1. Highlights

Vision

“As an older person, I will have confidence that if I am ‘at risk’ of falling, I will receive services and support to reduce my risk, such as reviewing the drugs that I need to take, inspecting my home for risks, physiotherapy to improve my strength, or installing equipment, such as grab bars. As a result, I have improved health and independence.”

“As stakeholders in the delivery of care and services to the client population ‘at risk’ of falling (Stakeholder Council), we see the falls prevention service as:

- a 24X7 service, with a single point of access,
- having commonality of services nomenclature across the localities,
- utilising a consistent risk assessment tool, and
- providing services that respond with an appropriate degree of urgency to perform assessments and ensure that follow-up occurs to put care and services in place in order to maintain an individual’s independence.”

“As a GP in Berkshire West, I will have the support of an Integrated Multi-disciplinary Falls Prevention Service. This support will enable my patients access to therapeutic services and equipment and will assist in maintaining their safety, independence and mobility in order that they may continue to live in the home of their choice for as long as possible.”
Vision

Background:
In 2007/08 in Berkshire West there were approximately 423 hospital admissions and 364 excess bed days associated with a diagnosis of fractured neck of femur in people aged 65 and over. According to the DOH, it is reasonable to estimate that 95% of these hospital admissions would have been the result of a fall. Injuries associated with falls frequently result in the long-term deterioration of the health status of the individual, leading to an increase in dependency on both health and social services. Berkshire West PCT patients who were admitted for hip fracture in 2007/08 also had 83 emergency readmissions to hospital subsequent to their admission for the fracture. Other consequences for the individual can include:

- psychological problems including a fear of falling and loss of confidence
- loss of mobility
- increase in dependency and disability
- infection
- admission to long term care
- death

Based upon this analysis, Berkshire West PCT has identified the need to develop a comprehensive and integrated Falls Prevention scheme for its ‘at risk’ (aged 65 and over) population. The programme will have 3 components:

1. Early Identification of individuals ‘at risk’
2. Risk Assessment and Falls Prevention support for those identified as being in the ‘at risk’ group
3. Effective treatment pathway including proactive discharge planning and Case Management for those who experience an injury because of falling.

This integrated falls programme will include the following:

- screening requirements and processes for ‘at risk’ individuals that have contact with the health and/or social care system
- multi-factorial assessment of those identified as being ‘at risk’, including physiological, mental, environmental, and social assessment of the individual’s current status
- Services (to be offered to patients), based upon assessment findings, to diminish the identified risk of falling and possible injury. This will reduce the need for urgent and acute care resources, and improve the quality of an ‘at risk’ patient’s life. The programme will put a care plan in place that will minimise their fear of falling, with community care and services.
- simple, consistent access to required community care and services across all localities
- proactive management of patients who require hospital admission due to an injury and to prevent readmission and further falls and/or injury
## Need for change

### What are the threats of not changing?

#### Impacting Efficiency
- Increased number of hospital admissions due to fractured neck of femur and other falls related diagnoses
- Increased costs to the PCT for inpatient hospital care

#### Impacting Effectiveness
- Continued access to a falls system that is very disjointed
- Increased number of injuries (particularly fractures) due to lack of falls prevention and integrated falls services
- Continued lack of access to urgent care follow-up and care post-fall and injury
- Continued lack of follow-up care for those who fall, but do not require acute medical intervention
- Continued lack of identification of individuals who are ‘at risk’ of falling or having repeat falls
- No access for patients or their carers to resources which would support them in feeling safe in their own home or usual environment leading to a potential decrease in their mobility and activity in and outside the home.

### What are the opportunities if we do change?

The benefits of this new integrated and sustainable system will be:

1. **Improved experience of patients both ‘at risk’ of falls and who have suffered falls**, as they will have their risk evaluated and a personalised plan of care/support will be put in place providing them with access to community based care and services to mitigate their risk of falling and continued follow-up for provision of additional care/support as the individual health status changes.

#### Aim:
- Establish a baseline programme satisfaction rating by patients and their carers, and achieve a 10% improvement over a 12 month period
- Develop a baseline of falls occurring in the PCT on an annual basis
- Reduce the number of individual falls by 10% on the initial baseline

#### Historical/Literature Review Facts:
- Falls are a major cause of disability and a leading cause of mortality due to injury in older people aged over 75 (DoH 2001)
- Falls prevention programmes can be effective in reducing falls in patients who are ‘at risk’. They can also reduce future falls for patients who have an initial fall (Cochrane Collection, 2008)
- 50% of the estimated cost associated with care of patients with fractured neck of femur is for social care and long-term hospitalisation. This is an indication of the impact on the lives of individuals who suffer from fractured neck of femur.
Need for change

2. **Reduce the number and cost of inpatient admissions** by implementing and managing a comprehensive integrated Falls Prevention Programme.  
**Aim:**
- Achieve a 10% reduction in admissions for fractured neck of femur which could generate secondary care savings of approximately £315,000 per annum.  
- Achieve a 10% reduction in readmissions of patients who become more frail as a result of the fall  
**Historical/Literature Review Facts:**
- In 2007/08, there were approximately 423 hospital admissions because of hip fractures in people aged 65 and over. An estimated 95% (ref: DOH) were the result of a fall. The 2008/09 national tariff for an emergency hospital admission for fractured neck of femur for patients 65 and older is £7,531.\((0.95 \times 423) \times £7,531\) x .10 = **£312,746**  
- Of the 262 patients over the age of 75 who were admitted for fractured neck of femur in the 12 months ending September 2007, there were 83 emergency readmissions. This reflects the deterioration in health status that frequently occurs in patients following fractured neck of femur.  
- A Canadian study reported that hip fractures represent approximately 40% of the admissions to hospital resulting from falls. The remaining 60% of hospital admissions resulting from falls represent a diverse group of injuries. (Canadian Institute for Health Information)

3. **Reduce the number and cost of excess bed days** due to a reduction in the number of spells as a result of the reduction in the number of falls.  
**Aim:** 10% reduction in excess bed days due to hip fractures.  
**Historical/Literature Review Facts:**
- There were 364 excess bed days for patients with a primary diagnosis of fractured neck of femur. These excess bed days cost over £72,000 and a majority of these were due to not being able to move them into the community due to lack of service availability. Patients with excess bed days are at increased risk of future emergency admission due to the lack of community support in place.

2. Description of change

Current process / state

The current process for falls within the Berkshire West PCT varies across the 3 localities (Reading, Wokingham and West Berkshire). Some localities have more services for falls prevention, risk assessment and care/support than others. There is also variation in who performs the risk assessments and follow up with the majority being undertaken by physiotherapists in West Berkshire, nurses in Reading and occupational therapists in Wokingham. Therefore, the current state is not consistent across the PCT causing difficulties for organisations, such as SCAS, trying to access services. There is minimal tracking of fall metrics in all areas and organisations. Currently, not everyone who falls receives follow up or evaluation of the fall by their GP or allied health professional for further fall risk assessment and prevention. Hence several admissions and readmissions associated with repeat falls.
## SWOT analysis

### Strengths
- Falls prevention and risk assessment available in certain localities
- Community Geriatrician to be employed by the PCT
- Elderly Care Consultant with expertise in falls based at the RBHFT
- Other experts within the PCT on falls and service availability

### Weaknesses
- No single point of contact for falls services
- No consistency of services or nomenclature across the three localities programme structure
- Disparate reporting
- No required follow-up on cases where injuries do not occur or where falls occur repeatedly
- No (standard) process for initiating a care plan and access to required resources
- Limited preventative falls services provided in residential/nursing homes

### Opportunities
- Decrease the number of hospital admissions and readmissions due to falls
- Decrease the costs of acute admission and A&E attendance as a result of falls
- Improve individual’s quality of life by decreasing the incidence of falls
- Improve individual’s quality of life by maintaining or improving mobility and social capabilities.

