SPSP Acute Adult Programme
Falls Change Package

Improvement Hub
Enabling health and social care improvement
Introduction

Welcome to the falls change package

The aim of the falls change package is to provide evidence-based guidance to support the delivery of falls prevention for patients in acute hospital settings. A change package consists of a number of high-level outcomes supported by activities that when tested and implemented, bring about improvement. It brings together what is known about best practices and processes based on evidence from literature, research, and the experiences of others.

Why have we developed this change package?

This change package is for acute hospital teams participating in falls improvement work. It will support teams to use quality improvement methods to improve falls reduction in their service.

How it was developed?

This change package was co-designed and co-produced with clinical and quality improvement experts from NHS boards. The clinical experts were from a range of disciplines such as nursing, including Excellence in Care Leads, physiotherapy, occupational therapy and medicine. A Falls Expert Reference Group (ERG) was convened in October 2020 with representation from across NHS Scotland. A benefit of working in a virtual space was the inclusion and contribution from colleagues in remote, rural and island NHS boards.
Contents and how to use the package

What is included in this change package?

• Driver diagram
• Change ideas
• Guides, tools and signposts to the supporting evidence and examples of good practice, and
• Guidance to support measurement

Guidance on using this change package

This change package is a resource to support NHS boards with falls improvement. It is not expected for teams to work simultaneously on all aspects of the driver diagram. It is designed to assist teams in the identification of areas for improvement relevant to their local context. The change ideas and measures are not exhaustive and it is expected that teams will develop their own to support their identified areas for improvement. We would encourage teams to seek support from their local quality improvement teams in the development of additional measures if required.

Using this package

We have made this an interactive document, if you click on the primary/secondary driver it will take you to additional information including tools and resources relating to that driver. At the top of each page of the secondary drivers, there is an arrow and home button. The arrow button will take you back to the primary driver page and the home button will take you to the main Driver Diagram page.
Setting a project aim

All quality improvement projects should have an aim that is: Specific, Time bound, Aligned to the NHS board’s objectives and Numeric (STAN).

The national aims for SPSP Acute Adult Falls are:

• Reduce inpatient falls by 20%
• Reduce inpatient falls with harm by 30%

by September 2023.

NHS boards are encouraged to set their own local aims specific to their context.

National Aim:
• reduce all falls by 20%
• reduce falls with harm by 30% by Sep 2023

Local Aim:
• reduce all falls by ....
• reduce falls with harm by .... by Sep 2023
**What is a driver diagram?**

A driver diagram visually presents an organisation or teams’ theory of how an improvement goal will be achieved. It articulates which parts of the system need to change, in which way, and includes ideas of how to make this happen. It is used to help plan improvement projects and ensure team engagement.

The primary drivers are the key components of the system that need to change to deliver the aim. The secondary drivers are the processes that influence the primary drivers. Changing the processes outlined in the secondary drivers should change the primary drivers and deliver the aim.

**Change ideas**

Change ideas are specific practical changes the project team can make to alter the processes in the secondary drivers. The following pages provide a list of change ideas for the early recognition and response to patient deteriorating. They are grouped by the primary driver that they influence. Project teams should select change ideas to implement. A range of change ideas will be needed to ensure there are changes to all primary drivers.

This change package does not contain an exhaustive list of change ideas. Project teams can also generate their own change ideas that will help drive change in the secondary drivers. One way of generating ideas is to use the question “How might we?” For example, “How might we engage with patients and their families to improve the experience of care when in hospital?”
### 2021 Falls Prevention Driver Diagram

