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Report title: Review of Falls Service Provision against Public Health Grant	
Report to: Cabinet	
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Date: 23 May 2017	**For:** Decision
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County Divisions affected: All Essex	

1. Purpose of Report

1.1 Falls prevention is a non-mandatory public health service. This report seeks authority to decommission the Falls Prevention Service across Essex as a result of a reduction in public health grant receivable from the Department of Health. The report outlines steps that will be undertaken with the providers and NHS partners over the duration of the notice period to mitigate the impact of this decision.

2. Recommendations

2.1 Agree to decommission the falls prevention service as soon as possible.

3. Summary of issue - Background to the falls service

3.1 Local authorities took over responsibility for delivery of public health outcomes on 1 April 2013, at which time historical allocations for public health spending from Primary Care Trusts (PCTs) were transferred to the local authority. An indicative value for falls prevention was transferred to ECC, based on PCT service provision at the time (Total £800,000, comprising of: Brentwood & Basildon: £0, Castle Point and Rochford: £60,000, Mid: £277,000, North East: £517,000 and West: £0).

3.2 As will be seen from the allocations, falls prevention service provision across Essex was variable. Recognising the potential of falls prevention as an invest to save early intervention opportunity to relieve pressures in acute health and social care, ECC enhanced the 'inherited' service offer by increasing investment by an additional £1.44m per annum from 2014/15. The additional investment was to:

- Procure services in the CCG areas of Brentwood and Basildon, Castle Point and Rochford and West Essex;
- Supplement existing services in Mid Essex; and
- Facilitate work towards an integrated service to benefit health and social care.

In areas outside dedicated falls prevention services have been funded from core NHS funding.

3.3 From 2014 to date ECC have commissioned a locality based falls prevention service, designed and operating within the specified NICE guidance for "Falls prevention: early intervention in health care settings".

3.4 The falls prevention service operates as a short term intervention which carries out some assessments and provides advice and signposts to other services. People do not receive these services for long periods of time. Under the current contractual arrangements provider interventions must provide or refer to the following elements:

- Information and publicity programme
- Screening / risk identification
- Multifactorial falls risk assessment
- NICE guidance compliant multi-factorial Intervention, including (but not exclusive to): strength and balance exercise programmes, (i.e. FaME/ Otago / postural stability) and home hazard and safety intervention (including follow up).
- Medication Reviews
- Vision testing
- Prescribing (post fracture osteoporosis treatment)
- Onward referral.
- Treatment plan preparation

3.5 Activity expectations across the five CCG areas were originally 3,000 per locality, with the exception of North East, which maintained previous activity as a result of a historic larger contract value. From 1 April 2016, each locality was moved to a fair shares allocation with a change to its budget and activity allocations.

4. Public Health funding position

4.1 Public health activity in Essex is funded by the Public Health Grant received from government. This grant is being reduced over time; by 2019/20 the Public Health Grant will be £10.6m lower than 2014/15 (excluding the 0-5 grant introduced in stages from 2015/16). A number of public health services are 'mandated', which means that the Council is required to provide them.

4.2 Increased efficiencies introduced mainly through re-commissioning and re-contracting have mitigated the effect of the £5.2m reduction in grant since 2014/15, however a further £5.4m reduction in grant needs to be absorbed by 2019/20.

4.3 Benchmarking indicates that most ECC public health services are already delivered at a lower cost per head of population than in comparable councils. The majority of the public health grant is expended on 'face to face' patient services which the County Council is required to provide by law. There is therefore very limited opportunity to find savings elsewhere from public health activity.

4.4 While they can be of benefit, falls services are not a mandatory public health service. In many neighbouring areas these services are still funded by core NHS funding eg Hertfordshire and Suffolk or through the Better Care fund (in Thurrock). Southend on Sea BC does fund falls services.

