ANNEX A

FALLS IN CAMBRIDGESHIRE: DRAFT BUSINESS CASE

BACKGROUND

A fall is defined as an unplanned descent to the floor with or without injury to the patient.¹Across the United Kingdom and Europe, falls account for a significant number of deaths, hospital admissions and fractures in the elderly population. There is strong evidence that up to 30% of falls in older people living at home can be prevented through both population and targeted intervention.²

Falls in older people are not purely random events but can be predicted by assessing a number of risk factors: ³⁴⁵

- Chronic health conditions such as heart disease and low blood pressure (hypotension) which can cause dizziness and a brief loss of consciousness
- Conditions that affect balance
- Physical impairments such as poor vision or muscle weakness
- Cognitive impairments such as dementia
- Multiple medications (notably sedating drugs)

Some of these risk factors (e.g. reduced muscle strength and impaired balance and gait) can be modified using exercise, whereas others (e.g. poor vision, psychoactive medication use) require different intervention approaches. Exercise can be used as a stand-alone falls prevention intervention or as a component of a multifaceted program. Multifaceted interventions can prevent falls in the general community, in those at greater risk of falls, and in residential carefacilities.⁶

The majority of fractures in older people occur as a result of a fall from standing height. These are low trauma fragility fractures commonly affecting the pelvis, wrist, upper arm or hip. Almost half of all women and one in six men experience a painful and disabling fragility fracture in later life.⁷ Furthermore there is evidence that the fear of falling has an impact on quality of life for both people who fall and their carers. For example, a recent study identified that fear of falling was common in people following a hip fracture and significantly associated with activity avoidance, disability and affected the lives of those recovering. Some patients were physically incapacitated by fear of falling.⁸

Falls are therefore a significant preventable cause of ill health, and of hospitalisation and social care requirements in older people. The prevention of falls can be categorised as primary (preventing a fall

¹National Database of Nursing Quality Indicators (2011).

²McClure RJ et al (2005). Population-based interventions for the prevention of fall-related injuries in older people. Cochrane Database of Systematic Reviews 2005, Issue 1. Art. No: CD004441. DOI:10.1002/14651858. CD004441.pub2.

³Clinical Guideline 21. Falls: The Assessment and Prevention of Falls in Older People. London, UK: National Institute for Clinical Excellence, 2004.

⁴ Ganz DA, Bao Y, Shekelle PG et al. Will my patient fall? JAMA 2007;297:77–86.

⁵ Gillespie LD, Gillespie WJ, Robertson MC et al. Interventions for preventing falls in elderly people. Cochrane Database Syst Rev 2003;Issue 4.

⁶ Gillespie LD, Gillespie WJ, Robertson MC et al. Interventions for preventing falls in elderly people. Cochrane Database Syst Rev 2003;Issue 4.

⁷ Department of Health (2009) Falls and Fractures: Effective interventions in health and social care.

⁸ Jellesmark A et al. Fear of falling and changed functional ability following hip fracture among community dwelling elderly people. Disability & Rehabilitation (2012).

in those who have not yet had a fall) or secondary (reducing the likelihood of subsequent falls). Further information about the role of physical activity in the primary prevention of falls in older people is detailed in Chapter 4 of the 2014 JSNA 'Primary Prevention of III Health in Older People'.⁹ Well organised services, based on national standards and evidence-based guidelines can prevent future falls, and reduce death and disability from fractures.¹⁰

AIMS AND OBJECTIVES

The overarching aim of the proposed business case is to improve the effectiveness of falls prevention in Cambridgeshire by investing in a system overview, enhancing existing services, and informingplanning of new services and integrated pathways. Effective falls prevention results in improved health and wellbeing outcomes for older people and reduced pressure and costs for health and social care services.

