

# Falls Prevention and Management in Scotland: the Impact of Local and National Policies

Falls prevention: Evidence into Practice  
European Seminar  
Glasgow, 19 November 2014

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# Falls Prevention and Management in Scotland

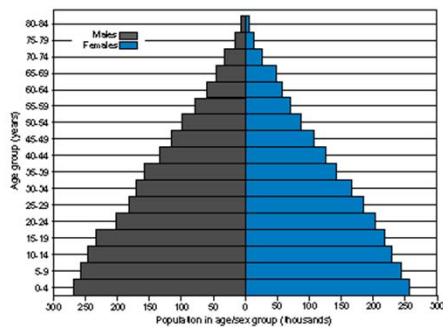
The next twenty minutes...



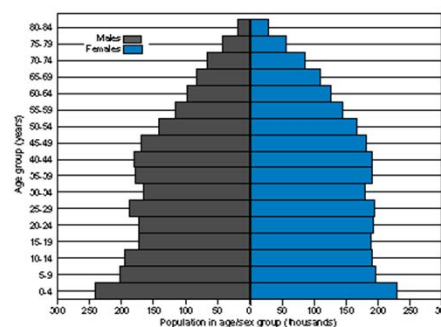
- The strategic direction provided by national policy.
- Role of the National Falls Programme in supporting the translation of policy into practice.
- The local response to national policy and improvement drives.
- Reflections on the journey so far.
- *Focus on falls in the community setting.*

# Setting the scene

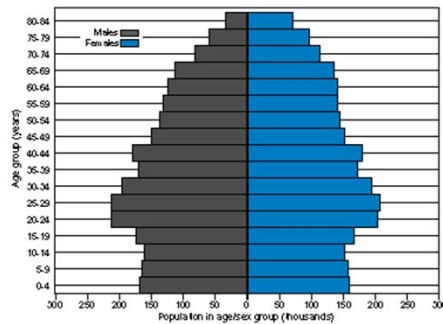
## Scotland at a glance



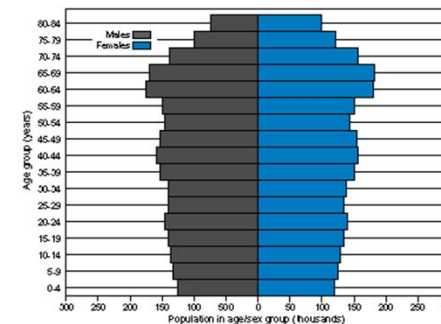
1911



1951



1991



Projection to 2031

- Population 5.2 million
- Approximately 17% 65 years or over
- National Health Service
- Health and Social care devolved to Scottish Government
- 14 territorial NHS boards; 35 Community Health Partnerships
- 32 local authorities
- Integration: 32 health and care Partnerships by April 2015
- Ageing population
  - 50% increase in people aged over 60 years by 2033



## Why falls matter

### Scale and cost (Scotland)

*In people 65 years and over:*

- Largest single presentation to the **Scottish Ambulance Service (over 35,000 attendances)**.
- One of the leading causes of **Emergency Department** attendance.
- Responsible for over **390,000 emergency bed days**.
- Implicated in up to **40% care home admissions**.
- **Highest reported incident** in hospital settings.

Costs to health and social care services in Scotland estimated to exceed **£471m** each year (est. rising to £666m by 2020):

- 45% long term care
- 40% NHS
- 15% care at home

(Hip fracture **£39,500** )

*(Craig 2012)*

# Falls Prevention and Management

Where we were in 2007



“The future is already here – it’s just not very evenly distributed.”

*William Gibson* 5

# Falls Prevention and Management in Scotland

## Policy context: creating the conditions



**2007**  
A Delivery Framework for Adult Rehabilitation in Scotland

Older people one of three priorities.

