West Mid Beds Falls Prevention Project

Supporting the Left Shift through VCSE, Neighbourhood Working and Prevention

Why this matters?

- Falls, frailty, loneliness and loss of confidence often develop before clinical intervention is required. The opportunity is to identify risk earlier and connect people to community support that keeps them well, independent and connected
- Move from reactive care to prevention. Work with existing VCSE infrastructure. Build social connection and resilience. Reduce loneliness and isolation. Support people to remain independent for longer
- Our approach was to work with existing services at a local level. We identified existing partnerships and services to help us shape our offer to patients of West Mid Beds.
- With support from ICB colleagues we followed a QI approach

West Mid Beds Neighbourhood

We have two Primary Care Networks, with five GP practices

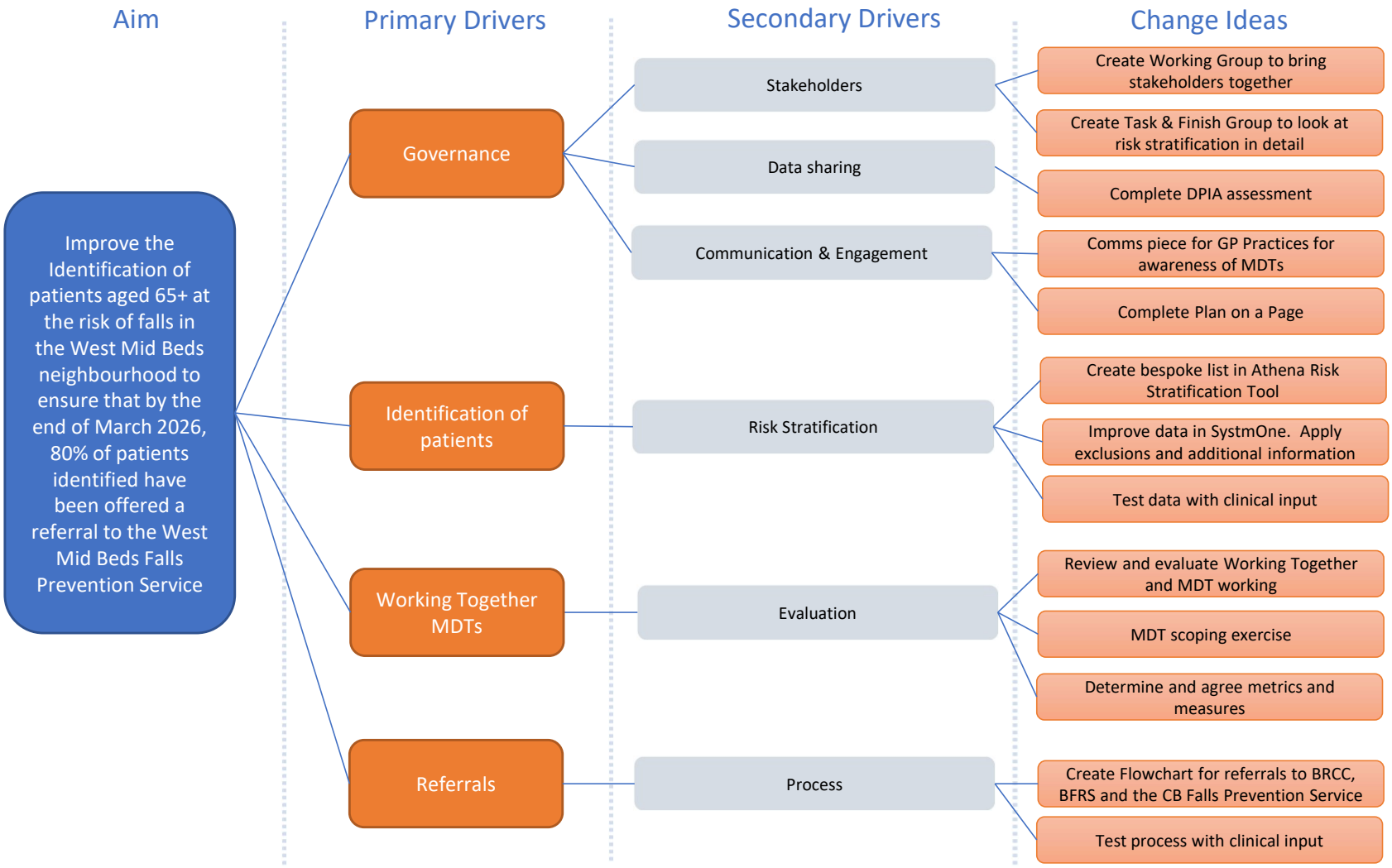
We have a registered population of 58,954 (January 2025)

Between 2024-2030, an extra 4,734 new houses in our neighbourhood will cause a 15% increase in our population

29% of our population has at least one long term condition

NHS
East London
NHS Foundation Trust

Driver Diagram for West Mid Beds Integrated Neighbourhood Working v1.3



Where do we want to be?

Our ambition "A team of teams, working together to deliver timely, personalised care and support in our neighbourhood with a focus on falls prevention"