<table>
<thead>
<tr>
<th>What are we trying to achieve...</th>
<th>We need to ensure...</th>
<th>Which requires...</th>
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<tbody>
<tr>
<td><strong>National Aim:</strong></td>
<td><strong>Person centred care</strong>*</td>
<td>Patient and family inclusion and involvement***</td>
</tr>
<tr>
<td>• reduce all falls by 20%</td>
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<td>Individualised assessment</td>
</tr>
<tr>
<td>• reduce falls with harm by 30%</td>
<td><strong>Promote mobilisation</strong></td>
<td>Targeted evidence based falls risk interventions</td>
</tr>
<tr>
<td>by Sep 2023</td>
<td></td>
<td>Regular review</td>
</tr>
<tr>
<td><strong>Local Aim:</strong></td>
<td><strong>Multidisciplinary Team intervention and communication</strong>*</td>
<td>Patient / family / carer involvement***</td>
</tr>
<tr>
<td>• reduce all falls by ....</td>
<td></td>
<td>Maintain a safe environment</td>
</tr>
<tr>
<td>• reduce falls with harm by ....</td>
<td><strong>Organisational safety culture</strong>*</td>
<td>Meaningful activity</td>
</tr>
<tr>
<td>by Sep 2023</td>
<td></td>
<td>Maximise opportunities for supported positive risk taking</td>
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</tbody>
</table>

*Essentials of Safe Care*

**National Aim:**
- reduce all falls by 20%
- reduce falls with harm by 30% by Sep 2023

**Local Aim:**
- reduce all falls by ....
- reduce falls with harm by .... by Sep 2023

**Which requires...**
- Patient and family inclusion and involvement***
- Individualised assessment
- Targeted evidence based falls risk interventions
- Regular review
- Patient / family / carer involvement***
- Maintain a safe environment
- Meaningful activity
- Maximise opportunities for supported positive risk taking
- Management of communication in different situations***
- Use of standardised communication tools***
- Communication between primary and secondary care
- Multidisciplinary falls risk assessment and intervention
- Psychological safety***
- Staff wellbeing***
- Safe staffing***
- System for learning***

**National Aim:**
- reduce all falls by
- reduce falls with harm by 30%
- by Sep 2023

**Local Aim:**
- reduce all falls
- reduce falls with harm by ....
- by Sep 2023

*Essentials of Safe Care*
<table>
<thead>
<tr>
<th>Secondary drivers</th>
<th>Change ideas</th>
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</thead>
<tbody>
<tr>
<td>Patient and family inclusion and involvement</td>
<td>Person centred visiting</td>
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<td>Conversation with patient / family about falls history</td>
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<td>Provide falls risk information to patient / family</td>
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<td>Individualised assessment</td>
<td>Timely initial falls risk assessment</td>
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<td>Early identification of delirium</td>
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<td>Early identification of frailty (CGA)</td>
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<td>Monitor patterns of behavior</td>
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<tr>
<td>Targeted evidence based falls risk interventions</td>
<td>Person centred care planning documentation</td>
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<tr>
<td></td>
<td>Risk based care rounding (or equivalent)</td>
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<td>Daily review of person centred care planning documentation</td>
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<td>Regular review</td>
<td>Structured ward round</td>
</tr>
<tr>
<td></td>
<td>Post-fall review</td>
</tr>
</tbody>
</table>
Person centred care

Evidence and Guidelines:
A Comprehensive Systematic Review of Visitation Models in Adult Critical Care Units within the Context of Patient and Family-Centred Care
University of York, 2011, Ciufo D, et al.
Practicing Realistic Medicine Scottish Government, 2018
Improving Clinician Carer Communication for Safer Hospital Care: Study of 'TOP 5' Strategy Patients with Dementia Luxford et al, 2015

Tools and Resources:
Shared Decision Making in Realistic Medicine: What Works
Scottish Government, 2019
Care Planning, Involvement and Person-Centred Care Social Care Institute for Excellence, 2017
What Matters to you? 2020
Always Events. NHS UK

Virtual Visiting HIS, Healthcare Improvement Scotland, 2020
'Not safe for discharge'? Words, Values, and Person-Centred Care
Hyslop, 2020
The Health Literacy Place, Tools and Techniques NHS Education for Scotland, 2021
Person centred care

