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DATE: 11 July 2018

To: Members of the
HEALTH AND WELLBEING BOARD

Councillor David Jefferys (Chairman)
Councillor Robert Evans (Vice-Chairman)
Councillors Marina Ahmad, Graham Arthur, Yvonne Bear, Mary Cooke, Judi Ellis, Keith Onslow, Colin Smith and Diane Smith

London Borough of Bromley Officers:

Janet Bailey	Director: Children's Social Care
Stephen John	Director: Adult Social Care
Dr Nada Lemic	Director: Public Health

Clinical Commissioning Group:

Dr Angela Bhan	Chief Officer: Bromley Clinical Commissioning Group
Harvey Guntrip	Lay Member: Bromley Clinical Commissioning Group
Dr Andrew Parson	Clinical Chairman: Bromley Clinical Commissioning Group

Bromley Safeguarding Adults Board

Lynn Sellwood	Independent Chair: Bromley Safeguarding Adults Board

Bromley Safeguarding Children Board:

Jim Gamble QPM	Independent Chair: Bromley Safeguarding Children Board

Bromley Voluntary Sector:

Colin Maclean	Community Links Bromley
Barbara Wall	Healthwatch Bromley

A meeting of the Health and Wellbeing Board will be held at Bromley Civic Centre on **THURSDAY 19 JULY 2018 AT 1.30 PM**

MARK BOWEN
Director of Corporate Services

Copies of the documents referred to below can be obtained from http://cds.bromley.gov.uk/

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

3 MINUTES OF THE MEETING OF HEALTH AND WELLBEING BOARD HELD ON 7TH JUNE 2018 (Pages 1 - 10)

4 QUESTIONS BY COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

In accordance with the Council's Constitution, questions to this Committee must be received in writing 4 working days before the date of the meeting. Therefore please ensure questions are received by the Democratic Services Team by 5.00pm on Friday 13th July 2018.

5 MYTIME ACTIVE: HEALTH AND WELLBEING INITIATIVES (PRESENTATION)

6 FALLS PREVENTION SYSTEM REVIEW: FINAL REPORT AND RECOMMENDATIONS (Pages 11 - 78)

7 CHILDREN'S JOINT STRATEGIC NEEDS ASSESSMENT (PRESENTATION) (Pages 79 - 82)

The Children's Joint Strategic Needs Assessment 2018 is available on the Council's website at the following link:

http://cds.bromley.gov.uk/ieListDocuments.aspx?CId=559&MId=6529&Ver=4

8 CHAIRMAN'S UPDATE ON CHILDHOOD OBESITY (VERBAL UPDATE)

9 EVALUATION OF THE COMMUNITY ALCOHOL PATHWAY PILOT PROGRAMME (Pages 83 - 88)

10 WINTER REVIEW (Pages 89 - 96)

11 BETTER CARE FUND 2017/18 - Q4 PERFORMANCE UPDATE (Pages 97 - 106)

12 WORK PROGRAMME AND MATTERS ARISING (Pages 107 - 118)

a NEW THEMES FOR HEALTH AND WELLBEING BOARD WORK PROGRAMME 2018/19 (DISCUSSION ITEM)

13 ANY OTHER BUSINESS

14 DATE OF NEXT MEETING

1.30pm, Thursday 27th September 2018
1.30pm, Wednesday 28th November 2018
1.30pm, Thursday 31st January 2019
1.30pm, Thursday 21st March 2019

HEALTH AND WELLBEING BOARD

Minutes of the meeting held at 1.30 pm on 7 June 2018

Present:

Councillor David Jefferys (Chairman)
Councillor Robert Evans (Vice-Chairman)
Councillors Marina Ahmad, Graham Arthur, Yvonne Bear, Judi Ellis, Kira Gabbert and Keith Onslow

Dr Nada Lemic, Director: Public Health
Lynn Sellwood, Independent Chair: Bromley Safeguarding Adults Board
Graham Mackenzie, Director: Transformation, Bromley Clinical Commissioning Group
Dr Andrew Parson, Clinical Chairman: Bromley Clinical Commissioning Group
Janet Tibbalds, Chair, Community Links Bromley
Peter Todd, Patient Experience Lead, Bromley Healthwatch

1 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Diane Smith, Dr Angela Bhan, Colin Maclean and Barbara Wall. Councillor Kira Gabbert, Graham Mackenzie, Janet Tibbalds and Peter Todd attended as their respective substitutes.

Apologies were also received from Councillor Mary Cooke, Councillor Colin Smith, Janet Bailey and Harvey Guntrip.

2 DECLARATIONS OF INTEREST

Councillor Judi Ellis declared that her daughter worked for Oxleas NHS Foundation Trust.

3 MINUTES OF THE MEETING OF HEALTH AND WELLBEING BOARD HELD ON 29TH MARCH 2018

The minutes were agreed subject to the final sentence of the first paragraph of Minute 64: Social Isolation – Update on Local and National Initiatives being amended to read:

"… the Prime Minister had appointed a Minister with responsibility *for loneliness with the aim of developing a cross-cutting national strategy later in 2018."*

RESOLVED that the minutes from the meeting held on 29th March 2018 be

agreed, subject to the amendment outlined above.

4 QUESTIONS BY COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

No questions had been received.

5 JSNA EVALUATION FINDINGS, RECOMMENDATIONS AND PROPOSED METHODOLOGY FOR IDENTIFYING PRIORITIES FOR THE JOINT HEALTH AND WELLBEING STRATEGY

Report CS18140

The Board considered a report outlining the Joint Strategic Needs Assessment (JSNA) Evaluation findings and recommendations, as well as the proposed methodology for identifying priorities for the Joint Health and Wellbeing Strategy.

Bromley's first Health and Wellbeing Strategy was published in 2012 for the period 2012-15 with an overall strategic vision for Bromley residents to "live an independent, healthier, happier life for longer." Nine priority areas were identified within the first strategy which were later refined to four areas considered to be the highest priority comprising Diabetes, Obesity, Dementia and Children and Young People's Emotional Health. At its meeting on 8th February 2018, the Health and Wellbeing Board agreed that a comprehensive evaluation of the Bromley JSNA be undertaken to review the structure, process and outcomes of the report to ensure it was fit for purpose and capable of answering the complex commissioning questions of the future, and that the Joint Health and Wellbeing Strategy be reviewed concurrently to this evaluation to inform the publication of a refreshed strategy later in the year. This work had now been completed, and Board Members were requested to consider the findings of both reviews as well as the proposed methodology for agreeing priority areas for the new Joint Health and Wellbeing Strategy and the Action Plan that would deliver them.

In considering the JSNA Evaluation findings, Board Members generally agreed the proposed recommendations.

Recommendation 3 proposed a more strategic and proactive approach be taken to identifying existing and planned opportunities to engage specific groups in aspects of JSNA development. Board Members discussed the scope to build on existing engagement mechanisms and offer new opportunities to enable Bromley residents to engage with the JSNA. The Chairman noted that engagement undertaken at a recent Carers' Conference had led to the development of the highly successful Connecting Bromley campaign which offered befriending services, volunteering opportunities and a searchable directory of activities to reduce social isolation. With regard to Recommendation 4, it was agreed that it would be beneficial for key partners to share data and analytical capacity and expertise as a means of achieving the best possible outcomes from available intelligence and to avoid duplicating work. There was an increasing amount of regional and national data

from organisations such as Public Health England which would also be used more widely in future.

In supporting Recommendation 5, Board Members requested that the Joint Strategic Needs Assessment production cycle be extended to three years which would allow additional capacity to produce in-depth needs assessments between updates to the core chapters. The Chairman noted that this could also include the exploration of emerging issues such as sleep hygiene which had been identified as having a significant impact on health and wellbeing. Members also agreed that the proposal at Recommendation 6 to combine the Joint Strategic Needs Assessments for children and adults would support the delivery of a more coordinated response. In response to a query from a Member, the Director: Public Health reported that the level of childhood immunisation and uptake of screening services such as for cervical cancer remained variable. Public Health England had responsibility for commissioning these services and the Health and Wellbeing Board might want to consider inviting Public Health England to a future meeting of the Board to explore how immunisation and screening services were being delivered across the Borough.

Recommendation 8 requested that Cardiovascular Disease, Cancer, Diabetes/Obesity, Dementia, and Accommodation for those with Learning Disabilities and Homelessness be agreed as the local priorities for the joint Health and Wellbeing Strategy. The Director: Public Health confirmed that dementia remained a key concern for the Borough as the levels of dementia were expected to increase in relation to Bromley's ageing population, despite a recent reduction in the incidence of vascular dementia. Members were concerned to note the high proportion of adults with a learning disability identified as not living in stable and appropriate accommodation, and also flagged the increasing level of statutory homelessness as a factor for concern. It was likely that a wider strategic approach was needed to support the health and wellbeing of people residing in inappropriate accommodation or who were homeless, such as in maintaining their access to community health and support services. The Chairman suggested that consideration be given to adding a Health Implications section to the standard Local Authority committee report template to place concerns around health and wellbeing at the heart of policy development, scrutiny and decision making. Board Members agreed that Suicide Prevention be added as an additional priority area within the new Joint Health and Wellbeing Strategy.

In response to a question from the Vice-Chairman about Recommendation 10, the Director: Public Health explained that the "Life Course" approach aimed to increase the effectiveness of interventions by targeting the needs of people at critical periods throughout their lifetime, such as by promoting breastfeeding, and addressing the causes rather than the consequences of ill health. A Board Member underlined the importance of empowering Bromley residents to make healthy choices. Another Member was encouraged by how the JSNA had evolved to become a living document that reflected the varying health needs across the Borough and allowed provision to be better targeted at vulnerable groups. A Member highlighted that the JSNA should be an accessible document which was understandable to Bromley residents.

RESOLVED that:

1) **The proposals for the revised methodology to identify priorities for the next Joint Health and Wellbeing Strategy be endorsed;**

2) **The suitability of the proposed priority areas for inclusion in the next Joint Health and Wellbeing Strategy be agreed with the addition of Suicide Prevention; and,**

3) **The proposal of using a "Life Course" approach as a way to help develop the Action Plan relating to priorities agreed for inclusion in the Joint Health and Wellbeing Strategy be agreed.**

6 SCOPING DISCUSSION ON PROPOSAL TO DEVELOP A SUICIDE PREVENTION STRATEGY FOR BROMLEY

Report CS18141

The Board undertook a scoping discussion on a proposal to develop a Suicide Prevention Strategy and Action Plan for Bromley.

In 2012, the Government published a cross-party Suicide Prevention Strategy which aimed to reduce the suicide rate in the general population and provide better support for those bereaved or affected by suicide. In the same year, Public Health England published a guidance note on "Local Suicide Prevention Planning: A Practice Resource" which endorsed three steps for local plan development originally recommended by the All-Party Parliamentary Group on Suicide and Self-Harm Prevention that comprised establishing a multi-agency stakeholder group, completing a suicide audit and developing a Suicide Prevention Strategy and Action Plan based on the national strategy and local data. In January 2018, the Bromley Mental Health Strategic Board requested the Public Health service lead on the development of a Suicide Prevention Strategy and Action Plan for Bromley. The Public Health service had subsequently established a multi-agency stakeholder group and was working towards developing a Suicide Prevention Strategy and Action Plan which was based on the six priority areas of the national strategy with an additional priority area of self-harm with the expectation that the strategy would be tailored to local need. It was expected that the draft Suicide Prevention Strategy and Action Plan for Bromley would be in place by Autumn 2018.

The Chairman emphasised the importance of the Suicide Prevention Strategy and Action Plan for Bromley. A Board Member reported that this issue had also been recognised by the Bromley Adult Safeguarding Board and that suicide prevention would be a key theme explored at the Bromley Adult Safeguarding Board's conference in Autumn 2018, with a focus on self-harm and self-neglect. Another Board Member noted that self-harm disproportionally affected the female population, with suicide tending to affect the male population. The Chairman requested that further information on the incidence of self-harm in Bromley be provided to Board Members following the meeting.

In response to a question from a Board Member, Helen Buttivant, Consultant (Public Health) confirmed that a mapping exercise was underway to identify existing suicide prevention activities. An example of this was work by British Transport Police to make the rail network safer for vulnerable service users.

Following discussion, Board Members agreed that Suicide Prevention be added as a further priority area within the new Joint Health and Wellbeing Strategy.

RESOLVED that the rationale and proposed process to develop a Suicide Prevention Strategy and Action Plan for Bromley be endorsed.

7 BROMLEY CLINICAL COMMISSIONING GROUP: ANNUAL ENGAGEMENT REPORT 2017/18

Report CS18138

Paulette Coogan, Director: Organisational Development and Kelly Scanlon, Head of Communications and Engagement, Bromley Clinical Commissioning Group presented the Bromley Clinical Commissioning Group's Annual Engagement Report 2017/18.

Bromley Clinical Commissioning Group was responsible for commissioning health care services based on local needs for the people of Bromley and had a legal duty under the Health and Social Care Act 2012 to ensure patients and residents were given a voice in commissioning processes and decisions. The Annual Engagement Report 2017/18 provided a comprehensive record of the work undertaken to meet the Bromley Clinical Commissioning Group's public involvement legal duties during the past year, and emphasised the Group's ongoing commitment to work closely with the Local Authority in engaging patients with integrated programmes of care and joint commissioning. Bromley Clinical Commissioning Group had delivered a range of work with young people over the last year as part of their co-production programme on child emotional and mental wellbeing, and was also working to support the Local Authority and key partners to engage the wider Bromley population with work to develop an Older Person's strategy. The Annual Engagement Report 2017/18 was approved by the Governing Body of the Bromley Clinical Commissioning Group at its meeting on 24th May 2018.

The Chairman led the Board in thanking Paulette Coogan and Kelly Scanlon for the excellent work of the Bromley Clinical Commissioning Group in the area of engagement which had recently been awarded a 'green star' by NHS England. The Chairman also noted the benefits of close working by the Engagement and Communication Teams of key partners in promoting health messages and communicating 'good news' stories.

RESOLVED that the Bromley Clinical Commissioning Group's Annual Engagement Report 2017/18 be noted.

8 UPDATE ON DELAYED TRANSFERS OF CARE PERFORMANCE

Report CSD18142

The Board considered a report providing an update on Delayed Transfers of Care.

The performance of Delayed Transfers of Care at the Princess Royal University Hospital had continued to improve with Delayed Transfers of Care reducing from a total of 311 total bed days in March and April 2017 to 139 in March and April 2018, representing a total of 172 total bed days saved compared to the previous year. Since September 2018 when national reporting requirements came into effect, 1208 total bed days had been saved at the Princess Royal University Hospital. National data had been published up to March 2018, with 319.7 Delayed Transfer of Care days reported for the month which did not include Mental Health data due to validation disputes, but which had subsequently been confirmed as 128 total bed days. There continued to be an ongoing issue with national published data and a deadline of 30th June 2018 had been agreed for all involved Health Trusts to resubmit validated Bromley data. The number of national disputed bed days totalled 1689 days, and 1928 days had been accepted by Bromley for the period of September 2017 to April 2018, which gave an average of 9.09 bed days per day and achieved the national target of 10.31 bed days per day for Bromley.

In considering the update, the Chairman was pleased to note the excellent work which had led to a significant reduction in Delayed Transfers of Care over the past year. A Board member asked about the reasons why patients experienced Delayed Transfers of Care from Oxleas NHS Foundation Trust, and the Associate Director: Discharge Commissioning, Urgent Care and Transfer of Care Bureau explained that health, social care and housing issues all contributed to delays in discharge experienced by patients from mental health services, and that the Local Authority and local hospital trusts were working closely to ensure that discharge planning was now taking place from the time a patient was admitted. A Board Member underlined that the focus should be on a quality discharge from hospital as this reduced the likelihood of a patient being readmitted.

In response to a question from a Board Member, the Director: Transformation (Bromley Clinical Commissioning Group) confirmed that the provision of frailty services at Orpington Hospital was being reviewed by the Bromley Clinical Commissioning Group and its health partners with a view to identifying the most effective future delivery model for community-based support.

RESOLVED that the update be noted.

9 UPDATE ON SEXUAL HEALTH

Report CS18143

The Board considered an update on sexual health services, including progress by the London Sexual Health Programme.

The Local Authority funded a range of mandated open access sexual health

services including Genito-Urinary Medicine. Collaboration on both a London and sub-regional basis had achieved lower unit price and marginal rates for these services, with the Local Authority being part of the South East London sub-region. As demand for sexual health services continued to increase further collaborative work had been undertaken, leading to the establishment of the London Sexual Health Transformation Programme which developed and implemented a set of tariffs known as Integrated Sexual Health Tariffs for London to support the provision of integrated Genito-Urinary Medicine and Contraception services. The London Sexual Health Transformation Programme ended in March 2017, with its programme activities transitioned to a new team being hosted by the City of London Corporation. The Local Authority continued to engage with the South East London sub-region in implementing the new London tariffs locally, and in preparing for a new London online service to be launched across South East London in July 2018. The Local Authority also had a range of provision in place to manage Sexually Transmitted Infections and contain costs including the provision of contraception and reproductive health services outside Genito-Urinary Medicine clinics which was a unique model within London and, when coupled with the General Practice and community pharmacist offer, had supported a continued decline in teenage conception rates.

The Director: Public Health was pleased to note the success of the London-wide programme which had been delivered collaboratively by the Public Health services of 31 London Boroughs. The introduction of the new London online service was considered to be a major step towards modernising Genito-Urinary Medicine provision in London and was expected to have a high uptake as an alternative offer to clinic attendance.

RESOLVED that the update be noted.

10 IMPROVED BETTER CARE FUND UPDATE

Report CS18139

The Board considered an update on the performance of the Improved Better Care Fund including both expenditure and activity up to the end of March 2018.

The Improved Better Care Fund was an additional funding element added to the Better Care Fund for 2017/18 for investment in adult social care services including meeting current and future adult social care needs, ensuring that the local social care provider market was supported and reducing pressure on the NHS such as through timely discharge from hospital. In the Spring Budget 2017 the London Borough of Bromley was awarded an IBCF Grant of £4.2M in 2017/18, with additional grant funding of £3.4M and £1.7M to be provided in 2018/19 and 2019/20 respectively. The Improved Better Care Fund 2017/18 had been utilised to deliver a range of schemes relating to the transformation of social care, investment in adult social care, supporting Joint Strategic Needs Assessment priorities, housing initiatives and researching older peoples' housing needs, support for Integrated Care Networks, Discharge to Assess procedures in Extra Care Housing, safeguarding in relation to mental health need, recruiting a Direct

Payments Lead Officer and work to develop and support the adult care market. As agreement on the final schemes was reached late in the financial year, there had been a delay in implementing the projects which had resulted in an underspend of £3.172M for 2017/18, which would be carried forward into 2018/19.

The Chairman reminded Members that the Health and Wellbeing Board had a statutory responsibility to be consulted on the use of the Better Care Fund and was required to agree any spending proposals. The Board also had a role in scrutinising proposals in relation to the use of the Improved Better Care Fund.

In considering the delivery of Improved Better Care Fund schemes, a Board Member highlighted the ongoing challenge in recruiting and retaining Adult Social Care staff. The Deputy Chief Executive confirmed that a number of measures were in place to support the recruitment and retention of high quality Adult Social Care staff such as the 'Caseload Promise'. A highly successful 'Assessed and Supported Year in Employment' recruitment event had been held on 14th May 2018, attracting 141 newly qualified Adult Services Social Workers from which it was hoped to recruit 10-15 high quality Social Workers. This would be further supported by the establishment of a Placements Coordinator role to engage with London South East Colleges and develop the Assessed and Supported Year in Employment programme in Bromley.

A Board Member was pleased to note investment of the Improved Better Care Fund grant in relation to safeguarding work with the South London and Maudsley NHS Foundation Trust, but underlined the need for any changes made as a result of the work to be sustainable beyond the three year grant period. Another Board Member was concerned that the Local Authority was not working sufficiently closely with the third sector in expanding the use of Direct Payments, and the Deputy Chief Executive would follow this up with relevant Officers following the meeting.

Members generally discussed the Care Homes Investment Options Appraisal which would explore the business case for the Local Authority investing in the building of a care home to improve access to affordable care home placements within Bromley. The Deputy Chief Executive confirmed that the appraisal would consider a full range of models to deliver affordable care home placements in a highly competitive market that often favoured self-funded care home residents. The Government's green paper on care and support for older people was due to be published in Summer 2018 and was expected to provide further clarity on the future model for adult social care funding. A Board Member noted the potential to link with a developer in delivering additional care home places in the Borough, provided that adequate nomination rights could be secured. Another Member suggested that the Local Authority consider funding two care homes to support older people to remain within their own communities. In response to a question from the Member around the investment of the Improved Better Care Fund as a contingency to raise the sustainability and performance of existing care, the Deputy Chief Executive explained that the scheme benefitted the Local Authority by maintaining a stable and good quality care market across the Borough. The Chairman requested that the brief for the Care Homes Investment Options Appraisal be provided to Board Members following the meeting.

RESOLVED that the performance and progress of Improved Better Care Fund schemes and the latest financial position be noted.

11 HEALTH AND WELLBEING BOARD INFORMATION ITEMS

There was one Health and Wellbeing Board Information item comprising:

- Annual Public Health Report – Diabetes Prevention

The Director: Public Heath encouraged Board Members to access the electronic version of the report which had interactive elements designed to assess an individual's risk of developing diabetes as well as links to a range of resources for diabetes prevention.

RESOLVED that the Information Briefing be noted.

12 WORK PROGRAMME AND MATTERS ARISING

The Board considered its work programme for 2018/19 and matters arising from previous meetings.

With regard to matters arising from previous meetings, the Chairman was pleased to announce that Mr Ashish Desai, Consultant Paediatric Surgeon, King's College Hospital NHS Foundation Trust would be invited to attend a future meeting of the Health and Wellbeing Board in relation to his work with childhood obesity. The Director: Public Health reported that work on the Falls Task and Finish Group was progressing and that the final report would be provided to the next meeting of the Health and Wellbeing Board on 19th July 2018, as well as to a future meeting of the Integrated Commissioning Board.

A number of items were added to the forward rolling work programme for the Health and Wellbeing Board as outlined below:

- Children's Joint Strategic Needs Assessment (July 2018)
- Discussion item on Childhood Obesity led by Mr Ashish Desai (July or September 2018)
- Proposal to Develop a Suicide Prevention Strategy for Bromley (September 2018)

The Chairman highlighted that the meeting of the Health and Wellbeing Board due to take place on 15th November 2018, had been scheduled too early to allow some key reports to be presented. Following discussion, the Board agreed that the meeting date be rescheduled to 28th November 2018.

RESOLVED that the work programme and matters arising from previous meetings be noted.

13 ANY OTHER BUSINESS

There was no other business.

14 DATE OF NEXT MEETING

The next meeting of the Health and Wellbeing Board would be held at 1.30pm on Thursday 19th July 2018.

15 LOCAL GOVERNMENT ACT 1972 AS AMENDED BY THE LOCAL GOVERNMENT (ACCESS TO INFORMATION) (VARIATION) ORDER 2006 AND THE FREEDOM OF INFORMATION ACT 2000

RESOLVED that the Press and public be excluded during consideration of the items of business listed below as it was likely in view of the nature of the business to be transacted or the nature of the proceedings that if members of the Press and public were present there would be disclosure to them of exempt information.

16 EXEMPT MINUTES OF THE MEETING OF HEALTH AND WELLBEING BOARD HELD ON 29TH MARCH 2018

RESOLVED that the exempt minutes of the meeting held on 29th March 2018 be agreed.

The Meeting ended at 3.33 pm

Chairman

Report No.
CS18159

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**Thursday 19th July 2018**
Title:	**FALLS PREVENTION SYSTEM REVIEW: FINAL REPORT AND RECOMMENDATIONS**
Contact Officer:	Dr Nada Lemic, Director: Public Health Tel: 020 8313 4220 E-mail: nada.lemic@bromley.gov.uk
Ward:	Borough-wide

1. Summary

1.1 This paper presents the final report of the Falls Task and Finish Group, convened to ensure that falls prevention work in Bromley is meeting the evidence based standards as described by NICE (Quality Standard 86).

