Rethinking Unscheduled Care: Strategic Planning Considerations

A companion resource

July 2023

Contents

Executive Summary

During 2021-22, Healthcare Improvement Scotland, Scottish Government, NHS 24, Police Scotland, and the Scottish Ambulance Service conducted a design investigation validated by user research on people's experiences and journey through unscheduled care. Rethinking Unscheduled Care: A design investigation into people's experiences and journey through unscheduled care adds to the evidence base of how people experience the existing system. This companion piece considers these findings through a strategic planning lens and identifies actionable learning insights for the design and delivery of unscheduled care services.

The design investigation identified three reasons why people access unscheduled care (see Figure 1). These reasons are all driven by different needs and require different responses to address need earlier and reduce demand for unscheduled care. Each of these demands has potential failure demand that occurs in unscheduled care.

Figure 1: Potential failure demand that occurs in unscheduled care

1. Sudden accident or illness

Where unnecessary demand for unscheduled care can arise from people presenting to A&E with minor injuries or the lack of availability of routine care leads people to seek urgent care.

Failure demand

People with minor injuries present to A&E, or the lack of availability of routine care leads people to seek urgent care.

2. Frailty, palliative and long term conditions

Where anticipatory care planning that has not been done well can lead to urgent care needed at a point of crisis.

Failure demand

Anticipatory care planning has not been done with the support network, and urgent care is needed at a point of crisis.

3. Multiple disadvantage

Where failure to provide coordinated care due to availability and a complex referral process can lead to a crisis response required within unscheduled care

Failure demand

Crisis response as a result of failure to provide coordinated care due to availability and a complex referral process.

When considered through a strategic planning lens, we identified the following implications of the design investigation.

1	The system isn't organised in a way that fits how people need services and this:

- places the burden on people to 'find the right place'
- requires people to find workarounds – which is easier for people who are well resourced leading to inequitable access
- results in people regularly not 'fitting' the way the services want them to and compromising the care they receive
- results in misaligned expectations where services have criteria and offerings that don't match with what people need.

2	The system doesn't follow the lead of the person and seeks information from people in a way that isn't how people seek help.

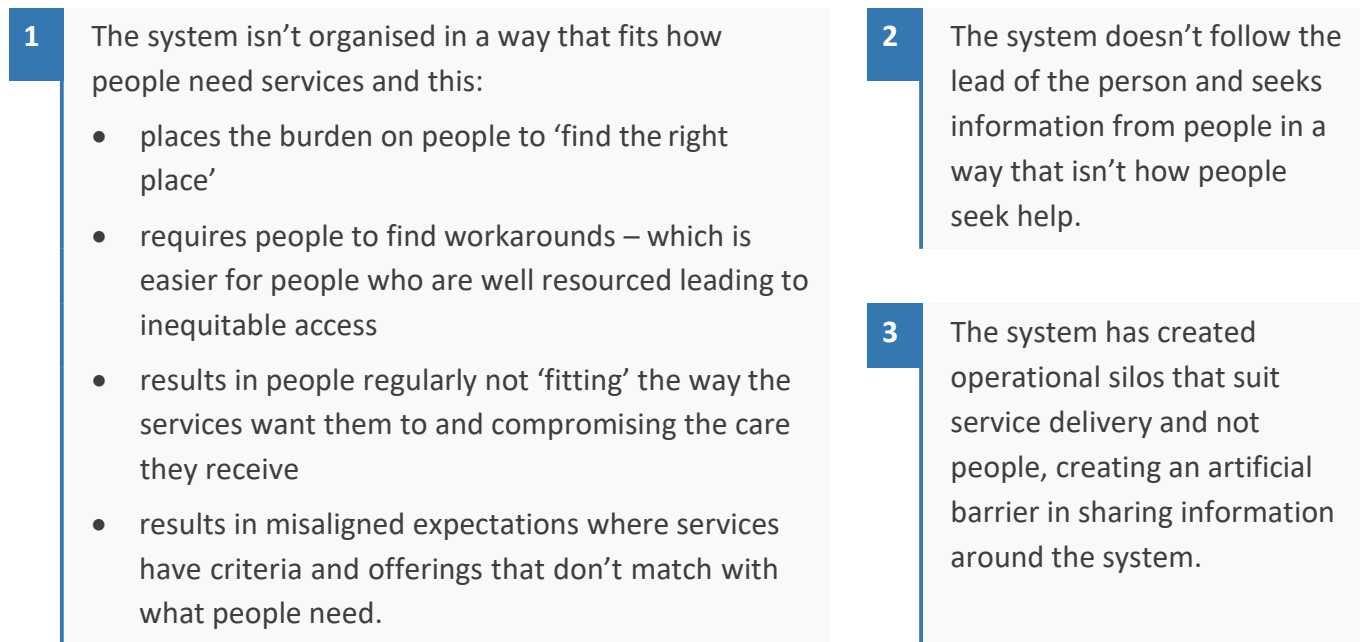|	
3	The system has created operational silos that suit service delivery and not people, creating an artificial barrier in sharing information around the system.

Figure 2 outlines what is clear from both the design investigation user research and our strategic planning analysis.

Figure 2: Findings from design investigation and strategic planning analysis

Our system design has failure built into it – when we fail to meet people's needs right then we see a high demand for unscheduled care as people reach crisis point.

If we considered unscheduled care from a person-centred perspective we would spend **more time thinking about it in the broader system** and not as an isolated system in itself.

Insights from the design investigation challenge us to **set a new strategic direction** for future improvement, redesign and transformation future work.