### Threats
- Resistance to change
- All disciplines compliant with new process
- Ability to report outcomes due to inadequate IT support
- Ability to have a falls referral/reporting service 8 hours per day/7 days a week

### Design changes to address weaknesses and capitalise on opportunities: (See future state process maps)

| 1 | Single point of Contact |
| 2 | Falls inquiry for patients 65 – 74 |
| 3 | Falls screening for patient 75+ |
| 4 | Multifactoral assessment based upon screening/inquiry results |
| 5 | Care Plan required based upon assessment findings and discharge needs |
| 6 | Reporting of all falls, screening, assessments and dispositions |
Future process / state

The future state for falls prevention will provide a required formal structured process which includes three components. 1) the early identification of individuals ‘at risk’ of falling, care planning and access to community resources for prevention of falls and injuries due to falls 2) preventive risk assessment for clients that have a reported history of falls, care planning and implementation of community resources for further prevention of falls and injuries due to falls, as well as case management of the ‘at risk’ individuals as their health condition changes and 3) the proactive discharge planning and ongoing case management of individuals who have been hospitalised due to an injury from a fall.

Component 1 – Early Identification

Target Population - proactively identify individuals within the PCT ‘at risk’ of falls;
- Age 65 - 74 - patient to be asked routinely about their falls history and concerns when they first access the healthcare system and then every 6 months thereafter, again when accessing the healthcare system
- Age 75 + - healthcare professional to complete a 5 question screening survey when a patient accesses the healthcare system for any reason and then every 6 months thereafter (when accessing the healthcare system). The five question screening tool will be a requirement for GPs, residential/nursing home providers, rehabilitation home providers, Community and District nurses, therapists, ambulance professionals and unitary authority’s to complete when they come into contact with a client within the targeted population.

Required Action - if identified as “at-risk” by either the falls history enquiry or the screening tool;
- Referral into the Falls Prevention Programme for a comprehensive falls assessment to be completed within 48 hours. This will be performed by a multi-disciplinary team based locally to the patient.
- Completion of a comprehensive multi-factorial assessment, including evaluation of current health status and any medical condition(s), falls history, medications, cognitive status, mobility, strength, fitness and exercise, vision, gait and balance, current biometrics (heart rate, blood pressure, vascular status, etc), foot health and environmental and carer factors (home assessment). Based upon the results of the multifactorial assessment a formal plan of care will be developed with appropriate access to health and social care support services.
Future process / state

Component 2 – Risk Assessment and Falls Prevention

Target Population
- Individuals who have reported a fall
- Individuals who have received outpatient care/A&E/minor injury services or Primary Care services for an injury as a result of a fall,
- Clients or their carers who have reported a fear of falling.

Required Action:
- Referral into the Falls Prevention Programme for a comprehensive falls assessment to be completed within 48 hours by a locally based multidisciplinary team. This comprehensive assessment will be multifactorial as described above.
- Again, based upon the results of the multifactorial assessment a formal plan of care support will be developed when appropriate, with the required access to community based social and healthcare services.

Component 3 – Proactive Discharge Planning and Case Management

The aim of this component is to proactively anticipate the needs of the patient before discharge, ensuring that all required care and services are in place to support timely discharge and to prevent further injury from falls or readmission.

Target Population:
- Individuals who are hospitalised due to an injury as a result of a fall.

Required Action:
- Proactively evaluate the individual’s needs for ongoing support prior to their anticipated discharge date
- Arrange for the required community care and services to be in place upon the client’s arrival regardless of the location to which they are being discharged i.e. nursing or residential home, rehabilitation, own home, carer’s home, etc.
- Enrol the client into case management
- Refer the patient into the Falls Prevention Programme for a comprehensive falls assessment (if not previously enrolled or a re-evaluation, if currently enrolled in the programme)
Component 1 Workflow

Early Intervention

- **Care Home**
- **Community Hospital**
- **A&E**
- **Hospital**
- **Community Provider**
- **GP**

**Encounter**

- **Aged 65 to 74?**
  - **IF YES**
    - **Falls Hx Inquiry**
    - **Question Screening Tool**
    - **Identified at risk?**
      - **YES**
        - **Referral for Multifactoral Assessment including Home Assessment**
      - **NO**
        - **Re-evaluate in 6 months upon accessing the healthcare system (if no other changes occur)**

- **Aged over 75?**
  - **IF YES**
    - **Referral for Multifactoral Assessment including Home Assessment**
  - **IF NO**
    - **Log call, disposition and fax report to the GP and Fall and Reporting Service**

**Decision Point**

- **End**
- **Predefined Process**
- **Description**
Component 2 Workflow

Falls – To Be Process

1. Contact Falls R&R Service - Referral for Multifactoral Assessment including Home Assessment

2. Log call, disposition and fax report to the GP and Fall and Reporting Service

3. Discharged

4. ADMISSION (SEE COMPONENT 3)

5. Assessment completed – patient either helped up either with equipment or with back up form another crew. Further observations will be taken

6. ATTENDANCE A&E

Falls – Westcall

- Ambulance
- Triage Call

No Injuries

Injuries

- Paramedics
- Serious Injuries

- Primary Care
- Secondary Care

Primary Care

Secondary Care

Predefined Process

Description

Decision Point

End

Primary Care

Secondary Care

Log call, disposition and fax report to the GP and Fall and Reporting Service

Discharged

ADMISSION (SEE COMPONENT 3)
Component 3 Workflow
Pro-active Discharge Planning & Case Management

1. Contact Falls R&R Service - Referral for Multifactorial Assessment including Home Assessment
2. Log call, disposition and fax report to the GP and Fall and Reporting Service
3. Referral to Case Management
4. Discharge Planning Assessment
5. Discharge Planning Development
6. Discharge Planning Implementation

Primary Care
Secondary Care

Decision Point
End
Predefined Process
Description

Hospital Admission due to fall
Elderly Care Ward
Orthopaedics Ward

Care Home / Rehabilitation Home
Continued to be followed by the Case Management for additional falls prevention needs

Home

Home safety evaluation (see Assessment Pathway)
Multifactorial Assessment (see Assessment Pathway)

Care Home Assessment
Comm Physio OT Rehab Plan
Social Services Care Plan
Multifactorial Assessment Workflow

Multifactorial Assessment

1) Detail history of falls
2) Current medication review (over the counter and prescription only)
3) Relevant medical history
4) Assessment of gait, balance and mobility
5) Assessment of vision
6) Physical examination
   a) Neurological exam
   b) Cardiovascular exam
   c) Muscle strength
   d) Vascular flow in lower extremities
   e) Examination of feet
7) Functional assessment
8) Home environment assessment (personal home, care home, nursing home, rehabilitation home etc)
9) Interview with carer (if applicable)

Falls Prevention Interventions - Care Plan Examples (all as appropriate)
1) Referral to specialty care
2) Modification of home environment
3) Treatment for postural hypotension
4) Exercise plan
5) Modifications to medications
   - vitamin D supplement
6) Vision impairment treatment
7) Social care needs
   - food preparation
   - home cleaning services
8) Podiatry for foot problems

Log call, disposition and fax report to the GP and Fall and Reporting Service

Prepared by: Carolyn Lawson, Barbara Johnson & Kelly Birch
Proposed scope

**Component:** The proposed Falls Prevention Programme

**Component 1: Early Identification**

**Component 2: Risk Assessment and Falls Prevention**

**Component 3: Proactive Discharge Planning and Case Management**

**Description:** This Falls Prevention Programme will provide a structured process for the early identification of individuals ‘at risk’ of falling, comprehensive assessment as to the risk of falling and resulting injury, establishment of care and support services to minimise the likelihood of falling and a process to support timely hospital discharge after a falls related injury and ongoing case management services to prevent readmission due to fall injuries or complications from a fall injury.

