UP AND ABOUT OR FALLING SHORT?

A report of the findings of a mapping of services for falls prevention and management and fracture prevention in older people in Scotland.

Report produced by:

The National Falls Programme in association with WorksOut as part of the Delivery Framework for Adult Rehabilitation in Scotland

March 2012

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Foreword

At a time when we are striving to address the challenges of demographic change and rising demands on public services, it is vital we understand the human and economic cost of falls. A fall can be a life-changing event for an older person; triggering a downward spiral of loss of confidence and independence, with increased dependence on health and social care services. Much of the activity of unscheduled care services is a consequence of falls and fractures among older people.

However, the good news is that falls and fractures do not have to be an inevitable part of ageing. Evidence suggests that with timely intervention, a significant proportion of falls and fractures are avoidable and that when they do occur, rehabilitation and re-ablement can be key to supporting older people to retain or restore their independence.

Since the publication of HDL (13) 2007 and the Delivery Framework for Adult Rehabilitation, considerable work has been undertaken locally and nationally to improve services for falls and fracture prevention and management in Scotland. It is clear from this mapping exercise, undertaken by the National Falls Programme, that many individuals, services and organisations are actively engaged and committed to this improvement agenda. However, the report also identifies that we need to do more to reduce undesirable variation in our practice by adopting, spreading and embedding best practice before we can achieve truly transformational change.

We have the opportunity to use the information in this report to reflect with all our partners on our progress to date, and identify the next steps that need to be taken to transform our falls and bone health services on a whole system basis. The actions and recommendations proposed aim to ensure that we deliver effective and person-centred care, but also enable us to measure and demonstrate the positive impact evidence-based falls and fracture prevention and management can make.

The Reshaping Care for Older People Programme for Change states, “Providing high quality care and support for older people is a fundamental principle of social justice and is an important hallmark of a caring and compassionate society”. Effective falls and fracture prevention can make a real difference to the lives of older people and has a significant contribution to make to enacting these principles.

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Executive Summary

With an ageing population, falls and the consequences of falls are a major and growing concern for older people and health and social care providers. Recurrent falls are associated with increased mortality, increased rates of hospitalisation, curtailment of daily living activities and higher rates of institutionalisation. Falls and fractures in people aged 65 and over account for over 390,500 bed days each year in Scotland. Injurious falls are the leading cause of accident-related mortality in older people.

However, falls are not an inevitable consequence of old age. Well-organised services, based on recommended practice and evidence-based guidelines can prevent many falls and fractures in older people in the community. As part of the National Falls Programme, a national mapping exercise benchmarked service provision in Scotland against these criteria. The main aim was to identify the extent to which recommended practices to prevent and manage falls and fragility fractures are built-in to the wider systems of care for older people in Scotland. Between May and October 2011, Community Health (and Care) Partnership (CH(C)P) Falls Leads completed a self-assessment of arrangements in their locality for falls prevention and management and fracture prevention for older people.

The findings presented in this report represent a snapshot of service organisation in June 2011 (or October 2011 for NHS GGC CH(C)Ps). They indicate that in some areas modest steps forward have been taken since a previous mapping in 2009/10 and that there is much improvement work in progress. Many services are currently in a state of transition. However, the findings also show that there is still unacceptable variation in service provision and quality within and across NHS board areas in Scotland, and in some localities services remain poorly developed. Scotland still has much to do to provide older people with equitable, high quality services for fall and fracture prevention.

To address the consistent shortfalls identified in this report, the following actions for the National Falls Programme and recommendations for NHS boards and partnerships are identified:

Actions for the National Falls Programme

- The National Falls Programme will develop, test and report on, the use of four community falls care bundles.
- A Health Economist will carry out an evaluation to quantify the potential clinical and financial benefits gained from implementing the bundles, (at CH(C)P, NHS board and Scotland level) and the resources and associated costs required to do so.
- The National Programme Manager will work with falls leads, osteoporosis leads, ISD, ehealth services and other partners to develop a national measurement framework.
- The National Programme Manager will work with the Scottish Centre for Telehealth & Telecare (SCTT) to share learning and explore further opportunities for the appropriate use of telehealthcare technologies.

Recommendations for NHS boards and partnerships

- CH(C)P Falls Leads, Strategic Falls Leads, Osteoporosis Leads and other relevant colleagues, such as Reshaping Care for Older People leads, Unscheduled Care leads and local authority partners, should critically review local responses to the questionnaire; consider recommendations in this report and develop and deliver a local action plan.

- To capitalise consistently on opportunities to prevent recurrent falls and fractures, health and social care services should establish:
  - Fracture Liaison Services or equivalent, with referral protocols and pathways to multidisciplinary services providing secondary falls prevention.
  - Basic falls risk screening in services providing urgent or acute care for older people who have fallen.
  - Robust referral pathways *from* services providing urgent or acute care for older people who have fallen/sustained a fracture *to* multidisciplinary services delivering secondary falls and fracture prevention.

- To ensure falls prevention programmes are effective, key evidence-based interventions should be available, when required, to older people throughout Scotland.

We cannot expect to demonstrate a significant reduction in emergency admissions from falls and fractures if key components of evidence-based care are missing or inadequate in most localities. A systematic and targeted approach, supported by strong leadership at all levels is required.

SECTION ONE: INTRODUCTION

Well-organised services, based on recommended practice and evidence-based guidelines can prevent many falls and fractures in older people in the community. A national mapping exercise benchmarked service provision in Scotland against these criteria.

As part of the National Falls Programme, between May and October 2011, CH(C)P Falls Leads completed a self-assessment of arrangements in their locality for falls prevention and management and fracture prevention for older people. The findings therefore are based on the Falls Leads' knowledge of current service provision. The purpose of the mapping was three-fold:

1. To identify the extent to which recommended practices to prevent and manage falls and fragility fractures are built-in to the wider systems of care for older people in Scotland.
2. To capture good and promising practice as well as common gaps in service organisation and provision, and where possible, identify developments and changes since a previous mapping in 2009/10.
3. To inform recommendations for the improvement of services in Scotland.

A 100% response rate was achieved, with all 35 CH(C)Ps in Scotland participating (including the three sectors within Glasgow CHP), demonstrating the CH(C)P Falls Leads' commitment to service improvement. The Programme team would like to thank everyone who was involved in providing a response.

The findings represent a snapshot of service arrangements in June 2011 (or October 2011 for NHS GGC CH(C)Ps). Responses indicate that there is much improvement work in progress, and in some cases there will have been significant steps forward since the mapping was carried out.

This report outlines the reasons why the prevention of falls and fractures should be a priority for all health economies, reports and discusses the main findings of the 2011 mapping exercise and presents recommendations to improve falls and fracture prevention services in Scotland and reduce unwanted variation.

Why focus on falls and fractures?

With an ageing population, falls and the consequences of falls are a major and growing concern for older people and health and social care providers. Recurrent falls are associated with increased mortality, increased rates of hospitalisation, curtailment of daily living activities and higher rates of institutionalisation[1]. Falls are the leading cause of accident related death in older people[2]. Falls are a common problem amongst older people with long term conditions, including dementia.

Falls and fractures, in people aged 65 and over, account for over 18,000 unscheduled admissions and 390,500 bed days each year in Scotland. Average lengths of stay for falls and hip fracture admissions exceed those for other emergency admissions in the same age groups: average lengths of stay for falls and

hip fractures in the 75+ population are 25 days and 36 days respectively (compared to an average stay of 13 days for a COPD admission in the same age group) (2010/11 data provided by ISD Scotland).

Around 1% of falls result in hip fracture[3]; although the percentage is low, this amounts to over six thousand hip fractures in Scotland each year. The acute management of hip fracture alone costs NHSScotland in excess of £73 million each year. Twenty percent of older people who sustain a hip fracture die within six months[4]; approximately half will never be 'functional' walkers again[2].

In addition, in the over 65 population, falls cases are the largest single presentation to the Scottish Ambulance Service (over 35,000 presentation each year)[5], one of the leading causes of Emergency Department attendance, and are implicated in over 40% of Care Home admissions[6]. Post - fall syndrome, a combination of fear of falling, anxiety, loss of confidence and depression is prevalent, leading in many to an inability to carry out day to day activities and social withdrawal and isolation.

Despite these statistics, falls are not an inevitable consequence of old age. An individual's risk of falling or fracturing is determined by a complex interaction of multiple risk factors relating to the ageing process, the presence of long term conditions, lifestyle choices, risk-taking behaviours and the surrounding environment. Well-organised services delivering evidence-based care can help to prevent future falls. Recognising and modifying an individual's risk factors is crucial in preventing falls and injuries, including fractures. In many cases early identification of risk and timely intervention can prevent falls and fractures and improve outcomes for older people, retaining or restoring independence and reducing health and social care needs.

Services in Scotland

In most NHS boards in Scotland, falls prevention and management is not provided by dedicated, specialist falls services, but by generalist assessment and rehabilitation services for older people, such as community multidisciplinary teams and day hospitals for older people. Even in NHS boards where dedicated falls services exist, other members of the health and social care team will have a role to play in falls and fracture prevention and management. As this is the case, it is essential that service providers are aware of, and implement, the key components of falls prevention and management and fracture prevention identified in this mapping.

The National Falls Programme and the wider policy context

Co-ordinated, Integrated and Fit for Purpose: the Delivery Framework for Adult Rehabilitation in Scotland [7],published in February 2007, gives strategic direction and support to health and social care services and practitioners who deliver rehabilitation or enablement services to individuals and communities. The vision underpinning the framework is the creation of modern, effective, multi-disciplinary, multi-agency rehabilitation services, which are flexible and responsive in meeting the needs of individuals and communities in Scotland. Rehabilitation co-ordinators were appointed to board areas to facilitate these re-designs. Specific high impact changes

were outlined around improving access to rehabilitation services, promoting self management, developing integrated rehabilitation / enablement services, and developing vocational rehabilitation programmes. Three specific high impact areas were identified: musculoskeletal redesign, vocational rehabilitation and older peoples' services with an emphasis on falls prevention and management. The National Falls Programme is part of the Delivery Framework for Adult Rehabilitation, and is led by the Scottish Government's Directorate of the Chief Nursing Officer, Patients, Public and Health Professions.

Reshaping Care for Older People; A Programme for Change 2010-2021[8]***,*** sets out the Scottish Government's headline ambitions for improving quality and outcomes of care for older people, against a background of demographic and funding pressures. Falls prevention and management is closely aligned with the aim, themes, outcomes and commitments outlined in the Programme for Change; effective falls care pathways can help avoid unnecessary admissions to hospital, optimise an older person's independence and well-being and enable him or her to remain at home. The Change Fund has provided an opportunity for partnerships to build on existing work to develop a co-ordinated, integrated approach to falls and fracture prevention. At the time of the mapping (June/October 2011) 13 partnerships had allocated a proportion of the Change Fund to directly support the prevention and management of falls in the community. A further eight partnerships had developed proposals and were waiting to hear whether funds would be allocated. The findings of this report will help to identify potential improvement areas for partnerships, and can inform future Change Fund expenditure.

Maximising Recovery and Promoting Independence: Intermediate Care's contribution to Reshaping Care[9] provides a framework for local health and social care partnerships to review and further develop Intermediate Care within their area. Intermediate Care services provide a set of 'bridges' at key points of transition in a person's life, in particular from hospital to home and from illness or injury to recovery and independence. Intermediate Care services can play a vital role at a point of crisis, such as in the event of serious fall, providing timely care and support, and beginning the process of optimising a person's recovery and restoring independence post fall.

Caring Together: The Carers Strategy for Scotland 2010-2011[10] acknowledges the vital contribution carers make to the health and social care system. In many situations, carers will have a critical role in falls prevention and management, and as such, must be fully involved along the care pathway. In addition, services providing effective falls prevention and management can support carers in their role and enable older people to continuing living safely in their own homes**.**

Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers (2011)[11] delivers the key public health message that physical activity has a vital contribution to make to achieving good health and well-being in later life. It presents the evidence that physical activity programmes, which emphasise balance training, limb co-ordination and muscle strengthening activity are safe and effective in reducing the risk of falls. Providing older people with opportunities for regular appropriate physical activity contributes to preventing both a first fall and recurrent falls.