We will…

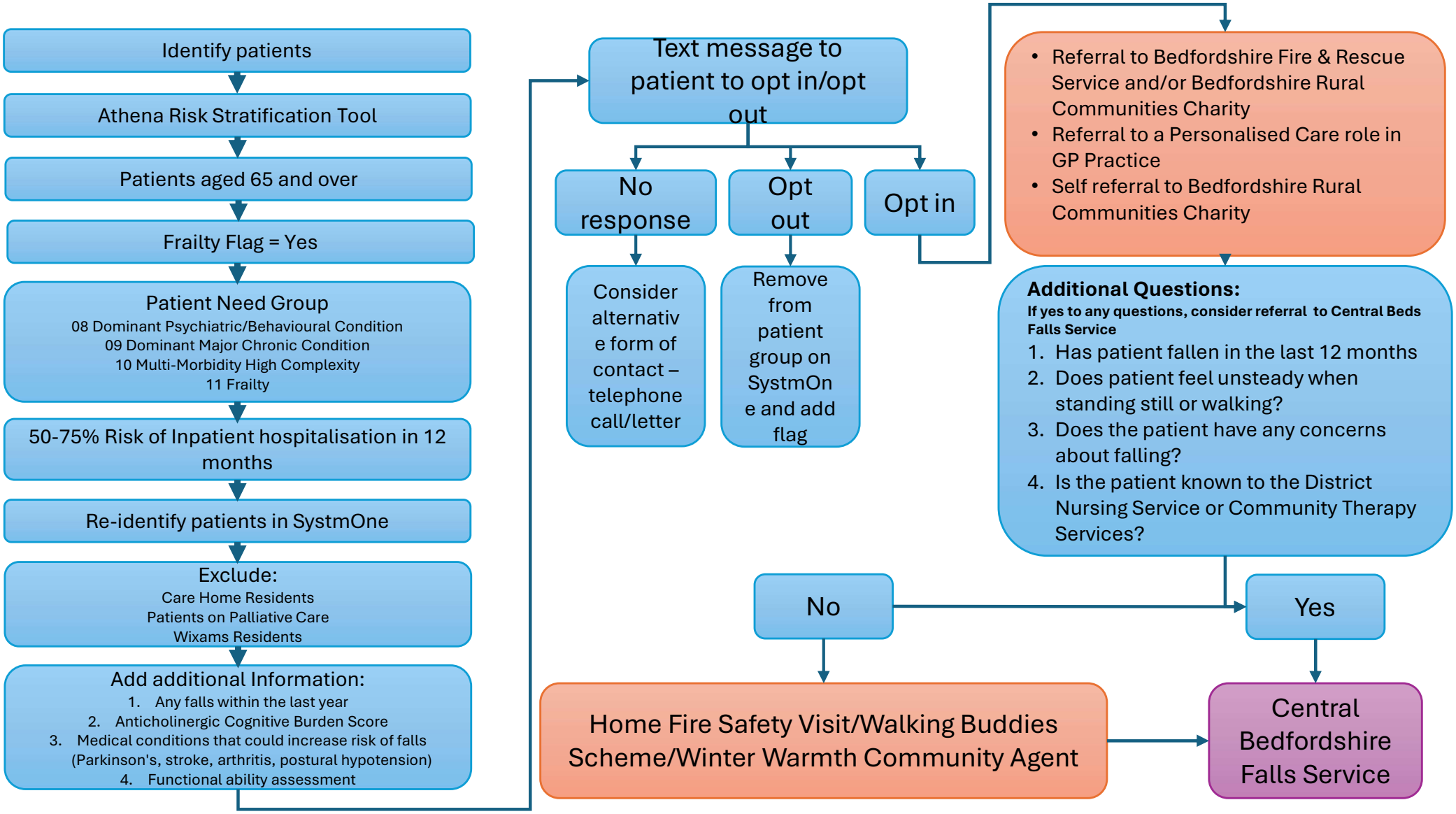
- Deliver care through the best channel for the person and in a suitable, sustainable environment
- Deliver support at the right time so that people can stay well, reducing the escalation of needs, wherever possible
- Provide personalised care and support that is accessible, safe and of a high quality.

Risk Stratification:

- John Hopkins model
- PNG 8-11
- Over 65
- Frailty flag
- 50-75% risk of hospitalisation in next 12 months
- Review of notes – exclusion for those receiving palliative care or in a care home

Central Bedfordshire West Mid Beds Falls Prevention Pathway

NHS East London NHS Foundation Trust



Connecting with our patient group

- 1st contact was a text message; no response
- 2nd contact letter posted to patients address; no response (Christmas break)
- 3rd contact the practice contacted 20 patients directly to have a personalised call; success!

Testing……..

- **1st December:** Testing process with 20 patients from Hillton PCN
- **5th January:** Pilot starts
- **Numbers:**
  - Greensand (Ampthill): 43
  - Flitwick: 36
  - Marston Forest: 34
  - Oliver Street: 28
  - Houghton Close: 56
  - Barton-le-Clay: 71

- Patients at risk of falls identified via Athena Risk Stratification Tool
- Text message and letter to patient to offer conversation with Social Prescriber to discuss available services
- Patient opts in or out
- Patient referred to Bedfordshire Fire and Rescue Service for a home fire safety visit, Beds RCC Walk Buddy support or Central Beds Falls Prevention Service,

Community Interventions

Social Prescribing conversation – Beds RCC

Falls Prevention Therapy - ELFT

Home Safety Check – Beds Fire Service

Walk Buddy Scheme – Beds RCC

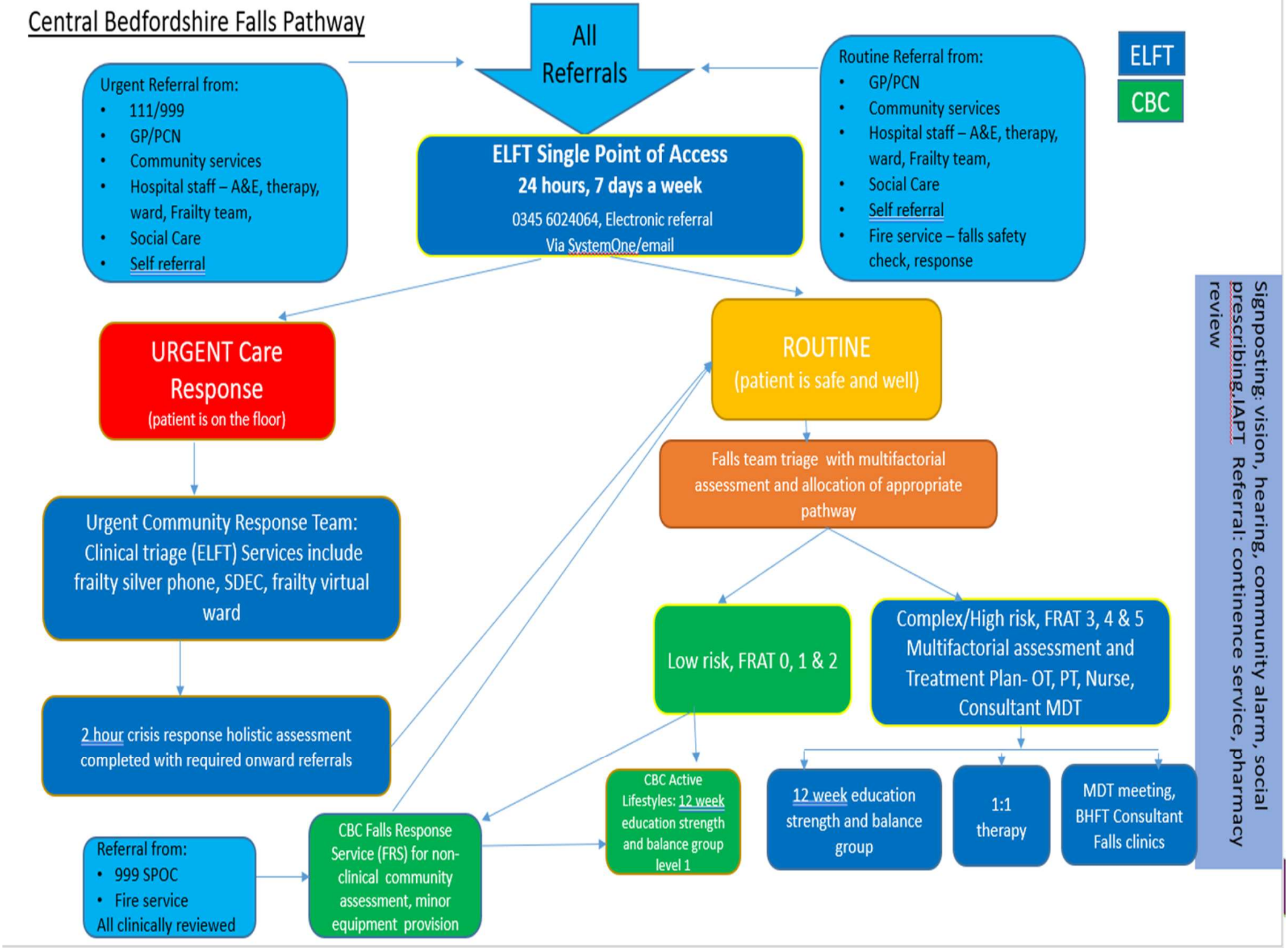
Central Bedfordshire Falls Service Background & Strategic Need

