

**Department of Human Services
Rural & Regional Health & Aged Care Services**

**Aged Care Branch Falls Prevention Program
Rationale and Funding Submission Guidelines**

***Whole of Community*
Phase 3 Falls Prevention Project**

Submission Due Date:10/...07/ 2006 [5:00 pm]
Submissions to: Department of Human Services
Region/Program Name
Region/Program Address
Contact: DHS Contact Officer
Tel: [03]

Submission Template @ 02-04

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A Background and Overview

This document has been prepared to assist prospective service providers in the preparation and lodgement of submissions for a *Whole of Community* Phase 3 Falls Prevention Project. The Department of Human Services (DHS) is seeking suitably qualified and experienced service providers to undertake the services described in this brief.

Key dates are indicated below.

Information/briefing session for interested service providers	Conducted 23 February 2006.
Closing date and time for submissions	Insert closing date and time for submissions
All service providers to be advised of outcome by	Insert date when service providers will be advised
Service commencement by	Insert service commencement date

1. Background

DHS is responsible for funding a wide range of services to diverse client groups across Victoria. The Department's principal function is to ensure the delivery of a range of health, housing and community services. Our mission statement is:

To enhance and protect the health and well being of all Victorians, emphasising vulnerable groups and those most in need.

It is State Government policy that the funding of non-government agencies for the provision of services to the community be undertaken in a context of partnership between the Government and the service sector. To this end, DHS signed a partnership agreement with funded agencies in the health, housing and community services sectors in October 2002. The agreement is supported by regular partnership forums. Regular partnership forums support the agreement, in this case by the quarterly Falls Prevention Program Network Meeting.

This document, *Whole of Community Project Rationale and Funding Submission Guidelines*, provides the overall rationale to guide Primary Care Partnerships (PCPs) intending to develop a submission to implement a 'Whole of Community' Falls Prevention project.

The PCP strategy has provided Victoria with an unprecedented opportunity to build the ongoing capacity of the human services system to plan and deliver effective, integrated health promotion. This falls prevention funding provides opportunities for PCPs to work with a range of partners across multiple settings, including public sector residential aged care services and other not for profit agencies within a designated local catchment area. Working directly with acute and residential services enables PCP member agencies to facilitate better admission and discharge planning and provides older people with a seamless response to reduce the risk of falls and improve injury prevention.

2. Service Objective and Scope

2.1 Falls Prevention Program Goals

The goal of the Falls Prevention Program is to implement multi-strategy falls prevention projects within an integrated health promotion framework to reduce the risk and incidence of falls, and the severity of fall-related injuries among older people.

The intended long-term benefits to municipalities and regions are improvements in the health, wellbeing and mobility of older people enabling them to live with greater confidence, independence and security.

2.2 Project Objectives

The objectives of falls prevention projects are to:

- Increase community recognition of falls as a '*whole of community*' responsibility.
- Increase community understanding that falls are not an inevitable part of growing older.
- Increase community understanding of the multifactorial risk factors that contribute to falls and benefits of falls prevention interventions.
- Increase the proportion of older people who actively participate in reducing their risk of falling, and as a consequence enjoy an independent and healthy lifestyle.
- Increase the safety of local environments for current and future generations.
- Integrate falls prevention interventions within the PCP Integrated Health Promotion Catchment Plan and Municipal Public Health Plan.

Whole of Community projects should also consider the collaboration's vision, priority issues and how the goal, aims and objectives, and outcomes for the falls prevention project fits within a defined template. Specifically:



- Vision setting
- Priority setting and problem definition
- Solution generation
- Capacity building-support and resources
- Planning for evaluation and dissemination

Other areas for consideration should include:

- Developing an **evidence-based rationale** for the mix of interventions chosen for your local catchment area to support a **multi-strategy falls prevention plan** that addresses the major falls risk factors and includes a focus on:
 - Screening, individual risk assessment (falls prevention related services)
 - Health education and skill development
 - Social marketing/health information (including awareness raising activities)
 - Community action (for social and environmental change)
 - Settings and supportive environments (including home, hospital, residential aged care facility/ies and public place audits)¹.
- **Identifying the timeframe for implementation** of each of the following stages of your proposal.
 - Planning and development
 - Implementation of activities
 - Ongoing monitoring and evaluation
 - Dissemination/communication of findings

(Note: A template is provided for your use – Attachment 2)

3. Performance Monitoring

Monitoring of service performance will be undertaken through liaison with the successful service provider. Service requirements will be monitored through the collation of performance indicators and supported by an analysis of issues impacting on the performance achieved. The Department will work with funded agencies to develop performance monitoring in the areas of financial viability, governance and service quality.

To assist service providers in the delivery of the service, DHS will undertake to provide:

- An ongoing commitment to the development of collaborative relationships;
- Formal support via regular meetings with the service provider;
- Regular updates on relevant policy directions and initiatives;
- Consultancy where appropriate; and
- Formal and informal contact as required.

The frequency of formal liaison meetings will be determined in consultation with the service provider. A DHS agency liaison officer will be nominated to act as the initial point of contact for the service provider.

DHS will communicate any information or recent development such as the release of new policies, initiatives or strategic documents or training opportunities to the provider in a timely manner. DHS will undertake to action funding in a timely manner.

¹ Integrated Health Promotion – A practice guide for service providers:
<http://www.health.vic.gov.au/healthpromotion/>

DHS will undertake to address any issues requiring clarification or discussion at the earliest opportunity in order to reach resolution.

DHS Regional Officers will be responsible for administering contractual and funding arrangements, monitor and receive progress reports from the project. These multi-setting projects will be funded through PCPs. PCPs will be required to nominate the name of the Organisation/Agency that will receive and be responsible for the funding allocated for the project and DHS Service Agreement. This organisation may not necessarily be the lead Organisation/Agency for the project.

Primary Care Partnerships

The PCP will be responsible for the management of tasks associated with the operation of the *Whole of Community* falls prevention project and will be responsible and accountable for:

- Meeting all conditions as outlined in the DHS Service Agreement
- Providing a quarterly report to the Aged Care Branch Central Office and relevant Regional Office (see Appendix 2 – Progress Report and Appendix 3 – PCP Reporting Requirements).

PCPs and collaborating agencies that are currently receiving other DHS funding to implement a falls prevention project, or are receiving funding from another source, for example the Australian Government or Metropolitan Health & Aged Care Services, will not be given a high priority. However, where PCPs have or are receiving funding for a *Foothold on Safety (FOS)* project they may be eligible to apply for *Whole of Community* funding. PCPs must demonstrate that the size of the aged population, physical and/or geographical distance between key agencies, have impacted on the capacity of the FOS project to provide key falls prevention interventions for older people in their community.

Monitoring, audit and review arrangements will apply uniformly to all service providers in line with Department of Human Services and State Government practice. PCPs and collaborating agencies should plan to include the following:

- Process – the planning process and the strategies and processes that will be used to implement the project.
- Impact – Identifying how the immediate effect(s) of the implementation of a falls prevention intervention or plan will be measured. For example, have objectives been met, changes in knowledge, attitudes and practices of people, stakeholders and settings (as stated in Project Aims and Objectives).
- Outcome – the long-term effects of the project. For example, the health and social outcomes that reduce the risk and incidence of falls and the severity of fall-related injuries from falls among older people (as stated in the Falls Prevention Program Goals).

Note:

Raised awareness and improved reporting of falls can lead to an apparent increase in incidents. Over time there should be a more accurate view of outcomes of the project.

Quality evaluation that is more fully integrated with the planning and implementation of projects will ensure a sound, secure and sustainable improvement in integrated health promotion practice.

Part B: Specifications and Evaluation

4. Service Specifications

Specification 1: The Service Provider

The successful service provider must have a background relevant to the service and be able to demonstrate a capacity to deliver the service to the required standards.

All service providers must address the following points in their submissions :

- Understanding of requirements

The service provider must be able to demonstrate an understanding of service requirements.

- Relevant experience

The submission must describe the service provider's experience in the provision of similar services. Where appropriate, suitable references may be provided.

- Staff competencies

The submission must describe the minimum competencies of staff and policies to maintain their competency over the period of service.

Note:

In considering the activities you may wish to include in a falls prevention project, older people attending activities have a right to expect that the people providing all services possess the necessary skills and knowledge to provide that service.

Consideration should be given to ensure all services that promote physical activity are provided or supervised by appropriately qualified health professionals. Service providers must ensure reasonable care is provided to individuals to avoid harm and to protect individuals from foreseeable risk of injury.

To enhance sustainability of falls prevention projects both in terms of personnel and service provision, Aged Care Branch is interested in workforce development, primarily through staff training. This is particularly important where skills, and the expertise needed to implement projects are not available locally or through other services.