The National Falls Programme (2009-2012) supports partnerships to implement the co-ordinated, evidence-based and person-centred approach to falls and fracture prevention referred to in HDL (13) 2007[12] (see below) and described in the 2010 NHSQIS resource, *Up and About*[13].A Programme Manager works with a network of CH(C)P Falls Leads, Rehabilitation Co-ordinators, AHP Directors/Leads and other key stakeholders to support the development of local falls and fracture prevention care pathways in the community setting. Partners in this work have included the Long Term Conditions Collaborative, the Care Inspectorate, the Scottish Ambulance Service, the Joint Improvement Team, the National Telecare Development Programme, NHS Education for Scotland, Healthcare Improvement Scotland, local authorities and the third sector.

Successful falls prevention and management contributes to the achievement of both HEAT targets and Community Care Outcomes relating to reductions in emergency inpatient bed days rates for people aged 75 and over.

The vision and aspirations of the National Falls Programme are consistent with the three Quality Ambitions of the ***Healthcare Quality Strategy for NHS Scotland***[14]: mutually beneficial partnerships between the NHS and patients and their families; care that is reliably safe; and appropriate, timely and efficient care and treatment.

SECTION TWO: ABOUT THE MAPPING

Questionnaire development

Questions were selected for the mapping which were considered specific to falls/fracture prevention and management. They related directly to national guidance and the current evidence base, and provided a good illustration of the local and national state of falls and osteoporosis services.

The questions were derived from:

- NHS Quality Improvement Scotland's *Up and About. Pathways for the Prevention and Management of Falls and Fragility Fractures,* 2010[13]
- The Scottish Executive's *HDL (13) 2007: Delivery framework for adult rehabilitation. Prevention of falls in older adults.*[12]
- The American Geriatrics Society and British Geriatrics Society's *Clinical Practice Guideline: Prevention of Falls in Older Persons,* 2009.[15]
- The British Orthopaedic Association's *The Care of Patients with Fragility Fracture*, 2007[16]
- The Department of Health's *Prevention Package for Older People*, 2009[17]
- The National Institute for Health and Clinical Excellence's Clinical Guideline 21 *Falls: The assessment and prevention of falls in older people.* 2004[18]

A number of questions were based on the Royal College of Physician's National Audit of the Organisation of Services for Falls and Bone Health of Older People [19], carried out in England, Wales and Northern Ireland in 2008.

Completion of the mapping

The National Falls Programme Manager asked CH(C)P Falls Leads, in association with other colleagues with an understanding of the organisation of local services, to complete the mapping. In CH(C)Ps without a Lead, the CH(C)P's Head of Health and Community Care was asked to identify an appropriate person to take responsibility for the completion and return of the questionnaire. The exercise was, in effect, a self-assessment.

Thirteen of the fourteen territorial NHS boards completed the mapping in June 2011. In NHS Greater Glasgow and Clyde, the timing of the mapping coincided with a major re-organisation of rehabilitation services, and their request to postpone the exercise to September/October 2011 was agreed.

Questionnaire format

There were two parts to the questionnaire: Part One, which was multiple choice with some supplementary questions, and Part Two which was free text, and included questions relating to strategic leadership, information management, improvements to

date, priorities for the next 12 months, barriers to change and the role of the National Falls Programme. Respondents were asked to complete both parts.

For a copy of the questionnaire, please contact the Falls Programme Manager at ann.murray3@nhs.net

Please find below an explanation of question/response table from Part One, including the key. Supplementary questions were included in some cases.

Question number and question		*No. of responses*
0 *No*	*Descriptor of this response.*	*No. (%) CH(C)Ps with this response*
DK *Don't know; mapping required*		
1 *No; need for further work identified*		
2 *No; work in progress but not CH(C)P/ partnership-wide*		
3 *No; work in progress CH(C)P/partnership-wide*		
4 *Yes; in part*		
5 *Yes; in full*		

The three sectors of Glasgow CHP (North East, North West and South) provided individual responses. To simplify reporting, each sector will be referred to in the report as a CHP.

A previous mapping carried out in 2009/10 asked similar questions, but at an NHS board level. This revised questionnaire focuses specifically on service provision for older people living in CH(C)Ps/partnerships, because variation in practice within boards was difficult to capture using the previous format. Where possible, 2009/10 and 2011 findings are compared.

Individual CH(C)Ps and NHS boards are not referred to by name in the report. Each NHS board will receive a supplementary report which will enable them to identify their CH(C)P/s, and will identify variation within their board (where there is more than one CH(C)P). The supplementary report will also provide local information on rates of admissions with falls and hip fractures over the last ten years.

SECTION THREE: RESULTS

The questions and responses have been presented under the following headings:

1. Implementation of HDL (13) 2007.
2. Delivering 'Up and About':
   - Stage 1 Supporting health improvement and self management to reduce the risk of falls and fragility fractures
   - Stage 2 Identifying individuals at high risk of falls and/or fragility fractures
   - Stage 3 Responding to an individual who has just fallen and required immediate assistance
   - Stage 4 Co-ordinated management.
3. Integration with bone health and osteoporosis services.
4. Falls assessment and rehabilitation in care homes for older people.
5. Educating staff in relation to falls and fractures.
6. Involving service users in service improvement.
7. Data collection for service evaluation and improvement.

1. Implementation of HDL (13) 2007

Background
In 2007, the Scottish Executive issued HDL (13) 2007 *Delivery Framework for Adult Rehabilitation. Falls Prevention in Older People*[12]*.* This letter introduced the Delivery Framework for Adult Rehabilitation in Scotland[7] and outlined a number of specific actions for NHS boards and CH(C)Ps in relation to falls prevention and bone health.

Within the letter:

NHS boards were asked to take the lead in developing with all relevant partners a combined falls prevention and bone health strategy, by the end of 2007-08 (where they did not have such a strategy).

Community Health Partnerships were asked to:
- appoint a falls lead or co-ordinator with management responsibility to liaise with primary and secondary care, social work, housing, the ambulance service, community alarm services, and the voluntary and private sectors to develop a coordinated approach to falls prevention and management; and
- develop an operational combined falls prevention and bone health implementation strategy – targeted at those for whom there is evidence that effective intervention will reduce the risk of future falls and fractures

Experience supported the need to have a co-ordinator to shape services, and to avoid gaps, inconsistencies and duplication of effort.

The letter also suggested that as part of a strategy, every NHS board or CH(C)P area should consider developing a **care pathway** for falls so that everyone understands

what is available at the different points on the pathway, including from other agencies (social work, housing etc). The letter stated, 'it is fundamental to map the care pathway and to make information about services available to everyone who needs them'.

Key Findings from the Mapping
Implementation of HDL (13) 2007

At the time of the mapping (June/October 2011):

- 9 NHS boards (64%) had a current, ratified, combined falls and bone health strategy; this compares to 4 NHS boards (29%) in January 2010.
- 23 CH(C)Ps (60%) were implementing a formal improvement plan.
- 34 CH(C)Ps (89%) had an identified falls prevention lead or co-ordinator. Time allocated to the role, responsibilities and permanency of the position varied significantly.
- In addition, 11 NHS boards (79%) had identified a strategic lead for falls and bone health.
- 22 CH(C)Ps (58%) reported a falls and fracture prevention pathway was in place; a further 14 CH(C)Ps (37%) were working towards this; this compares to 9 CH(C)Ps (24%) reporting in January 2010 that a pathway was in place.

Commentary

Despite an increase since 2009/10 in the number of NHS boards with a falls and bone health strategy, it is of concern that four years following the issue of HDL (13) 2007, only nine boards have a ratified, combined strategy and only 60% of CH(C)Ps an improvement plan relating to falls and fracture prevention in older people. In many cases CH(C)P Falls Leads have progressed developments in the absence of formal strategies or plans, however lack of strategic direction and support was identified by respondents as a barrier to change in a number of CH(C)Ps.

Although encouraging that 89% CH(C)Ps had appointed a Falls Lead, responses indicated that the role was often limited both in terms of permanency, allocated time, and strategic positioning in order to influence change across a range of professions, services and organisations. The mapping findings suggest that, in general, a more advanced stage of development of falls services correlates with the presence of strong and well-supported local leadership.

Since 2009/10, progress has been made and continues to be made in terms of pathway development. The only two partnerships that indicated in the 2011 mapping that no pathway developments were underway locally, have since initiated work in this area. However, it must be noted that responses indicate that in all CH(C)Ps further improvements are required to ensure all key stakeholders are included in the pathway.

Table 1 shows how many of the following four key recommendations from HDL (13) 2007, each CH(C)P has implemented:

- A current combined NHS board-wide falls and bone health strategy (Table 1 identifies the CH(C)Ps which answered ‘achieved in full’).
- A current CH(C)P implementation/improvement plan (Table 1 identifies the CH(C)Ps which answered ‘achieved in full’).
- An appointed Falls Lead or Co-ordinator (Table 1 identifies the CH(C)Ps which answered ‘yes, in part’ and ‘yes in full’ combined).
- A local falls and fracture prevention pathway (Table 1 identifies the CH(C)Ps which answered ‘yes, in part’ and ‘yes in full’ combined). Please note, some pathways are rudimentary and do not include all services, organisations and agencies which are considered key to a comprehensive pathway. Further details of pathway components can be found in Table 2.

Table 1 The number of key recommendations of HDL (13) 2007 implemented in each CH(C)P at time of mapping.

Key recommendations of HDL (13) 2007

Each CH(C)P identified by a number	Combined Strategy	Improvement Plan	Falls Lead	Pathway*	Total
1		•	•		2
2		•	•		2
3		•	•		2
4	•	•	•	•	4
5				•	1
6	•	•	•		3
7	•	•	•		3
8	•	•	•		3
9	•		•	•	3
10	•		•	•	3
11	•		•	•	3
12	•	•	•		3
13	•	•	•		3
14	•		•		2
15	•		•	•	3
16	•	•	•		3
17	•		•		2
18	•	•	•	•	4
19	•			•	2
20	•	•	•	•	4
21	•		•	•	3
22	•	•		•	3
23			•		1
24	•	•	•	•	4
25	•	•	•	•	4
26	•	•	•	•	4
27	•	•	•	•	4
28	•	•	•	•	4
29		•	•	•	3
30		•	•	•	3
31		•	•	•	3
32		•	•	•	3
33			•		1
34	•		•	•	3
35	•		•		2
36	•		•		2
37	•	•	•	•	4
38					0
Total	27	23	34	22	

Questions and responses

1.1 Is there an agreed and current *NHS board-wide* combined falls and bone health strategy or equivalent?		*n=38*
0	No; there is not an NHS board-wide strategy and no plans currently for work in this area.	**1 (3%)**
DK	Further mapping/information is required to identify current situation.	**0**
1	The need for a strategy has been identified, but no detailed work plan has been developed and agreed.	**0**
2	n/a	
3	There is active engagement in work to develop an NHS board-wide strategy. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**1 (3%)**
4	Achieved in part, for example there is an NHS board strategy, but it is for falls prevention only, *or* there is a combined strategy but it has not been agreed formally, *or* the combined strategy is no longer current.	**9 (24%)**
5	There is an agreed and current NHS board combined falls and bone health strategy or equivalent.	**27 (71%)**

Overview by NHS board

Nine NHS boards indicated that they had a current, combined falls and bone health strategy, or the equivalent.
Three NHS boards indicated that they had a strategy, but it is for falls only, *or* it has not been agreed formally, *or* the combined strategy is no longer current.
One NHS board indicated that it did not have a strategy, but there was active engagement in work to develop one.
One NHS board indicated it did not have a strategy and there were no plans to develop one.

