Business Case

PROJECT MANAGEMENT TOOLKIT

Business

Cambridgeshire County Council

Project Title: Falls Prevention Programme

Date: 7th June 2019

Strategic Lead: Laurence Gibson

Project Manager: Helen Tunster

Approvals:

1. **Health Committee**

Distribution:

1. Ageing Well Strategy Board
2. Cambridgeshire and Peterborough Falls Prevention Strategy Group
3. Cambridgeshire Adaptations Steering Group
4. See Section 8 for all Key Stakeholders

The Business Case is a description of the reasons for the project and the justification for undertaking it, based on the estimated costs, risks and the expected business benefits and savings.

*It is the **most important** set of information for the project as it drives the decision-making process. It is updated if any changes occur to the project to ensure it is still aligned to the business objectives.*

Before proceeding please consider whether it may be more appropriate to develop the Business Case on Verto.

VERSION HISTORY

Version	Date	Comments/evidence of decision (hyperlink to document)
1.0	**7th June 2019**	Final Version for Sign-off
2.0	**14th June 2019**	Updated version following discussed changes
3.0	**28th June 2019**	Updated version following feedback from Advanced Chair and Lead Members' briefing group, and Cambridgeshire and Peterborough Falls Prevention Strategy Group
4.0	**2nd August 2019**	Updated with feedback from Cambridgeshire and Peterborough Falls Prevention Strategy Group, Adaptations Steering Group, CPFT and individual organisational feedback
5.0	**13th August 2019**	Review and sign-off by Laurence Gibson
6.0	**29th August 2019**	Feedback from the Health Committee Advanced Chair and Lead Members' briefing
7.0	**9th September 2019**	Feedback from significant implications

1) Project Driver

A fall is defined as an unplanned descent to the floor with or without injury to the patient. 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. The estimated cost of falls and fractures to the health and social care system in Cambridgeshire and Peterborough in 2017 was £85.5M (STP Falls Prevention Business Case, 2017). In addition to these financial costs, there are additional costs that are more difficult to quantify. The intangible human costs of falling includes distress, pain, injury, loss of confidence and loss of independence, as well as the anxiety caused to patients, relatives, carers, and hospital staff.

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 23,000 people by 2028, an increase of 18%.

Table 1 Cambridgeshire population forecasts, and % change, people aged 65 years and over

Age	2020	2024	2028	% Change 2020-2028
65+	127,900	138,500	151,300	21%

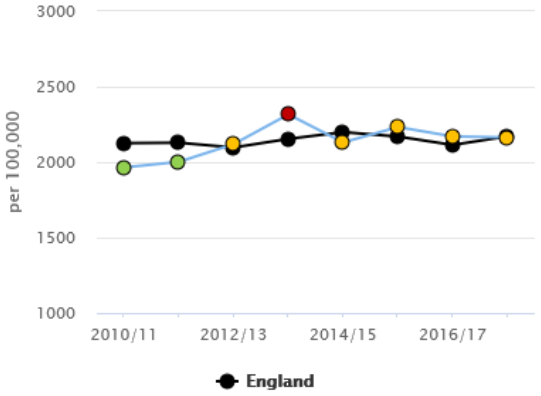
Source: ONS 2016-based subnational population projections

Incidence and outcome of falls

Hip fractures remain the most serious consequence of a fall and the most common cause of accident related death in older people. In 2017/18 in Cambridgeshire there were 2,659 people aged 65 and over who were admitted to hospital as an emergency with injuries due to falls and 654 people aged 65 and over admitted with a fracture of the hip. The rate in Cambridgeshire for falls

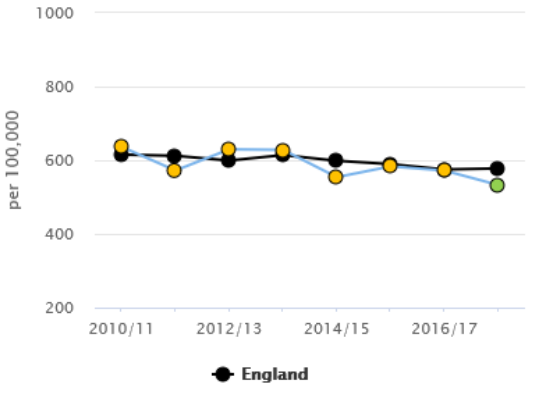
causing an admission to hospital in 2017/18 was 2,164 per 100,000, higher than the East of England region (2,026 per 100,000) but similar to the rate in England (2,170 per 100,000). In contrast, the rate of more serious falls (fractured neck of femur) in 2017/18 in Cambridgeshire was 533 per 100,000, lower than both the East of England region (577 per 100,000) and England (578 per 100,000).

Table 2 Emergency hospital admissions due to falls in people aged 65 and over. Cambridgeshire. Directly standardised rate - per 100,000



	Number	Rates per 100,000 DSR		
		Cambridgeshire	East of England	England
2010/11	1,973	1,965	1,886	2,126
2011/12	2,080	2,002	1,917	2,128
2012/13	2,291	2,119	1,973	2,097
2013/14	2,577	2,316	2,025	2,154
2014/15	2,448	2,130	2,026	2,199
2015/16	2,613	2,232	1,989	2,169
2016/17	2,600	2,170	1,974	2,114
2017/18	2,659	2,164	2,026	2,170

Table 3. Hip fractures in people aged 65 and over. Cambridgeshire Directly standardised rate - per 100,000



	Number	Rates per 100,000 DSR		
		Cambridgeshire	East of England	England
2010/11	639	636	607	615
2011/12	600	572	597	612
2012/13	683	630	601	599
2013/14	698	628	616	614
2014/15	635	554	582	599
2015/16	681	583	583	589
2016/17	684	572	579	575
2017/18	654	533	577	578

Source: PH Outcomes: accessed June 2019

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.[1] 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% 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 several associated costs of falls across health and social care. It is suggested that 55% of costs are incurred by social

[1] Craig 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.

care, mainly providing long term care following hospital discharge. The costs associated with social care after discharge are estimated at £36m[2], of which £27m are subsequent discharges to long term residential care.

Progress to date

Reducing the risk of a fall requires the active engagement of many individuals, disciplines and teams involved in caring for older people. Targeted evidence based interventions have shown to reduce falls by up to 30%, with specific programmes for improving strength and balance demonstrating reductions in risk of 55% in high-risk groups[3]. 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 to reduce the level of hospital admissions due to falling, a multi-faceted falls prevention approach is considered fundamental.

The STP Falls Prevention Programme commenced a two year pilot in October 2017, and in order to continue to address the number of falls across Cambridgeshire, an extension to the original programme is required. The STP Falls Prevention Programme was designed around the published evidence base, and findings from the Better Care Fund St Ives Falls Prevention pilot. The Programme specifically focussed on 1) Standardising provision and reducing the known local variation in quality and equitable accessibility of falls prevention services in the local community 2) Increasing the scale of delivery to reach higher numbers of older people known to be at risk of falls and 3) Building and strengthening co-ordination of the health and care system.