Specification 2: Service Deliverables

Submissions should contain a detailed and considered discussion of the proposed service methodology and how it addresses the key needs of the service as described in this brief. The following minimum deliverables are required:

Performance measures:

- Number of people aged 65+ participating in falls prevention activities.
- Number of health professionals/workers participating in falls prevention education and skill development.
- Number of agencies within the PCP catchment participating in education and skill development.

Monitoring/reporting activity:

The Department is required to report to Treasury for all budget allocations in the Budget Paper No. 3 by demonstrating funds have been appropriately used. To enable the Aged Care Branch to comply with this accountability requirement, PCPs will be required to provide a quarterly report to DHS Regional and Central Offices.

Reporting templates will be available electronically for successful applicants to provide:

- Quarterly reports in January, April and October of each year; (Appendix 2)
- Annual report in June/July of each year. (Appendix 3)

These reports substantially provide information about progress on project implementation and achievement of objectives.

Reports will be returned to your contact at the DHS Regional Office and Aged Care Branch on dates to be advised.

PCPs must comply with the Financial Accountability Requirements and reporting requirements established from a Service Agreement.

Specification 3: Price and Budget

Funding for *Whole of Community Falls Prevention* projects will be available from financial year 2006-2007 for a total of three years subject to Ministerial approval and available funding.

The amount of funding for each project will be in the vicinity of \$210,000 over three years. The funds will be structured to provide up to \$60,000 in Year 1 and \$75,000 in each of the following two years of the project on condition that satisfactory progress is achieved towards objectives and targets.

The exact amount per project may vary to accommodate innovative larger and/or smaller projects. However, given the program goals of supporting multi-strategic projects, it is not the intention to fund very small projects.

Service providers are required to include in their submissions a detailed budget identifying how the funding will be spent within a three-year time frame including administrative overheads and operating costs. This budget must be within the total available funding advised by DHS. (A template is provided for your use – Attachment 6.)

Specification 4: Infrastructure/Equipment

Note: This funding is not to cover depreciation or used for capital works. It is principally for integrated health promotion purposes.

5. Evaluation of Submissions

The following criteria will be used to evaluate all submissions and determine the successful service provider(s).

Criteria specified as 'mandatory' must be met. If they are not met, the submission may be rejected without further consideration unless it is clearly indicated to be an alternative proposal, and documentation is provided that supports its validity in achieving the requirements of this service.

Criteria Relating to Specification 1 (The Service Provider)

- Criterion 1 The service provider demonstrates an understanding of service requirements. The service provider has relevant and adequate experience, with demonstrated ability to deliver services that address falls prevention issues within prescribed timeframes and designated budgets.

Responses should include:

- Details of existing services demonstrating relevant experience and expertise in the delivery of services to prevent falls among older people;
 - Experience and expertise in working with various client group/s across a range of settings;
 - Understanding of the needs of the client groups and the range of appropriate service responses, and demonstrated capacity and willingness to work with the various client group/s.
- Criterion 2 The submission includes sufficient supporting documentation to demonstrate satisfactory financial, technical, planning and other resource capability and viability. Documentation should include audited financial statement and an annual report from the most recent financial period (or relevant equivalent, if not a corporate body); business or corporate plan covering current period.

This criterion is **mandatory**. Service providers that have a current service agreement with DHS will be assessed on the basis of information already provided. An assessment may also be made on the current overall performance of the agency.

- Criterion 3 The service provider has satisfactory staffing policies and practices and demonstrates commitment to equal employment opportunity and maintenance of occupational health and safety. The submission describes satisfactory minimum competencies of staff and policies to maintain competency over the period of service.

Responses should include:

- Details of how this service relates to the service provider's core business and how the service will be incorporated into current operations.
- Written evidence of appropriate management structure, which may include statement of roles, responsibilities and qualifications and competencies of key staff, staff training, reporting structures, supervision and infrastructure support policy and procedural documentation, articulated policies for managing critical incidents.

Criteria Relating to Specification 2 (Service Deliverables)

- Criterion 4 **Planning process.** The service provider has the demonstrated ability to provide a detailed, valid and integrated health promotion methodology and implementation plan for a *Whole of Community* Falls Prevention Project. The plan should demonstrate:
 - A commitment to continuous improvement in providing high quality, value for money services.
 - Documented evidence that all relevant stakeholders have been involved in the planning, design and development of the *Whole of Community* submission. (PCPs and collaborating agencies should identify the roles and responsibilities of the key stakeholders, community, older people and carer representatives.)
 - Show how links would be established between the PCP and the *Whole of Community* falls prevention working group and their project advisory group.
 - Capacity to deliver the service specified at the times or for the period indicated and deliver the outcomes specified.

Responses should also detail your planning process; proposed strategies, service delivery framework, and include:

- Your project goal
 - Project aims and objectives. (An objective must be SMART² and address the protective and risk factors for falls {Eg. Falls and fall-related injuries will be reduced by 10% in the catchment area.} Objectives will continue to change, as organisational/staff/participant needs change and therefore will need to be modified to assist in progress.)
 - Target group(s) – for example, please specify if you will be providing initiatives for people with dementia or Parkinson's disease or for people that have culturally and linguistically diverse backgrounds, or are part of an Indigenous community.
- Criterion 5 **Evaluation, Evidence and Outcomes**
 - Demonstrated ability to effectively identify and deliver the desired project outcomes. For example, the **estimated reach, impact and effectiveness** of the *Whole of Community* project. (A template is provided for your use – Attachment 5 – Part 1.) Please list:
 - Agency/facility
 - Partnerships - including:
 - Your PCP member agencies
 - Agencies/individuals (including older people and their organisations) that have been involved in developing your *Whole of Community* submission

² S – specific (clear and precise), M – measurable (amenable to evaluation), A – achievable (realistic), R – relevant (to the health issue, the population group and your organisation), T – time specific (time frame for achieving your objective). See:

http://www.health.vic.gov.au/healthpromotion/downloads/planning_may05.pdf

- Organisations you would like to further develop links with through your *Whole of Community* project.
 - Staff
 - participants
 - families/carers
- **Documented evidence** of recent successfully implemented aged-related integrated health promotion programs within the designated local catchment area. (A template is provided for your use – Attachment 5 – Part 2.)
- Criterion 6 Demonstrate appropriate **long-term and capacity building strategies** to ensure falls prevention initiatives will become an intrinsic part of the PCP catchment planning for integrated health promotion, and **sustained** beyond the period of project funding.
- This should include strategies to identify how community sector disability services, local Government, recreation services and private sector services will either be established and or enhanced to assist in the implementation of this initiative. Also identify the capacity your PCP has to leverage existing locally based initiatives already taking place within the catchment planning for integrated health promotion. (A template is provided for your use – Attachment 3)
- **Please comment on the following:**
 - Organisational development
 - Workforce development
 - Continuous improvement
 - Building partnerships
 - Transfer to other sites or locations in the PCP catchment area or adjacent catchment areas
 - On-going monitoring of projects. Please specify the project management, monitoring or evaluation tools you have used previously. (Eg: Primary and Community Health Planning and Reporting Guidelines, Well for Life project report.)

Evaluation Process

Submissions will be evaluated against the indicated criteria. An initial evaluation may be used to short-list submissions.

Following short-listing, one or more service providers may be approached to meet with the evaluation panel to provide clarification or further information.

All service providers will be advised in writing of the final outcome of the submissions process, including the identity of the successful service provider(s).

Scoring

Submissions will be initially scored against the following scale:

Evaluation	Score
Exceeds all aspects of the selection/evaluation criterion	4
Exceeds some aspects of selection/evaluation criterion (and meets all other aspects of the selection/evaluation criterion)	3
Meets the selection criterion	2
Fails some aspects of the selection criterion	1
Fails all aspects of the selection criterion.	0

Part C: Conditions Applying To This Submissions Process

6. General Conditions

Format of Submission

A pro-forma submission format is at Part D of this document and separately at Appendix 1. Service providers must address their submissions to the specifications and will be assessed against the evaluation criteria. The pro-forma submission format has been structured to reflect the information requirements of this submission process.

Service providers are strongly advised to use this format when preparing their submissions.

Legal Entity

Service providers must provide proof of their legal status. A legal agreement can only be entered into by DHS with a service provider or individual with legal status established under:

- Associations Incorporation Act
- Co-operatives Act
- Corporations Law
- Health Services Act
- An Individual Act of Parliament
- Natural Person (a person at least 18 years of age, with a mental capacity to understand the agreement, not under any order or bankrupt)
- Trustee Act.