1.2 Falls and their associated morbidity and mortality is an issue which has been raised in recent Joint Strategic Needs Assessments. This led to a discussion with members of the Health and Well-being board on falls prevention, and a decision to review the current system in Bromley. Professor Cameron Swift, a resident of Bromley and a national expert on falls, was asked to support this work.

1.3 The final report is presented to the Bromley Health and Well-being Board for agreement in addition to discussion as to how recommendations set out will be tracked going forward.

2. Reason for Report going to Health and Wellbeing Board

2.1 An interim report was presented at the 29 March 2018 Health and Well-being Board meeting. It was agreed at this meeting that a final report including recommendations would be reported to the Health and Well-being Board on 19 July 2018.

3. SPECIFIC ACTION REQUIRED BY HEALTH AND WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

3.1 The Health and Wellbeing Board is asked to:

i) Approve the final report; and,

ii) Support the presentation of the report to the Integrated Commissioning Board, with a proposal of a Bromley Joint Working Group to take the recommendations forward within a specified timescale. This will also include a prioritisation process of which recommendations to take forward over the next 12 months.

Health & Wellbeing Strategy

Falls prevention supports a health and wellbeing theme of the strategy to improve the quality of life and well-being of those with specific needs.

Financial

Not applicable at this stage. Some of the recommendations from the report may require additional resource, such as falls awareness training to a wider workforce and the role of a Falls Service Coordinator. However if greater use is made of an evidence-based approach to falls prevention, this should result in costs savings to the health and social care sector and provide a greater quality of life to those at risk.

Supporting Public Health Outcome Indicator(s)

The following Public Health Outcome Indicators are supported through this work:

2.24: Emergency hospital admissions due to falls in people aged 65 and over.
4.14: Hip fractures in people aged 65 and over.

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4. COMMENTARY

4.1 See report attached at Appendix A.

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 This work will support the routine identification of older people with a recent history of falls in order to take preventative action.

6. FINANCIAL IMPLICATIONS

6.1 Any recommended initiatives as a result of the review will be subject to appropriate business case preparations and approvals at the appropriate stage.

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROCESS THE ITEM

7.1 This project provides a focus for joint working between the London Borough of Bromley and Bromley Clinical Commissioning Group.

Non-Applicable Sections:	Legal implications, Comment from the Director of Author Organisation
Background Documents: (Access via Contact Officer)	Not Applicable.

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Bromley Falls prevention system review: Final report and recommendations

June 2018

Laura Austin Croft
Public Health Specialty Registrar

Acknowledgements

Professor Cameron Swift (Advisory Chair), NICE Falls Clinical Guideline Group and Quality Standards Advisory Committee

Dr Nada Lemic, Director of Public Health, Bromley Council

Dr Ruchira Paranjape, Principal Clinical Director, Bromley Clinical Commissioning Group

Dr Aza Abdulla, Consultant Physician, Princess Royal University Hospital (PRUH)

Sonia Colwill, Director of Quality, Governance and Patient Safety, Bromley Clinical Commissioning Group

Graham MacKenzie, Director of Integration and Transformation, Bromley Clinical Commissioning Group

Katherine Rowland, Falls Coordinator, Bromley Healthcare

Leah Bancroft, Senior Occupational Therapist, Bromley Council

Wendy Norman, Head of Contract Compliance and Monitoring, Bromley Council

Katherine Gausden, Lead Falls Practitioner, PRUH and Orpington Hospital

Debbie Hutchinson, Director of Nursing, Kings College Hospital

Christine Kerr, Matron for Emergency Medicine, PRUH

Jenni Gilbert, Quality Manager, Bromley Clinical Commissioning Group

Daniel Knight, Interim Programme Manager, Bromley Joint Care Homes Programme, Bromley Clinical Commissioning Group

Mark Ellison, Chief Executive, Age UK Bromley and Greenwich

David Gedala, Bromley Well Health and Wellbeing Manager, Age UK Bromley and Greenwich

Dr Adenike Dare, Consultant Physician and Clinical Gerontologist
Joint Lead for Frailty Orpington Hospital and Princess Royal University Hospital

Deborah Cooper, General Manager, Bromley Healthcare

Abbreviations

A&E	Accident and Emergency
BHC	Bromley Healthcare
CCG	Clinical Commissioning Group
ECH	Extra Care Housing
FFPS	Falls and Fracture Prevention Service
IMD	Index of Multiple Deprivation
LAS	London Ambulance Service
NOF	Neck of Femur
PRUH	Princess Royal University Hospital

Contents

Chapter one: Background to the review

A review into falls prevention in Bromley took place between the end of December 2017 and May 2018. It was led by the Bromley Public Health Team, with the support of Councillor David Jefferys and the advisory Chairmanship of Professor Cameron Swift, a key member of the NICE Falls Clinical Guideline Group and Quality Standards Advisory Committee that developed the core national guidance (CG161) and the updated Falls Quality Standard (QS86) (published in January 2017).

The aim of the review was to ensure that Bromley is maximising its opportunities for falls prevention work in community and healthcare settings, using as a guide the evidence based standards as specified by NICE (QS86 based on CG161). This includes assessing how well collaboration is taking place across primary, community (including care homes) and secondary healthcare settings.

To support this review a Task and Finish group was assembled to consider the work currently taking place in Bromley against evidence based standards, taking into account local contextual factors.

Objectives of the group were to:

a. Oversee and add to the Bromley public health team analysis of falls data to support understanding of how falls currently affect Bromley's population and what support services are in place.

b. To evaluate existing prevention services against good practice guidelines, using NICE Quality Statements introduced in 2017 as stated below, in conjunction with NICE CG161.

Statement 1: Older People are asked about falls when they have routine assessments and reviews with health and social care practitioners, and if they present at hospital.

Statement 2: Older people at risk of falling are offered a multifactorial falls risk assessment.

Statement 3: Older people assessed at being at increased risk of falling have an individualised multifactorial intervention.

c. Review evidence from the evaluation and agree any additional actions to help meet current guidance.

d. Seek the views of additional expert stakeholders outside of the group that can provide intelligence in terms of current or future falls prevention work.

The Task and Finish Group membership is listed in **Appendix A** and an example of a proforma used to support structured discussions with stakeholders is set out in **Appendix B**.

This report will be presented to the Bromley Health and Well-being Board for agreement in July 2018 in addition to discussion as to how recommendations set out will be tracked going forward.

Report remit:

The review focuses on falls amongst older people (aged 65 years old and above) taking place outside of a hospital setting. A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the ground or an object below knee level.

The resource and time limits of the review mean that it cannot cover all areas pertaining to risk of falls, for example an in depth look into issues around polypharmacy or hazards in the home environment. However, the review does explore whether someone at risk of falls is referred on for a multifactorial risk assessment and intervention, which should then include an assessment of these risk factors.

Chapter two: Falls prevention and the local policy context

Introduction

This section sets out the importance of focusing on falls prevention in Bromley. This includes referencing the evidence on the harm and costs associated with falls in addition to preventative measures known to make a difference. It also looks at what services and pathways currently exist in the borough.

The chapter is structured as follows:

- Making the case for a focus around falls prevention, with specific reference to Bromley.
- Providing an overview of the policy context for the review.
- Introducing the key themes around enhancing falls prevention work as identified through engagement with the Task and Finish group.

2.1 Why falls prevention matters to Bromley

Falls is an important public health issue owing to (1) the number of people affected each year, (2) the associated morbidity and mortality it signals, particularly for the older population, and the high use and cost of health services as a result of falls, and (3) the existence of a published evidence base which confirms the feasibility, effectiveness and cost-effectiveness of properly configured assessment and prevention measures. These factors are set out below with specific reference to Bromley's population.

1) The demographics of Bromley's population

Bromley borough has more people over the age of 65 years old than any other London borough[i]. As a result a high number of older people will be falling in the borough each year.

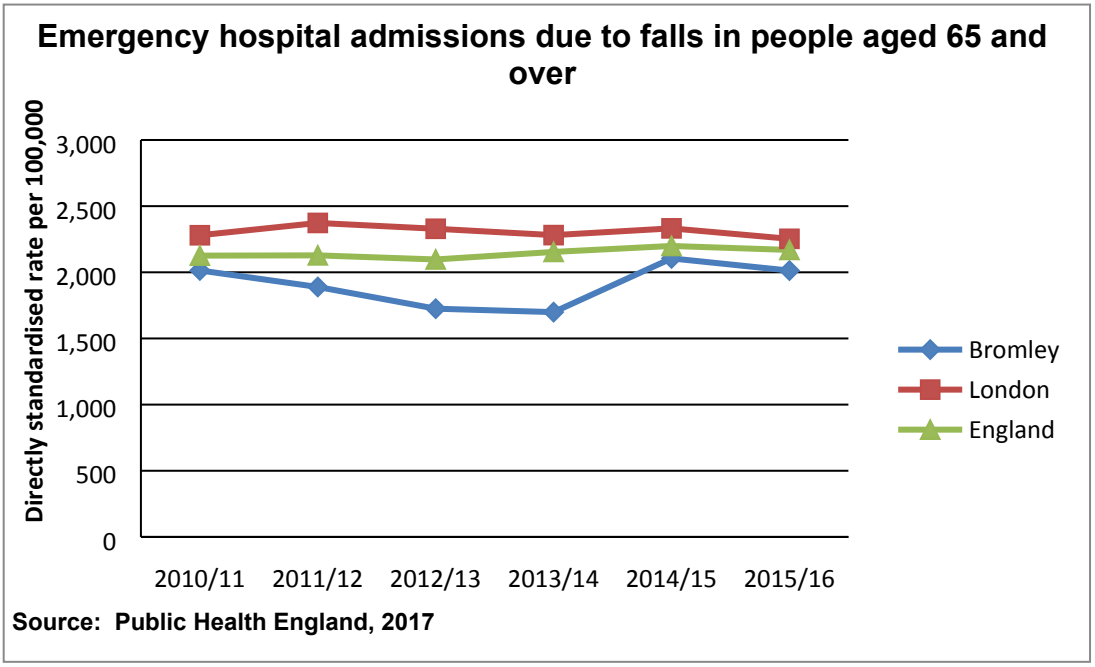
Using National Institute of Clinical Excellence (NICE) data[1], the following can be estimated:

[1] Interim 2015-based demographic projections, long term migration scenario, GLA 2017 https://data.london.gov.uk/dataset/interim-2015-based-population-projections/resource/af57691d-fcbf-4839-8a6c-181c1dd2f9df

- Around 19,082 people over 65 years in Bromley fall each year, representing a third of this age group.
- Around 8,577 of this group are aged 80 or over, with around a half of people in this age group expected to fall each year.
- The population aged 65 or over in the borough is expected to increase to 82,500 by 2035, an increase of 44%[ii]. This is expected to increase the frequency of falls.

The number of falls is important when comparing Bromley to other London boroughs. For example, Bromley's population rates for emergency hospital admissions for falls are below the national and London average (**see Figure 2.1**). However, when focusing on absolute numbers, Bromley is the second highest London borough for this indicator owing to the large number of older people in its population (see **Table 1**).

Figure 2.1



Source: Public Health England, 2017

Table 1: Absolute number of emergency hospital admissions due to falls in people aged 65 and over for 2015/16 in the highest top four London boroughs

London borough	All persons	Male	Female
Croydon	1,423	476	946
Bromley	1,234	381	853
Barnet	1,195	413	782
Ealing	1,180	419	761

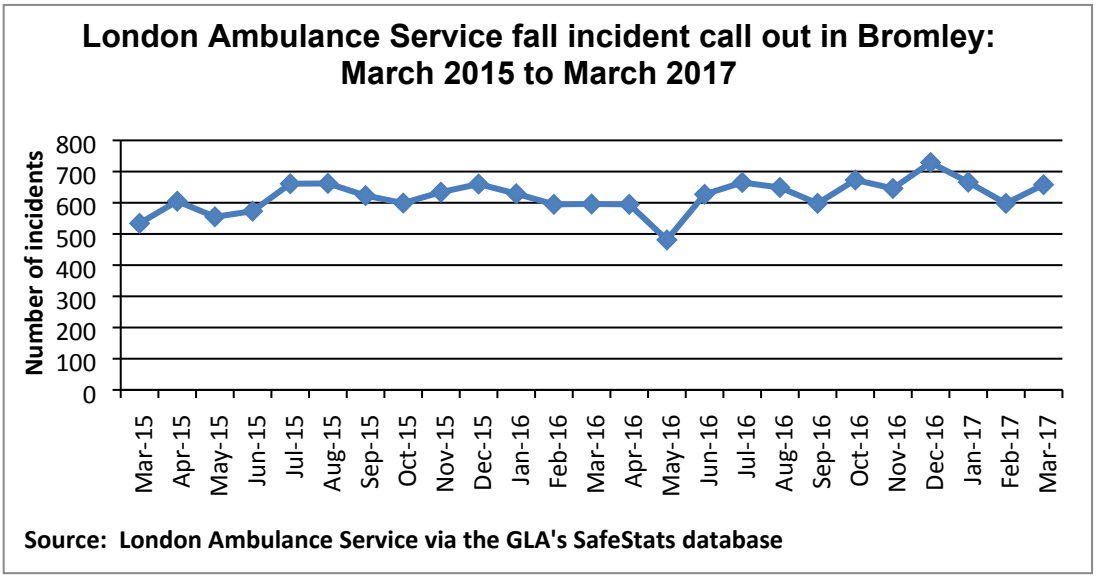
London Ambulance Service (LAS) data on call outs can be used as a proxy indicator to show the frequency of falls taking place in the community. To analyse this data for Bromley, London Ambulance Service data was obtained from the GLA SafeStats database for homes and public settings. The database was searched for Bromley from 2014/15 to 2016/17 for all dispatches and incidents[2] featuring the word 'fall', excluding 'fall from height' records.

When looking at LAS fall incident call out data over a two-year period a slight increase in number is observed, for example with 534 incidents recorded in March 2015 compared to 658 in March 2017 (see **Figure 2.2**). This data is not standardised by age so the upward increase may in part be due to an ageing population (with increases in the number of falls correlated with increases in frailty). LAS data also allows analysis of call outs by ward. The top five wards for fall related calls outs by number are Orpington, Bromley, Farnborough and Clifton, Bickley and Chislehurst (see **Figure 2.3**). Analysis was carried out to compare falls incident number with the proportion of older people in that ward and ward deprivation (measured by the Index of Multiple Deprivation). The analysis shows an association between the number of incident calls out and the proportion of older people in the borough, with the top five wards with the greatest proportion of older people all appearing in the

[2] To note, dispatches refer to vehicles and multiple vehicle dispatches may be present for a single incident. The data analysis focuses in general on incident data.

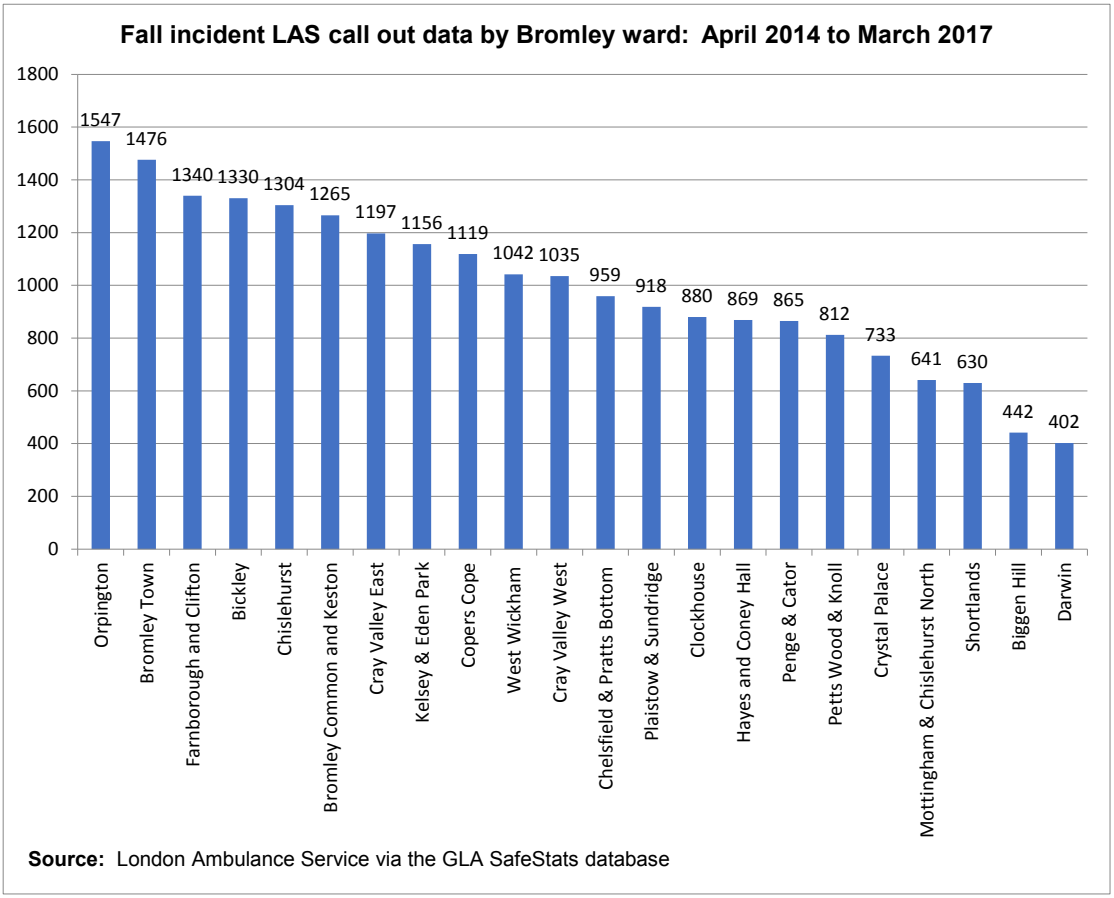
top ten for incident calls outs. The same relationship does not seem to exist for deprivation. The results of this analysis are set out in **Appendix D.**

Figure 2.2



Source: London Ambulance Service via the GLA's SafeStats database

Figure 2.3



Source: London Ambulance Service via the GLA SafeStats database

Owing to the number of older people in the borough, Bromley needs to ensure its using its services well for efficiency and quality purposes. Many falls have serious consequences including distress, pain, injury, loss of confidence, loss of independence and premature death[iii]. Falls can also lead to activity avoidance, social isolation and increasing frailty[iv]. At the same time, the evidence shows that those who fall, or are found to be at high risk of falling, are commonly found on systematic diagnostic assessment to have one or more unmet, undiagnosed or unrelated health problems. This means that a fall can be a valuable signal for early detection and intervention. The best means to support good quality of life is therefore to avoid falls in the first place, or if a recent fall has taken place and/or there is clear risk, ensure that assessment, diagnosis, intervention and support are provided to prevent future falls. This is particularly important as recurrent falls are estimated to occur in 60-70% of people who fall[v].

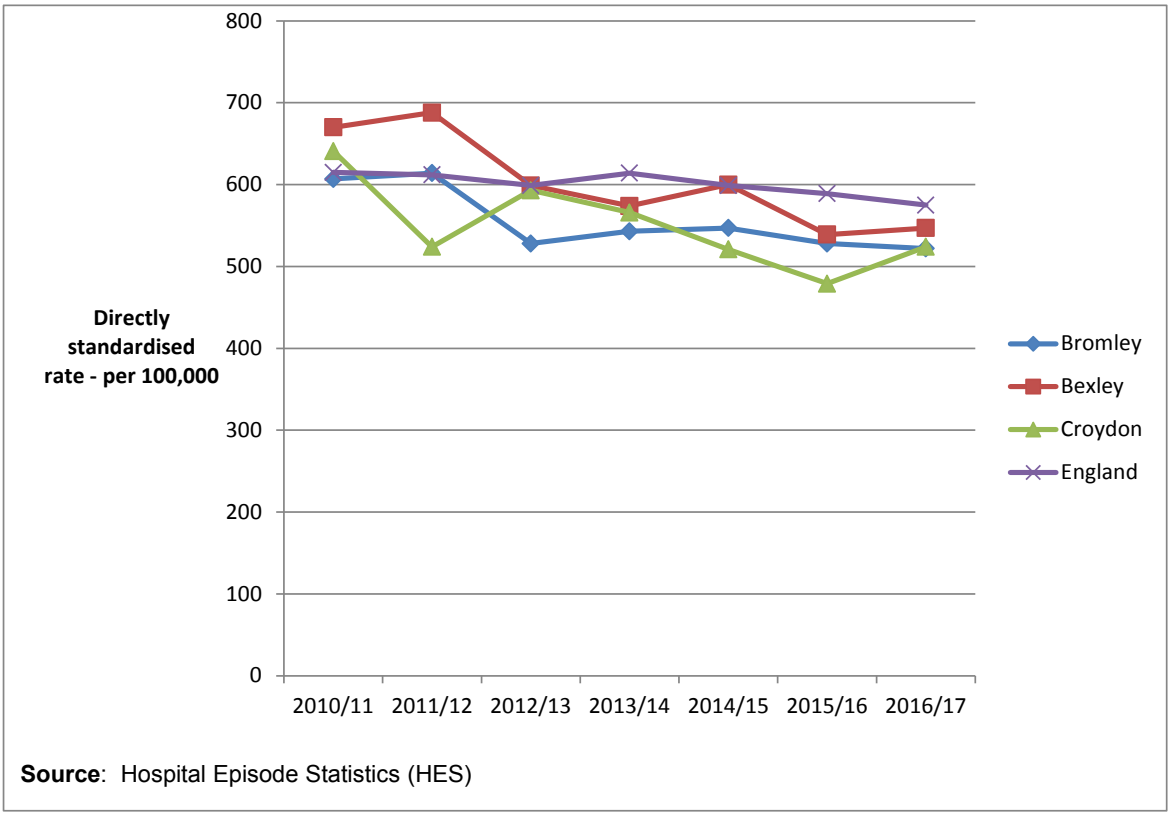
2) Utilisation of health and care services as a result of a fall

Each year, approximately 5% of older people living in the community who fall experience a fracture or need hospitalisation[vivii]. The most frequent significant injury due to falls are fractures, most commonly (and most seriously) of the hip and femur. It is estimated that approximately 95% of hip fractures occur as a result of falls[viii]. Hip fracture is a debilitating condition, with a 30% 12-month mortality rate (linked to prevalent comorbidity) and only one in three sufferers returning to their former levels of independence. It is therefore useful as an example of the benefits of focusing action on falls prevention, supporting independence and quality of life amongst the older age group at the same time as reducing health and social care costs.

Currently, 75,000 hip fractures occur annually in the UK at an estimated health and social care cost of £2 billion a year. This number is expected to increase by 34% in 2020, with an associated increase in annual expenditure[ix]. Data for Bromley over the past six years shows a decreasing trend in the rate of hip fractures, which since 2011/12 has been lower than the national rate (see **Figure 2.4**). This downward trend is similar to other London boroughs

with similar population numbers for people over 65 years old using 2011 census data. To note, the rates are based on small numbers (see Table 2) with Public Health England published data showing overlapping confidence intervals for all these values (i.e. we cannot conclude a significant difference between the four rates)[x].

Figure 2.4: Hip fractures in people aged 65 and over 2010/11 to 2016/17: Bromley, Bexley, Croydon and England



Source: Hospital Episode Statistics (HES)

Table 2: Hip fractures in people aged 65 and over in Bromley: Directly standardised rate per 100,000

Indicator	Time period	Sex	Bromley	Bexley	Croydon	England
4.14i	2016/17	Persons	522	547	524	575

Source: Public Health England Fingertips

When analysing Bromley LAS data for falls taking place in a community setting, the majority of incidents (63.5%) result in a hospital referral, with 54% (11,768) to the PRUH, 4.6% (1,136) to the PRUH urgent care centre and

4.9% (1,066) to Lewisham University Hospital. Only 10% (2,241) of incidents result in LAS assistance alone. The remaining incidents range from referrals to GPs, specialist teams, mental health trusts, maternity units and palliative care in addition to no action required. These referral patterns also help illustrate the health care costs associated with a fall.