Rethinking unscheduled care using a user research evidence informed strategic planning perspective means that we take forward the following **actionable learning insights.**

1 Have a shared understanding amongst stakeholders of the definition of unscheduled care and the wider system that it sits within including a shared understanding of what unscheduled care is and isn't suitable for.

4 Widen the role that the third, community and independent sectors play in a system wide approach to bring them proactively around the table to discuss and address upstream drivers of unscheduled care – eg unpaid carers, alcohol and drug services, primary care, elective care, mental health, social care, palliative care, social work and homelessness.

2 Understand why people are accessing unscheduled care and have a shared view about which support should be provided through unscheduled care and which should be better met further upstream to prevent the demand from arising – rather than focusing on where to send someone once they have sought care from unscheduled care.

5 Proactively identify the assets within primary and community settings and within planned/elective care that help to address and ensure they are clearly linked into unscheduled care demand management approaches.

3 Ensure that data and intelligence used to inform decisions includes both data and intelligence from within unscheduled care and data from the broader system to give a more balanced evidence base to make decisions from – eg unpaid carers, alcohol and drug services, primary care, elective care, mental health, social care, palliative care, social work and homelessness.

6 Focus improvement work on services in the wider system beyond unscheduled care that prevent demand for unscheduled care throughout the year as the primary driver for developing a resilient system that reduces winter pressures – eg unpaid carers, alcohol and drug services, primary care, elective care, mental health, social care, palliative care, social work and homelessness.

Introduction

Unscheduled care has regularly been the subject of reviews, research and service redesign processes as we seek to improve the way that a vital, highly demanded, and expensive part of our health and care system works. Two relevant recent reviews are detailed below.

1. **Improving unscheduled care: six essential actions**
   The six essential actions (6EA) work began in 2015 with the purpose to ensure that 95% of all patients attending Emergency Department (ED) are admitted, transferred, or discharged within 4 hours. It developed six essential actions focused on sustainable and continuous improvement including: clinically focused management, use of data to manage demand and capacity, improve both medical and surgical pathways, better care out of hours, and care in or closer to home[1].

2. **The Redesign of Urgent Care**
   This work began in 2020 following findings of the 6EA. This review focused on helping people find the right service in order to reduce the demand for urgent care services. It created and implemented a range of new services including: booking people into Minor Injury Units, Near Me telemedicine service, placing people directly on specialist clinical pathways to remove the need to go to ED for triage and referral[2].

3. **Rethinking Unscheduled Care: A design investigation into people's experiences and journey through unscheduled care**
   During 2021-22, Healthcare Improvement Scotland, Scottish Government, NHS 24, Police Scotland, and the Scottish Ambulance Service conducted a design investigation validated by user research on people's experiences and journey through unscheduled care. [Rethinking Unscheduled Care: A design investigation into people's experiences and journey through unscheduled care](#) adds to the evidence base of how people experience the existing system.

This companion resource

In 2023, the Strategic Planning for Redesign Portfolio within Healthcare Improvement Scotland undertook analysis of the key data, evidence, and reviews to articulate the strategic planning considerations of unscheduled care. This report is designed to support the strategic planning community and health and care decision makers to consider future efforts in relation to unscheduled care.

The design investigation presents us with a new lens to see unscheduled care through. This strategic planning resource is a companion piece to this design investigation, providing actionable learning insights. We have explored the implications for strategic planning from the insights gained from user experience to provide a new way to think about strategic planning for unscheduled care.

What is Strategic Planning

The Strategic Planning for Redesign Portfolio in Healthcare Improvement Scotland, is a national specialist team for strategic planning in health and care in Scotland. We use strategic planning to inform the improvement, redesign, and transformation of the way that services and support are provided in Scotland. Strategic planning describes the process of identifying the needs of your population, setting a clear and agreed-upon vision and objectives, assessing the effectiveness of existing provision, generating and assessing options for future services, and then commissioning, evaluating, and reviewing those services regularly. What makes good strategic planning is outlined in Figure 3.

Figure 3: Key elements of good strategic planning

Good strategic planning used for improvement, redesign and transformation:

takes a **whole system approach** considering the totality of resources across health and care

analyses **emerging trends and population need** against existing support and demand

looks to the future to ensure changes address future need and challenges to stay ahead of long term emerging trends.

The Good Practice Framework for Strategic Planning[3] (see Figure 4) was developed in 2019 and outlines the key features of good strategic planning under five key themes.

Figure 4: The Good Practice Framework for Strategic Planning

Build a planning culture
- Partnership and co-production
- Vision and values
- Breadth of focus
- Capacity
- Leadership

Analyse
- Breadth of data
- Needs assessment
- Supply
- Interpret

Plan
- Gap analysis
- Option generation
- Option appraisal
- Service design

Deliver
- Market/provider relationships and development
- Capacity building
- Service redesign and improvement