DHS prefers to deal with service providers that have an Australian Business Number (ABN).

Consortia and Coalitions

There are three legal and management options available to consortia in making a submission. Each of these types of arrangements is acceptable to DHS:

- incorporate as a single body;
- each member signs as part of a Non Incorporated Consortium; or
- subcontracting by the Lead Agency to other members of the Consortium.

The Department recognises that partnership arrangements may form within the service sector with the objective of promoting integration to better meet the needs of the community.

Where the service provider is a consortium, the submission must indicate the name of the Organisation/Agency assuming lead responsibility, which parts of the service each entity comprising the consortium is proposing to provide. The submission must also detail how the Lead Agency and Sub-contractor(s) would relate to each other to ensure cooperation and full provision of the required service across the PCP catchment area.

Form and application of Agreement

The PCP and collaborating agencies will be required to nominate an Organisation/Agency to coordinate and assume lead responsibility for the project.

This Organisation/Agency will be required to enter into a formal Service Agreement or agree to a Variation to an existing Agreement with the Department of Human Services, a sample copy of which is supplied as Attachment XXXX.

Payments

Service providers must have the capacity to accept electronic funds transfer as a facility for payments. A payment schedule will be negotiated with the successful service provider. DHS will make payments according to the satisfactory achievement of key stages.

The successful service providers may be required to authorise the Department to issue a Recipient Created Tax Invoice (RCTI) in respect of any part of the services

Statement of Departures

Service providers must state in their submissions that they have not proposed any changes ("departures") from the specification (Part B) of this document and the conditions of the standard DHS service agreement (Attachment I) or, where they are proposing departures from these sections, they should submit details with their submission.

By making a submission in response to this document, service providers are deemed to have accepted these conditions.

7. Lodgement of Submissions

The submission must be enclosed in a sealed envelope and clearly addressed as follows:

CONFIDENTIAL
Submission : *Whole of Community* Phase 3 Falls Prevention Project
Department of Human Services
.....Regional Office

Closing Date and Time: **10 July 2006**

and must arrive at the above address by 5.00 pm **10 July 2006**

Facsimiled, e-mailed or electronic submissions may be accepted at the discretion of the Department. Service providers wishing to submit via these means must contact **[insert contact officer name and telephone number]** at least two working days before the closing date. Late submissions may be accepted if the Department considers that genuine and reasonable extenuating circumstances exist. Service providers should contact the Department before the specified closing time in order for such circumstances to be considered. Incomplete submissions will be accepted at the Department's discretion.

Submissions forwarded through Australia Post should be posted (addressed as above) to ensure receipt no later than the closing time (registered post is recommended).

Submissions must be signed and dated by an authorised officer of the service provider.

An original and two copies plus **an electronic version** of the entire submission must be submitted.

All submissions must be in English.

Submissions will be opened after the closing time for submissions and notification of receipt will be forwarded to each service provider.

8. Requests for Further Information

Clarification of Processes

Service providers may telephone **[Enter name of designated officer]** on **[Enter contact telephone number]** to clarify matters relating to the submissions process, or to clarify aspects of the specification. Verbal explanations or instructions given to service providers prior to the acceptance of any submission shall not bind DHS.

Additional Information about falls prevention in Victoria (Appendix 4).

Additional Information that may be obtained from other organisations (Appendix 5).

Additional Information – Falls Prevention and Other Contacts (Appendix 6).

Additional Information Required by DHS

- Should information additional to that contained in a submission be required while submissions are being considered by DHS, written information and/or interviews may be requested at no cost to DHS.
- The name and telephone number of an officer or employee of the service provider capable of clarifying technical and commercial aspects of the submission must be provided.

9. Reservations

Withdrawal From Process

DHS may withdraw from the submissions process described in this document for any reason, prior to signing any agreement with any service provider for the delivery of the services described in this document.

Lowest Cost Submission

In the case of fixed price submissions, the lowest cost submission, or any submission, will not necessarily be accepted.

Negotiation

DHS may elect to negotiate with short-listed service providers after the nominated closing date for submissions.

Part Offers

DHS may accept submissions in relation to part of the scope of activity described in this brief, or appoint one, more than one or no service provider on the basis of the submissions received.

10. Conflicts of Interest

Declaration

Service providers must declare to DHS any matter or issue which is, may be perceived to be or may lead to a conflict of interest regarding their submission or participation in the provision of the services described. Where applicable, service providers must also describe a strategy designed to avoid any conflict of interest.

11. Confidentiality

Ownership of Submissions

All submissions and any accompanying documents become the property of DHS.

Ownership of Information

Ownership of all information, reports or data provided by DHS to service providers resides in the State of Victoria. The service provider shall not, without written approval of the Secretary to DHS, use the information or reports other than in the development of the submission or the performance of the assignment. This information, in whatever form provided by DHS or converted by the service provider, must be destroyed in a secure fashion following advice of the outcome of the submission process or at completion of the assignment.

12. Disclosure

Presumption to Full Disclosure

The Victorian Government has a strong presumption in favour of disclosing agreements and, in determining whether any clauses should be confidential, specific Freedom of Information (FOI) principles (including a public interest test) will apply. The Government cannot pre-empt the workings of the FOI Act or constrain the Auditor General's powers to secure and publish documents as appropriate.

Disclosure of Submission and Agreement Details

Subject to this clause and the Conditions of Agreement, all documents provided by the service provider will be held in confidence so far as the law permits. Notwithstanding any copyright or other intellectual property right that may subsist in any documents, by making a submission the service provider licenses DHS to reproduce the whole or any portion of the submission documents for the purposes of evaluation

In making its submission, the service provider accepts the Department may publish (on the internet or otherwise) the name of the successful or recommended service provider(s) and the value of the successful agreement(s), together with the provisions of the agreement generally.

Non-Disclosure of Agreement Provisions

Non-disclosure of agreement provisions must be justified under the principles for exemption within Section 34(1) of the *Freedom of Information Act 1982*,

providing that information acquired by an agency or a Minister from a business, commercial or financial undertaking is exempt under the Act if the information relates to trade secrets or other matters of a business, commercial or financial nature and the disclosure would be likely to expose the undertaking unreasonably to disadvantage. The Department will consider these arguments in the evaluation and negotiations with service providers.

13. Lobbying

Service providers are reminded that they should not attempt to exert influence on the outcome of the assessment process by lobbying, directly or indirectly, DHS staff or Members of Parliament.

Part D: Standard Submission Form

To assist with completing the required documentation an abbreviated version of the standard submission form at Appendix 1: 'Submission Form for *Whole of Community* Phase 3 Falls Prevention Project' will be forwarded separately to applicants in electronic format [in Word for Windows format]:

[Insert contact name, address and telephone number of person where documents may be sourced.]

Please note:

All submissions should be developed using the abbreviated version of the Submission Form.

All parts of the Form should be completed and the submission lodged before the closing date and time for submissions.

Any additional supporting information should be attached to the completed submission and clearly referenced.

The submission must be signed by an authorised officer of the service provider.

Submission Form

Department of Human Services
Rural & Regional Health & Aged Care Services
Falls Prevention Program
2006-2007

Whole of Community
Falls Prevention Projects
Phase 3

July 2006

Submission Due Date:10/...07/ 2006 [5:00 pm]

Submissions to: Department of Human Services
Region/Program Name
Region/Program Address

Contact: DHS Contact Officer
Telephone: (03)

Part 1 Service Provider Details

PRIMARY CARE PARTNERSHIP			
Name	Address	Telephone Numbers	Email Address
Executive Officer of PCP			
Collaborating Agencies (use separate lines for each agency)			
Lead Agency (if known)			
Executive Officer of Lead Agency			
Project Coordinator (if known)			

Part 2 Submission

2.1 Overview

Provide details of the service and its structure, to describe how the service will be implemented, managed and monitored. The extent to which a practical, workable and sector sensitive approach is developed is a key consideration. Describe how you intend to provide each of the service deliverables and your understanding of the nature of each deliverable.

Joint submissions for *Whole of Community* Falls Prevention projects are invited from PCPs and collaborating agencies to implement an innovative falls prevention project designed by, and for, the local community.

