Unscheduled Care Integrated Pathways for Frailty and Falls
Scottish Ambulance Service Community Pathways
Review of Pathways (June 2015)

Introduction
As part of the National Falls Programme, a report has been prepared for the Scottish Ambulance Service (SAS), Health and Social Care Partnerships (H&SCPs) and other partners regarding the implementation and spread of integrated SAS community pathways for people who fall and/or are frail. The report presents the background and rationale for the introduction of pathways, a detailed review of the pathways which had been implemented by June 2015, the process conducted for these reviews and, finally, actions to support further pathway development and improvement.

The intended outcome from the discussion of this paper with the SAS, HSCPs and other partners is agreement to undertake the actions outlined within.

The aim of the pathways
The pathways aim to improve the care, experience and outcomes of people presenting to the SAS following a fall or with frailty by:

- preventing unnecessary conveyance to the Emergency Department (ED) and/or
- supporting recovery and return to independent living following illness or a fall, and
- reducing risk of further falls.

The pathways enable SAS to directly refer the people they attend to a range of community-based services, including crisis care, intermediate care, assessment and rehabilitation services. In some cases, this will provide a safe and appropriate alternative to ED attendance.

Next steps
In 2016/17, the Active and Independent Living Improvement Programme (AILIP) will have a focus on supporting the implementation and spread of Scottish Ambulance Service Community Pathways. The driver diagram and 17 actions from the review report will provide direction for this work stream.

As a key stakeholder in the development of integrated SAS community pathways, we are asking for your feedback on the driver diagram and actions.

Below you will find the 17 actions, and for each one:

- The findings of the review that informed the action.
- Why each action matters.
- What we are trying to achieve through the action.

Summary of Actions for Comment (May 2016)
You will also find the Driver Diagram, which is based on the factors identified in the review that appeared to contribute to successful pathway development, implementation and sustainability.

**Please review the actions and driver diagram and tell us:**

Have you found any issues with pathway development, implementation and spread that are not highlighted in either the Driver Diagram or the 17 actions?

Does the Driver Diagram include the right ‘major contributing factors’ and ‘key elements’.

Are these the right actions and elements (in Driver Diagram) to support implementation, spread and sustainability of the pathways?

A template is attached for you to provide your feedback. Alternatively, please use track changes if this is easier.

Please respond by **Wednesday June 15th 2016**.

If you have any questions please contact ann.murray3@nhs.net
The 18 Actions

1. The findings presented in this report will be used nationally and locally to inform future pathway developments. H&SCPs and their SAS partners should take cognisance of the Driver Diagram when developing or improving local Pathways.

2. The SAS Integrated Care Pathway Framework: Design, Implementation and Evaluation Tool will be used in the development and review of integrated SAS falls and frailty pathways.

3. The SAS and partners will work towards broadening the scope of falls pathways to include people who have not fallen but present with other frailty syndromes, such as immobility, and people with dementia.

4. The SAS will introduce a clinical triage tool for frontline SAS practitioners with the aim of standardising the assessment process across Scotland.

5. The SAS will set up and utilise a national senior clinical support network for decision support.

6. The SAS will identify and implement a reliable process for enabling SAS crews to contact and refer to the correct point of access when they are working across SAS boundaries.

7. There will be a single point of access to community services which is part of an integrated service approach. At the time of SAS referral there will be an acknowledgement that the referral has been received and accepted, and that a telephone triage or response will be carried out within a specified time frame.

8. The nature of the community response will be determined by the needs of the individual. When a planned response is indicated (non crisis), there will be a telephone triage carried out on the same day if the referral is received within working hours, or the next day.

9. Analysis will be undertaken to better understand the causes and consequences of the increase in the percentage of people not conveyed to ED.

10. A working group will be established to identify a national core data set for SAS falls and frailty pathways. The data set will be collected and monitored locally to understand the impact of new and emerging pathways. The data set will include the number of service user declines for referral to community services.

11. SAS will monitor key pathway measures as part of their core suite of performance indicators.

12. SAS will explore the use of data codes for referral to community services. The codes should differentiate between referrals for a crisis response and referrals for a planned response.

