able to assess participants for suitability and have covered risk assessment as well as assessment of key outcome measures as part of their training ✓ PSI's can work in partnership with physiotherapy services by agreeing a formal 2-way referral pathway in order to support patients to continue with evidence based exercise at point of discharge from falls services

OEP and PSI working in different settings

- Health professionals (Physiotherapists, Occupational Therapists and others working in health settings within a falls service should/will be covered by their professional indemnity cover. The guidance below is for fitness professionals working in these roles
- Fitness Professionals should hold pre-requisite fitness qualifications
- Fitness Professionals should liaise with their insurer for appropriate cover
- It is not appropriate for volunteers to deliver these programmes (see FAQ at the end of this doc)
- Different settings will present older people with lesser/greater complexities (ie. fall risk, comorbidity, medical history). A higher duty of care is required when working with the very frail and appropriate support measures should be identified prior to setting up group exercise programmes

OEP Leaders in Residential Settings – exercise instructor considerations	**PSI's in Residential Settings – exercise instructor considerations**
✓ Should have support of a PSI, physiotherapist, or occupational therapist who can support decisions around suitability of participants for inclusion ✓ OEP Leaders should work with their supervisors to undertake venue/room and activity risk assessment for both home supported and group delivery of exercise ✓ Should ideally have referral links back to physiotherapy ✓ Standing balance training is not appropriate for all older people in residential settings. This setting will have a high proportion of residents who will present as high risk and to this end it will require an appropriately trained person to ascertain suitability for standing work. This assessment decision is <u>not</u> part of OEP Leader training	✓ PSI's are able to assess participants for suitability and have covered risk assessment as well as assessment of key outcome measures as part of their training ✓ Should ideally have referral links back to physiotherapy ✓ PSI's can accommodate a wide range of functional impairment and include chair based alternatives ✓ PSI's can assess for suitability for standing work

OEP Leaders in Community Settings – exercise instructor considerations	**PSI's in Community Settings – exercise instructor considerations**
✓ L2 Exercise instructors holding the OEP Leader Award should be supported and quality assured by a PSI – and ensure onward signposting to PSI sessions (where available) for continued progression of balance challenge and strength intensity to meet effective dose requirements ✓ OEP Leaders (who have a L2 Fitness as their highest level qualification) should not be assessing participants for suitability for inclusion into an OEP community session <u>unless local criteria (agreed by commissioners, physiotherapist, GP's) are in place</u>	✓ PSI's should ideally be linking with physiotherapy or GP's as part of an agreed referral pathway

Critical Considerations for Commissioners for Implementation

Governance:

- A referral pathway should be agreed by all parties (i.e. CCG's, physiotherapy services, falls and leisure services)
- Responsibilities and accountability for decisions made around entry criteria/appropriateness for inclusion should be clear and made by appropriate health professionals and/or exercise professionals
- The OEP and PSI programmes require partnership approaches to ensure older people at risk of fall have had adequate assessment/multi-factorial assessment if required
- Where private providers of exercise are commissioned for delivery of falls prevention – all of the above is still relevant

Key Messages for Commissioners:

- Exercise is not a one size fits all approach. Alas there is no quick fix! And although 'something is better than nothing' – as professionals we know better, and should work towards evidence based approaches known to be effective. There are many training organisations providing chair based exercise, and some including standing exercise. It is important to identify training providers that deliver training that includes strength and balance elements, and training that is specifically designed for frailer older people who are at risk of fall. There is a need for both. Your choice of training will align with your intending outcomes.
- The OEP/PSI programmes should ideally form part of a broader exercise continuum for all older people (CMO identified as; independently active, those in transition, frailer older people). This continuum for older people should form part of an overarching/broader 'exercise across the life course' approach.
- The challenge for exercise services is to provide adequate training/competencies to meet the needs of target populations. The complexities that present with pathologies, comorbidity alongside normal age related changes require higher levels of knowledge. Most importantly, people working with these higher risk populations also require more time to interact with people, to have conversations to address *motivational and behavioral change challenges*. Any exercise intervention can only be effective if pathways and protocols allow it to be effective
- The hardest message for commissioners and participants to take on board is that exercise as an intervention is not a 'quick fix', however, with support, time and sound rationale behind application – it can be and IS one of the most definite 'fixes' we have to reduce falls, halt age related decline, reverse sarcopenia, reduce frailty, improve mood, improve cognition and improve functional capacity.

In considering the commissioning of ANY physical activity programme for older people at risk of fall:

- Are you commissioning training with the primary aim of improving strength and balance, or is the primary aim to increase physical activity and reduce isolation?
- Do you have a requirement to commission evidence based training/published evidence to reduce falls, or are you looking at primary prevention (aimed at the risk factors for falls but may not actually impact on falls themselves)?
- At LLT we acknowledge, respect and support all forms of training and opportunities for older people. From experience we urge commissioners to pose a fundamental question when planning services and commissioning training; 'What is the specific purpose of your intended programme?' and, 'Does the training you are about to commission meet the needs of your desired outcomes?'

