Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Reference: **FOI.ICB-2223/118**

Subject: **Falls Service Commissioning**

I can confirm that the ICB ***does hold the information requested****; please see responses below:*

<table>
<tr><th>QUESTION</th><th>RESPONSE</th></tr>
<tr><td>I'm currently trying to form a better understanding of how falls services are provided for and commissioned in the Bristol, North Somerset and South Gloucestershire ICS.

i. I was interested to read about the BNSSG-wide Specialist Falls Service provided by Sirona - it seems that this service focuses on preventing falls, I was wondering if the BNSSG ICB has also commissioned specific services to respond to falls?

ii. I'd also be very keen to learn more about any such falls services are provided in the ICS and particularly their commissioning cycle, i.e. how long any service has been contracted for?</td><td>Please find enclosed the relevant elements from the existing contract held with Sirona care and health CIC in relation to the falls service. Sirona have a ten-year contract due to end on 31 March 2030.

Within the ICB's Ageing Well Programme we have commissioned a number of pilot schemes with a falls or falls prevention theme or aspect. Currently these are all pilots due to expire on 31 March 2023, however some of these may be future funded, with the decision not being made until January based on their evaluations.

The pilot schemes include:

<table><tr><th>Scheme Name</th></tr><tr><td>Shared Care Planning Training</td></tr><tr><td>Occupational Therapy support in Care Homes</td></tr><tr><td>Connecting Communities: Integrated Leg Clinic</td></tr><tr><td>Embedding physical activity in care pathways: Trailblazers Training Together</td></tr><tr><td>Active Hospitals</td></tr><tr><td>ReACT Project</td></tr></table></td></tr>
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	Evaluation LLB: Fall-proof campaign LLB: Walking groups with GP surgeries LLB: Hospital discharge LLB: Care homes LLB: Fall Prevention In addition, the ICB commissions services at the Acute Trusts for trauma linked to falls (A&E etc.) and patients being discharged will be assessed by Occupational Therapists etc. for risks of falls. Further information can be provided by the trusts, details of how to contact the trusts can be found via the links below: North Bristol NHS Trust (NBT): https://www.nbt.nhs.uk/about-us/information-governance/freedom-information/request-information University Hospitals Bristol and Weston NHS Foundation Trust (UHBW): https://www.uhbw.nhs.uk/p/how-we-use-your-data/freedom-of-information-foi-requests

The information provided in this response is accurate as of 25 November 2022 and has been approved for release by Sarah Truelove, Deputy Chief Executive and Chief Finance Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.

Falls prevention and non-emergency falls

The Provider will deliver a specialist falls prevention service through the Acute and Reactive Care service that is rapidly accessible once somebody has been identified as at risk of falling; either following a stay in hospital or as identified in the community. This also includes the ability to respond and link with pathways across Bristol, North Somerset and South Gloucestershire that respond to non-emergency falls to prevent avoidable admissions and attendances to acute trusts. The falls prevention function will have the capability to deliver a full, multifactorial assessment including evaluation of:

- Poly-pharmacy in conjunction with input from primary care pharmacists either via the CCG's medicines management team or local pharmacists
- Cognition
- Osteoporotic risk
- Functional ability
- Footwear
- Continence
- Vision
- Hearing
- Assessment of home and environmental hazards
- A full physiotherapy assessment should also be available and include as a minimum:
- Falls history- mechanical, medical, environmental and other/unexplained
- Past medical and medication history
- Balance assessment through validated outcome measures e.g., TUG, Berg Balance, Short FES-I, Elderly Mobility Scale (EMS)
- Muscle strength assessment- range of motion (ROM), gait analysis, gait aids, pain, activities of daily living assessment

Patients, families or carers should be asked to complete a validated environmental assessment questionnaire prior to their first review and this, along with the full assessment, may inform a decision to involve social services, occupational therapy or other home adaptation services. Following full assessment an exercise and rehabilitation programme will be set out based on clinical need, in line with the approach described above. This programme should include a set of specific goals agreed with the patient as well as exercises to complete regularly at home. The Provider will also run group sessions at accessible community locations for those able to attend. Following completion of the agreed programme the patient should be followed up to monitor progress and evaluate the effectiveness of the therapeutic intervention. This evaluation should include a repeat of the validated outcome measures used to derive a baseline assessment in order to provide a quantitative measure of patient outcomes.

Patients should have the ability to contact the therapist or appropriate member of the Acute and Reactive Care service prior to this review should they experience any further problems or falls

Therapy and rehabilitation input as part of the Integrated Locality Team will be accessed based on clinical need and will be made available to key patient cohorts including (but not limited to) those with:

- Neurological conditions- multiple sclerosis, stroke, Parkinson's disease, brain injury and motor neuron disease
- Balance, mobility or functional problems following an episode of clinical deterioration or spell of acute care or falls risk identified
- Complex frail elderly patients
- Long term conditions requiring education and/or therapeutic intervention

This holistic plan holistic plan is to be agreed between the Integrated Locality Team professionals, the care home and the supporting GP practice(s).Such a support plan is to capture, at a minimum:

The case mix and clinical requirements of residents

- Identification of high-risk residents for whom specific care plans should be developed detailing the inputs and frequency from the Integrated Locality Team (as described in the section below)
- The inputs, and their frequency, of GP practices with registered patients within the home
- An assessment of the care home staff skills and relevant training needs and facilitation of access to a matrix of training opportunities in collaboration with local partners
- An initial assessment of the homes operating processes e.g. staffing skill mix/establishment, record keeping, information sharing, care environment
- Agreement of a specific improvement plan relating to the above if required
- Identification of residents with end of life care needs for whom an advance care plan should be developed
- An assessment of what other service inputs are required by residents in the home and coordination of referrals to other services e.g. specialist end of life care services, falls prevention etc.
- RCA review of acute admissions and ambulance call outs