1.2 Is there a falls prevention and management improvement plan currently being delivered in your CH(C)P/partnership?		*n=38*
0	No; there is not an improvement plan and no plans currently for work in this area.	**0**
DK	Further mapping/information is required to identify current situation.	**1 (3%)**
1	The need for an improvement plan has been identified, but no detailed work plan has been developed and agreed.	**3(8%)**
2	n/a	
3	There is active engagement in work to develop and deliver an improvement plan. There is a work plan and agreement on aims, roles and timescales.	**11 (29%)**
4	n/a	
5	There is an improvement plan currently being delivered in the CH(C)P.	**23 (60%)**

1.3 Is there currently a CH(C)P falls prevention lead or co-ordinator? *"This lead officer will be responsible for the development and delivery of a coordinated, integrated falls service ensuring falls risk management and prevention is addressed within primary and secondary care, social work, housing, the ambulance service, community alarm services, and the voluntary and private sectors" HDL (2007) 13*		*n=38*
0	No; no plans currently to have a falls prevention lead or co-ordinator.	**1 (3%)**
DK	Further mapping/information is required to identify current situation.	**0**
1	The need for a falls prevention lead or co-ordinator has been identified, but no detailed plan to identify/recruit a lead has been developed and agreed.	**3 (8%)**
2	n/a	
3	There is active engagement in work to identify/recruit a falls prevention lead or co-ordinator. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**0**
4	Achieved in part, for example, there is a falls prevention lead or co-ordinator but the role is temporary *or* the lead has limited responsibilities, *or* the role is NHS board-wide.	**22 (58%)**
5	There is a CH(C)P falls prevention lead or co-ordinator.	**12 (32%)**

1.4 Is there a recognised local pathway for falls and fracture prevention and management? *A pathway is a multidisciplinary/multiagency outline of anticipated care, to help someone who has fallen/fractured or is at risk of falls/fracture move progressively through a clinical and/or care experience to positive outcomes. The pathway indicates services responsible for early identification of people at high risk (i.e. case finding) as well as screening, assessment, treatment and other interventions.*		*n=38*
0	No; no plans currently to develop a pathway.	**0**
DK	Further mapping/information is required to identify current situation.	**0**
1	The need to establish a pathway has been identified, but no detailed work plan has been developed and agreed.	**2 (5%)**
2	There is active engagement in work to establish a pathway ***but it does not include all the key stakeholders*** i.e. services, teams and agencies. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**2 (5%)**
3	There is active engagement in work to establish a pathway ***involving all the key stakeholders*** i.e. services, teams and agencies. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**12 (32%)**
4	Achieved in part, for example, there is a recognised pathway but it does not include ***all*** the key services, teams and agencies.	**10 (26%)**
5	There is a recognised local pathway for falls and fracture prevention and management.	**12 (32%)**

2. Delivery of Up and About

The NHS Quality Improvement Scotland resource, *Up and About, Pathways for the Prevention and Management of Falls and Fragility Fractures* (2010)[13], places the key aspects of falls prevention and management and fracture prevention in the context of a four stage journey of care for an older person living in the community. The mapping questionnaire enquired about arrangements to deliver key aspects of care at each stage.

Stage One: Supporting health improvement and self management to reduce the risk of falls and fragility fractures

Background

Stage One of the pathway represents the point at which the vast majority of the older population will be at any given time. Interventions and measures at this stage aim to prevent a first fall and benefit bone health, as well as reduce the risk of recurrent falls and fractures (including in the population who have already been through a secondary prevention programme). Many interventions or activities at this stage contribute to active ageing and healthy living generally; some are more specific to falls and fracture prevention. This part of the questionnaire focused on access to general exercise and physical activity for primary prevention or to support on-going self management post-fall.

Key Findings from the Mapping
Supporting health improvement and self management

At the time of the mapping (June/October 2011):

- 32 CH(C)Ps (84%) reported that community-based exercise and physical activity opportunities designed (or modified) for older people where available.
- 19 of these CH(C)Ps reported that these opportunities were limited i.e. they were only suitable for some older people, or available in some areas of the CH(C)P.
- A range of providers were reported including local authorities and the voluntary and independent sectors. Activity co-ordinators in care homes were mentioned in several responses.
- Settings for activities included care homes, day care and sheltered housing.
- Activities included walking programmes, tai chi, outdoor gyms and exercise and chat groups, as well as traditional exercise classes.

Commentary

Physical activity is core to active ageing and improving the health and well-being of older people. *Start Active, Stay Active: A report on physical activity for health from the four home countries*[11] highlights the benefits in relation to falls prevention and includes guidelines on physical activity for older adults.

Findings suggest that progress has been made in this area since 2009/10, with 14 CH(C)Ps reporting an increase in exercise and physical activity opportunities available to older people. It is also encouraging that activities are extending to care home settings, where falls and fracture rates are significantly higher than in the wider older population. In localities where this aspect of service provision is underdeveloped, NHS services need to work with local authority, independent and voluntary sector partners to improve provision. This is in light of strong evidence that physical activity programmes, which emphasise balance training, limb co-ordination and muscle strengthening activity are safe and effective in reducing the risk of falls.

Other measures that support self management, which were not asked about in the questionnaire include:

- effective long term condition management,
- yearly vision checks and other pro-active health checks,
- foot care,
- medication reviews,
- services which support safety at home and in the community,
- telecare, and
- accessible health information including advice on self management.

Questions and responses

2.1 Is there a range of local, accessible, community-based exercise and physical activity opportunities designed (or modified) for older people living in your CH(C)P?		*n=38*
0	No; no plans currently for improvement work in this area.	**0**
DK	Further mapping/information is required to identify current situation.	**1 (3%)**
1	The need for a range of exercise and physical activity opportunities has been identified, but no detailed work plan has been developed and agreed.	**1 (3%)**
2	There is active engagement in work to provide exercise and physical activity opportunities for older people in ***some*** areas of the CH(C)P only *and/or* suitable for ***some*** of the older population only. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**1 (3%)**
3	There is active engagement in work to provide ***a range*** of exercise and physical activity opportunities for older people, which will be available ***in all areas*** of the CH(C)P and be suitable for ***most*** of the older population. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**3 (8%)**
4	Achieved in part, for example, there are exercise and physical activity opportunities for older people but they are ***limited*** e.g. only available in some areas of the CH(C)P *and/or* only suitable for ***some*** older people.	**19 (50%)**
5	There are a range of local, accessible, community-based exercise and physical activity opportunities designed (or modified) for older people.	**13 (34%)**

Stage Two: Identifying individuals at high risk of falls and/or fragility fractures

Background

Falls and bone health are inextricably linked. Osteoporosis is a very common long term condition among older people, particularly older women. If an older person has osteoporosis, he or she is at greater risk of sustaining a ‘fragility’ fracture if they fall (a fragility fracture is a low trauma fracture, usually occurring from a fall from standing height or less). For this reason falls and fracture risk must be considered in combination.

Risk of falls

A fall is a symptom, not a diagnosis. It can be the first indication of a new or worsening health problem and/or can represent a tipping point, triggering a downward decline in independence. Older adults who fall once are two to three times more likely to fall again within a year[2].

Stage 2 of the pathway focuses on identifying older people who have fallen and/or are at high risk of falling. Once identified, interventions can be offered which aim to prevent further falls and restore independence post-fall.

National Institute for Health and Clinical Excellence Guidelines[18] and British Geriatrics Society Guidelines[15] recommend a multifactorial falls risk assessment:

- following recurrent falls (two or more falls in the previous year),
- following a fall requiring medical attention and/or resulting in injury,
- following a single fall in the previous year, in the presence of abnormal gait and balance, and
- in the presence of abnormal gait and balance.

This high risk group can be identified either when presenting to urgent care services and /or other services post-fall, or opportunistically, during any contact with a health and/or social care professional.

The Department of Health identifies 'early intervention to restore independence' as one of the four key objectives in *Falls and fractures, effective interventions in health and social care (2009)*[20]*.* The document suggests this can be achieved through falls care pathways linking acute and urgent care services to secondary prevention services providing assessment and management programmes.

Risk of fractures

The onset of osteoporosis is asymptomatic and is often only recognised after a person sustains a fragility fracture. Osteoporosis can be diagnosed using specialist bone density (DXA scans) and managed with medication and non-pharmacological interventions such as diet and exercise. Treatments for fracture secondary prevention have been endorsed by SIGN[21] and more recently, NICE[22].

An audit carried out in Scotland in 2004[23] found that approximately 40% of patients with hip fractures had previously experienced at least one fracture (about 20% had experienced two or more prior fractures). Almost none of these patients had been offered treatment that might have lessened their risk of experiencing their hip fracture.The Department of Health identifies 'responding to a first fracture to prevent the second' as one of the four key objectives in *Falls and fractures, effective interventions in health and social care (2009)*[20]*.*

Fracture Liaison Services identify people who have had a fragility fracture and provide an assessment of risk of further fracture. This often involves a DXA Scan, which will enable the diagnosis of osteoporosis. Fracture Liaison Services then provide GPs with recommendations for bone health management.

Key Findings from the Mapping
Identifying individuals at high risk of falls and/or fragility fractures

At the time of the mapping (June/October 2011):

Linking services providing urgent and acute care with secondary prevention services.

- 13 CH(C)Ps (34%) reported that Emergency Departments (ED) routinely identified high risk fallers (who were not admitted) and referred for further assessment; this compares to 3 CH(C)Ps (8%) in 2010. A further 11 CH(C)Ps (29%) were progressing work in this area.

- One CH(C)P (3%) reported that the Scottish Ambulance Service (SAS) had a pathway for referring fallers who are not conveyed to hospital, for further assessment and intervention; 19 CH(C)Ps (50%) were progressing work in this area with SAS and other partners.

- 9 CH(C)Ps (24%) had developed pathways between community alarm/telecare services and assessment and rehabilitation services; a further 20 CH(C)Ps (53%) were progressing work in this area.

- 20 CH(C)Ps (53%) reported pathways and protocols were in place for hospital staff to refer older people to community-based services providing further comprehensive assessment/intervention, on discharge from a hospital admission related to a fall.

Additional opportunities for case-finding.

- 16 CH(C)Ps (42%) used a screening tool or equivalent to enable primary care staff to identify older people at high risk of falling; 17 CH(C)Ps (45%) were progressing work in this area. Staff groups using the tool included community nurses, GPs, podiatrists, physiotherapists, occupational therapists and multidisciplinary rehabilitation teams.

- 8 CH(C)Ps (21%) had a similar tool for social care staff to use; 13 CH(C)Ps (34%) were progressing work in this area. Staff groups using the tool included reablement teams, care co-ordinators, sheltered housing wardens, home care staff and community alarm staff.

- 8 CH(C)Ps (%) included falls screening ***and*** a referral protocol in their shared assessment.

Identifying individuals at high risk of fragility fractures.

- People aged over 50 (or 55) living in 25 CH(C)Ps (66%) who sustained a new fragility fracture were systematically identified by a Fracture Liaison Service or equivalent; 4 CH(C)Ps (10%) were progressing work in this area.

Commentary

There have been modest improvements since 2009/10, but findings suggest that in the majority of NHS boards opportunities to prevent recurrent falls are being missed.

Most progress appears to have been made in the development of pathways between community alarm/telecare services and assessment and rehabilitation services, with 77% of CH(C)Ps with risk identification and a pathway in place or in the process of being developed. This may reflect a collaboration between the National Falls Programme, the Joint Improvement Team's Telecare Development Programme, Falls Leads and the Telecare Learning Network, which supported the strengthening of links between multidisciplinary falls prevention services and telecare service providers. Further information about this work can be found at http://www.jitscotland.org.uk/action-areas/telecare-in-scotland/learning-network/falls-prevention-network/

At the time of the mapping, falls pathways linking the SAS to secondary prevention services existed in one CH(C)P only, although half the CH(C)Ps were progressing work in this area. Since 2010 the SAS has been working with the National Falls Programme and a number of partnerships to test new pathways. This collaborative work has since progressed as part of the Reshaping Care for Older People work programme. To increase the spread and rate of developments, a 2012 report, *Proposals to Improve the Pathway for Unscheduled Presentations* will make recommendations to deliver redesigned unscheduled care pathways. Whereas early work focused on developing pathways for SAS patients who were not taken to the Emergency Department (ED), latterly there has been an additional focus on identifying *alternatives* to conveying an older person to hospital, when it is safe and sensible to do so. In order to achieve this, partnerships need to enhance the range of community-based support, telecare/community alarm, intermediate care services and ambulatory alternatives to admission, and ideally create a single point of access to these supports and services.

