# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

*This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the NHS Standard Contract Technical Guidance.*

|  |  |
| --- | --- |
| **Service Specification No.** |  |
| **Service** | Southampton City Falls Exercise Service |
| **Commissioner Lead** | Adrian Littlemore |
| **Provider Lead** | TBC |
| **Period** |  |
| **Date of Review** | July 2018 |

|  |
| --- |
| **1. Population Needs** |
| **National/local context and evidence base**  Up to one in three (around 3.4M) over 65’s suffer a fall each year, costing the NHS an estimated £2.3 billion a year. Falls remain a major cause of injury and death amongst the over 70’s and account for more than 50 per cent of hospital admissions for accidental injury.  Preventing falls and the resulting hospital admissions is clinically and economically effective and will result in substantial cost savings for health and social care services.  Southampton City is reported as having one of the highest rates of falls in over 65’s, in England. There were 1084 falls that ended up in an emergency hospital admission in 2017/18. Comparing Southampton’s rate of 3,135 falls per 100,000 against its statistical neighbours, it only comes below Liverpool who have the highest rate of falls in the country at a rate of 3,168 per 100,000.  Nationally there were a total of 210,553 falls in the over 65’s that ended up in an emergency admission. This was at a rate of 2,114 per 100,000.  **Evidence Base**  One of the factors evidenced to help reduce the number of people falling is through exercise with a strength and balance emphasis.   * Department of Health, 2009. Falls and Fractures: Effective interventions in health and social care. London: Department of Health. Available at: <http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_109122.pdf> * Department of Health, 2009. Fracture Prevention Services: An economic evaluation. London: Department of Health. Available at: <http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110099.pdf> * NICE Guidelines for Falls Prevention   <https://www.nice.org.uk/guidance/qs86/chapter/Quality-statement-8-Strength-and-balance-training>   * Royal College of Physicians, 2007. National Clinical Audit of Falls and Bone Health for Older People. London: Royal College of Physicians. Available at: <https://www.rcplondon.ac.uk/sites/default/files/national-clinical-audit-of-falls-and-bone-health-in-older-people-national-report-2007.pdf> * Journal of Frailty, Sarcopenia and Falls: Only the strong, why we need to focus on strengthening and balance activities in physical activity. <http://www.jfsf.eu/Article.php?AID=v03i02_056> * Public Health England: Falls and Fracture consensus statement – supporting commissioning for prevention**.** <https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/03/falls-fracture.pdf>   **General Overview**  Having a fall is still considered to be an inevitable part of the aging process, however this is an inaccurate reality as there are numerous things a person can do to prevent having a fall in their later years.  The right type of exercise, namely an integration of strength and balance exercise is part of a multi-factorial approach to reducing reoccurring and first time falls. The reasons why people fall in the first place are many and varied and range from environmental, physical, medication affects, psychological and social. The effective duration of exercise provision to show benefit from a fall is for 15-52 weeks. Strength resistance training should be carried out 2-3 times a week to increase muscles strength and effective bone health. Physical activities with a high challenge to balance, should be carried out 3 times per week for falls reduction.  Improving someone’s physical strength and balance capabilities in the body can reduce the likelihood that they will experience a further fall. The challenge is not only encouraging people to begin exercise to prevent falling, but to continue the physical exercise programmes introduced following a fall.  There is currently inequity across the country of continuation exercise programmes. NICE Guidelines state that Commissioners should ensure they commission services that have qualified and available staff trained up to deliver and monitor strength and balancing training programmes for individuals who have a known history of recurrent falls.  Southampton City have been providing post falls exercise classes for those individuals who have had a fall, in response to the high level of falls in the city, but more needs to be done to improve provision for pre-fallers and those who are at risk from falling. |
| **2. Outcomes** |
| **NHS Outcomes Framework Domains & Indicators**   | **Domain 1** | **Preventing people from dying prematurely** | **√** | | --- | --- | --- | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** |  | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **√** | | **Domain 4** | **Ensuring people have a positive experience of care** | **√** | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** |  |   **Local defined outcomes**   * To reduce the number of first time falls in the city by providing exercise classes and programs, delivered by qualified Postural Support Experts who embed the falls prevention element within the class. * To contribute to the reduction in the rate off falls with injury, in the over 65 population admitted to acute care, by providing falls related exercise programs * Reduce the number of people reported having a fear of falling * To raise awareness around the causes and prevention of falls * To develop a network of falls qualified exercise professionals who can deliver exercises to those who want to prevent falls * Improve or maintain independence with functional mobility measured by BERG * Contribution to the reduction of NEL admissions as a result of a fall in the over 65 population (from below 2 metres) * Contribution to the reduction of ED attendances as a result of a fall in the over 65 population (from below 2 metres)   **Social Value Act**  The service will work with communities and local partnerships to design and develop services and interventions that broaden the provision of wraparound support to people who are at risk of, or who have had a fall, building local capacity to improve outcomes which in turn will have a positive impact on the economic, social and environmental wellbeing, complying with the Public Services (Social Value) Act 2012. The service will support evidence based, meaningful activity.  