- Falls are a major national and local priority due to their impact on injury, loss of independence and demand on health and social care services.
- Central Bedfordshire has the oldest population in BLMK, with a rapidly growing population aged 65+ and 85+, increasing future demand for falls prevention services.
- In 2023/24, residents aged 65+ experienced **3,010 ambulance journeys**, **1,566 hospital admissions** and **20,358 acute bed days** related to falls, with estimated acute costs of approximately **£8.4 million**.
- Central Bedfordshire is the only locality in BLMK without a long-established therapy-led falls prevention service, creating inequity compared with Bedford, Luton and Milton Keynes.
- Evidence demonstrates that targeted falls prevention interventions can reduce falls risk, emergency admissions and wider system costs. A **5% reduction** in falls activity could theoretically avoid **78 admissions and 1,017** bed days annually

Central Bedfordshire Falls Service Aims and Objectives

- Provide a specialist, integrated falls prevention service offering evidence-based assessment, advice and intervention through a single point of access for people at all levels of falls risk.
- Reduce the likelihood of falls, recurrent falls and serious injury through holistic assessment, personalised care planning, therapy interventions, equipment provision, education and preventative support.
- Improve independence, confidence, mobility and long-term physical activity, while providing timely onward referral to wider health, social care and voluntary sector services.
- Integrated multidisciplinary pathway: The service works in partnership with the East of England Ambulance Service (EEAST), Bedfordshire Fire & Rescue Service, BRCC social prescribers, consultant-led falls clinics, community services and voluntary sector organisations to provide early identification, rapid referral, comprehensive assessment and coordinated intervention for people at risk of falls.

Central Bedfordshire Falls Pathway



Central Bedfordshire Falls Service Benefits

Benefits for Patients

- Reduced risk of falls, fractures and hospital admission through early intervention and multidisciplinary assessment.
- Improved mobility, confidence, independence and quality of life. Increased access to strength and balance programmes, education and self-management support.

Benefits for the Health & Care System

- Reduces demand on community therapy teams, primary care, ambulance services and acute hospitals.
- Supports prevention, admission avoidance and reduced reablement and care package requirements.
- Creates a streamlined, integrated pathway with improved partnership working across health, social care, leisure and voluntary sector organisations.

Strategic Benefits

- Directly supports BCF objectives and NHS priorities by shifting care:
  - From hospital to community
  - From treatment to prevention
  - Towards integrated neighbourhood working

Central Bedfordshire Falls Service Benefits

- **649 referrals** received between September 2025 and May 2026.
- **93%** of urgent referrals responded to within 10 days and **96%** routine referrals seen within 4 weeks.
- Strength & Balance programme **85% showed improvement** in Timed Up & Go outcomes among programme completers (3 of the 4 service users referred from West Mid Beds showed improvement across Rockwood and Frailty Efficacy Scale – no hospital admissions)
- Early evidence indicates improved wellbeing, confidence and reduced reliance on health and care services.
- Healthcare utilisation data not yet available for this pilot

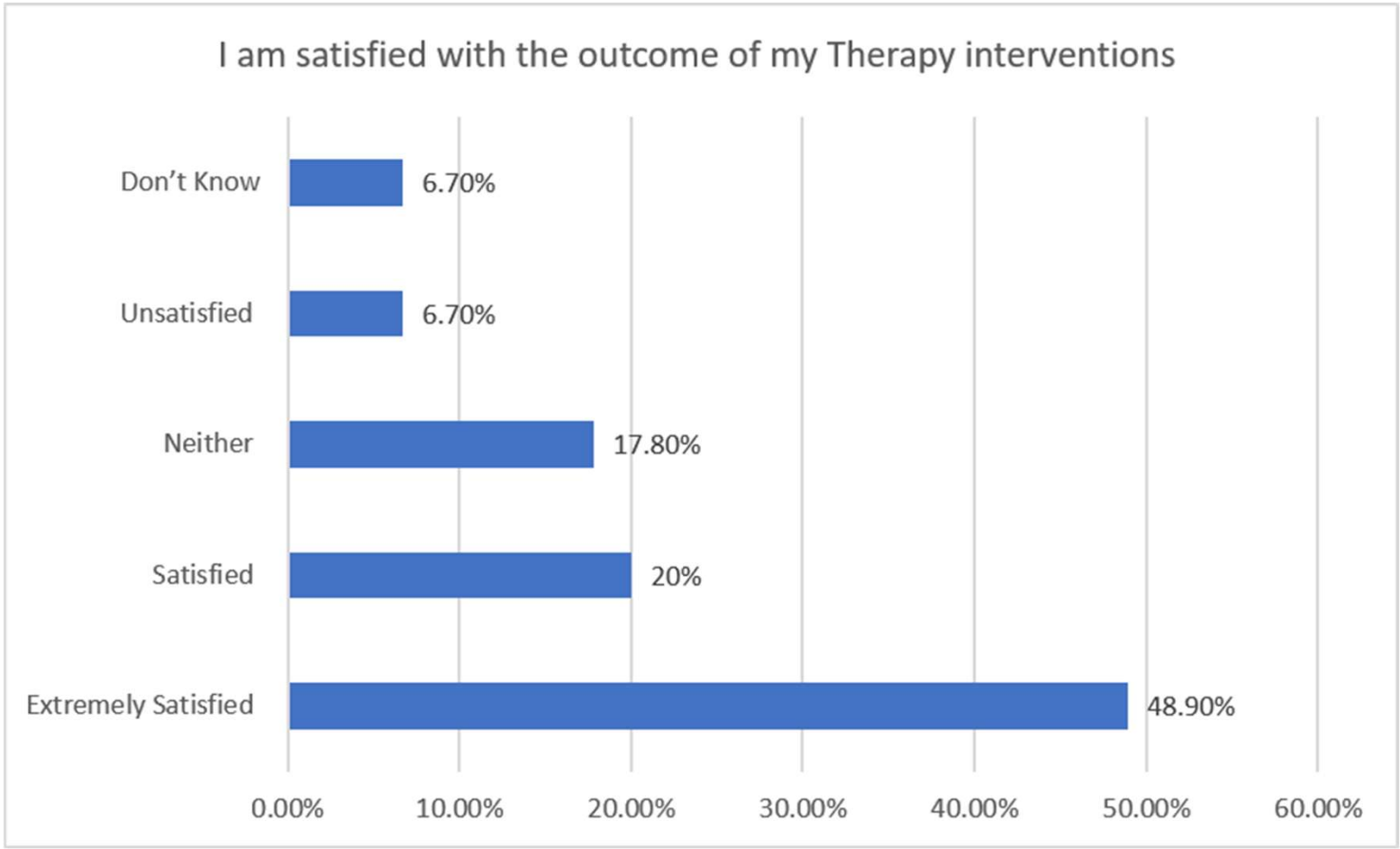
Central Bedfordshire Falls Service Benefits

- **High patient and carer satisfaction:** Patients consistently reported increased confidence, improved mobility and greater independence, with many praising the professionalism, kindness and support provided by the Therapy Falls Team.