**2007**  
Health Department Letter

**Actions**  
Falls Leads.  
Combined Falls & Bone Health Strategy.  
Integrated pathway.  
**Community of Practice.**

**2010**  
Reshaping Care for Older People. A Programme for Change 2011-21

**Change Fund**  
£370million  
2011-2015

**2012**  
The National Delivery Plan for Allied Health Professions in Scotland 2012-2015

**Actions**  
Pathway development.  
Implementation Plans.

# Falls Prevention and Management in Scotland

## Policy context: Reshaping Care for Older People



Preventative and Anticipatory Care	Proactive Care and Support at Home	Effective Care at Times of Transition	Hospital and Care Home(s)
Build social networks and opportunities for participation.	Responsible flexible, self-directed home care.	Reablement & Rehabilitation.	Urgent triage to identify frail older people.
Early diagnosis of dementia.		Specialist clinical advice for community teams.	Early assessment and rehab in the appropriate specialist unit.
Prevention of Falls and Fractures.	Integrated Case/Care Management.	NHS24, SAS and Out of Hours access ACPs.	Prevention and treatment of delirium.
Information & Support for Self Management & self directed support.	Carer Support.	Range of Intermediate Care alternatives to emergency admission.	Effective and timely discharge home or transfer to intermediate care.
Prediction of risk of recurrent admissions.	Rapid access to equipment.	Responsible and flexible palliative care.	Medicine reconciliation and reviews.
Anticipatory Care Planning.	Timely adaptations, including housing adaptations	Medicines Management.	Specialist clinical support for care homes.
Suitable, and varied, housing and housing support.	Telehealthcare	Access to range of housing options.	Carers as equal Partners.
Support for carers.		Support for carers.	

**Policy Goal:**  
 To optimise the independence and wellbeing of older people at home or in a homely setting.

# Falls Prevention and Management in Scotland

## Policy context: Recognising synergies



**2014**  
Active and Healthy Ageing: An Action Plan for Scotland  
2014-2016

*A Stitch in Time?*

A model to explain the third sector contribution to Reshaping Care for Older People



**2014**  
Third Sector Contribution to Reshaping Care for Older People

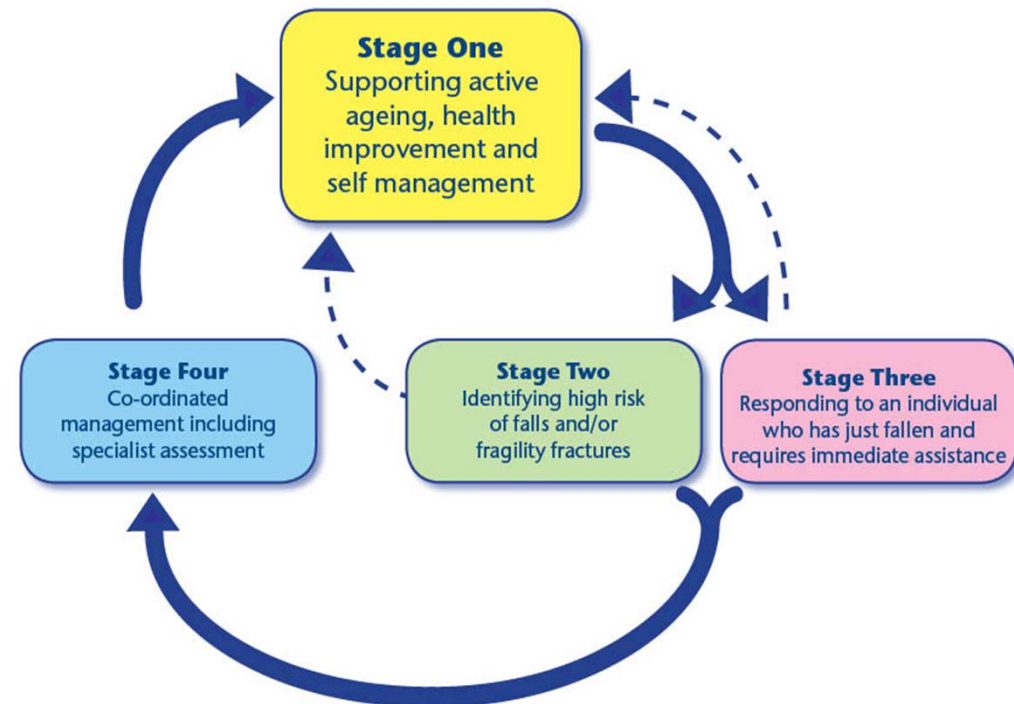


# The National Falls Programme in Scotland (2010 – present)

## What are we trying to accomplish?



- To reduce the personal, system and societal costs associated with falls in Scotland.
- For every health and social care partnership area in Scotland (32 partnerships) to have a local **integrated** falls prevention and management and fracture prevention pathway for older people *in operation* by the end of 2016.
- People have the opportunity to receive the right care and support, at the right time, in the right place to prevent harm from falls, **every time**.



