



MAKING THE RIGHT CALL FOR A FALL

Developing an Integrated Urgent Care
Pathway for Older People



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IMPROVING THE PATHWAY FOR OLDER PEOPLE WHO FALL OR ARE FRAIL

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About this Resource

This resource provides practical guidance and case study examples to help health and social care professionals, planners and managers. It aims to improve the experience and outcomes for older people who present to the Scottish Ambulance Service following a fall or with a flare up of their long term conditions on a background of general frailty. It has been produced by the Joint Improvement Team (JIT), the Scottish Ambulance Service (SAS) and the National Falls Programme Manager in collaboration with three Partnerships that have been developing and testing redesigned Pathways for older people who fall. It draws on the experience and expertise of Scottish Ambulance Service practitioners, Intermediate Care Services and Community Health Partnership Falls Leads.

Why is this Important ?

In the next 10 years the population over the age of 75 in Scotland will increase by over 25%, whilst the number of people with multiple and complex conditions will continue to grow. Many older people have a combination of physical, cognitive and functional impairments that increase their risk of a fall, sudden loss of mobility or worsening confusion. This situation can be caused by common and reversible problems such as a chest or urine infection, side effects from medicines, or by a flare up of another condition. Although these issues require prompt assessment and treatment, in many cases this can be done urgently by a specialist team visiting at home or in a day clinic. This alternative Pathway avoids the distress and disruption of an urgent transfer to hospital for frail older people who are also more susceptible to delirium and healthcare associated infection. An ambulance response may be triggered for a minor illness or injury which could be more appropriately managed at home or at an urgent clinic. If conveyed and admitted as an emergency, frail older people often face a lengthy stay and are at risk of deteriorating further in hospital to the extent that they may be unable to return home.

Choosing the Right Pathway

Anticipatory Care Plans (ACP) are 'thinking ahead' plans which summarise the wishes and preferred place of care for individuals in the event of an anticipated deterioration in their own condition or their carer's health. From April 2013, the GP contract will enable practices to develop an additional 80,000 ACPs by 2015 and to share these with the emergency services, as electronic Key Information Summaries, so that they can respond appropriately and choose the right Pathway for the individual.

Most **Partnerships** are developing or enhancing their Intermediate Care services as described in "*Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland*". These are integrated community health and care services that help to prevent unnecessary admission to acute hospital or long-term residential care, promote faster recovery from illness, support timely discharge from hospital and help people return to independent living. Some partnerships are developing rapid response and 'hospital at home' services that offer fast and effective alternative Pathways.

However there is often a gap in awareness and understanding of what these services offer, when they are available and how they can be accessed. Call handlers, Community Alarm / Telecare contact centres, NHS 24 advisors and ambulance crew are often not well sighted on emerging intermediate care services nor are they generally empowered to refer directly to the appropriate services. Intermediate Care Pathways need to include the emergency response or they will be bypassed by unscheduled care algorithms that automatically convey to hospital.

Integrated Pre-hospital Pathways

There is strong national and international evidence on the role of an ambulance service in providing high quality clinical care and navigating patients to the right care, either through telephone or face to face clinical assessment. This is supported by the development of intelligent telephone triage systems that are linked via knowledge management systems to local directories of health and social care services.

The Scottish Ambulance Service now manages 20% of all 999 calls by either providing telephone advice, transferring the call to NHS24 or by Paramedics treating the patients on scene. As a result, the role of the Scottish Ambulance, and the skills and competencies of its clinicians has changed, and continue to change significantly.

The Service responds to around 200,000 incidents involving people aged 65 years and older and conveys to hospital, typically, 80% of these cases. This equates to around £11m of the SAS budget alone, excluding the costs associated with assessment at the Emergency Department and subsequent inpatient care.

Falls are the most frequent single “diagnosis” presenting to the SAS in the over 65 cohort. Of similar volume is the SAS caseload categorised as a ‘sick person’. This diagnostic code is applied where there is a non specific deterioration in people who are frail or have multiple physical and / or cognitive impairments.

Breathing problems and **chest pain** are also common presentations in older people. However these codes will include significant numbers of older people with single cardiac or respiratory conditions or who have primarily cardiorespiratory disease without associated functional disability. These people are more commonly under 75 years and usually managed within condition specific protocols / Pathways.