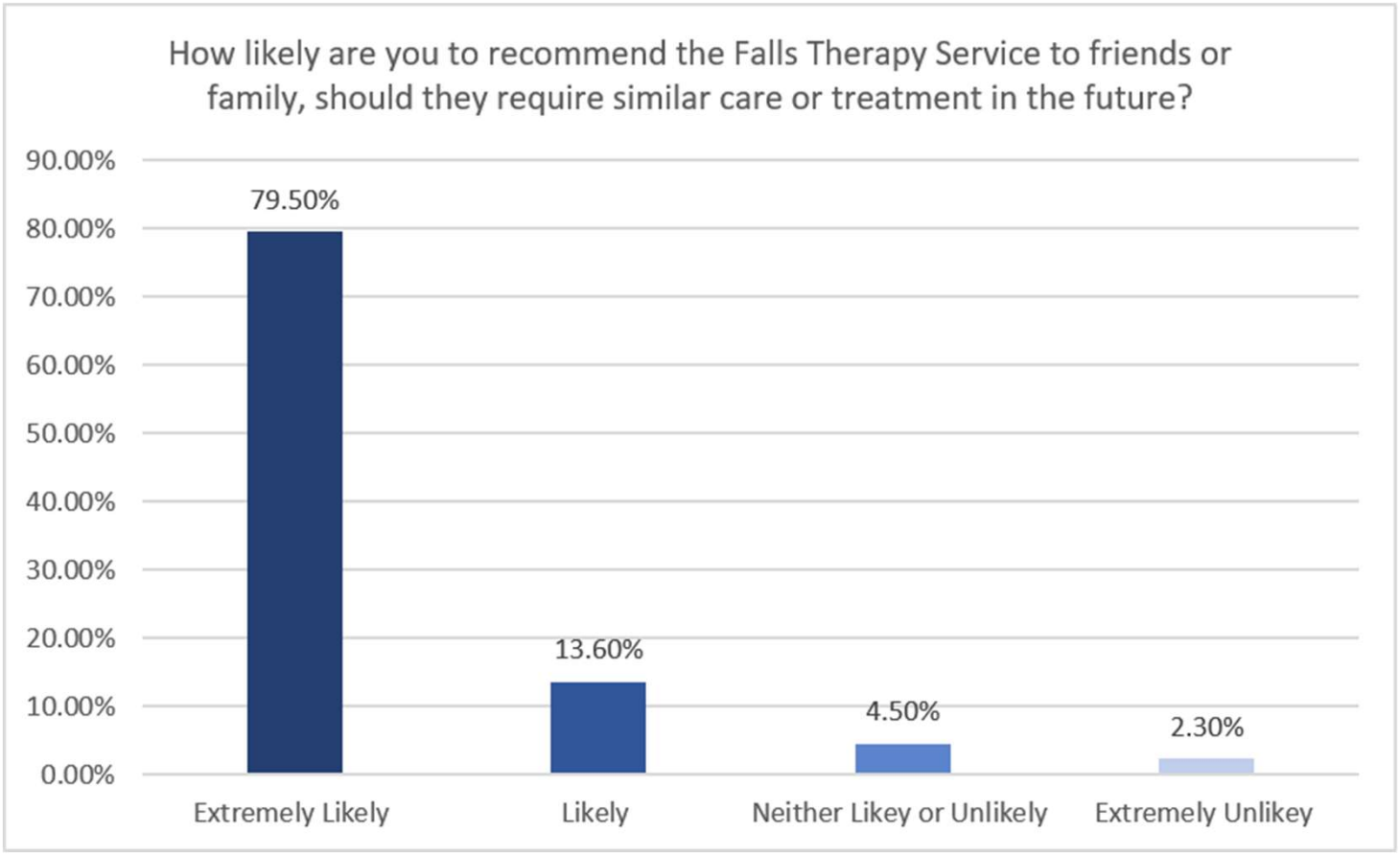
- **Improved outcomes but ongoing complexity:** Many patients reported walking more independently, feeling less fearful of falling and benefiting from equipment and advice; however, dementia, frailty and multiple long-term conditions continue to drive ongoing falls risk for some individuals.

- **Opportunities for service enhancement:** Feedback highlighted the value of additional follow-up, reassessment and ongoing support for people with complex needs, recurrent falls or those requiring continued encouragement to maintain exercises and mobility.