The Falls Exercise provider will be expected to include in their service development and planning a focus upon no less than two elements, selected from the table below. Progress towards delivery will then be included annually as part of contract monitoring.   |  |  |  |  | | --- | --- | --- | --- | | **Council Priority** | **Economic Value** | **Social Value** | **Environmental Value** | | *Southampton is a city with strong sustainable economic growth.* | Promote income generation and increase investment in to the city to increase capacity and sustainability of the voluntary and community sector. | Ensure local people have opportunities to develop skills and have access to fair employment and good work. | Create and develop healthy and sustainable places and communities including accessible green spaces. | | *Children and young people in Southampton get a good start in life.* | Ensure children and young people have opportunities to develop skills to make the best of employment opportunities. | Take a whole family approach and focus on prevention and early intervention to give every child the best start in life. | Promote active travel to school to increase physical activity, replace car journeys and reduce air pollution. | | *People in Southampton live safe, healthy, independent lives.* | Prioritise prevention and early intervention to reduce demand and cost of health and care services. | Make every contact count by using every opportunity to promote health and wellbeing. | Promote cycling and walking to encourage physical activity, and reduce air pollution. | | *Southampton is a modern and attractive city where people are proud to live and work.* | Improve the energy efficiency of homes and access to support mechanisms to tackle fuel poverty. | Promote community participation including citizen engagement and volunteering and the provision of community-led solutions. | Protect and improve the quality of existing green spaces and increase their accessibility and use of green spaces. | |
| **3. Scope** |
| **Aims and objectives of service**   * To provide and coordinate a Falls Exercise provision for adults in Southampton City who have either had a fall, or who are at risk of falling * To develop the activity/exercise local market with consideration to the supply of classes and the level of customer demand. Ensuring a good balance between expansion and economic viability * To promote the participation of older people in falls prevention exercise programmes with a range of different activity styles To contribute to the integration of a Frailty and Falls prevention Service across providers of health and care services for adults in Southampton City * To improve the health outcomes for older adults   The objectives of the service are to develop a network to:   * Provide strategic leadership to the development of exercise programs for falls throughout the city of Southampton * Develop a network of professionals across the city to contribute to the provision of falls exercise programmes, increase awareness and education around falls and improved outcomes for fallers and those at risk of falling. * Develop an offer within each cluster, to provide and encourage falls prevention exercise into care homes, working along side the city wide enhanced health and care team. * Receiving and coordinating referrals from providers in the network * Coordinate and signpost to a range of exercise options in each cluster where the provider of the class is trained to Level 4 Postural Stability Expert * Provide professional development * Raise awareness around falls, the cause and how to prevent them * Provide marketing for the exercise provision to specific groups e.g. Age, Condition, Ethnicity * Working with local communities, to create new activity groups to target people in the city who are inactive, guided by Sport England Market Segmentation. * Working in partnership with Living Well Service and Southampton Healthy Living Service to develop an affiliate scheme for exercise. * Collect participant data * Increase capacity of trained exercise professionals * Links with other partnerships e.g. Solent, UHS, Housing * Coordinate referrals   **Service description/care pathway**  The Falls Exercise provision will be commissioned to provide exercise intervention to all individuals who are at risk of falling, or who have had a fall. Patients that have fallen will have received a Comprehensive Falls Assessment (CFA) carried out by the Community Independence Service (CIS).  The service will include:   * Support and arrangements will be provided for those that need transport to and from the venues * A social element will be incorporated into the class providing participants the opportunity to socialise with others * The provider will receive payments for the classes from the participants * Develop a tailored offer for the needs of Southampton residents, both in terms of their geography, levels of ability and in developing appropriate referral mechanisms with existing agencies, specifically the Community Independence Team, Community Wellbeing Team and Fracture Liaison Service. * Strategies to ensure people are supported to achieve the NICE recommendations for exercise to prevent falls. * The provider will develop and implement robust measures to capture improvements in strength balance and wellbeing. * The provider will follow up with participants at 3, 6 and 12 months intervals to measure progression and levels of those still exercising.   