Paramedics face a number of challenges when responding to calls about the more frail older individuals, particularly those who live alone and/or are cognitively impaired. In these situations, the paramedic is often faced with challenges around poly-pharmacy, complexity and a lack of clinical information. This makes assessment and clinical decision making more difficult. Ambulance clinicians may lack the required urgent advice and support to enable them to confidently manage an older person at home or refer to an alternative Pathway of care.

Responding to requests for urgent care; from call handling, signposting to face to face clinical assessment and management needs to be fully embedded within an integrated whole system Pathway to reliably deliver safe, effective and person centred unscheduled care for older people. This is also critical to effective demand management across the whole system.

20:20 Vision

We need to transform our unscheduled care response to meet these changing needs in a way that is sustainable. An Unscheduled Care Expert Group is currently overseeing an Action Plan which aims to improve the quality of unscheduled care response to NHS Scotland's 20:20 Vision.

NHS Scotland 20:20 Vision

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting. We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day care treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

This resource makes an important contribution to implementing that Action Plan. NHS Boards and their partnerships are encouraged to work with their colleagues from the Scottish Ambulance Service to implement the Pathway described in this publication.

THE IDEAL INTEGRATED URGENT CARE PATHWAY FOR FALLS AND FRAILITY

The integrated Pathway has three steps:

- **Step 1: Triage**

The Ambulance Control Centre provides a person centred response to the urgent situation.

- **Step 2: Assessment**

Decisions made by the SAS Practitioner are informed, reliable and professionally supported.

- **Step 3: Management**

Where possible, see and treat at point of care with prompt access to integrated community services.

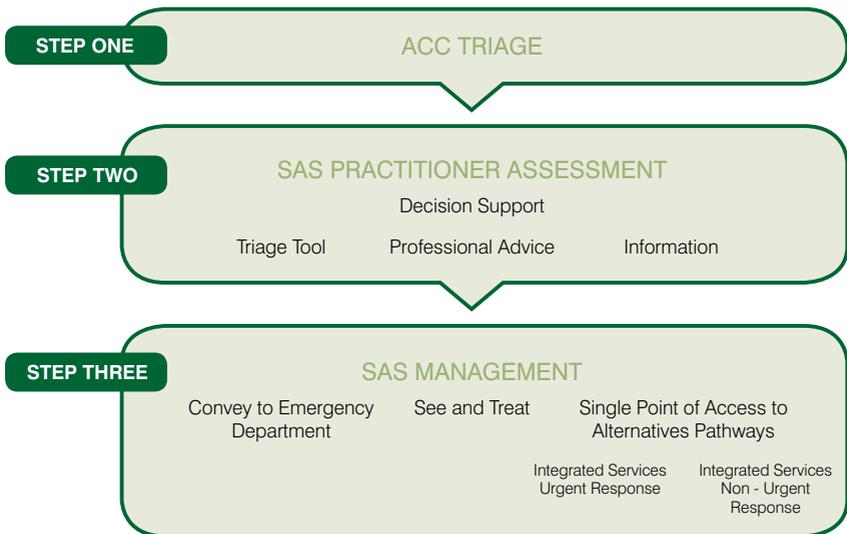


Figure 1 Urgent Response Pathway for Falls and Frailty

STEP 1: SAS AMBULANCE CONTROL CENTRE (ACC) TRIAGE

The urgent response will often be triggered by a “crisis” call to the ambulance service via 999. To achieve a more person-centred and integrated approach we need to change the way calls are triaged.

WHERE WE ARE NOW

Current telephone triage

- Ambulance specific
- Protocol driven
- Condition specific
- Universally rapid response
- Limited referral options

WHERE WE WANT TO BE

Single clinical triage system

- Integrated system wide context
- Flexible and person centred
- Designed for multimorbidity and frailty
- Response time appropriate to need
- Alternative referral options

A number of issues will influence the efficacy of the telephone triage process and consideration of the patient’s suitability for an alternative Pathway and response. These include:

- The quality of information provided by the caller – whether patient / proxy.
- The caller’s awareness of the clinical condition and circumstances of the patient (and carer).
- The call handler’s awareness of the Key Information Summary if that has been shared.
- Availability of a local alternative urgent response Pathway for this cohort.
- Awareness and confidence within the ACC of this alternative Pathway.
- Accessibility to the alternative Pathway - phone, fax, e-mail etc.

