National falls and fracture prevention strategy 2019-2024

Consultation Response

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

The BDA Scotland Board welcomes this strategy overall and agrees that this should improve services for those who experience falls if it is taken up and implemented across Scotland.

We are encouraged that the strategy recognises the multifactorial nature of the causes and solutions to falls and frailty, and that it specifically recognises that a multidisciplinary approach, co-produced with patients will be the best approach.

It is clear that Allied Health Professionals, including dietitians, can play a central role in the delivery of the strategy, and it is positive to see this identified within the document, although there are certainly opportunities to highlight more specifically where certain professional groups could be contributing to falls prevention and rehabilitation.

We also welcome the recognition of the important role of early identification of falls risk for patients with dementia and signposting to support from dietetics and other AHPs, including the specific link with *Connecting People, Connecting Support* (CPCS) framework[1] as part of the AHP Dementia Strategy from Alzheimer Scotland.

We agree entirely with the important to ensure this is a strategy that involves older people and others at risk of falls, and that the language or terminology used is important so as not to alienate older people who may not regard themselves as frail or at risk in any way. Support should be framed in a positive light as much as possible.

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

The BDA Scotland board agree with the currently listed outcomes, but believes there should be a specific outcome related to improved nutrition and hydration amongst at risk people in order to prevent falls and aid rehabilitation after a fall. There is currently an outcome specifically for physical activity and movement (Outcome 3) so feel strongly there should be an equivalent for nutrition and hydration – this will ensure these two important elements are placed on the same footing and afforded the same level of focus.

The evidence of the impact of poor nutrition on frailty, falls and fractures is clear. Studies show 50-64% of frail elderly adults are malnourished, compared to just 2% of fit elderly people[2,3], and those that are malnourished are significantly more likely to suffer a fracture than those that are well nourished[4]. 63% of

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[1] https://www.alzscot.org/ahp

[2] Boulos C, et al. Malnutrition and frailty in community dwelling older adults living in a rural setting. Clin Nutr. 2016;35(1):138-43.

[3] Bollwein J et al. Nutritional status according to the mini nutritional assessment (MNA®) and frailty in community dwelling older persons: a close relationship. Journal of Nutrition, health and ageing. 2013;17 (4) 351 – 356.

[4] Bonjour JP, et al. Bone. Nutritional aspects of hip fractures. 1996;18;3:139S-144S.

hip fracture patients have been reported as malnourished[5], which leads to slower recovery, delayed wound healing, longer rehabilitation and an increased risk of complications.

Further to adding a specific outcome relating to nutrition and hydration, we would encourage the Scottish government to include clearer, more measurable targets alongside those outcomes. This should include a clear articulation of what data will be used (for example on people admitted to hospital or in care who are malnourished or at risk of malnourishment) and if this is not already available, how it will be collected. The eFrailty Index in Primary Care[6] currently being implemented in England might be a useful approach to consider in Scotland.

On page 31, the consultation document recognises that "We need to explore new approaches to meaningful measurement and evaluation to continue to justify investment in interventions that reduce falls and harm from falls" – we agree with this sentiment entirely, and believe the strategy itself should reflect it.

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.

We believe that nutrition has not been given sufficient attention and profile within the strategy, given its central role in preventing falls in both the long and short term, and in helping people to recover from a fall when they do unfortunately occur.

Although nutrition is recognised at a number of points within the strategy, we feel there is insufficient detail, which might be illustrative of a lack of input from dietitians in the formation of the strategy. For example, we would encourage changes in a number of key places to ensure that the sections relating to nutrition recognise the full role of nutrition (and hydration, see q.4) in causing and preventing falls. The role of malnutrition in falls[7,8] in particular has not been sufficiently well recognised.

For example, on page 23, Outcome 5 where is currently states;

- *good nutrition and keeping hydrated: calcium and vitamin D are particularly important for bone health and inadequate nutrition contributes to frailty and loss of muscle mass.*

We would recommend that this is broadened and expanded as follows:

- *Adequate nutrition (food **and fluid**) is very important: Prevention of malnutrition and dehydration may reduce risk of falls. Identification of malnutrition through nutritional screening should be routine for anyone at risk of falls or who has experienced a fall. Consider referral to a dietitian for those identified at risk of malnutrition for nutritional intervention/ treatment. Calcium, vitamin D and protein in conjunction with exercise/ activity is particularly important for bone health and muscle strength. Inadequate nutrition contributes to frailty and loss of muscle mass. People who have progressive neurological conditions for example dementia and Parkinson's disease have a high risk of developing malnutrition and falls.*

Recognising the role of malnutrition, protein, fluid intake and nutrition-related conditions such as anaemia is important so that all health and care staff recognise that diet and hydration as a whole is a vital part of the mix, and don't simply believe it to be related to a small number of issues such as Vitamin

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[5] Murphy, MC et al. The use of the Mini-Nutritional Assessment (MNA) tool in elderly orthopaedic patients. Eur J Clin Nutr. 2000;54:556-562.