3) A robust evidence base for intervention

There is a good evidence base that certain interventions when delivered consistently and effectively can prevent some falls, improving health outcomes and quality of life for older people in addition to providing savings to health and care services[xi]. The text below summarises the evidence base in terms of preventing the occurrence and impact of falls:

a. Understanding risk factors

There are a number of known risk factors for falling. Individual risk factors include muscle weakness, poor balance, visual impairment, polypharmacy, low BMI, visual impairment and specific conditions (such as arthritis, diabetes, depression, cardiovascular and neurological causes, Benign paroxysmal positional vertigo (BPPV), high alcohol consumption etc.)[xii] External risk factors include hazards in the environment, including the home and outdoors. In any one individual, competent assessment entails a careful iterative search for any possible (often elusive) primary diagnostic cause as well as systematic identification of all potential contributory risk factors.

b. Routinely identifying people vulnerable to falling and referring to appropriate intervention(s)

Literature agrees that routine identification of those most vulnerable to falling allows interventions to be targeted to best effect[xiii]. NICE recommends that risk of falls should be assessed at least once per year in all people aged 65 or over[xiv]. This can be through active case finding, for example home visits, assessments in care home settings etc. Those over 65 who fall and attend A&E and those involved in ambulance call-outs who are not transferred to hospital have both been identified opportunistically as high-risk groups where appropriate intervention has been shown in randomised controlled studies to

substantially reduce both subsequent falls, hospital admissions and health and social care costs compared with controls over a subsequent 12-month follow-up[xvxvi].

c. Development of a multifactorial intervention.

Evidence shows that a risk assessment followed by appropriate interventions for falls prevention (also known as a multifactorial intervention) can reduce the rate of falls by 24%[xvii]. A systematic and individualised approach to assessment and intervention is needed, including a careful diagnostic review and corresponding tailored intervention, commonly within the context of a defined specialist falls service[xviii], involving appropriate partnership working between primary care and clinical gerontology. In addition to addressing specific causes, referral for strength and balance training, home hazard assessment and safety interventions, vision assessment and medication review are all common components of the multidisciplinary response required.

2.2 Policy context

The next section of this chapter focuses on the national, regional and local policy context which has the potential to support or complement further action around falls prevention.

A. National policy context

Public Health England in 2017 published a *Falls and fracture consensus statement* in addition to a resource pack, produced by the National Falls Prevention Coordination Group (NFPCG). This was produced to support commissioners recognise the wide range of professions and providers carrying out falls and fracture prevention activities and therefore highlight the need to support and encourage a 'whole-system' approach to local commissioning. These two published documents are referenced frequently in this report.

B. Regional policy context

Dementia and ageing is identified as one of the 10 prevention areas in the South East London Sustainable Transformation Plan. This includes a

commitment for Our Healthier South East London (OHSEL) to develop a *Frailty Strategy*.

C. Local policy context

Bromley CCG developed an *Out of Hospital (OOH) Strategy* in 2015, with a proposed outcome for the introduction of integrated care networks (ICNs) to provide a new model for the delivery of health and social care in the borough. This new approach to care recognised that the number of people living with long term conditions is increasing, in part consistent with a growing older population.

i) Two new pathways have developed as part of the ICNs: the Frailty pathway and the Proactive Care pathway. Both of these are outlined in more detail in **Appendix C**, in addition to other services in Bromley relevant to falls prevention in the borough. The CCG and the local authority has also established the Care Homes Programme Board to enable an integrated health and care strategy for care homes in Bromley.

ii) A joint Bromley Council and CCG Strategy is currently being developed for residents over 55 years of age. The Strategy is in its early days of development but plans to have three main themes:

1. Prevention and wellbeing
2. Self-care and management
3. Supporting the most vulnerable

A key focus of the strategy is expected to be on prevention and independence but it will also cover support for people with specific needs and who require support from health and social care, such as people at risk or with a frequent occurrence of falls. Its approach sets out to be pragmatic in recognising current pressures on resources.

What is common across all of the above strategy developments is a commitment to a whole system approach to prevention and support, where secondary, primary and community care are engaged and working together in the delivery of interventions and patient engagement. This partnership

approach also sits behind Bromley Well, an initiative delivered by a partnership of local voluntary sector organisations called Bromley Third Sector Enterprise CIC (BTSE) which brings together many years of expertise in the voluntary sector to provide a range of services for local people, including support for older people and adult carers. The number of practitioners involved in supporting older people's health and well-being is therefore widening beyond that currently covered by NICE guidance and is reflected in this review.

2.3 Themes identified through stakeholder engagement

The following two chapters of this report bring together qualitative and quantitative data on the following:

- Case findings and referrals
- Workforce development and service collaboration.

These two areas feed into each other, with the final report chapter bringing together recommendations from both themed areas. They are described in more detail below.

a. Case finding and referrals for risk assessments and appropriate intervention(s)

As mentioned earlier, the literature on falls prevention agrees that routine identification of those most vulnerable to falling allows interventions to be targeted to best effect[xix] and for the risk of falls to be assessed at least once per year in all people aged 65 or over[xx]. The range of practitioners active case finding refers to is broad, including GPs, practice nurses, pharmacists, district nurses, physiotherapists, occupational therapists, social workers and care home workers. For the purposes of this service review we have also considered the role of the voluntary sector.

Focusing on this area allows assessment of whether there is an appropriate number of partnerships in place to support older people to be asked about falls. Referral data from the Bromley Healthcare Falls and Fracture

Prevention Service (FFPS) supports this analysis in addition to qualitative data from stakeholder engagement.

b. Workforce development and service collaboration

To be able to effectively identify someone vulnerable to falls requires the know-how to appropriately ask questions of a sensitive nature, what other signs to look for in in terms of risk, in addition to what referral routes are available in the borough for a further risk assessment and development of a multifactorial intervention. This section focuses predominantly on the care home workforce in addition to identifying areas of the workforce where additional training can take place.

Key messages:

(1) The demographic profile and falls-related health care pattern of Bromley's population together with the evidence for benefit built into National Guidance constitute together a compelling rationale for the existence and ongoing development of a specific, defined Falls Prevention and Management Service

(2) In line with the evidence and guidance, in order for the service to deliver in terms of effectiveness and cost-effectiveness it needs to be strategically led and coordinated in a cross-disciplinary manner that ensures integration of assessment, intervention and the entire service across primary, secondary, social and voluntary care sectors.

(3) Local policy-driven initiatives, notably the Frailty and Pro-active Care pathways and Bromley Council Older People Strategy, have the potential to raise awareness and in other ways lend support to a comprehensive Falls Service, but do not in themselves constitute a substitute for it.

Chapter three: Case finding and referrals

Introduction

This section examines Bromley Healthcare data to help understand the referral patterns in Bromley to its main falls prevention service in addition to looking at any outcome related data. This is then supported by qualitative data with organisations involved in falls prevention, collected via interview. The analysis aims to help answer the question are we doing enough to identify people at risk of falls in Bromley, including subsequent referral for a risk assessment.

The Bromley Healthcare Falls and Fracture Prevention Service (FFPS)

The Bromley Falls and Fracture Prevention Service (FFPS) is a specialist service for all adults who have fallen or who are identified as being at risk of falling. The service is also available to people identified at high risk of osteoporosis and fragility fractures. The service is commissioned by Bromley CCG, using NICE CG161 and QS86 in addition to other guidelines described in **Appendix C**. Its services include:

- Multi-disciplinary, multifactorial assessment of all falls risk factors
- Exercise/ balance classes (provided by Mytime Active)
- Education and advice for patients and carers
- Home assessment of fall risk factors
- Case finding patients in the Emergency department, urgent care centre and fracture clinics
- Direct access to DEXA for those with suspected osteoporosis
- Training and advice on falls prevention and falls risk assessment for staff in primary, secondary, community, social care, care homes, the London Ambulance Service and the Voluntary Sector[xxi].

Overview of Falls and Fracture Prevention Service (FFPS) referral data

Bromley Healthcare started recording referral data in January 2014, around the time when the service began. By January 2018 6,501 referrals had been made to the service (to note, this will include some repeat referrals).

Figure 3.1 and Table 3 show how the pattern of referrals has changed over this time duration, with a sharp increase in referral number between January 2014 and mid-March 2015 when the service began, and then a levelling off to around 1,700-1,750 referrals per year. In conversation with the FFPS they state that they now receive around 100 referrals a month on a consistent basis, which is a number they are able to support in terms of managing a short waiting time prior to assessment.

Figure 3.1: Number of referrals accepted per month by the Bromley Falls and Fracture Prevention Service Jan 2014 – Jan 2018

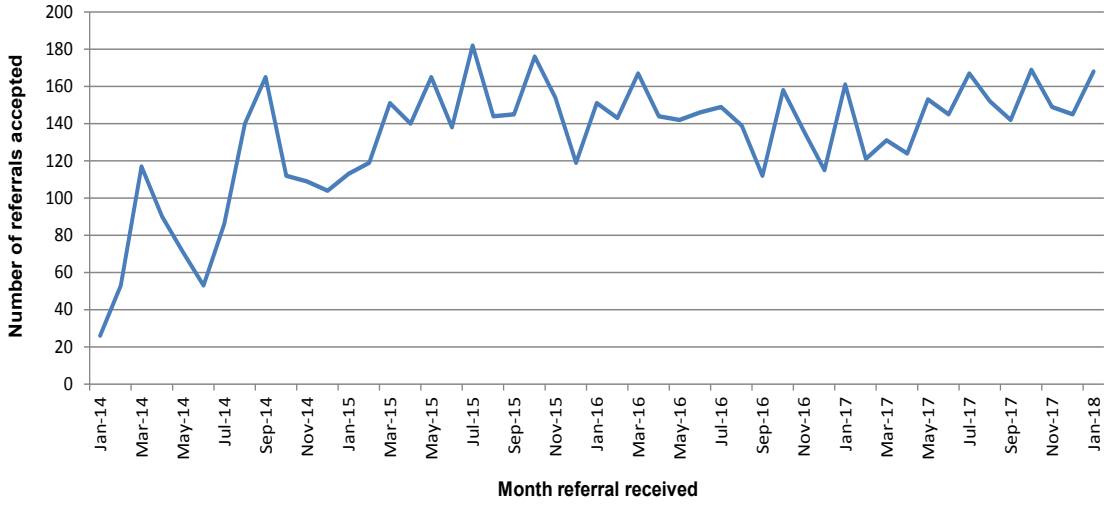


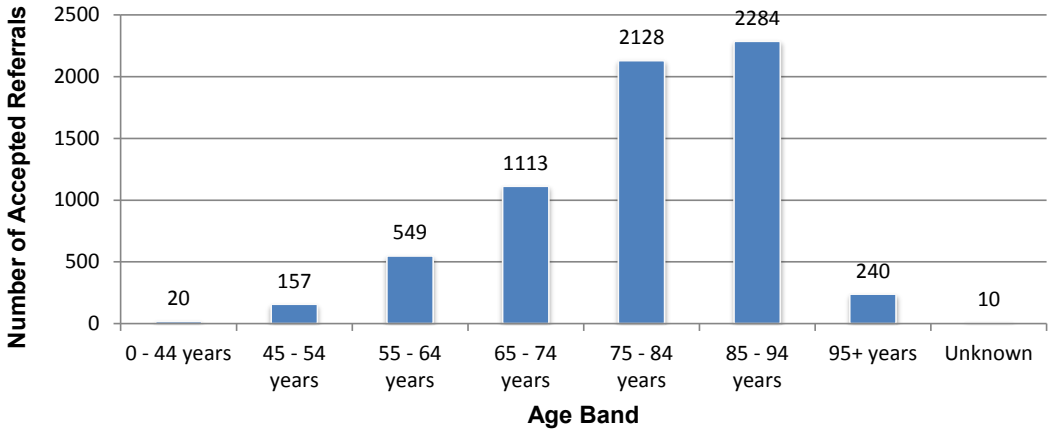
Table 3: Number of referrals to Bromley Healthcare FFPS service by year

Year	Total number of referrals	Percentage change from previous year	Difference in nos (+/ -) from previous year
Jan 14 – Dec 14	1126	-	
Jan 15 – Dec 15	1746	+ 55	+ 620
Jan 16 – Dec 16	1702	- 2.52	- 44
Jan 17 – Dec 17	1759	+3.35	+ 57

Age range of referrals to the FFPS

5,765 of referrals are over 65 years of age over the four year period, making up 88.7% of the total number. 2,524 were over 85 years of age (38.8%). This represents 7.6% (1,441) of the number of people who are estimated in Bromley to fall each year over 65 years of age (approximately 19,082).

Figure 3.2: Age of the patients referred to the Falls and Fracture Prevention Service



Source: Bromley Healthcare, 2018

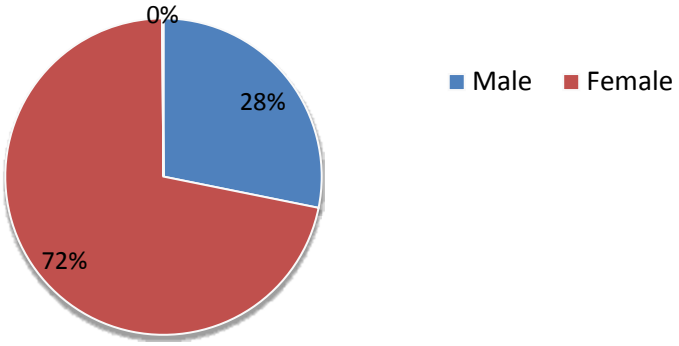
Gender profile of referrals

The majority of referrals to the FFPS are female (4,660, 72%) (**Table 4** and **Figure 3.4**). This percentage is similar to the gender split seen in the absolute numbers of emergency hospital admissions for falls in 2015/16 (male 33.4% (476) and female 66.4% (946)) and hip fractures (28% male (91) and 72% female (235)). This is likely to relate to the longer life expectancy of women in addition to known risk factors affecting women such as osteoporosis.

Table 4: Gender of patients referred to the FFPS service by number

Gender	No.	Percentage
Male	1831	28%
Female	4660	72%
Unknown	10	

Figure 3.3: Gender of patients (%) referred to the FFPS service



Source: Bromley Healthcare, 2018

Referral sources to the FFPS service

A breakdown of where referrals to the FFPS come from is provided in **Table 5.** This shows that the majority of referrals are from a GP. This is to be expected as patients are sign posted to GPs as a referral mechanism. In addition the ambulance service makes recommendations of referrals via a GP (hence the low number for ambulances in the table below). Interview data collected as part of this service review also suggests that the same is true for the local authority social services team and that care homes are also likely to use GPs via their Visiting Medical Officer service as the referral route.

The second largest group of referrals is from hospital inpatients/ outpatients (37%, representing approximately 607 referrals a year). This is separate to the Accident and Emergency Department, which makes up 13% of referrals made to the service to date, representing approximately 63 referrals a year. This appears quite low considering the number of older patients likely to be attending A&E on a regular basis.

Unfortunately, data is not collected on which area of hospital inpatients or outpatients' referrals come from, although there is an opportunity to record ward and hospital department information on the Bromley Healthcare referral form[xxii]. This information would be useful to know, for example in assessing how many referrals are from the Urology unit, where Urinary Tract Infections are known risk factors for falling. It would be useful for this data to be collected going forward to understand where referrals are coming from and where targeted activity may need to take place at the secondary care level to

make practitioners more falls aware (particularly those areas of hospital care which routinely work with patients who are 65 years old plus).

The third largest referral path is from the Bromley Healthcare Community Health Services, which includes community occupational therapy, physiotherapy, Community Matron District Nurse, the medical response team, home pathway, the neurological rehabilitation team, podiatry and the bed-based rehabilitation team. These teams can also be used to provide intervention support following assessment.

Table 5: Sources of referrals received by the Bromley Falls and Fracture Prevention Service Jan 2014 to Jan 2018

Referral sources	No.	Estimated no per year	Percentage
General Medical Practitioner	2,700	675	42%
Hospital Inpatients/Outpatients	2,426	607	37%
Community Health Service (Bromley Healthcare)	874	219	13%
Accident and Emergency Department	251	63	4%
Physiotherapy & Sport Injury Centre	108	27	2%
Community Mental Health team	70	18	1%
Other Source of Referral	48	12	1%
Care Home (Includes Nursing and Residential Care Homes)	7	1.8	0.1%
Local Authority Social Services	5	1.25	0.08%
Ambulance Service	3	0.75	-
Hospice	3	0.75	-
Unknown	3	0.75	-
Voluntary sector	2	0.5	-
Day Centre	1	0.25	-

Source: Bromley Healthcare, 2018

Primary and secondary care referrals will be looked at in more detail in the next section of this chapter.

Primary care referral data

Primary care referral data is recorded by GP practice. Referral data by GP practice to the Bromley FFPS between January 2014 and January 2018 is presented in **Appendix E** of this report.

In Chapter one, LAS data for call outs due to falls in community settings analysed by ward seemed to be associated with where there are high numbers of older people living in the borough. The same can be done for GP practices in terms of showing the proportion of people on a GP register who are over 65 years of age, 75 years of age and 85 years of age. Data on the percentage of the nursing home population as a proportion of the register and the prevalence of Osteoporosis per practice can also be looked at in case this helps show a relationship between the number of referrals and the GP register population. To help read the data in **Appendix E** the ranges for each indicator is set out in **Table 6** to and the relationship between the percentage of referrals compared to the percentage of patients on the GP register over 65 years of age for each GP practice is set out in **Figure 3.4**.

Table 6: Range of indicators potentially associated with risk of falls for Bromley GP practice registers (Source: Public Health England Fingertips)

Indicator	Range (lowest to highest percentage across Bromley GP practises) (%)
People over 65 years of age	5.2 to 24.9
People over 75 years of age	2 to 13.1
People over 85 years of age	0.5 to 4.2
Nursing home population	0-2.3
Osteoporosis prevalence	0-0.9

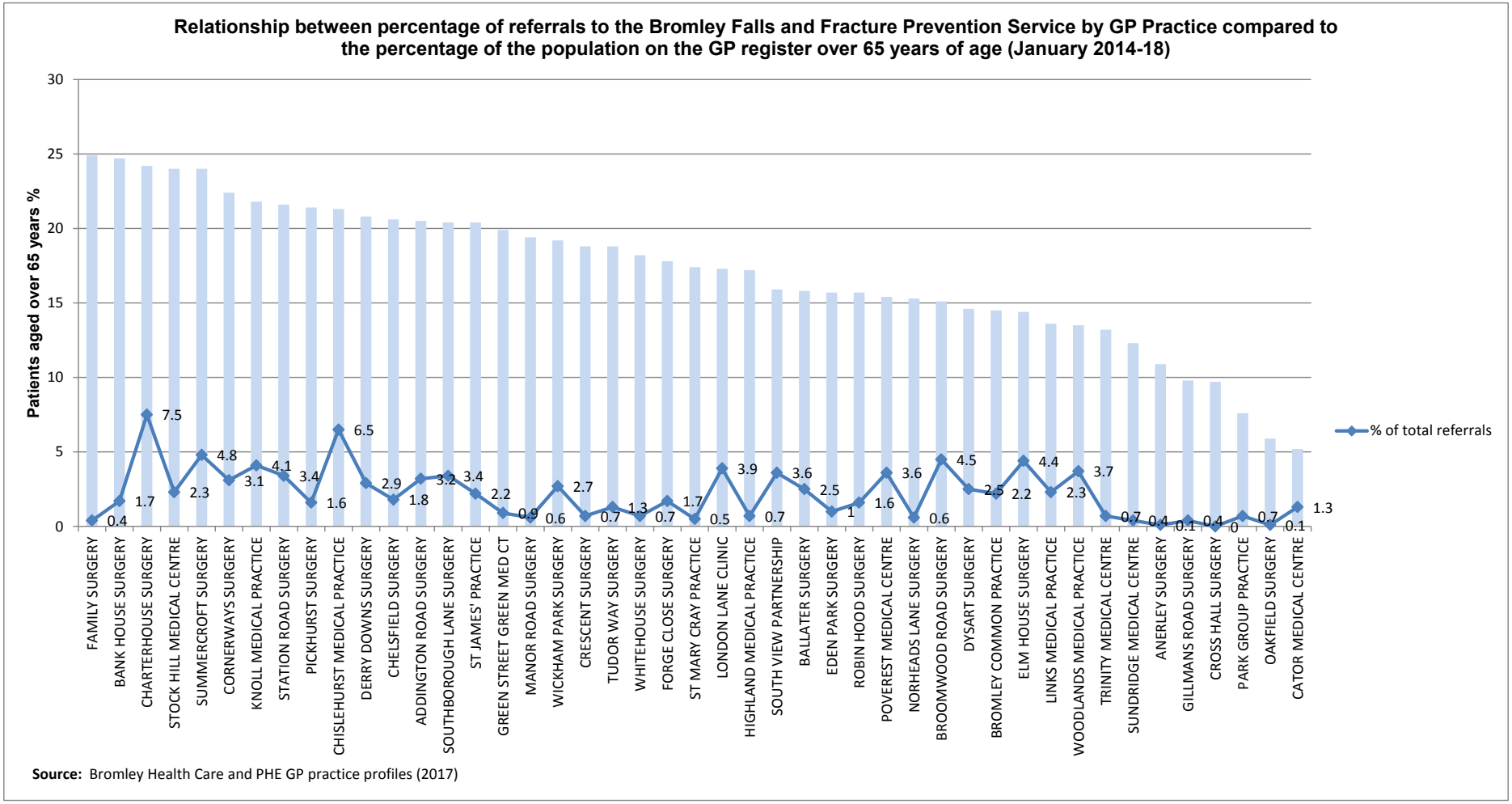
The top three GP practices with the highest number of referrals to the FFPS all have a relatively high proportion of people in their practice over 65, 75 and

85 years old. However, there is an inconsistency amongst practices, with some who have over 20% of their population over 65 years appearing in the bottom half of practices in terms of referral number. There are also practices with a relatively high nursing home population on their register and very low referral numbers and with relatively high osteoporosis prevalence and low referral numbers. Thirteen practices are recorded to have made less than 20 referrals since the falls and fracture prevention service began four years ago.

This analysis requires further investigation in terms of data recording and referral mechanisms. In addition, it would be useful to investigate whether patients over 65 years old are being routinely asked about falls during GP assessments and whether the practitioners in practices with low referral numbers are aware of the Bromley FFPS.

It is important to note that the FFPS is not the only way of providing support for people vulnerable to falls. In a meeting with primary and secondary care on falls prevention measures in the boroughs the role the Proactive Care pathway can also play in falls prevention was highlighted, described in more detail in **Appendix C**. It may be that GPs are using this pathway as a means of referring patients vulnerable to falls. This can be taken into account in any further analysis.

Figure 3.4


Relationship between percentage of referrals to the Bromley Falls and Fracture Prevention Service by GP Practice compared to the percentage of the population on the GP register over 65 years of age (January 2014-18)
Patients aged over 65 years %
30
25
20
15
10
5
0
% of total referrals
FAMILY SURGERY 0.4
BANK HOUSE SURGERY 1.7
CHARTERHOUSE SURGERY 7.5
STOCK HILL MEDICAL CENTRE 2.3
SUMMERCROFT SURGERY 4.8
CORNERWAYS SURGERY 3.1
KNOLL MEDICAL PRACTICE 4.1
STATION ROAD SURGERY 3.4
PICKHURST SURGERY 1.6
CHISLEHURST MEDICAL PRACTICE 6.5
DERRY DOWNS SURGERY 2.9
CHELSFIELD SURGERY 1.8
ADDINGTON ROAD SURGERY 3.2
SOUTHBOROUGH LANE SURGERY 3.4
ST JAMES' PRACTICE 2.2
GREEN STREET GREEN MED CT 0.9
MANOR ROAD SURGERY 0.6
WICKHAM PARK SURGERY 2.7
CRESCENT SURGERY 0.7
TUDOR WAY SURGERY 1.3
WHITEHOUSE SURGERY 0.7
FORGE CLOSE SURGERY 1.7
ST MARY CRAY PRACTICE 0.5
LONDON LANE CLINIC 3.9
HIGHLAND MEDICAL PRACTICE 0.7
SOUTH VIEW PARTNERSHIP 3.6
BALLATER SURGERY 2.5
EDEN PARK SURGERY 1
ROBIN HOOD SURGERY 1.6
POVEREST MEDICAL CENTRE 3.6
NORHEADS LANE SURGERY 0.6
BROOMWOOD ROAD SURGERY 4.5
DYSART SURGERY 2.5
BROMLEY COMMON PRACTICE 2.2
ELM HOUSE SURGERY 4.4
LINKS MEDICAL PRACTICE 2.3
WOODLANDS MEDICAL PRACTICE 3.7
TRINITY MEDICAL CENTRE 0.7
SUNDRIDGE MEDICAL CENTRE 0.4
ANERLEY SURGERY 0.1
GILLMANS ROAD SURGERY 0.4
CROSS HALL SURGERY 0
PARK GROUP PRACTICE 0.7
OAKFIELD SURGERY 0.1
CATOR MEDICAL CENTRE 1.3
Source: Bromley Health Care and PHE GP practice profiles (2017)

Secondary care referrals

Secondary care referrals to the FFPS are looked at in terms of referrals from the accident and emergency department and inpatients.

a) Accident and emergency referrals

As mentioned previously, BHC does not collect information that allows a breakdown of hospital referrals by specialist areas or differentiation between inpatient and outpatient (these referrals are all aggregated under the term acute). Data is available on the number of referrals from Accident and Emergency but without identifying an 'expected number' from this department it is hard to ascertain the unit is sufficiently 'falls aware'.

