FALLS AND FRACTURE PREVENTION STRATEGY FOR SCOTLAND 2019-2024

Consultation from the Scottish Government – July-August 2019
https://www.gov.scot/publications/national-falls-fracture-prevention-strategy-scotland-2019-2024/

Response from the Royal College of Occupational Therapists

Questions:

1. Do you agree the Strategy will improve services for those who experience Falls? Yes/No. If not what improvements do you suggest?

The Royal College of Occupational Therapists (RCOT) broadly agree that the strategy has the potential to improve services and is pleased to see a co-ordinated approach towards the identification of those at risk of falls and their subsequent management.

RCOT are of the view that a range of organisations should be supported to apply the principles and general thinking outlined within the strategy. However, we feel the consultation document lacks ambition and innovation; given it is a 5 year strategy we would hope to be in a different position by the end of that period, and we are not convinced the strategy is ambitious enough to make a meaningful difference. Furthermore, there is no obvious link to other current or impending strategies, such as The Active and Independent Living Programme (ALIP) or the National Action Plan on Neurological Conditions for example.

RCOT feel that the challenges posed by falls are not set out clearly enough - such as the increase in emergency admission rates. Greater emphasis should also be placed on the need for individuals to engage in their own falls prevention to make the most difference in reducing falls risk. The use of language also needs to be more positive – it should be about standing up, balancing and keeping active rather than the more negative concept of falling.

While we recognise that this strategy has been targeted at older people and mentions people with frailty; people with dementia and those with learning disabilities it should be highlighted that this omits a large section of the population who are at risk of falling. It is also important to ensure we have the best and most up-to-date evidence on which populations/clinical groups have benefited most from involvement in falls programmes.

RCOT are pleased that the impact of long term neurological conditions (e.g. stroke) has been referenced. We would like to see more recognition that falls and falls prevention is not just relevant to older people. People of all ages living with neurological conditions are also at potentially high risk of falls due to complex interacting motor and sensory disturbances, psychological (e.g. anxiety) and cognitive difficulties (e.g. impulsivity, poor attention, memory difficulties). This population are receiving better medical management and access to rehabilitation which in turn increases their life expectancy. We would like to see some level of commitment within the strategy that the principles, and subsequently any allocated funding, would be accessible to wider clinical groups at risk of falls.

RCOT would advocate that there is specific role for occupational therapists to work with people who fall; however, there is limited mention of occupational therapy in this document. Occupational therapists are an expert and finite resource, so a universal, targeted specialist model should be considered. A universal model would involve developing community resilience and working to upskill key stakeholders. This would include other health and social care professional and the wider community.

A holistic approach to personalised care is undertaken by occupational therapists who apply condition specific knowledge and an awareness of how this impact on the function of those we work with, including those who may have impaired balance and are at risk of falls. How this impacts on daily tasks such as managing in one's own home or being active in a local community needs to be better represented in the document with management being considered in a more functional way to enable people to continue to undertake the tasks which keep them independent and contribute to their quality of life.

We would suggest that working in different ways with a wider group of stakeholders such as occupational therapists within Fire and Rescue Services or occupational therapists within GP surgeries would ensure better links between stakeholders and facilitate skill sharing and earlier intervention for those who need advice or support.

2. **Do you agree with the outcomes in the Strategy? Yes/No. If not, why not?**

Broadly Yes – however

Currently, the strategy is broad and lacks specific measures as well as timescales. For example, the list of positive behaviours noted in Outcome 5 focuses on a medical model of care. This does not consider the home environment including whether, for example, floor surfaces are well maintained, the individual is making appropriate use of mobility aids / aid adaptations, maintaining contact with social networks to aid mental health or the importance of personalised outcomes focused on care and support.

Outcome 8 and Commitment 13 discuss people receiving a proportionate response at the time of a fall that minimises harm and enables recovery. However, this section doesn't discuss current good practice that bridges the gap from self-management to the need for a hospital admission.

3. **Do you have any comments or additions on topics which are not covered in the Strategy? Please be specific in your reasons and include any resources or references that should be considered.**

Yes

Public Health England reviewed the value of specific interventions including assessments of people's homes and modifications to the home. They compared the cost of this intervention versus usual care and considered the impact of the intervention against usual care on

quality of life (as measured in QALYs). These outputs were used to estimate the return on investment (ROI) for each intervention. Home assessment and home modification for people at high risk of a fall was found to offer a return on investment of £3.17 to every £1.00 spent.

The societal ROI, in which benefits are classified as the number of additional QALYs generated by the intervention plus the cost savings from the intervention, demonstrated as £7.34 to every £1.00 spent.
(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/679856/A_return_on_investment_tool_for_falls_prevention_programmes.pdf)

"Adaptations Without Delay: A guide to planning and delivering home adaptations differently" is a recently released report from RCOT that promotes a universal, targeted specialised approach to adaptions which will lead to shorter waits and better outcomes for service users.

The Royal College is also working in partnership with the National Fire Chiefs Council to create culture change so that it becomes routine practice for:

- NHS services and local fire and rescue services to have clear referral pathways for vulnerable adults to reduce fire risk and improve safety at home, e.g. falls prevention;
- A fire risk assessment to be part of occupational therapy assessment when visiting vulnerable people at home;
- Fire and rescue teams to use occupational therapy expertise for training and advice on how to adapt approaches and communication when visiting people with a range of conditions that may impact on their ability to understand, process and action new information.

The impact of this partnership:

- Examples of the benefits to peoples' safety can be accessed through RCOT's report on working with the fire service.(https://www.rcot.co.uk/promoting-occupational-therapy/occupational-therapy-improving-lives-saving-money)
- Establishment of new roles for occupational therapists within fire and rescue services e.g. Band 6 occupational therapist working with Nottingham Fire & Rescue Service has demonstrated a ROI of £7.16 to every £1.

4. Are there any key areas missing or any general amendments you would suggest?

The strategy should have a more functional bias and should also consider home environments and waiting times for complex adaptations which can have dramatic impact on the person's presentation and safety e.g. wet floor shower/ ramp. Another factor to consider is the discrepancy in access to adaptations if you own your own home compared to housing association or local authority tenant (years vs. weeks).

5. **Please comment your thoughts on how best to support the implementation of the Strategy.**

- The principle of falls reduction should be everyone's concern in the health and social care sector. It should therefore be acknowledged, within other strategies, that this is not a stand-alone piece of work. The list of professionals in Outcome 7 is limited and should be reviewed to consider the wider sense that reducing and preventing falls is a concern for a wider range of professionals but also the wider population.

- Currently IT infrastructure is a massive barrier with difficulties sharing information across health and social care. Any work looking to make whole system improvements is, therefore, supported by the Royal College of Occupational Therapists. We also recommend that collaboration and integrated working which follows an integrated, targeted, specialised approach is key to a successful strategy.

- As a profession, occupational therapy promotes the importance of prevention and taking early action and supporting high quality training. We, therefore, believe one of the ways to best support the Strategy is to include occupational therapists in the development and implementation of the Strategy and future work streams.

- RCOT believe that the Strategy should be implemented from a community level through health and social care services and through community support systems. This could include key interested and locally based partners, such as libraries, community councils, community pharmacists and community transport providers. Early conversations and signposting would support a move to a more preventative early interventionist approach.

6. **Do you have any further general comments on the Falls and Fragility Fracture Prevention Scotland Strategy?**

No