Review
- Strategic outcomes
- Strategy and marketing
- Share learning
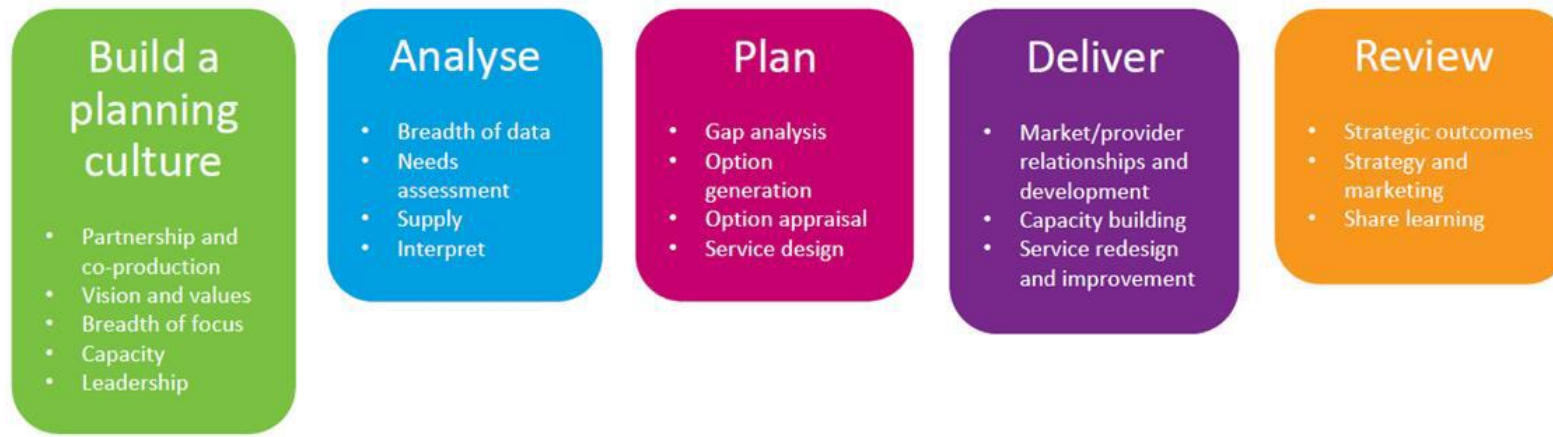
The Strategic Planning implications of the design investigation

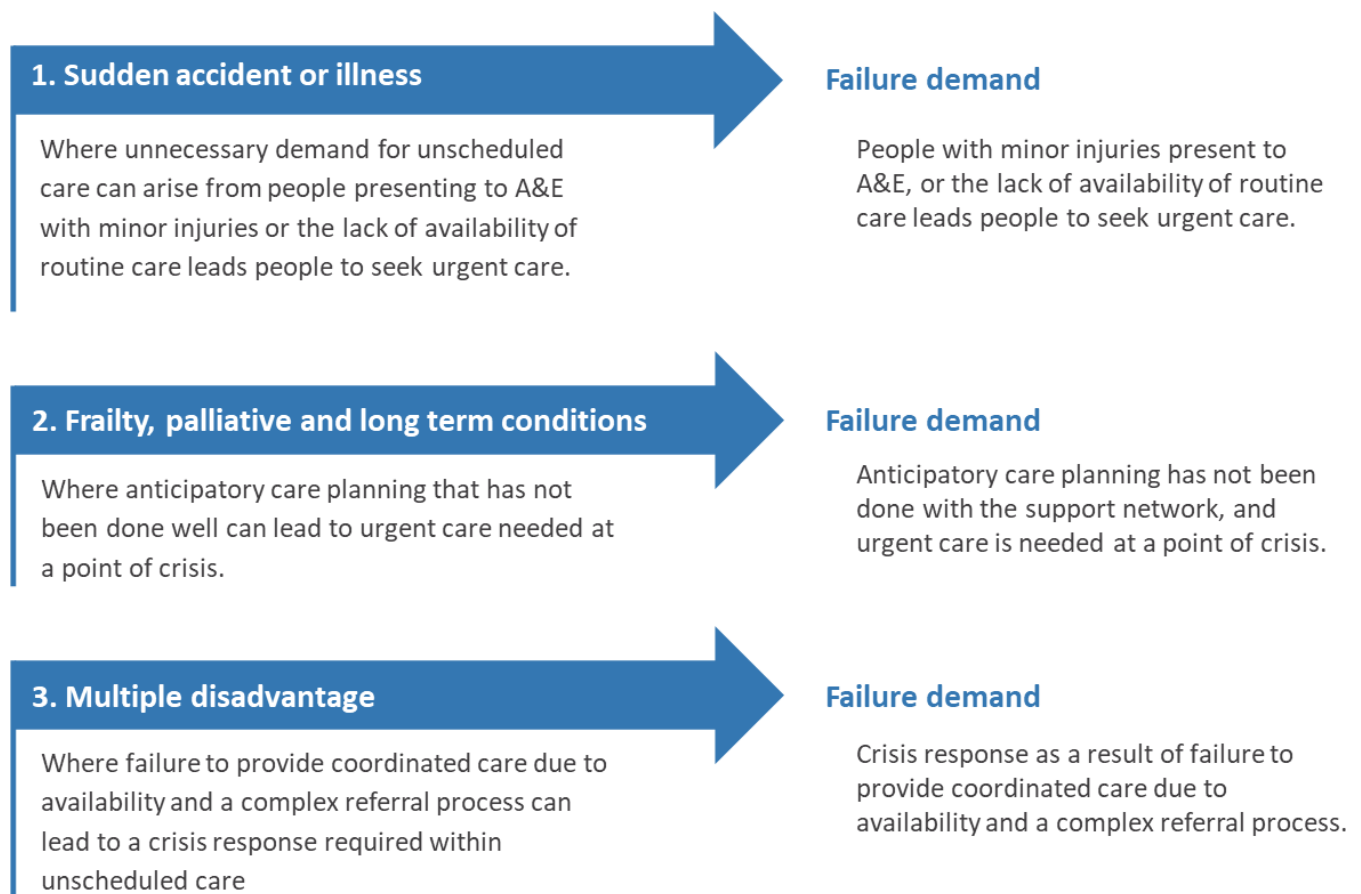This chapter outlines the strategic planning implications of the design investigation conducted by Healthcare Improvement Scotland, Scottish Government, NHS 24, Police Scotland, and the Scottish Ambulance Service during 20210-22.