[6] https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/efi/

[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6372028/

[8] https://www.researchgate.net/publication/323943524_How_can_dietitians_contribute_to_reducing_falls_risk_A_review_of_the_links_between_nutrition_hydration_and_falls

D or Calcium intake. For example, ESPEN recommend[9] that elderly patient have a significantly increased protein intake to ensure optimum muscle function and reduce of frailty, sarcopenia or falls.

We would also suggest that specific reference is made to tools that can be used to assess and identify malnutrition risk in elderly people in order to reduce the risk of frailty, falls and fracture. Existing tools, developed with dietetic input, that Scottish Government may wish to signpost include the Malnutrition Universal Screening Tool (MUST)[10] and Patients Association Nutrition Checklist toolkit[11].

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

Hydration

Although we would like to see elements relating to nutrition bolstered, we recognise that it is specifically identified within the document. By comparison, we believe hydration's direct role in falls has not been appropriately recognised at all.

While poor nutrition is a causal factor in the medium term, dehydration can acutely impact on somebody's mental and physical state, increasing weakness, dizziness and as a result the risk of falls. Even mild dehydration can have an impact on mental function and can set in very quickly – within days or even hours.

Older and frail people are also more susceptible to dehydration for reasons of physiology, physical and mental capacity and as a result of other conditions or medications. Dehydration not only increases risk of falls and disorientation, but can exacerbate other conditions and increase risk of infection.

Treating and preventing dehydration, just like nutrition, requires a multidisciplinary and multifactorial approach. Some may require direct assistance in order to remain properly hydrated and carers or support staff may require training to monitor and ensure appropriate hydration. The BDA[12], BNF[13] and others[14],[15] have plenty of resources and information about improving hydration for elderly people, especially those who are most vulnerable and at risk.

Access to dietetic expertise for care and health professionals

Given the complexity of malnutrition, which is so often multifactorial, ensuring that older people, care facilities and other healthcare professionals have appropriate access to dietetic expertise will be vital. Often it is about much more than just getting people to eat more or increase their energy intake. It might involve tackling wider issues such as swallowing difficulties, poor physical mobility, mental ill health or loneliness for example.

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

BDA Scotland Board agree that "It is important for people to know that information comes from a trustworthy source" and that therefore welcome Commitment 2 "to build on and improve the availability of information on healthy ageing, falls prevention and bone health in a range of formats." We would encourage Scottish Government to make use of and more widely promote existing guidance and information provided by organisations such as the BDA in their free and publicly available Food Fact Sheets[16]. Using Dietitians as the source of information on diet and nutrition in relation to falls and frailty

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[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4208946/
[10] https://www.bapen.org.uk/screening-and-must/must/introducing-must
[11] https://www.patients-association.org.uk/patients-association-nutrition-checklist-toolkit
[12] https://www.bda.uk.com/foodfacts/fluid.pdf
[13] https://www.nutrition.org.uk/nutritionscience/life/dehydrationelderly.html
[14] https://www.fote.org.uk/wp-content/uploads/2017/03/Guide-to-good-nutrition-and-hydration-in-older-age-2017-FINAL.pdf
[15] https://www.qcs.co.uk/hot-off-press-nutrition-hydration/
[16] E.g. https://www.bda.uk.com/foodfacts/osteoporosis.pdf

will be a key way of ensuring that this information is trustworthy and evidence based. Other trusted, evidence-based tools include the Patients Association Malnutrition Checklist as mentioned above.

Ensuring those at risk of a fall have access to dietetic support to both prevent and aid rehabilitation from falls will be an important way to implement this strategy. Digital solutions, already demonstrated across the UK, can allow people to access dietetic support from their home or within a care facility, without the need to visit a clinical setting.

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

The BDA Scotland Board would be keen to understand what dietetic input there was into the creation of this strategy. Although we welcome the inclusion of nutrition within the strategy, our impression is that the document was developed without the input of nutrition experts, which may explain the greater emphasis on physical activity and lack of detail on nutritional assessment and advice.

It is important that frailty, fracture and falls are viewed primarily as musculoskeletal issues, but much broader in their causes and solutions.

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