Making it Happen

If clinical telephone triage is to be effective in supporting the patient to access the care they need, first time, every time then staff and clinicians within the ACCs require to have up to date knowledge about the availability of local services. Partnerships have a key role to play in ensuring developments and changes to service provision are communicated, and are clear, accurate and up to date.

Figure 2 overleaf illustrates what the telephone triage model may look like where this is achieved.

STEP 2: SAS PRACTITIONER ASSESSMENT

Even with effective, well informed triage by the ACC, it may be necessary to dispatch an ambulance to more accurately assess the patient and to determine the most appropriate next steps. SAS practitioner assessment at point of care has been constrained by limited access to diagnostic and professional support. The assessment now needs to make use of new technology and decision support from other professionals.

WHERE WE ARE NOW

SAS unsupported assessment

- Limited diagnostic equipment.
- Limited access to clinical support for decision making.
- Limited access to patient information.
- Limited range of "see & treat" protocols.
- Limited referral options.

WHERE WE WANT TO BE

SAS supported assessment

- Good point of care diagnostic equipment.
- Telehealth and professional support for decision making.
- E-health solutions that share information.
- Range of 'see & treat' protocols.
- A menu of alternative Pathway options.

Things to Consider

A range of factors will influence an ambulance clinician's decision to convey an older person to the Emergency Department. These factors include:

- Their assessment and interpretation of clinical need of the older person.
- The expressed patient preference and choice.
- Their prior knowledge (or not) of the patient.
- The presence and influence of a relative or unpaid carer.
- Their perception of the suitability of the patient's home environment.
- Their experience and confidence.
- Awareness of community based alternatives.
- Time of episode.
- Distance from hospital.
- Waiting time at the Emergency Department.

Some older people who phone for an ambulance will not need to attend the Emergency Department. These people can be managed well at home with cooperation / follow up with other services. It is in the older person's best interest to get the care they require as close to their own home as is feasible. Informal triage to determine who can safely be left at home is common practice, albeit with significant local variation in outcomes. Decision support will enable a more standardised approach, and assist practitioners' decision-making on how best to meet the needs of the older person they are attending.

Making it Happen

Sharing Information and Plans

Anticipatory Care Plans and other forms of e-records need to be shared with the full range of care providers involved, including the SAS, NHS 24 and Out of Hours Services, so that all are aware and can respond to the needs and expressed wishes of patients. The Key Information Summary (KIS) has been designed to share a core set of fields from an ACP in order to support people with long term conditions, mental health problems and individuals requiring special alerts. It includes information on medical history, patient wishes, carer details and status with regards to Do Not Attempt Cardiopulmonary Resuscitation. Access to KIS will support NHS 24, SAS and Out of Hours practitioners to make informed and appropriate clinical decisions which support person centred care and choice in the event of unscheduled care episodes.

FAQs: www.ecs.scot.nhs.uk/wp-content/uploads/2012-07-03-KIS-FAQs-V2.2.pdf

A Common Approach to Face to Face Triage

In 2011, a Task and Finish Group reviewed a number of local triage tools for falls and considered the established tools used by the Welsh Ambulance Service and by the North West Ambulance Service. Common features were identified and a standardised national tool developed to enhance the triage and initial emergency assessment of frail older people and those who have fallen. The tool includes a prompt to seek decision support from an appropriate senior clinician and signposts ambulance practitioners to refer on to local rapid response and falls services.

TRANSFER THE PATIENT TO A&E

Criteria for transfer

Injury requires urgent hospital intervention - eg head injury?
Fracture? Anticoagulated?
Positive FAS Test.
Systolic BP < 90 mmHg.
Pulse < 50 or >120 bpm.
Respiratory Rate <10 or >29.
Temperature < 36.
GCS < 12.

Request professional to professional support

A professional to professional conversation (eg crew to GP) for advice to determine the most appropriate intervention if immediate transfer is not required or is declined.