Despite evidence that many falls will recur, and prevention initiated in the ED can be effective[24], at the time of the mapping only 34% of EDs routinely identified high risk fallers and referred for further assessment. Owing to the nature of ED work, any screening methods introduced must be simple and easy to employ. In addition, a single point of access for further intervention, rather than a complex postcode referral system, would facilitate onward referral by ED staff.

For older people who have been admitted to hospital following a fall, referral pathways from secondary care to community-based secondary falls prevention services existed in just over half of the localities. In many cases it is unlikely that a comprehensive falls management and prevention programme will be initiated and completed *in full* during a brief hospital stay. Access to secondary prevention services following discharge is essential if the aim is to optimise independence and prevent recurrent falls and harm from falls.

The findings indicate that a growing number of CH(C)Ps are using a simple screening tool to help health and social care staff identify older people at high risk of falls. In some partnerships the use of these tools appears limited to health staff. This represents a missed opportunity. For example, the (single) shared assessment

provides an excellent opportunity to routinely ask basic questions about falls risk. At the time of the mapping only eight CH(C)Ps included a simple falls screen and referral guidance in their assessment.

With an increasing number of services pro-actively identifying high risk fallers, there is growing demand for multifactorial falls risk screening and the services of community multidisciplinary assessment and rehabilitation teams. The Allied Health Professions' National Delivery Plan, which is currently out for consultation will facilitate the drive for a more community focused approach to delivering rehabilitation. In the future a higher percentage of the workforce will be delivering care within re-designed community services and this should provide the infra-structure for more upstream multidisciplinary interventions.

Fracture Liaison Service provision remains higher in Scotland than the rest of the UK: a 2009 audit[25] found that 77.6% of the Scottish population had access to routine post fracture assessment. The same audit identified that six NHS boards had board-wide access to post fracture assessment, three NHS boards had limited access, and five NHS boards had no formal arrangements. Findings in this mapping suggest some improvement in this area since 2009, but absence of a Fracture Liaison Service or equivalent continues to be an issue in some areas, particularly in the Islands and more rural NHS boards, where poor access to DXA scanning is also a drawback.

Pathway development in primary care has also been the subject of new productivity and efficiency indicators introduced in the 2011/12 Quality and Outcomes Framework (QOF) for GPs. Falls is one of the areas on which the Scottish Government has suggested GPs focus in order to reduce avoidable emergency admissions. In addition, the 2012/13 QOF includes osteoporosis and the secondary prevention of fragility fractures for the first time. The indicator promotes structured case finding for osteoporosis in people who have had a fragility fracture. Both of these initiatives contribute to the on-going efforts to prevent falls and fractures in older people.

Progress in identifying the high risk population and developing referral pathways for secondary prevention is encouraging, but lessons must be learned from the Royal College of Physician's *National audit of falls and bone health in older people*[26]*.* The audit found that where a local framework was in place that might suggest an integrated service had been created, the identification and referral of suitable patients was often less than adequate. Following the creation of a pathway, regular review is required to make certain that the pathway is being used, and used appropriately. On-going efforts to ensure potential referrers are familiar with benefits of further intervention, as well as screening and referral mechanisms, are often worthwhile.

Questions and responses

Linking with services providing urgent and acute care

2.2 Is a first level screening tool, algorithm or equivalent used by the Emergency Department (ED) and minor injury unit staff to identify high risk fallers (who are not admitted) and trigger referral for further assessment according to locally agreed protocol? *A first level screening tool is used to identify individuals who have fallen and/or at high risk of falling and may benefit from further assessment. It should be simple, quick and easy to apply. It may include basic questions about the frequency, characteristics and consequences of falls and observation of the individual's gait and balance. It should also provide clear guidance on specific actions required depending on the findings of the screen.*		*n=38*
0	No; no plans currently for improvement work in this area.	**4 (10%)**
DK	Further mapping/information is required to identify current situation.	**3 (8%)**
1	The need for screening/referral has been identified, but no detailed work plan has been developed and agreed.	**7 (18%)**
2	There is active engagement in work to introduce screening/referral in the ED ***or*** minor injury units (where they exist). Work is underway, there is a work plan and agreement on aims, roles and timescales.	**3 (8%)**
3	There is active engagement in work to introduce screening/referral in the ED ***and*** minor injury units (where they exist). Work is underway, there is a work plan and agreement on aims, roles and timescales.	**8 (21%)**
4	Achieved in part, for example, screening/referral is carried out in the ED but not minor injury units(where they exist) ***or*** in minor injury units but not in the ED.	**2 (5%)**
5	Screening/referral is carried out in the ED and minor injury units (where they exist), according to locally agreed protocol.	**11(29%)**

2.3 Are there recognised pathways and protocols for referring older people who the Scottish Ambulance Service attend following a fall (and are not taken to hospital), to services providing further assessment of falls risk?		*n=38*
0	No; no plans currently for improvement work in this area.	**2 (5%)**
DK	Further mapping/information is required to identify current situation.	**8 (21%)**
1	The need for work to develop referral pathways has been identified, but no detailed work plan has been developed and agreed.	**8 (21%)**
2	n/a	
3	There is active engagement in the development of referral pathways (which may include the piloting of new pathways). Work is underway, there is a work plan and agreement on aims, roles and timescales.	**19 (50%)**
4	n/a	
5	There are recognised pathways and protocols for referring older people who the Scottish Ambulance Service attend following a fall (and are not taken to hospital), to services providing further assessment of falls risk.	**1 (3%)**

2.4 Do telehealthcare/community alarm services operating in your CH(C)P have systems to identify repeat fallers and recognised pathways and protocols for referring to services providing further assessment?		*n=38*
0	No; no plans currently for improvement work in this area.	0
DK	Further mapping/information is required to identify current situation.	**1 (3%)**
1	The need to improve identification of frequent fallers and develop referral pathways has been identified, but no detailed work plan has been developed and agreed.	**8 (21%)**
2	There is active engagement in ***some*** community alarm/telehealthcare services to identify frequent fallers and/or develop referral pathways. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**4 (10%)**
3	There is active engagement with ***all*** community alarm/telehealthcare services to identify frequent fallers and develop referral pathways. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**7 (18%)**
4	Achieved in part, for example, ***some*** of the telehealthcare/community alarm services have systems to identify repeat fallers *and/or* recognised pathways and protocols for referring to services providing further assessment.	**9 (24%)**
5	Telehealthcare/community alarm services have systems to identify repeat fallers and recognised pathways and protocols for referring to services providing further assessment.	**9 (24%)**

2.5 On discharge from hospital following admission with a fall (+/- fracture), do individuals living in your CH(C)P receive on-going assessment and rehabilitation in the community, if required? *On discharge, there are recognised pathways and protocols for hospital staff to refer to community-based services providing further assessment/intervention.*		*n=38*
0	No; plans currently for improvement work in this area.	**0**
DK	Further mapping/information is required to identify current situation.	**0**
1	The need for work to improve on-going assessment and rehabilitation has been identified, but no detailed work plan has been developed and agreed.	**0**
2	There is active engagement in work with ***some*** key services and/or teams to improve on-going assessment and rehabilitation. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**4 (10%)**
3	There is active engagement in work with ***all*** key services and/or teams to improve on-going assessment and rehabilitation. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**1 (3%)**
4	Achieved in part, for example, on discharge from hospital following admission with a fall (+/- fracture), individuals living in your CH(C)P receive on-going assessment and rehabilitation from ***some*** key services and/or teams in the community.	**12 (32%)**
5	On discharge from hospital following admission with a fall (+/- fracture), individuals living in your CH(C)P receive on-going assessment and rehabilitation in the community as required.	**21 (55%)**

Additional opportunities for case-finding

2.6 Is a first level screening tool, algorithm or equivalent used by key primary care staff to identify high risk fallers and trigger referral for further assessment according to locally agreed protocol. *A first level screening tool is used to identify individuals who have fallen and/or at high risk of falling and may benefit from further assessment. It should be simple, quick and easy to apply. It may include basic questions about the frequency, characteristics and consequences of falls and observation of the individual's gait and balance. It should also provide clear guidance on specific actions required depending on the findings of the screen.*		*n=37*
0	No; no plans currently for improvement work in this area.	**0**
DK	Further mapping/information is required to identify current situation.	**1 (3%)**
1	The need for a screening tool or equivalent has been identified, but no detailed work plan has been developed and agreed.	**3 (8%)**
2	There is active engagement in work to introduce screening in ***some*** services and/or teams working with older people. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**7 (19%)**
3	There is active engagement in work to introduce screening in ***all*** key services, teams and agencies working with older people. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**10 (27%)**
4	Achieved in part, for example, a screening tool is used by ***some*** services and/or teams working with older people.	**14 (38%)**
5	A screening tool is used by ***all*** key primary care services, teams and agencies working with older people.	**2 (5%)**

2.7 Is a first level screening tool, algorithm or equivalent used by key social care staff to identify high risk fallers and trigger referral for further assessment according to locally agreed protocol?		*n=37*
0	No; no plans currently for improvement work in this area.	**0**
DK	Further mapping/information is required to identify current situation.	**5 (13%)**
1	The need for a screening tool or equivalent has been identified, but no detailed work plan has been developed and agreed.	**11 (30%)**
2	There is active engagement in work to introduce screening in ***some*** services, teams and agencies working with older people. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**1 (3%)**
3	There is active engagement in work to introduce screening in ***all key*** services, teams and agencies working with older people. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**12 (32%)**
4	Achieved in part, for example, a screening tool is used by ***some*** services, teams and agencies working with older people.	**7 (19%)**
5	A screening tool is used by ***all*** key social care services, teams and agencies working with older people.	**1 (3%)**

2.8 Is a first level screening tool, algorithm or equivalent included in the (single) shared assessment to identify high risk fallers and trigger referral for further assessment according to locally agreed pathway/protocol?		*n=37*
0	No; no plans currently for improvement work in this area.	**4 (11%)**
DK	Further mapping/information is required to identify current situation.	**7 (19%)**
1	The need for screening and a referral pathway/protocol has been identified, but no detailed work plan has been developed and agreed.	**12 (32%)**
2	There is active engagement in work to develop screening ***or*** a referral pathway/protocol. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**2 (5%)**
3	There is active engagement in work to develop screening ***and*** a referral pathway. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**4 (11%)**
4	Achieved in part, for example, the shared assessment includes screening ***or*** a referral pathway/protocol.	**1 (3%)**
5	The shared assessment includes screening ***and*** a referral pathway/protocol.	**8 (22%)**

Identifying individuals at high risk of fragility fractures

2.9 Are people over 50 (or 55) living in your CH(C)P who have sustained a new fragility fracture, systematically identified by a Fracture Liaison Service or equivalent?		*n=37*
0	No; no plans currently for improvement work in this area.	**5 (13%)**
DK	Further mapping/information is required to identify current situation.	**1 (3%)**
1	The need for a Fracture Liaison Service or equivalent has been identified, but no detailed work plan has been developed and agreed.	**3 (8%)**
2	n/a	
3	There is active engagement in work to introduce a Fracture Liaison Service or equivalent. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**4 (10%)**
4	n/a	
5	People over 50 (or 55) living in the CH(C)P who have sustained a new fragility fracture are systematically identified by a Fracture Liaison Service or equivalent.	**25 (68%)**

Stage 3 Responding to an individual who has just fallen and requires immediate assistance

Background

At this stage in the pathway an individual has just fallen and has requested assistance. The individual may have sustained an injury and/or be unwell *or*, is well, appears uninjured but is unable to get up from the ground or floor independently.

