APPENDIX C

NHS West Leicestershire Clinical Commissioning Group | NHS East Leicestershire and Rutland Clinical Commissioning Group | Leicestershire County Council

HEALTH AND WELLBEING BOARD: 1 APRIL 2014

REPORT OF THE DIRECTOR OF HEALTH AND CARE INTEGRATION

SUPPLEMENTARY BRIEFING PAPER ON BETTER CARE FUND METRICS AND TRAJECTORIES

Introduction

1. Since the draft submission of the Better Care Fund (BCF) Plan an impact analysis has been undertaken to assess the impact of the proposals on the six metrics.

2. The attached analysis was reviewed and finalised by the Integration Executive at their meeting on March 25, 2014 and the following recommendations are made for the Health and Wellbeing Board's approval.

3. It should be noted that each trajectory shows the impact of the improvement over a two year period in line with BCF requirements and the data supplied with the technical guidance. Following discussion at the Integration Executive meeting, and to help with understanding the total impact of our plan over this period for Leicestershire's population, we have shown two views of the expected improvement in each case:

   I. The impact of the improvement based on the expected population growth over the period; and

   II. The impact of the improvement if the population had remained the same (static).

Recommendations

4. The Health and Wellbeing Board is recommended to approve the submission of the metrics per the analysis in the attached paper with the following caveats:

   a. Further work is required to improve data quality for recording reablement at 91 days.

   b. The delayed transfers of care metric is subject to change due to further national work/consultation in 2014/15. Locally however we need to create a tier of analysis below this metric which looks at the source data by

setting (e.g. community, mental health and acute) and the impact of BCF interventions in each setting.

c. We have done further work on the metric for avoidable emergency admissions and expressed this as an illustrative trajectory over a five year period. This is shown in NHSE Template One on page 17, with supporting narrative indicating the improved pace of delivery (stretch to be applied) from 2015/16 onwards, in line with CCG operating plan/five year plan intentions.

d. The Integration Executive will build on this approach and oversee work to develop a five year trajectory for each metric during Q1 2014/15 which will link to the development of the LLR five year strategy by June 2014. In terms of stretching our level of ambition across the system, this work is an essential next step.

e. In terms of measuring patient experience, we continue to await national guidance for this metric.

f. The numerator for the falls metric currently increases over the course of the proposed trajectory. Further analysis is needed on the impact of the proposed schemes to deliver against this metric – see g. below

g. The Integration Executive should assess the potential introduction of an additional BCF scheme for the falls metric. This is because the schemes currently in the plan will not deliver sufficiently against this metrics in the first 18 months, but remain valid for prevention in the longer term. The feasibility of the EMAS falls prevention scheme should be explored, as this has good evidence from elsewhere in the East Midlands and could be a very effective addition to the integrated urgent response theme of the BCF. Based on the Northamptonshire scheme an indicative figure for part year effect in 2014/15 has been factored into the financial plan, while feasibility work is carried out.

h. There will be an ongoing programme of work on BCF impact analysis overseen by the Integration Executive. This will include:

    i. Confirming/developing performance indicators for each of the component schemes, so that the contribution of each component of the BCF plan to one or more of the 6 metrics can be further assured/challenged.

    ii. Strengthening the evidence base for the BCF

i. At the time of writing this report, the contract between Clinical Commissioning Groups and the University Hospitals of Leicester is being

finalised, so any update on this, which impacts on BCF assumptions, will be taken verbally at the meeting.

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BETTER CARE FUND IMPACT ANALYSIS

1. INTRODUCTION

The Leicestershire Better Care Fund (BCF) Plan for 2014/15 and 2015/16 will be submitted on 4 April 2014. This will compromise an updated BCF plan with a supporting financial and performance outcome template submission. The aim of this paper is to present the findings of an impact analysis of the thirty-seven components of the BCF plan against the plans of the six outcome metrics. NHS England provided technical guidance for the preparation of baselines and trajectories for each metric, including an indication of what would constitute a statistically significant improvement based on the population size.

2. FINDINGS FROM METRIC REVIEWS

Since the original BCF submission on 14 February 2014 a detailed impact analysis has been undertaken of the (five) national and (one) local metrics against which delivery of the BCF plan will be assessed. This initial impact assessment was presented for discussion at a multiagency workshop held on 12 March 2014. The findings are presented below.

2.1. METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

This is a nationally defined metric measuring delivery of the outcome to reduce inappropriate admissions of older people to residential care. Chart 1 shows a bar chart illustrating the proposed trajectory detailed in Table 1 below. The line chart shows that validation of this metric using BCF base data and the statistical significance calculator (see Appendix B) has ratified the proposed trajectory.