5. Current Contractual Position and Implications

5.1 The Council directly commissions the service in Castle Point and Rochford and is an associate commissioner as part of a larger NHS contract in North East Essex. Elsewhere in the county services are provided under agreements with the CCGs under section 75 of the National Health Service Act 2006. The CCGs then make arrangements with the provider. The current contractual position including annual cost and contract duration is provided in the table 1 below.

Table 1: Contract analysis

CCG geography	Contract Type	Provider	Contract Term	Early Termination Notice	Annual Value (£000)
Mid Essex CCG	S75	PROVIDE	2016 - 2021 (5 years)	6 Months	450
NE CCG	Associate commissioner to NEECCG Care Closer to Home	ACE	2016 - 2023 (7 years)	12 Months	548
WEST CCG	S75	SEPT	2016 - 2021 (5 years)	6 Months	413
B/B CCG	S75	NELFT	2016 - 2021 (5 years)	12 Months	412
CP & R CCG	Lead commissioner (direct contract)	NELFT	2017 - 2021 (4 years)	6 Months	375
					2,198

5.2 To support service redesign work towards improved integration of falls prevention across health, ECC and Mid, West and Brentwood & Basildon CCGs signed S75 agreements for falls prevention commencing 1 April 2016. Castle Point and Rochford required an additional year to cement their CCG strategic direction around integration, therefore the S75 agreement was agreed with a planned implementation date of 1 April 2017. Early termination notices across the four areas with active S75 agreements are between 6-12 months. In Castle Point and Rochford there is a direct contract between ECC and the provider.

5.3 There is a particular issue in the North East area where ECC have commissioned the service as part of the Care Closer to Home community contract between the CCG and Anglia Community Enterprise. This may mean that the Council is liable for provider redundancy costs that accrue in this area through early termination.

5.4 In Mid Essex and West Essex there is a difference between the length of notice between the Section 75 agreements with West and Mid (6 months) and the

notice periods the CCGs have with the Provider locally (12 months). This means that while ECC could terminate at 6 months' notice the CCG would be faced with a cost pressure should the provider insist on hold the CCG to the full notice.

5.5 These proposals are not made lightly but rather out of financial necessity. Without additional funding ECC has no alternative but to decommission services. There is an 'invest to save' figure of £816,000 in our plans due to avoided falls through the service. Over performance to date on other aspects of the public health invest to save plans, notably stopping strokes through better management of atrial fibrillation (a heart irregularity) will mitigate this.

5.6 These proposals have implications for CCGs and NHS providers; the falls prevention service is considered to deliver demand management benefits for CCGs. The wider health benefits of these preventative services will be lost, as will the longer term demand reduction benefits to social care. We are seeking to minimise the impact through pathway redesign and alternative mechanisms.

5.7 We are actively working with providers, voluntary sector partners and CCGs to look at alternative community led approaches to preventing falls that make use of alternative provision of falls prevention interventions. Some activity within the falls prevention NICE guidance compliant multi-factorial Intervention already occurs as part of other existing NHS and social care pathways and would continue; see Box 1.

Box 1: Mapping of providers of falls prevention interventions

Intervention	Current provision	Future provision
Screening	The following agencies refer and therefore can be assumed to screen: Ambulance service, **falls assessment clinics,** care coordinators, careline, Medicine for elderly clinics/other secondary care eg A&E, fracture clinics, day centre staff, community nurses, GP, OTs, PTs, rehabilitation services, social care workers including domiciliary care workers, reablement services, sheltered housing services, CVS, self referral	Ambulance service, care coordinators, careline, Medicine for elderly clinics/other secondary care eg A&E, fracture clinics, day centre staff, community nurses, GP, OTs, PTs, rehabilitation services, social care workers including domiciliary care workers, reablement services, sheltered housing services, CVS, self referral
Risk assessment	Most clinical or social care services eg GP, OT, PTs, community nurses, social care workers, **falls assessment team**	GP, OT, PTs, community nurses, social care workers,
Home hazard assessment	Most clinical or social care services eg GP, OT, PTs, community nurses, social care workers, reablement services, district councils, fire service, **falls prevention team**	GP, OT, PTs, community nurses, social care workers, reablement services, district councils, fire service,
Home improvements	Community nurses, social care workers, reablement services, district councils, handy man services, **falls prevention team**	Community nurses, social care workers, reablement services, district councils, handy man services,
Equipment	Community nurses, social care workers, reablement services, **falls**	Community nurses, social care workers, reablement