**In scope**

**Component 1: Early Identification**

Delivery of an initial ‘at risk’ identification process to identify those patients that warrant further detailed assessment of their falls risk. This component will include:

- The development and implementation of a PCT-specific paper-based screening tool for the early identification of patients potentially ‘at risk’ of falls and subsequent referral to the Falls Assessment Programme from multiple sources, such as GPs, acute trusts, district nurses, social services, intermediate care and other services.
- The development of a reporting policy and consistent process to collect data on falls, ‘at risk’ screening, referrals for further assessment and programme outcomes.

**Component 2: Risk Assessment and Falls Prevention**

Delivery of a comprehensive risk assessment tool and service, which identifies the specific service requirements a client, needs to mitigate the risk of falling and injury from falling. This component will include:

- The development and implementation of a comprehensive multi-factorial risk-assessment tool to assist in the identification of the community care and service needs of patients identified as at-risk of falls
- The identification and provision of programmes and services required to mitigate identified risks
Proposed scope

**Component 3: Proactive Discharge Planning and Case Management**

- Delivery of a proactive discharge planning process which identifies the specific service requirements a client will need to have in place to support timely hospital discharge and allows for access to community care and services required to mitigate the risk of extending the hospitalisation or future readmission to the hospital. This component will include:
  - The development and implementation of a proactive discharge planning process which will require management by the PCT’s case managers.
  - The development and implementation of a comprehensive discharge-planning tool.
  - The identification of programmes and services required for discharge to occur.

All Components:

- Identification and commissioning of the service specifications and key performance indicators
- Development and delivery of stakeholder specific training and engagement programmes to ensure the successful implementation of the Fall Prevention services by the PCT staff.
- Development of a data collection process and reporting tool to allow tracking of falls and reporting on the agreed upon key performance indicators
- Implementation of the Fall Prevention and Maintenance programme for the 09/10 operating plan.
- Multiple sources, such as GPs, acute trusts, district nurses, social services, intermediate care, and other services.
- The development of a reporting policy and consistent process for identified as requiring further screening

Prepared by: Carolyn Lawson, Barbara Johnson & Kelly Birch
Out of scope – All Components

- The development or further enhancements of programmes and services required to mitigate identified risks for fall prevention (non-PCT provider provisions).
- The development or further enhancements of programmes and services required to promote timely discharge and mitigate readmission due to fall, injury due to a fall or lack of care required creating complications from a fall.
- The development of IT system support for the falls programme
- The electronic incorporation of the falls screening and assessment tools into the GP Surgeries electronic medical records. (Opportunity for future investment)
- Staffing requirements for Programmes and services needed to provide community care and services to mitigate the risk of future falls or injury due to falls, delay in hospital discharge or future hospital admissions
- Case Management Process and Programme
- Policy recommendations for medicines to be included in the formulary and for DEXA scanning for the diagnosis and treatment of osteoporosis
- Identified services gaps will be considered for future commissioned projects in the next fiscal year for example adequate support services for patients presenting with dementia
3. Stakeholder management

Stakeholder map

<table>
<thead>
<tr>
<th>Interest</th>
<th>Influence/Power</th>
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</thead>
<tbody>
<tr>
<td>Low</td>
<td>Low</td>
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<tr>
<td>Moderate</td>
<td>High</td>
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<tr>
<td>High</td>
<td>High</td>
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</table>

- **INFORM**
  - Vol. Sector
  - BW Falls Group

- **CONSULT**
  - PCT Provider Services
  - Patients/Carers
  - Acute Hosp

- **INVOLVE**
  - Care Homes
  - Mental Health
  - GP's
  - Adult Ser.

- **PARTNER**
  - Ambulance Service
  - Westcall OOH
  - IC
  - Case Managers
  - Leisure & Rec
  - Public Health
Stakeholder Impact Map

**Before**

<table>
<thead>
<tr>
<th>Present Mindset</th>
<th>High</th>
<th>Moderate</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resistant</td>
<td>GP’s</td>
<td>Mental Health</td>
<td></td>
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<tr>
<td>Neutral</td>
<td>Patients/Carers</td>
<td></td>
<td></td>
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<tr>
<td>Supportive</td>
<td>Ambulance Service</td>
<td>Care Homes</td>
<td></td>
</tr>
<tr>
<td>Committed</td>
<td>Acute Hosp</td>
<td>Vol. Sector</td>
<td>PCT Provider Services</td>
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</table>

**Change**

<table>
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<tr>
<th>Present Mindset</th>
<th>High</th>
<th>Moderate</th>
<th>Low</th>
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<tbody>
<tr>
<td>Resistant</td>
<td>GP’s</td>
<td>Mental Health</td>
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<td>Neutral</td>
<td>Patients/Carers</td>
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<tr>
<td>Supportive</td>
<td>Ambulance Service</td>
<td>Care Homes</td>
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<tr>
<td>Committed</td>
<td>Acute Hosp</td>
<td>Vol. Sector</td>
<td>PCT Provider Services</td>
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**After**

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<th>Present Mindset</th>
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<th>Moderate</th>
<th>Low</th>
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<tbody>
<tr>
<td>Supportive</td>
<td>Care Homes</td>
<td>Leisure &amp; Rec</td>
<td>Westcall OOH</td>
</tr>
<tr>
<td>Required Mindset</td>
<td>GP’s</td>
<td>Mental Health</td>
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<tr>
<td>Committed</td>
<td>Ambulance Service</td>
<td>Adult Ser</td>
<td>Acute Hosp</td>
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</tbody>
</table>

* See Appendix I – Key Stakeholders for details

- = Partner Stakeholder
- = Involved Stakeholder
- = Consulting Stakeholder
### Benefits matrix

<table>
<thead>
<tr>
<th>Benefit / Stakeholder group</th>
<th>GP</th>
<th>Mental Health</th>
<th>Care Homes</th>
<th>Adult Services (Social Care)</th>
<th>Intermediate Care (IC)</th>
<th>Case Managers</th>
<th>Voluntary Sector</th>
<th>Acute Hospital Service</th>
<th>Ambulance Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Better for patients</strong></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Early ID of ‘at risk’ individuals</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>Maintain independence of the patients/reduce reliance on system</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Provides follow-up/further assessment for prevention of future falls/injury</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Acts with a greater sense of urgency</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Maintain a patient in their own home/ reduce the risk of mental deterioration.</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Provides 24X7 access</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Proactively, improving the health status of patients to deter a fall,</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Access to community care/required services</td>
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<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td><strong>Simpler for provider</strong></td>
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<tr>
<td>Consistent programme/single point of contact/commonality of services nomenclature.</td>
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<tr>
<td>Formal care planning process and service access requirements</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Properly funded and commissioned programmes for exercise and fitness</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td><strong>Cheaper for health economy / provider</strong></td>
<td></td>
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<tr>
<td>Reduction in calls due to the early identification and ongoing the management of ‘at risk’ individuals for falls</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</table>
Communication Timeline