Chart 1.1

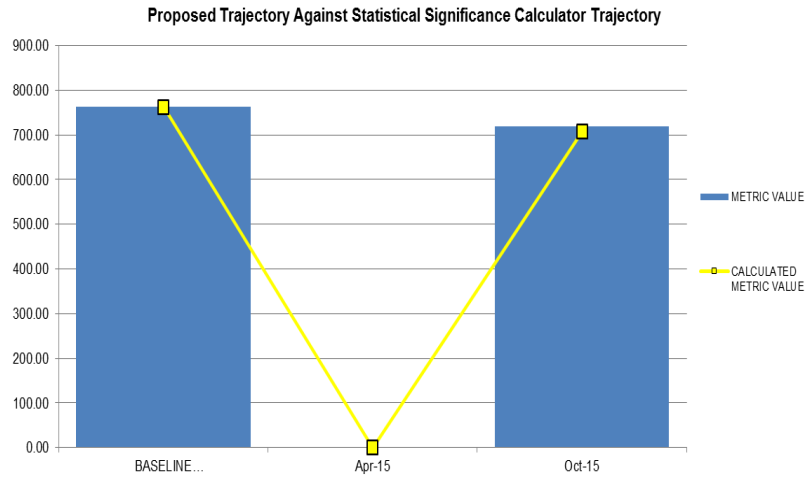

Chart 1.2

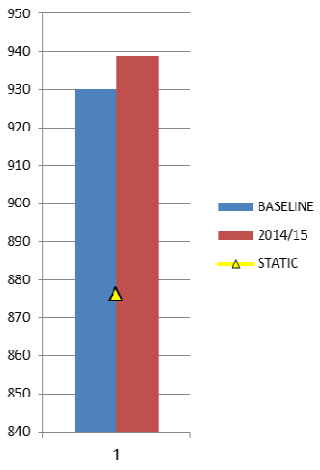

Table 1

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT	Oct-15 PAYMENT (Apr-14 – Mar-15)
NUMERATOR	930		939
DENOMINTOR	121,930		130,645
METRIC VALUE	762.73		718.74

The proposed trajectory is for a reduction from 762.73 permanent admissions per 100,000 population per year to 718.74 (or 5.77%) by 31 March 2015 (this is against a national benchmark of a reduction of 13%). It is noted that the numerator for the October 2015 payment is 939 which is an increase of 9 (0.97%) against the baseline of 930. Chart 1.2 illustrates this increase in the numerator. This chart also shows the effect of discounting population growth which would result in 54 fewer permanent admissions to residential or nursing care.

2.2. METRIC 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

This is a nationally defined metric measuring delivery of the outcome to increase the effectiveness of reablement and rehabilitation services whilst ensuring that the number of service users offered the service does not decrease. The aim is therefore to increase the percentage of service users still at home 91 days after discharge. Chart 2 shows a bar chart illustrating the proposed trajectory detailed in Table 2 below. The line chart shows that validation of this metric using BCF base data and the statistical significance calculator (see Appendix B) has ratified the proposed trajectory.

Chart 2.1

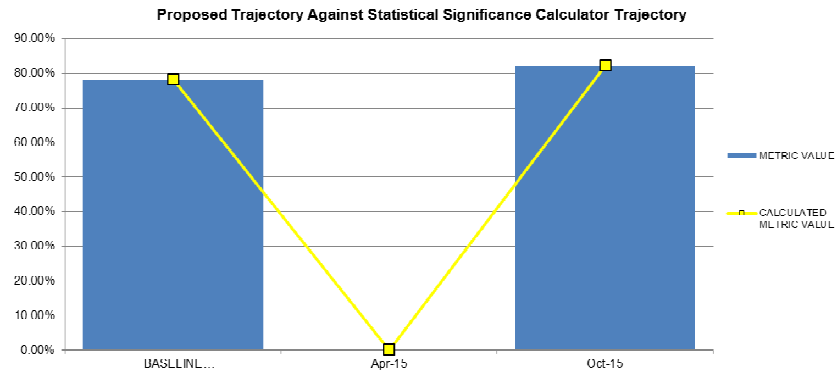

Chart 2.2

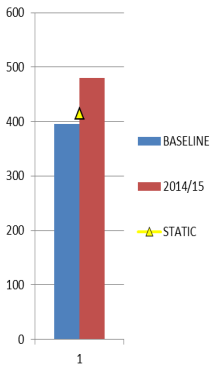

Table 2

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT	Oct-15 PAYMENT (Apr-14 – Mar-15)
NUMERATOR	395		480
DENOMINTOR	505		584
METRIC VALUE	78.22%		82.19%

The proposed trajectory is for an increase from 78.22% of service users still at home 91 days after discharge to 82.19% (or 5.08%) by 31 March 2015 (this is against a national benchmark of an increase of 6%). It is noted that an action plan is being developed to improve the data quality to more accurately measure the 91-day period from discharge. Chart 2.2 shows the effect of discounting population growth on the number of older people who were still at home 91 days after discharge. It is noted however, that the percentage delivery against this indicator remains the same.