	prevention team.	services,
Vision Assessment	Opticians, falls prevention services	Opticians
Medicines review	GPs, Pharmacists, **falls prevention services**	GPs, Pharmacists
Strength & Balance / postural stability	**Falls prevention services**, some VCS for less structured/follow on activities	some VCS for less structured/follow on activities

5.8 For example the service includes medication reviews, prescribing and vision assessments which are already funded by the NHS through general practice, pharmacy and opticians. Other elements of the service, such as home equipment assessments are already funded by NHS and social care under frailty assessment services. The recommended intervention without obvious alternative provision is the strength and balance training / postural stability and we will work with the voluntary sector to extend the access provided by these groups to complementary interventions such as seated exercise.

5.9 We plan to minimise the impact of decommissioning the service through alignment of the falls prevention agenda with existing community resilience work streams, and adopting a community asset approach in line with the new ways of working outlined in the PH strategic approach. Box 2 outlines our vision for integrated falls prevention under this model.

Box 2

Now

- Patient finally admits to the GP that they have fallen (likely several times before GP informed especially if unwitnessed falls).
- The GP should screen for risk – simple tools available but essentially key questions on history of falls, how many medications, certain risk conditions eg stroke, any problems with balance and visual assessment of ability to get out of chair. If low risk, then advice and guidance.
- If high risk the GP could do full assessment (depends on local situation wrt frailty assessments etc) or refer onto the falls team for assessment.
- The falls team would assess the patient and devise a care plan to address the key risk factors (the assessment and interventions focus on the core list given in the paper)
- The falls prevention team may have vision assessment and medicines review 'in house' or may simply advise the patient to go to opticians/GP (with responsibility to check that patient has done as advised)
- If home hazards or equipment needs identified then service can draw on equipment store directly eg grab rails or engages with partners about more significant improvements eg ramps
- The falls service should offer either group or 1:1 (maybe home based) strength and balance or postural stability instruction (S&B or PSI approved programmes)
- May or may not include identification and management of osteoporosis; most would refer back to general practice wrt primary and secondary management of osteoporosis (NICE guidance)
- The falls service may refer on for other identified risks eg podiatry, continence, dietary. If there are other underlying conditions that are cause of falls eg postural hypotension or CVD, then check with eg GP that patient is under appropriate care
- Once falls prevention plan is delivered patient would be discharged from the service

Possible future model

1. GP would risk stratify its frail elderly population and pro actively manage their care
2. Commissioned population segmentation and care management offered to high risk group and rising risk group which would include assessment of falls risk within more holistic assessment of health and care needs
3. Identified at-risk populations will have care coordinator who acts on care plan and coordinates all required services
4. GP offers medicines review and osteoporosis management as required
5. Patient accesses high street optician for comprehensive vision assessment not simply prescription check
6. Home hazard and equipment need as previous model
7. Patient accesses strength and balance training eg seated exercise through the community through social prescribing
8. Referral onto other services as identified eg podiatry, continence
9. Once care plan is delivered the patient is discharged from care planning approach

5.10 An Essex wide workshop is scheduled for the 19th June to progress the redesign process; this will start the process of locality based redesign work. Preparatory interviews are happening with the CCGs and providers to map what is available in each locality.

5.11 Regardless of the funding situation this is an opportune time to review delivery with a view to reducing duplication and promoting greater integration of provision and commissioning responsibilities as was always intended with the S75 approach.

5.12 We will continue to work with CCGs and local providers to explore opportunities during contract notice periods to accelerate decommissioning with redeployment of staff where possible to new and existing vacancies. This will help staff find new positions, shorten the period of uncertainty for them, minimise redundancies and optimise savings.