The findings of the design investigation

The design investigation identified three reasons why people seek unscheduled care (see Figure 5). Each of these demands has potential failure demand that occurs in unscheduled care.

Figure 5: Potential failure demand that occurs in unscheduled care

1. Sudden accident or illness

Where unnecessary demand for unscheduled care can arise from people presenting to A&E with minor injuries or the lack of availability of routine care leads people to seek urgent care.

Failure demand

People with minor injuries present to A&E, or the lack of availability of routine care leads people to seek urgent care.

2. Frailty, palliative and long term conditions

Where anticipatory care planning that has not been done well can lead to urgent care needed at a point of crisis.

Failure demand

Anticipatory care planning has not been done with the support network, and urgent care is needed at a point of crisis.

3. Multiple disadvantage

Where failure to provide coordinated care due to availability and a complex referral process can lead to a crisis response required within unscheduled care

Failure demand

Crisis response as a result of failure to provide coordinated care due to availability and a complex referral process.

The design investigation also identified nine problem statements that reflect concerns around unscheduled care. These statements are grouped under three themes.

Access to and navigation of unscheduled care

1. People don't know what service to access and find different numbers to call confusing.

2. People try to find workarounds based on their knowledge of the system.

3. People are not able to access services effectively because they are not entering the services through the channels the system expects.

Information provision during unscheduled care

4. People don't have the opportunity to tell services all of the information they feel is important, impacting care.

5. People accessing urgent care are often under extreme stress, which can impact their ability to process information, make decisions, or follow advice.

6. People feel the information they are asked for in initial contact is not always relevant and slows down care.

Individual experiences of unscheduled care

7. People often don't have the tools to describe what they need to ensure equity of access.

8. People often repeatedly share information or experience delays because it isn't shared between services.

9. There is a gap between patient expectations and the expectations of service providers.

Strategic Planning implications for unscheduled care

The nine problem statements from the design investigation have the following implications for strategic planning.

1 The system isn't organised in a way that fits the way that people need services and this:

- places the burden on people to 'find the right place'
- requires people to find workarounds – which is easier for people who are well resourced leading to inequitable access
- results in people regularly not 'fitting' the way the services want them to and compromising the care they receive
- results in misaligned expectations where services have criteria and offerings that don't match with what people need.

2 The system doesn't follow the lead of the person and seeks information from people in a way that isn't how people seek help.

3 The system has created operational silos that suit service delivery and not people, creating an artificial barrier in sharing information around the system.

While we already knew that we hadn't yet got unscheduled care right, these new insights from the design investigation help us refocus what we need to do about it (see Figure 6).

Figure 6: Insights from the design investigation

We have **designed a system that has failure built into it** – when we fail to meet people's needs right then we see a high demand for unscheduled care as people reach crisis point.
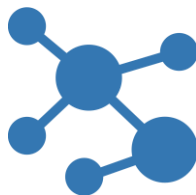
If we considered unscheduled care from a person-centred perspective we would spend **more time thinking about it in the broader system** and not as an isolated system in itself.

Insights from the design investigation challenge us to **set a new strategic direction** for future improvement, redesign and transformation future work.

It is clear that the system is failing to meet people's needs in the right place, at the right time and with the right support. This is driving high demand for unscheduled care leading to greater pressure on our services and workforce, as well as poorer outcomes for people. Many of the current challenges unscheduled care is facing is driven by two particular failures of our system.

System failure 1: unavailability of more suitable care

People are faced with the need to access care not designed for their needs due to the unavailability of more suitable care.

For example, someone attending the ED at night when a minor injury unit is closed or delayed discharge following an inpatient admission.

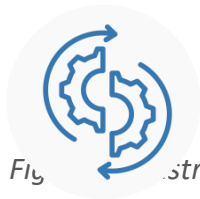## System failure 2: preventable escalation in care need

People are seeing an escalation in care need that is preventable due to insufficient access to routine care and anticipatory care planning.

For example, where someone is admitted due to a polypharmacy reaction due to a lack of availability of care at home services that can support the safe administration of complex medication combinations.

To demonstrate demand for unscheduled care generated from failures in our system, we created four illustrative pathways with personas that represent four examples of possible patient journeys. Personas are fictional characters developed to help understand the needs, experiences, and behaviours of target populations. They are a technique commonly used in service improvement, redesign, and transformation.

These four personas were developed as representations of patient journeys that we know are likely to exist based on our interpretation of the data and evidence available as well as case studies from our national improvement programmes. The four illustrative pathways we explore are:

- [Illustrative Pathway 1 Unnecessary mental health inpatient admittance](#)
- [Illustrative Pathway 2 Management of a long term health condition](#)
- [Illustrative Pathway 3 Preventable escalation of mental health acuity](#)
- [Illustrative Pathway 4 Preventable escalation of frailty](#)

Illustrative pathway 1: Unnecessary mental health inpatient admittance

Figure 1 Illustrative pathway 1

Finlay is brought to an inpatient mental health service for assessment following a police call for someone in distress. The individual is assessed as not needing to be admitted to an inpatient mental health ward.

There is a long waiting time to access psychological services and community mental health team (CMHT) support.