To achieve this aim, the following key objectives have been identified:

- 1. Realisation of a system- level overview of falls prevention
 - Providing intelligence to inform the development of an integrated strategy and pathwaysfor falls prevention.
- 2. Development of aCounty-wide systematic approach to falls prevention
 - Ensuring equity of core provision
 - Tailored to local community needs
- 3. Greater engagement by community services, third sector partners, housing and district council partners, and the wider health and social care workforce with older people to facilitate increased physical activity and to reduce falls
 - Establishingnew channels for health promotion, timely interventions and referrals to falls prevention services
 - Supportingolder adults to increase and sustain appropriate levels of physical activity
- 4. Establish a targetedfocus on approaches to prevent falls in people aged 75+
 - Ensuring an increased proportion of people 75+ are supported to be more physically active
 - Increasing emphasis on falls prevention communication through community and primary health services
 - Ensuring referral to falls assessment and prevention services for those at higher risk of falling

DEMOGRAPHIC CASE

Demography

Table 1 shows population forecasts for the Cambridgeshire population aged 65 and over. The number of older people aged 65 and over is expected to increase by over 40,000 people by 2028, a 34% change. In people aged 75 and over, an additional 31,300 people, a change of 59% is expected. Amongst the oldest old, the number of people aged 90 years and over is forecast to nearly double in the next 15 years.

⁹ Available at: <u>http://www.cambridgeshireinsight.org.uk/primary-prevention-ill-health-older-people2014</u> ¹⁰Royal College of Physicians.Falling standards, broken promises.Report of the national audit of falls and bone health in older people 2010. Available at: <u>http://www.rcplondon.ac.uk/sites/default/files/national_report.pdf</u>

Age	2012	2016	2020	2024	2028	Change 2016-28
65-69	32,980	36,790	33,930	35,930	40,700	11%
70-74	23,480	28,400	34,960	32,700	33,810	19%
75-79	19,120	20,940	24,890	31,980	30,590	46%
80-84	14,790	15,540	17,760	20,080	26,760	72%
85-89	9,170	10,300	11,400	13,150	14,770	43%
90+	5,230	6,710	8,470	10,310	12,670	89%
65+	104,780	118,690	131,400	144,150	159,300	34%
60+	141,460	153,370	168,960	187,090	205,950	34%
All ages	627,200	655,390	703,180	735,010	756,670	15%

Table 1: Cambridgeshire population forecasts, mid 2012 based, number and estimated %change, people aged 65 years and over

Source: CCC RP&T mid 2012 population forecasts(rounded)

Age distribution and outcome of fall

Hip fractures remain the most serious consequence of a fall and the most common cause of accident related death in older people. In 2013/14 in Cambridgeshire there were 2,132 people aged 65 and over who were admitted to hospital as an emergency with injuries due to falls and 604 people aged 65 and over admitted with a fracture of the hip.

Figures 1, 2 and 3 show rates of emergency admission for injuries due to falls and for fracture of the hip for Cambridgeshire residents between 2010/11 and 2012/13. Rates are generally higher in women than in men and increase substantially with age. Rates in Cambridgeshire as a whole are similar to the national average. Within Cambridgeshire, Cambridge City has rates that are statistically significantly higher than other districts and the national average (data not shown) for injuries due to falls.

Figure 1:







Source: Public Health England (PHE) Fingertips <u>http://www.phoutcomes.info/</u> Primary diagnosis code for Injury (ICD 10 S00-T19) with falls code (WOO-W19) anywhere in diagnostic string.

Figure 3:



Source: Public Health England (PHE) Fingertips <u>http://www.phoutcomes.info/</u> Primary diagnosis ICD 10 S72.0, S72.1, S72.2. Falls are the commonest cause of accidental injury in older people and the commonest cause of accidental death in the population aged 75 and over in the UK. In more active and younger people, wrist fractures are more common whereas in those over 75, hip fractures predominate and the need for particularly long-term care increases. From the above data it is clear that in Cambridgeshire the impact of falls is disproportionately greater in those aged 80 years and above which accentuates the case for preventive interventions targeted at age-bands preceding the rise in incidence of hip fractures and frailty.

STRATEGIC CASE

There are local assets in Cambridgeshire addressing both population-wide prevention of falls among older people, and early intervention services for individuals at high risk of falling. These assets include locally developed services commissioned by health, district council, housing and other sector partners, such as:

- Falls services (multifactorial assessments and interventions)
- Physical activity classes for falls prevention in the community
- Falls response initiatives, for example the Acute Geriatric Intervention Service in Greater Cambridge
- Home improvement and handyperson schemes
- Falls prevention coordination work in hospital and residential settings
- Work by Local Health Partnerships which have prioritised falls prevention

However there is little data available on the outcomes or quality of these services, and the adoption and practice of evidence based interventions. There are indications of variation in the quality and comprehensiveness of provision across the county, for example access to community exercise opportunities may be limited in some areas. There is currently no agreed Cambridgeshire model or service specification for a falls service, which might ensure consistency and reduce the potential for inequalities in access. In addition, there is no overarching agreed falls prevention pathway, with a resultant lack of system overview and integration to drive quality improvements and inform service development.

