Bromley Falls prevention system review: Final report and recommendations

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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.

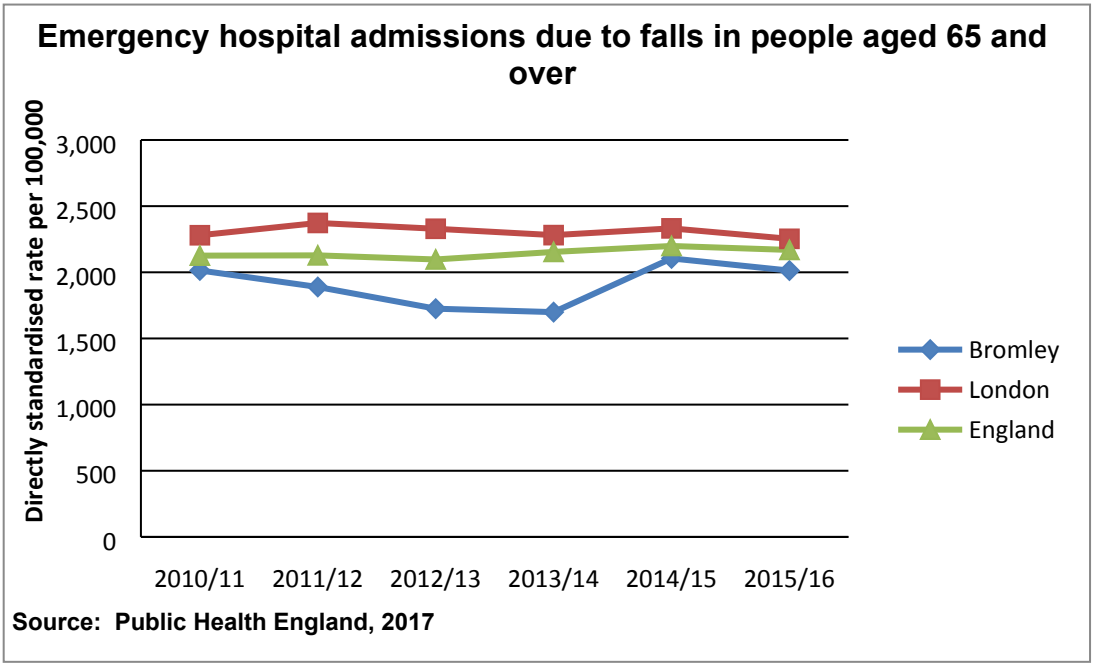
Using National Institute of Clinical Excellence (NICE) data[1], the following can be estimated:

[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

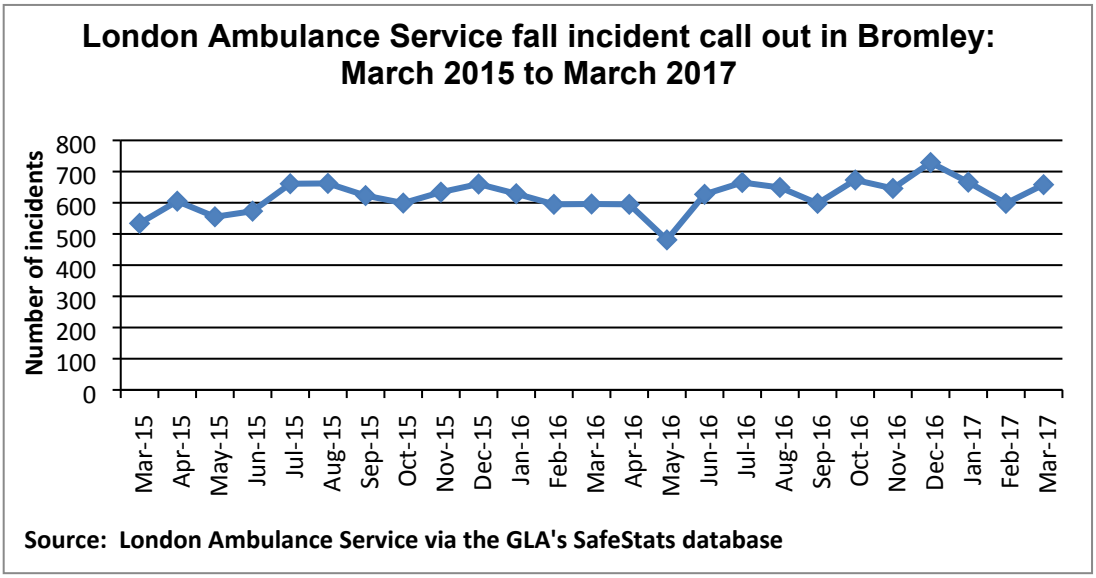
London Ambulance Service (LAS) data on call outs can be used as a proxy indicator to show the frequency of falls taking place in the community. To analyse this data for Bromley, London Ambulance Service data was obtained from the GLA SafeStats database for homes and public settings. The database was 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.

