Item No: 4.17 Enc No: 18

South Staffordshire NHS
Primary Care Trust

South Staffordshire NHS
Primary Care Trust

REPORT TO THE PBC GOVERNANCE COMMITTEE TO BE HELD ON: 9th June 2010

Enclosure:	**High-level Summary Paper**					
Subject:	**Community Falls Programme for Cannock Chase and Stafford and Surrounds**					
Lead Director:	**Mark Powell**					
Lead Officer:	**Nicky Brooks**					
Recommendation:	**For Approval**	√	**For Discussion**		**For Information**	

PURPOSE OF THE REPORT:

The purpose of this report is to provide a summary of the proposed Community Falls Programme for Cannock Chase and Stafford and Surrounds.

KEY POINTS:

The current day care services (Davy Unit and Bradbury House) where jointly reviewed by Mid Staffordshire NHS Foundation Trust (MSFT) and PBC Consortia for Cannock and Stafford (October 2009). The outcome of the review resulted in a termination notice to MSFT in relation to the day care services (£921k block contract). Following the de-commissioning of the day care services Cannock and Stafford PBC Consortia intend to commission a community falls programme to be delivered to the residents of Cannock Chase and Stafford and Surrounds.

The National Service Framework (NSF) for Older People sets out a programme of action and reform to deliver higher quality services for older people; Standard six aims to reduce the number of falls that result in serious injury and ensure effective treatment and rehabilitation for those who have fallen.

The NSF states that every health system should, in partnership with councils:

- Review the local system of services for falls, including the prevention of falls, identifying those at risk and minimising this risk, improving the care of those who have fallen, including rehabilitation and the continuing care for those whose falls have longer term consequences
- Agree and implement local priorities to reduce the incidence of falls, and to reduce the impact which a fall can have on health, well-being an independence including appropriate interventions and advice to prevent osteoporotic fracture.

People over the age of 65 years account for 66% of all hospital admissions, and 40% of all emergency admissions. At MSFT between April 2008 - March 2009 there were 423 admissions recorded (Patients 65 years old and over with a 1st-6th Secondary Diagnosis of a fall) equating to a cost of £1.4 million. Based on current trends, hip fractures among older people resulting from a fall may rise to 120,000 per annum by 2015.

IMPLICATIONS:

Legal and/or Risk	N/A
Standards for Better Health	C1, C4, C5, C6, C10, C11, C13, C17, C18, D5, D8, D9, D10, D11, D12
Financial	£700k released from MSFT contract from January 2011. Approximately £300k for new service (full year net saving £400k)
Training	N/A
PBC	To be funded by PBC
Other	This service is required to address a “gap” in the provision of a community based falls service in Cannock Chase and Stafford and Surrounds

RECOMMENDATIONS / ACTION REQUIRED:

The Board is asked to: Approve the attached Community Falls Programme specification

South Staffordshire NHS
Primary Care Trust

Service Specification for the Supply of a Community Falls Programme for Cannock Chase

Document Owner	South Staffordshire NHS Primary Care Trust
Date of Issue	May 2010
Target group	All patients in Cannock Chase
Area	Cannock Chase Locality Commissioning Consortium
Status	Version 0.3
Date for review	June 2010

Background:

The purpose of this specification is to describe a proposal for a community falls programme to be delivered to the residents of Cannock Chase.
The Cannock Chase PBC district comprises of 27 GP practices. It has a registered population of 129,992 of which 20,643 are over 65 years of age. This means that approximately 15.9% of the population are elderly (the PCT average is 16%).

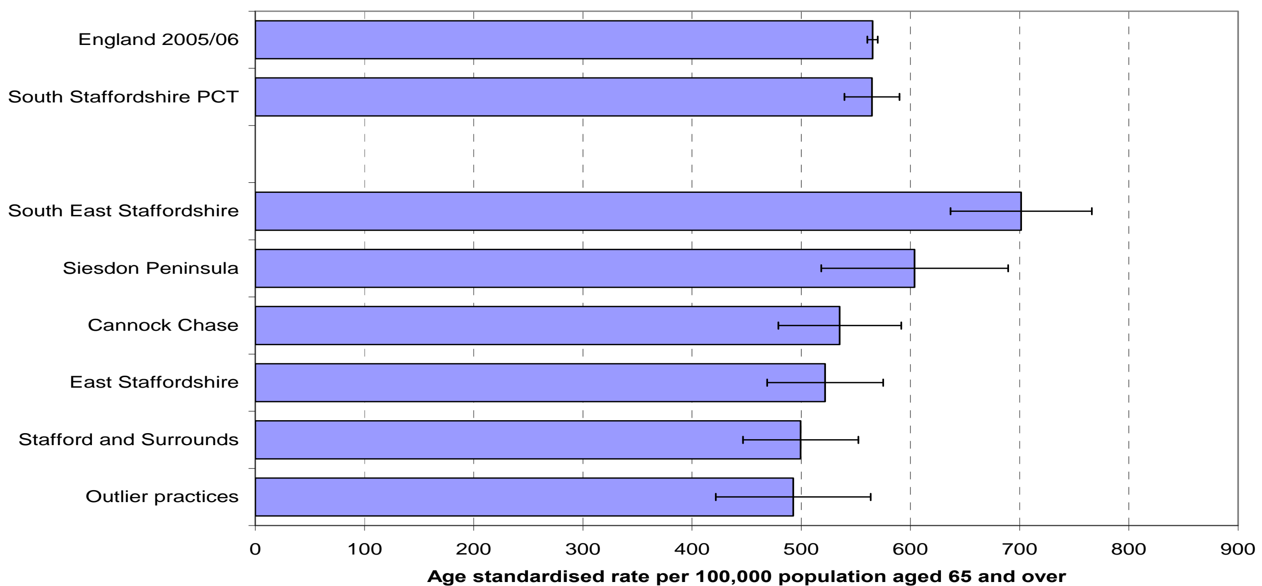

Figure 1 Admission rates for fractured neck of femur in people aged 65 and over by PBC Consortium, 2004/05 to 2006/07

Source: Hospital In-patient Common Minimum Data Set, South Staffordshire Health Informatics Service (HIS) data warehouse and Hospital Episode Statistics, The Information Centre, Copyright 2007

Falls are a major cause of disability and the leading cause of mortality due to injury among older people aged over 75 in the UK. Nearly a fifth of older people who break their hips die, and of those that survive, less than one third regain their same level of mobility. Hip fractures cost UK society an estimated £726 million per annum, of which half is attributed to social care.