2.3. METRIC 3: Delayed transfers of care from hospital per 100,000 population (average per month)

This is a nationally defined metric measuring delivery of the outcome of effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. The aim is therefore to reduce the rate of delayed bed days per 100,000 population. Chart 3.1 shows the cumulative monthly rate of delayed bed days per 100,000 population for the baseline period, 2014/15 and Q1 2015/16. Chart 3.2 shows the reduction in cumulative bed days comparing the end of the baseline period with 2014/15.

Chart 3.1

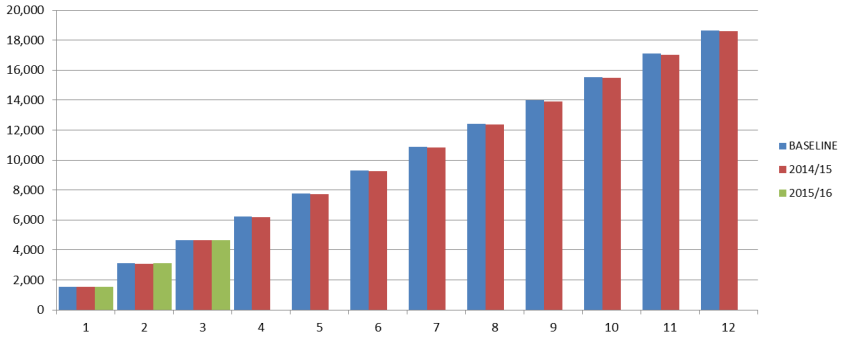

Chart 3.2

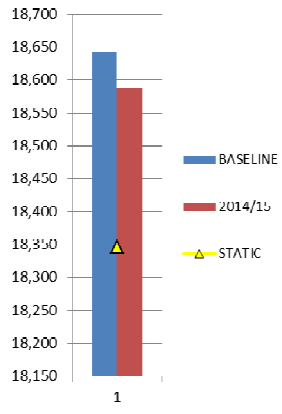

Table 3

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT (Apr-14 – Dec-14)	Oct-15 PAYMENT (Jan-15 – Jun-15)
NUMERATOR	12,429	13,915	9,348
DENOMINTOR	530,769	536,515	541,600
METRIC VALUE	292.71	288,18	287.67

Table 3 shows the proposed trajectory to be submitted for this indicator. The proposed trajectory is for a decrease from a baseline of 292.71 delayed bed days per 100,000 per month to 288.18 (1.55%) by 31 December 2014 followed by a further reduction to 287.67 (0.18%) by 30 June 2015. This is against a national benchmark of a reduction of 4%. Chart 3.2 also shows the effect of discounting population growth which would result in a further reduction of 242 delayed bed days at the end of 2014/15.

2.4. METRIC 4: Avoidable emergency admissions (composite measure)

This is a nationally defined metric measuring delivery of the outcome to reduce avoidable emergency admissions which can be influenced by effective collaboration across the health and care system. This is a composite measure of:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)
- Unplanned hospitalisation for asthma, diabetes and epilepsy in children
- Emergency admissions for acute conditions that should not usually require hospital admission (all ages)
- Emergency admissions for children with lower respiratory tract infections

Chart 4.1

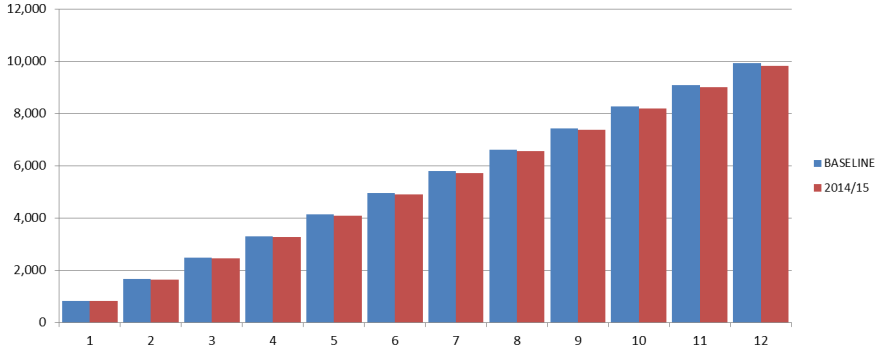

Chart 4.2

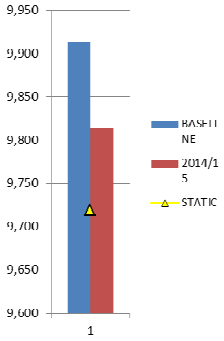

Chart 4.1 shows the cumulative monthly rate of emergency admissions per 100,000 population for the baseline period, 2014/15 and Q1 2015/16. Chart 4.2 shows the

reduction in cumulative bed days comparing the end of the baseline period with 2014/15.