However, the police identified when they attended the call out that Finlay's house is not in a liveable state as it hasn't been maintained or cared for well.

Therefore, the assessment concludes that it is in Finlay's best interest to admit him to an inpatient mental health ward even though their level of acuity is below what would ordinarily justify admitting a patient.

Did you know…

Four in every five police 999 calls do not involve a crime and are about welfare concerns or mental health incidents. [4]

8,197 (38%) of people were waiting over 18 weeks to begin psychological treatment as at December 2022.

2,095 (10%) were waiting over 53 weeks.[8]

24,520 individuals were admitted due to mental health conditions in 2020-21. Of these, 49.5% were admitted to a psychiatric ward.[5]

33% of admissions to psychiatric wards had length of stay between 8 and 28 days.

29% had length of stay between 29 days and 6months.[9]

Average cost of an unplanned admission to a general inpatient ward for a mental health condition in 2019/20 was £22,393.[6]
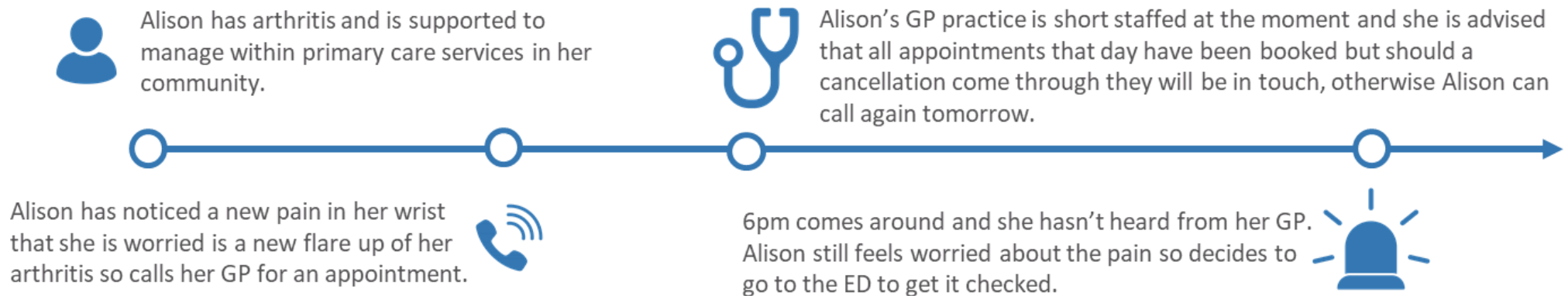
Average cost of an unplanned admission to a psychiatric ward in 2019/20 was £ 28,425; this equates to approximately £446 per bed day.[10]

People living in the most deprived areas were 3 times more likely to experience inpatient mental health care (2020-21 data).[7]

Illustrative pathway 2: Management of a long-term health condition

Figure 8. Illustrative pathway 2

Alison has arthritis and is supported to manage within primary care services in her community.

Alison's GP practice is short staffed at the moment and she is advised that all appointments that day have been booked but should a cancellation come through they will be in touch, otherwise Alison can call again tomorrow.

Alison has noticed a new pain in her wrist that she is worried is a new flare up of her arthritis so calls her GP for an appointment.

6pm comes around and she hasn't heard from her GP. Alison still feels worried about the pain so decides to go to the ED to get it checked.

Did you know…

Despite an increase in GP headcount between November 2019 and March 2022, the overall GP working time equivalent (WTE) has decreased by 3%.[11]

Estimated GP WTE for out of hours services has fallen by 29% between November 2019 and March 2022; falling from 340 to 241.[14]

Those aged <5 years, 75+ years and individuals living in most deprived areas have highest GP Out of Hours contact rates.[12]
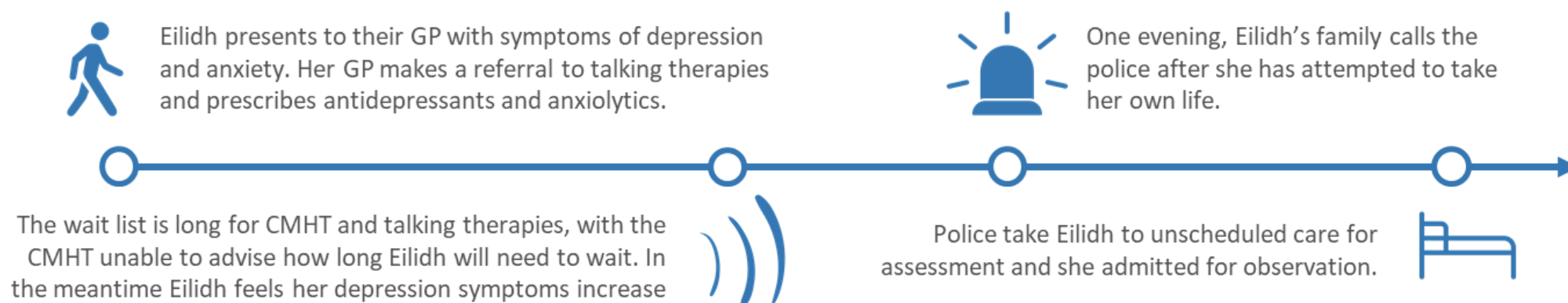
Around 20% of patients who have attended ED could have been managed in another clinically appropriate way.[15]

82,781 potentially preventable admissions due to a chronic or long-term condition were recorded in 2020-21; equating to a total of 605,531 bed days lost.[13]

Illustrative pathway 3: Preventable escalation of mental health acuity

Figure 9. Illustrative pathway 3

Eilidh presents to their GP with symptoms of depression and anxiety. Her GP makes a referral to talking therapies and prescribes antidepressants and anxiolytics.