The STP falls prevention programme was implemented across Cambridgeshire & Peterborough with a fundamental goal to embed the most effective interventions - multi-factorial falls risk assessments and strength and balance exercise programmes - into the processes and practices of the 14 Neighbourhood Teams, Everyone Health and the new Peterborough provider, Solutions4health. The implementation was enabled by a new IT falls pathway in CPFT (driven by the STP programme/falls working group), and comprehensive training and supervision of staff as part of the STP programme. A multi-media 'Stronger for Longer' social marketing campaign was launched on 1st October 2018 to raise awareness and encourage the uptake of strength and balance programmes. Furthermore, work to strengthen system level coordination was initiated to embed the links between community pathways and pathways in acute, primary care, care home, adult social care, and ambulance/emergency services. This system integration continues to be led by the Cambridgeshire and Peterborough Falls Prevention Strategy Group reporting to the Ageing Well Strategy Board.

The evaluation of the Falls Prevention Programme showed that the programme had substantially improved the identification of people at risk of falls compared to before the programme. Almost 7000 of the projected 119,070 over 65 population (approximately 6%) in Cambridgeshire were screened for falls risk between October 2017 and September 2018, leading to the pro-active identification of over 4400 people at risk of falls (approx. 10.8% of the 40,484 at risk). Over 2430 of these had received a high quality multi-factorial falls risk assessment completed by CPFT or Everyone Health (approx. 6% of the population at risk) by September 2018, and, as a result, had an intervention plan in place to reduce their risk of falling by addressing risk factors such as underlying medical causes of falls, high risk falls medications or 4+ medications, balance and gait issues, and vision impairments. Following the assessment, nearly 750 older people had a home strength and balance exercise programme set up and were working to improve their strength and

[2] 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.

[3] 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.

balance motivated by CPFT, Everyone Health and Solutions4Health. The evaluation of the 'Stronger for Longer' campaign demonstrated an additional 101 people attending community strength and balance exercise classes in the first three months after the launch (October 2018 – December 2018). In this time, the campaign received good coverage including: Interviews on radio (BBC Radio Cambridgeshire x3 with a reach of 40K-60K adults per show) and TV (Look East News and ITV News with a reach of 250K-300K adults per show); Local Newspapers (x3); 11 community newsletters; 44 council social media posts with 10.5K older adults clicking on posts; 400 posters; and approx. 36,000 'super six' exercise leaflets distributed. This resulted in 5,000 unique visits to the Be-Well website 2,300 downloads of exercise leaflets, and 29,000 views of videos and the animation challenge.

A preliminary analysis was conducted of the impact of the programme on falls admissions to Cambridge University NHS Foundation Trust (CUHFT). The analysis indicated there were promising, but not conclusive, reductions in the number of admissions. Comparing the eight month February-September period 2017 with the same period in 2018, there was a reduction of 50 admissions due to injurious falls (assuming falls would have increased at a rate of 2% per annum). This would equate to a saving of £302,000 to the commissioner in terms of secondary care activity savings and a saving of £305,000 to social care, £174,000 of which would be realised in the first year after the prevented falls. Based on the total spend on the programme of £307,720 from the STP, Public Health and Better Care Fund and the total savings of £612,000 (including future years), the programme can be shown to demonstrate an ROI of £1.98 for every £1 spent.

Lessons learned from the evaluation report

- The programme showed a reduction in admissions due to injurious falls but the programme was not at a sufficient scale to detect a statistically significant reduction in falls admissions. Any future programme should have sufficient scale, power and duration to detect changes in admissions at a population level.
- The additional falls work for CPFT Neighbourhood Teams generated by the falls programme were not fully understood and adequately resourced at the outset of the programme. This lead to increased workloads for Neighbourhood Teams, longer waiting lists and a lower threshold of activity reached than planned. Any future programme should ensure the delivery model is adequately resourced and financially sustainable to meet the demand and increase in future demand from an ageing population.
- The level of strength and balance exercise activity of the CPFT band 4 Therapy Assistants was lower than expected in comparison to the activity of the Everyone Health Falls Prevention Health Trainers. This was due to operational issues, a broadening of roles to support Neighbourhood Teams, and the client group having a higher level of need requiring more intensive follow up.
- The use of dedicated staff for falls prevention work should be considered in future and also, opportunities should be explored to integrate and cross populate assessments with falls risk assessment questions to streamline and improve efficiency
- There is a need to utilise more robust ways to monitor the impact and outcomes of the programme, including the wider impact on other services in the system in addition to hospital admissions.

New evidence since the programme was implemented:

Further evidence has now been published;

- Home-based and group based strength and balance programmes have strong evidence of effectiveness reducing the rate of falls by 29% and 32% respectively with both demonstrating a £1:£1 financial Return on Investment (ROI) and a societal ROI of around £2.20:1 (Public Health England, 2017[4]; Public Health England 2018[5]).
- Delivery of an Occupational Therapy-led Home Hazard Assessment and Improvement Programme reduces the rate of falls by 31% and shows a good ROI (Financial ROI is £3.17:£1 spent and a societal ROI of £7.34:£1)(Public Health England, 2017[4]; Public Health England 2018[5]). The effectiveness is greatest by delivery by OTs and targeting those at highest risk of falls (People aged 65+, with a history of falls, and also possess more than one other risk factor for falls)[6&7.]
- The Falls Management Exercise (FaME) programme is effective for all older people (no previous history of falling, higher and lower functioning adult) whereas OTAGO is only effective in frailer/lower functioning older adults and high risk fallers (>3 falls in previous year and frail).

[4] Public Health England (2017). Falls and Fragility Fracture Consensus Statement. London: Public Health England. Available at: https://www.gov.uk/government/publications/falls-and-fractures-consensus-statement [Accessed 14 June 2019]

[5] Public Health England (2018). A Return on Investment Tool for the Assessment of Falls Prevention Programmes for Older People Living in the Community. London: Public Health England. Available at: https://www.gov.uk/government/publications/falls-prevention-cost-effective-commissioning [Accessed 14 June 2019]

[6] Other risk factors includes use of mobility device, requiring assistance for activities of daily living (ADLs), use of psychoactive medicines and history of falls.

[7] Pighills et al (2019). What type of environmental assessment and modification prevents falls in community dwelling older people? BMJ: 264.

The lessons learned and the new evidence suggest a number of points to address in any programme extension:

- A falls specific home hazard assessment has been integrated into the existing high quality multi-factorial falls risk assessments, and capacity would be increased with four Therapy Assistants recruited in addition to extending the contracts of the two existing Therapy Assistants.
- Delivery of the FaME strength and balance exercise programme would be scaled up and a resource has been put in to manage a number of community strength and balance classes.
- Project outputs and outcomes will be specified to monitor uptake and compliance to interventions, and appropriate IT systems will be implemented as necessary.

2) Project Overview

The aim of the programme is to prevent any increase in the rate of injurious falls and improve the quality of life and health outcomes. This will be achieved by scaling up and targeting the delivery of the existing integrated Falls Prevention programme across Cambridgeshire. The proposal includes deploying the programme in areas of greatest need to demonstrate that an intensive local programme could reduce falls. This will provide a local evidence base to support a future funding requirement from the wider NHS and local government health and care systems.

It is proposed to extend the Falls Prevention Programme by a period of three years and reshape the programme in line with the lessons learnt so far and the emerging evidence base. The aim of the programme is threefold; 1) to deliver integrated Multi-Factorial Falls Risk Assessments (MFFRAs) with OT-led home hazard assessments and modifications in areas of greatest need; 2) to refocus the Falls Prevention Health Trainer service to deliver a programme that is effective in a greater cohort of the population, and; 3) to strengthen and pump prime the strength and balance classes run in the community.