Telecare can play an important role in falls management at this stage of the pathway. Technology combined with monitoring and response services can enable a fast response to a fall, as well as offer reassurance to older people and often carers. Community/pendant alarms are widely used, with other equipment, such as falls detectors also available. The role of telecare in the support of people at risk of falling is described in *Telehealthcare and falls*[27], which also proposes that response services are ideally placed to carry out basic falls risk assessment, as well as identify older people experiencing recurrent falls who may benefit from further assessment and intervention.

Of the 35,000 older people who have fallen that the SAS respond to every year[5], a significant number are uninjured, but require help to get up from the floor. In such cases, the SAS may not be the most appropriate service to provide a response; on rare occasions a faller will have to wait for assistance while the SAS responds to a more urgent medical emergency. A growing number of partnerships are identifying alternatives to an SAS response for fallers who are assessed on telephone triage as uninjured, but are unable to get up from the floor without assistance. This is in addition to the service provided by telecare/community alarm teams to existing clients.

Key Findings from the Mapping
Responding to uninjured fallers

At the time of the mapping (June/October 2011):

- 9 CH(C)Ps (24%) had an explicit local agreement on which service providers were responsible for assisting an *uninjured* individual from the floor (24 hours/day); in 7 of these CH(C)Ps the response service was able to offer individuals referral for further assessment of falls and fracture risk.

- The responding services included local authority mobile emergency care services (community alarm and telecare services) and district nurse teams.

Commentary

It is recommended that partnerships clarify local arrangements for responding urgently to an older person who has fallen. This is a critical point in the journey of care. A rapid and appropriate response, which provides both effective management of the immediate situation *and* consideration of further health and care needs, is key to preventing both an avoidable admission to hospital and further falls.

Questions and responses

2.10 Is there formal local agreement on which service providers are responsible for assisting an *uninjured* individual, living in your CH(C)P/partnership, from the floor (24 hours/day)? *This is for older people who do not have a community alarm/telecare service.*		*n=38*
0	No; no plans currently for improvement work in this area.	**4 (10%)**
DK	Further mapping/information is required to identify current situation.	**7 (18%)**
1	The need for work to identify and agree the responsible service providers has been identified, but no detailed work plan has been developed and agreed.	**12 (32%)**
2	There is active engagement in work in ***some*** parts of the CH(C)P to identify and agree the responsible service providers. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**2 (5%)**
3	There is active engagement in work to identify and agree the responsible service providers throughout the CH(C)P. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**4 (10%)**
4	Achieved in part, for example, in ***some*** parts of the CH(C)P the responsible service providers have been identified.	**1 (3%)**
5	There is explicit local agreement on which service providers are responsible for assisting an *uninjured* individual from the floor (24 hours/day).	**8 (21%)**

Stage 4 Co-ordinated management including specialist assessment

Background

At this stage an individual has been identified as at high risk of falling and/or sustaining a fracture. Further intervention is required to identify the reasons for the fall/s, assess fracture risk and provide a personalised prevention and management programme. Evidence suggests this approach can reduce falls by up to 30%[20]. The management of osteoporosis with appropriate medication can reduce the risk of fracture by 50% within a six month period[20].

A range of measures can be included in an individualised programme. The questionnaire focused on falls and bone health-specific interventions, so excludes general, but important, measures, such as vision checks, medication reviews and foot care, which should constitute ‘general’ healthcare for older people.

Key Findings from the Mapping
Co-ordinated management

At the time of the mapping (June/October 2011):

- 31 CH(C)Ps (82%) were using a clinical proforma (or equivalent) to deliver consistent multi-factorial risk assessment for older people; this compares to 9 CH(C)Ps (24%) in 2010.

- 10 CH(C)Ps (26%) routinely explained, discussed and agreed assessment findings and treatment plans with the individual and their carers*, and* provided a written intervention plan.

- 18 CH(C)Ps (47%) offered prescription of a validated exercise programme taught by appropriately trained healthcare professionals; a further 15 CH(C)Ps (39%) achieved this in part, for example, exercise programmes were prescribed by *some* teams and services providing rehabilitation, *or* exercise was prescribed but it is not validated.

- The majority of CH(C)Ps provided time-limited, supervised exercise classes, delivered by healthcare services. Older people were supported to continue to exercise following this intervention in a number of ways, including: by attending classes provided by local authority and other leisure services; carrying out programmes at home with the help of printed exercise instructions and DVDs; with support from voluntary services (British Red Cross buddies); with telephone follow-up; and with exercise classes at day care facilities.

- Older people living in 29 CH(C)Ps (76%) had access to a clinic (or equivalent) for medical assessment and intervention, if required; 19 CH(C)Ps (50%) had access to syncope services for older people with blackouts or unexplained falls.

- 9 CH(C)P (24%) used a validated home hazard assessment to identify potential hazards in the home environment.

- Older people living in 27 CH(C)Ps (71%) could access a DXA scanner locally for a bone density scan where this is indicated clinically; those living in 10 CH(C)Ps (26%) had access to a DXA scanner, but it was not located within a distance which is considered reasonable to ask a frailer older person to travel.

- 13 CH(C)Ps (34%) had a mechanism for checking that *all* agreed interventions in a prevention and management programme have been provided and completed prior to discharge; this compares with 4 CH(C)Ps in 2009/10.

Commentary

Interventions at stage four of the journey of care, which aim to identify and modify culprit risk factors, are central to preventing recurrent falls and fractures. If key interventions indicated at this stage are not provided, recurrent falls and fractures are unlikely to be prevented, regardless of whether there are strategies, falls leads, systematic risk identification and referral pathways in place.

The findings of the mapping highlighted the significant variation that continues to exist across Scotland.

Thirty-one CH(C)Ps were using a clinical proforma (or equivalent) to deliver consistent multi-factorial risk assessment for older people, compared to 9 CH(C)Ps in 2010. This indicates clear progress in the delivery of evidence-based care. Consistency of the approach *within* CH(C)Ps appears to remain an issue in some localities. Encouragingly, multifactorial risk assessment, where provided, did appear to include basic bone health questions, suggesting a combined approach to falls and fracture prevention at this level.

In 2008, NHSQIS held a series of focus groups for older people who had experienced falls[13]. Participants reported that they highly valued practitioners discussing with them assessment findings and how they related to the treatment plan proposed. The participants stated that this encouraged them to participate in a prevention programme. They also reported that in practice, this interaction did not happen routinely. The findings of the mapping confirmed this. This clearly does not represent person-centred care and needs to be addressed in localities where these approaches are underdeveloped.

Exercise prescription and provision continues to be an issue. Progressive strength and balance exercise of sufficient duration is now accepted as a key component of a programme to prevent falls[15,28]. Even as a single intervention it has been shown to be effective. At the time of the mapping more than half of CH(C)Ps were not consistently providing evidence-based exercise prescription by suitably trained professionals (usually a physiotherapist). Given the strength of the evidence-base, this is of major concern. Exercise to prevent falls can be home or group based, but needs to be of sufficient duration to be effective. Encouragingly, the majority of CH(C)Ps are working with local authority, independent and voluntary sector partners to ensure a continuum of exercise provision and/or support to enable on-going exercise following discharge from NHS services.

The findings suggest that a number of CH(C)Ps (24%) have limited or no access to a clinic or equivalent providing specialist medical assessment and intervention relating to falls. Lack of access to services which investigate transient loss of consciousness is an issue in a greater number of CH(C)Ps. Medical intervention is often a key component of falls prevention and NHS boards should take action to address this important gap in service provision.

Seventy-six percent of CH(C)Ps are not using validated tools to identify potential falls hazards in the home environment. This does not necessarily indicate that assessments and modifications are not being carried out. However it does raise the

issue of the use of validated tools and outcome measures to promote consistent evidence-based practice. Further work is required both locally and nationally to identify how validated tools, where available, can be used to improve care.

Although access to DXA scanning services for the majority of the Scottish population is good, lack of access to such a service continues to be an issue in some localities, particularly those in rural areas of the country. While solutions to this problem are being explored, and in the absence of DXA to assess bone density, it is important that GPs and other physicians in these areas work with specialists in osteoporosis to agree appropriate management for individuals with suspected osteoporosis.

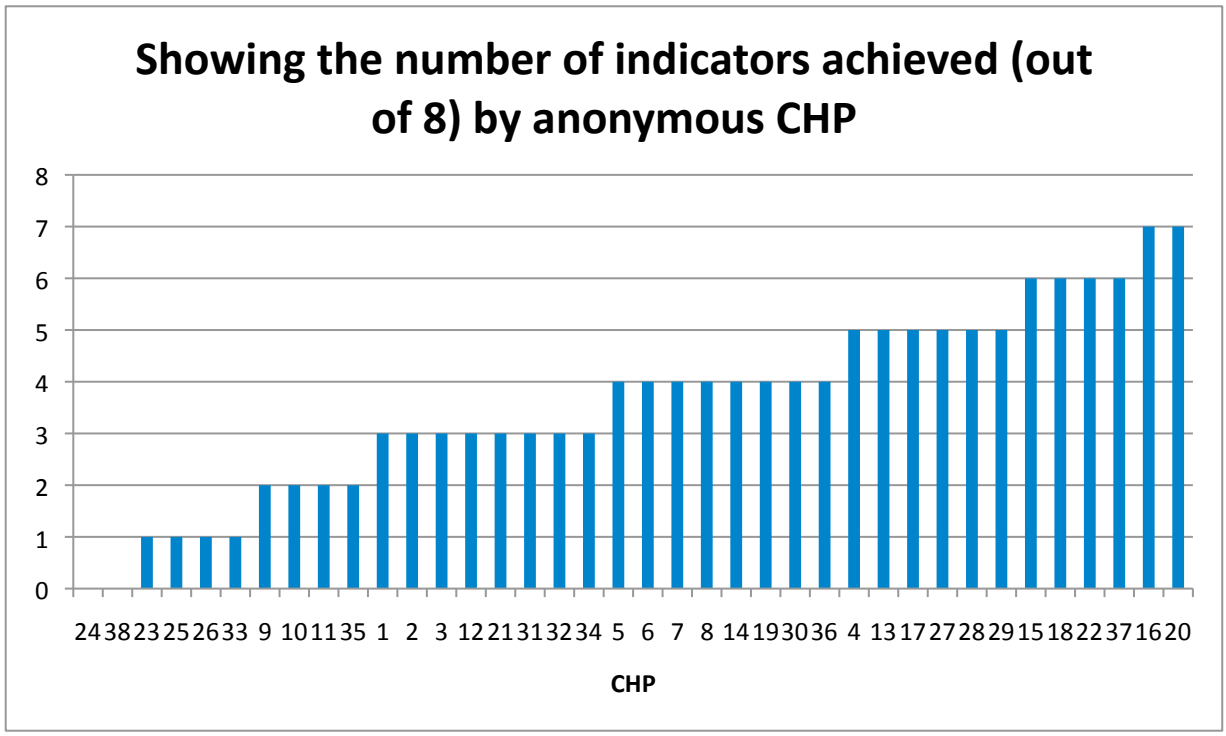
Only one third of services report that a mechanism is in place to check all agreed interventions have been provided as planned. An older person's personalised management plan can involve a range of professionals, services and agencies delivering a number of interventions. Previous studies suggest comprehensive assessment is not always followed by the interventions or treatments indicated. Good practice suggests there should be mechanism for ensuring all aspects of the management plan are completed. This can be a time-consuming exercise and is therefore a challenge to overstretched services. However, failure to deliver a complete programme negates the benefits of comprehensive assessment and inevitably impacts negatively on final outcomes.

In summary, the questionnaire asked about the following eight practices and interventions:

- Multifactorial falls risk assessment using a clinical proforma or similar tool.
- Explaining, discussing and agreeing management plans with the individual and carers, and providing a written copy of the agreed plan of action.
- Prescription of validated strength and balance exercise programmes.
- Focused medical assessment and intervention.
- Management of syncope.
- Assessment of falls hazards in the home using a validated tool.
- Availability of DXA scanning.
- Follow-up to check all interventions have been provided and completed.