One evening, Eilidh's family calls the police after she has attempted to take her own life.

The wait list is long for CMHT and talking therapies, with the CMHT unable to advise how long Eilidh will need to wait. In the meantime Eilidh feels her depression symptoms increase

Police take Eilidh to unscheduled care for assessment and she admitted for observation.

Did you know…

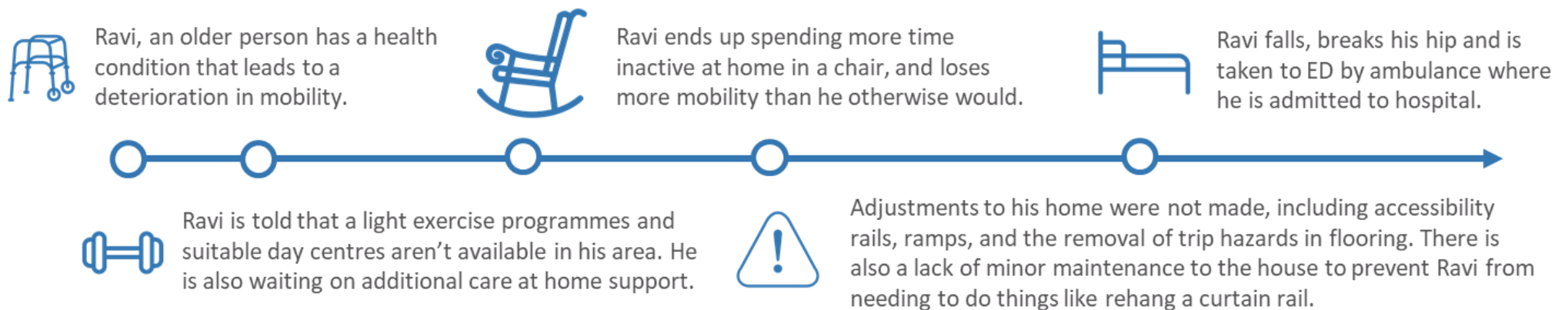|		
19.3% of the Scottish population were prescribed drugs for anxiety / depression / psychosis in 2020-21; this equates to 1,054,374 individuals.[16]	Prevalence of attempted suicide was highest in individuals living in most deprived areas (15% - most deprived vs. 4% - least deprived).[17]	Evidence illustrates links between suicide and deprivation; suicide rates are over 3 times higher in most deprived areas, compared to least deprived areas (23.4 per 100,000 compared to 6.8 per 100,000).[18]
9% (680) of children and young people on the CAMHS waiting list were waiting over 35weeks to begin treatment as at Dec 2022.[19]	22.5% (330) older adults were waiting over 18weeks to begin psychological treatment as at Dec 2022.[20]	13,186 unplanned admissions had a recorded diagnosis of self-harm in 2019/20. On average, each admission costs approximately £1,582; equating to £866 per bed day.[21]

Illustrative pathway 4: Preventable escalation of frailty

Figure 10. Illustrative pathway 4

Ravi, an older person has a health condition that leads to a deterioration in mobility.

Ravi ends up spending more time inactive at home in a chair, and loses more mobility than he otherwise would.

Ravi falls, breaks his hip and is taken to ED by ambulance where he is admitted to hospital.

Ravi is told that a light exercise programmes and suitable day centres aren't available in his area. He is also waiting on additional care at home support.

Adjustments to his home were not made, including accessibility rails, ramps, and the removal of trip hazards in flooring. There is also a lack of minor maintenance to the house to prevent Ravi from needing to do things like rehang a curtain rail.

Did you know…

30% of people aged 65 and over and 50% of people aged 80 and over fall about once a year.[22]	Repair and equipment fitting service in Dumfries and Galloway estimated to have prevented hundreds of falls within first year with an estimated service cost of circa £150,000 a year.[23]
5% of falls lead to fracture and hospitalisation.[24]	As at February 2023, a total of 4,445 were waiting on a care at home package.[25]
Moderate exercise reduces risk of falls by 23% - 32%.[26] [27] [28]	Fall related emergency hospital admissions cost £7,843 per admission.[29]

Considering the wider system

Unscheduled care often acts as a fail-safe or back stop for our health and care system. Those who are in crisis, don't know where else to go, or do not have other support alternatives will often end up reaching out to unscheduled care. If we take EDs as an example, Figure 11 describe the common drivers for why the public will attend an ED and why services such as NHS 24 will often recommend people attend an ED.

Figure 11: Common drivers of ED attendance and reasons for signposting to ED

Drivers of use of EDs by the public	Drivers of signposting to EDs by services
• People find accessing the system easy – they can just turn up rather than booking appointments or requiring one or more referrals over a period of time to access care.	• The service is 24/7 which provides somewhere safe for someone to be signposted to out of hours.
• EDs are well known by the public who may be unaware of other services and support available to them.	• There are no eligibility criteria so are useful for people who do not meet the criteria for other services.
• Most are easily accessible by public transport.	• It manages the risk that someone's condition deteriorates after being advised to wait and see their GP.
• People are able to receive support from high quality staff who provide rigorous and detailed diagnostic testing.	• It provides fast access to a wide range of diagnostics where staff are looking to support someone to receive a fast diagnosis.
• It can be the shortest time for someone to receive a diagnosis or care as referrals to specialists can take weeks or months through referral by primary care services.	