Each PCP and collaborating agencies will decide which organisations will participate in their project. The falls prevention project will be more effective if it actively involves a number of key stakeholders and representatives such as:

- Local government
- Community Health Services
- Falls and mobility clinic
- Local sport and recreation sector
- Organisations that represent older people or where older people are the majority of the membership
- Psychiatric disability support
- Psychogeriatric Assessment and Treatment Teams
- Aged Care Assessment Services (ACAS)
- Aboriginal community controlled health services
- Carer Agencies/Services
- Community drug treatment services
- Local ethno-specific health services, and
- Other integrated health promotion initiatives such as:
 - Well for Life
 - Active Script
 - Health and Active Living
 - Walk and Talk

Local partnerships should encourage the active participation of consumers, carers and the broader community. PCPs and collaborating agencies are required to:

- Respond, in order, to each of the submission headings on the pro-forma Submission Form (Attachment 1).
- Provide a short narrative that includes:
 - The number and proportion of the population of older people 65 + years in the designated local catchment area
 - The numbers and nature of fall-related injuries, eg. The number of people 65+ who are admitted to hospital for a fractured neck of femur. The settings where the falls are occurring, eg. In or outside of the home, residential aged care facility or acute hospital.
 - What services are available to assist older people who fall, and
 - Suggest the differences you consider this funding will make to the health and well being of older people, their families and carers.

In this brief narrative identify key features or special needs of the local population or particular groups within the community. PCPs should refer to the community health and well-being profile from their Community

Health Plan or investigate additional data sources, where necessary, to assist in planning an appropriate falls prevention project.

- Describe how the PCP will link the falls prevention project with the catchment planning for integrated health promotion, as reflected in the PCP Integrated Health Promotion Catchment Plan and the Municipal Public Health Plan.
- Nominate a representative of the PCP (or Lead Organisation/Agency) to liaise with DHS.

Consider the following aspects of the service in preparing and documenting response to this part:

- methodology: provide a detailed and considered discussion of the proposed methodology for service delivery and how it addresses the key needs of the service as described in this brief;
- components, sub components and major tasks;
- timetable indicating sequence and duration of each task, prepared in accordance with the key dates nominated in this brief;
- key review points;
- deliverables and outcomes
- data collection and analysis arrangements.

The response to this part should not exceed four (4) A4 pages.

- DHS acknowledges that PCPs may wish to nominate a Lead Organisation/Agency to implement the *Whole of Community* project.
- Funding can be used to establish ongoing, sustainable programs or for *further development and enhancement* of established programs.

The Selection Criteria that will be relevant to the evaluation of this part of your submission relate primarily to Specification 2 (Service Deliverables). These criteria are detailed in section 4 of this document.

2.2 Price/Cost of Submission

To enable the viability of pricing to be evaluated, the quotation must include an itemised budget with costings for each stage of the project (See Attachment 6 of the Submission Form).

- Specify if necessary, any non-recurrent establishment costs
- Staff costs (including staff on-costs)
- Consumables
- Infrastructure costs
- Non-salary costs
- Financial.

All prices quoted must be in Australian dollars.

In addition, the extent to which pricing has been affected by the use of volunteer labour or cross subsidisation or '*in kind*' contributions from other agencies should be clearly identified.

Participation in Falls Prevention Network

There is an expectation that a representative from the PCP or Lead Organisation/Agency will participate in quarterly Falls Prevention Network Meetings held at DHS Central Office, Melbourne. Sufficient funds should be allocated within the budget to cover this requirement.

The Falls Prevention Network provides opportunities for meeting and networking with other project representatives, and to encourage shared learning and promote practice change.

Please note this falls prevention project funding is not to be used for infrastructure/equipment, nor is it to cover depreciation or used for capital works. It is principally for integrated health promotion purposes.

Audit

PCPs and collaborating agencies should note that DHS might authorise an audit of a PCP/ Lead Organisation/Agency:

- If the financial returns of the service provider indicate concern about the nature of expenditure of funds provided by the Department.
- To establish or investigate the financial viability of the PCP or the Lead Organisation/Agency where funds provided by the Department comprise a significant proportion of the organisation's total budget.
- To establish whether the grant of funds has been applied for the purposes for which it was made and whether the money has been applied economically, efficiently and effectively.

2.3. Qualifications and Experience of Key Staff

Name	
Title/Office Held	
Qualifications	
Previous Experience	
Role/functions to be performed	

Name	
Title/Office Held	
Qualifications	
Previous Experience	
Role/functions to be performed	

Name	
Title/Office Held	
Qualifications	
Previous Experience	
Role/functions to be performed	

[Repeat as Required]

Part 3 Supporting Information

Service providers should describe the nature and extent of any relevant experience. The space provided below may be exceeded if necessary.

Service providers should disclose sufficient information to demonstrate that they have adequate experience and financial, technical and other resources capability to successfully undertake the submission. Provide details (such as title, year, etc.) of relevant supporting documents and attach copies to your submission. If this submission is being made electronically, any non-electronic attachments will need to be mailed or faxed separately.

Profile of Service provider

Range of services currently delivered	
Years of operation in this capacity	

The PCPs and collaborating agencies should:

- Identify the roles and responsibilities of the key stakeholders, including nominating the lead organisation/agency (if this option is decided upon), community, consumer and carer representatives.
- Provide (if known), contact details for the person/s responsible for:
 - Implementing the project
 - Managing the service agreement, and
 - Liaising with DHS Regional Officers.
- Identify how resources will be allocated.
- Specify if necessary, any non-recurrent establishment costs.
- Demonstrate how links will be established between the project, the PCP management group and the *Whole of Community* falls project advisory group, and
- Identify how the benefits of the project will be sustained beyond the life of the existing project within each PCP integrated health promotion catchment planning area.

Part 4 References

All service providers are required to provide referees, whether they have a current DHS service agreement or not.

Referee #1

Company Name	
Postal Address	
Street Address	
Contact Person	
Position/Title	
Telephone Number	
Facsimile Number	
Nature of work performed	

Referee #2

Company Name	
Postal Address	
Street Address	
Contact Person	
Position/Title	
Telephone Number	
Facsimile Number	
Nature of work performed	

Part 5 Disclosure of Submission and Agreement Information

Part C provides for disclosure of agreement information. If you withhold the disclosure of specific information, you must detail how its release will expose trade secrets or expose your service provider unreasonably to disadvantage. The Department will consider these arguments during the evaluation process and in negotiation with service providers.

Non-disclosure of agreement provisions must be justified under the principles for exemption within Section 34(1) of the *Freedom of Information Act 1982*, providing that information acquired by an agency or a Minister from a business, commercial or financial undertaking is exempt under the Act if the information relates to trade secrets or other matters of a business, commercial or financial nature and the disclosure would be likely to expose the undertaking unreasonably to disadvantage.

1 Trade secrets

In considering whether specific information should be categorised as a trade secret, service providers should assess:

- The extent to which it is known outside of your business
- The extent to which it is known by the persons engaged in your business
- Any measures taken to guard its secrecy
- Its value to your business and to any competitors
- The amount of money and effort invested in developing the information
- The ease or difficulty with which others may acquire or develop this information

Trade Secrets not to be Disclosed:

2 Unreasonable disadvantage

In determining whether disclosure of specific information will expose your business unreasonably to disadvantage, you should consider section 34(2) of the FOI Act. Broadly, you should consider whether:

- The information is generally available to competitors
- It could be disclosed without causing substantial harm to the competitive position of the business

Unreasonable Disadvantage disclosure would cause

Part 6 Acceptance Of Terms and Conditions

Service providers must indicate their understanding and acceptance of each part of this document, including the attached standard DHS service agreement, by signing in the table below. Where a part of this document is not understood or accepted, service providers must attach a tabulated Statement of Departures with an explanation of why that part is not accepted

If this submission is being made electronically, this page should be faxed or mailed separately.

Acceptance of Conditions

Part	Acceptance	Non-Acceptance (attach tabulated Statement of Departures)
Part A: General Information for Service providers		
Part B: Service Specifications		
Part C: Conditions Applying to this Submissions Process		
Part D: Standard Submission Format		

Endorsement

Signature of Authorised Officer for Service provider	
Name of Authorised Officer (Print)	
Title/Office Held	
Date	

Part 7 Evaluation of Submissions

The following criteria will be used to evaluate all submissions and determine the successful service provider(s).

Criteria specified as 'mandatory' must be met. If they are not met, the submission may be rejected without further consideration unless it is clearly indicated to be an alternative proposal, and documentation is provided that supports its validity in achieving the requirements of this service.

Criteria Relating to Specification 1 (The Service Provider)

- Criterion 1 The service provider demonstrates **an understanding of service requirements**. The service provider has relevant and adequate experience, with demonstrated ability to deliver services that address falls prevention issues within prescribed timeframes and designated budgets.

Responses should include:

- Details of existing services demonstrating relevant experience and expertise in the delivery of services to prevent falls among older people;
 - Experience and expertise in working with various client group/s across a range of settings;
 - Understanding of the needs of the client groups and the range of appropriate service responses, and demonstrated capacity and willingness to work with the various client group/s.
- Criterion 2 The submission includes sufficient supporting documentation to **demonstrate satisfactory financial, technical, planning and other resource capability and viability**. Documentation should include audited financial statement and an annual report from the most recent financial period (or relevant equivalent, if not a corporate body); business or corporate plan covering current period.