Falls on the stairs alone account for an estimated 1000 deaths of older people each year and a further 330,000 serious injuries. Falls are considered a major factor leading to premature admission to permanent residential care. The after effects of even the most minor fall can be catastrophic for an older person's physical and mental health. The UK population is ageing and therefore the cost of falls incurred by the NHS and other agencies is expected to escalate. Based on current trends, hip

fractures among older people resulting from a fall may rise to 120,000 per annum by 2015.

There is an abundance of research into falls in the elderly population, stating that falls are a leading cause of death from injury in people over the age of 75 years, and that people over the age of 65 years suffer from at least one fall a year. The impact on the NHS in the hospitalisation and treatment of injuries associated with falls injuries is phenomenal. People over the age of 65 years account for 66% of all hospital admissions, and 40% of all emergency admissions. At Mid Staffordshire NHS Foundation Trust between April 2008 - March 2009 there were 423 admissions recorded (Patients 65 years old and over with a 1st-6th Secondary Diagnosis of a fall) equating to a cost of £1.4 million.

The research into the contributing factors associated with falls all have a common theme, which identifies the factors as being either intrinsic or extrinsic or both and enables those charged with developing strategies for the management and prevention of falls, to develop a list of the most common causes and factors and provide prevention and management programs, specific to the needs of the individual person.

In March 2001, the Government launched the National Service Framework (NSF) for Older People. It sets out a programme of action and reform to deliver higher quality services for older people; Standard six aims to reduce the number of falls that result in serious injury and ensure effective treatment and rehabilitation for those who have fallen.
The NSF states that every health system should, in partnership with councils:

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Definition of a Fall:

'A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.'

Accidental Fall:
'A slipping, tripping or other mishap generally related to environmental factors.'

Anticipated Physiological Fall:
'Falls that occur with patients that are identified as at risk of falling.'

Unanticipated Fall:
'Attributed to physiological causes but are created by conditions that cannot be predicted before the first occurrence.'

Factors Known to Contribute to the Risk of Falls in Elderly People[1]:

Intrinsic:

- Ageing process (risk increases over 65years)
- Poor mobility
- Cognitive impairment / confusion/ agitation
- Continence problems
- History of falls
- Medical conditions
- Sensory deficits (vision, hearing, sensation)
- Poor nutritional status
- Emotional distress / depression

Extrinsic:

- Medication known to affect balance/cognition
- Polypharmacy
- Lack of exercise
- Environmental hazards (steps, stairs, worn carpets, rugs etc)
- Inability to provide appropriate nutrition due to physical factors (lack of transport to shops, inability to use equipment for preparing / cooking etc)

Summary of Services to Be Provided:

The Provider will be expected to provide the following:
- Access to the service via the Single Point of Access Team
- The service is accessible to all adults who reside in the Cannock area and are registered permanently or temporary with a GP within the above location at the time care is needed.
- The service accepts referrals from varying sources[2]
- To provide comprehensive assessment and screening in the identification of extrinsic and intrinsic factors, associated with falls in the elderly population.
- To provide a comprehensive program of therapy, information, exercise and medication review based on the assessed need of the individual.
- To provide personalised education and advice to attendees and their carers.
- With the consent of the individual and respecting the individual's rights

[1] Refer to Appendix 1
[2] Refer to Appendix 2

of confidentiality, to develop and maintain a register of attendance (for the purpose of monitoring and review)

- To ensure referral pathways from and to other professional services are in place ensuring a seamless, quality service for patients:
  - Referral pathway from the ambulance service
  - Osteoporosis referral pathway to General Practitioners (detailing treatment regimes
  - Referral pathway for open access to request DEXA scans (dual energy X-ray absorptiometry)
- To ensure links to voluntary services that provide support to patients and carers
- Prioritise referrals, based on the identified needs of the patient
- The service will work in partnership with general practitioners, secondary care, community matrons, intermediate care, social services, district nurses, community staff, mental health team and specialist nurses to deliver patient centred, efficient and effective care

Falls Education Programme[3]:

To improve disease management and reduce avoidable hospital admissions by co-coordinating and delivering a locally agreed education programme:

- Nutritional advice
- Effects of medication
- Medication regimes
- Walking equipment
- Footwear
- Foot health/interventions (including foot assessment, toenail cutting, removal of hard skin, patient education and teaching programme to maintain their own foot health)
- Home safety checks

Service Innovation:

- To develop a health promotion toolkit; using an evidence based approach to identify those patients most at risk of:
  - Recurrent falls
  - Admission
  - In-appropriate treatment and management plans
- To develop a Falls Winter plan to reduce unscheduled admissions; those patients most at risk of falling, admission and to highlight appropriate treatment and management strategies
- To attend the weekly virtual ward meeting to discuss individual cases and develop management plans with intermediate care, community matrons and social care and health

[3] Refer to appendix 3

Inclusions:

- Any adults who score 3 or more on the falls screening tool
- Adults who do not require care delivery in an acute hospital environment
- Adults who require a period of intensive support to enable them to remain in their own home

Exclusion:

- Any adults who score less than 2 on the falls screening tool
- Acute episode / exacerbation of illness that requires an acute hospital environment to deliver care needs
- Acute injury / trauma that requires an acute hospital environment to deliver care needs
- Acute episode of self-harm
- Adults who are under the influence of alcohol / substance misuse

Service Profile:

The falls service will be an integrated part of the current community teams (including the out-of-hours service).

They will respond to referrals from:

- General Practitioners
- Emergency Services (Ambulance)
- Secondary care inclusive of Accident and Emergency and out-patient clinics
- Social Care and health (including the emergency duty service)
- Community teams

Response / Waiting times:

- New referrals will be actioned at the point of receiving the referral, via Single Point of Access.

  For GP / Paramedic referrals / Accident & Emergency:
  - Verbal contact will be made on the same day of the referral being received.