1. To extend the number of MFFRAs incorporating a comprehensive, validated, functional home hazard assessment tool (Westmead Home Safety Assessment tool) with accompanying modifications proven to reduce falls. This will be through deployment of an additional four Band 4 CPFT Therapy Assistants in a particular geographical area(s) and through the activity of the two current Band 4 Therapy Assistants.

   1.1 The current programme is delivered by two Therapy Assistants and core Neighbourhood team staff across Cambridgeshire. While the take up of the existing programme has been successful, it is noted that it is not of sufficient scale to demonstrate an impact on admissions across Cambridgeshire[8]. Across Cambridgeshire there is a potential demand for 6000 MFFRAs per year (CPFT data, 2018/19), which would require an additional 13.6 Therapy Assistant staff[9] at an individual salary cost of £33k, and anticipated equipment and adaptations costs of between £2.8k and £27.8k per Therapy Assistant (Appendix 1). The proposal therefore seeks to implement the same level of programme intensity but to deliver it in a smaller geography within Cambridgeshire. The combined cost is £132k for the four additional salaries (two salaries are planned to be mainstreamed to support sustainability) and £10.6k housing equipment / adaptations. Wet room adaptations are funded through the DFG and are excluded from these predicted costs, but at this scale could equate to £100k.

[8] To demonstrate a statistically significant reduction, it is estimated that 134 admissions per year would need to be prevented in people aged 75+ or 163 admissions per year in people aged 65+ (based on 2018/19 SUS admissions data). To prevent this number of injurious falls, it is estimated that 6000 people who have fallen would need to receive a MFFRA/year.

[9] 13.6 staff would be expected to complete 3843 MFFRAs. This is in addition to the 2321 non-integrated MFFRAs conducted by core Therapy Assistant staff in all 14 neighbourhood teams in 2018/19 which are expected to continue as core business.

1.2 In order to identify which area(s) to deploy the integrated assessments, an options framework was developed (Appendix 3). The framework took into account the areas with the highest rate of falls related hospital admissions and the feasibility of implementation (Appendix 4 & 5). Two options are presented.

Option 1: Deployment at a locality level: 'Cambridge' locality.

Option 1 proposes to target older people in Cambridge City and South Cambridgeshire in full alignment with the CPFT locality of 'Cambridge' thus facilitating feasibility of operational delivery and maximum intensity in a concentrated area.

The option is proposed for the reasons outlined (Appendix 4):

- Rates of hospital admissions. Compared to the other two locality areas, Cambridge CPFT locality has the highest rate and number of hospital admissions due to falls; the highest number of admissions due to fractured neck of femur; the largest 65+ population; and highest population at risk of falls. Analysing the admissions data on a smaller geographical level shows that the Cambridge CPFT Locality has two of the top three Primary Care Network (PCNs) with the highest rates of admissions due to falls (Appendix 6). The area has also demonstrated the highest level of demand for MFFRAs between 1 January and 31 June 2019.
- Feasibility of implementation. CPFT have indicated that Cambridge locality would be the preferred option due to: availability / recruitment of staff; strong leadership skills of the Neighbourhood Team Leads; enthusiasm and engagement of Occupational Therapy and Physiotherapy staff; and the opportunity to link with the development of a joint CPFT, CUH and PCN frailty pathway/programme. The urban nature of Cambridge City will also facilitate easier access to the programme in terms of transport and venue provision.

Option 2: Deployment at district level: Cambridge City and Fenland

Option 2 proposes to target those areas with the highest rates of falls at a District level, which are Cambridge City and Fenland.

The option is proposed for the reasons outlined (Appendix 5):

- Rates of hospital admissions.
  - In Cambridgeshire, Cambridge City has the highest rate of any admission relating to a fall and Fenland has the highest rate of falls resulting in a hip fracture. However care should be taken in the interpretation of the Appendix 5, in terms of statistical significance only the rates of any admission relating to a fall in Cambridge is significantly worse than the rates in the whole East of England region. There is no statistically significant difference for falls with a hip fracture between the district areas and the East of England.
  - Analysing the admissions data at Primary Care Network (PCN) level shows that the PCN for the Wisbech Neighbourhood Team, has the highest rate of falls in the 75+ age group in Cambridgeshire and Peterborough, and is the only PCN with a statistically significantly higher rate of admissions compared to the CCG average[10] (Appendix 6). Cambridge City has two of the top three PCNs with the highest rates.
  - Fenland is ranked as the most deprived district for older people and Cambridge is the next most deprived.

[10] It should be noted that the PCN with the highest admissions (statistically significant compared to the CCG average) is PCN 15 which corresponds with the Wisbech NT in Fenland (worse off).

1.3 The home modifications required as a result of the assessment includes necessary equipment, minor adaptations and major adaptations which are delivered by different providers, some of which require grants (Appendix 1). It is proposed that funding (£10.6k) for equipment and minor adaptations for CPFT be administered via the Integrated Community Equipment Service (ICES) budget overseen by Cambridgeshire County Council. This is in line with current arrangements with CPFT as part of the existing Section 75 Community Occupational Therapy for Adults (Integrated Service) contract.

1.4 The Disability Facilities Grant (DFG) is used to fund major adaptations. The use of the grant is for negotiation with each District Council. Those areas with a fully utilised grant may incur further demand of up to £100k. (Appendix 1).

1.5 In terms of activity, it is anticipated that the four Therapy Assistants will be able to complete 960 MFFRAs/year which is expected to prevent 230 total falls per year (non-injurious and injurious)[11] of which 23 would be injurious and require medical attention. The need for people requiring evidence based falls prevention interventions exceeds the reach per year and thus a diminishing effect is not expected in the first three years of programme delivery.

2. To expand the Everyone Health Falls Prevention Health Trainer service by one member of staff, and to deliver the FaME (Falls Management Exercise) programme to target a population at a lower risk of falls, and prevent falls from first occurring. The FaME programme consists of 24 weekly classes per cohort with motivational support provided. A time for socialising after each class is planned to facilitate social connectedness.

2.1 Each Falls Prevention Health Trainer will be able to deliver approximately 12 FaME programmes per year consisting of cohorts of up to a maximum of 15 people per programme, with an anticipated attendance of 100 people per trainer. It is expected that this would prevent 90 falls per year of which 9 could be injurious and result in a hospital admission.

3. To commission a community provider(s) to deliver up to five cohorts of the FaME programme to support the Falls Prevention Health Trainer service in areas of high demand. This will enable up to 75 people to access the programme at the earliest opportunity when motivation is high. It is expected that this would prevent 14 total falls of which one hospital admission may be prevented.

4. To continue a 0.6WTE co-ordinator post based within the charity, Forever Active (Forum Ltd). The Development Officer post, originally funded for 3 years by CCC Adult Social Care, has been instrumental in increasing the availability and accessibility of strength and balance classes (and other physical activities for the 50+) across Cambridge City, South Cambridgeshire, East Cambridgeshire and Fenland. The role will support co-ordination and sustained delivery of more than 45 open access community strength and balance classes offering up to 640 weekly places[12] across the aforementioned districts. In addition, it will set up new physical activity opportunities to prevent the age-related decline in muscle strength, bone health and balance for the 50+, including strength and balance classes, tai chi, ball sports etc.