Central Bedfordshire Falls Service Benefits

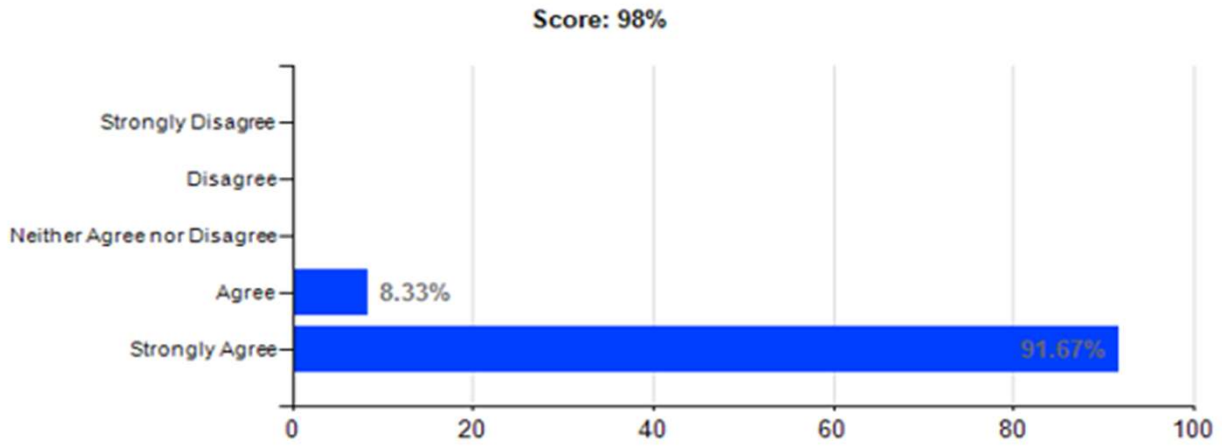


Central Bedfordshire Falls Service Benefits

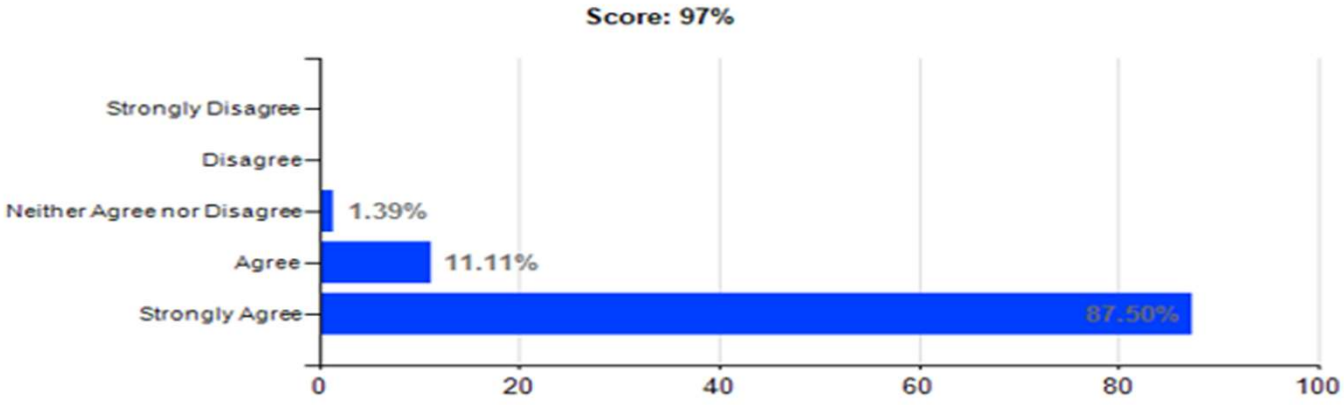


Central Bedfordshire Falls Service Benefits

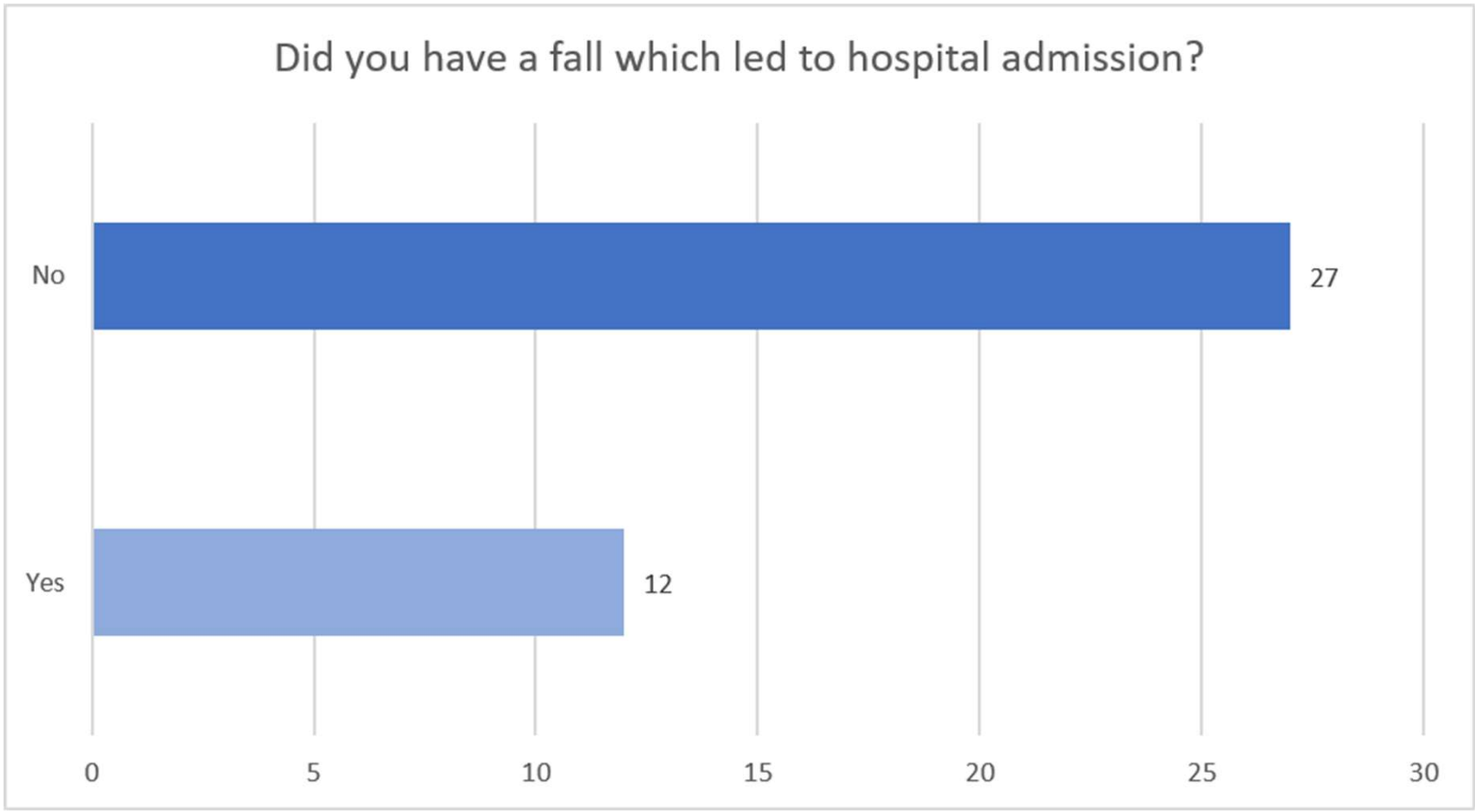
1.4 I felt listened to and understood by the people involved in my care and treatment