13. Robust systems and processes for data collection and retrieval in H&SCPs will be implemented and cross referenced to SAS data to better monitor referrals from SAS.

14. A focused piece of work will be undertaken to better understand the reasons why older people decline referral to community services, with a view to identifying strategies to improve uptake.

15. The SAS falls and frailty pathways will be developed, implemented and reviewed in combination with other urgent responses to a person who has fallen, such as uninjured fallen person pathways and community alarm pathways, so there is a fully integrated approach to responding to a fallen person.

16. The SAS will identify learning and development opportunities for their staff, such as including falls and frailty pathways in staff induction and practice development sessions.

17. A cost benefit evaluation will be undertaken to understand the economic value of the pathways.
**Actions tables**

1. The findings presented in this report will be used nationally and locally to inform future pathway developments. H&SCPs and their SAS partners should take cognisance of the Driver Diagram when developing or improving local Pathways.

<table>
<thead>
<tr>
<th>What did the review find?</th>
<th>There are a number of factors that appear to either enable or impede pathway development, implementation and sustained use. Some of these factors were identified consistently across Partnership areas.</th>
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<tbody>
<tr>
<td>Why does this matter?</td>
<td>There are opportunities to learn from, and build on the experience of Partnerships that have developed, tested and implemented pathways – including the learning from approaches that have not been successful.</td>
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<tr>
<td>What are we trying to achieve?</td>
<td>Partner organisations take into consideration the findings of the report and the Driver Diagram to guide and support pathway development or review, avoid pitfalls and increase probability of success.</td>
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2. The **SAS Integrated Care Pathway Framework: Design, Implementation and Evaluation Tool** will be used in the development and review of integrated SAS falls and frailty pathways.

<table>
<thead>
<tr>
<th>What did the review find?</th>
<th>There has been no formal guidance on pathway development for SAS staff to follow, resulting in variation in engagement, approach, success and sustainability.</th>
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<tbody>
<tr>
<td>Why does this matter?</td>
<td>For the SAS as an organisation there are important considerations when developing an integrated pathway, in terms of approvals required, clinical governance and risk management and processes for long term monitoring, evaluation and governance.</td>
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<tr>
<td>What are we trying to achieve?</td>
<td>The SAS takes a robust and consistent approach to pathway development and implementation, in particular in relation to governance.</td>
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</table>
The SAS and partners will work towards broadening the scope of falls pathways to include people who have not fallen but present with other frailty syndromes (such as immobility) and people with dementia.

<table>
<thead>
<tr>
<th>What did the review find?</th>
<th>Of the 13 implemented pathways, seven were for people who had fallen; six pathways were for people who had fallen and people with frailty. One Partnership reported that starting with a falls-only pathway, which was more easily defined, was a useful springboard to broadening the scope of the pathway to include people with frailty (who had not fallen).</th>
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<tr>
<td>Why does this matter?</td>
<td>In people aged 65 and over, falls are the leading presentation to SAS, and therefore were the initial focus of integrated SAS pathway development. However, safe and effective alternatives to ED attendance are needed for people presenting to SAS with a range of diagnoses, conditions, circumstances and health and social care needs. Falls, frailty, dementia/cognitive impairment are often inter-related and co-exist in one person. With this population, single ‘condition’ pathways are neither practical nor sustainable in the longer term.</td>
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</tbody>
</table>
| What are we trying to achieve? | There is an integrated pathway that is able to meet the needs of people presenting to the SAS with frailty syndromes, such as falls and immobility, dementia and cognitive impairment, and often multimorbidity. Specifically:  
- SAS control and crew have access to assessment and decision making support to enable them to determine whether a person with falls, frailty, a dementia or cognitive impairment needs to be conveyed to hospital, and if not, whether the person would benefit from further care and support.  
- A single point of access to community services that can provide timely triage and urgent or planned care and/or support to meet the range of needs of people with falls, frailty, a dementia or cognitive impairment. |
### 4. The SAS will introduce a clinical triage tool for frontline SAS practitioners with the aim of standardising the assessment process across Scotland.