  For secondary care referrals:
  - Verbal contact will be made within 2 weeks of the referral being received.
- All referrals will be prioritised based on the identified needs of the patient.

Quality and Performance:

Key Performance Indicators and Monitoring[4]:

- All referrals and contacts will be recorded on the Lorenzo system
- To report on the clinical outcomes of all patients managed by the service i.e. clinical and reliable change
- To report the number of weeks each client is in contact with the service and the number of interventions
- To report the number of referrals received – source specific
- To report the number of inappropriate referrals received (by referrer) and returned stating reasons for return.
- To report the number of referrals that are not responded to within the specified time period and reasons why.
- To report the number of avoidable hospital admissions
- To report the number of expedited discharges from hospital
- Reduction in unscheduled admissions
- To complete a quarterly monitoring report for the Cannock Commissioning Consortia[5]
- All falls patients will be followed up by the Falls co-ordinator within 4 weeks of discharge from the service and thereafter at 6 months, 12 months and annually for up to 3 years

Skill Mix / Accreditation:

Proposed workforce:

Designation	Band
Falls Co-ordinator (band 7)	**Mid Point = £34,410 + 22% = £41,980**
Occupational therapist (band 6)	**Mid Point = £28,816 + 22% = £35,155**
Physiotherapist (band 6)	**Mid Point = £28,816 + 22% = £35,155**
Health care assistant (band 3)	**Mid Point = £16,698 + 22% = £20,371**
	Grand Total = £132,661

Annual Leave/Sickness Cover:
The Provider is responsible for ensuring that periods of annual leave, study leave and sickness can be covered and the service is delivered. Where sickness leave cannot be covered appointments will be rearranged to enable patients to be seen as soon as possible.

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[4] This data will be produced at the end of each month for the Cannock Commissioning Consortia

[5] Refer to appendix 4

Volume of Service:

This contract is for a maximum of 5 days per week:

- To accommodate 15 patients per session; 2 sessions per day. Equating to:
    - 550 patient per year
    - 75% of patient attending a structured falls programme (core work)
    - 25% of patients having a domiciliary falls programme

- To provide active interventions that will promote independence and reduce the risk of falls

Responsibilities of the Provider:

It is a requirement that the Provider and any staff provided by the Provider in delivery of this service:

- Have appropriate professional registration, are a member of an appropriate professional body and operate within their professional body's standards, regulations and codes of conduct
- Have suitable qualifications to enable them to deliver a safe and effective service
- Can demonstrate continued professional development.
- Attend appropriate education and training programmes to maintain their level of competency and comply with requirements of their professional body.
- Undergo an annual appraisal.

The Provider will ensure that the service is provided in accordance with

- NHS standards of quality, access and effectiveness and comply with the core "Standards for Better Health.

Specific Quality Standards:

The service should be developed with reference to the following:

- Department of Health National Service Framework for older people
- NICE guidance on falls – the assessment and prevention of falls in older people (2004)
- NSF Long Term Conditions (2005)

In order to offer timely service urgent referrals need to be responded to on the same day. Non urgent referrals need to be seen within 2 weeks (maximum waits unless patient choice dictates otherwise).

Generic Quality Standards:

The service must be compliant with the PCTs policies in relation to training and development, risk management, health and safety, confidentiality and infection control.

Service Development and Amendments to Services:

The objective of the Cannock Practice Based Consortium is to "develop and deliver healthcare services that provide patients with access to the same range and quality of services as the general public receives from the NHS".

Should the nature of the service required change, and amendments to the service level agreement are needed, this will be undertaken through the prior agreement of both parties and following agreement of a suitable implementation period.

A variation notification will then be issued reflecting the changes to this agreement.

Accountability:

The Provider will be accountable to Cannock Practice Based Consortia and will ensure that the following are adhered to

- Ensure that maximum use is made of all sessions.
- Ensure clinical audits are undertaken
- Ensure all stakeholders are aware of how to access the service.
- Ensure the clinicians working within the service have an effective induction programme

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FALLS SCREENING TOOL

Cannock Falls Service

Appendix 1

Name:…………………………………………………… **D.O.B:** ……………… **G.P.:** ………………………………..

Address:………………………………………………… **NHS/Unit No:** ……………………………………………..

…………………………………………………………….. **Ethnic Origin:** ……………………………………………..

Tel No: ………………………………………………… **Date:** ………………………………………………………

History of falling in the past year	Yes	No	Risk Factors for Falling	Yes	No	Balance and Gait	Yes	No
3 + falls	6	0	**Takes 4+ medicines**	1	0	**Able to rise from a chair of knee height**	0	3
A fall with injury	6	0	**Uses sedatives**	1	0	**Stops walking when Talking**	6	0
2 falls	3	0	**Had a stroke**	1	0	**Client/Carer reports problems with balance**	6	0
1 fall	1	0	**Parkinson's Disease**	1	0			
			Problems with eyesight	1	0			

TOTAL SCORE ☐

SCORE 0 – 2

- **If they have scored "yes" for 4+medications or sedatives – GP medication review recommended.**
- **Advise client to get an eye-test with their optician if they have not had one in the last year.**
- **Discuss fall prevention with them and give Help the Aged "Staying Steady" leaflet.**
- **Advise activity is recommended and give Health Trainer leaflet.**
- **If assessment is undertaken by a non GP, please fax completed form to client's GP.**

SCORE 3 or MORE

- **Discuss referral to the Falls Service with client. Give service leaflet.**
- **Advise client to get an eye-test with their optician if they have not had one in the last year.**
- **Refer to Falls Team- fax this form to Falls Team via Single Point of Access on 01543**

ADDITIONAL RELEVANT INFORMATION

Location of Falls **Indoors** ☐ **Outdoors** ☐

Timing of Falls **Morning** ☐ **Night** ☐ **Any time** ☐

Type of Fall**: (please circle)**

Trip **slip** **dizzy** **loss of balance** **loss of consciousness**

Over reaching **legs give way** **unexplained** **Other (please state)** ………………………………

Uses a walking aid indoors**: (please circle)** **walking stick** **frame**

COMMENTS**:**

……
……

Signature: ………………………………………………….. Print Name:……………………………………………

Designation: ………………………………………………. Contact No:

South Staffordshire NHS
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FALLS SCREENING TOOL
Cannock Falls Service

Name:………………………………………………………… **D.O.B:** ……………… **G.P.:** ………………………………..
Address:……………………………………………………… **NHS/Unit No:** ………………………………………………..
…………………………………………………………………... **Ethnic Origin:** ………………………………………………..
Tel No: ………………………………………………………. **Date:** …………………………………………………….

