Falls and Fracture Prevention Strategy for Scotland: Consultation questions

1. Do you agree the Strategy will improve services for those who experience Falls?

The College agrees that the strategy *could* improve services, but it will require significant investment in the workforce, in training and in relevant resources.

If not, what improvements do you suggest?

2. Do you agree with the outcomes in the Strategy?

The outcomes in the Strategy are solid and the College supports them.

If not, why not?

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 we should consider.

The College's Fellows and Members largely work in hospital settings, and therefore have a specific perspective. Hospital is a key point for people experiencing falls as well as their families: the messages they receive regarding falls/reablement and the support they are given are critical. Fellows have particularly emphasised the need for investment in the workforce. An example given was that in a large teaching hospital, there is access to physiotherapy and occupational therapy seven days a week in Geriatrics, but for the rest of the hospital, there is a small, mobile team, with very limited availability especially at weekends. Clinicians find this a very difficult situation as it does not reflect patient need. Unfortunately, because of staffing pressures and lack of training, many staff still believe that it is better to keep patients in their beds than mobilise and enable them. It is therefore vital that there is widespread staff and public education on the risks of immobility and the need to promote and support independence.

There is little recognition in the Strategy of the role that geriatricians can play in coordinating services, assessing and managing polypharmacy, and leading multidisciplinary teams. Nor of the role of GPs who also play a very large part in coordinating care, providing information and managing concerns. In order to realise the desired outcomes of the Strategy, a substantial increase in workforce is required to address gaps at consultant and trainee geriatrician level, as well as tackle GP shortages. Healthcare professions such as physiotherapy also require support to meet increasing levels of demand. There is a clear need for more investment in integrated services at the hospital and consideration of access to eye tests, podiatry etc – almost a 'one stop shop' with coordinated community follow up where appropriate.

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

As above.

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

College Fellows consider that investment in public health, primary care and the wider NHS workforce will be vital to support the implementation of this Strategy. Additional healthcare staff with access to training will be needed to deliver commendable strategies such as these.

In more general terms, public health education and ongoing support for integration of health and social care will also be necessary to support the implementation of the Strategy.

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

College Fellows have highlighted a number of points for consideration:

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Our ambitions for this strategy are to: 4. build resilience at population level: working together across sectors and with individuals and communities to enable more people to maintain or build their resilience and reduce their exposure to risk factors for falls and osteoporosis

- "Resilience" is a broad term and can be interpreted in a number of ways: is it possible to provide more specific examples?

5. take action earlier: working together across sectors and with individuals and communities to cultivate a shared responsibility for recognising and exploiting valuable opportunities to take earlier preventative action when signs of frailty and functional decline are first recognised and, after one fall or fragility fracture, to prevent another

- "Exploiting" has many negative connotations and a better phrase may be "utilising".

- College Fellows have suggested that instead of "*first recognised and, after one fall or fragility fracture"* this should be an "and/or" statement. It is important to look for opportunities to take preventative action and not wait until a fall has occurred.

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When we talk about harm from falls, we don't only mean the physical and psychological harms (such as hip and other fractures, head injuries and soft tissue injuries, and fear of falling, anxiety and depression), but also negative impacts a fall can have on a person's life

- "*but also negative impacts"* should be changed to "but also **other** negative impacts", as without the addition of "other" it implies the other harms do not negatively impact.

Some actions and approaches to prevent falls will also help prevent or slow the progression of frailty. These include being physically active and less sedentary, improving muscle strength and balance, promoting continence, and ensuring good medicines management and adequate nutrition.

- Adjustments to the physical environment should also be added here.

People with advanced dementia symptoms can also be at greater risk of frailty and falling.

- It is not clear why this condition is specifically mentioned here, as ‘milder’ dementia and many other conditions also increase risks of both.