Table 4

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT (Apr-14 – Sep-14)	Oct-15 PAYMENT (Oct-14 – Mar-15)
NUMERATOR	9,913	4,907	4,907
DENOMINTOR	665,557	672,049	672,049
METRIC VALUE	124.12	121.69	121.69

Table 4 shows the proposed trajectory to be submitted for this indicator. The proposed trajectory is for a decrease from a baseline of 124.12 emergency admissions per 100,000 per month to 121.69 (1.96%) by 30 September 2014 and then remaining the same at 121.69 until 31 March 2015. Chart 4.2 also shows the effect of discounting population growth which would result in a further reduction of 99 avoidable emergency admissions at the end of 2014/15

2.5. METRIC 5: Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]

This will be a nationally defined metric however, at the time of writing this paper the guidance confirming the definition of the metric has not be released. The outcome will be to demonstrate local population/health data, patient/service user and carer feedback has been collated and used to improve patient experience. To provide assurance that there is a co-design approach to service design, delivery and monitoring, putting patients in control and ensuring parity of esteem.

In the absence of this clarity this metric was reviewed as part of the BCF workshop held on 12 March 2014.

2.6. METRIC 6: Injuries due to falls in people aged 65 and over

This is a locally defined metric measuring delivery of the outcome to reduce emergency admissions due to falls in people aged 65 and over. Chart 5.1 shows the cumulative monthly rate of emergency admissions per 100,000 population for the baseline period, 2014/15 the period October 2014 to September 2015. Chart 5.2 shows the increase in cumulative emergency admissions comparing the end of the baseline period with 2014/15 and the period October 2014 to September 2015.

Chart 5.1

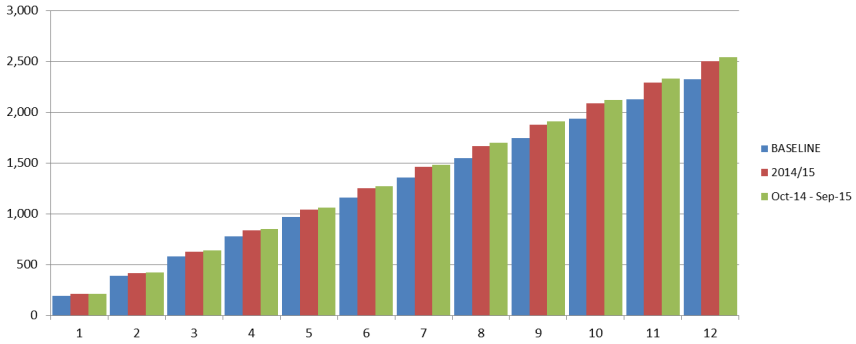

Chart 5.2

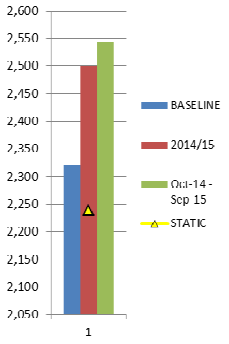

Table 5

	BASELINE (Apr-10 – Mar-11)	**Apr-15 PAYMENT (Apr-14 – Mar-15)**	**Oct-15 PAYMENT (Oct-14 – Sep-15)**
NUMERATOR	2,322	2,500	2,543
DENOMINTOR	115,044	128,466	130,645
METRIC VALUE	168.20	162.17	162.21

Table 5 shows the proposed trajectory to be submitted for this indicator. The proposed trajectory is for a decrease from a baseline of 168.20 emergency admissions per 100,000 per month to 162.17 (3.58%) by 31 March 2015 followed by a slight increase to 162.21 (0.02%) by 30 September 2015. Chart 5.2 also shows the effect of discounting population growth which would result in a further reduction of 83 emergency admissions due to falls at the end of 2014/15 in comparison to the baseline.