Total Score ☐

MEDICAL INFORMATION:- GP to complete if scored 3 or more.

(Please fax form directly back to Cannock Falls Service as soon as completed)

Date of medication review (DD/MM/YY) ______________________

Patient's medications (complete or attach a computer print-out)

Medication may contribute to fall **Yes** ☐ **No** ☐

If yes, are medication changes advised **Yes** ☐ **No** ☐

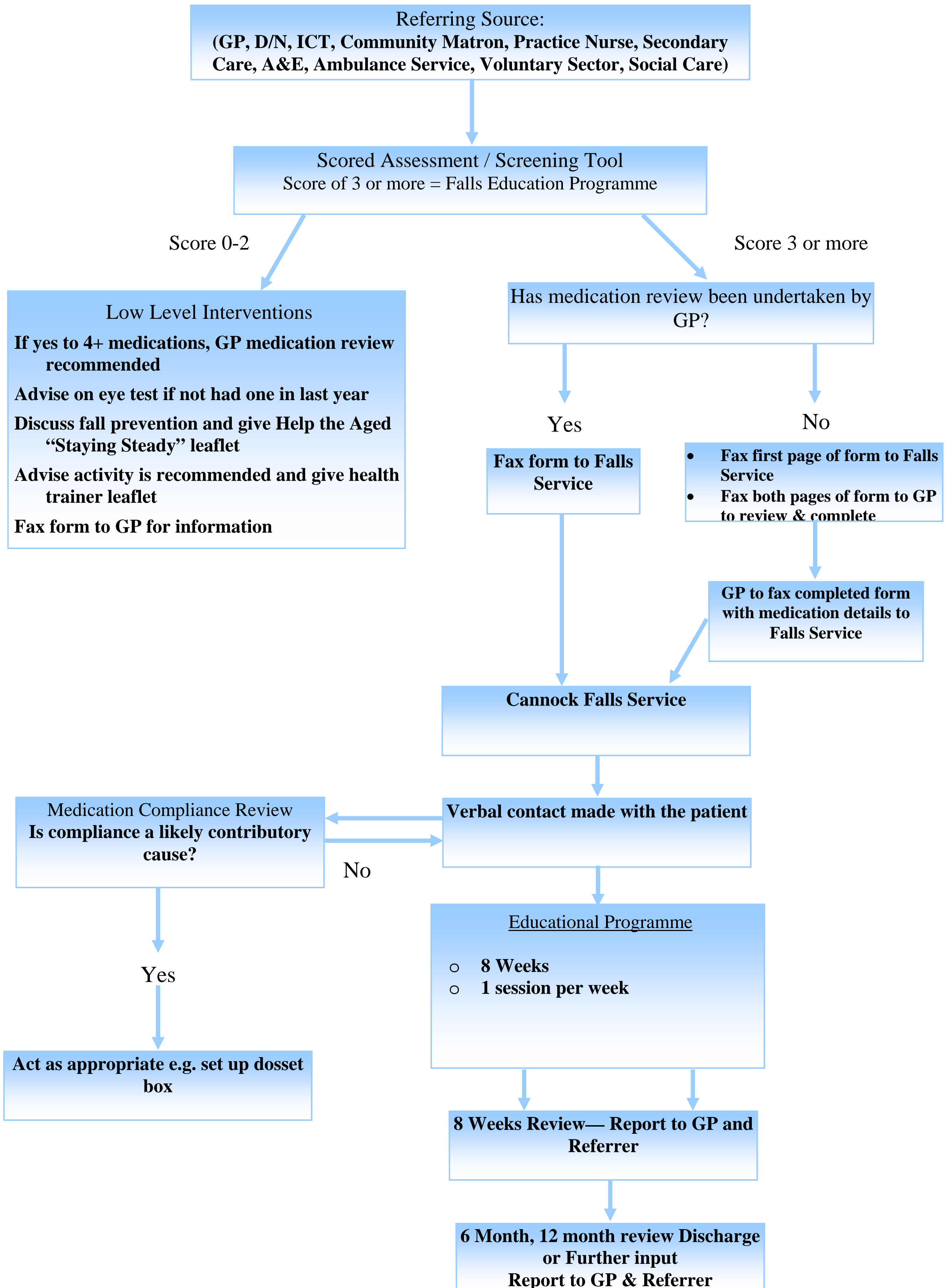
Details:

GP Signature ____________________________ Date ____________________________	Practice Stamp

South Staffordshire NHS Primary Care Trust

Appendix 2

Cannock Falls Pathway



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Appendix 3

Cannock Chase Community Falls Education Programme

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
1 Hour	Physiotherapy	Physiotherapist	Physiotherapist	Tai Chi Sloppy Slippers Initiative	Physiotherapy	Physiotherapy	Warm Up OT/Physio (getting up from the floor)	Warm Up OT/Physio (getting up from the floor)
15mins	**BREAK**							
30 minutes	Pharmacist	Dietetics	Podiatry	Clinical Psychology Nurse	Optician	OT Equipment Demo	Tai Chi	Age Concern
30 minutes	Q&A & Health assessments	Q&A & Health assessments	Q&A & Health assessments	Q&A & Health assessments	Q&A & Health assessments	Q&A & Health assessments	Q&A & Health assessments	Q&A & Assessments Service evaluation Audit

Staff at each session will include:

1 x Physiotherapist
1 x Occupational Therapist
1 x Health Care Assistant

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Appendix 4

Quarterly Monitoring Report

Locality:	
Completed by:	
Telephone Number:	

Reporting Period:	
Submission Deadline:	