Criteria for requesting professional to professional support

The patient meets the criteria for transfer but does not wish conveyed.
The patient meets the criteria for transfer but carer / valid ACP requests care at home.
Temperature > 37.5.
GCS 12-15.
Loss of consciousness (do 12 lead ECG).
Minor injury which does not require A&E intervention.
The patient appears confused.

Refer to local intermediate care services (joint health, social care and third sector) if patient is clinically stable but has new support needs.

Criteria for requesting same day or next day response for those not conveyed.

The patient will be alone.

The patient appears confused.

The patient has difficulty with transfers such as bed, toilet, chair.

The patient will have difficulty with washing, dressing and / or toileting.

The patient will have difficulty in preparing meals / hot drinks.

Refer to local services for falls risk assessment and management if the patient is uninjured, clinically stable and adequately supported

Criteria for non-urgent referral (e.g. within 5-10 working days)

The patient has fallen more than once in the last 12 months.

The patient is unsteady on their feet, or has difficulties with their walking or balance. (Reported by patient or observed by SAS attendee).

The patient experienced a blackout when they fell or found themselves on the ground and didn't know why.

Fig 2 – Triage Tool for older faller / frail older person

The role of Professional to Professional Networks

Advice from a suitably trained professional can support the ambulance practitioner to make the decision not to convey with confidence and ensure the appropriate follow up plan is actioned. This clinical advice can be provided by telephone, via a mobile video conference or through a home visit by the professional.

Good Practice Example

Professional to Professional Decision Support

NHS Borders and the Scottish Ambulance Service

The SAS has been testing the principles and outcomes of the use of telephone clinical decision support, provided by GPs. A pilot study of Professional – Professional decision support took place in NHS Borders over 10 months with support from medical management in both the SAS and NHS Borders. The aim of this pilot was to provide clinical support to attending SAS crews whilst on site at the home of a patient where they feel that conveying the person to hospital may not be required. In these circumstances, the paramedic can phone a GP at the local Out of Hours Centre for advice and support.

Key features of the model are:

- Standardised clinical information is recorded by the SAS crew while in the patient's home.
- The GP and paramedic speak while the crew is still in the patient's home. This offers reassurance to the patient that a GP is involved and it is a team decision.
- Letter left with the patient makes it clear what is going to happen next.

This approach has been highly successful with a significant reduction in conveyance rates to hospital. Only 9% of patients in this initial pilot phase were transferred to the Emergency Department, achieving a 5% reduction in attendances at the ED via ambulance.

Risk Assessment and Management

During the pilot a number of risks were identified and steps taken to reduce these to a minimum:

- Team leaders for both the Border Emergency Care Service (BECS) team and the SAS teams met regularly (6-8 weekly and ad hoc if required) to monitor progress.
- Meetings at which the team leaders can meet members of the others team were arranged.
- The Prof to Prof line was discussed at the BECS Salaried GP meeting monthly and on an ad hoc basis if required with the GP clinical line manager.
- IT was a regular item on SAS agendas locally.
- The BECS clinical lead met with SAS crews regularly to share feedback and learning.
- Adverse events reported to NHS Borders were escalated to the Clinical Lead for the Out of Hours Service.
- SAS staff escalated to their team leader who will subsequently escalate to the Clinical Lead for the South East Division.
- Within the NHS Borders governance structure adverse events will feed into the Borders General Hospital governance.

Food for Thought Questions:

Are there Professional to Professional relationships already in place in your area which can support ambulance clinicians?

Where these exist, how well are they used and what are the outcomes?

STEP 3: SAS MANAGEMENT OF THE PATIENT

At this point on the Pathway the ambulance practitioner has decided whether or not to convey the person to the Emergency Department. If the person has not been conveyed to hospital they may be managed by 'see and treat' protocols at the point of care and / or referred for further management by other services. A clear and simple local Pathway and referral protocols are essential to ensure the most appropriate interventions can be accessed promptly. The needs of the individual will determine the nature and urgency of this next stage of the Pathway.

WHERE WE ARE NOW

- Limited communication between SAS, primary, secondary and social care.
- Limited use of 'see and treat' or alternative care Pathways.
- Risk is discharged to partners.
- Learning is only informed by complaints.
- Patient outcomes and experience are not routinely fed back or shared.