5. To pump-prime community level 4 strength and balance classes, especially focussing on areas of low provision (Fenland and East Cambridgeshire). This will enable people to exit the FaME

[11] Injurious falls are defined as falls that result in injuries requiring medical attention
[12] Based on a maximum strength and balance community class size of 14.

programme and continue with equivalent level strength and balance exercise in the community (at a charge). In addition, it will enable higher functioning adults in the community to access a class directly thereby supporting a lifecourse approach to strength and balance and early intervention. The classes will be quality assured by CPFT employed exercise specialists.

6. To raise awareness of falls prevention messages through the Stronger for Longer campaign working group. The proposal is to continue the 'Stronger for Longer' marketing campaign, which may include the following: 1) the printing of more of the successful super six leaflets 2) a primary prevention falls leaflet designed to help people identify their risk factors for falling as the risk emerges and take appropriate action to reduce their risk 3) Promotion of evidence based activities to slow the natural decline and preserve strength, balance and bone health, in younger older adults 60+ years.

3) Project Objectives

- Implement an integrated multi-factorial falls risk assessment containing an evidence-based home-hazard assessment tool
- Target at risk older people that are most likely to benefit
- Ensure 960 people receive the integrated multi-factorial falls risk assessment with home-hazard assessment and necessary home improvements
- Ensure the people requiring equipment and adaptations receive it
- Ensure programmes are specified with explicit criteria and process KPIs
- Initiate delivery of the FaME programme to ensure a more effective strength and balance exercise programme is in place to reduce the risk of falls in a wider spectrum of older people with both high and low functional abilities
- Increase the number of people taking up and completing the FaME programme
- Increase the number of people maintaining their increased level of strength and balance following a FaME programme through attendance at community classes and/or continuing the exercises at home
- Strengthen the onward referral pathway to signpost people completing the FaME programme to a range of existing local physical activity pathways and activities to maintain their level of strength and balance, specifically focussing on activities proven to contribute to strength, balance and bone health (see [13,14])
- Improve and maintain system-level integration and join-up of partners across the system
- Increase awareness of falls prevention messages to the public.

[13] Public Health England (2018). Muscle and bone strengthening and balance activities for general health benefits in adults and older people: Summary of a rapid evidence review for the UK Chief Medical Officers' update of the physical activity guidelines. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721874/MBSBA_evidence_review.pdf [Accessed 28 June 2019]

[14] Activities include: Resistance training, Circuit training, Ball games, Racquet sports, Nordic Walking, Tai Chi, Yoga, Dance, Running, and Cycling

4) Key Benefits

Key Benefit	***Measure***	***Baseline***	***Target & Timescale***
To prevent any increase in hospital admission rates due to injurious falls	Observed **number** of emergency hospital admissions for injuries due to falls in persons aged 65+ Age standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+	There were 2,164 admissions per 100,000 over 65s in 2017/18 (Public Health Outcomes Framework, 2019) A baseline will be specified to represent the chosen area(s)	No more than 2164 over 65s admissions per 100,000 from 2020 - 2023
A reduction in the rate of self-reported falls post intervention	The number of falls per person per year Numerator: No. of falls reported in the completers Denominator: Total no. of completers	Baseline to be obtained from individuals pre-intervention	Target: 20% of completers. 960 people expected to receive an integrated MFFRA and interventions per year from the four CPFT Therapy Assistants (excludes non-integrated assessments of core staff across Cambs). 500 people are expected to receive a FaME programme from the Everyone Health Falls Prevention Health Trainers (FPHT). Up to 75 people are expected to receive a FaME programme from additional provider(s). **109 people will also receive a non-integrated MFFRA by the FPHT but this has been omitted to avoid potential double counting.*
Delivery of an effective, high quality, integrated assessment to improve an individuals' proxy falls risk functional outcomes	No. of integrated multi-factorial risk assessments completed by staff No. and % of patients completing at least 75% of their intervention plan	New assessment and therefore no baseline.	960 integrated assessments completed per year by 4x CPFT staff* **dependent on contract negotiations*
An improvement in an individuals' proxy falls risk functional outcomes following completion of a FaME exercise programme	Number and % improving: 1) static balance and the mean improvement 2) timed up and go score and mean improvement 3) sit to stand score and mean improvement 4) level of concern for falling and mean improvement	Baseline to be obtained from individuals pre-intervention	Target: 30% of completers* Approx. 575 people attending the FaME exercise programme per year, Falls Prevention Health Trainers (n=500) and 5 community programmes (n=75). **excludes those starting at the highest level and therefore not able to make an improvement*

Key Benefit	*Measure*	*Baseline*	*Target & Timescale*
People progressing to a community class to maintain strength and balance post intervention or self-reporting exercising at home	% who have carried on exercising post intervention	Placeholder - Data not currently collected	25% of completers
Positive patient experience of the falls prevention pathway	Qualitative feedback	Placeholder – No robust data collected currently	70% reporting a positive experience

5) Project Interdependencies

1) The programme is awaiting the outcome of contract negotiations with the STP to continue to fund the Locality Falls Leads which are required to supervise the six 'falls prevention' specific Therapy Assistants
2) The programme has some dependency on the provision of housing improvements, funding streams and funding eligibility requirements of:
    a. Home Improvement Agencies (HIAs) – the HIAs provide major adaptations, such as wet rooms, ramps, and stair lifts, which are means tested and funded through the Disability Facilities Grants (DFGs) (the grants are provided from central government via the BCF and are administered locally via CCC),
    b. Council Adaptation Services – responsible for providing adaptations for tenants of local authority housing stock using the Housing Revenue Account. Only Cambridge City and South Cambridgeshire District Councils have a housing stock. The housing stock of East Cambridgeshire, Huntingdonshire and Fenland moved over to social landlords (registered providers) predominantly Sanctuary Housing Association, Chorus Group (formerly Luminus) and Clarion, respectively.
    c. Age UK Handyperson Service – A chargeable service for the provision of repairs and maintenance services such as small plumbing jobs and grab rails; hospital discharge service; checks around the home (such as energy, fire and security), first-contact and referral services and other housing maintenance related services to older individuals at a very low cost to mainly owner occupiers or private sector tenants. Funded by all five Cambridgeshire District Councils until March 2021.
    d. Specialist Housing Advisors – the Advisors support clients to consider relocating homes as a different option to expensive major adaptations. Funded by CCC.
3) The completion of a high quality, comprehensive MFFRA requires primary care to assess underlying medical causes of falls and onward referrals to specialist services if required, and conduct medication reviews (including osteoporosis medication and management)
4) The continued delivery of quality assured strength and balance exercise specifically to prevent falls is dependent on the CPFT Clinical Specialists to continue to provide quality assurance and providers of classes - our key delivery Cambridgeshire partners are Forever Active, One Leisure (Huntingdonshire District Council), and Oak Activities Limited.
5) The delivery and promotion of appropriate physical activities to prevent the age-related decline in muscle strength, bone health and balance for the 50+ is dependent on linking with those activities being offered by existing providers/projects and developing opportunities to fill in any identified gaps. Providers include the aforementioned providers, existing services such as Everyone Health lifestyle service, Living Sport, and Let's Get Moving Co-ordinators, and others yet to be identified.
6) The identification and referral of those at highest risk of falling to CPFT from key partners such as at CPFT triage, hospital discharge, CCC through Reablement and the Enhanced

Response Service, and community providers such as Cambridgeshire Fire and Rescue Service through Safe and Well Visits and Age UK.

7) This programme will be integrated within the Adults Positive Challenge Programme and will contribute to the existing Adults Positive Challenge recurrent savings target of £3.8M in 2020/21.