**Evidence and Guidelines:**
- Comprehensive Geriatric Assessment [NICE Quality standard QS136, 2016](https://www.nice.org.uk/guidance/qs136)
- Comprehensive Geriatric Assessment Older Adults Admitted Hospital [Cochrane Database of Systematic Reviews, 2017, Ellis G et al.](https://doi.org/10.1002/14651858.CD011225)
- Preventing falls in older people: assessing risk and prevention [NICE Clinical guideline CG161, 2013](https://www.nice.org.uk/guidance/cg161)
- SIGN: Risk reduction and management of delirium [Healthcare Improvement Scotland, 2019](https://www.his.scot/)
- Falls in older people [NICE Quality standard, 2015](https://www.nice.org.uk/guidance/qs083)
- Rapid Clinical Test for Delirium [The 4AT](https://doi.org/10.1001/jamapediatrics.2020.0577)
- A hospitalist's role in preventing patient falls [Keuseman & Miller, 2020](https://doi.org/10.1001/jamapediatrics.2020.0577)

**Tools and Resources:**
- [ihub Delirium Resources](https://www.nhbs.org.uk/delirium) [Healthcare Improvement Scotland](https://www.his.scot/)
- [ihub Frailty Resources](https://www.nhbs.org.uk/frailty) [Healthcare Improvement Scotland](https://www.his.scot/)
- Acute Care Toolkit 3: Acute Care for Older People Living with Frailty [Royal College of Physicians](https://www.rcplondon.ac.uk/sites/default/files/Acute%20Care%20Toolkit%203%20-%20Acute%20Care%20for%20Older%20People%20Living%20with%20Frailty.pdf)
Person centred care

Targeted evidence based falls risk interventions
Person centred care planning documentation
Risk based care rounding (or equivalent)
Daily review of person centred care planning documentation

Evidence and Guidelines:
- Personalised Care Planning for Adults with Chronic or Long-term Health Conditions Cochrane, 2015, Angela Coulter, et al.
- Falls in Older People: Assessing Risk and Prevention NICE Clinical Guideline CG161, 2013
- Preventing Falls in Older People During a Hospital Stay NICE Clinical guideline CG161, 2013
- SIGN: Management of Osteoporosis and the Prevention of Fragility Fractures Healthcare Improvement Scotland, 2021
- Care of Older People in Hospital Standards Healthcare Improvement Scotland, 2015
- A Hospitalist's Role in Preventing Patient Falls Keuseman & Miller, 2020
- Interventions for Preventing Falls in Older People in Care Facilities and Hospitals Cameron et al, 2018

Tools and Resources:
- ihub SPSP Acute Adult - Falls Resources Healthcare Improvement Scotland
- Realistic Medicine Module NHS Education for Scotland
- Caring Conversations My Home Life Scotland, 2021
- Enhancing Person-centred Care NHS Education for Scotland
- Bedside Vision Check for Falls Prevention Royal College of Physicians
- Managing Falls and Fractures in Care Homes for Older People Care Inspectorate
Evidence and Guidelines:
- Falls in Older People: NICE Quality standard, 2015
- Care of Older People in Hospital Standards: Healthcare Improvement Scotland, 2015
- Chapter 28 Structured Ward Rounds: NICE Guideline, 2017

Tools and Resources:
- Modern Ward Rounds: Royal College of Physicians
- CEC - Structured Ward Rounds – Patricia’s Story: YouTube, 2015
- Rapid response report: Essential care after an inpatient fall (rcplondon.ac.uk): National Patient Safety Agency
<table>
<thead>
<tr>
<th>Secondary drivers</th>
<th>Change ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient / family / carer involvement</td>
<td>Test ‘What matters to you?’</td>
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<td>Personal outcomes discussions</td>
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<td>Family involvement in therapy sessions</td>
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<tr>
<td>Maintain a safe environment</td>
<td>Desks in bay with staff member presence</td>
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<td></td>
<td>Seats placed around the ward for patients to rest</td>
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<td>Bed rail assessment to inform plan of care</td>
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<td>Meaningful activity</td>
<td>Use of volunteers</td>
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<td>Risk enablement to encourage patient mobility</td>
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<td>Group based exercise programmes</td>
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<td>Structure staff and ward activity</td>
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<tr>
<td>Maximise opportunities for supported positive risk taking</td>
<td>Posters of activities around ward e.g. sit to stand at bed space</td>
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<td>Communication of patient mobility needs e.g. I Can</td>
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<td></td>
<td>Daily plan for patients to get up and dressed</td>
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<tr>
<td></td>
<td>Individualised prescribed mobility plans with visual exercise prompts</td>
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</table>
Promote mobilisation