### *The Up and About Pathway (2010)*

<http://www.scotland.gov.uk/Resource/0045/00459959.pdf>

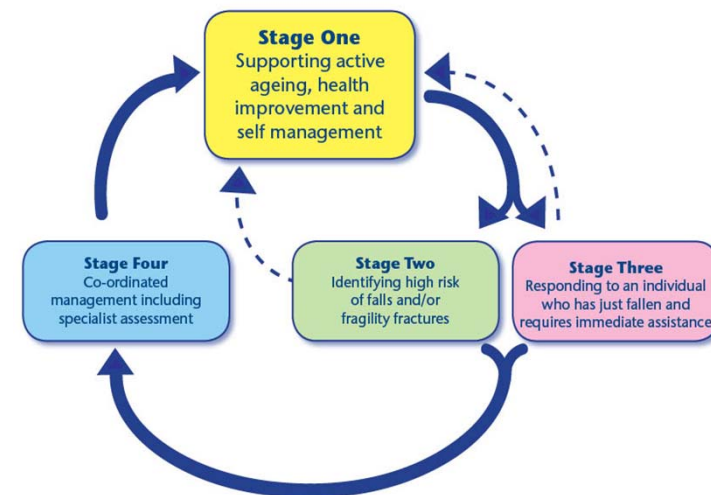
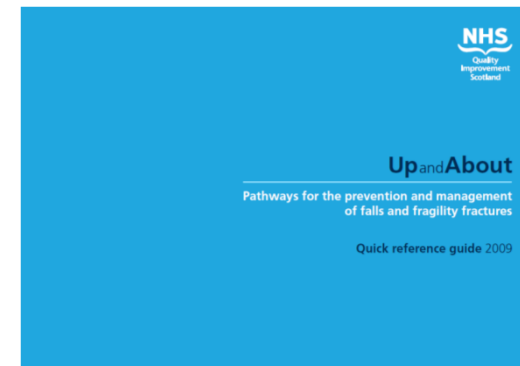
# The National Falls Programme in Scotland

## What are we doing?



The Falls Programme Manager **in partnership with** Falls Leads network and a range of stakeholders:

- Co-create a shared vision.
- Provide practical guidance.
- Share good practice, learning and experience; provide peer support.
- Identify & deliver national work streams.  
*“Do once for Scotland”*
- Nationally and locally, make falls prevention and management part of the conversation, when it needs to be.
- Monitor progress and provide accountability.



**The Up and About Pathway (2010)**<sup>10</sup>

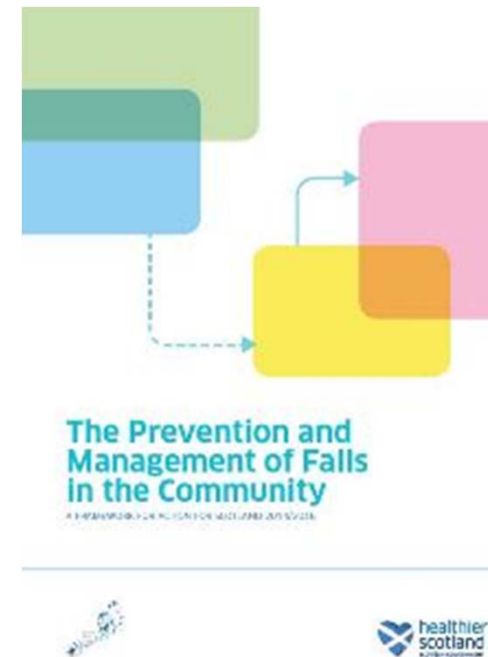
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### ***A Framework for Action for Scotland 2014/2016***

<http://www.scotland.gov.uk/Publications/2014/10/9431>

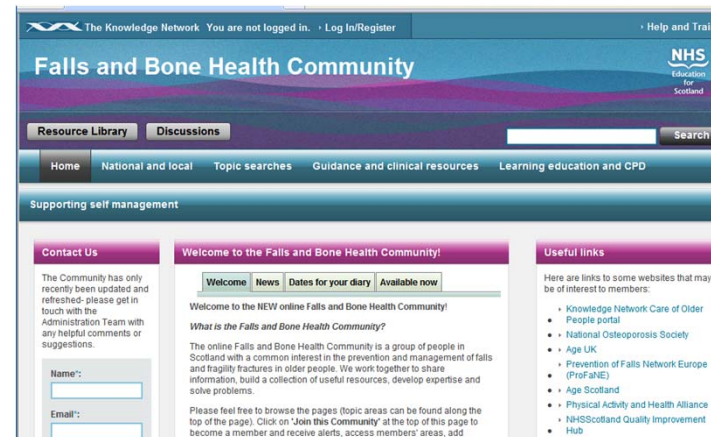
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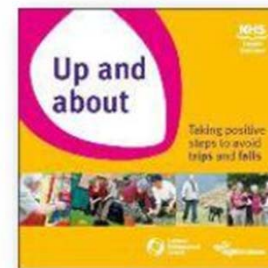