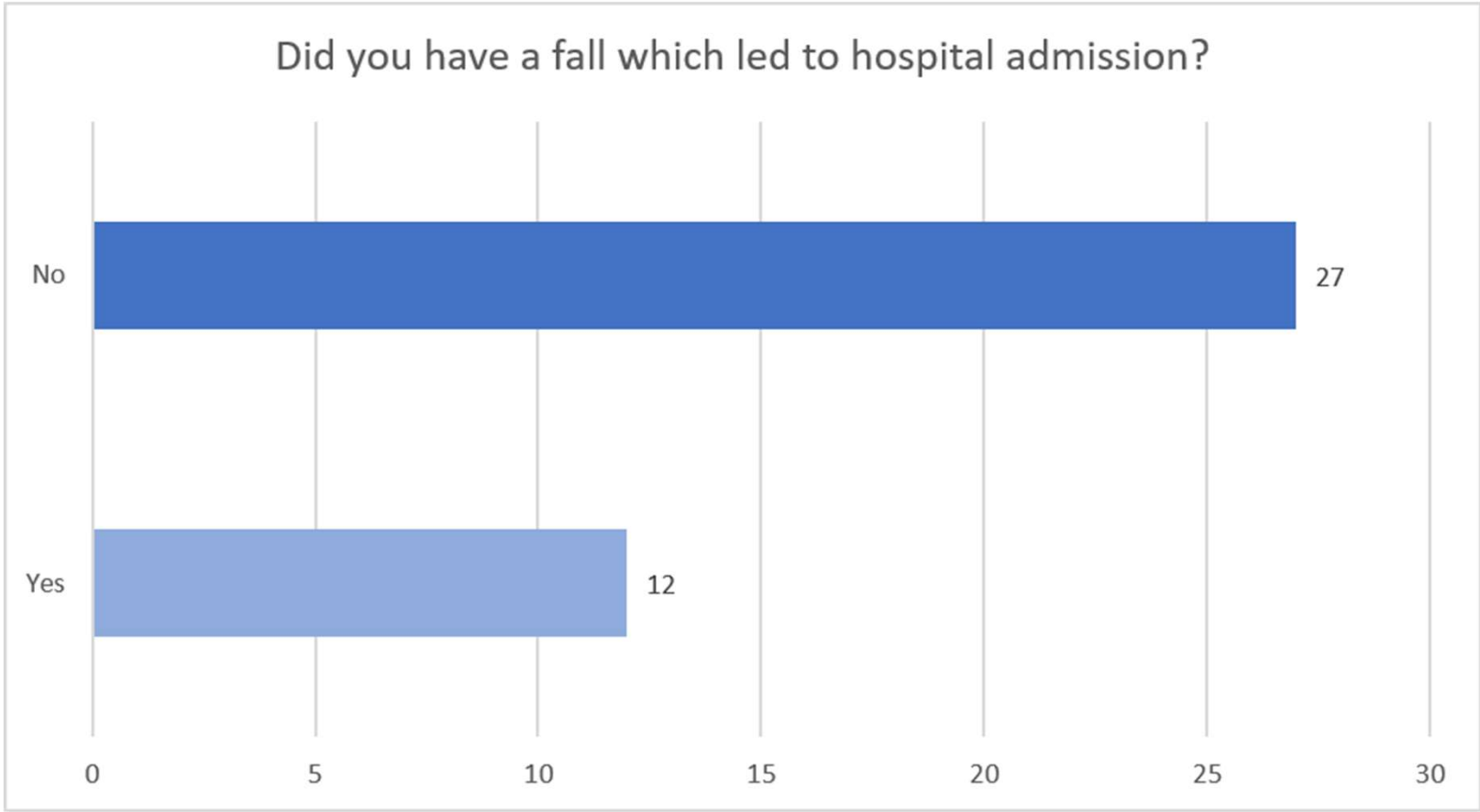
1.5 There was good collaboration between me and the professionals involved in my care and treatment



Central Bedfordshire Falls Service Benefits



Central Bedfordshire Falls Service Benefits - 12-week post discharge review period



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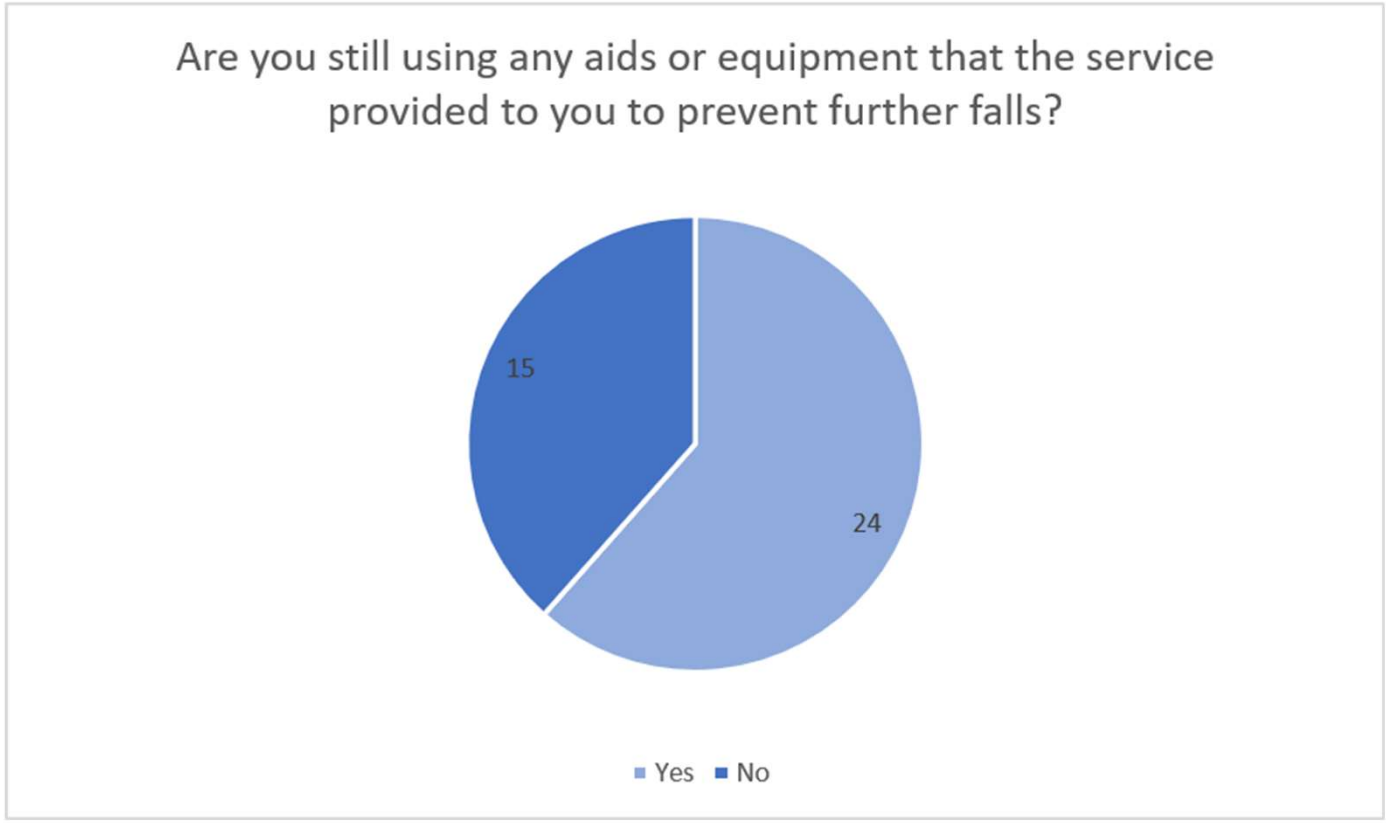