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<tr>
<th><strong>What did the review find?</strong></th>
<th>The SAS face to face assessment process for identifying the needs of a person was not consistent across Scotland. As well as variation, in some areas there was no clear or coherent process.</th>
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</table>
| **Why does this matter?**     | SAS need standardised assessment to enable SAS control and crew to determine whether a person with falls, frailty, a dementia or cognitive impairment, needs to be conveyed to hospital, and if not, whether the person would benefit from further care and support.  
Consistency gained from standardisation is important to ensure all service users receive the same high standard of care, regardless of where they live.  
Standardisation will also benefit SAS crew who work across geographical boundaries. |
<p>| <strong>What are we trying to achieve?</strong> | SAS have a clear and coherent process for assessing if a person who has fallen, is frail and/or has a dementia/cognitive impairment needs to attend the ED, and if not, would benefit from further care and support. |</p>
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<th>5.</th>
<th><strong>The SAS will set up and utilise a national senior clinical support network for decision support.</strong></th>
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<tr>
<td><strong>What did the review find?</strong></td>
<td>Professional to professional decision making support varied between Partnership and NHS board areas in terms of availability, the formality of the support and who provided the support. Formal and informal professional to professional support was provided by a range of professionals including medics, SAS clinical advisors, allied health professionals and nurses. In some Partnerships other forms of decision support were available, such as algorithms and screening tools. There is potential for technology to provide future decision making solutions.</td>
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<td><strong>Why does this matter?</strong></td>
<td>Historically the SAS either ‘see and treat’ a person they attend or convey the person to hospital. Decision making relating to referral to community services, either as an alternative to ED attendance or to access further support or care, is a new working practice for many staff. Access to senior clinical support, from a range of professionals will provide guidance for crews and build confidence with decision making relating to integrated pathways. This is of particular importance in the early stages of introducing a new pathway.</td>
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<td><strong>What are we trying to achieve?</strong></td>
<td>SAS crews have the option to access a professional to professional conversation with senior health or social care professional to support decision making relating to management options.</td>
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<td><strong>The SAS will identify and implement a reliable process for enabling SAS crews to identify, contact and refer to the correct point of access when they are working across SAS boundaries.</strong></td>
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<td><strong>What did the review find?</strong></td>
<td>SAS crews working across geographical boundaries were unclear on availability of, or how to access community services when they operated outside of their local area. This resulted in underutilisation of integrated pathways. “Better use of technology to support cross boundary working” was one of the opportunities cited most frequently in interviews.</td>
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<td><strong>Why does this matter?</strong></td>
<td>Cross-boundary working is common in the SAS. Because crews working ‘out of area’ are not familiar with the local integrated pathways, services users are: • being conveyed to ED when there are safe and effective community based alternatives available. • not receiving important ‘follow-up’ care and support when it is available.</td>
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<tr>
<td><strong>What are we trying to achieve?</strong></td>
<td>SAS crews working across SAS boundaries have a reliable process for finding out (a) the availability of local community services, and (b) how to make a referral through the correct point of access.</td>
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</table>
7. There will be a single point of access to community services which is part of an integrated service approach. At the time of SAS referral there will be an acknowledgement that the referral has been received and accepted, and that a telephone triage or response will be carried out within a specified time frame.

8. The nature of the community response will be determined by the needs of the individual. When a planned response is indicated (non crisis), there will be a telephone triage carried out on the same day (if the referral is received within working hours), or the next day.

What did the review find? A single point of access to integrated community services, ideally 24/7 was consistently cited as an enabler for pathway utilisation.

There were a number of variables in the points of access in the implemented pathways:
- Single point of access, or multiple points of access.
- Operating hours of the point/s of access.
- The range of services that could be accessed directly via the point of access.
- Three pathways had single point of access to community-based services operating 24/7.
- Four pathways had two or more points of access to community based services, which together operated 24/7.
- One pathway had a single point of access accepting referrals 24/7 but the response was limited to 0800 – 1800 hours.
- Only one pathway had single point of access that provided 24/7 direct access to a range of community services. Other 24/7 single points of access provided access to a single service or team, which could then refer on to others following the initial assessment/intervention.
- Six pathways had a single point of access to a single service that provided a planned response only.