1. Falls Assessments:		
1a	Number of people aged 65+ referred to the multi-disciplinary falls service following a fall and awaiting assessment following a fall at period end. **This question is intended to capture the size of the outpatient/community clinic waiting list for falls assessments to assess the scale of unmet demand**	
1b	Number of people aged 65+ who have had a multidisciplinary falls assessment during the period: **A multi-disciplinary falls assessment should include a falls history review and osteoporosis assessment and at least one more of the following components as required:** **- medication review** **- home safety check** **- vision assessment** **- physiotherapist-led gait/balance/mobility assessment**	
2. Falls Education/Raising Awareness for Older People and their Carers:		
2a	Number of people aged 65+ who have fallen, who have received specific falls prevention training during the period. **Training sessions must include:** **- how to summon help** **- how to get up from a fall** **- how to prevent further falls** **Patients attending one-to-one or group sessions can be included**	
2b	**Number of people aged 65+ who have fallen, who have received specific falls prevention training during the period. A significant part of session should be focused on falls prevention**	
2c	Number of carers of people aged 65+ who have attended a falls awareness session during period. **This question relates to relatives or informal carers of older people.**	
3. Falls Educations Session for Staff:		
3a	Number of staff (working with older people) who have attended basic education or training sessions during period. **Staff Volunteers can be included.** **Sessions should either include identification of falls risk factors and falls prevention or the identification and screening of fallers and the local referral pathway.**	
3b	Number of staff who have completed enhanced falls training to become key personnel in falls prevention during the period. **Could include in-house or external training such as a postural stability course, Otago etc.**	

4. Exercise Programmes for Older People:		
4a	Number of people aged 65+ who have fallen and who have completed a programme of progressive strength and balance exercises during the period. **Programmes should last at least six weeks and may comprise one-to-one or group sessions Programmes should be evidence based in falls prevention - e.g. Otago Programmes should be tailored to the individual by an appropriately trained professional**	
4b	Number of community based groups for people aged 65+, providing programmes of exercise to maintain independence and mobility in older people, at period end. **E.g. Extend or Tai Chi, but exercises must not be solely chair-based**	

Cross Reference Documents:

1. Office for National Statistics, *Mortality statistics 1998:* London Stationery Office, 1999.
2. Spirduso W (1996) *Physical dimensions of ageing,* Illinois, Human Kinetics.
3. Parrot S, The economic cost of hip fracture in the UK. Centre for Health Economics, University of York, 2000.
4. Hill LD, Haslam PA, Brooke-Wavell K, Sloane JE (2001) *Safety of older people on stairs: behavioural factors,* Loughborough University.
5. Department of Trade and Industry. *Research on the patterns and trends in home accidents. London:DTI, 1999 (URN 99/858)*
6. Johnell O, Gullberg B, Allander JA, Kanis JA, The MEDOS Study Group (1992) T*he apparent incidence of hip fracture in Europe: a study of national register sources. Osteoporosis International, 2, pp1248-50.*
7. Department of Health (2001) The National Service Framework for Older People, Department of Health, London
8. NHS Plan (2006)
9. South Staffordshire PCT's Strategic Plan (2008 – 2013)
10. Earlier, risk managed discharge plan = reduction in "bed blocking" days (Ward 2007, RCP 2005)

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Primary Care Trust

Service Specification for the Supply of a Community Falls Programme for Stafford and Surrounds

Document Owner	**South Staffordshire NHS Primary Care Trust**
Date of Issue	**May 2010**
Target group	**All patients in Stafford and Surrounds**
Area	**Stafford Locality Commissioning Consortium**
Status	Version 0.1
Date for review	**June 2010**

Background:

The purpose of this specification is to describe a proposal for a community falls programme to be delivered to the residents of Stafford and surrounds.
The Stafford and Surrounds PBC district comprises of 14 GP practices. It has a registered population of 146,336 of which 26,926 are over 65 years of age. This means that approximately 18.4% of the population are elderly (the PCT average is 16%).

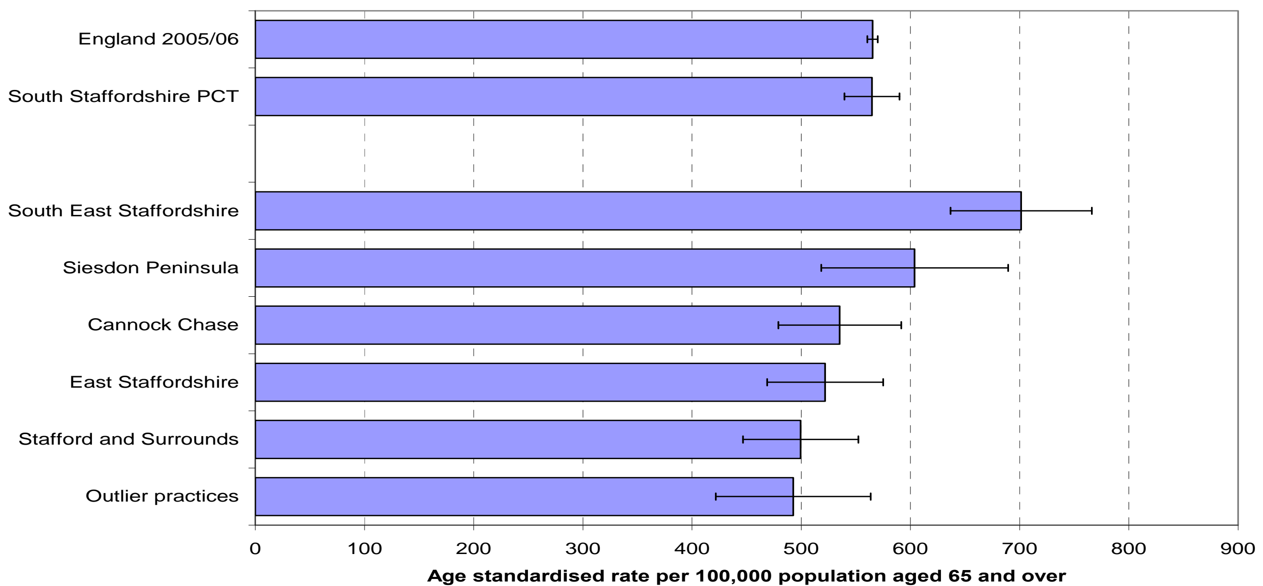

Figure 2 Admission rates for fractured neck of femur in people aged 65 and over by PBC Consortium, 2004/05 to 2006/07