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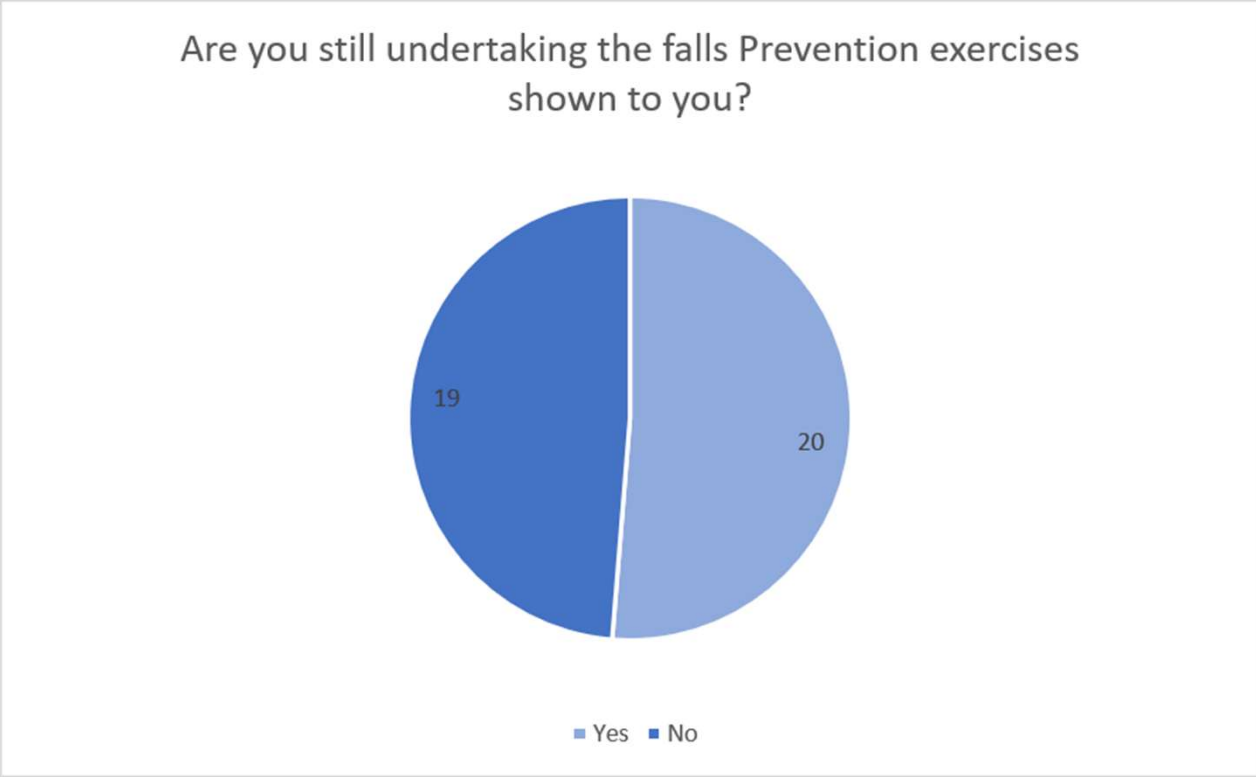

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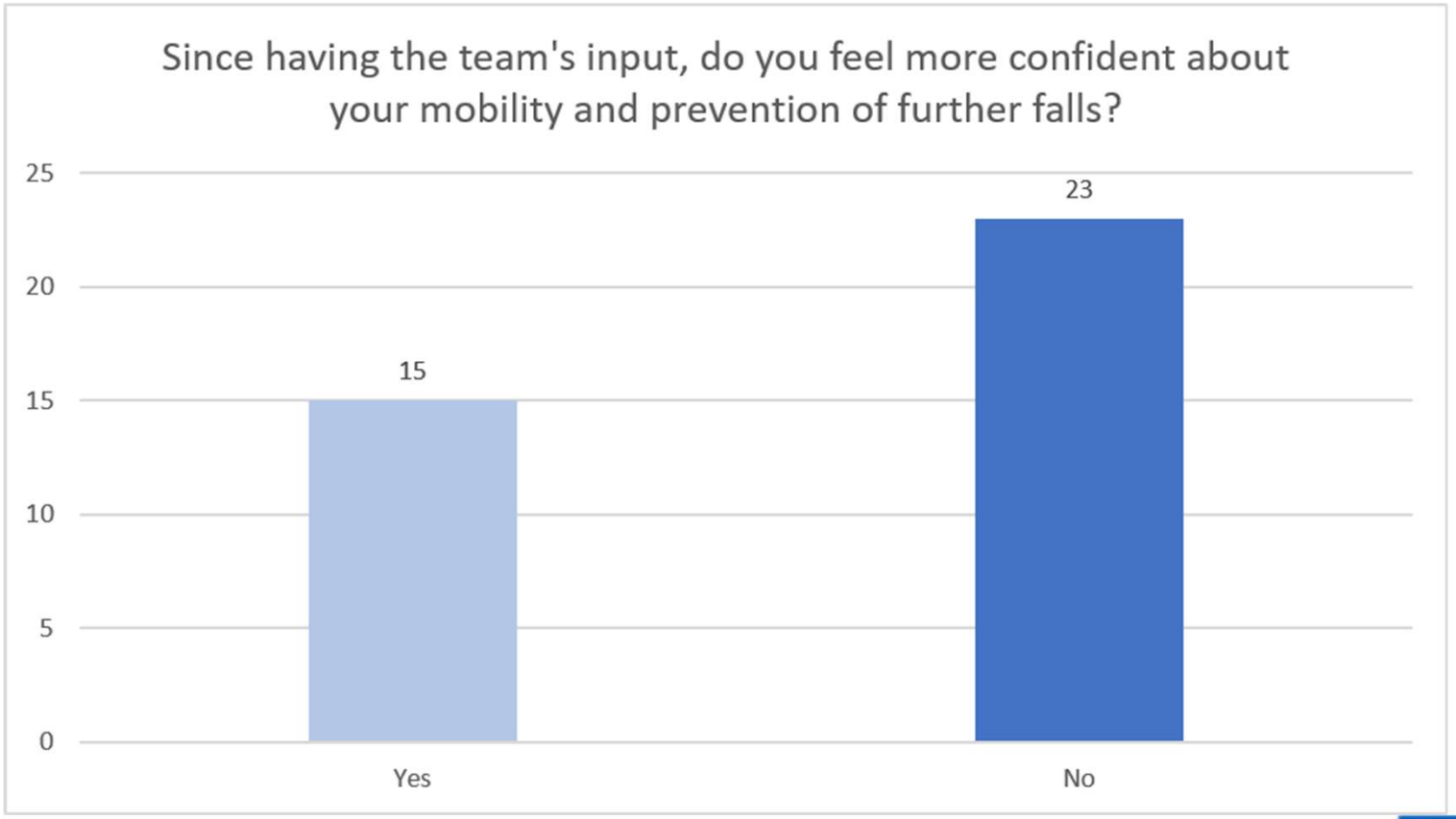


Central Bedfordshire Falls Service Benefits

Service User 1: Participated in both home therapy and Strength & Balance classes, reporting improved mobility, increased walking distance and greater confidence, while valuing the education, exercises and social aspects of the programme.

Service User 2: Benefited from home therapy, Strength & Balance classes and equipment provision, gaining confidence, improved awareness of falls hazards and new social connections that continued beyond the programme.