6) In Scope

- To extend the number of Multi-factorial Falls Assessments (MFFRAs) integrated with home hazard assessments and home adaptations/equipment. To expand the team by an additional four Therapy Assistants. **Total cost £142k p.a. (Appendix 2)**
- To expand the Falls Prevention Health Trainer Team by one member of staff, and to deliver the FaME (Falls Management Exercise) programme to target a cohort of people at a lower risk of falls. **Total cost £51.3k p.a.**
- To continue the 0.6WTE Forever Active Coordinator post. The role will support co-ordination, set up and maintenance of open access community strength and balance classes. **Total cost £20k p.a.**
- To commission a community provider(s) to deliver the FaME programme. Quality assurance of provision through CPFT employed exercise specialists. **Total cost £13.4k p.a.**
- To join-up with existing providers/projects to promote, develop and implement existing and new physical activity opportunities to prevent the age-related decline in muscle strength, bone health and balance for the 50+. To include pump-priming of quality assured level 4 strength and balance classes and activities such as tai chi, resistance training and ball sports. **Total cost £20.4k p.a**
- Implement a falls communications strategy. The proposal is to continue the marketing campaign to target those who may or may not have fallen. **Total cost £10k p.a.**
- Formal evaluation this programme. The proposal details the number of metrics which we believe will demonstrate the effectiveness of the programme. However, an in-depth and independent evaluation should be commissioned to advise further specification. Subject to negotiation. **Total cost £33k p.a.**

7) Out of Scope

The proposal described does not include;

- The existing Everyone Health Falls Prevention Health Trainer service. This service has four staff, and is funded from within existing Public Health revenue. The service delivers the MFFRAs and strength and balance programmes, and through an existing contract variation will deliver the FAME programme to target people at a less advanced stage of functional decline
- The Falls Clinical Lead, Falls Clinical Exercise Specialist and Falls Locality Leads currently funded by the STP
- OTAGO strength and balance exercise programme delivered by the six Therapy Assistants – OTAGO exercise programmes will be delivered by other staff as part of core CPFT business
- In-depth work with Care Homes
- Cambridgeshire County Council Enhanced Response Service (provides a lifting service for Lifeline users) for management of people who have fallen and are unable to get off the floor and referral for an MFFRA
- Cambridge University Hospital NHS Foundation Trust (CUHFT) Fracture Liaison Service
- Cambridgeshire Fire and Rescue Service Safe and Well Visits
- Cambridgeshire Home Improvement Agency Occupational Therapy Bathing pilot
- Early Intervention Vehicle Business Case proposal of East of England Ambulance Service

8) Key Stakeholders

Stakeholder	Involvement	Best way to communicate with them
CCG (Dr Catherine Bennett, Alecsandra Mecan, Ellie Addison)	Contact sought from the CCG lead for falls, to ensure partnership fit of the proposals	Email
CPFT (Annami Palmer, Karen Hurst, Elaine Young, Poonam Hyland, Annemie Waaning, Carol Claxton, Simon Hanna)	To discuss proposals for operational feasibility, and specification	Email or telephone
Adult Social Care CCC (Diana McKay, Lisa Sparks, Jane Crawford-White, Rebecca Bartram)	To raise awareness and opportunities for programme integration with ASC and the Community Occupational Therapy Integrated service with CPFT	Email or telephone
Cambridgeshire Home Improvement Agency (Frances Swann)	To ensure operational and strategic fit	Email or telephone
Age UK (Andrew Morris, Sarah Thomson)	Interdependency with Handyperson Service	Meeting
Everyone Health (Brigitte McCormack, Ryan Chillingworth)	To discuss proposals for operational feasibility, and specification	Meeting
Forever Active (Jane Jones)	To discuss proposals for operational feasibility, and specification	Meeting
Huntingdonshire District Council (Jo Peadon and Angie Skipper)	To discuss and develop proposals around the exercise and housing components	Email or Strategy/Steering Groups
East Cambridgeshire District Council (Liz Knox and Sophie Edwards)	To discuss and develop proposals around the exercise and housing components	Email or Strategy/Steering Groups
South Cambridgeshire District Council (Lesley McFarlane, Ellen Bridges, and Julie Fletcher)	To discuss and develop proposals around the exercise and housing components	Email or Strategy/Steering Groups
Cambridge City District Council (Carrie Holbrook and Helen Reed)	To discuss and develop proposals around the exercise and housing components	Email or Strategy/Steering Groups
Fenland District Council (Dan Horn and Kate Squires)	To discuss and develop proposals around the exercise and housing components	Email or Strategy/Steering Groups
Living Sport (Michael Firek, Rebecca Evans	To discuss and develop proposals around the exercise component	Email or telephone
Cambridgeshire Fire and Rescue service (Paul Clarke)	Join up with Safe and Well visits and member of Strategy Group	Email or telephone
Ageing Well Strategy Board	To consult and gain feedback on proposals	Meeting or email
Falls Prevention Strategy Group	To consult and gain feedback on proposals	Meeting or email
Adaptations Steering Group	To consult and gain feedback on proposals	Meeting or email

1) Delivering the Programme

Project management and governance

The options within the proposal relate to the scale of Home Hazard Assessments, and the recruitment of additional support for the Health Trainer team. The Forever Active Coordinator post and Community Classes in Fenland and East Cambridgeshire are time extensions of the existing provision. All aspects of the proposal remain the responsibility of the Falls Programme Manager within the Public Health department and will continue to be reviewed by the Falls Prevention Working Group.

All projects within the Programme will be managed by the Falls Programme manager, quarterly monitoring reports will be prepared and shared at the Falls Prevention Working Group. In addition the housing adaptations or aids to mobility will be managed, within a capped budget over the course of each year. The potential demand is a recognised risk to the project, detailed adaptation and aid costings will be specified and agreed before the project commences.

Commissioning and procurement

Option 1 (Section 75) : Under Section 75 of the NHS Act 2006 (as amended), the Secretary of State can make provision for local authorities and National Health Service (NHS) bodies to enter into partnership arrangements in relation to certain functions, where these arrangements are likely to lead to an improvement in the way in which those functions are exercised. The specific provision for these arrangements is set out in the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. The regulations sets out how partners can enter into arrangements whereby a NHS body may exercise the prescribed health-related functions of local authorities.

There are also a number of contracts that are excluded from the scope of the Public Contracts Directive. Articles 12 of the Directive outline situations whereby Public contracts between entities within the public sector are excluded. The establishment of a section 75 whereby delegation of duties are assigned to the Health Authority are not required to be procured.

The risks of pursuing this option may be mitigated by issuing a Voluntary Ex-Ante Transparency Notice (VEAT) outlining the proposed arrangement. A VEAT notice is a means of advertising the intention to let a contract without opening it up to formal competition evidencing that under the "Duty of Best Value" the arrangements being proposed secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness.

Timescales: VEAT Notice published, following a 10 day standstill.

Option 2 (Tender)

A procurement could be undertaken for the service under the EU Light Tough Regime. This would open the opportunity to any supplier that were able to demonstrate the ability to provide the service as outlined in the service specification. The benefits of a tender is that it could create efficiency or savings, however if the market is small the tender may not be able to deliver the required number of suppliers to make the competition viable.