Source: Hospital In-patient Common Minimum Data Set, South Staffordshire Health Informatics Service (HIS) data warehouse and Hospital Episode Statistics, The Information Centre, Copyright 2007

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- Continence problems
- History of falls
- Medical conditions
- Sensory deficits (vision, hearing, sensation)
- Poor nutritional status
- Emotional distress / depression

Extrinsic:

- Medication known to affect balance/cognition
- Polypharmacy
- Lack of exercise
- Environmental hazards (steps, stairs, worn carpets, rugs etc)
- Inability to provide appropriate nutrition due to physical factors (lack of transport to shops, inability to use equipment for preparing / cooking etc)

Summary of Services to Be Provided:

The Provider will be expected to provide the following:
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- The service is accessible to all adults who reside in the Stafford and Surrounds and are registered permanently or temporary with a GP within the above location at the time care is needed.
- The service accepts referrals from varying sources[7]

[6] Refer to Appendix 1

- To provide comprehensive assessment and screening in the identification of extrinsic and intrinsic factors, associated with falls in the elderly population.
- To provide a comprehensive program of therapy, information, exercise and medication review based on the assessed need of the individual.
- To provide personalised education and advice to attendees and their carers.
- With the consent of the individual and respecting the individual's rights of confidentiality, to develop and maintain a register of attendance (for the purpose of monitoring and review)

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- Footwear
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[7] Refer to Appendix 2
[8] Refer to appendix 3

Service Innovation:

- To develop a health promotion toolkit; using an evidence based approach to identify those patients most at risk of:
    - Recurrent falls
    - Admission
    - In-appropriate treatment and management plans
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Inclusions:

- Any adults who score 3 or more on the falls screening tool
- Adults who do not require care delivery in an acute hospital environment
- Adults who require a period of intensive support to enable them to remain in their own home

Exclusion:

- Any adults who score less than 2 on the falls screening tool
- Acute episode / exacerbation of illness that requires an acute hospital environment to deliver care needs
- Acute injury / trauma that requires an acute hospital environment to deliver care needs
- Acute episode of self-harm
- Adults who are under the influence of alcohol / substance misuse

Service Profile:

The falls service will be an integrated part of the current community teams (including the out-of-hours service).

They will respond to referrals from:

- General Practitioners
- Emergency Services (Ambulance)
- Secondary care inclusive of Accident and Emergency and out-patient clinics
- Social Care and health (including the emergency duty service)
- Community teams

Response / Waiting times:

- New referrals will be actioned at the point of receiving the referral, via Single Point of Access.
  For GP / Paramedic referrals / Accident & Emergency:
  - Verbal contact will be made on the same day of the referral being received.

  For secondary care referrals:
  - Verbal contact will be made within 2 weeks of the referral being received.
- All referrals will be prioritised based on the identified needs of the patient.

Quality and Performance:

Key Performance Indicators and Monitoring[9]:

- All referrals and contacts will be recorded on the Lorenzo system
- To report on the clinical outcomes of all patients managed by the service i.e. clinical and reliable change
- To report the number of weeks each client is in contact with the service and the number of interventions
- To report the number of referrals received – source specific
- To report the number of inappropriate referrals received (by referrer) and returned stating reasons for return.
- To report the number of referrals that are not responded to within the specified time period and reasons why.
- To report the number of avoidable hospital admissions
- To report the number of expedited discharges from hospital
- Reduction in unscheduled admissions
- To complete a quarterly monitoring report for the Stafford Commissioning Consortia[10]
- All falls patients will be followed up by the Falls co-ordinator within 4 weeks of discharge from the service and thereafter at 6 months, 12 months and annually for up to 3 years

[9] This data will be produced at the end of each month for the Stafford and Surrounds Commissioning Consortia
[10] Refer to appendix 4

Skill Mix / Accreditation:

Proposed workforce:

Designation	Band
Falls Co-ordinator (band 7)	**Mid Point = £34,410 + 22% = £41,980**
Occupational therapist (band 6)	**Mid Point = £28,816 + 22% = £35,155**
Physiotherapist (band 6)	**Mid Point = £28,816 + 22% = £35,155**
Health care assistant (band 3)	**Mid Point = £16,698 + 22% = £20,371**
	Grand Total = £132,661

Annual Leave/Sickness Cover:

The Provider is responsible for ensuring that periods of annual leave, study leave and sickness can be covered and the service is delivered. Where sickness leave cannot be covered appointments will be rearranged to enable patients to be seen as soon as possible.

Volume of Service:

This contract is for a maximum of 5 days per week:

- To accommodate 15 patients per session; 2 sessions per day. Equating to:
  - 550 patient per year
  - 75% of patient attending a structured falls programme (core work)
  - 25% of patients having a domiciliary falls programme
- To provide active interventions that will promote independence and reduce the risk of falls

Responsibilities of the Provider:

It is a requirement that the Provider and any staff provided by the Provider in delivery of this service:

- Have appropriate professional registration, are a member of an appropriate professional body and operate within their professional body's standards, regulations and codes of conduct
- Have suitable qualifications to enable them to deliver a safe and effective service
- Can demonstrate continued professional development.

- Attend appropriate education and training programmes to maintain their level of competency and comply with requirements of their professional body.
- Undergo an annual appraisal.

The Provider will ensure that the service is provided in accordance with

- NHS standards of quality, access and effectiveness and comply with the core "Standards for Better Health.

Specific Quality Standards:

The service should be developed with reference to the following:
- Department of Health National Service Framework for older people
- NICE guidance on falls – the assessment and prevention of falls in older people (2004)
- NSF Long Term Conditions (2005)

In order to offer timely service urgent referrals need to be responded to on the same day. Non urgent referrals need to be seen within 2 weeks (maximum waits unless patient choice dictates otherwise).

Generic Quality Standards:

The service must be compliant with the PCTs policies in relation to training and development, risk management, health and safety, confidentiality and

Infection control.