Meetings with secondary care colleagues as part of this service review confirmed that the following processes are in place at A&E:

- Falls prevention promotional material is displayed in A&E and referral forms to the Bromley FFPS are easily accessible to staff.
- The risk assessment form is used by all A&E staff and includes questions about falls.
- Regular training also takes place to promote falls awareness for all health practitioners.

However it was acknowledged by staff that it is a challenge to maintain high levels of awareness around falls prevention across all staff groups. Therefore a number of additional measures were identified to help increase falls awareness in the department, including:

- A reference to the Bromley FFPS to be included on the A&E routine risk assessment form in addition to questions on falls to encourage referrals.
- Bromley Healthcare (BHC) marketing materials for the FFPS to be displayed in the 'fit to sit' area of A&E to increase awareness of the service amongst patients and their relatives.
- Visible items (such as yellow grip socks) to be sourced for A&E to help identify patients at risk of falls and help promote general awareness of this issue amongst health practitioners, including the mandatory requirement to

complete risk assessment forms and how referrals can be made to the BHC service.

- A breakdown of referral figures from A&E to the Bromley FFPS to be shared with meeting attendees, providing a baseline figure to help monitor the impact of the above.

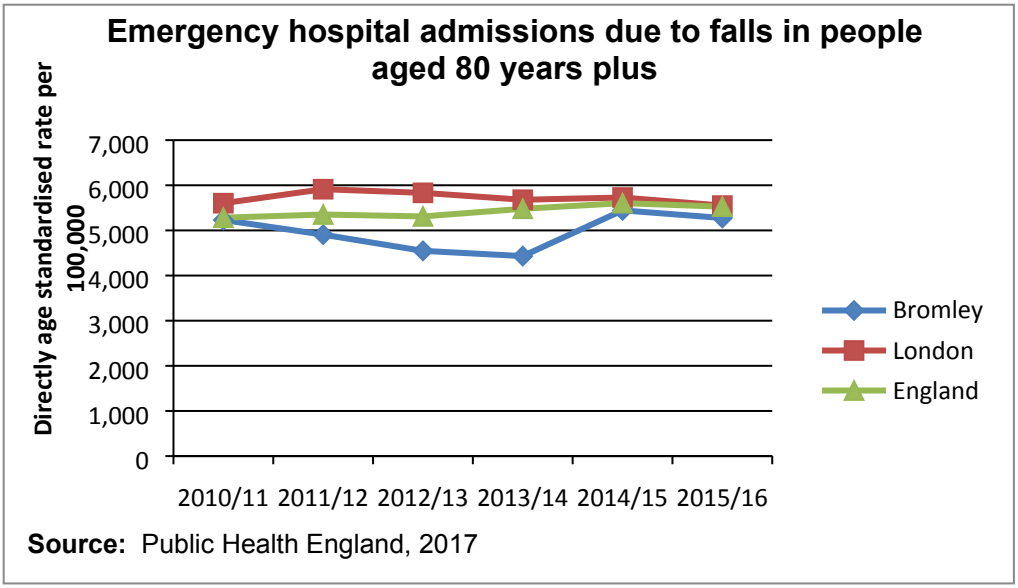
The Falls practitioner at the PRUH also raised an issue that A&E regularly see a cohort of patients who are recurrent fallers. These are patients with a high level of frailty, which represent an increasing number of patient type seen by secondary care. This cohort is potentially shown in the hospital emergency admission rate for Bromley, where the rate of hospital admissions due to falls is significantly greater in Bromley for people over 80 years than the 65 to 79 year age band, with the 80 years plus rate being close to the London and England average (see **Table 7** and **Figure 3.4**). A higher number is expected in the higher age bracket with falls being an age associated phenomena.

Table 7: Hospital emergency admissions due to falls 2015/16 (Directly standardised rate per 100,000)

Indicator	Time period	Sex	Age	Bromley	London	England
2.24i	2015/16	Persons	65+ years	2,013	2,253	2,169
2.24i	2015/16	Persons	65-79 yrs	888	1,116	1,012
2.24i	2015/16	Persons	80+ years	5,275	5,550	5,526

Source: Public Health Outcomes Framework, 2018

Figure 3.5



Source: Public Health England, 2017

As mentioned above, the Proactive Care pathway in Bromley provides a Multi-Disciplinary Team (MDT) assessment of patients that require more preventative support. These meetings take place weekly across the three Bromley Integrated Care Networks. During stakeholder engagement it was suggested that secondary care could help flag to primary care which patients may benefit from such an assessment. This may be suitable for some of the frequent attendees seen at A&E.

Data for frequent fallers presenting at A&E was also discussed. A potential audit which joins up data across primary and secondary care could assess when the last medication review took place for this patient cohort in addition to any other interventions related to falls prevention.

Secondary care colleagues also noted that infections cause the greatest number of attendances at A&E amongst older people, including UTIs, chest infections and cellulitis (in addition to heart failure). Falls can be a symptom of these conditions. They are therefore keen to understand how UTIs are currently being treated in primary and community care settings, including what pathways are in place to help avoid hospital admission for these patients. To note that training was delivered in 2015 via the CCG for carers and non-clinical nursing/ care home staff in 'dipstick' testing for patients aged 65 years

and older to facilitate early detection of UTIs and help reduce hospital admissions. Currently the Bromley Care Home Programme Board is following recommendations from the Enhanced Health in Care Homes (EHCH) model created by the six NHS England vanguard sites. A couple of these recommendations relate to UTIs, such as providing hydration and nutrition support to residents and standardising training and development for social care provider staff. This is picked up further in Chapter 4.

b) Inpatient referrals

Two aspects of inpatient patient referrals were discussed with secondary care colleagues with regards to falls prevention:

i) Neck of femur fracture (NOF) patients

The PRUH has discussed sharing details of older patients with a Neck of femur fracture (NOF) with BHC, allowing cross checking in terms of how many are subsequently referred to the service. This helps ensure everyone who needs a referral will receive one as part of their care package and is part of evidence based practice, with NICE guidance for hip fracture management (NICE CG124 updated in 2017) indicating that all patients with a fractured neck of femur should attend a strength and balance group on discharge[xxiii].

ii) Referrals via home-based rehabilitation pathway

It was noted that referrals to falls prevention services may occur via the home-based rehabilitation pathway, which supports people at home who have been discharged following a hospital stay. This service is provided by BHC.

BHC audit figures for 2017 include the home-based rehabilitation service in terms of falls risk assessment and referrals. This is an area that the audit notes requires improvement with its analysis of sample case records noting that only 48% (19) patients were asked about their falls risk over a two week period.

Social care/ occupational therapist team case identification and referrals

As detailed in **Appendix C,** falls risk assessment and follow up interventions are also made by the local authority social care occupational therapist team. An interview with a Senior Occupational Therapist for the team, using the standard proforma based on NICE guidance, identified the following areas to help improve case identification and subsequent referrals to either Occupational Health support or the BHC team.

- For there to be a routine means of asking or recording information about falls when a resident calls up the social care adult early intervention centre.
- That a falls procedure is developed for the Bromley Occupational Therapists team as a way to standardise practise (to note, questions on falls are part of the standard risk assessment form used by the team).
- For training to take place with the OT team to help with asking people about falls as part of assessments and reviews.

There are also other members of the social care team outside of the OT team which regularly work with the older 65 population, such as the benefits team. This wider social care workforce could also play a role in case identification and subsequent referral.

Case identification by non-health professionals

In the PHE consensus statement checklist for commissioners and strategic leads the following guidance is included:

- Non-specialist workforce development around falls awareness, case finding and risk reduction is delivered
- Local organisations sign up for falls case finding; routes for case finding are maximised.

Workforce development will be considered in more detail in the next section but the potential role of additional case finding was discussed in an interview with the Chief Executive of Age UK, Mark Ellison.

Age UK run a number of services to support older people in Bromley, estimating a reach of 20,000 encounters with adults over 50 years plus across Bromley and Greenwich[3]. This includes services which are relevant to falls prevention such as a toe clipping service which helps with foot health and balance and gait and supports 4,000 older people across Bromley and Greenwich per year, sitting and standing exercises at four different venues around Bromley, a post hospital discharge sitting service, and self-management group workshops covering exercise, nutrition and medication management. This provides opportunities to ask questions around any recent falls. Research from Age UK notes the challenges of talking about falls with older people[xxiv]. The interview with Age UK noted that voluntary sector staff often have built a relationship with their clients which places them in a trusted position, with information such as a recent fall more likely to be disclosed.

Age UK is a partner of Bromley Well and provides the Handyperson service as part of this partnership to support older people with mild frailty as well as other vulnerable adult residents who are living in the community or being discharged from hospital. The service aims to make a person's home environment safer and accessible and minimise risk of trips and falls including installation of safety measures such as fitting grip rails, securing floor coverings and re-arranging furniture for easier and safer access. Age UK staff also provide domiciliary care where they go into people's homes. These are all useful points for case identification.

Identifying outcomes as a result of case identification and referral

Outcome data made available for this review will be considered in terms of discharge outcomes and Fracture Liaison Service performance indicators, collated for audit purposes.

[3] This data was provided by Mark Ellison, Chief Executive Officer, Bromley and Greenwich Age UK

a) FFPS discharge outcomes

Table 8 displays data provided by Bromley Healthcare regarding discharge outcomes following referral to the FFPS. This shows that the majority of referrals (around a third) are then linked to the Fracture Liaison Service, a service for patients identified at high risk of osteoporosis and fragility fractures. Around a third of referrals go on to receive a multiple interventions package.

What is not apparent from the data is any longer term outcomes for patients following a referral and discharge from the FFPS. For example, the number of falls for people 12 months on following a referral/ case discharge to the FFPS (possibly collected at three months intervals for recall purposes). This information would help understand the effectiveness of the service. A Key Performance Indicator is currently being put in place to monitor falls recurrence at 3 month, 6 months and 12 months following referral to the service. Other outcome measures being collected include fear of falling and gait assessment.

Table 8: Outcomes of patients discharged from the service between 1 February 2016 and 31 January 2018 (2 years)

Outcome	No.	%
Fracture Liaison Service	1168	33%
Multiple Interventions	1046	30%
One Off Assessment	342	10%
Inappropriate Referral	300	8%
Other	267	7%
Referred to Therapy Service	261	7%
In Hospital	94	3%
Referred to outside organisation	30	1%
Care Incomplete - Self Discharge	23	1%

Source: Bromley Healthcare, 2018

b) Fracture Liaison Service performance indicators

The Royal College of Physician's has developed a Fracture Liaison Service Database (FLS-DB) which supports the production of clinical audits. This helps compare how the BHC FLS is performing against national benchmarks and also provides recommendations for secondary fracture prevention.

Table 9 below provides a summary of Bromley's performance with colour coding traffic light system demonstrating how the service is performing according to quality improvement standards (green equalling good, red in need of improvement). High level recommendations for the Bromley Fracture Liaison Service (FLS) in relation to the areas marked as red in the Falls and Fragility Fracture Audit Programme include that:

1) FLSs should ensure their local processes are identifying all patients aged 50 years and over who have a new fragility fracture, including hip fracture patients and those with newly reported / radiologically diagnosed vertebral fractures.

2) Falls interventions should be funded and monitored with the same rigour as FLS interventions.

3) FLSs should engage with their strength and balance class groups to improve communication and uptake.

4) FLSs should prioritise reviewing their monitoring pathway as part of their service KPI 10 Commenced bone therapy improvement plans.

Table 9: FLS performance in selected key areas

Performance indicator	Bromley Healthcare Fracture Liaison Service (%)
Number of fields with >20% missing data	**1 - GREEN**
Identification – all fractures	**32 - RED**
Identification – spine fractures	**2 - RED**
Time to FLS assessment within 90 days of their fracture	**99 - GREEN**
Time to assessment with a DXA scan within 90 days of their fracture	**91 - GREEN**
Falls assessment done or referral	**100 - GREEN**

Bone therapy recommended as inappropriate	**41 - AMBER**
Strength and balance commenced (patients >75)	**8 - RED**
Recorded follow up 12-16 weeks post index fracture	**82 - GREEN**
Patient commenced bone therapy at 16 weeks	**56 - AMBER**
Patient confirmed adherence to bone therapy at 12 months	**0 - RED**

Source: Fracture Liaison Service Database (FLS-DB), 2017

Key messages:

The scale and pattern of referrals to the existing Bromley Healthcare Falls and Fracture Prevention Service presents some issues for further clarification, as follows:

(i) The extent of agreed shared accountability, strategic teamwork and leadership of the service across primary and secondary care – including the scale and lines of access to diagnostically supported specialist assessment and intervention - is not currently clear to the working group.

(ii) The data suggest some anomalies (e.g. apparently low rates of referral from A&E) and possible areas for discussion and development (e.g. Ambulance service access; referral track from social care).

(iii) The variability in referral rates from GP Practices may suggest corresponding variation in awareness and ownership.

(iv) There does not seem to be a Falls coordinator in Bromley with a remit to coordinate across care sectors.

(vi) It is unclear what measures are in place to track specific outcomes (e.g. follow-up falls incidence)

Chapter four: Care homes and wider workforce development and collaboration

Introduction

Discussions around case identification and referrals are also very close to questions around workforce development and practitioner awareness about fall risk and prevention services available in the borough. Chapter four therefore builds on from the analysis in Chapter three, with a particular emphasis on the role of care homes.

Bromley Care Homes and their role around falls prevention

This section first describes the Bromley care home population and then analyses data on the number of falls in the care home setting, with reference to current strategic initiatives taking place across Bromley's care home sector.

a) Bromley's care home population

A care home has been defined as a residential setting where older people live, usually in single rooms, have access to on-site care services and where residents do not legally own or rent their homes. In Bromley there are also a number of sites offering Extra Care Housing. People who live in Extra Care Housing have their own self-contained homes, their own front doors and a legal right to occupy the property. However, this type of housing is designed with the needs of frailer older people in mind and with varying levels of care and support available on site.

There are 43 nursing, residential, mixed and Extra Care Housing care homes in Bromley with a total of 1,811 beds. Around 1 in 7 of people over 85 years of age live in a care home[xxv]. The 2015 Joint Strategic Needs Assessment (JSNA) describes the care home population, using searches of GP systems in 22 practices who act as Visiting Medical Officers (VMO) for care homes. Across the 22 practices, 1,110 patients resident in care homes and extra care housing were identified. Of these, 828 (74.6%) were female, and 740 (66.7%) were aged 85 years or over. The analysis noted that for Bromley the

proportion of women is similar to the national figure (73.5%), but the proportion over the age of 85 years is much higher than the national figure (59.1%), meaning that Bromley's care home population is likely to have higher levels of frailty than the national average. This will as a result lead to a higher number of falls, often signalling an undiagnosed medical condition which can be identified with appropriate assessment, as described in the NICE quality standards 86 statement 2 in terms of a multifactorial risk assessment for older people at risk of falling.

b) Prevalence of falls in a care home environment

LAS call out data to care homes in Bromley records illness type rather than whether a call out incident is specifically related to a fall. Call out data for care homes between April to November 2017 is provided in **Table 8**, with the categories highlighted which may indicate a fall. If all these incidents did relate to a fall, they total 266 out of 1,361 call outs, representing 19.5%. It is important to note that LAS data can be only used as a proxy indicator for falls as falls are often linked to other physical health and mental health issues, such as a urinary tract infection or dementia. However, research including the care home population shows that referrals to a falls prevention service for people who call an ambulance owing to a fall but are not admitted to hospital can reduce their longer-term fall rate and lead to improved clinical health compared to a control group which received standard medical and social care[xxvi]. This profiles a possible referral opportunity via the LAS.

In comparison to other boroughs, Bromley has the highest number of LAS incidents attended at care home locations (see **Table 9**). However, as described many of these calls out will not relate to falls. In addition, these are numbers rather than standardised rates which would take into account the differences in number of people living in care homes between London boroughs. For example, the Bexley care home population was estimated at 792 in 2013[xxvii] (compared to the Bromley estimate of 1,500 in 2015).

Table 8: Top 20 Illness types recorded for incidents attended at care home locations in NHS Bromley CCG: April to November 2017

	Illness type	Number
1.	Other medical conditions	215
2.	Generally unwell	164
3.	Head injury (minor)	138
4.	Pain - Other	125
5.	Sepsis	100
6.	Urological	95
7.	No injury or illness	90
8.	Dyspnoea	85
9.	Respiratory/ chest infection	71
10.	Pain - Chest	67
11.	Abdominal pains	56
12.	Minor cuts and bruising	53
13.	Fracture/ possible fracture	46
14.	Confusion/ distressed/ upset	45
15.	Vomiting	43
16	Pain - Back	38
17.	Stroke Fast Positive	31
18.	Collapse – reason unknown	31
19.	Minor injuries (other)	29
20.	Catheter problems	29

Source: LAS

Table 9: LAS incidents attended at Care Home Locations: April to November 2017

London borough	London borough rank	Incidents	Conveyed	Non-conveyed	Non-conveyed %
Bromley	1	1529	1263	266	15%
Bexley	8	1005	845	160	16%
Havering	2	1477	1294	183	12%
Croydon	4	1333	1124	29	16%

Source: LAS

From discussions with the Bromley local authority social care team in addition to the Clinical Commissioning Group it is Extra Care Nursing homes that tend to have the highest number of LAS call outs. The number of call outs for Extra Care Nursing homes for the period April 2017 to March 2018 is set out in **Table 10**. Approximate rates have been calculated for the ECN homes based on the number of people each resident setting can accommodate.

This allows for comparison across the different sites, although is a crude rate as is not adjusted for other confounding factors such as age of residents. Taking into account lack of adjustment, the highest rate for the 8 month data period is Apsley Court.

Table 10: Ranked Extra Care Nursing homes based on total incidents attended: April 2017 to March 2018 (8 months)

Location	No of incidents	No of residents (max)	Crude rate	Conveyed to hospital	% Non Conveyed
Regency Court	99	78	1.27	55	44%
Sutherland Court	98	59	1.66	72	27%
Crown Meadow Court	69	65	1.06	56	19%
Apsley Court	67	26	2.58	49	27%
Durham House	61	30	2.03	45	26%
Norton House	43	45	0.95	36	16%

In interview for this service review, a member of Bromley local authority noted that training did take place with Extra Care Nursing staff a couple of years ago around falls prevention, led by Bromley Healthcare. This seemed to be associated with a drop-in ambulance call outs. However this reduction has not been sustained or the training embedded, with challenges including a high turnover of staff. Interviews for this report also confirmed that equipment is in place in care homes and extra care scheme homes to provide assistance after falls to reduce the need for external assistance (such as camel and elk mangers).

As mentioned in Chapter one, Bromley CCG is leading a Care Home Programme Board to support an integrated approach to health and care. The aims of this programme board provide opportunities for falls prevention to be embedded in its work. Table 11 sets out an example of what this could look like:

Table 11: Terms of reference for Joint Programme Board Care Homes and how this could embed a falls prevention approach

Aims of Joint Programme Board Care Homes	What this looks like with regards to falls prevention
Integrated governance and oversight of the commissioning, procurement, quality assurance and delivery of care homes provision in Bromley between the partner agencies.	Falls prevention included as part of the quality framework for care homes. A performance dashboard established to highlight observed versus expected call out rates for care homes, taking into account case mix and population size variation. This could sit alongside the Enhanced Health in Care Homes benchmarking tool.
The integrated delivery of primary and community health and social care services within care homes, enabling people to be cared for within their home environment wherever possible, reducing the number of hospital admissions from care homes.	Falls prevention considered as part of the health and care offer package, including: - As part of the development and implementation of a model of integrated health and care services to support care homes based upon the Bromley MDT/ ICN model. - Reduction and/ or prevention of emergency hospital admissions. - The model of medicines management support for care homes
The provision of relevant and effective health & care training and development programmes within care homes to support best practise on a consistent basis	Evidence based falls training embedded across Bromley care homes, based on NICE quality standards and/ or published evidence. Awareness of pathways for patients at

	risk of falls, including referrals to the: - Proactive Care pathway - Bromley Falls and Fracture Prevention service

At the moment there is no evidence-based training for care home staff in terms of falls prevention. A research trial is taking place led by Nottingham University called **Falls in Care Homes (FinCH),** which is a multi-centre cluster Randomised Control Trial. The purpose of the trial is to determine the clinical and cost effectiveness of the Guide to Action (GtACH) process, a package of guidelines and training to reduce the number of falls in care homes compared to usual care. This is a three-year project which began in 2017 and is funded by the National Institute for Health Research.

In addition the Vanguard sites (defined as places trailing out new models of care) include Sutton Homes of Care, which has looked at ways to support a standardised response to falls in care homes. This includes use of:

- Fall pathway reference cards for Nursing Homes and Residential homes (http://www.suttonccg.nhs.uk/vanguard/Resources/Pages/default.aspx).
- Hospital discharge forms for care homes including routine assessment of falls.
- Posters and training films for staff[xxviii].

To note, the hospital discharge forms for care homes are already in use in Bromley via the Red Bag scheme.

The North East London Foundation Trust has also developed a 'Significant 7' training tool that focuses on identifying early signs of deterioration and taking action prior to requiring a hospital admission. Its use in the Thurrock Fellowship Project saw a reduction in falls by 17%[xxix].

Wider workforce development

Table 12 summarises opportunities to embed and extend falls awareness training to a wider workforce as identified through task and finish group

engagement. This will need further scoping in terms of cost, sustainability and monitoring outcomes as a result of the training. It may also require a discussion around how non-health professionals can refer or help refer clients to the BHC FFPS or other falls intervention services in an effective way. To note the Bromley CCG specification for the FFPS includes a commitment to "develop tools and training programmes for care homes on falls and fracture prevention, and work actively with other organisations in the provision of training."

Table 12: Opportunities to carry out falls awareness training

Voluntary sector staff	AgeUK has a staff team of 90 and is keen for them to be trained to support identification of older adults at risk of falls. From the training they would like to understand: - Routine questions to ask. - Key signs that a further falls risk assessment is required. - Information on how best to make that referral. This can also include Age UK staff providing Bromley Well services.
Social care staff	As mentioned in Chapter three, a number of different social care teams visit people over 65 years of age. Training could be delivered alongside voluntary sector staff.
Dementia hub	There is also an opportunity to support awareness and appropriate referral amongst healthcare staff through the Dementia hub. This is a one stop access to support for people diagnosed with dementia and their carers, working with Bromley and Lewisham Mind, Oxleas NHS Trust and Extra Care housing staff.

Prevention across the life course

The focus of the service review is the identification of people at risk of falling who are over 65 years of age. However, it is important to note that falls prevention work is important for people prior to entering this age bracket.

Two key health-related behaviours for healthy ageing are maintaining adequate nutrition and physical activity across all domains – aerobic, strength and balance[xxx]. Mytime Active works closely with Bromley Healthcare FFPS to support continuation of strength and balance class participation for the older age group, with its average age of attendance for these classes of around 70 years old. However it also offers strength and balance exercises on referral for other age groups, such as people requiring support following an operation.