6. Options

6.1 **Option 1**
Status quo: Continue commissioning of falls service, £2.2m savings will have to be found elsewhere in ECC.

6.2 **Option 2**
Decommission falls service, as soon as contract notice periods.

Since contract notice periods are of variable length, decommissioning sequence would be Mid, West and Castle Point & Rochford (6 months' notice), followed by Basildon and Brentwood CCG and North East Essex (12 months' notice). Savings in 2018/19 will be reduced by any redundancy costs in North East Essex which ECC may be contractually liable for in the event of early termination.

Mid and West Essex will need to negotiate with their providers to terminate this element of provision after 6 months or continue to provide the service for 6

months and we will work with them and providers to understand potential impact and flexibility around these contracts

Table 2: Analysis of options

Year		£000 Option 1	£000 Option 2
2017/18	Part year contract savings	0	413
	In-year savings	**0**	**413**
2018/19	Part year contract savings	0	2,038
	Maximum redundancy cost	0	(900)
	In-year savings	**0**	**1,138**
2019/20 onwards	Full year contract savings	**0**	**2,198**

NB: Part year savings as detailed are contingent upon notice being served on 1 June 2017.

6.3 **Option 2 is the recommended option.** This allows savings to be achieved to help manage the public health grant pressures.

7. Issues for consideration

7.1 Financial implications

7.1.1 The Public Health Grant is reducing over time; £5.4m of savings need to be found in the period 2017/18 to 2019/20 to meet the reduction in Public Health Grant over the same period.

7.1.2 Decommissioning the falls service as recommended (option 2) will make a significant contribution to the savings challenge of the next 3 years. If this service is not decommissioned, the decommissioning or reduction of other public health services will have to be considered if the Public Health service is to operate within the grant funding envelope.

7.1.3 Due to the notice periods required to terminate, the full year benefit of £2.2m will not be realised until 2019/20.

7.1.4 The Public Health Grant is however ring-fenced and any annual underspend (or overspend) is carried forward into the subsequent year.

7.1.5 If option 2 is approved, the carry forward into the 2018/19 financial year will be used to mitigate any in-year shortfall in the savings requirement arising from reduced in-year contract savings and one-off redundancy costs associated with the North East Essex contract in 2018/19.

7.2 **Legal implications**

7.2.1 The recommended option will involve termination of current contracts in accordance with their terms. The Council will need to consider liability for termination costs as it may have some liability under the legacy NHS contract in North East Essex. Any early termination costs would be lower than the cost of continuing with the contract.

7.2.2 The Council has not consulted providers or CCGs on the impact of termination but it will be exercising contractual rights under agreements which they have voluntarily entered into with the Council. CCGs will be able to negotiate with providers to mitigate the impact on the provider and the CCG.

7.2.3 The Council has not consulted with the public on the impact of termination. The service offers a short term intervention to patients and existing patients will be managed under the exit period. New demand for services will be managed under the mitigation plans outlined in paragraph 5.7.

8 Equality and Diversity implications

8.1 The Public Sector Equality Duty applies to the Council when it makes decisions. The duty requires us to have regard to the need to:

(a) Eliminate unlawful discrimination, harassment and victimisation and other behaviour prohibited by the Act. In summary, the Act makes discrimination etc on the grounds of a protected characteristic unlawful
(b) Advance equality of opportunity between people who share a protected characteristic and those who do not.
(c) Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding.

8.2 The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, gender, and sexual orientation. The Act states that 'marriage and civil partnership' is not a relevant protected characteristic for (b) or (c) although it is relevant for (a).

8.3 The equality impact assessment indicates that the proposal in this report will have an adverse impact on older people, women and disabled as these are all risk factors for falls. There are mitigating actions (see paragraph 5.7) which are being explored which will reduce the impact of the decommissioning. Some parts of the service will remain available within core NHS funding.

9 List of Appendices

9.1 Equality Impact Assessment

10 List of Background papers

- Section 75 agreements (sample version)
- Contracts