APPENDIX: BCF Metric Impact Analysis

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METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

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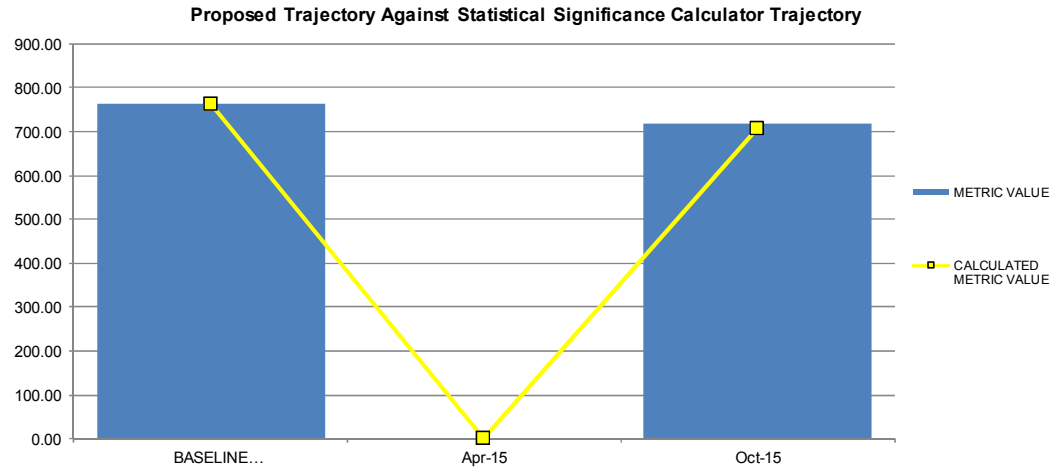

	BASELINE (Apr-12 - Mar-13)	Apr-15	Oct-15
SUBMITTED TRAJECTORY			
NUMERATOR	930		939
Variance against previous milestone			9
DENOMINATOR	121,930		130,645
METRIC VALUE	762.73		718.74
Improvement			-5.77%
STATISTICAL SIGNIFICANCE CALCULATOR TRAJ.			
CALCULATED NUMERATOR	930		924
Variance against previous milestone			-6
Variance	0		15
Percentage variance	0.00%		1.62%
CALCULATED METRIC VALUE	762.73		707.26
Variance	0.00		11.48
Percentage variance	0.00%		1.62%
Improvement			-7.27%

(Apr-14 - Mar-15)

Matches BCF base data

Matches BCF base data

Matches BCF base data

Matt Williams confirmed this was calculated using the Statistical Significance Calculator with a 90% confidence level

Calculated using the BCF Statistical Significance Calculator

INFORMATION RAG	A
PERFORMANCE RAG	A
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because the submitted metric has a) a numerator for Oct-15 greater than he baseline and although the metric shows an improvement, the absolute volume of admission increases to 939 for the submitted trajectory (using a 90% confidence level) b) the submitted trajectory has an improvement of -5.77% whereas the calculated trajectory (using a 95% confidence level) has a greater improvement of -7.27% (the national benchmark is -13%) - Amber Performance RAG given due to the current performance against this metric - Amber/Red Risk RAG given because delivery against this metric has been assessed to be very challenging

DEFINITIONS	
NUMERATOR:	Number of council-supported permanent admissions of older people to residential and nursing care, excluding transfers between residential and nursing care (aged 65 and over). This is from the ASC-CAR survey.
DENOMINATOR:	Size of the older people population in area (aged 65 and over). This is the ONS mid-year estimate.
METRIC:	rate of council-supported permanent admissions of older people to residential and nursing care.

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METRIC 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

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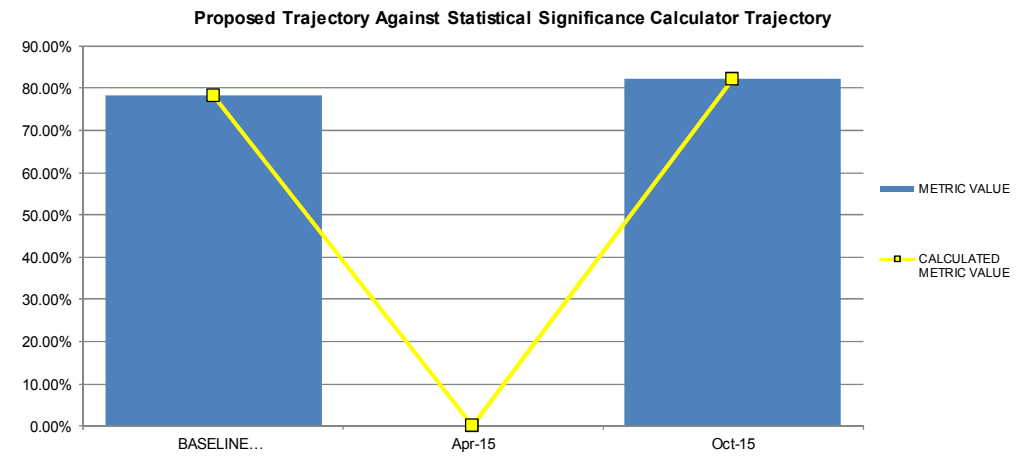