The service will receive referrals from the Community Independence Service for those who have had a Comprehensive Falls Assessment and home exercise interventions and/or 1:1 specialist falls physiotherapy. The service will also receive referrals from other services for individuals who are at risk of falling:   * Primary Care and practice nurses * Community Wellbeing Team * UHS specifically ED/CEDST/Fls/mop/Trauma & Orthopaedics. * Community Navigators * Community Nursing including case management   **Population covered**  The service will be available to:  All patients registered with a GP practice in Southampton City CCG and or resident population (the Better Care target is based on resident population).  Acceptance criteria for the service can be categorised in the following cohorts:   * **Fallers**   Patients who have had a fall and received a Comprehensive Falls Assessment from the Community Independence Service, will be able to access the falls exercise classes for prevention and post fallclasses.  Patients who have been medically assessed as fit to undertake exercise and referred via the Fracture Liaison Service.  Patients who have been medically assessed as fit to undertake exercise and referred by Medicine for Older People service   * **Pre-fallers**   Individuals who have been identified as frail, at risk of having a fall, or have a fear of falling are able to access the Falls Pathway classes.   * **Wider Community**   Individuals who have an interest in improving their strength and balance and overall health can access details of a wider network of independent exercise provision which includes level 3/4 trained teachers.  Classes need to be self financing with participant contributions to cover costs of room hire, instructor costs, materials, insurance, refreshments etc.  **Interdependence with other services/providers**  The service shall operate as part of an integrated system for the prevention of fractures and falls. It will, therefore, work closely with other parts of the health and social care system including:   * Community Independence Team (responsible for completing Comprehensive Falls Assessments) - Solent * Medical Assessment Unit - UHS * Orthopaedics and trauma –UHS * Medicine for Older People Geriatricians * Medicine and care of older people departments UHS/Solent * Emergency department –UHS * Community Emergency Department Support Team * Radiology -UHS * Advance health support into Care Homes –Solent/CCG (Quality Team) * Falls co-ordinators in each Cluster area Solent/Solent Medical Services * GPs * Community nurses - Solent * Community hospitals Solent/Spire/Care UK * Community Wellbeing Service – Solent Medical Service * Southampton City Clinical Commissioning Group * Public health - Southampton City Council * Physiotherapists -various * Other AHPs. –various * Third sector services * Local Solutions Groups |
| **4. Applicable Service Standards** |
| **Applicable national standards (eg NICE)**   * NICE Clinical Guideline CG161, Falls in older people: assessing risk and prevention, 2013. National Institute for Care and Health Excellence <http://www.nice.org.uk/guidance/cg161>   **Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**   * Royal College Physicians recommends that commissioners use the Department of Health prevention package to inform the commissioning of effective falls and fracture services. See Objective 2 in *Falls and Fractures: Effective interventions in health and social care* at <http://www.laterlifetraining.co.uk/wp-content/uploads/2011/12/FF_Effective-Interventions-in-health-and-social-care.pdf>   **Applicable local standards**   * Take into account cultural, religious and gender sensitivities and provide male or female clinicians when requested. The service need to be compliant with the Trusts Chaperone Policy. * Ensure that services are delivered to meet the specific needs of people with disabilities or mental health problems so they receive equitable access to services * Be responsive to service user views and opinions in developing integrated services that best suit user needs. * Ensure staff are trained to appropriate level in terms of safeguarding adults in line with requirements of Schedule C 6.2 (Safeguarding Children, LAC and Adults). * Provide access to interpretation services to facilitate communication with ethnic minority groups as necessary. * The provider must ensure systems and processes are in place to ensure continuity of support, advice and information * The provider must ensure that a senior officer is in place with managerial responsibility takes the lead for the day to day running of the service. * The provider must meet NHS Information Governance standards |
| **5. Applicable quality requirements and CQUIN goals** |
| **Applicable Quality Requirements (See Schedule 4A-C)**  **Applicable CQUIN goals (See Schedule 4D)** |
| **6. Location of Provider Premises** |
| **The Provider’s Premises are located at:**  Within Southampton City Boundary |
| **7. Individual Service User Placement** |
|  |
| **8. Management Information and Reporting Requirements** |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Performance indicator | Indicator |  | Method of measurement | Frequency of monitoring | | Outcome | Number of NEL admissions in over 65’s as a result of a fall (from below 2 metres) | See Public Health England HRG dataset | Written commentary on trend | Quarterly | | Outcome | Number of ED attendances in over 65’s as a result of a fall (from below 2 metres) | See Public Health England HRG dataset | Written commentary on trend | Quarterly | | Activity | No of referrals to Falls classes | 22 per class | Data report | Monthly | | Activity | No of participants to classes from particular settings e.g. Care Home, sheltered housing, private residence |  | Data report | Monthly | | Activity | No of people who complete the initial course | 22 per class | Data report | Monthly | | Activity | Retention rate greater than 70% completing the course | 70% | Data report | Monthly | | Activity | Improved Berg scores greater than 10% or 8 points | 56 points | Data report | Monthly | | Activity | % of people who are maintaining BERG score over the 52 weeks | 46 points or over | Data report | Monthly | | Activity | No of individuals still exercising at 3, 6 and 12 months post FR classes | 22 per class | Data report | Monthly | | Activity | Reduction in the number of falls for individuals attending classes as measured by non-elective admissions available via CHIE |  |  |  | |