For alternative models and approaches to support people in the right place at the right time and reduce unnecessary reliance on unscheduled care the proposed models need to provide a credible alternative to meeting these objectives. They need to be well known, with good out of hour's provision, accessible eligibility criteria without overly long wait times. Without meeting these requirements we are unlikely to see a meaningful shift in the use of unscheduled care

We need to think about the system beyond unscheduled care

When we think of unscheduled care we often think of this system of services working together with various routes in and triage points (see Figure 12).

Figure 12: Unscheduled care services

But in reality the factors that influence the need and demand for unscheduled care are a much broader system of services (see Figure 13). Provided by a combination of the public sector, private sector, community organisations, and the independent sector.

Figure 13: Broader system of services

Coming back to the reasons why people access unscheduled care from the design investigation, for someone with frailty, palliative and long-term conditions, their system of need to reduce demand for unscheduled care might include the services in pink (see Figure 14).

Figure 14: Service need for people with frailty, palliative and long-term conditions

For someone from multiple disadvantage, their system of need to reduce demand for unscheduled care might include the services in green (see Figure 15).
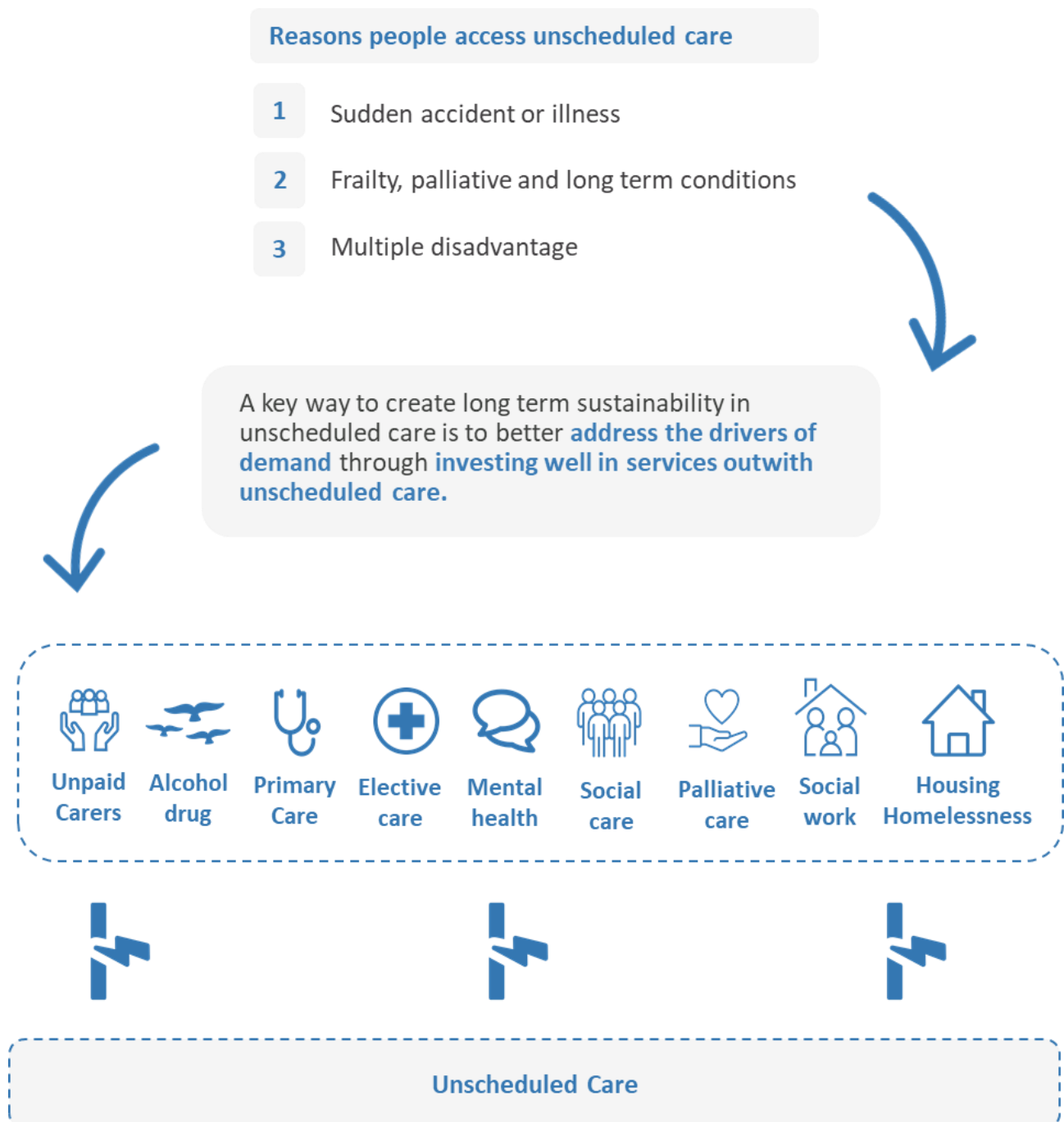
Figure 15: Service need for people with multiple disadvantage

We need a new strategic direction – our actionable learning insights

We need to **shift the way that we see demand for unscheduled care**. Instead of looking at how to divert demand away from unscheduled care once someone has reached out for support, we need to think about how the services that surround unscheduled care can be seen as assets in reducing the need and demand for unscheduled care – as outlined in Figure 16.