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SCOTTISH GOVERNMENT HEALTH AND SOCIAL CARE DIRECTORATES

Resources, costs and benefits associated with implementing care bundles to prevent falls in the community

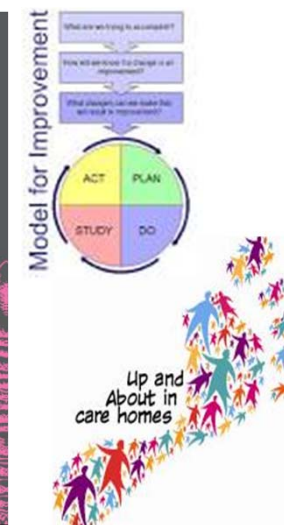
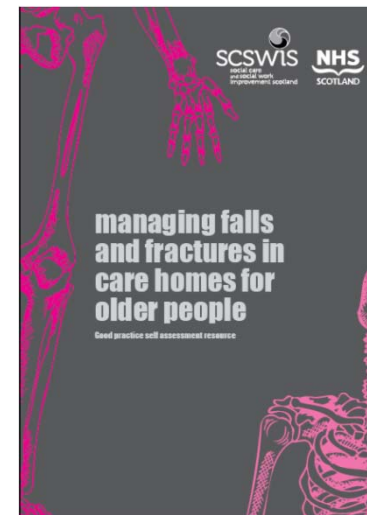
Final report

JOYCE CRAIG  
Consultant  
Craig Health Economics Consultancy Ltd  
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Giffnock  
Glasgow  
G46 7NZ

DATE DECEMBER 2012



Innovation Series 2012  
Using Care Bundles to Improve Health Care Quality

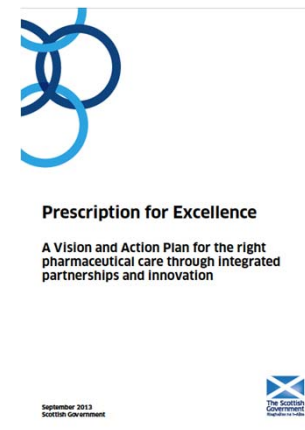


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Improving the identification and management of frailty  
A case study report of innovation on four acute sites in NHS Scotland



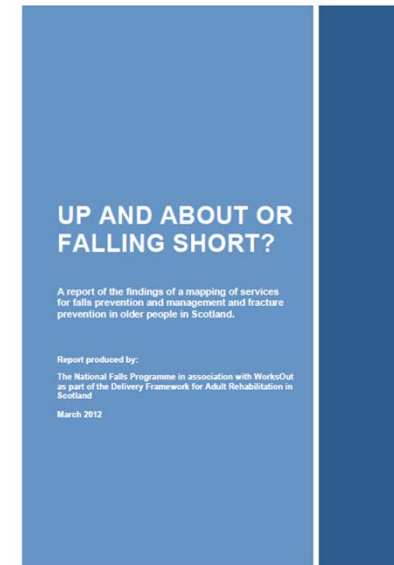
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Grouping	Question	Descriptor	CHP 1	CHP 2	CHP 3
HDL compliance	1.1	Combined board-wide strategy	5	5	5
	1.2	CH(C)P Improvement Plan	5	5	5
	1.3	Appointed CH(C)P Falls Lead	4	4	4
	1.4	Recognised local pathway in place	3*	3*	2
Delivering Up and About	2.1	Physical activity opportunities	4	5	5*
	2.2	Emergency Dept. referral pathway	4*	3*	3*
	2.3	SAS referral pathway	3*	3	3
	2.4	Community Alarm referral pathway	3*	2*	2*
	2.5	Secondary care referral pathway	4*	4	4
	2.6	Primary Care screening tool	4*	3	3*
	2.7	Social Care screening tool	3	3	3*
	2.8	Screening tool in shared assessment	3	3	3
	2.9	Uninjured faller pathway	3	1	2
	2.10	Multifactorial Falls Risk Screen tool	4*	4*	4*
Integration with osteoporosis services	2.11	Person-centred approach	4	1	4
	2.12	Strength and balance exercise	4	5	5
	2.13	Medical assessment	5	5	5
	2.14	Syncope service	5	5	5
	2.15	Home hazard assessment	4	5	3
	2.16	Access to DKA locally	5	5	5
	2.17	Review pre-discharge	2	1	4
	3.1	Fracture Liaison Service	1	1	5
Care Homes	3.2	Links between FLS and falls services	3	3	1
	4.1	Access to services for care homes	4	5	4
	4.2	Care home data re hip fractures	1	1	1
Training	4.3	Care home data re falls admissions	4	4	4
	5.1	Training for primary care staff	4	2*	4*
Service user involvement	5.2	Training for social care staff	4	4*	4*
	6	Service users involvement in service improvement	4	1	2