The announcement of the new provider for services for Older People and Community Services (OPACS) across the county and the development of new service design models, for example at neighbourhood team level, provides a timely opportunity to implement systematic approaches to integration and collaboration across local authority, primary and community services as well as acute hospitals. Preventing falls, reducing emergency admissions and costs associated with falls are clear priorities across services providing care for older people; so joined-up strategies and integration across service levels would be of mutual benefit.

SERVICE UTILISATION AND ECONOMIC CASE

Estimated costs of falls and hip fractures in Cambridgeshire

In 2013, results were published from a Scottish study which aimed to estimate the costs for health and social care services in managing older people in the community who fall.¹¹ The study used predominantly national databases and cost of illness methodologies and the authors noted that costs, while specific to Scotland, were anticipated to generalise to other parts of the UK. The study found that 34% of people aged 65 years and over living in the community fall at least once a year and 20%

¹¹Craig J, Murray A, Mitchell S et al. The high cost to health and social care of managing falls in older adults living in the community in Scotland. Scottish Medical Journal 2013;58(4):198-203. Available at: <u>http://scm.sagepub.com/content/58/4/198</u>.

of these people contacted a medical service for assistance. Applying the results from the Scottish study to local population figures for Cambridgeshire, we can estimate the costs of falls across health and social care (Table 3).

In Cambridgeshire, this level of falls would result in over 4,000 GP attendances, nearly 5,000 ambulance call outs, and more than 6,300 A&E attendances resulting in over 2,600 inpatient admissions in 2016. The associated costs are high and estimated to be over £57 million with 60% of costs incurred by social care, mainly providing long term care following hospital discharge. [Note: The paper describing the study does not make clear what proportion of these social care costs are re-charged to individuals, and public health are contacting the study authors to establish this]. Details of the costings used are available in the original paper and briefly described below.¹²Costings used in the paper are conservative estimates compared to social care costs in Cambridgeshire, for example the costs of providing residential care per week.

Clinical event		Number	Cost per event	Total cost (2016)	Total percentage
Population aged 65+		118,685			
Total people falling	34% of population	40,203			
Of whom serious	7% of population	8,041			
GP attendances	51% of serious falls	4,082	£36	£146,961	0.3
Ambulance callouts	61% of serious falls	4,934	£257	£1,268,074	2.2
A&E attendances	80% of serious falls	6,398	£101	£646,154	1.1
Inpatient admissions	35% of A&E attendances	3 2,261			
Falls (non hip fractures)	69% of admissions	1,560	£7,406	£11,556,457	20.1
Hip fracture	31% of admissions	701	£14,528	£10,184,962	17.7
Discharge falls					
Home	64%	1,000	£1,776	£1,776,408	3.1
Residential: short term	21%	333	£8,406	£2,802,992	4.9
Long term	15%	227	£65,942	£14,951,491	25.9
Discharge fractures					
Home	34%	240	£1,776	£425,506	0.7
Residential: short term	47%	327	£8,406	£2,746,470	4.8
Long term	19%	135	£65,942	£8,885,228	15.4
Re-admissions	7% of admissions	163	£7,406	£1,205,962	2.1
Mortality at one year	12% of admissions	279	£3,703	£1,033,682	1.8
Total cost				£57,630,349	100

 Table 2: Estimated number and cost of fall related events, Cambridgeshire 2016, based on

 Scottish study estimates applied to Cambridgeshire population

Source: CCC RP&T 2012 based forecasts (Costs and estimates modelled using Craig et al¹¹). Provisional results. Total percentage differs to published figures due to rounding.