This criterion is **mandatory**. Service providers that have a current service agreement with DHS will be assessed on the basis of information already provided. An assessment may also be made on the current overall performance of the agency.

- Criterion 3 The service provider has **satisfactory staffing policies and practices** and demonstrates commitment to equal employment opportunity and maintenance of occupational health and safety. The submission describes satisfactory minimum competencies of staff and policies to maintain competency over the period of service.

Responses should include:

- Details of how this service relates to the service provider's core business and how the service will be incorporated into current operations.
- Written evidence of appropriate management structure, which may include statement of roles, responsibilities and qualifications and competencies of key staff, staff training, reporting structures, supervision and infrastructure support policy and procedural documentation, articulated policies for managing critical incidents.

Criteria Relating to Specification 2 (Service Deliverables)

- **Criterion 4 Planning process.** The service provider has the demonstrated ability to provide a detailed, valid and integrated health promotion methodology and implementation plan for a *Whole of Community* Falls Prevention Project. The plan should demonstrate:
 - A commitment to continuous improvement in providing high quality, value for money services.
 - Documented evidence that all relevant stakeholders have been involved in the planning, design and development of the *Whole of Community* submission. (PCPs and collaborating agencies should identify the roles and responsibilities of the key stakeholders, community, older people and carer representatives.)
 - Show how links would be established between the PCP and the *Whole of Community* falls prevention working group and their project advisory group.
 - Capacity to deliver the service specified at the times or for the period indicated and deliver the outcomes specified.

Responses should also detail your planning process; proposed strategies, service delivery framework, and include:

- Your project goal
 - Project aims and objectives. (An objective must be SMART³ and address the protective and risk factors for falls {Eg. Falls and fall-related injuries will be reduced by 10% in the catchment area.} Objectives will continue to change, as organisational/staff/participant needs change and therefore will need to be modified to assist in progress.)
 - Target group(s) – for example, please specify if you will be providing initiatives for people with dementia or Parkinson’s disease or for people that have culturally and linguistically diverse backgrounds, or are part of an Indigenous community.
- **Criterion 5 Evaluation and Evidence.** Demonstrated ability to effectively identify the estimated reach, impact and effectiveness of the *Whole of Community* project. (A template is provided for your use – Attachment 5 – Part 1.) Please list:
 - Agency/facility
 - Partnerships - including:
 - Your PCP member agencies

³ S – specific (clear and precise), M – measurable (amenable to evaluation), A – achievable (realistic), R – relevant (to the health issue, the population group and your organisation), T – time specific (time frame for achieving your objective). See:

http://www.health.vic.gov.au/healthpromotion/downloads/planning_may05.pdf

- Agencies/individuals (including older people and their organisations) that have been involved in developing your *Whole of Community* submission
 - Organisations you would like to further develop links with through your *Whole of Community* project.
 - Staff
 - Participants
 - families/carers
- **Documented evidence** of recent successfully implemented aged-related integrated health promotion programs within the designated local catchment area. (A template is provided for your use – Attachment 5 – Part 2.)
- **Criterion 6** Demonstrate appropriate **long-term and capacity building strategies** to ensure falls prevention initiatives will become an intrinsic part of the PCP catchment planning for integrated health promotion, and **sustained** beyond the period of project funding.
 - This should include strategies to identify how community sector disability services, local Government, recreation services and private sector services will either be established and or enhanced to assist in the implementation of this initiative. Also identify the capacity your PCP has to leverage existing locally based initiatives already taking place within the catchment planning for integrated health promotion. (A template is provided for your use – Attachment 3)
 - Please comment on the following:
 - Organisational development
 - Workforce development
 - Continuous improvement
 - Building partnerships
 - Transfer to other sites or locations in the PCP catchment area or adjacent catchment areas
 - On-going monitoring of projects. Please specify the project management, monitoring or evaluation tools you have used previously. (Eg: Primary and Community Health Planning and Reporting Guidelines, Well for Life project report.)
- **Criterion 7** Demonstrated ability to deliver the desired project outcomes. For example, health and social outcomes that reduce the risk and incidence of falls and the severity of fall-related injuries from falls among older people (as stated in the Falls Prevention Program Goals).

Evaluation Process

Submissions will be evaluated against the indicated criteria. An initial evaluation may be used to short-list submissions.

Following short-listing, one or more service providers may be approached to meet with the evaluation panel to provide clarification or further information.

Scoring

Submissions will be initially scored against the following scale:

Evaluation	Score
Exceeds all aspects of the selection/evaluation criterion	4
Exceeds some aspects of selection/evaluation criterion (and meets all other aspects of the selection/evaluation criterion)	3
Meets the selection criterion	2
Fails some aspects of the selection criterion	1
Fails all aspects of the selection criterion.	0

All service providers will be advised in writing of the final outcome of the submissions process, including the identity of the successful service provider(s).

Attachment 1: Planning

Provide an outline of your initial plan for Phase 3, *Whole of Community falls prevention project*.

Project goal:

Project aims/objectives/interventions/strategies/actions

Name of setting	Target group	Aims	Objectives	Strategies/actions to meet objectives

Attachment 2: Implementation

Part 1 Evidence-based rationale for the mix of interventions chosen for your local catchment area to support a **multi-strategy falls prevention plan** that addresses the major falls risk factors and includes a focus on:

Proposed interventions	
Screening, individual risk assessment (falls prevention related services)	
Health education and skill development	
Social marketing / health information (including awareness raising activities)	
Community action (for social and environmental change)	
Settings and supportive environments (including home, hospital, residential aged care facility/ies and public place audits).	

Part 2 Identify the timeframe for implementation of each of the following stages of your proposal.

Planning and development	
Implementation of activities	
On going monitoring and evaluation	
Dissemination/communication of findings	

Attachment 3: Long term capacity building strategies

Record how you plan to ensure the sustainability of the *Whole of Community falls prevention project* in policy and practice, including program-funding sources beyond the funded period.

Sustainability	Policy	Practice
Organisational development		
Workforce development		
Continuous improvement		
Building partnerships		
Transferability		
On-going monitoring and evaluation		

Attachment 4: Partnerships

PCP Member Organisations	Other Relevant Stakeholders including Community/Consumer and Carer Representatives	Roles and Responsibilities/Links with other organisations

Attachment 5: Impact / Effectiveness (Part 1)

Describe how you will determine / measure the impact and effectiveness of the falls prevention project.

Impact	Information to be used	Means of gathering information	Anticipated results
Agency/facility			
Partnerships			
Staff			
Participants			
Families/carers			

Attachment 6: Funding**Please identify:**

- Resource Allocation – Identify how resources will be allocated
- Specify if necessary, any non-recurrent establishment costs
- Staff costs (including staff on-costs)
- Consumables
- Infrastructure costs
- Non-salary costs
- Financial or *in kind* contributions.

Resource Allocation	In kind contributions	Total Funds Available

Price validity

Prices quoted remain valid from the closing date for submissions until:	
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Appendix 2 - PROGRESS REPORT

**Local Initiatives for DHS Aged Care Branch Falls Prevention Program
Whole of Community Phase Project
Date:**

Project name:
Primary Care Partnership:
Project start date:
Project finish date:
Local government area/s:

Progress reports outline the progress and activities undertaken in relation to the objectives and targets outlined in the Service Agreement and its timelines. Please feel free to use this outline to inform your progress report.

Progress reports need to be completed at three monthly intervals to coincide with the Falls Prevention Program Network Meetings and should be less than one page (500 words).

Each project can use the progress reports to provide an update of your project at the meeting. (If you are unable to attend the Network Meeting please forward this report electronically to your DHS region and Central Office.) In addition to this, the progress reports may be used to inform your final report.

The following are a guide to inform your Progress Report.

- Are the project objectives and targets being achieved? Description of activities undertaken in order to achieve the objectives/targets. Refer to the tasks outlined in your Service Agreement including Key Performance Measures from July 2006:
 - o *Number of people aged 65+ participating in falls prevention activities*
 - o *Number of health professionals/workers participating in falls prevention education and skill development*
 - o *Number of agencies within the PCP catchment participating in education and skill development.*
 - o Consultation with health professionals and/or agencies.
 - o Participation of older people in the implementation of the project as distinct from participating in planned activities.
 - o Development of project material. It's appropriateness and quality.
 - o Education and awareness-raising activities
 - o Training – professional development
 - o Screening sessions undertaken
- Are any objectives not being achieved at this stage and why? Plans to remedy this.
- How well the project is reaching the target group/s?
- Any issues that have arisen during the course of the project?
 - o Barriers that have been faced and how have these been addressed.
- Evaluation of project activities – progress to date (Refer to your Evaluation Plan).
- Learnings from this phase of the project
 - o What worked well / success stories
 - o What didn't work / challenges
- Plans for the next three months of the project.