# In addition ... In hospitals

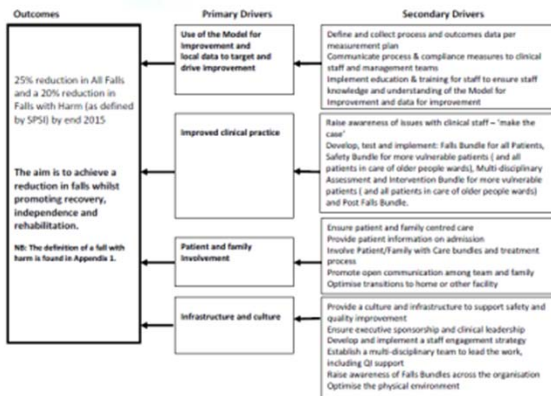
## MSK & Orthopaedic Quality Drive Spread & Sustainability of Five High Impact Workstrands



### Hip Fracture Care Pathway - Optimising care of frail older people



What drivers will support achieving the aim?	Measures of success
<b>Effective best-practice Emergency Department Interventions</b> <ul style="list-style-type: none"> <li>Triage Assessment &amp; Intervention - The Big Six (Analgesia administered/offer, SEWS &amp; Cognitive Screening inc Delirium, Pressure Area Inspection, Blood Samples &amp; IV Fluids)</li> <li>Triage Pathway Decision (i.e. to Orthopaedics or Medical) &amp; Notification to receiving specialty</li> <li>Inter-hospital Transfers (if medically fit)</li> </ul>	<ul style="list-style-type: none"> <li>All patients assessed &amp; interventions started for all 'at risk'</li> <li>Notification of all patients &amp; 50% transferred &lt;2hrs, All transfer &lt;4hrs</li> <li>All patients &lt;24hrs from presentation</li> </ul>
<b>Effective best-practice Pre-Peri- &amp; Post-Operative Interventions</b> <ul style="list-style-type: none"> <li>SEWS increase, Cognitive Assessment &amp; Delirium Care Bundle (COAs - Falls, Food, Fluid &amp; Nutrition and Pressure Areas)</li> <li>MOT Care (Ortho/Nurse/OT/Physio/Senior/Carer/Pharmacist/social in Comprehensive Geriatric Assessment for all patients identified as frail)</li> <li>Patients wait for theatre - determine and start interventions</li> <li>Departmental assessment guidelines for optimum peri-operative care to promptly identify, assess &amp; manage risk of Falls (see: 2hrs)</li> <li>Time to Theatre (medically fit patients)</li> <li>No patient in waiting corridor more than twice</li> <li>Low/modern proven cemented implants (GSA &amp; NICE guidelines)</li> <li>Pre-op (catheterisation not routine within range of national averages)</li> <li>Assess Feasibility of Mobilisation OT Assessment</li> <li>Outcomes Assessment &amp; intervention strategy</li> </ul>	<ul style="list-style-type: none"> <li>All patients assessed &amp; interventions started for all 'at risk' &lt;24hrs</li> <li>Regular All MOT meetings (Geriatrician input - 50% - 48hr/week - 72hrs)</li> <li>&lt;24hrs - Re-assess daily</li> <li>All follow assessment guidelines (95% on p.m. surgery not failed - 10hrs)</li> <li>0% no falls &lt;4hrs</li> <li>&lt;4hrs from admission</li> <li>As standard (unless contraindicated)</li> <li>Clinical need, not routine</li> <li>By end Day 1 post-op</li> <li>By end Day 3 post-op</li> <li>By discharge from acute/ rehab</li> </ul>
<b>Reduction in Delayed Discharges &amp; Outlier Hospitals</b> <ul style="list-style-type: none"> <li>MOT approach - discharge planning &amp; removal of reasons for delay started on admission. Work towards plans for 7 day services</li> <li>No outlier hospitals for - Mortality (at 30 days), % Readmissions (where patient hospitalised by any NHS care provider within 15 days (due to a 'failed discharge'), % Patients admitted from home not returned home at 120 days and % hospital beds</li> </ul>	<ul style="list-style-type: none"> <li>LOS (acute &amp; rehab), % discharge delayed for secondary/reason reasons</li> <li>Outliers identified by funnel gauge</li> <li>% patients compared with average</li> </ul>
<b>Patient/Carer Satisfaction</b> <ul style="list-style-type: none"> <li>Patient/carer experience, satisfaction and Patient Reported Outcome Measures consistently recorded and improvements implemented</li> <li>Full revision of care interventions to reduce wait</li> </ul>	<ul style="list-style-type: none"> <li>Regular measurement &amp; improvement cycles</li> <li>Feedback available</li> </ul>