	BASELINE (Apr-12 - Mar-13)	Apr-15	Oct-15
SUBMITTED TRAJECTORY			
NUMERATOR	395		480
Variance against previous milestone			85
DENOMINATOR	505		584
METRIC VALUE	78.22%		82.19%
Improvement			5.08%
STATISTICAL SIGNIFICANCE CALCULATOR TRAJ.			
CALCULATED NUMERATOR	395		480
Variance against previous milestone			85
Variance	0		0
Percentage variance	0.00%		0.00%
CALCULATED METRIC VALUE	78.22%		82.19%
Variance	0.00		0.00
Percentage variance	0.00%		0.00%
Improvement			5.08%

Apr-14 - Mar-15

Matches BCF base data

Calculated using the BCF Statistical Significance Calculator

Matches BCF base data

Matt Williams advised that the Oct-15 denominator value has been modelled locally

INFORMATION RAG	**A**
PERFORMANCE RAG	**A**
RISK RAG	**A**
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because a) the data quality of the numerator is not good due to the monitoirng of the 91-day window following discharge from reablement **(ACTION:** Matt Williams and Sandy McMillan to write a summary of issue and remedial solutions). It is noted that the submitted improvement is 5.08% against a national benchmark of 6% - Amber Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult due to the data quality issues

DEFINITIONS	
NUMERATOR:	The number of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting) who are at home or in extra care housing or an adult placement scheme setting three months after the date of their discharge from hospital. This excludes those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months. Collected 1 January to 31 March of relevant year for all cases in denominator.
DENOMINATOR:	The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital. Collected 1 October to 31 December for the relevant year. Alongside this measure is the requirement that there is no decrease in the proportion of people (aged 65 and over) discharged alive from hospitals in England between 1 October 2012 and 31 December 2012 (including all specialities and zero-length stays) that are offered this service.
METRIC:	The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services.

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METRIC 3: Delayed transfers of care from hospital per 100,000 population (average per month)

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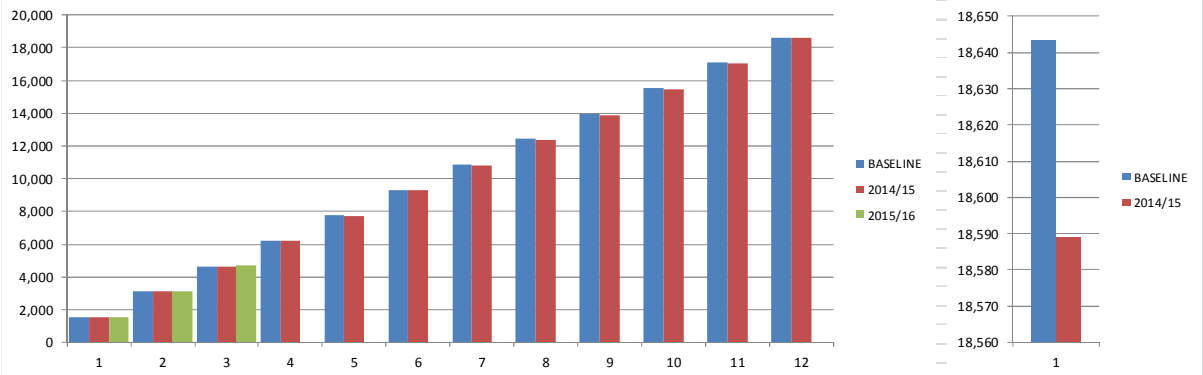

	BASELINE	Apr-15	Oct-15
NUMERATOR	12,429	13,915	9,348
DENOMINATOR	530,769	536,515	541,600
Number of months	8	9	6
Monthly rate	1,553.63	1,546.11	1,558.00
METRIC VALUE	292.71	288.18	287.67
		-1.55%	-0.18%
			-1.72%

	MONTH											
BASELINE	1	2	3	4	5	6	7	8	9	10	11	12
Cumulative activity per month	1,554	3,107	4,661	6,215	7,768	9,322	10,875	12,429	13,983	15,536	17,090	18,644
Combined annual activity	1,554	3,107	4,661	6,215	7,768	9,322	10,875	12,429	13,983	15,536	17,090	18,644
2014/15	1	2	3	4	5	6	7	8	9	1	2	3
Cumulative activity per month	1,546	3,092	4,638	6,184	7,731	9,277	10,823	12,369	13,915	1,558	3,116	4,674
Combined annual activity	1,546	3,092	4,638	6,184	7,731	9,277	10,823	12,369	13,915	15,473	17,031	18,589
2015/16	1	2	3									
Cumulative activity per month	1,558	3,116	4,674									
Combined annual activity	1,558	3,116	4,674									
												-55
												-0.29%