WHERE WE WANT TO BE

- Single point to access alternative community services.
- See and treat and alternative Pathways widely known and well used.
- Risks accepted and shared with partners.
- Joint learning also celebrates success.
- Joint feedback on patient outcomes and experience.

Ongoing management may include:

- Assessment of care at home needs and provision of care to enable an individual to remain safely in their own home.
- Further assessment and treatment of injuries sustained and/or acute ill health which prompted the call.
- Multi-factorial falls risk assessment to establish the causes of the fall and identify interventions which can reduce the risk of further falls and harm. Interventions commonly include, for example, medication review and modification, exercise to improve strength and balance, home environment assessment and management of osteoporosis.
- A period of rehabilitation or re-ablement to restore independence.
- Provision of telecare equipment and response service.

Tools and Resources

Up & About Pathways for the prevention and management of falls and fragility fractures. NHS Quality Improvement Scotland (2010). This document presents all aspects of falls and fracture prevention in the context of a four stage journey of care. It can be found at <http://www.healthcareimprovementscotland.org/default.aspx?page=13131>

Making it Happen

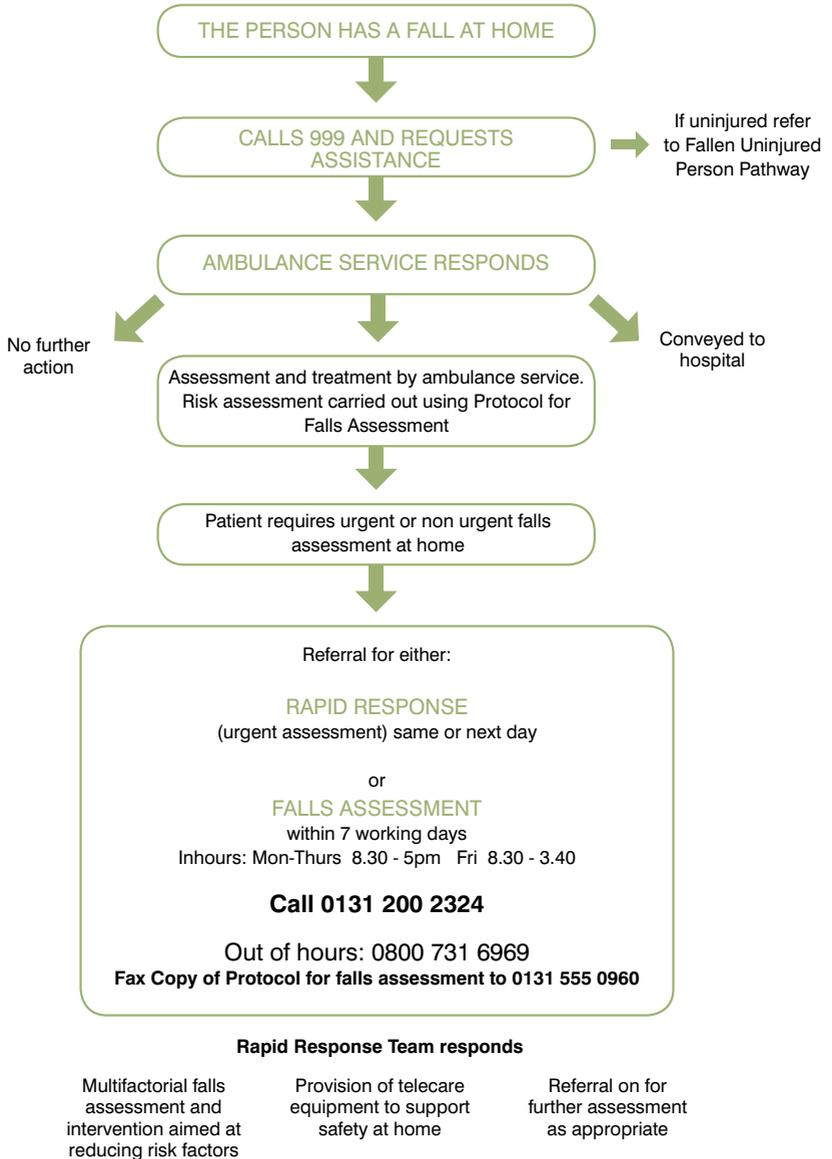
Single Point of Access to Integrated Health and Social Care Services in the Community

The availability and range of intermediate care services will vary locally. However, regardless of the configuration of local services, fast, easy access for the SAS to the most appropriate interventions and follow up is essential. A growing number of Partnerships are developing a single point of access to a suite of community services, some of which are available on a 24/7 basis. Call handlers at the point of access carry-out the further triage and/or assessment required to identify the best immediate management of the individual, based on the urgency and nature of their needs and services available in the locality.