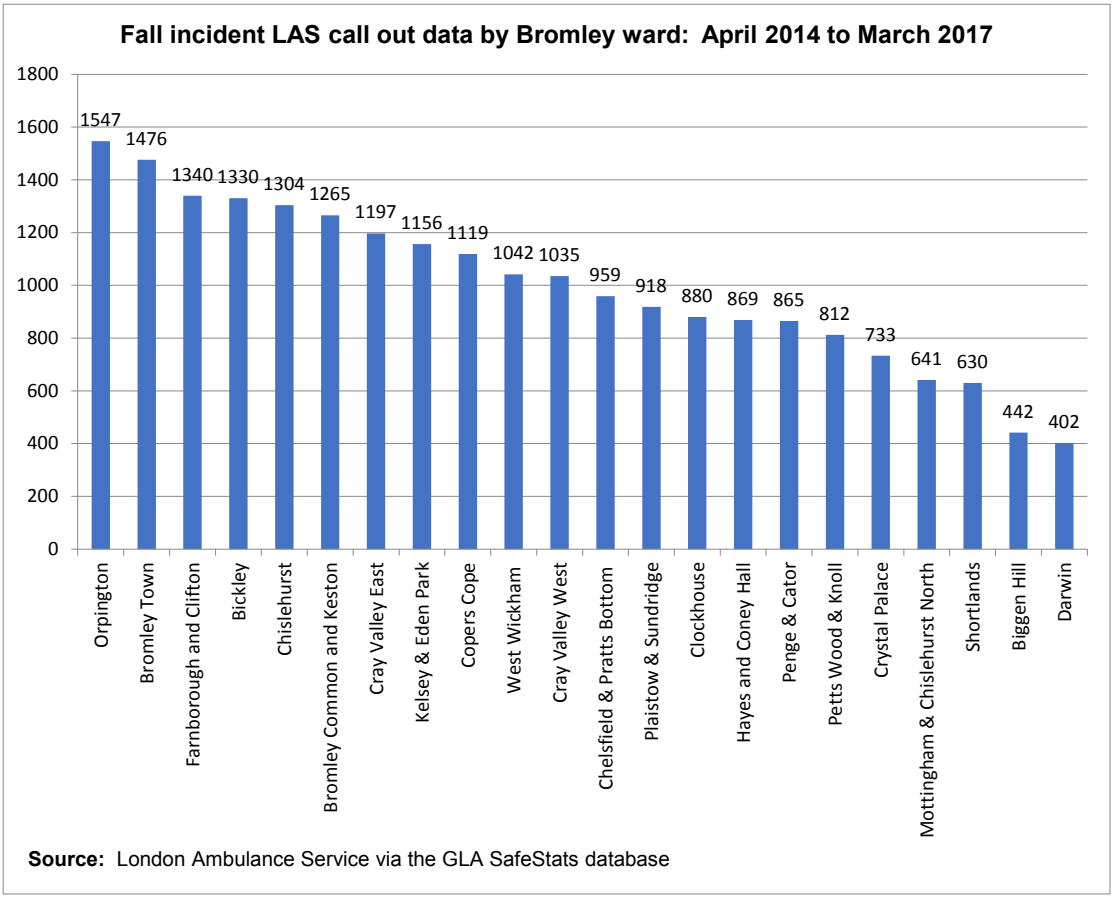
top ten for incident calls outs. The same relationship does not seem to exist for deprivation. The results of this analysis are set out in **Appendix D.**

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].