One of the key barriers to pathway utilisation cited by SAS staff was lack of SAS confidence in a timely and appropriate H&SCP response.

Why does this matter? A key requirement of the SAS pathway is the facility for SAS to make a referral simply and quickly; ideally, via a single point of access to a range of integrated services providing crisis and/or planned support. It is important to SAS crews that they have confirmation that a referral has been received and accepted and that a ‘timely’ triage and/or response is in progress.

It is important that SAS staff understand how quickly local community services can respond; if community services can only offer a less urgent response, this needs to be made clear to SAS staff. It is also important for SAS and community services to agree how quickly a SAS referral will be triaged as this may influence SAS crew’s decision to refer.

What are we trying to achieve? SAS have simple and quick access to integrated community services providing urgent and planned support.

For the SAS, there is absolute clarity locally on whether or not community services
services can provide (a) an urgent response (and what this means in practical terms) and/or (b) a more routine response (and what this means in practical terms).

At the time of referral SAS receive an acknowledgement that the referral has been received and accepted, and that a telephone triage or response will be carried out within a specified time frame.

There is a proportionate response to SAS referrals, specifically, there is only an urgent or crisis response when this is required.
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<tr>
<th>9.</th>
<th><strong>Analysis will be undertaken to better understand the causes and consequences of the increase in the percentage of people not conveyed to ED by SAS.</strong></th>
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</table>
| **What did the review find?** | In Scotland, there has been a reduction in the percentage of people conveyed to ED following a fall. Given the low number of referrals to community services through implemented fall/frailty pathways, the introduction of the pathways alone does not account for this reduction. It is not clear whether or not the increasing number of people not conveyed have the opportunity to access further advice, support or care following their SAS contact.

The review was not able to identify the cause of the reduction in conveyance, although a number of possible explanations were suggested, including:

- Improved telecare/community alarm pathways (this relates to SAS calls-outs originating from community alarm services).
- The availability of other local referral pathways for SAS that may be more appropriate.
- An increase in the use of technology enabled care, with ongoing monitoring of the person in place.
- Improved functional assessment by SAS staff and better provision of falls advice.
- An increase in refusals to attend hospital.
- A change in the way SAS code falls.
- Incorrect coding following triage by Control. |
| **Why does this matter?** | It is important to ascertain the causes and impact of the reduction in conveyances. Of particular importance is identifying whether or not the increasing number of people not conveyed receive the advice and support they need to (a) prevent physical and psychological decline and loss of independence often triggered by a fall, and (b) prevent further falls.

Even if there is no injury, in most cases the person will benefit from further information, advice, care and/or support. |
| **What are we trying to achieve?** | There is a reduction in the percentage of people conveyed to the ED by SAS and a corresponding increase in people referred by SAS directly to community services providing appropriate information, advice, care and/or support. |
A working group will be established to identify a national core data set for SAS falls and frailty pathways. The data set will be collected and monitored locally to understand the impact of new and emerging pathways. The data set will include the number of service user declines for referral to community services.

SAS will monitor key pathway measures as part of their core suite of performance indicators.

SAS will explore the use of data codes for referral to community services. The codes should differentiate between referrals for a crisis response and referrals for a planned response.

Robust systems and processes for data collection and retrieval in H&SCP will be implemented and cross referenced to SAS data to better monitor referrals from SAS.