From 40 years of age onwards adults start to lose muscle mass by 8%. Strength and balance training also has positive effects on risk factors for cardiovascular disorders, certain cancers, Type 2 diabetes and osteoporosis. These two messages could help younger age groups take up similar classes, promoted through routine health assessments. For example Mytime active Bromley is currently promoted through NHS Health Checks which are offered to all people over 40 years of age.

Key messages:

(i) Although the evidence base for the effectiveness of falls prevention initiatives in care homes is currently less robust than for other community-dwelling individuals, development of in-house strategies and access to a Falls and Fracture Prevention Service are clear priorities. Current local initiatives are a welcome development.

(ii) Non-identification of falling in the care home context as an underlying cause for any ambulance call-out is an inconsistency and probably inappropriate.

Chapter Five: Summary and recommendations

Introduction

This service review takes into account that organisations are working to a high capacity, with little resource to take on new responsibilities. Its recommendations therefore focus on working within systems already in place to strengthen falls prevention in the borough. Some of this may require additional resource, such as falls awareness training to a wider workforce. However if greater use is made of an evidence-based approach to falls prevention, this should result in costs savings to the health and social care sector and most importantly help provide a greater quality of life to those at risk.

Recommendations from the service review are set out below. The general recommendations summarise the big picture findings from the review, with some of these broken down into more detail within specific recommendations. Many of the recommendations were shaped though discussions with members of the Task and Finish group in terms of what more we can do to help prevent the occurrence of falls amongst the over 65 year age group in Bromley. In addition, a meeting took place on the 24 May 2018 to discuss recommendations of the report. To note leads for the recommendations are suggestions at this stage and have not been formally agreed with the wider group.

A. General Recommendations

(1) Given the strength of evidence and clarity of guidance for the provision of cost-effective Falls Prevention and Management services, a Bromley Joint Working Group should take forward the current review in line with current National Guidelines, in particular QS86 and CG161. Its cross-disciplinary membership, leadership, lines of accountability and seamless service strategy should encompass Primary, Secondary and Social Care. This approach is also endorsed by recommendations from the 2017 Royal College of Physicians Audit addressing inpatient falls[xxxi].

(2) Parallel initiatives, such as the Frailty and Pro-Active care pathways should not be seen as a substitute for a comprehensive, coordinated service focused definitively on Falls.

(3) Consideration should be given to ensuring the existence of a defined, accountable Falls Service Coordinator responsible for ensuring clear lines of access and referral across sectors (including the interfaces with Fracture Liaison and social care settings)

(4) Measures should be taken to address apparent referral, coordination and access anomalies currently identified. Access to the full range of diagnostic capability within Secondary care (focused in Medical Gerontology) should be seamless within the Falls Service. The documentation of a FALL as a reason for A&E attendance by those over 65 should be routine and constitute an automatic basis for referral to the Service. The same applies to ambulance call-outs not admitted, including those in care home settings.

(5) The Bromley Falls Service should continue to participate in the National data collection (e.g. the RCP Falls & Fragility Fractures Audit) and consideration should be given to enhancing follow-up local data collection (e.g.to include falls recurrence, hospital readmission) as an indicator of the Service's cost-effectiveness

B. Specific Recommendations

1. Improving data management and systems

The service review identified limitations on what is currently being captured on hospital referral forms to the BHC FFPS, leading to challenges in identifying potential secondary care variation in referral number. It also identified routine systems, such as the Bromley Council adult early intervention team, where questions on falls are not asked on initial contact with the service. In addition, there are challenges in understanding how to interpret proxy indicators for falls, such as LAS call outs, as the reported data is presented in absolute numbers rather than rates and does not state whether a call out is due to a fall when referring to call outs to GP or care home settings.

Recommendations:

Data capture and monitoring		
Timescale	**Actions:**	**Lead(s):**
Short term	Ensure secondary care referrals include information on the whereabouts in the hospital a referral is coming from, differentiating between inpatient, outpatient and specialty. This information to be recorded and monitored by Bromley Healthcare in terms of where regular referrals would be expected and where to target awareness campaigns/ training.	BHC working with the PRUH
Short term	For questions on falls to be asked and recorded by the LBB adult early intervention team, allowing monitoring and ensuring appropriate subsequent support takes place.	Social Care, Bromley Council
Short term	For LAS call outs to care homes to be calculated as rates to help analyse variation by care home and support any further investigation. To also enquire if 'falls' can be included as a category for call outs to care homes.	Bromley CCG
Short to longer term	BHC to share and/ or start collecting outcome data to help show the effectiveness of the FFPS in the borough.	BHC
Longer term	For referrals from A&E to BHC FFPS to be monitored from mid-2018 to identify any change in numbers following awareness raising measures with patients and staff, using baseline data provided in this report.	BHC/ Falls lead at the PRUH
Longer term	A Bromley borough falls dashboard to be developed to help standardize falls reporting and provide regular measurement reports to	Bromley CCG

	help identify areas of improvement and where further investigation is required.	

2. Share data to help identify a strategy to reduce falls in the borough in addition to maximising information about those at risk of falling

The data analysis included in this report suggests that there are an increasing number of older people falling in the borough (over 85 years plus). In addition, secondary care services are concerned about a patient cohort of frequent fallers who are also frail. Data sharing can help identify any common characteristics amongst this cohort and what other prevention strategies may be possible to take place, such as referring identified patients to the Proactive Care Pathway. Data sharing can also help ensure that those very visibly at risk of a fall or a recurrent fall are referred to the FFPS.

Recommendations:

Data sharing		
Timescale	**Actions**	**Owner**
Short term	The PRUH to share data on frequent attendees presenting at A&E with a fall (for example, via a query of how many patients seen in the past year experienced a previous fall in the past 6/12 months). Patient records can then be explored in partnership with primary care in terms of what prevention measures took place for these patients, for example timings of the last medication review, in addition to what further support can be provided.	PRUH, Bromley CCG
Short term	BHC and the PRUH to discuss sharing details of NOF patients and mechanisms to cross check against referral data to ensure no patients are missed who would benefit from this service.	BHC, PRUH

3. Increasing case identification and referrals to prevention services

This recommendation includes simple ways to encourage awareness of the FFPS amongst health care practitioners and patients at a secondary care level. It also considers ways to understand the variation in GP practice referral numbers to the FFPS.

Recommendations:

Increasing case identification and referrals		
Timescale	**Actions:**	**Lead(s):**
Short term	Reference to the Bromley FFPS included on the A&E routine risk assessment form to remind health practitioners of the prevention service.	PRUH
Short term	Bromley Healthcare (BHC) marketing materials for the FFPS to be displayed in the 'fit to sit' area of A&E to increase awareness of the service amongst patients and their relatives/ friends.	PRUH
Short term	Visible items (such as yellow grip socks) to be sourced for A&E to help identify patients at risk of falls and help promote general awareness of falls amongst health practitioners, including the mandatory requirement to complete risk assessment forms and how referrals can be made to the BHC service.	PRUH
Short term	Bromley CCG to explore with Primary Care partners/ GP practices reasons for referral variation amongst practices.	Bromley CCG
Short term	Bromley CCG to agree with Bromley Healthcare ways to build awareness of the FFPS and encouragement of use of routine assessments to ask questions	Bromley CCG/ GP practices

	about falls within GP practices.	
Longer term	Carry out an audit across a sample of GP practices in the borough to see if routine questions on falls are taking place with patients over 65 years old on a regular basis.	Bromley CCG/ Bromley public health team

4. Workforce development

It appears from the service review that existing opportunities could be better utilised to identify people at risk of falling and requiring further assessment. This is likely to involve training a wider workforce in case identification.. Workforce development also looks at what good practise can be put into place in both the short and longer time period in terms of training the care home workforce.

Recommendations:

Data sharing		
Timescale	**Actions**	**Lead(s)**
Short term	For training to take place with the OT team and other relevant areas of the LBB social care workforce to help with asking people about falls as part of assessments and reviews.	LBB social care/ Bromley Healthcare
Short term	For training to take place with Age UK with regards to identification of people at risk of falls and the next steps to take in terms of referral for further risk assessment.	Bromley Healthcare/ Age UK
Short term	Identify what processes and tools are in place in neighbouring boroughs/ vanguard sites to support a standard approach amongst care home staff in terms of falls prevention and intervention and when to call an ambulance.	Bromley CCG

Short term	Within the Care Home Programme, identify the most efficient means of embedding awareness raising and training on falls prevention amongst care home workers and for staff working in Extra Care Housing.	Bromley CCG
Longer term	Identify learning from the Nottingham research trial in terms of training for care home staff re falls prevention and look at piloting this in Bromley.	Bromley CCG

5. Collaboration across services

Collaborating across services is both efficient in terms of supporting standard and evidence based approaches to care in addition to avoiding potential duplication of services. In addition, working across services helps a wider group of practitioners understand what prevention initiatives are currently in place.

Recommendations:

Data sharing		
Timescale	**Actions:**	**Lead(s)**
Short term	The identification and agreement of a "core" diagnostic and multifactorial assessment/ intervention protocol for use in all Clinical Gerontology (CG) clinics to support their accessibility as a first-line referral for those identified at most risk of falling.	PRUH
Short term	A falls procedure is developed for the Bromley Occupational Therapists team as a way to standardise practise.	LBB social care
Short term	Ensure there is a common understanding and approach for services that help identify and provide interventions for	LBB occupational therapist team, Bromley

	hazards in the home.	Healthcare, the Bromley Well Handyman service
Short term	Initiate arrangements with the London Ambulance Service to refer call-outs for falls not admitted to the hospital for subsequent FFPS referral.	Bromley CCG, London Ambulance Service, Bromley Healthcare
Short term	Look into current processes for referring to the Bromley FFPS and whether this can be extended to include trained non-health and social care practitioners (for example, see the basic falls assessment form used by the Southwark and Lambeth Integrated Care Pathway for Older People with Falls http://www.slips-online.co.uk/forms/index.aspx)	Bromley Healthcare, Bromley CCG
Short term	Bromley CCG to support secondary care colleagues to understand what type of criteria can be used to identify patients suitable for the Proactive care pathway, and then for this to be subsequently flagged up by secondary care colleagues in discharge notes.	Bromley CCG, PRUH
Short term	Bromley CCG to share with secondary care colleagues what current plans are in place to reduce infection related hospital admissions such as UTIs.	Bromley CCG, PRUH

Next steps

The content of this report has been agreed with Task and Finish group members. In addition it was agreed at a meeting in May with members of the group that the next steps for taking this work forward include:

a) Agreement and discussion of the report at the Bromley Health and Well-being Board in July 2018.

b) That the report is then presented to the Integrated Commissioning Board, with a proposal of a Bromley Joint working group to take the recommendations forward within a specified timescale. This will also include a prioritisation process of which recommendations to take forward over the next 12 months.

Appendix A: Task and Finish Group membership

Strategic group

Key role: Review evidence from the evaluation and agree any additional actions required to help meet current guidance. This includes agreeing final recommendations for the report.

Membership:

Professor Cameron Swift (Chair)

Dr Nada Lemic, Director of Public Health, Bromley Council

Dr Ruchira Paranjape, Principal Clinical Director, Bromley Clinical Commissioning Group

Dr Aza Abdulla, Consultant Physician, Princess Royal University Hospital

Sonia Colwill, Director of Quality, Governance and Patient Safety, Bromley Clinical Commissioning Group

Graham MacKenzie, Director of Integration and Transformation, Bromley Clinical Commissioning Group

Operational group

Key role: Help draw together the final report including input into the report recommendations to put forward to the strategic group. This includes discussing best approaches for collaborative working.

Membership:

Katherine Rowland, Falls Coordinator, Bromley Healthcare

Leah Bancroft, Senior Occupational Therapist, Bromley Council

Wendy Norman, Head of Contract Compliance and Monitoring, Bromley Council

Katherine Gausden, Lead Falls Practitioner, PRUH and Orpington Hospital

Dr Adenike Dare, Consultant Physician and Clinical Gerontologist

Joint Lead for Frailty, Orpington Hospital and PRUH

Debbie Hutchinson, Director of Nursing, Kings College Hospital

Jenni Gilbert, Quality Manager, Bromley CCG

Daniel Knight, Interim Programme Manager, Bromley Joint Care Homes Programme, Bromley Clinical Commissioning Group

Appendix B: Example of proforma to support stakeholder engagement

Falls prevention engagement framework: Secondary care

Quality statement 1: Identifying people at risk of falling

Older people are asked about falls when they have routine assessments and reviews with health and social care practitioners, and if they present at hospital.

How do health practitioners in your setting identify people at risk of falling?	
What local arrangements are in place to support this?	
Can you identify the proportion of older people asked about falls during routine assessments when they present at hospital that does not involve an overnight stay (day case admissions, outpatient attendances and A&E attendances)? This can be based on local data collection based on reviews of individual care records.	
Any other comments based on this quality statement.	

Quality statement 2: Multifactorial risk assessment for older people at risk of falling

Older people at risk of falling are offered a multifactorial falls risk assessment.

What local arrangements are in place to ensure that older people at risk of falling are referred to healthcare professionals with skills and experience in carrying out multifactorial falls risk assessment?	

What local arrangements are in place to ensure that a multifactorial assessment comprises multiple components to identify individual risks of falling?	
What arrangements are in place for access to a specialist falls service?	
What arrangements are in place to ensure that all hospital staff are aware of how to refer patients for specialist assessment?	
Any other comments based on this quality statement.	

Quality statement 3: Multifactorial intervention

Older people assessed as being at increased risk of falling have an individualised multifactorial intervention.

What local arrangements are in place to ensure that older people assessed as being at increased risk of falling have an individualised multifactorial intervention?	
How are identified interventions to address an older person's specific risk factors: a) Discussed with the patient b) Shared with relevant health professionals to support delivery of a multifactorial intervention c) Recorded in the patient's record.	

Appendix C: Community falls prevention services in Bromley

Information for this section is gathered from Bromley Council's Mylifeportal: (https://bromley.mylifeportal.co.uk/falls.aspx), the Bromley CCG website and the Bromley CCG specification for the Falls and Fracture Prevention Service.

Service	Description
Bromley Healthcare Falls and Fracture Prevention Service (FFPS)	Run by Bromley Healthcare and can be referred into by health and social care professionals. It provides support for people who have fallen or are identified at risk of falling, involving a risk assessment and multifactorial care plan. Clinics operate across the borough and assessment can take place in a person's home if required. A Fracture Liaison Nurse (FLN) is part of the Falls and Fracture Service. This service work closely with care homes and the local secondary care service to identify patients who are at risk of falls or who have had a fall and can be managed in the community. The FLN completes bone health assessments and case-finding in the hospital fracture clinic, and is part of the service maintaining strong links with the acute services. This will include meetings with the Princess Royal University Hospital (PRUH) Fall Co-ordinator, quarterly Falls and Bone Health meetings, and working with the Emergency Department and Urgent Care. This service is commissioned by Bromley CCG using the following standards and guidelines: NICE CG161, NICE QS86, National Service Framework for Older People (DH), Falls and Fractures: Effective interventions ion Health and Social Care (DH, 2009), in addition to guidelines from Age UK and the British Geriatric Society.
Frailty pathway	Introduced in Jan 2017 by the CCG as part of its Integrated Care Networks (ICN). It includes a 38 bed facility at Orpington hospital, with input from medical, nursing, therapy and social staff and voluntary services. The unit helps prepare patients to leave hospital and move back to independent living.
The Proactive Care Pathway	Began in October 2016 by the CCG as part of its Integrated Care Networks (ICN). Patients are identified on a monthly if a GP feels they need more preventative help. Trigger signs may include deteriorating nutrition, mental health needs and/ or a

	recent history of falls. The electronic frailty index (eFI) aids in the identification of patients with frailty for presentation to the Integrated Care Networks (ICN). A community matron assesses the patient (including for fall risk) then develops a care plan, discussed at a Multidisciplinary Team meeting (MDTs). The Pathway includes a Memorandum of Understanding between secondary care, primary care and voluntary sector services and is being evaluated by the Health Innovation Network.
Bromley Council Community Occupational Therapy Service	Referral to this service takes place through the adult early intervention centre. The Occupational Therapy team will undertake a falls assessment and can provide advice, low cost equipment and can refer for more intensive support if required (such as to the Bromley Falls and Fracture Prevention Service).
Lewis House (run by X and X)	A home adaptations service. Clients are able to drop into Lewis House to look at the equipment which is there and X by X can provide advice however there is no OT based at Lewis House. However X by X can recommend a client to refer to the LBB OT team for further assessment at their home.
Mytime Active	Offers strength and stability sessions which can provide ongoing support once a client has completed a 12 weeks strength and balance programme via Bromley Healthcare FFPS.

Appendix D: Bromley fall incident LAS call outs Ward alongside the proportion of older people in the ward (75+) and Index of Multiple Deprivation (IMD) rating

Ward	Incident number	% older population (75+) (2017)	Ward rank	IMD 2015 (mean)	Ward rank2
Orpington	1547	11.4	20	12.8	15
Bromley Town	1476	6.4	5	9.1	13
Farnborough and Clifton	1340	13	22	6.2	6
Bickley	1330	10.9	19	6.6	7
Chislehurst	1304	11.8	21	7.1	8
Bromley Common and Keston	1265	7.4	10	13.3	16
Cray Valley East	1197	7.3	9	20.9	19
Kelsey & Eden Park	1156	9	11	7.3	10
Copers Cope	1119	8.5	11	8.9	12
West Wickham	1042	10.6	18	5	6.8
Cray Valley West	1035	7.2	8	22	21
Chelsfield & Pratts Bottom	959	8.9	13	6.2	5
Plaistow & Sundridge	918	7.2	7	13.6	17
Clockhouse	880	5.7	3	10.3	14
Hayes and Coney Hall	869	8.5	12	5.1	3
Penge & Cator	865	4.4	2	19.2	18
Petts Wood & Knoll	812	10.2	16	4.3	1
Crystal Palace	733	3.4	1	21.1	20
Mottingham & Chislehurst North	641	6.2	4	23.9	22
Shortlands	630	10.2	17	5.2	4
Biggen Hill	442	6.5	6	7.9	11
Darwin	402	9.4	15	7.2	9

Appendix E: Analysis of referral numbers to the Bromley Falls and Fracture Prevention Service by GP practice, January 2014 to January 2018

Referring GP Practice	No referrals Jan14 to Jan18	% of referrals	Patients aged over 65 years (%) (2017)	Patients aged over 75 years (%) (2017)	Patients aged over 85 years (%) (2017)	Nursing home patients % (2014/15)	Osteoporosis: QOF prevalence (50+) (2016/17)
CHARTERHOUSE SURGERY	202	7.50	24.2	11.5	3.6	0	0.1
CHISLEHURST MEDICAL PRACTICE	176	6.50%	21.3	10.9	3.5	0.8	0.3
SUMMERCROFT SURGERY	129	4.80%	24	12.4	4.2	0	0.2
BROOMWOOD ROAD SURGERY	121	4.50%	15.1	7.3	2	0	0.6
ELM HOUSE SURGERY	120	4.40%	14.4	6.6	2.1	0.1	0.1
KNOLL MEDICAL PRACTICE	112	4.10%	21.8	11.5	4.1	0.8	0.1
LONDON LANE CLINIC	105	3.90%	17.3	7.9	2.6	0.5	0.1
WOODLANDS MEDICAL PRACTICE	99	3.70%	13.5	6	1.7	0	0.3
POVEREST MEDICAL CENTRE	97	3.60%	15.4	7.3	2.1	0.4	0.2
SOUTH VIEW PARTNERSHIP	96	3.60%	15.9	7.1	2.2	0.8	0.2
SOUTHBOROUGH LANE SURGERY	91	3.40%	20.4	10.4	4	0.7	0.1
STATION ROAD SURGERY	91	3.40%	21.6	10.5	3.8	0.5	0.2
ADDINGTON ROAD SURGERY	86	3.20%	20.5	9.5	2.9	0	0.1
CORNERWAYS SURGERY	84	3.10%	22.4	11	3.8	0	0.7
DERRY DOWNS SURGERY	79	2.90%	20.8	10.3	2.7	0	0.1
WICKHAM PARK SURGERY	72	2.70%	19.2	9.2	3.5	0.1	0.3
BALLATER SURGERY	67	2.50%	15.8	7.3	2.5	0.1	0.2
DYSART SURGERY	67	2.50%	14.6	7	2.3	0	0.3
STOCK HILL MEDICAL CENTRE	62	2.30%	24	10.1	2.6	0	0.4
LINKS MEDICAL PRACTICE	61	2.30%	13.6	6.3	2.3	1.1	0.1
ST JAMES' PRACTICE	60	2.20%	20.4	10.3	3.2	0	0.6
BROMLEY COMMON PRACTICE	59	2.20%	14.5	7.2	2.1	0	0.9
CHELSFIELD SURGERY	49	1.80%	20.6	9.2	2.5	0	0.3
BANK HOUSE SURGERY	47	1.70%	24.7	10.9	3.3	0.3	0.3
FORGE CLOSE SURGERY	45	1.70%	17.8	8.3	2.8	0	0.6

Referring GP Practice	No referrals Jan14 to Jan18	% of referrals	Patients aged over 65 years (%) (2017)	Patients aged over 75 years (%) (2017)	Patients aged over 85 years (%) (2017)	Nursing home patients % (2014/15)	Osteoporosis: QOF prevalence (50+) (2016/17)
PICKHURST SURGERY	44	1.60%	21.4	9.2	3.1	1	0.2
ROBIN HOOD SURGERY	44	1.60%	15.7	7	2.2	0	0.1
CATOR MEDICAL CENTRE	36	1.30%	5.2	2	0.5	0	0.2
TUDOR WAY SURGERY	35	1.30%	18.8	8.8	2.9	0	0.5
EDEN PARK SURGERY	27	1.00%	15.7	7.1	2.5	0.3	0.1
GREEN STREET GREEN MED CT	25	0.90%	19.9	8.3	2.2	0	0.1
PARK GROUP PRACTICE	25	0.90%	7.6	2.8	0.7	0.1	0.5
CRESCENT SURGERY	19	0.70%	18.8	7.6	2	0	0.3
HIGHLAND MEDICAL PRACTICE	19	0.70%	17.2	9	3.1	0.3	0.3
TRINITY MEDICAL CENTRE	19	0.70%	13.2	6.6	2.3	0.8	0.2
WHITEHOUSE SURGERY	19	0.70%	18.2	9.3	2.4	0	0.5
MANOR ROAD SURGERY	15	0.60%	19.4	8.8	3.4	0.8	0
NORHEADS LANE SURGERY	15	0.60%	15.3	3.9	0.7	0.2	0.5
ST MARY CRAY PRACTICE	13	0.50%	17.4	8.8	3.4	0	0.2
SUNDRIDGE MEDICAL CENTRE	12	0.40%	12.3	6.2	2.7	1.5	0.2
FAMILY SURGERY	11	0.40%	24.9	13.1	4	0	0.3
GILLMANS ROAD SURGERY	11	0.40%	9.8	4.5	1.1	0	0.9
OAKFIELD SURGERY	3	0.10%	5.9	3.1	1.4	2.3	0.4
ANERLEY SURGERY	2	0.10%	10.9	4.8	1.3	0.1	0.1
CROSS HALL SURGERY	1	0.00%	9.7	4.5	1.1	0	0.3

Appendix F: Ranked Other Care Homes (excluding Extra Care Housing) LAS total incidents attended: April 2017 to November 2017 (8 months)