Figure 1 shows how many of the above eight interventions and practices are available, consistently in each CH(C)P. Despite clear gaps in provision, this represents a more positive picture than in 2009/10. In terms of improving care for older people at risk of falls and fractures, addressing gaps in these areas must be a priority. When reviewing local practice, it is important to also consider other evidence-based interventions not included in the questionnaire (see Up and About[13]).

Figure 1 How many of eight key interventions and practices are available, consistently in each CH(C)P.



Questions and responses

2.11 For all older people considered to need a multifactorial falls risk screen or assessment (second level), is this is undertaken in your CH(C)P/partnership using a clinical proforma or similar tool? *The proforma or tool specifies the individual risk factors that need to be considered in the screen or assessment and includes a screen of fracture risk).*		*n=38*
0	No; no plans currently for improvement work in this area.	**1 (3%)**
DK	Further mapping/information is required to identify current situation.	**1 (3%)**
1	The need for the development of a multifactorial tool or proforma has been identified, but no detailed work plan has been developed and agreed.	**1 (3%)**
2	There is active engagement in work to develop a multifactorial tool or proforma for use by ***some*** assessment and rehabilitation services. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**0**
3	There is active engagement in work to develop a multifactorial tool for use by ***all*** assessment and rehabilitation services. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**4 (10%)**
4	Achieved in part, for example, there is a multifactorial tool or proforma used by ***some*** assessment and rehabilitation services.	**20 (53%)**
5	For all older people considered to need a multifactorial falls risk screen or assessment, this is undertaken in your CH(C)P using a clinical proforma or similar tool.	**11 (29%)**

2.12 Following a multifactorial assessment or screening, are results/interventions explained, discussed and agreed with the individual and their carers *and* a written intervention plan provided?		*n=38*
0	No; no plans currently for improvement work in this area.	**1 (3%)**
DK	Further mapping/information is required to identify current situation.	**3 (8%)**
1	The need for developing this approach has been identified, but no detailed work plan has been developed and agreed.	**2 (5%)**
2	Work is underway to introduce this approach in ***some*** assessment and rehabilitation services and/or teams. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**0**
3	Work is underway to introduce this approach in ***all*** assessment and rehabilitation services and/or teams. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**4 (10%)**
4	Achieved in part, for example ***some*** assessment and rehabilitation services and/or teams take this approach, *or* results are explained, discussed and agreed ***but*** written plans are not provided, *or* carers are not always involved in discussions.	**18 (47%)**
5	Results/interventions are explained, discussed and agreed with the individual and their carers and a written intervention plan provided.	**10 (26%)**

2.13 Where indicated following multifactorial assessment, does intervention include prescription of a validated exercise programme taught by appropriately trained healthcare professionals. *For example FaME or Otago exercise programmes, i.e. individually prescribed, supervised, progressive programmes of sufficient duration, which focus on balance, strength and gait.*		*n=38*
0	No; no plans currently for improvement work in this area.	**0**
DK	Further mapping/information is required to identify current situation.	**1 (3%)**
1	The need for improvement work relating to this indicator has been identified, but no detailed work plan has been developed and agreed.	**0**
2	There is active engagement in work to provide validated exercise programmes in ***some*** teams and services providing rehabilitation***.*** Work is underway, there is a work plan and agreement on aims, roles and timescales.	**0**
3	There is active engagement in work to provide validated exercise programmes in ***all*** teams and services providing rehabilitation***.*** Work is underway, there is a work plan and agreement on aims, roles and timescales.	**4 (10%)**
4	Achieved in part, for example, validated exercise programmes are prescribed by ***some*** teams and services providing rehabilitation, *or* exercise is prescribed but it is not validated.	**15 (39%)**
5	Where indicated following mulitfactorial assessment, interventions include prescription of a validated exercise programme taught by appropriately trained healthcare professionals.	**18 (47%)**

2.14 Can older people living in the CH(C)P access a clinic(s) or equivalent facility for focused medical assessment and interventions related to falls prevention, if required? *At the clinic/facility there is direct clinical involvement of consultant grade or other trained medical staff.*		*n=38*
0	No; no plans currently for improvement work in this area.	**2 (5%)**
DK	Further mapping/information is required to identify current situation.	**1 (3%)**
1	The need for access to a clinic/facility where trained medical staff provide focused medical assessment has been identified, but no detailed work plan has been developed and agreed.	**0**
2	There is active engagement in work to provide access for older people living in ***some*** parts of the CH(C)P to a clinic/facility where trained medical staff provide focused medical assessment**.** Work is underway, there is a work plan and agreement on aims, roles and timescales.	**1 (3%)**
3	There is active engagement in work to access a clinic/facility where trained medical staff provide focused medical assessment. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**1 (3%)**
4	Achieved in part, for example, older people living in ***some*** parts of the CH(C)P can access a clinic/facility where trained medical staff provide focused medical assessment.	**4 (10%)**
5	Older people living in the CH(C)P can access a clinic(s) or equivalent facility for focused medical assessment and interventions related to falls prevention, if required.	**29 (76%)**

2.15 For older people living in your CH(C)P who have had blackouts and/or unexplained falls, is there an agreed process/pathway to access syncope services?		*n=38*
0	No; no plans currently for improvement work in this area.	**5 (13%)**
DK	Further mapping/information is required to identify current situation.	**9 (24%)**
1	The need for access to syncope services has been identified, but no detailed work plan has been developed and agreed.	**0**
2	There is active engagement in work to provide access to syncope services for older people living in ***some*** parts of the CH(C)P. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**0**
3	There is active engagement in work to develop a pathway to syncope services. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**3 (8%)**
4	Achieved in part, for example, older people living in ***some*** parts of the CH(C)P can access syncope services. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**2 (5%)**
5	There is an agreed pathway to syncope services.	**19 (50%)**

2.16 Is a validated home hazard assessment used for assessment of potential hazards in the home environment? For example *Homefast.*		*n=38*
0	No; no plans currently for improvement work in this area.	**0**
DK	Further mapping/information is required to identify current situation.	**1 (3%)**
1	The need for introducing a validated home hazard assessment has been identified, but no detailed work plan has been developed and agreed.	**0**
2	There is active engagement in work to introduce the use of a validated home hazard assessment in ***some*** services or teams providing assessment and rehabilitation. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**6 (16%)**
3	There is active engagement in work to introduce the use of a validated home hazard assessment in ***all*** services or teams providing assessment and rehabilitation. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**4 (10%)**
4	Achieved in part, for example, there is a home hazard assessment used, however it is not validated, *or* a validated assessment it is used by ***some*** services or teams.	**18 (47%)**
5	A validated home hazard assessment is used for assessment of potential hazards in the home environment.	**9 (24%)**

2.17 Can older people living in the CH(C)P access a DXA scanner locally for a bone density scan, where this is indicated clinically? *In this context, 'locally' suggests within a distance which is reasonable to ask most older people to travel.*		*n=38*
0	No; no plans currently for improvement work in this area.	**1 (3%)**
DK	Further mapping/information is required to identify current situation.	**0**
1	The need for work to improve access to DXA has been identified, but no detailed work plan has been developed and agreed.	**0**
2	There is active engagement in work to improve access to DXA, however this service will not be available locally. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**0**
3	There is active engagement in work to improve local access to DXA. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**0**
4	Achieved in part, for example, there is access to DXA but it is not available locally.	**10 (26%)**
5	Older people living in the CH(C)P can access a DXA scanner locally for a bone density scan, where this is indicated clinically.	**27 (71%)**

2.18 Where multifactorial falls prevention and management programmes are provided, is there a mechanism for checking that *all* agreed interventions have been provided and completed prior to discharge?		*n=37*
0	No; no plans currently for improvement work in this area.	**1 (3%)**
DK	Further mapping/information is required to identify current situation.	**1 (3%)**
1	The need for a mechanism to check all agreed interventions have been provided has been identified, but no detailed work plan has been developed and agreed.	**8 (22%)**
2	***Some*** teams, services, agencies are actively engaged in work to introduce a mechanism for checking that all agreed interventions have been provided. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**5 (13%)**
3	***All*** teams, services, agencies are actively engaged in work to introduce a mechanism for checking that all agreed interventions have been provided. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**2 (5%)**
4	Achieved in part, for example, ***some*** teams, services, agencies have a mechanism for checking that all agreed interventions have been provided.	**7 (19%)**
5	Where multifactorial falls prevention and management programmes are provided, there is a mechanism for checking that ***all*** agreed interventions have been provided and completed prior to discharge.	**13 (35%)**

The Delivery of Up and About: responses in summary

In the context of the questionnaire, the following 16 key indicators represent good practice:

PA local, accessible, community-based physical activity opportunities designed for older people

ED pathways from the Emergency Department to assessment and rehabilitation services

SAS pathways from the Scottish Ambulance Service to assessment and rehabilitation services

CA pathways from telecare/community alarm services to assessment and rehabilitation services

2C pathways from secondary care to community based assessment and rehabilitation services

FLS a Fracture Liaison Service

PC key primary care staff use a basic falls risk screen

SC key social care staff use a basic falls risk screen

SSA shared assessment includes a basic falls risk screen

MFA multifactorial falls risk screening using a clinical proforma

P explanation of, discussion with and agreement on intervention with the patient, and a written plan provided

Ex validated exercise programmes of sufficient duration

MA focused medical assessment

HH validated home hazard assessment

DXA DXA scan access locally

Rv review to ensure all agreed interventions are delivered

Table 2 shows how many of these 16 indicators, each CH(C)P delivered **in full** in June/October 2011.

Table 2 The number of key components of care, each CH(C)P delivered *in full* in June/October 2011.

Key indicators of good practice (16)

		Case finding (Stage 2)								Interventions (Stage 4)							
	PA	A&E	SAS	CA	2C	FLS	PC	SC	SSA	MFA	P	Ex	MA	HH	DXA	Rv	**Total**
1						•				•			•		•		4 (25%)
2						•				•			•		•		4 (25%)
3						•				•			•		•		4 (25%)
4						•						•	•	•	•		5 (31%)
5					•	•						•	•		•	•	6 (37%)
6		•		•	•	•				•				•	•	•	8 (50%)
7		•		•	•	•				•				•	•	•	8 (50%)
8		•		•	•	•				•				•	•	•	8 (50%)
9		•			•							•	•				4 (25%)
10		•		•	•							•	•				5 (31%)
11		•			•							•	•				4 (25%)
12													•		•		2 (12%)
13	•											•	•	•	•		5 (31%)
14	•					•						•	•		•		5 (31%)
15	•			•	•	•					•	•	•		•	•	9 (56%)
16					•	•			•	•	•	•	•		•	•	9 (56%)
17	•					•					•	•	•			•	6 (37%)
18	•				•	•			•	•	•	•	•		•		9 (56%)
19						•						•	•		•		4 (25%)
20	•			•	•	•				•	•	•	•	•	•		10(62%)
21	•				•	•						•	•		•		6 (37%)
22	•				•	•			•	•	•	•	•		•		9 (56%)
23													•				1 (6%)
24																	0
25	•	•			•										•		4 (25%)
26																•	1 (6%)
27						•					•		•	•	•		5 (31%)
28						•					•		•	•	•		5 (31%)
29	•	•		•	•	•	•	•				•	•		•	•	11(69%)
30		•			•	•		•	•				•		•	•	8 (50%)
31					•	•			•				•			•	5 (31%)
32	•	•			•	•							•		•		6 (37%)
33						•						•					2 (12%)
34			•	•	•						•			•		•	6 (37%)
35													•		•		2 (12%)
36	•				•								•		•	•	5 (31%)
37	•	•		•	•	•			•	•	•	•	•		•	•	12 (75%)
38																	0
Total	13	11	1	8	21	25	1	1	6	11	10	18	29	9	27	13	

CH(C)Ps indicated by numbers

3. Integration with Bone Health and Osteoporosis Services

Background

As the majority of fractures are preceded by a fall, the Fracture Liaison Service is ideally placed to identify people at high risk of falling. Likewise, services delivering falls prevention programmes are well positioned to identify older people who may have osteoporosis.