Service Development and Amendments to Services:

The objective of the Stafford and Surrounds Practice Based Consortium is to "develop and deliver healthcare services that provide patients with access to the same range and quality of services as the general public receives from the NHS".

Should the nature of the service required change, and amendments to the service level agreement are needed, this will be undertaken through the prior agreement of both parties and following agreement of a suitable implementation period.
A variation notification will then be issued reflecting the changes to this agreement.

Accountability:

The Provider will be accountable to Stafford and Surrounds Practice Based Consortia and will ensure that the following are adhered to

- Ensure that maximum use is made of all sessions.
- Ensure clinical audits are undertaken
- Ensure all stakeholders are aware of how to access the service.
- Ensure the clinicians working within the service have an effective induction programme

Item No: Enc No:

South Staffordshire NHS Primary Care Trust

Appendix 1

FALLS SCREENING TOOL

Stafford Falls Service

Name:…………………………………………………… **D.O.B:** ……………… **G.P.:** ………………………………..
Address:……………………………………………… **NHS/Unit No:** ………………………………………………..
…………………………………………………………... **Ethnic Origin:** ………………………………………………..
Tel No: ……………………………………………… **Date:** …………………………………………………………

History of falling in the past year	Yes	No	Risk Factors for Falling	Yes	No	Balance and Gait	Yes	No
3 + falls	**6**	**0**	**Takes 4+ medicines**	**1**	**0**	**Able to rise from a chair of knee height**	**0**	**3**
A fall with injury	**6**	**0**	**Uses sedatives**	**1**	**0**	**Stops walking when Talking**	**6**	**0**
2 falls	**3**	**0**	**Had a stroke**	**1**	**0**	**Client/Carer reports problems with balance**	**6**	**0**
1 fall	**1**	**0**	**Parkinson's Disease**	**1**	**0**			
			Problems with eyesight	**1**	**0**			

TOTAL SCORE

SCORE 0 – 2

- **If they have scored "yes" for 4+medications or sedatives – GP medication review recommended.**
- **Advise client to get an eye-test with their optician if they have not had one in the last year.**
- **Discuss fall prevention with them and give Help the Aged "Staying Steady" leaflet.**
- **Advise activity is recommended and give Health Trainer leaflet.**
- **If assessment is undertaken by a non GP, please fax completed form to client's GP.**

SCORE 3 or MORE

- **Discuss referral to the Falls Service with client. Give service leaflet.**
- **Advise client to get an eye-test with their optician if they have not had one in the last year.**
- **Refer to Falls Team- fax this form to Falls Team via Single Point of Access on 01785**

ADDITIONAL RELEVANT INFORMATION

Location of Falls **Indoors** ☐ **Outdoors** ☐

Timing of Falls **Morning** ☐ **Night** ☐ **Any time** ☐

Type of Fall**: (please circle)**

Trip **slip** **dizzy** **loss of balance** **loss of consciousness**

Over reaching **legs give way** **unexplained** **Other (please state)** ………………………………

Uses a walking aid indoors**: (please circle)** **walking stick** **frame**

COMMENTS**:**

……
……

Signature: ………………………………………………….. Print Name:…………………………………………….

Designation: ……………………………………………. Contact No:

South Staffordshire NHS
Primary Care Trust

FALLS SCREENING TOOL
Stafford Falls Service

Name:……………………………………………………… D.O.B: ……………… G.P.: ………………………………..
Address:…………………………………………………… NHS/Unit No: ………………………………………………..
………………………………………………………………... Ethnic Origin: ………………………………………………..
Tel No: …………………………………………………… Date: ………………………………………………………….

Total Score ☐

MEDICAL INFORMATION:- GP to complete if scored 3 or more.

(Please fax form directly back to Cannock Falls Service as soon as completed)

Date of medication review (DD/MM/YY) ___________________________

Patient's medications (complete or attach a computer print-out)

Medication may contribute to fall **Yes** ☐ **No** ☐

If yes, are medication changes advised **Yes** ☐ **No** ☐

Details:

GP Signature ________________________________ Date ____	Practice Stamp

South Staffordshire NHS
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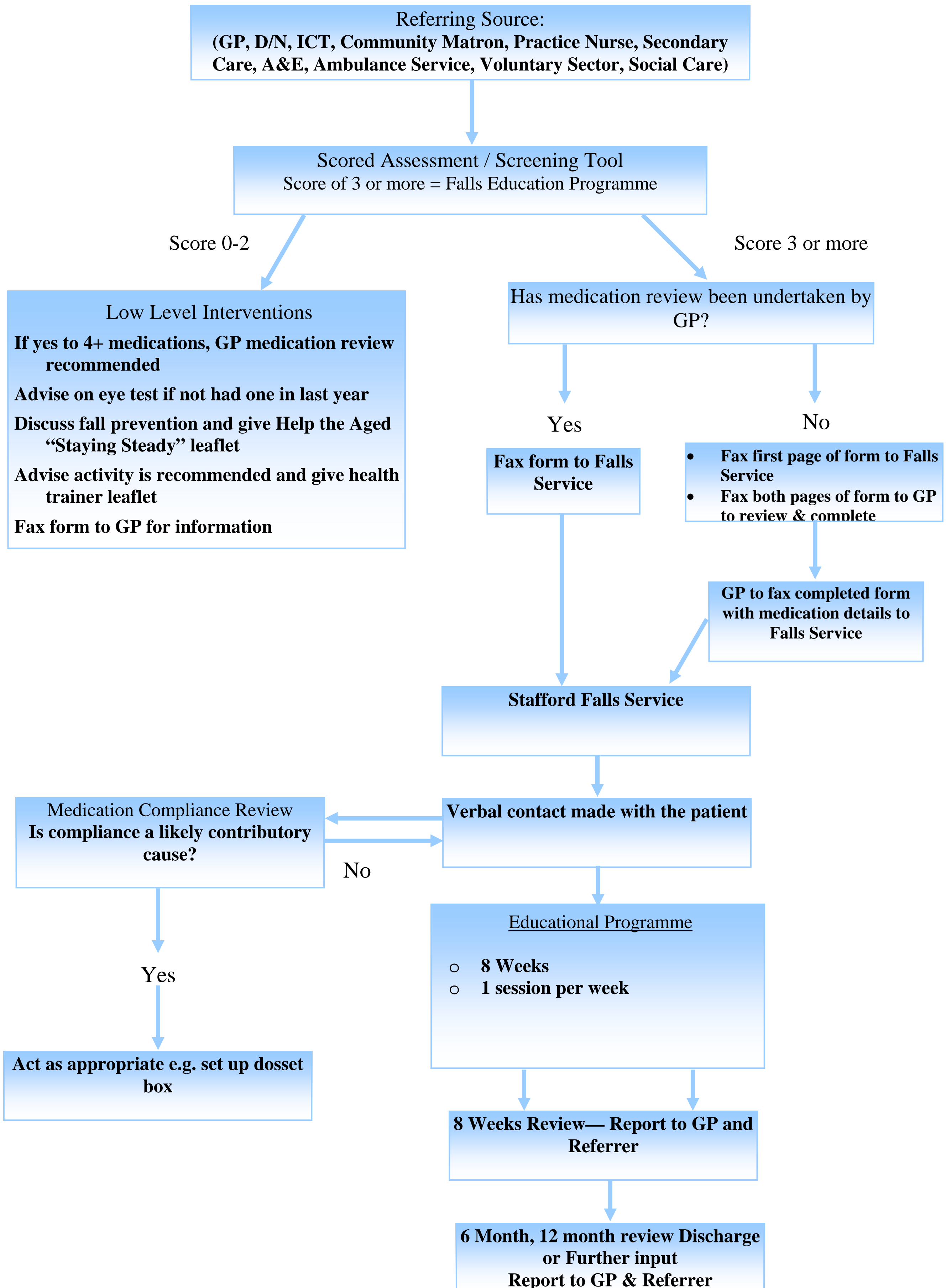
Appendix 2