GP Communication Timeline

- 12/6/2008: Stakeholder Meeting #1 - Program Introduction & Objectives
- 23/7/2008: Area Briefing - Wokingham (Program Introduction)
- 15/7/2008: Area Briefing - West Berkshire (Program Introduction)
- 13/9/2008: GP Forum Reading
- 14/9/2008: GP Forum Reading
- 16/9/2008: Area Briefing - Wokingham (Program Update)
- 02/10/2009: GP Newsletter Falls Program Articles
- 17/10/2008: Stakeholder Meeting #2 - Program Design Review
- 18/10/2008: Area Briefing - Reading (Program Introduction)
- 20/10/2008: GP Newsletter Falls Program Articles
- 29/10/2008: GP Newsletter Falls Program Articles
- 17/12/2008: GP Newsletter Falls Program Articles
- 13/9/2009: GP Newsletter Falls Program Articles
- 19/9/2009: GP Newsletter Falls Program Articles
- 10/10/2009: GP Newsletter Falls Program Articles
- 15/10/2009: GP Newsletter Falls Program Articles
- 02/12/2009: GP Newsletter Falls Program Articles
Public Communication Timeline

12/06/2008
Stakeholder Meeting #1 - Program Introduction & Objectives

18/07/2008
Stakeholder Meeting #2 - Program Design Review

02/07/2008
PPI Links - News Bulletin 07/07/2008

05/09/2008
PPI Links - News Bulletin

PCT AGM Forum

24/10/2008
Partners in Voluntary Services

05/12/2008
PPI Links - News Bulletin

19/12/2008
Annual Survey 19/12/2008
4. Financial appraisal – Cost benefit analysis - You will need to complete a separate analysis for each option

<table>
<thead>
<tr>
<th>Bid reference number(s) in Operating Plan</th>
<th>Bid 19 &amp; Bid 49</th>
</tr>
</thead>
</table>
| Agreed with finance manager | Name: Nigel Foster  
Date: 28/5/08 | Reasonable and complete: Yes  
Aligned with budget: Yes |

Current costs

Current costs for the falls management programme are unknown. One of the significant benefits of this programme is that we will develop the infrastructure to understand the total cost of caring for patients who fall, and to monitor changes to this cost over time on both a per patient and service-wide perspective. We are able to quantify the cost of secondary care for patients over 65 years of age who are admitted for fractured neck of femur. This totals approximately £3,026,000 per year for tariff, and £72,000 for excess bed days. The Market Forces Factor for Royal Berkshire Foundation Trust is 1.2275, resulting in a total cost for inpatient spells for fractured neck of femur in older people to be approximately £3.8 million in Berkshire West PCT.

Relevant costs

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3 (onwards)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>£63,977</td>
<td>£110,680</td>
<td>£110,680</td>
</tr>
<tr>
<td>Non-staffing</td>
<td>£37,500</td>
<td>£63,000</td>
<td>£63,000</td>
</tr>
<tr>
<td>Overheads*</td>
<td>PCT Overhead not Considered</td>
<td>PCT Overhead not Considered</td>
<td>PCT Overhead not Considered</td>
</tr>
<tr>
<td>Revenue implications of capital costs*</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Gross costs</td>
<td>£101,477</td>
<td>£173,680</td>
<td>£173,680</td>
</tr>
<tr>
<td>Miscellaneous income</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
**Net costs (affordability measure)** | £101,477 | £173,680 | £173,680
---|---|---|---
Estimated savings | £150,000 | £303,000 | £303,000

**Net costs (VFM measure)** | £48,523 savings | £129,320 savings | £129,320 savings
---|---|---|---

**Key assumptions**
- Secondary care savings include value of market forces factor
- 10% reduction in inpatient spells and excess bed days for fractured neck of femur.
- Forms, supplies, etc cost £3,000 pounds per annum
- 22% MFF included in the weighted tariff
- A Band 7 Falls Coordinator is recruited to support this programme beginning year 2.
- Additional medical equipment (potentially shared expense with local authorities) will cost £10,000 per annum
- 500 additional patients are prescribed formulary drugs to reduce fracture risk @£100 per patient per year
- GPs adhere to PCT formulary for prescribing
- Current PCT staff who provide falls prevention services to patients will be able to provide the service to additional patients without additional resource.
- Savings associated with reduced A & E attendances, admissions for other injuries caused by falls are not included in savings. We have not included any savings associated with reduced ambulance calls. We have not included savings associated with reducing the level of frailty.
- Staff for the Falls Referral and Reporting Service begin work on 1 September and the programme is effective 1 October.

**Sensitivity analysis**
- Impact of requiring a LES to assist GPs to perform the screening, fax reports, etc. could be approximately £25,000

**Project costs**

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3 (onwards)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>£57,279</td>
<td>Included in Revenue Costs</td>
<td>Included in Revenue Costs</td>
</tr>
<tr>
<td>Non-staffing</td>
<td>£47,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overheads*</td>
<td>PCT general overhead not included</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Change Programme Management Group
### Business case

<table>
<thead>
<tr>
<th>Gross costs</th>
<th>£104,279</th>
</tr>
</thead>
</table>

**Key assumptions**
- Assumes programme is implemented by 1 October 2008.
- Assumes programme development continues until 31 March 2009 with 3 days per week of Carolyn’s time (or her replacement while on leave) and 1 day per month of Cathy’s time.
- Assumes in-house resource for training, or cost comparable to in-house resource.
- Assumes no external support is required beyond September, 2008.

### Sensitivity analysis

<table>
<thead>
<tr>
<th>Capital costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key assumptions</strong></td>
</tr>
<tr>
<td><strong>Sensitivity analysis</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3 (onwards)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

### Gross costs

<table>
<thead>
<tr>
<th>Key assumptions</th>
<th>Gross costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumes programme is implemented by 1 October 2008. Assumes programme development continues until 31 March 2009 with 3 days per week of Carolyn’s time (or her replacement while on leave) and 1 day per month of Cathy’s time. Assumes in-house resource for training, or cost comparable to in-house resource. Assumes no external support is required beyond September, 2008.</td>
<td>£104,279</td>
</tr>
</tbody>
</table>
## Metrics

### Leading indicators

<table>
<thead>
<tr>
<th>Programme Component 1, 2, 3</th>
<th>Name</th>
<th>Baseline (Current value)</th>
<th>Target value</th>
<th>How will you measure it?</th>
<th>When will you measure it?</th>
<th>How often / starting when?</th>
<th>Who provides the data?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage of staff trained</td>
<td>Number of staff trained in falls prevention – not currently available</td>
<td>100 % of targeted stakeholders</td>
<td>Sign in requirements against staff listings</td>
<td>Weekly % complete</td>
<td>Weekly, first training session</td>
<td>Julia Bliss/Kelly Birch</td>
</tr>
<tr>
<td></td>
<td>Number of referrals</td>
<td>Number of referrals to the Falls Prevention Programme for further assessment</td>
<td>Number of age 65 and greater population screened vs. referred for further assessment</td>
<td>Screening reporting vs. referral reporting</td>
<td>Starting at the inception of programme implementation</td>
<td>Monthly, within 10 business days of month end, starting at the inception of programme implementation</td>
<td>Falls Referral and Reporting Service</td>
</tr>
<tr>
<td></td>
<td>Percentage of referrals assessed</td>
<td>Number of patients assessed per month-not currently available</td>
<td>100 % of referrals received</td>
<td>Referrals reported vs. Referrals assessed and care plans developed</td>
<td>Starting at the inception of programme implementation</td>
<td>Monthly, within 10 business days of month end, starting at the inception of programme implementation</td>
<td>Falls Referral and Reporting Service</td>
</tr>
<tr>
<td></td>
<td>Number of care homes assessed and trained</td>
<td>Number of care homes trained per month-not currently available</td>
<td>100 % of targeted stakeholders</td>
<td>Sign in requirements against staff listings</td>
<td>Weekly % complete</td>
<td>Weekly, first training session</td>
<td>Julia Bliss/Kelly Birch</td>
</tr>
</tbody>
</table>
### Lagging indicators