Key Findings from the Mapping
Integration with bone health and osteoporosis services

At the time of the mapping (June/October 2011):

- People aged over 50 (or 55) living in 25 CH(C)Ps (66%) who sustained a new fragility fracture were systematically identified by a Fracture Liaison Service or equivalent; 4 CH(C)Ps (10%) were progressing work in this area.
- There were agreed referral protocols and pathways between Fracture Liaison Services and assessment and rehabilitation services in 11 of these 25 CH(C)Ps.

Commentary

Findings suggest that a minority of falls prevention services in CH(C)Ps have formal links with Fracture Liaison Services (where they exist). These links include agreed referral protocols and pathways between services. This finding does not suggest an integrated approach to falls and bone health; it is also a less favourable finding than that of a 2009 audit[25] which suggested seven out of nine NHS boards with a Fracture Liaison Service had established pathways with falls services. This is an area of care where simple changes in practice could benefit older people at risk of falls and fractures considerably.

Questions and responses

3.1 Are people over 50 (or 55) living in your CH(C)P who have sustained a new fragility fracture, systematically identified by a Fracture Liaison Service or equivalent?		*n=37*
0	No; no plans currently for improvement work in this area.	**5 (13%)**
DK	Further mapping/information is required to identify current situation.	**1 (3%)**
1	The need for a Fracture Liaison Service or equivalent has been identified, but no detailed work plan has been developed and agreed.	**3 (%)**
2	n/a	
3	There is active engagement in work to introduce a Fracture Liaison Service or equivalent. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**4 (8%)**
4	n/a	
5	People over 50 (or 55) living in the CH(C)P who have sustained a new fragility fracture are systematically identified by a Fracture Liaison Service or equivalent.	**25 (68%)**

3.2 *If they are,* is this service linked with assessment and rehabilitation services providing falls prevention and management? *'Links' include recognised and agreed referral criteria and pathways between the services*		*n=25*
0	No; no plans currently for improvement work in this area.	**0**
DK	Further mapping/information is required to identify current situation.	**0**
1	The need for work to improve links has been identified, but no detailed work plan has been developed and agreed.	**10 (40%)**
2	There is active engagement in work to develop/improve links in ***some*** parts of the CH(C)P. Work is underway, there is a work plan and agreement on aims, roles and timescales	**0**
3	There is active engagement in work to develop/improve links. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**0 (%)**
4	Achieved in part, for example, Fracture Liaison Services are linked with assessment and rehabilitation services in ***some*** parts of the CH(C)P.	**4 (16%)**
5	Fracture Liaison Services and assessment and rehabilitation services are linked.	**11 (44%)**

4. Falls Assessment and Rehabilitation in Care Homes for Older People

Background

Older people living in care homes are three times more likely to fall than older people living in their own homes, with hip fractures 10 times more likely than in other environments. Up to 20% hip fractures occur in care home residents[29]

Improved access to rehabilitation for care homes residents is a recommendation in the Delivery Framework for Adult Rehabilitation (2007)[7].

Key Findings from the Mapping
Falls Assessment and Rehabilitation in Care Homes

At the time of the mapping (June/October 2011):

- Care home residents (all sectors) in 17 CH(C)Ps (45%) had access to multidisciplinary assessment and rehabilitation services for preventing and managing falls and fractures; limited access was available in 9 CH(C)Ps (24%).
- CH(C)P level data relating to emergency admissions from care homes due to a fall was available in 5 CH(C)Ps (13%); hip fracture data was available in 9 CH(C)Ps (24%).

Commentary

Although responses to Part Two of the questionnaire suggested there is much work in progress to address the problem of falls and fractures in care homes, the findings here suggest that there is an unexplained variation in service access for older people living in care homes.

To begin to address the issue of falls and fractures in care homes, in 2011 NHSScotland and the Care Inspectorate issued a new resource, *Managing Falls and Fractures in Care Homes for Older People; a good practice self assessment resource*[30] to all care homes for older people in Scotland. The resource provides direction, advice and guidance for care home staff to help improve the quality of care provided. However, while competent and empowered staff can do much to prevent and manage falls and prevent fractures, in some cases the specialist knowledge and skills of the wider multidisciplinary team will be needed to provide advice, assessment and a number of other interventions. This includes when a resident is discharged back to the care home following a hospital admission due to a fall or hip fracture.

Managing Falls and Fractures in Care Homes for Older People; a good practice self assessment resource is available from www.careinspectorate.com in the 'Professionals' section.

Information Services Division (ISD) of NHSScotland is currently working to provide better data on emergency admissions from care homes, including those as a result of hip fracture.

Questions and responses

4.1 Do care home residents in all sectors living in your CH(C)P have access to relevant community services for preventing and managing falls and fractures? *In this question, 'services' refers to assessment and rehabilitation services.*		*n=38*
0	No; no plans currently for improvement work in this area.	**0**
DK	Further mapping/information is required to identify current situation.	**1 (3%)**
1	The need for work to improve access to services has been identified, but no detailed work plan has been developed and agreed.	**6 (16%)**
2	There is active engagement in work to improve access to services for care home residents, however this is either in ***some care homes only*** (e.g. local authority care homes) *or* to a ***limited range of relevant services***. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**1 (3%)**
3	There is active engagement in work to improve access to all relevant services in ***all care homes*** (all types and sectors). Work is underway, there is a work plan and agreement on aims, roles and timescales.	**4 (10%)**
4	Achieved in part, for example, some care homes have access to ***some, but not all relevant services*** *or* ***some or all care homes*** have access to ***a limited range of relevant services.***	**9 (24%)**
5	Care home residents in all sectors have access to relevant community services for preventing and managing falls and fractures.	**17 (45%)**

4.2 Is the following data available to you? Number of people aged 65 and over living in care homes *in your CH(C)P* admitted with hip fractures.		*n=38*
0	No; not available, and no plans currently to collect this data.	**2 (5%)**
DK	Do not know if this data is available. Further information is required to answer this.	**4 (10%)**
1	The need for this data has been identified, but a plan to collect it has not been developed and agreed.	**16 (42%)**
2	There is work going on to enable collection of NHS board data, but not specific CH(C)P data . There is a work plan and agreement on aims, roles and timescales.	**0**
3	There is work going on to enable collection of this CH(C)P data. There is a work plan and agreement on aims, roles and timescales.	**0**
4	Achieved in part, for example, this data is available but it is NHS board data rather than specific CH(C)P data.	**7 (18%)**
5	This data is available.	**9 (24%)**

4.3 Is the following data available to you? Number of people aged 65 and over living in care homes *in your CH(C)P* with emergency admissions with a diagnosis of falls.		*n=38*
0	No; not available, and no plans currently to collect this data.	**6 (16%)**
DK	Do not know if this data is available. Further information is required to answer this.	**7 (18%)**
1	The need for this data has been identified, but a plan to collect it has not been developed and agreed.	**12 (32%)**
2	There is work going on to enable collection of NHS board data, but not specific CH(C)P data. There is a work plan and agreement on aims, roles and timescales.	**2 (5%)**
3	There is work going on to enable collection of this CH(C)P data. There is a work plan and agreement on aims, roles and timescales.	**2 (5%)**
4	Achieved in part, for example, this data is available but it is NHS board data rather than specific CH(C)P data.	**4 (10%)**
5	This data is available.	**5 (13%)**

5. Educating staff in relation to falls and fractures

Background

All heath and social care staff who are in regular contact with older people have a role to play in falls and fracture prevention. This role can range from providing simple information and advice, to identifying older people at risk, encouraging reporting of falls, signposting/referring to relevant services and encouraging participation in prevention programmes, to more specialist intervention. Learning programmes are essential to ensure staff have the understanding and skills to deliver their role.

Key Findings from the Mapping
Educating staff in relation to falls and fractures

At the time of the mapping (June/October 2011):

- 17 CH(C)Ps (45%) provided falls and fracture awareness training to some or all of primary care staff working regularly with older people; a further 9 CH(C)Ps (24%) were progressing work in this area.

- 15 CH(C)Ps (39%) provided falls and fracture awareness training to some or all social care staff working regularly with older people; a further 10 CH(C)Ps (26%) were progressing work in this area.

In the CH(C)Ps where training is provided:

- Much of the training is delivered by Falls Leads/Co-ordinators, sometimes in partnership with health colleagues, such as physiotherapists, occupational therapists and in one CH(C)P, an osteoporosis nurse specialist; online training is provided in some CH(C)Ps and is being developed in others; in some areas falls training planning groups have been formed to plan and deliver learning programmes; in one NHS board area, 120 ‘falls champions’ from health and social care have been trained.

- Some training has been provided for care home staff and managers in most areas, mostly by health professionals.

- A wide range of health and social care staff have received training, with training programmes delivered extensively in some CH(C)Ps; staff groups receiving training include community psychiatric nurses, community nurses, GPs, voluntary sector, home care staff, day care staff, reablement teams, community alarm teams, pharmacists, amongst others.

- In one CH(C)P social care staff have been trained to deliver strength and balance exercises.

- One NHS board indicated that falls awareness training was, until recently, mandatory for hospital and community allied health professionals and nurses. However the training discontinued when temporary Falls Leads post came to an end.

Commentary

Given the prevalence of falls, particularly amongst frailer older people, it could be argued that basic falls awareness training should be mandatory for both health and social care staff working regularly with older people. This would enable staff to understand the nature and size of the problem and their own role in supporting prevention. Historically, health professionals with a special interest in falls and fracture prevention have provided this type of training to health and social care colleagues locally. More recently the limited capacity of busy clinical staff has impacted on this method of provision and increasingly there is a preference in NHS boards and for online training.

The National Falls Programme, in partnership with NHS Education for Scotland, the Care Inspectorate and the Scottish Qualifications Authority have produced a learning resource, *Preventing falls and fractures in older people*, to help health and social care professionals adopt a consistent approach to delivering learning programmes. It provides a framework for designing training programmes that deliver key messages at an introductory level and is available at www.sqa.org.uk/carescotland The framework has been used to develop elearning modules as well as learning sessions delivered by health professionals.

Questions and responses

5.1 Is falls and fracture awareness training available to all *primary care staff* working regularly with older people? *Primary care staff includes AHPs and AHP support staff, GPs, nurses and nursing support staff, pharmacists etc*		*n=38*
0	No; no plans currently for improvement work in this area.	**1 (3%)**
DK	Further mapping/information is required to identify current situation.	**3 (8%)**
1	The need to introduce training has been identified, but no detailed work plan has been developed and agreed.	**8 (21%)**
2	There is active engagement in work to introduce training for ***some*** primary care staff working regularly with older people. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**5 (13%)**
3	There is active engagement in work to introduce training for ***all*** primary care staff working regularly with older people. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**4 (10%)**
4	Achieved in part, for example, falls and fracture awareness training is available to ***some*** primary care staff working regularly with older people, *or* training has been provided on a one-off basis.	**13 (34%)**
5	Falls and fracture awareness training is available to ***all*** primary care staff working regularly with older people.	**4 (10%)**

5.2 Is falls and fracture awareness training available to all *social care staff* working regularly with older people? *Social care staff includes care home staff, care managers, day care staff, home care staff, occupational therapists, re-ablement staff, social workers, telecare/community alarm staff etc*		*n=38*
0	No; no plans currently for improvement work in this area.	**1 (3%)**
DK	Further mapping/information is required to identify current situation.	**5 (13%)**
1	The need to introduce training has been identified, but no detailed work plan has been developed and agreed.	**7 (18%)**
2	There is active engagement in work to introduce training for ***some*** social care staff working regularly with older people. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**5 (13%)**
3	There is active engagement in work to introduce training for ***all*** social care staff working regularly with older people. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**5 (13%)**
4	Achieved in part, for example, falls and fracture awareness training is available to ***some*** social care staff working regularly with older people *or* training has been provided on a one-off basis.	**13 (34%)**
5	Falls and fracture awareness training is available to ***all*** social care staff working regularly with older people.	**2 (5%)**

6. Involving service users in service improvement

Background

Engaging older people in falls prevention has proved challenging: falls are under-reported, uptake of services is often poor, and drop-out rates from falls prevention programmes can be high. Studies also suggest that adherence with osteoporosis drug regimes can be sub-optimal. Involving service users in service improvements is therefore particularly important in this area of care.