An example of this approach is already in place in Lothian and is illustrated in Figure 3.

Figure 3

FALLS EMERGENCY PATHWAY (EDINBURGH)



Good Practice Example

Uninjured Fallers Partnership Initiative Between:

SAS, Falkirk Council, NHS Forth Valley

This initiative aims to meet the needs of older people the SAS respond to following a fall who are either uninjured and have no urgent medical issues, or who, historically, have been conveyed to hospital because the SAS had no means of addressing concerns regarding the individual's ability to cope at home following a fall.

The main aim of the Pathway is to prevent unnecessary conveyances to A&E and emergency admissions to hospital. This will be achieved by the SAS referring directly to (a) the Fastrack Therapy Service and (b) Falkirk Mobile Emergency Care Service (MECS).

Following their assessment, the SAS fax a 'critical/immediate' referral form to both the MECS and the Fastrack Therapy Service. These services will provide an immediate response and are able to initiate a range of urgent and/or planned interventions, including crisis care for up to five days, planned care at home, the provision of assistive equipment and/or walking aids, falls risk assessment and therapy/rehabilitation and the provision of telehealthcare.

Expected outcomes include:

- Reduced number of calls to the SAS from uninjured fallers.
- Reduced unnecessary SAS conveyances to hospital and emergency admissions for 'social reasons'.
- Early identification of frequent fallers who will benefit from multi-factorial intervention.
- Increased provision of telehealthcare services to frequent fallers.
- Provision of appropriate Crisis Care services geared towards rehabilitation and enablement, preventing some fallers from becoming long term Care and Support at Home service users.

For further information contact:

Linda Saunders, Team Manager, MECS and Telecare Development,
Falkirk Council Linda.saunders@falkirk.gov.uk

Food for Thought Questions:

Do you know how to access urgent community based services in your area?

Is there a single point of contact in your area?

Where patients are already being referred, are staff receiving feedback on the outcome for these patients?

Supporting Improvement

Several factors are critical to ensure everyone involved will have confidence in using the Pathway.

A commitment to put the person first - all involved in urgent assessment need to focus on what an individual wants and needs and take personal responsibility for delivering this, fully informed by the ACP and in discussion at the call or point of care.

Joint education and training - Ambulance service staff will need to understand the benefits to their patients and to the NHS of enhancing the treatment and care they currently provide. They also need to know about the available alternative Pathways and how to access them quickly. Those providing out-of hours services, primary care, intermediate care and voluntary services will need to work closely with the Scottish Ambulance Service to understand how they operate and how best to facilitate referral into their respective services.

Simple referral protocols and coherent accessible Pathways, developed collaboratively across services, will help avoid delays and inappropriate intervention and conveyances.

Effective communication within and across teams, services and organisations and with service users and carers so that all understand how this new way of working will improve the care which is currently provided, and the outcome of that care.

Measurement for Improvement - Measurement is required to drive change and demonstrate the impact of changes being made. The Joint Improvement Team (JIT) has a set of core measures for Reshaping Care.

One of the local improvement measures is to reduce the rate of people aged 65+ presenting to Service following a fall who are conveyed to A&E. To know how you are doing and improve your performance on this measure, sample for analysis over a short time period is necessary.

Take an extract of SAS activity with a code of ‘falls’ over a six month period and identify:

- What percentage was conveyed to A&E?
- What percentage remained at home and were not admitted?
- What proportion was directly referred on to a falls clinic or other community assessment and rehabilitation services?
- What percentage was referred to an intermediate care service as an alternative to attendance at an A&E department?
- Look at the main reasons for the fall, how can these be targeted?
- What time were the calls to SAS over the 24 hour period and on what days of the week?
- What telephone decision support was available to paramedics at these times?