<table>
<thead>
<tr>
<th>Programme Component 1, 2, 3</th>
<th>Name</th>
<th>Baseline (Current value)</th>
<th>Target value</th>
<th>How will you measure it?</th>
<th>When will you measure it?</th>
<th>How often / starting when?</th>
<th>Who provides the data?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2 &amp; 3</td>
<td>Number of falls – a common definition and assumptions will be used to create baseline and monitoring</td>
<td>Definition of number of falls</td>
<td>100% of falls reported vs. anticipated falls</td>
<td>Falls reporting requirements of the new programme</td>
<td>Starting at the inception of programme implementation</td>
<td>Monthly, within 10 business days of month end, starting at the inception of programme implementation</td>
<td>Falls Referral and Reporting Service</td>
</tr>
<tr>
<td>3</td>
<td>Number and cost of admissions associated with falls in frail elderly</td>
<td>Admitted activity – 423 of which 95% assumed falls related total activity baseline for admitted patients = 402</td>
<td>100% of falls reported associated with a falls associated HRG</td>
<td>Falls reporting requirements vs. admitted individuals with an HRG, that is associated with a fall injury.</td>
<td>Starting at the inception of programme implementation</td>
<td>Monthly, within 10 business days of month end, starting at the inception of programme implementation</td>
<td>Falls Referral and Reporting Service</td>
</tr>
<tr>
<td>3</td>
<td>Number and cost of excess bed days associated with falls in frail elderly</td>
<td>Excess bed days associated with falls- 364 in 12 months ending September, 2007</td>
<td>100% of admissions with a falls associated HRG</td>
<td>Case Manager will be required to report excess bed days per admission and the reason for the excess.</td>
<td>Starting at the inception of programme implementation</td>
<td>Monthly, within 10 business days of month end, starting at the inception of programme implementation</td>
<td>Falls Referral and Reporting Service</td>
</tr>
<tr>
<td>2 &amp; 3</td>
<td>Number and cost of A &amp; E attendances associated with falls in frail elderly</td>
<td>Need to develop a baseline</td>
<td>100% of falls associated A&amp;E attendances reported via the programme reporting requirements</td>
<td>Falls reporting requirements of the new programme</td>
<td>Starting at the inception of programme implementation</td>
<td>Monthly, within 10 business days of month end, starting at the inception of programme implementation</td>
<td>Falls Referral and Reporting Service</td>
</tr>
</tbody>
</table>
5. Project management

Key deliverables

*Current and future state analysis, including*

- A review of the current Falls Service, including geographical spread, referral criteria, and levels of activity;
- A review of the literature for best practices to identify high risk patients;
- A review of the literature study of osteoporosis prevention and treatment;
- Whole care system pathway review of a sample of patients who have had a recent admission with fractured neck of femur;

*Service model for Falls Prevention including:*

- Development of a 7 day per week falls referral and reporting service, which provides paper-based tools and is available to health care professionals for reporting of falls and ensuring that a consistent and appropriate referral occurs for further assessment based upon the services available in each locality.
- Establishing consistent and representative methods to count the number of falls
- Design of a comprehensive integrated programme to reduce/manage risk factors and ensure an effective care pathway for patients still experiencing a fall;
- A process for the case/risk identification of older people with a likelihood of falling and sustaining a fracture;
- A process for referrals of patients to the Falls Programme
- A falls risk assessment programme;
- Targeted interventions for those most ‘at risk’;
- An evidence based medicine review of patients with osteoporosis (to include the role of DEXA scanning);
- Design of a pro-active care management programme for patients with or at risk of developing osteoporosis;
- Development for KPIs for the falls service;

*Stakeholder management and enablement:*

- A stakeholder engagement strategy:
- Participation of those ‘at risk’ in prevention programmes including education and information giving; and
- Education for professionals dealing with the ‘at risk’ population.
## Dependencies

<table>
<thead>
<tr>
<th>Project / Area / Service</th>
<th>Delivers to / for</th>
<th>What?</th>
<th>When?</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBC</td>
<td>To Patients and PCT</td>
<td>Commissioning/service redesign of some provider services for a comprehensive and effective falls service</td>
<td>Present at the 22nd July agenda to review the project and discuss overlap and concerns</td>
</tr>
<tr>
<td>Acute Provider (RBHFT)</td>
<td>To PCT, patients and GPs</td>
<td>Referral of patients ‘at risk’ for fall to the falls service Proactive planning for discharge beginning upon admission to ensure the need for excess bed days is not due to lack of/ or untimely planning for community care and services</td>
<td>Present the programme at the Berkshire West falls group meeting at the July meeting.</td>
</tr>
<tr>
<td>Berkshire West Falls Group</td>
<td>To PCT</td>
<td>Identifies existing examples of good practices and develops strategy to support programme design</td>
<td>Monthly Berkshire West falls group meeting agenda starting in June meeting and monthly thereafter</td>
</tr>
<tr>
<td>District Nursing / Case Management Project</td>
<td>To PCT, patients and GPs</td>
<td>Service capacity to identify patients for referral to the falls programme, and potential application of the risk assessment tool</td>
<td>Falls Prevention Steering Group to discuss managing the interface between Falls, CM and Service Transformation project.</td>
</tr>
<tr>
<td>Intermediate Care Project</td>
<td>To PCT, patients and GPs</td>
<td>Service capability to identify patients for referral to the falls programme and potential application of the risk assessment tool</td>
<td>Falls Prevention Steering Group to discuss managing the interface between Falls, CM and Service Transformation project.</td>
</tr>
<tr>
<td>Integrate Intermediate Care with UAs Project (Social Care)</td>
<td>To Falls Project</td>
<td>Provides source of referral to Falls Prevention service and savings from in care home service requirement from UA. Will likely also result in additional, less expensive services provided by UA to reduce falls.</td>
<td>Falls Prevention Steering Group to discuss managing the interface between Falls, CM and Service Transformation project.</td>
</tr>
<tr>
<td>Service Transformation in Clinical Services Project</td>
<td>To Falls Prevention Project</td>
<td>Potentially provides released resource to support the Falls Prevention service</td>
<td>Falls Prevention Steering Group to discuss managing the interface between Falls, CM and Service Transformation project.</td>
</tr>
</tbody>
</table>
## Change Programme Management Group
### Business case

| Dementia Service Support | To Falls Prevention Project | Development of skilled practitioners in the community to maintain those with dementia at home. Working in partnership with local authority social services that support dementia care to ensure adequate provision of residential dementia care. | CPMG to consider investing in this service as a project |

## Risks and Issues

<table>
<thead>
<tr>
<th>Risk</th>
<th>Status</th>
<th>Owner</th>
<th>Mitigating action</th>
<th>Impact</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project lead going on maternity leave</td>
<td>Green</td>
<td>Cathy Winfield</td>
<td>Alternative project lead identified, however is currently on leave, not returning until 1/7/08 New project lead took over new responsibilities effective 01/07/08.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interdependency with other Community Services projects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPs will be required to support change in practice to refer patients to Falls programme.</td>
<td>Amber</td>
<td>Clinical Champion, Julia Bliss and Kelly Birch</td>
<td>Communicate reduction in effort for dealing with increasing fraility of patients who experience falls.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty of effecting change within primary care</td>
<td>Green</td>
<td>Clinical Champion, Julia Bliss and Kelly Birch</td>
<td>Early and ongoing engagement with stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem of capacity within primary care which may require additional resources</td>
<td>Amber</td>
<td>Clinical Champion, Julia Bliss and Kelly Birch</td>
<td>Make sure that the falls project links in with the intermediate care, case management and the service transformation project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems of capacity within Recreation and Leisure for exercise programmes</td>
<td>Amber</td>
<td>Clinical Champion, Julia Bliss and Kelly Birch</td>
<td>Ensure that communication occurs with this group, by actively involving them in the Stakeholder Counsel and the roll-out of the programme</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Project team