DHS Regional Office:
Email:

DHS Central Office: 9096 7391
Email: margaret.thomas@dhs.vic.gov.au

APPENDIX 3 - PCP Reporting Requirements

FALLS PREVENTION PROGRAM AGED CARE BRANCH, Department of Human Services (DHS) Planning and Reporting Guidelines July 2006 – June 2007

Introduction

The Falls Prevention Program is funded through the Aged Care Branch, Department of Human Service. The Falls Prevention Program aims to improve in the health, wellbeing and mobility of older residents who are able to live in the home of their choice with greater confidence, independence and security.

Goal

The goal of the Program is to implement falls prevention projects within a health promotion framework to reduce the risk and incidence of falls, and the severity of injuries from falls among older people aged 65 years and over:

- Living independently in their own homes
- In residential aged care services, and
- In acute or sub-acute hospitals.

Project Objectives (IMPACT)

Over the life of the project, the objectives are to incorporate the following:

- **Health Promotion:**
 - Integrate falls prevention interventions into the policy and practice of the health promotion strategy for the PCP.
- **Community Awareness:**
 - Increase community recognition of falls as a 'whole of community' responsibility.
 - Increase community understanding that falls are not an inevitable part of growing older.
- **Community Participation:**
 - Increase the proportion of older people who actively participate in reducing their risk of falling, and as a consequence enjoy an independent and healthy lifestyle.
- **Community Development:**
 - Increase the safety of any local environment for current and future generations.
- **Evaluation:**
 - To support you in evaluating the effectiveness of your Program it is recommended you refer to *Planning for effective health promotion evaluation*.
http://www.health.vic.gov.au/healthpromotion/downloads/planning_may05.pdf

Falls Prevention Standard Performance Measures 2006-2007:

- Number of people aged 65+ participating in falls prevention activities.
- Number of health professionals/workers participating in falls prevention education and skill development.
- Number of agencies within the PCP catchment participating in education and skill development.

Reporting requirements

The Falls Prevention Project lead agency is required to provide to the relevant DHS Regional Office, and Aged Care Branch, Falls Prevention Program Area at 12/50 Lonsdale Street, Melbourne (email: margaret.thomas@dhs.vic.gov.au):

- An annual report in July 2007 that includes Parts 1 and 2 attached, which can be used for your Primary Care Partnership's reporting purposes.
- Quarterly progress reports in October 2006, January and April 2007.
Please note a progress report will not be required in July 2007.

Insert PCP Name
Falls Prevention Project Report
July, 2006 – June 2007

For this report please use the guide below noting that there is a page limited of two A4 pages.
 (Note Part 1 of this report can be used as a case study for your report to your PCP.)

Part 1:

Project type:	Whole of Community Foothold on Safety
Priority goal: To reduce the risk and incidence of falls, and the severity of injuries from falls among older people aged 65 years and older.	
1. INTRODUCTION	
<ul style="list-style-type: none"> ▪ Provide a summary description of problem definition. ▪ Outline objectives to achieve the project goal. ▪ Describe the population group, for example frail older people aged 85 years and over. 	
2. WHO (and how many) are the key stakeholders (agencies/organisation and community reps)?	
Consider the following prompts when reflecting on this point:	
<ul style="list-style-type: none"> ▪ Who were the agencies/organisation and consumer representatives involved in planning and implementation? ▪ How many were involved? ▪ Were the right stakeholders involved? If not, please suggest who should have been involved, and how could this happen in future. ▪ How did the PCP facilitate and support partnership development? 	
3. HOW was the project implemented?	
Provide a summary of solution generation.	
<ul style="list-style-type: none"> ▪ Include the stage of implementation (eg early implementation, advanced implementation or complete). ▪ What strategies/interventions have been used? For example: education, community awareness, vision, home assessment etc. ▪ Of these, which were the most successful/least successful and why? ▪ Were any new resources developed or existing resources modified to suit local requirements? Please provide details. ▪ As part of this annual review will strategies/interventions change? ▪ In particular discuss progress on PCP HP capacity building. For example, have links been made with other program areas such as Health & Active Living (HALS) or <i>Well for Life</i>, as well as agency partnerships. Please provide details. 	
4. WHAT are the process indicators (REACH) you have achieved to date?	
Provide a summary of the process indicators achieved and reflect on evaluation processes in place. Falls Prevention Standard Performance Measures 2005-6 are:	
<ul style="list-style-type: none"> • Number of people aged 65+ participating in falls prevention activities. • Number of health professionals/workers participating in falls prevention education and skill development. • Number of agencies within the PCP catchment participating in education and skill development. 	
5. WHAT progress has been made against IMPACT indicators?	
<ul style="list-style-type: none"> ▪ Health Promotion ▪ Community Awareness ▪ Community Participation ▪ Community Development 	
6. WHAT else was revealed?	
Successes and unexpected outcomes, enablers and barriers, and lessons learned.	
7. CONCLUSION	
What difference has there been for consumers and agencies as a result of using the PCP integrated approach to health promotion programs to support the falls prevention project?	
8. ACKNOWLEDGEMENTS	

Part 2: Summary Grid

Priority Goal:		The goal of the Program is to implement falls prevention projects within a health promotion framework to reduce the risk and incidence of falls, and the severity of injuries from falls among older people aged 65 years and over: <ul style="list-style-type: none"> • Living independently in their own homes • In residential aged care services, and • In acute or sub-acute hospitals. 			
Objective 1:		For example: Health Promotion or Community Awareness			
Actual Impacts¹ (Qual/Quant) for Objective 1					
PCP key stakeholders²	Summary of mix of Interventions & Community Building strategies³	Population Target Group/s:	Actual timelines	Actual Reach⁴	Approximation of Resources used for intervention or strategy⁵
Consumers' Reps					\$
Community Health					\$
Residential Services					\$
Local Government					\$
GPs and Divisions					\$
Hospitals					\$
Total Human Resources (eg. Project coordinator)					\$
Total⁵:					\$
Total Budget for financial year 2005-2006: Whole of Community Projects		Total Budget for financial year 2005-2006: Foothold on Safety Projects			
Year 1	\$65,000	Year 1	\$50,000		
Years 2	\$75,000	Years 2	\$50,000		
Year 3	\$75,000	Year 3	\$50,000		

Note: Do not include administration on costs in Approximation of Resources.

Explanatory Notes for the reporting summary grid:

1. Actual Impacts (Qualitative &/or Quantitative): Please refer to the document *Measuring Health Promotion Impacts – A Guide to Impact Evaluation*. This is part of the Integrated Health Promotion Resource Kit. See also http://www.health.vic.gov.au/healthpromotion/hp_practice/eval_dissem.htm Depending on the objective numerous impact statements can be reported here.
2. For each project there may be a different set of PCP member agencies/organisations that were involved in implementation - the suggested headings here can be changed to reflect each PCP alliance.
3. Member agencies/organisations from each PCP are only required to give a **summary** of the interventions/strategies that were implemented; all other interventions/strategies categories can be deleted. Please refer to the Integrated Health Promotion Resource Kit, Chapter 5. See also http://www.health.vic.gov.au/healthpromotion/hp_practice/interventions.htm. This kit describes these interventions and strategy types.
4. Actual Reach: Planning required the development of process indicators for each program. However, the Department requires only one type of process indicator - *Reach* to be reported on in this section. Please refer to the Integrated Health Promotion Resource Kit. See *Planning for effective health promotion evaluation resource*: http://www.health.vic.gov.au/healthpromotion/downloads/planning_may05.pdf
5. Falls Prevention Projects reporting to PCP member agencies/organisations involved in the IHP program are required to include an approximation of the cost of resources used for each intervention/strategy (excluding project coordinator's wages, administration and on costs).

Health promotion interventions are the actions undertaken to achieve program objectives. A mix of interventions (applied to individuals and populations) as specified in the health promotion plan include: Screening/risk assessment – health educations/skill development – social marketing/health information – community action – settings/supportive environments, as well as capacity building strategies: workforce development, organisational development, resources (*Refer to DHS, IHP Resource Kit 2003, section 5*).