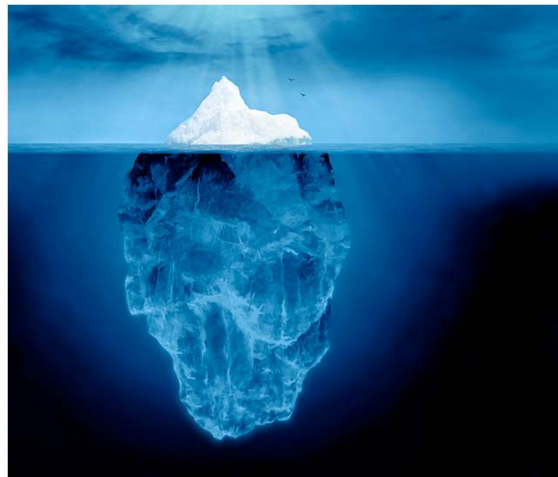
## Falls prevention in Acute Care

# Falls Prevention and Management in Scotland

## Impact



Is there a pathway for falls and fracture prevention and management in operation in your CH(C)P?			
	YES	WiP	No
<b>2010</b>	9 (24%)	24 (63%)	5 (13%)
<b>2012</b>	22 (58%)	16 (42%)	-



Credit: Pegasus Vertex, Inc.

### Measurement Framework

#### Includes:

- Scottish Ambulance Service presentations
- Scottish Ambulance Service conveyances to hospital
- Emergency admissions following a fall
- Emergency bed days following a fall
- Admissions with hip fracture

#### Stories:

- Service users
- Service providers

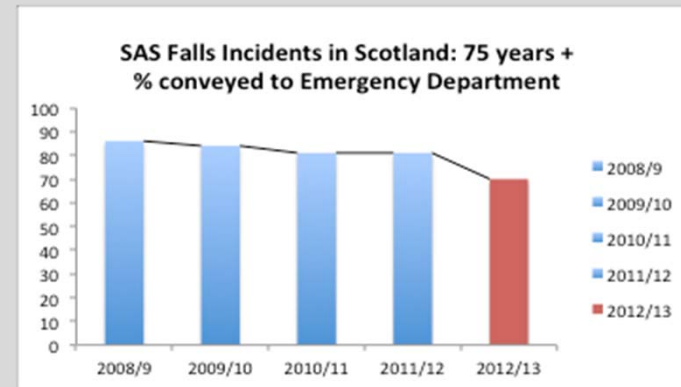
# The National Falls Programme in Scotland

## How do we know a change is an improvement?

### Scottish Ambulance Service Pathways

#### Scotland

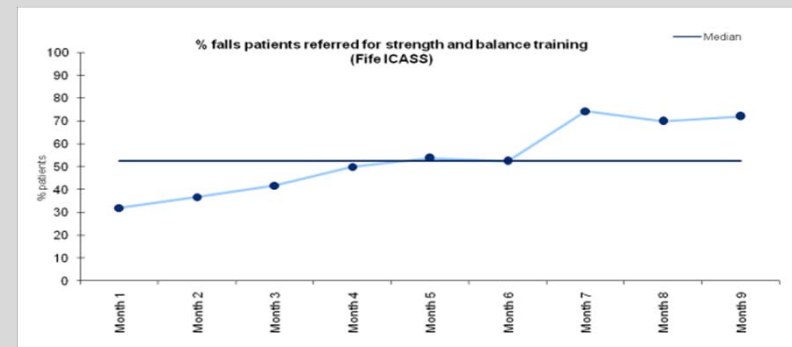
- Reduction in conveyances to hospital (86% down to 70%).