Key Findings from the Mapping
Involving service users in service improvement

At the time of the mapping (June/October 2011):

- 15 CH(C)Ps (39%) specifically sought the views of falls and osteoporosis service users to contribute to local improvement work; a further 10 CH(C)Ps (26%) were progressing work in this area.

Commentary

In 2008 NHS QIS held a series of group discussions with older people who had experienced falls. Nearly all participants described experiencing several falls (seven or eight in many cases) which they did *not* report, prior to having a fall resulting in an injury requiring treatment by a healthcare professional. Nearly all participants described informing a healthcare professional of the fall/s *only* if a significant injury was sustained[13]. Typically, fewer than half of the older people invited to take part in falls prevention interventions in the community take up the opportunity; uptake can be as low as 10%[31]. Poor adherence with osteoporosis medications has also been described[32].

To be able to reach the people who could potentially benefit from falls and fracture prevention services, the issue of under-reporting and poor uptake must be critically explored and then addressed. This can only be done through effective engagement with older people who have experienced falls, and their carers. Furthermore, clear messages must be given that falls are not an inevitable consequence of ageing, and that much can be done to reduce the risk of falls and restore independence and quality of life following a fall.

Questions and responses

6.1 Are service users views sought on the range of services provided by the CH(C)P, which aim to prevent and manage falls and fractures (to contribute to local improvement work)? *Methods may include meetings, focus groups, questionnaires and interviews.*		*n=38*
0	No; no plans currently for improvement work in this area.	**1 (3%)**
DK	Further mapping/information is required to identify current situation.	**5 (13%)**
1	The need for obtaining service users' views has been identified, but no detailed work plan has been developed and agreed.	**7 (18%)**
2	***Some*** services, teams or agencies within the CH(C)P are actively engaged in work to obtain service-users' views. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**5 (13%)**
3	There is active engagement in work to obtain service-users views on ***the range of services*** which prevent and manage falls and fractures. Work is underway, there is a work plan and agreement on aims, roles and timescales.	**5 (13%)**
4	Achieved in part, for example, ***some*** services, teams or agencies within the CH(C)P obtain service users' views.	**13 (24%)**
5	Service users views are sought on ***the range of services*** provided by the CH(C)P which aim to prevent and manage falls and fractures.	**2 (5%)**

7. Data collection and analysis for service evaluation and improvement

Background

Identifying the number of older people presenting to heath and social care services following a fall, and the number of serious injuries resulting from falls, is the first step to understanding the size and nature of the issue of falls and fractures at a local level. On-going monitoring of this data is essential to understand the impact of interventions to prevent fractures and prevent and manage falls.

Key Findings from the Mapping
Data collection for service evaluation and improvement

At the time of the mapping (June/October 2011), the following CH(C)P level data was available locally to Falls Leads:

- In 11 CH(C)Ps (29%), the number of people aged 65 and over with emergency admissions with a diagnosis of a fall.
- In 14 CH(C)Ps (37%), the number of occupied bed days for emergency admissions with a diagnosis of falls for people aged 65 and over.
- In 16 CH(C)Ps (42%), the number of people aged 65 and over admitted with hip fracture.
- In 10 CH(C)Ps (26%), the number of people aged 65 and over attending A&E following a fall.
- In 7 CH(C)Ps (18%), the number of people aged 65 and over who the Scottish Ambulance Service attend following a fall.
- In 23 CH(C)Ps (60%), the number of community alarm/telecare calls from people aged 65 who have fallen.
- In 9 CH(C)Ps (24%), the number of people aged 65 and over living in care homes admitted with hip fractures.
- In 5 CH(C)Ps (13%), the number of people aged 65 and over living in care homes with emergency admissions with a diagnosis of falls.
- In 4 CH(C)Ps (10%), the number of people aged 65 and over living in care homes who the Scottish Ambulance Service respond to following a fall.

Commentary

Availability of CH(C)P-level data relating to falls and fractures remains poor in the majority of NHS boards, despite the amount of work in progress to improve services. Care home data was particularly sparse, even though falls and fracture rates are recognised as being considerably higher in this population. The most accessible data relates to community alarm/telecare calls. This may reflect a collaborative piece of work between the National Falls Programme, the Joint Improvement Team's Telecare Development Programme, Falls Leads and the Telecare Learnng Network, which supported the strengthening of links between multidisciplinary falls prevention service and telecare service providers.

This baseline data is essential to measuring the impact of interventions and improving services. Although this questionnaire did not include questions about availability of data in relation to the activity of falls and fracture prevention and management services, a current national evaluation is exposing widespread gaps in availability of accurate data in this area too.

These findings may reflect a number of issues including limited access to, and adequacy of, IT systems and inconsistencies in reporting and coding falls. They may also reflect a general lack of recognition of the importance of falls and fractures and/or the importance of data and measurement to monitor and improve healthcare in this area.

Since the mapping, at the request of the National Falls Programme, ISD has provided CHP and Board-level data on emergency admissions for falls and fractures including numbers and rates per 1000 population over 65, length of stay, bed days and bed day rates. This has been circulated to the Falls Leads for information. The Scottish Ambulance Service also has available local data on responses to falls and conveyance rates to hospital (and there is a related Reshaping Care for Older People Local Improvement Measure). Emergency Department data remains limited, with accurate reporting and coding of falls continuing to be a challenge in some NHS boards- this is a critical area to be addressed to facilitate case finding to prevent recurrent falls and measure the impact of more upstream interventions.

The responses also indicated that the majority of CH(C)Ps (25) had not identified a specific falls and/or fracture data set but many had identified this as a priority for the next 12 months, with work already underway in a number of localities.

Given the multifactorial nature of falls and the range of services and organisations potentially involved in the journey of care, sharing of data is essential for integrated care. Issues around sharing of data, related to both confidentiality and incompatible systems, prevail in most localities. This is not a problem specific to falls prevention. New policies specifically focusing on integration may provide opportunities to take this forward.

SECTION FOUR: CONCLUSIONS, ACTIONS AND RECOMMENDATIONS

Conclusions

The findings presented in this report represent a snapshot of service organisation in June 2011 (or October 2011 for NHS GGC CH(C)Ps). They indicate that in some areas modest steps forward have been taken since the previous mapping in 2009/10 and that there is much improvement work in progress. Many services are currently in a state of transition. However, the findings also show that unacceptable variation in service provision and quality continues to exist within and across NHS board areas in Scotland, and in some localities services are poorly developed. There are also some examples of NHS boards disinvesting in falls and osteoporosis services.

The measure of success of the service arrangements described in this report will be their impact on older people and their carers, and health and social care services. The findings suggest that the whole system improvements necessary to make a significant impact have still to be achieved. However, steady progress continues to be made in many partnerships and there is much work in progress. It is essential that health and social care services make every effort to reach the population who will benefit most from support to prevent falls and fractures, and then deliver the care and interventions that have been shown to be effective. Primary prevention must also be addressed in partnership with a broad range of stakeholders. These changes will take dedicated time, persistence and close working across all organisations and sectors, with older people and their carers playing a central role.

The findings indicate that Scotland still has much to do to provide older people with equitable, high quality services for fall and fracture prevention. In short, this report outlines a number of inadequacies, and we cannot expect to demonstrate a significant reduction in emergency admissions with falls and fractures if key components of evidence-based care are missing or inadequate in most localities. A systematic and targeted approach, supported by strong leadership at all levels is required.

Actions for the National Falls Programme

The National Falls Programme will take the following four actions to address the consistent shortfalls identified in this report, and progress further improvements.

Action 1

The National Falls Programme will develop, test and report on, the use of four community falls care bundles. This will facilitate the consistent delivery of evidence-based practice and the development of co-ordinated local care pathways for falls and fracture prevention and management.

Four care bundles for secondary falls prevention in the community will be tested in NHS Fife in early 2012. The bundles aim to ensure that clear falls prevention and management pathways exist, and core falls assessments and interventions are delivered consistently and in line with current guidance. The introduction of the

bundles, in combination with the Model for Improvement and a measurement framework, will help services to systematically monitor, evaluate and improve the quality and effectiveness of the care they provide. This approach to secondary falls prevention in the community was first developed and introduced in Wales as part of the 1000 Lives Plus Campaign, Reducing Falls in the Community (http://www.wales.nhs.uk/sites3/page.cfm?orgid=781&pid=48636).

Action 2

A Health Economist will carry out an evaluation to quantify the potential clinical benefits gained from implementing the bundles, (at CH(C)P, NHS board and Scotland level) and the resources and associated costs required to do so. This will assess the feasibility of implementing an evidence-based approach across Scotland.

This evaluation will provide each NHS board with the information required to demonstrate the potential costs and benefits to the board of implementing the bundles. It should also assist planning at local and national level, including the implications for the demand for downstream interventions such as falls clinics, DXA scans and pharmacy reviews. The provisional date for completion of the evaluation is April 2012.

Action 3

The National Falls Programme Manager will work with Falls Leads, Osteoporosis Leads, ISD, ehealth services and other partners to develop a national measurement framework. This will facilitate the use of measurement to monitor, evaluate and improve falls prevention and management and fracture prevention.

Action 4

The National Falls Programme Manager will work with the Scottish Centre for Telehealth & Telecare (SCTT) to share learning and explore further opportunities for the appropriate use of telehealthcare technologies.

This will continue to assist with the early identification of people who are at risk of falling, enable effective responses to those who do fall, and will support further shared learning about technology related developments. The expanded use of telehealthcare within care home settings has been identified as an area of joint interest.

Recommendations for NHS boards and partnerships

NHS boards, CH(C)Ps, local authorities and other partners are urged to consider and action the following recommendations.

Recommendation 1

To identify and address any gaps in local service organisation and delivery, CH(C)P Falls Leads, Strategic Falls Leads, Osteoporosis Leads, Unsheduled Care Leads and other relevant colleagues, such as Reshaping Care for Older People leads and local authority partners, should critically review local responses to the questionnaire and recommendations in this report and formulate and deliver a local action plan.

This report will help to signpost partnerships to areas of service organisation and delivery requiring attention. Important areas on which to focus include workforce development in health and social care services, opportunities for the primary prevention of falls and fractures and synergies with the wider active ageing agenda, equity of service provision for residents of care homes in all sectors, and the consistent delivery of person-centred care. In addition to this, the two improvement areas outlined below should be prioritised.

Recommendation 2

To capitalise consistently on opportunities to prevent recurrent falls and fractures, health and social care services should establish:

- **Fracture Liaison Services or equivalent, with referral protocols and pathways to multidisciplinary services providing secondary falls prevention.**
- **Basic falls risk screening in services providing urgent or acute care for older people who have fallen.**
- **Robust referral pathways from services providing urgent or acute care for older people who have fallen +/- sustained a fracture to multidisciplinary services delivering secondary falls and fracture prevention.**

Urgent and acute care services include the Scottish Ambulance Service, Out of Hours Services, Emergency Departments and Minor Injury Units, community alarm/telecare services and secondary care services.

Recommendation 3

To ensure falls prevention programmes are effective, key evidence-based interventions should be available, when required, to older people throughout Scotland.

These interventions include:

- Multifactorial falls risk screening, including an initial basic screen of fracture risk.
- Prescription of a validated strength and balance exercise programme, taught by appropriately trained healthcare or exercise professionals, and necessary support to continue the programme for a sufficient duration.
- Clinic(s) or equivalent facilities to provide focused medical assessment and interventions related to falls prevention. This includes adequate arrangements for the assessment and treatment of transient loss of consciousness.
- Assessment of potential falls hazards within the person's home, using a validated home hazard assessment, by a suitably qualified professional.

Further information on evidence-based interventions can be found in Up and About[12].

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ISBN: 978-1-78045-810-6 (web only)

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for the Scottish Government by APS Group Scotland
DPPAS12957 (05/12)

Published by the Scottish Government, May 2012

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