Appendix 4 - Falls prevention in Victoria

Falls are a major cause of injury for older people. They are the leading cause of injury-related hospital admissions in people aged 65 years and over and, as such, are a major public health problem in terms of social, health and economic costs for both individuals and the general community. However, many older people experience numerous falls that do not result in hospital admission or death but they are a cause for concern as likely markers of proneness to future falling, perhaps with worse outcomes, and as indicators of deteriorating health status.

The Falls Prevention Program is an initiative of the Aged Care Branch of Rural & Regional Health and Aged Care Services Division of the Department of Human Services. The Department has identified falls prevention as a priority area for promoting health, safety and independence and looks to PCPs and collaborating public sector residential aged care services and *not for profit* agencies to incorporate falls prevention into the PCP's integrated health promotion strategy.

The Department understands and supports older people's desire to remain active and independent. It believes it is in the community's interest to find long-term solutions to preventing falls and reducing the injury toll among older people. A commitment between older people and a range of agencies to promote safer living environments will benefit *all* people as they age.

Fostering a positive attitude to growing older will assist the community to view the ageing process as a natural part of living. Involving and encouraging older people to remain connected with the community, will contribute to their overall health, wellbeing and independence.

To assist communities in this work, DHS provides falls prevention project grants to reduce the number of falls and the severity of injuries from falls.

To prevent falls a partnership approach is vital because of the complex personal and environmental factors known to contribute to falls. No single group can solve the problem. Local government planners, architects and builders, community health centres, hospitals, general practitioners, pharmacists, older people's organisations, service clubs, public and private transport companies, media, shopping centres, voluntary organisations and health, sport and recreation clubs are just a few examples of agencies that can collaborate to bring about a safe environment and address intrinsic risk factors for older people to live confidently and go about their business.

To be successful, older people, local government and health professionals must share in the design of the project and the development of the various strategies from the commencement of any falls prevention project. DHS recognises that older people are not always free to make healthy choices and that health education, in isolation, is not an effective strategy to modify behaviour.

The Aged Care Branch of the Victorian Department of Human Services provides program and policy direction for the delivery of DHS-purchased aged care programs and services and works closely with the other program areas of the Department to ensure the provision of a coordinated health and support system for older Victorians.

Aged Care has developed a comprehensive program to prevent falls among older people that will be implemented over several years. In previous years the Program has funded projects in the following areas:

- *Foothold on Safety* projects for older people living in their own homes
- Public sector Residential Aged Care Facilities
- Sub-Acute Services, and
- Acute Hospitals.

In recognition of the way older people move between and across settings, DHS now funds *Whole of Community* falls prevention projects. By agencies working together there are opportunities for organisations to effect long-term change.

Defining falls

The Aged Care Falls Prevention Program considers it is important that a standard definition of a fall is consistently used. There are many definitions of a fall. For consistent recording of relevant fall-related incidents, the following definition can be used:

DEFINITION OF A FALL

'An event, which results in a person coming to rest inadvertently on the ground or other lower level'.

World Health Organisation⁴

The Case for Preventing Falls

Falls are a major public health problem and an unnecessary toll on older people's health, vitality and independence. The following statistics attest to the current size of the issue and provide a projection of trends over the next century:

- About one in three older people living in their own homes fall each year.
- Even where no injury occurs, older people who have sustained a fall may develop a fear of falling. It should be noted that falling is not a prerequisite for fear of falling to occur. It becomes problematic when it immobilises or creates debilitating anxiety and interferes with daily activities. Any restriction of activities is itself a risk factor for falls because it can lead to muscle weakness and deconditioning, and reduced functioning. Up to a quarter of older persons with fear of falling report avoiding everyday activities either because of fear of injury (most commonly a fractured hip) and/or fear of being unable to get up from the ground following a fall⁵.
- Self-imposed activity limitations due to a fear of falling again are an additional challenge to promoting exercise among older people. The quality of life of older women, who have exceeded average life expectancy, is profoundly threatened by falls and hip fractures. Older women place a high value on their health. Any loss of ability to live independently in the community has a considerable detrimental effect on their quality of life (Salkeld et al 2000) and can lead to increased anxiety and loss of confidence, decreased activity and social interaction, and increased dependence on family and community services (Poulstrup, 2000). It can also increase the risk of falling.
- Falls are the leading cause of injury-related hospital admissions of older Victorians. In 2002-2003 Victorian Admitted Episodes Dataset (VAED) statistics indicate the average length of stay for older persons with an injury-related neck of femur (hip) fracture was 11.93 days. In total there were 9,625 episodes with an injury as a

⁴ World Health Organisation.

http://www.who.int/violence_injury_prevention/other_injury/falls/en/index.html

⁵ Tennstedt, S., Howland, J., Lachman, M., Peterson, E., Kasten, L. & Jette, A. (1998). A randomized controlled trial of a group intervention to reduce fear of falling and associated activity restriction in older adults. *Journal of Gerontology: Psychological Sciences* 53B (6): pp 384-92.

principal diagnosis resulting from an accidental fall among people aged 65 years and over.

- A recent report to the Australian Government of projected costs of fall related injury suggests: The cost of fall related injury is not just driven by the total proportion of people over 65 years but by the distribution mix of ages within this group. An increasing proportion of people over 65 will reach the age of eighty or ninety, resulting in an increased need for service over time if the current rate of fall injury continues ⁶.
- Approximately 47.1% of older people who fall at home and require hospital admission are subsequently discharged to a nursing home (Hazard Edition No. 45 December 2000). The probability of permanent admission to an aged care facility for community dwelling older people who fracture their hips is 28% in the year after fracture (MUARC 2002).
- The direct medical care cost of all fall injuries in older Victorians (aged 65 years and over) is estimated at \$323 million per year in 2002-2003 ⁷. People aged 65 years and over account for 12% of the Victorian population but 22% of the direct cost of injuries (mostly due to falls) because of their long recovery time from trauma ⁸.

Falls are Preventable

Contrary to popular belief, falls are not inevitable among the older population. The risk factors for falls are amenable to change and where falls do occur, the severity of injuries can be reduced.

The belief that falling is an inevitable consequence of growing older is an ageist perspective and is counterproductive to the preventive measures that organisations and individuals can implement to minimise falls.

Falls (and injuries generally) are the culmination of a set of circumstances and pre-existing conditions that may best be understood as a chain of events. There are three main factors that contribute to injury: the person at risk, the activity being undertaken, and the environment. These factors may interact in various ways to result in an injury.

By viewing falls, not as accidents that are inevitable or the fault of individuals but by considering the factors contributing to injury and intervening, injuries can be prevented or reduced in severity.

Profile of People Who Fall

Falling is not peculiar to older people; it occurs at all ages, among children and athletes. The special significance of falls by older people is the high incidence rate, increased susceptibility to injury and a prolonged recovery period.

Falls can also lead to death among older people. MUARC reported that there were approximately 250 fall-related deaths among Victorians aged 65+ years, 12,000 fall-related hospital admissions and at least 12,000 hospital emergency department presentations for fall-related injuries ⁹.

⁶ Moller, J. (2003). Projected costs of fall related injury to older persons due to demographic change in Australia. Report to the Commonwealth Department of Health and Ageing under the National Falls Prevention for Older People Initiative.

⁷ Monash University Accident Research Centre (2005). Unpublished report to DHS Public Health Branch.

⁸ (Watson, W. & Ozanne-Smith, J. 1997, MUARC November 2002).