Timescales:

- Pre-procurement (specification/ terms and conditions/ evaluation criteria/scoring/pricing will all need to be done prior to going to the market) 2 Months
- Procurement- once live the suppliers would be given 30 days to respond

- Evaluation- evaluation of the bids can be time consuming and a moderation will also need to be undertaken 1 month
- Award- 10 day Alcatel period
- Contract Award
- Mobilisation- 2 – 3 months (if new supplier)

Recommendation

Due to the successful programme so far and extension of existing streams of work, the recommendation is to commission this proposal as a Section 75 agreement with a full contract specification and monitoring process.

Is a Community Impact Assessment Required for this Project?

YES ☐ *<insert hyperlink here>*
~~NO~~ ☐ *<give the reason this is not required>*

Costs of what will be delivered?

Summary of estimated project costs (see separate template (http://camweb/Projects/tools/)	Next financial year (2019/20)	Year 2/3
Project running costs	£257.1k	£257.1k
Project Implementation costs	Met as part of existing staff roles	Met as part of existing staff roles
Procurement costs (Revenue costs - i.e. on-going costs such as contact maintenance)	-	-
Equipment / Property (Capital - one off costs i.e. new Library Management System)		£33k (Independent evaluation)
Total	£257.1k	£290.1k

2) Benefits

Cashable benefits (savings)	Current financial year	Next financial year
No cashable savings		
Total		

Non-cashable benefits	Current financial year	Next financial year
Evidenced based programmes demonstrate a reduction in falls, additionally research estimates the costs incurred to the health and care system as a result of falls[15] 24% of those completing a MFFRA or 26% completing a 6 month FaME S&B programme[16] will have a reduced rate of falls. Assuming the above, the expected reduction in falls are calculated as: **1) <u>For 960 people receiving an MFFRA/year</u>** 230 total falls prevented per year and 23 injurious falls (See Appendix 7, Table 1) *Assumptions: 100% uptake and implementation of the MFFRA and modifications, 24% effect size.* **2) <u>For 575 people attending the FaME programme/year</u>** 104 total falls prevented per year and 10 injurious falls (see Appendix 8, Table 1) *Assumptions: 100% uptake, 70% completion rate, 26% effect size in completers.* **N.B. There may be some degree of double counting with some clients having a MFFRA and a Strength and Balance programme. However, there may be an additive/synergistic effect in preventing falls with multiple interventions having a greater effect on reducing falls as the individual risk factors are likely to act independently of one another.**	£243k (adjusted for long term residential placements avoided over 27 months.) **1) <u>MFFRAs</u>** Total health and social care system savings anticipated as £208k The cost saved for Social Care is estimated as £114k relating to those clients discharged to home, residential care (short-term), and residential care (long-term, based on an average 27 month residency). (Appendix 7, Table 2.) **2) <u>S&B programmes</u>** The total health and social care system savings anticipated as £90.4k The cost saved for Social Care is estimated as £49.8k (Appendix 6, Table 2) relating to those clients discharged to home, residential care (short-term), and residential care (long-term, based on an average 27 month residency). (Appendix 8, Table 2). Further savings can be expected for other aspects of the programme, but predicting these savings is less robust.	£298k

[15] Craig 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.

[16] Iliffe S, Kendrick D, Morris R, et al. Multicentre cluster randomised trial comparing a community group exercise programme and home-based exercise with usual care for people aged 65 years and over in primary care. Health Technology Assessessment 2014;**18**(49):vii-xxvii, 1-105

3) Key Risks

- Project ownership and management. Current project and specification rests with two CCC employees. Mitigation is for a detailed contract and correspondence log to be stored on shared folders. Team members' roles and responsibilities stated on project implementation plan.
- Provider compliance to specification. Mitigation is that compliance will be sought during procurement, and monitored / sanctioned at subsequent quarterly monitoring meetings.
- Continuation of existing community provider (CPFT). Mitigation is to issue the specification through Section 75, and publish a VEAT notice to ensure legal compliance.
- Conflict resolution and incident management. Mitigation is that the team procedures will be written and stored centrally to detail the procedure to resolve conflicts, report clinical and information governance incidents and when to escalate to Senior Management specified within the project implementation plan.
- Recruitment to key staff is unsuccessful (Therapy Assistants, Falls Prevention Health Trainer, Forever Active Coordinator). Mitigation is to ask stakeholders of the risk before project implementation, and to monitor initial recruitment and retention of staff in quarterly monitoring meetings.
- The STP currently fund the Falls Clinical Lead, Falls Clinical Exercise Specialist and three Locality Falls Leads. The programme is dependent on supervision provided through the STP funded work stream to the six additional staff. If the STP funded work stream expires, additional managerial costs will need to be considered (Approx. £55k per Locality Lead) and/or alternative mechanisms of providing line management via the existing Neighbourhood Team Leads.
- Clinical supervision (Occupational Therapy) for the Therapy Assistants becomes compromised and ineffective. Mitigation is to specify clinical supervision within the contract specification and monitor compliance in quarterly meetings.
- Inability to provide high quality and routine process and outcome monitoring. Mitigation is to clearly specify requirements within contract specifications and seek assurance IT capabilities are scrutinised during contract agreement.
- Agreement of validated outcome measures. Mitigation is for clinical specialists to be involved in the contract specification.
- Future funding of Disability Facilities Grant (DFG). There is currently an underspend on the DFG in Cambridge City, South Cambridgeshire and East Cambridgeshire, however, this may change as is dependent on future funding allocation.
- Demand for housing adaptations and equipment. The budget for housing adaptations and equipment will be capped, demand will be carefully monitored in the first quarter of the programme to predict what level of adaptations can reasonably be supplied within the programme budget.
- There is a risk that the programme will create unexpected impact on capacity and financial pressure on other services. Mitigation is to gain agreement of providers to provide relevant data that would allow the monitoring of the impact and further management. In addition, to consider ways the Therapy Assistants can manage impact on service capacity by increasing their knowledge and skills to have productive conversations about relocation or Technology Enabled Care (TEC).
- Agreement of the target geographies for the programme. Mitigation is to highlight rationale of why a particular locality is chosen in terms of feasibility of project implementation and the relative rate of falls in the locality (Appendix 4 &5).
- Patient consent to identifying their record on a GP register for follow up and linkage to hospital data to determine subsequent falls admissions. Mitigation is for staff to seek

consent at earliest opportunity on the patient pathway, and to assure client that only a qualified health care professional will provide the follow up call, any that patient identifiable data used for data linkage will be done so in line with the GDPR and local LA and NHS policy.