Patient / family / carer involvement
Test ‘What matters to you?’
Personal outcomes discussions
Family involvement in therapy sessions

Evidence and Guidelines:
The Health Foundation: Person Centred Care from Ideas to Action Royal Health Foundation, 2014
Effectiveness of Patient-centered Interventions on Falls in the Acute Care Setting Compared to Usual Care: A Systematic Review Avanecan et al, 2017
Outcomes of Mobilisation of Vulnerable Elders in Ontario (MOVE ON): A Multisite Interrupted Time Series Evaluation of an Implementation Intervention to Increase Patient Mobilisation Liu et al, 2018
The Impact of Person-centred Care on Patient Safety: An Umbrella Review of Systematic Reviews Rossiter et al, 2020

Tools and Resources:
Falls Prevention in Hospital: a Guide for Patients, their Families and Carers Royal College of Physicians, 2016
What Matters to You Healthcare Improvement Scotland, 2021
What Happened to my Legs when I Broke my Arm Aims Medical Science, Harvey JA, et al, 2018
CollaboRATE Tool to Measure Impact of Shared Decision Making Glyn Elwyn
**Promote mobilisation**

- Maintain a safe environment
- Desks in bay with staff member presence
- Seats placed around the ward for patients to rest
- Bed rail assessment to inform plan of care

**Evidence and Guidelines:**
- [Prevention of Falls in Hospital](Clinical Medicine, 2017, Morris & O’Riordan)
- [The Use of Non-slip Socks to Prevent Falls among Hospitalized Older Adults: A Literature Review](Geriatric Nursing, Hartung & Lalonde, 2017)
- [Interventions for Preventing Falls in Older People in Care Facilities and Hospitals](Cochrane Database of Systematic Reviews, 2018)
- [Nursing Unit Design, Nursing Staff Communication Networks, and Patient Falls: Are they Related?](HERD, Brewer et al, 2018)

**Tools and Resources:**
- [Bed Rails: Management and Safe Use](UK Government, 2021)
- [RCP: Fall Safe Resources – Bed Rail Assessment](Royal College of Physicians)
- [Do Portable Nursing Stations within Bays of Hospital Wards Reduce the Rate of Inpatient Falls](Age & Ageing, Ali et al, 2018)
Promote mobilisation

Evidence and Guidelines:
- A toolkit for Improving Compassionate Care, Picker, 2017
- Occupational Therapy in the Prevention and Management of Falls in Adults, Royal College of Occupational Therapists, 2020
- Physical Activity Programs for Balance and Fall Prevention in Elderly: A systematic Review, Medicine, Thomas et al, 2019
- Comparisons of Interventions for Preventing Falls in Older Adults: A Systematic Review and Meta-analysis, JAMA, Tricco et al, 2017
- Outcomes of Mobilisation of Vulnerable Elders in Ontario (MOVE ON): A Multisite Interrupted Time Series Evaluation of an Implementation Intervention to Increase Patient Mobilisation, Age & Ageing, Liu et al, 2018

Tools and Resources
- The Role of Volunteers in the NHS, The King’s Fund, 2018
- Volunteering in Health and Care, The King’s Fund, 2013
- Active Hospitals, Public Health England, 2020
- Moving Medicine, Faculty of Sport and Exercise Medicine UK, 2021
- Care about Physical Activity, Care Inspectorate
- Using Activity Passports to Support People to Improve their Health and Wellbeing, Care Opinion, McInally L, 2018
- Improving Patient Activity in Hospital, Care Opinion, McInally L, 2017
Promote mobilisation

Maximise opportunities for supported positive risk taking
Posters of activities around ward e.g. sit to stand at bed space
Communication of patient mobility needs e.g. I Can
Daily plan for patients to get up and dressed
Individualised prescribed mobility plans with visual exercise prompts