INFORMATION RAG	A
PERFORMANCE RAG	A
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Red Information RAG given because a) the revised trajectory has a negative gradient against a national benchmark of -4%. The trajectory using the calculated numerators with a 95% confidence level shows a decrease of -5.89% for Apr-15 and a continued decrease of -12.66% for Oct-15. The trajectory using the calculated numerators with a 75% confidence level shows a decrease of -2.41% for Apr-15 and a continued decrease of -5.22% for Oct-15 - Amber Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult

DEFINITIONS	
NUMERATOR:	The total number of delayed transfers of care (for those aged 18 and over) for each month included
DENOMINATOR:	ONS mid-year population estimate This rate should be divided by number of months included in numerator in order to give average total monthly delayed discharges (this is important in order to allow comparison of rates across the different payment periods – see Reporting schedule for data source below)
METRIC:	Average delayed transfers of care per 100,000 population (attributable to either NHS, social care or both) per month. A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer.

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METRIC 4: Avoidable emergency admissions (composite measure)

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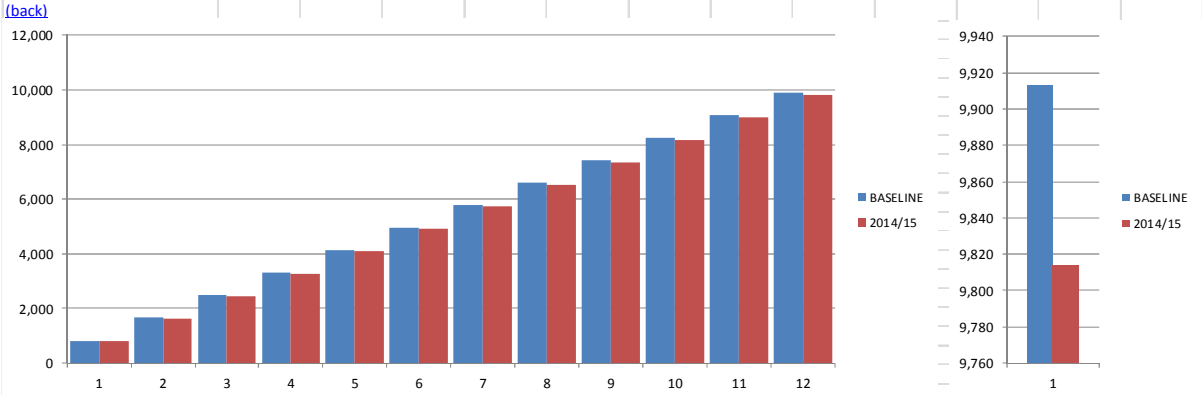


	BASELINE	Apr-15	Oct-15
NUMERATOR	9,913	4,907	4,907
DENOMINATOR	665,557	672,049	672,049
Number of months	12	6	6
Monthly rate	826.08	817.83	817.83
METRIC VALUE	124.12	121.69	121.69
		-1.96%	

	MONTH											
BASELINE	1	2	3	4	5	6	7	8	9	10	11	12
Cumulative activity per month	826	1,652	2,478	3,304	4,130	4,957	5,783	6,609	7,435	8,261	9,087	9,913
Combined annual activity	826	1,652	2,478	3,304	4,130	4,957	5,783	6,609	7,435	8,261	9,087	9,913
2014/15	1	2	3	4	5	6	1	2	3	4	5	6
Cumulative activity per month	818	1,636	2,454	3,271	4,089	4,907	818	1,636	2,454	3,271	4,089	4,907
Combined annual activity	818	1,636	2,454	3,271	4,089	4,907	5,725	6,543	7,361	8,178	8,996	9,814