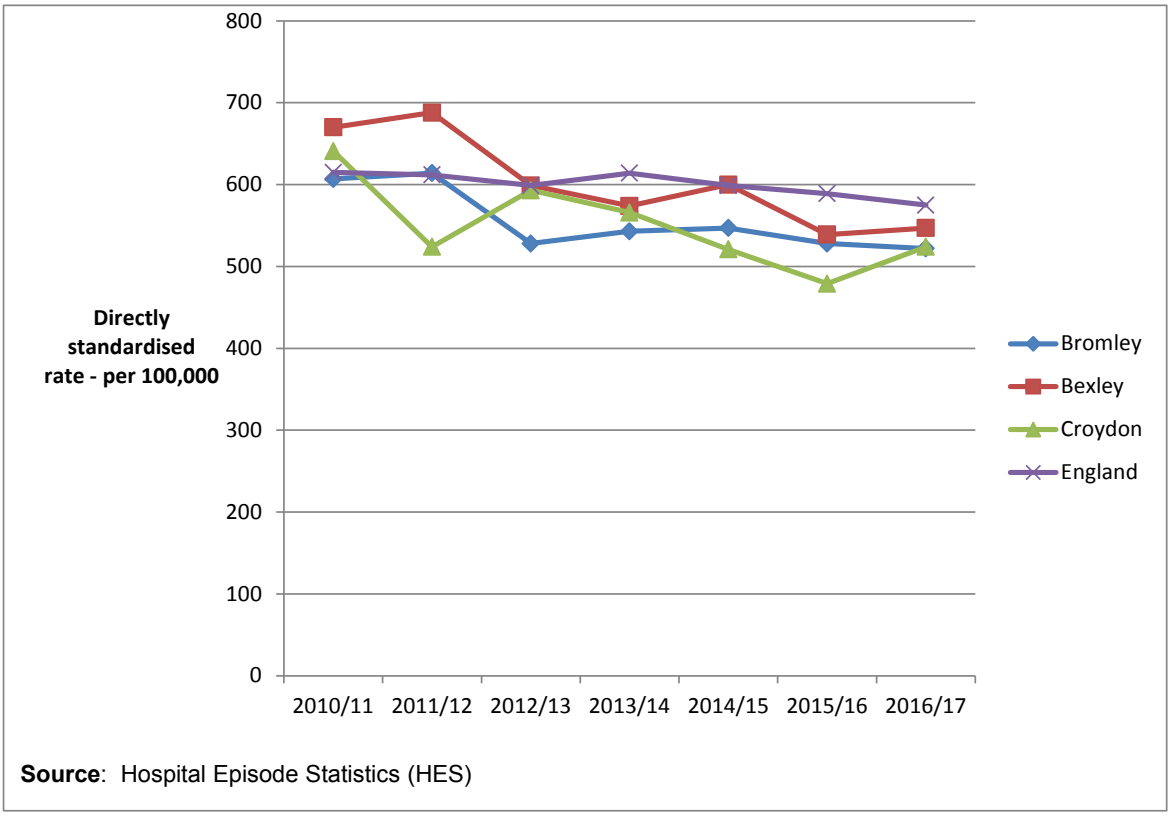
2) Utilisation of health and care services as a result of a fall