Evidence and Guidelines:

Preventing Falls in Older People During a Hospital Stay NICE Clinical guideline CG161, 2013
COVID-19 Technology for Strength and Balance NIHR Older People & Frailty Policy Research Unit
Falls Management Exercise (FaME) Implementation Toolkit NIHR Applied Research Collaboration East Midlands, 2021
The Use of Non-slip Socks to Prevent Falls Among Hospitalized Older Adults: A Literature Review Geriatric Nursing, Hartung & Lalonde, 2017

Tools and Resources:

Later Life Training Return on Investment – FaME (PSI) and Otago – Cost Effective Interventions for Falls Webinar
End PJ Paralysis 2020
Moving Medicine Faculty of Sport and Exercise Medicine UK, 2021
Safety Briefings Institute for Healthcare Improvement
Huddles Institute for Healthcare Improvement
# Essentials of Safe Care Driver Diagram

**Primary Driver**

Multidisciplinary Team intervention and communication

## Secondary drivers

- Management of communication in different situations
- Use of standardised communication tools
- Communication between primary and secondary care
- Multidisciplinary Team falls risk assessment and intervention

## Change ideas

<table>
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<tr>
<td>Management of communication in different situations</td>
<td>Hospital huddles</td>
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<td>Use of standardised communication tools</td>
<td>Structured communication (SBAR)</td>
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<td>Communication between primary and secondary care</td>
<td>Immediate discharge Letter</td>
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<td>Multidisciplinary Team falls risk assessment and intervention</td>
<td>Standardised handover from ambulance to hospital</td>
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<td>Joint primary and secondary care falls groups</td>
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<td>Multidisciplinary Team ward huddles</td>
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Multidisciplinary Team intervention and communication

Management of communication in different situations
Hospital huddles
Ward safety briefs

Evidence and Guidelines:
- The Impact of Post-fall Huddles on Repeat Fall Rates and Perceptions of Safety Culture: A Quasi-experimental Evaluation of a Patient Safety Demonstration Project BMC Health Services Research, Jones et al, 2019

Tools and Resources:
- Safety Briefings Institute for Healthcare Improvement
- Huddles Institute for Healthcare Improvement
Multidisciplinary Team intervention and communication

Evidence and Guidelines:

Tools and Resources:
- QI Tools - SBAR (NHS Education Scotland)
- SBAR - Situation-Background-Assessment-Recommendation (East London NHS Foundation Trust)
- Tools for Improvement - Improving Clinical Communication Using SBAR (1000 Lives Plus, NHS Wales)
Multidisciplinary Team intervention and communication

- Communication between primary and secondary care
- Immediate discharge letter
- Standardised handover from ambulance to hospital
- Joint primary and secondary care falls groups

Evidence and Guidelines:

Tools and Resources:
Up and About NHS Health Scotland
National Falls and Fracture Prevention Strategy 2019-2024 Draft Scottish Government, 2019
Multidisciplinary Team intervention and communication

Evidence and Guidelines:
- Falls in Older People: Assessing Risk and Prevention NICE Clinical Guideline CG 161, 2013
- Preventing Falls in Older People During a Hospital Stay NICE Clinical Guideline CG 161, 2013
- Implementing Multidisciplinary Ward Safety Huddles To Improve Situation Awareness QI Central, RCPCH, 2019

Tools and Resources:
- ihub Delirium Resources Healthcare Improvement Scotland
- ihub Frailty Resources Healthcare Improvement Scotland
- Clinical Update: Preventing Falls in Hospital Chartered Society of Physiotherapy, 2017
- Occupational Therapy in the Prevention and Management of Falls in Adults Royal College of Occupational Therapists, 2020
<table>
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<tr>
<th>Secondary drivers</th>
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<tr>
<td>Psychological safety</td>
<td>Compassionate leadership at all levels</td>
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<td>Staff wellbeing</td>
<td>Listening to the workforce and identifying areas for improvements</td>
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<td>Staff education and awareness</td>
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<td>System for learning</td>
<td>Post-falls staff debrief</td>
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<td>Collective leadership approach</td>
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<td>Test ideas for improvements in a timely manner</td>
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<td>Effective rostering</td>
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<td>Quality improvement and measurement support</td>
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<td>Real-time staff risk assessment</td>
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<td>Involvement of falls coordinators in improvement work</td>
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<td>Mitigation</td>
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<td>Establish local falls groups with MDT representation</td>
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<td>Structured 1:1 time</td>
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<td>Visible supportive leadership</td>
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<td>Celebrate success</td>
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Organisational safety culture