¹²Social care costs in this study are predominantly associated with hospital discharge. At discharge all patients were assumed to have a shared assessment by a social care worker and community. For those going directly home, a care package comprising a GP visit and eight weeks of 'low cost' care including home care and healthcare was assumed. For those discharged into a care setting two costs were assumed – those able to return home by 120 days, and costs for those remaining in residential care for average length of stay of 27 months. (reference 11)

Local Impact on social care utilisation

During 2013/14, as part of Thematic Review work, CCC officers conducted a project to identify 'triggers' of adult social care need. 152 records of service users from the Older People and Hospital key teams were reviewed. Falls were identified as a trigger for social care need but the project was not set up to assess this specifically, and it is acknowledged that the sample size for Older People teams is insufficient for sub-set analysis. These local results are therefore indicative – and likely to be an under-estimate of the impact of falls on social care utilisation and costs. The finding from the 'triggers' work suggested that 12.5% of older people came into service in 2012/13 as a direct result of a fall. Applying this figure of 12.5% to the total Older People based on 95% margin of error), as shown in Table 4. This is much lower than the estimates of social care usage from the Scottish study, although the number of hospital admissions for falls and hip fractures in Cambridgeshire are similar to the Scottish model. It is likely that this reflects local factors in Cambridgeshire such as a higher proportion of 'self-funders' who purchase their own care services or residential placements, and possibly higher levels of support provided by the voluntary sector for people discharged home from hospital.

	Number	Notes
Total new Older People intake in year	1,850	From RAP A7 (assessments), average of 2012-13 and 2013-14
Estimate of new intake as direct result of a fall	231	12.5% of review of Older People records (n=152)
Lower estimate of new intake as a direct result of a fall	93	If 5.01% of intake were triggered by fall
Upper estimate of new intake as a direct result of a fall	370	If 19.99% of intake were triggered by fall

Table 3: Estimate of new Older People intake into Adult Social Care as direct result of a Fall

Source: Cambridgeshire County Council, Thematic Reviews 2013-14. Triggers' of adult social care need. Draft report v1.

Further preliminary modelling work has been carried out by Adult Social Care officers to investigate the number of new entrants to social care that would need to be reached by an effective falls preventionintervention reduce social care utilisation costs. The average service user cost of £10,483 calculated for Cambridgeshire is a crude average of the total budget and total number of service users in one year. If 49 cases were avoided, a saving of over £510,000 could be made.

An additional caveat to this approach is that falls are likely to be only one of the triggers for intake to social care, as new entrants may have multiple conditions and limitations that affect their social care need, such as dementia, which has not been adjusted for. Thorough mapping and system analysis work, as advocated in this business case, could provide additional useful information to inform future targeted interventions which achieve the highest reduction in social care cost.

POTENTIAL OPTIONS FOR INTERVENTION: EVIDENCE REVIEW

Interventions and approach

On a population/public health basis, encouraging physical activity and the provision of exercise sessions as part of a wider campaign including literature, medication reviews and environmental changes has been shown to decrease fall related injuries. One large population approach trial, over 10 years, has seen a reduction in fracture rate by advocating increased physical activity and other

lifestyle changes.¹³The 'Greater Glasgow and Clyde' falls prevention programme has evidence of actual realised savings, the only UK model to have such evidence. Over a 10 year period the service has achieved a reduction in falls in the home of 32%, a reduction of falls in residential institutions of 27% and a reduction of falls in the street of almost 40%.¹⁴

Evidence of cost saving/effectiveness

Table 5 below demonstrates the impact of conservative estimates of reduction of falls on costs by applying a 10% and 15% reduction in falls to the costings in the Scottish study model. At a population level, the potential cost reductions are substantial as shown in Table 5. Using the 10% reduction results in a reduction of nearly £6 million of which costs related to social care (based on services following hospital discharge) total over £3 million. However it is important to note that the local work described on the previous page indicated a lower level of social care costs in Cambridgeshire than the Scottish model, and it is likely that in Cambridgeshire a considerable proportion of the social care costs outlined in table 5 would be self-funded by individuals rather than by the County Council.

Table 5: Potential cost savings in Cambridgeshire across health and social care from 10% and 15% reduction in falls related events, using the Scottish study model