- People living with Dementia (PLWD) will require additional considerations for successful participation across any physical activity programme. PLWD have specific needs. Additional training for staff will be required to achieve this

The PHE Falls and Fractures Consensus Resource Pack, aimed at commissioners and strategic leads, has in-depth information on:

- Key interventions (OEP and FaME) including evidence of cost and clinical effectiveness
- Links to an extensive selection of documents and tools including commissioning support resources, relevant clinical guidance and quality standards, research and policy documents and patient information
- An additional section on frailty given the links between falls and frailty at patient, service and strategic levels.
- Suites of indicators that can be chosen for local collection
- A handy commissioner's checklist with the recommendations from both documents in RAG (Red/Amber/Green) checklist form

Key Advice for Commissioners (prior to commissioning training from LLT)

- Ensure implementation plans are ready as soon as candidates complete training
- The evidence for OEP and PSI is undisputed however as we know implementation doesn't come without challenge. Short term programming without robust exit strategies will be ineffective, sustained participation is essential to eliminate revolving doors.
- Consider primary and secondary prevention. Secondary prevention must start with structured exercise, which has a robust evidence base, and people can then transition on to programmes which help maintain or continue improving strength and balance (eg. dance based programmes or tai chi)
- Identify what technical support and reporting pathways your OEP Leaders and PSI's will require in order to ensure the pathway remains cohesive
- If commissioning the services of private/self-employed exercise instructors for community provision;
    - Do they have adequate insurance?
    - Do you require them to collect outcome measures?
    - Do they have sufficient risk enablement/assessment documents in place?
    - Who will be assessing for suitability into the programmes – are links with therapy teams in place?

Frequently Asked Questions

Can PSI's also deliver the OEP?
Although these are different interventions, a PSI does have the skills and knowledge to lead the OEP strength and balance exercises (many of which are embedded in the FaME programme). PSI's who wish to deliver the OEP as a home-based programme would benefit from undergoing private study around the wider OEP elements (ie. motivational phone calls and walking).

Can an OEP Leader 'top up' their training to become a PSI?
No, these are two different interventions pitched at different academic levels of learning.

Can volunteers attend these training courses?
Due to pre-requisite knowledge, technical support and governance requirements, these programmes are not appropriate for volunteers unless they have a fitness qualification. We/LLT do work closely with projects engaging with the third sector around Chair based exercise and more recently Care to Move. If adequate insurance provision and robust support of volunteers from local falls services is in place (governance issues, quality assurance, assessment of suitability and agreed onward referral pathways) then LLT can train volunteers as OEP Leaders to work with low risk (non fallers) older adults (eg. ROAR-Connections for Life, Paisley). If in doubt, get in touch.

Why is a L2 Instructor with OEP allowed to work with a high risk older population?
As you may be aware, a L4 qualification is normally required to work with fallers and other high risk populations (such as PSI at L4). OEP is aligned with L2 because it is a pre-set programme of exercises with recommended progressions and a physiotherapist or PSI must assess suitability for inclusion of participants. An OEP Leader working on secondary prevention should always be part of an agreed falls pathway. If working within a primary prevention service (whose aim is to improve strength and balance but not in high risk fallers) they should still be able to access advice and be able to refer into falls services if any of their participants have a fall.

Are the OEP/PSI programmes appropriate for people living with dementia?
In the event that a participant has dementia, cognitive impairment or a mental health condition the person assessing suitability should take into consideration any additional support and adaptations that could be made (to the session, environment etc.). PLWD have expressed views and preferences as to this support and LLT, amongst others, offer training in how to have these conversations and support mechanisms for PLWD to participate in these programmes.

We can't support the delivery of these programmes in the community for the recommended time (6-12 months), we could only do 8-12 weeks. How do we manage this?
It is understandable that budget constraints lead to notions that 'we can start them off on the journey' but please bear in mind that a number of studies have now shown that in the first 8-12 wks confidence in ability increases more quickly than a persons ability to correct a trip or slip. So there may be an increased risk of a fall if participants do not continue to work on improved strength and balance to support more active lifestyles. The most effective services have a seamless transition from rehabilitation-based services to community provision and this may cross providers. The long term provision of strength and balance programmes generally sits within leisure/community settings so establishing a broader exercise continuum is critical to providing diverse opportunities for older people of all abilities to attend purposeful exercise sessions. However this is provided, it is VITAL as the effective dose of these two interventions requires more than 50 hours of specific exercise over one year. We also know that once stopped, people decondition and will increase risk, so ideally we need to facilitate changing habits and lifetime engagement. This requires longer term behaviour change and support.