Evidence and Guidelines:

- The 4 Stages of Psychological Safety: Defining the Path to Inclusion and Innovation Clark TR, 2020

Tools and Resources:

- Leadership Walk-rounds and Safety Conversations Healthcare Improvement Scotland
- Safety Culture Discussion Tool NHS Education for Scotland
- The Importance of Psychological safety – Edmondson YouTube, 2020
- Essentials of Safe Care, Readiness for Change Assessment & Prioritisation Tool Healthcare Improvement Scotland, 2021
Organisational safety culture

Evidence and Guidelines:
- Framework for Improving Joy in Work Institute for Healthcare Improvement, 2017
- National Trauma Training Programme Project Lift, 2020

Tools and Resources:
- National Wellbeing Hub for Health and Social Care Staff Healthier Scotland
- Coaching for Wellbeing Resources The Scottish Social Service Council
- 3 Things You Can Learn From Marriott About Taking Care Of Employees Forbes, Gibbons, 2020
- Upside Down Management Timpson, 2021
- Understanding staff wellbeing Picker Institute Europe, Paparella G, 2015
Organisational safety culture

Evidence and Guidelines:

Tools and Resources:
Safe Sustainable and Productive Staffing Case Studies NHS England
Staffing Workload Tools Healthcare Improvement Scotland
Safe Staffing Healthcare Improvement Scotland
A Call to Learn from What Works Well Learning from Excellence
Organisational safety culture

System for learning
Post-falls staff debrief
Quality improvement and measurement support
Involvement of falls coordinators in improvement work
Establish local falls groups with MDT representation

Evidence and Guidelines:
- An Organisation Without a Memory: A Qualitative Study of Hospital Staff Perceptions on Reporting and Organisational Learning for Patient Safety
- Reliability Engineering & System Safety, Sujan M, 2015
- Measuring Safety Culture The Health Foundation, 2011
- The Measuring and Monitoring of Safety The Health Foundation, 2013
- The 'How to' Guide for Reducing Harm from Falls Patient Safety First, 2009
- The Impact of Post-Fall Huddles on Repeat Fall Rates and Perceptions of Safety Culture: A Quasi-Experimental Evaluation of a Patient Safety Demonstration Project BMC Health Services Research, Jones et al, 2019

Tools and Resources:
- A call to Learn from what Works Well Learning from Excellence
- Achieving Sustainable Change NHS Education for Scotland
- Quality Improvement Made Simple, What Everyone Should Know about Health Care Quality Improvement The Health Foundation, 2021
Measurement is an essential part of improvement as it helps the project team understand if the changes they are making are leading to improved care. Below you will see an outline of three types of measures used in improvement and a link to the measurement framework.

**Outcome measures**
Outcome measures are used to understand if the changes are resulting in improvements towards the aim.

**Process measures**
Process measures demonstrate that change ideas are improving the underlying processes that contribute towards falls prevention.

**Balancing measures**
Balancing measures are used to determine if the changes are affecting things elsewhere in the system (unintended consequences).

More detailed information can be found in the measurement framework.
Contact details

<table>
<thead>
<tr>
<th>Edinburgh Office</th>
<th>Glasgow Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gyle Square</td>
<td>Delta House</td>
</tr>
<tr>
<td>1 South Gyle Crescent</td>
<td>50 West Nile Street</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>Glasgow</td>
</tr>
<tr>
<td>EH12 9EB</td>
<td>G1 2NP</td>
</tr>
<tr>
<td>0131 623 4300</td>
<td>0141 225 6999</td>
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</tbody>
</table>

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#spsp247 #spspFalls