Take an extract of A&E emergency attendances with a code of 'falls' over a six month period and identify:

- What percentage were conveyed to A&E from a care home?
- What percentage was admitted to hospital?
- What percentage was returned home but not admitted?
- What percentage was referred from A&E to a falls clinic or other community assessment and rehabilitation services?
- For those admitted, what proportion were discharged within 24 hours?

Look at a sample of falls A&E attenders in receipt of social care and identify:

- What percentage had been referred for a community alarm screening?
- What percentage had been assessed by an occupational therapist?

ARE YOU READY?

Evidence suggests that up to 70% of all organisational change efforts fail. Quality improvement often takes longer than expected to take hold and longer still to be adopted widely and firmly established. By understanding why changes are not sustained it is possible to put in countermeasures to manage that risk.

Below is a list of the principal reasons why change programmes are not sustained:

1. Loss of leadership interest.
2. Loss of clinical lead input.
3. Loss of team input.
4. Sustainability is planned as an afterthought.
5. Stakeholders are not included.
6. There is no infrastructure in place.
7. There is a loss of focus/monitoring of progress.
8. No whole system view.
9. Lack of adaptability.
10. There is a lack of training.

So - some food for thought prompts as you begin to redesign your local Pathway

- Is your partnership ready to redesign your unscheduled care Pathway for Falls / Frailty?
- Who are the champions and influencers who can make this a local priority?
- Whose senior leadership and support can help you unblock barriers?
- Have you brought together lead stakeholders from primary care, social care and secondary care?
- Are your Intermediate Care team and your CHP Falls lead supportive?
- Who needs to be involved from the local SAS team and your Out of Hours service?
- What support may local community groups and voluntary services offer?
- Are you clear about what 'good' looks like through the lens of patients, carers and staff?
- Have you captured and shared examples that are persuasive and change hearts and minds?
- What are your information needs?
- Have you agreed outcomes / quality indicators?
- Do you support teams to use their own data to reduce variance in practice?
- Are staff learning together across the Pathway?
- Have you drawn on support from your local practice development and improvement advisors?
- How may telehealth enhance the support to ambulance crews?
- How will you share Key Information Summaries with SAS crew?

Have you secured support from your Reshaping Care Change Fund and Local Unscheduled Care Action Plan to test small changes and improve the Pathway?

Annex 1 is a simple self-assessment of organisational readiness to take this work forward.

Top tips from the Pathway Demonstrator Partnerships

- Design referral forms, if required, to be as brief as possible and include essential information only.
- Explore e-health solutions to facilitate the Pathway.
- Clarify local guidance on the need for the SAS to gain the consent of the individual before referring on.
- Provide training and support for the SAS staff who will be making the referrals. Training for SAS call handlers can also be helpful as they are well-positioned to prompt the responding team to consider the new Pathways.
- Provide training and support for the call-handlers at the single point of access.
- Provide feedback to the SAS about the appropriateness of their referrals, and also the resulting positive outcomes experienced by their patients.
- It is useful for the SAS to provide the individual with written information on falls prevention and local services.
- Arrange for staff from the intermediate care services to spend some time shadowing colleagues in the ambulance service.
- Clarify arrangements for out of hours, weekends and public holidays.

Service clinical staff need to:

- Develop knowledge and understanding of the benefits to an older person of avoiding an unnecessary admission to hospital and of the positive outcomes for older people that can be achieved through intervention by intermediate care services.
- Develop knowledge and understanding that falls are not an inevitable consequence of ageing and further falls can be prevented by timely assessment and intervention.
- Understand the benefits to their service from reduced 'non-emergency' call outs- free capacity for blue light calls.

Service Managers need to:

- Get involved in local strategy and planning groups in order to raise the profile of ambulance services and influence decision-making at a local level.
- Contribute to initiatives to gather and share data, learning and good (and poor) practice to inform and influence decisions about services.
- Ensure the operational staff involved in onward referral are routinely and accurately informed about developments within the partnerships so that ambulance clinicians can discuss the referral with the individual/carer, and clearly explain what they can expect to happen next.
- Provide feedback to staff on the frequency of use of these new Pathways and share success.
- Collect data to capture changing practice and help the improvement process. This will include data on conveyances to hospital and how well the new Pathways are used.