Clinical event		Total cost	Estimated cost savings from % reduction	
		(2016)	-10%	-15%
Population aged 65+				
Total people falling	34% of population			
Of whom serious	7% of population			
GP attendances	51% of serious falls	£146,961	-£14,696	-£22,044
Ambulance callouts	61% of serious falls	£1,268,074	-£126,807	-£190,211
A&E attendances	80% of serious falls	£646,154	-£64,615	-£96,923
Inpatient admissions	35% of A&E attendances			
Falls (non hip fractures)	69% of admissions	£11,556,457	-£1,155,646	-£1,733,469
Hip fracture	31% of admissions	£10,184,962	-£1,018,496	-£1,527,744
Discharge falls				
Home	64%	£1,776,408	-£177,641	-£266,461
Residential: short term	21%	£2,802,992	-£280,299	-£420,449
Long term	15%	£14,951,491	-£1,495,149	-£2,242,724
Discharge fractures				
Home	34%	£425,506	-£42,551	-£63,826
Residential: short term	47%	£2,746,470	-£274,647	-£411,971
Long term	19%	£8,885,228	-£888,523	-£1,332,784
Re-admissions	7% of admissions	£1,205,962	-£120,596	-£180,894
Mortality at one year	12% of admissions	£1,033,682	-£103,368	-£155,052
Total cost		£57,630,349	-£5,763,035	-£8,644,552

Source: CCC RP&T 2012 based forecasts (Costs and estimates modelled using Craig et al¹⁵).

¹³ McClure RJ, Turner C, Peel N et al Population-based interventions for the prevention of fall related injuries in older people. Cochrane Database of Systematic Reviews 2005, Issue 1. Art. No.: CD004441. DOI: 10.1002/14651858.CD004441.pub2.

¹⁴Greater Glasgow and Clyde Falls Prevention and Osteoporosis Services. Available at: http://www.nhsqgc.org.uk/CONTENT/default.asp?page=s1361

¹⁵Craig J, Murray A, Mitchell S et al. The high cost to health and social care of managing falls in older adults living in the community in Scotland. Scottish Medical Journal 2013;58(4):198-203. Available at: http://scm.sagepub.com/content/58/4/198.

PROPOSED MODEL

It is anticipated thattargeted evidence based interventions can reduce falls and fracture rate by up to 30% (specific programmes for improving strength and balance have demonstrated reductions in risk of falling by as much as 55% in high-risk groups)¹⁶ and thatmuch can be achieved by redesign and coordination of existing services. The prevention of falls requires the active engagement of many individuals, including the multiple disciplines and teams involved in caring for people who fall. To ensure co-ordination, high-quality prevention requires an organisational culture and operational practices that promote teamwork and communication, as well as individual expertise. Therefore, improvement in falls prevention requires a system focus to make the necessary changes. Figure 4 provides a schematic overview of these key interventions to improve falls prevention work locally.



Figure 4: Interventions and approaches to prevent falls

¹⁶ P. A. Logan et al (2010). Community Falls Prevention for People Who Call an Emergency Ambulance after a Fall: Randomised Controlled Trial. BMJ; 340: c2102.

The focus of the proposed model is on individuals in the community aged 75 and over due to the disproportionate number of falls in those over 80 years. By targeting this group it is anticipated that earlier access to support, referral and engagement in physical activity groups and interventions will be more effective and the impact of prevention will be greater. This approach has also been advocated by stakeholders currently providing community falls prevention services who report that many referrals are received when the patient has reduced ability to benefit from interventions due to frailty, disability and illness. However the model also aims to promote public health approaches to improving physical fitness in people 60 years and over. The economic evidence available makes the case for investment in physical activity across the population for the prevention of falls, and the demonstrable value in establishing gold standard falls prevention services.

With the resource available for Cambridgeshire, and within the local context, this business case proposes an investment to strengthen access and participation in physical activity using existing infrastructure and services, and an investment to increase the numbers benefitting from evidencebased falls prevention assessments and interventions. Initial scoping work has emphasised that there are local services in place, but not all of those at-risk are benefitting from these services, and interventions are not always accessed at an early stage where there is greater potential benefit. A community engagement approach provides an opportunity to address both these objectives, including identifying people at risk who are not in contact with health and social care services.

The proposed model includesfive key components identified for investments, which are described below in detail, namely:

- Mapping, gap analysis and guality assurance
- Community engagement via Health Trainers
- Awareness raising with professionals
- Evaluation •
- Further investment following system mapping to pump prime falls interventions •

Mapping, gap analysis and quality assurance

Falls prevention work is shared across multiple agencies and partners, due to the multifaceted risk factors that contribute to falls and theservices and interventions that have an impact on the primary and secondary prevention of falls.¹⁷