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

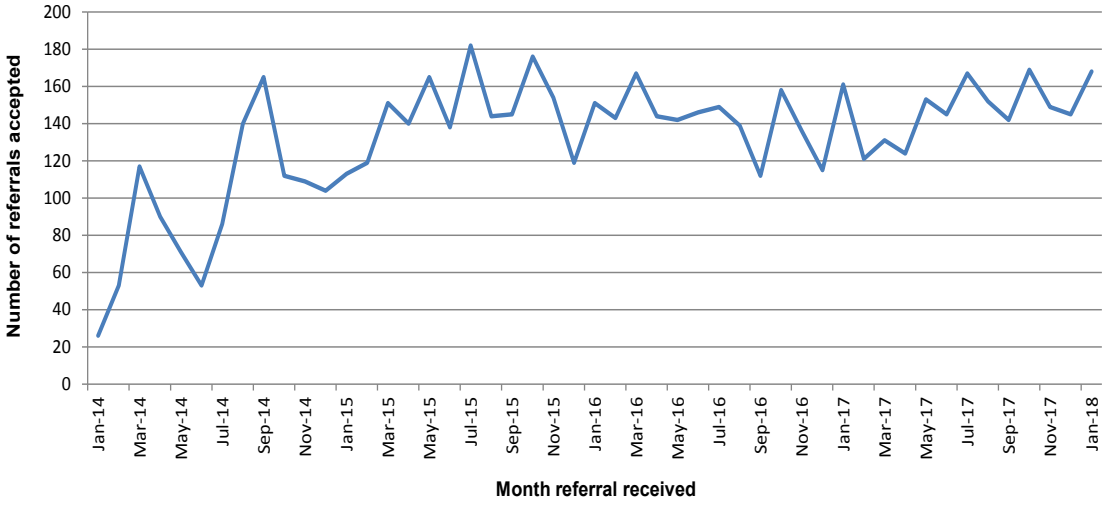


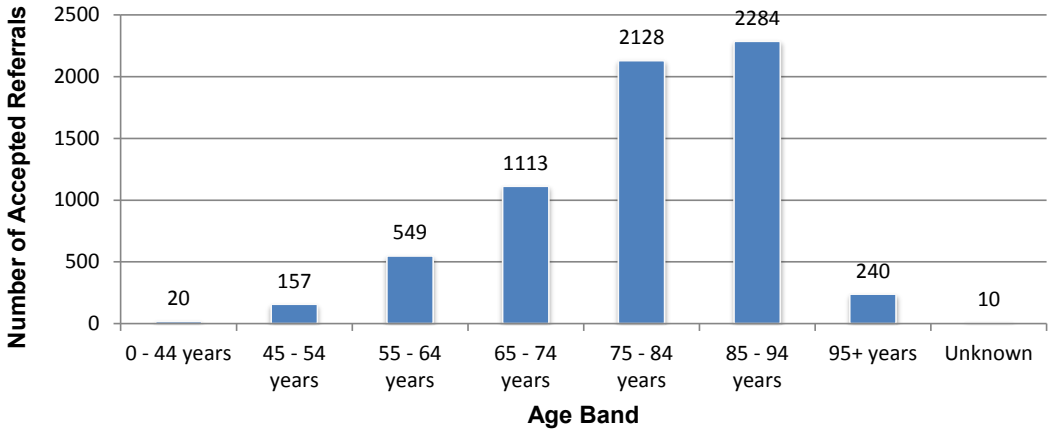
Table 3: Number of referrals to Bromley Healthcare FFPS service by year