⁹ <http://www.monash.edu.au/muarc//VISAR/falls/fallfact.pdf>

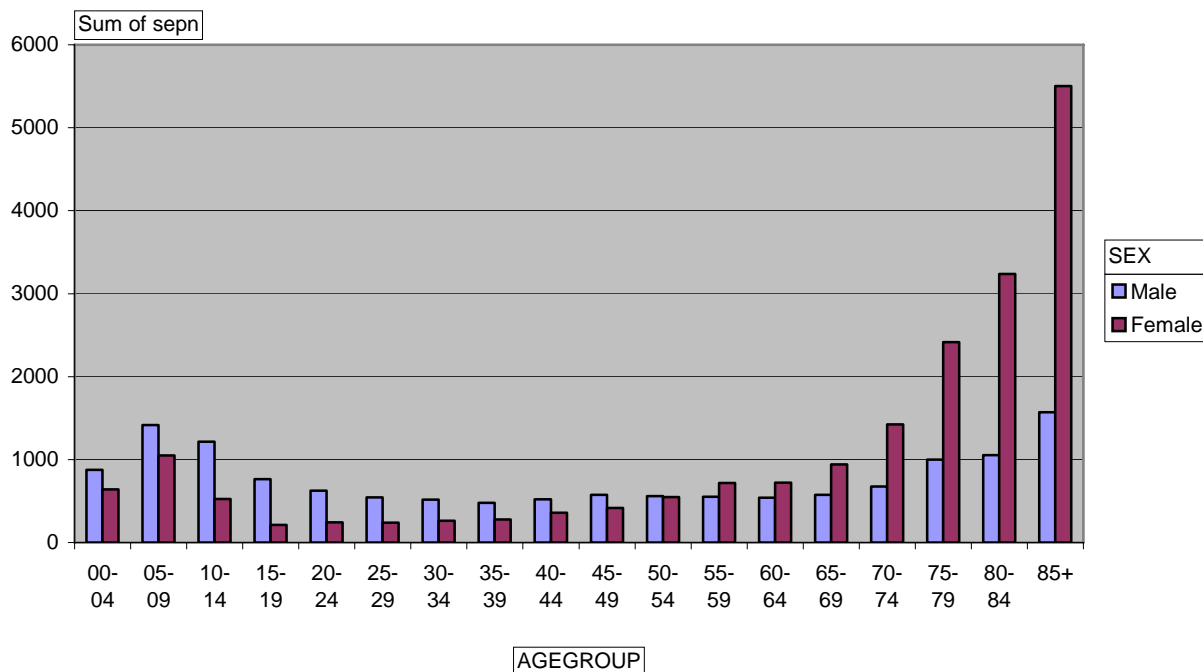
Fractures are a major cause of mortality and morbidity in older people, particularly hip fractures (the most serious fall-related injury) that contribute to an increase of 10-20% in the mortality rate ¹⁰.

There is no 'typical faller' but there are a number of attributes common to a large proportion of the older people who fall. These people are more likely to be:

- Advanced age group (over 80)
- Female
- Living alone
- Taking a number of medications (prescribed, in particular psychotropic drugs, or self-prescribed and administered)
- Ill or disabled
- With poor vision
- Using a walking aid
- Someone who has fallen recently and/or has had several slips or trips
- Socially isolated
- Depressed
- Cognitively impaired
- Experiencing a greater degree of:
 - postural sway
 - range of gait disorders
- Suffering from several chronic disabilities that increase the risk of falling

The following table based on Victorian Admitted Episodes Database (VAED) 2002-2003 statistics shows the difference between male/female fall-related hospital admissions:

hospflag|All



Falls groups: vigorous, transitional and frail

¹⁰ Francis, R.M. (2001). Falls and fractures. *British Geriatrics Society, Age and Ageing* **30-S4**: 25-8.

Research has demonstrated that fall experiences of people living at home vary with levels of wellbeing¹¹. Older people can be divided into three functional groups: vigorous, transitional (in transition from vigorous to frail) and frail, requiring different preventive approaches for each identified group. Speechley and Tinetti's study classified falls groups as follows:

Vigorous group

Averaged 78 years of age, were more active, had the highest alcohol and medication use (apart from sedatives) and the lowest rate of depression. Of this group 17% fell, usually when away from home and significantly, 22% of these falls resulted in serious injury.

Transitional group

Transitional from vigorous to frail. Spanned a wider age range, with an average age of 81years, and a fall rate of 32% with 11% of the falls causing serious injury.

Frail group

Older, averaging over 86 years, with multiple disabilities and 52% falling at home during the year with 6% of those falls resulting in serious injury.

The above findings confirm that a higher percentage of frail, older people fall. However, falls by vigorous older people incur a higher percentage of serious injury and occur mainly when they are involved in more active, potentially hazardous activities such as climbing ladders or playing sport. They are also more likely to be in more hazardous environments.

It must also be recognised there are some older people, for a range of reasons including personal choice, who may 'fit' into the above groups but do not have, or wish to have regular contact with services or their peers. It is this group that may prove to be the most difficult to locate and encourage to join in activities/interventions.

Applicants are asked to specify how their interventions target the various 'at risk' sub-groups as well as the general population of people 65 years and over.

¹¹ Speechley, M. & Tinetti, M. (1991). Falls and injuries in frail and vigorous community elderly persons. *Journal of American Geriatrics Society* 39: 46-52.

Appendix 5 – Requests for Further Information

The following agencies/organisations have considerable experience in falls prevention program implementation and are willing to discuss submissions with PCPs and collaborating agencies. The list is by no means exhaustive and there are many other agencies/organisation available to share information and resources.

Aged Care Branch, Department of Human Services

Margaret Thomas

Department of Human Services, Aged Care

Level 10, 555 Collins Street, Melbourne Vic 3000.

Tel. (03) 9096 7391 Fax (03) 9096 9163

Email: margaret.thomas@dhs.vic.gov.au

Website: <http://www.health.vic.gov.au/agedcare/maintaining/falls/index.htm>

Australian Injury Prevention Network (AIPN)

The Australian Injury Prevention Network's mission is to act as a national networking channel for injury prevention practitioners, researchers and policy makers.

AIPN Secretariat

Xenia Consulting

PO Box 3379

NORMAN PARK Q 4170

Fax: 07 3847 2148

Email: secretariat@aipn.com.au

Website: <http://www.aipn.com.au/>

Think Safe, Act Safe, Feel Safe, Be Safe

Contact: Lisa Purchase, Community Safety Month Coordinator on (03) 9651 1362

Email: lisa.purchase@justice.vic.gov.au

Website: <http://www.communitysafetymonth.com.au/index.asp>

Monash University Accident Research Centre (MUARC)

Wellington Road, Clayton Vic 3168.

Tel. 9905 4371, Fax (03) 9905 4363.

Website: <http://www.monash.edu.au/muarc/>

HAZARD

Website: <http://www.monash.edu.au/muarc/VISU/hazard/about.html>

Victorian Injury Surveillance Unit (VISU)

Website: <http://www.monash.edu.au/muarc/VISU/>

National Ageing Research Institute (NARI)

Dr Keith Hill

Poplar Road, Parkville Vic 3052.

Tel. (03) 8387 2639, Fax (03) 8387 2153

Email: k.hill@medicine.unimelb.edu.au

Website: <http://www.mednwh.unimelb.edu.au/>

Safety Centre

Royal Children's Hospital

Flemington Road, Parkville Vic 3052.

Tel. (03) 9345 5786 Fax (03) 9345 5086.

DHS Regional Office contacts

DHS Region	Contact	Phone
Barwon Southwestern	Andrea Tidey	5226 4756
Gippsland	Jennifer Mulvogue	5177 2587
Grampians	Kathleen Teggerth	5333 6080
Hume	Veronica Buchanan Mary Stapleton	5722 0916 5722 0907
Loddon Mallee	Maggie Fernie	5434 2338
Eastern Metropolitan	Christine Farnan	9843 6106
North & West Metropolitan	Stephanie McAdam Guy Pianella	9412 5316 9275 7392
Southern Metropolitan	Ann Fitts	8710 2812

Appendix 6 – Falls Prevention and Other Contacts

A list of currently funded projects can be downloaded from the DHS Aged Care website:

<http://www.health.vic.gov.au/agedcare/maintaining/falls/projects.htm>

Transport Connections Projects

Commenced July 2003

DHS Region/Project	Contact	Email/Phone
Barwon Southwestern <i>Two Rivers Transport –</i> Western District Health Service	Becky Morton	Rebecca.morton@wdhs.net 5551 8461
Gippsland <i>Bass Coast Transport Solutions -</i> Bass Coast Shire Council Let's GET Connected – Gippsland East Transport Project Wellington Shire and East Gippsland Shire	John Sanderson Rhonda James Sheryl McHugh	j.sanderson@basscoast.vic.gov.au 5671 2717 RhondaJ@egipps.vic.gov.au 5153 9441 SherylM@wellington.vic.gov.au 5142 3478
Grampians <i>Wimmera Transport Connections</i> – Wimmera Volunteers Inc. <i>Golden Connections –</i> Golden Plains Shire Council	Karen Fuller Bernie Trim	Karen@wimmvol.com.au 5382 5607 btrim@goldenplains.vic.gov.au 5220 7144
Hume <i>Valley to City efficiently –</i> Upper Hume Community Health Service	Elaine Hill	ehill@uchs.vic.gov.au 5754 3530
Loddon Mallee <i>Southern Mallee Transport</i> <i>Connections Project</i> Gannawarra Shire Council <i>Getting Around – A Sustainable</i> <i>Transport System</i> Macedon Ranges Shire Council	Pauline Thorson Anne McLennan	Pauline.thorson@bigpond.com 5450 3339 annem@macedon-ranges.vic.gov.au 5427 8224
North and West Metropolitan <i>Hume Transport Links –</i> Northern Care and Share Inc.	Narelle Staub	nstaub@ncs.org.au 9355 8484