<table>
<thead>
<tr>
<th>Team member</th>
<th>Time requirement (day per month)</th>
<th>Description of role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cathy Winfield</td>
<td>1</td>
<td>Programme Sponsor</td>
</tr>
<tr>
<td>Jan Thomas (external)</td>
<td>1</td>
<td>Programme Lead</td>
</tr>
<tr>
<td>Carolyn Lawson</td>
<td>8 (till 30/06/08)</td>
<td>Project Manager</td>
</tr>
<tr>
<td>Kelly Birch</td>
<td>8</td>
<td>Programme Lead</td>
</tr>
<tr>
<td>TBC (from June)</td>
<td>5</td>
<td>Project Support</td>
</tr>
<tr>
<td>Julia Bliss</td>
<td>1 (till 30/06/08)/ 8 (starting 01/07/08)</td>
<td>Falls Service/Project Manager</td>
</tr>
<tr>
<td>Barbara Johnson (external)</td>
<td>1</td>
<td>SME Lead</td>
</tr>
<tr>
<td>Falls Council Project Group – (in addition to the above)</td>
<td>0.25 per team member</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>Patient Representative –</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical GP Lead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Care Lead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate Care Lead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Improvement Locality Lead, Public Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls Services Lead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Matron Lead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geriatrician - OT Lead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy Lead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Development Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthogeriatrician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Lead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure and Recreation service Leads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Berkshire Care Association Rep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alzheimers Society Rep</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Governance

Change Programme Management Group
Chair: Charles Waddicor (CEO)

Project Sponsor
Cathy Winfield
(Director of Commissioning)

Falls Prevention Steering Committee
Chair: Cathy Winfield
(Monthly)

Berkshire West Falls Group
Chair: Julia Bliss
(Monthly)

Falls Stakeholder Counsel
(Consultative)
Chair: Julia Bliss

Clinical Services Project Steering Group
Anne Owen
(Monthly)

1st Line problem solving
Ensures the delivery of the project on time, in budget and scope

2nd Line problem solving
Removes strategic and operational blocks in the project. Overall accountability for

3rd Line problem solving
Escalate

Escalate

1st Line problem solving
Manages the day to day delivery of the project

Escalate

Removes strategic and operational blocks in the project. Overall accountability for
**Change Programme Management Group**

**Business case**

<table>
<thead>
<tr>
<th>Reports to</th>
<th>Change Programme Management Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Approve</strong></td>
</tr>
</tbody>
</table>

**Internal project governance**

Escalation procedure to be used as outline by the CPMG – Project Support (5d) -> Project Manager (5d) -> Programme Lead (3d) -> Project Sponsor (3d) -> CPMG

<table>
<thead>
<tr>
<th>Who / Group</th>
<th>Frequency of meeting and reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Delivery Team</td>
<td>Weekly</td>
</tr>
<tr>
<td>Falls Prevention Steering Committee</td>
<td>Monthly</td>
</tr>
<tr>
<td>Berkshire West Falls Group</td>
<td>Monthly</td>
</tr>
<tr>
<td>Falls Stakeholder Counsel</td>
<td>As Needed</td>
</tr>
<tr>
<td>CPMG</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
Timelines

Major Milestones

- 21/07/2008: Do – implementation begins
- 01/09/2008: KPIs Agreed, Staff hired
- 30/09/2008: Short Project End
- 02/06/2008: Set UP – PID Sign off
- 01/05/2008: Project Established
- 15/08/2008: Service Model Complete
- 21/07/2008: Planning – Project Plan sign off
- 21/07/2008: Project Review
- 21/07/2008: 02/07/2008: Plan – Sign off Business Case & Stakeholder Map
- 07/07/2008: Analysis Complete
- 31/07/2008: Analysis Complete
- 31/09/2008: Project Review
- 01/09/2008: KPI Sign Off
- 30/09/2008: First Falls Activity Report
- 30/09/2008: KPI Sign Off
- 07/04/2009: Annual (6 month) Falls Report to PEC
- 07/07/2008: Project Implementation Commences
- 14/07/2008: End of Fiscal Year
- 31/03/2009: End of Fiscal Year
- 07/04/2009: End of Fiscal Year
## Major Milestone descriptions

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1 Set UP – PID Sign off</td>
<td>2nd June</td>
</tr>
<tr>
<td>M2 Plan – Sign off Business Case &amp; Stakeholder Map</td>
<td>7th July</td>
</tr>
<tr>
<td>M3 Planning – Project Plan sign off</td>
<td>21st July</td>
</tr>
<tr>
<td>M4 Do – implementation to commence</td>
<td>21st July</td>
</tr>
<tr>
<td>M5 Current and Future State Analysis Complete</td>
<td>31st July</td>
</tr>
<tr>
<td>M6 Service Model for Falls Prevention Complete</td>
<td>15th August</td>
</tr>
<tr>
<td>M7 KPIs Agreed, Falls Referral and Reporting Service Staff hired</td>
<td>1st September</td>
</tr>
<tr>
<td>M8 KPI Sign Off</td>
<td>1st September</td>
</tr>
<tr>
<td>M9 Project Review</td>
<td>30th September</td>
</tr>
<tr>
<td>M11 First Falls Activity Report/Analysis/Data Validation</td>
<td>31st October</td>
</tr>
<tr>
<td>M12 Finalize Falls Report Format</td>
<td>19th November</td>
</tr>
<tr>
<td>M13 Annual Falls Report to PEC</td>
<td>7th April</td>
</tr>
</tbody>
</table>
Change Programme Management Group
Business case

Secondary Milestones

02/07/2008
Project Established
01/05/2008
Provider Oversight Cmte
20/08/2008 - 20/08/2008
Provider Oversight Cmte
22/10/2008 - 22/10/2008
Provider Oversight Cmte
21/01/2009 - 21/01/2009
November Falls Activity Report Accuracy Analysis
Stakeholder & PT Engagement
04/06/2008 - 04/07/2008
08/07/2008 - 01/09/2008
Operational Delivery / KPI Dev
03/09/2008 - 29/09/2008
Training Implementation
14/1/2008 - 14/11/2008
Stakeholder Meeting - Program Validation
16/01/2009 - 16/01/2009
Stakeholder Meeting - Program Validation
20/02/2009 - 20/02/2009
Stakeholder Meeting - Program Enhancement

07/04/2009
End of Fiscal Year
31/03/2009

07/04/2009
Annual (6 month) Falls Report to PEC

Screening and Assessment Tool Deployment
31/07/2008 – 31/07/2008

### Sustainability/Business Continuity

The Falls Prevention Programme requires a 1-year programme to measure return on investment. The sustainability of the project after September 2008 is dependent on:

1. **Consistent processes throughout the PCT that are clear and owned by the Sponsor and Project Manager.**
   - Cathy Winfield will ensure adequate project resource for project ownership over the full year
   - Development of the Falls Prevention Referral and Reporting Service, lead by a Falls Coordinator, to provide a single point of access for health care professional who identify individuals ‘at risk’ for falling or who have experienced a fall.

2. **Communication strategy that extends beyond September 2008.**
   - This will be developed and embedded by the close of Sept 2008
   - This communication strategy will raise awareness within Provider Services and the community as to the Falls Prevention Programme and the care and services associated with the programme.
   - This will assist in developing Stakeholder Buy-in for the Falls Prevention Programme and compliance with the screening, assessment, planning and reporting process

3. **Development of baseline data, where none exists today and maintenance of the Falls Prevention Database for monitoring, reporting and analytic purposes.**

4. **Comprehensive and ongoing training programme for health care professionals in the PCT**

5. **KPIs proven and in-place and operational by close of September 2008**

6. **Ongoing ownership.**
   - Project Group to continue on a bi-monthly basis for the duration of the year to ensure on-going progress is made.
   - Project Group to re-evaluate process to ensure that continuous improvement occurs on identified gaps.