4) Key Milestones - High Level Plan

Milestone Point/ Task/Phase	Date	Dependency/ Interface	Overall Responsibility	Resources agreed? Yes/No
Decision to proceed	19 September 2019		Health Committee	
Procurement process approved	30 September 2019	Section 75 decision, if full tender required project timescale will extend	Laurence Gibson	
Contract signature	31 October 2019	Provider compliance with specification	Laurence Gibson	
Job description and recruitment processes	1 November 2019 – 31 March 2020	Specification of roles Job evaluation and HR approval	Laurence Gibson	
IG assurance	31 December 2019	IG approval process across LA and any NHS requirement	Laurence Gibson	
Media and publicity materials, drafted and printed	28 February 2020	CCC Communications	Laurence Gibson	
Monitoring report technical compilation	31 March 2020	CPFT IT infrastructure	Laurence Gibson	
Project Start	1 April 2020	Provider contract	Laurence Gibson	
Quarterly monitoring meetings	1 April 2020 – 31 March 2023		Laurence Gibson	
Routine quality inspection of community based classes	1 April 2020	CPFT role description	Laurence Gibson	
Annual evaluation and client satisfaction report	1 April 2021		Laurence Gibson	
Project Closure	**31 March 2023**		Laurence Gibson	

10.6 Resources needed to deliver the project (please show days per month (full time equivalent)), if not known at this stage please show as to be confirmed) *(Note - this section maybe replaced by a reference to a full MS Project Plan if required)*												
Resource	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Sponsoring Service (Public Health)	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE	1 WTE
CCC Service Transformation Team												
Internal CCC Public Health Intelligence	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month	2 days per month
Internal CCC Supervision (Consultant in PH)	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.1 WTE
Internal CCC Other 3												
LGSS HR												
LGSS IT												
LGSS Finance	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month	1 day per month
LGSS Audit												
LGSS Property												
LGSS Legal												
LGSS Other 1												
LGSS Other 2												
External Resources 1 (program staff)	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE	7.2 WTE

Appendix 1

Table: Local quantification of the cost of home modifications recommended (A return on investment tool for falls prevention, PHE, 2018)

	Offered to	Take-up rate	Local cost per modification	Notes	No. of modifications expected based on 960 MFFRAs/yr	Total cost of modifications based on of 960 MFFRAs (£)	Recipient of funding
Use non-slip bathmat	24%	54%	n/a	These would be self-funded	0	£0	n/a - self-funded
Add rail to stairs (bannister rail)	12%	19%	£49.53	Based on a 3m rail, £16.51/m via NRS contract. Includes materials and labour	33	£1,084	ICES - Community Equipment Service
Move electrical cord	12%	67%	£10	Assumes 1 hour of labour time	116	£772	ICES
Add grab rails	15%	78%	£12	Could be done by either Age UK or NRS contract. NRS contract is average £3 per rail + delivery & fit of £9.17	168	£1,348	ICES or Age UK Handyperson Scheme
Use a raised toilet seat	24%	54%	£16.16	£6.99 for RTS + £9.17 delivery	187	£2,011	ICES
Add shower seat	13%	83%	£29.17	Approx. £20 + delivery of £9.17	155	£3,022	ICES
Use of a rollator walking frame	20%	58%	£21	£12 + delivery of £9.17	167	£2,339	ICES
Wet room conversion	10%	20%	£5,800	£5800. Mandatory through the DFG. Means tested. Assumed 90% were eligible for DFG and 10% self-funded	26	£100,224	Home Improvement Agency
Total equipment and minor adaptations (excludes wet rooms) ALL FOUR THERAPY						**£10,574**	
Total equipment and minor adaptations (excludes wet rooms) PER THERAPY						**£2,644**	
Total equipment and minor adaptations (includes wet rooms) (£) ALL FOUR THERAPY						**£110,798**	
Total equipment and minor adaptations (includes wet rooms) (£) PER THERAPY						**£27,700**	

Appendix 2

Table 1: Summary of delivery costs

	Project costs per annum*
Four Therapy Assistants (salary)(£33k each)	£132,000
Equipment and adaptations	£10,578
Additional Falls Prevention Health Trainer (salary & associated costs)	£39,488
Additional room hire and equipment for FaME delivery by 4x existing Falls Prevention Health Trainers	£11,798
Forever Active Co-ordinator (salary) and classes	£20,000
Deliver 5x FaME programmes	£13,419
Physical activity opportunities for muscle strengthening, bone health and balance	£20,361
Communications	£10,000
Independent evaluation	£33,000
TOTAL	**£290,644**

*Assumes no funding is required from Public Health for major adaptations

Appendix 3

Defining the criteria for choosing a Cambridgeshire locality in which to deliver an intensive falls prevention programme.

The Falls Prevention programme is an evidence based programme operating across different levels of at-risk individuals in different settings. It has been proposed that the programme is not of sufficient scale across Cambridgeshire and Peterborough to demonstrate an observed reduction in the rate of falls requiring hospitalisation. In order to demonstrate the effectiveness of the programme a single locality will be targeted with an intense programme. The targeting will be monitored and evaluated with the intention of demonstrating impact and therefore rolling out a highly specific programme across Cambridgeshire. This paper sets out how the Cambridgeshire and Peterborough Falls Prevention Strategy Group will assess and recommend the locality to be targeted.

The framework chosen consists of a Corporate view, a Comparative Analysis and an Epidemiological assessment.

The Corporate view will be provided through the C&P Falls Prevention Strategy Group. The group **will/have** agreed the criteria and associated weightings with each locality being scored against a number of criteria. The criteria are;

- Alignment with District objectives
- Availability and recruitment of staff
- Positive culture and attitude of staff towards falls prevention and new initiatives
- Transport availability
- Acceptability of Community organisations, Charities, and Voluntary groups
- Room availability
- Availability of Disability Facilities Grant

The **comparative and epidemiological views** concern the number of people at risk, now and in the future, and the number of injurious falls requiring hospitalisation, and the number of fractured neck of femurs. The criteria are;

- Assessed local demand for the service
- Current population size 75+
- Future population size 75+ in 2025
- Present size of high risk groups
- Rate and number of injurious falls
- Rate and number of fractured neck of femurs
- Number of Care homes

Appendix 4

Table 1: Comparison of comparative and epidemiological views by CPFT localities

	'Cambridge' CPFT Locality area (approx. covers Cambridge City and South Cambridgeshire districts)	**'Ely and Fenland' CPFT Locality area (approx. covers East Cambridgeshire and Fenland districts)**	**'Huntingdonshire' CPFT Locality area**
Assessed local demand for the service – *No. of MFFRAs completed 1 Jan – 30 June 19*	451	266	335
Current population size 65+ (2018/19)	48,699	34,795	31,715
Estimated high risk group population	16,558	11,830	10,783
Rate of admissions due to injurious falls in 65+ in 2017/18	2,156 per 100,000	2,121 per 100,000	1,908 per 100,000
Number of admissions due to injurious falls in 65+ in 2017/18	1050	738	605
Rate of fractured neck of femurs in 65+ in 2017/18	513.35 per 100,000	514.44 per 100,000	567.55 per 100,000
Number of fractured neck of femurs in 65+ 2017/18	250	179	180
Number of Care homes	Cambridge = 17 South Cambs = 31	East Cambs = 31 Fenland = 28	Huntingdonshire = 35

Appendix 5

Table: Comparison of comparative and epidemiological views by district

		East of England	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire
Current population size 65+ (2018/19)		122,764	16122	17842	23008	35209	30583
Estimated high risk group population		41,740	5481	6066	7823	11971	10398
Hip fractures 65 and over	Rate*	577.0	527.4	462.4	592.9	558.4	514.7
	Count	7,151	94	82	137	184	157
Hip fractures 65 - 79	Rate*	243.8	269.6	158.6	267.8	244.6	215.8
	Count	2,049	28	20	43	61	45
Hip fractures 80 and over	Rate*	1543.3	1275.0	1343.2	1535.9	1468.3	1381.3
	Count	5,102	66	62	94	123	112
Emergency hospital admissions due to falls 65 and over	Rate*	2026.3	2590.7	2013.6	2176.6	2055.9	2123.2
	Count	25,066	467	356	506	678	652
Emergency hospital admissions due to falls 65 -79	Rate*	916.1	1263.2	751.8	951.2	955.8	875.8
	Count	7,728	133	95	152	238	185
Emergency hospital admissions due to falls in people 80+	Rate*	5245.8	6440.5	5672.7	5730.5	5246.0	5740.5
	Count	17338	334	261	354	440	467
Income Deprived Older People - 2015 Index			12.7	11.7	16.4	9.6	8.4
Care Homes	142		17	31	28	35	31

*Directly age standardised rate per 100,000

Table 1 illustrates the size of the populations at risk and the observed level of hospital admissions for all falls, and for falls resulting in a hip fracture (fractured neck of femur). The table highlights the districts with the highest and lowest level of hospital related falls, in particular Cambridge has the highest rate of all falls admissions and Fenland the highest rate of falls resulting in a hip fracture. However care should be taken in the interpretation of the table, in terms of statistical significance only the rates of all falls in Cambridge are significantly worse than the rates in the whole East of England region. There is no statistically significant difference for falls with a hip fracture between the district areas and the East of England. Based on the analysis within the table the areas that could be prioritised are Fenland and Cambridgeshire.