NHS Board and Partnership leads need to:

- Work with the ambulance service to ensure they have knowledge of what local services can offer older people who have fallen and how the ambulance service can access these services.
- Ensure fast and easy access for ambulance patients to intermediate care services, where possible through a single point of access.
- Identify clear simple referral protocols- and be clear what information the ambulance staff require to provide when making a referral.

Organisational Readiness Self Assessment Tool

Area	Yes	No	Unsure
Collaboration and Partnership			
Have you engaged your local SAS manager, Intermediate Care lead and Unscheduled Care exec lead?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you engaged your Out of Hours Service, Primary Care leads, Falls lead and Voluntary Sector ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do Pathways for this group already exist and, if so, could they be improved?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you already undertake joint education and training opportunities that may offer a model for learning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do operational, clinical and management colleagues understand the aims and potential benefits from this work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measuring Success			
Do you have a clear vision of what "good" looks like from the perspective of the patient, carer and staff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you know what data and information you have and what you need to share?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you know what evidence (qualitative & quantitative) you want to develop and gather to demonstrate success?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Area	Yes	No	Unsure
Technology Developments			
Do you know of telehealth and/or telecare initiatives which may support this Pathway ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you know how patient information (ECS, KIS) will be shared?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can existing technology be used to streamline the referral Pathway?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leadership and Funding			
Is this a shared priority for the SAS, Intermediate Care leads and Unscheduled Care exec leads?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you accessing appropriate funding to support this work e.g. Change Fund and Local Unscheduled Care Action Plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



NHS
SCOTLAND

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Streszczenie dostępne jest na życzenie w innych językach lub formatach. Proszę skontaktować się telefonicznie z Biurem Tłumaczeń Ustnych i Pismemnych (ang. Interpretation and Translation Service) pod numerem telefonu: 0131 242 8181 i podać numer referencyjny: 08751.

我們可以按要求提供這份摘要的其他語言和格式的版本。請致電愛丁堡市議會傳譯及翻譯服務部 (ITS)，電話 0131 242 8181 並說明檔案編號 08751。

درخواست کرنے سے اس کا خلاصہ دوسری زبانوں اور مختلف شکلوں اور سائز میں حاصل کیا جاسکتا ہے۔ براہ مہربانی انگریزی میں انٹرنیشنل سروس (ITS) سے 0131 242 8181 پر رابطہ کریں اور ریفرنس نمبر 08751 کا حوالہ دیں۔

يوجد ملخص للنص وأشكال طباعة مختلفة عند الطلب. يرجى الاتصال هاتفياً بمكتب الترجمة بواسطة الرقم 0131 242 8181 وذكر الإشارة 08751

विनय सहित मांगने पर सातारा दूरी भाषाओं में उपलब्ध है। कृपया इंटर्प्रेटेशन एवं ट्रांसलेशन सर्विस को 0131 242 8181 पर फोन करें और संकेत नम्बर 08751 बोलिए।

ਖੇਤਰੀ ਕਰਨ ਤੇ ਸਾਹਾਜ ਹੋਰ ਜ਼ਬਾਨਾਂ ਅਤੇ ਰੂਪਾਂ ਵਿੱਚ ਉਪਲਬਧ ਹੈ। ਕਿਰਪਾ ਕਰਕੇ ਇੰਟਰਪਰੀਟੇਸ਼ਨ ਅਤੇ ਟ੍ਰਾਂਸਲੇਸ਼ਨ ਸਰਵਿਸ ਨੂੰ 0131 242 8181 ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ ਅਤੇ ਹਵਾਲਾ ਨੰਬਰ 08751 ਦਿਓ

এস সাহায্য অনুরোধ করলে বিভিন্ন ভাষায় এবং আকারে পাওয়া সম্ভব। ইন্টারপ্রেটেশন এ্যান্ড ট্রান্সলেশন সার্ভিস (আই.টি.এস.) - সাথে 0131 242 8181 নম্বরে যোগাযোগ করে রেফারেন্স নম্বর 08751 উল্লেখ করবেন।