7. **Perceived benefit by the stakeholders.**
   - 1 Year evaluation to be lead by the ongoing PCT Project Lead Julia Bliss, to determine all stakeholder group satisfaction with the programme

### Comments
### Key stakeholders

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Impact (H/M/L)</th>
<th>Present mindset (R/N/S/C)</th>
<th>Support needed (R/N/S/C)</th>
<th>Concerns / issues / resistance (with proposed change)</th>
<th>Benefits / what’s good about proposed change?</th>
<th>Actions to resolve concerns / responsibility / date</th>
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</table>
| GP                           | H              | N                         | C                        | More time requirement per patient/consultation  
Reporting/data collection requirements.                                                                                   | Early identification of “at risk” individuals  
Consistent programme with a single point of contact and commonality of services nomenclature.  
Developed to maintain independence of the patients and reduce reliance on healthcare system  
Improved hours of access.  
Action with a greater sense of urgency,  
Provides follow-up and further assessment for prevention of future falls/injury | Education on current costs due to lack of programme at present/project manager/08-08  
Education of new programme process and individual role and responsibility in process/project manager/08-08.  
Provide easy to use tools and reporting mechanisms/project manager/08-08  
Consider need to develop locally enhance services (LES) to gain GP support. |
| Care Homes (Nursing Homes / Rehabilitation Homes) | H              | S                         | C                        | Developing a new set of competencies in the homes due to the requirements of the future process.  
More time requirement per patient.  
Skills required for assessment not within competencies of existing staff  
Reporting required.                                                                                                       | Early identification of ‘at risk’ individuals  
Consistent programme with a single point of contact and commonality of services/ nomenclature.  
Developed to maintain independence of the patients,  
Provides 24X7 access,  
Acts with a greater sense of urgency.  
Requires follow-up and further assessment for prevention of future falls/injury | Education on current costs due to lack of programme at present/project manager/08-08  
Education of new programme process and individual role and responsibility in process/project manager/08-08.  
Provide easy to use tools and reporting mechanisms/project manager/08-08 |
## Stakeholder Impact

### Adult Services (Social Care)
- **Impact (H/M/L):** H
- **Present Mindset (R/N/S/C):** S
- **Support needed (R/N/S/C):** C
- **Concerns / issues / resistance (with proposed change):**
  - Change in current process.
  - Perceived threat to local ownership of service provision.
  - Reporting required.
- **Benefits / what’s good about proposed change:**
  - Early identification of ‘at risk’ individuals
  - Consistent programme with a single point of contact and commonality of services/nomenclature.
  - Developed to maintain independence of the patients,
  - Provides 24X7 access,
  - Acts with a greater sense of urgency,
  - Requires follow-up and further assessment for prevention of future falls/injury
- **Actions to resolve concerns / responsibility / date:**
  - Education on current costs due to lack of programme at present/project manager/08-08
  - Education of new programme process and individual role and responsibility in process/project manager/08-08.
  - Provide easy to use tools and reporting mechanisms/project manager/08-08.

### Intermediate Care (IC)
- **Impact (H/M/L):** H
- **Present Mindset (R/N/S/C):** S
- **Support needed (R/N/S/C):** C
- **Concerns / issues / resistance (with proposed change):**
  - Change in current process.
  - More time requirement per patient/increased workload.
  - Reporting required.
- **Benefits / what’s good about proposed change:**
  - Early identification of ‘at risk’ individuals
  - Consistent programme with a single point of contact and commonality of services/nomenclature.
  - Developed to maintain independence of the patients,
  - Provides 24X7 access,
  - Acts with a greater sense of urgency,
  - Requires follow-up and further assessment for prevention of future falls/injury
- **Actions to resolve concerns / responsibility / date:**
  - Education on current costs due to lack of programme at present/project manager/08-08
  - Education of new programme process and individual role and responsibility in process/project manager/08-08.
  - Provide easy to use tools and reporting mechanisms/project manager/08-08.
### Stakeholder Impact

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<tbody>
<tr>
<td>Case Management</td>
<td>H</td>
<td>R</td>
<td>C</td>
<td>Change in current process.</td>
<td>Early identification of ‘at risk’ individuals</td>
<td>Education on current costs due to lack of programme at present/project manager/08-08</td>
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<td>More time requirement per patient/additional caseload.</td>
<td>Consistent programme with a single point of contact and commonality of services/ nomenclature.</td>
<td>Education of new programme process and individual role and responsibility in process/project manager/08-08</td>
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<td>Capacity of staff members to be able to manage the elderly identified as ‘at risk’ for falls.</td>
<td>Developed to maintain independence of the patients,</td>
<td>Provide easy to use tools and reporting mechanisms/project manager/08-08</td>
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<td>Ability to timely put community care and services in place once the assessment is complete and the required actions are identified.</td>
<td>Provides 24X7 access,</td>
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<td>Reporting required.</td>
<td>Acts with a greater sense of urgency,</td>
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<td>Requires follow-up and further assessment for prevention of future falls/injury</td>
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<td>Formal care planning process and service access requirements</td>
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<td>Ambulance Service</td>
<td>H</td>
<td>S</td>
<td>C</td>
<td>Change in current process.</td>
<td>Reduction in calls due to the early identification of ‘at risk’ individuals for falls and the management of that risk on an ongoing basis.</td>
<td>Education on current costs due to lack of programme at present/project manager/08-08</td>
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<td>More time requirement per patient.</td>
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<td>Reporting required.</td>
<td>Provides 24X7 access,</td>
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<td>Acts with a greater sense of urgency, to decrease the number of repeat ambulance calls that might occur.</td>
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<tr>
<td>Patient/Carers</td>
<td>H</td>
<td>N</td>
<td>C</td>
<td>Change in current process.</td>
<td>Developed to maintain independence of the patients, Ensured access to community care and services required. Osteoporosis early screening.</td>
<td>Education of new programme and their role and responsibility in process/communications/08-08. Education on easy of access/communications/08-08</td>
</tr>
<tr>
<td>Westcall</td>
<td>H</td>
<td>S</td>
<td>C</td>
<td>Change in current process. More time requirement per patient. Reporting required.</td>
<td>Early identification of ‘at risk’ individuals Consistent programme with a single point of contact and commonality of services/nomenclature. Developed to maintain independence of the patients, Provides 24X7 access, Acts with a greater sense of urgency, Requires follow-up and further assessment for prevention of future falls/injury</td>
<td>Education on current costs due to lack of programme at present/project manager/08-08 Education of new programme process and individual role and responsibility in process/project manager/08-08. Provide easy to use tools and reporting mechanisms/project manager/08-08</td>
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<td>Acute Hospital</td>
<td>M - H</td>
<td>S</td>
<td>C</td>
<td>Change in current process. More time requirement per patient. Staffing requirements for falls reporting and follow-up Coordination requirement between the communities falls services and acute trust falls service. For areas like A&amp;E this is a new workload to provide falls reporting on patients accessing care. Reporting required.</td>
<td>Consistent programme with a single point of contact and commonality of services nomenclature. Provides 24X7 access,</td>
<td>Education on current costs due to lack of programme at present/project manager/08-08 Education of new programme process and individual role and responsibility in process/project manager/08-08. Provide easy to use tools and reporting mechanisms/project manager/08-08</td>
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<tr>
<td>Voluntary Sector</td>
<td>M</td>
<td>S</td>
<td>S</td>
<td>Change in current process. Increased workload in communicating service changes to their client group</td>
<td>Helping clients to maintain independence. Early identification of ‘at risk’ individuals Consistent programme with a single point of contact and commonality of services/ nomenclature. Developed to maintain independence of the patients, Provides 24X7 access, Acts with a greater sense of urgency, Requires follow-up and further assessment for prevention of future falls/injury</td>
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<td>Mental Health Professionals</td>
<td>M</td>
<td>R</td>
<td>C</td>
<td>Creation of a new workload for this role through the change in current process. More time requirement per patient. Reporting required.</td>
<td>Maintain a patient’s home environment where appropriate to reduce the risk of mental deterioration. Consistent programme with a single point of contact and commonality of services/ nomenclature. Developed to maintain independence of the patients, Provides 24X7 access, Acts with a greater sense of urgency, Requires follow-up and further assessment for prevention of future falls/injury</td>
<td>Education on current costs due to lack of programme at present/project manager/08-08 Education of new programme process and individual role and responsibility in process/project manager/08-08. Provide easy to use tools and reporting mechanisms/project manager/08-08</td>
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<td>Public Health</td>
<td>M</td>
<td>S</td>
<td>S</td>
<td>Change in current process. Reporting required. Proactively, improving the health status of patients before they can experience a fall, especially those with osteoporosis and early screening Early identification of ‘at risk’ individuals Consistent programme across the 3 localities with a single point of contact and commonality of services/ nomenclature.</td>
<td>Education on current costs due to lack of programme at present/project manager/08-08 Education of new programme process and individual role and responsibility in process/project manager/08-08. Provide easy to use tools and reporting mechanisms/project manager/08-08</td>
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**Key:**