The process of systematically mapping needs and the provision of appropriate services and interventions will require allocated investment - and is proposed as a primary and fundamental action within this business case. This would be undertaken in detail to map out the services available, and to analyse the gaps in provision and opportunities to assure quality. There are nationally available tools available for quality assurance. For example NICE has developed a baseline assessment tool, and clinical audit tools to accompany the Clinical Guideline 161 on Falls: Older People living in the community, 2013.¹⁸The resource is budgeted as a human resource for the mapping work to be undertaken by a fixed term post over the first year of the enhanced falls work service. This could alternatively be contracted as piece of system mapping research which would have the advantage of buying-in a range of skills from an external agency to take a running start, with potentially more

¹⁷ For further information see chapter 5 on falls prevention in the 2013 JSNA on Prevention of III Health in Older People, available at: http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsnareports/prevention-ill-health-older-people-2013. Further updated needs assessments on falls prevention will be posted on Cambridgeshire Insight. ¹⁸ Available at: http://www.nice.org.uk/guidance/cg161/resources

perceived neutrality when engaging with stakeholders. The outcomes of the system mapping component would include:

- Detailed mapping and records of all services and interventions by public and third sector organisations relevant to the preventing falls in Cambridgeshire
- Application of gold standard principles and other benchmarking tools to review the quality of services and interventions
- Identification of gaps and opportunities for further integration, investment and improvements
- Basis for potential county-wide falls prevention strategy.

It is anticipated that the mapping process will highlight the work that has been undertaken by Local Health Partnerships which have prioritised falls prevention. The mapping process will build on work completed locally to date, to provide a view across the county. The use of findings from the mapping work to develop and improve the effectiveness of services will include discussion and coordination with local partners, including Local Health Partnerships, to ensure changes are appropriate to local contexts.

Community engagement via Health Trainers

The proposed approach is to focus on raising awareness of the general public of the importance and role of physical activity for older people (to prevent falls and protect against other health outcomes), to support behaviour change of individuals and communities, to increase demand and take up of community physical activity classes including strength and balance, and increase timely referrals into local falls services by utilisingHealth Trainers, volunteers and existing service infrastructure.

Individuals who fall in the community are frequently not known to health or local authority services. The risk of falling increases with age and often individuals will not have received assessment or intervention to reduce the risks of falling. A significant proportion of the population at-risk of falls are not participating in physical activity or accessing services that may provide support. For example; as described in the JSNA on Primary Prevention of III Health in Older People¹⁹, the 2012 Health Survey for England²⁰ identified that the proportion of older adults nationally meeting physical activity recommendations was:

- 57% of men and 52% of women aged 65-74 years.
- 43% of men and 21% of women aged 75-84 years.
- 11% of men and 7% of women aged 85+ years.

Therefore there is a case to be made for increased investment in community engagement and supporting behaviour change to improve participation in physical activity. Health Trainers have been identified as a group of health workers with particular skills in supporting behaviour change that could be applied to falls prevention work.

In Cambridgeshire the current Health Trainer Service focuses on 20% most deprived areas where a Health Trainer is attached to the GP practices. They have therefore developed strong links with the primary care teams and patients registered at those practices, particularly in identifying vulnerable individuals that may benefit from support. The Service has Community Development Workers, who develop links with partner agencies across health, voluntary sector and community services, andwork directly with community members. The Health Trainers provide one-to-one support for individuals and

¹⁹ Available at: http://www.cambridgeshireinsight.org.uk/primary-prevention-ill-health-older-people2014

²⁰ British Heart Foundation National Centre (2014): Current levels of physical activity in older adults. Loughborough University.

facilitate group work in the community, placing them in an ideal position to play a fundamental role in the education, engagement and management of older people at risk of falling.

Investment in the Cambridgeshire Health Trainers Service is proposed to increase their responsibility for falls prevention as it would offer significant benefits and opportunities:

- Health Trainers already have a remit of working within the most deprived and complex communities and individuals and the skills to engage with those who may not be engaging with other health professionals, including those who are normally regarded as hard to reach, de-motivated or non-compliant.
- Health Trainers have up-to-date Motivational Interviewing training and they use techniques based on psychological evidence and theories to help people change behaviours that are known to cause ill-health. This would bring useful skills to falls prevention at an individual level.
- The Health Trainer service includes both the provision of individual lifestyle support, but also a responsibility for community development activities to support healthier lifestyles, with established links with local communities,
- Analysis of the current Health Trainer Service referrals indicates increasing numbers of referrals from GPs and practice nurses of people aged 65 years and over for support with lifestyle and health behaviour change, demonstrating a demand from primary care for primary prevention of ill health in older people in Cambridgeshire.
- The enhancement of an existing Health Trainer Service would mean that this work can pick up from a running start in the first year of delivery, building on provision that is already established in the most deprived parts of Cambridgeshire.
- Qualitative evidence notes that older people do not like the terms 'falls' and 'falling' and 'preventing falls', and may not consider their risk of falling, or describe any unsteadiness, trips and slips in those terms.²¹ Anecdotal information from local falls services describes referrals of people whose mobility and risk of falling is very high and would have benefited from more timely intervention. The Health Trainers work across the lifespan and across the population, and may be able to engage particularly with those who would be reluctant to discuss their balance and strength with health professionals, or to access a 'falls service'.

This would also be a timely approach as lifestyle services, including the provision of Health Trainer Services in Cambridgeshire are currently being re-tendered, with their capacity to be extended across Cambridgeshire. There is an opportunity to build in enhanced responsibility for outreach to increase engagement in falls prevention activities, alongside other service developments.

It is therefore proposed that:

- 1) All health trainers have an increased remit for falls prevention
 - Including screening for risk of falls in individual appointments
 - Supporting behaviour change for increased physical activity
 - Making appropriate signposts and referrals for additional support
- 2) Health trainer falls champions are identified (1 for each local area/locality) to continue to raise the profile and need for falls prevention
 - Falls champions might be particularly tasked with the responsibility for identifying those aged 75 years and over with a known risk factor for falls, providing them with

²¹Yardley L., et al. Older people's views of advice about falls prevention: a qualitative study. Health Educ. Res. (2006) 21 (4): 508-517.

support in participating in physical activity, and where appropriate, referring to falls service

- 3) The Health Trainer Service becomes responsible for a detailed programme of community engagement on falls prevention, particularly in raising awareness among local communities and identifying individuals who would benefit from support. A possible approach for this would be to undertake the 'Functional Fitness MOT' training developed by the British Heart Foundation National Centre in Loughborough and roll out Functional Fitness MOT events to target groups, to provide personalised information to participants on the benefits of physical activity for their health and independence.²² Other organisations are developing resources to promote physical activity among older people that could be used as an alternative for community engagement.
- 4) The community engagement activity by Health Trainers incorporates fostering strong partnerships with local day centres and day services, and services for older people. These services are well-placed in engaging with older people, encouraging and facilitating participation in physical activity, and preventing falls, including addressing the fear of falling. The Health Trainer Service will provide support on falls prevention within these settings, and within further services or health and social care community settings as identified.
- 5) The Health Trainer Servicewill maintain detailed records on their individual and community level interventions towards falls prevention and the outcomes achieved by the Service, and these details will be captured within their reporting mechanisms to Commissioners.

Awareness-raising with professionals

One component of the proposed model is to increase the number of people benefitting from evidencebased falls assessment and intervention services already available in Cambridgeshire. Promoting falls prevention and physical activity among older people is everyone's responsibility. The generic model creates the opportunities for everyday patient pathways to trigger a falls risk assessment and signposting.

While some appropriate referral routes are well established, it would be advantageous to increase the profile of falls prevention work across social and health care, voluntary sector organisations, local advocacy groups, housing professionals and the wider workforce who interact with older residents in Cambridgeshire. This would also include those working in fitness settings; recent training for exercise professionals highlighted that many are unfamiliar with CMO's guidelines for physical activity and how they apply to older people.²³ Furthermore, staff working in direct contact with older people, for example those working in day services may not have had routine training or recent promotion of their role in falls prevention.

Therefore a thorough programme of training and awareness-raising among the wider workforce is proposed with the following objectives for each participant:

- Increased knowledge of the scale of falls as a problem across Cambridgeshire and the detrimental impact of injurious falls
- Increased understanding of evidence-base on effectiveness of falls prevention

²² Further information on this 'Functional Fitness MOT' approach is available in the Impact assessment report: <u>http://www.bhfactive.org.uk/older-adults-training-and-events-item/489/index.html</u>

²³ This is a finding reported in the Impact assessment report for the 'Functional Fitness MOT' approach, available at: http://www.bhfactive.org.uk/older-adults-training-and-events-item/489/index.html