Rank	Location	Incidents	Conveyed	Non Conveyed
1	Lauriston House	139	128	8%
2	Foxbridge House	62	57	8%
3	Prince George Duke of Kent Court	59	48	19%
4	Elmstead Residential Home	57	53	7%
5	Archers Point Residential Home	37	34	8%
6	Mission Care	36	33	8%
6	Oatlands Care Limited	36	32	11%
8	Greenhill	35	33	6%
8	Fairmount Residential Care Home	35	28	20%
10	Ashglade	33	30	9%
11	The Sloane Nursing Home	32	27	16%
12	Coloma Court Care Home	31	23	26%
12	Bromley Park Dementia Nursing Home	31	22	29%
14	Eversleigh Residential Care Home	30	25	17%
14	Glebe Court Nursing Home	30	26	13%
16	Jansondean Nursing Home	28	24	14%
16	Queen Elizabeth House	28	26	7%
18	Burrows House	25	21	16%
19	Florence Nursing Home	24	21	13%
20	Antokol	22	19	14%
21	Beechmore Court	19	17	11%
22	Ashcroft - Bromley	15	14	7%
22	Nettlestead Care Home	15	14	7%
24	Ashling Lodge	14	12	14%
24	Fairlight & Fallowfield	14	14	0%
26	Clairleigh Nursing Home	13	13	0%
27	Park Avenue Care Centre	12	8	33%
27	Whiteoak Court Nursing Home	12	11	8%
29	Burrell Mead	11	9	18%
29	Sundridge Court Nursing Home	11	11	0%
31	Community Options Limited - 78 Croydon Road	9	6	33%
32	Willett House	8	5	38%
32	Rowena House Limited	8	8	0%
32	Community Options Limited - 56 High Street	8	4	50%
35	Tanglewood	7	7	0%
35	The Heathers Residential Care Home	7	6	14%
37	Community Options Limited - 33 Albemarle Road	6	3	50%
38	St Blaise	5	4	20%
38	Elmwood	5	4	20%
38	Benedict House Nursing Home	5	4	20%
38	118 Widmore Road	5	4	20%

40	Heatherwood	4	2	50%
40	Rosecroft Residential Care Home	4	4	0%
40	Angelina Care	3	3	0%
40	The Old Manse	3	2	33%
40	Blyth House	3	3	0%
40	Woodham House Newlands	2	2	0%
40	Avenues South East - 54 Cowden Road	1	1	0%

[i] Population data from 2011 Census published at: https://www.ageuk.org.uk/london/about/media-centre/facts-figures/ (accessed 13 May 2018)

[ii] Population aged 65 and over projected to 2035, POPPI, last accessed September 11, 2017, www.poppi.org.uk version 10.0

[iii] Gillespie LD, Robertson M, Gillespie WJ, Sherrington C, Gates S, Clemson LM, Lamb SE. (2012) Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews, Issue 9. Art. No.: CD007146. DOI: 10.1002/14651858.CD007146.pub3

[iv] Public Health England (2017) Falls and fracture consensus statement: Supporting commissioning for prevention (web) https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/03/falls-fracture.pdf

[v] Skelton, DA. 2007, *Exercise and falls prevention in older people,* volume 9(1):CME Geriatric Medicine, pp. 16-21. Accessed at: http://www.laterlifetraining.co.uk/wp-content/uploads/2011/12/ExFallsPreventOlderPeopleCME.pdf

[vi] National Institute for Health & Care Excellence (NICE) (2013) *Costing statement. Falls: assessment and prevention of falls in older people. Clinical Guideline 161.* s.l. : National Institute for Health & Care Excellence (NICE)

[vii] National Institute for Health & Care Excellence (NICE) (2015). *Falls in older people. Quality Standard 86.* s.l. : National Institute for Health & Care Excellence (NICE)

[viii] National Institute for Health & Care Excellence (NICE) (2013) *Costing statement. Falls: assessment and prevention of falls in older people. Clinical Guideline 161.* s.l. : National Institute for Health & Care Excellence (NICE)

[ix] National Institute for Health and Clinical Excellence (2017) The management of hip fracture in adults. Available at: https://www.nice.org.uk/guidance/cg124/evidence/full-guideline-183081997

[x] Public Health England Fingertips Older People's Health and Wellbeing (web) Available at: https://fingertips.phe.org.uk/profile/older-people-health/data#page/6/gid/1938133101/pat/6/par/E12000007/ati/102/are/E09000006/iid/41401/age/27/sex/4/nn/nn-1-E09000006 (accessed on 5 June 218)

[xi] Public Health England (2017) *Falls and fractures: Resource pack.* London : Public Health England. Web: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628732/Falls_and_fracture_consensus_statement_resource_pack.pdf

[xii] Public Health England (2017) *Falls and fractures: Resource pack.* London : Public Health England. Web: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628732/Falls_and_fracture_consensus_statement_resource_pack.pdf

[xiii] Public Health England. (2017)*Falls and fractures: Resource pack.* London : Public Health England. Web: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628732/Falls_and_fracture_consensus_statement_resource_pack.pdf

[xiv] —. Falls - risk assessment. NICE Clinical Knowledge Summary. [Online] January 2014. [Cited: 8 February 2018.] https://cks.nice.org.uk/falls-risk-assessment#!scenario

[xv] Davison, J, Bond, J, Dawson, P, Steen, N, Kenny, R (2005) Patients with recurrent falls attending Accident & Emergency benefit from multifactorial intervention – a randomised controlled trial. *Age and Ageing*. Vol. 34, pp162-168

[xvi] Close, J, Ellis, M, Hooper, R, Glucksman, E, Jackson, S, Swift, C (1999) Prevention of falls in the elderly trial (PROFET): a randomised controlled trial. The Lancet. Volume 353, Issue 9147, pp93-97

[xvii] Gillespie LD, Robertson M, Gillespie WJ, Sherrington C, Gates S, Clemson LM, Lamb SE. (2012) Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews, Issue 9. Art. No.: CD007146. DOI: 10.1002/14651858.CD007146.pub3

[xviii] National Institute for Health & Care Excellence (NICE) (2013) *Costing statement. Falls: assessment and prevention of falls in older people. Clinical Guideline 161.* s.l. : National Institute for Health & Care Excellence (NICE)

[xix] Public Health England. (2017)*Falls and fractures: Resource pack.* London : Public Health England. Web: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628732/Falls_and_fracture_consensus_statement_resource_pack.pdf

[xx] —. Falls - risk assessment. NICE Clinical Knowledge Summary. [Online] January 2014. [Cited: 8 February 2018.] https://cks.nice.org.uk/falls-risk-assessment#!scenario

[xxi] Information from Bromley Falls Service: Information for professionals (Bromley Healthcare) web: http://www.bromleyhealthcare.org.uk/wp-content/uploads/2015/02/bromley-falls-service-for-professionals-final.pdf (accessed 15 May 2018)

[xxii] See Bromley Healthcare Falls and Fracture Prevention Service website for Falls Referral form: https://www.bromleyhealthcare.org.uk/explore-our-services/falls-fracture-prevention/ (accessed 15 May 2018)

[xxiii] National Institute for Health & Care Excellence (NICE) (2011, last updated 2017) Hip fracture: management. National institute for Health and Care Excellence. Web: https://www.nice.org.uk/guidance/cg124 (accessed 15 May 2018)

[xxiv] Age UK. Don't mention the F-Word: advice to practitioners on communicating messages to older people [Internet]; 2012 [cited 2018 Jan 03]. Available from: www.ageuk.org.uk/professional-resources-home/servicesand-practice/health-and-wellbeing/falls-prevention-resources/

[xxv] Data taken from Joint Care Homes Programme slides 'Health and Care Offer – Workshop 1' presented by LBB and Bromley CCG on 3 May 2018.

[xxvi] Logan Philippa A, Coupland C A C, Gladman J R F, Sahota O, Stoner-Hobbs V, Robertson K et al. Community falls prevention for people who call an emergency ambulance after a fall: randomised controlled trial BMJ 2010; 340 :c2102

[xxvii]Bexley Council Joint Strategic Needs Assessment (2014) Web: http://www.bexley.gov.uk/sites/bexley-cms/files/Joint-Strategic-Needs-Assessment-2014.pdf (accessed 4 May 2018)

[xxviii] Vanguard: Sutton Homes of Care resources: web http://www.suttonccg.nhs.uk/vanguard/our-journey/PublishingImages/Pages/Case-studies/Case%20Study%20-%20Training%20and%20education%20resources%20-%20Sutton%20Homes%20of%20Care%20Vanguard_Final%20Mar17.pdf (accessed 15 May 2018)

[xxix] Taken from a slide set provided by the Bromley CCG Care Home Programme Board, slides produced by NELFT and Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

[xxx] Public Health England (2017) Falls and fracture consensus statement: Supporting commissioning for prevention (web) https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/03/falls-fracture.pdf

[xxxi] Royal College of Physicians (2017) *National Audit of Inpatient Falls* [report] Available at: https://www.rcplondon.ac.uk/projects/outputs/naif-audit-report-2017 (accessed 12 June 2018)

Report No.
CSD18160

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**Thursday 19th July 2018**
Title:	**CHILDREN'S JOINT STRATEGIC NEEDS ASSESSMENT**
Contact Officer:	Dr Jenny Selway, Consultant (Public Health) Tel: 020 8313 4769 E-mail: jenny.selway@bromley.gov.uk
Ward:	Borough-wide

1. Summary

1.1 Joint Strategic Needs Assessment (JSNA) has been a statutory requirement of local authorities and NHS primary care trusts since 1 April 2008. The Health and Social Care Act (2012) placed a revised duty on each upper tier local authority and CCG to prepare JSNA together through the health and wellbeing board.

1.2 The aim of the JSNA is to deliver an understanding of the current and future health and wellbeing needs of the population over both the short term (three to five years) and the longer term (five to ten years). It is intended to be the key mechanism for setting strategic priorities and informing local commissioning across health and social care. The Health and Social Care Act (2012) placed a statutory duty on both upper tier local authorities and CCGs to commission with regard to the JSNA and to refer to it in the development of the local Joint Health and Wellbeing Strategy.

1.3 The JSNA is an evidence based document highlighting need, as such it is distinct from the Health and Wellbeing Strategy which it informs.

1.4 The Bromley JSNA is updated annually and includes the health and wellbeing of children and young people. The first separate report on the Child Wellbeing Needs Assessment was published in September 2016. This Children's JSNA is an update of that paper. It covers social and educational factors as well as health needs.

1.5 It is proposed that the findings of this Children's JSNA feed into the new Joint Health and Wellbeing Strategy in 2018.

2. Reason for Report going to Health and Wellbeing Board

2.1 The Health and Social Care Bill (2012) placed a revised duty on each upper tier local authority and CCG to prepare JSNA together through the health and wellbeing board.

2.2 This report asks the HWB to approve the report of the Bromley Children's JSNA 2018.

3. SPECIFIC ACTION REQUIRED BY HEALTH AND WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

3.1 The Health and Wellbeing Board is asked to:

- Approve the Bromley Children's JSNA 2018; and,
- Consider the proposal to feed these findings into a new Joint Health and Wellbeing Strategy in 2018

Health & Wellbeing Strategy

The Children's JSNA is an evidence-based document, intended to inform the development of the Joint Health and Wellbeing Strategy. The Joint Health and Wellbeing Strategy outlines the priorities, identified in the JSNA and agreed by the HWB, together with the proposed actions and expected outcomes.

Financial

1. Cost of proposal: No Cost:

2. Ongoing costs: No Cost:

3. Total savings: Not Applicable:

4. Budget host organisation: Not Applicable

5. Source of funding: Not Applicable

6. Beneficiary/beneficiaries of any savings: Not Applicable

Supporting Public Health Outcome Indicator(s)

The JSNA provides evidence of the level of health need in the population. This includes reference to some of the National Public Health Outcome Indicators as well as other indicators of local health outcomes.

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4. COMMENTARY

4.1 Whilst the Public Health Team within LB Bromley have the lead responsibility for producing the Children's JSNA, a data working group has been established with representatives from:

- Performance and Information, Education, Care & Health Services, LBB
- Data Analysts, Bromley CCG
- SEN lead, Bromley CCG
- Children's Safeguarding

4.2 This working group have been able to review and comment on the draft report.

4.3 This Children's JSNA is an update of a Child Wellbeing Needs Assessment published in September 2016. It follows the same structure as the first report:

- Section 1: Demography
- Section 2: Risk Factors
- Section 3: Emerging Needs
- Section 4: Established Needs

4.4 Section 1 of this report will describe the population of children and young people aged 0-18 in Bromley. This report will then describe how prevention could affect the wellbeing of children and young people in Bromley. Prevention can be primary, secondary or tertiary.

4.5 Primary prevention aims to prevent a problem before it occurs by identifying families within the population who are more likely to suffer poor outcomes for their children. Section 2 uses evidence to identify risk factors in families in Bromley.

4.6 Secondary prevention aims to identify a potential or emerging problem in a child or young person at an early stage in order to minimise the impact of that problem. Section 3 reviews what we know about emerging health, education and social care needs of children and young people in Bromley. Children with emerging needs include those receiving support from Children and Family Centres or those identified as having Special Educational Needs but who do not have an EHC Plan.

4.7 Tertiary prevention aims to minimise the impact of a known need. Section 4 reviews information about children and young people with established needs, including those with an Individual Health Care Plan in school, those children with EHC Plans, and Looked After Children and those on a Child Protection Plan.

4.8 A key finding of the Children's JSNA is that the rate of substance misuse amoung young people in Bromley appears to be very high. Limited data shows that there appears to be a mismatch between the perception of youth violence in Bromley as low and the available evidence which appears to suggest this is a problem for young people in Bromley.

4.9 The Children's JSNA is being discussed at the following groups:

- Portfolio Holder for Adult, Care and Health services
- Portfolio Holder for Education, Children and Families
- Bromley Safeguardiong Children Board
- Secondary Head Teachers
- Primary Head Teachers
- Safer Bromley Partnership

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 The Children's JSNA 2018 includes information on a number of vulnerable populations of children and young people in Bromley.

6. LEGAL IMPLICATIONS

6.1 There has been a statutory requirement to produce a JSNA since April 2008. The Health and Social Care Act (2012) placed a revised duty on each upper tier local authority and CCG to prepare JSNA together through the health and wellbeing board.

Non-Applicable Sections:	Financial Implications, Implications for other Governance Arrangements, Boards and Partnership Arrangements, including any Policy and Financial Changes Required to Process the Item, and Comment from the Director of Author Organisation
Background Documents: (Access via Contact Officer)	Children's JSNA 2018

Report No.
CS18161

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**Thursday 19th July 2018**
Title:	**EVALUATION OF THE COMMUNITY ALCOHOL PATHWAY PILOT PROGRAMME**
Contact Officer:	Mimi Morris-Cotterill, Assistant Director: Public Health, ECHS Tel: 020 8461 7779 E-mail: mimi.morris-cotterill@bromley.gov.uk
Ward:	Borough-wide

1. Summary

1.1 The Community Alcohol Pathway aims to address the increasing prevalence of harmful alcohol consumption in LBB, and improve on the low treatment rates for alcohol users. The pathway covers brief advice in Primary Care through to community treatment and acute interface via liaison with local hospitals.

1.2 Change Grow Live (CGL) (the current provider of substance misuse services for adults and young people) was awarded the contract to pilot the Community Alcohol Pathway in December 2017. The 5-month Pilot Programme commenced in January 2018 with evaluation being completed in June 2018.

1.3 The Community Alcohol Pathway Pilot was delivered from 3 GP surgeries – Broomwood Surgery, Elm House Surgery and Cator Medical Centre.

1.4 The findings from the evaluation will support the roll out of the Community Alcohol Pathway more widely throughout the borough. It has been included, to be mainstreamed, as part of the newly commissioned Adult Substance Misuse Service which will go live on 1/12/18.

2. Reason for Report going to Health and Wellbeing Board

2.1 This report outlines the key findings of the pilot and the steps for mainstreaming the Community Alcohol Pathway.

3. SPECIFIC ACTION REQUIRED BY HEALTH AND WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

3.1 The Health and Wellbeing Board is asked to:

1) Note the findings from the pilot evaluation; and,

2) Support and promote the Community Alcohol Pathway amongst partners.

Health & Wellbeing Strategy

1. Related priority: Safer Bromley and Healthy Bromley

Financial

1. Cost of proposal: Not Applicable

2. Ongoing costs: Not Applicable

3. Total savings: Not Applicable

4. Budget host organisation: Not Applicable

5. Source of funding: Not Applicable

6. Beneficiary/beneficiaries of any savings: Not Applicable

Supporting Public Health Outcome Indicator(s)

Public Health Outcomes Framework Indicator 2.15 iii: Successful completion of alcohol treatment

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4. COMMENTARY

4.1 INTRODUCTION

4.2 The Communtiy Alcohol Pathway was designed to address the increasing prevalence of harmful alcohol consumption in Bromley and improve and increase access for those who require support to treatment services. The pilot was designed to provide in-reach and proactive interventions in partnership with GP practices, in order to reduce demands on practices and provide preventative measures for alcohol related health concerns.

4.3 The pilot project centred around the delivery of a community alcohol pathway, which includes Extended Brief Intervention (EBI)[1] sessions within GP surgeries. The 3 surgeries that took part in the pilot were Broomwood Road Surgery, Elm House Surgery and Cator Medical Centre.

4.4 The 5-month Pilot Programme commenced in January 2018 with evaluation taking place during May 2018 and was delived by CGL, the existing substance misuse treatment service provider.

4.5 It was delivered as a partnership between the GP Practices and BDAS (Bromley Drug & Alcohol Service). Primary care staff were trained by BDAS to carry out the initial screening (Audit C) to determine levels of alcohol consumption in their patients who were then referred on to the BDAS worker on site for EBI sessions (3 – 6 sessions) plus referral on to other treatment interventions provided by BDAS and or signposting to other appropratie services in the community.

4.6 PREVALENCE DATA

4.7 The pilot was informed by the following data which demonstrated need for targeted interventions for those drinking at harmful and hazardous levels:

- **28%** of adults in Bromley drink at **no or low risk levels** (Audit Score 0-7).
- **56%** of adults in Bromley drink at **hazardous drinking levels** (Audit Score 8-15) i.e. drinking above safe levels with avoidance of alcohol related problems.
- **13%** of adults in Bromley drink at **harmful drinking levels** (Audit Score 16-19) i.e. drinking above safe levels with evidence of alcohol related problems.
- **4%** of adults in Bromley drink are **alcohol dependent** (Audit Score 20+). [2]

4.8 It was also informed by the acknowledgement that in terms of treatment at Bromley Drug & Alcohol Service (BDAS), attrition is highest among non-dependent alcohol users. During Quarters 1 and 2 of 2017/2018, there were 85 referrals from GPs to BDAS, of these 35 (41%) attended for an assessment and only 24 (28%) commenced treatment.

4.9 Feedback received from service users and GP's indicated that individuals were reluctant to attend treatment at the substance misuse service base because they perceive it as a 'drug' service and that outcomes for this group could be improved if interventions were delivered within general practices. Hence, the pilot was being conducted in GP surgeries.

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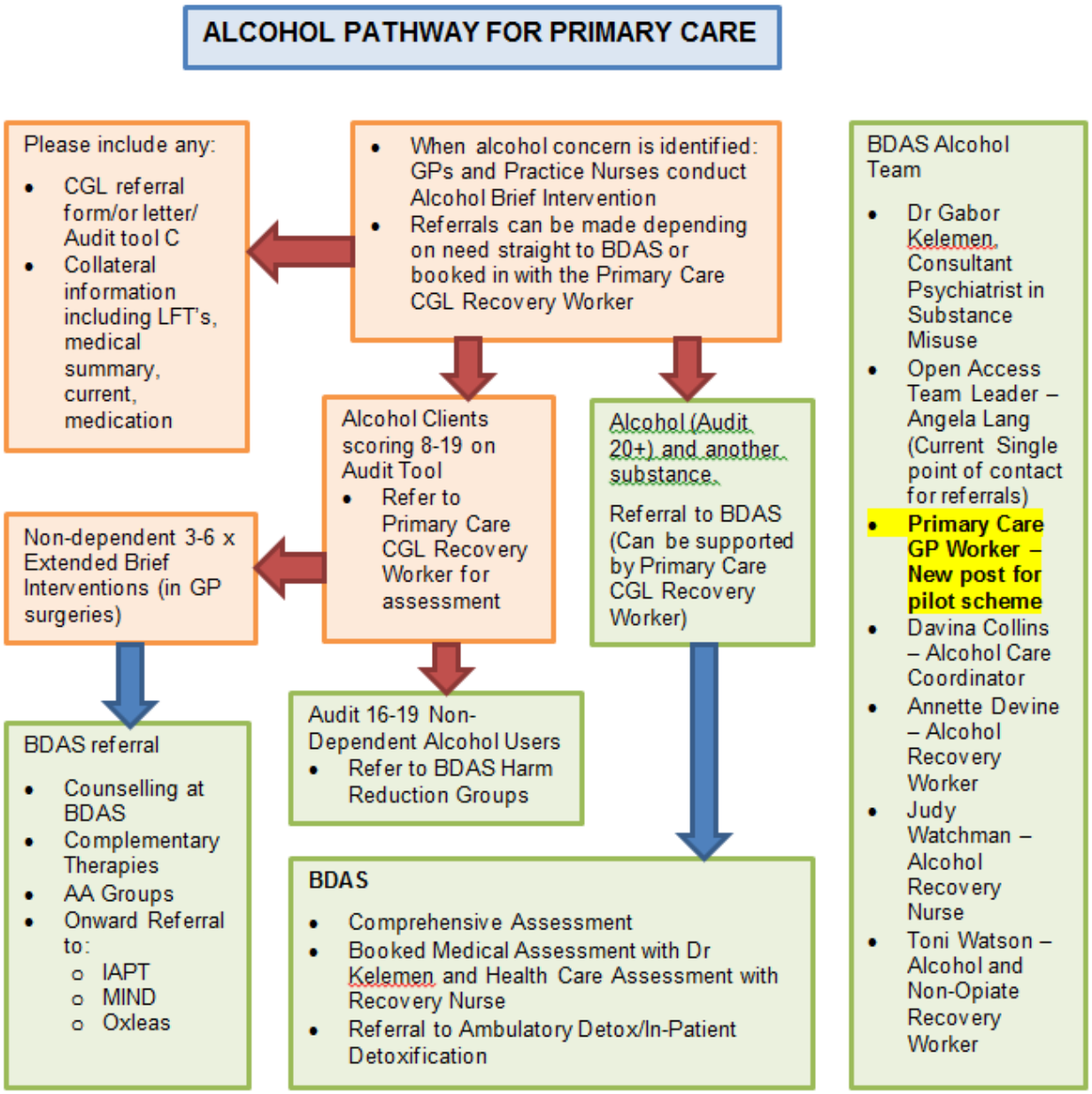
[1] IBA stands for 'Identification and Brief Advice', an alcohol brief intervention which typically involves: **Identification**: using a validated screening tool to identify 'risky' drinking, such as the AUDIT Tool C, **Brief Advice**: the delivery of short, structured 'brief advice' aimed at encouraging a risky drinker to reduce their consumption to lower risk levels

EBI: This is motivationally-based and can take the form of motivational-enhancement therapy or motivational interviewing. The aim is to motivate people to change their behaviour by exploring with them why they behave the way they do and identifying positive reasons for making change. In this guidance, all motivationally-based interventions are referred to as 'extended brief interventions'.

[2] **Source:** Bromley GP data 2016 (NB. Only 42% have recorded value in last three years).

4.10 THE COMMUNITY ACOHOL PATHWAY



4.11 SUMMARY OF FINDINGS

- 36 clients were referred – 20 men and 16 women with 89% being White British and 56% aged between 40 yrs – 59 years.
- Of the 36 clients: 3 declined treatment, 3 did not attend for arranged assessment appointments, 2 clients were referred for Cocaine treatment and 1 client has an assessment appointment booked. This currently gives a 75% engagement rate (27 out of 36 clients).
- The attrition rates amongst GP referrals were significantly reduced when compared with pre-pilot levels:
  - from referral to assessment (59% to 25%)and
  - from assessment to commencement of treatment (32% to 18%)
- Patient feedback at the surgery confirmed the strong preference to be seen at GP surgeries rather than being seen at a substance misuse service.
- Of those assessed, 48% (13 of 27) drank at harmful and hazardous levels, 11 of whom engaged with treatment, 9 (82%) have successfully completed and reduced their alcohol

consumption to within safe drinking levels – from an average audit score of 15.9 before intervention to an average audit score of 2.1.