### Community Falls Bundles

#### Fife

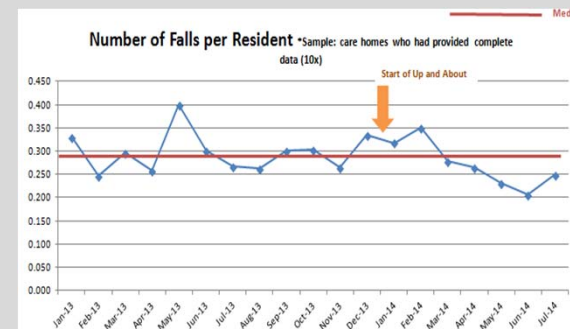
- Increase in percentage of people receiving strength and balance training.

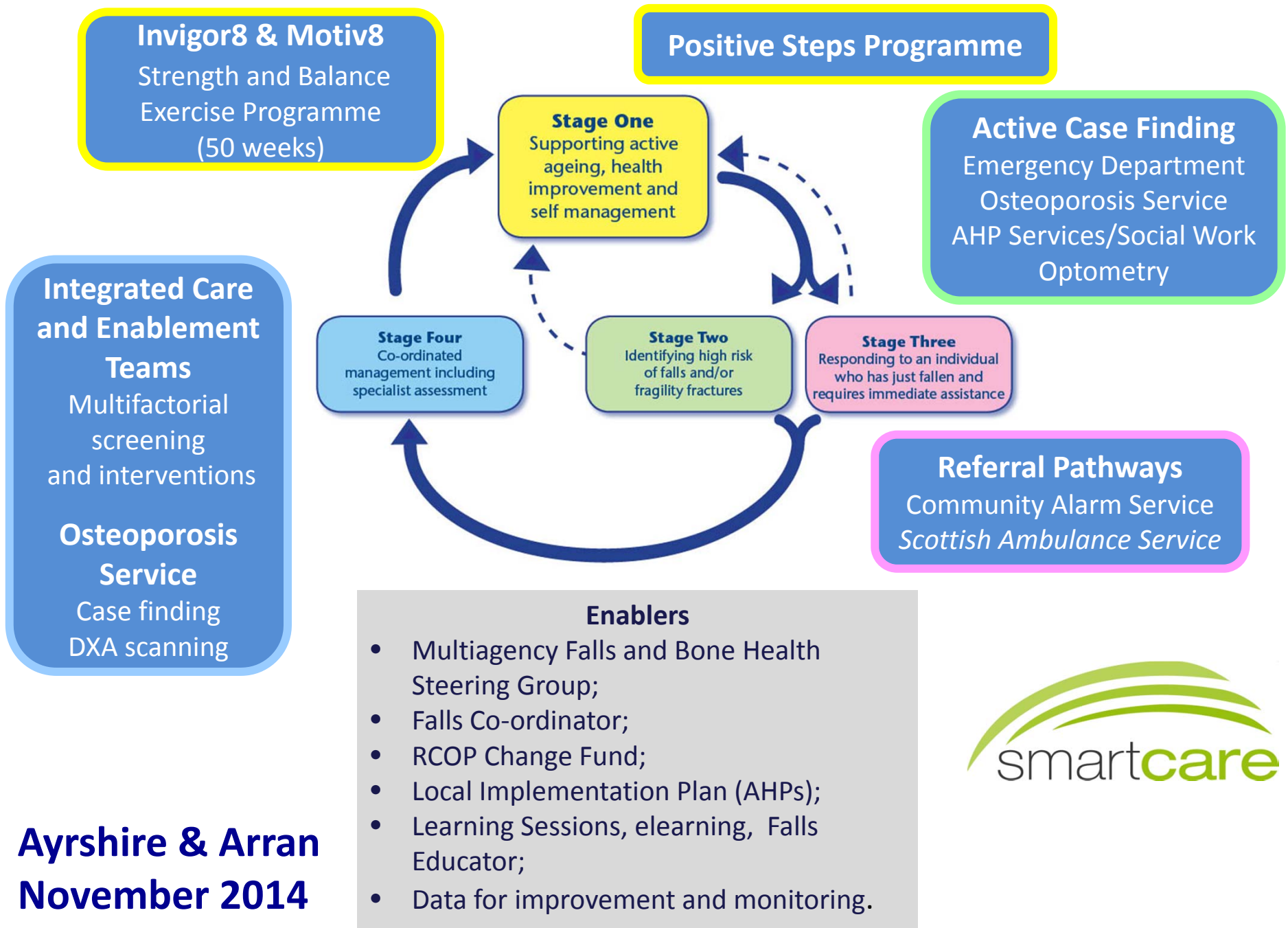


### Up and About in Care Homes

#### Three partnership areas

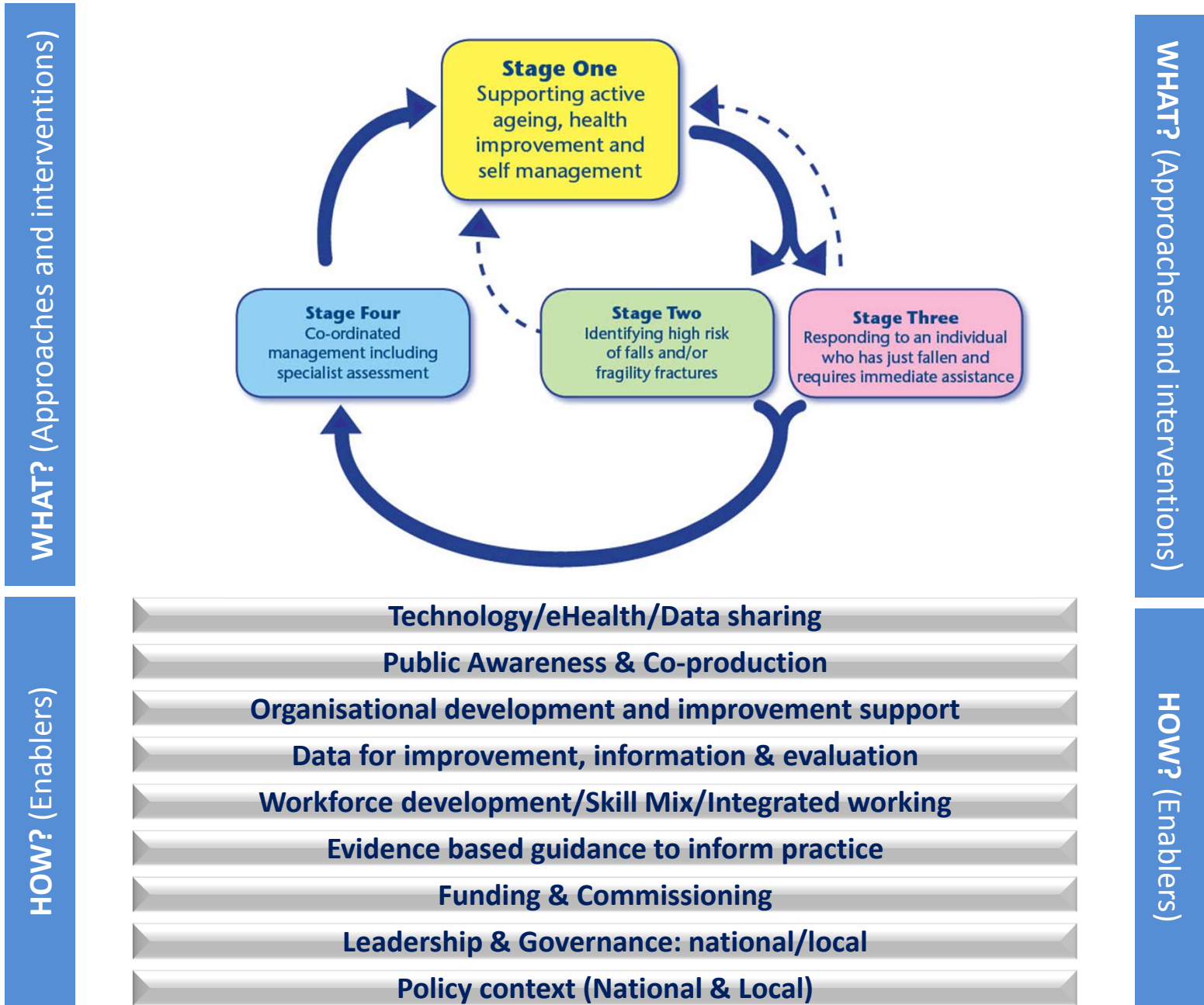
- Reduction in number of falls.
- Reduction in rate of ED attendances.





**Ayrshire & Arran  
November 2014**

# A Framework for a Whole System, Integrated Approach to Falls Prevention and Management



**Thank you for listening**  
**For more information, please contact:**

Ann Murray  
National Falls Programme Manager  
[ann.murray3@nhs.net](mailto:ann.murray3@nhs.net)



<http://www.knowledge.scot.nhs.uk/fallsandbonehealth/the-national-falls-programme>