- Increased understanding of common risk factors for falls and things to look out for
- Increased familiarity with using a very short question prompt (4Q) to screen for those at higher risk
- Increased confidence in making referrals to the falls services, and identifying any remedial interventions e.g. small home adaptations, that could be immediately recommended and expedited to reduce risk

Evaluation

The impact of this investment must be measured, and a protected sum has been allocated for evaluation purposes. This evaluation would be conducted by an external research agency or organisation, to explore the impact of the proposed model on the anticipated outcomes. Indicators for successful outcomes of falls service have been developed in other areas and can be adapted for Cambridgeshire. ²⁴ The proposed model includes system mapping and overview with capacity for further targeted investments. The evaluation would offer insight as to whether the model has been effective, and explore any improved outcomes directly attributable to specific components, which would inform future service developments.

Further investment following service mapping to pump prime falls interventions

In fulfilling the aim of increasing the effectiveness of falls prevention work, it is likely that there will initially be increased demands on local services. This would be the result of the identification of increased numbers of people who would benefit from measures to reduce their risk of falls, through the awareness-raising and health trainer activities. It is proposed that funds are set aside to pump prime surge capacity to meet this demand where necessary and ensure those identified receive appropriate interventions.

A funding allocation is also set aside to pump prime expenditure following the detailed system mapping, when key gaps in the system are identified. In particular it is anticipated that there will be some inequity in provision across the county, and opportunities for improvements in the use of evidence-based interventions, which will require further investment in services.

In recognition of the multitude of stakeholders involved in falls prevention work, the mapping and funding of capacity gaps will be informed by further strategic discussions across Cambridgeshire statutory and voluntary sector partners, including discussion of falls prevention work with the Cambridgeshire Executive Partnership Board. A detailed report will be provided to the Health Committee with proposals for year 2, in light of findings and achievements in the first year of delivery.

BUDGET AND ESTIMATED COSTS

²⁴http://www.bridgewater.nhs.uk/wp-content/uploads/2014/10/Falls-Services-Draft-Indicators.pdf

Table 6 outlines the associated costs of the proposed model described above.

Table 6: Estimated costs of proposed intervention across years 1 and 2

Component	Year 1 £	Year 2 £	Total £
Mapping, gap analysis and quality assurance	£50,000		£50,000
Community engagement via Health Trainers	£75,000	£75,000	£150,000
Awareness raising with professionals	£25,000	£25,000	£50,000
Evaluation		£50,000	£50,000
	TOTAL	ALLOCATED	£300,000
Pump priming of falls prevention services to meet demand from increased referrals, and			
address identified gaps in service	£150,000	£150,000	£300,000
	BUDGET TOTAL		£600,000
			Funding:
			non-recurrent

EXPECTED OUTCOMES

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The proposed model described above has been designed to achieve the overarching aim of improving the effectiveness of falls prevention in Cambridgeshire. The model makes use of existing service infrastructure and assets across the County which will ensure sustainability and facilitate integration across services. The proposed model would be developed together with ongoing service redesigns, currently been undertaken at a community level across the County, and enable a whole systems approach to falls prevention across providers and sectors.

There are a range of measurable indicators that can be used to capture the anticipated outcomes of this work, specifically including, but not limited to:

- Increased levels of physical activity in older people
 - Numbers of older people fulfilling physical activity guidelines
 - Specifically including increased levels in the population 75+
- Increased referral rates to support increased uptake and benefit from falls interventions
 - Referrals to the falls service from a wider range of professional groups
 - Numbers of people participating in falls-specific physical activity classes
- Increased engagement by Health Trainers with individuals and groups
 - Health Trainer activity and reporting mechanisms
- Reduction in emergency hospital admissions for injury due to falls and for fractured neck of femur in people aged 65 and over (Public Health Outcomes Framework indicators)
- Establishing a robust baseline for the numbers of new entrants to Adult Social Care as a result of a fall, and monitoring the impact of the new service model.

Further detail on the impact of implementation will be captured through a thorough evaluation of the model in year 2. The investment in this proposed business case, alongside commitments to existing services, provide a strong platform for further collaborative development of an integrated pathway, and co-ordination across the health and social care system to reduce falls. The activities in this proposal are designed to complement the interventions and services commissioned and provided by partners and stakeholders across the system, to increase the overall effectiveness of falls prevention work in Cambridgeshire.