- Of those assessed, 51% (14 of 27) drank at dependent levels and were referred for structured treatment at the substance misuse service. 11 out of 14 clients are still engaged in treatment at BDAS, either in Harm Reduction Groups (HRG) or Pre-Detox Groups (PDG).
- BDAS delivered brief intervention training to 20 members of staff across the 3 GP surgeries.
- All staff agreed that the training met objectives, increased their knowledge of how and when to refer patients for EBI sessions and for treatment at BDAS.

4.12 **LIMITATIONS**

- The training on Alcohol Brief Intervention (ABI) and how to refer clients to BDAS was positive and increased staff members' knowledge of who and when to refer clients for EBI sessions. However, this is not always reflected in the full alcohol audit scores conducted by CGL staff as 14 out of 27 clients scored above 20 during assessment and were subsequently referred to either the pre-detox sessions or Alcohol Harm Reduction Groups This may be due to ABI training not taking place until later in the pilot than originally intended.
- Training delivery and planning was delayed due to logistical factors for surgeries.
- Delays in the referral form being put on EMIS (GP IT system) impacted on analysing the completion of the Audit Tool C by surgery staff prior to referral to BDAS.
- There was limited opportunity to audit the referrals received, and identify the number of clients who self-referred.
- Systems and process around whether patients attended and treatment outcomes were not clearly defined. In one surgery the BDAS worker had access to EMIS and made entries and in the other 2 surgeries this was unclear.
- Due to the length of the pilot, it was not possible to identify the impact on the prevalence of harmful alcohol consumption in the borough – this would require examination over a longer timeframe and a larger sample.
- It was also not possible to assess whether the pilot reduced actual rather than perceived demands on primary care - again this would require more extensive evaluation.

4.13 **CONCLUSIONS**

- The Community Alcohol Pathway has been included in the specification for the new contract for Adult Substance Miisuse Service.
- The findings of the pilot will be taken into account when mobilising the new contract and will be a useful reference for informing the wider development of the Alcohol Pathway in LBB.
- The Community Alcohol Pathway will support improved treatment outcomes for problematic alcohol users and reduce alcohol related harm for the local community.
- The Community Alcohol Pathway will improve partnership working between primary care and the specialist substance misuse treatment service.

5 IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 The Community Alcohol Pathway enables early identification of vulnerable adults with alcohol problems and prompt access to treatment. Parents are also identified – this will impact on those children who may be living in families where parents/carers are using alcohol problematically and this is impacting on family life.

6 FINANCIAL IMPLICATIONS

6.1 The roll-out of the Community Alcohol Pathway has been included in the Adult Substance Misuse Contract which commencs on 1/12/18.

7 LEGAL IMPLICATIONS

7.1 Statutory requirement to provide a substance misuse service.

8 COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

8.1 The HWB is asked to note the report and its findings.

Non-Applicable Sections:	Implications for other Governance Arrangements, Boards and Partnership Arrangements
Background Documents: (Access via Contact Officer)	2014 Annual Public Health Report on Alcohol 2015 Alcohol Needs Assessment

Report No.
CS18163

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**Thursday 19th July 2018**
Title:	**WINTER REVIEW**
Contact Officer:	Dr Angela Bhan, Managing Director, Bromley CCG Tel:0203 930 0102 E-mail: angela.bhan@nhs.net
Ward:	Borough-wide

1. Summary

1.1 Bromley CCG fund £628k in additional capacity over the winter period to support managing increased seasonal demand. The report provides an evaluation of the impact of this resource and concludes with areas for consideration to influence future planning.

2. Reason for Report going to Health and Wellbeing Board

2.1 This report provides information to the Health and Wellbeing Board on how the local system is managing demand

3. SPECIFIC ACTION REQUIRED BY HEALTH AND WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

3.1 The CCG will continue to lead on the health winter preparedness, aligning to local authority and provider plans which is overseen by the A&E Delivery Board

Health & Wellbeing Strategy

1. Related priority: Not Applicable

Financial

1. Cost of proposal: Not Applicable: Funds have already been utilised.

2. Ongoing costs: Not Applicable

3. Total savings: Not Applicable

4. Budget host organisation: Bromley CCG

5. Source of funding: Not Applicable

6. Beneficiary/beneficiaries of any savings: Not Applicable

Supporting Public Health Outcome Indicator(s)

Not Applicable

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4. COMMENTARY

4.1 The attached report in Appendix A provides detail of the capacity that was commissioned by the CCG throughout winter to meet seasonal demand. The report also provides an evaluation of impact and suggested recommendations going forward.

4.2 The key learning and recommendations for future planning, as described in the report are:

4.2.1 Learning for Future Planning

- Increasing capacity within existing services worked better than previous winters when new provision has been introduced but not utilised;

- Although a significant increase in attendance was seen, performance remained better than previous years including improved A&E performance and considerable reduction in Delayed Transfers of Care (DToC);

- Significant numbers of attendances continued throughout the winter – further work to better understand the reason and prevent attendances is required; and,

- Although all services offered were utilised and showed positive impact, significant numbers of people still required hospital based care, especially those with complex health and social care situations. Due to the complexity and demographic of patients further work is required to provide a more integrated community response to admission and attendance avoidance that is able to be accessed by a range of community providers including domiciliary care services and placements as well as the Emergency Department.

4.2.2 Recommendations

- Earlier planning and mobilisation of schemes to allow for staff recruitment; and,

- Utilising existing service provision to develop an integrated urgent and emergency care system in the community providing a single point of access to a range of community services able to provide brief acute level interventions to support more people at home, preventing the need for hospital based care and support.

4.3 In addition to the attached report which focuses on health services specifically, the A&E Delivery Board undertook a system review of winter to identify how the whole of the partnership can utilise resources better together to support seasonal demand. The following recommendaitons were identified:

- LBB to consider Commissioning dedicated domicilary care to ‘bridge’ where the existing framework or reablement is unable to commence at the point of a patient being mesdically safe for discharge. With a particular focus on January – March where thei swas a significant issue;

- Increase availability of Discharge to Assess beds/interim beds in the community to reduce the number of people remaining in hospital unnecessarily for the assessment of long term care and support needs;

- Improve reactive resources to reduce the amount of social admissions due to carer breakdown;

- Consider a more robust, aligned response to support care homes including residential and Extra Care Housing bringing together the range of resources in existence across the provision;

- Further develop the access to community crisis provision for people with mental illhealth including launching the crisis line, developing the role of the Home Treatment Team as well as considering the capacity of psych liaison; and,

- Historically winter preparedness has been undertaken separately by each organisation, it is recommended that this is brought together into a single winter preparedeness strategy aligning resources from across the system which will also better support the systems ability to implement the recommendations provided.

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 Ensuring access to timely health and social care services is essential to support all residents particularly those most vulnerable.

6. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

6.1 The CCGs plans for winter 2017/18 made a positive impact and as a result even through demand has increased considerably, the resilience of the system overall meant that the recovery from significant pressure points was much faster then has previously been achieved. This is essential for a system to cope throughout the winter and ensure all Bromley residents are able to access safe and timely services.

Non-Applicable Sections:	Financial and Legal Implications and Implications for other Governance Arrangements, Boards and Partnership Arrangements
Background Documents: (Access via Contact Officer)	Not Applicable

NHS
Bromley
Clinical Commissioning Group

BROMLEY WINTER PRESSURE REVIEW

1. Background

Bromley CCG funded enhanced and additional capacity across the system to ensure health services continued to meet demand over the winter period. The CCG funded £628,517k worth of winter activity across a range of services during the period which saw the highest activity levels in the history of the Bromley system. However performance throughout winter 2017/18, although not meeting national standards, was better than that of previous years with responsiveness and recovery rates considerably improving showing increased resilience across the system as a whole.

The report provides an overview of what was commissioned by the CCG, the impact, lessons learnt and recommendations going forward.

2. Outline Of Bromley CCG Winter Pressure Schemes and Spend

For winter 2017 Bromley CCG enhanced capacity across a range of health services including increased primary care capacity through additional GP appointments and home visiting service as well as end of life community care. A multidisciplinary front end team was put into the PRUH with access to urgent community support to prevent avoidable admissions and additional discharge co-ordinators to increasing timeliness, safety and quality of discharge for people on the supported discharge pathway.

The following table shows the detail of what was commissioned and delivered

Provider		Grade	Unit cost (Oct-Mar)	WTE	Hours	17/18 Budget	17/18 Final Cost	18/19 Fin Year
	Admission Avoidance							
Transfer of Care	DisCo	Band 6	£38,200	1		£38,200	£38,200	
Transfer of Care	Community Matron (backfill)	Band 8a	£50,250	1		£50,250	£50,250	
Transfer of Care	POC		£18	10	183	£98,550	£98,550	
Transfer of Care	Beds (1 block)		£610	1	183	£55,185	£55,185	
GP Alliance	GP support in TOC		£100	20		£48,000		
Greenbrooks	HCA's in Beckenham and the PRUH		£16,464	2		£32,928	£32,928	£10,976
Greenbrooks	GP Enhanced rates					£16,000	£16,000	
Greenbrooks	Patient Champion 7 days a week (both sites)					£18,702	£18,702	£6,234
	Patient Flow							
Transfer of Care	DisCo	Band 6	£38,200	2		£76,400	£76,400	
St Christopher	St Christopher's		£38,600			£38,600	£38,600	
St Christopher	St Christopher's Recruitment					£43,072	£43,072	
St Christopher	St Christopher's (potential overspill)					£20,000		
	Primary Care							
GP Alliance	Additional appointments						£50,000	
BHC	Home visit service					£200,000	£100,000	£30,791
BCCG	Comms					£10,000	£10,000	
							£628,517	

3. Overview of Provision

Admission Avoidance

The total cost of schemes including those extended to the end of April is **£676,518**

4. Highlights

4.1 The following highlights were identified from each winter pressure funded scheme:

4.1.1 The Community Matron resource as part of the front end admission avoidance team was able to

- Enabled access to the Local Care Record and EMIs providing essential collateral histories (364 patients) on cases early which often changed the course of diagnostics or avoided admissions (260 patient) all together
- Identifying patients who presented as frail with no recent community involvement, frequent attenders or patients where there has been a significant change in their diagnosis and functioning to Community Matron colleagues as people who may benefit from an ICN review to prevent future admissions (8 patients)
- Having overview of all community health care services to advise in the most appropriate discharge plan, often having to use elements from several different services to initially facilitate the discharge, as a result over 40 early discharges were achieved
- Working alongside other organisations including St Christopher's to deliver safe and timely discharge for complex patients preventing readmissions with over 60 discharges supported by the in-reach community Matron
- Being able to flag patients who require urgent community follow up with community health colleagues to prevent possible readmission and support timely discharge.

4.1.2 Additional packages of care and emergency placement supported:

- Over 40 admissions were avoided due to availability of urgent support in the community
- Once up and running this formed part of the Discharge to Assess provision allowing earlier roll out for the front end

4.1.3 Additional Discharge Co-ordinator (DisCo) capacity provided:

- 45 Discharge to Assess (D2A) passports to facilitate D2A care packages/D2A beds which equates to 225 saved bed days

- Instrumental capacity in rolling out the D2A pathways and education of staff with regards to D2A
- Additional resource when the proportion of patients on supported discharge pathway rose to over 60% at times throughout the winter (ToCB commissioned for 20%)
- Additional resource to enable full time support to the front end of the hospital throughout the period

4.1.4 St Christopher's in-reach and additional community capacity:

- Having a skilled specialist onsite working alongside discharge co-ordinators to identify end of life patients supporting acute staff and managing the interface between the community and acute setting as a result 174 patients were identified of whom 120 (69%) were not previously known to any service at St Christopher's.
- Increased capacity (from 35 packages in October to 61 in January) in St Christopher's Personal Care Service (SCPCS) to allow for the increased number of referrals identified from the hospital throughout the period. A total of 121 patients spent 2306 days at home (99%) and 30 days in hospital (1%)
- The resource supported significant reduction in length of stay for EOL patients who are medically safe for transfer from 5 days to 1

4.1.5 Urgent Care Centre investment provided:

- Extended patient champion hours supported redirection and increased use of hub appointments including advise and sign-posting to reduce avoidance attendances
- Enhanced GP rates resulted in 100% rota fill across both sites including bank holidays and weekends enabling the UCCs to support ED and see as many patients as possible
- Valuable resource, across both sites including communication with patients and other professionals
- Increased Health Care Assistants allowed clinical staff to focus on treating and discharges more patients with HCAs completing ECGs, observations, plastering and some dressings
- Although urgent care centres saw a significant increase in attendances throughout winter, on the whole patients were seen in a timely manner

4.1.6 Increased GP access Hubs and home visits resulted in:

- Between 93-97% utilisation of appointments throughout the winter
- As of end of January 274 patients were visited in their own homes

4.2 Learning for Future Planning

- Increasing capacity within existing services worked better than previous winters when new provision has been introduced but not utilised

- Although a significant increase in attendance was seen, performance remained better than previous years including improved A&E performance and considerable reduction in Delayed Transfers of Care (DToC)
- Significant numbers of attendances continued throughout the winter – further work to better understand the reason and prevent attendances is required.
- Although all services offered were utilised and showed positive impact, significant numbers of people still required hospital based care, especially those with complex health and social care situations. Due to the complexity and demographic of patients further work is required to provide a more integrated community response to admission and attendance avoidance that is able to be accessed by a range of community providers including domiciliary care services and placements as well as the Emergency Department.

4.3 Recommendations

1. Earlier planning and mobilisation of schemes to allow for staff recruitment; and

2. Utilising existing service provision to develop an integrated urgent and emergency care system in the community providing a single point of access to a range of community services able to provide brief acute level interventions to support more people at home, preventing the need for hospital based care and support.

Report No.
CS18165

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**Thursday 19th July 2018**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**BETTER CARE FUND 2017/18 - Q4 PERFORMANCE UPDATE**
Contact Officer:	Jackie Goad, Executive Assistant, Chief Executive's Department Tel: 020 8461 7685 E-mail: Jackie.Goad@bromley.gov.uk
Chief Officer:	Ade Adetosoye, Deputy Chief Executive and Executive Director of Education, Health and Care Services, London Borough of Bromley Angela Bhan, Manager Director, NHS Bromley Clinical Commissioning Group
Ward:	Borough-wide

1. Summary

1.1 This report provides an overview of the performance of the Better Care Fund 2017/18 on activity and expenditure for the final quarter (January - end of March 2018).

2. Reason for Report going to Health and Wellbeing Board

2.1 This is the final performance report on the Better Care Fund for the year 2017/18 to keep the Board informed on the position of the pooled fund and progress of the locally agreed Better Care Fund schemes.

3. **SPECIFIC ACTION REQUIRED BY HEALTH AND WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS**

3.1 That the Health and Wellbeing Board notes the performance and progress of the Better Care Fund schemes and the financial position to end of March 2018.

Health & Wellbeing Strategy

1. Related priority:

   General overarching regard to local health and care priorities.

Financial

1. Cost of proposal: £22,125,000
2. Ongoing costs:: £22,125,000
3. Total savings: Not Applicable
4. Budget host organisation: Local Authority
5. Source of funding: Top slicing of existing budgets (primarily BCCG budgets) to create the BCF in 2015/16
6. Beneficiary/beneficiaries of any savings: Not Applicable

Supporting Public Health Outcome Indicator(s)

Yes

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4. **COMMENTARY**

4.1 Bromley's Better Care Fund 2017-19 local plan was formally agreed and endorsed by the Health and Wellbeing Board at its meeting on 7th September 2017. The plan was subsequently submitted to NHS England for approval on 11th September 2017 and formal approval was received on 27th October 2017.

4.2 The Better Care Fund (BCF) grant is ring fenced for the purpose of pooling budgets and integrating services between Bromley Clinical Commissioning Group (BCCG) and the local authority. For 2017/18 the Better Care Fund grant allocation was £22,125k.

4.3 In order to ensure that local areas are meeting the standard conditions of the Fund it is a requirement to report back to NHS England on a quarterly basis progress against the agreed plan including expenditure.

4.4 The purpose of this report is to provide the Health and Wellbeing Board with an overview of the final quarter performance for the Better Care Fund for 17/18. A report on Q1- Q3 performance was presented to the Board at its meeting on 8th February 2018.

Performance Metrics

4.5 Bromley is responding to the national metrics with the BCF. Under the BCF Policy Framework 2017-19 the national metrics continue as they were set out for 2016-17. In summary the metrics are:

a. Reduction in non-elective admissions
b. Rate of permanent admissions to residential care per 100,000 population
c. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.
d. Delayed transfers of care (DTOCS) (delayed days)

a. <u>Non-elective admissions (emergency admissions)</u>

4.6 There were 25,722 emergency admissions up to the end of March 2018.

	NE Admissions	Actual Performance#	Quarterly Plan	Variance
Apr-17	2,158			
May-17	2,201			
Jun-17	2,228	6,587	6,486	**101**
Jul-17	2,162			
Aug-17	2,126			
Sep-17	2,107	6,395	6,640	**-245**
Oct-17	2,246			
Nov-17	2,226			
Dec-17	2,142	6,614	6,929	**-315**
Jan-18	2,160			
Feb-18	1,914			
Mar-18	2052	6126	6780	**-654**

#Actual performance is derived from SUS activity.

4.7 There are a number of challenges facing us in the delivery of the reduction of non-elective admissions. Large and increasing elderly and frail population, with high numbers of self-funders which impacts on early engagement with statutory services before crisis, are all factors that are being addressed cross agency.

4.8 In terms of achievements however, the pro-active care pathway is now up and running with delivery and outcomes built into contracts across all key community providers underpinned by a robust Alliance Agreement. Social care are now also signed up to the MOU and all key agencies are now represented. Initial analysis is showing positive impact on reduced A&E attendances and closer working with LAS to reduce conveyance to hospital wherever possible, is ongoing.

b. Delayed Transfers of Care (DTOCS)

4.9 In compliance with the national 2017-19 BCF plan condition, a DTOC joint action plan has been developed which sets out Bromley's agreement to reduce delayed transfers of care.

		17-18 plans			
		Q1 (Apr 17 – Jun 17)	Q2 (Jul 17 - Sep 17)	Q3 (Oct 17 - Dec 17)	Q4 (Jan 18 - Mar 18)
Delayed Transfers of Care (delayed days)	**Number**	No target set as 2017/18 plans submitted after Q1	1321	991	928

		17-18 actuals			
		Q1 (Apr 17 – Jun 17)	Q2 (Jul 17 - Sep 17)	Q3 (Oct 17 - Dec 17)	Q4 (Jan 18 – Mar 18)
Delayed Transfers of Care (delayed days)	**Number**	1484	1446	1594	1475

Actual performance derived from NHS England Delayed Transfers of Care Data 2017/18
https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

4.10 An update report on Delayed Transfer of Care performance (report CS 18142) was presented to Members at its meeting on 7th June 2018. Please refer to the separate Delayed Transfer of Care (DToC) performance report which provides a more detailed update on published and local performance to date.

c. Admissions to residential care

4.11 During the final quarter there were 298.2 admissions into residential care and for the year 2017/18 there were a total of 387.1 admissions. Bromley has therefore exceeded its planned target of 425 admissions.

		Planned 17/18	Qtr 1 Actual	Qtr 2 Actual	Qtr 3 Actual	YTD Performance
Long term support of older people (aged 65 and over) met by admission to residential and nursing homes per 100,000 population	**Number**	425	95.9	195.3	298.2	387.1

4.12 Bromley's achievement in exceeding its target is due to some seasonal variation, often seeing an increase in placements during the winter period.

4.13 The increasing elderly population along with a high number of care homes and a high number of self-funders continues to pose a challenge for Bromley.

d. Reablement

4.14 Based on local data the percentage of people still at home 91days after discharge is 93.5% (392/419) as of end of March 2018. Bromley has exceeded its planned target of 90%.

		Planned 17/18	Qtr 1 Actual	Qtr 2 Actual	Qtr 3 Actual	YTD Performance
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	**Annual %**	90.1%	92.6%	93.0%	92.1%	93.5%
	Number	446/495	(88/95)	(172/185)	(269/292)	(392/419)

4.15 The use of Bridging (where a domiciliary care agency is used as a temporary measure to manage the needs of a person whilst they await the opportunity for the reablement service to work with them) has been adopted to facilitate timely discharges from hospital and the reablement service as a holding prior to reablement starting and after it has finished. It has proven successful in moving secondary users (SUS) through pathways of care.

Update on BCF Scheme Delivery

4.16 The BCF programme for 2017-19 continues to be aligned with the model of providing services with funding to underpin the wider objectives to move care from an acute setting into the community. Progress against the local projects are detailed below.

i) Reablement - Additional capacity

4.17 Increasing the capacity of reablement should enable more people to become independent on discharge from hospital, and in some cases reduce hospital admission. The effect of this should be a reduction in the number of residents requiring ongoing packages of care and enabled to live as independent as possible in the community.

4.18 The success of providing additional capacity is dependent on the recruitment to additional posts including occupational therapists, care management and reablement facilitators.

4.19 Further to the Q1-Q3 report to members (CSD18038), the two therapy posts and also the two additional care management assistants have now been recruited and are in post.

ii) Dementia Universal Support Service

4.20 The Dementia Universal Support Service (Dementia Hub) was commissioned to establish a clear pathway for people and their carers immediately following diagnosis. The service provides a 'one stop shop' in terms of information, advice, support and planning for people with dementia and their carers immediately following diagnosis.

4.21 Approval was given back in February to extend the current contract for a further year in order to demonstrate the longer term effects of the service. It has been agreed that a full review of the service will be undertaken by the latter end of 2018 including the options for future commissioning.

4.22 During the last quarter the service has continued to meet the target of triaging people within 3 working days and continues to capture an increase number of people who are re-referred to the service.

4.23 The Dementia Hub aims to continue to have a positive presence in the community. The evidence has been shown in the increase of self-referrals that the hub has received during the

last quarter. The hub team continues to receive a number of referrals from GPs and in the last quarter the hub has made positive links with Bromley Well and has started receiving referrals from the service.

4.24 The case study below provides just one example of how the service has been able to support Bromley residents.

Case Study – Dementia Advisor Service

Background

Mrs W has mixed type Dementia, Alzheimer's and Vascular. She was diagnosed in Feb 2016 and is being supported by her granddaughter who lives in Whitstable. Mrs. W. is very anxious and often her granddaughter, who has her own family needs to stay the night and rush out to help her grandmother manage her anxiety. As a result, the carer is very stressed. Also her grandmother is refusing to go out and socialise and this is causing her anxiety to get worse.

Information and support given

- Information on carers workshops
- Information on Day Centres
- Advice around understanding dementia and anxiety
- Support for carer around self-care strategies

Actions

- Referred to Bertha James Day Centre
- Signposted Driving Miss Daisy for personal transport
- Support session with carer around emotions of being a carer

Outcomes

- Mrs W. is now attending Bertha James weekly. She is enjoying social stimulation and has developed a relationship with staff and driver.
- Carer is able to manage her grandmother's anxiety and no longer rushes from Whitstable to care for her when she rings in an anxious state.
- Carer says she feels less stressed as she understands her behaviour and how to communicate. She also feels less alone as Bertha James are also involved in her care.

She says that the Hub's service has been 'fantastic' and has made such a difference to her and her grandmother's life. She feels supported and less stressed as she has a Dementia Advisor who she can call for support or queries. She says she particularly values the fact that the Hub have specialist knowledge of Dementia, which she feels other agencies do not have.
She has arranged for her Mum and Stepfather to have the hub Coaching service.

iii) Health Support in to Care Homes and Extra Care Housing

4.25 A new Care Homes Programme Board (which reports to the Integrated Commissioning Board) was established in November 2017 and covers the following three broad areas;

- Joint commissioning strategy between London Borough of Bromley and NHS Bromley CCG
- The health and care offer to residents of care homes
- Joint quality framework between London Borough of Bromley and NHS Bromley CCG

4.26 Since the programme started a number of milestones have been achieved including:

- A workshop held to look at the NHS England Care Homes Vanguard recommendations as set out in their report and toolkit 'Enhanced Health in Care Homes'. Further workshops are planned for July and August.
- The Hospital Transfer Pathway (Red Bag' scheme) has been delivered to 39 out of 43 elderly care homes and 2 learning/disability homes. Further 1-2-1 engagement is being undertaken with all care homes to support the flow of consistent documentation. Engagement is also taking place with the PRU as the Hospital Discharge letter is not currently being completed by them.
- A pilot has started to use a shared inspection form between Continuing Health Care (CHC) and LBB.
- A pilot has been agreed to share placement and review workload between CHC and LBB at Mission Care homes.
- The programme team has engaged with care home providers at two Care Homes Forums hosted by LBB.