*Stakeholder Impact/Influence:*

H = High
M = Medium
L = Low

*Stakeholder Current Mindset/ Stakeholder Support Required*

R = Resistant
N = Neutral
S = Supportive
C = Committed
## Communication plan

<table>
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<tr>
<th>Stakeholder</th>
<th>Message(s)</th>
<th>How communicated</th>
<th>When and how often</th>
<th>Feedback mechanism/ follow-up required</th>
<th>Responsible</th>
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</table>
| Those directly **involved** in implementing the New Falls Programme       | • Overview of current Falls Programme and services and current usage of healthcare resources.  
  GPs  
  Other Primary Care based health professionals (e.g. DNs, Case managers, Practice Nurses)  
  Residential and Nursing Homes  
  Unitary Authorities - Adult Social Services  
  Therapists (physiotherapists and OTs)  
  SCAS  
  Westcall  
  RBHFT  
  Intermediate Care | Introduction to the project and overview of the programme implementation plan via:  
  Chief Execs briefing – Bi-monthly falls, CM and IC projects for all PCT staff  
  PCT intranet Clinical Services Web Editor – monthly update of all 3 projects  
  PCT monthly newsletter, article on programme and then an update  
  Project Newsletter – 3 weekly  
  Area briefings for staff – 6 weekly in all 3 localities – presentation on falls programme 18th, July  
  regular scheduled meetings including PBC Leads, PBC Governance, System Reform Project Board, Partnership Board | Monthly  
  - Chief Exec briefing  
  - PCT newsletter  
  - PBC Leads and Governance meetings  
  - Provider Services newsletter  
  - PBC Governance meetings  
  Bi-monthly  
  - System Reform Project Board  
  Others as per existing schedule | Ensure Project Team details included on all communications and encourage feedback on proposals.  
  Regular update slots on key groups  
  Monthly feedback to key stakeholders on programme implementation/usage and outcomes | Julia Bliss and Kelly Birch  
  Maureen McCartney |
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<tr>
<td></td>
<td>Introduction on the new tools being developed to support the programme</td>
<td>Provider Services newsletter, West Call performance review meetings</td>
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<td>- PEC</td>
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<td></td>
<td>o Initial Screening Tool</td>
<td>GP Newsletter – 6 weekly</td>
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<td>- road show approach for GP practices and their staff</td>
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<td>o Multifactoral Assessment Tool</td>
<td>Existing Team Meetings</td>
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<td>- TIPs meetings</td>
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<td>o Referral Tool</td>
<td>Via Berkshire West Falls Group</td>
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<td>o Reporting Tool</td>
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<td>Review of the feedback mechanisms/follow-up activity that will occur to</td>
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<td>ensure the successful implementation and continued improvement of the</td>
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<td>New Falls Programme.</td>
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| Those **partners** who have a high influence and high interest in the successful implementation of the new Falls Programme | - Overview of current Falls Programme and services and current usage of healthcare resources.  
- Overview of the new Falls Prevention Programme including new assessment tools, pathways and services  
- Review of the quantitative and qualitative benefits of the Programme.  
- Review of the stakeholder’s role and responsibilities in the day-to-day implementation of the programme.  
- Review of the stakeholders role in the success of the programme | Voluntary Organisation.  
October, overview and scrutiny with all voluntary services.  
BW Falls Group  
Regular slot on all meetings & minutes  
Patient and public involvement forum | Initial overview followed by monthly follow up | Ensure Project Team details included on all communications and encourage feedback on proposals.  
Regular update slots on key groups  
Monthly feedback to key stakeholders on programme implementation/usage and outcomes | Julia Bliss and Kelly Birch |
| Those individuals that play a **consulting** role in the successful implementation of the New Falls Programme | - Public Health  
- Leisure and Rec  
- Carers  
- UHUK | Patient and Public involvement forum  
Meeting with all voluntary services | Overview and status report provided via Execs briefing/intranet home page/monthly newsletter/regular meetings/Provider Services newsletter, provided on a monthly basis for the first 6 months and then provide 6-month updates thereafter.  
Face to face training delivered 4 weeks prior to implementation via Face to face training | Perform an audit of all falls reported in the first 4 months to ensure the process is followed.  
Thereafter, sampling of reported falls to ensure process is continuing to be followed.  
Provide compliance reporting to the individual stakeholders as well as the project team.  
Elicit feedback from stakeholders regarding | Julia Bliss and Kelly Birch |
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<td>• Review of the stakeholder’s role in the success of the programme</td>
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<td>Non-compliance with the programme process and feedback on the tools and easy of use to perform process improvement reviews of the process.</td>
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<td>• Review of the stakeholder’s role in the collection of data and reporting of the programme metrics</td>
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<td>• Review of reporting process for stakeholder that occurs on a monthly, quarterly and annual basis.</td>
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|             | • Introduction and review of how to use the following tools associated with the Falls Programme  
  ▪ Referral Tool  
  ▪ Reporting Tool |                                                                                  |                                                                                  |                                                                                                                                                                                                                                |             |
<p>|             | • Review of the feedback/ follow-up activity that will occur to ensure the successful implementation and continued improvement of the new falls programme. |                                                                                  |                                                                                  |                                                                                                                                                                                                                                |             |</p>
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| Individuals in the community who need to be informed of the Falls Programme that is available in the community and how to access these services if required | • High level overview of Berkshire West's new Falls Prevention Programme.  
• Review of aims of the programme that is specific to the community and the improvement in the delivery of care and services available.  
• Review of how the public accesses the programme  
• Review of the stakeholders role in the success of the programme  
• Overview of mechanisms for evaluation and improvement of the programme on an annual basis and stakeholder’s role in this evaluation. | Attend AGM, 29/30 Sept. Green Park in Reading.  
Have a stand for all three projects and individuals available to answer questions. | – Via Newsletter/Website/Articles on a monthly basis for the first 6 months and then every 6 months thereafter. | Annual satisfaction survey for those who have access the programme in the last 12 months | Julia Bliss and Kelly Birch |