Service User 3: Received home-based therapy, exercises and adaptive equipment including a stair rail and toilet frame, resulting in significantly improved independence, confidence and ability to manage safely at home

Central Bedfordshire Falls Service Challenge

- Access to healthcare utilisation data and comparison to control group
- Admissions to hospital for 30% of people 12 weeks post discharge from falls prevention
- 40% more confident about mobility and prevention of further falls
- Adherence to recommended exercises and equipment use
- Ongoing funding challenges / left shift of resources

Community Referral Social Prescribing

Beds RCC
Bedfordshire Rural Communities Charity

Social prescribing takes a holistic approach in addressing people's non-medical needs. It plays a crucial role in transforming the underlying social, emotional, and practical circumstances that impact people's health & wellbeing. It empowers people to manage existing health problems and to make changes. It can help people to connect and to grow in confidence leading to meaningful, long-term improvements in their overall quality of life.

Social prescribing is available to anyone aged **18 and over** who would benefit from non-clinical support to improve their **health and wellbeing**. They can be referred by a GP, nurse, social worker, or community organisation or they can self refer.

Key features of Community Referral Social Prescribing (CRSP)

- Self-referral and statutory offer commissioned by CBC and BBC LA. We host a SPLW on behalf of 7 PCNs in Beds
- Qualified 4-day accredited Health & Wellbeing Coach
- Strategic partners with INW teams
- SPLW group facilitation trained
- SPLW embedded in CMHT blended teams commissioned through ELFT
- Delivering be-spoke Green Social Prescribing Offers to meet health needs
- Monthly data dashboards
- No waiting list
- Over 4000 people receive support from the service

Outcomes and Impact

Cohort = 20 patients

- 40% of patients contacted consented to a SPLW referral

Of the 8 consenting patients

- 37.5% of patients were referred to the Therapy Falls Service
- 50% of patients were referred to Beds Fire for a home safety check
- 25% of patients were referred to the Walk Buddy Scheme
- 50% of patients wanted the information and would think about it (follow up check-in is scheduled)

Walk Buddy Scheme

A community-based volunteer scheme, aligned to the Good Neighbour Scheme Networks and Neighbourhoods, offering support to residents who would be identified as **pathway 1** patients to complete short walks at home as part of their personalised care plan, enabling them to remain independent in their own home and feel confident to engage in light activities. The Walk Buddy Scheme will link the resident with a local volunteer who will meet with them to go for a short walk, building confidence to help improve their health and wellbeing and reduce social isolation.

Case Studies

1/ Patient S was referred for low motivation following illness and linked with a volunteer. They walked regularly from S's home to a local seated exercise group. The volunteer and S developed a positive relationship S has continued to attend the exercise group walking independently which has improved her mental wellbeing and motivation to walk locally.

2/ R was feeling isolated and becoming less mobile and less willing to try to go out independently. After being linked with a volunteer they walked regularly in the village and R started to chat with their neighbours. They built confidence walking and was able to go out independently. They enjoyed meeting people who lived locally that they had lost contact with

Home Fire Safety Visit

Bedfordshire Fire & Rescue Service

- 45 to 60-minute free visit with consent of the resident
- 75% target homes 65+ and/or long-term health condition or disability
- Smoke, heat, CO, impaired hearing alarms
- Safety in the home
  - Bedtime routine, escape routes
  - Slips, trips and falls
  - Kitchen safety
  - Electrical safety
  - Impact of medication and alcohol, drugs
  - Mobility concerns
  - Clutter, hoarding
  - Smoking
  - Emollient creams, oxygen, airflow mattresses

Impact

Bedfordshire Fire & Rescue Service

West Mid Beds Project Referrals

- ~25% of the project cohort (4 in total)
- Average total risk score - 31
- 3 live alone
- All have long term health conditions
- 1 smoking home (no onward referral but was an emollient cream user (2 in total) and had meds impacting alertness)
- 2 Falls referrals (CBC front door)
- 3 mobility concerns, 2 need assistance to evacuate
- Hearing impaired alarms all homes, 1 visually impaired resident
- Bedtime routines, escape routes

Central Bedfordshire overall (25/26)

- 1789 visits to people 65+ (32 Ampthill, 60 Flitwick)
- 1274 have long term health conditions
- 197 smoking homes
- 597 emollient cream users
- 203 Meds impacting alertness
- 935 Mobility concerns
- 539 need assistance to evacuate
- 185 Falls referrals (CBC front door)

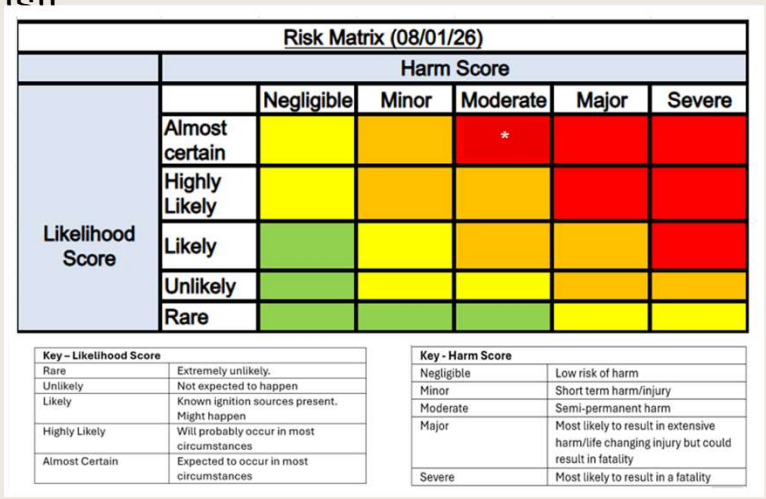
Adults At Risk Management Framework

Bedfordshire Fire & Rescue Service

A structured, enhanced risk evaluation process for people who present exceptionally high fire risk due to complex vulnerabilities beyond the Home Fire Safety Visit

AaRM provides:

- Deeper assessment following a standard HFSV
- Multi-agency collaboration
- As Low as is Reasonably Practicable- based risk reduction
- A clear escalation and safeguarding pathway



Risk Matrix (08/01/26)

Likelihood Score	Harm Score: Negligible	Minor	Moderate	Major	Severe
Almost certain			*		
Highly Likely					
Likely					
Unlikely					
Rare					

Key – Likelihood Score	
Rare	Extremely unlikely.
Unlikely	Not expected to happen
Likely	Known ignition sources present. Might happen
Highly Likely	Will probably occur in most circumstances
Almost Certain	Expected to occur in most circumstances

Key - Harm Score	
Negligible	Low risk of harm
Minor	Short term harm/injury
Moderate	Semi-permanent harm
Major	Most likely to result in extensive harm/life changing injury but could result in fatality
Severe	Most likely to result in a fatality

Example case: Stroke survivor restricted mobility, smokes in bed, scorch marks, medication that causes drowsiness, unsafe emptying of ashtray in bin, charges mobile scooter in lounge

- 39 (at present) in Central Bedfordshire; 111 overall across Bedford, Central Beds. Luton

Next Steps

- Finalise evaluation
- Pull through the patient voice
- Identify 26/27 onwards funding for Walk Buddy and the continuation of Therapy Falls Service
- Appetite for more collaboration; VCSE requires resourcing for testing phase

Beds RCC
Bedfordshire Rural Communities Charity

Questions & Comments…….

Did anything in the presentation inspire you to take action?

What barriers have you noticed, would you do anything differently?