Figure 16: How to create long-term sustainability in unscheduled care

Reasons people access unscheduled care

1   Sudden accident or illness

2   Frailty, palliative and long term conditions

3   Multiple disadvantage

A key way to create long term sustainability in unscheduled care is to better **address the drivers of demand** through **investing well in services outwith unscheduled care.**

Unpaid Carers • **Alcohol drug** • **Primary Care** • **Elective care** • **Mental health** • **Social care** • **Palliative care** • **Social work** • **Housing Homelessness**

Unscheduled Care

Rethinking unscheduled care using a user research evidence informed strategic planning perspective means that we take forward the following **actionable learning insights.**

| 1 | Have a shared understanding amongst stakeholders of the definition of unscheduled care and the wider system that it sits within including a shared understanding of what unscheduled care is and isn't suitable for. |

| 4 | Widen the role that the third, community and independent sectors play in a system wide approach to bring them proactively around the table to discuss and address upstream drivers of unscheduled care – eg unpaid carers, alcohol and drug services, primary care, elective care, mental health, social care, palliative care, social work and homelessness. |

| 2 | Understand why people are accessing unscheduled care and have a shared view about which support should be provided through unscheduled care and which should be better met further upstream to prevent the demand from arising – rather than focusing on where to send someone once they have sought care from unscheduled care. |

| 5 | Proactively identify the assets within primary and community settings and within planned/elective care that help to address and ensure they are clearly linked into unscheduled care demand management approaches. |

| 3 | Ensure that data and intelligence used to inform decisions includes both data and intelligence from within unscheduled care and data from the broader system to give a more balanced evidence base to make decisions from – eg unpaid carers, alcohol and drug services, primary care, elective care, mental health, social care, palliative care, social work and homelessness. |

| 6 | Focus improvement work on services in the wider system beyond unscheduled care that prevent demand for unscheduled care throughout the year as the primary driver for developing a resilient system that reduces winter pressures – eg unpaid carers, alcohol and drug services, primary care, elective care, mental health, social care, palliative care, social work and homelessness. |

References

We have drawn on a wide range of evidence and data sources to inform the conclusions drawn in this report. This has been supplemented with knowledge developed from our experience in both operational service settings and as strategic planners to help develop realistic and relevant conclusions.

The full list of evidence and data sources is included below.

[1] https://www.gov.scot/publications/improving-unscheduled-care-six-essential-actions/

[2] https://www.gov.scot/publications/nhs-scotland-redesign-urgent-care-first-national-staging-review-report-1-december-2020-31-march-2021/

[3] Healthcare Improvement Scotland (2019). Good Practice Framework for Strategic Planning

[4] BBC (2019). Concern over the time police officers spend at A&E - BBC News

[5] Public Health Scotland (2021). Data explorer - Mental health inpatient activity - 23 November 2021

[6] Public Health Scotland (2023). Mental health inpatient costs and preventable admissions

[7] Public Health Scotland (2021). Data explorer - Mental health inpatient activity - 23 November 2021

[8] Public Health Scotland (2022). Dashboard - Psychological therapies waiting times - Quarter ending December 2022 - Psychological therapies waiting times

[9] Public Health Scotland (2021). Data explorer - Mental health inpatient activity - 23 November 2021

[10] Public Health Scotland (2023). Mental health inpatient costs and preventable admissions

[11] Public Health Scotland (2022). General Practice - GP Workforce and practice list sizes 2012 - 2022 - General Practice

[12] Public Health Scotland (2022). Out of hours primary care services in Scotland - 1 April 2014 to 31 July 2022 - Out of hours primary care services in Scotland

[13] Public Health Scotland (2021). Unscheduled care, potentially preventable admissions

[14] Public Health Scotland (2022). General Practice - GP Workforce and practice list sizes 2012 - 2022 - General

[15] NHS Golden Jubilee (2021). Unscheduled care programmes: NHS Golden Jubilee

[16] Public Health Scotland (2021). ScotPHO profiles (shinyapps.io)

[17] Scottish Government (2019). Chapter 2: Mental Wellbeing - Scottish Health Survey 2019 - volume 1: main report - gov.scot (www.gov.scot)

[18] Public Health Scotland (2021). Suicide statistics for Scotland - Update of trends for the year 2021 - Suicide statistics for Scotland

[19] Public Health Scotland (2023). Dashboard - Child and Adolescent Mental Health Services (CAMHS) waiting times - Quarter ending December 2022 - Child and Adolescent Mental Health Services (CAMHS) waiting times

[20] Public Health Scotland (2023). Dashboard - Child and Adolescent Mental Health Services (CAMHS) waiting times - Quarter ending December 2022 - Child and Adolescent Mental Health Services (CAMHS) waiting times

[21] Public Health Scotland (2023). Mental health inpatient costs and preventable admissions

[22] Public Health England, 2017. Falls and fracture consensus statement: Supporting commissioning for prevention.

[23] DnG24 (2023). Elderly falls prevented through new project

[24] Public Health England, 2017. Falls and fracture consensus statement: Supporting commissioning for prevention.

[25] Public Health Scotland (2023). Dashboard - Social care - Demand for Care at Home Services 28 February 2023

[26] International Journal of Behavioural Nutrition and Physical Activity (2020). Evidence on physical activity and falls prevention for people aged 65+ years: systematic review to inform the WHO guidelines on physical activity and sedentary behaviour

[27] Cochrane (2019). Exercise for preventing falls in older people living in the community

[28] Public Health England (2019) A menu of interventions for productive healthy ageing, for pharmacy teams working in different settings

[29] Public Health England, 2017. Falls and fracture consensus statement: Supporting commissioning for prevention