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

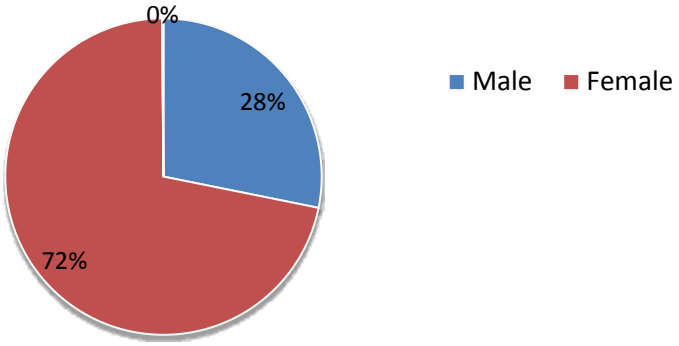
Gender profile of referrals

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

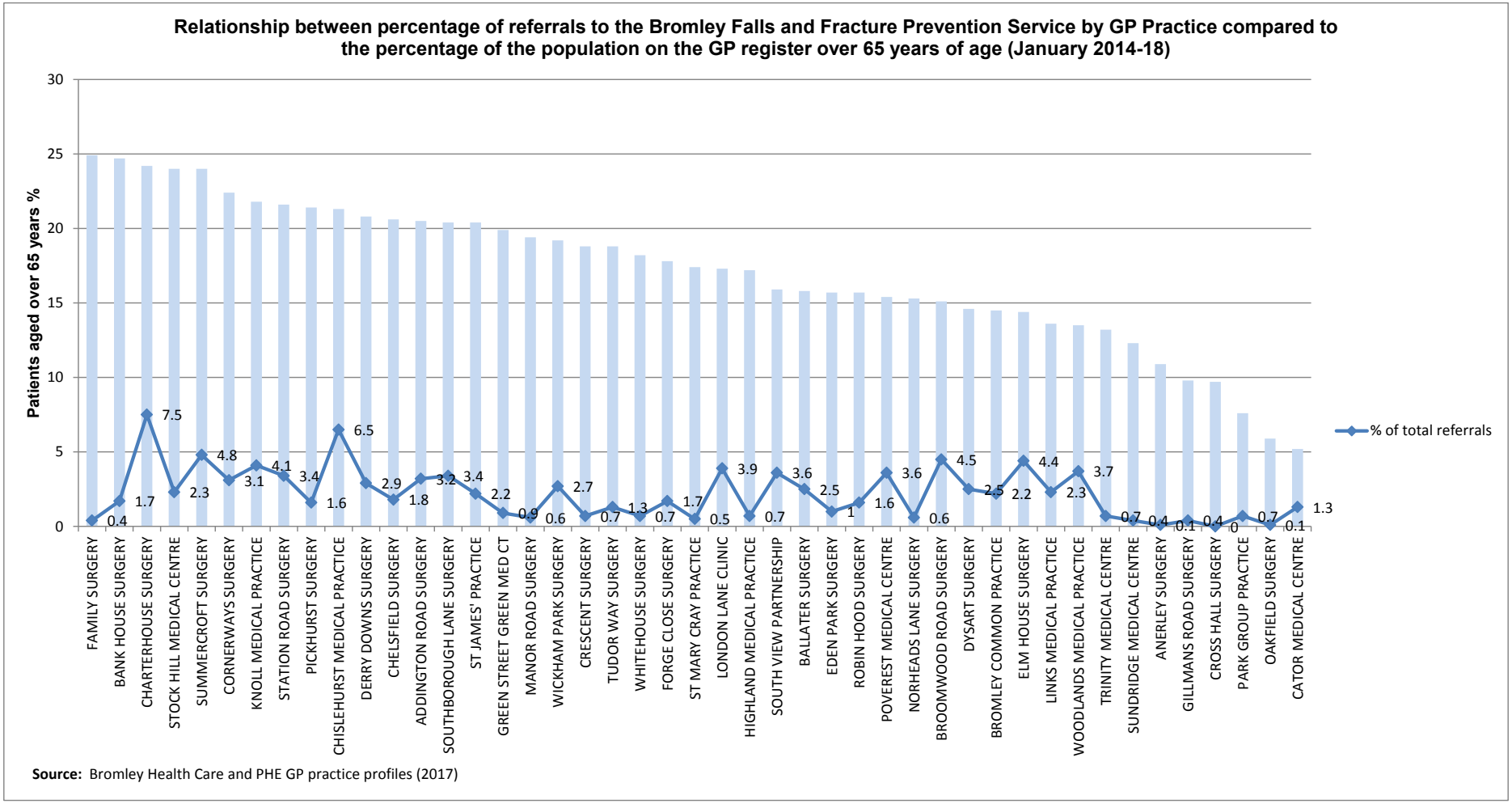
The top three GP practices with the highest number of referrals to the FFPS all have a relatively high proportion of people in their practice over 65, 75 and

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



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.

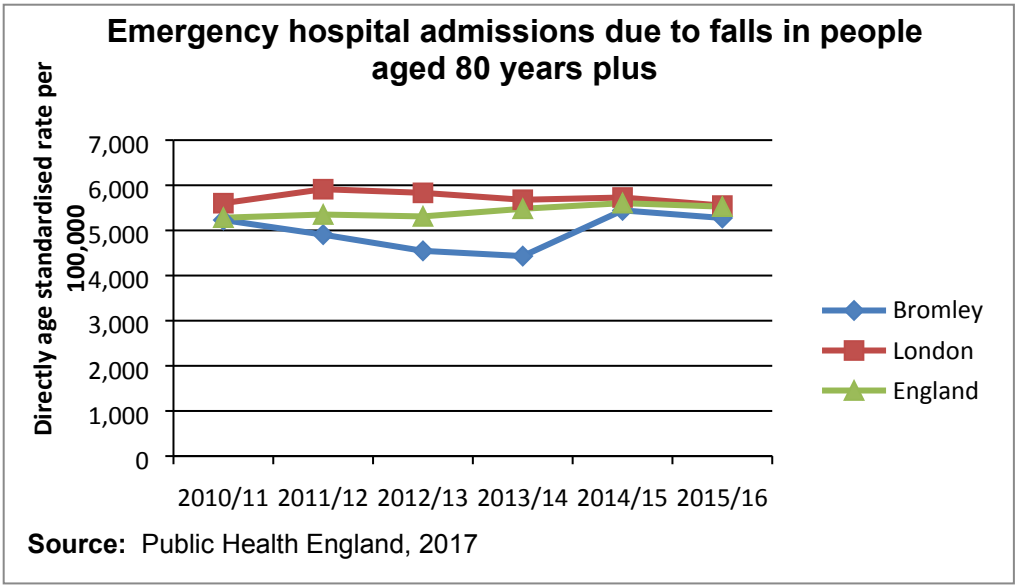
The Falls practitioner at the PRUH also raised an issue that A&E regularly see a cohort of patients who are recurrent fallers. These are patients with a high level of frailty, which represent an increasing number of patient type seen by secondary care. This cohort is potentially shown in the hospital 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%

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