INFORMATION RAG	A
PERFORMANCE RAG	G
RISK RAG	A
FINANCE RAG	TBC

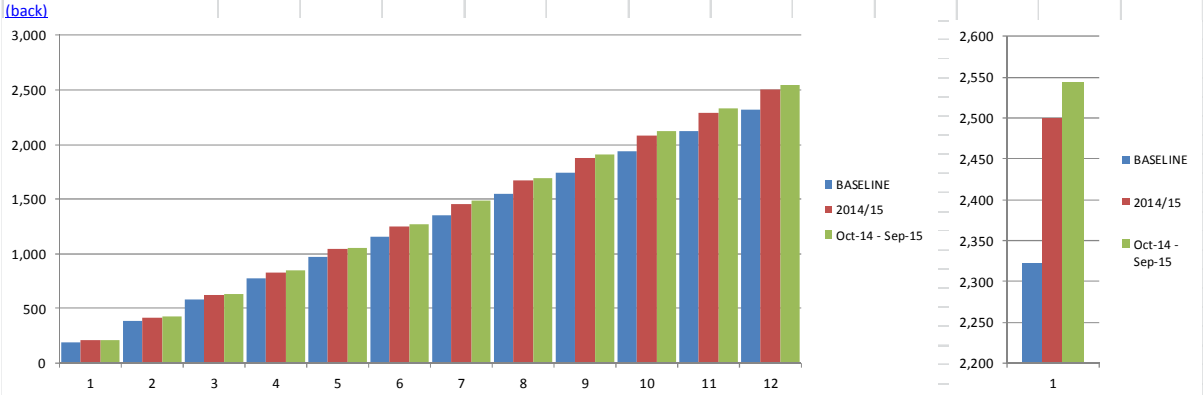
COMMENT	- Amber Information RAG given because a) the source of the numerator for Apr-15 and Oct-15 can not be replicated using the statistical significance calculator (the baseline numerator using the historic data would be 4,698) b) the submitted trajectory results in a different reduction in admissions than trajectories calculated using the statistical significance calculator with either a 75% or 95% confidence level (a national benchmark is not currently available) and c) the reduction in admissions from the baseline to the first and subsequent milestones are significant and is this reflected in 2014/15 contracts? It is noted that the sum of the two milestones for the submitted trajectory is 8,620 (a variance of 95 against the baseline) and the modelled trajectories are 8,446 and 8,677 respectively (variances of 269 and 38 respectively) - Green Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult

DEFINITIONS	
NUMERATOR:	Emergency admissions for primary diagnoses covering those in all 4 metrics above for all ages, by local authority of residence
DENOMINATOR:	Local authority mid-year population estimate/projected estimate (ONS) This will be used to give the crude rate of avoidable emergency admissions per 100,000 population
METRIC:	Composite measure of: □ unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages) □ unplanned hospitalisation for asthma, diabetes and epilepsy in children □ emergency admissions for acute conditions that should not usually require hospital admission (all ages) □ emergency admissions for children with lower respiratory tract infection. Details of each of these separate indicators can be found in the NHS Outcomes Framework: https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014 The composite measure will match that used in the Quality Premium except it will be based on Local authority (using resident population) rather than CCG geography (GP registered population). http://www.england.nhs.uk/wp-content/uploads/2013/05/qual-premium.pdf

LEICESTERSHIRE COUNTY COUNCIL

METRIC 6: Injuries due to falls in people aged 65 and over

(back)



	2018.3582	1946.0402	1946.4962
	BASELINE	**Apr-15**	**Oct-15**
NUMERATOR	2,322	2,500	2,543
DENOMINATOR	115,044	128,466	130,645
Number of months	12	12	12
Monthly rate	193.50	208.33	211.92
METRIC VALUE	168.20	162.17	162.21
		-3.58%	0.02%

	MONTH											
BASELINE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Cumulative activity per month	194	387	581	774	968	1,161	1,355	1,548	1,742	1,935	2,129	2,322
Combined annual activity	194	387	581	774	968	1,161	1,355	1,548	1,742	1,935	2,129	2,322
2014/15	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Cumulative activity per month	208	417	625	833	1,042	1,250	1,458	1,667	1,875	2,083	2,292	2,500
Combined annual activity	208	417	625	833	1,042	1,250	1,458	1,667	1,875	2,083	2,292	2,500
Oct-14 - Sep-15	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Cumulative activity per month	212	424	636	848	1,060	1,272	1,483	1,695	1,907	2,119	2,331	2,543
Combined annual activity	212	424	636	848	1,060	1,272	1,483	1,695	1,907	2,119	2,331	2,543

INFORMATION RAG	**A**
PERFORMANCE RAG	**A**
RISK RAG	**A**
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because a) no milestone has been included for Apr-15 b) is there a benchmark to appraise the submitted improvement? c) although the metric shows an improvement, the absolute volume of falls increases to 2,543 - Amber Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult

DEFINITIONS	
NUMERATOR:	This is measured by the number of emergency admissions due to falls
DENOMINATOR:	The denominator is the ONS mid-year population estimate provided by NHS England as part of the BCF toolkit. This is the estimated 65+ population of Leicestershire
METRIC:	This is our local measure which will enable us to monitor the effectiveness of the prevention programme of work in particular with our frail older population. This links with the improved housing offer which will enable a more rapid response to patients identified that require adaptations or alternative options that ensure that they are safe and independent within their homes. Furthermore the proactive and integrated care model involves risk stratification and proactive care planning for patients who can be supported to manage their long term conditions using the MDT approach - measuring the injuries due to falls will enable us to monitor the effectiveness of these plans.