4.27 BCF investments in care homes settings are currently committed within the 2017/18 programme. In future, available BCF funds in this area will be directly aligned with the priorities and initiatives led by the Care Homes Programme Board.

iv) Self-Management and Early Intervention

4.28 The Bromley Well service (launched in October 2017) provides a single point of access for local people to prevent them from falling into a crisis and improve their health, wellbeing and independence. Their services include support for:

- Older people
- Young carers
- Adult carers
- Mental health carers
- Mutual carers
- Learning difficulties
- Physical disabilities
- Mental wellbeing
- Long term health conditions
- Volunteering, training and paid employment
- Support to the sector

4.29 The first quarter monitoring meeting was held on 15th January 2018. Since the launch of the service a total of 4,596 people have been through the single point of access. Table 1. below provides an indication of the numbers referred to the various services during this period.

Table 1.

Support Service	Number of referrals
Long Term Health Conditions	190
Elderly Frail pathway	93
Employment and Education	77
Learning Disabilities	29
Physical Disabilities	47
Carers pathway	29
Mental Health pathway	173

4.30 The case study below provides just one example of how the service has been able to support Bromley residents to stay both emotionally and physically well, avoid or delay the use of health and social care services and remain independent.

Case Study – Learning Disability Pathway

Name of Service:
Learning Disability Pathway

What was your situation on first coming to the Bromley Well service?
When I contacted the Single Point of Access in January, I had been granted one week of temporary housing before I was to be street-homeless. I was living in a room with a bed and a cupboard with shared toilets and shared kitchen. I had failed a PIP assessment and my income was very low. I was very anxious, isolated and felt that no one was listening to me.

Describe the support you received and the difference it made
I received a call from X, who came to meet me at my temporary housing. He looked through my paperwork and read doctor's notes to see if I could prove to the housing office that I should be viewed as a priority and should be able to stay at the temporary housing until I could make other arrangements. He then spoke to the Council and wrote a description of my learning disability, assisted me to contact private landlords to view properties and assisted me to apply for housing with Clarion, detailing the support which Bromley Well can offer me, so that I could be considered for a tenancy. X put me in touch with the Cotmandene Community Resource Centre at an outreach session and I used their computers to track my housing application. This week X helped me to move to a Clarion house and is looking into my paperwork for energy bills, housing benefit and PIP.

Explain how your life and situation is different now
I am now in a new, spacious flat with local shops and a great view. I am very excited to start decorating and to feel like it is a place of my own and gain some independence, knowing that I still have support. Without this service I would be homeless, on the streets. I will continue to use the Bromley Well outreach sessions and now I feel that I have support in most aspects of my life which has greatly improved my wellbeing.

4.31 The service is still in its early stages and going forward solutions are required for measuring outcomes and the full impact of the service. A system for tracking the NHS numbers of the users also needs to be set up.

Update on progress for Integration of Health and Social Care

4.32 In line with the 2015 Spending Review which set out the Government's intention that, by 2020, health and social care will be more fully integrated across England, it was a requirement for BCF plans for 2017-19 to set out the joint vision and approach for integration and how CCGs and local authorities are working towards better co-ordinated care, both within the BCF and in wider services. During 2017/18 the following progress has been made:

- As part of our joint commitment towards integration and since the 2017-19 BCF plan submission, the joint Director of Transformation and Integration was appointed in September 2017. Priority areas for joint working have been identified, aligned with the BCF plan, and an integrated work programme has been developed on a collaborative basis between BCCG and the Council.
- The governance of joint working arrangements have been reviewed and a new Integrated Commissioning Board (ICB) has been established (formerly the Joint Integrated Commissioning Executive (JICE)) to lead and direct the transformation and integration programme.

- Implementation of the work programme, overseen and directed by the ICB, with accountability to the Health and Wellbeing Board was formally endorsed by the Health and Wellbeing Board at its meeting on 8th February 2018.
- During the final quarter of 17/18 proposals were put forward to the Integrated Commissioning Board (ICB) for the further development and strengthening of joint working arrangements particularly operational arrangements in order to make quicker progress on our local journey towards integration.

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 All services are designed to avoid people who are vulnerable reaching the point of crisis where they would be seeking support of statutory services and/or requiring unplanned admission.

6. FINANCIAL IMPLICATIONS

6.1 The budget and expenditure for the Better Care Fund up to the end of March 2018 is detailed in the table below.

BCF 2017/18 - QUARTER 4

Resp.	Description	2017/18 budget	Forecast Apr to Jun	Forecast Jul to Sep	Forecast Oct to Dec	Forecast Jan to March	Forecast Outturn	Difference bud/act
		£'000	£'000	£'000	£'000	£'000	£'000	£'000
LBB	Reablement capacity	853	213	213	213	134	774	-79
CCG	Winter Pressures Discharge (CCG)	646	162	162	162	162	646	0
LBB	Winter Pressures Discharge (LBB)	1,027	257	257	257	212	982	-45
CCG	Integrated care record	433	108	108	108	108	432	0
CCG	Intermediate care cost pressures	625	156	156	156	156	625	0
LBB	Community Equipment cost pressures	422	106	106	106	106	422	0
LBB	Dementia universal support service	520	130	130	130	88	478	-42
CCG	Dementia diagnosis	620	155	155	155	155	620	0
LBB	Extra Care Housing cost pressures	418	105	105	105	105	418	0
CCG	Health support into care homes/ECH	314	12	13	0	0	25	-289
CCG	Self management and early intervention (inc Vol sector)	1,047	0	0	0	1,047	1,047	0
CCG	Carers support - new strategy	633	0	0	0	510	510	-123
CCG	Risk against acute performance	1,347	0	449	449	449	1,347	0
CCG	Transfer of Care Bureau	611	153	153	153	153	611	0
LBB	Protecting Social Care	8,977	2,244	2,244	2,244	2,244	8,977	0
LBB	Disabled Facilities Grants - CAPITAL	1,838	226	304	274	543	1,347	-491
CCG	Carers Funding	527	132	132	132	132	527	0
CCG	Reablement Funds	952	238	238	238	238	952	0
LBB	Reablement Funds	315	79	79	79	79	315	0
LBB	Continuation of agreed joint schemes	0	0	0	0	550	550	550
	Total Recurrent Budget	**22,125**	**4,474**	**5,002**	**4,959**	**7,170**	**21,606**	**-519**

6.2 The underspend of £519k in year is split between £491k of capital funding and £28k of revenue funding. The total underspend will be carried forward into the new 2018/19 financial year to be used against BCF projects.

7. LEGAL IMPLICATIONS

7.1 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It provides the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund. NHS England and the Government allocate the Better Care Fund to local areas based on a framework agreed with Ministers.

7.2 The amended NHS Act 2006 gives NHS England the powers to attach conditions to the payment of the Better Care Fund. For 2017-19 NHS England set the following conditions to access the CCG element of the funding:

- The requirement that the Better Care Fund is transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.
- The requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent with plans signed off by the relevant local authority and clinical commissioning group(s).

7.3 Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of CCG funding where conditions attached to the BCF are not met, except for those amounts paid directly to local government.

7.4 In 2017-19, NHS England will require that BCF plans demonstrate how the area will meet the following national conditions:

- Plans to be jointly agreed;
- NHS contribution to adult social care is maintained in line with inflation;
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care; and
- Managing Transfers of Care

Report No.
CSD18094

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**Thursday 19th July 2018**
Decision Type:	Non Urgent Non-Executive Non-Key
Title:	**MATTERS ARISING AND WORK PROGRAMME**
Contact Officer:	Kerry Nicholls, Democratic Services Officer Tel: 0208 313 4602 E-mail kerry.nicholls@bromley.gov.uk
Chief Officer:	Mark Bowen, Director of Corporate Services
Ward:	N/A

1. Reason for report

1.1 The Health and Wellbeing Board is asked to review its Work Programme and to consider progress on matters arising from previous meetings of the Board.

2. RECOMMENDATION

2.1 The Health and Wellbeing Board is requested to:

1) **Review its Work Programme; and,**

2) **Consider matters arising from previous meetings, indicating any changes required.**

Impact on Vulnerable Adults and Children

1. Summary of Impact: Not Applicable

Corporate Policy

1. Policy Status: Existing Policy: As part of the Excellent Council workstream within Building a Better Bromley, the Health and Wellbeing Board should plan and prioritise its workload to achieve the most effective outcomes.
2. BBB Priority: Excellent Council

Financial

1. Cost of proposal: No Cost
2. Ongoing costs: Not Applicable
3. Budget head/performance centre: Democratic Services
4. Total current budget for this head: £350,650
5. Source of funding: 2018/19 revenue budget

Staff

1. Number of staff (current and additional): 8 posts (6.87 fte)
2. If from existing staff resources, number of staff hours: Maintaining the Board's work programme takes less than an hour per meeting

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Legal

1. Legal Requirement: None.
2. Call-in: Not Applicable. This report does not involve an executive decision

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Procurement

1. Summary of Procurement Implications: None.

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): This report is intended primarily for the benefit of members of this Board to use in controlling their work.

Ward Councillor Views

1. Have Ward Councillors been asked for comments? Not Applicable
2. Summary of Ward Councillors comments: Not Applicable

3. COMMENTARY

3.1 The Matters Arising table updates Board Members on “live” matters arising from previous meetings wand is attached at **Appendix 1**.

3.2 The Health and Wellbeing Board’s Work Programme is attached at **Appendix 2**. Meetings are scheduled to be held approximately two weeks after Bromley Clinical Commissioning Group Board meetings to facilitate the feedback mechanism from the Bromley Clinical Commissioning Group to the Health and Wellbeing Board. In approving the Work Programme, Board Members will need to be satisfied that priority issues are being addressed in line with the priorities set out in the Board’s Health and Wellbeing Strategy and Terms of Reference which were approved by Council in April 2013.

3.3 Dates of Meetings and report deadline dates are provided at **Appendix 3**.

3.4 The Constitution of the Health and Wellbeing Board is provided at **Appendix 4**.

3.5 The updated Glossary is provided at **Appendix 5**.

Non-Applicable Sections:	Impact on Vulnerable Adults and Children and Policy/Financial/Legal/Personnel Implications
Background Documents:	Previous matters arising reports and minutes of meetings.

APPENDIX 1

Health and Wellbeing Board: Matters Arising/Action List

Agenda Item	Action	Officer	Notes	Status
Minute 10 7th June 2018 Improved Better Care Fund Update	Members requested that the Deputy Chief Executive follow up concerns raised around how the Local Authority was working with the third sector in expanding the use of Direct Payments following the meeting. The Chairman requested that the brief for the Care Homes Investment Options Appraisal be provided to Board Members following the meeting.	Ade Adetosoye Paul Feven	The Deputy Chief Executive was taking this issue forward. A briefing note on user engagement within the Direct Payments workstream was provided to Board Members following the meeting. The brief for the Care Homes Investment Options Appraisal was provided to Board Members following the meeting.	**Completed** **Completed**
Minute 6 7th June 2018 Scoping Discussion on Proposal to Develop a Suicide Prevention Strategy for Bromley	Members requested that further information on the incidence of self-harm in Bromley be provided to Board Members following the meeting	Dr Nada Lemic	A briefing note on the incidence of self-harm in Bromley was provided to Board Members following the meeting.	**Completed**
Minute 59 29th March 2018 Minutes of the Previous Meeting	The Chairman agreed to hold discussions with Mr Ashish Desai, Consultant Paediatric Surgeon regarding work being undertaken by King's College Hospital NHS Foundation Trust in relation to childhood obesity.	**Councillor David Jefferys**	The Chairman had arranged a meeting with Mr Ashish Desai in August 2018 and would report the outcome to Board Members at the next meeting of the Health and Wellbeing Board.	**In progress**
Minute 11 7th September 2017 Scoping Paper for Falls and Task and Finish Group	Members resolved that a task and finish group be convened to produce a summary report with recommendations for future action.	**Dr Nada Lemic/ Laura Austin Croft**	Work on the task and finish group had been completed and the final report would be provided to the Board meeting in July 2018.	**Completed**
Minute 10 7th September 2017 Delayed Transfer of Care Performance	Members resolved that the Health and Wellbeing Board receive regular updates on Delayed Transfer of Care performance locally and progress made against plans to reduce delayed transfers	**Ade Adetosoye/ Jodie Adkin/ Dr Bhan**	This has been noted and the matter has been factored into the work plan and future agendas.	**Ongoing**

APPENDIX 2

HEALTH AND WELLBEING BOARD
WORK PROGRAMME

27th September 2018	
Better Care Fund Performance Update	Jackie Goad
Engagement Outcomes towards the Forthcoming Strategy for Older People and those approaching Old Age	Denise Mantell
Health Support to School Age Children: Update	Dr Jenny Selway
Improved Better Care Fund Projects: Winter Resilience 2017/18	Stephen John
Chairman's Update on Childhood Obesity	Councillor David Jefferys
Healthy Weight Bromley: Children and Young People Update	Dr Nada Lemic
Joint Older Persons Strategy	Tracy Gagetta
Proposal to Develop a Suicide Prevention Strategy for Bromley	Dr Nada Lemic
Promoting Exercise	Dr Nada Lemic
Update on DToC Performance	Jodie Adkin/Ade Adetosoye
Integrated Commissioning Board Update	Graham Mackenzie/Paul Feven
Work Programme and Matters Arising	Kerry Nicholls
Emerging Issues (standing opportunity: every meeting)	HWB members to contact Board Secretary with any emerging matters for discussion.
28th November 2018	
Better Care Fund Performance Update	Jackie Goad
Bromley Communications and Engagement Network – Activity Report	Susie Clark
Bromley Safeguarding Adults Board Annual Report	Lynn Sellwood
Bromley Safeguarding Children Board Annual Report	Jim Gamble/Joanna Gambhir
Local CAMHS Transformation Plan	Daniel Taegtmeyer (CCG)
Update on DToC Performance	Jodie Adkin/Ade Adetosoye
Work Programme and Matters Arising	Kerry Nicholls
Emerging Issues (standing opportunity: every meeting)	HWB members to contact Board Secretary with any emerging matters for discussion.
31st January 2019	
Better Care Fund Performance Update	Jackie Goad
Chairman's Annual Report	Councillor David Jefferys
Primary Care Commissioning Update	Dr Angela Bhan/Dr Andrew Parson
Update on DToC Performance	Jodie Adkin/Ade Adetosoye
Work Programme and Matters Arising	Kerry Nicholls
Emerging Issues (standing opportunity: every meeting)	HWB members to contact Board Secretary with any emerging matters for discussion.
21st March 2019	
Better Care Fund Performance Update	Jackie Goad
Healthy Weight Bromley: Children and Young People Update	Dr Nada Lemic
Update on DToC Performance	Jodie Adkin/Ade Adetosoye
Update on Infant Mortality Rate in Bromley	Dr Jenny Selway
Integrated Commissioning Board Update	Graham Mackenzie/Paul Feven
Information Item: Guide for Schools on the Month of Ramadan and Fasting (referral from SACRE)	Dr Omar Taha
Work Programme and Matters Arising	Kerry Nicholls
Emerging Issues (standing opportunity: every meeting)	HWB members to contact Board Secretary with any emerging matters for discussion.

Unprogrammed Outstanding Items:
Developing a System Wide Mental Health Strategy/Mental Health Act (Harvey Guntrip)
Update on Childhood Obesity Work by King's College Hospital NHS Foundation Trust (Chairman)
Mental Health Strategic Partnership Update (Harvey Guntrip)
Elective Orthopaedic Centres (CCG)
Health and Wellbeing Strategy (Dr Nada Lemic)
Implementation of Personal Health Budgets (LBB)
Improvements in Services for Dementia Suffers (LBB/CCG)
FGM Update (Mimi Morris-Cotterill)

APPENDIX 3

DATES OF MEETINGS AND REPORT DEADLINE DATES

The Agenda for meetings MUST be published five clear days before the meeting.

Report Deadlines are the final date by which the report can be submitted to Democratic Services. Report Authors will need to ensure that their report has been signed off by the relevant chief officers before submission.

Date of Meeting	Report Deadline (3.00pm)	Agenda Published
Thursday 7th June 2018	Tuesday 29th May 2018	Wednesday 30th May 2018
Thursday 19th July 2018	Tuesday 10th July 2018	Wednesday 11th July 2018
Thursday 27th September 2018	Tuesday 18th September 2018	Wednesday 19th September 2018
Wednesday 28th November 2018	Monday 18th November 2018	Tuesday 20th November 2018
Thursday 31st January 2019	Tuesday 22nd January 2019	Wednesday 23rd January 2019
Thursday 21st March 2019	Tuesday 12th March 2019	Wednesday 13th March 2019

A link to the agenda is emailed to the Board on the publication date. Hard copies are available on request.

Questions
Questions from members of the public to the meeting will be referred directly to the relevant policy development and scrutiny (PDS) committee of the Council, or to other meetings as appropriate, at the next available opportunity unless they relate directly to the work of the Board.

A list of the questions and answers will be appended to the corresponding minutes.

Minutes
The minutes are drafted as soon as possible after the meeting has finished. They are then sent to officers for checking. Once any amendments have been made, they are sent to the Chairman, and once he has cleared them, they are sent, in draft format, to Members of the board. Please note that this process can take up to two weeks.

The draft minutes are then incorporated on the agenda for the following meeting and are confirmed.

APPENDIX 4

LONDON BOROUGH OF BROMLEY
HEALTH & WELLBEING BOARD

Constitution

(11 Elected Members, including one representative from each of the two Opposition Parties; the two statutory Chief Officers (without voting rights); two representatives from the Clinical Commissioning Group (with voting rights); a Health Watch representative (with voting rights) and a representative from the Voluntary Sector (with voting rights). The Chairman of the Board will be an Elected Member appointed by the Leader. The quorum is one-third of Members of the Board providing that elected Members represent at least one half of those present. Substitution is permitted. Other members without voting rights can be co-opted as necessary.

1. Providing borough-wide strategic leadership to public health, health commissioning and adults and children's social care commissioning, acting as a focal point for determining and agreeing health and wellbeing outcomes and resolving any related conflicts.

2. Commissioning and publishing the Joint Strategic Needs Assessment (JSNA) under the Health and Social Care Act.

3. Commissioning and publishing a Joint Health & Wellbeing Strategy (JHWS) – a high level strategic plan that identifies, from the JSNA and the national outcomes frameworks, needs and priority outcomes across the local population, which it will expect to see, reflected in local commissioning plans.

4. Receiving the annual CCG commissioning plan for comment, with the reserved powers to refer the CCG commissioning plan to the NHS Commissioning Board should it not address sufficiently the priorities given by the JSNA.

5. Holding to account all areas of the Council, and other stakeholders as appropriate, to ensure their annual plans reflect the priorities identified within the JSNA.

6. Supporting joint commissioning and pooled budget arrangements where it is agreed by the Board that this is appropriate.

7. Promoting integration and joint working in health and social care across the borough.

8. Involving users and the public, including to communicate and explain the JHWS to local organisations and residents.

9. Monitor the outcomes and goals set out in the JHWS and use its authority to ensure that the public health, health commissioning and adults and children's commissioning and delivery plans of member organisations accurately reflect the Strategy and are integrated across the Borough.

10. Undertaking and overseeing mandatory duties on behalf of the Secretary of State for Health and given to Health and Wellbeing Boards as required by Parliament.

11. Other such functions as may be delegated to the Board by the Council or Executive as appropriate.

APPENDIX 5

GLOSSARY OF ABBREVIATIONS – HEALTH & WELLBEING BOARD

Acute Treatment Unit	(ATU)
Antiretroviral therapy	(ART)
Any Qualified Provider	(AQP)
Autistic Spectrum Disorders	(ASD)
Behaviour, Attitude, Skills and Knowledge	(BASK)
Better Care Fund	(BCF)
Black African	(BA)
Body Mass Index	(BMI)
British HIV Association	(BHIVA)
Bromley Clinical Commissioning Group	(BCCG)
Bromley Safeguarding Children Board	(BSCB)
Cardiovascular Disease	(CVD)
Care Programme Approach	(CPA)
Care Quality Commission	(CQC)
Children & Adolescent Mental Health Service	(CAMHS)
Child Sexual Exploitation	(CSE)
Chlamydia Testing Activity Dataset	(CTAD)
Clinical Commissioning Group	(CCG)
Clinical Decision Unit	(CDU)
Clinical Executive Group	(CEG)
Clinical Leadership Groups	(CLG)
Common Assessment Framework	(CAF)
Community Learning Disability Team	(CLDT)
Community Psychological Services	(CPS)
Delayed Transfer of Care	(DTOC)
Director of Adult Social Services	(DASS)
Director of Children's Services	(DCS)
Disability Discrimination Act 1995	(DDA)
Dispensing Appliance Contractors	(DAC)
Emergency Hormonal Contraception	(EHC)
Essential Small Pharmacy Local Pharmaceutical Services	(ESPLPS)
Female Genital Mutilation	(FGM)
Florence – telehealth system using SMS messaging	(FLO)
Health & Wellbeing Board	(HWB)

Health & Wellbeing Strategy	(HWS)
Health of the Nation Outcome Scales	(HoNOS)
Hypertension Action Group	(HAG)
Improved Better Care Fund	(IBCF)
Improving Access to Psychological Therapies programme	(IAPT)
Improvement Assessment Framework	(IAF)
In Depth Review	(IDR)
Integrated Care Network	(ICN)
Integration Transformation Fund	(ITF)
Intensive Support Unit	(ISU)
Joint Health & Wellbeing Strategy	(JHWS)
Joint Integrated Commissioning Executive	(JICE)
Joint Strategic Needs Assessment	(JSNA)
Kings College Hospital	(KCH)
Local Medical Committee	(LMC)
Local Pharmaceutical Committee	(LPC)
Local Pharmaceutical Services	(LPS)
Local Safeguarding Children's Boards	(LSCB)
Long Acting Reversible Contraception	(LARC)
Mental Health Champion	(MHC)
Multi Agency Planning	(MAP)
Medicines Adherence Support Service	(MASS)
Medicines Adherence Support Team	(MAST)
Medium Super Output Areas	(MSOAs)
Men infected through sex with men	(MSM)
Mother to child transmission	(MTCT)
Multi-Agency Safeguarding Hubs	(MASH)
Multi-Agency Sexual Exploitation	(MASE)
National Chlamydia Screening Programme	(NCSP)
National Institute for Clinical Excellence	(NICE)
Nicotine Replacement Therapies	(NRT)
National Reporting and Learning Service	(NRLS)
Nucleic acid amplification tests	(NATTS)
Patient Liaison Officer	(PLO)
People living with HIV	(PLHIV)
Pharmaceutical Needs Assessment	(PNA)

Policy Development & Scrutiny committee	(PDS)
Primary Care Trust	(PCT)
Princess Royal University Hospital	(PRUH)
Proactive Management of Integrated Services for the Elderly	(ProMISE)
Public Health England	(PHE)
Public Health Outcome Framework	(PHOF)
Quality and Outcomes Framework	(QOF)
Quality, Innovation, Productivity and Prevention programme	(QIPP)
Queen Mary's, Sidcup	(QMS)
Speech and Language Therapy	(SALT) or (SLT)
Secure Treatment Unit	(STU)
Serious Case Review	(SCR)
Sex and Relationship Education	(SRE)
Sexually transmitted infections	(STIs)
South London Healthcare Trust	(SLHT)
Special Educational Needs	(SEN)
Summary Care Record	(SCR)
Supported Improvement Adviser	(SIA)
Sustainability and Transformation Plans	(STP)
Tailored Dispensing Service	(TDS)
Unitary Tract Infections	(UTI)
Urgent Care Centre	(UCC)
Voluntary Sector Strategic network	(VSSN)
Winterbourne View Joint Improvement Programme	(WVJIP)

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