Stafford Falls Pathway



South Staffordshire NHS
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Appendix 3

Stafford Community Falls Education Programme

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
1 Hour	Physiotherapy	Physiotherapist	Physiotherapist	Tai Chi Sloppy Slippers Initiative	Physiotherapy	Physiotherapy	Warm Up OT/Physio (getting up from the floor)	Warm Up OT/Physio (getting up from the floor)
15mins	**BREAK**							
30 minutes	Pharmacist	Dietetics	Podiatry	Clinical Psychology Nurse	Optician	OT Equipment Demo	Tai Chi	Age Concern
30 minutes	Q&A & Health assessments	Q&A & Health assessments	Q&A & Health assessments	Q&A & Health assessments	Q&A & Health assessments	Q&A & Health assessments	Q&A & Health assessments	Q&A & Assessments Service evaluation Audit

Staff at each session will include:

1 x Physiotherapist
1 x Occupational Therapist
1 x Health Care Assistant

Appendix 4

South Staffordshire NHS Primary Care Trust

Quarterly Monitoring Report

Locality:	
Completed by:	
Telephone Number:	

Reporting Period:	
Submission Deadline:	

1. Falls Assessments:		
1a	Number of people aged 65+ referred to the multi-disciplinary falls service following a fall and awaiting assessment following a fall at period end. **This question is intended to capture the size of the outpatient/community clinic waiting list for falls assessments to assess the scale of unmet demand**	
1b	Number of people aged 65+ who have had a multidisciplinary falls assessment during the period: **A multi-disciplinary falls assessment should include a falls history review and osteoporosis assessment and at least one more of the following components as required:** **- medication review** **- home safety check** **- vision assessment** **- physiotherapist-led gait/balance/mobility assessment**	
2. Falls Education/Raising Awareness for Older People and their Carers:		
2a	Number of people aged 65+ who have fallen, who have received specific falls prevention training during the period. **Training sessions must include:** **- how to summon help** **- how to get up from a fall** **- how to prevent further falls** **Patients attending one-to-one or group sessions can be included**	
2b	**Number of people aged 65+ who have fallen, who have received specific falls prevention training during the period. A significant part of session should be focused on falls prevention**	
2c	Number of carers of people aged 65+ who have attended a falls awareness session during period. **This question relates to relatives or informal carers of older people.**	
3. Falls Educations Session for Staff:		
3a	Number of staff (working with older people) who have attended basic education or training sessions during period. **Staff Volunteers can be included.** **Sessions should either include identification of falls risk factors and falls prevention or the identification and screening of fallers and the local referral pathway.**	
3b	Number of staff who have completed enhanced falls training to become key personnel in falls prevention during the period. **Could include in-house or external training such as a postural stability course, Otago etc.**	

4. Exercise Programmes for Older People:		
4a	Number of people aged 65+ who have fallen and who have completed a programme of progressive strength and balance exercises during the period. **Programmes should last at least six weeks and may comprise one-to-one or group sessions Programmes should be evidence based in falls prevention - e.g. Otago Programmes should be tailored to the individual by an appropriately trained professional**	
4b	Number of community based groups for people aged 65+, providing programmes of exercise to maintain independence and mobility in older people, at period end. **E.g. Extend or Tai Chi, but exercises must not be solely chair-based**	

Cross Reference Documents:

1. Office for National Statistics, *Mortality statistics 1998:* London Stationery Office, 1999.
2. Spirduso W (1996) *Physical dimensions of ageing,* Illinois, Human Kinetics.
3. Parrot S, The economic cost of hip fracture in the UK. Centre for Health Economics, University of York, 2000.
4. Hill LD, Haslam PA, Brooke-Wavell K, Sloane JE (2001) *Safety of older people on stairs: behavioural factors,* Loughborough University.
5. Department of Trade and Industry. *Research on the patterns and trends in home accidents. London:DTI, 1999 (URN 99/858)*
6. Johnell O, Gullberg B, Allander JA, Kanis JA, The MEDOS Study Group (1992) T*he apparent incidence of hip fracture in Europe: a study of national register sources. Osteoporosis International, 2, pp1248-50.*
7. Department of Health (2001) The National Service Framework for Older People, Department of Health, London
8. NHS Plan (2006)
9. South Staffordshire PCT's Strategic Plan (2008 – 2013)
10. Earlier, risk managed discharge plan = reduction in "bed blocking" days (Ward 2007, RCP 2005)