| What did the review find? | Collecting and analysing a set of measures for improvement was often challenging, particularly for staff in Partnerships. The only measures consistently collected were:
| | • % and number of conveyances/non conveyances (collected by SAS)
| | • Referrals received from SAS (collected by H&SCP services)
| | Locally, SAS data was not always considered alongside community data. One of the reasons stated for this by community services, was the challenge of accessing SAS data locally.
| | Further potentially useful data to understand the impact of the pathways was not available, such as:
| | • Number of declines of referral to community services
| | • Percentage of SAS conveyed persons subsequently admitted
| | • Subsequent SAS/Emergency Department contacts
| | • Complaints
| | • SAS response times (balance measure)
| | • Uninjured fallen person pathway activity.
| | There is not currently a SAS code that indicates that a person has been referred directly by SAS to community services.
| Why does this matter? | Without a well-considered suite of measures it is not possible to fully understand the changes that have resulted from the pathway implementation and the impact on service users, the SAS, community services and the wider system.
| | Feedback on the experience of service users and their carers and families would be key to understanding the impact of the pathways.
| What are we trying to achieve? | Nationally there is an agreed suite of process, outcome and balance measures.
| | Locally, the suite of measures are collected reliably and analysed in partnership, to understand the impact of new and existing integrated pathways.
| | H&SCPs monitor key pathway measures as part of their core suite of performance indicators.  
Centrally, SAS monitor key pathway measures as part of their core suite of performance indicators. |
**14.** A focused piece of work will be undertaken to better understand the reasons why older people decline referral to community services, with a view to identifying strategies to improve uptake.

| **What did the review find?** | All pathways were utilised less than anticipated. A number of factors were thought to contribute to this. SAS interviewees specifically identified older people declining the offer of referral to community services as a key contributor.

A similar challenge was identified by Community Alarm Services when they introduced referral pathways into assessment and rehabilitation services. |
|---|---|
| **Why does this matter?** | People are not accessing advice, care and support that could enable them to remain confident, active and independent for longer and reduce the risk of harm from falls.

It can be challenging to engage older people in falls prevention and management. Either because of the stigma attached to falling in later life or because many people accept falling as an inevitable part of getting older, and believe nothing can be done.

Asking and talking about falls need not reinforce negative assumptions about old age, as setting goals to preserve or restore a person’s function and independence is positive and enabling. Overemphasising risks and focusing only on safety may inadvertently stigmatise falls or cause patients to restrict their activities. |
| **What are we trying to achieve?** | Older people are empowered to make informed decisions about accessing advice, care and support following a fall. |
The SAS falls and frailty pathways will be developed, implemented and reviewed in combination with other urgent responses to a person who has fallen, such as uninjured fallen person pathways and community alarm pathways, so there is a fully integrated approach to responding to a fallen person.

<table>
<thead>
<tr>
<th>What did the review find?</th>
<th>Having local alternatives to a SAS response for people who have fallen and are uninjured will impact on referrals to community services through the SAS pathway.</th>
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<td>One H&amp;SCP with robust response arrangements for people who had fallen and were uninjured (sometimes referred to as ‘pick-up’ services) reported that they expected to have lower referral numbers, as SAS or NHS 24 could re-direct calls to local response services via an ‘uninjured fallen person pathway’ if telephone triage indicated the person was neither injured nor unwell. This potentially would result in SAS seeing a lower percentage of people not requiring conveyance.</td>
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<td></td>
<td>Another H&amp;SCP noted a reduction in the number of SAS referrals when a new process was introduced by SAS to direct (via NHS 24) people who were uninjured to local response services for assistance to get up.</td>
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| Why does this matter? | To ensure the best outcomes for service users and the most appropriate use of SAS and health and social care resources, there needs to be absolute clarity at H&SCP level on arrangements for responding to and managing people who have fallen. This requires local partner organisations to be aware of and understand each other’s roles, responsibilities and operating procedures and how they dovetail. |

| What are we trying to achieve? | There is absolute clarity and agreement amongst all local responding services on the best possible arrangements for responding to: •injured and/or unwell individuals following a fall. •uninjured individuals following a fall. |
### 16. The SAS will identify learning and development opportunities for their staff, such as practice development sessions, and including falls and frailty pathways in staff induction.

**What did the review find?**
Limited SAS access to specific training about falls management and prevention and the benefits of the new pathways was frequently cited as a barrier to pathway development and utilisation. SAS staff training was consistently identified as an enabler, as was effective engagement with SAS staff.

The need for a ‘change in culture’ within SAS was frequently suggested as a challenge to pathway success – by both H&SCP and SAS interviewees. This refers to the SAS’ historic role of transporting a person to hospital.