Appendix 6: Table showing the rate of emergency falls admissions in the 75+ population, by Primary Care Network

Primary Care Network (PCN)	17/18 Falls Emergency Admission Number - 75+	17/18 Falls Emergency Admission (DASR per 100,000 - 75+)	Rank (highest to lowest falls admissions (DASR 75+)	CPFT Locality (approximate - not all PCNs are co-terminous with a locality)	Neighbourhood Team (approximate)
PCN15	218	4,860.3	1	CPFT Ely and Fenland locality	Wisbech
PCN03	73	4,467.4	2	CPFT 'Cambridge' locality	City South (S) & North (N)
PCN05	169	4,449.3	3	CPFT 'Cambridge' locality	City North
PCN21	122	4,342.3	4	CPFT 'Huntingdonshire' locality	St Neots
PCN04	149	4,281.3	5	CPFT 'Cambridge' locality	City S & N
PCN14	119	4,178.7	6	CPFT 'Huntingdonshire' locality	Huntingdon Centr.
PCN06	153	3,916.9	7	CPFT 'Cambridge' locality	North Villages
PCN13	250	3,890.6	8	CPFT Peterborough locality	Mix of P'boro
PCN09	122	3,842.1	9	CPFT Ely and Fenland locality	Isle of Ely
PCN12	163	3,836.9	10	CPFT 'Cambridge' locality	Cambridge East
PCN16	62	3,828.9	11	CPFT Peterborough locality	P'boro City 1
PCN11	159	3,762.4	12	CPFT 'Cambridge' locality	Cambridge East
PCN10	105	3,681.5	13	CPFT Ely and Fenland locality	Isle of Ely
PCN01	118	3,668.6	14	CPFT 'Huntingdonshire' locality	St Neots/Hunts
PCN07	79	3,573.9	15	CPFT 'Cambridge' locality	City North
PCN20	140	3,514.6	16	CPFT 'Huntingdonshire' locality	St Ives
PCN17	117	3,491.8	17	CPFT Ely and Fenland locality	Fenland
PCN19	184	3,478.1	18	CPFT Peterborough locality	Borderline/Central
PCN02	119	3,462.3	19	CPFT Peterborough locality	Pboro City 1&2
PCN08	19	3,140.8	20	CPFT Peterborough locality	Pboro City 1
PCN18	79	3,083.5	21	CPFT Ely and Fenland locality	Isle of Ely/ Fen
CCG Total	**2,719**	**3,869.1**			

Source: Hospital Episode Statistics

Key
Statistically significantly better than CCG average
Statistically significantly worse than CCG average

Appendix 7

Table 1: Table showing the expected reductions in the number of injurious falls as a result of the integrated MFFRA

	Receiving a new integrated MFFRA/month per Therapy Assistant	Receiving a new MFFRA/year per Therapy Assistant	Receiving a new MFFRA/year per 4x Therapy Assistants	Taking up and completing the modifications per year (100%)	In whom a fall has been prevented per year (Injurious or non-injurious) (24%)	In whom an injurious fall has been prevented per year (10%)
Number of people	20	240	960	960	230	23

Table 2: Table showing the cost savings of the 34 injurious falls prevented as a result of the integrated MFFRA

Clinical Event	-	Number	Cost per event (2018/19)	Total cost
No. of falls prevented by MFFRA		230	-	-
Of whom serious	10% of falls	23	-	-
GP attendances	51% of serious falls	12	£45.36	£532.07
Ambulance callouts	61% of serious falls	14	£323.82	£4,543.19
A&E attendances	80% of serious falls	18	£127.26	£2,341.58
Inpatient admissions	35% of A&E attendances	6	-	-
Falls (non hip fractures)	69% of admissions	4	£9,331.56	£41,465.72
Hip fracture	31% of admissions	2	£18,305.28	£36,544.66
Discharge falls - home	64%	3	£2,237.76	£6,363.97
Discharge falls - residential short term	21%	1	£10,591.56	£9,883.58
Discharge falls - long term	15%	1	£83,086.92	£55,380.76
Discharge fractures - home	34%	1	£2,237.76	£1,518.94
Discharge fractures - residential short term	47%	1	£10,591.56	£9,938.15
Discharge fractures - long term	19%	0	£83,086.92	£31,516.20
Re-admissions	7% of admissions	0	£9,331.56	£4,206.67
Mortality at one year	12% of admissions	1	£4,665.78	£3,605.71
Total savings to health and social care	-	-	-	£207,841.20
Total savings community health and social care (discharge of falls and fractures)				£114,601.59

Appendix 8

Table 1: Table showing the expected reductions in the number of injurious falls as a result of the FaME strength and balance exercise programme

	No. of people attending FaME prog/yr	No. of people taking up and completing the FaME prog/yr (70%)	No. of people in whom a fall has been prevented (Injurious or non-injurious) (26%)	No. of people in whom an injurious fall has been prevented (10%)
5 FPHT (based on current target)	500	350	90	9
5x FaME progs/year by another provider(s)	75	53	14	1
TOTAL	**575**	**403**	**104**	**10**

Table 2: Table showing the cost savings of the 10 injurious falls prevented as a result of the FaME programme

Clinical Event	-	Number	Cost per event (2018/19)	Total cost
No. of falls prevented by FaME		104	-	-
Of whom serious	10% of falls	10	-	-
GP attendances	51% of serious falls	5	£45.36	£231.34
Ambulance callouts	61% of serious falls	6	£323.82	£1,975.30
A&E attendances	80% of serious falls	8	£127.26	£1,018.08
Inpatient admissions	35% of A&E attends	3	-	-
Falls (non hip fractures)	69% of admissions	2	£9,331.56	£18,028.57
Hip fracture	31% of admissions	1	£18,305.28	£15,888.98
Discharge falls - home	64%	1	£2,237.76	£2,766.95
Discharge falls - residential short term	21%	0	£10,591.56	£4,297.21
Discharge falls - long term	15%	0	£83,086.92	£24,078.59
Discharge fractures - home	34%	0	£2,237.76	£660.41
Discharge fractures - residential short term	47%	0	£10,591.56	£4,320.93
Discharge fractures - long term	19%	0	£83,086.92	£13,702.69
Re-admissions	7% of admissions	0	£9,331.56	£1,828.99
Mortality at one year	12% of admissions	0	£4,665.78	£1,567.70
Total savings to health and social care	-	-	-	**£90,365.74**
Total savings community health and social care (discharge falls & fractures)	-	-	-	**£49,826.78**