**Why does this matter?**
A new practice is more likely to be accepted and adopted when (a) there is clear and coherent ask of staff, and (b) the benefits of the new way of working – and the risk associated with not changing practice - are understood.

**What are we trying to achieve?**
There is an engaged, competent and confident SAS workforce contributing to the integrated pathways.

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### 17. A cost benefit evaluation will be undertaken to understand the economic value of the pathways.

**What did the review find?**
Only three Partnerships reported carrying out some analysis of the economic impact of the pathways. This was predominantly in relation to costs avoided by not conveying a person to the Emergency Department.

No economic evaluation had been undertaken nationally.

**Why does this matter?**
It is important to identify and understand the impact of the pathway on the cost of delivering care. An evaluation with positive findings would strengthen the business case for implementing the pathway and act as a driver for change.

**What are we trying to achieve?**
There is a clear understanding of the financial costs and savings relating to the integrated pathway.
<table>
<thead>
<tr>
<th><strong>SAS Falls/Frailty Pathway Driver Diagram</strong></th>
<th><strong>Major contributing factors</strong></th>
<th><strong>Key elements</strong> (From scoping: what’s worked well and/or suggested solutions)</th>
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<tr>
<td><strong>AIM</strong></td>
<td><strong>Consistent multi-agency leadership and governance to develop and sustain the pathway.</strong></td>
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<td>TO improve the experience and outcomes of people the SAS respond to following a fall and/or with frailty.</td>
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<td><strong>BY</strong> the SAS providing access to the most appropriate support and care at the time of the response.</td>
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<td><strong>THROUGH</strong> a simple and coherent pathway (24/7) co-created, agreed and delivered involving all stakeholders.</td>
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<td><strong>Goals:</strong></td>
<td><strong>Local QI knowledge and support to agree/communicate the aim then develop, test implement and monitor the pathway.</strong></td>
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<tr>
<td>• Reduce unnecessary conveyance to ED.</td>
<td><strong>Engaged, competent and confident frontline SAS staff with support to take decisions re conveyance.</strong></td>
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<td>• Increase the number of non-conveyed people referred to community services providing:</td>
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<td>• Immediate care and support (as an alternative to ED attendance)</td>
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<td>• Planned intervention to support recovery following a fall and reduce the risk of further falls.</td>
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<tr>
<td><strong>Simple, quick access to integrated community services (including third sector) providing urgent and planned support.</strong></td>
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**Consistent SAS leadership at all levels (including Strategic Improvement Facilitators).**
• A local multi-agency group overseeing the development of the pathway.
• Written agreement of roles & responsibilities of contributing partners (duty of care).
• A local multi-agency group monitoring pathway activity and outcomes (including adverse incidents) and responding to findings (regular meeting monthly/6 weekly).  

• A project charter or equivalent that identifies aims and goals of the pathway and a measurement plan to monitor progress towards the aim.
• Application of appropriate improvement methodologies to develop, test, implement and spread the pathways, with QI support when required.
• Consistent use of measurement to understand the system and monitor activity and change.

• **Community coproduction.**
• Mechanism for service user feedback.
• Public access to information about the pathway.
• Clarity around consent.
• Information provided by SAS at point of care.

• Training for SAS staff to improve their understanding of the nature of falls/frailty, the aims of the pathway and how the pathway works.
• Effective communication to SAS staff of the local pathway and parameters (using technology?).
• Shadowing (SAS and community staff) to understand roles, contribution and challenges of others in the pathway.
• Decision making algorithms and guidance which is easily accessed.
• Timely professional to professional decision support (medical and other).
• Access to e-health solutions (including KIS, ACP, ECS) to access service user information.
• Feedback to SAS crews re outcomes of onward referral.

• A single point of access 24/7 (telephone or secure online) to integrated community services.
• Systems in place to receive, acknowledge, record and respond to referral from SAS.
• Co-ordination of the community response including GP involvement.
• Rapid telephone triage to ascertain response required.
• Services providing an immediate/crisis response to enable a person to remain in their home or close to home 24/7.
• Multidisciplinary/ multi-agency services providing a planned response within a defined timescale.